SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

Riverside University HEALTH SYSTEM Medical Center

ITEM: 15.2
(ID # 11418)
MEETING DATE:
Tuesday, December 10, 2019

FROM : RUHS-MEDICAL CENTER:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER: Approval of the Policies for Riverside University Health System-Medical Center, District 5. [$0]

RECOMMENDED MOTION: That the Governing Board:

1. Review and Approve the attached Medical Center Policies.

ACTION:Policy

Jennifer Cruikshank, Chief Executive Officer – Health System 12/2/2019

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Jeffries, seconded by Supervisor Washington and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	December 10, 2019
xc:	RUHS

Kecia R. Harper
Clerk of the Board
By: Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0

SOURCE OF FUNDS: N/A

Budget Adjustment: No

For Fiscal Year: 19/20

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Riverside University Health System-Medical Center (RUHS-MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893.

RUHS-MC is an Acute Hospital required by the State of California to have a "governing body" separate from its administrative leaders and medical staff leadership. The "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital." 22 CCR §70035. (See also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01). The Board of Supervisors serves as the "governing body" for the hospital.

Various regulatory requirements mandate that the Governing Board participate in the leadership and decision-making of the Medical Center by reviewing and approving its policies relating to certain topics. The policies developed and/or updated between May 29, 2019 and October 10, 2019 relate to:

Title	Eff Date
HW 106 Administrator On Call	7/25/2019
HW 112 Non-Smoking Campus	8/13/2019
HW 116 Contracting Professional Services	9/12/2019
HW 142 Access to Language Services for Limited English Proficient, Deaf, and Hearing Impaired Persons	10/10/2019
HW 145 Animals in the Hospital	10/10/2019
HW 148 Medicare Important Message Notice	7/25/2019
HW 200 Financial Assistance	5/22/2019
HW 400 Staffing	9/12/2019
HW 400.4 Personnel Conduct	7/25/2019
HW 401 Provisions for Religious/Cultural Conflicts in Patient Care	7/25/2019
HW 407 Fingernail and Hand Hygiene	7/25/2019

HW 407.1 Pre-Placement Physical Examinations and Employee Health Screenings and Immunizations	7/25/2019
HW 420 Dress Code	7/25/2019
HW 505.2 Restrictive Security Devices for Inmates	9/12/2019
HW 511 Code Pink	7/10/2019
HW 514 Workplace Violence, Threats, and Securities	9/12/2019
HW 523 Electical Equipment Safety	9/12/2019
HW 552 Powered Air Purifying Respirator (PAPR)	9/12/2019
HW 555 Reporting Broken and Malfunctioning Equipment	10/10/2019
HW 601 Patient Rights and Responsibilities	7/1/2019
HW 601.2 Physician Orders for Life Sustaining Treatment (POLST)	7/25/2019
HW 601.3 Advance Directives	7/1/2019
HW 601.7 Use of Abbreviations	9/12/2019
HW 601.8 Patient Written Materials	7/1/2019
HW 603 Provision for Patient Care	8/26/2019
HW 603.21 Critical Values Reporting	10/29/2019
HW 603.4 Pain Management	5/29/2019
HW 604.2 Massive Transfusion	9/16/2019
HW 605 Patient Identification	7/10/2019
HW 605.2 Color Coded Wristbands and Clasp Alerts	9/12/2019
HW 606.1 Blood Transfusions Consent: Paul Gann Act	7/1/2019
HW 614 Visitors, Visiting Hours, and Visitor Safety	9/12/2019
HW 618 Code Cart Readiness	10/10/2019
HW 619 Rapid Response Team Activation	7/25/2019
HW 620 Code Blue and White	9/16/2019
HW 623 Change in Code Status	9/17/2019
HW 627.1 Discharge of Minors	9/12/2019
HW 631 Code Green	9/12/2019
HW 632.1 Discharge Planning Homeless Patients	5/29/2019
HW 633 Unauthorized Leave of Patients	8/26/2019
HW 647 Specialty Clinic Referral	10/10/2019
HW 648 Referrals from Other Facilities	9/26/2019
HW 649 Complaints and Grievances	7/1/2019
HW 651 Brain Death and Family Accommodations	9/16/2019
HW 652 Decedent Affairs	9/12/2019
HW 654 Sentinel Events	7/10/2019
HW 660 Scope of Service Palliative Care	9/12/2019
HW 661 Hip Fracture Program Scope of Service	7/25/2019

HW 672 Electronic Signature	8/26/2019
HW 674 Child Passenger Restraint Education	9/12/2019
HW 675 Management of Malignant Hyperthermia	10/29/2019
HW 678 Blood Transfusion	8/26/2019
HW 689 Code Stroke	9/16/2019
HW 691 Sepsis Guidelines for the Management of Sepsis, Severe Sepsis, and Septic Shock in Adults	7/1/2019
HW 691.1 Scope of Service Sepsis RRT Program	7/1/2019
HW 693 Acquisition and Handling of Human Milk Products	8/13/2019
HW 694 Guidelines for NonPsychPatients Who Pose Danger to Selves	8/26/2019
HW 697 Clinical Alarms	7/10/2019
HW 698 Diabetes Team Scope of Service	8/26/2019
HW 700 Patient Privacy HIPAA	10/10/2019
HW 701.1 Notification of Privacy Breaches	7/25/2019
HW 705 Facsimile Transmissions	5/29/2019
HW 707 Patient Photography	10/29/2019
HW 711 Use of Social Media	5/29/2019
HW 712 Computer Access Use Security	10/10/2019
HW 805 Med Error and Adverse Reaction Reporting	10/29/2019
HW 810 Automated Dispensing Cabinet Controlled Substances	10/29/2019
HW 822 Downtime Inpatient Pharmacy Center	8/13/2019
HW 826 Certified Pharmacist Driven Immunizations for Patients and Employees	10/29/2019
HW 827 Pre-Operative Medication management by Clinical Pharmacist for Patients Undergoing Colonoscopy	7/25/2019
HW 833 Medication Stop Order Limitations Auto Stop	8/26/2019
HW 834 Medication Assisted Treatment for Opioid Addicted Patients	8/26/2019
HW 843 Management of Vancomycin and Aminoglycoside Therapy in Adults Per Pharmacy Protocol	8/26/2019
HW 846 Drug Samples	8/12/2019
HW 848 Automatic Substitution for Adult Inpatient	7/25/2019
HW 852 Medication Admin	8/12/2019
HW 854 Davita Dialysis Medication Storage	5/29/2019
HW 857 Patients Personal Home Medication	8/12/2019
HW 878 Ambulatory Care Clinical Pharmacist Managed Dyslipidemia Services	7/25/2019
HW 879 Adult Potassium Chloride Infusion	9/16/2019
HW 880 Lipid Rescue Therapy	9/16/2019
HW 881 Amb Care Clinical Pharmacist Managed Diabetes Services	9/16/2019
HW 882 Vinca Alkaloid Dispensing	9/16/2019

Impact on Residents and Businesses

RUHS-MC employs more than 3,000 individuals and contracts with over 1,000 businesses and professionals. An efficient, well-functioning medical center providing care of high quality creates many positive benefits for Riverside County citizens and its businesses.

ATTACHMENTS:

HW 106 Administrator On Call
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HW 880 Lipid Rescue Therapy
HW 881 Amb Care Clinical Pharmacist Managed Diabetes Services
HW 882 Vinca Alkaloid Dispensing
HW 883 Drug Storage and Access

Brianna Lontajo, Management Analyst 12/3/2019

Gregory P. Priamos, Director County Counsel 12/2/2019

RIVERSIDE UNIVERSITY HEALTH SYSTEM –
MEDICAL CENTER, COMMUNITY HEALTH CENTERS, and HOSPITAL BASED CLINICS

Housewide

	Document No: 116	Page 1 of 8
Title: Contracting for Professional Services	**Effective Date:** 9/12/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1. Affiliation Agreements for GME, RN, PA, Doctorial Training. These agreements provide university students with graduate field education opportunities under the supervision and oversight of the preceptor (e.g. attending physician, RN Supervisor, PA Supervisor, etc.). RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER is not obligate to pay the university student's salary, housing or other benefits. These affiliations are mutually beneficial; for the hospital these agreements aid in maintenance of the Joint Commission Teaching Hospital Accreditation.

1.2. Inter-facility Agreements for Hospitals and Skilled Nursing Facilities. These agreements provide for the transfer of patients between facilities when transitioning to a level of care not provided by the hospital which could be either lower level care such as a skilled nursing facility or higher level of care such as such as a Cardiac Intensive Care Unit.

1.3. Inter-Governmental Agency Agreement for Service (e.g., AIDS) or Funding. These agreements, inter-governmental agreements, allow RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER and/or ambulatory clinics to provide services to patients requiring care at agreed upon rates of reimbursement.

1.4. Commercial Insurance Payor Agreements and Successive Amendments. RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER will enter into commercial payment agreements to provide in-patient acute and outpatient hospital services to commercial insurance plan members who contract with employer groups and governmental entities for covered health care services for their members enrolled in HMO and PPO benefit plans.

1.5. Insurance Payor Agreements and Successive Amendments. RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER will enter into Medicare Advantage HMO payment agreements to provide acute in-patient services and outpatient hospital services to Medicare Advantage HMO plans that contract with the federal government Centers for Medicare/Medicaid Services (CMS) to provide or arrange for the provision of covered health care services to their senior members enrolled in their HMO benefit plans.

1.6. Medi-Cal Insurance Payor Agreements and Successor Amendments. RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER will enter into Managed Medicaid HMO plans that contract with the State and federal government Centers for Medicare/Medicaid Services (CMS) agencies to provide or to arrange for the provision of covered health care services to their Medicaid and Medi-Medi Duals members enrolled in their HMO plans.

1.7. Letters of Agreement for Medical Services. RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER will enter into patient specific Letters of Agreement with various payors (e.g., HMO Plans, PPO Plans, etc.) to provide patient acute care and outpatient services to their benefit plan members.

1.8. Grants. There are many grants that may support the Board's goal to continuously improve patient care. Medical Research grants provide one example. Grants that require a financial match will be subject to Board approval.

1.9. Clinical Trials – Investigative Studies. A clinical study involves research using human volunteers (also called participants). The intent is to add to current medical knowledge. There are generally two (2) types, clinical trials and observational studies.

1.10. Revenue Generating Agreements. These are operational agreements with service providers or related entities, e.g., pharmacies which generate revenue for the hospital.

2. POLICY

2.1. RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER shall establish and maintain Contracts Administration, as part of hospital Administration, to be responsible for assisting RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER staff in the development of professional service contracts which include but is not limited to: managed care, affiliation agreements, graduate medical education services, inter-facility agreements, inter-governmental agreements, letters of agreements for medical services, grant acceptance agreements, clinical trials, commercial insurance agreements, health plan agreements, membership/participation agreements, pharmacy 340B agreements professional consultant agreements and physician services agreements whereas, hospital Purchasing to be responsible for non-physician and all other professional services contracts.

2.2. Contracts Administration will serve to provide a central point of expertise to coordinate contract preparation and processing and to assure that RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER contractual agreements for professional services comply with legal codes, statutes, ordinances, and County and RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER policies related to contracting.

2.3. Requests to contract for professional medical services to be provided by a physician, physician group or other medical professionals (i.e., nurse practitioner, physician assistants, etc.) will be submitted directly to RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER Contracts Administration Department in Administration. Contracts Administration Department has the responsibility for developing and coordinating the provision of these services.

2.4. At its meeting of July 21, 2015, Agenda item 3-43, the Riverside County Board of Supervisors authorized the Assistant CEO – Health System to sign a limited list of specific types of agreements on behalf of the hospital, subject to those agreements being approved as to form by County Counsel. As part of that action the Board directed County Counsel to create guidelines for each agreement type to "include contractual terms common to County contracts that are designed to protect County interests and limit liability." The Board of Supervisors also directed the Assistant CEO-Health Systems to submit quarterly reports to the Board on all agreements executed pursuant to the delegated authority.

2.5. The Delegated Authority granted by the Board of Supervisors (Board) to the Assistant CEO-Health Systems for the Riverside University Health System Medical Center (RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER [which includes the Moreno Valley, Arlington Inpatient Treatment Facility (ITF) and the 10 Federally Qualified Health Centers (FQHC) facilities] covers the following list of agreement types:

a) Affiliation Agreements for Graduate Medical Education (GME), Registered Nurse (RN), Physician Assistant (PA), Doctoral Training, and other medical ancillary classifications;

b) Inter-Facility Agreements for Hospitals or Skilled Nursing Facilities;

c) Inter-Governmental Agency Agreement for Service or Funding (example AIDS program);

d) Commercial Insurance Payor Agreements & Successive Amendments;

e) Medicare Insurance Payor Agreements & Successive Amendments;

f) Medi-Cal Insurance Payor Agreements & Successive Amendments;

g) Letters of Agreement for Medical Services;

h) Grants;

i) Clinical Trials – Investigative Studies;

j) Revenue Generating Agreements.

2.6. At its meeting of July 21, 2015, Agenda item 3-42, the Riverside County Board of Supervisors authorized the Purchasing Agent to Initialize and Implement Public Contract Code Section 20131, subsection (c), for Procurement not to Exceed $750,000 per Vendor into County Procurement Policies and Procedures Relating to County Hospital Procurement Procedure and Activities and Direction to Riverside University Health System to Report Quarterly to the Board of Supervisors Regarding all Purchases Conducted Under this Resolution. The following list of items and services may be obtain without seeking competitive bids:

a) Physician Services (up to $250,000 annually per physician)

b) Nursing Services

c) Medical/Pharmacy Consultants

d) Medical Records Management Services

e) Case Management Services

f) Medical Product Distribution Services

g) Medical Advisory/Research

h) Patient Transport

i) Pharmaceuticals

j) Medical/Pharmaceutical Computer Systems

k) Laboratory Services

l) Medical Equipment Rental

3. PROFESSIONAL MEDICAL SERVICES

3.1 Any requests which fall under the items listed in Section 3.4 of this Policy "may not" require a Request for Supply Service (RSS) form unless payment to the vendor is involved. Refer to Attachment 1 for the RSS.

3.2 Contracts Administration will review, coordinate the processing, and ensure the necessary approvals are obtained.

3.3 Contracts Administration with the assistance of the requesting department expert/representative develop the contract requirements to ensure the following information has been addressed:

a) A detailed description of the service;

b) An estimated annual dollar amount of the services;

c) The time period for the service;

d) Background justification for the Form 11 (if needed);

3.4 Relevant medical staff and/or Executive Management Team may participate (as needed) in the development of such contracts.

3.5 Contracts Administration will request assistance from external County departments such as the Office of County Counsel, Central Purchasing, and County Risk Management as needed.

3.6 Contracts Administration will finalize the Agreement to execution by obtaining final signatures from either the Board of Supervisors (BOS), CEO – Health System or their designee, or the County Purchasing Agent via a Procurement Contract Specialist (PCS).

3.7 On approval, and execution by the BOS, CEO (or their designee), or the Purchasing Agent, distribute executed copies to the originator, the RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER Fiscal department (if needed), the Contractor/Vendor, and to any State or Federal agency as required.

3.8 Contracts Administration will upload each contract and respective amendments to RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER contract management system to maintain a centralized repository of all contracts.

3.9 Contract Administration will provide notification for contract renewals.

4. NON-PROFESSIONAL SERVICES

4.1 RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER Department Managers desiring to either procure or obtain professional services by contractual agreement shall complete an RSS form and follow the steps below:

a) Obtain RSS approval from respective Assistant Hospital Administrator, Assistant Chief Nursing Officer or Executive Director.

b) Obtain approval/sign off from Value Analysis for medical or surgical equipment or supplies that may be under Group Purchasing Organization (GPO).

c) Obtain approval/sign off from Plant Operations department for equipment purchasing including furniture to ensure it meets the hospital grade specifications.

d) Obtain approval/sign off from Information System (IS) department for all computer hardware and software to ensure items will meet network and configuration requirements. IS will assist in obtaining approval as it pertains to County Board of Supervisors H-11 Policy. Should County Policy for H-11 change, RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER will modify approval process.

e) Submit the approved RSS to Fiscal department for review / approval.

f) Once Fiscal approves, Fiscal will deliver the RSS to hospital Purchasing department to process and will assign a purchasing department number (PD-number) for ease of tracking.

g) Work with hospital Purchasing department as they will be responsible for these types of non-professional service Agreements and shall follow Form 11 specified in Section 3.5 of this Policy.

- Submit the approved RSS to Purchasing at least two (2) months or more prior to the effective date of a contract not requiring an RFP and four (4) months or more for a contract requiring an RFP to be conducted.

4.2 RSS should include the following information:

a) A detailed description of the service(s);

b) An estimated annual dollar amount of the service(s);

c) The time period for the services(s);

d) Background justification for the Form 11 (as needed);

e) Request for Proposal (RFP) information, as needed, including evaluation criteria, list of prospective vendors, and scope of service.

4.3 The requesting Department must appoint or designate an individual who will be responsible for monitoring the contractual activities/services for performance compliance.

4.4 Agreements must not commit the County or allocate or expend funds outside the general operating costs that are included in the annual budget. Costs should be incidental and included in the County approved budget. When referring to general operating costs, e.g., county does not incur additional costs, and does not include purchases of supplies or vendor services. For example, an Affiliation Agreement that requires the County to pay for services, e.g. Resident Physicians, does not fall within the Delegated Authority authorized by the Board.

4.5 Agreements must contain County Standard (as approved by the County Risk Manager and County Counsel) insurance and indemnity language. Any proposed deviation from those standards must first be approved by County Counsel and the County Risk Manager. Additionally, where a particular agreement exposes the County to higher levels of risk, the Risk Manager and County Counsel may require additional insurance, as appropriate.

4.6 Automatic renewals are disfavored. To the extent that the parties to an agreement desire to extend the term of an agreement, the terms must require specific action by the parties as well as execution of a written amendment extending the term. Such extensions shall not exceed a total term of 5 years. If there is a desire to continue such services, a new agreement shall be entered into by the parties.

4.7 In general, agreements shall be submitted to Counsel not less than 10 days prior to the anticipated BOS agenda schedule or the proposed implementation by the parties to allow for sufficient review. Counsel will strive to complete the review within that timeline. Some agreements, due to their complexity or other issues, may require more time for review. In those instances, County Counsel will timely notify the contract administrator of any anticipated delays and the reasons for the delay.

4.8 Agreements shall not be executed on behalf of the County without approval by County Counsel as indicated by a signature affixed to the document.

4.9 The CEO - Health System shall submit quarterly reports to the Board on all agreements executed pursuant to the delegated authority.

5. ATTACHMENTS:

5.1 Request for Supply/Service (RSS) Form

Document History:

Prior Release Dates: 4/4/1991, 3/24/2003, 3/20/2000, 4/26/2011, 8/25/2016	**Retire Date:** N/A
Document Owner: Contract Administration	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/19/2019	Brandy Arthur	No	No changes
9/3/2019	Policy Approval Committee	No	

ATTACHMENT 1

PURCHASING CONTROL NUMBER: PD__-_____

Request for Supplies / Capital Equipment/ Services

SECTION 1: *Required information	
*Requesting Department	
*Department Manager and Phone Extension	
*Description of request (purchase or contract)	
* If Contracts – (New / Renewal / Amendment)	
Current Vendor and Contact Information	
****Supply/Service Needed By (ASAP is not a date)***	Date:
SECTION 2: *Purchase Type	
Is this item a Sole Source Request? (Items with 1 manufacturer and 1 distributor are considered sole source)	Yes ☐ No ☐
Presented to Value Analysis Program?	Yes ☐ No ☐ Approved_____Date_____
Is GPO pricing available? Novation or Other	Yes ☐ No ☐ Contract#_____Expire_____

Justification

Complete page 2 of this document. Note ****All requests must have this document attached to the RSS form.**

Approval: Plant Operations and Information Services

For all equipment purchases including furniture, Plant Operations must sign off on the request to ensure that the requested items will meet the Hospital Grade Specifications.

Approved by Chief of Plant Operations_____ Date_____

For all computer hardware and software, Information Services must sign off on the request to ensure that the requested items will meet network and configuration requirements. You will also be required to submit an approved H-11 along with your RSS.

Approved by Information Services (Name)_____Date_____

SECTION 3: *Required Fiscal Approval*

Dept ID: _____	Request Amount: _____
Account Code: _____	Fiscal Officer: _____ Date:_____

SECTION 4: *Required **signatures** (Incomplete forms will be returned to departments unsigned.)

Department Manager (up to $5,000):_____ Date:_____

AHA/CNO/Director (up to $10,000): _____ Date:_____

COO/CFO (up to $100,000):_____ Date:_____

CEO (over $100,000):_____ Date:_____

Upon successful submission, you will receive an email indicating your control number for this request. Please use this number when contacting Purchasing for project status.

SECTION 5: ****Provide Responses to the items requested below:***

1) **If this is an annual renewal, this would be: Year _____ of _____** ***(skip 2 - 8).***

   If yes, will the rate remain the same?

   If no, proceed to number 2.

2) **Supply/Service being requested:**

3) **Alternative supplier that can or might be able to provide supply/service and extent of market search conducted (if none, state "none"):**

4) **Unique features of the supply/service being requested from this supplier:**

5) **Reasons why my department requires these unique features and what benefit will accrue to the County/Hospital:**

6) **Price reasonableness, including purchase price and any ongoing maintenance or ancillary costs from the supplier/vendor:**

   Rate: _____
   Grand Total: _____

7) **Does moving forward on this product or service further obligate the County/Hospital to future similar contractual arrangements or any ongoing costs affiliated with this request? (i.e., maintenance, support, or upgrades?):**

8) **Period of Performance. Is this a multi-year contract (fixed term) or to be renewed annually?**

9) **What is (are) the expected outcome(s) if the request is not approved?**

RIVERSIDE UNIVERSITY HEALTH SYSTEM -
Medical Center, Hospital Based Clinics, and Community Health Centers

	Document No: 145	Page 1 of 4
Title: Animals in the Hospital	**Effective Date:** 10/10/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 **The Americans with Disabilities Act (ADA)** prohibits discrimination and guarantees that people with disabilities have the same opportunities to participate in the mainstream of American life. The ADA was signed into law on July 26, 1990.

1.2 **Service Animal:** The U.S. Department of Justice (DOJ) defines a service animal as a dog or a miniature horse that is individually trained to do work or perform tasks for people with disabilities, whether or not they have been licensed or certified by a state or local government.

a. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties.

b. Service animals are working animals, not pets.

c. The work or task a dog has been trained to provide must be directly related to the person's disability.

d. Dogs or miniature horses whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

1.3 **Therapy Animal:** A therapy animal is an animal affiliated with Inland Empire Pet Partners. Inland Empire Pet Partners conducts the official RUHS – Medical Center therapy animal program.

1.4 **Pets:** A pet is a domesticated animal kept for companionship, and is NOT a service animal.

2. SERVICE ANIMALS

2.1 Any establishment that refuses to admit any type of service animal on the basis of local health department regulations or other state or local laws is in violation of the ADA. The ADA takes priority over the local or state laws or regulations.

2.2 Service animal verification: A public entity shall not ask about the nature or extent of a person's disability, but may make two inquiries to determine whether an animal qualifies as a service animal.

a. A public entity may ask if:

- The animal is required because of a disability and
- What work or task the animal has been trained to perform.

b. Generally, a public entity may not make these inquiries about a service animal when it is readily apparent that an animal is trained to do work or perform tasks for an individual with a disability (e.g., the dog is observed guiding an individual who is blind or has low vision, or is pulling a person's wheelchair).

2.3 A public entity shall not require documentation, such as proof that the animal has been certified, trained, or licensed as a service animal.

2.4 A service animal shall have a harness, leash, or other tether, unless the handler is unable to hold one, in which case the service animal must be otherwise under the handler's control at all times. (e.g., voice control, signals, or other effective means).

2.5 Individuals with disabilities shall be permitted to be accompanied by their service animals into all areas of a public entity's facilities where members of the public are allowed to go.

2.6 If the service animal needs to be taken into restricted areas, Infection Prevention and Control must be contacted first. These areas include: Perioperative Services, Surgical Nursing Units, and all Critical Care areas. The unit manager and the Infection Prevention and Control Nurse shall evaluate the situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk. (ADA 28 CFR 36.208)

2.7 A person with a disability cannot be asked to remove his/her service animal from the premises unless:

a. The animal is out of control and the animal's handler does not take effective action to control it.

b. Presence of the animal creates a fundamental alteration in the nature of services.

c. The animal is not housebroken. RUHS staff is not responsible for feeding or excretion activities.

2.8 If a public entity properly excludes an animal for the above reasons, it shall give the individual with a disability the opportunity to participate in the service, program or activity without having the service animal on the premises.

2.9 Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals.

2.10 People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals

3. THERAPY ANIMALS

3.1 All therapy animals that enter RUHS – Medical Center must be registered participants with Inland Empire Pet Partners and follow the rules and regulations of that program. Contact Volunteer Services to request a therapy dog visit.

4. PERSONAL PETS

4.1 Only service animals are permitted entry to RUHS clinics. All other animals are prohibited.

4.2 A dog or cat shall be permitted to visit individual patients admitted as an inpatient, by previous arrangement with Infection Control and the Unit Director prior to the animal entering any of the RUHS – Medical Center buildings.

a. Documentation of the health of the pet by a veterinarian, dated within the previous 6 months, must be provided to either Infection Prevention and Control or the Unit Manager prior to the animal's visit. A copy of the veterinarians report must be placed in the patient's medical record.

b. Personal Animals must be supervised at all times by an individual who accepts full responsibility for the animal. RUHS – Medical Center shall not be responsible for the care or supervision of a pet.

c. Pets shall not be permitted to have contact with any patients other than their owner, and they may not visit any other area or unit of the hospital.

d. Visits shall be kept brief enough so that the animal's feeding and excretion activities need not be addressed. Use of water bowls is not allowed due to safety and fall risks.

e. Staff shall take prompt action if an event of biting or scratching occurs and shall:

- Remove the animal from the facility.
- Promptly treat any scratches, bites, or other breaks in the skin.
- Report the incident to RUHS – Medical Center Infection Prevention and Control and RUHS – Medical Center Compliance Office.

5. REFERENCES

5.1 CDC Guidelines for Environmental Infection Prevention in Healthcare Facilities: Recommendations of CDC and the Healthcare Infection Prevention Practice Advisory Committee (HICPAC). MMWR 2003; 52 (No. RR-10).

5.2 APIC. Guidelines for Animal-Assisted Intervention in Health Care Facilities. Am J Infect Control 2008: 36: 504

5.3 Americans with Disabilities Act, 1990

5.4 U.S. Department of Justice, Civil Rights Division, Disability Rights Section publication on Service Animals, July 12, 2011

Document History:

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Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
10/1/2019	Policy Approval Committee	N	
10/2/2019	CHC Policy Workgroup	Y	Add only service animals are allowed in clinics. All other animals prohibited'

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 148	Page 1 of 8
Title: Medicare Notifications	**Effective Date:** 7/25/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. SCOPE

1.1 This policy is specific to Medicare beneficiaries only and does not apply to other payers including Medi-Cal unless Medicare coverage also exists.

2. PURPOSE

2.1 The purpose of this policy is to describe the circumstances in which the following notices must be issued to Medicare beneficiaries (Medicare fee-for-service or Medicare Advantage (MA) or other Medicare health plans subject to the MA regulations) regarding inpatient coverage issues: Important Message from Medicare (IMM), Hospital-Issued Notice of Non-Coverage (HINN), Hospital Request for Review (HRR) - by Quality Improvement Organization (QIO), and Detailed Notice of Discharge. The purpose of these beneficiary notices is to enable the beneficiary or representative to better participate in decisions affecting his or her care and financial liability.

3. DEFINITIONS

3.1 **"Inpatient":** any person who has been admitted for bed occupancy for purposes of receiving hospital services.

3.2 **"Outpatient":** a person who has not been admitted as an Inpatient but is registered as an Outpatient and receives services. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

3.3 **"Observation Services" or "Observation":** assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

3.4 **"INTERQUAL":** clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards

4. POLICY:

4.1 Issuance of Admission IMMs and Follow-Up Notices

a. Admission IMM

- Registration personnel will be responsible to issue and review the admission IMM and obtain signature to acknowledge receipt for all beneficiaries enrolled in Medicare fee-for-service, MA plans, and other Medicare health plans subject to the MA regulations who are admitted as inpatients, including those admitted as inpatients after receiving outpatient observation services. The patient will be provided with the original copy of the signed notice with a copy retained by the facility and placed in the medical record. (See Attachment A)
- The admission IMM must be given to the beneficiary as soon as possible within two (2) calendar days of admission, or at preadmission, but not more than seven (7) calendar days before admission.
- If the beneficiary is incapable of receiving or incompetent to receive the notice, or the hospital cannot obtain the signature of the beneficiary's representative through direct personal contact, then Registration should telephone the representative to advise him or her of the beneficiary's rights as a hospital patient, including the right to appeal a discharge decision. The date the hospital conveyed this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.
- If for any reason Registration is unable to obtain the signature of the beneficiary or their representative within 2 business days, the attempts should be documented and the Integrated Care Management (ICM) Department will be notified immediately to assist with the process. Notification of Integrated Care Management will be done by sending email to ICM leadership.
- If the beneficiary refuses to sign the IMM, hospital staff may annotate the notice to indicate the refusal. The date of refusal is considered the date of receipt of notice.

b. Follow-Up Notice

- The Follow-Up Notice must be given to the beneficiary as far in advance of discharge as possible, but no more than 2 calendar days before the planned date of discharge so the beneficiary has meaningful opportunity to act on it. If delivery of the original IMM is within 2 calendar days of discharge, no follow-up copy is needed.
- Integrated Care Management (ICM) will primarily be responsible for distribution and review of the follow-up IMM with the beneficiary. A copy of the signed IMM obtained at admission may be provided with no additional signature required but documented that distribution occurred. If ICM is not available, nursing personnel may complete this process.
- A follow-up IMM is not required prior to transfer from one inpatient hospital setting another inpatient hospital setting (for example, a short term acute care hospital to a long term acute care hospital). A follow-up IMM is required prior to discharge to a lower level of care such as SNF however.

- When the discharge cannot be predicted in advance, the follow-up copy of the notice may be delivered as late as the day of discharge. If the notice must be delivered on the day of discharge, the hospital must give beneficiary at least 4 hours to consider their right to request QIO review. Beneficiaries however may waive this right and choose to leave prior to that time.

c. Beneficiary Refusal to Sign

- If the beneficiary refuses to sign the IMM or Follow-up Notice, the refusal should be documented with date of refusal on the notice form. The original document is to be given to the beneficiary with copy retained in the medical record. The date of refusal is considered the date of receipt of notice.

d. Beneficiary Appeal Rights: Hospital Responsibilities

- A beneficiary who disagrees with the hospital's determination that inpatient care is no longer necessary has the right to request an expedited review of that determination by the QIO.
- If the beneficiary refuses discharge or requests the expedited QIO review process, the individual receiving this information must immediately contact the Integrated Care Management Department.
- The beneficiary must not be discharged if he or she requests expedited QIO review in writing or by telephone until the QIO determination has been made.
- If the beneficiary or beneficiary's representative refuses discharge and does not seek QIO review, follow guidance provided in this document.

4.2 Issuance of HINNs and HRRs

a. The hospital Case Manager (CM) or designee will conduct a clinical review of Medicare inpatients and potential inpatients using INTERQUAL and/or other clinical screening criteria including discharge screens.

b. If a Medicare beneficiary does not meet admission or continued stay INTERQUAL, the CM will contact the attending physician to determine whether there is additional clinical information that is not documented in the medical record and request that the attending physician document any additional pertinent information.

c. If the attending physician provides additional documentation, the CM will re-evaluate the case.

d. If the beneficiary still fails to meet admission or continued stay INTERQUAL, the CM will refer the case to the Physician Advisor (PA) for review.

e. If the PA concludes that a beneficiary does not meet medical necessity for admission or continued stay, the CM will issue a HINN to notify the beneficiary that the stay does not meet inpatient criteria, that the services will not be covered by Medicare, and that the beneficiary will be financially responsible for services rendered from the date and time noted in the HINN.

f. Common situations requiring Medicare beneficiary notices are described below, along with applicable procedures:

- Preadmission Determinations – When a beneficiary's attending physician has ordered an inpatient admission, but preadmission review indicates that the beneficiary does not meet criteria for inpatient admission, CM will issue a preadmission HINN. (See Attachment D)

- Determinations after Admission, but on the Date of Admission – When it is determined after admission, but still on the date of admission, that a beneficiary who has been admitted as an inpatient never met medical necessity criteria for hospital services, and the attending physician does not discharge the beneficiary, CM must issue an Admission HINN notice on the date of admission. (See Attachment D)
- Determinations after the Date of Admission

i. Beneficiary Never Met Inpatient Criteria –

A. When a beneficiary is found after the date of admission never to have met INTERQUAL criteria for admission, but the attending physician does not discharge the beneficiary, an Admission HINN is no longer appropriate, and the case must be referred for review by the PA and a second physician member of the UM Committee.

B. If the PA and a second physician member of the UM Committee agree that the beneficiary did not meet criteria for admission, but the beneficiary's attending physician does not concur, hospital must contact the QIO and issue a Notice of Hospital Requested Review to inform the beneficiary that the hospital has requested QIO review of the discharge decision because the attending physician does not concur. (See Attachment E)

ii. Beneficiary Originally Met, but No Longer Meets Inpatient Criteria and Attending Physician Concurs – When a continued stay review indicates that the beneficiary no longer meets inpatient criteria, that discharge screens are met, and that the attending physician agrees with the determination (i.e., writes a discharge order) a Follow-up Notice (IMM) indicating the planned discharge date must be given to the beneficiary or beneficiary's representative. The beneficiary must be allowed four hours prior to discharge to evaluate and exercise their rights to appeal.

A. If the beneficiary or beneficiary's representative refuses discharge and requests expedited QIO review, follow guidance set forth above.

B. If the beneficiary does not seek expedited QIO review, but still refuses to be discharged, CM must prepare and issue a Continued Stay HINN to the beneficiary; (See Attachment F/G)

C. The Case Manager must have the beneficiary date and sign the HINN and must contact the appropriate individuals to work with the patient to make financial arrangements for satisfaction of the beneficiary's account for services subject to the HINN.

- If the beneficiary is incapable of reading or understanding the HINN, the CM must speak with the beneficiary's representative in person to obtain a signature, or if necessary, attempt to discuss the notice by telephone with the beneficiary's representative and simultaneously mail the notice to the beneficiary's representative by certified mail with return receipt requested. The CM may also use email, consistent with the hospital's information privacy and security policies and standards, to request a telephone call from the representative, but leaving a voice mail message is not sufficient for this purpose.

- When direct telephone contact with the beneficiary's representative cannot be made, the CM must mail the notice by certified mail, with return receipt requested.
- If the beneficiary is unable to read or understand the notice and the beneficiary has no representative, the CM attempting to deliver the notice must clearly document his or her search for a beneficiary representative on a copy of the HINN to be placed in the beneficiary's medical record.
- If the beneficiary or representative refuses to sign the HINN, the CM must document who refused to sign and the date of the refusal. The CM must initial and date the annotation.
- A copy of the signed or otherwise annotated Continued Stay HINN must be retained in the beneficiary's medical record. The original document must be given to the beneficiary or representative.
- Within 24 hours of a signed or otherwise annotated Continued Stay HINN, the CM must notify the Hospital's Director of Revenue Cycle. The Director of Revenue Cycle must immediately place the patient account on manual bill hold.
- The Case Manager and Director of Revenue Cycle must notify the billing department that a HINN has been issued by completing Medicare Non-Covered Continued Stay (see Attachment G). Following the instructions on the form, the manual bill hold is released once all steps have been completed.

iii. Beneficiary Originally Met, but No Longer Meets Inpatient Criteria and Attending Physician Does Not Concur –

A. When a continued stay review indicates the beneficiary no longer meets inpatient criteria and that discharge screens are met, but the attending physician does not agree with the determination and does not discharge the beneficiary, the case must be referred to the PA and a second physician member of the UM Committee for review.

B. If the PA and a second physician member of the UM Committee agree that the beneficiary no longer meets criteria for inpatient care, but the beneficiary's physician still does not concur, the Case Manager must contact the QIO and issue a Notice of HRR to notify the beneficiary that the hospital has requested QIO review of the discharge decision because the attending physician does not concur.

g. Hospital Requests for QIO Review – HRR

- When the beneficiary's attending physician disagrees with the determination of the UM Committee that a beneficiary no longer needs inpatient care, the Case Manager must request QIO review of the case.
- In these circumstances, the hospital Case Manager must contact the Clinical Administrator of Integrated Care Management (ICM) for guidance and the Clinical Administrator of ICM must initiate the QIO review process.

- Concurrently, the hospital Case Manager must notify the beneficiary that the hospital has requested a review using a model language for the notice of HRR. The Case Manager must also distribute copies of the HRR to: the beneficiary; the beneficiary's medical record; the beneficiary's attending physician, and the QIO.
- The transmission to the QIO must be labeled "Attention: Immediate Review" and must include a copy of the relevant medical records, a copy of the IMM, any notes related to Follow-up Notice(s) and a copy of the HRR. The Case Manager must also assemble and supply any pertinent information that the QIO needs to conduct its review by telephone or in writing, by close of business on the first full day immediately following the date the hospital submitted the HRR request for review.

h. Detailed Notice of Discharge: Beneficiary QIO Appeals

- When the hospital receives notice that a beneficiary has requested an expedited determination by the QIO, Case Manager must prepare a Detailed Notice to advise the beneficiary in full sentences using plain language regarding the planned discharge date, why the services are no longer reasonable and necessary (or are otherwise non-covered), applicable Medicare coverage policies and specific information about the beneficiary's current medical condition rendering the identified coverage policies applicable and supporting the decision to discharge on the indicated date.
- The hospital's designated individuals must deliver the Detailed Notice to the beneficiary and to the QIO as soon as possible, but not later than noon of the day after the hospital received notice of the appeal from the QIO.
- Integrated Care Management staff must also compile any documentation and information required by the QIO for this determination, including the IMM and the Detailed Notice, and forward that documentation to the QIO and/or respond to telephone inquiries from the QIO no later than noon of the day following the date the hospital received notice of the appeal from the QIO. The Case Manager must respond to all inquiries from the QIO regarding the appeal and discharge decision.
- If the beneficiary requests copies of the documentation and/or information provided to the QIO (or any portion of it), the Case Manager must provide the requested copies and information to the beneficiary by close of business on the day after the request is received by the hospital.
- Within 24 hours of the beneficiary's request for a QIO review, the Case Manager must notify the Director of Revenue Cycle of the pending QIO determination. The Director of Revenue Cycle will immediately place the patient account on manual bill hold.
- When the QIO determination is received, the Case Manager and Director of Revenue Cycle will determine if there is continued stay patient liability:

  i. If the QIO determination upholds the discharge and the review was requested timely, patient liability begins no sooner than noon on the day after the patient received notice of the QIO determination.

ii. If the QIO determination upholds the discharge but the review was not requested timely, patient liability begins on a date as determined by the QIO

When there is patient liability, the Case Manager and Director of Revenue Cycle notify the billing department by completing form Medicare Non-Covered Continued Stay (see Attachment G). Following the instructions on the form, the manual bill hold will be released once all steps have been completed.

If the QIO does not uphold the discharge, there is no patient liability for continued stay. In this instance, no notification to the billing department is required and the Director of Revenue Cycle may release the bill hold.

All inquiries, requests for records and any determinations for any HINN for Medicare Inpatients related to QIO appeals must be documented/maintained in the Care Management documentation system.

5. REFERENCES

5.1 42 C.F.R. §§ 412.42(c), (d) and (g)

5.2 42 C.F.R. § 482.30 42 C.F.R. §§ 405.1205-405.1208

5.3 42 CFR § 489.20(y)

5.4 Medicare Claims Processing Manual 100-04, Chapter 29

5.5 Medicare Claims Processing Manual 100-04, Chapter 30

5.6 CMS Beneficiary Notices Initiative (BNI) website

6. ATTACHMENTS

6.1 Attachment A: Important Message from Medicare

6.2 Attachment B: MOON - Medicare Outpatient Observation Notice (used to notify patient of Observation status)

6.3 Attachment C: Detailed Notice of Discharge

6.4 Attachment D: HINN 1 – Pre Admission/Admission Form (used prior to an entirely non-covered stay)

6.5 Attachment E: HINN 10 – Hospital Requested Review Form (Note: issued by hospitals to beneficiaries in Original Medicare whenever a hospital requests QIO review of a discharge decision without physician concurrence)

6.6 Attachment F: HINN 11 – Non-Covered Services for Continued Stay (Note: used for non-covered items or services provided during an otherwise covered stay)

6.7 Attachment G: HINN 12 – Medicare Non-Covered Continued Stay Form (Note: inform beneficiaries of their potential liability for a non-covered continued stay)

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Director Integrated Care Management	**Replaces Policy:** None

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
06/04/19	Director, ICM	Yes	Minor clarifications
6/2019	Director, HIM	Y	
6/2019	Director, Admitting	Y	Deletion of incorrect procedures
7/2/2019	PAC	Y	Minor wording

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO **Livanta**

Telephone Number of QIO **(877) 588-1123, Fax (855) 694-2929**

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call Admitting at (951) 486-4255 and for medical necessity call Integrated Care Management at (951) 486-5125 or ask to speak to a Case Manager.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO **Livanta**

    Telephone Number of QIO **(877) 588-1123, Fax (855) 694-2929**
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name	Provider ID Number
Riverside university Health System	050292

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4**: The QIO will review your medical records and other important information about your case.
- **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Additional Information:

collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions: The Important Message From Medicare

Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display "Department of Health & Human Services, Centers for Medicare & Medicaid Services" and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _____.

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.

(Hospitals may include contact information or logo here)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative

Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email:AltFormatRequest@cms.hhs.gov.

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: _____ _____ {insert specific managed care policies}

  _____ Other _____ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____{insert hospital and/or plan telephone number}.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Instructions for Completing the Detailed Notice of Discharge

CMS 10066

This is a standardized notice. Hospitals may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice. Insertions must be typed or legibly hand-written in 12-point font or the equivalent.

Hospitals or plans may modify the following sections to incorporate use of a sticker or label that includes this information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in the patient's ID number. This should not be, nor should it contain, the patient's social security or HICN number.

Physician: Fill in the name of the patient's physician.

Date Issued: Fill in the date the notice is delivered to the patient by the hospital/plan.

Insert logo here: Hospitals/plans may elect to place their logo in this space. However, the name, address, and telephone number of the hospital/plan must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number (including TTY) of the hospital/plan must appear above the title of the form.

BLANK 1: "**This notice gives you a detailed explanation of why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on** _____. In the space provided, fill in planned date of discharge.

First Bullet: **"Medicare Coverage Policies:"** Place a check next to the applicable Medicare and/or managed care policies. If necessary, hospitals may also use the selection "Other" to list other applicable policies, guidelines or instructions. Hospitals or plans may also preprint frequently used coverage policies or add more space below this line, if necessary. Policies should be written in full sentences and in plain language. In addition, the hospital or plan may attach additional pages or specific policies or discharge criteria to the notice. Any attachments must be included with the copy sent to the QIO as well.

Second Bullet: **"Specific information about your current medical condition"** Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. Use full sentences and plain language.

Third Bullet: **"If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call** _____." The hospital/plan should also supply a telephone number for patients to call to get a copy of the relevant documents sent to the QIO. If the hospital/plan has not attached the Medicare policies and/or the Medicare managed care plan policies used to decide the discharge date, the hospital should supply a telephone number for patients to call to obtain copies of this information.

Hospitals or plans may add space below this section to insert a signature line and date, if they so choose.

240.6 – Exhibit 4 – Model Language for Preadmission/Admission Hospital Issued Notice of Noncoverage.

Hospital Identifier

Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)
Model Language

Name of Patient:
Name of Physician:
Patient ID Number:
Date Issued:

We believe that Medicare is not likely to pay for your admission for (specify service or condition) because:

____ *it is not considered to be medically necessary*
____ *it could be furnished safely in another setting*
____ *other*

However, this notice is not an official Medicare decision.

If you disagree with our finding:

- *You should talk to your doctor about this notice and any further health care you may need.*
- *You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare.* ***See page 2 for instructions on how to request a review and contact the QIO.***
- ***If you decide to go ahead with the hospitalization, you will have to pay for:***

1

CONTINUED ON PAGE 2

[1] For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

If you want an immediate review of your case:

(insert one of the following as appropriate)

Preadmission:

- *Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.*

Admission:

- *Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.*
- *You may also call the QIO for quality of care issues.*

QIO Contact Information: *Livanta*
(877) 588-1123, Fax (855) 694-2929

If you do not want an immediate review:

- *You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.*

Results of the QIO Review:

- *The QIO will send you a formal decision about whether your hospitalization is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.*
    - *IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.*
    - *IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on (specify date) . (see footnote[1] on page 1).*

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____	_____	_____
Signature of Patient or Representative	*Date*	*Time*

220.5 – Exhibit 3 – Model Language for Notice of Hospital Requested Review. (Rev.)

Hospital Identifier

Model Notice of Hospital Requested Review (HRR)

Name of Patient:

Name of Physician:

Patient ID Number:

Date Issued:

We believe that Medicare will not continue to cover your hospital care because these services are no longer considered medically necessary in your case. Because your doctor disagreed with our finding, the hospital is asking the quality improvement organization (QIO) to review your case. The QIO is an outside reviewer hired by Medicare to look at your case to decide if you are ready to leave the hospital. The name of the QIO is

Livanta: (877) 588-1123, Fax (855) 694-2929.

- The QIO will contact you to solicit your views about your case and the care you need.
- You do not need to take any action until you hear from the QIO.

For more information about this notice, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____ _____ _____

Signature of Patient or Representative Date Time

Letter 11 - Model HINN - Noncovered Service(s) during Covered Stay

INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION

Name of Patient or Representative

_____

Attending Physician

_____

Date of Notice

_____

Admission Date

_____

Street Address

_____

_____

City, State, Zip Code

_____

Health Insurance Claim (HIC) Number

_____

YOUR IMMEDIATE ATTENTION IS REQUIRED

The purpose of this notice is to inform you that:

(Blank 1 – Service name)_____

is/are not covered under Medicare because:

(Blank 2 – Reason for Noncoverage)

Our opinion was based upon the following Medicare policy we and our Medicare intermediary follow:
(Blank 3 – Justification of Assessment of Noncoverage)

_____. If you decide to receive the service(s) listed above, based on our customary charges for this/these service(s), you will have payment responsibility for:

(Blank 4 – Patient Financial Responsibility)

Your attending physician has been advised of our opinion. You should talk with your physician about your health care needs, including the service(s) listed above.

RECEIPT OF THIS NOTICE

This notice is not an official Medicare decision. Your signature below only shows you have received the notice and understand what you may have to pay for. On the next page is information to use if you get the service(s) and you want to ask Medicare if it agrees with our opinion. Note we will also give a copy of this notice to your physician listed above.

Signature of Beneficiary or Representative Date

YOUR RIGHT TO A MEDICARE REVIEW (APPEAL):

You can ask us to file a Medicare claim for the service(s) listed on this notice. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this/these service(s), and how to ask for an appeal of that decision if Medicare does not pay.

- If Medicare has covered your hospital stay, it reviews any individual service it does not cover during that stay, only after you file a claim.
- If you appeal and Medicare decides to pay despite our opinion, any charges we collected will be refunded to you.
- You can ask your physician among others to represent you in filing an appeal.

Your Medicare intermediary does the formal review and makes the payment decision on the service(s) listed on this notice when processing the related claim. If you have questions on that claim or the MSN

for the service(s) listed on this notice, you can contact your intermediary. **Your intermediary contact information:** *Livanta: (877) 588-1123, Fax (855) 694-2929*

Quality Improvement Organizations (QIOs) in each State do certain types of reviews for Medicare, including judging the need for certain medical services and quality of care. You can ask your QIO in your State to review the service(s) listed on this notice after you have received them. **Your QIO contact information:** *Livanta: (877) 588-1123, Fax (855) 694-2929*

Sincerely,

(Blank 7- Hospital Signature)

Model HINN 12 - Noncovered Continued Stay

INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION

Name of Patient or Representative Identification Number

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by Medicare because:

{Insert Reason Medicare Is Not Expected To Pay}

Based on our understanding of Medicare policy, we believe that beginning on

_____

you will be responsible for payment of your continued stay. **Beginning on this date, you or your other insurance may have to pay for your continued stay. We estimate the cost of your continued stay to be:**

{Insert Estimated Total or Average Daily Cost}

You should talk with your physician about your health care needs, including your continued stay.

You can ask us to file a Medicare claim for your continued stay. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this claim, and how to ask for an appeal of that decision if Medicare does not pay. If you appeal and Medicare decides to pay despite our opinion, any charges we collected (minus co-pays and deductibles) will be refunded to you. If you have questions you can call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

This notice is not an official Medicare decision. Your signature below only shows that you have received this notice and understand what you may have to pay for. You will receive a copy of this notice.

_____ _____

Signature of Beneficiary or Representative Date

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 200	Page 1 of 11
Title: Financial Assistance For Low Income, Uninsured/Underinsured Patients	**Effective Date:** 05/22/2019	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. PURPOSE

1.1 The RUHS – Medical Center mission is to improve the health and well-being of our patients and communities through dedication to exceptional and compassionate care, education, and research. Our vision is to lead the transformation of healthcare and inspire wellness, in collaboration with our communities, through an integrated delivery network to bring hope and healing to those we serve. This policy demonstrates the RUHS – Medical Center commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between RUHS – Medical Center and a third party payer, nor is it intended to provide discounts to a non-contracted third party payer or any other entity that is legally responsible for making payment on behalf of a beneficiary, covered person or insured.

1.2 This policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance program. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.

2. SCOPE

2.1 This policy covers hospital inpatient and outpatient departments. An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or High Medical Cost patients who are at or below 350 percent of the FPL. Emergency Room physician fees are covered under a separate policy. All other physician fees are excluded.

3. DEFINITIONS

3.1 Bad debt: A bad debt results from services rendered to a patient who is determined by RUHS – Medical Center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

3.2 Financial assistance patient: A financial assistance patient is a financially eligible Self-Pay patient or a High Medical Cost patient.

3.3 Emergent medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions:

- When there is inadequate time to effect a safe transfer to another hospital before delivery; or
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

3.4 High medical cost patient: A financially eligible High Medical Cost patient is defined as follows:

a. Not self-pay (has third party coverage)

b. Patient's family income at or below 350% of the Federal Poverty Level (FPL)

c. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of Patient's Family income

3.5 Medically necessary service: A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

3.6 Patient's family: For patients 18 years of age and older, patient's family is defined as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, patient's family means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

3.7 Reasonable payment plan: Monthly payments that are not more than 10 percent of a Patient's Family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments,

insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

3.8 Self-pay patient: A financially eligible self-pay patient is defined as follows:

a. No third party coverage;

b. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay;

c. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third party liability as determined and documented by the hospital;

d. Patient's Family income is at or below 350% of the Federal Poverty Level (FPL)

4. POLICY

4.1 This policy is designed to provide assistance to financially qualified patients who require medically necessary services, are uninsured, ineligible for third party assistance, or have high medical costs. Patients are granted assistance from unfunded financial assistance, State-funded California Healthcare for Indigent Program (CHIP), county programs, or grant programs for some or all of their financial responsibility depending upon their specific circumstances.

4.2 Patients with demonstrated financial need may be eligible if they satisfy the definition of a financial assistance patient or high medical cost patient as defined in section 3.8 of this document.

4.3 This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout RUHS – Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with RUHS – Medical Center legal counsel.

4.4 Services that are not medically necessary services or services that are separately-billed physician services are not eligible for Financial Assistance program. Emergency department physician services are covered under a separate policy.

4.5 This policy will not apply if the patient/responsible party provides false information regarding financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

4.6 Regardless of ability to pay, RUHS Medical Center shall accept, manage and track medically necessary referrals received from RUHS Community Health Centers for all patients. Discounted medical care made available under the RUHS-CHC Sliding Fee Discount Schedule Program will be provided to patients referred from RUHS-CHC to the Medical Center.

4.7 RUHS – Medical Center, will ensure that patients are made aware of the importance of financial screening and completion of necessary paperwork to gain appropriate healthcare coverage for costs incurred for healthcare services provided at RUHS - MEDICAL CENTER.

4.8 All patients will be provided emergency services in accordance with Emergency Medical Treatment & Active Labor Act (EMTALA) regulations. RUHS - MEDICAL CENTER staff will comply with federal and state laws regarding the conduct of county hospital financial business practices.

4.9 The Financial Assistance Program available through RUHS - MEDICAL CENTER will not substitute for personal responsibility of the patient. All patients are expected to contribute to the cost of their care based on their individual ability to pay.

4.10 Emergency Physicians, as defined in AB 1503, Stats. 2010, Ch. 445.) Section 127450, who provides emergency medical services in a hospital that provides emergency care, are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the Federal Poverty Level. This statement shall not be construed to impose any responsibilities upon the hospital.

4.11 Eligibility for the Financial Assistance Program will be consider for those individuals who are uninsured, underinsured, ineligible for any government health care benefits program and unable to pay for their care based upon a determination of financial need. Patients who are denied eligibility to government programs for failing to cooperate with the eligibility process will not be eligible for Financial Assistance.

4.12 Departmental Responsibilities

a. The RUHS - MEDICAL CENTER Financial Assistance shall be reviewed and updated to reflect the current Federal Poverty Level Guidelines (Attachment III).
b. MISP and Patient Accounts managers and staff will ensure that the policies and procedures established for the Financial Assistance Program are applied consistently. Likewise, registration shall provide to all patients the same information concerning services and charges for RUHS – Medical Center.
c. MISP eligibility staff will determine if the patient is required to apply for Federal or State sponsored programs. Patients not linked to SSI/SSDI, Medi- Cal, Medicare, or MISP will be screened for the RUHS – Medical Center Financial Assistance Program.
d. MISP eligibility staff will apply the following when determining eligibility for Financial Assistance:
    - Patient must meet the Resource limits established for the State of California's Medi-Cal program.
    - Monetary assets will be considered
    - The first $10,000 of monetary asset is exempt, 50% of all assets in excess of $10,000 are also exempt.
    - All remaining assets will be compared to the Medi-Cal resource limit. Individuals who exceed this limit will not qualify for assistance.
    - Retirement accounts, deferred compensation plans qualified under Internal Revenue code, or nonqualified deferred compensation plans are not included in the determination of monetary assets.
e. RUHS - MEDICAL CENTER will post and make available

- A statement (Attachment I) that indicates that, if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program.
- Notice (Attachment II) that provides information about the patient may be eligible for a government-sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program. This notice will be posted in areas throughout the hospital.

4.13 Customer Service

a. Patients (or their legal representatives) seeking financial assistance will be asked to provide information quarterly concerning their health benefits coverage, financial status, and any other information that is necessary for RUHS – Medical Center to make a determination regarding the patient's need for financial assistance.
b. Financial screening provided by MISP Eligibility staff, using eligibility criteria (income, family size), will determine the amount a patient is responsible to pay.
c. All RUHS – Medical Center staff shall be informed of availability of Financial Assistance Programs.

4.14 Eligibility

a. Patients with income at or below 100% of the federal poverty level are eligible for RUHS - MEDICAL CENTER Free Care Financial Assistance Program. Patients with combined income and assets at or below 350% of federal poverty level and are uninsured or underinsured will be eligible to apply for the RUHS - MEDICAL CENTER Partial Financial Assistance Program after all other types of assistance have been exhausted.
b. Patient with high medical costs" means an insured patient with high medical costs (co-payment, deductible, coinsurance and/or reached a lifetime limit, non-covered relating to services not medically necessary), with income at or below 350% of the Federal poverty level and not already receiving a discounted rate as a result of insurance coverage, then the patient may qualify for a discount from usual charges in accordance to the following guidelines herein, including but not limited to the California Fair Pricing Law. High medical costs" means (1) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
c. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program.
d. Medi-Cal or Medicare beneficiaries with share of cost, deductible, and/or co-insurance do not constitute being underinsured.
e. Patients applying for the RUHS - MEDICAL CENTER Financial Assistance Program, who are denied eligibility have the right to file an appeal within 10 days. A patient has 10 days from the date that the county mailed or provided written Notice of Action (NOA). An appeal may be made by the patient contacting the RUHS - MEDICAL CENTER - MISP office to make an appointment with the appeals supervisor.

f. If determined to be eligible for the RUHS - MEDICAL CENTER Partial Financial Assistance Program by MISP eligibility staff, the patient will be referred to Patient Accounts to arrange payment of the hospital bill(s).
g. Documentation of the financial screening process will be retained by MISP according to MISP policy

4.15 Documentation Includes:
a. Date of determination of eligibility or denial for this program
b. Level of eligibility per the RUHS - MEDICAL CENTER Financial Assistance program
c. Copy of the application form
d. Copy of the approval or denial letter

4.16 Coverage Restrictions
a. Outpatient prescriptions and cosmetic surgeries are not covered under the RUHS - MEDICAL CENTER Financial Assistance Program.

4.17 Billing
a. Amounts payable to medical service providers other than RUHS - MEDICAL CENTER are excluded from this policy.
b. A Patient qualifying for assistance under the RUHS - MEDICAL CENTER Financial Assistance Policy and cooperating with Patient Accounts will not be referred to a collection agency.
c. A patient that fails to comply with requested financial updates will be responsible for payment of the original balance owned for their Hospital bill(s) in full.
d. In the event that the cost of medical care received at RUHS - MEDICAL CENTER is less than the amount the patient is responsible for, the patient will only be billed for the cost of those services. The cost of services provided will be determined using the most recently filed Medicare cost report.
e. Payment arrangements will be made for any amount owed that exceeds 10% of the monthly income of the patient. Payment plans will not exceed 12 months.
f. If a patient is cooperating and complying with the payments required according to the established responsibility for that patient, RUHS – Medical Center will not place wage garnishments or liens on primary residencies or other properties as a means of collecting the unpaid hospital UMDAP (Uniform Method of Determining Ability to Pay) bills.
g. If a patient fails to comply with their established payment plan for more than 90 days, the payment plan may be declared inoperable and the patient will be responsible for payment of the original balance owed for their Hospital bill(s) in full. Patient Accounts will attempt to contact the patient at the last known address and at the last known phone number of the patient to re-negotiate the payment plan prior to declaring any payment plan inoperable.
h. If it is determined an overpayment by the patient has occurred, RUHS – Medical Center will refund any amount owed within 30 days of the determination. Interest owed on this overpayment by the hospital to the patient will be paid to the patient at the statutory rate (10% per annum) according to Civil Procedure Code 685.010 and Health and Safety Code section 127440. Interest will be accrued beginning on the date payment was received by the hospital. If the amount of interest due to the patient is less than five dollars ($5.00), the hospital is not required to pay the interest.
i. RUHS – Medical Center contracted collection agencies; billing services are required to conform to the billing/collection practices outlined in this policy.

5. REFERENCES

5.1 2004 CHA Voluntary Principles and Guidelines for Assisting Low Income, Uninsured Patients.

5.2 MISP policy number MISP 10

5.3 MISP policy number MISP 14

5.4 MISP policy number MISP 20

5.5 MISP policy number MISP 21

6. ATTACHMENTS

6.1 RUHS – Medical Center Financial Assistance Statement

6.2 RUHS – Medical Center Financial Assistance Notice

6.3 Federal Poverty Guidelines

ATTACHMENT 6.1

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS – MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medi-Cal
Medicare
MISP
RUHS - MEDICAL CENTER Financial Assistance – UMDAP

Inpatient Services – Patients expressing concern with payment for Hospital services should be referred to the Inpatient MISP Eligibility staff for assistance.

Outpatient/Emergency Room Services – Patients expressing concern with payment for outpatient or emergency room services can be referred to the MISP office to pick up an MISP/RUHS - MEDICAL CENTER Financial Assistance Program application and schedule an appointment to meet with an MISP eligibility staff.

As part of the interview/screening appointment with the MISP eligibility staff, the patient requesting assistance will be screened for eligibility for all programs named above.

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
7888 Mission Grove Pkwy, Suite 201
Riverside, Ca 92508
951-486-5375
Espanol 951-486-5400

Medi-Cal	MISP	Medicare
951-486-5750	1-877-501-5085	1-800-633-4227

ATTACHMENT 6.2

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS - MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
7888 Mission Grove Pkwy, Suite 201
Riverside, Ca 92508
951-486-5375
Español 951-486-5400

Medi-Cal	MISP	Medicare
951-486-5750	1-877-501-5085	1-800-633-4227

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

ATTACHMENT 6.3

Annual 2019 Poverty Guidelines for the 48 Contiguous States

Household/ Family Size	100%	138%	200%	350%	400%
1	$1,041	$1,437	$2,082	$3,644	$4,164
2	$1,410	$1,946	$2,820	$4,935	$5,640
3	$1,778	$2,454	$3,556	$6,223	$7,112
4	$2,146	$2,961	$4,292	$7,511	$8,584
5	$2,515	$3,471	$5,030	$8,803	$10,060
6	$2,883	$3,979	$5,766	$10,091	$11,532
7	$3,251	$4,486	$6,502	$11,379	$13,004
8	$3,620	$4,996	$7,240	$12,670	$14,480
Each Additional Person Add	$369	$509	$738	$1,292	$1,476

Document History:

Prior Release Dates: 9/1/2006	**Retire Date:** N/A
Document Owner: MISP	**Replaces Policy:** MISP policies Policy No. 204.2 and 204.3

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/30/2016	MISP		
10/3/2017	Policy Approval Committee (PAC)	Y	Minor formatting and wording
11/13/2017	Hospital Executive Committee	N	
7/25/2019	MISP	Yes	Attachment 6.3 FPL table updated for 2019

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 400	Page 1 of 3
Title: Staffing	**Effective Date:** 9/12/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Assembly Bill 394. Is the California Registered Nurse Staffing Ratio Law which mandates numerical nurse-to-patient ratios for acute care, acute psychiatric, and specialty hospitals in California.

2. RESPONSIBILITIES

2.1 Riverside University Health System – Medical Center Administration will ensure compliance to this procedure.

2.2 The Human Resources Manager or designee is responsible for:
- a. Verifying employee credentials.
- b. Ensuring contract, registry, per diem, and Riverside County Temporary Assistance Program (TAP) employees have the same qualifications and competencies required of permanent employees performing the same or similar services at the hospital prior to providing any care, treatment or services.
- c. Coordinating, providing, and documenting orientation to staff

2.3 Nursing Administration is responsible for the clinical activities of all nursing personnel. This would include the clinical activities of all non-employee nursing personnel (contract, registry, students, or volunteers).

2.4 Department Managers are responsible for:
- a. Developing a staffing plan for the department based upon the needs of the Hospital.
- b. Providing adequate staffing for clinical and non-clinical services.

3. PROCEDURES

3.1 Staffing
- a. Each department is assigned a number of positions with specific job classifications and staff qualification requirements specific to the job responsibilities. The positions may be permanent, temporary, or per diem.
- b. All hospital personnel must meet all applicable standards required by State or local law, regulations, and hospital policy to practice their professions and job responsibilities. This is verified and documented by Human Resources when staff are hired and when credentials are renewed. Elements include at a minimum:

- Licensing (MUST be verified thru a Primary Source), certification, and/or registration requirements;
- Legal and regulatory requirements;
- Minimum qualifications, training, education, and experience requirements;
- Criminal background check;
- Applicable health screenings;
- Permits (such as food handlers permits).

c. Clinical staff positions include employees who provide patient care, treatment, and services such as physicians, nurses, lab technicians, physical therapists, respiratory therapists, audiologists, pharmacists etc...
   - Physician assistants and advanced practice registered nurses who practice within the hospital are credentialed, privileged, and re-privileged through Medical Staff.

d. Non-clinical staff positions include personnel such as food services, safety, housekeeping, security, office assistants, medical records, administration, materials management, etc…

e. Department staff shall oversee the supervision of students when they provide patient care, treatment, and services as part of their training.

3.2 Schedules

a. Post schedule for employees at least two weeks before the new schedule starts.

b. Scheduling staff in hospital clinical areas where they do not have demonstrated competency, training, and orientation is not permitted.

c. Staff may be re-assigned (floated) to cover shortages but will only function within their demonstrated level of competency and licensure/certification.

3.3 Staffing Agencies/Registry

a. Utilization of registry is limited to periods when other means of staffing have been exhausted.

b. The Staffing Office provides assistance to the inpatient nursing units by temporarily reassigning nursing personnel or obtaining per diem registry nursing staff to keep the patient/caregiver ratios at appropriate levels.

c. Traveler/per diem registry/TAP staff may be requested on nursing units to fill vacancies.

4. REFERENCES

4.1 County of Riverside Memorandum of Understanding (MOU) with SEIU

4.2 Assembly Bill 394, Health and Safety Code Section 1276.4

4.3 The Joint Commission, Comprehensive Accreditation Manual for Hospitals, as revised September 2011, Section HR.01.02.05

Document History:

Prior Release Dates: 7/2002, 1/2003, 2/2012; 8/2016	Retire Date: N/A
Document Owner: Human Resources	Replaces Policy: N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
July, 2019	Chief Nursing Officer	Yes	Formatting
8/1/19	Human Resources Manager	Yes	Removal of 3.1.b. bullet point: "proficiency assessments" as this is not always a requirement and was listed as a minimum requirement.
8/21/2019	Nursing P&P	No	
9/3/2019	Policy Approval Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 400.4	Page 1 of 4
Title: Personnel Conduct	**Effective Date:** 7/25/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. RESPONSIBILITIES

1.1 Executive Administration will ensure compliance to this policy and procedure.

1.2 Personnel will:

a. Conduct themselves appropriately during interactions with other members of the workforce, patients, and visitors.

b. Restrict physical contact to that commonly associated with professional business and patient care interactions.

2. PROCEDURES

2.1 Prohibited Behaviors. All personnel will be subject to disciplinary action up to and including termination for any inappropriate or unprofessional conduct. Behavior prohibited includes but is not limited to:

a. Dishonesty.

b. Incompetence.

c. Inefficiency or negligence in performance of duties.

d. Neglect of duty.

e. Insubordination or willful violation of an employee regulations, policies and procedures prescribed by the Board of Supervisors or policies and procedures established by RUHS – MEDICAL CENTER and/or its departments.

f. Absence without leave.

g. Conviction of a felony or any offense, misdemeanor or felony, involving moral turpitude, or any offense in connection with or affecting the employee's duties other than minor traffic violations. Conviction means a plea of guilty or *nolo contendere* or a determination of guilt in a court of competent jurisdiction.

h. Discourteous treatment of the public or other personnel.

i. Political activity in violation of federal or state law.

j. Physical or mental unfitness to perform assigned duties.

k. Substance abuse in violation of County of Riverside Board Policy C-10 *Alcohol and Drug Abuse Policy*.

l. Making a material misrepresentation in connection with obtaining or maintaining employment or position.

m. Conduct either during or outside of duty hours which adversely affects the employee's job performance or operation of the department in which he/she is employed.

n. Failure to maintain the license, registration, certificate, professional qualifications, education, or eligibility required for the employee's classification or required by virtue of assignment to a specific unit or department, when the failure of the employee to maintain such requirements jeopardizes RUHS - MEDICAL CENTER licensing or accreditation or adversely affects the employee's ability to perform his/her job.

o. Violation of Board Policy C-27 Workplace *Violence, Threats, and Securities* or RUHS - MEDICAL CENTER compliance plan, and/or policies and procedures, such as RUHS - MEDICAL CENTER policy No. 514 *Workplace Violence, Threats, and Securities;* and violations of the County's Board Policy C-25 *Harassment Policy and Complaint Procedures*.

2.2 Other Prohibited Conduct. Additional examples of conduct not permitted include but are not limited to:

a. Borrowing or accepting money from patients, as well as selling things to patients and personnel.

b. Discussing or revealing confidential information concerning any patient or RUHS - MEDICAL CENTER business matter to anyone not authorized to receive it.

c. Posting information concerning any patient or RUHS - MEDICAL CENTER business to unauthorized websites.

d. Accessing, using, or disclosing patient information that is not necessary for patient care.

e. Personal interactions and socializing with prisoners.

f. Gambling in County facilities, during County time, or on County property.

g. Bringing, possessing, selling, or using alcoholic beverages in County facilities or on County property. Exception: Pharmacy can procure alcoholic beverages for patient use and can be in possession of them.

h. Bringing, possessing, selling, using, or being under the influence of any illegal drugs in County facilities, on County property, or during County time.

i. Returning to RUHS - MEDICAL CENTER after completing a shift, or on time off, to visit with patients or employees, unless visiting a patient during regular visiting hours.

j. Leaving duty station unless authorized or at the time of relief by an oncoming shift.

k. Deliberate destruction, removal, or unauthorized use of County property, such as supplies and equipment.

l. Deliberate destruction, removal, or unauthorized possession or use of property belonging to patients, visitors, or other personnel, including but not limited to any meals, medication, or supplies intended for patient use.

m. Deliberate destruction, removal, or unauthorized possession or use of confidential documents or records, including but not limited to personnel records, patient records, interview results, computerized or hard copies of employee work performance records, or any other personnel or confidential material.

n. Sexually suggestive behavior or overtures.

2.3 Interaction Guidelines. By the nature of assignment, physical interactions/behaviors are necessary in many positions, classifications, and situations in order to provide appropriate service and medical assistance.

a. Patient interactions will not be encouraged unless they are directly related to supervised treatment or social activities consistent with making their stay at the Hospital more pleasant. Special care should be taken to eliminate behavior which is inappropriate, in poor taste, or illegal.

b. Staff interactions shall demonstrate the highest degree of professional behavior and ethics when interacting with patients and their families/friends.

c. Staff should treat other staff in a professional and cooperative manner consistent with the RUHS - MEDICAL CENTER mission of providing a positive and safe work environment for all members of the workforce in order to promote the highest quality of patient care.

d. Any allegations of inappropriate behavior regarding the above may be subject to investigation and appropriate action taken as necessary and as consistent with applicable County and RUHS - MEDICAL CENTER policies and procedures.

3. REFERENCES

3.1 RUHS - MEDICAL CENTER Policy No. 514, Workplace Violence, Threats, and Securities

3.2 Board of Supervisors Policy C-10, Alcohol and Drug Abuse

3.3 Board of Supervisors C-23, Disciplinary Process Policy

3.4 Board of Supervisors Policy C-25, Harassment Policy and Complaint Procedures.

3.5 Board of Supervisors C-27, Workplace Violence, Threats, and Securities

Document History:

Prior Release Dates: 11/13/99, 3/25/03, 10/18/11, 10/26/2016	**Retire Date:** N/A
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Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
6/2019	Executive Director, Quality & Service Excellence	N	
6/2019	Human Resources	N	
7/12/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 401	Page 1 of 2
Title: Provisions for Religious/Cultural Conflicts in Patient Care	**Effective Date:** 7/25/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. POLICY

1.1 Departmental Orientation

a. At the time of new employee orientation to the department/unit, supervisors/ managers will advise newly hired patient care providers about this policy.

b. It is the responsibility of employees to provide written notification to the supervisor/manager if they need to be excused from an aspect of care or services because of cultural values, ethics, or religious beliefs.

c. The employee's written request shall include the cultural, ethical, or religious reasons and the aspect of care or service from which the employee wants to be excused.

1.2 Accommodation of Requests

a. Any accommodation must be in the best interest of patient care and operational needs.

b. If the accommodation meets the daily operational needs of the department, then the supervisor/manager may accommodate the employee's personal cultural beliefs, values, and/or religious beliefs by:

- Changing patient care assignments with other employees.
- If reassignment is not possible, excusing the employee from duty, using leave accruals or approved absence without pay.

c. Reassignments that compromise patient treatment or care shall not be considered.

d. In cases where the accommodation cannot be reasonably granted, the supervisor/manager shall inform Administration and/or Human Resources (HR) to assist with solutions.

e. When an accommodation request is granted, a record of that accommodation shall be placed in the employee file.

1.3 Patient Care Emergencies

a. In an emergency or life-threatening situation, employees granted an accommodation will be expected to perform assigned duties until other arrangements can be made.

2. REFERENCES

2.1 Civil Rights Act of 1964

Document History:

Prior Release Dates: 3/31/97, 9/20/08, 11/1/11, 9/2/2016		**Retire Date:** N/A	
Document Owner: Administration		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
6/2019	Executive Director, Quality & Service Excellence	N	
6/2019	Human Resources	N	
7/12/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Housewide

	Document No: 407	Page 1 of 5
Title: Hand and Nail Hygiene	**Effective Date:** 7/25/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Pathogen: a bacterium, virus, or other microorganism that can cause disease.

1.2 Subungual: situated or occurring under a fingernail or toenail.

1.3 WHO: The World Health Organization (WHO) is a specialized agency of the United Nations that is concerned with international public health.

2. BACKGROUND

2.1 Pathogen transmission in the health care setting primarily occurs via the contaminated hands of health care workers. Hand hygiene is one of the most important measures for prevention of health-care-associated infections.

2.2 Studies show high levels of bacteria subungually. The most frequently isolated organisms are coagulase-negative staphylococci, gram-negative rods (including *Pseudomonas* spp.), corynebacteria, and yeasts. These pathogens were isolated even after careful hand hygiene. Artificial nails increase the risk of harboring gram-negative pathogens. The length of nails is also a substantial risk factor and should be kept trimmed to less than ¼ inch in length beyond the fingertip.

2.3 Studies reveal that areas underneath rings are more heavily colonized than areas without rings. Rings increase the risk for carriage of gram-negative bacilli and S. aureus by the wearer. Wearing rings results in greater transmission of pathogens in health-care settings.

3. PROCEDURE

3.1 **Hand Hygiene for Healthcare Providers**

a. Handwashing/hand antisepsis shall be performed using warm water and agency approved liquid soap for a minimum of 15 to 30 seconds or until hands are dry if using alcohol based hand gel:

i. At the beginning and end of every shift.

ii. Before and after providing care or performing any procedures to/on a patient, including touching anything in the patient's immediate environment, including the medical record.

iii. Before and after eating.

iv. Before entering and prior to leaving any patient room and special care areas.

- Neonatal Intensive Care Unit (NICU) requires 3-minute scrub.

v. Any time the hands are visibly soiled.

vi. Before donning gloves, prior to inserting a central intravascular catheter, inserting an indwelling urinary catheter or other invasive device that does not require a surgical procedure.

vii. After removing gloves.

viii. After toileting.

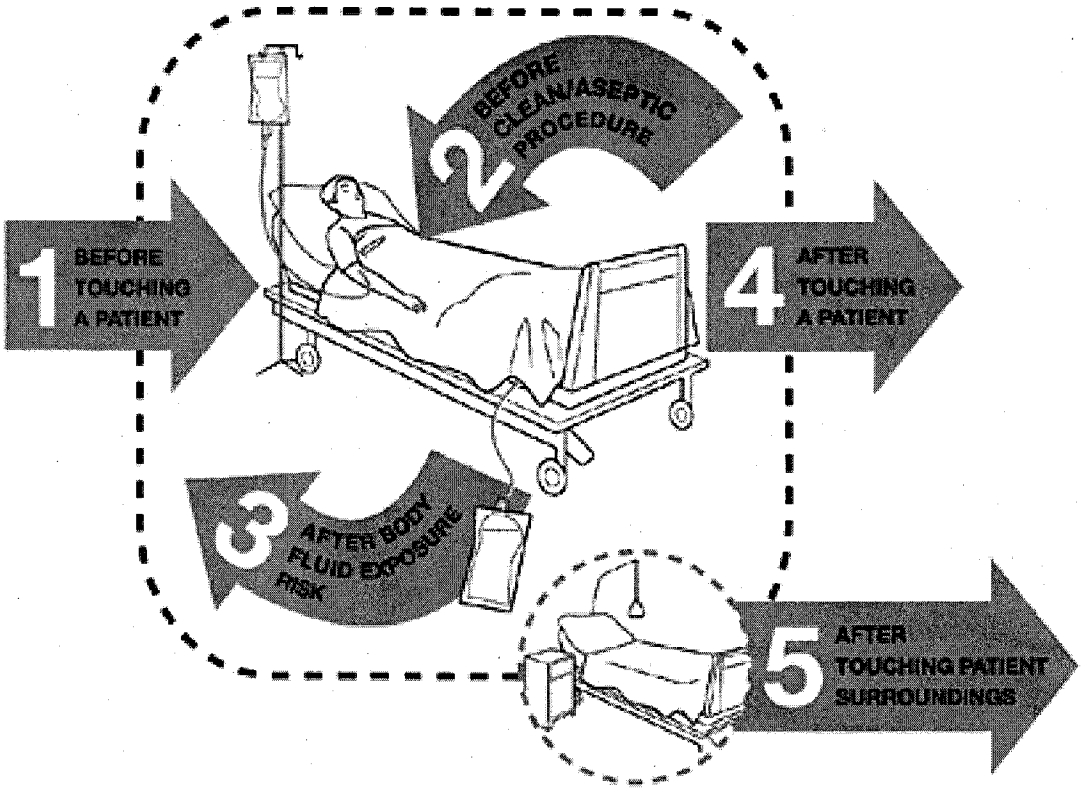
3.2 My 5 Moments for Hand Hygiene (a World Health Organization tool)

a. WHO's 'My 5 Moments for Hand Hygiene' approach defines the key moments when health-care workers should perform hand hygiene.

b. This evidence-based, field-tested, user-centered approach is designed to be easy to learn, logical and applicable in a wide range of settings.

c. This approach recommends health-care workers to clean their hands:

- Before touching a patient.
- Before clean/aseptic procedures.
- After body fluid exposure/risk.
- After touching a patient.
- After touching patient surroundings.



3.3 Hand Hygiene for Non-Healthcare Providers

a. Handwashing/hand antisepsis shall be performed using warm water and agency approved liquid soap for a minimum of 15 to 30 seconds or until hands are dry if using alcohol based hand gel:

- Upon cleaning or working in a patient care room or treatment area at the beginning and end of every shift.
- Before and after entering a patient care area that involves touching anything within a patient's immediate environment. This is not limited to medical records, medical equipment, patient items, conducting maintenance or performing environmental services activities.
- Before and after eating.
- Before entering and prior to leaving any patient room and special care areas. Before and after toileting.

3.4 Hand Sanitizing gels

a. Can be used up to five (5) times before hands are to be washed with soap and water.

b. Can be used if hands are not visibly soiled.

c. If gloves did not tear/rip in the performance of job.

d. Before and after providing care or performing any procedures to/on a patient, including the taking of vital signs.

e. Before donning and after removing gloves.

4. PROCEDURES

4.1 Handwashing

a. Wet hands with warm water. Note: avoid using hot water, as repeated exposure may increase the risk of dermatitis (chapped skin).

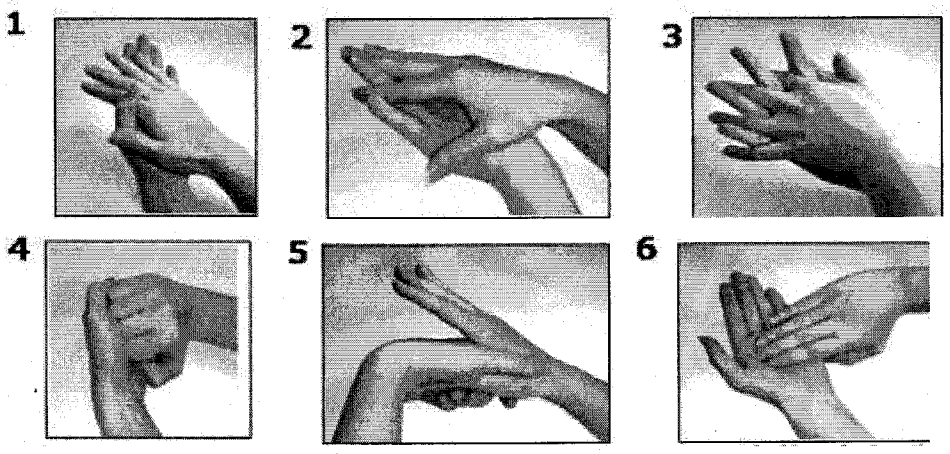
b. Apply the recommended amount of hospital approved liquid soap.

c. Rub hands together vigorously to create enough friction to work up a large amount of lather (this should take between 15-30 seconds), being sure to cover all surfaces of the fingers, hands and wrists. (See fig. below)

d. Rinse thoroughly under warm running water.

e. Dry fingers, hands and wrists thoroughly with disposable paper towel(s).

f. Once hands are dry, discard paper towel(s) in regular trash container.



4.2 Hand Sanitizing Gels

a. Squirt the manufacturer's recommended quantity of hand gel into the palm of one hand.

b. Rub hands together vigorously, being sure to cover the palmar and dorsal aspects of fingers and both hands and up to the wrist until hands are dry.

c. Be sure hands are dry prior to donning a new pair of gloves.

4.3 Hand-care

Nails

a. Keep cuticles trimmed and moisturized.

b. Natural nail tips are not to exceed more than ¼ inch in length beyond the fingertip.

c. Nail polish should not be chipped. If it is, it should be removed before providing tasks related to patient care.

d. The wearing of artificial fingernails, extenders, gels, silk wraps, tips, or nail jewelry is not allowed on employees/staff members who perform direct (e.g., Nurse, Physician) or indirect care (e.g., EVS, Nutritional Services).

Rings, Watches and Jewelry

a. Rings with stones or irregular surfaces may not be worn by employees/staff members who perform direct (e.g., Nurse, Physician) or indirect (e.g., EVS, Nutritional Services) patient care. A plain, smooth band without stones may be worn.

b. Pay careful attention to ring and ring finger during hand hygiene if plain band is worn.

c. Watches with expandable bands may be worn if they are pushed up the forearm during patient care and hand hygiene. It is recommended that watches be affixed to the employees/staff member's uniform.

d. Bracelets may not be worn.

Hands

a. Moisturize hands frequently to prevent hands from drying and cracking.

b. Cover with appropriate dressing/bandage, any cuts/scratches on the fingers, hands, or wrists before providing patient care.

Gloves

a. Hand hygiene is to be performed immediately before donning and immediately after removing gloves.

b. Wear gloves whenever contact with blood or body fluids, mucous membranes and non-intact skin is likely to occur.

c. Remove gloves after providing patient care.

d. Do not wear the same pair of gloves for the care of more than one patient, or for servicing more than one patient room.

e. Do not wash gloves between uses with different patients.

f. Change gloves during patient care if moving from a contaminated body site to a clean body site on the same patient, i.e., oral care then pericare.

g. Do not wear gloves while walking in hallways unless required by the task being performed, i.e., taking a red bag to dirty utility room for disposal. Once task is completed, gloves are to be removed and discarded in proper waste container. Hand hygiene is to be performed.

5. REFERENCES

5.1 **World Health Organization Guidelines on Hand Hygiene in Health Care**, First Global Patient Safety Challenge Clean Care is Safer Care, ISBN 978 92 4 159790 6, Geneva, Switzerland, 2009.

5.2 **John M. Boyce, MD; Didier Pittet, MD. Guideline for Hand Hygiene in Health-Care Settings:** Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect Control Hosp Epidemiol 2002;23[suppl]:S3-S40.

Document History:

Prior Release Dates: 11/1/2004, 12/28/2016	**Retire Date:** N/A
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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
11/8/2016	Infection Control Nurse	Yes	Formatting and wording
12/2/2016	Policy Approval Committee	Yes	Minor Wording
12/28/2016	Hospital Executive Committee	No	
7/14/2019	Manager, Infection Prevention and Control	No	No changes, Re-sign

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 407.1	Page 1 of 2
Title: Pre-Placement Physical Examinations and Employee Health Screening and Immunizations	**Effective Date:** 7/25/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. POLICY

1.1 All employees will be cleared by Occupational Health prior to work placement.

1.2 All employees will be offered Vaccines for Measles, Rubella, Mumps and Varicella if they are proven to not be immune. If they choose not to accept the vaccines they will be required to sign a letter of declination.

1.3 Employees who, by way of their essential functions of the job, would possible come into contact with Bloodborne Pathogens will be offered the Hepatitis Vaccine Series. If they choose not to get the vaccine, they will be required to sign a letter of declination.

1.4 All employees will have a medical assessment prior to work placement. The requirements of the physical will be dependent on the essential duties of their job.

1.5 All employees will be screened for TB. Those employees considered "high risk" for exposure will be screened every 6 months.

1.6 An annual health screen assessments is required for all employees. This consist of Fit Testing (as needed for essential functions of their job), TB Screening, and a Health Questionnaire.

1.7 All employees will be tested for drugs.

1.8 Bloodborne and Airborne Pathogen Exposures are to be reported to Occupational Health for case management.

1.9 Occupational Health will be the holder of employees Health Records.

1.10 All employees whose essential functions of their job require them to handle drugs are given a Hazardous Drug Handling Questionnaire and if applicable will have a complete blood count (CBC) drawn.

2. REFERENCES

2.1 State of California Title 22

2.2 State of California Title 8

2.3 County of Riverside Ordinance No. 440

Document History:

Prior Release Dates: 09/01/88, 05/05/97, 0322/00, 03/25/03, 9/21/2016	**Retire Date:** N/A
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6/2019	Executive Director, Quality & Service Excellence	N	
6/2019	Human Resources	N	
7/12/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 420	Page 1 of 6
Title: Dress Code	**Effective Date:** 7/25/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. SCOPE

1.1 This Policy and Procedure applies to all workforce members at RUHS – Medical Center's Moreno Valley campus, Arlington campus, and Campus Professional Center (CPC).

2. DEFINITIONS

2.1 Workforce Members is defined as any regular employee, temporary assistance employee (TAP), per diem employee, contract employee, volunteer, trainee, residents, medical students, and/or any other persons whose conduct, in the performance of work for RUHS – Medical Center, is under the direct control of RUHS – Medical Center, whether or not they are paid by RUHS – Medical Center.

3. RESPONSIBILITIES

3.1 The RUHS – Medical Center Administration and Management shall enforce this policy by:

a. Determining the appropriateness of their workforce member's attire/appearance based on RUHS – Medical Center guidelines and requirements for the delivery of services.

b. Counseling workforce members on acceptable attire/appearance.

c. Comply with the negotiated dress code provisions outlined in the Memorandum of Understanding (MOU) of the employee's respective Union.

3.2 All RUHS- Medical Center workforce members, at all RUHS – Medical Center facilities, shall be in compliance with this policy at all times.

4. POLICY

4.1 The policy of RUHS – Medical Center is to:

a. Create a professional appearance in order to promote a positive image to patients, visitors, and others while conducting business at RUHS – Medical Center.

b. Require workforce members to wear identification badges at all times. Please refer to RUHS – Medical Center Policy HW 420.1 Employee Identification.

c. Promote a safe environment by reducing the chance of injury or cross-infection caused by inappropriate attire or grooming practices.

4.2 General criteria. Male and female attire shall be clean, pressed, and well fitting. Grooming shall be free from offending odors and excessive perfume or cologne.

4.3 Religious Attire. RUHS – Medical Center recognizes the importance of individually-held religious beliefs to persons within its workforce. RUHS – Medical Center will reasonably accommodate a workforce member's religious dress and grooming practices unless the accommodation poses a safety concern or violates workplace regulations. Workforce members requesting a workplace attire accommodation based on religious beliefs should present the request directly to their supervisor/manager who shall consult with Executive Administration for approval.

4.4 Clothing. Clothing may be any color, pattern, and fabric which are appropriate for business wear. In addition to this policy, but not in conflict, there may be some dress differences among, divisions, offices, or units, depending on the work environment, nature of work performed, involvement in patient care activities, or uniform requirements.

4.5 Female Attire. Appropriate female attire includes:

a. Suits

b. Dresses, with a hemline of no more than 2 inches above the knee, any slits of not more than two inches above the knee, and of a length which does not drag on the ground.

c. Skirts, with a hemline of no more than 2 inches above the knee, any slits not more than two inches above the knee, and of a length which does not drag on the ground.

d. Slacks/trousers worn with:

- Blouses
- Sweaters
- Polo shirts, and/or
- Jackets

e. Hosiery/socks must be worn at all times when in patient care areas and Food & Nutrition Services Departments.

4.6 Male Attire. Appropriate male attire includes:

a. Suits

b. Jackets

c. Trousers (should skim the top of the shoe without dragging on the ground and must be secured at the waist)

d. Shirts (should be buttoned conservatively, shirt-tails should be tucked-in)

e. Sweaters

f. Polo shirts

g. Socks must be worn at all times

4.7 Shoes. Safety should be considered when selecting shoes for business wear. Shoes should protect the foot from injuries resulting from cold, heat, corrosives, toxic substances, falling objects, crushing, or pinching. Shoes must be worn at all times and must be neat, clean, and in good condition. The following footwear is not permitted:

a. Flip-flops/thongs

b. Mules, or any shoes without a back or back strap

c. Open-toe sandals when in Patient Care areas or in the Food & Nutrition Services Department

d. Sandals

e. High-heeled shoes with a heel of more than 3 inches high

f. Open toe shoes, shoes without flexible soles, and boots may be acceptable dependent upon the safety issues involved in the department and work environment

4.8 Hair/Makeup. Appearance should be appropriate for business.

a. Hair must be clean, neat, and styled for business wear

b. Sideburns, mustaches, beards, and goatees must be neat, clean, and properly trimmed

c. Makeup should be worn conservatively

d. Hands and nails should be clean (refer to RCHS Policy No. 407, Fingernails, regarding artificial nails)

4.9 Personal Hygiene. Personal hygiene is essential. All workforce members shall maintain a clean, presentable appearance.

4.10 Business Casual Friday Attire. RUHS – Medical Center has adopted a "Business Casual Friday Attire" in administrative and/or business departments. Workforce members are expected to use good judgment to ensure that their attire is appropriate for all activities, meetings, and public and patient contact in which they may be involved in that day.

4.11 Acceptable attire for business casual Fridays includes:

a. Open collar or polo-type shirts

b. Short-sleeved dresses, shirts, or tops

c. Casual pants and skirts that are not of denim material

d. Footwear which is clean and in good condition

4.12 Summer Business Attire. RUHS – Medical Center has adopted a "Summer Business Attire" and will be in effect from May 31 – October 1. The same criterion applies as in Business Casual Friday Attire. Not all casual or summer attire are appropriate for the office. Workforce members are required to dress in a manner that is consistent with their responsibilities. Keep the focus on a professional image.

4.13 Jeans (Black, Blue, and White) may be worn by the following classifications:

a. Stock Clerk

b. Laundry Department, recognizing that gowns must be worn over jeans

c. Medical Records Clerks

d. Information Services Technicians

e. Communications Department Technicians

4.14 Uniforms. Regular employees working in the classifications listed below will be provided four (4) shirts and two (2) pants or attire as allocated in the current Union Memorandum of Understanding. Damaged shirts and pants, as determined by the Department Manager, may be replaced by returning the damaged article to the Department Manager. All shirts and pants owned by the County shall be returned by the employee upon termination.

Supervising Food Service Worker – Shirt and Pants	Supervising Cook – Pants and Chef Coat	Stationary Engineers
Senior Cooks, Cooks, and Assistant Cooks – Pants and Chef Coat	Senior Food Service & Food Service Workers – Shirts, Pants, and Apron	Grounds Workers
Bio-Med	Supervising Dietitian, Dietician I & II, and Dietetic Technicians – Lab Coat	Electricians
Maintenance Mechanics	HVAC Mechanics	Store Keeper and Stock Clerk - Shirts, Pants, and Apron
Access Control Technicians (Key Shop)	Plumber	TAP Food Service Worker - White Shirt, Black Pants (Not provided by County)
Carpenters	Painters	

4.15 Lab Jackets. RUHS – Medical Center issues lab jackets to workforce members in designated classifications upon approval by the Department Manager and Executive Administration or designee.

4.16 Scrubs. RUHS – Medical Center workforce members may wear "scrubs" in any color or pattern which is appropriate for wear in a hospital setting when approved by Executive Administration or designee to do so. The scrubs shall be neat, clean, in good condition, and shall be provided and maintained by the workforce member. RUHS – Medical Center issues County-owned scrubs to workforce members who work in sterile environments and those who work in semi-sterile environments as approved by the Department Manager. County owned scrubs shall be returned to the Department Manager upon termination of employment. Workforce members, who receive scrubs owned by the County, shall:

a. Not wear the scrubs outside of the facility.

b. Not share the scrubs with other workforce members.

c. Return soiled scrubs to be laundered by the contracted, commercial laundry vendor.

4.17 Jewelry. For personal safety and security, workforce members are encouraged to wear limited jewelry keeping personal safety and professional appearance in mind at all times.

4.18 Facial Piercings. All facial piercings/jewelry such as nose, tongue, eyebrow, lip, or any other jewelry piercings are prohibited. Earrings are acceptable only when worn in the ears.

4.19 Tattoos/Body Art. Workforce members shall be required to cover any visible tattoos or body art expressions.

4.20 Unacceptable Work Attire. This list is an example only and may not include all items deemed inappropriate. Unless noted as an exception elsewhere in this policy, the following is unacceptable at all times:

a. Any attire of denim material

b. Overalls/coveralls

c. Shorts or "skorts" of any type

d. Athletic tee shirts, tee shirts normally worn as undershirts with or without graphics/slogans, or sleeveless (muscle) shirts

e. Athletic jerseys with or without graphics, including logos related to sports teams

f. Gym/sweat pants

g. Workout wear/gear

h. Leggings/spandex/stirrup pants

i. Tank tops

j. Shirts or dresses with spaghetti straps unless covered by:

- Jacket,
- Blouse, or
- Other acceptable outer garment.

k. Shirts that expose the stomach or midriff area

l. Halter or tube type shirts

m. Exposed undergarments, low necklines, and/or sheer fabric

n. Baseball caps, bandannas, or headgear including earphones, radios, Bluetooths, etc., unless required for safety or as part of a uniform

o. Sunglasses worn indoors

4.21 Enforcement. Managers and Supervisors are responsible for explaining and enforcing the dress code policy. Workforce members who report to duty and are non-compliant with the dress code policy may be sent home in accordance with the negotiated provisions outlined in the Memorandum of Understanding (MOU) of their respective Union. Failure to comply with this policy may be cause for disciplinary action up to and including termination. Consistent with this policy, exceptions may be made at the department level by the Department Manager due to the nature of work assignments or special events.

5. REFERENCES

5.1 RUHS – Medical Center policy HW 407.10 Hand and Fingernail Hygiene

5.2 RUHS – Medical Center policy HW 420.1 Employee Identification

5.3 Memorandum of Understanding, Service Employees International Union, Local 721

5.4 Memorandum of Understanding, Laborers International Union of North America, Local 777

5.5 California Assembly Bill 1964, The Workplace Religious Freedom Act of 2012

Document History:

Prior Release Dates: 8/1/1987, 9/11/2005, 9/6/2012, 11/15/2013, 12/28/2016	**Retire Date:** N/A
Document Owner: Administration	**Replaces Policy:** N/A

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
1/2016	Human Resources Services Manager	Yes	Minor changes made following meetings with the employee unions.
11/15/2016	Executive Director of Quality and Process Improvement	Yes	Wording and formatting
12/2/2016	Policy Approval Committee	Yes	Wording and formatting
7/12/2019	Executive Director, Quality & Service Excellence	N	No changes, re-sign

RIVERSIDE UNIVERSITY HEALTH SYSTEM –
MEDICAL CENTER and HOSPITAL BASED CLINICS
Housewide

	Document No: 505.2	Page 1 of 2
Title: Restrictive Security Devices for Incarcerated Patients	**Effective Date:** 9/12/2019	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Law Enforcement – (For purposes of this policy) any person assigned to the safety and security of a person who is in – custody and supervised by government or government contractors (e.g. city, county, state, federal, or private officers)

1.2 Restrictive security devices, such as handcuffs, shackles, or manacles, will be used for forensic purposes to contain patients who are inmates or prisoners in custody of law enforcement. Application of the restrictive security devices shall be the responsibility of assigned law enforcement personnel, not hospital or clinic staff. These devices are not to be considered restraints as defined in the RUHS – Medical Center policy 630 Restraints and Seclusion.

1.3 Restraints used for emergency behavioral management or restraints used for medical/surgical safety purposes are not to be confused with the restrictive security devices applied by law enforcement personnel for forensic custody, detention, and public safety reasons.

1.4 Forensic use of restrictive security devices will be used at the Arlington campus by law enforcement personnel for correctional inmates who are in the Emergency Treatment Services (ETS) undergoing a 4011.6 psychiatric evaluation. These devices are not authorized for use for any other patients in ETS or the Arlington campus Inpatient Treatment Facility (ITF).

1.5 The types of restraints (poly-urethane, soft, etc.) used by RUHS – Medical Center for the emergency management of a violent or self-destructive patient or for medical/surgical safety of a non-violent, non-self-destructive patient shall not be used by law enforcement or RUHS – Medical Center or clinic staff for the purpose of forensic detention or custody containment of inmate patients.

1.6 Physician or nursing staff orders, use, or removal of restrictive security device(s), are not permitted. Nursing staff responsibility for the restrictive security device(s) is limited to routine monitoring performed by nursing, such as during the nursing assessment, reassessment, the taking of vital signs, or other nursing care of the patient.

1.7 Safety of medical and law enforcement personnel is equally important as the physiological well-being of the inmate/patient.

2. PROCEDURES

2.1 Law enforcement personnel must maintain custody and direct supervision of their inmate (the hospital or clinic patient). Law enforcement personnel are responsible for the use, application, monitoring, and removal of the restrictive security devices in accordance with their respective departmental policies.

2.2 RUHS – Medical Center and clinic personnel are responsible for providing safe and appropriate medical care to inmate restrained by restrictive security devices applied by law enforcement personnel.

2.3 Law enforcement personnel assigned to an inmate, must be physically present and immediately available to any patient who is being held in restrictive security devices for the entire duration of their use.

2.4 Law enforcement personnel are responsible for being properly equipped to immediately remove or relocate a restrictive security device in order for clinical staff to provide urgent or emergency related medical care. For example, if the patient-assigned law enforcement personnel is told by a licensed clinical staff that the patient is "coding" or the patient "needs emergency care", the release from the restrictive security device(s) must be immediate to save the life of that patient.

2.5 For non-emergent medical care, licensed clinical staff must inform law enforcement personnel assigned to the inmate of the necessity for removal or relocation of the restrictive security device(s) for a specific medical intervention(s). Clinical staff must advise law enforcement personnel whenever the use of a restrictive security device interferes with, or adversely affects the physiological well-being of the patient so that the use or placement of the device(s) can be changed.

a. In response to removal requests, law enforcement personnel must be given the opportunity to determine when it is safe to remove the restrictive security device(s) based on the inmate's current behavior and prior history with staff.

b. To change the use or placement of the restrictive security device(s) for non-emergent medical care, law enforcement personnel must take into consideration the current and previous behavior of the inmate, departmental policies and information provided by the licensed clinical staff.

Document History:

Prior Release Dates: 11/02/2007, 2/14/2008, 8/24/16	**Retire Date:** N/A
Document Owner: Security	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/22/19	Safety, Security, RSO, BERT, Quality	Yes	Format and wording updates, standardization of language, definition added.
9/3/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 511	Page 1 of 4
Title: Code Pink	**Effective Date:** 7/10/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 Code Pink. A security alert issued in the event of an actual or suspected infant abduction from Labor and Delivery (L&D), Newborn Nursery (NBN), Obstetrics/Post-Partum (OB) or the Neonatal Intensive Care Unit (NICU).

2. POLICY

2.1 Riverside University Health System - Medical Center seeks to maintain the safety of infants in L&D, NBN, OB and the NICU by ensuring

a. The location of the infant is always known

b. The Code Pink response is uniformly carried out throughout the hospital in the event of a suspected or actual infant abduction

3. GUIDELINES

3.1 Medical Center Staff Responsibilities:

a. The hospital Chief Executive Officer and Chief Nursing Officer will ensure compliance to this Policy and Procedure.

b. The hospital Patient Safety Officer will ensure that all regulatory reporting is completed.

c. Medical Center Department Managers/Directors are responsible for ensuring staff members are trained in their duties during "Code Pink" alerts. Staff duties include:

- Ensure the safety of the infants assigned to their care and/or units;
- Observe the hospital exit / entry ways for any suspicious person(s) or activity and immediately notifying law enforcement of observations including taking notes and report any identifying factors or characteristic of suspicious person(s);
- Verify the identification of visitors
- Carrying-out other duties as assigned by the law enforcement personnel or management personnel.

3.2 Any hospital staff member may initiate a Code Pink upon suspicion or verification of an infant abduction from L&D, NBN, OB or NICU.

a. Staff who identifies a need for a Code Pink activation shall call the switchboard operator by dialing "911" from a hospital phone, and initiating an overhead page to announce a Code Pink.

b. Staff will physically search for the infant in the immediate area and in additional locations that may be identified via security cameras, radio frequency tracking devices or other means.

c. The Nurse Manager/Director, the House Supervisor, or their designee, will be the point of contact for the missing infant's legally recognized caregiver(s); and will coordinate activities with law enforcement personnel, the administrator on-call, and the legally recognized caregiver(s) of the missing infant.

d. Law enforcement personnel will dispatch personnel to respond to the Code Pink activation

- Law enforcement personnel will coordinate all activities related to the search for the missing infant and brief/debrief staff, as appropriate.

e. Integrated Care Management social workers will be available to assist with communication and support to the legally recognized caregiver(s) and relatives of the missing/abducted infant.

3.3 During a Code Pink, when it is confirmed that an infant is missing, staff will:

a. Perform duties as described earlier in Section 3.1 Medical Center Staff Responsibilities

b. Immediately notify the Nurse Manager/Director and House Supervisor, if not previously done;

c. Ensure that the involved area is preserved, undisturbed, or otherwise unchanged until approval is received from law enforcement personnel in charge of the incident;

d. Provide assistance to law enforcement personnel, as needed;

e. Remain available to assist the investigation until dismissed by Administration, law enforcement personnel, or respective designees;

f. Complete the Infant / Child Abduction Distribution Report (Attachment I);

3.4 In cases where an infant's whereabouts are unknown or if an actual abduction has occurred, an interdisciplinary team will be convened:

a. The Nurse Manager/Director or House Supervisor will notify the legally recognized caregiver(s) that the infant is missing, if not already done.

b. A private room, away from the affected area, will be provided for legally recognized caregiver(s) and their support persons.

c. Social worker(s) from Integrated Care Management will facilitate communication and services to the legally recognized caregiver(s) and their support persons.

d. The Nurse Manager/Director, House Supervisor or social worker will contact pastoral and/or other support person(s) as indicated and authorized by the legally recognized caregiver(s).

3.5 In the case of an actual abduction, regulatory reports, documentations, and analysis will be completed as follows:

a. The Medical Center staff who initiated the Code Pink will document the Code Pink events in the infant's medical record

b. Hospital Administration will complete steps required for a Sentinel Event.

c. Hospital Administration will notify County Risk Management and County Counsel of the abduction.

d. Hospital Administration will make a report to the California Department of Public Health.

3.6 Media, press, or other public statements regarding a Code Pink will be made only by the Chief Executive Officer (CEO), Public Information Officer or authorized designee. Media and public statements will be coordinated with law enforcement to ensure messages do not obstruct any criminal investigation or efforts to safely locate the child.

3.7 **"Code Pink, All Clear" will be determined and authorized by law enforcement personnel in charge of the incident** and will be announced by the hospital operator in an overhead page when notified.

4. ATTACHMENTS:

I. Infant / Child Abduction Distribution Report.

Document History:

Release Dates: February 28, 1993	**Retire Date:**		
Sponsored by: **Emergency Management Committee**	**Replaces Policy:**		
Date Reviewed	**Reviewed By:**	**Revisions Made?**	**Revision Description**
04/02/2019		Yes	Change in title to Integrated Care Management
12/28/2018	Nursing Director, NICU, PICU and Pediatrics	Yes	Definition of Code Pink changed to reflect only infant in designated areas; references to Sheriff and MVPD changed to Law Enforcement Personnel; Duplicate verbiage removed; Parents changed to legally recognized care giver(s); All references to HUGs removed; reference to Code Purple and HUGs policies added.
7/10/2019	PAC	Yes	Minor wording

ATTACHMENT 1.

RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER
INFANT / CHILD ABDUCTION DISTRIBUTION REPORT

OBSERVATIONS
SUSPECT'S
DESCRIPTION

Sex: Hair Color:

Approximate Age: Eye Color:

Race: Weight:

Unusual Characteristics:

Objects/packages being

carried: Clothing:

Synopsis (include Direction of travel, other parties with the suspect, time of occurrence, etc.)

OBSERVATIONS
INFANT/CHILD
DESCRIPTION

Sex: Hair Color:

Approximate Age: Eye Color:

Race: Weight:

Unusual Characteristics:

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 514	Page 1 of 7
Title: Workplace Violence, Threats, and Securities (RUHS Specific Roles and Responsibilities)	**Effective Date:** 9/12/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☒ Procedure ☐ Guideline

1. SCOPE

1.1 To ensure compliance with Riverside County Board of Supervisors (BOS) Policy C-27, *Workplace Violence, Threats and Securities,* at Riverside University Health System Medical Center. It is the additional purpose of this policy to provide a violence-free environment for all patients, visitors, and staff. Under no circumstances is this policy meant to supersede, interpret, or change the Board Of Supervisors (BOS) Policy C-27.

2. DEFINITION

2.1 Workplace Violence. Workplace violence is violence or the threat of violence against workers. It can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide, one of the leading causes of job-related deaths.

3. POLICY

3.1 The BOS Policy C-27, *Workplace Violence, Threats and Securities*, shall be followed at all times. Zero Tolerance for workplace violence is the policy standard for Riverside County and RUHS. This standard includes threats and violent behavior, direct, indirect, implied or actual, from any person, and directed toward any person, occurring at any RUHS facility or in connection with the conduct of County business without regard to location. For additional detailed information reference the BOS Policy No. C-27, *Workplace Violence, Threats, and Securities.*

4. RESPONSIBILITIES

4.1 Employees must:

a. Not make threats, either real or those which may be perceived as real or engage in violent behavior in connection with or during the course of Riverside County employment.

b. Immediately disengage, contact and report all incidents of threats or violent behavior to a supervisor. In the absence of the supervisor, report to the Executive Director and or the Safety Office, or after hours, the Nursing House Supervisor or the Administrator on Call. Community Health Centers (CHC) staff are to report to the Directors or Clinic Regional Managers.

c. Be knowledgeable of the zero-tolerance standard

Note: Employees are expected to exercise good judgment and inform the Human Resources/Safety Office if any employee exhibits behavior that could be a sign of a potentially dangerous situation. Such behavior might include:

- Discussing weapons or bringing them to the workplace
- Displaying overt signs of extreme stress, resentment, hostility, or anger
- Making threatening remarks; Verbal abuse
- Sudden or significant deterioration of performance; and/or,
- Displaying irrational or inappropriate behavior.

4.2 Directors/Supervisors/ Managers

In collaboration with Law Enforcement personnel and Hospital Security, must take steps immediately available to provide safety and security to the victim/ threatened individual and other person(s) at the work site by:

a. Reporting all incidents of actual violence, persons with weapons, and other cases when deemed necessary to the local law enforcement agency.

b. Ensuring that any threatening or violent person, employee, or member of the public, leaves the work site (except for incarcerated (jail) inmates, juvenile wards, and mental health patients)

c. Ensuring that an employee who has been the victim of a job-related threat or violence occurring away from County work site(s) does not revisit the scene until an investigation has been completed.

d. Adjusting, either temporarily or permanently, the threatened employees work schedule and/ or location if deemed necessary.

e. Immediately report all incidents to the Department Managers, or Executive Directors, Regional Managers, Human Resources, and the Safety Office; or after hours, to the Nursing House Supervisor or Administrator on Call and the Safety Office.

f. Immediately contacting an appropriate Law Enforcement Agency if necessary, to ensure removal of the offender from the scene; and Law enforcement personnel will conduct an investigation to take action to interview the threatening or violent person, employee, or member(s) of the public, prior to leaving the work site if a crime has been committed.

g. Investigate, review, and verify all reported threats and violent behavior.

h. Ensure that all employees attend the Human Resources/ Safety Office Workplace Violence Awareness Prevention Training.

i. Use resources and programs available within RUHS and within the County to address workplace violence concerns.

4.3 Hospital Administration must ensure that:

a. This policy is fully implemented in all work locations within their area of responsibility.

b. Managers and supervisors are fully informed of the Workplace Violence Zero Tolerance Board of Supervisors (BOS) Policy C-27.

c. All Executive, Directors, Managers and supervisors must attend the County Safety Division's Violence in the Workplace for Managers and Supervisors course.

d. RUHS staff members must attend the specific nonviolent crisis intervention training as identified by the Directors/ Manager of their unit.

e. All threats and violent behavior, direct, indirect, actual or implied, are reported to appropriate law enforcement agencies, Human Resources, Employee Relations, Hospital Safety Coordinator, and County Safety.

f. Investigation materials and disciplinary letters are sent to Human Resources and Employee Relations for review and approval in a prompt and timely manner.

g. All RUHS work sites and work practices within the Department/ Unit areas of responsibility are reviewed for the purpose of providing all employee, patients, visitors security and protection from the potential of reasonably foreseeable violent action.

h. Undertaking appropriate discipline, in accordance with County of Riverside Guidelines, with approval from Human Resources and Employee Relations.

5. PROCEDURES

5.1 Reporting

All workplace or work-related threats and violent behavior, including any perception of actual or implied threatening or violent behavior will be addressed promptly and in a timely manner - Department Supervisor/ Manager shall complete an Incident Report through Datix online incident reporting and the County Safety form attached to C-27 Riverside County Workplace Violence, Threats, and Securities policy.

5.2 Assaults

Any response to an incident involving an assault which has resulted in injury or death, should be limited in scope. The individual on scene who observes the incident should limit his/ her activities to the following:

I. Security Emergency Assistance: RUHS staff located in the main hospital building should dial 911 on their phone for in house emergency security response to assault or potential violence in the workplace. RUHS staff located in the Campus Professional Center (CPC), Off site campuses such as the Arlington campus, or Community Health Centers (CHC) do need to dial 9-9-1-1 for emergency assistance.

II. First Aid Assistance: Appropriately trained RUHS staff may render first aid assistance to any injured victims, utilizing appropriate body substance isolation precautions. First Aid assistance may consist of:

- Restoring breathing via Cardio-Pulmonary Resuscitation (CPR)
- Stopping bleeding
- Making the victim comfortable; and
- Calling for assistance.

III. Supervisor/ Manager Notification: Immediately notify his/her immediate supervisor. It is imperative that this notification occur immediately. The supervisor must also notify the Hospital Safety Office or if applicable the CHC Safety Coordinator in time for the Safety Coordinator to report to the County Safety Office **within eight (8) hours or sooner** of any assaults resulting in any injury above and beyond first aid (loss of limb, hospitalization). In situation where the Hospital Safety Coordinator or the CHC Safety Coordinator are not available, notification is to be made directly to the County Safety Office.

5.3 Direct or Indirect Threats and/ or Violence

All threatening comments or behavior indirect, actual, or perceived as threatening are to be taken seriously, and are never to be dismissed. Indirect and implied comments are to be reported to the immediate supervisor and may require further monitoring.

5.4 Reporting to the Supervisor

Threatening comments, actions, or violent behavior at any County location, or at any location where County business is being conducted are to be reported **immediately** to the supervisor, Nursing House Supervisor, and/ or Chief Operating Officer. Supervisors shall take necessary steps to assure the incident is reported **immediately** to an appropriate Directors, Assistant Nurse Managers, or Executive Directors as

appropriate, to law enforcement personnel as appropriate, to the RUHS Safety and Senior Safety Coordinator, the CHC Safety Coordinator and to Human Resources, except for incarcerated (jail) inmates, juvenile wards, and mental health patients.

5.5 Anonymous Reporting

Reports of any potentially dangerous situations or acts of violence can be made anonymously, and all reported incidents will be investigated. Reports or incidents warranting confidentiality will be handled appropriately, and information will be disclosed to others only on a need-to-know basis.

5.6 Incident Documentation

All threats and violent behavior implied, actual, direct, or indirect, are to be documented and investigated. Such documentation shall include a narrative of the incident including names and other appropriate identification of the parties involved, verbal comments made or description of the violent behavior, witness(es) names, and witness(es) statements.

5.7 Incident Investigation

a. The investigation report must be completed and sent to the County Safety Office within 24 hours after the initial incident. Therefore, the incident report must reach the Security Manager and Hospital Safety Coordinator immediately upon the occurrence of any workplace threat or violence. Within 24 hours, CHC incident reports must be provided to CHC Directors and to both the Safety Coordinator and the County Safety Office. Procedures for investigating incidents of workplace violence, such as threats and physical injury, include the following:

   I. Arriving at the scene of an incident as soon as possible.

   II. Immediately placing the employee allegedly making threats or violent behavior on paid administrative leave pending the review and determination of leave status by the Human Resources Office.

   III. Interviewing threatened or injured employee(s) and witness (es).

   IV. Examining the workplace for security risk factors associated with the incident after release of the scene by law enforcement personnel in the event that the incident involves injuries or death.

   V. Determining the cause of the incident.

   VI. Reviewing all related previous incidents.

   VII. Taking corrective action to prevent the incident from reoccurring.

   VIII. Contacting Human Resources, Hospital Safety Office, Security Manager, CHC Safety Coordinator, or the County Safety Office immediately upon knowledge of threats.

   IX. Completing and forwarding the Workplace Threat Incident Report to the Hospital Safety Coordinator for further forwarding to County Risk Management/ Safety Office.

5.8 Weapons at the Workplace

Unless specifically required or authorized in the course of employment, County employees are prohibited from possessing offensive or defensive weapons at any County facility or in connection with the conduct of County business without regard to location.

5.9 Enforcement

a. Threats, threatening conduct, or any other acts of aggression or violence in the workplace will not be tolerated. Any employee determined to have committed such acts will be subject to disciplinary action, up to and including termination. Non-

employees engaged in violent acts on County of Riverside premises will be reported to the proper authorities.

b. All reports of threats and violent behavior implied, actual, direct, or indirect, are to be documented and investigated. Such documentation shall include a narrative of the incident, including names and appropriate identification of the parties involved, verbal comments made or description of the violent behavior, witness (es) names, and witness statements.

c. For incarcerated (jail) inmates, juvenile wards, and mental health patients, the following procedures will be followed:
   I. Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.
   II. Establish a system, such as chart tags, logbooks, or verbal census reports, to identify patients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. The logbook/ records are to be made available upon request by Human Resources, Senior Safety Coordinator and/ or Human Resources Employee Relations.
   III. Prepare contingency plans to treat patients who are acting out or making verbal or physical attacks or threats.

d. County employees who engage in threats or violent behavior direct, indirect, implied, or actual, against co-workers or any other person in connection with County business, are to be subject to legal action by law enforcement authorities and disciplinary actions, up to and including termination of employment.

e. Directors, Managers and supervisors who fail to carry out their responsibilities in accordance with this policy and procedure will be subject to disciplinary action up to and including termination.

6. REFERENCES

6.1 BOS Policy No. C-27, *Workplace Violence, Threats, and Securities*, County Standard Safety Operations Manual Document No. 2010

6.2 RUHS Policy No. 631, Code Green: Assault by a Patient or Other Individual

Document History:

Prior Release Dates: 07/1997, 8/2008, 11/2011, 07/2017		**Retire Date:** N/A	
Document Owner: Environment of Care		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
08/26/2019	RUHS Safety	Yes	Updated Roles/Responsibilities/Reporting procedures, incident investigation section, Formatting changes and template update, including name change update for CHC, Directors
9/3/2019	Policy Approval Committee	Yes	Made title more specific Deleted overlap Added link to county policy

RIVERSIDE UNIVERSITY HEALTH SYSTEM –
MEDICAL CENTER, COMMUNITY HEALTH CENTERS, and HOSPITAL BASED CLINICS

Housewide

	Document No: 523	Page 1 of 5
Title: Electrical Safety	**Effective Date:** 9/12/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. SCOPE

1.1 The Environment of Care (EC) Medical Equipment Plan ensures that RUHS acquires and maintains medical equipment and systems that are reliable and meet clinical needs and are applied safely and accurately. The EC Plan applies to all powered clinical devices whether the device is part of a system or an individual piece of equipment intended for use in the care of the environment at RUHS.

2. PROCEDURES

2.1 Extension Cords

a. Extension cords shall be used only in emergency situations. They must be 16 gauge or heavier. Use of all electrical connecting adaptors is prohibited.

b. The Nursing supervisor or department manager requiring an extension cord shall submit a written request with justification of the emergency need to the RUHS Director / CEO for approval. If that individual is not available, the request shall be submitted to the Chief Operating Officer (days) and the on-duty Nursing House Supervisor (nights).

c. Approved requests shall be given to RUHS Material Management and an extension cord issued. Extension cords shall be safety checked by RUHS Plant Operations.

d. The requester is responsible for the return of the extension cord at the conclusion of the emergency situation.

2.2 Electrical Equipment: Testing and Approval

a. Electrical equipment brought into RUHS, whether by employees, patients, or visitors, and whether purchased, rented, leased, loaned, or donated, must be tested and approved in writing as electrically safe. Inspection and testing must be completed and approval given before the equipment is used in the RUHS facilities.

b. The Plant Operations Department is delegated the responsibility and authority for testing, evaluation, and approval of electrical equipment which includes all powered, devices used in the RUHS facilities.

c. Electrical equipment not owned by RUHS, found to be unsafe, will not be repaired by the Plant Operations Department. The owner of the equipment is responsible for seeking repair and the equipment is to be removed from RUHS.

d. Nursing supervisors and department managers shall be responsible for ensuring that all electrical equipment in their areas has been tagged as electrically safe by the Plant Operations Department. The Nursing supervisors and department managers shall notify the Plant Operations Department of any electrical equipment requiring approval.

e. Each piece of electrical equipment shall be certified as safe, and shall be issued a tag, sticker, or other marking that indicates:

    i. Certification as electrically safe.

    ii. Date certified.

    iii. Initials of the person certifying electrical safety.

f. The Plant Operations Department must record and maintain the records of all electrical safety tests completed.

g. Passing the electrical check does not give approval for use in the department. Use of equipment must be approved by the department manager/nurse manager.

    i. Acquisition and Use of Electrical Equipment

    ii. Prior to equipment being used, a memo will be sent to RUHS Plant Operations, with a copy to Administration. The memo will provide:

        - A description of the equipment (i.e., make and model number).
        - The serial number.
        - The intended use.
        - The proposed location.

h. All non RUHS owned electrical equipment (rented, leased, borrowed, or to be demonstrated) will be ordered and received only through Central Processing. Plant Operations shall inspect for safety all electrical equipment received by Central Processing.

i. Donated Electrical Equipment: Electrical equipment, including but not limited to microwave ovens, televisions, radios, etc., donated to RUHS, shall become RUHS property. By accepting donated equipment, RUHS accepts responsibility for regular inspection, repair, and maintenance of the equipment but not necessarily replacement.

j. Electrical Safety Clearance: All electrical equipment initially received at RUHS will be delivered to Material Management to make certain that it has electrical safety clearance prior to delivery of the equipment to the ordering department. Plant Operations will determine the equipment risk criteria and the PM interval, enter the required information of record into the equipment inventory database, and place the required sticker on the piece of equipment. Placing Equipment Orders.

k. Except for emergencies, orders must be placed so that equipment can be delivered Monday-Friday between 7:00 a.m. and 3:30 p.m. (0700-1530).

2.3 Electrical Equipment: Ordering, Delivering, and Receiving.

a. Use of non-RUHS owned equipment must be authorized by Administration or the Nursing House Supervisor prior to the equipment being ordered. Prior to any acceptance of loaned or rented equipment or new equipment demonstration, the Product Evaluation Committee (PEC) must review and approve it.

   i. In the case of rental equipment, the department manager or designee will obtain the signature of the authorizing administrative representative. The requesting person will then call Central Processing to request the needed equipment.

   ii. Central Processing will place the order with the vendor and will, at the time of the order, indicate the need for documentation of current PM to accompany any clinical equipment at the time of delivery.

   iii. When the order is placed with the vendor, Central Processing also will notify the Plant Operations Department so that appropriate plans can be made for the electrical safety check by authorized personnel, during normal duty hours, Monday-Friday, 7:00 a.m.-3:30 p.m. After hours other authorized Plant Operations personnel will do the electrical safety checks.

b. All non-RUHS owned electrical equipment must be delivered to Central Processing. No equipment may be delivered directly to the requesting department by the vendor or lender.

   i. Acceptable evidence of required PM must include documentation from the vendor, signed and dated by the vendor representative, that PM on the specific piece of equipment (identified by serial number or equivalent) was done on (date) or a copy of the PM sheet from the vendor indicating what PM includes, who did it, and the date it was done.

   ii. The unit/department charge person must verify, in Central Processing, the type and amounts of equipment. Central Processing has the only authorization to sign the company rental voucher. Central Processing will maintain the log of equipment into and out of the RUHS facility. They will provide the Nursing Office, Administration, and the RUHS Fiscal Office with a weekly list of rented equipment.

   iii. The unit/department charge person must verify completion of the safety checks prior to any equipment being used in the department.

c. Return of Equipment: When equipment is no longer needed, it can be cleaned by Environmental Services (EVS) if necessary and immediately returned to Central Processing. Central Processing will arrange for return of equipment to the vendor. Exception: Central Processing will be called whenever a Clinitron Bed is no longer needed so that they can contact the vendor to pick up the bed.

d. Preventive Maintenance (PM): All electrical equipment requiring PM will have it completed according to intervals defined by and recorded by Plant Operations.

e. All electrical equipment initially received at RUHS will be delivered to RUHS Purchasing (or Central Processing after hours) to make certain that it has electrical safety clearance prior to delivery of the equipment to the ordering department.

   i. Engineering will be responsible for maintaining the database records current and accurate and for completing_required PM and placing the required sticker on the piece of equipment.

   ii. The date on the sticker indicates the date the PM was done (not due). The code following the date indicates the number of times/year that PM is required, by what technician, and NSD (Next Service Date) indicates the date when the next PM is due.

   iii. Technicians performing the PM are the only personnel authorized to remove expired PM stickers.

f. Departments will be sent a list of the department's equipment for which PM is due. This list will be initiated by Plant Operations at least one month prior to the anticipated date for completion of the PM, and the list will include:

   i. The name of the equipment and the BEC identification number.

   ii. The month PM is due.

   iii. The scheduled date for completion of PM.

g. Departments/Units are responsible for identifying the location of equipment and setting up a time with Plant Operations for completion of PM. Plant Operations must be notified in advance and in writing of any equipment that cannot be located or of any equipment that is no longer used within the department. Department managers are responsible for making alternative arrangements to make equipment available for timely completion of PM.

h. Plant Operations must be notified by memo of any equipment that has been permanently transferred to another department so that the equipment list can be kept updated. Give the name of the equipment and control identification number. The department manager initiating this request must also send a copy of the request to the department to which the equipment has been transferred.

i. Verification of PM: Completion of PM will be indicated on each piece of bio-medical equipment by the presence of the required sticker.

j. Documentation of PM

   i. Those departments frequently surveyed under separate standards (i.e., Laboratory, Respiratory Therapy, Imaging Services) may wish to keep duplicate copies of PM documents in their departments, but original documents must be maintained by Plant Operations.

   ii. At least annually, and on request, Plant Operations will provide each department manager with a comprehensive list of each department's equipment and the scheduled months for PM on the separate pieces of equipment.

iii. Rental companies are expected to only deliver medical equipment that is current in its manufacturer's PM cycle, has a current PM and EST sticker on the device. If there is not an EST sticker, RUHS Plant Operations or Respiratory Technicians for respiratory equipment will do the test and tag the machine. Documentation must be completed and current prior to use of such equipment.

Document History:

Prior Release Dates: 10/10/2013, 08/29/2019	**Retire Date:** N/A
Document Owner: Plant Operations	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
08/29/2019	Angela Simpkins, Exec Director of Quality Marvin Granados, Plant Operations Manager	Yes	Used revised template
9/3/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM –
MEDICAL CENTER, COMMUNITY HEALTH CENTERS, and HOSPITAL BASED CLINICS

Housewide

	Document No: 552	Page 1 of 2
Title: Powered Air Purifying Respirator (PAPR)	**Effective Date:** 9/12/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Appropriate Usage of PAPR is defined as the performance of high hazard procedures on Airborne Infectious Disease (AirID) cases or suspected cases and for employees who perform high hazard procedures on cadavers potentially infected with Airborne Transmissible Diseases (ATD).

1.2 Fit Test is defined as a pass or fail assessment of the adequacy of a respirator. A qualitative fit test determines whether or not someone can detect various scents or flavors or can experience a negative reaction to a substance that can cause burning and / or watering eyes.

1.3 Hospital Equipment Management System (HEMS) is defined as a computerized equipment maintenance management system used to schedule preventive maintenance, create equipment logs and work orders, and track scheduled services/maintenance histories.

1.4 Powered Air-Purifying Respirator (PAPR) is defined as units that consist of a powered fan which forces incoming air through one or more filters for delivery to the user for breathing.

2. RESPONSIBILITIES

2.1 Occupational Health Department will identify those staff members who cannot be fit tested at the time of the initial health screening / annual health screening and shall:

a. Provide education to the employee on the appropriate use of the powered air purifying respirators.

b. Document the required information in the Occupational Health Employee File.

c. Notify the manager of the respective department.

d. Issue a PAPR competency card to each staff member for whom education and competency validation has been performed.

2.2 Bio-Medical Engineering Department (Bio-Med) shall:

a. Maintain a record of the maintenance of PAPR devices in HEMS.

b. Generate a work list quarterly that identifies devices that are due for preventative maintenance and send it to the Respiratory Care Department.

2.3 Respiratory Care Department shall:

a. Store the PAPR devices in the Respiratory Care Department.

b. Perform the routine inspection, testing, and battery checks quarterly on PAPR devices.

c. Perform air filter inspections and flow testing quarterly. The filters shall be changed when the air flow is insufficient to maintain the flow indicator above the minimum level indicated on the device.

d. Clean the PAPR devices with the hospital approved disinfectant between uses.

3. PROCEDURES

3.1 Employees assigned to use a PAPR shall complete the required orientation and annual education on the use and set-up of PAPRs at the initial and annual health screenings conducted by the Occupational Health Department. Staff competency is confirmed upon completion of the training and a PAPR competency card issued.

3.2 Upon receipt of the Bio-Med generated work list from the HEMS, Respiratory Care shall perform a quarterly battery check and return the appropriate documentation to Bio-Med for updated entry in to HEMS.

3.3 Units/Departments requiring a PAPR shall contact the Supervising Respiratory Care Practitioner (SRCP).

a. PAPR shall be signed out to the Unit/Department by the SRCP for the purpose of tracking.

b. PAPR Log shall be completed by the requesting personnel and must include Name, Date, Unit, Manager, and PAPR inventory number. This entry will be co-signed by the SRCP.

c. The SRCP is responsible for verifying the PAPR competency card prior to use.

d. The user of the PAPR is responsible for keeping the PAPR hood clean between uses.

e. The user of the PAPR is responsible for returning the PAPR to the SRCP to sign the PAPR back in after each use and reporting any problems with the PAPR device.

Document History:

Prior Release Dates: 8/6/12, 9/2/2016	**Retire Date:** N/A
Document Owner: Respiratory Therapy, Occupational Health and Bio Med	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
08/14/19	Respiratory Therapy, Occupational Health and BioMed, Infection Control	No	
9/3/2019	Policy Approval Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 555	Page 1 of 4
Title: Reporting Broken & Malfunctioning Equipment	**Effective Date:** 10/10/2019	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **BEC Number**: is the Biomedical Equipment Control Number and is used to identify equipment that is used in performing in direct patient care, such as infusion pumps, defibrillators, ventilators, etc.

1.2 **CPD**: Central Processing Department

1.3 **HEMS**: Hospital Equipment Maintenance Software used by RUHS – Medical Center.

1.4 **NCC Number**: is the Non-Clinical Control Number and is used to identify non-clinical equipment, such as wheel chairs, exam lights, exam tables, beds, gurneys, etc.

1.5 **Patient Care Area**: is the immediate area in which a patient resides or the area in which a procedure/examination is taking place (i.e., patient rooms, treatment areas, operating rooms, etc.)

1.6 **Plant Operations Staff**: is comprised of the following titles; Medical Electronics Technicians, Maintenance Mechanics, Maintenance Carpenters, Maintenance Electricians, Maintenance Painters, Maintenance Plumbers, Access Control Technicians, Stationary Engineers.

1.7 **Root Cause Analysis (RCA)**: is a process for identifying the basic or casual factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

1.8 **Sentinel Event**: is as defined by The Joint Commission's Comprehensive Accreditation Manual for Hospitals (CAMH);

a. An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
b. An event is called "sentinel" because it signals the need for immediate investigation and response.
c. The terms "sentinel event" and "error" are not synonymous, not all sentinel events occur because of an error, and not all errors result in sentinel events.
d. Severe Maternal Morbidity: Care that is unexpected and not directly related to the condition of the patient on admission, and that results in admission to the Intensive Care Unit (ICU) and/or transfusion of four or more units of packed red blood cells (PRBC).
e. For more information about sentinel events, please refer to RUHS – Medical Center Policy HW654 – Sentinel Events.

2. PROCEDURES

2.1 Reporting a suspected non-working piece of equipment where **there HAS BEEN patient harm**, or if the equipment is perceived to have possibly harmed the patient. These procedures are the same of both during and after business hours:

a. The staff member who discovers the potential equipment malfunction must immediately report it to the nurse manager, the charge nurse or person in charge of the shift or department, relaying all relevant details about the incident including a description of the potential equipment malfunction.
b. The nurse manager, the charge nurse or person in charge of the shift or department must review the situation immediately.
c. Department staff must take the proper steps to ensure immediate patient and employee safety.
d. Department staff must ensure that the patient continues receiving a proper level of care.
e. The equipment involved must remain intact in its present condition preserving evidence. The device is not to be touched or cleaned until released by reviewing department/agency.
f. The nurse manager, charge nurse, or person in charge of the shift or department must utilize the reporting chain, ensuring that the incident is reported to the Chief Nursing Officer or the Nursing House Supervisor (if after hours) or the equivalent Senior Administrator with oversight over the department. The Manager must also notify the Safety Officer.
g. An Incident Report must be completed in compliance with RUHS – Medical Center Policy HW122 – Incident Reporting.

2.2 If the patient harm qualifies as a sentinel event, staff must take all of the above procedural steps in response to patient harm, plus the following steps.

a. Complete all actions required by RUHS – Medical Center Policy HW654 – Sentinel Events, which includes a requirement to sequester the malfunctioned equipment.
b. The department manager/director must ensure that the required information is submitted to Riverside County Risk Management Division in compliance with the Safe Medical Devices Act of 1990.
c. If the device is considered a Medical Device, biomed will also report to the FDA's MedWatch program; the FDA safety information and adverse event reporting program.

2.3 Reporting suspected non-working piece of equipment where there **has NOT been patient harm**, nor possible patient harm.

a. Telephone Reporting Procedure
    1. During business hours telephone reporting procedure: the reporting party shall call hospital extension 64075. Plant Operations will dispatch a Bio-Medical Technician and/or Maintenance Mechanic depending on the type of the equipment.
    2. After business hours telephone reporting procedure: the reporting party shall call hospital extension 64075. The Stationary Engineers will log the reported call in the log book, and the Stationary Engineers will attempt to correct the issue or ensure that the proper personnel is notified immediately. If the proper personnel is not available, the Stationary Engineers will notify them at the start of the following work day.
    3. After hours support for BioMed procedure: Staff needing Biomedical must do so by calling the Nursing House Supervisor, they have the authority to bring in BioMed for after-hours support. They do this by notifying the hospital operator that BioMed is needed. The hospital operator will then place a call to the BioMed on-call and provide the appropriate level of support.

4. At the time of the call: the reporting party must provide the NCC number of the BEC number depending on the type of the equipment, the location (room number, nursing unit, etc.) the contact person, and a brief description of the suspected failure or malfunction.

b. The reporting party may drop off the equipment at Plant Operations without calling to report the malfunction. However, the reporting party (whether they call Plant Operations or not) must always complete the following steps prior to Plant Operations taking possession of the equipment.
   1. Ensure that the equipment is cleaned, disinfected and/or sanitized before it is removed from the patient care area by the appropriate staff in accordance with infection control guidelines. If the equipment is a bed, a completed form must be attached to the bed to certify it was properly cleaned.
      - Exceptions: If the equipment is part of the normal stocked items (such as infusion pumps), it can be placed in the dirty utility closet. During CPD's equipment rounds it will be picked up and cleaned in CPD before it is given to the appropriate repair trade.
   2. Fill out the maintenance/repair request form completely. Make a copy of the attached maintenance/repair request form (Attachment 4.1), if there are no forms accessible on the unit.
      - A completed maintenance/repair request form must include the NCC number or the BEC number depending on the type of the equipment, the location (room number, nursing unit, etc.) the contact person and a brief description of the suspected failure or malfunction. All of this information is required for Plant Operations to properly manage the equipment, to confirm that malfunctions are addressed thoroughly, and to protect our patients from harm.
   3. Make a copy of the maintenance/repair request form for department records.
   4. Deliver the original to Plant Operations using one of the following methods:
      - Hand the form directly to Plant Operations staff if they are picking up the equipment.
      - Fax the form to Plant Operations at (951) 486-4105.
      - Leave the form in the mailbox located outside of the Plant Operations office, located in room F0057 on the Lower Level.
      - Go to the Plant Operations office and hand the form to the staff.

3.4 Returning equipment back to service:
   a. Plant Operations will evaluate the equipment and schedule the repairs in accordance with manufacturer standards and recommendations.
   b. A detailed work order for the repairs will be created and captured in HEMS.
   c. Plant Operations staff will affix the green tag (Attachment 4.3) when the equipment is ready for service, clearly identifying that the equipment is fully operational.
   d. When appropriate, equipment will be returned directly to the department where the service request originated.
   e. when it is not appropriate to return the equipment to the department, it will be placed in a staging area designated by Plant Operations. Staff may only remove equipment form this area if the green tag is attached to the equipment. If there is no tag, or a red tag attached to the equipment, staff may not touch or move the equipment.
   f. All equipment must be cleaned and disinfected and/or sanitized according to infection and prevention control guidelines by the appropriate staff before being returned to patient care.

4 REFERENCES

4.1 The Joint Commission standard EC.02.05.07 "The organization inspects, tests, and maintains medical equipment

4.2 Safe Medical Devices Act of 1990.

5. ATTACHMENTS

5.1 Maintenance Request Form.

5.2 Sample Equipment tags.

Document History:

Prior Release Dates: 10/10/2013, 10/26/2016	**Retire Date:** N/A
Document Owner: Plant Operations	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
07/24/2019	Angela Simpkins, Exec Director of Quality Marvin Granados, Plant Operations Manager	Yes	Used revised template
10/26/2016	Hospital Executive Committee	No	
09/27/2016	Policy Approval Committee	No	
09/21/2016	Plant Operations Manager	No	
09/19/2016	Purchasing	Yes	Minor Wording
09/19/2016	Regulatory	Yes	Minor Wording
09/19/2016	Quality Management	Yes	Minor Wording
09/19/2016	Policy Coordinator	Yes	Formatting, wording, added elements for equipment return
11/18/2015	Respiratory		
09/20/2015	Safety Office		
09/20/2015	EVS Manager		
07/23/2015	Policy Approval Committee	Does not approve	Request major revisions
06/23/2015	Policy Approval Committee	Does not approve	Request major revisions
05/05/2015	Chief of Hospital Plant Operations		

DATE: _____

UNIT: _____

ROOM # _____

REPAIRED
CLEANED
READY TO USE

REPAIRED
DIRTY

CLEANED/
BROKEN

BROKEN / DIRTY

PLANT OPERATION EQUIPMENT REPAIR REQUEST

(THIS FORM TO BE USED FOR ALL EQUIPMENT REPAIRS)

DATE_____ DEPARTMENT_____ YOUR NAME_____ PHONE # _____

DEVICE_____ MANUFACTURER_____ NCC/BEC #_____ FAN # _____

MODEL _____ S/N_____ PROBLEM _____

ALL EQUIPMENT BROUGHT TO PLANT OPERATIONS FOR REPAIR MUST BE CLEANED FIRST.

SIGNATURE OF PERSON THAT CLEANED EQUIPMENT: _____

EQUIPMENT NOT SIGNED FOR BY PLANT OPERATIONS WILL NOT BE REPAIRED. EQUIPMENT LEFT IN TUNNEL WILL NOT BE ACCEPTED.

ACCEPTED FOR REPAIR BY PLANT OPERATIONS_____ DATE _____

REPAIR COMPLETED (DATE)_____ COMPLETED BY _____

UNIT PERSONNEL ACCEPTING REPAIRED EQUIPMENT

_____ DATE _____

FORM #215 (7/93)

RIVERSIDE UNIVERSITY HEALTH SYSTEM

	Document No: 601	Page 1 of 6
Title: Patient Rights and Responsibilities	**Effective Date:** 7/1/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental.**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Patient Rights - A list of rights that apply to all patients and/or their representative, Attachment 1.

2. POLICY

2.1 Information on Patient Rights and Responsibilities. Upon admission, or at the time of outpatient registration, patients or their representative, are provided with a Patient Guide that includes the following information.

a. If the patient's physical or mental condition does not allow him/her to receive the Patient Guide, the patient's representative shall be given the publication. The patient shall be provided with a copy when his/her condition improves, even if the patient representative has already received the Patient Guide.

b. The Patient Guides are available in both English and Spanish. The Admitting Office and the Hospital Patient Advocate have additional copies of the Patient Guides if the patient misplaces their copy.

c. Alternate formats are available, upon request of a patient or patient representative, to meet the needs of patients who have physical restrictions and/or have language or communication barriers.

d. RUHS Internet

- The Patient Rights and Responsibilities is available at RUHealth.org.

e. Patient Rights Posters

- Patient Rights posters are displayed in English and Spanish prominently at:
  - i. Major entrances and entrances to all nursing units.
  - ii. Emergency Department
  - iii. Business offices.
  - iv. Medical Mall.

2.2 Patient Rights Guaranteed by Law. Patients may also have additional rights guaranteed by Federal or State law, such as:

a. Provision of emergency medical services without regard to ability to pay and limits on transfers of a patient to another healthcare facility. These rights are addressed in the policy regarding Emergency Medical Treatment & Labor Act (*EMTALA)*. Signage is posted the emergency department for patient notification of these rights.

b. Release of patient identifiable information. Patients receive a Notice of Privacy Practices (NPP) to inform them of how their information may be used and/or disclosed. More information may be found in the policy regarding *Patient Confidentiality, Medical Records, and Release/Disclosure of Patient Information.*

2.3 Staff Education. RUHS Medical Center and Clinic personnel will receive education regarding patient rights at new employee orientation.

2.4 Mental Health/Behavioral Health Patient Rights

a. Any mental health/behavioral health patient who believes a right of his/hers has been abused, punitively withheld, or unreasonably denied may file a complaint with the Department of Behavioral Health Patient Rights Advocate at (951) 358-4600.

3. REFERENCES

3.1 42 CFR 482.13, Condition of participation: Patient's rights.

3.2 The Joint Commission Comprehensive Accreditation Manual for Hospitals, RI Chapter

3.3 California Code of Regulations, Title 22 § 70707 Patient Rights

4. ATTACHMENTS

4.1 Attachment I. Combined Patient Rights.

4.2 Attachment II. Patient Responsibilities

Document History:

Prior Release Dates: 2/13/91, 3/8/03, 8/11/05, 11/28/12, 4/2016, 5/11/2016	**Retire Date:** N/A
Document Owner: Patient Advocate	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
5/2019	Executive Director, Quality & Service Excellence	No	
5/29/2019	Policy Approval Committee	Yes	Minor clarifications

ATTACHMENT I. COMBINED PATIENT RIGHTS

(Combined Title 22 and other California Laws, the Joint Commission and CMS Conditions of Participation Requirements from California Hospital Association. Appendix 1-A / effective 3/17)

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of admission to the hospital.
3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures, and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medications, if you suffer from severe, chronic, or intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe, chronic pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physicians, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your requests, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage or registered domestic partner status, unless:
    a. No visitors are allowed.
    b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    c. You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitations and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitations privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling:

    Riverside University Health System
    26520 Cactus Avenue, Room E1008
    Moreno Valley, California 92555
    Attention: Hospital Patient Advocate
    Or call: 951-486-4313

    The grievance committee will review each grievance and provide you with a written response within 7 working days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).
23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is:

    California Department of Public Health
    Licensing and Certification Division
    625 Carnegie Drive, Suite 280
    San Bernardino, California 92408
    Or call: 909-388-7170

ATTACHMENT II. PATIENT RESPONSIBILITIES

(AS FOUND IN THE PATIENT GUIDE AND RUHEALTH.ORG)

1. **Providing information:** Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health, as well as reporting unexpected changes in the patient's condition to the responsible practitioner.
2. **Asking questions:** Asking questions when they do not understand what they have been told about their care or what they are expected to do.
3. **Following instructions:** Following the treatment plan developed with the practitioner and expressing any concerns about their ability to follow the proposed course of treatment.
4. **Accepting consequences:** Accepting the consequences and/or outcomes of refusing treatment, failing to follow the recommended course of treatment, or using other treatments.
5. **Following rules and regulations:** Following hospital rules and regulations concerning patient care and conduct.
6. **Showing respect and consideration:** Being considerate of other patients and hospital personnel by not making unnecessary noise, smoking, or causing distractions.
7. **Respecting property**: Respect the property of other persons and that of the hospital.

RIVERSIDE UNIVERSITY HEALTH SYSTEM
HOUSEWIDE

Title:	Document No: 601.2	Page 1 of 5
Physician Orders for Life Sustaining Treatment (POLST)	Effective Date: 7/25/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. SCOPE

1.1 To provide a guideline for staff on obtaining or completing a POLST.

a. The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders.

b. This document covers the following contents:

i. Patient in Emergency Department with a Completed POLST Form

ii. Patient Admitted with a Completed POLST Form

iii. Completing a POLST Form with the Patient

iv. Conflict Resolution

2. DEFINITIONS

2.1 Advance Directive: See Advance Directive Policy

2.2 California POLST Registry: A registry to connect POLST forms to physicians, hospitals, skilled nursing facilities, and the Health Information Exchange. The goal is to provide a more effective means of documenting, communicating, and ensuring desired treatment at the end of life to be honored.

2.3 Decisional capacity: is an individual's ability to 1) understand the nature and consequences of a health-care decision and 2) to make and 3) communicate a decision.

2.4 Physician Orders for Life-Sustaining Treatment (POLST): The POLST is a form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

2.5 Substitute Decision Maker (SDM): If a patient lacks capacity to provide consent or has been declared by a court of law to be incompetent, those who may provide consent on behalf of a patient, listed in order of authority:

a. Conservator: An adult designated by the court to make health-care decisions for the patient.

b. Healthcare Agent: An adult designated in an advance directive to make health-care decisions for the patient.

c. Surrogate: An adult, designated by the patient to make health-care decisions for the patient.

d. Closest Available Adult Relative or Friend.

2.6 Licensed Independent Practitioners (LIP). An individual permitted by law and by the organization to provide care, treatment and services without direction or supervision.

3. GUIDELINES

3.1 Patient in Emergency Department with a Completed POLST Form

a. During the LIP initial patient assessment, document the existence of the POLST form and confirm with the patient, if possible, or if the patient lacks decision making capacity the patient's SDM, that the POLST form in hand has not been voided or superseded by a subsequent POLST form. (See "Conflict Resolution" for additional guidance.)

b. LIPs or nurses may click the POLST button on the banner bar of the patient's electronic medical record to check the existence of a POLST in the California POLST registry (EMR).

c. A nurse or designated staff member will communicate to the emergency department LIP caring for the patient the existence of the POLST if identified with patient's property.

d. POLST orders will be followed by LIP as a valid physician order until the emergency department LIP reviews the POLST form and incorporates the content of the POLST into the care and treatment plan of the patient. The LIP should document his/her review of the POLST in the medical record.

e. If the emergency department LIP, upon review of the POLST and evaluation of the patient, determines that a new POLST is indicated, at discharge, he/she shall review the proposed changes with the patient and/or SDM, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The LIP should document the reasons for any deviation from the original POLST in the medical record. (See also "Reviewing/Revising a POLST form" regarding voiding a POLST.)

   i. Complete a new POLST order by clicking on the POLST button in the patient's banner bar, filling out the form electronically. Sign the POLST form along with the patient using the signature pad. Upon saving the POLST form, the form is stored in the EMR and on the California POLST registry.

   ii. Medical Unit Clerk (MUC) will then print out the POLST form from the BCA printer onto pink cardstock provided and provide this to the patient.

f. Discussions with the patient and/or the patient's SDM regarding the POLST and related treatment decisions should be documented in the medical record.

g. If the patient is admitted to an inpatient unit, send the current POLST copy with the patient to the inpatient unit.

3.2 Patient Admitted with a Completed POLST Form

a. During the initial physician patient assessment, document the existence of the POLST form, and confirm with the patient, if possible, or if the patient lacks decision making capacity the patient's SDM, that the POLST form in hand has not been voided or superseded by a subsequent POLST form. (See "Conflict Resolution" for additional guidance.)

b. LIPs may click the POLST button on the banner bar of the patient's electronic medical record to check the existence of a POLST in the California POLST registry (EMR).

c. POLST orders will be followed by LIP as a valid physician order until the admitting physician reviews the POLST form and incorporates the content of the POLST into the care and treatment plan of the patient, as appropriate. The LIP should document his/her review of the POLST in the medical record.

d. If the admitting physician, upon review of the POLST and evaluation of the patient, determines that a new order is indicated, on discharge, he/she shall review the proposed changes with the patient and/or SDM, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The LIP should document the reasons for any deviation from the POLST in the medical record. (See also "Reviewing/Revising a POLST form" regarding voiding a POLST.)

    i. Execute a new POLST order by clicking on the POLST button in the patient's banner bar, filling out the form electronically. Upon saving the POLST form, the form is stored in the EMR and on the California POLST registry.

    ii. Medical Unit Clerk (MUC) will then print out the POLST form from the BCA printer onto pink cardstock provided.

e. Discussions with the patient and/or the patient's SDM regarding the POLST and related treatment decisions should be documented in the medical record.

f. Because the current original POLST is the patient's personal property, ensure it goes home with the patient, or SDM, upon discharge or transfer.

g. At discharge, send the most current original POLST with patient during any transfers to another healthcare facility or to home. Document in the medical record that the POLST was sent with the patient at the time of discharge.

3.3 Completing a POLST Form with the Patient

a. If the patient, or if SDM, wishes to complete a POLST form, the patient's LIP should be contacted. The LIP should discuss treatment options with the patient or SDM. The discussion should include information about the patient's advance directive (if any) or other statements the patient has made regarding his/her wishes for end of life care and treatments. The benefits, burdens, efficacy and appropriateness of treatment and medical interventions should be discussed by the LIP with the patient and/or the patient's SDM.

b. The above-described discussions should be documented in the medical record.

c. Complete a new POLST order by clicking on the POLST button in the patient's banner bar, filling out the form electronically. Sign the POLST form along with the patient using the signature pad. Upon saving the POLST form, the form is stored in the EMR and on the California POLST registry.

d. Medical Unit Clerk (MUC) will then print out the POLST form from the BCA printer onto pink cardstock provided and provide this to the patient.

3.4 **Conflict Resolution**

a. If the POLST conflicts with the patient's previously expressed healthcare instructions or advance directive, then, to the extent of the conflict, the most recent expression of the patient's wishes governs.

b. If there are any conflicts or ethical concerns about the POLST orders, appropriate hospital resources—e.g., ethics committees, care conference, or other administrative and medical staff resources—may be utilized to resolve the conflict.

4. REFERENCES

4.1 RUHS – Medical Center policy 601.5 Identification of Next of Kin (Closest Available Relative)

4.2 The Joint Commission Certification Manual for Palliative Care, July 2018.

4.3 Consent Manual (46th Ed.). (2019). Sacramento, CA: California Hospital Association.

4.4 Coalition for Compassionate Care of California. Retrieved June 06, 2016, from http://coalitionccc.org/

4.5 POLST form English https://capolst.org/wp-content/uploads/2017/09/POLST_2017_Final.pdf

4.6 POLST form Spanish https://capolst.org/wp-content/uploads/2016/10/Spanish_POLST_2016.pdf

4.7 POLST form Armenian https://capolst.org/wp-content/uploads/2016/10/Armenian_POLST_2016.pdf

4.8 POLST form Chinese https://capolst.org/wp-content/uploads/2016/10/Chinese_Traditional_POLST_2016.pdf

4.9 POLST form Farsi https://capolst.org/wp-content/uploads/2016/10/Farsi_POLST_2016.pdf

4.10 POLST form Hmong https://capolst.org/wp-content/uploads/2016/10/Hmong_POLST_2016.pdf

4.11 POLST form Japanese https://capolst.org/wp-content/uploads/2016/10/Japanese_POLST_2016.pdf

4.12 POLST form Korean https://capolst.org/wp-content/uploads/2016/10/Korean_POLST_2016.pdf

4.13 POLST form Pashto https://capolst.org/wp-content/uploads/2016/10/Pashto_POLST_2016.pdf

4.14 POLST form Russian https://capolst.org/wp-content/uploads/2016/10/Russian_POLST_2016.pdf

4.15 POLST form Tagalog https://capolst.org/wp-content/uploads/2016/10/Tagalog_POLST_2016.pdf

4.16 POLST form Vietnamese https://capolst.org/wp-content/uploads/2016/10/Vietnamese_POLST_2016.pdf

4.17 California Legislature Assembly Bill No. 637 http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0601-0650/ab_637_bill_20150224_introduced.htm

4.18 Assembly Bill 3000 https://coalitionccc.org/wp-content/uploads/2014/01/policy-ab_3000_bill.pdf

5. ATTACHMENTS

5.1 EPIC tip sheet: Completing ePOLST

Document History:

Release Dates: New	**Retire Date:** N/A
Document Owner: Palliative Care Committee	**Replaces Policy:** Used to be included with HW 601.3 Advance directives: 3/12/97, 1/23/03, 2/4/11, 8/24/2016, but it was separated into its own policy.

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
5/23/18	Corinne Hendra RN, BSN, CHPN	Yes	Updated polst definition, added physician section with instructions on how to query polst registry and create electronic polst Added ePOLST and California registry
9/18/2018	Nursing P&P	Yes	
10/30/18	Marty Knutson, Deputy County Counsel	Yes	Split into 2 policies, POLST and Advance Directives
5/1/19	Marty Knutson, Deputy County Counsel	Yes	Removed educational definition. Removed advance directive definition, added that POLST be completed on discharge not on admission, removed section 3.4 reviewing/revising a POLST.
5/29/2019	PAC evote	Yes	Minor formatting
7/11/2019	MEC	No	

Tip Sheet

Create Electronic POLST

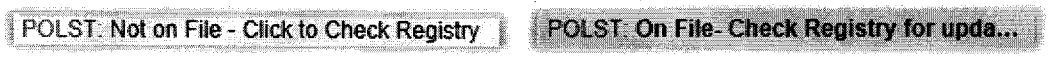
Creating an Electronic POLST form is easy but involves a critical first step, checking the Care Directive Registry for a pre-existing POLST. Accessing that database is accomplished through a link built into the patient information bar. From that link a user can view the POLST form, print a PDF of the existing POLST form, or create a new POLST.

Warning: To prevent a conflict between two different electronic programs, it is mandatory that no E-Consent or Registration processes be open in the patient's chart when completing an electronic POLST form. E-Consent and Registration both use the electronic signature pad and conflict with the POLST Registry use of the electronic signature pad. To complete the POLST process and use the electronic signature pad to sign the POLST form, the E-Consent process for procedures, treatment, and registration must be closed. Once the POLST process is complete, you must close the Registry window in order to use the signature pad for an E-Consent or Registration workflow.

Try it out

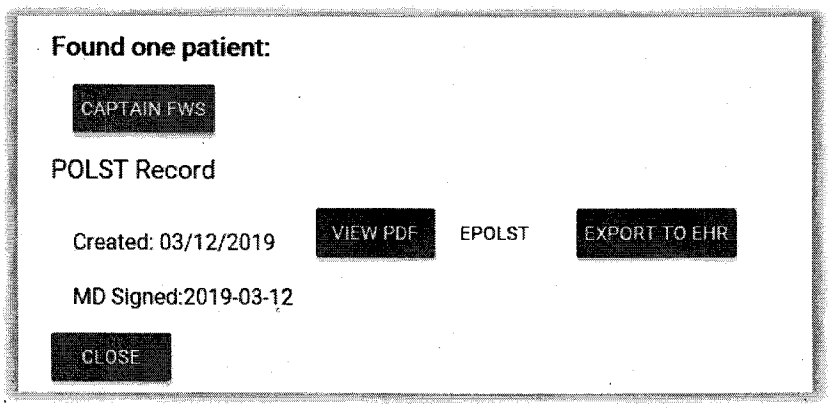
1. From the patient header:

2. Locate and click on the POLST link:

   a. 

3. Care Directives POLST Registry website opens and searches their system for a match to the patient.

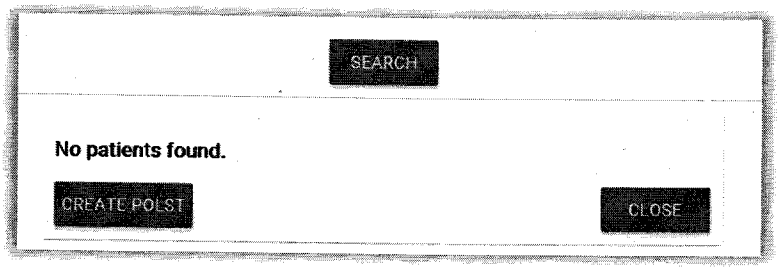
4. If the system **has located the patient's POLST form**, the window will populate:

   a. 

5. If the system **has not located** the patient's POLST form, the window will populate:

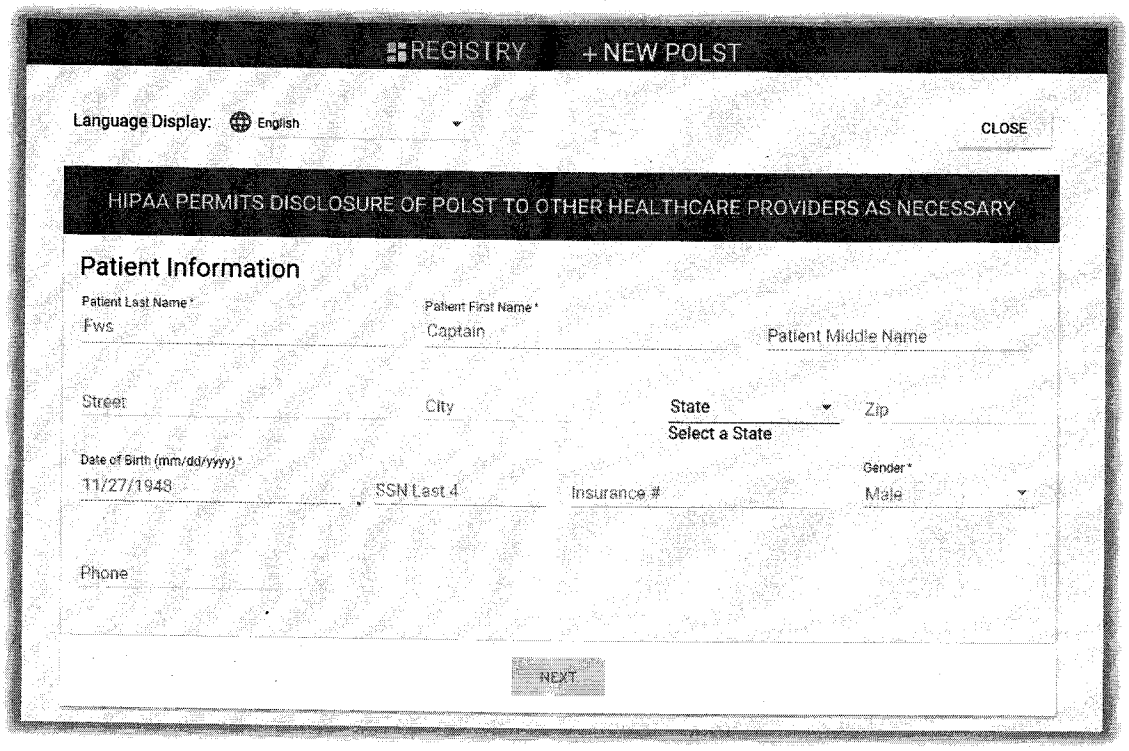
Continued on next page.SNunn ASAP v2018 3/12/2019

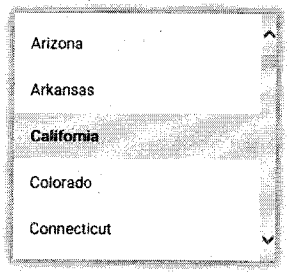
a.



6. To create a new POLST, click on CREATE POLST

7. The New POLST patient information window populates:





8. Select the State where the patient lives by using the drop down feature:

9. Click Next.

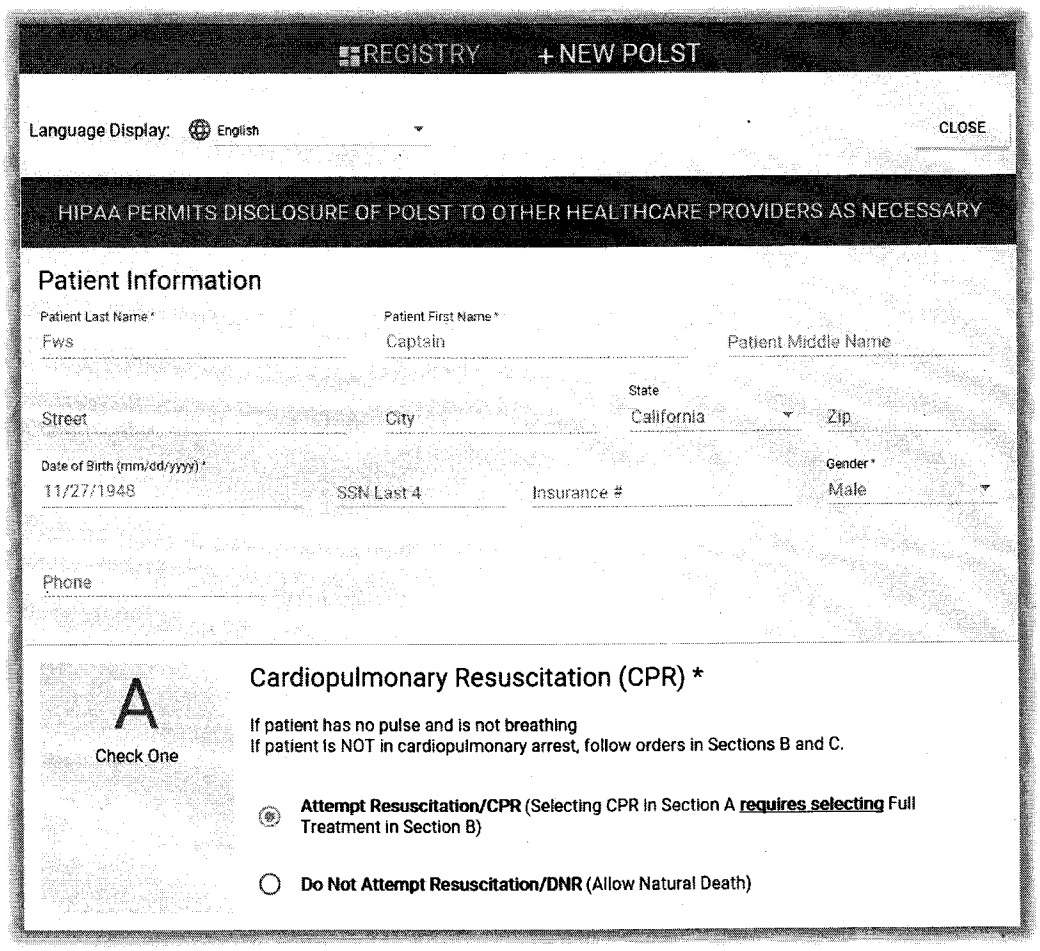
10. A blank POLST form is populated with the patient's Name.

11. To add or update the address, insurance, phone number, place the cursor in the associated section and enter the new data. Complete each section and use the tab key to move forward.

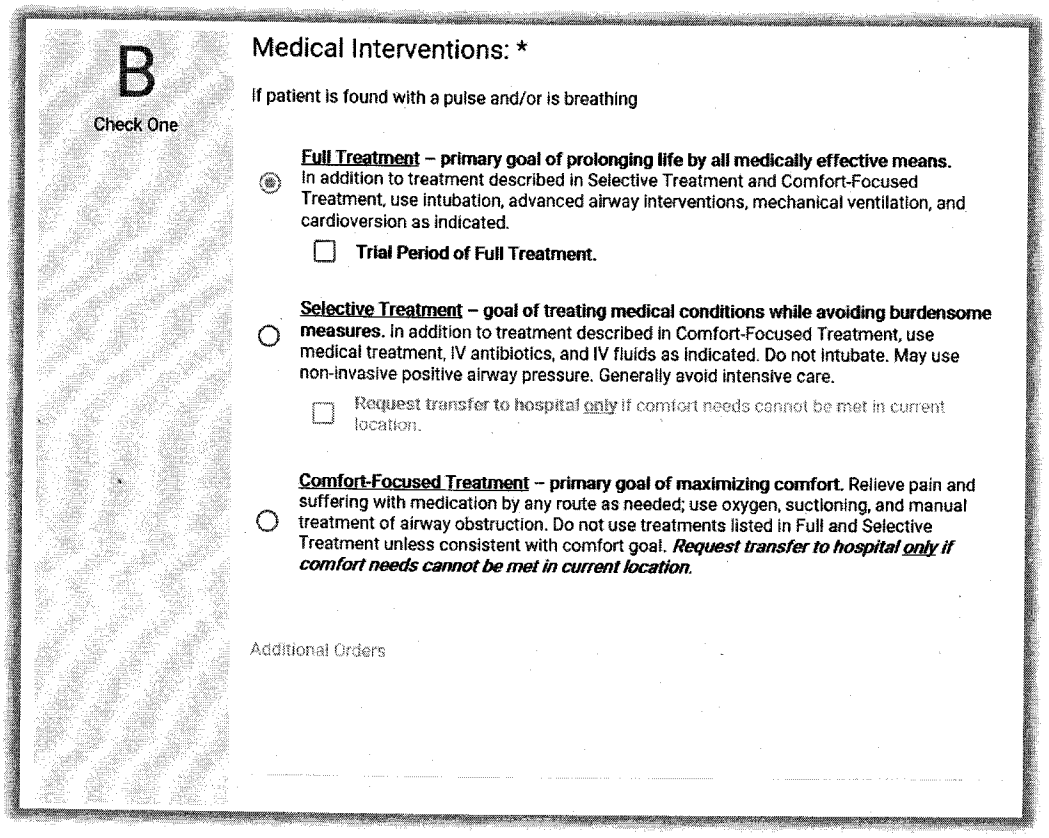
Continued on next page.

12. Click NEXT to proceed to Section A of the POLST form.

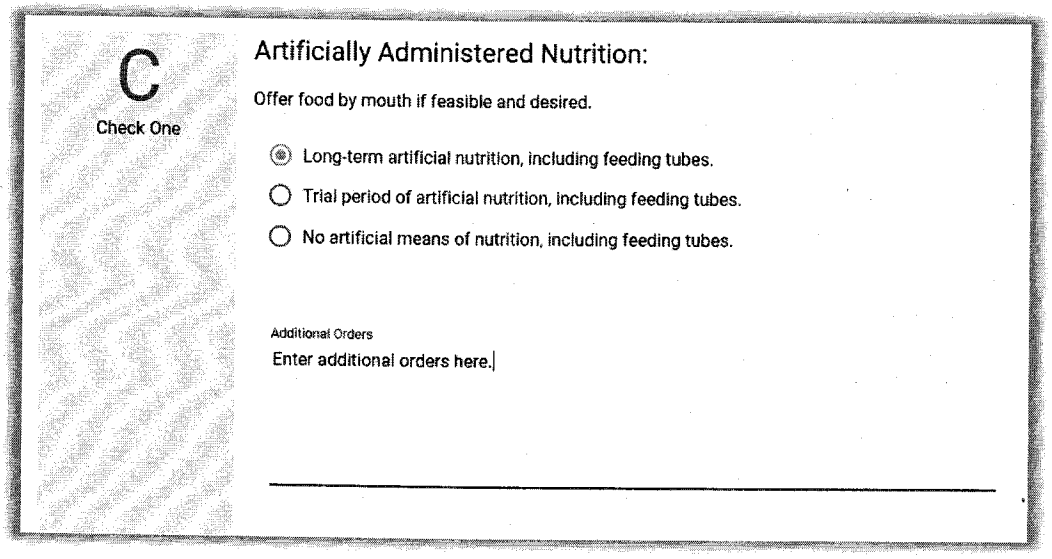
a.



b.



c.



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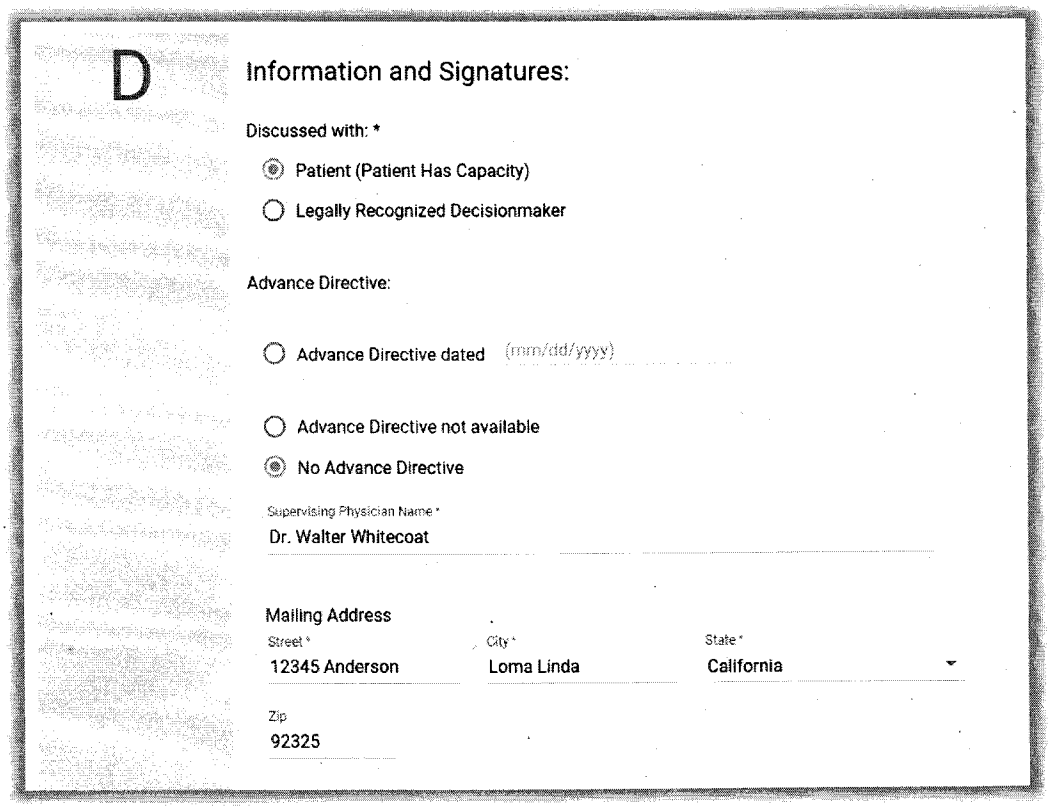
d.



D

Information and Signatures:

Discussed with: *

- (•) Patient (Patient Has Capacity)
- ( ) Legally Recognized Decisionmaker

Advance Directive:

- ( ) Advance Directive dated (mm/dd/yyyy)
- ( ) Advance Directive not available
- (•) No Advance Directive

Supervising Physician Name *
Dr. Walter Whitecoat

Mailing Address

Street * 12345 Anderson

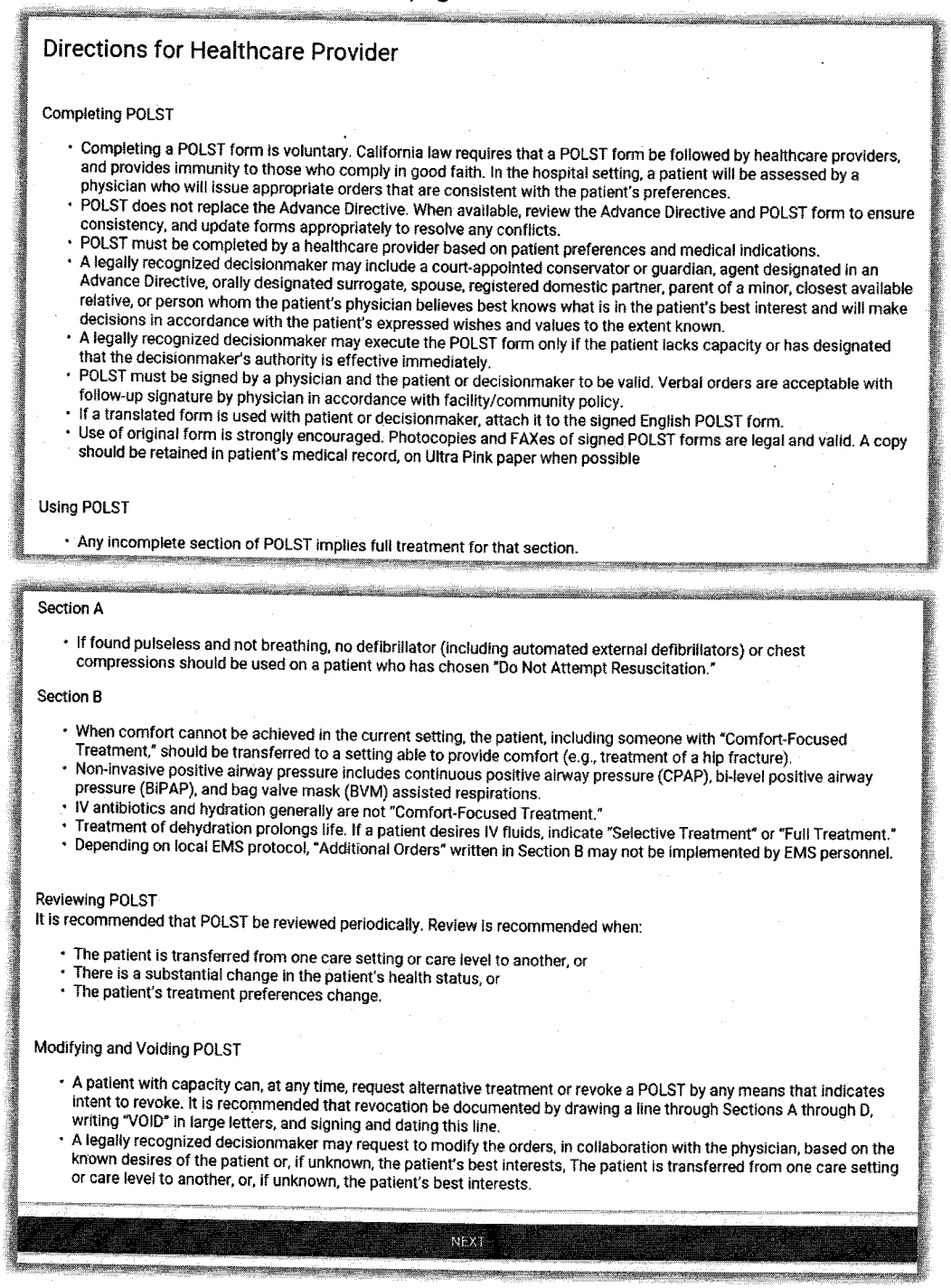
City * Loma Linda

State * California

Zip
92325

i. Note: The mailing address is the patient's address.

13. Directions for Healthcare Provider page is attached as a reference:



Directions for Healthcare Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

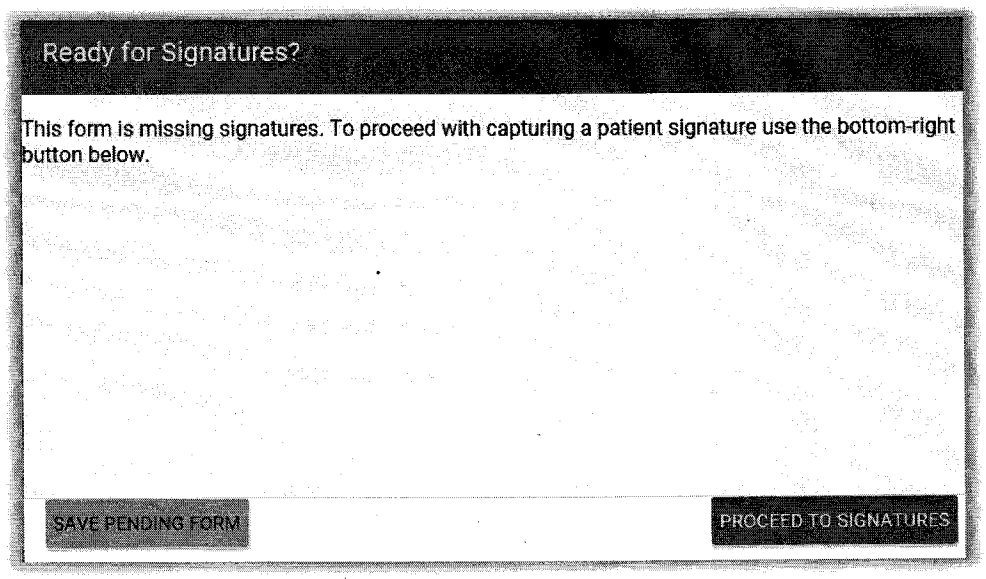
- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests, The patient is transferred from one care setting or care level to another, or, if unknown, the patient's best interests.

NEXT

14. The POLST form is complete but needs to be signed by the **Patient** and the **Provider** to be a legal document. Click **Next** to proceed to the next page for signatures.

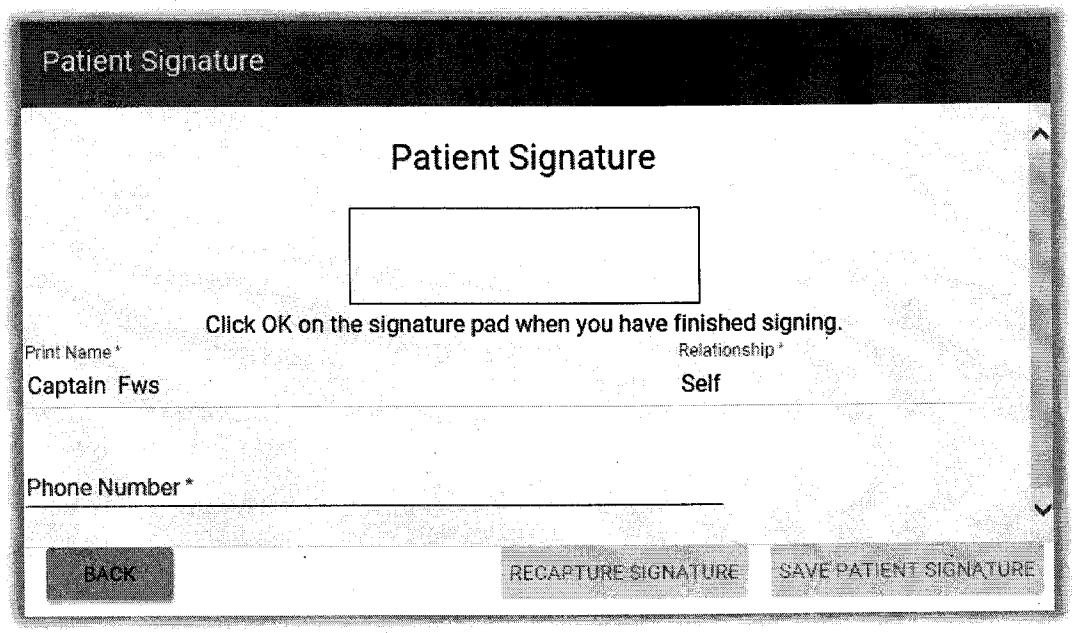
15. The Ready for Signatures page populates with two options available:

a.



16. Click on Proceed to Signatures.

17. Patient Signature window populates:

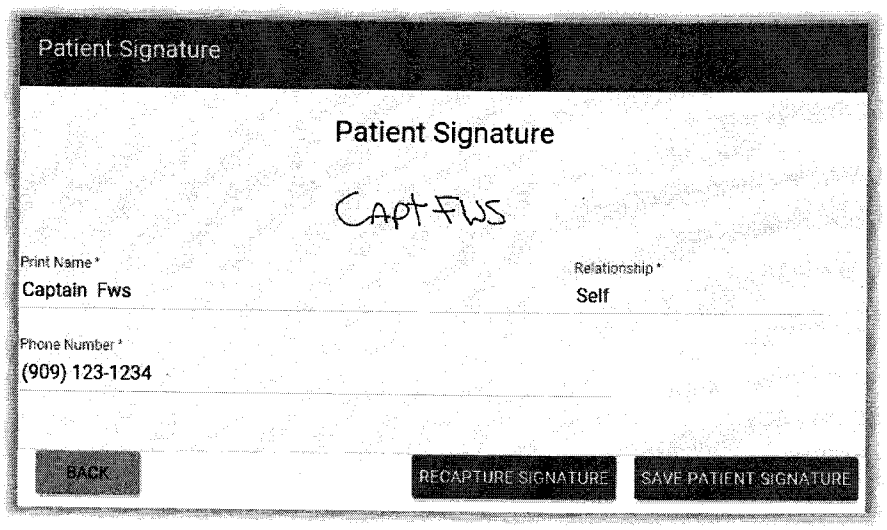


18. Enter the required phone number as needed.

19. Using the Signature Pad, the patient will sign the POLST form:

20. After the patient has signed, **Click OK on the signature pad.**

21. The patient's signature populates to the POLST form:

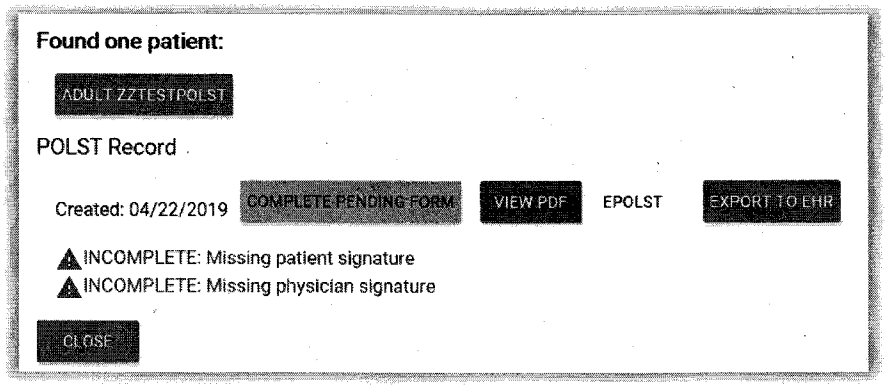


22. Click on Recapture to re-attempt the patient signature.

23. Click on Save Patient Signature to save it to the form and proceed to the next step.

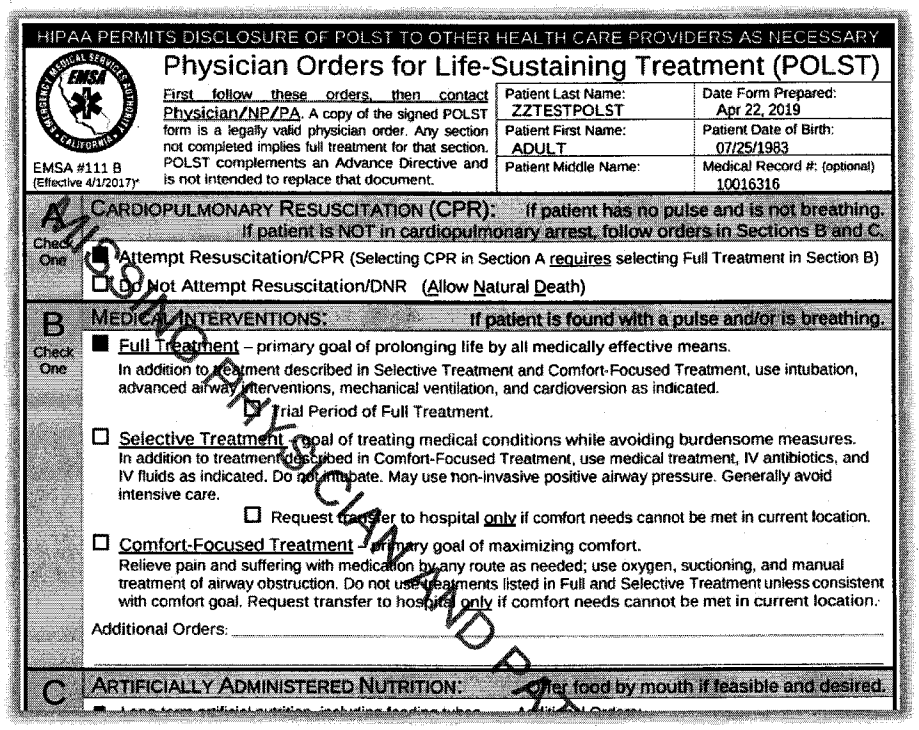
24. **Note**: If the form is submitted without the Patient or Physician signature, the Care Directives system will populate a warning:

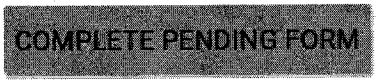
a.



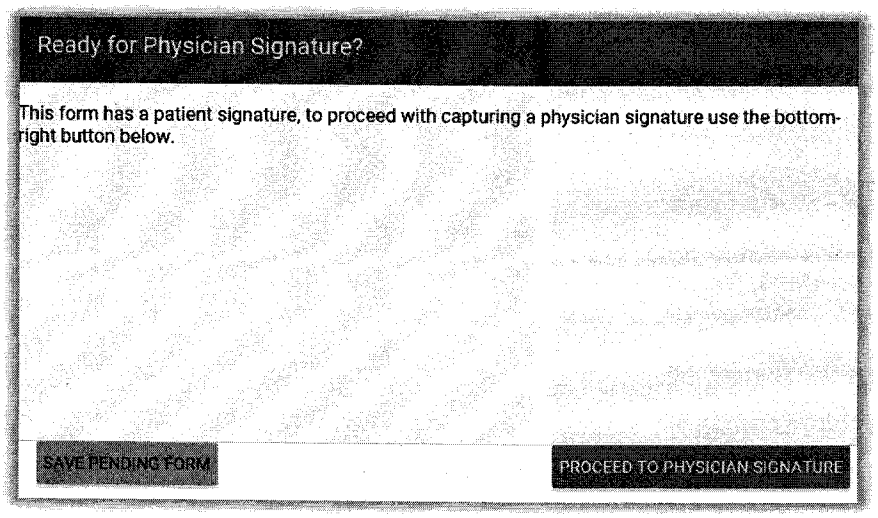
25. A POLST without the Patient and Physician signature is not valid and a watermark has been added to prevent use if printed.

a.



26. To complete the Unsigned POLST form, click on 

27. The Ready for Physician Signature window populates:



28. To save the POLST form for a later signature by the provider, click Save Pending Form.

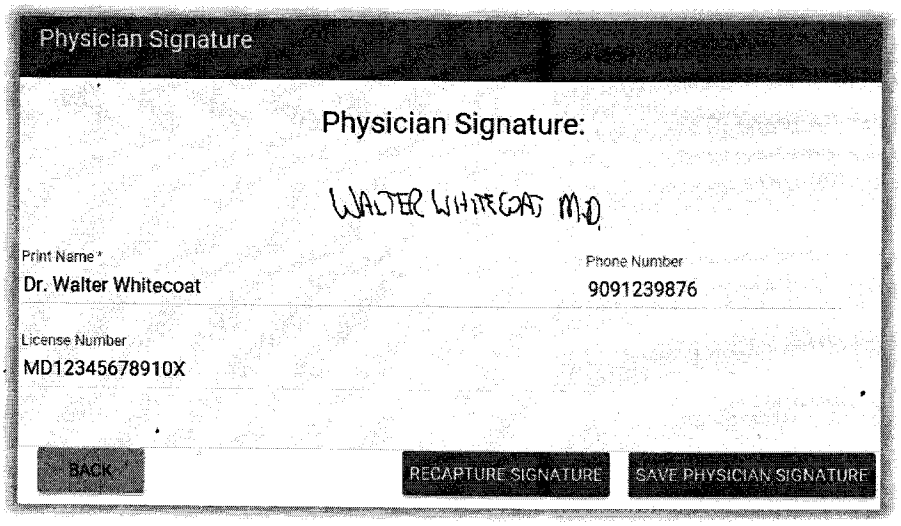
29. To proceed to the physician signature window, click Proceed to Physician Signature.

30. Physician Signature window populates.

31. Sign the signature pad.

32. **Click OK on the signature pad**. Failing to do so will prevent the processing of the signature.

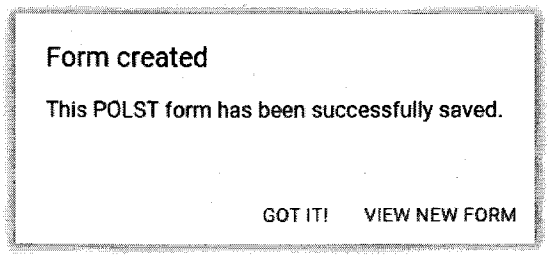
33. The Physician Signature populates to the POLST form:



34. Enter Physician Name, Phone Number and Medical License Number.

35. Click on Save Physician Signature to save it to the POLST form.

Continued on next page.

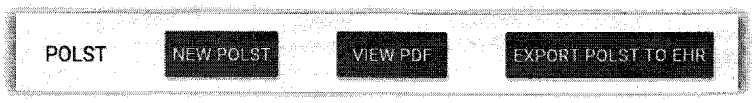


36. Confirmation window populates:

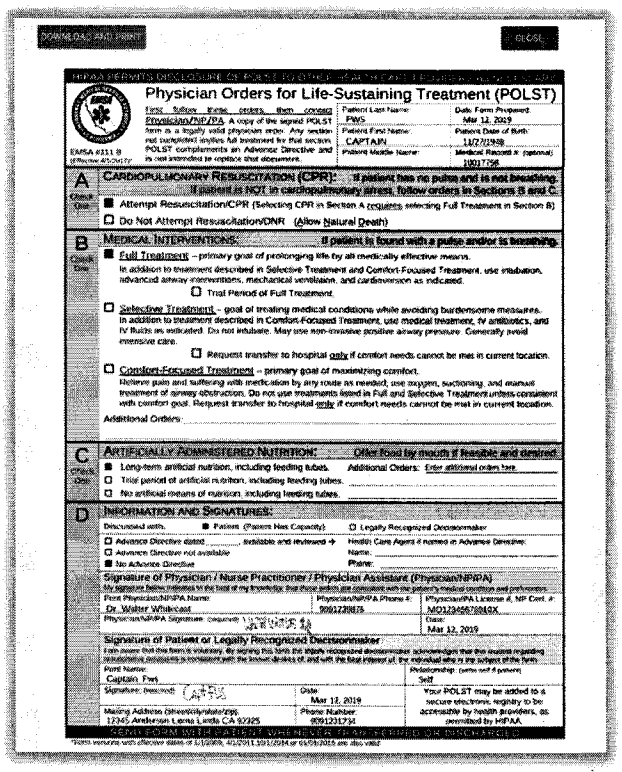
37. The new Electronic POLST form has been created and saved.

38. To **view the form**, click on VIEW NEW FORM.

39. 3 options are now populated:

a. 

40. To view the POLST, click on VIEW PDF

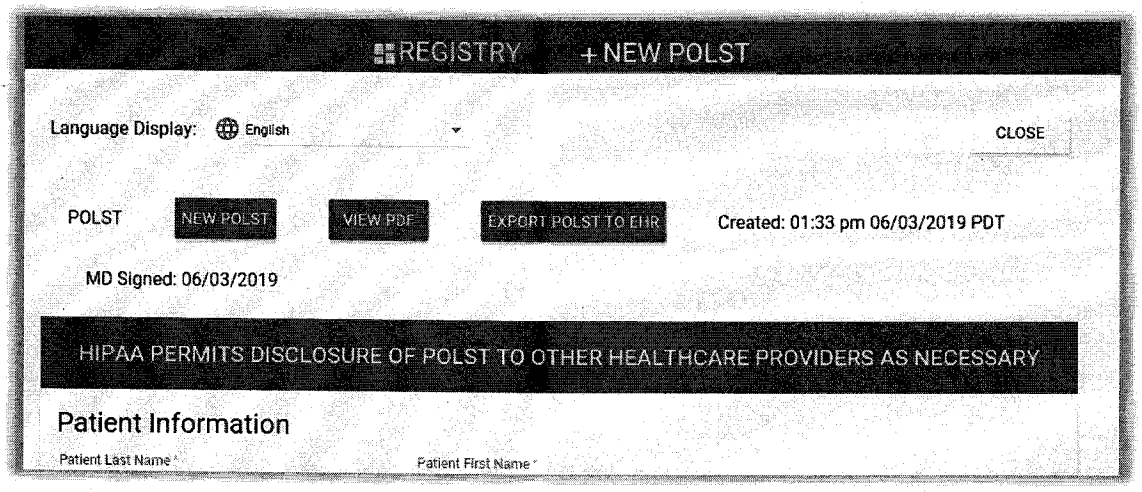
41. PDF Loads: 

42. To Export the new POLST into the patient's chart, click EXPORT POLST TO EHR

a. A confirmation window populates: 

Continued on next page.

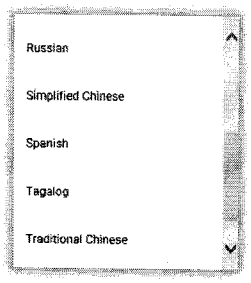
43. The **View Only** POLST form is populated. Any Changes to the saved POLST form will require creating a New POLST form. Click to return to the Registry page and the available options:



When interfacing with a non-English speaking patient it is important to switch the view of the POLST to the patient's primary language. Changing the language will allow the patient to view the POLST form on the computer screen.

To **View** the POLST in a different language when interfacing with the non-english speaking patient:

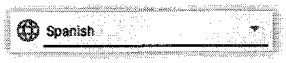
a. Use the down arrow to select the desired language 

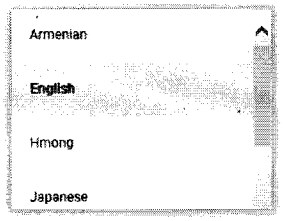


b. Scroll to locate
c. Click on the language.

44. The view only POLST form is now in the selected language:

a.

45. To return to the English version of the POLST form, click on the down arrow 

then select English from the dropdown list: 

46. To view a PDF version of the Electronic POLST, click VIEW PDF

47. Click CLOSE to return to the view only POLST form and the main page.

IMPORTANT: A SIGNED POLST CANNOT BE MODIFIED. A NEW POLST FORM WILL BE REQUIRED IF ANY OF THE INFORMATION HAS CHANGED TO AN EXISTING POLST.

48. To Create a New POLST form, click on NEW POLST

Tip Sheet

Edit POLST

A signed POLST cannot be edited. When any of the sections of a signed POLST need to be changed, it is required to create a New POLST form. Creating a new POLST form is easy but involves a critical first step, checking the Care Directive Registry for a pre-existing POLST. Accessing that database is accomplished through a link built into the patient information bar. From that link a user can view, print a PDF of the existing POLST form, or create a new POLST.

Warning: To prevent a conflict between two different electronic programs, it is mandatory that no E-Consent or Registration processes be open in the patient's chart when completing an electronic POLST form. E-Consent and Registration both use the electronic signature pad and conflict with the POLST Registry use of the electronic signature pad. To complete the POLST process and use the electronic signature pad to sign the POLST form, the E-Consent process for procedures, treatment, and registration must be closed. Once the POLST process is complete, you must close the Registry window in order to use the signature pad for an E-Consent or Registration workflow.

Try it out

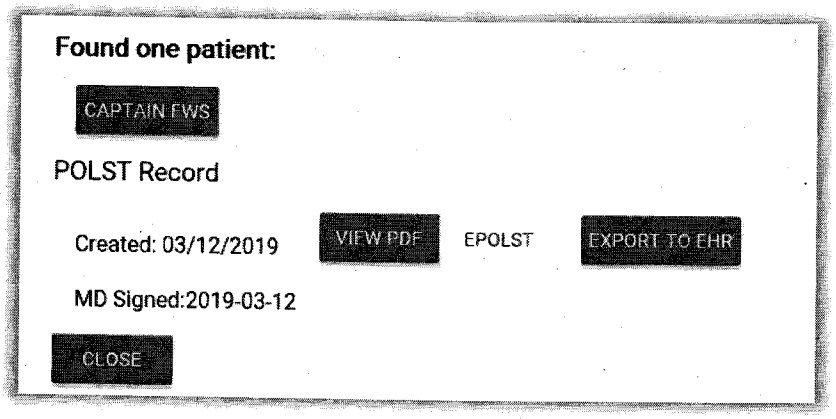
1. From the patient information bar:

2. Locate and click on the POLST link:

   a. 

3. Care Directives POLST Registry website opens and searches their system for a match to the patient.

4. If the system **has located the patient's POLST form**, the window will populate:

   a. 

5. From this window:

Continued on next page.SNunn ASAP v2018 3/12/2019

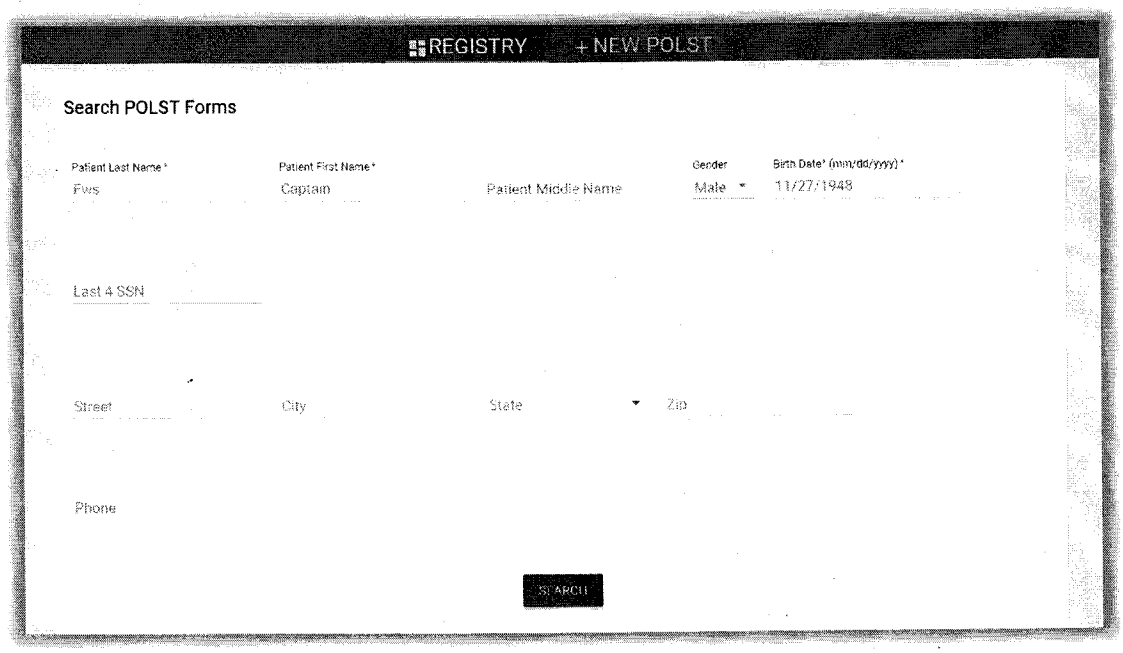
a. View and print the previously signed POLST, click on VIEW PDF

b. To view an Electronic version of the POLST form click on EPOLST
   i. From here, it's possible to view the Signed POLST form in different languages.
   ii. Note: A signed POLST cannot be edited.

c. To Export the Signed POLST to the Media Tab of the patient chart, click on EXPORT TO EHR

6. If the system has **no record of a POLST form**, the Search POLST forms window will populate with the patient's information pre-populated to the search window.

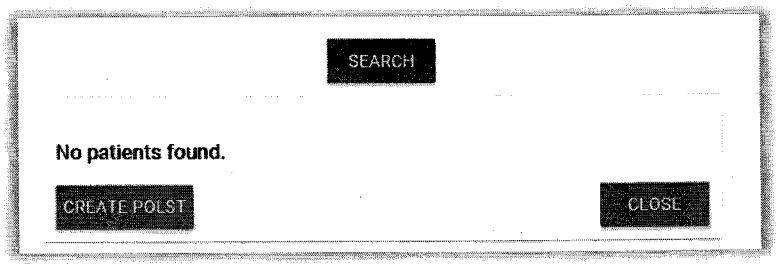
a.



7. Click on Search to complete the inventory seach of the database.

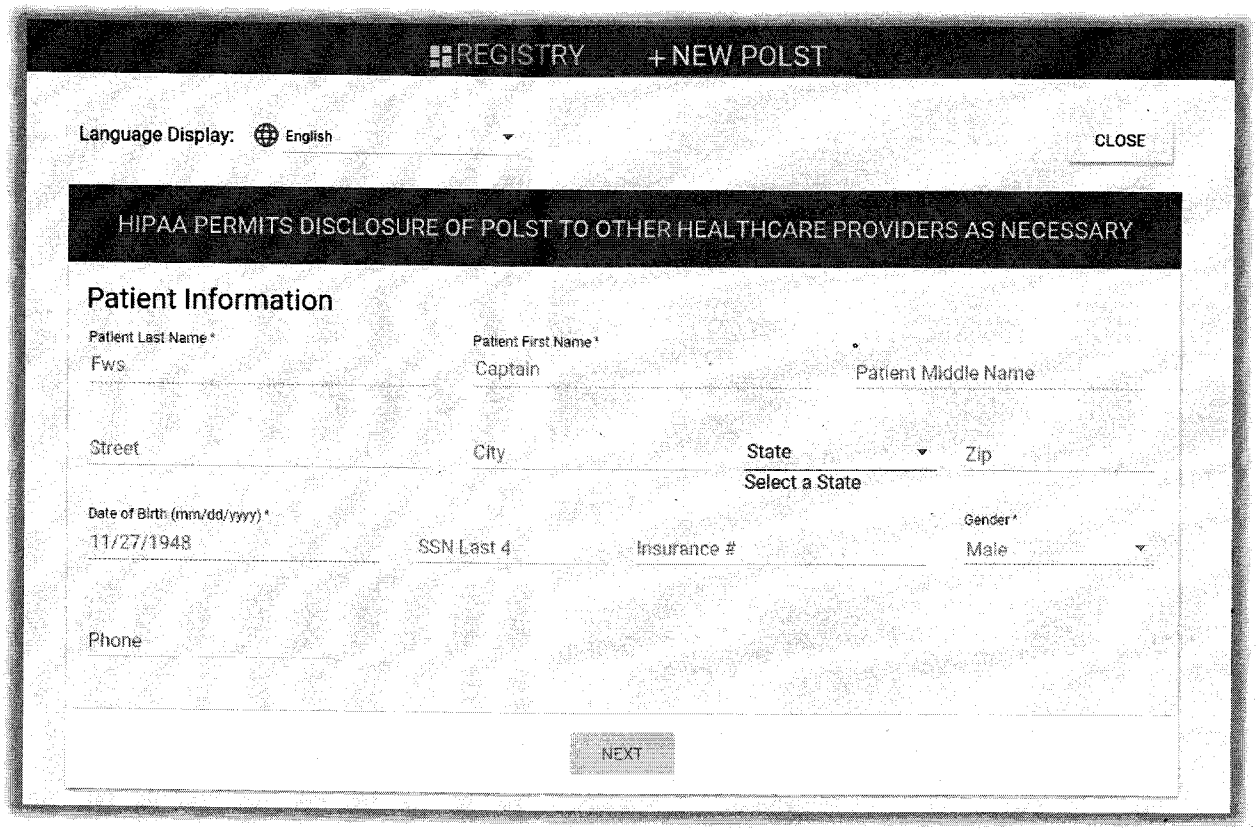
8. If the Search has not found a POLST form for the patient, a No Patients Found will populate just below the search button:

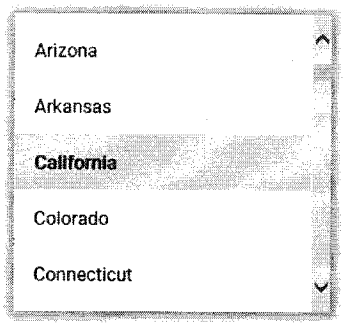
a.



9. To create a new POLST, click on CREATE POLST

10. The New POLST patient information window populates:





11. Select the State where the patient lives by using the drop down feature:

12. Click Next.

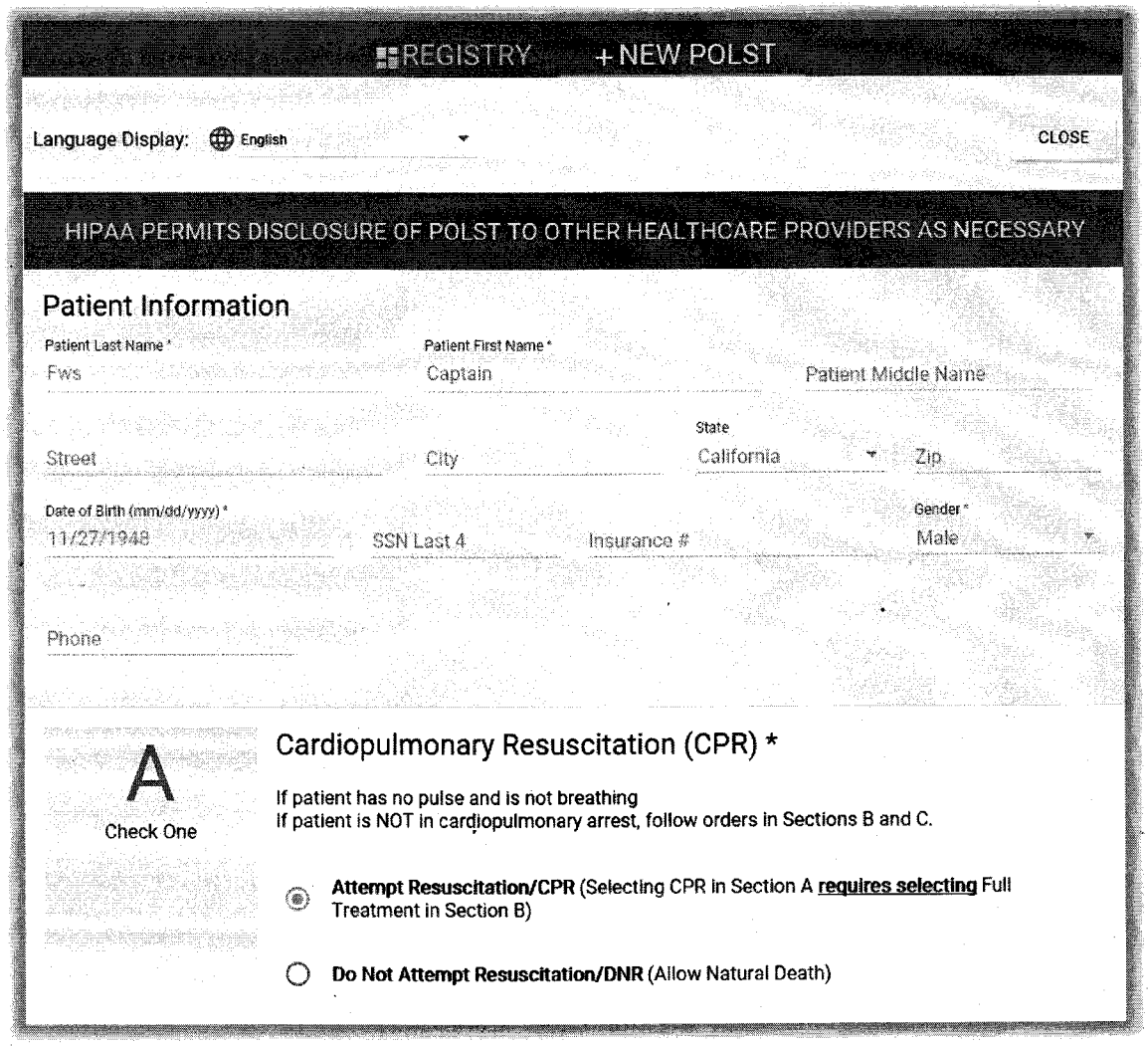
13. A blank POLST form with the patient's information populates. Complete each section.

14. To add or update the address, insurance, phone number, place the cursor in the associated section and enter the new data. Complete each section and use the tab key to move forward.

15. Click NEXT to proceed to Section A of the POLST form.

Continued on next page.

a.



b.

B

Check One

Medical Interventions: *

If patient is found with a pulse and/or is breathing

◉ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ **Trial Period of Full Treatment.**

○ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ Request transfer to hospital only if comfort needs cannot be met in current location.

○ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders

c.

C

Check One

Artificially Administered Nutrition:

Offer food by mouth if feasible and desired.

◉ Long-term artificial nutrition, including feeding tubes.

○ Trial period of artificial nutrition, including feeding tubes.

○ No artificial means of nutrition, including feeding tubes.

Additional Orders

Enter additional orders here.

D

Information and Signatures:

Discussed with: *

- (●) Patient (Patient Has Capacity)
- ( ) Legally Recognized Decisionmaker

Advance Directive:

- ( ) Advance Directive dated (mm/dd/yyyy)
- ( ) Advance Directive not available
- (●) No Advance Directive

Supervising Physician Name *
Dr. Walter Whitecoat

Mailing Address

Street *	City *	State *
12345 Anderson	Loma Linda	California

Zip
92325

d.

i. Note: The mailing address is the patient's address.

16. Directions for Healthcare Provider page is attached as a reference:

Directions for Healthcare Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests, The patient is transferred from one care setting or care level to another, or, if unknown, the patient's best interests.

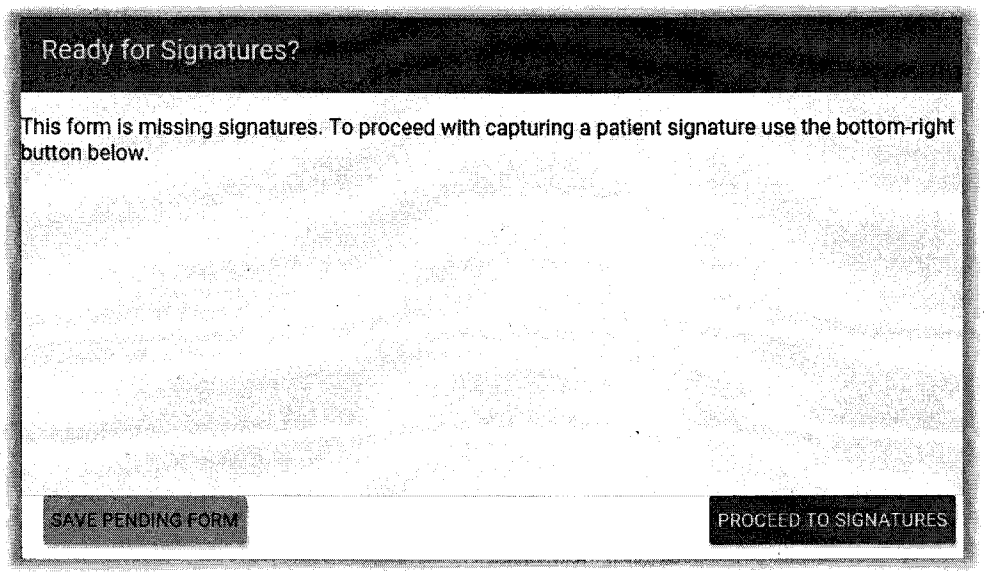
NEXT

Continued on next page.

17. The POLST form is complete but needs to be signed by the **Patient** and the **Provider** to be a legal document. Click **Next** to proceed to the next page for signatures.

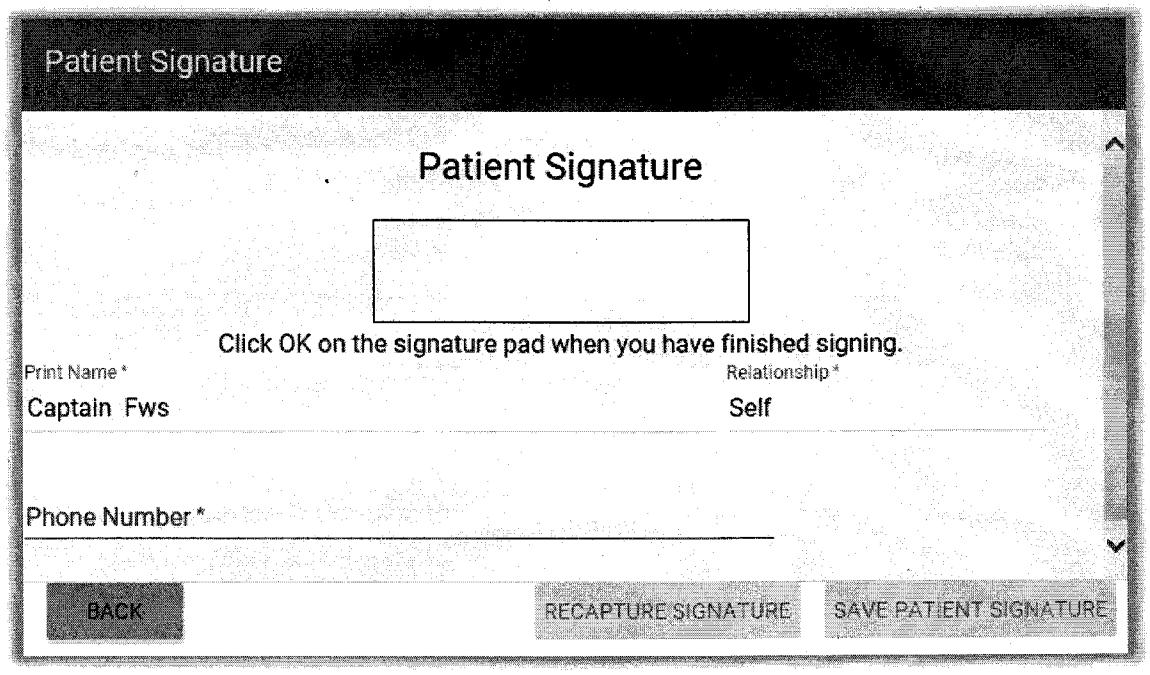
18. The Ready for Signatures page populates with two options available:

a.



19. Click on Proceed to Signatures.

20. Patient Signature window populates:

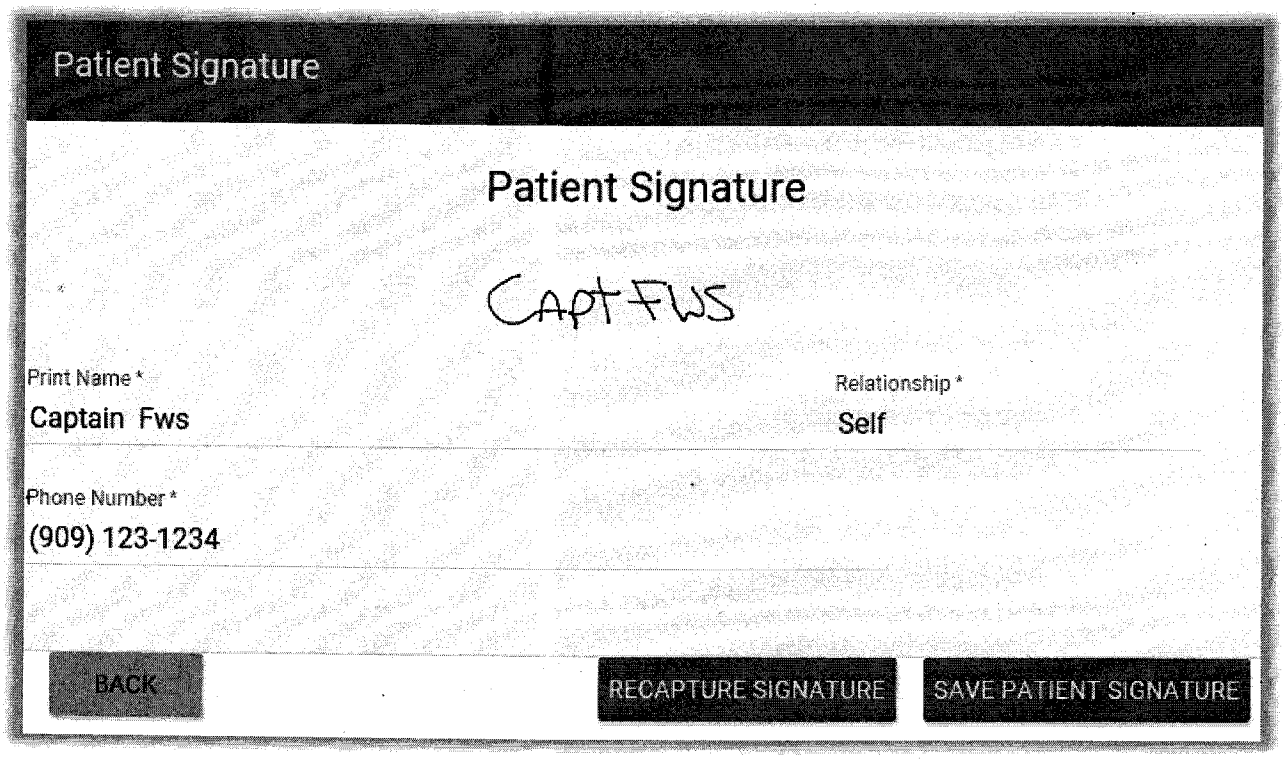


21. Enter the required phone number as needed.

22. Using the Signature Pad, the patient will sign the POLST form:

23. After the patient has signed, **Click OK on the signature pad**.

24. The patient's signature populates to the POLST form:



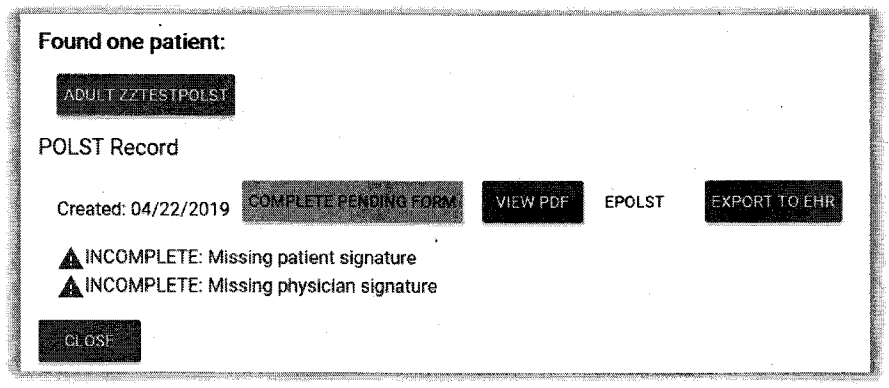
Continued on next page.

25. Click on Recapture to re-attempt the patient signature.

26. Click on Save Patient Signature to save it to the form and proceed to the next step.

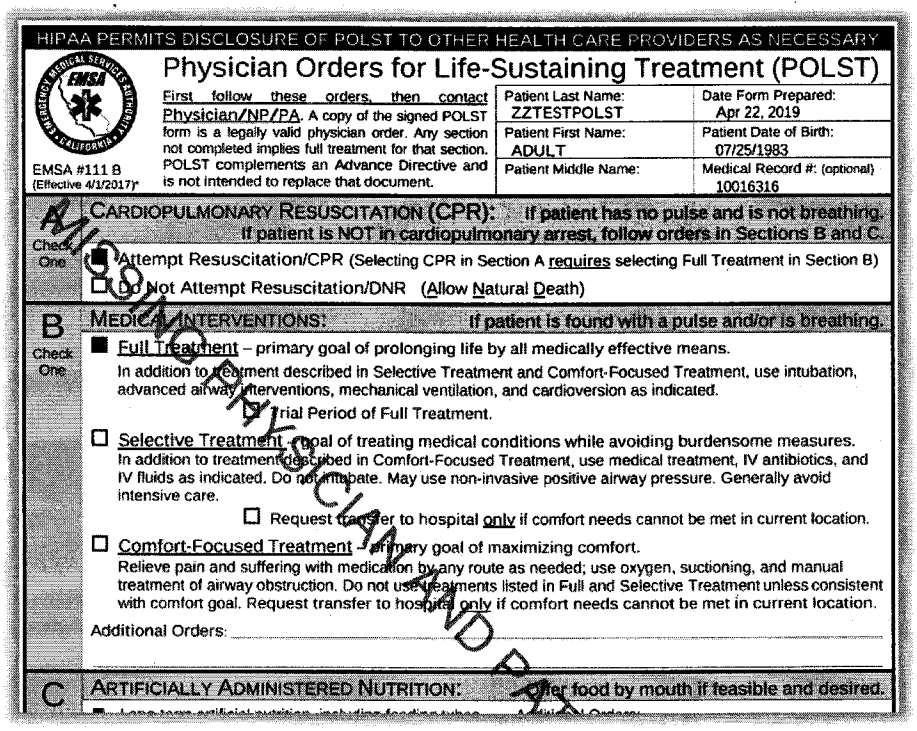
27. **Note**: If the form is submitted without the Patient or Physician signature, the Care Directives system will populate a warning:

a.



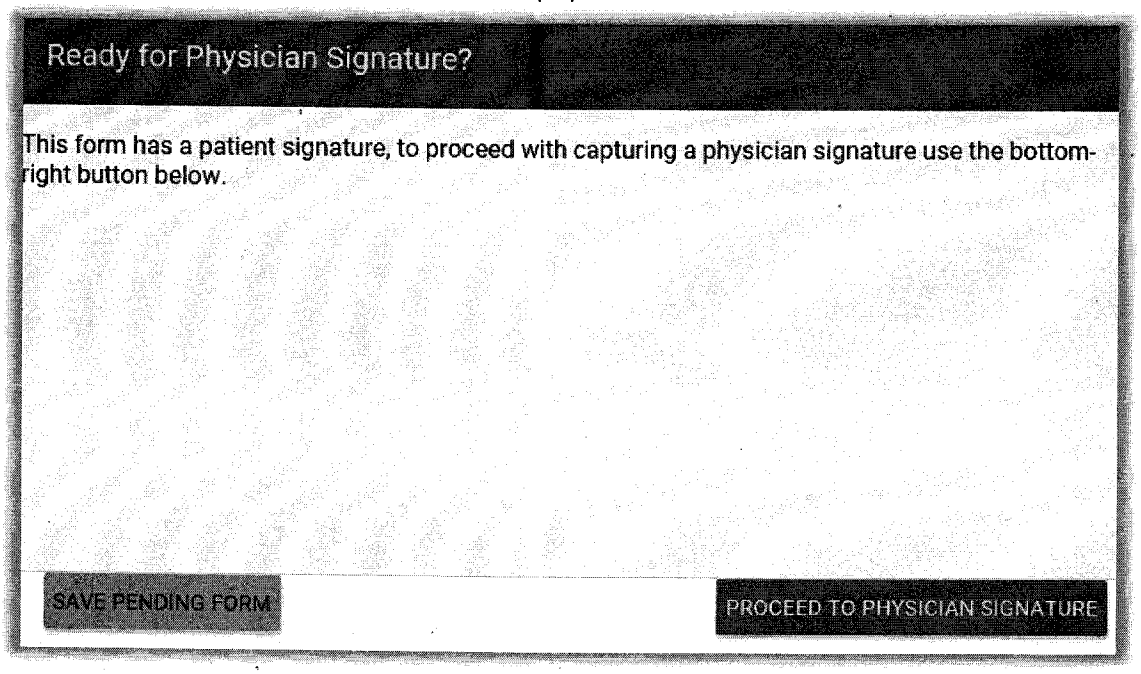
28. A POLST without the Patient and Physician signature is not valid and a watermark has been added to prevent use if printed.

a.



29. To complete the Unsigned POLST form, click on 

30. The Ready for Physician Signature window populates:



31. To save the POLST form for a later signature by the provider, click Save Pending Form.

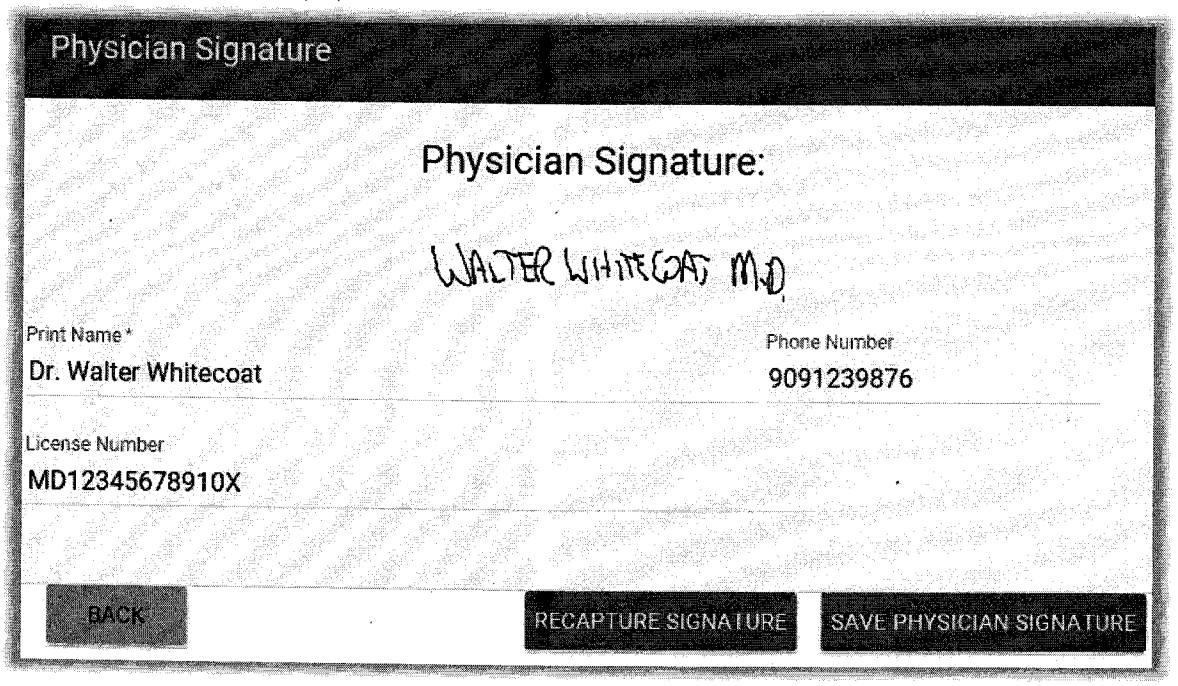
32. To proceed to the physician signature window, click Proceed to Physician Signature.

33. Physician Signature window populates.

34. Sign the signature pad.

35. Click OK on the signature pad.

36. The Physician Signature populates to the POLST form:

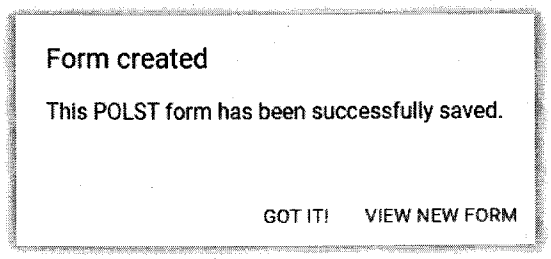


Continued on next page.

37. Enter Physician Name, Phone Number and Medical License Number.

38. Click on Save Physician Signature to save it to the POLST form.

39. Confirmation window populates:

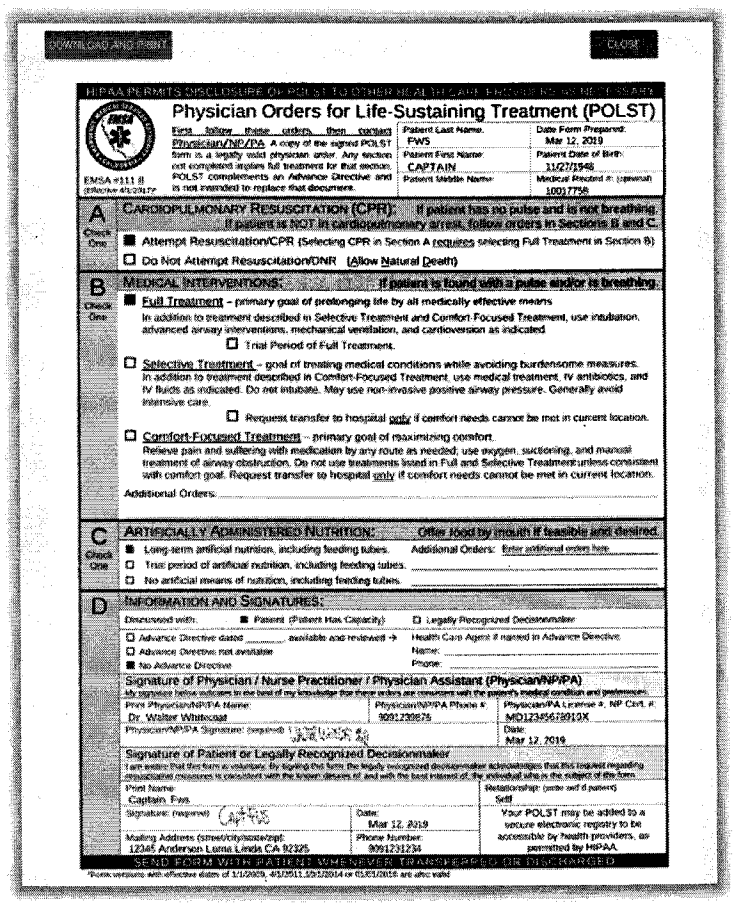


40. To **view the form**, click on VIEW NEW FORM.

41. 3 options are available:

a.

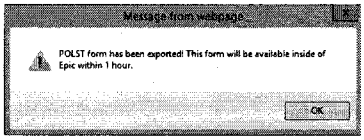
42. To view the POLST, click on VIEW PDF



43. PDF Loads:

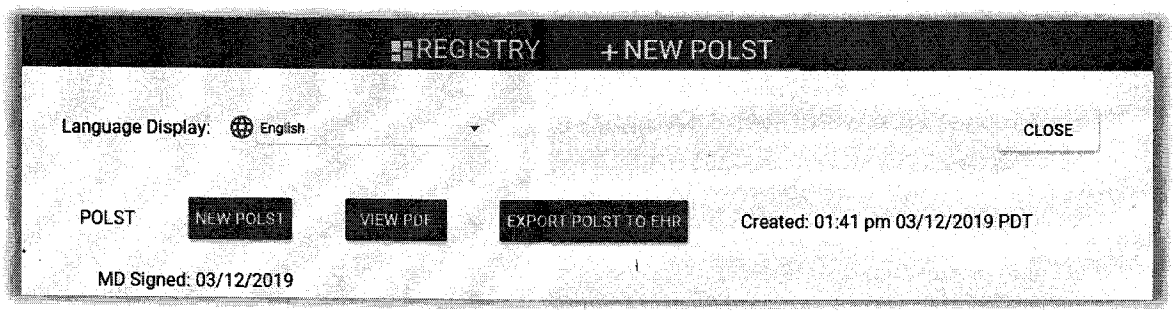
44. To Export the new POLST into the patient's chart, click EXPORT POLST TO EHR

a. A confirmation window populates:



45.

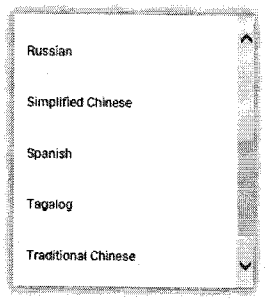
46. Click CLOSE to return to the Registry page and the available options:



When interfacing with a non-English speaking patient it is important to switch the view of the POLST to the patient's primary language. Changing the language will allow the patient to view the POLST form on the computer screen.

To **View** the POLST in a different language when interfacing with the non-english speaking patient:

a. Use the down arrow to select the desired language

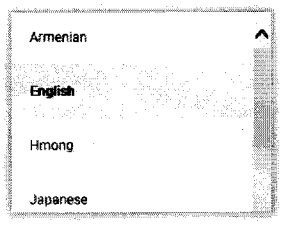


b. Scroll to locate
c. Click on the language.

47. The view only POLST form is now in the selected language:

a.

48. To return to the English version of the POLST form, click on the down arrow 

then select English from the dropdown list: 

49. To view a PDF version of the Electronic POLST, click VIEW PDF

50. Click CLOSE to return to the view only POLST form and the main page.

IMPORTANT: A SIGNED POLST CANNOT BE MODIFIED. A NEW POLST FORM WILL BE REQUIRED IF ANY OF THE INFORMATION HAS CHANGED TO AN EXISTING POLST.

51. To Create a New POLST form, click on NEW POLST

Tip Sheet

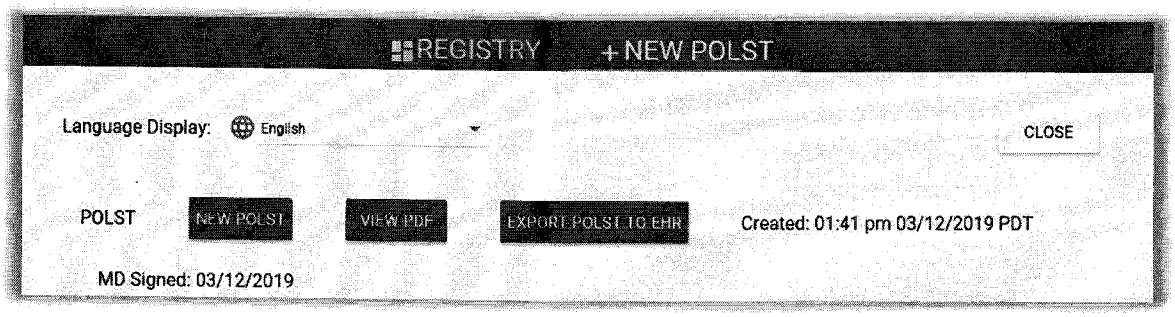
Print E-POLST

Printing the POLST form is an important part of the POLST process as it allows the patient to keep a printed copy with them at all times. Selecting the correct printer that is loaded with pink paper will ensure that the form is printed correctly and in the proper pink color. During emergency situations EMS personnel will look for the pink POLST form to assist in making pre-hospital care decisions. **Printing of the POLST form should be accomplished from a Downtime/BCA Workstation** and the printer that is associated with the BCA Workstation. Note: PINK color paper may need to be loaded into that specific printer and removed after printing is complete.

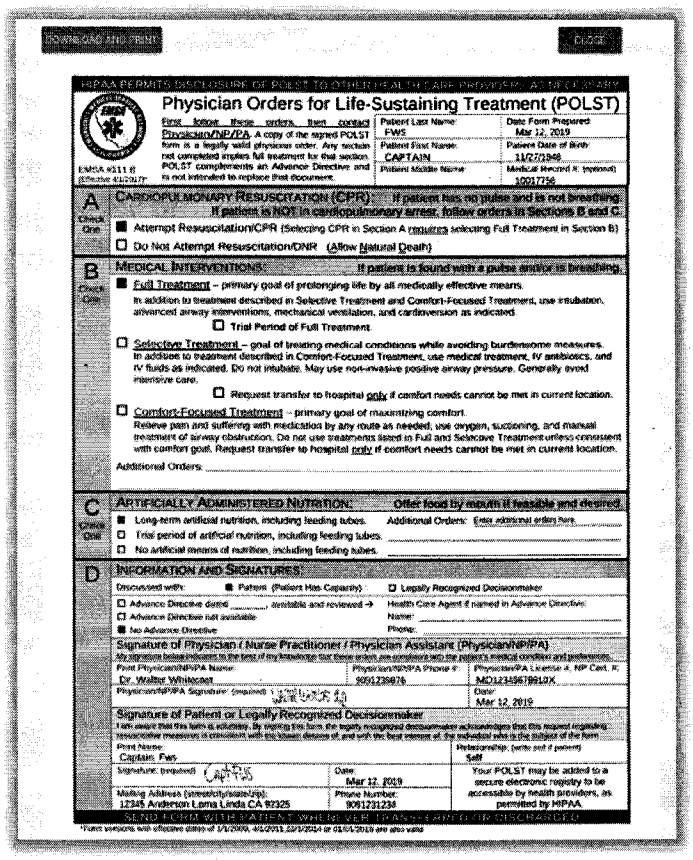
Warning: To prevent a conflict between two different electronic programs, it is mandatory that no E-Consent or Registration processes be open in the patient's chart when completing an electronic POLST form. E-Consent and Registration both use the electronic signature pad and conflict with the POLST Registry use of the electronic signature pad. To complete the POLST process and use the electronic signature pad to sign the POLST form, the E-Consent process for procedures, treatment, and registration must be closed. Once the POLST process is complete, you must close the Registry window in order to use the signature pad for an E-Consent or Registration workflow.

Try it out

1. From the POLST Registry, click on View PDF:

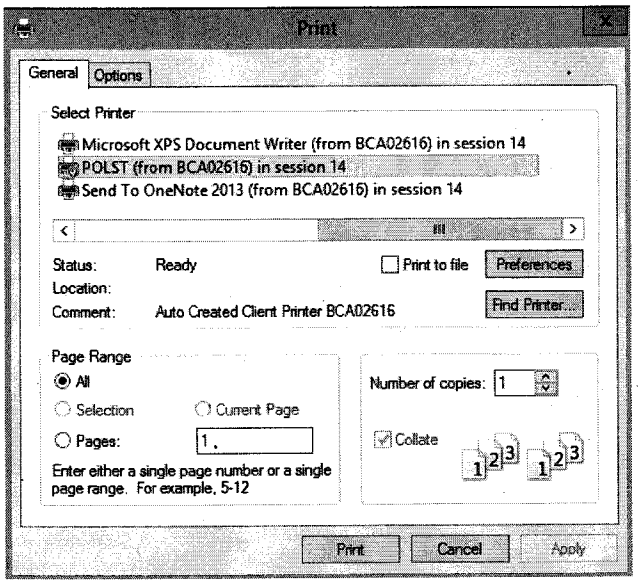


Continued on next page.



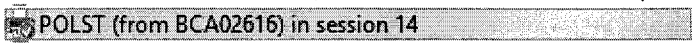
2. PDF populates:

3. From the top of the page, click DOWNLOAD AND PRINT



4. The system will open the Print window:

5. Select the BCA Downtime/ BCA Workstation POLST printer:



6. **Contact the Help Desk if no BCA Downtime/ POLST printer is listed or available.**

Continued on next page.

7. Before printing, be sure that PINK paper has been loaded into the paper tray.

8. Select Print to print the POLST form.

9. If the printer will be used for other functions, REPLACE the PINK paper with white paper.

10. Click Close 

to return to the Registry window.

11. Click Close to close out the process and return to the patient's chart.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 601.3	Page 1 of 4
Title: Advanced Directives	**Effective Date:** 7/1/2019	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 To provide a guideline for staff on obtaining or completing an advance directive.

2. DEFINITIONS

2.1 Advance Directive: A document signed by an adult patient to provide guidance for health-care decisions in the event the patient becomes unable to make such decisions.

2.2 Decisional capacity: is an individual's ability to 1) understand the nature and consequences of a health-care decision and 2) to make and 3) communicate a decision.

2.3 Physician Orders for Life-Sustaining Treatment (POLST): The POLST is a form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

2.4 Substitute Decision Maker (SDM): AKA: Legally Recognized Decision Maker, Durable Power of Attorney (DPOA), Medical Decision Maker, Designated Health Care Surrogate, or Legal Representative. If a patient lacks capacity to provide consent or has been declared by a court of law to be incompetent, those who may provide consent on behalf of a patient, listed in order of authority:

a. Healthcare Agent: An adult designated in an advance directive to make health-care decisions for the patient.

b. Surrogate: An adult, designated by the patient to make health-care decisions for the patient.

c. Closest Available Adult Relative or Friend.

d. Conservator An adult, designated by the court to make health-care decisions for the patient.

2.5 Licensed Independent Practitioners (LIP). An individual permitted by law and by the organization to provide care, treatment and services without direction or supervision.

3. PROCEDURE

3.1 Admitting Clerical staff: Upon admission, admitting staff shall ask the patient whether they have an Advance Directive:

- If yes: Request a copy and if provided, scan copy of Advance Directive into medical record.
- If No: Ask whether the patient wants more information regarding Advance Directives? If so, provide California Advance Health Care Directive.

3.2 Nursing staff: Upon admission, nursing staff shall ask the patient about an Advance Directive, specifically:

a. Does the patient have an Advance Directive?

If yes:

- Request a copy, from the patient or substitute decision maker, to place in the patient medical record.
- The nurse will communicate to the emergency department physician or physician or LIP caring for the patient the existence of the Advance Directive.
- If the patient does not have a copy available, request the patient to ask someone to bring a copy in for him/her.

If no:

- Ask the patient if they wish to create an Advance Directive.

b. Does the patient wish to create an Advance Directive?

If yes:

- Provide a referral to a social worker.

If no: Does the patient want more information regarding Advance Directives?

If yes:

- Provide an advance directive.

3.3 Social workers:

a. Provide information for patients about creating an Advance Directive as requested. If any legal questions are asked refer to legal aid.

b. Provide a California Advance Health Care Directive form to the patient.

3.4 Physician or LIP

- The physician or LIP should ask every patient over the age of 18 if they have an advance directive. If they have an advance directive, the physician or LIP should request a copy of the form. If they do not have an advance directive, the physician or LIP should encourage completion of the form.
- To review an advance directive in the EMR, click on Chart Review, click on Media tab, click the filter button labeled POLST Forms/Adv Dir.

3.5 Using a Written Advance Directive Provided by the Patient

a. If a patient provides an advance directive or if there is an advance directive in their EMR, treat the patient in accordance with the advance directive.

b. The designation of a "Medical Decision Maker" to make health care decisions on behalf of the patient is often addressed in the advance directive.

c. Individual health care instructions may be included in the advance directive.

d. Conflict Resolution

- If an Advance Directive conflicts with the POLST form, then, to the extent of the conflict, the most recent expression of the patient's wishes govern.

3.6 Patients Unable to Communicate or Emergent Cases: In cases where a patient lacks decision making capacity or is in such a condition that it is not practical to provide information regarding Advance Directives, the nurse shall:

a. Check the patient's medical record for a copy of an Advance Directive from a previous admission and if one is present.
   - To review an advance directive in the EMR, click on Chart Review, click on Media tab, click the filter button labeled POLST Forms/Adv Dir.
   - Place the Advance Directive in the current medical record and document the validity of the Advance Directive.

b. Refer the patient and/or legally recognized decision maker to a social worker for information and assistance.

4. REFERENCES

4.1 RUHS – Medical Center policy Identification of Next of Kin (Closest Available Relative)

4.2 *Consent Manual* (46th Ed.). (2019). Sacramento, CA: California Hospital Association.

4.3 Coalition for Compassionate Care of California. Retrieved June 06, 2016, from http://coalitionccc.org/

4.4 Probate Code Section 4695 & 4673 https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr04-08_Encl_2.pdf

4.5 California Advance Health Care Directive. https://med.stanford.edu/content/dam/sm/bioethics/documents/AdvanceDirective_English-easy-read.pdf

5. ATTACHMENTS

5.1 Form 380 your right to make decisions.

Release Dates: 2/4/11 1/23/03 3/12/97	**Retire Date:** N/A
Document Owner: Palliative Care Committee	**Replaces Policy:** 601.3 Advance directives

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
06/06/2016	Corinne Hendra RN, BSN	Yes	Revised
6/15/2016	Nursing Policy and Procedure Committee	Yes	Minor revisions
6/5/16	Martha Knutson, Deputy County Counsel	Yes	Legal revisions
5/26/16	Palliative Care Committee	Yes	Minor revisions
7/19/16	Policy Approval Committee	Yes	Minor formatting
8/24/2016	Hospital Executive Committee	No	
5/23/18	Corinne Hendra RN, BSN, CHPN	Yes	Updated polst definition, added physician section with instructions on how to query polst registry and create electronic polst Added ePOLST and California registry
10/30/18	Marty Knutson, Deputy County Counsel	Yes	Split into 2 policies, POLST and Advance Directives
11/30/18	Nursing P&P	Yes	LIP definitionSplit into 2 policies, POLST and Advance Directives
12/13/18	Corinne Hendra RN, BSN, CHPN	Yes	Minor revisions, policy sent to Tracy Howard, Lakesha Reese, Tim Emmons for review
5/1/19	Marty Knutson, Deputy County Counsel	Yes	Removed sections 3.7 oral designation of healthcare agent, 3.8 declination to comply with advance directive. Added LIP definition, section 3.2 nurse to give patient advance directive when requested. Added how to find advance directive in EMR, Minor edits.

Who decides about my treatment?
Your doctors will give you information and advice about treatment. You have the right to choose. You can say, "Yes" to treatments you want. You can say "No" to any treatment that you don't want – even if the treatment might keep you alive longer.

How do I know what I want?
Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects". Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

Can other people help with my decisions?
Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

Can I choose a relative or friend to make healthcare decisions for me?
Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

What if I become too sick to make my own healthcare decisions?
If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

Do I have to wait until I am sick to express my wishes about health care?
No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called 'advance' because you prepare one before healthcare decisions need to be made. They are called 'directives' because they state who will speak on you behalf and what should be done.
In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney for Health Care. The part where you can express what you want done is called and Individual Health Care Instruction.

Who can make an advance directive?
You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

Who can I name as my agent?
You can chose an adult relative or any other person you trust to speak for you when medical decisions must be made.

When does my agent begin making decisions?
Usually, a healthcare agent will make decisions only after you lose the ability to make them for yourself. But, if you wish, you can states in the Power of Attorney for Health Care that you want the agent to begin making decisions immediately.

How does my agent know what I would want?
After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

What if I don't want to name an agent?
You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.
Even if you have not filled out a written Individual Health Care Instruction, you can discuss your wishes with your doctor, and ask you doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will be probably be easier to follow your wishes if you write them down.

What if I change my mind?
You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

What happens when someone else makes decisions about my treatment?
The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a surrogate, whose name you gave to your

doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest.
The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

Will I still be treated if I don't make an advance directive?
Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that:
A Power of Attorney for Health Care lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatment – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.
You can create and Individual Healthcare Instruction by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf. These two types of Advance Health Care Directives may be used together or separately.

How do I get more information about making an advance directive?
Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

If you wish to receive more information regarding an Advance Directive, you may contact the Department of Patient and Family Services at (951) 486-4350.

FORM 380 (7/17)

Riverside University Health System
Medical Center

Your Right To Make Decisions About Medical Treatment

This brochure explains your rights to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

RIVERSIDE UNIVERSITY HEALTH SYSTEM –
MEDICAL CENTER, COMMUNITY HEALTH CENTERS, and HOSPITAL BASED CLINICS

Housewide

	Document No: 601.7	Page 1 of 2
Title: Use of Abbreviations	**Effective Date:** 9/12/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. PROCEDURES

1.1 Unapproved Abbreviations – Do Not Use List of Abbreviations

a. In compliance with patient safety standards of The Joint Commission published in the Comprehensive Accreditation Manual for Hospitals (CAMH), RUHS – Medical Center healthcare workers shall not use any abbreviation found on the "Do Not Use List".

1.2 Approved Abbreviations

a. RUHS – Medical Center has adopted Stedman's Abbreviations Acronyms & Symbols Manual of approved abbreviations. Only abbreviations found in this manual shall be used in the medical record, unless the abbreviation appears on the RUHS – Medical Center 'Do Not Use' list.

1.3 Additions to Approved Abbreviations

a. Any abbreviation not found in the Stedman's Manual but needing to be used at RUHS – Medical Center because of its common use by specialty service(s) shall be requested in writing to Administration for review for appropriateness. If the request is approved, Administration may submit any additions to the Medical Records Forms Committee for coordination of approved use.

Forms using specific abbreviations require a legend if the abbreviation is not found in the Stedman's manual.

2. ATTACHMENTS

2.1 RUHS – Medical Center Do Not Use List

Document History:

Prior Release Dates: 12/20/02, 07/31/05, 05/17/11, 9/2/2016	**Retire Date:** N/A
Document Owner: Health Information Management	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
08/09/19	Health Information Management	Yes	Minor wording/updates
9/3/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 601.8	Page 1 of 2
Title: Patient Written Materials	**Effective Date:** 7/1/2019	☐ RUHS – Behavioral Health ☒ RUHS – Community Health Centers ☒ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. POLICY

1.1 The policy of Riverside University Health System is to provide patients clear and legible written materials by:

a. Printing in either Arial or Times New Roman style font, 12-point size or larger, for the information to be readable.

b. Printing in black (or a dark color) on white for high contrast to improve readability.

c. Writing at a 5th grade level whenever possible to ensure readability by a majority of patients.

d. Translating written materials to Spanish and any other languages as applicable for Limited English Proficient patients and/or their family members, or a patient representative when applicable.

e. Follow the RUHS Brand Style Guide standards to ensure brand consistency across messaging.

1.2 The requirements detailed in this policy apply to the following materials:

a. Admission and discharge papers and forms.

b. Medical and therapeutic instructions prepared by RUHS specifically for an individual upon his or her discharge.

c. Any consent for hospitalization or agreement to assume financial responsibility between a patient and RUHS.

d. Instructions and forms for advance health care directives.

e. Information produced by RUHS regarding the rights and responsibilities of patients while receiving care at RUHS and/or regarding grievances and appeals, including forms and instructions.

f. Correspondence written, printed, or produced by RUHS.

g. Marketing collateral and consumer-facing website.

1.3 Exclusion: RUHS policies and procedures are specifically excluded from the requirements detailed in this policy.

2. References:

2.1 California Health and Safety Code - HSC: Division 106. Personal Health Care (Including Maternal, Child, and Adolescent), Part 1. General Administration, Chapter 4. Written Materials for Patients, Section 123222.1

2.2 RUHS Policy No. 142. Access to Language Services for Limited English Proficient, Dear, and Hearing Impaired Persons

2.3 The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.

Document History:

Prior Release Dates: 1/2/03, 8/24/2016		**Retire Date:** N/A	
Document Owner: Marketing		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
6/4/2019	Policy Approval Committee	Y	Change 6th grade to 5th grade as per TJC recommendations, add TJC reference. Specify fonts for readability.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 603	Page 1 of 6
Title: Provision for Patient Care	**Effective Date:** 8/26/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruickshank Chief Executive Officer		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Clinical leadership: is a collective term for the executives, directors, managers of the different departments and services that are involved in the patient care led by the Chief Nursing Officer. The departments are but not limited to Nursing, Pharmacy, Diagnostics Services, Food and Nutrition Services, Rehabilitation, Integrated Care Management Services.

1.2 Lean is a set of operating philosophies and methods that help create a maximum value for patients by reducing waste and waits. It emphasizes the consideration of the customer's needs, employee involvement and continuous improvement. It aims to fundamentally change organization thinking and value, which ultimately leads to the transformation of organization behavior and culture over time Based on the Toyota model, it focuses on how efficiently resources are being used and ask, 'what value is being added for the customer' in every process.

1.3 A3 is a Lean tool template created and utilized by Toyota as a means of identifying and solving problems. It is printed in a single sheet of paper that contains text, pictures, diagrams and charts to improve communication. It is used in process improvement projects.

2. POLICY

2.1 The provision of patient care at Riverside University Healthcare System-Medical Center is guided by the mission, vision and values of our organization and adopted by our staff. Medical care is directed by the Medical Staff, within the confines of policy, regulations and hospital services. The Nursing Department is at the center of patient care and collaborates, communicates and coordinates with the other healthcare disciplines for the complete plan of care of the patient and their families. Services and activities are a team effort involving a wide variety of disciplines, departments and licensed independent practitioners within many levels of care; making coordination of care, safety, and quality a priority.

2.2 RUHS-MC includes a Moreno Valley and Arlington campus, providing both medical and psychiatric care. RUHS-Medical Center is operated by the county of Riverside for the benefit of the residents of Riverside County and is operated under the legal authority and stewardship of the Riverside County Board of Supervisors (BoS). RUHS-Medical Center provides care, without discrimination, to the needy and indigent County residents and other patients/insured who elect to receive our services.

a. RUHS-Medical Center; the medical center in Moreno Valley and the Arlington campus, which provides psychiatric/mental health treatment. The medical center has patient care areas that include the Emergency Department, Trauma Services, Perioperative Services includes Preoperative Care (Pre-op) , Operating Room, Post Anesthesia Care Unit (PACU) , Same Day Surgery, Gastrointestinal Lab (GI Lab), Cardiac Catheterization Lab (Cath Lab) and inpatient units. Inpatient units include Intensive Care Units (Surgical Intensive Care Unit (SICU) and MICU), Intermediate Care/Telemetry, 6 Medical Surgical/Telemetry units (one of which is a Detention Care Unit), Labor and Delivery, Mother/Baby, Neonatal Intensive Care (NICU), Pediatrics and Pediatric Intensive Care (PICU). Arlington campus nursing units are Emergency Treatment Services (ETS), and Units A, B, C, and D, which provide inpatient adolescent and adult mental health treatment. Each unit is staffed according to the staffing plan, including by observing minimum staffing ratios as mandated by California Title XXII. Other staffing factors are considered as well, including patient acuity, extenuating circumstances, safety needs, staff competencies and experience, etc.

b. The patient populations served ranges from neonates (0-28 days) through Geriatric (65+ years). Age specific equipment is used and staff utilize an age specific treatment and communication style with the patients. The Arlington campus include emergency and inpatient psychiatric services for adolescents (13-17) and adults.

2.3 RUHS – Medical Center operates within the broader RUHS system, which includes RUHS – Behavioral Health, RUHS – Public Health, RUHS – Care Clinics and works to refer and coordinate care for patients across all entities.

2.4 Nursing practice at RUHS-Medical Center is also defined in accordance with the California State Board of Nursing as follows: "the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill." Nursing care within RUHS-Medical Center is guided by nationally recognized nursing standards including, but not limited to, American Nurses Association (*Scope & Standards of Practice* and *Scope and Standards for Nursing Administrators*), Title 22 and other national nursing organizations.

The Registered Nurse utilizes the Nursing Process and critical thinking skills in the care of their patient. The Nursing Process is the organized framework used by the professional nurse to address specific nursing needs of an individual patients. Components are assessment, nursing diagnosis, planning, intervention and evaluation. The Nursing Process is dynamic and enables the professional nurse to analyze and synthesize information received from the patient/family and other available data, to identify patient needs, set mutual goals and interventions and allows for evaluation of patient outcomes.

2.5 Nursing and Clinical Departments work in collaboration to support the care of patients. Clinical Departments include Food & Nutritional Services, Imaging, Laboratory, Respiratory Care, Pharmacy, Rehabilitation Services, Riverside Child Assessment Team, Patient and Family Services, Integrated Care Management and more. Clinical multidisciplinary teams work closely with the medical staff. Medical Center committees are multidisciplinary in nature, as indicated by the goals of the committee.

a. Facility and departmental policies, procedures and standards of practice guide clinical practice.

b. The RUHS-Medical Center Multidisciplinary Team works in collaboration within a variety of disciplines and departments to provide safe and quality care to our patients. Communication, collaboration and mutual respect are key to optimal outcomes in patient care. Communication between disciplines can occur by informal discussion, written communication, Interdisciplinary Care Plans, progress notes, SBAR reports and meetings. Communications regarding patients requires two patient identifiers.

2.6 Advanced Practice Nurses, including Nurse Practitioners and Nurse Midwives, may be utilized in approved, credentialed roles. Physician Assistants may be utilized as well.

2.7 RUHS-Medical Center has The Joint Commission (TJC) Disease Specific Care (Certification?)for Stroke, Diabetes, Sepsis and Total Hip/Knee.

2.8 RUHS-Medical Center Trauma Services is designated Level II Trauma center for adults and pediatrics.

2.9 RUHS-Medical Center NICU is designated Community NICU, is level III, and has a transport team.

2.10 RUHS-Medical Center is a 5150 designated facility and incorporates the use of a Psychiatrist and nurse team, Psychiatric Consultation Liaison Services (PCLS), to assist in the care of patients with psychiatric/behavioral health issues. A Behavioral Emergency Response Team (BERT) is designated at both campuses to assist with de-escalating situations with patients/families.

2.11 RUHS-Medical Center also offers services of the Sexual Assault and Forensic Evaluation (SAFE) with intervention for adults, adolescents and children.

3. PROCEDURE FOR OUR CORE COMPONENTS OF CARE PROCESS

3.1 Assessing patient needs:

a. Assessment assists in determining the care, treatment and services that meet the patient's initial and continuing needs. Assessment is initiated at the patient's entry into the RUHS-Medical Center system and reassessment is completed at regular intervals dependent upon the patient's needs, goals, changes in acuity, the services provided and the defined minimum assessments per each level of care. An assessment each twelve hour shift is the hospital baseline for assessment intervals. Higher acuity areas may include more frequent re-assessments. Assessment includes the patient's perception of the effectiveness of treatments.

b. Assessments include physical, psychological, social, nutritional, hydration, SOGI (sexual orientation, gender identity) and functional elements. Assessment includes the patient's spiritual and cultural values that may influence the patient/families preferences and perceptions in care. The initial assessment includes assessing for fall risk and for possible abuse, neglect and suicide. Referrals to other clinical disciplines are requested, following assessment, by physicians and, and in some instances, by a Registered Nurse.

3.2 Planning for care, treatment and Services:

a. The Plan of care is based upon the assessment of patient needs and a documented Plan of Care is created that utilizes identified issues and interventions. Patients are included in the plan of care and goals and staff evaluate the patient's progress. Goals may be immediate and long term.

b. The Plan of Care is one of the tools utilized to communicate patient identified issues, interventions, goals, modifications to, and progress towards goals.

c. RUHS-Medical Center periodically evaluates the needs of the community and patients and defines strategic and operational plans, develops budgets and allocates resources to meet the current and changing needs of its patient population and community.

d. The planning of human resources allocated to meet identified needs is a priority and is evaluated frequently. Whenever staffing allocation is dictated by minimum Registered Nurse staffing ratios, national standards or other regulations, RUHS=Medical Center plans for, and makes every effort, to meet and exceed these goals.

3.3 Providing Care:

a. Care is provided based on an individualized plan of care. The Plan of Care is developed through analysis of patient/family information and preferences, clinical data, nursing observations, physician diagnosis/orders and safety needs.

b. . RUHS-Medical Center care providers utilize active orders from a licensed independent practitioner.

c. Care is provided by the appropriate classification of staff member, based on hospital policy, regulations, licensure and scope of practice. Staffing plans within departments are developed based on the level and scope of care, the frequency of the care to be provided and a determination of the level and skill mix of staff than will provide the service.

3.4 Coordination of Care

a. Because the healthcare setting includes an array of care providers, procedures and treatments, RUHS-Medical Center promotes and values communication among disciplines and to the patient and family. The coordination of care is based upon the patient's needs.

b. RUHS-Medical Center shares necessary patient information with internal and external providers of care, as needed throughout the continuum of care.

c. When patient hand offs occur, communication regarding the patient occurs in the SBAR (Situation, Background, Assessment, and Recommendation) format to promote completeness and uniformity. SBAR can occur in a variety of situations but must include the opportunity for discussion or questions, as needed, in person or via phone.

d. Responsibility for the provision of patient care is a shared responsibility among the Board of Supervisors, RUHS-Medical Center Administration and the Medical Staff. Leadership communicates the mission, vision and values throughout the organization and promotes communication. Systems and processes have been developed to support safety, quality and consistency.

e. Department Managers and Directors are responsible for the integration and facilitation of care within their departments. The importance of collaborative, multidisciplinary team approach is paramount. Collaboration occurs through communication in the form of SBAR, the Plan of Care, committee meetings, care conferences and written progress notes.

4. ONGOING QUALITY OF CARE AND PERFORMANCE IMPROVEMENT

4.1 The clinical leadership have regularly scheduled meetings and activities to continuously facilitate communication about trends and issues and to plan the provision of care for the RUHS-Medical Center patient. Regular meetings include Nurse Executive Team meetings, Clinical Leadership Meetings, daily staffing/safety meetings, staff meetings, staff huddles and interdisciplinary meetings among departments.

4.2 Departments evaluate a variety of indicators to determine ongoing performance improvement and to select quality indicators. Selection of projects and indicators to monitor may be determined by, but not limited to, staff input, trends noted by committees such as Medication Safety or Fall Prevention, patient outcomes, input from patients, regulatory mandates, incident report trends, core measures, changes in delivery of care, safety concerns, program initiatives or requirements, research/evidence based practice and literature review.

4.3 With the approval of Clinical Leadership, individual clinical services may select quality or performance improvement monitors specific to their specialty or unit trends. The projects and data shall be reported through Clinical Leadership and designated committees, both those specific to the specialty and also Performance Improvement Patient Safety Committee (PIPSC). PIPSC reports data on to Medical Staff and through the hospital senior leadership structure. Data is posted in the nursing units and discussed at both staff meetings and staff huddles.

4.4 Clinical Leadership discusses and selects other performance improvement projects that may cross several service lines. Examples would include monitoring Hand Hygiene, compliance with documentation, fall rates, hospital acquired infections (HAI) and hospital acquired pressure ulcer wound rates. Data from all areas is compiled and discussed within the Clinical Leadership meeting and presented to Performance Improvement Patient Safety Committee (PIPSC). Analysis of data, actions taken and re-analysis of data after actions implemented are discussed. Data are posted in the clinical areas and discussed at both staff meetings and staff huddles. Results of Performance Improvement processes help determine topics for staff education and training.

4.5 Numerous departments participate in a variety of Quality Assurance Performance Improvement (QAPI) activities with other disciplines, including Medical Staff, Pharmacy, Physical Therapy, Laboratory, etc., to monitor and comply with safety and regulatory standards.

4.6 RUHS-Medical Center strives to continuously improve safety and quality. Each department participates in a variety of voluntary performance improvement projects within the organization. Lean training and A3 classes are offered regularly to encourage staff to be involved in improving safety and processes.

4.7 The Quality Department consults and assists departments with identifying projects and indicators of value to promote the quality process. Methods such as use of Root Cause Analysis (RCA), Failure Mode Evaluation Analysis (FMEA) and analysis of

trends and incidents are utilized. Evidence based practice, current literature and emerging technologies, trends and studies are also utilized to promote quality.

5. PRINCIPLES OF CARE

5.1 Each patient has a plan of care that is utilized in a multidisciplinary approach that promotes continuity of care and optimal outcomes.

5.2 Every patient is treated with courtesy and respect, with staff awareness that the family is an important part of the care of the patient.

5.3 Quality and safety are primary drivers of decisions made in the Nursing Department.

5.4 Patient privacy and confidentiality are maintained at all times.

6. REFERENCES

6.1 California Title XXII AB394

6.2 The Joint Commission (TJC) Accreditation Standards for Hospitals, Provision of Care, Treatment and Services

6.3 RUHS-Medical Center Nursing Administration policy 103: Acuity, Patient Classification System

6.4 RUHS-Medical Center Housewide policy 692, Interdisciplinary Plan of care

6.5 Lean management in health care: definition, concepts, methodology and effects reported (systematic review protocol) Adegboyega K Lawal, Thomas Rotter, Leigh Kinsman, Nazmi Sari, Liz Harrison, Cathy Jeffery, Mareike Kutz, Mohammad F Khan, Rachel Flynn Syst Rev. 2014; 3: 103. Published online 2014 Sep 19

Document History:

Prior Release Dates: 8/2016, 4/2017	**Retire Date:** N/A
Sponsored by: Chief Nursing Officer	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
5/16/2019	Nursing Leadership	Y	Changes throughout the document, appear red in the document.
5/30/2019	Nursing P&P	Y	Approved on e-vote , with corrections. Added 1.4, 1.5, and 1.6. Spelled out all acronyms; 2.11 changed SART to SANE, Added definitions 1.4, 1.5, 1.6. verbiage under 2.3 updated
7/12/2019	PAC Evote	N	
8/8/2019	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 603.21	Page 1 of 6
Title: Critical Values Reporting	**Effective Date:** 10/29/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Critical Value: A diagnostic test/exam result that, if not acted upon quickly, may result in harm to the patient.

1.2 Critical Value Report (CVR): Includes critical lab values and other diagnostic test results that require immediate and/or emergent response from a physician or other licensed responsible caregiver. Verbal or telephone reporting of critical values also may be used during procedures where it is impractical for the CVR to be written, such as in surgery or the Emergency Department.

1.3 Verbal and Telephone CVR: The oral transmission of CVR results done face to face or over the telephone.

1.4 Reporters of Verbal or Telephone CVR: A physician or authorized designated laboratory, diagnostic services, or imaging staff who has reported the CVR result(s).

1.5 Receivers of Verbal and Telephone CVR: Persons authorized to accept and communicate critical lab values/test results include; Respiratory Care Practitioners, registered nurses (RNs), Nurse Practitioners (NPs), Pharmacists and other licensed personnel such as medical doctors (MDs), osteopathic doctors (DOs), etc. Individual departments may develop a list of authorized personnel that is more restrictive than this definition but may not develop a list that is less restrictive.

1.6 Critical Tests/Exams: Defined as diagnostic tests/exams such as lab tests, blood gas tests, radiology exams, and cardiology diagnostic exams, which require rapid communication of results. Critical Tests and their results may be abnormal or normal.

1.7 Stat: Used as a directive to medical personnel during an emergency situation, which means immediately.

2. POLICY

2.1 All critical values for inpatients must be reported within one hour or less to the ordering physician or the licensed responsible caregiver who will act upon the information within a time frame appropriate to the issue.

2.2 All physicians and staff who receive a verbal/telephone communication of critical values will read-back and verify the results to the person reporting the information.

2.3 All critical values for all patients must be communicated directly, person to person

3. Responsibilities of the Person Reporting the Critical Value Result(s)

3.1 The Laboratory Department staff will report critical lab values for patients to the requesting Nursing Unit or Clinic within 10 minutes of testing completion.

Note: Repeat critical values of decreased white blood cells (WBC), neutrophils, and platelets that are on a documented leukopenic inpatient only need to be reported as a critical value once every 24 hours unless requested otherwise by the physician.

3.2 The Respiratory Department staff will report critical lab values for patients to the requesting Patient Care Unit, Emergency Department, or Clinic within 10 minutes of testing completion.

3.3 The Radiology Department staff will report critical test values for patients to the requesting Patient Care Unit, Emergency Department, or Clinic within 10 minutes of physician reading.

3.4 The Diagnostic Department staff report critical test values for patients to the requesting Patient Care Unit, Emergency Department, or Clinic within 10 minutes of physician reading.

3.5 After receiving a critical value notification, the Patient Care Unit, Emergency Department, or Clinic staff will report it to the ordering physician as soon as possible but never more than 50 minutes from having received the notification from the Critical Value reporting department.

Note: In the absence of the ordering physician, the report will be made to the physician or other licensed provider who is currently responsible for the care of the patient.

3.6 For verbal or telephonic reporting of critical values, verify the complete order or test result by having the person receiving the critical value "read back" and "verify" the complete test result.

3.7 The person reporting the CVR result will document and sign/initial the following information on the departmental/patient records:

a. The critical value reported;

b. The name of the person who received the information;

c. That "read-back" verification (RBV) occurred; and

d. Date and time of the communication.

4. Responsibilities of the Person Receiving the CVR Result

4.1 The person receiving the CVR will:

a. Write down the result;

b. Verify the identification of the patient by last name and first name and Medical

c. Record number (MR#);

d. "Read back and verify" the results to the person reporting;

e. Document Critical Value in the medical record as soon as possible;

f. Contact the physician or other Licensed Healthcare Practitioner responsible for the patient as soon as possible (but in no more than 50 minutes) to report the results; and

g. Request a "read back and verify" from the contacted physician or Licensed Healthcare Practitioner receiving the CVR.

4.2 The Registered Nurse (RN) receiving the CVR will document the physician notified, the critical value, the read back and verify, the date and time, and initial the entry using:

a. The Critical Value Reporting form within the Electronic Medical Record (EMR) Clinical documentation tab; and

b. The Orange Critical Value reporting sticker at the Riverside University Health System- Medical Center Arlington campus and during EMR downtime.

4.3 The physician or other licensed responsible caregiver receiving the CVR will:

a. "read-back and verify" the critical value(s); and

b. document the result(s) as soon as possible.

Note: In emergency situations, it may not be feasible to write down the critical value result and do a formal "read-back." In these circumstances, a "repeat back" should be performed.

5. Exclusions/Clinical

5.1 All written communication (including fax transmissions) of critical test/exam results do NOT require read-back verification or repeated documentation of the CVR.

5.2 Results of STAT labs and test/exam results are NOT considered a CVR unless they meet criteria established by the hospital.

5.3 It is prohibited for an RN or Licensed Healthcare Practitioner to refuse to accept reported critical values.

5.4 In the event a physician specifies specific time or value standards different than this policy states, the physician orders will override this policy. (For example, if the order reads: "Call House staff officer (H.O.) within 15 minutes if glucose < 30 mg/dl", the 15-minute time frame must not be exceeded.)

6. Outpatient and Discharged Patient Critical Value Reporting

6.1 During hospital clinic business hours, the CV reporting department shall report the critical value within 10 minutes of testing completion to a clinic staff member authorized to receive Critical values for the clinic.

6.2 If the clinic is closed, the CV reporting department shall report the critical value directly to the physician on call for the specific clinic/service identified using the hospital Daily Call Schedule within the 60 minute timeframe for reporting the critical value.

6.3 If the patient is discharged, the CV reporting department shall report the critical value directly to the physician on call for the specific service responsible for the admission

using the hospital Daily Call Schedule within the 60 minute timeframe for reporting the critical value.

7. Monitoring Compliance with Critical Value Reporting

7.1 Each relevant Department Manager and nursing will monitor compliance with the critical value reporting requirements by collecting and reporting data.

7.2 The relevant Department Manager and nursing will prepare a summary report of CVR compliance and submit it to the Performance Improvement Patient Safety Committee (PIPSC) for review, approval, and/or recommendations.

7.3 PIPSC will ensure that appropriate action is taken to improve the timeliness of reporting critical values as needed and to measure the effectiveness of those actions.

8. CRITICAL VALUES

8.1 Critical Values - Laboratory

Critical limits	ADULTS		NURSERY	
	LOW	HIGH	LOW	HIGH
Bilirubin, Total-Cord	N/A	N/A	N/A	≥ 2.0 mg/dL
Bilirubin, Total	N/A	N/A	1 day old	≥ 7.5 mg/dL
			2 days old	≥ 11.0 mg/dL
			3 days old	≥ 15.0 mg/dL
			4 days old	≥ 16.5 mg/dL
			5-30 days old	≥ 17.5 mg/dL
Glucose (Neonates) (0-30 days)	N/A	N/A	< 40 mg/dL	>180 mg/dL
			CHILD/ADOLESCENT	
			LOW	HIGH
Calcium	≤ 6.0 mg/dL	≥ 13.0 mg/dL	≤ 6.0 mg/dL	≥ 12.7 mg/dL
CO_2	≤ 10 mmol/L	≥ 40 mmol/L	≤ 10 mmol/L	≥ 40 mmol/L
Glucose (31 days & older)	< 50 mg/dL	> 370 mg/dL	< 50 mg/dL	>370 mg/dL
Hematocrit	N/A	N/A	≤ 22 %	≥ 62 %
Hemoglobin	≤ 6.0 g/dL	≥18.5 g/dL	≤ 6.9 g/dL	≥ 22.0 g/dL
K-Potassium	≤ 2.5 mmol/L	≥ 6.4 mmol/L	≤ 2.5 mmol/L	≥ 5.9 mmol/L
Lactate/Lactic Acid	N/A	≥ 2.0 mmol/L		≥ 3.0 mmol/L
Na-Sodium	≤ 120 mmol/L	≥ 160 mmol/L	≤ 120 mmol/L	≥ 150 mmol/L
Neutrophils (WBC)	≤ 0.5 x 10^9/L	N/A	≤ 0.5 x 10^9/L	N/A
Magnesium	≤ 1.0 mg/dL	≥ 6.5 mg/dL	≤ 1.0 mg/dL	≥ 6.5 mg/dL
Phosphorous	≤ 1.0 mg/dL	≥ 8.9 mg/dL	≤ 1.0 mg/dL	≥ 8.9 mg/dL
Platelets	≤ 36 x 10^9/L	≥ 910 x 10^9/L	≤ 52 x 10^9/L	≥ 913 x 10^9/L
Procalcitonin		≥ 2 ng/ml		

Troponin	N/A	≥ 0.1 ng/mL	N/A	N/A
PT INR	N/A	≥ 5.0	N/A	N/A
PTT	N/A	≥ 110 sec	N/A	≥ 110 sec
WBC Count	≤ 2.5 x 10^9/L	≥ 50 x 10^9/L	≤ 2.5 x 10^9/L	≥ 30 X10^9/L
Blood Culture	Positive		Positive	
India Ink,Gram Stain	Positive		Positive	
	Therapeutic Drugs			
Acetaminophen	≥ 200 mcg/mL	Carbamazepine	≥ 15 mcg/ml	
Digoxin	≥ 2.5 ng/mL	Lithium	≥ 2.0 mmol/L	
Phenobarbital	≥ 50.0 mcg/mL	Phenytoin	≥ 20 mcg/ml	
Salicylate	≥ 30.0 mg/dL	Valproic Acid	≥ 100 mcg/ml	
Vancomycin Trough	≥ 22.0 mcg/ml			

8.2 Critical Values – Respiratory Services

Parameters	Age	BGART < Low /> High	BGARTw/o < Low /> High	BGCO-ox only < Low /> High	BGCAP < Low / > High	BGVEN < Low / > High	BGCRDA < Low / > High	BGCRDV < Low/ >High
pH	<12 Months	7.250/7.500	7.250/7.500		7.270/7.500	7.270/7.500	**********	**********
	>12 Months	7.250/7.550	7.250/7.550		7.270/7.500	7.270/7.500	**********	**********
PCO2 mmHg	<12 Months	20.0/55.0	20.0/55.0		20.0/55.0	25.0/55.0	**********	**********
	>12 Months	25.0/55.0	25.0/55.0		25.0/55.0	25.0/55.1	**********	**********
PO2 mmHg	<12 Months	40.0/100.0	40.0/100.0		40.0/100.0	40.0/85.0	**********	**********
	>12 Months	55.0/250.0	55.0/250.0		55.0/250.0	40.0/85.1	**********	**********
HC03 mmol/L	<12 Months	17.0/30.0	17.0/30.0		17.0/30.0	17.0/30.1	17.0/30.2	17.0/30.3
	>12 Months	12.0/36.0	12.0/36.0		12.0/36.0	12.0/36.1	12.0/36.2	12.0/36.3
BE mmol/L	<12 Months	(-6) / 6	(-6) / 6		(-6) / 6	(-6) / 7	(-6) / 8	(-6) / 6
	>12 Months	(-7) / 10	(-7) / 10		(-7) / 10	(-7) / 11	(-7) / 12	(-7) / 10
SO2 %	<12 Months	85 / 100	85 / 100		85 / 100	50 / 99	**********	**********
	>12 Months	85 / 200	85 / 200		85 / 200	50 / 99	**********	**********
tHb g/dL	<12 Months	5 / 20		5 / 20	5 / 20	6 / 20	7 / 20	8 / 20
	>12 Months	6 / 21		6 / 21	6 / 21	7 / 21	8 / 21	9 / 21
COHb %	<12 Months	(-1) / 8		(-1) / 8	(-1) / 8	(-1) / 9	(-1) /10	(-1) / 11
	>12 Months	(-4) / 3		(-4) / 3	(-4) / 3	(-4) / 4	(-4) / 5	(-4) / 6
MetHb %	<12 Months	(-1) / 8		(-1) / 8	(-1) / 8	(-1) / 9	(-1) / 10	(-1) / 11
	>12 Months	0 / 3		0 /3	0 / 3	1 / 3	2 / 3	3 / 3
02Hb %	<12 Months	65 / 101		65 / 101	65 / 101	66 / 101	67 / 101	68 / 101
	>12 Months	10 / 104		10 / 104	10 / 104	11 / 104	12 / 104	13 / 104
cT02(a) mL/dL	<12 Months	1 / 40		1 / 40	2 / 40	3 / 40	4 / 40	5 / 40
	>12 Months	1 / 98		1 / 98	2 / 98	3 / 98	4 / 98	5 / 98

Note: ********** is No Criticals Programmed

8.3 Critical Values Reporting – Radiology Services Include but are not limited to the following

a. Tension pneumothorax
b. Aortic dissection/rupture
c. Aneurysm leak
d. New Free air under the diaphragm
e. Spinal cord compression
f. Pneumothorax on an intubated patient
g. Acute pulmonary embolus
h. Ectopic pregnancy with free fluid/ hemoperitoneum
i. New finding of intracranial herniation
j. Acute or increasing intracranial hematoma

9. References:

9.1 The Joint Commission, Improve staff communication, 2019 NPSG.02.03.01.

Document History:

Release Dates: 2/9/2006, 3/21/2006, 4/26/2006, 09/24/08, 03/20/09, 6/7/16	**Retire Date:** N/A
Sponsored by: Clinical Lab Director	**Replaces Policy:**

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
8/21/18	Clinical Lab Director	Yes	Revised selected lab test Critical Values.
01/2019	Nursing P&P	Yes	Added child/adolescent CV
9/9/19	P&T	No	Add documentation requirements in 6.3 and 6.3a
9/17/2019	PAC	Yes	Revised 6.3 reporting requirement
10/10/19	MEC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 603.4	Page 1 of 4
Title: Pain Management	**Effective Date:** 5/29/2019	☐ RUHS – Behavioral Health ☐ RUHS – Community Health Centers ☐ RUHS – Hospital Based Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 Pain: is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is always subjective, however patients without the ability to communicate may still experience pain. Pain has sensory, emotional, cognitive, spiritual, and behavioral components that are interrelated with environmental, developmental, sociocultural, and contextual factors.

1.2 Pain assessment: includes information from the patient about provoking factors, quality/characteristics, region/radiation, relieving factors, associated symptoms, timing, and pain scores obtained with a pain assessment tool. When movement/activity causes or is expected to cause pain, movement/activity pain scores are utilized.

1.3 Pain assessment and history: includes the information obtained from a pain assessment, the history of pain and its management and a history of analgesic use.

1.4 Pain assessment tool: is a reliable, validated tool used to measure pain.

2. POLICY

2.1 Riverside University Health Systems-Medical Center recognizes the patient's right to pain relief and supports a multidisciplinary approach to pain assessment and management. The purpose of this policy is to establish standards for pain assessment and management.

2.2 Responsibility: Physicians, patient care services staff, clinical support services personnel, consultants and other RUHS-MEDICAL CENTER personnel involved in providing care to the patient are responsible for following this policy.

2.3 Establishing Competency:

a. The Nursing staff shall complete and pass the On-line Moodle training on Pain Assessment and Management as part of their new hire Patient Care Orientation. And will demonstrate competency during their orientation period and on an on-as needed basis.

3. GUIDELINES

3.1 The physician, LIP, nurse, shall asses the presence of pain on all patients upon initial evaluation, or assessment and at an ongoing basis per physicians orders and whenever necessary.

a. Pain shall be assessed when new pain is reported and when procedures or activities that are expected to cause pain.
b. Determine the type of Pain.
c. Determine whether the pain is Acute or Chronic.
d. Assess the characteristic pain.

3.2 Pain management shall be individualized, with the consideration of the patient's clinical condition, past medical history, religious, and cultural concerns to establish realistic expectations and reasonable pain management goals.

a. Pain shall be addressed when the pain level interferes with function, activities of daily living, treatment, self-care, play or sleep.
b. The treatment strategies shall include pharmacologic, non-pharmacologic, or a combination of both approaches.
    - Pharmacologic intervention will be initiated by the Physician.
        - Opioid.
        - Non-opioid use.
    - Non-pharmacologic intervention.
        - Refer to pain assessment and management in Elsevier.
        - Identify the patient's preference for non-pharmacologic intervention.
c. Pain management treatment plan shall be reviewed and revised as needed by the multidisciplinary team lead by the primary physician.

3.3 The pain assessment tool utilized shall be consistent with the patient's developmental and intellectual capacity. Patient self-report shall be utilized whenever possible.

a. If applicable, movement/activity related scores are obtained/reported and used to determine the need for intervention and to evaluate effectiveness.
b. Approved and validated tools to measure pain are Self-reporting and Non-verbal Tools. RUHS-MC uses the following assessment tools:
    - **FLACC:** Face, Legs, Activity, Cry, and Consolability. Total points assigned may be from zero to ten. Commonly used for patients unable to verbalize pain: infants, toddlers, and those with cognitive impairment.
    - **CPOT**: Critical-Care Pain Observation Tool. Uses four behaviors: facial expression, body movement, muscle tension and compliance with ventilator patients. It can be used in nonverbal, non-ventilated patients, and sedated patients. It is reliable and valid for assessing pain in patients who are unable to self-report.
    - **FACES:** Wong-Baker FACES Pain rating scale. Generally used for patients ages 3 years and older.
    - **Numeric Pain Intensity (NPI) Scale:** Can be used for patients who can self-report pain. NPI provides a method for consistency in pain assessments. It determines treatment effects and easy to make comparative ratings.

- **N-PASS:** Neonatal Pain, Agitation and Sedation Scale. Used for patients less than 3 months corrected age (<3months). Points are assigned for both pain and sedation.

3.4 Pain reassessment

a. Reassess pain after each pain management intervention with appropriate intervals (i.e., at time of peak analgesic effect) to evaluate the effectiveness of pain management interventions.
   - Reassessment for IV medication intervention shall take place approximately 30 minutes after administration.
   - Reassessment for PO medication intervention shall take place approximately 60 minutes after administration.
   - Reassessment for non-pharmacologic shall take place not longer than 60 minutes after intervention.
   - Reassessment after pharmacologic intervention shall include assessing for the presence of analgesic side effects.

b. After intervention, and pain is still present, do NOT re-dose the patient, for any pain level, prior to ordered frequency. *Example: The patient received 1 mg of hydromorphone IV for pain of 10/10, 30 minutes later, the patient was reassessed and it is now at 7/10- do not give what is prescribed as appropriate for this pain level,* **instead call the primary physician for additional or alternative orders.**
   - Oral pain medication shall not be given more often than every 4 hours, unless otherwise ordered by the physician.
   - Injectable pain medications shall not be given more often than every 2 hours, unless otherwise ordered by the physician.

3.5 Patient and Family Education. Patients and family shall be educated about pain assessment, management plan and reasonable goals.

a. Education shall include the patient's right to medically appropriate pain management.
b. Review the patient's and the family's understanding of the pain scale selected to rate the patients pain.
c. Discuss the patient's goal for pain management and safe treatment options: safe use of opioid, and non-opioid medications when prescribed.
d. How activities of daily living might affect pain management and the strategies to address the issues.
e. Discharge should include side effects of pain treatment, safe use, storage, and disposal of opioids when prescribed.

3.6 Documentation

a. Initial assessment
b. Flow Sheets
c. Plan of care
d. Document Education provided
e. Multidisciplinary Notes if applicable

4. REFERENCES

4.1 Joint Commission Perspectives. (2017). *New and Revised Standards Related to Pain Assessment and Management*

4.2 Perry,A.G., Potter, P.A., Ostendorf W.R. (Eds.) 2018 Clinical Nursing Skills and Techniques(9th ed.) St. Louise: Elsevier

4.3 http://wongbakerfaces.org/Accessed December 7, 2018.

4.4 http://www.aacn.org/wd/Cetests/media/C1333.pdf. Accessed January 10, 2016.

4.5 http://ajcc.aacnjournals.org/content/15/4/420.full?sid=8db31f0a-bd82-4a2f-9d14-7f6ba307146b

Document History:

Release Dates: 1/2001, 4/2003, 9/2005, 3/2012, 12/28/2016		**Retire Date:** N/A	
Sponsored by: Nursing Administration		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made?**	**Revision Description**
11 /20/18	Internal Medicine and Pharmacy	Yes	Add the guidelines on how often med should be administered (3.6) Remove "break through pain" The purpose is to avoid accidental overdose.
12/11/18	Dr. A. Nguyen, Surgery Service	Yes	Agree with the changes listed above
12/11/2018	Pain Workgroup	Yes	Changed re-assessing time to matches task alert in Epic to achieve efficiency, better compliance, and standard documentation Removed brief pain inventory (BPI) which currently not being used in medical center
12/11/2018	Chee Wang	Yes	Removed assessment tool "BPI", no department/unit is using this tool in medical center
1/9/2019	Audrey Madarang	Yes	Improved overall document flow, deleted nurse extenders, pain screen, changed term measurement tools to assessment tool; added 3.4 b. example, separated b.i & bii; 3.5 added "reasonable goal", 3.6 Documentation added Elsevier as a reference
1/16/2019	Dr. Garrison, Davalyn	Yes	3.5.a Education shall include the patients right to "medically appropriate" pain management; 3.4.a no longer than 60 minutes,
2/20/2019	Marybeth	Yes	Section 3.4. "Approximately" to the reassessment times. Improved overall document
March 2019	Nursing P&P		
4/2/2019	PAC	Yes	Minor wording
5/9/2019	MEC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Housewide

	Document No: 605	Page 1 of 2
Title: Patient Identification	**Effective Date:** 7/10/2019	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Hard Stop is defined as a halt to a process when an inconsistency or error is discovered. The hard stop can be reversed once the inconsistency or error is resolved.

1.2 Financial Number is the number that is assigned to each encounter (visit) for every patient.

2. POLICY

2.1 The policy of Riverside University Health System-Medical Center is to:

a. Use at least two patient identifiers when providing care, treatment, or services

b. Reliably and correctly match the service or treatment to the correct patient

2.2 All healthcare team members will use two unique, patient-specific identifiers to assist in the correct identification of the patient.

2.3 Patient Identifiers – Active Patient Participation

a. When speaking to the patient, have the patient identify him/herself by stating the following:

- Full name, and
- Date of birth (DOB)

b. Note: a photograph of the patient, if at the Arlington Campus, may be used for purposes of visual identification by staff. Please refer to RUHS – Medical Center policy HW 707 Patient Photography.

2.4 The patient's room number or physical location may not be used as an identifier.

2.5 Patients unable to communicate or who have impaired mental status:

a. If a patient is unable to communicate, or if communication is unreliable, the patient wrist band (and/or photograph of patient if at the Arlington Campus) will be checked to compare two patient identifiers. One identifier will be the name and the other will be the Medical Record Number (MR#) or Date of Birth (DOB). The patient's family or caregiver shall be involved in the identification process, as needed.

b. Patients may be assigned a temporary "name", (e.g., Doe, Arizona or Smith, baby boy) and a medical record number. These identifiers may be used to identify the patient and match against specimen labels, medications ordered for the patient and/or blood product labels.

c. Newborn patients: Distinct methods of identification are used for newborn patients during the admission after birth.

- Newborn naming system after birth includes using mother's first and last names and the newborn's gender.
- Newborn identification bands will be placed on two body-sites.

2.6 Staff

a. May use the patient's medical record number, DOB and/or financial number when communicating with other staff about the patient's care.

2.7 "HARD STOP"

a. Orders (including medication orders), requisitions, consents, or any other document that leads to a procedure, treatment, or service that contains unclear patient identification, more than one patient's information, or the wrong patient identification, must be considered invalid.

3. REFERENCES

3.1 The Joint Commission, Comprehensive Accreditation Manual for Hospitals, National Patient Safety Goals, NPSG.01.01.01 EP 1, July 2019.

3.2 RUHS – Medical Center policy HW 513.1 Doe Registration.

Document History:

Prior Release Dates: 11/2008, 7/27/11, 8/26/2016	**Retire Date:** N/A
Document Owner: Regulatory	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
06/24/2019	Director, Regulatory Compliance	Y	Addition of TJC newborn patient identification methodology, and unknown trauma patients.
6/24/2019	Director, Quality	Y	
7/2/2019	PAC	Y	Minor clarifications

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 605.2	Page 1 of 3
Title: Color Coded Wristbands and Clasp Alerts	**Effective Date:** 9/12/2019	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Clasp Alert: Small plastic device that snaps securely onto a white wristband. This device is color coded and pre-printed to identify patient specific risk factors and/or special needs.

2. POLICY

2.1 The policy of Riverside University Health System- Medical Center is to apply white wristbands to all patients upon admission for patient identification. These wristbands will contain full patient name, date of birth and medical record number.

2.2 Color-coded clasp alerts

a. Shall be attached to the white wristbands that are applied to patients clasp alerts to communicate patient specific risk factors and/or special needs.

b. For any patient to whom the clasp alert may pose a risk, pre-printed color coded wrist bands, wall signage and door sliders (if available) shall be used.

i. Examples: Detention, Psychiatric, Pediatric and NICU patients.

c. In maternal and child areas, white bands with unique ID numbers shall be used to link each infant to his/her specific identified parent/caregiver.

2.3 Nursing staff shall:

a. Apply the appropriate color-coded clasp alert or wristband to patients.

b. Confirm that the color-coded clasp alerts and wristbands are consistent with the documentation in the medical record and with the knowledge of the patient and/or patient representative before any hand-off in care.

c. Correct any errors

2.4 Categories of the clasp alert and/or wrist band color and its meaning:

Alert Color: Wristband Only	Use/Meaning
White	• Patient identification. • All patients shall wear a white wristband with clearly legible patient identifiers.
Clear	• Blood Bank • Patient has consented to a blood transfusion
Alert Color: Wristband or Clasp Alert	
Purple	• Do Not Resuscitate
Red	• Allergy • Includes allergies to medication(s), food, and/or environmental allergens.
Yellow with Red Text	• Fall Risk
Alert Color: Clasp Alert Only	
Green	• Latex Sensitivity or Latex Allergy
Pink	• Limb Alert

2.5 Acceptance of Patient Use of Wristbands/Clasp Alerts

a. If the patient and/or representative accepts and wears color-coded wristband(s) /clasp alert(s), staff shall educate the patient and those involved in the patient's care about the purpose of the wristband(s)/clasp alert(s).

2.6 Refusal of Patient Use of Wristband/Clasp Alerts

a. If the patient, or patient representative, has the right to refuse to wear a color-coded wristband(s)/clasp alert(s). If a patient/patient representative refuses, the following is encouraged:

ii. Explain to the patient and/or representative the benefits of wearing the alert(s) and the risks of not wearing the alert(s).

iii. Reinforce that wearing the alert(s) is an opportunity to participate in efforts to prevent errors and take responsibility as part of the care team.

b. Documentation shall be clearly entered in the medical record regarding the use, or refusal to use the wristband(s) or clasp alert(s).

2.7 Precautions

a. Handwriting is not permitted on wristband

b. Ensure that the wristband being worn by the patient is a hospital issued band.

- If a patient is wearing a non-hospital wristband, staff shall explain to the patient the risks of wearing that wristband and ask the patient to remove the patient-owned band.

- Document in the record
  any patient refusal to remove patient-owned wristband(s).

3. REFERENCES

3.1 The Joint Commission, Comprehensive Accreditation Manual for Hospitals, National Patient Safety Goals, NPSG.01.01.01 EP 1, July 2019.

3.2 Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: A toolkit for improving quality of care. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013.

3.3 Cizek, Karen E. MSN, RN; Estrada, Nicolette PhD, MAOM, RN, FNP; Allen, Jan MSN, RN, CIC, CPHQ; Elsholz, Teresa MSN, RN, Crystal Clear call to standardize color coded-wristbands. Nursing2010: May 2010 - Volume 40 - Issue 5 - p 57–59

3.4 American Hospital Association Quality Advisory: Implementing Standardized Colors for Patient Alert Wristbands, 2008

Document History:

Release Dates: 10/7/2008, 9/2/2016	**Retire Date:** N/A
Sponsored by: Nursing Administration	**Replaces Policy:** 605.2 Color Coded Wristbands

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
7/31/2019	Nursing Policy & Procedure , quorum reached on 7/31/2019	Yes	2.2 c change pink and blue to white. New template, Added reference
9/3/2019	Policy Approval Committee	N	