Beaufort Memorial HOSPITAL

POLICY REVIEW FOR NON-NURSING STUDENTS AT BMH

All policies are published on the BMH Intranet via PolicyStat

DIRECTIONS:

1- Please read each policy and indicate the date it was read

2- As you read each item, be able to answer the following questions:

- What is the purpose of this policy?
- What is my role, if any, and the role of other members of the health care team?
- Are there any special considerations I should remember?

3 - When you finish reading the listed policies, please sign below (do not draw a line through the date. You must date each policy).

Beaufort Memorial Hospital Policies		
Date Read	**Title of Policy**	**Reference**
	Student Affiliation Program	**HR 02.13**
	Armband Policy	**POC 05.02**
	Rapid Response Team	**POC 05.08**
	Fall Prevention and Management Program	**POC 05.10**
	Documentation	**POC 06.02**
	Documentation (Rehab only)	**PC 4**
	Pain Assessment and Reassessment	**POC 10.01**
	Prevention of Skin Breakdown in the Adult Patient	**POC 12.03**
	Treatment of Hypoglycemic Episodes in Adults (Hypoglycemia Protocol Policy)	**POC 14.02**
	Hand Hygiene, Hand Wash, and Hand Antisepsis	**IPC 8.05**
	Patient Rights and Responsibilities	**RRI 05.02**
	Restraints and Seclusion	**RRI 05.08**
	Identification Badges	**HR 03.11**
	Tobacco Free Campus	**HR 3.20**
	Social Media	**HR 03.27**
	HIPAA Privacy and Patient Confidentiality	**HP 01.20**
	****09.12 Attachment: Notice of Privacy Practices**	**HP 09.12A**
	Information Systems Acceptable Use	**IM 03.07**
	Student Substance Policy	

Name (print) _____

Signature _____ **Date** _____

Beaufort Memorial

Original Date:	*10/2011*
Reviewed Date:	*11/2017*
Revision Date:	*11/2017*
Next Review Due By:	*11/2020*
Responsible Party:	*Brian Hoffman: Vice President Human Resources*
Policy Area:	*ORG: Human Resources*
Reference Tags:	

Student Affiliation Program, HR 02.13

PURPOSE:

The purpose of the Student Affiliation Program at Beaufort Memorial Hospital is to provide guidelines that promote patient safety and reduce risk to patients while providing nursing and non-nursing students with a meaningful educational experience. This policy pertains to any student who wishes to accompany a BMH employee and/or any individual with privileges to provide care on the BMH campus for more than one(1) day.

The program guidelines define expectations and limitations of Students, Educational Institutions and BMH care providers immediately prior to and during educational rotations through an affiliated training program. In addition, any student who wishes to observe a BMH care provider for more than one(1) day in their practice must follow the below procedure. For observations of one day or less, refer to the Facility Observation Policy (HR3.28)

Roles and responsibilities:

A. Beaufort Memorial Hospital

1. Establish and maintain a contract of affiliation with the educational institution. A signed copy will be held with the contract administrator. All affiliation agreements must be signed by the VP of HR.
2. Designate an HR department employee to serve as a BMH liaison to work directly with Education Institutions and coordinate all non-nursing student activities as well as maintain HR documents for all students.
    a. If applicable, designate an Education Department employee to serve as a Health-care Facility Liaison to work directly with Nursing Education Institutions and coordinate all nursing student activities.
3. Provide orientation to students and nursing instructors; include in this orientation: network access, systems security, facility HIPAA specific requirements to protect Electronic Protected Health Information, BMH Core Values, and emergency codes and their appropriate responses.
4. Establish and maintain a file for each student holding essential student affiliation documentation in compliance with the HR record retention policy.

B. Educational Institution

1. Collaborate with BMH liaison to establish a mutually acceptable timeframe for educational rotations.
2. Provide to BMH an updated affiliation agreement, including a current liability insurance certificate.

3. Provide a complete listing of all students assigned to the facility to the BMH liaison at least **6** weeks prior to the agreed upon orientation date for educational rotations.
4. Provide documentation of the following student requirements at least **2 weeks prior** to rotation start date:
    a. current CPR certification (if required)
    b. (2) MMR's or titers
    c. varicella history/titer
    d. completed Hepatitis B vaccination/declination statement
    e. current (within 12 months of rotation) Tuberculin test
    f. successful national criminal background check completed within 6 months of rotation which includes
        i. federal/stat/local criminal check
        ii. national sec offender check
        iii. Office of Inspector General check
    g. negative 9 panel drug screen completed within 6 months of rotation
    h. documentation of flu vaccine if rotation occurs during flu season October through March
5. Assure that students maintain professional liability and health insurance throughout the duration of their educational rotations.

C. Students and Instructors
1. Students will submit a completed Student Affiliation packet to the BMH HR liaison at least **2 weeks prior** to the start of the educational rotation.
2. Students and instructors shall not remove any patient care documents from the Healthcare facility.
3. Students and instructors must always wear hospital issued identification badges when on campus.
4. Students and instructors shall not accept critical value reports from any hospital department, any verbal or telephone order from any physician, obtain written consent from a patient, or initiate the infusion of any blood products.
5. Nursing instructors will supervise all patient care provided by student nurses.

D. BMH Care Provider
1. Although there exists a dual responsibility for the care of patients, all patient care remains the ultimate responsibility of Beaufort Memorial Employees and Privileged Staff.
2. The responsible care provider will offer assistance to students to assure proper care for the patient and appropriate education experience of the student.
3. IN conjunction with instructors, assure that students administer safe and effective patient care in accordance with all hospital policies by providing direct supervision for each affiliating student.
4. Provide appropriate support for educational activities such as clinical debriefing meeting space, use of hospital equipment for training, etc.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Staff Education Completed	Brian Hoffman: Vice President Human Resources	11/2017
Senior Administration	Russell Baxley: CEO/President	11/2017
Senior Administration	Shawna Doran: Vice President Quality/Risk/Patient Safety	10/2017
	Brian Hoffman: Vice President Human Resources	10/2017

Beaufort Memorial

Original Date: *06/2009*
Reviewed Date: *05/2018*
Revision Date: *03/2015*
Next Review Due By: *05/2021*
Responsible Party: *Marla Slock: Department Director, Med/Surg*
Policy Area: *ORG: Provision of Care*
Reference Tags:

Armband, POC 05.02

PURPOSE

To promote patient safety by providing guidelines for the use of patient armbands.

POLICY

The following armband colors will be used to designate the listed conditions/reasons.

Color of Armband	Reason for Armband
Red	Blood
Purple	Do Not Resuscitate
Green	Latex Allergy
White with Red	"No Blood Patient"
Pink	Restricted Limb
Yellow	Fall Risk

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Marla Slock: Department Director, Med/Surg	05/2018
HPI	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
Nurse Practice	Karen Carroll: Vice President Patient Care Services	04/2018
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	04/2018
Meditech Change Committee	Cheryl Brown: Director	03/2018
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical	03/2018
	Marla Slock: Department Director, Med/Surg	03/2018

Current Status: *Active*

PolicyStat ID: *4106465*

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Responsible Party: *Marla Slock: Department Director, Med/Surg*
Policy Area: *ORG: Provision of Care*
Reference Tags: *New Employee - Nsg Assist/Tech, New Employee Orientation- RN/ LPN, New Employee- Clinical non-nsg*

Beaufort Memorial

Adult Rapid Response Team (ARRT), POC 05.08

POLICY

The role of the Rapid Response Team (RRT) at Beaufort Memorial Hospital (BMH) will be to provide early rapid interventions for adult patients, to promote improved patient outcomes and reduce hospital mortality.

EXCEPTIONS:

The rapid response team will not cover:

- Labor and Delivery
- Nursery
- Pediatric patients
- Surgical Services (OR, PACU, Endo)
- ER
- Cath Lab
- ICU

PROCEDURE

1. The RRT Team shall consist of a Critical Care RN and a Respiratory Therapist.
2. Criteria for activating the Adult Rapid Response Team: **A nurse, patient or family member may call a rapid response when he or she believes a patient may be deteriorating.**
   The criterion to activate the ARRT may include any of the following:
   - Acute change in heart rate
   - Acute change in systolic BP
   - Acute change in respiratory rate
   - Acute change in oxygen saturation
   - Acute change in mental status
   - Acute change in urine output less than 50 mL for 4 hours
   - Chest pain

- Nurse or patient or family is acutely concerned
- Physician request
- Acute change in pain level
- New onset, prolonged or repeated seizures
- Stroke
- Massive transfusion

3. Procedure for activating the ARRT:
   - Dial 5555. Inform the operator that an Adult Rapid Response is in process and give the exact location.
   - The operator will activate the Rapid Response via the network computer alert and overhead page.
4. The attending physician will be contacted and given report on each RRT call as necessary.
5. Responsibilities during a Rapid Response Team call:
   - Primary Care Nurse Responsibilities:
     a. will provide the situation and background information to the RRT
     b. assist the RRT as needed
     c. Rapid Response Team may implement the Rapid Response Order Set prior to calling the physician
   - Critical Care Nurse Responsibilities
     a. assist with further assessment of the patient
     b. assist with communication between primary care nurse and the physician
     c. assist with / facilitate transfer to higher level of care, if indicated
     d. may assist with implementing interventions, as needed, per physician's order
   - Respiratory Therapist Responsibilities:
     a. assist with further assessment of the patient
     b. assist with communication between primary care nurse and the physician
     c. assist with / facilitate transfer to a higher level of care, if indicated
     d. assist with implementing interventions, as needed, per physician's order, ACLS guidleines and ARRT standing orders
     e. assess and treat within scope of practice
6. Required Documentation for RRT "Response":
   - The primary nurse :
     - add "Rapid Response" to the patient interventions
     - document time call was made and time responders arrived at bedside
   - The RRT responders will complete necessary documentation in the "Rapid Response" intervention.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Marla Slock: Department Director, Med/Surg	05/2018
HPI	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
Nurse Practice	Karen Carroll: Vice President Patient Care Services	04/2018
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	04/2018
Meditech Change Committee	Cheryl Brown: Director	03/2018
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical	01/2018
	Marla Slock: Department Director, Med/Surg	12/2017

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Responsible Party: *Marla Slock: Department Director, Med/Surg*
Policy Area: *ORG: Provision of Care*
Reference Tags: *New Employee - Nsg Assist/Tech, New Employee Orientation- RN/ LPN, New Employee-Clinical non-nsg*

Beaufort Memorial

Fall Prevention and Management, POC 05.10

DEFINITION:

National Database of Nursing Quality Indicators (NDNQI) defines a patient's fall as

a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can).
NDNQI counts only falls that occur on an eligible inpatient or ambulatory unit that reports falls. When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured.
An assisted fall is

a fall in which any staff member was with the patient ***and*** attempted to minimize the impact of the fall by slowing the patient's descent.

Example:
A patient who is ambulating becomes weak and the staff lowers the patient to the floor. This is considered a fall because the patient did not intend to go to the floor; it is an assisted fall because the staff eased the patient's descent to reduce the likelihood of injury.

PURPOSE:

To promote patient safety by:

- Effectively identifying patients who are at risk for falls.
- Providing early intervention to the patient at risk for falls.
- Communicating to appropriate staff the inpatient plan of care.
- Staff and patient education and training to increase awareness of the patient at risk for falls and prevention strategies.

POLICY:

To prevent falls &/or injury by:

- Effectively managing patients who fall.
- Analyzing fall data for trends and patterns.
- Educating patients and families on measures to prevent falls and promote safety.

PROCEDURE:

INPATIENT -

PROCESS FOR INITIAL ASSESSMENT:

Step	Action
1	• A licensed nurse will assess patients at the time of admission using the hospital approved Hendrich II **Fall Risk Assessment Tool** to determine their risk for falling. • Based on this assessment score, the patient's fall risk level will be determined and appropriate preventive interventions initiated.
2	• An individualized fall prevention plan will be initiated for the patient based on the level of risk identified from the Fall Risk Assessment. Variation from policy requires documentation.
3	• The Registered Nurse will enter the Fall Risk Level on the Interdisciplinary Plan of Care.

PROCESS FOR REASSESSMENT:

Assuring patient safety by prevention or reduction of falls is an ongoing process. Establishing defined times for reassessment and completion of a new Fall Screen accomplishes this. The table below outlines this process.

Step	Action
1	**Every shift**
2	**After a fall**
3	**Clinical status or treatment changes**
4	**Cognitive Changes** • Alteration in mental status • Agitation
5	**Certain Medication Additions/Changes** • Benzodiazepines • Antiepileptics
6	**At Specified Times During Hospital Stay** • Transfer to another unit or level of care • Identified as at risk during Interdisciplinary Care Planning conference • Placed in restraints • At discretion of Registered Nurse

POST FALL PROCESS:

There is no fall prevention strategy that will prevent all falls. Therefore, it is very important that the patient and his environment are carefully assessed when a fall occurs. The steps are outlined in the table below.

1	Assess for injuries – do not move until safety is assured. Initiate first aid measures as indicated. Assess for need of use of Minimal Lift equipment to return patient to bed.
2	Notify attending physician or on call physician of patient's fall and assessment of fall. Process any orders received.
3	Notify next of kin or Power of Attorney if patient is deemed incompetent or impaired. • If patient alert and oriented, confirm with patient if wants anyone notified.
4	The following documentation is required after a fall occurs: • Assessment after fall screen • Ongoing documentation based on patient's status • Complete new fall risk assessment tool • Update interdisciplinary plan of care and assure RISK OF INJURY problem is added
5	Reporting requirements: • Complete electronic quality report • Falls Team investigation worksheet

AMBULATORY SETTINGS:

- The Emergency Department and Ambulatory Care settings utilizes the Morse fall scale.
- As indicated, patients who self-identify with fall history will be educated on basic fall prevention which may include environmental safety (such as lighting, trip hazards, rugs) personal functional safety (such as proper shoe selection, use of mobility devices, etc), medication and dietary safety (such as effects and interactions).
- Patient and family education will be provided as indicated.

PERFORMANCE IMPROVEMENT

- Process Improvement will be conducted by periodic review of data for trends. Action Plans will be developed and implemented as necessary.

LITERATURE REFERENCE:

Henrich, A (2016) Fall risk assessment for older adults: The Henrich II fall risk assessment model. *Try this: Best practices in nursing care to older adults, issue #8,* revised 2016.

NDNQI A Press Ganey Solution, (2014). *Guidelines for Data Collection and Submission on Patient Falls Indicator* (Inpatient and Ambulatory Areas), pg 2-3.

Lippincott - Fall Prevention, Fall Management

considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

ED-Ambulatory Care Morse Fall Scale 5-2018.pdf
Inpatient Fall Risk Assessment tool 2-2018.pdf

Approval Signatures

Step Description	Approver	Date
Ready for publication	Marla Slock: Department Director, Med/Surg	08/2018
HPI	Shawna Doran: Vice President Quality/Risk/Patient Safety	07/2018
Nurse Practice	Karen Carroll: Vice President Patient Care Services	06/2018
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	05/2018
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical	04/2018
Meditech Change Committee	Cheryl Brown: Director	04/2018
	Marla Slock: Department Director, Med/Surg	04/2018

Beaufort Memorial

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Next Review Due By:	*02/2020*
Responsible Party:	*Marla Slock: Department Director, Med/Surg*
Policy Area:	*ORG: Provision of Care*
Reference Tags:	*New Employee Orientation- RN/LPN*

Nursing Documentation in the Inpatient Electronic Medical Record (EMR), POC 06.02

PURPOSE

- To communicate information to other members of the health care team.
- To provide a permanent record for future reference that may become a legal document in the event of litigation.
- To comply with regulatory agency standards.
- To ensure professional responsibility and accountability.
- To ensure reimbursement
- To consolidate assessment data, plan of care, nursing interventions, medication and blood administration, associated equipment, and evaluation of patient response to care, into one record providing an overall picture of the patient.

POLICY

Clinical staff members should document in the EMR throughout every shift and as patient condition/situation warrants (unusual events and/or circumstances).

Clinical documentation is based on the Nursing Process: Assessment, Planning, Intervention and Evaluation of patient care.

1. All information in the medical record is considered confidential and access should be restricted to health care professionals involved in the patient's plan of care and/or quality initiatives.
2. All documentation in the electronic medical record (EMR) should be located under patient name and account number.
3. The system will automatically date, time, and record the user's electronic signature. Real-time documentation should occur as often as possible.
4. The electronic signature may include the staff user identification.
5. Unapproved abbreviations should not be used.
6. Errors in charting can be undone/edited/amended within 48 hours. A staff member may not be able to edit another staff member's documentation. Edits should only be done by the original staff member. The system should document any changes made and note the time changed.

7. Late entries can be entered by set stamp or documented interventions within 48 hours. These entries should be electronically noted and placed in the electronic medical record in chronological order. The system should note the date and time the entry actually occurred and the recorded time. A late entry note can be entered by documenting via Add Notes.
8. Late entries/edits beyond 48 hours must be coordinated with Information Systems and HIS staff to allow access to the record. These entries should be electronically noted and placed in the electronic medical record in chronological order. The system should note the date and time the entry actually occurred and the recorded time. A late entry note should be entered by documenting via Add Notes the purpose of the late entry/edit.

Responsibilities for Charting

1. Applicable multidisciplinary care providers should be responsible for documenting all pertinent data related to care of the patient.
2. The Nurse, Certified Nursing Assistant, Nurse Intern, and Technician may chart vital signs, intake, output, meals, and those aspects of patient care provided within their qualifications. Abnormal values have alerts attached via the EMR. Abnormal values of these types require notification of a licensed clinical staff member. Unlicensed staff should document the name of the licensed clinical staff member notified of abnormal results.
3. Documentation should begin upon Inpatient admission with the Admission Assessment, the Admission height and weight, Admission vital signs, the Past Medical History, and the Physical Assessment. The initial data collection should be done by an LPN or RN. Assessments for specific departments default onto the Worklist. Some answers will allow specific questions to be skipped based on age, gender, location, or previous answers which on limited assessments will automatically be present by default. The Past Medical History should be initiated by a nurse, but may contain information entered by a physician, or from a previous encounter. All existing information should be reviewed, updated, and confirmed by the nurse.
4. After the initial data collection is completed, the RN may select a system specific care plan(s) based on patient diagnosis and nursing assessment. The care plan(s) is selected under the Plan of Care routine. (Plan of Care includes Care plan(s), problems, Standard of Care and miscellaneous interventions(s)).
5. Outcomes and Interventions identified through assessment and reassessment should be added and deleted under the Plan of Care routine to individualize the Plan of Care to the patient. Generic and unit specific policies, procedures, protocols, and Standards of Care may be utilized to establish outcomes and identify interventions to manage the problem. Interventions may be self-explanatory, include text, or have screens attached with specific information that should be documented. Some interventions include procedures and algorithms for quick review.
6. Editing and Documenting Plan of Care:
    - Clinical staff should identify issues/concerns and add specific interventions used to manage the issue/concerns via the Add Intervention routine in the Plan of Care or Worklist.
    - Interventions that are a result of a Physician order may be automatically opened on the Worklist and Plan of Care once the order is placed. These orders will be entered via CPOE, Unit Secretary, or Nurse.
    - Intervention Guide:
        i. A- Assessment, documentation may be required

ii. I- Intervention (time stamp)

iii. Yellow boxed: A, I, P, and O

1. A- Associated Data, data that is relevant to the intervention
2. P- policy/protocol/algorithm that guides an intervention
3. I- further information about the intervention that can be edited as needed
4. O- an intervention occurring because of a physician order

- Some interventions are self-explanatory within the realm of nursing
- Directions should include the minimal documentation required, but the documentation frequency may change based on the patient's condition/status and physician orders/protocols.

7. Evaluation of Outcomes
   - Evaluation of the effectiveness should be addressed by documenting Outcomes under Worklist Outcomes and Notes.
   - Each Outcome should be documented on each shift or with a change in patient's condition/status under the Worklist.
   - Each Outcome may be documented as Met, Met Ongoing, Ongoing or Not Met.
   - A list of indicators/obstacles may be placed in the text of each outcome based on overall assessment.
   - An Outcome that is Met should be considered to be complete.
   - Standards of Care represent the minimal care that should be provided to any patient admitted to our facility and are unit specific.
   - Standards of Care may be completed at discharge.
8. Cosign/Verification Requirements
   - Designated with "RN Co-Sign or RN Verification of LPN Data."
   - Verifying nurse should review the data, then document a verification using his/her own sign-on.

Downtime Procedures

- When Downtime is less than two (2) hours.
  1. Information should be gathered and entered by the clinical staff into the EMR once the system is restored.
- When Downtime is greater than two (2) hours.
  1. Downtime packets (available in all clinical areas) should be utilized to gather patient data per Downtime policy.

References

Unapproved Abbreviations, HIS 01.15

considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Staff Education Completed	Marla Slock: Department Director, Med/Surg	02/2017
HPI	Shawna Doran: Corporate Director of Quality	02/2017
Nurse Practice	Karen Carroll: Vice President Patient Care Services	02/2017
Policy Committee	Shawna Doran: Corporate Director of Quality	01/2017
	Shawna Doran: Corporate Director of Quality	01/2017
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	11/2016
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical	11/2016
Meditech Change Committee	Cheryl Hirleman: Director	11/2016
	Marla Slock: Department Director, Med/Surg	11/2016

Beaufort Memorial

Original Date: *02/1991*
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Next Review Due By: *01/2021*
Responsible Party: *Laurie Martin: Associate VP of Operations*
Policy Area: *DEPT: Rehabilitation Therapy Services*
Reference Tags:

Documentation Requirements, PC 4

PURPOSE

Documentation in the medical record serves as an accurate, timely, detailed account of patient care from the first to last point of contact with therapy services. All entries in the medical record reflect military time. All signatures in the medical record shall be timed and dated.

Types of Documentation

Therapy Screen

Inpatient

1. 72 hour response window to request for screen
2. Requests for screens may come from any member of the patient care team and may be responded to by PT or OT or SLP
3. Documentation reflects the result of a consultation for need for skilled therapeutic intervention which may include interview, basic observation but does NOT include physical evaluation unless there is a physician order.

Outpatient

1. Specific Screening tools may be used in the outpatient and community settings to provide a service to the community.
2. These screenings should be mutually agreed upon and in cases of in-clinic screenings (ie HealthLink) patient will be asked to sign a release for services – records of screening results recommending follow-up as needed will be provided via the referral directly to the patient.
3. In the community setting – Health fairs, CHIP events, employee screening – release will be signed based on the event and Risk Manager assessment of the need for release – records of screening results may or may not be retained.

Assessment/ Evaluation

The scope of Assessment may include but is not limited to the following elements:

OCCUPATIONAL THERAPY

- Impairments in performing activities of daily living, work readiness, or work performance, and play skills or leisure capacities, including educational performance needs of the patient, and or caregiver
- Impairments in performing components of sensory integration, neuromuscular skills, motor skills, cognitive integration, kinesthetic awareness, psychosocial skills, pain and psychological factors
- Requirements for interventions including adaptive equipment, assistive technologies, prosthetics and orthotics, application of ergonomic principals and community adaption

PHYSICAL THERAPY

- Impairments in static postures and physiologic responses to movement including posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and pain
- Prescription of Orthotic, Prosthetic, and assistive or mobility devices
- Management of physical function disability in daily living, movement dysfunction, and pain

SPEECH-LANGUAGE PATHOLOGY

- Speech disorders such as articulation, voice and fluency, language, swallowing, and cognitive communications
- Need for augmentative and alternative communication systems and devices
- Need for aural rehabilitation
- Need to enhance speech proficiency and communication effectiveness
- Assessment of verbal deficits and defenses to exercise underlying cognitive and communication skills
- Screening of hearing

Assessment Guidelines include:

Inpatient Referral response time is expected within one working day of receipt of referral based on hours of operation

Outpatient Referral response is earliest next available appointment

1. Rehabilitation referral reason and diagnosis noted
2. Review of patient's prior level of function
3. Pertinent past medical history, for recurring Outpatients this will also include medications, allergies, medical/surgical history, screens for Abuse, Nutrition, social services, discharge needs
4. Summary of patient's condition upon evaluation including for example:
    a. Objective measures of strength, ROM, balance, endurance, presentation,
    b. Functional measures of performance including ADL, cognition, pain, knowledge of disease
    c. Subjective statements of presentation and patient's goal for therapy
5. Rehab potential / prognosis/ limitations noted
6. Educational capacity and barriers to learning noted in the interdisciplinary educational record
7. Goals written in conjunction with patient are:
    a. Objective
    b. Measurable
    c. Functional
    d. Based on projected discharge disposition
    e. Divided into short and long term based on timelines pertinent to the service setting

i. Acute Care
    1. STG – 1-3 days
    2. LTG – discharge
ii. Rehab unit
    1. STG – 7 days
    2. LTG – discharge
iii. Adult Outpatient
    1. STG – 2 weeks
    2. LTG – 8 weeks
iv. Pediatric Outpatient
    1. STG – 4-8 weeks
    2. LTG – 3 month

8. Plan of Care documents clear need for skilled interventions
9. Plan of care reflects interventions anticipated to facilitate goal attainment
10. Non CMS payers may authorize treatment plans per their individual processes.
11. Discharge disposition, anticipated discharge needs and training opportunities are projected as a part of initial evaluation and treatment planning

Specific to Medicare Outpatient

1. Plan of Care includes frequencies and duration of projected interventions
2. Plan of Care requires physician approval indicated by signature.
3. Plan of Care must be Recertified every 90 days

Treatment or Progress Notes

1. Treatment of patient and response to treatment and progress are documented in the medical record upon completion of each treatment.
2. Treatment Notes reflect the care delivered including:
    a. Time care delivered
    b. Duration (start and stop time) of care delivered
    c. Subjective, Objective and Assessment information as well as Plan for next care intervention
    d. Note treatment and response to treatment
    e. Intermittently reflect progress toward goals
    f. Are signed dated and timed
    g. Provide record of missed or canceled visits/ attempts at treatment

Progress Summary and Reassessments

1. Acute care required patient reassessment every 7 days at minimum or as indicated by patient change.

2. Acute Rehab Unit requires reassessment every 7 days with updates to patient interdisciplinary plan of care
3. Outpatient Plans of Care must be updated according to payer guidelines
   Medicare – every 90 days
   Medicaid – every 90 days
   Other payers as indicated
4. Medicare outpatient regulations require Progress Note every 10th visit or at least once every 30 days
5. All venues should conduct reassessment in event of any significant change in patient's capability, presentation or stated long term goal and plan of care if indicated
6. Therapy Assistant Supervisory Notes must be completed per state regulations but do not require reassessment unless clinically indicated.
   1. Certified Occupational Therapy Assistant supervisory notes must be completed every XX visit
   2. Physical Therapist Assistant notes must be completed every XX visit

Discharge Summary

1. Required in outpatient and Acute Rehab Unit within 30 days of final treatment per hospital policy
2. Acute discharge note is only required if the patient is discharged by therapy
3. Note should reflect change from start to finish of intervention and reflect progress toward goal attainment
4. Should reflect discharge training, home programming for sustained impact
5. Should reflect progression through continuum of care as indicated
6. Paints the final picture – proves the effectiveness, efficiency, and efficacy of skilled interventions
7. The discharge summary information can be collected and recorded by the licensed Assistant (PTA OR OTA) and will be reviewed, amended as indicated, and signed by the licensed therapist (this is required by law in state of South Carolina for Physical Therapy – and is not required by law or regulation in the state of South Carolina for Occupational Therapy)
8. No physician signature is required on discharge summary but a copy may be made available to physician

Anecdotal Notes:

PLEASE NOTE that documentation of anecdotal events may be in the notes section of the medical record, as well as within the Rehabilitation Record.Anecdotal Notes may include examples below:

1. Documentation of conversations with physicians regarding the care of the patient
2. Documentation of discussions with other members of the care team including patient caregivers relevant to the care of the patient
3. Documentation of unanticipated event that is relevant to the care of the patient and if the event occurs outside the treatment note duration
4. Documentation of prioritization of coverage or of departmental/service closures in real time or after the event being documented.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is

impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Staff Education Completed	Laurie Martin: Associate VP of Operations	01/2018
Assoc Vice President	Laurie Martin: Associate VP of Operations	01/2018
	Laurie Martin: Associate VP of Operations	01/2018

Beaufort Memorial

Original Date:	*03/1994*
Reviewed Date:	*03/2016*
Revision Date:	*03/2016*
Next Review Due By:	*03/2019*
Responsible Party:	*Marla Slock: Department Director, Med/Surg*
Policy Area:	*ORG: Provision of Care*
Reference Tags:	*New Employee Orientation- RN/LPN*

Pain Assessment and Reassessment, POC 10.01

POLICY

Patients in this organization have the right to effective pain management.

PAIN ASSESSMENT AND REASSESSMENT

1. Pain should be assessed utilizing a measurement system:
   - The Numeric Pain Rating (NPR)
   - The FACES Scale
   - The FLACC Scale (For non-verbal patients)
   - Other assessment methods may include correlating those diagnoses/treatments that would be expected to cause pain, or considering a family member's report of how the patient typically responds to pain.
2. Pain should be assessed upon admission and any new report of pain. Assessment is documented in the Patient's EMR (Electronic Medical Record.) The initial/new pain assessment should include:
   - Location
   - Description/Intensity (based upon pain assessment methods listed above)
   - Duration (when did it start; ie. Acute vs. chronic pain)
   - Frequency (intermittent/constant)
   - Relieving/aggravating factors
   - Patient's expectation of what would be an acceptable pain management goal based appropriate for the patient's age and cultural diversity.
   - Any new report of pain shall be reported to the patient's physician or LIP (Licensed Independent Practitioner) and documented in the medical record.
3. Pain will be reassessed:
   - In a timely manner to determine if the intervention is working or if the patient is experiencing side effects.
   - Every shift and as needed.
   - Before and after pharmacological and non-pharmacological interventions including pain score,

sedation level (See Guideline for the Modified Post OPIOID-Induced Sedation Scale) , O2 saturations levels, if pain goal was met, and if additional interventions will be performed.

4. Prior to pain medication administration, the nurse should know and consider peak actions and duration of pain medications to pharmacological pain administration.

5. Patient/family education should include:

- use of the pain scale,
- the pain plan of care
- reporting any changes to their pain throughout the hospital stay.

6. Discharge planning should include:

- A plan for continued pain management for patient/caregiver
- Symptom management
- Follow-up pain management services, if appropriate

Guideline for the Modified Post OPIOID-Induced Sedation Scale

S = Sleep, easy to arouse

Acceptable: No action necessary; supplemental opioid may be given if needed.

1 = Awake and alert

Acceptable: No action necessary; supplemental opioid may be given if needed.

2 = Slightly drowsy, easily aroused

Acceptable: No action necessary; supplemental opioid may be given if needed.

3 = Frequently drowsy, arousable, drifts off to sleep during conversation

Unacceptable:

- *Review medication list for sedating drugs and call Physician or provider.*
- *Discuss need for recommended decrease in opioid dose by 50 percent.*
- *Administer oral acetaminophen or an oral NSAID, if not contraindicated, to control pain.*
- *Monitor sedation and respiratory status closely until sedation level is less than 3.**

4 = Somnolent, minimal or no response to physical stimulation

Unacceptable:

- *Stop opioid.*
- *Notify physician or provider and call Rapid Response Team.*
- *Administer IV naloxone 0.2 mg very slowly and assess response over 1-2 minutes.*
- *If still sedated administer another 0.2 mg naloxone IV.*
- *Administer oral acetaminophen or an oral NSAID, if not contraindicated, to control pain.*
- *Monitor sedation and respiratory status closely until sedation level is less than 3.**

**Interventions may not be appropriate for DNR/Comfort Care/Hospice patients. Please consult the patient's physician. This scale should not preclude your nursing clinical judgment.*

REFERENCES

Pasero C, McCaffery M. **Pain Assessment and Pharmacologic** Management. St. Louis, MO: Mosby; 2011. p. 510. Copyright Chris Pasero, 1994. used with permission.

Lippincott's - Pain assessment, Pain Management, Pain assessment- oncology, Pain Management- oncology, Pain assessment- pediatric

Attachments:

A: Wong-Baker Faces Rating Scale
B: FLACC Scale

Approval Signatures

Step Description	Approver	Date
HPI	Shawna Doran: Corporate Director of Quality	03/2016
Nurse Practice	Karen Carroll: Vice President Patient Care Services	03/2016
Policy Committee	Laurie Martin: Executive Director Rehab Svcs & Bluffton Svcs	01/2016
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	12/2015
	Marla Slock: Department Director, Med/Surg	12/2015

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PolicyStat ID: *2908048*

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Responsible Party: *Susan Roos: Associate VP of Patient Safety & Experience*
Policy Area: *ORG: Provision of Care*
Reference Tags: *New Employee - Nsg Assist/Tech, New Employee Orientation- RN/ LPN*

Beaufort Memorial

Prevention of Skin Breakdown in the Adult Patient, POC 12.03

PURPOSE

It is the policy of Beaufort Memorial Hospital to maintain the skin integrity of adult patients admitted to the hospital by performing a thorough skin inspection and risk screening on admission, identifying those adult patients at risk and implementing appropriate interventions to prevent skin breakdown.

POLICY

Nursing staff will identify at-risk individuals needing prevention and the specific factors placing them at risk. Patients admitted with intact skin should not develop skin breakdown during hospitalization. Patients admitted with impaired skin integrity should develop no additional breakdown.

PROCEDURE

ASSESSING FOR RISK

1. On admission all adult patients should have the Braden Scale Risk Assessment Tool completed by designated nursing staff.
2. All individuals at risk should have a systematic skin inspection completed every shift, paying particular attention to the bony prominences. Risk Assessment Tool should be repeated as indicated by shift risk assessment.
3. Two nurses should perform the skin risk assessment for patients on admission, and the second assessing nurse should co-sign the admission pressure injury assessment in Meditech with primary RN. Both nurses are accountable for capturing all non-surgical wounds that are present on admission into the Wound Injury Intervention during this assessment.
4. The Braden Scale should be used for reassessment.
5. Implement Recommended Prevention Interventions for patients identified at risk based on the Braden Scale.
   Low to Moderate Risk: 13-18 Points

- Inspect skin every shift.
- Individualize bathing schedule. Avoid hot water. Use a mild cleansing agent.
- Use moisturizers for dry skin to decrease friction injuries.
- If incontinent of bowel or bladder, protect skin on buttocks and sacrum by applying Extra Protective cream several times a day. See attached Skin Care Algorithm.
- Use proper positioning, transferring, and turning techniques.
- Turn patients every two hours or less.
- Minimize skin exposure to excess moisture.
- Use pillows to prevent contact between body surfaces – such as between knees and ankles.
- For oxygen patients, place ear protection devices on the ear portion of the oxygen cannula tubing, or use the soft oxygen cannulas.
- Float heels off of the bed surface using pillows.
- Prevent shear and friction damage to tissues, using slide sheets to move patients.
- No more than two linen layers between the patient and the mattress.
- Use Pressure Injury/Thearpy Bed Algorithm (or see attached) as needed for therapy choices.
- Obtain Dietary consult for :
  i. Braden less than 15 or
  ii. Braden less than 19 and a Braden nutrition score less than 3

  High Risk: 12 Points or Less
  Implement the interventions for Low to Moderate Risk plus:
- Increase frequency of turning schedule.
- Supplement turning with small body shifts.
- Avoid HOB elevation greater than 30° if consistent with medical conditions and other restrictions.
- Order and apply pressure redistribution surface per Pressure Injury/Therapy Bed Algorithm. If therapy is indicated, follow BMH Clinical Practice Guidelines for Pressure Injuries.
- **Pressure ulcer prevention dressings (RNs and LPNs) – Recommendations for Success**
  A bordered foam dressing in an appropriate size for the application site is to be applied to the sacrum and heels for any patient with a Braden Scale score of 18 or less, and **any one** of the following criteria:
  - Greater than a two-hour stay in the E.D.
  - Surgery lasting two hours or more
  - Vascular, thoracic or orthopedic surgery
  - Age >70 years
  - Serum albumin level less than 3
  - Diabetes
  - PVD

- Low Braden Score for mobility
- Low Braden Score for friction and shear
- Vasopressor use
- Quadriplegic or paraplegic
- History of previous pressure injury
- On the ventilator and/or having sedation
- End-stage organ system failure – ESRD, end-stage COPD, etc.
- Hypoxia or hypotension
- Suspected hospital stay of more than 5 days from admission
- Diastolic blood pressure below 60
- Hemodynamic instability

Instructions for bordered foam preventative dressing application and management:

- Cleanse the skin with Secura Personal Cleanser to remove skin oils and perspiration.
- SHOULD NOT USE WIPES – THEY LEAVE RESIDUE THAT WILL PREVENT DRESSING ADHESION
- Apply No-Sting Skin Prep wipes after cleaning and drying the skin.
- Apply the dressing flat on the skin without pulling or stretching it.
- Write the date, your initials and a "P" (for prevention) on the dressing
- If the dressing becomes soiled, clean it from the center of the dressing outward toward the edges
- The edge of the dressing should be lifted each shift to assess the skin under the dressing, and the border of the dressing reapplied.
- Change the prevention dressings only when loose or soiled beyond being able to be cleaned
- Document in the Wound Prevention Dressing intervention on the worklist every shift, to indicate when the dressing is applied or changed

6. Educate patient and caregiver regarding preventative interventions. Provide written materials and contact phone numbers as appropriate.
7. Document all interventions and patient instructions in Meditech.
8. Never use briefs or adult diapers on an incontinent, immobile patient.
    - A Physician's order must be obtained if utilized.
    - Notify the Certified Wound Care Nurse to provide further education after the Primary RN has initiated alternative, incontinent management interventions.

REFERENCES

" Prevention is protection – stopping pressure ulcers before they start". Professor Amit Gefen, Ph.D., Department of Biomedical Engineering, Tel Aviv University, Israel , October 21 2014

"A randomized controlled trial of the effectiveness of soft silicone multi-layered foam dressings in the

prevention of sacral and heel pressure ulcers in trauma and critically ill patients: the border trial". Santamaria N, Gerdtz M, Sage S, McCann J, Freeman A, Vassiliou T, DeVincentis S, Ng AW, Manias E, Liu W, Knott J. *International Wound Journal 2013* ; doi: 10.1111/iwj.12101

"Reduction of sacral pressure ulcers in the intensive care unit using a silicone border foam dressing." Chaiken N. *Journal of Wound Ostomy Continence Nursing 2012;39:143–5.*

"Systematic review of the use of prophylactic dressings in the prevention of pressure ulcers". Call E, Pedersen J, Bill B, Black J, Alves P, Brindle CT, Dealey C. *International Wound Journal* (Impact Factor: 2.02). 01/2014; 11(5). DOI: 10.1111/iwj.12212

Attachments:

BMH Pressure Ulcer-Therapy Bed Algorithm-rev-2017.xlsx
Skin care Algorithm3-8-2017.pdf
Specialty Bed Resource Tip Sheet 10-16-18.pdf

Approval Signatures

Step Description	Approver	Date
Staff Education Completed	Susan Roos: Senior Director Nursing Quality/Special Projects	05/2017
HPI	Shawna Doran: Corporate Director of Quality	02/2017
Nurse Practice	Karen Carroll: Vice President Patient Care Services	02/2017
Policy Committee	Shawna Doran: Corporate Director of Quality	02/2017
Provision of Care Committee	Marla Slock: Department Director, Med/Surg	02/2017
Meditech Change Committee	Cheryl Hirleman: Director	01/2017
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical	12/2016
	Susan Roos: Senior Director Nursing Quality/Special Projects	12/2016

Beaufort Memorial

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Responsible Party:	*Marla Slock: Department Director, Med/Surg*
Policy Area:	*ORG: Provision of Care*
Reference Tags:	

Treatment of Hypoglycemic Episodes-Adult, POC 14.02

See also:

Lippincott Blood Glucose Monitoring Protocol Link

PURPOSE:

To provide an evidence-based standard of care for the treatment of hypoglycemic episodes in adult diabetic patients admitted to Beaufort Memorial Hospital, excluding Birthing Center, newborns and pediatrics.

POLICY/PROCEDURE:

- Adult diabetic patients should be treated in accordance with the "Adult Hypoglycemic Protocol" for hypoglycemic episodes unless the physician/licensed independent practitioner (LIP) writes his/her own orders for hypoglycemia treatment.
- Registered nurses shall implement the Hypoglycemia: Adult Management Protocol where delay of patient treatment for blood glucose less than 70 mg/dL may cause harm to the patient, unless otherwise ordered by a physician.
- The attending physician should be contacted for hypoglycemic episodes according to the treatment protocol.
- Registered nurses will document ALL episodes of hypoglycemia, all blood glucose results, and treatments/treatment per protocol in the appropriate areas in medical record.
- Patient and family/caregiver education regarding hypoglycemia should follow any episodes of hypoglycemia.

LITERATURE REFERENCES

Cox D.J., Gonder-Frederick L., Ritterband L. & Kovatchec, C. (2007). Prediction of severe hypoglycemia. Diabetes Care, 30 (6):1370-1373.

Cryer, P.E, Axelrod L., Grossman A.B., Heller, S. R., Montori, V.M., Seaquist, E.R, & Service, F. J. (2009). Evaluation and management of adult hypoglycemic disorders: An Endocrine Society Clinical Practice Guideline. Journal of Clinical Endocrinology & Metabolism, 94(3): 709-728.

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disease: Systematic review and meta-analysis with bias analysis. British Medical Journal, 347, 4533.

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Seaquist E.R., Anderson J. & Childs B. (2013). Hypoglycemia and diabetes: A report of a workgroup of the American Diabetes Association and the Endocrine Society. Journal of Clinical Endocrinology & Metabolism, 98 (5):1845-1859.

Shih-hung, T., Yen-Yue, L., Chin-Wang, H., Chien-Sheng, C. & Der-Ming, C. (2011). Hypoglycemia revisited in the acute care setting. Yonse Medical Journal, 52(6), 898-908.

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Attachments:

Algorithm: Protocol for the Management of Hypoglycemic Episodes - Adults

Attachments: Algorithm: Protocol for the Management of Hypoglycemic Episodes - Adults

Approval Signatures

Step Description	Approver	Date
Ready for publication	Marla Slock: Department Director, Med/Surg [CB]	06/2018
HPI	Shawna Doran: Vice President Quality/Risk/Patient Safety [CB]	06/2018
Nurse Practice	Karen Carroll: Vice President Patient Care Services [CB]	06/2018
Provision of Care Committee	Marla Slock: Department Director, Med/Surg [CB]	06/2018
Meditech Change Committee	Mary Kaye Riley: Systems Analyst-Clinical [CB]	06/2018

Step Description	Approver	Date
Meditech Change Committee	Cheryl Brown: Director	06/2018
	Marla Slock: Department Director, Med/Surg [LM]	06/2018

Beaufort Memorial

Original Date:	*07/1992*
Reviewed Date:	*05/2017*
Revision Date:	*05/2017*
Next Review Due By:	*05/2020*
Responsible Party:	*Ashley Hildreth: Corporate Director of Quality*
Policy Area:	*ORG: Infection Prevention and Control*
Reference Tags:	

Hand Hygiene, Hand Washing, and Hand Antisepsis, IPC 08.05

Purpose:

To promote effective hand hygiene which reduces the transmission of infections.

Policy:

All healthcare workers will follow the recommendations below based on the Centers for Disease Control and Prevention.

Hand washing facilities or alcohol-based hand rubs which are readily accessible to all employees shall be provided in their workplace.

Procedure: Hand Hygiene

Hand antisepsis is the single most important means of preventing the spread of infection. The principle of good hand antisepsis is that of using friction to mechanically remove micro-organisms.

Hand Washing:

Hand washing facilities are located in patient rooms, utility rooms and decontamination rooms, all procedure areas, laboratories, bathrooms, and in all ancillary departments that care for patients, perform tests or procedures on patients or have contact with patient care equipment or linen.

A. How to wash hands with soap and water (technique):
   1. Turn on faucet to warm temperature.
   2. Wet hands first with water and apply soap.
   3. Rub hands together vigorously for at least 15 seconds covering all surfaces of the hands and fingers.
   4. Rinse hands with water and dry thoroughly with disposable paper towel.
   5. Use paper towel to turn off the faucet.
   6. Dispose of paper towels in appropriate containers.

B. When to Wash Hands:

Before and after entering the patient's room

BEFORE:

- Before patient contact
- Before performing invasive procedures (IVs, Central Lines, Urinary Catheters, Surgery, etc)
- Before preparing/administering medication
- Before and after contact with food or before eating
- Before contact with wounds

AFTER:

- **If hands are visibly soiled (dirty) or visibly contaminated with blood or other body fluids**
- After contact with a patient (taking BP, pulse, lifting patient, wound dressings)
- After contact with wounds
- After removing gloves, gowns, masks
- After using the restroom
- After moving from a contaminated body site to a clean body site during patient care
- After contact with objects located in the patient's environment, **including equipment**

ALCOHOL-BASED HAND RUB PRODUCT:

Alcohol-based hand rubs are located in all patient rooms and hallways outside patient rooms (except Mental Health Unit), and other locations as determined by department managers, Infection Preventionist and Plant Services.

A. How to decontaminate hands with alcohol-based hand rubs:
   1. Place enough product in your palm to thoroughly cover your hands.
   2. Rub hands together briskly, covering all surfaces of hands and fingers until hands are dry.
   3. Children under 6 years of age should be supervised when using this product.

B. When to use the alcohol-based hand rub product
   - If soap and water is not available
   - In place of washing hands with soap and water except as listed below under "Exceptions"

C. **EXCEPTIONS:**
   - ***Use Soap and Water i f Hands are Visibly Soiled or Contaminated with Blood or Other Body Fluids.***
   - ***Use Soap and Water After Using This Alcohol-Based Gel 4 or 5 Times In A Row to avoid a buildup of the product.***

D. Hand Lotions:
   1. Hospital approved hand lotion is available to be used to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or hand washing.
   2. Unapproved hand lotions are not to be used by care givers in patient care areas.

E. Finger Nails and Artificial Nails (see HR Personal Appearance Policy for specific personnel included):
   1. Artificial nails cannot be worn by clinical staff.
   2. Nails should be kept clean and should be no longer than ¼ inch in length from the end of the fingertips.

3. It is recommended natural nails be left unpolished. If polish is worn by clinical staff, it should be clear or a pale color and cannot be chipped, cracked or peeling.

Literature reference:

Centers for Disease Control and Prevention. (2016, March). *Hand Hygiene in the Healthcare Setting* . Retrieved from Centers for Disease Control and Prevention: www.cdc.gov/handhygiene

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Staff Education Completed	Mary Scott: Manager of Infection Control	05/2017
MEC - Norman Bettle, MD Chief of Staff	Trimmell Simmons: Medical Staff Coordinator	05/2017
HPI	Shawna Doran: Corporate Director of Quality [LM]	04/2017
Nurse Practice	Karen Carroll: Vice President Patient Care Services	04/2017
Infection Control Committee	Mary Scott: Manager of Infection Control	02/2017
Policy Committee	Shawna Doran: Corporate Director of Quality	02/2017
Meditech Change Committee	Cheryl Hirleman: Director	01/2017
	Mary Scott: Manager of Infection Control	12/2016

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Responsible Party: *Shawna Doran: Vice President Quality/Risk/ Patient Safety*
Policy Area: *ORG: Rights and Responsibilities of the Individual*
Reference Tags:

Beaufort Memorial

Patient Rights and Responsibilities, RRI 05.02

PURPOSE:

The purpose of this policy is to provide clear guidance on patient's rights and responsibilities to the patients that are served at Beaufort Memorial Hospital.

POLICY:

Beaufort Memorial Hospital (BMH) believes that effective health care requires collaboration between patients, physicians, and health care professionals. Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to optimal patient care. As the setting for the provision of health services, health care organizations should provide a foundation for understanding and respecting the rights of patients, their families, physicians, and other health care providers. They should ensure a health care ethic that respects the role of patients in decision-making about treatment choices and other aspects of their care. They should be sensitive to cultural, racial, linguistic, religious, age, gender, and other differences as well as the needs of persons with disabilities. Every patient admitted is entitled to the basic rights of human beings for independence of expression, decision, and action as well as concern for personal dignity and human relationships. BMH is committed to granting individuals impartial access to treatment or accommodations that are available and medically indicated, regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

PROCEDURE:

Patient Access Services (PAS) will provide each inpatient (or legal guardian) a copy of our designated Patient Handbook which advises the patient of her/his rights and responsibilities upon admission. Ambulatory Care settings will display patient Rights and Responsibilities information in public areas. If English is not the primary language of the patient or legal guardian, efforts are instituted to provide appropriate translation services.

PATIENT RIGHTS AND RESPONSIBILITIES

Patients served by Beaufort Memorial Hospital (BMH) have many rights that are in place to ensure they receive the best care possible with respect to their personal choices and best care decisions for their medical

care.

Rights:

- to receive information in a manner that is understandable to them or their legal guardian
- to have their inpatient admission status communicated as desired
- to have a family member, friend, or other individual be present with them for emotional support during the course of their stay within the boundaries of hospital policy
- to formulate an Advance Directive (such as a Living Will or Health Care Power of Attorney) with the expectation that the hospital staff and practitioners will honor the directive to the extent permitted by law and hospital policy
- to participate in the development and implementation of their plan of care, and be informed of proposed technical procedures and treatments including the potential benefit(s) and potential drawback(s) or risk(s) as well as alternatives for care and participate in decisions about their care
- to expect that, within the hospital's capacity and policies, the hospital will make a reasonable response to any patient's request for appropriate and medically indicated care and services. Treatment, referral, or transfer may be recommended. If requested or medically appropriate and legally permissible, the patient may be transferred to another facility after being informed about the need for, risks, benefits, and alternatives to transfer. The patient will not be transferred until the other facility agrees to accept them
- to receive considerate, respectful care and to expect privacy and dignity in treatment consistent with providing high quality medical and psycho-social care
- to have their pain assessed and managed appropriately
- to request or refuse medically appropriate treatment to the extent permitted by law and hospital policy
- to consent or decline to take part in research
- to be free from restraints of any form that are not medically necessary
- to receive considerate and compassionate care that respects their personal, spiritual, cultural, and religious values and beliefs
- to know the identity and professional status of those involved in their care
- to access information contained in their clinical records within a reasonable time frame, request amendments to, and obtain information on disclosures of their own health information, as permitted by law
- to be assured of the confidentiality of their clinical records, except in such cases as suspected abuse or public health hazards and/or when reporting is permitted or required by law to know the identity and professional status of those involved in their care
- to review their bill, have the information explained to them, and get a copy of their bill, regardless of source of payment, and have the right to know about payment methods
- to review policies, procedures and information about the relationship between care, treatment, and services and financial incentives
- to lodge a grievance through the BMH grievance process and / or with agencies that have licensure and survey responsibilities for the hospital
- to be informed of hospital policies and practices that relate to their care, treatment, and responsibilities
- to have the right to go outdoors on the BMH Campus when long lengths of stay are expected, unless doing so would compromise their health or the health of others

Responsibilities:

Patients served by Beaufort Memorial Hospital have responsibilities that help ensure safe and optimal care. These responsibilities include, but are not limited to the following:

- providing accurate and timely information that facilitates their care, treatment, and services
- asking questions or acknowledging when he or she does not fully understand the treatment course recommended
- following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital
- supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners
- meeting financial commitments

PRIVACY RIGHTS FOR ACTIVE DUTY MILITARY

According to the Defense Health Agency, the following website may be relied upon by health providers outside of the military system regarding privacy rights for Active Duty Military.

http://www.tricare.mil/tma/privacy/Military-Command-Exception.aspx.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
QIC of the Board	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
HPI	Mary Scott: Corporate Director of Quality	04/2018
Policy structure review	Laurie Martin: Associate VP of Operations	03/2018
	Shawna Doran: Vice President Quality/Risk/Patient Safety	03/2018

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Beaufort Memorial

Restraints and Seclusion, RRI 05.08

PURPOSE

To provide an organization approach to restraint and seclusion that seeks to protect the patient's health and safety and preserve his/her dignity and well being, including the right to be free from physical and mental abuse.

POLICY

1. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective to protect the patient, a staff member, or others from harm. It is the philosophy of the leadership of Beaufort Memorial Hospital to require that less restrictive interventions have been determined to be ineffective prior to the initiation of restraints. The exception to this would be if the patient is violent but alternatives must be considered.
2. It is the philosophy of the leadership of Beaufort Memorial Hospital to prevent, reduce, and strive to eliminate the use of restraints and seclusion. De-escalation techniques will be attempted to achieve this goal.
3. The decision to use restraint/seclusion is driven by a comprehensive individual assessment that is not specific to treatment setting or diagnosis and will be used only to ensure immediate physical safety of patient, staff, or others
4. Patients have the right to be free from physical or mental abuse and corporal punishment and patients and families have a right to know the organization's philosophy related to restraint/seclusion, including alternatives and reasons for restraint/seclusion.
5. Patients have the right to be free from restraint or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.
6. Restraint/Seclusion orders will be time limited.
7. Restraint/Seclusion orders will not be PRN or standing and will not be specific to treatment setting or diagnosis and will be discontinued at the earliest possible time.

8. The patient will be assessed to ensure that the type of restraint or the techniques used is the least restrictive that will be effective to protect the patient, a staff member, or others from harm. The patient will be monitored and reevaluated in order to prevent harm and unintentional limitation of their rights and dignity and to facilitate release at the earliest possible time.
9. Restraint and Seclusion will never be used simultaneously.
10. The Nursing Supervisor will be notified of each episode of restraint and seclusion.
11. The Nursing Supervisor or designee maintains a list of patients in restraints or seclusion. Opportunities for improvement and reduction in use of restraints and seclusion will be determined by the Restraint Team.

EXCEPTIONS

Forensic and correctional restraints used for security purposes by officers of the court are exempt from this policy. Use of pepper spray, tazers, and night sticks are not a health care intervention and, if used, are considered an action by officers of the court.

DEFINITIONS

Restraints Any manual method, physical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely. Two point restraints mean that the individual has two extremities in restraints. Four point restraints means that all four extremities are in restraints.

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

Seclusion The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Drugs used as a Restraint A drug is considered a restraint if it is used to manage the patient's behavior or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition. Drugs are considered a restraint if the overall effect of the medication is to reduce the patient's ability to effectively or appropriately interact with the world. Medications used as a restraint may not be written as a standing order or PRN order.

PROCEDURE FOR RESTRAINTS OR SECLUSION

Assessment for Restraint or Seclusion

Indications for the use of restraints on a patient will include:

- Danger to others.
- Interference with medical device.
- Patient safety - danger to self.

Application of Restraints or Seclusion

1. When less restrictive interventions have been determined to be ineffective and the patient's actions continue to interfere with medical treatment or patient/staff safety, then the physician or other LIP (Licensed Independent Practitioner) responsible for the care of the patient should order restraint or seclusion prior to the application of restraint or seclusion.
2. A registered nurse (RN), or another trained staff member under the direction of the registered nurse, may initiate restraints or seclusion.

Emergency application of restraints or seclusions:

1. In some situations, the need for a restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these circumstances, the Registered Nurse (RN), or another trained staff member under the direction of the registered nurse, may emergently initiate restraint or seclusion before obtaining an order from a physician or other Licensed Independent Practitioner (LIP).
2. The RN should notify the physician or other LIP who is primarily responsible for the patient's ongoing care, as soon as the situation is controlled, and consult with him/her about the patient's physical and psychological status and obtain an order for the intervention.
3. When emergency application of restraint is necessary, the order:
    - Must be obtained within one hour from a physician or other LIP.
    - If a telephone order, it must be signed within 24 hours.
    - The attending physician or his/her designee must be consulted as soon as possible, preferably within one hour, if the attending physician did not order the restraint or seclusion.

Physician Orders & Assessment for Restraints or Seclusion

- Restraints or seclusion may be ordered by a physician or other Licensed Independent Practitioner who is responsible for the care of the patient and is a member of the hospital medical staff.
    - The attending physician or his / her designee should be consulted as soon as possible, preferably within one hour, if the attending physician did not order the restraint or seclusion.
    - Standing orders and PRN orders are not permitted.
    - Ensure that the less restrictive methods have been, or would be ineffective to address this issue.
- The order should include, and is subject to time specifications listed below:
    - The order must specify the reason for the restraint or seclusion.
    - The type of restraint or seclusion to be used.
    - Location or part of the body to be restrained.
- Restraints or seclusion shall be discontinued as soon as the need no longer exists.
    - If restraint of seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint or seclusion.
    - A temporary, **directly-supervised** release from restraints or seclusion, that occurs for the purpose of meeting the patient's needs (e.g., personal hygiene, feeding, or range of motion exercises) may occur without triggering the need for a new restraint or seclusion order.

1. **Physician Orders and Assessment for Non Violent and Non Self Destructive Behavior**
   The physician or other LIP who is responsible for the patient's ongoing care should conduct a face to face

assessment of patient in restraints **within 24 hours of initiation** of restraints and **every calendar day** to either renew the order, or discontinue the order for restraints.

2. **Physician Orders and Assessment for Violent or Self Destructive Behavior:**

   A. The initial and all subsequent restraint or seclusion orders for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others shall expire in:

      - One (1) hour or less for patients under 9 years.
      - Two (2) hours for patients from 9 to 17 years.
      - Four (4) hours for patients 18 years and older.

   B. Physician face-to-face assessment within one hour of initiation of restraints for the management of **violent or self destructive behavior**:

      - The physician or other LIP shall perform and document a face-to-face assessment of the patient's physical and psychological status within one hour of the **initiation** of the restraint or seclusion for violent or self destructive behavior.
      - The in-person evaluation conducted within one hour of the **initiation** of restraint or seclusion includes the following:
         - An evaluation of the patient's immediate situation
         - The patient's reaction to the intervention
         - The patient's medical and behavioral condition
         - The need to continue or terminate the restraint or seclusion
      - When the in-person evaluation is done by a physician or other LIP other than the attending physician, the attending physician or his/her designee must be consulted as soon as possible after the evaluation, preferably within one hour.

   C. At the end of the age appropriate time limit noted above, if the continued use of restraint or seclusion to manage violent or self destructive behavior is deemed necessary based on an individualized patient assessment, another order is required (The order is renewed).

      - The initial restraint or seclusion order for violent or self destructive behavior may be **renewed** according to the age appropriate time limits noted above for a **maximum of 24 consecutive hours**.
      - A face-to-face patient evaluation is conducted within one hour of initiation by the physician or other LIP is **NOT** required when the initial order is **renewed**.

   D. Physician Every 24 Hour Face to Face Assessment for **Violent or Self Destructive Behavior**:

      - If a patient remains in restraint or seclusion for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others 24 hours after the original order, the physician or other LIP who is responsible for the care of the patient must see the patient and perform and document a face-to-face re-evaluation **before** writing a **new** order for the continued use of restraint or seclusion.
      - When the in-person evaluation is done by a physician or other LIP other than the attending physician, the attending physician or his/her designee must be consulted as soon as possible after the evaluation, preferable within one hour.

Formulation/Modifications to the Plan of Care

- The plan of care should be modified within 24 hours of the initiation of restraints or seclusion.
- The restraint intervention should include the type of restraint or seclusion and the goal of removal of soon as possible.
- Our goal is to involve the patient and family in the plan of care.
- The plan of care will be updated as per BMH Assessment and Reassessment policy.

RN Assessment, Monitoring, and Care

A. The RN **immediately** assesses the patient's physical and emotional status after application of restraints to include correct and safe application of restraints.
   - If the patient's response to restraints is negative, the RN will assure timely intervention is made with an alternative strategy.

B. RN assessment and monitoring for **Non Violent, Non Self Destructive Behavior**
   - The RN will assess the patient based on individual patient needs and response to intervention, preferably at least **every two hours.**

C. RN assessment and monitoring for **Violent or Self Destructive Behavior**
   Seclusion:
   - Monitoring of patients in seclusion is done through continuous in-person observation by a competent staff member.
   - *Exception:* After the first hour, a patient in seclusion may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition and wishes.

   Physical Hold
   - If the patient is on a physical hold, a second person shall be assigned to observe the patient.

   Restraint: (Violent and Self Destructive)
   - The RN will assess the patient based on individual patient needs and response to intervention, preferably **at least every 30 minutes.**

D. The assessment shall include the following, unless it is inappropriate for the type of restraint or seclusion employed:
   a. Signs of any injury associated with applying restraint or seclusion.
   b. Nutrition or hydration.
   c. Circulation and range of motion.
   d. Hygiene and elimination.
   e. Physical and psychological status and comfort.
   f. Readiness for discontinuation of restraint or seclusion.
   g. Vital signs will be done as condition warrants or as appropriate

Release Criteria

A. Restraint or seclusion shall be discontinued by registered nurse when:
   - The treatment dependent on the restraint or seclusion is discontinued.

- The patient exhibits the ability to cooperate with health care management.
- The patient no longer poses threat to self or others.
- Someone is available to stay with patient who can prevent patient from interfering with treatment or harming self or others.

B. The patient will be closely monitored for a return of the behavior that necessitated the use of restraints or seclusion.

C. A temporary, **directly-supervised** release from restraints or seclusion, that occurs for the purpose of meeting the patient's needs (e.g., personal hygiene, feeding, or range of motion exercises) may occur without triggering the need for a new restraint or seclusion order.

Documentation of Care

Each episode of restraints shall include the following documentation from the RN or other authorized staff member:

- The one-hour face-to-face evaluation by the physician or other LIP if restraint or seclusion is used to manage violent or self-destructive behavior.
- A description of the patient's behavior and the intervention used.
- Alternatives or other less restrictive interventions attempted (as applicable.)
- The patient's condition or symptoms(s) that warranted the use of the restraint or seclusion.
- The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
- Patient/family education and involvement in care.
- Specific restraint ordered and area of body restrained.
- Clinical assessment provided and safety assured during restraint episode.
- Reason that restraint is discontinued.

Patient/Family Rights and Education

The patient and/or his/her family are informed of the hospital's philosophy on restraints and seclusion.

LEADERSHIP NOTIFICATION RESTRAINT OR SECLUSION USE

The Hospital Nursing Supervisor should be notified of any instance of restraint or seclusion.

REPORTING OF INJURIES AND DEATH

Notify the Vice President of Quality Services or designee when hospital personnel become aware of a death within one week of the conclusion of restraint or seclusion due to a condition or episode that may be related to the restraint or seclusion episode.

The Nursing Supervisor shall notify the Vice President of Quality Services or designee whenever:

- A patient is injured or dies while in restraint or seclusion.
- A patient dies within twenty-four hours of the removal of restraints or seclusion.

The Vice President of Quality Services or designee will notify the Centers for Medicare and Medicaid Services (CMS) of:

- Each death that occurs while a patient is in restraint or seclusion.

- Each death that occurs within twenty four hours of removal of restraints or seclusions.
- Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death.
- Reporting will be completed within one business day.
- Document in medical record the date and time the death was reported to CMS.

EXCEPTION for CMS Notification of Injuries or Death:

When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:

- Records in a log or other system:
  - Any death that occurs while a patient is in restraint.
  - Any death that occurs within 24 hours after a patient has been removed from such restraints.
- Document the following information in the log or other system:
  - Patient's name
  - Date of birth
  - Name of attending physician or other licensed Independent practitioner responsible for the care of the patient
  - Medical record number
  - Primary diagnosis(es)
- The information is recorded within seven days of the date of death of the patient.
- Document in medical record the date and time the death was recorded in the log or other system.
- Make the information in the log or other system available to CMS immediately upon request.

TRAINING REQUIREMENTS FOR STAFF

Appropriate hospital and medical staff members shall receive training in the following subjects as it relates to duties performed under this policy. Such training shall take place during employee or medical staff orientation (before the staff member is asked to implement the provisions of this policy) and shall be repeated periodically as indicated in the hospital's training plan, which is based on the results of quality monitoring activities. The training programs should also include return demonstrations or post-training tests.

1. The physician or other Licensed Independent Practitioners who order restraints or seclusion shall be trained in the requirements of this policy and shall demonstrate a working knowledge of the policy through review of the policy and ongoing compliance.
2. Individuals providing staff training in restraints or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.
3. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.
4. Hospital staff who apply restraints, implement seclusion, monitor, assess and provide care for patients in restraint or seclusion shall receive training in the following:
   - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraints or seclusion.
   - The use of nonphysical de-escalation intervention skills.
   - Choosing the least restrictive intervention based on an individual assessment of the patient's medical or behavioral status or condition.

- The safe application, use, and removal of all types of restraint and seclusion used by a staff member, including training in how to recognize and respond to signs of physical and psychological distress or any signs of incorrect application of restraints.
- Clinical identification of specific behavioral changes or medical reasons that indicate that restraints or seclusion is no longer necessary.
- Assessment and monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, addressing hygiene, elimination, comfort, nutritional needs, and any other special requirements associated with the in-person evaluation conducted within 1 hour of initiation of restraint or seclusion.
- BLS Certification.

5. The Mental Health Unit, Emergency Department, Security and Nursing Supervisors will have initial and annual Crisis Prevention Intervention (CPI) certification.

PERFORMANCE IMPROVEMENT AND RISK MANAGEMENT

The Restraint Team will review data of restraint usage and implement a plan of action as needed. Individual nursing personnel will be invited as appropriate to participate in the review process. Resultant data and action plans shall be presented to the appropriate Quality Improvement Committees.

Attachments:

Restraint and Seclusion Pathway

Approval Signatures

Step Description	Approver	Date
Ready for publication	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
QIC of the Board	Shawna Doran: Vice President Quality/Risk/Patient Safety	05/2018
HPI	Mary Scott: Corporate Director of Quality	04/2018
Policy structure review	Laurie Martin: Associate VP of Operations	03/2018
	Shawna Doran: Vice President Quality/Risk/Patient Safety	03/2018

Beaufort Memorial

Original Date:	*01/2006*
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Responsible Party:	*Brian Hoffman: Vice President Human Resources*
Policy Area:	*ORG: Human Resources*
Reference Tags:	

Identification Badges, HR 03.11

POLICY:

The South Carolina Lewis Blackman Hospital Patient Safety Act of 2005 requires hospitals to provide specific information on Identification Badges, so that patients who require inpatient care or outpatient surgery can easily identify the person's responsible for their care.

Patients and visitors have a right to know the identity and professional status of those who care for them and their family members. All staff shall wear identification badges with their name, department, job title or trainee title while they are providing services to patients of Beaufort Memorial Hospital. All clinical trainees, medical students, interns, and physicians will be identified as such on their hospital supplied identification badge.

PROCEDURE:

A. All new employees, clinical trainees, physicians, medical students, interns, volunteers, and clinical instructors shall report to the Human Resources Department prior to providing services within the Hospital and its off-site departments to obtain an official Identification Badge.

B. All staff of Beaufort Memorial Hospital, clinical trainees, physicians, medical students, and interns, and clinical instructors shall wear their name badges with their name, department, job title or trainee title. All clinical trainees, medical students, interns, and physicians will be identified as such on the name badge.

C. Beaufort Memorial Hospital shall maintain an approved list of credentialed abbreviations that shall be routinely used on identification badges that are reasonably understandable to the average person. These abbreviations shall be made available to patients and visitors upon request.

D. The employees of the Emergency Department and the Mental Health Unit may execute the option to display just their first name, their job title and their Department.

E. Definitions include, but are not limited to:

1. **Clinical staff** means persons who work in a hospital whose duties include the personal care or medical treatment of patients. It includes, but is not limited to, credentialed physicians, physicians' assistants, nurses, nursing aides, medical technician, phlebotomists, and therapists.
2. **Clinical trainees** means persons who are receiving health care training in a hospital, either paid or unpaid, students or licensed professionals, whose training includes the personal care or medical treatment of patients. It includes, but is not limited to, resident physicians, medical students, nursing students, physical therapists, occupational therapists, and other students and individuals in health care professional training in a hospital.

3. **Credentialed caregiver** means a nurse practitioner or physician's assistant who is licensed to care for patients within his/her scope of practice.
4. **Credentialed physician** means a licensed physician who has completed his/her postgraduate medical training and has medical staff privileges at a hospital.
5. **Attending physician** means a licensed physician who has completed his/her postgraduate medical training and who has medical staff privileges at a hospital and who has primary responsibility for a patient's care while the patient is in the hospital.
6. **Designee** means a credentialed physician or a credentialed caregiver whom a patient's attending physician has designated to care for the patient in the absence of the attending physician.
7. **Medical student** means an individual enrolled in a program culminating in a degree in medicine.
8. **Resident physician** means an individual who is participating in any graduate medical education program and whose relationship to the patient is under the auspices of the medical education program.
9. **Intern** means an individual who is an advanced student or graduate in medicine gaining supervised practical experience.
10. **Approved Abbreviations:**

GENERAL	ABBREVIATION
Administrator	Adm
Assistant Vice President	Asst VP, AVP
Assistant	Asst
Associate	Assoc, Assc
Certified	Cert
Clinical	Clin
Coordinator	Coord
Counselor	Coun
Director	Dir
Health	Hlth
Home	Hm
Medical	Med
Manager	Mgr
Outpatient	OP
Patient	Pt
Procedure	Proc
Registered	Reg
Representative	Rep
Specialist	Spec
Senior	Sr

Supervisor	Supr, Supv
Surgical, Surgery	Surg
Services	Svcs
Technician, Technologist	Tech
Therapy	Ther
Vice President	VP
Volunteer	Vol
Worker's Compensation	WC
DEPARTMENTS	**ABBREVIATION**
Cardiology Services & Neurophysiology Services	
Cardiac	Cardio
Cardiovascular	CV
Cardiovascular Registered Nurse	CVRN
Cardiovascular Technician	CV Tech, CVT
Echocardiogram Technologist	Echo Tech
Electroencephalogram Technician	EEG Tech
Electrocardiogram Technician	EKG Tech
Monitor Technician	Mon Tech
Laboratory Services	
American Society of Clinical Pathologist	ASCP
Cytotechnologist	Cyto Tech
Histology Technician, Technologist	Histo Tech
Laboratory	Lab
Laboratory Technical Specialist	Lab Tech Spec
Medical Laboratory Technician	Med Lab Tech, MLT
Medical Technologist	Med Tech, MT
Pathology Assistant	Path Asst
Phlebotomist	Phleb
Specimen, Procurement and Procedure Technician	SP & P Tech
Nursing, Surgical & Related Services	
Anesthesia	Anes, Anest, Anesth
Adult Nurse Practitioner	Adult, NP; ANP
Care Team Technician	Care Team Tech, CTT
Certified Medical Assistant	Cert Med Asst, CMA
Certified Nursing Assistant	Cert Nursing Asst, CNA

Certified Registered Nurse Anesthetist	CRNA
Certified Surgical Technologists	Cert Surg Tech, CST
Clinical Nurse Specialist	Clin Nurse Spec, CNS
Employee Health Nurse	Emp Hlth Nurse
Endoscopy Technician	Endo Tech
Licensed Practical Nurse	LPN
Neonatel Nurse Practitioner	NNP
Nurse Practitioner	NP
Nurse Technician	NT or Nurse Tech
Nurse Technician Orthopedic	Ortho NT
Nursing Assistant	Nursing Asst, NA
Operating Room (Surgery) Tech	Surg Tech
Patient Care Administrator	Pt Care Adm
Patient Care Associate	Pt Care Assoc, PCA
Patient Care Technician	Pt Care Tech, PCT
Registered Nurse	RN
Surgical Technician, Technologist	Surg Tech, ST
Student Registered Nurse Assistant	SRNA
Pharmacy Services	
Certified Pharmacy Technician	Cert Pharm Tech
Clinical Pharmacist	Clin Pharm
Doctor of Pharmacy	Pharm D
Intravenous Pharmacy Tech	IV Tech, IV Pharm Tech
Pharmacy	Pharm
Registered Pharmacist	RPh
Physician and Physician Extenders	
Doctor of Osteopathy	DO
Medical Doctor	MD
Physician Assistant	PA
Resident Physician	Resident
Radiology Services	
Computerized Tomography Technologist	CT Tech
Magnetic Resonance Imaging Technician	MRI Tech
Mammography Technician	MMO Tech, Mammo Tech
Nuclear Medical Technologist	Nuc Med Tech

Radiation, or Radiological Technologist or Technician	Rad Tech, RT
Special Procedures Technologist	Spec Proc Tech
Rehabilitative Services	
Athletic Trainer	AT
Certified Occupational Therapist Assistant	Cert OT Asst, COTA, OTA, OTAC
Occupational	Occ
Occupational Therapist Registered	OTR, OT
Physical Therapist	PT, RPT
Physical Therapist Assistant	PTA, LPTA
Speech Language Pathologist	SLP, CCC
Respiratory Therapy Services	
Certified Respiratory Therapist/Technician	Cert Resp Ther/Tech, CRTT
Respiratory	Resp
Registered Respiratory Therapist	Reg Resp Ther, RRT
Social Services	
Licensed Bachelor Social Worker	LBSW, BSW
Licensed Independent Social Worker	LISW
Licensed Master Social Worker	LMSW, MSW
Licensed Professional Counselor	LPC
Social Worker	SW
OTHER DEPARTMENTS	**ABBREVIATIONS**
Mental Health	Men Hlth
Emergency Department	ED or spell out
Emergency Trauma Center	ETC
Endoscopy	Endo
Home Health	HH
Neurophysiology	Neuro
Occupational Health	Occ Hlth
Oncology	Onc
Operating Room	OR
Operating Room	OR
Orthopedic	Ortho
Pathology	Path
Pediatric	Ped
Pulmonary	Pulm

Rehabilitative	Rehab
Respiratory	Resp

F. Violations of this policy shall result in disciplinary action as outlined in HR policy **03.23**.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Brian Hoffman: Vice President Human Resources	01/2019
Senior Administration	Russell Baxley: CEO/President	01/2019
	Brian Hoffman: Vice President Human Resources	01/2019

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Policy Area: *ORG: Human Resources*
Reference Tags: *New Employee Orientation - ALL*

Beaufort Memorial

Tobacco-Free Policy, HR 03.20

POLICY:

The management and medical staff of Beaufort Memorial are committed to the hospital's mission of improving the health of the community. In order to promote good health and to reduce the risk of fire, smoking or use of tobacco products within Beaufort Memorial facilities and on its campus is prohibited. This policy applies to all persons including staff, physicians, inpatients, hospital based outpatients, visitors, students, vendors, contractors, subcontractors, children/youth, volunteers and others in buildings owned by Beaufort Memorial Hospital, on Beaufort Memorial grounds (leased or owned), parking lots and in all Beaufort Memorial vehicles. Physicians, inpatients, hospital-based outpatients, visitors, students, vendors, contractors, subcontractors, children/youth and volunteers are prohibited from smoking or using tobacco products or non-Food & Drug Administration approved nicotine delivery devises on all Beaufort Memorial Hospital premises.

The fact that BMH's campus and facilities are tobacco-free will be clearly posted in prominent areas. The sale of tobacco products is prohibited in all Beaufort Memorial Hospital facilities.

PROCEDURE:

The following regulations are provided to make staff members aware of their role and responsibilities in supporting Beaufort Memorial as a Tobacco-Free healthcare institution.

A. **STAFF**

Staff may not smoke or use tobacco products or non-FDA approved nicotine delivery devices (such as e-cigarettes) anywhere on Beaufort Memorial property. For the purposes of this policy tobacco products include, but are not limited to, cigarettes, cigars, pipes, chewing tobacco and snuff.

1. Smoking or using other tobacco products while in a vehicle on BMH premises or while walking to and from parking areas on the property is prohibited.
2. Under no circumstances should employees use adjacent properties such as the Technical College of the Lowcountry or public sidewalks for tobacco use.
3. Cigarettes, tobacco products or e-cigarettes should not be carried in open view while on duty.
4. Staff will receive periodic reminders regarding this policy. Staff is expected to assist in its enforcement by approaching violators and tactfully explaining the Tobacco-Free policy to patients and visitors.
5. New employees will be informed of the policy during the interview/hiring process. This includes

contract employees.

6. There will be no use of tobacco products in any BMH-owned vehicle.
7. Employees who violate this policy will be reported to their supervisor directly or by e-mail. The employees will be referred to a tobacco cessation program such as the LifeFit Smoking Cessation program, BMH health insurance resources or community resources. Employees who are cited for using tobacco products while on Beaufort Memorial premises will be subject to corrective action as outlined in the Corrective Action Section of the Human Resources Policies and Procedures.

B. **PATIENTS**

1. With assistance from our medical staff, patients will be informed that the Hospital and its campus are tobacco-free. Upon registration, patients shall be reminded of that fact that Beaufort Memorial Hospital is a tobacco-free campus both internally and externally. Additional resources for patients are available through the BMH patient handbook. Tobacco-free signage will be utilized at off campus Beaufort Memorial facilities to reinforce this policy.
2. Members of the medical staff may prescribe medications to help their patients remain tobacco-free during their hospitalization.
3. The following steps should be followed for patients that insist on non-compliance with the tobacco-free policy:

Nursing should remind the patient in a courteous and friendly manner that the hospital is tobacco-free. If a patient does not comply with this policy patient care staff should contact a manager or nursing administration for assistance. The patient's physician should be contacted with a request for further orders. Patients will be advised that failure to comply with this policy may be grounds for discharge or transfer from the facility.

C. **VISITORS**

1. Visitors wishing to smoke or use other tobacco products must leave the campus to do so.

D. **ASSISTANCE**

1. Assistance to staff for tobacco cessation will be offered through Employee Health Services and BMH health insurance. Assistance to inpatients is offered through FDA approved nicotine replacement therapies which are available by prescription through the Pharmacy.

E. **SAFETY**

1. In the event the tobacco violation involves a potential threat to health or safety (smoking where combustible supplies, flammable liquids, gases or oxygen are used or stored) and in other situations which may so warrant, the Security Department may be called upon for additional support.

valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Brian Hoffman: Vice President Human Resources	01/2019
Senior Administration	Russell Baxley: CEO/President	01/2019
	Brian Hoffman: Vice President Human Resources	01/2019

Beaufort Memorial

Original Date:	*02/2011*
Reviewed Date:	*01/2019*
Revision Date:	*02/2011*
Next Review Due By:	*01/2020*
Responsible Party:	*Brian Hoffman: Vice President Human Resources*
Policy Area:	*ORG: Human Resources*
Reference Tags:	

Social Media, HR 03.27

INTRODUCTION:

Beaufort Memorial Hospital, "BMH", recognizes the value of online Social Media sites and blogs as vital resources to positively promote the organization's mission, vision and values, operational goals, marketing and recruitment activities, as well as a forum for improved communication and patient care. At the same time, BMH has an interest in protecting the confidentiality of patient information and the image of Beaufort Memorial Hospital.

While employed at BMH, it is the expectation that all staff will be professional and act in an appropriate manner whether at work, in the general public or on Social Media sites. Employees represent the Hospital at all times. The same laws, behavior expectations, and guidelines for interacting with patients, employees, directors, students, and visitors apply online as in the Hospital and general public.

All postings to BMH-sponsored sites and other Social Media sites will be publicly available on the Internet and therefore publicly accessible without limitation or protection of any kind. Consider what information is shared, with the understanding that this information may be linked to your name and published on the Internet. What is posted can travel both fast and far, and can be very difficult, if not impossible, to retract or correct once it's out there.

POLICY:

BMH employees are prohibited from disclosing confidential hospital or patient information.

Employees are expected to protect the privacy of BMH, along with its employees and patients. All uses and disclosures of patient identifying health information shall be carried out in a manner compliant with applicable HIPAA privacy policies, regulations, and standards.

Employees are prohibited from posting on personal blogs or other sites the name, trademark or logo of BMH, including company-issued documents. Employees are not to use the BMH logo for endorsements, to promote a product, cause or political party or candidate.

DEFINITION OF SOCIAL MEDIA:

BMH defines Social Media as highly accessible content for which an individual is able to create and edit information for the purpose of social interaction via the Internet. Social Media includes, but is not limited to: video and wiki postings, such as YouTube and Wikipedia; networking sites such as Facebook and LinkedIn; micro blogging sites, such as Twitter; discussion boards/online forums, personal blogs or similar forms of

online journals, diaries or personal newsletters not affiliated with BMH.

BMH APPROVED USE OF SOCIAL MEDIA:

- Comments made to the BMH-sponsored sites, such as its Facebook page, are welcomed and encouraged. Comments should be courteous and productive. Profane, obscene, offensive, sexually explicit, inappropriate, inflammatory or statements that negatively impact the image of Beaufort Memorial Hospital will not be tolerated and will result in corrective action up to and including termination of employment.
- Only authorized employees may prepare and edit content for BMH's blog/Social Media entries. All content must be relevant, add value and meet at least one of the specified goals, purposes or core values developed by BMH. Administrators of BMH Social Media sites should consider their message, audience, and goals, as well as developing a strategy for keeping all information up-to-date.
- Posts made on Social Media sites should protect the Hospitals values by remaining professional in tone and in good taste.
- Employees are prohibited from using BMH's Social Media site to provide medical advice or medical commentary by non-BMH physicians or to use the Social Media site to make, recommend or increase referrals for physicians who are not employed by BMH.
- BMH reserves the right to monitor, prohibit, remove or delete any materials not compliant with these policies.
- The BMH Public Relations Department will be responsible for monitoring official BMH social sites.

BEST PRACTICES FOR ALL SOCIAL MEDIA SITES, INCLUDING PERSONAL SITES:

- Employees are personally responsible for their web postings and solely liable for web postings found to be an invasion of privacy, in violation of this Social Media policy and HIPAA.
- Any personal use of Social Media sites is expected to be on the user's non-working time and is not to interfere with the employee's job duties.
- Employees are expected to follow the guidelines and policies set forth to provide a clear line between you the individual and you as the employee.
- Employees may not make statements on behalf of BMH or appear to make statements of behalf of BMH. Identify your views as your own. If you identify yourself as a BMH employee online, it should be clear that the views expressed are not necessarily those of the Hospital.
- Employees may not post on personal blogs or Social Media sites photographs of patients unless compliant with the above policy.
- Employees cannot use Social Media sites to harass, threaten, or discriminate against employees. BMH will not tolerate harassment of any kind; this applies to all Social Media sites.
- Employees may not disclose BMH proprietary or confidential information such as Hospital documents, patient or employee information, intellectual property, and so forth.
- Employees should uphold the Hospitals value of respect for the individual and avoid making defamatory statements or disclosure of private facts about Hospital employees, former employees, patients and affiliates.
- Employees may not author posts that spread false information that could be harmful to the Hospital or community in general or threaten violence to any individual.
- Employees may not post any information that describes or makes light of, in any level of detail, specific medical conditions of patients receiving care at the Hospital.

- Employees may not disclose any patient-related information.

PROCEDURE:

BMH will take the necessary steps to protect its confidential information and enforce this policy. Any violation of this Social Media Policy will result in corrective action up to and including termination of employment. In addition, breach of confidential patient health information may also be subject to legal proceedings and/or criminal charges. For any questions regarding these guidelines or any matter related to Social Media, please contact the Human Resources Department at (843) 522-5680 or the PR and Marketing Department at (843) 522-5171.

RELATED POLICES:

There are a number of BMH policies that closely relate to this Social Media Policy. These include, but are not limited to:

Human Resource Policies

• HR 2.01	Equal Employment Opportunity
• HR 2.02	Anti - Harassment
• HR 3.15	Personal Conduct
• HR 3.23	Disciplinary/Corrective Action
• HR 3.18	Solicitation & the Distribution of Literature
• HR 3.25	Technology Device

Leadership Policies

• L.03	Code of Conduct
• MA 11	Media Relations
• MA 12	Release of Information

Administration

• HP 1.08	Minimum Necessary Rule for Use & Disclosure of PHI

If you are uncertain about any information, material or conversations, discuss the content with your department director or the Human Resources Department.

The above policy should not be interpreted to restrict or interfere with any employee's rights or protections under federal or state law.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Brian Hoffman: Vice President Human Resources	01/2019
Senior Administration	Russell Baxley: CEO/President	01/2019
	Brian Hoffman: Vice President Human Resources	01/2019

Current Status: *Active* **PolicyStat ID:** *4456466*

Beaufort Memorial

Original Date:	*02/2015*
Reviewed Date:	*04/2018*
Revision Date:	*04/2018*
Next Review Due By:	*04/2021*
Responsible Party:	*Allison Coppage: Avp Corp Comp, Priv & Conts*
Policy Area:	*ORG: Information Management*
Reference Tags:	

HIPAA Privacy/Breach Notification, HP 01.20

PURPOSE:

To ensure appropriate training, safeguards, and sanctions are in place to comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

POLICY:

Beaufort Memorial Hospital (BMH) and its affiliates will maintain appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information (PHI). The safeguards are intended to protect PHI from intentional or unintentional use or disclosure that is in violation of the privacy laws. Incidental disclosures, which happen as a result of an allowable use or disclosure, will be evaluated to ensure that only minimal information has been released. BMH has designated an individual to serve as HIPAA/Privacy Officer. This individual is responsible for: 1) ensuring the development, implementation, and maintenance of policies and procedures protecting patient confidential healthcare information; and 2) documenting, investigating, and responding to all patient complaints regarding confidential healthcare information.

DEFINITIONS:

A. **"Breach"** means an unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.

B. **"Breach Notification Rule"** means the HIPAA privacy regulations set forth in 45 CFR Part 164, Subpart D.

C. **"Disclosure"** means the release, transfer, provision of access to, or divulging of information to any persons or organizations other than the persons or organizations that already have the information.

D. **"Privacy Rule"** means the HIPAA privacy regulations set forth in 45 CFR Part 164, Subpart E.

E. **"Protected Health Information" or "PHI"** means individually identifiable health information that is transmitted by electronic media; maintained in any medium as described in the definition of electronic media; or transmitted or maintained in any other form. PHI excludes individual health information in education records and student health records covered by the Family Educational Rights and Privacy Act (FERPA) and employment records by a Covered Entity in its role as employer.

F. **"Unsecured Protected Health Information" or "Unsecured PHI"** means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section13402(h)(2)

of Public Law 111-5. Redaction **is not** an approved method of destruction

G. **"Use"** means the sharing, utilization, examination, or analysis of PHI within an entity that maintains PHI.

PROCEDURE:

Discovery - Following the discovery of a potential breach, BMH will conduct an investigation, perform a risk assessment and, based on the results, begin the process to notify each individual whose PHI has been accessed, acquired, used, or disclosed as a result of the breach.

Assessment – For the acquisition, access, use or disclosure of PHI to constitute a breach, it must violate the HIPAA Privacy Rule (HIPAA). A use or disclosure of PHI that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards would not be a violation of HIPAA and will not be viewed as a potential breach. The risk assessment and the supporting documentation shall be fact specific and address: 1) consideration of who impermissibly used or to whom the information was impermissibly disclosed; 2) the type and amount of PHI involved; and 3) the potential for significant risk of financial, reputation, or other harm.

Investigation – The BMH Privacy Officer will be responsible for the management of the breach investigation, completion of the risk assessment, and coordination with BMH Administration. He/she will facilitate notifications to the appropriate entities (HHS, OCR, media, law enforcement officials, etc.). All documentation related to the breach investigation will be retained for a minimum of six years.

Notification – A breach notification will be made to the patient no later than 60 calendar days after discovery. It is the responsibility of BMH to demonstrate that all notifications are made as required, including evidence demonstrating the necessity of delay. A delay may be requested by a law enforcement official when such notification or posting would impede a criminal investigation. A statement from law enforcement is required and may be written or verbal and needs to specify the time required for the delay. If the request is made verbally, document the statement, including the identity of the official and inform the individual that the notification or posting will be delayed no longer than 30 days unless a written request is submitted.

Employee Responsibilities – After the discovery of a suspected breach of PHI, the employee will notify the BMH Privacy Officer, the BMH Risk Manager, or contact the Compliance Hotline (1-888-398-2633). The call should include the identification of each individual whose PHI has been accessed, acquired, or disclosed and any other pertinent information. BMH provides training on how to identify and report breaches of PHI within the workplace.

Non - retaliation – When a person raises a good faith concern, including the exercise of privacy rights, retaliation is prohibited. If retaliation occurs, it will result in disciplinary action, up to and including termination of employment.

ATTACHMENTS:

Notice of Privacy Practices updated 1.27.15

LITERATURE REFERENCE:

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy

contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments: Notice of Privacy Practices

Approval Signatures

Step Description	Approver	Date
Ready for publication	Allison Coppage: Compliance Officer	04/2018
CFO	Kenneth Miller: Senior Vice President/Chief Financial Officer	03/2018
	Allison Coppage: Compliance Officer	03/2018

Beaufort Memorial

Notice of Privacy Practices (effective April 14, 2003; revised effective date: January 27, 2015)

Beaufort Memorial Hospital (sometimes referred as "we" "us" or "our") is a covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for the purpose of complying with the provisions that protect the privacy and security of your health information.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Except as provided by law, you have a right to adequate notice of the uses and disclosures of protected health information that may be made by us, and of your rights and our legal duties with respect to protected health information.

Protected health information (PHI) is information about you, including certain demographic information that may identify you and relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

We respect the privacy of your PHI and are committed to keeping it confidential. This Notice describes how we may use and disclose your PHI that we have received or created and describes your rights of access to and our obligations regarding your PHI.

We are required by law to take reasonable steps to protect the privacy of your PHI and to provide to you this Notice about our legal duties and privacy practices and your rights concerning your PHI and to notify you following any breach of unsecured PHI. We are required to abide by the terms of the Notice then in effect.

I. USE AND DISCLOSURE FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

We may use and disclose your PHI for purposes of payment, treatment, and health care operations. We have described these categories below and provide examples of the types of uses and disclosures we may make in each one.

For Payment. We may use and disclose your PHI so that we can bill and receive payment for the treatment and services you receive. For billing and payment purposes, we may disclose your PHI to your representative, insurance or managed care company, Medicare, or a third party payor. For example, we may contact Medicare to confirm your coverage for treatment by one of our providers.

For Treatment. We will use and disclose your PHI in providing you with treatment and services. We may disclose your PHI to our personnel and others who may be involved in your care, such as physicians, nurses, nurse aides, hospice staff, consultants, and therapists. For example, a nurse caring for you will report any change in your condition to your physician. We also may disclose PHI to individuals who will be involved in your care after you leave Beaufort Memorial Hospital.

For Health Care Operations. We may use and disclose your PHI to conduct and support our business and management activities. For example, we may use and disclose your PHI to conduct business planning activities, to carry out legal services and auditing functions, to manage and monitor our quality of care (including the performance of our staff) and for general administrative duties.

II. USE AND DISCLOSURE FOR OTHER SPECIFIC PURPOSES

Appointment Reminders. We may use or disclose PHI to remind you about appointments. If you are not at home, we may leave a message.

As Required By Law. We will disclose your PHI when required by law to do so.

Business Associates. We may disclose your PHI to a business associate who creates, receives, maintains or transmits information on our behalf that involves the use and/or disclosure of PHI, if we have a written contract with the business associate that contains terms designed to protect the privacy of your PHI. The definition of a business associate also includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate. A subcontractor also means a person to whom a business associate delegates a function, service, or activity other than as a member of the business associate's workforce. Examples of business associates include our attorneys or accountants and any of their subcontractors.

Beaufort Memorial Hospital Directory. Unless you object, we will include certain limited information about you in our directory. This information may include your name, your location, your general condition (e.g. "...is improving...") and your religious affiliation. Our directory does not include specific medical information about you. We may release information in our directory, except for your religious affiliation, to people who ask for you by name. We may provide the directory information, including your religious affiliation, to a member(s) of the clergy.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may disclose your PHI to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose your PHI to assist in a disaster relief effort.

Fundraising Activities. We may use certain PHI to contact you in an effort to raise money for our operations. We may also disclose demographic information and dates of health care to a business associate or foundation related to us so that the foundation may contact you to raise money for us. You may choose to opt out of receiving this information by so informing the Beaufort Memorial Hospital Director of Marketing and Communications.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for oversight activities authorized by law. These may include, for example, audits, investigations, inspections and licensure actions or other legal proceedings. These activities are necessary for government oversight of the health care system, government payment or regulatory programs, and compliance with civil rights laws.

Health-Related Benefits and Services. We may use or disclose PHI to inform you about health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose your PHI to a family member, other relative, or close personal friend who is involved in your care. If you are present and have the capacity to make health care decisions, we may use or disclose this information to notify these individuals of your location, general condition, or death, as long as we have obtained your agreement, given you an opportunity to object and you do not, or it is reasonable to infer from the circumstances that you do not object. If you are not present or are unable to agree or object due to incapacity or an emergency situation, we may exercise our professional judgment to determine whether disclosure of information relevant to the individual's involvement in your care is in your best interests.

Judicial and Administrative Proceedings. We may disclose your PHI that is expressly authorized by a court or administrative order. We may disclose your PHI in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if we have satisfactory assurance that you have been given notice of the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your PHI for certain law enforcement purposes, including:

- As required by law to comply with reporting requirements;
- To comply with a court order, warrant, subpoena, summons, investigative demand or similar legal process;
- to identify or locate a suspect, fugitive, material witness, or missing person (limited to certain categories of PHI);
- When information is requested about the victim of a crime if the individual agrees or under other limited circumstances;
- To report information about a suspicious death;

- To provide information about criminal conduct;
- To report information in emergency circumstances about a crime; or
- Where necessary to identify or apprehend an individual relevant to a violent crime or escape from lawful custody.

Military and Veterans. If you are a member of the armed forces, we may use and disclose your PHI as required by military command authorities. We may also use and disclose PHI about foreign military personnel as required by the appropriate foreign military authority.

National Security and Intelligence Activities: Protective Services for the President and Others. We may disclose PHI to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct special investigations.

Public Health Activities. We may disclose your PHI for public health activities. These activities may include, for example, the following:

- Reporting to a public health or other government authority for preventing or controlling disease, injury or disability, or reporting child abuse or neglect;
- Reporting to the federal Food and Drug Administration (FDA) concerning adverse events or problems with products for tracking products in certain circumstances, to enable product recalls or to comply with other FDA requirements, or
- Notifying a person who may have been exposed to a communicable disease or may otherwise is at risk of contracting or spreading a disease or condition.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your PHI to notify a government authority if required or authorized by law, or if you agree.

Research. We may allow PHI to be used or disclosed for research purposes provided that the researcher adheres to certain privacy protections. Your PHI may be used for research purposes only if the privacy aspects of the research have been reviewed and approved by a special Privacy Board or Institutional Review Board, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when we believe in good faith that the disclosure is necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone we, in good faith, reasonably believe is able to help prevent or lessen the threat.

III. AUTHORIZATION REQUIRED FOR OTHER USES OR DISCLOSURES

Other uses and disclosures of PHI not covered by this Notice will be made only with your written Authorization. If you give us written Authorization to use or disclose your PHI, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose your PHI for the purposes covered by the Authorization other than those described in the Notice. You understand that we are unable to take back any disclosures we have already made in reliance on the Authorization.

Most uses and disclosures of psychotherapy notes (where appropriate), PHI for marketing purposes, and disclosures regarding a sale of PHI require authorization, and other uses and disclosures not described in this Notice will be made only with your authorization.

IV. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI:

Right of Access to PHI. You have the right to inspect and obtain a copy of your medical or billing records or other written information that may be used to make decisions about your care, subject to limited exceptions such as psychotherapy notes or information compiled in anticipation of litigation. Your request for access must be made in writing and must be submitted to Beaufort Memorial Hospital Health Information Services Department on a form that is available in their office. We may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain limited circumstances. Access may be denied, for instance, to protect the confidentiality of another individual, to safeguard information covered by the Privacy Act, or in other circumstances outlined by the Privacy Rule. If you are denied access to PHI, in some cases you will have a right to request review of the denial, such as those that are based upon endangerment to another individual or those involving a reference to another individual. This review would be performed by a licensed health care professional we designate who did not participate in the decision to deny your initial request.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our website: http://www.bmhsc.org/patients-and-visitors/Medical-Records/Notice -of-Privacy-Practices/11690/Content.aspx

Right to an Accounting of Disclosures. You have the right to request an "accounting" of our disclosures of your PHI. This is a listing of certain disclosures of your PHI made by us or by others on our behalf, but does not include disclosures for payment, treatment, and health care operations or certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period beginning after April 14, 2003 that is within six years from the date of your request. An accounting will include, if requested: the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; a brief statement of the purpose of the disclosure or certain summary information concerning multiple similar disclosures. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

You have a right to or will receive notifications of breaches of your unsecured PHI should that event occur. This notice will come to you from the HIPAA privacy officer.

Right to Request Amendment. You have the right to request us to amend any PHI we maintain for as long as the information is kept by or for us. You must make your request in writing and must state the reason for the requested amendment. We may deny your request for amendment if the information:

- was not created by us, unless the originator of the information is no longer available;
- is not a part of the designated record set (e.g. medical or billing records) maintained by or for us;
- is not a part of the information to which you have a right of access; or
- is already accurate and complete, as we determine.

If we deny your request for amendment, we will give you a written denial including the reason for the denial and the right to submit a written statement disagreeing with the denial.

Right to Request Confidential Communications. You have the right to request that we communicate with you concerning PHI in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable requests. You must make your request in writing and specify how and where you wish to be contacted.

Right to Request Restrictions. You have the right to request restrictions in writing on our use or disclosure of your PHI for payment, treatment, or health care operations. You also have the right to restrict the PHI we disclose about you to a family member, friend, or other person who is involved in your care or the payment for your care. We are not required to agree to your requested restriction (except that while you are competent you may restrict disclosures to family members or friends) (and except that we must agree to restrict a disclosure of PHI to your insurance company/health plan if the disclosure would be for payment or health care operations purposes and is not otherwise required by law to be disclosed and we are paid in full for it by you (or a person acting on your behalf). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

V. STATE SPECIFIC REQUIREMENTS

Beaufort Memorial Hospital must follow both federal and state law to the extent they do not conflict with one another. HIPAA generally will take precedence over state laws that are contrary to HIPAA unless (1) the state law relates to the privacy of PHI and offers protections greater than those available to you under HIPAA or (2) the state law provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health. In those cases, the state law will take priority over HIPAA.

The following are just a few examples of some common situations where South Carolina or other federal laws require us to protect or share your information:

If you receive treatment for drug or alcohol use in a federally funded rehabilitation center, federal laws prevent us from releasing that information, except in certain situations. One or more of our facilities and services are subject to inspection by state and federal agencies and accreditation representatives who may review patient health information, which we are required to provide (you may have certain rights to object to review of your record).

VI. COMPLAINTS

If you believe that your privacy rights have been violated, you may submit a complaint in writing to Beaufort Memorial Hospital HIPAA privacy officer or you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Office of Civil Rights). We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request. We support your right to privacy of your PHI. We will not retaliate against you if you file a complaint with us or with the U. S. Department for Health and Human Services (Office of Civil Rights).

VII. CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and the terms of this Notice at any time. The revised Notice will be effective for all PHI we already received as well as for all PHI we receive in the future. We will post a copy of the current Notice in the administrative office of Beaufort Memorial Hospital. In addition, we will post a copy of the revised Notice on our web site and provide a copy to you upon request. Please make your request for a copy of this Notice to Beaufort Memorial Hospital privacy officer.

VIII. PRIVACY OFFICER

We have designated the compliance officer as the HIPAA privacy officer. If you have any questions about this Notice or would like further information concerning your privacy rights, the HIPAA Privacy Officer may be contacted at: 955 Ribaut Rd, 4th floor, Beaufort, SC 29902 or via telephone at (843) 522-5108.

Beaufort Memorial

Original Date:	*04/2015*
Reviewed Date:	*11/2018*
Revision Date:	*11/2015*
Next Review Due By:	*11/2021*
Responsible Party:	*Cheryl Brown: Director*
Policy Area:	*ORG: Information Management*
Reference Tags:	

Information Systems Acceptable Use, IM 03.07

Introduction

Access to information resources carries certain responsibilities and obligations as to what constitutes acceptable use of Beaufort Memorial's information resources.

Purpose

The purpose of this policy is to detail the acceptable use of Beaufort Memorial information resources for the protection of all involved.

Scope

The scope of this policy includes any and all use of Beaufort Memorial information resources, including but not limited to: computer systems, email, the network, and Beaufort Memorial Internet connections. This policy applies to all users (employees, contractors, consultants, agents, temporary staff, volunteers, etc.) who make use of Beaufort Memorial information resources, without exception.

Policy

In order to ensure *the* Beaufort Memorial's information resources are used appropriately, each user must accept the responsibility for their behavior and agree that they **WILL**:

- Logoff or badge out from any application or device that contains PHI when not actively working in the application;
- Report any suspected or actual violation. Any workforce member who observes or becomes aware of, or suspects a wrongful use or disclosure of PHI maintained by Beaufort Memorial is required to report their suspicion of the wrongful use or disclosure as soon as possible to their supervisor, the Director of Information Security or the Compliance Officer;
- Protect user IDs from unauthorized use;
- Protect all confidential and personal information used and collected by Beaufort Memorial from accidental or intentional disclosure;
- Recognize that each individual is responsible for all activities executed under their user ID;
- Access only files and data that they own, is publicly available, or to which they have been explicitly provided authorization to access;
- Respect the rights and property of others, including intellectual property rights, by using only legal versions of copyrighted software in compliance with all license or acceptable usage requirements set forth

by the copyright owner;
- Be considerate in their use of shared resources by refraining from monopolizing systems, overloading network resources with excessive data, wasting computer time, disk space, printer paper, manuals, or other resources;
- Comply with all applicable laws, regulations and Beaufort Memorial policies; and
- Behave responsibly with respect to Beaufort Memorial's information resources at all times.

In order to ensure Beaufort Memorial's information resources are used appropriately, each user must also agree that they will **NOT**:

- Access any patient's medical record for any purpose outside of treatment, payment, or health care operations, including education. This **specifically** includes but is **not** limited to Employees accessing their own medical record or protected health information in part or in full or that of family members, other hospital employees or acquaintances.
- Mail, email or fax a medical record to the wrong address or patient.
- Use a patient's PHI for personal reasons (such as developing a personal relationship with the patient) rather than for legitimate and authorized business reasons.
- Use another person's files or data without permission.
- Copy, store or transmit any data considered to be Protected Health Information (PHI) or deemed as sensitive or confidential in nature using removable media, non-Beaufort Memorial computing devices or external service providers, including, but not limited to, external hard drives, USB "sticks" or "thumb drives", home computers, web-based e-mail or data storage services, etc., unless directed to do so by Beaufort Memorial Management;
- Use computer programs to decode passwords or access control information;
- Engage in any activity that might be harmful to systems or to any information stored thereon, such as creating or propagating viruses, disrupting services, or damaging files;
- Make or use illegal copies of copyrighted software, store such copies on systems owned or managed by Beaufort Memorial, or transmit them over Beaufort Memorial networks;
- Use electronic mail or messaging services to harass, intimidate, or otherwise annoy another person;
- Disclose their password or use another person's user ID or password;
- Impersonate other Beaufort Memorial users to obtain support from Information Services personnel;
- Use Beaufort Memorial systems for personal gain, for example, by selling access to his/her user ID or by performing work in a manner not explicitly authorized by Beaufort Memorial leadership;
- Install or operate unauthorized software on Beaufort Memorial-owned or managed computing resources.
- Send unsolicited messages, mail or communications of any kind to persons who have not requested it or who cannot be reasonably expected to welcome such communication; and
- Print or display materials (images, sound, and messages) that create an atmosphere of discomfort or harassment for others.

The Beaufort Memorial network, and any external network to which the Beaufort Memorial network provides access, may not be used for:

- the creation, transmission, viewing or copying (other than for properly supervised and lawful research purposes) of any offensive, obscene or indecent images, data or other material, or any data capable of being resolved into obscene or indecent images or material;
- the creation or transmission of material which is designed or likely to cause annoyance, inconvenience or needless anxiety;
- the creation or transmission of defamatory material;
- the transmission of material that infringes upon the copyright of another person, organization, or entity;

- the transmission of unsolicited commercial or advertising material;
- deliberate unauthorized access to facilities or services accessible via the network;
- deliberate activities with any of the following characteristics:
  - wasting staff effort or networked resources, including time on end systems accessible via the network and the effort of staff involved in the support of those systems;
  - corrupting or destroying user or patient data;
  - violating the privacy of other users or patients;
  - disrupting the work of other users;
  - using the network in any way that denies service to other users (for example, deliberate or reckless overloading of access links or switching equipment);
  - continued use of any software or hardware that Information Systems has requested to be ceased.

By registering as a user of Beaufort Memorial information resources you agree to adhere to the following Acceptable Use Policy (AUP). Failure to adhere may lead to denial of access to part, or all, of Beaufort Memorial's information resources, or to other measures as defined under Beaufort Memorial's disciplinary procedures. This Acceptable Use Policy does not in any way supersede or invalidate other codes of conduct in operation at Beaufort Memorial.

The policies and procedures set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If this policy contains reference to clinical literature, the literature cited is only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Beaufort Memorial Hospital specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Ready for publication	Cheryl Brown: Director	11/2018
CFO	Kenneth Miller: Senior Vice President/Chief Financial Officer	11/2018
	Cheryl Brown: Director	11/2018

STUDENT SUBSTANCE POLICY CONSENT FORM

Name of School:_____ Name of Facility:_____

"Facility policy prohibits Students (as well as applicants, employees and contractors) from using "Substances" including, but not limited to, illegal drugs and legal prescription drugs without a current, legal and valid prescription. Alcohol may not be used in a manner that will cause Student to be impaired while at the Facility. Students shall be tested for Substances as directed by the School or the Facility.

THE SUBSTANCE POLICY

The Students are seeking Facility experience that is not granted to the general public.

It is the Facility policy to maintain and drug and alcohol free environment.

By choosing to access the Facility through the program, the Student *must* agree to follow the Facility's substance abuse policy, including Substance testing.

Any Student who chooses not to agree to this policy has chosen not to be in the program.

No Student shall be in the program who:

- Has chosen not to comply with the Facility's or School's directives;
- Is unfit for duty and/or
- Has not passed and Substance test within the six (6) months preceding Students provision of Patient Care Services.

The School Shall:

- Provide the Facility with a copy of each Student's completed Consent Form or request Student to provide the completed Consent Form to the Facility.
- Conduct testing of the Students through a licensed laboratory, if School is responsible for Substance testing; and
- Provide to the Facility copies of each Student's test result, for every test, if School is responsible for substance testing.

Substance testing may also be required by the Facility:

- When a Student is injured at the Facility;
- When a drug is not accounted for per Facility policy;
- For oversight of a Student who has previously completes a Substance rehabilitation program;
- For a Student who has been absent from the school program for more than 30 days (except for regularly calendared school breaks); and
- When a Student appears to be unfit for duty.