

## Reappointment Policy Review Requirements

As part of your reappointment to St. Mary Medical Center, a review of the following material is required.



SMPA - MSO - Reappointment Curriculum

SMPA - MSO - Use of Sedation and Analgesia by Non-Anesthesia Personnel Policy

SMPA - MSO - Restraints Use Policy

SMPA - MSO - Intimate Exam Policy

SMPA - MSO - Pain Management

SMPA - MSO - Code of Conduct - Trinity -Medical Staff Supplement

SMPA - MSO - Categories and Classifications of the Medical Staff

SMPA - MSO - Child Protective Services Law Requirements

SMPA - MSO - Memo

SMPA - MSO - MIDAS Patient Safety Reporting

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**EFFECTIVE DATE:** 10/04/2018

**POLICY & PROCEDURE TITLE:**

The Use of Sedation and Analgesia for Procedures by Non-Anesthesia Personnel Policy and Procedure

**REVIEW BY:** 10/31/2020

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As with all St. Mary Medical Center (SMMC) policies, we strive to advance our mission: “We, St. Mary Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. As a community of caring people, we are committed to extending and strengthening the healing ministry of Jesus.” By so doing, we live out our values of Reverence, Commitment to those who are Poor, Justice, Stewardship, Integrity and Excellence. As a Catholic Health System, we are also guided by the Ethical and Religious Directives for Catholic Healthcare Services as promulgated by the U.S. Conference of Catholic Bishops.

This policy & procedure impacts the following core values: Excellence

**PURPOSE**

To provide standards and guidelines for non-anesthesia clinicians to provide their patients with the benefits of sedation/analgesia while minimizing the associated risks.

**POLICY**

- I. The physician will have primary responsibility for the patient requiring sedation.
- II. All sedation shall be ordered and supervised by the physician privileged for the administration of sedation and analgesia.
- III. There will be sufficient qualified personnel present in addition to the physician performing the procedure to evaluate the patient, assist with the procedure, provide the sedation and/or analgesia, and to monitor and recover the patient.

**CREDENTIALING**

**Physicians**

Only physicians qualified by education, training and licensure to administer moderate sedation should supervise the administration of moderate sedation.

Education and Training

## Title: The Use of Sedation and Analgesia for Procedures by Non-Anesthesia Personnel Policy and Procedure

The non-anesthesiologist practitioner who is to supervise or personally administer moderate sedation should have completed a formal training in: (1) the safe administration of sedative and analgesic drugs used to establish a level of moderate sedation, and (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation.

For recent graduates (within 2 years) this may be accomplished through letters of recommendation from directors of residency or fellowship training programs, which include moderate sedation as part of their curriculum.

For those in practice, this may be accomplished through communication with department heads at the institutions where the individual holds privileges to administer moderate sedation with documentation of a minimum of 5 cases where the physician was responsible for sedation administration.

If an applicant has no prior experience, a physician credentialed to administer moderate sedation must proctor him for a minimum of 5 cases.

All applicants are required to read and review informational materials supplied by the medical staff office related to the administration of moderate sedation.

### **Qualified Healthcare Providers**

Only registered nurses qualified by education, training and licensure may administer sedative and analgesic medications on the order of an anesthesiologist or non-anesthesiologist sedation practitioner.

### Education and Training

The supervised nurse must be ACLS certified and have previous experience in critical care or post-anesthesia/sedation care. They should have completed a formal training program in

(1) the safe administration of sedative and analgesic drugs used for moderate sedation, (2) use of reversal agents for opioids and benzodiazepines, (3) monitoring of patient's physiologic parameters during sedation, and (4) recognition of abnormalities in monitored variables that require intervention by the non-anesthesiologist sedation practitioner or anesthesiologist.

On an annual basis, the RN will review a self-study packet related to moderate sedation and the use of reversal agents.

### **Performance Improvement**

Credentialing requires active participation in an ongoing process that evaluates the practitioner's clinical performance and patient care outcomes through a formal program of continuous performance improvement with peer review, assessment of ongoing competence through assessment of patient outcomes and adverse events.

## **PROCEDURE**

### **Patient Care/ Pre-Sedation**

1. Pre-procedural instruction to the patient should address NPO status, dietary restrictions, medication history and restrictions, the availability of a responsible adult for transportation home, explanation of the planned procedure and sedation and preparation instructions.
2. The physician responsible for the sedation will perform a pertinent pre-sedation patient assessment which includes at least the following:
  - a. NPO status (see addendum)
  - b. Review of past and present medical/surgical history
  - c. Weight and age of patient
  - d. Current medications
  - e. Any known allergies or adverse drug reactions
  - f. Past complications associated with sedation/anesthesia/surgery
  - g. Relevant diagnostic studies
  - h. Physical assessment which includes at least an airway, cardiac and pulmonary examination (see addendum)
  - i. Classification of physical status using the American Society of Anesthesiologists (see addendum)
  - j. Consideration for anesthesiology consult (see addendum)
3. A pre-procedure diagnosis and sedation plan will be documented
4. Obtain informed consent including risks, benefits and alternatives to sedation.
5. The site, procedure, and patient are accurately identified.
6. Intravenous access will be established.
7. Baseline vital signs will be recorded including: blood pressure, pulse, oxygen saturation, respiratory rate, sedation scale (see addendum) and pain assessment as appropriate.

### **Equipment**

Appropriate equipment must be present for patient care and resuscitation. This includes:

1. Oxygen and suction supply with attached regulators ready for use.
2. Oxygen delivery supplies, which are patient size appropriate including masks, cannulas, connectors, positive pressure delivery system and intubation equipment.



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3. Suction tubing and suction catheters.
4. Physiologic monitoring equipment with capability of continuous ECG, BP, pulse oximetry and ability to record ECG rhythm strip.
5. Reversal agents for benzodiazepines and/or narcotics as appropriate.
6. Appropriate resuscitative drugs and equipment (Crash Cart/Defibrillator)

**Patient Care / During Procedure**

1. The patient will be assessed immediately prior to sedation administration and documentation of such will be recorded on the sedation record.
2. Vascular access will be established and maintained throughout the procedure and recovery period. If intravenous access becomes non-functional after the procedure the physician will assess the requirement to re-establish access on a case-by-case basis.
3. The qualified healthcare provider within the scope of their practice may administer the sedative and/or analgesic under order of the privileged physician.
4. The qualified healthcare provider may not be involved in any tasks other than those relating to sedation administration and monitoring.
5. Patients receiving sedation will receive continuous monitoring of heart rate and rhythm and pulse oximetry.
6. Blood pressure, respiratory rate and level of consciousness will be recorded at least every 5 minutes.
7. A time based record of vital signs and events shall be recorded on the medical record including:
  - a. Start and completion time of the procedure
  - b. Drug name, dose and route of administration
  - c. Vital signs including heart rate, cardiac rhythm, blood pressure, respiratory rate, oxygen saturation, level of sedation and temperature (as appropriate) are recorded every 5 minutes.

Any adverse responses to the sedative/analgesic medications or procedures will be immediately reported to the responsible physician in order to institute corrective or emergency procedures. These responses and therapy will be documented accordingly.

**Patient Care / Post Procedure**

1. Patients are discharged from recovery after sedation by order of a credentialed practitioner.
2. Patients will be monitored for a minimum of 30 minutes post-procedure. Monitoring includes at least the following: continuous monitoring of cardiac rhythm and oxygen saturation, recording of vital signs (blood pressure, heart rate, respiratory rate and level of consciousness) every 15 minutes.
3. The patient will be assessed at the start and end of the recovery period by computing the REACT score Policy.

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4. Patients who receive reversal agents (naloxone, flumazenil) must be monitored for a minimum of 2 hours following the last dose of reversal agent. Appropriate monitoring as described in #2 will be continued throughout this period. The patient's response to the reversal agent will be documented by the RN.
5. Patients will be instructed they must provide a responsible adult for transport home (Mode of Transport Upon Discharge for Patients Receiving Anesthetics/Sedation Policy).
6. Written instructions will be explained to the patient, and/or responsible individual, and are to include at least the following:
  - a. Driving instructions
  - b. Diet restrictions
  - c. New/changes in medications
  - d. Activity
  - e. Access information (physician name and phone number) in the event questions/complications develop

### **Discharge Criteria**

Patients will be discharged home following sedation by order of a credentialed physician per the following criteria:

1. The patient is awake, alert and oriented or has returned to their pre-sedation baseline
2. Vital signs are stable with a REACT score greater than/equal 9
3. No reversal agents within 2 hours of discharge
4. Patient is experiencing no vomiting
5. Ambulating patients do so without dizziness
6. Discharge orders have been written/provided by a physician
7. Procedure specific criteria met (refer to unit specific standard of care or individual physician orders)
8. Minimum post-procedure time has been met (refer to unit specific standard of care or individual physician Orders)
9. No narcotic pain medication within 1 hour of discharge
10. Responsible adult to escort home

For Patients not meeting discharge criteria, document reason, date, time and name of physician notified.

### **Quality Improvement Indicators for Sedation**

If any of the following occur due to the sedation administered and not the result of the pre-existing condition a review of the chart will be performed:

1. Oxygen saturation less than 90% (if not baseline) for greater than 1 minute
2. Assisted ventilation or unanticipated intubation
3. A decrease in blood pressure or heart rate requiring pharmacologic intervention or rapid fluid administration
4. Failure to respond to physical stimulation

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5. Any reversal of analgesics or anxiolytics
6. Unplanned admission or transfer to a higher level of care
7. Cardiac or Respiratory arrest

**ADDENDUM**

I. GUIDELINES FOR CONSIDERATION OF AN ANESTHESIOLOGY CONSULT:

A. It is appropriate that an anesthesiology consultation be considered or that extra caution should be exercised prior to sedation if the H & P notes one or more of the following conditions, which may require skills outside the area of expertise of the physician (or physicians) present during the procedure:

1. patient has recently eaten and requires an emergency procedure
2. neurological disease, cardiopulmonary disease (e.g. recent MI, dyspnea, sleep apnea) or other organ system disease felt to present a significant hazard.
3. concerns related to airway management e.g., distorted anatomy or immobilization of the head and/or neck
4. significant (morbid) obesity
5. Patient taking medications that may adversely react with moderate sedation agents (e.g., MAO inhibitors)
6. previous adverse reaction to anesthesia or sedation
7. ASA physical Status level IV or V

II. NPO RECOMMENDATIONS\*\*

Ingested Material	Minimal Fasting
Clear Liquids <	2 hours
Breast Milk	4 hours
Infant formula *	6 hours
Non-human milk	6 hours
Solids	8 hours
<ul style="list-style-type: none"> <li>➤ clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee</li> <li>➤ * children younger than 6 months of age can be fed infant formula up to 4 hours prior to surgery or procedure.</li> </ul>	

\*\* These recommendations are for healthy patients who are undergoing elective procedures.

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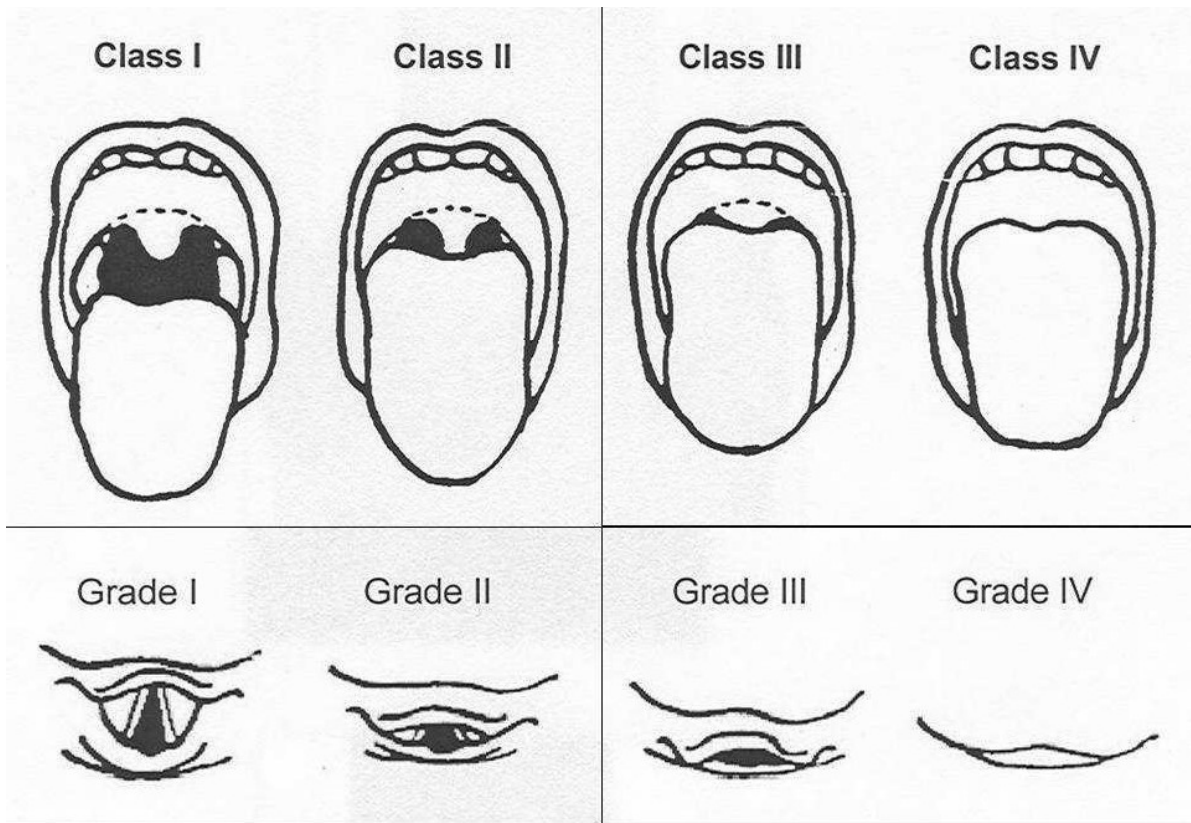
**MALLAMPTHI AIRWAY CLASSIFICATION**

**Class I** Soft palate, fauces, entire uvula, tonsillar pillars

**Class II** Soft palate, fauces, uvula

**Class III** Soft palate, base of uvula

**Class IV** Soft palate only (uvula not seen)



**SCOPE/APPLICABILITY**

These guidelines pertain to patients receiving sedation and/or analgesia for the purpose of lessening anxiety and discomfort while undergoing diagnostic or therapeutic procedures.

This policy does not apply to:

1. Patients receiving a single oral medication in standard outpatient

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- dosage prior to a diagnostic procedure.
2. Patients undergoing minimal sedation/anxiolysis. This is defined as the administration of one drug, one dose, one route, one time provided the patient meets the definition of minimal sedation as defined.
  3. Intubated patients in critical care areas who will be mechanically ventilated both during and after the procedure.
  4. The use of sedation in children 13 years of age or younger by non-anesthesia personnel except for oral medications.
  5. Patients under the care of anesthesia practitioners.

## DEFINITIONS

**Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Moderate Sedation/Analgesia (“Conscious Sedation”)** is a drug-induced depression of consciousness during which patients respond purposefully\*\* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

\*\*Reflex withdrawal from a painful stimulus is NOT considered a purposeful

response. **Sedation** as defined in this policy shall apply to moderate sedation/analgesia

### **Physician**

“Physicians” shall include physicians, dentists and podiatrists privileged to administer sedation.

### **Qualified Healthcare Provider**

“Qualified healthcare provider” is defined as a licensed Registered Nurse or Nurse Practitioner practicing within their scope of practice with demonstrated competency.

## RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Anesthesia

## RELATED PROCEDURES AND OTHER MATERIALS

**EFFECTIVE DATE:** 07/16/2020

**POLICY & PROCEDURE TITLE:**  
Restraint Use Policy and Procedure

**REVIEW BY:** 07/16/2022

As with all St. Mary Medical Center (SMMC) policies, we strive to advance our mission: “We, St. Mary Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. As a community of caring people, we are committed to extending and strengthening the healing ministry of Jesus.” By so doing, we live out our values of Reverence, Commitment to those who are Poor, Justice, Stewardship, Integrity and Excellence. As a Catholic Health System, we are also guided by the Ethical and Religious Directives for Catholic Healthcare Services as promulgated by the U.S. Conference of Catholic Bishops.

This policy & procedure impacts the following core values: Integrity, Justice, Reverence

**PURPOSE**

1. To promote a restraint-free environment.
2. To promote an environment of safety and comfort for each patient, respecting their rights and dignity while simultaneously protecting them from harm.
3. To provide a hospital-wide standard of care for the assessment, application, and evaluation of the use of physical-restraints.

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**NOTE:** To ensure the policy end user is using the most up-to-date document, the end user is to view the version on the electronic policy management system (Policy Tech).

Title: Restraint Use Policy and Procedure

**I. POLICY**

1. It is the philosophy of Trinity Mid-Atlantic to prevent, reduce, and strive to eliminate the use of restraint and to maintain patient's rights, dignity, and safety whenever restraint is used.
2. The Registered Nurse (RN) can initiate use of restraints after performing an assessment of patient's need and indication when alternative interventions failed.
3. Restraints are applied by a RN or designee. The nursing assistant, security personnel or emergency department technician applies a restraint only under the direction of the RN.
4. The purpose of ongoing assessment and reassessment is to remove restraint at the earliest moment when no longer needed. Without clear indication, restraints should be removed in favor of alternative measures.
5. The **least restrictive alternative is attempted first** prior to the use of physical restraint.
6. The type of restraint used is based on the patient assessment and need.
7. Restraints are not used for coercion, convenience, discipline, retaliation by staff, or for insufficient staffing.
8. Restraints are not a PRN (as needed) or as a standing order.
9. Administration of chemicals with the intent to restrict a patient's behavior or freedom of movement is not permitted; however, the use of standard dose treatment to achieve therapeutic response in order for the patient to interact in their environment is permitted.
10. Patients on a 4-point restraint is assigned a continuous 1:1 observation.

**II. TYPE OF RESTRAINTS**

1. Side Rails – The use of four side rails is considered a restraint when used to prevent the patient from exiting the bed, or/and to reduce the ability to move arms, legs, or body.
  - a. Exception: In the event that the patient is not physically able to get out of bed and thus does not influence freedom of movement.
  - b. Exception: Three raised side rails does not reduce the freedom of movement.
2. Elbow Immobilizer – Prevents the limb from bending to restrict self-extubating; least restrictive if not tied; intermediately restrictive if tied.
3. Mitts – Mitts applied to reduce tugging or pulling lines with free movement of the limbs; least restrictive if not tied; intermediately restrictive if tied.
4. Geri-chair with tray and the intent to restrain.
5. Soft Limb Restraints – Fabric bracelets (1, 2, 3 or 4 point) encasing the wrists and ankles of a person lying in beds, which are secured to the bed frame.
6. Four Point: Non-soft restraints that are applied to both wrists and ankles and secured to the bed frame. Not appropriate for non-violent patients.

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Table 1

*Least, Intermediate, and Most Restrictive Restraint*

Physical Restraints		Chemical Restraints
Least restrictive restraints	Velcro Seat Belt Geri-Chair/Reclining Chair Mitt(s) – untied Elbow Immobilizer -untied	Not permitted
Intermediate restraints	Wrist Restraints Leg Restraints Mitt(s) – tied Elbow Immobilizer – tied Four Side rails	
Most restrictive restraints	4 point (all limb) restraints Lock restraints	

**III. RESTRAINT EXCLUSIONS**

1. A positioning or securing device and medications used during a medical, dental, diagnostic or surgical procedure and the related post-procedure care processes are not considered a restraint. These mechanisms include, but are not limited to, body restraints during surgery, IV arm boards, gurney safety belts, and seat belts while in highchairs, wheelchairs, or any transportation vehicle for children six months to four years of age.
2. Protective devices used to compensate for a specific physical defect or prevent an unsafe event, such as bumper pads or protective helmets are not restraints.
3. Adaptive support mechanisms intended to permit a patient to achieve maximum functioning, such as orthopedic appliances, braces, and wheelchairs.
4. Assistive devices used to enable the patient to perform independent activities including eating, drinking, reading, or self-positioning, such as over-bed tables, Geri-chairs and side rails with controls.
5. Four side rails are not considered restraints under the following conditions with supportive documentation:
  - a. Placing a patient on seizure precautions with all padded side rails raised
  - b. Patients secured on a stretcher
  - c. Patients recovering from anesthesia or sedated
  - d. Patients experiencing involuntary movement
  - e. Certain types of therapeutic beds to prevent the patient from falling out
  - f. Cribs are and age-appropriate standard safety practice
  - g. At the patient’s request and supported by nursing documentation
6. Forensic and correctional restraints used for security purposes by officers of the court are exempt from this policy.



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#### IV. **RESTRAINT ALTERNATIVES**

1. Prior to the application of Non-Violent or Violent Restraint, the least restrictive intervention(s) are attempted first and document.
2. Document type of alternative restraint measured used.
3. Document patient's response to least restrictive alternative interventions.
4. Alternative measures of restraint includes but not limited to:
  - a. Re-orient patient to the environment
  - b. Relieve discomfort and pain management
  - c. Change or eliminate treatment causes distress when appropriate
  - d. Provide companionship (includes family members, friends, to accompany patient)
  - e. Re-direct patient using diversion technics and physical activities
  - f. Psychological interventions and reality orientation (example: use active listening to elicit the patient's feelings; engage in conversation; use television or clock)
  - g. Review medication with Licensed Independent Practitioner (LIP)
  - h. Anticipate toileting and hydration needs
  - i. Use bed or chair alarm
  - j. Comfort measures
  - k. Modify the environment to reduce sensory stimulation and promote a healing environment (alter lighting, lower bed, reduce noise, etc.)

#### V. **PROCEDURE FOR RESTRAINTS**

##### **A. General Restraint Orders**

1. Obtain a restraint order from Licensed Independent Practitioner (LIP).
2. No PRN or standing restraints orders permitted.
3. Order type is selected, either Non-Violent or Violent Restraint.
4. Licensed Independent Practitioner (LIP) are primarily responsible for the patient's ongoing care orders the use of restraint or seclusion.
5. Attending Physician is consulted or notified within 24 hours if restraint ordering LIP is not attending.
6. After an early release, if the patient's behavior exhibits need for a restraint subsequently, a new restraint order is required and either Non-Violent or Violent Restraint procedure is followed.

##### **B. Initial Assessment and Documentation**

1. Initial Restraint Assessment includes:
  - a. Primary/Attending physician notification
  - b. Type of Restraint and location
  - c. Date and time restraint applied
  - d. Least restrictive interventions attempted and patient response
  - e. Clinical justification (such as, protect patient safety or safety of others, prevent disruption of medical therapy) and describe behaviors patient is exhibiting.

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- f. Educate patient and families on use of restraints and expected behaviors for restraint removal
  - g. Individualized Plan of Care to reflect Non-Violent or Violent Restraint.
2. Continue patient-family education; Re-educate the necessity or purpose of restraint use and the discontinuation criteria.

**C. Non-Violent Restraint Order & Assessment Procedure**

1. Non-Violent restraint order expires in 24-hours after application.
2. An in-person evaluation is conducted on the Non-Violent Restraint by an LIP every 24 hours before entering new restraint order.
3. RN Assesses Non-Violent restraint patient every 2 hours for physical conditions, personal safety, and comfort:
  - a. Level of consciousness/mental status
  - b. Respiratory status
  - c. Skin circulation
  - d. Accessibility to call bell
  - e. Elimination/hygiene
  - f. Nutrition/hydration
  - g. Pain assessment
  - h. Skin integrity/repositioning/Range of Motion
  - i. Emotional needs and well-being, dignity and rights
  - j. Sign of Injury
  - k. Patient Behavior Observed

**D. Violent Restraint Order & Assessment Procedure**

1. The emergency use of restraint for Violent behavior can be initiated before obtaining an LIP order only when immediate intervention is required to prevent patient from harming self or others and non-physical interventions were ineffective. In this event, the RN documents the assessment immediately after initiating restraint and document the patient's behaviors that prompted the use of restraint. Notify primary or attending provider immediately.
2. Violent Restraints require frequent evaluation. All Violent Restraints expire and require re-ordering by the LIP according to the following specific time limitations:
  - a. Every 4 hours for adults age 18 and older
  - b. Every 2 hours for adolescent patients 9 to 17 years of age
  - c. Every 1 hour for children under 9 years
3. An in-person evaluation is conducted on *initial order* for Violent Behavior Restraint within **ONE HOUR**. LIP or RN conducts the in-person evaluation and documentation includes:
  - a. An evaluation of the patient's immediate situation,
  - b. The patient's reaction to the intervention,
  - c. The patient's medical and behavioral condition,
  - d. The need to continue or terminate restraint or seclusion.

**(LIP documents in progress note; RN documents under Violent Restraint Assessment)**
2. An in-person evaluation is conducted for *continued order* for Violent Behavioral Restraint by an LIP according to the following specific timeframe and documentation includes:
  - a. Every 8 hours for patients 18 years old and greater

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- b. Every 4 hours for patients less than 17 years old
- e. An evaluation of the patient's immediate situation,
- f. The patient's reaction to the intervention,
- g. The patient's medical and behavioral condition,
- h. The need to continue or terminate restraint or seclusion.

**(The in-person evaluation occurs even if the restraint is terminated within the designated timeframe)**

- 4. Patients with Violent Restraints are placed on continuous 1:1 observation.
- 5. Patients with Violent Restraints are observed every 15 minutes for physical conditions, personal safety, and comfort by nursing assistant/emergency department technician:
  - a. Level of consciousness/mental status
  - b. Respiratory status
  - c. Skin circulation
  - d. Accessibility to call bell
  - e. Elimination/hygiene
  - f. Nutrition/hydration
  - g. Comfort
  - h. Skin integrity/repositioning/Range of Motion
- 6. RN documents in EHR the physical conditions, personal safety and comfort every 1 hour in the Violent Restraint Flowsheet under:
  - a. Care Provided
  - b. Pain Assessment
  - c. Patient Behavior Observed for continued restraint justification
  - d. Signs of Injury
  - e. Emotional needs and well-being, dignity and rights

#### **E. Assessment and Reassessment**

- 1. After initial assessment and application of restraint, the RN continues to monitor the patient's physical conditions, personal safety, and comfort as outlined in the aforementioned procedure for either Non-Violent or Violent Restraint.
- 2. Assessment and Reassessment of Restraint includes:
  - a. Verify physician order is current
  - b. Type of Restraint and location
  - c. Date and time restraint applied
  - d. Least restrictive interventions attempted and patient response
  - e. Clinical justification (*describe behaviors, describe need for continued restraint*)
  - f. Educate patient and families on use of restraints and expected behaviors for restraint removal
  - g. Modification to Individualized Plan of Care (IPOC) to reflect Non-Violent or Violent Restraint.
  - h. Continued monitoring and reassessment activities for duration of restraint
  - i. Injuries sustained and treatment received (when applicable)
  - j. Date and time restraint terminated
- 3. Individualized Plan of Care (IPOC) to include the goal/expected behaviors to remove restraint.

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4. Continue patient-family education; Re-educate the necessity or purpose of restraint use and the discontinuation criteria.
  - a. Explanation of the behavior that might precipitate restraint use
  - b. Explanation of available alternatives to the use of restraint
  - c. Explanation of the type of restraint

#### **VI. Electronic Health Record Documentation Requirements**

1. RN documents required assessment and reassessment in appropriate Restraint Flowsheet: Non-Violent [every 2 hours] or Violent [every 1 hour].
2. Healthcare professional assigned to Continuous Observation for violently restrained patients are responsible to document in the EHR.
3. Document Patient and Family Education on restraint flowsheet.
4. Document in the IPOC.

#### **VII. DEFINITIONS**

1. Restraint: The use of any manual method, physical, or mechanical device, material or equipment applied to a patient that immobilizes one or reduces their ability to move their arms, legs, body, or head freely.
2. Chemical Restraint: A drug or medication is a restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement, and is not standard treatment or dose safe for the patient's condition.
3. Standard Treatment or Dosage: Use of drug or medication to treat a specific patient's clinical condition based on the patient's symptoms, overall clinical situation, and to achieve a therapeutic response in that the patient is able to interact in their environment.
4. De-escalate: Reduce the intensity of a conflict or potentially violent situation.
5. Imminent risk: About to occur; impending. The risk is here and now.
6. Non-Violent Behavior: Patient's behavior interferes with medical healing and poses a threat to the protection of physical safety.
7. Violent Behavior: An emergency situation when a patient's behavior becomes violent or aggressive present immediate, serious danger to his/her safety or that of others and requires psychiatric evaluation and management.
8. Seclusion: Is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.
9. Physical Escort: A physical escort is a "light" grasp to escort the patient to a desired location. If the patient cannot easily remove or escape the grasp, this is a physical restraint.
10. Physical Holding: Holding a patient in a manner that restricts the patient's movement against the patient's will is a restraint.
11. Early Release: A restraint discontinued prior to expiration of the original order.
12. Constant observation: face-to-face in-person monitoring.
13. Capacity: Possessing the clarity of mind to agree or refuse treatment (clinical assessment made by the LIP).
14. Episode of restraint: Each provider order counts as an episode of restraint.
15. Prolonged Use: The period of which restraint use went beyond what is reasonable to safely manage and de-escalate an acute restraint episode.

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**SCOPE/APPLICABILITY**

- 1. Nursing
- 2. Quality
- 3. Security
- 4. Risk Management

**RESPONSIBLE DEPARTMENT**

Contact Nursing for further guidance concerning this Policy

**CROSS REFERENCE POLICIES**

- 1. Telephone Order Policy & Procedure
- 2. Continuous Patient Observation Policy & Procedure

**RELATED PROCEDURES AND OTHER MATERIALS**

Hevener, S., Rickabaugh, B., Marsh, T. (2016). Using a decision wheel to reduce use of restraints in a medical-surgical intensive care unit. *American Association of Critical-Care Nurses, 25(6)*, 479-486.

Mitchell, D., Panchisin, T., & Seckel, M. (2018). Reducing use of restraints in intensive care units: a quality improvement project. *American Association of Critical-Care Nurses, 38(4)*, e8-e16. [dio:org/10.4037/ccn2018211](https://doi.org/10.4037/ccn2018211)

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**EFFECTIVE DATE:** 01/21/2019

**POLICY & PROCEDURE TITLE:**

Intimate Exam: Professional Conduct Regarding Examination, Procedure, Care and use of Chaperons Policy and Procedure

**REVIEW BY:** 01/21/2021

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As with all St. Mary Medical Center (SMMC) policies, we strive to advance our mission: “We, St. Mary Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. As a community of caring people, we are committed to extending and strengthening the healing ministry of Jesus.” By so doing, we live out our values of Reverence, Commitment to those who are Poor, Justice, Stewardship, Integrity and Excellence. As a Catholic Health System, we are also guided by the Ethical and Religious Directives for Catholic Healthcare Services as promulgated by the U.S. Conference of Catholic Bishops.

This policy & procedure impacts the following core values: Excellence

**PURPOSE**

All intimate exams shall be chaperoned, unless patient declines. The apparent intimate nature of many health care interventions, if not practiced in a sensitive and respectful manner, can lead to misinterpretation of intent and occasionally, allegations of abuse.

There are many forms of abuse such as neglect, physical injury, emotional and sexual abuse. Not understanding the cultural background of a patient can lead to confusion and misunderstanding with some patients believing they have been the subject of abuse. It is important that healthcare professionals are sensitive to these issues and alert to the potential for patients to perceive being victims of abuse.

**POLICY**

St. Mary Medical Center (SMMC) attaches the highest importance to ensuring a culture that values patient privacy and dignity during patient care practices within the organization and within other patient care entities associated with SMMC. This policy applies to the care of patients who require clinical support of an intimate nature. Intimate and personal care is a key area of a person's self-image and respect.

This policy applies to all SMMC employees working in the hospital or off site locations of the hospital that are working on behalf of SMMC and are involved in the direct care of patients.

Title: Intimate Exam: Professional Conduct Regarding Examination, Procedure, Care and use of Chaperons Policy and Procedure  
**PROCEDURE**

Medicine/Licensed Individual Practitioners I

Intimate examinations include the examination of breasts, genitalia or rectum, (although other areas may also be classified as intimate by patients of diverse cultures). Intimate examinations and procedures are often invasive and can be stressful and embarrassing for patients.

***Some examples include:***

- Vaginal Exam
- Rectal Exam
- Breast Exam

***Prior to the examination/procedure:***

Explain to the patient/patient's representative the purpose and necessity of performing the examination/procedure, and provide the patient/patient's representative an opportunity to ask questions.

Explain what the examination/procedure will involve in a way the patient /patient's representative/can understand to ensure the patient I patient' s representative has a clear idea of what to expect, including length of the exam, physical contact, and any associated pain or discomfort.

Always obtain the patient's/patient's representative's verbal permission before the examination/procedure and be prepared to discontinue the examination/procedure in the event the patient/ patient's representative requests to do so.

When a patient/ patient's representative is not able to fully understand the information given, it is the responsibility of the physician (licensed independent practitioner/LIP- NP, APN, PA) to explore ways of presenting the information in a more comprehensible manner.

When a patient decides not to give verbal consent; he/she normally has the right to have his/her decision honored. Only in the circumstances of immediate necessity, when the individual is unable to understand the consequences of his/her refusal, should an intimate exam be conducted, e.g. when caring for a patient with a learning disability.

All patients who desire the presence of a chaperon during intimate exams have the right to have a chaperon provided irrespective of organizational constraints.

- The prudent physician (LIP) should document the presence of a chaperon during an intimate exam.

Provide privacy for the patient to undress and redress.

Title: Intimate Exam: Professional Conduct Regarding Examination, Procedure, Care and use of Chaperons Policy and Procedure

- Do not assist the patient in removing clothing unless it has been clarified that assistance is needed.

**During the examination/procedure:**

Keep discussion relevant and avoid unnecessary personal comments.

Avoid unnecessary discussion

Ensure the patient's privacy and dignity is protected.

**On completion of the examination/procedure:**

Ensure the patient's privacy and dignity is protected.

Address any queries or concerns relating to the examination/procedure.

If a patient/patient representative states he/she is uncomfortable with the gender of the person providing personal/intimate care, the nurse/nurse assistant/allied health professional will make every effort to find another caregiver of the requested gender to provide personal/intimate care. If that is not possible, the current caregiver will enlist the help a chaperon during times of potentially intimate contact.

The prudent nurse/ nurse assistant, allied health professional should document the presence of a chaperon during personal/intimate care.

**PLEASE NOTE:** Staff has a professional duty to care for patients; they have responsibilities under their professional licensing bodies to act in the patient's best interests and are accountable for their actions. Staff should be sensitive to differing expectations associated with race, ethnicity and culture and the real potential for miscommunication/misinterpretation of intent to occur.

**SCOPE/APPLICABILITY**

Medical Staff

**DEFINITIONS**

**RESPONSIBLE DEPARTMENT**

Further guidance concerning this Policy may be obtained from Medical Staff

**RELATED PROCEDURES AND OTHER MATERIALS**

DOI: 10.1542/peds.2011-0322

Pediatrics 2011; 127;991; originally published online April 25, 2011;

Committee on Practice and Ambulatory Medicine

Beebe Medical Center Chaperone Policy and Procedure

Version #: 1

Page 3 of 4

**NOTE:** Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.



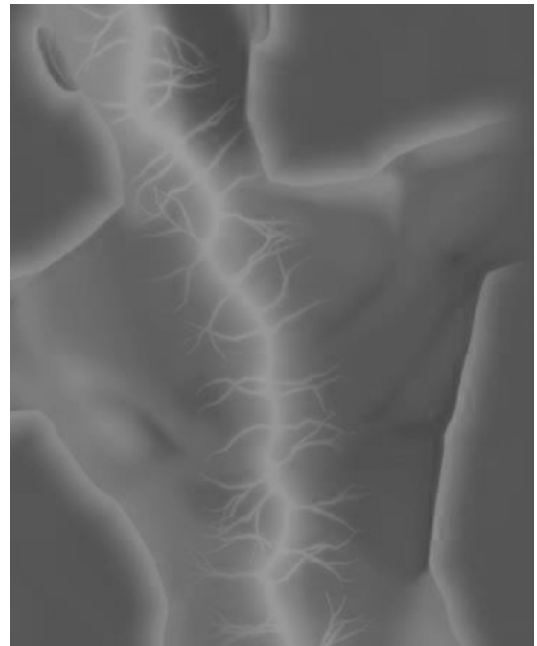
Title: Intimate Exam: Professional Conduct Regarding Examination, Procedure, Care and use of Chaperons Policy and Procedure

Creighton Medical Associates Policy and Procedure



## Pain Management

- Pain can have a serious impact on your patient's quality of life
- Pain can influence mood, sleep and activities of daily living.



## Statistics from the National Pain Awareness survey include:

- 43% of adults (83 million) report that pain frequently affects their participation in life's activities
- 55% of senior citizens report suffering from pain on a daily basis
- 64% of pain sufferers will see a doctor only when they cannot stand the pain any longer
- 42% of people believe their pain is misunderstood by their physician

## Patients have a right to good pain management

- This includes planning and coordination of activities to ensure
  - Initial screening, assessment and reassessment of pain
  - Education of healthcare providers
  - Education of patients and families
  - Consideration of cultural, personnel, spiritual and ethical beliefs
  - Communication

## Responsibility of healthcare professional

- Adequately assess every patient for pain
- Use pain relief methods correctly
- Teach patients and their families about pain management

You have now completed the reading portion of this module. Please proceed to the test portion. You will have completed the module in its entirety when you receive a passing score of 80%.

TRINITY HEALTH  
Code of Conduct



TRINITY HEALTH CODE OF CONDUCT

Supplement for Medical Staff



## Code of Conduct – Supplement for Medical Staff

As a member of the medical staff of a Trinity Health hospital, you serve as a trusted partner in the delivery of health care services to our patients and community. The Trinity Health Mission Statement calls us to serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Guided by our Core Values, we are committed to the delivery of people-centered care that leads to better health care, improved health outcomes, and overall lower costs for our patients, residents, members and communities we serve.

Trinity Health has established a system-wide Integrity and Compliance Program to support all who work in our health care ministry in understanding and following the laws, regulations, professional standards, and ethical commitments that apply. The Trinity Health Code of Conduct describes behaviors and actions expected of all who work in Trinity Health – colleagues, physicians, suppliers, board members and others. This Supplement describes those areas of the Code of Conduct that have particular application to our relationship with you as a member of the hospital's medical staff. If you have any questions regarding this information, please contact your Medical Staff Office or the Integrity & Compliance Officer at your Ministry. The complete Code of Conduct is available online at <http://www.trinity-health.org/documents/codeofconduct.pdf>.

\*\*\*\*

The following standards are expected of all clinical professionals who work in Trinity Health, including members the medical staff:

### Professionalism

- Deliver people-centered, quality health care services with compassion, dignity and respect for each individual.
- Deliver services without regard to race, color, religion, gender, sexual orientation, marital status, national origin, citizenship, age, disability, genetic information, payer source, ability to pay, or any other characteristic protected by law.
- Maintain a positive and courteous customer service orientation.
- Demonstrate the highest levels of ethical and professional conduct at all times and under all circumstances.
- Speak professionally and respectfully to those with whom you work and whom you serve.
- Respond to requests for information or assistance in a timely and supportive manner.
- Behave in a manner that enhances a spirit of cooperation, mutual respect, a supportive team environment and trust among all members of the team.

- Deliver services in accordance with all professional standards that apply to your position.
- Create and maintain complete, timely and accurate medical records consistent with medical staff bylaws.
- Protect the privacy and confidentiality of all personal health information - electronic, paper or verbal - you may receive.
- Maintain appropriate licenses, certifications and other credentials required of your position.
- Abstain from inappropriate physical contact or inappropriate behavior with others.
- Report any harassment, intimidation or violence of any kind..
- Maintain a safe work environment by performing your duties and responsibilities free from the influence of drugs or alcohol.
- Protect the confidentiality of all peer review information.

### **Commitment to Providing Quality Care that is Safe and Medically Appropriate**

- Commit to safety: every patient, every time.
- Speak up when you see a quality or safety issue and discuss mistakes you see with others so we can learn how to prevent future mistakes.
- Adhere to clinical guidelines and protocols that reflect evidence-based medicine.
- Actively engage and support efforts to improve quality of care, including organization-approved technology advancements.
- Actively participate in initiatives to improve care coordination between and among caregivers, community support agencies and other providers.
- Actively participate in initiatives to improve the health of the community as a whole.

### **Advocating for Our Patient's Needs**

- Provide comfort for our patients, including prompt and effective response to their needs.
- Communicate clinical information to patients and their designees in a clear and timely manner.
- Discuss available treatment options openly with patients, or their designees, and involve them in decisions regarding their care.
- Provide care to all patients who arrive at your facility in an emergency, as defined by law, regardless of their ability to pay or source of payment.
- Clearly explain the outcome of any treatment or procedure to patients, or their designees, especially when outcomes differ significantly from expected results.
- Respect patient advance directives.
- Address ethical conflicts that may arise in patient care, including end-of-life issues, by consulting your organization's medical ethics committee or Mission Officer.
- Provide care that is consistent with the *Ethical and Religious Directives for Catholic Health Care Services*.



## Stewardship of Resources

- Properly use and protect all resources including materials and supplies, equipment, staff time and financial assets.
- Respect the environment and follow your organization's policies for the handling and disposal of hazardous materials and infectious waste.

## Corporate Citizenship

- Act with honesty and integrity in all activities.
- Actively participate in training programs offered by your organization.
- Follow your organization's policies requiring the disclosure of outside activities or relationships that could represent a conflict of interest with your medical staff membership or role and any other responsibilities.
- Follow all requirements of Medicare, Medicaid, other federal and state health care programs, as well as those of commercial insurance companies and other third-party payers. These requirements generally involve:
  - Delivering high-quality, medically necessary and appropriate services.
  - Creating and maintaining complete and accurate medical records.
  - Submitting complete and accurate claims for services provided.
  - Protecting the privacy and security of health information we collect.
- Conduct all medical research activities consistent with the highest standards of ethics and integrity and in accordance with all federal and state laws and regulations, and your organization's Institutional Review Board policies.
- Immediately notify your Medical Staff Office if notified you have been excluded or debarred from participation in federal or state health care programs.

## Where to Find Help

If you have a question or concern about possible violations of law, regulation or the Code of Conduct you are encouraged to seek answers by contacting one of the following resources:

- Your Chief Medical Officer or Medical Staff Office
- Another member of your organization's senior management team
- Your Ministry's Integrity & Compliance Officer
- The Trinity Health Integrity and Compliance Line at 1-866-477-4661 or you may file a written report online at [www.mycompliancereport.com](http://www.mycompliancereport.com) using access code "THO"

## **Thank You!**

We appreciate your taking time to review this information and our commitment to carrying out our Mission with the highest standards of ethical behavior. Your dedication and support is critical to this important effort.

**ARTICLE I  
CATEGORIES AND CLASSIFICATIONS OF THE MEDICAL STAFF**

**Section 1. The Medical Staff**

All appointments to the Medical Staff shall be made by the Board of Directors.

**Section 2. Medical Staff Classifications Provisional Medical Staff**

Medical Staff Classifications Provisional Medical Staff members will be appointed to the Medical Staff into one of the following groups: Primary Care, Hospital Oriented, Hospital Based, or Resource Specialist. The specialties included in each group are listed below. Within the Hospital Oriented Group and the Resource Specialist group, there will be procedure oriented specialties and non-procedure oriented specialties. The list is not all inclusive and any specialties not named will be assigned to a group by the Board of Directors upon recommendation by the Medical Executive Committee.

- (a) Primary Care (Family Practice, General Internal Medicine, and Pediatrics).
- (b) Hospital Oriented,
  - (1) Procedure Oriented - Gastroenterology, Cardiovascular Surgery, Colon-Rectal Surgery, General Surgery, Neurosurgery, Ophthalmology, Orthopedics, Otolaryngology, Plastic Surgery, Thoracic Surgery, Urology, Obstetrics & Gynecology.
  - (2) Non-procedure Oriented - Cardiology, Hematology/Oncology, Nephrology, Neurology, Non-operative Obstetrics and Gynecology, Physical Medicine and Rehabilitation, Pulmonology, and Non-operative Surgery.
- (c) Hospital Based (Anesthesia, Emergency Medicine, House Physicians, Medical Administrator, Neonatology, Pathology, Radiology).
- (d) Resource Specialist.
  - (1) Procedure Oriented - Ophthalmologic Subspecialty, Oral Surgery, Pediatric Surgery, and Podiatry.
  - (2) Nonprocedural Oriented - Allergy/Immunology, Dentistry, Dermatology, Endocrinology, Infectious Disease, Nutritionist, Perinatology, Psychiatry, Rheumatology.

**Section 3. Provisional Staff**

All initial appointments to the Medical Staff, with the exception of the Consultant and Affiliate Staff, will be to the Provisional Staff. The provisional Medical Staff shall consist of physicians, dentists and podiatrists who have their initial appointment to St. Mary Medical Center Medical Staff, who have an office (where patient care is delivered) located within the service area of the hospital, and are being considered for active staff membership.

Members of the provisional staff shall be appointed to a specific department where their performance shall be observed for a two-year period by the chairperson of the department of his/her representative to determine the eligibility of such provisional members for active staff membership and for the appropriate exercise of the clinical privileges provisionally granted to them.

Provisional Primary Care physicians (Family Practice, General Internal Medicine and Pediatricians) and Hospital-Based physicians DO NOT have a patient encounter requirement, but are required to attend a minimum of 5 meetings per year.

Patient encounter requirements for the Hospital Oriented and Resource Specialist Provisional Staff are as follows for the two-year provisional period:

PROVISIONAL STAFF	HOSPITAL ORIENTED Patient Encounter Requirement		RESOURCE SPECIALISTS Patient Encounter Requirement	
	PROCEDURE ORIENTED	NON-PROC. ORIENTED	PROCEDURE ORIENTED	NON-PROC. ORIENTED
Minimum	20 Invasive Procedures	20 Admissions or Consults	5 Invasive Procedures*	No patient encounter requirement
Maximum	No Maximum	No Maximum	No Maximum	No patient encounter requirement
Meeting Attendance Requirements	A minimum of 5 meetings per year	A minimum of 5 meetings per year	A minimum of 5 meetings per year	A minimum of 5 meetings per year

**\*Invasive Procedures include surgical procedures performed in the Operating Room or ASU, endoscopic procedures and/or vaginal and caesarean section deliveries.**

Provisional members shall not be eligible to vote or to hold office or to take Emergency Room call unless so directed by the chairperson of their department. They are required to pay dues.

An assessment of the Medical Staff member's status will be made at the end of one year to advise the Medical Staff member of his/her performance and progress towards active staff membership, including his/her compliance with the requirements set forth in Article V, Section 3(d), the required number of encounters and meeting attendance.

Provisional Medical Staff Members who fail to make their meeting and/or encounter requirements may be reappointed for one additional provisional year. They will not have voting privileges or the right to hold office. They may be eligible for Emergency Room Call in accordance with their Departmental Rules & Regulations. For the next calendar year they will pay treble the Medical Staff dues.

If they fail to meet their meeting and/or encounter requirements during the additional provisional year, they may either resign or will be removed from the Medical Staff. If they resign or are removed, they are not eligible to reapply for staff privileges for six months. In the event that Medical Staff Membership terminates for failure to meet the meeting and/or encounter requirements, the procedures set forth in Articles VIII do not apply.

#### **Section 4. The Active Medical Staff**

The Active Medical Staff shall consist of physicians, dentists and podiatrists who have met their provisional requirements, who have an office (where patient care is delivered) located within the service area of the hospital and who assume all of the functions and responsibilities of membership on the active Medical Staff, including where appropriate, Emergency Room call and consultation assignments. Active Staff physicians are required to attend a minimum of 5 meetings per year during the two-year reappointment period. Members of the active staff shall be eligible to vote, to hold office, to take Emergency Room call as directed by the chairperson of their department, and to serve on Medical Staff committees. They are required to pay dues.

#### **Section 5. The Associate Staff**

The Associate Medical Staff shall consist of physicians, dentists and podiatrists qualified for staff membership who have an office (where patient care is delivered) in the service area of the hospital, but have only occasional patient encounters at the hospital. Associate Medical Staff members shall be appointed to a specific department and shall be eligible to serve on Medical Staff committees as non-voting members. Associate members shall not be eligible to vote or hold office in the Medical Staff or take Emergency Room call unless so directed by the chairperson of their department. They are required to pay dues. The meeting attendance requirement of Associate Medical Staff Members is 50% of the General Medical Staff meetings during the two-year reappointment period, **except Associate Staff Family Practitioners who have NO meeting attendance requirement.**

#### **Section 6. The Affiliate Staff**

Affiliate Staff shall consist of those physicians, dentists and podiatrists who wish to maintain an affiliation with the hospital. They shall have no admitting privileges, no consultation privileges and they shall not be authorized to manage patients in the hospital. Members of this category may perform outpatient preadmission and history and physical, order outpatient diagnostic tests and services, visit patient in hospital, review medical records, consult with attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon. Members are not required to be board certified or eligible for board certification. They are encouraged to attend medical staff meetings and department meetings but are not entitled to vote or hold office. Members of the Affiliate Staff Category will not be permitted to write any orders or document on the chart. Members will not be required to have a one year provisional period, they will be appointed directly into said category. They will be credentialed and reappointed, as per bylaws, in the same fashion as the Active Staff, but we will not conduct FPPE or OPPE as these physicians will not be admitting patients nor having any official activity in the hospital. If a request is made to transfer from said category to any other category except Emeritus (must be recommended by a Medical Staff Member) the applicant will be processed as per Section 3 of the Bylaws and complete a Provisional period and all other requirements per the Bylaws. Applicants will pay an application fee and will be required to pay dues.

#### **Section 7. The Emeritus Medical Staff**

The Emeritus Medical Staff shall consist of physicians, dentists and podiatrists who are not active in the hospital but have given support and service to the hospital and have been recommended for this status by the Medical Executive Committee of the Medical Staff. These may be physicians, dentists and podiatrists who have retired from active hospital practice. Emeritus staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff committees. Emeritus members shall not be required to pay dues.

#### **Section 8. The Consultant Medical Staff**

The Consultant Medical Staff shall consist of recognized specialists who are board certified in their specialty, have expressed willingness to accept such an appointment, and represent specialties that are needed for the purpose of providing complete medical care to the community. Those members of the medical staff who only have patient contact via telemedicine shall be considered members of the Consulting Staff and will be credentialed as other consultants. Members of the Consultant Staff shall be limited to the performing of consultations upon request of a Medical Staff member. They shall not be eligible to vote, hold office, admit patients nor be required to serve on standing Medical Staff committees. They shall not be required to pay dues. Consultant Staff members shall be subject to the same appointment and reappointment process as other Medical Staff members. Review of their qualifications will also include their continued necessity on the consultant staff.

#### **Section 9. House Staff**

All House Staff physicians shall be subject to the same appointment and reappointment process as other Medical Staff members. Rules and regulations governing house staff physicians shall be developed by the department to which they have been assigned and approved by the Medical Executive Committee of the Medical Staff. The Vice President of Medical Affairs, in conjunction with the appropriate department chair, will be responsible for clinical oversight of the physician. House Staff physicians shall not be required to attend Medical Staff meetings nor shall they have voting privileges. They shall not be required to pay dues.

#### **Section 10. Podiatrists**

(a) The practice of Podiatry shall be defined as that practice which is limited to examination, diagnosis, treatment and care of conditions and functions of the human foot.

#### **Administrative and Medical-Administrative Officers**

A physician-administrative officer, licensed in Pennsylvania and with clinical responsibilities, must be a member of the Medical Staff, achieving this status by the procedure provided in Article V. His/her clinical privileges must be delineated in accordance with Article VI. The Medical Staff membership and clinical privileges of any physician-administrative officer shall not be contingent on his/her continued occupation of that position.

To: Physicians and Allied Health Providers

Re: Child Protective Services Law (Title Act 23 PA. CS., Chapter 63)

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Pennsylvania Act 179 of 2006 and Act 73 of 2007 Child Protective Service Law require that all employees who have a "significant likelihood of regular contact with children, in the form of care, guidance, supervision or training" undergo the following background checks:

- FBI Criminal Background Check (using electronic fingerprinting through Identogo)
- Department of Public Welfare (DPW) Child Abuse History Clearance
- Pennsylvania State Police Clearance

In an effort to be compliant with these Acts, St. Mary Medical Center, with the support of the Medical Executive Committee requires compliance with the above background checks for any physician on our medical staff who falls under the above criteria of "*significant likelihood of regular contact with children*". This is to include but is not limited to Emergency Medicine, Anesthesia, Neonatology, Pediatrics, Family Practice, Trauma, Obstetrics, Orthopedics and ENT.

All of our colleagues, including our employed physicians and volunteer physicians, are subject to these Acts and are undergoing background checks to assure compliance. Directions for obtaining these checks are included.

Procedure for compliance:

1. Register with Identogo at <https://uenroll.identogo.com/workflows/1KG756>
2. Visit Identogo location to have fingerprints scanned.
3. Complete the form for PA Child Abuse History Clearance (attached to this packet) and mail with fee OR visit <https://www.compass.state.pa.us/cwis/public/home> and create an individual account to complete online.
4. Please provide the **Medical Staff Office** with copies of background checks when obtained.

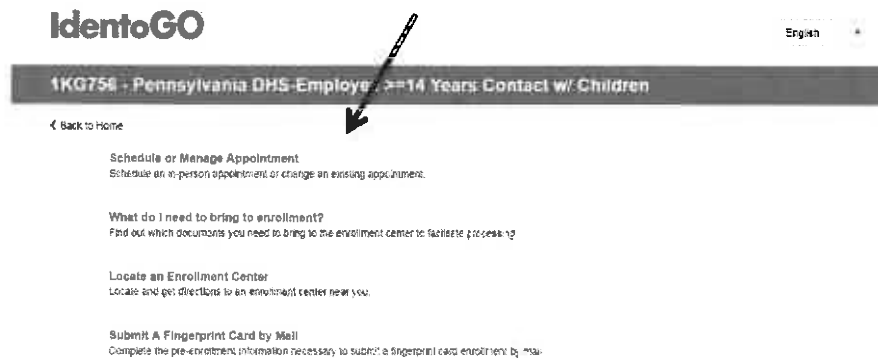
Please note the Pennsylvania State Police Clearance is now obtained by the Medical Staff Office.

If you have any questions, please contact the Medical Staff Office at 215-710-2008.

# Instructions for Obtaining Fingerprint Clearance through Identogo

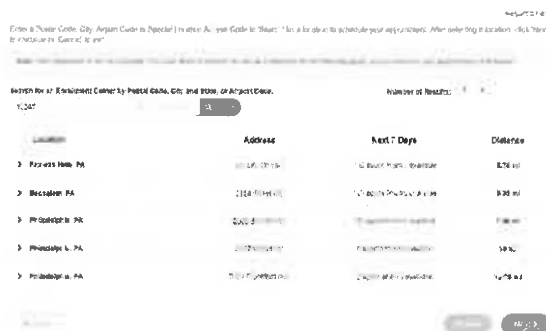
Go to: <https://uenroll.identogo.com/workflows/1KG756>

Select "Schedule or Manage Appointment" to pre-register and schedule and appointment



The next few screens will collect essential information such as name, date of birth, address, etc. You will need to complete all required information.

After entering all needed information, select an Identogo site to have your fingerprints scanned.



At each site you can schedule an appointment or select walk-in (wait time is typically brief).

Payment is accepted on site and Credit/Debit Card or Money Order accepted.

Upon completing the scan, Identogo will forward processing and results will be sent to your mailing address.

## **Pennsylvania Non-Resident Cardscan Universal Enrollment Platform Processing Overview**

Cardscan processing is available for those applicants residing outside of Pennsylvania or physically unable to visit an Identogo location. In order to complete the process, applicants must complete the following steps.

1. Obtain fingerprints on FBI (FD-258) fingerprint card and complete personal information fields on fingerprint card.
2. Pre-enroll for cardscan submission at [UEnroll.identogo.com](https://uenroll.identogo.com). All processing fees will be collected during the pre-enrollment process. A pre-enrollment confirmation page will be provided once registration is complete.
3. Print and sign the completed pre-enrollment confirmation page, which includes the barcode printed on the top right of the page. Mail the signed pre-enrollment confirmation page and the completed fingerprint card to the mailing address provided by your agency or during this pre-enrollment process.

# INSTRUCTIONS TO COMPLETE THE PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION APPLICATION:

## General:

- Type or print clearly and neatly in ink only.
- If obtaining this certification for non-volunteer purposes or if, as a volunteer having direct volunteer contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an \$13.00 money order or check for each application. No cash will be accepted. Personal, agency, or business checks are acceptable. Certifications for the purpose of "volunteer having direct volunteer contact with children" may be obtained free of charge once every 57 months. If no payment is enclosed for a non-volunteer purpose, you must provide a payment authorization code, otherwise your application will be rejected and returned to you.
- **DO NOT SEND POSTAGE PAID RETURN ENVELOPES** for us to return your results. Results are issued through an automated system generated mailing process.
- Certification results will be mailed to you within 14 days from the date the certification application is received at the ChildLine and Abuse Registry.
- Failure to comply with the instructions will cause considerable delay in processing the results of an applicant's child abuse history certification application.

## Purpose of Certification - Do not check more than one box:

- Check the **foster parent** box if applying for purposes of providing foster care.
- Check the **prospective adoptive parent** box if applying for the purpose of adoption.
- Check the **employee of child care services** box if applying for the purpose of child care services in the following:
  - Child day care centers; group day care homes; family day care homes; boarding homes for children; juvenile detention center services or programs for delinquent or dependent children; mental health services for children; services for children with intellectual disabilities; early intervention services for children; drug and alcohol services for children; and day care services or other programs that are offered by a school.
- Check the **school employee governed by the Public School Code** box if you are a school employee who is required to obtain background checks pursuant to Section 111 of the Public School Code and will continue to be required to obtain background checks prior to employment in accordance with that section and on the periodic basis required by Act 153.
- Check the **school employee not governed by the Public School Code** box if you are a school employee not governed by Section 111 of the Public School Code, but covered by Act 153 (pertaining to school employees in institutions of higher education).

Definition of school employee: A school employee is defined as an individual who is employed by a school or who provides a program, activity or service sponsored by a school. The term does not apply to administrative or other support personnel unless they have direct contact with children.

Definition of school: A facility providing elementary, secondary or postsecondary educational services. The term includes the following:

- (1) Any school of a school district.
  - (2) An area vocational-technical school.
  - (3) A joint school.
  - (4) An intermediate unit.
  - (5) A charter school or regional charter school.
  - (6) A cyber charter school.
  - (7) A private school licensed under the act of January 28, 1988 (P.L.24, No. 11), known as the Private Academic Schools Act.
  - (8) A private school accredited by an accrediting association approved by the state Board of Education.
  - (9) A non-public school.
  - (10) An institution of higher education.
  - (11) A private school licensed under the act of December 15, 1986 (P.L. 1585, No. 174), known as the Private Licensed Schools Act.
  - (12) The Hiram G. Andrews Center.
  - (13) A private residential rehabilitative institution as defined in section 914.1-A(c) of the Public School Code of 1949.
- Check the **self-employed provider of child-care services in a family child-care home** if providing child care services in one's home (other than the child's own home) at any one time to four, five, or six children who are not relatives of the caregiver.
  - Check the **individual 14 years of age or older who is applying for or holding a paid position as an employee** box if the employment is with a **program, activity, or service, as a person responsible for the child's welfare or having direct contact with children:** Applying as an employee who is responsible for the child's welfare or having direct contact (providing care, supervision, guidance, or control to children or having routine interaction with children) in any of the following in which children participate and which is sponsored by a school or public or private organization:
    - A youth camp or program;
    - A recreational camp or program;
    - A sports or athletic program;
    - A community or social outreach program;
    - An enrichment or educational program; and
    - A troop, club, or similar organization
  - Check the **individual seeking to provide child care services under contract with a child care facility or program** box if you are providing child care services as part of a contract or grant funded program.
  - Check the box for **individual 18 years or older who resides in the home of a foster parent for at least 30 days in a calendar year** if you are an adult household member in this setting and require certification.
  - Check the box for **individual 18 years or older who resides in the home of a certified or licensed child-care provider for at least 30 days in a calendar year** if you are an adult household member in this setting and require certification.

- Check the box for **individual 18 years or older, excluding individuals receiving services, who resides in a family living home, community home for individuals with an intellectual disability, or host home for children for at least 30 days in a calendar year** if you are an adult household member in this setting and require certification.
- Check the box for **individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year** if you are an adult household member in this setting and require certification.
- Check the **volunteer having direct volunteer contact with children** box if applying for the purpose of volunteering as an adult for an unpaid position as a volunteer with a child-care service, a school, or a program, activity or service as a person responsible for the child's welfare or having direct volunteer contact with children. In addition, check the box of one of the organizations listed, i.e. Big Brother/Big Sister, domestic violence shelter, rape crisis center. If you are **NOT** applying for a volunteer in one of the organizations listed, please check the **other** box and write the name of the organization in the space provided.
- Check the **PA Department of Human Services employment & training program participant** box if you are applying for the purpose of participating in a PA Department of Human Services employment and training program through a county assistance office (CAO) or the Office of Income Maintenance (OIM). The signature **AND** phone number of the CAO or OIM representative is required. If there is no signature and no phone number, your application will be rejected and returned to you.
- If you were provided a "**PAYMENT AUTHORIZATION CODE**" by an organization, please provide the **agency/organization name** in the space provided and the **payment authorization code** in the space provided.
- Please check the **CONSENT/RELEASE OF INFORMATION** box if you included a payment code in the space above and attached the completed Consent/Release of Information Authorization form to your Pennsylvania Child Abuse History Certification application when you mail it to our office. The Consent/Release of Information Authorization form allows the department to send your results to a third party. If the Consent/Release of Information Authorization form is **NOT** attached to the certification application, the results **WILL** be mailed to the applicant's home address and not to the third party.

#### Applicant Demographic Information:

- Name - Include the applicant's full legal name. Initials are not acceptable for a first name. If your full legal name is an initial, please provide supporting documentation along with your certification application.
- Social Security number - Include the applicant's social security number. A social security number is voluntary; **HOWEVER, PLEASE NOTE THAT APPLICATIONS THAT DO NOT INCLUDE SOCIAL SECURITY NUMBERS MAY TAKE LONGER TO BE PROCESSED.**
- Gender - Please check one box.
- Date of birth - Fill in the applicant's date of birth (Example: 01/22/1990).
- Age - Fill in the applicant's current age.

#### Address:

- The address listed must be the applicant's current home address. This is also where the results of the certification will be mailed, unless otherwise noted. If the **different mailing address** box is checked and a mailing address is provided in the "different" mailing address column, the results will be mailed to the "mailing" address and not the "home" address. **Note:** If the consent/release of information box is checked and an "other" address is provided, the results will be mailed to the "other" address.

#### Contact Information:

- Please provide your home, work or mobile telephone number. Fill in the number where the applicant can be reached in the event that there are questions about the information on the application.
- Please provide an email address. By providing an email address, you are consenting to ChildLine contacting you by email in the event that you cannot be reached by phone. **NO CONFIDENTIAL INFORMATION WILL EVER BE SHARED OR PROVIDED IN AN EMAIL FROM OUR OFFICE.**

#### Previous Names Used Since 1975:

- The applicant must list any and all full legal names that they have ever had since 1975. This includes maiden names, nicknames, aliases and also known as (aka) names.

#### Previous Addresses Since 1975:

- List all addresses where the applicant has resided since 1975. The applicant can attach an additional sheet of paper with all of the addresses listed if necessary. If the applicant cannot remember the exact mailing addresses since 1975, filling in as much information as possible about the location is acceptable.

#### Household Members:

- Include anyone that the applicant lived with since 1975 (parents, guardians, siblings, children, spouse (ex), paramour, friends, etc.). In addition, include the household member's relationship to the applicant, their age (to the best of your knowledge) and their gender. If the applicant was under the age of 18 in 1975, this section **MUST** include the applicant's PARENT(S) or GUARDIAN(S). If this section is left blank, the application will be rejected and returned to the applicant.

#### Signature:

- Applications **MUST** be signed and dated. Applications that are not signed and dated will be rejected and returned to the applicant.

#### CHILDLINE USE ONLY:

- Please **DO NOT WRITE** in this section. This is for CHILDLINE staff only.

#### Additional Information:

Applicants can visit <https://www.compass.state.pa.us/CWIS> for more information about submitting the child abuse certification online or to register for a business/organization account.



# PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

Type or print clearly in ink. If obtaining this certification for non-volunteer purposes or if, as a volunteer having direct volunteer contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an \$13.00 money order or check payable to the PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES or a payment authorization code provided by your organization. **DO NOT send cash.**

Certifications for the purpose of "volunteer having direct volunteer contact with children" may be obtained free of charge once every 57 months.

Send to CHILDLINE AND ABUSE REGISTRY, PA DEPARTMENT OF HUMAN SERVICES, P.O. BOX 8170 HARRISBURG, PA 17105-8170.

**APPLICATIONS THAT ARE INCOMPLETE, ILLEGIBLE OR RECEIVED WITHOUT THE CORRECT FEE WILL BE RETURNED UNPROCESSED. IF YOU HAVE QUESTIONS CALL 717-783-6211, OR (TOLL FREE) 1-877-371-5422.**

## PURPOSE OF CERTIFICATION (Check one box only)

- |   |  |
|---|--|
| <input type="checkbox"/> Foster parent<br><input type="checkbox"/> Prospective adoptive parent<br><input type="checkbox"/> Employee of child care services<br><input type="checkbox"/> School employee governed by the Public School Code<br><input type="checkbox"/> School employee not governed by the Public School Code<br><input type="checkbox"/> Self-employed provider of child-care services in a family child-care home<br><input type="checkbox"/> An individual 14 years of age or older applying for or holding a paid position as an employee with a program, activity, or service<br><input type="checkbox"/> An individual seeking to provide child-care services under contract with a child care facility or program<br><input type="checkbox"/> An individual 18 years or older who resides in the home of a foster parent for children for at least 30 days in a calendar year<br><input type="checkbox"/> An individual 18 years or older who resides in the home of a certified or licensed child-care provider for at least 30 days in a calendar year<br><input type="checkbox"/> An individual 18 years or older, excluding individuals receiving services, who resides in a family living home, community home for individuals with an intellectual disability, or host home for children for at least 30 days in a calendar year<br><input type="checkbox"/> An individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year | <input type="checkbox"/> Volunteer having direct volunteer contact with children<br><b>If purpose is volunteer having direct volunteer contact with children, choose SUB PURPOSE:</b><br><input type="checkbox"/> Big Brother/Big Sister and/or affiliate<br><input type="checkbox"/> Domestic violence shelter and/or affiliate<br><input type="checkbox"/> Rape crisis center and/or affiliate<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> PA Department of Human Services Employment & Training Program participant (signature required below) |
|---|--|

\_\_\_\_\_  
SIGNATURE OF OIM/CAO REPRESENTATIVE

\_\_\_\_\_  
OIM/CAO PHONE NUMBER

AGENCY/ORGANIZATION NAME:

PAYMENT AUTHORIZATION CODE, IF APPLICABLE:

- Consent/Release of Information Authorization form is attached. Applicant must fill in the "Other Address" sections. By completing the other address sections, you are agreeing that the organization will have access to the status and outcome of your certification application.

## APPLICANT DEMOGRAPHIC INFORMATION (DO NOT USE INITIALS)

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER ____-____-____	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not reported	DATE OF BIRTH (MM/DD/YYYY)	AGE

Disclosure of your Social Security number is voluntary. It is sought under 23 Pa.C.S. §§ 6336(a)(1) (relating to information in statewide database), 6344 (relating to employees having contact with children; adoptive and foster parents), 6344.1 (relating to information relating to certified or licensed child-care home residents), and 6344.2 (relating to volunteers having contact with children). The department will use your Social Security number to search the statewide database to determine whether you are listed as the perpetrator in an indicated or founded report of child abuse.

HOME ADDRESS	MAILING ADDRESS (if different from home address)	OTHER ADDRESS (if Consent/Release of Information Authorization form is attached)
ADDRESS LINE 1	ADDRESS LINE 1	ADDRESS LINE 1
ADDRESS LINE 2	ADDRESS LINE 2	ADDRESS LINE 2
CITY	CITY	CITY
COUNTY	COUNTY	COUNTY
STATE/REGION/PROVINCE	STATE/REGION/PROVINCE	STATE/REGION/PROVINCE
ZIP/POSTAL CODE	ZIP/POSTAL CODE	ZIP/POSTAL CODE
COUNTRY	COUNTRY	COUNTRY
<input type="checkbox"/> Different mailing address	ATTENTION	ATTENTION

## CONTACT INFORMATION

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
EMAIL (By submitting an email contact, you are agreeing to ChildLine contacting you at this address.)		

# PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

PREVIOUS NAMES USED SINCE 1975 (Include maiden name, nickname and aliases.)			
First	Middle	Last	Suffix
1.			
2.			
3.			
4.			
5.			

PREVIOUS ADDRESSES SINCE 1975 (Please list all addresses since 1975, partial address acceptable; attach additional pages if necessary.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

HOUSEHOLD MEMBERS (Please list everyone who lived with you at any time since 1975 to present. Please include parent, guardian or the person(s) who raised you; attach additional pages as necessary.)				
Name (First, Middle, Last)	Relationship	Present Age	Gender	
1.	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> person(s) who raised you			
2.	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> person(s) who raised you			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

I affirm that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code). If I selected volunteer, I understand that I can only use the certificate for volunteer purposes.

APPLICANT'S SIGNATURE
DATE

CHILDLINE USE ONLY		
DATE RECEIVED BY CHILDLINE	SUFFICIENT PAYMENT INFORMATION RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> VALID PAYMENT AUTHORIZATION CODE <input type="checkbox"/> WAIVED (supervisor initials) _____	CERTIFICATION ID #



**Memo: Allied Professional and Collaborating/Supervising Physician**

**From: Medical Staff Office**

**Re: Procedures/Informational**

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Please be advised that all Allied providers that will be performing procedures are required to provide the following:

If you have experience performing procedures in the area in which you are applying, the following must be provided:

- If you have experience provide a procedure log and a letter from the primary, that was in place when you performed the procedures, attesting to your competence, how many were done and outcomes. The data should be within a 2 year timeframe.

If you do not have previous experience performing procedures in the area you are applying, the following must be provided:

- Have your primary write a letter stating they will directly supervise you until competency is attained.
- Once your primary feels that competence has been attained they must write a letter addressing your current competence and quality. A procedure log must accompany the letter written by your primary. Until that is received primary must be present during those procedures.

# Patient Safety – Adverse Event Reporting / Management

Laureen Talenti, RN, MS  
Patient Safety Officer  
St. Mary Medical Center

# Adverse Event Reporting / Management

- PA Act 13 (2002): Mandates the reporting of adverse events, including near-miss events
- CMS (2014): Requires adverse events be identified through the “eyes of the patient”
- Midas<sup>+</sup> RDE (2009): Implemented as electronic event reporting system by SMMC (CHE); Selected as preferred vendor by Trinity Health

# Adverse Event Reporting / Management

- SMMC Challenges:
  - Recognition of reportable events
  - Timely reporting of events
  - Perception of punitive nature of reporting
    - Fear of repercussions
    - Use of report as retaliatory (Disruptive Behavior)
    - Lack of focus on patient impact / outcome

# Adverse Event Reporting / Management

- Leadership Support:
  - Encourage identification & reporting of adverse events to shift focus to improving patient safety initiatives / practices
  - Encourage real-time reporting for timely investigation, follow up and compliance with legal / regulatory requirements
  - Dispel negative connotations associated with reporting
  - Encourage focus on the patient when entering personnel- or system-related events

# Adverse Event Reporting / Management

- Leadership Support:
  - Promote “Just Culture” philosophy when addressing events related to human error
  - Utilize departmental resources to assist in “spreading the word” about Patient Safety initiatives (Team Leads, Midas Back-up Event Managers, Safety Ambassadors)