

**Certification
for
Medical Staff and Allied Health Professionals**

Medical Staff and Allied Health Professionals (individually a “Practitioner” and together “Practitioners”) periodically review compliance topics that directly or indirectly affect them.

Please review this document, sign and date the attestation on the last page. Return this document with your other credentialing material. This attestation must be signed for you to become credentialed or re-credentialed, as the case may be.

I. CODING AND DOCUMENTATION

- The medical record is a legal document. All care provided for the purposes of diagnosis and treatment of patients by Practitioners must be documented in the medical record.
- The medical record is used for coding and billing purposes. Clinical coders review the medical record to determine the appropriate billing codes to submit to Medicare and other insurance companies for reimbursement, documentation of compliance and review of performance measures.
- More complex patient diagnoses and care are generally reimbursed by Medicare and other insurance companies at a higher level of reimbursement.
- If Medicare or other insurance reviewers determine that the Hospital has assigned more complex codes than what the medical record supports, allegations of UPCODING may be made.
- Allegations of UPCODING can result in violations of federal law that may lead to large financial penalties and potential exclusion of the Hospital as a Medicare provider.
- As a Practitioner, you can assist the Hospital in avoiding this serious risk. If you believe UPCODING has occurred, please notify any one of the following:
 - *Lisa Manson , Compliance Officer for Guttenberg Municipal Hospital; 563-252-5526*
 - *Andrew Smith, MD Chief of Staff for Guttenberg Municipal Hospital; 563-252-2141*

II. HOSPITAL/PRACTITIONER FINANCIAL RELATIONSHIPS

- The federal government regulates business and financial relationships between Hospitals and Practitioners who refer patients to the Hospital.
- These laws are complex and are subject to legal interpretation.
- Violations may result in substantial financial penalties, exclusion from the Medicare and other governmental payer programs and possible criminal penalties for Hospitals and Practitioners.
- The basic rules for financial relationships between referring Practitioners and Hospitals are that those relationships must be:
 - In writing and signed by both parties;
 - Commercially reasonable;
 - Negotiated at arm’s length;
 - Reflective of fair market value for any services exchanged between the parties;
 - Void of any purpose to provide remuneration to induce the referral of patients covered by governmental healthcare programs or to induce the ordering of equipment or supplies paid for by governmental healthcare programs; and

- Structured so that payments between the parties do not impermissibly vary based upon the volume or value of patient referrals or business otherwise generated between the parties.

III. **PATIENT CONFIDENTIALITY**

- Practitioners have a legal, professional, and ethical obligation to keep patient medical condition and protected healthcare information confidential.
- Laws and regulations governing patient confidentiality include:
 - ❖ HIPAA-Health Insurance Portability and Accountability Act:
 - The disclosure of protected health information (PHI) is highly regulated by the provisions of HIPAA and its privacy and security regulations.
 - PHI may be disclosed for (TPO) treatment, payment, and health care operations (such as quality reviews) without the consent of the patient.
 - PHI may be shared between Practitioners on a need to know basis.
 - Practitioners have access to paper and electronic records to document their treatment of patients. If the Practitioner does not have a need to know the PHI in the record because they are not involved in the care of the patient, then the Practitioner may not access the PHI in paper or electronic format (i.e.; PHI of a spouse, relative, friend, or celebrity patient.)
 - Practitioner user ID and password for access to electronic health records may not be shared.
 - All use of electronic messages must comply with the UPH electronic messaging procedures and rules which include the use of encryption. Refer to HIPAA Security Policy 1.IT.03, Email Usage.
 - Patient privacy rules apply to all media, including social media.
 - The confidentiality of PHI applies inside and outside of Hospital. PHI should not be discussed in hallways, restaurants, or anywhere your conversations may be overheard by people who are not caring for your patient.
 - ❖ Disciplinary rules and regulations of the applicable state Practitioner licensing board prohibit inappropriate disclosure of PHI.
- If Practitioners have questions or want to report a privacy or security concern, please contact the following:
 - *Lisa Manson, 563-252-5526 E-mail: lisa.manson@guttenberghospital.org.*

IV. **SEXUAL HARRASSMENT**

- Sexual harassment is illegal in the workplace. It creates risk of personal, civil liability to the Practitioner if the Practitioner sexually harasses a Hospital employee, patient, or visitor.
- Sexual harassment occurs in many forms. The most common are verbal comments or physical contacts of a sexual nature that are unwelcome and create an offensive or hostile environment.
- Medical and Allied Health Professional Bylaws and supporting documents such as rules, policies, and procedures regulate the conduct and behavior of Practitioners.
- The applicable Practitioner state licensing boards prohibit sexual harassment by Practitioners.
- A private lawsuit may be brought by the person alleging sexual harassment. The lawsuit, if proven, may result in a judgment of monetary damages. The Practitioner's insurance may not cover the award of monetary damages.

V. **RISK MANAGEMENT**

- The nature of a Practitioner’s relationship with patients and family plays a significant role in patient satisfaction and efforts to reduce or mitigate potential liability claims.
- Several variables determine the likelihood of a malpractice claim:
 - The clinical result of the patient’s care;
 - The nature of the Practitioner/patient relationship; and
 - The communication skills of the Practitioner
- Practitioners are less likely to be sued when they and their patients share common bonds of courtesy, communication, and respect.
- Practitioners are more likely to be sued when they avoid contact and communication with patients or their families.
- Disclosure of adverse events to patients and families has not been proven to increase the risk of liability claim and may mitigate the risk.
- Practitioners have a duty to report equipment malfunctions, whether or not the malfunction results in harm to patients or others. Notify any of the following when equipment malfunction occurs:
 - *Lisa Manson, Compliance Officer for Guttenberg Municipal Hospital; 563-252-5526*
 - *Robin Esmann, Director of Performance Excellence for Guttenberg Municipal Hospital; 563-252-5531*
 - *CEO/Risk Management for Guttenberg Municipal Hospital; 563-252-5529*

VI. **EMTALA**

- The Emergency Medical Treatment and Labor Act is a federal law that requires Hospitals to provide an appropriate medical screening examination and stabilizing care and treatment, as necessary, to patients who present to the Emergency Department requesting medical care and treatment or to any other department of the Hospital requesting emergency treatment.
- An appropriate medical screening examination and stabilizing care and treatment, as necessary, must be provided without regard to the patient’s insurance status or ability to pay.
- Transfers or discharges of EMTALA patients must be properly documented to demonstrate compliance with this federal law.
- Emergency department personnel/obstetrical nurses/mental health Practitioners/and consulting Practitioners must document their determination that the patient either did or did not come to the Hospital in emergency medical condition and that at the time of transfer/discharge, the patient was in stable condition.
- See Hospital EMTALA policy in PolicyTech.
- The penalties for Hospitals and Practitioners violating EMTALA include civil monetary penalties (fines), exclusion from the Medicare program and in the case of Hospitals, a private right of action by the patient.
- If Practitioners have questions or wish to report an EMTALA issue they should notify any of the following:
 - *Lisa Manson, GMHC Compliance Officer; 563-252-5526*

VII. **USE OF RESTRAINT OR SECLUSION**

RESTRAINT POLICY - “PATIENT RESTRAINTS” (Nursing Policy):

Affects: Administration, Medical Staff, Nursing

Objective: To ensure each patient reaches his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use of circumstances in which the patient has medical symptoms that warrant use of restraints.

Policy: It is the policy of Guttenberg Municipal Hospital (GMH) to ensure a patient has the right to be free from physical and/or chemical restraints except when medically necessary to improve the patient's well-being and less restrictive interventions have been determined to be ineffective.

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 or seclusion of any form imposed as a means of correction, discipline, convenience or retaliation by staff. Restraint or seclusion 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.

Definitions:

A 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.
- 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.

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).

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.

Policy:

1. Restraint or seclusion 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.
2. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
3. Potential less restrictive alternate interventions include:
 - A. Physical Modifications
 1. Modify environment (i.e.; increase lighting, establish wandering paths, disguise exits).
 2. Adapt wheelchairs.
 3. Provide body props (orthotic devices, pillows, pads or lap trays) to achieve proper body position, balance & alignment.
 4. Use alternative beds.
 5. Lock wheels.

6. Apply Posey Alarm to patient.
 7. Reduce unnecessary visual or auditory stimuli (i.e.; eliminate buzzers, bells, intercoms, television).
 8. Personalize rooms.
 9. Apply trapeze to bed to increase mobility.
 10. Bed in lowest position.
- B. Physiological and Nursing Care Approaches
1. Evaluate underlying physical or psychosocial problems.
 2. Evaluate sleep patterns.
 3. Relieve pain (medications and/or adjunct interventions.)
 4. Use appropriate footwear (comfort and stability).
 5. Use eye glasses, hearing aids, or dentures.
 6. Increase hydration (creatively offer and encourage).
 7. Provide additional supervision and more frequent observation.
 8. Initiate activities.
 9. Relocate resident near nursing station.
 10. Institute toileting schedule.
 11. Implement repositioning techniques (consistency among staff is vital).
 12. Schedule daily nap.
 13. Re-evaluate drug use/medications (prescription and over-the-counter).
 14. Take out of room and out of facility, as appropriate.
 15. Provide frequent reminders or redirection to avoid a specific behavior.
 16. Provide repeated reassurances (This may not be helpful for a cognitively intact person).
 17. Encourage acceptance by staff and family of the resident with behavior symptoms.
 18. Institute more skilled therapy (or nursing rehabilitation, i.e.; physical therapy, medical, psychosocial, etc.)
 19. Provide massage.
 20. Provide snacks.
 21. Provide diversion/redirection.
- C. Activity Related Approaches
1. Structure daily activities.
 2. Permit or encourage wandering/pacing.
 3. Provide physical exercise.
 4. Provide night-time activities.
 5. Provide weekend activities.
 6. Use buddy system to monitor.
 7. Use reminiscence therapy through activities.
 8. Provide music therapy.
- D. Psychosocial Approaches
1. Actively listen/explore feelings & perceptions of resident.
 2. Encourage familiar possessions.
 3. Encourage independence in aspects of care.
 4. Use behavioral strategies (i.e.; eliminate mirror, utilize consistent caregiver assignment, reward positive behavior, hug when needed, validate feelings and

thoughts, use “rescue technique,” and assist in meeting the goals of agenda behavior.

5. Modify sensory behavior.
 6. Increase visiting/socialization.
 7. Provide reality orientation only if patient can be orientated to reality.
 8. Accept resident’s perceptions of their reality.
4. The use of restraint or seclusion must be:
- In accordance with a written modification to the patient’s plan of care and implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.
5. The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.
6. Orders for the use of restraint or seclusion must never be written as a Standing Order or on an as needed basis (PRN).
7. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.
8. Unless superseded by State law that is more restrictive:
- A. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours.
 - 4 hours for adults 18 years of age or older.
 - 2 hours for children and adolescents 9 to 17 years of age.
 - 1 hour for children under 9 years of age.
 - B. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under 482.12 (c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.
 - C. Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.
9. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
10. The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in hospital policy.
11. Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent

practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

12. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician or other licensed independent practitioner, a registered nurse or physician assistant who has been trained in accordance with hospital policy to:
 - Evaluate the patients immediate situation.
 - The patient's reaction to the intervention.
 - The patient's medical and behavioral condition.
 - The need to continue or terminate the restraint or seclusion.
13. States are free to have requirements by statute or regulation that are more constrictive than stated in this policy.
14. If face-to-face evaluation specified in this policy is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1 hour face-to-face evaluation.
15. All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
 - Face-to-face by an assigned, trained staff member.
 - By trained staff using both video and audio equipment, monitoring must be in close proximity to the patient.
16. When restraint or seclusion is used, there must be documentation in the patient's medical file record of the following:
 - The one hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
 - A description of the patient's behavior and the intervention used.
 - Alternatives or other less restrictive interventions attempted.
 - The patient's condition or symptoms that warranted the use of the restraint or seclusion.
 - The patient's response to the interventions used, including the rationale for continued use of the intervention.

TRAINING REQUIREMENTS:

1. The patient has the right to safe implementation of restraint or seclusion by trained staff.

2. Staff will be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion:
 - Before performing any of the actions specified in this policy.
 - As part of orientation.
 - Subsequently on a yearly basis.

TRAINING CONTENT:

1. Appropriate staff will have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following.
 - a.) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
 - b.) The use of non-physical intervention skills.
 - c.) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 - d.) The safe application and use of all types of restraint or seclusion used in the hospital including training in how to recognize and respond to signs of physical and psychological distress (i.e.: positional asphyxia).
 - e.) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
 - f.) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulator status, skin integrity, vital signs and any special requirements specified by hospital policy associated with the 1 hour face-to-face evaluation.
 - g.) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation including required periodic recertification.

TRAINER REQUIREMENTS:

1. Individuals providing staff training will be qualified as evidenced by education, training and experience in techniques used to address patient's behaviors.

TRAINING DOCUMENTATION:

1. Documentation in the staff's personnel records that the training and demonstration of competency were successfully completed.

DEATH REPORTING:

1. Nursing Staff must immediately notify the Chief Nursing Officer of any death that:
 - a.) Occurs while a patient is restrained, secluded or where it is reasonable to assume that a patient's death is a result of restraint. The C.N.O. must report the death to the hospital CEO and to CMS.
 - b.) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

- c.) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion 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.
- d.) Each death referenced in this policy 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.
- e.) Staff must document in the patient's medical record the date and time the death was reported to CMS.

PROVIDER ACKNOWLEDGMENT

I have reviewed this policy and understand my responsibilities as a patient care provider.

PRINT Legal Name

Provider Signature

Date