

St. Mary Medical Center Policies

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



- SMPA - MSO - Appointment Curriculum
 - SMPA – MSO - Universal Protocol and Comprehensive OR Checklist
 - SMPA – MSO - Impaired Practitioner
 - SMPA – MSO - Harassment (Sexual and Non-Sexual)
 - SMPA – MSO - Workplace Violence
 - SMPA – MSO - Substance Free Workplace
 - SMPA – MSO - Abbreviations and Medical Symbols
 - SMPA – MSO - Sedation for Procedures by Non-Anesthesia Personnel
 - SMPA – MSO - Disruptive/Unprofessional Physician Conduct
 - SMPA – MSO - Flu Vaccination Policy for Health Care Workers
 - SMPA – MSO - Intimate Exam
 - SMPA – MSO - Physician Education
 - SMPA – MSO - Code of Conduct

EFFECTIVE DATE: 10/15/2020

POLICY & PROCEDURE TITLE:
Universal Protocol

REVIEW BY: 10/15/2022

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: Excellence, Integrity, Reverence

PURPOSE

1. To promote patient safety by providing guidelines for verification of correct site, correct procedure, and correct patient for invasive and/or surgical procedures.

POLICY

1. Prior to the start of any invasive procedure/surgical procedure, a pre-procedure verification process takes place, the site is marked when applicable and a "time-out" performed immediately before starting the procedure; this process involves the entire team.
2. Universal Protocol/Time-Out precautions are not to interfere with the timely care of the patient in an emergent (lifesaving) situation.
3. **Surgical Services completes 4 elements for the Universal Protocol/Time-Out:**
 - a. Check-In Holding Pre-op (pre-procedure check-in)
 - b. Sign-In Before Induction (sign-in)
 - c. Time-Out Before Incision Start (time-out)
 - d. Sign-Out Before Surgeon Leaves (sign-out)
4. Inpatient Units and Emergency Department (ED) completes the Pre-Procedure Time-Out process and record Universal Protocol/Time-Out.

Title: Universal Protocol

PROCEDURE

A. Patient Identification

1. Patient's identity is confirmed and verified according to the St. Mary Medical Center Patient Identification Policy and Procedure
<https://stmaryhealthcare.policytech.com/dotNet/documents/?docid=10701>

B. Pre-Procedure Verification Process

1. Consent completed with signature, date, and time.
2. Verification of the correct person, correct procedure, correct site, and laterality (side) if applicable, must occur prior to all procedures
3. For all procedures, the history and physical examination is dated and not to exceed over 30-days prior to date of surgery.
4. The room is checked to identify the availability of items prior to moving the patient. Pertinent items may include:
 - a. Relevant documentation (for example, history and physical, accurately completed and signed surgical consent form, anesthesia consent form, and anesthesia assessment).
 - b. Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports, pregnancy test when appropriate).
 - c. Any required blood products, implants, devices, and/or special equipment for the procedure.

C. Procedural Site Verification (Site Marking): The procedural site is marked when there is more than one possible location for the procedure. The site shall be marked in the following manner:

1. The primary operator/surgeon, performing the procedure, who is privileged/credentialed for said procedure or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure will mark the site. This individual is involved directly in the procedure and is present at the time the procedure is performed.
2. If the site has laterality and is not palpable or easily identified on physical exam, corroborating diagnostic evidence is required.
3. Site marking will take place with the patient involved, awake and aware, when possible. Site marking will occur in the pre-procedure area prior to moving the patient to the location where the procedure is performed.
4. Procedures involving incision, percutaneous puncture or insertion, the intended procedure site is marked. The marking takes into consideration laterality, multiple structures, levels (spine), or specific digit or lesion to be treated.
 - a. For procedures that involve laterality of organs, but the incision(s) or approaches are from the mid-line or from a natural orifice, the site is marked, and the laterality noted.

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- b. For skin marking of the general spinal region, special intraoperative/invasive radiographic techniques may be used for marking the exact vertebral level.
 - c. Site marking for Cardiac-Cath Lab and insertion of ports are required for device insertions only, when consent indicates a laterality.
 - d. Site marking for central lines and PICCs are required when a restricted extremity is present or if doppler is needed for line placement.
5. The operative/invasive site are marked **with the primary operator/surgeon's initials**. Use three initials when appropriate.
 6. The mark is made at or near the incision site and is visible after the patient is prepped and draped, unless necessary draping must cover the mark.
 7. Ophthalmic surgeons will place his/her initials above the brow of the surgical side. Adhesive site markers are not be used as the sole means of marking the site.
 8. Final verification of the site mark will take place during the "time out".
 9. In procedures that include regional anesthesia, the Anesthesiologist marks the nerve block procedure site after the primary operator/surgeon has marked the surgical site and perform and document a "time-out" before proceeding with the block.
 10. For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or near the insertion site and remains visible after completion of the skin prep and sterile draping, unless necessary draping must cover the mark.
 11. For teeth, the tooth name(s) and number are indicated on documentation or the tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.
 12. Skin that is not intact:
 - a. The skin mark will not be placed on an open wound or lesion.
 - b. In the case of multiple lesions and when only some lesions are to be treated, the sites should be identified prior to the procedure itself.
 12. Procedures for second confirmation of selected spine level including Kyphoplasty and Vertebroplasty:
 - a. Interventional Radiologist or primary operator/designee will obtain a still fluoroscope image with a marker at the site/sites of kyphoplasty and will review to ensure adequate level. If question arises regarding the marked site a formal radiograph with a marker in place will be detained and reviewed by radiologist. Confirmation of level given by radiologist will be called to suite.

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- b. Interventional Radiologist or primary operator will prep patient and select site using appropriate marker.
 - c. A radiograph of the area are performed and placed in PACs along with a requisition for the localizing examination. This radiograph is large enough to show the marker and appropriate spinal landmarks to confirm level.
13. When there are multiple procedures/multiple primary operators surgical sites are marked:
 - a. If more than one primary operator utilizing same site(s) – both primary operators are to mark site(s) in pre-procedure area.
 - b. If both primary operators cannot mark site(s) in pre-procedure area - physician to physician face to face communication / hand off that includes verification of surgical site(s) & markings must occur.
14. Exemptions Not Requiring Site Markings: midline, single organ procedures, GI endoscopies, bilateral procedures (identical procedure, surgical team, and equipment), labor epidurals, interventional procedure cases for which the catheter/instrument insertion site is not predetermined.
15. Alternative Site Marking Process
 - a. An alternative process is employed for visually identifying the correct side and site by using a temporary (gray) wrist/ankle band labeled “procedure side” with the surgeon/primary operator initials and placed on the side of the procedure to qualify as the first identifier along with procedure consent as the 2nd identifier. The band is applied by the person performing the procedure who is privileged or permitted by the hospital. **The band is removed by circulator (for OR) or the procedure assistant before patient leaves the procedure area.**
 - b. The band method is used in the following situations:
 - i. For patients who refuse site marking
 - ii. For procedures which cannot easily be marked under the following conditions:
 - iii. For cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, teeth).
 - iv. For premature infants, for whom the mark may cause a permanent tattoo (colored band is placed on foot).

D. Procedural Area

1. In all procedural areas, the process includes identification of a wristband, active participation by the patient (if possible) which is to include patient’s name and birth date. Additionally, the signed operative/invasive consent indicating procedure, site, and side.
2. If the surgical procedure, prep, or patient position prevents access to the identification wristband, it is removed and kept with the patient's chart. **Before the patient leaves the OR suite**, it is the responsibility of the circulating RN to apply a new identification wristband.

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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.

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D. “Time out”

1. The goal of the time out is to prevent wrong-site or wrong-procedure surgery. The “time out” must occur in the location where the procedure is done, immediately prior to starting the procedure, or immediately prior to incision for OR cases.
2. The “time out” will involve the entire procedure team. This includes a hard-stop (all other activities stop, to the extent possible without compromising patient safety), audible cue and active participation by all team members, who are focused on the active confirmation of the correct patient, procedure, laterality, site, and other critical elements.
3. A designated member of the team starts the "time out" procedure.
4. "Speak-Up": Any team member can express concerns about the procedure verification and the case will not proceed until any differences in staff responses are reconciled. The primary surgeon/operator performing the procedure makes the final determination.
5. For a case involving multiple procedures with different surgeons/operators, the primary surgeon/operator who performs the initial procedure identifies the patient prior to induction. Each subsequent surgeon/operator identifies the patient prior to the initiation of his/her corresponding surgical/procedural phase. A “time out” is performed prior to the subsequent surgical/procedural phase to verify the correct patient, correct procedure, correct site and correct laterality.
6. For cases in which Anesthesia is performing a spinal/regional block for laboring delivery or post-operative block, a “time out” is performed by Anesthesia and documented.
7. In those situations where only a single primary surgeon/primary operator is present, the primary surgeon/primary operator will conduct a “time out” or a brief pause to perform verification.

D. Time Out Components - The process is standardized in all areas and verification steps are verbalized for all team members to hear:

1. Before incision, introduction of all team members by name and role if needed.

Circulator verifies:

- a. Identity of patient with two patient identifiers (Name and Date of Birth)
- b. Signed surgical and anesthesia consents
- c. Procedure, Site, Laterality, & Correct Patient Position
- d. Allergies
- e. Safety Concerns/Anticipated Transfusion
- f. Relevant Imaging or other studies available
- g. Blood products available if necessary

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- h. Allergies
- i. Verification of sterilization indicators
- j. Special Equipment &/or Implants available
- k. Fire Risk

2. Anesthesia Provider verifies:

- a. Antibiotic Prophylaxis has been given within designated timeframe.

4. Before the Patient Leaves the OR (De-Brief – Initiated by the RN) Circulator/Surgeon verify:

- a. Name of procedure and post-op diagnosis to be recorded
- b. Completion of Sponge, Needle, and Instrument counts
- c. Correct Number, Labeling and Disposition of Specimens
- d. Equipment/Instrument Concerns to be addressed
- e. Wound Class

Surgeon and Anesthesia provider verify:

- b. Estimated Blood Loss or Quantitative Blood Loss
- c. Any team concerns

E. Documentation

- 1. Universal Protocol/Time-Out procedures are documented in the electronic health record (EHR) or paper chart used during computer downtime.

DEFINITIONS

- 1. **Universal protocol:** The Universal Protocol focuses on safety for all surgical and nonsurgical invasive procedures that expose patients to more than minimal risk. Patient Safety is enhanced by correctly identifying the patient, making a correct diagnosis, selecting the appropriate procedure, identifying the correct site of the procedure, positioning the patient properly before surgery and providing all necessary equipment.
- 2. **Invasive Procedures:** Most procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, lithotripsy, biopsies, cardiac and vascular catheterizations, operating room procedures, endoscopies and lumbar punctures for NICU only.
- 3. **Exemptions:** Certain routine “minor” procedures such as venipuncture, repair of traumatic laceration, peripheral IV-line placement, insertion of NG tube, or foley catheter insertion.
- 4. **Primary surgeon/primary operator:** This is defined as medical staff and hospital personnel including but not limited to, the physician, or CRNP, or Physician’s Assistant, or Registered Nurse who are privileged/credentialed or permitted by the hospital to perform the procedure.

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SCOPE/APPLICABILITY

Clinicians areas where invasive procedures are performed.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Nursing Department

RELATED PROCEDURES AND OTHER MATERIALS

Time-Out

<https://procedures.lww.com/lnp/view.do?pId=2310338&hits=time&a=false&ad=false>

Procedure Site Verification

<https://procedures.lww.com/lnp/view.do?pId=2311119&hits=checklist,protocol,universal,comprehensive&a=false&ad=false>

The Joint Commission National Patient Safety Goal, Universal Protocol.

The Joint Commission. (n.d.). "Speak up: The universal protocol for preventing wrong site, wrong procedure, and wrong person surgery™: Guidance for health care professionals" [Online]. Accessed April 2020 via the Web at http://www.jointcommission.org/assets/1/18/UP_Poster1.PDF (Level VII)

EFFECTIVE DATE: 01/21/2019

POLICY & PROCEDURE TITLE:
Impaired Practitioner Policy and Procedure

REVIEW BY: 01/21/2021

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 establish a process for the identification, investigation and timely treatment of suspected cases of practitioner impairment while assuring patient safety.

POLICY

It is the policy of the St. Mary Medical Center and its Medical Staff to *educate* and address the issue of practitioner impairment in such a way as to provide quality patient care while dealing with the impaired practitioner in a comprehensive but compassionate and confidential manner in accordance with the Americans with Disabilities Act.

PROCEDURE

I. PRELIMINARY REPORT AND INVESTIGATION

- A. An individual who is concerned that a member of the Medical Staff or Allied Health Professional who is on hospital property is impaired and may reasonably be thought to be an imminent risk to patients, shall follow the procedure below:
 1. Observer will notify the Department Chair, the President of the Medical Staff or the Vice President of Medical Affairs.
 2. The Department Chair, President of the Medical Staff, Vice President of Medical Affairs or their physician designee will meet in a private location with the member who is suspected of being impaired and will make an assessment determination regarding the allegation and, if necessary to protect patients, may

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relieve the physician of patient care responsibilities. Additional appropriate consultation may be requested as required.

3. Upon completion of the assessment and, if possible, discussing the incident(s) with the person(s) who made the notification of suspected impairment, one or more of the following decisions will be made concerning the allegations:
 - a. No action required.
 - b. Refer the physician to an ad hoc committee of the Medical Executive Committee ("MEC"). At this meeting, the physician should be told that there is a concern that he or she may be suffering from an impairment and advised of the nature of the concern, but should not be told who filed the initial report.
 - c. Invoke immediate corrective action pursuant to the Medical Staff Bylaws which may include summary suspension and require immediate testing. The refusal of the allegedly Impaired Practitioner to consent to testing shall be grounds for immediate summary suspension.
- B. If an individual working in the Medical Center has a reasonable suspicion that a member of the Medical Staff or Allied Health Professional is impaired, without imminent danger to patients, the following procedure shall be followed:
 1. A written report shall be given to the President of the Medical Staff and Vice President of Medical Affairs. The report shall include a description of the incident(s) and the factual basis(es) (to the best of the individual's knowledge) that led to the belief that the practitioner may be impaired.
 2. After discussing the incident(s) with the individual who filed the report, if the President of the Medical Staff and Vice President of Medical Affairs believes that further investigation is warranted, he/she shall hold an informal meeting with the practitioner, at which time such practitioner shall be informed of the incident(s) and the factual basis supporting the report. Such disclosure shall also reveal the identity of the individual who initially filed the report. At the informal meeting, the practitioner shall be entitled to present relevant information. A written record of the meeting shall be made.

If, after such an informal meeting, the Medical Center President, the President of the Medical Staff or the Vice President of Medical Affairs believes that further investigation is warranted, he/she shall direct that an investigation be instituted and a report issued by individuals designated by the individual directing the investigation. Except in the event that the involved practitioner is a Hospital employee, the investigation is to be conducted by the practitioner's administrative Vice President. In some cases, the President of the Medical Staff, an outside consultant, or another individual or individuals appropriate under the circumstances, may be involved in the investigation.

The investigating individual(s) shall not be partner(s) or associate(s) of, or person(s) in direct competition with the practitioner who is the subject of the investigation.

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If, after the investigation and consideration of the relevant evidence, it is found that sufficient evidence exists to conclude that the practitioner is impaired, the Medical Center President shall, in writing, inform the allegedly Impaired Practitioner of such conclusions. The allegedly Impaired Practitioner shall also be notified, in writing, if the outcome of the evidence is found to be insufficient to support the charges. The investigation shall be concluded in a timely fashion.

- C. Licensed independent practitioners will be allowed to self-refer by notifying the Vice President- Medical Affairs.

II. COURSE OF ACTION

- A. Depending on the nature of the impairment, the MEC may itself take action consistent with the Medical Staff Bylaws or recommend to the Board of Trustees ("BOD") one or more of the following actions
 1. Impose appropriate restriction on the affected practitioner's practice, including but not limited to a requirement that the affected practitioner be proctored and or monitored, undergo psychiatric/psychological testing, or other steps deemed most conducive to the safety of the physician and patients;
 2. Require the affected practitioner to take a voluntarily leave of absence and undergo a rehabilitation program which, for physicians, has been approved by the Pennsylvania Medical Society's ("PMS") Physicians' Health Programs and which, for Allied Health Professionals, has been approved by the applicable Pennsylvania professional society, as a condition of continued appointment and clinical privileges; ;and/or
 3. Institute corrective action pursuant to the Medical Staff Bylaws which may include a summary suspension of the affected practitioner's Medical Center privileges if the Impaired Practitioner does not agree in, writing, to voluntarily take a leave of absence. Such summary suspension may entitle the Impaired Practitioner to those due process rights specified in the Medical Staff Bylaws.
- B. The Impaired Practitioner's leave of absence and/ or summary suspension shall continue until the Impaired Practitioner undergoes a rehabilitation program approved by PMS or the applicable professional society, and the Medical Center and President of the Medical Staff receive written verification that, in the professional judgment of the program director of the rehabilitation program ("Program Director"), the Impaired Practitioner is capable of resuming his/her professional practice and providing continuous competent care to patients. Recommended restrictions, monitoring and follow-up treatment deemed necessary by the Program Director shall be included in his/her report. The Impaired Practitioner's clinical privileges shall only be reinstated in accordance with Article III of the policy.
- C. The Medical Center shall seek the advice of legal counsel to determine whether any conduct must be reported to law enforcement authorities, professional or licensing authorities and/ or other governmental agencies and what further steps must be taken. The Medical Center shall inform the Impaired Practitioner and the President of the Medical Staff upon reporting such conduct or taking such further steps unless such notification is prohibited by law or unless it believes that providing such information will put the Impaired Practitioner or others at risk.

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- D. The report and a description of the actions taken by the MEC, the Medical Center President, the President of the Medical Staff, Vice President of Medical Affairs or Board of Directors shall be included in a confidential file . If the Impaired Practitioner is directed for additional evaluation, testing and/or treatment the file will also contain periodic reports from the treater which specify that treatment/testing is ongoing; reports, if appropriate, that the provider is non-complaint with the recommendations or that progress is not satisfactory; any recommendations for changes in privileges or status of the provider; notification that treatment/testing recommendations have been completed successfully, along with recommendations for any ongoing maintenance evaluation. These records shall be maintained separate from the standard Medical Staff Credentials file except that if privileges have been reduced or changed, the Medical Staff Credentials File will reflect those changes (such as a leave of absence). Confidential Files will be maintained indefinitely or until the Hospital becomes aware that the provider has retired permanently from practice. The affected practitioner shall have the opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her Confidential File.
- E. The Medical Center President, President of the Medical Staff, or Vice President of Medical Affairs shall inform the individual who filed the report that follow-up action was taken.
- F. Information gathered must be held in confidence and investigation of reports of impairment must be carried out discreetly and in a timely fashion. Records shall be maintained in a secure file. Throughout this process, the parties shall avoid speculation, gossip, and discussion of this matter with anyone outside those described in the policy.
- G. Actions that would result in a reduction or revocation of privileges or suspension from the Medical Staff shall be processed in accordance with the Medical Staff Bylaws, Rules and Regulations and other policies. The Impaired Practitioner will have the due process rights specified in the Medical Staff Bylaws (if any).
- H. Nothing in this policy restricts the Medical Staff, Program Director or Department Chairs/Division Directors from using corrective discipline to address the specific performance issues of the Impaired Practitioner who may be undergoing counseling or treatment for drug and/or alcohol addiction or psychological, emotion or medical conditions so long as the discipline is for performance related issues.

III. RESTORATION OF PRIVILEGES

- A. In the event the Impaired Practitioner's clinical privileges have been reduced, revoked, or suspended as a result of an impairment and he/she seeks restoration of such privileges, the Hospital and the Medical Staff shall comply with the following provisions:
 - 1. In considering an Impaired Practitioner for reinstatement, the BOD of the Medical Center and its Medical Staff leadership must consider patient care interests paramount.
 - 2. Upon sufficient proof that an Impaired Practitioner has successfully completed a rehabilitation program and has been deemed fit to return to duty, the MEC shall recommend to the BOD restoration of the Impaired Practitioner's privileges in

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(accordance with the Medical Staff Bylaws and shall consider any recommendations related to restoration from the Program Director.

3. The MEC may make additional recommendation(s) regarding restoration of clinical privileges, which may include the following:
 - a. The Impaired Practitioner shall identify two practitioners on the Medical Staff with appropriate clinical privileges who are willing to assume responsibility for the care of the Impaired Practitioner's patients in the event of his or her inability or unavailability;
 - b. The Impaired Practitioner may be required to obtain periodic reports as determined by the MEC with input from the Program Director stating that the Impaired Practitioner is continuing treatment or therapy, as appropriate, and that the Impaired Practitioner's ability to treat and care for patients in the Medical Center is not impaired.
 - c. The Impaired Practitioner's exercise of clinical privileges in the Medical Center shall be monitored by the department chairperson or by a practitioner appointed by the department chairperson. The nature of that monitoring shall be determined by the MEC after its review of all the circumstances.
 - d. The Impaired Practitioner shall agree to submit to alcohol and/or drug screening (as appropriate and as per his/her agreement with the MEC) for such period of time as the MEC and BOD deems necessary.
 - e. The Impaired Practitioner shall enter into a contract with the Medical Center and the ad hoc committee of the MEC which will set forth the terms of reinstatement including the terms set forth herein.
4. Requests for information concerning the Impaired Practitioner shall be forwarded to the Medical Center President and the President of the Medical Staff for response.

False allegations will be addressed by the Medical Staff Bylaws or hospital corrective action.

SCOPE/APPLICABILITY

Medical Staff

DEFINITIONS

"Impaired Practitioner": A member of the Medical Staff or any Allied Health Professional who, an after investigation and review as set forth herein, is considered to be impaired.

"Impaired" or "Impairment": A physical, mental, or emotional illness or condition, including but not limited to loss of cognitive or motor skill, or excessive use or abuse of drugs including alcohol which adversely affects an individual's ability to practice safely and competently.

The terms "Medical Staff" and "Allied Health Professionals" shall have the definitions ascribed to them in the Medical Staff Bylaws.

RESPONSIBLE DEPARTMENT

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Title: Impaired Practitioner Policy and Procedure

Further guidance concerning this Policy may be obtained from Medical Staff

RELATED PROCEDURES AND OTHER MATERIALS

EFFECTIVE DATE: 08/08/2018

POLICY & PROCEDURE TITLE:
Harassment (Sexual and Non-Sexual) Policy and Procedure

REVIEW BY: 08/17/2022

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: Excellence, Integrity, Justice

PURPOSE

It is the purpose of the policy to define inappropriate behavior in the workplace and to prohibit unlawful harassment.

POLICY

It is the policy of the Medical Center to promote a productive work environment and to respect the rights and dignity of each person that we encounter. Inappropriate workplace behavior and unlawful harassment create an environment that is inconsistent with this commitment.

The Medical Center prohibits verbal or physical conduct of any colleagues, patients, patients' family members, physicians, volunteers, contractors, vendors and others, that harasses, interferes with another colleague's work performance, or creates an intimidating, offensive or hostile work environment. No form of harassment will be tolerated, including harassment based on sex, race, religion, color, age, information derived from genetic testing, national origin, disability or any other characteristic protected by federal, state or local law.

Supervisors and managers have a responsibility to keep the workplace free of any form of harassment. Colleagues who witness or come to know of harassment in the Medical Center have a responsibility to report the situation.

PROCEDURE

1. Reporting and Investigation of a Complaint

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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).

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- a. If a colleague is a witness to, or believes that he or she has experienced harassment as defined in this policy, then he or she should immediately notify either his or her supervisor or Director, Colleague Resources, or any other management colleague with whom he or she is comfortable.
- b. Any manager who is notified of any complaint of harassment must notify Colleague Services immediately, even if the colleague states that he or she does not want to pursue the complaint.
- c. The Human Resources Department must notify legal counsel for the Medical Center upon receiving a complaint of any type of harassment.
- d. All reports of harassment will be investigated promptly and thoroughly by a member of the Human Resources Department may work in conjunction with a member of Medical Center management who is not involved in the alleged harassment.
- e. A colleague will not be subject to retaliation, intimidation, or discipline as a result of making a good faith complaint of harassment. A colleague found to have made a claim of harassment in bad faith or intentionally falsified the information, will be subject to appropriate corrective action.
- f. Confidentiality will be maintained to the extent possible, while still conducting a complete investigation.
- g. A report as to the outcome of the investigation will be made back to the complainant following the completion of the investigation.
- h. If an investigation confirms that harassment or other improper behavior has occurred either by a colleague or other person associated with the Medical Center, the Medical Center will take prompt corrective action to resolve the situation. This may include counseling or discipline of the harassing colleague, up to and including termination of employment.

SCOPE/APPLICABILITY

All Colleagues

DEFINITIONS

1. Sexual Harassment
 - a. Sexual harassment may include repeated offensive or unwelcome sexual advances, verbal comments or innuendo of a sexual nature, words of a sexual nature used to describe a person or depict a situation, or the display of sexually suggestive objects or pictures. Comments, physical touching of another person, or drawings which are not explicitly sexual in nature, may constitute sexual harassment.
 - b. Unwelcome sexual advances, requests or sexual favors and other verbal, physical, or visual conduct of a sexual nature constitute sexual harassment when:
 - i. Submission to such conduct is either an explicit or implicit term or condition of employment (e.g. promotion, training, timekeeping, assignments, etc.); or

EFFECTIVE DATE: 08/21/2018

POLICY & PROCEDURE TITLE:
Workplace Violence Policy and Procedure

REVIEW BY: 08/19/2022

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, Stewardship

PURPOSE

It is the purpose of the policy to define workplace violence, aid in its prevention and provide colleagues and others with a method for identifying, reporting and managing workplace violence.

POLICY

It is the policy of the Medical Center to maintain a work environment free from intimidation, threats or violent acts. Colleagues, patients, physicians, visitors, vendors and others using the Medical Center facilities are prohibited from initiating verbal or physical intimidating acts, threats or actual violence.

PROCEDURE

1. In the event of an emergency situation, staff should:
 - a. Remain calm, think safety first, and do not respond alone.
 - b. Dial 1-5555, notify security and notify the Switchboard.
 - c. Switchboard will immediately notify:
 - i. Security, 911 as appropriate and the President/Administrator on call.
 - ii. Plant Operations to lock down elevators in the vicinity and remain on standby to assist security as needed.
 - d. Remove non-essential patients, visitors and staff from the area.
 - e. Resist reacting with anger - anger may be all that is needed to push an individual over the

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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: Workplace Violence Policy and Procedure

- edge. Attempt to isolate the angry individual by asking them to accompany you to a secure area but do not force the issue.
- f. Attend to anxiety and non-verbal communication - be supportive by being empathetic and attempt to alleviate or reduce anxiety. Move slowly and deliberately. Let your eyes communicate that you are listening and concerned. Speak in low, calm tones and avoid being condescending. Take personal responsibility and acknowledge any legitimate contribution you may have made to the problem. This can often lead to the angry person taking responsibility as well. Do not exceed the bounds of your authority.
 - g. When an individual is verbally defensive, be direct - it is recommended that staff respond to defensive behavior by taking control of setting limits. Limits that are imposed are to be clear, concise and above all, enforceable.
 - h. Carefully take any weapons relinquished to you and promptly turn them over to Security or the Police.
 - i. If the assailant leaves, try to obtain a description of the vehicle, license plate number, and direction of escape.
 - j. Once Security arrives, let them take charge of the situation until the Police are on site.
 - k. Immediate post crisis management:
 - i. File an incident report
 - ii. Secure site to forensic evidence collection
 - iii. Managers are to inform staff of the availability of employee assistance counseling
 - iv. An investigation will be conducted; refer to paragraph 3.c
2. Non-Emergency Situation
- a. Threats and potentially violent situation are to be taken seriously.
 - b. Colleagues are to report incidents of harassment, threats, violent conduct and other incidents that have the potential for workplace violence promptly to their supervisor, Human Resources, Security or Risk Management
 - c. Notify Security as needed.
 - d. Secure the intended victim in a safe location as needed.
 - e. Document activity and behavior and complete an incident report.
3. Management/Follow-up
- a. When reporting a threat or potentially violent situation, provide the following information:
 - i. As closely as possible, the exact statement(s) made.
 - ii. The circumstances in which the statement was made.
 - iii. Any knowledge of the person making the statement or threat.
 - iv. The relationship between the colleague and the person making the statement or threat.
 - v. The name of others that may have witnesses the incident.
 - b. The Supervisor/Manager/Director will contact Social Services and or Domestic Violence Counselor to determine the need for a team meeting and who should participate as team members.
 - c. Human Resources or designee will conduct a prompt investigation of the incident when the alleged perpetrator is a colleague.
 - i. After notification of the incident, a confidential investigation will be initiated. At the discretion of the Chief Human Resources Officer/designee, the alleged offender

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- may be suspended without pay, pending the results of the investigation.
- ii. Confidentiality will be maintained to the extent possible, while still conducting a thorough investigation.
 - iii. If a colleague is found to be in violation of the Workplace Violence Policy, the Medical Center will take appropriate corrective action, which may, at the Medical Center's discretion, include termination of the offender.
 - iv. Disciplinary action, up to and including termination, may also be taken against anyone who knowingly makes a false accusation against another person in regard to the Workplace Violence Policy.
 - v. When an investigation supports the conclusion that a registered or licensed colleague has engaged in a violation of the Workplace Violence Policy, the supervisor in consultation with Human Resources may file appropriate report with the individuals licensing board.
4. Individuals who are not colleagues and who engage in violation of the Workplace Violence Policy will be reported to the appropriate law enforcement agency.
5. Security/Search
- a. Based on management's reasonable suspicion or actual knowledge of a violent or potentially violent situation or the presence of weapons, the Medical Center reserves the right to conduct searches and inspections of colleagues and colleague's personal effects, including, but not limited to, articles such as lunch containers, thermoses, purses, backpacks, personal packages or vehicles; or provided materials, including, but not limited to, articles such as lockers, desks, personal computer files, cabinets and file drawers. Searches will be conducted after consultation with Human Resources and simultaneously by the department director or manager (or designee) and a representative from Human Resources or Security.
 - b. Weapons or articles that could be potentially used as weapons that are discovered may be taken into custody and turned over to law enforcement representative.
 - c. A colleague who refuses to submit to a search or who is found in possession of weapons or articles that could be potentially used as weapons may be subject to disciplinary action up to and including termination.
 - d. Security has the authority to detain and or search patients or visitors to the hospital when there is sufficient concern of violence or potential for violence.
 - e. Police will be notified as deemed necessary by security, the administrator on call or the President.
6. Education
- a. The Domestic Violence Counselor will provide education regarding Workplace Violence, PFA's, and safety plans for victims of Domestic Violence.
 - b. An education program will be made available to staff during the yearly Mandatory Education day.

SCOPE/APPLICABILITY

All Colleagues

Title: Workplace Violence Policy and Procedure

DEFINITIONS

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Human Resources

RELATED PROCEDURES AND OTHER MATERIALS

EFFECTIVE DATE: 02/17/2020

POLICY & PROCEDURE TITLE:
Substance Free Workplace Policy and Procedure

REVIEW BY: 02/17/2022

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: Excellence, Integrity, Justice

PURPOSE

To enhance job productivity, promote the health and safety of our patients/residents, colleagues, physicians, volunteers and the public, and to delineate the course(s) of action to be taken in the event a job applicant, volunteer or a colleague is participating in substance abuse.

POLICY

St. Mary Medical Center (SMMC) and all its entities have a responsibility to provide a drug-free working environment that is safe for its patients/residents, colleagues, the physicians, volunteers and the public to ensure that their safety is protected. Compliance with this policy is a condition of employment and continued employment. St. Mary Medical Center substance abuse policy is applicable to all colleagues and volunteers. St. Mary Medical Center will NOT condone:

- A. The use, possession, manufacture, sale, transfer, purchase, or distribution of alcohol and/or illicit drugs (or the attempt of such conduct) on the organization’s premises.
- B. Any use of alcohol or illegal drugs is prohibited on the organization’s time, including where said use results in alcohol or drugs being present in a colleague/volunteer’s body while at work.
- C. Use or abuse of prescription drugs without a valid prescription or abuse of a prescription drug.

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D. Use of prescription or over-the-counter medication/drugs which causes impairment is prohibited while at work.

Possessing, consuming, selling, or being under the influence of alcohol, narcotics, or any other mind altering substance is considered colleague/volunteer misconduct, and is inconsistent with the “Expectations” of all colleagues/volunteers of the organization, and is grounds for disciplinary action up to and including termination of employment.

St. Mary Medical Center recognizes that job performance is adversely affected by the use of drugs/alcohol. These impairments can lead to increased accidents, decreased work performance, decreased productivity, and increased absenteeism. Additionally, this organization recognizes that chemical dependency is a disease that can be successfully treated when recognized before problems develop. The Colleague Assistance Program (CAP) is a confidential resource for colleagues and their families to utilize 24 hours a day/365 days a year. Toll-Free 1-800-343-2186.

Given the nature of our service, responsibilities, and potential liability, the employment of an individual who is under the influence of drugs or alcohol would pose an unacceptable safety risk, endangering fellow colleagues, the patients/residents, physicians, volunteers and the public.

Therefore, it is the policy of St. Mary Medical Center to:

1. Require all applicants selected for employment and the volunteer services program to submit voluntarily to, and pass, pre-placement screening for substance abuse.
2. Screen all past colleagues being “recalled” after a lay off and/or being rehired after prior termination of employment.
3. Screen all colleagues and volunteers when there is a reasonable suspicion that a colleague or volunteer may be “Under the Influence” of alcohol, drugs (legal or illegal), or mind altering over-the-counter or prescription medications.

It is the RESPONSIBILITY of all colleagues to always report individuals that they suspect or have “Reasonable Suspicion” may be under the influence.

PROCEDURE

A. Pre-Employment

1. After a conditional offer of employment (or volunteer position offer) has been made, applicants must consent to and submit a specimen for drug screening during their post-offer physical.
2. Individuals will be ineligible for employment or volunteer work if the individual:
 - refuses to undergo drug screening
 - alters, attempts to alter, or substitutes a specimen

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- has a verified positive drug test result
3. A positive test is a lab-based confirmatory study that reveals the presence of an illegal drug, prescription medication without a valid prescription or other medication detected in the drug screening specimen which may affect safe job performance. Positive test results will be reviewed, and the applicant will be contacted by the Medical Review Officer to determine whether there is a legitimate explanation for the positive result. If there is not a legitimate explanation for the result, it will be considered a verified positive result.
 4. An individual denied employment or volunteer work because of the results of drug or alcohol testing will be so advised by the VP Human Resources or his/her designee.
 5. SMMC Colleague Health Department will maintain records of drug and/or alcohol test results in a secure location. An individual, upon written request, may obtain copies of any records pertaining to his/her drug and/or alcohol testing.

B. Reasonable Suspicion of Alcohol and/or Drug Use

1. A drug and/or alcohol screening may be performed on colleagues/volunteers upon reasonable suspicion that the colleague/volunteer may be under the influence of drugs or alcohol while on duty. Testing is to be administered as soon as possible after there is suspicion that a colleague/volunteer may be under the influence of drugs or alcohol. A Physical Assessment of the Colleague must accompany a Reasonable Suspicion request to drug test, to help determine if signs of impairment are present and/or the need of further urgent/emergent medical evaluation is required. A screening will also be performed if a colleague/volunteer is involved in a workplace accident or incident which results in physical injury to self or others and/or property damage if reasonable suspicion of impairment exists.
2. Reasonable cause or suspicion may exist if, based on the colleague's/volunteer's speech, statements, behavior, conduct, or appearance, he or she reasonably appears to be under the influence of drugs or alcohol.
3. If a colleague/volunteer suspects another colleague/volunteer may be under the influence of alcohol/drugs he or she is obligated to immediately notify a manager of his or her concerns. During the day shift, the department head, or his/her designee is to be notified. During weekend hours, evenings and nights, the on-site Clinical Administrator is to be notified. If there is no Manager or designee present, the Clinical Administrator is to be notified.
4. The manager/department head or their designee, or the Clinical Administrator are responsible to complete the "Reasonable Suspicion Report" (attached).
 - The "Reasonable Suspicion Report" should include any witness statements, including observations of potential impairment.
 - Upon completion of this form, the manager/department head or their designee, or the Clinical Administrator will contact Colleague Health and/or Human Resources during normal business hours to coordinate testing.
 - If after normal business hours (e.g. weekends/evenings/nights), the Clinical Administrator will coordinate the testing procedures (attached).

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5. A colleague/volunteer will be subject to corrective action, up to and including termination of employment, if:
 - the colleague/volunteer is determined to be unfit for duty due to the influence of drugs/alcohol
 - if the colleague/volunteer refuses to participate in an investigation regarding drug or alcohol use
 - if the colleague/volunteer refuses to take a required drug or alcohol test
 - if the colleague/volunteer attempts to alter or tamper with a sample or the testing process

Positive Test Results

1. If the initial screening results for alcohol/drug testing are positive or inconclusive, and/or the final confirmatory results of the testing are pending, either the Clinical Administrator or Colleague Health Nurse will inform the colleague/volunteer that he or she is suspended until a decision is made by Human Resources regarding continued employment.
2. The colleague/volunteer is to be assisted in obtaining a ride home. If the colleague/volunteer refuses to accept alternate transportation and insists on driving himself or herself, the colleague/volunteer is to be told that the police will be notified. If the colleague/volunteer leaves anyway, the Clinical Administrator or Colleague Health Nurse will notify the police immediately. The colleague/volunteer shall remain under the care and supervision of the Clinical Administrator, Colleague Health Nurse and/or a Security Officer until such time as transportation is arranged, and the colleague/volunteer is safely transported off the premises.
3. The colleague/volunteer will be contacted by the Medical Review Officer to determine whether there is a legitimate explanation for the laboratory positive result. If the colleague/volunteer is unable to establish that the substance was prescribed by a physician, and if after further discussing this information with the colleague/volunteer directly, the Medical Review Officer determines that there are no legitimate medical explanations for the confirmed positive test result, the Medical Review Officer will report a Verified Positive test result to the Designated Employer Representative (DER). Human Resources, will then determine what employment action is appropriate.
4. Colleague Health will maintain records of its drug/alcohol test results in a secure location. An individual, upon written request, may obtain copies of any records pertaining to his or her drug/alcohol test results.
5. Costs of substance abuse testing required by SMMC will be paid by SMMC.
6. All confirmatory drug testing are to be performed in a SAMHSA Certified Laboratory, with exception of Evidential Breath Alcohol testing, if utilized.
7. All Positive Drug Test results are to be reviewed by a currently Certified Medical Review Officer.
8. The Employer reserves the right to modify the drug test panel at any time and to use any recommended confirmatory testing in the future and/or include the collection of any

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matrix, (oral fluid, urine, blood, hair, nails) deemed necessary to uphold the spirit of the Organizational Policy (unless prohibited by a Collective Bargaining Agreement).

Consequences of Positive Results

1. A violation of SMMC's "Substance Abuse" Policy may result in corrective action up to and including termination for colleagues. Volunteers will be removed from the volunteer program.
2. At SMMC's discretion, a colleague may be offered an opportunity to participate in an approved rehabilitation program. Any expenses associated with a rehabilitation program will be the responsibility of the colleague, and if available, paid time off (PTO) may be used. If eligible, colleagues may apply for a leave of absence.
3. A colleague who refuses to participate in an approved rehabilitation program, will be terminated from employment because of the results of substance abuse testing.
4. The Chief Nursing Officer (CNO), designee, or Chief Medical Officer (CMO), or designee, will report licensed personnel to the appropriate State Board.
5. A colleague who agrees to specific referral and treatment plans may be returned to work when recommended by the treating professional and upon clearance by Colleague Health.
6. Upon returning to work, the colleague will be subject to random drug/alcohol testing for a period of up to twenty-four (24) months and must fulfill all terms and conditions of recommended follow-up treatment and counseling. Failure to successfully comply with these requirements will be grounds for termination of employment.
7. If applicable, licensed personnel will also be required to fulfill the Impaired Professional Contract with the appropriate State Board.
8. A colleague/volunteer terminated for violating this policy may not be considered for rehire or participation in the volunteer program.

Negative Test Results

1. If the screening results are negative, but the colleague/volunteer still seems to be impaired, the Clinical Administrator and/or Colleague Health Nurse will assess whether the individual is fit for duty at this time and will refer the colleague/volunteer to seek additional medical treatment, as may be appropriate.
2. If the colleague is determined to be fit for duty, the colleague may be reinstated with back pay as necessary.

Colleague's Self-Identification of Substance Abuse Problem

1. If a colleague voluntarily self-identifies as having a drug and/or alcohol problem and requests assistance for such a problem, before violating this policy, SMMC will refer the colleague to the Colleague Assistance Program or the appropriate State Board Impaired Professional Program.
2. The colleague will be sent for an evaluation and for referral to an appropriate treatment or rehabilitation program.
3. The colleague must satisfactorily complete a counseling, treatment or rehabilitation

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program, be cleared by Colleague Health, and must comply with the random drug/alcohol testing and recommended follow-up treatment (see # 3 above) in order to be eligible to return to work.

4. The cost of counseling, treatment or rehabilitation is the colleague's responsibility.

Inspections

1. When there is reasonable suspicion to believe that a colleague may have or has violated this policy (which may include the loss or suspected theft of controlled substances) inspections of the colleague's person, his/her personal property such as, but not limited to, vehicles, lockers, clothing, packages, purses, brief cases, backpacks, lunch boxes or other containers brought on to SMMC premises) may be conducted.
2. Refusal to permit a requested inspection will result in corrective action up to and including termination of employment.

Arrests and Convictions

1. Colleagues must notify their department head and the Human Resources Department if arrested or charged in connection with any drug-related activity, on or off the job, by the next regular workday. The matter will be reviewed, taking into consideration several areas such as the severity of the charges, present job assignments, the colleague's work record, and the impact of the arrest on SMMC.
2. Colleagues convicted of any drug-related charges must notify the Human Resources Department immediately and will be subject to corrective action, up to and including termination. Colleagues may only be considered for re-employment after a conviction if, at a minimum, they have successfully completed an approved rehabilitation program and provide appropriate documentation of same.

Title: Substance Free Workplace Policy and Procedure
Reasonable Suspicion Report:

Colleague's Name _____ Workday ID # _____

Date _____ Time _____ Location _____

Colleague completing this report:

Name _____ Title _____

Date _____ Time _____

Signature _____

This checklist is to be completed when an incident has occurred which provides reasonable suspicion that an individual may have or has violated this policy. You are to note the pertinent behavior and physical signs or symptoms which lead you to reasonably believe that the individual has engaged in such prohibited conduct. Check each applicable item on this form and add any additional facts or circumstances which you have witnessed. A drug/alcohol test must be administered as soon as possible, but no later than two (2) hours following a reasonable suspicion determination. This document must be reviewed by the Clinical Administrator and/or Colleague Health Nurse before the colleague/volunteer is requested to submit to reasonable suspicion drug and/or alcohol tests.

PHYSICAL INDICATORS

- | | |
|---|---|
| <input type="checkbox"/> dilated pupils | <input type="checkbox"/> chronic redness of eyes |
| <input type="checkbox"/> constricted pupils | <input type="checkbox"/> chronic nasal problems |
| <input type="checkbox"/> drowsiness | <input type="checkbox"/> odor of marijuana |
| <input type="checkbox"/> cold sweats | <input type="checkbox"/> odor of alcohol |
| <input type="checkbox"/> tremors | <input type="checkbox"/> noticeable weight loss |
| <input type="checkbox"/> rapid breathing | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> ravenous appetite |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> unsteady walk, stumbling |

BEHAVIORAL INDICATORS

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> depression | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> moodiness | <input type="checkbox"/> irritability |
| <input type="checkbox"/> combativeness | <input type="checkbox"/> agitation |
| <input type="checkbox"/> panic reactions | <input type="checkbox"/> restlessness |
| | <input type="checkbox"/> euphoria |

SPEECH INDICATORS

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> thick | <input type="checkbox"/> rapid |
| <input type="checkbox"/> slurred | <input type="checkbox"/> incoherent |
| <input type="checkbox"/> excessively talkative | |

PERFORMANCE INDICATORS

- | | |
|--|---|
| <input type="checkbox"/> unable to concentrate | <input type="checkbox"/> frequent unscheduled absences |
| <input type="checkbox"/> errors in judgment | <input type="checkbox"/> frequent unexplained disappearances from work area |
| <input type="checkbox"/> loss of interest in work | |
| <input type="checkbox"/> impaired reasoning | |
| <input type="checkbox"/> involvement in a serious accident or injury | |

Title: Substance Free Workplace Policy and Procedure

VOLUNTARY CONSENT TO DRUG/ALCOHOL TEST

Per SMMC's Substance Abuse Policy, I understand that I have been requested to provide a specimen to be tested for the presence of drugs and/or alcohol based on reasonable suspicion that I may be in violation of the policy. I consent to such testing to determine the presence of drugs and/or alcohol. I understand that reporting to work under the influence of drugs (whether or not prescribed) or alcohol may affect my continued employment.

Please list any medications you are currently taking:

Medication	Dose	Reason	Physician Name	Date of Last Dose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Signature: _____ **Date:** _____

I certify that I will not tamper with my specimen or do anything that will interfere with accurate testing results.

I authorize my test results to be given to SMMC in accordance with its policy and agree to release and hold harmless SMMC, the Colleague Health Nurse, the Medical Review Officer, and the testing laboratory as well as each of their officers, agents, and colleagues from any liability based on SMMC's request that I undergo drug/alcohol testing. I consent that if I am a licensed healthcare worker, SMMC may release my positive test results to the appropriate state licensing board.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Title: Substance Free Workplace Policy and Procedure
Drug Testing FAQs

1. Should the colleague be tested?
 - Decision must be based on specific physical, behavioral or performance factors as listed in Reasonable Suspicion Report.
2. Is the colleague unable to perform their duties in a proper, safe, and competent manner?
 - If the answer is “Yes” or “Maybe” a reasonable suspicion of impairment exists and testing should take place.
 - Colleague is suspended with pay until investigation and results have been received.
3. Where does the testing take place?
 - Emergency or Off-Hours: In the event of concern of impairment due to medical condition, colleague should be taken to emergency room for evaluation prior to reasonable suspicion testing and registered under a protected ID# and processed with Human Resources as guarantor.
 - Non-Emergency: During normal business hours (Monday-Friday 8-4pm) non-emergency reasonable suspicion testing will take place in Colleague Health/WorkCare.
4. What is the Manager/Supervisor responsible for?
 - Meet privately with colleague to assess the individual’s fitness for duty.
 - Notify your HR Business Partner that testing is going to be requested.
 - Complete the Reasonable Suspicion Report.
 - Explain to colleague the decision to proceed with substance abuse testing and provide copy of policy.
 - If colleague refuses testing, notify HR immediately.
 - The colleague will be sent home (suspended) with pay pending investigation.
 - Manager, Supervisor, HR designee or Security must remain with Colleague until testing is complete and colleague has been picked up by family member or taxi.
5. What is process for testing during business hours (Monday-Friday 8-4pm)?
 - Manager will notify Colleague Health and bring colleague to Colleague Health/WorkCare office along with Reasonable Suspicion Report.
 - If medical emergency; coordinate for colleague via rapid response/emergency room/911 based on location and then notify Colleague Health/HR.
 - Manager will contact HR Business Partner to inform them that Reasonable Suspicion Drug Testing will be taking place.
 - Colleague Health will facilitate completing the Drug Information and Consent form with the colleague.
6. What is process for off-hours testing?
 - Notify the Nurse Supervisor of suspected impairment.
 - Supervisor will complete the Reasonable Suspicion Report gathering additional information from witnesses as indicated.
 - Nurse Supervisor will review paperwork and contact Hireright to request mobile drug and alcohol testing via hotline as indicated below.
 - Nurse Supervisor will scan and email Reasonable Suspicion Report to Designated HR Business Partner and bring original documents to Colleague Health office.

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- Any questions please contact Colleague Health via switchboard.
7. How do I contact HireRight for testing?
- To request emergency services call 800.841.7678.
 - If your call is not promptly answered it will be returned within 15 minutes.
 - Request mobile drug and alcohol testing
 - Provide location as to where tester is to come to provide testing
 - Provide company ID
 - ***St Mary sites: Trinity Health TRH033***
 - Colleague WorkDay ID number may serve as Employee ID in lieu of SS#
8. What happens after colleague is tested?
- The colleague will be sent home and placed on paid leave of absence coordinated by HR pending completion of investigation and results of testing.
 - Colleague must NOT drive home.
 - Taxi (vouchers) may be arranged through Colleague Health/Security or a family member may pick up colleague. If colleague insists on driving home notify Security immediately.

SCOPE/APPLICABILITY

All Colleagues

DEFINITIONS

Reasonable Suspicion:

Reasonable suspicion justifying drug testing under this policy means having the belief that a colleague/volunteer is using or has used drugs in violation of this policy. May be based on an colleague/volunteer who appears intoxicated, confused, uncoordinated, exhibits marked personality changes, shows irrational behavior, has the smell of alcohol, or demonstrates other activity suggesting impairment.

Substance Abuse:

The use of any drug, alcohol, or other substance that results in the mental or physical impairment of a colleague/volunteer.

Impairment:

To make worse, lessen, weaken, damage, or reduce the mental or physical ability of a colleague/volunteer to perform his/her job.

Specimen:

A tissue or product of the human body such as urine or blood chemically capable of revealing the presence of drugs in the human body.

Confirmation Test:

Title: Substance Free Workplace Policy and Procedure

A lab-based drug test on a specimen, (BAT excepted), to prove the results of an initial positive screening test.

Drug or Alcohol Test:

Means and includes urine drug tests or breathalyzer (BAT-Breath Alcohol Test).

Medical Review Officer (MRO):

A licensed physician designated by St. Mary Medical Center in the case of pre-employment screening or by the independent testing laboratory in the case of all other testing to conduct the final review of all test results prior to reporting to St. Mary Medical Center.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Human Resources

RELATED PROCEDURES AND OTHER MATERIALS

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

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.

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

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.

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

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

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

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"> ➤ clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee ➤ * children younger than 6 months of age can be fed infant formula up to 4 hours prior to surgery or procedure. 	

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

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

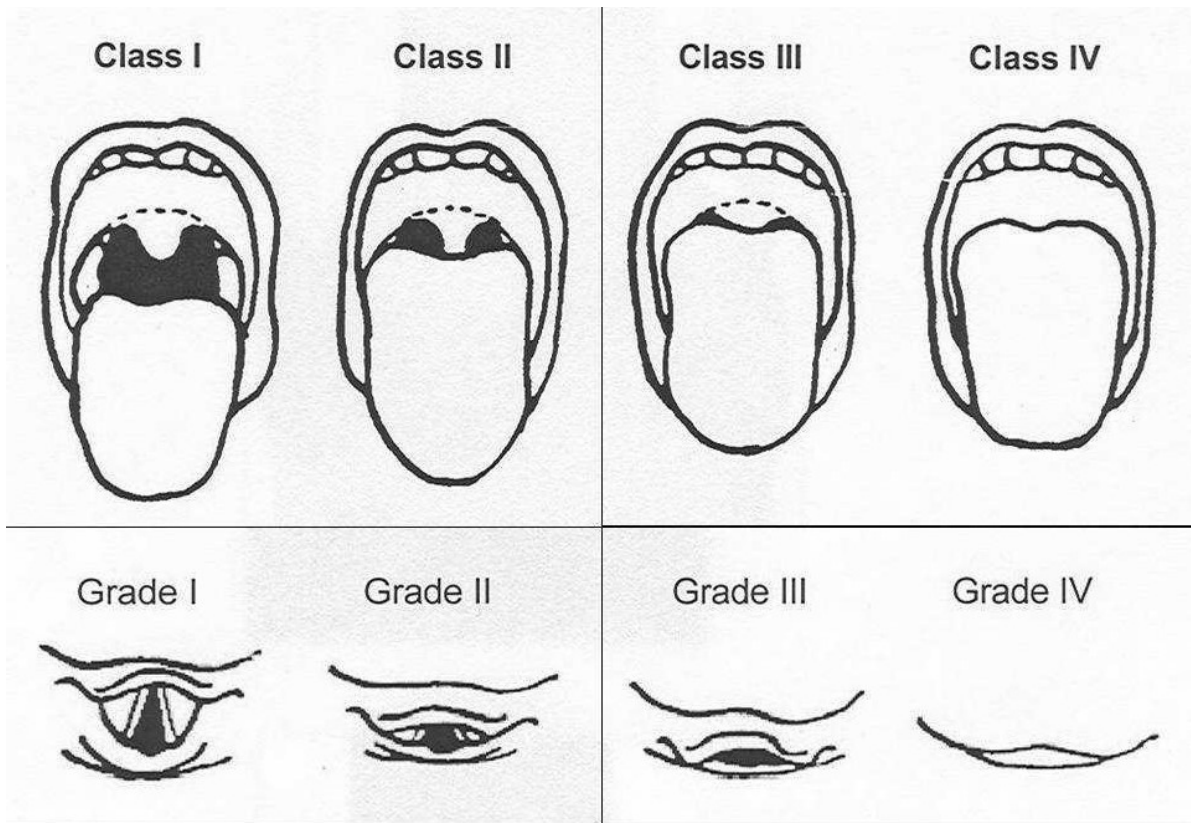
MALLAMPTHI AIRWAY CLASSIFICATION

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

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

- 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: 01/31/2019

POLICY & PROCEDURE TITLE:
Abbreviations and Medical Symbols Policy and Procedure

REVIEW BY: 01/31/2021

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 avoid misinterpretation and to comply with state regulations 115.32 (c); JCAHO Accreditation Standards, Medical Staff Bylaws Rules and Regulations, and National Patient Safety Initiatives.

POLICY

Symbols and abbreviations may be used only when they have been approved by the medical staff and when there exists a legend to explain them.

Abbreviations (additions/edits/deletions) are approved at the Medical Executive Committee.

Abbreviations from the approved Medical Staff Abbreviation List may be used in the patient record.

Abbreviations on the Unacceptable Abbreviations and Symbols List may not be used.

Copies of the approved Medical Staff Abbreviation List are distributed annually to the Health Information Management Committee, Medical Executive Committee, Forms Committee, Patient Registration, and Nursing Units.

Copies are available upon request from the Health Information Management Department.

PROCEDURE

Title: Abbreviations and Medical Symbols Policy and Procedure

1. Symbols and abbreviations may be used in the patient record as stated in The Joint Commission Standards and State Regulation §115.32 (c).
2. A copy of the approved abbreviation list is kept in the Medical Staff Office and is available to authorized personnel.
3. Each abbreviation or symbol has only one meaning.
4. Additions and/or deletions will be made as needed via the Health Information Management Committee. The abbreviation list will be reviewed and updated by the Health Information Management Committee or Quality Committee and approved by the Medical Executive Committee.

SCOPE/APPLICABILITY

Health Information Management, Medical Staff, Nursing, anyone who documents in the medical record, Patient Safety, Risk Management

DEFINITIONS

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Health Information Management

RELATED PROCEDURES AND OTHER MATERIALS

PA Department of Health Regulation: §115.33

EFFECTIVE DATE: 01/11/2019

POLICY & PROCEDURE TITLE:

Disruptive Unprofessional Physician Conduct Policy and Procedure

REVIEW BY: 01/11/2021

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

The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate, to the extent possible, conduct that:

- disrupts the operation of the hospital;
- affects the ability of others to do their jobs;
- creates a hostile work environment for hospital employees or other medical staff members;
- interferes with an individual’s ability to practice competently; or
- adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care.

POLICY

It is the policy of this hospital to treat all individuals within its facilities with courtesy, respect, and dignity. To that end, all individuals, including members of the governing body, employees, physicians, and other allied health practitioners, shall conduct themselves in a professional and cooperative manner in the hospital. Human resource policies address matters involving employees who fail to conduct themselves appropriately. The medical staff is accountable for effectively addressing disruptive behavior by physicians and other allied health practitioners with privileges. This policy reflects a structured formal approach with, when appropriate, an incremental process when necessary leading to the governing board level.

Title: Disruptive Unprofessional Physician Conduct Policy and Procedure

Medical Staff members cannot be subject to discipline for appropriate behavior. Appropriate behavior means any reasonable conduct to advocate for patients, to recommend improvement in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital such as serving on the medical staff of other hospitals or entities.

PROCEDURE

This policy will be implemented in a manner that carries out the following activities:

- Set and communicate clear expectations of behavior, including wide dissemination of this policy;
- Measure performance of individuals compared to these expectations;
- Provide timely and periodic feedback of performance to individuals;
- Manage poor performance when patterns of disruptive behavior persist;
- Take corrective action to terminate or limit a provider's medical staff membership or privileges following a single egregious incident or when the problem cannot otherwise be resolved in a timely manner.

Any individual including a physician, allied health practitioner, employee, patient, or visitor may report conduct that they deem disruptive. Individuals may submit a signed, written report to the Chief Medical Officer, Chairman, Member of the Medical Executive Committee or a member of hospital management, who will then forward the complaint to the Chief Medical Officer and the President of the Medical Staff (or to the Vice President of the Medical Staff if the President is the subject of the complaint). Once it is received, the Chief Medical Officer, in consultation with the President of the medical staff, and the Chairman of the Department where the physician is assigned will investigate the report. In all cases, the Medical Staff member who is the subject of the complaint shall be provided with a copy of this Policy and a copy of the complaint in a timely fashion but in no more than 30 days from receipt of the complaint by the Chief Medical Officer. The subject Medical Staff member shall be provided an opportunity to respond in writing to the complaint. The Chief Medical Officer with the Department Chairman, after consultation with the President, may dismiss any unfounded report and may dismiss any complaint if it is not possible to confirm it's authentic and severity and will notify both the complainant and the subject of the complaint of the decision reached, a confirmed report will be addressed as follows:

(See flow diagram)

1. It shall be made clear to the subject of the complaint that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question is a violation of this policy and grounds for further disciplinary action.

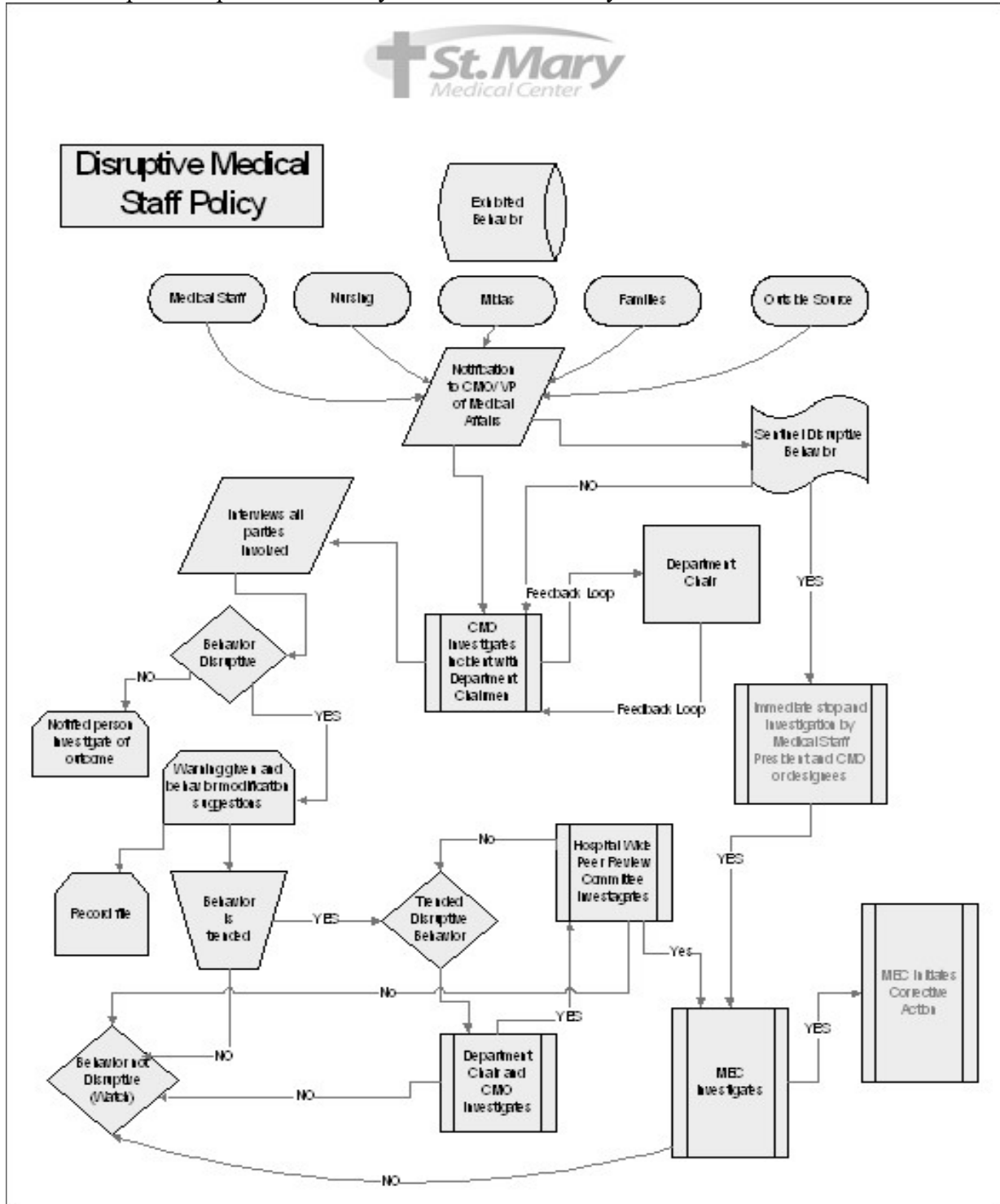
Title: Disruptive Unprofessional Physician Conduct Policy and Procedure

2. A single confirmed incident warrants a discussion with the subject of the complaint. The Chief Medical Officer, Department Chair or designee shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The offending Medical Staff member may be asked to apologize to the complainant. The Chief Medical Officer, Department Chairman or designee will provide the offender with a copy of this policy and inform the individual that the Medical Staff Bylaws requires compliance with this policy. The approach during such an initial intervention should be collegial and helpful to the individual and the hospital.
3. Further incidents that do not cluster into a pattern of persistent disruptive behavior will be handled by providing the individual with notification of each incident and a reminder of the expectation that the individual comply with this policy, i.e. as a rule violation.
4. If the Chief Medical Officer or Department Chairman determines the individual is demonstrating persistent disruptive behavior, the Chief Medical Officer, Department Chairman or designee shall discuss the matter with the individual as outlined below:
 - As with the single confirmed incident, the Chief Medical Officer, Department Chairman or designee will provide the offending individual with a copy of this policy and inform the individual that the medical executive committee (MEC) and board of trustees require compliance with this policy. Failure to agree to abide by the terms of this policy shall be grounds for incremental corrective action as defined by the policy.
 - Because documentation of each incident of disruptive conduct is critical as it is ordinarily not one incident alone that leads to corrective action, but rather a pattern of inappropriate conduct, the Chief Medical Officer, Department Chairman or designee shall document all meetings regarding professional conduct in writing through at least a follow-up confidential letter to the subject of the complaint. The letter will document the content of the discussion and any specific actions the subject of the complaint has agreed to perform or is required to perform.
 - If the offending behavior continues, the Chief Medical Officer, Department Chairman will forward the behavioral complaint to the Hospital Wide Peer Review for its confirmation. If this behavior is deemed by the Hospital Wide Peer Review Committee to be Disruptive Behavior then the MEC is informed. The MEC will hold a meeting(s) with the offending individual until the behavior stops or Corrective Action is initiated (see Medical Staff Bylaws for Corrective Action).
5. A confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending medical staff member, if any, shall be retained in the Medical Staff member's credentials file and shall include the following:
 - The date and time of the questionable behavior
 - A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient
 - The circumstances that precipitated the situation
 - A factual and objective description of the questionable behavior

Title: Disruptive Unprofessional Physician Conduct Policy and Procedure

- The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations
 - A record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening and follow up action steps agreed to by the individual involved and the individual(s) performing the intervention.
6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of any individual or individuals the offending individual may be summarily suspended or Corrective Action initiated as provided in the Medical Staff Bylaws. The Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

Title: Disruptive Unprofessional Physician Conduct Policy and Procedure



SCOPE/APPLICABILITY

Medical Staff Office

Version #: 1

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Title: Disruptive Unprofessional Physician Conduct Policy and Procedure

DEFINITIONS

Consistent with the objective above, unacceptable, disruptive conduct may include, but is not limited to, behavior such as the following examples:

- 1) Attacks—verbal or physical—leveled at r employees, other physicians, allied health practitioners and/or patients or patients’ families that are personal, irrelevant, or beyond the bounds of appropriate, professional conduct;
- 2) Inappropriate comments or illustrations made in patient medical records or other official documents that impugn the quality of care in the hospital or attack particular physicians, nurses, or hospital policies;
- 3) Criticism leveled at the recipient in such a way that is intended to undermine confidence, belittle, or imply stupidity or incompetence;
- 4) Behavior in committee, department, or other medical staff or hospital affairs that is intimidating, rude, disrespectful, threatening, or otherwise intentionally unprofessional or inappropriate. The AMA model policy also has as examples, deliberate lack of cooperation without good cause and deliberate refusal to return phone call, pages, or other messages concerning patient care and safety.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Medical Staff Office.

RELATED PROCEDURES AND OTHER MATERIALS

The Joint Commission, The American Medical Association

EFFECTIVE DATE: 07/31/2018

POLICY & PROCEDURE TITLE:

Flu Vaccination Policy and Procedure for Health Care Workers

REVIEW BY: 07/24/2022

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: Excellence

PURPOSE

The purpose of this policy is to protect the health and safety of patients, colleagues and the a community as a whole from influenza infection through annual influenza vaccination.

POLICY

It is the policy of St. Mary Medical Center ("SMMC") that all health care workers ("HCW") working at a SMMC facility are immunized against influenza on an annual basis. Influenza vaccination is a condition of employment at SMMC. HCW working at SMMC include all colleagues, licensed independent practitioners, volunteers, students/trainees, vendors and contractors. Colleagues include anyone who is on the SMMC payroll.

**PROCEDURE
PROCEDURE**

1. All HCW identified in this policy are required to be immunized against influenza each year unless a specific exemption is requested and approved by St Mary Medical Center. St. Mary Medical Center ("SMMC") that all health care workers ("HCW") will provide influenza vaccinations free of charge to all HCW.

Title: Flu Vaccination Policy and Procedure for Health Care Workers

2. Vaccine will be required and administered during pre-employment physicals for all new hires as soon as available continuing through March 31st. Otherwise, the colleague must receive the vaccine during the influenza vaccine program in the fall.
3. Annual vaccination will begin at the discretion of SMMC.
4. If HCW obtains the influenza vaccination from their physician, another health care facility, or other vaccination service available in the community, they must provide proof of immunization to SMMC Colleague Health Department on an annual basis. Proof of immunization is defined as a record of administration which includes vaccine manufacturer and lot number, date of administration and name of administrator.
5. Exemptions
 - a. SMMC may grant exemption to annual influenza vaccination for medical or religious beliefs only.
 - b. In either case, the requestor must complete an “Influenza Vaccination Exemption Request Form” and submit with either the Medical Exemption Form. All form is available through the Colleague Health Department and on the SMMC Intranet via the Colleague Health Department.
6. Medical Exemption
 - a. HCW requesting a medical exemption due to medical contraindications must submit an “Influenza Vaccination Medical Exemption Form.” The form must be completed by the HCW’s primary care physician and returned to the Colleague Health Department.
 - b. Standard criteria for medical exemption will be established based on recommendations from the Centers for Disease Control and Prevention (CDC). Medical exemptions may include:
 - i. Severe allergic reaction to eggs; laboratory testing to confirm egg allergy will be conducted at SMMC at no cost to the colleague and must be submitted along with the Medical Exemption Form from the HCW’s primary care physician or certified allergist.
 - ii. History of previous severe allergic reaction to influenza vaccine or a component of the vaccine.
 - iii. History of Guillain-Barre Syndrome.
 - c. The HCW requesting the medical exemption will be notified in writing as to whether his/her request has been granted by the Colleague Health Department
 - d. The HCW requesting the exemption is providing permission to release the medical request and any supporting documentation to SMMC representatives, on a need to know basis, who will be reviewing the exemption request.
 - e. If a medical exemption request is denied, the HCW may appeal the decision. The appeal will be decided by the CMO in conjunction with the VP of Colleague Resources and Development.
 - f. If a medical exemption is granted for a temporary medical condition, the individual must resubmit a request form for exemption annually.
 - g. If the exemption is granted permanently, the individual does not need to submit a request for medical exemption annually unless vaccine technology changes and eliminated issues related to allergies.
7. Exemption Denial
 - a. HCW whose exemptions are denied are required to receive the influenza vaccination.
8. Exemption Granted
 - a. HCW whose exemption is granted may be required to wear a surgical mask for the

Title: Flu Vaccination Policy and Procedure for Health Care Workers

duration of the influenza season in order to reduce the risk of influenza.

9. Compliance Monitoring
 - a. The Colleague Health Department will maintain records and monitor compliance for colleagues.
 - b. The Volunteer Office will maintain records and monitor compliance for volunteers and students.
 - c. The Medical Affairs Office will maintain records and monitor compliance for all licensed independent practitioners.
 - d. The area responsible for its own outside contractors will be responsible for maintaining records and monitoring compliance
10. Corrective Action Procedures
 - a. All HCW subject to this policy must be vaccinated or granted an exemption by the final day of the annual program. HCW without an approved exemption on file who do not get the flu shot and fail to provide acceptable documentation by the final day of the annual program to the Colleague Health Department may be subject to disciplinary action up to and including termination of employment.
11. Vaccine Shortages
 - a. In the event of an influenza vaccine shortage, the situation will be evaluated by SMMC, relying on the expertise of colleague health services, infection prevention and control, human resources, pharmacy, hospital management and medical leadership

In the even to of a shortage, influenza vaccination will be offered to HCW's based on job function and risk of exposure to influenza. Priority will be given to HCW's who provide direct, hands on patient care with prolonged face-to-face contact with patients, care for patients at high risk, for complications from influenza and/or have the highest risk of exposure to patients with influenza, as well as to personnel who are at high risk for complications from influenza.

SCOPE/APPLICABILITY

All Departments

DEFINITIONS

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Colleague Health and Human Resources

RELATED PROCEDURES AND OTHER MATERIALS

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

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

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

Creighton Medical Associates Policy and Procedure

Physician Education

Prevention of Central Line Associated BSI

- Use maximal barrier precautions when inserting a central line.
- Maximal barrier precautions includes:
 - Wash hands before line insertion
 - Don gown, cap, mask, large patient drape and gloves
 - Anyone in the room during line insertion must don gown, mask, cap and gloves
 - Use chlorhexidine prep as the solution to prep the skin site. Chlorhexidine must be allowed to completely air dry. Do not wave over the site or blow on the site.
- Limit the number of personnel in the room during line insertion
- If you are assisting with the insertion, you are empowered to **STOP** the procedure if maximal barrier precautions are not followed.
- During the "Time Out" – right patient, right procedure, right site is verified as well as **All maximal barrier precautions** are implemented



- Apply Biopatch to the insertion site before applying the dressing
Remove catheter as soon as possible

Prevention of Urinary Catheter Associated Infections

Approved Indications for Use:

- Strict I and O for the critically ill patient
 - Treating urinary retention that cannot be treated by other methods, such as intermittent catheterization or medication.
 - Palliative or hospice care for end of life.
 - Stage III or IV pressure ulcer of the trunk or perineal wound.
 - Treating certain urologic conditions such as prostate/urinary obstruction or those, individuals followed under the care of an urologist, recent urologic surgery, or trauma conditions.
 - Post-surgical procedure – the catheter is removed by postop Day 2 with day of surgery as Day Zero.
- Do not order urine specimens for smelly, cloudy urine
 - If someone complains of frequency or burning post catheter removal – this may happen within the first several hours –ask the question “Is this new and persistent” before ordering the culture
 - Do not treat asymptomatic bacteriuria
 - Ask “Is the catheter necessary?” If not, remove it.
 - If there is no indication that the patient will be treated - why order the culture?
 - Use an external catheter first and the bladder training protocol.
Remove catheter as soon as possible

Prevention of Ventilator Associated Pneumonia

- Elevation of the head of the bed 30-45 degrees
- Oral care with Chlorhexidine (every 2-4 hours)
- Daily “sedative interruption” and daily assessment of readiness to extubate
- Peptic ulcer disease (PUD) prophylaxis

- Deep venous thrombosis (DVT) prophylaxis (unless contraindicated)
 - Shut off tube feeds when lying patient flat
- Remove the ventilator as soon as possible**

Prevention of Surgical Site Infections

- Order CHG bath the night before surgery
- Obtain MRSA Screen if patient is high risk for infection or has a history of MRSA
- Order MRSA Screen preop for total joints, spinal, cardiac and CABG surgeries
- Preop: clip hair if needed. Clip hair in the Preop Area only
- Administer antibiotic within 1 hour of incision
- Administer the appropriate antibiotic for surgery type
- Postop antibiotics are not necessary for clean or clean-contaminated cases
- Remove urine catheters by Postop Day 2 (surgery day = Postop Day 0)
- Demonstrate aseptic technique with postop wound care. Wash hands before and after all wound care.
- Change wet dressings as soon as possible

Multidrug Resistant Organisms

MRSA Screens:

As per PA State Law, we must screen

- Those with a history of MRSA
- Those admitted from a nursing home, another hospital or Rehab facility
- Those on dialysis
- Those admitted or transferred into the critical care units

- Contact Precautions – automatic gloves. Do not wear gloves in the hallway. Remove gloves upon exiting the patient room.
- Foam in and Foam Out
- Wear gown with skin to skin, skin to clothing, body to body contact such as transferring a patient, getting the patient out of bed, cleaning the patient
- Clean equipment after each patient use

Clostridium difficile

Diarrhea Protocol

- Nurses complete a Diarrhea Protocol every 12 hours.
- The protocol will reflex to a culture if the patient meets criteria
- A physician order is not needed for culture

Day of Admission, Day 2 and 3:

- ✓ If patient presents with diarrhea, send the first stool – GIARRAY test is ordered

Day 4 and After:

- ✓ Wait for 3 loose stools in a 24 hour timeframe, with no laxatives – C. diff by PCR is ordered

Hand Washing

Hospital Policy: either,

**Foam In and Foam Out of every patient room
or Wash In and Wash Out**

EFFECTIVE DATE: 01/09/2020

POLICY & PROCEDURE TITLE:

Code of Conduct

REVIEW BY: 01/09/2022

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

PURPOSE

Our mission and core values will guide the behavior of all directors/trustees, colleagues, affiliated professionals, contractors, volunteers, students and others affiliated with Trinity-Health Mid-Atlantic (THMA). This policy sets forth the standards by which all those above will conduct themselves in order to protect and promote organization-wide integrity and to enhance the ability of THMA to achieve its business and strategic objectives in a manner consistent with the Mission and Values of THMA, the *Ethical and Religious Directives for Catholic Health Care Services (5th ed.)* and applicable laws and regulations.

POLICY

This policy sets forth for trustees/directors, colleagues, affiliated professionals, contractors, volunteers, students and others affiliated with THMA the ethical framework within which THMA operates. Anyone found to be in violation of the Code of Conduct is subject to discipline, up to and including termination.

PROCEDURE

In keeping with the Mission and Values of THMA, all of its trustees/directors, officers, colleagues, affiliated professionals, contractors, volunteers, students and others affiliated with THMA are expected to comply with the following guidelines.

THMA colleagues and affiliated professionals shall maintain high standards of business and ethical conduct in accordance with applicable federal, state, and local laws and regulations including fraud, waste and abuse. They shall adhere to both the spirit and letter of applicable

Title: Code of Conduct

federal, state and local laws and regulations. Instances of non-compliance shall be promptly reported, and appropriate corrective actions shall be immediately taken.

- All new colleagues will review and acknowledge their adherence to the Code of Conduct.
- All colleagues will annually review and agree to abide by the code of conduct.
- All medical staff members and affiliated professionals will review and agree to abide by the code of conduct as part of the medical staff credentialing and re-credentialing process.
- All trustees/directors will annually review and agree to abide by the code of conduct

SCOPE/APPLICABILITY

THMA and all its subsidiaries.

DEFINITIONS

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from Integrity and Compliance Department.

RELATED PROCEDURES AND OTHER MATERIALS

Refer to the Code of Conduct and related Supplements.