2025 NORTH MISSISSIPPI MEDICAL CENTER – MEDICAL STAFF ANNUAL EDUCATION

ABUSE/HARASSMENT

Abuse screening should be evaluated upon admission and anytime during the patient's hospital stay if there is cause. Any person who has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse or exploitation should report or cause a report to be made of the abuse or exploitation.

Reporting - For suspected abuse and/or neglect in patient's home, make oral report within approx. twenty-four (24) hours to Department of Human Services. For suspected abuse and/or neglect in care facility, make oral report within approx. twenty-four (24) hours, excluding weekends and legal holidays, to appropriate agency listed below. Make written report within approx. seventy-two (72) hours. Make accounting of disclosures in HIPAA database located on NMMC intranet.

- Mississippi State Department of Health Hotline – 1-800-222-8000
- Elder/Vulnerable Adult Abuse Hotline – 1-844-437-6282
- Medicaid Fraud and Abuse – 1-800-852-8341
- Alabama State Adult Protective Services – 1-800-458-7214
- Marion County Department of Human Resources – 205-921-6000

Recognition Criteria - Adult

- Physical signs – bruises; fractures; lacerations/cuts/skin tears/bite marks/bed sores; burns; untreated medical conditions; poor skin condition or personal hygiene; malnourished or dehydrated
- Sexual – torn, stained or bloody underclothing; lacerations or tears in vaginal area; bruises to breast area; bite marks; burns caused by friction from ropes or chains
- Behavioral/Psychological – reluctance to tell; embarrassment; fear; change in behavior; denial; changes to will or power of attorney; financial issues; feeling of helplessness, depression, diminished self-worth, insecurity; regressive behavior; changes in sleep patterns; over or under medication
- Victims – usually female and over age 75; usually live with abuser; reluctant to tell; may depend on abuser for care; fear consequences of reporting abuse
- Abusers – usually related to victim; usually adult child or spouse; typically, not a voluntary caregiver; usually male; often have problems with drugs or alcohol; may have emotional or chronic psychiatric problems; may be financially or emotionally dependent on victim

Recognition Criteria – Child

- Physical – bruises in various stages of healing and in unusual patterns or clusters; burns; multiple bone fractures in various stages of healing; lacerations, cuts, pinch marks, bite marks, abrasions; malnourished; patches of missing hair
- Neglect – dirty; hungry; poor hygiene; inappropriate dress for weather; lack of supervision; unattended physical problems; tired; listless; no immunizations; abandonment; school absenteeism
- Sexual – torn, stained, bloody underclothing; genital pain or itching; difficulty walking or sitting; venereal disease; swelling, redness, bruising or bleeding in external genitalia, vaginal or anal areas; presence of semen; pregnancy
- Psychological – habit disorders (sucking, biting, rocking, etc.); conduct disorders; neurotic traits; hysteria; obsessions; compulsions, phobias, hypochondria
- Behavioral – wary of adult contact; aggressive or withdrawn; frightened of adults or fear of going home; delinquent acts (vandalism, prostitution, substance abuse, running away from home); poor school attendance; regressive or adaptive behavior; poor peer relationships; appears overly compliant, passive or undemanding; lags in physical, emotional or intellectual development; attempts suicide; begs, steals, hoards or hides food; insatiable appetite; falls asleep in class; inattentive in class; poor grades; unusual sexual behavior or knowledge

CARETAKER'S BEHAVIOR:

- History of abuse
- Harsh discipline inappropriate to child's age, transgression or condition
- Misperception of child – sees as bad, worthless, dumb, useless
- Illogical, contradictory, or vague explanation of child's injury
- Psychotic or psychopathic
- Alcohol or drug abuse patterns
- Attempts to conceal child's injury or protect person responsible for injury
- Chaotic home life
- Shows evidence of apathy or futility
- Diminished intelligence
- Chronic illnesses
- Extremely protective or jealous of child
- Blames or belittles child
- Withholds love
- Withholds physical needs
- Appears unconcerned about child's problems
- Treats siblings unequally

"Abuse and Exploitation, Patient/Resident (Adult) Recognition/Reporting of" – Policy approved 03/22/2023; "Abuse/Neglect, Child: Recognition/Reporting of" Policy approved 03/10/2023

ADVANCED DIRECTIVES

North Mississippi Medical Center recognizes the rights of patients to make informed decisions concerning their treatment. Accordingly, the following guidelines should be followed:

1. Written policies and written procedures should be maintained by North Mississippi Medical Center

ADVANCED DIRECTIVES (CONTINUED)

2. Written information should be provided to each adult patient concerning:
   a. Rights under applicable Mississippi or Alabama law to make decisions about medical care, including the right to accept or refuse medical or surgical treatment, and right to execute advance directives, and
   b. North Mississippi Medical Center written policies to implement the adult's rights
3. Documentation should be maintained in the patient's medical record indicating whether or not the patient has executed an advance directive. If patient has an advance directive, patient should be asked to provide a copy to NMMC. If a copy of the Advance Directive is not received from the patient within approximately twenty-four (24) hours, staff should ask once more if patient fails to provide a copy of the Advance Directive.
4. It is the patient's responsibility to provide a copy of the advance directive to North Mississippi Medical Center. Two (2) types of advance directives are statutorily recognized in Mississippi and Alabama, the Individual Instruction and the Power of Attorney for Health Care (PAHC). North Mississippi Medical Center should follow as required by law each of these documents if properly executed. To be properly executed, the Individual Instruction:
   a. An adult or emancipated minor may execute a Power of Attorney for Health Care
   b. can be written or oral;
   c. the instructions may be limited to take effect only if a specified condition exists or arises;
   d. no specific format is required; however, Alabama statutes do specify an acceptable format for instructions dealing with end-of-life decisions – that document is the PAHC; and not have been revoked.
5. To be properly executed, the PAHC should:
   a. Contain the language set out in the law;
   b. Be witnessed by two (2) witnesses who personally know the declarant and believe the declarant to be of sound mind, or notarized.

      <u>The two (2) witnesses should not be:</u>
      i. The agent;
      ii. a health care provider;
      iii. an employee of a health care provider or facility; or
      iv. an employee of North Mississippi Medical Center, and
      v. at least one of the witnesses should also not be entitled to any part of the estate under a will or by operation of law or be related by blood, marriage or adoption to the patient.
   c. Appoint a proper agent to make health care decisions; and
   d. Not have been revoked
6. When a patient's advance directive cannot be honored because of legal, ethical, or questionable compliance with applicable laws, rules, and/or regulations, the patient should be informed of the physician(s) and/or health care facility declining to follow the advance directive. The physician and North Mississippi Medical Center should assist in the facilitation of the patient's transfer to another appropriate physician and/or health care facility.
7. If another physician and/or health care facility will not accept the patient, North Mississippi Medical Center may undertake appropriate legal action.
8. Advance directives not properly executed may not be legally binding, however, North Mississippi Medical Center recognizes these and other written instructions concerning care when the individual is incapacitated as the expressed wishes of the patient and should honor these to the extent possible under the law and considering the individual circumstances.
9. If no written advance directive exists, the patient may orally express their advance directive to their physician or supervisory nurses who may document the patient's intent.
10. A patient may revoke all or part of the advance directive and/or the PAHC in writing or by orally informing the supervisory healthcare provider.
11. Patients should be advised that their advance directive may not be effective during surgical procedures or other procedures utilizing conscious sedation.
12. Written advance directives from another state should be honored to the extent they comply with applicable Mississippi or Alabama law.
13. North Mississippi Medical Center should not condition the treatment of the individual or otherwise discriminate against him/her based upon whether or not the patient has executed an advance directive.
14. Education in advance directives should be provided to hospital staff through the PI/Education Department. Documentation of this participation should also be maintained by the Education Department.
    a. Education in advance directives to the community should be coordinated by the Community Outreach Department of North Mississippi Medical Center or North Mississippi Medical Center-Education Department.

    Upon each admission of an adult or emancipated minor (inpatient, observation or outpatient) the following guidelines should be followed:
    a. The existence of an advance directive should be determined by asking patient or representative.
    b. If patient has written directive and provides a copy, such should be placed as the top sheet of the medical record.
    c. If patient has written directive but does not have a copy,
       a. Instruct him/her to furnish a copy when/if available
       b. Document same in the patient's medical record.

ADVANCED DIRECTIVES (CONTINUED)

d. If patient does not have an advance directive, advance directive information (booklet) should be provided to the patient or the patient's representative. **Note:** ER and Outpatient areas provide advance directive information upon request.

e. Document in nursing admission or comparable pathway.

"Advance Directives" – Policy approved 04/05/2023

COMPLAINTS AND GRIEVANCES

A complaint is an oral or written expression of displeasure or dissatisfaction with service received that can be immediately resolved by staff present.

A grievance can be generally defined as a formal or informal written or verbal complaint by a patient, or patient's representative, regarding the patient's care, abuse or neglect, patient harm, issues related to compliance with CMS Conditions of Participation, or Medicare beneficiary billing issues related to rights and limitations, when the complaint is not resolved at the time by staff present.

Billing concerns and complaints **are not** considered grievances. Complaints and grievances involving patient privacy, potential peer review-related matters, any threatened lawsuit, and/or any claimed retention of, or letter from, an attorney are not considered grievances and should be forwarded to the NMHS Chief Legal Officer and handled at the NMHS Chief Legal Officer's direction.

For grievances, NMMC should, within approximately seven (7) to ten (10) business days after receiving the grievance, provide written notice to the patient acknowledging its receipt. Once resolved as determined by NMMC in its sole discretion, an additional written notice acknowledging its completion should be provided to the patient. A grievance is generally considered resolved when the patient is satisfied with the actions taken on his/her behalf. However, when the patient remains unsatisfied with NMMC's review and response, NMMC, in its sole discretion, may consider the matter closed.

The NMMC Performance Improvement Committee should review complaint and grievance data collected and should report same to the NMMC Governing Board.

Information regarding the NMMC grievance process is provided to patients and representatives. Information regarding the grievance process is given to all employees through New Employee Orientation, Annual Review, and additional training as needed.

A patient, legal guardian or other person designated by the patient as their patient representative, has the right to request a review by the following organization if their complaint or grievance is not resolved to their satisfaction:

MS State Department of Health
Post Office Box 1700
Jackson, MS 39215-1700
(601) 576-7400 or 1-866-458-4948

https://msdh.ms.gov/msdhsite/_static/30,0,83,787.html

AL State Department of Health, Division of Health Care Facilities, Complain Unit
Post Office Box 303017
Montgomery, AL 36130-3017
(1-800-356-9596)

DNV Healthcare USA Inc.
Attn: Hospital Complaints
4435 Aicholtz Road, Suite 900
Cincinnati, Ohio 45245
1-866-496-9647 (phone)
1-281-870-4818 (fax)
www.dnvhealthcareportal.com/patient-complaint-report

Medicare beneficiaries may contact the QIO (Quality Improvement Organization) to lodge a complaint or grievance:

Kepro-Quality Improvement Organization (QIO)
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
(888) 317-0751
https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10287.pdf

"Complaint & Grievance" – Policy approved 03/20/2023

EMERGENCY PREPAREDNESS

Emergency Code System
Code Red – Fire Notification
Code Blue – Patient Resuscitation
Code Green – Emergency Disaster
Code Gray – Inclement Weather
Code Yellow – Hazardous Spill Response
Code Black – Bomb Threat Notification
Code Adam – Infant/Child Abduction
Code Secure – Security Notification
Code Emergency Security Alert – Active Aggressor

Once the authorization to implement the Emergency Plan is received, the designee or the switchboard operator should activate the Emergency Plan by alerting the facility over the paging system using "CODE GREEN" level (1, 2 or 3)" every five seconds for thirty seconds and repeating periodically until an All Clear is given.

- Step 1 – As soon as the alert is given, the **switchboard** will begin calling the individuals on the Emergency Call Back List and the Medical Staff List also contained in the Emergency Plan. At this time the code Green Group page will be initiated by the **switchboard**. The Department Directors will then activate their respective response plans and any call back plans for essential personnel.
- Step 2 – At NMMC, the **switchboard** will contact the following areas by phone and relay "CODE GREEN" and the level since overhead paging is not available in these areas:
  The respective areas are then responsible for notification within their departments.

Infection Prevention	Clinical Quality	Employee Health
Case Management	Surgery	Food& Nutrition

- Step 3 – The switchboard or designee should contact Facility Operations during the hours 7:00 am till 3:30 pm. Local law enforcement, by phone if necessary, during the hours of 3:30 PM through 07:00 AM and on weekends.

EMERGENCY PREPAREDNESS(CONTINUED)

- Step 4 – The switchboard or designee should contact the Bio-Med technicians at NMMC-Tupelo,662-377-3032 or 662-377-3000, on call to provide for a response to any possible medical/communications systems failure.
  - Emergency Preparedness

NOTE: Portable, handheld cellphone/radios are available in Facility Operations, and are carried by Facility Operations and most departments at NMMC-Hamilton.

Text above taken from intranet: "Physical Environment Policies and Procedures", then "Emergency Preparedness", then "Code Green" then "Emergency Operations Plan".

FIRE SAFETY

IF FIRE OR SMOKE IS DISCOVERED:

- In a Patient's Room
  1. Don't panic. Be calm.
  2. **Rescue** the patient from danger and close the doors and windows to the room.
  3. Activate the Fire **Alarm** (pull station) on the wall nearest the exit.
  4. Notify the Communications Team by using the appropriate facility code given location of fire such as nursing room 26 or 4 south room 2201. **Contain** the fire to the room by closing all windows and doors, and if possible, placing linen or towels beneath the door.
  5. **Extinguish** the fire with the available extinguisher, if possible, with regard to your personal safety.
  6. Be prepared to shut off oxygen, if ordered to do so. (Respiratory Therapy should approve this action in accordance with R.T. guidelines.)
  7. Prepare to evacuate. Know your established evacuation route.
  8. Assist and cooperate with the Fire Department.

- In the Nursing Area
  1. Do not panic. Be calm. Do not excite the public.
  2. **Rescue** staff members from the fire area.
  3. Activate the Fire **Alarm** (pull station). Notify the Communications Team, giving exact location of fire. Keep telephone free for emergency calls.
  4. **Contain** the fire by closing all the corridor doors and windows.
  5. **Extinguish** the fire with the available extinguisher, if possible, with regard for your personal safety. Assist and cooperate with the Fire Department.
  6. Be prepared to shut off oxygen, if ordered to do so. (Respiratory Therapy should approve this action in accordance with R.T. guidelines.)
  7. Assign staff to clear halls of any items temporarily stored (deliveries, laptops, crash carts, wheelchairs, etc.)
  8. Prepare to evacuate. Know the evacuation plan for your area.

THE NURSE MANAGER OR THE CHARGE NURSE IN THE PATIENT AREA IS ALWAYS IN CHARGE.

- In a Non-Patient Area
  1. Do not panic. Be calm.
  2. **Rescue** those in the immediate fire area.
  3. Activate the Fire **Alarm**. Notify the switchboard/receptionist by dialing the appropriate number and giving the exact location of the fire.
  4. **Contain** the fire by closing all doors and windows.
  5. **Extinguish** the fire with available extinguisher, if possible, with regard to your personal safety.
  6. Be prepared to shut off oxygen, if ordered. (Respiratory Therapy should approve this action in accordance with R.T. guidelines.)
  7. Prepare to evacuate. Know your evacuation route. Supervisor/manager and/or their designee should document names of evacuees and remain with them as necessary.
  8. Cooperate with the Fire Department when it arrives.

THE DEPARTMENT/FACILITY MANAGER OR HIS DESIGNEE IS ALWAYS IN CHARGE. EXITS TO BE USED IN CASE OF EVACUATION ARE POSTED ON EACH FLOOR.

Text in this section taken from "Physical Environment Policies and Procedures" on intranet, found under "Fire Prevention", then "Fire Prevention Management Plan".

HAZARD COMMUNICATIONS

It is the policy of North Mississippi Medical Center to provide a safe work environment for its employees. The most important avenue for providing a safe work environment is educating employees about the materials they work with and/or the areas in which they work.

The Safety Officer will provide a location for the posting of a Safety Data Sheet (SDS), a list of hazardous chemicals in the workplace, and other safety materials that will advise employees what to do in case of accidents involving certain chemicals or agents is available on the NMHS Intranet.

The Safety Officer will ensure that all necessary safety equipment, clothing and other apparatuses necessary for the safe handling of hazardous waste or chemicals, is made readily available and instructions given in the

HAZARD COMMUNICATIONS (CONTINUED)

proper use and disposal to all employees in their workplace.

Education, along with the Employee Health Nurse, will provide in-depth orientation for all new employees. Education will maintain ongoing educational training for employees presently employed in their department.

The SDS are available on the NMHS Intranet.

Employees are encouraged and may request and receive at any time additional information about hazards in the work environment. This information can be obtained through the NMHS Intranet.

"Hazard Management" – Policy evaluated, revised, and approved June 13, 2024, and "Physical Environment Policies and Procedures" website

HIPAA

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, included Administrative Simplification provisions that required HHS to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

- HHS published a final Privacy Rule in December 2000, which was later modified in August 2022. This rule set national standards for the protection of individually identifiable health information by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct the standard health care transactions electronically. Compliance with the Privacy Rule was required as of April 14, 2003 (April 14, 2004, for small health plans).
- HHS published a final Security Rule in February 2003. This Rule sets national standards for protecting the confidentiality, integrity, and availability of electronic protected health information. Compliance with the Security Rule was required as of April 20, 2005 (April 20, 2006, for small health plans).
- The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules.
- HHS enacted a final Omnibus rule that implements a number of provisions of the HITECH Act to strengthen the privacy and security protections for health information established under HIPAA, finalizing the Breach Notification Rule.
- The official version of all federal regulations is published in the Code of Federal Regulations (CFR). View the official versions at 45 C.F.R.:
  - Part 160: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-160?toc=1
  - Part 162: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-162
  - Part 164: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164

https://www.hhs.gov/hipaa/for-professionals/index.html

INFECTION CONTROL

Hand Hygiene – Alcohol hand sanitizer use is strongly encouraged. Alcohol sanitizers have been shown to be as effective as hand washing for most uses. Perform hand hygiene:

- When entering and exiting patient care environment, regardless of contact with patient or an item in the patient room
- Before and after patient contact
- After touching inanimate objects, i.e., computers, phone, etc., in between caring for patients. ***Hands should be washed after 3-4 uses of alcohol hand sanitizer***
- Use soap and water (15-20 seconds) after caring for patients with C. difficile and if hands visibly soiled

Dispensers are located inside each patient room. Hand hygiene is monitored on staff and physicians, and compliance is reported to Chief Medical Officer monthly.

Prevent the spread of multi-drug-resistant organisms

- Contact precautions for patients with known or suspected MDRO, i.e., MRSA, VRE, ESBL
- Gloves and gowns should be worn upon entry; equipment is strategically located outside the patient room in a cabinet or cart
- Disinfect equipment between patients (this includes computer on wheels)

Prevention of Central-Line Associated Bloodstream Infections (CLABSI)

- Educate patients about CLABSI prevention
- Avoid femoral site – highest incidence of infection
- It is preferred that blood cultures be drawn peripherally and not be drawn from a central line unless absolutely necessary
- Perform hand hygiene; use full body drape; wear mask, cap, sterile gown and sterile gloves; use CHG skin prep

A central line insertion checklist is included in the central line kit and completed for each insertion for adherence.

- Hand hygiene and gloves before changing dressing or accessing port; scrub the hub 15 seconds before all access
- Remove any unnecessary catheter

Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

- Use catheters only when appropriately indicated
- Female and male external catheters are available
- Review necessity of catheter daily and remove as soon as possible
- Avoid unnecessary urine culturing
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INFECTION CONTROL (CONTINUED)

Prevention of Surgical Site Infections (SSI)

- Educate patients about SSI prevention
- Preoperative bathing with soap or antiseptic night before or morning of surgery
- Perform proper surgical scrub on hands
- Weight based prophylactic antibiotic dosing
- Antimicrobial prophylaxis within recommended time of incision
- Normothermia during perioperative period
- Glycemic control
- Minimal traffic in the operating room
- Strict sterile technique
- When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations
- Select an alcohol containing skin antiseptic such as isopropanol with chlorhexidine gluconate (CHG) or povidone iodine, unless contraindicated

For detailed information and guidance on infection control, please see Infection Control Policies & Procedures at the following intranet link:
http://iwww.nmhs.net/infectionctrl/policies.asp

Contagious Illness

- Report any signs or symptoms or positive diagnosis of contagious illness such as Flu, Covid or Norovirus to Employee Health
- Development of signs or symptoms while at work should be reported to Employee Health and staff must stop work **immediately**

Blood Borne Pathogens - Standard precautions imply that any bodily fluid is potentially infectious. This replaces universal precautions which emphasize that visible blood was necessary to consider a body fluid infectious. Standard precautions state that gowns, gloves and goggles or face mask plus shield are used when exposure to body fluids is anticipated, because any bodily fluid is considered potentially infectious.

Transmission precautions are used to supplement standard precautions for special circumstances: (Signage denotes PPE to be utilized)

- Airborne – N95 mask, gown, gloves, appropriate ventilation (HEPA or negative pressure room) – TB is an example
- Special Airborne – N95, gown, gloves, appropriate ventilation (HEPA or negative pressure room), eyewear – COVID is an example
- Contact – gloves, gown, hand hygiene – MRSA, MDRO, ESBL, C. diff are examples
- Droplet – surgical mask, gown, gloves – Influenza, RSV, Meningitis are examples

Sharp or Mucous Membranes Exposures – In the event of an exposure of a potentially infectious body fluid, Employee Health will be ready to assist the physician/provider, recognizing there are consequences of serologic testing after an exposure. That is, serology is obtained at baseline and serially for: syphilis, HBV, HCV, HIV-I.

How to Handle a Blood or Body Fluid Exposure – Clean puncture wounds immediately with soap and water. Mucus membranes should be flushed with water. Report the exposure IMMEDIATELY to Employee Health within the first 15 minutes following the incident by calling (662) 377-1107 Tupelo or (662) 377-3000 Community Hospitals (ask for Employee Health for specific hospital where you are) during business hours. After hours, call the hospital switchboard at (662) 377-3000 and have the on-call Employee Health nurse paged. If the patient is an outpatient, blood should be collected before the patient leaves the facility. Employee Health nurse will advise details.

For detailed information and guidance on exposures, please see the Exposure Control Plan at the following intranet link:
http://iwww.nmhs.net/employeehealth/2023/2023%20Exposure%20Control%20Plan%20with%20Signature.pdf

Antimicrobial Stewardship – Ongoing and systematic effort to optimize the use of antimicrobial medications within a healthcare organization. Key objectives:

- Comply with evidence-based guidelines or best practices regarding antimicrobial prescribing
- Promote rational and appropriate antimicrobial therapy
- Improve clinical outcomes
- Minimize unintentional side-effects of antimicrobial use including toxicity, unnecessary costs associated with pharmaceutical expenses and emergence of resistant organisms

Principles of antimicrobial prescribing:

1. Therapeutic decisions should be based on best available evidence
   a. Empirical antimicrobial therapy (the infective pathogen is not known) or prophylactic therapy should be prescribed according to evidence-based guidelines
   b. When the infective pathogen is known, antimicrobials should be prescribed according to microbiology results and antimicrobial susceptibilities, when available
2. Prescribed antimicrobials should be of the narrowest spectrum possible for achieving the intended effect
3. Dosage, route and frequency of prescribed antimicrobials should be appropriate for the individual patient, as well as the site and type of infection
4. The duration of antimicrobial therapy should be defined and/or regularly reviewed (based on evidence-based guidelines and clinical improvement)
5. Monotherapy should be used in most indications, where clinically appropriate

Restricted antimicrobials (use limited to physicians trained in infectious diseases):

INFECTION CONTROL (CONTINUED)

Amikacin	Amphotericin B Liposomal
Ceftaroline (Teflaro®)	Ceftazidine/Avibactam (Avycaz®)
Cetolozane/Tazobactam (Zerbaxa®)	Colistimethate sodium (Colistin®)
Daptomycin (Cubicin®)	Doripenem (Doribax®)
Isavuconazonium sulfate (Cresemba®)	Meropenem/ Vaborbactam (Vabomere®)
Oritavancin (Orbactiv®)	Posaconazole (Noxafil®)

Antibiotic Stewardship Program shall review antimicrobial regimens on selected patients for:

- Appropriate indication
- Local resistance patterns
- Dose optimization
- Preferred route of administration
- Duration of therapy
- Duplication of therapy
- Drug interactions
- Potential for toxicity

MALIGNANT HYPERTHEMIA

Malignant hyperthermia, although rare, does exist and prompt recognition and intervention are crucial. Malignant hyperthermia is triggered in susceptible patients by inhalational anesthetics (halothane, enflurane, isoflurane, desflurane, sevoflurane) and the muscle relaxant, succinylcholine.

Patients experiencing malignant hyperthermia may exhibit a number of different symptoms, including, but not limited to, unexplained muscle rigidity, unexplained tachycardia, or cardiac dysrhythmia, change in skin color from flush to mottling to cyanosis and tachypnea. A later symptom is fever, with temperatures elevating rapidly.

Please refer to the NAVEX policy on the intranet for detailed guidelines on the treatment of MH, or contact the Malignant Hyperthermia Association of the United States (MHAUS) emergency hotline at (800)-644-9737.

N95 FIT TEST

All employees, employed and non-employed providers, identified by NMHS who are required to wear a respirator must have an initial medical evaluation. Employing departments are responsible for the respirator user's complete medical evaluation and fit test. Respirators used at NMHS include N95, PAPR and other respirators assigned to specific departments; respirators are used per CDC guidelines.

Medical Evaluation – Prior to initial use, medical evaluations shall be provided to employees required to use a respirator while on the job.

- Medical evaluations are required under the following circumstances:
  - If an employee reports medical signs or symptoms related to the ability to use a respirator
  - If a physician or other licensed healthcare provider, program administrator or supervisor recommends
  - If change occurs in the workplace conditions that may increase the burden on the employee
- Medical evaluations will include:
  - A medical history
  - Psychological problems or symptoms of claustrophobia
  - Problems associated with breathing normal during work activities
  - Past or current use of medication
  - Any known physical deformities or abnormalities
- The following may disqualify an employee from wearing a respirator:
  - Facial deformity
  - Respiratory disease affecting pulmonary function
  - Symptomatic coronary disease
  - Endocrine disorders that may cause the employee to suffer sudden loss of consciousness or response capability
  - Any other medical condition or non-medical condition which the employee or provider believes might require restriction should be referred to Employee Health

Fit testing procedures:

- Fit testing will be completed by those specified staff within 30 days of their start date at NMHS
- Employees should be clean shaven initially, annually and when required for patient care
  - *Employees with facial hair will be accommodated for a period, up to but not greater than 12 hours, to shave in the event it becomes necessary for them to wear an N95 mask to provide patient care. All employees who must provide care for patients requiring an N95 mask must be clean shaven or able to maintain an adequate fit of the N95 mask as required.*
- Testing should be completed by your department's clinical educator or departmental safety officer
- Fit testing should be completed annually unless authorized under OSHA Temporary Enforcement Guidelines
- Departments should ensure that staff are fit tested annually and complete the required education unless authorized under OSHA Temporary Enforcement Guidelines
- Fit testing will be administered using the OSHA accepted protocol found in Appendix A in 29 CFR 1910.134. OSHA requires the respirator user to handle the respirator, have it fit tested properly, test the face-to-face seal and wear it in a normal air for a 10-minute period. The fit test must be performed using the same make, model, style and size respirator the employee will be using.
- Reference: https://www.osha.gov/dte/library/respirators/major_requirements.pdf

OPERATING ROOM FIRES (CODE RED PLAN)

Prevention Plan:

A. Reduce or eliminate use of flammable items
   1. Surgical gowns and drapes should resist combustion
   2. Allow surgical skin prep agent to dry completely with no pooling of agent on or under patient before the surgical field is draped.
   3. Fire Safety shall be included in "time out" during high-risk procedures

B. Mandatory staff education during orientation, annually, and PRN on causes/prevention of surgical fires. Education to include:
   1. Fire triad (oxygen, flammable items, heat source)
   2. Alarms, Dial "60"
   3. Location of fire extinguishers (inside each OR suite and one at entrance to OR area)
   4. Location of emergency gas shut off valves (Outside each OR suite along the wall and one in holding area for PACU)
   5. Fiber optic light sources (do not allow to remain on drapes)
   6. Exposed wiring
   7. Evaluate and announce high fire risk procedure during "TIME OUT"

C. Annual staff competency on ESU and OR safey.

D. Emergency Code flip chart that includes Code Red in each OR suite

Evacuation Plan:

A. Dial "60" and RACE:
   Rescue: Rescue those in the immediate fire area
   Alarm: Alarm adjacent areas
   Contain: By closing windows and doors
   Extinguish: Using the nearest available extinguisher with regard to personal safety

B. Plan of Evacuation: Determined by the location and severity of the fire; initiated by Surgery Desk
   1. Patients in PACU will return to their hospital room or other designated areas
   2. Anesthesia will triage patients in PACU in designated evacuation site.
   3. Evacuation from the OR:
      a. The primary surgeon makes the call when to evacuate
      b. Evacuation will be laterally to the Opposite OR suite, PACU or Outpatient department depending on available space and location of the fire. Use caution to maintain sterility of the wound as much as possible during transport.
      c. When patient and staff reach the safe evacuation site, evaluate the patient for injuries from the fire, complete the procedure if possible, and treat accordingly
   4. Assigned Responsibilities:
      a. Scrub Person:
         1. In the event of a small fire on the patient or drapes, immediately take a sterile towel and wet in basin or sterile water and pat or smother the drapes with the wet sterile towel.
         2. If unable to immediately smother the fire, remove the drapes from patient with the direction of the surgeon.
         3. Place necessary instruments and supplies needed to stabilize patient on the stretcher and cover with sterile towel.
         4. Assist with transport of the patient.
      b. Circulating Nurse:
         1. Assist in removing drapes and extinguishing fire if the fire is on the patient or on the drapes. Assist with transporting the patient and staff to designated evacuation site that is determined by surgeon. Dial "0" to report the location of the fire. Alert evacuation sites of incoming patient and staff.
         2. Clear a path from the table to the door
         3. Bring the stretcher into the OR and assist with moving the patient. The patient may be transported on the OR table, if necessary.
         4. Assist anesthesia with breakdown of patient from the anesthesia machine. Assist with supplies needed for transport (suture, drugs, monitor, O2).
         5. Listen for instructions by anesthesia to shutdown all gases via the emergency valves outside each OR room.
      c. Anesthesia personnel: Bring stretcher into the OR and assist with moving the patient. The patient may be transported on the OR table, if necessary.
         1. Gather supplies necessary to maintain airway and for transport (drugs, ambu bag, O2, fluids, etc.)
         2. Ensure shutdown of all gases via the emergency valves outside each OR room
         3. Assist with movement of patient to stretcher
         4. Maintain airway and ventilation of patient
      d. Surgeon(s):
         1. Stabilize the patient
         2. Assist in moving and transporting the patients
         3. Give final order to evacuate to a certain area.
         4. After reaching safe evacuation site, evaluate the patient for injuries from fire, complete the procedure, and treat.

C. Emergency Transport Supplies:

1. Ambu bags are located on each anesthesia machine and on each crash cart in the OR.
2. Additional Oxygen transport tanks are located beside anesthesia supply room. The number of patients needing O2 must be identified. If additional tanks and regulators are needed, respiratory therapy will need to be notified.
3. Portable vital sign monitors are available in PACU and in holding area for transport if anesthesia personnel deems necessary.

ORGAN, TISSUE, AND EYE PROCUREMENT

When identifying potential organ and tissue donor procurement, the guidelines below should be followed:

Definitions:

Criteria for death – a person is medically/legally dead when either of the following occurs:

A. Cardiac and respiratory functions irreversibly cease.
B. Irreversible cessation of brain function, including the brain stem, as determined by a licensed physician in accordance with acceptable medical standards. Physician pronouncing will complete the "brain death determination physician progress note".

Imminent Death – an individual who has sustained a severe neurological insult, on ventilator support with a Glasgow coma scale of 5 or less; or is determined to be non-survivable in which the family has made the conscious decision to terminate ventilator support.

Donor – an individual whose body or part is the subject of an anatomical gift.

Brain Dead Organ Donor – an individual who is pronounced brain dead and is being maintained on mechanical support.

Donation after Circulatory Death (DCD) Donor – an individual maintained on mechanical support in which the family has made a conscious decision to terminate the ventilator may be considered for Donation after Circulatory Death as an alternative option for organ donation.

Donor management should not be initiated prior to authorization from the family or designated legal representative. If authorization for organ donation has been obtained, Legacy of Hope (AL) or MORA (MS) should initiate donor management. In cases of DCD organ donation, Legacy of Hope (AL) or MORA (MS) should not assume management of the donor before cardiopulmonary cessation occurs. Legacy of Hope (AL) or MORA (MS) may offer clinical support to the attending physician(s) if requested. All treatment orders must come from the attending physician or designee.

Tissue Donor – any individual whose cardiac and respiratory functions have ceased may be considered for tissue donation.

Timely Notification – a timely referral is one that is made within one hour of expiration for tissue and eye donation or within one hour of meeting the clinical triggers for potential organ donation.

Implementation: Organ and Tissue Donation:

Nursing: The nurse should make a referral to Legacy of Hope (AL) or MORA (MS) within one hour of after patient expires or within one hour of patient meeting the clinical triggers for organ donation through the AL Donor Referral Line at 1-800-252-3677 or 1-800-423-7811 and the MS Donor Referral Line at 1-800-362-6169 for:

- Ventilated patients with a neurological injury or a Glasgow Coma Scale of five or less.
- Patients with a non-survivable illness and whose family has made the decision to remove ventilator.

Legacy of Hope (AL) Representatives should be available 24 hours a day through the Donor Referral Line at 1-800-252-3677 or 1-800-423-7811. MORA (MS) Representatives should be available 24 hours a day through the Donor Referral Line at 1-800-362-6169. The primary nurse should initiate the referral and document appropriately in the patient's medical record. (Legacy
of Hope (AL) or MORA (MS) referral made, date, and time, per policy and procedure.)

The primary nurse should provide the following information to MORA (MS) or Legacy of Hope (AL):

- Facility and unit where the patient is located
- Patient name, gender, age, race
- Medical record number
- Mechanism of injury
- Is the patient on a ventilator: Yes or No
- Does the patient still have a heartbeat: Yes or No

A. DONOR ELIGIBILITY:

ORGAN DONATION (Brain dead patient or DCD potential)
Patients meeting brain death criteria or DCD criteria should not be removed from ventilator or pharmacological support until Legacy of Hope (AL) or MORA (MS) has had the opportunity to initiate the authorization process.

Legacy of Hope (AL) or MORA (MS) representative should determine medical suitability for organ donation and notify the attending physician or designee of its assessment.

B. DCD DONATION PROCESS

Discontinuation of ventilator and support shall be carried out by the designated staff according to existing hospital operating procedure.

The procurement personnel should not participate in discontinuing of life support measures.

Legacy of Hope (AL) or MORA (MS) cannot assume management of the donor until cardiopulmonary cessation occurs. Legacy of Hope (AL) or MORA (MS) may offer clinical support to the attending physicians if requested to maintain organ viability prior to DCD; however, all treatment orders must come from the attending physician or designee.

Discontinuation of ventilator and support will occur in the OR, ICU or PACU.

The recovery/transplant team must be absent during the withdrawal of support until declaration of death.

An interval of three (3) minutes must elapse between cessation of cardiopulmonary function and the declaration of death, and the cessation of function to be verified by EKG and blood pressure monitoring.

ORGAN, TISSUE, AND EYE PROCUREMENT (CONTINUED)

Death may be pronounced by a physician or nurse practitioner. The physician or practitioner is responsible for documentation of findings in the medical record to include the date and time that death was pronounced and, if applicable, complete the death certificate.

If death does not occur within an acceptable time frame determined by the recovery team, the patient will be transported to a designated room where comfort measures will be maintained until expiration.

TISSUE/EYE DONATION (All expired patients)

A Legacy of Hope (AL) and/or MORA MS Lions eye bank representative should determine eligibility for tissue and/or eyes. The Legacy of Hope (AL) or MORA (MS) representative should contact the primary nurse for family contact information.

C. DONOR AUTHORIZATION: For potential donor candidates:

1. When the patient meets criteria for organ donation, the physician or healthcare provider has had the opportunity to notify and explain the diagnosis of brain death to the family, or the family has made the decision to withdraw ventilator support, Legacy of Hope (AL) or MORA (MS) should initiate the process of discussing the organ donation opportunity with the family.
2. If family asks for information regarding donation before brain death is pronounced, appropriate information may be provided. Notify Legacy of Hope (AL) at 1-800-252-3677 to ask a representative to provide this service. Notify MORA at 1-800-362-6169 to ask a representative to provide this service.
3. Family Care Specialists from Legacy of Hope (AL) or MORA (MS) shall collaborate with the hospital staff on all potential organ donors. This collaborative approach helps to ensure that all potential organ donor families are given information they need to make a fully informed decision concerning donation. Eligibility for organ donation must be determined prior to the family discussion.
4. Patients meeting brain death criteria or DCD criteria should not be removed from the ventilator or pharmacological support until Legacy of Hope has had the opportunity to initiate the authorization process.
5. For Alabama Legacy of Hope will access the pertinent state donor registry to determine if the potential donor has made an anatomical gift before his/her death, once authorization is verified, Legacy of Hope should notify the family of the potential donor's wishes prior to death and complete disclosure documentation. For Mississippi MORA will access the pertinent state donor registry to determine if the potential donor has made an anatomical gift before his/her death in accordance with the Revised Mississippi Uniform Anatomical Gift Act (first person authorization). Once authorization is verified, MORA should notify the family of the potential donor's wishes prior to death and complete disclosure documentation.
6. Legacy of Hope (AL) or MORA (MS) personnel will approach the family concerning their options of organ and tissue donation. Initiate the process of discussing the organ/tissue donation option with the family with reasonable discretion and sensitivity to the family's circumstances, values or beliefs and obtain consent if the family agrees to a donation. Information should be given to the next of kin so that a fully informed decision concerning donation may be made.

   The decision to donate or not should be documented in the patient's medical record. In the case of expired patients who will only be evaluated for tissue/eye donation, the family should be contacted by a Legacy of Hope (AL) or MORA (MS) representative to discuss. The Legacy of Hope representative should obtain a donor risk assessment from the family to confirm donation status.
7. For donation purposes, unless there has been a prior notice of opposition by the deceased, any of the following family members (in order of priority) may give consent for organ/tissue donation:
   - Agent of the decedent at time of death who could have made anatomical gift immediately before decedent's death
   - Spouse of the decedent
   - Adult child of the decedent
   - Parents of the decedent
   - Adult siblings of the decedent
   - Adult grandchildren of the decedent
   - Grandparents of the decedent
   - An adult who exhibited special care and concern for the decedent
   - Persons acting as guardians of the person of the decedent at the time of death
   - Any other person having the authority to dispose of the decedent's body
8. If there is more than one member of a class listed above, entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.
9. A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class is reasonably available to make or to object to the making of an anatomical gift.
10. The Legacy of Hope (AL) or MORA (MS) representative should make arrangements for the appropriate organs and/or tissues to be removed.

ORGAN, TISSUE, AND EYE PROCUREMENT (CONTINUED)

11. The death should be pronounced prior to recovery of organs and/or tissues.
12. Nursing should complete the morgue disposition which will accompany the donor to either the operation room and/or given to security when the body is placed in the morgue. The funeral home should NOT be notified until the patient's donation status has been determined. Once status is determined, the funeral home may be notified when the body is ready for transport.

    If confirmed for eye donation, the following procedure should be followed:
    1. Elevate head of bed with one or two pillows, if possible.
    2. Don sterile gloves and irrigate eyes with sterile normal saline.
    3. Close eyelids and tape shut with paper tape.
    4. Apply saline soaked gauze to closed lids.
    5. Apply ice packs over saline soaked gauze.
13. A Legacy of Hope (AL) or MORA (MS) representative should notify Nursing Supervisor when body is ready for release if the organ, eye, or tissue recovery occurs at the hospital.

PHYSICAL ENVIRONMENT

NMHS has a robust Equipment Management Program in place, which contains policies and procedures for the management of Medical Devices, including the installation, maintenance, repair, and disposal of equipment used in NMHS facilities. These procedures have been reviewed and are deemed appropriate and effective in the process of ensuring the health of the patients, staff and visitors who come in contact with NMHS.

The Equipment Management Program may be viewed in its entirety at the following intranet link:

www.nmhs.net/physicalenvironment policiesandrocedures/medicalequipmentplan/

RESTRAINT OR SECLUSION

A ***restraint*** is defined as any method, or device, that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely and is not standard treatment for the patient's medical or psychiatric condition. **Hand mitts are a type of non-violent restraint.**

A ***pharmacological (chemical) restraint*** is defined as a nonstandard treatment or dosage of medication when it is used to control or restrict the patient's behavior or to restrict the patient's freedom of movement.

Seclusion is involuntarily confining the patient in a locked or unlocked room or area where the patient is physically prevented from leaving. Seclusion is used only for the management of violent or self-destructive behavior to protect patients and others.
A ***restraint episode*** is defined as the period of time from one restraint order to the next restraint order.

Physical holding for forced medication: the use of force in order to medicate a patient.

A ***calendar day*** is the twenty-four-hour period from midnight to midnight.

Criteria for discontinuation of restraints/seclusion are that the precipitating behavior has ceased.

Generally, *a restraint does not include the following:*

- Orthopedically prescribed devices, surgical dressings or bandages, protective helmets;
- The physical holding of a patient for the purpose of conducting routine physical examinations or tests;
- Siderails used as defined in the NMMC "Siderails policy";
- A device to permit the patient to participate in activities without the risk of physical harm;
- A device used to maintain a position, limit mobility, or temporarily immobilize the patient during a medical, dental, diagnostic, or surgical procedure.

Medical restraints vs. Behavioral restraints, Chemical restraints, Physical Hold and/or seclusion

MEDICAL (non-violent) RESTRAINTS

For use when a patient is exhibiting behavior that may interfere with lifesaving and/or necessary medical treatment or behavior that indicates that he is unable to follow directions to avoid self-injury. **If a patient is in non-violent restraints for 72 hours, this is considered a prolonged use of restraints.**

BEHAVIORAL (violent) RESTRAINTS, CHEMICAL RESTRAINTS, PHYSICAL HOLD and/or SECLUSION

For use when a patient who is exhibiting violent and/or self-destructive behaviors, verbal/physical threats of harm, physically assaultive, and demonstrates imminent danger to self/others and the environment. **If a patient is in violent restraints for 24 hours, this is considered a prolonged use of restraints.**

IMPLEMENTATION

A. Less restrictive alternative measures to restraints or seclusion should be implemented and evaluated as appropriate. Selected interventions should address risks associated with vulnerable populations, such as pediatric, emergency, cognitively impaired, and/or physically limited patients.
B. Restraint and/or seclusion decisions should be made using clinical justification based on assessed need. This should include:
    1. Less restrictive alternative measures are inappropriate per the assessment and/or have been tried and failed;
    2. If the patient is at risk of harming himself and/or others;
    3. Implementation of least restrictive manner;
    4. Implementation in accordance with safe and appropriate restraining technique;
    5. Ending at the earliest possible time.

C. RESTRAINT OR SECLUSION (CONTINUED)

D. The physician, clinical psychologist, or other authorized licensed practitioner primarily responsible for the patient's ongoing care should order the restraint and/or seclusion prior to implementation but in an emergency situation, a Registered Nurse may initiate patient restraint(s) and/or seclusion. **An order from a physician should be obtained** either during the emergency application of restraint or immediately after the restraint has been applied. (This applies to both non-violent and violent restraint orders.) If the restraint is not ordered by the patient's treating physician, then the treating physician should be notified as soon as he or she rounds. Orders for restraint should be given by a physician and should, in addition to **date and time, type of restraint** and **clinical justification** include the following:

MEDICAL (non-violent)	*BEHAVIORAL (violent) &/OR SECLUSION*
Time limit – Not beyond the next calendar day (order for restraints must be signed each day between 12:01 am and 11:59 pm or the patient must be released at midnight)	**Time limit:** • Adults (age 18 or older) – 4 hours • Age 9 to 17 – 2 hours • < age 9 – 1 hour
Criteria for discontinuation: Precipitating behavior has ceased	**Criteria for discontinuation:** Precipitating behavior, actual or potential injury to self or others, has ceased
Patient should have **face-to-face evaluation** for need for medical (non-violent) restraints and a written order for such restraints by a treating physician **within approx. twenty-four (24) hours of initiation** and not less than once each calendar day thereafter	• A licensed provider should complete **face-to-face assessment within one hour after initiation of restraint and/or seclusion for behavioral (violent and/or self-destructive behavior) and after 24 hours again before a new behavioral (violent) restraint order can be written.** If RN performs face-to-face, attending physician should be notified to discuss findings and document that the physician was notified.
	• Four- or five-point restraints should be used only for violent, self-destructive behavior • **Notification of Clinical Leadership** for application, remainder in restraints and/or seclusion > 12 hrs., or two or more separate episodes of restraint of any duration within a 12-hour period for violent behavior • Physical holding for forced medicating – Get physician order prior to initiation; in urgent situation, RN can initiate physical hold and obtain order immediately thereafter; physician/LIP/competent RN to complete **face-to-face assessment within one hour after administration of the medication and/or physical hold** • Patient and/or family to be provided education regarding justification for restraint and/or seclusion and criteria for discontinuation.

SAFE CARE

Identification of patients at risk of harm to self or others

- Suicide Risk Factors:
  - Current plans
  - Age 50 or above
  - Recent rejection/lack of social support
  - History of suicide in family/social circle
  - Post history of suicide attempt
  - Self-inflicted burns/wounds present
  - History of accidents
  - Recent losses
  - Increasing use of alcohol and/or other substances
  - Chronic pain/health problems
  - Inability to visualize positive outcome to problems (hopeless/helpless)
- Assaultive Behavior Risk Factors:
  - History of violence
  - Exposed to violent lifestyle
  - History of arrests
  - Impulsive behavior
  - History of fire setting
  - Access to weapons
  - Patient threatens/fears loss of control
  - Cognitive/perceptual impairment
  - Recent substance abuse
  - History of sexual abuse
  - History of physical abuse
  - History of cruelty to animals

Identification of environmental patient safety risk factors and mitigation strategies

I. Safety Management -
   a. Employee Health
   b. Infection Control/Prevention
   c. Risk Management
   d. Hazard Surveillance
   e. ICES (Information, Collection and Evaluation System)
   f. Education

II. Security Management – Management of the Secure Environment -

III. Hazardous Materials Management (Parts I and II)
   Part I
   Part II

SAFE CARE (CONTINUED)

IV. Fire Prevention Management
V. Medical Equipment Management
iwww.nmhs.net/per manuals/

VI. Utility Systems Management
VII. Emergency Preparedness Management
VIII. Life Safety Management
iwww.nmhs.net/per manuals/

SAFETY SOLUTIONS/PROCESS IMPROVEMENT/CARE CONNECTIONS

- Care Connections is our system for capturing patient and family member concerns regarding care and treatment
- Safety Solutions: The event reporting process provides an effective method of reporting variances to the Department of Organizational Performance. The reported data is used to monitor, evaluate, and improve the quality and safety of medical services and the physical environment.

More information on Safety Solutions, including training videos and reference guides, may be viewed at the following intranet link:
iwww.nmhs.net/safety_solutions/default.html

- According to CMS, "an error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems."
  - There are many types of errors, including, but not limited to: medication administration errors, surgical errors, equipment failure, infection control errors, blood transfusion related errors, and diagnostic errors. Not every error may reach the patient. These are referred to as near misses. It is just as important to report near misses as it is actual events that cause harm to a patient. Notification through Safety Solutions of both types of events allows us to put processes in place to prevent future harm.
- It is imperative that all providers and staff members play a role in process improvement initiatives. These activities may be triggered from information obtained through Safety Solutions, trends or process variations. NMHS uses PDSA (plan, do, study, act) methodology and actively engages in PI and lean initiatives to standardize and improve processes.

STANDING ORDERS/PROTOCOLS

Creation, revision and periodic review of department order sets, hospital protocols and subdivision/group/individual standing orders follow a defined process. Predeveloped medical orders are reviewed by following the same process a minimum of every two (2) years. Standing and Protocol Orders will be reviewed yearly. The original order set(s) with signature(s) should be maintained by the Physician Order Coordinator for a period not less than that defined by state law, including revisions and versions placed in the EMR.

Guidelines:

1. Order Sets, standing orders and protocols should:
   A. Be reviewed and approved by appropriate medical staff, nursing leadership, pharmacy and other departments as deemed necessary. Minutes from the Order Set Committee Meeting will be shared with Medical Executive Committees at all facilities.
   B. Be evaluated for consistency with nationally recognized and evidence-based guidelines.
   C. Have regular review by the Order Set Committee to determine the continuing usefulness and safety of the order sets as determined by state law, CMS, DNV or other accrediting/regulatory body.
   D. Contain dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.
   E. Provide space for the physician to individualize a specific order within the set as needed.
   F. All sets must follow the naming convention, "Standing", "Protocol", "Convenience", Department i.e.: "CARD", "SURG", etc.
2. To request a new protocol/order set/standing order set or make a change to existing protocol/order set/standing order, **requesting department** should:
   A. Initiate Tracking Form
   B. Electronically submit order set to the Order Set Coordinator
   C. Provide evidence for best practice
   D. Be responsible for obtaining all appropriate signatures
   E. Be responsible for any and all education
3. Order Set Coordinator should ensure that Tracking Form is finalized, and appropriate documents archived

VISITATION (POLICY SUBJECT TO CHANGE)

For the care and protection of our patients, staff and other visitors, hospital reserves the right to limit, restrict or amend visitation.

Inpatients: Visitation 6 a.m. to 9:30 p.m. One visitor may stay overnight. Children must be accompanied by an adult at all times. Visitation may be limited as needed.

Pediatric Patients: Visitation from 6 a.m.-9:30 p.m. Children must be accompanied by an adult at all times. Mother and father or support person only may stay overnight. Visitation may be limited as needed.

VISITATION (POLICY SUBJECT TO CHANGE) (CONTINUED)

COVID-19 Suspected/Confirmed Patients: Two visitors per day at a time at designated times. For an end-of-life situation, visitation is limited to family and clergy.

COVID-19 Suspected/Confirmed Patients with mental status issues or significant disabilities: A family caregiver may stay with the patient. One additional visitor at designated times during the day. For an end-of-life situation, visitation is limited to family and clergy. Caregiver may switch during the stay.

Inpatient Hospice Patients: Unrestricted

Outpatient Surgical Patients: Limited to two visitors.

Emergency Department (ED) Patients: Limited to two visitors. For an end-of life situation, visitation is limited to family and clergy.

ED COVID-19 Suspected/Confirmed Patients: Limited to one designated visitor. For an end-of-life situation, visitation is limited to family and clergy.

We ask that individuals who meet these visitation guidelines refrain from visiting:

- If you have had a positive COVID-19 test in the last 10 days, are currently waiting on results of COVID 19 test, or are isolating because you may have been exposed to a person with COVID-19
- If you have any signs or symptoms of a respiratory infection in the past 48 hours
- Temperature of 100 degrees F or higher
- Cough
- Shortness of breath or difficulty breathing
- Chills
- Muscle pain
- Sore throat
- New loss of taste or smell

Visitors who do not follow personal protective equipment (PPE) guidelines will be asked to leave the premises to protect the safety of our patients and staff.
https://www.nmhs.net/patient-family-information/visitation-policy/ as updated on 09/18/23