

**Medical Staff Orientation and Education
For
Physicians, Allied Health Professionals and
Other Licensed Independent Practitioners**

Attestation:

My signature below indicates that I have reviewed and understand the information provided herein as part of my initial appointment or reappointment to the Medical Staff at MercyOne Clive Rehabilitation Hospital.

- Practitioner “Good Faith” Reporting Participation
- Safety
 - Fire Response Plan
- Vision, Mission, Purpose, Values and Goals
- Scope of Services
- Infection Control
- Preventing Central Venous Catheter-Associated Infections
- Multi-Drug Resistant Organisms
- Patient Rights Overview
- Pain Management
- Anticoagulant Therapy
- Unapproved Abbreviations
- Use of Restraints or Seclusion
- Organ Donation (*clear documentation on time of death and disposition*)
- 2023 National Patient Safety Goals
- Physician Quality Plan Overview
 - Falls, Medication Reconciliation, Antibiotic Stewardship, Critical Tests, Change in Condition
- Impaired Licensed Independent Practitioners
- Compliance
- 2023-2024 Influenza Vaccine Information Statement
- Ebola Virus Disease (EVD) Information Statement

Please return this signed page via fax to 515-222-2767

Signature: _____ Date: _____

Printed Name: _____

*The enclosed information has been prepared for presentation to you as a healthcare professional. The instructions are designed to help you **SAFELY** perform your responsibilities within our hospital. Your cooperation in following these instructions is appreciated.*

INTRODUCTION

As an accredited comprehensive inpatient rehab program, MercyOne Clive Rehabilitation Hospital is capable of caring for a wide variety of diagnoses. These include, but are not limited to stroke, brain injury, spinal cord dysfunction, medically complex, trauma, orthopedic, neurological, amputation, and debility. does not treat patients who require ventilator assistance. A determination is made by the admitting physician and admissions intake personnel on a case by case basis to determine whether a patient's illness or injury is appropriate for admission to inpatient rehab.



MercyOne Clive Rehabilitation Hospital is accredited by The Joint Commission (TJC), a non-profit organization that sets minimum standards for quality and safety in healthcare organizations. TJC is also a deemed-status agency authorized by the federal government to certify healthcare organizations as meeting Medicare Conditions of Participation.

TJC Standards require that physicians, allied health professionals and other licensed independent practitioners receive education on selected topics. This information packet has been developed to meet these requirements.

PRACTITIONER 'GOOD FAITH' REPORTING PARTICIPATION

Physicians, allied health professionals and other medical staff members who have concerns about the safety and quality of care at MercyOne Clive Rehabilitation Hospital may report those concerns without any worry that retaliatory disciplinary action will occur. This type of disciplinary action is prohibited not only by MercyOne Clive Rehabilitation Hospital, but also by The Joint Commission.

Anyone who has concerns about the safety or quality of care at MercyOne Clive Rehabilitation Hospital may share those concerns with The Joint Commission, Office of Quality Monitoring, by phoning 1-800-994-6610, or by sending an e-mail to complaint@jointcommission.org.

Additionally, you may contact the Director of Continuous Quality and Performance Improvement (CQPI) for MercyOne Clive Rehabilitation Hospital at 515-381-6549 or the CEO at 515-381-6525 with any questions or concerns relating to the quality and safety of patient care provided at MercyOne Clive Rehabilitation Hospital.

SAFETY

Responding to Incidents in the Care Environment

If you become aware of an unsafe or potentially unsafe situation, please report it immediately to the supervisor of the care or work area. If an incident occurs, please take necessary action to protect yourself and others from harm and report the incident immediately to the supervisor of the care or work area. You may also file an Incident Report.

Role in Emergency Management

MercyOne Clive Rehabilitation Hospital has established a comprehensive plan to respond to a variety of emergency situations. In the event of a significant emergency (disaster – either internal or external), members of the medical staff that are on-site at the time will be responsible for providing medical care and support. This may involve activities such as (but not limited to):

- Determining which patients under your care could be discharged to make room for emergency admissions
- Staffing triage and secondary care areas depending on your discipline and specialty
- Providing medical direction to care units

During an emergency, members of the medical staff shall report to the **Command Center, which will be located in the Executive Board Room.**

How does MercyOne Clive Rehabilitation Hospital provide for co-worker safety?

- Doors lock down at 9:00 p.m., 7 days per week-**may change based on COVID-19 recommendations**
- Video cameras are located at the visitor entrance, service (ambulance) entrance, and the back (employee / delivery) entrance
- 2-way intercom is available to communicate to visitors outside the building, after hours
- In the event of immediate threat or danger, call 911 for police support
- Incidents of workplace violence will be directed to the immediate supervisor

Fire Safety

- Immediately following is MercyOne Clive Rehabilitation Hospital Fire Response Plan (EC.02.03.01EP9-10), which details this hospital's standard response to fire, or the potential of fire.

EMERGENCY PLANS QUICK REFERENCE

<u>Emergency Situation</u>	<u>Phone</u>
Code Blue.....	911 and page overhead (#44)
Rapid Response.....	Page overhead (#44)
Safety Officer	515-971-6794
Emergency/Maintenance	515-971-6794
AOC (Administrator on Call).....	515-314-5248
Emergency Command Center (Executive Board Room).....	515-381-6594

Code Phrase of paged announcement (overhead page = #44))

- **Announce code and location, repeat 3 times**
- **AND call appropriate number- as specified**

<u>Announcement</u>	<u>Number to Call</u>
Cardiac/Respiratory Arrest.....	911/page overhead (#44)
Severe Weather/Tornado.....	Page overhead (#44)
Bomb Threat.....	Call List/Page overhead (#44)
Abduction/Elopement.....	Monitor exits/page overhead (#44)
Fire/Smoke.....	Pull fire alarm/page overhead (#44)
Security.....	Page overhead (#44)
Internal/External Disaster.....	Page overhead (#44)
Hazardous Chemical Spill.....	Page overhead (#44)
Active Shooter.....	911 / page overhead (#44)

*****Safety Data Sheets are available online.**

Subject: Fire Response Plan

Policy: EC.02.03.01EP9-10

Effective Date: 5/28/2018

Review Date: 11/16/2020

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PURPOSE

In order to assure the safety of patients, visitors, and staff, a standard response to fire, or to the potential of fire, defined plans are required. This fire plan describes the standard responses for all staff within the Hospital to an activation of the Fire Alarm or to conditions that indicate the presence of a fire in the area.

POLICY

In the event of a fire, the staff and licensed independent practitioners will follow the basic plan for the building in which they are located. They will use the same plans for fire drills as they do in actual events. Fire drills will be observed to measure the effectiveness of staff response, as well as to measure the response of building fire systems.

PROCEDURE

1. Fire In Your Work Area

Hospital:

- a. An alarm will sound throughout the building and where the pull station was activated or where the automatic sensors have detected smoke or heat.
- b. An overhead page will follow indicating the location of the fire.
- c. If you discover smoke, fire, or the alarm system is activated in your immediate area, the appropriate response will best be remembered by using the acronym R.A.C.E.:

R- Rescue Remove people

- Remove anyone in immediate danger to a safe area. This may be a patient, visitor, or employee.
- Do Not Use Elevators.

A- Alarm Sound the Alarm

- Go to the nearest pull station and activate. This notifies the Fire Department.
- Call to notify the operator of the location of the fire. The Operator will then overhead page “**FIRE, Area, and Location**” three times at 3-minute intervals until ALL CLEAR.

C- Confine Secure the Area

- Close all doors and windows
- Remove all items from the corridors
- The Administrator will assess the need if oxygen supply to the affected area should be discontinued. Only the Administrator, or his designee, or Fire Marshall is authorized to order a supply valve closed. A member of the Respiratory Department will be responsible for closing the valve after ensuring all persons dependent on oxygen delivery systems are properly treated.

E- Extinguish Attempt to extinguish fire

- Fight the fire only if you are not placing yourself in danger.
- Personnel in the immediate department area should take an extinguisher and proceed to the fire.

All Clear Situation is under control

The Fire Department Incident Commander at the scene verifies that the situation has been resolved. The Incident Commander will notify the Switchboard operator and “**FIRE IS ALL CLEAR**” will be paged overhead.

2. General Responsibilities for Fire Alarm Activation *Above, Below or Adjacent* to the Code Area

If your area is above, below, or adjacent to the point of origin, the following procedures are:

- i. Close all doors
- ii. Remove items from the corridors
- iii. Have patients return to their rooms
- iv. Remind patients and visitors not to use elevators
- v. Listen for overhead pages for status of situation

3. General Responsibilities for Fire Alarm Activation *Remote* from Your Work Area

If your area is away from the point of origin (not within your immediate area or above, below or adjacent to that area), the following procedures will need to be implemented:

- i. Be ready to accept patients from the point of origin
- ii. Remind patients and visitors not to use elevators
- iii. Listen for overhead pages for status of situation

4. Evacuation

- a. Evacuation will not take place until directed by the Incident Commander and/or Fire Department. At any time, when several patients are in immediate danger, moving them to a safer area can be done without these approvals. The Administrator or Administrator on Call evaluates the situation and determines the need to activate the Emergency Operations Plan.
- b. Do Not Use Elevators
- c. There are several types of evacuations, the following are the:

- i. Stage I-Horizontal-move them into an adjacent smoke compartment.
- ii. Stage II- Vertical- move one floor down taking the exit stairs if multi story building.
 1. Stage III- Building- all patients and visitors will be moved from the building to alternate care sites.
- d. Incident Commander in conjunction with the local Fire/Police department will determine the need for evacuation beyond horizontal evacuation to an adjacent smoke compartment.

For more information on evacuation, see Emergency Operations Plan- Appendix 1: Evacuation Plan.

5. FIRE EXTINGUISHERS

- a. Location of Fire Extinguishers:
All employees should be oriented to the location of the fire extinguishers in their respective work area/department. Storage or equipment should never block fire extinguishers. The Plant Operations Manager visually inspects extinguishers every month.
- b. Use of Fire Extinguishers:
Select the proper fire extinguisher for the fire. Position yourself as close to the fire as safely possible. Remember to leave a way out.

Use the **PASS** method to extinguish the fire:

- Pull** the pin on the extinguisher.
- Aim** the extinguisher nozzle at the base of the flames.
- Squeeze** the handle to discharge the extinguisher. Squeeze the handle as the contents are under pressure.
- Sweep** from side to side at the base of the fire. Remember that the extinguisher will empty quickly. Do not waste the extinguishing agent.

DO NOT ATTEMPT TO EXTINGUISH THE FIRE IF IT IS TOO LARGE OR DANGEROUS. CLOSE THE DOOR, LEAVE THE AREA AND AWAIT ARRIVAL OF THE FIRE DEPARTMENT.

6. Fire Drills Will:

- Be conducted a minimum of once per quarter per shift.
- Be evaluated for performance of fire safety equipment and staff.
- Be reviewed by the Safety Committee on a regular basis.
- Simulate real-life possibilities.
- Be scheduled at varied times.
- Be conducted by the Safety Officer.
- Be observed from varied locations.

Evaluation of Staff Knowledge will include:

- Compartmentalization and containment.
- Areas of Refuge.
- Fire extinguishment.
- Fire response duties.
- Vertical and horizontal evacuation.

Staff response will be observed at the drill location and:

- Adjacent compartment(s).
- The compartment above and below the drill location.

Improving Health, Function and Quality of Life

VISION

MercyOne Clive Rehabilitation Hospital will be the rehabilitation provider of choice, by providing high quality care resulting in excellent outcomes and high patient satisfaction.

MISSION

The mission of the Hospital is to improve the health, function & quality of life of the people in the communities we serve.

PURPOSE

The purpose of The Hospital is to provide comprehensive medical rehabilitative care to patients and families utilizing a team approach. We work with people of all abilities to achieve their highest level of wellness and independence.

VALUES

Be Kinder Than Expected
Do the Right Thing Always
Stay Focused on the Patient
Respect Individuality to Create the Team
Give Your Best
Create Fun in What You Do

GOALS

To provide comprehensive medical rehabilitation services that meet the needs of the patients in order to successfully discharge to the community.

SCOPE OF SERVICES

Admission Criteria

1. Patient must have an appropriate rehab related diagnosis as determined by the admitting physician and accepting administrator of the hospital
2. Patient must be medically stable enough to participate in 3 hours of therapy per day or 15 hours of therapy over a 7 day period
3. Patient must require the skilled services of at least two therapy disciplines (physical therapy, occupational therapy, speech language pathology)
4. Patient must require the specialized care of a physician with expertise in physical medicine and rehabilitation
5. Patient must have potential to participate and benefit from therapies
6. Patient must have potential to achieve measurable rehabilitation objectives
7. Patient must exhibit the desire to participate in therapies
8. Patient must have an appropriate, realistic, post-rehabilitation discharge plan
9. Patient must be at least 16 years of age

Continued Stay Criteria

Continued stay is dependent on the following:

1. Patient continues to satisfy admission criteria standards previously listed:
 - Patients must be demonstrating satisfactory functional progress in at least two therapy disciplines, (Physical Therapy, Occupational Therapy, Speech-Language Pathology) to justify continued stay on the Rehabilitation Unit
 - Patient must continue to be a willing participant in his/her medical and therapy treatment programs
 - Any patient unable to participate in 2.5 hours of therapy per day for 3 continuous days must be prepared for discharge to a more appropriate level of care
2. Patient does not meet previously listed discharge criteria
 - Any patient, who has achieved all of their original and revised goals in any therapy, must be discharged from that therapy if no further functional goals are identified
 - A patient who no longer meets criteria for continued stay must be prepared for discharge, as soon as possible, and no longer than 3 days following determination of need for discharge
 - A patient who has plateaued or fails to exhibit satisfactory progress in a specific therapy discipline must be discharged from that therapy, even if the original and revised goals have not been achieved

Discharge Criteria

Patients will be discharged from Inpatient Rehabilitation when one or more of the following criteria are met:

1. Treatment goals are met
2. It is determined by the interdisciplinary team that the patient has limited potential to benefit from further treatment/service
3. Intensity of inpatient rehabilitation services is no longer required
4. Failure to make measurable functional progress

5. Patient unwilling to fully participate in the program (i.e. patient refuses therapy)
6. Medical condition, or treatment for a medical condition (i.e. daily chemotherapy, radiation, etc.), excludes the patient from full participation in the program
7. Patient requires surgery
8. Funding source denies further coverage and the patient/family decline to pay out of pocket
9. Patient and/or significant other declines further service

Discharging Against Medical Advice (AMA)

No person determined to have decision-making capacity that desires discontinuation of medical treatment and release from the hospital shall be held against his/her will. If a patient chooses to leave against medical advice:

1. The patient will be informed of his/her right to refuse treatment and the potential risks of leaving the hospital
2. The attending physician will be notified of the patient's desire to terminate medical care and leave the hospital
3. If a patient chooses to leave against medical advice, he/she will be asked to sign AMA forms recognizing that he/she has been informed of the risks associated with discharge

Involuntary Discharge from Inpatient Rehabilitation

Involuntary Discharge means that the patient is being discharged from the hospital against their desire. The following are reasons for involuntary discharge:

1. The patient has achieved all treatment goals
2. The patient demonstrates limited potential to benefit from further treatment/service
3. The intensity of inpatient rehabilitation services are no longer required
4. The patient is not making measurable functional progress
5. The patient is unwilling to fully participate in the program (i.e. patient refuses therapy)
6. The patient's medical condition, or treatment for a medical condition (i.e. daily chemotherapy, radiation, etc.), excludes the patient from full participation in the program
7. The patient requires surgery
8. The patient will be more appropriately served at another level of care
9. The patient engages in use of alcohol or non-prescribed drug use while in the hospital
10. The patient demonstrates abusive or disruptive behavior towards hospital staff, other patients, or visitors that is not related to his/her diagnosis
11. Funding source denies further coverage and the patient/family decline to pay out of pocket

Integration of Patient Care and Support Services

Patient care is delivered using a team approach. The composition of teams will be determined based on patient personal goals, the goals set by the physician, the goals set by the therapists, and the strategies determined to be most important in reaching those goals/predicted outcomes. Teams meet weekly at a team conference to discuss patient needs and goals.

During the first team conference, a projected date is set for the patient to go home based on the admission diagnosis and an assessment of the patient's rehabilitation needs following admission.

Teams Consist of the Following:

Patient and Family

The philosophy of MercyOne Clive Rehabilitation Hospital is to create a team of healthcare and other professionals that is centered around the persons served and his/her family. Patient and family involvement is essential for optimal rehabilitation outcomes to be realized. Family's regular contact and reinforcement of treatment goals and strategies is crucial. Family and patient questions, concerns, and recommendations are important to the rest of the treatment team. Patients and family are encouraged to write down these questions/comments and share them with the Team.

Medical Staff / Physicians

Our Medical Director has specialized training and experience in acute rehabilitation. The Medical Director, and the other physicians on our medical staff, care for the patients physical and medical needs and provide direction and coordination for the treatment team and program. The treatment program is designed to increase patients' independence and help reach their goals.

The attending physician is a specialist in Physical Medicine and Rehabilitation (a Physiatrist) who closely monitors patients' progress and medical condition. In some circumstances, the physicians request consulting services of other physicians. Although physicians are in the building every day, we do not have a physician in-house at all times. However, an on-call physician is available twenty-four hours a day, seven days a week. In an emergent situation, when a physician is not in-house, the on-call physician is notified as well as the patient's personal physician.

Rehabilitation Case Manager

The Rehabilitation Case Manager works closely with the rest of the team to ensure the patients' stay in the hospital is effective in meeting the needs for discharge to home. The Case Manager reviews the patients' care plan and schedule of therapies daily to assure that the individual program is followed as planned. The Case Manager arranges for follow-up services, durable medical equipment, and can also address financial and insurance issues.

The Case Manager is available to help patients obtain maximum benefits during and after their hospitalization. Case Managers also provide support for patients and family, make referrals to community agencies, and arrange for services or special equipment for use after patients discharge from the hospital.

Rehabilitation Nursing

The nursing team is staffed with highly trained and skilled individuals who have extensive backgrounds in critical care, rehabilitation, and acute care settings. The nursing team consists of Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs).

Physical Therapist

The Physical Therapist works to improve patients' strength, balance, coordination, and ability to get around. The therapist will help patients to safely get in and out of bed and the bathroom, to walk, and to use a wheelchair, if necessary.

Occupational Therapist

The Occupational Therapist works to improve patients' ability to bathe, eat, get dressed, and manage at home and/or work. The therapist will make suggestions for special equipment and/or teach patients different ways to do things to help them perform these activities safely on their own.

Speech Therapist (As Needed)

The Speech Therapist works with patients to improve their ability to communicate verbally and to teach methods to improve the process of eating and swallowing, if these have become impaired. The therapist will make recommendations relating to improving or enhancing these areas of concern.

Respiratory Therapist (As Needed)

Respiratory Care is instrumental in the evaluation, treatment, management, and preventive care of patients with cardiopulmonary problems. All respiratory therapy procedures in this facility are provided by qualified respiratory care practitioners.

Other Providers (As Needed)

Other interdisciplinary team members may include, but are not limited to:

- Psychologist (if consulted)
- Dietitian (as needed)
- Chaplain (if desired)
- Other Specialist(s) (if consulted)

INFECTION CONTROL

The risk of development of a health care associated infection is minimized through a hospital wide infection control program. An effective Infection Control program identifies risks and responds appropriately involving all relevant programs and settings within the hospital.

Scope of Program

The Hospital provides comprehensive rehabilitation services to patients primarily diagnosed with neurological impairments, stroke, multiple trauma, head and spinal cord injury, and arthritis. The leading causes of mortality and morbidity in this highly populated area are heart disease, cancer, stroke, and injuries due to accident and lung disease. The majority of patients in the Hospital have previously been hospitalized at an acute hospital. Our goals are to assist these individuals regain function and return to independence. On admission, our patients may already have an infection or be in a weakened condition and susceptible to other illnesses and/or infections. Therefore, it is imperative that we provide an environment that focuses on prevention and control of infection. The Hospital will annually, or more often if indicated, perform a risk assessment based on probability, potential severity, intensity of response and our preparedness to address the risks.

Goals & Objectives

Reduce the risks of Hospital Acquired Infections as follows:

- Incorporate the Infection Prevention and Control Plan as a major component of safety and performance improvement
- Complete and as necessary, revise a risk assessment for the acquisition and transmission of infectious agents
- Employ hospital wide surveillance, collect, analyze and trend data.
- Implement an effective Infection Prevention Plan and evaluate effectiveness
- Engage Hospital leadership in the design and implementation of the Infection Prevention and Control Plan
- Educate physicians, staff, patients and others on prevention and control of infection including CAUTIs, and CLABSIs
- Integrate with healthcare and community leaders, recognizing that infection control and prevention is a communitywide effort
- Plan for responding to infections that may overwhelm our resources
- Meet employee expectations by providing a safe workplace environment.

Specific Goals Include:

- Reinforce and monitor Standard Precautions, emphasizing the importance of hand hygiene and use of hand sanitizers to limit unprotected exposures to pathogens and limit transmission of infection associated with procedures.
- Monitor and measure adherence of hand hygiene usage through routine surveillance to improve compliance with hand hygiene guidelines.
- Educate and monitor our employees regarding Transmission Precautions and proper techniques

- Educate and monitor our employees regarding care, cleaning and disinfection of equipment to limit the transmission of infections associated with the use of medical equipment, devices, and supplies.
- Collect, analyze and trend data on infections – primarily those caused by MRSA, VRE and *C. difficile*. Track by number of cases per 1000 patient days.
- Collect, analyze and trend data on Central Line Associated Blood Stream Infections (CLABSI) — primarily those caused by MRSA, VRE, and *C-difficile*. Track by number of cases per 1000 patient days.
- Educate all employees on the importance of the vaccination program – hepatitis, influenza and pneumonia. Monitor participation with a goal of increasing employee participation.
- Educate staff regarding TB Exposure and Exposure Control.
- Evaluate and assist departments to develop departmental specific infection control plans.
- Collaborate with the partner hospital, regional emergency management and the community regarding response to risks, bioterrorism, as identified on the Hazard Vulnerability Analysis.
- Educate staff regarding Pandemic Influenza Plan
- Reduce the number of indwelling catheters. Educate staff and physicians on importance of timely removal to reduce number of catheter-associated UTI's.

Hand Hygiene

Washing your hands is the single most effective way of preventing the spread of infection among staff and patients. Our organization adheres to the CDC recommendations for good hand hygiene. Wash hands or use gel/foam sanitizer:

- Prior to direct contact with patients
- Before donning sterile gloves for procedures
- After having contact with a patient's skin
- After contact with blood or body fluids
- After having contact with equipment near a patient
- After removing gloves

You must wash your hands with soap and water for any of the following situations:

- Engaged in food preparation
- After using the restroom
- If your hands are visibly soiled
- Caring for a patient with C-Difficile

IMPORTANT THINGS TO KNOW ABOUT PREVENTING CENTRAL VENOUS CATHETER-ASSOCIATED BLOOD STREAM INFECTIONS

It is the policy of MercyOne Clive Rehabilitation Hospital to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

Equipment & Supplies

The organization has assured that equipment and supplies are available when a central line is inserted. At a minimum this includes:

- Central venous catheter
- Central venous catheter insertion kit
- Sterile drapes
- Barrier protection as outlined in this policy
- Chlorhexidine based antiseptic skin preparation (not required for patients < 2 months of age)
- Local anesthetic
- Line maintenance anticoagulant appropriate to the line type and patient age / presentation
- Site dressing

Central Venous Catheter Insertion



Whenever a central venous catheter is inserted, the following shall occur:

1. If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
2. Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion
3. Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning / gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site.
4. If body hair needs to be removed, it should be clipped rather than shaved
5. A chlorhexidine-based antiseptic skin preparation shall be used on all patients over 2 months of age unless contraindicated. For all other patients, the physician shall determine the appropriate antiseptic skin preparation.
6. Catheters should not be inserted into the femoral vein unless other sites are not available
7. Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
8. Confirmation of proper placement (e.g. x-ray or other test) may be performed.

Accessing Central Venous Catheters

To reduce the risk of infection, accessing central venous catheters should be limited to necessary use. Catheter hubs and injection ports must be appropriately disinfected prior to use.

Dressing Changes

Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters

Catheters should be evaluated routinely and removed as soon as the patient's clinical status and needs will allow. Non-essential catheters should be removed.



MULTI-DRUG RESISTANT ORGANISMS

Periodic assessments are performed to identify the risk of acquisition and transmission of multi-drug resistant organisms (MDRO). Based on this assessment, the organization has identified the following MDRO to be of epidemiologic significance:

- MRSA (*methicillin resistant Staphylococcus aureus*)
- VRE (*vancomycin resistant Enterococcus*),
- CDI (*Clostridium difficile*)

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures have been employed:

Hand Washing

Staff and physicians should adhere to appropriate CDC recommendations on hand hygiene consistent with organization policy in this area. Touching environmental surfaces such as bedside rails and other patient equipment after hand washing should be avoided.



Patient Placement

When possible, patients should be placed in a private room. When a private room is not available, patients with a MDRO infection may be placed with other patients with active infection in the same site and organism and no other infection. Patients with colonization may be placed with other patients with colonization, as long as neither patient is being treated.

Isolation Precautions

Patients (both colonized and infected) shall be placed on contact isolation (precautions). Droplet isolation (precautions) should be instituted if the patient has known or suspected positive respiratory cultures.

Patients with positive cultures should remain in appropriate isolation (precautions) for the duration of their present admission and any future admissions to the hospital. Patients may be removed from isolation with the approval of the treating physician or Infection Preventionist.

Use of Personal Protective Equipment

Gloves, gowns, and masks should be worn as appropriate to the specific MDRO being treated. Consult appropriate infection control policy if you have any questions.

PATIENT RIGHTS OVERVIEW

- Right to a Notice of Privacy Practices
- Right to Access PHI
- Right to Request Amendment to PHI
- Right to Request Alternative Means of Communication
- Right to Request Restrictions of PHI
- Right to an Accounting of Disclosures
- Right to Complain about our Privacy Practices
- Right to opt out of hospital directory
- Right to restrict PHI from family and friends

PAIN MANAGEMENT

Patient Rights

Patients have the right to pain management. It is the policy of MercyOne Clive Rehabilitation Hospital to do the following:

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and service provided in the specific care setting in which the patient is being managed.
2. Require that methods used to assess a patient's pain are consistent with the patient's age, condition, and ability to understand
3. Assess the patient's response to care, treatment, and service implemented to address pain.
4. Treat the patient's pain or refer the patient for treatment.



Treatment of Pain

In general, all patients shall receive treatment for any active pain issue (acute or chronic), when intensity exceeds their acceptable level. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner.

Patient Refusal of Pain Management

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient's medical record.

ANTICOAGULANT THERAPY

Establishment of an Anticoagulant Management Program

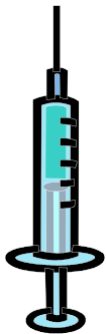
Patients receiving anticoagulant therapy shall have these medications ordered, prepared, dispensed, administered, and monitored in accordance with guidelines and requirements established in this policy.

The following requirements govern the overall approach to managing patients on anticoagulant therapy:

- There must be a clear and appropriate indication for use
- The particular type of anticoagulation used shall be the most appropriate and clinically indicated for the condition or reason for use.
- Where appropriate, patients laboratory values will be monitored while on anticoagulant therapy
- Pharmacy will review orders for anticoagulant therapy against normative and patient specific information regarding indications for use, dosage, route, frequency, contraindications, duplicative therapy, and drug/drug interactions. Issues or concerns will be brought to the attention of the prescribing practitioner for appropriate resolution (unless in emergent situations) before the medication is dispensed.

Management of Patients Placed on Warfarin Therapy

The following shall be required for patients placed on warfarin:



- The patient shall have a baseline International Normalized Ratio (INR) measured at the start of therapy.
- There shall be a current INR for the duration of therapy which shall be used to monitor and adjust therapy as warranted.
- The patient's baseline and current INR shall be available to Pharmacy for the duration of therapy and shall be reviewed prior to dispensing of warfarin. Issues or concerns will be addressed with the prescribing practitioner prior to the medication being dispensed.
- Authoritative resources shall be used in managing potential food / drug interactions

Education of Patients and Families

Patients and – as appropriate – families will be educated on anticoagulant therapy. This education shall include – but not necessarily be limited to – the following:

- Importance of follow-up monitoring,
- Compliance issues,
- Dietary restrictions,
- Potential for adverse drug reactions and interactions.

Evaluation of the Anti-Coagulant Therapy Program

The organization shall – at least annually – evaluate safety practices associated with the management of patients placed on anticoagulant therapy. This evaluation may take the form of:

- Analyzing medication errors and adverse drug reactions associated with the use of anticoagulant therapy
- Adherence to protocols developed to address specific conditions or indications for use
- Provision of education to patients / families
- Other measures as may be deemed appropriate

UNACCEPTABLE ABBREVIATIONS

Medication orders will not be accepted as valid if containing any of the listed abbreviations.
 Prescriber will be contacted for clarification.

Avoid	Intended Meaning	Correction
	1 mg	Do not use terminal zeros for doses expressed in whole numbers
	0.5 mg	Always use zero before a decimal when the dose is less than a whole unit.
	unit	“Unit” has no acceptable abbreviation. Use “unit.”
	every other day	Use “every other day”
	each day or daily	Use “every day” or “daily”
	International unit	Use “units”
	morphine or morphine salt	Use “morphine”
	magnesium sulfate	Use “magnesium sulfate”

USE OF RESTRAINT OR SECLUSION

At a minimum, physicians and other Licensed Independent Practitioners authorized to order restraint must have a working knowledge of this policy regarding the use of restraint. This training may include, but not necessarily be limited to, the following:

1. A patient's rights regarding the use of restraint.
2. Prohibitions on such use
3. Ordering requirements
4. Requirements and time frames for patient assessment

Rights of Patients

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Seclusion is not practiced in this facility

Seclusion is 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.

Requirements for Ordering of Restraint for any reason

This policy requires that a physician or other licensed independent practitioner (LIP) responsible for the care of the patient order restraint prior to the application of restraint.

In some situations, however, the need for a restraint intervention may occur so quickly that an order cannot be obtained prior to application. In these emergency application situations, the order must be obtained either during the emergency application of the restraint, or immediately (within a few minutes) afterwards.

Definition of a Licensed Independent Practitioner (LIP)

- For the purpose of ordering restraint, an LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints for patients.
- A resident who is authorized by State law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LIP by this policy. A medical school student is not an LIP.

Use of Restraint Protocols

- A protocol cannot serve as a substitute for obtaining a physician's or other LIP's order prior to initiating each episode of restraint use. If protocols are used that include the use of restraint, a specific physician or LIP order is still required for each episode of restraint use.
 - A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

Notification of the Patient's Attending Physician

- The attending physician must be consulted as soon as possible if the attending physician did not order the restraint. The attending physician is the physician who is responsible for the management and care of the patient.
- When the attending physician of record is unavailable, responsibility for the patient must be delegated to another physician, who would then be considered the attending physician.
- This policy does not specify that consultation with the attending physician be face-to-face. The consultation can occur via telephone.

Rehabilitation Hospital Provision of Care Policy and Procedure

PURPOSE

To define MercyOne Clive Rehabilitation Hospital (hereinafter referred to as the “organization”) policy regarding the restraint or seclusion of a patient

SCOPE AND APPLICABILITY

This policy addresses the use of restraint in a rehabilitation setting. It is applicable to:

- All locations within the hospital.
- All hospital patients, regardless of age, who are restrained.

DEFINITIONS

- **Physical Restraint**

Physical restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Under this definition, commonly used devices and other practices could meet the definition of a restraint, such as:

- Tucking a patient's sheets in so tightly that the patient cannot move;
- Use of splints that immobilize a patient's limb;
- Using 4 side rails to prevent a patient from voluntarily getting out of bed; or
- Recliners, only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.

- **General Exceptions to the Definition of Physical Restraint**

- Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, “*easily remove*” means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).
- A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this policy.

- **IV Armboards**

Use of an IV arm board to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.

- **Bodily Positioning Devices**

A mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint.

- **Hand Mitts**

The use of hand mitts would not be considered restraint. However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this would be considered restraint and the requirements would apply. Likewise, if the mitts are so bulky that the patient's ability to use their hands is significantly reduced, this would be considered restraint.

- **Use of Side Rails**

Raising the side rails when a patient is: on a stretcher, in a hospital bed being transported, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be considered restraint.

- However, side rails are frequently not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient's freedom to exit the bed. The use of side rails to prevent the patient from exiting the bed would be considered a restraint.
- If the side rails are segmented and all but one segment is raised to allow the patient to freely exit the bed, the side rail is not acting as a restraint. Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement.

- **Chemical Restraint**

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

- **Exceptions to the Definition of Chemical Restraint**
- Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition are not considered chemical restraint.
- Whether or not an order for a drug or medication is PRN or a standing-order does not determine whether or not the use of that drug or medication is considered a restraint.
- The use of PRN or standing-order drugs or medications is only prohibited if the drug or medication meets the definition of a drug or medication used as a restraint.
- Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

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

- **Seclusion**

Seclusion is not practiced in this facility.

Seclusion is 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.

Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded.

- **Exceptions to the Definition of Seclusion**

- A patient physically restrained alone in an unlocked room does not constitute seclusion. Confinement on a locked unit or ward where the patient is with others does not constitute seclusion.
- Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

POLICY

- **Rights of Patients**

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

- **Alternatives to the Use of Restraint**

The use of restraint is limited to those situations for which there is adequate and appropriate clinical justification

- The use of restraint is based on the assessed needs of the patient. Restraint may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.
- The use of restraint occurs only after alternatives to such use have been considered and / or attempted as appropriate. Such alternatives may include, but are not necessarily limited to:
 - Re-orientation
 - De-escalation
 - Limit setting

- Increased observation and monitoring
- Use of a sitter
- Change in the patient's physical environment
- Review and modification of medication regimens

- **Prohibitions on the Use of Restraint**

The use of restraint for the following reasons is prohibited:

- Coercion, discipline, convenience, or staff retaliation.
- Solely on the patient's history of dangerous behavior, if any
- The routine use of restraints for the prevention of falls. The rationale that a patient should be restrained because he or she "might" fall does not constitute an adequate basis for using a restraint. A history of falling without a current clinical basis for a restraint intervention is inadequate to demonstrate the need for restraint.

- **Requirements for Ordering of Restraint for any reason**

This policy requires that a physician or other licensed independent practitioner (LIP) responsible for the care of the patient order restraint prior to the application of restraint.

In some situations, however, the need for a restraint intervention may occur so quickly that an order cannot be obtained prior to application. In these emergency application situations, the order must be obtained either during the emergency application of the restraint, or immediately (within a few minutes) afterwards.

- **Definition of a Licensed Independent Practitioner (LIP)**

- For the purpose of ordering restraint, an LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints for patients.
- A resident who is authorized by State law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LIP by this policy. A medical school student is not an LIP.

- **Use of Restraint Protocols**

- A protocol cannot serve as a substitute for obtaining a physician's or other LIP's order prior to initiating each episode of restraint use. If protocols are used that include the use of restraint, a specific physician or LIP order is still required for each episode of restraint use.

- **PRN Ordering of Restraint**

- Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
- Staff cannot discontinue a restraint intervention, and then re-start it under the same order. This would constitute a PRN order. A "trial release" constitutes a PRN use of restraint, and, therefore, is not permitted.
 - A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

- **Notification of the Patient's Attending Physician**

- The attending physician must be consulted as soon as possible if the attending physician did not order the restraint. The attending physician is the physician who is responsible for the management and care of the patient.

- When the attending physician of record is unavailable, responsibility for the patient must be delegated to another physician, who would then be considered the attending physician.
- This policy does not specify that consultation with the attending physician be face-to-face. The consultation can occur via telephone.

- **Ordering of Restraint for Violent or Self-Destructive Behavior**

Each order for restraint used for the management of violent or self-destructive behavior (behavioral restraint) that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be obtained and renewed in accordance with the following limits for up to a total of 24 hours:

- Up to four (4) hours for adults age 18 and older.
- Up to two (2) hours for adolescents ages 14 to 17.

If restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint.

At the end of the time frame, if the continued use of restraint to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, another order is required.

When the original order is about to expire, a Registered Nurse (RN) must contact the physician or other LIP, report the results of his or her most recent assessment and request that the original order be renewed.

Whether or not an onsite assessment is necessary prior to renewing the order is left to the discretion of the physician or other LIP in conjunction with a discussion with the RN who is over-seeing the care of the patient.

- **Orders for Restraint for Violent or Self-Destructive Behavior Beyond 24 Hours**

- At a minimum, if a patient remains in restraint for the management of violent or self-destructive behavior 24 hours after the original order, the physician or other LIP must see the patient and conduct a face-to-face re-evaluation before writing a new order for the continued use of restraint.
- When the physician or other LIP renews an order or writes a new order authorizing the continued use of restraint, there must be documentation in the patient's medical record that describes the findings of the physician's or other LIP's re-evaluation supporting the continued use of restraint.

- **Orders for Restraint for Safety / Non-Violent / Non-Self-Destructive Behavior**

Orders obtained in accordance with this policy to address a patient's medical care-related needs (safety) that are evidenced by non-violent or non-destructive behavior (non-behavioral restraint) are considered in full force and effect for up to 24 hours – which includes the day the order was obtained.

If the patient remains in restraint for more than one consecutive calendar day, then a new order must be obtained. This order will be obtained the next day.

- **Documenting the Use of Restraint in the Patient's Plan of Care**

The use of restraint (including drugs or medications used as restraint as well as physical restraint) must be documented in the patient's plan of care or treatment plan.

This policy does not require that a modification to the patient's plan of care be made before initiating or obtaining an order for the use of restraint.

The use of a restraint intervention should be reflected in the patient's plan of care or treatment plan based on an assessment and evaluation of the patient. The plan of care or treatment plan should be reviewed and updated in writing within 24 hours following the initiation of restraint.

- **Discontinuation of Restraint**

Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Restraint may only be employed while the unsafe situation (clinical justification) continues. Once the unsafe situation ends, the use of restraint must be discontinued.

Physicians, other LIP', and RN' involved in the patient's care are authorized by this policy to determine whether or not restraint should be discontinued.

- **Special Assessment Requirement for Patients placed in Restraint for Violent or Self-Destructive Behavior**

When restraint is used to manage violent or self-destructive behavior, a physician or other LIP, or a registered nurse (RN) or physician assistant (PA) trained in accordance with this policy must see the patient face-to-face within one (1) hour after the initiation of the intervention. This requirement also applies when a drug or medication is used as a restraint to manage violent or self-destructive behavior.

The one (1) hour face-to-face patient evaluation must be conducted in person. A telephone call or telemedicine methodology is not permitted. If a patient's violent or self-destructive behavior resolves and the restraint intervention is discontinued before the practitioner arrives to perform the face-to-face evaluation, the practitioner is still required to see the patient face-to-face and conduct the evaluation within one (1) hour after the initiation of the intervention.

The one (1) hour face-to-face evaluation should include both a physical and behavioral assessment of the patient. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc., as well as to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint.

When a trained RN or PA conducts the required face-to-face evaluation, he or she must consult the attending physician or other LIP responsible for the patient's care as soon as possible after the completion of the evaluation. This consultation should include, at a minimum, a discussion of the findings of the one (1) hour face-to-face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraint.

The consultation must be conducted as soon as possible (i.e. within one hour of being performed unless circumstances prohibit) A consultation that is not conducted prior to a renewal of an order would not be consistent with the requirement, "as soon as possible."

- **Ongoing Monitoring & Assessment of a Patient in Restraint**

Determining the necessary frequency of assessment and monitoring should be individualized to the patient, taking into consideration variables such as the patient's condition, cognitive status, risks associated with the use of the chosen intervention, and other relevant factors.

Depending on the patient's needs and situational factors, the use of restraint may require more frequent monitoring and assessment.

- **Monitoring a Patient in Restraint**

- Monitoring means that the patient will be seen to determine if the use of restraint continues to be safely applied, and if there appears to be a need for an assessment of the patient to occur.

- **Minimum Frequency of Monitoring of a Patient in Restraint**
 - Patients placed in restraint for violent or self-destructive behavior should be monitored at least every fifteen (15) minutes.
 - Patients placed in restraint for safety, non-violent, and non-destructive behavior should be monitored at least every two (2) hours.
- **Ongoing Assessment of a Patient Placed in Restraint**
 - Ongoing assessment means that the patient will be evaluated to determine the patient's response to the restraint, and if the patient has any care needs. This assessment shall include checking the patient's vital signs, hydration and circulation; the patient's level of distress and agitation; or skin integrity), and may also provide for general care needs (e.g., eating, hydration, toileting, and range of motion exercises. This assessment shall also determine if the patient continues to require restraint.
- **Minimum Frequency of Ongoing Assessment of a Patient Placed in Restraint**
 - Patients placed in restraint for violent or self-destructive behavior should be assessed at least every four (4) hours.
 - Patients placed in restraint for safety, non-violent, and non-destructive behavior should be assessed at least every eight (8) hours.

- **Application of Restraint**

Restraint shall be applied / removed in accordance with the following:

- The type of restraint used shall be consistent with the type of restraint ordered.
- Restraints will be applied with safe and appropriate techniques.
- Restraint devices are to be applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose.
- Restraint devices are to be applied / removed in a manner that preserves the dignity, comfort, and well being of the patient.
- Restraints will be secured to the bedsprings or frame if being used while the patient is in bed. Restraints should never be tied to the mattress or side rails. Knots shall be tied so that they may be released quickly in the event of an emergency.
- Restraint devices are to be applied / removed only by staff authorized, trained, and with the demonstrated competency to do so.

- **Authorization to Initiate Emergent Use of Restraint Prior to Obtaining an Order**

RN's, PA's, and Advance Practice Nurses (APN), are authorized by this policy to initiate the emergent use of restraint prior to obtaining an order. If such use occurs, an order must be obtained in accordance with requirements outline in this policy.

- **Documentation of the Use of Restraint**

Each episode of restraint should contain at least the following documentation in the patient's medical record:

- Any in-person medical and behavioral evaluation for restraint used to manage violent or self-destructive behavior – including the one (1) hour face-to-face assessment for patients placed in restraint for violent or self-destructive behavior.
- A description of the patient's behavior and the intervention used
- Any alternatives or other less restrictive interventions attempted
- The patient's condition or symptom(s) that warranted the use of the restraint

- The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention
- Individual patient assessments and reassessments
- The intervals for monitoring
- Revisions to the plan of care
- The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint
- Injuries to the patient

- Death associated with the use of restraint
- The identity of the physician or other licensed independent practitioner who ordered the restraint
- Orders for restraint
- Notification of the use of restraint to the attending physician
- Consultations

- **Physician Education & Training on the Use of Restraint**

At a minimum, physicians and other LIP’s authorized to order restraint must have a working knowledge of this policy regarding the use of restraint. This training may include, but not necessarily be limited to, the following:

- A patient’s rights regarding the use of restraint.
- Prohibitions on such use
- Ordering requirements
- Requirements and time frames for patient assessment

- **Staff Competency & Training on the Use of Restraint**

All staff designated by the hospital as having direct patient care responsibilities, including contract or agency personnel must demonstrate the competencies specified in this policy prior to participating in the application of restraints, monitoring, assessment, or care of a patient in restraint.

Training should be targeted to the specific needs of the patient populations being served, and to the competency level of staff. Training and competence must be established:

- Upon hire as part of the initial orientation process
- Before participating in the use of restraint
- On an annual basis thereafter

- **Competency & Training Requirements of PA’s and RN’s Performing the One (1) Hour Face-to-Face Assessment**

- In addition to the training and competency requirements outlined in this policy, PA’s and RN’s who perform the one (1) hour face-to-face assessment must be competent to perform the following:
 - Evaluate the patient's immediate situation,
 - The patient's reaction to the use of restraint,
 - The patient's medical and behavioral condition, including a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient’s history, medications, most recent lab results, etc.
 - The need to continue or terminate the restraint.

- **Competency & Training Requirements of Staff who Assess, Monitor, or Provide Care to Patients Placed in Restraint**

- As appropriate to scope of practice and job function, staff performing assessments, monitor patients, and/or provide care to patients in restraint must be competent to perform the following:
 - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint.
 - The use of non-intervention skills

- Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical, or behavioral status, or condition.
- The safe application and use of all types of restraint used in the hospital, including recognition and response to signs of physical and psychological distress.
- Clinical indications of specific behavioral changes that indicate that restraint is no longer necessary.
- 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, and any special care issues.
- The use of first aide techniques and current certification in the use of cardiopulmonary resuscitation.

• **Competency of Staff who Provide Training and Competency Assessment of Other Staff**

- Individuals providing the training and competency assessments noted in this policy must be qualified as evidenced by education, training and experience in techniques used to address patients’ behaviors for the patient populations being served. Trainers should demonstrate a high level of knowledge of this policy, as well as state and federal law, and Joint Commission accreditation standards.

• **Reporting of Deaths Due to the Use of Restraint**

The organization will report deaths associated with the use of restraint to the Center for Medicare Services (CMS). Reporting may also occur to other external agencies as required by state law and/or organization policy. The following will be reported:

- Each death that occurs while a patient is in restraint.
- Each death that occurs within 24 hours after the patient has been removed from restraint.
- Each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient’s death. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

Each death referenced as above must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient’s death. Staff must document in the patient’s medical record the date and time the death was reported to CMS.

• **Exception to Reporting Requirement**

- When the only restraints used on the patient are those applied exclusively to the patient’s wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:
 - The patient’s name,
 - Date of birth,
 - Date of death,
 - Name of attending physician or other licensed independent practitioner who is responsible for the care of the patient,
 - Medical record number, and
 - Primary diagnosis(es).

Each entry must be made not later than seven days after the date of death of the patient. The information must be made available in either written or electronic form to CMS immediately upon request

• **Quality Assurance & Improvement**

The organization’s leadership is responsible for creating a culture that supports a patient’s right to be free from restraint. Leadership ensures that systems and processes are developed, implemented, and evaluated that support the patients’ rights addressed in this standard, and that eliminate the inappropriate use of restraint. By including

the use of restraint in the organization’s quality assurance and improvement program, the organization will:

- Collects data on at least an annual basis regarding the use of restraint
- Compiling data on the use of restraint in usable formats.
- Use statistical tools and techniques to analyze and display the data
- Compare the data over time to identify levels of performance, patterns, trends, and variations.
- Use the results of data analysis on the use of restraint to identify opportunities to improve the safety of patients and eliminate inappropriate use of restraint.
- Take action on its improvement priorities and evaluates changes to confirm they resulted in improvements.
- Take action when planned improvements are either not achieved or not sustained.

--- END ---

References:

- CMS Conditions of Participation for Acute Care Hospitals, 482.13(e), 482.13(f)
- Joint Commission Accreditation Standards for Acute Care Hospitals – PC.03.05.01 -> PC.03.05.19

**USE OF RESTRAINT FOR VIOLENT / SELF-DESTRUCTIVE BEHAVIOR
ONE HOUR FACE-TO-FACE EVALUATION**

Restraint Initiated: _____
Date Time

Face to Face Evaluation Done: _____
Date Time

PATIENT'S IMMEDIATE SITUATION

Describe the patient's current behaviors, physical status, etc.

PATIENT'S REACTION TO THE INTERVENTION

Note any statements or other evidence of how the patient is reacting to the intervention

PATIENT'S MEDICAL & BEHAVIORAL CONDITION

Parameter	Yes	No
• Does a review of system identify any significant issues, concerns, or information?		
• Does a behavioral assessment identify any significant issues, concerns, or information?		
• Does a review of the patient's history identify any significant issues, concerns, or information?		
• Does the patient's drug / medication regimen identify any significant issues, concerns, or information?		
• Does the patient's most recent lab results identify any significant issues, concerns, or information?		
• Is there any other information that identifies any significant issues or concerns?		

Comment on any yes answers

NEED TO CONTINUE OR TERMINATE INTERVENTION

Based on the above information (initial one):

- Continuation of the intervention is indicated
- Termination of the intervention is indicated
- The intervention was no longer in place at the time of the evaluation

Patient Label

Signature of Provider

Date / Time

Special Assessment Requirement for Patients placed in Restraint for Violent or Self-Destructive Behavior

When restraint is used to manage violent or self-destructive behavior, a physician or other LIP, or a registered nurse (RN) or physician assistant (PA) trained in accordance with this policy must see the patient face-to-face within one (1) hour after the initiation of the intervention. This requirement also applies when a drug or medication is used as a restraint to manage violent or self-destructive behavior.

The one (1) hour face-to-face patient evaluation must be conducted in person. A telephone call or telemedicine methodology is not permitted. If a patient's violent or self-destructive behavior resolves and the restraint intervention is discontinued before the practitioner arrives to perform the face-to-face evaluation, the practitioner is still required to see the patient face-to-face and conduct the evaluation within one (1) hour after the initiation of the intervention.

The one (1) hour face-to-face evaluation should include both a physical and behavioral assessment of the patient. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc., as well as to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint.

When a trained RN or PA conducts the required face-to-face evaluation, he or she must consult the attending physician or other LIP responsible for the patient's care as soon as possible after the completion of the evaluation. This consultation should include, at a minimum, a discussion of the findings of the one (1) hour face-to-face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraint.

The consultation must be conducted as soon as possible (i.e. within one hour of being performed unless

circumstances prohibit) A consultation that is not conducted prior to a renewal of an order would not be consistent with the requirement, “as soon as possible.”

ORGAN DONATION

This is a CMS Conditions of Participation. All Hospitals must notify Organ Procurement Organization (OPO) of all deaths and imminent deaths in a timely manner. All families are legally entitled to be given INFORMED consent about organ and tissue donation. Hospitals are required to maintain a patient hemodynamically until organ donation can be offered to family. Revised UAGA 2006 states that Hospitals must permit OPO to conduct any reasonable exam necessary to determine medical suitability of donation. Unless hospital or OPO knows individual expressed contrary intent, hospital *may not remove* measures

necessary to maintain organs (e.g. life support) during exam period. Hospital must give OPO access to individual’s medical records unless otherwise prohibited by law.

What Tissues Can Be Donated?

- Eyes
- Heart valves
- Pericardium
- Skin
- Bone
- Nerves
- Connective tissue
- Saphenous veins
- Femoral vessels

**Rehabilitation Hospital
Provision of Care Policy and Procedure**

SUBJECT: DEATH OF PATIENT AND ORGAN PROCUREMENT
 Policy: PC 325 Effective Date: 5/28/18
 (See LD 230 organ procurement)
 JC Standard: TS.01.01.01, TS.02.01.01 Review Date: 11/16/2020
 Page 1 of 3 Approved By: BOM

PURPOSE

A patient's death is a difficult experience for both the family and the caregivers. The purpose of this document is to integrate information about managing processes after a death, so that caregivers can compassionately guide the family through this period.

POLICY

The Hospital notifies the physician, family and appropriate agencies after a death.

PROCEDURES

- When death is imminent, nursing notifies family members, as necessary, the physician, if not present and the Organ Procurement Organization.

- Nursing
 - When death is imminent, notify Pastoral Care/Spiritual Care Service, and if appropriate the Case Manager/Social Worker, in order to provide support for family and friends of the patient.
 - Notify family members as necessary and physician if not present.
- Physician/Nursing
 - CMS requires all imminent deaths need to be referred to the Donor Services 24 hours a day. Collaboration between the Donor Services and Hospital staff is essential.
 - The Donor Services or Tissue Bank will approach the family about donation if appropriate. There is no cost to the family/significant other for removal of organs/tissue. Donation will not delay the funeral. The family must make the funeral arrangements.
 - Timely Notification – Timely notification must be made to the Organ Procurement Organization (OPO) Iowa Donor Network. Call (515) 727-7897.
 - As soon as it is anticipated the patient will meet, or within one (1) hour after the patient does meet, the criteria for imminent death (physician has determined that death is imminent as evidenced by unstable vital signs and whole system failure). Death occurs upon loss of blood pressure, cessation of pulse and cessation of respiration.
 - Additionally, the patient and/or family have indicated that life saving measures are not to be performed.
 - In circumstances where prior notification is not possible; within one (1) hour after patient is pronounced dead.
- When death occurs the Physician and Nursing perform additional responsibilities including but not limited to:
 - Responsibilities of physician:
 - Pronounce the patient
 - Contact the Donor Services, in collaboration with nursing, to determine medical suitability for donation
 - Sign the original white copy of the death certificate and complete all information including information about the Donor Services notification
 - Responsibilities of nursing:
 1. Ensure that the family is supported. Involve Pastoral Care/Spiritual Care Service, Social Work, Clinical Supervisor, Charge Nurse, Administration and other appropriate members of the interdisciplinary team
 2. Notify attending physician (if physician present has not done so)
 3. Contact the Donor Services in collaboration with the physician, to determine medical suitability for donation
 - The Donor Services/Tissue Bank will approach the family about donation if appropriate
 4. Prepare the body. Refer to "Postmortem Care Procedure"
 - a. If the deceased is a Medical Examiner's Case refer to "Medical Examiner's Case Procedure"
 - If written permission for autopsy is granted, "Refer to "Autopsy Procedure"
 - Complete the Record of Death form prior to release of the body
- Reporting

- The Hospital shall record on each deceased patient's record the name and address of the funeral home or person to whom the body was released for disposition, the date of the release, and who released the body.
- The hospital must report to the Centers for Medicare Medicaid Services (CMS):
 - Each death that occurs while a patient is in restraint or seclusion or within 24 hours of the patient being removed from restraint or seclusion.
 - Death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume the restraint/seclusion contributed directly or indirectly to a patient's death.

The Hospital shall check reporting requirements per the Department of State Health Services.

2023 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.



This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

PHYSICIAN QUALITY PLAN OVERVIEW

The Medical Staff of MercyOne Clive Rehabilitation Hospital is committed to a patient-centered philosophy and fully supports the hospital's goals of continuous performance improvement, high quality health care, and patient safety.

Accordingly, the Medical Staff has developed this Quality Plan to define its role in these processes. This Quality Plan delineates the Medical Staff structure and function which facilitates achieving these goals, such as the Medical Executive Committee (MEC) and other Medical Staff leadership, relationships with the hospital's Board of Managers, peer review, credentialing and re-credentialing, Ongoing Professional Practice Evaluation (OPPE), and Focused Professional Practice Evaluation (FPPE).

Through the processes of OPPE and FPPE, the Medical Staff is committed to maintaining the competency of all practitioners granted privileges according to the following six core competencies, as put forth by the Joint Commission: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems Based Practice.

The Medical Staff encourages and fully supports physician engagement and leadership in Hospital's performance improvement, quality, and patient safety activities. Examples include active participation in the Quality Council, as well as involvement in numerous Hospital performance improvement and patient safety initiatives, which may include, but aren't limited to:

- Review of clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of consultants
- Other relevant criteria as determined by the organized medical staff
 - Falls
 - Medication reconciliation
 - Critical labs
 - Change in condition

Falls

Rehabilitation Hospital Provision of Care Policy and Procedure

SUBJECT: FALL PREVENTION PLAN

Policy: PC 196

JC Standard: PC.01.02.08 EP2

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Effective Date: 5/28/18

Review Date: 11/16/2020

Approved By:

I. PURPOSE

To establish policy, assign responsibility, and provide procedure for patients at risk for falls; to systematically assess fall risk factors; provide guidelines for fall and repeat fall preventative with the goal to reduce the risk of patient harm resulting from falls.

II. POLICY

A. All patients admitted to the Hospital are assessed by a Registered Nurse to determine their risk for falls; appropriate precautions will be initiated and maintained to reduce the risk of a fall.

B. Definition

1. A fall is defined as an unexpected, involuntary loss of balance resulting in a person coming to rest on a lower or ground level.
2. Assisting a patient to the floor is considered a fall.
3. Individuals found on the floor with no explanation are considered to have fallen.

III. PROCEDURE

- A. A Registered Nurse is responsible for assessment of fall risk of a patient upon admission, following any change in condition and following any fall episode, including:
1. Determining risk for fall and establishing appropriate patient need related to fall risk in the patient plan of care;
 2. Implementing interventions using best clinical judgment and an approved list of fall risk interventions;
 3. Supervising personnel in delivering safe and individualized care; and
 4. Appropriately managing post fall assessment procedures.

B. The Morse Fall Scale is used to identify patients at High Fall Risk.

1. The Morse Fall Scale is to be completed:
 - a. On admission
 - b. On transfer from one facility to another,
 - c. Following any change of status,
 - d. Following a fall, and/or
 - e. On regular daily intervals
 - i. If the patient’s Morse Fall score is 45 or less, the patient is at low fall risk.
 - ii. If the patient’s Morse Fall score is greater than 45 the patient is at High Fall Risk.

IV. Medication Classifications are also used to identify patients at High Fall Risk.

A. If a patient is on four (4) or more of the following medications classification, they are considered to be High Risk for Falls:

Antihistamines	Psychotropics
Hypoglycemics	Sedatives/Hypnotics
Laxatives	Diuretics
Narcotics	Antihypertensives

B. High Fall Risk interventions are initiated for patients on 4 or more of the above medication classes and as identified on the Safety Algorithm. High Fall Risk interventions may include:

1. Initiate High Fall Risk identification, including: notation in patient record and yellow patient wristband identification
2. A falling star magnet (denotes Fall Precautions) will be placed at the patient’s door
3. Place patient care articles and call light within reach
4. Frequently reorient and repetitively reinforce use of call bell and ensure it is within reach
5. Provide physically safe environment (eliminate clutter, unnecessary equipment, etc.)
6. Provide adequate lighting (turn lights on as needed)
7. Provide additional night lighting as needed (example, keep bathroom light on at night if appropriate)
8. Consider option to re-assign patient’s room closer to nurse station
9. Use treaded socks/shoes as needed
10. Teach patient use of side rails and/or grab bars
11. Instruct patient in activities prior to initiating
12. Assist patient with all activities
13. Approach patient toward unaffected side to maximize participation in care

14. Assess patient's coordination and balance before assisting with transfers or mobility
15. Transfer patient toward stronger side
16. Apply bed alarm
17. Apply wheelchair alarm
18. Actively engage patient and family in safety awareness

V. Fall Risk determined by Morse Fall Risk Assessment Score and will contribute to mobility orders

A. Admission and Low Fall Risk Approved Interventions

1. Bed Alarm on all patients until mobility or nursing orders state otherwise
2. Wheelchair footrests with all patients unless otherwise noted
3. Mobility orders in the chart
4. No armband needed

B. Approved High Fall Risk Interventions

1. Yellow armband and magnet on door
2. Bed Alarm set on clinically appropriate level based on most recent assessment
3. Wheelchair alarm at all times unless otherwise ordered
4. Handoff 1:1
5. Bed in low position unless medically contraindicated
6. Consider mats at night at bedside
7. Room in direct sight of nurses' station when possible
8. Encourage family involvement
9. If regression or need for further means of control for safety, consider plan for 1:1 sitter
10. If 1:1 sitter needed, gain administrative approval prior to intervention
11. If improved on assessment, may revert to Low Fall Risk

VI. Post Falls- At the time of fall, the following actions are taken:

A. If no apparent injury:

1. Notify the charge nurse immediately
2. Communicate the incident as soon as possible to the attending physician and the family

B. If an injury is suspected:

1. IMMEDIATELY notify Charge nurse on duty for shift
2. IMMEDIATELY notify attending physician
3. Complete evaluation and/or tests for injury that are ordered
4. Notify family member, as soon as possible, after evaluation of injury is completed. (*note:* this may be before all tests are completed, but after a physician has seen his patient)

C. For a serious injury, such as fracture, dislocation, head injury, laceration requiring stitches and where expected length of stay may be impacted as a direct result of the injury:

1. Notify Risk Management of ANY of the above sustained injuries. Report:
 - a. Patient's name and room number
 - b. Time of fall
 - c. Injury sustained
 - d. Interventions in place at time of the fall
 - e. Morse Fall Scale score at the time of the fall
2. Review possible causes of patient fall and make immediate corrections
3. Complete head to toe assessment, obtain orthostatic vital signs (if possible) with pulse and blood pressure at minimum.
4. Documentation in patient record to include:
 - a. Description of the event and follow-up (with factual information only)
 - b. Communication with patient, physician and family
 - c. Review of fall prevention interventions and modification of plan of care
 - d. Reassess and document the Morse Fall Scale score and modify fall risk as necessary, implementing appropriate precautions
 - e. Educate patient/family regarding fall prevention program and interventions

- f. Speak with family about interventions that have been successful in the past
 - g. Complete confidential incident (event) report
 - D. Complete confidential event/incident report (THIS DOES NOT GO INTO PATIENT'S CHART) and forward to Risk Management
 - E. Nursing Leadership responsibilities
 - 1. Assessment of the fall, interventions taken
 - 2. Offer suggestions for alternative interventions
 - 3. Confirm plan of care is complete and updated
 - 4. Confirm family has been informed of event and plan of care
- VII.** Implement 24-hour Post Falls Assessment:
 - A. Vital signs every four (4) hours for next twenty-four (24) hours
 - B. Observe for possible injuries
 - C. Initiate High Fall Risk identification, including application of High Fall Risk Yellow wristband
 - D. Safety checks every two hours with toileting assistance as necessary
 - E. Review or revise High Fall Risk on plan of care
 - F. Consider 1:1 if patient is confused, cognitively impaired and repeated attempts to get out of bed without supervision and assistance
 - G. Physician and team consider recommendations of pharmacists regarding medications that increase the likelihood of falls
- VIII.** Side Rails Guideline
 - A. Two side rails for Low Fall Risk:
 - 1. Two side rails to remain up at all times to allow patient access to nurse call light, room controls, bed controls
 - 2. Use of two rails is for patient convenience in entering and exiting bed and for bed mobility
 - 3. If patient is low risk for falls, use of two upper rails is the standard of care
 - B. Three side rails up for High Fall Risk
 - 1. Three side rails up is the standard of care for High Fall Risks. This will allow patient access to communication system on the side rails and an area for entering and exiting with assistance
 - 2. All other High Fall Risk interventions are to be implemented. Patient is instructed to call for assistance with ambulating
 - C. Four side rails:
 - 1. Four side rails is considered a restraint. See restraint policy.
 - 2. Patient preference is considered and documented
 - 3. If the patient requests such, this is not considered a restraint
 - 4. Four side rails up is considered the standard for patient transportation
 - D. Patients admitted to the Rehabilitation Hospital are considered to be at risk for falls. The Universal Falls interventions should be implemented on admission for all patients. Universal Falls interventions include:
 - 1. Patients may be up ambulating with assist per MD order in their room only and must use a wheelchair for mobility outside their room until evaluation and mobility recommendations completed by Physical Therapy. .
 - 2. Any ambulation assistive devices brought in with patients at the time of admit may not be used until evaluated by physical therapy.
 - 3. Place patient care articles and call light within reach.
 - 4. Provide physically safe environment (eliminate clutter, unnecessary equipment, etc.).
 - 5. Provide adequate lighting (turn on lights as needed).
 - 6. Use treaded socks/shoes, as needed.
 - 7. Teach patient use of side rails and/or grab bars.
 - 8. Instruct patient in all activities prior to initiating.
 - 9. Instruct patient to call for assistance before getting up without assistance.
 - 10. Approach patient toward unaffected side to maximize participation in care.

11. Assess patient's coordination and balance before assisting with transfers or mobility.
12. Transfer patient toward stronger side
13. Lock bed and wheelchair brakes for all transfers
14. Actively engage patient and family in safety awareness.
15. Frequent offering of toileting and staff monitoring of patients.
16. Patient bed to remain in low position unless patient being attended to by staff.

APPENDIX A

**Rehabilitation Hospital Post-Fall Assessment Guidelines
to be completed after every fall.**

Ask the Patient

1. How did the fall happen?
2. What were you doing or where were you going?
3. Were you injured?
4. Do you have any pain?
5. Did you hit your head?
6. Can you move your arms and legs like you could before the fall?

Document the fall event including all that the patient states in "quotation marks" in a progress note.

Assess/Observe

Assess patient for potential fracture (ROM and pain) before moving the patient off floor.

1. Assess skin for bumps, bleeding, bruises, or deformities.
2. Assess for mental status changes.
3. If patient reports hitting head or fall was not witnessed perform a neuro check.
4. Assess ROM in all extremities.
5. Obtain vital signs.
6. Assess safety risks/factors contributing to fall.

Document all physical findings in progress note.

Implement

1. If patient hit head or cannot tell you that he did not hit his head and **not on anticoagulants**

Complete

1. Notify physician regarding details of fall, including any injury or new complaints and neurological assessment.
2. Complete incident report.
3. Vital signs every 4 hours for 24 hours.
4. Notify family if patient unable to make own decisions regarding ongoing care or has an activated POA. Otherwise, ask patient if they would like their family member called and informed of the fall.
5. Patient care plan will be updated, specifically mobility and safety.
6. Morse scale will be re-evaluated and patient made High Fall Risk if not already done.

Medication Reconciliation

Pharmacy Services – Medication Management Policy & Procedures

Subject:	MEDICATION RECONCILIATION/VERIFICATION	
Policy:	MM 23.1	Effective Date: 5/28/18
JC Standard:		Review Date: 11/16/2020
Page 1 of 1		Revision Date:

I. POLICY:

The Mercy Rehabilitation Hospital implements and maintains a process to obtain and document a complete list of a patient's current medications upon admission. Medication reconciliation is a multidisciplinary process between the nurse, the pharmacist, and the physician with patient/family involvement. Medication reconciliation/verification is performed: upon admission/entry into the facility, any transition of care where new medications are ordered or existing orders are rewritten, and at the time of discharge.

II. PROCEDURE:

- A. The pharmacist and nursing staff review the admission orders prescribed by the admitting physician. The home medication list is reviewed by the admission nurse upon the patient's arrival. The pharmacist assists with the retrieval of the home medication list, if requested. The admission orders are compared to the patient's home medication list, and any medication interactions, therapeutic duplications, or missed medications are discussed with the admitting prescriber.
- B. For medications that are to be continued at home, after discharge, the physician completes the discharge medication list in the electronic record to provide the remaining requirements of a legal prescription:
 - 1. Quantity to be dispensed (Num. Disp.)
 - 2. Refills, if any (Refill Times)
 - 3. Physician's information (print and sign name, DEA number for controlled substances)
- C. Medication Education Sheets are printed, as needed. Medication teaching is a collaborative effort between the pharmacist, the nurse, and the speech pathologist.
- D. On the day of discharge, the nurse or pharmacist updates the patient discharge medication list and discharge prescriptions with any medication changes that have occurred since writing the documents. The last page of the patient discharge medication list is signed by a licensed professional. The patient is given a copy and a copy is placed in the medical record.
- E. If a patient is transferred to another health care facility, a copy of the MAR and Home Medication List is provided to that location.

Antibiotic Stewardship Program

1. Leadership commitment is one of the core elements identified by the CDC for a successful Antibiotic Stewardship program.
2. MercyOne Clive Rehabilitation Hospital has an interdisciplinary approach to the Antibiotic Stewardship Program which provides education and training to its staff members.
3. Physician orders should specify the dose, duration and indication for the antibiotic.
4. Nursing documents in the computerized documentation system, the response to the first dose including if there was any adverse reaction.
5. Antibiotic educational material for patients is available from the nursing staff.
6. Nursing will document in the computerized documentation system on the specific education they gave

to the patient/caregiver.

- 7.** Our facility specific treatment recommendations are based on national guidelines and local susceptibilities. Formulary options can optimize antibiotic selection and duration for common indications of antibiotic use.
- 8.** A “time out” should be performed at 48 hours to review the culture and sensitivity. The nurse will communicate with the physician on any changes which need to be made at that time.
- 9.** Tracking and reporting antibiotic use and outcomes is critical to identify opportunities for improvement and assess the impact of improvement efforts.
- 10.** An antibiotic tracking tool is available and updated daily.

Critical Tests

**Rehabilitation Hospital
Provision of Care Policy and Procedure**

SUBJECT: CRITICAL VALUE TEST RESULTS COMMUNICATION – NPSG 2

Policy:	PC 460	Effective Date: 5/28/18
JC Standard:	NPSG.02.03.01 EP1-3	Review Date: 11/16/2020
Page 1 of 2		Approved By:

NPSG 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS

POLICY

Critical Tests are defined as any test that is ordered on a STAT basis. **Critical Results** (sometimes called Panic Values) are findings (even if from routine tests) which require rapid communication of the results. Critical test results are defined by the Hospital and approved by the Medical Executive Committee. M.E.C. may choose to adopt (and/or select certain) Critical Limits of the contracting laboratory of the partner facility. Critical results are those outside the normal range to a degree that may constitute an immediate health risk to the individual or require immediate action on the part of the ordering physician. It is the policy of the contracting clinical laboratory to call all critical results to the nursing unit. This holds true regardless of the priority of the order. Critical results generated on tests that are part of an instrument profile should also be called.

Results of tests involving an interpretive component may be determined by the Laboratory, Radiologist, or other Diagnostician to be critical to the patient’s treatment condition and will warrant rapid communication to the physician.

Physicians have defined **stat orders** as follows:

2 hours from the time of the order until the results are called to the physician, **regardless of the result.**

Physicians defined the time for notification of **critical results** as follows:

30 minutes from the time results are received by the nursing unit until the physician is notified of the results.

PROCEDURE

- Communicating critical results
 - Results will be called to the Hospital by the laboratory, radiology, cardiology, or other diagnostic department.
 - Critical results will be repeated back to the caller, by the party taking the call, for verification.
 - Nurse will notify a physician within 30 minutes.

- Record Keeping

After the results have been communicated, the first initial, last name, title of the person receiving the call and the date, time the call was made will be recorded.

- Use of Data

The Hospital collects data on the timeliness of reporting critical tests and critical results and values. The Hospital assesses the data and determines whether there is a need for improvement. The Hospital takes appropriate action to improve and measure the effectiveness of any actions that are taken.

Change in Condition

The Medical staff, in collaboration with the Hospital develops a list of signs and symptoms and/or selects certain clinical pathways designed to alert specially trained staff or, which will alert staff to recognize significant changes in a patient's condition.

If the patient's physician is not immediately available, the Medical staff has determined that another physician may be contacted to examine the patient and/or provide direction to the staff. Physician Assistants and/or Registered Nurses shall assess the patient's condition to provide information to the physician. Refer to policy for further guidance.

Examples of objective clinical changes/concerns:

1. SBP < 90 or > 200 mm HG
2. Heart rate < 40 or > 130 per minute
3. Respiratory rate < 8 or > 30 per minute
4. Acute changes in SpO₂ < 90%/Increasing O₂ needs
5. Chest pain not relieved with traditional interventions
6. Acute mental status change
7. Seizures
8. Failure to respond to treatment
9. Acute significant bleeding
10. Urine output < 50 ml in 4 hours
11. Suicidal ideation
12. Lab values outside of normal ranges or significantly changed—especially K⁺, Hgb, Hct, PLT, drug levels.

Assistance may be obtained from licensed nursing personnel or nursing management, a credentialed physician assistant or physician. If a physician is not in house, call RRT (Rapid Response Team), then call physician on call.

IMPAIRED LICENSED INDEPENDENT PRACTITIONERS

Physician impairment is a serious issue. The American Medical Association (AMA) defines disruptive behavior as—a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behavior exhibited as a pattern of being unable, or unwilling, to function well with others to such an extent that his/her behavior, by words, attitude or action, has the potential to interfere with quality healthcare. The physician's behavior (attitudes, words or actions) intimidate and demean others potentially resulting in a negative impact on patient care. The following may be signs that you or a colleague is impaired.

Personal

- Deteriorating personal hygiene (e.g. over-use of cologne or mouthwash, disheveled appearance).
- Multiple physical complaints
- Personality and behavioral changes (moods swings, emotional crises, irritability, loss of compassion)
- Physical symptoms (blackouts, sweating, tremors)
- Preoccupation with mood altering agents (hiding or protecting supply, using more than intended)

Friends and Community

- Personal isolation
- Embarrassing behavior
- Legal problems (e.g. drunken driving, speeding tickets)
- Neglect of social commitments
- Unpredictable, out of character behavior, such as inappropriate spending

Professional

- Change in work pattern (more or less hours), or disorganized scheduling
- Frequent “breaks” or absence
- Inaccessibility to patients and staff
- Excessive drug use (samples, prescriptions, etc.)
- Increase in complaints by patients regarding physician's behavior
- Alcohol on breath
- Rounding at inappropriate times
- Deteriorating relationship with staff, patients, and/or colleagues
- Deteriorating performance late to appointments; unknown whereabouts

If you suspect that a colleague may be impaired, it's important that he or she gets the help they need. The medical staff has established avenues where physicians can seek assistance in a safe and confidential way. Refer to medical staff policies for further information.

COMPLIANCE

Rehabilitation Hospital Infection Control Policy And Procedure

SUBJECT: IMMUNIZATION AGAINST INFLUENZA – HEALTH CARE WORKERS

Policy: IC 275
JC Standard: IC.02.04.01
Page 1 of 3

Effective Date: 5/28/18
Revision Date: 11/16/2020
Review Date:

It is the policy of MercyOne Clive Rehabilitation Hospital to take reasonable and lawful measures to protect our physicians, employees, visitors, patients, and our community from the transmission of communicable illnesses or disease. This policy outlines the procedures that will guide us in our efforts to minimize the spread of the influenza virus. This policy is based on practices and recommendations from various organizations, including but not limited to; Center for Disease Control, Joint Commission, Association for Professionals in Infection Control, state and local health departments, etc.

In addition to compliance with this policy, all Health Care Personnel (HCP) are required to comply with policies on Infectious/Communicable Diseases, Hand Hygiene, Personal Protective Equipment, etc.

INFLUENZA VACCINATION FOR STAFF:

1. Influenza vaccinations will be provided to all MercyOne Clive Rehabilitation Hospital employees according to published recommendations from the CDC and the local Health Department, with consideration given to the availability of vaccine.
2. The seasonal flu is typically experienced from December to February but may vary each year. The local Health Department will determine the onset and termination of any season and/or epidemic.
3. Vaccination timeframes may vary according to vaccine availability and Health Department recommendations.
4. In the event the influenza vaccine supply is limited, employee health will provide vaccine using a tiered process, beginning with staff most at risk for occupational acquisition and patient exposure, working through each level until supply is exhausted. The tiers will be developed by a task force comprised of representatives from Employee/Corporate Health, Infection Prevention, Infectious Disease and Administration.
5. In the event of an epidemic, Infection Prevention, Employee/Corporate Health and the Emergency Management team will communicate with the local Health Department on vaccine distribution, administration and reporting requirements.

STAFF AND PHYSICIAN RESPONSIBILITIES:

All MercyOne Clive Rehabilitation Hospital physicians and staff are required to receive the influenza vaccine. Physicians and staff may elect to obtain their influenza vaccine through MercyOne Clive Rehabilitation Hospital or another provider. If vaccination is not obtained through MercyOne Clive Rehabilitation Hospital following the process given, written documentation of immunization must be provided.

Participation in Mercy's influenza immunization program is mandatory. All physicians, faculty, staff, volunteers, residents, and students will be required to do one of the following:

- Receive a flu vaccination offered by MercyOne Clive Rehabilitation Hospital free of charge.

- Provide proof of immunization if received outside of our program. This may be a signed physician's note, receipt for payment, immunization record that is dated and signed or a medical record document. All vendors, contractors, non-MCHS students and any individual serving in a Mercy facility will be required to provide this proof.

- Obtain an approved request for exemption by filling out an Accommodation Request Form through Occupational Health. Employees with allergies to eggs, mercury, Gentamicin or have had Guillain-Barre Syndrome should not receive vaccination and should file an exemption form.

Process of Approval:

Staff members, students and volunteers may request a reasonable accommodation to this requirement on the basis of:

1. A medical contraindication to the flu vaccine requires a signed statement from the employee's healthcare provider and medical documentation that describes the nature, duration and severity of your medical condition.

2. A religious practice or creed that prohibits immunization requires supporting documentation that demonstrates how the employee's religious practice or creed prevents you from receiving the vaccine. Also a signed statement from your minister/religious leader explaining how the tenets of your religion prohibit you from being immunized.

Reasonable accommodation does not exempt the employee from the annual flu prevention program, but rather is an alternate method of compliance in place of the flu vaccine. All staff not receiving the flu vaccine, and granted an accommodation, will be required to wear respiratory protection in the form of a surgical mask. Employees will be required to wear the mask for the duration of the flu season as defined by the Centers for Disease Control (CDC). The mask has to be worn at all times with the exception of breaks and meal times. The mask should fit snugly and be secured to the face.

Masks are to be worn when in direct contact with a patient. Directors/Managers/Supervisors will be responsible for ensuring staff who report to them either receive the vaccination or comply with the masking requirement. Masks are to be kept clean and free from personal markings, artwork, etc. Failure to wear a mask will result in disciplinary action, up to and including termination

The mask should be discarded, at minimum, at the end of the shift and immediately if it becomes soiled or moist. It is recommended that the mask be changed every two (2) hours or more frequently if necessary. Employees who do not receive the immunization, or an approved exemption by the timeframe given, will be subject to the standard disciplinary process, including suspension and termination.

All new employees will receive the flu vaccine, or provide documentation of their immunization, prior to the start of employment.

All consents are kept in the employee's file as well as recorded electronically

This policy is essential to helping our community reduce the spread of influenza, especially to those most at risk. As staff/physicians, our values place us in a position of responsibility to protect those we serve and work with, to our best ability.

Influenza Vaccine

Medical Exemption Statement for Health Care Personnel

Instructions

Please have your physician fill out this form. Retain copy for your own records. Return original to Vicky Heitz.

1.	Patient Name _____	Date of Birth _____
2.	Please document the patient's contraindication/precaution here:	
3.	Date exemption ends (only if applicable):	
4.	An Iowa State licensed physician or nurse practitioner must complete this medical exemption statement and provide their information below.	

Provider Name (print) _____	IN Medical License # _____
Telephone (back office # or pager) _____	
Signature _____	Date _____

Guidance for medical exemptions for influenza vaccination

Guidance for medical exemptions for influenza vaccination can be obtained from the contraindications, indications, and precautions described by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Morbidity and Mortality Weekly Report. They can be found at the following website, <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.

Contraindications are conditions that indicate when vaccines should not be given. A **contraindication** is a condition that increases the chance of a serious adverse reaction. A **precaution** is a condition that might increase the chance or severity of an adverse reaction or compromise the ability of a vaccine to produce immunity. An **indication** is a condition that increases the chance of serious complications due to influenza infection. If an individual has an indication for influenza vaccination, it is recommended that they be immunized.

The following are not considered contraindications to influenza vaccination.

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media).
- Mild to moderate local reactions and/or low-grade or moderate fever following a prior dose of the vaccine.
- Sensitivity to a vaccine component (e.g., upset stomach, soreness, redness, itching, swelling at the injection site).
- Current antimicrobial therapy (taking prescription anti-influenza therapy is only a temporary contraindication for the live attenuated influenza vaccine [LAIV]).
- Disease exposure or convalescence.
- Pregnant or immunosuppressed person in the household.
- Breast feeding.
- Family history (unrelated to immunosuppression).
- Any condition which is itself an indication for influenza vaccination.

Contraindications and precautions to all influenza vaccines include the following.

- Severe allergic reaction* after a previous dose or to a vaccine component (e.g., eggs).
- History of Guillain Barré Syndrome.
- Current moderate or severe acute illness with or without fever (until symptoms have abated).

* A severe allergic reaction is characterized by a sudden or gradual onset of generalized itching, erythema (redness), or urticaria (hives); angioedema (swelling of the lips, face or throat); severe bronchospasm (wheezing); shortness of breath; shock; abdominal cramping; or cardiovascular collapse.

For Facility Use ONLY	
Medical Exemption Status:	
[] Accepted	
[] Not Accepted	Reason:
Init. _____	Date _____



Health Related Declination of Seasonal Influenza Vaccination

MercyOne Clive Rehabilitation Hospital requires that I receive an influenza vaccination to protect the patients I serve.

Due to medical reasons, I request to not participate in the Influenza Vaccination program for 2018-2019.

Below is the documentation required for a medical exception:

Print Staff Name: _____ Dept # _____

Department Name: _____

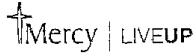
DOB: _____

Staff and physicians who are not immunized, including those who have a documented medical or religious exception, will be required to wear a mask. Masking of non-vaccinated individuals will help provide protection to patients, staff, physicians and visitors. The need for masking will begin when the local health department reports cases of influenza in the area and/or when probable exposure to influenza patients is identified by MercyOne Clive Rehabilitation Hospital’s Infection Prevention Department and will continue until the health department indicates flu cases have trended downward and risk of exposure subsides.

Masks are to be worn upon entering this facility and are to be worn at all times while in the facility. Directors/Managers/Supervisors will be responsible for ensuring staff who report to them either receive the vaccination or comply with the masking requirement. Failure to wear a mask will result in disciplinary action, up to and including termination.

I understand the requirement for me to wear a mask, and that disciplinary actions will be taken if I fail to do so and that should I have an influenza illness, **I will be required to be off work until cleared by Employee Health.**

Staff Signature: _____ Date: _____



Occupational Health Declination of Vaccine

Name: _____ Company: _____

SSN: _____ Date: _____

I will not be receiving the _____ vaccine today due to:
(Please Print)

- Personal Preference
- Allergy Concern: Explain _____
- Contraindication: Explain _____
- Pregnancy/Lactating
- Other: _____

I have been given the opportunity to read and discuss the Vaccine Information Sheets regarding the vaccine offered. I understand that by declining the vaccine I have the potential risk of Occupational Exposure that may result in acquiring an illness that may result in required time away from work or a serious disease.

Printed Name of Person Declining: _____

Signature of Person Declining: _____

Relationship, if signed by person other than patient: _____

Witness: _____ Date: _____

Comments: _____

CDC estimates that, from October 1, 2018 through May 4, 2019, there have been:

37.4 million – 42.9 million
flu **illnesses**



531,000 - 647,000
flu **hospitalizations**



36,400 – 61,200
flu **deaths**



*These estimates are preliminary and based on data from CDC's weekly influenza surveillance reports summarizing key influenza activity indicators.

EBOLA

Ebola, previously known as Ebola hemorrhagic fever, is a rare and deadly disease caused by infection with one of the Ebola virus species. Ebola can cause disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees).

Ebola is caused by a virus of the family *Filoviridae*, genus *Ebolavirus*. There are five identified Ebola virus species. Four of the five have caused disease in humans: Ebola virus (*Zaire ebolavirus*); Sudan virus (*Sudan ebolavirus*); Tai Forest virus (*Tai Forest ebolavirus*, formerly *Côte d'Ivoire ebolavirus*); and Bundibugyo virus (*Bundibugyo ebolavirus*). The fifth, Reston virus (*Reston ebolavirus*), has caused disease in nonhuman primates but not in humans.

Ebola viruses are found in several African countries. Ebola was first discovered in 1976 near the Ebola River in what is now the Democratic Republic of the Congo. Since then, outbreaks have appeared sporadically in Africa.

The natural reservoir host of Ebola viruses remains unknown. However, on the basis of evidence and the nature of similar viruses, researchers believe that the virus is animal-borne and that bats are the most likely reservoir. Four of the five subtypes occur in an animal host native to Africa.

Transmission

Because the natural reservoir of Ebola virus has not yet been identified, it is not known how the virus first appears in a human at the start of an outbreak. However, researchers believe that the first patient becomes infected through contact with an infected animal, such as a fruit bat or nonhuman primate.

Ebola is spread through direct contact (through broken skin or unprotected mucous membranes in, for example, the eyes, nose, or mouth) with

- blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, breast milk, and semen) of a person who is sick with Ebola,
- objects (like needles and syringes) that have been contaminated with the virus ,
- infected fruit bats or primates (apes and monkeys), and
- possibly from contact with semen from a man who has recovered from Ebola (for example, by having oral, vaginal, or anal sex)

Ebola is not spread through the air or by water, or in general, by food. However, in Africa, Ebola may be spread as a result of handling bushmeat (wild animals hunted for food) and contact with infected bats. There is no evidence that mosquitos or other insects can transmit Ebola virus. Only a few species of mammals (for example, humans, monkeys, and apes) have shown the ability to become infected with and spread Ebola virus.

Signs and Symptoms

A person infected with Ebola virus is not contagious until symptoms appear. Signs and symptoms of Ebola include:

- fever
- severe headache
- fatigue
- muscle pain
- weakness
- diarrhea
- vomiting
- stomach pain
- unexplained bleeding or bruising

Symptoms may appear anywhere from 2 to 21 days after exposure to the virus, but the average is 8 to 10 days.

Risk of Exposure

Healthcare providers and the family and friends in close contact with Ebola patients are at the highest risk of getting sick because they may come in contact with infected blood and body fluids. During outbreaks of Ebola, the disease can spread quickly within healthcare settings (such as a clinic or hospital). Exposure to Ebola virus can occur in healthcare settings where hospital staff are not wearing appropriate protective clothing including masks, gowns, gloves, and eye protection.

Ebola viruses are found in several African countries. Past Ebola outbreaks have occurred in the following countries:

- Democratic Republic of the Congo (DRC)
- Gabon
- South Sudan
- Ivory Coast
- Uganda
- Republic of the Congo (ROC)
- South Africa (imported)

Ebola (Ebola Virus Disease)

Diagnosis

Diagnosing Ebola in a person infected for only a few days is difficult because the early symptoms, such as fever, are nonspecific to Ebola and are seen often in patients with more common diseases, such as malaria and typhoid fever.

However, if a person has the early symptoms of Ebola and there is reason to believe that Ebola should be considered, the patient should be isolated and public health professionals notified. Samples from the patient can then be collected and tested to confirm infection.

Ebola virus is detected in blood only **after** onset of symptoms, most notably fever, which accompany the rise in circulating virus within the patient's body. It may take up to three days after symptoms start for the virus to reach detectable levels.

Treatment

There is no FDA-approved treatment (e.g., antiviral drug) for Ebola. Symptoms and complications are treated as they appear. The following basic interventions, when used early, can significantly improve the chances of survival:

- Providing intravenous fluids and balancing electrolytes (body salts)
- Maintaining oxygen status and blood pressure
- Treating other infections if they occur

Experimental treatments for Ebola are under development, but they have not yet been fully tested for safety or effectiveness.

Recovery from Ebola depends on good supportive care and the patient's immune response. People who recover from Ebola develop antibodies that last for at least 10 years, possibly longer. It isn't known if people who recover are immune for life or if they can become infected with a different species of Ebola. Some people who have recovered from Ebola have developed long-term complications, such as joint and vision problems.

Ebola virus has been found in the semen of some men who have recovered from Ebola. It is possible that Ebola could be spread through sex or other contact with semen. It is not known how long Ebola might be found in the semen of male Ebola survivors. Until more information is known, avoid contact with semen from a man who has had Ebola. It is not known if Ebola can be spread through sex or other contact with vaginal fluids from a woman who has had Ebola.

Prevention

There is no FDA-approved vaccine available for Ebola.

If you travel to an area affected by an Ebola outbreak, make sure to:

- Practice careful hygiene. For example, wash your hands with soap and water or an alcohol-based hand sanitizer.
- Avoid contact with blood and body fluids.
- Do not handle items that may have come in contact with an infected person's blood or body fluids (such as clothes, bedding, needles, and medical equipment).
- Avoid funeral or burial rituals that require handling the body of someone who has died from Ebola.
- Avoid contact with bats and nonhuman primates or blood, fluids, and raw meat prepared from these animals.
- Avoid facilities in West Africa where Ebola patients are being treated. The U.S. embassy or consulate is often able to provide advice on facilities.
- Monitor your health after you return for 21 days and seek medical care immediately if you develop symptoms of Ebola.

Healthcare workers who may be exposed to people with Ebola should follow these steps:

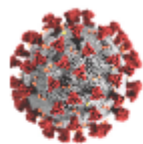
- Wear appropriate personal protective equipment (PPE).
- Practice proper infection control and sterilization measures.
- Isolate patients with Ebola from other patients.
- Avoid direct contact with the bodies of people who have died from Ebola.
- Notify health officials if you have had direct contact with the blood or body fluids of a person sick with Ebola.

More information about Ebola is available at <http://www.cdc.gov/vhf/ebola/index.html>.

National Center for Emerging and Zoonotic Infectious Diseases Division of High-Consequence Pathogens and Pathology



What you should know about COVID-19 to protect yourself and others



Know about COVID-19

- Coronavirus (COVID-19) is an illness caused by a virus that can spread from person to person.
- The virus that causes COVID-19 is a new coronavirus that has spread throughout the world.
- COVID-19 symptoms can range from mild (or no symptoms) to severe illness.



Practice social distancing

- Buy groceries and medicine, go to the doctor, and complete banking activities online when possible.
- If you must go in person, stay at least 6 feet away from others and disinfect items you must touch.
- Get deliveries and takeout, and limit in-person contact as much as possible.



Know how COVID-19 is spread

- You can become infected by coming into close contact (about 6 feet or two arm lengths) with a person who has COVID-19. COVID-19 is primarily spread from person to person.
- You can become infected from respiratory droplets when an infected person coughs, sneezes, or talks.
- You may also be able to get it by touching a surface or object that has the virus on it, and then by touching your mouth, nose, or eyes.



Prevent the spread of COVID-19 if you are sick

- Stay home if you are sick, except to get medical care.
- Avoid public transportation, ride-sharing, or taxis.
- Separate yourself from other people and pets in your home.
- There is no specific treatment for COVID-19, but you can seek medical care to help relieve your symptoms.
- If you need medical attention, call ahead.



Protect yourself and others from COVID-19

- There is currently no vaccine to protect against COVID-19. The best way to protect yourself is to avoid being exposed to the virus that causes COVID-19.
- Stay home as much as possible and avoid close contact with others.
- Wear a cloth face covering that covers your nose and mouth in public settings.
- Clean and disinfect frequently touched surfaces.
- Wash your hands often with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer that contains at least 60% alcohol.



Know your risk for severe illness

- Everyone is at risk of getting COVID-19.
- Older adults and people of any age who have serious underlying medical conditions may be at higher risk for more severe illness.



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[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

COVID-19

Updates will be made on an ad-hoc basis, per recommendations of the Centers for Disease Control (CDC) and local health departments.