Baylor Scott & White
MEDICAL CENTER – HILLCREST
WACO

EDUCATION PACKET

Rev. 5/20

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INTRODUCTION

Hillcrest Baptist Medical Center, DBA Baylor Scott & White Medical Center - Hillcrest is accredited by The Joint Commission (TJC) — a non-profit organization that sets minimum standards for quality and safety in healthcare organizations. TJC is also a deemed-status agency authorized by the federal government to certify healthcare organizations as meeting Medicare Conditions of Participation.

TJC standards require that physicians, other licensed independent practitioners, and other members of the medical staff receive education on selected topics. This packet has been developed to meet these requirements.

Please review the information contained in this packet. **UPON CONCLUSION, PLEASE SIGN THE ACCOMPANYING ATTESTATION RECORD INDICATING THAT YOU HAVE REVIEWED AND UNDERSTOOD THE INFORMATION CONTAINED HEREIN. RETURN THE ATTESTATION ALONG WITH YOUR APPLICATION FOR APPOINTMENT.**

TOPICS

REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION

Members of the medical staff have the right to report a concern regarding the quality or safety of treatment, care, and service rendered by the organization directly to TJC without fear of reprisal or disciplinary action.

ROLE IN THE EVENT OF A FIRE

In the event of a fire, please take the following actions: If you discover or are at the origin of the fire:

- Remove yourself and others from immediate danger
- Alert the nearest staff member of the fire or pull the nearest fire alarm and dial **4444**.
- Confine the fire if you are able by closing doors and windows
- Extinguish the fire if you are able, or take appropriate direction from staff.

If you are away from the origin of the fire:

- Take appropriate direction from staff in the area.

RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT

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

ROLE IN EMERGENCY MANAGEMENT

The organization has established a comprehensive plan to respond to a variety of emergency situations. In the event of a significant emergency (disaster), members of the medical staff will be responsible for providing medical care and support. This may involve such activities as:

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

During an emergency, members of the medical staff shall report to Respiratory Care waiting area 2nd floor. Please enter the building through the associate entrance near the Emergency Department.

BSW Plain Language Emergency Codes

Weather Alerts

- Severe Thunderstorm
  "Weather alert + Severe Thunderstorm Warning + Please remain inside until the weather clears"
- Tornado
  "Weather alert + Tornado Warning + Please remain inside until the weather clears"

Security Alerts

- Missing patient (adult or child)
  "Security alert + missing [child/person] + description [approximate age, gender, clothing if known] + last seen with + last seen location + please notify staff if you see someone that fits this description"
- Person with a weapon or Active shooter
  "Security alert + person with a weapon/active shooter + last known location + please avoid this area"
- Suspicious package
  "Security alert + suspicious package + location + please avoid this area"

Facility Alerts

- Fire/Fire drill
  "Facility alert + fire alarm activation/fire drill + location + please avoid this area"
- HazMat spill
  "Facility alert + hazardous spill + location + please avoid this area"
- Emergency Operations Plan Activation
  "Facility alert + Emergency plan activation + Incident description [ED surge, EPIC outage, Utility outage, etc.]"

Medical Alerts

- Cardiac arrest
  "Medical Alert + Code blue/Pediatric Code Blue + Inpatient/Outpatient + location"
- Rapid Response Team
  "Medical Alert + Rapid Response Team + Inpatient/Outpatient Emergency + location"
- STEMI and Stroke and Trauma
  "Medical Alert + STEMI/Stroke/Trauma Team + location"

MULTI-DRUG RESISTANT ORGANISMS

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

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

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

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

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

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

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

Use of Personal Protective Equipment
Gloves, gowns, and masks should be worn as appropriate to the specific MDRO being treated. Consult appropriate infection control policy or the Infection Control Professional if you have any questions.

Use of Antibiotics
The selection and ordering of antibiotics may be restricted as determined by the organization and medical staff.

Patient Transport
As much as possible and when appropriate, necessary treatments and procedures should be performed at the patient's bedside. If essential tests must be performed in another area, the department should be notified that the patient has an MDRO prior to transporting the patient to the department.

PREVENTING CENTRAL LINE INFECTIONS

It is the policy of *Hillcrest Baptist Medical Center* to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

Equipment & Supplies

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

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

Central Venous Catheter Insertion:

1. If possible, the procedure should be explained to the patient and family. Appropriate consent should be obtained for non-emergent need.
2. All staff involved in the procedure should perform hand hygiene prior to catheter insertion.
3. Maximum barrier precautions should be deployed, including hair cover, masking, and sterile gowning / gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site.
4. If body hair needs to be removed, it should be clipped rather than shaved if possible
5. Only approved antiseptic skin preparations should be used. These include, but are not limited to Chiorhexidine.
6. The femoral site should not be the primary location choice.
7. Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
8. Confirmation of proper placement (e.g. x-ray or other test) should be performed.

Accessing Central Venous Catheters

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

Dressing Changes

Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters

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

PREVENTING SURGICAL SITE INFECTIONS

Our organization is committed to reducing the incidence of surgical site infections. Please note the following evidence-based practices:

Preparation of the Patient

Whenever possible, infections remote to the surgical site should be identified and treated before elective procedures. Elective procedures should be postponed — if necessary — until the remote infection has resolved.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should be done in accordance with accepted standards of care.

The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. Alcohol-based, chlorhexidine-based, and iodine-based are acceptable for use as antiseptics. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary. Beware of patient potential allergy to the antiseptic agent.

Administration of Prophylaxis Antimicrobial Therapy

Prophylactic antimicrobial agents should be administered only when indicated, and selected based on its efficacy against the most common pathogens causing SSI for a specific operation and published recommendations. For questions on appropriate antibiotics please speak with the Director of Surgery or the Quality Department Staff.

Antisepsis for Operative Personnel

Nails should be kept short. Artificial nails should not be worn. Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows. After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.

Surgical Attire and Drapes

A surgical mask that fully covers the mouth and nose must be worn when entering the operating room if an operation is about to begin or already under way, or if sterile instruments are exposed. The mask is to be worn throughout the operation. A cap or hood to fully cover hair on the head and face must be worn when entering the operating room. Sterile gloves must be worn by all scrubbed surgical team members. Surgical gowns and drapes that are effective barriers when wet (i.e., materials that resist liquid penetration) should be used. Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials should be changed out.

Asepsis and Surgical Technique

Principles of asepsis should be adhered to when placing intravascular devices (e.g., central venous catheters), spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs. Tissue should be handled gently, maintain effective hemostasis, minimize devitalized tissue and foreign bodies (i.e., sutures, charred tissues, necrotic debris), and eradicate dead space at the surgical site. A delayed primary skin closure should be used or leave an incision open to heal by second intention if the surgeon considers the surgical site to be heavily contaminated (e.g., Class III and Class IV).
If drainage is necessary, a closed suction drain should be used. The drain should be placed through a separate incision distant from the operative incision, and removed as soon as possible.

Postoperative Incision Care

For an incision that has been closed primarily, the site should be protected with a sterile dressing for 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be deployed. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

USE OF RESTRAINT OR SECLUSION

Policy Statement & Patient Rights

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a convenience, or retaliation by staff.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

The organization will work to actively decrease the use of restraint or seclusion. When restraint or seclusion is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well being. The use of restraint/seclusion is a last resort, after alternative interventions have either been considered or attempted.

Training Requirements for AHP's

All allied health professionals that manage patients placed in restraint or seclusion will have a working knowledge of the hospital policy. Reference policy X.1146.3.100 located in the My Baylor Scott & White Policies and Procedures Library.

Prohibitions to Use of Restraint or Seclusion

The use of restraint or seclusion for the following reasons is strictly prohibited:

- Use that is based solely on a patient's prior history and/or behavior.
- Use as a convenience to staff.
- Use as a method of coercion or as punishment.
- Use as a method for the prevention of a fall.

Requirements for Patient Assessment & Ordering of Restraint or Seclusion

The use of restraint or seclusion must be in accordance with the order of a physician who is responsible for the care of the patient. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Each order for restraint or seclusion must contain at least the following information:

- The name of the patient being restrained or placed into seclusion
- The date and time of the order
- The name of the physician ordering the restraint or seclusion
- The type of restraint or seclusion to be applied
- The time limit (duration) of the restraint or seclusion

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order.

Renewal orders for non-violent/non-self destructive (medical) restraint shall be obtained daily. Renewal orders shall be based on an examination of the patient by a physician.

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

Four (4) hours for adults age 18 and older, Two (2) hours for children and adolescents ages 9 to 17

- One (1) hour for patients under age 9.

The initial order for violent/self-destructive (behavioral) restraint must be time limited and shall not exceed 24 hours.

After 24 hours, before writing a new order, a physician who is responsible for the care of the patient must see and assess the patient.

When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a Physician; or RN or PA who has been trained in accordance with the requirements of this policy.

The purpose of the face-to-face evaluation is to assess; the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.

PAIN MANAGEMENT

Patient Rights

Patients have the right to pain management. It is the policy of our organization to do the following:

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

Treatment of Pain

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

Patient Refusal of Pain Management

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

Decision not to Treat Pain

If a decision is made not to treat a patient's pain and/or refer the patient for treatment, then the clinical justification for that decision should be documented in the patient's medical record.

ANTICOAGULANT THERAPY

Establishment of an Anticoagulant Management Program

Patients receiving anticoagulant therapy shall have these medications ordered, prepared, dispensed, administered, and monitored in accordance with guidelines and requirements established in this policy. The following requirements govern the overall approach to managing patients on anticoagulant therapy:

- There must be a clear and appropriate indication for use
- The particular type of anticoagulation used shall be the most appropriate and clinically indicated for the condition or reason for use.
- Where appropriate, patients laboratory values will be monitored while on anticoagulant therapy

- Pharmacy will review orders for anticoagulant therapy against normative and patient specific information regarding indications for use, dosage, route, frequency, contraindications, duplicative therapy, and drug/drug interactions. Issues or concerns will be brought to the attention of the prescribing practitioner for appropriate resolution (unless in emergent situations) before the medication is dispensed.

Management of Patients Placed on Warfarin Therapy

The following shall be required for patients placed on warfarin:

- The patient should have a baseline International Normalized Ratio (INR) and Complete Blood Count (CBC) drawn within 24 hours of initiation.
- There should be a current INR for the duration of therapy which shall be used to monitor and adjust therapy as warranted.
- INR values should be checked no later than the third day of therapy, and then daily until therapeutic. After therapeutic levels are achieved INRs may be drawn as needed, but not less than weekly for inpatients.
- A CBC should be drawn at least weekly to monitor hemoglobin and platelet levels.
- Authoritative resources shall be used in managing potential food / drug interactions

Management of Patients Placed on Heparin & LMWH

- Patients should have a baseline Complete Blood Count (CBC) and serum creatinine within 24 hours of initiation of LMWH/heparinoid therapy.
- LMWH/heparinoids are dispensed in the commercially provided unit dose product for each patient via the automated dispensing machines or from the central pharmacy.
- Platelet counts should be monitored 2-3 days to evaluate for heparin-induced thrombocytopenia for 14 days from initiation or until the product is stopped, whichever comes first.
- Therapeutic doses of enoxaparin should be based on actual body weight and rounded to the nearest 10mg with no dose capping. Therapeutic doses of fondaparinux should be based on actual body weight.

Ordering of Anticoagulants

Therapeutic anticoagulation prescribing should follow the guidelines as listed above. The Adult Anticoagulant Order form and the Hillcrest Cardiology Heparin Protocol are available for prescribers to utilize. If therapeutic anticoagulation is ordered without recommended laboratory monitoring, a pharmacist may order the necessary laboratory work as recommended by anticoagulation guidelines.

Education of Patients and Families

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

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

PHYSICIAN IMPAIRMENT

Physician impairment is a serious issue. The following may be signs that you or a colleague is impaired.

Personal

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

Friends and Community

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

Professional

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

If you suspect that a colleague may be impaired, it's important that he or she gets the help they need. The medical staff has established avenues where physicians can seek assistance in a safe and confidential way. Refer to medical staff policies for further information. The Compliance HOTLINE is also available at 202-8888.

INFECTION PREVENTION & HAND HYGIENE

Standard Precautions (refer to policy BSWH.ICP.001.P)

Standard precautions are to be used with patient contact or with handling of potentially infectious material or equipment to prevent the spread of infection. Standard precautions consist of:

- Handwashing or use of hand sanitizer
- Using personal protective equipment (gloves, gowns, masks, face shield, eye protection)
- Handling contaminated materials/equipment to prevent cross contamination
- Cleaning/disinfecting environmental surfaces
- Respiratory hygiene/cough etiquette
- Safe injection practices

Isolation Precautions (refer to policy BSWH.ICP.001.P)

Airborne Precautions — requires negative pressure room, enter with N95 mask (TB, Varicella, Shingles)

Disease Reporting: Central Texas

WACO – McLennan Health District
225 W. Waco Dr.
Waco, Texas 76707
Day Phone: (254)750-5450
24/7 Reporting
(254)750-5411

Droplet Precautions — requires mask with eye shield, no special ventilation (Bacterial Meningitis, Influenza, Mumps, Pertussis)

Contact Precautions gown, gloves, disposable equipment (MRSA, MDR-AB, VRE, CRE, CDiff, RSV, Lice, Scabies, any uncontained body fluids/respiratory secretions)

Hand Hygiene

Washing your hands is the single most effective way of preventing the spread of infection. Our organization adheres to the CDC recommendations for hand hygiene:

Wash hands or use hand sanitizes.

- Prior to patient contact
- Before donning gloves
- After patient contact
- After contact with blood or body fluids
- After contact with patient equipment
- After removing gloves

Use soap and water when hands are visibly soiled or when caring for a patient with C-Diff.

MULTI-DRUG RESISTANT ORGANISMS

The antimicrobial stewardship program will follow appropriate therapy for multi-drug resistant organisms (MDRO). Prophylactic antimicrobial agents should be administered only when indicated, and selected based on its efficacy against the most common pathogens causing SSI for a specific operation and published recommendations. For questions on appropriate antibiotics, please contact the pharmacy.

To reduce the risk of transmitting MDRO's or acquiring an infection from them, the following measures should be employed:

- Hand Washing
- Isolation Precautions
- Personal Protective Equipment
- Appropriate use of Antibiotics

PREVENTING HOSPITAL ACQUIRED CONDITIONS (HAC's)

Our organization is committed to patient safety and infection prevention by utilizing evidence-based practices to prevent hospital acquired conditions such as:

- Catheter Associated Urinary Tract Infections (CAUTI's)

- Central Line Associated Bloodstream Infections (CLABSI's)
- Surgical Site Infections (SSI's)
- Ventilator Associated Events (VAE's)

These practices are based on CDC recommendations. http://www.cdc.gov

List of Adjunct Intuitive Resources for Inpatient Care:

Interpretation Line (InDemand): Each floor should have a video capable interpretation line (tablet on wheels) to be able to effectively communicate with your patient in which English is not their first language.

TelePsych: For patients who have higher level psychiatric needs, while medically unfit to be in an inpatient behavioral health, there is a Skype video enabled tablet located in the Emergency Department for use. Call ED Charge Nurse **202-0181** to check for availability and algorithm for use.

TeleStroke: For patients who have an acute onset of stroke symptoms (4.5 hours from last known well) whether inpatient or ambulatory, there is a Skype video enabled tablet located in the Emergency Department for use. Call ED Charge Nurse **202-0181** to check for availability and algorithm for use.

MIDAS/Adverse Reporting system:

Capturing and documenting information about the non-conforming event is a means to improve processes by learning from near misses, which occur at a much higher frequency than adverse events.
Once a non-conforming event is reported, a sequence of actions usually occurs. Immediate action should occur to rectify an NCE. The employee should respond to the extent possible. Employees should always notify a person in charge when a NCE is discovered.
Refer to attachment (BSWH.LAB.QM.0800.A1) for mandatory events that must be reported within the Midas system.

MIDAS reporting system can be found on: https://www.mybaylorscottandwhite.com/Pages/default.aspx
then going to **Home > Services > Environment of Care > MIDAS Reporting**

Midas+
Midas+
Care Management

MIDAS SAFETY AND SERVICE OPPORTUNITY SYSTEM (SSOS)
ADVERSE EVENT ENTRY FUNDAMENTALS

Midas+
Midas+
Care Management

- All **required** fields on the form are in **bold;** they must be completed to submit form successfully.
- Midas uses the **Tab** key instead of the Enter key.
- Right click on any field and select Display Field Instructions for help text.
- To search any field for an answer selection containing a specific word, use the "[" contains key. For example, when searching for only Roberts building floors, enter "[roberts". Midas will pull only dictionary terms containing the word "roberts".*

Facility- WAHH (for Hillcrest)

Patient has to be in Allscripts/Epic at the facility chosen for patient to pull up in Midas.

Event Date

Patient event date has to be **within the patient's LOS** for patient to pull up in Midas.

ALL DATE FIELDS in Midas

Select the date from the calendar or
Enter a "T" for today's date to appear or
Enter a "-1" for yesterday's date or "-2" for two days ago and so on.

Affected Individual

Select Patient if the issue involves a patient. Lookup By: Number asks that you enter patient's account number, MRN, SSN or Universal ID (# specific to Midas). **The most effective way to locate a patient is using the account number.**
Select Non-Patient if the event is an Employee Incident, Risk or Patient Relations event that does not involve a patient.
Select Non-Patient for all non-Epic interfaced locations. Examples include EMS, Hospice, Home Care and some Hillcrest Clinics.

ALL TIME FIELDS in Midas

Enter an "N" for the current time to appear (N for now).
Enter military time or am/pm, Midas will convert time to a 12 hour clock.

Where did Event Occur- WAHH (to located where event took place)

Enter the location where the event occurred.
Enter the patient's facility's initials (BUMC, BIR, BASMC, etc.) and click the ellipsis to see locations for that facility. *Use the "[" contains key to narrow selection.

Entered by- RESIDENT, FHC (for all residents entering event)

Enter your last name and click the ellipsis.
Enter the last five digits of your employee ID.
To enter a report anonymously enter "ANONYMOUS,ANONYMOUS". All contractors enter a report as "CONTRACTOR,CONTRACTOR" All Aramark employees not in the listing enter "ARAMARK,EMPLOYEE" All physicians or other non-employees enter "OTHER,NON-EMPLOYEE" *Use "[" contains key to narrow selection.

What Department(s) should be Notified- WAHH (for department heads to be notified)

This field is extremely important because the departments that are selected will be notified upon saving the form.
Be sure to include all departments that should be notified.Enter the patient's facility's initials (BUMC, SWRR, SWMH) and click the ellipsis to see locations for that facility.
*Use the "[" contains key to narrow selection.

Briefly describe what happened

Do not copy from Outlook or MS Word only copy from **NotePad** or **TextPad** because using other applications will insert hidden characters within Midas.

Emergency Medical Treatment and Active Labor Act (EMTALA) Education for BSWH Physicians

Rev'd 10.2018

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History

- The earliest US "hospitals" were poor houses run by charities.
- The "well-off" began to go to hospitals when technology provided diagnosis and treatment.
- For much of the 20th century, indigent care was subsidized by payment received for treating the "well-off."
- The rise of health insurance plans, with fixed, cost-based reimbursement schedules, made cost-shifting difficult.
- Hospitals began turning away patients who could not pay

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The Government Steps In

- Hospitals built under the Hill-Burton Act (1946) were obliged to offer emergency treatment to those unable to pay.
- The Emergency Medical Treatment and Active Labor Act (EMTALA), was enacted in 1986, extended that obligation to all hospitals that participate in Medicare programs.
- The intent of EMTALA is to require hospitals to provide "adequate first response" to all patients.
- Some translate EMTALA's purpose as: "to prevent hospitals from dumping indigent patients."

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Basic Rules of the Road

- **EMTALA applies to:**
  - Facilities with a "dedicated emergency department" (broadly defined).
  - Off campus facilities and departments defined as "dedicated emergency departments".
  - Hospital owned ambulances – ground and air
- **EMTALA generally <u>does not</u> apply to:**
  - Outpatient settings

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EMTALA Requirements

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Requirements of EMTALA

To comply with EMTALA a hospital MUST:

1) **Provide a medical screening examination** to patients to determine if an Emergency Medical Condition (EMC) exists,
   a) Screening must be by a qualified medical professional
2) **Provide stabilizing treatment to** patients with emergency medical conditions,
3) However, unstable patients with emergency medical conditions may be transferred under the following two circumstances:
   I. If patient requests transfer in writing; or
   II. With physician certification

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What is an Emergency Medical Condition?

An **EMC** is the presence of acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in –

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

A pregnant woman who is having contractions has an EMC if:

- There is inadequate time to effect a safe transfer to another hospital before delivery, or
- That transfer may pose a threat to the health or safety of the woman or the unborn child

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Requirement 1: Medical Screening

- A qualified medical professional must provide an appropriate medical screening exam (MSE) to any patient:
  - Who requests care (regardless of that patient's ability to pay) **or**
  - Who appears, based on the individual's appearance or behavior, to need examination or treatment for a medical condition.
- The MSE should be the same for all patients regardless of their ability to pay
- Triage is not an MSE

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Who is a Qualified Medical Professional (QMP)?

- EMTALA requires individual hospitals to identify qualified medical professionals (QMP), in their Medical Staff Bylaws or Rules & Regulations.
- Qualified medical personnel may be defined as licensed caregivers can be physicians [MD/DO] including residents or fellows acting under appropriately documented Medical Staff member supervision, physician assistants and advanced practice nurses.
- A nurse providing triage services is not a QMP. (And Triage is not an MSE)

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What is an Appropriate Medical Screening?

- A medical screening examination is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.
- Depending upon the patient, this process will vary from only a brief H&P to a complex process involving ancillary studies and specialty consultations.

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Requirement 2: Stabilizing Patients with Emergency Medical Conditions

If an emergency medical condition exists, the hospital must:

- Provide stabilizing treatment within the capability of the facility; and
- If the hospital cannot stabilize the patient (i.e. does not have the capacity or capability to do so) then transfer the patient to a medical facility that has the capacity and capability to provide the necessary stabilizing treatment.

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When is a patient stabilized?

- When no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.
  - Hospitals are not required to provide screening services beyond what is needed to determine if an EMC exists.
  - Hospitals are not required to resolve the underlying medical condition(s) to achieve stabilization.
- With respect to a pregnant woman having contractions, delivery is not likely to result from or occur during the transfer of the individual to another facility.

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Requirement 3: Transfer of Unstable Patients

Non-stabilized patients may be transferred ONLY IF:

- The patient (or someone acting on the patient's behalf) requests a transfer in writing after being informed of the risks involved and the hospital's duty to treat under EMTALA, **or**
- A physician certifies that the medical benefits expected from transfer outweigh the risks involved in the transfer and seeks the patient's consent.
  - *Benefits of transfer might be expected to outweigh risks if, for example, the receiving hospital has more specialized facilities or more staff expertise in handling medical emergencies of the type the patient presents*

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Transfer of Unstable Patients Continued…

- An appropriate transfer includes determining *capacity and capability.*
  - Receiving hospital has the *capacity*, e.g., beds to provide medical treatment
  - Receiving hospital has the *capability* to provide specialized services by qualified personnel
- Document existence or absence of EMC, as well as stabilization of existing EMC

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Requirements of Transferring Hospital

- Document that the patient needs treatment at the receiving facility, and the medical benefits of transferring the patient outweigh the risks of the transfer;
- Obtain patient's written consent for transfer if possible;
- Obtain an accepting physician and administrative approval from the receiving facility;
  - The sending facility does not need to prove their lack of capability, or capacity.
- Provide signed certificate of transfer and retain a copy of transfer paper work;
- Assure that the transfer takes place with qualified personnel and equipment;
- Provide medical records related to the emergency condition.

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Obligations of Receiving Hospital

- Have available space (capacity) and qualified personnel (capability) for treating the patient,
- Agree to accept transfer of the patient and to provide appropriate medical treatment.
- The receiving hospital is obligated to accept the transfer if it has the ability to treat the patient and its capabilities exceed those of the referring hospital, even if only because of overcrowding or temporary unavailability of personnel.
- The statute and the regulations provide that any participating hospital which has "specialized capabilities or facilities" such as burn units, shock-trauma units, or neonatal intensive care units, or which is a "regional referral center" for a rural area, may not refuse to accept a patient in transfer, if it has the capacity to treat the individual. [42 USC 1395dd(g); 42 CFR 489.24(f)]

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Medical Staff and On-Call Physician Obligations

- Hospitals must maintain a list of physicians by name who are on call to evaluate ED patients. List must include contact information.
  - List of on-call physicians must include specialists
  - Physician services that are available to hospitalized patients must be available to ED patients
- Hospitals are responsible for ensuring that on-call physicians respond within a "reasonable time."
- On-call physicians are liable under EMTALA.
  - Their obligation to respond is not dependent on whether the physician participates in patient's medical care organization (MCO) or insurance.

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Medical Staff and On-Call Physician Obligations Continued…

How soon must the on-call physician respond?

- Within a reasonable amount of time as defined by the facility rules and regulations absent extenuating circumstances (in non-elective surgery, weather, etc.)
- "Office full of patients" not a legitimate excuse
- Simultaneous call process – The physician and the hospital must have planned back-up in the event the physician is unable to respond to an on-call request within in a reasonable amount of time.

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Liabilities under EMTALA

There are three courses of action for violations of EMTALA:

- Private civil suits against the hospital (but not the physician).
- Penalty fines against hospital, physician, or both.
- Onsite regulatory surveys

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Potential Fines and Punishment under EMTALA

- Up to $104,826 per patient incident
- Termination from Medicare and Medicaid
- Lawsuit for civil damages
- Civil rights violations
- Physician's fines up to $104,826 per incident
- Publication of violation and penalty
- In cases of unresponsive on-call physicians, punitive damages for intentional failure to protect patients from a known hazard
- Medical staff suspension, subsequent report to the state medical board and the National Practitioner Data Bank (NPDB)
- CMS Survey

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Practical Lessons
Case Review

Our hospitalist receives a call from a hospital wanting to transport a 50 y/o male with ongoing chest pain to your facility. The referring hospital has done an EKG, performed blood work and administered aspirin and nitroglycerin. Our hospitalist denies the transfer on the grounds that the patient can be admitted to the referring hospital for observation. The referring hospital does not have a cardiologist on staff.

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Case Review
Is this an EMTALA violation?

- **YES.**
- Why?
  - Under EMTALA, if a hospital does not have the staff or the resources to treat and stabilize a patient with an emergency medical condition, a tertiary care center (or any hospital) who does have the resources, has to accept the patient if requested.

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Question:
To whom does EMTALA apply?

- EMTALA applies to patients who present at a hospital's "dedicated emergency department"
  - *"Dedicated emergency department" has been broadly defined to possibly include anywhere on the hospital's property*
- For inpatients, CMS' final rule states that once a hospital admits a patient for further treatment after screening, it's EMTALA obligation ends.

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Question:
Can we refuse a transfer request from an emergency department if the patient has recently received care at a different hospital or if the patient's regular physician or surgeon is based at a different hospital (e.g. post-op patients)?

- **NO.**
- It is OK to suggest the patient go to the previous hospital to promote continuity of care, yet we can't refuse if the sending hospital does not want to contact previous hospital.
- Ultimately, if our hospital has capacity and capability, we are obligated to accept the patient transfer.

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Question:

Can a surgeon or other physician, on –call at Hospital A refuse a transfer request and request that the patient be transferred to Hospital (B) where the on-call surgeon just happens to have OR cases scheduled that day?

- **NO.**
- If the physician is on-call for Hospital A and that hospital has capacity and capability Hospital A should accept the patient transfer. Declining the transfer in order to re-route the patient to another hospital (B) could be cited as an EMTALA violation.

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Question:

What if we think a referring hospital attempting to transfer a patient from their ER has capacity and capability?

- You may inquire at the time of transfer, but the referring hospital does not have to 'prove' they do not have capacity or capability.
- Remember, the receiving hospital is obligated to accept the transfer in most cases, so long as we have the capability and capacity to treat the patient.

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Question:

Is there anything our institution must do if we feel a referring hospital has violated EMTALA?

- **YES.** A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.
- This also applies in the reverse; if a transferring hospital believes a receiving hospital has declined to accept a transfer in violation of EMTALA, the transferring hospital must report to CMS or to the state
- Contact Legal/Risk Management if you feel an EMTALA violation has occurred.

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