Agenda
Mangum City Hospital Authority
February 23, 2021 at 5:00 PM
via Videoconference

The Trustees of the Mangum City Hospital Authority will meet in regular session on **Tuesday, February 23, 2021, at 5:00 PM**. This session will be held via Videoconference in accordance with the State of Oklahoma Statutes. In accordance with Oklahoma State Statutes during the Declared Emergency for the COVID-19 outbreak, all public meetings for the Hospital board will be held via Videoconference. The public is invited to join the meeting by clicking on the following link.

Join Zoom Meeting
https://us02web.zoom.us/j/87471811337?pwd=RWg3ZXk0eVY5d3A4d0lHS05pdXZQUT09

The public can just view the videoconference live on the City of Mangum webpage (www.cityofmangum.com/Stream.html) as well as the City's YouTube Channel (Search YouTube for "City of Mangum").

CALL TO ORDER

SEAT NEW BOARD MEMBERS

1. Welcome Carson Vanzant and Laretha Vincent. The Mayor has administered the Oath of Office just before this meeting.

   Carson Vanzant's is filling Ms. Kane's term which expires September 2021.

   Laretha Vincent is filling Mr. Reeves' term which expires September 2022.

ROLL CALL AND DECLARATION OF A QUORUM

ELECT CHAIRMAN AND VICE CHAIRMAN

2. Discussion and possible action to elect a Chairman and Vice Chairman for the Mangum City Hospital Board.

CONSENT AGENDA

3. Approve minutes for the cancelled January 26, 2021 meeting.

4. Approve minutes for the cancelled December 15, 2020 meeting.

5. Approve the minutes for the special meeting held on December 2, 2020.

6. Approve the minutes for the cancelled November 24, 2020 meeting.

7. Approve the minutes for the cancelled October 28, 2020 meeting.

8. Approve January 2021 Claims.

9. Approve additional February 2021 estimated claims.

10. Approve estimated claims for March 2021.

11. Approve Hospital Departmental Reports.

12. Approve Hospital Departmental Reports for December 2020

13. Approve Hospital Departmental Reports for January 2021.

14. Approve Clinic Operations Report for November 2020.

15. Approve Clinic Operations Reports for December 2020.

16. Approve January 2021 Clinic Operations Report.

17. Approve Hospital Respiratory Policies and Procedures.

18. Approve Hospital Drug Room Policies and Procedures.

19. Approve Hospital Emergency Department Policies and Procedures

20. Approve Clinical Policies and Procedures

21. Approve Wound Care Policies and Procedures Form

22. Approve Human Resources Performance Evaluation Policy.

23. Approve Hospital Rehab Department Policies and Procedures

24. Approve Patient Discharge Safety Checklist.

25. Approve Blood Transfusion Outcome Review Form

26. Approve 2020 Financial Reports

27. Approve Financial Reports for December 2020.

28. Approve Financial Reports for January 2021.

29. Approve CEO Report for November 2020.

30. Approve CEO Report for December 2020.

31. Approve CEO Report for January 2021.

FURTHER DISCUSSION

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

REPORTS

OTHER ITEMS

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

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

34. Discussion and Possible Action to approve quote for Spacelabs Healthcare.

35. Discussion and Possible Action to approve contract between Mangum City Hospital Authority dba Mangum Regional Medical Center and LifeShare Transplant Services of Oklahoma, Inc.

36. Discussion and Possible Action to approve amendment to agreement between Mangum City Hospital Authority dba Mangum Regional Medical Center and Press Ganey Associates LLC.

37. Discussion and possible action to approve COVID Expenses.

38. Discussion and Possible Action to approve Consulting Services Agreement between Mangum City Hospital Authority dba Mangum Regional Medical Center and OFMQ.

39. Discussion and Possible Action to approve Master Subscription Agreement between Mangum City Hospital Authority dba Mangum Regional Medical Center and Wolters Kluwer Health, Inc.

40. Discussion and possible action regarding possible changes to the agenda and the presentation of data as requested by Board Member Heiskell. Specifically, to remove all financial reports from the current format of the consent agenda, making them a separate item on the agenda, to be presented monthly.

41. Discussion and possible action regarding possible changes to the agenda and the presentation of data as requested by Board Member Heiskell. Specifically, requiring the local CEO cover all operational reports, therefore eliminating parts of the current monthly department reports, yet providing more details of local operations.

42. Discussion and possible action regarding possible changes to the agenda and the presentation of data as requested by Board Member Heiskell. Specifically, requiring all participants that are attending the meetings remotely to have video on while presenting information.

43. Discussion and possible action regarding joining the Oklahoma Hospital Association as requested by Board Member Heiskell, paying associated variable rate membership fees of $14,387.00 for the first year.

44. Discussion and possible action for future joint session with City Commissioners.

EXECUTIVE SESSION

45. 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 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

d. John J. Chiaffitelli, DO - Active Privileges - Re-Credentialing

e. Terri Gibson, MD - Courtesy Privileges - Re-Credentialing

f. Mary Holmboe, MD - Courtesy Privileges - Re-Credentialing

g. Ruth Oneson, MD - Courtesy Privileges - Re-Credentialing

h. Ricky Reaves, MD - Courtesy Privileges – Re-Credentialing

i. Barry Rockler, MD - Courtesy Privileges – Re-Credentialing

j. Sherrita Wilson, MD, - Courtesy Privileges – Re-Credentialing

OPEN SESSION

46. 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 4:00 p.m. on the 23rd day of February 2021, by the Secretary of the Mangum City Hospital Authority.

_____
Billie Chilson, Secretary

Minutes
Mangum City Hospital Authority Regular Session
January 26, 2021 at 5:00 PM
Mangum Welcome Center 119 E Jefferson

The Trustees of the Mangum City Hospital Authority were to meet Regular session on Tuesday, January 26, 2021, at 5:00 PM but due to lack of quorum the meeting was canceled before the start of the meeting.

Billie Chilson, Secretary

Zac Zachary, Chairman

Minutes
Mangum City Hospital Authority Regular Session
December 15, 2020 at 5:00 PM
Mangum Welcome Center 119 E Jefferson

The Trustees of the Mangum City Hospital Authority were to meet Regular session on Tuesday, December 15, 2020, at 5:00 PM but due to lack of quorum the meeting was canceled before the start of the meeting.

Billie Chilson, Secretary

Zac Zachary, Chairman

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

Minutes
Mangum City Hospital AuthoritySession
November 24, 2020 at 5:00 PM
via Videoconference

The Trustees of the Mangum City Hospital Authority did not meet due to a lack of quorum available for meeting.

Billie Chilson, Secretary *, Chairman*

Minutes
Mangum City Hospital AuthoritySession
October 28, 2020 at 5:00 PM
via Videoconference

The Trustees of the Mangum City Hospital Authority did not meet due to a lack of quorum.

Billie Chilson, Secretary *, Chairman*

Mangum Regional Medical Center
Claims List
January 2021

Check#	Ck Date	Amount	Paid To	Expense Description
15180	1/8/2021	2,025.00	ABC BIOMEDICAL	IV Pumps Rental
15218	1/15/2021	19.00	AMBS CALL CENTER	Hotline
15181	1/8/2021	1,732.65	AMERIPRIDE SERVICES INC	Linen Services
15219	1/15/2021	1,732.65	AMERIPRIDE SERVICES INC	Linen Services
15241	1/22/2021	1,755.25	AMERIPRIDE SERVICES INC	Linen Services
15242	1/22/2021	514.50	ANESTHESIA SERVICE INC	Telemetry sensors
15182	1/8/2021	330.02	BAXTER HEALTHCARE	Pharmacy Supplies
15243	1/22/2021	491.37	BAXTER HEALTHCARE	Pharmacy Supplies
15183	1/8/2021	1,000.00	BENISH AND ASSOCIATES	1099 Provider
15184	1/8/2021	2,950.00	BRIAN BLUTH, M.D.	1099 Provider
15185	1/8/2021	690.56	CARDINAL HEALTH	Pharmacy Supplies
15186	1/8/2021	898.90	CINTAS CORPORATION #628	Linen Service
15220	1/15/2021	742.90	CINTAS CORPORATION #628	Linen Service
15244	1/22/2021	892.90	CINTAS CORPORATION #628	Linen Service
15187	1/8/2021	4,479.80	CITY OF MANGUM	Utilities
15188	1/8/2021	2,850.00	CLIFFORD POWER SYSTEMS INC	Compliance reports
15189	1/8/2021	45,351.68	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15221	1/15/2021	50,035.72	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15222	1/15/2021	121,619.47	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15190	1/8/2021	2,525.25	COHESIVE MEDIRYDE LLC	Swing bed purchase service
15223	1/15/2021	59,718.93	COHESIVE REVOPS	Billing purchased service
15191	1/8/2021	43,103.05	COHESIVE STAFFING SOLUTIONS	Agency staffing
15224	1/15/2021	69,021.32	COHESIVE STAFFING SOLUTIONS	Agency staffing
15245	1/22/2021	46,743.83	COHESIVE STAFFING SOLUTIONS	Agency staffing
15192	1/8/2021	11,709.65	CONEXUS SOLUTIONS LLC	Agency staffing
15225	1/15/2021	12,739.39	CONEXUS SOLUTIONS LLC	Agency staffing
15246	1/22/2021	8,885.26	CONEXUS SOLUTIONS LLC	Agency staffing
15193	1/8/2021	2,500.00	CORRY KENDALL, ATTORNEY AT LAW	Legal Fees
15247	1/22/2021	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
15248	1/22/2021	2,500.00	DOERNER SAUNDERS DANIEL ANDERS	Legal Fees
15249	1/22/2021	105.00	DONNA MCKELVEY	employee reimbursement
15194	1/8/2021	5,766.67	DR W. GREGORY MORGAN III	1099 Provider
15195	1/8/2021	10,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15250	1/22/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15196	1/8/2021	2,550.00	F1 INFORMATION TECHNOLOGIES IN	Software license
15251	1/22/2021	100.35	FEDEX	Postage
15226	1/15/2021	2,456.99	FFF ENTERPRISES INC	Pharmacy Supplies
15252	1/22/2021	12,976.50	FULLER SELLE LLC DBA PHARMACAR	Payment for outstanding pharmacy debt
15197	1/8/2021	155.00	GEORGE BROS TERMITE & PEST CON	plant ops purch svs
15198	1/8/2021	500.00	GERAINT HARRIS	1099 Provider
15199	1/8/2021	816.21	GRAINGER	Plant Ops supplies
15227	1/15/2021	719.60	GRAINGER	Plant Ops supplies
15200	1/8/2021	277.00	GRAYSTONE MEDIA GROUP	advertising
15229	1/15/2021	273.84	HAC INC	Dietary food
15201	1/8/2021	43.80	HEALTH CARE LOGISTICS	Patient Supplies
15230	1/15/2021	7,752.22	HENRY SCHEIN	Lab supplies
15253	1/22/2021	8,164.50	HENRY SCHEIN	Lab supplies
901007	1/4/2021	9,805.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease

Check#	Ck Date	Amount	Paid To	Expense Description
15202	1/8/2021	53.90	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15231	1/15/2021	55.90	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15239	1/15/2021	3,021.26	INTERMETRO INDUSTRIES CORP	Minor eq. and supplies
15203	1/8/2021	653.76	JANUS SUPPLY CO	Cleaning Supplies
15254	1/22/2021	428.12	JANUS SUPPLY CO	Cleaning Supplies
15232	1/15/2021	881.89	KAY ELECTRIC	Repair and maintenance
15204	1/8/2021	173.62	KITTY JEANENE LEWIS	employee reimbursement
15205	1/8/2021	1,959.09	LAMPTON WELDING SUPPLY	Patient Supplies
15233	1/15/2021	1,527.30	LANDAUER	radiology purch svs
15255	1/22/2021	70.15	LYNDA JAMES	employee reimbursement
901010	1/8/2021	10,048.13	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901014	1/21/2021	4,219.56	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901018	1/31/2021	3,850.44	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
15206	1/8/2021	3,595.37	MEDLINE INDUSTRIES	Patient Care Supplies
15234	1/15/2021	5,887.00	MEDLINE INDUSTRIES	Patient Care Supplies
15256	1/22/2021	5,247.16	MEDLINE INDUSTRIES	Patient Care Supplies
901008	1/5/2021	8.00	NATIONAL DATA BANK	Credentialing
901015	1/21/2021	14.00	NATIONAL DATA BANK	Credentialing
15207	1/8/2021	36.99	OFFICE DEPOT	Office Supplies
15235	1/15/2021	75.00	OK STATE BOARD OF MED LICENSUR	Credentialing
15257	1/22/2021	563.70	OKLAHOMA BLOOD INSTITUTE	blood bank
15258	1/22/2021	1,140.00	RAMSEY AND GRAY, PC	Legal Fees
15208	1/8/2021	9,350.00	SARA MCDADE	1099 Provider
15259	1/22/2021	8,400.00	SARA MCDADE	1099 Provider
15209	1/8/2021	3,890.68	SIEMENS HEALTHCARE DIAGNOSTICS	lab svs contract
15210	1/8/2021	3,536.23	SIZEWISE	Equipment rentals
15260	1/22/2021	1,735.00	SMAART MEDICAL SYSTEMS INC	smaart pac rental
15261	1/22/2021	141.62	SPARKLIGHT BUSINESS	Cable Service
15211	1/8/2021	2,382.74	STANDLEY	printer lease
15212	1/8/2021	1,935.48	STAPLES ADVANTAGE	Office Supplies
15236	1/15/2021	115.58	STAPLES ADVANTAGE	Office Supplies
15262	1/22/2021	8,439.00	SYSMEX AMERICA INC	lab svs contract
15213	1/8/2021	2,190.00	THE COMPLIANCE TEAM	RHC consulting
15214	1/8/2021	5,692.64	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15237	1/15/2021	5,455.80	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15238	1/15/2021	1,911.02	TOUCHPOINT MEDICAL, INC	Medispense support
901011	1/11/2021	478.59	TSYS	CC processing
15263	1/22/2021	1,099.98	ULTIMATE IT GUY LLC	IT Minor equipmemt
15215	1/8/2021	326.46	ULTRA-CHEM INC	Housekeeping supplies
901016	1/21/2021	4,310.82	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
901012	1/12/2021	1,418.38	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901009	1/6/2021	1,398.23	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901013	1/19/2021	1,097.36	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901017	1/27/2021	1,127.76	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
15216	1/8/2021	1,710.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15264	1/22/2021	1,710.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15217	1/8/2021	8,047.33	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
	TOTAL	**695,472.53**		

NOT ON APPROVED LIST, OPERATIONAL & EMERGENT	Description	Amount
AMERISOURCE BERGEN	Pharmacy Supplies	52,000.00
DOBSON	Internet	1,809.00
HENRY SCHEIN	Lab supplies	6,301.36
	TOTAL	**60,110.36**

Mangum Regional Medical Center
March Estimated Claims

Row Labels	Description	Estimated
ABC BIOMEDICAL	IV Pump rental	6,075.00
ADP INC	QMI Payroll Service Provider	
ADP SCREENING AND SELECTION	QMI Payroll Service Provider	
ALCO SALES & SERVICE CO	Supplies	1,200.00
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees	
ALPHA TECHNICS	Lab eq repair	183.96
AMBS CALL CENTER	Call Center	50.00
AMERICAN HEALTH TECH	Rental Equipment-Old	
AMERIPRIDE SERVICES INC	Linen Services	10,525.89
ANESTHESIA SERVICE INC	Service	1,500.00
BAXTER HEALTHCARE	Pharmacy Supplies	2,500.00
BEC INTEGRATED	Nurse Call	462.00
BKD LLP	Cost Report Filing	3,588.00
C & C	Supplies	2,500.00
C.R. BARD INC.	Surgery Supplies-Old	
CANON FINANCIAL SERVICES INC	Ultrasound Lease	5,569.35
CARDINAL HEALTH	Pharmacy Supplies	88.20
CINTAS CORPORATION #628	Linen Services	4,464.50
CITY OF MANGUM	Utilities	12,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	500,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	370,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	6,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	205,000.00
COMMERCIAL MEDICAL ELECTRONICS	Equipment Inspection Service	2,450.00
COMPLIANCE CONSULTANTS	Lab Consultant	
CONEXUS SOLUTIONS LLC	Agency Staffing	65,000.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	6,500.00
CPSI	EHR service	80,000.00
CULLIGAN WATER CONDITIONING	Clinic Purchased Service	200.00
DAN'S HEATING & AIR CONDITIONI	Repairs	500.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	3,618.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	15,000.00
DR. JOHN CHIAFFIETELLI	1099 Provider	20,000.00
ELISE ALDUINO	1099 consultant	
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	5,478.00
FEDEX	Postage	300.00
FOX BUILDING SUPPLY	Plant Ops Supplies	1,000.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	465.00
GLOBAL EQUIPMENT COMPANY INC.	Minor Equipment	254.94
GRAINGER	Maintenance Supplies	6,000.00
GRAYSTONE MEDIA GROUP	Advertising	305.00
GREER COUNTY TREASURER	Property taxes	5,460.50
HAC INC	Dietary Supplies	300.00

Row Labels	Description	Estimated
HEADRICK OUTDOOR MEDIA INC	Advertising	
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00
HENGST PRINTING	Pharmacy Supplies	222.94
HENRY SCHEIN	Lab Supplies	18,000.00
HERC RENTALS INC	Old Rental Service	
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	9,805.00
IMEDICAL INC	Supplies	
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	300.00
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,000.00
KCI USA	Supplies	1,500.00
LABCORP	Lab purch svs	50,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	2,500.00
LOCKE SUPPLY	Plant Ops Supplies	500.00
LYNDA JAMES	Employee reimbursement	200.00
MATT MONROE	Staff House Rent	850.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	25,000.00
MEDLINE INDUSTRIES	Patient Care Supplies	25,000.00
MEDSURG CONSULTING LLC	Equipment Rental Agreement	
MEDTOX DIAGNOSTICS, INC	Lab supplies	1,500.00
MICROSURGICAL MST	Surgery Supplies	
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies	
NEXTIVA, INC.	Phones	3,000.00
NINJA RMM	IT Service	
NUANCE COMMUNICATIONS INC	Supplies	500.00
OKLAHOMA BLOOD INSTITUTE	Lab Supplies	2,197.20
OKLAHOMA DEPARTMENT OF LABOR	Misc	25.00
OPTUM	Insurance Portal	376.17
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	1,300.00
PHILIPS HEALTHCARE	Supplies	641.98
PIPETTE COM	Supplies	180.00
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	347.00
PRESS GANEY ASSOCIATES, INC	Purchased Service	2,048.28
QUARTZ MOUNTAIN RESORT	Alliance Travel	
RAMSEY AND GRAY, PC	Legal Fees	5,000.00
SCHAPEN LLC	Clinic Rent	4,109.00
SCRUBS AND SPORTS	Employee Appreciation	105.64
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	3,470.00
SOUTHWEST HOT STEAM CLEANING	Dietary Purchased Service	300.00
SPARKLIGHT BUSINESS	Cable service	2,500.00
STANDLEY	Printer Lease	100.00
STANDLEY SYSTEMS LLC	Printer Lease	6,000.00
STAPLES ADVANTAGE	Office Supplies	2,500.00
STERICYCLE ENVIRONMENTAL SOLUT	Waste Disposal Service	5,839.00
STERICYCLE INC	Waste Disposal Service	3,959.00
STRYKER INSTRUMENTS	Surgery Supplies	
SUNBELT RENTALS	Air Scrubber Rental - COVID	348.00

Row Labels	Description	Estimated
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	3,000.00
THE COMPLIANCE TEAM	RHC Consultant	2,190.00
ULINE	Equipment	1,835.82
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	10,000.00
US MED-EQUIP LLC	Swing bed eq rental	6,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	4,500.00
WELCH ALLYN, INC.	Supplies	
WORTH HYDROCHEM	Water treatment svs	783.40
DR. MORGAN	1099 Provider	4,766.67
SARA MCDADE	1099 Provider	30,000.00
GERAINT HARRIS	1099 Provider	15,000.00
BLUTH FAMILY MEDICINE	1099 Provider	2,000.00
BENISH AND ASSOCIATES	1099 Provider	16,000.00
COHESIVE REVOPS	Billing svs	65,000.00
CRYSTAL WILLIAMS	Employee reimbursement	500.00
SARA COX	Employee reimbursement	800.00
CONTROL SOLUTIONS	Supplies	1,000.00
AMERISOURCE BERGEN	Pharmacy Supplies	52,000.00
TOTAL MEDICAL STAFFING	Agency Staffing	12,000.00
UMPQUA	Lab Eq Note	6,800.00
TSYS	CC processing service	1,500.00
SHRED-IT	Secure doc disposal	1,000.00
CARDINAL 110 LLC	Prepaid Pharmacy Supplies	30,000.00
AT&T	Fax Service	3,000.00
CENTERPOINT	Utilities	3,000.00
DONNA MCKELVEY	Employee reimbursement	500.00
DR RYAN MAJOR, MD	1099 Provider	15,000.00
PATIENT REFUNDS	Credits due to payors	10,000.00
TOTAL ESTIMATED		**1,826,938.44**

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
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

Chief Clinical Officer Report
December 2020

Excellent Patient Care

- Monthly Education topics included: Representative from Mimedx presented education regarding Epifix grafts for wound patients.
- Staff are updated regularly regarding Cohesive COVID Task Force directives.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days decreased from 441 in November to 265 (*seems to happen every December*). This represents an average daily census of 8.5
- MRMC Wound Care Team is proud to offer Epifix grafts and products that are now available for Inpatients and Outpatients. These products have tons of evidence-based research which has demonstrated significant improvement in outcomes for wound care patients.

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	16
Swing Bed	27	27	21	13	16	19	18	21	13	17	23	20
Observation	0	0	0	0	1	1	2	0	0	0	3	2
Emergency Room	179	180	182	66	88	115	115	127	145	134	137	125
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	2251/ 204

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.
- Human Resources promptly responding to any and all applications.

Mangum Regional Medical Center
Medical Staff Meeting
December 09, 2020

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
William Gregory Morgan, III, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

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

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

1. Call to order
    a. The meeting was called to order at 12:30 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the November 19, 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.
- 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, and August: 2.4% Prevalence, September: 2.73% Prevalence, October: 6.47% Prevalence, November: 21.63%, 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.
- 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 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
- 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 will be installed at the clinic on November 17, 2020.
- Notified by Dave Andren that board meetings will return to in-person beginning in November.
- 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.
- Jessica Pineda was awarded the Employee of The Month of November during the MRMC All-Staff meeting on December 07, 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.
- 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 is scheduled for November 24, 2020 and provided by Cohesive Healthcare.
- MRMC KPIs for November were reviewed. The quality improvements continued to be significant: 2 Falls without injury and 1 Fall with minor injury, Zero Employee Work Related Injury, 4 Med Variances, 1SWB 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 OHA Pressure Ulcers. A total of 137 ER patients were admitted which was a decrease of 2.24% over previous month, primarily due to COVID-19 surge in October.
- 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 are preparing for November's board meeting:
    - MSDSOnline
    - MimeDx

- PARA
- Bad Debt Process planning and implantation 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.
- Discussed a 3-stage audit process with checklists for survey preparedness with CCO and Quality Manager.

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: 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 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 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.

Written report remains in minutes.

   c. 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
  Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –
i.i. 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 Receptacles - All 15 AMP Receptacles will be replaced with 20 AMP Receptacles 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 have been ordered
k. Complete Active Shooter Exercise – Mangum Police Department returning call with date

i.i.i. New Business
a. None

Written Report remains in minutes.

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

f. Radiology
i. There was a total of – 204 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates: CT wend down on Nov. 24th, the table hardware went out. The CT was fixed and was back up and running on Dec. 1. Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacist.
i.i. Vaccination Plan
i.i.i. P & T Meeting not this month

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/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 for 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
  - 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

Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for November: 441
   i.i. Total Medicare days for November: 383
   i.i.i. Total Medicaid days for November: 5
   i.v. Total Swing bed days for November: 377
   v. Total Medicare SB days for October: 346

Written reports remain in minutes.

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

6.New Business

a. Approval of Emergency Department Policies & Procedures
   i.Motion: made by Dr. Chiaffitelli to approve Emergency Department Policies & Procedures.
b. Approval of Clinical Policies and Procedures.
   i.Motion: made by Dr. Chiaffitelli to approve Clinical Policies & Procedures.
c. Approval of Wound Care Orders
   i,Motion: made by Dr. Chiaffitelli to approve Wound Care Orders.
d. Approval of Consent Agenda – HR Performance Evaluation Policy
   i.Motion: made by Dr. Chiaffitelli to approve HR Performance Evaluation Policy
e. Discussion of OGA Business Auto Liability Insurance Renewal
   i.Motion: made by Dr. Chiaffitelli to enter into discussion of the OGA Business Auto Liability Insurance Renewal.

7. Adjourn

a. Dr. Chiaffitelli made a motion to adjourn the meeting at 1:25 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center

Quality/Risk/Compliance Report

DECEMBER 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.
  3. Clinical Policies and Procedures
  4. Emergency Department Policies and Procedures
  5. Wound Care Procedure Form

  Consent agenda – HR performance Evaluation Policy

- Policies and forms approved by Quality Committee on January 14, 2021.
  1. REHAB POLICIES AND PROCEDURES
  2. GENERAL HOSPITAL POLICIES AND PROCEDURES
  3. EMD-016 BLOOD ALCOHOL COLLECTION FOR LAW ENFORCEMENT
  4. EMD-016A BLOOD ALCOHOL CONCENTRATION FORM
  5. EMD-016B TESTING FOR BLOOD ALCOHOL CONCENTRATION LOG

- HIM – Showed improvement on completing documentation. Physician access to EMR outside of the facility is getting set up. Also, the Kiosk is being set up and putting in place the end of January. This will help with the completion of consents.
  They will be able to sign in and complete any paperwork. MRMC conducted a Provider time study from December 7th-20th.
- COMPLIANCE

- One Grievances for December. Thorough investigation was done with no findings. Matter was resolved and letter was sent.

- Contracts that were approved for December:

  1. Life share contract and log
  2. Space Labs for telemetry

Mangum Regional Medical Center

3. Press Ganey Contract

- Contracts up for review from November: Not approved by GB as of 1/15/21
    1. OGA auto insurance (Business Auto Liability Insurance Renewal Policy)

RISK MANAGEMENT

- 3 Medication Variance
- 3 AMA – 2 AMS's were ER. One didn't like Covid-19 restrictions. One didn't want further treatment. 1 AMA IP was that patient wanted to leave so he could go back to work. On all 3 Providers described the risks of leaving and the benefits of staying.
- LWBS – Patient was triaged, and nurse told the patient that both ER rooms are full and it would be just a little bit. When the nurse went to get the patient, she had left. Patient waited under 30 min.
- 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. Immunizations have been given to clinical and direct patient contact employees. Next phase of immunizations will be in January.
- 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
January 21, 2020

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
William Gregory Morgan, III, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

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

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

1. Call to order
    a. The meeting was called to order at 12:05 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the December 09, 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.
- 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.

- December COVID-19 Stats at MRMC: 161 Swabs, 16 Positive (9.93%), 145 Negative (90.06%), 0 Pending and 1(0.62%) 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%, and December Prevalence: 9.93% Median Age: 66.81.
- Greer County December COVID-19 Statistics: 390 Positive Cases and 9 Deaths (2.30% 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 12.03.2020.
- Participated in all OSDH Region 5 Vaccine Planning Meetings.
    - Drafted our MRMC Vaccination Plan for Phase 1 and beyond
      Administered the Pfizer-BioNTech Vaccine to 3 groups of Phase 1 recipients.
    - Everything went well and no serious adverse reactions were reported.
- Registered MRMC as a Pandemic Provider and received our approval.
- Moved our outpatient registration back to the main hospital building at the beginning of December.
- We reopened the front entrance and moved our COVID -19 Screener to the front entrance during daytime operating hours.
- A COVID – 19 screener is available at the front entrance for employees during 7:30 am – 8:00 am to accommodate the staff that would like to enter the building prior to daytime screening shift.
- Due to COVID-19 surge in December we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- MRMC Census Daily Average for November: 8.5 Swing bed and Acute patients per day; Average Daily Census for 2020 was 10.95.

- Cohesive Healthcare provided staff lunches for December 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-February.
- No staff issues or concerns currently. Teams are all working together very well.
- In person interview with Dr. Chiaffitelli, Marie and Dr. Spear on December 18, 2020. Meeting went well. Dr. Chiaffitelli approved of his recommendation for Randy's supervision. He lives here at Lake Altus in Granite and has retired to this area.
- So proud of our team for completing the Employee Satisfaction Surveys by the end of December. We had 62 out of 66 (94%) completion!
- COVID-19 Bonuses were approved by the Board on December 23, 2020. We will include the bonuses on the January 8, 2021 paycheck.
- Charlene Holder was awarded the Employee of The Month of November during the MRMC All-Staff meeting on December 07, 2020.
- Christmas lunch was scheduled for December 22, 2020 and provided by Cohesive Healthcare.
- End of the Year inventory was conducted on December 29, 2020,
- All roof leaks (clinic, lab, and hospital) have been addressed and are still pending. Lab and clinic roof will be repaired in December.
- MRMC KPIs for December were reviewed. The quality improvements continued to be significant: 2 Falls without injury and 1 Fall with minor injury, Zero Employee Work Related Injuies, 3 Med Variances, 1 IP AMA,1 ER AMA, 1 LWBS, 8 Referrals, 2 Denials, 6 Inpatient Mortalities, 1 ER Patient Mortality, 1 Re-Admission within 30 days, 8 ER Readmissions within 72 hours, 1 Grievance/Complaints. Zero CAUTIs, CLABSIs, or CAEs, and OHA Pressure Ulcers. A total of 125 ER patients were admitted which was a decrease of 8.76% over previous month.
- 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 and items, we prepared for January board meeting:
    - Auto Insurance
    - LifeShare
    - Spacelabs
- Received the RHC initial rate letter from Novitas for the clinic. The initial Medicare visit rate was $86.31. Received an updated

- Received the RHC initial rate letter from Novitas for the clinic. The initial Medicare visit rate was $86.31. Received an updated Novitas Rate Letter on December 8, 2020 for our new initial Medicare visit of $257.21. Very Pleased.
  Written report remains in the minutes.

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

   b. Nursing

Excellent Patient Care

- Monthly Education topics included: Representative from Mimedx presented education regarding Epifix grafts for wound patients.
- Staff are updated regularly regarding Cohesive COVID Task Force directives.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days decreased from 441 in November to 265 (seems to happen every December). This represents an average daily census of 8.5.
- MRMC Wound Care Team is proud to offer Epifix grafts and products that are now available for Inpatients and Outpatients. These products have tons of evidence-based research which has demonstrated significant improvement in outcomes for wound care patients.

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.
- Human Resources promptly responding to any and all applications.

Written report remains in minutes.

   c. Infection Control
      Date of Meeting: January 14, 2020

- Infection Control
  a. OSIIS updated system
  b. Phases of Covid Vaccinations
     1. Pfizer
     2. Moderna
- Employee Education
  a. HealthStream/Orientation Process

b. Immunization in CPSI
c. Flu/Pneumo Paperwork with New Nursing
d. Foley Cather/PICC Bundles with New Nursing

- Employee Health
  a. Employee Files – Annual TB
  b. COVID Vaccinations
- Policy & Procedure
  a. Changes to EMR
  b. Rapid Covid Testing – 90 day prelim
- 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. "CT IN Use" Light—Wire cut between control room and light will need new wiring before light can be connected
  b. Flooring in nurses break area and med prep room - rescheduled - could not close off area due to patient care
  c. Evaluation and approval of annual plans – plans will be presented in January meeting
  d. Install additional outlets on east side of patient hall – scheduled but has been postponed due to COVID-19
  e. New oxygen/suction headwall needed in ER1 – scheduled visit has been postponed – contacted Apex – not allowing vendors inside at this time – COVID-19
  f. New covered pegboard needed for supplies in ER1 - pegboards will have to be custom made
  g. Wall repair around window in room 19 has been postponed due to COVID-19
  h. Roof over OR2 area damaged and in need of repair – engineer came 10/1/2020 – claim still pending – item on City Agenda for discussion
  i. Rubber mats in kitchen need replaced – New mats in place
  j. Code drill schedule – will check to see if drills can be tracked QAPI
  k. Complete Active Shooter Exercise – Mangum Police Department scheduled twice – no call no show both times – will

schedule with Greer County Sheriff Dept.

l. 15 AMP receptacles – all 15 AMP receptacles will be replaced with 20 AMP receptacles through out the hospital – replacement has started.

i.i.i. New Business

a. Room 9 needs electrical coming through floor addressed
b. Exit sign in COVID Wing
c. Additional electrical circuits for COVID Wing

Written report remains in minutes.

e. Laboratory

i. Tissue Report – Approved – December 2020
i.i. Transfusion Report – Approved – December 2020

f. Radiology

i. There was a total of – 204 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. We have a new part time tech, she started on December 21, 2020. Her name is Jayci Carothers.

Written report remains in minutes.

g. Pharmacy

i. Verbal Report by Pharmacist.
i.i. Bamlanivimab – 42 in house.
i.i.i. P & T Meeting in January.

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/No approval from Governing Board.
    1. Respiratory policies and procedures.
    2. Drug Room policies and procedures.
    3. Clinical Policies and Procedures
    4. Emergency Department Policies and Procedures
    5. Wound Care Procedure Form

Consent Agenda – HR Performance Evaluation Policy

- Policies and forms approved by Quality Committee on January 14, 2021.
    1. Rehab Policies and Procedures
    2. General Hospital Policies and Procedures
    3. EMD-016 Blood Alcohol Collection for Law Enforcement
    4. EMD-)016A Blood Alcohol Concentration Form
    5. EMD-016B Testing for Blood Alcohol Concentration Log

- HIM – Showed improvement on completing documentation. Physician access to EMR outside of the facility is getting set up. Also, the Kiosk is being set up and putting in place the end of January. This will help with the completion of consents. They will be able to sign in and complete any paperwork. MRMC conducted a Provider time study from December 7th – 20th.

- Compliance
    - One Grievances for December. Thorough investigation was done with no findings. Matter was resolved and letter was sent.
    - Contracts that were approved for December:
        1. Life Share contract and log
        2. Space Labs for Telemetry
        3. Press Ganey Contract
    - Contracts up for review from November: not approved by GB as of 1/15/21
        1. OGA auto insurance (Business auto liability insurance renewal Policy)

- Risk Management
    - 3 Medication Variance
    - 3 – AMA – 2 AMS's were ER. One didn't like COVID-19 restrictions. One didn't want further treatment. 1 AMA IP – the patient wanted to leave so he could go back to work. On all 3 – the Providers described the risks of leaving and the benefits of staying.
    - LWBS – Patient was triaged, and nurse told the patient that both ER rooms are full and it would be just a little bit. When the nurse went to get the patient, she had left. Patient waited under 30 min.
    - 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 Immunizations have been given to clinical and direct patient contact employees. Next phase of immunizations will be in January.

- 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 December: 265
i.i. Total Medicare days for December: 242
i.i.i. Total Medicaid days for December: 1
i.v. Total Swing bed days for December: 219
v. Total Medicare SB days for December: 217

Written reports remain in minutes.

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

6.New Business

a. Approval of Rehab Policies and Procedures
i.Motion: made by Dr. Chiaffitelli to approve Rehab Policies & Procedures.

b. Approval of General Hospital Policies and Procedures.
i.Motion: made by Dr. Chiaffitelli to approve General Hospital Policies & Procedures.

c. Approval of EMD-016 Blood Alcohol Collection for Law Enforcement.
i,Motion: made by Dr. Chiaffitelli to approve EMD-016 Blood Alcohol Collection for Law Enforcement.

d. Approval of EMD-016A Blood Alcohol Concentration Form
i.Motion: made by Dr. Chiaffitelli to approve EMD-016A Blood Alcohol Concentration Form.

e. Approval of EMD-016B Testing for Blood Alcohol Concentration Log
i.Motion: made by Dr. Chiaffitelli to approve Testing for Blood Alcohol Concentration Log.

f. Approval of Life Share Contract and Log

i.Motion: made by Dr. Chiaffitelli to approve Life Share Contract and Log.

g. Approval of Space Labs for Telemetry

i.Motion: made by Dr. Chiaffitelli to approve Space Labs for Telemetry.

h. Approval of Press Ganey Contract

iMotion: made by Dr. Chiaffitelli to approve Press Ganey Contract.

7. Adjourn

a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:53 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center

Quality/Risk/Compliance Report

JANUARY 2021

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.
  3. Clinical Policies and Procedures
  4. Emergency Department Policies and Procedures
  5. Wound Care Procedure Form
  6. REHAB POLICIES AND PROCEDURES
  7. GENERAL HOSPITAL POLICIES AND PROCEDURES
  8. EMD-016 BLOOD ALCOHOL COLLECTION FOR LAW ENFORCEMENT
  9. EMD-016A BLOOD ALCOHOL CONCENTRATION FORM
  10. EMD-016B TESTING FOR BLOOD ALCOHOL CONCENTRATION LOG

  Consent agenda – HR performance Evaluation Policy

- Policies and forms approved by Quality Committee on February 10th, 2021.
  1. Form – Blood transfusion outcome review
  2. Form – Patient discharge safety plan

- HIM – Keeps showing improvement on completing documentation. Physician access to EMR outside of the facility is set up and going. Also, the Kiosk is being set up and were put into place the end of January. This will help with the completion of consents. They will be able to sign in and complete any paperwork.

- **COMPLIANCE**

- One Grievances for January. Thorough investigation was done with no findings. Matter was resolved and letter was sent.

- Contracts that were approved in Quality for January:
  1. Wolter Kluwer Health
  2. Lippincott Procedures

Mangum Regional Medical Center

- Contracts up for review from November: Not approved by GB as of 1/15/21
    1. OGA auto insurance (Business Auto Liability Insurance Renewal Policy)
    2. Life share contract and log
    3. Space Labs for telemetry
    4. Press Ganey Contract

RISK MANAGEMENT

- 3 Medication Variance
- 2 AMS's ER. One didn't like Covid-19 restrictions and said she felt better. She was informed of benefits of staying and the risks of leaving. Patient signed AMA. AMA # 2 was CP patient was being treated and was put on NPO. Patient wanted to eat, and kept becoming more verbally irritated. Provider verbalized the benefits of staying and the risks of leaving. Patient still left without signing AMA paperwork.
- 3 Incidents in nursing
- Working with Infection Control Nurse, CEO and CNO to stay informed with updates and information about Covid-19. Immunizations have been given to clinical and direct patient contact employees. We have had more immunizations in January.
- 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

Chief Clinical Officer Report
January 2021

Excellent Patient Care

- Monthly Education topics included: Administration of Bamlanivimab for COVID-19 positive patients.
- Staff are updated regularly regarding Cohesive COVID Task Force directives.
- Implemented and initiated Oklahoma State Dept. of Health COVID-19 Pandemic Provider status.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days decreased from 265 in December to 183 in January. This represents an average daily census of 5.90.
- MRMC Outpatient services are proud to begin offering Bamlanivimab. Bamlanivimab is a neutralizing antibody infusion available for Outpatients that are positive for COVID-19. The drug may help to limit the amount of virus in the body. This may help their symptoms to improve sooner – and may be less likely to need to be admitted to the hospital.
- MRMC continues to collaborate with Oklahoma State Dept of Health in providing COVID-19 vaccination clinics.

Preserve Rural Healthcare

Hospital												
2021 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec2020
Inpatient	15											16
Swing Bed	10											20
Observation	0											2
Emergency Room	104											125
Lab Completed/ Rad completed	2140/ 180											2251/ 204

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN, and CNA.
- Recruiting efforts included direct mailing of postcards to qualified recipients.
- Hired 3 LPN's for core staff.

Mangum Regional Medical Center

Chief Clinical Officer Report
January 2021

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

Clinic Operations Report

Mangum Medical Clinic

December 2020

Clinic Operations

- Ongoing Monthly Clinic Manager Meetings

Quality Improvement

- New QAPI report format-Clinic specific metrics

Community Outreach

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

Number of Clinic Visits

Provider	December	November	October	September	August	July
Benish	202	192	242	261	212	254

Productive Hours

Provider	December	November	October	September	August	July
Benish	131	127	168.9	156.95	119.48	167.5

Visits per Productive Hour-Target 2.5

Provider	December	November	October	September	August	July
Benish	1.54	1.51	1.43	1.66	1.77	1.52

Clinic Operations Report

Mangum Medical Clinic

January 2021

Clinic Operations

- Partnering with Revenue Cycle to develop Process for RHC/Facility Lab billing to reduce denials and allow lab to be resulted appropriately.
- Equalize Report Training for Managers: Review of weekly reports and National Benchmarks of each value.

Quality Improvement

- New QAPI report format-Clinic specific metrics in progress.
- Implementation of Review Goals for Equalize Weekly Reports to empower Clinic Managers to identify trends and process opportunities to include:
  - Days in AR for Insurance (<40)
  - Insurance AR%>90 days (<15%)
  - Rejection Review
  - Denial Review
  - Unbilled Review
  - Aging trends of AR

Visits per Productive Hour=Goal 2.00

Mangum Clinic	21-Jan	feb	mar	apr	may	jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	YTD Average
Visits	235.00	0.00	0.00	0.00	0.00	0.00	254.00	212.00	261.00	242.00	192.00	202.00	133.17
Provider hours	154.2	0.0	0.0	0.0	0.0	0.0	167.5	119.5	157.0	168.9	127.0	131.0	85.42
Vists per Productive Hr	1.52						1.52	1.77	1.66	1.43	1.51	1.54	1.56

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Scope of Service		**RES-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**3/2020**	**07/2020**
DEPARTMENT	REFERENCE	
Respiratory	See below	

SCOPE

This policy applies to all Respiratory Care Practitioners and Licensed Nursing Personnel of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel to ensure safe and effective care is provided to patients.

DEFINTIONS

NA

POLICY

In accordance with the recommendations set forth by the American Association for Respiratory Care (ARRC), the following scope of practice shall be followed by all respiratory care practitioners.

1. Respiratory Care Practitioners are health care professionals whose responsibilities include the assessment, evaluation, management, education, rehabilitation and care of patients with deficiencies and abnormalities of the cardiopulmonary system. The scope of practice includes the application of technology and the use of treatment protocols across all care sites including, but not limited to, the hospital.

2. The practice of respiratory care encompasses activities in assessment, evaluation, therapy, and education of the patient and family. These activities are supported by education, evidence-based practices, and standards of care as recommended by the AARC. Diagnostic activities include but are not limited to:
    a. Obtaining and analyzing physiological specimens;
    b. Interpreting physiological data

3. Therapy includes but is not limited to the application and monitoring of:
    a. Mechanical ventilator support;
    b. Artificial airway care;
    c. Bronchopulmonary hygiene;
    d. Pharmacological agents related to respiratory care procedures;
    e. Electrocardiogram (EKG)
    f. Arterial Blood Gas (ABG)

4. Licensed and trained nursing personnel may provide and administer respiratory services to patients who require such services as ordered for their care and treatment. In addition, responsibilities may include assessment and evaluation, and monitoring of response to therapy.

5. Respiratory Care Practitioners and Licensed Nursing Personnel are qualified to provide and administer respiratory services through professional education and training, licensure, and competency in the performance of respiratory services and within their scope of practice. Respiratory competencies will be completed on hire and annually. Supervision will be required until the employee is able to demonstrate satisfactory competence and performance of the procedure.

6. Nothing in the Respiratory Care Practice Act shall limit, preclude, or otherwise interfere with the lawful practices of persons working under the supervision of the responsible physician. In addition, nothing in the Respiratory Care Practice Act shall interfere with the practices of health care personnel who are formally trained and licensed by appropriate agencies of this state.

REFERENCES

American Association for Respiratory Care

Respiratory Care Practice Act

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Clinical Resource Guide for Respiratory Therapy		**RES-002**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**02/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy is applicable for Respiratory Therapy clinicians and Licensed Nursing Personnel 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 respiratory and licensed nursing staff. 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

Respiratory therapy services will utilize the standards of care for clinical procedures from the Lippincott Clinical Resource Guide for Respiratory Services. This resource is designed to provide a uniform standard of practice for respiratory 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 respiratory 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
Nebulized Aerosol Medication		**RES-004**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy is intended to provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel in providing nebulizer treatments to the patients of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and/or Licensed Nursing Personnel who are responsible for providing nebulizer treatments in a safe manner.

DEFINITIONS

NA

POLICY

The Respiratory Care Practitioner and/or Nursing Personnel are to administer aerosol treatments on a routine or emergency basis as ordered by a physician.

PROCEDURE

1. Follow the Lippincott Clinical Resource Guide.

REFERENCES

Lippincott Clinical Resource Guide.

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Oxygen Therapy		**RES-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory	See below	

SCOPE

This policy is intended to provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel in providing oxygen therapy to the patients of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and/or Licensed Nursing Personnel who are responsible for providing oxygen therapy in a safe manner.

DEFINITIONS

NA

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide for oxygen administration.
2. All oxygen devices will be changed when visibly soiled.
3. Safety Precautions:
    - Allow no hazardous materials or devices near the patient while oxygen in in use (petroleum products; Vaseline, electric razors, etc.);
    - Watch for patient sensitivity to oxygen administration, (i.e. COPD);
    - Only properly licensed personnel are allowed to set-up and/or monitor oxygen therapy.

REFERENCES

Lippincott Clinical Resources Guide

ATTACHMENTS

RES-003A Oxygen Protocol
REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Metered Dose Inhaler		**RES-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy is intended to provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel in providing metered dose inhaler therapy to the patients of Mangum Regional Medical Center.

POLICY

Upon order of the physician, the Respiratory Therapist or Licensed Nurse will administer the metered dose inhaler (MDI).

DEFINITIONS

NA

PURPOSE

To provide guidelines for Respiratory Care Practitioners and/or Licensed Nursing Personnel who are responsible for providing metered dose inhaler therapy in a safe manner.

PROCEDURE

1. Verify physicians order.
2. Identify patient, introduce yourself, and explain procedure.
3. Obtain equipment.
4. Wash hands and apply gloves.
5. Assemble equipment:
    a. Attach cartridge to mouthpiece unit.
    b. Attach reservoir.
6. Perform patient assessment: pulse, breath sounds, respirations.
7. Instruct patient in proper use of inhaler:

a. Shake inhaler prior to each use;
b. Exhale completely;
c. Place mouthpiece into mouth and close lips tightly;
d. Press down firmly on inhaler cartridge and inhale slowly and deeply;
e. Hold breath for 10 seconds and then exhale slowly;
f. Wait at least 1 minute for next administration. Continue administration for as many "puffs" as prescribed;
g. Perform patient assessment after treatment: pulse, respiratory rate, breath sounds;
h. Have patient rinse mouth thoroughly

8. Cleaning of inhaler:
    a. Clean mouthpiece thoroughly with warm water after each use.
    b. Rinse inhaler canister with warm water daily.
    c. Store in clear plastic bag in designated medication storage area.

REFERENCES

NA

ATTACHMENTS

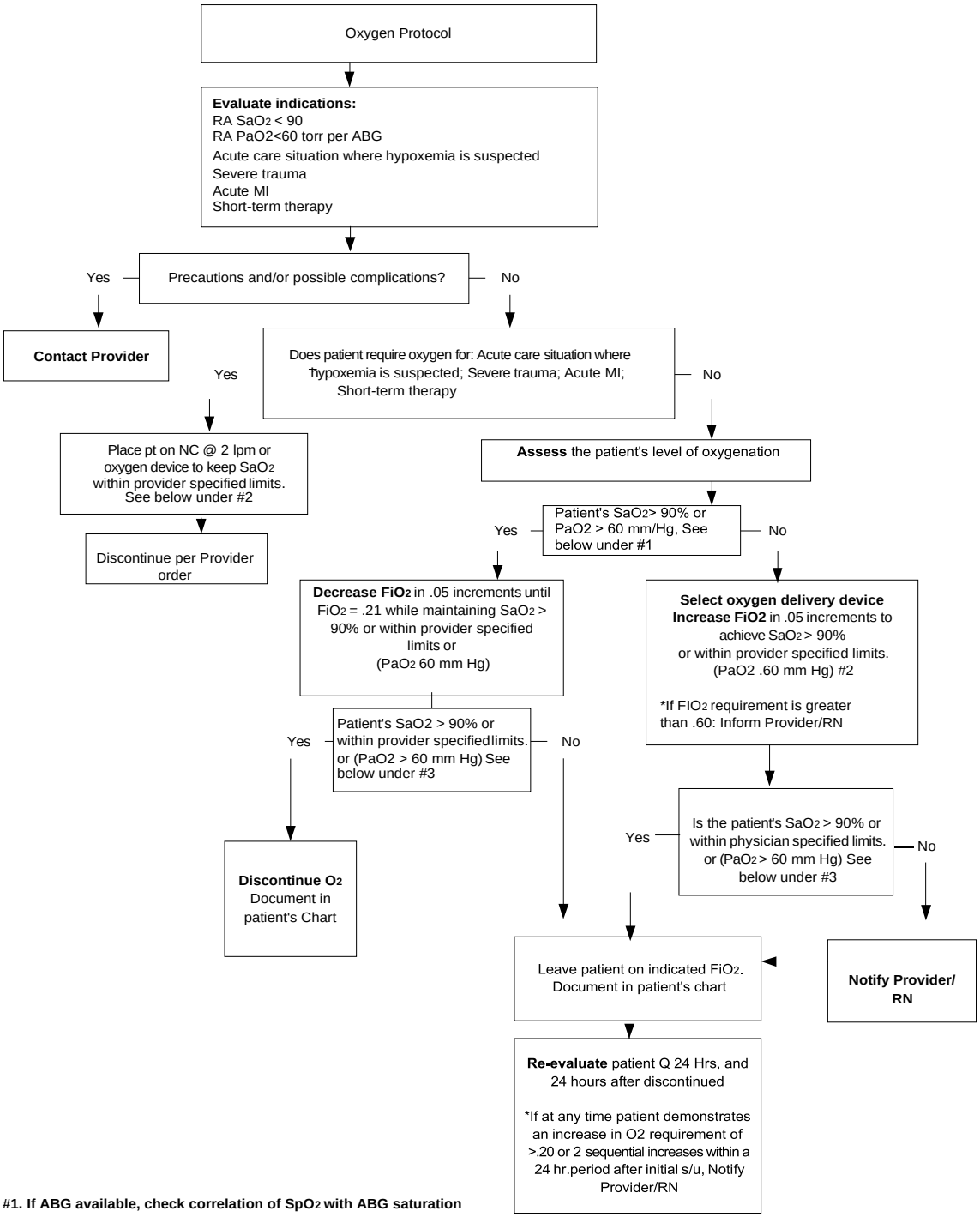
NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE
MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL
CENTER

OXYGEN PROTOCOL



#1. If ABG available, check correlation of SpO_2 with ABG saturation

#2. Oxygen device should be appropriate for patient's pathophysiology

#3. Acceptable FiO_2 may vary with the clinical situation or physician

Nurse Signature: _____ Date:_____/_____/_____ Time: _____

Provider Signature: _____ Date:_____/_____/_____ Time: _____

References for the Oxygen Protocol

1. Fulmer JD, Snider GL. ACCP-NHLBI National Conference on Oxygen Therapy. Chest 1984;86(2):234-247. Concurrent publication in Respir Care 1984;29(9):922-935.

2. Winter PM, Miller JN. Carbon monoxide poisoning. JAMA 1976;236(13):1502-1504.

3. Office of Professional Standards Review Organization, Health Care Financing Administration. Technical assistance document: approaches to the review of respiratory therapy services. Respir Care 1981;26(5):459-478.

4. Blue Cross and Blue Shield Association. Medical necessity guidelines for respiratory care (inpatient). Chicago: Blue Cross/Blue Shield, 1982.

5. Snider GL, Rinaldo JE. Oxygen therapy in medical patients hospitalized outside of the intensive care unit. Am Rev Respir Dis 1980;122(5 Pt 2):29-36.

6. Maroko PR, Radvany P, Braunwell E, Hale SL. Reduction of infarct size by oxygen inhalation following acute coronary occlusion. Circulation 1975;52(3):360-368.

7. Fairley HB. Oxygen therapy for surgical patients. Am Rev Respir Dis 1980;122(5 rt 2):37-44.

8. Fugere F, Owen H, Ilsley AH, Plummer JL, Hawkins DJ. Changes in oxygen saturation in the 72 hours after hip surgery: the effect of oxygen therapy. Anaesth Intensive Care 1994;22(6):724-728.

9. Clayer M, Bruckner J. Occult hypoxia after femoral neck fracture and elective hip surgery. Clin Orthop 2000 Jan;(370):265-271.

10. Mithoefer JC, Karetsky MS, Mead GD. Oxygen therapy in respiratory failure. N Engl J Med 1967;277(18):947-949.

11. Fisher AB. Oxygen therapy: side effects and toxicity. Am Rev Respir Dis 1980;122(5 Pt 2):61-69.

12. Hanson CW 3rd, Marshall BE, Frasch HF, Marshall C. Causes of hypercarbia with oxygen therapy in patients with chronic obstructive pulmonary disease. Crit Care Med 1996;24(1):23-28.

13. Chien JW, Ciufo R, Novak R, Skowronski M, Nelson J, Coreno A, McFadden ER Jr. Uncontrolled oxygen administration and respiratory failure in acute asthma. Chest 2000;117(3):728-733.

14. Frank L, Massaro D. Oxygen toxicity. Am J Med 1980;69(1):117-126.

15. Lodato RF. Oxygen toxicity. Crit Care Clin 1990;6(3):749-765.

16. Ingrassia TS 3rd, Ryu JH, Trastek VF, Rosenow EC 3rd. Oxygen-exacerbated bleomycin pulmonary toxicity. Mayo Clin Proc 1991;66(2):173-178.

17. Schramm VL Jr, Mattox DE, Stool SE. Acute management of laser-ignited intratracheal explosion. Laryngscope 1981;91(9 Pt 1):1417-1426.

18. Reinarz JA, Pierce AK, Mays BB, Sanford JP. The potential role of inhalation therapy equipment in nosocomial pulmonary infections. J Clin Invest 1965; 44:831-839.

19. Pierce AK, Sanford JP, Thomas GD, Leonard JS. Long-term evaluation of decontamination of inhalation-therapy equipment and the occurrence of necrotizing pneumonia. N Engl J Med 1970;282(10):528-531.

20. U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control. Guideline for prevention of nosocomial pneumonia and guideline ranking scheme. Atlanta: CDC; 1982.

Reprinted from RESPIRATORY CARE (Respir Care 2002; 47(6):717-720)

AARC Clinical Practice Guideline

Oxygen Therapy for Adults in the Acute Care Facility -- 2002 Revision & Update

OT-AC 1.0 PROCEDURE:
The procedure addressed is the administration of oxygen therapy in the acute care facility other than with mechanical ventilators and hyperbaric chambers.

OT-AC 2.0 DEFINITION/DESCRIPTION:
Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air with the intent of treating or preventing the symptoms and manifestations of hypoxia.(1)

OT-AC 3.0 SETTING:
This Guideline is confined to oxygen administration in the acute care facility.

OT-AC 4.0 INDICATIONS:

4.1 Documented hypoxemia. Defined as a decreased PaO_2 in the blood below normal range.(2) PaO_2 of < 60 torr or SaO_2 of < 90% in subjects breathing room air or with PaO_2 and/or SaO_2 below desirable range for specific clinical situation.(1)

4.2 An acute care situation in which hypoxemia is suspected(1,3-6) substantiation of hypoxemia is required within an appropriate period of time following initiation of therapy.

4.3 Severe trauma(5,6)

4.4 Acute myocardial infarction(1,7)

4.5 Short-term therapy or surgical intervention (eg, post-anesthesia recovery(5,8), hip surgery(9,10))

OT-AC 5.0 CONTRAINDICATIONS:
No specific contraindications to oxygen therapy exist when indications are judged to be present.

OT-AC 6.0 PRECAUTIONS AND/OR POSSIBLE COMPLICATIONS:

6.1 With PaO_2 > or = 60 torr, ventilatory depression may occur in spontaneously breathing patients with elevated $PaCO_2$.(6,11-14)

6.2 With FIO_2 > or = 0.5, absorption atelectasis, oxygen toxicity, and/or depression of ciliary and/or leukocytic function may occur.(12,15,16)

6.3 Supplemental oxygen should be administered with caution to patients suffering from paraquat poisoning(17) and to patients receiving bleomycin.(18)

6.4 During laser bronchoscopy, minimal levels of supplemental oxygen should be used to avoid intratracheal ignition.(19)

6.5 Fire hazard is increased in the presence of increased oxygen concentrations.

6.6 Bacterial contamination associated with certain nebulization and humidification systems is a possible hazard.(20-22)

OT-AC 7.0 LIMITATIONS OF PROCEDURE:
Oxygen therapy has only limited benefit for the treatment of hypoxia due to anemia, and benefit may be limited with circulatory disturbances. Oxygen therapy should not be used in lieu of but in addition to mechanical ventilation when ventilatory support is indicated.

OT-AC 8.0 ASSESSMENT OF NEED:
Need is determined by measurement of inadequate oxygen tensions and/or saturations, by invasive or noninvasive methods, and/or the presence of clinical indicators as previously described.

OT-AC 9.0 ASSESSMENT OF OUTCOME:
Outcome is determined by clinical and physiologic assessment to establish adequacy of patient response to therapy.

OT-AC 10.0 RESOURCES:
For other types of oxygen delivery devices used outside of the acute care facility, reference the AARC

Clinical Practice Guideline: Oxygen Therapy in the Home or Extended Care Facility for further description. Respir Care 1992;37(8):918-922.

10.1 Equipment

10.1.1 Low-flow systems deliver 100% (ie, $FDO_2 = 1.0$) oxygen at flows that are less than the patient's inspiratory flowrate (ie, the delivered oxygen is diluted with room air) and, thus, the oxygen concentration inhaled (FIO_2) may be low or high, depending on the specific device and the patient's inspiratory flowrate.(23,24)

10.1.1.1 Nasal cannulas can provide 24-40% oxygen with flowrates up to 6 L/min in adults (depending on ventilatory pattern).(1) Oxygen supplied via nasal cannula at flowrates < or = 4 L/min need not be humidified.(25,26) Care must be taken when assigning an estimated FIO_2 to patients as this low-flow system can have great fluctuations.(27)

10.1.1.2 Simple oxygen masks can provide 35-50% FIO_2, depending on fit, at flowrates from5-10 L/min. Flowrates should be maintained at 5 L/min or more in order to avoid rebreathing exhaled CO_2 that can be retained in the mask.(1,20,28) Caution should be taken when using a simple mask where accurate delivery of low concentrations of oxygen is required.(29) Long-term use of simple mask can lead to skin irritation and pressure sores.(30)

10.1.1.3 Partial rebreathing mask is a simple mask with a reservoir bag. Oxygen flow should always be supplied to maintain the reservior bag at least one third to one half full on inspiration. At a flow of 6-10 L/min the system can provide 40-70% oxygen. It is considered a low-flow system. The non-rebreathing mask is similar to the partial rebreathing mask except it has a series of one-way valves. One valve is placed between the bag and the mask to prevent exhaled air from returning to the bag. There should be a minimum flow of 10 L/min. The delivered FIO_2 of this system is 60-80%.

10.1.1.4 Patients who have been receiving transtracheal oxygen at home may continue to receive oxygen by this method in the acute care facility setting provided no problems present. If difficulties related to the transtracheal route of administration appear, oxygenation should be assured by other means.

10.1.2 High-flow systems deliver a prescribed gas mixture -- either high or low FDO_2 at flowrates that exceed patient demand.(23,24,31)

10.1.2.1 Currently available air-entrainment masks can accurately deliver predetermined oxygen concentration to the trachea up to 40%. Jet-mixing masks rated at 35% or higher usually do not deliver flowrates adequate to meet the inspiratory flowrates of adults in respiratory distress.(7,24,31,32)

10.1.2.2 Aerosol masks, tracheostomy collars, T-tube adapters, and face tents can be used with high-flow supplemental oxygen systems. A continuous aerosol generator or large-volume reservoir humidifier can humidify the gas flow. Some aerosol generators cannot provide adequate flows at high oxygen concentrations.(1)

10.2 Personnel

10.2.1 Level I personnel -- ie, any person who has adequately demonstrated the ability to perform the task -- may check and document that a device is being used appropriately and the flow is as prescribed.

10.2.2 Level II personnel -- licensed or credentialed respiratory care practitioners or persons with equivalent training and documented ability to perform the tasks -- may assess patients, initiate and monitor oxygen delivery systems, and recommend changes in therapy.

OT-AC 11.0 MONITORING:

11.1 Patient

11.1.1 clinical assessment including but not limited to cardiac, pulmonary, and neurologic status

11.1.2 assessment of physiologic parameters: measurement of PaO_2s or saturation in any patient treated with oxygen. An appropriate oxygen therapy utilization protocol is suggested as a method to decrease waste and to realize increased cost savings.(33) Consider need/indication to adjust FDO_2 for increased levels of activity and exercise.

11.1.2.1 in conjunction with the initiation of therapy; or

11.1.2.2 within 12 hours of initiation with $FIO_2 < 0.40$

11.1.2.3 within 8 hours, with $FIO_2 >$ or = 0.40 (including postanesthesia recovery)

11.1.2.4 within 72 hours in acute myocardial infarction7

11.1.2.5 within 2 hours for any patient with the principal diagnosis of COPD

11.2 Equipment

11.2.1 All oxygen delivery systems should be checked at least once per day.

11.2.2 More frequent checks by calibrated analyzer are necessary in systems
11.2.2.1 susceptible to variation in oxygen concentration (eg, high-flow blending systems)
11.2.2.2 applied to patients with artificial airways
11.2.2.3 delivering a heated gas mixture
11.2.2.4 applied to patients who are clinically unstable or who require an FIO_2 of 0.50 or higher.
11.2.3 Care should be taken to avoid interruption of oxygen therapy in situations including ambulation or transport for procedures.

OT-AC 12.0 FREQUENCY:

Oxygen therapy should be administered continuously unless the need has been shown to be associated only with specific situations (eg, exercise and sleep).

OT-AC 13.0 INFECTION CONTROL:

Under normal circumstances, low-flow oxygen systems (including cannulas and simple masks) do not present clinically important risk of infection and need not be routinely replaced.1 High-flow systems that employ heated humidifiers and aerosol generators, particularly when applied to patients with artificial airways, can pose important risk of infection. In the absence of definitive studies to support change-out intervals, results of institution-specific and patient-specific surveillance measures should dictate the frequency with which such equipment is replaced.

Revised by Thomas J Kallstrom RRT FAARC, Fairview Hospital, Cleveland, OH, and approved by the 2002 CPG Steering Committee.

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Mechanical Ventilation		**RES-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners of Mangum Regional Medical Center.

PURPOSE

To provide ventilatory support for the patient who is temporarily unable to maintain cardiopulmonary homeostasis.

DEFINITIONS

NA

POLICY

The purpose of this policy is to provide guidelines for patients being mechanically ventilated.

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide.
2. The Respiratory Therapist in consultation with the medical provider and the interdisciplinary care team will discuss planning for ventilator weaning of the patient.
3. Infection Control Measures:
    - The complete ventilator circuit will be changed as needed;
    - Replace the manual resuscitation device as necessary;
    - Follow strict sterile technique while suctioning;
    - Follow proper PPE and hand washing.
4. Safety:
    - Alarms on ventilator will be activated at all times.
    - Exercise caution when handling liquids near electrical devices to avoid electrical shock or damage to machine.

- Only properly licensed and competency trained personnel are allowed to set-up, monitor or make any adjustments to a mechanical ventilator.

5. The Respiratory Care Practitioner must perform a ventilator check at a minimum of every 4 hours and document in the patient's medical record.

REFERENCES

Lippincott Clinical Resource Guide

ATTACHMENTS

RES-006A Ventilator Weaning Protocol

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
CPAP & BIPAP		**RES-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners and Licensed Nursing Personnel of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel for the patient who requires non-invasive ventilation.

DEFINTIONS

NA

POLICY

The Respiratory Care Practitioner and/or Nursing Personnel will administer CPAP and BIPAP according to the physician's order.

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide.
2. The Respiratory Care Practitioners and/or Licensed Nursing personnel must perform a BIPAP and CPAP check at a minimum of every 4 hours and document in the patient's medical record.

REFERENCES

Lippincott Clinical Resource Guide.

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Ventilator Weaning Protocol (RES-006A)

The Ventilator Weaning Protocol will allow the Respiratory Care Practitioner, upon order of the physician, to progress patients, who meet the weaning criteria, through the stages of weaning.

Weaning Criteria

- Underlying cause for being on ventilator has resolved
- HR <120 and >50
- RR < 30 and > 8
- LOC adequate
- Good cough effort
- No paralytics
- Min. Sedation
- No vasopressors
- Sp02 > 90% on Fi02 < 50% and PEEP < 8
- NIF < -20
- MV < 15
- RSBI < 105

Terminate Weaning if:

- Respiratory Rate is > 30 bpm
- Sp02 < 90% on no more than 50% Fi02
- Heart rate changes by 20% of baseline
- Worsening anxiety/diaphoresis or complaints of SOB
- Paradoxical breathing

PROCEDURE

CPAP MODE

1. Place the patient in CPAP using a CPAP pressure equivalent to the current PEEP level, not to be less than 5 cm H20. Preferably in the AM.

2. Apply Pressure Support (PS) to achieve a Tidal Volume (VT) of 4-6 ml/kg of ideal body weight (IBW). PS levels will not exceed 20 cm H20 nor be maintained at < 5 cm H20.

3. If patient is stable, decrease PS by 2 every 1-2 hours until a level of 5-8 cm H20 is reached.

4. As the patient progresses to tolerate CPAP with low level PS (5-8 cm H20) for 12-15 hours a day for two consecutive days, trach collar trials may be initiated.

5. Once a weaning attempt has reached the 2200 hour or has failed, place back on the previous settings and resume the weaning attempt the following AM.

6. Special care must be taken to avoid unnecessary muscle overload. If at any point during the weaning procedure the patient exhibits indicators of intolerance, return to the last level of tolerated PS. If necessary, the patient may be returned to the settings maintained prior to the weaning attempt.

SIMV MODE

1. Switch patient to SIMV with a PS of 10.

2. If patient is stable for 1 hour, begin decreasing the SIMV rate and PS by 2 every 1-2 hours as tolerated until the patient reaches an SIMV of 4 and a PS of 6.

3. Once patient reaches SIMV of 4 and PS of 6, place patient on CPAP with a PEEP of 5.

4. If patient is stable for 2 hours, proceed with CPAP weaning protocol.

Trach Collar Trials

1. Place Vent on standby.

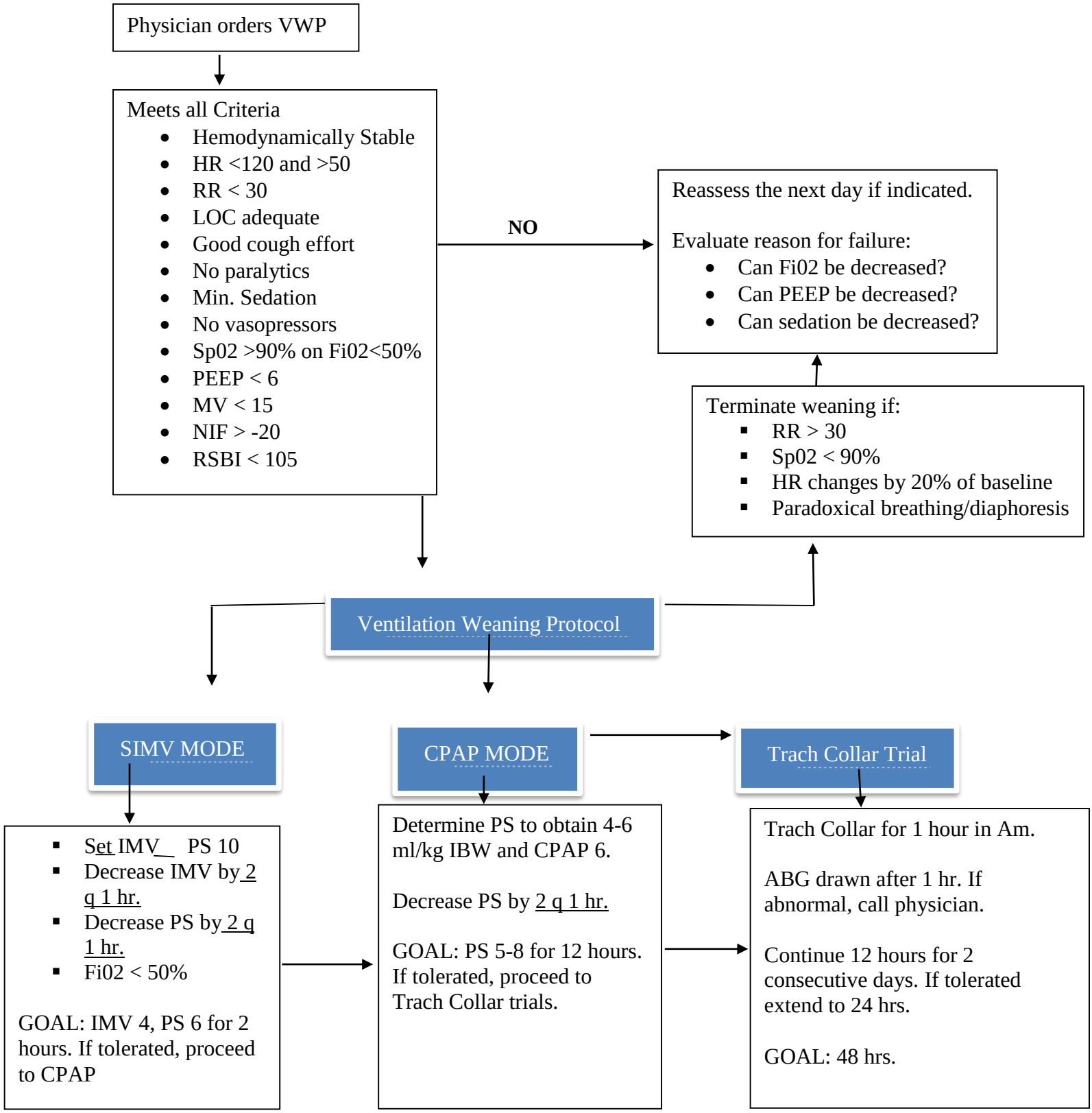
2. Place a trach collar on patient with Fi02 10% greater than on vent.

3. An ABG should be drawn after the first hour. Abnormal results will be called to the physician.

4. As trach collar trials are tolerated 12-15 hours per day for two consecutive days, the trials may be extended to 48 hours.

5. After 48 hours of non-use, the ventilator may be removed from the patient room.

Ventilator Weaning Protocol



COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Incentive Spirometry		**RES-009**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners and Licensed Nursing Personnel of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel for the patient who requires volume expansion using an incentive spirometer.

DEFINTIONS

NA

POLICY

The Respiratory Care Practitioner and/or Nursing Personnel will provide patient education and instruction on incentive therapy.

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide.

REFERENCES

Lippincott Clinical Resource Guide

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Positive Expiratory Pressure (PEP)		**RES-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners and Licensed Nursing Personnel of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel for the patient who requires bronchial hygiene.

DEFINTIONS

Positive Expiratory Pressure-A bronchial hygiene adjunct used to mobilize secretions and treat atelectasis.

POLICY

The Respiratory Care Practitioner and/or Nursing Personnel will provide patient education and instruction on PEP therapy.

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide.

REFERENCES

Lippincott Clinical Resource Guide.

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Trach Decannulation		**RES-010**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for planned trach decannulations.

DEFINTION

NA

POLICY

To provide a safe process for planned decannulations.

PROCEDURE

1. Refer to Lippincott Clinical Resource Guide.
2. Requirements: A patient is considered a candidate for decannulation once the following conditions are met:
   a) Patient is alert and oriented and responsive to commands.
   b) Patient is no longer dependent on a ventilator for assisted breathing.
   c) The frequency requirement for tracheal suctioning is less than once a day or patient has adequate cough and ability to clear secretions effectively and independently.
   d) A physician order is obtained.
   e) Patient has met the criteria for decannulation outlined below.
   f) The patient should have their tracheostomy tube downsized to a size 6 or less or similar tracheostomy tube and they should not have breathing difficulty in the presence of this tube.
   g) The size should be a size 6 or less or similar tube should be occluded (with a trach plug/cork) for twelve hours during the day with close monitoring of the nursing and

respiratory staff with no evidence of respiratory difficulty or requiring of suctioning of the trach tube.

h) Once the patient is able to tolerate the previous steps listed above, the trach is plugged for twenty-four hours and they are monitored for respiratory difficulty or suction requirement.
i) Once the patient is decannulated the Respiratory Care Practitioner must remain at the bedside for a minimum of 15 minutes to monitor the patient for tolerance to the decannulation.

In the event of Respiratory Distress:

Patients fail decannulation for several reasons; therefore, the patient requires close observation post decannulation. Reasons for failure include increased work of breathing, inability to clear secretions and damage to the trachea including stenosis, tracheomalacia and granuloma that may have previously been undiagnosed. Clinical indications of these latter complications include stridor, change in voice quality and/or an increase in work of breathing. Notify the Medical Provider and appropriate personnel if any acute respiratory distress is observed.

REFERENCES

Lippincott Clinical Resource Guide

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Speaking Valve		**RES-011**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners, Licensed Nursing Personnel, and Speech Therapy of Mangum Regional Medical Center.

PURPOSE

To provide guidelines on the safe and effective use of a speaking valve.

DEFINITIONS

NA

POLICY

It is the policy of this facility to assess the ability of the tracheostomy patient to vocalize and communicate with a speaking valve if indicated and ordered by a physician.

INDICATIONS

-Ventilator Dependency
-Quadriplegia
-COPD
-Mild Tracheal and/or Laryngeal Stenosis
-Neuromuscular Disease
-Head Trauma
-Tracheomalacia
-Bilateral Vocal Cord Paralysis

CONTRAINDICATIONS

-Unconscious and/or Comatose Patients
-Foam Filled Tracheostomy Cuff
-Thick and Copious Secretions
-Inflated Tracheostomy Tube Cuff
-Severe Airway Obstruction
-Severe Aspiration

PROCEDURE

1. Refer to the Lippincott Clinical Resource Guide.

2. Follow the manufacturer's recommendations for cleaning and storing the speaking valve.

REFERENCES

Lippincott Clinical Resource Guide

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Concurrent Therapy		**RES-013**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners and Licensed Nursing Personnel of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel to ensure the safe administration of medications is provided to patients.

DEFINITIONS

Concurrent Therapy- is defined as the practice of treating more than one patient at a time, also known as "stacking treatments"

POLICY

It is the policy of this hospital to provide quality patient care, to ensure the safe administration of medications according to evidence-based practice and standards of care. An exception will be allowed only as defined by: under extreme circumstances, such as, when there is a surge in respiratory patients, in which without concurrent therapy patients' treatments may be missed or delayed. Only patients who are stable and their condition is such that the treatment may be administered without supervision when the following are met:

- Treatments are administered to patients on the same floor or unit.
- The patient is instructed and understands the purpose of therapy and is able follow directions.
- The patient understands that the mouthpiece or mask can be removed and pushed aside anytime the patient feels it is necessary.
- The patient's vital signs are stable.
- The medication is delivered to the patients on mechanical ventilation.

REFERENCES

American Association of Respiratory Care

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Laryngeal Mask Airway (LMA)		**RES-012**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**03/2020**	
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy is intended to provide guidelines for Respiratory Care Practitioners and Licensed Nursing Personnel in advanced airway management to the patients of Mangum Regional Medical Center.

PURPOSE

To provide guidelines for Respiratory Care Practitioners and/or Licensed Nursing Personnel who are responsible for providing advanced airway management in a safe manner.

DEFINTIONS

NA

POLICY

To provide an airway to patients when endotracheal is not possible and/or in known or suspected difficult airway situations.

PROCEDURE

1. Refer to the Lippincott Clinical Resource Guide.

REFERENCES

Lippincott Clinical Resource Guide

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Arterial Blood Gases		**RES-014**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory	**07/2020**	
DEPARTMENT	REFERENCE	
Respiratory	See below	

SCOPE

This policy applies to all Respiratory Care Practitioners (RCPs), lab, and/or trained Licensed Nursing Personnel for the performing of Arterial Blood Gases (ABGs).

POLICY

Respiratory Care Practitioners (RCP), lab, and/or trained Nursing Personnel shall provide sampling for arterial blood gas analysis, as ordered by a patient's medical provider.

Blood shall be drawn anaerobically from the radial, or brachial artery via needle puncture.

Arterial blood samples shall be obtained by trained healthcare staff. Healthcare staff who perform arterial blood sampling shall be evaluated for ABG skills and competency upon hire and annually.

Only attempt an arterial puncture twice, use a new and sterile needle for each puncture. Perform post-puncture care.

Indications:

- To evaluate the adequacy of ventilatory ($PaCO_2$), acid-base (pH and $PaCO_2$), oxygenation (PaO_2 and SaO_2) status, and the oxygen-carrying capacity of blood (PaO_2, HbO_2, Hbtotal and dyshemoglobins);
- To determine the patient's response to therapeutic intervention and/or diagnostic evaluation (i.e., oxygen therapy, exercise testing);
- To monitor severity and progression of a documented disease process;
- Preoperative assessment of high-risk patients receiving general anesthesia;
- Smoke inhalation or suspicion of carbon monoxide poisoning

Contraindications:

- Negative results of a modified Allen test;
- DO NOT perform an arterial puncture through a lesion or through or distal to a shunt (i.e., dialysis patient);
- Evidence of an infection or peripheral vascular disease in the selected extremity; choose an

alternate site;
- The patient is on a medium to high dose of anticoagulation therapy

PROCEDURE

1. Verify the physician's order;
2. Review the patient's medical record (i.e., Is patient receiving anticoagulants? Does patient have a history of bleeding disorders?);
3. Obtain supplies & equipment:
    - Blood Gas Kit
    - Patient Label
    - 70% isopropyl or other suitable antiseptic solution
    - 4 x 4s
    - Gloves
    - Syringe cap
4. Introduce yourself and explain procedure to the patient;
5. Reassure the patient as necessary;
6. Verify the patient's identity using two (2) patient identifiers;
7. Perform hand hygiene prior to procedure, put on gloves;
8. Palpate radial pulse;
9. Perform Allen's test to check for collateral circulation
10. **Technique:**
    - The radial and ulnar arteries are then palpated followed by the Allen's test:
        - The hand is clenched into a tight fist and pressure applied to the radial and ulnar arteries. The hand is opened (but not fully extended); the palm and the fingers are blanched.
        - Removal of the pressure on the ulnar artery should result in flushing (positive test).
        - If the ulnar artery does not adequately supply the entire hand (negative test), the radial artery should not be punctured.
    - If the collateral circulation is adequate, continue with the procedure.
    - If the collateral circulation is not adequate, test patient's other hand. If collateral circulation to both hands is inadequate, notify the physician.
    - The physician or medical provider may request that an alternate site be used for the puncture.
    - The physician or medical provider may decide to attempt the radial arterial puncture himself/herself.
    - Prep puncture site with an alcohol swab.
    - Using aseptic technique, insert the needle into the artery at a 30-degree angle, needle bevel pointing up.
    - Blood will pulsate into the syringe. Collect the amount needed for ABGs (usually 1-2 mL). If the artery is missed, withdraw the needle until the tip is just beneath the skin; adjust the needle angle and proceed again.
    - Remove needle after obtaining blood sample and apply pressure to the puncture site with a sterile piece of gauze for a minimum

of five (5) minutes.
- Assess puncture site before applying a pressure dressing. Do not constrict blood flow to the wrist.
- Remove and dispose of the needle per policy and procedure. Apply syringe cap.
- Roll the syringe between hands to mix the blood and heparin in the syringe.
- Ensure there are no air bubbles in the syringe.
- Label syringe with patient information that includes two (2) patient identifiers. Label the syringe in the presence of the patient.
- Immediately send the blood sample to the laboratory, along with a completed lab requisition.
- Assess puncture site for hematoma.
- Assess the distal pulse and capillary refill of the nailbeds of the affected extremity to ensure that the patient's circulation has not been interrupted.
- Remove gloves and wash hands.

11. Excess bleeding:
    a) **The Medical Provider should be alerted to excess bleeding.**
    b) If bleeding persists longer than five minutes, the attending physician should be notified of the problem. Pressure must be continued on the site as long as necessary to stop the bleeding.
    c) If the patient is under anticoagulant therapy or has prolonged clotting time, hold pressure on the site for a longer period. Two minutes after relieving pressure, inspect the site over the artery to ascertain that no hematoma is developing and that the distal circulation is intact.
12. Limitations:
    - RCP and Nursing will not perform femoral arterial punctures.
    - RCP and Nursing will be limited to two skin punctures before requesting assistance from a second phlebotomist.
    - Nursing will not draw arterial blood on children under the age of six.
13. Documentation should include:
    - Date and time;
    - Vital Signs, including temperature;
    - Oxygen therapy;
    - Patient's activity level;
    - Results of Allen test;
    - Site of puncture;
    - Pressure applied;
    - Site or puncture site post procedure;
    - Patient's tolerance of the procedure;
    - Blood specimen sent to laboratory
14. Possible Complications:
    - Air or clotted-blood emboli
    - Anaphylaxis from local anesthesia
    - Arterial occlusion

- Arteriospasm
- Hematoma
- Hemorrhage
- Infection
- Pain
- Trauma to the vessel
- Vasovagal response

15. Notes:
    - Specimens from mechanically ventilated patients with minimal pulmonary pathology adequately reflect the effects of a change in oxygen concentration 10 minutes after the change has been made.
    - In spontaneously breathing patients, at least 20-30 minutes should elapse following oxygen concentration change before an arterial puncture is performed. Patients with obstructive defects and increased residual volumes may require 30 minutes or longer for the change in oxygen concentration to take effect.
16. When orders are written for the physician to be notified of ABG results, it will be the responsibility of the RCP or Nursing personnel drawing the ABG to notify the physician of the patients ABG values.

REFERENCES

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ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Chest Physical Therapy and Postural Drainage		**RES-015**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Respiratory		
DEPARTMENT	REFERENCE	
Respiratory		

SCOPE

This policy applies to all Respiratory Care Practitioners who provide Chest Physical Therapy and Postural Drainage to patients of Mangum Regional Medical Center.

POLICY

Respiratory Services shall provide postural drainage procedures as ordered by the patient's medical provider.

PURPOSE

To provide guidelines for Respiratory Care Practitioners for the patient who requires an airway clearance technique to help clear the lungs of mucus build up.

PROCEDURE

1. Verify order by checking the patient's medical record.
2. Review the patient's medical record for information relevant to respiratory therapy, such as x-ray results, blood gas values, position restrictions, etc.
3. Gather equipment and supplies:
    - Pillows;
    - Towel;
    - Tissues/Basin
    - Personal Protective Equipment, as applicable
    - Stethoscope
    - Suctioning Equipment
    - Oxygen Equipment, as needed
4. Introduce yourself to the patient.
5. Perform hand hygiene.
6. Identify the patient using two (2) patient identifiers.
7. Explain the procedure to the patient.

COMPONENTS OF POSTURAL DRAINAGE THERAPY

A. Postural Drainage:
   - Utilize gravity to aid in the removal of secretions from one or more lung segments to the central airway where the secretions can be removed by coughing or mechanical aspiration

B. Chest Percussion:
   - Clapping/cupping against the chest wall and lung to better mobilize secretions

C. Chest Vibration:
   - Vibrating the chest in an attempt to mobilize secretions

D. Turning:
   - Turning the patient promotes lung expansion and improves arterial oxygenation

CONTRAINDICATIONS:

The decision to use the postural drainage procedure requires an assessment of the potential benefits versus the potential risks to the patient. Therapy shall be provided for no longer than needed to obtain the desired therapeutic results.

A. All positions are contraindicated for the following:
   - Intracranial pressure (ICP) greater than 20 mm/Hg;
   - Head and neck injury until stabilized;
   - Active hemorrhage with hemodynamic instability;
   - Recent spinal surgery or acute spinal injury;
   - Acute spinal injury;
   - Active hemoptysis;
   - Empyema;
   - Bronchopleural fistula;
   - Pulmonary edema associated with congestive heart failure;
   - Large pleural effusions;
   - Pulmonary embolism;
   - Aged, confused or anxious patients who will not tolerate position changes;
   - Rib fracture, with or without flail chest

B. Trendelenburg position is contraindicated for the following:
   - Intracranial pressure (ICP) greater than 20 mm Hg;
   - Patients in whom increased intracranial pressure is to be avoided (i.e., neurosurgery, aneurysms, eye surgery);
   - Uncontrolled hypertension;
   - Distended abdomen;
   - Esophageal surgery;
   - Recent gross hemoptysis related to recent lung carcinoma treated surgically or with radiation therapy;
   - Uncontrolled airway at risk for aspiration (tube feeding or recent meal)

C. Reverse Trendelenburg is contraindicated in the presence of hypotension or vasoactive medication.

D. External manipulation of the thorax.

E. In addition to contraindications previously listed, the following should be considered:
- Subcutaneous emphysema;
- Recent epidural spinal infusion or spinal anesthesia;
- Recent skin grafts, or flaps on the thorax;
- Burns, open wounds and skin infections of the thorax;
- Recently placed transvenous pacemaker or subcutaneous pacemaker (particularly if mechanical devices are to be used);
- Suspected pulmonary tuberculosis;
- Lung contusion;
- Bronchospasm;
- Osteomyelitis of the ribs;
- Osteoporosis;
- Coagulopathy;
- Complaint of chest wall pain

POSTURAL DRAINAGE:

1. Have the patient sit upright (erect) to drain the apical segments of both upper lobes.
2. Have the patient sit at a 45-degree angle to drain the anterior segment of the left upper lobe.
3. Ask the patient to sit forward, leaning on a pillow at a 45-degree angle to drain the posterior segment of the left upper lobe.
4. Position the patient ¾ prone, resting on the left side to drain the posterior segment of the right upper lobe.
5. Position the patient in a 3/4 supine position with his/her head down 15 degrees. Lying on the right side will drain the left lingula, and lying on the left side will drain the right middle lobe.
6. The superior segments of both lower lobes are drained by putting the patient prone with a pillow under the abdomen to flatten his/her back.
7. The anterior segments of the lower lobes are drained by putting the patient supine with his/her head down 30 degrees and a pillow under the knees.
8. The lateral segments of each lower lobe are drained by having the patient lay on his/her side with head down 30 degrees. Lying on the right side will drain the left lobe and vice versa.
9. The medial segment of the right lower lobe is drained when the patient lies on his/her right side 3/4 supine, hips twisted back and head down 30 degrees.
10. The posterior segments of both lower lobes are drained when the patient is prone, a pillow under his/her hips and head down 30 degrees.

CHEST PERCUSSION:

1. Cup hands to trap air.
2. Move wrists, not arms.
3. Clap chest wall over draining segment.
4. Clap for one to two (1-2) minutes over each area. (Five [5] minutes over each segment for cystic fibrosis.)

CHEST VIBRATION:

1. Cover area to be vibrated with a towel.
2. Place hands on both (anterior and posterior) sides of the patient's chest.
3. Produce a rapid vibratory motion by contracting the muscles of the upper arms and shoulders.
4. While vibrating, compress the chest wall, moving hands down and away from the trachea.
5. This is done during an exhalation following a deep inspiration for three or four (3 or 4) breaths.

IMPORTANT POINTS:

1. Positions are modified to accommodate the patient's clinical conditions and tolerance.
2. This procedure should be done no sooner than two (2) hours following any meal.
3. Positions should be held for two to three (2-3) minutes for postural drainage. If chest percussion is done, hold positions for three to five (3-5) minutes.
4. With patient in each position, follow these steps:
    - Auscultate segment;
    - Percuss draining area;
    - Vibrate;
    - Have patient cough;
    - Auscultate segment

COUGH:

1. Place the patient in a semi-Fowler's position (45-degree angle) with the knees flexed.
2. Instruct the patient to slowly inhale through the nose and exhale through pursed lips several times.
3. Instruct the patient to cough twice during each exhalation.
4. Patient should be instructed **NOT TO TAKE A LARGE, DEEP BREATH PRIOR TO COUGHING**. (This type of coughing may lead to a coughing spasm and is ineffective).
5. If there is pain as a result of surgery of abdomen or a chronic lung condition, patient should be encouraged to cough using some type of support.
    - Pillows may be held over the area of pain to brace the patient while coughing.
6. If a patient is unable to cough, use suction equipment as necessary.

PATIENT MONITORING DURING POSTURAL DRAINAGE:

1. The following shall be monitored and documented in the patient's medical record before, during and after postural drainage therapy:
    - Vital signs;
    - EKG, if available;
    - Breath sounds;
    - Skin color;
    - Breathing pattern; symmetrical chest expansion; flail chest
2. Sputum production:
    - Quantity;
    - Color;
    - Consistency;
    - Odor;
    - Effectiveness of cough;
    - Patient's response to procedure

INFECTION PREVENTION AND CONTROL:

1. Perform hand hygiene before and after contact with the patient.
2. Dispose of used tissues in waste receptacle.
3. If suctioning is required, follow sterile technique.

SAFETY PRECAUTIONS:

1. Percussion is never done over bare skin, bony prominences or female breast tissue.
2. Exercise extreme caution when doing this procedure on very old or fragile patients.
3. Modify the positions as needed to accommodate the patient's clinical condition and/or tolerance.
4. Be alert for possible complications of this procedure, such as reflux of gastric juices, bruised skin, etc.
5. Only properly licensed staff are allowed to administer this procedure.

REFERENCES

Nettina, Sandra M. (2014). *Lippincott Manual of Nursing Practice, Tenth Edition*. Philadelphia, Pennsylvania: Lippincott Williams and Wilkins.

Cystic Fibrosis Foundation. (n.d.). Basics of Postural Drainage and Percussion. Retrieved from https://www.cff.org/Life-With-CF/Treatments-and-Therapies/Airway-Clearance/Basics-of-Postural-Drainage-and-Percussion/

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Respiratory Services

Table of Contents

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Abdominal Pain		**DRP-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This protocol applies to adult patients at Mangum Regional Medical Center for the acute management of abdominal pain.

PURPOSE

Abdominal pain comprises 5 to 10 percent of emergency department (ED) visits. The purpose of this protocol is to assist with streamlining the diagnostic work-up of abdominal pain at Mangum Regional Medical Center.

PROCEDURE

Nursing Orders:

- ☐ Vital signs x1
- ☐ Pulse oximetry
- ☐ Oxygen administration to keep saturation greater than or equal to 95%
- ☐ Cardiac Monitor
- ☐ Peripheral IV (Saline lock) x1
- ☐ NPO

Labs:

- ☐ ABG
- ☐ Amylase
- ☐ Beta HCG Qualitative
- ☐ CBC with differential
- ☐ CMP
- ☐ CRP
- ☐ D-Dimer
- ☐ Lactic acid
- ☐ Lipase
- ☐ Magnesium

- ☐ Phosphorus
- ☐ Procalcitonin
- ☐ PTT
- ☐ Troponin-I
- ☐ Urinalysis
- ☐ Urine culture and sensitivity (send out)
- ☐ Urine Pregnancy Test

Radiology and Other Procedures:

- ☐ CT ABD/Pelvis with Contrast
- ☐ CT ABD/Pelvis without Contrast
- ☐ ECG 12 Lead Panel
- ☐ XR Chest AP (1 view)
- ☐ XR Abdomen Series with PA Chest

IV fluids:

- ☐ Sodium Chloride 0.9% 1000mL, 999mL/Hr Bolus
- ☐ Sodium Chloride 0.9% 1000mL, _____ mL/Hr
- ☐ Lactated Ringers 1000mL, 999mL/hr Bolus
- ☐ Lactated Ringers 1000mL, _____ mL/Hr
- ☐ Sodium Chloride 0.9% 10mL Flush PRN for line patency

Anti-emetics:

- ☐ Zofran 4mg IV push x1
- ☐ Zofran 4mg ODT x1
- ☐ Phenergan 25mg IM x1
- ☐ Phenergan 50mg IM x1
- ☐ Reglan 10mg IV push x1
- ☐ Protonix 40mg IV push x1
- ☐ GI Cocktail PO x1

Pain meds:

- ☐ Acetaminophen 500mg PO x1
- ☐ Acetaminophen 625mg PO x1
- ☐ Hydromorphone 1mg IV push x1
- ☐ Hydromorphone 2mg IV push x1
- ☐ Morphine 2mg IV push x1
- ☐ Morphine 4mg IV push x1
- ☐ Ketorolac 15mg IV push x1
- ☐ Ketorolac 30mg IV push x1
- ☐ Ketorolac 60mg IM x1

Antimicrobials:

- Cipro® 400mg IV x1
- Flagyl® 500mg IV x1
- Merrem® 1g IV x1
- Rocephin 1 gram IV x1
- Zosyn 3.75g IV x1

REFERENCES

https://www.uptodate.com/contents/evaluation-of-the-adult-with-abdominal-pain-in-the-emergency-department

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Anaphylaxis/Adverse Drug Reaction Policy		**DRM-053**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

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 nurses 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 (see Attachment A for details)
16. Any ADR that involves a newly FDA approved medication or involves an unusual or serious reaction not previously listed in a medication package insert, is to be submitted to the FDA through the MEDWATCH reporting program.

REFERENCES

https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program

ATTACHMENTS

Anaphylaxis/Adverse Drug Reaction Reporting Form

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Anaphylaxis/Adverse Drug Reaction Reporting Form

Medical Records Number: _____ Patient Name: _____ Provider _____
Sex: Male _____ Female _____ Date/Time of: _____
Observer's Name: _____ Date of Report: _____ Time of Report: _____

Event Detail: _____

Suspected Medication: _____ Dose: _____

Route: _____ Frequency: _____ Rate of administration (if IV): _____
Date Med Ordered: _____

Information on this reaction can be found on (date) _____/_____/_____ in: _____ Nurses Notes

Reaction:
_____

Reaction on-set Time: _____ Was the Reaction Treated: _____Yes _____No
Date of Adverse Reaction: _____
Describe Treatment:
_____

GENERAL CLASSIFICATION OF REACTION

_____ Anaphylactic
_____ bleeding
_____ Brady Cardia
_____ Cardiac Arrest
_____ Cardiovascular
_____ Coma
_____ Dermatologic
_____ Elevated Temp
_____ Elevated INR
_____ GI
_____ Hematologic
_____ Hepatic
_____ Hypotensive
_____ Infection
_____ Itching
_____ Metabolic (electrolytes)
_____ Musculoskeletal
_____ Neurologic
_____ Psychological
_____ Pulmonary
_____ Renal
_____ Tachycardia
_____ Urticaria
_____ Vascular
_____ Vaccine

Other: _____

OUTCOME:

MILD:
_____ required no intervention, no apparent harm to patient.

MODERATE:
_____ required treatment or intervention due to temporary harm.
_____ Increased monitoring.
_____ Prolonged hospitalization required.

SEVERITY:

_____ Death _____ Permanent Disability _____ Increased length of stay

Anaphylaxis/ADR outcome: _____ Reason for Admission _____ Preventable _____ Dose Related
_____ to be reported to FDA

Person Completing this Form: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Anaphylaxis		**DRP-002**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This protocol applies to all patients that require treatment for anaphylaxis at Mangum Regional Medical Center.

PROCEDURE

Nursing Orders:

- ☐ Lay patient flat
- ☐ Check vital signs x1
- ☐ Place patient on Pulse Oximetry
- ☐ Oxygen administration to keep saturation greater than or equal to 95%
- ☐ Cardiac Monitor
- ☐ Saline Lock x1

Radiology and Other Procedures:

- ☐ ECG 12 Lead Panel

Medication Orders:

- ☐ Certirizine 10mg PO x1
- ☐ Diphenhydramine 25mg IV x1
- ☐ Diphenhydramine 50mg PO x1
- ☐ Diphenhydramine liquid ____ (up to 1mg/kg) PO x1
- ☐ Epinephrine 0.3mg IM x1
- ☐ Epinephrine 0.15mg IM x1
- ☐ Famotidine 20mg IVPB x1
- ☐ Famotidine _____ (0.5mg/kg) IVPB x1
- ☐ Hydrocortisone 50mg IV Once
- ☐ Methylprednisolone 40mg IV Once
- ☐ Normal Saline _____ (20mL/kg) IV Bolus x1

REFERENCES

https://www.allergy.org.au/hp/papers/acute-management-of-anaphylaxis-guidelines

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Annual Inventory		**DRM-049**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define a process for the annual inventory of all medications stored in the medical facility.

DEFINITIONS

N/A

POLICY

An Accurate and consistent assessment of inventory counting, valuation, and reporting should be conducted on at least an annual basis for all medication storage areas.

PROCEDURE

1. Count:
    a. Count shall be performed on all items at either the open or close of the business day.

2. Inventory monetary valuation
    a. Valuation must be based on CURRENT PRICING for the hospital facility at net cost.

3. Medications allocated for patient use
    a. Any medication(s) in patient specific drawers in the med cart are not to be included in the annual inventory.

4. Verification

a. After the count has been completed, another qualified employee of the medical facility must validate the inventory count by selecting a few items to count throughout the hospital Drug Room.
b. If any variance occurs during verification, they should be investigated, and appropriate adjustments made to the final inventory count as needed.

5. Final report
    a. A copy of the completed annual inventory report shall be given to the controller and a copy is filed in the hospital Drug Room.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Anticoagulation Policy		**DRM-051**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**The Joint Commission**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to ensure the safe administration of anticoagulants (e.g. Heparin, Enoxaparin, and Warfarin). These medications are considered High-Alert/High-Risk medications.

DEFINITIONS

Anticoagulation therapy: medications intended for preventing, treating, and reducing the recurrence of venous thromboembolism and/or preventing stroke in patients with atrial fibrillation.

POLICY

The hospital will establish protocols for the safe administration of anticoagulants including IV Heparin. Anticoagulation protocols and monitoring parameters for anticoagulation will be utilized by the medical staff and the Pharmacist in Charge.

PROCEDURE

1. A licensed nurse on-duty will review all pertinent laboratory results available prior to the administration of any new anticoagulant therapy. Refer to Table 1 for anticoagulation therapy and administration guidelines.
2. Medical Staff approved Heparin Drip Protocols are strongly encouraged to be utilized. See Table 2 and 3 for reference.
    a. A second licensed personnel is required to verify all intravenous anticoagulant therapy doses and drug calculations prior to administration.
    b. Documentation of such should be recorded in the patient's medical record.

   c. The use of a programmable infusion pump is recommended for intravenous administration of heparin.
3. A sufficient supply of any potential anticoagulant reversal agent should be readily available:
   a. IV or PO Vitamin K for the reversal of Warfarin
   b. IV Protamine for the reversal of Heparin
4. Patient education and adverse reaction monitoring for anticoagulation therapy should include:
   a. Abnormal bleeding
   b. Bruising
   c. Local irritation and discomfort at the site of administration
   d. Heparin induced thrombocytopenia (HIT)

REFERENCES

https://www.jointcommission.org/media/tjc/newsletters/r3_19_anticoagulant_therapy_final2pdf.pdf?db=web&hash=710D79BDAEFFCA6C833BB823E1EEF0C6

ATTACHMENTS

Table 1: Guidelines for Anticoagulation Therapy and Administration
Table 2: Heparin Protocol Low Dose: ACS, Stroke
Table 3: Heparin Protocol Standard Dose: DVT, PE

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Table 1: Guidelines for Anticoagulation Therapy and Administration

Anticoagulant	Monitoring Parameters:
Warfarin	• Draw INR and review INR prior to administration of the first dose. • Draw INR level's at least twice weekly for all active in-patients on Warfarin • Hold or discontinue use if INR is greater than 3.5
Direct Oral Anticoagulants (e.g., Pradaxa®, Xarelto®, Eliquis®)	• Draw CBC prior to administration of the first dose • Draw CBC at least weekly for all active in-patients on a direct oral anticoagulant • Draw BMP at least weekly for all active in-patients on a direct oral anticoagulant • Monitor Hgb and Platelet count trends closely (hold or discontinue use if Hgb is less than 8.5 or if Platelet count is less than 50,000)
All Heparin products intended for the treatment of Direct Vein Thrombosis (DVT)	• Draw CBC prior to administration of the first dose • Draw CBC at least three times a week for all active in-patients on any heparin product • Draw BMP at least three times a week for all active in-patients on any heparin product • Monitor Hgb and Platelet count trends closely (hold or discontinue use if Hgb is less than 8.5 or if Platelet count is less than 50,000) • Record daily weights for all active patients on any Heparin product for the treatment of a DVT

Table 2: Heparin Protocol Low Dose: ACS, Stroke

INITIATION:

1. Weigh patient STAT if baseline measured weight not in medical record. Dosed using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2

MEDICATIONS:

1. Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
   60 units/kg x Dosing Weight (**Maximum of 5,000 units)**

2. Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.

   12 units/kg-hour x DW **(Maximum of 1,000 units/hr initially) _____** units/hour

LABS:

1. If not drawn already: STAT
   - CBC
   - PT/INR
   - PTT

2. Routine labs while on Heparin Drip:
   - PTT every 6 hours after initiation and after every dose change
   - Daily weight while on Heparin Drip
   - CBC every other day while on Heparin Drip
   - GUAIAC stool as needed

OTHER:

1. Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

2. If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

3. Do not interrupt heparin infusion unless ordered.

4. Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

Table 3: Heparin Protocol Standard Dose: DVT, PE

INITIATION:

1. Weigh patient STAT if baseline measured weight not in medical record. Dosed using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2

MEDICATIONS:

1. Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
   80 units/kg x Dosing Weight (**Maximum of 10,000 units)**

2. Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.

   18 units/kg-hour x DW **(Maximum of 2,000 units/hr initially) _____** units/hour

LABS:

3. If not drawn already: STAT
   - CBC
   - PT/INR
   - PTT

4. Routine labs while on Heparin Drip:
   - PTT every 6 hours after initiation and after every dose change
   - Daily weight while on Heparin Drip
   - CBC every other day while on Heparin Drip
   - GUAIAC stool as needed

OTHER:

1. Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

2. If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

3. Do not interrupt heparin infusion unless ordered.

4. Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Antimicrobial Stewardship		**DRM-048**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish a checklist and protocol(s) for optimizing antimicrobial therapy throughout the medical facility.

DEFINITIONS

Antimicrobial stewardship: a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

POLICY

The Antimicrobial Stewardship Program at Mangum Regional Medical Center is dedicated to providing optimal antimicrobial therapy (e.g., right drug, right dose, and appropriate duration of therapy) to our patients in order to maximize therapeutic benefit and reduce antimicrobial resistance.

The Antimicrobial Stewardship Program will be led by the following individuals:

1. Physician Leader: Hospital Medical Director
2. Drug Expert: Pharmacist in Charge
3. Hospital Administrator
4. Infection Prevention Nurse/Director of Quality Management
5. Nursing Leader: Chief Nursing Officer
6. Laboratory Manager

PROCEDURE

1. The hospital will review and evaluate the following tools on an annual basis:
    1. Implement antimicrobial practices as recommended by the Centers for Disease Control and Prevention, Infectious Diseases Society of America, and Oklahoma Department of Health (see Attachment A)
    2. Review and approve a hospital antimicrobial formulary (See Attachment B)
    3. Review and complete the Centers for Disease and Prevention Checklist for Core Elements of Hospital Antibiotic Stewardship Programs
    4. Submit antimicrobial surveillance related data to appropriate state and national agencies

2. Opportunities for improvement:
    a. Develop and utilize hospital order sets for specific disease states (e.g., community acquired pneumonia and hospital-acquired pneumonia)
    b. Develop a hospital specific antibiogram to assess for local antimicrobial resistant patterns
    c. Assess for appropriateness of physician prescribing of antimicrobials in the emergency room

REFERENCES

https://www.cdc.gov/antibiotic-use/core-elements/hospital.html

ATTACHMENTS

Attachment A: Practices implemented through Pharmacy and Therapeutics (P&T) committee
Attachment B: Antimicrobials (oral) on Hospital Formulary

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Attachment A: Practices implemented through Pharmacy and Therapeutics (P&T) committee

- Review appropriateness of antimicrobial therapy prescribing, dosing, route of administration, and duration of therapy upon admission to the hospital
- Order labs for antimicrobials that are dosed based on lab values within 72 business hours
- Review appropriateness of antimicrobial dosing regimens based on kidney and liver function
- Review appropriateness of antimicrobial dosing regimens based on CBC w/ differentials
- Utilization of a sepsis protocol
- De-escalation of antimicrobial therapy based on culture/lab results
- Document targeted stop dates for antimicrobial therapy and discontinue antimicrobials in a timely manner
- Utilize antimicrobials on the Pharmacy and Therapeutics approved formulary
- Document duration of antimicrobial therapy and provide discharge prescription(s) for antimicrobial therapy continued post-discharge
- Develop a facility specific antibiogram and assess community-wide antimicrobial resistant patterns on an on-going basis
- Minimize interruptions in continuous IV antimicrobial therapy
- Discontinue the use of antacids (e.g., proton pump inhibitors) when patients do not meet criteria for use
- Document antimicrobial related adverse drugs events (including IV administered related adverse drug events) in a timely manner
- Utilize quality improvement template(s) for retrospective review of antimicrobials that require therapeutic drug level monitoring

Attachment B: Antimicrobials on the Hospital Formulary

Antimicrobials intended for oral/gastric administration

Acyclovir 400mg capsules

Amoxicillin 500mg capsules, 200mg/5mL oral suspension

Amoxicillin/Clavulanic acid 500mg/125mg tablets

Azithromycin 250mg tablets, 200mg/5mL oral suspension

Cefadroxil 500mg capsules

Cefdinir 300mg capsules

Ciprofloxacin 500mg tablets

Clindamycin 150mg capsules

Doxycycline 500mg capsules

Fluconazole 150mg tablets

Fosfomycin 3g oral solution

Levofloxacin 500mg tablets

Metronidazole 250mg tablets

Nitrofurantoin 100mg capsules

Oseltamivir 75mg capsules, 6mg/mL oral suspension

Sulfamethoxazole/Trimethoprim 800mg/160mg tablets, 200mg/40mg/5mL oral suspension

Antimicrobial injectables

Ampicillin 1g

Ampicillin/Sulbactam 1.5g, 3g

Azithromycin 500mg

Cefazolin 1g

Cefepime 2g

Cefoxitin 1g

Ceftriaxone 1g

Ciprofloxacin 400mg/200mL premix

Clindamycin 600mg/4mL

Doxycycline 100mg

Gentamicin 80mg/2mL

Levofloxacin 500mg, 750mg

Lincomycin 600mg/2mL

Meropenem 500mg, 1g

Metronidazole 500mg/100mL premix

Piperacillin/Tazobactam 2.25g, 3.375g

Vancomycin 500mg, 1g

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Automated Dispensing Machine Access		**DRM-014**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

PURPOSE

To ensure the safe and accurate dispensing of medications, accountability of controlled substances and other medications, accurate patient billing, patient confidentiality, medication security and to ensure compliance with state and federal rules and regulations.

POLICY

Nurses, physicians, respiratory therapists, pharmacists and Drug Room Supervisor, Materials Manager shall have access to designated automated dispensing machine(s).

The above staff shall be assigned a permanent identification code and temporary password to access the automated dispensing machine(s).

PROCEDURE

The Nurse Manager/Department Manager shall request an identification code and temporary password for designated staff. Staff must complete an automated dispensing machine orientation before the assignment of ID code andpassword.

Drug Room Services shall assign the ID code and temporary password and enter the new user into the system by the next business day.

Once the staff member receives his/her temporary password, the staff member must immediately sign on to the automated dispensing machine with the temporary password and replace it with a new individual password. This password is an electronic signature which shall be attached to all transactions for which it is used on the automatic dispensing system.

The staff member must change his/her individual password once every three (3) months (quarterly). If the staff member neglects to change his/her individual password, Drug Room Services shall contact the staff member and request password revision.

If the password remains unchanged after the three (3) monthtime period, Drug Room Services shall deactivate the staff member's access to the automated dispensing machine until the password is revised.

The Drug Room Supervisor may assign temporary access codes for floating nurses, nursing students or nurses working on another patient care unit for a period of 12 hours. See manufacturer's instructions for temporary access procedure.

Contracted staff, i.e., traveling nurses, shall receive an ID code and password with an expiration date that is the end date of their contract.

Drug Room Services shall be notified of any staff changes, within 24 hours, by the nurse manager/department manager. This includes terminations, leaves of absence, promotions or a permanent assignment to another unit.

If a staff member suspects someone is using his/her password, he/she must immediately change his/her password in the system and notify his/her nurse manager/department manager.

If a staff member forgets his/her password, Drug Room Services must be notified. The staff member shall present him/herself to Drug Room Services with his/her hospital ID to receive a new password.

A new temporary password shall be issued and then entered into the computer system. As above, the staff member must then sign on to the automated dispensing machine and enter a new individual password.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Automated Dispensing Machine CDS Access and Distribution		**DRM-015**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

PURPOSE

The purchase, storage, distribution and accounting of controlled drugs shall be done in accordance with all federal and state laws and standards of professional practice, to maintain optimal quality control over these high-risk substances and to prevent diversion.

POLICY

Drug Room Services shall be responsible for compliance with this policy.

A transaction record for all controlled substances in schedules II, Ill and IV shall be maintained by the hospital. All controlled drug records shall be maintained for the period required by law and be readily retrievable.

A perpetual inventory record of all schedule class II drugs stored in the main Drug Room shall be maintained.

PROCEDURE

Each dispensing and each drug administration transaction shall be recorded separately; therefore, there should be two (2) transaction records for each dose given to a patient. If the nurse retrieves the dose from the controlled drug stock inventory in the automated dispensing machine (ADM), the record of dispensing shall be made on the automated dispensing machine computer system and/or on the perpetual inventory record. The dose administered shall also be recorded by the nurse on the patient's medication administration record (MAR). Documentation shall include patient's name, date, time, amount of medication removed, remaining balance and the signature of the staff member removing the medication.

The automatic dispensing system shall prompt the user to complete an inventory count and enter the number when a controlled substance is removed. If the count is incorrect per the

system, the user shall be prompted to perform a recount. If the recount remains incorrect, a discrepancy shall be created and communicated to Drug Room Services.
Controlled substance discrepancies shall be reported to the Drug Room and Therapeutics Committee immediately.

Controlled substance discrepancies must be resolved at the time of discovery or by the end of shift.

Run a Discrepancy Report which will list the name(s) of person(s) who last had access to the controlled substance. All discrepancies must be resolved by the end of the shift.

Resolution of each discrepancy must be documented in the automatic dispensing system and witnessed by a second nurse.

When an error occurs in the inventory count which cannot be explained on investigation, the error shall be reported using the hospital's routine risk management reporting system. These reports shall be reviewed monthly by the Drug Room and Therapeutic Committee per law and regulation.

Unresolved discrepancies must be documented in the automatic dispensing system as unable to resolve. The nurse must complete an incident report.

A controlled substance inventory count shall be performed once a shift in each applicable department. This applies only to controlled substances stored in the automatic dispensing machine.

Drug Room Services shall refill controlled substances into the automated dispensing machines based on inventory printouts. Drug Room Services shall verify the actual count of the controlled substance at this time and enter it into the system.

End of shift check shall be performed by the Charge Nurse for controlled and non-controlled substances. The Charge Nurse shall run a Discrepancy Report at the end of each shift to verify that all transactions were performed correctly.

Drug Room Services shall notify the CCO when discrepancies are not resolved by the end of a shift.

Controlled substances removed from the automatic dispensing system that are not administered and are still in their original packaging shall be returned via the automated dispensing machine. The return option is used on the automatic dispensing machine to credit the patient. A second nurse/provider must witness the return of the controlled substance to the automated dispensing machine and co-sign in the automated dispensing system.

If the controlled substance is not administered and it is not in its original packaging, the nurse must waste the controlled substance. The waste option is used on the automated dispensing machine. A second nurse/provider must witness the wasting of the controlled

substance and co-sign in the automated dispensing system. The nurse must also document how the drug was wasted, i.e., crush and flush, sink, sharps container.

The nurse shall use the waste option of the automated dispensing machine if all or part of a control substance must be wasted. This must be witnessed by a second nurse/provider and co-signed in the automated dispensing system. The amount used shall be entered into the system.

NOTE:

Medication filled syringes shall not be put into the Sharps container.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Authorized Providers		**DRM-030**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define parameters for ordering medications by Authorized Providers at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Oklahoma-licensed Physician Assistant (PA): Have prescribing authority under the direction of a supervising physician. They must prescribe within the Medical Board's adopted Drug Formulary.

Oklahoma-licensed Advance Practice Registered Nurse (APRN): Has prescribing authority under the direction of a supervising physician. They must prescribe within the Nursing Board's adopted Drug Formulary.

POLICY

Medications will be prescribed/ordered for patient use only by authorized providers of the hospital's medical staff or other individual who has been granted appropriate clinical privileges to order medications. All providers must maintain a license in good standing with their respective licensing board.

PROCEDURE

1. Members of the Medical Staff, as outlined in the Bylaws and Regulations of the Medical Staff of MANGUM REGIONAL MEDICAL CENTER, are authorized to prescribe and order medications.

2. Each practitioner who hand writes medication orders must do so in compliance with the Unacceptable Abbreviations policy (DR-045).
3. Each practitioner will adhere to the scope of medications that can be ordered based on approval from his or her respective licensing board and the Oklahoma State Board of Pharmacy.
    a. Oklahoma-licensed Physician Assistant (PA):
        a. C-II's are limited to orders for immediate or ongoing administration on-site pursuant to an Oklahoma supervising physician and on-site facility approved written protocol.
        b. A PA may not issue prescriptions for drugs that his or her supervising physician is not permitted to prescribe.
    b. Oklahoma-licensed Advance Practice Registered Nurses (APRN)
        a. An APRN is NOT authorized to order C-II controlled drug substances.
        b. An APRN may not issue prescriptions for drugs that his or her supervising physician is not permitted to prescribe.
4. The hospital Drug Room will maintain a list of active authorized providers and a copy of his or her signature for reference.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Chest Pain		**DRP-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.heart.org**	

SCOPE

This protocol applies to adult patients at Mangum Regional Medical Center for the acute management of chest pain.

PURPOSE

Chest pain caused by acute coronary syndromes can come on suddenly, as is the case with a heart attack. Other times, the pain can be unpredictable or get worse even with rest, both hallmark symptoms of unstable angina.

The purpose of this protocol is to assist with optimizing the work-up of chest pain at Mangum Regional Medication Center in a timely manner.

DEFINITIONS

Acute Coronary Syndrome: medical term for when the blood supply to the heart is suddenly blocked.

PROCEDURE

Nursing Orders:

- Cardinal monitor
- Vital signs every 15 minutes
- Pulse oximetry
- Oxygen 2L/minute per NC
- Cardiac Monitor
- Peripheral IV (Saline lock) x1
- Document patient's height and weight
- Evaluate for Pulmonary Hypertension and Erectile Dysfunction medication (e.g., Viagra®, Cialis®, and Revatio®)

Radiology and Other Procedures:

- ☐ ECG 12 Lead Panel
- ☐ XR Chest AP (1 view)
- ☐ CT Chest/Thorax with contrast to rule out PE

Labs:

- ☐ ABG
- ☐ BNP
- ☐ CBC with differential
- ☐ CK Total
- ☐ CK MB
- ☐ CMP
- ☐ CRP
- ☐ D-Dimer
- ☐ Fibrinogen
- ☐ Magnesium
- ☐ Phosphorus
- ☐ PT/INR
- ☐ PTT
- ☐ TSH
- ☐ Troponin-I
- ☐ Urinalysis

IV fluids:

- ☐ Sodium Chloride 0.9% 1000mL, 999mL/Hr Bolus
- ☐ Sodium Chloride 0.9% 1000mL, _____ mL/Hr

Pain Management:

- ☐ Morphine 2mg IV push x1
- ☐ Morphine 4mg IV push x1
- ☐ Hydromorphone 1mg IV push x1

Nitroglycerin:

- ☐ Nitroglycerin 0.4mg Sublingually q5m x3 doses for chest pain
- ☐ Nitroglycerin 2% 1" topically x1
- ☐ Nitroglycerin 25mg/250mL premix (Start at 5mcg/min and titrate by 5mcg/min every 3 minutes until chest pain is relieved or SBP less than 130)

Nitroglycerin alternative:

- ☐ Labetaolol 20mg IV push every 30 minutes (Max dose: 300mg)

Anti-platelets, Anticoagulants:

- Aspirin 324mg PO x1 (administer four 81mg chewable tablets)
- Plavix® 300mg PO x1
- Lovenox® 1mg/kg subcutaneous x1 (Max dose 100mg)
- Heparin 60 units/kg IV push x1 (Not to EXCEED 5000 units)
- Heparin infusion (Start at 12 units/kg/hr – refer to Heparin protocol)
- TNKase® IV push over 5 seconds x1 (weight-based dosing – refer to dosing chart)

Anti-emetics:

- Ondansetron 4mg IV push x1
- Ondansetron 4mg ODT x1
- Promethazine 25mg IM x1
- Promethazine 50mg IM x1
- Metoclopramide 10mg IV push x1
- Pantoprazole 40mg IV push x1
- GI Cocktail PO x1

REFERENCES

https://www.heart.org/en/health-topics/heart-attack/about-heart-attacks/acute-coronary-syndrome

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Automated Dispensing Machines		**DRM-013**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

POLICY

All Drug Room Services and Nursing Services policies and procedures covering the storage, prescribing or ordering, preparation, distribution and administration of controlled and non-controlled substances shall apply to the automatic dispensing system used in Mangum Regional Medical Center.

DEFINITIONS

Automated Dispensing Machine or ADM: A mechanical system controlled by a computer that perform operations or activities, relative to the storage, packaging, compounding, labeling, dispensing, administration, or distribution of medications, and which collects, controls, and maintains all transaction information.

Controlled Drug Substance Automated Dispensing Machine or CDS ADM: A mechanical system controlled by a computer that perform operations or activities, relative to the storage, packaging, compounding, labeling, dispensing, administration, or distribution of controlled medications, and which collects, controls, and maintains all transaction information.

PROCEDURE

1. The PIC shall maintain control to ensure that direct pharmacist intervention and responsibility (and certification of medication order) is present and consistent in any cycle of automated dispensing from acquisition of product through the terminal dispensing act prior to administration to the patient of any medication.

2. The terminal act of automated dispensing must be to a licensed caregiver (nurse, prescriber, or person authorized by law to administer the drug.

1. All clinical staff shall receive education on the safe use of automated dispensing

systems at orientation and annually thereafter.

REFERENCES

Oklahoma Pharmacy Law Book

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Automatic Stop Orders		**DRM-026**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to limit the duration of drug therapy in the absence of a medical provider's specific indication of drug therapy duration or other circumstances outlined in the Drug Room Policies and Procedures Manual.

DEFINITIONS

N/A

POLICY

The Pharmacy and Therapeutics Committee shall review the list of medications by drug class included in the Automatic Stop Policy on an annual basis.

PROCEDURE

1. All medication orders shall be reviewed for appropriateness when a patient is transferred to a different level of care (e.g., acute, observation, and swing bed status).
2. The Pharmacist in Charge (PIC) and the Drug Room Supervisor (DRS) will assist nursing personnel to notify medical providers of any medication orders that need to be re-evaluated/re-ordered based on defined automatic stop orders.
    a. If a medication is ordered with a duration of therapy defined by the ordering provider, it will be exempt from reevaluation.

b. Automatic stop orders for medications by drug, drug class, or patient encounter type are as follows:

Drug, drug class, or patient encounter type	Automatic Stop Time
Ketorolac	5 days
Antimicrobials unless Indication and Duration of Therapy Documented	10 Days
Acute care patient's medications	72-96 hours from admission
Swing bed patient's medications	Within 7 days of admission

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	**Brief Description of Revision/Change**

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Confidentiality Statement		**DRM-002**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to the Mangum Regional Medical Center's Drug Room in conjunction with the hospital's confidentiality statement.

PURPOSE

To provide a concise statement on the policy of Mangum Regional Medical Center regarding all confidential information.

DEFINITIONS

N/A

POLICY

The hospital's relationship with patients is confidential. Any violation of this confidential relationship may subject the employee, the hospital, and physician to liability. Any exchange of information regarding the patient other than what is necessary in the performance of one's job function is unethical, illegal, and will not be tolerated.

PROCEDURE

1. Any exchange of information with other patients, visitors, family, friends or other employees inside or outside the hospital may harm the patient, the physician, the employees and the hospital will not be given without consent.
2. Any violation of this confidentiality policy is grounds for disciplinary action up to and including termination.
3. All employees will sign a copy of this policy verifying that they have read the policy, they understand the policy, and they will abide by the policy.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Conscious Sedation		**DRM-045**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

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

Refer to nursing policies.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Controlled Drug Substances Distribution and Control		**DRM-016**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the controlled drug substances distribution and control measures at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The hospital drug room will adhere to controlled drug substances distribution and control measures as outlined by the Oklahoma Bureau of Dangerous Drugs and Narcotics (OBN), Drug Enforcement Administration (DEA), and the Oklahoma State Board of Pharmacy.

DEFINITIONS

Controlled drug substance (CDS): Any medication designated by the DEA as a Class I – V scheduled medication.

POLICY

All controlled drug substances will be monitored and distributed by the Drug Room Supervisor (DRS) and the Pharmacist in Charge (PIC). Measures shall be taken to ensure security and safety of these drugs. Adequate records shall be kept to account for these drugs and any others that the PIC deems necessary.

PROCEDURE

Procurement:

1. CDS may be ordered by the Drug Room Supervisor (DRS), PIC, or Drug Room Staff. All individuals must be designated as a Power of Attorney by the hospital administrator.
2. All Schedule III, IV, and V CDS can be ordered electronically via the pharmacy wholesaler's website.
3. All Schedule II CDS can be ordered by an authorized person using CSOS or DEA Form 222. A complete listing of all DEA 222 Forms will be maintained using a log book by the

DRS, and all DEA 222 Forms will be stored in a designated locked CDS cabinet in the hospital drug room.

Receiving:

a. The DRS, PIC, or Drug Room Staff will document all CDS in a perpetual inventory log book upon receipt from the hospital drug room wholesaler**.**
b. The perpetual inventory is maintained on paper forms.
    a. The invoice number or the DEA 222 Form number will be entered along with the quantity received for all CIIs.
    b. The invoice number will be entered along with the quantity received for all CIII-Vs.
c. The CDS received will be checked against the invoice (and DEA 222 Form if the drug is a CII).
    a. For CIII-V CDS, the DRS and PIC will initial the invoice which will be placed in the CIII-V invoice file.
    b. For CII CDS, the DRS and PIC will initial the DEA 222 Form and the invoice and staple them together prior to placing them in the CII invoice file.
        i. All lines on the DEA 222 Form must be completed with the date and quantity received.
d. All CII-V CDS stored in the hospital Drug Room will be kept in a locked cabinet, and according to manufacturers' recommended storage requirements.
e. Copies of all CDS purchase invoices will be stored in the hospital Drug Room.
f. The hospital Drug Room pharmacy wholesaler will be contacted immediately for any discrepancies between the CDS ordered, received, and invoiced.

Distribution:

1. CDS can be removed from the designated narcotic cabinet in the hospital Drug Room by the DRS, CCO, or PIC and distributed to patient care area(s).
2. The Perpetual Narcotic Log Book will be updated to document the quantity of medication removed from the Drug Room, initials of the individual removing the medication from the Drug Room, date, time and where the medication is being distributed to (e.g., med cart room)
3. The CDS in patient care area(s) will be secured in the med cart room.

Administration:

1. Narcotic Administration Sheets will be made for each day and counts confirmed by nursing personnel twice a day.
2. These sheets will include brand and generic name of each drug, strength, quantity, and sheet number.
3. When a CD is administered to a patient, the patient's name, dose given, dose wasted (if applicable), date, time, ordering provider, and nurse's signature will be recorded on this sheet.
4. If a medication is wasted or spoiled, it shall be recorded and witnessed by another licensed nurse and both signatures will be documented on the sheet to show a witness verified the medication was wasted.

Count:

1. CDS stored in the designated narcotic cabinet in the hospital Drug Room shall be counted monthly by the DRS and PIC for quality control measures.
2. The CDS stored in patient care area(s) are counted every shift by nursing staff to assure accuracy.

Outdates

1. CDS shall be checked monthly by the DRS or PIC for outdates.
2. If outdated CDS are found, they will be removed from patient care area(s).
    a. Outdated CDS will be temporarily stored in the locked narcotic cabinet in the hospital Drug Room.
    b. Outdated CDS will be logged in the Perpetual Narcotic Log by the DRS or PIC.
3. A reverse distributor company representative will process and submit for credit outdated CDS every quarter or more often as needed.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Contrast-Induced Nephropathy Prevention		**DRM-057**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.acr.org**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

This purpose of this protocol is to limit the risk of contrast induced nephropathy (CIN) for adult patients after the administration of contrast media.

DEFINITIONS

Contrast induced nephropathy (CIN): a serious complication following angiographic procedures resulting from the administration of contrast media. CIN is defined as an elevation of serum creatinine (SCr) of more than 25% or ≥ 0.5 mg/dL from baseline within 48 hours after contrast media administration.

PROCEDURE

GFR	Recommendation
> 60 mL/min	☐ Hold metformin until 48 hours post-procedure
30-60 mL/min	☐ Hydrate the night before the procedure o At least 4-6 glasses of water up to 4 hours pre-procedure ☐ Hold ACE inhibitors, angiotensin receptor blockers, diuretics, NSAIDs, and COX-2 inhibitors 24 hours before the procedure o Aforementioned medications may be resumed 24 hours after the procedure ☐ Hold metformin until 48 hours post-procedure or until creatinine is stable

< 30 mL/min	□ For in-patient administration: □ 0.9% Normal saline at 100 mL/hr beginning 6-12 hours prior to administration of IV contrast and continuing for 4-12 hours afterwards □ 50 mEq NaHCO3 in 1 Liter NaCl 0.45% 1mL/kg for 12 hours before/after IV contrast administration □ For out-patient administration: □ 0.9% Normal saline 500mL IV bolus prior to IV contrast □ 50 mEq NaHCO3 in 1 Liter NaCl 0.45% 3mL/kg for 1 hour before IV contrast then reduce rate to 1mL/kg for 6 hours □ Acetylcysteine (Mucomyst®) 600 mg orally every 12 hours the day before and the day of the procedure (total of 4 doses) □ Hold ACE inhibitors, angiotensin receptor blockers, diuretics, NSAIDs, and COX-2 inhibitors 24 hours before the procedure o □ Aforementioned medications may be resumed 24 hours after the procedure □ Hold metformin until 48 hours post-procedure or until creatinine is stable

REFERENCES

https://www.acr.org

ACR Manual on Contrast Media Version 10.3, 2017: 6-15, 24-30

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Crofab® Protocol		**DRP-004**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://crofab.com/**	

SCOPE

This protocol applies to all patients at Mangum Regional Medical Center for the acute management of envenomation due to a snake bit.

PURPOSE

The purpose of this protocol is to assist with optimizing the treatment plan for envenomation from a snake bite and providing guidelines for the administration of Crofab® to treat envenomation.

DEFINITION

Envenomation: process by which venom is injected by the bite or sting of a venomous animal.

POLICY

Mangum Regional Medical Center shall have available 2 doses of Crofab® for snake envenomation. Any medication vial(s) close to expiration will be returned to the manufacturer for credit and new vial(s) will be replenished by the manufacturer.

PROCEDURE

Assess the Patient:

1. Mark leading edges of swelling and tenderness every 15-30 minutes
2. Immobilize and elevate extremity
3. Treat pain (IV opioids preferred)
4. Obtain initial lab studies (prothrombin time, CBC, CMP, fibrinogen)
5. Update Tetanus vaccine patient history
6. Contact Poison Control (1-800-222-1222)

Check for signs of envenomation:

1. Swelling, tenderness, redness, ecchymosis, or blebs at the site
2. Elevated prothrombin time, decreased fibrinogen or platelets
3. Systemic signs, such as hypotension, bleeding beyond the puncture site, refractory vomiting, diarrhea, angioedema, neurotoxicity

If none of these signs are present it is an apparent dry bite/no bite. For this you do the following:

1. DO NOT administer Crofab®
2. Observe patient for up to 8 hours
3. Repeat labs prior to discharge
4. If patient develops signs of envenomation proceed to next step

Check for Progression of Clinical Effects:

1. Swelling that is more than minimal and that is progressing
2. Elevated prothrombin time, decreased fibrinogen or platelets
3. Any systemic signs

For minor apparent Envenomation:

1. DO NOT administer Crofab®
2. Observe patient 12-24 hours
3. Repeat labs at 4-6 hours and prior to discharge
4. If patient develops progression of any signs of envenomation proceed to next step

For significant apparent Envenomation:

1. Establish IV access and give IV fluids
2. Administer Crofab® **UNLESS** patient a known hypersensitivity to papaya or papain
    a. Pediatric Crofab® dose = adult dose
    b. Reconstitute each vial with 18mL of 0.9% Normal Saline and mix by gentle manual inversion. **Do NOT shake the vials**.
3. Dilute reconstituted Crofab® vials in a Normal Saline 250ml bag
    a. Initiate infusion at 25mL/Hr for the first 10 minutes assessing for any possible allergic reaction, hypersensitivity reaction
    b. If no infusion related reaction occurs in the first 10 minutes, infusion rate may be increased to 250mL/Hr
4. Initiate transfer immediately

Post Discharge Planning for Non-Venomous bite or Ruled-out Envenomation:

1. Instruct patient to return for; worsening swelling that is not relieved by elevation, experiences abnormal bleeding(e.g., gums, easy bruising, melena et cetera)
2. Instruct patient where to seek care if symptoms of serum sickness develop (fever, rash, muscle/joint pain)
3. Bleeding precautions; no contact sports, elective surgery, or dental work for 2 weeks in patients with rattlesnake envenomation, or abnormal prothrombin time, fibrinogen, or platelet count

REFERENCES

https://crofab.com/

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Destruction of Drugs		**DRM-023**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the destruction of medications at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a process for the destruction of medications (i.e. rendering medications unusable for human consumption).

DEFINITIONS

N/A

POLICY

The Drug Room Supervisor will assure that all medications unable to be returned to the manufacturer or processed by a reverse distributor company will be disposed of properly.

PROCEDURE

1. All non-controlled, outdated, unusable drugs and biologicals that cannot be restocked or returned to a manufacturer will be logged into the Destroyed Drug Log Book with the following information:
   a. Date
   b. Name of drug
   c. Strength
   d. Quantity
   e. Mode of destruction
2. The Drug Room Supervisor and another licensed nurse will waste and witness the destruction of the medication(s).

3. The medications will be disposed of in the appropriate Biohazard containers at the nurses' station.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Diversion of Controlled/Non-Controlled Substances		**DRM-017**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The hospital will adhere to controlled substance diversion guidelines as outlined by the Oklahoma Bureau of Dangerous Drugs and Narcotics (OBN), Drug Enforcement Agent (DEA), and the Oklahoma State Board of Pharmacy.

DEFINITIONS

Drug diversion: the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit (i.e. not medically prescribed) use.

POLICY

The hospital will assure that all medications are accounted for and follow the appropriate procedure to report and investigate any suspected diversion. Theft or diversion of prescription medications is a violation of state law and federal law.

PROCEDURE

1. If diversion of any medication is found, notify the appropriate personnel:
   a. Hospital Administrator
   b. CNO
   c. PIC
   d. Drug Room Supervisor
2. Take appropriate action;
   a. Validate the count of the medication found to have a discrepancy two or more appropriate personnel (e.g., nursing staff member and DRS).

   b. Change locks if needed on the drug room, night cabinets or med cart
   c. Gather appropriate data on the incident such as narcotic sheets etc.
3. For controlled drug diversion, contact the OBNDD at 1-800-522-8031;
   a. Inform the OBNDD of the problem and follow their recommendations on confrontation and in-house investigation
   b. Request DEA Form 106 and fill out the entire form according to the instructions
   c. Return the original and 2 copies to the OBNDD. Retain 1 copy for two years for hospital records
   d. The OBNDD will notify the OSBI if indicated
4. If a licensed nurse is involved in diversion, notify the Oklahoma Board of Nursing at 405-525-2076
5. If a licensed pharmacist is involved in diversion, notify the Oklahoma Board of Pharmacy 405-521-3815
6. If a licensed medical personnel is involved in diversion, notify the Oklahoma Board of Medical Examiners
7. Contact the medical facility's attorney for further information of proceedings if necessary

Other Medications:

1. If an employee is suspected of taking medication for personnel use, notify the hospital administrator and Chief Clinical Officer for appropriate action and follow up.
2. If medication is missing and cannot be located, notify the Drug Room Supervisor and the Chief Clinical Officer for appropriate follow up.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Recalls		**DRM-022**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a process for reviewing manufacturer issued drug recalls and removing any affected medication from patient care areas at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Class I recall: products that could cause serious health problems or death.

Class II recall: products that may cause a temporary or reversible adverse health problem or where the probability of a serious health problem is remote.

Class III recall: products that are unlikely to cause any adverse health problems but violate FDA manufacturing or labeling laws.

POLICY

In the event of a manufacturer drug recall affecting hospital medication inventory, the Drug Room Supervisor (DRS) shall remove the recalled medication from hospital stock and return the recalled medication as instructed by the manufacturer.

PROCEDURE

1. The DRS will be notified by pharmaceutical manufacturers when a medication is recalled.

2. The DRS shall inspect all patient care areas, advise staff as needed, and isolate any medication that coincides with each drug recall.
3. Recalled medications will be returned to the manufacturer as requested and locked in the secure outdated medication area prior to being returned to the manufacturer for processing.
4. All drug recall records will include the date the drug recall was received by the DRS, the date the hospital inventory was reviewed for recalled medications, and the quantity of any recalled medication in stock.

REFERENCES

Oklahoma Pharmacy Law Book

https://www.fda.gov/drugs/drug-safety-and-availability/drug-recalls

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
DKA/Insulin Drip Protocol		**DRP-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.aafp.org**	

SCOPE

This protocol applies to adult patients at Mangum Regional Medical Center for the acute management of Diabetic Ketoacidosis (DKA).

PURPOSE

The purpose of this protocol is to assist with streamlining the diagnostic work-up and treatment of DKA.

DEFINITION

DKA: Moderate ketonemia, arterial pH <7.3, serum glucose >250 mg/dL, serum bicarbonate <18 mEq/L

PROCEDURE

Monitor and Record:

- Vital signs & I&O every hour until stable, then every 2 hours x 24 hours
- Insert Foley if no urine output within the first hour
- STAT finger stick (capillary) blood glucose
  (Use venous or arterial draw if glucose >450 or <45 mg/dL or SBP <60 mmHg)
- Accuchecks every hour
- Accuchecks every 4 hours
- Neuro checks every 2 hours (maintain seizure precautions) x 24 hour
- Initiate and complete Insulin Drip Flowsheet until patient is transitioned off insulin drip

Diet:

- NPO
- NPO except Ice Chips
- Other_____

Admission Labs:
□ CBC with Differential
□ Comprehensive Metabolic Profile
□ Serum Magnesium level
□ Serum Phosphorus level
□ Venous blood gas
□ Blood cultures x 2
□ Urine C&S
□ Hgb A1C
□ TSH
□ Serum osmolarity (measured)
□ Record acidosis-ketosis gap (AKG = arterial pH – plasma ß-hydroxybutyrate. AKG >3 may indicate drug abuse)
□ Other labs: _____

Adult DKA Every 4 hour Labs for initial 24 Hours:

□ Basic Metabolic Panel with Total Calcium, Magnesium, Phosphorus
□ Serum ketones
□ Venous Blood Gas

Additional Diagnostic Tests:
□ EKG
□ CXR
□ Portable CXR

Initial IV Fluids:
□ Consider IV Bicarbonate therapy for pH less than or equal to 7
□ Bolus Sodium Chloride 0.9% IV to run at 999ml/hr for _____ liters

Maintenance IV Fluids:

□ Dextrose 5% - Sodium Chloride 0.45% to run at ____ ml/hr
□ Sodium Chloride 0.9% IV to run at ____ mL/hr
□ Sodium Chloride 0.9% with KCl 20mEq/L IV to run at ____ mL/hr
□ Sodium Chloride 0.9% with KCl 40mEq/L IV to run at ____ ml/hr
□ Sodium Chloride 0.45% to run at ____ ml/hr
□ Sodium Chloride 0.45% with 75mEq of Sodium Bicarbonate to run at ___ mL/hr

Insulin Bolus and Infusion:

□ Regular insulin 0.15 units/kg IV x 1 dose now
□ Regular insulin ____ units IV x 1 dose now (Typically dosed 10-15 units)
□ Regular insulin 100units/100mL IV to start at 0.1units/kg/hr
□ Regular insulin 100units/100mL IV to start at maintenance dose
(Initial rate typically dosed based on glucose level divided by 100)

Insulin Infusion Rate Algorithm:

Blood Sugar Level	Insulin Drip units/hour
< 60	Treat Hypoglycemia
61-69	Turn IV Drip Off
70-109	0.5
110-119	1
120-149	1.5
150-179	2
180-209	3
210-239	4
240-269	5
270-299	6
300-329	7
330-359	8
> 360	12

Treatment of Hypoglycemia:
□ Initiate Hypoglycemic Protocol

Electrolyte Supplementation:
□ Magnesium Supplementation
- Magnesium sulfate 1gm IVPB x 1 dose

□ Phosphate Supplementation
- Potassium phosphate 10mmol IVPB x 1 dose
- Potassium phosphate 20mmol IVPB x 1 dose

□ Potassium Supplementation
- Potassium chloride 20mEq IVPB x 1 dose

Stress Ulcer Prophylaxis:
□ Carafate 1gm NG Tube every 6 hours
□ Zantac 50mg IVPB every 8 hours

 Protonix 40mg IV Push daily

REFERENCES

https://www.aafp.org/afp/2005/0501/p1705.html

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Room Security – After Hours		**DRM-012**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the security of MANGUM REGIONAL MEDICAL CENTER's Hospital Drug Room during after-hours.

PURPOSE

The hospital drug room will adhere to security requirements of the hospital drug room during after-hours as required by the Oklahoma Pharmacy Practice Act.

DEFINITIONS

Hospital drug room normal business hours: Mondays through Fridays 8:00AM – 4:30PM.

Hospital drug room after-hours: anytime outside of the Drug Room's normal business hours.

POLICY

The hospital drug room is to remain locked and the door shut at times when it is unoccupied by authorized staff. Authorized staff is defined as the RN in charge and is responsible for accessing the drug room in the event medications are not available to staff for patients.

PROCEDURE

1. All authorized personnel shall complete training established by the Pharmacist in Charge and presented by the Drug Room Supervisor upon hire and on a yearly basis.
2. The RN in charge will be responsible for accessing the drug room to obtain medications when needed.
3. Authorized nursing personnel will have access to only one key to the Drug Room.
4. The key shall not be passed off to anyone else unless it is an emergency, and then another licensed staff nurse can access the drug room to obtain emergency medications only.
5. Upon entering the hospital drug room, the authorized RN shall complete the following:

a. Verify the medication order and retrieve the appropriate medication
b. Complete the After Hours Log (located on the counter) for each After Hours entry into the drug room. See Attachment A for sample After Hours Log.
c. A sample of the medication shall be placed in a designated After Hours blue bin on the counter for the Drug Room Supervisor to confirm that the right medication was removed.
d. If a medication is not available that was ordered by a provider, it shall be noted in the log book for tracking purposes.

6. The Drug Room Supervisor and Pharmacist in Charge will review medications removed from the drug room during after-hours in a timely manner.
7. The Pharmacist in Charge will be on call during after-hours (i.e. available by phone) to answer any medication related questions.
8. If an after-hours issue requires someone to be physically be on site at the hospital, the Drug Room Supervisor should be notified.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

Attachment A: After Hours Log

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Room Library		**DRM-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

To provide a concise statement on the policy of MANGUM REGIONAL MEDICAL CENTER's drug information library and how often the library needs to be updated.

DEFINITIONS

Pharmacy library: A library that contains current drug information reference books and computer sources.

POLICY

A library shall be maintained which includes four current references (not more than 2 years old or most current). Current electronic sources may be substitute for two hard copy resources.

PROCEDURE

1. Every two years new Drug Information Handbooks shall be purchased for the drug room and nursing station.
2. Two electronic references shall be placed on desktop computers that the drug room personnel or nursing staff have access to.
3. All other medication references will be available if requested by the P&T committee in a timely manner.
4. The library shall be able to retrieve an electronic copy of the latest Oklahoma Pharmacy Law Book and any rules pertaining to the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control in a timely manner.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Room Services		**DRM-003**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

To define who is responsible for meeting the standards for a hospital drug room that is consistent with the State Department of Health and Oklahoma State Board of Pharmacy Standards.

DEFINITIONS

Drug Room: A secured room where drug inventories are maintained for use in a hospital, with less than 100 licensed beds including bassinets, licensed and regulated by the Oklahoma Health Department and by the Oklahoma Board.

Drug Room Supervisor (DRS): Oklahoma registered nurse, licensed practical nurse, or licensed pharmacist.

Pharmacist in Charge (PIC): Licensed Oklahoma pharmacist that oversees all medication processes within the Hospital and Hospital Drug Room.

POLICY

The hospital drug room will meet the medicinal needs of the patients of MANGUM REGIONAL MEDICAL CENTER. The Hospital shall abide by the Oklahoma Pharmacy Law Book Subchapter 6 to operate the drug room in a competent, adequate and safe way that shall meet the needs of the patients of the hospital facility.

PROCEDURE

1. The DRS and/or the PIC shall establish written procedures for the safe and efficient acquisition, distribution, and utilization of all medicine products, and medications administered or distributed in the hospital.
2. The DRS and/or PIC shall be responsible for the safe and efficient monitoring, distribution, control, purchasing, acquisition and accountability of all drugs or drug products. The hospital facility shall cooperate with the pharmacist in meeting these responsibilities.
3. The normal business hours of the hospital Drug Room are Mondays through Fridays 08:00AM – 4:30PM.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Room Supervisor (DRS)		**DRM-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the MANGUM REGIONAL MEDICAL CENTER Hospital Drug Room Supervisor credentials and expectations.

PURPOSE

To define who is responsible for meeting the standards for a hospital drug room supervisor that is consistent with Oklahoma State Board of Pharmacy Standards.

DEFINITIONS

Drug Room Supervisor (DRS): Oklahoma registered nurse, licensed practical nurse, or licensed pharmacist.

POLICY

The hospital drug room shall have adequate staff during working hours to manage the day to day activities of the drug room and ensure staff adheres to policies and procedures set forth by the pharmacist in accordance with state and federal regulations.

PROCEDURE

1. The drug room supervisor shall be a licensed nurse and shall be chosen by appropriate staff and PIC.
2. Shall be responsible for monitoring, distribution, control, purchase acquisition and accountability of all medications and medication products.
3. Shall be a member of the Quality Program and submit data as appropriate.
4. Shall attend all Pharmacy and Therapeutics meetings, take minutes, and provide data to staff regarding drug room activities.
5. Assist PIC in providing education for nursing staff yearly and for new nursing staff hires.
6. Shall be available Monday – Friday from 8:00AM-4:30PM to assist nursing staff in obtaining medications ordered by medical providers for patients and after hours for emergencies.

7. Will report to CCO and PIC.
8. Shall be responsible for removing outdates and recalled medications from stock.
9. Shall be responsible for record keeping.
10. Shall adhere to all rules and regulations set forth by the Oklahoma Pharmacy Act concerning Hospital Drug Rooms.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Drug Storage Inspections		**DRM-041**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define the expectations of the Pharmacist in Charge (PIC) for inspecting all areas of medication storage on a routine basis.

DEFINITIONS

N/A

POLICY

The Pharmacist in Charge or his/her appropriate designee shall conduct an inspection of all drug areas within the hospital on at least a monthly basis.

PROCEDURE

1. The monthly storage inspection shall verify at least the following:
    a. Drugs for internal use are stored separately from drugs and disinfectants for external use.
    b. Drugs requiring special storage conditions to ensure their stability are properly stored.
    c. No outdated drugs are stocked in the facility and are removed from the facility within 6 months after the expiration date.
    d. Distribution and administration of controlled substances are properly and adequately documented and reported.
    e. Emergency drugs are adequate and in proper supply.
    f. All necessary and required security and storage standards are met.
    g. Metric apothecary weight and measure conversion tables and charts are reasonably available to all medical personnel.

h. Policies and procedures of the hospital drug room are followed.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Electrolyte Protocol		**DRP-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	http://www.surgicalcriticalcare.net	

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

The purpose of this protocol is to assist with streamlining the treatment of electrolyte abnormalities in a timely manner and provider administration instructions for these medications.

PROCEDURE

Electrolyte Replacement Protocol

Medication/ How supplied	Dosing/Admin. Instructions	Monitoring Parameters
Calcium Chloride (1g/10mL prefilled syringe)	Infuse over 2-5 minutes IV push for life-threatening cardiac arrhythmias	3 times more concentrated than Calcium Gluconate. Not compatible with Rocephin.
Calcium Gluconate (1g vial)	**Calcium gluconate 1g/NS 100mL** Infuse over 1 hour (100mL/hr) **Calcium gluconate 2g/NS 100mL** Infuse over 1 hour (100mL/hr)	Admin. as IV PB to reduce the risk of extravasation. Not compatible with Rocephin.

Magnesium Sulfate (1g/D5W 100 premix)	Infuse each 1 gram ordered no faster than 1 hour (100mL/hr)	Ideally admin. Magnesium Sulfate first if ordered at the same time as Potassium Chloride.
Potassium Chloride (20mEq/NS 100mL premix)	For peripheral IV line: Admin. no faster than 10mEq/hr (50mL/hr) For central IV line: Admin. no faster than 20mEq/hr (100mL/hr)	For doses > 20mEq: use multiple premix bags. Use cardiac monitoring for admin. rates greater than 10mEq per hour.
Potassium Phosphate 30mMol/15mL vial	K Phos dose/NS 250mL Infuse over 6 hours (42mL/hr)	Max dose is K Phos 30mMol every 24 hours.

REFERENCES

http://www.surgicalcriticalcare.net/Guidelines/electrolyte_replacement.pdf

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Duplication Order Policy		**DRM-050**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish a procedure to prevent medication duplicate orders on a patient medication profile, which may lead to medication errors with possible adverse patient outcomes and inaccurate documentation.

DEFINITIONS

Therapeutic duplication: the situation when multiple medications are ordered for the same clinical indication without clear criteria for selecting the use of one medication order over the other.

POLICY

The pharmacist verifying medication orders or a licensed nurse on-duty can review the appropriateness of medication orders and discontinue duplicate medication orders as defined in this policy.

PROCEDURE

1. The pharmacist verifying medication orders or a licensed nurse on-duty can discontinue identified duplicate medication orders unless otherwise stated by the provider to continue both medications (e.g., Potassium 20mEq by mouth ordered twice).
2. Any active order for a PRN opioid will be discontinued when a new PRN opioid (involving the same route of administration) is ordered, unless clear criteria for order of use is included in the orders.

a. Example: Morphine 4 mg IV every 4 hours PRN severe pain AND Hydromorphone 0.5 mg IV every 4 hours PRN severe pain are ordered.
    i. If both medications are ordered at the same time (or within 60 minutes of each other), the orders will need to be clarified with the ordering provider before they are verified by a pharmacist.
    ii. If the medications were ordered at different times (greater than 60 minutes), then the oldest order will be discontinued and the new order verified by a pharmacist.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Electronic Health Record Downtime Procedure		**DRM-056**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish a downtime procedure for the timely review of medication orders by a pharmacist during an electronic health record (EHR) downtime.

DEFINITIONS

Electronic Health Record (EHR) downtime: planned or unplanned downtime in which a medical facility's electronic health records are not available for at least two hours.

POLICY

In the event of EHR down time lasting longer than two hours, the medical facility will have a procedure in place to ensure medication orders are verified by a pharmacist in a timely manner.

PROCEDURE

1. Pharmacist(s) verifying medication orders will be notified of new medication orders via a HIPPA compliant, cloud-based S Fax of the medication order (1-855-708-6623) during any EHR downtime lasting longer than two hours.
2. In order to view faxed medication orders, the pharmacist(s) on duty will have to log into the S fax website using a unique ID and password.
3. An electronic copy of all S faxed medication orders will be securely stored on the S fax website for at least two years.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Heparin Low Dose Protocol – ACS and Stroke		**DRP-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.accessdata.fda.gov**	

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

This protocol applies to adult patients at Mangum Regional Medical Center receiving low dose heparin intravenous (IV) therapy for Acute Coronary Syndrome (ACS) or Stroke management.

PROCEDURE

Nursing Orders:

- Weigh patient STAT. Actual body weight _____ kg
- Determine Ideal Body Weight _____ kg
- Determine Adjusted Body weight _____ kg
- Determine Heparin Dosing Weight (DW): **dose using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2. DW _____ kg**

Medications:

- Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
  Bolus dose based on Heparin 60 units/kg x Dosing Weight (**Maximum of 5,000 units)**

- Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.
  Heparin 12 units/kg-hour x DW **(Maximum of 1,000 units/hr initially) _____** units/hour

Labs:

- CBC – STAT
- CMP -STAT
- PT/INR - STAT
- PTT - STAT
- PTT every 6 hours after initiation and after every Heparin rate change
- Daily weight while on Heparin Drip
- CBC every other day while on Heparin Drip
- GUAIAC stool as needed

Monitoring Parameters:

- Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

- If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

- Do not interrupt heparin infusion unless ordered.

- Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

REFERENCES

https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/017029s140lbl.pdf

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Emergency Dispensing of Medications		**DRM-025**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a process for emergency dispensing of medications intended for patient use after discharge from MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

The Pharmacist in Charge or a licensed practitioner on duty may label and dispense an appropriate supply of a medication from the hospital Drug Room when ordered by a licensed practitioner for a patient to take home when discharged from the hospital.

PROCEDURE

1. The Pharmacist in Charge or a licensed practitioner on duty may label and dispense medications in sufficient quantities to meet the immediate needs of patients post-discharge from the hospital.
    a. An appropriate supply would include only sufficient dose(s) required from the time of dismissal until resumption of normal business hours of local pharmacies.
    b. Any medication(s) dispensed to a patient at discharge must be documented in the electronic health record and signed out from the hospital drug room appropriately.
2. All emergency dispensed medications sent home with a patient after hospital discharge must be labeled appropriately with the following:
    a. Patient name

b. Prescriber's name
c. Name and address of the medical facility
d. Directions for use
e. Date issued to the patient
f. Beyond use date & storage instructions (if applicable)

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Formulary		**DRM-020**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a hospital wide medication formulary and to review the medications on the formulary on a routine basis.

DEFINITIONS

N/A

POLICY

The Pharmacy and Therapeutics (P&T) Committee will determine the medications on the hospital formulary. The Drug Room Supervisor (DRS) will provide a list of these medications to the nursing staff and physicians. The Drug Room Formulary will be evaluated and revised on a yearly basis by the P&T Committee.

PROCEDURE

1. Every medical provider request to order a non-formulary medication will be evaluated by the DRS and the Pharmacist in Charge.
2. Upon request of a non-formulary medication order, the PIC may suggest to the prescribing provider an alternative medication(s) on the hospital formulary
3. The DRS or PIC will provide an estimated delivery time for which a non-formulary medication can be delivered to the hospital intended for patient use when a formulary approved medication is not an acceptable alternative.
4. When a request for a non-formulary drug has been received by the P&T Committee, the request will be reviewed by the Committee in a timely manner.

5. The P&T Committee will review therapeutic interchanges on the hospital formulary on an annual basis.
6. The use of medication samples will be prohibited at Mangum Regional Medical Center and are not eligible to be included as part of the hospital formulary.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Heparin Standard Dose Protocol – DVT and PE		**DRP-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.accessdata.fda.gov**	

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

This protocol applies to adult patients at Mangum Regional Medical Center receiving standard dose heparin intravenous (IV) therapy for Deep Venous Embolism and Pulmonary Embolism.

PROCEDURE

Nursing Orders:

- ☐ Weigh patient STAT. Actual body weight _____ kg
- ☐ Determine Ideal Body Weight _____ kg
- ☐ Determine Adjusted Body weight _____ kg
- ☐ Determine Heparin Dosing Weight (DW): **dose using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2. DW _____ kg**

Medications:

☐ Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
Bolus dose based on Heparin 80 units/kg x Dosing Weight (**Maximum of 5,000 units)**

☐ Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.
Heparin 18 units/kg-hour x DW **(Maximum of 1,000 units/hr initially) _____** units/hour

Labs:

- CBC – STAT
- CMP -STAT
- PT/INR - STAT
- PTT - STAT
- PTT every 6 hours after initiation and after every Heparin rate change
- Daily weight while on Heparin Drip
- CBC every other day while on Heparin Drip
- GUAIAC stool as needed

Monitoring Parameters:

- Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

- If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

- Do not interrupt heparin infusion unless ordered.

- Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

REFERENCES

https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/017029s140lbl.pdf

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Inspections		**DRM-039**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define how hospital Dug Rooms are inspected by the Oklahoma State Board of Pharmacy.

DEFINITIONS

Inspection: hospital Drug Rooms are subject to inspection. The Board and/or its authorized representatives may conduct on-site periodic routine inspections and investigations during reasonable business hours.

POLICY

The Oklahoma Pharmacy Board's qualified designee shall inspect all aspects of the management and operations of all hospital drug rooms in the state of Oklahoma, to verify compliance with the law, rules and other standards as may be appropriate to ensure that the health, safety and welfare of patients of the facility serviced by the hospital drug room are protected.

PROCEDURE

1. The hospital Drug Room will abide by all laws set forth in Subchapter 6 of the Oklahoma Pharmacy Law Book.
    a. The hospital Drug Room will be prepared for an inspection(s) at any time during normal business hours.
    b. All discrepancies noted on an inspection report shall be corrected as soon as possible.
    c. A record of all discrepancies noted on an inspection will be maintained in the hospital Drug Room.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Investigational Drugs		**DRM-046**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	Oklahoma Pharmacy Law Book	

SCOPE

This policy applies to patients that are using investigational drug therapy at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish standards in coordination with the Pharmacy and Therapeutics committee for the use and control of investigational drugs at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Investigational drug: A chemical or biological substance that has been tested in the laboratory and approved by the US Food and Drug Administration (FDA) for testing in people during clinical trials.

POLICY

The Hospital shall ensure that if investigational drug(s) are used in the facility, it is done in a safe manner that adheres to regulations defined in the Oklahoma Pharmacy Law Book, Subchapter 6 Hospital Drug Room.

PROCEDURE

1. This facility does not initiate investigational drug use.
2. In the event a patient is admitted to the hospital and is currently taking investigational drug(s), the medical staff in coordination with the Pharmacy and Therapeutics Committee will determine if it is medically appropriate to continue the investigation drug(s).
    a. The following is to be obtained from the principal investigator: a copy of the investigational protocol, forms required for tracking dispensing, administration and/or

destruction of each dose, a copy of the signed consent, the IRB approval letter, any product information sheets, staff educational materials, and the study medication(s).

b. If the investigational medication(s) is to be continued during a hospital admission, a medication order is required prior to administration.

3. All investigational drugs shall be labeled in accordance with the labeling requirements of non-investigation drugs.
4. Information needed to safely administer the medication is to be obtained and provided for nursing staff and the patient.
5. Investigational drugs shall be stored in an area separated from approved pharmaceuticals and shall be secured in the hospital drug room.

REFERENCES

Oklahoma Pharmacy Law Book

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
High-Alert, High Risk Policy		**DRM-043**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to reduce the risk of patient harm from medication variances by establishing additional safeguards for High-Alert, High Risk medications.

DEFINITIONS

High-Alert, High Risk Medications: medications known to be error-prone or which pose a significant hazard to the patient if not properly handled, and are designated as High-Alert, High Risk by the Pharmacy and Therapeutics (P&T) Committee.

Independent Double Check: To improve the effectiveness of the double check process, **both individuals check the final product or result by performing all operations independently, without the knowledge of the other's input or of any prior calculations.** Once each individual has their independent final product or result, only then is it shared to compare for the same outcome.

Self-Double Check: the final verification process of correct patient, correct medication, correct dose, correct time, and correct route during an emergent situation when a second person is not available.

POLICY

Mangum Regional Medical Center will develop and review a list of High-alert, High-risk medications on an annual basis. The hospital Drug Room will implement strategies designed to prevent the misuse of high risk medications.

PROCEDURE

1. The P&T committee will identify a hospital specific list of High- Alert, High-Risk medications (see Table 1 for details).
    i. The High-Alert/High-Risk medications list is reviewed and updated on an annual basis.
        a. Updates/revisions made to this list are based on:
            i. The addition of any new medications to the hospital formulary
            ii. Any emerging patient safety data (i.e. reported medication variances, reported adverse drug events/reactions, or sentinel events).
        b. High-Alert/High-Risk medications will be labeled as such in the hospital Drug Room and patient care area(s).
    ii. Strategies will be implemented to reduce the risk associated with specific High-Alert, High-Risk Medications (see Table 2 for details).
2. High-Alert, High-Risk medications should be verified by nursing personnel using the provider order and two patient identifiers.
    i. The patient's nurse before administering any High-Alert, High-Risk medication must utilize the five rights of medication administration (right drug, right time, right route, right dose, and right patient).
3. High-Alert, High-Risk medications that require an independent double check are outlined in Table 3.
    i. An independent double check is performed by two licensed nurses prior to administration and is documented in the patient's medical record.
    ii. In an emergent situation when a second person is not available to serve as a witness, the nurse administering certain High-Alert, High-Risk medications should perform a second verification via a Self-Double Check.

REFERENCES

Institute for Safe Medication Practices

ATTACHMENTS

Table 1: High-Alert, High-Risk Medication List
Table 2: Specific strategies to reduce the risk of High-alert, High-risk medications
Table 3: High-Alert, High-Risk medications that require an independent double check

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Table 1: High-Alert, High-Risk Medication List

All Insulin formulations	Controlled drug substances/opioids	Epinephrine, subcutaneous
Heparin IV	Hypertonic IV solutions	Inotropic medications
Magnesium sulfate inj.	Moderate sedation medications	Neuromuscular blockers
Oral hypoglycemic medications	Potassium chloride inj.	Promethazine inj.

Table 2: Specific strategies to reduce the risk of High-alert, High-risk medications

Medication name	Strategies to reduce the risk of High-Alert, High-Risk Medications
Controlled drug substances/opioids	• Limit floor stock of parenteral CDS/opioids • Inventory CDS in patient care areas during each shift change
Fentanyl patches	• All Fentanyl patches are to be removed, folded together and placed in a Drug Buster container upon all instances of patch removal including: o Order discontinuation o Dosage change o Patient death

	○ 72 hours after patch placement
Heparin intended for intravenous administration	• Limit the strengths of injectable heparin in the hospital Drug Room • Add premix IV heparin to the hospital Drug Room formulary • Bolus doses of IV heparin more than 5000 units are prohibited • Heparin vials should not be stored in close proximity with insulin vials
Hypertonic IV solutions	• Do not stock hypertonic IV solutions in patient care areas • Limit access to hypertonic IV solutions
Insulin formulations	• Avoid use of the abbreviation U for units, and instead write out units • Insulin vials should not be stored in close proximity with heparin vials
Potassium chloride inj.	• Utilize pre-mixed potassium chloride IV bags as much as possible • Include infusion rate instructions
Promethazine inj.	• Promethazine injection will be restricted to IM and IV infusion only • IV infusions will be Promethazine 25mg in 50mL of 0.9% Normal Saline at no faster than 200mL/hr

Table 3: High-Alert, High-Risk medications that require an independent double check

1. All insulin formulations
2. Hypertonic IV solutions
3. IV heparin
4. Medication orders intended for pediatric patients
5. Total parenteral nutrition

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
IV Drips and Titration Parameters		**DRM-060**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

The purpose of this policy is to develop a framework for the ordering, initiation and titration of vasoactive and sedative Intravenous (IV) medications administered as IV continuous drips.

DEFINITION

Vasoactive medication: has the effect of either increasing or decreasing blood pressure and/or heart rate through its vasoactivity (i.e. affects blood vessels).

Titration parameters: process of determining the optimal dose of a medication that reduces a patient's symptoms effectively while avoiding as many side effect(s) as possible associated with a medication.

POLICY

Vasoactive and sedative medications administered as a continuous IV infusions play a vital role in supporting critical care patients and prompt titration of these agents is essential. The rate and frequency of dose titration is dependent upon the patient's individual hemodynamic parameters and response to therapy. Prompt titration is best accomplished by the bedside nurse with continuous monitoring to parameters specified in medication orders by the ordering provider.

PROCEDURE

1. The on-duty provider shall enter an order for a vasoactive or sedative IV continuous drip with an initial starting dose, titration parameters, and targeted goal of medication therapy.
    a. The rate and frequency of dose titration is dependent upon the patient's hemodynamic parameters, clinical status, and response to treatment.

   b. Rate and dose titrations shall be guided by the "Titration Dose Increment" and "Rate of Titration's columns of Table 1.
2. The patient's nurse will document each dose increase or decrease in the patient's medical record.
   a. Vital signs will be monitored at least hourly for patient(s) on any vasoactive or sedative IV continuous drip.
   b. Vital signs will be monitored and documented within 15 minutes after each rate change while on a continuous IV infusion.
      i. If the patient requires frequent or emergent dose titration, the patient will have continuous or cycled monitoring of vital signs.
      ii. Vital signs and rate will then be documented at least every 15 minutes until vital signs are stable.
3. If the dose of any vasoactive or sedative medication reaches the maximum ordered dose as defined in Table 1, the on-duty provider must be notified. He or she should consider additional medication(s) or order a trial dose escalation.
4. When additional IV drips are ordered subsequent to the initial vasoactive or sedative medication, the following titration will occur:
   a. The initial medication(s) will remain at the current rate
   b. Subsequent vasoactive or sedative medication(s), except vasopressin, will be titrated up according to the "Titration Dose Increment" and "Rate of Titration" columns of Table 1
   c. If vasopressin is ordered by the on-duty provider, it will be initiated at the "Typical Starting Dose" listed in Table 1 or per the provider's order, and the dose will not be titrated up without an order by the on-duty provider
5. Initiation of weaning the vasoactive medication(s) to off occurs after the patient maintains their blood pressure at goal for 1-2 hours or as directed after other therapies are begun.
   a. Vasoactive and sedative infusions will be titrated off in the reverse order as they were started unless directed by the on-duty provider.
   b. Vasoactive and sedative infusions will be weaned off as indicated in the "Titration Dose Increment" and "Rate of Titration" columns of Table 1 based on reverse order of initiation.

REFERENCES

Overgaard CB, Dzavik V. Inotropes and vasopressors: review of physiology and clinical use in cardiovascular disease. *Circulation*. 2008;118:1047-1056.

Ellender TJ, Skinner JC. The use of vasopressors and inotropes in the emergency medical treatment of shock. *Emerg Med Clin North Am*. 2008;26:759-786, ix.

ATTACHMENTS

Table 1: Vasoactive and Sedative Medication Titration Table
Attachment A: Dosing Instructions for Vasoactive and Sedative Medications

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Table 1: Vasoactive and Sedative Medication Titration Table

Medication	Typical Starting Dose	Titration Dose Increment	Rate of Titration	Targeted Goal of Therapy	Max Ordered Dose: Notify Provider if reached
Dexmedetomidine	0.2 mcg/kg/hr	0.1 mcg/kg/hr	30 minutes	RASS 0 to -2	1.5 mcg/kg/hr
Diltiazem	5 mg/hr	2.5 mg/hr	30 minutes	HR < 120	15 mg/hr
Dobutamine	2 mcg/kg/min	2.5 mcg/kg/min	15 minutes	MAP > 65 or SBP > 90	15 mcg/kg/min
Dopamine	5 mcg/kg/min	5 mcg/kg/min	15 minutes	MAP > 65 or SBP > 90	20 mcg/kg/min
Epinephrine	0.05 mcg/kg/min	0.05 mcg/kg/min	15 minutes	MAP > 65 or SBP > 90	2 mcg/kg/min
Fentanyl	25 mcg/hr	12.5 mcg/hr	15 minutes	Pain at ___ or less per FLACC scale	150 mcg/hr
Labetalol	10 mg/hr	10 mg/hr	15 minutes	SBP < 140 mmHg	120 mg/hr
Lidocaine	1 mg/min	1 mg/min	15 minutes	Stabilization of cardiac arrhythmia	4 mg/min
Midazolam	3 mg/hr	1 mg/hr	15 minutes	RASS 0 to -2	10 mg/hr
Nicardipine	5 mg/hr	2.5 mg/hr	15 minutes	SBP < 140 mmHg	15 mg/hr
Nitroglycerin (mcg/min)	10 mcg/min	10 mcg/min	15 minutes	SBP < 140 mmHg	200 mcg/min
Nitroglycerin (mcg/kg/min)	0.2 mcg/kg/min	0.5 mcg/kg/min	15 minutes	SBP < 140 mmHg	3 mcg/kg/min
Norepinephrine (mcg/min)	0.5 mcg/min	1 mcg/min	15 minutes	MAP > 65 or SBP > 90	12 mcg/kg/min
Norepinephrine (mcg/kg/min)	0.1 mcg/kg/min	0.1 mcg/kg/min	15 minutes	MAP > 65 or SBP > 90	2 mcg/kg/min
Phenylephrine	0.25 mcg/kg/min	0.25 mcg/kg/min	15 minutes	MAP > 65 or SBP > 90	5 mcg/kg/min
Propofol	5 mcg/kg/min	5 mcg/kg/min	5 minutes	RASS 0 to -2	50 mcg/kg/min
Vasopressin	0.04 units/min	Do not titrate; Wean off by 0.01 units/min	For weaning: 30 minutes	MAP > 65 or SBP > 90	N/A

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
IV Admixture and IV Admixture Prep Area		**DRM-036**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to designate an area for the preparation of intravenous (IV) medications in order to minimize the likelihood of disease transmission and/or IV admixture contamination.

DEFINITIONS

Immediate use IV preparation: the preparation and dispensing of compounded sterile products (CSPs) without the need to be in compliance with USP <797> requirements such as an ISO Class 5 hood or isolator, facility design, environmental controls, personnel cleansing and garbing.

POLICY

The hospital facility shall have a designated area for preparing IV admixtures. This area will be kept clean and free of potential contamination and will be located in the nursing medication room.

PROCEDURE

1. The designated IV admixture prep area is located in the nursing medication room.
2. Eating and drinking are not permitted in the IV admixture preparation area.
3. The IV admixture prep area shall be labeled as a clean area.
    a. The clean area is to be cleaned with 70% Isopropyl alcohol disposable wipes (e.g., Sani® cloth wipes) or bleach.
        i. The IV prep area should be cleaned at least daily AND
        ii. Before and after each use

4. Review the medication order and documented patient allergies prior to preparing an IV admixture.
5. Reconstitute and/or dilute a medication as indicated from a drug library medication reference or a medication packaging insert utilizing aseptic technique.
    a. Use the metric system for medication calculations if necessary
    b. Have another licensed personnel check your medication calculations prior to administering to patient.
6. All IV medications shall be prepared in the designated IV admixture prep area utilizing aseptic technique.
    a. Orienting nursing personnel are to be supervised by a licensed nurse trained in aseptic technique to assure adherence to proper procedures and technique.
    b. Medications shall be visually inspected for any signs of deterioration or contamination during IV admixture preparation.
7. IV admixtures prepared shall be intended for immediate use only.
    a. This process involves the simple transfer of no more than 3 commercially available products and not more than 2 entries into any other container/medication intended for IV use.
    b. Unless required for preparation as outlined in the packaged insert for a specific medication, IV admixture preparation for a medication should not last more than one hour.
8. All IV admixture preparations shall have proper labeling indicating:
    a. Patient identification information (e.g, patient name, medical record number)
    b. Name of the medication
    c. Dose/amount of medication added
    d. Date and time of IV admixture preparation
    e. Date and time of IV admixture expiration
    f. Initials of the licensed nurse responsible for the IV preparation
    g. The only exception to labeling requirements is if the licensed nurse responsible for the IV preparation is the same nurse who administers the IV preparation to a patient.
9. Nursing personnel shall have reference(s) available to check for the compatibility of IV admixtures prior to administration.
10. If administration is not started within the one hour following the start of IV admixture preparation, the medication admixture should be discarded.
11. All licensed nursing personnel shall complete annual training on IV admixture preparation and on the IV admixture prep area.

REFERENCES

Oklahoma Pharmacy Law Book

https://www.usp.org/compounding/general-chapter-797

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Iodine Allergy and IV Contrast Pre-treatment Protocol		**DRM-058**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.acr.org/**	

SCOPE

This protocol applies to adult patients that require treatment for an Iodine Allergy prior to IV contrast administration.

PROCEDURE

- Prednisone 50mg PO Once (Administer 13 hours prior to scan)
- Prednisone 50mg PO Once (Administer 7 hours prior to scan)
- Prednisone 50mg PO Once (Administer 1 hour prior to scan)
- Diphenhydramine 50mg PO Once (Administer 1 hour prior to scan)
- Diphenhydramine 50mg IV Once (Administer 1 hour prior to scan)
- Hydrocortisone 200mg IV Once (Administer 1 hour prior to scan)
- Methylprednisolone 40mg IV Once (Administer 1 hour prior to scan)

REFERENCES

https://www.acr.org/

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
IV Fluid Changes		**DRM-034**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to intravenous (IV) fluid bag changes at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to enhance patient safety by defining when IV fluid bag changes should be completed at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

IV fluids and tubing will be changed regularly in accordance with the hospital facilities Infection Control Policy.

PROCEDURE

1. All bags of IV fluids will be changed and labeled every 24 hours.
2. All IV fluids with additive medications will be changed every 12 hours.
3. IV tubing will be labeled with the date and time it was hung and the date and time of expiration which is every 72 hours. All labels will be initialed by the nurse performing the procedure.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
IV Fluid Outer Wrapper Outdating		**DRM-035**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to enhance patient safety by defining when IV fluid bags outdate at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

The outer plastic wrappers of IV bags should not be removed until immediately prior to their use or preparation. If the outer plastic wrapper of an IV bag is removed prior to use, then the IV bag must have a beyond use date.

PROCEDURE

1. If the outer wrapper(s) is removed, beyond use dating should be added to the IV bag (e.g., place an outdate/expiration sticker on the IV bag) based on the following out-dating requirements per the Manufacturer:
    a. Baxter (100ml or less) no longer than 15 days
    b. Baxter (More than 100ml) no longer than 30 days
    c. ICU Medical (Hospira) : Less than 50ml 21days
    d. ICU Medical (Hospira) : Greater than 50ml 30 days
    e. B.Braun (up to 1000ml) : 30 days

2. For IV bags that outdate, the IV bags will be disposed per guidelines defined in the Destruction of Drugs Policy.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Licensure		**DRM-040**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define the licensure requirements in order to keep a hospital Drug Room in good standing with all state and federal entities.

POLICY

The hospital facility will keep current all licenses required by state and federal entities for a hospital drug room.

PROCEDURE

1. The hospital Drug Room license with the Oklahoma State Board of Pharmacy will be renewed every year.
2. The Oklahoma Bureau of Narcotics and Dangerous Drugs Control license will be renewed every 3 years.
3. The Drug Enforcement Administration license will be renewed every 3 years via DEA Form 224a.

REFERENCES

Oklahoma Pharmacy Law Book

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Loan/Borrowed Medications		**DRM-019**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to loaned/borrowed medications intended for patient use at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The hospital drug room will adhere to loaned/borrowed medication regulations outlined by the Oklahoma State Board of Pharmacy and the Food and Drug Administration (FDA).

DEFINITIONS

N/A

POLICY

Any medications loaned or borrowed through the hospital facility or another medical facility shall be recorded and documented properly.

PROCEDURE

1. A loan/borrowed record shall be completed and filed properly.
2. The Drug Room Supervisor shall be responsible for these items.
3. All medications borrowed or loaned will be returned to the lender upon arrival of the replacement medication.
4. If medication is being purchased to replace a loaned medication, advise the business office to expect a bill for the medication unless it is being replaced.
5. All medications borrowed or loaned will be documented as follows:
   a. Name of Institution
   b. Date
   c. Description of the medication (e.g., drug name and strength)
   d. Quantity

e. Lot number
f. Expiration Date
g. Signatures of persons involved

6. All documentation shall be kept on file in the hospital drug room.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Medical Staff-Pharmacist Collaborative Practices		**DRM-055**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to identify, develop, and implement collaborative practices between medical providers and pharmacists at MANGUM REGIONAL MEDICAL CENTER. Aspects of patient care subject to collaborative practices include laboratory monitoring, medication therapeutic drug level monitoring, and streamlining of antimicrobials based on culture results.

DEFINITIONS

N/A

POLICY

Medical Staff-Pharmacist collaborative practices are intended to optimize medication therapy and pro-actively managed medication dosing based on medication package insert dosing guidelines.

PROCEDURE

Pharmacist(s) may enter laboratory orders and medication orders for patients per “Protocol” (or “Physician Protocol” or “Other” order source as allowed in an electronic health record). A medical provider will sign-off/acknowledge on all orders entered by a pharmacist in a timely manner. Refer to Table 1 and Table for details.

Table 1: Laboratory Orders

Laboratory Order	Reason for Ordering
Vancomycin trough, random levels; Aminoglycoside peak, trough levels	To monitor therapeutic dosing range of select antimicrobials
PT/INR	To monitor Warfarin dosing
Phenytoin, Valproic acid, Oxcarbazepine	To monitor effectiveness of anti-seizure and mood stabilizing medication dosing
Digoxin	To monitor Digoxin dosing
CBC, CMP, BMP, Renal Panel, Magnesium, Phosphorus, Lipid Panel, Total Creatine Kinase	To monitor trends in blood chemistries than can be affected by medications (e.g., medications that require renal dosing adjustments)

Table 2: Pharmacist Renal Dosed Medications

Medication	**>60mL/min**	**60-30mL/min**	**30-10mL/min**	**<10mL/min (HD)**
Acyclovir IV	5-10mg/kg q8H	5-10mg/kg q8H	5-10mg/kg q24H	2.5-5mg/kg q24H
Ampicillin/ Sulbactam	3g q6H	3q q8H	1.5g q 6H	1.5g q12H
Ampicillin IV	1-2g q4-6H	1-2g q6H	1-2g q 8H	1-2g q 12H
Aztreonam	2g q 6-8H	2g q8H	1g q12H	500mg q12H
Cefazolin	1g q8H	1g q8H	1g q12H	500mg-1g q24H
Cefepime	1-2g q8H	1-2g q12-24H	1-2g q24H	500mg-1g q24H
Ceftazidime	1-2g q8H	1g q8H	1g q12H	500mg-1g q24H
Cipro IV	400mg q8H	400mg q12H	200-400mg Q24H	
Cipro PO	500mg-750mg q12H	500mg q12H	250-500mg q24H	
Daptomycin	4mg/kg q24H	4mg/kg q 24H	4mg/kg q48H	
Empagliflozin	Limit use if CrCl < 45 mL/min		Contraindicated	
Enoxaparin (DVT ppx)	40mg q24H	40mgq24H	30mg q24H	
Enoxaparin (DVT & PE)	1mg/kg q12H	1mg/kg q1H	1mg/kg q24H	
Ertapenem	1g q24H	1g q24H	500mg q 24H	
Famotidine	20mg q12H	20mg q24H	20mg q24H	20mg q48H
Fluconazole IV/PO	200mg-800mg q24H	200mg-400mg q24H	100mg-200mg q24H	

Levofloxacin IV/PO	500mg-750mg q24H	500mg q24H	500mg q48H	500-750mg x1, 250mg q48H
Levetiracetam	500mg-1000mg q12H	250mg-1000mg q12H	250mg-500mg q12H	500-1000mg q24H
Meropenem	500mg q6H	500mg q8H	500mg q12H	500mg q24H
Metoclopramide IV/PO	10mg q6H	10mg q8H	5mg-10mg q 12H	
Metronidazole IV/PO	500mg q8H	500mg q8H	500mg q8H	250mg q8H
Nafcillin	1-2g q4H	No adjustment necessary		
Penicillin G	2-4 MU q4H	1-3 MU q4H	0.5-2 MU q4H	0.5-2 MU q6H
Piperacillin/ Tazobactam	3.375-4.5g q6H	3.375g q6H	2.25g q6H	2.25g q8H
Rivaroxaban (for A. fib)	15mg with supper	15mg with supper	Avoid use	
Sitagliptin	100mg daily	50mg daily	25mg daily	25mg daily
Vancomycin	15mg/kg q12H	Consult with Pharmacist		

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Medication Administration		**DRM-033**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define strategies to enhance patient safety and optimize medication administration at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

Nursing personnel shall use the 5 rights of medication administration. Additional procedures and guidance on medication administration shall be set forth under the guidance of the hospital Drug Room Pharmacist in Charge and the Chief Clinical Officer.

PROCEDURE

1. A medication order is entered in a patient's medical chart electronically or on paper.
2. The patient's nurse will ensure that the medication order(s) are entered correctly, and confirm that the patient does not have any allergies to the medication(s) ordered.
    a. The patient's nurse will request the medication(s) from the Drug Room Supervisor if the medication order requested is not stored in the ADM.
3. The nurse administering the medication(s) will utilize the 5 rights of medication administration:
    a. Confirm the patient's name
    b. Confirm the medication name
    c. Confirm the medication dose

   d. Confirm the medication strength
   e. Confirm the route of administration
   f. Confirm the date/time of administration compared to the medical provider medication order
4. The nurse will take the medication(s) in its original packaging to the patient's bedside.
5. The nurse will ask the patient their name and date of birth to verify the correct patient.
6. When barcode scanning is available, the nurse will then scan the patient's armband and the medication barcode to further verify that the right patient and medication has been selected.
7. The nurse can then administer the medication to the patient.
8. If an error occurs during this process, the nurse must stop and review the medication order to make sure the appropriate medication is being given. If the error cannot be found. The nurse must verify with another licensed nurse that the correct medication is being given.
9. Nursing personnel are to notify the Drug Room Supervisor in a timely manner of any errors with scanning medications.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Look-Alike, Sound-Alike Policy		**DRM-044**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish and maintain a list of Look-Alike, Sound-Alike (LA/SA) medications that are stored, dispensed, or administered throughout the hospital in an effort to prevent medication errors involving the interchange of these medications.

DEFINITIONS

Look-Alike, Sound-Alike medications: medications with similar names, drug strengths, or packaging that medical professionals should be aware to reduce the risk of medication errors.

POLICY

The hospital Drug Room, in conjunction with the nursing department and the medical staff, shall develop and review a list of Look-Alike, Sound-Alike medications on an annual basis that are used throughout the hospital.

PROCEDURE

1. Medication errors involving Look-Alike, Sound-Alike medications will be reviewed on a routine basis to assess for the likely of patient harm from such errors.
2. The hospital will establish and review annually a list of highest risk Look-Alike, Sound-Alike pairs (See Table A for details).
3. The highest risk pairs list will be distributed to medical staff and posted in the medication room on an annual basis.

4. Strategies to reduce medication errors involving Look-Alike, Sound-Alike medications include the use of Tall-man lettering, labeling of LA/SA medications stored in the hospital drug room, and identification of LA/SA medications in the electronic health record.

REFERENCES

Institute for Safe Medication Practices

ATTACHMENTS

Table A: Look-Alike, Sound-Alike Highest Priority Medication Pairs

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Table A: Look-Alike, Sound-Alike Highest Priority Medication Pairs

MASTER LIST		CONFUSION
Activase®	TNKase®	Name
ALPRAzolam	LORazepam	Name/dose
Benadryl®	Benazepril	Name
buPROPion	busPIRone	Name
captorpil	Carvedilol	Name/dose
Cardura®	Coumadin®	Name/dose
ceFAZolin	cefTRIAXone	Name/dose
Cetirizine	Sertraline	Name
clonazePAM	cloNIDine	Name
clonazePAM	LORazepam	Name/dose
Colace®	Cozaar®	Name/dose
Depo-Medorl®	Solu-MEDROL®	Name/dose
Desyrel®	SEROquel®	Name/dose
DOBUTamine	DOPamine	Name/packaging
Flumazenil	Influenza virus vaccine	Name
FLUoxetine	PARoxetine	Name/dose
glipiZIDE	glyBURIDE	Name/dose
HYDROcodone	OXYcodone	Name/dose
HydrOXYzine	hydrALAZINE	Name/dose
Keppra®	Keflex®	Name/dose
klonoPIN®	cloNIDine	Name
Lipitor®	zyrTEC®	Name
Lithium	Ultram	Name
metFORMIN	metroNIDAZOLE	Name/dose
Motrin®	Neurontin®	Name/dose
Mucinx®	Mucomyst®	Name/dose
Nalbuphine	Naloxone	Name
Plavix®	Paxil®	Name
PrednisoLONE	PredniSONE	Name/dose
PriLOSEC®	PROzac®	Name/dose
Protonix®	Protamine	Name

RisperDAL	Restoril	Name
risperiDONE	roPINIRole	Name/dose
Solu-Cortef®	Solu-MEDROL®	Name
Tetanus diphtheria toxoid	Tuberculin purified protein derivative	Name
Toprol-XL®	Topamax®	Name/dose
traMADol	traZODone	Name/dose
Xanax®	Zantac®	Name
Zocor®	Cozaar®	Name

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Medication Pricing Formula – OTC Items		**DRM-052**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to address OTC medication pricing. OTC medications are not covered under Medicare Part B benefits. CMS does not define the pricing (i.e. billing) formula for OTC medications administered at a medical facility intended for in-patient use.

DEFINITIONS

Over-the-counter (OTC) medication: A medication that can be purchased without a prescription

POLICY

See procedure.

PROCEDURE

Mangum Regional Medical Center will charge patient accounts $1.00 for every OTC medication ordered and administered to patients at the hospital.

REFERENCES

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Mission Statement		**DRM-001**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

MISSION STATEMENT

Mission of Mangum Regional Medical Center is to provide the highest level of healthcare possible at our facility.

We pledge to recognize the healthcare needs of our community and surrounding area and provide cost-effective services necessary to enhance the quality of life.

Understanding the constant and dramatic change in the healthcare industry, we strive to achieve excellence and continue our support of the community we love.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Medication Variance Reporting		**DRM-027**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

To provide a non-punitive reporting and feedback system to track medication variances at MANGUM REGIONAL MEDICAL CENTER. The hospital will use this data to monitor the effectiveness and safety of services, analyze the causes of adverse patient events, and implement actions and mechanisms to prevent the recurrence of medication variances.

DEFINITIONS

Medication variance: Any situation involving medication(s) that can potentially lead to inappropriate medication use, patient harm, or an adverse medication reaction.

Significant incident: Is defined as any incident that is unexpected or has an unexpected outcome.

POLICY

All medication variances associated with the hospital, personnel, patients, or the public will be documented and reported to the Pharmacist in Charge (PIC), Chief Clinical Officer (CCO), and the Director of Quality Management (DQM). The PIC, in collaboration with other hospital leaders, shall be responsible for ensuring appropriate review, response, and actions are taken for all medication variances.

PROCEDURE

REPORTING PATIENT SAFETY EVENTS OR OTHER INCIDENTS

1. Mangum Regional Medical Center will foster and support a culture of safety. They will be dedicated to patient safety through the promotion of voluntary reporting by the staff, providers, patients, and visitors.
2. The hospital will utilize four key components to ensure an effective event reporting system:
    a. Maintain a supportive environment for event reporting that protects privacy of staff who report incidents
    b. Reports will be received from a broad range of personnel
    c. Summaries of reported events must be disseminated in a timely fashion
    d. A structured mechanism must be in place for reviewing reports and developing action plans
3. Mangum Regional Medical Center utilizes an Incident Reporting System to report patient safety events. A Medication Variance Report form is readily available to hospital personnel for reporting medication variances.
    a. Each form will be completed by the staff member or individual discovering the event as soon as possible and no later than the end of the person's shift.
    b. Upon discovery of a patient safety event, the immediate supervisor or person in charge must be notified of the event.
    c. The form must be completed as soon as possible or by the end of the working day on the day of the incident.
    d. Failure to complete an incident report in a timely manner may result in coaching/education or corrective action.
    e. If assistance is needed in completing the Incident Form, the House Supervisor, Quality/Risk Manager, or department manager may be consulted for completion of the form.
4. There shall be no retaliation to staff, providers, patients, or visitors for reporting medication variances at MANGUM REGIONAL MEDICAL CENTER.
5. All medication variance reports will be reviewed by the CCO and PIC prior to submission to the DQM.
6. Serious adverse events that result in patient harm will be reported to the CCO and DQM as soon as possible by the staff member discovering the incident or adverse event.
7. All HIPAA related incidents will be directed to and investigated by the HIPAA Officer or designee.
8. Neither the medication variance, nor the circumstances surrounding the incident, are to be discussed with or in the presence of patients, outside agencies, or individuals without need to know.
9. Medication Variance Reports will be logged and stored in the office of the DQM. They are not to be filed or referred to in the patient's medical record or used in lieu of charting.
10. Each medication variance involving a patient will be documented in the medical record at the time it occurred or was discovered. Documentation will include a factual description of the incident, nursing interventions, name, date, and time medical provider was notified.
11. For a medication variance concerning an employee injury, an Employee Incident Report must be completed by the Employee Health Nurse and Department Manager.

PROCEDURE FOR COMPLETION OF INCIDENT REPORT

1. Form must be completed in full.
2. Specify all parties involved, date, time, location, and the nature of the incident.
3. Record all known details of the incident facts in an objective and legible manner.
4. Record name of medical provider and date and time of medical provider notification.
5. List the individual(s) involved in the incident and any witnesses.
6. Signature and date of person preparing report.
7. PIC and CCO will review the report for accuracy, completeness, objectivity, and severity. The report may be forwarded to the appropriate Department Manager for review and/or investigation.
8. The CCO will review the completed incident report and determine if any corrective action taken is warranted.
9. Medication Variance Reports will be discussed at Pharmacy and Therapeutics AND Med Staff Committee meetings for educational purposes only.

LEADERSHIP INVESTIGATION OF INCIDENTS

1. If a medication error or event is deemed as a Sentinel Event Incident:
   a. The PIC, CCO, and the DQM shall be notified upon identification that Sentinel Event has occurred.
   b. The PIC, CCO, and DQM will conduct a thorough Root Cause Analysis (RCA) and investigation of the event.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

Medication Variance Report

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Narcotic Waste Management – Cactus Sink®		**DRM-059**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

PURPOSE

To provide guidelines for the proper disposal of CDS waste based upon federal, state and facility restrictions and recommendations.

PROCEDURE

Documentation

- Unusable controlled substances removed from the ADS shall be properly wasted with a nurse witness if no longer intact or in the original sealed container. If all or part of a controlled substance is to be wasted, an electronic record should be kept. Two nurses are required for wasting all controlled substances. All medications dispensed under a certain patient must be wasted under the patient for whom the medication(s) were originally removed.
- The documentation of the wastage should be completed at the time the controlled substance is wasted. If not, after the controlled substance is administered to the patient, waste the unused portion to document the amount not administered.
- All unusable controlled substances shall be wasted in the Cactus Smart Sink® System with a nurse witness present.

Wastage

- The Cactus Smart Sink System will be used for waste of non-hazardous controlled-substances that are in solid, liquid or patch forms. It is NOT for syringes, needles, vials, ampules, gloves, packaging or trash of any kind.
- Return refused (but reusable) drugs to the ADS
- Isolate defective or questionable drugs and contact the drug room so that drug room personnel can pick them up.
- Dispose of glass containers and syringes in the Red Biohazard Sharp’s container.
- The medication contents of a full or partially empty ampule, vial or bottle will be wasted in the Cactus Smart Sink System

For Disposing into the Cactus Smart Sink System:

- Solids: Place solid pharmaceutical waste in the solids only one-way pill maze.
- Patches: Fold patches in half so the sticky side is in. Once in half, place in the patch slot and use the patch plunger to push the patch completely down.
- Liquid: Administer liquids pharmaceutical waste into the liquid only funnel
- Place ALL used or unused syringes WITH OR WITHOUT needles into the Red Biohazard Sharp's container.

Waste Removal:

Removal of the Cactus Smart Sink System canisters by drug room personnel may occur when the red alert lights come on signifying that the canister associated with that light is 95% full. If the canisters are not full, they should also be proactively removed after 180 days of use.

Management of Outdated Drugs:

A reverse distributor or waste management company, approved by the DEA, shall be contacted for return of drugs or destruction of drugs identified to be toxic to the environment.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Pass/Leave of Absence Medications		**DRM-032**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the use of Pass/Leave of Absence medications at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define a process for the authorization and dispensing of Pass/Leave of absence medications for Swing Bed patients at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

The Drug Room shall not routinely allow Pass/Leave of Absence medications to be sent with patients during Leave of Absence.

PROCEDURE

If an exception is made to this policy, then the following procedures must be observed.

1. Pass/Leave of absence medications require an order from an authorized prescribing practitioner and should be recorded in a patient's medical record.
2. The patient should not receive more medication than is prescribed during the timeframe the patient is out of the facility.
3. Medications must be labeled for outpatient use as per the Oklahoma State Board of Pharmacy labeling requirements. The medication label must include:
   a. Name, address and phone number of the medical facility
   b. Date
   c. Name of the patient

d. Drug name, strength, dosage form, and quantity of drug dispensed
e. Directions for patient use
f. Name of prescribing practitioner
g. Name and initials of individual preparing the medication
h. Pertinent cautionary labels as applicable
i. Beyond Use Date

4. Dispensing containers for these medications shall meet specifications of the Oklahoma State Board of Pharmacy and the Food and Drug Administration.
5. The patient's medical record should indicate the amount of Pass medication(s) that were sent with the patient.
6. Upon return to the medical facility, unused drugs (if any) should be returned to the hospital drug room and disposed of as unusable drugs. See Medication Destruction Policy for details.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Patient Home Medications		**DRM-031**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define the scope of patient home medication use at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

Whenever a patient's home medication(s) are brought into the hospital facility, such medications shall not be administered unless they can be appropriately identified and a medical provider has specifically indicated in a patients chart that the patient home medication(s) can be administered.

PROCEDURE

1. If a patient brings his or her own home medication(s) with them to the hospital, home medication(s) will be reviewed as follows:
    a. If the patient is admitted for observation, is in the medical facility for an outpatient visit, or an order for patient home medications has been written by a medical provider; then patient home medication(s) can be administered.
        i. The patient's nurse will use a pill identifier resource to verify that the patient's home medication is indeed what is stated on the medication label and that the medication is not outdated before the medication is administered to the patient.

ii. For a patient to self-administer their own medication(s), there must be an order to do so from a medical provider.
iii. Patient home medications will be kept in the ADM or in the Drug Room in a secured area.
iv. If a patient home medication supply runs out during hospitalization, the patient and/or the patient's family is responsible for obtaining an additional supply of the medication.

b. If the patient is admitted for acute care or swing bed care, home medications should not be ordered for patient use.
    i. The patient home medication(s) should be sent home with a family member or caregiver.
    ii. If a family member or caregiver cannot readily remove a patient's home medication supply from the hospital, the patient's home medication(s) will be counted by two nurses.
        1. The medication name and quantity of each home medication will be documented in the Patients Own Medication Verification/Consent Log.
        2. The medications will be secured in the hospital's nursing med room and given back to the patient upon discharge from the hospital.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

Patients Own Medication Verification/Consent Log

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Outdates		**DRM-021**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a process for removing outdated expired medications from patient care areas at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

The Drug Room Supervisor (DRS) will remove all outdated (i.e. expired) medications from drug room stock and patient care areas on a monthly basis.

PROCEDURE

1. The DRS will complete monthly visual inspections for outdates of all medications in the drug room and other areas of the hospital facility. These areas include:
    a. Drug Room
    b. IVF room
    c. Medication Cart
    d. Night Cabinet
    e. CT emergency box
    f. Emergency Room
    g. Crash Carts (adult/pediatrics)
    h. Clinic/Clinic Emergency Kit

2. All non-scheduled, outdated, mislabeled or unusable drugs and biologicals shall be removed from patient care areas and stored in a secured area.
3. All controlled, outdated drugs will be stored in a designated area of the controlled drug cabinet in the hospital Drug Room.
4. The DRS will ensure that all outdated, unusable medications are returned for credit to a reverse distributor for processing within 6 months of outdating.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Pharmacist in Charge		**DRM-004**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to Mangum Regional Medical Center's Hospital Pharmacist in Charge credentials and expectations.

PURPOSE

To define who is responsible for meeting the standards for the Pharmacist in Charge of the hospital drug room that is consistent with Oklahoma State Board of Pharmacy Standards.

DEFINITIONS

Pharmacist-in-Charge or PIC: An Oklahoma licensed pharmacist director or consultant of the hospital drug room, either employed or a contract employee.

POLICY

The PIC shall be assisted by a sufficient number of additional pharmacists (D.Ph.s) to operate the drug room competently, safely and adequately to meet the needs of the patients of the hospital facility. The hospital drug room shall have oversight by a PIC who shall be responsible for certifying that the drug room meets the requirements of the Oklahoma Pharmacy Act.

PROCEDURE

1. The PIC shall be responsible for drug purchasing, acquisition, preparation, distribution, monitoring, security, storage and control.
2. The hospital drug room and PIC shall establish written procedures for the safe and efficient acquisition, distribution, and utilization of all medicine products.
3. The hospital drug room and PIC shall have responsibility for establishing policies for the security and integrity of any patient information, confidential and non-confidential, and must abide by all relevant State and Federal regulations applicable to the hospital system.
4. The hospital drug room and PIC shall develop and maintain a program to monitor the actual and potential adverse drug events including pharmacist interventions, medication errors, and

adverse drug reactions for all medications utilized in the hospital to include system wide programs if an integrated system is involved. Records indicating the tracking, review, and outcome of the Adverse Drug Events shall be kept current and available for Board inspection.

5. The PIC shall establish a policy for investigational drug use.
6. The PIC shall cause medication orders to be reviewed by a pharmacist in a timely manner.
7. The hospital drug room and PIC shall document a minimum of 52 routine in-house visits per year to be made to a hospital with a drug room as required by health department rule OAC 310:667-21-2(a) et seq.
8. The PIC shall be a participating member in the Pharmacy and Therapeutics Committee.
9. The hospital drug room and PIC shall establish and maintain effective controls against the diversion of prescription drugs.
10. The PIC shall adhere to all rules and regulations set forth by the Oklahoma Pharmacy Act concerning Hospital Drug Rooms

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Pharmacy and Therapeutics Committee		**DRM-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to MANGUM REGIONAL MEDICAL CENTER's Pharmacy and Therapeutics Committee, which serves in an advisory capacity to the hospital and medical staff in all matters pertaining to medication utilization.

PURPOSE

To recommend the adoption or assist in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, administration, best practices, and other matters pertinent to medications in the hospital.

To recommend or assist in the formulation of programs designed to meet the needs of the professional staff (medical providers, nurses and pharmacists) for complete knowledge on matters related to medications and medication utilization.

DEFINITIONS

Pharmacy and Therapeutics Committee (P&T): Hospital committee that focuses on matters concerning medication utilization.

POLICY

The Pharmacy and Therapeutics Committee exists as part of the hospital medical staff. This committee shall be selected under the guidance of the medical staff, and it shall also be a policy and procedure recommending body to the medical staff and administration of the hospital on all matters related to the use of medications.

PROCEDURE

Organization:

1. Composition: Membership will include the PIC, CCO, and CEO, Drug Room Supervisor, Infection Control representative, and medical staff.
2. Officers: The medical director will be P&T chairman.
3. Meetings will be held quarterly and will be documented with meeting minutes.
4. Minutes will be included in medical staff records as a permanent record.

Function:

1. Serve as an advisory group on matters pertaining to the selection of medications used in the hospital.
2. Develop and review a hospital formulary on annual basis.
3. Make recommendations concerning medications to be stocked on the nursing floor and other service areas.
4. Evaluate data on any new medications and devices for hospital use.
5. Establish safe standards for use and control of investigational drugs if applicable.
6. Establish suitable educational plan for staff on matters concerning medications and their use.
7. Recommend specifications for quality, quantity, administration and storage of medications.
8. Establish a policy for the control of dangerous drugs (i.e. controlled drugs) by means of automatic stop orders.
9. Establish policies for the safe use and administration of medications.
10. Review medication errors and adverse reactions and advise if any further action is to be taken. PIC is responsible for reporting to the FDA or other agencies if advised by the committee.
11. Monitor the use of antibiotics in the presence of infection, and the prevention of infection through an antibiotic stewardship program.
12. Provide information to medical staff on relative cost of equivalent or generic medications when appropriate.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Physical Drug Room Requirements		**DRM-010**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the physical requirements of MANGUM REGIONAL MEDICAL CENTER's Hospital Drug Room.

PURPOSE

The hospital drug room will adhere to physical requirements set forth by the Oklahoma Pharmacy Act.

DEFINITIONS

Hospital drug room: a secured room where drug inventories are maintained for use in a hospital, with less than 100 licensed beds including bassinets, licensed and regulated by the Oklahoma Health Department and by the Oklahoma Pharmacy Board.

POLICY

All medications bearing a federal legend such as RX only and medications administered in hospital shall be stored in designated areas within the hospital which are sufficient to insure proper sanitation, temperature, light, ventilation, moisture control, segregation and security.

PROCEDURE

1. All areas occupied by the hospital drug room shall be capable of being locked to prevent access by unauthorized personnel.
2. Unattended areas in the absence of authorized personnel shall remain locked.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Pneumonia Protocol		**DRP-009**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.idsociety.org**	

SCOPE

This policy applies to all adult patients receiving care and treatment at Mangum Regional Medical Center.

PURPOSE

As part of Mangum Regional Medical Center's antimicrobial stewardship program, the hospital is committed to developing protocols to assist with optimizing antimicrobial therapy for patients based on current practice guidelines and antimicrobial resistance patterns in the community.

PROCEDURE

Labs:

- ABG
- CBC with differential
- CMP
- Cortisol level
- Lactic acid
- Magnesium level
- Phosphorus level
- Procalcitonin

Cultures:

- Culture Blood Culture x 2
- Culture Sputum Induced with Gram Stain
- Urinalysis
- Urine culture and sensitivity
- Legionella urinary antigen
- Streptococcal urinary antigen
- Respiratory Virus PCR Panel

Radiology and Other Procedures:
- XR Chest AP
- ECG 12 Lead Panel
- Saline Lock

ED Nursing Orders
- Oxygen administration to keep saturation greater than or equal to 95%
- Cardiac monitor
- Initiate Influenza vaccine protocol
- Initiate Pneumococcal vaccine protocol

IV Fluids
- Sodium chloride 0.9% IV to run at _____ mL/hr
- Sodium chloride 0.45% IV to run at _____ mL/hr
- Dextrose 5% - NaCl 0.45% IV to run at _____ mL/hr
- Dextrose 5% - NaCl 0.9% IV to run at _____ mL/hr

Respiratory Medications
- Albuterol 2.5mg/3mL SVN Q4H prn shortness of air or wheezing
- Ipratropium 0.5mg/2.5mL SVN Q4H prn shortness of air or wheezing
- Dexamethasone 4mg IV once
- Dexamethasone 4mg IV every 6 hours x 6 doses
- Duoneb 3mL SVN QID while awake
- Duoneb 3mL SVN Q4H prn shortness of air or wheezing
- Sodium chloride 0.9% SVN prn shortness of air or wheezing
- Pulmicort 0.5mg SVN BID
- Mucomyst 4mL SVN QID while awake
- Solumedrol 125mg IV once
- Solumedrol 125mg every 8 hours
- Prednisone 60mg PO once
- Prednisone 40mg PO daily x 3 days

Antimicrobials – Community Acquired Pneumonia
- Azithromycin 500mg IV Daily (joined order with Ceftriaxone 1gram daily)
- Ceftriaxone 1gram daily (joined order with Azithromycin 500mg IV Daily)
- Levaquin 750mg IV Daily (if CrCl greater than 50 mL/min)
- Levaquin 750mg IV times one, then Levaquin 500mg every 48 hours (if CrCl less than 50mL/min)

Antimicrobials – Hospital Acquired Pneumonia (Beta-lactam, Non Beta-lactam and Vancomycin)

- Zosyn 4.5gram IV every 6 hours (if CrCl greater than 60mL/min)
- Zosyn 3.37gram IV every 6 hours (if CrCl 30-59 mL/min)
- Zosyn 2.25gram IV every 6 hours (if CrCl 10-29 mL/min)
- Meropenem 1g IV every 8 hours (if CrCl greater than 60 mL/min)
- Meropenem 1g IV every 12 hours (if CrCl 30-59mL/min)
- Meropenem 1g IV every 24 hours (if CrCl less than 30mL/min)
- Vancomycin 1 gram every 12 hours (if CrCl greater than 60mL/min)
- Levaquin 750mg IV Daily (if CrCl greater than 50 mL/min)
- Levaquin 750mg IV times one, then Levaquin 500mg every 48 hours (if CrCl less than 5mLl/min)

REFERENCES

https://www.idsociety.org/practice-guideline/community-acquired-pneumonia-cap-in-adults/

https://www.idsociety.org/practice-guideline/hap_vap/

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Poison Control		**DRM-009**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to MANGUM REGIONAL MEDICAL CENTER's Hospital Drug Room regarding contact information for Poison Control.

PURPOSE

To provide a concise statement on the contact information for Poison Control.

DEFINITIONS

Oklahoma Center for Poison & Drug Information (OCPDI): Exists to provide information concerning the prevention and management of potential toxic exposures to the people of Oklahoma.

POLICY

Current antidote charts or information and the telephone number of a regional poison control center should be readily available in the Drug Room and/or medication preparation areas.

PROCEDURE

The National Poison Control Center can be reached at 1-800-222-1222 or text "Poison" to 797979.

REFERENCES

Oklahoma Center for Poison & Drug Information

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Probiotic Protocol		**DRM-054**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this protocol is to pro-actively replace healthy gastrointestinal tract flora with probiotic supplementation for patients prescribed broad spectrum antibiotic(s).

DEFINITIONS

N/A

POLICY

A formulary probiotic will be ordered on patients to reduce the risk of Antibiotic-associated Diarrhea/*Clostridium difficile* prophylaxis.

PROCEDURE

1. Dosing/Administration:
   a. Formulary probiotic will be ordered two capsules daily
   b. Initiate therapy within 48 hours of antibiotic being started and continue for at least 5 days after antimicrobial therapy is completed or upon patient discharge from the hospital (whichever comes first)

2. Indications for ordering probiotic (based on antimicrobial ordered)
   a. Clindamycin
   b. Broad Spectrum Penicillin
   c. Cephalosporin
   d. Fluoroquinolones

e. Carbapenems
f. Any antimicrobial ordered for the treatment of Osteomyelitis or Endocarditis

3. Contra-indications:
   a. Immunosuppression WBC equal to or less than 2

4. Other Considerations:
   a. Probiotics will not be ordered for one-time antimicrobial orders
   b. Probiotics will not be ordered for any patient under the age of 18; providers will be required to order a probiotic for this patient population.

REFERENCES

N/A

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Purchasing/Receiving Medications		**DRM-018**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the purchasing of medications for patient use at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The hospital Drug Room will adhere to medication purchasing requirements as outlined by the Oklahoma Bureau of Dangerous Drugs and Narcotics (OBN), Drug Enforcement Administration (DEA), and the Oklahoma State Board of Pharmacy.

DEFINITIONS

N/A

POLICY

The hospital drug room will maintain and make available a sufficient inventory of medicines, including antidotes and emergency medications, for patient use within the hospital facility.

PROCEDURE

When the Drug Room Supervisor is on duty:

1. The Drug Room Supervisor will be responsible for ordering medications from a pharmacy wholesaler.
2. A Purchase Order (PO) will be generated for every medication order.
3. The order must be approved by the hospital administrator, accounts payable representative, or Chief Clinical Officer prior to submitting the order for processing.
4. The Drug Room Supervisor will be responsible for receiving medications into the hospital and placing medications in the appropriate areas of the drug room and hospital.
5. The Drug Room Supervisor will date and initial each invoice and file them appropriately.

6. The Drug Room Supervisor will be responsible for communicating with Accounts Payable any issues with ordering or outstanding payments pending to the pharmacy wholesaler.

When the Drug Room Supervisor is not available to receive a medication order from the pharmacy wholesaler:

1. Authorized RN's will be instructed to place all medications received in the hospital Drug Room.
2. Any items received in blue tote(s) from the pharmacy wholesaler will be placed in the hospital Drug Room refrigerator.

When medication(s) is not available from the pharmacy wholesaler or only a small quantity of medication(s) is needed:

1. Medication(s) may be purchased from a local drug store by an authorized RN or the Drug Room Supervisor.
2. There must be an order for the medication by a medical provider.
3. The sales ticket (i.e. receipt) from a local drug store must be copied.
    a. One copy is to be filed in the hospital Drug Room.
    b. Another copy is to be submitted to Accounts Payable for payment processing.
4. Medication(s) will be labeled to ensure identification and for the purpose of removing medication(s) from inventory in the event of a drug recall.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Record Retention		**DRM-038**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define how long Hospital Drug room records must be maintained and readily retrievable.

DEFINITIONS

N/A

POLICY

The hospital Drug Room shall keep all records for a period of time for review by auditors or other hospital staff member following state and federal guidelines.

PROCEDURE

1. All Drug Enforcement Administration (DEA) forms must be retained for at least 2 years.
2. All other records, both paper and electronic records, will be retained for at least 5 years.

REFERENCES

Oklahoma Pharmacy Law Book

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Quality Program		**DRM-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The Quality Assurance and Performance Improvement (QAPI) Plan and Program is the medical facility's roadmap to achieving and providing excellent quality of care and quality of life for our patients. Quality Assurance and Performance Improvement is our top priority and guides our day to day operations and is a barometer for how we are providing care to our patients.

DEFINITIONS

Performance improvement: measuring the output of a particular business process or procedure, then modifying the process or procedure to increase the output, increase efficiency, or increase the effectiveness of the process or procedure.

POLICY

The management and governing board take an active role in assuring Quality Assurance and Performance Improvement is adequately resourced to conduct its work and that policies are established to sustain the Quality Assurance and Performance Improvement. It is a collaborative effort of all medical and clinical staff, administrative and managerial leadership, and all departments and services provided throughout the facility (including those services furnished under contract or arrangement). The QAPI Plan and Program is the central performance improvement plan in the organization and encompasses the inter-related functions and processes of clinical, governance, operational and support services.

PROCEDURE

The QAPI will apply facility-wide and to any contract provided services. It is the responsibility of every leader and every person providing and supporting care in our facility to ensure an

environment where care is safe, effective and centered on patient's needs. Leaders foster performance improvement through planning, educating, setting priorities, and providing time and resources. Leaders play a major role in creating an environment where staff feel safe and free to engage in performance improvement and understand it is their responsibility to not only report quality and safety issues and concerns, but to participate in developing solutions and to ensure the right thing gets done.

Data collection and performance monitoring may include, but not limited to the following areas:

- Patient perception of care
- Patient safety
- The effectiveness of pain management
- Medication errors and adverse drug reactions
- Blood Products; use and transfusion reactions
- Restraint Use
- Resuscitative services and outcomes
- Mortality Data
- OPO Data
- Emergency Services
- HAI
- Readmission rates

The following departments/functional areas will be responsible for data collection, analysis and interpretation of the data, action planning and evaluation of the actions taken to improve performance:

- HIM
- Human Resources
- Infection Prevention
- Drug Room
- Case Management
- Risk Management
- Nursing Services
- Respiratory Services
- Rehab Services
- Administration
- Business Office
- Environment of Care
- Environmental Services

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Remote Medication Order Processing		**DRM-037**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define who can perform the duties of remote medication order processing (RMOP) at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Remote medication order processing (RMOP): The processing of a medication order for a hospital facility by a pharmacist located in a remote medication order processing pharmacy site.

POLICY

The hospital facility will have all medication orders reviewed by the Pharmacist in Charge (PIC) in a timely manner. In the event that the PIC is unable to verify medication orders, a remote medication order processing pharmacy by an Oklahoma licensed pharmacist(s) will be responsible for the verification of medication orders in a timely manner.

PROCEDURE

1. The hospital facility shall allow the PIC and any RMOP Pharmacist to have secured, remote access to the electronic health record in order to review patient records and verify medication orders in a timely manner.
2. The PIC and any RMOP pharmacist will communicate to the hospital's Drug Room Supervisor, Chief Clinical Officer, the Charge Nurse, or the medical provider on-duty if they have a recommendation(s) for optimizing medication therapy while completing medication order processing.
    a. These recommendations can be communicated via the internal message system of the electronic health record.

b. The PIC is expected to follow-up to make sure any recommendations are acknowledged in a timely manner.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Repackaging		**DRM-024**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to the repackaging of medications at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to create a process for repackaging medications from a stock bottle into unit doses for patient use at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

N/A

POLICY

The Drug Room Supervisor and the Pharmacist in Charge will ensure that the process of repackaging and unit dosing medications is safe and consistent.

PROCEDURE

1. The Drug Room Supervisor will create labels for unit dose packaging.
2. Each label must contain at least the following information:
    a. Generic name of the medication
    b. Dosage form of the medication
    c. Strength and unit of measure of the medication
    d. Lot number
    e. National Drug Code (NDC) number or barcode that identifies the NDC number
    f. Unit Dose Expiration Date
        a. Oral solids/liquids outdate 12 months from the date of repackaging or sooner based on the expiration date of the stock bottle used for repackaging.
    g. Name of the person who repackages the medication

3. During the unit dose process, use gloves when handling medications.
4. A log book of repackaged medications must be maintained in the Drug Room with the following information:
   a. Lot Number
   b. Date of unit dosing
   c. Medication name
   d. Strength and unit of measure of the medication
   e. Manufacturer
   f. Manufacturer expiration
   g. Unit dose expiration
   h. Quantity of the medication repackaged
   i. Initials of the person performing unit dosing repackaging
   j. Verifying pharmacist's initials
5. No unit dosed medication will be available for patient use in the hospital until after it is verified by a pharmacist.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Security Camera		**DRM-042**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to establish a process for reviewing security camera footage from inside the hospital Drug Room.

DEFINITIONS

N/A

POLICY

The hospital facility will ensure that unauthorized access to the Drug Room is not obtained.

PROCEDURE

1. The hospital Drug Room will have a security camera on at all times.
2. The Drug Room Supervisor will access video footage routinely to ensure there has been no unauthorized access into drug room.
3. If someone accesses the drug room who is not authorized, the individual will be wrote up and counseled by the Chief Clinical Officer.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Respiratory Treatments		**DRP-010**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This protocol applies to readily available breathing treatments at Mangum Regional Medical Center.

PURPOSE

The purpose of this protocol is to assist with streamlining the treatment of respiratory distress at Mangum Regional Medical Center.

PROCEDURE

Nursing Orders:

- Vital signs x1
- Pulse oximetry
- Oxygen administration to keep saturation greater than or equal to 95%
- Cardiac Monitor
- Peripheral IV (Saline lock) x1

Respiratory Therapist Orders:

- Small Volume Nebulizer
- BiPAP per protocol
- Vent per protocol

Radiology and Other Procedures:

- ECG 12 Lead Panel
- XR Chest AP (1 view)

Respiratory Medications:

Albuterol
- Albuterol 2.5mg SVN x1
- Albuterol 5mg SVN x1
- Albuterol 5mg SVN every 10 minutes x 3 doses
- Albuterol 15mg SVN x1
- Albuterol 2.5mg SVN every 4 hours PRN SOA, Wheezing

Duoneb
- Duoneb 2.5mg/0.5mg SVN x1
- Duoneb 2.5mg/0.5mg SVN every 4 hours PRN SOA, Wheezing

Xopenex
- Xopenex 0.63mg SVN x1
- Xopenex 1.25mg SVN x1
- Xopenex 0.63mg SVN every 10 minutes x 3 doses
- Xopenex 1.25mg SVN every 10 minutes x 3 doses
- Xopenex 1.25mg SVN every 4 hours PRN SOA, Wheezing

Atrovent
- Atrovent 0.25mg SVN x1
- Atrovent 0.5mg SVN x1
- Atrovent 0.5mg SVN every 10 minutes x 3 doses
- Atrovent 0.5mg SVN every 4 hours PRN SOA, Wheezing

NaCl
- NaCl 0.9% SVN PRN Breathing Treatments

Racemic Epinephrine
- Racemic Epinephrine 0.5mL (max dose for pediatric patients) x1
- Racemic Epinephrine _____ mL (dosed 0.05mL x weight in kg) x1
- NaCl 0.9% 3mL x1 (Diluent for Racemic Epinephrine)

Steroids
- Solu-Medrol 125mg IV push x1
- Solu-Medrol 40mg IV push x1
- Decadron 4mg IV push x1
- Decadron 10mg IV push x1
- Decadron 10mg IM x1
- Prednisone 20mg PO x1
- Prednisolone _____ (1mg/kg) PO x1

REFERENCES

https://emj.bmj.com/content/28/2/94.long

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Sepsis Protocol		**DRP-011**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**https://www.cdc.gov/sepsis/what-is-sepsis.html**	

SCOPE

This protocol applies to adult patients at Mangum Regional Medical Center that require treatment for sepsis.

PURPOSE

As part of Mangum Regional Medical Center's antimicrobial stewardship program, the hospital is committed to developing protocols to assist with optimizing antimicrobial therapy for patients based on current practice guidelines and antimicrobial resistance patterns in the community.

PROCEDURE

Nursing Orders:

- ☐ Vital signs every 15 minutes
- ☐ Pulse oximetry continuous
- ☐ Oxygen administration to keep saturation greater than or equal to 95%
- ☐ Cardiac Monitor continuous
- ☐ Neurovascular checks every 15 minutes
- ☐ Peripheral IV (Saline lock) #1
- ☐ Peripheral IV (Saline lock) #2

Labs:

- ☐ ABG
- ☐ Blood Culture # 1 (send out)
- ☐ Blood Culture # 2 (send out)
- ☐ CBC with differential
- ☐ CMP
- ☐ Lactic acid
- ☐ Lactic acid (repeat 1 hour later if initial Lactic acid is greater than 2.0 with IV fluids)
- ☐ Magnesium
- ☐ Phosphorus

- ☐ Procalcitonin (send out)
- ☐ PTT (send out)
- ☐ Troponin-I
- ☐ Urinalysis
- ☐ Urine culture and sensitivity (send out)

Radiology and Other Procedures:

- ☐ XR Chest AP
- ☐ ECG 12 Lead Panel

IV fluids:

- ☐ Sodium Chloride 0.9% 1000mL, 999mL/Hr Bolus
- ☐ Sodium Chloride 0.9% 1000mL, 999mL/Hr Bolus
- ☐ Sodium Chloride 0.9% 1000mL, 999mL/Hr Bolus
- ☐ Sodium Chloride 0.9% 1000mL over 30 minutes
- ☐ Sodium Chloride 0.9% 500mL over 15 minutes
- ☐ Sodium Chloride 0.9% 1000mL, _____ mL/Hr
- ☐ Lactated Ringers 1000mL, 999mL/hr Bolus
- ☐ Lactated Ringers 1000mL, _____ mL/Hr
- ☐ Sodium Chloride 0.9% 10mL Flush PRN for line patency

Antimicrobials:

- ☐ Azithromycin 500mg IV one-time order
- ☐ Aztreonam 1 gram IV one-time order
- ☐ Ceftriaxone 1 gram IV one-time order
- ☐ Ciprofloxacin 400mg IV one-time order
- ☐ Meropenem 500mg IV one-time order
- ☐ Vancomycin 1gram IV one-time order
- ☐ Zosyn 4.5gram IV one-time order

Vasopressors:

- ☐ Norepinephrine 4mg/D5W 250mL IV
  (Start _____ mcg/min and titrate as needed every 30 minutes to keep MAP greater than 60 mmHg)

Norepinephrine (Levophed® 4mg/D5W 250mL) Dosing Chart

Dosed in mcg/min	Dose Rate in mL/Hr
0.5	2
1	4
2	8
3	11
4	15
5	19
6	22
7	26
8	30
9	34
10	38
11	41
12	45
13	49
14	52
15	56
16	60
17	64
18	68
19	71
20	75

REFERENCES

https://www.cdc.gov/sepsis/what-is-sepsis.html

https://www.sepsisinstitute.org/?gclid=EAIaIQobChMIv_Du_pro6QIVk8DACh1xnAqoEAAYAiAAEgJu7fD_BwE

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Standing Orders		**DRM-028**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define the scope of Standing Orders at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Standing orders: group of orders that commonly apply to all or most all patients of a like category, relating to routine care or standard treatment measures for common problems or conditions.

POLICY

Standing orders must meet specific criteria and must be approved by the medical staff. Standing orders may address emergency measures, which may be required in life threatening situations to stabilize a patient's condition or prevent more serious complications, injury or death.

Implementation of standing orders in emergency situations when a physician is not available requires critical decision making by nursing personnel who are competent in the recognition, understanding and interpretation of the patient's condition. Therefore standing orders must also be approved by the nursing staff. Standing orders are to be considered a starting point for provider orders and should be individualized to the needs of each patient.

PROCEDURE

1. General Criteria for Standing Orders includes the following:
    a. Reflect generally accepted medical practices and therapies.

b. Be consistent with the legal scope of nursing practice in the state of Oklahoma.
c. Be approved for the use in the institution through the appropriate medical staff and nursing processes.
d. Be authorized and countersigned by the appropriate provider(s) within 24 hours of implementation.
e. Be individualized as appropriate to the needs and conditions of the specific patient to which the order is being applied.
f. Be transcribed and verified with the appropriate provider(s) prior to being implemented.
g. Be reviewed by both medical and nursing staffs on an annual and as needed basis for revisions as necessary.
h. Be implemented by a nurse or other licensed healthcare provider whose training and experience qualifies him or her for the duties and responsibilities outlined in the standing orders.
i. The patient must be assessed for appropriateness of implementing the standing order.

2. In the event that a change in a standing order is deemed necessary for the well-being of the patient, the ordering provider shall be notified and the order should be countersigned by the ordering provider in timely manner.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Temperature Monitoring		**DRM-011**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to MANGUM REGIONAL MEDICAL CENTER's Hospital Drug Room requirements for temperature monitoring for the storage of medications.

PURPOSE

The hospital drug room will adhere to temperature monitoring requirements set forth by the Oklahoma Pharmacy Act.

DEFINITIONS

Room temperature: shall be within the range of 68-77 degrees F.

Fridge temperature: shall be within the range of 35- 46 degrees F.

POLICY

The hospital drug room will be monitored on a regular basis to assure the temperatures in the drug room and refrigerator are correct and within the acceptable range.

PROCEDURE

1. The drug room supervisor or any authorized personnel with access the hospital drug room (e.g., charge nurse) will check the room temperature and fridge temperatures twice daily during normal business hours.
2. If the temperature is out of range, the HVAC or refrigerator temperature shall be adjusted and rechecked one hour after any adjustment is made.
3. If a refrigerator is out of service for more than one hour, all medications stored in that refrigerator will be transferred to another medication designated refrigerator in the hospital.
4. The temperature monitoring sensors will be utilized until the calibration expires. At that time, a new temperature monitoring sensor will be purchased.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Total Parenteral Nutrition Management		**DRP-012**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room		

SCOPE

This policy applies to adult patients that require total parenteral nutrition (TPN) therapy at Mangum Regional Medical Center.

PURPOSE

Mangum Regional Medical Center is dedicated to ensuring the safe administration of TPN. TPN is considered a High Alert/High Risk medication.

DEFINITIONS

High Alert/High Risk Medications: medications known to be error-prone or which pose a significant hazard to the patient if not properly handled, and are designated as High Alert/High Risk medications by the Pharmacy and Therapeutics Committee.

PROCEDURE

Diet:

□ NPO
□ NPO except Ice Chips
□ Other_____

Labs:

□ Accucheck every 6 hours
□ Accuchecks AC&HS
□ Accuchecks As Needed
□ CBC with Differential every 7 days
□ Comprehensive Metabolic Profile every 7 days

- Lipid Panel every 7 days (if Lipids ordered as well)
- Pre-albumin every 7 days
- Renal Panel every 7 days
- Magnesium level every 7 days
- Phosphorus level every 7 days
- Triglycerides level every 7 days
- Other_____

Clinimix® Formulas:

- Clinimix® 4.25/10 1000mL/run at ____ mL/hr (use a 0.22 micron filter)
- Clinimix® E 4.25/10 1000mL run at ____ mL/hr (use a 0.22 micron filter)
- Clinimix® 5/15 1000mL/run at ____ mL/hr (use a 0.22 micron filter)
- Clinimix® E 5/15 1000mL run at ____ mL/hr (use a 0.22 micron filter)

Additional IV Supplementation:

- Fat Emulsion 20% 250mL run at 10 mL/hr on Tuesdays and Thursdays
- Multi-trace 5 Concentrate (MT5) three times a week (Mondays, Wednesdays, and Fridays). Dilute 1mL of MT5 in at least NS 100mL and infuse over 4 hours.
- Infuvite Adult Multi Vitamin three times a week (Mondays, Wednesdays, and Fridays). Dilute 10mL in at least NS 500mL and infuse over 4 hours.

Maintenance IV Fluids:

- Dextrose 10% to run at ____ ml/hr (use D10W for any interruptions in TPN)
- Dextrose 5% to run at ____ ml/hr
- Dextrose 5% - Sodium Chloride 0.45% to run at ____ ml/hr
- Sodium Chloride 0.9% IV to run at ____ mL/hr

For any interruptions in the administration of TPN:

- Infuse D10W at same rate as TPN
- Recheck blood sugar prior to re-starting TPN
- Hold insulin dose(s) prior to any planned interruption in TPN

Treatment of Hypoglycemia:

- Follow hospital approved Hypoglycemia protocol

Electrolyte Supplementation:

□ Magnesium Supplementation
- Magnesium sulfate 1gm IVPB x 1 dose
- Magnesium sulfate 2gm IVPB x 1 dose

□ Phosphate Supplementation
- Potassium phosphate 10mmol IV (Dilute in NS 250mL and infuse over 6 hours) x 1
- Potassium phosphate 20mmol IV (Dilute in NS 250mL and infuse over 6 hours) x 1

□ Potassium Supplementation
- Potassium chloride 10mEq IV (Infuse no faster than 10mEq per hour) x 1
- Potassium chloride 20mEq IV (Infuse no faster than 10mEq per hour) x 1

Stress Ulcer Prophylaxis:

□ Carafate 1gm solution per Tube every 6 hours
□ Famotidine 20mg IV daily
□ Famotidine 20mg IV per Tube BID
□ Protonix 40mg IV Push daily

REFERENCES

https://onlinelibrary.wiley.com/doi/10.1002/jpen.1669

https://www.baxtermedicationdeliveryproducts.com/nutrition/clinimix.html

ATTACHMENTS

None.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Verbal Orders		**DRM-029**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**Oklahoma Pharmacy Law Book**	

SCOPE

This policy applies to Verbal Orders at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to define the scope of Verbal Orders at MANGUM REGIONAL MEDICAL CENTER.

DEFINITIONS

Verbal Orders: Verbal or telephone orders received by authorized hospital staff when it is not feasible or practical for the authorizing provider to write or electronically place an order.

POLICY

Verbal Orders (including telephone orders) should be minimized and will be transcribed by nursing personnel on a physician's order form in a timely manner. These orders will include the signature of the person who received the order, the date, time, and prescriber's name. The medical provider or other authorized practitioner will co-sign these orders following the institution's guidelines.

PROCEDURE

1. Persons who may transmit verbal orders:
   a. Authorized providers, as designated in medical staff rules and regulations that are consistent with federal laws and regulations of this state, may transmit verbal orders.
2. Hospital personnel who may accept verbal orders:
   a. Registered Nurses
   b. Licensed Practical Nurses
   c. Registered Pharmacists
   d. Registered Respiratory Therapists (respiratory therapy medications only)

   e. Registered Dietitians (dietary and supplemental food orders only)
3. Transcribed Verbal Orders:
   a. Every verbal order should be read back to the authorized provider after it has been written down on a physician order form or entered into the electronic health record.
   b. Next, the prescriber must give confirmation of the read-back.
4. Signing Verbal Orders:
   a. All verbal orders will be signed off electronically in the electronic health record by the authorizing provider within 72 hours of the order being given.

REFERENCES

Oklahoma Pharmacy Law Book

ATTACHMENTS

N/A

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Unacceptable Abbreviations		**DRM-047**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	Institute for Safe Medication Practices	

SCOPE

It is the policy of Mangum Regional Medical Center to follow the "Do Not Use" list of abbreviations recommended by the ISMP (Institute for Safe Medication Practices) and The Joint Commission to improve patient safety and outcomes.

PURPOSE

To define abbreviations that have been proven to be a safety risk when used and to avoid the use of "dangerous" abbreviations, acronyms and symbols in clinical documentation (including order forms, progress notes, and consultation reports).

POLICY

To improve the effectiveness of communication among caregivers, the following list of unacceptable abbreviations will be maintained and followed. These unacceptable abbreviations should **NEVER** be used when communicating medical information including but not limited to: internal communications, telephone/verbal orders, computer-generated labels for drug storage bins, medication administration records, preprinted forms, medication-related documentation and transcribed reports, either hand-written or within the electronic medical record system.

PROCEDURE

A. The use of abbreviations is discouraged at MANGUM REGIONAL MEDICAL CENTER. The abbreviations listed in attachment A are **not** to be used.
B. It is the responsibility of the Medical Staff Committee to approve the "Do Not Use" abbreviation list for use at MANGUM REGIONAL MEDICAL CENTER.
C. Unacceptable abbreviations cannot be used in any of its form, that is, upper or lower case; with or without periods.
D. If a prescribing physician or mid-level provider utilizes an unacceptable abbreviation, the physician or mid-level provider must be contacted by the licensed care provider and the

treatment order clarified before it is acted on. If the Pharmacy receives the order before it is clarified, the Pharmacist will contact the prescribing physician or mid-level provider to have it clarified.

E. In the event an unacceptable abbreviation IS used and in the judgement of the licensed care provider, the delay in clarifying the order with the prescribing physician or mid-level provider would put the patient at greater risk, the order should be carried out and the clarification obtained as soon as possible thereafter.

F. A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as laboratory results, imaging studies that report size of lesions, or catheter tube sizes. It may **not** be used in medication orders or other medication-related documentation.

G. Abbreviations should not be used on consents. Appropriate medical terminology should be used to describe the procedure to which the patient is consenting. Abbreviations **WILL NOT** be used on any consent form to distinguish laterality.

H. The use of other abbreviations ("approved abbreviations") for the purpose of standardizing terminology, definitions, vocabulary, and nomenclature is allowed if the use of the abbreviation(s) is considered customary in the scope of the service and/or discipline and the abbreviation(s) does not pose the potential for miscommunication or compromising patient safety. An "approved abbreviations" list **MAY** be created/maintained by a department/discipline if deemed necessary/beneficial. When writing an abbreviation, evaluate the context in which it is used.

I. Additional guidelines/recommendations:

1. The use of symbols is discouraged.
2. Do **not** abbreviate drug names, especially when communicating medical information (i.e. APAP, HCI, HCTZ, TNK, Vanc or tPA, etc.).
3. It is preferred that the Metric system be used for writing dosages.
4. Always use a space between drug name, dose, and unit of measure.
5. "Left" and "Right" are to be spelled out on all consent forms, and procedural records.

PROHIBITED ABBREVIATIONS	INTENDED MEANING	MISINTRPRETATION	CORRECT USE
IU	International unit	Misread as IV (intravenous) Or the number "10" (ten)	Write **"international unit"**
ug	Microgram	Mistaken for "mg" when handwritten	Use **"mcg"**
Q.D., QD, q.d., qd	Every Day Daily	Mistaken for each other. Misread as "q.i.d." especially if the period after the "q" or tail of the "q" is misread as an "i"	Write **"daily"**
Q.O.D., QOD, q.o.d., qod	Every other day	The "O" can be mistaken for "i"	Write **"every other day"**
U or u	Unit	Misread for "0" (zero), The number "4" (four) or "cc".	Write **"unit"**
Apothecary symbols	Dram Minim	Misunderstood or misread (symbol for dram misread for "3" and minim misread as "mL")	Use the metric system
Trailing zero	X.0 mg	Decimal point is missed or not visible, leading to an inaccurate dose.	Do not use **terminal zeros** for doses expressed in whole numbers
Lack **of leading zero**	.X mg	Decimal point is missed or not visible, leading to an inaccurate dose.	Always use **zero** before a decimal point when the dose is less than a whole unit
MS MSO4 MgSO4	Morphine Or Magnesium Sulfate	Confused for one another.	Write **"Morphine sulfate"** OR **"Magnesium sulfate"**
SC, SQ, sub q	Subcutaneous	Mistaken as SL (sublingual). Mistaken as "5 every" the "q" in "sub q" has been mistaken as "every".	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or ½ (apothecary)	Mistaken for "55"	Spell out "sliding scale" Use "one-half" or "1/2"
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken for Strong Solution of Iodine (Lugol's)	Spell out "sliding scale (insulin)"

RESPONSIBILITIES

A. It is the responsibility of the Medical Record Department to coordinate the review of the list of abbreviations by the Hospital and Medical Staff.
B. All Mangum Regional Medical Center personnel responsible for documenting in the patient medical record will abide by the list of unacceptable abbreviations.

REFERENCES

The Joint Commission (2019). Official "Do Not Use" List Fact Sheet. [Electronic Version] Retrieved on 07/15/19 from www.jointcommission.org/facts_about_do_not_use_list/

Institute for Safe Medication Practices (2015). ISMP's List of Error-Prone Abbreviations, Symbols and Dose Designations. [Electronic Version] Retrieved on 07/15/19 from www.ismp.org

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
IV Drips and Titration Parameters - Diltiazem		
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room		
DEPARTMENT	REFERENCE	
Drug Room		

Cardizem® (Diltiazem 125mg/NS 125mL, 25mg/5mL vial)

Bolus dosing (25mg/5mL vial):

- Bolus IV dose is 0.25mg/kg (average dose is 15-20mg) slow IV push over 2 minutes
- After 15 minutes, a second Bolus IV dose of 0.35mg/kg (average dose is 20-25mg) slow IV push over 2 minutes may be administered if needed

Maintenance dosing (Diltiazem 125mg/NS 125mL):

- Dosed at 5-15mg/Hr (5-15mL/Hr)
- Dose typically increased by 2.5mg/hr every 30 minutes to keep Heart Rate less than 120
- Max dose: 15mg/hr

Dosed in mg/hr	Dose Rate in mL/Hr
5	5
10	10
15	15

Notes: Transition to oral medication within 24 hours of starting IV therapy

- If patient stable on Diltiazem 3 mg/hr: transition to Diltiazem PO 120 mg/day
- If patient stable on Diltiazem 5 mg/hr: transition to Diltiazem PO 180 mg/day
- If patient stable on Diltiazem 7.5 mg/hr: transition to Diltiazem PO 260 mg/day
- If patient stable on Diltiazem 10 mg/hr: transition to Diltiazem PO 330 mg/day
- If patient stable on Diltiazem 15 mg/hr: transition to Diltiazem PO 480 mg/day

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center

Dopamine (Intropin® 400mg/250mL D5W pre-mix)

Initial dosing: Initiate at 1-5mcg/kg/min

Maintenance dosing: Typical maintenance dose rage is 5-20mcg/kg/min

Notes: Ideally infuse via a central line; Do not mix with Intravenous Sodium bicarbonate

Weight		**Dose Rate in mL/Hr**			
Pounds	Kilograms	5mcg/kg/min	10mcg/kg/min	15mcg/kg/min	20mcg/kg/min
2	1	0.2	0.4	0.5	0.75
6	3	1	1	2	2
8	4	1	2	2	3
13	6	1	2	3	4
17	8	2	3	4	6
22	10	2	4	6	8
24	11	2	4	6	8
28	13	2	5	7	10
33	15	3	6	8	11
44	20	4	8	11	15
55	25	5	9	14	19
66	30	6	11	17	22
77	35	7	13	20	26
88	40	8	15	22	30
99	45	8	17	25	34
110	50	9	19	28	38
121	55	10	21	31	41
132	60	11	22	34	45
143	65	12	24	37	49
154	70	13	26	39	52
165	75	14	28	42	56
176	80	15	30	45	60
187	85	16	32	48	64
198	90	17	34	51	68
209	95	18	36	53	71
220	100	19	38	56	75
231	105	20	39	59	79
242	110	21	41	62	82
254	115	22	43	65	86
> = 265	> = 120	22	45	68	90

Mangum Regional Medical Center

Epinephrine 4mg/NS 250mL

Initial dosing: Initiate at 0.2 mcg/kg/min (typical staring rate of 0.5mcg/min for Adult patients) to keep MAP greater than/equal to 65.

Titration Parameters: Titrate by 0.01 mcg/kg/min every 5 minutes to keep MAP greater than/equal to 65.

Maintenance Dosing: 1-10 mcg/min. Soft max rate: 10 mcg/min. Hard max rate: 20 mcg/min.

Notes: Ideally infuse via a central line if administered for more than 24 hours; Do not mix with Intravenous Sodium bicarbonate.

Dosed in mcg/min	Dose Rate in mL/Hr
0.5	2
1	4
2	8
3	11
4	15
5	19
6	22
7	26
8	30
9	34
10	38
11	41
12	45
13	49
14	52
15	56
16	60
17	64
18	68
19	71
20	75

Heparin Protocol Standard Dose: DVT, PE

INITIATION:

1. Weigh patient STAT if baseline measured weight not in medical record. Dosed using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2

MEDICATIONS:

1. Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
   80 units/kg x Dosing Weight (**Maximum of 10,000 units)**

2. Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.

   18 units/kg-hour x DW **(Maximum of 2,000 units/hr initially)** _____ units/hour

LABS:

1. If not drawn already: STAT
   - ☐ CBC
   - ☐ PT/INR
   - ☐ PTT

2. Routine labs while on Heparin Drip:
   - ☐ PTT every 6 hours after initiation and after every dose change
   - ☐ Daily weight while on Heparin Drip
   - ☐ CBC every other day while on Heparin Drip
   - ☐ GUAIAC stool as needed

OTHER:

1. Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

2. If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

3. Do not interrupt heparin infusion unless ordered.

4. Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

Mangum Regional Medical Center

Title		Page
DKA/Insulin Drip Protocol		**Page 1 of 4**
Manual	Effective Date	Revise Date
Drug Room	**04/18/18**	**NA**
Department	Reference	
Drug Room	**NA**	

DKA: Moderate ketonemia, arterial pH <7.3, serum glucose >250 mg/dL, serum bicarbonate <18 mEq/L

HHS: Serum glucose >600 mg/dL, minimal ketonemia or ketonuria, serum bicarbonate >15 mEq/L, pH ≥7.3

Monitor and Record:

1. Vital signs & I&O every hour until stable, then every 2 hours x 24 hours

    □ Insert Foley if no urine output within first hour or within hours

2. STAT finger stick (capillary) blood glucose

   (Use venous or arterial draw if glucose >450 or <45 mg/dL or SBP <60 mmHg)

3. Accuchecks every hour and as needed

4. Neuro checks every 2 hours (maintain seizure precautions) x 24 hour

5. Initiate and complete Insulin Drip Flowsheet until patient is transitioned off insulin drip

Diet:

□ NPO
□ NPO except Ice Chips
□ Other_____

Admission Labs:

□ CBC with Differential

□ Comprehensive Metabolic Profile

□ Serum ketones

□ Serum Magnesium and Phosphorus level

□ Venous blood gas

□ Blood cultures x 2

□ Urine C&S

□ A1C

□ TSH

□ ß-hydroxybutyrate

□ Serum osmolarity (measured)

□ Record acidosis-ketosis gap (AKG = arterial pH – plasma ß-hydroxybutyrate. AKG >3 may indicate drug abuse)

□ Other_____

Adult DKA Every 4 hour Labs for 24 Hours:

□ Basic Metabolic Panel with Total Calcium, Magnesium, Phosphorus
□ Serum ketones
□ Venous Blood Gas

Additional Diagnostic Tests:

□ EKG
□ CXR
□ Portable CXR

Initial IV Fluids:

□ Consider IV Bicarbonate therapy for pH less than or equal to 7
□ Bolus Sodium Chloride 0.9% IV to run at 999ml/hr for _____ liters

Maintenance IV Fluids:

□ Dextrose 5% - Sodium Chloride 0.45% to run at ____ ml/hr
□ Sodium Chloride 0.9% IV to run at ____ mL/hr
□ Sodium Chloride 0.9% with KCl 20mEq/L IV to run at ____ mL/hr
□ Sodium Chloride 0.9% with KCl 40mEq/L IV to run at ____ ml/hr
□ Sodium Chloride 0.45% to run at ____ ml/hr

Insulin Bolus and Infusion:

□ Regular insulin 0.15 units/kg IV x 1 dose now
□ Regular insulin ____ units IV x 1 dose now (Typically dosed 10-15 units)
□ Regular insulin 100units/100mL IV to start at 0.1units/kg/hr
□ Regular insulin 100units/100mL IV to start at maintenance dose
(Initial rate typically dosed based on glucose level divided by 100)

Insulin Infusion Rate Algorithm:

Blood Sugar Level	Insulin Drip units/hour
< 60	Treat Hypoglycemia
61-69	Turn IV Drip Off
70-109	0.5
110-119	1
120-149	1.5
150-179	2
180-209	3
210-239	4
240-269	5
270-299	6
300-329	7
330-359	8
> 360	12

Treatment of Hypoglycemia:

□ Glucose < 40mg/dL: Give 1 ampule D50W (25 grams) by slow IV push over 30 seconds
- Decrease insulin infusion by moving down 1 algorithm?
- Recheck glucose in 15 minutes; repeat D50W if necessary

□ Glucose 40-59mg/d:: Give ½ ampule D50W by slow IV push over 30 seconds
- Recheck glucose in 15 minutes; repeat D50W if necessary

Electrolyte Supplementation:

□ Magnesium Supplementation
- Magnesium sulfate 1gm IVPB x 1 dose

□ Phosphate Supplementation
- Potassium phosphate 10mmol IVPB x 1 dose
- Potassium phosphate 20mmol IVPB x 1 dose

□ Potassium Supplementation
- Potassium chloride 20mEq IVPB x 1 dose

Stress Ulcer Prophylaxis:

- Carafate 1gm NG Tube every 6 hours
- Protonix 40mg IV Push daily
- Pepcid 20mg IV every 12 hours

Mangum Regional Medical Center

Lidocaine (Intropin® 1g/250mL pre-mix)

Bolus dosing:
For treatment of cardiac arrest from VT/VF: initial dose is 1-1.5 mg/kg IV/IO (average dose is 50-100mg) slow IV push over 2-3 minutes; may repeat bolus dose every 3-5 minutes (max of 3 doses)

For refractory VF: additional IV push dose of 0.5-0.75mg/kg IV/IO may be administered and repeated every 5-10 minutes as needed (max of 3 doses or a total of 3mg/kg)

In stable VT situation, dose varies from 0.5-1.5mg/kg IV/IO slow IV push over 2-3 minutes; may repeat 0.5-0.75mg/kg (max of 3 doses or a total of 3mg/kg)

Maintenance dosing:
Initiate dosing at 1-4mg/min (Max dose 4mg/min)
Reduce dose by 50% for certain patient populations: CHF, Impaired liver function, Elderly, and septic shock

Dosing Chart based on a 70kg patient (Dosed 0.02-0.05mg/kg/min)	
Dosed in mg/min	Dose Rate in mL/Hr
1	15
2	30
3	45
4	60

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Hospital Drug Room Policy Manual

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Nitroglycerin (Intropin® 25mg/250mL pre-mix)

Start at 5mcg/min and titrate by 5mcg/min every 3 minutes until chest pain is relieved or SBP less than 130.

Use caution in patients with right ventricular infarct.

No fixed maximum dose.

Dosed in mcg/min	Dose Rate in mL/Hr
5	3
10	6
15	9
20	12
25	15
30	18
35	21
40	24
45	27
50	30

Mangum Regional Medical Center

PURPOSE:

To establish a standard of care in Rapid Sequence Intubation.

PROCEDURE:

1. Prepare: Equipment, medications, medical team, patient basic airway management, and positioning.
2. Pre-oxygenate: 100% O2 for 3-5 minutes, add nasal cannula @ 4L/min.
3. (Optional): Pre-medications: Atropine 0.02mg/kg IV (max dose: 0.5mg) all infants less than 1 year old.
4. IV push sedative: USE ONLY ONE OF THE FOLLOWING:
    a. Etomidate 0.2-0.6 mg/kg IV push over 30-60 seconds
    b. Midazolam 0.2-0.3 mg/kg IV push for adult patients
    c. Midazolam 0.1-0.4 mg/kg IV push for pediatric patients
    d. Midazolam 0.05-0.1 mg/kg IV push for neonates
    e. Ketamine 1-2 mg/kg IV push over 30-60 seconds. Avoid use for eye injury, head trauma, and stroke/CVA (cerebrovascular accident)
5. Paralytic: USE ONLY ONE OF THE FOLLOWING
    a. Rocuronium 0.6-1.2 mg/kg IV push (adults and peds)
    b. Rocuronium 0.45-1.2 mg/kg IV push (neonates)
    c. Vecuronium 0.15 mg/kg IV push over (adults)
    d. Vecuronium 0.15-0.2 mg/kg IV push (peds)
    e. Vecuronium 0.1 mg/kg IV push (for neonates and infants less than 7 weeks old)
    f. Wait for 60-120 seconds for medication to have full-effects. Do not bag unless hypoxic: turn up nasal cannula to 15L/minute to minimize de-saturation
6. Position airway: head/neck position; laryngeal manipulation; BURP (cricoid pressure) as needed.
7. Pass the tube: maintain in-line cervical immobilization in head/neck trauma.
8. Patent airway assessment: use EID (Esophageal Intubation Detector), check breath sounds, end-tidal CO2, and chest x-ray.
9. Post-intubation plan: Medications and dosages depend of medications used during intubation.

a. Analgesia:
    i. Fentanyl 1-3 mcg/kg IV over 1-2 minutes as needed
    ii. Morphine 0.05-0.2 mg/kg IV push as needed
b. Paralysis:
    i. Vecuronium 0.1mg/kg IV every 60 minutes as needed
c. Sedation
    i. Midazolam IV 50mg in Normal Saline 0.9% 250mL

Table 1: Midazolam IV Drip Titration Table

Desired Dosage	Infusion Rate
2 mg/hr	10 mL/hr
3 mg/hr	15 mL/hr
4 mg/hr	20 mL/hr
5 mg/hr	25 mL/hr
6 mg/hr	30 mL/hr
7 mg/hr	35 mL/hr
8 mg/hr	40 mL/hr
9 mg/hr	45 mL/hr
10 mg/hr	50 mL/hr

10. **If RSI fails; use other methods of airway management such as King Airway, Transtracheal needle, Cricothyrotomy, or Tracheotomy.**

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

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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						

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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

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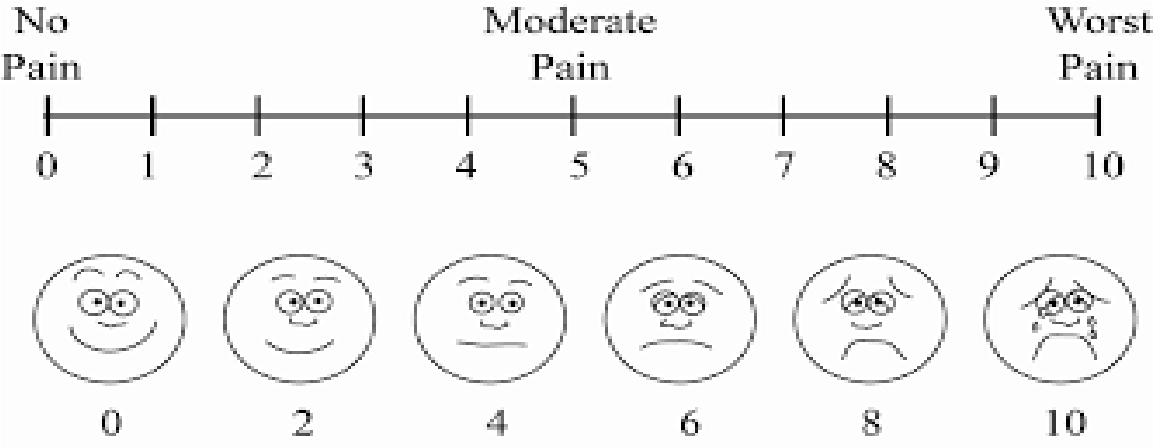
REVISIONS/UPDATES

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

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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

Emergency Nurses Association (2017). *Emergency Nursing: Scope and Standards of Practice. 2nd Edition.*

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

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

INTERACTIVENESS
□ WNL
□ Unable to Stimulate
□ Altered Mental Status
□ Obstructed Airway

CONSOLABILITY
□ WNL
□ Abnormal Response to Environment
□ Unable to Console/Comfort

LOOK/GAZE
□ WNL
□ No Eye Contact
□ Vacant Stare
□ Unable to Recognize

SPEECH
□ WNL
□ Absent/Abnormal
□ Absent/No Cry
□ Unable to Stimulate

AIRWAY SOUNDS
□ WNL □ Muffled/Hoarse
□ Snori Speech
□ Strid□ Use of Accessory
□ Grun Muscles to Breathe
□ Wheezing

POSITIONING
□ WNL
□ Sniffing Position
□ Tripoding
□ Prefers Seated Posture

RETRACTIONS
□ None
□ Supraclavicular
□ Intercostal
□ Substernal

NASAL FLARING
□ Yes
□ No

AIRWAY
□ Patent
□ Impaired

BREATHING
□ Unlabored
□ Labored
□ Shallow
□ Deep

CIRCULATION
□ Palpable Pulse
□ Strong □ Jaundice
□ Weak □ Cyanotic
□ Regular □ Pallor
□ Irregular □ Mottling
□ Normal □ Pale

NEURO
□ Alert
□ Oriented
□ Confused
□ Unresponsive
□ Clear
□ Slurred
□ Garbled

VITAL SIGNS	
Temp Oral/Rectal	
Pulse	
Resp	
BP Rt/Lt	
O2 Sat Room Air	
FSBS	
WEIGHT/KG	
Actual	
Stated	
HEIGHT	

Glasgow Coma Scale (GCS)

Best Eye Opening
4-Spontaneous
3-To Voice
2-To Pain
1-None

Best Verbal
5-Oriented (Coos/Babbles)
4-Confused
3-Inappropriate Words (Screams/Grunts)
2-Incomplete Sounds
1-None

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

GCS Total	

Med Reconciliation
□ See form

Sepsis Screening Completed
Yes
No

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

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: _____
_____

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

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: _____

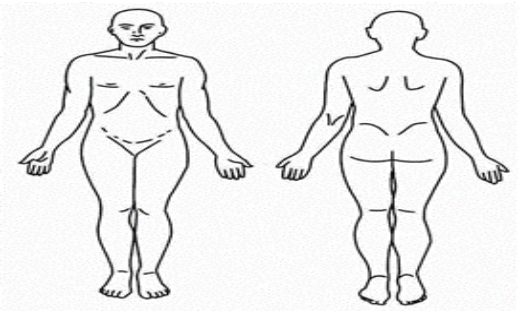
EXTREMITY

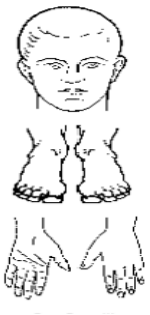
Capillary Refill	
Rt Arm	Rt Leg
Lt Arm	Lt Leg
Sensation	
Rt Arm	Rt Leg
Lt Arm	Lt Leg
Movement/Strength	
Rt Arm	Rt Leg
Lt Arm	Lt Leg

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**	**S**
□ 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

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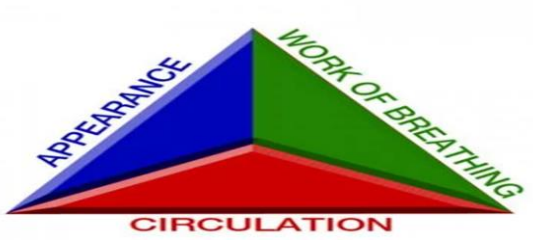
REVISIONS/UPDATES

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 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)** **Hib (PRP-OMP)**	ActHIB® Hiberix® 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** **MenACWY-CRM**	Menactra® Menveo®
Meningococcal serogroup B vaccine	**MenB-4C** **MenB-FHbp**	Bexsero® 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** **RV5**	Rotarix® 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								or	Annual vaccination 1 dose only			
or																	
Influenza (LAIV)											Annual vaccination 1 or 2 doses		or	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
Ask Suicide-Screening Questions

Suicide Risk Screening Tool

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. **If YES, ask: *Was this within the past three months?***	**Lifetime** **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: _____

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. 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*

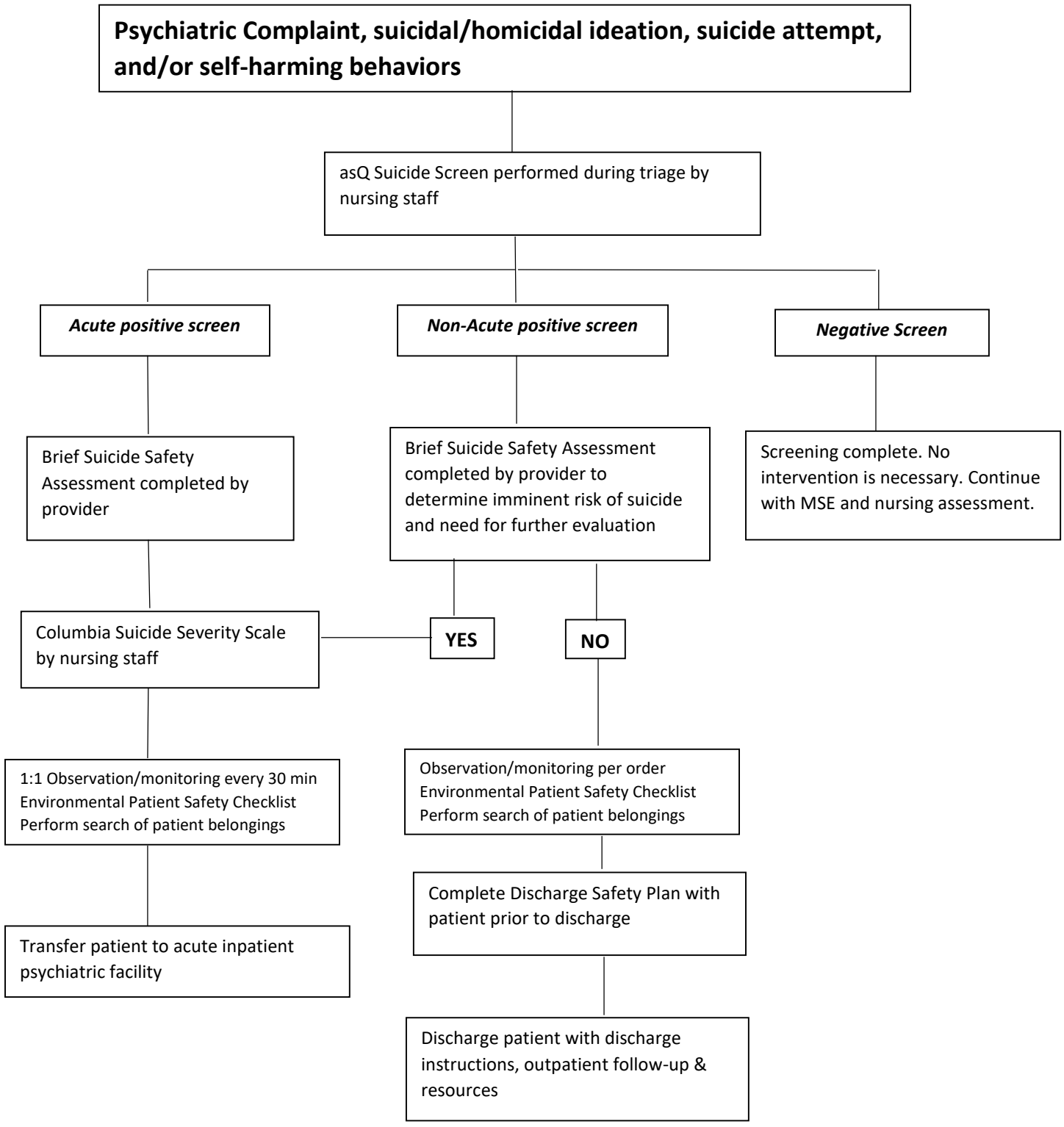
_____

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

XII. 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

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

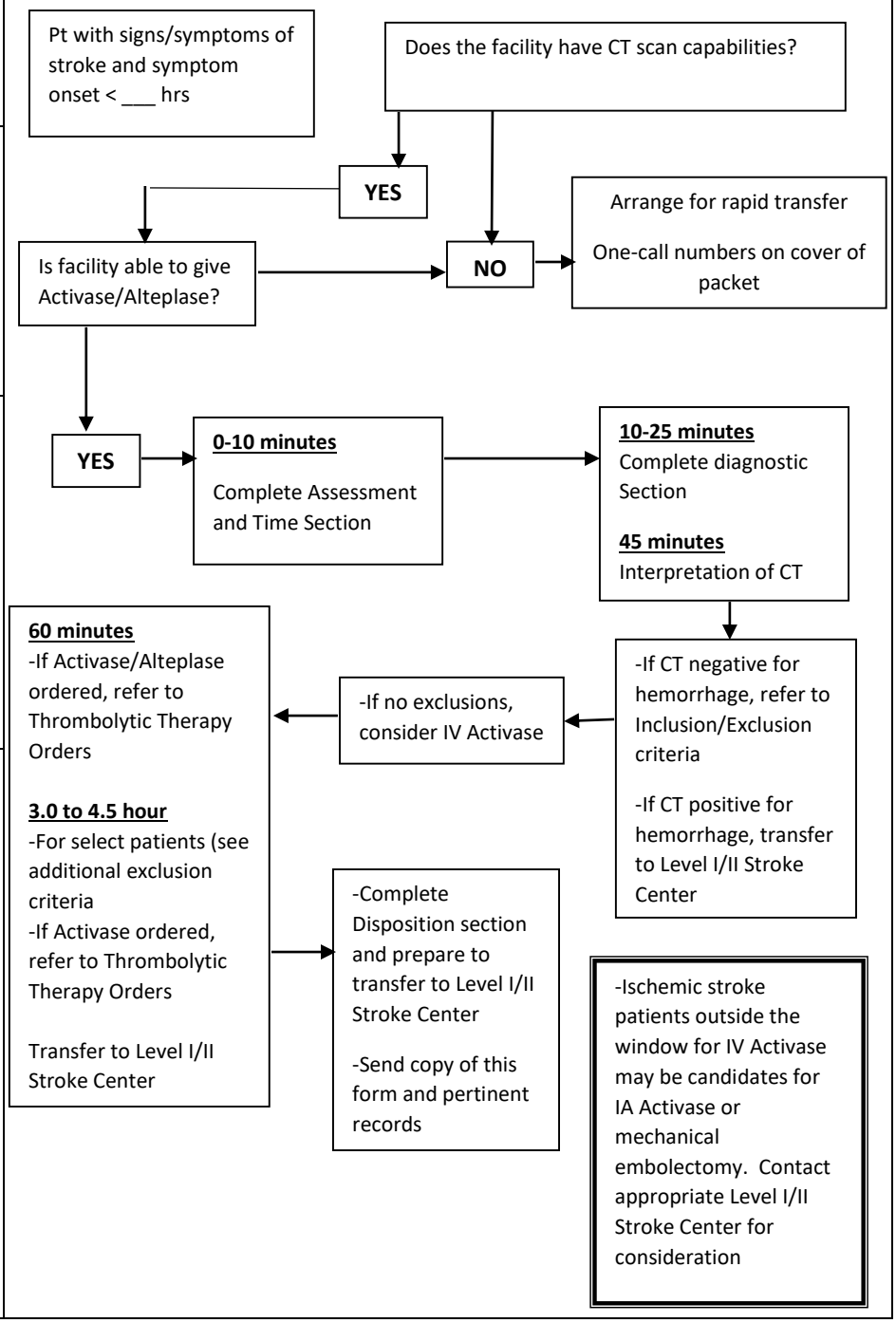
TREATMENT

□ 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 9 *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

Item 19.

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?"

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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

Institute on Alcohol Abuse and Alcoholism, 2000.

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12 Longabaugh R, Minugh PA, Nirenberg TD, Clifford PR, Becker B, Woolard R. Injury as a motivator to reduce drinking. *Acad Emerg Med.* 1995;2:817-825.

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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. Ra 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

American Society of Addiction Medicine. (2020). *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.* Retrieved on 07/01/20 from https://www.asam.org/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf?sfvrsn=ba255c2_2

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

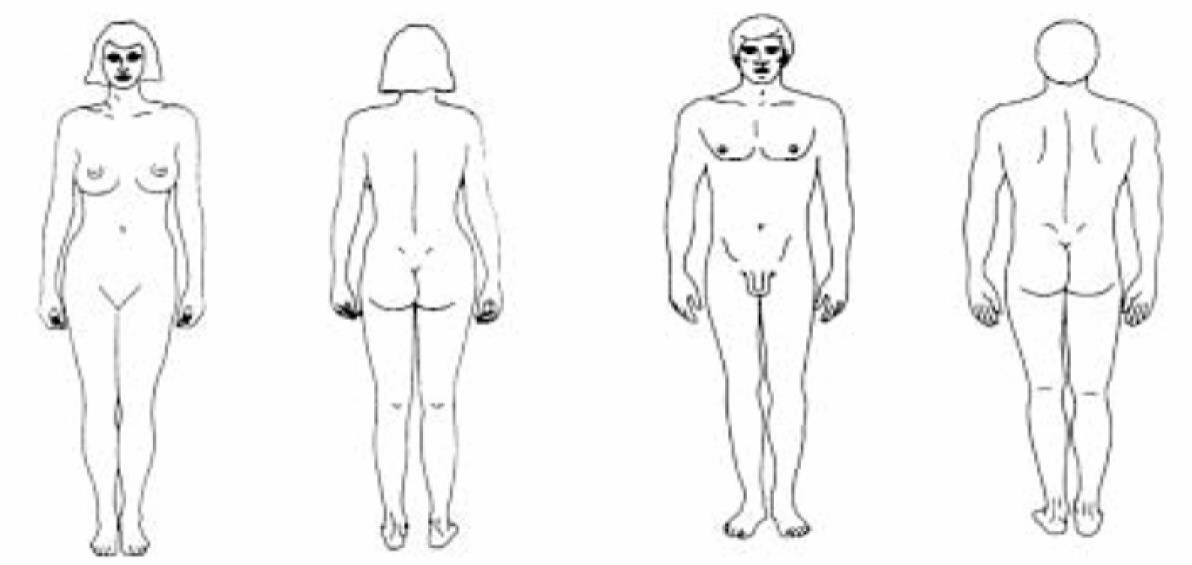
4. Within the last year, has anyone forced you to have sexual activities?
   □ YES □ NO
   If yes by whom? _____
   Total number of times _____

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

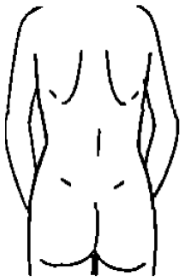
EYES
__PERRL
__EOMI

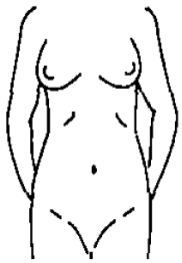
ENT
__nml external inspection
__no dental injury

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*)

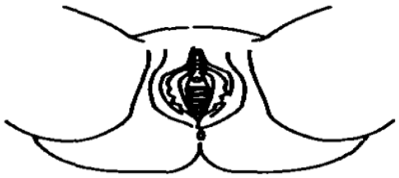
__bimanual exam nml (*uterus, adnexo*)

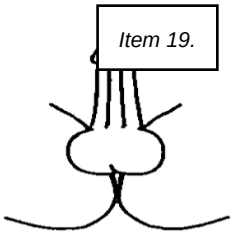
__see diagram _____
__herpes-like ulcerations _____

__ 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
_____





Item 19.

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-exa

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

___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, bu[t] 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 tim 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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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

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

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 → Troponin elevated or high-risk patient

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

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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

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

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7. ***Anti-emetics:***
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□ 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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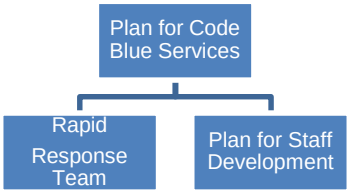
EMD Form A	Numeric Pain Scale		
EMD Form B	Wong-Baker Pain Scale		
EMD Form C	Pediatric FLACC Pain Scale		
EMD Form D	Stroke Log		

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

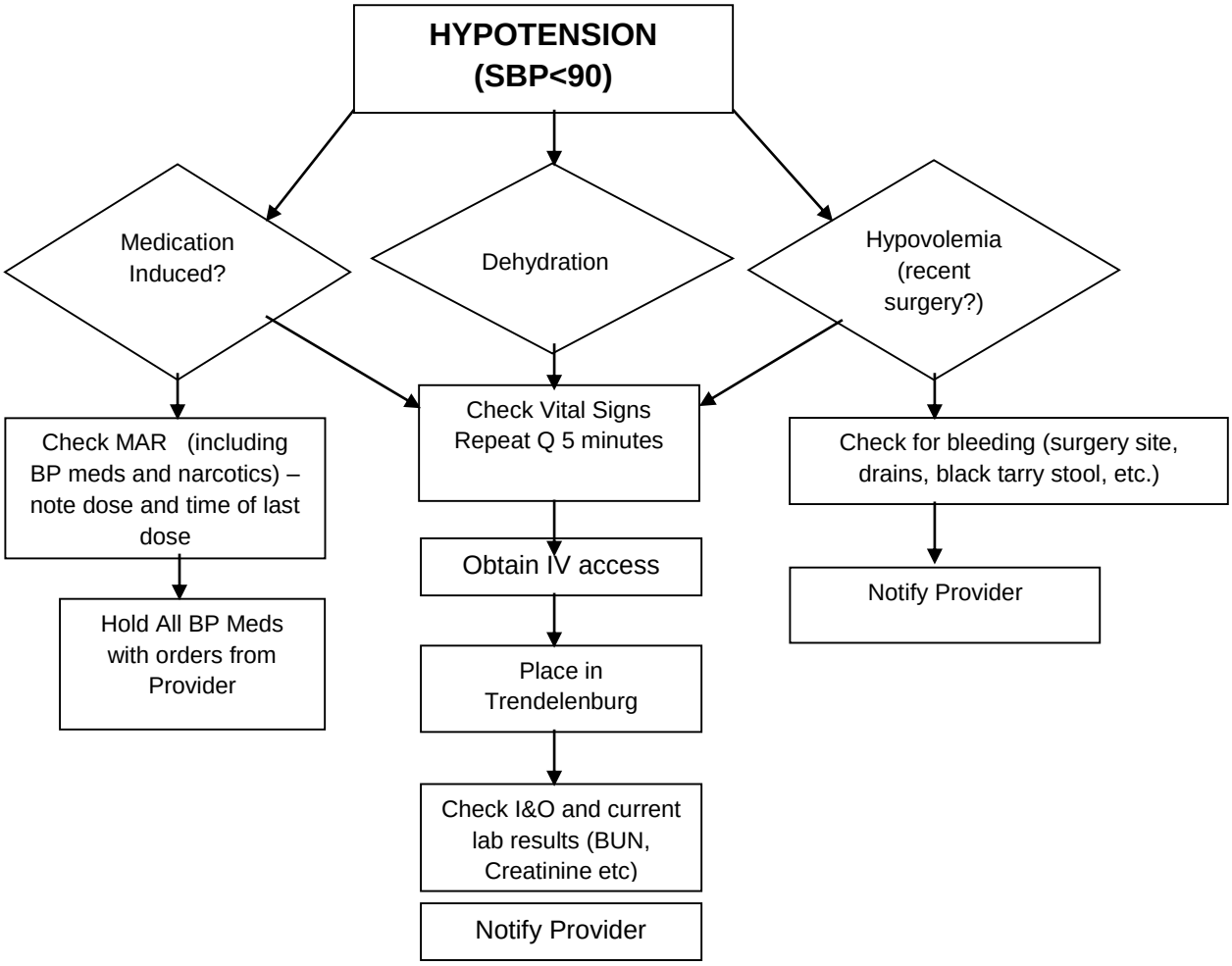
Nurse Signature: _____ Date: _____ Time: _____

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

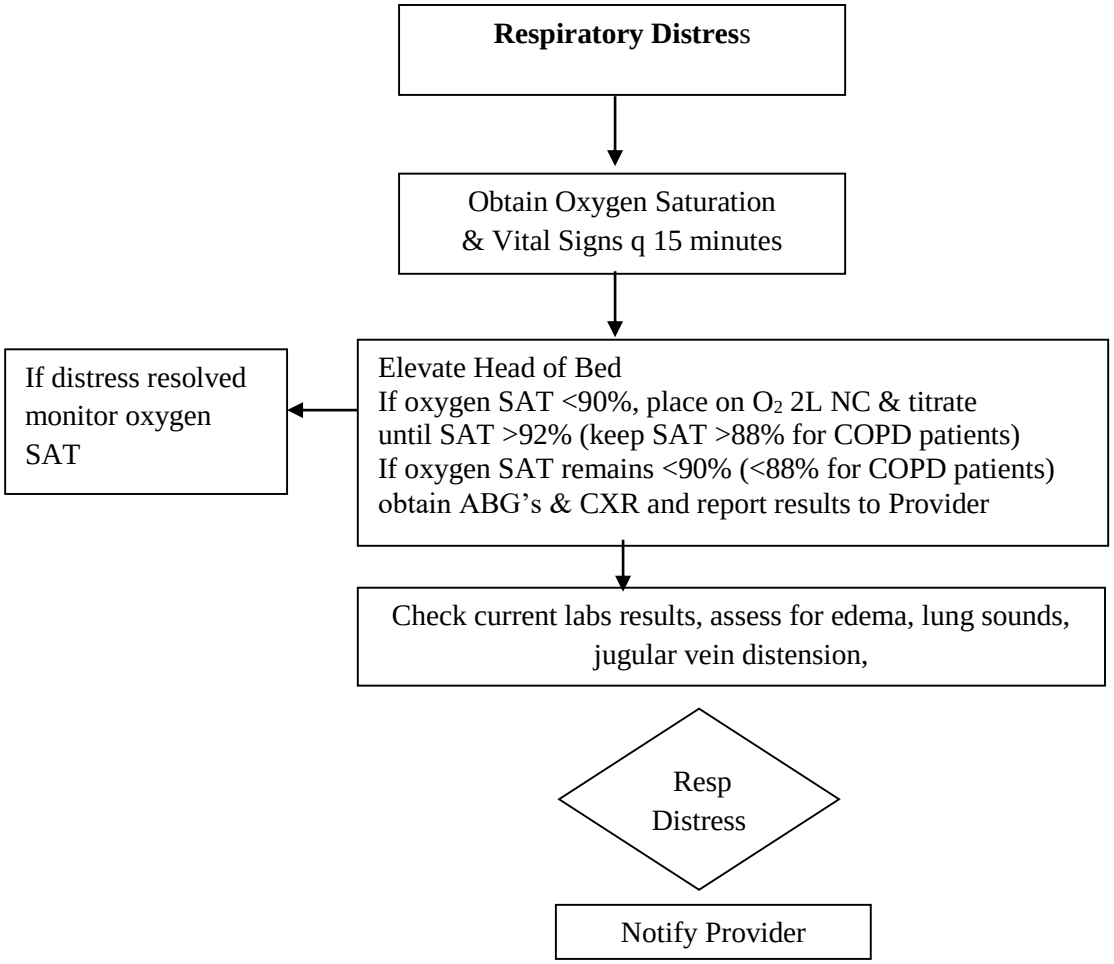
Nurse Signature: _____ Date: _____ Time: _____

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: _____

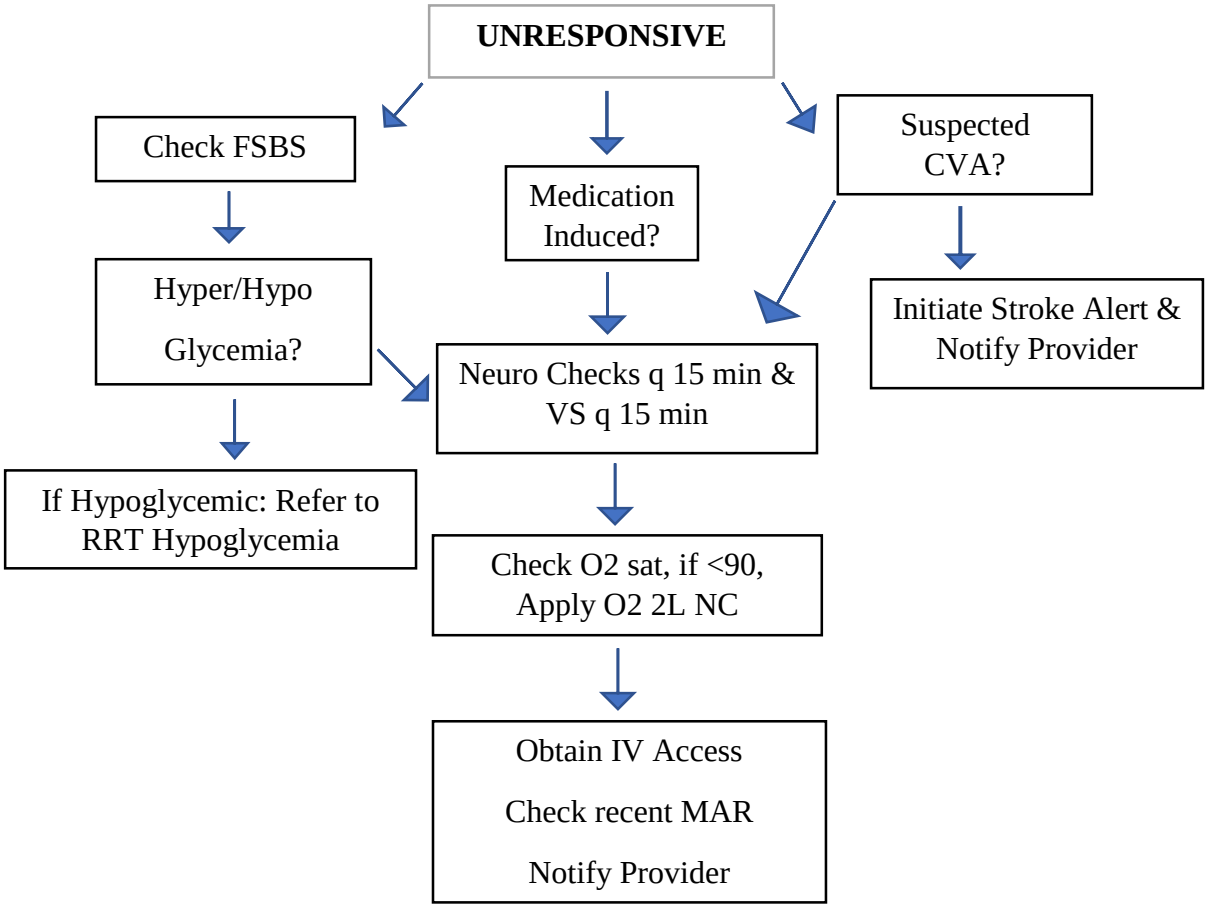
Provider Signature: _____ Date: _____ Time: _____

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:

_____
_____
_____
_____
_____
_____

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

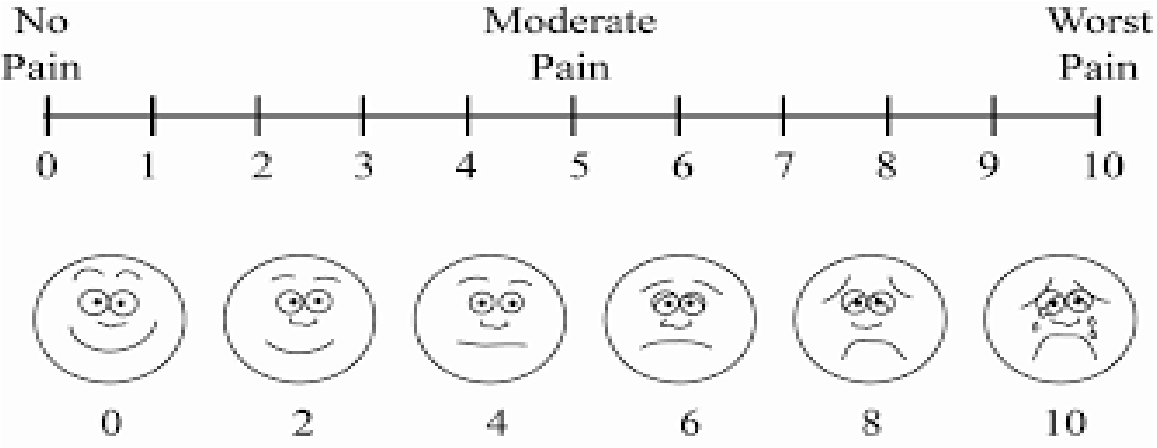
WONG-BAKER FACES PAIN SCALE (NUR-019C)

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

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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:

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3. Frightened: characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
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Pain Assessment IN Advanced Dementia (PAINAD)
Pain Assessment Scale - MANGUM REGIONAL MEDICAL CENTER

Body Language:

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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.
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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

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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

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

Mangum Regional Medical Center

After Sedation

Patient Education for the Adult

(NUR-022C)

Mangum Regional Medical Center

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	

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

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE:		POLICY: 100
Rehabilitation Standards		
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Standards of practice relating to Rehabilitation Services.

PURPOSE: To outline and maintain the Rehabilitation Services policy as it relates to standards of practice.

POLICY: Rehabilitation Services will adhere to specific standards in order to provide guidance to therapy services within each rehabilitation department.

PROCEDURE:

1. Rehabilitation Services consists of professional, paraprofessional and support staff whose qualifications are determined by discipline specific practice acts and State and Federal regulations/guidelines.
2. The goal of Rehabilitation Services is to help patients reach their maximum functional level. This is done through evaluation and patient specific plans of treatment/care.

    a. The therapist determines if services are reasonable and necessary under accepted standards of practice; and are specific and effective treatment for each individual patient's needs and conditions.

    b. There is interdisciplinary collaboration with other care providers for the integration of the comprehensive treatment or care plan. The plan of care is communicated through direct and indirect systems (e.g. team meetings, report writing, in-servicers, family education, and discharge planning, etc.)

    c. Rehabilitation programs provide education to patients, families, and staff. There is an expectation that the condition of the patient will improve within a reasonable and predictable period of time (i.e. specified number of treatments). Under accepted standards of practice, treatment programs will be specific, effective, and reasonable for the patient's condition, including the amount, frequency, duration, and type of treatment provided. In addition, the rehabilitation staff participates in equipment selection and supplies and systems that facilitate the attainment of the rehabilitation goals.

3. Services are provided based on receipt of physician orders/prescription from an individual holding a license authorized to prescribe therapy services for evaluation and treatment if indicated. Furthermore, treatment clarification orders will be obtained from the referring physician/providers for all patients served by rehabilitation, under the following conditions.

    a. Any time the therapist has questions regarding diagnosis, precautions and/or treatment, or the reason for referral is unclear to the therapist.

    b. Orders are not legible

    c. Prescription is not dated

    d. Prescription is not signed by referring physician/provider

4. Rehabilitation Services will participate in the facility's quality improvement program to monitor the quality of important aspects of patient care. Scope of review can include, but is not limited to, clinical supervision, technical documentation, and quality treatment plans. After identification of problem areas and trends are made, necessary changes in service delivery are planned and implemented by rehabilitation staff.

5. Guidelines for utilizing rehabilitation staff is based on the following:

    a. Therapy services require clinical diagnosis, patient care plans, formal evaluation process, active treatment plans and collaboration within the inter-disciplinary team.

    b. Rehabilitation personnel with appropriate licensure, certification, education, knowledge, experience, competence, technical skill and motivation will be utilized.

    c. The rehabilitation staff must have the experience and knowledge to meet the needs and expectations of the patient.

6. All clinical rehabilitation staff are licensed or certified by the appropriate state licensure board (PT, PTA, OT, COTA, SLP, ATC, and Kinesiologist). Records of current licensure, certifications, and registrations are maintained on file in the rehabilitation department or with human resources. All rehabilitation staff are employed based on individual qualification and abilities without regard to race, creed, social-economic status, culture, background, pollical belief, national origin, gender, or age.

7. Rehabilitation services provide limited representation at appropriate committee meetings based on the potential and need for contribution. Involvement may include, but is not limited to:
    a. Quality improvement
    b. Safety

c. Infection control
d. Accidents, incidents, and falls
e. Restraint reduction
f. Wound care

8. Rehabilitation services endeavors to provide:
   a. Clinical staff to evaluate and/or screen all admissions; and if appropriate, to initiate a plan of treatment
   b. A clean, safe, healthy environment. Utilization of appropriate infection control procedures, including universal/standard precautions.
   c. Functional level assessment using appropriate evidence-based evaluation assessments/techniques.
   d. Adherence to standards of privacy, confidentiality, and patient's rights.
   e. Ongoing assessment to the patient's responsiveness to treatment, and modification of plan of care as needed and necessary.
   f. Patient, family, caregiver, and staff training/education as indicated by the plan of care.
   g. Discharge planning as an integrated, interdisciplinary process.
   h. Family conferences, staffing, care planning, and scheduled therapy in-services.
   i. Patient involvement in the rehabilitation process including, but not limited to evaluation, assessment, planning, and goal setting for implementation of their rehabilitation treatment plan to the fullest extent of their capabilities.

9. The staff of rehabilitation services is expected to be able to exercise judgment based on training, education, and experience in deciding what is appropriate for the individual patient, following each individual discipline's code of ethics and practice acts/standards.

10. The rehabilitation staff acknowledges and support Resident's Rights and are proactive promotors of that policy within the facility.

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE:		POLICY
Professional Standards		**101**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	**AOTA, NBCOT, APTA, ASHA, State Board**	

SCOPE: All professional rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy as it relates to professional standards.

POLICY: Facility personnel shall meet the professional standards established by each discipline's professional organization, state practice act, federal guidelines, and facility protocol.

PROCEDURE:
Facility personnel shall meet the professional standards established by each discipline's professional organization(s), State Practice Act, and facility protocol.

ATTACHMENTS:
AOTA: www.aota.org (some documents may have members only access.)
NBCOT: www.nbcot.org

- Enforcement Procedure for OT Code of Ethics
- Guidelines for Supervision, Roles, & Responsibilities during the delivery of OT services
- Occupational therapy Code of Ethics
- Scope of Practice
- Standards of Practice for Occupational Therapy

APTA: www.apta.org (some documents may have members only access.)

- Guide to Physical Therapist Practice
- Criteria for Standards of Physical Therapy Practice
- Code of Ethics Physical Therapist
- Code of Ethics Physical Therapist Assistant

ASHA: www.asha.org (some documents may have members only access.)

- Scope of Practice in SLP
- Guidelines for SLPs performing VSS
- Standards for Certification in SLP
- Guidelines for Roles & Responsibilities

Oklahoma Medical Board: www.okmedicalboard.org

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center

Annual Policy/Plan and Procedure Review

Rehabilitation Services

The polices and/or plans and procedures of Mangum Regional Medical Center have been reviewed and are approved for use. Decisions to adopt these guidelines are made by the practitioner based on available resources and by circumstances presented by individual patients. The recommendations in the guideline may not be appropriate for use in all circumstances.

_____ _____/_____/_____

Department Manager Date

_____ _____/_____/_____

Quality Manager Date

_____ _____/_____/_____

Hospital Administrator Date

_____ _____/_____/_____

Medical Director Date

_____ _____/_____/_____

Governing Board Member Date

Mangum Regional Medical Center

Rehabilitation Services

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Scope of Services		**200**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy as it relates to scope of services.

POLICY: As an integral part of the interdisciplinary team, rehabilitation therapists will assist each patient in maximizing their potential to the extent that it enables them to return to a lower level of care, or to achieve their most practical level of functional independence.

PROCEDURE:

1. Rehabilitation Services are provided in accordance with the facility's mission and plan for the provision of care.
2. Services are provided to the following age groups as appropriate and indicated:
   - Pediatric 28 days - 18 years
     - ** Infant 28 days - <1 year
     - ** Toddler/Pre-school 1 year - <4 years
     - ** School Aged 4 years - <12 years
     - ** Adolescent 12 years - <18 years
   - Adult 18 years - <64 years
   - Geriatric 65+ years
3. Assessment and treatment will address functional skills and signs/symptoms which affect function.
4. Patient and Family/Caregiver Education:
   a. Patient advocacy
   b. Adapting/Obtaining home equipment
   c. Home program instruction
   d. Referral to community agencies
   e. Restorative/functional maintenance programs as appropriate
   f. Family/caregiver education and training
5. Equipment Training and Recommendations:

a. Adaptive aids for independence with ADLs/Instrumental ADLs (IADLs)
b. Splints
c. Walking Aids
d. Wheelchair
e. Communication Aids
f. Positioning Aids
g. Pressure Relief Aids
h. Orthopedic/Prosthetic Aids
i. Other equipment as needed and applicable

6. Rehabilitation Services will provide treatment as the patient's clinical needs dictate.

All therapy is provided by/under the supervision/direction of licensed professionals according to state and federal regulations. Scope of practice for each discipline is based upon state and federal regulations.

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Hours of Operation		**201**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To establish Hours of Operation for Rehabilitation Service Departments

POLICY: The scheduled hours of operation shall meet the scope of services, the patients' plan of care and payor guidelines.

PROCEDURE:

1. Hours of Operation may be modified in response to changes in patient volume, complexity of care, based on facility needs, and/or scope of services with the approval of the Rehabilitation Director, Facility CCO/CNO or designee.
2. A list of professional therapy staff home telephone numbers is provided to the Rehab Director, Therapy Directors and Hospital Administration in the event of an emergency during non-operational hours.
3. Staff shall follow the hospital's policy regarding planned and unplanned absences.
4. Lunch break is 30 minutes. If you require a longer break, please communicate this to your supervisor and hospital administration.
5. Rehabilitation services shall generally be available:

PHYSICAL THERAPY

Monday through Friday: 8:00 am to 4:30 pm

OCCUPATIONAL THERAPY

Monday through Friday: 8:00 am to 4:30 pm

SPEECH-LANGUAGE PATHOLOGY

Monday through Friday: As needed, dependent on caseload

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Staffing Plan		**202**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To ensure an adequate number of staff members with experience and training are available to serve and fulfill the scope, goals, responsibilities, and hours of operation of Rehabilitation Services in a safe and efficient manner.

POLICY: Staffing plan and staff ratio are determined by:

1. Scope of Services
2. Anticipated patient volumes
3. Complexity of patient care
4. Rehabilitation Standards
5. Professional Governing Organization Code of Ethics and supervision standards
6. State Practice Regulation and Rules
7. Supervision standards determined by licensure/registration, HCFA, or other payer sources
8. Staff productivity (as set by facility administration and department director)

PROCEDURE:

1. It is the responsibility of the Rehab Director, Therapy Director, Administration or facility designee to determine the staffing plan.
2. Staffing pattern is recorded and monitored utilizing management of productivity and monitoring timeliness of the initiation of patient care.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Prioritization of Patient Treatments		**203**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All members of the rehabilitation staff serving at Mangum Regional Medical Center.

PURPOSE: To establish Prioritization of Patient Treatment during staffing shortages for Rehabilitation Service Departments

POLICY: To ensure proper treatment under unanticipated adverse conditions of staff and equipment.

PROCEDURE:

1. In the event there is a significant staff shortage as a result of an unforeseen incident, the department experiencing the shortage may contact area facilities/departments servicing patients under the management of the organization
2. The supervising therapist of the department being contacted will make the determination if that department/discipline can spare staff with required skills/competency to assist with the staff shortage.
3. Supervisor may also contact an on-call contingent (PRN) staff member.
4. In the event there is no additional staff support available, priority treatment shall be given according to patient's diagnosis and rehabilitation potential in the following order:
   a. At risk patients, wounds, dysphagia evaluation for high risk of aspiration, falls
   b. Potential decline in the absence of treatment
   c. Potential impact on length of stay.
5. Nursing staff and patient will be notified of any change in the patient's treatment schedule.
6. New outpatients calling for services will be provided with a list of outside facilities available or may choose to be placed on a waiting list for the first available appointment.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Continuum of Care		**208**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All members of the rehabilitation staff serving at Mangum Regional Medical Center.

PURPOSE: To provide accurate information about a patient's care, treatment, and services, current condition, and any recent or anticipated changes upon the transfer/hand-off of a patient from one therapy service to another and to ensure the continuum of care.

POLICY: Patients may be transferred from one facility providing therapy to another facility within the hospital system:

- At the patient's request.
- If the facility does not offer the services required by the patient or the physician/provider.
- At the request of a therapist to try a treatment not available at the current facility.

Therapy patients may also be transferred from a facility outside the hospital system.
Rehabilitation staff will adhere to Facility policy regarding the release of medical information. The information communicated during a transfer/hand-off must be accurate in order to meet patient safety goals.

PROCEDURE:

1. Transfer within the hospital/facility setting:
   a. The sending facility providing the services will contact the receiving facility to make arrangements for transfer of the patient.
   b. The sending facility will send the patient's current documentation to include up-to-date information regarding the patient's care, treatment, and services, condition, and any recent or anticipated changes.
   c. The receiving therapist, following review of the documentation and as determined by the receiving therapist, communication with the sending therapist, will determine if the patient requires a re-evaluation on the first visit or whether the treatment program can simply be resumed.

i. If patient does not require re-evaluation, the receiving therapist is to document that the existing evaluation summarized the patient's current status and plan of care.

ii. Verification of the received information or orders will include repeat-back or read-back as appropriate.

d. The receiving facility will establish an appointment time with the patient.

2. Transfer from outside Hospital System:

a. Receiving therapist to review discharge/transfer information documents.

b. If discharge or transfer information documents are not available, the receiving, evaluating therapist will contact the sending Therapy Department or referring physician/provider as applicable via telephone to obtain additional patient information or orders.

Verification of the received information or orders will include repeat-back or read-back,

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Changing of Linen		**402**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To protect patients from possibility of cross-contamination caused by soiled linen.

POLICY: All linen utilized during treatment shall be completely changed after each patient treatment.
Clean linen shall be stored in a designated cabinet and covered if stored on open shelving.
Soiled linen shall be discarded in a dedicated covered soiled linen hamper.
Employees will utilize Standard and Transmission Based Precautions and Personal Protective Equipment (PPE), in adherence to Facility and Infection Control Policies.

PROCEDURE:

1. Clean linen shall be delivered per schedule by designated staff to the Therapy Department(s).
   a. The linen supply shall be delivered per schedule as set up by Rehab Director.
   b. If additional linen is required by the Therapy Department during the course of the day, designated staff shall access linen per facility procedure.
2. Therapy staff is responsible for stocking clean linen in designated storage areas.
   a. All linen must be kept covered or stored to prevent soiling or cross contamination.
3. Staff shall perform the following procedures after each patient treatment.
   a. Strip soiled linen from treatment table/mat.
   b. Place soiled linen in laundry hamper.
   c. Obtain clean linen from storage area.
4. The filled soiled linen hamper shall be replaced per facility process.
5. Hand washing shall be employed following handling of soiled linen per facility policies.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Therapy Screening		**502**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Licensed therapist PT/OT/ST serving at Mangum Regional Medical Center.

PURPOSE: To outline and maintain Rehabilitation Services' policy for screening of patients.

POLICY: Patients will be screened for skilled intervention as per facility procedure and upon request:

1. To determine if any declines in functional statuses have occurred:
2. To determine if patient shows potential to benefit from skilled therapy services:
3. Upon new functional problem development:
4. To assure patient needs are fully addressed.

PROCEDURE:

1. A screen is generally a brief (less than 15 minutes), non-invasive review of a patient to determine if rehabilitation evaluation is medically necessary. Information should be obtained from patient/staff/family interview, chart, and observation of the patient.
   a. Physician order is not required, and service is not billed to the patient.
   b. Reason for requesting a screen should be clear and defined per nursing, physician, provider, or other documentation.
2. Screens can be performed by one member of the rehabilitation services team, for all disciplines, or per discipline by patient performance deficit area.
   a. Specific questions related to a specific patient's need for a skilled evaluation can be referred to the appropriate discipline when completing cross-disciplinary screen, when necessary.
3. The therapy department, upon receipt of notification from nursing unit or other care provider initiates the screening process.
   a. Patients who experience a change in functional status or are experiencing a newly identified risk situation should be screened by therapy if an evaluation has not been initiated.
   b. Status change may be identified through:
      - Nursing, physician, family, or caregiver observation

- Fall reports, etc.

4. Initial screening(s) must be completed within twenty-four (24) work hours excluding holidays and weekends, and documentation placed in the medical record.
5. Post screen, the therapist making the recommendation for skilled evaluation will follow the facility procedure to request physician order for evaluation, and if applicable, treatment.
6. By exception, a recommendation can be provided when the screen identifies that a skilled evaluation is not needed.
    a. Recommendations that do not require the unique skills of a therapist are made when the problem is not at a level of complexity that skilled evaluation or therapy services are medically necessary.
    b. Recommendations are defined as giving advice or information to another healthcare provider related to general programming, care, or other issues, or related to a specific patient.
        6.b.1 Example of recommendation: Patient was referred for eating problems (not dysphagia). Recommend attempt to fix denture problems and request screen again if eating problem is not resolved.

7.0 A therapist may request a screen by another healthcare provider as applicable.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for PT		**503**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Physical Therapists and Physical Therapist Assistance (under the supervision of a licensed PT) practicing physical therapy at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy and procedure as it relates to treatment, and discharge of patients by Physical Therapy.

POLICY: Assessments are performed within Physical Therapy's scope of practice, state licensure laws, applicable regulations, or certifications.

The scope and intensity of the assessment are based on the patient's diagnosis, the care setting, and patient's desire for care, and the patient's response to previous care.

Assessments are individualized to meet the special needs of the patient. The following are assessed and documented as appropriate to the patient's age and needs for an infant, child, or adolescent:

1. Emotional, cognitive, communication, education, social, and daily activity needs:
2. Developmental: age, length, head circumference, and weight:
3. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family:
4. Immunization status:
5. Family's/guardians expectations for and involvement in the patient's assessment, initial treatment, and continuing care.

PROCEDURE: Established procedures as outlined will be followed.

1. Identify the relevant medical diagnoses for the patient being treated. These include, but are not limited to:
   a. CVA
   b. Traumatic Brain Injury (TBI)
   c. Orthopedic conditions (fractures, joint replacements, etc.)

d. Spinal Cord Injury
e. Oncology Diagnosis
f. Renal Diagnosis
g. General Medical Diagnosis
h. Cardiac Diagnosis
i. Pulmonary Diagnosis

2. Evaluation: General
   a. Chart review inclusive of pertinent previous medical history, present medical status, psychosocial information, and possible barriers.
   b. Patient/family interview inclusive or previous level of functioning, patient/family goals, reason for referral, discharge plans, and other pertinent information.
   c. Written evaluation may be adapted per needs of patient.
      1. Evaluation my include, but is not limited to:
         2.c.1.1 Range of motion
         2.c.1.2 Muscle strength, tone
         2.c.1.3 Balance and posture
         2.c.1.4 Sensation and proprioception
         2.c.1.5 Activity tolerance/endurance
         2.c.1.6 Dexterity/coordination
         2.c.1.7 Bed mobility/transfers
         2.c.1.8 WC management and mobility
         2.c.1.9 Gait (including stairs, curbs, uneven surfaces)
         2.c.1.10 WC seating/positioning
         2.c.1.11 Prosthesis/orthosis evaluation
         2.c.1.12 Evaluation of Cognition: the ability to learn and retain learning
         2.c.1.13 Evaluation of Cognition: functional reasoning/problem solving
   d. Developmental Evaluation may include, but is not limited to:
      1. Denver Developmental Screening Inventory
      2. Gessell Development Appraisal
      3. Battelle Developmental Inventory (BDI)
      4. Bayley Scales of Infant Development II (IDA)
      5. Vineland Social Maturity Scale
      6. Catell Infant Intelligence Test
      7. Bruininks-Oseretsky Test of Motor Proficiency
      8. Alberta Infant Motor Scare (AIMS)
      9. Toddler and Infant Motor Evaluation (TIME)
      10. Gross Motor Function Measure (GMFM)
      11. Infant Motor Screen (IMS)
      12. Movement Assessment Battery for Children (Movement ABC)
      13. Peabody Developmental motor Scares (PDMS) (PDMS II)
      14. Test of Gross Motor Development (TGMD)

15. HELP Stands
16. Infant-Toddler Developmental Assessment (IDA)
17. Pediatric Evaluation of Disability Inventory (PEDI)
18. School Function Measure
19. Wee Functional Independence Measure (WeeFIM)

e. Impressions, problems, and assessments
   1. Contraindications/barriers
   2. Prognostic Indicators
   3. Recommendations

f. Plan of Care/treatment
   1. Establish both long-term and short-term goals
   2. Establish objectives
   3. Estimate length of stay
   4. Referrals as indicated
   5. Reason for skilled intervention

g. Treatment
   1. Rehabilitation procedures are designed to maximize functional mobility.
   2. They may include, but are not limited to:
      - 2.g.2.1 Follow-up on recommendations from the evaluation
      - 2.g.2.2 Coordination, communication, and documentation
      - 2.g.2.3 Caregiver/patient/family training
      - 2.g.2.4 Therapeutic exercise
      - 2.g.2.5 Functional training in self-care and home management
      - 2.g.2.6 Functional training in community integration/reintegration
      - 2.g.2.7 Manual therapy techniques
      - 2.g.2.8 Wound management
      - 2.g.2.9 Electrotherapeutic modalities
      - 2.g.2.10 Physical agents and mechanical modalities

h. Ongoing Assessment
   1. Daily documentation
   2. Every 10th visit day and monthly progress notes/recertifications
   3. Update, review goals/care plan as necessary.

i. Engaging in consultation and education as appropriate.

3. Discharge
   a. Planning for discharge begins with the initial plan of care.
   b. Ongoing adaptation and modification of discharge goals as indicated as the patient progresses through plan of care.
   c. Multi-disciplinary approach

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for OT		**504**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Occupational Therapists and Occupational Therapy Assistants (under the supervision of a licensed OT) practicing occupational therapy at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy and procedure as it relates to treatment, and discharge of patients by Occupational Therapy.

POLICY: Assessments are performed within Occupational Therapy's scope of practice, state licensure laws, applicable regulations, or certifications.
The scope and intensity of the assessment are based on the patient's diagnosis, the care setting, and patient's desire for care, and the patient's response to previous care.
Assessments are individualized to meet the special needs of the patient. The following are assessed and documented as appropriate to the patient's age and needs for an infant, child, or adolescent:

1. Emotional, cognitive, communication, education, social, and daily activity needs:
2. Developmental age, length, head circumference, and weight:
3. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family:
4. Immunization status:
5. Family's/guardians expectations for and involvement in the patient's assessment, initial treatment, and continuing care.

PROCEDURE: Established procedures as outlined will be followed.

1. Identify the relevant medical diagnoses for the patient being treated. These include, but are not limited to:
   a. CVA or other neurological condition
   b. Traumatic Brain Injury (TBI)
   c. Orthopedic conditions (fractures, joint replacements, etc.)
   d. Spinal Cord Injury
   e. Oncology Diagnosis
   f. Renal Diagnosis

g. General Medical Diagnosis
h. Cardiac Diagnosis
i. Pulmonary Diagnosis
j. Arthritis
k. Debilitation Illness
l. Amputation
m. Burns
n. Hand Trauma
o. Mental Illness
p. Developmental Illness

2. Evaluation: General
   a. Chart review inclusive of pertinent previous medical history, present medical status, psychosocial information, and possible barriers.
   b. Patient/family interview inclusive or previous level of functioning, patient/family goals, reason for referral, discharge plans, and other pertinent information.
   c. Written evaluation may be adapted per needs of patient.
      1. Evaluation my include, but is not limited to:
         2.c.1.1 Range of motion
         2.c.1.2 Muscle strength, tone
         2.c.1.3 Balance and posture
         2.c.1.4 Sensation, kinesthesia, and proprioception
         2.c.1.5 Activity tolerance/endurance
         2.c.1.6 Dexterity/coordination
         2.c.1.7 Bed mobility/transfers
         2.c.1.8 WC management and mobility
         2.c.1.9 Gait (including stairs, curbs, uneven surfaces)
         2.c.1.10 WC seating/positioning
         2.c.1.11 Prosthesis/orthosis evaluation
         2.c.1.12 Evaluation of Cognition: the ability to learn and retain learning
         2.c.1.13 Evaluation of Cognition: functional reasoning/problem solving
         2.c.1.14 Patient's level of reflex integration
         2.c.1.15 Sensory Integration
         2.c.1.16 Reciprocal Motion
         2.c.1.17 ADL management
         2.c.1.18 IADL management
         2.c.1.19 School function
   d. Developmental and Perceptual Evaluation may include, but is not limited to:
      1. Denver Developmental Screening Inventory
      2. Gessell Development Appraisal
      3. Developmental Test of Visual Perception (DTVP-2)
      4. Test of Visual-Perceptional Skills-Non motor (Gardner)

5. Battelle Developmental Inventory (BDI)
6. Bayley Scales of Infant Development II (IDA)
7. Vineland Social Maturity Scale
8. Catell Infant Intelligence Test
9. Bruininks-Oseretsky Test of Motor Proficiency (I and II)
10. Alberta Infant Motor Scale (AIMS)
11. Lincoln Osertslay Development Scale
12. Handwriting Without Tears
13. Evaluation Tool of Children's Handwriting
14. Toddler and Infant Motor Evaluation (TIME)
15. Gross Motor Function Measure (GMFM)
16. Infant Motor Screen (IMS)
17. Movement Assessment Battery for Children (Movement ABC)
18. Peabody Developmental motor Scares (PDMS) (PDMS II)
19. Test of Gross Motor Development (TGMD)
20. HELP Stands
21. Infant-Toddler Developmental Assessment (IDA)
22. Pediatric Evaluation of Disability Inventory (PEDI)
23. School Function Measure
24. Wee Functional Independence Measure (WeeFIM)
25. Motor Free Visual Perceptual Test
26. Test of Visual Perceptual Skills
27. Barthel Index (Original and Modified)
28. Southern California Sensory Integration Test
29. Frostig Developmental Test of Visual Perception
30. Purdue Perceptual Motor Survey
31. Berry Buktenica Developmental Form Sequence
32. Visual Motor Integration Evaluation (VMI)
33. Functional Self Care Adaptive skill level
34. Prosthesis and Orthosis Evaluation
35. Pre-Vocational Evaluation
36. Homemaking Evaluation
37. Psychosocial/Leisure Evaluation
38. Low Vision Screening

e. Impressions, problems, and assessments
   1. Contraindications/barriers
   2. Severity level
   3. Prognostic Indicators
   4. Recommendations/referrals

f. Plan of Care/treatment
   1. Establish both long-term and short-term goals
   2. Establish objectives
   3. Estimate length of stay

4. Referrals as indicated
5. Reason for skilled intervention

g. Treatment
   1. Rehabilitation procedures are designed to maximize functional mobility and independence with ADL and IADL skills at home, work, or in the classroom setting.
   2. They may include, but are not limited to:
      - 2.g.2.1 Follow-up on recommendations from the evaluation
      - 2.g.2.2 Coordination, communication, and documentation
      - 2.g.2.3 Caregiver/patient/family training
      - 2.g.2.4 Therapeutic exercise
      - 2.g.2.5 Functional training in self-care and home management
      - 2.g.2.6 Functional training in community integration/reintegration
      - 2.g.2.7 Modification of the environment
      - 2.g.2.8 ADL/IADL management
      - 2.g.2.9 Electrotherapeutic modalities
      - 2.g.2.10 Physical agents and mechanical modalities
      - 2.g.2.11 Adaptations to treatment to meet patient needs
      - 2.g.2.12 Development and facilitation of compensatory strategies
      - 2.g.2.13 Consultation with other allied health professionals
      - 2.g.2.14 Planning for discharge setting and modifications

h. Ongoing Assessment
   1. Daily documentation
   2. Every 10th visit day and monthly progress notes/recertifications
   3. Update, review goals/care plan as necessary.

i. Engaging in consultation and education as appropriate.

3. Discharge
   a. Planning for discharge begins with the initial plan of care.
   b. Ongoing adaptation and modification of discharge goals as indicated as the patient progresses through plan of care.
   c. Family/caregiver conference as needed for discharge environment and provision of ongoing care needs
   d. Multi-disciplinary approach
   e. Referral for post discharge care and resources as appropriate/necessary

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for ST		**505**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Speech Therapist practicing speech therapy at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy and procedure as it relates to treatment, and discharge of patients by Speech and Language Therapy.

POLICY: Assessments are performed within Speech and Language Therapy's scope of practice, state licensure laws, applicable regulations, or certifications.
The scope and intensity of the assessment are based on the patient's diagnosis, the care setting, and patient's desire for care, and the patient's response to previous care.
Assessments are individualized to meet the special needs of the patient. The following are assessed and documented as appropriate to the patient's age and needs for an infant, child, or adolescent:

1. Emotional, cognitive, communication, education, social, and daily activity needs:
2. Developmental age, length, head circumference, and weight:
3. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family:
4. Immunization status:
5. Family's/guardians expectations for and involvement in the patient's assessment, initial treatment, and continuing care.

PROCEDURE: Established procedures as outlined will be followed.

1. Communication Disorder
   a. Though other communication disorders may be present and identified in the evaluation report, it is the major communication disorder that is to be used for diagnostic purposes, outcome studies, and justification for third party payor services.
   b. Diagnostic Evaluation includes, but is not limited to:
      1.b.1 Identifying information
      1.b.2 Case history

1.b.3 Reason for referral
1.b.4 Background information
1.b.5 Previous status
1.b.6 Interview(s)
1.b.7 Chart review
1.b.8 Written evaluation: May be adapted per needs of patient
1.b.9 Behavioral observations
1.b.10 Sensory deficits (e.g. vision, hearing, etc.)
1.b.11 Oral motor/peripheral examination
1.b.12 Motor speech examination
1.b.13 Swallow screening
1.b.14 Voice and fluency screening
1.b.15 Language assessment
1.b.15.1 Expressive skills: Verbal, gestural, written
1.b.15.2 Receptive skills: Auditory, reading, gestural
1.b.15.3 Cognitive status: Memory, orientation
1.b.15.4 Attention, problem solving/judgment
1.b.15.5 Pragmatic skills: Eye contact, turn taking
1.b.15.6 Topic maintenance, referencing, topic initiation
1.b.15.7 Where appropriate, impressions of psychological state
1.b.15.8 Other applicable information/assessments

c. Impressions, problems, conclusions, assessments
1.c.1 etiological factors
1.c.2 severity levels
1.c.3 contraindications/barriers
1.c.4 prognostic factors/indicators
1.c.5 recommendations (including frequency, duration, type of treatment and/or modalities:
1.c.6 referrals

d. Plan of treatment/care
1.d.1 Establish long-term and short-term goals
1.d.2 Establish objectives
1.d.3 Develop estimated length of stay or treatment duration
1.d.4 Set-up referrals

e. Rehabilitation procedures are designed to maximize functional communication skills and to facilitate achievement of the long-term goals. They may include, but are not limited to:
1.e.1 Follow-up on recommendations from the evaluation
1.e.2 Projection of rehabilitation potential
1.e.3 Adaptation to needs of the patient/resident
1.e.4 Facilitate rehabilitation goals
1.e.5 Modify environment
1.e.6 Develop and facilitate compensatory strategies

1.e.7 Ongoing assessment of changes and other possible problem areas
1.e.8 Caregiver/family/resident/patient education and training
1.e.9 Planning for discharge
1.e.10 Other consultation in conjunction with treatment

f. Ongoing assessment
1.f.1 provision of treatment with modification to plan of care as needed
1.f.2 Every 10th visit day and monthly progress summaries
1.f.3 Trial treatment utilizing facilitative and compensatory techniques
1.f.4 Update and review of goals/care plan, as necessary

g. Discharge
1.g.1 Planning for discharge begins at the initial plan of care
1.g.2 Ongoing adaptation and modification of discharge goals as indicated
1.g.3 Attainment of goals
1.g.4 Failure to progress over a maximum of a 2-week period
1.g.5 Development of other problems contraindicating further treatment
1.g.6 Goals modified to reflect the patient's needs and/or status
1.g.7 Referral to other disciplines in healthcare as appropriate
1.g.8 Indication of refusal to participate.

2. Swallowing disorder
a. The diagnosis of dysphagia is to be used
b. The medical diagnosis can be dysphagia or other diagnosis (e.g. vocal cord paralysis)
c. Diagnostic evaluation
2.c.1 Identifying information
2.c.2 Case history
2.c.2.1 Reason for referral
2.c.2.2 Background information
2.c.2.3 Previous status
2.c.2.4 Interview(s)
2.c.2.5 Chart review
2.c.3 Written evaluation: May be adapted per need of the patient
2.c.3.1 Behavioral observation
2.c.3.2 Any sensory deficits (e.g. vision, hearing, etc.)
2.c.3.3 Current P.O. intake (if any)
2.c.3.4 Respiratory status
2.c.3.5 Communication screening
2.c.3.6 Cognitive screening
2.c.3.7 Oral motor/oral peripheral examination
2.c.3.8 Condition of dentition
2.c.3.9 Sitting posture, head control
2.c.3.10 Strength, coordination, ROM, and mobility of oral structure
2.c.3.11 Presence/absence of asymmetries
2.c.3.12 Presence or absence of laryngeal evaluation during swallow

2.c.3.13 Cough reflex
2.c.3.14 Cough to command
2.c.3.15 Presence or absence of wet vocal quality

d. Deglutition Assessment
- 2.d.1 Consistencies of solids and liquids tried, method of presentation and amount of presented material.
- 2.d.2 Adequacy of mastication
- 2.d.3 Timeliness of preparation to swallow, oral preparatory phase
- 2.d.4 Adequacy of bolus control and formation
- 2.d.5 Presence or absence of stasis and place of stasis
- 2.d.6 Adequate labial seal results of trial positioning techniques.
- 2.d.7 Oral transit time, timeliness, efficiency, swallow initiation, laryngeal elevation
- 2.d.8 Other

e. Impressions, problems, conclusions, assessments.
- 2.e.1 Etiological factors
- 2.e.2 Severity levels
- 2.e.3 Contraindications/barriers
- 2.e.4 Strengths/weaknesses
- 2.e.5 Prognostic factors/indicators
- 2.e.6 Recommendations (including frequency, duration, type of treatment and/or modalities needed
- 2.e.7 Referrals

f. Plan of treatment/care
- 2.f.1 Establish long-term and short-term goals.
- 2.f.2 Establish objectives
- 2.f.3 Develop estimated length of stay or treatment duration
- 2.f.4 Set-up referrals
- 2.f.5 Rehabilitation procedures are designed to maximize functional swallow skills and to facilitate achievement of all long-term goals. They ay include, but are not limited to:
  - 2.f.5.1 Follow-up on recommendations from the evaluation
  - 2.f.5.2 Projection of rehabilitation potential
  - 2.f.5.3 Adaptation to needs of the patient
  - 2.f.5.4 Facilitate rehabilitation goals.
  - 2.f.5.5 Modify environment
  - 2.f.5.6 Develop and facilitate compensatory strategies
  - 2.f.5.7 Ongoing assessment of changes and other possible problems
  - 2.f.5.8 Caregiver/family training
  - 2.f.5.9 Development of restorative programs
  - 2.f.5.10 Planning for discharge
  - 2.f.5.11 Other consultation in conjunction with treatment

g. Ongoing assessment
   - 2.g.1 Provision of treatment with modifications to plan of care as needed
   - 2.g.2 Every 5th visit and monthly progress notes
   - 2.g.3 Trial treatment utilizing facilitative and compensatory techniques
   - 2.g.4 Update and review of goals/care plan as necessary

h. Discharge
   - 2.h.1 Planning for discharge begins at the initial plan of care
   - 2.h.2 Ongoing adaptation and modification of discharge goals as indicated
   - 2.h.3 Attainment of goals
   - 2.h.4 Failure to progress over a maximum of a 2-week period
   - 2.h.5 Development of other problems contraindicating further treatment
   - 2.h.6 Goals modified to better reflect the patient's needs and/or status referral to restorative type nursing care
   - 2.h.7 Indication of refusal to participate

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Initiating Treatment and Care Plan		**506**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All licensed/registered PT/OT/ST providing patient care at Mangum Regional Medical Center.

PURPOSE: To outline standards for the rehabilitation staff regarding treatment plans and documentation.

POLICY: Treatment shall be initiated under physician's orders and documentation shall be in compliance with regulatory standards and processed in a way that meets facility needs.

PROCEDURE:

1. Order
   a. Therapist will check with chart to verify the physician's order before evaluating the patient. This can be done as initial data is being gathered.
   b. If it is a payor requirement, after the evaluation and before initiating treatment, a specific treatment order (type of treatment and frequency, example: gait training and exercise 5X/week) must be obtained, if the initial order was not specific. This can be done as a telephone order.
   c. If changes in the plan of care are made after initial orders, then new orders are needed prior to implementing change.
2. Evaluation
   a. The completed evaluation is placed in the medical record.
      2.1.1. Medicare Part B (outpatient) and Hospital Swing bed status: Evaluation and/or POC certification form is provided to the physician for signature, and a copy is placed in the medical record to be replaced with the original when it is returned. Physician certification for outpatient POC certification should be obtained every 30 calendar days. Additional documentation is required in the event of delayed certification.
   b. All narrative documentation forms must follow the Medicare and discipline specific documentation to assure all necessary information is present.

c. Evaluation must include recent onset/exacerbation date and information as to why a skilled rehabilitation evaluation is needed.

3.0 Integrated Care Plan

Therapy plan of care must be integrated, in language that is understandable by all disciplines, into the facility integrated plan of care.

a. If patient is to be placed on an active treatment program, then the problems, goals, and approaches must be integrated into the facility integrated plan of care. Integrated care plan must be updated to reflect any changes in the rehab plan of care.

b. If the therapist is going to design a program for rehabilitation nursing, then this program must be entered, by therapy or nursing, into the integrated care plan.

c. Therapy should participate in the care plan meeting, as per facility procedure.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Timeliness of Services and Documentation		**500**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members serving at Mangum Regional Medical Center.

PURPOSE: To describe and maintain the Rehabilitation Services' policy and procedure for the timeliness of completion of professional services and documentation rendered to patients.

POLICY:

Evaluation, documentation and discharge summaries will be completed within a specific time frame.

PROCEDURE:

1. Evaluations shall be initiated upon referral as follows:
   a. Inpatient and hospital based skilled nursing facility: within seventy-two (72) hours excluding date of admit, holidays and weekends.
   b. Outpatient: within one week.
2. Written evaluation/Plan of Treatment are placed in the patient chart within twenty-four (24) hours of evaluation completion.
3. Daily treatments will be documented and completed by the end of each day.
4. Progress notes are completed every 10th treatment by the registered, evaluating, and supervising therapist of record. They should contain objective, measurable and functional information. These notes are to be written comparatively. Comparisons of previous treatment period and/or baseline date must be present in the body of each note on approved form/format.
5. Discharge summaries are to be completed within seventy-two (72) hours of discharge or discontinuation of therapy services. The discharge summary is completed on the approved form/format.
6. Documentation is kept in the medical record.
7. Interdisciplinary Care Plans are written for each patient utilizing the facility form for interdisciplinary care planning. These care plans are written at the time of the initial

evaluation and updated as the condition of the patient warrants it, or therapy is discontinued.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Treating in Groups		**507**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation Services		
DEPARTMENT	REFERENCE	
Rehabilitation	www.cms.gov	

SCOPE: All professional rehabilitation staff members providing therapy in groups at Mangum Regional Medical Center.

PURPOSE: To outline procedures for rehabilitation staff regarding the treatment of patients in a group setting.

DEFINITION: Group therapy consists of simultaneous treatment to two or more patients who may or may not be doing the same activities.

POLICY: Services provided in a group setting will be medically necessary and skilled, addressing each patient's individualized plan of care goals.

PROCEDURE:

Skilled rehabilitation services may be provided to patients in a group when this method meets the individualized plan of care to achieve identified goals.

1. Treatment order must indicate that up to 25% of treatment may be provided in a group setting.
2. Supervising therapist or assistant should treat no more than 4 patients at any given time.
3. Treatment setting and the number of patients in the group should be identified to most effectively and efficiently meet patient goals.
4. A portion of the patient's rehabilitation program needs to be per individual therapy sessions.
5. Regularly scheduled for frequently occurring groups need a written format, including patient criteria, group goal, and potential activities.
6. Groups address components of function that interfere with functional living skills (such as impaired UE strength that interferes with eating skills) or functional skills.
7. Treatment time provided in a group should not exceed 25% of the total treatment time.
8. **CONTRAINDICATIONS:**

a. Patient whose behavior jeopardizes the safety and/or ability of others to complete their goals.
b. Not medically stable.

9. **DOCUMENTATION:**
   a. Individual patient goals will be addressed either individually or in a group setting.
   b. Progress notes will identify individualized progress toward goals and treatment and goals will be revised as appropriate.
   c. Treatment log: will use applicable CPT group therapy code, when services provided simultaneously to two patients, are represented by CPT codes requiring direct one on one contact with the provider.

REFERENCES:
https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/11_Part_B_Billing_Scenarios_for_PTs_and_OTs.pdf

ATTACHMENTS:

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Criteria for Discharge from Therapy		**508**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All PT/OT/ST staff providing therapy services at Mangum Regional Medical Center.

PURPOSE: To delineate authority and outline the process of discontinuation of an adult patient's treatment.

POLICY: A patient will be discharged from therapy service(s) under the following criteria:

1. The patient has met all therapy goals and is ready to be discharged from therapy:
2. The patient has met modified goals that would allow discharge to the next level of care or with the appropriate support:
3. The patient has reached maximum potential as evidenced by either failure to progress and/or not demonstrating functional, measurable changes for a period not to exceed two weeks, unless new treatment approaches are being trialed or other documented reasons for continuing are present:
4. The patient is transferred out and admitted to the hospital for 24 hours or more:
5. The patient leaves against medical advice:
6. The patient indicates refusal to participate:
7. Upon completion of their prescribed allotment of treatments if no further treatment is warranted:
8. Outpatients will be discharged after a two-week unnotified absence from therapy. Referring physician will be notified. Patient will need to contact department to reschedule appointment and require new physician order for services.

PROCEDURE:

1. Patients may be discontinued upon missing/refusing their third consecutive scheduled treatment
   a. Interdisciplinary care team will be consulted to assist in encouraging patient's participation in POC prior to discharging from therapy

b. Patients cancelling due to other medical appointments or in the case of conflicting schedules with other services shall be excused.
c. Cancellations due to illness will be excused.
d. Referring physician will be notified.

2. Discharge/discontinued order shall be obtained from referring physician unless:
   a. Patient leaves the facility
   b. Plan of Care has been met.
3. A discharge summary shall be written on all discontinued/discharged patients.
   3.1 The original summary should be filed in the medical record.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Patient Scheduling		**501**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Rehabilitation staff members responsible for scheduling therapy patients serving at Mangum Regional Medical Center.

PURPOSE: To assist in coordinating patients schedule and avoid scheduling conflicts.

POLICY: A tentative schedule of patient therapy treatment times shall be communicated with nursing staff when it impacts patient plan of treatment/care.

PROCEDURE:

1. Coordinate schedule with consideration to patient needs and wishes as well as needs of the multidisciplinary care team.
2. Provide outpatient therapy schedule at agreed upon time, date, and location.
3. Update schedule daily for new referrals, admissions, discharges, and time changes.
4. Maintain an appropriate level of flexibility to meet patient and multidisciplinary care team needs.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Treatment Refusal		**510**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing patient care at Mangum Regional Medical Center.

PURPOSE: To ensure rehabilitation services personnel understands effective and appropriate understanding and documentation of a patient's right to refuse treatment.

POLICY: The patient has the right to refuse treatment.

PROCEDURE:

1. First Refusal:
   a. Explain the consequences of treatment refusal to the patient.
   b. Notify nursing and, if appropriate, physician, social worker or caregiver of the patient's refusal.
2. Subsequent Refusals
   a. Address any issues related to refusal. Make sure medical conditions, fear, or other factors are not interfering. Try alternative treatment approaches, when possible.
   b. Engage interdisciplinary team and/or caregiver support to address refusals.
   c. Inform patient/legally responsible party as to the consequences of discontinuation of treatment and any alternative to such action.
   d. Inform physician, when appropriate.
3. After three refusals by the patient from inpatient, skilled nursing or outpatient services, obtain a discharge order from the physician. In addition, the therapist should notify the physician if:
   a. Refusal pattern is such that the patient is unable to benefit from treatment.
   b. There are no medical or other complicating factors that may temporarily impact treatment attendance.
   Note: Treatment may be put on hold for a specified amount of time or with specified restart criteria.

4.0 Document all these steps clearly.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Change in Patient Medical Status		**511**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members providing patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that rehabilitation service's personnel adhere to and implement certain actions with regard to a change in patient medical status during the course of the patient's treatment.

POLICY: Basic patient safety considerations are implemented when a patient presents with one or more of the following signs or symptoms.

1. Changes in vitals, i.e. blood pressure, pulse and/or respiration
2. Illness – apparent and specific complaints
3. Shortness of breath
4. Dizziness
5. Specific complaints of pain
6. Swallowing difficulty and/or discoloration
7. Restlessness and/or decrease in physical endurance
8. Other medical symptoms

PROCEDURE:

1. When patient presents with general signs or symptoms including, but not limited to:
   a. Assesses blood pressure, pulse, and respirations:
   b. Notify primary nurse and/or referring physician/provider of a change in condition, reporting vital signs, observable signs, and or patient complaints:
   c. Follow instructions given by nurse of physician/provider:
   d. Document what occurred and action taken:
   e. Before continuing therapy, check with nursing and/or referring physician/provider to see if there was a medical status change that would impact the patient's ability to continue with therapy services.
2. Change in medical status
   a. Therapy re-start orders are needed if there is a significant medical status change with the patient:

b. Re-evaluate if there is a significant change, having checked the medical record and with nursing and/or referring physician to see if there was a medical status change:
c. If episode does not result in medical or functional change, continue treatment plan:
d. If change necessitates discharge from the facility, then a discharge is completed with new orders and evaluation upon return.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Rehabilitation Input to Interdisciplinary Care Team		**514**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff or providing patient care or designee at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy as it relates to therapy input into the care plan.

POLICY: Each therapy discipline providing treatment or consultation for a patient in the facility will be required to develop individualized care plans for all patients served. The therapy discipline provides specific input for patients served by therapy at the time of the interdisciplinary care team assessment.

PROCEDURE:

1. Each therapy discipline will be responsible for writing a care plan, which addresses problems, and/or strength identified during the evaluation for the patient goals of treatment, specific approaches, and time frames for reaching goals.
2. As appropriate, therapist may choose to add approaches and time frames for reaching goals to already existing problems.
3. Care plans are to be updated and revised as necessitated by the patient's response to treatment
4. Care plans are to be initiated by the therapists after completion of the initial evaluation.
5. Therapists are to use the designated facility care plan form.
6. Therapy supervisor will designate a representative to attend care plan meetings as part of the interdisciplinary team, as indicated. Whenever possible the therapist seeing a patient in active treatment will be that designee.
7. The therapy department will supply information to the interdisciplinary team weekly per facility procedure.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Therapeutic Leave of Absence		**513**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members providing patient care at Mangum Regional Medical Center.

PURPOSE: To define the structure and goals of a therapeutic leave and maximize safety and success in home discharges.

POLICY: Each therapy discipline must consider whether a therapeutic pass or home visit is appropriate in determining an appropriate discharge location and recommendations.

PROCEDURE:

1. A therapeutic leave of absence is used with a patient who will be discharged home from the facility (i.e. home, apartment, ALF, etc.)
2. A physician's order must be secured before any level of a therapeutic absence occurs.
3. A therapeutic leave of absence will typically last no more than 18 hours and will never exceed 23 hours.
4. There are several levels of a therapeutic leave of absence.
   a. Ride in a car:
      Training on car transfers must be done with family and resident prior to going for a ride.
   b. Going out to eat:
      Training on therapeutic diet, medication education, car transfers, and toilet transfers must be completed prior to going out for a meal with the family and the patient.
   c. Going to a family member's home:
      Training on diet, medication, car transfers, toilet transfers, accessibility of the family member's home must be discussed prior to the leave of absence.
   d. Going to a patient's home:
      Home assessment must be completed as well as the previously stated functional goals prior to going on a pass.

5. The therapy team will complete the facility form prior to each therapeutic leave of absence with the goals checked and any comments under each goal.
6. Family will complete the form as to how the resident did on the therapeutic leave of absence. The form will be given to the nurse upon the patient's return. Nursing will give the form to therapy for review. The completed form will be placed in the medical record.
7. Therapy will address the difficulties the patient and/or family had on pass during treatment sessions.
8. The therapeutic leave of absence typically occurs when the patient is not participating in therapy i.e. weekends, evenings, and late afternoons.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Patient Hold		**509**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing patient care at Mangum Regional Medical Center.

PURPOSE: To establish guidelines for the rehabilitation professional to place a patient on hold.

POLICY: A physician's order must be obtained if treatment is to be held for a specific time frame or condition.

A patient shall be placed on hold following a surgical procedure pertaining to the area being treated.

A patient shall be placed on hold following a change in medical status that requires consultation with the physician prior to continuation or modification of the plan of care.

PROCEDURE:

1. Nursing should be notified if a patient hold is being considered by therapy.
   a. Documentation of hold status is to be written in medical record.
2. When conditions are present that a patient will be unable to participate in or benefit from therapy for at least 3 working days, a hold order must be obtained.
3. Hold status order must indicate either a specific time frame or condition under which treatment can be restarted. Reason for the hold order should be in the medical record (in order, nursing notes, or therapy notes).
   Examples:
   Patient has a severe depression which is preventing her ability to benefit from treatment: "Hold patient for one week to allow new medication for depression to improve ability to benefit from program."
   Patient on SLP dysphagia program to eliminate NG tube had a sudden onset of confusion related to a new UTI: "Hold speech pathology, restart in one week if confusion is involved."

4. Payor impact of hold status may need to be addressed.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Communication Between Rehabilitation Services and Nursing		**512**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members providing patient care at Mangum Regional Medical Center

PURPOSE: To facilitate interdisciplinary care planning and communication.

POLICY: Rehabilitation services will communicate with nursing in a coordinated system to maximize the benefits of rehabilitation for the hospitalized patient.

The nursing staff at each patient's unit shall be made aware of the patient's therapy treatment program via the written therapy evaluation and treatment plan contained in the patient's chart.

The nursing staff shall be notified whenever a patient from their unit is transported to the therapy department and when the patient is returned to their unit.

When requested by the respective physician/provider, or deemed necessary by the therapist, the nursing staff shall be instructed in procedures or techniques to be carried out by the nursing staff as an extension of the patient's therapy program.

PROCEDURE:

1. Following each patient's evaluation for therapy, the nursing staff shall be alerted as to the therapy treatment plan via the written treatment program and evaluation contained in the patient's chart.
2. The therapy staff shall communicate to the nurse prior to transporting that patient to/from therapy for treatment.
3. Therapy shall coordinate scheduling with other interdisciplinary team members or departments.
4. Any medical problem associated with therapy shall be discussed between the therapist and the nurse caring for the patient.

5. If the therapist or physician determines that a patient's treatment should extend beyond the capabilities of the therapy department, the nursing staff may be requested to participate in the patient's rehabilitation program.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Precautions		**516**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff providing or assisting with patient care at Mangum Regional Medical Center.

PURPOSE: To provide for safe and effective patient care.

POLICY: Clinicians will implement care strategies related to "precautions" that will protect the patient, protect the staff, and optimize the rehabilitation outcome.

PROCEDURE:

1. As a part of the evaluation process clinicians will list precautions or risk factors, related to that discipline and care management, that have been identified in the patient medical record or as a part of the therapy evaluation.
2. Care strategies shall be followed related to the identified precautions. Examples:
   a. Falls
      2.a.1 Therapists shall address the reason for the falls as a part of the evaluation process, if it is appropriate to that discipline.
      2.a.2 Therapists may be engaged in therapeutic activities to reduce the risk of falls.
      2.a.3 Safety devices identified in the care plan shall be in place when the therapist is not treating the patient.
      2.a.4 Gait belts shall be used when patient is identified as at risk for falls, unless contraindicated, when therapist is performing activities such as mobility training or ADL training that includes standing or moving from surface to surface.
   b. Infections
      2.b.1 Therapists will follow Standard or Transmission Based Precautions.
      2.b.2 Therapists will follow any other special precautions, such as isolation techniques, as identified per the plan of care.
   c. Use of oxygen
      2.c.1 Clinicians will be in-serviced by facility staff on the use of oxygen.

2.c.2 Clinicians will follow the process identified in the patient care plan for the use of oxygen

2.c.3 Clinicians will report to the charge nurse if there are any problems related to use of oxygen.

2.c.4 If doing O2 saturations are a part of the rehab plan of care, these shall be recorded in the medical record and the rehab program shall be modified to meet the patient needs.

d. Swallow

2.d.1 Rehab staff shall adhere to the identified swallow precaution, if any, except if evaluating or working on new strategies as a part of the skilled care program for that discipline.

2.d.2 Therapist will be a part of the care team in identifying when modified barium swallows may be medically necessary.

3.0 Rehab staff shall report to nursing any new behaviors that create a risk situation to nursing and document this communication.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Cancel/No Show Policy		**517**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff involved in a patient's plan of care at Mangum Regional Medical Center.

PURPOSE: To define rehabilitation service's policy as it relates to appointment cancellations and no shows.

POLICY: Rehabilitation services will adhere to and be consistent in the policy for cancellations and no shows within each rehabilitation department.

PROCEDURE:

1. "No show" definition: Patient does not show up for an appointment.
   a. Action: Report as a "no show"
   b. Attempts should be made to contact the patient. These attempts should be recorded.
   c. If no contact has been made and patient no shows for the next appointment; you should count the second as a "no show" and again attempt to contact the patient.
   d. If patient misses next appointment, count as a "no show" and discharge the patient.
2. "Cancellation" definition: If notified on the day of the appointment that patient cannot make their appointment and if they cannot be rescheduled complying with the plan of care, or if a patient cancels on day of appointment and the therapist can't fill the spot with another patient.
   a. Action: Report as a cancellation.
   b. If patient cancels future appointments only count the day of as a cancellation, document in the chart the reason to support the change in frequency for the week.
   c. Do not report as a cancellation if we have to alter the schedule due to our staffing and a patient is not able to meet the new appointment.
3. "Schedule Adjustment" definition: If notified 24 hours or more in advance, we should be able to fill the slot and would not need to report a cancellation.
4. Manually track/record evaluation, cancellations, and no show incidents

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Discharge Procedure		**602**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing therapy services at Mangum Regional Medical Center.

PURPOSE: To describe and maintain the Rehabilitation Services' Policy and Procedure for discharging a patient.

POLICY: Patients will be discharged from rehabilitation services with the necessary documentation and orders in accordance with state and federal guidelines.

PROCEDURE:

1. Treatment ordered by the physician shall be continued until the treatment duration completed, plan of care functional outcome goal(s) is achieved, patient discharged from facility, or until a written or telephone order to discharge is obtained.
2. Patient will be informed as to why skilled services will no longer be provided and how terminating treatment may affect condition.
    a. In the event the patient has refused treatment, documentation will reflect notification to the patient/legal representative as 2 alternatives, if available, and possible outcome.
3. Discharge summary is completed and signed by discharging clinician.
    a. Any follow-up care/discharge instructions to nursing, patient, and/or caregiver to be included in discharge summary and integrated in the care plan.
    b. Caregiver education is provided and documented, as well as home programs issued, and home assessment done (if applicable).
4. Nursing will be notified of discharge an provided with appropriate information for follow through.
5. Therapy discharge recommendation will be integrated into the facility discharge plan.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Physician Orders		**601**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing therapy services at Mangum Regional Medical Center.

PRUPOSE: To describe and maintain the Rehabilitation Services' Policy and Procedure for physician orders.

POLICY: Treatment provided to the patient shall be in accordance with specific written physician orders, the authorized physician or non-physician practitioner certified care plan and documented according to state and federal regulations.
Orders are valid for 30 days from the date of the prescription if not specified by federal, state, facility or payer.

PROCEDURE:

1. Prior to initiating services evaluation, and if applicable, treatment orders will be obtained following facility procedure and therapist will check medical records to verify presence of order.
2. Prior to initiation of treatment, specific treatment orders (order clarification) shall be done as required by 3rd party payer or when recommended plan of care is not within the scope of the physicians/non-physician practitioner's order. Exception: initial orders were specific and contained necessary components. These orders at minimum are to contain:
   a. Date of order or date received:
   b. Discipline, if applicable, and
   c. All treatments, modalities, and/or therapeutic procedures to be rendered or evaluate and treat
   d. Area to be treated , if applicable
   e. Frequency or evaluate and treat
   f. Duration or evaluate and treat
   g. Precautions, if applicable
   h. Authorized physician/non-physician practitioner signature
3. Initial physician/non-physician practitioner signature on the plan of care/evaluation (certification of plan of care) will be obtained prior to billing for services, per facility

procedure for all hospital based SNF patients and outpatients as required by 3rd party payer.

a. If any services are to be provided in a group, this should be included in the plan of care that the physician certifies.
b. Exception: follow facility procedure to obtain prior authorization for Medicaid, HMO/PPO, and worker's compensation patients.

4. Continue treatment must be re-certified or approved by referring physician/non physician practitioner, as required by 3rd party payer, per facility procedure.
   a. Follow facility procedure to obtain prior authorization to continue services for Medicaid, HMO/PPO, and worker's compensation patients.
5. Physician's orders must be obtained to discharge a patient unless:
   a. Patient discharged from the facility:
   b. Treatment was provided and/or goal obtained as per plan of care:
   c. Patient self-discharges:
   d. Copy of discharge summary is provided to the physician

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Transcribing		**605**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All PT/OT/ST staff responsible for receiving physicians verbal or telephone orders at Mangum Regional Medical Center.

PURPOSE: To improve communication and care of the patient receiving rehabilitation services. In addition, to aid in receiving complete and specific orders concerning therapy treatments consistent with facility and regulatory guidelines and policies.

POLICY: Verbal or phone orders are part of the medical record which is a legal document. Only physician orders concerning therapy treatment may be received and transcribed by the therapist.

Physician signature of all verbal and phone therapy orders is required within 72 hours.

PROCEDURE:

1. General: For each order, write the following:
   - a. Date of order:
   - b. Time of order:
   - c. Write the order as stated by the physician:
   - d. Number the orders if more than one order received:
   - e. Assure that writing is legible:
   - f. At the end of the order:
     - 1.f.1 Record as either “Read Back Telephone Order” or RBTO.
     - 1.f.2 Record the physicians name, then slash (/),
     - 1.f.3 Therapists first initial, last name, and credentials.
2. Person receiving the verbal or telephone order will read back the complete order for verification and record.
3. Inpatient orders are written on the physician order sheet in the patient’s chart and flagged for physician signature.
   - a. Notify nursing order has been written.
4. Outpatient orders are written on an approved prescription pad/form or clinical notes form.

a. Document telephone/verbal order on clinical notes form. Request signed prescription to be faxed by physician's office to the Department, or
b. Document telephone/verbal order on prescription pad/form. Therapy clerical staff to fax completed prescription pad/form to referring physician for signature and request physician's office to return via fax the signed prescription. A copy of the completed prescription pad/form will be kept in the patient's file pending return of the original signed prescription along with the FAX confirmation sheet.
c. If physician's office does not have a fax machine, request prescription to be sent via mail.
d. Physician countersignature may also be obtained per physician certification of the therapy plan of care.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Therapy Documentation		**600**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing therapy services at Mangum Regional Medical Center.

PURPOSE: To describe the rehabilitation services' policy for completing the evaluation referral and required documentation.

POLICY: Documentation will be completed on approved rehabilitation services and facility forms or electronic record. Only approved abbreviations will be utilized. Authorized, licensed rehabilitation staff only, will document in the medical record.

PROCEDURE:

1. General documentation includes:
   a. Physician's orders
   b. Admission intake
   c. Initial evaluation and treatment plan
   d. Daily treatment record
   e. Progress summary
   f. Care plans
   g. Billing record
   h. Discharge summary
2. Daily documentation should include:
   a. Treatment and education received:
   b. Reason if treatment missed:
   c. Response to treatment:
   d. Units of service per procedure:
   e. Total treatment minutes:
   f. Total time-based treatment minutes or minutes per procedure code:
   g. Date and time with signature:
   h. And any other information relevant to the patient.

3. Co-signature of the assistant's notes will comply with state requirement and/or payor requirement, whichever is more restrictive.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Abbreviations		**604**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members who will be documenting in patient charts at Mangum Regional Medical Center.

PURPOSE: To provide a list of commonly used therapy abbreviations.

POLICY: Only facility approved abbreviations or symbols will be utilized when documenting in the patient's medical record.

PROCEDURE:

1. Commonly used therapy abbreviations:
   - a. O.T. — Occupational Therapy
   - b. OTR/L — Occupational Therapist Registered and Licensed
   - c. COTA — Certified Occupational Therapy Assistant
   - d. P.T. — Physical Therapy
   - e. PT — Physical Therapist
   - f. PTA — Physical Therapy Assistant
   - g. S.P. — Speech Pathologist
   - h. SL/P — Speech and Language Pathologist
   - i. S.T./ST — Speech Therapy
   - j. AFO — ankle foot orthosis
   - k. Amb — ambulate
   - l. AROM — active range of motion
   - m. AAROM — active assistive range of motion
   - n. ROM — range of motion
   - o. PROM — passive range of motion
   - p. PRE — progressive resistive exercise(s)
   - q. ORIF — open reduction internal fixation
   - r. LBQC — large base quad cane
   - s. LOB — loss of balance
   - t. BOS — base of support

u.	WBOS	wide base of support
v.	NBOS	narrow base of support
w.	COG	center of gravity
x.	NWB	non-weight bearing
y.	WBAT	weight bearing as tolerated
z.	PWB	partial weight bearing
aa.	TTWB	toe touch weight bearing
bb.	RW	rolling walker
cc.	PNF	proprioceptive neuromuscular facilitation
dd.	SLR	straight leg raise
ee.	TKE	terminal knee extension
ff.	VC(s)	verbal cues
gg.	TC(s)	tactile cues
hh.	SBA	stand-by assist
ii.	CGA	contact guard assist
jj.	Sup	supervision
kk.	MinA	minimal assist
ll.	ModA	moderate assist
mm.	MaxA	maximal assit
nn.	D	dependent
oo.	I	independent
pp.	ModI	modified independent
qq.	DIP	distal intraphalangeal
rr.	PIP	proximal intraphalangeal
ss.	MP	metacarpal-phalangeal
tt.	TE	therapeutic exercise(s)
uu.	TA	therapeutic activity
vv.	Gt	gait training
ww.	MT	manual therapy
xx.	MET	muscle energy technique
yy.	JSCS	Jones strain counter strain
zz.	MFR	myofascial release
aaa.	ADLs	activities of daily living
bbb.	IADLs	instrumental activities of daily living
ccc.	UBD	upper body dressing
ddd.	LBD	lower body dressing
eee.	NPWT	negative pressure wound therapy
fff.	SLR	straight leg raise
ggg.	LAQ	long arc quad
hhh.	SAQ	short arc quad
iii.	QS	quad set
jjj.	HS	heel slide
kkk.	ABD	abduction

lll.	ADD	adduction
mmm.	AP	ankle pumps
nnn.	GS	gluteal sets
ooo.	MMT	manual muscle test
ppp.	TUG	timed up and go

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Positioning and Draping		**700**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff providing patient care at Mangum Regional Medical Center.

PURPOSE: To establish guidelines for proper positioning and draping of patients.

POLICY: To provide guidelines for positioning and draping a patient during treatment to preserve patient's modesty and privacy.

PROCEDURE:

1. General
   a. Cover patients with clean linen or exam paper.
   b. Pull curtain around treatment area if applicable.
   c. Assist patient on and off plinth as needed.
   d. Utilize footstool if needed.
2. Supine (back lying):
   a. Place one pillow under patient's head and another one under patients' knees or use appropriate bolster, make sure patient is comfortable more pillows can be added if needed.
   b. Cover patient with clean linen, exposing only the treatment area as necessary.
3. Prone (stomach lying):
   a. For a low back treatment: place a pillow under hips and abdomen, and another one under the head.
   b. For cervical treatment: place pillow under chest and a towel roll under patients' forehead.
   c. An additional pillow under the patient's ankles may be used.
   d. Cover patient with clean linen, exposing treatment area only as necessary.
4. Side lying:
   a. After having patient roll onto side with pillow under head, place one pillow between legs at the knees.

b. Another pillow may be tucked under the patient's back to prevent patient from rolling backwards.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Therapeutic Activity		**705**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	**CPT AMA**	

SCOPE: All professional rehabilitation staff providing therapeutic activity for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all therapeutic activity is administered safely and effectively within established guidelines.

DEFINITION: Therapeutic Activity is the use of dynamic activities to improve functional performance.

POLICY: Physician order is received

- Order may be for "exercise", range of motion", "strengthening", "therapeutic activity", "patient education", "activity modification", "ADLs" or other variations of terms. Order may state therapist to evaluate and treat as indicated.

Therapeutic activity is a direct (one-on-one/patient-therapist) modality optimizing the use of dynamic activities to improve functional performance.
Indications:

- Any pathology or condition which effects the patient's functional performance of an activity including limitations in strength, flexibility, range of motion, circulation, balance, coordination, and endurance.

Contraindications:

- Physician order specific for "no activity" or "exercise".
- Physician order states specific modalities and physician signs prescription under "may not substitute".

Precautions:

- Aggressiveness with passive range of motion/strengthening.
- Cardiac and respiratory patients
- acute pain
- Recent fracture

- Fall risk

PROCEDURE:
Before initiating treatment, patient is evaluated by therapist to determine appropriateness of therapeutic activity.

1. The use and design of specific activities is based upon:
   a. The therapist assessment of the patient's problem and need;
   b. Therapist knowledge of therapeutic activity and the pathology involved;
   c. Limitations/precautions indicated by the physician.
2. Progression of therapeutic activity may be determined by the therapist assistant under the supervision of the therapist.
3. Technicians/aids may only assist directly with the therapist/therapist assistant with provision of therapeutic activity.
4. Therapeutic activity may include use of furniture, beds, toilets, transfers, matt, treatment plinths, free weights, and any other exercise/activity equipment.

REFERENCES: AMA CPT Professional 2019

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Therapeutic Exercise		**704**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	**APTA**	

SCOPE: All professional rehabilitation staff providing therapeutic exercise for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all therapeutic exercise is administered safely and effectively within established guidelines.

DEFINITION: **"**Therapeutic exercise is the systematic performance or execution of planned physical movements or activities intended to enable the patient or client to remediate or prevent impairments of body functions and structures, enhance activities and participation, reduce risk, optimize overall health, and enhance fitness and well-being. Therapeutic exercise may include aerobic and endurance conditioning and reconditioning; agility training; body mechanics training; breathing exercises; coordination exercises; developmental activities training; muscle lengthening; movement pattern training; neuromotor development activities training; neuromuscular education or reeducation; perceptual training; range of motion exercises and soft tissue stretching; relaxation exercises; and strength, power, and endurance exercises." **doi: 10.2522/ptguide3.0_40**Published in: Guide to Physical Therapist Practice 2014.

POLICY: Physician order is received. Order may be for "exercise", range of motion", "strengthening" or other variations of terms. Order may state therapist to evaluate and treat as indicated.

Indications:

- Any pathology or condition in which the patient's strength, flexibility, range of motion, circulation, or endurance has been impaired.
- .

Contraindications:

- Physician order specific for "no exercise".
- Physician order states specific modalities and physician signs prescription under "may not substitute".

Precautions:

- Aggressiveness with passive range of motion/strengthening.
- Cardiac and respiratory patients
- acute pain
- Recent fracture

PROCEDURE:

1. Before initiating treatment, patient is evaluated by therapist to determine appropriateness of exercise.
2. The use and design of specific exercises is based upon:
   a. The therapist assessment of the patient's problem and need;
   b. Therapist knowledge of exercise and the pathology involved;
   c. Limitations/precautions indicated by the physician.
3. Progression of exercises may be determined by the therapist assistant under the supervision of the therapist.
4. Rehabilitation technician/aids with demonstrated/validated competencies may guide patients through specific exercises under the direct supervision of the therapist or the therapist assistant, where allowable by state regulations and pay or coverage.
   a. Direct supervision requires that the therapist, or where allowable by law, the therapist assistant, be physically present (within visual and/or auditory range) and immediately available to direct in supervised tasks that are related to patient client management. The direction and supervision is continuous throughout the time that these tasks are performed.
   b. Technicians/aids may not do hands-on passive range of motion or stretching exercises with a patient.
5. A therapist or therapist assistant always administers exercises for the first time.
6. Exercises may include use of matt, treatment plinths, free weights, and any other exercise equipment.

REFERECNES: APTA Guide to Physical Therapist Practice

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Neuromuscular Re-education		**707**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members providing neuromuscular re-education for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all neuromuscular re-education is administered safely and effectively within established guidelines.

DEFINITION: Neuromuscular reeducation represents a series of therapeutic techniques to restore normal function of nerves and muscles, to include movement, balance, coordination, decreased kinesthetic sense, and impaired proprioception.

POLICY: Physician order is received

- Order may be for "neuromuscular re-education", "exercise", range of motion", "strengthening", "therapeutic activity", or variation of terms. Order may state therapist to evaluate and treat as indicated.

Neuromuscular re-education exercise is a direct (one-on-one/patient-therapist) procedure used to improve a patient's balance, strength, coordination, posture, proprioception, and restore normal soft tissue tone and elasticity.
Indications:

- Any pathology or condition which effects the patient's balance, strength, coordination, posture, kinesthetic sense, proprioception

Contraindications:

- Physician order specific for "no activity" or "exercise".
- Physician order states specific modalities and physician signs prescription under "may not substitute".

Precautions:

- Aggressiveness with passive range of motion/strengthening.
- Cardiac and respiratory patients
- Acute pain
- Recent fracture

- Fall risk

PROCEDURE:

1. Before initiating treatment, patient is evaluated by therapist to determine appropriateness of neuromuscular re-education.
2. The use and design of neuromuscular re-education is based upon:
   a. The therapist assessment of the patient's problem and need;
   b. Therapist knowledge of neuromuscular re-education and the pathology involved;
   c. Limitations/precautions indicated by the physician
3. Progression of neuromuscular re-education may be determined by the therapist assistant under the supervision of the therapist.
4. Technicians/aids may only assist directly with the therapist/therapist assistant with provision of neuromuscular re-education.
5. Neuromuscular Re-education may include use of furniture, beds, toilets, transfers, matts, treatment plinths, free weights, and any other exercise/activity equipment.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Activities of Daily Living and Self Care Techniques		**706**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	APTA Guide to Physical Therapist Practice	

SCOPE: All professional rehabilitation staff providing activities of daily living/self-care techniques for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all ADL training is administered safely and effectively within established guidelines.

DEFINITION: **"***Functional training in self-care and domestic life* integration and reintegration is the education and training of individuals to improve their ability to perform physical actions, tasks, or activities in an efficient, typically expected, or competent manner. *Self-care* includes activities of daily living (ADL), such as bed mobility, transfers, dressing, grooming, bathing, eating, and toileting. *Domestic life* includes more complex ADL and instrumental activities of daily living (IADL), with training in activities such as caring for dependents, maintaining a home, performing household chores and yard work, and shopping. Education and training may include accommodation to or modification of environmental and home barriers, guidance and instruction in injury prevention or reduction, functional training programs, training in the use of assistive technology during self-care and domestic life activities, task simulation and adaptation, and travel training.

Functional training in education life integration or reintegration is the education and training of individuals in the assumption and resumption of roles and functions in the education environment, so that the physical actions or activities required for these roles and functions are performed in an efficient, typically expected, or competent manner. Education and training may include accommodations to or modifications of environmental barriers, functional training programs (eg, conditioning programs), guidance and instruction in injury prevention or reduction, and training in the use of assistive technology in a school environment." **doi: 10.2522/ptguide3.0_36**Published in: Guide to Physical Therapist Practice 2014.

POLICY: Physician order is received, order may be for "exercise", range of motion", "strengthening", "therapeutic activity", "patient education", "activity

modification", "ADLs" or other variations of terms. Order may state therapist to evaluate and treat as indicated.

ADL/self-care/home management training (ADLs) is a direct (one-on-one/patient-therapist) procedure optimizing the patient's ability to perform activities of daily living and home management activities.
Activities of Daily Living includes:

- Personal hygiene (bathing, grooming, oral, peri, nail and hair care).
- Continence management, patients mental and physical ability to properly use the bathroom
- Upper body and lower body dressing
- Meal preparation and feeding
- Ambulation
- Memory care and stimulation
- Medication management

Indications:

- Any pathology or condition which effects the patient's ability to perform activities of daily living/home management activities including limitations in strength, flexibility, range of motion, circulation, balance, coordination, cognition, vision, and endurance.
- Patients needing to learn compensatory training strategies/techniques
- Patients needing to learn how to use assistive technology devices/adaptive equipment.

Contraindications:

- Physician order specific for "no activity" or "exercise".
- Physician order states specific modalities and physician signs prescription under "may not substitute".

Precautions:

- Cardiac and respiratory patients
- Acute pain
- Recent fracture
- Fall risk

PROCEDURE:

1. Before initiating treatment, patient is evaluated by therapist to determine appropriateness of ADLs/self-care activity.
2. The use and design of specific activities is based upon:
   a. The therapist assessment of the patient's problem and need;
   b. Therapist knowledge of self-care/ADLs training and the pathology involved;
   c. Limitations/precautions indicated by the physician.

3. Progression of self-care/home management activity may be determined by the therapist assistant under the supervision of the therapist.
4. Technicians/aids may only assist directly with the therapist/therapist assistant with provision of ADLs/self-care training
5. Self-care/home management training may include use of furniture, beds, toilets, transfers, matts, treatment plinths, free weights, adaptive equipment, assistive technologies, and any other exercise/activity equipment.

REFERENCES:

APTA: Guide to Physical Therapist Practice

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Gait Training		**708**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff that will be providing gait training for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all gait training is administered safely and effectively within established guidelines.

DEFENITION: Gait Training is the process of training a patient to perform ambulation tasks where their walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma. Gait Training can include but is not limited to adaptive equipment, prosthetics, orthotics, treadmill, and pattern improvement.

POLICY: Physician order received specific for gait training or functional activity training, or order states therapist to evaluate and treat. Weight bearing status is determined by the physician and will be obtained by Therapist if not specified in treatment order for orthopedic or wound weight bearing extremities prior to initiation of services. If not specified in physician order, use of an assistive device(s) is determined by the physical therapist.

Gait training or functional activity training is the teaching of ambulation/functional mobility to patients whose walking abilities have been impaired/hindered by neurological, muscular, or skeletal abnormalities or trauma. Gait training requires direct patient contact (patient/therapist)
Indications:

- Any pathology or condition which effects the patient's functional mobility/ambulation including limitations in strength, flexibility, range of motion, circulation, balance, coordination, and endurance.

Contraindications:

- Patient is non weight bearing on bilateral lower extremities
- Patient is non weight bearing and unable to follow weight bearing status/commands

Precautions:

- Circulatory issues
- Intermittent claudication
- Respiratory issues
- Severe osteoporosis
- Joint instability
- Severe contractures
- Osteogenesis imperfecta

PROCEDURE:

1. Patient is evaluated by therapist to determine appropriateness of order and current ambulatory status.
2. General guidelines:
   a. Gait training is to only be performed by the therapist or therapist assistant; a therapy tech/aide may assist the therapist/therapist assistant if needed.
   b. Have the patient sit in a wheelchair immediately if he becomes short of breath or complains of feeling dizzy or faint during ambulating.
3. Types of weight bearing:
   a. NWB: non-weight bearing – the patient may not support any of his weight on affected leg/limb
   b. PWB: partial weight bearing – the patient may support some portion of weight on the affected leg/limb
   c. FWB: Full weight bearing- patient may support his total body weight on affected leg/limb.
   d. WBAT: weight bearing as tolerated- the patient may bear as much weight as tolerated up to full body weight on affected leg/limb.
   e. TDWB: touch down weight bearing- the patient may only touch affected foot on floor for balance, less than 5% total body weight.
4. Types of Gait Training:
   a. Gait without assistive device,
   b. Walker Training,
   c. Crutch Training,
   d. Cain Training,
   e. Parallel Bars,
   f. Treadmill Training,
   g. Stair Training.
5. Precautions:
   a. Observe Standard and Transmission Based Precautions.
   b. A gait belt is recommended if patient requires physical assistance greater than 25% of task and position of belt does not compromise respiratory status, incisions, IV's, etc.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Manual Therapy Techniques		**701**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	**APTA**	

SCOPE: All professional rehabilitation staff members that will providing manual therapy techniques for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all manual therapy techniques are administered safely and effectively within established guidelines.

DEFINITIONS:

"Manual therapy techniques are skilled hand movements and skilled passive movements of joints and soft tissue and are intended to improve tissue extensibility; increase range of motion; induce relaxation; mobilize or manipulate soft tissue and joints; modulate pain; and reduce soft tissue swelling, inflammation, or restriction. Techniques may include manual lymphatic drainage, manual traction, massage, mobilization/manipulation, and passive range of motion." **doi: 10.2522/ptguide3.0_38**Published in: Guide to Physical Therapist Practice 2014.

POLICY: Physician's order received. Order may be for "mobilization, manual therapy, PROM, MFR, massage, manual traction, manual lymphatic drainage," or other variation of terms. Order may state therapist to evaluate and treat.

Indications:

- Pain
- Muscle spasms
- Muscle tension
- Edema
- Soft tissue restriction
- Adhesions
- Scars
- Arthritis
- Circulatory disorders
- Sprains/strains

- ROM limitations

Contraindications:

- Open wound on treatment area
- Skin breakdown on treatment area
- Rash
- S/Sx of DVT
- Acute circulatory disorders
- Abdominal massage

Precautions:

- Acute inflammation
- Tactile sensitivity

PROCEDURE:

1. Before initiating treatment, the patient is evaluated by a therapist for appropriateness of treatment.
2. Treatment is explained to the patient.
3. Therapist administers manual therapy techniques within scope of practice as permitted by state specific practice regulation.
4. The specific manual therapy techniques will be administered at the discretion of the therapist based on their knowledge of the pathology and treatment technique.
5. The specific manual therapy techniques administered and delegated to a therapist assistant with advanced training, including competency validation, is at the discretion of the therapist based on his or her knowledge of the pathology, and specific treatment technique.
6. The patient is monitored regularly for increased pain or any unusual reaction.
7. The therapist determines treatment time.
8. Following treatment, the treatment area is cleansed, and therapist washes his/her hands.

REFERENCES:

APTA Guide to Physical Therapist Practice **doi: 10.2522/ptguide3.0_38**Published in: Guide to Physical Therapist Practice 2014.

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Paraffin		**800**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff that will be utilizing paraffin as a treatment modality at Mangum Regional Medical Center.

PURPOSE: To provide comprehensive information and procedure for paraffin use.

DEFINITION: Paraffin wax is a white or colorless soft, solid wax. It is made from saturated hydrocarbons. Paraffin wax is a therapeutic modality that is used for the purpose of heat therapy to help increase blood flow, relax muscles, decrease joint stiffness, and pain.

POLICY: Physician order received specific for "paraffin" or "heat modality."

Indications:

- Hands or feet
- Arthritis
- Chronic joint disease
- Bursitis
- Joint stiffness
- Contractures
- Scar tissue
- Tenosynovitis
- Sudek's atrophy
- CVA spasticity

Contraindications:

- Open or damaged skin
- Patient under isolation precautions/guidelines

Precautions:

- Dermatological disorders
- Impaired sensation or circulation/sensory deprivation
- Surgical hardware

PROCEDURE:

1. Prior to receiving treatment, the patient is evaluated by the therapist for appropriateness of the modality.
2. Explain treatment to patient.
    a. A paraffin bath is a metal tank containing an electrical resistance-heating unit in the bottom of the tank. A rheostat controls the heater and maintains the paraffin at an even temperature.
    b. Commercial paraffin is used for the bath with paraffin oil added to lower the temperature. This allows the bath to maintain a temperature of 124 degrees to 128 degrees. The lower specific heat and minimal convection of melted paraffin prevent burning of the patient's skin. Penetration is spherical.
    c. The bath produces an intense erythema, leaving the skin moist, soft and pliable. This results from an increase in temperature, vasodilation and an increase in circulation. Local metabolic activity increases, and the sweat glands are stimulated. Phagocytosis increases in areas of inflammation. Sedation, relief of pain and muscular tension are also effects of this local heat.
3. Remove all jewelry. Area to be treated is washed with soap and water, following CDC guidelines for hand washing.
    a. This patient washes his or her own hands, staff will observe to assure CDC guidelines followed.
4. Drape and position patient.
5. Check bath thermometer temperature and instruct patient to dip the affected part in the bath removing immediately.
6. Following removal, the patient is instructed not to move the part in order not to break the wax seal.
7. When the liquid wax solidifies on the part, it is again immersed in the wax bath avoiding dipping new layers beyond previous ones and immediately remove without breaking the seal.
8. Repeat steps 5 through 7 until patient has dipped between 7 to 10 times as determined by therapist.
9. Part is then wrapped in a plastic bag and towel and elevated for approximately 20 minutes without breaking the wax seal.
10. Provide patient with audible alarm system if not in direct line of sight.
    a. Instruct patient to report any sensation of burning or discomfort during treatment procedure.
    b. Therapist to note undo redness after wax removal.
11. Treatment follow-up:
    a. Carefully remove the paraffin from patient and discard.
    b. Check skin condition.
    c. Check paraffin level in bath. Add additional paraffin wax as needed.
    d. Clean up area replacing all items used in designated location.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Patient Education		**709**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff that will be providing patient education for patient care at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the rehabilitation services policy to maximize functional status and improve patient functional outcomes by promoting healthy behavior and involving the patient and, when appropriate, the family or caregiver in care and care decisions.

DEFINITION:

Patient education is when a provider educates a patient, family member or caregiver about the management of the patient's health care needs.

POLICY: Patient/family/caregiver education will be provided in accordance with physician orders and established Care Plan. Education will be tailored to the individual patient's needs and learning style or method. Patient's abilities, strengths, needs and goals reflected in professional assessments will be utilized for formulating patient's educational goals.

PROCEDURE:

1. To ensure that patient education is successful, the following steps will be taken:
   a. Assess organization wide patient education programs and activities
   b. formulate patient program goals
   c. allocate resources for patient education
   d. determine and prioritize specific patient educational needs
   e. provide education to meet identified patient needs
   f. recognize the intense educational needs of the majority of patients in rehabilitation programs.
2. The ultimate goals of patient education are to:
   a. help the patient understand his/her health status, care options, and the risks or benefits of the options selected
   b. encourage patient and family participation in care decisions

c. Increase the likelihood that the patient will follow his or her care plan
d. maximize the patient's ability to cope with his/her health status, prognosis, or functional outcome
e. enhanced patient involvement in continuing care
f. promote quality of life
g. improving the patient's potential for discharge to home or an alternate level of care

3. It is the intent of Rehabilitation Services to develop, implement, evaluate and improve systems to:
   a. provide the patient with appropriate education and training about his/her illness and care needs.
   b. Incorporate information from the patient's assessment about his/her education needs into the care planning process.
   c. Educate the patient as appropriate to his/her assessed needs, abilities, strengths, goals, readiness, preferences, and length of stay.
   d. Provide education that includes explanation of the patient's, family/caregiver's responsibilities in the patient's care.
   e. Include education regarding how to safely and effectively use medication, when applicable, in accordance with the patients' needs and legal requirements.
   f. Discuss how to safely and effectively used medical equipment, when applicable.
   g. council on hydration intervention, modified diet's, and oral health when applicable.
   h. Provide education regarding the use of rehabilitation techniques to adapt to the environment or improve functional independence.
   i. Improve self-care activities, as appropriate.
   j. Access available community resources, if needed.
   k. Know when and how to obtain further care or treatment after discharge.
   l. Provide continuity through discharge instructions, which are given to their patient and those responsible for the patient's continuing care.
   m. monitor the effectiveness of patient education.
   n. Plan patient education within the established interdisciplinary framework as appropriate to the plan of care.
4. Education needs, goals and plans will be documented on the patient's plan of care.
5. Resources, teaching methods, lesson plans, outcomes, and effectiveness of patient teaching will be documented in the therapy notes and or facility education form.
   a. Patient education needs, goals and success will be reviewed as will all the other plan of care interventions as per the facility plan of care policy and procedures.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Use of Moist Hot Packs		**804**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members who will be applying moist hot packs to a patient at Mangum Regional Medical Center.

PURPOSE: To ensure that all moist hot packs are administered safely and effectively within established guidelines.

POLICY: Physician order is received.

- Order may be specific for "hot packs," or "superficial heat,"
- Order may state for therapist to evaluate and treat as indicated

Indications:

- Arthritis
- Bursitis
- Contusions
- Edema
- Fibrosis
- Inflamed joints
- Muscle spasms
- Neuralgia/neuritis
- Pain
- Spasms, strains, sprains
- Synovitis, tenosynovitis

Contraindications:

- Suspected metastatic lesions

Precautions:

- Desensitized areas
- Geriatric patient
- Bony areas and areas of decreased circulation
- Open areas, which should be covered or avoided

PROCEDURE:

1. Before initiating treatment, the patient is evaluated by Therapist to determine appropriateness of the treatment.
2. Treatment is explained to the patient.
3. Position and drape the patient properly according to area being treated and patient comfort.
4. The hydrocollator temperature is checked to be between 140º-160º deg F
5. The hot pack is removed from the unit with tongues, allowing the excess water to run back into the unit.
6. The hot pack is laid on toweling with the excess water wiped from the hot pack.
7. The hot pack is laid on a hot pack cover and the hot pack is layered appropriately.
    a. A hot pack cover is 2 layers of thickness.
    b. 1 layer of a towel is one thickness.
    c. The hot pack is padded with 7-11 layers, if the patient will be weight bearing on the pack.
    d. The hot pack is padded with 6 to 8 layers, if the patient will not be weight bearing on the pack.
    e. The layer next to the patient's skin must be a towel.
8. The area to be treated is exposed and examined for redness or breakdown.
    a. If redness or skin breakdown (rash, open wound/sore) is present, the therapist determines if treatment should be given based on the degree and nature of the redness/breakdown. Extra padding over this area may be indicated.
9. The moist hot pack is applied to appropriate area with the padding facing the patient.
10. Patient is provided with audible alarm and is instructed in its use to notify staff for assistance if needed.
    a. If patient complains of excessive heat, hot pack is removed, and area is examined.
    b. Therapist determines whether additional towels should be added, or treatment should be discontinued.
    c. If the patient cannot communicate to staff that it is too hot, the area is visually checked throughout the treatment.
11. Set timer or record time for 15 to 20 minutes or as determined by therapist.
12. The patient is checked at least once during treatment time to be sure the pack is not excessively hot.
13. Notify therapist immediately if any of the following is noted:
    a. reddened area
    b. skin breakdown
    c. blister
14. Upon completion of treatment, hot pack is removed with treatment area examined for excessive redness.
15. Hot pack is returned to hydrocollator unit in determined rotation pattern to ensure proper heating for future use.
16. Hot pad covers are hung up to dry.
17. Towels are placed in dirty linen container.

18. If patient has received all treatments, dispose of used linen and clean up area replacing all items used in proper place.
19. Wash hands per facility policy.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Cold Pack		**805**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members that will be applying to cold packs for patient care at Mangum Regional Medical Center.

PURPOSE: To provide guidelines for the use of cold packs.

POLICY: Indications:

- Vasoconstriction of capillaries to decrease blood flow
- Decrease metabolic activity
- Provide an analgesic effect for the reduction of muscle spasms, pain, and inflammation

Contraindications:

- Hypersensitivity
- Rheumatoid arthritis

Precautions:

- Use with caution over bony prominence
- Impaired circulation
- Impaired skin integrity

PROCEDURE:

1. Therapist to evaluate patient to determine appropriateness of use.
2. Explain treatment to patient.
   a. Sensation -usually 4 stages: cold, burning, pain, and numbness.
3. Starting the treatment:
   a. Position and drape patient properly in accordance with Department policy
   b. Expose and examine area to be treated
   c. Place cold pack in a towel or pillow case. Wet towel will enhance transfer of cold to body segment
   d. Tuck the cold pack around joint or place on area to be treated.

e. Instruct patient regarding patient alarm system, if not in direct line of sight.

4. Treatment follow-up:
   a. Remove all linen and cold pack from treatment area.
   b. Dry the patient thoroughly.
   c. Check the patient's skin condition.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Electrical Stimulation Treatments		**806**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff members that will be utilizing electrical stimulation treatments for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all electrical stimulation treatments are administered safely and effectively within established guidelines.

DEFINITION: Electrical stimulation is a therapy treatment modality used to improve muscle function, decrease pain, or promote healing.

POLICY: Physician's order is received.

- Order may be specific for electrical stimulation, TENS, or variations of terms, or state for therapist to evaluate and treat as indicated.

Indications:

- Muscle spasm
- Muscle weakness
- Denervated muscle
- Peripheral nerve injury
- Bell's palsy
- Muscle re-education

Contraindications:

- Over the carotid sinuses
- Venous or arterial thrombosis or thrombophlebitis
- Near indwelling phrenic nerve or urinary bladder stimulators
- Healing fractures unless used for bone stimulation
- Active bleeding or infection
- Superficial metal implants
- Pregnancy
- Pharyngeal or laryngeal muscles
- Patients with demand-type pacemaker or myocardial disease
- Suspected epilepsy or seizure disorder

Precautions:

- Cardiac disease
- Impaired mental status
- Impaired sensation, skin irritation, or open wounds
- Malignant tumors
- Patients with hypotension or hypertension
- In areas of excessive adipose tissue or edema
- Bleeding disorders

PROCEDURE:

1. Before initiating treatment, the patient is evaluated to determine appropriateness of treatment by the therapist.
2. When administrating electrical stimulation, all manufacturer's procedures/recommendations will be followed.
3. The specific parameters for the electrical stimulation will be determined by the therapist to produce the desired results.
4. Types of electrical stimulation:
   a. direct (galvanic): A low voltage, uninterrupted, unidirectional current.
   b. Alternating: a series of low voltage 60-cps sine waves.
   c. Faradic: a series of medium voltage, rapid asymmetrical, alternating surges with a frequency of about 100-cps.
   d. Tetanizing: a series of low voltage unidirectional square waves with a frequency of 50cps to 200-cps
5. Effects:
   a. Ionic change
   b. Alter membrane permeability
   c. Restore or maintain muscle tone
   d. Retard atrophy
   e. Increase local blood flow
   f. Relax muscle spasms
6. Protocols may be based on manufacturer information or accepted guidelines from APTA/AOTA accredited schools or from the literature.
7. All parameters are documented in the patient's chart.
8. Electrical stimulation unipolar techniques:
   a. Check unit for loose connections or frayed wiring;
   b. Know how to operate the unit
   c. Check patient's skin for cuts, abrasions and new skin scar tissue.
   d. Make sure skin is clear and metal is removed from area to be treated.
   e. Explain treatment procedure to patient
   f. Describe sensation patient will be feeling and what will be occurring and why it is being used
   g. Place moistened/dispersive electrode, if applicable, usually on the same side of the body as is being treated.

h. Place moistened/active electrode over motor points or muscle belly of involved muscles.
i. Start with intensity setting at 0 and increase intensity as tolerated until good muscle contraction is achieved.
j. Stimulate involved muscles 10 to 20 times.
k. At termination of treatment remove electrodes, dry patient and check for skin for any unusual marks, and place reusable single patient electrodes (if utilized) in package with patient's name and date in designated area.

9. Bipolar techniques:
   a. Check unit for loose connections or frayed wiring
   b. Know how to operate unit.
   c. Check skin for cuts, abrasions, new skin and recent scar tissue.
   d. Make sure skin is clean and all metal is removed from area to be treated.
   e. Explain treatment procedure to patient.
   f. Describe sensation patient will be feeling and what will be occurring and why it is being used.
   g. Determine/set appropriate mode of treatment, current and parameter as per therapist instructions.
   h. Place gel or moistened gauze covered electrodes, or reusable single patient electrode over involved muscle or muscle group.
   i. Secure electrodes with tape or strap if needed.
   j. Start with intensity setting at 0 and increase intensity as tolerated until good muscle contraction is achieved.
   k. Set timer.
   l. At termination of treatment, remove electrodes, dry patient and check patient skin and place reusable single patient electrodes in package with patient's name and date in designated area.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
High Voltage Galvanic Stimulator		**807**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff that will be utilizing High Volage Galvanic Stimulation for patient care at Mangum Regional Medical Center.

PURPOSE: This modality is a mild electrical stimulation used to reduce pain, muscle spasm, edema and increase circulation.

DEFINITION: High voltage pulsed galvanic stimulation combines very short pulse duration (of constant intensity) and high peak voltage, yet low total current per second, to give relative comfort and avoid tissue damage while stimulating deep tissues. It is also an efficient means of exciting nerve fibers.

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POLICY: Indications:

- Muscle spasm
- Muscle weakness
- Denervated muscle
- Peripheral nerve injury
- Bell's palsy
- Muscle re education

Contraindications:

- Malignant or potentially malignant lesion
- Acute localized infections
- Decreased or absent sensation
- Denuded areas
- Follow other electrical stimulation treatment contraindications

Precautions:

- Low voltage current is applied in vicinity of heart or brain: this shall be administered by therapist

PROCEDURE:

1. Before initiating treatment, the patient is evaluated by therapist to determine appropriateness of treatment.
2. Position and drape patient properly.
3. Explanation to patient:
    a. description: refer to purpose.
    b. Duration- as determined by therapist usually 20 minutes.
    c. Sensation-adjust electrical stimulation to patient comfort, a mild sensation should be noted.
4. Adjust intensity to “0” and plug in machine.
5. Adjust pulses per second/frequency and switching rate as indicated by therapist.
6. Adjust to negative or positive pole as indicated by therapist.
7. Cover electrodes with moist 4’’x 4’’ gauze or utilize reusable electrodes; cover round pad (if applicable) with moist washcloth.
8. Apply ground pad to broad surface area and electrodes to treatment site, as indicated by therapist.
9. Set timer as indicated by therapist, usually 20 minutes.
10. Slowly adjust intensity to patient comfort
11. Instruct patient in use of audible alarm system for assistance.
12. Treatment follow up:
    a. Readjust intensity to “0” and unplug machine.
    b. Remove electrodes and ground pad if applicable.
    c. Wipe moisture from patient skin with towel dispose of used linen
    d. clean up booth replacing all items used in proper place
    e. wash hands per facility policy
13. Electrical Precautions:
    a. Notify therapist immediately if machine has any broken or frayed wires.
    b. Do not operate machinery with wet hands.
    c. Do not use dry pads.
    d. Check the wire connections 2 electrodes prior to each use.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Mangum Regional Medical Center

TITLE		POLICY
High Voltage Galvanic Stimulator with Ultrasound		**808**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Professional rehabilitation staff members that will be utilizing high voltage galvanic stimulation with ultrasound for patient care at Mangum Regional Medical Center.

PURPOSE: To provide guidelines for administrating High Voltage Galvanic Stimulator with Ultrasound

DEFINITION: A modality of mild electrical stimulation combined with ultrasound (deep heat) to reduce pain, muscle spasm, edema and increase circulation).

POLICY: Physician order is received:

- Order may be specific for electrical stimulation and ultrasound (in or not in combination), or if order states for therapist to evaluate and treat as indicated

Indications:

- Muscle spasms
- Muscle weakness
- Denervated muscle
- Peripheral nerve injury
- Bell's palsy
- Muscle re-education

Contraindications:

- Malignant or potentially malignant lesion
- Acute localized infections
- Decreased or absent sensation
- Denuded areas

Precautions:

- Low a voltage current is applied in vicinity of heart or brain: therapist will provide treatment.

PROCEDURE:

1. Before initiating treatment, the patient is evaluated by therapist to determine appropriateness of treatment.
2. Position and drape patient properly.
3. Explanation to patient:
    a. Description -refer to purpose.
    b. Duration -as determined by therapist (usually 7 to 10 minutes).
    c. Sensation -mild electrical stimulation adjusted to comfort and superficial warmth.
4. Adjust intensity to “0”and plug in machine.
5. Adjust pulses per second/frequency, polarity and switching rate as indicated by therapist.
6. Adjust do duty cycle to continuous or pulsed as indicated by therapist.
7. Adjust intensity on ultrasound to “0”.
8. Adjust selector switch to combination.
9. Prepare ground pad, if applicable, as per rehabilitation services policy high voltage galvanic stimulator, and apply to broad surface area.
10. Plug in both units as applicable.
11. Apply coupling medium to treatment site and spread with sound head
12. While keeping soundhead moving slowly and in constant contact with skin, set timer on high voltage galvanic stimulator unit and adjust intensity to maximal patient comfort.
13. Set timer on ultrasound unit, if required, and adjust intensity to patient’s comfort continuing to keep soundhead moving at all times.
14. Treatment follow up:
    a. Return intensity on both machines, if applicable, to off position after the timer has switched off.
    b. Remove sound head from patient, clean with towel and facility approved disinfectant, and replace in holder.
    c. Wipe coupling medium from treatment area with towel.
    d. Remove ground pad from patient, if applicable, and wipe moisture from patient’s body.
    e. Dispose of used linen.
    f. Clean up booth replacing all items used in proper place.
    g. Wash hands per facility policy.
15. Electrical Precautions:
    a. Avoid bony areas with ultrasound, especially spinal column.
    b. Notify therapist immediately of any reddened or open area on skin before or after treatment.
    c. Keep soundhead moving at all times.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Ultrasound		**801**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	American Medical Association	

SCOPE: All professional rehabilitation staff who will utilize ultrasound as a treatment modality for patient care at Mangum Regional Medical Center.

PURPOSE: To provide guidelines for the use of continuous or pulsed ultrasound in the therapy Department.

DEFINITION: Ultrasound is a therapeutic modality for the purpose of providing deep heat to specific areas using sound waves. It is an ideal modality for increasing mobility in tissues with restricted range of motion. Ultrasound is considered medically necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and for the increase of muscle, tendon and ligament flexibility.

POLICY: Physician order is received:

- Order may be for "heat, deep heat, ultrasound, ultrasonic waves, other variations of terms, or state for therapist to evaluate and treat.

Indications

- Pain, sprains, strains
- Contracture/decreased range of motion
- Wound healing (with coupling dressing)
- Arthritis
- Contusions
- Bursitis
- Edema
- Scar tissue

Contraindications:

- Malignancy
- Severely decreased circulation
- Pregnancy
- Over epiphyseal plates
- Open wounds (directly)

- Over fracture site before callus has formed
- Decreased sensation
- Over CNS tissue
- Joint cement
- Directly over plastic components
- Carotid sinuses
- Reproductive organs
- Over or in the area of cardiac pacemakers
- Vital areas such as brain, ear, eye, heart, and cervical ganglia
- Over or near an area with thrombophlebitis
- Acute inflammation (thermal/high dose US)

Precautions:

- Over the spinal column, pt must provide feedback of any abnormal sensations.

PROCEDURE:

1. Before initiating treatment, patient is evaluated by therapist to determine appropriateness of treatment.
2. Treatment is explained to patient.
   a. This modality uses electrical energy to produce mechanical vibrations which causes a deep healing effect in soft tissues to decrease pain, increase circulation and relax tight muscles.
3. Patient is questioned regarding contraindications.
4. Treatment area is exposed and examined.
5. A warmed coupling agent is applied to the area using sound head.
6. Intensity dial is checked to be at 0 before turning on machine, if applicable.
7. The timer is set for time as indicated by therapist.
   a. Usual time is 3 to 10 minutes depending on area treated
8. Machine is set to continuous (100%), or pulsed as indicated by therapist.
9. Intensity dial is turned to intensity as determined by therapist.
10. Treatment is administered maintaining the sound head contact with the skin.
    a. For continuous ultrasound, the sound head is kept continually moving in small circles about the treatment area.
    b. If pulsed, 25 to 50% of the sound head may be placed and held on the treatment area with intensity ranges 1-1.2 W/cm2.
11. If the patient complains of discomfort, the intensity is turned down. If patient continues to complain treatment is discontinued.
12. Conclusion of treatment:
    a. Examine treatment area; notify therapist immediately if reddened skin or skin breakdown noted.
    b. Remove coupling medium and cleanse area.
    c. Disinfect transducer with facility approved disinfectant and store unit in designated area.

REFERENCE: American Medical Association, Coding Ahead CPT code 97035 Ultrasound

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Wound Debridement		**810**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	APTA House of Delegates: "Position on Direct Interventions Exclusively Performed by the physical therapist."	

SCOPE: All licensed physical therapy staff (PT/PTA) providing wound care at Mangum Regional Medical Center.

PURPOSE: To establish policy for wound debridement.

DEFINITION: Wound debridement is the removal of devitalized tissue either selectively or non-selectively to help a wound heal.

POLICY: Mechanical debridement of necrotic tissue will be performed on all wounds of patients referred to therapy for Whirlpool or wound care unless physician's order specifies otherwise.
Therapist or therapist assistant shall perform all mechanical/serial instrumental debridement.
The therapist shall perform all selective sharp debridement as per discipline's scope of practice/care and permitted by State Practice Act, Rules and Regulations.
Physician's order received for wound care, debridement, or evaluate and treat for wound care as appropriate.
Patient consent for wound debridement will be obtained prior to wound debridement.

PROCEDURE:

1. The therapist will evaluate patient prior to initiation of debridement and determine necessity to debride and debridement method.
   a. Selective sharp debridement involves the use of sharp instruments to remove specific areas of necrotic tissue from a wound, cutting along a line of demarcation separating viable and necrotic tissue and does not require prior softening of tissue.
   b. Serial instrumental debridement is performed over several patient interactions as necrotic tissue loosens from the wound. Debridement is performed with instruments such as forceps and, on occasion, scissors to remove loosely adherent

necrotic tissue; non-specific types of debridement such as pulsatile lavage, irrigation and Whirlpool are frequently applied in advance.

2. Standard and Transmission Based precautions are followed at all times.
3. Wound debridement will be performed at least every other treatment or as appropriate depending on status of wound and debridement method.
4. Hands are washed according to facility policy.
5. Sterile debridement tools are opened and placed on sterile field.
6. Sterile debridement tools are handled with clean gloves only.
7. New sterile debridement tools are used with each wound unless wounds are infection free per culture.
8. Dressing is applied to wound per Rehabilitation Services policy "dressing preparation and application."
9. Single use debridement tools are disposed of in the designated sharps container per facility procedure.
10. Sterilized tools (non-sharps) will be returned to packaged and taken to facility approved location for sterilization of equipment.

REFERENCES:

OSHA Guideline Exposure Category I
PPE: gloves and mask with fluid shield or goggles
Optional: gown if soiling likely

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Dressing Preparation and Application		**811**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services	Treatment of Pressure Ulcers, Clinical Practice Guideline, Number 15, US Dept of Health and Human Services	

SCOPE: All licensed physical therapy staff (PT/PTA) that will be providing wound care at Mangum Regional Medical Center.

PURPOSE: To establish guidelines for the preparation and application of dressings to ensure minimal risk of contamination.

POLICY: Dressings will be applied to wounds upon physician referral for wound care, hydrotherapy, dressing application, or procedure requiring removal and re-application of dressing.
If not specified by physician, the therapist will determine the topical agents and/or type of dressing to be utilized.
Physician order will be obtained for prescription topical agents prior to use.
Nonsterile gloves and a no touch technique will be utilized when removing or applying dressings to a wound.
Sterile gloves and sterile technique will be utilized when removing or applying a surgical dressing.

PROCEDURE:

1. General:
   a. Hands are washed according to facility policy and procedure.
   b. Provide privacy.
   c. Explain procedure.
2. Preparation of sterile dressings:
   a. A sterile towel is laid out carefully on a clean, dry surface with care to touch only the edges of the towel.
   b. Dressings as requested by the therapist, are opened and placed carefully on the sterile towel.
   c. Topical agents are applied to the dressing with care not to touch the dressing with the tube or any contaminated material.
   d. Once the dressings are prepared, another sterile towel is placed over the field if the dressings are not going to be applied immediately.

3. Sterile dressing application:
    a. Cover towel is removed from dressings and patient's wounds.
    b. Sterile gloves are donned with appropriate technique.
    c. Dressing is applied to the wound.
    d. Anchor is applied to the dressing.
    e. Hand hygiene will be performed and new sterile gloves must be donned after touching an infected wound(s) before dressing another infection free wound
4. "No-touch" technique:
    a. Gather dressing supplies.
    b. Open dressing packages just prior to use.
    c. Don gloves.
    d. Apply dressings without touching the wound or the surface of any dressing that may be in contact with the wound.
    e. When dressing multiple wounds, if gloves become soiled with wound secretion, blood, or other contaminants, gloves will be removed, hands washed, and new gloves donned before coming in contact with remaining clean dressings or supplies.
    f. Topical agents are applied to the dressing with care not to touch the dressing with the tube or any contaminated material.
    g. Anchor is applied to the dressing.

REFERENCE: OSHA guideline: Exposure Category I

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Vacuum Assisted Closer (VAC)/Negative Pressure Wound Therapy (NPWT)		**812**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All licensed physical therapy staff (PT/PTA) that provide wound care and will be applying NPWT for patient wound care at Mangum Regional Medical Center.

PURPOSE: To establish guidelines for use of the vacuum assisted closure system.

DEFENITION: Negative pressure wound therapy (NPWT), also known as a vacuum assisted closure (VAC), is a therapeutic technique using a suction pump, tubing and a dressing to remove excess exudate and promote healing in acute or chronic wounds.

POLICY: Physician order received for vacuum assisted closure system or negative pressure wound therapy (VAC/NPWT)

- If not a current therapy wound care patient, additional MD order for wound evaluation is required.
- Consent for NPWT will be obtained from the patient/caregiver before application of the wound vacuum system.

PROCEDURE:

1. Nursing unit clerk or R.N. to contact NPWT representative for system delivery and supplies.
2. Therapist to evaluate wound and determine appropriateness.
3. Therapist will initiate the VAC dressing application and connect to VAC canister.
4. Therapeutic suction setting will be determined for patient safety and optimum therapeutic effect.
   a. Range 50 mmHG with unit default setting 125 mmHG
5. Dressing will be monitored daily by the therapist and therapist assistant.
   a. Nursing will monitor PRN.
6. Upon loss of suction (air leak), if therapist is on site, therapist will repair or replace dressing as required per plan of care.

a. If suction loss occurs during hours therapy department not available, nursing will try and repair by sealing any areas where seal may be broken.
b. If nursing is not able to achieve adequeate seal, they will contact therapist and try to problem shoot by phone.
c. If problem is still not able to be fixed, nursing will turn off VAC. VAC dressing will remain intact unless there is to much drainage requiring a more absorptive dressing.
d. Therapist will repair or replace dressing as required per plan of care, the next business day.

7. If the NPWT system is not operating properly, VAC will be turned off and VAC representative notified so that a replacement unit can be obtained/delivered.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Iontophoresis		**815**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff utilizing iontophoresis for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all iontophoresis treatments are administered safely and effectively within established guidelines.

DEFINITION: Iontophoresis is a therapeutic modality used to introduce medications into the skin and mucous membranes of the body using direct current to decrease inflammation and pain in localized areas. The principle on which it is based is the repulsion of ions by the similarly charged electrode.

POLICY: Physician order is received for Iontophoresis, or order states therapist to evaluate and treat as indicated. Initial evaluation must be certified prior to initiation.

- If not specified, drug to be administered must be approved and written order obtained.

Indications:

- An Iontophoresis drug delivery system is used to apply ant-inflammatory or analgesic drugs to localized areas of inflammation and pain.

Contraindications:

- Patients who are electrically sensitive, have electrically sensitive support systems (i.e. pacemaker).
- Allergic reactions to drugs being administered.

PROCEDURE:

1. Obtain prescribed medication.
2. There are several types of units, which perform this desired function of iontophoresis.
   a. Refer to use of medication policy for administration
   b. Follow procedure outlined in the manufacturer's/operator manual depending on the unit to be used.
3. At the completion of the treatment:

a. Note any discoloration or irritation of the skin beneath the electrodes.
b. Discard the electrodes.
c. If applicable, store medication as per Department Policy, “Use of Medication.”

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Phonophoresis		**816**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff utilizing phonophoresis for patient care at Mangum Regional Medical Center.

PURPOSE: To ensure that all phonophoresis treatments are administered safely and effectively within established guidelines.

DEFINITION: Phonophoresis is the movement of a substance into the underlying tissues, away from the patient surface of the transducer, by virtue of having been exposed to ultrasonic energy.

POLICY: Physician order received

- Order must be specific for "phonophoresis" or state evaluate and treat as indicated and initial evaluation certified by Physician prior to initiation of treatment.

Indications:

- As per Rehabilitation Services Policy: Ultrasound
- Pathologies involving inflammation and/or pus

Contraindications:

- As per Rehabilitation Services Policy: Ultrasound
- Allergy to topical agent ordered

Follow Rehabilitation Services Policy and Procedure: "Use of Medication" and "ultrasound".

PROCEDURE:

1. Before initiating treatment, the patient is evaluated by therapist to determine appropriateness of the treatment.
   a. Verify medication allergies.
2. Obtain topical agent per facility procedure.
   a. Verify patient name, medication name, and physician order.
3. Treatment explained to patient.

a. position and drape the patient for comfort, modesty and ease of accessibility keeping the part to be treated exposed.
b. Apply topical agent to treatment area with a tongue depressor, or directly through the bottle without making contact to patient's skin.
c. Apply coupling agent over topical agent.
d. Follow ultrasound treatment procedures as outlined in Rehabilitation Services Policy and Procedure: ultrasound.

4. TOPICAL AGENT GUIDELINE IF NOT SPECIFIED PER M.D.
   a. Initial treatment should consist of Myoflex 10% cream for a daily treatment for six days.
   b. If patient does not get adequate relief: use Hydrocortisone (HC) 10% cream (or other facility approved steroidal cream/gel i.e. Dexamethasone), for daily treatment for six days.
   c. If the patient gets adequate relief, discontinue treatment.
   d. If the patient does not receive adequate relief, continue HC 10% cream 3 times/wk for 2 weeks.
5. Discontinue treatment if not successful accept:
   a. I for patient with clear signs and symptoms of nerve root or spinal cord impingement, treatment may continue on an indefinite basis one time per week period
6. For patient other than identified in 4.1, phonopheresis with HC 10% cream should not exceed 12 treatments.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Continuous Passive Motion Unit (CPM)		**817**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff who will be utilizing CPM for patient care at Mangum Regional Medical Center.

PURPSOSE: To outline procedures for use of Continuous Passive Motion unit (CPM).

DEFINITION: Continuous passive motion (CPM) is a passive therapy in which a machine is used to move a patient's joint through a specific range of motion.

POLICY: Physician Order:

- Order received for CPM
- Specific Physician protocol that includes use of CPM in specified protocol.

Indications:

- Post-operative extremity joint procedure

Precautions:

- Healing, sutured or stapled surgical incision
- Hemovac

PROCEDURE:

1. Therapist evaluates patient for appropriateness of referral.
2. Explain treatment to patient.
3. Unit is adjusted per manufacturers guidelines.
   a. Unit access of motion in line with joint axis of motion.
   b. Unit attached to overhead frame or stabilized.
   c. Foot of bed level flat and power to the foot of bed control turned off, if applicable.
4. Initial and revision of parameters are determined as follows:
   a. Per physician order.
   b. Per position protocol.
   c. Per therapist if not specified per physician.
      4.c.1 therapist determination will be based on the joint's current passive range of motion measurement and patient tolerance.

4.c.2 Total knee replacement parameter recommendations: 0 degrees extension, 40 degrees flexion, slow speed (1-3), applied for minimum 8 out of 24 hours, increasing flexion 10 degrees daily. Note: 8 hours need not be continuous and may be interrupted by meals, sleep, toileting, or therapy sessions.

5. Patient instructed in use of patient on/off switch.
6. Therapist to notify primary nurse, unit has been applied and reviews and or instructs in the operation of unit.
   a. Donning/doffing of unit.
   b. On/off switch.
   c. Treatment time.
   d. Foot of bed to remain level/flat and foot control power to be disabled while unit operating.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Cleaning of Paraffin		**901**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff that will be cleaning paraffin unit at Mangum Regional Medical Center.

PURPOSE: To maintain proper operation and cleanliness of paraffin unit and prevent nosocomial infection and cross-contamination.

POLICY: Paraffin unit will be cleaned following manufacturers guidelines:

- Monthly with daily use
- Quarterly with infrequent use

PROCEDURE:

1. Clean paraffin unit per schedule or anytime the melted wax has a cloudy appearance or residue noted in the bottom of paraffin tank.
2. Unplug the unit before cleaning so the wax can harden.
3. After the wax solidifies, scrape it into a trash can. Scrape/slash wipe the sides of the tank until all residue is removed.
4. Wipe the tank with a paper towel and facility approved disinfectant.
5. Refill the clean tank with new wax and oil as per manufacturer's directions on package.
6. Plug in the unit.
   6.1 Initial and date Cleaning and Maintenance Log.
7. Check for correct temperature (126º-130º F) prior to initial use.

Reference: Cleaning and Maintenance Log

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Vibration for Muscle Re-education		**817**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff that will be utilizing vibration for muscle re-education at Mangum Regional Medical Center.

PURPOSE: To establish policy for use of vibration in muscle re-education.

DEFINITION: Vibration therapy is a treatment technique for neuro-muscular re-education for the purpose of improving the level of communication between the body and brain via the nervous system.

POLICY: Physician order received for facilitation, muscle re-education, therapeutic exercise or stroke/neuro rehab.

Indications:

- Denervated muscle
- Peripheral nerve injury
- Bell's palsy

Contraindications:

- Open sores or lesions of the skin
- Areas of ecchymosis
- Areas of inflammation
- Patient with a history of calf tenderness, phlebitis or emboli
- Painful areas

PROCEDURE:

1. Use of vibration is determined by therapist post patient evaluation.
2. The use of a vibrator for muscle re-education and facilitation is explained to the patient and his/her role in the process is fully explained.
3. The vibrator is checked to be sure that it is in proper working order.
4. The patient's skin is inspected for lesions.
5. The vibrator is turned on and applied to the muscle to be facilitated.
6. The patient is simultaneously asked to contract the muscle if possible.
7. The therapist/assistant closely monitors the muscle for signs of activity.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Use of Medication		**814**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All professional rehabilitation staff who will be utilizing medication for patient care at Mangum Regional Medical Center.

PURPOSE: To outline the procedure for receiving and dispensing topical medications utilized in rehabilitation services.

POLICY: Therapists are authorized to administer medications restricted to topical medications associated with specific treatments.
Therapist assistants may administer topical medication, when authorized by facility policy and permissible per state law.
Medications will be stored under proper conditions of sanitation, light, temperature, moisture, ventilation, segregation, and security, consistent with facility pharmacy policy.

PROCEDURE:

1. All prescription topical medications will be placed in a secure drawer or cabinet.
2. All topical medications requiring refrigeration will be placed in the designated patient medication refrigerator.
3. Prior to administration of topical medication, the therapist will verify necessary information:
   a. patient name
   b. medication name
   c. physician order
   d. medication route
   e. medication dosage
   f. frequency of medication
4. Following application of medication to the patient, the therapist will document medication administration in the patient's medical record.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Utilization and Handling of Patient's Individual/Reusable Equipment		**903**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff members that will be handling patient's individual/reusable equipment at Mangum Regional Medical Center.

PURPOSE: To prevent the spread of infection through the proper utilization and handling of patients' individual use of equipment.

POLICY: Reusable/disposable individual use of equipment shall be requisitioned to the appropriate patient and disposed of after use.
Reusable items will be labeled with the patient's name and stored for future use, for the duration of the treatment plan.
Outpatients receiving hydro therapy (if applicable) shall be encouraged to bring their own clothing to be worn during this treatment, taken home, and laundered.
Staff will utilize Standard and Transmission Based precautions, personal protective equipment as outlined in facility infection control and exposure control plan policies.

PROCEDURE:

1. Disposable equipment/supplies:
   a. Rehabilitation services manager shall determine type and quantity of disposable equipment necessary to maintain for patient use.
   b. These items shall be requisitioned to the appropriate patient per facility procedure.
   c. After use, the item shall be disposed of per facility policy.
2. Reusable/disposable equipment/supplies:
   a. Equipment/supplies shall be requisitioned to the appropriate patient per facility procedure.
   b. The item shall be labeled with the patient's name and date.
   c. After use, the equipment/supply shall be returned to the package and or stored for future use, for the duration of the treatment plan.
   d. Upon completion of the patient's course of therapy, the equipment supply shall be discarded per facility policy.

3. Reusable equipment:
   a. All equipment will be labeled either with patient's name or department name.
   b. Equipment will be cleaned per rehabilitation services policy Care and Maintenance Procedures.
   c. When not in use, equipment will be stored in designated location.

Per OSHA requirement, this task requires a Class I

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Cleaning of Hydrocollator		**902**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff responsible for the cleaning of hydrocollator at Mangum Regional Medical Center.

PURPOSE: To maintain proper operation and cleanliness of the hydrocollator unit and prevent nosocomial infection and cross-contamination.

POLICY: Hydrocollator unit will be cleaned following manufacturer's guidelines on a biweekly basis.

PROCEDURE:

1. Unplug and drain tank completely from hose in base of unit into a drain.
2. Remove all hot packs and hardware from the interior of unit.
3. Wash interior of tank and hardware with a facility approved abrasive cleaner to remove deposits and stains.
4. Rinse tank thoroughly.
5. Rinse all hot packs before returning to unit.
    a. Discard and replace any damaged/leaking packs.
6. Return all hardware and equipment into unit.
7. Refill tank with water (140º-160º F) ½ inch above hot packs.
8. Clean outside of unit with facility approved stainless steel polish.
9. Return unit to proper area and plug into electrical outlet.
10. The date and initials of personnel cleaning the unit shall be recorded on the Cleaning and Maintenance log.
11. Verify unit has reached operating temperature prior to initial use.

Per OSHA Requirements this task requires a Class III

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Cleaning of Toys		**906**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: All rehabilitation staff that are responsible for the cleaning of toys utilized for therapy in rehabilitation department at Mangum Regional Medical Center.

PURPOSE: To assure proper cleanliness and prevent cross contamination by toys utilized during rehabilitation.

POLICY: All toys shall be cleaned with a facility approved disinfectant.
All toys visibly soiled, coming in direct patient contact without protective barrier, or utilized by a patient in isolation shall be cleaned immediately post use with a facility approved disinfectant or placed in the designated "**soiled container"** until cleaned.

PROCEDURE:

1. All soiled toys shall be disinfected immediately after each patient used with facility approved
   disinfectant or placed in the "soiled toys" container.
2. All toys in the "soiled toys" container shall be cleaned and appropriately stored prior to department closing.
3. To clean/disinfect toy:
   a. Scrub toy in warm, soapy water, using a brush to reach crevices.
   b. Rinse the toy in clean water, then immerse in bleach solution and soak for 10 minutes.
   c. Rinse with clear water.
   d. Air dry or dry with clean towel.
4. Clean/disinfected toys shall be stored in designated clean toys storage container and/or closet.

Per OSHA Requirement this task requires a Class III.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Patient Discharge Safety Checklist

PURPOSE: The transition out of the hospital is crucial for a good recovery and can reduce chances of future hospital stays. When planning for patient discharge, there are some key questions to address to clear up any confusion about care and to ensure a safe, successful transition to home.

INSTRUCTIONS:

1) The Case Manager assigned to the patient will initiate this form upon the patient's admission to the hospital.
2) The Case Manager shall include the patient and/or family/patient representative in the discharge planning process to assist in a safe and successful transition to home.
3) A review of the Patient's Discharge to Home Plan shall be done at each IDT meeting or more frequently as indicated by the patient's hospital course to discuss barriers/challenges to home discharge and the need for appropriate interventions to prevent a failed home discharge or hospital readmission.
4) The Case Manager will provide routine updates of the review to the patient and/or family/patient representative to assist in mitigating any barriers or impediments to a safe and successful transition to home.
5) Patient and/or family/patient representative understanding should be confirmed by using a technique known as "teach-back." A "yes" answer far too often does not guarantee understanding by the patient and/or family/patient representative. Ask the patient and/or family/patient representative to explain back the information that has been communicated to them. Repetition and reinforcement should be utilized as often as necessary to ensure the information is understood.
6) Use the attached Patient Discharge Safety Checklist to consider when preparing for a discharge to home. The Patient Discharge Safety Checklist shall be retained as part of the patient's medical record.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Patient Discharge Safety Checklist

Patient Name: _____ Date of Admission: _____/_____/_____

Admission Diagnosis: _____

Patient/Family Representative: _____ Relationship: _____ Contact Number: _____

Patient/Family Representative: _____ Relationship: _____ Contact Number: _____

Name of PCP: _____ City/State: _____

(Check each item as applicable to the patient's status at time of discharge)

Discharge Date: _____/_____/_____

□ Discharge to Home □ Family/Patient Representative Support (Describe): _____

□ Discharge Instructions Ordered & Copy Provided to Patient □ Yes □ No

□ Discharge Condition: □ Stable □ VS WNL □ Independent Ambulation □ Ambulatory with assistive device (circle): W/C Walker Cane □ Bedbound

□ Home Health (HH) Set-Up: □ Yes □ No □ N/A Name of HH: _____ Frequency of Visits: _____

□ Medical Equipment Set-Up: □ Yes □ No □ N/A (Describe): _____ Name of Company: _____

□ Medications/Prescriptions Set-Up: □ Yes □ No □ N/A (Describe): _____ Name of Pharmacy: _____

□ F/U Appointments Set-Up: □ Yes □ No □ N/A (Describe): _____

□ *Assistive Services Set-Up: □ Yes □ No □ N/A (Describe): _____

(*Includes assistance with meals, household chores, transportation, personal care, etc.)

□ Education, Teaching, & Training Completed as Applicable: □ Yes □ No □ N/A (Describe): _____

_____

□ **Discharge Call Completed Within 48 hours of Discharge (excluding holidays & weekends): Date: _____/_____/_____ Time: _____:_____**

Comments: _____ Case Manager Signature: _____

Case Manager Discharge Summary:

_____

_____

_____

Case Manager: _____ Date: _____/_____/_____

MANGUM REGIONAL MEDICAL CENTER

Mangum Regional Medical Center

Blood Transfusion Outcome Review

Patient Name _____ **Date of Birth** _____

Medical Record # _____ **Date of Transfusion** _____

Type of Blood Product ❑ PRBCs ❑ LRBCs ❑ Platelets ❑ FFP **Unit #** _____

Documentation

Skill	Yes	No	N/A	Comments/Areas to Improve
Blood Consent Form Completed				
Pre-Transfusion Hct/Hgb				
Order in Healthland for Type and Screen for PRBCs				
Blood Properly Checked out from Blood Bank and documented				
Patient Verified X2 prior to Administration to include Blood ID Band				
At least one RN at bedside during blood verification along with another RN/LPN				
Blood Transfusion started within 30 mins of receiving from Blood Bank				
Blood Transfusion Assessment completed in Healthland				
OBI Transfusion Record Completed				
RN initiated Blood Transfusion				
Vital Signs taken before Transfusion				
Vital Signs taken Q 15 mins for first hour				
Vital Signs taken Q 30 mins for second hour				
Vitals Signs taken Q hour until completed				
Vital Signs taken 1 hour Post-Transfusion				
Transfusion completed within 4 hours				
Any Transfusion Reactions Noted				
Blood Transfusion Nursing Log completed				
Post-Transfusion Hct/Hgb				

Comments:

RN Signature	Date
QM/CNO Signature	Date

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	-	-	-

MANGUM REGIONAL MEDICAL CENTER
BALANCE SHEET

	12/31/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Audited
CASH AND CASH EQUIVALENTS	1,193,977.29	612,885.01	60,783.93	133,204.52
RESERVED FUNDS	3,597,082.63	-	-	-
PATIENT ACCOUNTS RECEIVABLE, NET	1,704,448.97	2,400,091.11	2,332,884.75	2,673,217.00
INVENTORY	69,909.34	47,000.43	102,691.19	235,404.12
PREPAIDS AND OTHER ASSETS	1,034,287.86	930,494.09	274,934.60	34,011.66
CAPITAL ASSETS, NET	1,229,195.48	1,503,097.40	1,660,334.36	-
Total Assets	8,828,901.57	5,493,568.04	4,431,628.83	3,075,837.30
ACCOUNTS PAYABLE	12,474,571.45	7,482,135.89	3,112,072.41	2,786,346.45
DUE TO MEDICARE	6,260,875.37	8,222,080.63	8,108,674.03	3,299,317.54
COVID GRANT FUNDS	3,597,082.63	-	-	-
DUE TO COHESIVE - PPP LOANS	-	-	-	-
NOTES PAYABLE - COHESIVE	242,500.00	242,500.00	120,000.00	-
NOTES PAYABLE - OTHER	471,032.37	1,020,189.77	23,564.77	514,485.34
ALLIANTZ LINE OF CREDIT	-	-	-	-
LEASES PAYABLE	366,252.10	406,645.64	1,408,363.63	-
Total Liabilities	23,412,313.92	17,373,551.93	12,772,674.84	6,600,149.33
NET ASSETS	(14,583,412.35)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
Total Liablities and Net Assets	8,828,901.57	5,493,568.04	4,431,628.83	3,075,837.30
	-	-	0.00	-

MANGUM REGIONAL MEDICAL CENTER
OPERATING STATEMENT

	12/31/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Audited
Inpatient revenue	2,230,761.99	1,839,186.54	3,509,513.55	1,537,078.71
Swing Bed revenue	11,519,484.90	10,178,066.65	2,000,373.85	311,888.47
Outpatient revenue	6,754,385.45	9,926,042.34	36,517,907.05	14,771,826.44
Professional revenue	1,708,155.05	1,758,285.97	2,114,186.49	774,339.20
Contractual adjustments	(9,181,056.04)	(8,340,605.44)	(28,195,967.19)	(11,245,416.08)
Contractual adjustments: MCR Settlement	1,811,951.00	(1,154,857.00)	(2,152,550.00)	-
Bad debts	(2,714,251.14)	(2,310,613.91)	(3,155,273.67)	(2,780,983.05)
Net patient revenue	12,129,431.21	11,895,505.15	10,638,190.08	3,368,733.69
Other operating revenue	718,289.40	49,000.44	(1,082,033.47)	12,274.10
Salaries and benefits	4,530,484.70	4,798,286.83	4,782,977.71	2,056,908.78
Professional Fees	1,794,618.71	1,838,300.17	1,100,288.20	416,247.12
Contract labor	2,363,994.27	2,098,120.24	-	-
Purchased/Contract services	1,035,762.12	791,163.84	3,528,764.11	2,107,627.89
Management expense	2,832,132.00	3,162,462.00	152,419.00	-
Supplies expense	1,154,108.08	1,251,445.39	2,403,755.62	762,024.23
Rental expense	294,967.40	248,152.83	685,357.92	73,081.47
Utilities	170,793.30	180,462.17	205,309.20	86,197.96
Travel & Meals	3,976.25	8,556.85	124,900.37	88,602.66
Repairs and Maintnenance	38,981.08	52,185.37	291,016.76	48,028.86
Insurance expense	131,981.68	129,821.74	165,895.73	60,804.10
Other Expense	492,975.99	326,854.92	412,990.40	1,151,223.16
Interest	408,329.87	276,351.31	437,037.63	54,573.59
Depreciation	298,043.62	321,279.81	82,177.94	-
TOTAL EXPENSES	15,551,149.07	15,483,443.47	14,372,890.59	6,905,319.82
Change in Net Assets	(2,703,428.46)	(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	(14,583,412.35)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
	0.00	-	-	-

Mangum Regional Medical Center
Admissions, Discharges & Days of Care
Fiscal Year 2020

12/31/2020

	January	February	March	April	May	June	July	August	September	October	November	December	YTD
Admissions													
Inpatient	23	18	16	13	9	10	11	15	16	12	20	16	179
Swingbed	27	27	21	13	16	19	18	21	13	9	10	20	214
Observation	0	0	0	0	1	1	2	0	0	0	3	0	7
	50	45	37	26	26	30	31	36	29	21	33	36	400
Discharges													
Inpatient	20	17	16	12	7	9	10	14	16	17	23	15	176
Swingbed	18	16	13	3	5	11	8	15	7	5	12	18	131
Observation	0	0	0	0	1	1	2	0	0	0	3	0	7
	38	33	29	15	13	21	20	29	23	22	38	33	314
Days of Care													
Inpatient-Medicare	42	30	29	15	11	30	31	30	42	29	37	25	351
Inpatient-Other	7	23	28	21	6	4	4	16	20	9	27	21	165
Swingbed-Medicare	324	305	268	274	300	278	258	216	168	246	346	217	3,200
Swingbed-Other	0	26	37	0	24	32	22	26	7	47	31	2	254
Observation	0	0	0	0	1	1	3	0	0	0	4	0	9
	373	384	362	310	342	345	318	288	237	331	445	265	3,979
Calendar days	31	29	31	30	31	30	31	31	30	31	30	31	366
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	8.55	10.87
ADC	12.03	13.24	11.68	10.33	11.00	11.47	10.16	9.29	7.90	10.68	14.70	8.55	10.85

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	12/31/20
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	28.02
Current ratio	0.48	0.45	0.39	0.39	0.70	0.65	0.61	0.58	0.58	0.61	0.57	0.61
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	51.43
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	0.83
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	0.79

12/31/2019 PY Comparison
215
164
26
405
213
159
26
398
424
165
3,734
198
0
4,521
365
12.39
12.39

12/31/19
14.45
0.53
73.64
0.88
100%
0.81

Mangum Regional Medical Center
Medicare Payables by Year
January 26, 2020 Board Meeting

Year	Original Loan Balance	Balance as of 12/31/2020	Total Interest Paid as of 12/31/2020
2016 C/R Settlement	1,397,906.00	498,931.05	205,415.96
2017 Interim Rate Review - 1st	723,483.00	358,759.99	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	50,566.42	20,332.88
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	938,969.30	203,093.96
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	1,155,352.40	162,088.62
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement *8/31 Est. Receivable per C/R tool*	(1,815,759.00)	(1,360,472.00)	-
Total	**8,076,228.21**	**6,260,875.37**	**745,994.04**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended December, 2020

MTD				YTD		
Actual	Prior Year	Prior Yr Variance		Actual	Prior Year	Prior Yr Variance
225,516	103,945	121,571	Inpatient revenue	2,230,762	1,839,187	391,575
742,060	1,444,167	(702,108)	Swing Bed revenue	11,519,485	10,178,067	1,341,418
626,329	974,218	(347,889)	Outpatient revenue	6,754,385	9,926,042	(3,171,657)
142,105	416,216	(274,111)	Professional revenue	1,708,155	1,758,286	(50,131)
1,736,010	2,938,546	(1,202,536)	Total patient revenue	22,212,787	23,701,582	(1,488,794)
251,714	1,992,907	(1,741,193)	Contractual adjustments	9,181,056	8,340,605	840,451
(495,378)	(971,775)	476,397	Contractual adjustments: MCR Settlement	(1,811,951)	1,154,857	(2,966,808)
428,249	369,569	58,680	Bad debts	2,714,251	2,310,614	403,637
184,585	1,390,701	(1,206,116)	Total deductions from revenue	10,083,356	11,806,076	(1,722,720)
1,551,424	1,547,845	3,579	Net patient revenue	12,129,431	11,895,505	233,926
215,527	(6,818)	222,345	Other operating revenue	718,289	49,000	669,289
1,766,951	1,541,027	225,924	Total operating revenue	12,847,721	11,944,506	903,215
			Expenses			
427,957	379,062	48,894	Salaries and benefits	4,530,485	4,798,287	(267,802)
140,831	176,272	(35,441)	Professional Fees	1,794,619	1,838,300	(43,681)
266,086	246,200	19,886	Contract labor	2,363,994	2,098,120	265,874
93,023	20,870	72,153	Purchased/Contract services	1,035,762	791,164	244,598
225,000	291,066	(66,066)	Management expense	2,832,132	3,162,462	(330,330)
159,093	126,950	32,143	Supplies expense	1,154,108	1,251,445	(97,337)
31,333	12,876	18,456	Rental expense	294,967	248,153	46,815
11,372	14,570	(3,198)	Utilities	170,793	180,462	(9,669)
397	554	(156)	Travel & Meals	3,976	8,557	(4,581)
2,781	3,055	(273)	Repairs and Maintnenance	38,981	52,185	(13,204)
11,482	10,688	794	Insurance expense	131,982	129,822	2,160
45,339	35,016	10,323	Other Expense	492,976	326,855	166,121
1,414,695	1,317,179	97,516	Total expense	14,844,776	14,885,812	(41,037)
352,257	223,849	128,408	EBIDA	(1,997,055)	(2,941,307)	944,252
19.9%	14.5%	5.4%	EBIDA as percent of net revenue	-15.5%	-24.6%	9.1%
27,449	42,138	(14,689)	Interest	408,330	276,351	131,979
25,083	26,643	(1,561)	Depreciation	298,044	321,280	(23,236)
299,725	155,068	144,657	Operating margin	(2,703,428)	(3,538,938)	835,509
-	-	-	Other	-	-	-
-	-	-	Total other nonoperating income	-	-	-
299,725	155,068	144,657	Excess (Deficiency) of Revenue Over Expenses	(2,703,428)	(3,538,938)	835,509
16.96%	10.06%	6.90%	Operating Margin %	-21.04%	-29.63%	8.59%

Mangum Regional Medical Center
Statement of Revenue and Expense Trend
Fiscal Year 2020

	January	February	March	April	May	June	July	August	September	October	November	December	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**	**225,516**	2,230,762
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**	**742,060**	11,519,485
Outpatient revenue	**697,297**	**618,768**	**737,709**	**283,525**	**316,908**	**472,711**	**525,246**	**555,398**	**603,806**	**708,089**	**608,600**	**626,329**	6,754,385
Professional revenue	**203,801**	**200,242**	**197,098**	**76,616**	**60,862**	**128,778**	**135,786**	**138,768**	**154,083**	**128,848**	**141,168**	**142,105**	1,708,155
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	1,736,010	22,212,787
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**	**251,714**	9,181,056
Contractual adjustments: MCR Settlement	**-**	**-**	**-**	**-**	**(791,984)**	**-**	**-**	**(528,397)**	**-**	**-**	**3,808**	**(495,378)**	(1,811,951)
Bad debts	**155,999**	**73,647**	**498,548**	**304,754**	**298,496**	**2,681**	**289,329**	**303,736**	**43,115**	**95,228**	**220,470**	**428,249**	2,714,251
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	184,585	10,083,356
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**	**1,551,424**	12,129,431
Other operating revenue	**1,497**	**7,902**	**1,066**	**3,157**	**5,941**	**1,005**	**195,079**	**257,371**	**971**	**28,339**	**434**	**215,527**	718,289
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	1,766,951	12,847,721
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**	**427,957**	4,530,485
Professional Fees	**158,406**	**146,618**	**160,166**	**154,059**	**160,275**	**157,070**	**144,358**	**134,124**	**168,677**	**145,847**	**124,187**	**140,831**	1,794,619
Contract labor	**220,920**	**125,589**	**214,312**	**185,713**	**200,590**	**270,408**	**183,794**	**231,131**	**191,331**	**130,097**	**144,022**	**266,086**	2,363,994
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**	**93,023**	1,035,762
Management expense	**291,066**	**291,066**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	2,832,132
Supplies expense	**36,323**	**76,084**	**76,070**	**96,282**	**122,112**	**100,530**	**106,055**	**80,204**	**106,872**	**94,185**	**100,297**	**159,093**	1,154,108
Rental expense	**20,352**	**20,596**	**24,300**	**25,258**	**24,869**	**21,195**	**24,872**	**17,256**	**31,467**	**34,285**	**19,184**	**31,333**	294,967
Utilities	**13,290**	**13,865**	**12,124**	**15,385**	**15,097**	**13,826**	**14,672**	**18,301**	**15,449**	**13,518**	**13,894**	**11,372**	170,793
Travel & Meals	**578**	**230**	**730**	**347**	**224**	**419**	**455**	**392**	**12**	**168**	**25**	**397**	3,976
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**	**2,781**	38,981
Insurance expense	**10,696**	**10,696**	**10,696**	**10,695**	**11,039**	**11,039**	**11,039**	**11,039**	**11,039**	**11,039**	**11,482**	**11,482**	131,982
Other	**29,460**	**23,914**	**72,241**	**63,363**	**65,243**	**38,727**	**10,923**	**7,360**	**80,980**	**23,607**	**31,818**	**45,339**	492,976
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	1,414,695	14,844,776
EBIDA	$ (249,212)	$ (198,025)	$ (530,402)	$ (675,051)	$ 122,900	$ (433,418)	$ (63,269)	$ 230,184	$ (278,396)	$ (243,808)	$ (30,815)	$ 352,257	$ (1,997,055)
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%	19.9%	-15.5%
Interest	**40,917**	**39,634**	**38,411**	**37,175**	**36,740**	**35,020**	**33,714**	**32,398**	**31,157**	**27,044**	**28,672**	**27,449**	408,330
Depreciation	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,748**	**24,993**	**24,993**	**24,993**	**25,083**	298,044
Operating margin	$ (314,877)	$ (262,407)	$ (593,561)	$ (736,974)	$ 61,412	$ (493,185)	$ (121,730)	$ 173,039	$ (334,545)	$ (295,845)	$ (84,480)	$ 299,725	$ (2,703,428)
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)	299,725	(2,703,428)
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%	16.96%	-21.04%

Mangum Regional Medical Center
Cash Receipts by Month
January 26, 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	1,940,134	
					10,425,338	4,274,873
Subtotal FY 2018	15,276,562	Subtotal FY 2019	11,571,384	Subtotal FY 2020	14,700,211	

Mangum Regional Medical Center
Comparative Balance Sheet
Fiscal Year 2020

	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	12/31/2020	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**	**1,322,140**	**1,193,977**	**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**	**3,597,083**	**-**
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**	**1,773,523**	**1,704,449**	**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**	**69,909**	**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**	**1,034,288**	**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**	**1,229,195**	**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	8,828,902	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**	**12,474,571**	**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**	**6,260,875**	**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**	**3,597,083**	**-**
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**	**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**	**471,032**	**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**	**366,252**	**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	23,412,314	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)**	**(14,583,412)**	**(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	8,828,902	5,493,568

January 26, 2020

Board of Directors
Mangum Regional Medical Center

December 2020 Financial Statement Overview

- Balance Sheet
  - Operating Cash decreased $128,163 from the November 30, 2020 balance. This is primarily driven by:
    - An adjustment to the stimulus fund balance was made to replenish the $1.041M initially borrowed for operating cash. (previously - $1.492M borrowed - $451K that had 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.
  - A $967,967 Medicare receivable was paid to the facility in December and an additional adjustment of $495,378 to increase the 2020 interim rate receivable estimate, along with principal payments on debt service resulted in the net increase of $341,364 seen in the Due to Medicare liability account.

- Income Statement
  - Net Patient Service Revenue increased $405,757 from November. This is primarily driven by a positive adjustment to contractual allowances regarding the 2020 interim rate receivable.
  - Total operating expenses for October were $1,467,267. This amount is substantially higher than the YTD average of $1.2M due to a surge in contract labor, stimulus bonuses through payroll, and inventory audit adjustments regarding year end physical count.

Other Updates

- 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. As of 12/23/20, Novitas has confirmed a receivable owed to the hospital in the amount of $1,360,472. We are awaiting the rebuttal letter to request the cash be paid out to the hospital.
- 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. Cohesive successfully completed the rebuttal request and the funds were paid and received to the hospital 12/17/20.

February 23, 2021

Board of Directors
Mangum Regional Medical Center

January 2021 Financial Statement Overview

- Balance Sheet Highlights
  - Operating Cash of $1.4M increased $190K from the December 31, 2020 balance.
  - A small adjustment of $54,842 was made to the Stimulus fund reserve for supplies related to the treatment of COVID-19.
  - AP increased $431K in January, this is primarily driven by the $210K net operating loss for the month combined with timing of a delayed check run processed 2/1.
  - The Medicare 8/31/20 Interim rate review letter showing a receivable of $1.3M was issued and funds applied to the four oldest Medicare ERS payables resulting in the payoff of the 2016 Cost report, and both 2017 interim rate ERS payables, as well as a partial payment of $452K on the 2018 Cost Report ERS payable. Results are reflected in the provided Medicare Payable Schedule.

- Income Statement Highlights
  - Reported patient days in January of 183, inclusive of 156 Medicare days. This is a decrease of 82 days from the prior month.
  - Net Patient Service Revenue in January is $878K. This is a decrease of $132K from the previous month year to date average.
  - Total operating expenses for January were $1.1M. This is primarily driven by the decrease in contract labor related to lower patient days.

Mangum Regional Medical Center
Comparative Balance Sheet
Fiscal Year 2021

	January	Prior Year End 2020
Cash And Cash Equivalents	**1,384,085**	**1,193,977**
Reserved Funds	**3,542,241**	**3,597,083**
Patient Accounts Receivable, Net	**1,636,678**	**1,704,449**
Inventory	**72,955**	**69,909**
Prepaids And Other Assets	**1,015,985**	**1,034,288**
Capital Assets, Net	**1,204,113**	**1,229,195**
Total Assets	8,856,056	8,828,902
Accounts Payable	**12,905,466**	**12,474,571**
Due To Medicare	**6,161,350**	**6,260,875**
Covid Grant Funds	**3,542,241**	**3,597,083**
Due To Cohesive - PPP Loans	**-**	**-**
Notes Payable - Cohesive	**242,500**	**242,500**
Notes Payable - Other	**435,254**	**471,032**
Alliantz Line Of Credit	**-**	**-**
Leases Payable	**362,765**	**366,252**
Total Liabilities	23,649,575	23,412,314
Net Assets	**(14,793,519)**	**(14,583,412)**
Total Liablities and Net Assets	8,856,056	8,828,902

Mangum Regional Medical Center
Cash Receipts by Month
February 23, 2020 Board Meeting

2018 Month	Amount	2019 Month	Amount	2020 Month	Amount	Stimulus Funds	2021 Month	Amount
January-18	165,685	January-19	417,231	January-20	1,183,307		January-21	830,598
February-18	752,169	February-19	242,680	February-20	750,899		February-21	
March-18	1,098,956	March-19	1,357,203	March-20	843,213		March-21	
April-18	1,449,073	April-19	1,299,323	April-20	617,307	778,925	April-21	
May-18	1,429,917	May-19	1,289,344	May-20	605,061	3,405,872	May-21	
June-18	999,979	June-19	559,288	June-20	562,725		June-21	
July-18	4,525,796	July-19	1,576,072	July-20	521,080	78,499	July-21	
August-18	924,838	August-19	346,302	August-20	611,529		August-21	
September-18	1,228,910	September-19	876,966	September-20	785,446		September-21	
October-18	1,101,494	October-19	1,148,666	October-20	1,168,624	11,577	October-21	
November-18	1,140,874	November-19	957,993	November-20	836,014		November-21	
December-18	458,871	December-19	1,500,316	December-20	1,940,134		December-21	
					10,425,338	4,274,873		
Subtotal FY 2018	15,276,562	Subtotal FY 2019	11,571,384	Subtotal FY 2020	14,700,211		Subtotal FY 2021	830,598

MANGUM REGIONAL MEDICAL CENTER
BALANCE SHEET

	1/31/21	12/31/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Unaudited	Audited
CASH AND CASH EQUIVALENTS	1,384,085.42	1,193,977.29	612,885.01	60,783.93	133,204.52
RESERVED FUNDS	3,542,240.97	3,597,082.63	-	-	-
PATIENT ACCOUNTS RECEIVABLE, NET	1,636,677.73	1,704,448.97	2,400,091.11	2,332,884.75	2,673,217.00
INVENTORY	72,954.99	69,909.34	47,000.43	102,691.19	235,404.12
PREPAIDS AND OTHER ASSETS	1,015,984.57	1,034,287.86	930,494.09	274,934.60	34,011.66
CAPITAL ASSETS, NET	1,204,112.63	1,229,195.48	1,503,097.40	1,660,334.36	-
Total Assets	8,856,056.31	8,828,901.57	5,493,568.04	4,431,628.83	3,075,837.30
ACCOUNTS PAYABLE	12,905,465.68	12,474,571.45	7,482,135.89	3,112,072.41	2,786,346.45
DUE TO MEDICARE	6,161,350.38	6,260,875.37	8,222,080.63	8,108,674.03	3,299,317.54
COVID GRANT FUNDS	3,542,240.97	3,597,082.63	-	-	-
DUE TO COHESIVE - PPP LOANS	-	-	-	-	-
NOTES PAYABLE - COHESIVE	242,500.00	242,500.00	242,500.00	120,000.00	-
NOTES PAYABLE - OTHER	435,253.77	471,032.37	1,020,189.77	23,564.77	514,485.34
ALLIANTZ LINE OF CREDIT	-	-	-	-	-
LEASES PAYABLE	362,764.67	366,252.10	406,645.64	1,408,363.63	-
Total Liabilities	23,649,575.47	23,412,313.92	17,373,551.93	12,772,674.84	6,600,149.33
NET ASSETS	(14,793,519.16)	(14,583,412.35)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
Total Liablities and Net Assets	8,856,056.31	8,828,901.57	5,493,568.04	4,431,628.83	3,075,837.30
	-	-	-	0.00	-

MANGUM REGIONAL MEDICAL CENTER
OPERATING STATEMENT

	1/31/21	12/31/20	12/31/19	12/31/18	6 Months Ending 12/31/17
	Unaudited	Unaudited	Unaudited	Unaudited	Audited
Inpatient revenue	257,967.41	2,230,761.99	1,839,186.54	3,509,513.55	1,537,078.71
Swing Bed revenue	448,244.89	11,519,484.90	10,178,066.65	2,000,373.85	311,888.47
Outpatient revenue	478,855.29	6,754,385.45	9,926,042.34	36,517,907.05	14,771,826.44
Professional revenue	110,524.58	1,708,155.05	1,758,285.97	2,114,186.49	774,339.20
Contractual adjustments	(204,983.25)	(9,181,056.04)	(8,340,605.44)	(28,195,967.19)	(11,245,416.08)
Contractual adjustments: MCR Settlement	-	1,811,951.00	(1,154,857.00)	(2,152,550.00)	-
Bad debts	(211,971.13)	(2,714,251.14)	(2,310,613.91)	(3,155,273.67)	(2,780,983.05)
Net patient revenue	878,637.79	12,129,431.21	11,895,505.15	10,638,190.08	3,368,733.69
Other operating revenue	55,094.66	718,289.40	49,000.44	(1,082,033.47)	12,274.10
Salaries and benefits	368,755.41	4,530,484.70	4,798,286.83	4,782,977.71	2,056,908.78
Professional Fees	112,344.12	1,794,618.71	1,838,300.17	1,100,288.20	416,247.12
Contract labor	85,909.86	2,363,994.27	2,098,120.24	-	-
Purchased/Contract services	102,240.34	1,035,762.12	791,163.84	3,528,764.11	2,107,627.89
Management expense	225,000.00	2,832,132.00	3,162,462.00	152,419.00	-
Supplies expense	137,287.44	1,154,108.08	1,251,445.39	2,403,755.62	762,024.23
Rental expense	16,781.32	294,967.40	248,152.83	685,357.92	73,081.47
Utilities	12,796.14	170,793.30	180,462.17	205,309.20	86,197.96
Travel & Meals	334.71	3,976.25	8,556.85	124,900.37	88,602.66
Repairs and Maintnenance	4,528.92	38,981.08	52,185.37	291,016.76	48,028.86
Insurance expense	11,660.46	131,981.68	129,821.74	165,895.73	60,804.10
Other Expense	22,501.08	492,975.99	326,854.92	412,990.40	1,151,223.16
Interest	18,616.61	408,329.87	276,351.31	437,037.63	54,573.59
Depreciation	25,082.85	298,043.62	321,279.81	82,177.94	-
TOTAL EXPENSES	1,143,839.26	15,551,149.07	15,483,443.47	14,372,890.59	6,905,319.82
Change in Net Assets	(210,106.81)	(2,703,428.46)	(3,538,937.88)	(4,816,733.98)	(3,524,312.03)
Net Assets, Beginning of Year	(14,583,412.35)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)	-
Net Assets, End of Period	(14,793,519.16)	(14,583,412.35)	(11,879,983.89)	(8,341,046.01)	(3,524,312.03)
	0.00	0.00	-	-	-

Mangum Regional Medical Center
Medicare Payables by Year
February 23, 2020 Board Meeting

Year	Original Loan Balance	Balance as of 1/31/2021	Total Interest Paid as of 1/31/2021
2016 C/R Settlement	1,397,906.00	-	205,415.96
2017 Interim Rate Review - 1st	723,483.00	-	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	-	20,332.88
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	435,242.96	211,212.12
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	1,107,339.21	171,836.90
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement *8/31 Est. Receivable per C/R tool*	(1,815,759.00)	-	-
Total	**8,076,228.21**	**6,161,350.38**	**763,860.48**

Mangum Regional Medical Center
Admissions, Discharges & Days of Care
Fiscal Year 2021

	January	12/31/2020 PY Comparison	12/31/2019 PY Comparison
Admissions			
Inpatient	15	23	15
Swingbed	10	27	12
Observation	0	0	2
	25	50	29
Discharges			
Inpatient	14	20	13
Swingbed	5	18	13
Observation	0	0	2
	19	38	28
Days of Care			
Inpatient-Medicare	23	42	40
Inpatient-Other	27	7	40
Swingbed-Medicare	133	324	353
Swingbed-Other	0	0	21
Observation	0	0	0
	183	373	454
Calendar days	31	31	31
ADC - (incl OBS)	5.90	12.03	14.65
ADC	5.90	12.03	14.65
Ratio Analysis	1/31/21	12/31/20	12/31/19
Days cash on hand	37.51	28.02	14.45
Current ratio	0.59	0.61	0.53
Days revenue in AR, net	57.75	51.43	73.64
Total reserves as a % of gross A/R	0.83	0.83	0.88
Bad debt allowance as a % of > 120 days	100%	100%	100%
% of aging > 120 days old	0.82	0.79	0.81

Mangum Regional Medical Center

Statement of Revenue and Expense

For The Month and Year To Date Ended January, 2021

MTD				YTD		
Actual	Prior Year	Prior Yr Variance		Actual	Prior Year	Prior Yr Variance
257,967	169,988	87,980	Inpatient revenue	257,967	169,988	87,980
448,245	1,070,140	(621,895)	Swing Bed revenue	448,245	1,070,140	(621,895)
478,855	697,297	(218,441)	Outpatient revenue	478,855	697,297	(218,441)
110,525	203,801	(93,276)	Professional revenue	110,525	203,801	(93,276)
1,295,592	2,141,226	(845,633)	Total patient revenue	1,295,592	2,141,226	(845,633)
204,983	997,171	(792,188)	Contractual adjustments	204,983	997,171	(792,188)
-	-	-	Contractual adjustments: MCR Settlement	-	-	-
211,971	155,999	55,972	Bad debts	211,971	155,999	55,972
416,954	1,153,170	(736,215)	Total deductions from revenue	416,954	1,153,170	(736,215)
878,638	988,056	(109,418)	Net patient revenue	878,638	988,056	(109,418)
55,095	1,497	53,598	Other operating revenue	55,095	-	55,095
933,732	989,553	(55,820)	Total operating revenue	933,732	988,056	(54,323)
			Expenses			
368,755	386,311	(17,556)	Salaries and benefits	368,755	386,311	(17,556)
112,344	158,406	(46,062)	Professional Fees	112,344	158,406	(46,062)
85,910	220,920	(135,011)	Contract labor	85,910	220,920	(135,011)
102,240	65,990	36,251	Purchased/Contract services	102,240	65,990	36,251
225,000	291,066	(66,066)	Management expense	225,000	291,066	(66,066)
137,287	36,323	100,965	Supplies expense	137,287	36,323	100,965
16,781	20,352	(3,571)	Rental expense	16,781	20,352	(3,571)
12,796	13,290	(493)	Utilities	12,796	13,290	(493)
335	578	(244)	Travel & Meals	335	578	(244)
4,529	5,374	(846)	Repairs and Maintnenance	4,529	5,374	(846)
11,660	10,696	965	Insurance expense	11,660	10,696	965
22,501	29,460	(6,959)	Other Expense	22,501	29,460	(6,959)
1,100,140	1,238,765	(138,625)	Total expense	1,100,140	1,238,765	(138,625)
(166,407)	(249,212)	82,805	EBIDA	(166,407)	(250,709)	84,302
-17.8%	-25.2%	7.4%	EBIDA as percent of net revenue	-17.8%	-25.4%	7.6%
18,617	40,917	(22,300)	Interest	18,617	40,917	(22,300)
25,083	24,748	335	Depreciation	25,083	24,748	335
(210,107)	(314,877)	104,770	Operating margin	(210,107)	(316,374)	106,267
-	-	-	Other	-	-	-
-	-	-	Total other nonoperating income	-	-	-
(210,107)	(314,877)	104,770	Excess (Deficiency) of Revenue Over Expenses	(210,107)	(316,374)	106,267
-22.50%	-31.82%	9.32%	Operating Margin %	-22.50%	-32.02%	9.52%

MRMC AP AGING SUMMARY
For Month Ending
1/31/2021

VENDOR - Under Litagation	Description	0-30	31-60	61-90	Over 90	1/31/2021	12/31/2020	11/30/2020
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
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
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**	**1/31/2021**	**12/31/2020**	**11/30/2020**
ABC BIOMEDICAL	IV Pump rental		2,025.00			2,025.00	4,050.00	2,025.00
ALPHA TECHNICS	Lab eq repair		183.96			183.96	183.96	-
AMERICAN HEALTH TECH	Rental Equipment-Old				22,025.36	22,025.36	22,025.36	22,025.36
AMERIPRIDE SERVICES INC	Linen Services	6,982.62	5,197.95			12,180.57	10,418.50	8,458.27
ANESTHESIA SERVICE INC	Service		636.97			636.97	1,151.47	476.95
AT&T	Fax Service	1,198.30				1,198.30	-	-
BAXTER HEALTHCARE	Pharmacy Supplies	489.00	695.85			1,184.85	1,509.47	3,135.21
BEC INTEGRATED	Nurse Call	462.00				462.00		
BENISH AND ASSOCIATES	1099 Provider	16,000.00				16,000.00	-	16,000.00
BKD LLP	Finance Purch svs	728.00			2,860.00	3,588.00		
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	1,113.87	5,569.35	1,113.87	4,455.48	12,252.57	11,138.70	4,455.48
CENTERPOINT ENERGY ARKLA	Utilities	2,355.94				2,355.94	-	1,292.57
CINTAS CORPORATION #628	Linen Services	6,914.50	2,473.70			9,388.20	4,115.50	4,179.50
CITY OF MANGUM	Utilities	5,742.71				5,742.71	4,479.80	5,771.76
COHESIVE HEALTHCARE MGMT	Mgmt Fees	281,610.66	45,045.34	271,786.02	3,437,420.90	4,035,862.92	3,849,639.66	4,044,701.41
COHESIVE HEALTHCARE RESOURCES	Payroll	361,077.36	349,195.66	365,061.42	4,230,018.07	5,305,352.51	4,997,812.42	3,998,394.61
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	490.00		2,829.75		3,319.75	2,525.25	53,486.50
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	62,300.44	123,283.74	120,541.12	1,466,300.23	1,772,425.53	1,848,242.04	1,912,805.57
COMMERCIAL MEDICAL ELECTRONICS	Equipment Inspection Service				2,450.00	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	2,466.00	77,678.70			80,144.70	109,013.00	23,821.04
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	2,000.00	80.00	2,200.00		4,280.00	4,780.00	4,700.00
CPSI	EHR Software	34,996.40	779.70			35,776.10	-	3,096.00
CULLIGAN WATER CONDITIONING	Clinic Purchased Service	23.50	11.00			34.50	11.00	21.43
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees		1,590.77	24,785.91	195,092.18	221,468.86	222,378.09	171,846.72
DONNA MCKELVEY	Employee Reimbursement	159.56				159.56		
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	5,478.00		2,550.00		8,028.00	7,650.00	-
FOX BUILDING SUPPLY	Plant Ops Supplies	89.77				89.77	-	183.30
GEORGE BROS TERMITE & PEST CON	Pest Control Service	155.00	155.00			310.00	310.00	310.00
GLOBAL EQUIPMENT COMPANY INC.	Minor Equipment	254.94				254.94	-	-
GRAINGER	Maintenance Supplies	1,285.77				1,285.77	816.21	1,658.01
GRAYSTONE MEDIA GROUP	Advertising			305.00		305.00	582.00	1,264.00

VENDOR	Description	0-30	31-60	61-90	Over 90	1/31/2021	12/31/2020	11/3
GREER COUNTY TREASURER	Property taxes		5,460.50			5,460.50	5,460.50	-
HAC INC	Dietary Supplies	2.78				2.78	216.43	-
HEALTHSTREAM	Employee Training Puchased Service		1,432.50			1,432.50	1,432.50	-
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00	1,000.00			3,000.00		
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	9,805.00
IMEDICAL INC	Supplies				1,008.29	1,008.29	1,008.29	1,008.29
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service		55.90			55.90	165.70	80.85
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	391.22	955.42			1,346.64	2,037.30	1,779.16
JERI BERRY	Employee Reimbursement	19.69				19.69		
KCI USA	Supplies				8,270.20	8,270.20	8,270.20	8,270.20
LABCORP	Lab purch svs	28,592.29				28,592.29	-	-
LINET AMERICAS, INC.	COVID equipment	9,846.00				9,846.00	9,846.00	-
LOCKE SUPPLY	Plant Ops Supplies		755.00			755.00	755.00	176.27
MARK CHAPMAN	Employe Reimbursement	992.72				992.72		
MATT MONROE	Staff House Rent	850.00				850.00	-	-
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	(10,026.25)	12,310.60			2,284.35	11,447.48	16,421.22
MEDLINE INDUSTRIES	Patient Care Supplies	30.21	10,204.35	18,840.72		29,075.28	41,446.06	37,187.50
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
NEXTIVA, INC.	Phones	(213.06)				(213.06)	-	1,852.67
NINJA RMM	IT Service				2,625.00	2,625.00	2,625.00	2,625.00
NUANCE COMMUNICATIONS INC	Clinic Purch svs	123.00		123.00		246.00		
OKLAHOMA BLOOD INSTITUTE	Lab Supplies			2,197.20		2,197.20	2,508.30	311.10
OPTUM	Insurance Portal		376.17			376.17		
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies		418.86			418.86	418.86	416.66
PARA HEALTHCARE ANALYTICS, LLC	CMD Review		5,500.00			5,500.00		
PITNEY BOWES GLOBAL FINANCIAL	Postage rental		347.00			347.00	347.00	-
PRESS GANEY ASSOCIATES, INC	Purchased Service	2,048.28			2,048.28	4,096.56	2,048.28	2,048.28
RAMSEY AND GRAY, PC	Legal Fees		540.00		27,510.00	28,050.00	28,650.00	28,650.00
SCHAPEN LLC	Clinic Rent	1,750.00				1,750.00	-	-
SCRUBS AND SPORTS	Employee Appreciation		105.64			105.64	105.64	-
SHRED-IT USA LLC	Secure Doc disposal service	524.40				524.40	-	496.40
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	3,470.00				3,470.00	3,470.00	1,735.00
SOUTHWEST HOT STEAM CLEANING	Dietary Purchased Service	300.00				300.00	300.00	-
SPARKLIGHT BUSINESS	Cable service	129.44			816.26	945.70	816.26	945.70
STANDLEY	Printer Lease	16.92				16.92	2,382.74	-
STANDLEY SYSTEMS LLC	Printer Lease	2,373.89				2,373.89	-	-
STAPLES ADVANTAGE	Office Supplies	252.93	230.41			483.34	2,281.47	1,336.75
STERICYCLE ENVIRONMENTAL SOLUT	Waste Disposal Service	5,839.00				5,839.00		
STERICYCLE INC	Waste Disposal Service				(2,794.46)	(2,794.46)	(2,794.46)	-
STRYKER INSTRUMENTS	Surgery Supplies				31,845.65	31,845.65	31,845.65	31,845.65
SUNBELT RENTALS	Air Scrubber Rental - COVID			348.00	196.93	544.93	544.93	196.93
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	1,995.00				1,995.00	-	-
TOTAL MEDICAL PERSONNEL STAFF.	Agency Staffing	6,998.36				6,998.36	7,420.54	2,273.26
UMPQUA BANK VENDOR FINANCE	Lab Equipment	-				-		

VENDOR	Description	0-30	31-60	61-90	Over 90	1/31/2021	12/31/2020	11/3
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	2,651.01	1,018.22			3,669.23	2,816.61	3,906.84
US MED-EQUIP LLC	Swing bed eq rental		1,879.45	1,659.60		3,539.05	-	1,482.90
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	1,710.00				1,710.00	3,420.00	3,420.00
WELCH ALLYN, INC.	Supplies				(628.66)	(628.66)	(628.66)	(628.66)
WORTH HYDROCHEM	Water treatment svs		783.40			783.40	783.40	-
BIO-RAD LABORATORIES INC	Lab Supplies						-	455.72
BRIAN BLUTH, M.D.	1099 Provider						1,950.00	-
CARDINAL HEALTH	Medical Supplies						690.56	-
CLIFFORD POWER SYSTEMS INC	Plant Ops purch svs						2,850.00	-
COHESIVE REVOPS	RCM fee						59,718.93	19.01
DR W. GREGORY MORGAN III	1099 Provider	4,766.67				4,766.67		
DR. JOHN CHIAFFIETELLI	1099 Provider						9,615.38	-
EMD MILLIPORE CORPORATION	Lab Supplies						-	6,028.40
FEDEX	Postage service	98.94				98.94	100.35	-
FFF ENTERPRISES INC	Pharmacy Supplies						5,913.79	2,456.99
HEALTH CARE LOGISTICS	Pharmacy Supplies						43.80	-
HENRY SCHEIN	Lab Supplies	4,558.70				4,558.70	9,474.04	1,216.22
KAY ELECTRIC	Repairs/maintenance						881.89	-
LAMPTON WELDING SUPPLY	Patient Supplies						1,959.09	-
LANDAUER	Radiology purch svs						1,527.30	-
MSDSONLINE INC	Materials purchased service						-	3,299.00
OFFICE DEPOT	Office Supplies						36.99	-
OKLAHOMA DEPARTMENT OF LABOR	Misc	25.00				25.00		
PHILIPS HEALTHCARE	Pharmacy Supplies	641.98				641.98		
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance						-	395.00
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract						3,890.68	-
SIZEWISE	Swing bed purch service						3,536.23	-
SYSMEX AMERICA INC	Lab eq svs contract						8,439.00	-
THE COMPLIANCE TEAM	Clinic Survey						2,190.00	4,880.00
ULTRA-CHEM INC	Housekeeping Supplies						326.46	-
Vendor Subtotal		83,849.89	43,373.42	23,473.52	84,391.92	**11,798,609.27**	**11,417,512.32**	**10,480,785.38**
Grand Total		83,939.66	43,373.42	23,473.52	84,391.92	**12,647,841.00**	**12,266,744.05**	**11,330,017.11**
					Conversion Variance	(13,340.37)	(13,340.32)	(13,340.32)
					AP Control	12,634,500.63	12,253,403.73	11,316,676.79
					Accrued AP	270,965.05	221,167.72	942,405.73
					TOTAL AP	**12,905,465.68**	**12,474,571.45**	**12,259,082.52**

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.

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Mangum Regional Medical Center

December 2020 CEO Report for MRMC Hospital Board

CEO: Marie Harrington

January 19, 2021

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.
- ✓ December COVID-19 Stats at MRMC: 161 Swabs, 16 Positive (9.93%), 145 Negative (90.06%), 0 Pending and 1 (0.62%) 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 December Prevalence: 9.93% Median Age: 66.81
- ✓ Greer County December COVID-19 Statistics: 390 Positive Cases and 9 Deaths (2.30% 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 12.03.2020.
- ✓ Participated in all OSDH Region 5 Vaccine Planning Meetings.
    - Drafted our MRMC Vaccination Plan for Phase 1 and beyond
    - Administered the Pfizer-BioNTech Vaccine to 3 groups of Phase 1 recipients.
    - Everything went well and no serious adverse reactions were reported.
- ✓ Registered MRMC as a Pandemic Provider and received our approval.
- ✓ Moved our outpatient registration back to the main hospital building at the beginning of December.
- ✓ We reopened the front main hospital entrance and moved our COVID-19 Screener to the front entrance during daytime operating hours.
- ✓ A COVID-19 Screener is available at the front entrance for employees during 7:30 am – 8:00 am to accommodate the staff that would like to enter the building prior to daytime screening shift.
- ✓ 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.
- ✓ Completed COVID Preparedness Surge questionnaire.
- ✓ Due to continued COVID-19 surge in December we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- ✓ MRMC Census Daily Average for December: 8.5 Swing bed and Acute patients per day; Average Daily Census for 2020 was 10.95.
- ✓ Make hospital rounds every morning for inspection.
- ✓ Cohesive Healthcare provided staff lunches for December 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-February.

Hospital Staff Overview:

- ✓ No staff issues or concerns currently. Teams are all working together very well.
- ✓ Conducted MRMC Morning Director's Huddle each day. Continued meetings on Microsoft Teams and we have seen improved work efficiencies due to not traveling to main building for meeting. Excellent attendance as well.
- ✓ In person interview with Dr. Chiaffitelli, Marie and Dr. Spear on December 18, 2020. The interview went well and feel he would be a good choice for the permanent supervising physician position that has not been filled yet. Dr. Chiaffitelli approved of his recommendation for Randy's supervision. He lives here at Lake Altus in Granite and has retired to this area. Currently, Dr. Brian Bluth is serving as Randy's temporary supervising physician. Cohesive is also working on recruitment for this position.
- ✓ So proud of our team for completing the Employee Satisfaction Surveys by the end of December. We had 62 out of 66 (94%) completion!
- ✓ COVID-19 Bonuses were approved by the board on December 23, 2020 and these bonuses were distributed to all staff the first payroll in January. A thank you letter was sent to all staff thanking them for their heroic efforts during this pandemic.
- ✓ IT successfully worked on CPSI access for providers to finish any charting after they have finished a shift and not at our facility. This will help greatly with mitigating delays in the patient revenue cycle billing process due to medical records not completed.
- ✓ Jessica Pineda was awarded the Employee of The Month for November during the MRMC All-Staff meeting on December 7, 2020.
- ✓ Christmas lunch was scheduled for December 22, 2020 and provided by Cohesive Healthcare.
- ✓ Created Elfster Secret Santa Gift Exchange for Directors to participate in some holiday cheer.
- ✓ Central Supply ordered stockings for the staff to have available in the cafeteria. Different staff members filled the stockings with treats.

- ✓ 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:

- ✓ Reviewed and approved policies in December for QAPI and Med Staff
  - Clinical Policy and Procedures: Daniel and Zach approved
  - ED Policy and Procedures: Daniel and Dr. C approved
  - Wound Care Procedure Form: Daniel and Marie approved
  - HR Performance Evaluation Policy: Approved during QAPI Meeting
- ✓ Distributed December Monthly Calendar for MRMC Meeting schedules and reporting/agenda deadlines on December 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 December 31, 2020.
- ✓ End of the Year inventory was conducted on December 29, 2020.
- ✓ NRHA CEO Certification Program is excellent and thankful to be a part of this program!
- ✓ Signed checks every Friday or Monday for MRMC Accounts Payable Clerk.
- ✓ All roof leaks (clinic, lab, and hospital) have been addressed and hospital roof repair is still pending.
  - Lab and clinic roof were repaired in December.
- ✓ MRMC KPIs for December were reviewed. The quality improvements have continued to be significant: 2 Falls without injury and 1 Fall with minor injury, Zero Employee Work Related Injuries, 3 Med Variances, 1 IP AMA, 1 ER AMA, 1 LWBS, 8 Referrals, 2 Denials, 6 Inpatient Mortalities, 1 ER Patient Mortality, 1 Re-Admission within 30 days, 8 ER Readmissions within 72 hours, 1 Grievance/Complaints. Zero CAUTIs, CLABSIs, or CAEs, and 0 HA Pressure Ulcers. A total of 125 ER patients were admitted which was a decrease of 8.76% over previous month.
- ✓ Conducted monthly MRMC Finance Meeting on December 17, 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 and items, we prepared for January board meeting:
  - Auto Insurance
  - LifeShare
  - Spacelabs
- ✓ Continued to work with CPSI through the month of December on Promoting Interoperability Initiatives. We made significant improvements to continually strive for excellence in all quality measures.
- ✓ Participated in Cohesive Leadership Meeting on December 17, 2020.
- ✓ Continue to prepare for survey readiness each month.
- ✓ CMS Price Transparency and Chargemaster Initiative Update:
  - PARA contracts were fully executed.

- Update from Cohesive RCM Director:
  - They sent the files over to PARA for review.
  - PARA will start the build and complete the review. This will take several weeks due to the amount of line items listed in our chargemaster.
  - Implementing Price Transparency for MRMC at the end of January.

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Mangum Regional Medical Center

January 2021 CEO Report for MRMC Hospital Board

CEO: Marie Harrington

February 15, 2021

COVID - 19 Activity and Overview:

- ✓ We continue to swab any admits due to continued increase in number of COVID-19 positive patients in Mangum. Treating all patients in our ER as if they have COVID-19 until proven otherwise.
- ✓ Continue to participate 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.
- ✓ January COVID-19 Stats at MRMC: 157 Swabs, 7 Positive (4.45%), 139 Negative (88.53%), 0 Pending and zero deaths.
- ✓ 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, December Prevalence: 9.93%, and January Prevalence: 4.45%, Median Age: 49.4
- ✓ Greer County January COVID-19 Statistics: 461 Positive Cases and 13 Deaths (2.81% 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 12.03.2020.
- ✓ Participated in all OSDH Region 5 Vaccine Planning Meetings.
  - Administered the Pfizer-BioNTech Vaccine to Phase 1 recipients, both front line and EMS.
  - Conducted several successful vaccine clinics with no serious adverse reactions.
  - New vaccinate@mangumregional.org email address for directing all patients interested in the vaccine to sign up.
- ✓ Completed Savance COVID-19 Screening Kiosk Implementation and Training in January. We tested a small number of the administration/business office team members the week of January 18th-22nd. Went well but worked through some technical difficulties.
  - Go Live was scheduled for the week of January 25, 2021 and went well. Successful implementation with minor issues that continue to be improved and resolved.
- ✓ Enrolled RHC as a Pandemic Provider and received status approval on January 13, 2021. Hospital and Clinic are Pandemic Providers.

- ✓ 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.
- ✓ Due to continued COVID-19 surge in January we have prohibited vendor visitation to hospital and limited patient visitation to only palliative care patient visitation.
- ✓ Make hospital rounds every morning for inspection.
- ✓ Cohesive Healthcare provided staff lunches for January 2021 during this pandemic. All staff members are very thankful for this support.

Hospital Staff and Operations Overview:

- ✓ No staff issues or concerns currently. Teams are all working together very well.
  - 3 new core staff employees started in January.
- ✓ Respiratory Lead was promoted to Respiratory Therapy Manager on January 20, 2021. She was so happy and excited to receive this recognition of her hard work and dedication.
- ✓ Conducted MRMC Morning Director's Huddle each day. Continued meetings on Microsoft Teams. Draft daily agendas each day and include a motivational "Quote of The Day".
- ✓ Meet with CMO and Quality Director each week.
- ✓ Working on improvements to our new hire orientation and onboarding process. Working on strengthening the legacy MRMC leaves behind with each employee. I have spoken so much in the past about the legacy each employee leaves behind, but now focusing on the legacy we leave behind ensuring they have a wonderful employment experience while at MRMC. Onboarding and orientation plays a significant role in the future success for these new employees and so we are focusing on personal touches during this process.
- ✓ Randy's permanent supervising physician contract is still pending.
- ✓ Desiree Sutherland was awarded the Employee of The Month for January during the MRMC All-Staff meeting on February 9, 2021.
- ✓ 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:

- ✓ Reviewed and approved policies in February for QAPI and Med Staff
  - Patient Discharge Safety Plan:
  - Blood Transfusion Outcome Review:
- ✓ PLICO Risk Assessment was conducted on January 27, 2021. Excellent assessor, and departmental managers/directors were prepared. We look forward to reviewing the finalized risk assessment report.

- ✓ Price Transparency Link from PARA was embedded into our Mangum website and went live on January 27, 2021. It looks wonderful and I went through a demo to review what the patients would experience submitting a price request.
- ✓ CDM PARA Review is completed but will need to be reviewed by Marie, Kasi, and Laurie next week before upload.
- ✓ Distributed January Monthly Calendar for MRMC Meeting schedules and reporting/agenda deadlines on January 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 January 31, 2021.
- ✓ NRHA CEO Certification Program is excellent and have made practical application to many of the pearls of wisdom gained.
- ✓ Signed checks every Friday or Monday for MRMC Accounts Payable Clerk.
- ✓ All roof leaks for hospital have been addressed and hospital roof repair is still pending board approval.
- ✓ MRMC KPIs for January were reviewed. The quality improvements have continued to be significant: 0 Falls, 1 Employee Work Related Injuries, 3 Med Variances, 2 AMAs, 0 LWBS, 5 Referrals, 3 Denials, 0 Inpatient Mortalities, 0 ER Patient Mortality, 1 Readmission to Acute, 1 Grievance and 0 Complaints. Zero CAUTIs, CLABSIs, or CAEs, and 0 HA Pressure Ulcers. A total of 104 ER patients were admitted which was a decrease of 16.8% over previous month. A total of 252 Outpatient visits. Average Daily Census: 5.9
- ✓ Conducted monthly MRMC Finance Meeting on January 22, 2021.
- ✓ Continue to work with RCM teams to enhance overall revenue cycle process.
- ✓ Dietary staff participated in an allergy in-service training that our wonderful Dietary Manager facilitated.
- ✓ The hospital generator update:
    - Reyes Electric began the project and performed a will perform a new assessment when approved. Project is still pending.
- ✓ Contracts and items, we prepared for February Board Meeting:
    - Lippincott (Wolters Kluwer Health, Inc.)
    - OFMQ
    - Spacelabs
- ✓ Participated in Cohesive Leadership Meeting on January 14, 2021.
- ✓ HSEEP/HPP 2021 Exercise Planning Meeting for Concepts and Objective was excellent and held on January 28, 2021. Daniel, Robert, Glynadee, and Melissa were present. We will have out next meeting on March 5, 2021.
- ✓ Continue to prepare for survey readiness each month.

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

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**

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

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 32.

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

914

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 Clear roof of trash and limps Pressure wash surface for better adhesion	$6,000.00
Silicone Coating Roof System Install Silicone Roof Coating 10 year workmanship warranty 20 year material warranty	$77,000.00

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

SPACELABS HEALTHCARE

Mangum City Hospital
Request for Proposal

Submitted Date: October 23, 2020
Valid Until: December 23, 2020

Marco Morrow
Account Sales Executive
marco.morrow@spacelabs.com | 405.503.1177

SPACELABS HEALTHCARE

The Spacelabs Advantage

Patient Safety, Cost Control, and Clinical Efficiency

Mangum City Hospital Monitoring Proposal

Spacelabs' proposal fulfills and exceeds the requirements designated in the Mangum City Hospital RFP as described, including hardware, software, network, education, and installation for complete functionality. We are seeking a symbiotic partnership with Mangum City Hospital to bring the best patient monitoring solution possible to Mangum and the surrounding community that the hospital serves.

Proposal Highlights

Included in the proposal

- Barcode scanning on all monitoring devices quoted
- One year warranty, four years of no charge depot repair
- Two tuition credits for Biomedical Engineer training at no charge
- Five years of software support
- Trade-in of existing equipment

Total Proposal Price $297,113.14

Marco Morrow
Account Sales Executive
405.503.1177

Mangum Regional Hospital Patient Monitoring RFQ Summary & Vendor Agreement

Project Description

Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports, Mangum Regional Hospital / Enterprise-Level Bi-Directional CPSI Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device

Instructions: RFQ Disclosure Worksheet

All quoted equipment must be NEW and of the bidding manufacturer's most current model utilizing their latest technology.
Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. *ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED*

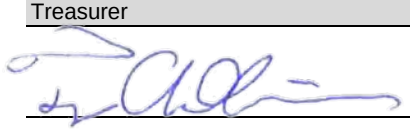
Total 5-Year Proposal Price

Proposal Price MUST include 5-Year total for ALL costs associated with Complete & Functioning system as specified in Project Description and supplemental documents & vendor presentations; including, but not limited to Hardware, Infrastructure, Software, Licensing, Warranty, Service, Labor, Professional Services, Design, etc.

Total Proposal Price:	**$ 315,375.99**	(Including System Requirements; Must match official quote)
	$ (18,262.85)	Premier Competitive Trade-in Discount
	$ 297,113.14	Grand Total

Vendor Agreement

Please ensure that included proposal meets ALL of the required and/or referenced systems, monitors, parts, service, etc., at the time of go-live.
If deployed monitoring system does not meet what is requested or required within this proposal, vendor must provide necessary systems, monitors, parts, service, etc., at no charge.

Vendor Name:	Spacelabs Healthcare
Authorized Signatory Name:	Tony Challancin
Title:	Treasurer
Signature	

	Mangum Regional Hospital Patient Monitoring System Requirements (Networking, Server, Software Licensing, Integration, Test Environment & Professional Services Req's)	Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
		Yes	No	Partial	Details / Functional Description	
Networking	***Hard Wired*** **:** It is preferred that all Physiologic Monitoring equipment will reside on the HOSPITAL LAN. Hospital will provide network drops at each monitor, & central location. If vendor requires proprietary network, it is the sole responsibility of equipment vendor to disclose and include all costs of design & labor to create this network. ALL COSTS FOR FUNCTIONING NETWORK MUST BE INCLUDED HEREIN	X			All bedside monitors communicate on a dedicated VLAN(s). Spacelabs fully supports routing between VLAN's for bedside monitors and central stations to leverage a fully redundant, hospital managed network. Monitors fully support DHCP at the edge of the network on the device and DNS.	Included
	Wireless **:** It is preferred that all Physiologic (*Transport)* Monitoring equipment will reside on the HOSPITAL 802.11 WLAN. If vendor requires proprietary network, it is the sole responsibility of equipment vendor to disclose and include all costs of design & labor to create this network. ALL COSTS FOR FUNCTIONING NETWORK MUST BE INCLUDED HEREIN Hospital will provide a wireless site survey and cable pulling.	X			A proprietary network is not required, monitors can reside on the Hospital WLAN. Spacelabs compact and portable monitors support 802.11 a/b/g.	Included
	Telemetry **:** It is **REQUIRED that telemetry equipment will reside on a 1.4GHz WMTS networ**k. 608MHz and / or Wi-Fi telemetry will not be accepted or considered. It is the responsibility of equipment vendor to cover all costs and labor to create this network except for cable pulling. Hospital will provide cable pulling.	X			Spacelabs Telemetry requires the use of the protected WMTS including 1.4GHz. If multiband antenna is installed, 608MHz is also fully supported. ***NOTE: antenna price quoted on the Coverage Area_Telemetry tab.*	Included
	WAN Connectivity to ALL Mangum Regional Hospital facilities: *Vendor must provide the ability for equipment to communicate across the hospital wide area network to remotely monitor patient monitoring devices and capture all data required in the sections below. This includes capturing data from all monitored departments through Mangum Regional Hospital.*	X			Any bedside, in any facility can be viewed by any other bedside or central across the enterprise. No central, database or proprietary equipment for communication is required. This includes full, interoperability to adjust alarms, admit, etc. if required. Subnets can be excluded to the node/edge level on the device. Management of telemetry at the remote site requires local administration within that broadcast domain. Viewing of any telemetry at another central station is supported across the WAN. This includes capturing data from all monitored departments through Mangum Regional Hospital.	Included
	Traffic Segmentation **:** It is preferred that all vendor equipment residing on the Mangum Regional Hospital network will be segmented onto its own VLAN.	X			Spacelabs fully supports hospital sanctioned and managed wired and wireless networks. This includes routing over layer3 without any proprietary servers or central stations.	Included
	Remote Displays **:** HOSPITAL to provide network for remote displays including audio-video transmitters/receivers and cable for connectivity from central stations to the associated remote displays. HOSPITAL will also provide the TV's/Displays and mounts for these remote displays.					
Servers	**Server Location:** Vendor must provide Network architecture, including all server infrastructure, WAN / LAN requirements, physical location requirements, data flow diagram, and EMR [CPSI] integration, as specified by Mangum Regional Hospital IT staff	X			Spacelabs will provide Network architecture, including all server infrastructure, WAN / LAN requirements, physical location requirements, data flow diagram, and EMR [CPSI] integration, as specified by Mangum Regional Hospital IT staff.	$5,000.00
	Server Virtualization **:** Vendor is allowed to utilize hospital's virtual server environment. Vendors must provide access to their software to hospital Clinical Engineering & IT personnel for support.	X			Server virtualization is fully supported. Since 2007, Spacelabs has deployed ICS within a virtual environment to leverage fault tolerance, high availability and redundancy as the core of a virtualized system. Recommendations are provided and customers are encouraged to use active management of the VM instances of databases and distribution servers (Monitor Loaders, Application Servers, etc.).	Included
	Physical Servers **:** In the event vendor doesn't support virtualization, vendor is required to provide all servers necessary for the operation and interfacing of their system. This includes redundant servers. Vendors must provide access to their servers & software to hospital Clinical Engineering & IT personnel for support.	X			Not Applicable	Included
are Licensing	***Device Interfacing/Integration*** : Vendors shall provide licensing for ALL devices included in this RFP to communicate with the electronic medical record.	X			All bedside, wired or wireless, and patient worn devices are being interfaced to the EMR. A single inbound ADT and a single outbound Vital Signs interface is all that is required for a traditional HL7 feed to CPSI.	Included
	Device Software **:** Vendors shall provide licensing for "unlimited" software updates, for the life of the system, required for interoperability in the event additional items are purchased in the future. This includes monitor, central and server software.	X			Devices (modules and monitors) are not required to be on the same version of software for interoperability or communication to enterprise applications. As of today, the current Spacelabs enterprise applications support devices introduced in 2003 along side devices introduced in 2017. Software support contracts provide for an annual medical device software updates as part of the value of the agreement. Costs are quoted on the Emergency Department tab.	Included

Softw	***Patient Data Transfer*** : CONTINUOUS FULL DISCLOSURE RECORD ACROSS ALL DEPTS. System shall provide continuous Full Disclosure record for ALL monitoring devices (telemetry, bedside, wireless), across ALL departments, including those where central monitors are not required in hospital provided specifications. All Full Disclosure records MUST be accessible from any central monitor located on patient monitoring network. This is a site license.	X			Transferred data includes all waveforms, alarms, alerts, print jobs, demographics and trends of all devices and modules connected to the bedside or patient worn monitors. This can include up to 3 days post discharge patient data.	Included
	Remote Access Software **:** Vendors will provide Remote Access ability from any mobile device or hospital PC, for unlimited users (or as specified in dept tabs), this remote access must be available for ALL quoted bedside monitors, compact monitors, and telemetry. Data to be available to remote users include: Raw Waveforms, Arrhythmia Analysis, Alarms, Custom Trend Creation & Display (Graphical and Tabular), Diagnostic 12 Lead EKG Reports with interpretation, Saved Events, Printed Item Audit Trail (Auto and Manual). Additionally, user must have ability to print the following all required data from any PC connected to the HOSPITAL network. This may be accomplished through a web interface or client application.	X			Spacelabs will provide Remote Access ability from any mobile device or hospital PC, for unlimited users. Remote access to data and waveforms is accomplished with Spacelabs Clinical Access. The Client on the central station is identical to the format at the bedside and is identical at the workstation or other device.	Included
Integration	**ADT Integration:** Vendor to provide ADT connection to the Mangum Regional Hospital ADT system.	X			The ADT interface is included as part of the Interface Bundle licenses.	$5,025.00
	Barcode Scanning: allows all quoted bedside monitors, compact monitors, transport monitors, and central monitors to utilize hospital provided barcode scanner for patient admission through ADT integration	X			Barcode scanning can be used to admit a patient to the monitor through ADT integration.	Included
	Electronic Strip Export to EMR [CPSI]: All bedside, compact, transport, and central monitors must print electronic waveform strip (pdf) and reports directly to EMR [CPSI] patient folder	X			Patient data including electronic waveforms (in pdf format) can be dropped into a shared folder for CPSI to pick up and process.	Included
	Alarm / Event Notification System : All monitoring devices must be able to transmit alarms to the middleware communication system allowing for alarms to be forwarded on to clinician phones.	X			The Enterprise Network Interface (ENI) licenses are included in the Interface Bundle licenses. Using ENI, alarm retrospective information will be sent to third party systems for processing to user devices (e.g. smartphone) supported by the middleware application. This can be implemented at a time of customer's choosing for just the implementation charges. Mangum does not currently have the middleware or 3rd Party devices to interface.	Included
	EMR [CPSI] Interface via HL7: This interface allows for transmission of numerics to the EMR [CPSI] system	X			The HL7 Vital Signs Interface is included as part of the Interface bundle licenses which allows for transmission of numerics to CPSI.	Included
	Full Disclosure Integration with EMR [CPSI]: Allows vendor's full disclosure application to be opened "in context" within the EMR [CPSI] view a staff member will be accessing.	X			CPSI does not currently support opening in context. Once they do, Spacelabs can provide an API integration packet that would allow CPSI to deploy Clinical Access (Full Disclosure) from CPSI dashboard at no additaional charge.	Included
Test System	Vendor will provide a separate test system for validating all interfaces listed above as well as remote access. HOSPITAL will provide information regarding test requirements as well as the virtual space requirements for the test system.	X			Spacelabs complies	Included
Professional Services	Vendors will provide a project manager to manage and coordinate all aspects of the project. Please include all costs for design and travel, implementation, and all other associated professional services required for a successful implementation and go-live.	X			Spacelabs will provide a project manager to manage and coordinate all aspects of the project. Installation and education are included on each tab if applicable.	$3,500.00
	Vendors will provide project plan with minimal disruption to existing patient monitoring devices until new network goes live.	X			Spacelabs will provide a project plan confirmed and approved by Mangum Hospital that will provide minimal disruption to existing patient monitoring devices until new network goes live.	Included
					System Requirements TOTAL	**$13,525.00**

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device

MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES
As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.

VENDOR RESPONSE SECTION
Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	Emergency Dept		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Central Monitors and / or Full Disclosure										
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1		X			Comply	1	96102-16C	Xhibit Remote Interactive Client	12,067.57
Total Number of Centrally Monitored Patients per Nurses Station #1	16	Secondary RN Hospital Station	X			Comply	1	011-0241-01	Xhibit display	1,686.46
Total Number of Centrally Monitored Patients per Nurses Station #2										
Total Number of Centrally Monitored Patients per Nurses Station #3										
Total Number of Centrally Monitored Patients per Nurses Station #4										
Total Number of Centrally Monitored Patients per Nurses Station #5										
Total Number of Centrally Monitored Patients per Nurses Station #6										
Central Station Remote Display (non-functioning), ≥22"	1	ED OFC *			X	Spacelabs will supply equipment needed to repeat the signal. Hospital responsible for display, mounting and cable drop.	1	Multiple	HDMI over IP display repeater solution	2,038.36
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	3		X			Exceeds: Unlimited Licensing	unlimited		ICS Clinical Access	Included
Uninterruptible Power Supply (UPS)	1	Hospital Provides	X			Hospital to provide				N/A
≥72-hour Full Disclosure at all Central Stations	1		X			Comply	1	910-3810-00	72 hour Smart Disclosure	Included
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16		X			Comply			Included in 72 hour Smart Disclosure	Included
Bedside & Transport Monitors										
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen										
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen										
MID-ACUITY Bedside 6 traces, ≥15" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	2	*Wifi	X			Comply	2	Multiple	Qube Monitor (91390)	15,788.04
MID-ACUITY Bedside 6 traces, ≥8" touch screen										
LOW-ACUITY Bedside 4 trace, ≥8" touch screen										
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen										
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen										
Add 802.11 wireless / Wi-Fi for portable or transport	2	*Wifi	X			Comply	2	91390-P	Wireless (802.11 a/b/g)	1,012.30
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital		X						see Coverage Area Transport Tab	N/A
Mounts (provide description)	2	rollstands	X			Comply	2	Multiple	Roll Stand	858.60
Mounts (provide description)										
Bedside Monitor Acuity Options										
ECG	2		X			Comply	2	91496-A	Non-invasive parameter set	8,997.28
Basic Cardiac Arrhythmia										
Advanced Cardiac Arrhythmia	2		X			Comply	2	91496-H	Advanced Multiview Arrhythmia	1,789.28
ST-segment Analysis	2		X			Comply	2	91496-S	ST Segment Analysis	472.76
Custom Trending (Sepsis, ST, Histograms, etc.)	2		X			Comply	2	910-3998-01	ICS Clinical Access Bed License	636.00
Respiration	2		X			Comply	2	91496-R	Respirations	609.50
Nellcor / Covidien Pulse oximetry	2		X			Comply	2	91496-N	Nellcor SpO2	1,486.00
Masimo Pulse oximetry										
NIBP	2		X			Comply			Included in Parameter Set	Included
2 invasive pressure capability, at each bedside monitor										
4 invasive pressure capability, at each bedside monitor										
Core temperature (surface - rectal) at each bedside monitor	4		X			Comply			Included in Parameter Set Each module can measure two temperatures	Included
Cardiac Output - thermodilution, at each bedside monitor										
12-lead ECG - interpretive & diagnostic	2		X			Comply	2	91496-D	Diagnostic ECG	1,726.74
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)										
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	2		X			Comply	2	92516-A	Capnopod	6,678.00
BISx (# of modules / beds equipped for concurrent use)										
Multi-Gas / Anesthetic Gas Analysis										
SVO2										
ECG 3 lead cable & lead wires (snap or clip)										
ECG 5 lead cable & lead wires (snap or clip)										
ECG 12 lead cable & lead wires (snap or clip)	2		X			Includes 2 sets lead wires, use together 10 lead, separate for 5 lead	2	Multiple	5 + 5 ECG cable and lead wire sets	1,050.00
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	2		X			Equal to or greater than a 2 week supply	Multiple	Multiple	Supplies and Accessories	1,397.98
Data Distribution / IT Integration										
Workflow: Alarm Management Consulting, Diagnostics, & Reporting	2		X			Includes unlimited use and users. This is for all departments. *Price is locked in for 5 years upon signing of contract*	5	910-0282-00	SafeNSound Standard for up to 100 devices, one year of service	30,000.00
Workflow: Alarm Management Reports (total quantity)	20	5yr qtrly reports	X			SafeNSound includes Alarm Management Consulting, Diagnostics & reporting with unlimited and on demand reporting.			Included in SafeNSound Standard	Included
Workflow: Patient Data Transfer / Seamless Full Disclosure Record Across All Depts	2	all depts	X			Comply			Included in ICS Clinical Access Bed License	Included
Workflow: Barcode scanning patient admission (Qty identifies bedside & central)	2		X			Comply			Included in the monitor	Included

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device

MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES
As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.

VENDOR RESPONSE SECTION
Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	Emergency Dept		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Workflow: WAN Connectivity / Multi-facility remote monitoring (telemed)			X			This capability is included in the monitoring system				
Remote Access: Web enabled remote Bedside View (PCs, WoWs, Tablets, etc.)	2		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Web enabled remote Full Disclosure (PCs, WoWs, Tablets, etc.)	2		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Concurrent User License quantity (total for all remote view apps)	5		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Concurrent User License Annual Renewal quantity	5 yrs	Unltd licenses	X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Printing: Electronic Strip image Export to EMR (pdf)	2	license & install	X			Comply			see System Requirements for details	Included
Printing: Laser Printer or Network Printer (ALL centrals & bedsides)	2	Networked	X			Comply			Included in ICS Clinical Access Bed License	Included
Interface: Functioning HL7 Demographics INBOUND from ADT	2		X			Comply	2	910-3999-01	ICS Interface Bed License	424.00
Interface: Functioning HL7 Vital Signs OUTBOUND to EMR	2		X			Comply			Included in ICS Interface Bed License	Included
Interface: Alarm Distribution (i.e. secondary alarming to mobile devices)	2	Want Future Capability, include in quote	X			Comply			Included in ICS Interface Bed License	Included
Interface: Ventilator Interface (bedside to EMR)										
Interface: Hemodynamic (CCO) Interface (bedside to EMR)										
Interface: 12-Lead Interface (bedside to EKG archival system)										
Servers: Virtual or Physical	virtual preferred	provide specs	X			Comply			Ability to use virtual servers is included as part of ICS licenses	Included
Test Server Application Licensing	yes		X			Comply			Included as part of ICS licenses	Included
Data Center: Local or Remote	Local		X			Comply			Included as part of ICS licenses	Included
Network: Install on Managed / Hospital Network (via VLAN); IEC 80001 compliant	Hospital	via VLAN			X	Comply			Spacelabs monitors can be installed on the hospital's network. IEC 80001-1 compliance is the customer's responsibility. Spacelabs has and follows a risk management process in accordance with ISO 14971:2019 as part of the Quality Management System, which aligns with applicable FDA and AAMI standards for medical devices.	Included
Warranty, Service, Education, Workflow										
Clinical Workflow and Implementation Consulting Program & Follow-up	yes		X			Comply			Included in Clinical Education	
Clinical Training: Online monitor education module	yes	SCORM file	X			Comply	1	999-0503-27, 999-0503-30	eLearning and SCORM files	950.00
Clinical Training: onsite education and go-live support & Follow-up	yes				X	Follow up not included	1	999-0222-51, 999-0222-52	(1) Basic Clinical Education (1) Additional Clinical Support (for go-live)	2,958.50
Clinical Training: How many Nurses (onsite user training)	25	ALL DEPTs	X			Comply	25		Included in Clinical Education	Included
Clinical Training: How many Physicians (onsite user training)	5	ALL DEPTs	X			Comply	5		Included in Clinical Education	Included
Clinical Training: How many Super Users (onsite user training)	4	ALL DEPTs	X			Comply	4		Included in Clinical Education	Included
Biomed Training: operation, preventative maintenance & basic corrective maintenance	yes		X			Comply			Two tuitions of Level 1&2 Xprezzon/Qube/Xhibit training are provided at no charge as part of your Premier contract. $12,000 value	Included
Software: HL7 & Clinical App Service Agreement in # of years	5yrs		X			Comply	1		Enhanced Software Support for all units	5,745.61
Software: Monitor / Central Firmware & Compatibility Service Agreement in # of years	5yrs		X			Comply			Included in Enhanced Software Support	
Hardware: Warranty / Service Parts & Labor Coverage in # of years	5yrs		X			Comply, One year warranty, four years depot repair	4	999-9999-42	Depot Repair (years)	Included
Installation: Complete Installation, Design, Implementation	yes		X			Comply	1	999-9999-97	Installation	1,783.08
Project Management: manage and coordinate all aspects of the project	yes		X			Comply			see System Requirements tab	Included

Department Total: 100,156.06

Mangum Regional Hospital **Patient Monitor RFP Product Disclosure**	*Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device*									
MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.	**VENDOR RESPONSE SECTION** Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED									
Hospital: Mangum Regional Hospital- Mangum, OK	**MedSurg/Tele**		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Central Monitors and / or Full Disclosure										
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1					Comply	1	96102-16	Xhibit Central Station	29,654.03
Total Number of Centrally Monitored Patients per Nurses Station #1	16	Primary RN Station				Comply	2	011-0241-01	Xhibit display	3,372.92
Total Number of Centrally Monitored Patients per Nurses Station #2										
Total Number of Centrally Monitored Patients per Nurses Station #3										
Total Number of Centrally Monitored Patients per Nurses Station #4										
Total Number of Centrally Monitored Patients per Nurses Station #5										
Total Number of Centrally Monitored Patients per Nurses Station #6										
Central Station Remote Display (non-functioning), ≥22"										
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	4					Exceeds: Unlimited Licensing	unlimited		ICS Clinical Access	Included
Uninterruptible Power Supply (UPS)	1	Hospital Provides				Hospital to provide				N/A
≥72-hour Full Disclosure at all Central Stations	1					Comply			Included in 72 hour Smart Disclosure on Emergency Department tab (row 18)	Included
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16					Comply			Included in 72 hour Smart Disclosure	Included
Bedside & Transport Monitors										
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen										
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen										
MID-ACUITY Bedside 6 traces, ≥15" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	2	*Wifi				Comply	2	Multiple	Qube Monitor (91390)	15,788.04
MID-ACUITY Bedside 6 traces, ≥8" touch screen										
LOW-ACUITY Bedside 4 trace, ≥8" touch screen										
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen										
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen										
Add 802.11 wireless / Wi-Fi for portable or transport	2	*Wifi				Comply	2	91390-P	Wireless (802.11 a/b/g)	1,012.30
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital								see Coverage Area Transport Tab	N/A
Mounts (provide description)	2	rollstands				Comply	2	Multiple	Roll Stand	858.60
Mounts (provide description)										
Bedside Monitor Acuity Options										
ECG	2		X			Comply	2	91496-A	Non-invasive parameter set	8,997.28
Basic Cardiac Arrhythmia										
Advanced Cardiac Arrhythmia	2		X			Comply	2	91496-H	Advanced Multiview Arrhythmia	1,789.28
ST-segment Analysis	2		X			Comply	2	91496-S	ST Segment Analysis	472.76
Custom Trending (Sepsis, ST, Histograms, etc.)	2		X			Comply	14	910-3998-01	ICS Clinical Access Bed License	4,452.00
Respiration	2		X			Comply	2	91496-R	Respirations	609.50
Nellcor / Covidien Pulse oximetry	2		X			Comply	2	91496-N	Nellcor SpO2	1,486.00
Masimo Pulse oximetry										
NIBP	2		X			Comply			Included in Parameter Set	Included
2 invasive pressure capability, at each bedside monitor										
4 invasive pressure capability, at each bedside monitor										
Core temperature (surface - rectal) at each bedside monitor	4	no supplies	X			Comply			Included in Parameter Set Each module can measure two temperatures	Included
Cardiac Output - thermodilution, at each bedside monitor										
12-lead ECG - interpretive & diagnostic	2		X			Comply	2	91496-D	Diagnostic ECG	1,726.74
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)										
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	2		X			Comply	2	92516-A	Capnopod	6,678.00
BISx (# of modules / beds equipped for concurrent use)										
Multi-Gas / Anesthetic Gas Analysis										
SVO2										
ECG 3 lead cable & lead wires (snap or clip)										
ECG 5 lead cable & lead wires (snap or clip)										
ECG 12 lead cable & lead wires (snap or clip)	2		X			Includes 2 sets lead wires, use together 10 lead, separate for 5 lead	2	Multiple	5 + 5 ECG cable and lead wire sets	1,050.00
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	2		X			Equal to or greater than a 2 week supply	Multiple	Multiple	Supplies and Accessories	783.03
Telemetry										
Workflow: Device, Communication, Documentation Management System	12		X			Comply	1	Multiple	XTR	35,591.60
ECG only										
ECG & Pulse Oximetry	12		X			Comply	12	Multiple	AriaTele MPT w/ Display	27,607.56
Integrated Display	12		X			Comply	12	Multiple	Included in the transmitter price	Included
Basic Cardiac Arrhythmia										
Advanced Cardiac Arrhythmia	12		X			Comply	1	Multiple	Included in XTR	Included
ST-segment Analysis	12		X			Comply	1	Multiple	Included in XTR	Included
Custom Trending (Sepsis, ST, Histograms, etc.)	12		X			Comply			Included in ICS Clinical Access Bed License	Included
ECG 3 lead cable & lead wires (snap or clip)										
ECG 5 lead cable & lead wires (snap or clip)	12		X			Comply	1	700-0006-32, 700-0008-88	ECG Combiner Adapter and disposable lead wire set (25/bx)	855.00
Telemetry Wireless Coverage Area (1.4 MHz - WMTS; provide floor plans)	See Hospital Covered Area ≈10,000sq ft	1.4MHz Only	X			Comply			See Coverage Area_Telemetry tab for price/details	Included
Data Distribution / IT Integration										

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

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MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES
As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.

VENDOR RESPONSE SECTION
Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	MedSurg/Tele		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Workflow: Alarm Management Consulting, Diagnostics, & Reporting	14		X			Includes unlimited use and users. This is for all departments. *Price is locked in for 5 years upon signing of contract* (see Emergency Department, row 72)			Included in SafeNSound Standard in Emergency Department	Included
Workflow: Alarm Management Reports (total quantity)	20	5yr qtrly reports	X			SafeNSound includes Alarm Management Consulting, Diagnostics & reporting with unlimited and on demand reporting.			Included in SafeNSound Standard in Emergency Department	Included
Workflow: Patient Data Transfer / Seamless Full Disclosure Record Across All Depts	14	all depts	X			Comply			Included in ICS Clinical Access Bed License	Included
Workflow: Barcode scanning patient admission (Qty identifies bedside & central)	14		X			Comply			Included in the monitor	Included
Workflow: WAN Connectivity / Multi-facility remote monitoring (telemed)			X			This capability is included in the monitoring system				
Remote Access: Web enabled remote Bedside View (PCs, WoWs, Tablets, etc.)	14		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Web enabled remote Full Disclosure (PCs, WoWs, Tablets, etc.)	14		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Concurrent User License quantity (total for all remote view apps)	5		X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Remote Access: Concurrent User License Annual Renewal quantity	5 yrs	Unltd licenses	X			Comply	unlimited		Included in ICS Clinical Access Bed License	Included
Printing: Electronic Strip image Export to EMR (pdf)	14	license & install	X			Comply			see System Requirements for details	Included
Printing: Laser Printer or Network Printer (ALL centrals & bedsides)	14	Networked	X			Comply			Included in ICS Clinical Access Bed License	Included
Interface: Functioning HL7 Demographics INBOUND from ADT	14		X			Comply	14	910-3999-01	ICS Interface Bed License	2,968.00
Interface: Functioning HL7 Vital Signs OUTBOUND to EMR	14		X			Comply			Included in ICS Interface Bed License	Included
Interface: Alarm Distribution (i.e. secondary alarming to mobile devices)	14	Want Future Capability, include in quote	X			Comply			Included in ICS Interface Bed License	Included
Interface: Ventilator Interface (bedside to EMR)										
Interface: Hemodynamic (CCO) Interface (bedside to EMR)										
Interface: 12-Lead Interface (bedside to EKG archival system)										
Servers: Virtual or Physical	virtual preferred	provide specs *Need Server Rack & UPS	X			Comply			Included as part of ICS licenses	Included
Test Server Application Licensing	yes		X			Comply			Included as part of ICS licenses	Included
Data Center: Local or Remote	Local		X			Comply			Included as part of ICS licenses	Included
Network: Install on Managed / Hospital Network (via VLAN); IEC 80001 compliant	Hospital	via VLAN			X	Comply			Spacelabs monitors can be installed on the hospital's network. IEC 80001-1 compliance is the customer's responsibility. Spacelabs has and follows a risk management process in accordance with ISO 14971:2019 as part of the Quality Management System, which aligns with applicable FDA and AAMI standards for medical devices.	Included
Warranty, Service, Education, Workflow										
Clinical Workflow and Implementation Consulting Program & Follow-up	yes		X			Comply			Included in Clinical Education	
Clinical Training: Online monitor education module	yes	SCORM file	X			Comply			Included in eLearning on the Emergency Department tab (row 96)	Included
Clinical Training: onsite education and go-live support & Follow-up	yes				X	Follow up not included	1	999-0222-51, 999-0222-52	(1) Basic Clinical Education (1) Additional Clinical Support (for go-live)	2,958.50
Clinical Training: How many Nurses (onsite user training)	25	ALL DEPTs	X			Comply	25		Included in Clinical Education	Included
Clinical Training: How many Physicians (onsite user training)	5	ALL DEPTs	X			Comply	5		Included in Clinical Education	Included
Clinical Training: How many Super Users (onsite user training)	4	ALL DEPTs	X			Comply	4		Included in Clinical Education	Included
Biomed Training: operation, preventative maintenance & basic corrective maintenance	yes		X			Comply			Two tuitions of Level 1&2 Xhibit Telemetry training are provided at no charge as part of your Premier contract. $9,600 value	Included
Software: HL7 & Clinical App Service Agreement in # of years	5yrs		X			Comply				
Software: Monitor / Central Firmware & Compatibility Service Agreement in # of years	5yrs		X			Comply			Included in Enhanced Software Support on the Emergency Department tab (row 102)	
Hardware: Warranty / Service Parts & Labor Coverage in # of years	5yrs		X			Comply, One year warranty, four years depot repair	4	999-9999-42	Depot Repair (years)	Included
Installation: Complete Installation, Design, Implementation	yes		X			Comply	1	999-9999-97	Installation	5,003.33
Project Management: manage and coordinate all aspects of the project	yes		X			Comply			see System Requirements tab	Included

Department Total: 153,714.47

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MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.	**VENDOR RESPONSE SECTION** Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	ISO/COVID		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Central Monitors and / or Full Disclosure										
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")										
Total Number of Centrally Monitored Patients per Nurses Station #1										
Total Number of Centrally Monitored Patients per Nurses Station #2										
Total Number of Centrally Monitored Patients per Nurses Station #3										
Total Number of Centrally Monitored Patients per Nurses Station #4										
Total Number of Centrally Monitored Patients per Nurses Station #5										
Total Number of Centrally Monitored Patients per Nurses Station #6										
Central Station Remote Display (non-functioning), ≥22"	1	View MS/Tele Primary RN Stn			X	Spacelabs will supply equipment needed to repeat the signal. Hospital responsible for display, mounting and cable drop.	1	Multiple	HDMI over IP display repeater solution	2,038.36
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	3		X			Exceeds: Unlimited Licensing	unlimited		ICS Clinical Access	Included
Uninterruptible Power Supply (UPS)										
≥72-hour Full Disclosure at all Central Stations										
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)										
Warranty, Service, Education, Workflow						Spacelabs does not require separate clinical education, licensing, or installation for this unit.				
Clinical Workflow and Implementation Consulting Program & Follow-up	yes		X			Comply			Included in Clinical Education	
Clinical Training: Online monitor education module	yes	SCORM file	X			Comply			Included in eLearning on the Emergency Department tab (row 96)	Included
Clinical Training: onsite education and go-live support & Follow-up	yes				X	Follow up not included			Included in Clinical Education on the Emergency Department tab (row 96)	Included
Clinical Training: How many Nurses (onsite user training)	25	ALL DEPTs	X			Comply	25		Included in Clinical Education on the Emergency Department tab (row 96)	Included
Clinical Training: How many Physicians (onsite user training)	5	ALL DEPTs	X			Comply	5		Included in Clinical Education on the Emergency Department tab (row 96)	Included
Clinical Training: How many Super Users (onsite user training)	4	ALL DEPTs	X			Comply	4		Included in Clinical Education on the Emergency Department tab (row 96)	Included
Biomed Training: operation, preventative maintenance & basic corrective maintenance	yes		X			Comply			Two tuitions of Level 1&2 Xhibit Telemetry training are provided at no charge as part of your Premier contract. $9,600 value	Included
Software: HL7 & Clinical App Service Agreement in # of years	5yrs		X			Comply				
Software: Monitor / Central Firmware & Compatibility Service Agreement in # of years	5yrs		X			Comply			Included in Enhanced Software Support on the Emergency Department tab (row 102)	
Hardware: Warranty / Service Parts & Labor Coverage in # of years	5yrs		X			Comply, One year warranty, four years depot repair	4	999-9999-42	Depot Repair (years)	Included
Installation: Complete Installation, Design, Implementation	yes		X			Comply			Installation not required	
Project Management: manage and coordinate all aspects of the project	yes		X			Comply			see System Requirements tab	Included

Department Total: 2,038.36

Mangum Regional Hospital **Patient Monitor RFP Product Disclosure**	*Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device*
MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.	**VENDOR RESPONSE SECTION** Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	Biomed Spares		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration 08/03/20	Confirmed by Daniel/Zach	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
Central Monitors and / or Full Disclosure										
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1		X				1	Multiple	Factory Certified Xhibit Central Station, does not include display (96102)	14,827.01
Total Number of Centrally Monitored Patients per Nurses Station #1	16		X						Included in Xhibit Central Station	Included
Total Number of Centrally Monitored Patients per Nurses Station #2										
Total Number of Centrally Monitored Patients per Nurses Station #3										
Total Number of Centrally Monitored Patients per Nurses Station #4										
Total Number of Centrally Monitored Patients per Nurses Station #5										
Total Number of Centrally Monitored Patients per Nurses Station #6										
Central Station Remote Display (non-functioning), ≥22"										
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)										
Uninterruptible Power Supply (UPS)										
≥72-hour Full Disclosure at all Central Stations	1		X			Comply			Included in 72 hour Smart Disclosure on Emergency Department tab (row 18)	Included
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16		X			Comply			Included in 72 hour Smart Disclosure	Included
Bedside & Transport Monitors										
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen										
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen										
MID-ACUITY Bedside 6 traces, ≥15" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
LOW-ACUITY Bedside 4 trace, ≥12" touch screen										
MID-ACUITY Bedside 6 traces, ≥8" touch screen										
LOW-ACUITY Bedside 4 trace, ≥8" touch screen	1	*Wifi	X			Comply	1	Multiple	Factory Certified Qube Mini (91389)	3,740.59
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen										
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen										
Add 802.11 wireless / Wi-Fi for portable or transport	1		X			Comply	1	91390-P	Factory Certified Wireless (802.11 a/b/g)	281.92
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital		X						see Coverage Area Transport Tab	N/A
Mounts (provide description)										
Mounts (provide description)										
Bedside Monitor Acuity Options									Total	$4,022.59
ECG	1		X			Comply	1	91496-A	Non-invasive parameter set	2,436.44
Basic Cardiac Arrhythmia										
Advanced Cardiac Arrhythmia	1		X			Comply	1	91496-H	Advanced Multiview Arrhythmia	894.64
ST-segment Analysis	1		X			Comply	1	91496-S	ST Segment Analysis	236.38
Custom Trending (Sepsis, ST, Histograms, etc.)	1				X				Not needed for Biomed Spares	
Respiration	1		X			Comply	1	91496-R	Respirations	304.75
Nellcor / Covidien Pulse oximetry	1		X			Comply	1	91496-N	Nellcor SpO2	743.00
Masimo Pulse oximetry										
NIBP	1		X			Comply			Included in Parameter Set	Included
2 invasive pressure capability, at each bedside monitor										
4 invasive pressure capability, at each bedside monitor										
Core temperature (surface - rectal) at each bedside monitor	2	no supplies	X			Comply			Included in Parameter Set Each module can measure two temperatures	Included
Cardiac Output - thermodilution, at each bedside monitor										
12-lead ECG - interpretive & diagnostic	1		X			Comply	1	91496-D	Diagnostic ECG	863.37
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)										
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)										
BISx (# of modules / beds equipped for concurrent use)										
Multi-Gas / Anesthetic Gas Analysis										
SVO2										
ECG 3 lead cable & lead wires (snap or clip)										
ECG 5 lead cable & lead wires (snap or clip)	1	Disposable reusable			X	Comply	1	700-0008-56	5 + 5 ECG cable only	150.00
ECG 12 lead cable & lead wires (snap or clip)										
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)		no supplies								
Warranty, Service, Education, Workflow										
Clinical Workflow and Implementation Consulting Program & Follow-up										
Clinical Training: Online monitor education module										
Clinical Training: onsite education and go-live support & Follow-up										
Clinical Training: How many Nurses (onsite user training)										
Clinical Training: How many Physicians (onsite user training)										
Clinical Training: How many Super Users (onsite user training)										
Biomed Training: operation, preventative maintenance & basic corrective maintenance										
Software: HL7 & Clinical App Service Agreement in # of years										
Software: Monitor / Central Firmware & Compatibility Service Agreement in # of years										
Hardware: Warranty / Service Parts & Labor Coverage in # of years									Factory certified receives one year warranty	
Installation: Complete Installation, Design, Implementation										
Project Management: manage and coordinate all aspects of the project										

Mangum Regional Hospital **Patient Monitor RFP Product Disclosure**	*Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device*
MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.	**VENDOR RESPONSE SECTION** Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

Biomed Spares		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
08/03/20	Daniel/Zach								

Department Total: **24,478.10**

Mangum Regional Hospital Patient Monitoring System Requirements 1.4GHz WMTS Telemetry Coverage Area			Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
Building	**Department**	**Coverage Area (Sq. Ft.)**	Yes	No	Partial	Details / Functional Description	
Mangum Regional Hospital	Areas Specified	10,000	X			5 powered, 3 unpowered Multiband antenna kits	$21,464.00
		**Approximate, please confirm					
	Total	**10,000**					**$21,464.00**

*See attached drawings

Mangum Regional Hospital Patient Patient Monitoring System Wireless Transport & Wireless Monitor Coverage Area			Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
Building	**Department**	**Coverage Area (Sq. Ft.)**	Yes	No	Partial	Details / Functional Description	
Mangum Regional Hospital	Areas Specified	10,000			X	We will use existing hospital infrastructure	$0.00
		**Approximate, please confirm					
	Total	**10,000**					**$0.00**

*See attached drawings

SPACELABS HEALTHCARE

Mangum City Hospital

Value Summary

Quotation Summary

Department Name	Quote Total
Emergency Department	$100,156.06
MedSurg – Tele	$153,714.47
ISO-Covid	$2,038.36
Biomed Spares	$24,478.10
Telemetry Coverage Area	$21,464.00
System Requirements	$13,525.00
Trade-in Discount	$18,262.85
Quote Total	**$297,113.14**

Spacelabs Partnership Value Adds

Clinical Education	Basic Clinical Education is included at no charge	$9,700 value
eLearning	Initial year of eLearning is included at no charge	$3,000 value
SafeNSound Implementation	Implementation for SafeNSound Standard has been included a no charge	$5,000 value
Depot Repair	Four years of post-warranty Depot Repair for capital equipment is included at no charge. This provides a total of five years of service on your capital equipment.	$65,149 value
Technical Training	Two biomed training tuition credits per facility for Level 1 and 2 courses for patient monitoring and telemetry products.	$19,200 value
Trade-in Discount	Trade-in of existing Spacelabs equipment.	$18,029
Total of Partnership Value Adds:		**$120,078**

Proposal Summary

Mangum City Hospital
1 Wickersham
Mangum OK 73554

Quote Number:2020-206478 Rev. 3
Expiration Date: December 14, 2020

Department	List Price	Net Price
Emergency Dept. Secondary RN Station: 16-Zone Xhibit RIC Central Station and ED Office Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display	$32,998.57	$16,475.47
Emergency Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2]	$104,625.06	$47,131.14
Med/Surg Dept Main RN Station: Xhibit 16-Zone Central Monitor [qty 1]; Customer will provide own UPS unless requested [qty 1]	$74,624.25	$34,705.49
Med/Surg Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2]	$89,999.91	$42,607.69
Med/Surg Dept: 1.4 MHz Aria Tele Tx with Display & SpO2 & 1.4 MHz XTR Tele Rcvr [qty 12]; Tele WTMS Multiband Antennas [10 PWR / 6 No PWR]	$179,940.22	$91,074.74
COVID RN Station Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display	$2,038.36	$2,038.36
BIOMED BACKUP Equipment: Factory Certified 16-Zone Xibit Central Station CPU, Wireless Qube Mini ECG Monitor & "C" Command Module [1 qty each]; comes with 1 Year Warranty	$66,746.46	$24,478.10
BIOMED Training [2 Credits Each for Levels I&II]	$19,200.00	$0.00
ICS Bundled Bed Licenses [16 QTY]	$24,779.78	$16,980.00
ICS Clinical Access, ADT, and Vital Signs Interface implementation. For facilities with no more than 25 monitored beds.	$6,700.00	$5,025.00
SafeNSound STANDARD Year 1 of 5 Year Contract for $6,000 per Year [16 Devices]	$35,000.00	$30,000.00
Enhanced Software Support Plan Years 2-5	$6,480.00	$4,860.00
Premier Tier Equipment Trade-In Discount	$0.00	$-18,262.85
Total List Price.....		$643,132.61
Total Discount.....		$346,019.47
Total Proposal Price.....		**$297,113.14**

Pricing within this quote is contingent upon signing of Premier Tier 4 Letter of Committment (LOC) prior to PO submission.

Upon acceptance, please sign and return this quotation, together with your purchase order, to Sales Support via fax at **425-363-5761 or email it to po.us@spacelabs.com.**

By accepting this quotation or by performing hereunder, the customer identified above ("Customer") agrees to purchase or lease (as applicable) the products identified herein subject to the terms of this Customer Quotation and Spacelabs Healthcare's Subscription Software Terms (in the case of SafeNSound) or Spacelabs Terms of Sale (in the case of all other products). The terms are available on the About Us/Terms/Policies page of our website at http://www.spacelabshealthcare.com. The applicable terms are incorporated herein by this reference. Notwithstanding the foregoing, if Customer has a separate contractual agreement in place with Spacelabs Healthcare relating to the products identified herein (such as a group purchasing agreement, distribution agreement, or master purchasing agreement), the terms of that contractual agreement shall control to the extent such terms conflict with the applicable terms.

Accepted By:

_____	_____
Authorized Signature	Customer Purchase Order Number
_____	_____
Title Date	Email Address for order confirmation
_____	_____
Telephone Number	Tax Exemption Number (if any)
_____	
Requested Delivery Date	

This quotation shall remain firm for 60 days unless otherwise stated. Delivery: 21 days after acknowledgement of order, unless otherwise noted in this quotation.

The pricing in this quotation reflects your Premier Healthcare Alliance pricing per contract PP-MM-623. Payment terms are per your contract. FOB is factory. Freight and insurance are no charge. Warranty is per the terms of your contract.

Depot Support

After the standard 12-month warranty has expired, Company agrees to provide all Spare Parts and labor necessary for the repair of any Equipment failure which may require corrective action upon Customer's return of Equipment to Company's facility ("Depot Support"). Such Depot Support shall be provided as follows:

Customer agrees to promptly notify Company by phone of any Equipment failure, which may require corrective action. If Equipment issues cannot be resolved telephonically through good faith efforts of the parties, Company shall provide at Company's facility all Spare Parts and labor necessary for the repair of any Equipment failure that may require corrective action. Customer shall be responsible for all freight and insurance charges in shipping the Equipment to Company; risk of loss shall pass to Company only upon receipt of the Equipment. Company shall pay all costs for return shipment to Customer.

Company shall, within the limits of equipment availability, use reasonable efforts to satisfy Customer's requests for loan equipment, prior to requests from customers not covered by a warranty or similar agreement.

"Spare Part(s)" mean replaceable spare parts and assemblies used in the Equipment and listed in the Company Spare Part Price List. Spare Parts do not include disposable or user parts that must be routinely replaced, items listed in the Supplies & Accessories Price List, or computer products and peripheral devices not manufactured by Company or produced on Company's behalf. Any original Spare Part for which Company has supplied a replacement Spare Part shall become the property of Company. Any replacement Spare Part shall have equivalent function and performance as the original Spare Part, when new. Company reserves the right to use a refurbished part as a replacement Spare Part.

The Spacelabs Ultraview SL network supports clinical network sizes up to 1000 nodes. Networks consisting of mixed generations of Spacelabs devices may have lower capacities depending on specific models and age of equipment. Alarm Watch and Remote View functionality directly affect maximum network size. Please consult your field service engineer to determine the maximum size and functionality for your specific Spacelabs network.

Spacelabs Healthcare's installation is based upon the use of standard PVC jacketed interconnecting cables. If local conditions or regulations require use of plenum-rated cabling, 10BaseT is available at no additional charge (please specify on your purchase order). Plenum-rated 10Base5 (AUI and MAU) cabling requires an additional charge of $1.00 per foot. Any SDLC cables quoted herein are not plenum rated and may need to be run in hospital conduit to comply with local regulations.

An estimated antenna system is included with the quoted Telemetry System. A Pre-Installation Questionnaire (PIQ) will need to be completed to determine the exact antenna requirements for the hospital's particular installation. Associated costs will vary dependent upon the size and complexity of the installation.

Spacelabs Healthcare's telemetry antenna installation is based upon the use of standard PVC jacketed interconnecting cables. If local conditions or regulations require use of plenum-rated cabling, antenna kits specifying that plenum-rated cable is included must be purchased. If, upon completion of the Pre-Installation Questionnaire by our local FSE, additional plenum cabling is required (beyond that which is included in the antenna kits), Spacelabs will charge $1.00 per foot for the additional plenum-rated cable.

Wireless Monitors

Prior to an acceptance of a purchase order for the wireless monitors quoted herein, Spacelabs Healthcare requires a Signed Acknowledgement regarding the Hospital's decision to have a Site Qualification Survey performed to validate the wireless coverage area.

To determine the costs associated with the Site Qualification Survey (SQS), Spacelabs will need some basic information from the Hospital. Cooperation of hospital employee's should be expected in providing such information. Your Spacelabs Sales Executive will email a link to a web based Site Profile Form to the IT department. The responses to this form will immediately be forwarded to our Wireless Team upon completion by your Hospital representative. This information will allow Spacelabs to provide the Hospital with a quote for the Site Qualification Survey. The cost of this service varies and is dependent upon network design and size of the coverage area. The Site Qualification Survey will be an additional expense incurred by the Hospital.

In some instances the quote for this Site Qualification Survey is included within the enclosed wireless monitoring quote. However, if the cost for the Site Qualification Survey is not already included within, the Hospital will receive a separate quote for such services from Spacelabs or our network design partner, **Global Technology Resources, Inc. (GTRI)**. The quote for the SQS will be delivered to the Hospital within one day of receipt of the completed Site Profile Form. A follow-up call will be scheduled with the Hospital to review the quote and to answer any questions regarding its necessity. The Hospital will need to review the quote for the SQS services and inform Spacelabs of their decision to proceed with an SQS. Hospital will be asked to sign an Acknowledgement confirming whether or not they would like to proceed with the Site Qualification Survey or not. Spacelabs cannot accept a P.O. for the wireless monitors until such signed Acknowledgement has been received.

Upon acceptance of the P.O. for the Site Qualification Survey, Spacelabs or our partner, **GTRI**, will contact the Hospital to schedule a mutually convenient time for performance of the SQS at the Hospital site. Once the SQS is completed, a detailed report will be provided to the Hospital which may or may not include possible modifications to the infrastructure to ensure optimal performance of Spacelabs wireless monitors. The cost for such modifications is the responsibility of the Hospital and all work must be completed by an authorized vendor approved by Spacelabs Healthcare.

Data shuttle has been quoted herein. In order for the concept of data shuttle to be used correctly, the hospital must have data shuttle on the transport monitor and data shuttle on the receiving or originating monitor.

Installation and professional services have been included as an estimate based on the requirements as they are currently understood. Significant deviations from the quote may incur additional charges. The Scope of Work is mutually agreed upon during the planning phase of the project and will govern the implementation.
Factory Certified product does not receive installation, clinical or biomedical training, and has a one year warranty. Any Subsequent Warranty Agreed Coverage via depot repair in your contract with Spacelabs, if any, will not apply to Factory Certified products. Purchase is subject to availability of Factory Certified items at the time of order.

Spacelabs is committed to the safety and wellbeing of our customers and staff. In order to prevent the spread of the virus, products purchased during the COVID-19 crisis cannot be returned or exchanged.

Emergency Dept. Secondary RN Station: 16-Zone Xhibit RIC Central Station and ED Office Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Xhibit Remote Interactive Client	96102-16C	1	22,769.00	12,067.57	12,067.57
2	Depot Support Plan. Unit price is per year. Monitoring Products only.	999-9999-42	4	1,024.61	0.00	0.00
3	Enhanced Software Support Plan (ICS/XprezzNet/Xhibit). Unit price is per year.	999-1898-00	1	341.54	256.16	256.16
4	Operation Manual, CD, Xhibit/Telemetry	084-2301-06	1	0.00	0.00	0.00
5	Service Manual, CD, Xhibit/Telemetry	084-1479-06	1	0.00	0.00	0.00
6	Splitter display port 4WAY 96102	010-1975-00	1	949.58	949.58	949.58
7	DP to HDMI converter	P136-06N-ACT	1	70.00	70.00	70.00
8	Cable, HDMI, 6ft, black	012-0993-00	2	17.33	17.33	34.66
9	HDMI over IP extender	ST12MHDLAN	1	950.00	950.00	950.00
10	Cable, Display Port, Latching, 6ft	012-1013-00	1	34.12	34.12	34.12
11	Xhibit display, 22" high resolution touchscreen	011-0241-01	1	3,182.00	$1,686.46	1,686.46
12	Installation	999-9999-97	1	569.23	$426.92	426.92
	Emergency Dept. Secondary RN Station: 16-Zone Xhibit RIC Central Station and ED Office Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display Total					**$16,475.47**

Emergency Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	qube Compact Monitor	91390	2	0.00	0.00	0.00
2	qube Compact Monitor, base unit	91390-A	2	11,515.00	6,102.95	12,205.90
3	English Language	91390-1	2	0.00	0.00	0.00
4	Four Waveforms	91390-04	2	1,315.00	696.95	1,393.90
5	Data Shuttle	91390-Q	2	450.00	238.50	477.00
6	Full View	91390-V	2	710.00	376.30	752.60
7	Full Bed Review	91390-W	2	665.00	352.45	704.90
8	Wireless (802.11 a/b/g)	91390-P	2	955.00	506.15	1,012.30
9	Up to 8 Hour Battery Operation	91390-Z	2	204.10	108.17	216.34
10	Ultraview SL Command Module	91496	2	0.00	0.00	0.00
11	English Language	91496-1	2	0.00	0.00	0.00
12	Non-Invasive Parameter Set	91496-A	2	8,488.00	4,498.64	8,997.28
13	Advanced Multiview Arrhythmia (MVII)	91496-H	2	1,688.00	894.64	1,789.28
14	Nellcor SpO2	91496-N	2	743.00	743.00	1,486.00
15	12-lead diagnostic ECG with measurements and interpretation	91496-D	2	1,629.00	863.37	1,726.74
16	Adult/Neonatal Respiration	91496-R	2	575.00	304.75	609.50
17	ST Segment Analysis	91496-S	2	446.00	236.38	472.76
18	Capnography Pod	92516	2	0.00	0.00	0.00
19	English Language	92516-1	2	0.00	0.00	0.00
20	Capnography Pod, base unit	92516-A	2	6,300.00	3,339.00	6,678.00
21	Basic CEC Support. Includes 3 consecutive weekdays of customized clinical training (workflow process development, alarm management, eLearning administration). Up to 7 hours of class time per day, between the hours of 8 A.M. and 8 P.M.	999-0222-51	1	4,850.00	0.00	0.00
22	Additional Week of Clinical Support. Includes 3 consecutive weekdays of support. Up to 7 hours of class time per day, between the hours of 8 A.M. and 8 P.M. Required for units with >50 users to train and/or >11 beds.	999-0222-52	1	4,850.00	2,958.50	2,958.50
23	Interactive eLearning Bundle. Bundled 1 year eLearning for monitoring devices, surveillance and Clinical Access (TOS subscription).	999-0503-27	1	3,000.00	0.00	0.00

24	eLearning Upgrade to Include SCORM Files. Upgrade to 5 years eLearning of all monitoring products, licensed for use in customer learning management system (LMS), subject to separate letter agreement between customer and Spacelabs (TOS only).	999-0503-30	1	950.00	950.00	950.00
25	Depot Support Plan. Unit price is per year. Monitoring Products only.	999-9999-42	4	3,254.77	0.00	0.00
26	Roll Stand, Quick Release with Drop-In Backplate	016-0940-00	2	330.00	330.00	660.00
27	Universal Power Supply Holster, Rollstand Mounted	016-0760-00	2	110.00	58.30	116.60
28	Mounting Adapter Plate, Quick Release, for Mounts with Drop-In Backplate	016-0942-00	2	41.00	41.00	82.00
29	ECG combiner disp lead wire set,5L, multi-pinch, AAMI, 127cm/50 in, 25/bx	700-0006-32	1	510.00	375.00	375.00
30	Nellcor OxiMax DS-100A finger sensor, adult	690-0003-01	2	150.00	74.63	149.26
31	BP hose, single tube, adult	714-0018-00	2	100.00	34.30	68.60
32	BP hose, single tube, neonatal	714-0019-01	2	100.00	21.30	42.60
33	BP cuff, SoftCheck vinyl neonatal, 1T, size 3, 6-11cm, M316, 10/bx	VNN3ST-M316-10	1	31.05	22.50	22.50
34	BP cuff, SoftCheck vinyl neonatal, 1T, size 4, 7-13cm, M316, 10/bx	VNN4ST-M316-10	1	31.05	22.50	22.50
35	BP cuff, SoftCheck vinyl neonatal, 1T, size 5, 8-15cm, M316, 10/bx	VNN5ST-M316-10	1	31.05	22.50	22.50
36	BP cuff, TruLink vinyl, 1T, adult, 26-35cm, HP, 5/bg	715-1142-10	1	25.00	17.65	17.65
37	BP cuff, TruLink vinyl, 1T, lg adult, 32-42cm, HP, 5/bg	715-1162-10	1	32.20	20.08	20.08
38	LABEL,HANDLE,MODULE,DEEPRED	334-5934-07	2	2.91	2.91	5.82
39	CO2 Nomoline adapter, sidestream, FLL, multi-use, 25/bx	103-0234-00	1	549.00	411.75	411.75
40	CO2 nasal cannula w/O2 delivery, MLL, adult, 2.1m/7 ft, 25/cs	704-0181-00	1	133.00	93.10	93.10
41	Nellcor OxiMax sensor adapter cable	700-0792-00	2	362.00	260.81	521.62
42	ECG combiner cable, 5+5-Lead Spacelabs monitors, AAMI	700-0008-56	2	250.00	150.00	300.00
43	ECG combiner disp lead wire set, 5V, multi-pinch, 127cm/50 in, 25/bx	700-0006-33	1	510.00	375.00	375.00

44	Patient Monitoring Service Manual, CD-ROM	084-0700-03	1	0.00	$0.00	0.00
45	Ultraview SL Network Operations Manual, CD-ROM, English	084-1101-05	1	0.00	$0.00	0.00
46	Power Cord	161-0032-00	2	18.70	$18.70	37.40
47	Installation	999-9999-97	1	1,808.21	$1,356.16	1,356.16
	Emergency Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2] Total					**$47,131.14**

Med/Surg Dept Main RN Station: Xhibit 16-Zone Central Monitor [qty 1]; Customer will provide own UPS unless requested [qty 1]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Xhibit Central Station	96102	1	0.00	0.00	0.00
2	Xhibit central station, base Computer	96102-B	1	0.00	0.00	0.00
3	Xhibit central station, 16 bed bundle	96102-16	1	55,951.00	29,654.03	29,654.03
4	Single patient license for Xhibit central station	910-6102-01	16	0.00	0.00	0.00
5	Depot Support Plan. Unit price is per year. Monitoring Products only.	999-9999-42	4	2,517.80	0.00	0.00
6	Enhanced Software Support Plan (ICS/XprezzNet/Xhibit). Unit price is per year.	999-1898-00	1	839.27	629.45	629.45
7	Operation Manual, CD, Xhibit/Telemetry	084-2301-06	1	0.00	0.00	0.00
8	Service Manual, CD, Xhibit/Telemetry	084-1479-06	1	0.00	0.00	0.00
9	Xhibit display, 22" high resolution touchscreen	011-0241-01	2	3,182.00	$1,686.46	3,372.92
10	Installation	999-9999-97	1	1,398.78	$1,049.09	1,049.09
	Med/Surg Dept Main RN Station: Xhibit 16-Zone Central Monitor [qty 1]; Customer will provide own UPS unless requested [qty 1] Total					**$34,705.49**

Med/Surg Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	qube Compact Monitor	91390	2	0.00	0.00	0.00
2	qube Compact Monitor, base unit	91390-A	2	11,515.00	6,102.95	12,205.90
3	English Language	91390-1	2	0.00	0.00	0.00
4	Four Waveforms	91390-04	2	1,315.00	696.95	1,393.90
5	Data Shuttle	91390-Q	2	450.00	238.50	477.00
6	Full View	91390-V	2	710.00	376.30	752.60
7	Full Bed Review	91390-W	2	665.00	352.45	704.90
8	Wireless (802.11 a/b/g)	91390-P	2	955.00	506.15	1,012.30
9	Up to 8 Hour Battery Operation	91390-Z	2	204.10	108.17	216.34
10	Ultraview SL Command Module	91496	2	0.00	0.00	0.00
11	English Language	91496-1	2	0.00	0.00	0.00
12	Non-Invasive Parameter Set	91496-A	2	8,488.00	4,498.64	8,997.28
13	Advanced Multiview Arrhythmia (MVII)	91496-H	2	1,688.00	894.64	1,789.28
14	Nellcor SpO2	91496-N	2	743.00	743.00	1,486.00
15	12-lead diagnostic ECG with measurements and interpretation	91496-D	2	1,629.00	863.37	1,726.74
16	Adult/Neonatal Respiration	91496-R	2	575.00	304.75	609.50
17	ST Segment Analysis	91496-S	2	446.00	236.38	472.76
18	Capnography Pod	92516	2	0.00	0.00	0.00
19	English Language	92516-1	2	0.00	0.00	0.00
20	Capnography Pod, base unit	92516-A	2	6,300.00	3,339.00	6,678.00
21	Depot Support Plan. Unit price is per year. Monitoring Products only.	999-9999-42	4	3,254.77	0.00	0.00
22	Roll Stand, Quick Release with Drop-In Backplate	016-0940-00	2	330.00	330.00	660.00
23	Universal Power Supply Holster, Rollstand Mounted	016-0760-00	2	110.00	58.30	116.60
24	Mounting Adapter Plate, Quick Release, for Mounts with Drop-In Backplate	016-0942-00	2	41.00	41.00	82.00
25	ECG combiner disp lead wire set,5L, multi-pinch, AAMI, 127cm/50 in, 25/bx	700-0006-32	1	510.00	375.00	375.00
26	Nellcor OxiMax DS-100A finger sensor, adult	690-0003-01	2	150.00	74.63	149.26
27	BP hose, single tube, adult	714-0018-00	2	100.00	34.30	68.60
28	BP cuff, TruLink vinyl, 1T, adult, 26-35cm, HP, 5/bg	715-1142-10	1	25.00	17.65	17.65
29	BP cuff, TruLink vinyl, 1T, lg adult, 32-42cm, HP, 5/bg	715-1162-10	1	32.20	20.08	20.08
30	LABEL,HANDLE,MODULE,DEEPRED	334-5934-07	2	2.91	2.91	5.82

31	Nellcor OxiMax sensor adapter cable	700-0792-00	2	362.00	260.81	521.62
32	ECG combiner cable, 5+5-Lead Spacelabs monitors, AAMI	700-0008-56	2	250.00	150.00	300.00
33	ECG combiner disp lead wire set, 5V, multi-pinch, 127cm/50 in, 25/bx	700-0006-33	1	510.00	375.00	375.00
34	Patient Monitoring Service Manual, CD-ROM	084-0700-03	1	0.00	$0.00	0.00
35	Ultraview SL Network Operations Manual, CD-ROM, English	084-1101-05	1	0.00	$0.00	0.00
36	Power Cord	161-0032-00	2	18.70	$18.70	37.40
37	Installation	999-9999-97	1	1,808.21	$1,356.16	1,356.16
	Med/Surg Dept: Wireless Qube ECG Monitor with A-Module, Capnopod on Roll Stand [qty 2] Total					**$42,607.69**

Med/Surg Dept: 1.4 MHz Aria Tele Tx with Display & SpO2 & 1.4 MHz XTR Tele Rcvr [qty 12]; Tele WTMS Multiband Antennas [10 PWR / 6 No PWR]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	AriaTele Telemetry Transmitter	96281	12	0.00	0.00	0.00
2	ECG and SpO2 Transmitter with Display	96281-C	12	4,200.00	2,226.00	26,712.00
3	T&V Band (1400 MHz)	96281-09	12	0.00	0.00	0.00
4	Wideband (50 kHz bandwidth)	96281-W	12	0.00	0.00	0.00
5	5-lead, AHA/AAMI color code	96281-J	12	0.00	0.00	0.00
6	Xhibit Telemetry Receiver	96280	1	0.00	0.00	0.00
7	Xhibit Telemetry Receiver, Base	96280-A	1	0.00	0.00	0.00
8	T Band Receiver, 1395-1400 MHz	96280-T	1	0.00	0.00	0.00
9	Xhibit Telemetry Receiver Housing, 12 Patient Bundle	96280-12	1	66,700.00	35,351.00	35,351.00
10	Quad Receiver, T Band, 96280	96280--T	3	0.00	0.00	0.00
11	Active antenna kit, MultiBand WMTS, with 110v power supply	040-1428-03	5	2,800.00	2,800.00	14,000.00
12	Active antenna kit, MultiBand WMTS, without power supply	040-1429-04	3	2,488.00	2,488.00	7,464.00
13	Basic CEC Support. Includes 3 consecutive weekdays of customized clinical training (workflow process development, alarm management, eLearning administration). Up to 7 hours of class time per day, between the hours of 8 A.M. and 8 P.M.	999-0222-51	1	4,850.00	0.00	0.00
14	Depot Support Plan. Unit price is per year. Monitoring Products only.	999-9999-42	4	6,235.38	0.00	0.00
15	Nellcor OxiMax DS-100A finger sensor, adult	690-0003-01	12	150.00	74.63	895.56
16	ECG combiner adapter, Aria Telemetry, 96281, AAMI	700-0008-88	12	60.00	40.00	480.00
17	ECG combiner disp lead wire set,5L, multi-pinch, AAMI, 127cm/50 in, 25/bx	700-0006-32	1	510.00	375.00	375.00
18	CD-ROM, Manual, Ops, 96281, ariaTele	084-2201-01	1	0.00	0.00	0.00
19	AriaTele Service Manual, CD-ROM	084-2202-01	1	0.00	0.00	0.00
20	Operation Manual, CD, Xhibit/Telemetry	084-2301-06	1	0.00	0.00	0.00
21	Service Manual, CD, Xhibit/Telemetry	084-1479-06	1	0.00	0.00	0.00
22	Additional Week of Clinical Support. Includes 3 consecutive weekdays of support. Up to 7 hours of class time per day, between the hours of 8 A.M. and 8 P.M. Required for units with >50 users to train and/or >11 beds.	999-0222-52	1	4,850.00	2,958.50	2,958.50

23	Power Cord, North America, 3 ft, 120V, 10A	161-0246-00	6	40.10	$40.10	240.60
24	Installation	999-9999-97	1	3,464.10	$2,598.08	2,598.08
	Med/Surg Dept: 1.4 MHz Aria Tele Tx with Display & SpO2 & 1.4 MHz XTR Tele Rcvr [qty 12]; Tele WTMS Multiband Antennas [10 PWR / 6 No PWR] Total					**$91,074.74**

COVID RN Station Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Splitter display port 4WAY 96102	010-1975-00	1	949.58	949.58	949.58
2	DP to HDMI converter	P136-06N-ACT	1	70.00	70.00	70.00
3	Cable, HDMI, 6ft, black	012-0993-00	2	17.33	17.33	34.66
4	HDMI over IP extender	ST12MHDLAN	1	950.00	950.00	950.00
5	Cable, Display Port, Latching, 6ft	012-1013-00	1	34.12	34.12	34.12
	COVID RN Station Remote Display Solution [qty 1]; Mangum to provide Display & Mounting Solution for Remote Display Total					**$2,038.36**

BIOMED BACKUP Equipment: Factory Certified 16-Zone Xibit Central Station CPU, Wireless Qube Mini ECG Monitor & "C" Command Module [1 qty each]; comes with 1 Year Warranty

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Factory Certified Discount for receiving a factory certified 91389 Qube Mini Monitor	999-SVCD-91389	1	-3,842.69	-3,842.69	-3,842.69
2	Qube Mini Transport Monitor	91389	1	0.00	0.00	0.00
3	Qube Mini, base unit	91389-A	1	9,000.00	4,770.00	4,770.00
4	Six Waveforms	91389-06	1	2,200.00	1,166.00	1,166.00
5	Data Shuttle	91389-Q	1	450.00	238.50	238.50
6	Patient Data Logger (PDL)	91389-R	1	950.00	503.50	503.50
7	Full View	91389-V	1	710.00	376.30	376.30
8	Full Bed Review	91389-W	1	655.00	347.15	347.15
9	English Language	91389-1	1	0.00	0.00	0.00
10	Wireless (802.11 a/b/g)	91389-P	1	531.92	281.92	281.92
11	Factory Certified Discount for receiving a factory certified 91496 Command Module	999-SVCD-91496	1	-5,478.58	-5,478.58	-5,478.58
12	Ultraview SL Command Module	91496	1	0.00	0.00	0.00
13	Invasive/Cardiac Output Parameter Set	91496-C	1	12,800.00	6,784.00	6,784.00
14	12-lead diagnostic ECG with measurements and interpretation	91496-D	1	1,629.00	863.37	863.37
15	Advanced Multiview Arrhythmia (MVII)	91496-H	1	1,688.00	894.64	894.64
16	Adult/Neonatal Respiration	91496-R	1	575.00	304.75	304.75
17	ST Segment Analysis	91496-S	1	446.00	236.38	236.38
18	Varitrend 4	91496-V	1	2,134.00	1,131.02	1,131.02
19	English Language	91496-1	1	0.00	0.00	0.00
20	Nellcor SpO2	91496-N	1	743.00	743.00	743.00
21	Factory Certified Discount for receiving a factory certified 96102 Xhibit Central Station	999-SVCD-96102	1	-14,827.02	-14,827.02	-14,827.02
22	Xhibit Central Station	96102	1	0.00	0.00	0.00
23	Xhibit central station, base Computer	96102-B	1	0.00	0.00	0.00
24	Xhibit central station, 16 bed bundle	96102-16	1	55,951.00	29,654.03	29,654.03
25	Single patient license for Xhibit central station	910-6102-01	16	0.00	0.00	0.00
26	Power Supply	119-0480-02	1	163.13	163.13	163.13

27	ECG combiner cable, 5+5-Lead Spacelabs monitors, AAMI	700-0008-56	1	250.00	150.00	150.00
28	Power Cord	161-0032-00	1	18.70	$18.70	18.70
	BIOMED BACKUP Equipment: Factory Certified 16-Zone Xibit Central Station CPU, Wireless Qube Mini ECG Monitor & "C" Command Module [1 qty each]; comes with 1 Year Warranty Total					**$24,478.10**

BIOMED Training [2 Credits Each for Levels I&II]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Service Training: Xhibit, XTR & AriaTele Telemetry Systems. Operations, Configuration and PMs - Levels 1 & 2	999-1887-54	2	3,600.00	0.00	0.00
2	Service Training for Xprezzon, Qube & Xhibit - Levels 1 & 2 operation, preventative maintenance & basic corrective maintenance	999-1887-30	2	6,000.00	0.00	0.00
	BIOMED Training [2 Credits Each for Levels I&II] Total					**$0.00**

BIOMED Training [2 Credits Each for Levels I&II] Proposal Notes

NOTE: The discount offered herein requires that the biomedical engineers be employed as staff members by the member facility. Tuition credits are valid for 24 months after equipment installation. Travel, lodging and per diem are the responsibility of the hospital. Training will be at a mutually agreeable time and place. It is recommended that the hospital make technical training arrangements as soon as possible as seats for Snoqualmie training, and selected U.S. cities, are on a first come, first served basis. For registration, please contact Spacelabs University at (800) 287-7108 Ext. 5439.

ICS Bundled Bed Licenses [16 QTY]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	1 Bed Clinical Access Bundle License	910-3999-01	16	600.00	318.00	5,088.00
2	1 Bed Interface Bundle License	910-3998-01	16	400.00	212.00	3,392.00
3	Project Management: Manage all aspects of the equipment, technology, clinical workflow, and go-live activities from the initial project kickoff to project closure utilizing the 5 stages of the Project Management Process.	999-1510-13	1	3,500.00	3,500.00	3,500.00
4	SL Network Impact Analysis. Determine and evaluate the impact of SL on the local network. Remediation, Testing and Go Live Support.	999-1510-01	1	5,000.00	5,000.00	5,000.00
5	Enhanced Software Support for new ICS 5.0 installations with bundles. Price is per year.	999-1898-02	1	279.78	0.00	0.00
6	72 hr Smart Disclosure License, ICS 5.0	910-3810-00	1	0.00	0.00	0.00
7	ICS 5.0 Documentation CD	084-1530-00	1	0.00	0.00	0.00
8	ICS Clinical Access, Client Installation Software CD (v5.5.0)	063-1829-18	1	0.00	$0.00	0.00
9	ICS Software CD (v5.5.0)	063-1830-17	1	0.00	$0.00	0.00
10	ICS Clinical Access Help, Installation CD (v5.5.0)	063-1833-12	1	0.00	$0.00	0.00
	ICS Bundled Bed Licenses [16 QTY] Total					**$16,980.00**

ICS Clinical Access, ADT, and Vital Signs Interface implementation. For facilities with no more than 25 monitored beds.

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	ICS Clinical Access, ADT, and Vital Signs Interface implementation. For facilities with no more than 25 monitored beds.	999-2034-00	1	6,700.00	5,025.00	5,025.00
	ICS Clinical Access, ADT, and Vital Signs Interface implementation. For facilities with no more than 25 monitored beds. Total					**$5,025.00**

SafeNSound STANDARD Year 1 of 5 Year Contract for $6,000 per Year [16 Devices]

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	SafeNSound Standard 1 Year Contract (Includes up to 100 Devices)	910-0282-00	5	5,000.00	5,000.00	25,000.00
2	Xprezznet Bed License, SafeNSound, waveforms off	910-0270-01	16	0.00	0.00	0.00
3	XprezzNet	96190	1	0.00	0.00	0.00
4	Xprezznet Implementation with SafeNSound Standard	999-2899-01	1	5,000.00	0.00	0.00
5	SafeNSound Software Support	999-1898-13	5	1,000.00	1,000.00	5,000.00
	SafeNSound STANDARD Year 1 of 5 Year Contract for $6,000 per Year [16 Devices] Total					**$30,000.00**

Enhanced Software Support Plan Years 2-5

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Enhanced Software Support Plan (ICS/XprezzNet/Xhibit). Unit price is per year.	999-1898-00	4	1,620.00	1,215.00	4,860.00
	Enhanced Software Support Plan Years 2-5 Total					**$4,860.00**

Premier Tier Equipment Trade-In Discount

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	Trade in discount, monitoring items. **REQUIRES** the completion and return of the Trade-in Equipment Form on page 24 with your purchase order.	7000-0001-999	1	0.00	-18,262.85	-18,262.85
	Premier Tier Equipment Trade-In Discount Total					**-$18,262.85**

TRADE-IN EQUIPMENT FORM

MUST BE COMPLETED AND RETURNED WITH YOUR PURCHASE ORDER

In order to ensure that you receive full credit for your trade-in equipment, please complete this form and send it in with your Purchase Order. If you are trading in Spacelabs Healthcare equipment, please note the serial number that appears on the unit.

Equipment Manufacturer	Model Number or Model Type	Serial Number (SpaceLabs Equipment)	Qty	Equipment Age

Customer Signature Date

Purchase Order Number

Please make sure to return all trade-in equipment to:
Spacelabs Healthcare
Attn: Robert Mcphetridge / Arnaldo Santos
35301 SE Center St
Snoqualmie, WA 98065

**PLEASE NOTE: Trade-in equipment must be returned to Spacelabs Healthcare within 60 days of shipment of the new equipment. If the equipment is not returned, the amount of the trade-in discount will be invoiced to the customer. Spacelabs Healthcare will pay return freight charges for the trade-in equipment specified herein, using our preferred carrier(s). If a problem should occur in meeting this requirement, please contact your Sales Executive for assistance.

eLearning Courses

We are pleased to offer you access to Spacelabs' interactive eLearning courses, as well as five years of updates to eLearning course content. ELearning courses can be accessed by your personnel at http://www.spacelabselearning.com after individual login credentials are provided. If you choose to incorporate the eLearning courses directly into your learning management system, we will provide you with access to Dropbox SCORM files containing the eLearning material (the material can be provided on a USB if you do not have Dropbox access).

Except as modified below, the eLearning courses are provided to you subject to Spacelabs' Terms of Sale, (available on the About Us/Terms/Policies page of our website at http://www.spacelabshealthcare.com) or, if you have a separate applicable agreement in place with Spacelabs (such as a GPO agreement or standalone contract), subject to such contract.

The information in the eLearning courses is copyrighted by Spacelabs Healthcare. You are granted a non-exclusive, non-transferable, non-sublicensable license for use of the courses by your personnel. You agree that you will not alter, modify, create derivative works, or publicly display outside of your organization any content from the eLearning courses.

The eLearning courses are intended to supplement, and not replace, the information provided in a product's operators manual and a clinician's use of good clinical judgment. The information in each eLearning course SCORM file is current as of the date Dropbox shows the file was modified (or, if we provide the files via USB, when the files are provided to you). Spacelabs eLearning SCORM course files require Adobe Flash Player 11.7 or higher.

The eLearning courses are provided on an AS-IS basis. We expressly disclaim all warranties beyond those stated in this letter, including, without limitation, warranties of fitness for a particular purpose. We make no guarantee that eLearning SCORM courses will work on your learning management system. However, if they do not, upon your request within 30 days of purchase and your destruction or return of the SCORM files, we will refund the license fees you have paid. Any customization or deployment support you request from Spacelabs relating to the eLearning courses will be provided on a time and materials basis, should Spacelabs agree to provide such support. Spacelabs Technical Support does not support the eLearning SCORM files.

SPACELABS HEALTHCARE
An OSI Systems Company

NON-CONTRACT SERVICES

INSTALLATION SERVICES

We've covered all of the bases.

Signing on the dotted line doesn't simply complete the sale, it initiates a partnership between Spacelabs and our customers. During an installation, we follow through on the commitments made during the sales process and show you what our **Customer First philosophy** means in action.

STANDARD INSTALLATION INCLUDES:

Unpacking and inventory of the received equipment; Assembling and testing the equipment prior to use; Customer will dispose of packing material.

Mounting the equipment on hospital-installed wall channels. Customer will install any necessary wall channels, cabinetry or casework for mounting equipment. Customer, or its contractor, will mount wall or ceiling hardware to structure. Customer will provide electrical requirements such as conduit, emergency or standard power, as required.

Designing local area network for the monitoring system; Terminating and verifying customer pulled cable; Providing unmanaged switches, Category 5 network cable, wall plates and Category 5 connectors on wall plates; Verifying the functionality of the installed network.

Designing telemetry antenna systems, as required for the coverage area purchased; Providing telemetry antennas, coaxial cable and other components required for a functional telemetry system according to the coverage area specified in the purchase agreement; Customer will install Spacelabs-provided cable per the specification of the antenna system design; Customer will provide emergency power (if needed) to antenna components. Under no circumstance can Spacelabs install in asbestos areas or other environments deemed hazardous. Customer will provide skilled labor in these areas.

Customer is responsible for pulling cable, performing modifications to existing structures, or electrical requirements. Customer is responsible for penetration and sealing of firewalls.

Installation is scheduled for normal working hours. Requests for overtime or after-hours installation work should be reviewed with the local Spacelabs Regional Service Manager and will be billed at the prevailing time and material rate.

TruLink™

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www.spacelabshealthcare.com

SUPPORT PLAN PORTFOLIO

WARRANTY AND SUPPORT PLAN OPTIONS

Warranty Options

8 x 5 Warranty
On-site coverage during normal business hours.

Warranty description identical to the Depot Support Plan specification provided below.

Depot Warranty
Return to depot coverage.

Warranty description identical to the Depot Support Plan specification provided below.

Support Plan Options

24 x 7 Support Plan
On-site coverage 24 hours a day, 7 days a week, 365 days a year. Designed for customers who prefer that Spacelabs meets all of their service support needs 24 hours a day. All safety updates are included, our technical support and field service teams are available 24 hours a day, 7 days a week to ensure that your equipment is kept in peak operating condition. In the event that there is a problem that we can't fix immediately, priority access to our dedicated pool of loaner equipment is assured.

8 x 5 Support Plan
On-site coverage during normal business hours. Designed for customers who prefer that Spacelabs meets all of their service support needs within normal working hours. All safety updates are included, our technical support team is available 24 hours a day, 7 days a week and our field service teams are available 8 hours a day, 5 days a week to ensure your equipment is kept in top operating condition.

Depot Support Plan
Return to depot coverage. Designed for Spacelabs customers who have less urgent equipment servicing needs All safety updates are included and our technical support team is available 24 hours a day, 7 days a week. If there is a problem that we can't fix remotely, arrangements will be made to get the device returned to the factory for immediate update or repair.

Parts Exchange Support Plan
Spare part coverage for trained biomeds. Designed for Spacelabs customers whose biomed teams have completed our Spacelabs Certified Technical Training courses. Our technical support team is available 24 hours a day, 7 days a week to help diagnose problems and to then supply any parts required for your Spacelabs certified biomed staff to perform the repair.

Enhanced ICS Software Support Plan/Basic Software Support Plan
Software update coverage. These low cost agreements are designed for Spacelabs customers who simply wish to ensure that their equipment's software is updated to the most current level every year. The Enhanced plan is required for customers purchasing ICS G2. For 'Mission Critical' users the Enhanced Plan also provides 24 hours a day, 7 days a week access to our team of IT Product Specialists and an option to include remote Preventive Maintenance checks for a small additional charge of 0.5%.

Custom Support Plan
An à la carte approach allowing customers select coverage to suit specific needs. We appreciate that on occasion, a hospital may have some very individual and unique support requirements. For this reason, we've included a 'Custom' column in the specification matrix on the back of this sheet. Place a check mark by each of the services you require and we'll be delighted to provide you with a quotation tailor-made for you.

Support Plan Portfolio

	WARRANTY TYPE	8 X 5 Warranty	Depot Warranty	SUPPORT PLAN TYPE	24 X 7 Support Plan	8 X 5 Support Plan	8 X 5 Support Plan (Cardiology Products)	Depot Support Plan	Parts Exchange Support Plan	Enhanced ICS Software Support Plan	Basic Software Support Plan (Patient Monitoring Products)	Basic Software Support Plan (Cardiology Products)	Custom Support Plan
US TECHNICAL SUPPORT													
8x5 Telephone Support		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
24x7 Telephone Support (Includes weekends & holidays)		✓	✓		✓	✓		✓	✓	✓	✓		
8x5 Access to Product Specialists		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
24x7 Access to IT Product Specialists (Includes weekends & holidays)										✓			
Remote Diagnostics Support (Availability subject to equipment specification)		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
PREVENTATIVE MAINTENANCE (PM) - Full OEM specification													
25% Discount for On-site PM Coverage (Discount from normal travel & labor charges)		✓			✓	✓	✓						
10% Discount for PM Parts used by FSE (Discount provided in addition to any discounts currently in place)		✓			✓	✓	✓						
Remote ICS Preventative Maintenance (Two system performance evaluations per year)										OPT			
CORRECTIVE MAINTENANCE (CM) - Full OEM specification													
08:30AM - 05:00PM On-site CM Coverage (Customer local time, FSE travel & labor included)		✓			✓	✓	✓						
24 X 7 On-site CM Coverage (Includes weekends & holidays, FSE travel & labor included)					✓								
Return to Depot CM Coverage (Labor & return shipping included)		✓	✓		✓	✓	✓	✓					
CM Repair Parts Coverage (Excludes supplies & accessories)		✓	✓		✓	✓	✓	✓	✓				
Priority Loan Equipment (No charge, subject to availability)					✓								
SOFTWARE SUPPORT													
Safety Updates (Includes FSE travel & labor)		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Annual Performance Enhancing Updates (Includes FSE travel & labor)										✓	✓	✓	
Spacelabs ICS Software Upgrades (Includes upgrade to Intesys Clinical Suite (ICS) 5)										✓			
Discount on Post Implementation Interface Support (Includes any FSE travel & labor required)										25%	25%	25%	
ANNUAL PRICE													
Calculated as a percentage of the selling price of all products covered (Subject to maximum discount of 25% from list price)					9%	6%	12%	45%	3%	1.5%	1%	6%	QUOTE

A detailed description of the service offerings and applicable terms shall be included in the Spacelabs Customer Quotation form.

SPACELABS HEALTHCARE

35301 SE Center St Snoqualmie, WA 98065 | T +1 425 396 3300 | +1 800 522 7025 • 1 Harforde Court, John Tate Road, Hertford, SG13 7NW, UK | T +44 (0)1992 507700 | F +44 (0)1992 5012
www.spacelabshealthcare.com

EXHIBIT A-2
PARTICIPATING MEMBER DESIGNATION FORM

SELLER: **Spacelabs Healthcare, LLC**
CONTRACT NUMBER: **PP-MM-623**
CONTRACT DATES: **6/1/2018 - 5/31/2021**
PRODUCT CATEGORY: **Physiological Monitoring Systems**

1. Tier. The undersigned Participating Member hereby designates the following desired tier under the above-referenced Premier Healthcare Alliance, L.P. Group Purchasing Agreement:

a. Select one Tier by initialing below

VOLUME TIERS	TOTAL PRODUCT PURCHASES (COMMITMENT % PER CALENDAR YEAR)
TIER 1	No commitment required; PMDF not required
TIER 2	75% Commitment
TIER 3	85% Commitment
TIER 4	85% Commitment for a conversion Participating Member who is converting a minimum of 80% of their units from a competitor's equipment to Seller Products

b. Seller shall not reduce a Participating Member's tier level without first (i) notifying the Participating Member and Premier in writing that the Participating Member's purchase volume is below the tier level selected by the Participating Member (the "Tier Reduction Notice") and (ii) providing the Participating Member sixty (60) calendar days from the date of notice to remedy the purchasing volume issues described in the Tier Reduction Notice. If the Participating Member does not remedy the issues described in the Tier Reduction Notice within sixty (60) days, Seller may move the Participating Member to the appropriate tier based on the Participating Member's Product purchases. Any tier adjustment pursuant to this paragraph that results in a less favorable tier for the Participating Member will apply for Products purchased after the effective date of the tier reduction.

2. Aggregation Pricing Option. By initialing where indicated below, the undersigned Participating Member or Participating Member group purchasing organization ("GPO") hereby elects to invoke the Aggregation Pricing Option whereby such Participating Member which operates multi-facility systems and has the ability to coordinate the purchasing decisions of such facilities, or such entity that has an established network of facilities for purposes of group purchasing, shall be entitled to aggregate the purchasing volume within their respective systems and networks in order to meet the tier designated in Item 1 above. In order to invoke this election, the undersigned must be a Participating Member that is able to coordinate the purchasing decisions of the facilities it wishes to aggregate or a GPO with members that are Participating Members. Attached hereto as Schedule 1 is a list of all such facilities. Seller shall be responsible for checking the Membership Roster for updates as specified in Section 3.0 of the Agreement. The undersigned Participating Member or GPO hereby elects to invoke the Aggregation Pricing Option: **Participating Member's (or GPO's) Initials**: _____.

Participating Member's Primary Distributor: _____ Secondary Distributor: _____

The undersigned Participating Member hereby acknowledges and confirms the above designations.

Participating Member/GPO

Print Name of Person Signing _____
Signature _____
Title of Person Signing _____
Phone Number _____
E-mail Address _____
Date Signed _____
Entity Code _____
Print Name of Participating Member/GPO _____
Address _____
City and State _____

Spacelabs Healthcare, LLC

Print Name of Person Signing _____
Signature _____
Title of Person Signing _____
Date Signed _____

Upon completion, please submit this form to both Seller and Premier.

Spacelabs Healthcare
Fax: 425-363-5399
Email: slcorporateaccounts@spacelabs.com

Premier Healthcare Alliance, L.P.–
Fax: 704.816.3509
Email: PremierPMDF@PremierInc.com

EXHIBIT A-2
PARTICIPATING MEMBER DESIGNATION FORM

SELLER: Spacelabs Healthcare, LLC
CONTRACT NUMBER: PP-MM-623
CONTRACT DATES: 6/1/2018 - 5/31/2021
PRODUCT CATEGORY: Physiological Monitoring Systems

SCHEDULE 1

LIST OF PARTICIPATING MEMBER'S (or GPO's) FACILITIES
(For Purposes of Implementing the Aggregation Pricing Option)

[TO BE COMPLETED BY THE PARTICIPATING MEMBER OR GPO]

Participating Member/GPO name: _____

Premier Entity Code	Participating Facility Name	City	ST	Phone Number	Contact Name

Qube shown with 91496-C Command Module and 92516 Capnography Module (both sold separately)

Spacelabs 91390 Qube® is a compact patient monitor with a 12-inch touchscreen that is well-suited for use in high acuity neonatal, pediatric and adult care, as well as perioperative environments. Its clever design and compatibility with the Spacelabs Command Modules, Spacelabs Capnography Pod, and Exergen Temporal Artery Thermometer provide a versatile solution with a full range of measurement choices.

Qube stores up to 96 hours of trends, and features remote viewing, Alarm Watch, and three user-selectable screen formats harmonized with Xprezzon® and Qube Mini to facilitate learning and navigation. With wireless networking and two batteries, Qube supports extended transport for up to eight hours. When deployed with the Spacelabs Xhibit® Central Station and Intesys® Clinical Suite, Qube offers enterprise connectivity to your hospital EMR, ECG management systems, paging systems, and remote access solutions.

Physical Specifications

Dimensions (H x W x D)	26.2 x 31.5 x 13.2 cm (10.3 x 12.4 x 5.2 in)
Weight	4.1 kg (9.1 lbs) with one battery, excluding module and Capnography Pod
Display type	Resistive TFT LCD
Display size	30.37 cm (12.1 in) diagonal
Display resolution	1024 x 768 pixels
Number of waveforms	Choice of 4 or 6
Screen layouts	Selectable, 3
Controls	Power On/Off (side of unit) Touchscreen user interface

Indicators

Alarms	Audible tones, visual on display, integrated alarm light
Alarm levels	High, Medium, Low
Power	AC power and battery charge status indicators

Connections

Measurement connections	Slot for 91496 Command Modules SDLC port for 90499 two-slot module housing and Flexport® interfaces 92516 Capnography Pod interface
USB ports	4 USB ports for optional 91449 printer, bar code reader, Exergen Temporal Artery Thermometer (P/N 010-2157-00), mouse (P/N 010-1622-00), and/or language-specific keyboard
Network	LAN: Ethernet 10/100 Base T port WLAN: 802.11 a/b/g (optional)
Video interface	DVI-D for optional 94267 secondary display
Serial port	RS-232 (UART) connector for secondary display touchscreen, Patient Data Logger, or troubleshooting
Docking	Qube docking station (optional)
Alarm relay output–nurse alert	14-pin SCSI (female) connector for alarm relay output–nurse alert. Compatible with third-party alarm devices (e.g. hospital alarm lights) that conform to the Spacelabs pinout for alarm relay. Relay contact ratings must not exceed 250 ma or 28 V AC/DC.
Mount interface	75 mm VESA mounting pattern. GCX compatible; contact Spacelabs Healthcare for mounting options.
Grounding	Equipotential terminal

Recorder

Type	Optional integrated recorder/printer (option U) or USB connection to 91449 thermal array recorder/printer
Wave traces	2-channel
Paper width	50 mm (2 in)

Electrical Specifications

Power Supply

Power source	Battery or external AC power supply, P/N 119-0552-xx
AC input	100 to 240 VAC, 50 to 60 Hz, 3 to 1.5 A
Safety classification	60601-1: Class I, chassis connected to protective earth (hospital grade safety ground)
Mode of operation	Continuous

Battery

Type	Rechargeable lithium-ion, P/N 146-0142-xx
Number of batteries	1 or 2
Voltage	10.8 V (7.2 Ah) each
Battery operation	Approximately 4 hours with 1 battery; approximately 8 hours with 2 batteries
Battery recharge time	1 battery: approximately 2 hours from depletion to 90% charge in normal use 2 batteries: approximately 4 hours from depletion to 90% charge in normal use
Battery life	300 cycles

Environmental Requirements

Ambient temperature	Operating: 0° to 40° C (32° to 104° F) Storage and Transport: -25° to 60°C (-13° to 140° F)
Relative humidity	Operating, storage, transport: 95% non-condensing
Altitude	Operating: 0 to 3,000 meters (0 to 9,843 feet) Storage and transport: 0 to 12,192 meters (0 to 40,000 feet)
Water ingress	Meets EN 60529 IPX1

Ordering Information

Software options	4-waveform display (04) 6-waveform display (06) Perioperative (D) Vital signs calculations (N) Data Shuttle (Q) Patient Data Logger (R) Full 12-lead view (V) Full bed review (W)
Hardware options	Integrated recorder/printer (U) Wireless 802.11 a/b/g (X or P) Second battery (Z) Battery charger, 2-battery capacity (P/N 015-0696-00) Docking station (P/N 016-0922-00) 94267-L19 secondary display, 19-inch (48.26 cm) 94267-L15 secondary display, 15-inch (38.1 cm) Exergen Temporal Artery Thermometer (P/N 010-2157-00) 91449 thermal array recorder/printer 90499 module housing External alarm light (P/N 011-0246-00)

For further ordering information and details on compatible accessories, please contact your Spacelabs Healthcare representative or refer to the product documentation.

This product may not be approved for market release in all countries.

Documentation

All operations, system administration, and service manuals are available in PDF format on CD-ROMs that ship with the product.

Regulatory Approvals

	CSA certified. Meets CSA C22.2 No. 60601-1, ANSI/AAMI ES60601-1, and IEC 60601-1 for basic safety and essential performance.
	CE marked in accordance with the Medical Device Directive 93/42/EEC.
	Does not contain hazardous substances — Europe
	Does not contain hazardous substances — China
	The wireless option X 802.11a/b/g radio transceiver of this device complies with part 15 of the FCC Rules, and with RSS-210 of Industry Canada. The wireless option P 802.11a/b/g radio transceiver of this device complies with part 15 of the FCC Rules, with RSS-247 of Industry Canada, and with the Radio Equipment Directive (2014/53/EU). Operation of the wireless option is subject to the following two conditions: (1) this device may not cause harmful interference, and (2) this device must accept any interference received, including interference that may cause undesired operation. The radio transceiver may only be used for Wireless Local Area Network (WLAN) operation within a medical facility. It is not intended for home or vehicle use. Changes or modifications not expressly approved by Spacelabs Healthcare will void the user's authorization to operate this equipment. To comply with the FCC's RF safety Specific Absorption Rate (SAR) requirements, the user must ensure that the monitor which contains the radiating element of the antenna, is located at least 20 cm (8 in) away from a person's head or body.

91496-A | 91496-B | 91496-C | 91496-I | 91496-L

Summary

The Ultraview SL™ Command Module is a multiparameter module used with Spacelabs Healthcare patient monitors. Five different parameter configurations provide vital sign monitoring for any range of acuity. Configurable settings assure customized care for neonatal, pediatric, and adult patients.

Features

Module Configurations	*Note:* *Module use is restricted to one patient at a time.*
91496-A	Noninvasive Parameter Set Provides multi-lead ECG, respiration, noninvasive blood pressure, pulse oximetry, and two temperature channels
91496-B	Invasive Parameter Set Provides multi-lead ECG, respiration, noninvasive blood pressure, pulse oximetry, and two temperature channels, plus two invasive pressure channels
91496-C	Invasive Parameter Set with Cardiac Output Provides multi-lead ECG, respiration, noninvasive blood pressure, pulse oximetry, and two temperature channels, plus four invasive pressure channels and thermodilution cardiac output
91496-I	Noninvasive Parameter Set Provides noninvasive blood pressure, pulse oximetry, and two temperature channels
91496-L	Invasive Parameter Set Provides four invasive blood pressure channels, pulse oximetry, and two temperature channels *Note:* *91496-L is intended for use in conjunction with another module to provide additional parameter monitoring, such as dual SpO_2 (SpO_2D).*

Alarm Limit Review	Provides a snapshot view of bedside alarm limits for all active parameters *Note:* *This feature only functions with specific monitors.*
Data Shuttle®	Provides data transfer features for up to 24 hours of data in the monitor's database, including continuous and episodic events, and trend information for all parameters monitored, including modules and Flexport® system interfaces (requires monitor option Q); module will retain data for up to 10 minutes. 91496-I and 91496-L configuration do not support Data Shuttle.
Module Configuration Manager	This feature provides the ability to define all the module's user-configurable settings. Once a module has been configured, these settings control its operation whenever the module is first powered ON.
Module Parameter Count	When computing parameter capacity for monitors, each configuration counts as follows:
91496-A	Minimum of 5, maximum of 7
91496-B	Minimum of 7, maximum of 9
91496-C	Minimum of 10, maximum of 12
91496-I	3 parameters
91496-L	6 parameters
Dimensions	
Height	11.3 cm (4.45 in)
Width	5.66 cm (2.23 in)
Depth	18 cm (7.1 in)
Weight	0.8 kg (1.75 lb)

Options

D	Diagnostic 12-lead reports with measurements and interpretation*
E	Diagnostic 12-lead reports without measurements or interpretation*
F	Basic arrhythmia, provides alarms for high and low heart rate, asystole, and ventricular fibrillation*
G	Standard Multiview™ I Arrhythmia (MVI); provides alarms for high and low heart rate, asystole, ventricular fibrillation, ventricular runs, ventricular couplets, ventricular beats per minute, atrial fibrillation, pauses, and supraventricular tachycardia*
H	Advanced Multiview II Arrhythmia (MVII); enables users to review the dominant morphology, as well as episodes or classes of ventricular fibrillation, ventricular runs, ventricular couplets, isolated ventricular beats, supraventricular tachycardia, pauses, atrial fibrillation, ventricular and atrio-ventricular pacing; provides alarms for high and low heart rate, asystole, ventricular fibrillation, ventricular runs, ventricular couplets, ventricular beats per minute, atrial fibrillation, pauses, and supraventricular tachycardia*
M	Masimo SET SpO_2 technology

N	Nellcor OxiMax SpO_2 technology
R	Respiration*
S	ST segment analysis; review, and trends*
U	Spacelabs Healthcare SpO_2 technology
V	Varitrend® 4; define, trend, and document critical physiological events containing data from up to four parameters, including heart rate, SpO_2 (pre- and post-ductal sites), respiration rate, $EtCO_2$, $TcpCO_2$, and $TcpO_2$*

* *Not available with 91496-I and 91496-L configuration.*

Product Specifications

Refer to the specific parameter section for the appropriate specifications.

Electrocardiogram (ECG)

Input	10-lead, 5-lead, or 3-lead ECG cable (cables use 1 kΩ ±10% resistors in series with each electrode)
Maximum Input	±5 mV (±10%)
DC Offset	Up to ±300 mV with no more than 2% signal amplitude degradation
Overdrive Recovery Time	<2 seconds with defibrillator discharge of 360 joules or voltage step-up to ±300 mV
Noise	<30 µV peak-to-peak referred to input (rti)
CMRR	>110 dB at line frequency (monitor mode) with patient cable and maximum 50 kΩ imbalance (referenced to chassis [earth] ground)
Pacer Rejection	Single and double pulse pacers with less than 4-msec tails
Pacer Detection	Detects pacer pulses of ±2 mV to ±200 mV with pulse widths of 0.25 to 2 msec and rise times 10% of width not to exceed 100 µsec
Signal Bandwidth (-3 dB)	0.05 to 150 Hz ±10%
Display Bandwidth (-3 dB)	2 settings: 0.5 to 40 Hz ±10% in monitor mode, and 0.05 to 150 Hz ±25% in extended mode
Sample Rate	896 samples per second (sps)
QRS Detection	Performed on up to 2 leads simultaneously; detects QRS complexes with durations of 40 to 120 ms and amplitudes of 0 .2 to 5 mV (adult/pediatric) or 0.15 to 5 mV (neonate)
Defibrillator Protection	Meets IEC 60601-2-27, AAMI EC-13
Resolution	2.5 µV per LSB, rti
Input Impedance	>10 MΩ minimum differential at 10 Hz
Gain Accuracy	±5%
Ventricular Beats Per Minute Counter	Displays counts up to 99 beats per minute

Heart Rate Range	15 to 300 bpm; heart rates >300 bpm are displayed as "+++"
Heart Rate Resolution	1 bpm
Heart Rate Alarm Limits	• High — 5 to 300 bpm • Low — 0 to 200 bpm
Accuracy	±1% or 3 beats per minute (whichever is greater)
Numeric Update Rate	Every 3 seconds or immediately at the onset of an alarm
Test Signal	1 mV peak-to-valley (displayed via touch key)
Display Size	Adjustable from 0.5 to 10 cm/mV; direct selection of a 1 cm/mV size
Bedside Display	Up to 12 leads; number of leads depends on host monitor configuration • Standard (1- or 2-lead display) • Split-view (6-lead display) • Full-view (12-lead display)
Waveform Sweep Speeds	50, 25, or 12.5 mm/sec
High Level Analog Output	
Connector (Front Panel)	0.174 in (4.42 mm) diameter, three conductor TT-phone plug
Dynamic Range	±5 mV (±10%) rti
Gain	ECG × 1,000 (±5%)
Output Impedance	400 Ω maximum
Defibrillator Sync Input	
Input Level	±1 V minimum upper HLO, ring connection
Input Impedance	2,000 Ω minimum

ST Segment Analysis

Resolution	0.08 mm
Range	±9 mm (1 mV = 10 mm)
Leads	ST segment analysis continuously performed on up to 12 leads
Alarms	Single lead or multiple leads; individual leads can be deselected
Displays	12-lead waveforms and numerics
Snapshot Storage	Up to nine 12-lead ST segment waveform sets can be saved in memory; data may be acquired automatically at pre-selected intervals or in the event of an alarm
Trends	Up to 24 hours of trend data may be displayed in 1.5-, 3-, 6-, 12-, or 24-hour time bases

Diagnostic ECG Analysis

Instrument Type	12-lead interpretive electrocardiograph
Standard Leads	I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5, V6
Input Channels	Simultaneous acquisition of all standard leads
Sample Rate	500 sps
Algorithm Features	Arm lead reversal detection, lead-off detection, artifact detection, baseline correction, line voltage rejection
Printer Speed	25 mm/sec
Sensitivity	10 mm/mV

Respiration

Input	10-lead, 5-lead, or 3-lead ECG cable (cables use 1 kΩ resistors (±10%) in series with each electrode)
Measurement Technique	Impedance pneumography through ECG leads RA/LA (R/L), RL/LL (N/F), RL/LA (N/L), or RA/LL (R/F)
Patient Source Impedance	0 to 1,500 Ω
Excitation Frequency	62.5 kHz (±2%)
Excitation Amplitude	120 µAmp (±20%) rms, 330 µAmp (±20%) peak-to-valley
Noise	<0.05 Ω peak-to-valley at 500 Ω patient source impedance
Signal Bandwidth	• Adult/Pediatric — 0.12 to 3 Hz (±10%) • Neonate — 0.15 to 3.5 Hz (±10%)
Recovery Time	<3 seconds after overload
Sample Rate	112 sps
Detection Sensitivity	2 settings: 0.1 Ω (shallow) and 0.25 Ω (normal) at 500 Ω input source impedance
HR Artifact Rejection	Selectable inspiration detector improves respiratory rate and alarm accuracy by ignoring most cardiovascular artifact
Respiration Rate Range	0 to 200 breaths per minute; respiration rates >200 breaths per minute are displayed as "+++"
Respiration Resolution	1 breath per minute
Respiration Rate Alarm	• High — 1 to 200 breaths per minute • Low — 0 to 195 breaths per minute Alarms automatically enabled in neonate patient type.
Apnea Alarm	Selectable between 5 and 40 seconds in 5-second increments; in neonate patient type, alarms automatically enable
Accuracy	±5% or 1 breath per minute (whichever is greater)
Numeric Update Rate	Every 3 seconds or immediately at the onset of an apnea alarm
Display Size	Adjustable from 0.5 to 10.0 cm/Ω

Waveform Sweep Speeds	25, 12.5, 6.25, or 1.56 mm/sec
High Level Analog Input/ Output	
Connector (Front Panel)	4.42 mm (0.174 in) diameter, three conductor TT-phone plug
Dynamic Range	±4 V minimum
Gain	0.6 V/Ω ±20%

Invasive Blood Pressure (IBP)

Transducer Type	Strain-gauge, standardized to 5 µV/V/mmHg ±1%
Transducer Excitation Voltage	4 VDC ±1%
Dynamic Waveform	-50 to +500 mmHg (-6.7 to +66.7 kPa)
Signal Bandwidth	0 to 40 Hz
Sample Rate	112 sps
Measurement Units	mmHg or kPa
Measurement Range	-50 to +300 mmHg (-6.7 to +40 kPa); displays "+++" for pressures >+300 mmHg (+40 kPa) and "---" for pressures <-50 mmHg (-6.7 kPa)
Accuracy	±2 mmHg (0.27 kPa) or 2% of reading (whichever is greater)
Zero Drift	(exclusive of transducer) <0.1 mmHg/° C (<0.01 kPa/° C) after a 5-minute warm-up
Zero Adjust	±200 mmHg (±26.7 kPa)
Filter Frequency	Adjustable from 3 to 40 Hz
Labels	Arterial (ART), Arterial 2 (ART2), Arterial 3 (ART3), Central Venous (CVP), Intracranial (ICP), Left Atrial (LAP), Pulmonary Artery (PA), Right Atrial (RAP), Umbilical Artery (UA), Umbilical Venous (UV), and Generic Pressure (PRS)
Display Parameters	Systolic, diastolic, and mean pressures displayed for arterial, pulmonary artery, umbilical artery, umbilical venous, and generic pressure; mean pressures displayed for all others; cerebral perfusion pressure (CPP) displayed automatically with intracranial pressure monitoring (when ART pressure available)
IBP Alarms	• High and low alarms for all measured parameters (e.g., systolic, diastolic, mean, cerebral perfusion pressure) • Transducer disconnect and out-of-range alarms for all measured parameters • Catheter disconnect alarm for the following pressures: Arterial (ART, ART2, ART3), Pulmonary Artery (PA), Umbilical Artery (UA), Generic (PRS)
IBP Alarm Limits	• High — -45 to +300 mmHg (-6 to +40 kPa) • Low — -50 to +295 mmHg (-6.7 to +39.3 kPa)
Waveform Sweep Speeds	50, 25, 12.5, or 6.25 mm/sec
Numeric Update Rate	Every 3 seconds

High Level Analog Input/ Output	
Connector (Front Panel)	4.42 mm (0.174 in) diameter, three conductor TT-phone plug
Dynamic Range	-0.5 to +3.5 V
Gain	ART, ART2, ART3, PRS, UV, UA 10 mV/mmHg (75 mV/kPa) ±5%; other pressure labels: 25 mV/mmHg (187.5 mV kPa) ±5%

Noninvasive Blood Pressure (NIBP)

Measurement Method	Oscillometry
Measurement Units	mmHg or kPa
Measurement Ranges	• Neonate/Pediatric 1 — 15 to 140 mmHg (2.0 to 18.7 kPa) • Pediatric 2/3 — 30 to 190 mmHg (4 to 25.4Pa) • Pediatric 4/Adult— 30 to 260 mmHg (4 to 34.7 kPa)
Measurement Range	30 to 250 bpm (Pulse Rate)
Measurement Start/Stop	Automatic or user demand
Automatic Measurement Intervals	Adjustable intervals of: • 1, 2, 2.5, 3, 4, 5, 10, 15, 20, and 30 minutes • 1, 2, 4, 6, and 8 hours
Measurement Reading Time	Typically less than 45 seconds
Cuff Deflation Rate	Rapid Exhaust Mode • Neonate/Pediatric 1 — <5 seconds from150 mmHg (20 kPa) to 5 mmHg (0.7 kPa) • Pediatric 2, Pediatric 3, Pediatric 4 and Adult — <10 seconds from 260 mmHg (34.7 kPa) to 15 mmHg (2 kPa)
Air Leakage	Maximum 1 mmHg/min (0.13 kPa/sec) at 260 mmHg (34.7 kPa) on 500-ml vessel
Autozero	Automatically zeroes prior to each reading
Artifact Rejection	Software discriminates between pressure signals and extraneous signals, such as patient movement.
Accuracy and Resolution	Satisfies ANSI/AAMI SP10: 2002; and EN 1060:1996
Accuracy of Pressure Measurement	Meets or exceeds ANSI/AAMI standard SP-10 [mean error ±4.5 mmHg (0.6 kPa), standard deviation ±7.3 mmHg (1 kPa)]
Display Parameters	Systolic, diastolic, and mean
NIBP Alarms	High and low alarms for all measured parameters

NIBP Alarm Limit Ranges	
Neonate/Pediatric 1	• High — 20 to 140 mmHg (2.6 to 18.7 kPa) • Low — 15 to 135 mmHg (2 to 18 kPa)
Pediatric 2/3	• High — 35 to 190 mmHg (4.7 to 25.4 kPa) • Low — 30 to 185 mmHg (4 to 24.7 kPa)
Pediatric 4/Adult	• High — 35 to 260 mmHg (4.7 to 34.7 kPa) • Low — 30 to 255 mmHg (4 to 34 kPa)

Spacelabs Healthcare SpO_2 (Option U)

Measurement Method	Functional saturation (oxygen saturation of functional hemoglobins)
Measurement Range	
O_2 Saturation	30% to 100%
Pulse Rate	30 to 249 bpm
Measurement Accuracy (A_{rms})	Established accuracy is the root-mean-square of the error between measured values and reference values obtained from a laboratory hemoximeter during adult human blood studies. Assuming a normal distribution, A_{rms} encompasses 68% of the data population.
Adult	• 70% to 100% ±3% • 0% to 69% unspecified
Neonate	• 70% to 100% ±3% • 0% to 69% unspecified
Saturation Resolution	1%
Pulse Rate Resolution	1 bpm
Averaging Time	Selectable to 4, 8, or 16 seconds
Saturation Alarm Limits	• High — 51% to 100% • Low — 50% to 99% • Desat — 50% to 98%
Numeric Update	Every 3 seconds
TruLink® Sensors	Operate at or near 660 nm and 940 nm; total radiated optical power from 500 to 1,000 nm does not exceed 60 mW

Masimo SET SpO_2 (Option M)

Measurement Method	Functional saturation (oxygen saturation of functional hemoglobins)
Measurement Range	
O_2 Saturation	1% to 100%
Pulse Rate	25 to 240 bpm
Masimo SET SpO_2 Measurement Accuracy (A_{rms})	These sensors have been clinically validated by Masimo.

Masimo Sensor Models	Weight Range	Saturation Accuracy 70 to 100%	
		No Motion	Low Perfusion†
LNCS Reusable Sensors			
LNCS DC-I	>30 kg	±2%	±2%
LNCS DC-IP	10 to 50 kg	±2%	±2%
LNCS TC-I	>30 kg	±3.5%	±3.5%
LNCS TF-I	>30 kg	±2%	±2%
LNCS Adhesive Sensors			
LNCS Adtx	>30 kg	±2%	±2%
LNCS Pdtx	10 to 50 kg	±2%	±2%
LNCS Inf-L	3 to 20 kg	±2%	±2%
LNCS Neo-L	<3 kg	±3%	±3%
	>40 kg	±2%	±2%
LNCS NeoPt-L	<1 kg	±3%	±3%
LNOP Reusable Sensors			
LNOP DC-I*	>30 kg	±2%	±2%
LNOP DC-IP*	10 to 50 kg	±2%	±2%
LNOP Y-I*	>1 kg	±2%	N/A
LNOP TC-I**	>30 kg	±3.5%	±3.5%
LNOP DC-195*	>30 kg	±2%	±2%
LNOP TF-I**	>30 kg	±2%	±2%
LNOP Adhesive Sensors			
LNOP Adt*	>30 kg	±2%	±2%
LNOP Pdt*	10 to 50 kg	±2%	±2%
LNOP Neo*	<10 kg	±3%	±3%
LNOP NeoPt*	<1 kg	±3%	±3%
LNOP Neo-L*	<3 kg	±3%	±3%
	>40 kg	±2%	±2%
LNOP NeoPt-L*	<1 kg	±3%	±3%

Masimo Sensor Models	Weight Range	Saturation Accuracy 70 to 100%	
		No Motion	Low Perfusion†
LNOP Inf-L*	3 to 20 kg	±2%	±2%
LNOPv In*	3 to 20 kg	±2%	±2%
LNOPv Ne*	<3 kg	±3%	±3%
LNOPv Ad*	>30 kg	±2%	±2%
LNOP Hi-Fi Neo/Adult	<3 kg	±3%	±3%
	>30 kg	±2%	±2%
LNOP Hi-Fi Inf/Ped	3 to 10 kg	±3%	±3%
	10 to 30 kg	±2%	±2%
LNOP Blue**	2.5 to 30 kg	±3%††	±3%
		±4%††	±3%
		±3.3%††	±3%
LNOP Adtx	>30 kg	±2%	±2%
LNOP Pdtx	10 to 50 kg	±2%	±2%
RD SET Sensors			
RD SET Adt*	>30 kg	±2%	±2%
RD SET Pdt*	10-50 kg	±2%	±2%
RD SET Inf*	3-20 kg	±2%	±2%
RD SET Neo/Adult*	<3 kg	±3%	±3%
	>40 kg	±2%	±2%
RD SET NeoPt*	<1 kg	±3%	±3%
RD SET DCI-P	>30 kg	±2%	±2%

* *The accuracy specification under motion conditions is ±3%. Motion is defined as continuous rubbing and tapping motions at 2 to 4 Hz, at an amplitude of 1 to 2 cm, and continuous random frequency motion between 1 to 5 Hz, at an amplitude of 2 to 3 cm.*

** *These sensors were not validated under motion conditions.*

† *Pulse amplitude >0.2%; % transmission >5% (LNOP Y-I sensor was not validated for low perfusion).*

†† *Saturation accuracy under no motion for neonatal, infant, or pediatric patients with congenital cyanotic cardiac lesions ±3% for 80 to 100%, ±4% for 60 to 80%, and ±3.3% for 70 to 100%.*

Pulse Rate Accuracy	• No Motion — ±3 bpm • Motion — ±5 bpm • Low Perfusion — ±3 bpm
Saturation Resolution	1%
Pulse Rate Resolution	1 bpm
Saturation Alarm Limits	• High — 51% to 100% • Low — 50% to 99% • Desat — 50% to 98%

Numeric Update	Every 3 seconds
Masimo Sensors	Operate at or near 660 nm and 905 nm; total radiated power from 500 nm to 1000 nm does not exceed 0.79 mW
No Implied License	Possession or purchase of this device does not convey any express or implied license to use the device with unauthorized sensors or cables that would alone, or in combination with this device, fall within the scope of the Masimo patent rights.

Nellcor OxiMax SpO_2 (Option N)

Measurement Method	Functional saturation (oxygen saturation of functional hemoglobins)
Measurement Range	
O_2 Saturation	1% to 100%
Pulse Rate	25 to 300 bpm
Nellcor OxiMax Measurement Accuracy (A_{rms})	These sensors have been clinically validated by Nellcor.

Nellcor Sensor Models	Saturation Accuracy 70% to 100%
OxiMax Sensors, Single Patient Use	
MAX-A* MAX-AL*	±2%
MAX-N* † (Adult)	±2%
MAX-N* † (Neonate)	±3%
MAX-P*	±2%
MAX-I*	±2%
MAX-FAST	±2%
MAX-R**	±3.5%
OxiCliq Sensors, Single Patient Use	
OxiCliq A	±2.5%
OxiCliq P	±2.5%
OxiCliq N † (Adult)	±2.5%
OxiCliq N † (Neonate)	±3.5%
OxiCliq I	±2.5%
Reusable Sensors	
D-YS (Infant to Adult)	±3%
D-YS (Neonate)	±4%
D-YS and D-YSE	±3.5%
DS-100A	±3%
OXI-AN (Adult)	±3%
OXI-A/N (Neonate)	±4%
OXI-P/I	±3%

* *The accuracy specification under motion conditions is ±3%.*
** *The accuracy specification has been determined between saturations of 80% and 100%.*
† *The MAX-N and the OxiCliq N were tested on patients >40 kg.*

Neonatal Accuracy	When sensors are used on neonatal subjects as recommended, the specified accuracy range is increased by ±1 digit as compared to adult usage, to account for the theoretical effect on oximeter measurements of fetal hemoglobin in neonatal blood. For example, MAX-N accuracy on neonates is ±3 digits, rather than ±2 digits.
Saturation Resolution	1%
Pulse Rate Resolution	1 bpm
Saturation Alarm Limits	• High — 51% to 100% • Low — 50% to 99% • SatSeconds — OFF, 10, 25, 50, 100
Numeric Update	Every 3 seconds
Nellcor Sensors	Operate at or near 660 nm and 880 nm; total radiated optical power from 500 to 1,000 nm does not exceed 15 mW

Temperature

Probe Type	YSI 400 or YSI 700; automatically identifies series number and processes both
Sample Rate	14 sps
Measurement Range	0° to 50° C; displays “--.-” for temperatures <0° C and “++.+” for temperatures >50° C
Display Parameters	TEMP (single probe attached); T1, T2, and delta temperature (DT) (two probes attached)
Accuracy	±0.2° C (0° to 25° C); ±0.1° C (25° to 41° C); ±0.2° C (41° to 50° C)
Resolution	0.1° C
Numeric Update Rate	Every 3 seconds
Alarms	High and low for all displayed temperature values
Alarm Limits	• High — 0.1° to 50° C • Low — 0° to 49.9° C

Cardiac Output (CO)

Calculation Method	Thermodilution technique
Sample Rate	112 sps
Measurement Units	CO in L/min, Temperature in degrees Celsius
CO Measurement Range and Accuracy	0.1 to 18 L/min ±10%
Resolution of CO Numeric	0.1 L/min
Temperature Measurement	Monitored via thermistor, injectate 0° to 28° C, blood 17.2° to 43° C

Temperature Measurement Accuracy	±0.2° C

Calculated Values

Body Surface Area (BSA), Cardiac Index (CI), Stroke Volume (SV), Stroke Volume Index (SVI), Systemic Vascular Resistance (SVR), Pulmonary Vascular Resistance (PVR), Left Ventricular Stroke Work (LVSW), Right Ventricular Stroke Work (RVSW), Systemic Vascular Resistance Index (SVRI), Pulmonary Vascular Resistance Index (PVRI), Left Ventricular Stroke Work Index (LVSWI), and Right Ventricular Stroke Work Index (RVSWI)

Entered Values and Ranges	
Patient Height	20 to 215 cm (8 to 84 in)
Patient Weight	1 to 250 kg (2 to 551 lb)
Heart Rate	0 to 300 bpm
Mean Arterial Pressure	0 to 300 mmHg (0 to 40 kPa)
Central Venous Pressure	0 to 99 mmHg (0 to 13.2 kPa)
Mean Pulmonary Artery Pressure	0 to 99 mmHg (0 to 13.2 kPa)
Pulmonary Wedge Pressure	0 to 99 mmHg (0 to 13.2 kPa)

High Level Outputs

Quantity	2 Ports
User Configurable	• ECG1 and ECG2 • ECG1 and RESP • ECG1 and PRES1 • PRES1 and PRES2

Note:
High level outputs on the 91496-L module only support PRES1 and PRES2.

Volatile Memory

Data is preserved for 10 minutes. Module ceases data collection when power is removed.

Classification

MDD	Class IIb
EN 60601-1	Type CF defibrillator proof Rated for continuous operation

Environmental Requirements

Operating	
Temperature	0° to 50° C (32° to 122° F)
Humidity	95% (noncondensing) up to 30° C (86° F), 10% to 75% up to 40° C (104° F), 10% to 45% up to 50° C (122° F)

Altitude	0 to 3,000 meters (0 to 9,843 feet)
Transport and Storage	
Temperature	-40° to 75° C (-40° to 167° F)
Humidity	95% (noncondensing) up to 50° C (122° F), 10% to 50% up to 75° C (167° F)
Altitude	0 to 12,192 meters (0 to 40,000 feet)

Accessories

Refer to the *Spacelabs Healthcare Supplies and Accessories Catalog* for availability of ECG cables, lead wires, and electrodes, pressure transducers, temperature probes, cardiac output cables, delivery system, injectate temperature probes, injectate housings, blood pressure cuffs, and SpO_2 sensors.

Documentation

CD-ROM Part Numbers	*Bedside, Central, and Telemetry Operations Documents CD-ROM* (P/N 084-1101-xx) *Spacelabs Healthcare Service Documents CD-ROM* (P/N 084-0700-xx)
Supplies and Accessories	*Spacelabs Healthcare Supplies and Accessories Catalog* (sa.spacelabshealthcare.com)

Regulatory Approvals

C SA US	CSA certified. Meets CSA C22.2 No. 60601-1 and ANSI/AAMI ES60601-1. IEC 60601-1: basic safety; IEC 60601-2-25: ECG; IEC 60601-2-27: ECG; ISO 80601-2-30: NIBP; IEC 60601-2-34: IBP; IEC 60601-2-49: multiparameter monitors; ISO 80601-2-56: clinical thermometers; ISO 80601-2-61: SpO_2.
CE 0123	CE marked in accordance with the Medical Device Directive 93/42/EEC. EN 1060-3: NIBP; IEC 60601-1: electrical safety; EN 60601-1-2: EMC; IEC 60601-2-25: ECG; IEC 60601-2-27: ECG; ISO 80601-2-30: NIBP; IEC 60601-2-34: IBP; IEC 60601-2-49: multifunction monitors; ISO 80601-2-56: clinical thermometers; ISO 80601-2-61: SpO_2.
RoHS2 2011/65/EU	Does not contain hazardous substances — Europe
	Does not contain hazardous substances — China

Please refer to http://www.spacelabshealthcare.com/en/company/trademarks for a full listing of Spacelabs Healthcare trademarks. Other brands and product names used herein are trademarks of their respective owners.

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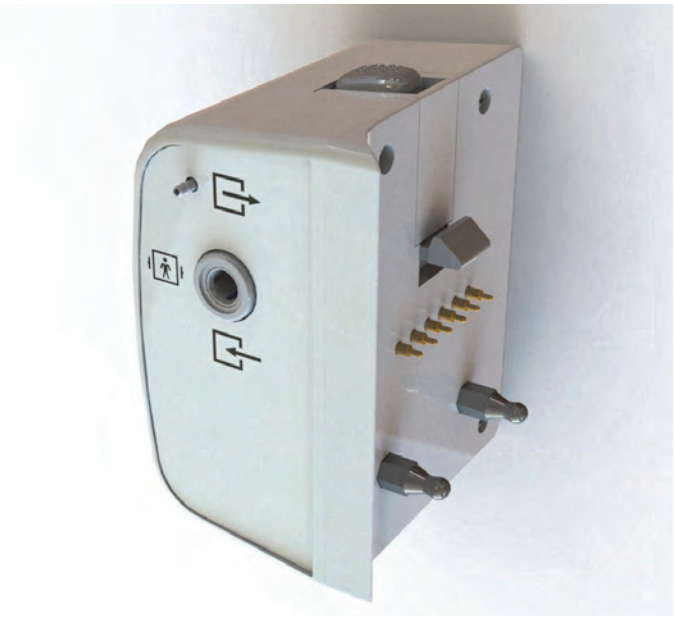

Capnography Pod

Pod attached to the qube monitor

Summary

The Capnography Pod is a sidestream gas analyzer designed to measure the concentration of carbon dioxide in a gas mixture and to aid in determining the patient's ventilatory, circulatory, and metabolic status. Its small, compact form makes it ideal for use with the qube® monitor (see photo) and qube® mini monitor.

The Capnography Pod includes a small, lightweight sensor that continuously measures the end-tidal and minimum carbon dioxide (CO_2) levels in the patient's airway. The sensor is connected to the airway by a disposable or reusable Nomoline sample line. A constant-flow vacuum system maintains the flow rate through the sample line.

Features

Measurement of Respiration Rate and Carbon Dioxide	Continuously measures end-tidal CO_2, minimum CO_2, and respiration rate
Suspend Mode	Disables gas sampling while maintaining power to the sensor to minimize warm-up time between cases
Pressure Compensation	Automatically compensates for ambient barometric pressure assuring measurement accuracy

Product Specifications

Physical Dimensions	
Height	9.7 cm (3.8 in)
Width	7.5 cm (3 in)
Depth	5.8 cm (2.3 in)
Weight	0.3 kg (0.6 lb)

Carbon Dioxide	Sidestream — FiO_2 and $ETCO_2$ are displayed after one breath and have a continuously updated breath average. ET will typically decrease below nominal value (ETnom) when respiration rate (RR) exceeds the RR threshold (RRth) according to the following formula: CO_2: ET=ETnom × 125⁄RR for RRth > 125 Measured at I/E ratio 1:1 using breath simulator according to EN ISO 80601-2-55 fig. 201.101
Range	0 to 120 mmHg (0 to16 kPa), 15%
Resolution	1 mmHg (0.1 kPa), 0.1%
Measurement Rise Time	<250 msec typically
Accuracy	±(0.2 vol% + 2% reading)
Values	Inspired/expired
Gas Cross Effects	<0.2% (O_2, N_2O, anesthetic agents)
Respiratory Rate	Measurement based on CO_2 waveform; breath detection is based on a 1% change in CO_2 level Measured at I/E ratio 1:1 using breath simulator according to EN ISO 80601-2-55 fig. 201.101
Range	1 to 150 BPM
Accuracy	±1 BPM
Apnea	
Range	20 to 45 seconds
Resolution	5 seconds
Accuracy	±1 second
Warm Up	<10 seconds for concentration reporting and full accuracy specification
Sample Line Flow Rates	50 ml/min ±10 ml/min
Total System Response Time	Sidestream: <3 seconds
CO_2 Waveform Scales	Selectable at 0 to 120 mmHg, 0 to 100 mmHg, 0 to 80 mmHg, 0 to 60 mmHg, 0 to 40 mmHg, 0 to 15 kPa, 0 to 12.5 kPa, 0 to 10 kPa, 0 to 7.5 kPa, 0 to 5 kPa, 0 to 15%, 0 to 12.5%, 0 to 10%, 0 to 7.5%, 0 to 5%
Waveform Speeds	Selectable at 25, 12.5, 6.25, 3.12, or 1.56 mm/second
Measurement Units	%, mmHg, kPa for CO_2; BPM for respiration rate
Alarms	User-selectable; respiration rate (high and low limits), $EtCO_2$ (high and low limits), $MINCO_2$ (high limits), and apnea
Gas Calibration	Calibration from external gas mixture
Occlusion	Automatically detects and attempts to clear sample line occlusions
Suspend Sampling	In suspend mode, sensors continue to operate but pumps stop and waveform and numeric zones are cleared, allowing sensors to remain warmed up.

Monitor Compatibility	qube 91390 qube mini 91389

Classification

MDD	Class IIb
EN 60601-1	Class I — Type BF defibrillator proof Device is not affected by patient defibrillation
CISPR11	Group 1, Class B Suitable for use in domestic establishments connected to a low-voltage supply network

Electrical Specifications

Power supplied by monitor.

Environmental Requirements

Operating	
Temperature	0° to 50° C (32° to 122° F)
Ambient Humidity	95% (non-condensing)
Atmospheric Pressure	394 to 900 mmHg (52.5 to 120 kPa)
Storage	
Temperature	-40° to 70° C (-40° to 158° F)
Ambient Humidity	95% (non-condensing)
Altitude	0 to 12,192 meters (0 to 40,000 feet)

Accessories

Refer to the *Spacelabs Healthcare Supplies and Accessories Catalog* for availability of the specially designed Nomoline sample lines and accessories.

Nomoline Sampling Adapter (single patient use)	P/N 015-0683-00
Nomoline Sampling Adapter (reusable)	P/N 103-0234-00
Nomoline Line Extension (single patient use)	P/N 166-7085-00

Documentation

CD-ROM Part Numbers	*Bedside, Central, and Telemetry Systems Operations Documents CD-ROM* (P/N 084-1101-xx) *Spacelabs Healthcare Service Documents CD-ROM* (P/N 084-0700-xx)
Supplies and Accessories	*Spacelabs Healthcare Supplies and Accessories Catalog* (sa.spacelabshealthcare.com)

Regulatory Approvals

C US

CSA certified. Meets IEC 60601-1, CAN/CSA C22.2 No. 60601-1, and ANSI/AAMI ES60601-1 for electrical safety, and ISO 80601-2-55 for respiratory gas monitors.

CE 0123

CE marked in accordance with the Medical Device Directive 93/42/EEC.

RoHS2 2011/65/EU

Does not contain hazardous substances - Europe

Does not contain hazardous substances - China

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The Spacelabs Healthcare 96281 AriaTele™ Telemetry Transmitter provides a range of choices for ambulatory patient monitoring, from basic ECG to multiparameter with a liquid crystal display (LCD). The color display allows a clinician to assess ECG and/or SpO_2 signal quality while at the patient's side.

The design is sleek and smooth for patient comfort, as well as water-resistant and durable.

Note:

Not all products are available in all locales. Check with your local Spacelabs Healthcare representative.

Features

	96281-A ECG without Display	96281-B ECG with Display	96281-C ECG and SpO_2 with Display
			
Leads transmitted	II and V (narrowband) / 7 from 4 vectors (wideband)		7 from 4 vectors
Leads shown on display	N/A	I, II, III, and V	
Electrode configuration	individually replaceable DIN standard safety lead wires		
Lead fault indicator	yellow LED flashes for lead fault		
Pacemaker pulse display capability	detects pacemaker pulses of ±0.5 mV with pulse widths of 0.2 to 2 ms and ±1.0 mV at 0.1 ms pulse widths		
Pacemaker rejection	pulse period of width 0.1 msec, amplitude up to 700 mV (2 mV, 10 mV, 300 mV, and 700 mV tested), with an overshoot of less than or equal to 4 msec		
Remote record button	yes		
Dimensions (H × W × D)	132 × 75 × 22 mm (5.20 × 2.95 × 0.98 inches)	132 × 75 × 22 mm (5.20 × 2.95 × 0.98 inches)	132 × 75 × 22 mm (5.20 × 2.95 × 0.98 inches)
Weight	<200 g (7.055 oz.) without grouper, batteries, leads	<200 g (7.055 oz.) without grouper, batteries, leads	<200 g (7.055 oz.) without grouper, batteries, leads, SpO_2 cable
Display size (H × W)	N/A	35 × 47 mm	
Display type	N/A	color LCD	

	96281-A ECG without Display	96281-B ECG with Display	96281-C ECG and SpO_2 with Display
ECG display	N/A	heart rate, ECG waveform, lead indicator, pacemaker flag	
SpO_2 display	N/A	N/A	O_2 saturation, signal quality, pulse rate, pulse waveform
Water resistance	meets EN 60529 IPX7 (temporary immersion of 30 minutes at a depth of 1 meter)		
Output power	608 MHz (-05 model): <7 mW EIRP		
	1400 MHz (-09 model): <7 mW EIRP		
	433 MHz (-32 model): <1 mW ERP		
	442 MHz (-48 model): <1 mW ERP		N/A
System ECG Signal Range	±4 mV		
DC offset	up to ±300 mV		
Noise	≤50 µV peak-valley		
CMRR	>95 dB		
QRS detection	detects QRS complexes with durations of 40 to 120 ms and amplitudes of 0.5 to 5 mV		
Defibrillator protection	meets IEC 60601-2-27		
System Resolution	4 µV per LSB referred to input		
Input impedance	>10 MΩ differential at 10 Hz		
Gain accuracy	±5%		
Accuracy of signal reproduction	meets IEC 60601-2-27		
Signal bandwidth	0.05 to 40 Hz		
SpO_2 measurement accuracy	N/A		±2% (at 70 to 100%, Pediatric or Adult) ±3.25% (at 70 to 100%, Neonate)
Battery types	two AA/LR6 alkaline or two NiMH batteries		
Battery Life, typical alkaline batteries (hours)	>72		>72 for ECG; >24 for ECG and continuous SpO_2
Battery status indicators	yellow battery indicator LED flashes when the battery level is low		
RF signal shutdown	1.9 VDC ±0.1		
Radio Compliance FCC	608MHz (-05 model): 47CFR Part 95 FCCID: CM6-670-1187-608 1400MHz (-09 model): 47CFR Part 95 FCCID: CM6-670-1187-1400		
Radio Compliance IC	608MHz (-05 model): RSS210-2010 ICID: TAC 2434A-6701187608 1400MHz (-09 model): RSS210-2010 ICID: TAC 2434A-6701632		

	96281-A ECG without Display	96281-B ECG with Display	96281-C ECG and SpO_2 with Display
Radio Compliance EU	433MHz (-32 model): EN300 220-2 V2.4.1:2012 442MHz (-48 model): EN300 220-2 V2.4.1:2012		
Radio Compliance Bluetooth	FCC ID: CM6-WT12 ICID: TAC 2434A-WT12 EU: EN300 328 V1.9.1		

Options

Option Groups	Option Identifier	Description of Option	Availability
Transmitter	-A	ECG	-A
	-B	ECG + display	-B
	-C	ECG + display + SpO_2	-C
Bands	32	G band (433.0625 to 434.7875 MHz)	-A, -B, -C
	48	H band (442 to 446 MHz) *Note:* *Only available in the Netherlands.*	-A48N, -B48N
	05	Q band (608 to 614 MHz)	-A, -B, -C
	09	T band (1395 to 1400 MHz) and V band (1427 to 1431.5 MHz)	-A, -B, -C
Channels	N	narrowband (25 kHz bandwidth)	-A, -B
	W	wideband (50 kHz bandwidth)	-A, -B, -C
Leadwires	I	5 leadwires IEC	-A, -B, -C
	J	5 leadwires AHA/AAMI	-A, -B, -C

Relationship to Other Systems

The 96281 telemetry transmitter is directly related only to Spacelabs Healthcare monitoring systems. Data collected by the transmitter may be interfaced from the monitoring system to a hospital clinical information system.

Compatibility

All options of the 96281 telemetry transmitter are compatible with the 96280 Xhibit Telemetry Receiver and related Xhibit™ Central Station. All options—except two—are compatible with the 90478 Digital Telemetry Modular Receivers* and related Ultraview SL™ bedside and central monitors. The two exceptions are Options 32 G (wideband) and 48 H band. These two options are only compatible with the 96280 Xhibit Telemetry Receiver and cannot be used with the 90478 telemetry receiver.

For information that relates to the 96280 Xhibit Telemetry System, refer to the *Xhibit Central Station 96102 (includes Xhibit Telemetry 96280) Operations CD-ROM* (P/N 084-2301-xx) and to the *Xhibit Central Station 96102 (includes Xhibit Telemetry 96280) Service CD-ROM* (P/N 084-1479-xx).

For information that relates to the 90478 receiver and digital telemetry systems, refer to the *Bedside, Central, and Telemetry Systems Operations Documents CD-ROM* (P/N 084-1101-xx) and to the *Spacelabs Healthcare Service CD-ROM* (P/N 084-0700-xx).

**National radio frequency allocations restrict distribution to all locales. Check with your local Spacelabs Healthcare representative.*

Classification

MDD	Class IIb
EN 60601-1	Type CF applied part, defibrillator proof Rated for continuous use

Environmental Requirements

Operating	
Temperature	0° to 50° C (32° to 122° F)
Humidity	95% (noncondensing)
Altitude	0 to 3,000 m (0 to 9,843 ft)
Storage	
Temperature	-40° to 75° C (-40° to 167° F)
Humidity	95% (noncondensing)
Altitude	-152.4 to 12,192 m (-500 to 40,000 ft)

Accessories

Refer to the Spacelabs Healthcare Supplies and Accessories Catalog for a complete list of available ECG lead wires and electrodes and SpO_2 sensors from Spacelabs Healthcare.

Transmitter Pouch	P/N 015-0500-02
DIN Standard Safety ECG Lead Wire Set (5 lead), 61 cm (24-inch) snap	P/N 012-0285-11 (AHA/AAMI) P/N 012-0328-00 (IEC)
DIN Standard Safety ECG Lead Wire Set (5 lead), 61 cm (24-inch) pinch	P/N 012-0286-01 (AHA/AAMI) P/N 012-0327-10 (IEC)
TruLink® finger sensor, adult, reusable	P/N 015-0660-00
TruLink foam sensor, adult, single-patient use	P/N 015-0662-00
TruLink vinyl sensor, adult, single-patient use	P/N 015-0663-00
Vinyl sensor, pediatric, single-patient use	P/N 015-0665-00
TruLink cloth sensor, neonate, single-patient use	P/N 015-0667-00
Nellcor OXIMAX DS-100A finger sensor, adult, reusable	P/N 690-0003-01
SpO_2 adapter cable	P/N 700-0014-00

Leadwire Grouper 5 WAY, AHA, labelled	P/N 706-0184-00
Leadwire Grouper 5 WAY, IEC, labelled	P/N 706-0185-00

Documentation

CD-ROM Part Numbers	*96281 AriaTele Operations Documents CD-ROM* (P/N 084-2201-xx) *96281 AriaTele System Service CD-ROM* (P/N 084-2202-xx) *Bedside, Central, and Telemetry Systems Operations Documents CD-ROM* (P/N 084-1101-xx) *Xhibit Central Station 96102 (includes Xhibit Telemetry 92680) Operations CD-ROM* (P/N 084-2301-xx) *Spacelabs Healthcare Service Documents CD-ROM* (P/N 084-0700-xx) *Xhibit Central Station 96102 (includes Xhibit Telemetry 96280) Service CD-ROM* (P/N 084-1479-xx)
Supplies and Accessories	*Spacelabs Healthcare Supplies and Accessories Catalog* (sa.spacelabshealthcare.com)

Regulatory Approvals

Medical telemetry spectrum allocations may be assigned to frequencies already allotted to other priority users. This means that telemetry operations may be exposed to radio frequency interference that may disrupt or impede telemetry patient monitoring. Additionally, medical telemetry spectrum allocations may be changed by government action. Spacelabs Healthcare accepts no responsibility for such changes, including the possibility that the product may not operate in the modified permissible spectrum ranges other than those expressly set forth in Spacelabs Healthcare's published product data sheets. Spacelabs Healthcare cannot and does not guarantee interference-free telemetry operation.

Operation of this equipment in the U.S. Wireless Medical Telemetry Service (WMTS) bands requires coordination and registration with the FCC designated frequency coordinator.

96281 Telemetry Transmitters operating in the Wireless Medical Telemetry Service (WMTS) band are approved by the FCC (47CFR Part 95) and Industry Canada (RSS-210).

C SA US

CSA certified. Meets IEC 60601-1, CSA C22.2 No. 60601.1, and ANSI/AAMI ES60601-1 for electrical safety.

CE 0123

The 96281-32 and 96281-48 medical telemetry transmitter is CE marked in accordance with Medical Device Directive 93/42/EEC.

CE 0981

The 96281-x32y is CE marked in accordance with the Radio and Telecommunications Terminal Equipment (RTTE) Directive 99/5/EC and operates in the European 433.05 to 434.79 MHz harmonized Short Range Device (SRD) band.

CE 0981 !

The 96281-x48N is CE marked in accordance with the Radio and Telecommunications Terminal Equipment (RTTE) Directive 99/5/EC and operates in the Dutch 442 and 446 MHz licensed telemetry channels.

Consult your local Spacelabs Healthcare sales representative for available frequency bands.

The Xhibit™ Telemetry Receiver (96280) provides wireless reception for the Spacelabs Healthcare patient-worn wireless telemetry transmitters. Capable of receiving and analyzing up to 16 patients, the telemetry receiver processes and communicates vital signs data for display on the central station.

Features

ECG analysis	
Arrhythmia	• Asystole • Ventricular fibrillation • High and low heart rate • Pacemaker detection • Ventricular tachycardia • Pause • PSVT • Couplet • Ventricular run • R on T PVC • Ventricular ectopic per minute • Atrial fibrillation
ST measurement	• Single ST change • ST index (user-configurable)
Status indicators shown at the Xhibit™ Central Station	• Low battery • SpO_2 signal strength • Technical alarms • Radio signal loss

Physical Dimensions

Height	17.8 cm (7 inches)
Depth	35.7 cm (14 inches)
Width	48.3 cm (19 inches)

Electrical specifications

Mains power	100 to 240 VAC, 50 to 60 Hz, 2 to 1 A • Requires Protective Earth (Ground) • Rated for continuous use • For uninterrupted monitoring, an Uninterruptable Power Supply (UPS) is recommended.
External indicators	Power ON lamp

Environmental Requirements

Operating	
Temperature	0 to 40 °C (32 to 104 °F)
Humidity	95% (noncondensing)
Altitude	0 to 3,000 m (0 to 9,843 feet)
Storage	
Temperature	-20 to 75 °C (-4 to 167 °F)
Humidity	95% (noncondensing)
Altitude	0 to 12,192 m (0 to 40,000 feet)

Options

G band	433 to 435 MHz
H band	442 to 448 MHz
Q band	608 to 614 MHz
T band	602 to 608 MHz (down-converted from 1395 to 1400 MHz by the antenna system)
V band	614 to 620 MHz (down-converted from 1427 to 1431.5 MHz by the antenna system)

Compatibility

The Xhibit™ Telemetry Receiver is compatible with the Xhibit™ Central Station. Not all products are available in all locales. Check with your local Spacelabs Healthcare representative.

Documentation

Xhibit Central Station Operations Documentation CD-ROM (P/N 084-2301-xx)

Xhibit Central Station Service Documents CD-ROM (P/N 084-1479-xx)

Spacelabs Healthcare Supplies and Accessories Catalog (www.spacelabshealthcare.com)

Regulatory Approvals

CSA certified. Meets IEC 60601-1, CSA C22.2 No. 60601-1, and ANSI/AAMI ES 60601-1 for electrical safety.

Software CE marked in accordance with the Medical Device Directive 93/42/EEC.

Does not contain hazardous substances — Europe

Does not contain hazardous substances — China

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The 96102 Xhibit® Central Station provides remote centralized monitoring and alarm management for up to 48 patients. Up to four high-resolution flat panel touchscreen displays allow network control and views of real time surveillance, trends, and patient demographics. The Xhibit Central Station is an integrated system with embedded Clinical Access to review enterprise retrospective data for monitored patients. It also provides access to hospital information sources through Dynamic Network Access™ (DNA™).

Features

Patient Capacity	Shows all parameters monitored for up to 48 patients. Each display can present data from one to 16 patients for maximum parameter viewing.
User Interface	Intuitive controls on the touchscreen interface provide simplified patient management. Keyboard and mouse can also be used.
Printing	Print strips and reports from the Central Station. Receive and print strips from bedside monitors and telemetry transmitters.
Retrospective Review	Embedded Clinical Access allows review of enterprise retrospective data for monitored patients (requires Intesys® Clinical Suite (ICS)). Available information may include: • Waveform review including retrospective ECG analysis • Vital signs trends customizable per patient—sorted, grouped, and prioritized • Alarm history • 12-Lead report review • Print jobs from patient monitors that can be captured, previewed, and printed from the Central Station.
Bedside View	See all monitored parameters from a bedside monitor or telemetry transmitter on a single display for optimum review. Freeze data for close inspection and print as needed.

Trends	Shows trend data directly from a bedside monitor or telemetry receiver in an easy-to-read format (replaced by Clinical Access if ICS is present). • Graphic — Data presentation shows in the same format as the bedside monitor. • Tabular — Time increments and periodic intervals show that match the bedside monitor.

Product Specifications

CPU	
Mains Power	100 to 240 VAC, 50 to 60 Hz, 5 A
Connection	• Six USB connections: mouse, keyboard, touchscreen display, and printer. Supports a hub for additional USB ports. • Four high resolution display port connections • Two ethernet ports
Display	
Power	100 to 240 VAC, 50 to 60 Hz; 2 A
Resolution	1680 x 1050 pixels
Viewing Angle	• Left/Right: 89°/89° • Up/Down: 89°/89°
Diagonal Size	56 cm (22 inches)
Touchscreen	Projected capacitive, edge-to-edge glass screen; USB connection
Connections	Display Port, USB
Internal Speakers	Two at 2 W each

Physical Dimensions (Typical)

CPU	
Height	32 cm (12.6 inches)
Depth	31 cm (12.2 inches)
Width	14 cm (5.5 inches)
Display with Stand	
Height	39.4 cm (15.5 inches)
Depth	19.3 cm (7.6 inches)
Width	52.3 cm (20.6 inches)

Weight	5.2 kg (11.5 lbs)
Display without Stand	
Height	34.3 cm (13.5 inches)
Depth	4 cm (1.6 inches)
Width	52.3 cm (20.6 inches)
Weight	4.2 kg (9.2 lbs)

Compatibility

The Xhibit® Central Station is compatible with Spacelabs Healthcare Ultraview SL®, qube®, qube® mini, and XPREZZON® bedside monitors, and the Xhibit® Telemetry Receiver. The Central Station is also compatible with Intesys® Clinical Suite (ICS), and selected Flexports. Not all products are available in all locales. Check with your local Spacelabs Healthcare representative.

Environmental Requirements

Operating — CPU	
Temperature	0° C to +40° C (32° F to 104° F)
Humidity	5% to ±95% relative (noncondensing)
Altitude	2,000 meters (6,562 feet)
Operating — Display	
Temperature	+5° C to +35° C (41° F to 95° F)
Humidity	20% to ±80% relative (noncondensing)
Altitude	3,000 meters (9,843 feet)
Storage — CPU	
Temperature	-40° C to +70° C (-40° F to 158° F)
Humidity	5% to ±95% relative (noncondensing)
Altitude	15,000 meters (49,213 feet)
Storage — Display	
Temperature	-20° C to +60° C (-4° F to 140° F)
Humidity	5% to ±95% relative (noncondensing)
Altitude	15,000 meters (49,213 feet)

Accessories

Touchscreen Display	P/N 011-0241-xx
Remote Display Assembly Kit	P/N 041-1226-xx
Printers	The printers are IEC/UL 60950 office equipment and not for use in the patient vicinity.
HP LaserJet M506, 110V	P/N 010-1971-01
HP LaserJet M506, 220V	P/N 010-1886-01
	A variety of GCX-brand mounting solutions are available from Spacelabs Healthcare or GCX directly.

Licensing

Patient Zone License (up to 48)	P/N 910-6102-01
DNA License	P/N 910-6102-03

Classifications

MDD EN 60601-1-6 EN 60601-1-8 EN 60950	Class IIb medical device, rule 10

Documentation

	Xhibit Central Station Operations Documentation CD-ROM (P/N 084-2301-xx) *Xhibit Central Station Service Documents CD-ROM* (P/N 084-1479-xx) *Spacelabs Healthcare Supplies and Accessories Catalog (http://sa.spacelabshealthcare.com)*

Regulatory Approvals

C SA US CE	CSA certified. Meets CSA 60950-1-07, second edition UL 60950-1, second edition Hardware Information Technology Equipment (ITE) is NRTL certified and CE marked in accordance with the EMC Directive. ITE is not suitable for use in the patient vicinity.
CE 0123	Software CE marked in accordance with the Medical Device Directive 93/42/EEC.
RoHS2 2011/65/EU	Does not contain hazardous substances — Europe
	Does not contain hazardous substances — China

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Summary

Intesys® Clinical Suite (ICS) is a system that consists of core services, database, data interface applications, and clinical interface applications. The products that follow are all components of ICS.

92810	Smart Disclosure
92842	Admit Discharge Transfer Interface
92843	Vital Signs Interface
92848	Enterprise Network Interface (ENI)
92876	Custom Trends
92877	12-Lead Electrocardiogram (ECG) Interface
92880	Vital Signs Viewer
92881	Print Manager

Technical Product Requirements

The technical specifications that follow apply to all ICS applications.

Server Requirements	Windows Server 2012 R2 (64 bit)
SQL Database	• SQL Server 2012 SP4 (64 bit) -or- • SQL Server 2014 SP2, with Cumulative Update 10 (64 bit)
Recommended Workstation Requirements	• Keyboard and mouse • 17-inch or larger display (recommended screen resolution is 1280 x 1024 pixels) *Note:* *Minimum resolution is 1024 x 768* • At a minimum, 10/100 Ethernet network interface card (NIC). For best performance, a 100-Mbps network or higher between workstation and server is recommended. • Windows 7 SP1 (32 bit or 64 bit) • Windows 10 (64 bit)
Compatibility	ICS is compatible with Spacelabs Healthcare Ultraview SL®, DM3, Xprezzon®, Qube® and Qube® Mini bedside monitors, as well as the Xhibit® Central Station, Xhibit® XC4, Xhibit Telemetry, and Ultraview SL telemetry products.
Security	ICS provides centralized user access management for all ICS applications. Each user provides a user name and password to log on to the Clinical Access application. A log is maintained of functions accessed for everyone using the system.

Licensing Requirements

Configurations vary depending on the needs of the institution. Contact your Spacelabs Healthcare representative for details.

Recommended Server Requirements

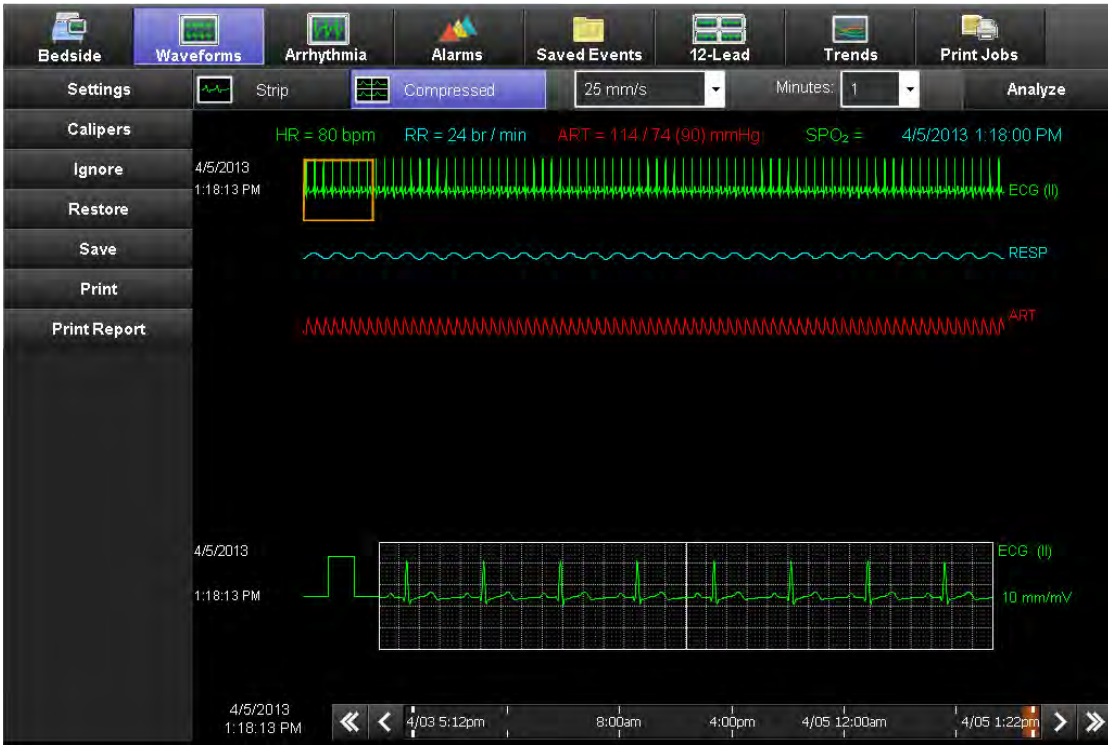
Server sizing depends on the complete set of ICS applications and the number of monitors from which data is collected.

Contact your Spacelabs Healthcare representative for version specifics.

Documentation

Intesys Clinical Suite (ICS) Manuals CD-ROM
(P/N 084-1530-xx)

Smart Disclosure (92810)



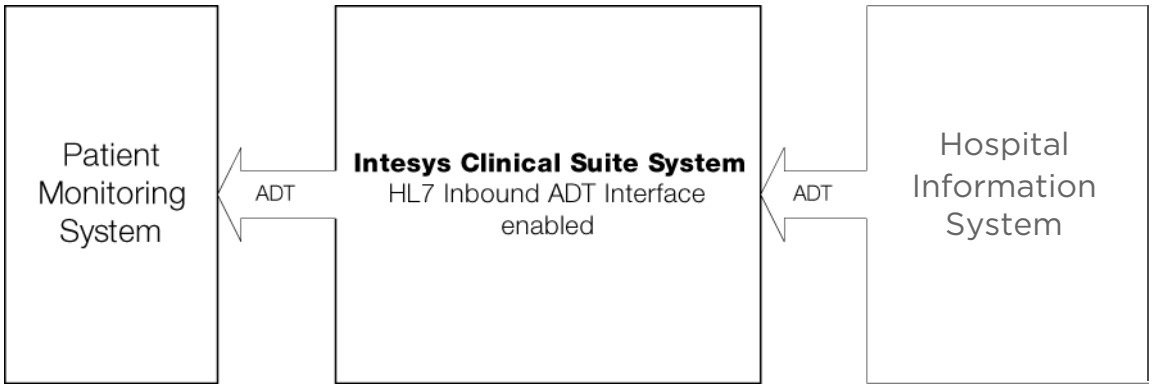
The Smart Disclosure product collects patient waveforms, alarms, vital signs, and 12-lead reports. A 24-hour waveform acquisition is standard, with an upgrade option to 72 hours. The product provides basic trends in both tabular and graphical format, along with a retrospective ECG analysis. The analysis may be defined by patient, and the data may be presented in multiple formats, including a rhythm, a histogram, and a summary view. Standard reports are available from Smart Disclosure, including saved events, disclosure, trends, histogram, and summary. Smart Disclosure is an integrated component of the Intesys® Clinical Suite (ICS).

Capabilities

Patient Census	The patient list provides access to all monitored patients. A menu allows the user to easily view all departments in a hospital collecting patient data and reports.
Alarms	Review all patient bedside alarms by type, parameter, or priority in two different views: thumbnail or strip view.
Trends	Review patient vital signs, including flexports and peripheral devices, in tabular or graphical format. Vital signs may be logically organized into groups. Groups may be individually expanded or collapsed.
Analysis	Smart Disclosure provides retrospective analysis of acquired ECG waveforms and identifies ventricular rhythms based on an initial dominant rhythm.
Arrhythmia Review	Use a summary, histogram, or thumbnail view to review events. Calipers measure ECG events. Waveforms from other patient parameters are also recorded.
Data Acquisition	Standard 24-hour recording (72-hour option) captures alarm events, waveforms, and 12-lead reports from monitors.
Architecture	Client/Server. Using Smart Disclosure, data from all hospital beds is collected on a single enterprise server and accessed from any network personal computer.

Reports	All Smart Disclosure data and graphs may be printed or saved in PDF format to any location on the network. Reports are user-configurable as to data intervals, time ranges, and inclusion of graphs. • Waveform report • Saved event report • 12-lead report • Histogram report • Summary report • Tabular trend report

Admit Discharge Transfer Interface (92842)



The Admit Discharge Transfer (ADT) interface facilitates the process of loading patient identity and demographic information into the Intesys® Clinical Suite (ICS). The interface functions by receiving Health Level Seven (HL7) messages from the Hospital Information System (HIS). This information is made available to applications in the suite and is used to update Spacelabs Healthcare patient monitors. ADT is an integrated component of the Intesys Clinical Suite (ICS).

Capabilities

Automation	ADT facilitates the entry of patient information into ICS applications and patient monitors.
Message Filtering Standard Configuration	No filtering is provided; all supported messages are processed. Filtering may be performed prior to message delivery by the HL7 Interface Adapter (P/N 999-1900-00) by request.
Message Standard	HL7 version 2.3.1
Messages Supported	A01, A02, A03, A04, A05, A06, A07, A08, A31.
Monitor Update	ADT messages update patient information in Spacelabs Healthcare monitors when the patient ID in the monitor matches the patient identification number in the message.
System Administration	System administration is performed through the ICS Administration Tool, and an HL7 message log.

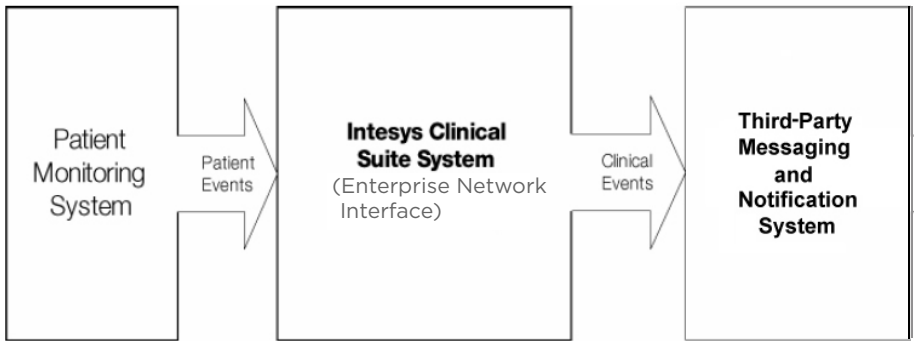
Vital Signs Interface (92843)

The Vital Signs Interface transfers vital signs data from Spacelabs Healthcare monitors and attached peripheral devices to a hospital clinical information system (CIS). The interface provides solicited and unsolicited Health Level Seven (HL7) result messages to the destination system at a rate that is configurable by clinical unit. The Vital Signs Interface is an integrated component of the Intesys® Clinical Suite (ICS).

Capabilities

Vital Signs Interface	The interface sends solicited and unsolicited vital signs collected from patient monitors and telemetry devices to the CIS. Solicited HL7 messages result from queries sent by the CIS to the ICS.
Enterprise Solution	ICS HL7 aggregates all vital signs into a single interface to the CIS.
Data Frequency	Data frequency is configurable from 30- to 36000-second intervals.
Message Standard	HL7 version 2.3.1
Messages Supported	ORU R01, QRY R02, ORF R04
Peripheral Devices	The product supports Flexport® system interface data from devices such as ventilators and infusion pumps.
System Administration	System administration is performed through the ICS Administration Tool, and an HL7 message log.

Enterprise Network Interface (ENI) (92848)



The ENI product provides historical information regarding past patient alarm events. The information is not provided in real time and is not intended as a basis for diagnosis, clinical decisions, or active patient monitoring. ENI is intended to transfer data to other vendors' information systems using an industry standard data exchange protocol, such as XML or HL7. ENI is intended for use only when the patient is otherwise actively monitored.

Capabilities

Messaging Standard	The ENI messaging standard is an XML format.
Network Connection	The ENI communicates using TCP/IP protocol.
System Administration	ENI system administration is performed through the ICS Administration Tool, and various configuration files.

Messages

Alarm Information	The historical alarm information may be configured as text-only messages or text with waveform images.
Message Content	The ENI messages includes the Bed Name, Patient Name, Event Data, Event Time, Waveform Images, Patient ID(s), Node ID, Unit Name, Message ID, Sequence Number, Type, and Priority.

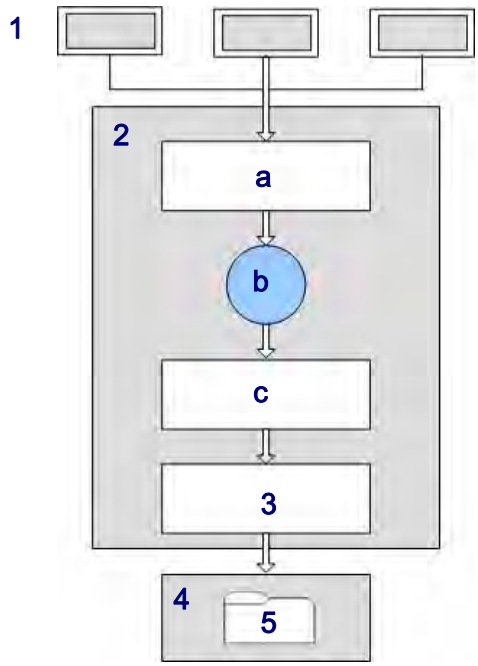
Custom Trends (92876)

Custom Trends enables you to save custom views for vital signs data from Spacelabs Healthcare monitors and attached peripheral devices. Data may be viewed in user-configurable flowsheets or graphs. Comments and notes may be added to trends to document specific items. Reports may be printed or saved in PDF format. Custom Trends is an integrated component of the Intesys® Clinical Suite (ICS).

Capabilities

Trends Review	The trends flowsheet is an automated collection of numeric vital signs from Spacelabs Healthcare monitors. Graphical trends are optional and may or may not be displayed, depending on user preference.
Views	Create custom views for departments or individual clinicians. Save and reuse default flowsheet formats or specific flowsheet protocols.
Reports	All flowsheet data and graphs may be printed or saved in PDF format. Reports are user-configurable as to data intervals, time ranges, and inclusion of graphs.
Comments	Add comments. Changes are tracked via audit logs.
User Interface	Create and modify trend templates in ICS Administration Tool. Numerous flowsheets may be created for care areas, patient types, or user preferences.
Flowsheet Groups	Vital signs may be logically organized into groups. Groups may be individually expanded or collapsed.
Data Collection Interval	Intervals are configured, per department, from once per minute to once per day. Collection rates may be changed at any time via the ICS Administration Tool. Default automatic collection rates may be set by clinical units. System default collection rate upon installation is one minute.
Peripheral Devices	The product supports Flexport® system interface data from devices such as ventilators and infusion pumps.

12-Lead ECG Interface (92877)



1 Bedside monitors
2 ICS system
   a *Monitor Loader*
   b *ICS database*
   c *12-Lead ECG report interface*
3 12-Lead Format Translator
4 Third-party ECG management system
5 Destination folder

The 12-Lead Electrocardiogram (ECG) Interface is a product in the Intesys® Clinical Suite (ICS). This interface enables Spacelabs Healthcare patient monitors, with 12-Lead capability, to send 12-Lead reports to an ECG management system.

A 12-Lead ECG Format Translator is available for ECG management systems not capable of reading the Spacelabs Healthcare 12-Lead ECG report format. The 12-Lead Interface and Format Translator run as background applications, with no user interface.

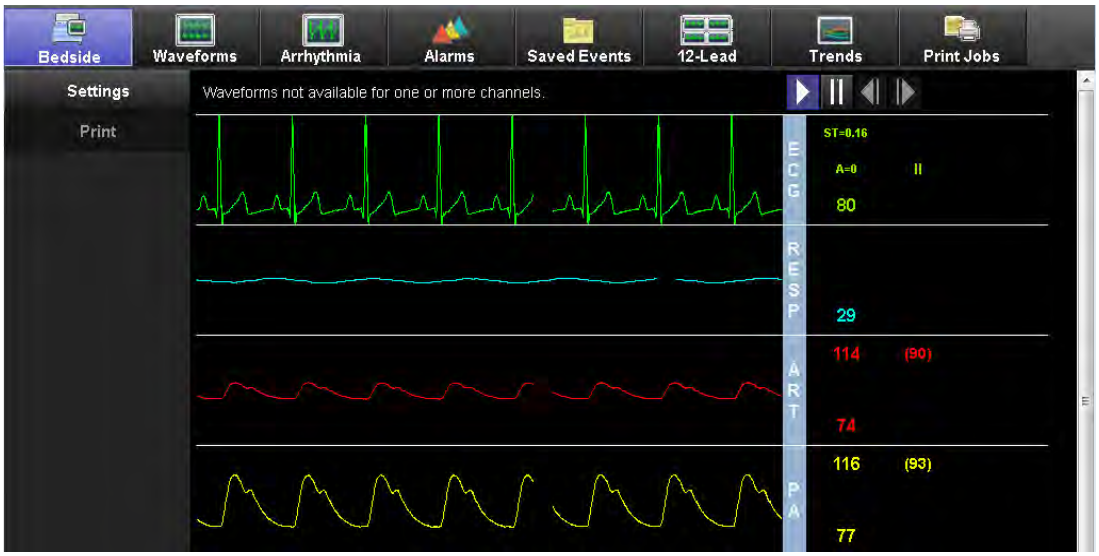
Capabilities

Architecture	The 12-Lead ECG Interface functions as a Windows service on an ICS server. All 12-Lead reports are stored in the ICS Database for use of applications or interfaces.
Data Acquisition	The 12-Lead ECG Interface captures monitor-initiated 12-Lead ECG reports and places them in a network shared directory for access by an ECG management system.
Data Translation	The format translator translates captured ECG reports from Spaclabs Healthcare format to formats of other ECG management systems.
Export Frequency	The export frequency for the 12-Lead ECG Interface is user-configurable. The default setting is every 60 seconds.
Monitor Setup	The monitor may be configured to send all 12-Lead ECG reports, or to send only user-selected 12-Lead ECG reports.
Monitor Configuration	Monitors must be equipped with an ECG parameter module capable of producing 12-Lead ECG reports.

12-Lead ECG Format Translator

ECG Management System Compatibility	The 12-Lead ECG Format Translator is required to interface to most ECG management systems, such as GE Muse, Epiphany, or Philips Tracemaster. Spacelabs Healthcare uses the DataMedFT solution to translate to external systems. We recommend that you check the ECG management system compatibility list shown in the *12-Lead ECG Format Translator System Administration Manual* (P/N 070-1302-xx). *Note:* *The ECG management system compatibility list is based on information provided by DataMed Solutions.*
Server Specification	The 12-Lead ECG Format Translator may be installed on an ICS server. Network access to the hospital Local Access Network (LAN) is required. Network access to an ECG management system is required. No additional hardware is required. Contact your Spacelabs Healthcare representative for version specifics.

Vital Signs Viewer (92880)



Vital Signs Viewer enables you to remotely view near real-time waveforms generated by Spacelabs Healthcare monitors. This application also allows you to view up to six waveforms with associated numerics. They may be paused, scrolled backwards up to 30 seconds, and printed. Vital Signs Viewer is an integrated component of the Intesys® Clinical Suite (ICS).

Capabilities

Display	Up to six waveforms may be selected by the user.
Print	Paused screen waveforms may be printed to the default printer.
Sweep Speed Control	Sweep speeds are adjusted independently for each parameter.
User Interface	Clinical Access hosts the application, displaying patient waveforms and associated numerics; the application is controlled by a mouse or other pointing device.
Waveform Color	Color is selected independently for each parameter. The same color is used by all components of Clinical Access. These defaults are established in ICS Administration.
Waveform Control Keys	Keys operate like those found on cassette tape or compact disk players
Play	Restarts the waveforms after being paused
Pause	Stops the movement of the waveforms for review
Rewind	Rapidly scrolls the waveforms back 30 seconds in time
Fast Forward	Rapidly scrolls the waveforms forward in time up to the present *Note:* *This product is not intended for use as a diagnostic tool.*

Print Manager (92881)

Print Manager enables you to print waveforms and associated annotation values and reports from a monitor to a network printer, instead of using the strip chart printer. Print Manager also retains the print jobs so that you can reprint them at a later time. Print Manager is an integrated component of the Intesys® Clinical Suite (ICS).

Capabilities

Centralized Management	All printer assignments are performed in ICS Administration
Configuration	Standard Windows print spooler
Chart Speeds	12.5, 25, or 50 mm/sec; dependent on the waveform sweep speed shown on the monitor. With Xhibit ™ Telemetry, a sweep speed of only 25 mm/sec is used for printed alarms.
Paper	Letter or A4-size plain paper
Printer	Standard Windows network printer. Print Manager is not compatible with parallel port printers.
Print Log	Maintains a log of all print jobs for later review and reprinting from Clinical Access
Print Request Output	Requested waveforms with patient name or ID, parameter ID and values, alarm message and limits (when in alarm), time, and date; arrhythmia class printout; ST printout; non-waveform graphics
Resolution	Dependent on the printer
System Recordings	All recordings are initiated from Spacelabs Healthcare Ultraview SL®, DM3, Xprezzon® and Qube® or Qube® Mini bedside monitors, as well as the Xhibit® Central Station, Xhibit® XC4, Xhibit® Telemetry, and Ultraview SL telemetry products.
Unit Assignment	Supports both a default and an alarm printer for each unit

Regulatory Approvals

Smart Disclosure (92810)	CE 0123 CE marked in accordance with the Medical Device Directive, 93/42/EEC
Enterprise Network Interface (92848)	CE CE marked in accordance with the Medical Device Directive, 93/42/EEC.
Print Manager (92881)	CE CE marked in accordance with the Medical Device Directive, 93/42/EEC.

A GLOBAL LEADER IN PATIENT MONITORING, ANESTHESIA AND ULTRASOUND SYSTEMS

PROPOSAL FOR:

MANGUM REGIONAL MEDICAL CENTER

PREPARED BY:
Larry Cornelius
Jul 20, 2020

Proposal Summary

Proposal Date:	Jul 20, 2020	Mindray DS USA, Inc.
Proposal Number:	Q-55812	800 MacArthur Blvd.
Proposal Exp. Date:	Sep 27, 2020	Mahwah, NJ 07430
Sales Rep:	Larry Cornelius	Tel: 201-995-8000
Proposal For:	MANGUM REGIONAL MEDICAL CENTER	Fax: 800.266.9624

Contact:	Jared Palmer
Title:	
Phone:	(405) 620-3053
Email:	jarod@cohesiveheatlhcare.net

Total Price By Department

IT infrastructure

Department Name	List Price	Departmental Discount	Net Price
IT Infrastructure	USD 98,020.02	USD -37,179.02	USD 60,841.00
		IT infrastructure TOTAL:	USD 60,841.00

ED

Department Name	List Price	Departmental Discount	Net Price
ED	USD 76,526.00	USD -22,958.00	USD 53,568.00
		ED TOTAL:	USD 53,568.00

MedSurg Tele

Department Name	List Price	Departmental Discount	Net Price
MedSurg Tele	USD 133,677.00	USD -40,104.00	USD 93,573.00
		MedSurg Tele TOTAL:	USD 93,573.00

EMR Connectivity

Department Name	List Price	Departmental Discount	Net Price
EMR Connectivity	USD 21,452.00	USD 0.00	USD 21,452.00
		EMR Connectivity TOTAL:	USD 21,452.00

TOTAL: USD 229,434.00

To: Jared Palmer
MANGUM REGIONAL
MEDICAL CENTER
HIGHWAY 60 NE P.O. BOX 720
SEILING, OK 73663

Affiliation: REG

Sales Representative: Larry Cornelius
Quote Number: Q-55812

Proposal Date: Jul 20, 2020

Phone: +1 4052295060
E-mail: l.cornelius@mindray.com

IT infrastructure

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
1	NTI	NTI	USD 0.00	USD -26,075.02	1	USD -26,075.02
2	115-051209-00	BeneVision DMS host package (2U Rack)	USD 6,000.00	USD 3,300.00	1	USD 3,300.00
3	121-001373-00	BeneVision CS Bed License (FD, Bed, Adv) - Per Channel	USD 400.00	USD 220.00	16	USD 3,520.00
4	121-001372-00	BeneVision CS Server License	USD 9,700.00	USD 5,885.00	1	USD 5,885.00
5	5000-CS-ABMT-01	Cable pull and tenting procedures	USD 11,330.00	USD 9,621.00	1	USD 9,621.00
6	045-003660-02	BeneVision DMS R4 Software Media Kit, Version: 04.04	USD 0.01	USD 0.01	1	USD 0.01
7	803-070875-00	Project Management Service Tier 3 provides project management for High complexity projects	USD 1,000.00	USD 1,000.00	12	USD 12,000.00
8	121-001405-01	BeneVision R4 CMS Viewer license	USD 18,000.00	USD 18,000.00	1	USD 18,000.00
9	803-070485-00	Professional Services	USD 284.00	USD 284.00	2	USD 568.00
10	803-070282-00	BeneVision DMS PDF Printing capability	USD 0.01	USD 0.01	1	USD 0.01
11	803-070485-00	Professional Services	USD 284.00	USD 284.00	2	USD 568.00
12	803-070492-00	Hospital Network Integration Services includes design and implementation required for interoperability solutions	USD 4,532.00	USD 4,532.00	1	USD 4,532.00
13	803-040080-00	WMTS/HW System Design & Implementation per 5 Servers.	USD 19,500.00	USD 19,500.00	1	USD 19,500.00
14	803-040081-00	WMTS controller redundancy providing full redundancy at the controller level for a WMTS system. Does not include any additional APs.	USD 9,422.00	USD 9,422.00	1	USD 9,422.00
				IT infrastructure TOTAL:		USD 60,841.00

ED

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
15	NTI	NTI	USD 0.00	USD -22,958.00	1	USD -22,958.00
16	115-050935-00	BeneVision DMS Workstation, Mini PC	USD 3,000.00	USD 3,000.00	1	USD 3,000.00
17	0992-00-0002-04	OEM Uninterrupted power supply APCBR800	USD 186.00	USD 186.00	1	USD 186.00
18	803-040052-00	WorkStation/Tower Install & Setup w/o CABL includes programming, configuration and verification	USD 2,670.00	USD 2,670.00	1	USD 2,670.00
19	121-001453-00	BeneVision DMS Widescreen Touch Display	USD 2,975.00	USD 2,975.00	1	USD 2,975.00
20	121-001375-00	BeneVision WorkStation Server License	USD 3,400.00	USD 3,400.00	1	USD 3,400.00

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
21	110-004115-00	BeneVision WorkStation Bed Licenses. Supports 4-32 beds	USD 300.00	USD 300.00	16	USD 4,800.00
22	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	2	USD 1,522.00
23	023-001566-00	HP LaserJet Enterprise M608n Printer	USD 3,700.00	USD 3,700.00	1	USD 3,700.00
24	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	1	USD 761.00
25	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	2	USD 1,522.00
26	803-070877-00	N1 Install & Setup includes programming, configuration and verification	USD 180.00	USD 180.00	2	USD 360.00
27	121-001522-00	N12 Monitor with Early Warning Score and 2.4/5GHz wireless N12 Monitor-includes 5 year warranty, battery, 4 module slots, quick reference guide, line cord and 1 roll of paper	USD 9,605.00	USD 9,605.00	2	USD 19,210.00
28	045-003255-00	N12 rolling stand with quick release mount	USD 445.00	USD 445.00	2	USD 890.00
29	121-001528-00	N1 Monitor with Nellcor® OxiMax® SpO2, ST/ Arrhythmia analysis, , CO2, 3/5/12-lead NIBP, two invasives, dual temperature, integrated battery, 2.4/5GHz wireless enabled (12-lead ECG accessories must be ordered separately). Multiparameter Modules-include Masimo or Nellcor SpO2 adult reusable sensor, Masimo or Nellcor SpO2 cable, reusable adult NIBP cuff and hose, ECG 5 lead adult defib proof cable and ECG 5 lead snap 24" wire set, and MR420B adapter cable for YSI probe. All other accessories must be ordered separately.	USD 15,700.00	USD 15,700.00	2	USD 31,400.00
30	0010-30-42902	12-Lead ECG wire, limb, clip	USD 65.00	USD 65.00	2	USD 130.00
				ED TOTAL:		USD 53,568.00

MedSurg Tele

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
31	NTI	NTI	USD 0.00	USD -40,104.00	1	USD -40,104.00
32	115-050935-00	BeneVision DMS Workstation, Mini PC	USD 3,000.00	USD 3,000.00	1	USD 3,000.00
33	0992-00-0002-04	OEM Uninterrupted power supply APCBR800	USD 186.00	USD 186.00	1	USD 186.00
34	803-040052-00	WorkStation/Tower Install & Setup w/o CABL includes programming, configuration and verification	USD 2,670.00	USD 2,670.00	1	USD 2,670.00
35	121-001453-00	BeneVision DMS Widescreen Touch Display	USD 2,975.00	USD 2,975.00	1	USD 2,975.00
36	121-001375-00	BeneVision WorkStation Server License	USD 3,400.00	USD 3,400.00	1	USD 3,400.00
37	110-004115-00	BeneVision WorkStation Bed Licenses. Supports 4-32 beds	USD 300.00	USD 300.00	16	USD 4,800.00

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
38	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	2	USD 1,522.00
39	023-001566-00	HP LaserJet Enterprise M608n Printer	USD 3,700.00	USD 3,700.00	1	USD 3,700.00
40	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	1	USD 761.00
41	803-040040-00	Device Install & Setup w/o CABL for one of the following - patient monitor, printer or display. Includes programming, configuration and verification	USD 761.00	USD 761.00	2	USD 1,522.00
42	803-070877-00	N1 Install & Setup includes programming, configuration and verification	USD 180.00	USD 180.00	2	USD 360.00
43	121-001522-00	N12 Monitor with Early Warning Score and 2.4/5GHz wireless N12 Monitor-includes 5 year warranty, battery, 4 module slots, quick reference guide, line cord and 1 roll of paper	USD 9,605.00	USD 9,605.00	2	USD 19,210.00
44	045-003255-00	N12 rolling stand with quick release mount	USD 445.00	USD 445.00	2	USD 890.00
45	121-001528-00	N1 Monitor with Nellcor® OxiMax® SpO2, ST/ Arrhythmia analysis, , CO2, 3/5/12-lead NIBP, two invasives, dual temperature, integrated battery, 2.4/5GHz wireless enabled (12-lead ECG accessories must be ordered separately). Multiparameter Modules-include Masimo or Nellcor SpO2 adult reusable sensor, Masimo or Nellcor SpO2 cable, reusable adult NIBP cuff and hose, ECG 5 lead adult defib proof cable and ECG 5 lead snap 24" wire set, and MR420B adapter cable for YSI probe. All other accessories must be ordered separately.	USD 15,700.00	USD 15,700.00	2	USD 31,400.00
46	0010-30-42902	12-Lead ECG wire, limb, clip	USD 65.00	USD 65.00	2	USD 130.00
47	121-001921-00	TM70 WMTS Telepack	USD 4,600.00	USD 4,600.00	1	USD 4,600.00
48	009-004782-00	5-Lead ECG Mobility Leadset, AHA, Snap, 24" Compatible with TM80/TD60	USD 135.00	USD 135.00	1	USD 135.00
49	125-000015-00	Nellcor SpO2 module	USD 1,175.00	USD 1,175.00	12	USD 14,100.00
50	9000-10-05161	SENSOR,SPO2,NELL,ADULT,DS100A	USD 277.00	USD 277.00	12	USD 3,324.00
51	115-030107-00	BeneVision TM80/TD60 Rechargeable Lithium-Ion Battery Pack.	USD 325.00	USD 325.00	16	USD 5,200.00
52	115-030108-00	BeneVision Central Charger. Charges up to 10 Lithium-Ion Battery Packs simultaneously	USD 2,200.00	USD 2,200.00	1	USD 2,200.00
53	803-040050-00	Telepack installation & setup includes programming, configuration and verification	USD 92.00	USD 92.00	1	USD 92.00
54	803-040082-00	WMTS Installation per 100 SQFT includes material, installation and verification	USD 275.00	USD 275.00	100	USD 27,500.00
				MedSurg Tele TOTAL:		USD 93,573.00

EMR Connectivity

Line #	Part Number	Description	List Price	Net Price	QTY	Total Net
55	121-001473-00	eGateway Software only (VMware compatible), please refer to the Host Platform Requirements and Configuration Guide. This configuration includes licenses for Results (discrete trended numerical values), ADT (demographics for positive patient identification), 12-Lead export (with bedsides /w 12-lead and DMS) and Document Management interface. One eGateway supports up to 32 continuous bedside monitors. Capacity can easily be increased to 1200 continuous bedside monitors by increasing the device license to 200 and stacking 5 more eGateways.	USD 10,000.00	USD 10,000.00	1	USD 10,000.00
56	803-070244-00	HL7 Mapping for ADT and Results (32 Bed eGateway)	USD 5,500.00	USD 5,500.00	1	USD 5,500.00
57	803-070485-00	Professional Services	USD 284.00	USD 284.00	5	USD 1,420.00
58	803-070492-00	Hospital Network Integration Services includes design and implementation required for interoperability solutions	USD 4,532.00	USD 4,532.00	1	USD 4,532.00
				EMR Connectivity TOTAL:		USD 21,452.00

To:	Jared Palmer MANGUM REGIONAL MEDICAL CENTER HIGHWAY 60 NE P.O. BOX 720 SEILING, OK 73663	**Sales Representative:** **Quote Number:** **Proposal Date:** **Phone:** **E-mail:**	Larry Cornelius Q-55812 Jul 20, 2020 +1 4052295060 l.cornelius@mindray.com
Affiliation:	REG		

Affiliation Notes: * Service: Two-hour telephone response time with 24 hour on-site service. Product Warranty: Passport Monitors, T1 Monitors, Gas Module, Central Stations - Standard One Year Warranty. Anesthesia Machines - Standard Three Year Warranty. Accutorr Monitors - Standard Three Year Mail-In Warranty. N Series Monitors - Standard 5 year warranty. Ultrasound Machines (M5, 7 & 9) & Transducers (Except: TEE Transducer - Standard One Year) - Standard Five Year Mail-In Warranty with overnight loaners available at no charge during warranty period. DC8: Standard One Year-On Site Warranty. DC8 Expert Ultrasound Machine & Transducers - Standard five year warranty. Resona7 Ultrasound Machine & Transducers - Standard 5 Year Warranty. EXCEPTION: DEMO EQUIPMENT & ACCESSORIES (6 MONTHS ONLY)

Payment Terms: NET 30 DAYS

Shipping Terms: F.O.B. Mahwah, NJ (CUSTOMER PAYS FREIGHT)
"To ensure on-time delivery of your orders, Mindray may drop ship products directly from our overseas factories or distribution warehouses"

Proposal Notes:

Product Notes: Biomedical training credits issued to customers at the time of sale, are for the sole use of employees of the facility purchasing the equipment, and are non transferable.

Central Station - Hospitals, or buying groups, that require special containment procedures while opening plenum spaces including the use of a negative chamber tent system will be billed separately for the containment costs. These cost will include, but not be limited to, rental of a containment system, plus the additional cost incurred by the cable installer and the Mindray Representative who are required to use the system. This will also apply to any containment costs incurred after the installation for Mindray Representatives when performing maintenance on the system.

Trash Removal responsibility
Mindray is not responsible for the disposal of packing material associated with newly installed Mindray products. Mindray will work with the customer to collect and centralize the packing material for ease of disposal by the customers' personnel. The customer will be responsible for sorting and disposal of packing material.

De-Installation of existing cabling
Mindray is not responsible for the de-installation of existing cabling associated with an existing patient monitoring system. Mindray will provide this service on a time and material basis in the event that the customer would like to have this work done by Mindray at the time of the installation. Customer will be responsible for pulling of cable and certification, if these items are not charged on the body of this quote.

Fiber Optics Requirements
In the event that fiber optics network runs are necessary due to the location of the central rack, then it will be the customer's responsibility to add the necessary fiber optic run(s). Mindray Technology service will provide this service on a T+M basis in the event that the customer would like to have this work done by Mindray.

Pricing for cable pull and certification is based on nonunion labor. If Union labor is required customer will be invoiced for any additional cost. Pricing for cablepull includes installation of cables above ceilings or any horizontal/vertical pathways and shall be supported per BISCI standards utilizing communications rated J-hooks. Pricing does not include major structural changes to go between walls or floors, e.g., penetration of interior or exterior cement walls or the installation of conduit/Raceway.

Core Drilling requirements
In the event that core drilling (i.e drilling between floors to accommodate network runs) is required to complete an installation, the customer will be responsible for customary costs associated with this work. Mindray Technology Services will provide this service on a T+M basis if requested by the customer.
(Customary charges are approximately $450 each)
Purchase order acceptance and delivery of Mindray Certified Refurbished products is subject to inventory availability.

Product Notes:

Please complete at time of purchase:

Receiving Dock Hours: _____

Lift Gate Required: YES / NO

Inside Delivery Required: YES / NO

Contact Name: _____

Department: _____

Contact Phone #(s) _____

E-mail Address(s) _____

Uncrating Needed: YES / NO

Debris Removal: YES / NO

Prior Notification: YES / NO

Purchase order acceptance and delivery of Mindray Certified Refurbished products is subject to inventory availability.

This quotation contains no provisions for Biomedical training tuition or credits.

If your terms are Cash-in-advance, please remit check directly to:

Mindray DS USA, Inc. 24312 Network Place, Chicago, IL 60673-1243

Total Price By Department

IT infrastructure

Department Name	List Price	Departmental Discount	Net Price
IT Infrastructure	USD 98,020.02	USD -37,179.02	USD 60,841.00
		IT infrastructure TOTAL:	USD 60,841.00

ED

Department Name	List Price	Departmental Discount	Net Price
ED	USD 76,526.00	USD -22,958.00	USD 53,568.00
		ED TOTAL:	USD 53,568.00

MedSurg Tele

Department Name	List Price	Departmental Discount	Net Price
MedSurg Tele	USD 133,677.00	USD -40,104.00	USD 93,573.00
		MedSurg Tele TOTAL:	USD 93,573.00

EMR Connectivity

Department Name	List Price	Departmental Discount	Net Price
EMR Connectivity	USD 21,452.00	USD 0.00	USD 21,452.00
		EMR Connectivity TOTAL:	USD 21,452.00

TOTAL: USD 229,434.00

Quotation

Total List Amount	**USD 329,675.02**
Total GPO Discount	**USD 11,104.00**
Total Additional Discount/TradeIn	**USD 89,137.02**
Total Net Amount	**USD 229,434.00**

Mindray Capital Leasing Options

Monthly Lease Payment Amount:

36 months USD 0.00
48 months USD 0.00
60 months USD 0.00

Leasing Notes:

This quote is non-binding and is subject to credit approval and acceptance by Mindray Capital. Monthly payments do not include applicable freight and taxes.

Total Net Price For Purchase: **USD 229,434.00**

To: Jared Palmer
MANGUM REGIONAL
MEDICAL CENTER
HIGHWAY 60 NE P.O. BOX 720
SEILING, OK 73663

Affiliation: REG

Sales Representative: Larry Cornelius
Quote Number: Q-55812

Proposal Date: Jul 20, 2020

Phone: +1 4052295060
E-mail: l.cornelius@mindray.com

Title of Buyer	Printed Name of the Buyer

Purchase Order Number	Date	Signature of the Buyer

Ship to Address:

Bill to Address:

We have selected a non-Masimo SpO2 technology and have requested a proposal using an alternate SpO2 technology.

Although we have been educated on the Masmio SpO2 option by Mindray, we have independently chosen the alternate SpO2 option based upon our business needs.

Signature of buyer _____

Mindray North America now has a $150 minimum order policy.
Unless otherwise stated, the total net price of this quotation does not include, freight or sales tax.

Warranty Statement

mindray

Patient Monitoring Systems

June 1, 2019

SCOPE

The following warranty summary supersedes all previously issued warranties and is effective for patient monitoring solutions purchased directly from Mindray North America ("Mindray") and shipped starting June 1, 2019. To the extent that there is any conflict between any earlier warranty and this warranty summary, the terms of this warranty summary shall be controlling. For patient monitoring solutions purchased from Mindray authorized distributors ("Distributors"), please contact your Distributor directly for the warranty statement.

TERM

Mindray warrants that its patient monitoring solutions, when purchased directly from Mindray, will be free from defects in workmanship and materials for a period set forth below from the date of Mindray shipment:

- **New patient monitoring solutions** (multi-parameter patient monitors, parameter modules, telemetry transmitters, server hardware {central station, workstation, eGateway}, software only products {Mobile App, CMS Viewer, eGateway}): **One (1) year**.
- **New N-Series patient monitors** (multi-parameter patient monitors, BeneLink, parameter and recorder modules, module racks and docks): **Five (5) years**.
- **New vital signs monitors: Three (3) years**.
- **New accessories serialized by Mindray** (including central station displays, parameter cable pods, telemetry battery chargers): **One (1) year**.
- **New non-serialized accessories** (including reusable ECG cables, reusable NIBP cuffs, rechargeable batteries, power cords): **Ninety (90) days**.
- **New consumable accessories** (including paper, single patient use ECG lead wires and electrodes, single patient use temperature probes and probe covers, single patient use NIBP cuffs, single patient use SpO_2 sensors, single patient use CO_2 accessories, and disposable batteries): **Up to first use within six (6) months**.
- **Mindray Certified Refurbished monitoring solutions: Six (6) months**.

Damage to any product or parts through misuse, neglect, accident, or by attaching any non-standard accessories, or by any customer modification, voids this warranty. Mindray makes no warranty whatsoever in regard to third-party accessories, such being subject to the warranties of their respective manufacturers.

REPAIR OR REPLACEMENT

In the case that repair or replacement is required during the applicable warranty term as identified above, Mindray will provide the following services:

- T1 & N1 patient monitors & vital signs monitors: Upon request and authorization by Mindray service personnel, a service loaner will be shipped via overnight delivery (provided such service is available). Prior to shipping the customer system to Mindray's Repair Center, the customer is solely responsible for backing up all stored data and system presets. Mindray shall not be responsible for any lost data. Upon receipt at Mindray, the system will be repaired and returned. The service loaner must be returned promptly to avoid additional charges.
- Multi-parameter patient monitors, central stations, gateway products: On-site repair is provided by Mindray service representatives during normal business hours. In the event that repairs cannot be completed on-site, a service loaner will be configured and put in place prior to shipping the customer system to Mindray's Repair Center. The customer is solely responsible for backing up all stored data and system presets. Upon receipt at Mindray, the system will be repaired and returned. The service loaner must be returned promptly to avoid additional charges.

A condition of this warranty is that the equipment or accessories which are claimed to be defective be returned when authorized, freight prepaid to Mindray North America or its authorized representative. Mindray shall not have any responsibility in the event of loss or damage in transit.

SOFTWARE UPDATES

Software updates are offered at the sole discretion of Mindray. Software updates provide changes, which enable the software to perform in accordance with the product specifications defined at the time of equipment purchase. Software updates do not include new features, options, and new hardware or software operating systems when such hardware or software is specifically required for operation of the software update.

DISCLAIMER: LIMITATION OF LIABILITY

Except as expressly set forth herein, Mindray disclaims all other express and implied warranties, including warranties of merchantability, non-infringement and fitness for a particular purpose, and of any other obligation on the part of Mindray. Mindray shall not be liable for any incidental, special, or consequential loss, damage, or expense directly or indirectly arising from the use of its products. Liability under this warranty, and the buyer's exclusive remedy under this warranty, is limited to servicing or replacing, at Mindray's sole option, any product which shall, under normal use and service, appear to Mindray to have been defective in material or workmanship.

WARRANTY

Mindray warrants that components within its products will be free from defects in workmanship and materials for the period of time defined in the "Terms" section above commencing from date of shipment from Mindray to the user.

Recommended preventative maintenance, as prescribed in the service manual, is the responsibility of the user and is not covered by this warranty.

No agent, employee, or representative of Mindray has any authority to bind Mindray to any affirmation, representation, or warranty concerning its products, and any affirmation, representation or warranty made by any agent, employee, or representative shall not be enforceable by buyer or user.

EXCLUSIONS

Mindray's obligation or liability under this warranty does not include any transportation (or other) charges; liability for direct, indirect or consequential damages or delay resulting from the improper use, failure to follow recommended maintenance procedures, application of the product or the use of parts or accessories not approved by Mindray or repairs by people other than Mindray authorized personnel.

This warranty does not extend to:

- Malfunction or damage caused by improper use or man-made failure.
- Malfunction or damage caused by unstable or out-of-range power input.
- Malfunction or damage caused by force majeure events, such as (i) flood, fire and earthquake or similar elements of nature or acts of God; (ii) riots, war, civil disorders, rebellions, or revolutions in any country; or (iii) any other cause beyond the reasonable control of Mindray.
- Malfunction or damage caused by improper operation or repair by unqualified or unauthorized service people.
- Malfunction of the instrument or part whose serial number is not legible.
- Others not caused by instrument or part itself.

Mindray North America 800 MacArthur Blvd. Mahwah, NJ 07430 Tel: 201.995.8000 www.mindray.com

05/20 P/N: 0002.08-939

Proposal Summary

Mangum City Hospital
1 Wickersham
Mangum OK 73554

Account Number: 90545341
Quote Number: 2020-207420 Rev. 1
Expiration Date: December 18, 2020

Department	List Price	Net Price
SafeNSound Enterprise 5-Year Contract [16 Beds]: Contract can be billed Annually or in lump sum for 5 Years	$75,410.00	$52,560.00
Total List Price.....		$75,410.00
Total Discount.....		$22,850.00
Total Proposal Price.....		**$52,560.00**

SafeNSound [SNS] can be billed annually or in lump sum for the 5-Year contract. Any beds added during the contract period will be added on at $657/bed/year from that time forward. If this quote is purchased with *Whole House Upgrade Quote#2020-206478*, all SNS installation fees of $22,950 will be waived.

Upon acceptance, please sign and return this quotation, together with your purchase order, to Sales Support via fax at **425-363-5761 or email it to po.us@spacelabs.com.**

By accepting this quotation or by performing hereunder, the customer identified above ("Customer") agrees to purchase or lease (as applicable) the products identified herein subject to the terms of this Customer Quotation and Spacelabs Healthcare's Subscription Software Terms (in the case of SafeNSound) or Spacelabs Terms of Sale (in the case of all other products). The terms are available on the About Us/Terms/Policies page of our website at http://www.spacelabshealthcare.com. The applicable terms are incorporated herein by this reference. Notwithstanding the foregoing, if Customer has a separate contractual agreement in place with Spacelabs Healthcare relating to the products identified herein (such as a group purchasing agreement, distribution agreement, or master purchasing agreement), the terms of that contractual agreement shall control to the extent such terms conflict with the applicable terms.

Accepted By:

Authorized Signature	Customer Purchase Order Number
Title Date	Email Address for order confirmation
Telephone Number	Tax Exemption Number (if any)
Requested Delivery Date	

This quotation shall remain firm for 60 days unless otherwise stated. Delivery: 21 days after acknowledgement of order, unless otherwise noted in this quotation.

The pricing in this quotation reflects your Premier Healthcare Alliance pricing per contract PP-MM-623. Payment terms are per your contract. FOB is factory. Freight and insurance are no charge. Warranty is per the terms of your contract.

Spacelabs is committed to the safety and wellbeing of our customers and staff. In order to prevent the spread of the virus, products purchased during the COVID-19 crisis cannot be returned or exchanged.

SafeNSound Enterprise 5-Year Contract [16 Beds]: Contract can be billed Annually or in lump sum for 5 Years

Line	Description	Item Number	Qty	Unit List Price	Unit Net Price	Ext. Net Price
1	SafeNSound Enterprise 5 Year Contract (1-30 devices, price per device)	999-1284-00	16	3,285.00	3,285.00	52,560.00
2	Xprezznet Bed License, SafeNSound, waveforms on	910-0271-01	16	0.00	0.00	0.00
3	XprezzNet	96190	1	0.00	0.00	0.00
4	XprezzNet Implementation with SafeNSound Enterprise	999-1296-00	1	18,000.00	0.00	0.00
5	Clinical Training and Implementation of Enterprise SafeNSound - includes 1 Clinical Educator for up to 3 consecutive weekdays. Quantity varies based on size of project. Non-discountable.	999-0222-65	1	4,850.00	0.00	0.00
6	SNS Enterprise LiveView App License	999-1298-02	1	0.00	0.00	0.00
	SafeNSound Enterprise 5-Year Contract [16 Beds]: Contract can be billed Annually or in lump sum for 5 Years Total					**$52,560.00**

HERC

Authorized Dealer and Installation Services for:
NIHON KOHDEN
Patient Monitoring Systems

Quotation

HERC
Hospital Equipment Rental Co.
21900 E. 96th Street
Broken Arrow, OK 74014

To: Mangum City Hospital
1 Wichersham Drive
Mangum, OK 73554

Attention: Jarod Palmer

Date	Sales Representative	Cell Phone	Quote Number
12.11.20	Brian Miller	918-269-9224	7855643

Qty	Item Number	Description	Per Unit	Total
		IT		
1	NK-HIQ-EG/ZA	NK HL7 Enterprise Gateway - CAH Program	$24,495	
1	HL7-PSF-PE	One time implementation Fee Send to EMR	$5,997.00	$5,997.00
1	A/NK-HIQ-RNS	CNS Remote Client Extension	$5,997.00	$5,997.00
1	A/Vitrac-PSF	Remote View Software	$5,997.00	$5,997.00
1	NK-HIQ-EGTest	Test Server	$5,997.00	$5,997.00
		NO Charge on NK HL7 Interface - CAH Program		
		MedSurg		
1	CNS-6801-16	Nihon Kohden 16 Bed Central	$28,657.00	$28,657.00
1	Non- Int	24 Inch Non-interactive Screen	$1,850.00	$1,850.00
2	ORG-9100A	Nihon Kohden 6 Bed Telemetry Receiver	$6,845.55	$13,691.10
12	ZM-530PA	Nihon Kohden Telemetry Transmitter - SPO2 - Resp	$2,604.00	$31,248.00
2	BSM-3572A	Nihon Kohden 3500 Bedside Monitor	$3,012.00	$6,024.00
2	RS-3500	Rolling Stand for NK 3500 Monitor	$545.00	$1,090.00
2	QI-430P	Wireless Antenna for NK 3500 Monitor	$950.00	$1,900.00
1	BJ-900PA	12 Lead ECG Cable	$341.00	$341.00
1	TG-920P	CapOne CO2 Module - Intubated and Non-Intubated	$1,940.89	$1,940.89
1	HP404N	Laser Printer	$320.00	$320.00
1	Non- Int	24 Inch Non-interactive Screen	$1,850.00	$1,850.00
		ER-ISO Covid		
2	RNS-6801ZA	16 Bed Remote CNS Client	$13,541.00	$27,082.00
3	BSM-3572PA	Nihon Kohden 3500 Bedside Monitor	$3,012.00	$9,036.00
2	RS-3500	Rolling Stand for NK 3500 Bedside Monitor	$545.00	$1,090.00
2	QI-4300P	Wireless Antenna for NK 3500 Monitor	$950.00	$1,900.00
2	BJ-920P	12 Lead ECG Cable	$341.00	$682.00
2	TG-920P	CapOne CO2 Module - Intubated and Non-Intubated	$1,940.89	$3,881.78
1	HP404N	Laser Printer	$320.00	$320.00
1	Install	Turnkey Install and Training	$6,434.00	$6,434.00

Warranty: 5 year Warranty

Subtotal	$163,325.77
S&H	No Charge
TOTAL	$163,325.7

Mangum Regional

Project Description

Mangum Regional Hospi
access for data mining &
network accessible devic

Instructions: RFQ Disc

All quoted equipment mu
Vendor Response Sectio
listed as optional; vendor
licensing, etc... Vendor's
OWNERSHIP FOR FUN

Total 5-Year Proposal F

Proposal Price MUST inc
including, but not limited

Total Proposal Price:

Vendor Agreement

Please ensure that includ
If deployed monitoring sy

Vendor Name:
Authorized Signatory Name:
Title:

Signature

Mangum Regional Hospital Patient Monitoring System Requirements (Networking, Server, Software Licensing, Integration, Test Environment & Professional Services Req's)		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
		Yes	No	Partial	Details / Functional Description	
Networking	***Hard Wired*** **:** It is preferred that all Physiologic Monitoring equipment will reside on the HOSPITAL LAN. Hospital will provide network drops at each monitor, & central location. If vendor requires proprietary network, it is the sole responsibility of equipment vendor to disclose and include all costs of design & labor to create this network. ALL COSTS FOR FUNCTIONING NETWORK MUST BE INCLUDED HEREIN	x			Customer choosing to pull their own cable have the following responsibilities Customer is responsible for: Purchasing cable and hardware as required; Pulling the cable runs per specified drawing; Testing the cable runs and providing a verification report ; Hanging the [illegible]	see quote
	Wireless **:** It is preferred that all Physiologic (*Transport)* Monitoring equipment will reside on the HOSPITAL 802.11 WLAN. If vendor requires proprietary network, it is the sole responsibility of equipment vendor to disclose and include all costs of design & labor to create this network. ALL COSTS FOR FUNCTIONING NETWORK MUST BE INCLUDED HEREIN Hospital will provide a wireless site survey and cable pulling.		x		Covers cable pulls, access points, & material for the installation, setup of a 2.4/5GHz network Quantity equals the total square footage of the coverage area divided by 100. Customer pulling their own cable qualifies for a 35% discount off list price.	see quote
	Telemetry **:** It is **REQUIRED that telemetry equipment will reside on a 1.4GHz WMTS networ**k. 608MHz and / or Wi-Fi telemetry will not be accepted or considered. It is the responsibility of equipment vendor to cover all costs and labor to create this network except for cable pulling. Hospital will provide cable pulling.	x				see quote
	WAN Connectivity to ALL Mangum Regional Hospital facilities: *Vendor must provide the ability for equipment to communicate across the hospital wide area network to remotely monitor patient monitoring devices and capture all data required in the sections below. This includes capturing data from all monitored departments through Mangum Regional Hospital.*	x				see quote
	Traffic Segmentation **:** It is preferred that all vendor equipment residing on the Mangum Regional Hospital network will be segmented onto its own VLAN.	x				see quote
	Remote Displays **:** HOSPITAL to provide network for remote displays including audio-video transmitters/receivers and cable for connectivity from central stations to the associated remote displays. HOSPITAL will also provide the TV's/Displays and mounts for these remote displays.					
Servers	**Server Location:** Vendor must provide Network architecture, including all server infrastructure, WAN / LAN requirements, physical location requirements, data flow diagram, and EMR [CPSI] integration, as specified by Mangum Regional Hospital IT staff	x				see quote
	Server Virtualization **:** Vendor is allowed to utilize hospital's virtual server environment. Vendors must provide access to their software to hospital Clinical Engineering & IT personnel for support.		x		Gateway server quoted as virtual. Mindray . Server install will build 1/2 rack or use existing 1/2 rack.	see quote
	Physical Servers **:** In the event vendor doesn't support virtualization, vendor is required to provide all servers necessary for the operation and interfacing of their system. This includes redundant servers. Vendors must provide access to their servers & software to hospital Clinical Engineering & IT personnel for support.	x				see quote
Software Licensing	***Device Interfacing/Integration*** : Vendors shall provide licensing for ALL devices included in this RFP to communicate with the electronic medical record.	x				see quote
	Device Software **:** Vendors shall provide licensing for "unlimited" software updates, for the life of the system, required for interoperability in the event additional items are purchased in the future. This includes monitor, central and server software.	x				see quote
	Patient Data Transfer *:* CONTINUOUS FULL DISCLOSURE RECORD ACROSS ALL DEPTS. System shall provide continuous Full Disclosure record for ALL monitoring devices (telemetry, bedside, wireless), across ALL departments, including those where central monitors are not required in hospital provided specifications. All Full Disclosure records MUST be accessible from any central monitor located on patient monitoring network. This is a site license.	x				see quote
	Remote Access Software **:** Vendors will provide Remote Access ability from any mobile device or hospital PC, for unlimited users (or as specified in dept tabs), this remote access must be available for ALL quoted bedside monitors, compact monitors, and telemetry. Data to be available to remote users include: Raw Waveforms, Arrhythmia Analysis, Alarms, Custom Trend Creation & Display (Graphical and Tabular), Diagnostic 12 Lead EKG Reports with interpretation, Saved Events, Printed Item Audit Trail (Auto and Manual). Additionally, user must have ability to print the following all required data from any PC connected to the HOSPITAL network. This may be accomplished through a web interface or client application.	x			CMS viewer quoted	see quote
Integration	**ADT Integration:** Vendor to provide ADT connection to the Mangum Regional Hospital ADT system.	x				see quote
	Barcode Scanning: allows all quoted bedside monitors, compact monitors, transport monitors, and central monitors to utilize hospital provided barcode scanner for patient admission through ADT integration	x				see quote
	Electronic Strip Export to EMR [CPSI]: All bedside, compact, transport, and central monitors must print electronic waveform strip (pdf) and reports directly to EMR [CPSI] patient folder	x			Print to PDF set up quoted	see quote
	Alarm / Event Notification System : All monitoring devices must be able to transmit alarms to the middleware communication system allowing for alarms to be forwarded on to clinician phones.			x	additional fees might be experienced due to 3rd party requirements.	see quote
	EMR [CPSI] Interface via HL7: This interface allows for transmission of numerics to the EMR [CPSI] system	x				see quote
	Full Disclosure Integration with EMR [CPSI]: Allows vendor's full disclosure application to be opened "in context" within the EMR [CPSI] view a staff member will be accessing.	x				see quote
Test System	Vendor will provide a separate test system for validating all interfaces listed above as well as remote access. HOSPITAL will provide information regarding test requirements as well as the virtual space requirements for the test system.	x				see quote
Professional Services	Vendors will provide a project manager to manage and coordinate all aspects of the project. Please include all costs for design and travel, implementation, and all other associated professional services required for a successful implementation and go-live.	x				see quote
	Vendors will provide project plan with minimal disruption to existing patient monitoring devices until new network goes live.	x				see quote

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

Mangum Regional Hospital enterprise-wide Bedside Monitors & Telemetry with Seamless Patient Full Disclosure (Data Transfer) across all departments, Enterprise-level patient data aggregation and access for data mining & reports,Mangum Regional Hospital / Enterprise-Level Bi-Directional Vital Signs & ADT Integration, Remote Clinician Access to monitor data from any networked or network accessible device

MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES

As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.

VENDOR RESPONSE SECTION

Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; vendor must include any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be responsible for satisfactory installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	Emergency Dept		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted			
	Configuration	Confirmed by	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name	Extended Price
	08/03/20	Daniel/Zach								
Central Monitors and / or Full Disclosure										
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1		x							
Total Number of Centrally Monitored Patients per Nurses Station #1	16	Secondary RN Hosptial Station	x							
Total Number of Centrally Monitored Patients per Nurses Station #2										
Total Number of Centrally Monitored Patients per Nurses Station #3										
Total Number of Centrally Monitored Patients per Nurses Station #4										
Total Number of Centrally Monitored Patients per Nurses Station #5										
Total Number of Centrally Monitored Patients per Nurses Station #6										
Central Station Remote Display (non-functioning), ≥22"	1	ED OFC *	x							
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	3		x			CMS viewer				
Uninterruptible Power Supply (UPS)	1	Hospital Provides	x							
≥72-hour Full Disclosure at all Central Stations	1		x							
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16		x							
Bedside & Transport Monitors										
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen										
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen										
MID-ACUITY Bedside 6 traces, ≥15" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
MID-ACUITY Bedside 6 traces, ≥12" touch screen										
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	2	*Wifi	x							
MID-ACUITY Bedside 6 traces, ≥8" touch screen										
LOW-ACUITY Bedside 4 trace, ≥8" touch screen										
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen										
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen										
Add 802.11 wireless / Wi-Fi for portable or transport	2	*Wifi			x	will work on Mindray access points				
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital				x	will work on Mindray access points				
Mounts (provide description)	2	rollstands	x							
Mounts (provide description)										
Bedside Monitor Acuity Options										
ECG	2		x							
Basic Cardiac Arrhythmia										
Advanced Cardiac Arrhythmia	2		x							
ST-segment Analysis	2		x							
Custom Trending (Sepsis, ST, Histograms, etc.)	2		x							
Respiration	2		x							
Nellcor / Covidien Pulse oximetry	2		x							
Masimo Pulse oximetry										
NIBP	2		x							
2 invasive pressure capability, at each bedside monitor										
4 invasive pressure capability, at each bedside monitor										
Core temperature (surface - rectal) at each bedside monitor	4		x							
Cardiac Output - thermodilution, at each bedside monitor										
12-lead ECG - interpretive & diagnostic	2		x							
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)										
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	2		x							
BISx (# of modules / beds equipped for concurrent use)										
Multi-Gas / Anesthetic Gas Analysis										
SVO2										
ECG 3 lead cable & lead wires (snap or clip)										
ECG 5 lead cable & lead wires (snap or clip)										
ECG 12 lead cable & lead wires (snap or clip)	2		x							
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	2		x							
Telemetry										
Workflow: Device, Communication, Documentation Management System										
ECG only										
ECG & Pulse Oximetry										
Integrated Display										
Basic Cardiac Arrhythmia										

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

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MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES

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VENDOR RESPONSE SECTION

Vendor Response Section MUST be completed in full for consideration; all products must precisely align with official quote; requested items must be included in official quote total and may NOT be listed as optional; ve any/all additional items required for fully functioning solution; including, but not limited to network, design, Professional Services, installation, hardware, software, licensing, etc... Vendor's representative shall be respons installation of the complete and functioning system. ALL VENDOR QUOTES MUST INCLUDE 5-YEAR TOTAL COST OF OWNERSHIP FOR FUNCTIONING SOLUTION AS SPECIFIED

Hospital: Mangum Regional Hospital- Mangum, OK

	MedSurg/Tele		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted		
	Configuration 08/03/20	Confirmed by Daniel/Zach	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name
Central Monitors and / or Full Disclosure									
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1		x						
Total Number of Centrally Monitored Patients per Nurses Station #1	16	Primary RN Station	x						
Total Number of Centrally Monitored Patients per Nurses Station #2									
Total Number of Centrally Monitored Patients per Nurses Station #3									
Total Number of Centrally Monitored Patients per Nurses Station #4									
Total Number of Centrally Monitored Patients per Nurses Station #5									
Total Number of Centrally Monitored Patients per Nurses Station #6									
Central Station Remote Display (non-functioning), ≥22"			x						
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	4		x			CMS viewer			
Uninterruptible Power Supply (UPS)	1	Hospital Provides	x						
≥72-hour Full Disclosure at all Central Stations	1		x						
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16		x						
Bedside & Transport Monitors									
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen									
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen									
MID-ACUITY Bedside 6 traces, ≥15" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	2	*Wifi	x						
MID-ACUITY Bedside 6 traces, ≥8" touch screen									
LOW-ACUITY Bedside 4 trace, ≥8" touch screen									
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen									
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen									
Add 802.11 wireless / Wi-Fi for portable or transport	2	*Wifi			x	will work on Mindray access points			
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital				x	will work on Mindray access points			
Mounts (provide description)	2	rollstands	x						
Mounts (provide description)									
Bedside Monitor Acuity Options									
ECG	2		x						
Basic Cardiac Arrhythmia									
Advanced Cardiac Arrhythmia	2		x						
ST-segment Analysis	2		x						
Custom Trending (Sepsis, ST, Histograms, etc.)	2		x						
Respiration	2		x						
Nellcor / Covidien Pulse oximetry	2		x						
Masimo Pulse oximetry									
NIBP	2		x						
2 invasive pressure capability, at each bedside monitor									
4 invasive pressure capability, at each bedside monitor									
Core temperature (surface - rectal) at each bedside monitor	4	no supplies	x						
Cardiac Output - thermodilution, at each bedside monitor									
12-lead ECG - interpretive & diagnostic	2		x						
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)									
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	2		x						
BISx (# of modules / beds equipped for concurrent use)									
Multi-Gas / Anesthetic Gas Analysis									
SVO2									
ECG 3 lead cable & lead wires (snap or clip)									
ECG 5 lead cable & lead wires (snap or clip)									
ECG 12 lead cable & lead wires (snap or clip)	2		x						
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	2		x						
Telemetry									
Workflow: Device, Communication, Documentation Management System	12		x						
ECG only									
ECG & Pulse Oximetry	12		x						
Integrated Display	12		x						
Basic Cardiac Arrhythmia									

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

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MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES

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ndor must include
sible for satisfactory

Hospital: Mangum Regional Hospital- Mangum, OK

	Extended Price
Central Monitors and / or Full Disclosure	
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	
Total Number of Centrally Monitored Patients per Nurses Station #1	
Total Number of Centrally Monitored Patients per Nurses Station #2	
Total Number of Centrally Monitored Patients per Nurses Station #3	
Total Number of Centrally Monitored Patients per Nurses Station #4	
Total Number of Centrally Monitored Patients per Nurses Station #5	
Total Number of Centrally Monitored Patients per Nurses Station #6	
Central Station Remote Display (non-functioning), ≥22"	
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	
Uninterruptible Power Supply (UPS)	
≥72-hour Full Disclosure at all Central Stations	
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	
Bedside & Transport Monitors	
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen	
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen	
MID-ACUITY Bedside 6 traces, ≥15" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥8" touch screen	
LOW-ACUITY Bedside 4 trace, ≥8" touch screen	
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen	
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen	
Add 802.11 wireless / Wi-Fi for portable or transport	
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	
Mounts (provide description)	
Mounts (provide description)	
Bedside Monitor Acuity Options	
ECG	
Basic Cardiac Arrhythmia	
Advanced Cardiac Arrhythmia	
ST-segment Analysis	
Custom Trending (Sepsis, ST, Histograms, etc.)	
Respiration	
Nellcor / Covidien Pulse oximetry	
Masimo Pulse oximetry	
NIBP	
2 invasive pressure capability, at each bedside monitor	
4 invasive pressure capability, at each bedside monitor	
Core temperature (surface - rectal) at each bedside monitor	
Cardiac Output - thermodilution, at each bedside monitor	
12-lead ECG - interpretive & diagnostic	
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)	
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	
BISx (# of modules / beds equipped for concurrent use)	
Multi-Gas / Anesthetic Gas Analysis	
SVO2	
ECG 3 lead cable & lead wires (snap or clip)	
ECG 5 lead cable & lead wires (snap or clip)	
ECG 12 lead cable & lead wires (snap or clip)	
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	
Telemetry	
Workflow: Device, Communication, Documentation Management System	
ECG only	
ECG & Pulse Oximetry	
Integrated Display	
Basic Cardiac Arrhythmia	

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

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VENDOR RESPONSE SECTION

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Hospital: Mangum Regional Hospital- Mangum, OK

	ISO/COVID		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted		
	Configuration 08/03/20	Confirmed by Daniel/Zach	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name
Central Monitors and / or Full Disclosure									
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")									
Total Number of Centrally Monitored Patients per Nurses Station #1									
Total Number of Centrally Monitored Patients per Nurses Station #2									
Total Number of Centrally Monitored Patients per Nurses Station #3									
Total Number of Centrally Monitored Patients per Nurses Station #4									
Total Number of Centrally Monitored Patients per Nurses Station #5									
Total Number of Centrally Monitored Patients per Nurses Station #6									
Central Station Remote Display (non-functioning), ≥22"	1	View MS/Tele Primary RN Stn			x	customer to provide repeater screen set up			
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	3				x	customer to provide repeater screen set up			
Uninterruptible Power Supply (UPS)									
≥72-hour Full Disclosure at all Central Stations									
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)									
Bedside & Transport Monitors									
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen									
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen									
MID-ACUITY Bedside 6 traces, ≥15" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
LOW-ACUITY Bedside 4 trace, ≥12" touch screen									
MID-ACUITY Bedside 6 traces, ≥8" touch screen									
LOW-ACUITY Bedside 4 trace, ≥8" touch screen									
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen									
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen									
Add 802.11 wireless / Wi-Fi for portable or transport									
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)									
Mounts (provide description)									
Mounts (provide description)									
Bedside Monitor Acuity Options									
ECG									
Basic Cardiac Arrhythmia									
Advanced Cardiac Arrhythmia									
ST-segment Analysis									
Custom Trending (Sepsis, ST, Histograms, etc.)									
Respiration									
Nellcor / Covidien Pulse oximetry									
Masimo Pulse oximetry									
NIBP									
2 invasive pressure capability, at each bedside monitor									
4 invasive pressure capability, at each bedside monitor									
Core temperature (surface - rectal) at each bedside monitor									
Cardiac Output - thermodilution, at each bedside monitor									
12-lead ECG - interpretive & diagnostic									
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)									
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)									
BISx (# of modules / beds equipped for concurrent use)									
Multi-Gas / Anesthetic Gas Analysis									
SVO2									
ECG 3 lead cable & lead wires (snap or clip)									
ECG 5 lead cable & lead wires (snap or clip)									
ECG 12 lead cable & lead wires (snap or clip)									
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)									
Telemetry									
Workflow: Device, Communication, Documentation Management System									
ECG only									
ECG & Pulse Oximetry									
Integrated Display									
Basic Cardiac Arrhythmia									

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

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ndor must include
sible for satisfactory

Hospital: Mangum Regional Hospital- Mangum, OK

	Extended Price
Central Monitors and / or Full Disclosure	
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	
Total Number of Centrally Monitored Patients per Nurses Station #1	
Total Number of Centrally Monitored Patients per Nurses Station #2	
Total Number of Centrally Monitored Patients per Nurses Station #3	
Total Number of Centrally Monitored Patients per Nurses Station #4	
Total Number of Centrally Monitored Patients per Nurses Station #5	
Total Number of Centrally Monitored Patients per Nurses Station #6	
Central Station Remote Display (non-functioning), ≥22"	
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	
Uninterruptible Power Supply (UPS)	
≥72-hour Full Disclosure at all Central Stations	
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	
Bedside & Transport Monitors	
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen	
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen	
MID-ACUITY Bedside 6 traces, ≥15" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥8" touch screen	
LOW-ACUITY Bedside 4 trace, ≥8" touch screen	
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen	
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen	
Add 802.11 wireless / Wi-Fi for portable or transport	
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	
Mounts (provide description)	
Mounts (provide description)	
Bedside Monitor Acuity Options	
ECG	
Basic Cardiac Arrhythmia	
Advanced Cardiac Arrhythmia	
ST-segment Analysis	
Custom Trending (Sepsis, ST, Histograms, etc.)	
Respiration	
Nellcor / Covidien Pulse oximetry	
Masimo Pulse oximetry	
NIBP	
2 invasive pressure capability, at each bedside monitor	
4 invasive pressure capability, at each bedside monitor	
Core temperature (surface - rectal) at each bedside monitor	
Cardiac Output - thermodilution, at each bedside monitor	
12-lead ECG - interpretive & diagnostic	
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)	
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	
BISx (# of modules / beds equipped for concurrent use)	
Multi-Gas / Anesthetic Gas Analysis	
SVO2	
ECG 3 lead cable & lead wires (snap or clip)	
ECG 5 lead cable & lead wires (snap or clip)	
ECG 12 lead cable & lead wires (snap or clip)	
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	
Telemetry	
Workflow: Device, Communication, Documentation Management System	
ECG only	
ECG & Pulse Oximetry	
Integrated Display	
Basic Cardiac Arrhythmia	

Mangum Regional Hospital
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Hospital: Mangum Regional Hospital- Mangum, OK

	Biomed Spares		Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Specific Product Quoted		
	Configuration 08/03/20	Confirmed by Daniel/Zach	Yes	No	Partial	Details / Functional Description	Qty	Model / Part #	Product Name
Central Monitors and / or Full Disclosure									
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	1			x					
Total Number of Centrally Monitored Patients per Nurses Station #1	16			x					
Total Number of Centrally Monitored Patients per Nurses Station #2									
Total Number of Centrally Monitored Patients per Nurses Station #3									
Total Number of Centrally Monitored Patients per Nurses Station #4									
Total Number of Centrally Monitored Patients per Nurses Station #5									
Total Number of Centrally Monitored Patients per Nurses Station #6									
Central Station Remote Display (non-functioning), ≥22"									
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)									
Uninterruptible Power Supply (UPS)									
≥72-hour Full Disclosure at all Central Stations	1			x					
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	16			x					
Bedside & Transport Monitors									
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen									
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen									
MID-ACUITY Bedside 6 traces, ≥15" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
MID-ACUITY Bedside 6 traces, ≥12" touch screen									
LOW-ACUITY Bedside 4 trace, ≥12" touch screen									
MID-ACUITY Bedside 6 traces, ≥8" touch screen									
LOW-ACUITY Bedside 4 trace, ≥8" touch screen	1	*Wifi		x					
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen									
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen									
Add 802.11 wireless / Wi-Fi for portable or transport	1			x					
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	Hospital			x					
Mounts (provide description)									
Mounts (provide description)									
Bedside Monitor Acuity Options									
ECG	1			x					
Basic Cardiac Arrhythmia									
Advanced Cardiac Arrhythmia	1			x					
ST-segment Analysis	1			x					
Custom Trending (Sepsis, ST, Histograms, etc.)	1			x					
Respiration	1			x					
Nellcor / Covidien Pulse oximetry	1			x					
Masimo Pulse oximetry									
NIBP	1			x					
2 invasive pressure capability, at each bedside monitor									
4 invasive pressure capability, at each bedside monitor									
Core temperature (surface - rectal) at each bedside monitor	2	no supplies		x					
Cardiac Output - thermodilution, at each bedside monitor									
12-lead ECG - interpretive & diagnostic	1			x					
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)									
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)									
BISx (# of modules / beds equipped for concurrent use)									
Multi-Gas / Anesthetic Gas Analysis									
SVO2									
ECG 3 lead cable & lead wires (snap or clip)									
ECG 5 lead cable & lead wires (snap or clip)	1	Disposable reusable		x					
ECG 12 lead cable & lead wires (snap or clip)									
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)		no supplies		x					
Telemetry									
Workflow: Device, Communication, Documentation Management System									
ECG only									
ECG & Pulse Oximetry									
Integrated Display									
Basic Cardiac Arrhythmia									

Mangum Regional Hospital
Patient Monitor RFP Product Disclosure

erprise-level
note Clinician

MINIMUM REQUIRED BID SPECIFICATIONS & GUIDELINES

As a reference of standard of quality, functionality and operation, the Hospital requests that bids be based on the specific products listed below. All equipment will be NEW and of the bidding manufacturer's most current model utilizing their latest technology.

ndor must include
sible for satisfactory

Hospital: Mangum Regional Hospital- Mangum, OK

	Extended Price
Central Monitors and / or Full Disclosure	
Number of Nurses Stations in Unit Requiring Centrals (touchscreens ≥22")	
Total Number of Centrally Monitored Patients per Nurses Station #1	
Total Number of Centrally Monitored Patients per Nurses Station #2	
Total Number of Centrally Monitored Patients per Nurses Station #3	
Total Number of Centrally Monitored Patients per Nurses Station #4	
Total Number of Centrally Monitored Patients per Nurses Station #5	
Total Number of Centrally Monitored Patients per Nurses Station #6	
Central Station Remote Display (non-functioning), ≥22"	
Remote Full Disclosure Terminals / Workstations (in addition to central monitors)	
Uninterruptible Power Supply (UPS)	
≥72-hour Full Disclosure at all Central Stations	
≥72-hour Full Disclosure capture all monitored parameters (bed quantity)	
Bedside & Transport Monitors	
HIGH-ACUITY Bedside 8 trace, ≥19" touch screen	
HIGH-ACUITY Bedside 6 trace, ≥17" touch screen	
MID-ACUITY Bedside 6 traces, ≥15" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥12" touch screen	
LOW-ACUITY Bedside 4 trace, ≥12" touch screen	
MID-ACUITY Bedside 6 traces, ≥8" touch screen	
LOW-ACUITY Bedside 4 trace, ≥8" touch screen	
LOW-ACUITY, Non-ECG Vital Signs Monitor, ≥7" touch screen	
Secondary Configurable Display (or Dock w/ Display) 8 trace, ≥19" touch screen	
Add 802.11 wireless / Wi-Fi for portable or transport	
Transport 802.11 Wireless Coverage Area (hospital or dedicated WLAN - provide plans)	
Mounts (provide description)	
Mounts (provide description)	
Bedside Monitor Acuity Options	
ECG	
Basic Cardiac Arrhythmia	
Advanced Cardiac Arrhythmia	
ST-segment Analysis	
Custom Trending (Sepsis, ST, Histograms, etc.)	
Respiration	
Nellcor / Covidien Pulse oximetry	
Masimo Pulse oximetry	
NIBP	
2 invasive pressure capability, at each bedside monitor	
4 invasive pressure capability, at each bedside monitor	
Core temperature (surface - rectal) at each bedside monitor	
Cardiac Output - thermodilution, at each bedside monitor	
12-lead ECG - interpretive & diagnostic	
ETCO2 stationary bedside (# of modules & sensors / beds equipped for concurrent use)	
ETCO2 functional on transport (# of modules & sensors / beds equipped for concurrent use)	
BISx (# of modules / beds equipped for concurrent use)	
Multi-Gas / Anesthetic Gas Analysis	
SVO2	
ECG 3 lead cable & lead wires (snap or clip)	
ECG 5 lead cable & lead wires (snap or clip)	
ECG 12 lead cable & lead wires (snap or clip)	
Supplies: ALL required cables, wires, accessories for functional go-live (Qty indicates# weeks)	
Telemetry	
Workflow: Device, Communication, Documentation Management System	
ECG only	
ECG & Pulse Oximetry	
Integrated Display	
Basic Cardiac Arrhythmia	

Mangum Regional Hospital Patient Monitoring System Requirements 1.4GHz WMTS Telemetry Coverage Area			Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
Building	**Department**	**Coverage Area (Sq. Ft.)**	Yes	No	Partial	Details / Functional Description	
Mangum Regional Hospital	Areas Specified	10,000	x				
		**Approximate, please confirm					
	Total	**10,000**					**$0.00**

*See attached drawings

Mangum Regional Hospital Patient Patient Monitoring System Wireless Transport & Wireless Monitor Coverage Area			Does QUOTED item FULLY comply w/ Required Bid Specs & Guidelines as STATED BY HOSPITAL?			If quoted product varies in name, description or functionality from that requested, provide complete and accurate description	Extended Price
Building	**Department**	**Coverage Area (Sq. Ft.)**	Yes	No	Partial	Details / Functional Description	
Mangum Regional Hospital	Areas Specified	10,000	X				
		**Approximate, please confirm					
	Total	**10,000**					**$0.00**

*See attached drawings

Num	Product	List Unit Price	Quantity
1	NTI	USD 0.00	1
2	BeneVision DMS Server Closet Setup	USD 0.00	1
3	New 2U Server	USD 0.00	1
4	CS host package (2U Rack)	USD 6,000.00	1
5	BeneVision CS Bed License (FD, Bed, Adv)	USD 400.00	16
6	BeneVision CS Server License	USD 9,700.00	1
7	TENTING (CONTAINMENT ONLY)	USD 11,330.00	1
8	BeneVision 04.04 Media Kit	USD 0.01	1
9	Project Management Tiers	USD 0.00	1
10	Project Management Services Tier 3	USD 1,000.00	12
11	BeneVision R4 CMS Viewer bed license Sal	USD 18,000.00	1
12	Professional Services	USD 284.00	2
13	BeneVision R3 PDF Printing	USD 0.01	1
14	Professional Services	USD 284.00	2
15	Hospital Network Integration Services	USD 4,532.00	1
16	WMTS/HW System Design & Implementation	USD 19,500.00	1
17	WMTS Controller Redundancy	USD 9,422.00	1
18	NTI	USD 0.00	1
19	BeneVision DMS Expansion Of Current System	USD 0.00	1
20	Workstation Expansion	USD 0.00	1
21	WS host package (mini PC)	USD 3,000.00	1
22	OEM UPS APCBR800	USD 186.00	1
23	WorkStation/Tower Install&Setup w/o CABL	USD 2,670.00	1
24	BeneVision Widescreen Display	USD 2,975.00	1
25	BeneVision WS Server License	USD 3,400.00	1
26	WS one bed	USD 300.00	16
27	Number of Hardwired Bedside Monitors for this department	USD 0.00	2
28	Device Install & Setup w/o CABL	USD 761.00	2
29	HP LaserJet Enterprise M608n Printer	USD 3,700.00	1
30	Device Install & Setup w/o CABL	USD 761.00	1
31	Number of Wireless Bedside Monitors for this department	USD 0.00	2
32	Device Install & Setup w/o CABL	USD 761.00	2
33	N1's for this department	USD 0.00	2
34	N1 Install & Setup	USD 180.00	2
35	N12,WL,EWS Sales BOM	USD 9,605.00	2
36	N12 Mounting Accessories	USD 0.00	1
37	N12 roll stands(With iPM/iMEC adapter)	USD 445.00	2
38	N1, Nellcor, ST, Glasgow, CO2 Sales BOM	USD 15,700.00	2
39	N Series ECG Accessories	USD 0.00	1
40	12-Lead Leadset,Limb,AHA,Clip	USD 65.00	2
41	NTI	USD 0.00	1
42	BeneVision DMS Expansion Of Current System	USD 0.00	1
43	Workstation Expansion	USD 0.00	1
44	WS host package (mini PC)	USD 3,000.00	1
45	OEM UPS APCBR800	USD 186.00	1
46	WorkStation/Tower Install&Setup w/o CABL	USD 2,670.00	1

47	BeneVision Widescreen Display	USD 2,975.00	1
48	BeneVision WS Server License	USD 3,400.00	1
49	WS one bed	USD 300.00	16
50	Number of Hardwired Bedside Monitors for this department	USD 0.00	2
51	Device Install & Setup w/o CABL	USD 761.00	2
52	HP LaserJet Enterprise M608n Printer	USD 3,700.00	1
53	Device Install & Setup w/o CABL	USD 761.00	1
54	Number of Wireless Bedside Monitors for this department	USD 0.00	2
55	Device Install & Setup w/o CABL	USD 761.00	2
56	N1's for this department	USD 0.00	2
57	N1 Install & Setup	USD 180.00	2
58	N12,WL,EWS Sales BOM	USD 9,605.00	2
59	N12 Mounting Accessories	USD 0.00	1
60	N12 roll stands(With iPM/iMEC adapter)	USD 445.00	2
61	N1, Nellcor, ST, Glasgow, CO2 Sales BOM	USD 15,700.00	2
62	N Series ECG Accessories	USD 0.00	1
63	12-Lead Leadset,Limb,AHA,Clip	USD 65.00	2
64	BeneVision TM70 Telemeter Sales BOM	USD 4,600.00	1
65	5-Lead, New Telemetry, AHA, Snap, 24”	USD 135.00	1
66	Nellcor SpO2 module	USD 1,175.00	12
67	SENSOR,SPO2,NELL,ADULT,DS100A	USD 277.00	12
68	TP Li-ion battery Package	USD 325.00	16
69	Charger Package(US cord)	USD 2,200.00	1
70	Telepack Install & Setup	USD 92.00	1
71	WMTS Installation per 100 SQFT	USD 275.00	100
72	eGateway	USD 0.00	1
73	eGateway SW Spot Check/Surgery 32bd BOM	USD 10,000.00	1
74	Spot Check Mapping	USD 5,500.00	1
75	Professional Services	USD 284.00	5
76	eGateway Mapping Fees	USD 0.00	1
77	No Mapping Required for Spot Check	USD 0.00	1
78	Hospital Network Integration Services	USD 4,532.00	1

Net Total	$ Net Price	Product Code	Pre Discount Price	SAP Department Code
USD -26,075.02	($26,075.02)	NTI	USD -26,075.02	Z063-IT
USD 0.00	$0	GRP-DMS-SERVER	USD 0.00	Z063-IT
USD 0.00	$0	New-2UServer	USD 0.00	Z063-IT
USD 3,300.00	$3,300	115-051209-00	USD 3,300.00	Z063-IT
USD 3,520.00	$220	121-001373-00	USD 3,520.00	Z063-IT
USD 5,885.00	$5,885	121-001372-00	USD 5,885.00	Z063-IT
USD 9,621.00	$9,621	5000-CS-ABMT-01	USD 9,621.00	Z063-IT
USD 0.01	$0.01	045-003660-02	USD 0.01	Z063-IT
USD 0.00	$0	GRP-PROJECT-MGMT	USD 0.00	Z063-IT
USD 12,000.00	$1,000	803-070875-00	USD 12,000.00	Z063-IT
USD 18,000.00	$18,000	121-001405-01	USD 18,000.00	Z063-IT
USD 568.00	$284	803-070485-00	USD 568.00	Z063-IT
USD 0.01	$0.01	803-070282-00	USD 0.01	Z063-IT
USD 568.00	$284	803-070485-00	USD 568.00	Z063-IT
USD 4,532.00	$4,532	803-070492-00	USD 4,532.00	Z063-IT
USD 19,500.00	$19,500	803-040080-00	USD 19,500.00	Z063-IT
USD 9,422.00	$9,422	803-040081-00	USD 9,422.00	Z063-IT
USD -22,958.00	($22,958)	NTI	USD -22,958.00	Z019-Emergency
USD 0.00	$0	GRP-DMS-EXP-DEPARTMENT	USD 0.00	Z019-Emergency
USD 0.00	$0	Exp-WorkStation	USD 0.00	Z019-Emergency
USD 3,000.00	$3,000	115-050935-00	USD 3,000.00	Z019-Emergency
USD 186.00	$186	0992-00-0002-04	USD 186.00	Z019-Emergency
USD 2,670.00	$2,670	803-040052-00	USD 2,670.00	Z019-Emergency
USD 2,975.00	$2,975	121-001453-00	USD 2,975.00	Z019-Emergency
USD 3,400.00	$3,400	121-001375-00	USD 3,400.00	Z019-Emergency
USD 4,800.00	$300	110-004115-00	USD 4,800.00	Z019-Emergency
USD 0.00	$0	HW-QTY	USD 0.00	Z019-Emergency
USD 1,522.00	$761	803-040040-00	USD 1,522.00	Z019-Emergency
USD 3,700.00	$3,700	023-001566-00	USD 3,700.00	Z019-Emergency
USD 761.00	$761	803-040040-00	USD 761.00	Z019-Emergency
USD 0.00	$0	WB-QTY	USD 0.00	Z019-Emergency
USD 1,522.00	$761	803-040040-00	USD 1,522.00	Z019-Emergency
USD 0.00	$0	N1-QTY	USD 0.00	Z019-Emergency
USD 360.00	$180	803-070877-00	USD 360.00	Z019-Emergency
USD 19,210.00	$9,605	121-001522-00	USD 19,210.00	Z019-Emergency
USD 0.00	$0	GRP-N12-MOUNTING	USD 0.00	Z019-Emergency
USD 890.00	$445	045-003255-00	USD 890.00	Z019-Emergency
USD 31,400.00	$15,700	121-001528-00	USD 31,400.00	Z019-Emergency
USD 0.00	$0	GRP-ECG-NSERIES	USD 0.00	Z019-Emergency
USD 130.00	$65	0010-30-42902	USD 130.00	Z019-Emergency
USD -40,104.00	($40,104)	NTI	USD -40,104.00	Z037-Medical/Surg
USD 0.00	$0	GRP-DMS-EXP-DEPARTMENT	USD 0.00	Z037-Medical/Surg
USD 0.00	$0	Exp-WorkStation	USD 0.00	Z037-Medical/Surg
USD 3,000.00	$3,000	115-050935-00	USD 3,000.00	Z037-Medical/Surg
USD 186.00	$186	0992-00-0002-04	USD 186.00	Z037-Medical/Surg
USD 2,670.00	$2,670	803-040052-00	USD 2,670.00	Z037-Medical/Surg

USD 2,975.00	$2,975	121-001453-00	USD 2,975.00	Z037-Medical/Surg
USD 3,400.00	$3,400	121-001375-00	USD 3,400.00	Z037-Medical/Surg
USD 4,800.00	$300	110-004115-00	USD 4,800.00	Z037-Medical/Surg
USD 0.00	$0	HW-QTY	USD 0.00	Z037-Medical/Surg
USD 1,522.00	$761	803-040040-00	USD 1,522.00	Z037-Medical/Surg
USD 3,700.00	$3,700	023-001566-00	USD 3,700.00	Z037-Medical/Surg
USD 761.00	$761	803-040040-00	USD 761.00	Z037-Medical/Surg
USD 0.00	$0	WB-QTY	USD 0.00	Z037-Medical/Surg
USD 1,522.00	$761	803-040040-00	USD 1,522.00	Z037-Medical/Surg
USD 0.00	$0	N1-QTY	USD 0.00	Z037-Medical/Surg
USD 360.00	$180	803-070877-00	USD 360.00	Z037-Medical/Surg
USD 19,210.00	$9,605	121-001522-00	USD 19,210.00	Z037-Medical/Surg
USD 0.00	$0	GRP-N12-MOUNTING	USD 0.00	Z037-Medical/Surg
USD 890.00	$445	045-003255-00	USD 890.00	Z037-Medical/Surg
USD 31,400.00	$15,700	121-001528-00	USD 31,400.00	Z037-Medical/Surg
USD 0.00	$0	GRP-ECG-NSERIES	USD 0.00	Z037-Medical/Surg
USD 130.00	$65	0010-30-42902	USD 130.00	Z037-Medical/Surg
USD 4,600.00	$4,600	121-001921-00	USD 4,600.00	Z037-Medical/Surg
USD 135.00	$135	009-004782-00	USD 135.00	Z037-Medical/Surg
USD 14,100.00	$1,175	125-000015-00	USD 14,100.00	Z037-Medical/Surg
USD 3,324.00	$277	9000-10-05161	USD 3,324.00	Z037-Medical/Surg
USD 5,200.00	$325	115-030107-00	USD 5,200.00	Z037-Medical/Surg
USD 2,200.00	$2,200	115-030108-00	USD 2,200.00	Z037-Medical/Surg
USD 92.00	$92	803-040050-00	USD 92.00	Z037-Medical/Surg
USD 27,500.00	$275	803-040082-00	USD 27,500.00	Z037-Medical/Surg
USD 0.00	$0	GRP-eGATEWAY	USD 0.00	Z063-IT
USD 10,000.00	$10,000	121-001473-00	USD 10,000.00	Z063-IT
USD 5,500.00	$5,500	803-070244-00	USD 5,500.00	Z063-IT
USD 1,420.00	$284	803-070485-00	USD 1,420.00	Z063-IT
USD 0.00	$0	GRP-eGWY-Mapping	USD 0.00	Z063-IT
USD 0.00	$0	SPOT-CHECK-ONLY	USD 0.00	Z063-IT
USD 4,532.00	$4,532	803-070492-00	USD 4,532.00	Z063-IT

LifeShare
TRANSPLANT DONOR SERVICES OF OKLAHOMA

A Donate Life Organization

December 8, 2020

Marie Harrington
Mangum Regional Medical Center
1 Wickersham Drive
Mangum, OK 73554

Dear Ms. Harrington:

As you know, LifeShare Transplant Donor Services of Oklahoma, Inc., (LifeShare) is the federally-designated and certified Organ Procurement Organization (OPO) for the state of Oklahoma. The Center for Medicare & Medicaid Services (CMS) requires that each OPO enter into an agreement with each hospital in its donation service area (DSA). I reference the CMS standard detailing that requirement:

> (Std) §486.322 (a) *Standard*: Hospital Agreements.
>
> An OPO must have a written agreement with… the Medicare and Medicaid participating hospitals and critical access hospitals in its service area….. The agreement must describe the responsibilities of both the OPO and hospital or critical access hospital in regard to donation after cardiac death… and the requirements for hospitals at §482.45 or §485.643."

The enclosed Agreement, describes the responsibilities of both Hospital and OPO and will be requested when you are audited by CMS, the Oklahoma State Department of Health or the Joint Commission.

Please note that LifeShare as an OPO, is not considered a "business associate" of the hospital. In regard to determination that as an OPO it is not a business associate of the Hospital, I refer to the *Federal Register*, Volume 65 page 82688. In comments on the Health Insurance Portability and Accountability Act (HIPAA), the following Federal response is found:

> *Response:* We agree that OPOs and tissue banks are generally not business associates of hospitals.

It is on the basis of this response that our legal counsel believes it inappropriate for LifeShare to execute the various and detailed business associate agreements with which it is presented from time to time.

Your current agreement with LifeShare will expire soon. For your convenience and ours, the revised agreement, will be in effect for three years and if not terminated, will automatically renew for one additional year. It is my hope that the new agreements can be quickly signed and returned to LifeShare via DocuSign. Once returned, I will sign and forward a fully executed original electronic version for your files.

If in your review of these materials you have questions, feel free to call LifeShare at (405) 488-3540, the direct number of my assistant, Nora White.

I enclose with this cover letter the following documents for your review:

42CFR § 482.45 - Condition of Participation Organ, Eye and Tissue Procurement
42CFR § 485.643 - Condition of Participation Organ, Eye and Tissue Procurement

As I write this letter the national organ transplant waiting list has the names of nearly 113,000 Americans. At any given moment, more than 650 Oklahomans are on the list. Tissue transplants occur several times every day in Oklahoma, improving and enhancing the lives of the recipients.

We have enjoyed a long and successful relationship with your facility and on behalf of LifeShare and the many patients awaiting lifesaving transplant therapy, I thank you for your continued support of organ and tissue donation.

Respectfully,

Jeffrey P. Orlowski
President / CEO

JPO/nw

ORGAN AND TISSUE RECOVERY AGREEMENT

This AGREEMENT is made and entered into effective as of January 1, 2021 (the "**Effective Date**"), between Mangum Regional Medical Center with its principal place of business at 1 Wickersham Drive, Mangum, OK 73554 ("**Hospital**") and LifeShare Transplant Donor Services of Oklahoma, Inc., an Oklahoma not-for-profit 501(c)3 corporation, with its principal place of business at 4705 NW Expressway, Oklahoma City, Oklahoma 73132-5213, ("**LifeShare**"), with respect to the following circumstances:

WHEREAS, Hospital, being required by 42 CFR Part 482.45 to notify an organ procurement organization designated by the Secretary of the Department of Health and Human Services or third party designated by LifeShare, in a timely manner, of individuals for whom death is imminent or who have died at Hospital,

WHEREAS, LifeShare, being the Organ Procurement Organization ("**OPO**") designated by the Secretary of the Department of Health and Human Services for procurement of transplantable organs in Oklahoma,

WHEREAS, Hospital and LifeShare, desiring to facilitate the procurement of organs and tissues for transplantation and are committed to maximizing donation from suitable donors,

NOW THEREFORE, Hospital and LifeShare do agree as follows:

Section 1: Definitions

1.1 Imminent Death: 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.

1.2 Timely Referral: A referral by a Hospital is considered timely when made within sixty (60) minutes of determination that a patient meets clinical triggers for imminent death, or for patients not meeting such triggers within sixty (60) minutes following cardiac death.

1.3 Tissue: For purposes of this Agreement, the word "tissue" means bone, bone marrow, heart valves, skin, fascia, pericardium, nerve, tendon, cartilage, corneas/eyes, blood vessel and all other tissues as specified by applicable federal, state and local laws and/or regulations, and Joint Commission Standards or Det Norske Veritas Healthcare, Inc. ("**DNV**").

Section 2: Responsibilities of Hospital

2.1 Make a timely referral of all patients meeting clinical triggers for imminent death using the toll-free referral number (800) 241-4483;

2.2 Make a timely referral of all Hospital deaths using the toll-free referral number (800) 241-4483; (Note: Deaths which occur during transport from one hospital to another should be reported by the receiving hospital);

2.3 Grant to LifeShare the exclusive right to coordinate organ and tissue donation for deaths referred during the term of this Agreement;

2.4 Work collaboratively with LifeShare in assuring all appropriate Hospital staff participate in training provided or approved by LifeShare on organ and tissue donation;

2.5 LifeShare has the responsibility to verify that employees and physicians functioning in roles for the purpose of organ recovery are qualified and have the appropriate licensure, credentialing as defined in paragraph 3.9 below;

2.6 LifeShare will perform as the designated requester for organ and tissue donation. LifeShare staff are the only personnel trained according to CMS regulation to approach families of medically suitable patients regarding the option of organ and tissue donation. Hospital staff will not be trained, or designated, as requestors;

2.7 In cooperation with LifeShare, protect the rights of every individual having made an anatomical gift through first person authorization (a right protected by state law: "…in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part…") by honoring the deceased's first person authorization to donate in every case where said authorization is appropriately documented through a state or national donor registry;

2.8 In cooperation with LifeShare, protect the right of the legal next of kin to make or decline to make an anatomical gift in the absence of a first person decision to make or decline to make an anatomical gift;

2.9 In keeping with patient or family wishes, require that reasonable efforts be made to maintain physiological support and management of organ viability for a patient who is brain dead or for whom brain-death is considered imminent, to allow evaluation for organ donation;

2.10 Allow LifeShare staff full access 24/7/365 to all medical records including Electronic Medical Record ("**EMR**") remotely when possible, for evaluation of medical suitability, and to order lab tests, x-rays, diagnostic procedures such as bronchoscopy, etc. on patients who are authorized donors;

2.11 Encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors;

2.12 Make medical records of deceased patients available, electronically and remotely when possible, for death record review as required by Centers for Medicare and Medicaid Services ("**CMS**"), Association of Organ Procurement Organizations ("**AOPO**"), United Network for Organ Sharing ("**UNOS**"), Federal Food and Drug Administration ("**FDA**"), and the American Association of Tissue Banks ("**AATB**");

2.13 The hospital will have a Donation after Circulatory Death Policy ("**DCD**") or a transfer policy to a facility that supports DCD. Evaluation of the patient for DCD will be performed by LifeShare staff in collaboration with the hospital healthcare team;

2.14 Assure that Hospital and nursing service policies for organ and tissue donation are current and available to Hospital staff and LifeShare personnel and notify LifeShare of any change in credentials of any Hospital organ recovery surgeon or other recovery personnel from the hospital routinely recovering organs for LifeShare;

2.15 Provide LifeShare access to Hospital services such as laboratory and radiology, as well as ensure operating rooms and anesthesia services are made available 24/7/365 on a priority basis when organ recovery is planned;

2.16 Provide initial information to allow LifeShare to screen patients for medical suitability for organ and/or tissue donation;

2.17 Work cooperatively with, and actively participate in, LifeShare's comprehensive QAPI program related to donor referral/recovery including facilitating follow-up on occurrences identified and tracked by the LifeShare QAPI program; and,

2.18 In the event of a natural or man-made disaster in the Hospital's service area, Hospital shall to the best of its ability under such circumstances notify LifeShare of Hospital's status and shall provide LifeShare with continued access to referral sources and appropriate contacts at the Hospital.

Section 3: Responsibilities of LifeShare

3.1 In consultation with its Medical Director(s) determine medical suitability of potential donors for organ and/or tissue donation; in some cases LifeShare could transfer the patient to a central donation facility or other hospital in order to ensure that all needed services are available to maximize the donor's gift.

3.2 Work collaboratively with Hospital by providing programming and resource materials to educate members of Hospital staff regarding organ and tissue donation and provide orientation training for new Hospital staff as well as on-going training to current Hospital staff including DCD;

3.3 Make available to Hospital the services of appropriately trained LifeShare staff for timely communication and prompt response by LifeShare on a 24/7/365 basis;

3.4 A member of LifeShare staff will be available, with respect for family wishes, to discuss all options for donation of organs and tissue with the legal next-of-kin (NOK) in a sensitive, caring, and informative manner, to answer all questions the NOK may have, and when appropriate assure correct documentation of the NOK's authorization of donation. In cases of first person authorization, the LifeShare staff will verify the first person authorization by accessing the appropriate donor registry, will inform the NOK of the donor's pre-existing authorization for donation, and in a sensitive, caring, and informative manner discuss the process with the NOK including answering questions the NOK may have;

3.5 Provide, upon request, sample protocols for organ donation including DCD;

3.6 Meet all legal requirements regarding the use and disclosure of confidential patient information (HIPAA): This includes adherence to the HI TECH ACT of 2013, which addresses the security patient data;

3.7 Following declaration of brain-death, LifeShare staff will oversee medical management of the potential organ/tissue donor, coordinate the allocation of organs through the UNOS DonorNet system, and coordinate the retrieval of suitable organs and tissues;

3.8 For DCD donation, LifeShare staff determines whether the patient has the medical potential to become a candidate for DCD. If the patient is deemed a candidate, LifeShare staff will present the option of donation to the family, as applicable. Upon obtaining authorization for DCD, LifeShare will notify the Hospital staff. The Hospital staff and physicians then are responsible for the withdrawal of care, comfort care, and pronouncement of death per hospital policy and with no involvement from LifeShare staff or transplant surgeons. Following asystole, the attending physician, or his/her designee, pronounces the patient dead and the organ recovery team enters to coordinate the retrieval of suitable organs/tissues;

3.9 Ensure employees and physicians functioning in roles for the purpose of organ/tissue recovery are qualified and have the appropriate licensure, competency and the proper composition and credentials in the recovery teams;

3.10 Ensure organ and tissue recovery services are in compliance with all applicable standards, rules and regulations and provide these services with discretion, sensitivity and respect for the views and beliefs of the families of potential donors;

3.11 Notify Hospital of any LifeShare policy changes that affect recovery, perfusion or transport and provide timely communication and prompt response on a 24x7 basis;

3.12 Provide to Hospital administration a summary of deaths referred to LifeShare's toll-free referral number, 800-241-4483, manned 24/7/365 and the number of referrals that result in anatomical donation;

3.13 LifeShare will provide data reports on referral/conversion rate/timeliness of referral/donor activity with trends on a monthly, quarterly, or annual basis with frequency dependent upon volume of referrals (more referrals equates to more frequent reporting). These reports will include reports/data generated by the LifeShare QAPI process;

3.14 Upon pronouncement of death and consent for organ donation, LifeShare will assume and pay reasonable and customary charges at negotiated or discounted rates associated with donor evaluation, maintenance and surgical recovery of donor organs and tissues;

3.15 LifeShare will cooperate with the hospital's designated eye/cornea bank to facilitate ocular donation;

3.16 LifeShare will cooperate with the Oklahoma State Medical Examiner's Office to assure appropriate release for donation is obtained in cases where medicolegal investigation is to occur;

3.17 If pharmaceuticals are not readily available at Hospital, LifeShare shall provide those necessary for donor support; and,

3.18 LifeShare will ensure that proper documentation is prepared for the transplant program regarding the recovered organ(s) including blood type and other identifying information; and,

3.19 In the event of a natural or man-made disaster in the Hospital's service area, LifeShare shall to the best of its abilities under such circumstances i) provide notification to the Hospital of the status of the donor referral and recovery process and ii) provide donor referral services for screening and evaluation; including a) laboratory testing for infectious diseases and HLA, b) donor management as part of continued organ and tissue recovery services, c) adequate protection of potential donor PHI, d) resources for patient triage and care, and e) any other services that LifeShare can provide to serve the community. In the event of a natural or man-made disaster effecting LifeShare's corporate office functions and operations, LifeShare shall communicate with Hospital regarding the procedure LifeShare has adapted to deal with the impact such disaster has had on LifeShare's functions and operations and shall update Hospital as any of such disaster-response procedures are adjusted.

Section 4: Term and Termination.

4.1 This Agreement shall become effective as of the Effective Date set forth above and shall remain in effect until December 31, 2023 (the "**Initial Term**"), unless terminated as provided herein. Either party may terminate this Agreement at the end of the Initial Term by providing written notice of its intent to terminate to the other party within ninety (90) days of the expiration of the Initial Term.

4.2 Unless either party hereto provides the other party written notice of its intent to terminate this Agreement ninety (90) days prior to expiration of the Initial Term, this Agreement shall automatically renew for an additional one (1) year term (the "**Renewal Term**").

4.3 If at any time during the Initial Term or Renewal Term of this Agreement LifeShare fails to meet federal requirements as an Organ Procurement Organization, Hospital shall have the right to terminate this Agreement at that time.

4.4 If at any time during the Initial Term or Renewal Term of this Agreement Hospital loses its state license or is debarred as an eligible provider under any Federal Healthcare Program, LifeShare shall have the right to terminate this Agreement at that time.

Section 5: Indemnify and Hold Harmless

5.1 Hospital agrees to defend, hold harmless, and indemnify LifeShare, its directors, officers, employees or agents against any legal liability in respect to bodily injury, death, and property damage arising from the negligence of Hospital, its directors, officers, employees or agents during its performance of its responsibilities under this Agreement.

5.2 LifeShare agrees to defend, hold harmless, and indemnify Hospital, its directors, officers, employees or agents against any legal liability in respect to bodily injury, death, and

property damage arising from the negligence of LifeShare, its directors, officers, or employees or agents during its performance of its responsibilities under this Agreement.

Section 6: Insurance

6.1 LifeShare and Hospital shall maintain malpractice and general liability insurance with minimum limits of $1,000,000 per occurrence and $3,000,000 in the aggregate throughout the term of this Agreement. Upon reasonable request of either party, the other party shall furnish the requesting party proof of adequate insurance. Such insurance shall be obtained from a reputable insurance company authorized to sell insurance policies in the State of Oklahoma and be satisfactory to the other party.

Section 7: Force Majeure

7.1 Neither party shall be responsible to the other for nonperformance or delayed performance of the terms and conditions hereof due to acts of God, acts of government, wars, riots, accidents and transportation, fuel shortages, or other causes (except strikes), in the nature of force majeure which is beyond its control.

Section 8: Independent Contractor

8.1 LifeShare is providing its services hereunder as an independent contractor. Nothing herein shall create any affiliation, partnership or joint venture between the parties hereto, or any employer/employee relationship. Neither is LifeShare, as an organ procurement organization, considered a Business Associate of the hospital as described in the Health Insurance Portability and Accountability Act ("**HIPAA**").

Section 9: Notices

9.1 All notices and other communications provided for hereunder shall be in writing and shall be mailed by certified mail, return receipt requested, sent by facsimile transmission, with a copy sent promptly thereafter by U.S. mail, overnight delivery or hand delivery, as follows:

If to Hospital:
Name: Marie Harrington (Please print)
Title: _____
Mangum Regional Medical Center
PO Box 280
1 Wickersham Drive
Mangum, OK 73554
Telephone: _____
Email: ceo@mangumregional.org

If to LifeShare:
Jeffrey P. Orlowski, President and CEO
LifeShare Transplant Donor Services of Oklahoma
4705 NW Expressway
Oklahoma City, Oklahoma 73132-5213
Telephone: (405) 840-5551
Email: LSHospitalDevelopment@lifeshareok.org

Section 10: Applicable Law

10.01 This Agreement shall be understood in accordance with the laws of the State of Oklahoma, without giving effect to any conflict of laws principles.

Section 11: Entire Agreement. This Agreement and any addenda hereto sets forth the entire Agreement between the parties. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect. The obligations in these provisions shall survive the termination or expiration of this Agreement for a period of one (1) year.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized officers as of the date first written above.

"HOSPITAL" Mangum Regional Medical Center

By: _____
Name: Marie Harrington
Title: _____

Date: _____

"LIFESHARE" LifeShare Transplant Donor Services of Oklahoma, Inc.

By: _____
Name: Jeffrey P. Orlowski
Title: President and Chief Executive Officer

Date: _____

§ 482.45 - Condition of participation: Organ, tissue, and eye procurement.

(a) *Standard: Organ procurement responsibilities.* The hospital must have and implement written protocols that:

(1) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose;

(2) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(3) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes or to decline to donate. The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(4) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(5) Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(b) *Standard: Organ transplantation responsibilities.* (1) A hospital in which organ transplants are performed must be a member of the Organ Procurement and Transplantation Network (OPTN) established and operated in accordance with section 372 of the Public Health Service (PHS) Act (42 U.S.C. 274) and abide by its rules. The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given

the OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.

(2) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, or pancreas.

(3) If a hospital performs any type of transplants, it must provide organ-transplant-related data, as requested by the OPTN, the Scientific Registry, and the OPOs. The hospital must also provide such data directly to the Department when requested by the Secretary.

[63 FR 33875, June 22, 1998]

§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

[65 FR 47110, Aug. 1, 2000, as amended at 66 FR 39938, Aug. 1, 2001]

AMENDMENT TO AGREEMENT

This Amendment is entered into by and between **Press Ganey Associates LLC** (d/b/a Press Ganey Associates, Inc.) ("Press Ganey") and **Mangum Regional Medical Center** ("Client") (and together with Press Ganey, the "Parties") as of **April 1, 2021** ("Amendment Effective Date").

WHEREAS, the Parties have entered into a Master Services Agreement effective July 23, 2018, (the "Agreement"); and

WHEREAS, the Parties desire to amend the Agreement with the terms and conditions set forth herein; and

NOW THEREFORE, in consideration of the premises set forth above and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. **Amendments to the Agreement.** As of the Amendment Effective Date, the Agreement is hereby amended as follows:

   a. Beginning **April 1, 2021** and running concurrently to the Agreement, the Parties agree to replace the existing Phone Methodology for Inpatient with HCAHPS service and Emergency Department service with eSurvey Blend and Text Invitation Methodology as outlined in Exhibit A-1 and Attachment A-1, attached hereto. These services shall renew as outlined in Section 3. TERM of the Agreement.

      - Fees are as outlined on Attachment A-1, attached hereto.

   b. **Section 13(d)** of the Agreement is hereby repealed and replaced with the following language:

      The Parties understand and agree that according to the CAHPS Quality Assurance Guidelines, Client may only change CAHPS vendors at the start of a calendar quarter, and that Press Ganey, as Client's CAHPS vendor, must complete certain activities related to CAHPS Services beyond Client's final applicable patient discharge date, in accordance with such CAHPS Quality Assurance Guidelines and other CMS regulations. Therefore, notwithstanding any purported termination by Client of any CAHPS Services, (i) this MSA, the applicable SOW(s), and such CAHPS Services shall continue with respect to Client's applicable patient discharges occurring through the current calendar quarter and (ii) the obligations of each Party regarding such CAHPS Services, including but not limited to Client's obligation to pay applicable fees to Press Ganey, shall continue through the calendar quarter subsequent to Client's final applicable patient discharge date.

   c. Attachment A of the Agreement is hereby repealed and replaced with Attachment A-1, attached hereto.

   d. Exhibit A, Patient Experience Mid-Market Statement of Work of the Agreement is hereby repealed and replaced with Exhibit A-1, attached hereto.

2. **Limited Effect.** Except as expressly provided in this Amendment, all of the terms and provisions of the Agreement are and will remain in full force and effect and are hereby ratified and confirmed by the Parties. On and after the Effective Date, each reference in the Agreement to "this Agreement," "the Agreement," "hereunder," "hereof," "herein" or words of like import, and each reference to the Agreement in any other agreements, documents or instruments executed and delivered pursuant to, or in connection with, the Agreement, will mean and be a reference to the Agreement as supplemented by this Amendment.

3. **Conflicts.** To the extent there is a conflict between the terms of this Amendment and the Agreement, the terms of this Amendment shall control.

IN WITNESS WHEREOF, the undersigned have executed this Amendment as of the Effective Date.

MANGUM REGIONAL MEDICAL CENTER (Client #33187)	**PRESS GANEY ASSOCIATES LLC (D/B/A PRESS GANEY ASSOCIATES, INC.)**
By:	**By:**
Name:	**Name:**
Title:	**Title:**
Date:	**Date:**

EXHIBIT A-1
PATIENT EXPERIENCE MID-MARKET
STATEMENT OF WORK

This Statement of Work ("SOW") is entered into as of **April 1, 2021** ("Effective Date") by and between **Press Ganey Associates LLC (d/b/a Press Ganey Associates, Inc.)**, an Indiana limited liability company ("Press Ganey") and **Mangum Regional Medical Center** ("Client," and together with Press Ganey, the "Parties") pursuant to and subject to the terms and conditions of the Master Services Agreement between the Parties effective July 23, 2018, (the "MSA"). Capitalized terms not defined in this SOW will have the meanings assigned to them in the MSA.

1. SERVICE SUMMARY.

a. Patient Experience Survey Products. Press Ganey shall use commercially reasonable efforts to:

- Create and send multiple versions of the survey tool, as necessary and as requested by Client. Client may request one revision per survey per calendar year. Additional revisions requested by Client may result in additional fees, at a cost of $500 per revision per service.
- Conduct multiple wave surveying services to satisfy Client's participation requirements, pursuant to applicable initiatives set forth in the Consumer Assessment of Health Providers and Systems, sponsored by the Centers for Medicare and Medicaid Services, if applicable.
- Provide access to survey images and recordings, if available and permitted based on CMS guidelines.
- Offer Client the ability to monitor the number of surveys administered, returned, and completed.
- Transcribe all patient survey comments made in English collected via mail or telephone verbatim (for example, grammar mistakes would not be corrected) and apply a comment rating to each comment.
- Apply a comment rating to each eSurvey comment made in English using a sentiment analysis software algorithm, which yields a rating accuracy of ninety-three (93) percent.

b. Patient Experience Reports. Press Ganey shall use commercially reasonable efforts to:

- Provide a worldwide, royalty-free non-exclusive, limited, non-transferable, non-assignable, non-sublicensable license to use Press Ganey's Patient Experience web-based application(s), for an unlimited number of users at each facility; client must designate a primary root user who will be responsible for user access and management of adding, maintaining and deleting users for their organization. For the avoidance of doubt, Client shall have no right or license to use any source code associated with the application and agrees not to reverse engineer the application or otherwise attempt to obtain the source code for the application or make any other use of the application except as authorized by Press Ganey in writing;
- Provide reporting of patient experience results that include, but are not limited to:
  (1) Static reports of Press Ganey CAHPS performance for standard time periods.
    - Static reports will be provided within thirty (30) days of the close of data collection.

  (2) Interactive reporting, including the ability to create configurable data views
  (3) Benchmarking to allow organizational comparison with selected peer groups
  (4) Priority indices
  (5) Comment reports

- Make comments available for review through the web-based application and provide the capability for Client's designated staff to review comments containing concerning content through specialized reporting, also referred to as "Hot Comments". The determination regarding the content to be flagged by the Hot Comments functionality requires Client's input. Client acknowledges that (i) Press Ganey does not guarantee that Hot Comments will identify all content that Client considers to be concerning and (ii) Press Ganey has no obligation to flag comments for any reason.
- Provide additional reports through the web-based application on a monthly, quarterly, or annual basis upon Client's request. There may be a fee associated with these additional reports.

c. Client Support Services. Press Ganey shall use commercially reasonable efforts to:
   - Provide access to improvement content related to major service lines.
   - Provide access to Press Ganey's Online Forum – an information exchange forum that allows facilities to review industry best practices and collaborative solutions for improving patient experience.
   - Offer educational networking opportunities with other Press Ganey clients through the National Client Conference and Regional Education Symposia.
   - Provide periodic access to online Press Ganey publications.

d. Advisor Support. Press Ganey will provide a Patient Experience Advisor ("Advisor") who will support Client through unlimited virtual support in the following activities:

   - Advise in the development and promotion of a new patient experience strategy or the revitalization of existing one
   - Support data interpretation, including goal setting guidance, and data management guidance
   - Provide Product and Press Ganey tool Training and Education
   - Best practice sharing via approved Tool Kits and Press Ganey publications
   - Facilitate networking
   - As mutually agreed, provide an annual Improvement Plan

   Support days can be provided at an additional fee of $3500 per day. If onsite time is provided, these days can be scheduled in 4 or 8 hour increments only. Travel expenses for any onsite Advisory visits will be billed as incurred.

e. Account Manager Support. Press Ganey shall use commercially reasonable efforts to provide access to a designated Account Manager who will:
   - Work collaboratively with client on the implementation of new survey products and continuous on-going support:
   - Cooperate with client to determine survey customization that aligns with organizational goals and initiatives. Survey customizations can be made once annually.
   - Recommend appropriate sampling strategies aimed toward obtaining actionable data. Client may request sampling adjustments quarterly, and Press Ganey will cooperate with Client to determine whether the requested adjustment is recommended.
   - Collaborate with client and Advisor to align inbound data with expected reporting outputs that drive improvement initiatives.
   - Provide reasonably detailed information from audits proactively performed in connection with Client setup and otherwise throughout the term of the SOW to guide compliance with CAHPS regulations and guidelines. Client acknowledges that this is not an assurance of compliance with any federal and/or state laws, regulations or requirements. Client understands that it has a separate and distinct non-delegable

legal obligation to comply with all federal and/or state law, regulations or requirements and Press Ganey is not liable for Client's failure to comply with these requirements.

f. Client Support Desk. Press Ganey shall use commercially reasonable efforts to provide access to our client support desk who will:
    - Provide virtual, real time client user assistance, Monday – Friday, 8:00 am – 8:00 pm EST.

2. **DATA COLLECTION METHODOLOGY.** Provided that Client is in compliance with its obligations under Section 4, Press Ganey shall use commercially reasonable efforts to:

a. InfoTurn Surveying (Mail Methodology):
    - Provide surveys and accompanying cover letters for each contracted patient survey service;
    - Provide surveys and a return, business reply envelope with each mailing;
    - Complete mailings within three (3) business days of receipt of electronic patient data;
    - Provide access to scanned survey images within three (3) business days of their return via the PG Application; and
    - Transcribe all survey comments made in English within five (5) business days of Press Ganey's receipt, if Client has contracted for Press Ganey's "Comments Service".

b. eSurvey Blend with Text Invitation (Electronic Internet Surveying):
    - Send and process mail survey first before sending one SMS text invitation and/or email notifications to all survey takers who provide a mobile number or email address to Client, provided that Client has obtained valid "prior express consent" or "prior express written consent," as applicable, from such survey takers in accordance with its obligations under Section 4 herein;
    - Enter survey results into the Press Ganey database and make them available for viewing via the PG Application within three (3) business days following submission.

3. **SERVICE ASSURANCE.**

a. Press Ganey Hours of Operations: Monday – Friday, 8:00 am – 5:00 pm during Client's local time.

b. Press Ganey Holidays. Press Ganey recognizes the following nine (9) holidays and all offices are closed on these days or their days of observance:
    - New Year's Day (January 1)
    - Martin Luther King Day (third Monday in January)
    - Memorial Day (last Monday in May)
    - Independence Day (July 4)
    - Labor Day (first Monday in September)
    - Thanksgiving (fourth Thursday in November)
    - Day after Thanksgiving
    - Christmas Eve (December 24)
    - Christmas (December 25)

c. Federal Closures. Press Ganey services may be impacted by federal closures, such as federal holidays, federal shutdown, states of emergency, severe weather, or natural disaster. Every reasonable effort will be made to notify the Client and return to normal business operations once the federal closure ends. The timing for this return to normal business operations will be dependent upon the cause and duration of the closure as well as the

resulting aftermath. Information on these closures may be found at www.pressganey.com/terms.

d. Other Closures. There may be occasions where Press Ganey closes all offices, such as for a corporate meeting or a day of community service. If these instances occur, the client will be notified by Press Ganey a minimum of thirty (30) days in advance of such a closure. Information on these closures may be found at www.pressganey.com/terms.

4. CLIENT RESPONSIBILITIES. Client shall at all times during the term:

- Comply with certain hardware and software requirements to receive Press Ganey's online services, as amended from time to time, which requirements may be found at www.pressganey.com/terms.
- Designate a primary root user for the Press Ganey Online System and Applications that is responsible for user access and management of users within their organization;
- Upon the departure of an employee from Client's facility, immediately terminate their access to Press Ganey Applications and other Press Ganey systems;
- Prior to processing data, provide Press Ganey a completed demographic profile for the contracted service(s). Profiles must be completed and returned to Client's Account Manager by the first of the month preceding the month in which the facility is to receive the first report.
- Notify Press Ganey of changes to the demographic profiles prior to the first business day of the month proceeding the report month, including changes in unit configurations and specialty designations.
- Obtain any and all patient consents, authorizations, and/or approvals required by applicable laws, rules, regulations or policy to enable Press Ganey to execute its obligations under this Agreement.
- Obtain any and all patient consents, authorizations, and/or approvals required by applicable U.S. federal and state laws, rules, regulations, policy, or industry guidelines to enable Press Ganey to execute its obligations under this Agreement, including but not limited to privacy policies, laws regarding the transfer and/or transmission of data, the Telemarketing Sales Rule and the Telephone Consumer Protection Act (the "TCPA"), and the CTIA Short Code Handbook.
- Ensure that the Patient providing the "prior express consent" or "prior express written consent" to send texts to a telephone number as required by the TCPA, that Patient is the current subscriber or customary user for that telephone number, and that the consent obtained from such Patient/subscriber has not been revoked.
- Ensure that the email addresses provided to Press Ganey are currently assigned to the designated Patient and that no Patient has opted out or unsubscribed from receiving emails from Client.
- Comply with the requirements of sampling strategy and survey distribution methodology. Client recognizes that a common distribution methodology must be used in order to avoid bias, enable comparative data to be valid, and meet the highest standards of reporting. Additionally, Client acknowledges that reporting standards require that a minimum number of surveys must be returned before a statistically-valid report can be issued by Press Ganey. The minimum requirement for small hospital databases and for other services not mentioned below is thirty (30) returned surveys. The minimum requirements for the large hospital comparative databases are as follows:

  Inpatient – one hundred and seventy-five (175)

  Pediatric Inpatient – one hundred and forty-two (142)

  Emergency Room – one hundred and forty-five (145)

  Ambulatory Surgery – one hundred and six (106)

  Medical Practice – thirty (30)

  Outpatient Services – one hundred and forty-nine (149)

1060

5. **PAYMENT TERMS.**
   a. Contract fees are as indicated on **Attachment A-1**.

6. **ACKNOWLEDGEMENT; DISCLAIMER.** THE PARTIES AGREE THAT FOR PURPOSES OF THE TCPA, PRESS GANEY SHALL BE DEEMED TO BE CONTACTING PATIENTS AT THE CLIENT'S DIRECTION, UNDER THE CLIENT'S SUPERVISION, AND FOR THE CLIENT'S BENEFIT AND CLIENT SHALL HAVE SOLE RESPONSIBILITY TO OBTAIN ANY AND ALL NECESSARY CONSENTS FROM PATIENTS AS DEFINED UNDER THE TCPA.

IN WITNESS WHEREOF, the undersigned have executed this SOW as of the Effective Date.

MANGUM REGIONAL MEDICAL CENTER (Client #33187)	**PRESS GANEY ASSOCIATES LLC (D/B/A PRESS GANEY ASSOCIATES, INC.)**
By:	**By:**
Name:	**Name:**
Title:	**Title:**
Date:	**Date:**

ATTACHMENT A-1

1. Beginning **April 1, 2021** and running concurrently to the Agreement, Client agrees to pay Press Ganey an annual fee of $8,193.12 ("Annual Fee") for the service described below and in Exhibit A-1, attached hereto. This fee will be prorated, invoiced, and payable in monthly increments.

    a. The Annual Fee includes:

        i. Up to 1,500 mailed surveys (Wave 1 and Wave 2) annually (prorated) through the United States Postal Service for the services of:
            - Inpatient with HCAHPS
            - Emergency Department

        ii. Email surveys (unlimited) and Text for the services of:
            - Inpatient
            - Emergency Department

        iii. Comment processing.

2. Additional mailed surveys over the included volume above shall be invoiced monthly as incurred at a rate of $2.65 per survey, plus any annual price increases allowed under this Agreement.

3. Additional services and/or facilities may be added by mutual written agreement of the Parties at mutually agreed upon pricing.

Estimate

January 5, 2021

Reyes Electric, L.L.C.
P. O. Box 773
Altus, OK 73522
License #31663
Cell 580-481-0106
Office 580-482-4913

Mangum Regional Medical Center
1 Wickersham Dr.
Mangum, OK 73554
Mark Chapman
580.471.0559
mchapman@mangumregional.org

Re; Hallway for Covid Patients

- Providing and installing conduit and wire
- Providing and installing circuits for window units
- Providing and installing circuits for vent on the roof
- Providing and installing keyless switches for 4 rooms
- Providing and installing receptacles in 4 rooms

Quote $8,750.00

Thank you
Thomas Reyes

This Work Order has been prepared for use in connection with that certain Consulting Services Agreement between OKLAHOMA FOUNDATION FOR MEDICAL QUALITY, an Oklahoma not-for-profit corporation ("OFMQ") and Mangum City Hospital Authority DBA Mangum Regional Medical Center .

Service Description

	Description	Allotted Time
OFMQ will provide **12 cases,** including: • Medical necessity and appropriateness of review • Address quality of care concerns • Validate diagnosis and procedural information • Compliance with national standards and regulations • Peer Review.	Customer will: •Provide point of contact for project •Provide medical records to be reviewed that are **1,000 pages or less** •Provide needs or concerns to be addressed	60 days following the receipt of the medical record.

Pricing/Fees

Customer shall pay a total of $ 350 for each completed review to OFMQ according to the following schedule:

Payment		
Payments **$350 per completed review**	Invoiced quarterly at the completion of reviews	Paid within 30 days of invoice

Terms

OFMQ shall perform the Work until completion of the Work and not to exceed (1) year from the effective date below which may be extended by written agreement of OFMQ and Customer.

Capitalized terms used and not defined herein shall have the meaning for such terms set forth in the Agreement. The terms and conditions of this Work Order shall be an integral part of the Agreement and shall be incorporated by reference into the Agreement. This Work Order may not be amended or modified by the parties other than pursuant to the procedures set forth in the Agreement. In the event of any conflict between any term or provision in this Work Order and the Agreement, the Agreement shall control unless the Work Order specifically states the parties' intent that the Work Order amend the conflicting term or provision of the Agreement.

Customer Contact

Customer Name: _____

Primary Contact: _____ Phone: _____

Email: _____ FAX: _____

Address: _____

City: _____ State: _____ Zip: _____

Send Invoices to: _____ Phone: _____

Email: _____ Fax: _____

Authorization

"CUSTOMER" _____
Print Customer Name

By: _____
Signature

_____
Print Name and Title

"OFMQ" Oklahoma Foundation for Medical Quality (OFMQ), an Oklahoma not-for-profit corporation

_____
By: Authorized Signer

Dated effective the ____ day of _____, 20_____.

THIS CONSULTING SERVICES AGREEMENT (the "Agreement') is made effective this __1st_ day of _March__, 2021__ (the "Effective Date"), by and between OKLAHOMA FOUNDATION FOR MEDICAL QUALITY, an Oklahoma not-for-profit corporation ("OFMQ") and _Mangum City Hospital Authority DBA Mangum Regional Medical Center_ a ____hospital_____ ("Customer").

Recitals

A. Customer may, from time to time, request that OFMQ provide certain consulting services pursuant to a Work Order, which shall be in a form substantially similar to that attached hereto as Exhibit A (the "Work").

B. In the event Customer and OFMQ enter into a Work Order for OFMQ to perform Work for Customer, such Work and all rights and obligations of Customer and OFMQ concerning the Work shall be governed and controlled by this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

1. Scope of Work. OFMQ shall provide the Work as specified in a Work Order. OFMQ shall be responsible for providing all services and materials necessary to complete the Work, unless agreed otherwise in writing between Customer and OFMQ.

2. Payment. Customer shall pay OFMQ the amount(s) set forth in the Work Order within thirty (30) days of OFMQ's invoice. OFMQ's invoices may be for partial or progress payments, if provided in the Work Order.

3. Independent Contractor. OFMQ is an independent contractor and shall have the right to control the manner in which the Work is performed. Neither OFMQ nor anyone employed by OFMQ shall be deemed for any purpose to be an employee, agent, servant or representative of Customer. Customer shall have no power or authority to direct, supervise or control OFMQ with respect to the means, manner or method of performance of the Work or services performed or rendered hereunder. Customer is not responsible for withholding, and shall not withhold, FICA or taxes of any kind from any payments it owes OFMQ.

4. Confidentiality. OFMQ acknowledges that in the course of its performance of the Work, it may receive information from Customer of a confidential or proprietary nature. Customer shall clearly mark such information as confidential on the document, material, or information itself in order to receive the protections set forth in this Section 4. OFMQ shall hold such confidential information in strict confidence and shall not disclose any such confidential information. Provided, however, OFMQ may disclose Customer's confidential information: (i) in the course of performing the Work; (ii) as authorized by Customer in writing; or (iii) as required by subpoena or applicable law.

5. Intellectual Property Rights and Ownership of the Work. OFMQ shall retain any all copyrights and intellectual property rights in the Work. Customer shall not assign or transfer the Work developed by OFMQ, in whole or in part, to any other party (including, without limitation, another hosting provider) absent OFMQ's written consent. All text, data, and imagery provided by Customer shall remain the property of Customer.

6. Term and Termination. The term of this Agreement shall commence on the Effective Date specified above. For each Work Order, the Work shall commence and terminate as set forth in the applicable Work Order. Provided, however, in the event OFMQ completes Work prior to the termination date in the applicable Work Order or if no terminate date is set forth in the Work Order, such Work Order shall automatically terminate upon OFMQ's completion of the Work provided for therein and Customer's payment of all outstanding amounts owed to OFMQ, without notice or action required of either party. The termination of any Work Order shall not operate as a termination of this Agreement, u

expressly stated in writing and signed by both parties. This Agreement may be terminated without cause by mutual written agreement of OFMQ and Customer. In the event a party is in breach of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days' written notice to the breaching party, which notice shall specifically identify the alleged breach and provide the breaching party an opportunity to cure the breach during such thirty (30) day period. OFMQ shall be compensated in full for all Work provided prior to the effective date of any termination. Notwithstanding the foregoing, in the event an invoice from OFMQ to Customer is past due, OFMQ may immediately suspend Work upon twenty-four (24) hours' prior notice to Customer, which notice may be given by way of email, telephone, or other written communication. Such suspension of Work shall not operate as a termination of this Agreement. This Agreement shall remain in effect until OFMQ has received full payment or until the invoice becomes thirty (30) days past due (sixty (60) days from the date of invoice), at which point OFMQ may immediately terminate this Agreement upon written notice to Customer.

7. Warranty. OFMQ shall perform the Work by and through personnel possessing competency consistent with applicable industry standards. This is the sole warranty provided by OFMQ and all other warranties, whether express or implied, are excluded.

8. Indemnification. Customer shall indemnify, release, defend, and hold OFMQ (including, its owners, officers, employees, agents, and representatives) harmless from and against any and all claims, losses, damages, causes of action, and liabilities of every kind (including, without limitation, interest, attorneys' fees, expert witness fees, and all expenses of litigation) arising from special, punitive, indirect, incidental or consequential damages including, without limitation, loss of profit or business or revenue, costs and expenses resulting from business interruptions, or cost of or loss of use of property, equipment, materials and services, including without limitation those provided by contractors or subcontractors of every tier or by third parties, without regard to the fault or negligence of any party.

9. Force Majeure. Each party shall be excused from performing its obligations under this Agreement, except as to payment, if and only to the extent that performance is delayed or prevented by an event of force majeure. In the event either party's performance hereunder is affected by an event of force majeure, it shall promptly notify the other party of the same.

10. Customer. The term "Customer" shall also include any person or entity: (i) which is at any time the parent, subsidiary, or affiliate of Customer, by virtue of common (although not identical) ownership; or (ii) for which OFMQ is providing Work under this Agreement.

11. Assignment. Neither party may assign any of its rights or duties under this Agreement without the prior written consent of the other party.

12. Severability. If a court of competent jurisdiction rules that any provision in this Agreement is unenforceable, it will not affect the enforceability of the remaining provisions. Such a court may enforce all remaining provisions to the extent permitted by law.

13. Attorney Fees. In any action brought by a party to enforce this Agreement against the other party, the prevailing party shall be entitled to collect from the other party the prevailing party's reasonable attorney fees, court costs, and other expenses reasonably incurred in connection with such action.

14. Notices. All notices and communications required or permitted to be given hereunder shall be given by delivering the same in hand, by electronic mail, or by mailing the same by certified or registered mail, return receipt requested, postage prepaid, as follows:

If to Customer:

Customer Name: _____

Primary Contact: _____ Phone: _____

Email: _____ FAX: _____

Address: _____

City: _____ State: _____ Zip: _____

If to OFMQ:

Name: Oklahoma Foundation for Medical Quality

Primary Contact: _____ Phone: (405) 840-2891

Address: 515 Central Park Drive, Suite 101

City: Oklahoma City State: Oklahoma Zip: 73105

or such other address as either party furnishes to the other by like notice.

15. Cumulative Remedies. Each and all of the several rights and remedies provided for in this Agreement shall be cumulative. No one right or remedy shall be exclusive of the others or of any right or remedy allowed in law or in equity. No waiver or indulgence by either party of any failure by the other party to keep or perform any promise or condition of this Agreement shall be a waiver of any preceding or succeeding breach of the same or any other promise or condition. No waiver by either party of any right shall be construed as a waiver of any other right. Neither party shall be required to give notice to enforce strict adherence to all terms of this Agreement.

16. Entire Agreement. This Agreement constitutes the full, entire, integrated, and complete agreement of the parties respecting the subject matter addressed herein. No force or effect shall be given to prior written agreements between the parties or to representations, promises, agreements, or understandings, written or oral, not herein contained. This Agreement may not subsequently be amended or modified except by a writing signed by both parties hereto. This Agreement shall be binding upon, and inure to the benefit of, OFMQ and Customer and their respective heirs, representatives, successors and permitted assigns.

17. Governing Law. The validity, interpretation, enforceability, and performance of this Agreement must be governed by and construed in accordance with the laws of the State of Oklahoma, exclusive of its choice-of-law rules. Any action arising under or relating to this Agreement must be commenced and maintained in the federal or state courts as applicable in Oklahoma County, Oklahoma.

18. Counterparts. This Agreement may be signed in one or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

Authorization

IN WITNESS WHEREOF, the parties hereto have caused this Consulting Services Agreement to be executed and effective as of the day and year first above written.

"CUSTOMER" _____
Print Customer Name

By: _____
Signature Date

_____
Print Name and Title

"OFMQ" Oklahoma Foundation for Medical Quality (OFMQ), an Oklahoma not-for-profit corporation

By: _____
Authorized Signer Date

Wolters Kluwer Health, Inc.

Two Commerce Square
2001 Market Street
Philadelphia, PA 19103 USA
Tel: 844-303-4860
eFax: 301-560-5423
Federal ID # 13-2932696
ACH Routing: 071000039
Account: 5801001438

Quote # 600568
Date 29-Jan-2021
Page 1 of 2

Bill To:
Customer#: 124335
Mangum Regional Medical Center
Attention: Accounts Payable
1 Wickhersham Drive
Mangum, OK 73554
Phone #: 580-782-3353
Fax #:
Email: ap@mangumregional.org

Sold To:
Customer#: 124335
Mangum Regional Medical Center
Marie Harrington
1 Wickhersham Drive
Mangum, OK 73554
UNITED STATES
Phone #: 580-782-3353
Fax #:
Email: marie@cohesivehealthcare.net

Quote#: 600568

Product	Usage Level	Qty	Charges $	Total $
WKLP-CS-PHH Lippincott Procedures License Type: Site Authorized Sites: All Authorized Sites Listed Product Type: Subscription Start Date: 01-Mar-2021 End Date:01-Mar-2022	SITE	1	Price: 4,866.00	4,866.00

Sub-Total:	**$4,866.00**
Total S&H:	**$0.00**
Total Tax:	**$0.00**
Grand Total:	**$4,866.00**

REMITTANCE & PAYMENT METHODS: EFT and ACH are the preferred payment modes for Wolters Kluwer Health, Inc.
Payment by credit card may be subject to additional processing fees.
EFT Routing: 026009593 | ACH Routing: 071000039 | Account: 5801001438
ACH payment portal: https://portal.ovid.com/payments

Pay by Check: Wolters Kluwer Health. 4603 Paysphere Circle, Chicago, IL 60674

*Prices valid for 30 Days from Quote Date
*Plus Applicable Sales Tax: If tax exempt, please attach a copy of your state tax exempt certificate.

THE PAYMENT INSTRUCTIONS SET FORTH ON THIS QUOTE ARE THE ONLY INSTRUCTIONS AUTHORIZED BY WOLTERS KLUWER HEALTH, INC OR OVID TECHNOLOGIES, INC. OR ITS APPLICABLE AFFLIATE FOR USE. IF YOU RECEIVE ANY COMMUNICATIONS TRANSMITTING DIFFERENT PAYMENT INSTRUCTIONS OR REQUESTING OR REQUIRING ALTERNATE PAYMENT ARRANGEMENTS, DO NOT RESPOND TO SUCH COMMUNICATIONS, AND CONTACT SUPPORT IMMEDIATELY AT +1-844-303-4860.

Wolters Kluwer Health, Inc.

Two Commerce Square
2001 Market Street
Philadelphia, PA 19103 USA
Tel: 844-303-4860
eFax: 301-560-5423
Federal ID # 13-2932696
ACH Routing: 071000039
Account: 5801001438

Quote # 600568
Date 29-Jan-2021
Page 2 of 2

Authorized Sites:

Key	Institution / Site	Address
1	Mangum Regional Medical Center (#124335) / (#1)	1 Wickhersham Drive, Mangum, OK, UNITED STATES, 73554
2	Mangum Regional Medical Center (#124335) / Mangum Family Clinic (#2)	118 S Louis Tittle, Mangum, OK, UNITED STATES, 73554

By signing this quote, you represent and warrant that you are authorized to sign this quote and to bind the Customer set forth on this quote to the terms and conditions of this quote, and that the Customer is agreeing to pay to WKH the amount set forth on this quote.

Signature: _____ Date:_____

Printed Name: _____

REMITTANCE & PAYMENT METHODS: EFT and ACH are the preferred payment modes for Wolters Kluwer Health, Inc.
Payment by credit card may be subject to additional processing fees.
EFT Routing: 026009593 | ACH Routing: 071000039 | Account: 5801001438
ACH payment portal: https://portal.ovid.com/payments

Pay by Check: Wolters Kluwer Health. 4603 Paysphere Circle, Chicago, IL 60674

*Prices valid for 30 Days from Quote Date
*Plus Applicable Sales Tax: If tax exempt, please attach a copy of your state tax exempt certificate.

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WOLTERS KLUWER HEALTH, INC.

MASTER SUBSCRIPTION AGREEMENT

This Master Subscription Agreement (the "Agreement") is entered into as of January 29th, 2021 (the "Effective Date") by and between Wolters Kluwer Health, Inc. ("WKH") and Mangum Regional Medical Center ("Subscriber").

1. **Definitions**. For purposes of this Agreement, in addition to the terms defined elsewhere herein and in the applicable Order, the following capitalized terms have the definitions set forth below:

1.1. "Access Codes" means unique identification numbers that each allow one Authorized User to access the applicable Online Tools.

1.2. "Authorized Facilities" means the specific facilities at the geographic locations (by address) designated in the applicable Order.

1.3. "Authorized Users" means individual users of Subscriber who are authorized to access the Online Tools licensed hereunder in accordance with the following, as applicable based on Subscriber's entity type, which is specified in the applicable Order:

- Corporate Market: employees of Subscriber and independent contractors of Subscriber who are bound by a legal obligation to comply with the terms of this Agreement, solely to the extent such employees and independent contractors are accessing the Online Tools in accordance with the Permitted Use.
- Academic Institution: currently Enrolled Students, faculty, and staff, solely to the extent such Enrolled Students, faculty and staff are accessing the Online Tools in accordance with the Permitted Use.
- Medical Service Provider: Healthcare Professionals employed by Subscriber and independent contractors of Subscriber who are bound by a legal obligation to comply with the terms of this Agreement, solely to the extent such employees and independent contracts are accessing the Online Tools in accordance with the Permitted Use.

Any individuals users of institutions, associations or organizations (i) related or affiliated with Subscriber, or (ii) acquired by or merged with Subscriber during the term of this Agreement, will not be deemed "Authorized Users" without WKH's express written consent or unless expressly provided for in the applicable Order.

1.4. "Content" means the medical, nursing, drug information and other related content, including without limitation, any concepts, data, recommendations, instructions, alternatives, methods, techniques, procedures or other information supplied by WKH hereunder and made available through the Online Tools. Content may include Third Party Material.

1.5. "Enrolled Student" means a student enrolled in the applicable Academic Institution in the applicable academic year.

1.6. "Full-Time Equivalent (FTE)" means the following, as applicable based on Subscriber's entity type, which is specified in the applicable Order:

- Corporate Market: the full-time equivalent of the number of individuals employed by Subscriber and independent contractors who provide services for Subscriber, whether employed or contracted on a full-time or part-time basis.
- Medical Service Provider: the full-time equivalent of the number of Healthcare Professionals and other individuals employed by Subscriber and independent contractors who provide services for Subscriber, whether employed or contracted on a full-time or a part-time basis.

1.7. "Healthcare Professional" means any and all health care professionals, including without limitation, physicians, physician's assistants, nurses, registered nurses, nurse practitioners and other nursing professional and pharmacists.

1.8. "License Cap" means, if applicable and as set forth on the applicable Order, either (i) the maximum number of Authorized Users licensed to access the applicable Online Tools, or (ii) the maximum number of Access Codes that Subscriber is licensed to distribute to its Authorized Users for access to the applicable Online Tools.

1.9. "License Count" means, if applicable and as set forth on the applicable Order, the metric used to calculate the Subscription Fees, including, without limitation, Enrolled Students, Licensed Beds, FTEs, or Access Codes, as applicable.

1.10. "Licensed Beds" means patient beds that Subscriber is licensed (by an applicable governing authority) to operate at the Authorized Facilities (without regard to the number of beds actually located at the Authorized Facilities or available for patient care).

1.11. "License Fee" means the fees for the Online Tools, as specified in the applicable Order, including any Perpetual Access Fees and any Subscription Fees.

1.12. "LMS" means a learning management system licensed from a third party provider.

1.13. "Online Tools" means the Content, the online application software and platforms through which such Content is made available to Subscriber, and any related services, software, or other solutions provided by WKH, as set forth on the applicable Order. Online Tools do not include an LMS licensed from a third party provider.

1.14. "Order" means the order for licensing of the Online Tools that WKH and Subscriber may enter into hereunder from time to time.

1.15. "Permitted Use" means the purposes for which Subscriber's Authorized Users may use the Online Tools, which, unless otherwise specified in the applicable Order, will be as follows based on Subscriber's entity type, as specified in the applicable Order:

- Corporate Market: internal business purposes.
- Academic Institution: educational and research (i.e., non-commercial) purposes.
- Medical Service Provider: professional and related administrative work.

The term "Permitted Use" also includes any relevant terms and conditions applicable to Authorized Users included in the terms and conditions governing access to and use of the applicable platforms for the Online Tools.

1.16. "Perpetual Access Basis" means the license type for the applicable Online Tools designated in the Order as 'Perpetual Access,' if any, whereby Subscriber pays a Perpetual Access Fee to WKH and Subscriber is granted the right to have its Authorized Users access and use the applicable Online Tools on a perpetual basis in accordance with Section 2.2. Online Tools are only available on a Perpetual Access Basis if specifically so indicated on the applicable Order.

1.17. "Perpetual Access Fees" means the fees paid by Subscriber to WKH for access to the Online Tools licensed on a Perpetual Access Basis, based on the Subscriber's License Count, as set forth on the applicable Order.

1.18. "Subscription Basis" means the license type for the applicable Online Tools designated in the applicable Order as 'Subscription,' if any, whereby Subscriber pays a Subscription Fee to WKH and Subscriber is granted the right to have its Authorized Users access and use the applicable Online Tools for the duration of the Subscription Term in accordance with Section 2.1.

1.19. "Subscription Fee" means the fees paid by Subscriber to WKH for access to the Online Tools licensed on a Subscription Basis during the Subscription Term, based on the Subscriber's License Count as set forth on the applicable Order.

1.20. "Subscription Term" means one (1) year from the date of initial access to the Online Tools, unless otherwise specified in the applicable Order.

1.21. "Third Party Material" means any content and software supplied or licensed to WKH by third parties and made available as part of the Online Tools. Third Party Material does not include an LMS licensed from a third party provider.

2. **License and Access to the Online Tools**.

2.1. Subscription License. For Online Tools to be licensed to Subscriber on a Subscription Basis as set forth in the applicable Order, WKH grants to Subscriber, in conjunction with such Order, the non-transferable, nonexclusive, limited license to allow its Authorized Users (subject to the License Cap, if any) to access and use the Online Tools during the applicable Subscription Term, in accordance with Section 2.3, for the Permitted Use, subject to the terms and conditions of this Agreement.

2.2. Perpetual Access License. For Online Tools to be licensed to Subscriber on a Perpetual Access Basis as set forth in the applicable Order, WKH grants to Subscriber, in conjunction with such Order, the non-transferable (except as set forth herein), nonexclusive, limited, perpetual (except as set forth herein) license to allow its Authorized Users (subject to the

License Cap, if any) to access and use the Online Tools, in accordance with Section 2.3, for the Permitted Use, subject to the terms and conditions of this Agreement.

2.3. Access to and Use of the Online Tools. Except as set forth herein or in the applicable Order, access to and use of the Online Tools is permitted only through the method(s) and/or platform(s) identified on the Order.

2.3.1. If Subscriber will access and use the Online Tools through an LMS, then such access and use shall also be governed by the terms of Exhibit 1 attached hereto.

2.3.2. Subscriber agrees that the Access Codes, passwords or other authentication method(s) are valid and may be used only in the countries identified on the Order.

2.3.3. In order for WKH to make access available through Internet Protocol address validation, Subscriber must first provide the technical and other information required on the applicable Order. For Online Tools access through Internet Protocol address verification, Subscriber and its Authorized Users will be permitted to access and use such Online Tools solely from the Authorized Facilities. Notwithstanding the foregoing, for certain Online Tools, as specified in the applicable Order, Subscriber may elect to use proxy servers to allow Authorized Users to access the Online Tools remotely through the Authorized Facilities. If Subscriber elects to provide such remote access, Subscriber will strictly limit such access only to Authorized Users and in accordance with the License Cap, if any, through a secure method of user verification.

2.3.4. Subscriber will immediately notify WKH if it believes unauthorized access has occurred and take reasonable steps to block future unauthorized access.

2.4. Availability. WKH will use commercially reasonable efforts to provide access to the Online Tools on a 24 x 7 basis, subject to (i) downtime for maintenance (both scheduled and unscheduled); (ii) problems affecting WKH's connection to the Internet; (iii) general connectivity issues; and (iv) issues associated with access to or use of the Online Tools through an LMS. In addition, as a consequence of factors affecting the availability and/or transmission of the Online Tools that are beyond WKH's control, WKH will not guarantee performance of the Online Tools through the Internet, other transmission modes, or an LMS.

2.5. Third Party Material. Additional terms and conditions may apply to Subscriber's use of Third Party Material. Such additional terms and conditions, if any, shall be made available to Subscriber. In the event of changes in the terms applicable to such material, WKH reserves the right to terminate access to such material, remove such material from the Online Tools, modify the Third Party Material accessible hereunder, or add additional terms and conditions applicable to such material, in each case effective immediately upon notice being made reasonably available to Subscriber. In the event of any conflict between the terms hereof and the terms governing the Third Party Material, the terms governing the Third Party Material shall control. WKH grants no right or license to Subscriber to access or use any Third Party Material through an LMS and makes no representation or warranty to Subscriber that Subscriber has any right to access or use any Third Party Material through an LMS.

2.6. Updates and Discontinuation. WKH may update, modify or replace the Online Tools, including any Content available therein, from time to time. WKH reserves the right to discontinue offering access to an Online Tool, or a portion thereof, through any or all platforms at any time for any reason. WKH will use commercially reasonable efforts to provide at least thirty (30) days' notice of any such discontinuation. In the event that WKH elects to discontinue offering such access to an entire Online Tool, (i) for Online Tools licensed on a Subscription Basis, the unused prorated portion of any Subscription Fees applicable to such Online Tool will be refunded to Subscriber; and (ii) for Online Tools licensed on a Perpetual Access Basis, WKH will provide Subscriber, upon request, with an electronic copy of the applicable Content subject to Subscriber's payment of a media, fulfillment and/or delivery fee and Subscriber's execution of an additional agreement. If Subscriber is permitted to access and use the Online Tools through an LMS, Subscriber shall be solely responsible for complying with the terms of Exhibit 1 relating to updating and/or discontinuation of Content.

3. **Proprietary Rights and Use Restrictions**.

3.1. Proprietary Rights. No provision of this Agreement conveys any ownership interest to Subscriber in or to any of the Online Tools or any Content therein, in whole or in part, and, except for the express licenses herein, all intellectual property rights, including copyright, patent, trademark and trade secret, are retained by WKH, its affiliates and/or licensors of Third Party Material, all rights reserved.

3.2. Additional Terms. Access to and/or use of the Online Tools by Subscriber's Authorized Users may be subject to and require acceptance by each Authorized User of additional terms and conditions, including (i) terms and conditions governing access to and use of the applicable platforms, and (ii) terms and conditions governing use of any Third Party Material that may be incorporated into the Online Tools, as made available by WKH from time to time, in electronic or print form.

3.3. Enforcement of Rights. Subscriber hereby grants to WKH, its affiliates and/or licensors the right to enforce or assert on their own behalf the provisions of this Agreement.

3.4. Responsibility for Authorized Users.

3.4.1. Subscriber shall control access to the Online Tools so as to limit access solely to its Authorized Users and in accordance with the License Cap, if any. In no event shall Subscriber provide access to any unauthorized users or to any Authorized Users in violation of an applicable License Cap.

3.4.2. Subscriber shall be responsible for (i) all uses of the Online Tools by Authorized Users in accordance with (a) the terms hereof, (b) the terms of access and use for the platforms as set forth in the terms and conditions available online in conjunction with the Online Tools, (c) where applicable, the terms and conditions in Exhibit 1 for use of the Online Tools through an LMS, and (d) any and all other terms, conditions, and restrictions provided by WKH, from time to time; and (ii) the confidentiality and security of the Access Codes, passwords or other authentication issued to Subscriber by WKH, if any.

3.4.3. Subscriber shall ensure that all Authorized Users are aware of the limitations and restrictions on the use of the Online Tools.

3.4.4. Subscriber shall report any breach of this Agreement to WKH promptly (but in no event later than five (5) business days) after becoming aware of the facts or circumstances constituting such breach. Subscriber agrees to promptly notify WKH of, and to provide full cooperation and assistance to WKH with any investigation of, any Authorized User's potential violation of the terms, conditions, or restrictions referenced herein.

3.4.5. Subscriber shall indemnify WKH, its officers, directors, employees, contractors and agents for all liability resulting from (i) use of the Online Tools by Authorized Users other than in accordance with terms, conditions, or restrictions set forth in this Agreement; or (ii) use of the Online Tools by users other than Subscriber's Authorized Users as a result of Subscriber's failure to maintain the confidentiality or security of Access Codes, passwords or other authentication in accordance with this Agreement; provided however, that Subscriber will not be required to indemnify WKH for any charges against any Access Codes, passwords or other authentication that are lost or stolen if Subscriber has provided WKH with prompt notice to such effect.

3.5. Restrictions on Use. Subscriber shall not, and shall ensure that its Authorized Users shall not (i) use, or permit the use of the Online Tools except in accordance with the terms of this Agreement; (ii) download or print in whole or in substantial part the Online Tools; (iii) modify, translate, reverse engineer, decompile, disassemble, create derivative works of, or otherwise attempt to derive or alter any source code of the Online Tools or any underlying software; (iv) copy or permit the copying of the Online Tools, other than copying in accordance with the Permitted Use; (v) use the Online Tools to provide service bureau, time sharing, or similar services to third parties; (vi) distribute, sublicense, sell, assign, transfer, rent, lease, pledge, or encumber the Online Tools; (vii) permit access to the Online Tools to any person except for Authorized Users; or (viii) alter, remove, or otherwise hinder the delivery of any copyright, disclaimer, or other proprietary notice appearing in the Online Tools. Redistribution of the Online Tools for any purpose is strictly prohibited.

4. **Term**.

4.1. The term of this Agreement will commence as of the Effective Date and continues in effect, unless earlier terminated as provided for below, while any Order hereunder remains in effect. If no Order hereunder is in effect, either party may terminate this Agreement upon thirty (30) days' prior written notice to the other.

4.2. Subject to earlier termination in accordance with Section 5, (i) with respect to any Online Tools licensed on a Perpetual Access Basis hereunder, the applicable Order shall remain in effect in perpetuity, and (ii) with respect to any Online Tools licensed on a Subscription Basis hereunder, the applicable Order shall remain in effect during the Subscription Term.

5. **Termination**.

5.1. Termination for Material Breach. Either party (the "Non-Breaching Party") shall have the right to terminate this Agreement and/or any Order by written notice to other party (the "Breaching Party") if the Breaching Party materially breaches any term of this Agreement and such breach or default is not cured to the Non-Breaching Party's reasonable satisfaction within ten (10) business days of such notice; provided, that the Non-Breaching Party shall have the right to immediately terminate this Agreement and/or any Order in the event of any breach by the Breaching Party that cannot be cured within such ten (10) business day cure period.

5.2. Termination for Non-Payment; Enforcement Costs. If any payment due from Subscriber hereunder is not paid in full when due, WKH shall have the right to terminate this Agreement and/or any Order upon ten (10) business days' written notice to Subscriber. Subscriber agrees to pay all costs and expenses incurred by WKH, including costs of collection and attorneys' fees, as a result of enforcing the terms of this Agreement.

5.3. Effect of Expiration or Termination. Upon expiration or termination of any Order for any reason, all rights granted to Subscriber hereunder or under the applicable Order shall terminate, and WKH shall have the right to deny or block all access to the applicable the Online Tools and to invalidate any Access Codes, passwords, Internet Protocol address validation, or other authentication method. Upon expiration or termination of any Order for any reason, Subscriber shall immediately cease all use of the applicable the Online Tools, take such steps as are necessary to prohibit further use of the applicable the Online Tools by Authorized Users, and furnish a written description of the steps taken if requested by WKH.

5.4. Survival. The obligations and rights of the parties pursuant to Articles 1, 3, 6, 7, 8, 9, 10, and 11 and Sections 5.3, and 5.4 hereof, Exhibit 1 (where applicable), and any other provisions that by their nature should survive the termination or expiration of this Agreement shall survive the termination or expiration of this Agreement.

6. **Fees**.

6.1. Subscription Fees. With respect to Online Tools licensed on a Subscription Basis, Subscriber shall pay the Subscription Fee specified in the Order at the beginning of the Subscription Term, in advance, within thirty (30) days of receipt of WKH's (or its authorized agent's) invoice. WKH may adjust the Subscription Fee applicable to any Subscription Term by giving notice thereof at least sixty (60) days before renewal of the Subscription Term.

6.2. Perpetual Access Fees. With respect to Online Tools licensed on a Perpetual Access Basis, Subscriber shall pay the Perpetual Access Fees specified in the Order within thirty (30) days of receipt of WKH's (or its authorized agent's) invoice.

6.3. Adjustment for Changes. No later than thirty (30) days following any changes with respect to the information contained in the applicable Order, Subscriber shall update the information contained in the applicable Order by notice of such changes to WKH, including, without limitation, any changes to the applicable License Count (i.e. FTEs, Enrolled Students, or Licensed Beds), or any additional facilities acquired that should be listed as Authorized Facilities. In the event that the total License Count at such date differs from the number specified in the Order, the Subscription Fees shall be adjusted, in accordance with WKH's then-current pricing. In the event that Subscriber fails to provide such updated information, WKH reserves the right to charge Subscriber additional fees to cover any period of underpayment by Subscriber.

6.4. Late Payments. If any amounts owed by Subscriber hereunder are not paid when due, WKH (or its authorized agent) may charge interest at a rate of the lesser of one and one half percent (1.5%) per month or the highest rate permissible under law and may terminate access to the relevant Online Tools until such payment is made in full by Subscriber.

6.5. Taxes. Unless Subscriber provides proof of tax-exempt status (e.g., a written exemption certificate), Subscriber shall pay all sales, use, value-added and similar taxes assessed upon the license and other transactions hereunder, excluding taxes based on WKH's net income. If Subscriber is tax-exempt, Subscriber shall provide its tax-exempt certificate to WKH upon execution of this Agreement and/or an applicable Order hereunder.

7. **Limited Warranties**.

7.1. THE ONLINE TOOLS, INCLUDING ANY CONTENT THEREIN, OR ANY SERVICES PROVIDED IN CONNECTION THEREWITH, ARE FURNISHED BY WKH, ITS AFFILIATES AND LICENSORS AND ACCEPTED BY SUBSCRIBER "AS IS" AND WITHOUT ANY WARRANTY WHATSOEVER. WKH, ITS AFFILIATES AND LICENSORS MAKE NO REPRESENTATIONS OR WARRANTIES WITH RESPECT TO THE ONLINE TOOLS, INCLUDING ANY CONTENT THEREIN, OR ANY SERVICES PROVIDED IN CONNECTION THEREWITH, AND DISCLAIM ALL REPRESENTATIONS AND WARRANTIES OF ANY KIND OR NATURE, EXPRESS OR IMPLIED, ARISING OUT OF OR RELATED TO THIS AGREEMENT, THE ONLINE TOOLS, THE CONTENT, OR THE

RESULTS DERIVED THEREFROM, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES REGARDING ACCURACY, QUALITY, CORRECTNESS, COMPLETENESS, COMPREHENSIVENESS, CURRENCY, SUITABILITY, SYSTEM AVAILABILITY, COMPATIBILITY, MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE, OR NON-INFRINGEMENT (IRRESPECTIVE OF ANY COURSE OF DEALING, CUSTOM OR USAGE OF TRADE).

7.2. WKH, ITS AFFILIATES AND LICENSORS MAKE NO REPRESENTATIONS OR WARRANTIES WITH RESPECT TO ONLINE TOOLS OR CONTENT THAT ARE MODIFIED OR ALTERED BY SUBSCRIBER, AUTHORIZED USERS, OR ANY THIRD PARTY, OR (II) AVAILABILITY OF, ACCESS TO OR USE OF ONLINE TOOLS OR CONTENT THROUGH A THIRD PARTY PLATFORM OR SERVER.

7.3. NO WKH EMPLOYEE OR AGENT IS AUTHORIZED TO MAKE ANY STATEMENT THAT ADDS TO OR AMENDS THE WARRANTIES OR LIMITATIONS CONTAINED IN THIS AGREEMENT.

7.4. SUBSCRIBER ACKNOWLEDGES THAT ACCESS TO THE ONLINE TOOLS, AND THE CONTENT THEREIN MAY BE SUBJECT TO LIMITATIONS, DELAYS, LATENCY ISSUES AND OTHER PROBLEMS INHERENT IN THE USE OF THE INTERNET AND ELECTRONIC COMMUNICATIONS, AND THAT WKH IS NOT RESPONSIBLE FOR ANY DELAYS, DELIVERY FAILURES, OR OTHER DAMAGE RESULTING FROM SUCH PROBLEMS.

7.5. THE ONLINE TOOLS (INCLUDING THE CONTENT THEREIN) ARE NO SUBSTITUTE FOR INDIVIDUAL PATIENT ASSESSMENT BASED UPON THE SUBSCRIBERS' HEALTHCARE PROFESSIONALS' EXAMINATION OF AND JUDGMENT REGARDING EACH PATIENT AND CONSIDERATION OF, AMONG OTHER THINGS, AGE, WEIGHT, GENDER, CURRENT OR PRIOR MEDICAL CONDITIONS, MEDICATION HISTORY, LABORATORY DATA AND OTHER FACTORS UNIQUE TO THE PATIENT. WHILE THE ONLINE TOOLS MAY DESCRIBE VARIOUS BASIC PRINCIPLES OF DIAGNOSIS AND THERAPY, THE ONLINE TOOLS SHOULD BE USED AS GENERAL MEDICAL REFERENCE MATERIALS TO ASSIST THE HEALTHCARE PROFESSIONAL TO REACH DIAGNOSTIC AND TREATMENT DECISIONS, BEARING IN MIND THAT INDIVIDUAL AND UNIQUE CIRCUMSTANCES MAY LEAD THE SUBSCRIBER (AND ITS HEALTHCARE PROFESSIONALS) TO REACH DECISIONS NOT REPRESENTED IN THE ONLINE TOOLS. SUBSCRIBER (AND ITS HEALTHCARE PROFESSIONALS) SHOULD EXERCISE THEIR OWN INDEPENDENT PROFESSIONAL AND CLINICAL JUDGMENT, TAKING INTO ACCOUNT SPECIFIC INFORMATION ABOUT PARTICULAR INDIVIDUAL PATIENTS THAT CANNOT BE ASCERTAINED OR TAKEN INTO ACCOUNT AS A PART OF NECESSARILY GENERIC OR SUMMARY ONLINE TOOLS. NO REFERENCED OR SUGGESTED TEST, PROCEDURE OR RESPONSIVE ACTION SHOULD BE DIRECTED OR UNDERTAKEN UNLESS, IN THE SUBSCRIBER'S (AND ITS HEALTHCARE PROFESSIONALS') PROFESSIONAL JUDGMENT, ITS USE IS MEDICALLY APPROPRIATE FOR THE INDIVIDUAL PATIENT IN THE PARTICULAR CIRCUMSTANCES. SUBSCRIBER AND ITS HEALTHCARE PROFESSIONALS ARE SOLELY RESPONSIBLE FOR THE USE OF ANY CONTENT CONTAINED IN THE ONLINE TOOLS, AND SUBSCRIBER'S HEALTHCARE PROFESSIONALS ARE RESPONSIBLE FOR INDEPENDENTLY REACHING ANY MEDICAL JUDGMENT AND FOR ANY RESULTING DIAGNOSIS AND TREATMENTS, NOTWITHSTANDING ANY USE OF THE ONLINE TOOLS OR THE CONTENT CONTAINED THEREIN BY SUCH HEALTHCARE PROFESSIONAL.

7.6. GIVEN CONTINUOUS, RAPID ADVANCES IN MEDICAL SCIENCE AND HEALTH INFORMATION, INDEPENDENT PROFESSIONAL VERIFICATION OF MEDICAL DIAGNOSES, INDICATIONS, APPROPRIATE PHARMACEUTICAL SELECTIONS AND DOSAGES, AND TREATMENT OPTIONS SHOULD BE MADE BY SUBSCRIBER AND ITS HEALTHCARE PROFESSIONALS. SUBSCRIBER AND ITS HEALTHCARE PROFESSIONALS SHOULD CONSULT A VARIETY OF SOURCES. WHEN PRESCRIBING MEDICATION, INCLUDING SPECIFICALLY THE MEDICATION MANUFACTURER'S PRODUCT INFORMATION SHEET ("PACKAGE INSERT") TO VERIFY, AMONG OTHER THINGS, CONDITIONS OF USE, WARNINGS AND SIDE EFFECTS AND IDENTIFY ANY CHANGES IN DOSAGE SCHEDULE OR CONTRAINDICATIONS, PARTICULARLY IF THE MEDICATION TO BE ADMINISTERED IS NEW, INFREQUENTLY USED OR HAS A NARROW THERAPEUTIC RANGE.

8. **Limitation of Liability**.

8.1. IN NO EVENT SHALL WKH, ITS AFFILIATES, OR LICENSORS, OR ANY OF ITS OR THEIR RESPECTIVE DIRECTORS, OFFICERS, EMPLOYEES, OR AGENTS, BE LIABLE TO SUBSCRIBER, ITS AUTHORIZED USERS OR ANY THIRD PARTY WHOSE CLAIM IS RELATED TO THIS AGREEMENT, UNDER ANY THEORY OF TORT, CONTRACT, STRICT LIABILITY OR OTHER LEGAL OR EQUITABLE THEORY, FOR (A) LOST PROFITS, LOST

REVENUES, LOST BUSINESS OPPORTUNITIES OR EXEMPLARY, PUNITIVE, SPECIAL, INCIDENTAL, INDIRECT, CONSEQUENTIAL OR SIMILAR DAMAGES, EACH OF WHICH IS HEREBY EXCLUDED BY AGREEMENT OF THE PARTIES, REGARDLESS OF WHETHER SUCH DAMAGES WERE FORESEEABLE OR WHETHER THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES; OR (B) ANY CLAIMS, DAMAGES OR COSTS OF ANY NATURE IN EXCESS OF THE LICENSE FEES UNDER AN APPLICABLE ORDER PAID BY SUBSCRIBER TO WKH DURING THE TWELVE MONTHS PRECEDING THE EARLIEST EVENT GIVING RISE TO SUCH LIABILITY UNDER AN APPLICABLE ORDER.

8.2. WKH ASSUMES NO RESPONSIBILITY OR LIABILITY RESULTING FROM (I) ANY MODIFICATION OF OR ALTERATION TO ANY ONLINE TOOLS OR CONTENT BY SUBSCRIBER, AUTHORIZED USERS, OR ANY THIRD PARTY, (II) ANY DISABLING OR IMPEDING OF ACCESS TO ANY ONLINE TOOLS OR CONTENT CAUSED BY A THIRD PARTY, OR (III) USE OF ANY ONLINE TOOLS OR CONTENT UPLOADED TO OR ACCESSED THROUGH A THIRD PARTY PLATFORM OR SERVER.

8.3. TO THE MAXIMUM EXTENT PERMITTED UNDER APPLICABLE LAW, WKH ASSUMES NO RESPONSIBILITY OR LIABILITY FOR ANY INJURY AND/OR DAMAGE TO SUBSCRIBER'S, AUTHORIZED USERS' OR ANY THIRD PARTY'S PERSONS OR PROPERTY, AS A MATTER OF PRODUCTS LIABILITY, NEGLIGENCE LAW OR OTHERWISE, OR FROM ANY REFERENCE TO OR USE BY SUBSCRIBER (OR ANY OF ITS HEALTHCARE PROFESSIONAL) OF ANY OF THE ONLINE TOOLS.

8.4. SUBSCRIBER ACKNOWLEDGES THAT THE LIMITATIONS OF LIABILITY AND THE DISCLAIMERS SET FORTH IN THIS AGREEMENT ARE AN ESSENTIAL ELEMENT TO MAKING THE ONLINE TOOLS AVAILABLE UNDER THE TERMS OF THIS AGREEMENT, AND THEREFORE THE LIMITATIONS OF LIABILITY AND THE DISCLAIMERS SET FORTH IN THIS AGREEMENT WILL SURVIVE AND APPLY EVEN IF SUCH REMEDIES ARE FOUND TO HAVE FAILED OF THEIR ESSENTIAL PURPOSE.

9. **Indemnification**.

9.1. WKH Indemnification. WKH shall indemnify and hold harmless Subscriber and its officers, directors, employees, contractors and agents, from and against any final judgment of liability resulting from any third party claim that the Online Tools (excluding any Third Party Material) infringe upon, violate or misappropriate any third party proprietary U.S. copyright rights, in consequence of the authorized use or possession of the Online Tools, unless such claim arises from and to the extent of (i) the combination or use of the Online Tools, the Content therein, or results derived therefrom with any software, data, information or materials not furnished by WKH; (ii) the use of the Online Tools, the Content therein, or results derived therefrom other than as permitted hereunder; (iii) any modifications to the Online Tools, the Content therein, or results derived therefrom by any individual or entity other than WKH; (iv) any disabling or impeding of access to any Online Tools or Content caused by a party other than WKH; or (v) access to or the use of any Online Tools or Content uploaded or otherwise accessed through a third party platform or server. If the Online Tools become or, in WKH's opinion, may become, the subject of any claim of infringement, then WKH may, in its sole discretion and at its expense, (i) procure the right for Subscriber to continue using the Online Tools; (ii) modify the Online Tools to render them non-infringing; or (iii) replace the Online Tools with reasonably equivalent non-infringing Online Tools, as applicable. If none of the foregoing is commercially practicable, either party may terminate this Agreement, in which case WKH will refund to Subscriber any prepaid License Fees (which in the case of Subscription Fees, will be prorated based on the number of full months remaining in the Subscription Term as of such termination). THIS SECTION 9.1 SETS FORTH WKH'S ENTIRE LIABILITY, AND SUBSCRIBER'S SOLE AND EXCLUSIVE REMEDY, WITH RESPECT TO ANY INFRINGEMENT CLAIMS RELATING TO THE ONLINE TOOLS.

9.2. Subscriber Indemnification. Except with respect to third party claims for which Subscriber is entitled to indemnification pursuant to Section 9.1, Subscriber shall defend, indemnify and hold harmless WKH and its affiliates and their respective officers, directors, employees, contractors and agents ("WKH Indemnified Parties"), from and against all claims, damages, liabilities, and expenses (including reasonable attorneys' fees and court costs) arising out of, connected with, or resulting in any way from third party claims against the WKH Indemnified Parties based on Subscriber's or any Subscriber user's (including any Authorized User's) use or modification of the Online Tools.

9.3. Indemnification Procedures. In the event of a claim subject to indemnification hereunder (a "Claim"), the party entitled to indemnification (the "Indemnified Party") shall provide written notice to the party obligated to provide indemnification hereunder (the "Indemnifying Party") in a timely manner. The Indemnifying Party shall have the right, at its expense, to employ counsel reasonably acceptable to the Indemnified Party to defend the Claim, and to compromise, settle or otherwise dispose of the Claim; provided, however, that no compromise or settlement of any Claim admitting liability of or imposing duties or restrictions upon the Indemnified Party may be effected without the prior written consent of the

Indemnified Party. The Indemnified Party will cooperate in such action by making available to the Indemnifying Party, at the Indemnifying Party's expense, records reasonably necessary for the defense of the Claim. If the Indemnifying Party does not avail itself of the opportunity to defend or otherwise dispose of the Claim within thirty (30) days after receipt of notice thereof (or such shorter time as may be specified in the notice if the circumstances so dictate), the Indemnified Party may investigate, defend, settle or otherwise dispose of the Claim.

10. **Confidentiality**.

10.1. Confidentiality of the Online Tools. Subscriber acknowledges that the terms of this Agreement, the Online Tools, the Content therein, and the associated platforms are the proprietary property of WKH, its affiliates and its licensors, and that the terms of this Agreement, the processes and methodology used in producing the Online Tools, the Content therein and the associated platforms are valuable trade secrets. Subscriber shall protect the confidentiality thereof with at least the same level of efforts that it employs to protect the confidentiality of its own proprietary and confidential information of like importance and in any event, by reasonable means. Subscriber shall not disclose the terms of this Agreement, except as required by law. In the event that Subscriber is compelled by valid legal process to disclose the terms this Agreement to any third party, Subscriber will provide WKH with prompt notice of such legal process and will, if requested by WKH, take reasonable steps to give WKH the opportunity to contest such legal process and/or disclosure before disclosing such information.

10.2. Injunctive Relief. Subscriber acknowledges that any breach of any provision of this Article will cause immediate and irreparable injury to WKH, and in the event of such breach, WKH shall be entitled to seek injunctive relief in addition to any and all other remedies available at law or in equity without the necessity of proving actual damages or the posting of a bond.

11. **General Provisions**.

11.1. Amendments. Except as otherwise expressly provided herein, this Agreement may not be modified, amended, or in any way altered except by a written agreement signed by the parties hereto that states it is an amendment to this Agreement.

11.2. Assignment. Subscriber shall not assign this Agreement, nor delegate any of its duties, in whole or in part, without the prior written consent of WKH. In no event shall WKH's consent be construed as discharging or releasing Subscriber in any way from the performance of its obligations under this Agreement. WKH may freely assign this Agreement to any affiliate or successor of WKH or in connection with any sale transaction or change of control transaction involving any of the Online Tools and may delegate its duties, in whole or in part, in each case without any consent of Subscriber. An assignee of either party authorized hereunder shall be bound by the terms of this Agreement and shall have all of the rights and obligations of the assigning party set forth in this Agreement. If any assignee refuses to be bound by all of the terms and obligations of this Agreement or if any assignment is made in breach of the terms of this Agreement, then such assignment shall be null and void and of no force or effect.

11.3. Compliance with Laws. Subscriber shall comply with all applicable federal, state or provincial, and local laws, rules, and regulations in conjunction with its performance pursuant to this Agreement.

11.4. No Competitive Online Tools. Notwithstanding anything herein to the contrary, under no circumstances shall Subscriber use the Online Tools or information contained therein or results derived therefrom to develop any products or services that could be competitive with the Online Tools or any other products or services provided by WKH or its affiliates.

11.5. Public Disclosures. Neither party will make any press release, public statement or other disclosure regarding the terms of this Agreement without the prior written consent of the other party, which consent will not be unreasonably withheld. Notwithstanding the foregoing, WKH will have the right to issue public statements pertaining to the existence of the business relationship between WKH and Subscriber, including the right to limited use of Subscriber's name, logo and other reasonable non-confidential information in press releases, web pages, advertisements, and other marketing materials. WKH will not claim Subscriber's endorsement of WKH's Online Tools or services without Subscriber's prior written consent.

11.6. Audit. During normal business hours, at its own cost, WKH or its designated representative may audit and review Subscriber's compliance with the terms of this Agreement. Any such review shall be conducted so as not to unreasonably interfere with Subscriber's business, and Subscriber shall provide access to its facilities and provide personnel to answer WKH's inquiries.

11.7. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same document. Facsimile or Portable Document Format (PDF) signatures shall be deemed originals for purposes of the execution of this Agreement.

11.8. Entire Agreement. This Agreement, together with all Orders and any other document expressly referenced herein, constitutes the complete and exclusive statement of the agreement of the parties with respect to the subject matter hereof and supersedes all prior proposals, understandings, and agreements, whether oral or written, between the parties with respect to the subject matter hereof. Subscriber acknowledges that there were no representations or promises made by WKH on which Subscriber has relied in entering into this Agreement that are not expressly stated herein. In the event Subscriber submits work orders, change orders, invoices or other similar documents for accounting or administrative purposes or otherwise, no pre-printed or similar terms and conditions contained in any such form shall be deemed to supersede any of the terms and conditions herein.

11.9. Force Majeure. Neither party shall be liable for any failure or delay in performing its obligations under this Agreement, or for any loss or damage resulting therefrom, due to acts of God, the public enemy, terrorist activities, riots, fires, and other causes beyond such party's control.

11.10. Governing Law. This Agreement shall be governed by and interpreted in accordance with the laws of the United States and the State of New York, without giving effect to the conflicts of law provisions thereof and excluding the United Nations Convention on Contracts for the International Sale of Goods.

11.11. Dispute Resolution Method and Venue. The parties agree that any dispute arising hereunder shall be submitted for dispute resolution in the method and venue determined by Subscriber's principal place of business, as specified in the applicable Order, as follows: in the United States, disputes shall be submitted to a state or federal court sitting in New York, New York, U.S.A.; in Canada, disputes shall be submitted to the federal and provincial courts sitting in Toronto, Ontario; in the Americas, except Canada and the United States, disputes shall be submitted to arbitration in New York, New York, U.S.A., under the rules of the American Arbitration Association; in Europe, the Middle East and Africa: disputes shall be submitted to arbitration in London, England, under the Arbitration Rules of the London Court of International Arbitration; in Asia Pacific: disputes shall be submitted to arbitration in Sydney, (NSW) Australia, under the rules of the Australian Commercial Disputes Centre Ltd. Nothing herein shall be deemed to limit or otherwise affect either party's right to seek immediate equitable (including injunctive) relief for alleged violations of the party's intellectual property rights or interests.

11.12. Arbitration Procedures. The parties agree that the following procedures shall apply to any disputes under this Agreement that are submitted to arbitration. Arbitration shall be conducted before a single arbitrator selected in accordance with the applicable arbitration rules, unless the amount in dispute exceeds the equivalent of US$250,000. If the amount in dispute exceeds the equivalent of US$250,000, it shall be decided by three arbitrators, one to be selected by each party and the two party-appointed arbitrators to agree upon the third. The arbitrators must have experience with and knowledge of the licensing of software, and have been admitted to the practice of law for at least ten years. Under no circumstances are the arbitrators authorized to award damages contrary to Section 8 of this Agreement. The arbitrators shall be authorized to award costs and attorney's fees or to allocate them between the parties. Any court with jurisdiction shall enforce the agreement of the parties to arbitrate their disputes and enter judgment on any award.

11.13. Jury Trial Waiver**. EACH PARTY HEREBY WAIVES ITS RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY DISPUTE OR LEGAL PROCEEDING ARISING OUT OF THIS AGREEMENT OR THE SUBJECT MATTER HEREOF.**

11.14. Information Collected. WKH may collect information regarding queries submitted through the Online Tools, Content reviewed, and other uses of the Online Tools by Authorized Users. WKH shall own (and Subscriber hereby assigns to WKH) such information and may use it in any manner it chooses, including to improve its Online Tools and to offer customizations to Content delivered to Authorized Users. WKH may share any such information collected with its affiliates and licensors.

11.15. Notice. Any notice or other document or communication required or permitted hereunder to the parties hereto shall be deemed to have been duly given only if in writing and delivered by any of the following methods: (a) certified U.S. mail, return receipt requested, postage prepaid, to Wolters Kluwer Health, Inc. at Two Commerce Square, 2001 Market Street, Philadelphia, PA 19103, with a copy to Wolters Kluwer Health, Inc., 333 7th Avenue, New York, NY 10001, Attn: General Counsel, or to Subscriber at the address set forth in the Order, or such other address as the parties may dictate according to the notice provisions hereof; or (b) overnight delivery service at such addresses. Notices shall be deemed delivered pursuant to clause (a) three (3) days after deposit in the U.S. mail and upon receipt pursuant to clause (b).

11.16. Severability. If any provision of this Agreement or its application to particular circumstances is determined by a court of competent jurisdiction to be invalid or unenforceable, that provision (or its application to those circumstances) shall be deemed stricken and the remainder of this Agreement (and the application of that provision to other circumstances) shall continue in full force and effect insofar as it remains a workable instrument to accomplish the intent and purposes of the

parties; the parties shall replace the severed provision with the provision that will come closest to reflecting the intention of the parties underlying the severed provision but that will be valid, legal, and enforceable.

11.17. Third Party Rights Excluded. This Agreement is an agreement between the parties, and, except as may be provided in Section 3.3, confers no rights upon (i) any of the parties' respective employees, agents, or contractors, (ii) any third party, including without limitation, any person that is treated by Subscriber's Healthcare Professionals, or (iii) any other person or entitiy.

11.18. Waivers. No purported waiver by any party of any default by any other party of any term or provision contained herein (whether by omission, delay or otherwise) shall be deemed to be a waiver of such term or provision unless the waiver is in writing and signed by the waiving party. No such waiver shall in any event be deemed a waiver of any subsequent default under the same or any other term or provision contained herein.

IN WITNESS WHEREOF, the duly authorized representatives of the parties have executed this Agreement as of the Effective Date.

MANGUM REGIONAL MEDICAL CENTER	**WOLTERS KLUWER HEALTH, INC.**
_____	_____
By: _____	By: _____
Its: _____	Its: _____
Date: _____	Date: _____

Wolters Kluwer Health

EXHIBIT 1
ACCESS TO AND USE OF THE ONLINE TOOLS THROUGH AN LMS

1. **General Requirements.** In order for Subscriber to access and use the Online Tools and Content through an LMS, Subscriber must: (i) have a current and valid license to use the LMS from a third party provider; (ii) perform initial implementation procedures that either provide links in the LMS to the Online Tools and Content (generally applicable to course Content) or upload Content to the LMS (generally applicable to test Content); and (iii) perform periodic review and maintenance to ensure that Online Tools and Content are accessible through the LMS. WKH recommends that Subscriber include in any license agreement with an LMS provider, terms that ensure the LMS provider will not block or impede access to and use of third party content, provided that Subscriber has the right or license to use the content, and at the time the license is signed, the content is compatible the LMS and not disruptive to the LMS provider's system. Subscriber is responsible for obtaining the information necessary to access and use the Online Tools and Content through an LMS. Such information is generally available through the LMS documentation or from publicly available sources. WKH is not responsible for providing such information to Subscriber or ensuring that Subscriber has ongoing access to such information. Subscriber understands that the Online Tools and Content are designed to work with LMS technology that complies with current E-Learning Standards. WKH makes no representation or warranty (a) that the Online Tools and Content are or will continue to be compatible with any particular LMS or any future E-Learning Standards, (b) that Subscriber has any right or license to access or use any Third Party Material through an LMS, (c) or that access to and use of the Online Tools and Content in an LMS will not be interrupted by factors outside of WKH's control. Subscriber agrees that a change in an LMS's functionality or compatibility with the Online Tools or Content or any other limitation on access to or use of the Online Tools and Content by an LMS provider does not provide a basis for terminating this Agreement.

2. **WKH Support.** As part of this Agreement, WKH will provide implementation, maintenance and update support to Subscriber at no additional cost through its Customer Service team. Subscriber understands, however, that WKH makes no additional express or implied representations or warranties in connection with providing such support and ultimate responsibility rests with Subscriber to make sure that content is properly implemented, maintained and updated.

3. **Updating Content.** Subscriber understands that certain Content (generally applicable to course Content) can be accessed in an LMS through internet links to WKH controlled systems, and that such Content will be automatically updated by WKH and available to Subscriber as long as the links are working correctly. Subscriber further understands that certain other Content (generally applicable to test Content) can be accessed in an LMS only by uploading that content to the LMS provider's server, and that WKH will provide Subscriber with updated content when it becomes available, but it is Subscriber's responsibility to upload updated content to the LMS as soon as it is received from WKH.

4. **Responsibility for Content Uploaded to an LMS.** Subscriber agrees that it is solely responsible for ensuring that any Content that it uploads or otherwise transmits to an LMS provider is protected from misuse, misappropriation or redistribution. WKH recommends that Subscriber include in any license agreement with an LMS provider, terms that limit the LMS provider's access to and use of any content that Subscriber uploads or transmits to the LMS.

SUBSCRIBER AGREES THAT: (I) WKH MAY SUSPEND OR TERMINATE SUBSCRIBER'S RIGHTS UNDER THIS AGREEMENT AS A RESULT OF MISUSE, MISAPPROPRIATION, OR REDISTRIBUTION OF ONLINE TOOLS OR CONTENT THAT HAVE BEEN UPLOADED OR TRANSMITTED TO AN LMS PROVIDER; AND (II) SUBSCRIBER WILL INDEMNIFY WKH FOR ANY LOSSES OR DAMAGES SUFFERED BY WKH AND ARISING FROM MISUSE, MISAPPROPRIATION, OR REDISTRIBUTION OF ONLINE TOOLS OR CONTENT THAT HAVE BEEN UPLOADED OR TRANSMITTED TO AN LMS PROVIDER BY SUBSCRIBER.

Type I Institutional Membership

Application

Type I institutional membership may be granted to licensed acute care, general and specialty hospitals.

Please print or type the information below:

Name of Organization _____

Name of Chief Executive Officer _____

Address _____

City _____ State _____ Zip _____

Phone #: _____ FAX: #: _____

E-mail Address of CEO: _____

Website Address: _____

Owned by_____ Managed by _____

Number of Beds _____Year Established _____

Is your organization a member of the American Hospital Association?
Yes ____ No ____

_____ _____
Signature of Chief Executive Officer Date

Return application to:
Patti Davis, President
Oklahoma Hospital Association
4000 Lincoln Boulevard
Oklahoma City, OK 73105
(405) 427-9537
(405) 424-4507
oha@okoha.com
www.okoha.com

OHA Membership

Membership in the Oklahoma Hospital Association allows you to tap into an existing and growing network of health care professionals whose concerns, interests, and goals parallel yours.

Primary Services

Probably THE most important way OHA serves its members is by representing them – as a unified voice – before members of our federal and state legislatures, governmental agencies and other groups that influence public policy. In addition to representation and advocacy, other primary membership services include:

- Educational workshops that keep members up-to-date on the latest information, issues and trends affecting our industry;
- Ongoing communications with members to keep them informed of current activities and events taking place on the state and national level that would affect our industry;
- The sharing of local and national health care information and data, used to assist members with internal management decisions or to explain a particular health care issue to internal or external audiences.
- Assisting hospitals in providing safe patient care, promoting a healthy workforce and community to achieve health improvement for Oklahomans.

Benefits

Specific benefits provided to OHA Type I institutional members include the following:

- A weekly Association newsletter – HOTLINE;
- Legislative updates, published periodically during legislative session to track key pieces of legislation of importance to health care organizations;
- OHA Alerts, published periodically to provide members with information of special importance and urgency;
- Attendance at any OHA-sponsored program at the reduced member rate;
- Access to annual OHA member information, including a comprehensive list of ALL Oklahoma hospitals, contact information and administrative personnel. In addition, it lists OHA board, council and committee members;
- Opportunity to participate in and derive information from:

    - Comprehensive Wage & Salary Survey of hospital personnel; the survey includes more than 280 job titles, including hospital execs. The results tool allows members to run an unlimited number of custom job reports, and includes pay practices and benefits information.
    - DATABANK: a Web-based database of hospital utilization and financial performance indicators.
    - The OHA Hospital Productivity Management Program; a straightforward and efficient, yet valuable, program to compare productivity data at the nursing unit and department level.

Cost

See the attached explanation sheet regarding the dues structure for institutional membership.

Application

To apply for Type I institutional membership, complete the application form and return it, along with a copy of your organization's bylaws, if available.

Questions

If you need assistance in completing the application or have any questions about OHA membership or any of the services provided, please call, write, fax, or e-mail: Oklahoma Hospital Association, 4000 Lincoln Boulevard, Oklahoma City, OK 73105, 405-427-9537, Fax: 405-424-4507; e-mail winters@okoha.com.