The office is a part of the large faculty practice of the Emory University School of Medicine: Emory Clinic, Inc. (TEC), and as such is also governed by the overarching TEC Policies and Procedures manual. The Emory Clinic is Joint Commission accredited and the Policies and Procedures manual is aligned with that process.

The following Policy and Procedure Manual contains policies that pertain to The Emory Clinic and have been compiled into this document for the purpose of the SCOPE certification application.
Table of Contents

Women’s Health Patient Safety Goals .............................................................................................................. 5

MA4: Credentialing Process
Emory Healthcare Policy: Staff Credentials ........................................................................................................ 6

MA5: Credential Verification, Ongoing Assessment of Credentialing, Complaints and Disruptive Behaviors

MA6: Granting Privileges for Procedures
Emory Healthcare Policy: Specialty Board Certification .................................................................................. 8
Emory Healthcare Policy: Credentialing and Privileging .................................................................................. 10
Emory Healthcare Policy: Disruptive Behavior Management ........................................................................... 17

MA7: Ongoing Monitoring of Competency for All Providers that Privileges are Granted
Emory Hospitals Policy: Ongoing Professional Practice Evaluation ............................................................... 21
Emory Hospitals Policy: Focused Professional Practice Evaluation ............................................................... 24

MA8: Standard Format for Peer Review
Emory Healthcare Policy: Peer Review .............................................................................................................. 27

MA13: Basic Life Support Accessibility
Emory Healthcare Policy: Basic Life Support, Advanced Cardiac Life Support ......................................... 30

MA14: Emergency Management Plan
Emory Healthcare Policy: Medical Emergency Management ........................................................................ 32

MA15: Formal System for Reporting Unsafe Practices
Emory Healthcare Policy: Emory Trust Line ...................................................................................................... 34

MA16: Triage Staff Training
Department Policy: Triage Staff Training ........................................................................................................ 37

MA17: Access to Provider
Department Policy: Access to Provider During and After Clinic Hours ....................................................... 38

DR10: Do Not Use Abbreviations
Emory Healthcare Policy: Medical Record Development and Maintenance ................................................. 39

MS1: Review of Patient Medication List
Emory Healthcare Policy: Medication Reconciliation .................................................................................... 40
MS6: Documentation for Medication Administration
Emory Healthcare Policy: Medication Administration ................................................................. 43

MS7: Medication Storage and Disposal
Emory Healthcare Policy: Storage and Inventory Control .......................................................... 47

MS9, MS10, MS11: Medication Ordering and Transcription
Emory Healthcare Policy: Ordering and Transcription ................................................................. 52

SP1: Office-Based Surgical Procedures – Selection Criteria
Department Policy: Office-Based Surgical Procedures- Selection Criteria................................. 56

SP4: Informed Consent
Emory Healthcare Policy: Informed Consent............................................................................... 57

SP6: Post-Operative Care: Escort
Emory Healthcare Policy: Post Procedure Care and Discharge of Patients.................................... 59

SP9: Post-Operative Phone Calls
Department Policy: Postoperative Follow-up Telephone Calls.................................................... 61

SCM4: Tobacco-Free Campus
Emory Healthcare Policy: Tobacco-Free Policy........................................................................... 62
The Emory Clinic, Building A, Department of Gynecology and Obstetrics Patient Safety Goals

At the Emory Clinic Department of Gynecology and Obstetrics, we are committed to providing our patients with the highest quality and most advanced health services, with a strong focus on patient safety. Our women’s health safety goals include, but are not limited to:

- Abide by National Patient Safety Goals as set forth by The Joint Commission.
- Provide timely access and care for patients with the following needs:
  - Cancer
  - Complex Contraceptive Needs
  - Newly pregnant health concerns
  - Female Pelvic Reconstruction needs
- Maintain blood pressure control for 73% of our patients based on current national guidelines
- Measure vital signs for 90% of patients per Meaningful Use requirements for EMRs.
- Provide post-discharge screening for all medically complex cases to reduce potential for post-operative complications
Policy: STAFF CREDENTIALS

Submitted By: Recruitment and Retention                                      Approved By: Dallis Howard-Crow
Initial Date: August 1, 2011                                                  Title: Chief Human Resources Officer

POLICY:

To ensure that all credentialing requirements are met in accordance with applicable state and federal regulations for those employees who are required to have “credentials” (including, but not limited to licenses, registrations, and certifications) in their Emory Healthcare positions.

As an on-going condition of employment, employees must maintain all required credentials, including valid State of Georgia and/or national credentials, at all times. Offers of employment are contingent upon primary source verification of current, valid credentials.

Proof of renewed credentials must be verified by department leadership on or before expiration date of previously verified credential. An employee’s failure to provide such credential(s) at the required time will result in suspension from active employment until such time a current credential is primary source verified by leadership. Renewal primary source credentials will be maintained in the employee’s departmental regulatory file.

PROCEDURES:

Primary source verification will be completed on all new hires in job classifications that require license, certification or registration. Employment Services representative(s) will obtain the primary source verification prior to confirming a new hire’s date to report to work for orientation or employment. A copy of the online or other credential confirmation verification from the primary source will be maintained in the Human Resources and employee’s departmental regulatory files. A new hire’s employment and orientation can begin only after the credential, permanent or temporary, is primary source verified.

Prior to the expiration date of a credential on an employee, an Emory Healthcare PeopleSoft report will be forwarded to the appropriate department manager. The department leader will verify the renewal of the credential, indicating this verification by signature, and the new expiration date on the report. The verified renewal information will be forwarded to Human Resources for data entry into PeopleSoft. The Human Resources representative verifying the credential reports will advise the Human Resources management of employees whom have not obtained credentialing renewals. Human Resources will immediately contact the department leadership to determine status of employee's credential and any necessary course of action such as, suspension from duty. It is the department manager’s responsibility to prevent employees from performing any job, which requires a credential until such document is secured.

SCOPE/APPLICABILITY:
All employees employed in a position or performing duties of a position requiring a State of Georgia or national credential.

CONSEQUENCES OF NON-COMPLIANCE:

Violation of this policy may lead to corrective action, up to and including discharge. Employees for which credentials or renewal of credentials have not been verified, will be placed on suspension until such verification can be obtained. The period of suspension shall not exceed 30 days. During the period of suspension, the employee is not permitted to perform any work within Emory Healthcare.

In instances where credentials cannot be verified within a thirty-day period, the employee will be terminated.

X Administrative

_ Departmental
Policy Statement:

The Emory Clinic, Inc., (The Clinic) requires that all members be certified to practice their primary specialty by the appropriate credentialing board of the American Board of Medical Specialists (ABMS), the American Osteopathic Association, or the American Board of Oral and Maxillofacial Surgery, or have the equivalent training and certification in a foreign country when such certification is deemed to be equivalent to ABMS certification.

Once certified in a primary specialty, all Clinic physicians must maintain continuous certification in compliance with the recertification requirements of their certifying board(s).

Scope/Procedure:

1. Physicians in a primary specialty that requires a written examination only must pass the examination within three years of completing their specialty training program.

2. Physicians in a primary specialty requiring sequential written and oral examinations must pass both examinations within five years of completing their specialty training program. In this circumstance, the initial written examination must be passed within the first three years of this five year time period. If the physician completes additional fellowship training, the time period for passing the written and oral examinations will be extended by the length of the fellowship.

3. In the event that a physician fails to achieve primary board certification in the time specified time period, he/she will be subject to adverse action that may include reduction of income or loss of Clinic privileges, at the discretion of the Clinic Director in consultation with the physician's section head.

4. Physicians who fail to maintain continuous certification will use the next testing opportunity offered by their specialty board to become certified. Physicians who fail to gain recertification after this grace period will be subject to adverse action that may include reduction of income or loss of Clinic privileges, at the discretion of the Clinic Director in consultation with the physician's section head.

5. Physicians providing clinical services, who are not board certified and have completed their residency training before August 31, 1990 are exempt from this requirement but are encouraged to seek and gain certification. Physicians providing clinical services who are not board certified and were appointed to The Clinic between August 31, 1990 and April 5, 1999...
must become certified in their primary specialty as specified in the policy above by August 31, 2002.

6. The Clinic Director may grant exceptions or time extensions upon the recommendation of the section head.
HR-7: CREDENTIALING AND PRIVILEGING

Statement: The Emory Clinic, Inc. (The Clinic) will grant, renew, or revise delineated clinical privileges through a defined credentialing process for its employed licensed independent practitioners and supervised clinical practitioners.

INITIAL CREDENTIALING:

1. Qualifications- practitioners must meet the following requirements for credentialing:
   - Be a graduate of an approved medical or osteopathic school or a graduate of an approved program in oral/maxillofacial surgery or be a graduate of an approved school pertinent to their area of specialty.
   - Have training and experience, including formal postgraduate training in a program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Commission on Dental Accreditation if trained in the United States, equivalent formal training and experience in an approved program in a foreign country.
   - A full time faculty appointment to the Emory University School of Medicine.
   - Be licensed to practice medicine or surgery in the State of Georgia or maintain licensure, if applicable, for practice/care in the State of Georgia.
   - Unrestricted current Drug Enforcement Agency (DEA) registration with the exception of Pathology.
   - Adhere to the professional liability insurance requirements through Clifton Casualty Insurance Company.
   - Fulfill Board Certification Requirements by the applicable specialty board or eligible to take examination within the time frame recommended by specialty board and Emory School of Medicine.

2. Application- a complete credentialing package for privileges will include the following:
   - A completed, signed and dated application form, including a recent government issued photograph.
   - Current curriculum vitae
   - Completed request for clinical privileges, if applicable
   - Copies of applicant’s Georgia medical license and DEA certificate, if applicable.
   - Documentation of attestation to ability to perform requested clinical privileges
• Name and address of two peer references that have knowledge of and attest to the applicant’s clinical performance, satisfactory discharge of professional obligations, and acceptable ethical conduct.
• Acknowledge and agreement statement that the applicant agree to comply with the policies and performance standards of The Clinic and the bylaws and policies of Emory Hospitals.
• Pending Investigations or Challenges/Criminal Indictments or Convictions: Information about currently pending investigations, any limitation on privileges, or placement on 100% review or challenges to any licensure or registration (state or district Drug Enforcement Administration), or to the Applicant’s membership status and/or clinical privileges at any other hospital or health care institution. Information concerning any indictment or conviction of a criminal offense (excluding parking violations). A criminal background check will be performed for each application for initial appointment is processed.
• Suspended/Sanctioned/Excluded Provider Status: Information as to whether the applicant has ever been suspended, sanctioned, or excluded from participation in any federal or state health care program.
• Agrees to complete all training or educational programs required by Emory Hospitals’ policy, including, but not limited to, the Infection Control Module and Computerized Provider Order Entry module.

3. Processing the Application

• The applicant has the burden of producing adequate information for a proper evaluation of the applicant’s experience, training, demonstrated ability, physical and mental health status, and resolving any doubts about any of the basic qualifications. To meet this requirement, the applicants will deliver to the Emory Healthcare Office of System Credentialing (OSC) a completed application and all requested documents.
• The OSC will seek to collect and verify the references, licensure and other evidence of qualifications. This process will include enrollment in NPDB’s Proactive Disclosure Service, queries for sanction through the Office of Inspector General (OIG) and, exclusion from Medicare through Health Integrity & Protection Data Bank (HIPDB).
• The OSC will transmit, after verification, the application and supporting documents to the section head that will review and make a recommendation on the applicant’s credentials and request for privileges at The Clinic. The section head’s recommendation will be forwarded to The Clinic Credentials Committee for review.

4. Credentials Committee Action

The Credentials Committee, following its review of the application file, shall then transmit on the prescribed form a written report and recommendations as to applicant’s clinical privileges or any additional requirements for the recommended privilege to the Expedited Credentialing Committee of Emory Healthcare Care Board of Directors. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the
Credentials Committee, all of which shall be transmitted with the report. A summary of any extensive discussion regarding a recommendation, whether favorable or adverse, shall be included in the report.

5. Referral to Expedited Credentialing Committee (EHC Board)

After completion of the credentialing process, those physicians and other credentialed practitioners who meet minimum approved criteria, set forth more fully in the Expedited Credentialing Policy, are eligible to have the Expedited Credentialing Committee review and consider their applications for clinical privileges in The Clinic. The Expedited Credentialing Committee is authorized by the Governing Body to approve to grant appropriate clinical privileges. The Committee also may refer applications back to the Credentials Committee for further investigation. A decision not to approve an application will result in the application being sent to the Board for consideration, unless in the case of clinical privileges expiring prior to the next Board meeting. In the latter case, the practitioners will need to reapply for privileges and will need to meet the criteria specified for an initial credentialing. At the reasonable discretion of the Expedited Credentialing Committee, credentialing decisions on any applicant may be referred to the full Emory Healthcare Board for further review and/or action. Credentialing decisions referred to the full Emory Healthcare Board directly from the Credentialing Committee or Expedited Credentialing Committee will require a signed letter to the Board from the chair/chief of service describing in detail the recommendation for privileges requested by the applicant. The Board may, at its discretion, require the section head to appear personally before the Board to discuss the recommendation for privileges requested by the applicant.

RE-CREDENTIALING:

1. The Clinic will re-credential licensed independent practitioners and supervised clinical practitioners every two years from the date of granting clinical privileges by the EHC Board of Directors.

2. The qualifications for clinical privileges are identical to initial credentialing as described above.

3. The re-credentialing application package for clinical privileges will include the following elements:
   - A completed, signed and dated application for re-credentialing and clinical privileges.
   - Copies of the applicant’s Georgia medical license, DEA certificate and any new board certification certificates if applicable.
   - Attest to absence of any physical or mental condition(s) that may affect their ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which they are submitting the application.
   - Complete and document at least 40 hours (every 2 years) of continuing education, for licensure and renewal, as required by State law.
   - Statement of any applicant having been subject of an investigation or adverse action (or is an investigation or adverse action currently pending) by: a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis, etc.); an education facility or program (medical school, residency, internship, etc.); a professional organization or society, a professional licensing body (in any jurisdiction for any
profession); a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC network, system, managed care organization, etc.); a state or federal agency (DEA, etc.) regarding prescriptions of controlled substances.

- Details about malpractice insurance, claims, suits, and settlement including current tail insurance coverage.
- The name and address of any other healthcare organization where applicant provided clinical services or maintained membership status and/or clinical privileges during the preceding two years.
- Other information about the applicant’s professional ethics, qualifications or ability that may bear on the ability to provide quality patient care.

4. Processing the Re-credentialing Application

- The OSC will provide the applicant with a re-credentialing application and clinical privilege approximately 120 days prior to the expiration of the current clinical privileges.
- The re-credentialing application will be managed by the OSC and Clinic Leadership in the same manner as an initial credentialing.
- The chair/section head or designee will complete a Physician Performance Evaluation. For any evaluation domain assessed as “needs development”, the chair will prepare a letter to the physician, including an action plan for remediation of the issues and submit the letter to the applicant. At the chair’s discretion, the physician may be recommended for a formal peer review.

5. Credentials Committee Action

The Credentials Committee, following its review of the application file, shall then transmit on the prescribed form a written report and recommendations as to applicant’s clinical privileges or any additional requirements for the recommended privilege to the Expedited Credentialing Committee. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Credentials Committee, all of which shall be transmitted with the report. A summary of any extensive discussion regarding a recommendation, whether favorable or adverse, shall be included in the report.

6. Expedited Credentialing Committee

After completion of the credentialing process, those physicians and other credentialed practitioners who meet minimum approved criteria, set forth more fully in the Expedited Credentialing Policy, are eligible to have the Expedited Credentialing Committee review and consider their applications for clinical privileges in The Clinic. The Expedited Credentialing Committee is authorized by the Governing Body to grant appropriate clinical privileges. The Committee also may refer applications back to the Credentials Committee for further investigation. A decision not to approve a request for clinical privileges will result in the application being sent to the Board for consideration, unless in the case of clinical privileges expiring prior to the next Board meeting. In the latter case, the practitioners will need to reapply for privileges and will need to meet the criteria specified for an initial credentialing. At the reasonable discretion of the Expedited Credentialing Committee, credentialing decisions on any
applicant may be referred to the full Emory Healthcare Board for further review and/or action. Credentialing decisions referred to the full Emory Healthcare Board directly from the Credentialing Committee or Expedited Credentialing Committee will require a signed letter to the Board from the chair/chief of service describing in detail the recommendation for privileges requested by the applicant. The Board may, at its discretion, require the section head to appear personally before the Board to discuss the recommendation for privileges requested by the applicant.

**DISCONTINUANCE OR REDUCTION OF CLINICAL PRIVILEGES:**

1. Should a practitioner be the subject of an adverse decision regarding re-credentialing, e.g. denial, reduction, suspension, or revocation of privileges for clinical quality or patient safety, that practitioner may appeal the decision. The appeal request must be made in the form of a written statement to the Clinic Director addressing the practitioner’s basis for the appeal and factual support for why the decision or credentialing action was erroneous.

2. Upon receipt of appeal request, the Clinic Director will appoint an *ad hoc* hearing panel of three Clinic practitioners to include one practitioner from the same Section. The Associate Clinic Director will serve as a non-voting and scribe for the panel.

3. The chair will schedule a hearing within 15 working days of the request for appeal. The chair will provide to the panel a statement of the organization’s credentialing action and the practitioner’s letter of appeal at least one week in advance of the hearing.

4. The appealing practitioner will be invited to meet with the panel to present his or her position on the adverse credentialing action and any supporting documentation that the practitioner deems appropriate. Legal representation of The Clinic or the practitioner is not permitted to be present at the hearing.

5. The hearing panel will, after due consideration, present a written report and recommendation to the Clinic Director. The Clinic Director will in turn notify the appealing practitioner of his or her decision regarding the appeal. Should the adverse decision be upheld by the Clinic Director, the appealing practitioner may request a secondary appeal to the Clinic’s Board of Directors. Such request should be made in writing to the Secretary of the Clinic’s Board of Directors and include the basis of the additional appeal and factual supporting documentation.

6. The Clinic’s Board of Director Executive Committee will serve as hearing panel for the secondary appeal; the Board’s Chair or designee will serve as scribe for the hearing, will schedule a hearing within 30 working days of the request for the secondary appeal, and provide panel members with the background information of the issues at hand and documents from the initial appeal. Legal representatives of The Clinic or the appealing practitioner are not permitted to be present at the hearing. The decision of the hearing panel is final and not subject to further appeal through the organization.

**TEMPORARY PRIVILEGES:**

1. Upon the written concurrence of the Department Chair/Chief of Service where the clinical privileges will be exercised, temporary privileges may be granted to meet an important patient care need and a new applicant for initial clinical privileges. To grant temporary privileges there must be verification of the following:
   - Current licensure
   - Relevant education training or experience
   - Current competence
   - Ability to perform the privileges requested
   - A query and evaluation of the NPDB
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - May not have been subject to involuntary termination of professional or medical staff membership at another organization and may not have been subject to involuntary limitation, reduction, denial, or loss of privileges

2. Temporary privileges for new applicants and to meet an important patient care need are granted for no more than 120 days.

3. If, at any time during the review of a pending application, the Credentials Committee, or the Governing Body issues an unfavorable recommendation, any temporary privileges granted to the applicant will be automatically revoked.

4. A Licensed Independent Practitioner or Allied Health Professional shall not be entitled to the appeal process due to the Licensed Independent Practitioner’s or Allied Health Professional’s inability to obtain temporary clinical privileges or because of any termination, suspension, or revocation of such privileges.

**DISASTER PRIVILEGES:**

The Emory Clinic will allow temporary privileging of physicians and allied health practitioners to handle immediate patient care needs in the event of a disaster.

- Activation of Emergency Preparedness Plan (internal/external) by Associate Director of The Emory Clinic or designee declares a disaster exists and Environment of Care Plan (EOC) is activated.
- All volunteer practitioners arriving at the clinic will be routed to a designated waiting area for assignment in accordance with the EOC.
- The Associate Director of The Emory Clinic has the responsibility of processing the granting of temporary privileges based upon the presentation of one of the following forms of identification and verification of Board Certification and an active medical license:
  - A current medical license to practice in Georgia or another state with valid photo ID issued by state, federal, or regulatory agency; or
  - An Emory Healthcare hospital ID badge.
• All volunteers shall complete a "Disaster Emergency Privilege Form" and be issued a generic badge "MD Volunteer" or "Medical Volunteer" or "Allied Health Volunteer" for the benefit of employees and medical staff personnel.
• The scope of privileges granted would be core privileges consistent with the training, knowledge, and experience to practice in the specialty identified on the "Disaster Emergency Privilege Form".
• Oversight of the care, treatment and services provided by “MD Volunteer” or “Medical Volunteer” or “Allied Health Volunteer” will be by the Associate Director of The Emory Clinic or designee.
• Unless sooner terminated, temporary privileges granted will automatically terminate upon the termination of the disaster as determined by the Command Center. The termination, denial, modification, or limitation of temporary privileges shall not give rise to appeal rights under the appeal process or any other authority.
• Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner present to the organization
• All temporary privileges granted to “MD Volunteers” or “Medical Volunteers” or “Allied Health Volunteers” during the disaster will be presented to the Credentials Committee at the next meeting after the disaster is declared to be over.

Approved By

Penny Castellano, M.D.
Douglas Morris, M.D.
Policy: Disruptive Behavior Management (Formerly "Mutual Respect")

Statement: Emory Healthcare (EHC) expects all Medical Staff Members, non-physician Licensed Independent Practitioners (LIP) with clinical privileges (e.g., Dentists, Podiatrists, Optometrists and Scientific Staff), sponsored Allied Health Professional Staff, and all EHC employees to conduct themselves in a professional and cooperative manner. Accordingly, EHC will not tolerate disruptive behavior.

Definitions:

For the purposes of this policy, “disruptive behavior” includes, but is not limited to, any conduct or behavior that might reasonably jeopardize or be inconsistent with the quality and/or safety of patient care. Escalating levels and examples of disruptive behavior are:

Level I: Verbal abuse - unwarranted yelling, swearing or cursing; threatening, humiliating, or sexually explicit language; or, similar verbal abuse, which is undirected or directed at-large and which is reasonably perceived by a witness(es) to be disruptive.

Level II: Verbal abuse - unwarranted yelling, swearing or cursing; threatening, humiliating, or sexually explicit language; or, similar verbal abuse, which is directed at a specific person and which has been reasonably perceived by the person at whom the verbalization was directed or by a witness(es) to be disruptive.

Level III: Physical abuse or violence, including sexual harassment.

Scope/Procedure:

This policy is applicable to all Medical Staff Members (including both Emory University School of Medicine faculty and community physicians), non-physician LIP’s and non-Emory Healthcare employed Allied Health Professional Staff sponsored by Members of the Medical Staff practicing at Emory Hospitals (EUH, EUOSH, EUHM, Wesley Woods Center) and the Emory Clinic.

Complaints of disruptive behavior against other Emory Healthcare employees including EHC- employed Allied Health Professional Staff will be investigated and managed as outlined in EHC Human Resources policies for Equal Employment Opportunity and Discriminatory Harassment and/or Corrective Disciplinary Action (Section VIII, Part E)

Procedure: The procedures for reporting, reviewing, investigating, managing complaints of disruptive behavior will vary among Medical Staff Members, non-physician LIPs, Allied Health Professionals and employees not in the previous categories.
Medical Staff Member/Licensed Independent Practitioner

1. Reporting - Complaints of Level I or II disruptive behavior against a medical staff member or a licensed independent practitioner may be submitted in three ways:

   a) In writing to the Chief Medical Officer (CMO), or designee, of the affected EHC facility,
   b) Electronically to administration using the STARS incident reporting system (available via the Intranet at www.ourehc.org/applications/Business/stars/index.html). When using STARS, the complainant may choose to identify him/her self or remain anonymous,
   c) By phone call through the anonymous trust line at 1-888-550-8850. Complaints of Level III disruptive behavior should be made immediately, either verbally or in writing, to the CMO. The CMO will promptly acknowledge receipt of the allegation to the complainant, if identified.

2. Review and Investigation - The CMO or his/her designee will conduct a preliminary inquiry, make an initial determination of the complaint’s merit, and thereafter inform the subject medical staff member (the subject member) of the complaint. The CMO may involve the administrator (CNO, CEO) overseeing the employee who filed the complaint and the Chief Quality Officer (CQO). If the CMO finds the complaint to lack merit, the subject and complainant, if identified, will be advised that no action is warranted.

The review by the CMO or his/her designee may end with interviewing the complainant, witnesses and the medical staff member or LIP. Factors included in this determination include:

   a. Egregiousness of the offence,
   b. Past history of behavioral issues involving the physician
   c. Extenuating circumstances including reciprocal disruptive behavior on the part of the complainant.

Complaints that are deemed serious by the CMO or repeat complaints against a member of the medical staff or LIP, in accordance with Medical Staff Bylaws Article IX(Corrective Action), may be referred to the Medical Executive Committee (MEC) for further review, investigation, and/or determination of appropriate corrective action.

If the MEC decides not to initiate a formal investigation under Article IX of the Bylaws, it shall forward the request for corrective action to the Department Chair (for Emory faculty) or Chief of Service (for community medical staff member). The Department Chair/Chief of Service shall immediately review the matter and make a recommendation to the CMO as to proposed corrective action.

Should a reviewing or investigating entity find no material evidence of disruptive behavior, the CMO may take no further action. If a reviewing or investigating entity finds evidence for disruptive behavior, the CMO with advice of the subject member’s Department Chair or Chief of Service will recommend a
specific corrective action or sanction commensurate with the nature and level of disruptive behavior. Options for action(s) may include:

a. Verbal warning

b. Letter of warning or reprimand

c. Written apology to the complainant

d. Referral of the subject member to an appropriate provider for behavioral disorder evaluation and care. Referral to the Emory University Faculty Staff Assistance Program is recommended.

e. Suspension or revocation of Medical Staff Privileges, or recommendation of the same

If the proposed corrective action involves:

1) Imposing terms of probation, or requirements of consultation, monitoring, or supervision;

2) Modifying, suspending, or terminating clinical privileges;

3) Reducing Medical Staff category or limiting certain Medical Staff prerogatives;

4) Suspending or terminating Medical Staff appointment; or

5) Any other Corrective Action that may result in reporting to the National Practitioners Databank or that would trigger a right to a Fair Hearing under the Bylaws the CMO shall bring the matter to the MEC, which shall initiate a Formal Investigation under Article IX of the Medical Staff Bylaws if it concurs with the CMO’s assessment.

Should the complaint solely involve employees of The Emory Clinic or Emory Children’s Center, the CMO will refer the matter directly to the Departmental Chair/Section Head for further review or investigation.

If the MEC decides to open an Investigation, the ad hoc committee will submit a written report of findings to the requesting authority within 30 calendar days. A 14 day extension may be granted by the requesting authority for extenuating circumstances.

3. Documentation -- The CMO or designee will prepare a confidential memorandum summarizing the nature, investigative findings, and disposition of substantiated complaints. If the subject member is referred for evaluation and/or therapy, a follow up report should be prepared.

This report should address the following: attendance of therapy, compliance with therapy, recommendations for behavioral monitoring in the professional environment, and recommendations for change in clinical privileges.

Documentation of the preliminary complaint investigation summary, follow up summaries, and documentation of internal/external professional behavior evaluations should be retained by the
CMO. The documents should be labeled, “Privileged and Confidential - Peer Review Document Pursuant to O.C.G.A. §31-7-12, 131-133.” Copies should be sent to the EHC Office of System Credentialing for inclusion in the subject’s Confidential Credentialing File for indefinite retention.

4. Coordination - The CMO will coordinate his/her investigation and actions regarding Emory faculty with leadership of The Emory Clinic, Emory Children’s Center, and the Emory University School of Medicine

Allied Health Professional Staff (non-Emory Healthcare Employee)

The steps listed above for the reporting, review, and/or investigation of complaints of disruptive behavior by Members of the Medical Staff, shall also apply to Allied Health Professional Staff sponsored by Members of the Medical Staff and not employed by Emory Healthcare. Decisions regarding corrective actions, sanctions, or referral to appropriate providers of behavioral disorder evaluation shall be made in consultation with the sponsoring Medical Staff Member.

Original: November 27, 2006
Revised: December 2, 2006
Revised: December 8, 2006
Revised: October 2007, EHS Professional Services Committees
Revised April 2013, EHC Medical Practice Committee

Related Policies/Procedures:

Emory Healthcare Human Resources, Section VIII, Part E: Corrective and Disciplinary Action; Emory Healthcare Human Resources: Equal Employment Opportunity and Discriminatory Harassment;
Medical Staff Bylaws: Article V: Dental, Podiatric, Optometrist, and Scientific and Allied Health Professional Staffs;
Medical Staff Bylaws: Article IX: Corrective Action

Approved By

Approved by Emory Healthcare Senior Management
Emory Hospitals Senior Management
Policy: Ongoing Professional Practice Evaluation

Statement:

It is the policy of Emory Hospitals (EUH, EUHM, EUOSH, Wesley Woods) to conduct appropriate monitoring of the care, treatment, and service delivered within its institutions by members of the Medical Staff, and to promote safety and high quality health care for its patients.

To ensure the competency of physicians practicing within the Emory Hospitals, a systematic process of Ongoing Professional Practice Evaluation [OPPE] is established to routinely monitor and evaluate the clinical competence of all credentialed practitioners. The OPPE process will be completed in accordance with The Joint Commission Standard MS.08.01.03. The OPPE is a documented summary of ongoing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior. The information resulting from the OPPE is used to determine whether to continue, limit, or revoke any existing privileges(s) prior to or at the time of renewal. OPPE clinical indicators fall into six areas of general competency including:

a. Patient care
b. Medical/clinical knowledge
c. Practiced-based learning and improvement
d. Interpersonal and communication skills
e. Professionalism
f. Systems-based practice

All findings and information associated with any Ongoing Professional Practice Evaluation shall be considered as confidential peer review protected under Georgia statutes governing peer review activities.

Scope/Procedure:

1. OPPE will be completed at least every 9 months for all providers with clinical privileges
2. The type of data to be collected is determined by individual departments and approved by the Medical Executive Committee (MEC)
3. The professional and clinical indicators included in OPPE may include, but is not limited to the following:
   a. Utilization data including length of stay and readmission rates
b. Periodic chart reviews for appropriateness of care  
c. Department specific indicators  
d. Patient activity/volume  
e. Core measures performance  
f. # and/or rate of adverse events including surgical site infection rates  
g. # and/or rate of complications including patient safety indicators  
h. # of cases referred to the Peer Review Committee for which physician quality issues were identified  
i. Complaints from patients/family  
j. Complaints related to professionalism from staff  
k. Patient/Family/Staff written positive feedback  
l. Medical records compliance (e.g., discharge summary completion)  
m. Clinical documentation initiative compliance  
n. Mortality reviews  

4. For most Departments, the Quality Management Specialist will review the data/documentation received and generate OPPE profiles for review by the relevant Chief of Service for each provider as well as review by the Chief Medical Officer and Chief Quality Officer.  
   a. OPPE data generated/overseen by the Quality Management Specialist will be stored in a central location under the direction of the Chief Medical Officer.  

5. Some Departments, primarily hospital based services not involved with the admission and discharge of patients, may generate their own internal OPPE reports. For these Departments, the Quality Management Specialist will ensure that reports are generated with sufficient frequency and acted upon in accordance with the hospital OPPE policy.  
   a. Departments that internally generate OPPE reports may store data within departmental offices  

6. If a provider has insufficient clinical activity to judge clinical competency, the Quality Management Specialist and Chief of Service may utilize OPPE data generated at other Emory Hospitals for the performance evaluation.  

7. If no data/documentation is available (including chart reviews), the Quality Management Specialist will indicate this on the OPPE evaluation form (Attachment A).  

8. Upon review of the OPPE for each medical staff member, the Chief of Service will make recommendations to the Credentials Committee by completing the OPPE Confidential Peer Review Document (Attachment A). This document will identify practitioners as:  
   a. Having acceptable performance; privileges continued  
   b. Requiring additional monitoring for trends on subsequent OPPE  
   c. Requiring Focused Professional Practice Evaluation  
   d. Requiring referral to the Peer Review Committee for possible limitation of or revocation of existing privileges.  

9. The OPPE review will be factored into the decision to maintain existing privileges(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal.  

**Regulatory References:** O.C.G.A. 31-7-130 et. Seq.; 31-7-140 et. Seq
Related Policies/Procedures:

Medical Staff Bylaws, Rules and Regulations:

Article VII: Procedures for Appointment and Reappointment;

Article VIII: Determination of Clinical Privileges;

Fair Hearing

Related Document: "Emory University Hospitals - Ongoing Professional Practice Evaluation (OPPE), Medical Staff (Attachment A)"

Approved By

Approved by Emory Healthcare Senior Management
Policy: Focused Professional Practice Evaluation

It is the policy of Emory Hospitals (EUH, EUHM, EUOSH, Wesley Woods) to conduct appropriate monitoring of the care, treatment, and service delivered within its institutions by members of the Medical Staff, and to promote safety and high quality health care for its patients.

A systematic process of Focused Professional Practice Evaluation [FPPE] is established to evaluate and confirm the competence of practitioners to perform privileges granted to them. FPPE is defined as a time limited evaluation of practitioner competence in performing/related to a specific privilege. This process is implemented for all initially requested privileges and whenever a concern arises regarding a practitioner’s ability to provide safe, high-quality care. The FPPE process will be completed in accordance with The Joint Commission Standard MS.08.01.01.

To ensure that this process is appropriately, consistently, and fairly applied to all relevant medical staff members, the process will be conducted in accordance with the following procedures. All findings and information associated with any FPPE shall be considered as confidential peer review protected under Georgia statutes governing peer review activities.

Scope/Procedure:

I. The FPPE process will be initiated under the following conditions:

   a. For evaluation of privilege specific competence of all new medical staff members;

   b. For evaluation of new privilege[s] or use of new technology requested by current medical staff members; and

   c. For addressing a concern about a currently privileged practitioner’s ability to provide safe, high quality patient care as identified through peer review, incident reports, complaints, direct observations, identified trends or patterns of practice, or other ongoing professional practice evaluations.

II. Information for FPPE may include:

   a. Chart review

   b. Monitoring clinical practice patterns

   c. Simulation

   d. Proctoring
e. External peer review
f. Discussions with other individuals involved in the care of each patient (e.g. consulting physicians, assistants at surgery, nurses or administrative personnel)

III. New Physician:

a. After initial privileges are granted, Medical Staff Services (MSO) will send a notice and evaluation form initiating FPPE to Department Chair/Chief of Service (COS).

b. The FPPE process should be completed within 6 months of granting privileges to new medical staff members. If the provider does not have sufficient clinical activity at the hospital to allow completion of FPPE within a 6 months period, FPPE may be extended for an additional 6 months

c. If a medical staff member has privileges at another Emory Hospital, the Chief of Service (COS) may utilize FPPE results from that Emory hospital for the performance evaluation.

d. The FPPE process will be privilege specific as designated by each department’s Chief of Service with approval of the Chief Medical Officer and Chief Quality Officer.

IV. Current Medical Staff Member Requesting New Privilege:

a. After new privilege is granted, the Medical Staff Office will send a notice and evaluation form initiating FPPE to Department Chair/Chief of Service (COS) and the Quality Management Specialist.

b. The Quality Management Specialist will consult with COS on any data needed to complete FPPE and will provide data to COS.

V. Triggered Review of Physician’s Privileges:

a. The CMO, CQO, COS and the Peer Review Committee can trigger FPPE based on an incident, an identified pattern of practice or ongoing professional practice evaluation [OPPE] findings suggesting a quality concern

b. The CMO and/or CQO will be engaged in all decisions to conduct triggered FPPE

c. Triggered FPPE will be conducted either by the COS (or designee) or the Peer Review Committee.

1. The Quality Management Specialist will consult with COS on any data needs related to completion of FPPE.

2. FPPE to be completed no later than three months after initiation of Triggered Review.
VI. FPPE results will be reported to the Director of Medical Staff Services and System Credentialing at Decatur Plaza, Suite 300; or fax the completed and signed document to the Director of System Credentialing at 404-778-3002.

a. For initial appointments and new privileges, a copy of the FPPE summary and recommendations, and any supporting documentation remains in the Department.

b. For Triggered review, a copy of the FPPE summary/recommendations/documentation will be kept by the CMO.

VII. Recommendations for Action Based on FPPE Findings:

a. FPPE validates competency for granted privileges. Physician retains privileges and moves into the OPPE process.

b. FPPE demonstrates that physician is not competent to perform privilege[s] under evaluation. Recommendation by COS and/or CMO that privilege[s] be restricted or revoked.
   - Recommendations referred to Credentials Committee and to Medical Executive Committee (MEC) in accordance with Medical Staff Bylaws, Rules and Regulations, Articles VII: Procedures for Appointment and Reappointment, and VIII: Determination of Clinical Privileges
   - Physician has right to request initiation of Fair Hearing Process.

c. FPPE Process does not provide enough information to complete evaluation of competence. FPPE may continue for another six months (three months for triggered FPPE).

Approved By

Approved by Emory Healthcare Senior Management

Emory Hospitals Senior Management
Policy: Peer Review

Statement: Evaluating and improving the quality of healthcare provided by individual practitioners will be assessed by the timely peer review of cases identified through routine monitoring or unusual occurrences (may include Trigger events).

Peer Review Committee: A review organization, as defined by O.C.G.A. Section 31-7-131 (3) known as the Peer Review Committee (PRC) may be established by the MEC to facilitate the process of peer review. The PRC shall be comprised of no fewer than 6 members of the active medical staff representing diverse medical specialties.

Members will be appointed for a two year term by the MEC and will be eligible for reappointment. The committee will meet as needed to review cases referred to it. The PRC shall report its findings and recommendations to the MEC. The PRC may also commend exemplary care delivered by members of the medical staff.

The scope of peer review may be determined and revised with approval of the MEC in order to meet ongoing and changing needs of the individual facilities and its medical staff. The findings of the PRC will be incorporated into medical staff performance improvement initiatives including the Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE) program. The activities generally described below constitute privileged peer review activities.

All reports, recommendations, actions and minutes made or taken pursuant to the activities described in this policy are confidential and covered under the provisions of O.G.C.A. Section 31-7-15, O.G.C.A. Section 31-7-131 et seq., and the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 et seq. In no event shall the activities described below constitute Corrective Action pursuant to Article IX of the Emory Hospitals Medical Staff Bylaws.

Scope/Procedure:

Initiation of Peer Review

1. Peer review may be initiated for, but is not limited to:
   a. Allegation of or inferior care related to inattention, carelessness, lack of skill or intentional misconduct
   b. A single event leading to an unexpected or adverse outcome
   c. Failure to be continuously available for timely patient care or to arrange for coverage by an appropriate attending practitioner
   d. Abandonment of hospitalized patient under his or her primary care
e. Intentional concealment of an adverse outcome or sentinel event
f. Case or cases identified by routine performance monitors
g. Patient, family, or staff concerns or complaints
h. Issues raised by third party payers
i. Unprofessional behavior that may have a negative or potentially negative impact to patient care.

Peer Review Process

1. Cases for peer review may come from physicians or hospital staff referrals, cases identified through routine quality monitoring, adverse events or unanticipated deaths. The Quality Management Specialist will enter the case into a log and track the screening/review process when a peer review concern has been identified.

2. The PRC Chair, CMO and/or CQO will review the case in question and determine if it is appropriate for PRC review. If it is deemed inappropriate for PRC, the case may be referred to the Chief of Service or other appropriate body. The PRC Chair, CMO and CQO may decide that no other review is warranted.

3. The PRC Chair shall assign cases to be reviewed to PRC members in relevant specialties. With rare exception, as approved by PRC Chair, the PRC members assigned to review the case will include a member(s) of the Medical Staff who practice in the same medical specialty as the individual whose case is under review. If there is no member of the PRC in the specialty of the physician under review, an ad hoc reviewer(s) will be appointed by the PRC Chair. Any PRC member(s) conducting peer review shall not have been involved in the care of any patient(s) whose case is under review; provided, however, this shall not preclude the peer reviewer(s) from obtaining opinions and information from individuals involved in the patient’s care. If a PRC member perceives that he (she) has a conflict of interest and cannot render an objective assessment, he (she) shall be recused from review of the case in question.

4. Upon the initiation of the peer review process, the CMO shall send a notice to the Medical Staff member that is the subject of the peer review process with a copy to the respective Chief of Service. The notice shall include a concise description of the allegation and inform the Medical Staff member that he/she shall be given the option to participate in the peer review process by providing a relevant written explanation concerning the issues under review or may attend a PRC meeting in person to provide additional information and/or respond to questions that arise during the review. Any failure or delay of the Medical Staff member to participate in the peer review process shall not extend overall review period.

5. Within 60 days following the initiation of peer review, the PRC shall make appropriate recommendation(s) to the respective MEC, with a copy to the CMO and the respective Chief of Service. A quorum of 50% of the PRC membership shall be required to render a decision and generate recommendations regarding a case. All recommendation(s) or conclusion(s) of the PRC must be documented and supported by literature and relevant clinical practice, as appropriate. Corrective action, if indicated, will be determined by the MEC or delegated by the MEC to the Chief of Service and/or CMO.
6. Once the PRC has completed their review and recommendations, the PRC Chair must notify the Medical Staff Member in writing of the outcome of the review, with a copy to the CMO, Chief of Service, and CQO. A copy of the notice shall also be placed in the Medical Staff member’s Red Credentialing File.

7. In certain cases, the PRC Chair, CMO, or CQO may determine that peer review by an external source may be necessary.

8. If at any time during the peer review process the PRC Chair, in conjunction with the CMO, believes that satisfactory progress has not been made or is not being made with respect to the peer review process, the PRC Chair may either appoint new reviewers to conduct the review or submit the case for external review.

9. System or process issues discovered during the course of peer review will be referred to Risk Management and the Medical Practice Committee or other appropriate group.

10. Unprofessional behavior for the purpose of this policy is defined as “disruptive behavior” that includes, but is not limited to, any conduct or behavior that has or may have had an impact to the care of the patient. The PRC may consider this behavior when it accompanies a case that has been referred due to concerns regarding clinical management. PRC may recommend evaluation of a provider under the Disruptive Behavior Management and or Workplace Threats and Violence policies.

11. All communication, disclosures, recommendations or other actions taken under this policy constitute confidential peer review activities under the Georgia peer review laws. In order to preserve and protect the privileged nature of the peer review process, all materials obtained or generated in the peer review process will be treated and maintained with strict confidence and should be labeled “Privileged and Confidential Peer Review Information”.

12. When there is a situation that could potentially result in substantial loss/termination of a physician’s clinical privileges, the guidance of legal counsel will be sought.

13. Formal documentation of physician specific reports, generated in the peer review process, will be placed in the physician's quality file for consideration at the time of reappointment.

Approved by Emory University Hospital MEC, Emory University Hospital

Midtown MEC, January 2014

Approved By

Approved by Emory Healthcare Senior Management

Emory Hospitals Senior Management
Policy: Basic Life Support, Advanced Cardiac Life Support Training Program

Submitted By: Employee Health
Initial Date: August 1, 2011
Approved By: Dallis Howard-Crow
Title: Chief Human Resources Officer

POLICY:
To ensure that patients have available at all times persons who are knowledgeable in the performance of Basic Life Support and/or Advanced Cardiac Life Support.

All EHC employees who provide “direct patient care,” as defined below, must successfully complete Basic Life Support and/or Advanced Cardiac Life Support training every two years, and must take appropriate measures to ensure that documentation of the successfully completed training is on file at EHC.

The Resuscitation Committee is responsible for providing guidance for the Basic Life Support and the Advanced Cardiac Life Support training programs.

Nursing Education is responsible for coordinating the programs and providing guidance.

The department/unit director of each direct patient care area is responsible for assuring compliance with this policy.

The department/unit director of each direct patient care area is responsible for:

1. Identifying as a job requirement the employee’s ability to perform the procedures. For the purposes of this policy "direct patient care staff" are employees whose job responsibilities involve:
   a) Provision of patient care at the bedside
   b) Invasive procedures
   c) Patient care treatments in non-nursing care locations
   d) Patient transport services and/or
   e) Code Team membership

2. Maintaining documentation of participating in the training program.

3. Recommending employees who demonstrate potential for becoming BLS and ACLS instructors.

All training is provided in accordance with the guidelines of the American Heart Association and follows the AHA recommended renewal date for retraining which is the last day of the month two years from the date of course completion. The renewal date on the card is indicated by the two-digit month or name of the month and four-digit year.

Nursing Education coordinates the programs by offering regularly scheduled classes; maintaining instructional material (such as learning objectives, teaching methods, evaluation data; and equipment); coordinating the teaching schedule of the instructor pool, providing the BLS/ACLS Instructor Course, and disseminating guidelines and procedures for the operation of the program.

SCOPE/APPLICABILITY:
All Emory Healthcare direct patient care staff

CONSEQUENCES OF NON-COMPLIANCE:
Beginning with the first day of failure to recertify before the renewal date for retraining will result in the employee being suspended without pay and documentation to that effect will be placed in the employee’s file.
The employee may return to work after recertification has occurred and appropriate documentation of recertification has been submitted to the Department/Unit Director.

If certification expires while an employee is on leave, the employee must recertify prior to returning to work.

Completion of CPR/ACLS recertification after the expiration date will be reflected by a decrease of one rating level in the Performance Advantage WHAT rating.

If the employee does not recertify and return to work by the 46th day following CPR/ACLS expiration, he/she will be separated from employment.
Policy: Medical Emergency Management

Status: Active
Activation Date: 08/30/2005
Last Review Date: 09/12/2012
Approved By: Penny Z. Castellano, MD
Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: TJC: PC.02.01.09

Policy Statement:
The Emory Clinic, Inc. (The Clinic) will be capable of responding to clinical emergency events, urgent and emergent.

Basis:
The purpose of this policy is to ensure that appropriate, safe, and timely emergency care is provided to patients, visitors, and staff.

Administrative Responsibility:
The TEC Resuscitation Committee is responsible for emergency supplies and processes for all TEC locations. Section Heads or designees are responsible for ensuring the competence of physicians and other practitioners, as appropriate, in medical triage and life support skills. They are also responsible for ensuring the presence and proper function of emergency and life support resources in their areas of responsibility. The Clinic pharmacist is responsible for oversight of emergency medications.

Definition:
A “CODE BLUE” is a medical emergency known as a clinical event characterized by the sudden loss or impending loss of vital life functions, e.g., cardiac or respiratory arrest.

A “CODE MET” is a less urgent circumstance which may or may not be life-threatening, and may escalate to a “CODE BLUE” if clinically necessary.

For the purpose of this policy, cardio-pulmonary arrest, loss of consciousness, severe chest pain, respiratory distress, or hemorrhage will be the key criteria for initiating the Code Blue call.

Scope/Procedure:
1. Immediate Response to a Medical Emergency on Clifton Campus: Building A, B, and C, or “Winship”.
   - Upon becoming aware of a medical emergency, any Clinic employee observing the event will immediately call for assistance from co-workers and thereafter attend the person in distress.
   - Determine the need for, and as appropriate, initiate Basic Cardiac Life Support (BCLS) measures.
   - If a Code MET is initiated in Buildings A, B, or C, two ACLS RNs from the appropriate building will respond to assess person in need, initiate treatment, and coordinate any needed transport.
   - IF a Code Blue is initiated, the full code team responses in that building will be activated.
   - A physician and/or ACLS RN will assume the role of the code team leader.
   - In the event of a delayed physician response, the ACLS certified RN team leader may implement ACLS protocols.
• On the Clifton Campus, transport service staff will be notified of need for stretcher or wheelchair transport once determined by the Code Team Leader. The Code Team Leader may utilize EMS to transport patients if deemed in the patient’s best interest due to acuity, care needs, location, etc.

• On the Clifton Campus, in the event that the patient is transported to the Emory Hospital Emergency Department by stretcher, a nurse or physician with the appropriate scope of practice will accompany the patient and provide a handoff report to the receiving care team.

• For all Clinic Satellite locations (including Executive Park and 1525), the principle goals of managing a medical emergency should be to: initiate BCLS, stabilize the patient’s vital functions, and transport the patient to the nearest hospital emergency department. All satellite locations will call 8-8888 to log event for appropriate follow up by TEC Leadership.

• Communication Procedure Specific to Clifton Campus (Buildings A, B, C): Call the Emory University Network Communications (NetCom) emergency number, 8-8888, say to the operator, "CODE BLUE" or “Code MET”, and clearly provide the exact location (building, floor, name of care unit and room number). The NetCom operator will: activate the emergency paging list and provide an overhead announcement for the appropriate building where the event is in progress.

• The paging lists’ membership will be verified quarterly by the TEC Resuscitation Committee Chair or designee.

• During TEC’s non-business hours, call 911 immediately after disconnecting from NetCom. All 911 calls from Emory University facilities are answered by the Emory Police Department (EPD). The EPD dispatcher will: obtain information about the precise location and nature of the medical emergency; direct an EPD unit to the location; and summon the DeKalb Fire Rescue Service (DCFRS) to the defined location. EPD personnel will remain at the main entrance of the facility to guide DCFRS personnel to the site of the medical emergency.

2. Communications Procedure Specific to Emory University Hospital Midtown (EUHM) Medical Office Tower

• Call the EUHM emergency number, 6-1777, say to the operator, "Code Blue" or Code MET, and clearly provide the exact location (building, floor, name of care unit, and room number).

• The EUHM operator will: summon internal medical responders (Code Blue team or Code MET team), EUHM administrative responders, and EUHM Security.

3. Communication Procedure Specific to Other Emory Clinic Satellite Locations

• Call 911 on a phone designated for contacting the appropriate city/county emergency service.

4. Emergency Equipment and Maintenance

• "Crash Carts" are available in selected high-risk areas. These carts contain: a cardiac monitor/defibrillator, manual ventilator and airway accessories, endotracheal intubation equipment,
• oxygen, intravenous access supplies, and a full array of emergency medications.
• Emergency Medication Boxes ("Tackle Boxes") are located on each floor of Buildings A, B, C and
• 1525 on the Clifton campus, the MOT, Wesley Woods and in each satellite clinic. These boxes contain a limited supply basic emergency medications and intravenous access supplies.
• First Responder Kits ("Jump Bags") are located in each Clifton Campus building and are transported and utilized by the responding ACLS RNs. The kits contain basic ACLS emergency medications, intravenous access supplies, diagnostic instruments, and an automated external defibrillator.
• The integrity of all emergency medications, equipment and supplies is maintained by designated Section staff, checked, and documented every working day. Records should be retained for the previous twelve running months.
• Clinic Pharmacist will check the emergency medications for integrity and accuracy, prior to being distributed to the clinics.

5. Mock Code Training
• Code Blue mock codes training exercises will be conducted monthly in each clinic. Such exercises must be documented and include the participants, an evaluation of the exercise, and corrective action plans for any identified deficiency in the exercise. Record will be submitted and maintained on the Safety Scorecard in Lotus Notes.
• On the Clifton Campus, the Code Blue teams will conduct mock code training exercises for each building's response team. This will be conducted with various clinical areas as part of their mock code training.
• Section leadership will ensure appropriate staff are trained and continuously certified in Basic Cardiac Life Support (or BLCS as required by scope of practice and Employee Commitment. Leadership will ensure that staff in operative and/or procedural areas are continuously certified in BLCS and Advanced Cardiac Life Support as required by scope of practice. If operative and/or procedural areas provide care for pediatric patients, at least two appropriate staff members are continuously certified in Pediatric Advanced Life Support (PALS) and must be available during operational hours.

6. Deceased Patients
Should a patient expire as a consequence of a medical emergency or non-emergency in a Clinic facility during working hours, the body should appropriately be draped and secured in the clinical area where death occurred, pending notification of next of kin and the arrival of mortuary personnel. The EUH Morgue can be utilized for expired patients in Buildings A, B, and C. Should the responsible physician have concern about the cause or circumstances of death, the local county medical examiner or appropriate law enforcement authority should be contacted for direction.
Active

**EHc Compliance Policy/Procedures**

**Activated:** 07/28/2014  
**Last Review Date:** 07/28/2014

---

**Emory Trust Line**

**SCOPE:** Emory University (EU) and Emory Healthcare, Inc. (EHC) and all affiliated entities.

**POLICY:**
The Emory Trust Line (1-888-550-8850) and web reporting tool (www.mycompliancereport.com/EmoryTrustLineOnline), hereinafter Trust Line, exist to allow individuals with compliance and misconduct concerns relating to EU and EHC an alternative, anonymous method to report compliance concerns. The Emory Trust Line is available to all callers at all times 365 days a year and 24 hours a day.

**PROCEDURE:**

**Management**
The following departments (collectively Departments) shall designate staff to have access to the Emory Trust Line database:

1. EU Office of Internal Audit  
2. EU Office of Research Compliance  
3. EHC Office of Compliance Programs

The EHC Office of Compliance Programs shall have primary responsibility for the Trust Line database and for the coordination and routing of new reports that are received through the Trust Line.

**Investigation**
All concerns reported through the Trust Line will be investigated. In the event a concern falls outside the scope of the Departments listed above (such as human resources concerns), the report will be forwarded to the correct personnel for review and investigation.

Once received, the appropriate department will be responsible for investigating and resolving the concern. Resolutions of the investigation shall be documented and appropriate results listed in the Trust Line database.

**Reporting of Activities**
The Departments may use the data from the Trust Line database for reporting purposes to various committees or as otherwise needed.

**Confidentiality**
Reports to the Trust Line may be anonymous. Reasonable protections shall be made to protect the confidentiality of reporters, including limiting the sharing of information, discouraging others from attempting to identify reporters, and other safeguards.

**Non-Retaliation**
Reports issued through the Emory Trust Line and web reporting tool are covered under the EU and EHC
policies on non-retaliation. No reporter shall be retaliated against for bringing a concern forward who reports the concern in good faith.

Revised: 11/07/2013; 06/25/2014

Approved By
Anne Adams
Chief Compliance Officer
Office of Compliance
Policy: Triage Staff Training

<table>
<thead>
<tr>
<th>Reviewed By:</th>
<th>Gynecology &amp; Obstetrics Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Applicable To:</td>
<td></td>
</tr>
<tr>
<td>☑ Clifton Campus, Building A</td>
<td>☑ Emory University Hospital Midtown</td>
</tr>
</tbody>
</table>

Policy Purpose:

To create standard and formal training for all qualified triage staff in order to provide medical advice by phone

Process:

Each site has appointed nurses as “triage staff” to field any clinically related phone calls. Nurses must have specialized nursing knowledge and discriminative judgment for providing care and must demonstrate competency to triage phone calls.

During clinical services orientation, nurses will complete formal electronic medical record training through the Emory Clinic. Triage nurses are then oriented and trained utilizing a preceptor model with the Women’s Health Nurse Practitioner Lead.

Training will include the following:

- Complete CD-ROM disc training on Telehealth Nursing by the American Academy of Ambulatory Health Care Nursing.
- Acclimated to the triage book Telephone Triage for Obstetrics and Gynecology, Long, V.
- Complete Women’s Health specific online video training program, which includes post tests for demonstrated competencies for general OB/GYN and subspecialty practices.
- Preceptorship with triage nurses
- Completion of Emory Electronic Medical Record training
- Completion of clinical services orientation
- Completion of physician shadowing and confirmation the physician(s) agree the new staff member is prepared to being phone triage

The Nurse Practitioner Clinical Lead will follow up with all physicians to ensure the quality of information being provided to both physicians ad patients.
Policy: Access to Provider During and After Clinic Hours

<table>
<thead>
<tr>
<th>Reviewed By:</th>
<th>Gynecology &amp; Obstetrics Management Team</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy Applicable To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Clifton Campus, Building A</td>
</tr>
<tr>
<td>☑ Emory University Hospital Midtown</td>
</tr>
<tr>
<td>☑ Emory Reproductive Center</td>
</tr>
</tbody>
</table>

Policy Purpose:

To ensure that a patient can always reach a provider during and after clinic hours.

Process:

During clinic office hours, a generalist physician is scheduled for the day to attend to any urgent patient care needs. A physician for each subspecialty is always available by phone and/or pager during clinic hours.

Any patient calls after clinic office hours will be forwarded through the Emory electronic paging system. The office publishes an on-call calendar on the Emory electronic paging system.
Policy: MEDICAL RECORD DEVELOPMENT AND MAINTENANCE

Status: Active

Activation Date: 02/21/2014  Approved By: Penny Z. Castellano, MD

Last Review Date: 02/21/2014  Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: TJC:IM.01.01.03, TJC:IM.02.02.01, TJC:RC.01.02.01, TJC:RC.01.03.01, TJC:RC.01.04.01, TJC:RC.01.05.01, TJC:RC.02.01.07

Policy Statement:

The Emory Clinic, Inc. (The Clinic) manages medical information Clinic-wide such that it is recorded in a uniform, generally understandable format, accessible within a reasonable time period to providers and staff, maintained in a standardized and efficient fashion and available only to administratively and legally authorized persons.

Scope/Procedure:

M. Abbreviations

Prohibited Abbreviations:

<table>
<thead>
<tr>
<th>DO NOT USE these</th>
<th>Problem and Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for 0 (zero), the number 4 (four) or cc.</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten).</td>
</tr>
<tr>
<td>Write international unit.</td>
<td></td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other. Period after the Q mistaken</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>I and the O mistaken for I.</td>
</tr>
<tr>
<td>Write daily.</td>
<td></td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed.</td>
</tr>
<tr>
<td>Write X mg.</td>
<td></td>
</tr>
<tr>
<td>Lack of leading zero (.Xmg)</td>
<td>Can mean morphine sulfate or magnesium sulfate.</td>
</tr>
<tr>
<td>MS, MSO4 and MgSO4</td>
<td>Confused for one another.</td>
</tr>
</tbody>
</table>

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
Policy: Medication Reconciliation

Status: Active

Activation Date: 01/29/2012  Approved By: Penny Z. Castellano, MD

Last Review Date: 01/29/2012  Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: TJC: NPSG.03.06.01

Policy Statement:

The Emory Clinic (The Clinic) will perform medication reconciliation for all patients, at all applicable clinical encounters.

The following patient visits are considered exempt from medication reconciliation:

- Patient visits for lab draw only
- Patient visits for Radiology when no medication/contrast is administered (if medication/contrast may be used, then medication reconciliation will be performed)
- Patient visit for Cardiac Rehabilitation and Physical Therapy, if no medication is to be administered

Basis:

There is evidence that medication discrepancies can affect patient outcomes. The reconciliation process compares those medications that a patient is taking (or should be taking) with any medications that are being ordered. This comparison identifies medications that should be omitted or may create harm via drug-drug interactions.

Administrative Responsibility:

Providers

Definition:

National Patient Safety Goal 03.06.01 (The Joint Commission 2012): Maintain and communicate accurate patient medication information.

- The Emory Clinic utilizes the Emory Healthcare Electronic Medical Record (EeMR) to order and document all medications for each patient. The EeMR “Medication List contains this information for each patient and is considered the official medication list for all patients.
- As part of the patient visit process, the Medication List is updated with compliance information, new medications and discontinued medications.
- At the completion of the visit, a copy of the updated Medication List is provided to the patient and family. A copy of this information is available for communication to the next provider of care.

Scope/Procedure:
1. At each visit to The Emory Clinic, the patient will be asked to give an updated list of all current medications. Established patients will be presented with their current “Medication List” from EeMR and will be involved with the updating process. New patients will participate in the creation of their Medication List. Family members will be involved in this process as needed/desired by the patient.

2. Clinical staff members who are able to create/update a Medication List include physicians, advanced practice nurses, physician assistants, nurses, pharmacists. Medical assistants, athletic trainers and clinical technicians may contribute to the updating process as well.

3. During patient intake, new medications to be added to the patient’s Medication List should be listed by medication name (brand or generic). Dosing information may be provided, but only by licensed personnel. Dosing and route information is not required to be added unless the medication will be actively managed (refilled, dose adjusted, changed) during the visit. It is the managing provider’s responsibility to ensure that any dosing information is correct for any given medication.

4. Medications that are no longer being taken, or those being taken in a way other than the prescribed method listed in EeMR, should be so noted by the “compliance” portion of the list.

5. The updated Medication List will be reviewed by the provider rendering care for the patient during the visit. Any potential drug-drug interactions should be resolved. Only providers with prescription privileges should discontinue or remove a medication from the patient’s Medication List. Providers should remove medications from the list if the patient has completed a course of therapy that is clear (e.g., use of an antibiotic for a resolved, limited illness), or if the provider is comfortable with the discontinuing the medication (e.g., reliable history of a change in antihypertensive medications, and the provider is comfortable with removing the old medication from list now that new medication has been added).

6. It is acceptable to leave a medication on the Medication List, with a “not taking” comment in the compliance notes, as a means of communicating with other providers. From a clinical standpoint, it is up to the provider conducting the visit to decide if any additional communication is needed to alert another provider of a patient’s non-compliance with a medication. This additional communication may include, but is not limited to, direct provider-to-provider phone call, phone communication between office staff, or asking the patient to discuss the issue with the other provider.

7. Any new medications written, medications discontinued, or dose modifications made will be relayed to the patient verbally and documented in the EeMR Medication List utilizing the electronic prescribing process as applicable.

8. At the conclusion of the visit, the patient (and/or family member) will be provided with a copy of the updated Medication List. The list will indicate to the patient any new medications that have been prescribed at that visit (with dosing information and instructions), any medications that should be continued, and any pertinent compliance information. (It is acceptable to leave any medication on the medication list, with a
“not taking” comment in the compliance notes, as a means for communicating with the patient and other providers). This information will be available for communication to next providers of care.

9. Auditing of this process will occur at the local and global level, by manual and automated methods
Policy: Medication Administration

Status: Active

Activation Date: 09/10/2009  Approved By: Penny Z. Castellano, MD

Last Review Date: 07/29/2013  Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: MM.03.01.01, MM.06.01.05

Scope/Procedure:

1. Personnel Authorized to Administer Medications

Only licensed medical providers and authorized clinical staff, acting within their legally defined scope of practice and Clinic policies may administer medications to patients. These practitioners include: doctors of medicine, osteopathy, dentistry, oral surgery, optometry and podiatry; physician’s assistants, nurse practitioners, certified nurse anesthetists, certified mid-wives, registered nurses, licensed practical nurses, respiratory therapy practitioners, athletic trainers, medical assistants, ophthalmology technicians, pulmonary function technicians. Students in these practitioner disciplines may administer medications under the direct supervision of licensed practitioners.

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Physician</th>
<th>CRNA</th>
<th>APP</th>
<th>RN</th>
<th>LPN</th>
<th>SN</th>
<th>ATC</th>
<th>MA</th>
<th>PULM Tech</th>
<th>RAD/NUC</th>
<th>PT</th>
<th>ENDO/</th>
<th>OPHTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Push</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>e</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IV Piggyback</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xa</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IV Solutions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xa</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Xb</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IV Narcotics</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IV Insulin</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IV Heparin</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Chemo</td>
<td>X</td>
<td>-</td>
<td>Xa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>IM/SQ</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>Xa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>PO</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Inhalants</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>Xa</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Topicals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>X</td>
<td>Xa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>RECT/VAG</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>X</td>
<td>Xa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Investigational</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>Xa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ophthalmics</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>Xa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Contrast/Injection</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>Xa</td>
<td>Xb</td>
<td>X</td>
<td>Xb</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Blood</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Xc</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Mod Sedation</td>
<td>Xa</td>
<td>Xa</td>
<td>Xa</td>
<td>Xa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>General Anesth</td>
<td>Xd</td>
<td>Xb</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Neuromuscular</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suffix Key</th>
<th>Personnel Title Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Competency required</td>
<td>CRNA – Certified Registered Nurse</td>
</tr>
<tr>
<td>(b) Under supervision of MD</td>
<td>APP – Advanced Practice Professional</td>
</tr>
<tr>
<td>(c) Under direct observation of</td>
<td>RN – Registered Nurse</td>
</tr>
<tr>
<td>(d) Certification by</td>
<td>LPN – Licensed Practical Nurse</td>
</tr>
</tbody>
</table>

43
<table>
<thead>
<tr>
<th>(e) No epidural/PCA bolus</th>
<th>SN – Student Nurse</th>
<th>PT – Physical Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ATC – Certified Athletic Trainer</td>
<td>ENDO-CATH TECH – Endoscopy</td>
</tr>
<tr>
<td></td>
<td>OPHTH TECH – Ophthalmology Technician</td>
<td></td>
</tr>
</tbody>
</table>

Refer to Student Clinical Experience, Nursing Policy

2. Administration of Medication

Before administering a medication the administering health professional will perform the following actions:

- Identify patient using two pieces of identifying information, i.e., patient name and date of birth.
- Additional identifiers include: social security number, third-party payer card, driver license, current address, etc. If the patient is cognitively or communicatively impaired, the patient must be identified through an accompanying relative or caregiver.
- Check for any history of allergy or reaction to the medication ordered for administration.
- Staff administering medication are responsible for having current knowledge regarding medication indications; side effects, including potential food-drug interactions; drug–drug interactions and usual dosages before administering any medication to a patient. This information is located in:
  a. Micromedex
  b. Depart Tool – Medication Leaflet
- Verify that the medication selected for administration is the correct one based on the medication order and product label.
- Verify that the medication is stable based on visual examination for particulates or discoloration and that the medication is not expired.
- Verify that there is no contraindication for administering the medication.
- Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.
- Determine the patient’s readiness to learn. Advise the patient or, if appropriate, the patient’s family, about any potential clinically significant adverse reaction or other concerns about administering a new medication.
- Discuss any unresolved, significant concerns about the medication with the patient’s physician, prescriber (if different from the physician and/or relevant staff involved with the patient's care, treatment, and service.
- High Risk and High Alert medications must be checked by two licensed staff before administering to patient. These include high risk cytotoxic drugs.
  - For Medications that require double-checking before administration:
Nurse administering medication
- Performs own calculations and draws up medication as ordered
- Takes order form, medication and source container (e.g. vial) to 2nd nurse and requests a double-check
- Gives appropriate data such as blood glucose level

Nurse checking dose:
- Completes own calculations
- Verifies that “like” answers obtained
- Verifies the source container
- Verifies the correct amount to be administered

Both nurses:
- Collaborate to identify any error and make corrections if discrepancy identified

For a complete list of High Risk and High Alert medications, refer to MM-10 High Risk and High Alert Medication Management Policy.

- Administer the medication
- Observe the patient
  - For all oral and injected medications, observe patient for at least 15 minutes
  - Patients receiving high risk medications, high alert medications or allergy injections should be observed for 30 minutes
  - Once the appropriate observation time is completed, a clinical staff member should observe the patient for possible adverse reactions.
  - Effective September 10, 2009, seasonal flu vaccine does not require a 15 minute observation period. All other process steps noted above should be followed as outlined.
- Dispose of used equipment according to protocol; DO NOT RECAP NEEDLES; return supplies and secure remaining medication.
- In the event of a medication error:
  - Assess and care for the patient
  - Notify physician and Clinic Leader
  - Enter STARS medication variance report

3. Documentation

- Documentation of all medications is done at the time of administration in the medication Powerform
- Record in the medical record: date/time; medication name, dose, route, site of administration; and administering practitioner name, title, signature.
- Documentation of patient response following observation.
- Record controlled medication administration on approved Controlled Drug Administration & Inventory log.
4. Administration of Medications to Non-Patient Employees or Visitors

Medications may not be administered to non-patient employees, patient family members, or visitors.

5. Investigational Drugs

The administration of investigational drugs will follow the procedures noted above in addition to all procedures and constraints, including informed consent, as described in the Emory University Institutional Review Board approved protocol.
Policy: Storage and Inventory Control

Status: Active

Activation Date: 10/27/2010
Last Review Date: 08/17/2012

Approved By: Penny Z. Castellano, MD
Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: TJC:MM.02.01.01

Policy Statement:

The Emory Clinic, Inc. (The Clinic) will comply with all applicable federal, state, local laws and regulations and with accepted pharmaceutical practices regarding the storage and maintenance of pharmaceutical products in the ambulatory environment.

Scope/Procedure:

Storage

1. Medication Storage Environment

- All medications present are approved according to an authorized inventory. Drug concentrations are standardized and limited in number.
- Internal and external medications are physically separated.
- Open multiple dose containers are initialed and dated upon opening, as per Joint Commission standards. **All containers will be discarded 28 days after opening.**
- Open single dose containers (injections or irrigation solutions without bacteriostatic or preservative agents) are discarded immediately after initial use.
- No expired medications are present.
- Medications in examination rooms are secured from patient access.
- Extemporaneously compounded or repackaged stock solutions are correctly labeled with applicable manufacturer solution name, strength, , and expiration date, and time. If solution is for external use only, container must be labeled as such.
- Medications with "look-alike/sound-like" names that are easily confused will be segregated and labeled with standard alert labeling.
- Concentrated electrolytes will be stored and maintained only in the pharmacy and will not be stored in patient care areas.
- Each and every container of medications, reagents, or other substances will be accurately labeled. **Unlabeled containers of any kind are not permitted in patient care areas.** Any medications drawn up or placed in any vessel or container for use must be labeled immediately with medication name and strength/dose.
- Medications may NOT be carried in pockets or belt packs.
2. Medication Refrigerators and Freezers

- No unauthorized, expired, or discontinued medications are present.
- Temperatures will be measured using standard, Clinic-approved high/low recording devices.
- Storage refrigerator temperatures will be maintained between 36 and 46 degrees F (2 and 8 degrees C). Storage freezer temperatures will be maintained between -4 and -14 degrees F (-20 and -26 degrees C).
- Storage temperatures will be recorded only on the standard Clinic-approved, colored graphic monitoring form titled, “Refrigerator (or Freezer) Temperature High/Low Graph in accordance with instructions on the front of the form. **Using black-and-white and/or one-sided photocopies of the form is strictly prohibited.**
- If an observed temperature is out of acceptable range, that is in the red zone of the graph, the “Red Zone Action Plan” located on the back of the respective graph will be implemented and documented in accordance with the related instructions:
  - Thermometer expired – yes/no
  - Place control thermometer in refrigerator/freezer, clear memory.
  - Record control thermometer temperature after one hour.
  - Record departmental thermometer temperature after one hour with control.
  - If control/departmental thermometers both in-range, remove control thermometer, continue to use departmental device.
  - If control thermometer is in-range and departmental thermometer is out-of-range, order a replacement from Material management, and use the control thermometer until replacement arrives.
  - If control and departmental thermometers are both out-of-range, call Facilities Management (8-3226) for a loaner thermometer; record the report ticket number.
  - If control and departmental thermometers are both out-of-range, call Clinical Pharmacist to check stability of medications at out-of-range temperatures.
  - Move stable medications to alternative refrigerator/freezer.
  - Discard unstable medications.
- If adjustments in the thermostat of the refrigerator are made, such adjustments will be documented in the “Thermostat Adjustment Log” located on the back of the Refrigerator/Freezer Temperature High/Low Graph.
  - Adjusted thermostat UP ½ turn
  - Adjusted thermostat DOWN ½ turn
  - Alarm silenced/attributable cause, memory cleared
- The location, year, month, and thermometer expiration date must be documented in the appropriate spaces on each Refrigerator Temperature High/Low Graph.
- All Refrigerator/Freezer Temperature High/Low Graphs must be retained in the Section for two years.

3. Storage of Non-Controlled Medications
All non-controlled medications will be stored in a low-traffic area secure from access by patients and visitors. The area will be monitored by authorized staff during business hours and locked during non-business hours.

4. Storage of Controlled Medications and Substances

- All controlled substances will be properly stored and secured; Schedule 2 and 2N medications (narcotics) will be stored in a double-lock cabinet or a safe; Schedule 3, 3N, 4, and 5 medications will be stored in a single-lock cabinet or safe.
- The narcotic cabinet keys will be kept in the possession of an authorized person during business hours; the keys will secured under lock during non-business hours.
- No expired medications are present
- All medications are intact or unopened

5. Storage of Emergency Medications

- Emergency medications, supplies, and devices are configured in several tiers based on clinical need. These include:
- Standardized "crash-carts" located in high risk areas contain a full panel of emergency medications, intravenous access devices and fluids, oxygen, airway management and endotracheal intubation equipment, and a defibrillator (portable or AEDs).
- Emergency "Jump Bags" located in key clinical areas for the purpose of response to emergent events in advance of the arrival of a crash cart contain intravenous access devices and fluids, airway management devices, a limited number of key emergency medications, and a portable automatic external defibrillator.
- Emergency Kits located in clinical units for the purpose of managing emergency events, including basic cardiac life support contain a moderate panel of emergency medications and intravenous access devices. They are proximate to airway management kits and oxygen. Pediatric Kits (designated by orange color) are located in applicable clinic areas.
- Emergency supplies are stored in appropriate containers and secured with numbered, plastic breakaway security seals to ensure integrity and completeness. An inventory, including expiration dates, is attached to each storage module. Should the security seal be broken for any reason, the Clinic Pharmacist will be contacted to ensure that replacement medications are obtained. Clinic Pharmacist will check medications for accuracy and completeness and provide sealed module to the clinic.

6. Sample Medications

Sample medications are prohibited in all practices of The Emory Clinic. From time to time and in special extenuating clinical circumstances, exceptions to this policy may be needed to ensure patient safety. All such exceptions require written approval from the Chief Medical Officer of The Emory Clinic.
7. Expired Non-Controlled Medications

Non-controlled medications will be audited monthly by clinical unit staff to identify expired medications. Disposal of expired medications will be coordinated with Clinic facilities management department for disposal according to Emory University policy for hazardous substances. Disposal techniques must comply with rules of the Georgia Board of Pharmacy.

8. Expired Controlled Medications and Substances

Controlled medication supplies will be audited monthly by clinical unit staff to identify expired medications. The DEA requires that expired or unwanted controlled medications and substances be transferred to a disposal agent, which is approved and registered by the DEA. All disposal should be coordinated through Emory Hospitals Pharmacy Services Department.

9. Medications Brought to Clinic by Patients or Families

- The physician will be responsible for determining which medications can be brought in by the patients for administration by the clinic staff. The physician (or physician’s designee) will verify the medications prior to administration.
- Medications brought to Clinic facilities by patients and family may be self-administered by patients at will. Exceptions to this policy are medications brought to the Ambulatory Surgery Center, Ambulatory Treatment Center of WCI, and the Cardiac Catheterization Laboratory, where self-administration is not permitted unless authorized by the attending physician. If the attending physician has a concern about the nature or identity of the medication, it may be submitted to the Emory Hospitals Pharmacy Services Department for review.
  - This policy, at all times, will remain consistent with Emory Healthcare's policy on Use of Personal Patient Medications.

**Inventory Control**

1. Medication inspections will be conducted quarterly by clinic staff for the purpose of ensuring standards, regulatory, and policy compliance. Documentation will be provided to the clinic pharmacist and will be retained in the clinic for two fiscal years via Pharmacy standards.
2. An inventory should be maintained for unit-approved medications. Authorized inventory lists will include: vendor catalogue number, medication name, number in package, container description, medication strength, dosage form and par level.
3. An authorized inventory may be utilized as a “standing order” for the purpose of purchasing through the Emory Hospitals Pharmacy Service.
4. Controlled medication inventory requirements

- All inventory records (receipt, dispensing, and disposal) of Schedule 2 and 2N medications must be maintained separately and readily retrievable from all other medication records, including purchaser copies (Copy 3) of DEA Form 222. Purchasing records for medications in
Schedules 3, 3N, 4, and 5 must be maintained separately and readily retrievable from other medication records or inventories.

- Perpetual inventory records for controlled medications should contain at least the following items: name; strength; dosage form; date/time of receipt, dispensing, and disposal; patient; number dispensed; number remaining; section to indicate receipt and deletion from inventory; signature of dispenser, signature of person witnessing wasting; reason for wasting; manufacturer lot number and expiration date.

- Separate inventories will be maintained for each controlled medication. Inventories will be audited at intervals defined locally by the frequency of use, but at least weekly. The number of available drugs will be counted by a nurse, pharmacist, or physician; a second licensed professional will witness the count. Both parties will sign the inventory form indicating that the inventory accurately reflects the number of dosage units remaining in the locked cabinet or box. At each inventory, all discrepancies or missing medication will be resolved.

- All records for controlled medications will be maintained and readily retrievable for a minimum of two years. A physician or other licensed professional who dispenses or regularly engages in administering controlled medications must take an inventory every two years of all stock on hand. That inventory must include: the name, address, and DEA registration number of the physician; date/time of inventory; signature of the inventory taker; and separate records for Schedule 2 and 2N medications.
Policy: Ordering and Transcription

Status: Active

Activation Date: 03/17/2009       Approved By: Penny Z. Castellano, MD

Last Review Date: 10/15/2013       Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: MM.04.01.01, R.C.02.03.07

Policy Statement:

The Emory Clinic, Inc. (The Clinic) will ensure that all orders for medical therapy originating from a licensed practitioner or supervised resident, will comply with all applicable federal, state, and local laws/regulations, and will be conform to the procedures described below.

Scope/Procedure:

1. Medication Orders

   • All medication orders must include: patient name, drug name (generic preferred), dose form, dose (metric measure), route of administration, frequency of administration, date/time, and ordering practitioner name/signature and contact number.

   • A contact number (pager identification or telephone number) for the accountable practitioner will be included on all orders. If the order is written by a nurse practitioner, the order will include the name of the sponsoring physician, e.g., J. Jones, NP, PIC #12345/S. Sponsor, MD.

   • Medication error preventive measures will be observed: legible; avoid leading decimals and trailing zeroes; spell out word “unit”; use mcg for micrograms, and avoid abbreviating medication names; avoid prohibited abbreviations.

   • When discontinuing medications, separate orders should be written by name for each discontinued medication. Blanket reinstatement of ("resume") previous orders is not permitted.

   • To change an order, the practitioner will initiate a new order and discontinue the original order.

   • Orders may be corrected by drawing a single horizontal line through the erroneous text, initialing, and dating the change.

   • As needed (PRN) orders must cite the indication for the drug in the order, e.g. oxycodone 5 mg. PRN pain.

2. Special Orders Applicable to Clinic Ambulatory Care

   • Standing orders - those approved by the Clinic or Emory Healthcare may be utilized, e.g., clinical pathways, research protocols, or those unique to a clinical unit. Periodic review and update at least annually is required.
• Pre/Post Operative orders - pre-operative orders will be automatically discontinued post-operatively, and new post-operative orders must be written. “Continue previous medications” is not acceptable.
  ▪ Hold orders - use is permissible
• Medical devices, e.g. oxygen - use must describe the therapy, appliance, dose parameters, and frequency
• Investigational medication orders may be issued only in accordance with approved research protocols
• Discharge medication orders should be issued by electronic Prescription Writer in PowerChart or by hand-written prescription on approved forms in the event that the electronic system is unavailable.
• Preprinted orders must be reviewed and updated at least annually.

3. Special Orders Not Permissible to Clinic Ambulatory Care

"Resume," titrating, taper, and range orders, are not permitted, except in the setting of the Ambulatory Surgery Center and Ambulatory Treatment Center where, in unusual clinical circumstances titrating, tapering, and range orders may be issued.

• Range Orders: If range orders are used, therapy should start with the lowest effective dose with the specific parameters included (e.g., “for moderate pain rated 4-7”). If symptomatic relief is not obtained, then the dose can be increased or the interval decreased, depending on the drug and situation.
• Titrate Orders: Include the amount of dose increase or decrease for each response and the interval or frequency. Include an upper limit.
• Taper Orders: Include the amount of dose decrease for each step of the taper and the interval between each step.

4. Transcribing Orders

• Registered nurses (RN) and licensed practical nurses (LPN) are authorized to transcribe written orders. Responsibility for complete and accurate transcription lies with the verifying RN or LPN.
• The transcribing and/or verifying RN or LPN will note the date/time and sign on the order form adjacent to the order.

5. Transfer Orders

In the event of transfer to a hospital or other health care facility, transfer orders must accompany the patient. All prior orders will be discontinued. The RN or LPN will sign, date and time those transfer orders which have already been implemented.
6. Clarifying Orders

- The standard process of The Emory Clinic is to write down the order, read the order back and verify the order with the ordering provider.
- If the ordering practitioner is unavailable, the attending practitioner on-call will be contacted. If needed, escalation to the Section Head should be utilized to clarify the order or resolve any concern about implementing the order.
- The read back and verify process should be documented in the medical record.
- Only licensed practitioners may receive and respond to inquiries from internal or external pharmacists or pharmacy technicians on behalf of Clinic physicians. Medical assistants and secretarial staff may not do so.

7. Verbal Orders

- Verbal orders are not to be accepted, when the prescribing practitioner and the patient record are present, except in an emergent event.
- Verbal orders may be issued by licensed, independent practitioners or licensed dependent practitioners acting under supervision.
- Verbal orders may be accepted and transcribed and implemented per scope of practice by the following practitioners employed by Emory Healthcare or Emory University: registered nurse, licensed practical nurse, registered pharmacist, and respiratory care practitioner; also within their scope of practice by registered occupational therapist, registered physical therapist, registered dietician, licensed psychologist, licensed radiology technologists, certified speech pathologist, certified audiologist, EMG technologist, athletic trainers, and ophthalmology technicians.
- The person receiving the verbal orders will transcribe the orders and then read back the orders to the prescribing practitioner for the purpose of avoiding misinterpretation. Unfamiliar language or words should be spelled out.
  - The receiver of the verbal orders will note on the record the prescriber’s or agent’s name, contact number, receiver name/title/signature and date/time. The following statement must appear on the order form following all verbal (including telephone) orders: v.o. Dr. _____/contact or pager number _____; Read back/verified by ______” (title). In emergent events, the verbal order must be repeated back to the prescribing practitioner before implementation. In the later case, the term “read back” will be replaced by “repeated back.”
- Nursing may accept and transcribe verbal orders from the practitioner (or his or her designee) for the above identified individuals.
- All verbal orders must be signed by the prescribing practitioner within seven days.
- Properly documented verbal orders may be implemented immediately.

8. Telephonic Prescriptions
Only licensed practitioners may transmit verbal orders on behalf of a physician to a pharmacist or pharmacy technician. Medical assistants, secretarial staff and other non-licensed personnel can only call in a telephone prescription from a signed written order.

9. Prescription Forms

Prescription should be created by using the electronic prescription writer tools in EeMR. Printing of prescriptions as needed should be on appropriate paper, utilizing tamper resistant paper when required or desired. In extenuating circumstances (e.g.: EeMR down-time), handwritten prescriptions should be utilized and should be executed on TEC tamper resistant pads.

- Minimum information for either method will include: patient name; date; medication name, form, dose and quantity; directions for use; number of refills to equivalent of 12 months; requirement to label; designation of generic or brand (for the latter, practitioners must hand write “brand only” on the form); prescribing practitioner signature; NPI, DEA registration number (managed care payers may require this information for both controlled and non-controlled medications); preprinted name and address; and both the general Clinic and prescribing practitioner’s office contact telephone numbers. The patient address is required for controlled medications. Including known drug allergies is encouraged, but not required.

- Should a supervised resident write prescriptions on behalf of a licensed, independent practitioner, the prescribing resident should legibly sign the prescription form using their own name (not the attending practitioner’s name), and include beneath his/her signature the name of the attending practitioner.

- Prescription paper and pads will be stored in a secured location, out of access of patients, at all times.

- The use of separate prescription pads for controlled and non-controlled medications is discontinued.

- Georgia Pharmacy Board approved security paper with lot number, serial number and State seal of approval will be used for issuing all Schedule II controlled substance prescriptions.

- The use of computer-generated prescriptions using EeMR is addressed in separate policies and procedures of Emory Healthcare Information Services.
Policy: Office-Based Surgical Procedures – Selection Criteria

Reviewed By: Gynecology & Obstetrics Management Team

Policy Applicable To:
- Clifton Campus, Building A
- Emory University Hospital Midtown
- Emory Reproductive Center

Policy Purpose:
To define the process of patient selection for any office-based surgical procedures.

Policy Process:
Patients being considered for office-based procedures are evaluated in full with regard to their overall medical condition and baseline health. Given the complexity in the Emory Healthcare practice, ASA criteria is not the only criteria used for office-based procedure performance.

For patients with medical conditions that would normally qualify for ASA III or higher (not excluding all ASA II patients), providers will consult with referring physicians and applicable specialists to decide on the safest venue for the procedure to be performed.

Patients who are unstable due to severe or complex systemic disease are managed in conjunction with anesthesiology (either Ambulatory Surgical Center or inpatient based) and applicable referring physician specialists.
Policy: Informed Consent

Status: Active

Activation Date: 07/28/2008  
Approved By: Penny Z. Castellano, MD

Last Review Date: 08/23/2012  
Title: Chief Medical Officer, Chief Quality Officer

Regulatory References: TJC: RI.01.03.01

Policy Statement:

The Emory Clinic, Inc. (The Clinic) supports the right of the patient to have all necessary information before consenting to any kind of diagnostic or therapeutic intervention and to be informed of reasonable alternatives.

Scope/Procedure:

1. General versus Specific Consent

   At the time of registration, all patients are asked to execute a consent to general care, e.g. medical history, physical examination, phlebotomy for laboratory studies, etc. Such consent is not specific to the clinical activity nor is effort made to provide detailed information of benefit, risk, etc. Specific "informed" consent is obtained for each and any care of treatment, which is invasive or associated with material harm.

2. Care or Treatment Specific Consent

   In obtaining specific informed consent for care or treatment, when required, the following elements will be discussed with each patient or their surrogate (if applicable):
   
   a. Patient condition and diagnosis
   b. Nature and purpose of propose care, treatment, and services (C/T/S), medications, interventions, or procedures described in lay terms
   c. Potential benefits, material risks or side-effects, including potential problems related to recuperation, of the proposed C/T/S
   d. The likelihood of success of such proposed C/T/S
   e. Reasonable alternatives to such proposed C/T/S and the relevant potential benefits, material risks or side-effects, including potential problems related to recuperation, of the alternative C/T/S.
   f. Prognosis if treatment/procedure not performed
g. When indicated, any limitations on the confidentiality of information learned from or about the patient

The patient’s family will be included in the discussion in accordance with the wishes of the patient or their surrogate

3. What Persons May Obtain Informed Consent

Information required to be provided to patients in obtaining informed consent may be disclosed through nurses, physician's assistants, trained counselors, patient educators or similar persons known by the responsible physician to be knowledgeable and capable of communicating such information.

4. Signatures

The patient signature, or if applicable, the signature of the patient’s surrogate must appear on the consent form. Optimally, the signature of an independent witness who is not the physician or the agent of that physician should also be included. The signature of the person obtaining consent must appear on the consent form. If that person is not the physician responsible for the C/T/S, that physician should later co-sign the consent form.

5. If a pre-printed consent form is utilized, additional information may be handwritten on the form; however, the patient or surrogate should initial the additions.

6. If a pre-printed consent form is not utilized, the treatment plan and related discussions between physician and patient or surrogate should be documented in the medical records, and initialed by the patient or surrogate.

7. Should there be concern for the accuracy of the patient's or surrogate's identification, employees should request documentation in the form of a driver’s license, state identification card, social security card, passport or other official governmental document. Note that it is NOT necessary to request identification from each and every patient, but simply those whose identity is in doubt. The section administrative staff with the advice of the Office of General Counsel will withhold all but emergent care for any patient or surrogate believed to be using an alias or false name until the patient's identity has been established.
Post Procedure Care and Discharge of Patients from PPCA

Statement: To provide assessment and monitoring for patients undergoing diagnostic/therapeutic procedures and to ensure appropriate post procedure care and discharge for patients receiving moderate sedation.

Scope/Procedure:

Post Procedure Recovery

1. Upon admission to the Post Procedure Care Area (PPCA) patients must have physician orders addressing care and discharge.
2. The physician order must include discharge criteria regarding moderate sedation, vital sign monitoring, site care monitoring, site care management, fluid, and nutrition status.
3. Upon arrival to the PPCA a report on the patient's condition is to be given by the healthcare provider who administered the moderate sedation. The report should include but not be limited to:
   a. Last vital signs and overview of vital signs before and during the procedure.
   b. Oxygen saturation on room air and/or with oxygen.
   c. Overview of drugs administered with dosage totals and time of last dose.
   d. Overview of pertinent medical history and medications.
   e. Any information that will maintain continuity of patient care.
4. The PPCA will obtain and document:
   a. Admission vital signs
   b. Assess Level of Consciousness (LOC)
   c. Assess puncture site or dressing site
   d. Assess distal pulses for arterial punctures
5. The patient should be monitored continuously and vital signs documented q15 minutes if stable, more frequently as dictated by the patient's condition, or as ordered by the physician.
6. In the event of respiratory depression or other untoward event, the nurse will notify the physician immediately. The nurse will institute appropriate airway support and administer reversal agents as ordered by the physician.
7. All patients will be monitored for a minimum of 30 minutes after the last dose of medication unless otherwise specified by the physician. The 30 minutes includes time in the procedure room and if the patient meets all other discharge criteria, may be sent directly back to the inpatient unit and by-pass PPCA. Patients receiving a reversal agent will be monitored for an additional 45 minutes to 2 hours in order to assess for re-sedation.
8. Outpatients will be discharged home and inpatients will be transferred to their appropriate unit when all established criteria are met per Emory Hospitals’ Moderate Sedation Policy. A telephone report will be given to the receiving unit nurse by the radiology nurse. The report will include:
a. Patient's status post procedure - LOC, procedure performed, including puncture site and dressing.
b. Vital signs, oxygen saturation.
c. Overview of drugs administered with dosage totals and time of last dose.
d. Intake and Output totals.
e. Any information that will maintain continuity of patient care.

Discharge guidelines

1. Outpatients **must** have a responsible adult drive them home. Taxi rides are permitted as long as the patient is accompanied by a responsible adult. Taxi fees are the responsibility of the patient. Social Services will be notified if the patient is unable to pay for their transportation.
2. Outpatients will be assessed for their ability to ambulate independently or with assistance based on the following:
   a. medical condition
   b. mental stability
   c. age and physical limitations
   d. use of assisted devices or aides
   e. amount of sedation or analgesia administered during the procedure
3. The PPCA RN will review written discharge instructions to include follow up appointments, perform discharge teaching with return demonstration by patient, family, or significant other and provide the patient with a copy of these instructions.
4. The PPCA staff will escort the patients via appropriate mode of transportation (i.e. ambulatory, wheelchair) to the hospital exit and assist them into the vehicle.

Reviewed by:
Vicki R. White; Kevin Kim, MD; Richard Wright; Karen Booker; Perlita Kitt; Richard Elliott

Regulatory References: The Joint Commission (TJC) Manual for Hospitals

Related Policies/Procedures:
Moderate (Conscious) Sedation
DOC: Moderate Sedation Performance Monitoring Form
DOC: Moderate (Conscious) Sedation - Competency Checklist
DOC: Potential Medications Used in IV Moderate Sedation
Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery/Procedure
Policy: Post-Operative Follow-Up Phone Call

Reviewed By: Gynecology & Obstetrics Management Team

Policy Applicable To:
☒ Clifton Campus, Building A  ☒ Emory University Hospital Midtown  ☒ Emory Reproductive Center

Policy Purpose:

To provide patients with appropriate post-operative phone calls to ensure patient safety.

Process:

A post-operative follow-up phone call will be conducted by either a nurse or physician, for any procedure that the physician deems necessary within 48 hours. A report of the phone call will be recorded in the patient’s medical record.
Policy: Smoking
Status: Active
Activation Date: 01/14/2010
Last Review Date: 01/16/2013
Approved By: Larry S. Ingram
Title: Director, Facilities Management and Safety

Policy Statement:

It is the policy of The Emory Clinic to provide a healthy and smoke-free environment for all who enter the facility. Therefore, smoking is not permitted in any clinic structure and only at exterior locations marked as smoking areas. This policy also extends to all private offices owned, leased, and/or operated by The Emory Clinic.

Scope/Procedure:

PROCEDURE

1. "NO SMOKING" signs will be posted in all buildings and areas controlled by The Emory Clinic where patients are seen.
2. Outpatients are informed by signage at registration and by other postings.
3. All new employees will be instructed on this policy at new employee orientation and reinforced at the departmental/section level.
4. Personnel and medical staff who are non-compliant are subject to progressive disciplinary action.
5. Patients who are non-compliant must be warned.
6. Visitors who are non-compliant will be asked to leave the building.
7. If any difficulty arises with non-compliant person(s), notify your supervisor or call security for assistance.
8. Enforcement of this policy is the shared responsibility of ALL clinic personnel.
9. Incidents of smoking, including evidence of smoking, is documented on incident reports, aggregated, and evaluated for trends and patterns.
10. Where a pattern is identified, an improvement project will begin to identify and implement corrective activity.
11. All employees share in the responsibility for adhering to and enforcing this policy. Enforcement of the policy will depend on the thoughtfulness, consideration and cooperation of all staff. Compliance is expected and will be enforced with compassion and by tact, diplomacy, and the exercise of appropriate judgment. Conflicts should be brought to the attention of the Department/Section Supervisor. The Departments of Safety and Security should be contacted for additional assistance if necessary and will be responsible for monitoring areas where continuous violations are found. *The clinic reserves the right to remove and prohibit possession / delivery of smoking materials from those individuals found in violation to this policy. Additional measures may be taken by Human Resources and/or clinic administration for those determined ‘repeat offenders.’
### Table of Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Table of Contents</td>
</tr>
<tr>
<td>2</td>
<td>Role of Medical Director</td>
</tr>
<tr>
<td>3</td>
<td>Credentialing &amp; Privileging Information</td>
</tr>
<tr>
<td>4</td>
<td>Education and Training Requirements for Office Procedures</td>
</tr>
<tr>
<td>5-7</td>
<td>Key Quality Improvement Indicators</td>
</tr>
<tr>
<td>8-22</td>
<td>Office Procedures</td>
</tr>
<tr>
<td>13-15</td>
<td>Hysteroscopy</td>
</tr>
<tr>
<td>16-18</td>
<td>LEEP</td>
</tr>
<tr>
<td>19-22</td>
<td>Essure</td>
</tr>
<tr>
<td>23-25</td>
<td>IUD Placement</td>
</tr>
<tr>
<td>26-27</td>
<td>Patient Rights and Responsibilities and Records Transfer</td>
</tr>
<tr>
<td>28-29</td>
<td>Communication with Patients</td>
</tr>
<tr>
<td>30-31</td>
<td>Management and Tracking of Labs, Imaging studies, and Referrals</td>
</tr>
<tr>
<td>32-33</td>
<td>Medication Safety</td>
</tr>
<tr>
<td>35</td>
<td>Triage</td>
</tr>
<tr>
<td>36-38</td>
<td>Emergency Management ,Fire Safety, and Emergency Drills</td>
</tr>
</tbody>
</table>

This manual is for the specific use of the Loch Haven OB/GYN Group and is not intended for use elsewhere. The manual may not be used or published in any context, including but not limited to paper, Internet, educational presentations, slide shows or other media without express written permission from the medical director or Florida Hospital Graduate Medical Education Administration.

This manual does not take the place of Florida Hospital or Graduate Medical Education Policy and Procedures.
The Medical Director of the Loch Haven OB/GYN Group is assigned by the Graduate Medical Education Administration and has several responsibilities:

**Office Safety**
- Develop and maintain a “culture of safety” for clinical operations at the office.
- Meet regularly with appropriate hospital and office leadership to review safe practice operations.
- Review quality of care issues with clinicians and office leadership.
- Supervise regular team office safety drills.
- Review adverse events and “near misses” with office team and provide leadership for resolving safety issues.
- Have an “open door” policy with regards to patient and staff safety.

**Clinical Privileges**
- Assign or revoke clinician privileges for office-based procedures.
- Ongoing assessment of clinical competency of office clinicians.
- Perform annual clinician peer review and procedural performance evaluation.
- Develop clinical Policies and Procedures for office procedures.

**Quality Outcome**
- Develop quality outcome measures for surgical procedures.
- Conduct quality improvement activities to monitor and measure the quality of office procedures and patient care/safety.

**Practice Operations**
- Meet regularly with hospital and practice management team.
- Provide clinician call and office schedules.
- Conduct regular, focused clinician meetings where safety and practice operations are discussed and problems resolved. When indicated, some of these meetings will involve review of office procedures or orientation to new equipment.
- Meet regularly with office staff to discuss safety and practice operations, and promote an open relationship between clinicians and staff.
Clinician Credentialing, Privileging and Scope of Practice

This section of the Standard Operating Procedures manual contains information on clinician and clinical staff privileges for performing office procedures.

Clinician Privileges

- The Medical Director will assign privileges based on the experience of each clinician and generate a Delineation of Privileges Form for each clinician. New clinicians to the practice will undergo training by the medical director (or designee) on office equipment, location of personal protection equipment (PPE), SOP’s for procedures, pre and post procedure instructions, and which team members have been granted privileges to assist with office procedures.
- New clinicians to the practice will undergo observation by a physician preceptor who has already been granted privileges for the procedure(s) under review, using a form designed for this practice (Office Procedures Preceptor Evaluation Form). The medical director will designate privileges based on review of the form and discussion with the preceptor and new clinician.
- The medical director will conduct an annual peer review with each clinician, which in part will involve a review of each type of procedure the clinician performs. This review should include a review of the number of each procedure performed that year, any adverse events or “near misses,” any concerns the clinician or staff has regarding procedure performance, and, if necessary, mandating specific educational activities or preceptor oversight to improve performance.
- The medical director will conduct focused discussions with clinicians on an “as needed” basis during the year if any privileging issues arise.
- Privileging forms are kept on file in the medical director’s office.

Clinical Staff Privileges

- Clinical Staff are trained and signed off to assist with office procedures/Surgery during their orientation process and yearly by the nurse manager or her trained designee.
- Review with office nursing and management leadership the competency of each clinical staff member and, when indicated, conduct training sessions for office procedures.
Education and Training Requirements for Office Procedures

For all procedures:

- Review equipment with medical director or designee.
- Discuss expectations for using procedure checklist for every procedure.
- Review SOP’s for each procedure (see appropriate sections of the Standard Operating Procedures Manual).
- Review appropriate staff for assisting with procedures.
- Review location of PPE and safety equipment and process for emergency transfer to nearest hospital.
- Review provider experience with each procedure, potential complications, and appropriate informed consent discussion and documentation.
- The office nurse manager (or designee) will orient each new clinical staff and will review and complete the office procedure competency form, which is kept on file in the head nurse's office.

Hysteroscopy

- Assure that hospital has granted hysteroscopy privileges.
- Review indications and contraindications for hysteroscopy.
- Review use of distention fluid and hysteroscopy equipment.

Essure

- Assure that hospital has granted Essure privileges
- Review manufacturer’s guidelines for Essure coil sterilization.
- Review indications and contraindications for Essure.
- Review use of contraceptive until HSG confirmation of tubal occlusion.

LEEP

- Review indications and contraindications for LEEP.
- Review LEEP settings (i.e. depending on wire used).
- Review use of grounding pad and smoke evacuator.
- Orient team to LEEP machine components and electrical safety.

IUD Placement

- Review indications and contraindications to IUD usage.
- Review pitfalls and solutions to difficult IUD placement.
Key Quality Improvement Indicators and Peer Review

Loch Haven OB/GYN will monitor Key Quality Indicators (KQI’s) on a quarterly basis. These KQI’s will be reviewed yearly to determine if they are to be continued, or if new ones will be implemented. Key Quality Indicators are monitored to make sure that the clinicians and staff are providing safe care. An adequate KQI will measure an important aspect of quality that the care team can control and that can be improved by the provider or care team changing the way they render care. The current KQI’s are:

Prenatal Care

- Percentage of postpartum patients who have delivered > 20 weeks gestational age who have been screened for postpartum depression.
  - ICD: V24.2 ; V24.0
  - Documentation of Edinburgh Depression Scale by 6 week postpartum visit.
- Percentage of pregnant patients with a history of previous spontaneous preterm delivery (not due to preterm premature rupture of membranes) who receive intramuscular 17-hydroxyprogesterone injections during this pregnancy.
  - ICD: 644.03 ; V23.49

Ambulatory Gynecology

- Percentage of patients less than or equal to age 25 who undergo urine or cervical screening for Chlamydia trachomatis during annual examinations.
  - ICD: V74.5
  - CPT: 87800A ; 87801C
- Percentage of office procedures where clinicians and the assistant(s) use the verification process for every patient.
  - CPT: 58300 (IUD); 58565 (Essure); 58555, 58558, 58562, 100111 (Hysteroscopy); 57460, 57522 (LEEP).
  - Use of .verify or .LHverify phrases in documentation.
Office Safety

- Achieving a mean score of 90% or greater for the practice overall on the question “How well staff protects safety” using the Press-Ganey patient satisfaction survey.

- All employees attend at least 2 office safety drills yearly.

Quality Improvement Process

- Each quarter staff will generate data regarding the quality indicators and report these to the medical director, practice manager and nurse manager.

- The office leadership will meet to discuss indicator results, then meet with the office staff and providers to discuss results and work through methods to improve outcomes.

- If any team member identifies an adverse outcome or “near miss” then that team member is encouraged to use the “open door policy” regarding patient and staff safety. They will complete the Office Safety and Quality Improvement Reporting form and turn it in to the medical director, nurse manager, or practice manager. Alternative, team members wishing to remain confidential can turn the form in without using their name, or utilize the hospital’s confidential “Safety Hot Line.”

- Examples of possible adverse outcomes or “near misses” might include:
  1. Allergic reaction.
  2. Vagal response (“fainting”).
  3. Excessive bleeding.
  4. Provider or assistant(s) not washing hands.
  5. Provider or assistant(s) not using safety checklist.
  6. Pregnancy test not performed if patient < age 55.
  7. Office equipment not working or correct equipment not available.
  8. Incorrect medication given (or almost given) to patient.

- The medical director will review physician credentials on an ongoing basis (see section on Credentialing and Privileging).

- The nurse manager will review clinical staff credentials on an ongoing basis (see section on Credentialing and Privileging).
• The medical director, nurse manager, and practice manager will meet regularly with the office team and as part of those meetings discuss which quality indicators are useful and whether different indicators would improve patient care.
Office Based Procedures

Our team performs several ambulatory surgical procedures. It is extremely important for each clinical team member to understand how each procedure is performed and be aware of potential safety issues. This section of the SOP’s describes these procedures and the process for performing them safely.

Providers (clinicians) perform the following procedures at our practice: Hysteroscopy, LEEP, Essure sterilization and IUD placement. These are described in more detail later in this manual.

Credentialing for procedures:

A list of which clinicians are credentialed for procedures is located in the Medical Director’s office. If any team member is in doubt whether a clinician is privileged to perform a specific procedure, do not begin the procedure without discussing this with the medical director, head nurse, or practice manager. In addition, a list of which clinical staff are credentialed to assist for specific procedures is available in the head nurse’s office.

Adverse Events during procedures:

If any team member identifies an adverse outcome or “near miss” then that team member is encouraged to use the “open door policy” regarding patient and staff safety and use the Office Safety and Quality Improvement Reporting form and turn this in to the medical director, head nurse, or practice manager. Alternative, team members wishing to remain confidential can turn in the form without using their name, or utilize the hospital’s confidential “Safety Hot Line.”

- Examples of possible adverse outcomes or “near misses” might include:
  1. Allergic reaction.
  2. Vagal response (“fainting”).
  3. Excessive bleeding.
  4. Provider or assistant(s) not washing hands.
  5. Provider or assistant(s) not using safety checklist.
  6. Pregnancy test not performed if patient < age 55.
  7. Office equipment not working or correct equipment not available.
  8. Incorrect medication given (or almost given) to patient.
Maintaining Equipment

- The head nurse will communicate with the hospital Biomedical Engineering department when equipment needs maintenance. The Biomedical Engineering department keeps a log of all equipment maintenance and keeps a maintenance schedule.
- The head nurse will notify the medical director and practice manager when equipment needs maintenance.
- If any member of the clinical team notices a maintenance issue or is concerned about equipment not functioning appropriately or safely, that team member can request that the head nurse or medical director evaluate equipment for maintenance.
- If the medical director, head nurse, or practice manager do not believe that equipment is safe for continued usage, then that equipment will be marked prominently with “Do Not Use” or similar and, when possible, removed from the clinical area. In addition, the Biomedical Engineering team will be notified, a notice will be sent to all clinical team members, and, when possible, the staff will notify and reschedule patients.

Emergency Plan

- If an emergency develops, first call for assistance.
- Stabilize the patient’s airway.
- Obtain patient blood pressure and pulse.
- Administer oxygen either by nasal cannula (2 Liters) or by mask (10 Liters) of flow if directed by provider or patient reports shortness of breath.
- If transfer to hospital is indicated, either phone 911 using office phone, or direct someone to do this. Obtain verbal confirmation from other team member if you designate someone else to do this.
- Direct front office staff to await EMS team and to redirect flow of patients away from your location.
- Provider will phone Florida Hospital Orlando emergency department physician or charge nurse to provide clinical “handoff.”
Protocol for all procedures:

- Identify patient by name and a second identifier (i.e. birthdate).
- Identify if the patient has any questions prior to the procedure.
- All patients should sign standard office procedure consent form.
- Identify if the patient requires a ride home after the procedure.
- Use the Loch Haven Procedure Checklist form for all procedures. This is an important process where team members “pause” prior to a procedure to identify the patient, confirm the procedure, identify any allergies, and run down a safety checklist. This is similar to the type of checklist a pilot uses prior to taking off and landing an airplane. *The most important aspect of a safety checklist is that it will not work unless team members use it for every procedure, no matter how many times you have performed or assisted with that procedure.*
- Make certain that you know where the oxygen tank, tubing, mask and resuscitation equipment is located and how to use them.
- Make sure you are familiar with how to notify office leadership team if an emergency occurs and how to dial 911 from the phones in the office procedure rooms and exam rooms.
- Document that the safety checklist is used and that you document in the computerized health record every medication dispensed, including the strength, amount given, route of administration (i.e. Intramuscular), lot number and expiration date.
- All medications used should be labeled with the strength (i.e. lidocaine 1%) and the expiration date verified.
- If indicated, instrument and sponge counts should be performed by the clinician and assistant.
- Order the procedure and (if indicated) label and order the pathology specimen.
- Print a post-procedure instruction sheet for the patient before departure.
- Set up any follow up appointments.
Identifying appropriate patients for office-based procedures

Patients appropriate for office-based procedures should be healthy patients with appropriate pain tolerance and who do not have co-morbidities that may make office-based procedures potentially unsafe. Patients appropriate for office-based procedures include American Anesthesia Society (ASA) **Category I and II patients**.

ASA 1: Normal health patient. No significant organic, physiologic or psychiatric disturbance.

ASA 2: Patients with mild systemic disease: No functional limitations. Well controlled diseases. Examples include well-controlled hypertension or diabetes.

The following patients are generally not appropriate for office procedures, depending on the procedure and patient status:

ASA 3: Patients with severe systemic disease that is a constant threat to life. Has at least one severe disease that is poorly controlled or at end stage; possible risk of death; Examples include: unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure.

In addition, consider whether patients with an increased risk of bleeding or a history of poor pain control should have their procedure performed in the outpatient setting rather than the office.

Competency Assessment for All Procedures

**Initial Competency**

- A provider with proficiency with the planned procedure and who has already achieved office certification will function as a preceptor.
- The preceptor will review the indications, contraindications, procedure protocol and equipment, and verify that the provider being proctored follows the *Office Procedures Preceptor Evaluation Form*.
- Afterwards the preceptor will review the procedure and form with the proctored provider.
- The preceptor will turn in the form to the medical director, who will review the form and, when indicated, discuss the findings with both providers.
- In general, the medical director will consider granting “stand alone” privileges to a provider who completes 3 successful procedures, including following the guidelines listed in the *Office Procedures Preceptor Evaluation Form*. 
Continued Proficiency

- The medical director will review proficiency on an ongoing basis, and review with each provider at least once a year.
- The medical director will use the *Delineation of Privileges Form* to note which providers have received privileges.
Office Hysteroscopy

Procedure Definition:
Hysteroscopy is the visualization of the uterus and endocervix using a fiberoptic scope.

Indications:
• Evaluation of abnormal uterine bleeding.
• Removal of intrauterine or endocervical polyps, small fibroids, malpositioned IUDs, or foreign objects.

Precautions/Contraindications:
The following conditions are contraindications to office hysteroscopy:
• Known or suspected pregnancy.
• Untreated cervical or uterine infection.
• Active PID (pelvic inflammatory disease).

The following are relative contraindications to office hysteroscopy:
• Poor tolerance to prior ambulatory procedures.
• Known endometrial cancer.
• Suspected uterine length > 10 cm.

Materials:
• Mayo stand or other sterile field.
• Sterile gloves.
• Speculum.
• Povidone iodine solution and swabs or alternate antiseptic.
• Silver Nitrate sticks.
• Single toothed tenaculum.
• Uterine sound (measuring device).
• Either flexible or rigid hysteroscope (per provider preference).
• Grasping device (per provider preference).
• Hysteroscopy equipment stand with video monitor and light source.
• IV tubing for water infusion, including Luer lock.
• One liter (1 L) bag of sterile saline for infusion.
• Plastic garbage bag for water collection.
• Absorbent pad placed under patient’s buttocks.
• Paracervical block solution (if requested by provider):
  o Preloaded control syringe with lidocaine (1%, 2%, with or without).
  o 22-gauge needle with extender.
  o Medication labeled including expiration date, strength, and lot number.
Pretreatment patient evaluation:

- Pregnancy test for all patients < age 55 or if requested by provider.
- Identify patient by name and second identifier.
- Procedure consent form signed by patient and provider.
- Document any pre-procedure medications taken by patient (i.e. ibuprofen) and any medications administered to patient (i.e. ketorolac).
- Patient provided with post-procedure instructions including possibility of bleeding, how to manage pain, and when to return to office for both acute and routine follow up.
- All equipment listed above available in room prior to beginning procedure.

Procedure

1. Start light source and video equipment to make sure they are operating.
2. Using clean gloves perform bimanual exam to determine uterine size and position.
3. Place disinfected hysteroscope on Mayo stand or sterile field with light source connected.
4. Insert appropriate speculum and cleanse the cervix with either povidone iodine or other appropriate antiseptic.
5. Apply tenaculum to stabilize cervix.
6. Connect inflow and outflow tubing to appropriate channels, then insert hysteroscope.
7. Paracervical block and/or cervical dilation may be necessary if the hysteroscope does not easily pass through the internal cervical os.
8. Use just enough fluid to distend cavity, while observing patient for pain control.
9. Perform endometrial biopsy if indicated.
10. Turn off light source and equipment.
11. Count all instruments, needles and sponges.

Post-procedure

- Assess patient for pain control and observe for signs of vasovagal reaction.
- Instruct the patient to observe pelvic rest for 2 days or as clinically indicated.
- Advise the patient to anticipate intermittent uterine cramping for 1-7 days. Unless allergic, she may use over the counter NSAIDs for pain relief.
- Instruct the patient to observe for abnormally heavy bleeding or signs and symptoms of infection, (i.e. fever/chills, pelvic pain, severe abdominal cramping, abnormal or malodorous vaginal discharge) and to call if any problems develop.
- Review plan of care and/or follow up plans and provide written follow up information sheet to patient (or driver, as indicated).
Documentation

• Procedure consent signed by patient and provider, then filed per office protocol.
• Provider or assistant documents use of safety checklist.
• Documentation discusses informed consent process, lists all medications given, records hysteroscopy findings, and describes any abnormal clinical presentation or adverse response to the procedure or medications, patient instructions, and follow up plans.
• Order procedure, medications, and pathology specimen, if indicated, in computer.

Policy Revisions

• Policy created October 30, 2012.
LEEP Procedure

Procedure Definition:
A LEEP (loop electrosurgical excision procedure) uses an electrical current passed through a thin wire, usually to remove part of the uterine cervix as a treatment for cervical precancer (dysplasia).

Indications:
- Diagnosis and/or treatment of cervical pre-cancer (dysplasia).
- Removal of cervical lesions.
- Cauterization of vaginal granulation tissue.

Precautions/Contraindications:
The following conditions are contraindications to office LEEP:
- Known or suspected pregnancy.
- Untreated cervical or uterine infection.
- Active PID (pelvic inflammatory disease).
- Prior excessive bleeding during surgical procedures.

The following are relative contraindications to office hysteroscopy:
- Poor tolerance to prior ambulatory procedures.

Materials:
- Mayo stand or other sterile field.
- Sterile gloves.
- LEEP Speculum (has cannula for insertion of smoke evacuator tubing).
- Povidone iodine solution and swabs or alternate antiseptic.
- Single toothed tenaculum.
- Uterine sound (measuring device).
- Absorbent pad placed under patient’s buttocks.
- Colposcope (if procedure is being done for cervical dysplasia).
- LEEP machine including smoke evacuator / tubing and grounding pad.
- LEEP wires: 10mm, 15mm, 20mm, 25mm, 1mm “top hat” and ball cautery.
- Monsel’s solution
- Silver Nitrate sticks.
- 3-0 Vicryl suture, long needle driver, long forceps, and long scissors.
- Paracervical block solution:
  - Cntrolol syringe with lidocaine (ask provider about using lidocaine with epinephrine).
  - 22-gauge needle with extender.
  - Medication labeled including expiration date, strength, and lot number.
  - Maximum amount of lidocaine is 30 mL per patient.
Pretreatment patient evaluation:

- Pregnancy test for all patients < age 55 or if requested by provider.
- Identify patient by name and second identifier.
- Consent form signed by patient and provider.
- Document any pre-procedure medications taken by patient (i.e. ibuprofen) and any medications administered to patient (i.e. ketorolac).
- Patient provided with post-procedure instructions including possibility of bleeding, how to manage pain, and when to return to office for both acute and routine follow up.
- All equipment listed above available in room prior to beginning procedure.

Procedure

1. Place disposable grounding pad under patient’s buttocks or thigh. Make sure that the grounding pad completely adheres to the skin. It may be necessary to wipe away any skin lotion beforehand. NEVER PLACE THE GROUNDING PAD HIGHER THAN THE PATIENT’S HEART.
2. Make sure the patient is wearing socks or shoes, and that the metal stirrups are covered!
3. Place the disposable handpiece wire securely into the electrical connector at the machine. You may have to push harder than expected.
4. Attach the disposable tubing and filter to the smoke evacuator canister.
5. Insert appropriate speculum (with suction cannula).
6. Perform colposcopy if indicated.
7. Cleanse the cervix with either povidone iodine or other appropriate antiseptic.
8. Apply tenaculum to stabilize cervix. Place paracervical block.
9. After confirming analgesia, choose appropriate LEEP wire.
10. Set instrument to correct setting for the size wire you have chosen, using manufacturer’s suggested settings:
   a. 15mm wire: 38 (cut)
   b. 20mm wire: 40 (cut)
   c. 25mm wire: 42 (cut)
   d. Top Hat: 38 (cut)
   e. Ball cautery: 50 (cautery)
11. Use PPE including mask for provider and assistant(s).
12. Turn on smoke evacuator.
13. Complete LEEP procedure and send each specimen to pathology separately.
14. Cauterize LEEP bed with cautery ball and/or Monsel’s solution as indicated.
15. Remove speculum and verify there are no vaginal foreign objects. Count all needles, sponges and equipment.
**Post-procedure**

- Assess patient for pain control and observe for signs of vasovagal reaction.
- Instruct the patient to observe pelvic rest for 14 days or as clinically indicated.
- Advise the patient to anticipate intermittent uterine cramping for 1-7 days. Unless allergic, she may use over the counter NSAIDs for pain relief.
- Instruct the patient to observe for abnormally heavy bleeding or signs and symptoms of infection, (i.e. fever/chills, pelvic pain, severe abdominal cramping, abnormal or malodorous vaginal discharge) and to call if any problems develop.
- Review plan of care and/or follow up plans, including future cervical dysplasia/cancer screening.

**Documentation**

- Informed consent signed by patient and provider, then filed per office protocol.
- Provider or assistant documents use of safety checklist.
- Documentation discusses informed consent process, lists all medications given, records colposcopy findings (if performed), and describes procedure and any abnormal clinical presentation or adverse response to the procedure or medications, patient instructions, and follow up plans.
- Order procedure, medications, and pathology specimen in computer.

**Competency Assessment**

**Initial Competency**

- In addition to the competency requirements aforementioned, for LEEP procedures the preceptor and proctored provider will review the electrosurgical settings for each wire and the importance of the grounding pad and smoke evacuator.

**Policy Revisions**

- Policy created October 30, 2012.
Office Essure Coil Sterilization

Procedure Definition:
Permanent sterilization procedure where small coils are inserted into both tubal openings (ostia) using a rigid hysteroscope.

Indications:
• Patient desired permanent surgical sterilization.

Precautions/Contraindications:
The following conditions are contraindications to the Essure procedure:
• Known or suspected pregnancy.
• Untreated cervical or uterine infection.
• Known or suspected uterine malignancy.
• Active PID (pelvic inflammatory disease).
• Undiagnosed abnormal uterine bleeding.

The following are relative contraindications to the Essure procedure:
• Poor tolerance to prior ambulatory procedures.
• Uterine fibroids which distort endometrial cavity.

Materials:
• Mayo stand or other sterile field.
• Sterile gloves.
• Speculum.
• Povidone iodine solution and swabs or alternate antiseptic.
• Silver Nitrate sticks.
• Single toothed tenaculum.
• Uterine sound (measuring device).
• Rigid hysteroscope
• Grasping device.
• Hysteroscopy equipment stand with video monitor and light source.
• IV tubing for water infusion and compression sleeve.
• One liter (1 L) bag of sterile saline for infusion.
• Unopened Essure device package.
• Plastic garbage bag for water collection.
• Absorbent pad placed under patient’s buttocks.
• Paracervical block solution:
  o Preloaded control syringe with lidocaine.
  o 22-gauge needle with extender.
  o Medication labeled including expiration date, strength, and lot number.
Pretreatment patient evaluation:

- Pregnancy test for all patients < age 55 or if requested by provider.
- Identify patient by name and second identifier.
- Consent form signed by patient and provider.
- Document any pre-procedure medications taken by patient (i.e. ibuprofen) and any medications administered to patient (i.e. ketorolac).
- Note that use of NSAIDS prior to the procedure may increase effective coil placement.
- Patient provided with post-procedure instructions including possibility of bleeding, how to manage pain, and when to return to office for both acute and routine follow up.
- All equipment listed above available in room prior to beginning procedure.

Procedure

1. Start light source and video equipment to make sure they are operating.
2. Using clean gloves, perform bimanual exam to determine uterine size and position.
3. Place sterilized hysteroscope on Mayo stand or sterile field with light source connected.
4. Insert appropriate speculum and cleanse the cervix with either povidone iodine or other appropriate antiseptic.
5. Apply tenaculum to stabilize cervix.
6. Perform paracervical block.
7. Connect fluid tubing and outflow tubing to hysteroscope. Place under-buttocks bag for fluid collection.
9. Terminate procedure if fluid deficit exceeds 1500cc or hysteroscopic time exceeds 20 minutes.
10. Identify and assess both tubal ostia prior to insert placement. Do not attempt placement in one tubal ostium unless expectation of contralateral tubal patency exists.
11. Insert introducer through sealing cap on the operating channel of the hysteroscope. Keep the channel open to avoid damage to the device and introducer.
12. Insert delivery catheter through the introducer; avoid bending the insert tip. Under direct visualization, advance catheter through the operating channel into the proximal fallopian tube with gentle, constant forward movement to prevent tubal spasm. If excessive resistance occurs (i.e. catheter does not advance toward tubal ostium and/or catheter bends or flexes excessively), terminate procedure to avoid uterine perforation or placement into a false passage.
13. Align the proximal end of the **black** positioning marker with the ostium. Do not rotate the thumbwheel until the marker is properly aligned.

14. Stabilize the delivery system handle against the hysteroscope to prevent inadvertent forward movement. Rotate the thumbwheel on the handle toward you until the wheel no longer rotates (corresponds to the symbol on the delivery system handle). The delivery catheter and black positioning marker will move away from the tubal ostium and disappear into the operating channel, exposing approximately 1 cm of the wound-down insert. **NOTE:** The thumbwheel cannot be reversed, therefore, ensure that the proximal edge of the black positioning marker is aligned at the ostium before rotating thumbwheel.

15. Stop and check proper positioning, which corresponds to the symbol on the delivery system handle. Confirm placement of the **gold marker band** just outside the ostium, and confirm visualization of the distal tip of the green release catheter. If more than 1 cm of the insert is visible in the uterus, then the insert should be repositioned by moving the entire system further into the tube, if possible.

16. Press the button on the delivery handle which corresponds to the symbol on the handle button. This enables the thumbwheel to be rotated further for insert deployment. **NOTE:** DO NOT PUSH THE BUTTON until delivery system is in correct position for insert placement.

17. Rotate the thumbwheel once more until the thumbwheel cannot turn any further. When the thumbwheel cannot be rotated any further and the expanded outer coils are visible, remove the delivery system. Note: Hold the valved introducer in place during removal of the delivery system as it may also be inadvertently withdrawn. If the introducer is removed, replace with a new introducer.

18. Perform procedure on contralateral fallopian tube.

19. Verify and document the number of coils present on each side. Ideally, each tubal opening will have between 3-8 coils. Do not attempt to remove coils.

20. In the event of placement failure, inform patient permanent contraception is not complete. Approximately 80% of patients will have successful placement of the remaining insert after their next menses.

21. Turn off light source and equipment. Count all needles, sponges and equipment.

**Post-procedure**

- Assess patient for pain control and observe for signs of vasovagal reaction.
- Instruct the patient to observe pelvic rest for 2 days or as clinically indicated.
- Advise the patient to anticipate intermittent uterine cramping for 1-7 days. Unless allergic, she may use over the counter NSAIDs for pain relief.
- Instruct the patient to observe for abnormally heavy bleeding or signs and symptoms of infection, (i.e. fever/chills, pelvic pain, severe abdominal cramping, abnormal or malodorous vaginal discharge) and to call if any problems develop.
• Review plan of care and/or follow up plans, including 3 month post-procedure hysterosalpingogram (HSG). Remind patient to continue contraception or prescribe contraception and remind patient that she cannot rely on the Essure procedure for contraception until the HSG in 3 months reveals bilateral tubal occlusion.

Documentation

• Informed consent signed by patient and provider, then filed per office protocol.
• Provider or assistant documents use of safety checklist.
• Documentation discusses informed consent process, lists all medications given, records hysteroscopy findings, and describes any abnormal clinical presentation or adverse response to the procedure or medications, patient instructions, and follow up plans.
• Essure-specific documentation includes the number of coils placed in each tubal opening and discussion with the patient about inability to rely on Essure for sterilization until she has undergone confirmatory HSG.
• Order procedure, medications, and pathology specimen, if indicated, in computer.

Policy Revisions

• Policy created October 30, 2012.
INTRAUTERINE DEVICE INSERTION

Procedure Definition:
Intrauterine placement of the Paragard® Ior Mirena® IUD for long term contraception.

Indications:
Patients desiring long term contraception.

Precautions/Contraindications:
The following conditions are contraindications for IUD/IUS placement:
- Known or suspected pregnancy
- Uterine didelphys (“double uterus”)
- Untreated cervical or uterine infection.
- Active PID (pelvic inflammatory disease).
- Unexplained abnormal uterine bleeding.

The following are relative contraindications for IUD/IUS placement:
- Uterus sounds (measures) < 6cm or > 10 cm.
- Prior ectopic pregnancy.
- History of PID.
- Multiple sexual partners.
- HIV positive or other impaired immune system.
- Allergic to copper (Paraguard only).
- Active liver disease (Mirena only).
- History of breast cancer (Mirena only).
- Allergic to progestogens (Mirena only).

Materials:
- Sterile field.
- Sterile gloves.
- Speculum.
- Mirena or Paraguard IUD, unopened until requested by provider.
- Povidone iodine solution and swabs or alternate antiseptic.
- Silver Nitrate sticks.
- Single toothed tenaculum.
- Uterine sound (measuring device).
- Long-handled scissors.
- Paracervical block solution (if requested by provider):
  - Preloaded control syringe with lidocaine.
  - 22-gauge needle with extender.
  - Medication labeled including expiration date, strength, and lot number.
Pretreatment patient evaluation:

- Pregnancy test for all patients < age 55 or if requested by provider.
- Identify patient by name and second identifier.
- Consent form signed by patient and provider.
- Patient aware of long-term aspect of this contraceptive.
- Patient provided with post-procedure instructions including possibility of bleeding, how to manage pain, and when to return to office for both acute and routine follow up.
- All equipment listed above available in room prior to beginning procedure.

Procedure

16. Using clean gloves, perform bimanual exam to determine uterine size and position.
17. Insert appropriate speculum and cleanse the cervix with either povidone iodine or other appropriate antiseptic.
18. Apply tenaculum to stabilize cervix, then sound (measure) the uterus. Do not open IUD package until uterus has been sounded and provider requests IUD.
19. Open IUD package and remove IUD (using sterile gloves).
20. Using sterile gloves, withdraw the IUD into the cannula per system directions.
21. Set “hard stop” flange on IUD insertion shaft according to uterine sound measurement.
22. Insert the IUD into the uterine cavity according to manufacturer’s instructions.
23. Paracervical block and/or cervical dilation may be necessary if the sound (or IUD) does not easily pass through the internal cervical os.
24. Cut strings to appropriate length (approximately 3cm).
25. Count all needles, sponges and equipment. Verify no vaginal foreign objects.

Post-procedure

- Assess patient for pain control and observe for signs of vasovagal reaction.
- Instruct the patient to observe pelvic rest for 2 days.
- Advise the patient to anticipate intermittent uterine cramping for 1 day to 2 weeks. Unless allergic, she may use over the counter NSAIDs for pain relief.
- Instruct patient how and when to check for IUD strings.
- Instruct the patient to observe for abnormally heavy bleeding or signs and symptoms of infection or perforation, (i.e. fever/chills, pelvic pain, severe abdominal cramping, abnormal or malodorous vaginal discharge) and to call if any problems develop.
- Review possible changes in bleeding pattern with IUD use.

Documentation

- Informed consent signed by patient and provider, then filed per office protocol.
- Provider or assistant documents use of safety checklist.
- Documentation discusses informed consent process, lists all medications given, records the IUD lot number, and describes any abnormal clinical presentation or
adverse response to the procedure or medications, patient instructions, and follow up plans.
- Order procedure, medications, and IUD in computer.
Patient Rights and Responsibilities and Protected Health Information

PHI (Protected Health Information)

Our practice follows federal and Florida Hospital requirements for protecting our patient’s health information. PHI (Protected Health Information)

Please refer to the hospital’s PHI (Protected Health Information) statement on the Intranet or the statement that is available at registration.

Protected Health Information (PHI)
PHI is individually identifiable health information maintained in, or transmitted by, electronic media (Internet, extranet, leased lines, dialup lines, private networks, magnetic tapes, disks, or compact disk media). This definition specifically excludes education and employment records.
PHI also includes ALL patient records that are created, received, or stored by Florida Hospital and any patient records that are transmitted in any form.

Notice of Patient Privacy Practices (NPPP)
Individuals have the right to be informed of the privacy practices of the Medical Education Department through the NPPP. The NPPP is given to patients during the registration process. An acknowledgement of receipt of NPPP is obtained also during the registration process as required by HIPAA. This acknowledgement is located on the bottom of the Consent to Treatment and Authorizations.

Restriction of PHI
The Medical Education Department recognizes that patients have the right to request restrictions to their PHI. Refer to the General Regulatory Guidelines, Section Z, of these guidelines for the Medical Education Department Restriction of PHI Policy.

Consent to Treatment and Authorizations
The Medical Education Department Consent to Treatment and Authorizations is signed yearly by the patient and filed in the Registration Area

This office provides an English and Spanish PHI form to all patients at the registration area.

All office employees are required to sign a statement upon initial employment, then annual, that acknowledging that compliance of PHI is mandated.

If you believe that patient PHI is being accessed inappropriately report this immediately to the practice manager, head nurse, or medical director.
Records Transfer

Transferring records between providers or healthcare entities is an important mechanism for assuring safe continuity of care.

Please refer to the Florida Hospital Medical Education Department Medical Records Guidelines, which is available on the “H” drive on the Intranet.
Communication with Patients:

There are several methods of communicating with patients, including reporting test results. The practice uses a secure, password protected EHR to document patient encounters, including telephone calls.

Telephone:

- Telephone calls from patients require an entry into the EHR, usually within the “telephone encounter” section.

Email:

- The practice does not use email as a form of secure communication of PHI. For example, emails should not be used for patient questions, plan of care discussions, results and PHI.

- On occasion a patient, usually a hospital employee, will send an email to a provider or team member. The appropriate response is to copy that email and “paste” it into the EHR under a telephone encounter. Then generate any orders or communication with other team members that are necessary to care for the patient.

Mail:

- The practice uses US Mail to send letters to patients regarding lab and imaging results.

After hours or on call communication:

- There is always a physician available on call for our practice.

- During practice operating hours, any team member can reach the on call physician using the pager (either numeric or alpha text), via telephone, or by calling the labor and delivery unit.

- Clearly state why you need the on call physician, and be prepared to provide the patient’s name and second identifier (usually a birth date), the clinical situation, any relevant objective information such as vital signs, labs, or imaging study results, and your interpretation of the situation.

- If the patient requires evaluation at the hospital, notify the patient of where to proceed (for example, specific directions to labor unit, or directions to emergency department). Also be prepared to fax information to the labor unit or other hospital unit using the hospital’s fax system.
• The on call physician can generate a telephone encounter or similar method of documenting an after-hours call. If the physician wishes the clinical team or scheduling staff to speak with a patient the next day during normal operating hours, the physician can send a telephone encounter to a team member using the EHR. An alternative is to phone the team member the next morning. However, in all cases the provider or team member should document the discussion and plan of care within the EHR.
Management and Tracking of Labs, Imaging Studies and Referrals

The Loch Haven practice uses an electronic health record (EHR) to order medications, labs, radiologic studies, and referrals. In order to prevent a result “falling through the cracks” the practice utilizes a system to track results.

Tracking results:

The medical director, practice manager and head nurse work with the EHR team to set parameters for when a result is considered overdue. The overdue notice populates the provider’s EHR “Overdue” inbasket, triggering a review by the provider who ordered the lab, imaging study, or referral.

Notifying patients of results:

- All results, regardless of severity, require notification of the patient.
- Providers have several options for notifying patients of results:
  - Discuss results at a follow up office visit.
  - Telephone patient.
  - Generate a letter in the EHR.
  - Forward the results using EHR to one of the clinical staff, who will phone patient.
- In all cases except when a letter is generated, the team member who notifies patient will generate documentation in the EHR detailing the date and time they spoke with or notified the patient, and any discussion or plan of care that resulted from that discussion.

Managing overdue results:

- When a provider is notified of an overdue result, there are several options:
  - Forward the overdue notice to a nurse or MA for disposition.
  - Notify patient by telephone.
  - Discuss with patient at a follow up office visit.
  - Send a letter to the patient.
  - Finalize the overdue notice.
- In all cases, the person finalizing the notice will document the reason for finalizing. For example, “patient has scheduled appointment” or “patient declines lab for the following reason:” or “patient will obtain mammogram in 2 months and verifies that she has appointment.”
- If a clinical team member is concerned that the patient will not obtain a necessary lab, imaging study, or referral, then the team member should...
generate an EHR notification to the provider who ordered the test, study, or referral.

Generating and Tracking Referrals:

• The provider generates a referral order in the EHR.

• The referral coordinator generates the appropriate insurance information and mails or hands patient a copy of the referral letter and relevant information.

• When the referral correspondence returns (for example, an office note or letter), the team member entering the note into the EHR will finalize the referral order.

• When an overdue notice arrives in the HER, the provider has several options, similar to those used for labs and imaging studies (also, see “Managing Overdue Results” section):
  o Forward the overdue notice to a nurse or MA for disposition.
  o Notify patient by telephone.
  o Discuss with patient at a follow up office visit.
  o Send a letter to the patient.
  o Finalize the overdue notice.

• The team member finalizing the overdue notice will document resolution or any discussion with the patient or consulting physician in the EHR.
Medication Safety

In order to decrease the risk of medication errors the practice uses the following policies.

Administering medications:

- Only trained clinical staff members may administer medications, per Florida Hospital policies.
- The head nurse has a list of which clinical team members may administer medications.
- The team member administering a medication (for example, a contraceptive injection) should identify the patient and a second identifier (for example the birth date) and ask about medication allergies. The team member should also notify the patient of the medication being given and route of administration.
- Always check the name of the medication and expiration date.
- After washing hands and donning gloves, prep the area with an alcohol pad.
- The team member administering the medication must document the medication, strength, route of administration, lot number, expiration date, and any adverse events (for example, hypotension or fainting).
- If a medication is drawn from another source and placed into a different container, the new container must be labeled with today’s date, medication name, strength, lot number and expiration date.
- It is a safe practice to confirm each medication administered with the provider. For example, “I am verifying that this is 1% plain lidocaine.”

Local Anesthetics

Local anesthetics like lidocaine can cause allergic reactions and cardiovascular collapse, seizures, and death. Here are some general guidelines to improve the safe administration of these medications:

- Lidocaine comes in 1% plain, 2% plain, and 1% or 2% with epinephrine, sometimes called “with or without epi.”
- The vials used in the office are usually 10mg/mL. Therefore, a 10mL syringe contains 100mg of lidocaine. A 20-mL syringe would contain 200mL.
- The ADULT dose of lidocaine should not exceed 7mg/kg (about 3.5mg/pound). A safe guideline is not to exceed 300mg (a 30-mL syringe) at one time.
- If you notice lightheadedness, dizziness, ringing in the ears, or drowsiness then the injection should stop immediately and you should institute patient assessment and treatment, including securing the patient’s airway, notification of office leadership for assistance, and placing patient in a recumbent position if possible.
- Worsening symptoms like convulsions, coma, respiratory depression or arrest, muscle twitching, syncope, or cardiovascular shock require notification of 911 for transport to the hospital.
Prescribing practices:

- Only legally authorized providers may prescribe medications.
- All prescribed medications require an entry into the EHR.
- Medication requests by telephone, fax, or email require documentation in the EHR. Documentation should include who is requesting the medication, the dosage, strength, route of administration, and refills.
- Triage team members should generate a medication request in the EHR and forward this to the prescribing provider (also see triage policy section).
- If a power outage prevents contemporaneous documentation in the EHR, and the provider uses a paper prescription, that information will be entered into the EHR once the service interruption has resolved.

Using abbreviations:

Many medications sound the same or have similar abbreviations. Using "look alike, sound alike" medications can be dangerous. In order to prevent prescribing or administrating the incorrect medication, the practice uses the Florida Hospital list of "unapproved abbreviations." However, it is safe practice to enter the entire medication name rather than an abbreviation whenever possible.

The following is a list of abbreviations NOT to be used at Florida Hospital per Policy #700.703:

- Cc cubic centimeter
- U unit
- IU international unit
- MS morphine sulfate
- MS04 morphine sulfate
- MgSO4 magnesium sulfate
- QD every day
- QOD every other day
- Ss sliding scale
- Sub q or SC Subcutaneous

Lack of leading _0_ (.4 mg) (Should be 0.4 mg)
Trailing _0_ (4.0 mg) (Should be 4 mg)

Verbal orders:

- Verbal orders should be uncommon in an ambulatory practice.
- Verbal orders from a provider to a nurse or MA require a “read back” by the nurse or MA to assure that the verbal order is accurate.
- The nurse or MA must document the medication in the EHR as described above and forward the encounter to the ordering provider for co-signature.
Medication Storage:

- Only clinical team members have access to stored medications.
- All refrigerated medications require storage in a hospital-approved refrigerator.
- Narcotics are not stored or administered at this practice.

Medication Samples:

- The medication sample closet must remain locked.
- Only clinical team members have access to the locked sample closet.
- When providing samples, providers must use the medication sample log to record the medication information. The log is located in the sample closet.
- The EHR has the capability of entering medications as samples and providers are encouraged to use this function.
- Samples cannot be provided to anyone who is not a patient at the practice.
**Triage Policies**

**Telephone Triage:**

- Also refer to the Graduate Medical Education Telephone Triage Guidelines available on the “H” drive on the hospital’s Intranet.
- All triage calls require documentation in the EHR, usually in the “telephone encounter” section.
- Always ask patients under age 50 whether the patient could be pregnant or is pregnant.
- When the patient has symptoms that necessitate evaluation by a physician, the options are to discuss with an office physician, refer patient to labor unit, or refer patient to emergency department. These encounters require that the triage team forward the encounter to the provider for review.
- If a patient is referred to the labor unit or emergency department, notify the on-call physician. Be prepared to fax the patient’s records to the labor unit if indicated.
- When in doubt of the best response, utilize the head nurse, a provider in the office, or the medical director.

**Medication Triage**

- Only legally authorized providers may prescribe medications.
- All prescribed medications require an entry into the EHR.
- Always ask the patient about medication allergies and update the EHR if necessary.
- Medication requests by telephone, fax, or email require documentation in the EHR. Documentation should include who is requesting the medication, the dosage, strength, route of administration, and refills.
- Triage team members should generate a medication request in the EHR and forward this to the prescribing provider. Notify the patient (or pharmacy) that the provider may take several days to respond, depending on the provider’s schedule.
- If the medication request is urgent, either forward the request to a provider who is in the office, or notify the on-call physician by numeric page, alpha page (preferred) or phoning the hospital on-call telephone.
- On occasion a pharmacy or patient will request the substitution of a similar oral contraceptive due to insurance or co-pay reasons. The triage team is authorized by the medical director to make a similar substitution as requested by the pharmacy or patient. However, this requires that the encounter be forwarded
Emergency Management and Fire Safety

Medical emergencies can occur in outpatient medical offices. Our practice follows Florida Hospital requirements for Basic Life Support (BLS) training. If a medical emergency occurs, the initial response involves obtaining help and making sure the patient is breathing appropriately.

1. Call for help. Each room has a telephone to call extension 1449 (back line) and 911 when indicated to request assistance.
2. If a physician is not in the room, request that a physician respond immediately.
3. Secure the “ABCs” (Airway, Breathing and Circulation).
4. There is an oxygen tank with a mask and tubing located either in the procedure room, or in the clean supply closet in the hallway. Place the oxygen cannula in the patient’s nose and turn the dial on the tank to 2Liters. (If the provider requests this, or the patient is short of breath, then place the mask securely over the patient’s nose and mouth and turn the dial to 10 Liters of flow). Check to make sure that oxygen is flowing into the mask.
5. Obtain vital signs (blood pressure and pulse and respiratory rate), record these and the time, and report these to the physician.
6. If the patient is unstable or bleeding heavily then call 911 and provide the practice name and address and nature of the emergency. Then phone the front desk to notify them to send someone downstairs to wait for the emergency medical team (EMS).
7. Once the patient is stable enough, or after transport, the lead clinician will call the emergency department and provide a “hand off” to transfer care.

Heavy Bleeding:

If a patient is bleeding heavily, call for assistance and notify a physician in the office. Provide the following equipment to assist:
- Multiple gauze packs.
- Monsel's solution.
- “Tool Box” with various sutures, needle driver, and long scissors.
- There is IV equipment in the clean room.
- Call 911 for hospital transport if the bleeding cannot be stopped quickly or as directed by the physician.

Cardiac Arrest:

- Secure the airway.
- Obtain vital signs (BP, pulse, respirations) and record.
- Initiate CPR if indicated per BLS Guidelines,
- There is an AED located on the first floor. Direct one of the office staff to obtain this if it appears that the patient is having a cardiac event.
- Call 911 for hospital transport.
Precipitous Delivery:

- If a patient appears to be delivering in the office, obtain the delivery pack from the clean room.
- Place a pillow under the patient’s left or right hip and back so that she is not flat on the table.
- Call 911 as soon as possible to transport patient (or patient and baby) to the hospital.

Disruptive patient or visitor:

- If a patient or visitor is disruptive, notify the office leadership.
- If it appears the patient or visitor is dangerous or threatening, dial 911 away from the disruptive person and ask for immediate assistance.
- If you are in fear for the safety of our patients or yourself or our staff, initiate office evacuation. The most likely evacuation point will be the back stairwell, although if the disruptive person is in the back clinical area, it may be more appropriate to evacuate from the front stairwell.
- Follow fire evacuation procedures for clearing each exam room.

Fire Safety:

- Follow Florida Hospital fire safety guidelines.
- Notify all office staff that there is a fire and to evacuate the office.
- Direct someone to call 911.
- Patients and staff in the waiting room should evacuate by the front stairs if able.
- Patients and staff in the back office should evacuate by the back stairs if able.
- Clinical staff will evacuate each of their hallways and the procedure room at the end of their hallway.
- The triage nurses will evacuate the back bathrooms including the bathrooms in the main hallway and the office lounge.
- The front office staff will evacuate the front bathrooms.
- Notify each patient to leave urgently and direct them to the nearest stairwell.
- Check each room and leave the door open. Once clear, evacuate the office and meet in the parking area. Do not leave the parking area until our leadership team can obtain a staff head count, or unless directed to leave by emergency response personnel.

Non-office Emergencies:

- Our practice will follow the Florida Hospital emergency management plan, which includes a “call list” for office personnel.
Emergency Drills

Clinical emergency drills, or team safety drills, are designed to foster team communication, help team members learn what to do when an uncommon emergency occurs, and identify areas where better communication, different equipment, or safer office processes can improve patient care.

At least once a quarter all available office team members will participate in a safety drill. In general, the drill will be help at a time which maximizes staff participation. The medical director (or designee) and head nurse (or designee) will supervise the drills. The goal of the safety drill is to respond to a staged emergency the same way team members would respond to an actual emergency.

Examples of emergency drills:

- Vasovagal response.
- Excessive bleeding.
- Vaginal delivery in the office.
- Umbilical cord prolapsed.
- Allergic reaction.
- Cardiac arrest.

Emergency drill procedure:

1. Medical director and head nurse will prepare staging area.
2. Practice manager or head nurse will notify team of drill.
3. Supervisor will use Office safety drill checklist form during the drill.
4. After the drill, the team will hold a debriefing to evaluate what worked correctly, where we can make improvements, and identify equipment or process concerns.
5. Team members will sign in using the log sheet on the Office safety drill checklist form.

Attendance:

- It is expected that all staff, including providers, clinical staff, and “front office” staff attend at least 2 emergency drills every year.