Agenda
MANGUM CITY HOSPITAL AUTHORITY
December 15, 2020 at 5:00 PM
Mangum Welcome Center 119 E Jefferson

The Trustees of the Mangum City Hospital Authority will meet in regular session on **Tuesday, December 15, 2020, at 5:00 PM**. This session will be held publicly at the Welcome Center 119 E Jefferson. This session will be open to the public and the session will be broadcast live on YouTube (Search YouTube for "City of Mangum". In an effort to follow the Mayors Executive Order that prohibits gatherings of 10 or more people on City owned and operated property, we may ask that visitors move to a location that is not full, or to watch the proceedings live on YouTube. Masks are required to be worn by all those in attendance.

CALL TO ORDER

ROLL CALL AND DECLARATION OF A QUORUM

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

1. Approve the minutes for the special meeting held on December 2, 2020.
2. Approve claims and purchase orders for November 2020.
3. Approve Hospital Departmental Reports.
4. Approve Clinic Operations Report.
5. Approve Hospital Respiratory Polices and Procedures. (Tabled last meeting)
6. Approve Hospital Drug Room Policies and Procedures. (Tabled last meeting).
7. Approve Hospital Emergency Department Policies and Procedures
8. Approve Clinical Policies and Procedures
9. Approve Wound Care Policies and Procedures Form
10. Approve Human Resources Performance Evaluation Policy.
11. Approve 2020 Financial Reports
12. Approve CEO Report.

FURTHER DISCUSSION

REMARKS
Remarks or inquiries by the audience not pertaining to any item on the agenda.

REPORTS

OTHER ITEMS

13. Discussion and Possible Action to approve OGA Business Auto Liability Insurance Renewal Policy.

14. Discussion and Possible Action to approve the hospital roof repair proposal from the City of Mangum.

EXECUTIVE SESSION

15. Discussion and possible action to enter into executive session in accordance with Oklahoma Statute 25 O.S. 307 (B) 1 for the purpose of discussing and the proposed approval of medical staff privileges/credentials between the providers a. b. and c. and Mangum Regional Medical Center.

    a. Sara McDade, APRN - Courtesy Privileges

    b. Dave Spear, MD - Courtesy Privileges

    c. Mary Barnes, APRN - Courtesy Privileges - Re-Credentialing

OPEN SESSION

16. Discussion and possible action with regard to executive session, if necessary.

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, City Manager, City Attorney or City Employees

NEW BUSINESS

Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

ADJOURN

Duly filed and posted at 12: 30 p.m. on the 11th day of December 2020, by the Secretary of the Mangum City Hospital Authority.

Billie Chilson, Secretary

Minutes
Mangum City Hospital Authority Special Session
December 02, 2020 at 5:00 PM
Mangum Welcome Center 119 E Jefferson

The Trustees of the Mangum City Hospital Authority will meet in Special session on Wednesday, December 2, 2020, at 5:00 PM. *This session will be held publicly at the Welcome Center 119 E Jefferson. This session will be open to the public and the session will be broadcast live on YouTube (Search YouTube for "City of Mangum"). In an effort to follow the Mayors Executive Order that prohibits gatherings of 10 or more people on City owned and operated property, we may ask that visitors move to a location that is not full, or to watch the proceedings live on YouTube. Masks are required to be worn by all those in attendance.*

CALL TO ORDER

Chairman Zachary called the meeting to order at 5:03

ROLL CALL AND DECLARATION OF A QUORUM

PRESENT
Cheryl Lively
Ilka Heiskell
Zac Zachary

ALSO PRESENT BY VIDEOCONFERENCE

Dave Andren, City Manager, Billie Chilson, City Clerk/Board secretary
Marie Harrington-Hospital CEO, Daniel Coffin-Hospital CCO, Christie Armstrong-Director of Clinics, Dennis Boyd-Corporate CFO, Chee Her-Corporate Compliance, Robin Klahr-Corporate CCO, Leslie Kerr-Corporate HR, Melissa Tunstall-Hospital Quality/Risk/Compliance Director. Andrea Snider-Hospital Controller, Andrea Rizer-Regional Finance Director

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

Remove items 5 & 6 for further discussion.

Motion made by Heiskell, Seconded by Lively.

Voting Yea: Lively, Heiskell, Zachary

Approve the consent agenda as presented with items 5 & 6 removed.

Motion made by Heiskell, Seconded by Lively.
Voting Yea: Lively, Heiskell, Zachary

1. Approve minutes for the special meeting held on November 5, 2020.
2. Approve claims and purchase orders for October 2020.
3. Approve Hospital Departmental Reports.
4. Approve Clinic Operations Report.
5. Approve Hospital Drug Room Policies and Procedures. Removed to further discussion.
6. Approve Hospital Respiratory Policies and Procedures. Removed to further discussion.
7. October 2020 Financial Reports.
8. October CEO Report.

FURTHER DISCUSSION

Further discussion on items 5 and 6.

5. Approve Hospital Drug Room Policies and Procedures.

6. Approve Hospital Respiratory Policies and Procedures.

Heiskell stated that she is not comfortable approving policies dealing with medical procedures. The other Trustees agreed with this.

Table

Motion made by Heiskell, Seconded by Lively.
Voting Yea: Lively, Heiskell, Zachary

REPORTS

OLD BUSINESS

OTHER ITEMS

9. Discussion and Possible Action to approve contract between Mangum City Hospital Authority d/b/a Mangum Regional Medical Center and VelocityEHS

   This is what is known as MSDS online. Notifies us when something is changed.

   Approve contract with VelocityEHS.

   Motion made by Heiskell, Seconded by Lively.
   Voting Yea: Lively, Heiskell, Zachary

10. Discussion and Possible Action to approve contract between Mangum City Hospital Authority d/b/a Mangum Regional Medical Center and MiMedx Group, Inc.

    Consignment agreement. MiMedx Group is a company that offers skin grafts. Studies show that skin grafts show improvement with wound care. Dr. Morgan has agreed to partner them. This is strictly a consignment agreement.

    Approve the contract with MiMedx Group, Inc.

    Motion made by Heiskell, Seconded by Lively.
    Voting Yea: Lively, Heiskell, Zachary

11. Discussion and Possible Action to approve contract between Mangum City Hospital d/b/a Mangum Regional Medical Center and PARA HealthCare Analytics, an HFRI Company.

    Chargemaster and Price Transparency.

    Approve both the Chargemaster and Price Transparency modules with Para Healthcare Analytics.

    Motion made by Heiskell, Seconded by Lively.
    Voting Yea: Lively, Heiskell, Zachary

EXECUTIVE SESSION

Discussion and possible action to enter into Executive Session in accordance with Oklahoma Statute 25 O.S. § 307(B)1 for the purpose of discussing the proposed approval of medical staff privileges/credentials between above listed providers and Mangum Regional Medical Center. This Executive Session will occur live in a Zoom Videoconference Breakout Room and will not be viewable to the public.

This was a template and should not be on this meeting.

OPEN SESSION

ADJOURN

Adjourn at 5:43 p.m.

Motion made by Heiskell, Seconded by Lively.
Voting Yea: Lively, Heiskell, Zachary

_____ _____

Billie Chilson, Secretary Zac Zachary, Chairman

Mangum Regional Medical Center
Claims List
November 2020

Check#	Ck Date	Amount	Paid To	Expense Description
14976	11/13/2020	2,025.00	ABC BIOMEDICAL	IV Pump rental
14977	11/13/2020	7,106.55	ACCUVEIN	Old - Vein Illuminator
14978	11/13/2020	19.00	AMBS CALL CENTER	Hotline
14962	11/6/2020	1,871.64	AMERIPRIDE SERVICES INC	Linen Services
14979	11/13/2020	1,601.70	AMERIPRIDE SERVICES INC	Linen Services
15013	11/19/2020	1,506.64	AMERIPRIDE SERVICES INC	Linen Services
14980	11/13/2020	635.33	ANESTHESIA SERVICE INC	Telemetry sensors
14963	11/6/2020	3,027.69	AT&T	Fax lines
14981	11/13/2020	1,113.35	BAXTER HEALTHCARE	Pharmacy Supplies
14964	11/6/2020	16,152.00	BENISH AND ASSOCIATES	1099 Provider
14982	11/13/2020	2,100.00	BRIAN BLUTH, M.D.	1099 Provider
15014	11/19/2020	3,173.46	CARDINAL HEALTH	Pharmacy Supplies
14975	11/10/2020	25,000.00	CARDINAL HEALTH 110, LLC	Prepaid Pharmacy Supplies
15046	11/30/2020	15,000.00	CARDINAL HEALTH 110, LLC	Prepaid Pharmacy Supplies
14965	11/6/2020	644.40	CENTERPOINT ENERGY ARKLA	Utilities
14983	11/13/2020	485.78	CENTRAL INFUSION ALLIANCE, INC	PPE Supplies
14966	11/6/2020	898.90	CINTAS CORPORATION #628	Linen Service
14984	11/13/2020	895.45	CINTAS CORPORATION #628	Linen Service
15015	11/19/2020	898.90	CINTAS CORPORATION #628	Linen Service
14967	11/6/2020	6,591.46	CITY OF MANGUM	Utilities
14968	11/6/2020	150,817.92	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15016	11/19/2020	207,468.74	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15017	11/19/2020	1,426.00	COHESIVE MEDIRYDE LLC	Swing bed purchase service
15047	11/30/2020	36,863.86	COHESIVE REVOPS	Billing purchased service
14969	11/6/2020	74,439.29	COHESIVE STAFFING SOLUTIONS	Agency staffing
15018	11/19/2020	27,009.94	COHESIVE STAFFING SOLUTIONS	Agency staffing
14985	11/13/2020	11,158.03	CONEXUS SOLUTIONS LLC	Agency staffing
15019	11/19/2020	12,825.79	CONEXUS SOLUTIONS LLC	Agency staffing
15048	11/30/2020	8,962.09	CONEXUS SOLUTIONS LLC	Agency staffing
14970	11/6/2020	31,900.00	CPSI	Lables
14986	11/13/2020	3,096.00	CPSI	Lables
15020	11/19/2020	1,054.00	CPSI	Lables
15049	11/30/2020	31,900.40	CPSI	Lables
15050	11/30/2020	25.26	CULLIGAN WATER CONDITIONING	Clinic patient water service
15021	11/19/2020	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
14987	11/13/2020	95.00	DOYLE HOPPER	Plumber
14971	11/6/2020	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
14988	11/13/2020	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15051	11/30/2020	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15022	11/19/2020	2,292.00	EMILY EAKLE	Legal Services
15023	11/19/2020	159.70	FEDEX	Postage
14989	11/13/2020	301.00	FIRE EXTINGUISHER SALES & SERV	repair and maintenance
14990	11/13/2020	301.21	FOX BUILDING SUPPLY	Plant Ops Supplies
15024	11/19/2020	76.95	FOX BUILDING SUPPLY	Plant Ops Supplies
15052	11/30/2020	12,978.81	FULLER SELLE LLC DBA PHARMACAR	Payment for outstanding pharmacy debt
14991	11/13/2020	4,320.00	GERAINT HARRIS	1099 Provider
14992	11/13/2020	24.73	GINA DAVIS	Employee Reimbursement
14993	11/13/2020	838.67	GRAINGER	Plant Ops supplies

Check#	Ck Date	Amount	Paid To	Expense Description
15053	11/30/2020	1,084.81	GRAINGER	Plant Ops supplies
15054	11/30/2020	149.85	HAC INC	Dietary food
15025	11/19/2020	363.00	HENGST PRINTING	Pharmacy Supplies
15026	11/19/2020	10,185.44	HENRY SCHEIN	lab supplies
9E+05	11/2/2020	9,805.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
15027	11/19/2020	232.50	HUMPHREYS COOP-ALTUS	Plant Ops Supplies
14994	11/13/2020	53.90	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15055	11/30/2020	53.90	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
14995	11/13/2020	612.49	JANUS SUPPLY CO	Cleaning Supplies
15028	11/19/2020	445.44	JANUS SUPPLY CO	Cleaning Supplies
14972	11/6/2020	6,389.60	LABCORP	lab supplies
15056	11/30/2020	7,615.88	LABCORP	lab supplies
15029	11/19/2020	1,252.41	LAMPTON WELDING SUPPLY	Patient Supplies
14996	11/13/2020	371.54	LOCKE SUPPLY	Plant Ops supplies
15030	11/19/2020	236.64	LOWES	Plant Ops supplies
15031	11/19/2020	83.48	LYNDA JAMES	Employee Reimbursement
14997	11/13/2020	4,395.33	MARK CHAPMAN	Employee Reimbursement
14998	11/13/2020	177.92	MARY BARNES APRN	Employee Reimbursement
15032	11/19/2020	360.00	MARY BARNES APRN	Employee Reimbursement
15057	11/30/2020	850.00	MATT MONROE	Rent
15033	11/19/2020	3,735.85	MCABEE FOX ROOFING LLC	Roof Repair
9E+05	11/6/2020	3,684.87	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
9E+05	11/13/2020	9,514.96	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
9E+05	11/20/2020	3,936.69	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
14973	11/6/2020	1,275.00	MEDICAL EDUCATION OPTIONS LLC	Employee Training
14999	11/13/2020	3,320.69	MEDLINE INDUSTRIES	Patient Care Supplies
15034	11/19/2020	2,099.76	MEDLINE INDUSTRIES	Patient Care Supplies
15000	11/13/2020	367.84	NATIONAL INDEMNITY	Van insurance
15001	11/13/2020	1,852.67	NEXTIVA, INC.	Phone Service
15058	11/30/2020	155.88	OFFICE DEPOT	Office Supplies
15002	11/13/2020	75.00	OK STATE BOARD OF MED LICENSUR	Credentialing
15003	11/13/2020	416.66	ORTHO-CLINICAL DIAGNOSTICS INC	Lab supplies
15004	11/13/2020	347.00	PITNEY BOWES GLOBAL FINANCIAL	Postage Rental
9E+05	11/17/2020	2,729.08	QUICKFEE	REDW pmt plan
15005	11/13/2020	2,400.00	SARA MCDADE	1099 Provider
15059	11/30/2020	7,200.00	SARA MCDADE	1099 Provider
15060	11/30/2020	1,750.00	SCHAPEN LLC	Clinic Rent
15006	11/13/2020	420.00	SIZEWISE	Equipment rentals
15061	11/30/2020	210.72	SIZEWISE	Equipment rentals
15007	11/13/2020	69.00	SOUTHWEST MEDICAL	Suppiles
15008	11/13/2020	129.44	SPARKLIGHT BUSINESS	Cable Service
15035	11/19/2020	283.12	SPARKLIGHT BUSINESS	Cable Service
15009	11/13/2020	2,263.16	STANDLEY SYSTEMS LLC	Printer rental
15010	11/13/2020	1,281.38	STAPLES ADVANTAGE	Office Supplies
15062	11/30/2020	748.20	SUNBELT RENTALS	Air scrubber rental
15042	11/19/2020	900.00	TECUMSEH OXYGEN & MEDICAL SUPP	Swing bed purchase service
14974	11/6/2020	3,994.43	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15043	11/19/2020	4,761.92	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15063	11/30/2020	9,383.36	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
9E+05	11/10/2020	2,188.34	TSYS	CC processing
9E+05	11/10/2020	147.75	TSYS	CC processing

Check#	Ck Date	Amount	Paid To	Expense Description
15044	11/19/2020	409.94	ULTIMATE IT GUY LLC	COVID Minor Eq.
9E+05	11/23/2020	4,310.82	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
9E+05	11/4/2020	1,096.95	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
9E+05	11/11/2020	1,165.97	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
9E+05	11/18/2020	1,840.38	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
9E+05	11/25/2020	1,439.07	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
15011	11/13/2020	2,565.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15045	11/19/2020	855.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15012	11/13/2020	8,047.33	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
	TOTAL	**874,981.43**		

MRMC AP AGING SUMMARY
For Month Ending
11/30/2020

VENDOR - Under Litagation	Description	0-30	31-60	61-90	Over 90	11/30/2020	10/31/2020	9/30/2020
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees				698,000.00	698,000.00	698,000.00	698,000.00
ELISE ALDUINO	1099 consultant				12,000.00	12,000.00	12,000.00	12,000.00
HEADRICK OUTDOOR MEDIA INC	Advertising				25,650.00	25,650.00	25,650.00	25,650.00
MEDSURG CONSULTING LLC	Equipment Rental Agreement				98,670.36	98,670.36	98,670.36	98,670.36
QUARTZ MOUNTAIN RESORT	Alliance Travel				9,514.95	9,514.95	9,514.95	9,514.95
ADP INC	QMI Payroll Service Provider				4,276.42	4,276.42	4,276.42	4,276.42
ADP SCREENING AND SELECTION	QMI Payroll Service Provider				1,120.00	1,120.00	1,120.00	1,120.00
SUBTOTAL-Vendor Under Litagation					**849,231.73**	**849,231.73**	**849,231.73**	**849,231.73**
VENDOR	**Description**	**0-30**	**31-60**	**61-90**	**Over 90**	**11/30/2020**	**10/31/2020**	**9/30/2020**
ABC BIOMEDICAL	IV Pump rental	2,025.00				2,025.00	2,025.00	2,025.00
ACCUVEIN	Vein Finder equipment						7,106.55	7,106.55
AIRGAS USA LLC	Patient Supplies						-	9.04
ALCON LABORATORIES INC	Supplies Payable						-	8,975.05
AMERICAN HEALTH TECH	Rental Equipment-Old				22,025.36	22,025.36	22,025.36	22,025.36
AMERICAN PROFICIENCY INSTITUTE	Lab Supplies						-	5,025.00
AMERICAN WHOLESALE DISTRIBUTOR	Bulk PPE COVID						-	-
AMERIPRIDE SERVICES INC	Linen Services	6,951.63	1,506.64			8,458.27	4,884.92	4,830.26
ANESTHESIA SERVICE INC	Service		476.95			476.95	906.99	-
AT&T	Fax Service						3,027.69	3,015.92
BAXTER HEALTHCARE	Pharmacy Supplies	2,387.31	747.90			3,135.21	62.96	544.01
BEC INTEGRATED	Nurse Call						-	-
BENISH AND ASSOCIATES	1099 Provider	16,000.00				16,000.00	-	16,000.00
BIO-RAD LABORATORIES INC	Lab Supplies	455.72				455.72	-	1,899.01
BKD CPAS & ADVISORS	Cost Report Filing						-	16,900.00
C.R. BARD INC.	Surgery Supplies-Old				3,338.95	3,338.95	3,338.95	3,338.95
CANON FINANCIAL SERVICES INC	Ultrasound Lease		3,341.61	1,113.87		4,455.48	1,113.87	-
CARDINAL HEALTH	Medical Supplies						2,193.52	3,637.04
CENTERPOINT ENERGY ARKLA	Utilities	1,292.57				1,292.57	644.40	591.47
CENTRAL INFUSION ALLIANCE, INC	Medical Supplies						485.78	984.05
CINTAS CORPORATION #628	Linen Services	3,485.60	693.90			4,179.50	1,797.80	3,595.60
CITY OF MANGUM	Utilities	5,771.76				5,771.76	6,591.46	7,870.06
COHESIVE HEALTHCARE MGMT	Mgmt Fees	225,000.00	282,361.17	332,465.84	3,204,874.40	4,044,701.41	4,123,215.46	3,984,950.30
COHESIVE HEALTHCARE RESOURCES	Payroll	1,008,839.27	237,347.71	100,918.87	3,298,288.76	4,645,394.61	3,509,921.05	3,331,301.22
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service		1,721.75	379.50	51,385.25	53,486.50	50,059.00	47,957.75
COHESIVE REVOPS	RCM fee	19.01				19.01	-	39,558.89
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	58,156.37	113,005.43	134,109.30	1,607,534.47	1,912,805.57	1,903,192.33	1,825,414.94
COMMERCIAL MEDICAL ELECTRONICS	Equipment Inspection Service		2,450.00			2,450.00	-	2,450.00
COMPLIANCE CONSULTANTS	Lab Consultant				1,000.00	1,000.00	1,000.00	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	23,821.04				23,821.04	26,543.21	10,007.13
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	2,200.00	2,000.00	500.00		4,700.00	2,500.00	3,643.90
CPSI	EHR Software	3,096.00				3,096.00	34,996.00	-

VENDOR	Description	0-30	31-60	61-90	Over 90	11/30/2020	10/31/2020	9/30/
CULLIGAN WATER CONDITIONING	Clinic Purchased Service	21.43				21.43	-	-
DAN'S HEATING & AIR CONDITIONI	Repair and Maintenance						-	2,600.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees			16,847.04	154,999.68	171,846.72	171,846.72	95,979.05
DR. JOHN CHIAFFIETELLI	1099 Provider						-	9,615.38
EMD MILLIPORE CORPORATION	Lab Supplies	6,028.40				6,028.40	-	-
F1 INFORMATION TECHNOLOGIES IN	IT Support Services						-	2,550.00
FASTENAL COMPANY	Bulk PPE COVID						-	-
FEDEX	Postage service						40.16	29.52
FFF ENTERPRISES INC	Pharmacy Supplies	3,456.80			(999.81)	2,456.99	(999.81)	(999.81)
FIRE EXTINGUISHER SALES & SERV	Plant Ops repair/maint						301.00	-
FOX BUILDING SUPPLY	Plant Ops Supplies	183.30				183.30	-	29.37
GEORGE BROS TERMITE & PEST CON	Pest Control Service	155.00	155.00			310.00	155.00	155.00
GLOBAL EQUIPMENT COMPANY INC.	Minor Equipment						-	-
GRAINGER	Maintenance Supplies	1,658.01				1,658.01	-	-
GRAYSTONE MEDIA GROUP	Advertising		277.00	277.00	710.00	1,264.00	-	277.00
HAC INC	Dietary Supplies						-	512.77
HEALTH CARE LOGISTICS	Pharmacy Supplies						-	-
HEALTHSTREAM	Employee Training Puchased Service	(1,432.50)		1,432.50		-	-	1,432.50
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant						-	1,000.00
HENGST PRINTING	Pharmacy Supplies						-	-
HENRY SCHEIN	Lab Supplies	1,216.22				1,216.22	-	1,647.15
HERC RENTALS INC	Old Rental Service				7,653.03	7,653.03	7,653.03	7,653.03
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	9,805.00				9,805.00	9,805.00	-
HUMPHREYS COOP-ALTUS	Generater gas						232.50	-
IMEDICAL INC	Supplies				1,008.29	1,008.29	1,008.29	1,008.29
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	80.85				80.85	53.90	53.90
INTERGRA LIFESCIENCES CORP.	Supplies						-	-
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	1,779.16				1,779.16	1,057.93	1,073.06
KCI USA	Supplies				8,270.20	8,270.20	8,270.20	8,270.20
LABCORP	Lab purch svs						6,389.60	-
LAMPTON WELDING SUPPLY	Patient Supplies						183.25	-
LOCKE SUPPLY	Plant Ops Supplies	154.64	21.63			176.27	371.54	-
MARK CHAPMAN	Employe Reimbursement						-	-
MATT MONROE	Staff House Rent						850.00	1,700.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	16,421.22				16,421.22	13,199.83	1,764.76
MEDLINE INDUSTRIES	Patient Care Supplies	20,819.09	11,987.48	4,380.93		37,187.50	15,872.12	16,110.97
MEDTOX DIAGNOSTICS, INC	Lab Supplies						-	-
MICROSURGICAL MST	Surgery Supplies				2,233.80	2,233.80	2,233.80	2,233.80
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies				3,607.60	3,607.60	3,607.60	3,607.60
MSDSONLINE INC	Materials purchased service		3,299.00			3,299.00		
NEXTIVA, INC.	Phones	1,852.67				1,852.67	-	1,848.89
NINJA RMM	IT Service				2,625.00	2,625.00	2,625.00	2,625.00
OFFICE DEPOT	Office Supplies						-	-
OK STATE DEPT OF HEALTH	Xray renewal						-	-
OKLAHOMA BLOOD INSTITUTE	Lab Supplies	505.20		252.60	(446.70)	311.10	(446.70)	(446.70)

VENDOR	Description	0-30	31-60	61-90	Over 90	11/30/2020	10/31/2020	9/30/
OPTUM	Insurance Portal						-	-
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	416.66				416.66	-	416.66
PRESS GANEY ASSOCIATES, INC	Purchased Service	2,048.28				2,048.28	-	-
QUICKFEE	REDW pmt plan						2,729.08	5,458.21
RAMSEY AND GRAY, PC	Legal Fees				28,650.00	28,650.00	28,650.00	32,697.88
REDW	Audit Service						-	-
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	395.00				395.00	-	330.00
SAVANCE, LLC	COVID Screening tool						-	45,450.00
SCHAPEN LLC	Clinic Rent						1,750.00	3,500.00
SCRUBS AND SPORTS	Employee Appreciation						-	-
SHRED-IT USA LLC	Secure Doc disposal service	496.40				496.40	-	365.79
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract						-	-
SIZEWISE	Swing bed purch service						-	-
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider		1,735.00			1,735.00	-	3,470.00
SOUTHWEST MEDICAL	Supplies						69.00	-
SOUTHWEST TAB & COMMISSIONING	Repair and Maintenance						-	-
SPARKLIGHT BUSINESS	Cable service	129.44			816.26	945.70	945.70	816.26
STANDLEY	Printer Lease						-	-
STANDLEY SYSTEMS LLC	Printer Lease						2,263.16	2,408.34
STAPLES ADVANTAGE	Office Supplies	1,299.59	37.16			1,336.75	1,281.38	1,461.17
STERICYCLE INC	Waste Disposal Service						-	2,309.00
STIMWAVE LLC	Surgery Supplies						-	-
STRYKER INSTRUMENTS	Surgery Supplies				31,845.65	31,845.65	31,845.65	31,845.65
SUNBELT RENTALS	Air Scrubber Rental - COVID				196.93	196.93	196.93	196.93
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies						900.00	1,080.00
THE COMPLIANCE TEAM	Clinic Survey				4,880.00	4,880.00	4,880.00	4,880.00
TOTAL MEDICAL PERSONNEL STAFF.	Agency Staffing	2,273.26				2,273.26	3,994.43	-
TOUCHPOINT MEDICAL, INC	Med Dispense Monitor Support						-	-
ULTIMATE IT GUY LLC	Minor Eq						409.94	-
ULTRA-CHEM INC	Housekeeping Supplies						-	-
UMPQUA BANK VENDOR FINANCE	Lab Equipment						-	-
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	3,906.84				3,906.84	3,872.44	-
US MED-EQUIP LLC	Swing bed eq rental	1,482.90				1,482.90	-	-
VERATHON	COVID Minor Eq						-	10,622.50
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	3,420.00				3,420.00	3,420.00	3,420.00
WELCH ALLYN, INC.	Supplies				(628.66)	(628.66)	(628.66)	(628.66)
Vendor Subtotal		1,438,074.14	663,165.33	592,677.45	8,433,868.46	**11,127,785.38**	**10,038,521.31**	**9,667,086.96**
Grand Total		1,438,074.14	663,165.33	592,677.45	9,283,100.19	**11,977,017.11**	**10,887,753.04**	**10,516,318.69**
					Conversion Variance	13,340.32	13,340.32	13,340.32
					AP Control	11,963,676.79	10,874,412.72	10,502,978.37
					Accrued AP	295,405.73	351,598.36	465,639.22
					TOTAL AP	**12,259,082.52**	**11,226,011.08**	**10,968,617.59**

Mangum Regional Medical Center

Chief Clinical Officer Report
November 2020

Excellent Patient Care

- Monthly Education topics included: American Heart Association's Basic Life Support Class for all staff including non-clinical staff. Additionally, staff are updated weekly regarding Cohesive COVID Task Force directives.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 331 in October to 441 in November! This represents an average daily census increase of 4.01%. In other words, MRMC went from 10.68 to 14.7 patients per day!

Preserve Rural Healthcare

Hospital												
2020 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient	23	18	16	13	9	10	11	15	16	12	20	
Swing Bed	27	27	21	13	16	19	18	21	13	17	23	
Observation	0	0	0	0	1	1	2	0	0	0	3	
Emergency Room	179	180	182	66	88	115	115	127	145	134	137	
Lab Completed/ Rad completed	2152/ 162	2096/ 150	2152/ 96	1462/ 49	1729/ 66	2216/ 92	2004/ 106	2141/ 96	2018/ 182	2223/ 249	2330/ 205	

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN, and CNA.
- Actively recruiting locally as well as posting positions on Indeed & Hospital Website.
- Currently utilizing Agency staff to provide coverage. Many of these staff members are from Southwest Oklahoma.

Mangum Regional Medical Center

Quality/Risk/Compliance Report

NOVEMBER 2020

QUALITY

- Quality minutes from previous month included as attachment

  Previous policies approved by Quality/Med Staff/No approval from Governing Board.

  1. Respiratory policies and procedures.
  2. Drug room policies and procedures.
- Policies and forms approved by Quality Committee on December 03, 2020.
  1. Clinical Policies and Procedures
  2. Emergency Department Policies and Procedures
  3. Wound Care Procedure Form

     Consent agenda – HR performance Evaluation Policy

- HIM – Showed improvement on reporting. Cohesive IT has approved and is working with MRMC IT to put into place a secure way to allow Providers access to EMR outside of the facility. They will be able to sign in and complete any paperwork. MRMC will be conducting a Provider time study from December 7th-20th. This will all help with Quality and improving patient care.

COMPLIANCE

- No complaints or grievances for November.
- Contracts that were approved for October:
  1. MiMedx Group
  2. Contract with Velocity EHS MSDS Online
  3. PARA Price Transparency Tool Agreement
  4. Charge Master Review Data Maintenance and PTT

Mangum Regional Medical Center

- Contracts up for review for November:
    1. OGA auto insurance

RISK MANAGEMENT

- 4 Medication Variance
- 1 AMA – Inpatient was wanting to go home. Provider and staff counseled with the patient to let her know the importance of staying. They explained the risks and the benefits to the patient. Patient ended up calling a cab and leaving AMA. Paperwork was signed.
- 2 Patient falls with no injury
- 1 Patient fall with minor injury (skin tear)
- Working with Infection Control Nurse, CEO and CNO to stay informed with updates and information about Covid-19. Coming immunizations.
- During the outbreak we have in place:
    1. No visitor for the patient (unless near end of life)
    2. Screening for all entering the Hospital and annex
    3. Drive through swab for Covid-19
    4. Possible positive Covid-19 patients are seen in the OR2 room with direct ventilation
    5. Positive Covid-19 patients are to stay in Covid wing. We have 5 rooms on the wing. Rooms 12 and 13 have direct ventilation. The other 3 rooms are available for use as well.

WORKMAN'S COMP

- There are currently no Workman's Comp cases currently open.

Mangum Regional Medical Center
Medical Staff Meeting
November 12, 2020

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

David Arles, APRN
Mary Barnes, APRN
Randy Benish, PA

NON-MEMBERS PRESENT:
Marie Harrington, CEO
Daniel Coffin, CCO
Chelsea Church, Pharmacist
Melissa Tunstall, Quality Director
Candy Denney, RN, Utilization Review
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 12:00 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the October 22, 2020, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. CEO report – Marie Harrington, CEO

- We continue to swab any admits due to increased number of positive COVID-19 patients in Mangum. Treating all patients in our ER as if they have COVID-19 until proven otherwise.
- October COVID-19 Stats at MRMC: 174 Swabs, 13 Positive (6.47%), 70 Negative (95.8%), 0 Pending and 1 death.
- COVID – 19 Prevalence Overview by Month at MRMC significant decrease in COVID 19 prevalence: March: 32%

Prevalence, April: 25% Prevalence, May: 6%, Prevalence, June 0% Prevalence, July: 10% Prevalence, and August: 2.4% Prevalence and September: 2.73% Prevalence, October 6.47% Median Age: 44.

- Greer County August COVID-19 Statistics: 154 Positive Cases and 8 Deaths (5.19% death rate).
- PPE and Swab supplies have been adequate to manage during this current crisis.
- Updated COVID-19 Binder at Nurse's station, City Annex and Provider room to ensure communication and COVID-19 updates and education are read. Signature is required for all read and sign documents in binder. Providers are kept up to date with the COVID-19 Provider Update/Education Binder in the provider sleep room. CEO has also communicated with providers via email, cell phone and text messages during this continued COVID-19 Pandemic. Last update was 10.01.2020.
- Participated in all Cohesive Healthcare's COVID-19 Task Force Teleconference calls.
- Significant COVID-19 surge in October which resulted in daycare closures. Worked with staff to ensure all their needs were met. Approved non-clinical team members remote work requests to accommodate daycare issues.
- Due to COVID-19 surge in October we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- On October 22, 2022, Mangum Public Schools moved to voluntary virtual learning through Thanksgiving Break. They will leave the school open for essential workers, students and special needs. We prepared to adjust to the needs of our staff and families.
- MRMC Census Daily Average for October: 11 Swing bed and acute patients per day
- Cohesive Healthcare provided staff lunches for October 2020 during this pandemic. All staff members are very thankful for this support.
- Savance COVID-19 Screening Kiosk implementation and installation date is scheduled for late November.
- MRMC Plant Ops Director spoke to Cohesive about business office enclosure.
- Carport will be installed at the clinic on November 17, 2020.
- No staff issues or concerns currently. Teams are all working together very well.
- New core staff RN
- New Hospital housekeeper for MRMC.

- Awaiting contracts for new providers starting in November and December.

- Lynda James was awarded the Employee of The Month of October during the MRMC All-Staff meeting on November 10, 2020.
- Continued to work on name change for MRMC with Novitas.
- Chief Clinical Officer will purchase Lippincott manuals to have at the Nurse's Station and ER.
- Lippincott Platform contract was initiated on September 17, 2020.
- All roof leaks (clinic, lab, and hospital) have been addressed and are still pending. Lab and clinic roof will be repaired in November/December. The insurance company will not pay for the hospital roof to Dave Andren has added it to their meeting to discuss. The winter months and weather are an issue with major leaks.
- Code Drill colors and badges were updated on October 12, 2020 to include our MRMC Mission Statement on the back.
- Received email from Corry Kendall on October 7 regarding request for documentation for Alliance litigation by October 23, 2020. Documentation was sent by deadline.
- Cohesive approved Thanksgiving and Christmas special staff lunches. Employees will bring desserts to these lunches. Thanksgiving lunch is scheduled for November 24, 2020 and Christmas lunch is scheduled for December 22, 2020.
- MRMC KPIs for October were reviewed. The quality improvements have continued to be significant: 1 Fall without injury and 1 Fall with minor injury, 1 Employee Work Related Injury, 8 Med Variances, 1 ER AMA, 1 LWBS, 3 Referrals, 1 Denial, 0 Inpatient Mortality, 1 ER Patient Mortality, 1 Re-Admission, Zero Grievances or Complaints. Zero CAUTIs, CLABSI, or CAEs, and O HA Pressure Ulcers. A total of 134 ER patients were admitted which was a decrease of -7.59% over previous month, primarily due to COVID-19 surge in October.
- Skin Grafts substitutes will be offered at MRMC when we finalize agreements with vendor. Contracts are still pending and will be ready for November board meeting.
- Received $11K grant and was deposited from the OHA on October 29, 2020.
- Contracts we are preparing for November's board meeting:
    - MSDSOnline
    - MimeDx
    - PARA
- Bad Debt Process planning and implantation continued in October to prepare for November Implementation

- Statement process for Mangum was reviewed to correct lack of itemized statements sent to patients. Met with CPSI and RCM team members to resolve before next statement cycle. First Time statement cycle. First Time statement, which are itemized were not being sent and we have corrected the process and should be ready before next billing cycle in November.

Written report remains in minutes.

5. Committee / Departmental Reports
   a. Medical Records
      i. No report was given.

   b. Nursing

Excellent Patient Care

- Monthly Education topics included: Mock code blue drills with dayshift and nightshift.
- Staff now compliant on their HealthStream assignments.

Excellent Client Service

- MRMC experienced strong growth in average daily census in October.

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN and CNA
- Posting positions on Indeed & Hospital Website.

Written report remains in minutes.

   c. Infection Control

Date of Meeting: November 5, 2020

- Infection Control
  a. Positive Employee Covid Outbreak
  b. N95 Fit Tests
  c. Use of Masks and Distancing
- Employee Education
  a. Request for Education Material
     1. Wound Vae Procedures
     2. CathFLo
- Employee Health
  a. Employee Flu vacs to start November 9, 2020
     1. Administered by CCO or IP - making rounds when available
     2. Declination/Received Previous Documents
- Policy & Procedure
  a. New EMResource Data Input Procedures

- Education/In-Services
  a. Flu/Pneumo Paperwork with New Nursing
  b. Foley Cather/PICC Bundles with New Nursing

- Committee Updates:
  a. Performance Improvement Projects
     - N/A
  b. Regulatory Compliance/Site Visits
     - N/A
  c. Changes in process, procedure, or protocol
     - N/A
- Recommendations from Committee
  Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Isolation Caddy's - Caddy brackets delivered 9/2020.
b. Flooring in nurses break area and med prep room -- tile will be replaced week of the 19th
c. New oxygen/suction headwall needed in ER1—Apex Site has been postponed – Contacted Apex - - Waiting to hear back on next scheduled appointment
d. New covered pegboard needed for supplies in ER1- - Pegboards will have to be custom made.
e. Bathroom floor replacement in room 15—Replacement will begin 9/15/2020
f. Wall repair around window in room 19 has been postponed due to COVID-19
g. Emergency Water Supply—Order Placed—Waiting on delivery
h. Food Cart for COVID Wing—New Food Cart delivered 9/9/2020
i. Enclose Lobby for Business Office—Construction has been put on hold.
j. Roof over OR2 area damaged and in need of repair—Engineer came 10/01/2020—Claim Pending
k. Rubber mats in kitchen need replaced—checking with US Foods
l. Complete "CODE BLUE" (Cardiac Arrest/Medical Emergency exercise—Completed 10/11/2020
m. Complete Active Shooter Exercise—Coordinating with Mangum Police Department

i.i.i. New Business

a. None

Written Report remains in minutes.

e. Laboratory
   i. Tissue Report – Approved – October 2020
   i.i. Transfusion Report – Approved – October 2020

f. Radiology
   i. There was a total of – 249 X-Rays/CT/US
   i.i. Nothing up for approval
   i.i.i. Updates: No updates at this time.
   Written report remains in minutes.

g. Pharmacy
   i. Verbal Report by Pharmacist.
   i.i. P&T Meeting is to be held next month
   i.i.i. Adding back TNKase back to the Chest Pain – Policy and Procedure.
   iv. Motion made by Dr. Chiaffitelli to approve the Policy and Procedures – Drug Room – Chest Pain after correction.

h. Physical Therapy
   i. No report.

i. Emergency Department
   i. No report

j. Quality Assessment Performance Improvement

- Quality
  - Quality Minutes from previous month included as attachment
  - Previous policies approved by Quality/Med Staff/GB:
    1. None
  - Policies and forms approved by Quality Committee on November 5, 2020:
    1. Respiratory Policies and Procedures
    2. Drug Room Policies and Procedures
  - HIM – Showed improvement on reporting. IT is working with Cohesive IT to figure out a safe way to allow for Providers to be able to get into EMR outside of the facility so they can sign the paperwork within the allotted time. Showing improvement on paperwork.

- Compliance
  - No complaints or grievances for October.
  - Contracts that were approved for September:
    - PharmaForce
  - Contracts up for review for October:

1. MiMedx Group
2. Contract with Velocity EHS MSDS Online

- Risk Management
    - 8 Medication Variance
    - 1 - LWBS
    - 1 – AMA - Patient were treated in a timely manner. Patient wanted specific procedures done that Provider did not have a reason to perform. X-ray was ordered but before it could be performed patient eloped from the facility. Staff called patients cell phone and patient stated she did not want to be treated anymore.
    - 1 Patient fall with no injury
    - 1 Patient fall with minor injury (abrasion)
    - Working with Infection Control Nurse, CEO and CNO to stay informed with updates and information about COVID-19
    - During the outbreak we have in place:
        1. No visitor for the patient (unless near end of life)
        2. Screening for all entering the Hospital and Annex
        3. Drive through swab for COVID-19
        4. Possible positive COVID-19 patients are seen in the OR2 room with direct ventilation
        5. Positive COVID-19 patients are to stay in COVID wing. We have 5 rooms on the wing. Rooms 12 and 13 have direct ventilation. The other 3 rooms are available for use as well.

- Workman's Comp
    - There are currently no Workman's Comp cases currently open

Written report remains in minutes.

k. Utilization Review
    i. Total Patient days for October: 331
    i.i. Total Medicare days for October: 275
    i.i.i. Total Medicaid days for October: 3
    i.v. Total Swing bed days for October: 293
    v. Total Medicare SB days for October: 246

Written reports remain in minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports.

6.New Business

a. Approval of Drug Room Policies & Procedures

i.Motion: made by Dr. Chiaffitelli to approve Drug Room Policies & Procedures.

b. Approval of Respiratory Policies and Procedures.

i.Motion: made by Dr. Chiaffitelli to approve Respiratory Policies & Procedures.

7. Adjourn

a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:26 pm.

_____ _____

Medical Director/Chief of Staff Date

MANGUM REGIONAL MEDICAL CENTER
ENVIRONMENT OF CARE & SAFETY MEETING

DATE: 11/4/2020	TIME: 9:30AM	MARK CHAPMAN	
MEMBERS PRESENT: TANYA KNIGHT, SARAH DILLAHUNTY, MARIE HARRINGTON, PAMELA ESPARZA, JENNIFER WAXELL, MELISSA TUNSTALL, DANIEL COFFIN, LYNDA JAMES, KAYE HAMILTON (PHONE), CANDY DENNY AND MARK CHAPMAN			
TOPIC	**FINDINGS/CONCLUSIONS**	**ACTIONS/RECOMMENDATIONS**	**FOLLOW/UP**
I. CALL TO ORDER			
CALLED TO ORDER BY MARK CHAPMAN AT 9:30 AM			

II. REVIEW AND APPROVAL OF MINUTES
MOTION TO APPROVE MINUTES BY SARAH DILLAHUNTY SECOND BY PAM ESPARZA

III. OLD BUSINESS
A--EAST DOOR TO LOADING DOCK LEFT UNLOCKED--PLANT OPS WILL MONITOR DOOR
B--FLOORING IN NURSES BREAK AREA AND MED PREP ROOM--TILE WILL BE REPLACED WEEK OF NOVEMBER 9TH
C--NEW OXYGEN/SUCTION HEADWALL NEEDED IN ER1--APEX SITE VISIT HAS BEEN POSTPONED--CONTACTED APEX--NOT ALLOWING VENDORS INSIDE AT THIS TIME--COVID
D--NEW COVERED PEGBOARD NEEDED FOR SUPPLIES IN ER1--PEGBOARDS WILL HAVE TO BE CUSTOM MADE
E--ER DOOR BUZZER--BUZZER REPLACED AT NURSES STATION AND ADDITIONAL BUZZER PLACED IN ER AREA
F--WALL REPAIR AROUND WINDOW IN ROOM 19 HAS BEEN POSTPONED DUE TO COVID 19
G--EMERGENCY WATER SUPPLY--DELIVERED 10-16-2020
H--15 AMP RECEPTICLES--ALL 15 AMP RECEPTICLES WILL BE REPLACED WITH 20 AMP RECEPTICLES THROUGHOUT HOSPITAL--REPLACEMENT HAS STARTED
I--ROOF OVER OR2 AREA DAMAGED AND IN NEED OF REPAIR--ENGINEER CAME 10/1/2020--CLAIM STILL PENDING
J--RUBBER MATS IN KITCHEN NEED REPLACED--MATS ORDERED
K--COMPLETE ACTIVE SHOOTER EXERCISE--MANGUM POLICE DEPARTMENT RETURNING CALL WITH DATE

IV. NEW BUSINESS

V. ANNUAL BUSINESS			
A. Annual Evaluation of Plans: EOC, EM, Life Safety			
B. Annual Approval of Plans: EOC, EM, Life			
C. Annual Approval of Patient Safety Plan			
D. Safety Officer Annual Appointment			

VI. STANDING REPORTS			
1. EQUIPMENT MANAGEMENT			
A. Preventative Maintenance Reports			
B. Events, Failures and Repairs			
C. Electrical Safety Verification Logs			

2. ANNUAL HAZARDOUS VULNERABILITY ASSESSMENT (HVA)			

3. EMERGENCY PREPAREDNESS			
A. Community & Hospital Drills			
B. Other EP Activities/Status			

4. UTILITIES MANAGEMENT			
A. Generator Report			
B. Medical Gases			
C. Water Quality Reports			
D. Boiler Report			

5. SECURITY			
A. Security Incidents & Risk Events			

6. HAZARDOUS WASTE			
A. Exposures			
B. Disposal: Manifest Review			

7. FIRE SAFETY			
A. Drills			
B. Training			
C. Fire Hazards			
D. Fire Marshall/Fire Chief Reports			

8. SAFETY			
A. Product Recalls & Advisories			
B. Food Recalls & Advisories			
C. Safety Inspections			
D. Safety Rounds & Hazard			
E. Health Alerts & Advisories			
F. Patient Safety Events			

9. ENVIRONMENTAL ROUNDS/HOUSEKEEPING SERVICES			
A. Report & Action Plans			

10, EMPLOYEE HEALTH/OSHA			
A. Employee Health Report			
B. OSHA Log Review			

11. NEW PRODUCTS			

12. REGULATORY COMPLIANCE: SURVEYS/FINDINGS			

13. EDUCATION & TRAINING			

14. OTHER

VI. DISCUSSION

NURSES BREAK ROOM FLOORING REPLACEMENT HAS BEEN SCHEDULED FOR WEEK OF NOVEMBER 9TH. PEGBOARDS FOR ER1 AND ER2 WILL HAVE TO BE CUSTOM MADE TO MEET OUR NEEDS. APEX MEDICAL GAS SITE VISIT HAS BEEN POSTPONED FOR NEW HEADWALL IN ER1. EMERGENCY WATER SUPPLY HAS BEEN DELIVERED. ROOF OVER OR2 AREA IS NEEDING REPAIRED--ENGINEER INSPECTED ROOF 10/1/2020--CLAIM STILL PENDING . RUBBER MATS FOR KITCHEN HAVE BEEN ORDERED. ACTIVE SHOOTER DRILL PENDING WITH MANGUM POLICE DEPARTMENT. ALL 15 AMP RECEPTICLES WILL BE REPLACED WITH 20 AMP RECEPTICLES THROUGHOUT HOSPITAL. NEW BUZZER ADDED IN ER AREA. A FEW ITEMS IN PATIENT HALL HAS BEEN POSTPONED DUE TO COVID.

VII. ADJOURNMENT

ADJOURNMENT CALLED BY PAM ESPARZA AT 10:05 AM SECOND BY CANDY DENNEY

Submitted By _____ Date _____

Chairperson _____ Date _____

Mangum Regional Medical Center
Medical Staff Meeting Addendum
November 19, 2020

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

None.

NON-MEMBERS PRESENT:

Marie Harrington, CEO
Daniel Coffin, CCO
Melissa Tunstall, Quality Director
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 12:52 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the November 12, 2020, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. None

5. Committee / Departmental Reports
    a. No reports were given.

6. New Business
    a. Charge Master Review Data Maintenance and PTT
        i. Motion: Dr. Chiaffitelli made a motion to approve the Charge Master Review Data Maintenance and PTT
    b. PARA Price Transparency Tool Agreement
        i. Motion: Dr. Chiaffitelli made a motion to approve the PARA Price Transparency Tool Agreement

7. Adjourn
    a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:55 pm

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center
Medical Staff Meeting
October 22, 2020

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

David Arles, APRN
Mary Barnes, APRN
Randy Benish, PA

NON-MEMBERS PRESENT:
Marie Harrington, CEO
Daniel Coffin, CCO
Chelsea Church, Pharmacist
Melissa Tunstall, Quality Director
Candy Denney, RN, Utilization Review
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 12:40 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the September 17, 2020, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. CEO report – Marie Harrington, CEO

- We continue to swab any admits due to increased number of positive COVID-19 patients in Mangum. Treating all patients in our ER as if they have COVID-19 until proven otherwise.
- October COVID-19 Stats at MRMC: 174 Swabs, 13 Positive (6.47%), 70 Negative (95.8%), 0 Pending and 1 death.
- COVID – 19 Prevalence Overview by Month at MRMC significant decrease in COVID 19 prevalence: March: 32%

Prevalence, April: 25% Prevalence, May: 6%, Prevalence, June 0% Prevalence, July: 10% Prevalence, and August: 2.4% Prevalence and September: 2.73% Prevalence, October 6.47% Median Age: 44.

- Greer County August COVID-19 Statistics: 154 Positive Cases and 8 Deaths (5.19% death rate).
- PPE and Swab supplies have been adequate to manage during this current crisis.
- Updated COVID-19 Binder at Nurse's station, City Annex and Provider room to ensure communication and COVID-19 updates and education are read. Signature is required for all read and sign documents in binder. Providers are kept up to date with the COVID-19 Provider Update/Education Binder in the provider sleep room. CEO has also communicated with providers via email, cell phone and text messages during this continued COVID-19 Pandemic. Last update was 10.01.2020.
- Participated in all Cohesive Healthcare's COVID-19 Task Force Teleconference calls.
- Significant COVID-19 surge in October which resulted in daycare closures. Worked with staff to ensure all their needs were met. Approved non-clinical team members remote work requests to accommodate daycare issues.
- Sue to COVID-19 surge in October we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- On October 22, 2022, Mangum Public Schools moved to voluntary virtual learning through Thanksgiving Break. They will leave the school open for essential workers, student and special needs. We prepared to adjust to the needs of our staff and families.
- MRMC Census Daily Average for October: 11 Swing bed and acute patients per day
- Cohesive Healthcare provided staff lunches for October 2020 during this pandemic. All staff members are very thankful for this support.

  Savance COVID-19 Screening Kiosk implementation and installation date is scheduled for late November.
- MRMC Plant Ops Director spoke to Cohesive about business office enclosure.
- Carport will be installed at the clinic on November 17, 2020.
- No staff issues or concerns currently. Teams are all working together very well.
- New core staff RN
- New Hospital housekeeper for MRMC.
- Awaiting contracts for new providers starting in November and December.

- Lynda James was awarded the Employee of The Month of October during the MRMC All-Staff meeting on November 10, 2020.
- Continued to work on name change for MRMC with Novitas.
- Chief Clinical Officer will purchase Lippincott manuals to have at the Nurse's Station and ER.
- Lippincott Platform contract was initiated on September 17, 2020.
- Completed new process for Clinic Home Health Recertification
    - Home Health facilities to submit claims electronically, fax, or in person, within 24-48 hours of completion
    - Clinic will review for accuracy and/or missing information
    - Clinic will review the patient's history and determine if the new claim overlaps with the prior certification period.
    - The order will be sent to the physician for signature via Right Signature once it is verified that the certification period does not overlap.
    - The physician will return the signed order within 24-48 hours of receipt.
    - The claim will be submitted to the payor for payment.
- Identified deficiencies within MRMC RCM process with Indian Health Services and created an algorithm flowchart for the CBO and registration team members to use.
- Installed new large flatscreen TV in provider room that one of the providers donated.
- MRMC Chief Clinical Officer notified CEO of new EMS services representative on September 25, 2020.

- All roof leaks (clinic, lab, and hospital) have been addressed and are still pending. Insurance adjuster came on September 14, 2020. The insurance will not cover the roof.
- MRMC KPIs for September were reviewed. The quality improvements have continued to be significant: 1Fall without injury, 1 Med Variances, 2 AMAs, 2 referrals, 1 Inpatient Mortality, 1 ER Patient Mortality, 1 Re-Admission, Zero Grievances or Complaints. Zero CAUTIs, CLABSIs or CAEs. A total of 145 ER patients were admitted which is an increase of 14.7% over previous month.
- Skin Grafts substitutes will be offered at MRMC when we finalize agreements with vendor. Contracts are still pending and will be ready for November board meeting.
- MRMC September 23, 2020 Finance Meeting Overview:
    - MCR Receivable: $1.3M = $200K month increase

        - MCR Rates should increase
    - MRMC Controller met with RCM Directors regarding registration errors and charge buckets. (revenue leaks)
        - Charges in wrong buckets
        - Charge Codes
    - HHS/COVID-19 Funding Update
        - Applied to all COVID-19 expenses first
        - Apply to lost revenue last
        - Baseline was Sept 2019 through Feb 2020, but this has changed: year to year, which may not be as advantageous
    - Provider Contracts
        - Several are expiring soon and up for renewal
        - Move towards all providers contracted with hospital
        - Cost-cutting measures
        - Goal for mid-level providers at MRMC: 3 full-time mid-levels, preferably 1099
    - Review financials with Controller and CFO each month to prepare for board meetings
    - Controller will send check register and AP Aging to MRMC CEO
- Approved contracts presented at September Board Meeting.
    - PharmaForce

Written report remains in minutes.

5. Committee / Departmental Reports
    a. Medical Records
        i. No report was given.

    b. Nursing

Excellent Patient Care

- Monthly Education topics included: Skills Fair covering multiple clinical functions and procedures on 09/21/20 and 09/22/20.
- Staff worked diligently on their HealthStream assignments.

Excellent Client Service

- Tablet device received to allow patients to have virtual visitation to meet psychosocial needs.

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN and CNA
- Hired a Full Time RN for Core Staff
- Posting positions on Indeed & Hospital Website.

Written report remains in minutes.

c. Infection Control
Date of Meeting: October 15, 2020

- Infection Control
  a. NHSN
  b. N95 Fit Tests
- Employee Education
  a. HealthStream per HR
  b. Certification Updates with HR/CCO
  c. New-Hire Employee Education
- Employee Health
  a. Vaccination records
  b. Employee Flu vacs to start in October
  c. New Hire Titers for all Clinical Personnel, including EVS
- Policy & Procedure
  a. Working with Ivy at Corporate to review protocols/updates coming
  b. Check out Flu/Pneumo meds from Pharmacy for patients
- Education/In-Services
  a. Updated Covid-19 response protocols per Cohesive Task Force via binders
  b.PALS/BLS/ACLS courses per CCO
  c.Flu/Pneumo Bundles with Nursing
- Committee Updates:
  a. Performance Improvement Projects
    - N/A
  b. Regulatory Compliance/Site Visits
    - N/A
  c. Changes in process, procedure, or protocol
    - N/A
- Recommendations from Committee
  Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –
i.i. Old Business - -
  a. Isolation Caddy's – Caddy hanging brackets ordered
  b. Flooring in nurses break area and med prep room has been prioritized and scheduled
  c. New oxygen/suction headwall needed in ER1—Apex Site has been postponed
  d. New covered pegboard needed for supplies in ER1- - Pegboards will have to be custom made.

e. Bathroom floor replacement in room 15—Replacement will begin 9/10/2020
f. Wall repair around window in room 19 has been postponed due to COVID-19
g. Emergency Water Supply—Approved—PO will be issued
h. Food Cart for COVID Wing—PO will be issued
i. Enclose Lobby for Business Office—Estimate figured—Pending approval
j. Roof over OR2 area damaged and in need of repair—Adjuster will be out for inspection 9/14/2020

i.i.i. New Business
a. New Rubber Mats needed for kitchen
b. Complete "Code Blue" Drill
c. Complete "Active Shooter" Drill

Written Report remains in minutes.

e. Laboratory
i. Tissue Report – Approved – September 2020
i.i. Transfusion Report – Approved – September 2020

f. Radiology
i. There was a total of 182– X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates: No updates at this time.

Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacist.
i.i. P&T Meeting is to be held. Minutes kept in Medical Staff Minutes.
i.i.i. Flu Shot Update

h. Physical Therapy
i. No report.

i. Emergency Department
i. No report

j. Quality Assessment Performance Improvement

- Quality
  - Quality Minutes from previous month included as attachment
  - Previous policies approved by Quality/Med Staff/GB:
    1. None for September
  - Policies and forms approved by Quality Committee:
    1. No policies to approve for September.

- HIM – Working on processes to improve the paperwork that shows the response time for Providers. Training for nursing was held to educate the appropriate area to chart for paperwork. Also, IT is working on getting access for Providers to be able to get into EMR outside of the facility so they can sign the paperwork within the allotted time. Showing improvement on paperwork.

- Compliance
  - No complaints or grievances for September.
  - Contracts that were approved for August:
    - PharmaForce
  - Contracts up for review for September:

- Risk Management
  - 1 Medication Variance
  - 0 - LWBS
  - 2 – AMA Both patients were treated in a timely manner. Both patients were informed of the dangers of leaving and the advantages of treatment. Patients still chose to leave AMA. 1 left without signing AMA and eloped. The other was signed and document and documented.
  - 1 Patient fall with no injury
  - Working with Infection Control Nurse, CEO and CNO to stay informed with updates and information about COVID-19
  - During the outbreak we have in place:
    1. No visitor per patient (unless near end of life)
    2. Screening for all entering the Hospital and Annex
    3. Drive through swab for COVID-19
    4. Possible positive COVID-19 patients are seen in the OR2 room with direct ventilation
    5. Positive COVID-19 patients are to stay in COVID wing. We have 5 rooms on the wing. Rooms 12 and 13 have direct ventilation. The other 3 rooms are available for use as well.

- Workman's Comp
  - There are currently no Workman's Comp cases currently open

Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for September: 237
   i.i. Total Medicare days for September: 210
   i.i.i. Total Medicaid days for September: 10
   i.v. Total Swing bed days for September: 175

v. Total Medicare SB days for August: 168
Written reports remain in minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports.

6. New Business

7. Adjourn
   a. Dr. Chiaffitelli made a motion to adjourn the meeting at 1:10 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center

SUMMARY OF COMMITTEE MEETING

Name of Committee: Infection Control

Date of Meeting: December 9, 2020

- **Infection Control**
  a. **OSIIS updated system**
  b. **Covid Surge**
  c. **Remdesivir/FFP**
- **Employee Education**
  a. **Remdesivir/FFP administration**
- **Employee Health**
  a. **Employee Flu Vaccinations**
  b. **Covid Vaccinations**
- **Policy & Procedure**
  a. **New EMResource Data Input for Remdesivir supply- pharmacy**
  b. **New OSIIS vaccination input**
  c. **No In-House antibody testing until OID number obtained**
  d. **Employee Covid Testing/RTW update**
- **Education/In-services**
  a. **Flu/Pneumo Paperwork with New Nursing**
  b. **Foley Cather/PICC Bundles with New Nursing**
- **Committee Updates:**
  a. **Performance Improvement Projects**
    - **N/A**
  b. **Regulatory Compliance/Site Visits**
    - **N/A**
  c. **Changes in process, procedure, or protocol**
    - **N/A**
- **Recommendations from committee**

Mangum Utilization Review Report November 2020

Inpatients:

Total patient admissions to acute care: 20

Total discharges from acute care: 15

Discharge to Swing bed care: 7

Average Length of stay for all acute cares: 15 patients @ 48 days, ALOS 3.2 days

Average length of stay for Medicare: 10 patients @ 31 days, ALOS 3.1 days

Total Acute Medicare days for month: 37 Medicaid days: 5 Ins days: 8 Self pay days: 14

Total Acute days for the month: 64

Swing Bed:

Total patients admitted: 23

Previous month still in house: 12

Patients discharged: 12 patients @ 136 days, ALOS 11.3 days

Medicare patient discharged: 10 patients @ 123 days, ALOS 12.3 days

Total Swing bed days for the month: 377

Total Medicare SB days: 346 Total Ins days: 31

Discharged with Home Health and Hospice: 5

Discharge to home without referrals: 1, patient left AMA

Discharge to SNF at LTC: 5

Discharge to STAC: 0

Expired: 1

23 Hour Observation: 3 patients, 4 days

Total Patient days for November: 441

Total Medicare days for November: 383

Total Medicaid days for November: 5

Total Insurance days for November: 39

Total Private pay days for November: 14 Total Indian Health days for November: 0

MRMC J Nov-20 Utilization Review Report	Case Management: Candy Denney		
Service Lines	**Patients**	**Days**	**Previous Month %**
Inpatients:			
Acute Care Patient Admissions:	20		66.7%
Patients Discharged to SWB Care:	7		-22.2%
Discharges from Acute Care:	15		66.7%
Total Patient Discharged Days:		48	54.8%
ALOS Days:		3.2	-5.8%
Total Discharged Medicare Patients:	10		42.8%
Total Medicare Patient Discharged Days:		37	27.6%
ALOS Days for Medicare Patients:		3.1	0.0%
Total Acute Medicare Days:		37	27.6%
Total Acute Medicaid Days:		5	66.7%
Total Acute Insurance Days :		8	33.3%
Total Acute Self-Pay Days:		14	1400.0%
Total Acute Days:		64	68.4%
Total Indian health service days:			0.0%
Swing Bed:			
Patients Admitted:	23		35.3%
Previous Month Still In-House:	12		100.0%
Patients Discharged:	12		140.0%
Total Patient Discharged Days:		136	156.6%
ALOS Days:		11.3	6.7%
Discharged Medicare Patients:	10		100.0%
Total Medicare Patient Discharged Days:		123	132.0%
ALOS Days for Medicare Patients:		12.3	16.0%
Total SWB Days for the Month:		377	28.7%
Total Medicare SWB days:		346	40.7%
Discharged with Home Health and Hospice:		5	66.7%
Discharged to Home w/o Referrals:		1	-100.0%
Discharged to SNF at LTC:		5	150.0%
Discharged to STAC:		0	-100.0%
Expired:		1	100.0%
Left AMA:		1	0.0%
23 Hour Observation:			
Summary Totals:			
Total Patient Days for November:		441	33.2%
Total Medicare Days for November:		383	39.3%
Total Medicaid Days for November:		5	66.7%
Total Insurance Days for November:		39	-26.4%
Total Private Pay Days for November:		14	1400.0%
Total Indian Health Services days flys for November:		0	0

Clinic Operations Report

Mangum Medical Clinic

November 2020

Clinic Operations

- Clinic Manager Amber Jackson earned Certification as a Rural Healthcare Professional
- Ongoing Monthly Clinic Manager Meetings

Quality Improvement

- COVID readiness assessments and action plans

Community Outreach

- Continued Telehealth Appointments
- Did you know….series of awareness-appropriate content for social media posting

Number of Clinic Visits

Provider	November	October	September	August	July
Benish	192	242	261	212	254

Productive Hours

Provider	November	October	September	August	July
Benish	127	168.9	156.95	119.48	167.5

Visits per Productive Hour-Target 2.5

Provider	November	October	September	August	July
Benish	1.51	1.43	1.66	1.77	1.52

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

WONG-BAKER FACES PAIN SCALE

Designed to be used for patients age 3 years to adult	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Nurse Name/Title
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

PEDIATRIC FLACC PAIN SCALE					
The scale is designed to help clinicians assess the level of pain in children who are too young to cooperate verbally. It can also be used in adults who are unable to communicate.	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Nurse Name/Title**
FACE					
0-No particular expression or smile					
1-Occasional grimace or frown, withdrawn, disinterested					
2-Frequent to constant quivering chin, clenched jaw					
LEGS					
0-Normal position or relaxed					
1-Uneasy, restless, tense					
2-Kicking or legs drawn up					
ACTIVITY					
0-Lying quietly, normal position, moves easily					
1-Squirming, shifting back and forth, tense					
2-Arched, rigid, or jerking					
CRY					
0-No cry (Awake or Asleep)					
1-Moans or whimpers; occasional complaint					
2-Crying steadily, screams or sobs, frequent complaints					
CONSOLABILITY					
0-Content, relaxed					
1-Reassured by occasional touching, hugging or being talked to, distractible					
2-Difficult to console or comfort					
Total Score					
REASSESSMENT					
REASSESSMENT SCORE					

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Plan for the Provision of Emergency Services		**EMD-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department	See below	

SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and prioritization of patients based on level of acuity and resources using an evidence based five-level triage assessment tool for patients presenting to the Emergency Department (ED). The Emergency Department offers emergency care twenty-four hours a day with at least one physician and/or medical provider experienced in emergency care on duty.

PURPOSE

The Hospital has adopted the Emergency Severity Index (ESI) for triaging patients arriving in the ED to improve the quality and safety of patient care. The ESI is an evidence based five level triage scale that facilitates the prioritization of patients based on the urgency of treatment for the patients' condition. The triage nurse should initially perform a quick assessment of the patient using the Emergency Severity Index Assessment Tool.

DEFINITIONS

Emergency Medical Condition-a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part;
d) With respect to a pregnant woman who is having contractions:
   1) there is inadequate time to affect a safe transfer to another hospital before delivery, or
   2) that transfer may pose a threat to the health or safety of the woman or the unborn child

Emergency Services- Any individual seeking emergency services shall receive a medical screening exam, and in the presence of an emergency medical condition, stabilizing treatment

within the capabilities of the hospital and if indicated, an appropriate transfer to another medical facility.

Stabilized-with respect to an "emergency medical condition" that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an "emergency medical condition." The woman has delivered the child and the placenta.

POLICY

I. **Classification of trauma and emergency operative services**
   A. Mangum Regional Medical Center is classified as a Level IV facility**.** Mangum Regional Medical Center shall provide emergency medical services within the capabilities and capacities of the staff and facilities available at the hospital.
   B. No surgical, or medical specialty services are provided.
   C. A registered nurse shall be on site twenty-four (24) hours a day. The on-site registered nurse shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.
   D. Every patient will receive an assessment and evaluation by a registered nurse. The patient will be assessed for any immediate life-threatening medical or psychiatric emergencies. BLS and ACLS interventions will be utilized for medical emergencies as indicated. The RN will use the ESI triage tool to assess whether the patient is 1-Immediate, 2-Emeregent, 3-Urgent, 4-Semi-Urgent, and 5-Non-Urgent.
   E. A stroke Alert will be initiated for all patients who present with stroke or stroke-like symptoms. Stroke patients will receive immediate care and treatment. See Stroke Plan.
   F. For all patients who present with mental health/psychiatric issues including suicidal/violent behavior will be placed in the emergency department safe room with one-on-one supervision and receive immediate care and treatment. See Care and Treatment of Psychiatric Patient.
   G. If an individual comes to a hospital's dedicated emergency department and a request is made on his or behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.
   H. A minor child can request an examination or treatment for an "emergency medical condition." The hospital will conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel will not delay the medical screening exam by waiting for parental consent. If after screening the minor, it is

determined that no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

II. Medical Oversight

A. The hospital shall be responsible for providing adequate medical coverage for emergency services. Qualified physicians or medical providers shall be regularly available for the emergency service, either on duty or on call.
B. On call physicians or medical providers shall be available to present in the emergency room within twenty (20) minutes of notification.
C. A physician or licensed independent practitioner shall be responsible for all patients who present for emergency services.
D. All medications and treatments shall be provided under the direction and order of a physician or licensed independent practitioner.
E. Mangum Regional Medical Center shall maintain a list of physicians and/or medical providers who are on call for duty to provide the initial screening, evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.
F. The hospital shall maintain an on-call list of available physicians and medical providers on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving emergency services in accordance with the resources available to the hospital.

III. Nursing Services

A. Registered nurses shall be available on site at all times and in sufficient number to deal with the number and extent of emergency services.

PROCEDURE

IV. Procedure for emergency room visits

A. If an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) presents to the emergency department, the hospital shall provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (EMC) exists.
B. The medical provider-will be notified of all emergency department admissions. The RN will provide findings of the assessment and evaluation of the patient to the medical provider.
C. If an emergency medical condition is determined to exist, the hospital shall provide any necessary stabilizing treatment within the capabilities

and capacities of the staff and facilities available at the hospital or provide an “appropriate transfer” as defined below.

V. Patient Transfers

A. A patient transfer to another medical facility will be appropriate only in those cases in which:
    1. Mangum Regional Medical Center as the transferring hospital, provides medical treatment within its capability and capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; AND
    2. The receiving facility has available space and qualified personnel for the treatment of the individual; AND
    3. The receiving facility has agreed to accept transfer of the individual and to provide appropriate medical treatment.

B. If an individual at Mangum Regional Medical Center has an emergency medical condition that has NOT been stabilized, the hospital may not transfer the individual unless:
    1. The transfer is an appropriate transfer (as defined in (a) above); AND
    2. The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer; AND
    3. A Provider has signed a certification that based upon the information available at the time of transfer; the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based;
    4. Mangum Regional Medical Center, as the transferring hospital, shall send to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including:
        a. available history,
        b. records related to the individual's emergency medical condition,
        c. observations of signs or symptoms,

d. preliminary diagnosis,
e. results of diagnostic studies or telephone reports of the studies,
f. treatment provided,
g. results of any tests,
h. the informed written consent or certification or copy thereof,
i. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer.

C. The transfer shall be conducted through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

VI. Emergency Room Log

A. Mangum Regional Medical Center will maintain a central log on each individual who comes to the emergency department, seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.
B. Mangum Regional Medical Center shall maintain medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer.

VII. Supplies and Equipment

A. The hospital shall have equipment for use in the resuscitation of patients of all ages on site, functional, and immediately available, including at least the following:
    1. Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;
    2. Suction devices;
    3. Electrocardiograph-oscilloscope-defibrillator-pacer;
    4. Standard intravenous fluids and administration devices, including large-bore intravenous catheters;
    5. Sterile surgical sets for:
        a) Airway control/cricothyrotomy;
        b) Vascular access; and
        c) Chest decompression
    6. Equipment for gastric decompression
    7. Thermal control equipment for patients

8. Two-way communication with emergency transport vehicles

ATTACHMENTS

NA

REFERENCES

Department of Health and Human Services, Centers for Medicare and Medicaid Services. 42 CFR Part, 489.24, and 489.20. Medicare and Medicaid Programs; Hospital Conditions of Participation: Federal Regulations Oklahoma State, OSDH Emergency Services 310.667-39-14, SOM Appendix V Interpretive Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases, 42 U.S. Code §1395dd, §42 CFR 489.23

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center
Stroke Log

Time Provider Notified	TIME EMS NOTIFIED	TIME EMS ARRIVED	DEPARTURE TIME	Stroke Center Location	Time of Arrival @ Stroke Center	NUI

RSE

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Scope of Services and Practices of the Emergency Department		**EMD-002**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center Emergency Department (ED), a Level IV Emergency Department providing emergency services to patients who present to the ED seeking treatment for perceived serious health concerns. The Hospital ED is a dedicated emergency department providing services across the lifespan.

II. DEFINITIONS

A. **"Dedicated Emergency Department" (DED):** is defined as any department or facility of the Hospital, regardless of whether it is located on or off the main Hospital, that meets at least one of the following requirements:

1. The hospital department is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or
2. The hospital department is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or
3. The hospital department during the preceding calendar year in which a determination under this Section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third (1/3) of all its outpatient visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. *This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric intake or assessment units of hospitals) where patients are routinely evaluated and treated for EMCs.*

B. **Emergency Services:** refers to any healthcare services provided for immediate attention and management of patients with a serious medical condition that a prudent layperson with an average knowledge of medicine and health perceives is a serious medical condition requiring treatment within the hospital's capabilities.

C. **EMTALA (Emergency Medical Treatment and Labor Act):** refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, which obligates hospitals to provide medical screening, stabilizing treatment, and/or transfer of patients who may have an EMC (emergency medical condition) and women in labor.

D. **Conditions of Participations (CoPs):** refers to health and safety standards developed by the Centers for Medicare & Medicaid Services (CMS) that healthcare organizations including Critical Access Hospitals (CAHs) must meet in order to participate in the Medicare and Medicaid programs. The health and safety standards are the core for the improvement of quality and ensuring the health and safety of beneficiaries. Through this process CMS ensures that the standards of accrediting organizations that are recognized by CMS must meet or exceed the standards set forth by Medicare in the CoPs.

E. **Competent**: refers to staff that have completed a competency assessment initially and on an ongoing basis.

III. SCOPE OF SERVICES

A. General

Mangum Regional Medical Center, an 18-bed licensed bed facility, deemed by the Centers for Medicare & Medicaid Services (CMS) as a Critical Access Hospital (CAH) has a 25-bed maximum acute care capacity. The DED provides emergency services 24 hours a day and has a total of 2 rooms. The Hospital provides emergency services within the capabilities of a DED to the following patient populations:

- Adults
- Geriatrics
- Pediatrics
- Adolescents
- Newborns

All patients presenting to the Hospital's DED seeking emergency medical services shall be triaged using the Emergency Severity Index (ESI) to determine prioritization based on urgency of treatment secondary to the patient's condition. A medical screening examination (MSE), including necessary ancillary testing (i.e. labs, diagnostic studies, etc.) will be provided to each patient who presents to the DED within defined time parameters and based on the patient's assessed medical condition. Stabilizing treatment will be provided by the medical provider to the patient within the capabilities of the Hospital. A disposition decision will be determined by the medical provider that may include admission to the hospital, discharge to home, or transfer to a higher level of care.

The following patients are provided an MSE, treated and stabilized, discharged, referred, or transferred due to lack of medical, equipment, nursing or diagnostic resources:

- Multiple of massive trauma injuries
- Acute neurological conditions that may require further evaluation or surgical intervention.

- Severe burns including:
  - Partial to full thickness burns over 10% TBSA in ages <10 and >55 years of age
  - 20% TBSA in all others
  - Full thickness – all pediatrics and adults with >5% TBSA
  - All specialty burns (i.e. chemical, electrical, etc.)
- Acute cardiac conditions that may require invasive procedures such as PTCA, stent placement, angioplasty, bypass surgery, or permanent pacemaker placement.
- Any trauma to the spinal column that results or may result in significant or life-threatening condition (i.e. paralysis, c-spine fractures, etc.).
- Emergency surgery conditions.
- High risk obstetrical patients (within EMTALA restrictions)
- Significant orthopedic injuries such as hip fractures.
- Significant ophthalmic injuries.
- Significant overdoses requiring critical care monitoring/intervention.
- Psychiatric conditions including suicidal attempts, suicidal ideations, or psychotic behaviors, etc.
- Any other conditions the ED medical provider determines is not within the capabilities of the Hospital to safely treat the patient.

B. Minimum Staffing

1. A medical provider will always be on duty or on-call in the DED. If the medical provider is on-call, they are required to return a call from the Hospital within 5 minutes and be at the patient's bedside within 20 minutes of the initial notification from the Hospital.
2. A Registered Nurse (RN) will always be staffed and on duty in the DED. A minimum of one (1) RN will always remain in the DED.
3. Additional RNs, Licensed Practical Nurses (LPNs) and other healthcare staff will be available for emergency care needs based on the influx, acuity and assessment of patient care needs.

C. Qualifications of Staff

1. All medical providers will be duly licensed to practice medicine or hold an advanced practice nursing license in the State of Oklahoma. Medical providers shall be a member of the Medical Staff of the Hospital. All ED Medical Staff shall be credentialed and have privileges for Emergency Medicine and any other specific requirements delineated upon recommendation of the Medical Staff Committee and approved by the Governing Board.
2. All RNs and LPNs will have an unrestricted Oklahoma or Multi-State Nursing License.
3. All ED nursing staff will maintain certification in BLS, ACLS and all RNs will be PALS certified.
4. All ED nursing staff will have initial orientation and ongoing competency education in emergency management and triage using ESI.

5. All RNs working in the ED is recommended to obtain TNCC within two years of employment.

D. Services Provided

1. Medical Services
   a. Medical providers and nursing staff are competent in emergency management to deliver expert and compassionate care to patients with major and minor injuries and illnesses including but not limited to infectious diseases, respiratory conditions, drug overdoses, and psychiatric illnesses.
   b. For ED patients in need of brief, intensive monitoring and treatment, the ED provides observation of the patient with competent nursing staff and any other necessary staff until an appropriate transfer can be arranged.
2. Stroke Services
   a. The ED medical and nursing staff have specialized knowledge to provide rapid triage, assessment and initiation of treatment for stroke using standardized evidence-based treatment and transfer protocols to ensure the patient has the best chance of survival and recovery from this critical diagnosis.
   b. The Hospital contracts with Level I and Level II stroke centers for the rapid transfer of stroke patients to a higher level of care after initial assessment and treatment.
   c. The Hospital collaborates with area emergency air flight service providers to transport patients via helicopter or fixed wing to Level I or Level II stroke centers for higher level care. The Hospital also partners with Emergency Medical Services (EMS) for overland transfers.
3. Cardiovascular Emergencies
   a. The ED medical and nursing staff have specialized knowledge to provide rapid triage, assessment and initiation of treatment including but not limited to Chest Pain and Acute Myocardial Infarction (MI) using standardized evidence-based treatment and transfer protocols to ensure the patient has the best chance of survival and recovery from these critical diagnoses.
   b. The Hospital contracts with acute care hospitals with expertise in caring for patients with cardiovascular emergencies to ensure an appropriate transfer of the patient.
4. Trauma Services
   a. The Hospital is a Level IV Trauma Center that provides medical and nursing staff with specialized knowledge in the rapid triage, initial assessment, management, stabilization and transfer of trauma patients using standardized evidence-based treatment and transfer protocols to ensure trauma patients have the best chance of survival and recovery.

b. The Hospital contracts with Levels II & III Trauma Centers for the rapid transfer of trauma patients to a higher level of care.

5. Diagnostic and Laboratory Services
   a. Diagnostic Services
      i. The Hospital provides x-ray and CT-scan 24 hours a day.
   b. Laboratory Services
      i. The Hospital provides laboratory services 24 hours a day.

IV. ATTACHMENTS

N

V. REFERENCES

American College of Emergency Physicians (2015). Definition of an emergency service. *Policy Statement.* [Electronic Version]. Retrieved on 02/18/20 from https://www.acep.org/patient-care/policy-statements/definition-of-an-emergency-service/

Centers for Medicare and Medicaid Services (2013). Conditions of Participations (CoPs). Retrieved on 02/18/20 from https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs

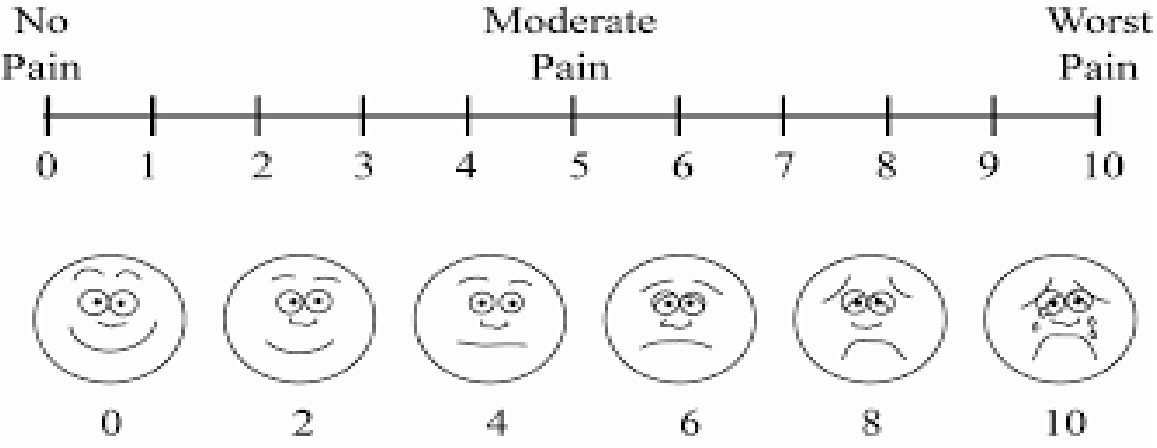
REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

NUMERICAL RATING PAIN SCALE



Designed to be used for patients over the age of 9 years	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Nurse Name/Title
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Emergency Department Purpose and Objectives		**EMD-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center. This policy is an emergency department policy applying to all Medical and Hospital Staff employed or working in the emergency department.

II. PURPOSE

The purpose of the Hospital is to provide the following functions:

- To provide emergency services 24/7 to the following patients presenting to the emergency department (ED):
  - Traumatic or Non-traumatic patients
  - Patients who perceive they have a serious medical condition
  - Outpatient procedures/treatments
  - Victims of mass casualty incidents
- To provide general medical services to the following patients presenting to the ED:
  - Cardiopulmonary resuscitative (CPR) measures to patients who present to the ED with life-threatening medical conditions
  - Medical screening examinations (MSE) and assessments
  - Stabilizing treatment within the capabilities of the ED
  - Referral to appropriate providers, facilities and/or services for follow-up or definitive management after being seen in the ED.
- To provide a system of triaging patients who need to be placed in special areas (such as isolation rooms) and who need to be transferred to another hospital for a higher level of care.
- To network with other hospitals for transfer of patients who cannot be admitted into the ED or hospital.

The goal of the Hospital ED is to provide integrated services that will improve healthcare outcomes and ensure patient safety.

III. DEFINITIONS

A. **Emergency Services:** refers to any healthcare services provided for immediate attention and management of patients with a serious medical condition that a prudent layperson with an average knowledge of medicine and health perceives is a serious medication requiring treatment within the hospital's capabilities.

B. **EMTALA (Emergency Medical Treatment and Labor Act):** refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, which obligates hospitals to provide medical screening, stabilizing treatment, and/or transfer of patients who may have an EMC (emergency medical condition) and women in labor.

C. **Conditions of Participations (CoPs):** refers to health and safety standards developed by the Centers for Medicare & Medicaid Services (CMS) that healthcare organizations including Critical Access Hospitals (CAHs) must meet in order to participate in the Medicare and Medicaid programs. The health and safety standards are the core for the improvement of quality and ensuring the health and safety of beneficiaries. Through this process CMS ensures that the standards of accrediting organizations that are recognized by CMS must meet or exceed the standards set forth by Medicare in the CoPs.

IV. OBJECTIVES

The objectives of the ED for [insert name of hospital] include but are not limited to the following:

- To provide emergency services to patients to preserve life, prevent deterioration before more definitive treatment can be given and when possible restore the patient to a baseline level of function.
- Delivering safe and effective healthcare to patients who present to the ED seeking emergency medical services.
- Ensuring compliance with Hospital policies and procedures, State & Federal Laws including but not limited to: EMTALA and CMS CoPs
- ED Medical and nursing staff will maintain a specialized knowledge in emergency management, triage, and team communication, to provide high quality care, support and patient outcomes.
- Utilization of skills in critical assessment, communication and organization to elevate patient care and contribute to the performance of the ED.
- Assessing, developing and implementing healthcare plans for patients, including post discharge care that may include home care for injuries, additional diagnostic testing, further healthcare provider evaluation or coordinated ED care such as referrals/transfers for follow-up services.
- Provision of exceptional services to patients and their families.

ATTACHMENTS

NA

REFERENCES

Emergency Nurses Association (2019). *Position Statement: Safe Discharge from the Emergency Department.*

Emergency Nurses Association (2018). *Emergency Nursing: Core Curriculum. 7th Edition.*

Han, C., Barnard, A. & Chapman, H. (2009). Discharge planning in the emergency department: A comprehensive approach. Journal of Emergency Nursing, 35(6), 525–527. https://doi.org/10.1016/j.jen.2009.01.015

West, R. MA PhD. (2000). Objective standards for the emergency services: emergency admission to the hospital. Journal of the Royal Society of Medicine. [Electronic Version]. Retrieved on 02/12/20 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1310596/pdf/11383429.pdf

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
ED Nursing Standard of Practice		**EMD-004**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center. This policy is an emergency department policy applying to all nurses employed as emergency department nurses or working in the emergency department.

II. POLICY

The practice of emergency nursing is a specialized area of practice and requires a specialized body of knowledge and skills. The emergency nurses at Mangum Regional Medical Center are accountable to standards of practice and professional role performance identified by the Emergency Nurses Association (ENA) and all applicable laws and regulations to ensure safe, quality emergency care. The ENA standards of practice and professional role performance are as follows:

A. STANDARDS OF ED NURSING PRACTICE

STANDARD 1: Assessment

The ED nurse is responsible for the collection of pertinent data and information to the patient's health and/or situation. These ED nurse competencies include but are not limited to:

- The collection of pertinent data including but not limited to: demographics, physical, functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual, social determinants of health, health disparities, and economic assessments in a systematic, ongoing process.
- Prioritizing the collection of data based on the patient's immediate condition, anticipated needs, or situation.
- The implementation and use of evidenced based assessment and tools relevant to the situation.

- Eliciting the patient's values, preferences, needs (expressed and unexpressed), and healthcare situation knowledge.
- Being cognizant of the impact of personal attitudes, values and beliefs on the assessment process.
- Recognizing barriers to effective communication based on psychosocial, literacy, financial, and cultural considerations.
- Adhering to ethical, legal, regulatory, and privacy guidelines in the collection, maintenance, use, and dissemination of data and information.
- Recognizing the patient or their designated proxy as the authority on their healthcare decisions by honoring their healthcare preferences.
- Documenting relevant data in a manner accessible/retrievable to the interdisciplinary team

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Performing an assessment, including an H&P exam, and EMTALA-specific medical screening examination.
- Ordering diagnostic tests and procedures.
- Using advanced assessment, knowledge, and skills to maintain, enhance, or improve health conditions, including responding to rapidly changing physiological or mental status of the patient.

STANDARD 1a: Triage

The ED nurse is responsible for triaging each patient who presents to the emergency department and optimizing the flow to expedite those who require immediate care. ED nurse competencies include but are not limited to:

- Understanding and being compliant with EMTALA and HIPAA requirements.
- Prioritizing ED patients and their care needs.
- Appropriately using the ESI Triage system, including utilization of age and developmentally appropriate and culturally sensitive practices to determine the appropriate triage acuity level.
- Assisting other ED team members with facilitating placement of patients who require immediate care.
- Implementing interventions or diagnostics according to established Hospital policies/protocols, as warranted by the patient's condition.
- Documenting the triage acuity level for each patient in the patient's medical record.
- Communicating significant triage findings to ED team members in a timely manner.
- Collaborating with other ED team members to reassess patients already triaged in the waiting room according to the Triage Using the ESI Index or Pediatric Triage and acuity levels.

- Initiating the patient educational process and documenting education in the patient's medical record.
- Collaborating with appropriate disaster personnel and incident command for institutional awareness, safety and security measures.
- Modifying the triage decision-making process depending on the circumstances, as dictated by either routine operations or disaster management.
- Participating in process improvement projects when appropriate.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- The provision of an appropriate medical screening examination.
- Facilitating diagnostic evaluations, procedural interventions, and medication administration as needed.

STANDARD 2: Diagnosis

The ED nurse is responsible for analyzing assessment data collected to determine actual or potential diagnoses, problems, and issues. ED nurse competencies include but are not limited to:

- Identifying actual or potential barriers to the patient's health and safety or risks to health, which may include but are not limited to: interpersonal, systematic, cultural, or environmental circumstances.
- Validating the diagnoses, problems and issues with the individual, family, and interdisciplinary team members.
- Prioritizing diagnoses, problems and issues based on mutually established goals to meet the needs of the patient across the health-illness continuum.
- Documenting diagnoses, problems, and issues in a manner that facilitates the expected outcomes and plan.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Formulating a differential diagnosis list based on the assessment, history, diagnostic tests, and physical examination.
- Determining a final diagnosis.

STANDARD 3: Outcomes Identification

The ED nurse is responsible for identifying the expected outcomes for a plan individualized to the patient or the situation. ED nurse competencies include but are not limited to:

- Formulating culturally sensitive expected outcomes derived from assessments and diagnoses.

- Using clinical expertise and current evidence-based practice to identify health risks, benefits, costs, and/or expected trajectory of the condition.
- Collaborating in shared decision-making between the patient and healthcare providers to define expected outcomes integrating the patient's culture, values, and ethical considerations.
- Engaging the patient, family and the interdisciplinary team to identify expected outcomes.
- Developing expected outcomes that facilitate coordination of care.
- Generating an estimated time frame for attainment of expected outcomes that is communicated to the patient and the patient's family.
- Documenting expected outcomes as measurable goals in the patient's medical record.

STANDARD 4: Planning

The ED nurse is responsible for developing a plan that prescribes strategies to attain expected, measurable outcomes. ED nurse competencies include but are not limited to:

- Developing an individualized, holistic, evidence-based plan in partnership with the patient and interdisciplinary team.
- Establishing the plan priorities with the patient and interdisciplinary team.
- Advocating for responsible and appropriate use of interventions to minimize unwarranted or unwanted treatment and/or patient suffering.
- Prioritizing elements of the plan based on the assessment of the patient's level of risk and safety needs.
- Ensuring evidence-based strategies in the plan to address each of the identified diagnoses, problems or issues. These strategies may include but are not limited to:
    - Promotion of wellness and restoration of health
    - Prevention of illness, injury, and disease
    - Facilitation of healing
    - Alleviation of suffering
    - Supportive end-of-life care
- Considering the economic impact of the plan on the patient, family, caregiver, or other affected parties.
- Developing a plan that reflects compliance with current statutes, rules and regulations, and standards.
- Modifying the plan according to ongoing assessments, data evaluation, the patient's response, available resources, and other outcome indicators.
- Documenting the plan using transparent, standardized language and recognized terminology.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Integrating assessment and diagnostic strategies, and therapeutic interventions that reflect current evidence-based knowledge and practice.
- Utilizing assessment and diagnostic findings to determine an appropriate disposition and outcome.

STANDARD 5: Implementation

The ED nurse is responsible for the implementation of the identified plan. ED nurse competencies include but not limited to:

- Partnering with the patient to implement a safe, effective, efficient, timely, patient-centered and equitable plan.
- Implementing a plan through collaboration and communication across the continuum of care with the interdisciplinary care team.
- Demonstrating caring behaviors to develop therapeutic relationships.
- Using evidence-based interventions and strategies to achieve the mutually identified goals and outcomes specific to the problem or needs.
- Integrating critical thinking and technology solutions to implement the nursing process to collect, measure, record, retrieve, trend, and analyze data and information to enhance nursing practice and patient outcomes.
- Delegating according to the health, safety and welfare of the patient and considers the circumstance, person, task, direction or communication, supervision, and evaluation, as well as the state nurse practice act regulations, institution, and regulatory entities, while maintaining accountability for the care.
- Documenting implementation and any modification, including changes or omissions of the identified plan.
- Assuming responsibility for transparency during the planning and implementation process.

Additional competencies for the Advanced Practice Registered Nurse include but not limited to:

- Using prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.
- Managing an identified population based on professional preparation and board certification.
- Prescribing traditional and integrative evidence-based treatments, therapies, and procedures that are compatible with the patient's cultural preferences and norms.
- Prescribing evidence-based pharmacologic agents and treatments according to clinical indicators and results of diagnostic and laboratory tests.
- Providing clinical consultations for patients and professionals related to complex clinical cases to improve care and population outcomes.

STANDARD 5a: Coordination of Care

The ED nurse is responsible for the coordination of the patient's care delivery. ED nurse competencies include but are not limited to:

- Organizing the components of the patient's plan.
- Collaborating with the patient to help manage healthcare delivery based on mutually agreed upon outcomes.
- Engaging patients in self-care to achieve preferred goals for quality of life.
- Assisting the patient to identify barriers and provide alternative options for care.
- Communicating with the patient, interdisciplinary team, and community-based resources for safe transitions in continuity of care.
- Advocating for the delivery of dignified and holistic care by the interdisciplinary team.
- Documenting the coordination of care in the patient's medical record.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Managing an identified patient population based on professional preparation and board certification.
- Serving as the patient's direct care provider and coordinator of healthcare services in accordance with all applicable laws and regulations.
- Synthesizing patient data and information to prescribe and provides necessary system and community support measures.
- Supervising patient care delivered by the interdisciplinary team as appropriate.

STANDARD 5b: Health Teaching and Health Promotion

The ED nurse is responsible for employing strategies to promote a healthy and safe environment. ED nurse competencies include but are not limited to:

- Providing opportunities for the patient to identify barriers and knowledge gaps in healthcare promotion, disease prevention, and self-management topics
- Using health promotion and health teaching methods in collaboration with the patient's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preferences, spirituality, culture, and socioeconomic status.
- Using feedback and evaluations from the patient to determine the effectiveness and satisfaction of the employed strategies.
- Using technologies to communicate health promotion and disease prevention information to the patient.
- Providing appropriate and applicable instructions and anticipatory guidance to patients to promote health and prevent or reduce the risk of negative health outcomes.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Providing appropriate chronic disease anticipatory guidance, health promotion instructions, and applicable referrals that improve health and prevent or reduce the risk of negative health outcomes.

STANDARD 6: Evaluation

The ED nurse is responsible for evaluating the patient's progress toward attainment of goals and outcomes. The ED nurse competencies include but are not limited to:

- Conducting a systematic, ongoing, and criterion-based evaluation of the goals and outcomes in relation to the structure, processes, and timeline prescribed in the plan.
- Collaborating with the patient and others involved in the care or situation in the evaluation process.
- Using ongoing evaluation and assessment data to revise the diagnoses, outcomes, plan, and implementation strategies.
- Sharing evaluation data and conclusions with the patient and other stakeholders in accordance with federal and state regulations.
- Documenting the results of the evaluation in the patient's medical record.

B. STANDARDS OF ED NURSING PROFESSIONAL PERFORMANCE

STANDARD 7: Ethics

The ED nurse will practice in an ethical manner. ED nurse competencies include but are not limited to:

- Integrating the *Code of Ethics for Nurses with Interpretive Statements* to guide nursing practice.
- Practicing with compassion and respect for the inherent dignity, worth, and dynamic attributes for all people.
- Advocating for patients' rights to informed decision-making and self-determination.
- Seeking guidance in situations where the rights of the individual conflict with public health guidelines.
- Endorsing the understanding that the primary commitment is to the patient regardless of setting or situation.
- Maintaining therapeutic relationships and professional boundaries.
- Advocating for the rights, health, and safety of the patient and others by taking appropriate action regarding illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the patient or situation.
- Safeguarding the privacy and confidentiality of patients, others, and their data and information within ethical, legal, and regulatory parameters.
- Demonstrating professional accountability and responsibility for nursing practice.

- Maintaining competences through continued personal and professional development.
- Contributing to the establishment and maintenance of an ethical environment that is conducive to safe, quality healthcare.

STANDARD 8: Culturally Congruent Practice

The ED nurse is responsible for a practice that is congruent with cultural diversity and inclusion principles. ED nurse competencies include but are not limited to:

- Demonstrating of respect, equity, and empathy in actions and interactions with all patients.
- Participating in life-long learning to understand cultural preferences, worldview, choices, and decision-making processes of diverse patients and their families.
- Performing critical reflection by taking inventory of one's own values, beliefs, and cultural heritage.
- Appling knowledge of variations in health beliefs, practices, and communication patterns in all nursing practice activities.
- Considering the effects and impact of discrimination and oppression on practice within and among vulnerable cultural groups.
- Communicating with appropriate language and behaviors, including the use of medical interpreters and translators in accordance with patient preferences.
- Identifying the cultural-specific meaning of interactions, terms, and content.
- Respecting patient decisions based on age, tradition, belief, family influence, and stage of acculturation.

Additional competencies for the Advanced Practice Registered Nurse include but not limited to:

- Promoting shared decision-making solutions in planning, prescribing, and evaluating processes when the patient's cultural preferences and norms may conflict with current evidence-based practice.
- Leading interdisciplinary teams to identify the cultural and language needs of the patient.

STANDARD 9: Communication

The ED nurse is responsible for communicating effectively in all areas of their practice. ED nurse competencies include but are not limited to:

- Assessment of one's own communication skills and effectiveness.
- Demonstrating cultural empathy when communicating.
- Assessing communication ability, health literacy, resources, and preferences of patients to inform the interdisciplinary team and others.
- Using transparent, linguistically sensitive language and translation resources to ensure effective communication.

- Incorporating appropriate alternative strategies to communicate effectively with patients and family members who have visual, speech, language, or communication difficulties.
- Using communication styles and methods that demonstrate caring, respect, deep listening, authenticity, and trust.
- Conveying accurate and timely information.
- Maintaining communication with the interdisciplinary team and others to facilitate safe transitions and continuity in care delivery.
- Exposing care processes and decisions when they do not appear to be in the best interest of the patient.
- Disclosing concerns related to potential or actual hazards and errors in care or the practice environment to the appropriate level.
- Demonstrating continuous improvement of communication skills.

STANDARD 10: Collaboration

The ED nurse is responsible for collaborating with the patient and other key stakeholders in the conduct of nursing practice. ED nurse competencies include but are not limited to:

- Identifying the areas of expertise and contribution of other professional and key stakeholders.
- Clearly articulating the nurse's role and responsibilities within the team.
- Partnering with the patient and key stakeholders to advocate for and effect change, leading to positive outcomes and quality care.
- Using appropriate tools and techniques, including information systems and technologies, to facilitate discussion and team functions in a manner that protects dignity, respect, privacy, and confidentiality.
- Promoting engagement through consensus building and conflict management.
- Using effective group dynamics and strategies to enhance team performance.
- Demonstrating dignity and respect when interacting with others and giving and receiving feedback.
- Partnering with stakeholders to create, implement, and evaluate a comprehensive plan.

STANDARD 11: Leadership

The ED nurse is responsible for leading within the professional practice setting and the profession. ED nurse competencies include but are not limited to:

- Contributing to the establishment of an environment that supports and maintains respect, trust and dignity.
- Encouraging innovation in practice and role performance to attain personal and professional plans, goals, and vision.
- Communicating to manage change and address conflict.

- Mentoring colleagues for the advancement of nursing practice and the profession to enhance safe practice, safe care through participation in administrative teams, councils, and committees.
- Retaining accountability for delegated nursing care.
- Supporting nursing autonomy and accountability to establish an environment that motivates constructive change.

STANDARD 12: Education

The ED nurse is responsible for seeking knowledge and competence that reflects current nursing practice and promotes futuristic thinking. ED nurse competencies include but are not limited to:

- Identifying learning needs based on nursing knowledge and the various roles the nurse may assume.
- Participation in ongoing educational activities related to nursing and interprofessional knowledge bases and professional topics.
- Mentoring nurses new to their roles for the purposes of ensuring successful integration into the emergency care setting, including assistance with skill advancement, knowledge acquisition, orientation, and emotional support.
- Demonstration of a commitment to lifelong learning through self-reflection and inquiry for learning and personal growth.
- Seeking experiences to maintain current practice while advancing knowledge, skills, abilities, attitudes, and judgment in clinical practice or role performance.
- Acquiring knowledge and skills relative to the role, population, specialty, setting, and local health situation.
- Participation in formal consultations or informal discussions to address issues in nursing practice as an application of education and knowledge.
- Identifying modifications or accommodations needed in the delivery of education based on patient or family members' needs.
- Sharing educational findings, experiences, and ideas with interprofessional team members.
- Supporting acculturation of nurses new to their roles by role modeling, encouraging, and sharing pertinent information relative to optimal care delivery
- Facilitating a work environment supportive to ongoing education of the healthcare team.

STANDARD 13: Evidence-Based Practice and Research

The ED nurse is responsible for integrating evidence and research finding into practice. ED nurse competencies include but are not limited to:

- Articulating the values of research and its application relative to the healthcare setting and practice.
- Identifying areas and questions in the healthcare setting and practice that can be answered by nursing research.

- Using current evidence-based knowledge, including the dissemination of research findings, to guide practice.
- Incorporating evidence when initiating changes in nursing practice.
- Participation in the formulation of evidence-based practice through research and quality improvement activities.
- Sharing peer-reviewed research findings with colleagues to integrate knowledge into nursing practice.

STANDARD 14: Quality of Practice

The ED nurse is responsible for contributing to nursing practice quality. ED nurse competencies include but are not limited to:

- Ensuring nursing practice is safe, effective, efficient, equitable, timely, and patient-centered.
- Participation in self-reflection, performance appraisal, and peer review to improve the quality of care provided.
- Identifying barriers and opportunities to improve healthcare delivery, safety, effectiveness, efficiency, equitability, timeliness, and patient- and family-centeredness.
- Recommending strategies to improve nursing quality.
- Using creativity and innovation to enhance nursing care.
- Participation in quality improvement activities.
- Collecting data to monitor the quality of nursing practice.
- Contributing in efforts to improve healthcare efficiency.
- Collaborating with the interdisciplinary team to implement quality improvement teams and interventions.
- Documenting nursing practice in a manner that supports quality and performance improvement initiatives.
- Participation in developing and maintaining triage competency standards, including education, peer review, and continuous quality improvement chart audits.
- Using health communication strategies and information technology to improve healthcare equity, quality, and outcomes.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Engaging in comparison evaluations of the effectiveness and efficacy of diagnostic tests, clinical policies and procedures, therapies, and treatment plans with the interdisciplinary team.
- Applying knowledge obtained from advance preparation, as well as current research and evidence-based information, to clinical decision-making at the point of care to achieve optimal health outcomes.

- Using available benchmarks as a means to evaluate practice at the individual, departmental or organizational level.
- Maintaining population-focused and/or emergency specialty board certification.

STANDARD 15: Professional Practice Evaluation

The ED nurse is responsible for evaluating one's own and others' nursing practice. ED nurse competencies include but are not limited to:

- Engaging in self-reflection and self-evaluation of nursing practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial.
- Ensuring nursing practice is consistent with regulatory requirements pertaining to licensure, relevant statutes, rules, and regulations.
- Using organizational policies and procedures to guide professional practice.
- Providing evidence for practice decisions and actions as part of the formal and informal evaluation processes.
- Seeking formal and informal feedback regarding one's own practice from patients, peers, colleagues, supervisors, and others.
- Providing peers and others with formal and informal constructive feedback regarding their practice or role performance.
- Taking action to achieve goals identified during the evaluation process.

STANDARD 16: Resource Utilization

The ED nurse is responsible for utilizing recourse to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible. ED nurse competencies include but are limited to:

- Assessing patient care needs and resources available to achieve desired outcomes.
- Assisting the patient in factoring costs, risks, and benefits in decisions about care.
- Assisting the patient in identifying and securing appropriate services to address needs across the healthcare continuum.
- Delegating in accordance with applicable legal and policy parameters.
- Identifying impact of resource allocation on the potential for harm, complexity of the task, and desired outcomes.
- Advocating for resources that support and enhance the nursing process.
- Using organizational and community resources to implement interdisciplinary plans.
- Addressing discriminatory healthcare practices and utilization of resources.

Additional competencies for the Advanced Practice Registered Nurse include but are not limited to:

- Engaging in organizational and community resources to formulate and implement interdisciplinary plans, optimize transitions of care, and improve patient care outcomes.
- Incorporating knowledge of payment and reimbursement systems and financial resources into the plan of care for patients receiving emergency care.

STANDARD 17: Environmental Health

The ED nurse is responsible for practicing in an environmentally safe and healthy manner. ED nurse competencies include but not limited to:

- Promoting a safe and healthy workplace and professional practice environment.
- Using environmental health concepts in practice.
- Assessing the environment to identify risk factors.
- Reducing environmental health risks to self, colleagues, and patients.
- Communicating information about environmental health risks and participates in adaptation, mitigation, and exposure-reduction strategies.
- Advocating for the safe, judicious, and appropriate use and disposal of healthcare products.
- Incorporating technologies to promote safe practice environments. Use products or treatments consistent with evidence-based practice to reduce environmental threats.
- Participating in developing strategies to promote healthy communities.
- Supporting the integration of environmental health policy into nursing education, practice, research, advocacy, and public policy.

ATTACHMENTS

NA

REFERENCES

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
ED Assessment Reassessment Policy		**EMD-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center Emergency Department's (ED) nursing and medical staff and any other individuals acting on behalf of Mangum Regional Medical Center.

II. PURPOSE

To provide the ED nursing and medical staff with direction and expectations for the initial assessment, ongoing reassessment, transition of care and discharge assessments of patients in the ED to ensure safe and quality patient care.

III. DEFINITIONS

A. **Assessment:** means the collection of data regarding the patient's physiological, psychological, sociological and spiritual condition by a registered nurse (RN).

B. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an EMC does or does not exist.

B. **Triage:** entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other QMP.

IV. POLICY

Triage is a process that will be initiated upon patient arrival to rapidly assess the severity of the patient's injury or illness and assign priorities of care to be provided. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs. Goals of triage include:

- Rapid identification of life-threatening illnesses or injuries

- Prioritizing care for patients with emergent needs
- Facilitate the flow of patients through the ED
- Refer patients to the appropriate level of care in the ED

The ED triage assessment of the patient will include the rapid systematic collection of subjective and objective data that is relevant to each patient. A primary nursing assessment will be obtained for all patients presenting to the ED, regardless of initial complaint, to ensure that potentially life-threatening conditions are identified and immediately addressed. Nursing staff will perform a secondary nursing assessment (brief focused assessment) after the primary assessment and any resuscitation efforts. The purpose of the secondary assessment is to identify any other abnormalities or injuries the patient may have that are not life-threatening.
All patients who present to the ED will receive an appropriate medical screening examination (MSE), including any labs and/or diagnostic testing if indicated by a physician or mid-level provider.
The assessment of patients is an interdisciplinary process. Data received from the patient and/or family will be included in the assessment. Assessment data is documented in the patient's medical record and will be shared among disciplines to enhance the continuity of care.

V. PROCEDURE

A. Triage Assessment

1. All patients who present to the ED will be assessed using the Emergency Severity Index (ESI) triage tool to assign an acuity score based on the patient's presenting chief complaint, signs/symptoms, triage assessment, and vital signs.
2. Vital signs may be deferred in triage if the patient is being transferred on arrival to an ED room for emergent/urgent assessment. The triage assessment and primary nursing assessment may be completed concurrently if the patient is being transferred immediately to an ED room on arrival.
3. Complete set of vital signs will be obtained on all patients and include the following:
    a. Blood Pressure (BP);
    b. Heart Rate (HR)/pulse;
    c. Respiratory Rate (RR);
    d. Temperature (T);
    e. Oxygen Saturation (O2 sat); and
    f. Pain Score or the absence of pain as applicable: using a validated pain rating scale (i.e. Numeric Pain Scale, Wong-Baker Faces Scale, etc.)
4. All pediatric patients' HR/pulse, RR, O2 sat, temperature and pain score (if applicable) will be obtained as part of the triage assessment. Blood pressures will be obtained on pediatric patients aged five (5) years and older.
    a. When there is difficulty obtaining a blood pressure on a pediatric patient, it is acceptable to defer BP measurement until the patient is taken into the ED room.

b. A weight will be obtained on all pediatric patients. It is acceptable to defer obtaining the weight until the patient is roomed in the ED area. All weights will be obtained in kilograms (kg). A length-based resuscitation tape (i.e. Broselow Pediatric Emergency Tape) may be used for higher acuity presentations.

5. Neurological vital signs will be assessed based on patient presentation (i.e. altered level of consciousness, suspected stroke, suspected head injury, seizures, etc.) and include but not limited to the following:
   a. Glasgow Coma Scale (GCS);
   b. Pupil size and reaction
   c. Motor assessment
   d. Sensation assessment

B. Triage Reassessment

1. Triage nurse will perform accurate and timely reassessment of the patient's condition and vital signs for those waiting examination by the physician/mid-level provider per the following timeframes:

ESI	I	II	III	IV-V
	Immediate; life-threatening	Stable; as soon as possible	Stable; no distress	Stable; no distress
Reassessment	Continuous	Every 15 minutes	Every 60 minutes & PRN	Every 2-4 hours & PRN
Examples	Cardiac arrest; major trauma; respiratory distress	Stroke; severe pain; open fracture	Closed fracture; acute abdomen	Rash; constipation;

2. [insert Hospital's name] recognizes that there may be times when acuity is high or ED volume is at maximum and it may prohibit meeting the identified reassessment guidelines, and therefore the RN may have to modify the minimal reassessment timeframes to meet the needs of all patients.

C. Nursing Assessment and Reassessment

1. The initial primary patient assessment should be completed on all patients within 5 minutes after admission to the ED and should include but not be limited to the following:
   - Chief complaint including precipitating event/onset of symptoms, mechanism of injury
   - Progression of condition: from symptom onset or injury to initiation of care including history of present illness/injury, location of problem, duration of symptoms, characteristics, aggravating/relieving factors, treatment prior to arrival
   - Objective data collection (**ABCDE**):
     - **A**irway patency with cervical spine protection for all suspected trauma patients: assessment of airway
     - **B**reathing effectiveness: assessment of breathing
     - **C**irculation effectiveness: assessment of circulation, perfusion and signs of bleeding

- **D**isability (brief neurologic examination)
- **E**xposure/environmental controls: assessment of environmental, infectious exposure, environmental trauma, substances/alcohol

2. The goal of resuscitation is to correct a life-threatening condition and should follow the same **ABCDE** mnemonic to ensure interventions occur simultaneously during the primary assessment. These include but should not be limited to the following:
   - **A**irway/Cervical Spine protection: basic airway management, immobilization/stabilization of the cervical spine
   - **B**reathing: non-invasive ventilation, CPAP, Bipap, advanced airway management including rapid sequence induction protocols
   - **C**irculation/Bleeding: chest compressions, control significant bleeding, splint fractures, control of epistaxis, administer fluids and/or blood
   - **D**isability (Neurologic status): identify possible etiologies of decreased level of consciousness or altered mental status, perform neurological assessments including Glasgow Coma Scale and National Institutes of Health Stroke Scale, administer pharmacological therapy as indicated.
   - **E**xposure/Environmental Controls: remove clothing, caution for sharp objects, weapons. Prevent heat loss and increase in coagulopathies.
3. The secondary patient assessment is a brief/focused assessment that should occur after the initial primary assessment and any resuscitation efforts. The purpose of the secondary patient assessment is to identify any other abnormalities or injuries that are not life threatening. This assessment should include but not be limited to:
   - A full set of vital signs, including assessment of pain
   - Head to Toe assessment: a complete/comprehensive head-to-toe assessment should be completed for all critically ill or injured patients. A more focused head-to-toe assessment may be completed for patients who present to the ED with a specific minor injury or complaints that are limited to one body system.
4. The frequency of reassessment and/or vital signs to be completed on all patients, unless otherwise ordered should be as follows:
   a. A minimum of every four (4) hours for all patients; and/or
   b. A minimum of every hour for all patients who require continuous cardiac monitoring.
   c. More frequent reassessments may be considered in the following situations:
      i. clinical judgment;
      ii. vital signs or patient assessment not within expected limits for the patient;

iii. after administration of medication with the potential to alter vital signs or patient condition (i.e. narcotics, anti-arrhythmics, blood pressure medications)
iv. any change in patient's medical condition.

d. Vital sign frequency may be determined based on established protocols/guidelines, including but not limited to:
i. Diagnosis based (i.e. stroke, STEMI, Chest pain, Sepsis)
ii. Medication (Heparin, Cardene, Alteplase)

e. Documentation in the patient's medical record should include assessment of:
i. Effects of medication
ii. Complete set of vital signs
iii. Observations of the patient's medical condition
iv. All treatments/procedures/interventions, and the patient's response

D. Physician/Mid-Level Provider Assessment

1. An appropriate MSE will be performed on each patient who presents to the ED and be tailored to each patient's presenting symptoms and complaints. Depending on the patient's presenting symptoms and complaints, the MSE may be as simple as a brief history and physical exam or a more complex process that involves ancillary studies, lab test, x-rays, and/or other diagnostic studies.
2. If the patient experiences a change in condition while in the ED the physician/mid-level provider will perform a reassessment that may include additional ancillary studies depending on the patient's condition.
3. The physician/mid-level provider must document the MSE and any treatment in the patient's medical record.

E. Shift Change or Transition of Care Assessments

1. At the beginning of each shift or transfer of care, the RN should assess and document in the patient's medical record the following information:
a. a comprehensive or focused patient assessment depending on patient presentation;
b. a complete set of vital signs, including assessment of pain;
c. verify placement of invasive lines and/or tubes (i.e. foley, nasogastric tubes, etc.)
d. assessment of IV site patency;
e. review of the IV solution, rates and pump settings;
f. update intake and output (I&O); and
g. obtain cardiac rhythm strip if patient is being monitored and attach to patient's chart.
2. At the beginning of shift or transfer of care the RN should review the orders in the patient's medical record.

F. Discharge Assessment

1. Prior to discharge the RN should perform a focused reassessment to determine the patient's clinical condition and readiness for discharge.

2. Any changes in the patient's clinical condition should be immediately reported to the physician/mid-level provider.

VI. DOCUMENTATION

All assessment, reassessment, interventions, and patient responses should be documented in the patient's medical record.

VII. RESPONSIBLE PARTIES/QUALITY ASSURANCE

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Nursing Officer and an incident report completed.

All incident reports will be forwarded to the Quality Risk Manager and reported to the QAPI, MEC, and Governing Board.

ATTACHMENTS

NA

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Triage using the Emergency Severity Index		**EMD-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and prioritization of patients based on level of acuity and resources using an evidence based five-level triage assessment tool for those patients presenting to the Emergency Department (ED).

PURPOSE

The Hospital has adopted the Emergency Severity Index (ESI) for triaging patients arriving in the ED to improve the quality and safety of patient care. The ESI is an evidence based five level triage scale that facilitates the prioritization of patients based on the urgency of treatment for the patients' condition. The triage nurse initially performs a brief focused assessment to assign a triage acuity level, which determines how long a patient can safely wait to be seen by a physician/mid-level provider and receive a medical screening examination (MSE) and treatment. In 2010 the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) revised their original statement regarding the use of triage scales as follows: "*the ACEP and ENA believe that the quality of patient care benefits from implementing a standardized emergency department (ED) triage scale and acuity categorization process. Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five level triage scale such as the Emergency Severity Index (ESI).*" In 2010 the Centers for Disease Control and Prevention National Center for Health Statistics provided a report that categorized acuity on arrival as a five-level based on how urgently the patient needed to be seen by the physician or healthcare provider and included the following categories:

Acuity Level	Time Seen
Level 1 - Immediate	Immediately
Level 2 - Emergent	10-20 minutes
Level 3 - Urgent	15-60 minutes
Level 4 – Semi-Urgent	1-2 hours
Level 5 – Non-Urgent	2-24 hours

Finally, the triage nurse is responsible for determining resources necessary to move the patient to a final disposition (admission, discharge, or transfer) for those patients who do not meet a high acuity level. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs.

DEFINITIONS

A. **Acuity:** refers to the severity of the illness or injury, as well as the potential for complications. Acuity is determined by the stability of the patient's vital functions and the potential for the threat to life, limb or organ.
B. **Emergency Severity Index (ESI):** an evidence-based five-level triage scale developed as a triage tool to help facilitate the prioritization of patients arriving in the ED based on the urgency of the patients' condition.
C. **Disposition:** means where the patient is being discharged to such as admitted to the hospital, discharged to home or transferred to another facility.
D. **High-Risk Situation:** refers to a patient with a condition that could easily deteriorate or presents with symptoms suggestive of a condition requiring time-sensitive treatment. This patient presents with a potential for a threat to life, limb or organ. Examples include but not limited to active chest pain, signs of stroke, suicidal or homicidal patient.
E. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an emergency medical condition (EMC) does or does not exist.
F. **Resources:** refers to the number of resources a patient is expected to consume for a disposition decision to be reached. Resources would include but not limited to hospital services, tests, procedures, consults or interventions that are above and beyond the history and physical, or simple interventions such as applying a bandage.
G. **Triage:** entails the clinical assessment of the patient's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the patient will be seen by the physician or other QMP.

POLICY

Triage is a process that will be initiated upon the patient's arrival to rapidly assess the severity of the patient's injury or illness and assign priorities of care to be provided. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs. Goals of triage include:

- Rapid identification of life-threatening illnesses or injuries
- Prioritizing care for patients with emergent needs
- Facilitate the flow of patients through the ED
- Refer patients to the appropriate level of care in the ED

The ED triage assessment of the patient will include the rapid systematic collection of subjective and objective data that is relevant to each patient. The triage nurse will then assign an acuity

level using the ESI Triage Algorithm (see EMD-006A) based on the needs of the patient and determine how long the patient can safely wait before receiving an MSE and treatment by a physician/mid-level provider. If the triage nurse determines the patient is not a high acuity patient, then the triage nurse will then determine the number of resources the patient is going to consume for the patient to reach a disposition decision. The triage nurse will estimate the number of resources based on the patient's brief subjective/objective assessment, past medical history, allergies, medications, age/gender and ED standards of practice. The triage nurse will review the patient's vital signs and if outside accepted parameters the nurse will consider upgrading the patient to a Level 2 based on the ESI Triage Algorithm. If all ED beds are full and the patient is stable enough to wait in the ED waiting room, reassessment will be performed at defined intervals. Any significant symptoms will be reassessed, and acuity level will be increased if necessary. The triage nurse will use ESI criteria to determine to triage level and assign ED room assignment regardless of method of arrival.

PROCEDURE

A. All patients presenting to the ED will initially be triaged using the ESI Triage Algorithm in order to identify life-threatening conditions and prioritize patients according to acuity.
B. The triage nurse will determine if the patient requires immediate life-saving intervention. If the patient requires life-saving intervention, then the triage process is complete, and the patient will be triaged as a Level 1 and taken directly to an ED room and seen by a physician/mid-level provider immediately.
    1. When determining if the patient requires immediate life-saving intervention, the triage nurse must also assess the patient's level of consciousness using the AVPU (alert, verbal, pain, unresponsive) scale.

AVPU	LEVEL OF CONSCIOUSNESS
A	Alert. The patient is alert, awake and responds to voice. The patient is oriented to time, place and person. The triage nurse is able to obtain subjective information.
V	Verbal. The patient responds to verbal stimuli by opening their eyes when someone speaks to them. The patient is not fully oriented to time, place, or person.
P	Painful. The patient does not respond to voice, but does respond to a painful stimulus, such as a squeeze to the hand or sternal rub. A noxious stimulus is needed to elicit such a response.
U	Unresponsive. The patient is nonverbal and does not respond even when a painful stimulus is applied.
Emergency Nurse Association, 2000	

    2. Once Level 1 criteria has been met and the patient has been taken to an ED room a full set of vital signs should be obtained which should include the following:
        a. Blood pressure
        b. Heart Rate (HR)
        c. Respiratory Rate (RR)
        d. Temperature

e. Oxygen Saturation (SpO2)

3. Examples of ESI Level 1 patients include but are not limited to:
    - Cardiac arrest
    - Respiratory arrest
    - Severe respiratory distress
    - SpO2 < 90%
    - Critically injured unresponsive trauma patient
    - Overdose patient with respiratory rate of 6 or less
    - Severe respiratory distress with agonal or gasping type respirations
    - Severe bradycardia or tachycardia with signs of hypoperfusion
    - Trauma patient who requires immediate crystalloid and colloid resuscitation
    - Chest pain, pale, diaphoretic, blood pressure 70/palpation
    - Weak and dizzy, heart rate 30
    - Anaphylactic shock
    - Unresponsive patient with strong odor of alcohol
    - Hypoglycemia with change in mental status
    - Intubated head bleed with unequal pupils

C. If the triage nurse determines the patient does not meet ESI Level 1 criteria, and does not need immediate life-saving treatment, the triage nurse will determine if the patient can safely wait to be seen by a physician/mid-level provider. The nurse will then consider three (3) questions and obtain pertinent subjective and objective information through a brief focused assessment to determine if the patient meets Level 2 criteria:
    - Is this a high-risk situation?
    - Is the patient confused, lethargic or disoriented?
    - Is the patient in severe pain or distress?

    1. A high-risk patient will be determined based on a brief interview and observation by the triage nurse. In most cases a high-risk patient will not require a detailed physical assessment or vital signs. Examples of high-risk situations include but are not limited to:
        - Active chest pain that does not require immediate life-saving interventions (stable)
        - Signs of stroke that does not meet Level 1 criteria
        - Suicidal/Homicidal patient
    2. To determine Level 2 criteria the triage nurse will assess for an acute change in level of consciousness. Patients with a baseline mental status of confusion would not meet Level 2 criteria.
    3. The triage nurse will assess patients presenting with signs and symptoms of pain with a validated evidence-based pain scale such as the Numeric Pain Scale (See EMD Form B) or the Wong-Baker Faces Scale (See EMD Form C) and clinical observation (i.e. distressed facial expression, diaphoresis, body posture, vital sign changes).
        a. Clinical observation and pain rating should be used to determine Level 2 criteria. For example: severe abdominal pain, diaphoretic, elevated heart rate and blood pressure would meet Level 2 criteria.

4. Once Level 2 criteria has been met and the patient has been taken to an ED room a full set of vital signs should be obtained which should include the following:
    a. Blood pressure
    b. Heart Rate (HR)
    c. Respiratory Rate (RR)
    d. Temperature
    e. Oxygen Saturation (SpO2)

D. If the triage nurse determines the patient does not meet Level 2 criteria, the nurse will then make an estimation of the number of resources the patient will need to reach a disposition decision based on the patient's brief subjective/objective assessment, past medical history, allergies, medications, age/gender and ED evidence-based standards of practice.
    1. To differentiate between ESI Levels 3, 4 and 5 the nurse will need to estimate if the patient needs one (Level 4), two (Level 3), or no (Level 5) resources reach a disposition decision.
        a. Once the nurse determines the patient needs two or more resources, there is no need to continue to estimate resources.
        b. The triage nurse should not count the number of individual tests when estimating resources. The triage nurse should only estimate the number of resources. Examples:
            i. CBC and electrolyte panel, equals one resources (lab test)
            ii. CBC and chest x-ray equal two resources (lab test, x-ray)
            iii. Cervical spine x-ray and head CT scan equals two resources (x-ray and CT scan)
        c. List of resources include but are not limited to:

Resources	Not Resources
Labs (blood, urine	History & physical (including pelvic)
ECG, x-rays, CT-MRI-ultrasound, angiography	Point of care testing
IV fluids (hydration)	Saline or heplock
IV, IM, or nebulized medications	PO medications, Tetanus immunization, Prescription refills
Specialty consultations	Phone call to PCP
Simple procedure = 1 (lac repair, Foley cath)	Simple wound care (dressing, recheck)
Complex procedure = 2 (conscious sedation)	Crutches, splints, slings

E. The triage nurse will obtain a full set of vital signs prior to determining Level 3 criteria. If the patient's vital signs are outside accepted parameters, the nurse will consider upgrading the triage level to ESI Level 2.
    1. A full set of vital signs will include the following:
        a. Blood pressure

b. Heart Rate (HR)
c. Respiratory Rate (RR)
d. Temperature
e. Oxygen Saturation (SpO2)

2. The triage nurse will document the triage level decision in the patient's medical record. The nurse will include the rationale for the triage decision in the patient's medical record.

F. Five-Level ESI Categories and Reassessment Objectives

1. ESI Level 1 – Immediate
    a. Any condition presenting an immediate threat to the patient's life or limb requiring immediate interventions to save the patient's life or to prevent irreversible damage.
    b. Time to Treatment: Immediate.
    c. Reassessment: Continuous.
    d. Presentation: Includes but not limited to patients that are unresponsive, intubated, apneic, pulseless.
    e. When Level 1 criteria is met the triage process must stop and the patient taken directly to an ED room and seen immediately by a physician/mid-level provider and treatment initiated.
2. ESI Level 2 – Emergent
    a. Any condition that potentially threatens the patient's life or limb and could worsen without intervention.
    b. Time to Treatment: Immediate.
    c. Reassessment: Every 15 to 30 minutes, and PRN (as needed).
    d. Presentation: Includes but not limited to patients that have new onset confusion, lethargy or disorientation, severe pain or distress; patients that require two or more resources; heart rate, respiratory rate or oxygen saturation in the danger zone; or high-risk situations.
    e. When Level 2 criteria is met the triage process must stop and the patient taken directly to an ED room and the patient evaluated by a physician/mid-level provider within 20 minutes or less.
3. ESI Level 3 – Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: Less than 1 hour.
    c. Reassessment: Every 1 hour, and PRN.
    d. Presentation: Patients requiring two or more resources with vital signs that are not in the danger zone.
4. ESI Level 4 – Semi-Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: 2 to 4 hours.
    c. Reassessment: Every 2 to 4 hours, and PRN.
    d. Presentation: Patients who only require one (1) resource.
5. ESI Level 5 – Non-Urgent

a. Any condition that requires minimal interventions and will not worsen if treatment is delayed for several hours to days.
b. Time to Treatment goal: 2 to 8 hours.
c. Reassessment: Every 2 to 4 hours, and PRN.
d. Presentation: Patients requiring no resources.

G. If all ED beds are full and the patient's condition is stable enough to wait in the ED waiting room, reassessment should be performed at appropriate intervals. Any significant symptoms should be reassessed for change and the acuity category increased if necessary. Reassessment guidelines are as follows based on the five-level ESI categories:

Acuity Level	Reassessment
Level 1 - Immediate	Continuously
Level 2 - Emergent	Every 15 minutes
Level 3 - Urgent	Every 1 hour, PRN
Level 4 – Semi-Urgent	Every 2 hours, PRN
Level 5 – Non-Urgent	Every 4 hours, PRN

Triage is a dynamic process; a patient's condition may improve or deteriorate at any time during the patient's wait in the ED.

H. If the triage nurse is in doubt regarding a triage category, the triage nurse should choose the higher triage acuity level to avoid under-triaging a patient.
I. The triage nurse will use ESI criteria to determine the triage level and assign ED room assignment regardless of method of arrival.
    a. Arriving by ambulance will not be used a criterion to assign a higher-level acuity and place the patient in an available ED room.
J. Any patient with a cough or fever and/or a rash will be assessed by the triage nurse to determine if isolation is required. If the nurse determines the patient requires isolation a mask will immediately be placed on the patient and the patient will be placed in the isolation ED room. The triage nurse will immediately notify the physician/mid-level provider of the presence of patients requiring isolation.
K. Documentation:
    1. The triage assessment and triage level must be documented in the appropriate area of the nursing note, including the date and time the assessment was completed.
    2. All re-assessments should be documented including date and time completed in the nursing note.
    3. Documentation should be clear, concise and objective.
    4. Documentation should include the time to nurse and time to medical provider in the nursing note.

QUALITY MONITORING

The Quality Manager will review all ED patients presenting to the ED for accurate triage level. The Quality Department will track and monitor the door-to-triage time as it is a key indicator of

a vital emergency department processes. The goal of the ED will be to assign an accurate triage score for immediate, emergent and urgent cases in less than 5 minutes.

Hospital leadership including but not limited to, the Quality Manager and Chief Nursing Officer are responsible for ensuring that all hospital staff adhere to the requirements of this policy, procedures are implemented and followed at the Hospital. All instances of non-compliance with the policy should be reported to the Quality Manager and the Chief Nursing Officer and an incident report completed. All incidents will be reported to following committees: Quality, Medical Staff and Governing Board.

EDUCATION AND TRAINING

All nursing staff (RN and LPNs) are required to have initial orientation and annual education and competency (except as otherwise noted) in the following:

- Emergency Severity Index course
- Emergency Department core competencies

All nursing staff will also be certified in CPR, ACLS, and all RNs will be PALS certified in accordance to the American Heart Association (AHA) standards of training. All clinical staff is required to have CPR certification.

ATTACHMENTS

See Forms:
See EMD Form 006A: ESI Triage Scale
EMD Form B: Numeric Pain Scale
EMD Form C: Wong-Baker Pain Scale

IV. REFERENCES

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

EMERGENCY SEVERITY INDEX TRIAGE ALGORITHM (ESI)

Level 1-Immediate Level II-Emergent Level III-Urgent Level IV-Semi-Urgent Level V-Non-Urgent

A-REQUIRES IMMEDIATE LIFE-SAVING INTERVENTION? YES → **1**

NO ↓

B-HIGH RISK SITUATION? (INCLUDES PSYCHIATRIC/SUBSTANCE ABUSE/SUICIDAL/HOMICIDAL/VIOLENT) OR CONFUSED/LETHARGIC/DISORIENTED? OR SEVERE PAIN/DISTRESS OR YES → **2**

↓

C-HOW MANY DIFFERENT RESOURCES ARE NEEDED?

NONE	ONE	MANY
↓	↓	↓
5	**4**	**DANGER ZONE VITALS?**

DANGER ZONE VITAL SIGNS	AGE	HR	RR & SaO2
Consider uptriage to ESI 2 if any vital sign criterion is exceeded	<3 mo	>180	>50/<92 %
	3mo-3yr	>160	>40/<92 %
Pediatric Fever Considerations	3yr-8yr	>140	>30/<92 %
● 1day-28 days: assign ESI 2 if temp >38°C/100.4°F ● 1 mo-3mo: assign ESI 2 if temp >38°C/100.4°F ● 1 mo-3 yr: assign ESI 3 if temp >39°C/102.2°F, or incomplete immunizations, or no obvious source of fever	>8yr	>100	>20/<92 %

YES → **CONSIDER UPTRIAGE TO 2**

NO ↓

3

A. Immediate life-saving interventions required: airway, emergency medications, or other hemodynamic interventions (IV, O2, ECG, labs DO NOT COUNT); and or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SaO2<90%, acute mental status changes, or unresponsive.
Unresponsiveness: 1. nonverbal and not following commands or 2. requires noxious stimulus **PU on AVPU scale: A=Patient Awake; V=Patient Responds to Verbal Stimuli; P=Patient**

B. High Risk Situation: is a patient you would put in your last open bed. Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale

RESOURCES*

● Labs
●ECG
● X-rays
● CT, MRI, US
● IV fluids (hydration)
●IV or IM or nebulized meds
● Specialty Consultation
●Simple Procedure = 1 (laceration repair, foley)
●Complex Procedure = 2 (conscious sedation)
***NOT RESOURCES:** H&P (including pelvic), POC testing, IV heplock, PO meds, Tetanus, Prescription refills, call to PCP, simple wound care, crutches/splints/slings

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (i.e., CBC, electrolytes, coags = 1 resource; CBC + Chest x-ray = 2 resources

EMERGENCY DEPARTMENT PEDIATRIC FLOWSHEET

Patient Name:			Age:	DOB:
Date:	Time of Arrival:	Mode of Arrival: □ Walk □ EMS □ Police	ESI Triage Category Level: 1 2 3 4 5	
Room:	Time:	Placed in Room By:		

RAPID TRIAGE ASSESSMENT

CHIEF COMPLAINT:

Does patient have infection or suspicion of infection? YES NO Is patient on antibiotics (not prophylaxis)? YES NO

ALLERGIES: (Drug/Food Reaction) □ NKA

TONE	□ WNL □ Limp □ Rigid □ Absent Muscle Tone	**AIRWAY SOUNDS**	□ WNL □ Muffled/Hoarse □ Snori Speech □ Strid□ Use of Accessory □ Grun Muscles to Breathe □ Wheezing	**AIRWAY**	□ Patent □ Impaired	**VITAL SIGNS**	
INTERACTIVENESS	□ WNL □ Unable to Stimulate □ Altered Mental Status □ Obstructed Airway	**POSITIONING**	□ WNL □ Sniffing Position □ Tripoding □ Prefers Seated Posture	**BREATHING**	□ Unlabored □ Labored □ Shallow □ Deep	Temp Oral/Rectal Pulse Resp BP Rt/Lt O2 Sat Room Air FSBS	
CONSOLABILITY	□ WNL □ Abnormal Response to Environment □ Unable to Console/Comfort	**RETRACTIONS**	□ None □ Supraclavicular □ Intercostal □ Substernal	**CIRCULATION**	□ Palpable Pulse □ Strong □ Jaundice □ Weak □ Cyanotic □ Regular □ Pallor □ Irregular □ Mottling □ Normal □ Pale	**WEIGHT/KG** Actual Stated **HEIGHT**	
LOOK/GAZE	□ WNL □ No Eye Contact □ Vacant Stare □ Unable to Recognize	**NASAL FLARING**	□ Yes □ No	**NEURO**	□ Alert □ Oriented □ Confused □ Unresponsive □ Clear □ Slurred □ Garbled	**Glasgow Coma Scale (GCS)** **Best Eye Opening** 4-Spontaneous 3-To Voice 2-To Pain 1-None	
SPEECH	□ WNL □ Absent/Abnormal □ Absent/No Cry □ Unable to Stimulate					**Best Verbal** 5-Oriented (Coos/Babbles) 4-Confused 3-Inappropriate Words (Screams/Grunts) 2-Incomplete Sounds 1-None	

Date &Time of Assessment: **Rapid Triage Nurse Signature:**

PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

On Arrival: _____

Pain Onset: _____

Location: _____

VISUAL ACUITY

LT	RT	BOTH	CORRECTED
			□ YES □ NO

SKIN SIGNS

□ Normal/Warm/Dry □ Cyanotic □ Clammy □ Pale □ Hot

□ Diaphoretic □ Jaundice □ Flushed □ Hot □ Cool

Best Motor

6-Obeys Commands (Spontaneous)
5-Localizes Pain
4-Withdrawal
3-Flexion
2-Extension
1-None

INTERVENTION

□ Ice □ Acetaminophen
□ Elevated □ Ibuprofen
□ Soft Splint
□ Dressing Applied
□ Bleeding Controlled
□ Hard Collar Placed
□ NPO Instruction Given
□ Other

GAIT

□ Steady □ W/Crutches/Cane □ W/C
□ Not Observed

HISTORY

□ None □ Seizure □ Diabetes □ HTN □ Cardiac □ Asthma
□ Pulmonary □ GI □ GU □ CVA □ CA □ Substance Abuse
□ ETOH □ Psych □ Smoker □ Vape □ Migraines □Thyroid
□ Dialysis Last Tx:
□ Other: _____
_____

GCS Total

Med Reconciliation

□ See form

Sepsis Screening Completed

Yes
No

PRE-HOSPITAL CARE

TPR/BP:	SPO2: %	O2 @ LPM	CARDIAC RHYTHM:	C-SPINE PRECAUTIONS: □ YES □ NO

RESPIRATORY ARREST □ YES □ NO ETT □ YES □ NO	CPR □ Y □ N	FSBS:	IV: □ Y □ N GUAGE: SITE:

ASSESSMENT

NEURO

□ WNL □ Unconscious
□ Alert □ Cooperative
□ Oriented □ Restless
□ Clear □ Combative
□ Slurred □ Crying
□ Garbled

CARDIOVASCULAR

□ WNL

PULSES

□ Strong □ JVD
□ Regular □ Pedal Edema
□ Irregular

PEDIATRICS

Fontanel: _____
# of wet diapers: _____x24 hrs
Tears: _____
Mucous Membranes: _____

GI/GU

□ WNL

ABDOMEN

□ Soft □ Masses
□ Firm □ Rigid
□ Distended □ Rebound
□ Tender □ Nausea
□ Nontender □ Vomiting x
□ Painful □ Diarrhea x

BOWEL SOUNDS

□ Present Last BM: ___/___/___
□ Absent
□ Hypoactive
□ Hyperactive

INCONTINENCE

□ Bowel □ Bladder
□ Catheter Present
□ Ostomy Present

OTHER

□ Dysuria □ Hematuria
Genitals: Discharge □ Yes □ No
Color: _____
□ Bleeding
□ Maxi Pad _____ HR
□ Mini Pad _____ HR
□ Tampon _____ HR
Gravida: _____ Para: _____
TAB: _____ SAB: _____

RESPIRATORY

Characteristics

□ WNL
□ Symmetrical □ Asymmetrical
□ Unlabored
□ Deep □ Shallow
□ Retractions
□ Nasal Flaring
□ Accessory Muscle Use
□ Absent
□ Painful

Respiratory Lung Sounds

	Left	Right
Clear	□	□
Wheezes	□	□
Rales	□	□
Rhonchi	□	□
Diminished	□	□

□ Mechanical/Supported: _____

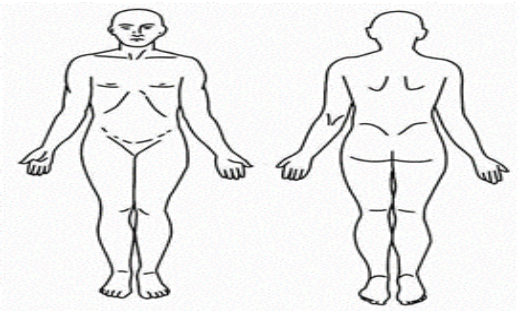
EXTREMITY

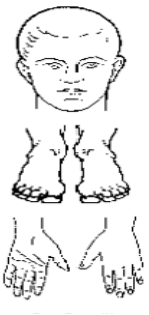
Capillary Refill	
Rt Arm	Rt Leg
Lt Arm	Lt Leg
Sensation	
Rt Arm	Rt Leg
Lt Arm	Lt Leg
Movement/Strength	
Rt Arm	Rt Leg
Lt Arm	Lt Leg

KEY

W-Weak P-Painful
A-Absent I-Intact
T-Tingling B-Brisk
Ir-Irregular
D-Delayed Over 2 Seconds
N-Numbness

SKIN INTEGRITY





A-Abrasion	E-Ecchymosis	P-Painful/Tender	1	Stage I
B-Burns	F-Edema	L-Laceration	2	Stage II
C-Redness	FB-Foreign Body	PW-Puncture Wound	3	Stage III
D-Deformity	H-Hematoma	R-Rash	4	Stage IV
S-Swelling			O	Other

SCREENING TOOL

SERVICE	NON-CONTRIBUTORY	REFERRAL
NUTRITION		
DOMESTIC/CHILD VIOLENCE/ABUSE		
PSYCHOSOCIAL		
SKIN INTEGRITY		
EDUCATION		
COMMUNICATION BARRIER		
INTERPRETER		
INTERVENTION		

SUICIDE SCREENING □ YES □ NO □ NA SUICIDE PRECAUTIONS □ YES □ NO □ NA

MEDICATIONS

Time	Medication	Route	Site	Reason	RN/LPN

MEDICATIONS

Time	Medication	Route	Site	Reason	RN/LPN

SEDATION SIDE EFFECTS

Time	Medication	Route	Site	Pain Scale/BP	RN/LPN

COMMENTS

INTAKE

Time	Oral	IVF	Rate/Pump	Site	Gauge	End Time	Amount	RN/LPN
Total								

OUTPUT

Time	Urine	Emesis	NG	Diarrhea	BM	Other	RN/LPN
Total							

IV PLACEMENT

Time	# of Attempts	Gauge	Site	RN/LPN
Time	# of Attempts	Gauge	Site	RN/LPN
Time	# of Attempts	Gauge	Site	RN/LPN

IV Discontinued

Time	Catheter Intact, W/O redness, swelling, tenderness at Site	Bleeding Controlled	RN/LPN

Isolation Precautions

□ CONTACT □ DROPLET □ AIRBORNE INFECTION ISOLATION □ NEUTROPENIC/PROTECTIVE □ OTHER

DIAGNOSTIC STUDIES-LABORATORY

STUDY	SENT	STUDY	SENT	STUDY	SENT	STUDY	SE
□ CBC DIFF/CBC		□ PT/PTT		□ Amylase/Lipase		□ ETOH Legal/Medical	
□ Lactic Acid		□ D-Dimer		□ Ammonia		□ Dilantin	
□ BMP		□ BNP		□ ASA/Tylenol		□ Sed Rate	
□ CPK/CPKMB/ Troponin		□ CA/Mg/Phos		□ Hepatic Function Panel		□ Beta HCG/RH	

DIAGNOSTIC STUDIES

URINE		STOOL		BACTERIOLOGY			
STUDY	**SENT**	**STUDY**	**SENT**	**STUDY**	**SENT**	**STUDY**	**SENT**
□ UA □ Cath □ Voided		□ O&P		□ Blood		□ Gram Stain	
□ Urine tox		□ C. diff		□ GC/Chlamydia		□ Rapid Strep	
□ UA C&S		□ Other		□ Wet Mount		□ Sputum C&S	
□ Urine Pregnancy				□ Wound			

□ 12 Lead EKG □ Repeat EKG

DIAGNOSTIC STUDIES-IMAGING

STUDY	TIME TO X-RAY	TIME BACK TO BED	STUDY	TIME TO X-RAY	TIME BACK TO BED
□ CHEST X-RAY			□ Abd Series		
□ PORTABLE			□ Rt/Lt/Hip/Pelvis		
□ Cross Table			□ Extremity		
□ C-Spine			□ CT Scan		
□ LS Spine			□ IVP/KUB		
□ Other					

SPECIAL PRECAUTIONS

□ **Patient on C-Spine Precautions**

□ **Patient on cardiac monitor, nurse accompanying on transport**

FSBS

TIME	RESULTS	RN/LPN

NURSING NOTES

Nurse _____ Date _____

Nurse _____ Date _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Pediatric Triage		**EMD-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and prioritization of pediatric patients based on level of acuity and resources using an evidence based five-level triage assessment tool for patients presenting to the Emergency Department (ED).

PURPOSE

The Hospital has adopted the Emergency Severity Index (ESI) for triaging pediatric patients arriving in the ED to improve the quality and safety of patient care. The ESI is an evidence based five level triage scale that facilitates the prioritization of pediatric patients based on the urgency of treatment for the patients' condition. The triage nurse should initially perform a quick assessment of the pediatric patient using the Pediatric Assessment Triangle (See Attachment A) :

The triage nurse should quickly determine whether the pediatric patient requires life-saving interventions to assign a triage acuity level by assessing the pediatric patient's appearance, breathing and circulation (ABC). This assessment will determine how long a patient can safely

wait to be seen by a physician/mid-level provider and receive a medical screening examination (MSE) and treatment.

In 2010 the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) revised their original statement regarding the use of triage scales as follows: "*the ACEP and ENA believe that the quality of patient care benefits from implementing a standardized emergency department (ED) triage scale and acuity categorization process. Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five level triage scale such as the Emergency Severity Index (ESI)*." In 2010 the Centers for Disease Control and Prevention National Center for Health Statistics provided a report that categorized acuity on arrival as a five-level based on how urgently the patient needed to be seen by the physician or healthcare provider and included the following categories:

Acuity Level	Time Seen
Level 1 - Immediate	Immediately
Level 2 - Emergent	1-14 minutes
Level 3 - Urgent	15 – 60 minutes
Level 4 – Semi-Urgent	1 – 2 hours
Level 5 – Non-Urgent	2 – 24 hours

Finally, the triage nurse is responsible for determining resources necessary to move the pediatric patient to a final disposition (admission, discharge, or transfer) for those patients who do not meet a high acuity level. This process ensures pediatric patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs.

DEFINITIONS

A. **Acuity:** refers to the severity of the illness or injury, as well as the potential for complications. Acuity is determined by the stability of the patient's vital functions and the potential for the threat to life, limb or organ.

B. **Disposition:** means where the patient is being discharged to such as admitted to the hospital, discharged to home or transferred to another facility.

C. **Emergency Severity Index (ESI):** an evidence-based five-level triage scale developed as a triage tool to help facilitate the prioritization of patients arriving in the ED based on the urgency of the patients' condition.

D. **High-Risk Situation:** refers to a patient with a condition that could easily deteriorate or presents with symptoms suggestive of a condition requiring time-sensitive treatment. This patient presents with a potential for a threat to life, limb or organ. Examples include but not limited to active chest pain, signs of stroke, suicidal or homicidal patient.

E. **Infant:** refers to a child less than one (1) year of age and has not reached their first birthday.

F. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an emergency medical condition (EMC) does or does not exist.

G. **Neonate:** refers to a child who is less than 28 days old

H. **Pediatric Assessment Triangle:** refers to an assessment tool used in the ED to rapidly to determine the acuity of a child and can be used to determine whether the child is in respiratory distress, respiratory failure or shock.

I. **Resources:** refers to the number of resources a patient is expected to consume for a disposition decision to be reached. Resources would include but not limited to hospital services, tests, procedures, consults or interventions that are above and beyond the history and physical, or simple interventions such as applying a bandage.

J. **Triage:** entails the clinical assessment of the patient's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the patient will be seen by the physician or other QMP.

POLICY

Triage is a process that will be initiated upon the pediatric patient's arrival to rapidly assess the severity of the pediatric patient's injury or illness and assign priorities of care to be provided. This process ensures pediatric patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the pediatric patient's medical needs. Goals of triage include:

- Rapid identification of life-threatening illnesses or injuries
- Prioritizing care for patients with emergent needs
- Facilitate the flow of patients through the ED
- Refer patients to the appropriate level of care in the ED

The ED triage assessment of the pediatric patient will include the rapid systematic collection of subjective and objective data that is relevant to each pediatric patient. The triage nurse will then assign an acuity level using the ESI Triage Algorithm (see EMD-006A) and the Pediatric Assessment Triangle to determine how long the patient can safely wait before receiving an MSE and treatment by a physician/mid-level provider. Once the triage nurse has determined the pediatric patient does not require life-saving intervention, the nurse will perform a primary assessment using an ABCDE (airway, breathing, circulation, disability and exposure) format. The triage nurse will obtain a pertinent history using the mnemonic CIAMPEDS (chief complaint; immunizations/isolation; allergies; medications; past health history; events preceding problem; diet/elimination; symptoms associated with problem) to ensure avoiding missing important information.

If the triage nurse determines the pediatric patient is not a high acuity patient, then the triage nurse will then determine the number of resources the pediatric patient is going to consume for the patient to reach a disposition decision. The triage nurse will estimate the number of resources based on the pediatric patient's brief subjective/objective assessment, past medical history, allergies, medications, age/gender and ED standards of practice. The triage nurse will review the pediatric patient's vital signs and if outside accepted parameters the nurse will consider upgrading the pediatric patient to a Level 2 based on the ESI Triage Algorithm. If all ED beds are full and the pediatric patient is stable enough to wait in the ED waiting room, reassessment will be performed at defined intervals. Any significant symptoms will be reassessed, and acuity level will be increased if necessary. The triage nurse will use ESI criteria to determine the triage level and assign ED room assignment regardless of method of arrival.

PROCEDURE

A. All patients presenting to the ED will initially be triaged using the ESI Triage Algorithm in order to identify life-threatening conditions and prioritize pediatric patients according to acuity.

B. Pediatric patients presenting to the ED will be assessed in a standardized manner.

1. To determine high acuity level criteria the triage nurse will perform a brief urgent assessment using the Pediatric Assessment Triage tool (See Pediatric Nursing Flowsheet, Attachment C) and assess the following three areas:

a. Appearance:

i. Tone (muscle tone):

- Normal: good movement in all extremities with good tone, moves spontaneously. Strong resistance by infants to straighten limbs, resists examination, sits or stands (age appropriate).
- Abnormal: limp, rigid, absent muscle tone.

ii. Interactiveness:

- Normal: appears alert/engaged with clinician or caregiver, interacts well with people /environment, reaches for objects.
- Abnormal: Unable to stimulate the infant/child to engage with clinician or environment. Indicators of altered mental status or obstructed airway.

iii. Consolability:

- Normal: able to console or comfort infant/child by normal caregivers (i.e. parents). Normal response to environmental stimuli by infant/child.
- Abnormal: normal caregivers unable to console or comfort infant/child.

iv. Look (gaze)
- Normal: infant/child is able to make eye contact.
- Abnormal: unable to make eye contact, vacant stare. Infant/child may not be able to recognize normal caregivers.

v. Speech
- Normal: able to express self in an age appropriate manner. Speech (or crying for infants) is normal.
- Abnormal: unable to express self in an age appropriate manner. Absent or abnormal speech (or crying for infants).

b. Work of Breathing:
i. assess/observe the infant/child for respiratory effort and signs of respiratory distress.
ii. Signs of increased work of breathing include but not limited to:
- Retractions
- Noisy breathing (i.e. grunting)
- Use of accessory muscles to breathe
- Nasal flaring

iii. Signs of decreased work of breathing include but not limited to:
- Breathing to slow (bradypneic).
- Too weak to use the muscles required to breathe.

c. Circulation to Skin:
i. assess/observe for signs of pallor, cyanosis, and other obvious signs of bleeding.

d. Abnormalities in any of these three areas, the triage nurse will triage the pediatric patient as a high acuity patient and taken directly to an ED room and seen by a physician/mid-level provider within the identified time parameters based on their assigned triage level.

2. After the initial brief assessment/observation the triage nurse or ED nurse will perform a primary assessment using the ABCDE format (See Pediatric Nursing Flowsheet, Attachment C).
- **A**irway: airway patency.
- **B**reathing: respiratory rate and quality.
- **C**irculation: heart rate, skin temperature, capillary refill, blood pressure (where clinically indicated, i.e. cardiac or renal disease).
- **D**isability: assess neurological status including level of consciousness and pupillary reaction.
- **E**xposure: assess for injury or illness (need to undress to assess, promptly re-dress when assessment completed).

3. After an initial assessment has been obtained the triage/ED nurse will obtain a pertinent history from the pediatric patient using a standardized format (CIAMPEDS, See Pediatric Nursing Flowsheet, Attachment B) to ensure important information is not missed.
    - **C** = chief complaint
    - **I** = immunizations and isolation
    - **A** = allergies
    - **M** = medications
    - **P** = past health history
    - **E** = events preceding problem
    - **D** = diet and elimination
    - **S** = symptoms associated with the problem
4. The triage/ED nurse will obtain vital signs for the pediatric patient as follows:
    - Heart Rate (HR)
    - Respiratory Rate (RR)
    - Temperature
        - Neonates and infants will have rectal temperatures.
    - Oxygen saturation (SpO2)
    - Blood pressure (as clinically indicated)

    a. SpO2 will be obtained for pediatric patients who present to the ED with respiratory complaints or signs/symptoms of respiratory distress or as otherwise clinically indicated.

    b. The triage/ED nurse will use the appropriate equipment and size when obtaining vital signs to ensure accurate assessment and findings.
5. The triage/ED nurse will consider the pediatric patient's clinical condition, immunizations completed and age when the patient presents with a fever.
    a. neonates presenting with a fever of 100.4°F(38°C) or greater will be triaged as high-risk (Level 2) as the patient may have a serious infection.

    b. infants between the ages of 1to 3 months who presents with a fever of 100.4°F(38°C) or greater will be triaged as high-risk (Level 2) as the patient may have a serious infection.

    c. The triage nurse will obtain an immunization history for all pediatric patients at the time of triage if possible.
        i. The CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years and younger for the current year (See Attachment C) will be posted in triage and the ED.

    d. For pediatric patients greater than 2 years of age who have not completed their primary immunization series the triage/ED nurse will consider the patient a higher risk based on the patient's clinical condition and age.
        i. These patients will be considered a minimum ESI Level 3 if there is no obvious source of the fever identified.

6. The triage/ED nurse will assess pediatric patients presenting with signs/symptoms of pain with a validated pediatric pain scale such as the Wong-Baker Faces scale (See EMD Form C) or the FLACC (Face, Legs, Activity, Cry and Consolability) scale (see EMD Form D) and by clinical observation.
    a. The triage/ED nurse should use clinical judgment in assigning an ESI Level 2 triage assignment for pediatric patients who meet a pain score of ≥ 7 criteria. The triage/ED nurse will use the clinical condition of the pediatric patient in making the decision to assign an ESI Level 2.

C. Assigning ESI Levels for Pediatric Patients
1. ESI Level 1 criteria
    a. If the pediatric patient requires life-saving intervention, the triage process is complete, and the patient will be triaged as a Level 1 and taken directly to an ED room and seen by a physician/mid-level provider immediately.
    b. To determine ESI Level 1 criteria the triage nurse will utilize the Pediatric Assessment Triangle to perform a brief initial assessment of the pediatric patient.
    c. Once Level 1 criteria has been met and the pediatric patient has been taken to an ED room a full set of vital signs will be obtained which should include the following:
        i. Heart Rate (HR)
        ii. Respiratory Rate (RR)
        iii. Temperature
            1. rectal temperatures in neonates and infants
        iv. Oxygen Saturation (SpO2) (if clinically indicated)
        v. Blood Pressure (if clinically indicated)
    d. Examples of ESI Level 1 conditions include but are not limited to:
        - Respiratory arrest
        - Cardiopulmonary arrest
        - Major head trauma with hypoventilation
        - Active seizures
        - Unresponsiveness
        - Petechial rash with altered mental status (regardless of vital signs)
        - Respiratory failure:
            - Hypoventilation
            - Cyanosis
            - Decreased muscle tone
            - Decreased mental status
            - Bradycardia (late finding, concerning for impending cardiopulmonary arrest)
        - Shock/sepsis with signs of hypoperfusion:
            - Tachycardia
            - Tachypnea

- Alteration in pulses (diminished or bounding):
  - Alteration in capillary refill time > 3-4 seconds
  - Alteration in skin appearance: cool/mottled or flushed appearance
  - Widened pulse pressure
  - Hypotension (often late finding in the prepubescent patient)
- Anaphylactic reaction (onset in minutes to hours):
  - Respiratory compromise (dyspnea, wheeze, stridor, hypoxemia)
  - Reduced systolic blood pressure
  - Hypoperfusion (example: syncope, incontinence, hypotonia)
  - Skin and/or mucosal involvement (hives, itch-flush, swollen lips, tongue or uvula)
  - Persistent gastrointestinal symptoms

2. ESI Level 2 criteria
   a. If the triage nurse determines the pediatric patient does not meet ESI Level 1 criteria and does not need immediate life-saving treatment, the triage nurse will determine if the patient can safely wait to be seen by a physician/mid-level provider. The triage nurse will consider three (3) questions and obtain pertinent objective and subjective information through a brief focused assessment to determine if the patient meets Level 2 criteria:
      - Is this a high-risk situation?
      - Is this patient confused, lethargic or disoriented?
      - Is the patient in severe pain or distress?

   b. To determine ESI Level 2 criteria the triage nurse will perform a brief assessment of the pediatric patient using the ABCDE format.
      i. In most cases a high-risk pediatric patient will not require a detailed physical assessment or vital signs.

   c. The triage nurse will assess pediatric patients presenting with signs and symptoms of pain with a validated pain scale such as the FLACC pain scale or the Wong-Baker Faces pain scale and clinical observation (i.e. crying, grimacing, irritability, etc.)

   d. Once Level 2 criteria has been met and the pediatric patient has been taken to an ED room a full set of vital signs will be obtained which should include the following:
      i. Heart Rate (HR)
      ii. Respiratory Rate (RR)
      iii. Temperature
         1. rectal temperatures in neonates and infants
      iv. Oxygen Saturation (SpO2) (if clinically indicated)
      v. Blood Pressure (if clinically indicated)

e. Examples of ESI Level 2 conditions include but are not limited to:
- Syncope
- Immunocompromised patients with fever
- Hemophilia patients with possible acute bleeds
  - Joint pain or swelling
  - History of fall or injury
  - Vital signs and/or mental status outside of baseline
- Febrile infant < 28 days of age with fever ≥ 38°C rectal
- Hypothermic infants >90 days of age with temperature <36.5°C rectal
- Suicidal
- Rule out meningitis (headache, stiff neck, fever, lethargy, irritability)
- Seizures – prolonged postictal period (altered level of consciousness)
- Moderate to severe croup
- Lower airway obstruction (moderate to severe)
  - Bronchiolitis
  - Reactive airway disease (asthma)
  - Respiratory distress
    - Tachypnea
    - Tachycardia
    - Increased effort (nasal flaring, retractions)
    - Abnormal sounds (grunting)
    - Altered mental status

3. ESI Level 3, 4 and 5
   a. If the triage nurse determines the pediatric patient does not meet Level 2 criteria, the nurse will then make an estimation of the number of resources the pediatric patient will need to reach a disposition decision based on the patient's brief standardized CIAMPEDS assessment and ED evidence-based standards of practice.
   b. To differentiate between ESI Levels 3, 4 and 5 the nurse will need to estimate if the pediatric patient needs one (Level 4), two (Level 3), or no (Level 5) resources to reach a disposition decision.
   c. Once the nurse determines the pediatric patient needs two or more resources there is no need to continue to estimate resources.
   d. The triage nurse should not count the number of individual test when estimating resources. The triage nurse should only estimate the number of resources. Example:
      i. CBC and electrolyte panel equals one resource (lab test)
      ii. CBC and chest x-ray equal two resources (lab test, x-ray)
      ii. Cervical spine x-ray and head CT scan equals two resources (x-ray and CT scan)

e. List of resources include but are not limited to:

Resources	Not Resources
Labs (blood, urine	History & physical (including pelvic)
ECG, x-rays, CT-MRI-ultrasound, angiography	Point of care testing
IV fluids (hydration)	Saline or heplock
IV, IM, or nebulized medications	PO medications, Tetanus immunization, Prescription refills
Specialty consultations	Phone call to PCP
Simple procedure = 1 (lac repair, Foley cath)	Simple wound care (dressing, recheck)
Complex procedure = 2 (conscious sedation)	Crutches, splints, slings

d. Pediatric patients may require sedation in certain situations. When sedation is required the patient will be triaged as an ESI Level 3 secondary to the establishment of IV access and the administration of IV medications. Examples of situations that may require the use of sedation for pediatric patients include but are not limited to the following:

- Fracture/dislocation repair
- Chest tube insertion
- Facial lacerations
- Intraoral lacerations
- Lacerations requiring a multilayered closure
- Lacerations across the vermillion border
- Extremely dirty wounds
- MRI/CT procedures
- Image guided procedures
- Joint aspiration with ultrasound
- Lumbar punctures (except in infants)

D. Five-Level ESI Categories and Reassessment Objectives

1. ESI Level 1 – Immediate

a. Any condition presenting an immediate threat to the patient's life or limb requiring immediate interventions to save the patient's life or to prevent irreversible damage.

b. Time to Treatment: Immediate

c. Reassessment: Continuous

d. Presentation: Includes but not limited to pediatric patients that are unresponsive, cool/mottled/flushed appearance, decreased mental status, decreased muscle tone, tachycardia, tachypnea.

e. When Level 1 criteria is met the triage process must stop and the patient taken directly to an ED room and seen immediately by a physician/mid-level provider and treatment initiated.

2. ESI Level 2 – Emergent
    a. Any condition that potentially threatens the patient's life or limb and could worsen without intervention.
    b. Time to Treatment: Immediate.
    c. Reassessment: Every 15 to 30 minutes, and PRN (as needed).
    d. Presentation: Includes but not limited to pediatric patients that present with syncope, fever ≥38°C, reactive airway disease, seizures, suicidal.
    e. When Level 2 criteria is met the triage process must stop and the patient taken directly to an ED room and the patient evaluated by a physician/mid-level provider within 10 minutes.
3. ESI Level 3 – Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: Less than 1 hour
    c. Reassessment: Every 1 hour, and PRN
    d. Presentation: Pediatric patients requiring two or more resources with vital signs that are not in the danger zone.
4. ESI Level 4 – Semi-Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: 2 to 4 hours
    c. Reassessment: Every 2 to 4 hours, and PRN
    d. Presentation: Pediatric patients who only require one (1) resource.
5. ESI Level 5 – Non-Urgent
    a. Any condition that requires minimal interventions and will not worsen if treatment is delayed for several hours to days.
    b. Time to Treatment goal: 2 to 8 hours
    c. Reassessment: Every 2 to 4 hours, and PRN
    d. Presentation: Pediatric patients requiring no resources.

E. If all ED beds are full and the pediatric patient's condition is stable enough to wait in the ED waiting room, reassessment should be performed at appropriate intervals. Any significant symptoms should be reassessed for change and the acuity category increased if necessary. Reassessment guidelines are as follows based on the five-level ESI categories:

Acuity Level	Reassessment
Level 1 - Immediate	Continuously
Level 2 - Emergent	Every 15 minutes
Level 3 - Urgent	Every 1 hour, PRN
Level 4 – Semi-Urgent	Every 2 hours, PRN
Level 5 – Non-Urgent	Every 4 hours, PRN

Triage is a dynamic process; a pediatric patient's condition may improve or deteriorate at any time during the patient's wait in the ED.

F. If the triage nurse is in doubt regarding a triage category, the triage nurse should choose the higher triage acuity level to avoid under-triaging a patient.

G. The triage nurse will use ESI criteria to determine the triage level and assign ED room assignment regardless of method of arrival.
   1. Arriving by ambulance will not be used a criterion to assign a higher-level acuity and place the pediatric patient in an available ED room.

H. Any pediatric patient with a cough or fever and/or a rash will be assessed by the triage nurse to determine if isolation is required. If the nurse determines the patient requires isolation a mask will immediately be placed on the patient and the patient will be placed in the isolation ED room. The triage nurse will immediately notify the physician/mid-level provider of the presence of patients requiring isolation.
   1. A pediatric patient presenting with a petechial rash and altered mental status will be triaged as an ESI Level 1 secondary to a risk of meningococcemia and possible shock.

I. Documentation
   1. The triage assessment and triage level must be documented in the appropriate area of the Pediatric Nursing Flowsheet, including the date and time the assessment was completed.
   2. All re-assessments should be documented including date and time completed in the Pediatric Nursing Flowsheet.
   3. Documentation should be clear, concise and objective.
   4. Documentation should include the time to nurse and time to physician times documented in the Pediatric Nursing Flowsheet.

VII. QUALITY MONITORING

The Quality Manager will review all ED patients presenting to the ED for accurate triage level or a minimum of 20 charts per month. The Quality Department will track and monitor the door-to-triage time as it is a key indicator of a vital emergency department processes. The goal of the ED will be to assign an accurate triage score for immediate, emergent and urgent cases in less than 5 minutes.

Hospital leadership including but not limited to, the Quality Manager and Chief Nursing Officer are responsible for ensuring that all hospital staff adhere to the requirements of this policy, procedures are implemented and followed at the Hospital. All instances of non-compliance with the policy should be reported to the Quality Manager and the Chief Nursing Officer and an incident report completed. All incidents will be reported to following committees: Quality, Medical Staff and Governing Board.

VIII. EDUCATION

All nursing staff (RN and LPNs) are required to have initial orientation and annual education and competency (except as otherwise noted) in the following:

- Emergency Severity Index course
- Emergency Department core competencies

All nursing staff will also be certified in CPR, ACLS, and all RNs will be certified in PALS according to the American Heart Association (AHA) standards of training. All clinical staff is required to have CPR certification.

IX. ATTACHMENTS

Attachment A: Pediatric Assessment Triangle
See EMD-006A: ESI Triage Algorithm
Attachment B: Pediatric Nursing Flowsheet
Attachment C: CDC Recommended Child & Adolescent Immunization Schedule
For Ages 18 years and younger
See EMD Form C: Wong-Baker Pain Scale
See Form EMD E: FLACC Pain Scale

X. REFERENCES

Agency for Healthcare Research and Quality (2012) *Emergency Severity Index (ESI): A triage tool for Emergency Department care. Version 4. Implementation Handbook 2012 Edition.* [Electronic Version]. Retrieved on 01/27/20 from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf

American College of Emergency Physicians (ACEP) (2015). Screening questions and streamlining triage. *ACEP Emergency Medicine Practice Committee.* [Electronic Version] Retrieved on 01/26/20 from https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/administration/triage_screening_quest-resources-final_110215.pdf

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Domagala, S.E., MSN RN; and Vets, J. BSN RN (2015). Emergency nursing triage: Keeping it safe. *Journal of Emergency Nursing* [Electronic Version]. Retrieved on 01/27/20 from https://www.jenonline.org/article/S0099-1767(15)00025-2/pdf

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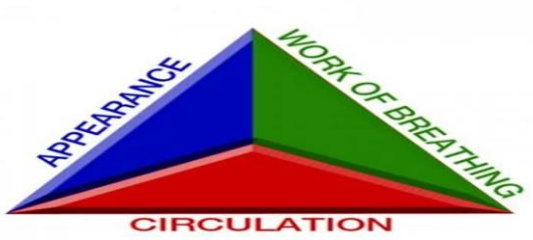
REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Pediatric Assessment Triangle



The PAT functions as a rapid, initial and global assessment using only visual and auditory observations to determine severity of illness and effectively triage the pediatric patient. This should be immediately followed by/not delay the ABCDEs. It can be utilized for serial assessment of patients to track response to therapy.

Appearance: The "Tickles" (TICLS) Mnemonic		
Characteristic	**Features**	
Tone	Normal:	Moves spontaneously, good movement in all extremities with good tone, resists examination, strong resistance by infants to straighten limbs, sits or stands (age appropriate)
	Abnormal:	Limp, rigid, absent muscle tone
Interactiveness	Normal:	Appears alert/engaged with clinician or caregiver, interacts well with people/environment, reaches for objects
	Abnormal:	Unable to stimulate the infant/or child to engage with clinician or environment. Indicators of altered mental status or obstructed airway.
Consolability	Normal:	Able to console/comfort by normal caregivers (i.e. parents). Normal response to environmental stimuli, has differential response to caregiver vs. examiner.
	Abnormal:	Normal caregivers unable to console/comfort
Look/Gaze	Normal:	Able to make eye contact with provider, tracks visually
	Abnormal:	Unable to make eye contact, vacant stare, infant/child may not recognize normal caregivers
Speech	Normal:	Use age-appropriate speech, strong cry in infants
	Abnormal:	Unable to express self in age appropriate manner, Absent or abnormal speech, absent or no cry in infants, unable to stimulate the infant/child to cry.

Work of Breathing	
Characteristic	**Abnormal Features**
Abnormal airway sounds	Snoring, muffled/hoarse speech, stridor, noisy breathing (grunting), wheezing, use of accessory muscles to breathe
Abnormal positioning	Sniffing position, tripoding, prefers seated posture
Retractions	Supraclavicular, intercostal, or substernal, head bobbing (infants)
Flaring	Nasal flaring on inspiration

Circulation to skin	
Characteristic	**Abnormal Features**
Pallor	White/pale skin or mucous membranes
Mottling	Patchy skin discoloration due to variable vasoconstriction
Cyanosis	Bluish discoloration of skin/mucous membranes

Dieckmann, R. et al. (2010) The Pediatric Assessment Triangle: A novel approach for the rapid evaluation of children Pediatric Emergency Care, 26(4) 312-315; Horeczko, T, MD et al. (2013) The Pediatric Assessment Triangle: Accuracy of its application by nurses in the triage of children. Journal of Emergency Nursing. 39(2), 182-189.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED S 2020

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	**DT**	No trade name
Haemophilus influenzae type b vaccine	**Hib (PRP-T)**	ActHIB® Hiberix®
	Hib (PRP-OMP)	PedvaxHIB®
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV**	Multiple
Influenza vaccine (live, attenuated)	**LAIV**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R® II
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-D**	Menactra®
	MenACWY-CRM	Menveo®
Meningococcal serogroup B vaccine	**MenB-4C**	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	**PCV13**	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	**PPSV23**	Pneumovax® 23
Poliovirus vaccine (inactivated)	**IPV**	IPOL®
Rotavirus vaccine	**RV1**	Rotarix®
	RV5	RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel® Boostrix®
Tetanus and diphtheria vaccine	**Td**	Tenivac® Tdvax™
Varicella vaccine	**VAR**	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel®
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix® Quadracel®
Measles, mumps, rubella, and varicella vaccine	**MMRV**	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child/adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition and other indications **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), and American College of Nurse-Midwives (www.midwife.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: www.cdc.gov/vaccines/pubs/surv-manual

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310020-A

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	2nd dose			◄---------- 3rd dose ----------►												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose		◄----- 4th dose -----►					5th dose					
***Haemophilus influenzae* type b (Hib)**			1st dose	2nd dose	See Notes		◄-- 3rd or 4th dose, See Notes --►										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		◄----- 4th dose -----►										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	◄---------- 3rd dose ----------►							4th dose					
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
or													**or**				
Influenza (LAIV)											Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes		◄----- 1st dose -----►					2nd dose					
Varicella (VAR)							◄----- 1st dose -----►					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														Tdap			
Human papillomavirus (HPV)														See Notes			
													*				
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos)			See Notes											1st dose		2nd dose	
Meningococcal B														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Recommended based on shared clinical decision-making or *can be used in this age group

No recommendation/ not applicable

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who are More than 1 month Behind, United States, 2020

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) ***and*** were administered before the 1st birthday.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old. **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is < 4 years. **6 months (as final dose)** if current age is 4 years or older.	**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday. **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2020

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count[1]		Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leaks or cochlear implants	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm3	≥15% and total CD4 cell count of ≥200/mm3						
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, & acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV)										
or										
Influenza (LAIV)						Asthma, wheezing: 2–4yrs[3]				
Measles, mumps, rubella										
Varicella										
Hepatitis A										
Tetanus, diphtheria, & acellular pertussis (Tdap)										
Human papillomavirus										
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										

- Vaccination according to the routine schedule recommended
- Recommended for persons with an additional risk factor for which the vaccine would be indicated
- Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
- Not recommended/ contraindicated—vaccine should not be administered
- Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine indicated
- No recommendation/ not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote D) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2 Severe Combined Immunodeficiency
3 LAIV contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months.

For vaccine recommendations for persons 19 years of age or older, see the Recommended Adult Immunization Schedule.

Additional information

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information regarding vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before 12 months and dose 2 before 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **Unvaccinated at 15–59 months:** 1 dose
- **Previously unvaccinated children age 60 months or older** who are not considered high risk do not require catch-up vaccination.
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through 14 months) OR no doses (15 months or older)

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series (minimum interval: 6 months) beginning at age 12 months

Catch-up vaccination
- Unvaccinated persons through 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).

International travel
- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between 12 and 23 months of age
  - **Unvaccinated age 12 months and older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)
- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series
- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination
- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents 18 years and older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).
- For other catch-up guidance, see Table 2.

Special situations
- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination
- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9 through 14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- If completed valid vaccination series with any HPV vaccine, no additional doses needed

Special situations
- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV], 18 years [recombinant influenza vaccine, RIV])

Routine vaccination
- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2019, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2019
  - 1 dose for **all persons age 9 years and older**
- For the 2020–21 season, see the 2020–21 ACIP influenza vaccine recommendations.

Special situations
- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions
- **LAIV should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Received influenza antiviral medications within the pr 48 hours

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination
- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

Special situations
International travel
- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series with dose 1 at 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months and older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra])

Routine vaccination
- 2-dose series at 11–12 years, 16 years

Catch-up vaccination
- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations
Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**
- Children less than age 24 months:
  - **Menveo (age 2–23 months):**
    - Dose 1 at 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months):**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose **Menveo** or **Menactra**

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:
- 1 dose **Menveo** or **Menactra**

Adolescent vaccination of children who received MenACWY prior to age 10 years:
- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk (see below).
- **Children for whom boosters are not recommended** (e.g., those who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and for additional meningococcal vaccination information, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Shared clinical decision-making
- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations
Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series.
For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and for additional meningococcal vaccination information, see www.cdc.gov/vaccines/acip/recommendations.html and www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13
- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13
- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations
High-risk conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during the same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma treated with high-dose, oral corticosteroids), diabetes mellitus:
Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Cerebrospinal fluid leak, cochlear implant:
Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 we… the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks af… most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations at www.cdc.gov/mmwr/pdf/rr/rr5911.pdf for complete schedule details.

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose at or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended at or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need to receive the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered at or after age 7 years**:
  - **Children age 7–9 years**: DTaP may count as part of catch-up series. Routine Tdap dose at age 11–12 years should be administered.
  - **Children age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.
- For information on use of Tdap or Td as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2-dose series:
  - **Age 7–12 years**: routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older**: routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

ASQ BRIEF SUICIDE SAFETY ASSESSMENT

(for Providers)

Praise Patient ***I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."***	
Frequency of Suicidal Thoughts	
In past two (2) weeks have you been thinking about killing yourself? **If YES**, how often? _____	YES ☐ NO ☐
Are you having thoughts of killing yourself right now? **If YES: patient requires immediate transfer to a psychiatric facility, urgent/STAT mental health evaluation and patient cannot be left alone. A positive response indicates imminent risk.**	YES ☐ NO ☐
Suicide Plan	
Assess if the patient has a suicide plan, regardless of how they responded to any other questions. (ask about method and access to means)	
Do you have a plan to kill yourself? **If NO**, If you were going to kill yourself, how would you do it? _____	YES ☐ NO ☐
Past Behavior ***(Strongest predictor of future attempts)***	
Have you ever tried to hurt yourself?	YES ☐ NO ☐
Have you ever tried to kill yourself? **If YES:** How: _____ When: _____ Why: _____	YES ☐ NO ☐
Did you think [method] would kill you?	YES ☐ NO ☐
Did you want to die?	YES ☐ NO ☐

Did you receive medical/physical treatment? Location: _____ Date: _____	YES ☐ NO ☐

Symptoms

Depression: In past two (2) weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?	YES ☐ NO ☐
Anxiety: In the past two (2) weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?	YES ☐ NO ☐
Impulsivity/Recklessness: Do you often act without thinking?	YES ☐ NO ☐
Hopelessness: In the past two (2) weeks, have you felt hopeless, like things would never get better?	
Irritability: In the past two (2) weeks, have you been feeling more irritable or grouchier than usual?	YES ☐ NO ☐
Substance or alcohol use: In the past two (2) weeks, have you used drugs or alcohol? **If YES:** What: _____ How Much: _____	YES ☐ NO ☐
Other Concerns: Recently, have there been any concerning changes in how you are thinking or feeling? _____	YES ☐ NO ☐

Support & Safety

Support Network: Is there a trusted person/adult you can talk to?	YES ☐ NO ☐
Have you ever seen a therapist/counselor? **If YES?** When? _____	YES ☐ NO ☐
Safety Question: Do you think you need help to keep yourself safe? (a NO response do not indicate the patient is safe, but a YES is a reason to act immediately to ensure safety)	YES ☐ NO ☐
Reason for living: What are some of the reasons you would **NOT** kill yourself? _____	

Pediatric (≤18 years of age) Assessment/Interview

Say to parent: After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective.

Your child said (reference positive responses on the asQ). Is this something he/she shared with you?	YES ☐ NO ☐
Does your child have a history of suicidal thoughts of behaviors that you're aware of? **If YES**: Please explain: _____	YES ☐ NO ☐
Does your child seem sad or depressed?	YES ☐ NO ☐
Withdrawn?	YES ☐ NO ☐
Anxious?	YES ☐ NO ☐
Impulsive?	YES ☐ NO ☐
Hopeless?	YES ☐ NO ☐
Irritable?	YES ☐ NO ☐
Reckless?	YES ☐ NO ☐
Are you comfortable keeping your child safe at home?	YES ☐ NO ☐
How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)? _____	YES ☐ NO ☐
Is there anything you would like to tell me in private? _____	YES ☐ NO ☐

Determine Disposition

After completing the assessment choose the appropriate disposition.

☐ **Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts). Transfer to psychiatric facility. Urgent/STAT mental health evaluation. Keep patient safe in ED.

☐ **No further evaluation in the ED:** Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

- ☐ Send home with mental health outpatient referrals

  OR

- ☐ No further intervention is necessary at this time

Provider Signature: _____ Date/Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Care and Treatment of the Psychiatric Patient		**EMD-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department/Nursing Services		

I. SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and management of patients with suicidal/homicidal/self-harm/harm of others ideations, psychiatric disorders and/or substance abuse.

II. PURPOSE

The intent of this policy is to describe the procedures for identifying individuals at risk, provision of a safe environment for the patient's emotional and physical health with appropriate interventions, and development of a plan or care for patients with suicidal/homicidal/self-harm/harm of others ideations, psychiatric disorders and/or substance abuse.

Risk Factors for suicide include but are not limited:

A. Psychosocial Factors include: previous suicide attempt, self-harm behaviors, alcohol and/or substance abuse disorders, current and/or previous psychiatric disorders (especially mood disorders, schizophrenia, anxiety and personality disorders), previous trauma/physical/sexual abuse, major physical illness, chronic pain, family history of suicide, and/or history of violent/aggressive behavior.

B. Environmental Factors include: a triggering event that may lead to feelings of humiliation, despair, loss (job, financial, relational, social), and/or easy access to lethal means (i.e. firearms).

Mangum Regional Medical Center's goal is to accurately recognize, rapidly triage using the Emergency Severity Index (ESI) and Algorithm (See EMD-006A Form), assess for suicide risk using the ASQ Suicide Risk Screening Tool (See Attachment A), provision of an appropriate medical screening examination with any necessary stabilizing treatment, and initiate appropriate

transfer or discharge with safety plan for patients with suicidal/homicidal ideations, self-harming behaviors, other psychiatric disorders and substance abuse disorders.
Performing a suicide risk assessment screening and providing appropriate interventions should not be considered a "one size fits all" process and will be completed through the use of procedures that are specific to the patient setting and circumstances while meeting the elements of this policy.

III. DEFINITIONS

A. **Suicidal Ideations** (suicidal thoughts) means thinking about death considering and/or planning to take their own life, with or without a specific plan. Suicidal ideations can range from fleeting thoughts to a detailed plan.

B. **Homicidal Ideations** means thoughts about homicide that can range from vague ideas to detailed and formulated plans to commit homicide.

C. **Suicide** means death caused by injuring oneself with the intent to die.

D. **Suicide Attempt** means when someone harms themselves with the intent to end their life but did not die as the result of their actions.

E. **Suicidal Behavior** means intentional injury to self-associated with some level of intent, development of a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end their life.

F. **Self-Harming Behaviors** means behavior that is self-directed and deliberately results in injury or the potential for injury to self or others. Self-harming behaviors may or may not be categorized as suicidal.

G. **Suicide Statement** means any statement made by a patient that suggests that the patient is contemplating suicide. This includes but not limited to, non-verbal statements such as written statements, photos, text messages, etc.

H. **"One to One Observation"** means one competent observer to one patient within "arm's reach", in close proximity with no physical barriers in the same room/area with the patient.

I. **"Line of Sight Observation"** means one competent observer in direct line of sight (LOS) with one or more patients.

J. **Competent Staff** are those who have completed a facility-based competency assessment initially and ongoing basis related to core elements required to monitor a patient under suicidal/self-harm precautions.

K. **"Qualified Medical Professional"** means A Practitioner or AHP who is or who will be providing clinical services pursuant to a contract with the Hospital must meet the same

basic qualifications for appointment to the Staff, must be evaluated for appointment, reappointment, and clinical privileges in the same manner as all other Practitioners or AHP's.

IV. POLICY

The approach to the care of suicidal/homicidal ideations, self-harming behaviors, other psychiatric disorders and substance abuse disorders is multidisciplinary. At a minimum all patients who present to the Emergency Department with a psychiatric related complaint or show signs/symptoms of being a self-harm risk will be screened using the ASQ Suicide Risk Screening Tool. An "acute positive screen" requires an immediate safety/comprehensive risk assessment. Nursing staff will place the patient under one to one observation at all times by a **competent** health care provider who is monitoring the patient. Nursing staff will use the Environmental Patient Safety Checklist to ensure that the patient has been provided a safe environment. The hospital will provide a prompt medical and psychiatric assessment with appropriate stabilizing treatment by the qualified medical provider as recognized in the Hospital Medical Staff Bylaws/Rules, Regulations and Policies. The Hospital will arrange and expedite an appropriate transfer to a mental health facility or discharge with a safety plan and discharge instructions.

V. CARE OF SUICIDAL, SUICIDAL/HOMICIDAL IDEATION, SELF-HARMING BEHAVIORS OR OTHER PSYCHIATRIC COMPLAINTS

A. Assessment

1. Upon presentation to the hospital all patients with a psychiatric complaint or who exhibit signs/symptoms of suicidal/homicidal ideation, attempt or self-harming behaviors will be triaged using the Emergency Severity Index Scale.
2. During triage all patients with a psychiatric related primary complaint, suicidal/homicidal ideation, or self-harming behaviors will be screened for the risk of suicide using the ASQ Suicide Risk Screening Tool.
    a. If the patient answers "no" to questions #1 through #4 screening is complete and no additional intervention is necessary (clinical judgment can always override a negative screen).
    b. If the patient answers "yes" to any of the questions #1 through #4 it is considered a **positive screen**. Question #5 should be asked to assess acuity.
    c. If the patient answers "yes" to question #5 it is considered an **acute positive screen** and an "imminent risk" identified.
    d. If the patient answers "no" to question #5 it is considered a **non-acute positive screen** and a "potential risk" identified.

B. Evaluation

The hospital has two options in which to evaluate the patient presenting with a psychiatric complaint or who exhibits signs/symptoms of suicidal/homicidal ideations, attempt or self-harming behaviors:

1. Licensed Mental Health Provider.

a. If the patient has an **acute positive screen** hospital staff will contact a participating behavioral health center with telehealth capabilities to obtain a Licensed Mental Health Professional (LMHP) evaluation.
    i. Place patient under one to one observation
    ii. Staff nurse to complete and document the Columbia Suicide Severity Scale (CSSS)(Attachment C) in the patient's medical record.
    iii. Complete the Environmental Patient Safety Checklist (See Attachment D) and ensure all dangerous objects are removed from the patient's room.
b. The LMHP will complete a full mental health evaluation to determine the need for in-patient psychiatric treatment.
    i. Ensure the LMHP Statement is placed in the patient's medical record.
c. If the LMHP determines the patient does not meet criteria for in-patient psychiatric treatment and should be discharged home for out-patient psychiatric follow-up, the LMHP should complete a discharge safety plan with the patient and family (if present).
    i. If the LMHP does not complete the discharge safety plan with the patient and family (if present), hospital staff will complete a discharge safety plan prior to discharge.

2. Emergency Department Provider
    a. If the patient answers "yes" to question #5 it is considered an **acute positive screen** and an "imminent risk" identified. Patient requires an immediate Brief Suicide Safety Assessment (BSSA) (See Attachment B) and the ED physician/mid-level provider will obtain/initiate a mental health evaluation for purposes of transfer to an acute psychiatric facility. Patient cannot be transferred until the evaluation for safety has been completed and documented in the patient's medical record.
        i. Place patient under one to one observation
        ii. Staff nurse to complete and document the Columbia Suicide Severity Scale (CSSS)(Attachment C) in the patient's medical record.
        iii. Complete the Environmental Patient Safety Checklist (See Attachment D) and ensure all dangerous objects are removed from the patient's room.
        iv. Alert physician or mid-level provider responsible for patient's care.
    b. If the patient answers "no" to question #5 it is considered a **non-acute positive screen** and a "potential risk" identified. Perform the BSSA to determine the need for completion of the CSSS and full mental health evaluation. Patient cannot be transferred or discharged until the BSSA has been completed and documented in the patient's medical record.
3. If the patient cannot be screened at triage due to the patient's medical status (i.e. unconscious, intubated, intoxicated or mentally unstable) screening may be postponed until the patient has been stabilized and can be assessed. The screening should be performed as soon as possible as the patient's condition permits.
4. On admission to the ED the patient will be asked to remove personal clothing and dress in a hospital gown, while a search is performed for any unsafe items (i.e. weapons, sharp objects, drugs/medications, etc.). This search should result in the removal of jewelry, cigarette lighters, matches, medications, shoelaces, belts, plastic bags, or any other item which may be a safety risk while the patient remains a suicide

risk. The search should be performed with another staff member present, or per patient preference. All clothing and personnel belongings/items should be removed from the patient's room, inventoried and placed securely in the Emergency Department until time of transfer or discharge.

5. The physician/mid-level provider responsible for the patient's care will perform an appropriate MSE including any tests (i.e. labs, etc.), to rule out a medical illness as the cause for or contributing to the patient's mental condition.
6. If medical causes are ruled out for patient's mental condition and has been determined to be at risk for suicide/self-harm, a comprehensive risk assessment should be completed by physician/mid-level provider.

C. Observation and Monitoring

1. All patients who screen "**acute-positive** for suicide/self-harming behaviors will be placed under one to one observation with a patient attendant. Those patients who screen "**non-acute positive**" for suicide/self-harming behaviors will have level of observation and monitoring determined by physician/mid-level provider based on BSSA/comprehensive risk assessment.
2. If a patient has any concerning/contributing history, circumstances or signs/symptoms that might indicate an increased risk of suicide the patient should be placed on one to one observation with a patient attendant until a full evaluation has been completed by the physician/mid-level provider. Physician/mid-level provider based on full evaluation of the patient will place an order for the appropriate level of observation and monitoring.
3. If a patient presents with a psychiatric complaint has a negative ASQ Suicide Risk Screening and has no concerning/contributing history, circumstances or signs/symptoms that might indicate an increased risk for suicide the physician/mid-level provider based on full evaluation of the patient may order the appropriate level of observation and monitoring based on the patient's clinical presentation.

D. Documentation

1. The ASQ Suicide Risk Screening should be documented as part of the triage process in the Emergency Department by the triage nurse.
2. Nursing staff must complete the Environmental Patient Safety Checklist for a patient at risk for suicide or self-harming behaviors at the time of admission and at the beginning of each shift. If risks are identified on the checklist that cannot be removed, staff should mitigate risk to the patient.
3. If patient is one to one, line of sight (LOS) or close observation as determined by physician/mid-level provider, environmental assessment, the required observation will be recorded on the Psychiatric Flow Sheet (See Attachment E) by the assigned patient attendant.
4. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
5. Hospital staff assigned as a patient attendant to monitored suicidal/self-harming patients will document observations every 30 minutes on the Psychiatric Flow Sheet.
6. The Environmental Patient Safety Checklist should be completed and documented by the assigned patient attendant on admission, each shift change, any change in staff and any changes in behavior.

7. Physician/mid-level provider will document in the patient's medical record the MSE including any tests performed, any stabilizing treatment provided, and disposition of patient. If the patient has sign/symptoms and/or concerning/contributing history or circumstances that might indicate increased risk of suicide and ASQ Suicide Risk Screen negative, physician/mid-level provider should document the rationale for appropriate level of observation and monitoring in the patient's medical record.

E. Any threat to the security and safety of patients, visitors, staff and/or the hospital environment will be reported promptly to the Mangum Police Department. Complete incident report for all involvement by law enforcement and forward to the Risk Manager.

F. Two critical assessments should be performed as soon as possible and documented in the patient's medical record:

VI. ENVIRONMENTAL RISK ASSESSMENT (Safety Check)

A. Prior to admission to patient room:
   1. Remove all sharp objects
   2. Remove unnecessary monitor cables, cords and equipment
   3. Remove telephone
   4. Remove call light unless necessary to use to call for assistance. If needed to call for assistance, ensure call light cord is shortened so as not useful to cause harm.
   5. Remove any bottles/containers that contain solutions
   6. Limit linen available in the room
   7. Remove all plastic trash liners. Use only paper trash liners
   8. Visitors are not permitted to take anything into room; this includes what may be in their pockets which could be used to cause harm. All handbags, cell phone chargers and other bags should be secured in the visitor's personal vehicle until visitors are ready to leave. The physician may order "No Visitors" if appropriate and necessary for patient safety.
   9. Patient belongings are searched upon arrival for potential self-harm items or contraband.
      a. If any potential self-harm items are found on patient, items should be inventoried and secured in a designated area in the ED until the patient is transferred or discharged.
      b. If staff discovers any contraband or illegal substances, the item(s) should be confiscated from the patient and local law enforcement notified. The item(s) should be inventoried and secured until arrival of local law enforcement.

B. On admission to room:
   1. Explain to patient and family that the patient is on suicide/self-harm precautions for their safety.
   2. Immediately place the patient on constant one to one observation
      a. Hospital staff assigned to monitor patient should be of same gender as patient whenever possible, or per patient preference.
      b. Family members are not permitted to provide one to one observation.
      c. Law enforcement/correction officers are not allowed to provide monitoring of patients. Law enforcement staff may be allowed to provide the one to one observation, but hospital staff must still perform ongoing monitoring every 30 minutes and document observations on the Psychiatric Flowsheet.

3. Assist patient into hospital gown.
4. Search all belonging, including pockets in clothing, purse/bags:
    a. This must be completed by two hospital staff in the patient's presence
    b. Items which could be used for self-injurious behavior include but are not limited to:
        i. Belts
        ii. Shoelaces
        iii. Cellphones/phones
        iv. Ties/necklaces/jewelry
        v. Medications brought by the patient (OTC and prescription)
        vi. Other dangerous items (i.e. glass, scissors, knives, razors, nail files, electrical cords, lighters, cleaning chemicals, ink pens, alcohol foam, compact with mirror, phone charger/cord or any other items which could be used to harm self/staff).
    c. Contraband will be turned over to law enforcement.
    d. Explain to the patient/family we are doing this for their safety and according to policy.
    e. If the patient's physical person is searched, a hospital staff member of the same gender (or per patient preference) as the patient must assist in carrying out the search.
5. Document all patient belongings, removed from the room and secure them **[designate area]** or return to a family member to be taken from the hospital (this includes cell phones).

C. Assessment:
1. Patient's environmental safety must be assessed and documented by nursing staff on admission, each shift, change in hospital staff member and with any reported change in behavior using the Environmental Patient Safety Checklist.

VII. DISCHARGE WITH A SAFETY PLAN

A. A Discharge Safety Plan (See Attachment F) is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in **the patient's own words**, and is **easy** to read.

B. After medical evaluation and risk assessment screening either the LMHP or the ED provider will determine if the patient can safely be discharged home. If it is determined the patient can return home safely a safety plan will be completed with the patient and family (if present) prior to discharge by either the LMHP or hospital staff.
    a. If the discharge safety plan is completed by the LMHP nursing staff will document the completion of the safety plan with the patient and family (if present) in the patient's medical record, and ensure patient and/or family have no additional questions or concerns prior to discharge.

C. Safety planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.
1. There are six (6) steps to completing the Safety Plan with the patient using the Discharge Safety Plan. Identify Warning Signs

a. Ask: ***"How will you know when the safety plan should be used?"***
b. Ask: ***"What do you experience when you start to think about suicide or feel extremely depressed"***
c. List warning signs (thoughts, images, thinking process, mood, and/or behaviors) using the patient's **own words**.

2. Identify Internal Coping Strategies
   a. Ask: ***"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"***
   b. Assess likelihood of use: Ask: ***"How likely do you think you would be able to do this step during a time of crisis?"***
   c. If doubt about use is expressed, ask: ***"What might stand in the way of you thinking of these activities or doing them if you think of them?"***
   d. Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.
3. Identify Social Contacts Who May Distract from the Crisis
   a. Instruct patients to use Step 3 if Step 2 does not resolve crisis or lower risk.
   b. Ask: ***"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"***
   c. Ask for safe places they can go to be around people (i.e. coffee shop).
   d. Ask patient to list several people and social settings in case the first option is unavailable.
   e. Remember, in this step the goal is distraction from suicidal thoughts and feelings.
4. Identify Family Members or Friends Who May Offer Help
   a. Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
   b. Ask: ***"Among your family or friends, who do you think you could contact for help during a crisis?"*** or ***"Who is supportive of you and who do you feel that you can talk with when you're under stress?"***
   c. Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
5. Identify Professionals and Agencies to Contact for Help
   a. Instruct the patient to use Step 5 if Step 4 does not resolve crisis or lower risk.
   b. Ask: ***"Who are the mental health professionals that we should identify to be on your safety plan?"*** and ***"Are there other health care providers?"***
   c. List names, numbers and/or locations of clinicians, local urgent care services.
6. Identify How to Make the Environment Safe
   a. Ask patients which means they would consider using during a suicidal crisis.
   b. Ask: ***"Do you own a firearm, such as a gun or rifle?"*** and ***"What other means do you have access to and may use to attempt to kill yourself?"***
   c. Collaboratively identify ways to secure or limit access to lethal means: Ask: ***"How can we go about developing a plan to limit your access to these means?"***

D. Assess likelihood patient will engage during each step; ID potential obstacles, and problem solve.

E. The Discharge Safety Plan should be completed collaboratively with the patient and family (if present) by nursing staff prior to discharge. The original should be provided to the patient and a copy placed in the patient's medical record.
F. Upon discharge the patient will be provided with the appropriate discharge instructions and information and a list of mental health resources (See Attachment G).

VIII. EMERGENCY ORDER OF DETENTION

A. Patients who meets the definition of a "person requiring treatment" may be subject to an Emergency Order of Detention.
B. A "person requiring treatment" means a person who because of his or her mental illness or substance abuse dependency:
    1. poses a substantial risk of immediate physical harm to self as manifested by evidence of serious threats of or attempts at suicide or other significant self-inflicted bodily harm,
    2. poses a substantial risk of immediate physical harm to another person or persons as manifested by evidence of violent behavior directed toward another person or persons,
    3. has placed another person or persons in a reasonable fear of violent behavior directed towards such person or persons or serious physical harm to them as manifested by serious and immediate threats,
    4. is in a condition of severe deterioration such that, without immediate intervention, there exists a substantial risk that severe impairment or injury will result to that person, or
    5. poses a substantial risk of immediate serious physical injury to self or death as manifested by evidence that person is unable to provide for and is not providing for his or her basic physical needs.
C. History of mental illness or substance abuse may be used as part of the evaluation to determine whether a person requires treatment but shall not be the sole basis for determination.
D. Homelessness, dementia, developmental disability or mentally retarded, seizure disorder, or traumatic brain injury alone is not enough to have a person placed in Emergency Detention. He/she must also meet one of the criteria of a person requiring treatment.
E. If the patient meets the criteria for a person requiring treatment a Third-Party Statement (See Attachment H) should be completed by the person who personally observed the concerning behavior.
F. Once a third party statement has been completed and LMHP or BSSA by provider has determined the patient is a "person requiring treatment", law enforcement should be notified (if not already present) to take the patient into protective custody for transport to a psychiatric facility.
G. A LMHP examination must be completed within twelve (12) hours of being placed into protective custody for the purpose of determining whether emergency detention of the patient is necessary.

IX. AGITATION AND DE-ESCALATION

A. Types of Aggression

1. Instrumental Aggression: used by those who have found they can get what they want by violence or threats of violence. This type of aggression can be handled by using counter offers to the aggressor's threats.
2. Fear Driven Aggression: patient wants to avoid being hurt and may attack to prevent someone from hurting them. This type of aggression can be handled by giving the patient plenty of space. Do not have a show of force or in any way intimidate the patient. Provide ongoing reassurance to the patient they are safe.
3. Aggression: This type of aggression comes in two forms:
    a. Person who has had boundaries violated; someone has cheated, humiliated, or otherwise emotionally wounded them. This type of aggression can be handled by setting conditions for the patient to be heard.
    b. Persons who are chronically angry at the world and are looking for an excuse to "go off". This type of aggression can be handled by giving the patient choices, let them know you will work with them but only if they are willing to be cooperative. Set firm limits to protect staff, patients, and others.

B. De-escalation of the agitated patient.

1. History is critically important in determining whether the source of agitation is likely related to a general medical condition such as hypoglycemia, hypoxia, or neurological problem versus an exacerbation of a psychiatric illness.
2. Identifying the underlying etiology is key to treating agitation in the ED setting.
3. When working with an agitated patient there are four (4) main objectives:
    a. Ensure the safety of the patient, staff, and others in the area.
    b. Help the patient manage their emotions and distress and maintain or regain control of their behavior.
    c. Avoid the use of restraints (mechanical, chemical and/or physical hold) when at all possible.
4. Avoid coercive interventions that escalate agitation.
5. Methods of de-escalation may include, but are not limited to the following interventions:
    a. Respect the patient's personal space.
    b. Maintain calm speech, demeanor, and facial expression.
    c. Establish verbal contact (designate one staff member to directly communicate and interact with the patient whenever possible).
    d. Listen closely to what the patient is saying.
    e. Be concise.
    f. Identify wants and feelings.
    g. Find a way to respond that agrees with or validates the patient's position.
    h. Explain to the patient what you want them to do.
    i. Clearly inform the patient of acceptable behaviors.
    j. Set clear limits.
    k. Offer choices and optimism.
    l. Show kindness (offer blankets, magazines, food, beverage if not contraindicated by environmental safety check).
    m. Never promise the patient something that cannot be delivered.
    n. Stand at an angle from the patient, hands should be visible.

i. Physical Environment
   a. The physical environment is important for the safe management of the agitated patient.
   b. The ability to remove furniture from the area can expedite the creation of a safe environment.
   c. There should be adequate exits (except in the case of suicidal/self-harm patients), and extremes in sound, wall color and temperature of environment should be avoided to minimize abrasive secondary stimulation.
   d. Hospital staff must remain aware of the potential for an agitated patient throwing objects that may cause injuries to others. Any sharp objects such as pens, sharp objects, table lamps, etc. that may be used as weapons should be removed or secured.

X. FOLLOW-UP CARE

For those patients that require further mental health services, the medical provider or LIP will make the appropriate referrals. A list of community resources will be made available to patients and or family if needed or required.

XI. RESPONSIBLE PARTIES/QUALITY ASSURANCE

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Nursing Officer and an incident report completed.

All patient and visitor reports of law enforcement involvement or security risk events will require the completion of an incident report.

All incident reports will be forwarded to the Quality Risk Manager and reported to the Safety/EOC, QAPI, MEC, and Governing Board.

VII. ATTACHMENTS

See EMD-006A: Emergency Severity Index Algorithm
Attachment A: ASQ Suicide Risk Screening Tool
Attachment B: Brief Suicide Safety Assessment
Attachment C: Columbia Suicide Severity Scale
Attachment D: Environmental Patient Safety Checklist
Attachment E: Psychiatric Flowsheet
Attachment F: Discharge Safety Plan
Attachment G: Local Mental Health & Substance Abuse Resources
Attachment H: Third Party Statement
Attachment I: Psychiatric Flowsheet Algorithm
Attachment J: Psychiatric Patient Outcome Review

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Emergency Department***

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: *Was this within the past three months?*	**Past 3 Months**	

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Environmental Patient Safety Checklist

Patient Safety Checklist/Suicide Precautions

Checklist must be completed on admission, every shift, change of staff, reported change in behavior for all patients at risk for suicide, suicidal/homicidal ideation, or has self-harm behaviors.

√	ITEMS CHECKLIST	INITIALS			
	Room inspection completed at beginning of each shift.				
	Communicate initiation of Level of Observation to other hospital staff.				
	Place patient in a room or treatment area which provides the best observation and protection. Never leave patient unattended behind a closed curtain or door. Keep curtain or door open at all times.				
	Remove in-room sharps container or ensure sharps container is locked and secure.				
	Remove ALL sharp objects (*needles, scalpels, knives, scissors, nail files, glass items, etc.*)				
	Remove all detachable/removable hanging risk items, if possible and unless medically necessary: • Electric cords, telephone cords, bed cords (if detachable), window blind cords • Oxygen tubing/flowmeter (unless required for continuous use) • Monitoring equipment (BP/EKG cables) unless items are required for continuous monitoring • Excessive IV tubing • Suction tubing • Nurse call light in room and bathroom (if removable)				
	Remove plastic trash bag liners, linen container and all plastic bags.				
	Remove extra linens (sheets, towels, pillowcases, gowns)				
	Visually inspect room and bathroom remove/mitigate risk of potentially harmful objects as much as possible: • Shower curtain • Note shower heads for hanging risks and observe patient closely while using shower • Remove any hanging curtains • Lock all cabinets • Remove any items that are dangerous if ingested • Disable bathroom door locks				
	Inspect patient belongings (initiate Patient Belongings Record): remove potentially harmful objects or contraband from patient and environment. This includes: patient medications, glass or sharp items, toiletry items containing alcohol, matches, lighter, aerosol spray cans, curling iron, hair dryer, razor, belts, straps, ties, shoelaces, dental floss and jewelry. Remove items from patient remove and place in a secured location or send home with family. Allowable items: cordless electric razor, eyeglasses, and non-breakable toiletries.				

	Provide patient gown. No clothing with any type of strings or drawstrings.				
	Request disposable cups, plates and utensils from dietary (count before and after meals) or serve finger foods only.				
	Ask patient if there is a family member or friend he/she wants involved in care. Inform family/visitors the level of observation, suicide precautions, associated restrictions and rationale.				
	No purses or bags allowed into patient's room by visitors. Secure visitor belongings during visit with patient. Re-assess room for safety after visitor leaves.				

Initials	Printed Name	Signature	Date	Time

Mangum Regional Medical Center

Psychiatric Flow Sheet

7AM-7PM SHIFT ASSESSMENT

Patient Name: _____ Date:_____

EMERGENCY SEVERITY INDEX TRIAGE LEVEL		1-Immed/Life Saving		2-High Risk Situation
Check appropriate box				
Check all that apply	**Yes**	**No**	**NA**	**Nurse Signature**
asQ Suicide Risk Screening Tool Completed				
Environmental Patient Safety Checklist Completed				
Brief Suicide Safety Assessment Completed				
Columbia Suicide Severity Rating Scale Completed				
Discharge Safety Plan Completed				
Mental Health Resources Provided to Patient or Family				

LEGEND

Instructions: **Enter appropriate symbol into each element of the flowsheet as indicated**

Observation Status							**One-On-One**	**Line of Sight**	**Close Observation**
Neuro Status (NS)	**Awake**	**Confused**	**Talkative**	**Withdrawn**	**Agitated**	**Sleep**	1	2	3
	A	C	T	W	AT	S			
7A-7P	**0700**	**0730**	**0800**	**0830**	**0900**	**0930**	**1000**	**1030**	**1100**
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									
7A-7P	**1130**	**1200**	**1230**	**1300**	**1330**	**1400**	**1430**	**1500**	**1530**
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									
7A-7P	**1600**	**1630**	**1700**	**1730**	**1800**	**1830**			
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									

Signature of Nurse: _____ Signature of Nurse: _____

Signature of Nurse: _____ Signature of Nurse: _____

INSERT HOSPITAL NAME AND LOGO

Psychiatric Flow Sheet

7PM-7AM SHIFT ASSESSMENT

Patient Name: _____ Date:_____

EMERGENCY SEVERITY INDEX TRIAGE LEVEL		**1-Immed/Life Saving**		**2-High Risk Situation**
Check appropriate box				
Check all that apply	**Yes**	**No**	**NA**	**Nurse Signature**
asQ Suicide Risk Screening Tool Completed				
Environmental Patient Safety Checklist Completed				
Brief Suicide Safety Assessment Completed				
Columbia Suicide Severity Rating Scale Completed				
Discharge Safety Plan Completed				
Mental Health Resources Provided to Patient or Family				

LEGEND

Instructions: **Enter appropriate symbol into each element of the flowsheet as indicated**

Observation Status							**One-On-One**	**Line of Sight**	**Close Observation**
Neuro Status (NS)	**Awake**	**Confused**	**Talkative**	**Withdrawn**	**Agitated**	**Sleep**	1	2	3
	A	C	T	W	AT	S			
7P-7A	**1900**	**1930**	**2000**	**2030**	**2100**	**2130**	**2200**	**2230**	**2300**
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									
7P-7A	**2330**	**0000**	**0030**	**0100**	**0130**	**0200**	**0230**	**0300**	**0330**
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									
7P-7A	**0400**	**0430**	**0500**	**0530**	**0600**	**0630**			
Neuro Status									
Observation									
Room Safety Check									
Visitors @ BS									
Provider Notified for Change									
Initials									

Signature of Nurse: _____ Signature of Nurse: _____

Signature of Nurse: _____ Signature of Nurse: _____

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

SUICIDE DISCHARGE SAFETY PLAN

STEP 1: Warning Signs: (thoughts, images, thinking process, mood, and/or behaviors)

1. _____
2. _____
3. _____

STEP 2. Internal coping strategies – Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

STEP 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

STEP 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

STEP 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____Phone_____
   Clinician Pager or Emergency Contact # _____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255) En Espanol: 1-888-628- 9454
   24/7 Crisis Text Line: Text “HOME” to 741-741
4. Local Emergency Service _____
   Emergency Service Address _____
   Emergency Services Phone _____

STEP 6: Making the Environment Safe:

1. _____
2. _____
3. _____

Discharge Safety Plan
Instructions

*A safety plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.*

If after a complete medical evaluation and comprehensive risk assessment the physician has determined the patient can safely be discharged, complete the discharge safety plan with the patient and family (if present) prior to discharge.

STEP 1:

- Assist the patient and family **identify warning signs**
    - Ask: "*How will you know when the safety plan should be used?*"
    - Ask: "*What do you experience when you start to think about suicide or feel extremely depressed?*"
    - List warning signs (thoughts, images, thinking process, mood, and/or behaviors) using the patient's own words

STEP 2:

- Assist patient to **identify internal coping strategies**
    - Ask: "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
    - Assess likelihood of use: Ask: "How likely do you think you would be able to do this step during a time of crisis?"
    - If doubt about use is expressed, ask: "What might stand in the way of you thinking of these activities or doing them if you think of them?"
    - Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

STEP 3:

- Assist patient to **identify social contacts** who may distract patient during a crisis
- Instruct patients to use Step 3 if Step 2 does not resolve crisis or lower risk.
    - Ask: "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
    - Ask for safe places they can go to be around people (i.e. coffee shop, movies, etc.)
    - Ask patient to list several people and social settings in case the first option is unavailable.
    - Remember in this step the goal is distraction from suicidal thoughts and feelings.

STEP 4:

- Assist patient to **identify family member or friends who may offer help** during a crisis
- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
    - Ask: "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"

- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. I step, unlike the previous step, patients reveal they are in crisis to others.

STEP 5:

- Assist the patient **identify Professional and Agencies to contact for help**
- Instruct the patient to use Step 5 if Step 4 does not resolve crisis or lower risk.
  - Ask: "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
  - List names, numbers and/or locations of clinicians, local urgent care services.

STEP 6:

- Assist the patient to **identify how to make their environment safe**
  - Ask patient which means they would consider using during a suicidal crisis.
  - Ask: "Do you own a firearm, such as a gun or rifle?" and "What other means do you have access to and may use to attempt to kill yourself?
  - Collaboratively identify ways to secure or limit access to lethal means: Ask: "How can we go about developing a plan to limit your access to these means?"

Additional Steps:

- Assess the likelihood the patient will engage during each step; ID potential obstacles, and problem solve with the patient. Document in the patient's medical record.
- Make a copy of the discharge safety plan and place in the patient's medical record and provide the original to the patient at discharge.

Mental Health Facilities

Facilities are arranged in proximity to the hospital

ATTENTION QUALITY MANAGERS YOU WILL HAVE TO ARRANGE THESE FACILITITES THAT ARE CLOSEST TO YOUR FACILITY AND THEN REMOVE THIS STATEMENT-IT IS ONLY A REMINDER

RED ROCK LOCATIONS:

111 N. Hudson St.
Altus, OK 7352
1-580-379-4085
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, alcohol and drug assessments, Health Team services, drug court services

Canadian County
7777 East Highway 66
El Reno, OK 73036
1-405-422-8800
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

112 N. McKinley
Chandler, OK 74884
1-405-258-3040
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

70 N. 31st
Clinton, OK 73601
1-580-323-6021
Services: Adult crisis stabilization services

90 N. 31st
Clinton, OK 73601
1-580-323-6021
Services: Adult and Children's Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, Adult and Children's medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services, adult drug court, intensive outpatient services.

804 W. Choctaw
Chickasha, OK 73018
1-405-222-0622
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

3080 W. 3rd
Elk City, OK 73644
1-580-225-5136
Services: Adult and Children's Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, Adult and Children's medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services, adult drug court, intensive outpatient services.

216 S. Main
Hobart, OK 73651
1-580-726-2452
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, peer support services, emergency services, Health Team services

107 N. Main St.
Kingfisher, OK 73750
1-405-776-0500
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, peer support services, emergency services, Health Team services

4400 N. Lincoln Blvd.
Oklahoma City, OK 73105
1-405-424-7711
Services: Mental Health Court, outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

4400 N. Lincoln Blvd.
Oklahoma City, OK 73105
1-405-425-0333
Services: Children's Crisis Unit – crisis stabilization services for children

4130 N. Lincoln Blvd.
Oklahoma City, OK 73105
1-405-424-7711
Services: Children's outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services for children

Expressions/LGBTQ
2245 NW 39th Street
Oklahoma City, OK 73112
1-405-528-2210
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, services to homeless individuals, peer support services, emergency services

Planet Rock
4130 N. Lincoln Blvd.
Oklahoma City, OK 73105
1-405-424-7711
Services: Children's outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services for children

Griffin Memorial
900 E. Main Street, Building 52, Unit 200
Norman, OK 73070
1-405-307-4800
Services: Norman Crisis Unit – crisis stabilization services for adults

Norman Regional
901 N. Porter Avenue
Norman, OK 73071
1-405-307-4800
Services: Norman Crisis Unit – crisis stabilization services for adults

Jordan's Crossing
West I-240 Service Road
Oklahoma City, OK 73139
1-405-604-9644
Services: Residential substance abuse treatment for women with dependent children

101 N. Union
Shawnee, OK 74801
1-405-275-7100
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

216 West A Street
Watonga, OK 73772
1-580-952-3900
Services: Outpatient therapy services, case management services, screening intake and referral services, psychiatric rehabilitation services, medication clinic services, services to homeless individuals, peer support services, emergency services, wellness activities and support, Health Team services

Toll Free Number: 1-855-999-8055

Locations: https://www.red-rock.com/locations.php

INPATIENT MENTAL HEALTH FACILITIES:

Facilities are arranged in proximity to the hospital

Rolling Hills Hospital
Ada, OK
http://www.rollinghillshospital.com
1-855-980-5993 (Service/Intake)
1-580-436-3600 (Alternate Service/Intake)
Services: inpatient for adolescents, adults and seniors

Cedar Ridge Bethany Behavioral Health Center
Oklahoma City/Bethany, OK
http://www.cedarridgebhs.com
1-405-605-6111 Phone
1-405-424-0457 Fax
Services: inpatient for adults/seniors, children/adolescents

Integris Meadowlake
Enid, OK
http://integrisok.com
1-580-234-2220 Phone
Services: inpatient for children/adolescent, includes dual diagnosis of developmental disabilities paired with emotional disorders

SSM St Mary's Regional Medical Center
Enid, OK
http://www.stmarysregional.com
1-580-233-6100 Phone
Services: Inpatient Adults and Seniors

Northwest Center for Behavioral Health
Fort Supply, OK
http://www.ncbhok.org/
1-580-766-2311 Phone
1-800-545-0518 Crisis Hotline
Services: inpatient treatment for adults

Comanche County Memorial Hospital
Lawton, OK
http://ccmhonline.com/
info@ccmhonline.com
Services: inpatient geriatric patient unit >65 years, adult female unit >21 years 7 months

Jim Taliaferro Community Mental Health Center
Lawton, OK
http://wwwodmhsas.org
1-580-248-5780 Phone

Services: outpatient and emergency mental health services, counseling, screening, referral

Griffin Memorial Hospital
Norman, OK
http://www.ok.gov/odmhsas/Mental_Health/Griffin_Memorial_Hospital.html
JDismukes@odmhsas.org
1-405-321-4880 Phone
Services: inpatient mental health services for adults >18 years

Oakwood Springs
North Oklahoma City, OK
http://www.oakwoodsprings.com/
1-405-400-0351 Phone
Services: Inpatient mental health and addiction treatment for adults >18 years

SSM Health St. Anthony Healthplex South
Oklahoma City, OK
http://www.saintsok.com/
1-405-815-5600 Phone
1-405-713-5706 Service/Intake
Services: Adult/Seniors inpatient, Chemical/Substance Abuse, Positive Outcomes Program for male juvenile sex offenders 13-17, Stages partial hospitalization & intensive outpatient

SSM Health St. Anthony Hospital
Oklahoma City, OK
http://www.saintsok.com/
1-405-272-6216 ext. 1 Phone
1-800-851-0888 Toll Free
1-405-713-5706 24 Hr Crisis Line/main inpatient line
1-405-231-8809 Service/Intake – Accents Program
1-405-272- 4932 Service/Intake – Human Restoration Program
Services: behavioral health inpatient adults/seniors, children/adolescents ages 3-17 years

Integris Mental Health Spencer
Spencer, OK
http://integrisok.com/mental-health-oklahoma-ok
1-405-424-2441 Phone
1-405-951-2273 Emergency
1-405-427-4703 Fax
Services: inpatient mental health and medical detox child/adolescent (mood/anxiety disorders, schizophrenia, psychotic disorders, grief issues, substance related disorders, emotional mental health problems related to other medical conditions & medication adjustments)

Brookhaven Hospital
Tulsa, OK
http://www.brookhavenhospital.com
wecanhelp@brookhavenhospital.com
1-918-438-4257 Service/Intake
Services: inpatient services adults (addictions, depression, anxiety, TBI, and other behavioral and neurological disorders)

Laureate Psychiatric Clinic and Hospital
Tulsa, OK
http:// www.laureate.com
carold@saintfrancis.com
1-918-481-4000 Service/Intake
Services: inpatient mental health services for adults and seniors >60 years, including anxiety, depression, bipolar, dementia, obsessive/compulsive, PTSD, Trauma, aggressive/confrontational.

Parkside Psychiatric Hospital
Tulsa, OK
http://www.parksideinc.org
esachau@parksideinc.org
1-918-588-8888 Service/Intake
Services: inpatient mental health services for Adolescents 13 to 17 years (depression, mood disorders, psychotic disorders, trauma and behavioral problems) and Adults >18 years (mental health and substance abuse)

Shadow Mountain Behavioral Health
Tulsa, OK
http://www.shadowmountainbhs.com
1-918-492-8200 Service/Intake
1-800-821-6993 Alternate Service/Intake
Services: inpatient mental health services for Children/Adolescents that are danger to themselves or others. Adolescents include treatment of autism spectrum disorders, delayed functioning & reactive attachment disorder. Adults >18 years include treatment for depression, schizophrenia, bipolar and dual diagnosis treatment (i.e. substance abuse and psychiatric disorder)

Red River Hospital
Wichita Falls, TX
http://www.redriverhospital.com
1-844-240-9477 24 hour
Services: inpatient mental health for Children/Adolescents 5 to 17 years (anxiety, depression, bipolar, PTSD, ADHD, adjustment disorder, aggression, self-harming, suicidal/homicidal ideation). Adults >18 years (anxiety, depression, bipolar, PTSD, schizophrenia, schizoaffective disorder, ADHD, adjustment disorder, aggression, SI/HI, substance abuse, detox) and Seniors.

Muscogee Creek Nation Medical Center
Okmulgee, OK
Hope Unit
1-918-756-4233 Phone
1-918-758-3101 Emergency Department
Services: inpatient mental health geriatrics >55 years

McAlester Regional Medical Center
McAlester, OK
http://www.mrhcok.com/
1-918-421-4700

Life Bridge Geriatric Psychiatric Unit
Services: inpatient mental health services for seniors

Mercy Hospital ADA
Ada, OK
http://www.mercy.net/practice/mercy-hospital-ada
Reflections Behavioral Health
1-580-421-1234 Service/Intake
1-580-332-2323 Alternate Service/Intake
Services: inpatient adult >18years/Seniors

Hillcrest Hospital Claremore
Claremore, OK
http://www.hillcrestclaremore.com
1-918-341-2556 Service/Intake
Senior Focus Program
Services: short term inpatient for seniors >55 years

Mercy Hospital Ardmore
Ardmore, OK
https://www.mercy.net/practice/mercy-senior-behavioral-health-ardmore/
1-580-220-6190
Services: short term inpatient for seniors >65 years

Duncan Regional Hospital
Duncan, OK
http://www.duncanregional.com/
info@duncanregional.com
1-580-252-5300 Phone
1-877-252-5300 Toll Free
Horizons Unit
Services: inpatient for seniors >65 years

Southwestern Behavioral Health Center
Lawton, OK
https://swconline.com/departments/behavioral-health/
1-580-536-0077 Phone
1-580-510-2751 Fax
Services: inpatient services for children/adolescents, adults

Integris Miami Hospital
Miami, OK
http://www.integrisok.com/miami
1-918-542-3391 Service/Intake
Generations
Services: short-term inpatient services for seniors >55 years

Willowcrest Hospital
Miami, OK
http://www.willowcresthospital.com/
1-800-950-7577 24 hr Helpline
Services: inpatient services for children/adolescents 5-17 experiencing emotional, behavioral and substance related disorders

Wagoner Community Hospital
Wagoner, OK
http://wagonerhospital.com/
1-918-485-5514 Phone
Services: inpatient mental health services for adults and drug/alcohol withdrawal treatment

Alliance Health Midwest
Midwest City, OK
http://www.alliancehealthmidwest.com/
1-405-610-4411 Phone
Services: inpatient mental health for adults >18 years

Norman Regional Hospital
Norman, OK
http://www.normanregional.com/
nrhfoundation@nrh-ok.com
1-405-307-1000 Phone
Services: inpatient mental health for adults/seniors, medical detox, outpatient senior counseling

Southern Plains Treatment Services
Norman, OK
http://www.splains.org/
info@splains.org
aburnett@splains.org
1-405-8400 Phone
Services: inpatient mental health for adolescents focus on emotional and/or behavioral difficulties ages 12-17

Hillcrest Medical Center
Tulsa, OK
http://www.hillcrest.com
1-918-579-1000 Service/Intake
Services: inpatient mental health for adults 18 to 65 years for variety of mental health issues including substance abuse or multi diagnose issues, suicidal/homicidal ideations, excessive aggression, delusions/hallucinations, agitation/restlessness, self-neglect, self-harm, obsessive/compulsive, hypomanic or manic behavior, etc.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

THIRD PARTY STATEMENT

The Third Party Statement may be filled out by anyone who is concerned about the patient's safety or who witnessed concerning behavior (i.e. family, friend, nurse, physician).

The Third Party Statement ***MUST*** have enough detailed information to justify the placement of the patient into protective or police custody (it cannot simply say "suicidal;" it must list specific examples of how the patient has been a danger to him/herself or others within the past 24 hours).

I, _____ the undersigned being _____ years of age, declare:

I observed the activities or incidents as described below by (name of person under concern):

_____

at (location): _____ in _____ County, Oklahoma.

Time of occurrence: _____ AM/PM Date of occurrence: _____/_____/_____.

Statement of Observation (describe in detail activity or incident personally observed):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Based upon the behavior I personally observed, I have reasonable belief that this person has a condition to a degree that immediate emergency action is necessary.

I, the undersigned attest to the above statement to be factual and true to the best of my knowledge.

_____ _____/_____/_____

Name (Print) *Date*

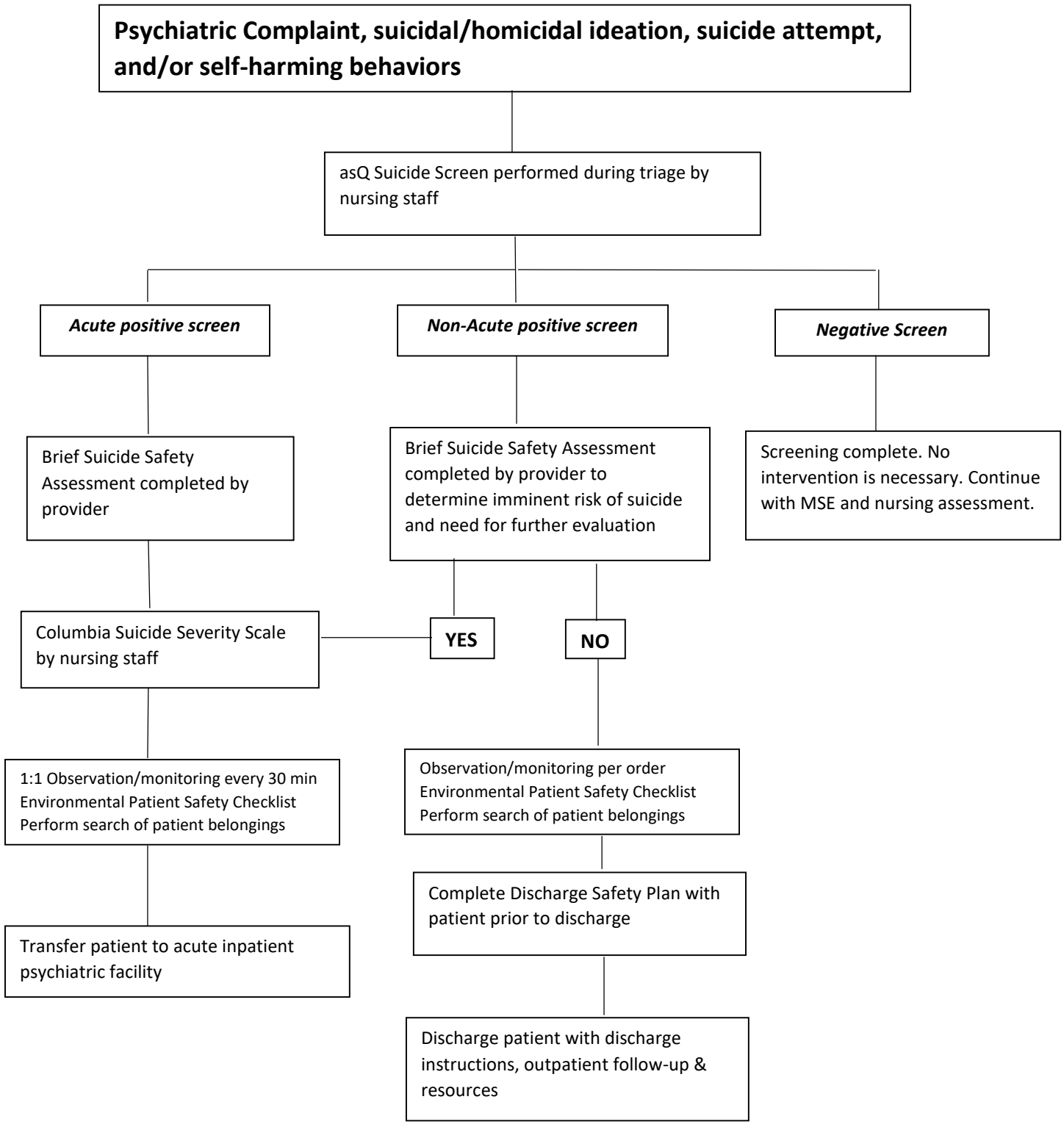
_____

Name (Signature)

_____ _____ _____

Address *City & State* *Zip*

Care of Psychiatric Patient Algorithm



All patients should have:

- MSE to determine an EMC and any medical condition(s) contributing to presenting complaints
- Nursing assessment to determine any medical condition(s) contributing to presenting complaints

Psychiatric Patient Outcome Review

Patient Name _____ □ ER Patient □ Inhouse Patient

Admit Date: _____ **Admit Time:**_____ □ Visitor □ Other

EOD □ **Yes** □ **No** **RN in Charge:** _____

Police: Notified: _____ **Arrived:** _____ **Physician/LIP Present:** _____

Immediate Actions Taken			
			Comments
Code Status	Full	DNR	
Patient stable	Yes	No	
ESI Triage on arrival	Yes	No	

Psychiatric/Suicidal Patient Critique				
Skill	**Yes**	**No**	**NA**	**Comments/Areas to Improve**
ASQ Suicide Risk Screen for those exhibiting SI/HI, self-harming behaviors				
BSSA completed by physician/mid-level provider				
Acute + Screen: mental health evaluation, or determined by BSSA				
Acute + Screen: CSSS completed				
Acute + Screen: one to one observation, or as ordered by physician/mid-level provider				
Environmental Patient Safety Checklist completed				
Clothing removed, search for unsafe items, 2 staff present, all items inventoried and secured				
Medical screen performed				
Focused nursing assessment performed				
Restraint(s) required to manage behavior and patient safety				
One-on-One Monitoring (if Indicated)				
Line of Sight Monitoring (if Indicated)				
Close Observation Monitoring (if Indicated)				
Documentation				
Patient Record complete				
EMTALA paperwork completed for Ground Transport (EMTALA Form, Local EMS, OHCA form, EMS Order Sheet)				
Family notified				
Discharge Safety Plan completed for discharges to home				
Patient Records sent with patient or faxed to psychiatric facility				
Environmental Patient Safety Checklist completed Q shift, change in staff and change in patient behavior				
Observations documented Q30min on Psychiatric Flowsheet				
Patient Departure Time:	**Final Disposition:**			
Atmosphere of Psychiatric Event:	□ **Well Organized**	□ **Fairly Well Organized**		
	□ **Disorganized**	□ **Chaotic**		
RN Signature				**Date:**
QM/CNO Signature:				**Date:**

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Management of Stroke (Level IV Stroke Center)		**EMD-009**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department	See References below	

I. SCOPE

This policy applies to Mangum Regional Medical Center for the initial assessment, stabilization and rapid transfer of patients presenting to the Emergency Department (ED) with signs and symptoms suggestive of stroke.

II. PURPOSE

Mangum Regional Medical Center has attested as a Level IV Stroke Center in the State of Oklahoma, adheres to the 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke and other evidence-based standards of practice. Stroke is one of the leading causes of death and disability in the U.S. Each year approximately 795,000 people experience a new or recurrent stroke. On average every 40 seconds someone in the Unites States will experience a stroke. Stroke is currently the leading cause of serious long-term disability. In Oklahoma, stroke is the 5th leading cause of death accounting for more than 1 in 20th deaths.

Risk factors for stroke include but are not limited to the following:

- Age > 45 years of age;
- History of transient ischemic attack (TIA), previous stroke or myocardial infarction (MI);
- Atrial fibrillation (increases risk 5-fold);
- Hypertension;
- Smoking;
- Sleep apnea;
- Substance abuse or alcoholism;
- Heredity;
- Ethnicity (Black, Hispanic, Asian);
- Female gender (women age 55-75 have a slightly higher risk of stroke compared to men).

The five most common signs and symptoms of stroke are:

- Sudden numbness and/or weakness of the face, arm, and/or leg;
- Sudden confusion, trouble speaking, and/or understanding, others;
- Sudden trouble seeing in one or both eyes;
- Sudden dizziness, trouble walking, and/or loss of balance or coordination;
- Sudden severe headache with no known cause;

There are two different types of strokes:

- Ischemic Stroke: an interruption of blood flow to the brain due to a clot.
- Hemorrhagic Stroke: caused by bleeding into and around the brain due to ruptured blood vessels. There are two types:
    - Intracerebral hemorrhage: caused when a blood vessel ruptures and bleeds into the brain itself.
    - Subarachnoid hemorrhage: caused when a blood vessel ruptures and bleeds into the space surrounding the brain.

For every 15 minutes we are faster with diagnoses and treatment, more stroke patients have better outcomes including less mortality and morbidity (Saver, et al. 2013; Jahan, R., et al. 2019). Therefore, the effectiveness of organized stroke care in reducing mortality, institutionalization and dependency in activities of daily living has been clearly shown. Organized stroke care is intended to facilitate the use of best practices to minimize or prevent, when possible, the complications of a stroke through rapid identification of symptoms, initial assessment, timely and appropriate stabilization and rapid transfer to the appropriate higher level of stroke center.

III. DEFINITIONS

A. **Stroke:** also known as a "brain attack", occurs when a clot blocks the blood supply to the brain (ischemic stroke) or when a blood vessel in the brain bursts (hemorrhagic stroke).

B. **Last Known Normal:** the time prior to hospital arrival at which the patient was last known to be without signs or symptoms of the current stroke or at his or her baseline state of health.

C. **Activase/Alteplase:** a tissue plasminogen activator (tPA), also known as the "clot buster", the only FDA approved drug to treat ischemic stroke. It is a natural enzyme that initiates fibrinolysis (break down of the thrombus). The FDA has approved intravenous Alteplase for the use in eligible acute ischemic stroke patients within 3 hours of last known normal. The ASA and other organizations have recommended the use of intravenous Alteplase with additional exclusionary criteria within 4.5 hours of last known normal.

D. **Endovascular treatment:** refers to the non-surgical treatment for acute stroke. The treatment uses microcatheters (thin tubes visible under x-rays) which are inserted into the blood clot from the groin or the arm.

E. **Stroke Alert:** a rapid stroke team response that facilitates the evaluation and management of stroke patients presenting to the hospital for treatment.

F. Competent Staff: refers to those staff that have completed a facility-based competency assessment initially and on a minimum of a bi-annual basis related to the core elements required to assess, stabilize and rapidly transfer an acute stroke patient.

IV. POLICY

Competent ED hospital staff will immediately triage, provide initial assessment, initiate indicated resuscitation and appropriate evidence-based emergency stroke care for patients presenting with signs and symptoms suggestive of stroke. A patient presenting with signs and symptoms suggestive of stroke will initially be triaged using the Emergency Severity Index (ESI) tool (See EMD-006A) and should be considered for a minimum ESI score of 2 indicating a high-risk situation. After initial triage a presumptive stroke patient will be screened using the ***B.E.F.A.S.T.*** Screening Tool on the Stroke Alert Nurse note to assess the patient's presenting symptoms of stroke and identify the patient's last known normal (onset of symptoms) time. The ***B.E.F.A.S.T***. is an evidence-based neurological assessment tool that can detect changes in neurological status in a rapid manner which may indicate a stroke is occurring. The acronym B.E.F.A.S.T. stands for:

- **B – Balance:** Sudden loss of balance or coordination
- **E – Eyes:** Sudden vision change/trouble seeing
- **F – Face:** One side of the face droops when the person smiles
- **A – Arm:** One arm (or leg) drifts down when the person raises the arm (or leg)
- **S – Speech:** Person's speech is slurred, garbled, slow or strange
- **T – Time:** Time the person was last known to be normal (onset of symptoms) if within the last 12 yours it is time to initiate a STROKE ALERT!

If the patient's last known normal was within 12 hours of arrival to the ED a STROKE ALERT will be initiated, and the provider notified. Hospital staff will immediately notify emergency medical services (EMS) of an acute stroke patient needing emergent transfer to a higher-level stroke center. Upon arrival to the ED the provider will perform an initial assessment which will include completion of the National Institutes of Health Stroke Scale (NIHSS) to assess stroke-related neurological deficits. The provider will use the VAN Stroke Screening Assessment Tool (See Attachment A) to rule out a large vessel occlusion.

The patient will be provided stabilizing treatment while awaiting transfer to a higher-level stroke center that may include but not be limited to the following:

- Resuscitative efforts following ACLS protocol
- Performance of a CT scan to rule out a hemorrhage or other brain pathology that may be responsible for the patient's neurologic symptoms
- Treatment of blood pressure following ASA recommended parameters (See Blood Pressure Management Protocol for Acute Stroke (See Attachment B).
- Labs including a point of care of glucose to rule out any electrolyte or metabolic conditions that may be responsible for the patient's neurologic symptoms

Once the stroke patient has been stabilized and determined ready for transfer, the provider and Registered Nurse (RN) will provide a hand-off to EMS providers using the Acute Stroke Interfacility Transfer Protocol (See Attachment C). The patient arrival to departure time will be 60 minutes or less.

V. PROCEDURE

All patients with signs and symptoms suggestive of strokes who present to the ED should be treated as a potential life-threatening situation. The provider should be immediately notified of the patient's presentation, taken directly to an ED room and assessed by the RN.

A. STROKE PROTOCOL (See Stroke Alert Standing Orders Attachment D)

1. The patient should be triaged immediately using the ESI upon arrival to the ED.
    a. Assignment of an ESI triage category should be done in < 5 minutes of patient's arrival.
2. Rapid assessment of airway, breathing, circulation, and disability.
3. Perform brief screening exam using the BE-FAST scale to determine neurological deficits suggestive of stroke and identify the patient's last known normal (onset of symptoms).
    a. Date and time of last known normal should be documented in the patient's medical record.
4. If patient has a positive BE-FAST screening exam and onset of symptoms was within 12 hours of arrival, hospital staff will initiate a STROKE ALERT immediately.
5. Notify provider of positive assessment and patient's last known normal (onset of symptoms) time.
6. Initiate the Stroke Alert Standing Orders
6. Notify EMS or Air Evac within 10 minutes of patient arrival of the need for emergent transfer to a higher-level stroke center.
    a. Hospital staff should request an expected estimated time of arrival (ETA) from EMS/Air Evac dispatch. This time should be documented in the patient's medical record.
7. Provider will perform an appropriate medical screening examination (MSE) within 15 minutes of the patient's arrival in the ED using the STROKE ALERT – Provider Note (see Attachment E).
    a. The provider will perform an NIHSS to determine the extent of any stroke-related neurological deficits.
    b. The completed (MSE) including the NIHSS will be documented in the patient's medical record.
8. Nursing staff will complete a full nursing assessment, obtain a complete set of vital signs (HR, BP, RR, Temp, O2 sat), assessment of pain, place the patient on continuous cardiopulmonary and pulse oximetry monitoring using the STROKE ALERT- Nurses Note (See Attachment F) .
    a. Neurological checks and vital signs will be monitored and documented in the patient's medical record every 15 minutes.

b. A nursing assessment, including neurological check and vital signs will be completed at the time of discharge. All should be documented in the patient's medical record prior to discharge.

9. Transfer patient to radiology for a STAT non-infused CT scan.
10. Laboratory staff should obtain STAT labs including blood glucose, PT/INR, PTT, CBC, and BMP or CMP.
    a. Obtain a urine drug screen and/or ETOH level if substance abuse or intoxication is suspected.
    b. Hyperglycemia should be treated to achieve blood glucose levels in the range of 140 to 180 mg/dL and closely monitored through frequent finger stick blood sugar (FSBS) to prevent hypoglycemia.
    c. Hypoglycemia (blood glucose <60mg/dL) should be treated.
11. Obtain an EKG and Chest X-ray if ordered.
12. Supplemental oxygen should be provided to maintain oxygen saturation >94%.
    a. Supplemental oxygen is not recommended in non-hypoxic patients with acute ischemic stroke.
13. Manage BP if greater than 220/120 mmHg or otherwise ordered
14. The patient will remain NPO (nothing by mouth) including all medications until transfer to decrease the risk of possible aspiration, unless a swallow screen is performed and documented in the patient's medical record by the nursing staff using the Nursing Bedside Swallow Screen (See Attachment G).
15. Expediate transfer arrangements to a higher-level Level II Primary or Level I Comprehensive Stroke Center immediately or within 60 minutes of patient arrival.

VI. ROLE RESPONSIBILITIES

A. Code Stroke Nurse (House Supervisor/Charge Nurse)

1. Announce "STROKE ALERT" via hospital intercom system. State "STROKE ALERT" and location of the patient.
2. Serve as recorder.
3. Immediately notify EMS or Air Evac of need for emergent transfer of an acute stroke patient to a Level II Primary or Level I Comprehensive Stroke Center within 10 minutes of the patient's arrival.
    a. Obtain an estimated ETA.
3. Assign specific duties.
4. Supports and transfer information to the patient's family and/or patient's representative.
5. Assist with supplies and medications if needed.

B. ED Nurse or Floor Nurse (RN or LPN)

1. Stabilize patient, initial assessment.
2. Immediate triage for suspected stroke using ***B.E.F.A.S.T.*** method.
3. Establish time last known normal (onset of symptoms).
4. Notify House Supervisor/Charge nurse to call STROKE ALERT.
5. Initiate Stroke Protocol upon provider determination of stroke symptoms.

6. Communicate patient's history and condition to provider.
7. Perform a full nursing assessment, including neurological assessment, pain assessment and vital signs.
    a. Perform vital signs and neuro/stroke assessments every 15 minutes.
8. Perform FSBS and treat hyper/hypoglycemia.
9. Coordinate emergent transfer to a Level II or Level I Stroke Center.
    a. If House Supervisor/Charge Nurse is unavailable it will be the ED nurse's responsibility to notify EMS/Air Evac of need for emergent transfer within 10 minutes of the patient's arrival.
10. Coordinate transfer of the patient to radiology for STAT non-contrast CT scan of the head if time allows prior to transfer of the patient.
11. Manage BP if greater than 220/120mmHg or otherwise ordered.
12. Ensure patient remains NPO, until completion of a validated dysphagia screen.

C. Provider

1. Assist in stabilizing the patient and perform an appropriate MSE within 15 minutes of patient's arrival.
2. Perform baseline NIHSS to determine stroke-related neurological deficits and document score in the patient's medical record.
3. Discuss need for emergent transfer to a Level II or Level I Stroke Center with patient/family.
4. Contact Level II or Level I Stroke Center and request emergent transfer and acceptance of acute stroke patient within 20 minutes of patient's arrival.
5. Place orders for the emergency management of stroke as needed based on patient assessment and CT findings.
6. Complete transfer orders and Acute Stroke Inter-Facility Transfer Protocol.
7. Ensure all appropriate EMTALA forms are completed prior to patient transfer.

VII. DOCUMENTATION

Documentation in the patient's medical record should include but not be limited to the following:

A. Assessments and reassessments per policy and procedure.
B. Date, time of last known normal (onset of symptoms), and "STROKE ALERT" initiated.
C. Responses to interventions.
D. Results of dysphagia screen utilizing screening tool.
E. Completion of all appropriate EMTALA forms
F. Patient and family discussions, education and response.

IX. QUALITY ASSURANCE

A. A log will be maintained of all patients who present to the ED with acute stroke signs and symptoms. The log will include the following information:
   1. Date;
   2. Patient Name;
   3. Time of Arrival;
   4. Time of provider notification;
   5. Time EMS or Air Evac notified;
   6. Time EMS or Air Evac arrived;
   7. Departure time;
   8. Primary or Comprehensive Stroke Center location;
   9. Receiving Nurse.

   All occurrences of stroke will be reported to the Quality Committee, Medical Staff Committee, and the Governing Body.

B. The Quality Department will track and report the following data:
   1. EMS/Air Evac notification of emergent transfer within 15 minutes of patient arrival.
   2. Transfer of patient to a Level II or Level I Stroke Center within 60 minutes of patient arrival.
      a. If the arrival-to-departure time exceeds >60 minutes more than 35% of time over two consecutive quarters the hospital will implement a quality improvement initiative in order to improve this indicator.
   3. Completion of an appropriate MSE by the provider within 15 minutes of patient arrival.
   4. Number of stroke patients.
   5. Number of acute stroke patients.
   6. Number of stroke patients determined eligible for thrombolytics and indications for why they were not treated.

C. Each Stroke Alert will be evaluated by the Quality Manager using the Stroke Alert Outcome Review Form (see Attachment H). Stroke Alerts will be forwarded and reviewed by the CCO to determine compliance with hospital policy and procedure.

X. STROKE TRAINING

All nursing staff (RN and LPNs) and providers are required to have initial orientation and bi-annual education and competency (except as otherwise noted) in the following:

A. Management of the acute stroke patient.

B. National Institutes of Health Stroke Scale (NIHSS) and other stroke assessment scales.

All nursing staff will also be certified in BCLS and ACLS according to the American Heart Association (AHA) standards of training. All clinical staff are required to have BCLS certification.

XI. ATTACHMENTS

See EMD-006A: Emergency Severity Index (ESI) Algorithm
Attachment A: VAN Screening Tool
Attachment B: Blood Pressure Management Protocol for Acute Stroke
Attachment C: Acute Stroke Inter-Facility Transfer Protocol
Attachment D: Stroke Alert Standing Orders
Attachment E: STROKE ALERT – Provider Note
Attachment F: STROKE ALERT – Nurses Note
Attachment G: Nursing Bedside Swallow Screen
Attachment H: Stroke Alert Outcome Review Form

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

EMERGENCY SEVERITY INDEX TRIAGE ALGORITHM (ESI)

Level 1-Immediate Level II-Emergent Level III-Urgent Level IV-Semi-Urgent Level V-Non-Urgent

A-REQUIRES IMMEDIATE LIFE-SAVING INTERVENTION? YES → **1**

NO ↓

B-HIGH RISK SITUATION? (INCLUDES PSYCHIATRIC/SUBSTANCE ABUSE/SUICIDAL/HOMICIDAL/VIOLENT) OR CONFUSED/LETHARGIC/DISORIENTED? OR SEVERE PAIN/DISTRESS OR YES → **2**

↓

C-HOW MANY DIFFERENT RESOURCES ARE NEEDED?

NONE	ONE	MANY
↓	↓	↓
5	**4**	**DANGER ZONE VITALS?**

DANGER ZONE VITAL SIGNS	AGE	HR	RR & SaO2
Consider uptriage to ESI 2 if any vital sign criterion is exceeded	<3 mo	>180	>50/<92 %
	3mo-3yr	>160	>40/<92 %
Pediatric Fever Considerations	3yr-8yr	>140	>30/<92 %
● 1day-28 days: assign ESI 2 if temp >38°C/100.4°F ● 1 mo-3mo: assign ESI 2 if temp >38°C/100.4°F ● 1 mo-3 yr: assign ESI 3 if temp >39°C/102.2°F, or incomplete immunizations, or no obvious source of fever	>8yr	>100	>20/<92 %

YES → **CONSIDER UPTRIAGE TO 2**

NO ↓

3

A. Immediate life-saving interventions required: airway, emergency medications, or other hemodynamic interventions (IV, O2, ECG, labs DO NOT COUNT); and or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SaO2<90%, acute mental status changes, or unresponsive.
Unresponsiveness: 1. nonverbal and not following commands or 2. requires noxious stimulus **PU on AVPU scale: A=Patient Awake; V=Patient Responds to Verbal Stimuli; P=Patient**

B. High Risk Situation: is a patient you would put in your last open bed. Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale

RESOURCES*

● Labs
●ECG
● X-rays
● CT, MRI, US
● IV fluids (hydration)
●IV or IM or nebulized meds
● Specialty Consultation
●Simple Procedure = 1 (laceration repair, foley)
●Complex Procedure = 2 (conscious sedation)
***NOT RESOURCES:** H&P (including pelvic), POC testing, IV heplock, PO meds, Tetanus, Prescription refills, call to PCP, simple wound care, crutches/splints/slings

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (i.e., CBC, electrolytes, coags = 1 resource; CBC + Chest x-ray = 2 resources

Stroke & Neurovascular Services

NIHSS:

Patient Sticker

Large Artery Stroke Screening Forms for VAN + Protocol

1. ***How weak is patient on one side of body?***
   If patient shows no weakness then CTA not urgent. Patient is VAN negative.

   - ☐ Mild (minor drift) ***(hold both arms up for 10 seconds)***
   - ☐ Moderate (severe drift - touches or nearly touches ground)
   - ☐ Severe (flaccid or no antigravity)
   - ☐ Patient shows no weakness. Patient is VAN negative. CTA not urgent. **(exception are confused or comatose patient's with dizziness, focal findings or no reason for their altered mental status then Basilar artery thrombus must be considered, CTA is warranted)**

2. ***Visual Disturbance?***

   - ☐ Field Cut (which side) ***(4 quadrants)***
   - ☐ Double vision (ask patient and look to right then left, evaluate for uneven eyes)
   - ☐ Blind new onset
   - ☐ NONE

3. ***Aphasia?***

   - ☐ Expressive (inability to speak or errors) **don't count slurring of words** ***(repeat & name 2 objects)***
   - ☐ Receptive (not understanding or following commands) ***(close eyes, make fist)***
   - ☐ Mixed
   - ☐ NONE

4. ***Neglect?***

   - ☐ Forced gaze or inability to track to one side
   - ☐ Unable to feel both sides at same time, or unable to identify own arm
   - ☐ Ignoring one side
   - ☐ NONE

All VAN positive patients should be sent to endovascular capable hospital & notified ahead of time. NeuroIR paged w VAN positive patient arriving. CT/CTA done on arrival.

If patient has **any weakness PLUS any one of the below:**
Visual Disturbance (field cut, double, or blind vision)
Aphasia (inability to speak or understand)
Neglect (gaze to one side or ignoring one side)
This is likely a large artery clot (cortical symptoms) = VAN Positive

Blood Pressure Management Protocol for Acute Stroke[IB1]

IV Thrombolytic Therapy (Alteplase) Patient

Patient is otherwise eligible for IV Alteplase except BP >185/110 mmHg

- Systolic >185mmHg and/or Diastolic >110mmHg
  - Labetalol 10 to 20 mg IV over 1 to 2 minutes, may repeat x 1 (do not use in asthmatics); **OR**
  - Nicardipine infusion, 5mg/hr titrate up by 2.5 mg/hr at 5 to 15-minute intervals, maximum dose 15mg/hr, when desired BP attained, adjust to maintain proper BP limits; **OR**
  - Clevidipine 1-2mg/hr IV, titrate by doubling the dose every 2-5 minute intervals. Maximum dose of 12mg/hr.
  - ***If blood pressure is not maintained at or below 185/110mmHg, DO NOT administer thrombolytic therapy.***

Management of BP during and after treatment with IV Alteplase

Maintain BP at or below 180/105 for at least the first 24 hours after IV Alteplase treatment
Monitor BP every 15 minutes for 2 hours from the start of IV Alteplase therapy, then every 30 minutes for 6 hours, then every hour for 16 hours.

- If Systolic >180 to 230mmHg or Diastolic 105 to 120mmHg
  - Labetalol 10mg IV followed by continuous IV infusion 2-8 mg/min (do not use in asthmatics); **OR**
  - Nicardipine 5mg/hr IV, titrate up to desired effect by 2.5mg/hr every 5 to 15 minute intervals, maximum dose 15mg/hr; **OR**
  - Clevidipine 1-2mg/hr IV, titrate by doubling the dose every 2-5 minute intervals. Maximum dose of 12mg/hr.
  - If BP not controlled or diastolic BP >140 mmHg, consider IV sodium nitroprusside
  - **Maintain BP below 180/105mmHg for at least first 24 hours after IV Alteplase treatment**

Different treatment options may be appropriate in patients who have co-morbid conditions that may benefit from acute reductions in BP such as an acute coronary event, acute heart failure, aortic dissection or pre-eclampsia/eclampsia.

Non-Thrombolytic Therapy (Alteplase) Patient

Most patients do not require treatment for hypertension following acute stroke; however, it is generally agreed that patients with markedly elevated BP may have their BP lowered. A reasonable goal would be to **lower BP ~ 15% during the first 24 hours after onset of stroke**. The level of BP that would mandate such treatment is not known, but consensus exists that **medications should be withheld unless the systolic BP is >220mmHg or the diastolic BP is >120mmHg**. Avoid hypotension.

Acute Intracerebral Hemorrhage

ICH patients presenting with SBP between 150 and 220 mmHg without contraindications to acute BP treatment, lowering SBP to 140 is safe.
ICH patients presenting with SBP > 220 mmHg consider aggressive reduction of BP with continuous IV and every 15 minute vital sign assessments unless otherwise indicated by medication recommendations.

- Labetalol 10 to 20 mg IV over 1 to 2 minutes, may repeat x 1 (do not use in asthmatics); **OR**
- Labetalol 10mg IV followed by continuous IV infusion 2-8 mg/min (do not use in asthmatics); **OR**
- Nicardipine infusion, 5mg/hr titrate up by 2.5 mg/hr at 5 to 15 minute intervals, maximum dose 15mg/hr, when desired BP attained, adjust to maintain proper BP limits

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Acute Stroke Interfacility Transfer Protocol

Patient Name_____

DOB: _____/_____/_____

ASSESSMENT

□ BP □ Pulse
□ V/S q 15 min w/neuro checks
□ Continuous Cardiac Monitoring
□ Weight _____ kg

□ NIHSS on arrival _____

□ Keep NPO (including meds)

TIME

Date: _____

ED TRIAGE TIME :

Date: _____

TIME OF ONSET :

DIAGNOSTICS

□ CT Head w/o contrast

CT results:
□ No acute findings □ Hemorrhage
□ New ischemic stroke □ Other

Labs:
□ Stroke Panel: CBC w/Diff, Platelets, PT/INR, PTT, CMP, blood glucose
□Other
□ 12 Lead EKG

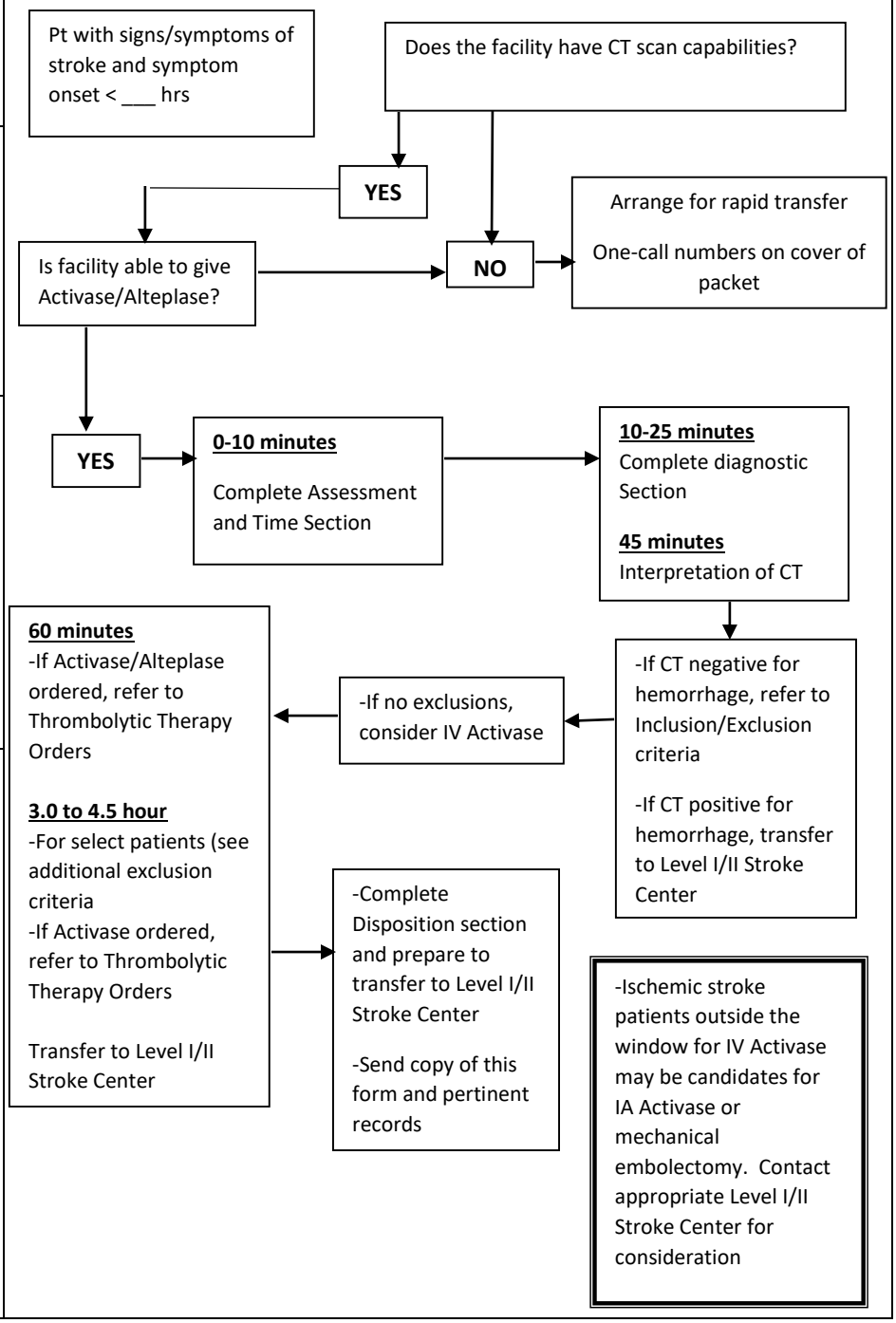
TREATMENT

□ NPO (including meds) until Dysphagia Screen
□ ASA 325 mg po or 300 mg PR administer only if not eligible for Alteplase
□ Administer IV Alteplase per protocol if eligible
□ BP Protocol
- IV Alteplase ≤ 180/105
- Ischemic no Alteplase ≤ 220/120
- Hemorrhagic ≤140/80

□ Baseline O2 sat _____%
- O2 to keep SATs ≥94%

□ Acetaminophen PR for temp >100.4 F

Acute Stroke Intervention Algorithm



DISPOSITION	□ Transfer to Primary/Comprehensive Stroke Center □ Activate EMS or Air Evac Transfer Family/Contact Name & Cell _____ _____ ED or Primary Physician Name & Number _____ _____	**Alteplase Checklist** □ Onset SX to Alteplase bolus < 3 hrs □ Onset Sx to Alteplase bolus up to 4.5 hrs in select patients (see additional criteria) □ CT scan negative for hemorrhage □ Thrombolytic Inclusion/Exclusion Checklist completed. No Exclusions □ discuss risks/benefits/alternatives Patient/family □ Consent obtained from Patient/Family who are eligible in 3.0 to 4.5 hr window □ If Foley needed, consider insertion prior to Alteplase administration □ Review blood glucose	IV Alteplase *0.9mg/kg (max dose 90 *10% total dose as bolus over 1 min *Remainder over 60 min *V/S + neuro assess Q15 min during infusion, then Q15 min x 1 hr, Q30 min x6hr, then Q1 hr x 16 hr after treatment *Maintain BP <180/105 *Repeat CT head if neuro status declines *No anticoag/antiplatelets for 24 hrs

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Stroke Alert Standing Orders

Date: _____ **Time:** _____

ASSESSMENTS:			
√	Record time of last know normal (time patient last seen without stroke symptoms) Date/time: _____		
√	Initiate Stroke Alert		
√	Notify provider Time: _____		
√	Notify EMS/Air Evac Time: _____		
√	Complete vital signs with neuro/stroke assessment on arrival, as needed and at discharge/transfer		
√	Complete NIH Stroke Scale on admission, with any neurological changes and prior to discharge/transfer		
√	STAT Finger Stick Blood Sugar (FSBS)		
√	Vital signs with neuro checks every 15 minutes		
√	NPO until dysphagia screen completed and documented in medical record		
√	Transfer to Primary or Comprehensive Stroke as soon as possible		
□	Start peripheral large bore IV (if indicated)		
DIAGNOSTICS:			
√	**STAT** non-infused head CT scan	√	**STAT** CMP
√	**STAT** CBC	□	**STAT** 12 Lead EKG
√	**STAT** PT/INR	□	**STAT** Chest X-ray
√	**STAT** PTT		
MEDICATIONS:			
□	Acetaminophen (Tylenol) 650mg PO/Rectal (SUPP) every 4 hours PRN temperature 100.4 F		
□	1000 mL 0.9% Normal Saline @_____ mL/hr		
BLOOD PRESSURE MANAGEMENT: ***Ischemic stroke*** *do not treat unless* ***≥220/120mmHg*** *or have a comorbid condition requiring urgent antihypertensive treatment.* ***Hemorrhagic stroke: SBP > 220mmHg*** *consider aggressive reduction of BP with continuous IV infusion. SBP between 150 to 220mmHg without contraindications to acute BP treatment, lowering to 140mmHg is probably safe (ASA Guidelines).*			
□	Labetalol **10** mg IV over 1 to 2 minutes. **Do not use in asthmatics.**		
□	Labetalol **20** mg IV over 1 to 2 minutes. **Do not use in asthmatics.**		
□	Nicardipine IV infusion 5mg/hr, titrate up by 2.5mg/hr every 5- 15 minute intervals. Maximum dose of 15mg/hr.		
□	Hydralazine initially **10** mg IV push. Repeat as needed, every 4 hours if SBP ≥ 220 or DBP ≥ 110**.**		
□	Hydralazine initially 2**0** mg IV push. Repeat as needed, every 4 hours if SBP ≥ 220 or DBP ≥ 110**.**		
□	Enalaprilat _____mg IV every 6 hours (Dose range 1.25 to 5mg). May be administered undiluted or in 0.9% sodium chloride injection or up to 50 mL of another compatible IV solution. Administer slowly over 5 minutes.		
TREATMENTS:			
√	O2 per NC @ 2-4 L/min to maintain saturation >94%, notify physician/mid-level provider if unable to maintain oxygen saturation		
ADDITIONAL ORDERS			

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

□ Telephone Order Read Back □ Verbal Order Read Back □ N/A Recorded by: _____ Date:_____ Time: _____ Physician/LIP: _____ Date: _____ Time: _____

Name: _____

DOB: _____

Age: _____ **Gender:** _____

Date: _____ **MR#** _____

Time **ER Provider:** _____

STROKE ALERT - Provider Note

EMERGENCY DEPARTMENT EXAMINATION RECORD

Mangum Regional Medical Center

1 Wickersham Drive Mangum, OK 73554

(580)782-3353

PMH:

CC: ☐Weakness/Paresis ☐Altered Level of Consciousness ☐Aphasia/Language Disturbance ☐Sudden severe HA.

Time last seen well:_____ , by who?_____. Seizure at onest: ☐Y ☐N. Fall at onset: ☐Y ☐N.

Have any of the following occurred in the last 3 months: ☐Surgery ☐Head injury c Trauma ☐GI bleed

Last PO intake: _____ . ☐Current Pregnancy-due date_____. ☐Recent Pregnancy-delivery date_____.

ALLERGIES: ☐ NKDA ☐:

MEDICATIONS: _____

Patient IS taking the following ANTICIOAGULANT:

☐ ASA ☐Coumadin ☐ Plavix ☐ Brilinta

☐ Xarelto ☐ Pradaxa ☐ Effient ☐ Aggrenox

☐ Ticlid ☐ Eliquis ☐ Savaysa ☐ Effient

PMH:

☐Prior CVA ☐TIA ☐PE ☐Head Injury ☐Hypothyroid ☐Depression ☐Anxiety

☐Arrhythmia ☐A-fib ☐CHF ☐DVT ☐Aneurysm ☐Headaches ☐Seizures ☐Obesity

☐Diabetes ☐Hyperlidemia ☐HTN ☐COPD ☐Dementia ☐Long-Term Anti-Coag Meds

Other:

SURGERIES:

☐CABG ☐Pacemaker ☐Appendectomy ☐Hip Replacement ☐Hysterectomy ☐B Tubal Ligation

☐Carotid Endarectomy ☐Angiogram ☐Cholecystectomy ☐Knee Replacemnt ☐Tonsillectomy ☐Other_____

FAMILY HISTORY: ☐CAD_____ ☐MI_____ ☐CVA_____ ☐DM_____ ☐CA_____ ☐Other_____

SOCIAL HISTORY: ☐Smoker_____ ☐Oral-Tobacco_____ ☐Ex-smoker_____ ☐ETOH_____ ☐Illicit Drugs_____

ROS: **GEN:** fever, chills. **EYES:** diplopia, blurred vision. **ENT:** pharyngitis, otalgia, rhinorrhea. **NECK:** Swelling, tenderness. **RESP:** SOB, cough. **CV:** CP, Palpitations. **EXT:** Swelling of- feet, ankles, lower legs. BACK: Pain, loss of bowel or bladder control. **INTEG:** Rash, non-healing wounds. **NEURO:** Headache, dizziness, numbness/tingling _____. **PSYCH:** Anxiety, depression.

PHYSICAL EXAM: ❍=Circle if present/positive.

Gen	Alert	Awake	Lethargic	No acute distress	Unresponsive		
Head	Facial droop- R or L.		Ecchymosis	Battle signs	Raccoon eyes	Wound:_____	
Eyes	Makes eye contact		PERRL	EOM intact	Nystagums	Peripheral vision loss- R L	
ENT	Hemotympanum- R L		Rhinorrhea	Pharyngeal erythema		Oral mucosa- moist dry	
Neck	Lymphadenopathy	JVD	Carotid bruit- R L		Full ROM	Vertebral point tenderness	
CV	Regular rate & rhythm		Gallop	Murmur	Rub	Chest wall tenderness	
Resp	Respirations even & unlabored		Wheeze	Rhonchi	Rales	Chest movement symmetrical	
GI	Ecchymosis	Pulsations	Tenderness	BS- normo- hypo-hyperactive		Guarding	Rebound
GU	Suprapubic pain						
Back	CVA tenderness	Vertebral point tenderness					
Extrem	Pedal Edema	Full ROM	Homan's- R L	Weakness- RUE LUE RLE LLE			
Integ	Warm	Dry	Diaphoretic	Rash	Lesions	Wounds	
Neuro	Oriented to- Person Place Time Situation						*See NIH Tool
Psych	Anxious	Depressed	Flat	Withdrawn	Restless		

CT/Head Results: _____

Comments: _____

NP/PA Signature:_____ Physician Signature:_____

Name: _____

DOB: _____

Age: _____ **Gender:** _____

Date: _____ **MR#** _____

ER Provider:

STROKE ALERT - Provider Note

EMERGENCY DEPARTMENT EXAMINATION RECORD

Name of Hospital

Address, City, State, Zip

Phone Number

NIH STROKE SCALE:

0=No stroke. 1-4=Minor stroke. 5-15=Moderate stroke. 21-42=Severe stroke.

Category	Description	Time>		
1a. LOC: (Alert, drowsy etc.)	Alert		0	0
	Drowsy		1	1
	Stuporous		2	2
	Coma		3	3
1a LOC Questions: (Month, Age)	Both correct		0	0
	One correct		1	1
	Incorrect		2	2
1c. LOC Commands: (Open/close eyes make fist, let go)	Obeys both correctly		0	0
	Obeys 1 correctly		1	1
	Incorrect		2	2
2. Best Gaze: (Eyes open - follows fingers or face)	Normal		0	0
	Partial gaze palsy		1	1
	Forced deviation		2	2
3. Visual: (Introduce visual stimulus/ threat to pt's visual field quadrants)	No visual loss		0	0
	Partial hemianopia		1	1
	Complete hemianopia		2	2
	Bilateral hemianopia		3	3
4. Facial Palsy: (Show teeth, rasie eyebrows & squeeze eyes shut)	Normal		0	0
	Minor		1	1
	Partial		2	2
	Complete		3	3
5a. Motor Arm-L: (Elevate extremity to 90 degrees & score drift/movement)	No drift		0	0
	Drift		1	1
	Can't resist gravity		2	2
	No effort against gravity		3	3
	No movement		4	4
*	Amputation, joint fused		9	9
5b. Motor Arm-R: (Elevate extremity to 90 degrees & score drift/movement)	No drift		0	0
	Drift		1	1
	Can't resist gravity		2	2
	No effort against gravity		3	3
	No movement		4	4
*	Amputation, joint fused		9	9

Category	Description	Time>		
6a. Motor Leg-L: (Elevate extremity to 30 degrees & score drift/movement)	No drift		0	0
	Drift		1	1
	Can't resist gravity		2	2
	No effort against gravity		3	3
	No movement		4	4
*	Amputation, joint fused		9	9
6b. Motor Leg-R: (Elevate extremity to 30 degrees & score drift/movement)	No drift		0	0
	Drift		1	1
	Can't resist gravity		2	2
	No effort against gravity		3	3
	No movement		4	4
*	Amputation, joint fused		9	9
7. Limb Ataxia: (Finger-nose, heel down shin)	Absent		0	0
	Present in 1 limb		1	1
	Present in 2 limbs		2	2
8. Sensory: (Pin prick face, arm, trunk, & leg - compare side to side)	Normal		0	0
	Partial loss		1	1
	Severe loss		2	2
9. Best Language: (Name items, describe picture, and read sentences of NIH scale)	No aphasia		0	0
	Mild to mod aphasia		1	1
	Severe aphasia		2	2
	Mute		3	3
10. Dysarthria: (Evalute speech carity by patient repeating the NHI scale word list)	Normal articulation		0	0
	Mild to mod dysarthria		1	1
	Near to unintelligable or worse		2	2
	Intubated or other physical barrier		9	9
11. Extinction & Inattention: (Use info from prior testing to ID	No neglect		0	0
	Partial neglect		1	1
	Complete neglect		2	2
	TOTAL			

*Explain:_____

PROVIDER NOTES:

DIAGNOSES: _____

DISPOSITION: (see EMTALA form) Phone call at (time)_____ transfer coordinator (name)_____

Patient accepted to _____by Dr. _____ at (time)_____ Transfer time:_____ Face Time: _____min

Transfer notes:

NP/PA Signature:_____ Physician Signature:_____

Name: _____

DOB: _____

Age: _____ Gender: _____

Date: _____ MR# _____

STROKE ALERT - Nurse Note

EMERGENCY DEPARTMENT RECORD

Mangum Regional Medical Center

1 Wickersham Dr. Mangum OK 73554

(580) 782-3353

Time	
:	**CC:** ☐Weakness/Paresis ☐Altered Level of Consciousness ☐Aphasia/ Language Disturbance ☐Sudden severe HA ☐Other:
:	Onset of symptoms / Time last seen well
:	Time of arrival at ER EMS Cincinnati Stroke Score _____
:	Arrival Method: ☐EMS ☐POV ☐Ambulatory ☐LawEnforcement
	EMS Prehospital Care: ☐ Oxygen ☐ CPR ☐ S/L ☐ IVF _____ ☐ FSBS _____ ☐ Cardiac Monitor ☐ Other: _____
:	**A** Airway is patent ☐ Yes ☐ No ☐Adv Directive
	B Patient is breathing? ☐ Yes ☐ No ☐DNR
	C Pulse is present? ☐ Yes ☐ No ☐FullCode
:	Titrate oxygen for SPO2 >94% Oxygen applied: __ L ☐NC ☐NRB ☐ Simple
:	B Balance: Loss of Balance/Coordination ☐ Yes-R ☐ Yes-L ☐ No
	E Eyes: Trouble seeing out of eyes ☐ Yes-R ☐ Yes-L ☐ No
	F Facial drooping? ☐ Yes-R ☐ Yes-L ☐ No
	A Arm drift? ☐ Yes-R ☐ Yes-L ☐ No
	S Speech slurred or strange? ☐ Yes ☐ No
	T Time-Initiate CODE STROKE if any of the above are present
:	Notified ER provider on call. Time of provider arrival at bedside ____:____
:	Activation of "STROKE ALERT" by overhead page
:	**CT Head**
:	Notified AirEvac of "STROKE ALERT" ☐Red phone ☐800-247-3822
	Acceptance time: _____, ETA_____ . ☐Declined r/t _____.
:	Notified Police/EMS "STROKE ALERT in progress" (580-654-1444)
:	Arrival time of Air Evac or EMS
:	Arrival FSBS _____ ☐ Patient & family advised of NPO
:	Arrival EKG obtained ☐ Cardiac monitor on the patient
:	1st large bore S/L initiated. Gauge: ____ Location: _____
	# attempts ____ ☐ Pressure dressing at unsuccessful sites
:	2nd large bore S/L initiated. Gauge: ____ Location: _____
	# attempts ____ ☐ Pressure dressing at unsuccessful sites

VS & Neuro Q15m	Time	: Arrive	: 15	: 30	: 45	: 60
Vital Signs	T					
	P					
	R					
	SBP					
	DBP					
	SPO2					
Pupils	Size-R mm					
	Size-L mm					
	Reactive-R ✔					
	Reactive-L ✔					
Conscious State	Calm ✔					
	Restless ✔					
	Combative ✔					
	Lethargic ✔					
Eye Opening	Spont-4					
	Loud Voice-3					
	Pain-2					
	None-1					
Verbal Response	Oriented-5					
	Confused-4					
	Inapprop-3					
	Incompre-2					
	None-1					
Motor Response	Obeys-6					
	Localizes-5					
	Withdraws-4					
	Abn flexion-3					
	Ext postur-2					
	None-1					
Glascow Coma Scale						

Nursing Actions:

:	HOB ☐Flat ☐Unable to tolerate flat r/t_____, HOB @_____.
:	☐Foley inserted. Size ____ Fr. Urine output _____mL. ☐Yellow ☐Dark ☐Clear ☐Cloudy ☐_____
:	☐NG Tube inserted. Size_____Fr. Placement confirmed by: ☐GI contents ☐Auscultated ☐X-ray

Notes: _____

MEDICATION RECORD		Adm	Pre-Administration				Eval	Post-Administration				
Medication	Dose	Time	SBP	DBP	P	FSBS	Time	SBP	DBP	P	FSBS	Comments

RN Signature _____

Nursing Bedside Swallow Screen

*To be completed by qualified staff on ALL **TIA/Stroke** patients prior to administering oral medication, food or fluids*

EXCLUSION CRITERIA: RISK IS TOO HIGH – DEFER ADMINISTRATION	
♦ Unable to remain alert for testing	♦ Tracheostomy tube present
♦ Head of bed restrictions < 30 °	♦ NPO (nil per os) by physician order
♦ Existing enteral tube feeding (stomach or nose)	♦ Eating a modified diet due to pre-existing dysphagia
Does patient meet any of the exclusion criteria mentioned above?	
☐ **YES - STOP SWALLOW SCREEN** Follow RN Actions & Orders for Failed Screen.	☐ **NO – CONTINUE SWALLOW SCREEN**

1	**BRIEF COGNITIVE SCREEN: Failure to answer questions correctly may be associated with increased risk of aspiration but does not prevent screening**		
	♦ What is your name?		
	♦ Where are you?		
	♦ What year is it?		
2	**ORAL MECHANISM EXAM: Weakness and/or asymmetry may warrant modified solid textures/fluids, but does not exclude patient from the 3 oz water swallow challenge.**		
	♦ Lip closure: Puff your cheeks with air and hold. Is there asymmetry/weakness?	Yes	No
	♦ Tongue: Stick out your tongue, move it side to side. Is there asymmetry/weakness?	Yes	No
	♦ Facial Symmetry: Smile/Pucker Is there asymmetry/weakness?	Yes	No
3	**3 OZ WATER SWALLOW CHALLENGE: Stopping while drinking, coughing, or throat clearing indicates a fail and an elevated aspiration risk.**		
	♦ Sit patient upright at 90 degrees or as high as tolerated > 30°		
	♦ Instruct patient to drink the entire 3 ounces of water from a cup or straw with sequential swallows – slow and steady but without stopping. (Note: cup or straw can be held by RN or patient)		

RESULTS
☐ **PASS:** Did not observe patient starting/stopping while drinking, coughing, choking, or throat clearing during or immediately after drinking.
☐ **FAIL:** Observed patient starting/stopping while drinking, coughing, choking, or throat clearing during or immediately after drinking.

Signature Date Time

RN Actions and Orders:

☐ Failed Screen:

- Obtain physician orders for NPO, if need to administer medications obtain orders for alternative route.
- Document in patient medical record (NO = Fail)

☐ Passed Screen:

- Document in patient medical record (YES = Pass)
- Collaborate with MD/PA/LIP for appropriate oral diet.
- May administer ordered medications.
- Results of cognitive screen and oral mechanism exam may warrant modified solid textures and fluids

Name: _____

DOB: _____

Age: _____ Gender: _____

Date: _____ MR# _____

STROKE ALERT- Nurse Note

EMERGENCY DEPARTMENT RECORD

Mangum Regional Medical Center

1 wickersham Dr. Mangum, OK 73554

(580)782-3353

Height **Weight**

Marital Status: ☐Single ☐Married ☐Divorced ☐Other_____

Race: ☐White ☐AfricAmer ☐Hispanic ☐NatHawaii/PacificIsl ☐NativeAmer/AKNative ☐Asian ☐Other_____

ALLERGEIS: ☐ NKDA _____

MEDICATIONS: Pharmacy_____ ☐See pharmacy/pt list

PO Blood Thinners

☐ ASA	☐ Coumadin	☐ Plavix	☐ Brilinta
☐ Xarelto	☐ Pradaxa	☐ Effient	☐ Aggrenox
☐ Ticlid	☐ Eliquis	☐ Savaysa	☐ Effient

Name of Medication	Dose	Frequency	Last Dose Taken
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today
			☐ Today

Past Medical History: ☐Carotid Disease

☐Hyperlidemia	☐Prior CVA	☐TIA
☐Arrhythmia	☐A-fib	☐CHF
☐Diabetes	☐COPD	☐HTN
☐Depression	☐Head Injury	☐PE
☐Hypothyroid	☐Dementia	☐DVT
☐Aneurysm	☐Obesity	☐PVD

☐Long-Term Anti-Coag Meds

Other :_____

Current FLU VACCINE: ☐Y ☐N ☐Out of Season

PNEUMONIA VACCINE: ☐None Year:_____

Last TETANUS: ☐Unknown Year:_____

SURGERIES: ☐CABG ☐Carotid Endarectomy

☐Pacemaker ☐Angiogram

☐Appendectomy ☐Cholecystectomy

☐Knee Replacemnt ☐Hip Replacement

☐Bilat Tubal Ligation ☐Hysterectomy

☐Tonsillectomy Other:_____

SOCIAL HISTORY: ☐Smoker ☐Ex-Smoker

☐ETOH use ☐Illicit Drug use

PRESENT ILLNESS: _____

PHYSICAL EXAM: Circle if present/positive.

Gen	Alert	Awake	Lethargic	No acute distress	Unresponsive	
Head	Facial droop- R or L.	Ecchymosis	Battle signs	Raccoon eyes	Wound:_____	
Eyes	Makes eye contact	PERRL	EOM intact	Nystagmus	Peripheral vision loss- R L	
ENT	Hemotympanum- R L	Rhinorrhea	Pharyngeal erythema	Oral mucosa- moist dry		
Neck	Lymphadenopathy	JVD	Carotid bruit- R L	Full ROM	Vertebral point tenderness	
CV	Regular rate & rhythm	Gallop	Murmur	Rub	Chest wall tenderness	
Resp	Respirations even & unlabored	Wheeze	Rhonchi	Rales	Chest movement symmetrical	
GI	Ecchymosis	Pulsations	Tenderness	BS- normo- hypo-hyperactive	Guarding	Rebound
GU	Suprapubic pain					
Back	CVA tenderness	Vertebral point tenderness				
Extrem	Pedal Edema	Full ROM	Homan's- R L	Weakness- RUE LUE RLE LLE		
Integ	Warm	Dry	Diaphoretic	Rash	Lesions	Wounds
Neuro	Oriented to- Person Place Time Situation					*See Neurochecks
Psych	Anxious	Depressed	Flat	Withdrawn	Restless	

Comments: _____

RN Signature: _____ TIME OF TRANSFER: _____

Stroke Alert Level IV Outcome Review

Patient Name: _____
Admit Date: _____ **Admit Time:** _____
Date of Stroke: _____ **RN in Charge:** _____
Time of Stroke: _____ **Physician/LIP Present:** _____
□ **ED Patient** □ **Inhouse Patient** □ **Visitor** □ **Other**

Immediate Actions Taken					
					Comments
Triage in <5 minutes					
Patient stable					
Exact time of onset known (LKWT)					
Physician notified <5 minutes					
Stroke Alert Announced					
During the Stroke Critique					
Skill	**Time**	**YES**	**NO**	**NA**	**Comments/Areas to Improve**
Nursing assessment completed within 10 min of patient arrival					
Physician assessment completed within 15 min of patient arrival					
EMS/Air Evac notified <15 minutes					
Contact Stroke Center for transfer <20 minutes					
Documented EMS/Air Evac estimated arrival time					
EMS/Air Evac arrival time					
BEFAST Screen completed/documented					
Initial NIHSS completed/documented					
VAN Screening Tool completed/documented					
FSBS obtained, documented					
VS monitored, documented Q15 minutes					
Neuro checks monitored, documented Q15 minutes					
Provider Note completed & scanned					
Nurses Note completed & scanned					
Acute Stroke Interfacility Transfer Protocol completed					
Patient transferred <60 minutes					
Documentation					
Patient record complete					
EMTALA paperwork completed for Ground transport (EMTALA form, EMS, OHCA form, EMS order sheet)					
Family notified					
Air Evac paperwork (Med necessity for Air Transport, EMTALA)					
Patient Records sent with patient faxed to appropriate stroke center					
Patient Departure Time:	**Final Disposition:**				
Atmosphere of Stroke Alert:	□ **Well Organized**		□ **Fairly Well Organized**		
	□ **Disorganized**		□ **Chaotic**		
RN Signature:					**Date:**
QM/CCO Signature:					**Date:**

Mangum Regional Medical Center

TITLE		POLICY
Management of the Agitated/Aggressive/Disturbed Patient		**EMD-010**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department/Nursing Services		

I. SCOPE

To ensure the safety and security of all patients, visitors and staff, the policy of Mangum Regional Medical Center shall be to effectively manage patients who display agitated, aggressive or disturbed behaviors.

II. PURPOSE

The purpose of this policy is to manage any occurrence of agitation, aggression, violence, and/or behavioral disruption in the emergency department and create a safe and therapeutic environment. The safety and security of all patients, visitors, and staff are a priority. Mangum Regional Medical Center will not tolerate violent or threatening behavior by anyone and will impose penalties appropriate to the nature and severity of the violation.

To strongly discourage disruptive or violent behavior, hospital staff will work cooperatively with law enforcement agencies to make reports and file criminal charges (if deemed necessary).

III. DEFINITIONS

A. Agitated means an unpleasant state of extreme arousal and behavioral dyscontrol that will likely result in harm to the patient or healthcare workers without intervention. Often agitation can fall along a continuum and can range from mild agitation resulting in feelings of being excited or stirred up to severe agitation leading to harmful aggressiveness and destructive behaviors.

B. Aggressive behavior means behaviors that are intended to harm another individual who does not wish to be harmed.

C. Disruptive behavior means the use of profane, loud and offensive language or any other action that disrupts the normal operations of the ED and potentially jeopardizes the safe delivery of emergency care to others.

D. Violent behaviors means any intentional act or threat of harm by one individual to another. Assault is any threat of harm including a physical gesture such as waving a clenched fist. Battery is when a person intentionally or knowingly, without justification, and by any means causes bodily harm to an individual or makes physical contact of an

insulting or provoking nature (i.e. hitting, spitting, kicking, etc.). Aggravated Assault and Battery occurs when the above occurs and a weapon is involved, or the victim was an ED worker. "Aggravated" is synonymous with a felony and is subject to more harsh penalties.

E. Close Observation means one competent observer to one or more patients in the same room/area.

F. Competent staff means those who have completed a facility-based competency assessment initially and ongoing basis related to core elements required to monitor a patient under self-harm precautions.

G. A chemical restraint does not include medications used as a standard treatment for patient's medical or psychiatric condition, such are excluded from the standards for chemical restraint use. A standard treatment is defined as a medication used to address a patient's medical or psychiatric condition and include but are not limited to the following:

    1. The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer, for the indications it is manufactured and labeled to address, listed dosage parameters, etc.
    2. The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization.
    3. The use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation, and on the provider's knowledge of that patient's expected and actual response to the medication.
    4. An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him or her than would be possible without the use of medication. Psychotherapeutic medications are to enable, not to disable. If a psychotherapeutic medication reduces the patient's ability to effective or appropriately interact with the world around him or her, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition. Examples of standard treatment:
        - Clinical treatment of patients who are suffering from serious mental illness who need appropriate therapeutic doses of psychotropic medication to improve their level of functioning.
        - Appropriate doses of sleeping medication prescribed for patients with insomnia.
        - Anti-anxiety medication that is prescribed to calm a patient who is anxious.

IV. POLICY

The approach to the care of patients presenting with agitation, aggression, self-harming, violent, and/or disturbing behaviors is multidisciplinary. At a minimum all patients who present to the Emergency Department (ED) will be assessed using the Emergency Severity Index (ESI) (See EMD-006A) to determine the severity of the patients illness and assign priorities of care to be provided. The patient will place under close observation at all times by a **competent** health care provider who is responsible for monitoring the patient.

A. Inclusion Criteria

1. Patients who present with acute agitation, aggressive, self-harming, violent and/or disturbed behaviors.
2. Develop agitation, aggressiveness, self-harming, violent and/or disturbed behaviors during ED admission.
3. Agitation can progress in stages:
   a. Verbal stage: use of general threats and/or abusive language.
   b. Motor stage: remains in a constant state of motion (i.e. pacing).
   c. Property damage: destructive, throwing items, breaking objects.
   d. Attack stage: self-harming, attempting to harm others.

B. Triage Considerations

1. All patients upon presentation to the ED should be initially triaged using the Emergency Severity Index (ESI).
2. The triage assessment and triage level must be documented in the appropriate area of the **[insert name of appropriate form or flowsheet]**, including the date and time the assessment was completed.

C. Assessment (See Aggressive/Agitated/Disturbed Patient Order Protocol Attachment A)

1. The physician/mid-level provider responsible for the patient's care will perform an appropriate Medical Screening Examination (MSE) including any tests (i.e. labs, diagnostic imaging, etc.), to rule out a medical illness as the cause for or contributing to the patient's mental condition.
2. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
3. Constant monitoring and frequent reassessment of the patient treated with medications or physically restrained, to optimize patient safety and to determine the earliest possible time for discontinuation or removal of these non-risk-free interventions.
4. Vital signs every 30 minutes unless otherwise ordered by the physician/mid-level provider or patient is in physical restraint, has received calming medications (chemical restraint) or based on patient's medical condition.

D. Laboratory and Diagnostic Studies

1. Lab and diagnostic studies that may be considered in the management of the aggressive/agitated/disturbed patient (See Aggressive/Agitated/Disturbed Patient Order Protocol):
    a. Finger stick blood sugar (FSBS)
    b. Urine β-hCG (pregnancy test)
    c. Complete blood count (CBC)
    d. Comprehensive metabolic panel (CMP)
    e. Total CK
    f. Ethanol Level
    g. Urine analysis (UA)
    h. Thyroid stimulating hormone (TSH)
    i. Serum Salicylate Acid
    j. Serum Acetaminophen Level

E. De-escalation Methods

1. De-escalation should be attempted prior to the use of medication or physical restraint.
2. Top 10 Tips for De-escalation
    a. Be Empathic and Nonjudgmental
        a. When someone says or does something you perceive as weird or irrational, try not to judge or discount their feelings. Whether or not you think those feelings are justified, they're real to the other person. Pay attention to them. Keep in mind that whatever the person is going through, it may be the most important thing in their life at the moment.
    b. Respect Personal Space
        i. If possible stand 1.5 to 3 feet away from a person who's escalating. Allowing person space tends to decrease a person's anxiety and can help you prevent acting-out behavior. If you must enter someone's personal space to provide care, explain your actions so the person feels less confused and frightened.
        ii. If possible, before interacting with the agitated person, call for help so that help is on the way.
        iii. Place yourself (always keep yourself) between the person and the exit.
    c. Use Nonthreatening Nonverbals
        a. The more a person loses control, the less they hear your words, and the more they react to your non-verbal communication. Be mindful of your gestures, facial expressions, movements and tone of voice. Keeping your tone and body language neutral will go a long way toward defusing a situation.
    d. Avoid Overreacting
        a. Remain calm, rational and professional. While you can't control the person's behavior, how you respond to their behavior will have a direct effect on whether the situation escalates or defuses. Positive thoughts like "I can handle this" and "I know what to do" will help you maintain your own rationality and calm the person down.

e. Focus on Feelings
    a. Facts are important, but how a person feels is the most critical. Yet some people have trouble identifying how they feel about what's happening to them. Watch and listen carefully for the person's real message. Try saying something like, "That must be scary". Supportive words like these will let the person know that you understand what's happening, and you may get a positive response.
f. Challenging Questions
    a. Answering challenging questions often results in a power struggle. When a person challenges your authority, redirect their attention to the issue at hand. Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.
g. Set Limits
    a. If a person's behavior is belligerent, defensive, or disruptive, give them clear, simple, and enforceable limits. Offer concise and respectful choices and consequences. A person who's upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.
h. Choose Wisely What You Insist Upon
    a. It's important to be thoughtful in deciding which rules are negotiable and which are not. For example, if a person doesn't want to shower in the morning, can you allow them to choose the time of day that feels best for them? If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.
i. Allow Silence for Reflection
    a. We've all experienced awkward silences. While it may seem counterintuitive to let moments of silence occur, sometimes it's the best choice. It can give a person a chance to reflect on what's happening, and how he or she needs to proceed. Silence can be a powerful communication tool.
j. Allow Time for Decisions
    a. When a person is upset, they may not be able to think clearly. Give them a few moments to think through what you've said. A person's stress rises when they feel rushed. Allowing time brings calm.

2. History is critically important in determining whether the source of agitation, aggression, self-harming, violent and/or disturbing behavior is likely related to a general medical condition such as hypoxia or neurological problem versus an exacerbation of a psychiatric illness.
3. Identifying the underly etiology is key to treating agitation, aggression, self-harming, violent and/or disturbing behavior in the ED setting.
4. When working with patients with agitation, aggression, self-harming, violent and/or disturbing behavior there are four (4) main objectives:
    a. Ensure the safety of the patient, staff, and others in the immediate area.

   b. Help the patient manage their emotions, distress and maintain or regain control of their behavior.
   c. Avoid the use of restraints (mechanical, chemical and/or physical hold) when all possible.
   d. Avoid coercive interventions that escalate agitation, aggression, self-harming, violent and/or disturbing behaviors.
5. Methods of verbal de-escalation may include but are not limited to the following interventions:
   a. Respect the patient's personal space.
   b. Maintain calm speech, demeanor, and facial expression.
   c. Establish verbal contact (designate one staff member to directly communicate and interact with the patient whenever possible).
   d. Listen closely to what the patient is saying.
   e. Be concise.
   f. Identify wants and feelings.
   g. Find a way to respond that agrees with or validates the patient's position.
   h. Explain to the patient what you want them to do.
   i. Clearly inform the patient of acceptable behaviors.
   j. Set clear limits.
   k. Offer choices and optimism.
   l. Show kindness (offer blankets, magazines, food, beverage if not contraindicated by environmental safety check or medical condition).
   m. Never promise the patient something that cannot be delivered.
   n. Stand at an angle from the patient, hands should be visible.

F. Restraint Use

1. Progress from the least restrictive (environmental alterations) to most restrictive (medications or physical restraints), unless safety is immediately at risk.
2. Goal should be to use physical restraints as a "last resort" and as a bridge to chemical restraint. Typically, the use of restraints should be used no longer than 5 to 15 minutes with the appropriate dosing of medication.
3. Placing the patient in a physical hold in order to provide calming medications (chemical restraint) is one option to avoid the use of physical restraints. Another option would be to place the patient into physical restraints for a short period to administer intramuscular (IM) calming medications (chemical restraint) and release the patient immediately upon becoming calm.
4. The use of physical restraints should always be followed by the use of calming medications.
5. Avoid covering an agitated, aggressive, violent and/or disturbed patient's mouth and/or nose with a gloved hand. This can lead to asphyxia, metabolic acidosis, and death. Use an oxygen mask to prevent the patient from spitting on staff.
6. If the use of four-point restraints are necessary, place the patient in the supine position with 30-degree head of bed elevation, restraints tied to the bed frame (rather

than the side rails) and one arm above the head and the other below the waist.

G. Chemical Restraint or Sedation

1. The goal of calming medication is to enable rapid stabilization of the acutely agitated patient and to enable the expeditious search for potential life-threatening medical conditions that could be contributing to the patient's behavior.
2. See the Standardized Use of Restraints Policy PTR-002 for the use of chemical restraint or sedation.

H. Admission or Discharge/Transfer Criteria

1. Admit to inpatient medical floor:
   a. Evidence of etiology of agitation or co-morbid condition requiring medical management
   b. Medication side-effects requiring acute monitoring and/or treatment in an in-patient setting.
   c. Social situation preventing a safe return to home.
2. Discharge/Transfer to higher level of care or acute psychiatric facility:
   a. Ongoing, uncontrolled or poorly controlled agitation, aggression, self-harming, or violent behavior.
   b. Respiratory depression after medical therapy for agitation.
   c. History or laboratory evidence of life-threatening ingestion (in consultation with poison control).
   d. Agitation caused by an unknown or unconfirmed etiology.
   e. Suicidal or homicidal ideation.
   f. Drug overdose, intentional or accidental.
   g. Behavior concerns rendering outpatient management unsafe or impractical.

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VI. ATTACHEMENTS

See EMD-006A-ESI Triage Algorithm
Attachment A: Aggressive/Agitated/Disturbed Patient Order Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

AGGRESSIVE/AGITATED/DISTURBED PATIENT ORDER PROTOCOL

******All Items With a Box Must Be Checked by the Provider******

Date:	**Time:**
Patient Name:	
Allergies:	

Protocol Orders

1. Nursing Orders

a) Safety Precautions: Assess fall risk, suicide/self-harming behaviors (clear room of all objects that may cause harm, one-on-one observation if required). Implement safety precautions as indicated. ***If patient suicidal/homicidal ideation; use the ASQ Suicide Risk Screening Tool & if positive see Care & Treatment of the Psychiatric Patient Policy.***

b) De-escalation Methods

2. Vital Signs
a) Every 30 minutes and PRN

3. Labs if indicated (check box if indicated): □ FSBS □ Urine β-hCG (pregnancy test) □ CBC □ CMP □ Total CK □ Ethanol Level □ UA □ Urine Drug Screen □ TSH □ Serum Salicylate Acid □ Serum Acetaminophen Level

4. Diagnostics if indicated: □ Chest X-ray □ Non-contrast Head CT □ EKG

5. □ Insert Peripheral IV. Sodium Chloride 0.9% 10 ml flush prn for line patency

Mild Agitation Medications

□ Haloperidol 1 mg PO x1	□ Haloperidol 2 mg PO x1	□ Haloperidol 5 mg PO x1
□ Haloperidol 10 mg PO x1	□ Lorazepam 1 mg PO x 1	□ Lorazepam 2 mg PO x1
□ Olanzapine 5mg PO x1	□ Olanzapine 5mg PO x1	□ Olanzapine 10 mg PO x1
□ Risperidone 1mg PO x 1	□ Risperidone 2 mg PO x1	□ Risperidone 4 mg PO x 1
□ Seroquel 25 mg PO x1	□ Seroquel 50 mg PO x1	□ Seroquel 100 mg PO x1

Moderate Agitation Medications

□ Diphenhydramine 50 mg IM x 1	□ Diphenhydramine 50 mg IV x 1	□ Haloperidol 5 mg IM x 1
□ Hydroxyzine 25 mg IM x1	□ Hydroxyzine 50 mg IM x1	□ Lorazepam 1mg IM x1
□ Lorazepam 1 mg IV x 1	□ Lorazepam 2 mg IM x 1	□ Lorazepam 2 mg IV x 1
□ Olanzapine 5 mg IM x 1		

Severe Agitation Medications

□ Haloperidol 10 mg IM x 1	□ Olanzapine 10 mg IM x 1	

6. If the medication prescribed is not used as a standard of treatment for the patient's behavior or condition based on the chemical restraint assessment protocol, obtain a Restraint Order and follow the Restraint Policy: Violent or Self-Destructive Behavior.

ADDITIONAL ORDERS

Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Management of Alcohol Intoxication and Alcohol Withdrawal		**EMD-011**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center for the assessment, management, and treatment of patients who present to the Emergency Department (ED) with signs and symptoms of acute alcohol intoxication or withdrawal.

II. PURPOSE

Alcohol is the most commonly used drug and is a leading cause of morbidity and mortality in the United States. An annual average of approximately 88,000 deaths are attributed to excessive alcohol use. Every day approximately 29 people are killed in alcohol related motor vehicle crashes, accounting for 28% of all traffic-related deaths in the United States. The rate of alcohol-related Emergency Department (ED) visits have increased over 50% since 2006.

Alcohol intoxication causes physical and mental impairments in a progressive manner as the alcohol level increases and the person becomes more intoxicated. Alcohol intoxication causes:

- Poor judgment
- Disinhibition of normal social functioning
- Slurred speech
- Loss of memory
- Euphoria
- Ataxia
- Vomiting
- Confusion and disorientation
- Progressive lethargy to coma
- Possible death

Effects of alcohol can vary dramatically from person to person. Many factors can account for the differences in how the amounts of alcohol affect one person more than another, including the

signs and symptoms. The major factors that account for the variations in the signs and symptoms include but are not limited to the following:

- Prior experience with alcohol (tolerance): a heavy drinker can achieve high blood alcohol concentration (BAC) levels without developing signs and symptoms of intoxication whereas a novice drinker may have severe symptoms.
- Taking medications: alcohol can enhance the effects of medications, especially those of the sedative class such as sleeping pills or anti-anxiety medications.
- Co-morbidities: co-existing medical conditions may affect how a person reacts to alcohol.
- Smell of alcohol on person's breath: there is a poor correlation between the strength of the smell of alcohol on the person's breath and the BAC level.
- Blood alcohol concentration (BAC): effects of alcohol vary from person to person, and not all people exhibit all the identified effects (based on typical social drinker):
    - **50mg/dL**: loss of emotional restraint, vivaciousness, feeling of warmth, flushing of skin, mild impairment of judgment;
    - **100mg/dL**: slight slurring of speech, loss of control of fine motor movements (such as writing), confusion when faced with tasks requiring thinking, emotionally unstable, inappropriate laughter;
    - **200mg/dL**: very slurred speech, staggering gait, double vision, lethargic but able to be aroused by voice, difficulty sitting upright in a chair, memory loss;
    - **300mg/dL**: stuporous, able to be aroused only briefly by strong physical stimulus (such as a face slap or deep pinch), deep snoring;
    - **400mg/dL**: comatose, not able to be arouse, incontinent, low blood pressure, irregular breathing; and
    - **500mg/dL**: death possible, either from cessation of breathing, excessively low blood pressure, or vomiting entering the lungs without the presence of the protective reflex to cough it out

Alcohol withdrawal syndrome is a clinical diagnosis that cannot be confirmed by laboratory or diagnostic testing. It is a diagnosis of exclusion. The tremor of alcohol withdrawal is critical to the diagnosis. Characteristic tremor is an intention tremor, meaning at rest there is no tremor, if the patient extends their arms there will be a fine motor tremor that is constant and does not fatigue. Patient may also have a tongue tremor that is a more sensitive of alcoholic tremor than the hand tremor. It is critical to recognize alcohol withdrawal syndrome early to prevent life-threatening complications such as alcoholic seizures or delirium tremens (DTs) from occurring. Mild withdrawal typically occurs about six (6) hours after cessation or decrease of alcohol intake and lasts up to 24 to 48 hours. Symptoms of mild withdrawal include but are not limited to: tremors, sweating, tachycardia, gastrointestinal upset, headache, and headache. Moderate to severe withdrawal progresses from mild withdrawal and includes conditions such as alcoholic hallucinosis, alcoholic withdrawal seizures and/or DTs.

Alcohol is a significant factor for suicidal and self-harming behaviors. A person addicted to alcohol is 120 times more likely to attempt suicide than a person without a substance abuse disorder. Alcohol is often used as a mechanism for coping for other risk factors such as a loss of a loved one or failing health. Some statistics show that more than 50% of all people who compete suicide were intoxicated with alcohol or other substances at the time of death.

The purpose of this policy is to minimize morbidity and mortality through:

- Standardization of the management and treatment of patients who present to the hospital's ED with acute alcohol intoxication or withdrawal;
- Recognition of all patients with alcohol use disorders through the use of evidence-based screening tools;
- Identification of those patients with, or at risk of, potentially life-threatening complications; and
- Prompt initiation of appropriate medical management based on an individual patient assessment

III. DEFINITIONS

A. **Alcohol Use Disorder:** refers to a "chronic relapsing brain disorder characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational or health consequences." (NIAAA, 2020). Alcohol use disorder can range from mild to severe depending on the number of symptoms the patient presents with. To meet diagnosis patient must have any two of the 11 signs during the same 12-month period to receive a diagnosis of AUD. Signs and symptoms can include:

- Drinking more or longer than intended;
- Unable to limit alcohol intake;
- Wanting to cut down alcohol intake or making unsuccessful attempts;
- A lot of time spent drinking, being sick or getting over after-effects;
- Strong cravings or urges to drink alcohol;
- Failure to fulfill obligations at work, school or home to due to repeated alcohol use;
- Continued consumption of alcohol, regardless of physical, social, or interpersonal consequences, or after having had a memory blackout;
- Missing social and work activities and hobbies;
- Use of alcohol in unsafe situations, such as driving, using machinery, etc.;
- Need for increased alcohol consumption to feel same effect due to developing a tolerance, or found that usual number of drinks had less effect than before;
- Withdrawal symptoms such as nausea, sweating and shaking, when stop drinking or drink to avoid these symptoms

B. **Alcohol Dependence:** means a cluster of behavioral, cognitive and physiological factors that typically include a strong desire to consume alcohol that results in difficulties controlling its use. Three (3) or more of the following six (6) behaviors, occurring together for at least one (1) month or occurred repeatedly within one (1) year period:

- Compulsion to drink;
- Lack of control;
- Withdrawal state;

- Tolerance;
- Salience; and
- Persistence use

A person who is alcohol dependent may persist in consuming alcohol, despite the harmful effects. A higher priority will also be placed on alcohol than other activities and obligations. This dependence results in significant problems in one or more areas of the person's life.

C. **Alcohol Intoxication:** means a transient physiological state of high level of alcohol. This occurs when the quantity of alcohol a person consumes exceeds the person's tolerance for alcohol, resulting in behavioral and/or physical abnormalities. Also known as "drunkenness". Symptoms may include slurred speech, euphoria, poor coordination, disturbances in level of consciousness, erratic behavior, impaired balance or other psychophysiological functions and responses. If left uncontrolled may cause ataxia, coma and even death.

D. **Alcohol Withdrawal:** refers to a group of symptoms that may occur from the sudden reduction of alcohol use after chronic or prolonged ingestion. Symptoms include but not limited to: anxiety, agitation, irritability, depression, mood swings, insomnia, tremor of hands, tongue, eyelids, fever (with or without infection), hypertension, tachycardia, sweating, nausea, vomiting, diarrhea, headache, and dilated pupils.

E. **Alcoholic hallucinosis:** refers to hallucinations, usually visual hallucinations (auditory and tactile hallucinations also) that develop within 12 to 24 hours of cessation of alcohol. Patients are typically aware they are hallucinating and can become very distressed. Alcoholic hallucinosis is not associated with global clouding of the sensorium as with delirium tremens, and vital signs are usually normal.

F. **Binge Drinking:** means a pattern of excessive drinking defined as men who consume five (5) or more alcoholic drinks or women who consume four (4) or more alcoholic drinks in two (2) hours or less. Binge drinking has serious health consequences such as: unintentional injuries (car crashes, falls, burns, alcohol poisoning), violence (suicide, sexual assault), and chronic diseases (hypertension, stroke, heart disease and liver disease).

G. **Delirium Tremens (DTs):** refers to the most severe form of alcohol withdrawal syndrome, manifested by altered mental status and sympathetic overdrive (autonomic hyperactivity such as sweating, palpitations, upset stomach) which can progress to cardiac collapse. DTs usually occurs 48 to 96 hours after the cessation or reduction of alcohol intake and lasts one (1) to five (5) days. Risk factors for the development of DTs include:

- History of sustained drinking
- History of alcohol withdrawal seizures
- History of DT

- Age > 30 years of age
- Presence of a concurrent illness
- Presence of severe alcohol withdrawal and elevated BAC
- Greater period since person's last drink

Approximately 5% of withdrawal patients will suffer from DT. Symptoms include agitation, global confusion, disorientation, hallucinations, fever, hypertension, tachycardia and diaphoresis. ***DTs are a medical emergency with a high mortality rate.***

H. **Wernicke's Encephalopathy:** refers to a syndrome that occurs due to a deficiency of thiamine (vitamin B1). This neurological disease classically presents with a clinical triad of confusion, ataxia and ocular abnormalities, but only 10% of patients present with all three features. The syndrome may develop rapidly or over several days. Inappropriately managed may result in death or Korsakoff's syndrome (disproportionate memory loss, psychosis) in up to 85% of survivors.

IV. POLICY

The approach to the management and treatment of patients with acute alcohol intoxication or withdrawal is multidisciplinary. At a minimum all patients who present to the ED with signs or symptoms of acute alcohol intoxication or withdrawal will be screened using the Cage Questionnaire (see Attachment A) to screen for harmful drinking and alcohol use disorders. Nursing staff will be responsible for reporting the results of screening to the responsible ED physician/mid-level provider. Nursing staff will perform a full physical and psychosocial assessment of the patient and document the findings in the patient's medical record. The hospital will provide a prompt medical assessment with appropriate stabilizing treatment by the qualified medical provider as recognized in the Hospital Medical Staff Bylaws/Rules, Regulations and Policies. For those patients who have been identified with an alcohol misuse disorder the ED physician/mid-level provider will provide a brief intervention as recommended by the American College of Emergency Physicians using the EDDIRECT method (see Attachment B).

A patient presenting with signs and symptoms suggestive of acute alcohol intoxication and suspected suicidal/homicidal ideation or self-harming behaviors should be carefully screened and medically cleared. After the physician/mid-level provider has completed the MSE and ruled out all medical causes for suicidal/homicidal ideations or self-harming behaviors, patient has had a chance to sober up and is still expressing these behaviors a Licensed Mental Health Professional evaluation should be obtained per the Care and Treatment of the Psychiatric Patient Policy prior to referring the patient to mental health facility.

Once the patient has been assessed and treated the hospital will discharge the patient following the brief intervention with discharge instructions and referral resources (i.e. primary care

provider, out-patient substance abuse centers, AA, etc.). If indicated the Hospital will arrange and expedite an appropriate transfer of the patient to a mental health or substance abuse facility.

V. PROCEDURE

A. Management of Alcohol Intoxication

1. **Assessment**
   a. All patients presenting to the ED will initially be triaged using the Emergency Severity Index (ESI) in order to determine the order in which they will receive a medical screening examination (MSE) by a physician/mid-level provider.
   b. During triage all patients who present with signs and symptoms suggestive of alcohol intoxication will be screened using the Cage Questionnaire to screen for harmful drinking and alcohol use disorders.
      i. Results should be reported to the physician/mid-level provider and documented in the patient's medical record.
      ii. If the patient cannot be screened at triage due to the patient's medical status (i.e. unconscious, intubated, or mentally unstable) screening may be postponed until the patient has been stabilized and can be assessed. The screening should be performed as soon as possible as the patient's condition permits.
   c. If the patient presents with suicidal/homicidal ideation or self-harming behaviors the patient should be screened for the risk of suicide using the ASQ Suicide Risk Screening Tool. If the patient has a positive screen see Care and Treatment of the Psychiatric Patient Policy.
      i. Patient should be allowed to sober up and the physician/mid-level provider should re-assess the patient to determine the patient's mental state.
   d. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
      i. Any abnormalities should be reported to the physician/mid-level provider promptly.
   e. The physician/mid-level provider responsible for the patient's care will perform an appropriate MSE including any tests (i.e. labs, etc.), to rule out a medical illness as the cause for or contributing to the patient's presenting condition.
   f. Patients presenting with acute alcohol intoxication should be re-evaluated hourly by nursing staff to determine if the patient is returning to baseline. If the patient's mental and physical status is

not returning to baseline nursing staff should immediately notify the responsible physician/mid-level provider.

i. Evaluations should be documented in the patient's medical record.
ii. Hourly evaluations should include at minimum: pupils, neurological, mental status, cardiac activity, vital signs, and musculoskeletal exam.

2. **Observation and Monitoring**
   a. Patient should be placed in a quiet room with low lighting and minimal stimulation.
   b. Patient should be assessed for fall risk and interventions initiated based assessment
      i. Patients who are agitated or have gait disturbances may need one-to-one observation to ensure patient safety.
   c. If patient has screened positive for suicide, self-harming behaviors of determined to be depressed ensure the room is clear of objects that may be used to harm themselves or others.
   d. Vital signs should be assessed and documented in the patient's medical record as follows unless otherwise ordered:
      - Every hour until patient shows signs of returning to baseline; then
      - Every 4 hours
      - At discharge or transfer
      - As needed (PRN)

3. **Labs and Diagnostics**
   a. Point-of-care (POC) blood glucose should be done ***immediately*** for all patients presenting with suspected alcohol intoxication.
   b. Labs
      i. CBC
      ii. CMP
      iii. Ethanol level
      iv. Serum salicylate and APAP levels
      v. PT/INR, PTT
      vi. Urinalysis
      vii. Lactate (if indicated)
      viii. Blood gases (if indicated)
   c. Diagnostics (if indicated)
      i. ECG
         may assist in evaluating for cardiac ischemia or other toxic ingestions
      ii. Chest X-ray
         can be useful in ruling out pulmonary co-morbidities such as pneumonia
      iii. Non-contrast Head CT scan

may be necessary if there is a concern for any type of trauma or if the patient remains altered.

4. **Pharmacological Management**
   a. See Alcohol Intoxication & Withdrawal Protocol (Attachment D).

B. **Management of Alcohol Withdrawal**

1. **Assessment**
   a. All patients presenting to the ED will initially be triaged using the Emergency Severity Index (ESI) in order to determine the order in which they will receive a medical screening examination (MSE) by a physician/mid-level provider.
   b. During triage all patients who present with signs and symptoms suggestive of alcohol withdrawal will be screened using the Cage Questionnaire to screen for harmful drinking and alcohol use disorders.
      i. Results should be reported to the physician/mid-level provider and documented in the patient's medical record.
      ii. If the patient cannot be screened at triage due to the patient's medical status (i.e. unconscious, intubated, or mentally unstable) screening may be postponed until the patient has been stabilized and can be assessed. The screening should be performed as soon as possible as the patient's condition permits.
   c. If the patient presents with suicidal/homicidal ideation or self-harming behaviors the patient should be screened for the risk of suicide using the ASQ Suicide Risk Screening Tool. If the patient has a positive screen see Care and Treatment of the Psychiatric Patient Policy EMD-008.
      i. If the patient is medically unstable the physician/mid-level provider should re-assess the patient to determine the patient's mental state.
   d. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
      i. Any abnormalities should be reported to the physician/mid-level provider promptly.
   e. The physician/mid-level provider responsible for the patient's care will perform an appropriate MSE including any tests (i.e. labs, etc.), to rule out a medical illness as the cause for or contributing to the patient's presenting condition.
   f. Nursing staff will assess the patient's withdrawal symptom severity using the Clinical Institute Withdrawal Assessment Scale for Alcohol, Revised (CIWA-Ar) (See Attachment C).

i. The completed CIWA-Ar Protocol will be documented in the patient's medical record.
ii. If the patient is having DT's the CIWA-Ar should not be performed.

2. **Observation and Monitoring**
   a. Patient should be placed in a quiet room with low lighting and minimal stimulation.
   b. Patient should be assessed for fall risk and interventions initiated based assessment
      i. Patients who are agitated or have gait disturbances may need one-to-one observation to ensure patient safety.
   c. If patient has screened positive for suicide, self-harming behaviors or determined to be depressed ensure the room is clear of objects that may be used to harm themselves or others.
   d. Vital signs should be assessed and documented in the patient's medical record as follows unless otherwise ordered:
      - Mild withdrawal every 4 hours
      - Moderate withdrawal every 2 hours
      - Severe withdrawal every hour
      - As needed (PRN)
      - At discharge or transfer

3. **Labs and Diagnostics**
   a. Point-of-care (POC) blood glucose should be done ***immediately*** for all patients presenting with suspected alcohol intoxication.
   b. Labs
      i. CBC
      ii. CMP
      iii. Ethanol level
      iv. Serum salicylate and APAP levels
      v. PT/INR, PTT
      vi. Urinalysis
      vii. Lactate (if indicated)
      viii. Blood gases (if indicated)
   c. Diagnostics (if indicated)
      i. ECG
      may assist in evaluating for cardiac ischemia or other toxic ingestions
      ii. Chest X-ray
      can be useful in ruling out pulmonary co-morbidities such as pneumonia
      iii. Non-contrast Head CT scan

may be necessary if there is a concern for any type of trauma or if the patient remains altered.

4. **Pharmacological Management**
   a. See Alcohol Intoxication & Withdrawal Protocol (Attachment D).

5. **Symptom Triggered Withdrawal Management**
   a. Treatment of alcohol withdrawal should be symptom triggered, meaning tailored to the patient's individual needs and determined by the severity of withdrawal signs and symptoms.
   b. Patients who have been screened and identified as alcohol dependent will be assessed for alcohol withdrawal syndrome. This should be supported by using the CIWA-Ar assessment tool and clinical judgment.
   c. Nursing staff should assess patients in alcohol withdrawal using the CIWA-Ar assessment tool.
   d. Alcohol Withdrawal Prophylaxis Medications
      i. See Alcohol Intoxication & Withdrawal Protocol (Attachment D).

   e. Nursing staff should assess the patient's response using the CIWA-Ar assessment tool as follows:
      - IV benzodiazepines every 15 minutes
      - PO or IM benzodiazepines every 2 hours
      - No treatment every 4 hours

C. **Aggressive/Agitated Patient**
   a. Initially the physician/mid-level provider should assess to determine whether the patient is agitated/aggressive due to being intoxicated or secondary to injury, infection or other factors that may have contributed to the confusion.
   b. Ensure the patient is in a calm environment. Minimize the stimulation.
   c. Ensure the room is clear of objects that may be used as a weapon or thrown.
   e. Staff may attempt to defuse escalating aggressiveness/agitation through de-escalation measure such as:
      i. Respect the patient's personal space.
      ii. Maintain calm speech, demeanor, and facial expression.
      iii. Establish verbal contact (designate one staff member to directly communicate and interact with the patient whenever possible.
      iv. Listen closely to what the patient is saying.
      v. Stand at an angle from the patient, hands should be visible.

vi. Identify wants and feelings.
vii. Find a way to respond that agrees with or validates the patient's position.
viii. Explain to the patient what you want them to do.
ix. Clearly inform the patient of acceptable behaviors.
x. Set clear limits.
xi. Offer choices and optimism.
xii. Show kindness (offer blankets, magazines, food, beverages, if not contraindicated).
xiii. Never promise the patient something that cannot be delivered.

d. Patients who are agitated or aggressive secondary to acute alcohol intoxication may require one-to-one observation to ensure their own, other patient's, visitors and staff safety.
   i. If the patient becomes violent or out of control staff should contact local Law Enforcement.

d. Pharmacological Management of Agitation
   i. See Aggressive/Agitated/Disturbed Patient Order Protocol EMD-010A.

D. Brief Intervention

a. After the nursing staff has screened the patient and determined the patient to be an "at-risk", "harmful" or "dependent" drinker the ED physician/mid-level provider will be responsible for providing a brief intervention using the EDDIRECT framework supported by the ACEP.
b. The brief intervention will be provided based on the patient's medical stability.
c. For "at-risk" or "harmful" drinkers the brief interventions may consist of goal setting within safe limits, discharge instructions and a referral to the patient's primary care provider.
d. For "dependent" drinkers or those patients the ED physician/mid-level provider is unsure of the patient's alcohol problems, the brief intervention may consist of a negotiation process with the patient to seek further assessment and referral to a specialized treatment program.
e. The ED physician/mid-level provider will conduct the brief intervention using EDDIRECT as follows:
   i. **E**mpathy:
      - Adopt a warm, reflective and understanding style. Avoid a blaming, confrontational or coercive style.
   ii. **D**irectness.
      - Maintain eye contact and raise the subject.
      - "I would like to take a few minutes to talk about your alcohol use."
   iii. **D**ata.

- Feedback: "I am concerned about your drinking. Our screening indicates that:
  1. You are above what we consider the safe limits of drinking, and
  2. You are at risk for alcohol-related illness, injury and death."
- Offer comparison to national norms. (See Quick Reference Card – Screening for Alcohol Problems in the ED.)

iv. **I**dentify willingness to change.

- "On a scale from 1-10 how ready are you to change your drinking patterns?"
- If the response is 6 or less, then ask "Why not less?"
- If the response is greater than or equal to 7, the patient is ready, move on to recommendations.
- The response will help the physician/mid-level provider to identify discrepancies and assist the patient to move along the continuum from ambivalence to change.

v. **R**ecommend action/advice

- All patients:
  "We recommend that you never drive after drinking."
- At-Risk/Harmful Drinkers:
  Statement of recommended drinking limits (See Quick Reference Card – Screening for Alcohol Problems in the ED)
  Follow-up with your primary care physician
- Screen positive, but unsure if dependent drinker:
  Abstain from drinking, and refer for further assessment to social work, psychiatry or a specialized treatment facility or alcohol counselor
- Dependent drinkers:
  Abstain from drinking and refer to a detoxification center, specialized alcohol treatment facility, Alcoholics Anonymous (AA), and/or primary care.

vi. **E**licit response

- "How does this sound to you?" or "Where does this leave you?"

vii. **C**larify and confirm action

- Possible clarification:
  "We have just completed a screening test for a whole spectrum of alcohol problems that may lead to an increase risk of illness and injury. WE are not attempting to label you as an alcoholic. We are recommending what we know to be safe drinking limits. We want you to follow up with your primary care physician, just as we would with any patient who has screened positively for other health

problems such as high blood pressure or a high sugar level."

- Possible confirmation:
  "We are very concerned about your drinking. In the interest of your health (and family) we recommend immediate referral for further assessment and treatment. We know that cutting back or abstaining from alcohol is very difficult to do on you own. We would like to offer you help."

viii. **T**elephone referral.

- "Would you be willing to speak with a counselor, social worker, etc. now?"
- "I'd like to call right now for an appointment or referral. What do you think?"

VI. REFERENCES

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VI. ATTACHMENTS

Attachment A: Cage Questionnaire
Attachment B: EDDIRECT Brief Intervention Tool
Attachment C: Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA, Ar)
Attachment D: Alcohol Intoxication & Withdrawal Order Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

CAGE QUESTIONNAIRE

"CAGE" is a simple screening questionnaire to identify problems with alcohol. "CAGE" is an acronym from the italicized words in the questionnaire (cut-annoyed-guilty-eye).

Date: _____ Time: _____

QUESTION	YES	NO
Have you ever felt you should ***C****ut* down on your drinking?		
Have people ***A****nnoyed* you by criticizing your drinking?		
Have you ever felt bad or ***G****uilty* about your drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (***E****ye opener*)?		
TOTAL		
Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.		

Source: *Dr. John Ewing, Founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill*

Patient Label

Alcohol use and abuse is a major preventable public health problem, contributing to over 100,000 deaths each year and costing society over 185 billion dollars annually.[1] Patients presenting to the ED represent the entire spectrum of alcohol-related problems. This includes drinkers "at-risk" for injury and illness, those presenting with "harmful/problem drinking" such as the impaired driver, all the way to those with signs and symptoms of alcohol dependence.

Fortunately, we now know several truths.

- **Brief intervention does work** There is compelling evidence in the literature that screening and brief intervention (SBI) for alcohol problems does work.[2] A recent evidence-based review on SBI revealed 39 published studies including 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies.[3] Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, including general populations, primary care,[4] emergency departments [5, 6, 7,8] and inpatient trauma centers. [9]

- **The ED visit is an opportunity for intervention[10]** Patients presenting to the ED are more likely to have alcohol-related problems than those presenting to primary care. Cherpitel[11] recently compared patients presenting to an ED with those presenting to a primary care setting in the same metropolitan area. She found that ED patients were one and a half to three times more likely to report heavy drinking, consequences of drinking, alcohol dependence, or ever having treatment for an alcohol problem, than patients presenting to a primary care clinic. In addition, the ED visit offers a potential "teachable moment" due to the possible negative consequences associated with the event.[12, 13.]

- **Linking patients immediately to services has proven to be successful** As early as 1957 Chafetz[5] reported that 65% of patients with alcohol dependence who were directly referred to an alcohol clinic from the ED kept their initial appointment compared to 5.4% of the control group. Bernstein[8] found that 50% of patients with alcohol and drug dependence in Project ASSERT reported follow-up with the treatment referral. Recently, another institution using Project ASSERT[14] reported similar positive results. Of the 719 patients who received a direct referral for a specialized alcohol and drug treatment program during a one year period of time, 41% were contacted. Of these, 80% made contact with the treatment facility and 78% enrolled.

- **Emergency physicians have been reluctant to screen because of perceived barriers: lack of education, time and resources** This resource kit was developed to make the process as easy as possible. The resource kit includes recommended screening tools, an algorithm for providing brief intervention and a template for developing referrals in your community.

SCREENING

A variety of screening tools are available. Their effectiveness varies according to their availability, ease of administration, adverse consequences, and test characteristics. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) recommends the use of quantity and frequency (Q&F) questions as well as the CAGE questionnaire. (See Quick Reference Card) The Q&F questions can elicit whether the patient is over the recommended levels for moderate drinking and therefore "at risk" for illness and injury. The CAGE questionnaire is better for identifying dependence with 90% specificity and 76% sensitivity when used in the ED.[15] Since the CAGE was originally designed for lifetime prevalence, it may be helpful to specify "during the past 12 months."

Asking Q&F questions, then adding the CAGE questions if the responses exceed moderate levels is one way to use the screens. Another approach is to jump to the CAGE questions for patients who present intoxicated with very high ethanol levels, or when dependence is suspected. This eliminates the negative connotations and resistance that can occur when the patient is asked to quantify their drinking.

BRIEF INTERVENTION

Brief interventions are short counseling sessions that can be as short as 5 minutes.[16] They often incorporate the six elements proposed by Miller and Sanchez summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy and self-efficacy. ED DIRECT is an acronym that incorporates these concepts. For "at-risk" or "harmful" drinkers that are not dependent, goal setting within safe limits, discharge instructions and a referral to primary care is all that may be needed. For those patients who are dependent or that you are unsure of their position along the spectrum of alcohol problems, the brief intervention is a negotiation process to seek further assessment and referral to a specialized treatment program.

REFERRAL/AVAILABLE RESOURCES

Each ED must develop their own resource list for their community. Surprisingly there are often more referral sources than one would expect. Enclosed is a sample brochure and a temp
developing a resource list and educational materials for your

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Empathy

- Adopt a warm, reflective and understanding style. Avoid a blaming, confrontational or coercive style.

Directness

- Maintain eye contact and raise the subject, "I would like to take a few minutes to talk about your alcohol use."

Data

- Feedback: "I am concerned about your drinking." Our screening indicates that:
  1. You are above what we consider the safe limits of drinking; and
  2. You are at risk for alcohol-related illness, injury, and death."
- Offer comparison to national norms (See Quick Reference Card - Screening for Alcohol Problems in the ED)

Identify willingness to change

- "On a scale from 1-10 how ready are you to change your drinking patterns?"
- If the response is 6 or less, then ask, "Why not less?"
- If the response is greater than or equal to 7, then the patient is ready, move on to recommendations.
- The response will help the physician to identify discrepancies and assist the patient to move along the continuum from ambivalence to change.

Recommend action/advice

- All Patients:
  "We recommend that you never drive after drinking."
- At-Risk/Harnful Drinkers:
  Statement of recommended drinking limits (See Quick Reference Card - Screening for Alcohol Problems in the ED)
  Follow-up with your primary care physician
- Screen positive, but unsure if dependent drinker:
  Abstain from drinking, and refer for further assessment to social work, psychiatry or a specialized treatment facility or alcohol counselor.
- Dependent Drinkers:
  Abstain from drinking and refer to a detoxification center, specialized alcohol treatment facility, Alcoholics Anonymous (AA), and primary care.

Elicit response

- "How does this sound to you?" or "Where does this leave you?"

Clarify and confirm action

- Possible clarification:
  "We have just completed a screening test for a whole spectrum of alcohol problems that may lead to an increase risk of illness and injury. We are not attempting to label you as an 'alcoholic.' We are recommending what we know to be safe drinking limits. We want you to follow up with your primary care physician, just as we would with any patient who has screened positively for other health problems such as high blood pressure or a high sugar level."
- Possible confirmation:
  "We are very concerned about your drinking. In the interest of your health (and family) we recommend immediate referral for further assessment and treatment. We know that cutting back or abstaining from alcohol is very difficult to do on your own. We would like to offer you help."

Telephone referral

- "Would you be willing to speak with a counselor, social worker, etc. now?"
- "I'd like to call right now for an appointment or referral. What do you think?"

Alcohol Withdrawal Assessment Flowsheet

Assessment Protocol a. Vitals, Assessment now b. If initial score ≥8, repeat c. If initial score <8, assess d. If indicated (see indications below) administer PRN medications as ordered and record on MAR and below.	**Date**										
	Time										
	Pulse										
	RR										
	O2 Sat										
	BP										
Assess and rate each of the following CIWA-Ar Scale:	**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**										
Nausea/Vomiting (0-7) 0 – none; 1 – mild nausea, no vomiting; 4 – intermittent nausea; 7 – constant nausea, frequent dry heaves & vomiting											
Tremors (0-7) 0 – no tremors, 1 – not visible but can be felt, 4 – moderate w/arms extended, 7 – severe, even w/arms not extended											
Anxiety (0-7) 0 – none, at ease, 1 – mild anxious, 4 – moderately anxious or Guarded, 7 – equivalent to acute panic state											
Agitation (0-7) 0 – normal activity, 1 – somewhat normal activity, 4 – moderately Fidgety/restless, 7 – paces or constantly thrashes about											
Paroxysmal Sweats (0-7) 0 – no sweats, 1 – barely perceptible sweating, palms moist 4 – beads of sweat obvious on forehead, 7 – drenching sweat											
Orientation (0-4) 0 – oriented, 1 – uncertain about date, 2 – disoriented to date by no more than 2 days, 3 – disoriented to date by >2 days; 4 – disoriented to place and/or person											
Tactile Disturbances (0-7) 0 – none, 1 – very mild itch, P&N, numbness, 2 – mild itch, P&N, burning, numbness, 3 – moderate itch, P&N, burning, numbness, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucinations, 7 – continuous hallucinations											
Auditory Disturbances (0-7) 0 – not present, 1 – very mild harshness/ ability to startle, 2 - mild harshness, ability to startle, 3 – moderate harshness, ability to startle, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucinations, 7 – continuous hallucinations											
Visual Disturbances (0-7) 0 – not present, 1 – very mild sensitivity, 2 – mild sensitivity, 3 – moderate sensitivity, 4 – moderate hallucinations, 5 – severe hallucinations, 6 – extremely severe hallucination 7 – continuous hallucinations											
Headache (0-7) 0 – not present, 1 – very mild, 2 – mild, 3 – moderate, 4- moderately severe, 5 – severe, 6 – very severe, 7 – extremely severe											
Total CIWA-Ar score:											
PRN med: (circle one) Diazepam Lorazepam	**Dose given (mg)**										
	Route										
Time of PRN medication administration											
Assessment of response (CIWA-Ar score 30 to 60 minutes after medication administered) unless otherwise ordered											
RN Initials											

Signature/Title	Initials	Signature/Title	Initials

Patient Label

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA-Ar)

Nausea/Vomiting - Rate on scale 0-7 0 – None 1 - Mild nausea with no vomiting 2 3 4 – Intermittent nausea 5 6 7 – Constant nausea and frequent dry heaves and vomiting	**Tremors** – have patient extend arms & spread fingers. Rate on scale 0-7 0 – Normal 1 – Not visible, but can be felt fingertip to fingertip 2 3 4 – Moderate, with patient's arm extended 5 6 7 – severe, even with arms not extended
Anxiety – Rate on scale 0-7 0 – No anxiety, patient at ease 1 – Mildly anxious 2 3 4 – Moderately anxious or guarded, so anxiety is inferred 5 6 7 – Equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions	**Agitation** – Rate on scale 0 -7 0 – Normal activity 1 – Somewhat normal activity 2 3 4 – Moderately fidgety and restless 5 6 7 – Paces back and forth, or constantly thrashes about
Paroxysmal Sweats – Rate on scale 0-7 0 – No sweats 1 – Barely perceptible sweating, palms moist 2 3 4 – Beads of sweat obvious on forehead 5 6 7 – Drenching sweats	**Orientation and clouding of sensorium** – Ask, "What day is this? Where are you? Who am I?" Rate on Scale 0-4 0 – Oriented 1 – Cannot do serial additions or is uncertain about date 2 – Disoriented to date by no more than 2 calendar days 3 – Disoriented to date by more than 2 calendar days 4 – Disoriented to place and/or person
Tactile Disturbances – Ask "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin? 0 – None 1 – Very mild itching, pins & needles, burning or numbness 2 – Mild itching, pins & needles, burning or numbness 3 – Moderate itching, pins & needles, burning or numbness 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 –Continuous hallucinations	**Auditory Disturbances** – Ask "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?" 0 – Not present 1 – Very mild harshness or ability to startle 2 – Mild harshness or ability to startle 3 – Moderate harshness or ability to startle 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations
Visual Disturbances – Ask "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?" 0 – Not present 1 – Very mild sensitivity 2 – Mild sensitivity 3 – Moderate sensitivity 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations	**Headache** – Ask "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. 0 – Not present 1 – Very Mild 2 – Mild 3 – Moderate 4 – Moderately Severe 5 – Severe 6 – Very Severe 7 – Extremely Severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (i.e. start on withdrawal medication).
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Flowsheet. Document administration of PRN Medications on the assessment as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center
ALCOHOL INTOXICATION & WITHDRAWAL PROTOCOL

******All Items With a Box Must Be Checked by the Provider******

Date:	**Time:**
Patient Name:	
Allergies:	
Protocol Orders	
1. Nursing Orders	
a) Place in quiet room, low light, minimal stimulation	
b) Safety Precautions: Assess fall risk, suicide/self-harming behaviors (clear room of all objects that may cause harm, one-on-one observation if required). Implement safety precautions as indicated. ***If patient suicidal/homicidal ideation; use the ASQ Suicide Risk Screening Tool & if positive see Care & Treatment of the Psychiatric Patient Policy.***	
2. Insert Peripheral IV. Sodium Chloride 0.9% 10mL flush prn for line patency	
3. Vital Signs & Monitoring	
Alcohol Intoxication • Every hour until patient shows signs of returning to baseline; then every hour until patient shows signs of returning to baseline; then • Every 4 hours • As needed (PRN) • At discharge or transfer	
Alcohol Withdrawal • **Mild** withdrawal every 4 hours • **Moderate** withdrawal every 2 hours • **Severe** withdrawal every hour • As needed (PRN) • At discharge or transfer	
4. Assess patient (**in withdrawal**) response using the CIWA-Ar Assessment Tool as follows: ☐ If an IV Benzodiazepine is administered, perform CIWA-Ar assessment 15 minutes after dose ☐ If a PO/IM Benzodiazepine is administered, perform CIWA- Ar assessment 2 hours after dose ☐ If no treatment provided, perform CIWA-Ar assessment every 4 hours	
5. FSBS immediately. If FSBS 60 mg/dL or less, recheck FSBS. If FSBS less than 40 mg/dL obtain serum glucose and select appropriate treatment sequence from options below:	
Patient Conscious & Able to Swallow	**Patient Unable to Swallow**
Administer one of the following: ☐ 3 Glucose Tablets ☐ 4 ounces orange juice (if not renal patient) ☐ 8 ounces of skim/2% milk ☐ 4 ounces of regular soft drink ☐ Repeat FSBS 15 minutes post treatment. If FSBS still 60 mg/dL or less, repeat treatment above and notify provider for additional orders	**If patient has IV access:** ☐ Administer D50W 50 (25 grams) IV push. Recheck Blood Glucose in 10 minutes. ☐ If FSBS 60 mg/dL or less give D50W (25 grams) IV push and notify provider for additional orders **If patient has NO IV access:** ☐ Administer glucagon 1mg subcutaneously. Repeat FSBS 15 minutes post treatment ☐ If FSBS 60 mg/dL or less and IV access obtained, give D50W (25 grams) IV push and notify provider for additional orders

6. Labs if indicated: □ CBC □ CMP □ Ethanol Level □ Amylase □ Lipase □ PT/INR □ PTT □ UA □ Lactate □ ABGs □ Urine Drug Screen □ Blood Cultures □ FSBS every 6 hours □ FSBS AC&HS
7. Diagnostics if indicated: □ ECG □ Chest X-ray □ Non-contrast Head CT
8. IV fluids (check box as applicable): □ Normal Saline 0.9% 1000mL 999mL/hr bolus □ Normal Saline 0.9% 1000mL at _____/hr □ Lactated Ringers 1000mL 999mL/hr bolus □ Lactated Ringers 1000mL at _____/hr □ Banana Bag at _____/hr (NS 1000mL with Multivitamin 10mL, Folic acid 1mg) x1 □ D5W 50mL with Thiamine 100 mg IV x1. Infuse over 30 minutes; rate = 50mL/hr □ Magnesium sulfate 1 gram IV x1. Infuse over 60 minutes; rate = 100mL/hr
9. □ Maintenance Banana Bag(s): Daily for 3 days only: □ D5W 50mL with Thiamine 100 mg IV x1. Infuse over 30 minutes; rate = 50mL/hr □ Magnesium sulfate 1 gram IV x1. Infuse over 60 minutes; rate = 100mL/hr □ NS 0.9% 500mL with Folic acid 1 mg IV x 1. Infuse over 5 hours; rate = 100mL/hr □ NS 0.9% 500 mL with Multivitamin 10mL IV x 1. Infuse over 5 hours; rate = 100mL/hr
10. Additional Medications to start on day 4 or after Banana Bag discontinued: □ Thiamine 100 mg PO daily □ Folic acid 1 mg PO daily □ Multivitamin 1 tab PO daily
11. Alcohol Withdrawal Prophylaxis Medications: □ Baclofen 10mg PO TID □ Chlordiazepoxide 25 mg PO TID □ Chlordiazepoxide 50 mg PO TID □ Diazepam 5 mg PO TID □ Diazepam 5 mg PO every 6 hours prn agitation/withdrawal symptoms □ Diazepam 10 mg PO TID □ Diazepam 10 mg PO every 6 hours prn agitation/withdrawal symptoms □ Diazepam 5 mg IV every 6 hours prn agitation/withdrawal symptoms □ Diazepam 10 mg IV every 6 hours prn agitation/withdrawal symptoms □ Lorazepam 1 mg PO QID □ Lorazepam 1 mg PO every 4 hours prn agitation/withdrawal symptoms □ Lorazepam 2 mg PO every 4 hours prn agitation/withdrawal symptoms □ Lorazepam 2 mg IV every 6 hours prn agitation/withdrawal symptoms if unable to take PO □ Lorazepam 2 mg IM every 6 hours prn agitation/withdrawal symptoms if unable to take PO or IV
ADDITIONAL ORDERS

Severe Withdrawal- Borgundvaag, B. MD.; and Kahan, M. MD. (2016). Alcohol Withdrawal and Delirium Tremens: Diagnosis and Management. Emergency Medicine Cases. [Electronic Version] Retrieved on 01/17/20 from https://emergencymedicinecases.com/alcohol-withdrawal-delirium-tremens/ Fluid recommendations

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Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Intimate Partner Violence Screening		
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center for the identification, screening, and response of patients who present to the Emergency Department (ED) with signs and/or symptoms of intimate partner violence or abuse.

II. PURPOSE

Intimate partner violence (IPV), also known as domestic violence, is a serious public health problem that is found across all cultural, ethnic, religious, educational, socioeconomical backgrounds, ages, races or sexual orientation. IPV is also associated with increased gynecologic, gastrointestinal, central nervous system, musculoskeletal and cardiac complaints, as well as an increased risk of depression, anxiety, post-traumatic stress disorder, suicidal ideation and/or attempts, and substance abuse.

According to data from the Center for Disease Control and Prevention's Intimate Partner and Sexual Violence Survey (NISVS) during their lifetime approximately 1 in 4 women and 1 in 10 men have experienced some form of sexual or physical violence, and/or stalking by an intimate partner, and over 43 million women and 38 million men have reported experiencing some form of physical aggression in their lifetime. Approximately 11 million women and 5 million men have reported experiencing teen dating violence which is some form of sexual/physical violence, stalking of psychological aggression by an intimate partner before the age of 18. Of those who experience intimate partner violence research has found that 44% of women who have been murdered by their partner had visited an ED within two years of their death. And of these, 93% had at least one visit to the ED related to an injury.

Information developed by the Family Violence Prevention Fund represents findings that may suggest intimate partner violence or abuse. The list includes but is not limited to the following indicators of abuse:

Common Complaints:

- Indication of having been hurt physically, sexually, and/or emotionally
- Unexplained injuries or injuries inconsistent with the history provided by the patient
- Allegedly assaulted by a stranger
- Chronic pain syndromes, headaches
- Overdose/suicide attempts
- Anxiety, depression, insomnia, multiple somatic complaints
- Miscarriage, sexually transmitted disease, and non-specific gynecologic complaints (i.e. pelvic pain, painful intercourse), as well as rapid repeated pregnancies and (unwanted) abortions
- Multiple motor vehicle and single vehicle accidents

Red Flags in Medical History:

- Any old unexplained injuries
- Delay in seeking care
- "Accident prone" patient
- Documented history of family violence
- Frequent Emergency Department, urgent care, or office visits
- Drug/alcohol addiction (patient and/or partner)
- Request for medication for anxiety, sleep or "nerves"

Red Flags for Patient Presentation:

- Evasive/guarded
- Appears embarrassed and/or exhibits poor eye contact
- Presents with injuries and depressed
- Financial concerns
- Denies abuse too strongly
- Minimizes injury or demonstrates unexpected responses (i.e. cries, laughs)
- Intense and/or fearful behavior with partner
- Appears angry and defensive "Last straw phenomena"
- Defers to partner
- Partner answers questions and/or refuses to leave patient alone

Physical Findings:

- Injuries to areas not prone to injuries by falls
- Injuries to multiple sites
- Symmetrical injuries
- Wounds in varying stages of healing
- Mid arm injuries (defensive)
- Strangulation marks: petechiae, ligature marks and subconjunctival hemorrhage
- Weapon injuries or marks
- Bites/burns (scald and cigarette)

- Black eyes
- Dental injuries
- Mid-face injuries
- Breast/abdomen (particularly during pregnancy)
- Neck injury
- Injuries to hidden sites (covered by clothes)
- Internal injuries

The purpose of this policy is to minimize the morbidity and mortality of intimate partner violence through:

- Universal screening for all adolescent and adult patients in a private and safe setting without the patient's partner, friends, family, caregiver or children over the age of two.
- Use of a framing statement to show the patient the screening assessment is done universally and not because IPV is suspected, and to inform patients of the confidentiality of the discussion.
- Provision of interdisciplinary approaches for interventions and safety planning for victims of intimate partner violence.
- Provision of community resources and appropriate referrals for victims of intimate partner violence.

III. DEFINITIONS

Specific definitions used in this policy reflect guidelines provided by the Centers for Disease Control and Injury Prevention sponsored panel of experts from the government, private sector, and education/research areas and published in the *Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements*. These include:

A. **Intimate Partner Violence:** refers to "physical and/or sexual violence, stalking, psychological aggression including coercive tactics by a current or former intimate partner."

B. **Intimate Partner:** refers to "anyone with whom a person has a close personal relationship with and that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship does not need to involve all these dimensions. Intimate partner relationships include current and former: spouses (married, common-law, civil union, domestic), boyfriend/girlfriend, dating partners, and ongoing sexual partners. Intimate partners may or may not be living together…and may be of the same sex."

C. **Physical Violence/Abuse:** refers to "the intentional use of physical force or coercion with the possibility of causing harm, injury, death or disability. Physical violence includes but is not limited to: hitting, kicking, scratching, shoving,

throwing, grabbing, choking, shaking, slapping, punching, pushing, hair-pulling, burning, use of a restraint and/or use of a weapon."

D. **Sexual Violence/Abuse:** refers to "forcing or attempting to force a partner to take part in a sex act, sexual touching, or a non-physical sexual event such as sexting when the partner does not or cannot consent."

E. **Stalking:** refers to "a pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety or the safety of someone else (i.e. family member or close friend)."

F, **Psychological Aggression:** also known as "emotional abuse" refers to the "use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person." Areas of emotional abuse include humiliation, deprivation, and coercion. Other examples of emotional or psychological abuse are rooted in financial and social areas and include controlling money, use of the car, monitoring whereabouts and electronic communications, contact with friends and family and other extracurricular activities.

IV. POLICY

Often the victims of intimate partner violence have utilized the ED many times without being identified as victims, even when an injury was the presenting complaint. Multiple organizations including the American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA) and the Joint Commission recommend universal screening of all patients due to higher rates of identification of intimate partner violence.

The Abuse Assessment Screen (See Attachment A) will be utilized by hospital staff to assess for physical, sexual and/or emotional abuse. The screening will take place in a private place and no friends, relatives, caregivers or children over the age of two will be allowed during the screening. The patient will be notified of the confidentiality of the screening, including the limits of that confidentiality mandated by state law.

If the patient discloses any form of violence or abuse hospital staff will encourage and support intervention and safety strategies. Hospital staff will encourage and assist the patient to create a safety plan that will include domestic violence resources.

The hospital staff will document all clinical interactions in the patient's medical record to provide an accurate account of the patient's medical condition, including any pertinent photographs or body maps. There should be as many patient quotes as possible. If abuse is denied, but the hospital staff suspects abuse, the hospital staff should document their suspicions and validate with objective observations that the injuries are inconsistent with patient explanations.

V. PROCEDURE

A. Upon presentation to the hospital all patients will be triaged using the ESI Triage Algorithm in order to identify a life-threatening or high-risk situation condition and prioritize patients according to acuity.

B. During triage all adolescent (10-19) and adult (20 and older) patients will be screened for intimate partner violence using the Abuse Assessment Screen.
   1. Screening will be done in private with no friends, relatives, caregivers, or children present over the age of two.
   2. Screening questions should be performed using a respectful and non-judgmental tone of voice and body language.
   3. Limits of confidentiality will be discussed PRIOR to doing the screening, and report as necessary.

C. If the Abuse Assessment Screen is positive for intimate partner violence:
   1. Hospital staff will validate the patient's feelings. Reassure them that they are not responsible, and that abuse occurs in many relationships. Tell the patient that they are not alone, and help is available. If the Abuse Assessment Screen is positive an expanded assessment using the Intimate Partner Violence Screening Form will be performed by the provider.
   2. Provider will complete the Intimate Partner Violence Screening Form (Attachment B) as part of the patient assessment.
      a. Review the Intimate Partner Violence Screening with the patient, explaining that the screen assists victims in identifying the danger present in their life so that they can make informed decisions about their safety.
      b. Upon completion of the Intimate Partner Violence Screen, hospital staff will ask the patient if it is safe to go home.
         i. If the patient indicates it is not safe to return home, hospital staff will offer to make a referral to a battered woman's shelter or other community resource upon completing the patient's exam.
         ii. If the patient indicates they wish to return home, hospital staff will emphasize ways to increase their safety in all situations using the Domestic Violence Personalized Safety Plan (Attachment C).
   3. The provider will perform an expanded assessment that will include assessment of:
      a. Immediate safety needs
      b. Patient's state of mind
      c. Chief complaint and present illness
      d. Patient's past safety strategies
      e. Current access to advocacy and support resources
      f. Pattern and history of abuse
      g. Present intact coping skills
      h. Present intact resources
      i. Effects of abuse on patient's health

j. Effects on children in the family
k. Patient's mental health issues (depression, suicide, homicide, substance abuse, etc.)
l. Ability to manage other illnesses
m. Risk of suicide/homicidal thoughts
n. Questions about the batterer

D. If the Abuse Assessment Screen is negative, patient denies abuse and no indicators of abuse are present, hospital staff will document the findings in the patient's medical record and offer referral information for future reference.

E. If the Abuse Assessment Screen is negative and patient denies abuse, but hospital staff still suspects abuse, hospital staff may advise the patient:

1. "Even though you have said that you have not experienced any type of violence, you seem (describe patient's affect that increases the index of suspicion). Is there anything else that you can tell me that might explain your being uncomfortable with these questions? OR
2. "If you are ever experience abuse, please come back to the hospital or contact the local domestic violence program:"

Oklahoma Hotline 1-800-522-SAFE (7233)

3. There are experts and help available provide contacts to local and national hotlines (See Attachment D Domestic Violence Resource Brochure).
5. Do not write any domestic violence referral on discharge papers that will be taken home with the patient.

VI. INTERVENTIONS

Hospital staff will encourage or provide interventions for suspected or known victims of intimate partner violence. Appropriate interventions may include:

A. Assess the immediate safety of the patient and the children (if any).
B, Verbal reassurance that they are not alone.
C. Verbal reassurance that no one deserves to be abused.
D. Verbal reassurance that the violence is not their fault.
E. Affirm that it is hard to talk about abuse.
F. Verbal reassurance that they can talk to someone privately for information and support.
G. Offer information about intimate partner violence, community resources (i.e. mental health services, crisis hotlines, shelters, and police contact information) and appropriate referrals.
H. Offer a private phone to use to call a domestic violence agency.
I. If the patient requests, hospital staff will assist in making a safety plan which respects the integrity and authority of the victim in making his/her own choices about the abusive relationship.
J. Advocacy and assistance in accessing the services of other community agencies.
K. Information will be provided to the patient regarding confidentiality. Hospital staff will inform patient that staff will not reveal information about their violence experiences with their families or perpetrators.

1. Keep the chart and abuse documentation in a secure area isolated from visitors.

L. Information will be provided regarding mandatory reporting of child abuse if indicated.
M. Information will be provided regarding mandatory reporting of vulnerable adult abuse if indicated.
N. Reassurance that they will continue to be offered assistance whenever they seek help.
O. Assist the patient to identify trusted individuals that they can approach for assistance.

VII. DOCUMENTATION

Findings of intimate partner violence or suspected abuse should be clearly documented so that future providers know to follow up on the issue. Medical records can provide crucial evidence in support of the victim in court. Documentation should include:

A. Document findings objectively.
B. Use as many patient quotes as possible. Use terms such as "stated" and "said".
C. Date and time of arrival.
D. Attempt to record name, address, and phone number of anyone accompanying the patient.
E. Primary complaint
F. Detailed description of injuries, including type, number, size, location, resolution, possible causes, and explanation from patient on how injury occurred.
G. Patient's statements of past battering incidents (direct quotes).
H. Complete medical history and relevant social history.
I. Laboratory and diagnostic results.
J. Describe detailed positive and negative findings from the physical assessment and interview.
K. Note the patient's general demeanor.
L. Completed Abuse Assessment Screen, with the body map indicating designated areas of injury.
M. Completed Intimate Partner Violence Screening Form.
N. Documentation of non-bodily evidence of abuse, such as torn clothing or damaged jewelry.
O. Attempt to record any identifying information of the alleged abuser.
P. Photographs, when permitted by patient prior to treatment, from different angles, at least two photographs of every major injury. Obtain patient consent for any photographs taken. Photographs should be taken on facility-owned equipment. All photographs must be appropriately identified with the patient name, medical record number, and date taken and retained in the patient's medical record. External disclosures that require patient authorization include, but are not limited to:
    i. Requests by law enforcement;
    ii. Requests by Social Services

Q. Document the completion of a safety plan if the patient requests to complete one, specific referrals and plans made.
R. Document contacts with police and other community resources if requested that were initiated prior to patient discharge.
S. Describe discharge plans (i.e. patient's plans for safety after leaving the ED).
T. If abuse is denied, but abuse is suspected the provider should document the suspicions and validate with objective observations that the injuries are inconsistent with the patient's explanation.

VIII. DISCHARGE SAFETY PLAN

A safety plan is intended to be a personalized, practical plan that describes a plan of actions that can help keep the victim remain safe in a relationship, planning to leave or after they leave the abusive relationship.

The hospital staff should start from the assumption that an abuser is dangerous and try to assist the victim/survivor identify the circumstances under which the abuser typically becomes violent and how the abuser may react to help seeking strategies.

If requested by the patient Hospital staff will assist the patient with completing the Domestic Violence Safety Plan prior to discharge. Hospital staff will ensure the patient has all the appropriate contact numbers for law enforcement and community resources on the safety plan prior to discharge.

If the patient does not wish to complete a safety plan prior to discharge the patient will be offered harm reduction strategies, referral to an advocate when appropriate to promote safety, and resources including local and national domestic violence hotlines.

IX. QUALITY MONITORING

Hospital leadership including but not limited to, the Chief Clinical Officer (CCO) are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Clinical Officer and an incident report are completed.

All patient and visitor reports of law enforcement involvement or security risk events will require the completion of an incident report.

All incident reports will be forward to the Quality Risk Manager and reported to Safety/EOC, QAPI, MEC, and Governing Board.

X. EDUCATION AND TRAINING

All hospital staff will be required to have orientation and on-going education and competency for initiate partner violence that includes the following standards:

- Statistics for Intimate Partner Violence as a Public Health Problem
- Definition of Intimate Partner Violence/Domestic Violence
- The etiology of Intimate Partner Violence/Domestic Violence
- Barriers to identify victims
- The importance of universal screening
- Diagnosis and clinical indicators
- Documentation
- Appropriate interventions
- Understanding and Compliance with Hospital Policy

XI. ATTACHMENTS

Attachment A: Abuse Assessment Screen
Attachment B: Intimate Partner Violence Screening Tool
Attachment C: Domestic Violence Personalized Safety Plan
Attachment D: Domestic Violence Resource Brochure
Attachment E: Consent for Photograph and Multimedia

XII. REFERENCES

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change

ABUSE ASSESSMENT SCREEN

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
   □ YES □ NO
   If yes, by whom? _____
   Total number of times _____

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
   □ YES □ NO

3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   □ YES □ NO □ N/A

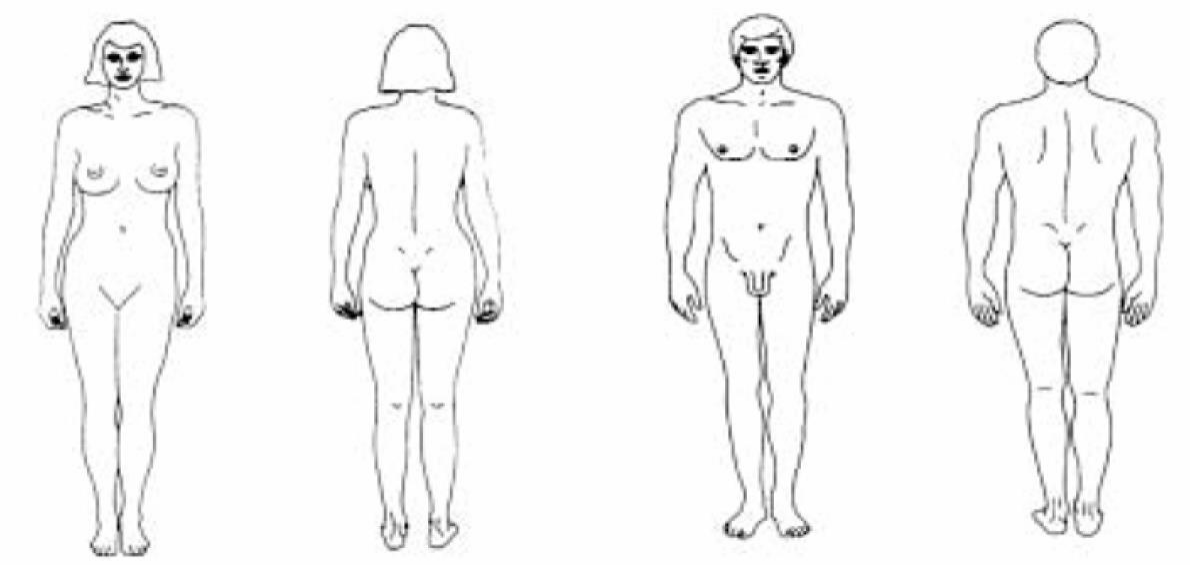
4. Within the last year, has anyone forced you to have sexual activities?
   □ YES □ NO
   If yes by whom? _____
   Total number of times _____

5. Are you afraid of your partner or anyone you listed above?
   □ YES □ NO

MARK THE AREA OF INJURY ON A BODY MAP AND SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

If any of the descriptions for the higher number apply, use the higher number.

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon



Mangum Regional Medical Center

EMERGENCY PHYSICIAN RECORD

Intimate Partner Violence

TIME SEEN:_____ □ on arrival ROOM: _____ _____ EMS Arrival
HISTORIAN: patient spouse paramedics _____
__HX/__EXAM LIMITED BY:_____

HPI

chief complaint: _____
_____

onset / duration:	**where:**
just prior to arrival	home school neighbor's
today / yesterday _____	park work street
_____ min / hrs / days ago	_____

mechanism of trauma: fists kicked choking
pushed / thrown down pushed / thrown against wall
weapon(s) or object(s) used:
_____

vaginal penetration **Assailant:**
rectal penetration known unknown
oral penetration multiple assailants: _____
_____
_____
_____

location of pain/injuries:	-right-		-left-	
head face mouth	shldr	hip	shldr	hip
neck chest abdomen	arm	thigh	arm	thigh
breast *R / L*	elbow	knee	elbow	knee
back *upper mid lower*	f-arm	leg	f-arm	leg
radiating to R / L thigh / leg	wrist	ankle	wrist	ankle
	hand	foot	hand	foot

severity of pain:
pelvic pain _____
mild / mod / severe (1/10) ____ sudden/ intermittent/ constant
cramping / pressure / "pain" burning / sharp
vulvar / vaginal pain _____ rectal _____
low back pain _____
flank pain _____

LNMP: _____ *post-menop. s / p hyst.*
pregnant / post home HCG _____ MOS EDC _____
irregular / missed period(s) _____
prior abnormal period(s) _____
_____

vaginal bleeding:
abnormal bleeding (started) _____
compared to menstrual periods: severe / heavier / similar/ lighter
spotting / passing clots / tissues _____
_____

ROS

cough _____
trouble breathing _____
chest pain _____
abdominal pain _____
vaginal discharge _____
vomiting _____
diarrhea _____
problem urinating _____
LNMP _____ *preg post-menop*

headache_____
problems with vision_____
skin rash _____
swelling _____
joint pain _____
fever / chills _____
anxiety / depression _____
_____
□ all systems neg except as marked

PAST HX

diabetes *Type I Type 2 diet / oral / insulin*
_____
_____
Obstetric Hx: Grav _____ Para _____ Ab _____
Tetanus immun. UTD / given in ED _____
Meds - ___none / see nurses note _____

SOCIAL HX

smoker ____PPD drugs _____
alcohol (recent / heavy / occasional) _____ occupation _____
_____

FAMILY HX

____ negative _____
_____

□ Nursing Assessment Reviewed □ Vitals Reviewed _____
VS BP _____ HR _____ RR _____ Temp_____ O2Sat _____

PHYSICAL EXAM

General Appearance
__no acute distress
__alert

HEAD
__no evidence of trauma

NECK
__non-tender
__painless ROM

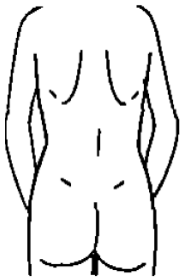
EYES
__PERRL
__EOMI

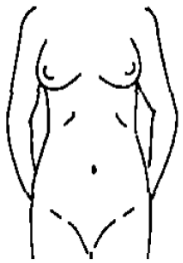
ENT
__nml external inspection
__no dental injury

RESP/CVS
__chest non-tender
__breath sounds nml
__heart sounds nml

__c-collar / backboard (PTA / in ED) _____
__mild / moderate / severe distress _____
__anxious / lethargic _____
_____
__see diagram _____
__raccoon eyes / Battle's sign _____
_____
__see diagram_____
__vertebral point-tenderness_____
__muscle spasm / decreased ROM _____
__pain on movement of neck _____
__EOM entrapment / palsy _____
__subconjunctival hemorrhage _____
_____
__hemotympanum _____
__nasal septal hematoma _____
__TM obscured by wax _____
__clotted nasal blood _____
__dental injury / malocclusion _____
__see diagram _____
__decreased breath sounds _____
__splinting / paradoxical movements _____
__tachycardia / bradycardia _____
_____

T = Tenderness
PtT = Point Tenderness
S = Swelling
E = Ecchymosis
Lac = Laceration
A = Abrasion B = Burn
(Ø = without m = mild
mod = moderate
sv = severe)





ABDOMEN
__non-tender
__no organomegaly
__see diagram _____
__rebound / guarding /tenderness _____
__mass / organomegaly _____
_____

NEURO / PSYCH
__oriented x 3
__mood / affect nml
__CN's nml (2-12)
__sensation nml
__motor nml
__disoriented to *person / place / time* _____
__facial asymmetry _____
__depressed mood / affect _____
__unsteady / ataxic gait _____
__slow / no response to commands _____
__sensory / motor deficits _____
__non-communicative / hostile / tearful _____
__suicidal / homicidal ideation _____
_____

SKIN
__intact
__warm, dry
_____
__see diagram _____
__crepitus / diaphoresis _____
__decubitus

BACK
__no CVA tenderness
__no vertebral tenderness
__see diagram _____
__vertebral point-tenderness_____
__CVA tenderness _____
__muscle spasm _____
_____

EXTREMITIES
__no evidence of trauma
__nml ROM
__see diagram _____
__bony point tenderness _____
__painful / unable to bear weight _____
__pulse deficit _____
Joint Exam:
__limited ROM / ligaments laxity / joint effusion

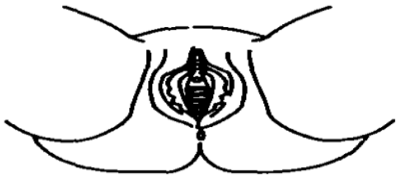
PELVIC EXAM
__external

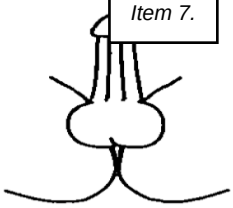
exam nml

__speculum exam nml (*vagina, cervix*)

__bimanual exam nml (*uterus, adnexo*)
__see diagram _____
__herpes-like ulcerations _____
__ external trauma _____
__secretions on skin _____
__abrasions / ecchymosis _____
__vaginal discharge _____
__vaginal fluid leakage (pregnant) _____
nitrazine pos / neg _____
__active bleeding mild / mod / severe _____
__blood / clots in vaginal vault _____
__cervicitis _____
__tissue present in cervix / vagina _____
__cerv. Motion tenderness _____
__cervical dilation / cervical os open _____
__adnexal / uterine mass / tenderness _____
__enlarged uterus _____
__consistent with dates _____wk

RECTAL
__non-tender
__heme neg stool
__black / bloody / blood-streaked stool ____
__gross blood present _____
__external hemorrhoid _____
thrombosed ruptured inflamed bleeding
__pain on exam _____
rectal prostate unable to examine digitally
_____





PROCEDURES

Wound Description/Repair: **Time:** _____
length_____cm location: _____
linear stellate irregular flap into: subcut / muscle
clean contaminated *moderately / heavily* _____
distal NVT: neuro/vasc intact galea intact
anesthesia: local topical ____ lidocaine / bupivacaine epi / bicarb
prep: Hibiclens / Betadine _____
irrigated with saline
wound explored
to base / in bloodless field
no foreign bodies identified
foreign material removed
debrided *mod. / extensive*
wound margins revised
multiple flaps aligned
galea repaired
_____
repair: *Wound closed with: wound adhesive / Dermabond/ steri-strips*
SKIN- #_____ _____ -0 nylon / prolene / staples / silk / ethilon _____
SUBCUT #_____ _____ -0 vicryl / chromic _____

LABS & XRAYS

CBC	**Chemistries**	**HCG**	**UA**
normal except	*normal except*	serum / urine	*normal except*
WBC_____	Na_____	POS NEG	WBC_____
Hgb_____	K_____	_____	RBC_____
Hct_____	CO2_____	_____	bacteria_____
Platelets_____	Gluc_____	_____	dip: _____
segs _____	BUN_____	_____	_____
_____	Creat _____	_____	_____

sexual assault evidence kit complete _____
cultures obtained _____
GC wet mount sperm present
Chlamydia _____
HIV hepatitis VDRL _____
_____

XRAYS ☐ Interp. By me ☐ Reviewed by me ☐ Discsd w/ radiologist

C-Spine T-Spine LS-Spine
__nml / NAD __no fracture __nml alignment __soft tissues nml

CXR
__nml / NAD __no pneumothorax __nml heart size
__nml mediastinum

CT Scan ☐ Discsd w/radiologist
head C-Spine chest abdomen/pelvis
__nml /NAD _____

Other _____

Patient Safety and Needs

Is the assailant still in the home? __ YES __ NO
Is the patient afraid to go home? __ YES __ NO
Has the assailant threatened to kill? __ YES __ NO
Is the patient/assailant suicidal? __ YES __ NO
Does the assailant have any mental health issues? __ YES __ NO
Has the abuse increased in frequency/intensity? __ YES __ NO
Does the assailant's violent behavior extent outside of the home? __ YES __ NO
Is there a weapon in the home? __ YES __ NO
Does the patient have/want a restraining order? __ YES __ NO
Are alcohol or drugs involved? __ YES __ NO
How much? _____ How often _____
Does the assailant increase his/her violent behavior when under the influence? __ YES __ NO
Does the patient need immediate shelter? __ YES __ NO
Victims Assistance/COBRA called? __ YES __ NO
Is there a safe # where the patient can be reached? _____
Photographed? __ YES __ NO
Consent to be photographed? __ YES __ NO
Community resources given to patient? __ YES __ NO
Follow-up appointment made? __ YES __ NO
Date: _____ Provider: _____
Referrals made? __ YES __ NO

_____
_____

Has IPV been documented in medical record? __ YES __ NO

_____
_____
_____
_____

Safety Strategies:
Does the patient have a safety plan: □ YES □ NO
□ *declines safety plan*
Past safety strategies: _____
_____

Coping Skills:
□ deep breathing □ exercise □ walking □ visualization
□ connecting with friends/family
□ other: _____

History of Abuse:

_____
_____
_____
_____

Mental Health:

□ anxiety □ depression □ suicidal ideation □ suicide attempt
□ homicidal ideation □ substance abuse: _____
□ other: _____

Time _____ unchanged improved re-exam

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

___STD prophylaxis given _____
Rocephin Doxycycline other _____
___pregnancy prophylaxis given _____
___Discussed with Dr._____Time:_____
will see patient in: ED / hospital / office

Reporting:

□ Law enforcement report made: Time: _____
□ At scene □ In ED
Agency name: _____
Officer's Name _____
Badge # _____
□ ***patient declines to report***
□ Child Protective Services report made
□ Adult Protective Services report made

Referrals:

□ Hotline numbers given □ Victim advocate referral made
□ Shelter number given
□ Social Services consult: _____
□ Other referral made: _____

Counseled patient / family regarding: Additional history from:
lab / rad. results diagnosis need for follow-up family caretaker paramedics
__RX given_____
_____
CRIT CARE TIME *(excluding separately billable procedures)* _____ *min*

_____
_____

CLINICAL IMPRESSION

DISPOSITION - □ home □ transferred to _____
Time _____ □ admitted _____ to Dr._____
__**POA** *decubitus / UTI*
*(foley)*_____
CONDITION - □ unchanged □ improved □ stable _____
Care transferred to Dr. _____ Time: _____
_____***NP/PA***
_____***MD/DO***
□ Template Complete □ See Addendum (Dictated / Template #_____)

EMC? YES NO

DOMESTIC VIOLENCE PERSONALIZED SAFETY PLAN

Name: _____ **Date:** _____

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

STEP 1: Safety during a violent incident. *Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.*

I can use some of the following strategies:

A. If I decide to leave, I will _____.
(Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them *(location)* _____ _____ in order to leave quickly.

C. I can tell _____ about the violence and request that she or he call the police if she or he hears suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police, the fire department, and 911.

E. I will use _____ as my code with my children or my friends so they can call for help.

F. If I have to leave my home, I will go to _____.
(Decide this even if you don't think there will be a next time.)

G. I can also teach some of these strategies to some or all of my children.

H. When I expect we're going to have an argument, I'll try to move to a place that is low risk, such as _____. *(Try to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.)*

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we

STEP 2: Safety when preparing to leave. *Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.*

I can use some or all of the following strategies:

A. I will leave money and an extra set of keys with _____ so I can leave quickly.

B. I will keep copies of important documents or keys at _____.

C. I will open a savings account by _____, to increase my independence.

D. Other things I can do to increase my independence include: _____ _____.

E. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month's phone bill will show my batterer those numbers I called after I left. To keep my phone communications confidential, I must either use coins, or I might ask to use a friend's phone card for a limited time when I first leave.

F. I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

G. I can leave extra clothes or money with _____.

H. I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend's name) has agreed to help me review this plan.

I. I will rehearse my escape plan and, as appropriate, practice it with my children.

STEP 3: Safety in my own residence. *There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.*

Safety measures I can use:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second oor windows.

E. I can install smoke detectors and fire extinguishers for each oor of my house/apartment.

F. I can install an outside lighting system that activates when a person is close to the house.

G. I will teach my children how to make a collect call to me and to _____ (name of friend, etc.) in the event that my partner takes the children.

H. I will tell the people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include:

_____ (name of school)
_____ (name of babysitter)
_____ (name of teacher)
_____ (name of Sunday-school teacher)
_____ (name[s] of others)

I. I can inform _____ (neighbor) and _____ (friend) that my partner no longer resides with me and that they should call the police if he is observed near my residence.

STEP 4: Safety with an Order of Protection. *Many batterers obey protection orders, but can never be sure which violent partner will obey and which will violate protective orders.* I recognize that I may need to ask the police and the courts to enforce my protective order.

The following are some steps I can take to help the enforcement of my protection order:

A. I will keep my protection order _____ (location). *Always keep it on or near your person. If you change purses, that's the first thing that should go in the new purse.*

B. I will give my protection order to police departments in the community where I work, in those communities where I visit friends or family, and in the community where I live.

C. *There should be county and state registries of protection orders that all police departments can call to confirm a protection order.* I can check to make sure that my order is on the registry. The telephone numbers for the county and state registries of protection orders are: _____ (county) and _____ (state).

D. I will inform my employer; my minister, rabbi, etc.; my closest friend; and _____ that I have a protection order in effect.

E. If my partner destroys my protection order, I can get another copy from the clerk's office.

F. If the police do not help, I can contact an advocate or an attorney and file a complaint with the chief of the police department or the sheriff.

G. If my partner violates the protection order, I can call the police and report the violation, contact

STEP 5: Safety on the job and in public. *Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family, and co-workers can help to protect women. Each woman should carefully consider which people to invite to help secure her safety.*

I might do any or all of the following:

A. I can inform my boss, the security supervisor, and _____ at work.

B. I can ask _____ to help me screen my telephone calls at work.

C. When leaving work, I can _____.

D. If I have a problem while driving home, I can _____.

E. If I use public transit, I can _____.

F. I will go to different grocery stores and shopping malls to conduct my business and shop at hours that are different from those I kept when residing with my battering partner.

G. I can use a different bank and go at hours that are different from those kept when residing with my battering partner.

STEP 6: Safety and drug or alcohol use. *Most people in this culture use alcohol. Many use mood-altering drugs. Much of this is legal, although some is not. The legal outcomes of using illegal drugs can be very hard on battered women, may hurt her relationship with her children, and can put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. Beyond this, the use of alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him an excuse to use violence. Specific safety plans must be made concerning drugs or alcohol use.*

If drug or alcohol use has occurred in my relationship with my battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. If my partner is using, I can _____ and/or _____.

C. To safeguard my children I might _____.

STEP 7: Safety and my emotional health. *The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy.*

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and am returning to a potentially abusive situation, I can _____ _____.

B. When I have to communicate with my partner in person or by telephone, I can _____ _____.

C. I will try to use "I can ... " statements with myself and be assertive with others.

D. I can tell myself, "_____" whenever I feel others are trying to control or abuse me.

E. I can read _____ to help me feel stronger.

F. I can call _____ and _____ for support.

G. I can attend workshops and support groups at the domestic violence program or _____ _____ to gain support and strengthen relationships.

STEP 8: Items to take when leaving. *When women leave partners, it is important to take certain items. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.*

Money: Even if I never worked, I can take money from jointly held savings and checking accounts. If I do not take this money, he can legally take the money and close the accounts.

Items on the following lists with asterisks by them are the most important to take with you. If there is time other items might be taken, or stored outside the home. These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly. When I leave, I should take:

*Identification for myself
*My birth certificate
*School and vaccination records
*Checkbook, ATM card
*Key - house, car, office
*Medications
*Welfare identification, work permits, green cards
*Children's birth certificate
*Social Security cards
*Money
*Credit cards
*Driver's license and registration
*Copy of protection order

Passport(s), divorce papers
Medical records - for all family members
Lease/rental agreement, house deed, mortgage payment book
Bank books, insurance papers
Address book
Pictures, jewelry
Children's favorite toys and/or blankets
Items of special sentimental value

Telephone numbers I need to know:

Police/sheriff's department (local) - 911 or _____
Police/sheriff's department (work) _____
Police/sheriff's department (school) _____
Prosecutor's office _____
Battered women's program (local) _____
National Domestic Violence Hotline: 800-799-SAFE (7233)
800-787-3224 (TTY)
www.ndvh.org
County registry of protection orders _____
State registry of protection orders _____
Work number _____
Supervisor's home number _____

I will keep this document in a safe place and out of the reach of my potential attacker.

Review date: _____

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NATIONAL CENTER
on Domestic and Sexual Violence
training • consulting • advocacy
7800 Shoal Creek, Ste 120-N • Austin, Texas 78757
tel: 512.407.9020 • fax: 512.407.9022 • www.ncdsv.org

DOMESTIC VIOLENCE HOTLINE

OKLAHOMA HOTLINE:

1-800-522-SAFE (7233)

[Recipient Name]
[Address]
[City, ST ZIP Code]

Mangum Regional Medical Center

1 Wickersham Drive Mangum, Ok 73554

Mangum Regional Medical Center

DOMESTIC VIOLENCE RESOURCES

NEED HELP RIGHT AWAY

If you feel like you are in immediate physical danger, call 911.

Oklahoma Safeline:

1-800-522-SAFE (7233)

National Sexual Assault Hotline:
1-800-656-HOPE (4673)

If you are the victim of a sexual assault, you can call the National Sexual Assault Hotline for assistance. Your call will be routed to a local RAINN-affiliated organization. Most calls will be routed to an agent you can speak to immediately, but it is possible you might reach a voicemail box.

Oklahoma Resources

24-hour Safeline:

1-800-522-SAFE (7233)
Provides assistance with safety planning, crisis intervention, emergency shelter and advocacy to victims of domestic violence, sexual assault, stalking.

Abuse Hotline
1-800-522-3511

Elder Abuse Hotline
1-800-522-3511

Oklahoma Department of Human Services:

Domestic Violence Resources
http://www.okdhs.org/purpleribbon/Pages/default.aspx

National Resources

- **National Domestic Violence Hotline:**
  1-800-799-7233
- **National Sexual Violence Hotline:**
  1-800-656-4673
- **National Teen Dating Abuse Helpline:**
  1-866-331-9474

Contact Us

Mangum Regional Medical Center
[Address]
[City, ST ZIP Code]

[Telephone]
[Email]

Visit us on the Web:
[Web Address]

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Consent for Photography/Multimedia and Authorization for Use or Disclosure

Patient or Employee Name: _____

Consent for Photograph or Multimedia

□ **Patient or Patient Representative:**

I hereby consent to be photographed while at Mangum Regional Medical Center by its employees to record or document my care or treatment, or other images of me. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Patient/Patient Representative Signature*_____

□ **Employee:**

I hereby consent to be photographed at Mangum Regional Medical Center by its employees, on hospital property, or other areas that the hospital may deem appropriate. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Employee Signature*_____

A**uthorization for Use and Disclosure**

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

_____
(Person(s)/Organization(s) authorized to receive the information)

_____
(Address: Number, Street, City, State, Zip Code)

This Authorization expires (*insert date):*_____
Upon expiration of this Authorization, the hospital will not permit further release of any photograph(s), but will not be able to call back any photographs or information already released.

Purpose

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (check all that apply):
□ Dissemination to Hospital staff (medical providers, health professionals) □ Emergency/Disaster Notification
□ Educational □ Treatment □ Research □ Scientific □ Public Relations □ Marketing □ News Media
□ Charitable Purposes □ Law Enforcement □ Legal □ Other: _____

Date: _____/_____/_____ Time: _____ AM/PM

I and any persons as my successors agree to release Mangum Regional Medical Center and its employees from any claim or cause of action, now or in the future from any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient/Patient Representative or Employee Signature:_____

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

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Safe Haven		**EMD-013**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department	See below	

SCOPE

This policy applies to all infants 7 days of age or younger that have been voluntarily relinquished to Mangum Regional Medical Center by a parent and the parent did not express intent to return for the child.* A medical services provider or child rescuer may take possession of a child not older than seven days without a court order if the child is voluntarily surrendered to such entity by its parent and the parent did not express intent to return for the child.

*Protection for Relinquishing Parent Citation: Ann. Stat. Tit. 10A, § 1-2-109 A parent shall not be prosecuted for child abandonment or child neglect when the allegations of child abandonment or child neglect are based solely on the relinquishment of a child 7 days of age or younger to a medical services provider or a child rescuer.

PURPOSE

To protect and save newborns who might otherwise be abandoned and left for dead. To ensure a safe disposition of the infant to the appropriate child-care services in a timely manner.

DEFINITIONS

Medical Services Provider-means a person authorized to practice the healing arts, including a physician's assistant or nurse practitioner, a registered nurse, or practical nurse, and a nurse aide.

Child Rescuer-means any employee or other designated person on duty at a police station, fire station, child protective services agency, hospital, or other medical facility.

POLICY

Mangum Regional Medical Center will adhere to the Oklahoma Safe Haven Law. The hospital will assess and evaluate the infant and provide appropriate medical care necessary to protect the physical health and safety of the infant. In addition, the local office of the Department of Human Services will be notified.

PROCEDURE

1. The hospital shall establish from the person that this a voluntary relinquishment of the infant without intent to return for the infant. Two (2) hospital staff shall witness and verify this statement. This statement shall be included in the incident report.
2. The hospital may request, but not demand, any information about the child that the parent is willing to share. The hospital staff is encouraged to ask about, but not demand, the details of any relevant medical history relating to the child or the parents of the child. The hospital shall respect the wish of the parent if the parent desires to remain anonymous;
3. Perform or provide for the performance of any act or medical care necessary to protect the physical health or safety of the child;
4. All infants that present to the hospital with a parent who is requesting "Safe Haven" provision under Oklahoma Law must be seen in the hospital's Emergency Department.
5. An appropriate medical screening examination (MSE) must be performed by the medical provider or other qualified medical personnel to determine if an "emergency medical condition" exists and if necessary stabilizing treatment is required. If the MSE determines an emergency medical condition exists, the hospital must follow the EMTALA policy and guidelines and provide any necessary stabilizing treatment. The hospital must provide notice to DHS of this circumstance and all actions taken.
6. If the infant requires a higher level of care beyond the capability and capacity of the hospital, the hospital can make arrangements for the transfer of the infant to an accepting medical facility (follow EMTALA policy & guidelines for transfer). The hospital must provide notice to DHS of this circumstance and all actions taken.
7. Release of Infant to DHS: The infant may be released to DHS when the infant is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the infant has reached the point where their continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient ***or*** that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the infant from the hospital to DHS custody.
8. Provide the parent with printed information relating to the rights of the parents, including both parents, with respect to reunification with the child and sources of counseling for the parents, if desired;
9. Complete the "Statement of Voluntary Relinquishment of Infant (See Attachment). This is requested information only by the hospital and is not obtained by demand per Oklahoma Statute.
10. Encourage the mother (if applicable) to receive medical care;
11. Be supportive, empathetic, and avoid judgmental comments to the person relinquishing the infant;
12. Notify the local office of the Department of Human Services that a parent of a child seven (7) days of age or younger, in the best judgment of the receiving

hospital personnel, has relinquished such child and that the hospital has taken possession of the child. (*The Department of Human Services shall immediately check with law enforcement authorities to determine if a child has been reported missing and whether the missing child could be the relinquished child. The department shall disseminate information about parents' rights with regard to reunification with a child, including, but not limited to, information on how a parent can contact the appropriate entity regarding reunification and information on sources of counseling for relinquishing parents*). Use the number listed below to contact DHS:

Statewide 24-hour Child Abuse and Neglect Hotline
1-800-522-3511

13. A medical services provider or child rescuer with responsibility for performing duties pursuant to the provisions of this law shall be immune from any criminal liability that might otherwise result from the actions of the hospital, if acting in good faith in receiving a relinquished child. In addition, such medical provider or child rescuer shall be immune from any civil liability that might otherwise result from merely receiving a relinquished child.
14. An incident report shall be completed by the Charge Nurse or medical provider with a full account of the event and forwarded to the Quality Manager. Include the person's statement of voluntary relinquishment of the infant and the names of the hospital personnel who witnessed the voluntary relinquishment of the child by the parent.
15. The hospital will notify the Administrator as soon as possible, but no later than one day of the event occurrence.
16. The hospital will take measures to ensure the confidentiality and any protected health information of the infant and/or the individual who relinquished the infant are maintained.
17. Any media or other enquiries will be referred to the hospital Administrator.
18. ***Special note***-If you believe or have reasonable suspicion that a child or infant is being abused or neglected, the hospital has a legal responsibility to report it to the **Statewide 24-hour Child Abuse and Neglect Hotline: 1-800-522-3511.**

Education

All staff including medical providers will be educated and trained on the Safe Haven Policy and Procedure upon new hire orientation, annually, and as needed. Education of the staff will be retained in the employee's HR file.

RESOURCES

1. Oklahoma Department of Human Services
2. National Safe Haven Alliance (NSHA) Hotline- 1-888-510-BABY (2229) or text SAFEHAVEN to 313131 or contact@nationalsafealliance.org. National Safe Haven Alliance are subject matter experts and are committed to supporting parents and providers in desperate circumstances including parenting resources, adoption support, and Safe

Haven information. Contact NSHA for questions, resources, education, legislation resources, best practice models, training materials or support from trained Crisis Response Team available 24/7.

REFERENCES

Ok Law Children and Juvenile Code 10A O.S. § 1-2-109 Relinquishment of child 7 days of age or younger to medical services provider or child rescuer
State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases §489.24

ATTACHMENTS

Attachment A: Statement of Voluntary Relinquishment of Infant
Attachment B: FAQs Infant Safe Haven Law
Attachment C: Safe Haven Brochure

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
Mangum Regional Medical Center

Statement of Voluntary Relinquishment of Infant

- ***The hospital may request, but not demand, any information about the child that the parent is willing to share. The hospital staff is encouraged to ask about, but not demand, the details of any relevant medical history relating to the child or the parents of the child. The entity shall respect the wish of the parent if the parent desires to remain anonymous.***
- ***The information contained in this document is strictly confidential and will be shared with only those individuals with a need to know (i.e. Quality Manager, Hospital Administrator)***

Instructions

(The hospital may request information, but not demand information)

1. Ask the individual if they are willing to share any or all of the information as outlined below.

2. Explain to the individual the purpose of this document is only to provide relevant information they would like to ***voluntarily share with the hospital and will not be used in a punitive manner or they have the right to refuse to give information to the hospital.***

2. The Hospital personnel will check each box or fill-in information the parent is willing to share. The individual providing the information must have the freedom to share information without prodding or coercion by the hospital staff.

3. Contact the Department of Human Services listed below:

Statewide 24-hour Child Abuse and Neglect Hotline
1-800-522-3511

4. Forward this document to the Quality Manager upon completion.

Infant/Parent Information

(Hospital staff to complete this section based upon the information received from the parent)

☐ I hereby express my will as the parent of this infant to voluntarily relinquish my infant to the hospital and have no intent to return for the child.

Witnessed by:

1. Name & Title: _____ Date: _____/_____/_____

2. Name & Title: _____ Date: _____/_____/_____

□ I wish to remain anonymous and do not want to share any information with the hospital personnel.

□ I agree to share any or all information as requested by the hospital. I understand I may choose what if any information I would like to share. This decision has been made by my own free will without demand or coercion by the hospital staff.

□ I hereby state the infant is _____ days old and was born on _____/_____/_____.

☐ Place of Birth: _____.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

☐ I hereby state the infant is a ☐ male ***or*** I hereby state the infant is a ☐ female.

☐ I am willing to share any or all of the details of any relevant medical history relating to the infant or parentage.

□ I am ***NOT*** willing to share any or all of the details of any relevant medical history relating to the child or parentage.

□ I wish to leave my name and contact information with the hospital.

Name: _____ Phone: (____) _____-_____

To Be Completed By Hospital Staff

☐ I hereby state the hospital has made no demands of the person relinquishing the infant for any or all of the information contained in this document, but only as voluntarily expressed by the person.

Name & Title: _____ Date: _____/_____/_____

Date of Event: _____/_____/_____ Time of Event: _____/_____/_____

☐ MSE Completed by: _____ Date: _____/_____/_____

☐ I confirm during the transfer of the infant from the hospital to DHS custody that no material deterioration of the infant is likely, to result from or occur within reasonable medical probability.

Medical Provider: _____ Date: _____/_____/_____

Release of Infant

Department of Human Services (DHS) Notified: Date: ____/____/____ Time: _____:_____

Name of Department of Human Services Representative: _____

Contact Number of DHS Representative: (_____) _____-_____

Infant released to:

Name & Title of DHS Representative: _____

Date: ____/____/____ Time: ____:____

Infant Condition Upon Release: Vital Signs: Temp:_____ Pulse: _____ Resp: _____ BP:____/_____

_____

_____

_____

_____ _____/_____/_____

Name of Person Completing Report *Date*

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

FAQs INFANT SAFE HAVEN LAW

1. **Once a child is relinquished to the hospital, can the parent change their mind and take the infant back at the time of the drop off without additional follow-up to DHS?**
   A: Yes, once DHS is involved we gather all information and if the parent changes their mind, we will work with them to return their child. The timeframe would depend on when the parent changed their mind, if it was prior to our involvement, but after a referral was made, we would just complete our safety evaluation as normal.

2. **Should the parent be allowed to leave the hospital before DHS is notified?**
   A: Yes, DHS would like as much demographic information as possible, but the parent does not have to wait.

3. **What printed materials are available regarding the parent's rights and reunification with the infant? Does DHS make printed materials available?**
   A: DHS has a Safe Haven pamphlet made available for hospitals, DHS offices, etc. to be provided to the parent upon relinquishment.

4. **Does the hospital need to ensure there is no suspected harm or abuse has occurred to the infant before the parent leaves?**
   A: We would want basic questions about the infants care, but it's necessary to inquire about abuse or neglect if the infant is presenting with any injuries or concerns for neglect, such as being malnourished.

5. **If there is suspected abuse/harm/neglect and the parent leaves anonymously, what does the hospital need to do in addition to notifying the Child Abuse hotline?**
   A: Ensure the child receives medical care.

6. **What number does the hospital need to use to contact DHS if an infant is dropped off under the "Safe Haven" law?**
   A: The hotline, 1-800-522-3511.

7. **What is the average turnaround time from hospital notification to DHS that an infant has been dropped off under the "Safe Haven" law and the time DHS retrieves the infant from the hospital?**
   A: It would be assigned as a P1, I would say the initial response would be no more than 2 hours depending upon hospital location.

8. **Can a non-parent in the state of Oklahoma utilize the "Safe Haven" law? If so, is this person under the same umbrella as the parent?**
9. A: No, that person would need to contact DHS and indicate an infant was left with them that they cannot care for.

10. How does the law work?

A: The law saves babies from unsafe abandonment. It says that parents who do not harm their baby will not be prosecuted for abandonment if they hand their newborn to a responsible adult at a Safe Haven location. It gives a desperate parent a responsible alternative.

11. What do I say when I leave my baby?

A: Once you get to one of the accepted locations (Hospitals, Law Enforcement Agencies, etc.- depending on your state) You will need to relinquish your baby with one of the staff members at the location, and explain that you are relinquishing your infant to them under the Safe Haven Law. You might be asked to fill out some medical information and other important facts about your newborn, yourself, and the father, mainly for the reason of passing along any and all information that might be important to the adoptive parents for the infant. The person who you are relinquishing your baby to will make sure that the baby is unharmed in anyway, and if that is the case, then you will be free to go with no questions asked, and no trouble.

12. Can a mother or parent get baby back?

A: Safe Haven law provides an anonymous and confidential safe place for a newborn when a mother or parent is unable or unwilling to care for the baby. The intent is that a parent would not return for the newborn. If a situation does occur that a parent wishes to reclaim the baby the parent would contact Department of Child and Family Services to initiate this process and consider obtaining legal assistance to regain custody of child.

Frequently Asked Questions & Information Provided Inside

SAFE HAVEN

Oklahoma Department of Human Services

Child Welfare Services

Oklahoma Department of Human Services

Child Welfare Services

DHS Pub. No. 16-02 Rev. 05/2017
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Oklahoma Safe Haven Law

SAFE HAVEN

Oklahoma Safe Haven Law

10A O. S. § 1-2-109. Relinquishment of child 7 days or younger to medical services provider or child rescuer.

A parent shall not be prosecuted for child abandonment or child neglect under the provisions of any statute which makes child abandonment or child neglect a crime, when the allegations are based solely on the relinquishment of a child seven (7) days of age or younger to a medical services provider or a child rescuer.

"Medical services provider" means...

a person authorized to practice the healing arts, including a physician's assistant or nurse practitioner, a registered or practical nurse, and a nurse aide.

"Child rescuer" means...

any employee or other designated person on duty at a police station, fire station, child protective services agency, hospital, or other medical facility.

Does the parent have to provide any information to the medical services provider/child rescuer?

The medical services provider or child rescuer can ask for, but not demand any information about the child. This includes medical history for the child or the parent(s) of the child.

What happens to the parent(s) giving up the infant to a medical services provider/child rescuer?

A parent will not be arrested or charged for child neglect or child abandonment.

What happens to the child?

The Oklahoma Department of Human Services (DHS) will assume custody after obtaining a court order.

Can a parent(s) get the child back?

A parent(s) can ask for the child's return. The parent(s) would need to contact his or her local DHS office to begin this process. **http://www.okdhs.org**

Counseling resources are available statewide by calling 211.

The medical services provider or child rescuer will detach the family history section and provide the information to DHS.

Mother: _____

Mother Medical History: _____

Father: _____

Father Medical History: _____

Infant: _____

Date of Birth: _____

Infant Medical History: _____

Relative Information: _____

Additional Information: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Management of Acute Chest Pain and Acute Coronary Syndromes		**EMD-014**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department	**02/2020**	
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center and all medical staff, nursing staff, agency staff, and other persons performing work for or at the Hospital for the triage, assessment and initial management of patients presenting with chest pain and Non-ST-Elevation Acute Coronary Syndromes.

II. PURPOSE

Acute chest pain is one of the most common reasons patients seek treatment in the emergency department (ED). Chest pain accounts for 7.6 million ED visits annually in the United States. Serious and relative common causes of chest pain are due to acute coronary syndromes (ACS) that are the result of heart disease. Heart disease is currently the leading cause of death in the U.S. Annually 647,000 people die from heart disease accounting for 1 in every 4 deaths.

Chest pain associated with cardiac disease is often described as a vague discomfort that may not necessarily be identified as pain by the patient. Chest discomfort that may be related to ACS or another cardiac event may include but not be limited to one or more of the following:

- Pressure, fullness, burning or tightness in the chest
- Crushing or searing pain that radiates to the back, neck, jaw, shoulders, and one or both arms
- Pain that lasts more than a few minutes, gets worse with activity, goes away and comes back, or varies in intensity
- Shortness of breath
- Cold sweats
- Dizziness or weakness
- Nausea or vomiting
- Changes in vital signs (hypertension or hypotension, tachycardia, tachypnea, decreased oxygen saturation and cardiac rhythm abnormalities)

Women often present with atypical symptoms that may include but are not limited to:

- Shortness of breath
- Fatigue
- Lethargy
- Indigestion
- Back pain
- Anxiety prior to an acute MI

Risk factors for coronary artery disease (CAD) include both modifiable and non-modifiable risk factors. Non-modifiable risk factors include:

- Age: risk for developing CAD increases after the age of 35.
- Gender: men are at greater risk then women, but outcomes are worse for women.
- Ethnicity: African Americans, Hispanics, Latinos and Southeast Asians are at increased risk for CAD morbidity and mortality.
- Family history: a significant risk factor.

Modifiable risk factors have been shown to lead to significant reductions in CAD events and include:

- Hypertension: 1 out 3 patients have hypertension. Considered a major risk factor for CAD.
- Hyperlipidemia: second most common risk factor for CAD.
- Diabetes: more than 1 out of every 3 adults have prediabetes in the U.S., which puts one at risk of developing, diabetes, heart disease and stroke.
- Obesity: 69% of U.S. are either overweight or obese and at least 35% of U.S. adults are considered obese.
- Smoking: it is estimated that smoking causes approximately 800,000 deaths per year.
- Poor diet: recent studies have shown a correlation between trans-fat, soft drinks/sweetened beverages, red meat and processed meats correlate with an increased risk of cardiac events.
- Sedentary lifestyle: exercise has a protective effect against CAD and a lack a physical exercise increases the risk of CAD.

The purpose of this policy is to optimize the triage, assessment and management of patients presenting to Mangum Regional Medical Center emergency department by:

- Standardizing the care of patients who present with chest pain suggestive of a coronary event.
- To rapidly identify, stabilize and transfer patients presenting with a Non-ST Elevation Myocardial Infarction (NSTEMI) or ST-Elevation Myocardial Infarction (STEMI).
- Treat acute life-threatening complications of acute coronary syndromes including but not limited to ventricular fibrillation (VF), pulseless ventricular tachycardia (VT), unstable

tachycardias, symptomatic bradycardias, pulmonary edema, and cardiogenic shock utilizing the ACLS Acute Coronary Syndromes Algorithm (See Attachment A).

III. DEFINITIONS

A. **Acute Coronary Syndrome (ACS):** refers to a group of clinical symptoms associated with a sudden, reduced, blood flow to the heart. Includes unstable angina (UA), Non-ST-Elevation myocardial infarction (NSTEMI) and ST-Elevation myocardial infarction (STEMI).

B. **Stable Angina:** also known as "effort angina" refers to chest pain that occurs with some form of activity or with minimal or no symptoms at rest after the administration of sublingual nitroglycerin.

C. **Unstable Angina (UA):** refers to symptoms that are due to impaired blood flow within the coronary arteries that is inadequate to meet metabolic demands but does not result in actual cell death and without elevated cardiac troponin levels. The typical classifications include:

- Prolonged >20 minutes angina at rest
- New onset of severe angina
- Anginal symptoms occurring at rest or with minimal activity
- Symptoms occurring with increasing frequency (also known as crescendo angina), that require less exertion than previously to provoke, or more nitroglycerin to alleviate than before, longer in duration, lower in threshold, or that occurs after a recent episode of myocardial infarction.

D. **Non-ST-Elevation Myocardial Infarction (NSTEMI):** refers to symptoms that are characteristic of persistent elevation of cardiac troponin levels and myocardial cell death in the absence of diagnostic criteria for STEMI.

E. **ST-Elevation Myocardial Infarction (STEMI):** symptoms characteristic of cardiac ischemia due to complete occlusion of a coronary artery with persistent ST segment elevation (>1mm in two or more leads) or a new left bundle branch block (LBBB) on electrocardiography (ECG).

IV. POLICY

The approach to the management and treatment of patients presenting to the ED with complaints of chest pain is multidisciplinary. All patients who present to the ED with complaints of chest pain will be immediately triaged by nursing staff using the Emergency Severity Index (ESI) Algorithm (See Policy Attachment EMD-006A) to determine the severity of the patient's illness and assign a triage level. If the patient's chest pain is determined to be of cardiac origin an ECG will be obtained within 5 minutes of the patient's arrival. Nursing staff will immediately notify

the provider on-call of cardiac chest pain in the ED. ECG results will be provided to the provider upon arrival in the ED.

An initial comprehensive evaluation including interpretation of the ECG will be performed by the provider within 15 minutes of the patient's arrival in the ED. If a STEMI or NSTEMI is suspected emergency medical service (EMS) or Air Evac will be immediately notified by hospital staff for emergent transfer to a higher-level medical center.

V. PROCEDURE

A. Triage

1. All patients who present to the ED with complaints of chest pain will be **immediately** triaged using the ESI Algorithm and according to the Triage using the Emergency Severity Index Policy EMD-006.
    i. Patients presenting to the ED with complaints of chest pain or discomfort suggestive of ACS should be given a high priority at triage.
    ii. Nursing staff should determine date and time of onset of chest pain and document in patient's medical record.
    iii. The triage assessment and triage level must be documented in the appropriate area of the electronic medical record, including the date and time the assessment was completed.
2. Provider will be immediately notified of patient's arrival in the ED (if not in the ED).
3. An initial ECG will be obtained within 5 minutes of the patient's arrival during triage.
    i. The report will be provided to the provider and interpreted within 15 minutes of the patient's arrival.
    ii. If ECG show persistent ST elevation >1mm, new LBBB or ST depression hospital staff should immediately notify emergency medical services (EMS) or Air Evac of need for emergent transfer.
4. Nursing staff can initiate the Chest Pain/Acute Coronary Syndromes Protocol (see Attachment C) for any patients with suspected cardiac related chest pain.

B. Assessment

1. Nursing staff should complete a full nursing assessment, obtain a complete set of vital signs (HR, BP, RR, Temp, O2 sat), place the patient on continuous cardiopulmonary and pulse oximetry.
2. Nursing staff should perform a comprehensive pain assessment, including assessment of pain level using one of the approved pain scales. (see policy NUR-019 Pain Screening, Assessment and Management).
    i. Nursing staff will document at minimum the following:
        a. Character of pain

b. Pain intensity by patient self-report when possible.
c. Time of onset.
d. Duration.
e. Location.
f. Radiation.
g. Aggravating factors.
h. Alleviating factors.

3. Providers will perform a comprehensive evaluation within 15 minutes of the patient's arrival. This evaluation will include at a minimum the following components:
   i. History of Present Illness
      a. Pain: character of pain, onset, duration, timing of recurrent episodes, location, radiation, aggravating/alleviating factors.
      b. Associated symptoms: dyspnea, tachypnea, presyncope/syncope, nausea/vomiting, diaphoresis.
   ii. Past History
      a. Such as ischemic or other heart disease, diabetes, hypertension, smoking, high cholesterol, peripheral or cerebral artery disease, venous thromboembolism (VTE), pulmonary disease, upper gastrointestinal disease.
   iii. Medications & Allergies
      a. All meds but focused on antiplatelets, anticholesterol, calcium channel blockers, ACE inhibitors, angiotension II receptor blockers (ARBs), beta blockers, nitrates, antiarrhythmics, anticoagulants, phosphodiesterase inhibitors (i.e., Viagra®, Cialis®, and Revatio®).
   iv. Review of Systems
      a. Including but not limited to cardiorespiratory, neurologic or upper GI symptoms.
   v. Family History
      a. Such as ischemic heart disease, cerebrovascular accident (stroke), diabetes, sudden unexplained death, and VTE.
   vi. Social History
      a. Such as history of alcohol/recreational drug use, and smoking.
   vii. Physical Examination
      a. Provider will perform a focused evaluation of the patient looking for signs of possible congestive heart failure, valvular disease, chest wall tenderness, signs of poor peripheral or central perfusion, or other differential diagnostic considerations.

VI. MANAGEMENT OF PATIENT WITH CHEST PAIN

A. Vital signs (BP, HR, R, O2sat) will be assessed every 15 minutes and documented in the patient's medical record.
   1. Consult provider for vital signs:
      i. HR >120
      ii. SBP <90
      iii. RR >28
      iv. SaO2 <90%
   2. Document patient's height and weight

B. Place on pulse oximetry and measure SaO2. Administer supplemental oxygen to maintain oxygen saturation > 94%, for indications of respiratory distress, or other high-risk features for hypoxemia.
   1. Oxygen therapy is **not indicated** for SaO2 > 94% and may cause harm.

C. Initiate continuous cardiac monitoring, assess rhythm, and monitor for dysrhythmias.

D. Insert peripheral intravenous (IV) (18 gauge or larger) hep-lock or administer IV fluids as ordered.
   i. If IV fibrinolytics are ordered insert another peripheral IV.

E. Nursing staff will perform a complete nursing examination, including a comprehensive pain assessment that includes a pain intensity score using an approved pain scale.

F. Provider will perform a comprehensive evaluation of the patient within 15 minutes of arrival in the ED, including a comprehensive assessment of the patient's chest pain.

G. Diagnostic Imaging:
   1. An ECG will be obtained within 5 minutes of patient arrival in the ED by nursing staff.
      i. Report will be interpreted by the provider within 15 minutes of the patient's arrival in the ED.
      ii. Perform ECG at 15 to 30-minute intervals depending on patient status.
      ii. Interpretation of the report will be documented in the patient's medical record by the provider.
   2. A Chest x-ray will be obtained and interpreted within 30 minutes of patient arrival in the ED
   3. Additional diagnostic imaging to be obtained may include (if indicated):
      i. CT Chest/Thorax with contrast to rule out pulmonary embolism and aortic dissection.

H. Laboratory:
   1. The following labs should be obtained:
      i. ABG

ii. BNP
iii. CBC with differential
iv. CK Total
v. CK MB
vi. CMP
vii. CRP
viii. D-Dimer
ix. Fibrinogen
x. Magnesium
xi. Phosphorus
xii. PT/INR
xiii. PTT
xiv. Troponin-I
    a. Serial Troponin-I will be obtained at presentation and at 3 and 6 hours for all patients who present with symptoms consistent with ACS.
    b. Additional Troponin-I levels will be obtained beyond 6 hours in patients with normal troponins on serial examination when ECG changes and/or clinical presentation identify a suspicion for ACS.
xv. Urinalysis

I. NSTEMI/Unstable Angina (See Chest Pain/Acute Coronary Syndrome Protocol Attachment B)
1. NSTEMI
    i. Notify EMS/Air Evac for emergent transfer to higher-level medical center.
        a. Hospital staff should request an expected estimated time of arrival (ETA) from EMS/Air Evac dispatch. This time should be documented in the patient's medical record.
    ii. Perform serial ECG every 15 minutes. Place report in patient's medical record. Provider will document interpretation in patient's medical record.
    iii. See Chest Pain/Acute Coronary Syndrome Protocol for additional management.
2. Unstable Angina
    i. After full evaluation provider will make disposition determination (i.e. transfer, observation, or discharge).
    ii. Perform serial ECG every 15 to 30 minutes. Place report in patient's medical record. Provider will document interpretation in patient's medical record.
    iii. See Chest Pain/Acute Coronary Syndrome Protocol for additional management.

J. STEMI (See STEMI Protocol Attachment C)

1. Notify EMS/Air Evac for emergent transfer to a higher-level medical center.
2. Fibrinolytic therapy will be given to patients with STEMI and onset of ischemic symptoms within the previous 12 hours if the patient cannot be transferred to a higher-level medical center for a primary percutaneous coronary intervention (PCI) within 120 minutes (ACCF/AHA Guidelines, 2013).
3. Provider will perform a full evaluation including interpretation of the ECG to determine diagnosis of STEMI. If STEMI is identified the provider will determine the patient's eligibility for fibrinolytic therapy.
    i. Documentation of interpretation of the ECG and patient's eligibility for fibrinolytic therapy will be documented in the patient's medical record.
4. Risks and benefits of fibrinolytic therapy will be discussed with patient and/or patient representative by provider.
    i. Documentation of risks and benefits will be documented in the patient's medical record.
5. Fibrinolytic therapy will be administered within 30 minutes of patient arrival for patients determined to be eligible for treatment. See STEMI Protocol for administration and management of fibrinolytic therapy (ACCF/AHA Guidelines, 2013).

K. Medication Management

(See appropriate protocol for full medication management)

1. Nitrates
    i. Administer sublingual nitroglycerin every 5 minutes x 3 for continuing chest pain and then assess need for IV nitroglycerin (AHA, Guidelines, 2014).
    ii. Administer IV nitroglycerin for persistent ischemia, heart failure or hypertension (AHA Guidelines, 2014).
    iii. **Nitrates are contraindicated with recent use of a phosphodiesterase inhibitor (i.e., Viagra®, Cialis®, and Revatio®)** (AHA Guidelines, 2014)**.**
2. Pain Management
    i. IV morphine sulfate may be reasonable for continued ischemic chest pain despite maximally tolerated anti-ischemic medications (AHA Guidelines, 2013).
    ii. NSAIDS are contraindicated (except Aspirin) and should be discontinued during hospitalization (AHA Guidelines, 2013).
3. Anti-platelets
    i. Non-enteric-coated chewable Aspirin (162-324 mg) should be given to all patients with Non-ST-elevation ACS without

contraindications as soon as possible after presentation to the ED (AHA Guidelines, 2013).

ii. In patients with Non-ST-elevation ACS who are unable to take Aspirin due to a hypersensitivity or major gastrointestinal intolerance, a loading dose of (300-600 mg) of Clopidogrel should be given (AHA Guidelines, 2013).

iii. For STEMI patients receiving fibrinolytic therapy Aspirin (162-324mg loading dose) and Clopidogrel (300mg loading dose) for patients ≤75 years of age or 75mg dose for patients ≥75 years of age (ACCF/AHA Guidelines, 2013).

4. Anticoagulants
   i. In patients with Non-ST-elevation ACS anticoagulation in addition to antiplatelet therapy is recommended for all patients regardless of treatment strategy (AHA Guidelines, 2014).
   ii. Patients with STEMI undergoing reperfusion with fibrinolytic therapy should receive anticoagulant therapy for a minimum of 48 hours (ACCF/AHA Guidelines, 2013).
5. Beta Blockers
   i. Oral beta blockers may be initiated within the first 24 hours for patients with Non-ST-elevation ACS or STEMI who do not have the following contraindications:
      a. Signs of heart failure
      b. Low-output state
      c. Increased risk of cardiogenic shock
      d. Contraindications to beta blockade (i.e. PR interval >0.24 seconds, 2nd or 3rd degree heart block without a pacemaker, active asthma, or reactive airway disease)

      (AHA Guidelines, 2014; ACCF/AHA Guidelines, 2013).
   ii. In patients with Non-ST-elevation ACS and risk factors for shock administration of IV beta blockers is potentially harmful. (AHA Guidelines, 2014).
   iii. For patients with STEMI it is reasonable to administer IV beta blockers for when the patient is hypertensive or has ongoing ischemia and no contraindications (ACCF/AHA Guidelines, 2013).

VI. EDUCATION AND TRAINING

All hospital staff will be required to have orientation and on-going education and competency for chest pain and acute coronary syndromes that includes the following:

- Management and treatment of chest pain and acute coronary syndromes
- Management and treatment of STEMI
- Hospital Protocols including Chest Pain/Acute Coronary Syndrome and STEMI

- Fibrinolytic Therapy for STEMI

All nursing staff will also be certified in BCLS and ACLS according to the American Heart Association (AHA) standards of training. All clinical staff are required to have BCLS certification.

VII. QUALITY MONITORING

Hospital leadership including but not limited to, the Chief Clinical Officer (CCO) are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Clinical Officer and an incident report are completed.

The Quality Department will track and report the following data:

1. EMS/Air Evac notification of emergent transfer for NSTEMI or STEMI patients within 20 minutes of patient arrival.
2. Transfer of NSTEMI or STEMI patient to a higher-level medical center within a target goal of 60 minutes of patient arrival.
3. Completion of an appropriate MSE by the provider within 15 minutes of patient arrival.
4. Completion of an ECG within 5 minutes of patient arrival.
5. Completion of a Chest x-ray within 30 minutes of patient arrival.
6. Fibrinolytic therapy administered within 30 minutes of patient arrival for eligible patients.

Each Chest Pain/ACS/STEMI will be evaluated by the Quality Manager using the Cardiac Chest Pain/ACS/STEMI Outcome Review Form (see Attachment E). All cardiac chest pain events reviewed by the QM will be forwarded and reviewed by the CCO to determine compliance with hospital policy and procedure.

VII. REFERENCES

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VIII. ATTACHMENTS

Attachment A: 2020 ACLS Acute Coronary Syndromes Algorithm
Attachment B: Chest Pain/Acute Coronary Syndromes Protocol
Attachment C: STEMI Protocol
Attachment D: ECG Screening Criteria
Attachment E: Fibrinolytic Therapy Indications/Contraindications Checklist
Attachment F: TNKAse Dosing Instructions

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Acute Coronary Syndromes Algorithm

ACLS Training Center®
ACLS Online Since 1998

Syndromes Suggestive of Ischemia or Infarction

EMS assessment and care and hospital preparation*

- Aspirin 160–325 mg
- O_2 Oxygen (If O_2 sat< 94% or O_2 Sat>90% with COPD)
- 12–Lead ECG
- Activate Cardiac Cath Lab
- Pain Control

Concurrent ED assessment (<10 minutes)

- Check Vital Signs
- IV Access
- Physical Exam
- Activate Cardiac Cath Lab
- Cardiac Marker Levels
- Chest X-ray (<30 mins)
- 12–Lead ECG

Immediate ED general treatment

- O_2 If O2 sat<94% Start Oxygen
- Aspirin 160–325 mg (If not already taken)
- Pain Control
- Nitroglycerin Sublingual or spray

ECG Interpretation**

ST-elevation MI (STEMI)

Start adjunctive therapies as indicated

Do not delay reperfusion

Time from onset of symptoms ≤ 12 hours?

- >12 hours → Troponin elevated or high-risk patient
- ≤12 hours

Reperfusion goals:

Door-to-balloon inflation (PCI)*** goal of 90 minutes

Door-to-needle (fibrinolysis) goal of 30 minutes

High-risk unstable angina/non-ST-elevation MI (UA/NSTEMI)

Troponin elevated or high-risk patient

Consider early invasive strategy if:

- Refractory ischemic chest discomfort
- Recument/persistent ST deviation
- Ventricular tachycardia
- Hemodynamic instability
- Signs of heart failure

Start adjunctive treatments as indicated

- Nitroglycerin
- Heparin (UFH or LMWH)
- Consider: PO β-blockers
- Consider: Clopidogrel
- Consider: Glycoprotein IIb/IIIa inhibitor

Admit to monitored bed Assess risk status Continue ASA heparin, and other therapies as indicated

ACE inhibitor/ARB; HMG CoA reductase inhibitor (statin therapy)

Not at high risk: cardiology to risk stratity

Low-/Intermediate-risk ACS

Consider admission to ED chest pain unit or to appropriate bed and follow:

- Serial cardiac markers (including troponin)
- Repeat ECG/continuous ST-segment monitoring
- Consider noninvasive diagnostic test

Develops 1 or more:

- Clinical high-risk features
- Dynamic ECG changes consistent with ischemia
- Troponin elevated

Y → Troponin elevated or high-risk patient

N

Abnormal diagnostic noninvasive imaging or physiologic testing?

Y → Admit to monitored bed Assess risk status Continue ASA heparin, and other therapies as indicated

N

If no evidence of ischemia or infarction by testing, can discharge with follow-up

* O'Connor RE, Brady W, Brooks SC, Diercks D, Egan J, Ghaemmaghami C, Menon V, O'Neil BJ, Travers AH, Yannopoulos D. "Part 10: acute coronary syndromes: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care". Circulation. 2010;122(suppl 3):S787-S817. http://circ.ahajoumals.org/content/122/18_suppl_3/S787

**Afolabi BA, Novaro GM, Pinski SL, Fromkin KR, Bush HS. Use of the prehospital ECG improves door to balloon times in ST segment elevation myocardial infarction irrespective of time of day or day of week. Emerg Med J. 2007;24:588-591

*** O'Connor, RE AL, Ali, Brady , WJ, Ghaemmaghami CA, Menon V, Welsford M, Shuster M. Part 9: acute coronary syndromes: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation 2015;132(suppl2):S483-S500

Version control: This document is current with respect to 2015 American Heart Association Guidelines for CPR and ECC. These guidelines are current until they are replaced on October 2020. If you are reading this page after October 2020, please contact ACLS Training Center at support@acls.net for an updated document. Version 2018.10.a

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center
CHEST PAIN/ACUTE CORONARY SYNDROME PROTOCOL

******All Items With a Box Must Be Checked by the Provider******

Date:		**Time:**		Allergies:
Patient Name:				

PROTOCOL ORDERS

1. ***Nursing Orders:***

a) Triage immediately, complete comprehensive pain assessment and document time of onset

b) Notify provider of chest pain immediately

c) Initiate continuous cardiac monitoring, assess rhythm and monitor for dysrhythmias

d) Vital signs with pulse oximetry every 15 minutes notify provider of:
- HR >120
- SBP <90
- RR >28
- SaO2 <90%

e) Document patient's height and weight

f) Evaluate for pulmonary hypertension and erectile dysfunction medication (e.g., Viagra®, Cialis®, and Revatio®)

f) Initiate O2 at 2-4L per nasal cannula if O2 sat <94%

g)Insert large gauge peripheral IV hep-lock Sodium Chloride 0.9% flush prn for line patency

Diagnostics

2. STAT 12 Lead ECG within 5 minutes of patient arrival

3. STAT Chest X-ray AP (1 view)

□ CT Chest/Thorax with contrast to rule out PE

Laboratory

ABG	BNP	CK Total	CK MB
CBC with differential	D-Dimer	CMP	CRP
Fibrinogen	Magnesium	Phosphorus	PT/INR
PTT	Urinalysis	Serial Troponin-I on arrival, 3 hr and 6 hr	

Medication

4. ***Nitrates***

□ Nitroglycerin 0.4mg sublingually every 5 minutes x 3 for chest pain

□ Nitroglycerin 25mg/250mL premix initiate at 5mcg/min and titrate by 5mcg/min every 3 minutes until chest pain is relieved or SBP less than 130

5. ***Antiplatelets and Anticoagulants***
- STAT Aspirin 324mg PO x1 (give four 81mg chewable tablets)

□ Clopidogrel (Plavix®) 300mg PO x 1

□ Lovenox® 1mg/kg subcutaneous x1 (Max dose 100mg)

□ Heparin 60 units/kg IV push x 1 (not to EXCEED 5000 units)

□ Heparin infusion (start at 12 units/kg/hr – refer to Heparin Protocol)

6. ***Pain Management***

□ Morphine 2mg IV push x 1

□ Morphine 4mg IV push x 1

□ Hydromorphone 1mg IV push x 1

7. ***Anti-emetics:***
□ Odansetron 4 mg IV push x 1
□ Odansetron 4mg ODT x 1
□ Promethazine 24 mg IM x 1
□ Promethazine 50mg IM x 1
□ Metoclopramide 10 mg IV push x 1
□ Pantoprazole 40mg IV push x 1
□ GI Cocktail PO x 1
8. ***IV Fluids***
□ Sodium Chloride 0.9% 1000mL 999mL/hr bolus
□ Sodium Chloride 0.9% 1000mL _____mL/hr
ADDITIONAL ORDERS

Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center
STEMI PROTOCOL

******All Items With a Box Must Be Checked by the Provider******

Date:		**Time:**		Allergies:
Patient Name:				

PROTOCOL ORDERS			
1. ***Nursing Orders:***			
a) Triage immediately, complete comprehensive pain assessment and document time of onset			
b) Immediately notify EMS/Air Evac of emergent transfer, document estimated time of arrival in patient's medical record.			
c) Notify provider of chest pain immediately Time of arrival:			
d) Initiate continuous cardiac monitoring, assess rhythm and monitor for dysrhythmias			
e) Vital signs with pulse oximetry every 15 minutes notify provider of: • HR >120 • SBP <90 • RR >28 • SaO2 <90%			
f) Document patient's height and weight			
g) Evaluate for pulmonary hypertension and erectile dysfunction medication (e.g., Viagra®, Cialis®, and Revatio®)			
h) Initiate O2 at 2-4L per nasal cannula if O2 sat <94%			
i) Insert 2 large gauge peripheral IVs hep-lock Sodium Chloride 0.9% flush prn for line patency			
Diagnostics			
2. STAT 12 Lead ECG within 5 minutes of patient arrival			
3. STAT Chest X-ray AP (1 view)			
□ CT Chest/Thorax with contrast to rule out PE			
Laboratory			
ABG	BNP	CK Total	CK MB
CBC with differential	D-Dimer	CMP	CRP
Fibrinogen	Magnesium	Phosphorus	PT/INR
PTT	Urinalysis	Serial Troponin-I on arrival, 3 hr and 6 hr	
Medication			
4. ***Nitrates***			
□ Nitroglycerin 0.4mg sublingually every 5 minutes x 3 for chest pain			
□ Nitroglycerin 25mg/250mL premix initiate at 5mcg/min and titrate by 5mcg/min every 3 minutes until chest pain is relieved or SBP less than 130			
5. ***Antiplatelets and Anticoagulants***			
• STAT Aspirin 324mg PO x1 (give four 81mg chewable tablets)			
□ Clopidogrel (Plavix®) 300mg PO x 1			
□ Lovenox® 1mg/kg subcutaneous x1 (Max dose 100mg)			
□ Heparin 60 units/kg IV push x 1 (not to EXCEED 5000 units)			
□ Heparin infusion (start at 12 units/kg/hr – refer to Heparin Protocol)			
6. ***Pain Management***			
□ Morphine 2mg IV push x 1			

□ Morphine 4mg IV push x 1
□ Hydromorphone 1mg IV push x 1
7. ***Anti-emetics:***
□ Odansetron 4 mg IV push x 1
□ Odansetron 4mg ODT x 1
□ Promethazine 24 mg IM x 1
□ Promethazine 50mg IM x 1
□ Metoclopramide 10 mg IV push x 1
□ Pantoprazole 40mg IV push x 1
□ GI Cocktail PO x 1
8. ***IV Fluids***
□ Sodium Chloride 0.9% 1000mL 999mL/hr bolus
□ Sodium Chloride 0.9% 1000mL _____mL/hr
9. ***Fibrinolytic Therapy*** ****only to be administered to patients who presented within 12 hours from time of onset and cannot be transferred within 120 minutes of arrival****
□ TNKase® IV push over 5 seconds x1 (See TNKase Dosing Instructions)
□ Alteplase IV bolus 15mg x1, 0.75mg/kg for 30 minutes (max 50mg), then 0.5mg/kg (max 35mg) over next 60 minutes; total dose not to exceed 100mg
ADDITIONAL ORDERS

Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

Chest Pain = Immediate ECG (5 minutes or less) for any patient who presents to the ED that is:

- ***Less than 30 years of age with any of the following:***
  - Chest discomfort with recent cocaine use
  - Chest discomfort with congenital heart disease
  - Chest discomfort with prior stent placement/cardiac surgery

- ***Greater than 30 years of age with any of the following:***
  - Non-traumatic chest discomfort now, or prior to arrival (may be pressure, aching, tightness, heaviness, burning, sharp, stabbing, pleuritic)
  - Chest discomfort with recent cocaine use
  - Shortness of breath
  - Non-traumatic arm, shoulder or jaw pain
  - Dizziness/near syncope
  - Palpitations

- ***Greater than 50 years of age with any of the following:***
  - Nausea/vomiting
  - Upper abdominal pain
  - Weakness

- Any patient with symptoms you think may be cardiac in origin

- Any patient with a recent history of having a coronary stent placed (Less than 9 months)

MUST HAVE AN IMMEDIATE ECG PERFORMED AND HANDED TO THE PROVIDER!!!

Maame Yaa, A.B. MD, et al. (2017). Performance of emergency department screening criteria for an early ECG to identify ST-segment elevation myocardial infarction. Journal of American Heart Association. [Electronic Version]. Retrieved on 08/13/20 from https://www.ahajournals.org/doi/full/10.1161/jaha.116.003528

Fibrinolytic Therapy
Indications and Contraindications

Indications		Yes	No
Ischemic symptoms < 12 hours			
Evidence of ongoing ischemia 12 to 24 hours after symptom onset and a large area of myocardium at risk of hemodynamic instability			
ECG showing **ANY** of the following:	ST depression, except if true posterior (inferobasal) MI is suspected or when associated with ST elevation in lead aVR		
	Ischemic ST elevation (>1mm) in 2 or more contiguous leads		
	Hyperacute T waves		
	Signs of acute posterior MI or LBBB obscuring ST segment analysis with MI history		
History of acute coronary syndrome			
Pain/symptoms within the past 24 hours with or without ongoing symptoms			
Absolute Contraindications		**Yes**	**No**
Any prior intracranial hemorrhage			
Ischemic stroke within 3 months (except acute ischemic stroke within 4.5 hours)			
Known intracranial neoplasm			
Known structural cerebral vascular lesion (i.e. AVM)			
Active internal bleeding (does not include menses)			
Suspected aortic dissection			
Significant closed head or facial trauma within 3 months			
Intracranial or intraspinal surgery within 2 months			
Severe uncontrolled hypertension (unresponsive to emergency therapy)			
Cautions and Relative Contraindications		**Yes**	**No**
History of chronic, severe, poorly controlled hypertension			
Significant hypertension on presentation (SBP >180mmHg or DBP >110mmHg)			
History of prior stroke > 3 months			
Known intracranial pathology not covered in absolute contraindications			
Current warfarin therapy (INR > 2 – 3)			
Known bleeding diathesis			
Current therapy with direct oral anticoagulant (DOAC)			
Traumatic or prolonged (> 10 minute) CPR			
Dementia			
Known intracranial pathology not covered in absolute contraindications			
Major surgery (> 3 weeks)			
Recent (within 2-4 weeks) internal bleeding			
Non-compressible vascular punctures			
Pregnancy			
Active peptic ulcer			
Age > 75 years			

Conclusion: Must choose one

□ Patient meets criteria for Fibrinolytic Therapy with (TNKase / Alteplase)

□ Patient does not meet criteria for Fibrinolytic Therapy

Comments:

MD/LIP Signature: _____

Date/Time: _____/_____/_____ **:**

TNKase Dosing Instructions

(see STEMI Protocol for management)

Weight (in Kg)	Dose (IV bolus over 5 seconds)	Notes	Indications	Contraindications
< 60	30mg	***Do not give if GPI (GP IIb/IIIa inhibitor) was given*** (i.e. abciximab, eptifibatide, or tirofiban) Also begin Enoxaparin with TNKase bolus	- Ischemic symptoms < 12 hours - Evidence of ongoing ischemia 12 to 24 hours after symptom onset and a large area of myocardium at risk of hemodynamic instability ECG showing **ANY** of the following: - ST depression, except if true posterior (inferobasal) MI is suspected or when associated with ST elevation in lead aVR - Ischemic ST elevation (>1mm) in 2 or more contiguous leads - Hyperacute T waves - Signs of acute posterior MI or LBBB obscuring ST segment analysis with MI history - History of ACS - Pain/symptoms within the past 24 hours with or without ongoing symptoms	- Any prior intracranial hemorrhage - Ischemic stroke within 3 months (except acute ischemic stroke within 4.5 hours) - Known intracranial neoplasm - Known structural cerebral vascular lesion (i.e. AVM) - Active internal bleeding (does not include menses) - Suspected aortic dissection - Significant closed head or facial trauma within 3 months - Intracranial or intraspinal surgery within 2 months - Severe uncontrolled hypertension (unresponsive to emergency therapy)
60 - 69	35mg			
70 - 79	40mg			
80 - 89	45mg			
>90	50mg			

Cautions and relative contraindications:

- Severe, uncontrolled hypertension on presentation (>180/110mmHg) or history of chronic severe hypertension
- History of prior stroke > 3 months
- Known intracranial pathology not covered in absolute contraindications
- Current warfarin therapy (INR > 2 – 3); known bleeding diathesis
- Current therapy with direct oral anticoagulant (DOAC)
- Recent trauma, prolonged CPR (> 10 minutes), or major surgery (< 3 weeks)
- Non-compressional vascular punctures
- Recent (within 2 – 4 weeks) internal bleeding
- Age > 75 years
- Pregnancy
- Active peptic ulcer

Kushner, F.G. MD, et. al. (2013). 2013 ACCF/AHA Guidelines for the management of ST-elevation myocardial infarction. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Journal of American College of Cardiology (61) 4 e78-140 [Electronic Version] Retrieved on 08/10/20 from https://www.onlinejacc.org/content/61/4/e78

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
EMTALA – Medical Screening and Treatment of Emergency Medical Conditions		**EMD-015**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center and any entities operating under the Hospital's Medicare Provider Number including, but not limited to, the following:

- All Clinical Departments
- Administration
- Ancillary Departments
- Quality/Risk Management
- Admitting/Registration
- Employed Physicians
- Emergency Department
- Hospital owned Medical Office Buildings
- Hospital owned Clinics
- Billing Finance

II. PURPOSE

The intent of this policy is to set forth policies and procedures for the Hospital's use to ensure compliance with the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C., Section 1395 and all Federal regulations and interpretive guidelines promulgated thereunder.

III. DEFINITIONS

A. **Appropriate Transfer:** is accomplished (once a physician has certified the need for transfer or the patient has requested transfer after an explanation of the risks and the Hospital's obligation to provide stabilizing services) when:

1. The transferring Hospital has provided medical care and treatment within its capability and capacity and minimized the risks to the individual's health and in the case of a woman in labor, the health of the unborn child.

2. The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical care and treatment.
3. The transferring Hospital sends to the receiving Hospital all medical records related to the emergency medical condition (EMC) for which the individual presented, available at the time of transfer, including records related to the EMC, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of diagnostic studies (or telephone reports), and the informed written consent or certification required, and any other records that are not readily available at the time of transfer are sent as soon as practicable after the transfer; and
4. The transfer is effected through qualified personnel, transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

B. **Capability of Hospital:** means the physical space, equipment, supplies, services provided, and the level of care provided by Hospital personnel within the training and scope of their professional licenses/certifications.

C. **Capacity of Hospital:** means the ability of the Hospital to accommodate a patient, including the number and availability of qualified staff, beds, equipment, and the Hospital's past practices of accommodating patients in excess of occupancy limits. For example, if the Hospital in the past has called in additional staff or moved patients to other units (areas), these factors will be considered in the definition of the Hospital's capacity.

D. **Central Log:** is a log that a Hospital is required to maintain on each individual who comes to the emergency department or any location on Hospital property seeking assistance. The Log must contain at a minimum the disposition of each individual, whether he/she refused treatment, was refused treatment, or whether he/she was transferred, admitted and treated, stabilized and transferred or discharged. The purpose of the central log is to provide a listing of each individual who comes to the DED or onto Hospital property seeking examination or treatment for a potential EMC.

E. **Certification of False Labor:** A physician or Qualified Medical Provider (QMP) diagnoses after a reasonable period of observation that a woman is in "false labor" and certifies the diagnosis prior to discharge.

F. **"Comes to the Emergency Department":** for purposes of this policy, an individual is deemed to have "come to the emergency department" if the individual:
1. Presents at the dedicated emergency department (DED), and requests an exam or treatment for what may be an EMC, or has such a request made on his/her behalf. In the absence of such request by or on behalf of the individual, a request on behalf of the individual should be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition; or
2. Presents on Hospital property, other than a DED, and requests an exam or treatment for what may be an EMC, or has such a request made on his/her

behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual should be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment; or

3. Is in a ground or air non-hospital-owned ambulance on Hospital property for presentation or examination for a medical condition at the Hospital's DED.

G. **"Dedicated Emergency Department" (DED):** is defined as any department or facility of the Hospital, regardless of whether it is located on or off the main Hospital, that meets at least one of the following requirements:

1. The hospital department is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or
2. The hospital department is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or
3. The hospital department during the preceding calendar year in which a determination under this Section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third (1/3) of all its outpatient visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. *This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric intake or assessment units of hospitals) where patients are routinely evaluated and treated for EMCs.*

H. **Emergency Medical Condition (EMC):** means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to: severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either:
   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
   b. Serious impairment to bodily function, or
   c. Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another Hospital before delivery, or
   b. That the transfer may pose a threat to the health and safety of the woman or her unborn child.

I. **EMTALA:** refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, which obligates hospitals to provide medical screening, stabilizing treatment, and/or transfer of patients who may have an EMC and women in labor.

J. **Hospital property:** means the entire Hospital campus, including the physical area immediately adjacent to the Hospital's main building (i.e. parking lot, sidewalks and driveways), and other areas and structures that are not attached to the Hospital's main building but are located within 250 yards of the Hospital's main building. Hospital property excludes areas or structures that are not part of the Hospital such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare.

K. **Labor:** means the process of childbirth beginning with the latent or early phase and continuing through the delivery of the placenta. A woman is in true labor unless a physician or other qualified medical person certifies, after a reasonable period of observation that she is in false labor. Certification of false labor by a non-physician (i.e. physician assistant, nurse practitioner, or qualified nurse) requires physician certification.

L. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an EMC does or does not exist.

M. **Medical Transport:** preferred medical transport includes ambulance, helicopter and wheelchair van.

N. **Obstetrical emergency:** refers to a pregnant woman who is having contractions and;

1. There is inadequate time to affect a safe transfer to another hospital before the patient's delivery; or
2. That transfer pay pose a threat to the health or safety of the woman or unborn child.

O. **Physician Certification:** refers to the pre-transfer written certification by the physician ordering the transfer, that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk of transfer to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer. The certification should include a summary of the risks/benefits upon which the certification is based and the reason(s) for transfer. If a physician is not physically present at the time of transfer, a qualified QMP may sign the certification in consultation with the transferring physician. The consulting physician must countersign the certification within seventy-two (72) hours of the transfer.

P. **Prudent Layperson:** means any non-medical but reasonable attentive observer.

R. **Psychological/Psychiatric emergency:** refers to medical conditions including but not limited to: history of drug ingestion in a comatose or impending comatose conditions; depression with feeling of suicidal ideations or attempts; history of suicidal attempt or suicidal ideation; history of recent physical aggressiveness, self-harming or destructive behavior; delusions, severe insomnia or helplessness; inability to maintain nutrition in a person with altered mental status; impaired reality testing accompanied by disordered behavior; impending DTs or acute intoxication; seizures (withdraw or toxic); a patient expressing suicidal or

homicidal thought or gestures, if determined to be dangerous to self or others, any of these psychiatric conditions would be considered an EMC.

S. **Qualified Medical Person (QMP):** means an individual, other than a licensed physician, who is designated by the Medical Staff Bylaws or rules and regulations (and consistent with state licensure) as qualified to administer one or more types of MSEs and/or complete and sign a transfer certification in consultation with a physician in a Hospital document that is approved by the Medical Staff Committee and Governing Board.

T. **Stabilize:** means in relation to an EMC:
   1. that no material deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility; or
   2. that the woman has delivered the child and the placenta.

U. **To Stabilize:** means in relation to an EMC:
   1. to provide such medical treatment of the patient's condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely from or occur during the transfer of the individual from a facility; or
   2. that the woman has delivered the child and placenta.

V. **Stable for Discharge:** means:
   1. the physician has determined, within reasonable clinical confidence, the patient has reached a point where his/her continued medical treatment, including any diagnostic work-up or treatment, could reasonably be performed as an out-patient or later as an in-patient, as long as the patient is given a plan for appropriate follow-up care with discharge instructions; or
   2. the patient with a psychiatric condition has been determined to no longer be a threat to himself/herself or others.
   3. Stable for Discharge does not require resolution of the EMC. The patient is never considered stable for discharge if within a reasonable medical probability the patient's condition would materially deteriorate after discharge.

X. **Stable for Transfer:** between medical facilities means:
   1. The physician or QMP in consultation with the responsible physician determines, within reasonable clinical confidence, that the patient will sustain no material deterioration in his/her medical condition as a result of the transfer, and that the receiving facility has the capability to manage the EMC and any reasonably foreseeable complication; or
   2. The patient with a psychiatric condition, a physician or QMP in consultation with the responsible physician should determine the patient is protected and prevented from injuring himself/herself or others.
   3. Stable for Transfer does not require resolution of the EMC.

Y. **"Stable Patient":** means a patient for whom a physician or QMP has documented the performance of an appropriate MSE and the determination that the patient did not present with an EMC, or the patient's EMC has been stabilized.

Z. **Triage:** entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other QMP.

AA. **"Unstable Patient":** means a patient who has an EMC that has not been stabilized.

IV. POLICY

Any individual who comes to the Hospital or on Hospital property requesting examination or treatment is entitled to and shall be provided an appropriate MSE performed by a physician or other QMP to determine whether or not an EMC exists.

If an EMC exists, the Hospital will (without regard for the patient's insurance coverage or ability to pay) provide:

- Stabilizing treatment within the capabilities and capacity of the Hospital, and/or
- An appropriate transfer to another Hospital (if required for the patient's treatment or requested by the patient).

The Hospital will not base the provision of emergency services and care upon an individual's race, ethnicity, religion, national origin, citizenship, culture, language, age, sex, pre-existing medical condition, physical or mental disability, sexual orientation, gender identity or expression, economic status, insurance status or ability to pay for medical services, except to the extent that a circumstance is relevant to the provision of appropriate medical care.

V. PROCEDURE

A. Triage and Registration

1. Triage
   a. Individuals who come to the DED should be triaged as soon as possible after arrive using the ESI triage tool in order to determine the order in which they will receive an MSE.
   b. **Triage is NOT an MSE**, as it does not determine the presence or absence of an EMC, but rather, simply determines the order in which individuals will receive an MSE.
2. Registration
   a. The Hospital will not delay the provision of an MSE or any necessary stabilizing medical examination and treatment in order to inquire about the individual's method of payment or insurance status.
      1) The Hospital may, however, follow reasonable registration processes after triage has been completed, but prior to the provision of the MSE, including asking whether an individual is insured and, if so, what the insurance is. Such processes will not unduly discourage individuals from remaining for further evaluation. Further such inquiry will not delay provision of the MSE. The collection of

insurance information will occur at times when an individual is waiting for an available exam room. Once an exam room is available, the individual will be immediately taken to the exam room to receive the MSE.

2) The Hospital will not seek authorization from the individual's insurance company for screening or stabilization services until the Hospital has provided the appropriate MSE, and initiated any further medical exam and treatment required to stabilize the individual EMC.

3) Physicians or QMPs are not precluded from contacting the individual's physician at any time to seek advice regarding medical history and needs that may be relevant to the medical treatment and screening of the individual as long as the consultation does not inappropriately delay services required.

B. Medical Screening Examination (MSE)

1. General

a. The Hospital will provide within the capability of the DED an appropriate MSE by a physician or QMP to all patients who present to the DED to determine within reasonable medical probability whether or not an EMC (including active labor) exists. The MSE and any treatment must be documented in the patient's medical record.

b. A patient who presents anywhere outside the DED and is seeking treatment for a potential EMC the patient will be immediately transported to the DED for an MSE and any necessary stabilizing treatment.

c. If an EMC does exist, Hospital staff will provide stabilizing treatment for the patient's EMC within the capability and capacity of the Hospital.

b. An appropriate MSE is tailored to each individual patient's presenting symptoms and complaints. Depending on the patient's presenting symptoms and complaints, the MSE may be a simple process involving only a brief history and physical exam or a complex process that involves ancillary studies, lab test, x-rays, and/or other diagnostic studies.

c. Patients with similar medical conditions must receive similar MSE's.

d. The medical record must reflect continued monitoring according to the patient's needs until it is determined whether or not the patient has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

e. Triage, a nursing process that, among other things, determines the order in which patients will be seen, **does not constitute a MSE**.

2. Minors

a. If a minor, or someone legally authorized to make a request on a minor's behalf, requests examination or treatment for an EMC, Hospital staff will not delay the provision of the MSE by waiting for parental consent. If a parent or other legally authorized person is present, consent should be sought. If the minor does not have an EMC, consent should be obtained in accordance with the Hospital's Informed Consent/Refusal policy.

3. Pregnant Women
   a. The MSE should include frequent and ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (i.e. ruptured, leaking, intact), as appropriate. Such additional information must be documented in the patient's medical record.
4. Behavioral Health Patients
   a. The MSE should include an assessment of but not limited to: suicide or homicide attempt or ideation/risk, orientation, assaultive, aggressive behavior that indicates a danger to self or others using the ASQ Suicide Risk Screening Tool and Brief Suicide Safety Assessment. Such additional information must be documented in the patient's medical record.

C. Presents to Dedicated Emergency Department for Non-Emergent Services
1. Scheduled Visits: If a patient presents to the DED seeking non-emergent services, the DED staff may provide such services without conducting and documenting an MSE if:
   - The patient has a documented, scheduled appointment to receive such services; and
   - The DED staff has a written or verbal order for such services; and
   - The nature of the patient's request and his/her appearance and behavior make it clear that the patient does not seek attention for a possible EMC.
2. Unscheduled Visits: If a patient presents to the DED seeking non-emergent services, but does not have a scheduled appointment and a written or verbal order for such services, a MSE is required. The physician or QMP is only required to perform an MSE that would be appropriate for any patient presenting in that manner, to determine whether an EMC exists or not.

D. Medical Screening Examinations requiring Services in Other Departments
1. The MSE may require ancillary services available in other areas of the Hospital outside of the DED. In these circumstances, the patient may be transported to such an area if:
   a. The physician or QMP determines the risk and benefits of the movement of the patient outweighs the potential for the movement to adversely affect the patient's health and safety;
   b. Patients with the same or similar medical conditions are moved to this location regardless of their ability to pay for treatment;
   c. There is a valid medical reason to move the patient; and

d. Appropriate medical personnel and/or equipment to accompany the patient, as necessary

F. Individuals Who Do Not Have an EMC
1. If a physician or QMP has determined the patient does not have an EMC after the completion of an appropriate MSE, the patient may be transferred to another medical facility (if in need of further medical treatment) or discharged.
2. The appropriate portions of the "Transfer Certificate for Stable Patients" (Attachment A) is completed if the patient is transferred to another medical facility.
3. Patients who have been determined not to have an EMC and are to be discharged must receive a follow-up care plan with written discharge instructions.
4. Pregnant Patients
   a. If after a reasonable time of observation the provider has determined the patient is in "false labor" the provider must complete the Certification of False Labor form (Attachment B).

G. Individuals Who Have an EMC
1. When the physician or QMP determines the patient has an EMC, the Hospital will:
   a. within the capability of the Hospital, stabilize the patient to the point where the patient is either stable for discharge or stable for transfer; or
   b. provide for an appropriate transfer of an unstabilized patient to another medical facility in accordance with these procedures. Transfers of unstabilized patients are allowed only pursuant to patient request, or when a physician or QMP in consultation with the responsible physician, certifies that the expected benefits to the patient from the transfer outweighs the risks of transfer; or
   c. after stabilizing the patient, admits him/her to the Hospital for further treatment.

H. Refusal of Treatment
1. Refusal of Examination or Treatment: If the Hospital offers examination and treatment and informs the patient/family/patient representative of the risks/benefits of the patient/family/patient representative refusing the examination and treatment, but the patient/family/patient representative refuses to consent to the examination and treatment, the Hospital will take all reasonable steps to have the patient/family/patient representative sign a "Refusal to Permit Further Medical Screening Examination and Treatment for Emergency Medical Condition Form" (Attachment C). The medical record must contain a description of the examination, treatment, or both, if applicable, that was proposed but refused by the patient/family/patient representative, the risks/benefits of the examination and/or treatment; the

reasons for refusal; and if the patient/family/patient representative refused to sign Attachment C, the steps taken in an effort to secure the written informed refusal. A patient who has refused medical examination and/or treatment may be transferred in accordance with the procedures set forth for patients with an unstabilized EMC.

2. Refusal of Transfer: If the Hospital offers an appropriate transfer but the patient/family/patient representative refuses the transfer, after being informed of the risks/benefits of the transfer, such refusal is considered a refusal to permit further treatment and the Hospital should take all reasonable steps to have the patient/family/patient representative sign a "Refusal of Transfer to Another Medical Facility" form (Attachment D). In addition, the medical record must contain a description of the reasons for the purposed transfer.

VI. TRANSFERS

A. Transfer or Discharge of a Stable Patient

1. A physician or QMP may discharge or transfer a stable patient from the Hospital to a receiving facility for ongoing care if ALL the following requirements have been met:
    a. The physician or QMP documents that an appropriate MSE has been completed and:
        i. The patient does not suffer from an EMC; or
        ii. The patient had an EMC, but the physician or QMP has determined with reasonable clinical confidence that the patient has been stabilized and has reached the point where his/her continued care, including diagnostic work-up, treatment, and/or other follow-up care could be reasonably performed in another facility;
    b. Hospital staff has documented in the patient's medical record the patient has received a plan for appropriate follow-up care and discharge instructions; and
    c. If a physician or QMP has determined the patient does not have an EMC after the completion of an appropriate MSE, the patient may be transferred to another medical facility (if in need of further medical treatment) or discharged.
        i. The appropriate portions of the "Transfer Certificate for Stable Patients" (Attachment A) is completed if the patient is transferred to another medical facility.

B. Discharge of Unstable Patients

1. An unstable patient **MAY NOT BE DISCHARGED** from the Hospital unless he/she leaves the Hospital against medical advice (AMA). If this should occur, Hospital staff must document the patient's informed refusal (see Refusal of Transfer section H) using the "Refusal of Transfer to Another Medical Facility" form (Attachment D).

C. Transfer of Unstable Individuals

1. When a patient has been determined to have an unstable EMC, the patient may be transferred only if the transfer is conducted in accordance with the procedures as set forth below. The patient may be transferred:
   a. Patient/Family/Patient Representative Request: a transfer may be initiated if the patient/family/patient representative is first fully informed of the risks of the transfer, the alternatives (if any) to the transfer, and the Hospital's obligations to provide further examination and treatment sufficient to stabilize the patient's EMC and provide appropriate transfer. The transfer should then occur if the patient/family/patient representative:
      1. makes a request for transfer to another medical facility, including the reason for such transfer (reason must be documented on the transfer form); and
      2. acknowledges his/her request and understanding of the risks/benefits of the transfer, by signing the "Transfer Certificate for the Unstable Patient" (Attachment E); or
   b. Physician Certification: the patient may be transferred if a physician, or if the physician is not physically present at the time of transfer, a QMP in consultation with a physician has certified the medical benefits expected from the transfer outweigh the risks. The date and time of the physician certification should closely match the date and time of the transfer. A physician certification that is signed by a non-physician QMP must be countersigned by the responsible physician within seventy-two (72) hours.
2. When the hospital transfers a patient with an un-stabilized EMC to another medical facility the transfer shall be conducted as follows:
   a. The Hospital shall, within its capability, provide medical treatment that minimizes the risks to the patient's health and, in the case of a woman who is having contractions, the health of the unborn child.
   b. A representative of the receiving hospital confirms that the receiving medical facility has available space (bed) and qualified personnel to treat the patient, has agreed to accept the transfer, to provide the appropriate medical treatment, and a physician at the receiving medical facility has agreed to accept the patient transfer; and
   c. The Hospital will document its communication with the receiving medical facility including the date and time of the transfer request(s) and the name and title of the person accepting the transfer; and
   c. Prior to transfer the Hospital will send to the receiving facility copies of all pertinent medical records available at the time of transfer including but not limited to the following:
      - Available history
      - Records related to the individuals EMC
      - Results of diagnostic tests (or telephone reports of studies)
      - Results of any tests

- Observations of signs and symptoms
- Preliminary diagnoses
- Treatment provided
- Written patient consent or physician certification to transfer

The Hospital will forward all relevant records, pending lab work and test results to the receiving facility that were not available at the time of transfer once they become available.

d. The transfer of the patient will be affected through appropriately trained professionals and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer. The physician or QMP in consultation with responsible physician is responsible for determining the appropriate mode of transport, equipment, and transporting professionals to be used for transfer.

D. Internal Procedures for Transfer

1. The physician or QMP shall:
   a. contact the receiving facility who will be responsible to assume care of the patient and assure the receiving facility has the capacity to care for the patient.
   b. document on the appropriate transfer form the name of the receiving facility, the name and title of the person accepting the transfer.
   c. write an order for transfer that will include the following:
      i. Name of designated facility
      ii. Mode of transportation
      iii. Personnel to accompany the patient
      iv. Specific equipment needs not routinely available
      v. Medical orders for care during transfer
2. Nursing staff shall:
   a. complete a nursing assessment prior to transfer, this will be documented in the patient's medical record. Vital signs will be assessed and documented within 15 minutes prior to the time of transfer.
   b. arrange transport as ordered by the physician or QMP.
   d. provide the receiving facility with a telephone report of the patient's condition.
   e. ensure the receiving facility is provided with copies of pertinent medical records that shall include but not limited to the following: appropriate EMTALA transfer form, H&P, lab work, diagnostic studies (or telephone reports), progress notes, nursing assessment/notes, medication administration records (MAR), face sheet and any data requested by the receiving physician and/or facility.
      i. Record the time of departure, mode of transfer and personnel accompanying the patient on the appropriate transfer form.

ii. Ensure the appropriate transfer form is completed prior to transfer. The original transfer form should be maintained within the patient's medical record and a copy sent with the patient to the receiving facility. In the event the copy is not sent with the patient, a completed transfer form should be faxed to the receiving facility as soon as possible. The receiving facility should be made aware via telephone that the form is being faxed.

E. Patient Transfers to the Hospital

1. The Hospital will accept an appropriate transfer of a patient with an un-stabilized EMC if it has the capacity and capabilities that are not available at the transferring facility. The Hospital must accept appropriate transfer of a patient needing care and treatment if the Hospital has capacity and capabilities to treat the patient.
2. The following Hospital personnel are authorized to accept or reject transfers from another facility on behalf of the Hospital:
    a. Emergency Department Physician
    b. Mid-Level Provider in consultation with consulting physician
    c. Chief Clinical Officer
3. Hospital personnel who accept or reject another facility's request for transfer will record the following information on the central log:
    a. Response to the request
    b. Basis for denial of such request

F. Management of Data Relevant to Transfers

1. The Hospital must maintain medical and other records related to patients who are transferred to or from another healthcare facility for a period of ten (10) years from the date of the transfer. The medical record will include the following information:
    a. Name of the patient
    b. Name of the referring physician/medical provider
    c. Name of accepting physician
    d. Time of acceptance
    e. Name of accepting facility
    f. Name of person accepting transfer
    g. Time transfer was accepted
    h. Reason for transfer
    i. Time patient left for receiving facility
    j. Initials of physician who was on call and refused or failed to appear within a reasonable period to provide treatment to stabilize the condition.
2. The following will be maintained in the patient's medical record:
    a. Transfer form, either:
        i. Transfer Certificate for Stable Patients
        ii. Transfer Certificate for Unstable Patients
    b. Refusal of Transfer to Another Medical Facility (if applicable)

G. Reporting Suspected EMTALA Violations

1. Hospital staff or employee who believes the Hospital received an inappropriate transfer from another facility in violation of the law, or the Hospital violated EMTALA, are required to report the incident to the Compliance Officer or designee, as soon as possible for investigation. If, based on the investigation, the Compliance Officer or designee, in consultation with Counsel, determines that an inappropriate transfer has been received by the Hospital, the Compliance Officer or designee shall report the transfer to CMS or the state survey agency. Reports of inappropriate transfers must be made to CMS within 72 hours of the violation.

VII. CENTRAL LOG

A. Central Log

1. The Hospital will maintain a central log on all individuals who come to the DED seeking assistance and will include the following information:
    - Patient's Name
    - Date and Time
    - Triage Level
    - Treatment received
    - Diagnosis
    - Disposition: whether patient refused treatment, was refused treatment, or was treated, admitted, stabilized and/or transferred, or discharged.
2. The log must register all patients who present for examination or treatment, even if they leave prior to triage or MSE.
3. The central log will include, directly or by reference, patient logs from other areas of the Hospital that may be considered dedicated emergency departments, such as pediatrics and labor and delivery where a patient might present for emergency services or receive an MSE instead of in the "traditional" emergency department.
4. In non-ED departments of the Hospital where an individual may present with an EMC, the department will provide the necessary information from the point of contact to the DED for documentation in the central log.
5. The Hospital will have discretion to maintain the central log in a form that best meets their needs.
6. The central log of individuals protected by EMTALA will be available within a reasonable amount of time for review and must be retained for a minimum of five years from the date of disposition of the individual.

B. Signage

1. The Hospital will post signage that, at a minimum, meets the following requirements:
    - Signage must be conspicuously posted in the DED or in a place or places likely to be noticed by all individuals entering the DED, as well as those individuals waiting for examination and treatment in

areas other than the traditional ED (i.e.: entrance, admitting area, waiting room, treatment area);
- Signage must be readable from anywhere in the area; and
- Wording of the sign(s) must be clear and in simple terms and language(s) that are understandable by the population served by the Hospital.

2. The contents of the signage must accomplish the following:
   - Specify the rights of individuals under section 1867 of the Act with respect to examination and treatment of EMCs and women in labor; and
   - Indicate whether or not the hospital participates in a Medicaid program approved under a State plan under Title XIX.
3. The signage content must include the following languages:
   - English
   - Spanish

VIII. QUALITY

A. Responsible Person
   1. The Hospital's [insert title(s)] is/are responsible for assuring that this policy is implemented and followed, and that instances of noncompliance with this policy are reported immediately to the Compliance Officer and Quality Manager.

B. Monitoring of EMTALA Compliance
   1. Any concern with compliance with this policy should be reported to Quality Assurance/Risk Management @ (580)782-3353 ext. 241:
      a. If after an investigation by [insert title] it is found that the Hospital breached the EMTALA procedure, action plans to correct and prevent other occurrences will be documented, implemented and practice monitored by Quality Assurance/Risk Management @ (580)782-3353 ext. 241
      b. The Hospital will not penalize or take adverse action against a physician or QMP because they refused to authorize the transfer of a patient with an EMC that has not been stabilized or against Hospital staff who reports a violation of this policy or EMTALA.
   2. The Hospital will monitor compliance with EMTALA and this policy; such monitoring will occur on a monthly basis.

IX. ENFORCEMENT

All Hospital and Medical staff whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, including the Medical Staff Bylaws, Rules and Regulations.

X. RECORDKEEPING

The Hospital must maintain the following:

1. Medical and other records related to patients transferred from [insert Hospital's name], for a minimum period of ten (10) years from the date of the transfer; and
2. A central log on each patient who comes to the DED seeking screening or treatment, for a minimum period of five (5) years. The log must indicate at a minimum whether the individual refused treatment or transfer, was refused treatment, or was transferred prior to stabilization, admitted and treated, stabilized and transferred, or discharged.

XI. TRAINING

All Hospital and Medical staff in the DED will be periodically trained on Mangum Regional Medical Center EMTALA obligations and this policy to ensure that Mangum Regional Medical Center EMTALA obligations are met.

XII. REFERENCES

Social Security Act § 1867

CMS State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 191, 07-19-19)

XIII. ATTACHMENTS

Attachment A: Transfer Certificate for Stable Patients
Attachment B: Certification of False Labor Form
Attachment C: Refusal to Permit Further Medical Screening Examination and Treatment for Emergency Medical Condition Form
Attachment D: Refusal of Transfer to Another Medical Facility
Attachment E: Transfer Certificate for the Unstable Patient
Attachment F: EMTALA Sign [English]
Attachment G: EMTALA Sign [Spanish]

IT IS THE LAW!

IF YOU NEED EMERGENCY MEDICAL ASSISTANCE OR IF YOU ARE PREGNANT AND HAVING CONTRACTIONS

YOU ARE ENTITLED TO RECEIVE WITHIN THE CAPABILITY OF THE HOSPITAL'S STAFF AND FACILITY:

AN APPROPRIATE MEDICAL SCREENING EXAM

APPROPRIATE MEDICAL TREATMENT TO STABILIZE YOUR MEDICAL CONDITION (INCLUDING THE DELIVER OF AN UNBORN CHILD); AND, IF NECESSARY,

AN APPROPRIATE TRANSFER TO ANOTHER FACILITY, EVEN IF YOU ARE NOT ABLE TO PAY OR DO NOT HAVE MEDICAL INSURANCE OR WERE NOT ENTITLED TO PARTICIPATE IN THE MEDICARE OR MEDICAID PROGRAMS.

THIS HOSPITAL <u>DOES</u> PARTICIPATE IN THE MEDICAID PROGRAM.

ES LA LEY!

SI USTED NECESITA ATENCION MEDICA DE EMERGENCIA O SI ESTA EMBARAZADA CON CONTRACCIONES DE PARTO

USTED TIENE DERECHO A RECIBIR, SIEMPRE Y CUANDO EL HOSPITAL CUENTE CON LAS INSTALACIONES ADECUADAS Y TENGA DISPONIBLE AL PERSONAL CALIFICADO

UN EXAMEN MEDICO ADECUADO PARA PRUEBAS DE DETECCION

TRATAMIENTO MEDICO QUE SEA NECESARIO PARA ESTABILIZAR SU CONDICION MEDICA (INCLUYENDO EL PARTO DE UN NINO NO NARCIDO AUN); Y, SI ES NECESARIO,

SER TRASLADADO APOPIADAMENTE A OTRA INSTITUCION DE ATENCION MEDICA, AUNQUE USTED NO PUEDA PAGAR O NO TENGA SEGURO MEDICO O NO TENGA DERECHO DE PARTICIPAR EN LOS PROGRAMAS DE MEDICARE O MEDICAID.

ESTE HOSPITAL <u>SI PARTICIPA</u> EN EL PROGRAMA MEDICAID.

EMTALA

TRANSFER CERTIFICATE FOR STABLE PATIENTS

(SEND COPY WITH PATIENT)

FOR UNSTABLE PATIENTS, COMPLETE
"TRANSFER CERTIFICATE FOR UNSTABLE PATIENTS"

Transfer Date:_____ Time: _____

SECTION I Physician Certification

□**STABLE FOR TRANSFER** – Based on the examination of the medical information available to me at this time, I have concluded that, as of the time of the transfer and/or discharge, the patient's emergency medical condition, if any, has been stabilized such that no material deterioration of the patient's condition is likely, within reasonable medical probability, to the result from or occur during the transfer of the patient and/or after discharge.

Reason for Transfer □ _____

□ Patient requests transfer □ Other _____

Medical Benefits of Transfer (Check all that apply)

□Necessary, staff resources, or capabilities are not available at this facility, OR

□Specialized care is not available at this facility; OR

□Other _____

All transfers have inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain, turbulence, and the limitations of equipment and personnel present in the vehicles, all of which endanger the health, medical safety, and survival of the patient(s).

I certify that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual and, in the case of labor, to the unborn child, from accepting the transfer.

Physician/Qualified Medical Person Signature:_____ Date: _____ Time: _____

Physician Countersignature, if applicable: _____ Date: _____ Time: _____

SECTION II

□ Receiving physician has agreed to accept patient transfer

Name: _____ Contact Time: _____

□ Receiving facility has agreed to accept patient transfer, provide appropriate personnel and treatment, and has available space.

Facility: _____ Contact Time: _____

Person accepting transfer _____ Title: _____

□ Receiving facility will be provided with appropriate medical/treatment information.

□ EKG □ LAB □ X-RAY/REPORT □ ED RECORD □ H&P □ OTHER (specify): _____

SECTION III Transportation

Patient will be transferred by qualified personnel and transportation equipment, as required, including the use IF necessary and medically appropriate life support measures during the transfer.

Mode of transportation/provider (check one)

□ Ambulance Service _____

□Air transport service _____

□Private vehicle _____

□Law Enforcement _____

□Other _____

Personnel to accompany patient in transfer (check all applicable)

EMS: □Basic □Intermediate □Paramedic

□Nurse

□Respiratory Therapist

□Physician

□Other _____

Primary Nurse Signature: _____

SECTION IV Patient Acknowledgement/Request – Check ONE of the following if transferred:

□**TRANSFER ACKNOWLEDGEMENT –** I understand that I have/the patient has the right to receive medical screening, examination and evaluation by a physician, or other appropriate personnel, without regard to my/the patient's ability to pay, prior to any transfer from this hospital. I have/the patient has the right to be informed of the reason(s) for any transfer. I have/the patient has, been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I acknowledge that I have/the patient has received medical screening, examination, and evaluation by a physician, or other appropriate personnel, and that I have been informed of the reason(s) for my/the patient's transfer. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

□**PATIENT REQUEST FOR TRANSFER –** I have/the patient has, requested a transfer and acknowledge that I have been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I also acknowledge the obligation of this hospital to provide such further examination and treatment, within its available staff and facilities, as may be required to stabilize my/the patient's care. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

Patient/Legally Responsible Person _____

Relationship if other than patient_____ Date: _____ Time_____

Witness_____ Title_____ Date:_____Time_____

Physician/Qualified Medical Person Signature_____ Date:_____Time_____

Print Physician/Qualified Medical Person Signature _____

Physician Countersignature, if applicable_____ Date _____ Time_____

Interpreter Signature/ID#_____ Date_____Time_____

EMTALA
CERTIFICATION OF FALSE LABOR

(SEND COPY WITH PATIENT)

I hereby acknowledge that _____(patient) has been examined and monitored in the Emergency Department for a reasonable period of time of observation and certify that this patient is in false labor.

_____	_____	_____
Physician/Qualified Medical Person Signature	Date	Time
_____	_____	_____
Physician Counter Signature, if applicable	Date	Time

EMTALA

REFUSAL TO PERMIT FURTHER MEDICAL SCREENING EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITION

(SEND COPY WITH PATIENT)

I hereby acknowledge that a physician or qualified medical person has informed me of the nature of my medical condition and about the risks and complications that might arise if I do not receive further examination or treatment. He or she has also explained to me the risks and expected benefits of alternatives to further examination and treatment, as well as probable consequences of my not receiving further medical treatment for my emergency medical condition.

The Further examination and treatment recommended:

_____

_____

The expected benefits of the recommended examination and treatment:

_____

_____

The risks of not receiving the recommended examination or treatment:

_____

_____

I understand that if I do not receive this further medical examination and treatment, my health and life and, if I am pregnant and having contractions, the health and life of my unborn child, may be at risk. I also understand that **[insert Hospital name]** is obligated by federal law to provide me with further examination to the extent necessary to determine whether I have an emergency medical condition and with treatment necessary to stabilize any emergency medical condition within the hospital's capabilities regardless of whether I am able to pay for that examination or treatment or if I do not have insurance.

Notwithstanding the recommendation of the physician or qualified medical person. I hereby request the above treatment may not be administered to me at the hospital, and hereby release the hospital, its personnel, the physician, or any other persons participating in my care from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a consequence of my refusal to permit this medical treatment.

_____ _____

Patient/Legally Responsible Person Date

_____ _____

Relationship if other than the patient

_____ _____

Print Witness Name

I have explained to the patient (or legally responsible person) the probable consequences of not receiving further medical examination and treatment for the Emergency Medical Condition.

_____ _____ _____

Physician/Qualified Medical Person Signature Date Time

_____ _____ _____

Physician Counter Signature, if applicable Date Time

_____ _____ _____

Primary Nurse Signature Date Time

_____ _____ _____

Interpreter Signature/ID# Date Time

NOTE: If the patient refuses to sign such a statement, he/she cannot be forced to do so nor may his/her release be withheld until he/she signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement written on the form ***"Risks explained but signature refused."***

EMTALA

REFUSAL OF TRANSFER TO ANOTHER MEDICAL FACILITY

(SEND COPY WITH PATIENT)

I hereby acknowledge that a physician or qualified medical person has informed me of the nature of my medical condition and about the risks and complications that might arise if I am not transferred to another facility for further medical examination and treatment. He or she has also explained to me the risks and expected benefits of alternatives being transferred to another medical facility as well as probable consequences of refusing the transfer

The expected benefits of the recommended examination and treatment:

_____

_____

The risks of not receiving the recommended examination or treatment:

_____

_____

I understand that if I am not transferred to another medical facility, my health and life, and if pregnant and having contractions, the health and life of my unborn child, may be at risk. I also understand that [insert Hospital's name] is obligated by federal law to provide me with further examination to the extent necessary to determine whether I have an emergency medical condition and with treatment necessary to stabilize any emergency medical condition within the capability of the hospital regardless of whether I am able to pay for that examination or treatment or if I do not have insurance.

Notwithstanding the recommendation of the physician or qualified medical person, I hereby request that I not be transferred to another medical facility because:

_____

_____

I hereby release [insert Hospital's name] its personnel, my attending physician or QMP, and any other persons participating in my care from any responsibility whatsoever from unfavorable or untoward results which I understand may occur as a result of my refusal to permit this transfer.

_____ _____

Patient/Legally Responsible Person Date

_____ _____

Relationship if other than the patient

_____ _____

Print Witness Name

I have explained to the patient (or legally responsible person) the probable consequences of not receiving further medical examination and treatment for the Emergency Medical Condition.

_____ _____ _____

Physician/Qualified Medical Person Signature Date Time

_____ _____ _____

Physician Counter Signature, if applicable Date Time

_____ _____ _____

Primary Nurse Signature Date Time

_____ _____ _____

Interpreter Signature/ID# Date Time

NOTE: If the patient refuses to sign such a statement, he/she cannot be forced to do so nor may his/her release be withheld until he/she signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement written on the form ***"Risks explained but signature refused."***

EMTALA

TRANSFER CERTIFICATE FOR UNSTABLE PATIENTS

(SEND COPY WITH PATIENT)

FOR STABLE PATIENTS, COMPLETE
"TRANSFER CERTIFICATE FOR STABLE PATIENTS"

Transfer Date:_____ Time: _____

SECTION I Physician Certification

□**TRANSFER OF UNSTABLE PATIENT: (if checked, entire form must be completed)** – Based on the examination, the information available to me at this time, and the responsible risk and benefits to the patient, I have concluded for the reasons which follow that, as of the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment/care at another facility outweigh the increased risks (if any) to the patient and, if in labor, to the unborn child, from effecting the transfer.

Reason for Transfer □ _____

Medical Benefits of Transfer (Check all that apply)

□Necessary, staff resources, or capabilities are not available at this facility, OR

□Specialized care is not available at this facility; OR

□Other _____

All transfers have inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain, turbulence, and the limitations of equipment and personnel present in the vehicles, all of which endanger the health, medical safety, and survival of the patient(s).

I certify that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual and, in the case of labor, to the unborn child, from accepting the transfer.

Physician/Qualified Medical Person Signature:_____ Date: _____ Time: _____

Physician Countersignature, if applicable: _____ Date: _____ Time: _____

SECTION II Additional Requirements for Transfer (*Unstable patients may not be transferred unless ALL requirements are met, this section must be completed if Section I is checked)*

□ Receiving physician has agreed to accept patient transfer
Name: _____ Contact Time: _____

□ Receiving facility has agreed to accept patient transfer, provide appropriate personnel and treatment, and has available space.
Facility: _____ Contact Time: _____
Person accepting transfer _____ Title: _____

□ Receiving facility will be provided with appropriate medical/treatment information.
□ EKG □ LAB □ X-RAY/REPORT □ ED RECORD □ H&P □ OTHER (specify): _____

SECTION III Transportation

Patient will be transferred by qualified personnel and transportation equipment, as required, including the use IF necessary and medically appropriate life support measures during the transfer.

Mode of transportation/provider (check one)

□ Ambulance Service _____
□Air transport service _____
□Private vehicle _____
□Law Enforcement _____
□Other _____

Personnel to accompany patient in transfer (check all applicable)

EMS: □Basic □Intermediate □Paramedic
□Nurse
□Respiratory Therapist
□Physician
□Other _____

Primary Nurse Signature: _____

SECTION IV Patient Acknowledgement/Request – Check ONE of the following if transferred:

□**TRANSFER ACKNOWLEDGEMENT –** I understand that I have/the patient has the right to receive medical screening, examination and evaluation by a physician, or other appropriate personnel, without regard to my/the patient's ability to pay, prior to any transfer from this hospital. I have/the patient has the right to be informed of the reason(s) for any transfer. I have/the patient has, been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I acknowledge that I have/the patient has received medical screening, examination, and evaluation by a physician, or other appropriate personnel, and that I have been informed of the reason(s) for my/the patient's transfer. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

□**PATIENT REQUEST FOR TRANSFER –** I have/the patient has, requested a transfer and acknowledge that I have been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I also acknowledge the obligation of this hospital to provide such further examination and treatment, within its available staff and facilities, as may be required to stabilize my/the patient's care. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

Patient/Legally Responsible Person _____
Relationship if other than patient_____ Date: _____ Time_____
Witness_____ Title_____ Date:_____Time_____
Physician/Qualified Medical Person Signature_____ Date:_____Time_____
Print Physician/Qualified Medical Person Signature _____
Physician Countersignature, if applicable_____ Date _____ Time_____
Interpreter Signature/ID#_____ Date_____Time_____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medial Center

Emergency Department

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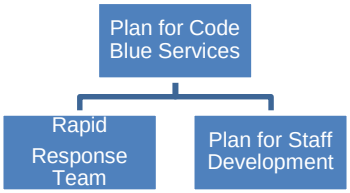
COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		
Code Blue Management		**EMS-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		



SCOPE

This policy applies to all patients of Mangum Regional Medical Center.

PURPOSE

Code Blue is a process that includes all responses necessary to deal with sudden and life-threatening events affecting the cardiovascular, cerebrovascular, and pulmonary systems. The purpose of the Code Blue Management plan is to provide a framework for the provision of immediate basic life support and advanced cardiovascular life support.

DEFINITIONS

NA

POLICY

Mangum Regional Medical Center Hospital shall maintain the capability to provide basic life support and advanced cardiovascular life support services always. This capability will be evidenced by:

1. Maintaining resuscitative clinical equipment and supplies in a state of constant readiness.
2. Appropriate training and/or certification necessary to provide resuscitative services.
3. Designation of Code Blue Team members at the start of every shift with delineation of roles and responsibilities.
4. Administrative review of resuscitative services and outcome measures.

The Code Blue response is not limited to cardiopulmonary arrest where the patient is found pulseless and/or apneic. Code Blue response may also be viewed as a mechanism to mobilize

the equipment and personnel necessary to avert cardiopulmonary arrest by recognition of early warning signs of impending arrest and initiating appropriate interventions.

The hospital's resuscitative services must be integrated with all clinical services of the hospital such as rehab services, pharmacy services, pastoral services, and diagnostic services. The integration must be such that the hospital can immediately make available the full extent of its patient care resources to assess and render appropriate care for emergent patients. Integration includes:

1. Physical access to emergency equipment and supplies;
2. The immediate availability of services, equipment, personnel, and resources;
3. The provision of services, equipment, personnel, and resources is within timeframes that protect the health and safety of patients and is within acceptable standards of practice.

Resuscitative Services are provided for inpatients, emergency room patients, and “man-down” scenarios involving family members or visitors.

PROCEDURE

A. House Supervisor and/or Charge Nurse
   1. Pre-event procedures:
      a. Designates Code Blue Team members and documents on shift report;
      b. Assigns roles to team members based on certification and competency;
      c. Verifies the Crash Cart is in a state of readiness (i.e. locked, stocked, defibrillator charged and tested)
   2. Code Blue procedure:
      a. Primary care nurse or designee contacts physician;
      b. Team Leader will lead ACLS interventions until medical provider arrives on scene
   3. Post-code procedures:
      a. Team Leader or House Supervisor and/or Charge Nurse assures Code Blue documentation and performance improvement audit is complete and accurate. Documentation includes posting ECG recordings of the initial rhythm, any rhythm changes, and post code rhythm;
      b. If the resuscitation attempt was unsuccessful, in conjunction with the physician, determines if the Medical Examiner criteria for autopsy has been met. If the criterion is not met, the body may be prepared for family viewing. Follow the Deceased Patient Policy.

B. Code Blue Team
   1. Arrives with Crash Cart;
   2. Provide ACLS measures within scope of practice for potential/actual life-threatening situations;
   3. Team roles:
      a. Team Leader- directs Code Blue until the physician arrives on the scene, verifies code status;
      b. Respiratory Therapist- manages airway & ventilation;
      c. RN/LPN- Administers medications;
      d. Clinical staff- performs chest compressions;

e. RN/LPN- records interventions and times

Performance Improvement

A. Resuscitative services are integrated into the hospital-wide quality management plan. All Code Blues and activation of the RRT is reported to the QA/PI committee, the Medical Executive Committee and the Governing Board.

B. All Code Blues events will be reviewed by the Chief Clinical Officer (CCO) within 72 hours of the event.

C. The purpose of the review procedure is to assess the effectiveness of resuscitative services and to identify opportunities for improvement.

D. Performance improvement indicators:
- Compliance with ACLS guidelines
- Timeliness of services (response time)
- Physician notification times
- Physician response time
- Accuracy and completeness of resuscitation documentation.

Competency Assessment

A. The medical staff shall establish criteria, in accordance with State law and regulations and acceptable standards of practice, delineating the qualifications required for Code Blue Team members.
1. All licensed nurses and Respiratory Care Practitioners are required to maintain certification in Basic Life Support (BLS) and Advance Cardiac Life Support (ACLS). All Registered Nurses and Respiratory Care Practitioners are required to maintain certification in PALS.

B. The hospital, as a prudent practice, will conduct periodic assessments of the readiness and functionality of resuscitative services to anticipate the policies, procedures, staffing, training, and other resources that may be needed to address likely demands of the patient population served.
1. All licensed nurses and Respiratory Care Practitioners are required to participate in Code Blue Drills;
2. Code Blue Drills
    a. Proficiency in managing cardiopulmonary arrest is a critical core competency for licensed clinical staff. Code Blue Drills are the primary mechanism for evaluating the readiness of resuscitative services prior to an actual arrest event. Code Blue Drills provide an interactive educational experience by simulating arrest scenarios and reinforces ACLS evidenced-based resuscitative guidelines.

b. The goal of Code Blue Drills is to ensure the provision of resuscitative services that:
   - Improve cardiac arrest survival rates by rapid recognition and activation of the Code Blue team
   - Effectively treat cardiopulmonary arrest
   - Affords humane support when death is evident

c. Schedule
   - Code Blue Drills will be conducted at a minimum of 2 per quarter. One will be conducted on the night shift (1900-0700) and one on the day shift (0700-1900). Frequency will be based on drill performance or other demonstrated needs.

d. Evaluation
   - Evaluation will include response time, team dynamics, familiarity with crash cart supplies/equipment, and knowledge of clinical algorithms
   - Individual components as well as overall performance will be scored
   - Code Blue Drill performance will be tracked over time and will include personal performance improvement plans for identified deficiencies.

Oversight

A. The hospital's resuscitative services are under the direction of the Medical Executive Committee in accordance with State law and acceptable standards of practice.

B. The Quality Committee is the forum for reporting and reviewing all resuscitative events and activities.

C. Ultimate responsibility for optimum care for all patients who are treated in this hospital rests with the Governing Body. The specific responsibility for this plan is delegated to the CCO, which acknowledges its responsibility for same in accordance with the hospital by-laws approved by the governing body.

REFERENCES

Reference Standards: Department of Health and Human Services, Centers for Medicare and Medicaid Services, Hospital Conditions of Participation: Federal Regulations. 42 CFR Part 482.55; American Heart Association. Guidelines 2011 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care: International Consensus on Science

ATTACHMENTS

EMS-002A Code Blue Record Form
EMS-002B Code Blue Resuscitation & Outcome Review Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Code Blue Record – Name of Hospital (EMS-001A)

Date of arrest	Time:	Time CPR started:	Time CPR ended:	Admitting Diagnosis:

ARREST TYPE

☐ On Telemetry ☐ Previous Rapid Response
☐ Witnessed ☐ Unwitnessed
☐ Cardiac Arrest ☐ Respiratory Arrest
☐ Bradycardia ☐ Asystole
☐ Ventricular Fib ☐ Ventricular Tach
☐ PEA (Pulseless Electrical Activity)

VENTILATION

Airway	Yes/No	Time	By
Oral Airway	☐ Yes ☐ No		
Ambu/Mask/ O2	☐ Yes ☐ No		
ET/Trach.	☐ Yes ☐ No		
Intubated	☐ Yes ☐ No		
Placement checked	☐ Yes ☐ No		

DEFIBRILLATION

Dysrhythmia Identified	Time	Joules	Converted	Rhythm
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

PROCEDURE

Procedure	Time	Size	By
IV			
NG Tube			
External Pacer			
Foley Catheter			
Other:			

MEDICATIONS - IVP

Drug	Route	Dose/ Time	Dose/ Time	Dose/ Time	Dose/ Time
Epinephrine					
Atropine					
Na. Bicarb					
Cordarone					
D 50					
Lidocaine					
$CaCl_2$					
Magnesium					
Vasopressin					

INTRAVENOUS

Fluids/Drips	Dose/ Solution	Site	Rate	Time Started

COMMENTS

Synopsis of Events:

Family Notified ☐ Yes Time: _____ Who:_____

Physician:

VITAL SIGNS

Time						
BP						
Pulse						
Resp.						
02 Sat						

CODE TEAM

Time Code Ended		☐ Survived	☐ Expired
Code Leader			
RT			
RN/LPN			
RN/LPN			
RN/LPN			
Recorder			

LABS / DIAGNOSTICS

Time of ABG	pH	PCO_2	PO_2	HCO_3

Other Labs: ☐ CBC ☐ Chemistry ☐ Cardiac Enzymes

Diagnostics :

Notes:

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

CONFIDENTIAL: For purposes of Quality Assessment / Performance Improvement
INADMISSABLE IN ANY ADMIN, STATE or FEDRAL PROCEEDINGS
*****TO BE COMPLETED BY THE RN IN CHARGE AT THE TIME OF THE CODE, PRIOR TO END OF SHIFT****

Code Blue – Resuscitation and Outcome Review (EMS-001B)

Date of Code:	**RN in Charge of Code:**	**Physician Present:**

Prior to the Code

Code Status	**Yes**	**No**	**Clinical Status**	**Yes**	**No**	**Respiratory Status**	**Yes**	**No**
Was the patient a full code?			Was the patient stable?			Was patient on ventilator?		
Was this documented in the medical record?			Was the patient on Tele?			If yes, was patient weaning?		
Was a Rapid Response called?			Did the patient have IV access? Type:			If weaning, was this the initial wean episode?		

During the Code - Critique

Skill	**YES**	**NO**	**N/A**	**Comments / Areas to Improve**
Did the crash cart arrive promptly?				
Identification of code leader was prompt and appropriate				
Key positions were promptly assigned by code leader & appropriate for mix				
Code leader dismissed excess people/employees				
Was patient put on backboard or bed deflated?				
Attending physician notified?				
Physician in attendance/on phone?				
Pillow removed to open airway?				
Was CPR initiated immediately?				
Were monitor leads and defibrillation pads placed timely?				
Was the monitor changed to manual mode vs. AED mode?				
Was an IV line established?				
Did the code leader complete an assessment of EKG and algorithm?				
Was CPR resumed immediately between interventions?				
Were leads double checked in a systole?				
Was the correct algorithm/med and interventions followed?				
Did nurse/RT implementing interventions (meds/joules delivered/intubation) call out loudly after for a completed scribe?				
Did code leader call out interventions clearly and loudly?				
Did code leader maintain a leadership role throughout entire code? (hands off as much as possible)				
Did RT intubate patient successfully and in a timely manner? Should not take longer than 5mins. Total with bagging between each attempt				# of attempts:_____ # of people attempted:_____
Were ABG's and STAT CXR obtained?				
Did nurse/RT implementing interventions (meds/joules delivered/intubation) call out loudly after completed for scribe?				
Was the appropriate equipment immediately available **without** malfunction? (suction, oxygen, ambu bag, defibrillator)				
Documentation				
Was **thorough** documentation completed regarding the patient's assessment before, during and after the code? This should include: B/P readings, heart rate, respirations, cardiac rhythms (initial and changes), defibrillation (time and amount of joules), Transcutaneous pacing (rate, capture) and intubation)?				
Was the family notified?				

Code Start Time:	**Code End Time:**	**Final Disposition: ( ) Successful ( ) Transferred ( ) Expired**

What was the atmosphere of the code? ( ) Well Organized ( ) Fairly Well Organized ( ) Disorganized ( ) Chaotic

RN Signature:	**Date:**
DQM/CNO Signature:	**Date:**

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Rapid Response Team		**EMS-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	Joint Commission NPSG	

SCOPE

This policy applies to all patients of Mangum Regional Medical Center.

PURPOSE

To rapidly provide an interdisciplinary team approach (Code Team and other personnel delineated) to support assessment and treatment of a patient, whose condition is deteriorating, through the use of a defined set of early warning criteria**.**

DEFINITIONS

Rapid Response Team (RRT)-An interdisciplinary team that responds to urgent patient situations.
Non-Invasive Positive Pressure Ventilation (NPPV)-A type of mechanical ventilation which provides inspiratory and/or expiratory positive pressure ventilation via nasal or full-face mask in order to improve hypoxemia, reduce ventilatory muscle fatigue and support ventilation.

POLICY

The goal of the team is to provide clinical support and facilitate early and rapid intervention in order to promote better patient outcomes such as:

1. Reduced cardiac and/or respiratory arrests in the hospital;
2. Reduced or timelier transfers to a higher level of care hospital for diagnostic testing or treatment not available at the current facility;
3. Reduced patient intubations;
4. Reduced number of hospital deaths and reduced length of stay;
5. Reduced patient complication

PROCEDURE

1. When a member of the health care team is concerned about the condition of a patient or feels that a patient needs immediate intervention, they can call the RRT via overhead pager and state "Rapid Response Team to patient's room number". The Rapid Response Team will make appropriate recommendations for notification of Providers and family members.
2. Once the call is received, the RRT members will simultaneously respond to that room/location within 5 minutes.
3. **Rapid Response Team Responsibilities:**

1. Primary nurse:
   a. Assesses patient for evidence of early warning sign criteria
   b. Activates RRT
   c. Communicates to RRT members
   d. Initiates documentation on the Rapid Response Team Record.
2. House Supervisor and/or Charge Nurse, and or Registered Nurse
   a. Speaks with primary nurse to get the situation, background and assessment of the patient
   b. Assists with further assessment of the patient
   c. Initiates interventions as necessary according to approved protocols to include:
      1) Respiratory Distress
      2) Unresponsive Patient
      3) Hypotension
      4) Hypoglycemia
      5) Shock
   d. Speaks with family/patient about the situation
   e. In collaboration with the responsible Medical Provider, assesses the patient's physical status, reviews the medical record for pertinent history/lab findings, initiates treatment as the situation warrants, determines if patient requires a higher level of care.
   f. Places protocol in Provider's order section of medical record
   g. Documents incident and interventions on the Rapid Response Team Flowsheet

REFERENCES

Joint Commission NPSG
Lippincott Procedures

ATTACHMENTS
EMS-003A Hypoglycemia Management Protocol
EMS-003B Hypotension Management Protocol
EMS-003C Respiratory Distress Management Protocol
EMS-003D Unresponsive Patient Protocol
EMS-003E Shock Management Protocol
EMS-003F Rapid Response Team Flowsheet
EMS-003G Rapid Response Team Outcome Review

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RRT-HYPOGLYCEMIC ADULT MANAGEMENT PROTOCOL (EMS-003A)

- **SERUM or FINGER STICK BLOOD GLUCOSE 60 mg/dL or LESS Recheck FSBS**
- **If less than 40 mg/dL** call **RAPID RESPONSE AND**
  - Obtain serum glucose
  - Assess patient situation and select appropriate treatment sequence from the options below:

Treatment Sequence A: **Patient is conscious and able to swallow**	**Treatment Sequence B:** **Patient is unable to swallow**
• Administer ***one*** of the following carbohydrates: o 3 Glucose tablets (primary treatment of choice) **OR** o 4 ounces of orange juice (IF NOT A RENAL PATIENT) **OR** o 8 ounces of skim / 2 percent milk **OR** o 4 ounces of a regular soft drink • ***Notify provider*** • Repeat finger stick blood glucose 15 minutes post treatment. If result ***STILL 60 mg/dL or LESS,*** repeat treatment above and ***notify provider*** for additional orders	**If no IV access:** • Administer Glucagon 1mg subcutaneously (use insulin syringe) • **Insert saline lock if not present** • Obtain finger stick blood glucose 15 minutes after subcutaneous Glucagon. If result ***60 mg/dL or LESS*** and **if IV access has been obtained**, give D50W 50 mL IVP (25 grams) and ***notify physician*** **If patient has IV access:** • Give D50W 50 mL (25 grams) IV push. • **Recheck FSBS in 10 minutes.** If result ***60 mg/dL or LESS, notify provider*** for additional orders

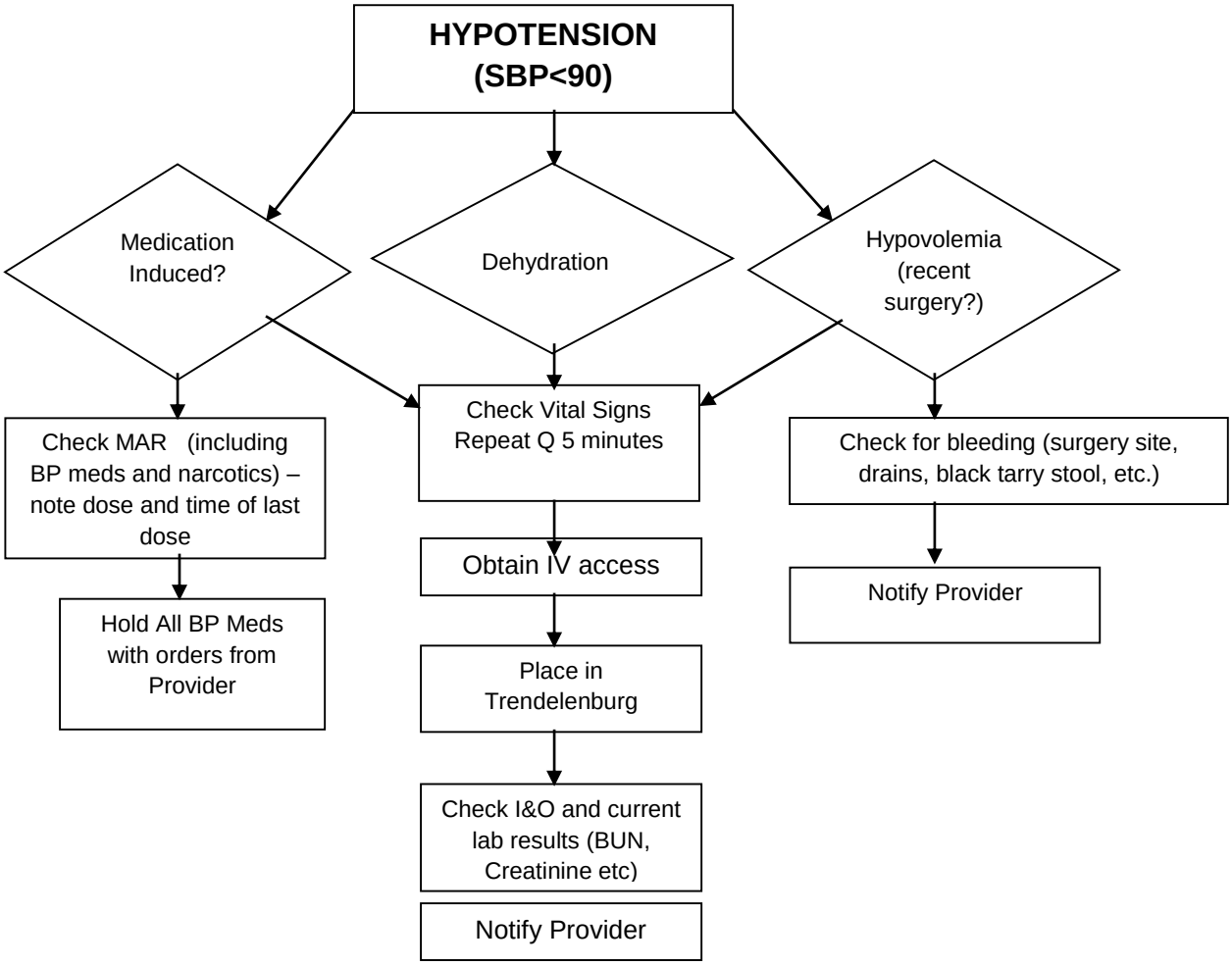
Nurse Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RRT-HYPOTENSION PROTOCOL (EMS-003B)



RRT - HYPOTENSION PROTOCOL ORDERS

- Vital Signs & recheck Q 5 min
- Obtain IV access
- Position in Trendelenburg position
- Check most current lab & I/O
- Check current MAR to include BP meds & narcotics (note dose and time of last dose)
- Hold all BP meds and Notify Provider immediately.
- Notify MD

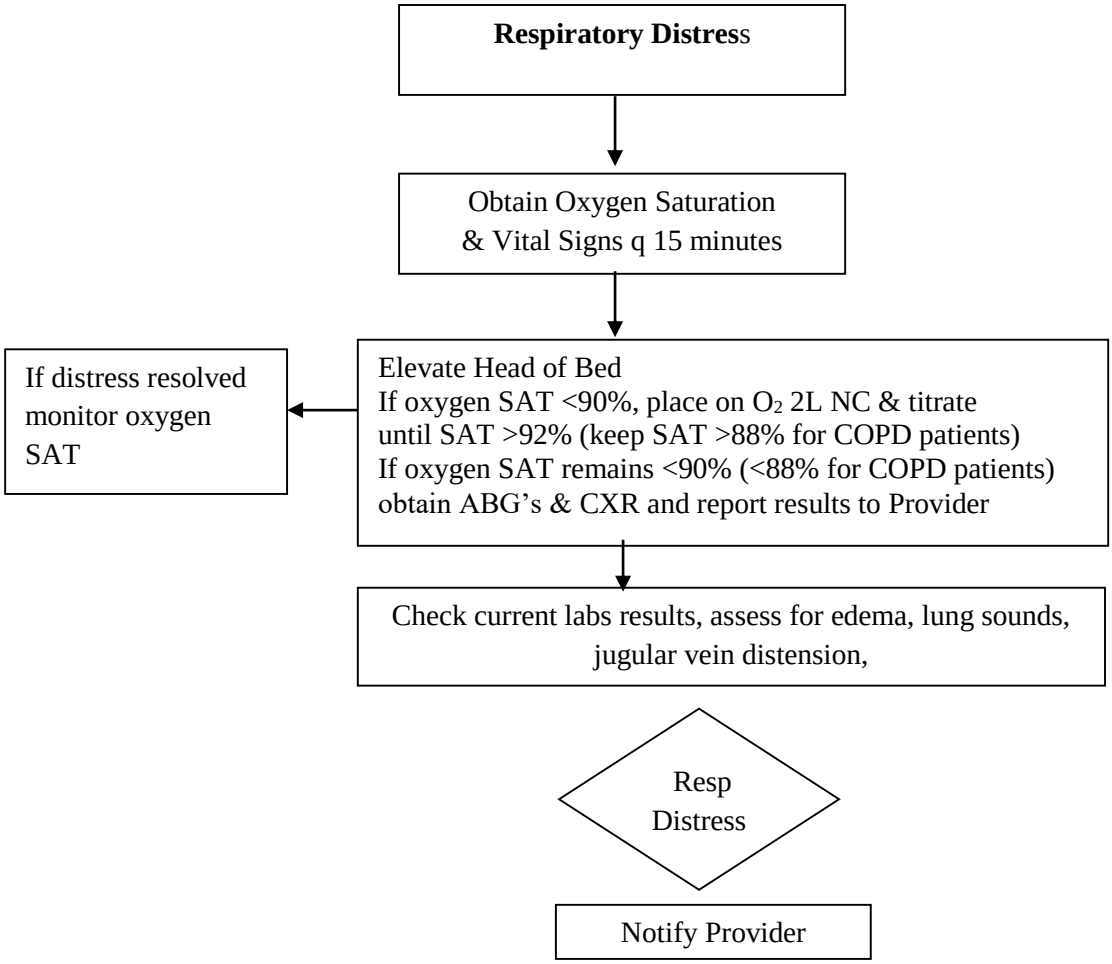
Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RRT-RESPIRATORY DISTRESS PROTOCOL (EMS-003C)



RRT-RESPIRATORY DISTRESS PROTOCOL ORDERS

- Obtain O_2 Saturation (SAT) and vital signs q 15 minutes
- Elevate HOB to 45 degrees
  - □ If O_2 SAT <90%, place on Nasal Cannula @ 2 LPM and titrate until SAT >92%
  - □ If O2 SAT remains <90%, obtain ABG's & CXR
- If distress resolved, monitor O2 SAT
- Check current lab results (ABG)
- Notify Provider

Nurse Signature: _____ Date: _____ Time: _____

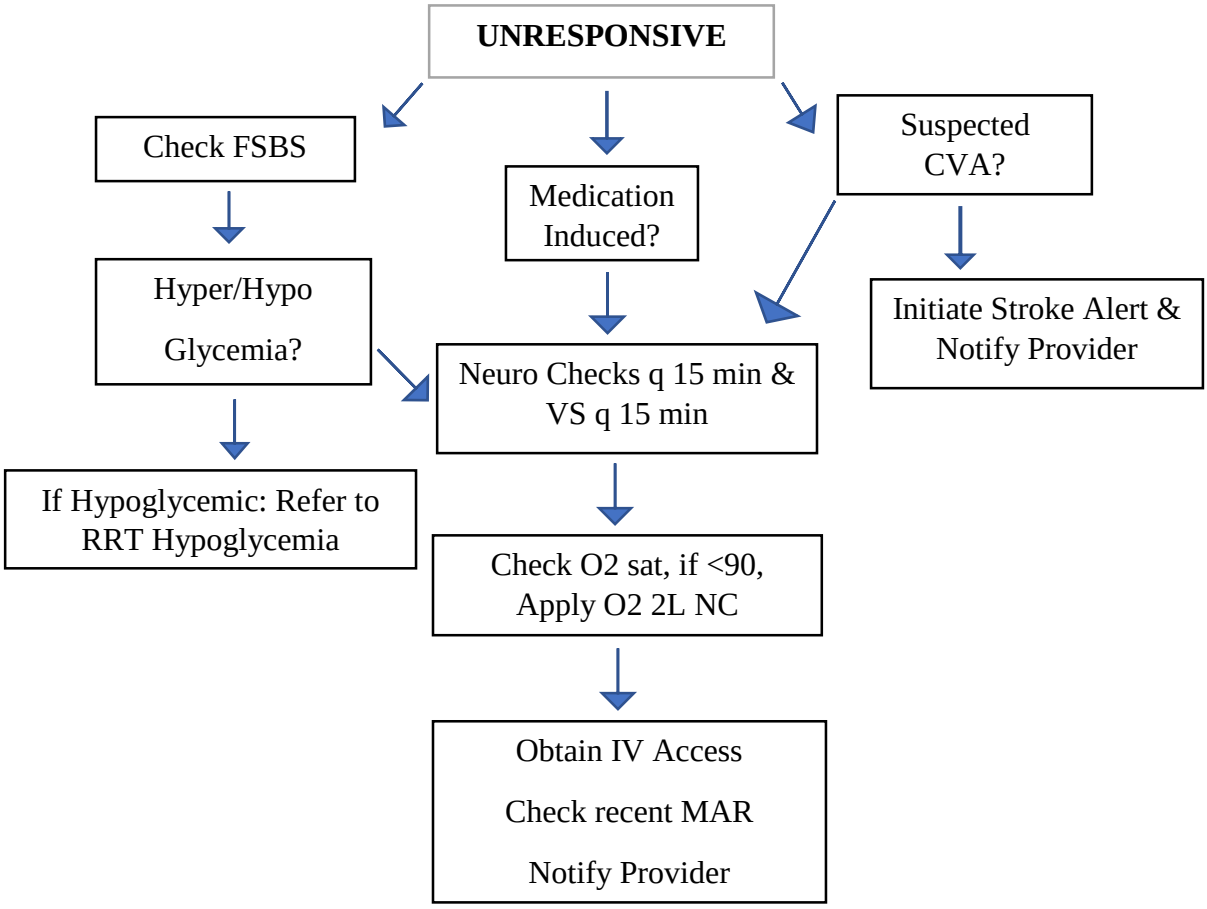
Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RRT-UNRESPONSIVE PATIENT PROTOCOL

(EMS-003D)



RRT-UNRESPONSIVE PATIENT PROTOCOL ODERS

- Obtain Neuro Checks
- Glasgow Coma Scale (GCS)
- Vital Signs & SPO2 every 15 minutes
- If SPO2 < 90%, apply O2 2L NC
- Check FSBS
- Obtain IV Access
- Check most recent MAR
- Notify Provider
- If suspect CVA, initiate Stroke Alert and notify provider

Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER (EMS-003E)

SHOCK

Monitor neuro checks and vitals q 15 minutes

- Temp <96.8F > 100.9 F
- HR <50 or > 90
- SBP < 90
- MEAN BP < 65
- RR < 10 or > 20
- O2 Sat < 90%
- Acute change in LOC

Monitor Signs and Symptoms of Shock
Assess for Confusion/Lightheadedness Sleepy/Losing Consciousness, Weakness, Severe Pain or Swelling, Agitation/Restlessness, Pale, Cool, Clammy Skin, Rapid, Weak Pulse, Nausea, Vomiting, Decreased Urine Output, Rapid, Shallow Breathing, Cyanosis, Hypotension, Tachycardia

- Get labs; BMP, CBC, Lactic Acid, Blood Culture x2, UA
- Insert peripheral IV

Notify Provider

RRT-SHOCK MANAGEMENT PROTOCOL

- Assess and maintain airway
- Titrate Oxygen to keep O2 saturation at 90% or greater
- Neuro Checks and vital signs every 15 minutes
- BMP, CBC, Lactic Acid, Blood Culture x2, UA
- Insert Peripheral IV
- Notify Provider

Nurse Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RAPID RESPONSE TEAM FLOWSHEET (EMS-003F)

Date: _____ Room#/Location: _____ Time Called: _____ Arrival Time: _____ Event Ended: _____

Primary Reason for Call:

☐ Staff concerned/worried
Specify: _____
☐ HR less than 40 OR >130 ☐ Uncontrolled pain
☐ SBP less than 90 mmHg ☐ HR greater than 130
☐ Acute change in LOC ☐ RR greater than 25
☐ RR less than 8 ☐ FiO_2 50% or greater
☐ SpO_2 less than 90% ☐ Seizures
☐ Acute Significant Bleed ☐ Urine output < 30ml for 2 consecutives
☐ Failure to respond to tx ☐ Acute change in LOC
☐ Shock_____

Immediate Interventions:

RT	RN
☐ Oral airway/Nasal airway	☐ IV Fluid Volume Adjustment
☐ Suctioning	☐ Cardiac Monitoring
☐ Nebulizer Treatment	☐ O_2
☐ Intubated	☐ CPR
☐ NPPV	☐ Defibrillation
☐ Bag Mask	☐ IV access
☐ O_2 Mask/Nasal	☐ Ordered PRN Medications
☐ ABG	☐ _____
☐ _____	☐ _____
☐ No Intervention	☐ No Intervention

Protocols Initiated:

□ Rapid Response Hypotension Protocol
□ Rapid Response Respiratory Distress Protocol
□ Rapid Response Unresponsive Patient Protocol
□ Hypoglycemia Protocol/Hyperglycemia Protocol
□ Shock Protocol

Medication(s): _____
_____
_____
_____

Other Interventions

Specify: _____
_____
_____
_____

Outcome: ☐ Stayed in room ☐ Expired
☐ Transferred: _____
☐ Other: _____
☐ Notified Provider: _____ Time: _____
(Name)

RRT Signatures:

RN: _____
RN: _____
RT: _____
Other: _____

Situation:
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Background: _____
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Assessment:
Temp_____BP_____HR____RR_____SpO_2____GCS____
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See back for additional Vital signs & documentation

Recommendation: _____

RRT - HYPOTENSION PROTOCOL

- □ Obtain Vital Signs & recheck Q 5 min
- □ Obtain IV access
- □ Position in Trendelenburg position
- □ Check most current lab & I/O
- □ Check current MAR to include BP meds & narcotics (note dose and time of last dose)
- □ Hold all BP meds and Notify Provider immediately.
- □ Notify MD

RRT – RESPIRATORY DISTRESS PROTOCOL

- □ Obtain O_2 Saturation (SAT) and vital signs q 15 minutes
- □ Elevate HOB to 45 degrees
- □ If O_2 SAT <90%, place on Nasal Cannula @ 2 LPM and titrate until SAT >92%
- □ If O2 SAT remains <90%, obtain ABG's & CXR
- □ If distress resolved, monitor O2 SAT
- □ Check current labs results (ABG)
- □ Notify Provider

RRT- HYPOGLYCEMIC MANAGEMENT PROTOCOL

If less than 40 mg/dL call **RAPID RESPONSE** and

- Assess patient situation and select appropriate treatment sequence from the options below:

Treatment Sequence A: Patient is conscious and able to swallow

- Administer ***one*** of the following carbohydrates:
  - 3 Glucose tablets (primary treatment of choice)
    OR
  - 4 ounces of orange juice (IF NOT A RENAL PATIENT)
    OR
  - 8 ounces of skim / 2 percent milk
    OR
  - 4 ounces of a regular soft drink
- ***Notify provider***
- Repeat finger stick blood glucose 15 minutes post treatment. If result ***STILL 60 mg/dL or LESS,*** repeat treatment above and ***notify provider*** for additional orders

Treatment Sequence B: Patient is unable to swallow
If no IV access:

- Administer Glucagon 1mg subcutaneously (use insulin syringe)
- **Insert saline lock if not present**
- Obtain finger stick blood glucose 15 minutes after subcutaneous Glucagon. If result ***60 mg/dL or LESS*** and **if IV access has been obtained**, give D50W 50 mL IVP (25 grams) and ***notify physician***

If patient has IV access:

- Give D50W 50 mL (25 grams) IV push.
- **Recheck FSBS in 10 minutes.** If result ***60 mg/dL or LESS, notify provider*** for additional orders

RRT- UNRESPONSIVE PATIENT PROTOCOL

- □ Obtain Neuro check, GCS, Vital Signs q 15 minutes
- □ If O_2 SAT <90%, place on O_2 2L NC
- □ If Hyper/Hypoglycemia Suspected
- □ Check Blood Glucose
- □ Obtain IV access
- □ Check most recent MAR
- □ Notify MD
- □ If suspected CVA, notify Provider

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FOLLOW-UP REPORT (To be done within 24 hours):

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Signature:
_____

Date/Time: _____

RRT-SHOCK PATIENT

- □ Assess and maintain a patent airway
- □ Place oxygen via mask at 10-15 liters per minute
- □ Assess level of consciousness
- □ Assess Glasgow Coma Scale
- □ Place on cardiac monitor and obtain baseline rhythm
- □ Obtain initial vital signs
- □ Control obvious external bleeding
- □ Initiate intravenous lines with large-bore catheters using normal saline
- □ Obtain venous blood for Clinical Laboratory per Provider Orders
- □ Type and cross for possible transfusion per Provider Orders
- □ If available, check glucose and H&H per Provider orders
- □ Obtain baseline electrocardiogram
- □ Continuously monitor the patient's:

- □ Temp <96.8F > 100.9 F
- □ HR <50 or > 90
- □ SBP < 90
- □ MEAN BP < 65
- □ RR < 10 or > 20
- □ O2 Sat < 90%
- □ Acute change in LOC

TIME	Temp	Pulse	RR	BP	SpO_2	Cardiac Monitor	IV titration Drug: _______	IVF Intake	Urine Output	BS	SSI	Nurse Initials

PATIENT LABEL

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RAPID RESPONSE TEAM REVIEW (EMS-003G)

RRT Intervention Date: _____ Time: _____

Screening Criteria	NA	YES	NO	
RRT Response within 5 minutes				
Crash Cart at Bedside				
Medications needed were available				
Equipment/Supplies needed were available and functioning properly				
Interventions avoided Code Blue				
Physician notified in timely manner				
Appropriate protocols/interventions applied				
Patient remained at hospital				
Patient transferred to higher level of care				
RRT Flowsheet completed				
Family notified				
Patient Outcome	Stable	Unstable	Transfer	Death

Actions/Recommendations for Improvement:

_____
_____
_____
_____
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_____

RN Signature: _____ Date: _____

DQM Signature: _____ Date: _____

CONFIDENTIAL: For purposes of Quality Assessment / Performance Improvement
INADMISSABLE IN ANY ADMIN, STATE or FEDERAL PROCEEDINGS

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Nursing Services Policies

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Clinical Resource Guide for Nursing, Respiratory, & Physical Therapy Services		**NUR-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy is applicable for Nursing, Respiratory, and Physical Therapy clinicians of Mangum Regional Medical Center, as a guide for clinical procedures.

PURPOSE

To provide instant, evidence-based procedure guidance at the point of care for the clinical staff (nursing, respiratory, and physical therapy). In addition, the resource guide assists with:

- Workflow functionality,
- Enable staff to save time and increase the amount of time devoted to the care of the patient,
- Standardize care,
- Reduce variability of care,
- Reduce errors,
- Maintain compliance with current national guidelines, and
- Promote effective inter-collaborative practice.

DEFINITIONS

NA

POLICY

Clinical services will utilize the standards of care for clinical procedures from the Lippincott Clinical Resource Guide for Nursing, Respiratory, and Physical Therapy Services. This resource is designed to provide a uniform standard of practice for nursing, respiratory, and physical therapy services. Standards drive consistency and quality outcomes in patient safety, care, service, and operations. The clinical resource systems which are evidence-based and updated annually or more often, take precedence in practice. The frequency of review of a

standard is determined by a need resulting from a process or technology change by regulatory requirements or by the governing body, which requires annual review.

PROCEDURE

1. The staff will utilize the Hospital approved Clinical Resource Guide Resource system in order to provide direction and guidance for carrying out clinical procedures performed by nursing, respiratory, or physical therapy.
2. All staff members are expected to adhere to the hospital policy directives for utilizing the Clinical Resource Guide that set forth essential requirements and are based upon statutes, standards, and evidence-based practice guidelines.
3. Staff members should approach their supervisors with any questions.

REFERENCES

NA

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Advance Directives		**NUR-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing		
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center and notifies patients of their rights to make health care decisions, to formulate advance health care directives, and to accept or refuse medical or surgical treatment.

PURPOSE

Health care providers are required by the Patient Self-Determination Act of 1990 and other applicable law to advise adult patients of their rights to make health care decisions, to formulate advance health care directives, and to accept or refuse medical or surgical treatment. Mangum Regional Medical Center will inform adult patients with capacity about their options and rights to make their own decisions; provide support and assistance to individuals desiring advance directives; and provide education to patients, professionals, and the community. The purposes of this policy are to ensure statutory compliance and to enhance patient autonomy and self-determination.

DEFINITIONS

Advance Directive is defined as a legal document signed by a competent person that provides guidance for medical and health-care decisions (such as the termination of life support or organ donation) in the event the person becomes incompetent to make such decisions. An Advance Directive may include a living will, the appointment of a health care proxy, and anatomical gift donations (or all or any of the foregoing).

Advance Directive for Mental Health Treatment. Oklahoma law recognizes the fundamental right to control decisions related to mental health treatment and provides that a competent adult may make an Advance Directive for Mental Health Treatment to express mental health treatment preferences or instruction which may include, but is not limited to, consent to mental health treatment.

Capacity is defined as the functional ability to (1) comprehend information relevant to the particular decision to be made; (2) deliberate regarding the available choices, considering his or her own values and goals; and (3) communicate a decision verbally or non-verbally.

Durable Power of Attorney for Health Care (DPOA-HC) is a document that allows a patient to appoint an individual called an "Agent" or "Attorney-in-Fact." An Attorney-in-Fact cannot execute an Advance Directive on behalf of a patient.

Patient Representative is an attorney-in-fact for health care decisions acting in accordance with the Uniform Durable Power of Attorney Act, a health care proxy acting in accordance with the Oklahoma Advance Directive Act, or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.

Physician Orders for Life-Sustaining Treatment (POLST) is a document, completed and signed by the treating physician, which is intended to interpret the wishes of a patient who has an advanced, progressive illness, into physician orders that must be followed by all health care providers who interact with the patient. The POLST form is designed to focus end-of-life health care on the patient's treatment wishes by making them more explicit for any subsequent caregivers.

POLICY

A. To comply with the Oklahoma Advance Directive Act, the Oklahoma Uniform Statutory Form Power of Attorney Act, the Oklahoma Physician Orders for Life-Sustaining Treatment Act, and other applicable laws regarding informed consent and the patient's right to accept or refuse medical or surgical treatment. Because of these requirements and to honor the wishes of the patient or patient's legal representative regarding medical treatment and the withdrawal or withholding of life-sustaining procedures, it is the policy of the hospital to provide written information to all adult inpatients and outpatients who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery, with capacity, regarding:
    1. Their rights to accept or refuse medical or surgical treatments; and
    2. Their rights to make advanced directives

    The written information will include a statement of limitation if the hospital cannot implement an advance directive on the basis of conscience. The Hospital's issuance of the written information to the patient or the patient's representative will be documented in the patient's medical record.

B. To document in each patient's medical record whether or not they have executed an advance directive.

C. To not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

D. To allow a surrogate decision-maker, under the specified provisions in the Oklahoma Advance Directive Act, to consent to care and medical treatment to maintain the physical and mental condition of an adult patient who does not have the capacity or ability to make health care decisions or who does not have a legal guardian or agent named under the Durable Power of Attorney for Health Care Act.

E. To provide educational opportunities to its staff and the community on issues concerning advance directives.

PROCEDURE

A. Upon admission, a case manager, or member of the nursing staff will provide each patient with information regarding Advance Directives; however, if a patient is incapacitated at the time of admission, then the case manager or member of the nursing staff may present the information to the patient's family or surrogate. The case manager or nursing staff member must present the information to the patient when the patient is no longer incapacitated (or to the patient's representative if patient is mentally incapacitated.)

An advance directive may be revoked in whole or in part at any time and in any manner by the declarant (the patient), without regard to the declarant's (patient's) mental or physical condition. A revocation is effective upon communication to the attending physician or other health care provider by the declarant (patient or a witness to the revocation). The attending physician or other health care provider will make the revocation a part of the declarant's (patient's) medical record and communicate the revocation to the appropriate persons.

B. If the patient desires, the patient may complete an Advance Directive or an Advance Directive for Mental Health Treatment. A patient should seek the assistance of an attorney in completing a Durable Power of Attorney for Health Care. The patient's physician may complete and sign a Physician Order for Life-Sustaining Treatment, but the physician should only complete a POLST for patients who are near the end of life.

C. If the patient already has executed an Advance Directive prior to admission, the patient shall provide the executed original, or a copy with an original signature, to a hospital admissions staff member for filing in the patient's medical record. If the admissions staff member has any questions regarding the validity of the Advance Directive, he or she will present the questions to the Chief Clinical Officer. If the staff member has no questions regarding validity, the staff member shall place a copy of the advance directive to the physician's order sheet. The Advance Directive shall become part of the patient's medical record. If the patient asserts he or she previously has provided an executed Advance Directive to the hospital, the medical record department will retrieve the document.

D. If the Chief Clinical Officer or other administrative staff receive questions regarding the validity of the Advance Directive, the CCO will notify the attending physician or other

healthcare provider of the questions and notify the Risk Manager and/or hospital counsel to resolve the questions.

E. If the patient asks to complete an Advance Directive, a designated hospital staff member shall assist the patient in completing the Advance Directive. If the staff member questions the competency or capacity of the patient, the staff member shall notify the attending physician or other healthcare provider to resolve the question.

F. The attending physician or other healthcare provider will make a notation in the patient's medical record when the Advance Directive becomes operative. An Advance Directive becomes operative when it is communicated to the attending physician and the declarant (patient) is no longer able to make decisions regarding administration of life-sustaining treatment.

G. If an adult patient is incompetent or incapable of communication at the time of admission and has not executed or issued an Advance Directive, then Oklahoma law prioritizes classes of persons who are authorized to make general health care decisions for any person who is persistently unconscious, incompetent, or is mentally or physically unable to communicate. The statutory decision-making authority does not authorize every decision-maker to make *all* healthcare decisions for the patient.
    a. A general or limited Guardian appointed by the court pursuant to the Oklahoma Guardianship and Conservatorship Act;
    b. Health Care Proxy;
    c. Agent/Attorney-in-Fact (per a DPOA-HC);
    d. Spouse;
    e. Adult Children;
    f. Parents;
    g. Adult Siblings;
    h. Other Adult Relations (in order of kinship); and
    i. Close Friends who have maintained regular contact with the patient sufficient to be familiar with the patient's personal values. Execution of an affidavit stating specific facts and circumstances documenting such contact constitutes prima facie evidence of close friendship.
    j. Prior to making a health care decision for a patient pursuant to this section, a person shall provide to the attending physician or other healthcare provider a signed copy of the following statement. The attending physician or other healthcare provider will enter the signed statement into the patient's medical record. "I hereby certify that:
        - I have not been convicted of, pleaded guilty to or pleaded no contest to the crimes of abuse, verbal abuse, neglect or financial exploitation by a caregiver; exploitation of an elderly person or disabled adult; or abuse, neglect, exploitation or sexual abuse of a child;
        - I have not been found to have committed abuse, verbal abuse or exploitation by a final investigative finding of the State Department of Health or Department of Human Services or by a finding of an administrative law judge, unless it was overturned on appeal; and

- I have not been criminally charged as a person responsible for the care of a vulnerable adult with a crime resulting in the death or near death of a vulnerable adult."

H. If a patient is admitted with an Advanced Directive or Durable Power of Attorney for Health Care and lacks the capacity to make health care decisions as certified in writing by the patient's attending physician, then the designated representative under the applicable document may make treatment decisions on behalf of the patient according to the terms of the document.

I. The hospital shall provide community education regarding advance directives, and hospital personnel shall document when they provides such community education.

REFERENCES

Patient Self-Determination Act of 1990
Oklahoma Advance Directive Act, 63 O.S. § 3101.1 et seq.
Oklahoma Uniform Statutory Form Power of Attorney Act, 15 O.S. § 1001 et seq.
Oklahoma Physician Orders for Life-Sustaining Treatment Act, 63 O.S. § 3105.1 et seq.

ATTACHMENTS

Attachment A: State of Oklahoma Advance Directive Form
Attachment B: Certification of Individual Making Health-Care Decision for Patient
Attachment C: Oklahoma POLST Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Triage for Bed Allocation		**NUR-002**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to patients who may be admitted to Mangum Regional Medical Center during times of high volume to ensure the appropriate level of care can be safely accommodated.

PURPOSE

To provide a mechanism for the allocation of bed spaces during times of high utilization.

DEFINITIONS

NA

POLICY

The hospital will utilize the triage bed allocation methodology* during times of high utilization.

PROCEDURE

Patients requiring acute treatment (Priority I) will have admission and treatment priority over patients requiring monitoring (Priority II), and patients who may be terminally ill (Priority III).

In case of a conflict regarding admission criteria, the Chief Clinical Officer (CCO), after consultation with the primary physician, may decide which patients will be given priority for available beds. In the absence of the CCO, conflicts may be resolved by their designee or the House Supervisor.

Patients will be triaged in accordance to the following guidelines:

A. ***Priority III:** These patients may or may not be acutely ill, the condition and/or chronic nature of problems may require interventions to relieve an acute condition but have a poor

recovery prognosis and/or limitation to resuscitative measures, including do not resuscitate status.

B. ***Priority II:** These patients may or may not be, at the time of admission, acutely ill but are at risk of requiring immediate treatment, monitoring, and/or interventions.

C. ***Priority I:** These patients are acutely ill, requiring immediate treatment, monitoring, and/or frequent nursing interventions for a disease(s) or unstable condition.

For inhouse patients, consideration may be given to discharge to an appropriate level of care if indicated and can be safely accommodated. Transfers or discharges will only occur with a medical provider's order when a patient no longer requires medical care as outlined, and the receiving entity or discharge disposition is able to safely manage the nursing care required.

REFERENCES

NA

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
AMA		**NUR-004**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all patients who may wish to leave AMA.

PURPOSE

When a patient at the hospital wishes to leave prior to the completion of their visit, the benefits/risks to the patient shall be explained.

PROCEDURE

Once the patient expresses the desire to leave, the nurse shall do the following:

A. Notify the Medical Provider promptly, giving him/her the opportunity to inform the patient of the benefits/risks that may be involved in leaving.

B. Educate the patient what leaving against medical advice means. Advise the patient of the risks of leaving against medical advice. Seek to ensure that the patient and/or significant other voice understanding of the risk of their decision and clearly document this in the nurse's narrative notes.

C. Advise the patient or responsible other to seek medical attention elsewhere if choosing to leave against medical advice.

D. Complete and have the patient or responsible other sign the Discharge Against Medical Advice and Release of Responsibility form.

E. If the patient should refuse to sign the AMA form, the nurse should document refusal of the patient to sign the AMA form and notation of second nurse as a witness.

F. Attach form to patient chart to become a part of the medical record.

G. In the event the patient/responsible other refuses to sign the form, this fact shall be documented in the chart and on the Discharge Against Medical Advice and Release of Responsibility form.

H. An incident report will be completed by the primary care nurse or the House Supervisor/Charge Nurse and forwarded to the Quality Manager for review.

I. House Supervisor and/or Charge Nurse will review situation or contributing factors or problems and will report findings to the Administrator and the Chief Clinical Officer (CCO) on the next business day.

J. All occurrences of the AMA will be reported to the Quality Committee (QC), Medical Staff Committee (MSC), and Governing Board (GB) on a routine basis.

REFERENCES

NA

ATTACHMENTS

NUR-004A Discharge Against Medical Advice and Release of Responsibility Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Anaphylactic/Adverse Drug Reaction		**NUR-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

To recognize the potential danger associated with any anaphylactic or adverse drug reaction to any drug given. To provide a consistent method of treating and reporting anaphylactic and adverse drug reaction.

DEFINITIONS

Adverse Drug Reaction-The American Society of Health-System Pharmacists (ASHP) defines an adverse drug reaction (ADR) as "Any unexpected, unintended, undesired, or excessive response to a drug that:

a) Requires discontinuing the drug (therapeutic or diagnostic)
b) Requires changing the drug therapy
c) Requires modifying the dose (except for minor dosage adjustments)
d) Necessitates admission to a hospital
e) Prolongs stay in a health care facility
f) Necessitates supportive treatment
g) Significantly complicates diagnosis
h) Negatively affects prognosis, or
i) Results in temporary or permanent harm, disability, or death.

Anaphylaxis-a life-threatening allergic reaction that affects two or more parts of the body at once, including your skin, mouth, stomach, lungs or heart. Often it occurs as a series of reactions.

POLICY

All anaphylactic and/or adverse drug reactions will be reported to the Medical Provider, Pharmacy and Therapeutics (P&T), Quality, Medical Staff, and Governing Board committees.

PROCEDURE

1. In the initial nursing assessment, notes of allergy history of the patient and /or a strong family history associated with an allergy to any drug or food associated with drug reaction should be documented.
2. Food allergies associated with latex allergy such as kiwi, chestnut, bananas and avocados should be considered as potential warning signs.
3. Instruct the patient of the possibilities of allergic reaction which may manifest itself by symptoms such as generalized itching, tightness in the chest, a feeling of pressure, or difficulty breathing and immediately report these symptoms to healthcare personnel.
4. Establish a baseline data for vital signs of B/P, pulse, temp, respiration and pulse oximetry.
5. Keep a crash cart available.
6. Be alert for anaphylaxis or adverse drug reaction when administering any drug especially those with high potential for reaction such as PCN, Tetanus, allergy shots or any drug your patient has never taken before. Signs of anaphylaxis:
    a) Urticaria
    b) Edema
    c) Hypotension
    d) Disorientation
    e) Cyanosis
    f) Respiratory difficulty with or without wheezing
    g) Hives
7. Discontinue drug at the first sign of possible symptoms.
8. Maintain an open IV.
9. Maintain an airway; apply oxygen as needed, and notify Respiratory Therapy.
10. Place the patient in Trendelenburg position unless contraindicated.
11. Notify the ER provider or the medical provider on call.
12. If patient's condition is critical and the above measures fail, prepare to call for a Code Blue.
13. Document in nurse's notes the reaction, condition and action taken.
14. Notify the House Supervisor and/or Charge Nurse of the anaphylactic or adverse drug reaction.
15. Complete an Incident Report and complete the information under Adverse Drug Reaction and forward to the Quality Manager.

REFERENCES

NA

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

CONSENT FOR BLOOD AND BLOOD PRODUCTS (NUR-006A)

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo the procedure after knowing the risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you a may give or withhold your consent to the procedure.

DESCRIPTION OF PROCEDURE: Blood is introduced into one of your veins, commonly in the arm, using a sterilized disposable needle. The amount of blood transfused, and whether the transfusion will be of blood, blood components, or blood products, such as plasma, is a judgement the medical provider will make based on your needs.

RISK OF TRANSFUSION: Most transfusions do not cause reactions or complications, but there are risks or possible complications that cannot be anticipated and prevented in some cases. MINOR and temporary reactions include: slight bruising, swelling, local infection, headache, fever, chills, or mild skin reactions such as itching or rash. Some of the MAJOR, but extremely rare risks include: transfusion reaction, which may include kidney failure and/or anemia, heart failure, seizure, death, and infectious diseases such as viral hepatitis, Acquired Human Immunodeficiency Syndrome (AIDS), and other infections which cannot be tested for at this time or which are unknown at this time. The risk of acquiring an infectious disease from transfused blood or blood components from the community blood supply is relatively low since the units have been donated by volunteer donors and have been tested for infectious diseases as required by State and Federal standards. These tests are used along with a detailed health history on the donor to make the blood as safe as possible.

AUTOLOGOUS DONATION *(Receiving your own blood):* I understand that in some instances it may be possible to donate my own blood for elective medical procedures. (Although this eliminates infectious disease transmission, the transfusion still carries with it the risks of adverse reactions, such as fever, chills and bacteria contamination. In addition, the previously donated autologous units may not be enough to meet all my transfusion needs. An intraoperative autologous transfusion (blood recovered during my operation and given back to me) is another alternative approved by me if my physician/provider advises to use.

Circle One- I (have) (have not) made prior arrangements for <u>AUTOLOGOUS</u> transfusions.

DIRECTED DONATION *(Receiving blood from friends or relative):* I understand that in some cases it is possible to arrange for direct donations. However, I understand that directed donations have not been demonstrated to be safer than blood from the volunteer blood supply. In addition, the directed units may be enough to meet all my transfusion needs.

Circle One - I (have) (have not) made prior arrangements for <u>DIRECTED</u> donations.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee or warranties have been made to me concerning the results of the procedure(s). I hereby state that I have read and understand the above information and that all my questions about the procedures, and risks and benefits have been answered in a language that I understand, and I hereby consent to such transfusion as my Provider(s) may deem medically necessary.

_____ _____ _____

Signature of Patient (or Legal Representative or Relative) *Witness to Signature* *Date/Time*

_____ _____

Physician/Provider Signature *Date/Time*

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

REFUSAL TO PERMIT THE ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS

(NUR-006A)

Patient Name _____

Date: _____ Time: _____

I request that no blood or blood products be administered to me during the hospitalization. I hereby release and hold harmless the hospital, its employees, my Providers, and any other person participating in my care from any responsibility or unfavorable results due to my refusal to permit the use of blood or blood products.

The possible risks and consequences of such refusal, including shock, coma and death, have been explained to me by my Providers and I fully understand that such risks and consequences may indeed occur as a result of my refusal.

_____ _____/_____/_____ _____

Signature of Patient or Legal Guardian *Date* *Time*

_____ _____/_____/_____ _____

Signature of Witness *Date* *Time*

_____ ____/____/____ _____

Second Witness (if telephone refusal) *Date* *Time*

_____ _____/_____/_____ _____

Signature of Provider or Physician *Date* *Time*

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Blood Product Administration		**NUR-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to Mangum Regional Medical Center, Registered and Licensed Practical Nurses who are involved in the administration of blood products.

PURPOSE

To set guidelines and to define the responsibilities of nursing personnel for the proper administration and monitoring of blood products

DEFINITIONS

See under Types of Transfusion Reactions

POLICY

Blood products should be initiated only by a Registered Nurse who has demonstrated competency in blood product administration. Blood products can be monitored by a LPN under the supervision of a RN. "Supervision" means the RN is on the premises and immediately available.

1. Administration of blood products must be meticulously monitored. Serious and fatal transfusion reactions have occurred from clerical errors in identification of the correct patient and/or products to be transfused. No amount of checking is excessive when administering blood products.
2. Blood specimens are viable for cross-matching for seventy-two (72) hours after collection.
3. A Blood ID band is placed on the patient when blood is collected for Type and Screen.
4. The Blood ID numbers on units being transfused must match the armband before the blood product is given.
5. If the Blood ID band becomes detached from the patient's arm or leg, a new sample is collected with a new Blood Bank armband.
6. Following transfusion, the blood transfusion form is attached to the patient's medical record. **Do not remove** the tag from the unit of blood until the transfusion is complete.
7. Standard precautions are adhered to by the nurse during this procedure.

8. The hospital consent for blood transfusion must be obtained, completed, witnessed and signed by the patient or patient representative and one consent is sufficient per hospital stay.
9. A consent for Blood Transfusion is not required if the physician orders the blood transfusion for life-threatening situations (e.g., trauma).

PROCEDURE

1. For the administration and monitoring of all blood products, refer to the Hospital's Professional Resource Guide.
2. **Requesting Blood Components:**
    a) The physician enters an order into the patient's chart for Type and Screen and/or blood products.
    b) **EXCEPTIONS:** In case of emergency, type O negative blood may be given, and the physician/provider must sign the permit within twenty-four (24) hours.

3. **Notification of Unit Availability:** Once blood product is received by the lab, lab personnel will notify the patient care area of the blood product availability.

4. **Blood Issuance**

a) Blood for one patient will be issued at a time. Units are packed in a cooler.
b) The physician order will be used for each issue of blood product until the order is completed.
c) The Blood Bank personnel will issue the blood product per department policy.
d) The blood product is taken directly and *immediately* to the patient's bedside.
e) Never store blood in an unmonitored refrigerator.
f) Blood must be started within thirty (30) minutes after receiving from Blood Bank.
    a. If the transfusion cannot be started, return he blood *immediately* within 30 minutes of issue to the Blood Bank. Delay in return will force the component to be discarded.
g) Each blood product will have a sticker identifying the unit to the patient. A copy of this sticker is placed on the Transfusion Record. The sticker remains attached to the blood product always. The blood product must always be positively identified to the recipient.

5. **Blood Verification**

a) Before beginning the transfusion, it is extremely important to correctly identify the patient and the blood product by qualified personnel by an RN and second verification by a RN or LPN.
b) Both nurses must indicate on the Transfusion Record that this verification process has been completed by signing the form (2 signatures are required).

6. **Monitoring during Infusion**

a) The nurse observes the patient closely. Vital signs are taken immediately prior to obtaining the blood, within fifteen (15) minutes after initiating the transfusion, every 15 minutes for the first hour then every 30 minutes during the remainder of the transfusion, and then *one* (*1) hour AFTER the transfusion had been discontinued.*
b) **Note:** If the blood is stopped for a transfusion reaction, the Transfusion Reaction form should be filled out and a copy sent to Quality Management and Blood Bank.

7. **Refusal to Permit Blood Transfusion**

a) The patient must sign the Refusal for Blood Transfusion.

b) Notify the House Supervisor or Charge Nurse, and the provider or physician.

REFERENCES

American Association of Blood Banks (AABB) Technical Manual, current edition
AABB Standards for Transfusion Services, current edition. CDC.gov
https://www.cdc.gov/bloodsafety/basics.html

ATTACHMENTS

NUR-006A Consent for Blood & Refusal of Transfusion
NUR-006B Transfusion Reaction Form
NUR-006C Blood Transfusion Administration Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Types of Transfusion Reactions

- **Allergic reaction**
  An allergic reaction results from an interaction of an allergen in the transfused blood with preformed antibodies in the person receiving the blood transfusion. In some instances, infusion of antibodies from the donor may be involved. The reaction may present only with irritation of the skin and/or mucous membranes but can also involve serious symptoms such as difficulty breathing.
- **Acute hemolytic transfusion reaction (AHTR)**
  An acute hemolytic transfusion reaction is the rapid destruction of red blood cells that occurs during, immediately after, or within 24 hours of a transfusion when a patient is given an incompatible blood type. The recipient's body immediately begins to destroy the donated red blood cells resulting in fever, pain, and sometimes severe complications such as kidney failure.
- **Delayed hemolytic transfusion reaction (DHTR)**
  A delayed hemolytic transfusion reaction occurs when the recipient develops antibodies to red blood cell antigen(s) between 24 hours and 28 days after a transfusion. Symptoms are usually milder than in acute hemolytic transfusion reactions and may even be absent. DHTR is diagnosed with laboratory testing.
- **Delayed serologic transfusion reaction (DSTR)**
  A delayed serologic transfusion reaction occurs when a recipient develops new antibodies against red blood cells between 24 hours and 28 days after a transfusion without clinical symptoms or laboratory evidence of hemolysis. Clinical symptoms are rarely associated with DSTR
- **Febrile non-hemolytic transfusion reaction (FNHTR)**
  Febrile non-hemolytic transfusion reactions are the most common reaction reported after a transfusion. FNHTR is characterized by fever and/or chills in the absence of hemolysis

(breakdown of red blood cells) occurring in the patient during or up to 4 hours after a transfusion. These reactions are generally mild and respond quickly to treatment. Fever can be a symptom of a more severe reaction with more serious causes and should be fully investigated.

- **Hypotensive transfusion reaction**
  A hypotensive transfusion reaction is a drop in systolic blood pressure occurring soon after a transfusion begins that responds quickly to cessation of the transfusion and supportive treatment. Hypotension also can be a symptom of a more severe reaction and should be fully investigated.
- **Post-transfusion purpura (PTP)**
  Post-transfusion purpura is a rare but potentially fatal condition that occurs when a transfusion recipient develops antibodies against platelets, resulting in rapid destruction of both transfused and the patient's own platelets and a severe decline in the platelet count. PTP usually occurs 5-12 days after a transfusion and is more common in women than in men.
- **Transfusion-associated circulatory overload (TACO)**
  Transfusion-associated circulatory overload occurs when the volume of blood or blood components are transfused cannot be effectively processed by the recipient. TACO can occur due to an excessively high infusion rate and/or volume or due to an underlying heart or kidney condition. Symptoms may include difficulty breathing, cough, and fluid in the lungs.
- **Transfusion-related acute lung injury (TRALI)**
  Transfusion-related acute lung injury is a serious but rare reaction that occurs when fluid builds up in the lungs but is not related to excessive volume of blood or blood products transfused. Symptoms include acute respiratory distress with no other explanation for lung injury such as pneumonia or trauma occurring within 6 hours of transfusion. TRALI is a leading cause of transfusion-related death reported to the FDA. The mechanism of TRALI is not well understood but is thought to be associated with the presence of antibodies in donor blood.
- **Transfusion-associated dyspnea (TAD)**
  Transfusion associated dyspnea is the onset of respiratory distress within 24 hours of transfusion that cannot be defined as TACO, TRALI, or an allergic reaction.
- **Transfusion-associated graft vs. host disease (TAGVHD)**
  Transfusion-associated graft vs. host disease is a rare complication of transfusion that occurs when donor T-lymphocytes (the "graft") introduced by the blood transfusion rapidly increase in number in the recipient (the "host") and then attack the recipient's own cells. Symptoms include fever, a characteristic rash, enlargement of the liver, and diarrhea that occur between 2 days and 6 weeks post transfusion. Though very rare, this inflammatory response is difficult to treat and often results in death.
- **Transfusion-transmitted infection (TTI)**
  A transfusion-transmitted infection occurs when a bacterium, parasite, virus, or other potential pathogen is transmitted in donated blood to the transfusion recipient.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Blood Transfusion Administration Form (NUR-006C)

Patient Name: _____ Date: _____/_____/_____

Verification Section **To Be Completed by RN and Second Licensed Nurse** **All Safety Checks Must Be Verified By Both Nurses Together Prior to Administration of Blood Product** ***Involve patient in identification process*** ***See Back for Patient Monitoring Flowsheet***					
Safety Check Indicators	**Verified By (Initials)**	**Verified By (Initials)**	**Safety Check Indicators**	**Verified By (Initials)**	**Verified By (Initials)**
Patient Name			Blood ID Patient Wristband & Blood ID on Unit Match		
Second Patient Identifier Checked (DOB, MR#)			Blood Type		
Physician Order			Expiration Date Checked & Within Range		
Patient Consent Completed			Blood Bag Unit Number & Unit Number on Lab Slip Match		
Nurse Name & Title:					
Nurse Name & Title:					

Place & Secure Blood Requisition Here

Patient Sticker

Blood Administration
Patient Monitoring

Patient Name: _____ Date: _____/_____/_____

Type of Blood Product: □ RBC □ LRBC □ Platelets □ FFP □ Irradiated Blood □ CMV negative

Time & Date Unit Received from Lab: _____:_____ _____/_____/_____ Unit Number: _____

Type & Gauge of Venous Access Device: _____

Infusion Device Used: _____ Flow Rate: _____ IVF used to Prime & Flush Line: _____

Transfusion Initiated By (Print Name & Title): _____

Vital Signs	Time	Temp	Pulse	Resp	Blood Pressure	O2 Sat	Nurse Initials & Title
Pre-Transfusion							
Start of Transfusion							
15 minutes after initiation of transfusion							
Every 15 minutes x1 hour							
Every 15 minutes							
Every 15 minutes							
Every 15 minutes							
Every 30 minutes for remainder of transfusion							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Transfusion Completed/Stopped Time: _____:_____ Date: _____/_____/_____							
One Hour Post-Transfusion							

	NOTES

Signature of Nurse (RN): _____ Initials: _____ Date: _____/_____/_____

Signature of Nurse (RN/LPN): _____ Initials: _____ Date: _____/_____/_____

Signature of Nurse (RN/LPN): _____ Initials: _____ Date: _____/_____/_____

Patient Sticker

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Critical Test Reporting		**NUR-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to Registered and Licensed Practical Nurses who are involved in the care and treatment of Mangum Regional Medical Center patients.

PURPOSE

To report critical results of test and diagnostic procedures on a timely basis. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

DEFINITIONS

Critical value – a pathophysiological state at such variance with normal as to be life-threatening unless something is done promptly and for which some corrective action could be taken.

POLICY

Critical testing results are to be managed and reported to the responsible licensed caregiver in a timely manner.

PROCEDURE

1. Identification of a critical lab result by laboratory personnel.
2. Results for Emergency Department patients will be called to the on-call provider. If the provider is unavailable, results can be called to the House Supervisor or Charge Nurse.
3. Inpatient results will be called to the patient's primary nurse. The primary care nurse will be responsible for contacting the medical provider to report critical results and accept new orders as needed. If the patient's primary care nurse is unavailable the result may be given to the House Supervisor or Charge Nurse.
4. The process of reporting from lab to medical provider will be less than 60 minutes.

5. The nurse will document in the patient's medical record the critical results, time called to physician and any new orders received.
6. The primary care nurse will be responsible for documenting all critical lab results on the Critical Values Report Log.

CRITICAL DIAGNOSTIC/IMAGING NOTIFICATION PROCEDURES

1. Identification of an abnormal result by radiology personnel.
2. Results for Emergency Department patients will be called to the on-call provider. If the provider is unavailable, results can be called to the House Supervisor or Charge Nurse.
3. Inpatient results will be called to the patient's primary nurse. The primary care nurse will be responsible for contacting the medical provider to report critical results and accept new orders as needed. If the patient's primary care nurse is unavailable the result may be given to the House Supervisor or Charge Nurse.
4. The process of reporting from radiology to medical provider will be less than 60 minutes.
5. The nurse will document in the patient's medical record the critical results, time called to physician and any new orders received.
6. The primary care nurse will be responsible for documenting all critical radiology results on the Critical Values Report Log.

ESCALATION PROCEDURES

This is a fail-safe mechanism when laboratory or radiology personnel are unable to reach a responsible licensed provider. Laboratory or radiology personnel will then contact their direct supervisor, Emergency Room medical provider, Chief Clinical Officer (CCO), or Medical Director and document the name of the staff member receiving the results, verification of results "read back" by staff member, date and time results reported to staff member, and the name of the laboratory personnel reporting the critical values.

QUALITY ASSURANCE

Critical test reporting will be monitored monthly and reported to the Quality, Med Staff and Governing Board Committees. An action plan will be developed and implemented to correct any variances from the target.

REFERENCES

The Joint Commission NPSG 02.03.01 2019
https://www.jointcommission.org/assets/1/6/NPSG_Chapter_CAH_Jan2019.pdf

ATTACHMENTS

NUR-008A Critical Values Report Log

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Care Plans		**NUR-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to Mangum Regional Medical Center, Registered and Licensed Practical Nurses who are involved in the care of inhouse patients.

PURPOSE

To assure proper management and care for the patient, the nursing staff will develop and update a care plan for each patient. This will provide coordinated treatment and care, and smooth transition of the patient between departments and shifts.

DEFINITIONS

NA

POLICY

This hospital provides a care plan for each patient admitted. The care plan will be individualized to the patient' s needs and initiated upon admission, updated or modified as patient care needs change, or when a change in care or condition occurs for resolution of problems and to stay current with other problems which might arise.

PROCEDURE

A. On admission, a patient care plan will be initiated and placed in the patient’s medical record;
B. The care plan will be initiated by the admitting RN;
C. The care plan will be individualized for the needs of the patient by a RN;
D. The plan will be updated for resolution of problems and presenting problems as they arise.

E. The patient has the right to participate in the development and implementation of his or her plan of care including discharge planning as part of the patient's plan of care.
F. The hospital will take appropriate actions to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation (a patient's goals and preferences may be, in the hospital's view, unrealistic. Identifying divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation).
G. Required components of the care plan:
    - It includes planning the patient's care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge.
    - The nursing care plan is based on assessing the patient's nursing care needs (not solely those needs related to the admitting diagnosis).
    - The assessment considers the patient's treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge
    - planning.
    - The plan develops appropriate nursing interventions in response to the identified nursing care needs.
    - The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments.
    - The nursing care plan is part of the patient's clinical.
    - The nursing care plan is part of a coordinated interdisciplinary plan of care. This method may serve to promote communication among disciplines and reinforce an integrated, multi-faceted approach to a patient's care, resulting in better patient outcomes and serves to promote the collaboration between members of the patient's health care team.

REFERENCES

Appendix W §485.635(d)(4)

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER

Patient Label

Tranfusion Reaction Form (NUR-006B)

Retain Original Copy in Medical Record; Send Copy to Lab

1. Patient and Blood Product Unique Identification Verification

Is the information IDENTICAL on all the following:
●Patient ID band ●Transfusion Record/Compatibility Tag ●Blood Product Label □ Yes □ No

If no, explain:

2. Clinical History (Check all that apply)

□ Pre-existing fever	□ History or evidence of circulatory overload
□ Transfusion pre-medication Specify:	
□ Immune-compromised Specify:	□ Antibiotic Specify:

□ History of Transfusion: □ Yes □ No □ Unknown □ Within 3 months □ Greater than 3 months

□ History of Previous Transfusion Reaction: □ Yes □ No Date (if known):

3. Location, Date & Time of Transfusion Reaction

Patient location: □ Med/Surg □ ER □ Outpatient

Date of Transfusion:	Time Transfusion Started:
Time Reaction Occurred:	Time Transfusion Stopped:
Time Transfusion Restarted:	

4. Clinical Signs & Symptoms

Vital Signs	Temp	Pulse	RR	BP	O2 Sat	Room Air	Supplementary O2
Pre-transfusion							O2 @ _____LPM
Post-transfusion							

□ Hives	□ Chills	□ Restlessness	□ Chest Pain	□ Diffuse Hemorrhage
□ Itching	□ Rigors	□ Anxiety	□ Heat/Pain @ IV site	□ Facial Swelling
□ Skin rash	□ Flushing	□ Nausea/Vomiting	□ Jaundice	□ Tongue Swelling
□ Hypertension	□ Hypotension	□ Tachycardia	□ Shock	□ Shortness of Breath
□ Fever:	□ Headache	□ Joint/Muscle Pain	□ Red or Brown Urine	□ Wheezing
Oral T > 100.4°F or higher AND 1.8°F or more rise above baseline	□ Dizziness	□ Back Pain	□ Oliguria	□ Hypoxemia
	□ Other:			

5. Blood Product(s) & Equipment Information

Blood Product Type	Unit Number	Volume Transfused (total # of ml)	

Filters/Equipment Used: □ Standard Blood Filter □ IV Pump □ Blood Warmer □ Rapid Infusion Device
□ Other:

6. Measures & Notifications

□ Antipyretics	□ Vasopressors	□ Blood Samples
□ Antihistamines	□ Analgesics	□ Urine Sample
□ Steroids	□ Supplementary O2	□ IV tubing changed & KVO with NS
□ Diuretics	□ Chest X-ray	□ Blood Bag & Tubing Saved for Blood Bank
□ Antibiotics	□ Ventilation	

□ Blood Bank Notified Date: _____ Time: _____ By: _____

Name of Physician/Provider Notified: _____ Date: _____ Time: _____

Report Completed By: _____ Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER

CRITICAL VALUES REPORT LOG (LABS, TESTS, DIAGNOSTICS (NUR-008A)
NOTIFY MEDICAL PROVIDER WITHIN SIXTY (60) MINUTES OF RECEIPT OF RESULT

Results Called to Staff						Physician Notification			
Date	Time	Critical Test	Result	Patient	Signature of Person Receiving Result (Read Back & Verified)	Person Reporting to Provider (Read Back & Verified)	Provider Name	Date	Time

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Deceased Patient		**NUR-009**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to deceased patients of Mangum Regional Medical Center.

PURPOSE

- To ensure the hospital has appropriate systems in place for the care of a deceased patient and their family.
- To ensure deceased patients are managed with dignity and respect.
- To provide compassionate support to families in a difficult time of loss.

DEFINITIONS

1. **Autopsy-**defined as a post-mortem examination if the body of a person, including x-rays and an examination of the internal organs and structures after dissection, to determine the cause of death or the nature of any pathological changes that may have contributed to the death.
2. **Inquest-**defined as a means of investigation into the cause and circumstances of the death of a person, and a determination, made with or without a formal court hearing, as to whether the death was caused by an unlawful act or omission.

POLICY

1. Determination of death by a medical provider.
2. Notify the attending physician or provider, if not present.
3. The House Supervisor/Charge Nurse or designated nurse will notify the next of kin.
4. Complete the Deceased Patient Checklist. If the answer is ‘yes’ to any of the suspected causes of death requiring notification of the Medical Examiner, do the following:

PROCEDURE

1. Determine whether ME/Coroner notification is necessary by completing the Deceased Patient Checklist.
2. Contact LifeShare Donor Referral group at 1-800-241-4483 within 1 hour of death. Record in the LifeShare Death Log. Hospital staff do not inquire as to organ donation wishes. The LifeShare donation specialist will address donation with the family and obtain related consents.
3. If ME/Coroner case, nothing is to be removed from the patient. Greer County Medical Examiner & Coroner 1-405-239-7141. Contact the ME immediately for the following:
    - Death involving an accident, resulting sequelae of an accident
    - Suicide, homicide or suspicious circumstances of any type;
    - Circumstances where the death may have been caused by unlawful means;
    - Deaths unattended by a licensed medical or osteopathic physician for a fatal or potentially fatal illness; or unexplained coma; deaths that are medically unexpected and occur during a therapeutic procedure;
    - Deaths related to disease which might constitute a threat to public health;
    - Deaths of persons whose bodies are to be cremated, buried at sea, transported out of state, or otherwise made ultimately unavailable for pathological study.

    Should the death require contacting the Chief Medical Examiner (CME), staff are instructed to hold the body undisturbed and do not remove any devices, or other physical surroundings of the body, until the CME releases the body). The CME will direct the staff as to the disposition of the body.

4. If death does not require ME/Coroner notification, the body of the deceased is cared for by removing all tubes, tape and bandages.
5. If the patient has an internal pacemaker or defibrillator leave in place. The funeral home will need to be aware if the patient has an internal defibrillator, so they know to turn it off prior to removal as to avoid shock.
6. Bathe patient, change linens and position body in a presentable, natural looking position, if possible. Cover with sheet or blanket to patient's shoulders.
7. Clear room of all unnecessary equipment.
8. Family may be present always and allowed to view the body until they are ready for the funeral home to be notified.
9. Send the patient's personal belongings with family and chart on the Deceased Patient Checklist.
10. Contact the family's funeral home of choice to arrange transport to the funeral home.
11. Assist funeral home personnel with moving body from bed to gurney. Supply funeral home personnel with copy of the face sheet.
12. If the staff has knowledge that the patient had, at the time of death, a communicable disease, staff should inform the funeral home of such.
13. Chart the name of the funeral home, the name of the personnel receiving body, and time body released on the Deceased Patient Checklist and in the patient's chart.
14. Complete the Body Release Form and retain in patient's chart.

15. Should the family request an autopsy, and there is no question in the cause of death, and there is no reason to suspect criminal actions, it is the family's responsibility to contact the pathologist, make autopsy arrangements and provide payment to the pathologist for autopsy services.

Special Considerations

1. Right to control disposition of remains:
    a) The right to control the disposition of the remains of a deceased person, the location, manner and conditions of disposition, and arrangements for funeral goods and services vests in the following order, provided the person is eighteen (18) years of age or older and of sound mind:
        - The decedent, provided the decedent has entered into a pre-need funeral services contract or executed a written document that meets the requirements of the State of Oklahoma;
        - A representative appointed by the decedent by means of an executed and witnessed written document meeting the requirements of the State of Oklahoma;
        - The surviving spouse;
        - The sole surviving adult child of the decedent whose whereabouts is reasonably ascertained or if there is more than one adult child of the decedent, the majority of the adult siblings, whose whereabouts are reasonably ascertained;
        - The surviving parent or parents of the decedent, whose whereabouts are reasonably ascertained;
        - The surviving adult brother or sister of the decedent whose whereabouts are reasonable ascertained, or if there is more than one adult sibling of the decedent, the majority of the adult surviving siblings, whose whereabouts are reasonable ascertained;
        - The guardian of the person of the decedent at the time of death of the decedent, if one has been appointed;
        - The person in the classes of the next degree of kinship, in descending order; under the laws of descent and distribution to inherit the estate of the decedent. If there is more than one person of the same degree, any person of that degree may exercise the right of disposition;
        - If the decedent was an indigent person or other person the final disposition of whose body is the financial responsibility of the state or a political subdivision of the state, the public officer or employee responsible for arranging the final disposition of the remains of the decedent;
        - In the absence of any person under paragraphs 1 through 9 of this section, any other person willing to assume the responsibilities to act and arrange the final disposition of the remains of the decedent, including the personal representative of the estate of the decedent or the funeral director with custody of the body, after attesting in writing that a good faith effort has been made to no avail to contact the individuals under paragraphs 1 through 9 of this section.

2. Oklahoma does not require the involvement of a licensed funeral director in making or carrying out final arrangements (Oklahoma Code § 63-1-317).
3. In Oklahoma, a body must be embalmed or refrigerated if final disposition will not occur within 24 hours O.A.C. 235: 10-11-1 (14). Refrigeration or dry ice can usually preserve a body for a short time. There are resources available to help persons learn how to prepare a body at home for burial or cremation:
(see National Home Funeral Alliance http://www.homefuneralalliance.org/).
4. Oklahoma law requires a death certificate to be filed with the state department of health within three (3) days after the death. The hospital will be responsible for submitting the required information needed to file the death certificate.
5. A special permit is not required in the state of Oklahoma to move a body in Oklahoma. A burial-transit permit from the medical examiner will be required to move the body out of state (Oklahoma Code § 63-6-101).
6. There are no state laws in Oklahoma that prohibit home burial, but local governments may have rules governing private burials. Before conducting a home burial or establishing a family cemetery, consultation with the town or county clerk is required to see if there are zoning rules to follow.
7. Available means of disposition include: burial, entombment, cremation, or donation for scientific study. Donation of human bodies to medical institutions can be made to the State Anatomical Board. Contact information:

   State Anatomical Board
   P.O. Box 26901
   Oklahoma City, Ok 73190-3040
   (405) 271-2424
8. Prior to cremation, a cremation authorization signed by the next of kin and a special permit from the State Medical Examiner must be obtained before a body can be cremated.
9. Financial assistance and support for deceased indigent patients may be available through the county, local funeral home, social support services, and Native American burial assistance programs.

REFERENCES

OK Statutes Title 63.938, 63.941a and 63.941b, Title 21 Chapter 47 Section 1158, Oklahoma Code §63-1-317, §63-6-101, Oklahoma Funeral Board; Funeral Services Licensing Act, 11/1/17.

ATTACHMENTS

NUR-009A Deceased Patient Checklist & Body Release Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER
Deceased Patient Checklist (retain in medical record) (NUR-009)

Name of Deceased: _____ Medical Record Number: _____ Date of Death: _____

Please review the patient's medical record to see if this patient died due to or a delayed consequence of any of the following suspected causes or under any of the following circumstances:

	Yes	No		Yes	No
Violent (homicidal, suicidal, accidental/casualty, including but not limited to thermal, chemical, electrical, radiation, deaths due to criminal abortion (self-induced or not; maternal/fetal)			Medically unexpected and that occur in the course of a therapeutic procedure		
Suspicious, Unusual, Unnatural Circumstances			Deaths of inmates occurring in penal incarceration		
Disease that may constitute a public health threat			Unexplained Coma		
Unattended by a licensed medical/osteopathic physician for a fatal/potentially fatal illness			Bodies for cremation/burial at sea, transported out of state, or otherwise unavailable for pathological study		

If the answer to any of the above listed questions is "Yes," notify the medical examiner/coroner before the deceased body is removed from place of death. All therapeutic items must be left in place until ME/Coroner has authorized removal. Retain all personal items of the deceased and release to family after authorization by the ME/Coroner. ME/Coroner number: Name of County ME (xxx) xxx-xxxx. Ok Stat Ann. 63.938

Name of Medical Provider pronouncing death: _____ Time: _____

Name of Attending/Admitting Physician: _____

Was the Attending/Admitting Physician notified? □ Yes □ No Time: _____
By Whom: _____

Name of ME/Coroner notified: _____ Time: _____

Notify LifeShare Oklahoma within 1 hour of death or imminent death to determine medical suitability for donation: 1-800-241-4483.

Name of Contact at OPO agency: _____ Referral Number: _____

Date Contacted: _____ Time Contacted: _____

Eligible: □Yes □No □ Corneas □ Organ □ Tissue □ Non-Candidate □ Family Refused □ Coroner/ME refused

Physician or Family Request for Autopsy □ Yes □ No Permit Signed □ Yes □ No

Family Member/Patient Representative notified: Name: _____ Time: _____
Chaplin/Clergy notified: _____ Time: _____
Name of Funeral Home: _____ Time: _____

Signature of Nurse completing checklist: _____
Date: _____ Time: _____

Body Received By (signature): _____
Date: _____ Time: _____

Body Release Form

(retain in medical record)

Mangum Regional Medical Center is hereby authorized to release the body of:

_____ to _____

(funeral home)

Name of Family Member/Patient Representative notified: _____

Relationship to Deceased: _____

Date Contacted: _____ Time notified: _____

Date of Expiration: _____ Time of Expiration: _____

Name of Physician notified: _____

Date & Time Physician notified:_____

Post Mortem Care: □ Yes □ No

List of personal belongings: _____

_____

_____

Belongings given to: _____

Signature of Family/Personal Representative: _____

Date: _____ Time: _____

Body picked up by: _____

Date: _____ Time: _____

Signature of Nurse: _____

Date: _____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Do Not Resuscitate (DNR)		**NUR-011**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all patients of Mangum Regional Medical Center.

PURPOSE

To offer guidance to health professionals on the ethical and legal issues involved in withholding life sustaining treatments. This policy will decrease uncertainty in the decision-making process to insure consistency and identify the lines of accountability.

DEFINITIONS

The following definitions are utilized to ensure that application and implementation of the DNR policy is understood by all hospital personnel.

1. **Cardiopulmonary Resuscitation** – Those measures used to restore or support cardiac or respiratory function in the event of a cardiac or respiratory arrest.
2. **DNR Order –** A do-not resuscitate (DNR) order or a "no-code" refers to the written order to suspend the initiation of cardiopulmonary resuscitation (CPR). This order may only be written by the attending physician.
3. **Competent Patient -** A competent patient is defined to be an adult under applicable state law who is conscious, alert, oriented and able to understand the nature and severity of his or her illness or condition and who has not been declared incompetent by a court. Such a patient can make informed and deliberate choices about the treatment or non-treatment of the illness or condition and is able to understand the probable consequences of such decisions. No prior judicial approval is necessary for a competent patient to request the entry of a DNR order, if the attending physician has consulted with the patient to ascertain that the patient fully understands the consequences of the order.
4. **Patient Representative -** A patient representative is an attorney-in-fact for health care decisions acting in accordance with the Uniform Durable Power of Attorney Act, a health

care proxy acting in accordance with the Oklahoma Advance Directive Act, or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.

POLICY

To provide each patient the opportunity to exercise his or her right to make known his or her medical decisions in the event emergency advanced life sustaining interventions may be required.

PROCEDURE

A. Every person shall be presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest, unless one or more of the following conditions, of which the health care provider has actual knowledge, apply:
   1. The patient has notified his or her attending physician that the patient does not consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest and that notification has been entered in the medical record.
   2. The parent or guardian of a minor child, after consultation with the minor child's attending physician, has notified the attending physician that the parent or guardian does not consent to the administration of cardiopulmonary resuscitation in the event of the minor child's cardiac or respiratory arrest, and that the minor child, if capable of doing so and possessing sufficient understanding and appreciation of the nature and consequences of the treatment decision despite the minor child's chronological age, has not objected to this decision of the parent or guardian, and such notification has been entered in the patient's medical records.
   3. An incapacitated person's representative has notified the incapacitated person's attending physician that the representative, based on the known wishes of the incapacitated person, does not consent to the administration of cardiopulmonary resuscitation in the event of the incapacitated person's cardiac or respiratory arrest and that notification has been entered in the patient's medical records;
   4. An attending physician of an incapacitated person without a representative knows by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that the person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.
   5. A do-not-resuscitate consent form in accordance with the provisions of the Oklahoma Do-Not-Resuscitate Act has been executed for that person.
   6. An executed advance directive for health care, or other document directing that life-sustaining treatment not be performed in the event of cardiac or respiratory arrest, is in effect for that person, as provided by Oklahoma law.

B. All decisions with respect to the administration of cardiopulmonary resuscitation shall be made by the patient unless it is appropriate under this section for the patient's representative to do so. The attending physician or other healthcare provider shall

document the reason the representative, rather than the patient, has made a decision in the patient's medical record.

C. No decision by the patient's representative shall be made until the representative has been instructed in writing by the patient's attending physician that such representative is deciding what the incapacitated person would have wanted if the incapacitated person could speak for himself or herself. In addition, the attending physician shall encourage consultation among all reasonably available representatives, family members, and persons close to the incapacitated person to the extent feasible in the circumstances of the case.

D. Whenever possible, the attending physician shall explain to the representative and family members the nature and consequences of the decision to not resuscitate. Evidence that this explanation was provided shall be documented in the medical records of the incapacitated person.

E. The attending physician or other healthcare provider shall also document in the patient's medical record the patient's DNR decision, the patient's mental and physical condition, and any necessary authorization by the patient's representative, the patient's family or judicial approval, where appropriate.

F. It is recommended that a nurse be present when the attending physician discusses the DNR Order with the patient, that patient's representative, and/or the patient's family. The nurse shall document in his or her notes the discussion and the outcome of the discussion.

G. Requirements for DNR Orders:
   1. The patient's attending physician must enter a DNR Order in the patient's medical record. DNR Orders must be written, signed, dated and timed by the patient's attending physician.
   2. The attending physician shall include all appropriate documentation supporting the DNR Order in the physician's progress notes.
   3. The attending physician will place the DNR Order in the front of the chart or in the electronic medical record.

H. Progress Notes
   1. The physician will review the DNR order, as with any order, as often as medically appropriate.

I. Change in Patient's Condition
   1. If the patient's medical condition changes, the patient or the patient's representative may request the physician to withdraw the DNR Order.

J. Continuity of Care
   1. The attending physician and nursing staff must continue to monitor the condition of the patient and provide basic care and comfort measures even though there is a DNR Order for the patient.

2. The physician and nursing staff may not withhold hydration, nutrition, pain medication, and/or patient care because of a DNR order.
3. A patient is permitted to request the revocation of the DNR order at any time to any hospital personnel. In the event of a revocation:
   a. The hospital personnel shall immediately notify the attending physician, and the attending physician will cancel the DNR Order.
   b. The attending physician and nursing staff shall document the revocation of the DNR Order in their applicable progress notes and the patient's medical record.
   c. The revoked DNR Order should not be discarded. The attending physician shall draw a diagonal line across the DNR Order and write "Revoked". The attending physician shall sign and date the revocation in the patient's medical record.

K. Prior to surgery, the anesthesiologist or attending physician shall meet with the patient, the patient's guardian, or the patient's representative to discuss whether the DNR Order shall remain in effect during surgery. If the surgery will require the patient to undergo general anesthesia, the health care provider should explain that the patient will be under artificial respiration, and therefore the surgery could not be performed with a DNR Order in place. If the patient agrees, the anesthesiologist or attending physician shall document in the medical record that the DNR order is suspended during the surgery. The health care provider shall also document this discussion in the progress notes of the patient's medical record.

L. If the patient is transferred to another facility, the physician or his designee shall notify the receiving facility of the existence of the DNR Order in advance of the patient's arrival.

M. The hospital shall provide ongoing education to parents, health care providers, and the community on issues concerning the use of the DNR consent form.

REFERENCES

Oklahoma Do-Not-Resuscitate Act, 63 O.S. § 3131.1 et seq.

ATTACHMENTS

Attachment A: Oklahoma DNR Consent Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Intravascular Line Assessment		**NUR-013**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all patients of Mangum Regional Medical Center.

PURPOSE

To establish evidenced-based practice guidelines for the prevention of central line associated infections (CLABSI's) for patients in need of either short- or long-term central line devices.

DEFINITIONS

NA

POLICY

Each patient with a central venous catheter, midline catheter, picc line, or implantable port will be assessed daily by a qualified and trained clinical staff member (RN, LPN, Medical Provider) for insertion or continued need for such device based on established indicators for intravenous lines. After a thorough assessment and based upon the indications, a RN or LPN will consult daily with the medical provider for continued need for the intravenous line.

PROCEDURE

Maintain intravascular catheter devices only for appropriate indications (see protocol).

REFERENCES

CDC 2018 National Healthcare Safety Network (NHSN) Patient Safety Component Manual, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011, Drewett, S. Central venous catheter removal: Procedures and rationale. *British Journal of Nursing, 9(*22).

ATTACHMENTS

NUR-013A Intravascular Catheter Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Intravascular Catheter Protocol
Mangum Regional Medical Center

Date of Review: _____ Nurse: _____

1. Does patient meet criteria to justify insertion or continuing intravascular catheter?

   a) If ***YES***, check indications below:

   □ **PIV:** Short term access (up to 96 hours) Indications: IV fluids, IVP medications, short-term antibiotics < 7 days.
   The lines listed below must be checked daily for continued necessity:
   □ **Midline:** Short term access (used for 1-4 weeks) Indications: IV fluids, IVP medications, antibiotics
   □ **PICC:** Medium term access (up to 6 months) Indications: antibiotics, parenteral nutrition, chemotherapy, transfusions, medications, critically ill, hemodynamic monitoring, vasoactive drips
   □ **Central Venous Line (CVL):** Emergent (remove as soon as possible) Indications: IV fluids, medications, blood products, irritating/vesicant agents, inaccessible peripheral venous access, parenteral nutrition, critically ill, hemodynamic monitoring, vasoactive drips

   b) If ***NO,*** obtain order for line removal.

   c) Discontinued: Date: _____ Time: _____

   Removed By: _____

   d) If patient admits with femoral or jugular site central venous line (CVL) notify medical provider to as soon as possible. Continue or discontinue as ordered by medical provider.

   e) Discontinued: Date: _____ Time: _____

   f) If line site exhibits any of the following signs: warmth, tenderness, redness, positive blood cultures, fracture/fault in the line, immediately notify medical provider.

1) Provider Notified: Date: _____ Time: _____

2) Nurse: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
IV Administration Privileges		**NUR-014**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all Registered Nurses and Licensed Practical Nurses of Mangum Regional Medical Center.

PURPOSE

To establish who may give, mix and start IV push medications, piggybacks and establish IV fluids for patient administration.

DEFINITIONS

Supervising-The term "supervising" is defined in the Rules of the Oklahoma Nursing Practice Act as: "providing guidance for accomplishing the nursing task or activity, with initial direction of the task or activity and periodic inspection of the actual act of accomplishing a task or activity". [OAC § 485:10- 1-2] C.

Delegating-The term "delegating" is defined in the Rules of the Oklahoma Nursing Practice act as: "entrusting the performance of selected nursing duties to individuals qualified, competent and legally able to perform such duties". [OAC § 485:10-1-2.

POLICY

To provide guidelines on who may administer IV medications/fluids.

PROCEDURE

1. RN's may administer all classes of IV medications, blood and blood products.
2. IV Medication Administration by Licensed Practical Nurses:
    - **Guideline I. Introduction/Purpose:**
        A. In accordance with the Oklahoma Nursing Practice Act, specifically 59 O.S. § 567.3a.2., "the practice of nursing" includes "execution of the medical regime including the administration of medications and treatments prescribed by any person authorized by state law to so prescribe." Therefore, IV therapy and medication administration may be within the scope of practice of the Licensed Practical Nurse (LPN) who has appropriate educational training and supervision.
        B. The Registered Nurse (RN) is responsible for the patient assessment and analysis of data collected during the assessment in determining nursing care needs of the patient. The RN delegating IV medication administration to the LPN must be available to assess the patient and to analyze assessment data, as required.
    - **Guideline II:**
        A. The RN delegating IV therapy/medication administration to an LPN working under the RN's supervision must be able to verify that the LPN has been trained and is competent to perform the skill.
        B. The individual delegating IV therapy to the LPN has the responsibility to adequately supervise the LPN.
3. Training and IV Privileges of the Licensed Practical Nurse:
    A. Appropriate training will be conducted by the employer and should be documented and maintained in the employee file.
    B. The LPN's education, training and competency validation of skills must be specific to the types of access devices and medications used in the hospital, new devices, or other changes that affect the administration of IV medications and treatments. Education and will be completed upon hire, annually, and as needed.
    C. LPN's may perform the following functions regarding intravenous lines, IV medications and fluids, and care maintenance and access of IV lines:
        1. LPN's may access, maintain, and care for peripheral, central and picc line devices (line flushes, dressing changes, and accessing line for medication/fluid administration);
        2. LPN's may perform venipuncture for obtaining lab specimens or the insertion of a peripheral venous line;
        3. LPN's may administer medications and fluids via peripheral, central and picc line devices;
        4. **Exceptions for LPN's:** LPN's may not administer cardiac push/bolus medications or blood or blood products via peripheral, central and picc line devices. LPN's may monitor IV infusion of blood or blood products;
        5. LPN's may draw blood from a central or picc line device;
        6. LPN's who are ACLS certified may administer emergency medications per ACLS guidelines via peripheral, central or picc line devices

REFERENCES

Oklahoma Board of Nursing

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Foley Catheter Line Assessment		**NUR-012**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to patients at Mangum Regional Medical Center.

PURPOSE

To establish evidenced-based practice guidelines for the prevention of catheter associated urinary tract infections for patients in need of either short or long term urinary catherization. Virtually all healthcare associated UTI's are caused by instrumentation of the urinary tract. CAUTI can lead to patient complications as prostatitis, epididymitis, orchitis in males, cystitis, meningitis pyelonephritis, gram-negative bacteremia, endocarditis, vertebral osteomyelitis, septic arthritis, and endophthalmitis. In addition, CAUTI can cause discomfort to the patient, prolonged hospitalization, increased cost, and mortality.

DEFINITIONS

NA

POLICY

Each patient with or without an indwelling urinary catheter will be assessed by a qualified and trained clinical staff member (RN, LPN, Medical Provider) prior to insertion or evaluation of continued need for such device based on established indicators for indwelling urinary catheters. After a thorough assessment and based upon the indications, a trained clinical staff member can insert, continue, or remove the indwelling urinary catheter.

PROCEDURE

Appropriate Urinary Catheter Use: Insert indwelling urinary catheter only for appropriate indications and leave in if needed.

1. Examples of Appropriate Indications for Indwelling Urethral Catheter Use:
    - Acute urinary retention or bladder outlet obstruction;

- Need for accurate measurements of urinary output in critically ill patients;
- Perioperative use for selected surgical procedures (urologic surgery or other surgery on contiguous structures of the genitourinary tract, anticipated prolonged duration of surgery, administration of large-volume infusions or diuretics during surgery, need for intraoperative monitoring of urinary output);
- To assist in healing of open sacral or perineal wounds in incontinent patients;
- Patient requires prolonged immobilization (potentially unstable thoracic/lumbar spine, multiple traumatic injuries e.g. pelvic fractures);
- Patients with chronic indwelling urinary catheter in place on admission;
- Improve comfort for end of life care if needed.

Examples of Inappropriate Uses of Indwelling Catheters:

- As a substitute for nursing care of the patient with incontinence;
- As a means of obtaining urine for culture or other diagnostic tests when the patient can voluntary void;
- For prolonged postoperative duration without appropriate indications.

2. Each patient with or without an indwelling urinary catheter will be assessed by a qualified and trained clinical staff member (RN, LPN, LIP) prior to insertion or evaluation of continued need for such device based on established indicators for indwelling urinary catheters. After a thorough assessment and based upon the indications, a trained clinical staff member can insert, continue, or remove the indwelling urinary catheter.
3. Medical Provider order for Indwelling Urinary Catheter Removal Protocol.
4. If the patient does not meet at least one of the indicators for appropriate use of an indwelling catheter, the catheter will be removed by a nurse.
5. Education and Training: Healthcare personnel and others who take care of catheters are given periodic in-service training regarding techniques and procedures for urinary catheter insertion, maintenance, and removal.

REFERENCES

CDC 2018 National Healthcare Safety Network (NHSN) Patient Safety Component Manual, MedSurg Nursing Jan/Feb 2014 *23*(1), CDC/HICPAC Guideline for Prevention of Catheter Associated Urinary Tract Infection Feb 2017

ATTACHMENTS

NUR-012A Indwelling Urinary Catheter Removal Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Indwelling Urinary Catheter Removal Protocol
Mangum Regional Medical Center

Date of Review: _____ Nurse: _____

1. Does patient meet criteria to justify insertion or continuing indwelling urinary catheter?

   a) If ***YES***, check indications below:

   □ Acute urinary retention or bladder outlet obstruction
   □ Need for accurate measurements of urinary output in critically ill patients
   □ Perioperative use for selected surgical procedures (urologic or other surgery on contiguous structures of the genitourinary tract, anticipated prolonged duration of surgery, need for intraoperative monitoring of urinary output)
   □ To assist in healing of open sacral or perianal wounds in incontinent patients
   □ Patient requires prolonged immobilization (unstable thoracic/lumbar spine, multiple traumatic injuries e.g. pelvic fractures)
   □ Patients with chronic indwelling urinary catheter in place on admission
   □ Improve comfort for end of life care if needed

   b) If ***NO,*** remove indwelling urinary catheter. Initiate post-catheter Removal Assessment and Care: Nurse will assess the patient for:

   - ✓ Spontaneously voiding
   - ✓ Not voiding; however, patient is comfortable and expresses no urge to void
   - ✓ Uncomfortable and urge to void

   c) Indwelling Urinary Catheter Discontinued: Date: _____ Time: _____

   Removed By: _____

   d) If the patient is uncomfortable or has the urge to void and/or has not voided in over 6 hours, initiate the following actions:

   1) Straight cath patient times 1, then notify Provider if patient is unable to void adequately.

   2) Provider Notified: Date: _____ Time: _____

   3) Nurse: _____

Oklahoma Do Not Resuscitate

State of Oklahoma DNR Consent Form

FRONT PAGE

OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____OR_____

Signature of Person Signature of Representative

(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____	_____	_____
Date	Signature of Witness	Address
_____	_____	_____
Date	Signature of Witness	Address

BACK OF PAGE

CERTIFICATION OF PHYSICIAN

(This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.)

I hereby certify, based on clear and convincing evidence presented to me, that I believe that would not have consented to the Name of Incapacitated Person adminstration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

Physician's Signature/Date

Physician's Name (PRINT)

Physician's Address/Phone

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Limits of Care		**NUR-015**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all patients of Mangum Regional Medical Center.

PURPOSE

To provide practice guidelines for healthcare professionals to ensure patients and/or the patient's representative right to self-determination in health care decisions are communicated and protected in conjunction with the Patient Self-Determination Act of 1990. To ensure patients make informed decisions about their treatment and the services they receive.

DEFINITIONS

Comfort Care - A patient care plan that is focused on symptom control, pain relief, and quality of life. It is typically administered to patients who have already been hospitalized several times with further medical treatment unlikely to change matters.

Competent Patient - A competent patient is defined to be an adult under applicable state law who is conscious, alert, oriented and able to understand the nature and severity of his or her illness or condition and who has not been declared incompetent by a court. Such a patient can make informed and deliberate choices about the treatment or non-treatment of the illness or condition and is able to understand the probable consequences of such decisions.

Palliative Care - Patient care that focuses on relief from physical suffering. The patient may be being treated for a disease or may be living with a chronic disease and may or may not be terminally ill. Palliative care addresses the patient's physical, mental, social, and spiritual well-being, is appropriate for patients in all disease stages, and accompanies the patient from diagnosis to cure. The attending physician may treat the patient with life-prolonging medications.

Patient Representative - A patient representative is an attorney-in-fact for health care decisions acting in accordance with the Uniform Durable Power of Attorney Act, a health care proxy

acting in accordance with the Oklahoma Advance Directive Act, or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.

POLICY

To inform all patients about their illness, prognosis and care options in a timely manner to make treatment decisions based on reasonable expectations. It is the responsibility of the medical and clinical staff to respect the patient's right to autonomy and his or her right to determine what happens to them in accordance with his or her personal values, health beliefs and right to medical decision-making and in accordance with an advanced directive if the patient has one.

PROCEDURE

1. The attending physician or other healthcare provider shall establish ongoing communication with the patient or the patient's representative, as applicable, in order for the patient or patient's representative to make informed decisions regarding care. The attending physician or other healthcare provider shall discuss the following:
    a. Health Status;
    b. Disease and expected course;
    c. Treatment options;
    d. Patient preferences;
    e. Spiritual, cultural beliefs and values that influence preferences;
    f. The right of the patient to choose and to change his or her choices at any time; and
    g. The legal requirements for expressing desires and the meaning of the documents and or directives.

2. The attending physician or other healthcare provider will validate the patient's and/or patient's representative's understanding of the information and introduce new information and choices as the patient's condition changes.

3. If the patient or patient's representative chooses to limit or refuse treatment options, such decisions will be honored and supported by the medical and clinical staff. In order for the patient to consent to the limitation of treatment options, the patient must be competent.

4. The attending physician or other health care provider will discuss with the patient and/or the patient's representative what treatment options and interventions may be continued, discontinued, or added in order to assist with symptom management and other issues related to end of life decisions.

5. Limitations of care may include:
    a. Managing pain aggressively and effectively;
    b. Providing treatment of symptoms according to the wishes of the patient or family;
    c. Respecting the patient's privacy, values, religion, and philosophy;

d. Involving the patient and family in every aspect of care, including the decision-making process for end of life issues;
e. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and family; and
f. Assuring that all staff members caring for the patient are aware of the patient's wishes and respectful of the patient's decisions.

6. Orders must be written by the attending physician defining and specifying the care, treatment, and interventions the patient and/or the patient's representative has chosen. The attending physician may choose to implement the "Limits of Care" order set. In addition, the attending physician must specify by an order what interventions and medications will be discontinued, continued, or added.

7. The attending physician or other healthcare provider will document the patient's wishes and his or her discussions with the patient and treatment plan in the progress notes.

8. The patient or patient's representative may choose to contact his or her clergy of choice.

9. If the patient is competent, the patient shall make his or her own healthcare decisions. Family members cannot make healthcare decisions on behalf of a competent patient. If issues arise regarding differences of opinion among the patient, family, or health care team members about the suitability of the treatment plan, the attending physician or other healthcare provider may consult with the Hospital Administrator, the Chief Clinical Officer, Quality Manager, Case Manager, Medical Director, the hospital chaplain, and other appropriate personnel. In the event a patient voices a concern that the hospital's chaplain, if available does not represent his or her beliefs, the patient may request that a specific chaplain also be included in the meeting~~s~~ related to that patient.

REFERENCES

Joint Commission
COP Appendix A §482.13(a)(1), Patient Self Determination Act 1990

ATTACHMENTS

NUR-015A Limits of Care Order Set

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Medication Administration		**NUR-017**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) at Mangum Regional Medical Center.

PURPOSE

To safely administer medication ordered for the patients by the medical provider.

DEFINITIONS

NA

POLICY

It is the policy of the hospital to administer medication in a safe and acceptable manner and record that administration of medication in order that the patient is protected as well as an accurate and timely record is kept.

PROCEDURE

1. RN's and LPN's may administer medications under the guidance of medical provider order.
2. RN's may administer all classes of medications.
3. LPN's may administer medications as defined by their scope of practice and/or facility policy.
4. Training shall be provided as part of staff's initial assessment of competency upon hire and annually.

REFERENCES

Lippincott Nursing Center https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Limits of Care Orders

(NUR-015A)

Date: _____ Time: _____

Allergies: _____

Routine Patient Care (Check box to initiate order)

☐ Pain and other symptom assessment every 4 hours while awake. Call medical provider for unrelieved pain or other symptoms.

☐ Oral hygiene every 2-4 hours prn

☐ Titrate Oxygen 2-6L via NC prn dyspnea or to maintain O2 saturation greater than 90%

☐ Oxygen Mask prn dyspnea or to maintain O2 saturations greater than 90%

☐ Diet as tolerated: Type: _____

☐ Discontinue all enteral feedings

☐ Turn & Reposition every 2 hours or as needed

☐ Foley prn for comfort

☐ Vital Signs every _____ hour(s)

☐ Vital Signs only at request of family

☐ Pulse oximeter checks every _____ hour(s)

☐ Pulse oximeter checks only at request of family

☐ Intake & Output

☐ Glucose Monitoring every _____ hour(s)

☐ Discontinue lab tests

☐ Discontinue all therapy services

☐ Telemetry ☐ Discontinue Telemetry

PATIENT STICKER

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

☐ Insert Intravenous line ☐ Discontinue Intravenous line

☐ Discontinue all medications

☐ Continue the following medications:

_____

_____

Medications (Check box to initiate order)

☐ IV fluids: _____ ml/hour

☐ Morphine sulfate _____ mg PO SL IV every _____ hours prn for pain **(circle route)**

☐ Dilaudid _____ mg PO IV every _____ hours prn for pain **(circle route)**

☐ Oxycodone _____ mg PO every _____ hours prn for pain

☐ Fentanyl Transdermal Patch _____mcg/hour every 72 hours for pain

☐ Tylenol _____mg PO every _____ hours prn for pain or mild discomfort or temp greater than 100.4°F

☐ Tylenol suppository _____ mg rectal every _____ hours prn for pain or mild discomfort or temp greater than 100.4°F

☐ Other pain medication: _____

☐ Ativan _____ mg PO IV SL every _____ hours prn for anxiety, seizures (avoid if delirium present) **(circle route)**

☐ Zofran _____ mg PO IV every _____ hours prn for nausea/vomiting **(circle route)**

☐ Other nausea medication: _____

☐ Dulcolax Suppository _____ mg rectally x1 if no bowel movement in 72 hours

☐ Senokot-S _____ mg PO BID

☐ Other bowel medications: _____

PATIENT STICKER

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

☐ Hyoscyamine _____mg PO SL every _____ hours prn for secretions **(circle route)**

☐ Scopolamine Transdermal Patch topically 1.5mg every 3 days prn for secretions

□ Atropine 1% 1-2 drops SL every 1-hour prn for secretions

☐ Other secretion medications: _____

☐ Artificial tears (Isopto Tears) to both eyes every 12 hours prn for dryness to eyes

☐ Saliva substitute (Xero-Lube) _____ ml PO every 12 hours prn dryness to mouth

☐ Mouth lubricant to lips every 12 hours prn for mouth dryness

☐ Additional Orders:

_____ Date: _____ Time: _____

Medical Provider Signature

_____ Date: _____ Time: _____

Nurse Signature

PATIENT STICKER

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Medical Device Alarm Safety		**NUR-016**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

The scope of this policy addresses the use of medical devices in designated patient care and high-risk areas.

PURPOSE

To ensure a process for safe medical device alarm management and response in patient care or high-risk areas. To ensure a systematic and coordinated approach to clinical alarm system management. Clinical alarm systems are intended to alert caregivers of potential problems. Mangum Regional Medical Center views medical device alarm safety as a top priority.

DEFINITIONS

Medical Device- A piece of equipment designated by the Food & Drug Administration as a medical device.

High Risk Clinical Condition-A medical condition that is considered life threatening to a patient.

Critical/High Risk Alarms-Alarms on medical equipment designed to alert staff to the presence of a life-threatening condition and/or conditions that may impact patient safety. Critical/High risk alarms include ventilator alarms, bipap/cpap alarms, telemetry alarms, pulse oximeter alarms, and fall prevention alarms.

Non-Critical Alarms-Alarms on medical equipment designed to alert staff to the presence of a non-life-threatening condition. Non-critical alarms include enteral feeding pumps, IV pumps, and wound vacuums.

POLICY

This policy applies to medical devices that contain alarms designed to alert staff to high-risk clinical conditions and/or conditions that may impact patient safety. Patient care and high-risk areas

- Monitored care units
- Emergency department
- Other: any area where a medical device/medical equipment with clinical alarms are utilized

PROCEDURE

Critical Alarm Parameters shall be defined by the Medical Director.

TELEMETRY MONITIORING
The alarms for critical dysrhythmias will be in the "on" position at all times and will be audible to staff. Alarms will be maintained in the "on" position as long as the equipment is being used on the patient. Telemetry monitors with parameter settings, will be established by the Medical Director to alert staff of conditions that may be life threatening or impact patient safety. The House Supervisor and/or Charge Nurse has the authority to change alarm parameters based on a medical provider order. The House Supervisor and/or Charge Nurse will be responsible for checking telemetry monitoring for accurate settings and proper operation every shift.

VENTILATOR OR OTHER NON-INVASIVE RESPIRATORY DEVICES
- Alarm volumes will never be turned down or muted.
- Alarm parameters will be set in such a manner that they are consistent with the patient's clinical presentation and care needs as determined by the medical provider.

MONITORING AND RESPONDING TO ALARM SIGNALS
All clinical, licensed or non-licensed staff are responsible for responding to alarms and implementing interventions within their scope of practice.

NON-CRITICAL ALARM SETTINGS
Non-critical alarm parameters shall be set to the default settings established by the manufacturer or as clinically warranted based on the patient's condition. Non-critical alarms should not be turned off.

STAFF TRAINING
Staff training on the proper operation of medical devices will include the identification and verification of critical alarms and settings.
- Training shall be provided as part of staff's initial assessment of competency upon hire, when new medical devices are introduced into the organization, and as necessary.

REFERENCES

Joint Commission NPSG.06.01.01Improve the safety of clinical alarm systems

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Organ/Tissue/Eye Donation		**NUR-018**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all patients a Mangum Regional Medical Center.

PURPOSE

To ensure the family of each potential organ, tissue or eye donor is informed of their option to donate. To ensure Mangum Regional Medical Center will use discretion and sensitivity with respect to circumstances, views, and beliefs of the patient and patient's family.

DEFINITONS

Donation after Brain Death (DBD)-Organ donation takes place from a donor who has been declared brain dead according to current standards of practice for neurologic death and applicable hospital policy. This donor is maintained on the ventilator until the time of organ removal.

Donation after Circulatory Death (DCD)-Organ donation takes place from a donor after planned withdrawal of life sustaining therapies and after irreversible cessation of circulatory and respiratory functions has been observed and documented by the attending physician according to current standards of practice and applicable hospital policy. This patient is ventilator support and the authorized party or the patient themselves have made the decision to withdraw life support independently of the decision to donate organs.

Tissue Donor-Tissue donation (skin, bone, tendons, veins, eyes, heart valves) takes place from a donor after irreversible cessation of circulatory and respiratory functions according to current standards of practice and applicable hospital policy.

Imminent Death-Imminent Death (as defined by the Oklahoma LifeShare Organ Procurement Organization):

a) Any patient on ventilator with Glasgow Coma Score ("GCS") of five or less and no sedation or paralytics.

b) Any patient with brain death testing ordered.
c) Prior to decelerating care or withdrawal of support on any ventilator patient.
d) Any patient who experiences cardiac death.

POLICY

Mangum Regional Medical Center will work collaboratively with LifeShare Transplant Donor Services of Oklahoma and the Oklahoma Lions Eye Bank to facilitate the retrieval, processing, preservation, storage and distribution of donated organs, tissues or eyes.

PROCEDURE

1. Mangum Regional Medical Center will notify LifeShare Transplant Donor Services of Oklahoma of every death or imminent death at Mangum Regional Medical Center. Notification should be within sixty (60) minutes of death, patient placement on a ventilator due to severe brain injury or being declared brain dead.
2. If the patient is determined by LifeShare Transplant Donor Services of Oklahoma to be an eligible candidate for donation, LifeShare will contact the family to discuss consent and arrangements for donation.
3. Staff will not inquire if the patient and/or family would like to approve of organ, tissue, or eye donation upon the death of the patient.
4. Information regarding notification to LifeShare will be recorded on the patient deceased checklist.
5. All deaths and resultant reporting to LifeShare will be recorded on the OPO log.
6. All results of the LifeShare reporting will be reported to the Quality Committee (QC), Medical Staff Committee (MSC), and Governing Board (GB) on a routine basis.

REFERENCES

SOM Appendix Y, Title 63: Health & Safety Oklahoma Statutes, Chapter 46: §2200.27Q, §2200.1A-§2200.27A Oklahoma Uniform Anatomical Gift Act, 42 CFR 482, 486

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

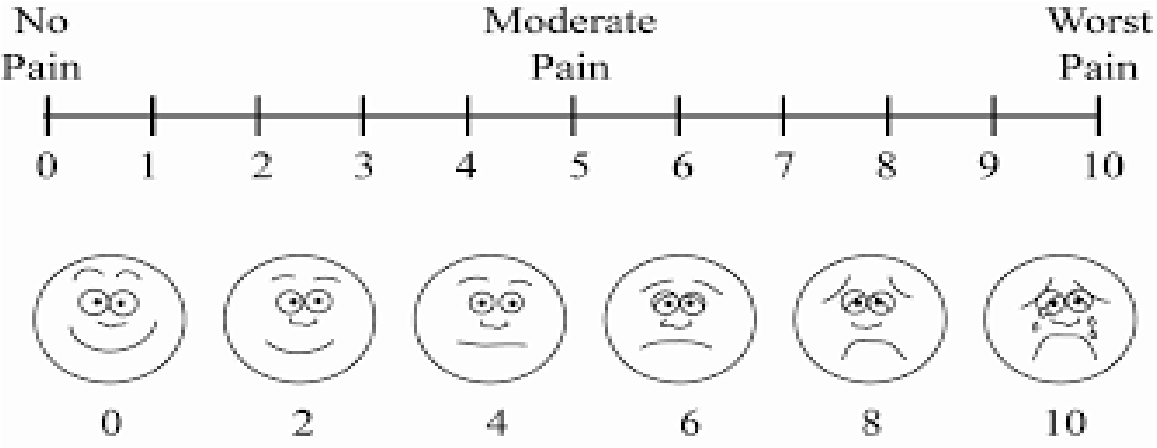
WONG-BAKER FACES PAIN SCALE (NUR-019C)

Designed to be used for patients age 3 years to adult	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Nurse Name/Title
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

NUMERIC RATING PAIN SCALE (NUR-019B)



Designed to be used for patients over the age of 9 years	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Nurse Name/Title
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						
Pain Rating						
Reassessment						

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Pain Screening, Assessment and Management		**NUR-019**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

I. SCOPE

This policy applies to Mangum Regional Medical Center and all medical staff, nursing staff, agency staff, and other persons performing work for or at the Hospital for the assessment and management of pain including but not limited to the screening, routine assessment, reassessment, documentation, implementation of pharmacologic and non-pharmacologic interventions, and development of an individualized plan of care as appropriate to the patient's condition.

II. PURPOSE

Pain is a serious public health problem that has been linked to many physical and behavioral health conditions and contributes to rising health care costs and lost productivity (CDC, 2016). Pain is one of the most common reasons patients present to the Hospital for treatment.

Approximately 1 in 5 adults in the United States experience chronic pain. Chronic pain costs the U.S. between $560-$635 billion annually in medication expenses, disability programs and lost productivity. Patients presenting to the hospital for the treatment of pain have steadily risen over 46% and continue to grow. Despite the continued trend, pain continues to be undertreated resulting in oligoanalgesia. Inadequately treated pain can result in the development of co-morbidities such as anxiety, depression, immune system dysfunction, restricted mobility, poor perceived health, and a reduced quality of life.

The purpose of this policy is to optimize the prevention, assessment and management of pain for all patients by:

- Informing patient at the time of their initial evaluation that relief of pain is an important part of their care and respond quickly to reports of pain in an effort to maximize comfort.
- On initial evaluation and at regular intervals, assess for the presence, quality, and intensity of pain and use patients' self-report as the primary indicator of pain.
- Collaborate with the patient, responsible others, and healthcare providers to establish a goal for pain relief and develop and implement a plan of care to achieve that goal when possible.

- To provide the best pain management to include pharmacological and non-pharmacological methods.
- To provide pain management evidence-based guidelines and maintain individuality for each patient.

III. DEFINITIONS

A. **Acute Pain:** is characterized by sudden onset and short duration. The pathology and cause are often obvious (i.e. surgery, trauma, etc.)

B. **Chronic Pain:** is any pain that lasts longer than six months. Pain can become progressively worse and reoccur intermittently outlasting the usual healing process. The original condition may or may not have healed. Regardless, chronic pain is pain that has become independent of the underlying injury or illness that started it all.

C. **Pain:** "an unpleased sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." Pain is characterized by several quantifiable features, including intensity, time, course, quality, impact, and personal meaning. "Pain is whatever the patient says it is, existing whenever the experiencing person says it does". (IASP, 2020, McCaffery & Pasero, 2011).

D. **Oligoanalgesia:** the inadequate treatment of pain, usually in patients who have difficulty communicating the amount of pain they are experiencing. At risk groups include but are not limited to, children, different cultures, language barriers, developmentally delayed, cognitively impaired, severe emotional stress, and mentally ill.

E. **Pain Assessment:** An assessment of pain that is performed with the report of pain presence.

F. **Comprehensive Pain Assessment:** an assessment process that includes evaluation of the origin/cause, location, duration, intensity, aggravating and alleviation factors, effects of pain, and the current pain regimen effectiveness that is performed if the initial pain screening indicates a history of persistent or current pain.

G. **Pain Intensity Level:** a pain rating reported by the patient that represents pain presence and intensity.

H. **Pain Scales:** tools to assess pain in the patient who can/cannot self-report and in those who are nonverbal. Selection is based on the patient's ability to provide a self-report, age, patient preference, and ability to understand.

I. **Pain Screening:** A process that includes the initial and ongoing evaluation of the presence of pain.

J. **Acceptable Pain Intensity:** the pain intensity, on a self-report pain scale, identified by the patient, at which the patient can perform necessary and desired activity. It should be appreciated that this often is a dynamic process and will vary depending upon the experience with interventions attempted.

K. **Assume Pain Present:** the result of nursing evaluation that may suggest pain or the identification of potential causes of pain (i.e. pathological causes, procedures,

interventions that typically result in pain) for the patient who is unable to provide a self-report.

L. **Opioid Withdrawal:** an acute preventable state resulting from abrupt withdrawal of opiates after prolonged or heavy use. Symptoms may include irritability, anxiety, apprehension, muscular/abdominal pain, chills, nausea, diarrhea, yawning, sweating, sneezing, rhinorrhea and insomnia.

M. **Opioid naïve:** an opioid naïve person has not recently taken enough opioids on a regular enough basis to become tolerant to the effects of an opioid.

N. **Opioid tolerant:** patients who are taking, for one week or longer, at least 60mg oral morphine/day, 25ug transdermal fentanyl/hour, 30mg oral oxycodone/day, 8mg oral hydromorphone/day, 25mg oral oxymorphone/day, 60 mg oral hydrocodone/day or an equianalgesic dose of any other opioid (as defined by the FDA, 2019).

O. **Sedation Assessment:** Assessment of Sedation Level for patients receiving medications that may result in unintended sedation.

P. **Sedation Level:** A level identified on a Sedation Scale to identify changes in the patient's alertness or arousability.

IV. POLICY

It is the policy of Mangum Regional Medical to provide excellence in patient care throughout the lifespan. The treatment of pain is inherent in the care of the patient and includes relief of the physical and psychosocial symptoms associated with untreated pain. All patients have the right to individualized pain assessment in addition to safe and effective pain management. Healthcare providers will respect the patient's right to pain management and to be informed of available and appropriate methods of pain relief along with possible positive and negative consequences. The prevention and relief of pain is contingent upon pain assessment and reassessment, pharmacological and non-pharmacological interventions, and the treatment of side effects that may be associated with analgesia.

Self-report is one of the most reliable indicators of pain presence and intensity. For patients who are unable to self-report staff will assume pain is present for conditions/procedures that are known to be painful, use an approved pain assessment tool and/or solicit information from caregivers/family. Pain screenings will be performed on admission, continue throughout hospitalization, with routine vital signs, and based on individual patient needs. A comprehensive pain assessment will be performed if the initial pain screening reveals current pain or a history of persistent/chronic pain. Pain will be reassessed after interventions to evaluate effectiveness and to recognize undesirable side effects and documented in the patient's medical record. Nursing staff will notify the provider if comfort is not achieved following pain management interventions for changes in pain characteristics, and/or with occurrence of advancing, unintended sedation.

The commitment of Mangum Regional Medical Center to prevent and treat pain is based on a body of scientific knowledge, evidence-based guidelines, and regulations from the following organizations:

- International Association for the Study of Pain (IASP)

- American Pain Society (APS)
- American Society for Pain Management (ASPM)
- American College of Emergency Physicians (ACEP)
- Emergency Nurses Association (ENA)
- American College of Occupational and Environmental Medicine (ACOEM)
- Centers for Disease Control and Prevention
- Oklahoma Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines
- Oklahoma Senate Bill 1446: Best Practice for an Act Regulating of Opioid Drugs.

The Hospital also endorses the American Nurses Association Code of Ethics for Nurses, and the American Nurses Association Position Statement on Pain Management and Control of Distressing Symptoms in Dying Patients.

V. PROCEDURE

A. **Screening**

1. Patients will be screened using one of the approved pain scales for the presence or absence of pain during ED visits and at the time of admission. Identify whether the patient is opioid tolerant.
2. For patients with symptoms suggestive of myocardial ischemia (MI) the goal is "No Pain".
3. Screening should be documented in the appropriate section of the patient's medical record.

B. **Assessment**

1. Initial Assessment of Patients in Pain
    i. Initial assessment for patients in pain identified by the pain screening will include a comprehensive pain assessment. This assessment takes into consideration:
        a. Pain assessment using the Hospital's approved pain scales appropriate for the patient's age, medical condition, and ability to understand.
        b. Patient self-report of pain will be considered the "gold standard" and the most reliable information about the patient's pain.
        c. Patient goals and expectations for pain relief.
        d. The patient's medical condition, scope of care, treatment and services.
    ii. The comprehensive pain assessment should include the following:
        a. Origin/cause of pain
        b. Pain intensity by patient self-report when possible.
        c. Behavioral indicators or non-verbal signs of pain for patients not able to self-report using behavioral pain assessment tools appropriate to the patient's age and medical condition.

d. Pain quality and characteristics (onset, location, description, intensity), aggravating and relieving factors, previous treatment and effectiveness.
e. Impact of pain on functional ability and quality of life including activity, mood, appetite, sleep, social relationships, leisure and pleasure activities, etc.
f. Alternative methods of pain control used
g. Level of influence of pain on necessary activities

iii. Once pain is assessed, it will be classified for treatment purposes as follows:

On pain scales from zero to 10 – (zero indicating no pain)

- **Mild:** Pain level 1 to 3
- **Moderate:** Pain level 4 to 6
- **Severe:** Pain level 7 to 10

iv. Patient's acceptable level of pain can be used to guide treatment.

v. Prior to initiating opioid therapy patients will be assessed by a provider to determine if the patient can be treated with appropriate non-opioid alternatives. If the severity of the pain can be reasonably assumed to warrant their use, the patient's risk level for adverse outcomes related to opioid treatment will be determined by the responsible provider.

iii. Assessment information will be used to develop a plan of care based on the patient's clinical condition and pain management goals.

C. **Reassessment**

1. Emergency Department
   i. Patients in the ED experiencing pain will be assessed by nursing staff at a minimum every 4 hours or more frequently based on interventions, prescriber order, assessment or patient condition.
   ii. Nursing staff will perform a pain assessment using an approved pain scale after pain interventions as follows:
      a. 15 to 30 minutes after IV administration
      b. 60 minutes after oral administration
      c. 60 minutes after all non-pharmacological interventions
   iii. Reassess more frequently for patients experiencing severe, rapidly changing pain and patients exhibiting excess sedation.
   iv. Reassess with any new patient report of pain or following a pain-producing event
2. In-Patient and Swing-Bed
   i. Patients admitted to the Hospital or Swing-Bed status who are experiencing pain will be assessed by nursing staff at a minimum every shift or more frequently based on interventions, prescriber order, assessment or patient condition.
   ii. Nursing staff will perform a pain assessment using an approved pain scale after pain interventions as follows:
      a. 15 to 30 minutes after IV administration

b. 60 minutes after oral administration
c. 60 minutes after all non-pharmacological interventions

iii. Reassess more frequently for patients experiencing severe, rapidly changing pain and patients exhibiting excess sedation

iv. Reassess with any new patient report of pain or following a pain-producing event.

D. Assessment When Patient is Sleeping or Appears to be Sleeping

1. Patients who are receiving opioid analgesics are at increased risk of opioid induced respiratory depression during the first 24 hours of treatment. This can occur more frequently during 11:00 pm and 7:00 a.m. when most patients are sleeping (Jarzyna, et al; Pasero, 2009).
2. Nursing staff will consider a patient's need for sleep along with patient safety when determining whether or not to wake the patient for assessment.
3. The nurse may use their discretion to not wake the patient if the patient's respiratory rate (RR) and quality (depth and regularity) are within normal limits (WNL) for the patient.
4. If the patient appears to be sleeping:
   i. Assess the patient's respiratory status **PRIOR** to waking the patient, as arousing the patient will stimulate respirations.
   ii. Perform a comprehensive respiratory assessment that includes respiratory rate, depth, regularity and noisiness. RR should be counted for a full minute.
   iii. Compare RR, depth and quality to the patient's baseline status. **Shallow respirations, periods of apnea, and snoring require immediate attention and further evaluation.**
   iv. Call out the patient's name in a normal tone of voice.
      a. If the patient does not arouse and RR and quality are WNL for the patient, assessment/reassessment may be delayed until the patient wakes and "sleep" should be charted in the patient's medical record. Additionally, RR and quality should be charted.
      b. **If the patient's RR and quality are not WNL, the patient must immediately be stimulated/awakened to complete more thorough pain, sedation, and respiratory assessments.**
   v. RR alone is not sufficient enough to assess for respiratory depression. Assessing quality (regularity and depth) is necessary to determine if the patient is experiencing clinically significant respiratory depression. A patient may breathe at a rate of 8-10 breaths per minute and be well ventilated if the quality is regular and deep. On the other hand, a patient with a RR with shallow respirations may not be ventilating adequately.

E. **Pain Scales**

1. **Pediatrics 3 years of age/Patients unable to communicate:**

i. Use the Face, Legs, Activity, Cry, Consolability (FLACC) scale (See Attachment A)

2. **Pediatrics 3 years of age and over:**
   i. Use Wong-Baker Faces Pain Rating Scale (See Attachment B)
3. **Pediatrics over 6 years of age who understand concepts of rank & order:**
   i. Use Numeric Pain Rating Scale (See Attachment C)
4. **Adults:**
   i. Use the Numeric Pain Rating Scale
   ii. Consider options of the Wong-Baker or FLACC for adults with difficulty expressing numeric values for pain assessment.
5. **Geriatrics:**
   i. Use the Numeric Pain Rating Scale
   ii. Consider options of the Wong-Baker or Pain Assessment in Advance Dementia (PAINAD) (See Attachment D) for patients who have difficulty expressing numeric values for pain assessment.

F. **Sedation Assessment**

1. Sedation and respiratory depression occur on a continuum. Sedation always precedes opioid-induced respiratory depression.
2. The inability of the patient to stay awake to maintain a conversation is the hallmark of clinically significant sedation.
3. The POSS (Pasero Opioid-Induced Sedation Scale) (See Attachment E) will be used for patients receiving opioids for pain management in which advancing, unintended sedation may occur.
4. Assess sedation prior to and after opioid administration. Document assessment in the patient's medical record.
5. Reassess Sedation Level to evaluate a change in alertness or arousability and recognize unintended, advancing sedation:
   i. When using the POSS: if the patient is sleeping and pain has been well managed without occurrence of Sedation Levels 3 or 4, the RN may document "sleep, easy to arouse" if respirations are quiet, regular, deep and rate >10/minute and light touching of the patient's shoulder or gentle movement of the bed results in patient movement or change in position.
   ii. <u>WAKE</u> the patient and perform Pain and Sedation assessments if the respiratory rate is <10/minute or respirations are irregular, shallow, or noisy (even mild snoring) and/or the patient does not change position or demonstrate movement in response to light touching of the patient's shoulder or gentle moving of the bed.
6. If the patient is assessed to have respiratory depression or unintended sedation, collaborate with provider and pharmacist to identify other potentially sedating medications administered within at least the prior six hours.

G. **<u>Plan of Care</u>**

1. Patients who have pain will have their pain managed based on an individualized plan of care that is evidence-based considering the patient's clinical condition, past medical history, and pain management acceptable level of pain. The patient and/or their representative(s) should be actively involved in developing the plan of care including establishing pain management goals and strategies. This plan should be an interdisciplinary approach and include:
   i. Input from the patient and/or their representative(s);
   ii. The patient's pain intensity goal;
   iii. Development of realistic, measurable goals for the degree, duration, and reduction of pain including functional goals.
   iv. Discussion of criteria used to evaluate treatment process (for example, pain relief and improved physical and psychosocial function)
   v. The pharmacologic/non-pharmacologic interventions appropriate to the patient's condition and age, such as positioning, physical therapy, cold/heat applications, behavioral therapies, diversional activities, relaxation and imagery techniques, etc.
2. The Plan of Care should be documented in the appropriate section of the patient's medical record and revised as indicated by the patient's condition and response to treatment.
3. Anticipated Pain: patients who need to be treated for pain at a zero-pain level before participating in potentially pain provoking activities such as prior to a dressing change, procedure, or PT/Rehab should have a specific order to support the treatment for anticipated pain.

H. **Patient Education**

1. Explain that pain can be managed but not always completely relieved, the importance of reporting pain and the benefits of safe pain control.
2. Explain the importance of preventing rather than chasing pain in effective pain management. Hospital staff will teach patients and/or patient representatives to report pain as soon as it is experienced.
3. Describe to the patient and/or patient representative atypical manifestations of pain such as:
   i. Changes in function and gait;
   ii. Withdrawn or agitated behavior;
   iii. Increased behavior.
4. Teach patients and/or patient representatives to use the appropriate pain scale. Once the appropriate pain scale has been determined, continue to use that scale.
5. Teach patients and/or patient representative about the safe use of opioids when prescribed; including person risk factors for adverse events related to opioid treatment.
6. Explain common side effects of pain management medications (constipation, sedation, and nausea).
7. Teach non-pharmacological interventions and inform patient and/or patient representative that these interventions complement the plan of care.

8. Educate patients and/or patient representatives on discharge plans related to pain management including:
    i. Pain management Plan of Care
    ii. Side effects of pain management treatment
    iii. Activities of daily living, including the home environment, that might exacerbate pain or reduce the effectiveness of the pain management Plan of Care; as well as strategies to address these issues.
    iv. Safe use, storage, and disposal of opioids when prescribed.
9. Patients and/or patient representatives will also be educated regarding:
    i. Their rights to have their pain recognized and managed as part of their treatment.
    ii. Their role and participation in the overall treatment plan and management of their pain, including identifying cultural, spiritual, or personal beliefs, which should be taken into consideration in formulating an individualized pain management plan.
    iii. Other education as identified by assessment and reassessment process.
10. Education and demonstration of understanding will be documented in the appropriate section of the patient's medical record.

I. **Discharge/Follow-Up Care**

1. The discharge process provides for continuing care by referral for treatment based on the patient's assessed needs at discharge.
2. The Pain Management Plan of Care will be communicated to the next care provider, when applicable (i.e. patient, family, skilled nursing facility, home care, etc.).
3. This plan will identify the patient' plan level, the patient's goal of treatment, the scale utilized, location of pain, pharmacological interventions including last dose given and non-pharmacological strategies.
4. The plan will be documented in the discharge summary or appropriate portion of the patient's medical record so that it may be accessed by providers as necessary.
5. Discharge instructions will be provided to the patient and/or patient representative that will include but not limited to:
    i. Pain management
    ii. Symptoms which require physician notification or prompt attention by a health care provider.
    iv. Referral for treatment (if indicated)

VI. PAIN MANAGEMENT INTERVENTIONS

A. Nursing stall will administer scheduled medications "Around-the-Clock" (ATC), at the prescribed interval, to achieve and facilitate the patient's comfort. Nursing staff will collaborate with the provider to prevent nausea or constipation related to analgesics.

B. Nursing staff will collaborate with the patient to administer PRN pain medications as required to achieve the patient's desired comfort level.
C. As prescribed for the patient, nursing staff may use clinical judgement to:
    1. Determine the analgesic and dose to administer.
    2. Evaluate the patient's previous experience with the procedure, intervention or activity and response to the analgesic.
    3. Pre-emptively medicate prior to procedure/intervention or activity.
D. Collaborate with patient to identify non-pharmacologic comfort interventions including integrative therapies, positioning, music, heat/cold application and distraction.

VII. OPIOID PRESCRIBING

A. Providers will consider non-pharmacological therapies and/or non-opioid pain medications prior to prescribing opioids for the treatment of pain.
    1. Providers will consider prescribing opioids only if the expected benefits for both pain and function are anticipated to outweigh risks to the patient.
    2. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.
B. Opioids should only be used for the treatment of acute pain when the severity of pain warrants the prescribing of opioids.
C. When administering or prescribing opioids, the provider should start with the lowest possible effective dose for the management of the patient's pain.
D. When prescribing opioids for pain, the provider should prescribe no more than a short course, except in special circumstances.
    1. ED: no more than a three-day supply
    2. Inpatient: no more than a seven-day supply
E. Prior to prescribing opioids providers should query the Oklahoma Prescription Monitoring Program (PMP) for patients presenting with pain. In circumstances where a patient's pain is resulting from an objectively diagnosed disease process injury, a provider may prudently opt not to review the Oklahoma PMP.
F. For exacerbations of chronic pain, the provider should attempt to notify the patient's primary opioid prescriber that the patient is under evaluation in the ED. If the provider deems it necessary to prescribe opioids (i.e. new, acute injury or objectively diagnosed disease process/injury), Oklahoma PMP data should be reviewed, and only enough pills prescribed to last until the office of the patient's primary opioid prescriber opens.
G. Patients receiving opioid prescriptions at the time of discharge will receive information on the risk of overdose and addiction, as well as safe storage and proper disposal of unused medications.

VIII. QUALITY MONITORING

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are

implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Clinical Officer and an incident report completed.

All incident reports will be forwarded to the Quality Risk Manager and reported to the QAPI, MEC, and Governing Board.

IX. REFERENCES

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VIII. ATTACHMENTS

Attachment A: Face, Legs, Activity, Cry, Consolability (FLACC) Scale
Attachment B: Wong-Baker Faces Pain Rating Scale
Attachment C: Numeric Pain Rating Scale
Attachment D: Pain Assessment in Advanced Dementia Scale (PAINAD)
Attachment E: Pasero Opioid-Induced Sedation Scale (POSS)

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

PEDIATRIC FLACC PAIN SCALE (NUR-019D)					
The scale is designed to help clinicians assess the level of pain in children who are too young to cooperate verbally. It can also be used in adults who are unable to communicate.	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Nurse Name/Title**
FACE					
0-No particular expression or smile					
1-Occasional grimace or frown, withdrawn, disinterested					
2-Frequent to constant quivering chin, clenched jaw					
LEGS					
0-Normal position or relaxed					
1-Uneasy, restless, tense					
2-Kicking or legs drawn up					
ACTIVITY					
0-Lying quietly, normal position, moves easily					
1-Squirming, shifting back and forth, tense					
2-Arched, rigid, or jerking					
CRY					
0-No cry (Awake or Asleep)					
1-Moans or whimpers; occasional complaint					
2-Crying steadily, screams or sobs, frequent complaints					
CONSOLABILITY					
0-Content, relaxed					
1-Reassured by occasional touching, hugging or being talked to, distractible					
2-Difficult to console or comfort					
Total Score					
REASSESSMENT					
REASSESSMENT SCORE					

Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

Instructions: *Observe the older person before scoring his/her behaviors. For each of the items included in the PAINAD, select the score (0, 1, 2) that reflects the current state of the persons behavior. The patient can be observed under different conditions (i.e., at rest, during a pleasant activity, during caregiving, after the administration of pain medication, etc.). Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.*

Note: *Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.*

Behavior	0	1	2	Score
Breathing Independent of Vocalization	Normal	Occasional labored breathing □ Short period of hyperventilation □	Noisy labored breathing □ Long period of hyperventilation □ Cheyne-Stokes respirations □	
Negative vocalization	None	Occasional moan or groan □ Low-level speech with a negative or disapproving quality □	Repeated trouble calling out □ Loud moaning or groaning □ Crying □	
Facial expression	Smiling or inexpressive	Sad □ Frightened □ Frown □	Facial grimacing □	
Body Language	Relaxed	Tense □ Distressed pacing □ Fidgeting □	Rigid □ Fists clenched □ Knees pulled up □ Pulling or pushing away □ Striking out □	
Consolability	No need to console	Distracted or reassured by voice or touch □	Unable to console, distract, or reassure □	
			TOTAL SCORE	

(Total scores range from 0 to 10 [based on a scale of 0 to 2 for five items], with a higher score indicating more severe pain [0=”no pain” to 10=”severe pain”])

Adapted from: Warden V., Hurley, AC, et al. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. Journal of American Medical Directors Association, 4(1):9-15.

Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

Item Descriptions

Breathing:

1. Normal breathing: characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing: characterized by episodic bursts of harsh difficult or wearing respirations
3. Short period of hyperventilation: characterized by intervals of rapid, deep breaths lasting a short period of time
4. Noisy labored breathing: characterized by negative sounding respirations on inspiration or expiration. May be loud, gurling, wheezing. Strenuous or wearing.
5. Long period of hyperventilation: characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations: characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea.

Negative Vocalization:

1. None: characterized by speech or vocalization that has a neutral or pleasant quality
2. Occasional moan or groan: characterized by mournful or murmuring sounds, wails or laments. Groaning characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality: characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated trouble calling out: characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning: characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying: characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression:

1. Smiling or Inexpressive: characterized by upturned corners of mouth, brightening of eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed or blank look.
2. Sad: characterized by an unhappy, lonesome, sorrowful or dejected look. May tears in the eyes.
3. Frightened: characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. Frown: characterized by downward turn of the corners of mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing: characterized by a distorted, distressed look. Brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

Body Language:

1. Relaxed: characterized by a calm, restful, mellow appearance. Seems to be taking it easy.
2. Tense: characterized by a strained, apprehensive or worried appearance. Jaw may be clenched (exclude any fractures)
3. Distressed pacing: characterized by activity that seems unsettled. May be a fearful, worried or distressed element present. Rate may by faster or slower.
4. Fidgeting: characterized by restless movement. Squirming about or wiggling. Repetitive touching, tugging or rubbing body parts may also be observed.
5. Rigid: characterized by stiffening of body. Arms and/or legs are tight and inflexible. Trunk may appear straight and unyielding (exclude any fractures).
6. Fist clenched: characterized by tightly closed hands. May be open and closed repeatedly or held tightly closed
7. Knees pulled up: characterized by flexing legs and drawing knees up toward chest. Overall troubled appearance (exclude any contractures)
8. Pulling or pushing away: characterized by resistiveness upon approach to care. Person is trying to escape by yanking or wrenching free or shoving person away.
9. Striking out: characterized by hitting, grabbing, punching, biting, or other form of personal assault.

Consolability:

1. No need to console: characterized by a sense of well-being. Person appears content.
2. Distracted or reassured by voice or touch: characterized by a disruption in the behavior when the person is spoken to or touched. Behavior stops during period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure: characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Safe Handling of Medications		**NUR-020**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all personnel of Mangum Regional Medical Center who handle medications.

PURPOSE

To establish guidelines for the prevention of spills or leakage of cytotoxic drugs which can be harmful to the skin, ophthalmic or respiratory systems. To provide guidelines for proper handling of accidental spills of such drugs.

DEFINITIONS

NA

POLICY

Precautions shall be exercised when preparing or administrating any drugs. Drug leaks and/or spills are to be cleaned up immediately by personnel following established procedures.

PROCEDURE

1. Exercise precautionary measures when preparing or administering any drug:
    a. Protect and secure drug containers or packages;
    b. Wear non-powder latex gloves when handling damaged packages or leaking drug containers;
    c. Avoid inadvertent ingestion of drugs by refraining from eating, drinking, applying make-up or chewing gum while preparing or administering any drug;
    d. Tap gently the ampule to remove drugs from the neck of the ampule before opening the ampule;
    e. Apply a gauze pledget or alcohol square to the neck of the ampule before opening the ampule to protect your hands from medication and cuts;

f. Use a filter needle to withdraw medication from ampule;
g. Avoid activities that can cause splattering, spraying, and aerosol generation e.g.:
    i. Withdrawing the needle carelessly from the drug vial;
    ii. Drug transfers involving needles and syringes;
    iii. Breaking open ampule when there is an accumulation of fluid in the neck of the container;
    iv. Air filled drug syringes;
    v. Loose intravenous connection sites
h. Use syringes and intravenous sets that have a luer-lock type fitting when preparing or administering drugs
i. Prime IV sets with fluid into a proper receptacle: (sink, or alcohol sponge)

i. Check solution containers to insure the caps, entry portals, and tubing connections for a tight seal.
j. Labels should be appropriate for the drug contained.
k. Wear gloves when preparing or administering any potentially caustic or cytotoxic drug.
l. Treat personal contamination of gloves, clothing, skin, or eyes as follows:
    1. Remove contaminated gloves, clothing or gown and discard in a proper biohazard receptacle;
    2. Wash affected skin area immediately with soap and cool water;
    3. Immediately flood the affected eye with isotonic eye wash solution for a minimum of five (5) minutes. Report to the emergency room if needed;
    4. Complete and forward an employee incident report according to hospital policy.

Spill Clean-up

a. Block access to a spill;
b. Gather proper supplies needed to clean up spill:
    1) Gloves
    2) Absorbent material for spills
    3) Recommended cleanser for the spill.
    4) Dustpan.
c. Put on Gloves
d. Apply absorbent material to the spill;
e. Wipe area with appropriate absorbent disposable towel or if glass is present sweep absorbent material and waste into a dustpan with a small hand broom or mop;
f. Use a wet absorbent pad if the spill is solid or powdered substance;
g. Discard the waste, in a biohazard, impermeable container such a sharps container;
h. Clean the area where the spill occurred 3 times with an appropriate cleaner;
i. Follow the cleaning with 2 rinses of cool water;
j. Discard used equipment and soiled gloves and pads in a biohazard waste receptacle

REFERENCES

NA

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Sexual Assault Care and Treatment		**NUR-021**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department	**02/2020**	
DEPARTMENT	REFERENCE	
Emergency Department		

SCOPE

This policy applies to all persons who are victims of sexual assault.

PURPOSE

To delineate the procedure for assessing, examining and supporting the person who has been sexually assaulted.

DEFINITIONS

Sexual Assault Nurse Examiners- Sexual Assault Nurse Examiners (SANE) are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse (International Association of Forensic Nurses).

POLICY

Persons that are victims of sexual assault will be offered the option of an exam by a SANE nurse.

PROCEDURE

1. Persons with complaints of a sexual assault will be screened immediately in the Emergency Room by the RN, House Supervisor, and/or Charge Nurse will immediately notify the SANE nurse for consultation as appropriate.
2. If the person requires stabilization for any reason, the person will receive the appropriate medical care and treatment.
3. The SANE nurse assumes control of the person upon arrival.
4. If the person has not reported the incident to the police, they are encouraged to, but not forced to do so. Police should be notified if the person wishes to report the assault.

ATTACHMENTS

NUR-021A Oklahoma List of SANE Programs

REFERENCES

International Association of Forensic Nurses Retrieved from https://www.forensicnurses.org/

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Pasero Opioid-Induced Sedation Scale (POSS) with Interventions - MANGUM REGIONAL MEDICAL CENTER

Date:_____ **Time:_____**

Assessment	Score
S = Sleep, easy to arouse • *Acceptable; no action necessary; may increase opioid dose if needed*	[ ]
1 = Awake and alert • *Acceptable; no action necessary; may increase opioid dose if needed*	[ ]
2 = Slightly drowsy, easily aroused • *Acceptable; no action necessary; may increase opioid dose if needed*	[ ]
3 = Frequently drowsy, arousable, drifts off to sleep during conversation • *Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at < 3 and respiratory status is satisfactory; notify prescriber for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.*	[ ]
4 = Somnolent, minimal or no response to verbal and physical stimulation • *Unacceptable; stop opioid; consider administering naloxone; notify prescriber; monitor respiratory status and sedation level closely until sedation level is stable at < 3 and respiratory status is satisfactory*	[ ]

See appropriate action in italics at each level of sedation

_____

Nurse Signature

Adapted from: Pasero, C. (2009) Assessment of sedation during opioid administration for pain management. Journal of PeriAnesthesia Nursing. 24(3): 186-90.

Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

Instructions: *Observe the older person before scoring his/her behaviors. For each of the items included in the PAINAD, select the score (0, 1, 2) that reflects the current state of the persons behavior. The patient can be observed under different conditions (i.e., at rest, during a pleasant activity, during caregiving, after the administration of pain medication, etc.). Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.*

Note: *Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.*

Behavior	0	1	2	Score
Breathing Independent of Vocalization	Normal	Occasional labored breathing □ Short period of hyperventilation □	Noisy labored breathing □ Long period of hyperventilation □ Cheyne-Stokes respirations □	
Negative vocalization	None	Occasional moan or groan □ Low-level speech with a negative or disapproving quality □	Repeated trouble calling out □ Loud moaning or groaning □ Crying □	
Facial expression	Smiling or inexpressive	Sad □ Frightened □ Frown □	Facial grimacing □	
Body Language	Relaxed	Tense □ Distressed pacing □ Fidgeting □	Rigid □ Fists clenched □ Knees pulled up □ Pulling or pushing away □ Striking out □	
Consolability	No need to console	Distracted or reassured by voice or touch □	Unable to console, distract, or reassure □	
			TOTAL SCORE	

(Total scores range from 0 to 10 [based on a scale of 0 to 2 for five items], with a higher score indicating more severe pain [0=”no pain” to 10=”severe pain”])

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Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

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5. Rigid: characterized by stiffening of body. Arms and/or legs are tight and inflexible. Trunk may appear straight and unyielding (exclude any fractures).
6. Fist clenched: characterized by tightly closed hands. May be open and closed repeatedly or held tightly closed
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3. Unable to console, distract or reassure: characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

OKLAHOMA SANE PROGRAMS

County	City	Site	Contact #
Pontotoc	Ada	Ada Care Cottage	(580) 992-6677
		After Hours	(580) 320-5457
Jackson	Altus	Jackson County Memorial Hospital	(580) 379-5000
Carter	Ardmore	C-Sara	(580) 226-7283
Washington	Bartlesville	Ray of Hope (9 to 5) Jane Phillips Medical Center After hours	(918) 337-6177 (918) 333-7200 (918) 214-8886
Caddo	Carnegie	Carnegie Tri-County Municipal Hospital	(580) 654-1050
Grady	Chickasha	Grady County Memorial Hospital	(405) 224-2300
Stephens	Duncan	Duncan Regional Hospital	(580) 252-5300
Beckham	Elk City	Great Plains Regional Medical Center	(580) 225-2511
Garfield	Enid	YWCA	(580) 234-7581
		Crisis Line	(800) 966-7644
Texas	Guymon	Texas County Memorial Hospital	(580) 338-6515
Choctaw	Hugo	Choctaw Memorial Hospital	(580) 317-9500
McCurtain	Idabel	McCurtain Memorial Hospital	(580) 286-7623
Comanche	Lawton	Comanche County Memorial Hospital	(580) 585-5523
Pittsburgh	McAlester	PC Care	(918) 420-2273
Muskogee	Muskogee	Kids Space	(918) 682-3841
Cleveland	Norman	Women's Resource Center	(405) 364-9424
Okfuskee	Okemah	Creek Nation Community Hospital	(918) 732-7979
Oklahoma	Oklahoma City	YWCA	(405) 948-1770
Okmulgee	Okmulgee	Muskogee Creek Nation Department of Health	(918) 732-7979
Kay	Ponca City	The Dearing House	(580) 762-5266
		Emergency	(580) 762-2873
Leflore	Poteau	Leflore County Child Advocacy Network	(918) 647-3814

OKLAHOMA SANE PROGRAMS

Sequoyah	Sallisaw	Sequoyah Memorial Hospital	(918) 774-1100
Beckham	Sayre	Sayre Memorial Hospital	(580) 928-5541
Pottawatomie	Shawnee	Unzner Child Advocacy Center	(405) 878-9597
Payne	Stillwater	Stillwater Medical Center	(405) 372-1480
Adair	Stillwell	Adair Co. Care Center-Memorial Hospital	(918) 696-3101
Cherokee	Tahlequah	Tahlequah City Hospital	(918) 456-0641
Leflore	Talihina	Choctaw Nation Hospital	(918) 567-7000
Tulsa	Tulsa	Hillcrest Medical Center	(918) 743-5763
Wagoner	Wagoner	Wagoner Community Hospital	(918) 485-5514
Woodward	Woodward	Woodward	(580) 256-5511
Delaware	Grove	Integris Grove Hospital	
		Community Crisis Center Advocacy	(800) 400-0883

Conscious Sedation/Procedure Form (NUR-022B) MANGUM REGIONAL MEDICAL CENTER

Section I NURSING ASSESSMENT:

Date: _____/_____/_____ Time: _____ CODE STATUS: □ Full □ DNR ID Band Checked: □ Yes □ No

Patient Name: _____ Gender: □ M □ F Age: _____ DOB: _____/_____/_____

Allergies/Type of Reaction:

Allergen	Type of Reaction	Allergen	Type of Reaction

Current Medications:

Previous Reaction to Sedation: □ Yes □ No □ Unknown If yes, explain: _____

_____

Height: _____inches Weight: _____kilograms IV: Site: _____ Gauge:_____ Fluid:_____ Rate: _____

Time of last PO food intake: _____ Time of last fluid intake: _____

Nursing Pre-Assessment

Neuro	Cardio	Resp	GI/Urinary	MS	Skin	Limitations
□ Alert/Oriented	□ HR Reg	□ Normal	□ Abd Soft/NT	□ Freely Moves UE x2	□ Warm	□ None
□ Calm/Relaxed	□ HR Irreg	□ Dyspnea	□ Abd Distended	□ Freely Moves LE x2	□ Dry	□ Auditory
□ Follows Commands	□ Murmur	□ Tachypnea	□ Abd Tender	□ Ambulates W/O Assist	□ Pale	□ Visual
□ Restless/Agitated	□ Pacemaker	□ Bradypnea	□ BS Present	□ Ambulates With Assist	□ Diaphoretic	□ ROM
□ Lethargic	□ Edema	□ O2@ LPM/NC	□ Continent	□ Ambulates with Device	□ Cyanotic	□ Language
□ Confused	□ Tachycardia		□ Incontinent	□ Weak	□ Rash	
□ Anxious	□ Bradycardia		□ Other:			
□ Other:						

Narrative Notes:

_____

_____

_____

_____

_____

_____

Assessment Reviewed With Provider: □ Yes □ No

Nurse Signature: _____ Date: _____/_____/_____ Time: _____

Section II MEDICAL PROVIDER ASSESSMENT:

Date: _____/_____/_____ Time: _____

Patient History:

□ HTN	□ DM I	□ DM II	□ CAD	□ Renal Disease	□ Liver Disease	□ COPD	□ Asthma	□ Heart Disease
□ Cancer	□ Mental DO	□ Autoimmune Disease	□ Lupus	□ DVT	□ Hematologic DO	□ Inf. Disease	□ Epilepsy	□ Stroke
□ Pregnant	□ MI	□ Drug Abuse	□ ETOH Abuse	□ CHF	□ CVD	□	□	□

Chief Complaint: _____

Physical Exam:

Neuro	
Cardiovascular	
Respiratory	
MS	
Genitourinary	
Skin	
Other Findings	

Procedure: _____

Indication for Procedure: _____

Sedation Required: □ Yes □ No Sedation Medication: _____

Previous Reaction to Sedation: □ Yes □ No □ Unknown If yes, explain: _____

_____

□ Medication Review □ Review of patient's sedation history Sedation Plan: □ Minimal □ Moderate

ADULT ASA Physical Status	Description of Status	PEDIATRIC ASA Physical Status	Description of Status
□ PI	Normal healthy **patient**	□ PI	Normal healthy **child**
□ P2	**Patient** with mild systemic disease	□ P2	**Child** with mild systemic disease
□ P3	**Patient** with severe systemic disease	□ P3	**Child** with severe systemic disease
□ P4	**Patient** with severe systemic disease that is constant threat to life	□ P4	**Child** with severe systemic disease that is constant threat to life
□ P5	Moribund **patient** not expected to survive w/o procedure	□ P5	Moribund **child** not expected to survive w/o procedure
□ P6	**Patient** declared brain dead whose organs are being removed for donor purposes	□ P6	**Child** declared brain dead whose organs are being removed for donor purposes

Medical Provider Signature: _____

Date: _____/_____/_____ Time: _____

Section III PRE-PROCEDURE

ACTIVE TIME OUT	***Verified by Primary Care Nurse (Signature of Nurse)***	***Verified by 2nd Nurse & Medical Provider (Signature of Nurse/Medical Provider)***
Verification of 2 Patient Identifiers □ Patient ID verified □ Date of Birth Verified □ Medical Record # Verified □ Other □ ID Verified with Patient/Patient Representative □ Verified Type and Site of Procedure as Applicable with Patient/Patient Representative		

Procedure: _____

Medical Provider Verification Signature: _____

Mark Site: _____

Verified by (Signature):

Primary Care Nurse: _____

Nurse: _____

Medical Provider: _____

PRE-PROCEDURE ALDRETE SCORE

Activity (A)	**Respirations (R)**	**Circulation (CR)**	**Consciousness (LOC)**	**Oxygenation (OX)**	**Criteria**	**Score**
2 Voluntarily moves all 4 extremities	**2** Able to breath deep/cough on command	**2** BP & HR within 20% of pre-sedation level or asymptomatic alteration	**2** Fully awake	**2** Sats > 92%	Activity	
1 Voluntarily moves 2 extremities	**1** Limited breathing, Dyspnea	**1** BP & HR within 20%-50% of pre-sedation level or mildly symptomatic (fluid bolus or dopamine < 10mcg/kg/min for heart failure patients)	**1** Arousable to verbal stimuli	**1** Needs O2 to maintain O2	Respiration	
0 No voluntary extremity movements	**0** Apnea or requires airway support	**0** BP & HR > 50% of pre-sedation level or dopamine > 10mcg/kg/min for heart failure patients	**0** Unresponsive	**0** Sats < 90%	Circulation	
If score less than 8; continue monitoring and re-evaluate every 15 minutes. ***If score greater than 8; DC monitoring and transfer or discharge when stability criteria met***					Consciousness	
					Oxygenation	
					Total	

PRE-PROCEDURE BASELINE VITAL SIGNS

TIME	EKG RHYTHM	TEMP	PULSE	RESP	BP	O2 SATS	SIGNATURE OF NURSE

PRE-PROCEDURE PAIN RATING

□ **Numeric Pain Score (NPS): _____**

□ **Non-Communicative Pain Scale (NCPS): _____**

0=sleeping

2=grimacing with movement

4=moaning with movement

6=restless

8=constant moaning without stimuli

10=grimacing with constant moaning without stimuli

Section IV SEDATION ADMINISTRATION

Medication Administered	Date	Time	Route	Dosage	Signature of Medication Administrator

Monitor VS & Aldrete Score Every 5 minutes until end of sedation administration

VITAL SIGNS							ALDRETE SCORE						PAIN		NURSE INITIALS
TIME	EKG RHYTHM	TEMP	PULSE	RESP	BP	O2 SATS	A	R	CR	LOC	OX	SCORE	0-10 SCALE	NON-COMM	

Other Interventions

□ O2 at _____LPN via NC FACE MASK Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

Section V INTRA-PROCEDURE MONITORING

Monitor VS & Aldrete Score Every 5 minutes until end of procedure

VITAL SIGNS							ALDRETE SCORE						PAIN		NURSE INITIALS
TIME	EKG RHYTHM	TEMP	PULSE	RESP	BP	O2 SATS	A	R	CR	LOC	OX	SCORE	0-10 SCALE	NON-COMM	

Other Interventions

□ O2 at _____LPN via NC FACE MASK Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

Section VI POST-PROCEDRE MONITORING

Monitor VS every 15 minutes until stable; stable VS include:

- O2 sats > 90% on room air
- Patient easily arousable, or as prior to procedure
- Intact protective reflexes (cough/gag reflex)
- Patient alert, oriented to person, place, time, or as prior to procedure
- Able to ambulate as able prior to procedure
- Vital signs are stable
- Aldrete score returns to pre-sedation level

VITAL SIGNS							ALDRETE SCORE						PAIN		NURSE INITIALS
TIME	EKG RHYTHM	TEMP	PULSE	RESP	BP	O2 SATS	A	R	CR	LOC	OX	SCORE	0-10 SCALE	NON-COMM	

Other Interventions

□ O2 at _____LPN via NC FACE MASK Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

□ Other: _____ Time: _____

Narrative Notes:

_____

_____

_____

_____

_____

_____

Complications/adverse event □ Yes □ No If yes; Describe complication/adverse event:

_____

_____

_____

_____

_____

_____

Assessment Reviewed With Provider: □ Yes □ No
Nurse Signature: _____ Date: _____/_____/_____ Time: _____

Patient meets the following criteria for routine care or discharge (check each box as applicable):

□ O2 sats > 90% on room air

□ Patient easily arousable, or as prior to procedure

□ Intact protective reflexes (cough/gag reflex)

□ Patient alert, oriented to person, place, time, or as prior to procedure

□ Patient out of bed 30 minutes prior to discharge

□ Able to void

□ Able to retain oral fluids

□ Able to ambulate as able prior to procedure

□ Vital signs are stable

□ Aldrete score returns to pre-sedation level

□ No complications or adverse event associated with procedure

Discharge VS:

VITAL SIGNS							ALDRETE SCORE						PAIN		NURSE INITIALS
TIME	EKG RHYTHM	TEMP	PULSE	RESP	BP	O2 SATS	A	R	CR	LOC	OX	SCORE	0-10 SCALE	NON-COMM	

Discharge:

□ Discharge instructions reviewed with patient and/or family by Registered Nurse

□ Copy of discharge instructions provided to patient and/or family by Registered Nurse

Patient discharged at time: _____ date:_____/_____/_____

Patient discharge disposition: _____

Patient escorted by: _____

Nurse Signature: _____ Date: _____/_____/_____ Time: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Patient Fall Prevention Plan		**NUR-023**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all patients in all areas of Mangum Regional Medical Center.

PURPOSE

Preventing falls among patients in the hospital setting requires a multifaceted approach. This plan provides the framework for a comprehensive falls prevention program designed to reduce the risk of patient harm resulting from falls and methods to evaluate the effectiveness of the program.

DEFINITIONS

Fall-is defined as an unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or is reported to have landed on the floor (un-witnessed) not due to any intentional movement or extrinsic force such as stroke, fainting, seizure.

Accidental falls- occur when patients fall unintentionally. For example, they may trip, slip, or fall because of a failure of equipment or by environmental factors such as spilled water or urine on the floor.

Unanticipated physiologic falls- occur when the physical cause of the falls is not reflected in the patient's risk factor for falls. A fall in one of these patients is caused by physical conditions that cannot be predicted until the patient falls. For example, the fall may be due to fainting, a seizure, or a pathological fracture of the hip.

Anticipated physiologic falls- occur in patients whose score on risk assessment scales (e.g. Morse Fall Scale (MFS) indicates that they are at risk of falling. According to the MFS, these patients have some of the following characteristics: a prior fall, weak or impaired gait, use of a walking aid, intravenous access, or impaired mental status.

A. Falls are classified into the following categories:
    1. Fall without injury

2. Fall with minor injury (minor cuts, minor bleeding, skin abrasions/contusions/tears, swelling, pain)
3. Fall with major injury (fractures, subdural hematomas, other major head trauma, cardiac arrest, excessive bleeding, lacerations requiring sutures, loss of consciousness, and death)

POLICY

Name of Hospital believes that patients are at greater risk for falls when hospitalized. Therefore all hospitalized patients are considered a fall risk and will be assessed to minimize their risk of falling. Name of Hospital staff will work to actively reduce the risk of falls across the continuum of care by ensuring a safe physical environment and appropriate identification of fall risk patients.

PROCEDURE

A. All staff are responsible for reducing fall risks and ensuring a safe environment free from hazards. All clinical and non-clinical staff will work within their scope of practice to prevent patient falls. Staff works as a cohesive team to eliminate the potential for patient falls through an all hazards approach. This is accomplished by:

a) Monitoring the hospital environment for potential hazards and taking proactive actions to mitigate any fall risks to the patients by assessing: cords, equipment, uneven surfaces to eliminate trip hazards, and lighting.
b) Immediately clean up spills and place caution signs if floors are wet.
c) Ensure patients immediate physical safety is maintained while notifying appropriate clinical staff if unsafe patient activity is observed.

B. Patients will be assessed for their fall risk at a minimum, but not limited to :

1. On admission to the hospital
2. On any transfer from one unit to another within the hospital
3. Following any change of status
4. Following a fall
5. On a regular interval, such as each shift
6. Patient's mobility status will be assessed by the primary care nurse and the rehab therapy on an ongoing basis at a minimum on each shift and with changes in the patient's mobility status. All disciplines shall communicate any changes in the patient's mobility status via face-to-face communication and on the Mobility Fall Precautions Poster to be maintained at the patient's head of bed.

C. Patients will be assessed using a standardized fall assessment tool. Assessment of risk factors for falls is essential for a number of reasons:

a) It aids in clinical decision making.
b) Use of a standardized assessment helps ensure that key risk factors are identified and therefore can be acted on.
c) It allows the targeting of preventive interventions to the correct patients.
d) It facilitates care planning. Care plans can better focus on the specific dimensions that place the patient at greatest risk.

e) It facilitates communication between health care workers and between care settings.
f) Workers have a common language by which they describe risk.
g) The hospital will utilize the Morse Fall Scale Risk Assessment for adults (See below). The Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling. It consists of six (6) variables that are quick and easy to score, and it has been shown to have predictive validity and inter-rater reliability.
h) The Humpty Dumpty Fall Risk Assessment Scale (See Attachment PTR-023B) will be utilized for pediatric patients. For pediatric fall prevention interventions see Attachment PTR-023C.

Morse Fall Scale (MFS)

Item	***Scale***	***Scoring***
1. History of falling; immediate or within three (3) months	No 0 Yes 25	_____
2. Secondary diagnosis (more than one (1) diagnosis listed on the patient chart)	No 0 Yes 15	_____
3. Ambulatory aid a. None/bed rest/nurse assist/wheelchair b. Crutches/cane/walker c. Furniture	0 15 30	_____
4. IV/Heparin Lock	No 0 Yes 20	_____
5. Gait/Transferring a. Normal/bed rest/immobile b. Weak c. Impaired	0 10 20	_____
6. Mental status a. Oriented to own ability b. Forgets limitations	0 15	_____
TOTAL SCORE MORSE FALL RISK **>=51 High Risk** **25-50 Moderate Risk** **<= 24 Low Risk**		

The items in the scale are scored as follows:

a. ***History of falling*:** This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as

from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. **Note:** If a patient falls for the first time, then his or her score immediately increases by 25.

b. ***Secondary diagnosis*:** This is scored as 15 if more than one (1) medical diagnosis is listed on the patient's chart; if not, score 0.
c. ***Ambulatory aids*:** This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.
d. ***IV/Heparin Lock*:** This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.
e. ***Gait*:** A ***normal gait*** is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a ***weak gait*** (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an ***impaired gait*** (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and they watch the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.
f. ***Mental status*:** When using this Scale, mental status is measured by checking the patient's own self-assessment of their own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging their own ability is consistent with the ambulatory order on the nursing assessment tool, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate their own abilities and to be forgetful of limitations and scored as 15.
g. ***Scoring and Risk Level*:** The score is then tallied and recorded on the patient's chart. The Risk level (see below) and recommended actions (e.g. no interventions needed, standard fall prevention interventions, and high-risk prevention interventions) are then identified.

D. Implement Standard fall precautions for all patients. Standard fall precautions are called universal because they apply to all patients regardless of fall risk. Standard fall precautions constitute the basics of patient safety. They apply across all hospital areas and help safeguard not only patients, but also visitors and staff in many cases. Maintaining a safe and comfortable environment is the responsibility of the hospital independent of a patient's particular risks for falls, because failure to do so can put any patient at risk. For example, virtually any patient could slip and fall if there is a spill on the floor. Standard fall precautions include:

- Orient patient to surroundings and assigned staff;
- Lighting adequate to provide safe ambulation;
- Instruct to call for help before getting out of bed;
- Demonstrate nurses' call system;
- Call light within reach, visible and patient informed of the location and use;
- Light cord within reach, visible and patient informed of the location and use;

- Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unneeded equipment);
- Personal care items within arm length;
- Bed in lowest position with wheels locked;
- Instruct patient in all activities prior to initiating;
- Assign bed that enables patient to exit towards stronger side whenever possible.

E. Hourly rounding can be carried out by clinical staff (i.e., nurse, nursing assistant, respiratory) alternating with a nursing assistant (such as a certified nurse assistant, patients are not disturbed if sleeping, except as needed to provide care. Benefits of hourly rounding is that it is proactive; it reduces patients‘ need to use the call light to ask for help and therefore decreases the number of unscheduled call lights that require response. These regular rounds allow many needs like toileting and access to drinking water to be met by staff who are scheduled to visit the patient‘s room. When rounding staff can utilize the 5 P’s when rounding on the patient:

1) *Pain:* Assess the patient‘s pain level. Provide pain medicine if needed.
2) Personal Needs: Offer help using the toilet; offer hydration, offer nutrition, empty commodes/urinals.
3) *Position:* Help the patient get into a comfortable position or turn immobile patients to maintain skin integrity.
4) *Placement:* Make sure patient‘s essential needs (call light, phone, reading material, toileting equipment, etc.) are within easy reach.
5) *Prevent Falls:* Ask patient/family to put on call light if patient needs to get out of bed.

F. Additional strategies for preventing falls in hospitalized patients involves engaging patients and families in a three-step prevention process to reduce the risk of falls:

1) Fall risk screening/assessment;
2) Tailored/personalized care planning;
3) Consistent preventative interventions:
    a) Universal precautions
    b) Tailored interventions to address patient-specific areas of risk

Involving the patient and family in completing the fall risk assessment helps them understand their personal risk factors and including patients in developing a personalized prevention plan makes them more likely to accept and follow it. In addition, informing patients of their risk for injury if they fall increases the likelihood that they will follow their plan.

Interventions should be tailored to identified risk factors, not risk level, and work collaboratively with the patient and family to help ensure understanding of the prevention plan.

Consistent implementation of the fall prevention plan requires communicating the patient’s risk factors and plan to the healthcare team (including the patient and family). Direct-care team members, such as nurses and patient care assistants should reinforce the plan with the patient. If the patient’s risk status changes, the patient should be reassessed, and the plan updated to prevent a fall.

G. Post Fall Procedures and Management-The hospital will use a comprehensive post-fall tool to analyze the fall event. The Quality Manager will retain the post-fall assessment tool.

Note: There are two (2) key elements of the post fall procedures/management: Initial post-fall assessment and documentation and follow-up

Initial Post Fall Assessment

1. **First priority** is to assess the patient for any obvious injuries and find out what happened.
2. **Second priority** is family/patient representative and physician notification.
3. **Third priority** is to find out what happened.
4. **Environmental Assessment**
5. **Contributing Factors**
6. **Treatment Plan**

H. Pediatric Patients

a) Neonates and infants are by definition at risk for falls due to their developmental age. Such patients are maintained in bassinets for their safety. No assessment/reassessment of fall risk is required for these patients.

b) Children under 10 have the greatest risk for fall related death and injury. At name of hospital, the Humpty Dumpty Pediatric Fall Assessment Scale is utilized in the care of Pediatric patients.

I. Documentation and Follow-up

1. Following the post-fall assessment and any immediate measures to protect the patient:
   a. An incident report should be completed. All incident reports must be forwarded to the Director of Quality Management.
   b. A progress note should be entered into the patient's record including the results of the post-fall nursing assessment and fall precautions.
   c. Notify the medical provider that a patient fall event has occurred.
   d. Notify the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate.
   e. Communicate to all shifts that the patient has fallen and is at risk to fall again. Place a falling star fall indicator outside the room and place the appropriate wristband on the patient, and appropriate colored socks on the patient, if not already in place.

J. Responsibilities of Staff

Responsible Party	Actions
Medical Director	The Medical Director is responsible for ensuring that falls and fall-related injury prevention is: *1. A high priority at the hospital* *2. Promoted across the hospital through direct care, administrative and logistical staff*
Chief Clinical Officer	The Chief Nursing Officer is responsible for: *1. Establishing population-based fall risk levels/units/programs* *2. Deploying evidence-based standards of practice* 3. *Overseeing the policy within the hospital*

	4. Developing competencies for nursing staff about the falls prevention program
House Supervisors/Charge Nurses	The House Supervisors/Charge Nurses are responsible for: *1. Making fall and fall-related injury prevention a standard of care* *2. Enforcing the responsibilities of the clinical staff to comply with interventions* *3. Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with hospital equipment experts* *4. Ensuring that all nursing staff receive education about the falls prevention program at the hospital and understand the importance of complying with the interventions* *5. Providing education to patients and/or families regarding fall prevention.* *6. Assuring Fall Prevention is incorporated in the patient's plan of care.*
Staff and Contract Nurses Including RNs, LPNs and CNAs	Staff Nurses including RNs, LPNs and CNAs are responsible for: *1. RNs: Completing the fall-risk assessment on admission* *2. Notifying the care team of any patients assessed as high-risk* *3. Following the identification procedure for high fall-risk admissions (i.e. specific color armband, ensuring the bed assigned is close to the nursing station, ensuring there is visual cue outside of patient's room and over patient's bed, and applying the appropriate colored socks.* 4. *Ensuring compliance of fall and fall-related injury interventions* 5. *Completing fall-risk assessments on transfers, following a change in status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use* 6. *Ensuring that rooms with high fall-risk patients are assessed and corrected as necessary depending on the patient's current fall risks*
Medical Providers (MD/DO, ARNP, PA)	Medical Providers are responsible for: *1. Identifying and implementing medical interventions to reduce fall and fall-related injury risk* *2. Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls*
Pharmacists	Pharmacists are responsible for: *1. Reviewing medications and supplements to ensure that the risk of falls is reduced* *2. Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls*
Rehab Therapists	Physical and occupational therapists are responsible for: *1. Conducting balance assessments for all high fall-risk patient referrals* *2. Developing an intervention program for patients to reduce their fall-risk*

	3. Assistive equipment, such as wheelchairs, walkers and canes are checked regularly and equipped with devices to prevent falls
Quality Management	The Quality Management is responsible for: *1. Collecting data to ensure that fall and fall-related injury prevention strategies are effective* *2. Conducting case-by-case reviews for all falls to ensure that medications are reviewed, and prevention measures are recommended* *3. Providing assistance to interdisciplinary treatment teams when requested to recommend prevention strategies for a patient*
Hospital Management Staff	The hospital management staff are responsible for: *Ensuring a safe environment of care by conducting environmental assessments*

K. Evaluation of Program Effectiveness

- Measurements

1. **Rates:** The most commonly used statistic to measure and track falls is the "fall rate," which is calculated as follows:

$$\frac{\text{Number of patient falls x 1000}}{\text{Number of patient days}}$$

The fall rate for a specified time period is defined as the total number of eligible falls divided by the total number of eligible patient days, multiplied by a constant or "k" of 100 to create a rate per 1000 patient days. Note that all falls are included in the formula, so that repeated falls experienced by the same patient are included in the numerator.

2. **Other rates** found in the literature are also used to track and trend fall data and include:

a. The number of patients at risk;
b. The number of patients who fell;
c. The number of falls per bed.

L. Tracking and Reporting

1. All falls should be reported to the House Supervisor/Charge Nurse immediately following the event. Quality management should be notified within 24 hours of the event.
2. Each fall incident is investigated and summarized in the Incident Log.
3. All falls are reviewed by the Environment of Care Committee (EOC) as they pertain to the environment, the Quality Committee (QC), the Medical Staff Committee (MS), and the Governing Board (GB).
4. Quality Management reviews and analyzes fall data to ensure that fall and fall-related injury prevention strategies are effective. A fall review or Root Cause analysis is used to evaluate and understand what problems contributed to the fall or undesired outcomes. The data collection will obtain information that may help prevent the next fall in this patient or future patients. The post-fall assessment analysis captures information from the patient, staff, and other witnesses about how the fall occurred.

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ATTACHMENTS

PTR-023A Morse Fall Scale Interventions Visual Management Tool
PTR-023B Humpty Dumpty Fall Risk Assessment Scale
PTR-023C Pediatric Fall Interventions Visual Management Tool
PTR-023D Mobility Fall Precautions Poster
PTR-023E Fall Incident Update Poster
PTR-023F Post Fall Assessment

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center

After Sedation

Patient Education for the Child

(NUR-022D)

Mangum Regional Medical Center

It's our mission to make a difference every day by delivering compassionate, exceptional healthcare through collaboration and team commitment.

for

MRMC

One Wickersham Dr. Mangum, OK 73554

Caring is our passion

- Infants under 18 months; begin with formula or breast milk, juices; if no vomiting occurs, continue with child's usual feeding routine
- Children over 18 months; begin with clear liquids, if no vomiting occurs after 30 minutes, continue with solid foods
- If child vomits, allow his/her stomach to settle for one hour, then offer clear liquids. Do not force child to drink. Have child drink slowly (about 4-8 ounces over 30 minutes)

Discharge Instructions

1. Call 911 if any of the following occur:
   - Sudden trouble breathing
   - Child cannot be roused or awakened or does not return to normal state of coordination
2. Return to the emergency department for:
   - Severe headache or dizziness
   - Heart is beating faster than usual
   - Fever
   - Nausea & Vomiting
   - Itchy skin, rash
   - Severe Pain
3. Special Precautions:
   - Adult sit next to child to ensure child's airway positioned carefully in car seat while traveling after sedation
   - Adult escort with child when child walking/crawling until child fully awake
   - Avoid dangerous activities (biking, sports, playing outside) until child fully awake
   - Avoid daycare for one day and child has returned to usual state of awareness
   - Provide rest and quiet activities
   - See back for additional instructions

Moderate sedation or conscious sedation medication is provided for the relief of discomfort and anxiety associated with a procedure so that the patient remains motionless and can cooperate actively following verbal commands throughout the procedure.

After receiving sedation medication, the effects of the medication may persist for several hours. As a result, precautions will need to be taken to ensure no adverse event occurs.

Contact Us

MRMC
One Wickersham Drive.
Mangum, OK 73554

580-782-3353

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Conscious Sedation		**NUR-022**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy will apply to all patients receiving conscious sedation at Mangum Regional Medical Center.

PURPOSE

The purpose of conscious sedation is to provide the patient with relief of discomfort and anxiety associated with the proposed procedure so that the patient remains motionless and can cooperate actively following verbal commands throughout the procedure.

DEFINITIONS:

Minimal Sedation (Anxiolysis)-is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate (Conscious) Sedation-is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands. **NOTE:** *Reflex withdrawal from a painful stimulus is not considered a purposeful response, either alone or accompanied by light tactile stimulation.* No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Routes of Administration for Conscious Sedation:

- Intravenous (IV)
- Oral
- Nasal inhalation
- Rectum

POLICY

To provide guidelines for the safe and effective administration of sedation to patients of all ages. Sedation may be administered by a Physician, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), or Registered Nurse. The Registered Nurse may administer, manage, and/or monitor conscious sedation (minimal/moderate) of patients for short-term therapeutic or diagnostic procedures within the limitations of licensure and the State Nurse Practice Act. The Licensed Practical Nurse (LPN) functions within the limitations of licensure and the State Nurse Practice Act. The Licensed Practical Nurse is authorized by policy to monitor moderate (conscious) sedation patients during short-term therapeutic, diagnostic or surgical procedures. All personnel who administer, manage, and/or monitor conscious sedation will function within their scope of practice.

PROCEDURE

1. Conscious sedation will be performed by trained and qualified personnel.

2. The Physician must be available on site during the initial and continued administration of sedation or the procedure will not be started.

3. An RN may not administer medications classified as anesthetics. A licensed nurse who is not a Certified Registered Nurse Anesthetist may not administer medications or assess the level of sedation for any drugs used for moderate (conscious) sedation if the drug manufacturer's general warning advises the drug should be administered and/or monitored by persons experienced in general anesthesia who are not involved in the conduct of the surgical and/or diagnostic procedure.

4. Reversal medications such as Romazicon or Narcan will be available for patients undergoing conscious sedation. Prior to the administration of Romazicon, the patient will be evaluated for the use of anti-anxiety medications.

5. Documentation of a Physician examination must be performed by the Physician or Medical Provider immediately prior to the procedure on all patients receiving conscious sedation; to include at a minimum:
    - an examination specific to the procedure to be performed;
    - height and weight (kilogram wt.);
    - level of consciousness and mental status;
    - mobility status;
    - baseline vital signs;
    - examination of heart and lungs by auscultation;
    - indications for procedure requiring sedation;
    - emotional status;
    - communication ability

6. Documentation in the medical record will include the risks, benefits, and alternatives for this type of sedation that have been explained to the patient and informed consent has been executed. The informed consent is the responsibility of the Physician or Medical Provider; nursing staff may witness the signing of the consent.

7. ACLS and PALS personnel skilled in airway management must be present.

Quality Assurance and Performance Improvement

1. The Hospital will maintain evidence of the Medical Providers, RN's, LPN's competency, knowledge and skills related to the management and monitoring of patients who receive sedation on a periodic basis, at least every 2 years.
2. The Quality/Risk Manager and or Chief Clinical Officer will review all episodes of sedation. The findings will be reported to the Quality, Medical Staff, and Governing Board Committees.

REFERENCES

Oklahoma Board of Nursing; Moderate (Conscious Sedation Guidelines for Registered Nurse Managing and Monitoring Patients, and Monitoring of Moderate (Conscious) Sedation Patient by Licensed Practical Nurse Guidelines, Lippincott 12/14/18, American Society of Anesthesiologists, AANA Non-Anesthesia Provider Procedural Sedation and Analgesia 2016, Parents-Society for Pediatric Sedation https://pedsedation.org/resources/parents/, Clinical Pharmacology 2019

ATTACHMENTS

NUR-022A Consent for Conscious Sedation
NUR-022B Conscious Sedation Care Form
NUR-022C After Sedation Adult Patient Education
NUR-022D After Sedation Child Patient Education
NUR-022E Moderate Sedation Study Guide and Test

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center

After Sedation

Patient Education for the Adult

(NUR-022C)

Mangum Regional Medical Center

It's our mission to make a difference every day by delivering compassionate, exceptional healthcare through collaboration and team commitment.

for

MRMC

One Wickersham Dr. Mangum, OK 73554

Caring is our passion

Discharge Instructions

1. Call 911 if any of the following occur:
   - Sudden trouble breathing
   - You cannot be roused or awakened
2. Return to the emergency department for:
   - Severe headache or dizziness
   - Heart is beating faster than usual
   - Fever
   - Nausea & Vomiting
   - Itchy skin, rash
   - Severe Pain
3. Special Precautions:
   - Have someone stay with you for 24 hours
   - Do not drive, operate, or use dangerous machines/tools for 24 hours
   - Rest quietly for 24 hours. Avoid sudden standing or rising
   - Avoid exercise, bike riding, sports, or strenuous activities for 24 hours
   - Drink liquids as tolerated
   - Eat small, frequent meals as tolerated to prevent nausea and vomiting
   - Do not drink alcohol or take medicines that cause drowsiness

Moderate sedation or conscious sedation medication is provided for the relief of discomfort and anxiety associated with a procedure so that the patient remains motionless and can cooperate actively following verbal commands throughout the procedure.

After receiving sedation medication, the effects of the medication may persist for several hours. As a result, precautions will need to be taken to ensure no adverse event occurs.

Contact Us

MRMC
One Wickersham Drive
Mangum, OK 73554

580-782-3353

MOBILITY FALL PRECAUTIONS

DATE: INITIALS:

WEIGHT BEARING	☐ As Tolerated	☐ L ☐ R Partial Weight Bearing	☐ L ☐ R Non-Weight Bearing	
ASSIST	 ☐ Independent	 ☐ Standby	 ☐ 1 Person	 ☐ 2 Person
AID	 ☐ Cane	 ☐ Walker	 ☐ Wheelchair	
TRANSFER	☐ Pivot	☐ Hoyer Lift	☐ Bedrest	
TOILETING	 ☐ Bedpan	 ☐ Bedside Commode	 ☐ Toilet	
	Bed/Chair	☐ Yes	☐ No	

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Medical Marijuana: Patient Use		**NUR-025**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing		
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to all patients that utilize the services at Mangum Regional Medical Center.

PURPOSE

On June 26, 2018 State Question (SQ) 788 was passed and codified in Oklahoma Statutes Title 63 Sections 420A-426. This law makes it legal to possess, cultivate, manufacture and/or sell medical marijuana, medical marijuana products and paraphernalia pursuant to the terms of state-issued licenses (although illegal under Federal Law). The law establishes 8 license categories: medical marijuana patient, caregiver, temporary MMJ holder (out of state), grower, processor, dispensary, transportation and research. The purpose of this policy is to provide guidance regarding medical marijuana prescribing and patient use.

DEFINITIONS

NA

POLICY

The hospital is committed to following the rules, regulations, and laws as set forth by the State and Federal governments and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation. It is the policy of this hospital to strictly prohibit the use, prescription, administration, distribution, and dispensation of non-medical marijuana or medical marijuana by its employees, medical providers, patients, or visitors while on the hospital premises or associated areas.

According to Federal Law, no prescriptions may be written for Schedule I substances, and they are not readily available for clinical use. Tetrahydrocannabinol (THC, marijuana) is still considered a Schedule 1 drug by the DEA, even though some U.S. states have legalized marijuana for personal, recreational use or for medical use. Schedule I substances are defined as:

a) drug or other substance has a high potential for abuse;
b) drug or other substance has no currently accepted medical use in treatment in the United States;
c) a lack of accepted safety for use of the drug or other substance under medical supervision.

Cannabis use by patients is illegal under federal law. Failure of the hospital to comply with the Federal Law and because the hospital is accredited through the Center for Medicare & Medicaid Services, the hospital could be found to be in violation, lose federal funding, and face penalties. Clinicians are also prohibited from prescribing or providing the drug in a hospital because it is not approved by the US Food and Drug Administration (FDA).

As a result, regardless of the state's medical marijuana laws, a health-care provider may not prescribe marijuana for medical use due to the federal prohibitions on prescribing schedule 1 substances. Medical providers are prohibited from prescribing, storing, or dispensing marijuana while providing professional services to the patients of the hospital. This plan does not apply to the medical provider's practice.

The hospital must ensure that drugs and biologicals are managed in a manner that is safe and appropriate, and that its pharmacy system provides all drugs and biologicals prescribed by the hospital's practitioners in a timely manner for administration to its patients.

The hospital must comply with the rules in accordance with accepted professional principles of pharmacy and medication administration practices. Accepted professional principles include compliance with applicable Federal and State law and adherence to standards or guidelines for pharmaceutical services and medication administration issued by nationally recognized professional organizations, including, but not limited to: U.S. Pharmacopeia (www.usp.org), the American Society of Health-System Pharmacists (http://www.ashp.org/), the Institute for Safe Medication Practices (http://www.ismp.org/default.asp), the National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org); the Institute for Healthcare Improvement (http://www.ihi.org/ihi); or the Infusion Nurses Society (http://www.ins1.org).

PROCEDURE

Patient Guidelines

1. Patient use of medical or non-medical marijuana is strictly prohibited on the hospital premises and its associated areas.
2. If on admission a patient informs hospital staff they are a medical marijuana user and are in possession of medical marijuana, the patient will be given the option to send the medical marijuana home with a personal representative of their choice or have it secured by the hospital as a personal belonging. The Charge Nurse or Administrator shall be notified immediately.
3. If the patient chooses to send the medical marijuana home, the patient will be required to sign a "Medical Marijuana Release" form. All medical marijuana will be inspected and

verified for quantity and description by the patient and the responsible staff member for accuracy. The Charge Nurse or Administrative staff will be responsible for reviewing the form with the patient and ensuring the form is signed. The medical marijuana will be released to the patient's personal representative of choice and a copy of the release form will be given to the patient. In addition, a copy of the patient's medical marijuana license will be provided to the personal representative with permission of the patient. The original copy of the Medical Marijuana Release form will be retained by the responsible administrative staff.

4. If the patient chooses to have the medical marijuana secured by the hospital as a personal belonging, the patient will be required to sign a "Medical Marijuana Release" form. The Charge Nurse or Administrative staff will be responsible for reviewing the form with the patient and ensuring the form is signed. All medical marijuana will be inspected and verified for quantity and description by the patient and the responsible staff member for accuracy. The medical marijuana and the release form will be retained in a secure manner and location by the responsible administrative staff until the patient discharges. The hospital will secure such personal patient belongings as related to this policy in the Administration safe.
5. Upon discharge the patient's medical marijuana will be released to the patient and the release form signed by the patient. All medical marijuana will be inspected and verified for quantity and description by the patient and the responsible staff member for accuracy. A copy of the release form will be given to the patient and the original release form will be retained by the responsible administrative staff.
6. The patient's medical provider will be notified, and consideration will be given to alternative medications that can be ordered appropriate to the patient's need and condition.
7. To meet compliance with Federal Law, the hospital will not be able to store or maintain the marijuana for use by the patient.
8. No hospital personnel will be allowed to assist with the administration or dispensing of any form of marijuana.
9. For all instances of patient possession of marijuana, the hospital administrative staff will be notified, and an incident report completed by the person of discovery. All reports will be forwarded to the Quality Manager.

Medical Marijuana Waste Disposal

All medical marijuana waste generated must be disposed of as set forth by the Uniform Controlled and Dangerous Substances Act, 63 O.S. §2-101 et seq., and OAC 252:205.

REFERENCES

§802, §812 USC Title 21 Controlled Substances Act, Drug-Free Workplace Act of 1988, SOM Appendix W §485.635(a)(3)(iv), 42 CFR §482.25, Title 40 Oklahoma Statutes §40-554, OSHA 29 CFR §1904.35(b)(1)(iv), SQ 788, OS Title §63 420A-426

ATTACHMENTS

GEN-025A Medical Marijuana Release Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

STAFF VISUAL MANAGEMENT MORSE FALL SCALE INTERVENTIONS BY SCORE

Low Risk Score 0-24

Mod. Risk Score 25-50

High Risk Score > 50

Prevention: Environmental Rounds

The facility management, housekeeping, clinical services and biotech staff perform environmental rounds.

Facility management and/or Housekeeping staff confirm:

- ❑ *Hallways and patient areas are well lit*
- ❑ *Hallways and patient areas are uncluttered and free of spills*
- ❑ *Locked doors are kept locked when unattended*
- ❑ *Handrails are secure and unobstructed*
- ❑ *Tables and chairs are sturdy*

Biotech staff confirms:

- ❑ *All assistive devices are working properly by inspecting them on a regular basis*

Nursing Staff confirm:

- ❑ *Locked doors are kept locked when unattended*
- ❑ *Patient rooms are set up in a way that minimizes the risk of falling (see High Fall-Risk Room Set-up in Intervention section)*

Everyone confirms:

- ❑ *Unsafe situations are dealt with immediately either by dealing with the situation or notifying the appropriate staff and ensuring that they arrive and correct the situation.*

Standard Fall Preventions Measures:

Orientation & Environment

- ❑ Orient patient to surroundings and assigned staff.
- ❑ Lighting adequate to provide safe ambulation.
- ❑ Instruct to call for help before getting out of bed.
- ❑ Demonstrate nurses' call system.
- ❑ Call bell within reach, visible and patient informed of the location and use.
- ❑ Light cord within reach, visible and patient informed of the location and use.
- ❑ Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unneeded equipment).
- ❑ Personal care items within arm length.
- ❑ Bed in lowest position with wheels locked.
- ❑ Instruct patient in all activities prior to initiating.
- ❑ Assign bed that enables patient to exit towards stronger side whenever possible.

Mobility & Transfer Interventions

- ❑ Rehab team (PT and OT) is to make recommendations for the safest type of transfer.
- ❑ Ambulate as early and frequently as appropriate for the patient's condition.
- ❑ Non-slip footwear.
- ❑ Transfer towards stronger side.
- ❑ Assess the patient's coordination and balance before assisting with transfer and mobility activities.

Communication & Education

- ❑ Educate and supply patient and family with fall prevention information.
- ❑ Actively engage patient and family in all aspects of the fall prevention program.
- ❑ Place an "at risk" indicator on the chart, outside the room and at the bedside
  - ❑ Identify patient with a yellow colored wrist band.
  - ❑ Place a colored star outside of patient's room.
  - ❑ Place a colored star over patient's bed.
- ❑ Consult with pharmacy. ❑ Medications reviewed.
- ❑ Instruct patient in medication time/dose, side effects, and interactions with food/medications
- ❑ **Rounding** (include positioning as indicated; pain management, offering fluids, snacks when appropriate and ensuring patient is warm and dry). Every 2 hours
- ❑ **Implement bowel and bladder programs to decrease urgency and incontinence**.

Equipment and assistive devices.

- ❑ Individualize equipment specific to patient needs.
- ❑ Lock movable equipment prior to use
- ❑ Bed alarm / Wheelchair alarm
- ❑ Check tips of canes, walkers and crutches for non-skid covers.
- ❑ Bedside mat/perimeter mattress.
- ❑ Low bed.
- ❑ For risk of head injury consider consult for PT for consideration of a helmet
- ❑ Elevated toilet seat.
- ❑ Instruct patient in use of grab bars.

Rest and Diversion.

❑ Request OT consult. ❑ Relaxation tapes/music. ❑ Diversional activities. ❑ Exercise program. ❑ Minimize distractions.

High Risk Fall Prevention Measures

- ❑ Consider use of family as sitters for cognitively impaired
- ❑ Room placement closer to nurses' station.
- ❑ Repeatedly reinforce activity limits and safety needs to the patient and family
- ❑ Comfort rounds to every hour

(Include positioning as indicated; pain management, offering fluids, snacks when appropriate and ensuring patient is warm and dry).

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

HUMPTY DUMPTY FALL RISK ASSESSMENT SCALE

Patient Name:		**Age:**		**Room Number:**				
Parameter	**Date**							
	Time							
Age	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
< 3 yrs	**4**							
3 yrs-7yrs	**3**							
7 yrs-13 yrs	**2**							
13+ yrs	**1**							
Gender								
Male	**2**							
Female	**1**							
Diagnosis								
Neurological Diagnosis	**4**							
Alteration in oxygenation (e.g., Respiratory Diagnosis, Dehydration, Anemia, Syncope, Dizziness, etc.)	**3**							
Psychological/Behavioral Disorders	**2**							
Other Diagnosis	**1**							
Cognitive Impairment								
Not aware of limitations	**3**							
Forgets limitations	**2**							
Oriented to own ability	**1**							
Environmental Factors								
History of falls or Infant-Toddler placed in bed	**4**							
Uses assistive devices	**3**							
Placed in bed	**2**							
Outpatient area	**1**							
Patient had Surgery/Deep Sedation								
Within 24 hours	**3**							
Within 48 hours	**2**							
More than 48 hours/None	**1**							
Medication Usage								
Multiple usage of Sedatives (excluding ICU): Hypnotics, Barbiturates, Antidepressants, Laxatives, Diuretics, Narcotics	**3**							
One of the medications listed above	**2**							
Other medications/None	**1**							
Total Score								
Nurse Initials								
Low Fall Risk = Score 7-11 (Initiate Low-Risk Standard Protocol								
High Fall Risk = Score > 12 (Initiate High-Risk Standard Protocol								
Nurse Name & Signature								

Prevent A Fall

CALL! DON'T FALL!

Fall Prevention Program

How many days WITHOUT a patient fall?

DAYS

Previous Record _____

Manum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

PEDIATRIC FALL INTERVENTIONS

Low Risk Standard (Score 7-11)

- Assess elimination needs, assist as needed
- Call light is within reach
- Educate patient/family on its functionally
- Environment clear of unused equipment, furniture in place, clear of hazards
- Orientation to room
- Bed in low position, brakes on Side rails X2 or 4 up, assess large gaps, such that a patient could get extremity or other body part entrapped
- Use additional safety precautions
- Use of non-skid footwear for ambulating patients
- Use of appropriate size clothing to prevent risk of tripping
- Assess for adequate lighting, leave nightlights on
- Patient and family education available to parents and patients
- Document fall prevention teaching and include in the plan of care

High Risk Standard (Score > 12)

- Evaluate medication administration times
- Remove all unused equipment out of room
- Protective barriers to close off spaces, gaps in the bed
- Keep door open at all times unless specified isolation precaution are in use
- Keep bed in the lowest position, unless patient is directly attended
- Educate Patient/Family regarding falls prevention
- Document in the nursing narrative teaching and plan of care
- Identify Patient with Fall Risk Bands on patient

All Pediatric Patients

- Identify Patient with Fall Risk Bands on patient
- Check patient minimum every hour
- Accompany patient with ambulation
- Move patient closer to nurses' station
- Assess need for 1:1 supervision

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Inhouse Patient Transfer/Transport Plan		**NUR-024**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy shall govern all transfers including those covered by a transfer agreement. Hospital administration has the authority to represent the hospital during the transfer from or receipt of patients into the hospital.

PURPOSE

In the presence of an emergency medical condition, stabilizing treatment will be provided within the capabilities of the hospital and if indicated, an appropriate transfer to another medical facility.

PROCEDURE

A. Emergent Transfers- The patient will be examined and evaluated by a physician or Licensed Independent Practitioner to determine if the patient:

a) Has an emergent condition, AND
b) Requires medical services that are not provided at the hospital.

Medical Oversight

1) The hospital shall be responsible for adequate medical coverage for inpatient services. Qualified Medical Providers shall be regularly available at all times, either on duty or on call.
2) On call Medical Providers shall be available to present in the hospital within twenty (20) minutes of notification.
3) All medications and treatments shall be provided under the direction and order of a Medical Provider.
4) The transferring Medical Provider shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and to sustain the patient during transfer.

5) The transferring Medical Provider shall determine and order the utilization of appropriate personnel and equipment for the transfer. In determining the use of medically appropriate life support measures, personnel, and equipment, the transferring physician shall exercise that degree of care which a reasonable and prudent Medical Provider exercising ordinary care in the same or similar locality would use for the transfer.

Emergent Condition Requiring Transfer

1) If a Medical Provider is not present in the hospital, a Registered Nurse (RN) shall perform a nursing assessment on the patient and notify the physician on call who will determine whether:
    a) The assessments and findings are adequate to make a diagnosis of the patient's condition,
    b) To order additional diagnostic tests and examination,
    c) To request for a specialty consultation,
    d) To order the transfer of the patient.
2) The Medical Provider may make the determination that the patient requires medical services not available at the hospital based on the RN's assessments and/or results of the additional test ordered.
    a) These communications must be clearly documented in the medical record and the Medical Provider must sign the medical record on his next visit to the hospital.
3) If the patient requires medical services for an emergent condition that are not available at the hospital, the hospital shall provide any necessary stabilizing treatment within the capabilities of the staff and facilities available and provide an "appropriate transfer" as defined below.

Transfer Procedure

1) Establish an accepting physician (capability) and a receiving hospital (capacity).
    a) Prior to transfer, the transferring Medical Provider shall secure a receiving physician and a receiving hospital that are appropriate to the medical needs of the patient and that will accept responsibility for the patient's medical treatment and hospital care.
2) Appropriate Transfer
    a) A patient transfer to another medical facility will be appropriate only in those cases in which:
        i. Mangum Regional Medical Center as the transferring hospital, provides medical treatment within its capacity that minimizes the risks to the individual's health AND
        ii. The receiving facility has available space and qualified personnel for the treatment of the individual; AND

iii. The receiving facility has agreed to accept transfer of the individual and to provide appropriate medical treatment.

3) Unstable patients requiring transfers-If an individual has an emergency medical condition that has **NOT** been stabilized, the hospital may not transfer the individual unless:
   i. The transfer is an appropriate transfer (as defined in (a) above); AND
   ii. The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer; AND
   iii. A Medical Provider has signed a certification that based upon the information available at the time of transfer; the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual from being transferred. The certification must contain a summary of the risks and benefits upon which it is based.
4) Mangum Regional Medical Center as the transferring hospital, shall send to the receiving facility all medical records (or copies thereof) related to the emergency condition including, at a minimum, the H&P, progress notes, consultations, vital sign flow sheets, medication administration records, results of diagnostic studies treatment provided, and the informed written consent or certification or copy thereof.
5) The RN will perform a patient assessment within the hour preceding the patient's departure and record the assessment in the medical record. Pre-transfer assessment will include, at a minimum, a focused system survey, pain assessment, vital signs, and the presence and condition of any tubes, lines or drains.
6) The primary nurse shall phone a detailed patient report to the receiving facility RN and document the name and credentials of the individual receiving the verbal patient report in the medical record.

B. Non- emergent Transports -Non-emergent transfers are defined as the movement of a stable patient from Mangum Regional Medical Center to another hospital with the understanding and intent of both hospitals that the patient is going to the second hospital for a procedure and scheduled for return.

Medical Oversight

1) The Medical Provider shall determine and order the utilization of appropriate personnel and equipment for the transport. In determining the use of medically appropriate measures, personnel, and equipment, the hospital shall exercise that degree of care which a reasonable and prudent Medical Provider exercising ordinary care in the same or similar locality would use for the transport.

Transport Procedure

1) The RN will perform a patient assessment within 1 hour of the patient's departure and record the assessment in the medical record. Pre-transport assessment will include, at a minimum, a focused system survey, pain assessment, vital signs, and the presence and condition of any tubes, lines or drains.
2) The primary nurse shall phone a detailed patient report to the receiving facility RN and document the name and credentials of the individual receiving the verbal patient report in the medical record.

Memorandum of Transfer for Emergent and Non-Emergent

1) The hospital's policy shall provide that a memorandum of transfer be completed for every patient who is transferred for a higher level of care or transported for procedure or diagnostic testing.
2) The memorandum shall contain the following information:
    a) The patient's full name,
    b) The patient's race, religion, national origin, age, sex, physical handicap, if known;
    c) The patient's address and next of kin, address, and phone number if known;
    d) The time and date on which the transferring Medical Provider secured a receiving physician;
    e) The physician certification stating the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual from being transferred.
    f) Mode of Medical Transport required to transport patient;
    g) Type of equipment and personnel required for transport;
    h) Name and city of hospital to which patient was transferred or transported;
    i) Diagnosis by transferring Medical Provider;
    j) Documents by transferring hospital
3) A copy of the memorandum of transfer shall be retained in the patient's medical record.

TRANSPORTS (DIAGNOSTIC/TESTING/PROCEDURES)

Transports (diagnostic/testing/procedure)

A. The movement of a stable patient from a hospital to another hospital is not considered to be a transfer if it is the understanding and intent of both hospitals that the patient is going to the second hospital only for a procedure or testing.
B. Medical Oversight- The Medical Provider shall determine and order the utilization of appropriate personnel and equipment for the transportation.
C. Service Agreement-Prior to any patient leaving the hospital for diagnostic testing, Mangum Regional Medical Center must ensure that the hospital performing the

diagnostic testing has the capability to perform the ordered testing and has agreed to provide those services to Mangum Regional Medical Center Hospital's patients. This service agreement will be expressed in a:

a) Purchased services contract,
b) Memorandum of understanding, or
c) Single patient service agreement

D. Transport Procedure- Establish a receiving hospital, hospital department, diagnostic testing date and time.
   a) Verify the receiving facility has available space for the patient;
   b) Verify the receiving facility has agreed to accept the patient and to provide appropriate supportive care during the diagnostic testing.
   c) Arrange transportation in accordance with the Medical Provider order for the appropriate personnel and equipment for the transportation.
   d) Mangum Regional Medical Center, shall send to the receiving facility all medical records (or copies thereof) related to the patient's medical condition including, at a minimum, the H&P, progress notes, consultations, vital sign flow sheets, medication administration records, results of diagnostic studies treatment provided, and the informed written consent or certification or copy thereof.

PATIENT RIGHTS

Patient Refusal of Transfer / Transport

A. Patient Rights

1) The patient has the right to refuse transfer and/or transport.
2) All reasonable steps are taken to secure the informed refusal of a patient refusing a transfer or a related examination and treatment or of a person acting on a patient's behalf refusing a transfer or a related examination and treatment. Reasonable steps include:
   a) a factual explanation of the increased medical risks to the patient reasonably expected from not being transferred, examined, or treated at the transferring hospital;
   b) a factual explanation of any increased risks to the patient from not effecting the transfer; and
   c) a factual explanation of the medical benefits reasonably expected from the provision of appropriate treatment at another hospital.

B. Documentation

1) The informed refusal of a patient, or of a person acting on a patient's behalf, to examination, evaluation or transfer shall be documented and signed if possible by the patient or by a person acting on the patient's behalf, dated and witnessed by the Medical Provider or Primary Care

Nurse, House Supervisor/Charge Nurse, and placed in the patient's medical record

Performance Improvement

All patients requiring a transfer for a higher level of service will be reported to the Quality Committee (QC), Medical Staff Committee (MSC), and Governing Board (GB) on a routine basis.

REFERENCES

Department of Health and Human Services, Centers for Medicare and Medicaid Services. 42 CFR Part, 489.24, and 489.20. Medicare and Medicaid Programs; Hospital Conditions of Participation: Federal Regulations. Oklahoma State Appendix W

ATTACHMENTS:

NUR-024A Patient Transfer Form
NUR-024B Patient Transport Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

POST-FALL ASSESSMENT FORM (NUR-023F)

Directions: This form should be completed for ALL falls and forwarded to the Quality Manager. This analysis should be done ASAP after the fall, but less than 24 hours. This review should include all staff involved in the patient/visitor fall, the staff who found the patient/visitor and facilitated by the House Supervisor/Charge Nurse or Department Manager at the time of fall. This report is not intended to place blame or serve for disciplinary action.

SECTION A: FALL DETAILS – To be filled out by RN

Date of fall: **Time of fall:**

Department/Nursing Unit where fall occurred:

Staff Involved:

Patient's fall risk level prior to fall: ☐ Low ☐ Moderate ☐ High ☐ N/A

When was the last time the patient was rounded on: _____

Which was of the following were assessed during rounds:

☐ Pain ☐ Toileting ☐ Positioning ☐ Placement of Items ☐ N/A

Physical location of fall: ☐ from bed ☐ between bed and bathroom ☐ from chair ☐ between chair and bathroom ☐ from BSC ☐ from toilet ☐ from cart/gurney ☐ hallway ☐ shower/tub ☐ therapy/other treatment ☐Other:

Was fall witnessed: ☐ Yes ☐ No **Was fall assisted?** ☐ Yes ☐ No

Pre-fall Activity Status:

☐ Independent ambulation ☐ Independent ambulation w/assistive device (i.e. cane, walker, crutches, etc.)

☐ Ambulation w/staff assistance ☐ Transfer w/staff assistance ☐ Bedbound

If fall was staff assisted, what transfer equipment was in use at the time of the fall?

☐ None ☐ Transfer belt ☐ Walker ☐ Sliding board/transfer sheet ☐ Other: _____ ☐ N/A

If patient fell from bed, number of side rails in use at time of fall:

☐ N/A

Medications administered within 8 hours prior to fall: ☐None ☐PCA ☐Opiates ☐Anticonvulsants ☐Antihypertensives ☐Antiarrhythmics ☐Diuretics ☐Hypnotics ☐Sedatives ☐Laxatives ☐Antidepressants ☐Antipsychotics ☐Benzos ☐Antihistamines ☐Antiparkinsonians ☐Alzheimer drugs

Is the patient on anticoagulants? ☐ Yes ☐ No ☐ N/A

Preventative measures in place prior to the fall: ☐Low Bed ☐Chair alarm on ☐Bed alarm on ☐Bed in low position/locked ☐Non-skid socks on ☐Hourly rounding done/toileting offered ☐Wheelchair locked ☐Room free of obstructions ☐Call light within reach ☐Patient/family education done ☐Room close to nursing station ☐ N/A

If the patient had a bed or chair alarm in place, were the alarms properly set? ☐ Yes ☐ No

If yes, did the alarms prompt the staff response to the fall? ☐ Yes ☐ No

Describe Event: Include patient/visitor activity and symptoms at time of fall and just prior to fall.

How was the patient/visitor evaluated for injury?	Describe the actual/suspected patient/visitor injury(s): ☐ No apparent injury ☐ Minor (bruises, abrasions) ☐ Moderate (fracture, laceration that requires repair) ☐ Major (requires surgery, transfer to higher level of care) ☐ Death

Contributing Factors (please indicate ALL that apply in the Incident Event Report):

Patient-Related:	Environmental:
☐ Behavioral (agitated, impulsive)	☐Equipment/Supplies (bed/chair alarm, call light malfunction)
☐Cognitive impairment (dementia, TBI)	☐Wet floor
☐Physical impairment (weakness, amputee, etc)	☐Poor lighting
☐Sensory impairment (vision, hearing, balance)	☐Trip hazards
☐Assessment (incomplete, inaccurate)	☐Personal items within reach
☐Medications (new/changed, opioids, benzos,etc)	
☐Physiological (dizziness, blood sugar changes, etc)	
☐Other:	

What was the Fall Risk Assessment for the patient prior to the fall?

What was the patient's fall risk score and level of risk prior to this fall? ☐ N/A	Score: ☐ Low Risk ☐ Moderate Risk ☐ High Risk
What was the date/time of the patient's last fall risk assessment?	Date:_____ Time: _____ ☐ N/A
Was fall risk assessment documented on: Admission to unit?	☐ Yes ☐ No ☐ N/A
Every ___ since admission?	☐ Yes ☐ No ☐ N/A
Each change in level of care?	☐ Yes ☐ No ☐ N/A
Has the patient/visitor had a fall in the past 3 months?	☐ Yes ☐ No ☐ N/A

SECTION B: POST FALL CHECKLIST – To be completed by RN

☐Perform full nursing assessment and obtain set of vital signs.

☐MD notified – policy is to notify MD for ALL patient falls. If the fall was unwitnessed or involved a potential head injury, complete a neuro every 15 minutes x ___, then every hour x 4 hours, then every 4 hours x 24 hours.

☐Notify Chief Nursing Office and Director of Quality of fall event by **[insert hospital preference for notification]**

☐Perform Post-Fall Risk Assessment, making patient an automatic "High Risk" for falls

☐Update patient's Care Plan

☐Complete a program note, including the following information: 1) Was the fall witness/unwitnessed and by whom. 2) Orientation status of patient at time of the fall: confused, drowsy, alert, etc. 3) Type of injury. 4) How was the patient lifted following the event – what equipment was used and how many staff members assisted?

☐Was family notified? ☐ Yes ☐ No

☐Was modification to patient's fall precautions implemented: ☐ Yes ☐ No
If yes, what precautions were implemented:

SECTION C: ACTION PLAN
What could have been done to prevent this fall?
What will be done to prevent patient from falling again?
How can we prevent this from happening to other patients?

Staff Signature:_____ Staff Signature: _____

Staff Signature: _____ Staff Signature: _____

Staff Signature: _____ Staff Signature: _____

Mangum Regional Medical Center

Medical Marijuana Release (NUR-025A)

I, _____ am an Oklahoma license holder for medical marijuana. I have been informed of the hospital's policy on the restriction to use or consume medical marijuana in any form during my stay in the hospital. I understand this policy applies to all inside and outside areas of the hospital and property that is owned or maintained by the hospital. As a result of this I have been informed of the options listed below regarding medical marijuana:

1. I have been given the opportunity to send my medical marijuana home with a personal representative of my choice if that is my desire. I understand that a copy of my medical marijuana license will be sent home with my personal representative of choice along with any medical marijuana. I agree to release the hospital of any liability for any loss or damage to my medical marijuana product(s) that may occur as a result of my decision to release my medical marijuana to my personal representative of choice.
2. I have been given the opportunity to have my medical marijuana secured as a personal belonging with the hospital administrative staff if that is my desire. I understand that upon discharge from the hospital I will be able to have my medical marijuana returned to me.

Medical Marijuana Release

1. □ I agree to send my medical marijuana home with my personal representative of choice along with a copy of my medical marijuana license. I have had the opportunity to inspect all product(s) that have been sent with my personal representative.

   Patient Name: _____
   Date: _____ Time: _____
   Personal Representative: _____
   Date: _____ Time: _____

2. □ I agree to have my medical marijuana secured with the hospital administrative staff. I have had the opportunity to inspect all product(s) that have been secured with the hospital administrative staff.

   Patient Name: _____
   Date: _____ Time: _____
   Hospital Representative: _____
   Date: _____ Time: _____

Description of Product(s)

Date	Quantity	Description of Product	Patient Initials	Personal Rep Initials	Hospital Rep Initials

Release of Medical Marijuana Upon Patient Discharge

3. My medical marijuana product(s) has been returned to me upon my discharge from the hospital. I have had the opportunity to inspect all product(s) that have been secured for me and find no issues or concerns with my medical marijuana product(s) as released to me by the hospital representative.
   Patient Name: _____
   Date: _____ Time: _____
   Hospital Representative: _____
   Date: _____ Time: _____

Hospital Logo

MRMC INPATIENT TRANSFER FORM

(This form applies to inpatients *only)*

PHYSICIAN ASSESSMENT AND CERTIFICATION TO TRANSFER

(Retain Original Copy in Medical Record)

Patient Name: _____ Age: _____ yrs Medical Record #: _____ Date: ____/____/____

Family/Patient Representative: _____ Contact Information/Number: _____

Date Family/Patient Representative Notified: _____/_____/_____ Time: _____:_____ am/pm Staff: _____

Patient Diagnosis: _____

Patient Condition	
□ The patient is stable so that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the transfer.	
□ The patient is unstable, but the expected medical benefits of transfer outweigh potential risks associated with the transfer.	
Transfer Notification to Patient, Family/Patient Representative	
□ I have been informed and educated of the plan to transfer my care and treatment to the designated location listed below. I have been given the opportunity to ask questions and receive answers to my questions regarding the transfer. I have been educated and informed on the reason, risks, and benefits of my transfer. _____ (*Patient's Initials*) □ I have been informed and educated of the plan to transfer the care and treatment of the patient to the designated location listed below. I have been given the opportunity to ask questions and receive answers to my questions regarding the transfer. I have been educated and informed on the reason, risks, and benefits of the patient transfer. _____ (*Family/Patient Representative Initials*) Name of Family/Patient Representative:_____ Relationship to Patient:_____ ***(If patient/family/patient representative is unable to initial document, verify response with two (2) witnesses)*** Name of Patient/Family/Patient Representative: _____ Relationship to Patient: _____ Witness Signature: (1)_____ (2)_____ Date: _____/_____/_____	
Reason for Transfer	
□ The transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the facility and is medically indicated	
□ The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility	
□ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient;	
□ The health of individuals in the facility would otherwise be endangered;	
□ The patient has failed, after reasonable and appropriate notice, to pay for or to have paid under Medicare or Medicaid a stay at the facility. *(Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay).*	
□ The facility ceases to operate.	
□ Patient/Resident Appeal, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	
□ Patient/Family Request	
□ Physician Recommendation	
□ On call or Qualified Medical Professional (QMP) refused or failed to respond in a timely manner: Name of QMP:	
Benefits of Transfer	**Risks of Transfer**
□ Specific benefit of transfer:	□ Primary risk of transfer:
□ Specialized equipment, services, specialist & technology at receiving facility	□ Deterioration related to transport (e.g., accident, time delay)
□ Continuity of care:	□ Deterioration in condition □ Death □ Complications □ Permanent Disability
□ Benefits of transfer explained to: □ patient □ family □ patient representative	□ Risks of transfer explained to: □ patient □ family □ patient representative
Mode of Transport/Support/Treatment During Transport	
□ Ground EMS □ Air EMS □ Private Vehicle □ Police/Law Enforcement Agency:	
□ BLS □ ACLS □ IVF/IV Pump □ Medications: _____ □ Other:	
Ground Transport: (1) Is the treatment for which the patient is being transferred available at the hospital of origin? □ YES □ NO **(2)** If treatment is not available, what is the specific service(s) for which the patient is being transported?: _____. **(3)** Can the patient sit up in a chair? □ YES □ NO **(4)** If patient can sit in chair, amount of time patient can tolerate sitting: _____. **(5)** If patient confined to bed, what movement limitations prevent the patient from getting out of bed (e.g., paralysis, balance, etc.)?_____. **(6)** What illness created the limitations in #3? _____. **(7)** Does the patient require O2 for this transport? □ YES □ NO	

Hospital Logo

MRMC INPATIENT TRANSFER FORM

(This form applies to inpatients *only*)

PHYSICIAN ASSESSMENT AND CERTIFICATION TO TRANSFER

(Retain Original Copy in Medical Record)

(8) For what condition is it required? _____.
Other Conditions: (1) Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____
(2) What harm might be expected? _____.

Air Transport: □ Needs higher level of care □ Weather conditions prohibit ground transport □ Patient's condition is too critical to allow longer transport time by ground □ Patient's condition is too unstable for a ground unit from this institution to transport the patient and requires the special skills and abilities of the transport team □ Physician specialist is required for the patient's care and is not available at this institution (circle care option): cardiologist, vascular surgeon, neurosurgery, neurologist, trauma surgeon, cardiothoracic surgeon, burn specialist, gastroenterologist, pulmonologist, other: _____
□ Intensive care required for this patient which is not available at this institution □ Patient may require an emergent procedure that is not available at this institution. Anticipated procedure (circle care option): CABG, emergent catherization, emergent CT scan to rule out operable lesion, emergent surgery by a specialist not available at this institution (circle care option): balloon angioplasty, emergent dialysis, other: _____

ACCEPTANCE FOR ONGOING CARE

At _____ am/pm, _____ spoke with a representative of _____ (indicate receiving facility) who indicated that the hospital/facility would accept the transfer of the above referenced patient.

At _____ am/pm, I talked with Dr. _____ at _____ who was advised of this patient's condition and who agreed to accept the transfer of this patient for provision of appropriate medical treatment.

Nursing report given to _____ by _____at _____ am/pm on _____/_____/_____.

Accompanying Documentation	**Copies Sent Via**
□ Lab/X-ray/EKG □ H&P □ Progress Notes (last 5 days) □ Court Order □ Advance Directive □ Face Sheet □ Transfer Order □ Medication Record	□ Patient □ Fax □ Transport Personnel

Patient Assessment Time: _____:_____ Date: _____/_____/_____	
Vital Signs	Temp: Pulse: RR: O2 Sat: %
Neuro	
Cardio/Pulmonary	
GI/Urinary	
MS	
Integumentary	
MS/Mobility	
Last BM	
Lines/Tubes	
Fall/Safety Risk	
Special Precautions/Instructions	

PATIENT CONSENT

□ I hereby consent to transfer after having been informed of the risks and benefits of the transfer. In addition, I hereby authorize and request any and or all health information relevant to my medical condition in the possession of the facility as it exists at this time may be released and delivered to the above-named receiving facility.

□ I hereby request transfer to _____ after having considered the risks and benefits of the transfer and the physician's recommendation.

_____ _____Date: _____/_____/_____

(Patient/Patient Representative) *(Relationship to Patient)*

_____ Date: _____/_____/_____

(Witness)

Hospital Logo

MRMC INPATIENT TRANSFER FORM

(This form applies to inpatients *only)*

PHYSICIAN ASSESSMENT AND CERTIFICATION TO TRANSFER

(Retain Original Copy in Medical Record)

PATIENT REFUSAL

I hereby □ refuse to be transferred □ refuse to let the patient be transferred □ refuse ambulance transport □ refuse air transport. The hospital's responsibilities, risks and benefits of appropriate transfer and the physician's recommendations have been considered and this refusal of transfer or ambulance or air transport is made by me, independently and voluntarily.

_____ _____ Date: _____/_____/_____

(Patient/Patient Representative) *(Relationship to Patient)*

_____ Date: _____/_____/_____

(Witness)

PATIENT TRANSFER INFORMATION

Time of Transfer: _____:_____ am/pm Date of Transfer: _____/_____/_____ Transfer Disposition: _____

Transferring Nurse Signature: _____ Date: _____/_____/_____

PROVIDER CERTIFICATION

I have examined the patient and explained the risks and benefits of being transferred and/or refusing transfer of the patient as indicated by the patient's decision to consent or refuse.

Based on these reasonable risks and benefits to the patient, and based upon the information available at the time of the patient's examination, I certify:

□ The medical benefits reasonably to be expected from the provision of appropriate treatment at another medical facility outweigh the risks, if any, to the individual's medical condition.

□ The transfer is at the request of the patient/family after explanation that the potential risks outweigh the benefits, if any, to the individual's medical condition.

Physician Signature: _____ Date: _____/_____/_____

Contact Information for Care Provider

Name: _____ Contact Number: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER
Patient Transport for Procedure or Diagnostic/Test Services

Name of Patient: _____ Date of Transport: _____/_____/_____

Diagnostic/Test or Procedure: _____

Destination Facility: _____ Department: _____

Diagnostic/Test or Procedure Time: _____:_____ am/pm Transport Name:_____

Transport Mode: □ W/C Van □ Stretcher Van □ ALS Ambulance □ Private Vehicle

Equipment Needs: □ O2 □ Mechanical/Respiratory Support Devices □ IV Pump □ Other _____

Transport Consent

I acknowledge that my medical condition has been evaluated and explained to me by the Medical Provider or other qualified medical person(s), who has recommended that I be transported to _____ (facility) for the purpose of _____ and then return to Mangum Regional Medical Center. The potential benefits and potential risks associated with transport, and the probable risks of not being transported have been explained to me and I fully understand them. The benefits include the receipt of specialized services and continuity of care. The risks of transport or refusing consent to transport may include deterioration related to transport (e.g., accident, time delay), deterioration in condition (e.g., death, complications, permanent disability). With this knowledge and understanding, I agree and consent to be transported.

_____
Signature of Patient or Patient Representative

_____
Relationship to Patient

_____ _____/_____/_____ _____:_____
Witness Signature ***Date*** ***Time***

Mangum Regional Medical Center

Wound Care Orders

Patient Name: _____ Date: ____/____/____ Time: _____

Check all boxes as appropriate

INTERVENTIONS:

□ Wound Care Consult if any of the following are present:

- Fever > 100.4
- Chills
- Redness, swelling, or warmth to wound site
- Foul smelling
- Moderate or large amount of purulent or sanguineous drainage
- Pressure Ulcer Stage II or greater
- Any opening in the skin
- Non blanchable areas of the skin

□ Dietary Consult if any of the following are present:

- Pressure Ulcer Stage II or greater
- Non-healing surgical wound
- Chronic non-healing wounds

□ Low Air Loss Mattress

□ Turn every 2 hours or more frequently as needed

MEDICATIONS:

□ Vitamin C 500mg PO Daily

□ Zinc Oxide 220mg PO Daily at 1800

□ Multivitamin 1 (one) tab PO Daily

LABS

□ Prealbumin on Admit and weekly on Monday for all wound patients

□ Aerobic and Anerobic wound culture if wound is open and draining

Mangum Regional Medical Center

WOUND CARE:

□ Clean wound with wound cleanser, pat dry. Apply Maxorb to wound. Cover with gauze dressing. Change dressing on Tuesday and Friday and prn if loose or soiled.

□ If patient allergic to Acticoat or Silver, apply medihoney to wound. Cover with gauze dressing. Change dressing on Tuesday and Friday and prn if loose or soiled.

Nurse Signature: _____ Date: ___/___/____ Time: _____

Physician Signature: _____ Date: ___/___/____ Time: _____

Cohesive Healthcare Resources Mangum
MANGUM REGIONAL MEDICAL CENTER

Title		Page
Performance Evaluation Policy		**Page 1 of 2**
Manual	Effective Date	Revise Date
Human Resources Policy and Procedures	**12/01/2020**	
Department	Reference	
Organization Wide		

PURPOSE

To establish a policy and set expected guidelines for employee performance evaluations and merit increases.

POLICY

Employees performance will be evaluated and completed by employee's immediate supervisor at ninety (90) days of employment and/or ninety (90) days post transfer to a new position. Employees are also evaluated on performance annually thereafter.

PROCEDURE

90-day Evaluation

Performance evaluations will be populated and distributed through Paycom prior to the 90-day anniversary date of the employee concerned.

1. The employee will complete their Self-Evaluation in Paycom and submit prior to the department manager.
2. After an employee completes their self-evaluation, the Department Manager will complete the 90-Day Performance Evaluation and submit to Human Resources for approval. Human Resources will approve, correct, or recommend changes in accordance with present state or local laws and the hospital's policies and procedures. This should eliminate any labor practice errors.
3. Department Managers will discuss the approved evaluation with the employee, obtaining all signatures and optional responses from the employee.
4. The approved evaluation will be kept electronically in Paycom.

Generally, merit increases are not given at 90-day evaluations.

Annual Evaluation

Annual Performance evaluation notices will be prepared and distributed through Paycom in January of each year. The employee will have the opportunity to self-evaluate prior to the department manager beginning the evaluation. The Department Manager should complete steps 1-4 as noted above.

Guidelines for Annual Merit Increases

1. The Administrator will outline the merit budget to be used for merit review and allocation purposes.
2. Merit increase amounts will be approved by the board to be disbursed in the month of February.
3. Hospital based employees have established salary pay ranges. Employees identified with a current pay rate at or above the maximum of the approved position pay range will NOT be eligible for a base rate increase but may be eligible for a lump sum payment.
4. PRN/Per-Diem employees are NOT eligible for an annual merit pay increase although they will be given a performance evaluation.
5. Corporate Human Resources Office will provide the performance evaluation form to be used for recording employee performance ratings.
6. Human Resources will be integrally involved in assisting with the annual performance and merit review process through completion.
7. Performance scoring is to be based on an objective and fair assessment of each employee based on their performance throughout the performance evaluation period.
8. Regular full-time employees who have received a promotional increase or a rate of adjustment between October 1st and December 31st will NOT be eligible for an annual merit increase for that year.
9. New employees hired between October 1st and December 31st will not be eligible for an annual performance evaluation or an annual merit increase.
10. Each department head must plan an adequate amount of time to meet with each of their eligible regular Full-time employees to conduct the formal performance

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

December 15, 2020

Board of Directors
Mangum Regional Medical Center

November 2020 Financial Statement Overview

- Balance Sheet
  - Operating Cash decreased $40,435 from the October 31, 2020 balance. This is primarily driven by an increase in Accounts Receivable.
    - No stimulus fund adjustments were recorded in October to affect this number, leaving an unchanged balance owed to the stimulus funds of approximately $1.041M or ($1.492M borrowed - $451K that has been identified to qualify to be retained as operating cash). The stimulus funds have been segregated within the financial statements to track and report these separately ($2,771,296 asset less $3,812,296 liability or net liability of $1,041,000).
  - We continue to increase our inventory supplies in relation to COVID surge preparation. This figure has doubled since 12/31/19, now at $98,476.
  - Accounts payable increased substantially in November as a result of reclassifying the Cohesive PPP loan passthrough from long-term debt to short-term payable.
  - Accounts Receivable increased $159,154, this is primarily driven by a slight delay in billing in November due to charge entry delay, now resolved.
  - Total Due to Cohesive – PPP loans has amounted to $647K. This amount has been reclassified from long term to short term debt. Cohesive will be applying for loan forgiveness of the PPP loans. We are awaiting further updates.

- Income Statement
  - Net Patient Service Revenue increased $280,526 from October. This is primarily driven by a significant increase in inpatient days. Total days increased 114 from October for a total of 441.
  - No adjustment to the stimulus funds was recorded in November as further guidance is pending on new reporting requirements for the HHS CARES ACT funding.
  - Total operating expenses for October were $1,176,917. This is $39,628 lower than our average of $1,225,316.

Other Updates

- On 9/28/20, Novitas issued a Medicare determination letter reflecting a receivable to the hospital in the amount of $455,287 based on the 5/31/20 Interim Rate Review. This was received 10/17.
- The Medicare 2nd Interim Rate Review has been submitted. It reflects an estimated receivable in the amount of $1,320,381 for the 8 months ended 08/31/20. This amount will be decreased by the $455,287 referred to about in the October financial statements.
- 2019 Medicare Cost Report was submitted resulting in a receivable of $971,775. We have received a Novitas letter confirming a receivable of $967,961 and an additional letter to submit a rebuttal to have these monies paid directly to the hospital instead of applied to open ERS loan balances. This is in progress as of 12/10/20.

Mangum Regional Medical Center
Cash Receipts by Month
December 15, 2020 Board Meeting

2018 Month	Amount	2019 Month	Amount	2020 Month	Amount	Stimulus Funds
January-18	165,685	January-19	417,231	January-20	1,183,307	
February-18	752,169	February-19	242,680	February-20	750,899	
March-18	1,098,956	March-19	1,357,203	March-20	843,213	
April-18	1,449,073	April-19	1,299,323	April-20	617,307	778,925
May-18	1,429,917	May-19	1,289,344	May-20	605,061	3,405,872
June-18	999,979	June-19	559,288	June-20	562,725	
July-18	4,525,796	July-19	1,576,072	July-20	521,080	78,499
August-18	924,838	August-19	346,302	August-20	611,529	
September-18	1,228,910	September-19	876,966	September-20	785,446	
October-18	1,101,494	October-19	1,148,666	October-20	1,168,624	11,577
November-18	1,140,874	November-19	957,993	November-20	836,014	
December-18	458,871	December-19	1,500,316	December-20		
					8,485,204	4,274,873
Subtotal FY 2018	15,276,562	Subtotal FY 2019	11,571,384	Subtotal FY 2020	12,760,077	

Mangum Regional Medical Center
Statement of Revenue and Expense Trend
Fiscal Year 2020

	January	February	March	April	May	June	July	August	September	October	November	YTD
Inpatient revenue	**169,988**	**241,544**	**224,924**	**99,905**	**67,905**	**154,409**	**138,076**	**227,447**	**186,712**	**168,692**	**325,643**	2,005,246
Swing Bed revenue	**1,070,140**	**1,210,296**	**1,170,659**	**977,723**	**1,055,023**	**1,012,643**	**742,570**	**690,499**	**576,187**	**1,025,904**	**1,245,780**	10,777,425
Outpatient revenue	**697,297**	**618,768**	**737,709**	**283,525**	**316,908**	**472,711**	**525,246**	**555,398**	**603,806**	**708,089**	**608,600**	6,128,057
Professional revenue	**203,801**	**200,242**	**197,098**	**76,616**	**60,862**	**128,778**	**135,786**	**138,768**	**154,083**	**128,848**	**141,168**	1,566,050
Total patient revenue	2,141,226	2,270,850	2,330,391	1,437,769	1,500,698	1,768,541	1,541,679	1,612,113	1,520,788	2,031,533	2,321,191	20,476,778
Contractual adjustments	**997,171**	**1,256,683**	**1,065,624**	**580,094**	**582,169**	**913,633**	**381,849**	**632,343**	**497,367**	**1,071,164**	**951,246**	8,929,342
Contractual adjustments: MCR Settlement	-	-	-	-	**(791,984)**	-	-	**(528,397)**	-	-	**3,808**	(1,316,573)
Bad debts	**155,999**	**73,647**	**498,548**	**304,754**	**298,496**	**2,681**	**289,329**	**303,736**	**43,115**	**95,228**	**220,470**	2,286,002
Total deductions from revenue	1,153,170	1,330,330	1,564,172	884,848	88,681	916,315	671,178	407,681	540,481	1,166,391	1,175,523	9,898,771
Net patient revenue	**988,056**	**940,520**	**766,220**	**552,921**	**1,412,017**	**852,226**	**870,501**	**1,204,432**	**980,307**	**865,142**	**1,145,667**	10,578,007
Other operating revenue	**1,497**	**7,902**	**1,066**	**3,157**	**5,941**	**1,005**	**195,079**	**257,371**	**971**	**28,339**	**434**	502,762
Total operating revenue	989,553	948,422	767,286	556,078	1,417,957	853,231	1,065,580	1,461,803	981,278	893,480	1,146,101	11,080,769
Expenses												
Salaries and benefits	**386,311**	**369,309**	**404,861**	**373,075**	**394,985**	**358,110**	**365,517**	**379,331**	**331,762**	**363,584**	**375,683**	4,102,528
Professional Fees	**158,406**	**146,618**	**160,166**	**154,059**	**160,275**	**157,070**	**144,358**	**134,124**	**168,677**	**145,847**	**124,187**	1,653,788
Contract labor	**220,920**	**125,589**	**214,312**	**185,713**	**200,590**	**270,408**	**183,794**	**231,131**	**191,331**	**130,097**	**144,022**	2,097,908
Purchased/Contract services	**65,990**	**66,331**	**94,709**	**76,897**	**73,248**	**84,769**	**40,414**	**126,226**	**90,756**	**93,561**	**129,841**	942,739
Management expense	**291,066**	**291,066**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	2,607,132
Supplies expense	**36,323**	**76,084**	**76,070**	**96,282**	**122,112**	**100,530**	**106,055**	**80,204**	**106,872**	**94,185**	**100,297**	995,015
Rental expense	**20,352**	**20,596**	**24,300**	**25,258**	**24,869**	**21,195**	**24,872**	**17,256**	**31,467**	**34,285**	**19,184**	263,635
Utilities	**13,290**	**13,865**	**12,124**	**15,385**	**15,097**	**13,826**	**14,672**	**18,301**	**15,449**	**13,518**	**13,894**	159,422
Travel & Meals	**578**	**230**	**730**	**347**	**224**	**419**	**455**	**392**	**12**	**168**	**25**	3,579
Repairs and Maintnenance	**5,374**	**2,149**	**2,479**	**5,055**	**2,376**	**5,554**	**1,749**	**1,254**	**6,328**	**2,398**	**1,484**	36,200
Insurance expense	**10,696**	**10,696**	**10,696**	**10,695**	**11,039**	**11,039**	**11,039**	**11,039**	**11,039**	**11,039**	**11,482**	120,500
Other	**29,460**	**23,914**	**72,241**	**63,363**	**65,243**	**38,727**	**10,923**	**7,360**	**80,980**	**23,607**	**31,818**	447,637
Total expense	1,238,765	1,146,447	1,297,687	1,231,129	1,295,057	1,286,649	1,128,849	1,231,619	1,259,673	1,137,289	1,176,917	13,430,081
EBIDA	$ (249,212)	$ (198,025)	$ (530,402)	$ (675,051)	$ 122,900	$ (433,418)	$ (63,269)	$ 230,184	$ (278,396)	$ (243,808)	$ (30,815)	$ (2,349,312)
EBIDA as percent of net revenue	-25.2%	-20.9%	-69.1%	-121.4%	8.7%	-50.8%	-5.9%	15.7%	-28.4%	-27.3%	-2.7%	-21.2%
Interest	**40,917**	**39,634**	**38,411**	**37,175**	**36,740**	**35,020**	**33,714**	**32,398**	**31,157**	**27,044**	**28,672**	380,881
Depreciation	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,993**	**24,993**	**24,993**	272,961
Operating margin	$ (314,877)	$ (262,407)	$ (593,561)	$ (736,974)	$ 61,412	$ (493,185)	$ (121,730)	$ 173,039	$ (334,545)	$ (295,845)	$ (84,480)	$ (3,003,153)
Other	-	-	-	-	-	-	-	-	-	-	-	-
Total other nonoperating income	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess (Deficiency) of Revenue Over Expenses	(314,877)	(262,407)	(593,561)	(736,974)	61,412	(493,185)	(121,730)	173,039	(334,545)	(295,845)	(84,480)	(3,003,153)
Operating Margin % (excluding other misc. revenue)	-31.82%	-27.67%	-77.36%	-132.53%	4.33%	-57.80%	-11.42%	11.84%	-34.09%	-33.11%	-7.37%	-27.10%

Mangum Regional Medical Center
Comparative Balance Sheet
Fiscal Year 2020

Cumulative Amt of Stimulus Funds **$ (1,041,000)**

	1/31/2020	2/29/2020	3/31/2020	4/30/2020	5/31/2020	6/30/2020	7/31/2020	8/31/2020	9/30/2020	10/31/2020	11/30/2020	Prior Year End 2019
Cash And Cash Equivalents	**650,902**	**487,305**	**502,637**	**83,171**	**(221,626)**	**(398,068)**	**(47,080)**	**694,238**	**939,665**	**1,362,580**	**1,322,145**	**612,885**
Reserved Funds	**-**	**-**	**-**	**778,925**	**4,184,797**	**4,184,797**	**3,302,296**	**2,771,296**	**2,771,296**	**2,771,296**	**2,771,296**	**-**
Patient Accounts Receivable, Net	**1,965,649**	**2,004,473**	**1,760,771**	**1,527,856**	**1,377,969**	**1,487,353**	**1,669,859**	**1,526,495**	**1,602,630**	**1,614,364**	**1,773,519**	**2,400,091**
Inventory	**53,371**	**55,475**	**50,520**	**62,716**	**59,445**	**51,665**	**62,995**	**84,681**	**86,001**	**96,697**	**98,476**	**47,000**
Prepaids And Other Assets	**993,277**	**983,551**	**965,582**	**949,829**	**966,519**	**970,520**	**981,373**	**1,003,012**	**972,651**	**973,891**	**1,010,960**	**930,494**
Capital Assets, Net	**1,478,350**	**1,453,602**	**1,428,854**	**1,404,106**	**1,379,358**	**1,354,610**	**1,329,863**	**1,305,115**	**1,296,692**	**1,271,699**	**1,250,442**	**1,503,097**
Total Assets	5,141,549	4,984,406	4,708,365	4,806,603	7,746,462	7,650,877	7,299,306	7,384,836	7,668,935	8,090,529	8,226,838	5,493,568
Accounts Payable	**7,628,679**	**7,918,840**	**8,422,481**	**8,666,124**	**9,119,282**	**9,706,734**	**9,775,900**	**10,415,471**	**10,968,618**	**11,226,011**	**12,259,203**	**7,482,136**
Due To Medicare	**8,092,953**	**7,962,724**	**7,831,384**	**7,698,925**	**6,773,352**	**6,638,625**	**6,502,748**	**5,847,494**	**5,719,559**	**6,045,823**	**5,919,512**	**8,222,081**
Covid Grant Funds	**-**	**-**	**-**	**778,925**	**4,184,797**	**4,184,797**	**4,069,296**	**3,812,296**	**3,812,296**	**3,812,296**	**3,812,296**	**-**
Due To Cohesive - PPP Loans	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**232,920**	**474,215**	**647,000**	**-**	**-**
Notes Payable - Cohesive	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**	**242,500**
Notes Payable - Other	**968,899**	**917,513**	**866,033**	**814,457**	**762,785**	**711,017**	**666,762**	**622,409**	**577,959**	**542,386**	**506,744**	**1,020,190**
Alliantz Line Of Credit	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Leases Payable	**403,380**	**400,096**	**396,795**	**393,475**	**390,137**	**386,781**	**383,406**	**380,013**	**376,601**	**373,170**	**369,721**	**406,646**
Total Liabilities	17,336,410	17,441,674	17,759,193	18,594,406	21,472,853	21,870,453	21,640,612	21,553,103	22,171,747	22,889,186	23,109,975	17,373,552
Net Assets	**(12,194,861)**	**(12,457,268)**	**(13,050,828)**	**(13,787,803)**	**(13,726,390)**	**(14,219,576)**	**(14,341,306)**	**(14,168,267)**	**(14,502,812)**	**(14,798,658)**	**(14,883,137)**	**(11,879,984)**
Total Liablities and Net Assets	5,141,549	4,984,406	4,708,365	4,806,603	7,746,462	7,650,877	7,299,306	7,384,836	7,668,935	8,090,529	8,226,838	5,493,568

Mangum Regional Medical Center
Medicare Payables by Year
December 15, 2020 Board Meeting

Year	Original Loan Balance	Balance as of 11/30/2020	Total Interest Paid as of 11/30/2020
2016 C/R Settlement	1,397,906.00	516,815.25	201,109.17
2017 Interim Rate Review - 1st	723,483.00	371,601.93	146,290.20
2017 Interim Rate Review - 2nd	122,295.00	52,384.02	19,907.26
2017 6/30/17-C/R Settlement *Estimate*	1,614,760.00	1,614,760.00	-
2017 12/31/17-C/R Settlement *Estimate*	(535,974.00)	(535,974.00)	-
2017 C/R Settlement Overpayment *Estimate*	3,539,982.21	3,539,982.21	-
2018 C/R Settlement	1,870,870.00	990,039.56	194,534.25
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	1,202,963.87	151,938.61
2019 C/R Settlement	(967,967.00)	(967,967.00)	-
2020 C/R Settlement *8/31 Est. Receivable per C/R tool*	(1,320,381.00)	(865,094.00)	-
Total	**8,571,606.21**	**5,919,511.84**	**719,416.52**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended November, 2020

MTD				YTD		
Actual	Prior Year	Prior Yr Variance		Actual	Prior Year	Prior Yr Variance
325,643	211,058	114,585	Inpatient revenue	2,005,246	1,735,242	270,004
1,245,780	1,107,813	137,966	Swing Bed revenue	10,777,425	8,733,899	2,043,526
608,600	1,118,521	(509,922)	Outpatient revenue	6,128,057	8,951,824	(2,823,768)
141,168	147,945	(6,777)	Professional revenue	1,566,050	1,342,070	223,980
2,321,191	2,585,337	(264,147)	Total patient revenue	20,476,778	20,763,035	(286,258)
951,246	1,023,032	(71,787)	Contractual adjustments	8,929,342	7,456,801	1,472,541
3,808	-	3,808	Contractual adjustments: MCR Settlement	(1,316,573)	2,126,632	(3,443,205)
220,470	361,228	(140,758)	Bad debts	2,286,002	2,136,676	149,326
1,175,523	1,384,260	(208,736)	Total deductions from revenue	9,898,771	11,720,109	(1,821,338)
1,145,667	1,201,078	(55,410)	Net patient revenue	10,578,007	9,042,926	1,535,080
434	765	(331)	Other operating revenue	502,762	55,818	446,944
1,146,101	1,201,843	(55,741)	Total operating revenue	11,080,769	9,098,745	1,982,024
			Expenses			
375,683	403,007	(27,324)	Salaries and benefits	4,102,528	4,419,225	(316,697)
124,187	138,275	(14,088)	Professional Fees	1,653,788	1,662,028	(8,241)
144,022	162,370	(18,348)	Contract labor	2,097,908	1,851,920	245,988
129,841	73,050	56,791	Purchased/Contract services	942,739	770,294	172,446
225,000	291,066	(66,066)	Management expense	2,607,132	2,871,396	(264,264)
100,297	72,981	27,315	Supplies expense	995,015	1,124,495	(129,481)
19,184	8,707	10,477	Rental expense	263,635	235,277	28,358
13,894	14,842	(948)	Utilities	159,422	165,892	(6,471)
25	428	(403)	Travel & Meals	3,579	8,003	(4,424)
1,484	10,602	(9,118)	Repairs and Maintnenance	36,200	49,131	(12,931)
11,482	10,688	794	Insurance expense	120,500	119,134	1,366
31,818	25,774	6,044	Other Expense	447,637	291,839	155,798
1,176,917	1,211,791	(34,874)	Total expense	13,430,081	13,568,634	(138,553)
(30,815)	(9,948)	(20,868)	EBIDA	(2,349,312)	(4,469,889)	2,120,577
-2.7%	-0.8%	-1.9%	EBIDA as percent of net revenue	-21.2%	-49.1%	27.9%
28,672	28,320	351	Interest	380,881	234,213	146,667
24,993	27,587	(2,594)	Depreciation	272,961	294,636	(21,676)
(84,480)	(65,855)	(18,625)	Operating margin	(3,003,153)	(4,998,739)	1,995,586
-	-	-	Other	-	-	-
-	-	-	Total other nonoperating income	-	-	-
(84,480)	(65,855)	(18,625)	Excess (Deficiency) of Revenue Over Expenses	(3,003,153)	(4,998,739)	1,995,586
-7.37%	-5.48%	-1.89%	Operating Margin %	-27.10%	-54.94%	27.84%

Mangum Regional Medical Center
Admissions, Discharges & Days of Care
Fiscal Year 2020

	January	February	March	April	May	June	July	August	September	October	November	12/31/2020 YTD	12/31/2019 PY Comparison
Admissions													
Inpatient	23	18	16	13	9	10	11	15	16	12	20	163	196
Swingbed	27	27	21	13	16	19	18	21	13	9	10	194	146
Observation	0	0	0	0	1	1	2	0	0	0	3	7	26
	50	45	37	26	26	30	31	36	29	21	33	364	368
Discharges													
Inpatient	20	17	16	12	7	9	10	14	16	17	23	161	194
Swingbed	18	16	13	3	5	11	8	15	7	5	12	113	142
Observation	0	0	0	0	1	1	2	0	0	0	3	7	26
	38	33	29	15	13	21	20	29	23	22	38	281	362
Days of Care													
Inpatient-Medicare	42	30	29	15	11	30	31	30	42	29	37	326	394
Inpatient-Other	7	23	28	21	6	4	4	16	20	9	27	165	157
Swingbed-Medicare	324	305	268	274	300	278	258	216	168	246	346	2,983	3,337
Swingbed-Other	0	26	37	0	24	32	22	26	7	47	31	252	189
Observation	0	0	0	0	1	1	3	0	0	0	4	9	0
	373	384	362	310	342	345	318	288	237	331	445	3,735	4,077
Calendar days	31	29	31	30	31	30	31	31	30	31	30	335	334
ADC - (incl OBS)	12.03	13.24	11.68	10.33	11.03	11.50	10.26	9.29	7.90	10.68	14.83	11.15	12.21
ADC	12.03	13.24	11.68	10.33	11.00	11.47	10.16	9.29	7.90	10.68	14.70	11.12	12.21

Ratio Analysis	1/31/20	2/29/20	3/31/20	4/30/20	5/31/20	6/30/20	7/31/20	8/31/20	9/30/20	10/31/20	11/30/20	12/31/19
Days cash on hand	14.97	11.43	11.67	1.93	-5.13	-9.15	-1.10	16.30	21.99	32.23	31.35	14.45
Current ratio	0.48	0.45	0.39	0.39	0.70	0.65	0.61	0.58	0.58	0.61	0.57	0.53
Days revenue in AR, net	61.67	62.36	59.46	56.92	44.95	49.11	55.73	49.09	51.26	52.20	56.17	73.64
Total reserves as a % of gross A/R	0.90	0.90	0.87	0.88	0.88	0.87	0.86	0.87	0.85	0.86	0.85	0.88
Bad debt allowance as a % of > 120 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of aging > 120 days old	0.84	0.84	0.76	0.79	0.82	0.80	0.78	0.77	0.78	0.79	0.76	0.81

MANGUM REGIONAL MEDICAL CENTER
BALANCE SHEET

	11/30/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Audited
CASH AND CASH EQUIVALENTS	1,322,144.86	612,885.01	60,783.93	133,204.52
RESERVED FUNDS	2,771,295.96	-	-	-
PATIENT ACCOUNTS RECEIVABLE, NET	1,773,518.76	2,400,091.11	2,332,884.75	2,673,217.00
INVENTORY	98,475.86	47,000.43	102,691.19	235,404.12
PREPAIDS AND OTHER ASSETS	1,010,960.39	930,494.09	274,934.60	34,011.66
CAPITAL ASSETS, NET	1,250,442.48	1,503,097.40	1,660,334.36	-
Total Assets	8,226,838.31	5,493,568.04	4,431,628.83	3,075,837.30
ACCOUNTS PAYABLE	12,259,203.44	7,482,135.89	3,112,072.41	2,786,346.45
DUE TO MEDICARE	5,919,511.84	8,222,080.63	8,108,674.03	3,299,317.54
COVID GRANT FUNDS	3,812,295.96	-	-	-
DUE TO COHESIVE - PPP LOANS	-	-	-	-
NOTES PAYABLE - COHESIVE	242,500.00	242,500.00	120,000.00	-
NOTES PAYABLE - OTHER	506,743.71	1,020,189.77	23,564.77	514,485.34
ALLIANTZ LINE OF CREDIT	-	-	-	-
LEASES PAYABLE	369,720.50	406,645.64	1,408,363.63	-
Total Liabilities	23,109,975.45	17,373,551.93	12,772,674.84	6,600,149.33
NET ASSETS	(14,883,137.14)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
Total Liablities and Net Assets	8,226,838.31	5,493,568.04	4,431,628.83	3,075,837.30
	0.00	-	0.00	-

MANGUM REGIONAL MEDICAL CENTER
OPERATING STATEMENT

	11/30/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Audited
Inpatient revenue	2,005,245.82	1,839,186.54	3,509,513.55	1,537,078.71
Swing Bed revenue	10,777,425.04	10,178,066.65	2,000,373.85	311,888.47
Outpatient revenue	6,128,056.66	9,926,042.34	36,517,907.05	14,771,826.44
Professional revenue	1,566,050.17	1,758,285.97	2,114,186.49	774,339.20
Contractual adjustments	(8,929,342.13)	(8,340,605.44)	(28,195,967.19)	(11,245,416.08)
Contractual adjustments: MCR Settlement	1,316,573.00	(1,154,857.00)	(2,152,550.00)	-
Bad debts	(2,286,001.81)	(2,310,613.91)	(3,155,273.67)	(2,780,983.05)
Net patient revenue	10,578,006.76	11,895,505.15	10,638,190.08	3,368,733.69
Other operating revenue	502,762.48	49,000.44	(1,082,033.47)	12,274.10
Salaries and benefits	4,102,528.05	4,798,286.83	4,782,977.71	2,056,908.78
Professional Fees	1,653,787.51	1,838,300.17	1,100,288.20	416,247.12
Contract labor	2,097,908.23	2,098,120.24	-	-
Purchased/Contract services	942,739.25	791,163.84	3,528,764.11	2,107,627.89
Management expense	2,607,132.00	3,162,462.00	152,419.00	-
Supplies expense	995,014.74	1,251,445.39	2,403,755.62	762,024.23
Rental expense	263,634.71	248,152.83	685,357.92	73,081.47
Utilities	159,421.53	180,462.17	205,309.20	86,197.96
Travel & Meals	3,578.86	8,556.85	124,900.37	88,602.66
Repairs and Maintnenance	36,199.84	52,185.37	291,016.76	48,028.86
Insurance expense	120,499.50	129,821.74	165,895.73	60,804.10
Other Expense	447,636.78	326,854.92	412,990.40	1,151,223.16
Interest	380,880.72	276,351.31	437,037.63	54,573.59
Depreciation	272,960.77	321,279.81	82,177.94	-
TOTAL EXPENSES	14,083,922.49	15,483,443.47	14,372,890.59	6,905,319.82
Change in Net Assets	(3,003,153.25)	(3,538,937.88)	(4,816,733.98)	(3,524,312.03)
Net Assets, Beginning of Year	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)	-
Net Assets, End of Period	(14,883,137.14)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
	0.00	-	-	-

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Mangum Regional Medical Center

November 2020 CEO Report for MRMC Hospital Board

CEO: Marie Harrington

December 7, 2020

COVID - 19 Activity and Overview:

- ✓ We continue to swab any admits due to increased number of positive COVID-19 patients in Mangum. Treating all patients in our ER as if they have COVID-19 until proven otherwise.
- ✓ Participated in daily Region 3 Merc Briefings to increase communication during COVID-19 surge. We review open beds, transfer plans and all pertinent COVID-19 information to coordinate care. Robert Stewart is our Region 3 RMRS Director that facilitates each daily briefing.
    - He encouraged us to work as partners together if we are on divert. Build relationships locally if we must go onto divert.
    - He submitted the document to FEMA to request additional staffing. We may not get it, but it will be put in the que and be reviewed.
    - He discussed the monoclonal antibody and stated that we will have an equitable share. We have received 10 vials in-house.
- ✓ November COVID-19 Stats at MRMC: 208 Swabs, 45 Positive (21.63%), 164 Negative (78.84%), 0 Pending and 1 death.
- ✓ COVID-19 Prevalence Overview by Month at MRMC: March: 32% Prevalence, April: 25% Prevalence, May: 6% Prevalence, June: 0% Prevalence, July: 10% Prevalence, August: 2.4% Prevalence, September: 2.73% Prevalence, October: 6.47% Prevalence, November: 21.63% Prevalence, and Median Age: 54.68
- ✓ Greer County November COVID-19 Statistics: 262 Positive Cases and 8 Deaths (3.05% death rate).
- ✓ PPE and Swab supplies have been adequate for us to manage during this current crisis.
- ✓ Updated COVID-19 Binder at Nurse's station, City Annex and Provider room to ensure communication and COVID-19 updates and education are read. Signature is required for all read and sign documents in binder. Providers are kept up to date with the COVID-19 Provider Update/Education Binder in the provider sleep room. CEO has also communicated with providers via email, cell phone and text messages during this continued COVID-19 Pandemic. Last update was 11.25.2020.
- ✓ Participated in all Cohesive Healthcare's COVID-19 Task Force Teleconference calls.
- ✓ Kept teams motivated, educated, and informed daily during COVID-19 crisis. Addressed any issues, concerns, anxiety, and fear with any individual during this crisis.
- ✓ Significant COVID-19 surge in November which resulted in schools moving to 100% virtual learning. On November 29, 2020, Mangum Public Schools moved to 100% virtual learning through January 5, 2020. We adjusted to the needs of our staff and families by approving non-clinical team members remote work requests.

- ✓ Due to continued COVID-19 surge in November we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- ✓ MRMC Census Daily Average for November: 14.67 Swing bed and Acute patients per day
- ✓ Make hospital rounds every morning for inspection.
- ✓ Cohesive Healthcare provided staff lunches for November 2020 during this pandemic. All staff members are very thankful for this support.
- ✓ Savance COVID-19 Screening Kiosk implementation and installation date is scheduled for early to mid-December.
- ✓ Carport was installed at the clinic on November 17, 2020.
- ✓ Notified by Dave Andren that board meetings will return to in-person beginning in November.

Hospital Staff Overview:

- ✓ No staff issues or concerns currently. Teams are all working together very well.
- ✓ BLS Certification offered to staff members on November 12, 2020. We have encouraged all non-clinical team members to be certified as well with a goal of 100% of all staff certified.
- ✓ EMTALA Training was held on November 18th and 19th. Excellent training held in 4 different sessions each day.
- ✓ Conducted MRMC Morning Director's Huddle each day. Moved to Microsoft Teams to reduce traffic during COVID-19 surge in November.
- ✓ Jessica Pineda was awarded the Employee of The Month for November during the MRMC All-Staff meeting on December 7, 2020.
- ✓ Continued effective weekly HR meetings, monthly Finance Meeting, Housekeeping Meeting, Dietary Meeting, HIM and Credentialing Meeting, Clinic Admin Meeting, and many more important meetings to increase all important communication.

Additional Items:

- ✓ Distributed November Monthly Calendar for MRMC Meeting schedules and reporting/agenda deadlines on November 1, 2020.
- ✓ Continued to work on name change for MRMC with Novitas. Still pending the tie-ins from the regional CMS office. No update as of November 30, 2020.
- ✓ We received our RHC CCN # and we have continued to meet each week to set up billing and plan for "go live" date. Excellent teamwork by all involved.
- ✓ Signed checks every Friday or Monday for MRMC Accounts Payable Clerk.
- ✓ All roof leaks (clinic, lab, and hospital) have been addressed and are still pending. Lab and clinic roof will be repaired in November/December.
- ✓ Thanksgiving lunch was scheduled for November 24, 2020 and provided by Cohesive Healthcare.

- ✓ MRMC KPIs for November were reviewed. The quality improvements have continued to be significant: 2 Falls without injury and 1 Fall with minor injury, Zero Employee Work Related Injury, 4 Med Variances, 1 SWB AMA, Zero ER AMA, Zero LWBS, 4 Referrals, 3 Denials, 1 Inpatient Mortality (COVID-19 positive), 1 ER Patient Mortality, 2 Re-Admission within 30 days, 7 ER Readmissions within 72 hours, Zero Grievances or Complaints. Zero CAUTIs, CLABSIs, or CAEs, and 0 HA Pressure Ulcers. A total of 137 ER patients were admitted which was an increase of 2.24% over previous month, primarily due to COVID-19 surge in October.
- ✓ Conducted monthly MRMC Finance Meeting on November 20, 2020.
- ✓ The hospital generator update:
    - Ray's Electric began the project and performed a new assessment for a new bid on November 24, 2020. Project is still pending.
- ✓ Contracts we prepared for November's board meeting:
    - MSDSOnline
    - MimeDx
        - MiMedx Skin Grafts substitutes will be offered at MRMC. Contracts were approved at the board meeting on December 2, 2020
    - PARA
        - Charge Master and Price Transparency Update:
            - Cohesive RCM Director and CFO chose PARA to conduct the Charge Master Review and Maintenance. Went through monthly approval process and approved by the board during the November board meeting held on December 2, 2020.
            - Para Price Transparency Tool was approved by the board during the November board meeting held on December 2, 2020.
- ✓ Bad Debt Process planning and implementation continued in November to prepare for December to January implementation
- ✓ Celebrated National Rural Health Day on November 20. We took a group photo that we entered in the OOORH Photo Contest.
- ✓ Worked with CPSI through the month of November on Promoting Interoperability Initiatives. We made significant improvements to continually strive for excellence in all quality measures.
- ✓ Participated in Cohesive Leadership Meeting on November 19, 2020.
- ✓ Discussed a 3-stage audit process with checklists for survey preparedness with CCO and Quality Manager.

Your One General Agency

November 23, 2020

Aubrey Gardner
Tolson Agency Inc
511 Kihekah Ave
Pawhuska, OK 74056

Re: Mangum Regional Medical Center
Proposed Effective Date: 1/30/2021
Policy Number: 73APR384525-01
Coverage: Business Auto Liability

Dear Aubrey,

We are pleased to provide you with the attached renewal quotation for the above captioned insured. Please review the terms and conditions of the quote. All conditions of the quote must be met in order to bind coverage.

You must fax or email a written request in order to bind coverage. Please don't hesitate to contact us with any questions you may have.

Sincerely,

Brittni Allen, Ext. 263
Associate Underwriter
ballen@youroga.com

Reference #: 1084729

RENEWAL QUOTATION

Renewal Of: 73APR384525-01 - **Expiring On:** 1/30/2021

Quote Dated: November 23, 2020

Producer: Aubrey Gardner - Tolson Agency Inc
511 Kihekah Ave
Pawhuska, OK 74056

Insured: Mangum Regional Medical Center
Mailing Address: 1 Wickersham Dr, Mangum, OK 73554
Physical Address: 1 Wickersham Dr , Mangum, OK 73554

Carrier: National Liability & Fire Insurance Company, Admitted, A++ Superior XV

Coverage: Business Auto Liability

Limits:
See attached

Deductible:
See attached

Endorsements:
Including but not limited to the forms list attached

Terms/Subject To:
Request to bind must be in writing via email or fax
Completed Renewal Questionnaire - Dated and signed
This quote is subject to No Losses from date of quote to inception date
Drivers must be between the ages of 35 to 75 w/2 yrs. min. experience & clean MVRs or surcharges apply
Quote based on airbags
Quote based on anti-lock brakes
Credit was applied to the risk for no losses. If the insured has a loss prior to the renewal date, the credit could be removed
Credit was applied to this risk for driver quality. If any driver has any new citations, the credit will be reduced or removed and the citation could be surcharged

Premium:
$2,089.00

Commission:
10%

Brittni Allen - Reference #: 1084729A

Account Summary For MANGUM REGIONAL MEDICAL CENTER

Quote #: 11137882
Status: Pending
Policy Type: AP

Originally Quoted: 1/01/1900 12:00 AM
Quote Printed: 11/06/2020 9:42 AM EST
Proposed Effective: 1/30/2021 12:00 AM
Proposed Expiration: 1/30/2022 12:00 AM

Quoted By: Help Desk
National Indemnity Company
1314 Douglas Street, Suite 1400
Omaha, NE 68102
Phone - (402) 916-3000

HelpDesk@nationalindemnity.com

DOT #: Unknown
MC #: Unknown

Symbol	Coverage	Limit ($)	Premium ($)
7	Liability	1,000,000 CSL	1,215
10	UM - BI Only	1,000,000 CSL	226
7	Medical Payments	5,000	45
7	Physical Damage	See Specific Unit	528
	Total Ins Value	38,000	
	Add'l Ins'd		50
	Waiver of Sub		25

Total **$2,089.00**

Revision: 73OK2019R04

Vehicle Information NICO-Rate Version: 8.6.38347.1219

Unit		Liability	UM	Med Pay	Phys Dam	Cargo/ In-Tow	Al/Lessor	Unit Sub Total
1	2013 DODGE GRAND CARAVAN (62128)	1,215	Incl.	45	528	N/A	N/A	1,788

Comp/Coll $38,000 **Deductible:** 1,000/1,000
Radius: Up to 50 Miles

National Indemnity Company
Since 1940

Driver Information for MANGUM REGIONAL MEDICAL CENTER

NICO-Rate for Oklahoma

National Liability & Fire Insurance Company

Policy Driver Rating Factor: 0.9000

Driver Turnover Percent: 0.00%

Quote #: 11137882 Revision: 73OK2019R04

	Driver	Date of Birth
1	Jeniffer Pettijohn	4/1/1972

Schedule of Forms & Endorsements

IL 0177 (10/2010) Oklahoma Changes - Concealment, Misrepresentation or Fraud
M 4487 (04/1994) Auto Medical Payments Coverage
CA 0132 (10/2013) Oklahoma Changes
M 5872 (04/2017) Changes to Common Policy Conditions - Cancellation
M 5479 (04/2010) Towing and Storing Costs
M 5355 (01/2013) State of Oklahoma - Security Verification Form
M 5144a (06/2007) Waiver of Transfer of Rights of Recovery Against Others To Us
CA 0001 (10/2013) Business Auto Coverage Form
CA 3143 (11/2015) Oklahoma Uninsured Motorists Coverage - Non-Stacked
M 5605 (02/2011) Business Auto Coverage Declarations
M 3745a (06/2009) Additional Insured Endorsement
M 3795 (03/1987) Punitive Damage Exclusion Duty to Defend Amendment
M 5408 (07/2009) Oklahoma Compulsory Insurance Law Notice
M 4600a (04/2003) Commercial Policy Jacket
M 4459 (09/1993) Oklahoma Insurance Fraud Warning
CA 2402 (10/2013) Public Transportation Autos
M 5878 (06/2016) Oklahoma Changes - Cancellation & Nonrenewal
M 4803 (02/1998) Abuse or Molestation Exclusion
CA 2018 (10/2013) Professional Services Not Covered
M 5279a (10/2007) Notice of Coverage Changes
M 4572 (12/1994) Schedule of Forms and Endorsements at Policy Inception
M 5171 (06/2004) Schedule of Covered Autos
M 3912b (08/2001) Stated Amount Insurance

Auto Renewal Questionnaire

COLUMBIA INSURANCE COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
NATIONAL INDEMNITY COMPANY
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL INDEMNITY COMPANY OF THE SOUTH
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

One General Agency
PO Box 54017
Oklahoma City, OK 73154
(800) 299-1951 FAX: (405) 840-9388

Item 13.

Policy Term From:_____ To _____

Named Insured: _____ Policy No. _____

Renewal Date _____

1. Complete the following: Have there been any changes - if yes, explain.

		Yes	No	
(a)	Named Insured	☐	☐	
(b)	Address of Insured	☐	☐	
(c)	Largest city entered	☐	☐	
(d)	Maximum radius operated	☐	☐	
(e)	No. of Vehicles owned	☐	☐	
(f)	No. of Vehicles leased	☐	☐	

(g) Are all owned & leased vehicles covered under this policy? ☐ Yes ☐ No If no, explain: _____

2. Is there any change in operations? ☐ Yes ☐ No If yes, explain: _____
3. Indicate any changes in units or coverages to be made at renewal: _____
4. For public vehicles: Is your operation ☐ For Profit ☐ Non-Profit
5. If insured is leased out, to whom is he currently leased? _____
6. Do you presently have or are you applying for a permit(s) for transportation of hazardous material and/or radioactive materials?
7. Is there any change in types of commodities hauled? ☐ Yes ☐ No If yes, explain: _____
8. Person to contact for inspection (name and phone number): _____
9. Have you ever filed or are you contemplating filing for reorganization or bankruptcy? ☐ Yes ☐ No If yes, show date (month and year) and explain: _____
10. **MUST BE COMPLETED FOR ALL DRIVERS** (If not enough space attach list)

Driver's Name	Date of Hire	Date of Birth	Driver's Licenses			Experience	
			State	Number	No. of Years Licensed	Type of Unit (Bus, Van, etc.)	No. of Years
1.							
2.							
3.							
4.							
5.							

11. When physical damage provided, indicate current depreciated value(s): _____
12. Any accidents or violations in the past twelve (12) months? ☐ Yes ☐ No If yes, explain: _____
13. Are DOT filings required? ☐ Yes ☐ No If yes, list MC number and required filings: _____
    Are state filings required? ☐ Yes ☐ No If yes, identify all states/filings/ID numbers: _____
14. Are there any changes to loss payees? ☐ Yes ☐ No If yes, explain: _____

The Applicant's representative acknowledges that he/she has advised the Insured and the Insured agrees that if the foregoing statements and answers are materially false, the Company shall have the right to rescind any policy it may issue or any renewal thereof. All terms, conditions, and applicable endorsements of the previous policy shall apply. Representations made on the Insured's original Company application shall survive renewal unless modified by this document.

Date _____ _____
Applicant's Representative

_____
Address of Applicant's Representative

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ESTIMATE

Billy City Of Mangum Hospital
102 S. Pennsylvania
Mangum, OK
(580) 782-2250

McAbee Fox Roofing LLC
P.O. Box 140 Lic#80002994
Hobart, OK 73651
Phone: (580) 530-0033
Email: sales@mcabeefoxroofing.com

Estimate # 001827
Date 06/25/2020

Description	Total
Prep for New Roof	$6,000.00
Clear roof of trash and limps Pressure wash surface for better adhesion	
Silicone Coating Roof System	$77,000.00
Install Silicone Roof Coating 10 year workmanship warranty 20 year material warranty	

Subtotal	$83,000.00
Total	**$83,000.00**

Notes:

By breaking it down into 3 sections and doing them in a level of priority. This job can be broke down into the north south and central areas. The south and central sections are the 2 biggest sections and that equal to $30,000 each. The north section is the smaller of the 3. It would cost $23,000.

In doing it this way, MFR will put the 4 drains in for free of charge to help with the cost of this project to ensure that the roof leaks stop.

We appreciate the opportunity to do business for the city of mangum and the community.
Thanks, Ryan Fox