MEDICAL STAFF RULES & REGULATIONS

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ARTICLE I - ADMISSIONS

Section 1: Who May Admit Patients

Patients may be admitted to the Hospital only by Active members of the Medical Staff. Patients shall be assigned to the Department and/or Division concerned in the treatment of the condition which necessitated admission. Every patient admitted to the Hospital must have a designated Medical Staff member who is responsible for his/her care. Patients presenting for admission who have no personal physician/dentist shall be assigned an attending physician/dentist.

Section 2: Responsibilities of Admitting Physician/Dentist

Information pertinent to the patient's general health as well as information necessary to protect the patient and others from harm shall be provided by the admitting physician/dentist.

Section 3: Provisional Diagnosis Requirements

Except in emergency, no patient shall be admitted to the Hospital until after a provisional admitting diagnosis has been made and recorded in the medical record. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

Section 4: Required Pre-Admission/Admission Tests

The requirement for pre-admission tests is based on the needs of individual patients. Each patient admitted to the Hospital shall have diagnostic studies performed as necessary for the diagnosis and treatment of his/her condition.

Section 5 – Patient Acceptance

The Hospital shall accept patients regardless of race, gender, disability, age, national origin or sexual preference (See also, SLCH Policy entitled Patient Age Guidelines for Admission concerning patients aged 18 years or older).

Section 6 – Family Members

A Medical Staff member shall not render direct patient care to a member of his/her immediate family without expressed written permission from his/her Department Chief. "Immediate Family" includes a spouse, parent, child or sibling. A Medical Staff member may, however, serve as a consultant on a case involving an Immediate Family member.

ARTICLE II - ATTENDING PHYSICIAN/DENTIST

Section 1: Responsibilities of Attending Physician/Dentist

a) Physician

The attending physician shall be responsible for the medical care and treatment of his/her patient, for prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the patient's condition to the referring physician, other relevant care providers and the parent(s)/guardian of the patient. The attending physician shall also be responsible for the medical supervision of all who participate in the delivery of care for his/her patient.

b) Dentist

The attending dentist shall be responsible for the care and treatment of his/her patient, for prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the patient's condition to the referring physician/dentist, other relevant care providers and the parent(s) guardian of the patient. Attending dentists shall have the same responsibilities as physicians except that, at all times, the patient's general medical condition shall be the responsibility of a physician. See Article VII Dental Care, Section 2 of these Rules and Regulations.

ARTICLE III - COLLABORATIVE PRACTICE AGREEMENT

Section 1: Definition

Collaborative practice AGREEMENTS may be entered into by physicians, physician assistants ("PA") and advanced practice nurses ("APN"). Such arrangements shall be established through written agreements for the delivery of health care services and must include the approval of the appropriate Department Chair of Washington University School of Medicine and the President of the Hospital through the Credentialing Subcommittee reviewed by the Children's Medical Executive Committee ("CMEC). Collaborative practice agreements authorize physician assistants and advanced practice nurses to provide assessments, diagnosis, treatment, and to prescribe, administer and dispense drugs as the delivery of such health care services is within the scope of practice of the physician assistant or advanced practice nurse and is consistent with his or her skill, training and experience. Collaborative practice arrangements do not, however, authorize physician assistants and advanced practice nurses to prescribe controlled substances.

Section 2: Definition – APN and PA in Collaborative Practice

An advanced practice nurse is a registered nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Missouri State Board of Nursing. Advanced practice nurses will be credentialed and approved by the medical staff organization in accordance to the administrative policy attached entitled "Advanced Practice Registered Nurse Credentialing and Scope of Practice Policy".

Use of the term "advance practice nurse" in the Medical Staff Rules and Regulations refers to those advanced practice nurses who have entered a collaborative practice arrangement at St. Louis Children's Hospital and who have received a Document of Recognition from the State Board of Nursing in accordance with applicable Missouri statutes and regulations.

Section 3: Relationships between APNs, PAs and Attending Physicians

When a Physician Assistant and APN in collaborative practice has been delegated responsibility by his or her collaborating physician to care for a patient, it remains the collaborative physician's responsibility to coordinate the patient's care with any other attending physician responsible for the patient.

ARTICLE IV - INFORMED CONSENT

Section 1: Definition

"Informed consent" means consent obtained by a physician, dentist, advanced practice nurse OR PROVIDER for the patient's course of treatment for those procedures he/she will perform, or, for placement of PICC lines only, registered nurses who are trained to insert a PICC and will be personally performing the procedure. Informed consent should be obtained from the patient, his/her parent(s) or person(s) responsible for care based on discussion of the nature, benefits, significant risks and alternatives to the proposed treatment, care or services.

Section 2: Responsibility of Obtaining Informed Consent

At the time of admission or as soon thereafter as practical, the Hospital's standard admission consent form(s) must be obtained and signed by the parent(s) or person(s) responsible for care or, when appropriate, by the patient. The admitting department shall notify the attending physician/dentist whenever such consent has not been obtained.

After admission, it shall be the responsibility of the appropriate physician/dentist to obtain consent from the patient, his/her parent(s), person(s) responsible for care, or other authorized representative, e.g. individual authorized under durable power of attorney for healthcare decisions in accordance with the Hospital policy on Informed Consent (Attached as St. Louis Children's Hospital Informed Consent).

1. In cases requiring anesthesia, the anesthesiologist shall obtain consent for administration of the anesthesia.

2. In cases requiring sedation, the physician, dentist, or provider shall obtain consent for administration of sedation.

An advanced practice nurse in collaborative practice who performs procedures may obtain informed consent for procedures the APN will perform. Nurses who are trained in PICC placement may obtain consent for PICC placements they personally perform.
Telephone consent from a parent or person responsible for care of the patient is permissible in such circumstances as long as it is obtained by physician/dentist and witnessed by a licensed health care professional. Telephone consent must be documented in the medical record and signed by the physician dentist and the witness.

Except in emergencies, no procedure shall be performed without a documented consent in the patient's medical record prior to the performance of the procedure. Oral consents are permitted if obtained by a physician/dentist and witnessed by a licensed health care professional. Such oral consents must be documented in the medical record.

Section 3: Emergency Care and Treatment Without Consent

1. Emergency care and treatment may be provided to a patient without consent when, in the judgment of the treating physician/dentist, any delay may increase the risk to the

patient's life, health, mental health or welfare, or unduly prolong suffering. In such cases, the treating physician/dentist shall document in the patient's medical record the reasons for rendering care without consent. If the treating physician/dentist is a resident or fellow, the note shall be finalized by the attending physician/dentist.

2. When emergency treatment (other than surgery or special procedures) is begun without parental or guardian consent, attempts to reach the parent(s) or person(s) responsible for care by telephone shall be initiated as soon as possible.

Section 4: Duration of Validity of Informed Consent

Signed consent is valid for the duration of an admission unless significant change in the patient's condition warrants consent based on new information. Signed consent for outpatient procedures is valid unless there has been significant change in the patient's condition since consent was first obtained.

ARTICLE V - CONSULTATIONS

Section 1: Required Consultations

Consultation shall be obtained whenever the responsible physician or other responsible practitioner believes that such consultation may prove beneficial to the patient, when the patient's condition requires expertise beyond the scope of the responsible practitioner, or if appropriate, at the request of the parent or person(s) responsible for care.

Section 2: Definition of a Consultant

Members of the Medical Staff or their designees may serve as consultants. In special situations, qualified practitioners not on the Medical Staff who have been granted temporary privileges may be invited to visit patients in the Hospital and advise the requesting practitioner, as well as observe the course of treatment. Such consultants may not assume responsibility for the patient; responsibility for the patient remains with the attending physician/dentist.

Section 3: Composition of Consultations

A consultation includes an examination and/or observation of the patient, review of the record and timely communication with the requesting physician/dentist. A recorded opinion finalized by the consultant must be included in the medical record. If a medical/psychiatric consultation is performed by a designee who is not a member of the Medical Staff, it must be countersigned by a member of the active Medical Staff. When operating procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

ARTICLE VI - DEATHS

Section 1: Pronouncement of Death

Death is officially pronounced by a physician and documented in the medical record.

Documentation shall include the events leading to the death, date and time the patient was pronounced dead and the signature of the physician and his/her appellation.

Section 2: Determination of Brain Death

Brain death shall be determined in accordance with current St. Louis Children's Hospital policy, attached as Exhibit 3. Medical record entries for death by neurologic criteria shall be made in accordance with this policy.

Section 3: Reporting of Deaths to the Medical Examiner

Physicians shall report deaths of children fifteen years and under to the St. Louis City or County Medical Examiner in accordance with the State statute. In addition, State statute requires reporting of death as a result of:

A. Violence by homicide, suicide or accident;

B. Thermal, chemical, electrical, or radiation injury;

C. Criminal abortion including those self-induced;

D. Disease thought to be of a hazardous and contagious nature or which may constitute a threat to public health; or

E. When any person dies

1. Suddenly when in apparent good health,
2. When not attended by a physician or licensed practitioner during the period of thirty-six hours immediately preceding the death,
3. While in the custody of the law or while an inmate in a public institution, or
4. In an unusual or suspicious manner.

Section 4: Autopsies

It shall be the duty of all physicians/dentists to request consent for autopsy in the following situations (as recommended by The College of American Pathologists):

A. Deaths in which autopsy may help to explain unknown and unanticipated medical complications.
B. Deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
C. When the autopsy may help to allay concerns of the family, physicians and/or the public regarding the death.
D. When unexpected or unexplained deaths occur during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
E. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (1) persons dead on arrival at hospitals, (2) deaths occurring in hospitals within twenty-four (24) hours of admission, and (3) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
F. Deaths resulting from high-risk infectious and contagious diseases.
G. All perinatal and pediatric deaths.

H. Deaths at any age in when it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
I. Deaths known or suspected to have resulted from environmental or occupational hazards.

No autopsy shall be performed without the proper written legal consent and administrative approval. No autopsy shall be performed without a complete medical history, including establishing status regarding Kreutzfeldt-Jakob disease. All autopsies shall be performed by a Hospital Pathologist or by a physician delegated this responsibility.

ARTICLE VII - DENTAL CARE

Section 1: Oral and Maxillofacial Surgeons

Qualified oral and maxillofacial surgeons may perform the history and physical examination in accordance with their delineated privileges. Patients with medical problems outside the scope of the oral and maxillofacial surgeon's expertise require joint evaluation and management with a physician.

Section 2: Other Dental Specialists

Services not requiring general anesthesia may be provided by the dental specialist who is responsible for the dental-related history and physical examination and for administration and monitoring of local anesthesia and sedation in accordance with the St. Louis Children's Hospital Medical Staff policy on sedation.

Services requiring general anesthesia require a history and physical examination performed by a physician as specified in the Surgical Care section of this document. Patients with medical problems require joint evaluation and management with a physician. See Article II Attending Physician/Dentist, Section 1.b of these Rules and Regulations.

ARTICLE VIII - DISCHARGES

Section 1: General

At the time of discharge, the medical record must reflect all relevant diagnoses and operative procedures performed and an assessment of the patient's needs for services after hospitalization. Discharge instructions, prescriptions and any referrals should be finalized and reviewed with the patient and family/adult care provider prior to discharge.

Section 2: Leaving Against Medical Advice

If a patient leaves the Hospital against the advice of the physician/dentist, or without proper discharge, a notation of the incident shall be made in the patient's medical record. When possible, the patient or family/adult care provider shall be asked to sign the Hospital's release form.

ARTICLE IX - EMERGENCY SERVICES

Section 1: General

The Emergency Unit provides initial evaluation and treatment to pediatric patients seeking unscheduled care at St. Louis Children's Hospital for medical, dental and/or surgical problems. All patients presenting to the Emergency Unit will receive a medical screening examination to determine whether an emergency condition exists. This exam will be performed by a registered nurse, an advanced practice nurse (including pediatric nurse practitioner), or a physician. An attending physician or designee will be available at all times for consultation regarding medical screening examinations. Specifics regarding Emergency Unit physician's responsibilities and coverage, documentation, consent to treatment, collaborative practice arrangements and admission to the Hospital are enumerated in the Emergency Unit policy and procedure manual. The contents of such manual shall be developed by the Emergency Unit Policy and Procedure Committee and approved by the Children's Medical Executive Committee.

All emergency department patients shall be assessed prior to discharge by a physician or an advanced practice nurse.

Section 2: Coverage

At least one (1) attending physician shall be on duty twenty-four (24) hours per day, seven (7) days per week to provide emergency services.

Each Department Chief is responsible for providing call lists of House Staff and/or attending physicians on duty or on call to respond to calls from the Emergency Department. On-call or on-duty physicians taking emergency call shall arrive at the Emergency Department within thirty (30) minutes of being summoned. The Trauma attending physician on-call or on-duty shall arrive at the Emergency Department within fifteen (15) minutes of being summoned.

ARTICLE X - INTENSIVE CARE UNITS

Section 1: Admission and Discharge Criteria

Admission to and discharges from the intensive care units shall be in accord with the policies and procedures reviewed by the appropriate hospital and medical staff leaders and approved by the Children's Medical Executive Committee.

ARTICLE XI - MEDICAL RECORDS

Section 1: General Rules.

A medical record shall be created for each patient, and it shall be the responsibility of the attending physician, or his/her designee (House Staff, APN in collaborative practice) to maintain the record complete, current, legible, dated, timed, authenticated, recorded, pertinent, and in accordance with the policies recommended by the Health Information Management (HIM) Subcommittee and established by the Medical Executive Committee. The medical record includes both paper and electronic documents which include: patient's name, unique identifying medical record number, pertinent identifying personal data, a

history of present illness, if injury, how it occurred, past history, family history, physical examination, admitting diagnosis, Medical Staff orders, progress notes, nurses' notes, discharge summary, final diagnosis and evidence of informed consent. Where applicable, the medical record should also contain reports from clinical laboratory, radiology, consultations, echocardiogram, surgical procedures, therapy, anesthesia, pathology, autopsy, referral information from other agencies and providers, any other reports pertinent to the patient's care and treatment.

Section 2: History and Physical Examinations – Inpatient/Outpatient

1. History and Physical Examination: For patients admitted/registered to the hospital for inpatient services; outpatient services such as surgery and diagnostic tests or procedures requiring anesthesia or sedation; a physician, APN, or physician assistant must perform and document a history and physical examination ("H&P") within 24 hours after the patient's admission/registration, or prior to any surgery requiring anesthesia services (except in the case of emergencies), whichever comes first. An update to an H&P performed within 30 days prior to admission may be used if an updated examination of the patient occurs as described below. The supervising or precepting physician for the non-physician practitioner performing the history and physical examination must sign and retains full responsibility for the history and physical examination.

For inpatients and outpatients (as described above), the documentation of a history and physical must include, when pertinent:

a. the chief complaint;
b. history of present illness;
c. past medical history;
d. family history;
e. psychosocial history;
f. review of systems,
g. medication and allergies
h. physical examination;
i. provisional diagnosis or clinical impression;
j. treatment plan.

For Dental care, the history and physical examinations must include:

a. chief complaint;
b. details of disease;
c. injury and/or defect of the jaws and/or contiguous structures; and
d. its implications on the patient's general health.

If an H&P was performed within 30 days prior to a patient's admission to the hospital, a reasonably durable, legible copy of the history and physical report may be used for the patient's current hospital admission (including outpatient surgeries or procedures requiring anesthesia or sedation), provided that the attending physician or other authorized individual within 24 hours of admission but prior to any surgery or procedure requiring sedation, examines the patient, documents any additions to the history or changes in the patient's current physical findings and signs the history and physical examination to update the examination. If, upon examination, the authorized practitioner finds no change in the patient's condition since the H&P was reviewed, he/she may just document the H&P was

reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.

If a H&P is not completed and documented before the time stated for the surgery/procedure, the surgery/procedure shall be cancelled or, when feasible, delayed until the history and physical examination is completed unless the attending physician documents that the surgery or procedure is an emergency.

All history and physical examinations entered by medical students must be countersigned, and amended, if necessary, by the responsible licensed preceptor physician, who is either a member of the House Staff or an Attending Physician. These rules govern all medical student clinical preceptorship assignments, whether titled "clinical clerkship," "externship" or any other term that might be used.

Section 3: Progress Notes

Progress notes must be recorded by the physician/dentist, medical student, physician assistant, or advanced practice nurses in a collaborative arrangement to ensure continuity of care and document the patient's problems, progress and assessment. Progress notes entered by medical students must be co-signed by a licensed physician.

Section 4: Operative Notes

The attending surgeon or his/her designee will enter an operative progress note in the medical record immediately following the completion of the operation or procedure and before the patient is transferred to the next level of care; unless the surgeon or his/her designee accompanies the patient from the operating room to the next unit or area of care where he/she will enter the operative progress note.

The operative progress note shall contain: (1) the name of physician and assistant(s); (2) preoperative diagnosis (3) postoperative diagnosis (4) procedure(s) performed , if any; (5) findings; (6) estimated blood loss; (7) specimens removed; and (8) complications.

The attending surgeon or his/her designee will record an operative report immediately following the operative procedure. The operative report shall contain the elements listed above as well as the patient name and hospital identification number, date and times of surgery/procedure, description of surgical technique; type of anesthesia administered, and any prosthetic devices, grafts or devices implanted. The attending surgeon will finalize the operative report.

Section 5: Procedure Notes

A written procedure note shall be recorded in the progress notes immediately following the procedure. The procedure note shall contain: (1) the name of physician or provider and assistant(s); (2) preoperative diagnosis (3) postoperative diagnosis (4) procedure(s) performed, if any; (5) findings; (6) specimens.

Section 6: Discharge Summaries

A discharge summary shall be documented in the patient's medical record within thirty (30) days of the patient's discharge consistent with the Medical Record Delinquency Policy,

attached as Exhibit 4. All discharge summaries shall include: 1) the reason for hospitalization; 2) significant findings; 3) complications; 4) procedure(s) performed and treatment(s) rendered; 5) condition of patient at discharge; 6) examinations and reports, including pathology; and 7) instructions given to the patient and/or his/her family members or responsible persons, to include instructions for follow-up, medications, diet, physical activity, and final diagnosis. For patients who expire, the summary should include the exact date/time of death and consent for autopsy. A discharge summary may be documented by Medical Staff members, House Staff, APNs in collaborative practice or Physician Assistants within supervision agreements as determined by the respective Department Chief. The Medical Staff member, House Staff or APN shall sign the summary, either electronically or by hand. A copy of the hospital discharge summary will be sent to the admitting and/or referring physician or practitioner.

A final progress note or discharge note may be substituted for the discharge summary in the case of patients with problems of a minor nature as defined by the Medical Staff and who require a hospital stay of less than 48 hours.

Section 7: Symbols and Abbreviations

Only those symbols and abbreviations recommended by the Health Information Management Subcommittee and approved by the Children's Medical Executive Committee shall be used. A copy of this list shall be placed on file in the Health Information Management Department.

Section 8: Access and Confidentiality of Records.

All records are the property of the Hospital and the original may only be removed by court order, subpoena, for microfilming or for offsite storage. Records may accompany patients who require medical care in other parts of the medical center. These records shall be available only as authorized by state law. Access to medical records by all others may be had only by authorization of the patient, the patient's parent or legal guardian, or the executor of the patient's estate. Such authorization must be renewed at the end of ninety (90) days, unless the authorization allows otherwise. All physicians, dentists and advanced practice nurses who provided care to the patients may review the medical records on those patients. Physicians/dentists may have access to medical records for bona fide study and research consistent with preserving the confidentiality of the patient.

Section 9: Delinquency

All medical records shall be completed within 30 days after discharge. If the medical record is not completed 30 days after discharge, it shall be considered delinquent pursuant to the Medical Record Delinquency Policy. Report of the delinquent record is made to the responsible physician with a copy sent to the respective department chief and the Health Information Management Subcommittee. The department chief and/or appropriate division director is held responsible for the completion of the delinquent record. No medical record shall be filed until it is complete except on the order of the Health Information Management Subcommittee pursuant to the Medical Record Delinquency Policy. (See Exhibit 4) Physicians/dentists who fail to complete medical records within the allotted time are subject to disciplinary action in accordance with Hospital Bylaws.

Section 10: Medical Student Notes

Histories and physicals and orders entered by medical students must be reviewed and countersigned, and amended if necessary, by the student's supervising physician prior to being acted upon or implemented.

Section 11: Computerized Patient Record & Electronic Signature

The use of the computerized patient record and electronic signature and related policies shall be recommended by the Health Information Management Subcommittee and approved by the Children's Medical Executive Committee.

ARTICLE XII – ORDERS

Section 1: General Rules

All practitioner orders shall be in writing or by electronic entry and signed by the responsible Medical Staff member as soon as possible but no later than the calendar day after the order is given.

Active members of the medical staff may delegate writing or electronic entry of orders to a designee (House Staff or PA, APN in collaborative practice). However, practitioner orders shall be the ultimate responsibility of the physician. In addition, an APN / PA may write or enter orders consistent with his/her clinical privileges and Missouri law.

Admission orders must be signed by a member of the Medical Staff with active admitting privileges.

Orders must be entered clearly, legibly and completely. Orders which are illegible or improperly entered will not be completed until clarified.

A medical student in a clinical preceptorship position may write orders on the order sheets or enter orders in the electronic version of the Hospital medical records. A medical student must clearly write or enter his/her name and appropriate designation as a medical student so that the orders are clearly identifiable as the work of a student and are not confused with those of a physician. The nursing staff shall not implement any such order until the order has been finalized and amended, if necessary, by a licensed preceptor physician.

Section 2: Medications

Medications may be administered by, or under the supervision of, licensed personnel in accordance with Missouri State law. Medications will be dispensed to patients only upon a physician, advanced practice nurse in collaborative practice, physician assistant with a supervision agreement or dentist's order. Generic drug names are preferred in writing medication orders; all medication orders must comply with the standards outlined in the Provider Orders Policy (see Exhibit 5).

The Pharmaceutical, Diagnostics & Therapeutics Subcommittee shall be responsible for the formulary of medications used in the Hospital, and the addition, restriction or deletion of drug products from the formulary. Medication must be listed in the latest edition of Approved Drug Products with Therapeutic Equivalence Evaluation (U.S. Department of Health and Human Services, Food and Drug Administration), or Facts and Comparison to be

considered by the Subcommittee, with the exception of drugs prescribed for bona fide clinical investigations. Exceptions to these rules must be approved by the Pharmaceutical, Diagnostic & Therapeutics Subcommittee.

The Pharmacy may dispense a generic or chemical equivalent for medications in accordance with state and federal laws, unless the proprietary name of the medication is used, followed by the words "No Substitute."

The Pharmaceutical, Diagnostics & Therapeutics Subcommittee shall adopt specific regulations for other aspects of medication procurement, storage, distribution, dispensing, administration, documentation and disposal. These regulations are subject to approval of the Children's Medical Executive Committee.

Section 3: Order templates

Templates for hospital orders shall require the approval of the Health Information Management Subcommittee prior to use. Such orders shall not supersede specific orders entered by physicians, advanced practice nurses, physician assistants or dentists. The pre-printed forms shall always be signed and dated by the physician, advanced practice nurse, physician assistant or dentist.

Section 4: Verbal and Telephone Orders

In an effort to minimize miscommunication of orders, St. Louis Children's Hospital strongly encourages the use of written or electronic orders from physicians and other practitioners authorized to record such orders when they are present in the hospital, or provide written or electronic orders via remote means.

Verbal or oral telephonic communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible and sound medical practice dictates the institution of therapy prior to the time in which a written or electronic order can reasonably be provided by the physician or practitioner.

Verbal or telephone orders for medications shall be given only to registered nurses, respiratory therapists, (for respiratory-related medications only), transport team or emergency department paramedics (under the direction of the supervising physician or nurse), radiology technologist, or to pharmacists. Verbal and telephone medication orders must be recorded using the Provider Orders Policy stated in Exhibit 5 of these Medical Staff Rules and Regulations. Physicians and other practitioners shall communicate orders unrelated to medications only to licensed, registered or certified professional individuals within the scope of such individual's specialty.

In order to verify and validate the order, the person receiving the verbal or telephone order will record, then read back to the prescriber or individual transmitting the order. The person receiving the verbal or telephone order will document the order in the patient's medical record specifying whether it is a verbal or telephone order and record his/her name and title in accordance to hospital policy.

The prescriber or his/her designee (as permitted by these Rules & Regulations) will finalize all verbal and telephone orders within 48 hours of the order being given. The prescriber, or

his/her designee, should review orders daily and should finalize as soon as possible, especially before patient transfer to another medical/surgical service.

Section 5: Do Not Resuscitate Orders

Do Not Resuscitate orders entered in accordance with the protocol developed by the Children's Medical Executive Committee and approved by the St. Louis Children's Hospital Board of Trustees may be implemented upon an entered order on the physician's order sheet. (Exhibit 6)

Section 6: Automatic Review Orders

An automatic review of antibiotics and Schedule II controlled substances orders is established by the Pharmaceutical, Diagnostics & Therapeutics Subcommittee and approved by the Children's Medical Executive Committee, except in cases where the physician, advanced practice nurse in collaborative practice, physician assistant (excluding order for controlled substances) or dentist states a specific number of days or doses in the order.

Pharmacists shall review patient medication orders and discuss with the physician, dentist, physician assistant or advanced practice nurse the need to continue the medication.

All medications not listed in the above categories shall also be reviewed by the pharmacist for appropriateness of continuing therapy.

All medication orders shall be automatically canceled when the patient goes to surgery.

Section 7: Medications Brought from Home

Patients may not use medications that are not dispensed from the St. Louis Children's Hospital Pharmacy with the exception of:

1. Investigational drugs which are kept by the patient or parent/guardian;
2. Total Parenteral Nutrition (TPN) solutions
3. Oral contraceptives
4. Medications that are integral to the patient's ongoing care, which are not included on the SLCH Medication Formulary, and are to be continued during hospitalization.

Other exceptions may be made to this list by the Pharmaceutical Diagnostics & Therapeutics Subcommittee.

When patients are allowed to take medications (one of the above exceptions) that they have brought into the Hospital, the physician/dentist must record an order for the non-formulary medication, including the notation, to "administer patient's own medication" with an indication of the medication, dose, route and frequency. Such medications shall be stored in the medication area of the nursing unit, under appropriate storage conditions. Administration of such medications shall be documented according to policy. The identification and potency of medications brought from home shall be the responsibility of the attending physician/dentist, house officer or clinical pharmacist.

Any medication that is brought by patients to the Hospital, but is not one of the above exceptions, shall be returned to the parents or person(s) responsible for care with instructions to take the medications home.

Section 8: Self-Administration of Medications

A physician, physician assistant, advanced practice nurse or dentist must enter an order for self-administration of medications in the patient's medical record.

Section 9: Special Treatment Procedures

Documentation is necessary in the patient's medical record for special treatment procedures. Psychiatric restraint or seclusion or behavioral modification procedures that use aversive condition require written orders and time limitations in the patient's medical record (see Restraint Policy attached as Exhibit 7).

Section 10: Advance Directives

Advance Directives may be utilized in accordance with the policy adopted by the Children's Medical Executive Committee, attached as Exhibit 8. A copy of the directive shall be placed in the patient's medical record.

ARTICLE XIII - SURGICAL CARE

Section 1: Surgery

A history and physical, pre-operative diagnosis and appropriate lab test results must be recorded in the patient's medical record prior to any surgery. Outpatients must be provided instructions for follow-up care. Except during emergency situations, surgery should only be performed after the patient or his/her person(s) responsible for care have given informed consent. The consent form signed by the patient or the person(s) responsible for care shall be included in the medical record.

Section 2: Presence of Attending Surgeon

The patient will not enter the operating room until the attending surgeon is present on the hospital grounds or not further than a five minute walk to the operating room. Any exception to this rule requires the approval of the attending anesthesiologist. The attending surgeon must be present during the critical portion of the case.

Section 3: Emergency Surgery

In emergencies, surgery can be performed before a full pre-operative work-up is completed, provided the surgeon documents that delay would cause a hazard to the patient.

Section 4: Surgical Specimens

Specimens removed during a surgical procedure are ordinarily sent to the pathologist for evaluation. The medical staff, through the Surgical Services Subcommittee and in consultation with the pathologist, decides the exceptions to sending specimens removed during a surgical procedure to the laboratory (See surgical specimen exemptions attached as

Exhibit 9). Surgical specimens may be used for research purposes in accordance with the state and federal law, and only with appropriate consent.

ARTICLE XIV - ANESTHESIA

Section 1: Pre-Anesthesia Evaluations

All patients having general, regional or monitored anesthesia must have a Pre-anesthesia evaluation performed and recorded in the medical record within 48 hours of a planned surgical procedure. The pre-anesthesia evaluation is the responsibility of the anesthesiologist. The evaluation should include the history and physical examination; anesthetic, drug and allergy history; essential laboratory data; and any other diagnostic test results to establish the patient's potential risks of anesthesia. These procedures may be waived in the event of an emergency, provided the surgeon documents the emergency in the patient's record. All pre-anesthesia evaluations performed by a certified registered nurse anesthetist or other attending physician designee shall be reviewed and countersigned by an anesthesiologist prior to the administration of anesthesia. The anesthesiologist shall review the patient's condition immediately prior to the induction of anesthesia, and any changes in patient condition or anesthetic plan will be noted in the medical record.

Section 2: Parameters of Care

Record keeping, monitoring and equipment safety verification will be carried out in accordance with the recommendations published by the American Society of Anesthesiologists, but at a minimum, during anesthesia, patient monitoring, dosage of all drugs and agents used, type and amount of all fluids administered, including blood and blood products, the technique or techniques used, unusual events during the anesthesia period, and the status of the patient at the conclusion of anesthesia must be documented.

Section 3: Discharge from Post-Anesthesia Care Unit and Post-Anesthesia Evaluations

A patient must be discharged from the Post Anesthesia Care Unit by a physician. A post-anesthesia evaluation for any patient remaining in the hospital for at least 24 hours and having any general, regional or monitored anesthesia shall be entered into the medical record within 24 hours after surgery reflecting evidence of the patient's present physical condition, tolerance to anesthesia, and any unusual events or post-anesthesia complications and the management of any such event or condition.

Section 4: Sedation

Sedation within the Hospital shall be carried out in accordance with the current guidelines described in the Procedural Sedation Guidelines.

ARTICLE XV - TRANSFERS

Section 1: Transfer of Attending Physician/Dentist Responsibility for In-House Transfers

Whenever attending physician/dentist responsibilities are transferred to another attending physician/dentist or clinical service, an order for the transfer of responsibility is documented.

Section 2: Transfers in Emergency Situations

Designation of the chief medical officer and specific transfer protocols are contained in the Hospital's Emergency Preparedness Manual.

Section 3: Transfers Out of the Facility

It shall be the responsibility of the transferring physician/dentist to make arrangements with the accepting physician/dentist and Administration of the accepting Hospital. Transfers shall be carried out in accordance with applicable state and federal guidelines (EMTALA). All pertinent medical information shall accompany the patient.

Section 4 – Transfers during Disaster

Whenever the Hospital disaster plan is declared to be in operation, all transfers and transports shall be made in accordance with the Hospital's Emergency Preparedness Plan and Procedures.

ARTICLE XVI - PREGNANT PATIENTS

Section 1: Treatment

Except in an emergency, patients known to be pregnant are not admitted for treatment of pregnancy. Patients known to be pregnant or discovered to be pregnant may be treated for illness or injury unrelated to pregnancy with consultation by an obstetrician as indicated or they may be transferred according to applicable transfer procedures.

ARTICLE XVII - HOUSE STAFF

Section 1: Definition

The House Staff shall consist of interns, residents, clinical fellows and research fellows. House Staff will not be considered members of the Medical Staff, and will only have those rights specifically set forth in this Section, and as explained in more detail in the Procedure for Review of Academic and Disciplinary Decisions Relating to Residents (Exhibit 10) and procedures adopted by the Washington University/Barnes Jewish Hospital/St. Louis Children's Hospital Graduate Medical Education Consortium.

Section 2: Criteria

House Staff must hold or secure, and maintain, either a permanent or temporary license to practice medicine from the Missouri State Board of Registration for the Healing Arts and meet the requirements of the Department within which they would like to practice.

Section 3: Prerogatives

House Staff may attend to patients under the supervision and direction of physician members of the Medical Staff. House staff may also perform specific services as authorized by these Rules and Regulations.

Section 4: Supervision

House Staff, including fellows, shall be supervised by members of the Medical Staff in carrying out their patient care responsibilities in accordance with the procedures set forth in the Medical Staff Bylaws, these Rules and Regulations, and Hospital policies, and if applicable, any process and procedure adopted by the GME consortium. Such supervision may be evidenced by, among other things, attestation of House Staff entries and/or a parallel note in the medical record for activities such as:

1. History and physical examination must be reviewed and attested by the responsible member of the Medical Staff;
2. Operative notes dictated by House Staff must be reviewed and attested by the responsible surgeon member of the Medical Staff, and
3. Discharge summaries submitted by House Staff may be reviewed and attested by the responsible member of the Medical Staff.

ARTICLE XVIII - MISCELLANEOUS

Section 1: Practice Coverage

Each attending physician/dentist must assure timely, adequate, professional care for his/her patients in the Hospital by being available, or having available, an alternative physician/dentist with whom prior arrangements have been made and who has at least the equivalent clinical privileges at the Hospital. If a Medical Staff member fails to name an alternate, the appropriate Department Chair, Division Director or his/her designee shall have authority to call any member of the Active Staff to care for the absent physician's patients.

Section 2: Emergency Preparedness Plans

An Emergency Preparedness Manual shall be developed by the Emergency Preparedness Committee. This manual shall contain information and action plans to assist in dealing effectively with emergencies such as earthquakes, fire, severe weather, mass casualties etc.

Section 3: Revision of Rules and Regulations

The CMEC and the St. Louis Children's Hospital Board of Trustees may provisionally approve minor corrections and changes to these Rules and Regulations when such correction or change is necessary due to spelling, punctuation, grammar, and context or as required by laws, state or federal regulation or Joint Commission standards. No prior notice of such change to or vote of the Medical Staff is required. All changes approved by the CMEC shall be reported to each Department Chief for circulation to its members.

For any substantive changes to the Rules and Regulations, the CMEC may approve the changes, as long as the proposed changes have been communicated to the Medical Staff at

least seven (7) days prior to the CMEC meeting either by email or some other similar method, where the changes are to be considered and the Medical Staff has had an opportunity to comment. The CMEC shall consider any comments when it votes on the proposed changes.

Section 4: Allied Health Professionals

Policies related to allied health professionals shall be reviewed and endorsed by the Children's Medical Executive Committee.

Section 5: Exhibits Attached to Rules and Regulations

Unless otherwise stated in the Medical Staff Bylaws, the Exhibits referenced in these Rules and Regulations are for information purposes only and may be revised, as necessary, to reflect current practices by the Hospital in conjunction with the Children's Medical Executive Committee.

Section 6: Smoking Policy

Smoking will not be permitted in any of the facilities of the Hospital.

Section 7: Safety Committee Authority

The Vice President of Facilities or appropriate designee is authorized to take immediate, unilateral action regarding hazardous conditions which could result in personal injury to individuals or damage to equipment or buildings.

Section 8: Infection Control Committee Authority

The Infection Control Committee and its Chair or appropriate designee is authorized to implement infection control measures in the case of an epidemic or potential exposure to communicable infectious diseases.

Adopted by the CMEC: 06/09/93
Adopted by the Medical Staff: 06/14/93
Ratified by the Board of Trustees: 06/28/93
Amended: 09/26/94, 11/25/97, 02/22/00, 09/26/00, 09/25/01, 12/19/01, 06/04/02, 09/09/02, 09/23/03, 06/08/04, 09/28/04, 11/23/04, 10/25/05, 10/24/06, 06/05/07, 09/16/08, 12/03/08, 12/02/09, 12/07/10, 9/29/15, 03/12/2024

Exhibit #1

Administrative Policy
St. Louis Children's Hospital

INFORMED CONSENT

The purpose of this policy is to define when consent is necessary and the steps to obtain and document informed consent.

Related Policies: Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery
Language Services: Interpreter and Translation

I. Informed Consent Process

A. The Discussion:

Informed consent is the process by which a Licensed Independent Practitioner[1] provides adequate information to a patient, parent, or primary caregiver to allow him/her to make an informed decision about a proposed treatment or procedure. The information discussed with the patient, parent or primary caregiver must include:

1. A description of the proposed care and treatment (including any anesthesia to be used); the reasons why the patient needs the care and treatment; and, what happens if the patient declines the care and treatment; and

2. Material risks and benefits to the patient, including likelihood of each; and

3. Any reasonable alternatives to the care and treatment, including material risks and benefits of the alternatives; and

4. The individuals who will be providing treatment, performing the surgical intervention and/or administering the anesthesia (i.e. residents, fellows, students, and others) and, for surgical procedures, whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks[2] related to the surgery, and in those cases, the consent discussion is encouraged to include the following:

   i. Residents may participate in the surgery based on the level of competency and under the supervision of the operating practitioner/teaching surgeon; and
   ii. Those residents performing surgical tasks will always be under the supervision of the operating practitioner/teaching surgeon; and
   iii. The operating practitioner/teaching surgeon will be present during all key and critical portions of the surgery until they are completed. When there is no reasonable expectation there will be a need for the operating practitioner/teaching surgeon to return

[1] The licensed healthcare professional performing the treatment or procedure without direct supervision, within the scope of the individual's license and consistent with individually granted privileges– ie, physician, dentist, LIP or APN.
[2] Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, and implanting devices.

for further care, that practitioner may leave the room and may engage in the surgical procedure of a second patient.

5. An opportunity to ask questions and receive additional information if requested.

A licensed independent practitioner or Allied Health Professional working within the scope of his/her practice must ensure the patient is appropriately informed and consents to the specific procedure or treatment.

B. **When to Have the Discussion:**

Generally: Before each new medical and/or surgical treatment or procedure. Informed consent is required for: anesthesia administration; every surgical procedure; autopsy; organ/tissue donation; blood and blood products; sedation and procedures performed under sedation or anesthesia; and treatment governed by research protocol.

Patients who are in certain therapeutic programs involving a course of the same treatments may consent to an entire course of routine therapy prior to the first treatment, and a single consent form may be signed for the entire course of treatment (not to exceed one year) if:

1. The patient, parent or caregiver consents to the entire course of treatment at once, and;
2. No material change occurs in the risks and/or benefits of treatment alternatives; the mode of treatment; the patient's medical condition; or the patient's capacity to consent; and
3. The patient, parent or caregiver does not revoke consent; and consent is re-obtained and re-documented at least annually.

Examples of therapeutic programs covered by this provision include, but are not limited to, the following: chemotherapy, repetitive blood or blood product transfusion; retroperitoneal dialysis and hemodialysis; and plasmapheresis procedures.

C. **Who Should Obtain Informed Consent?**

1. **Who should have the *discussion* with the Patient/Parent/Caregiver?**

Physician or licensed independent practitioner performing procedure or treatment or, in the case of organ donation, the designated requestor/representative of an organ procurement organization (i.e., Mid-America Transplant Services).

2. **Who should *obtain the Patient's/Parent's/Caregiver's Signature* on the Procedure Form?**

A healthcare provider (often nurse) who can verify with patient/parent/caregiver what procedure or treatment is occurring and whether the patient/parent/caregiver has any questions or concerns.

3. If the physician or licensed independent practitioner has already had the consent discussion with the patient prior to the patient's admission (for example, in a clinic or the office), a healthcare provider must verify with the patient/parent/caregiver the consent discussion occurred and obtain the patient/parent/caregiver's signature on the Procedure Form (see paragraph I.C.2 above).

D. **Who May Consent** (see also Attachment A – Minor Consent Chart):

1. Emergency[3] Treatment for Minors (patients 17 years or younger)

    a) When a medical emergency exists, treatment may be provided and must be limited to the emergency medical condition, even if the patient's representative is unable to provide consent.

    In such cases, the treating physician, whenever practical, may obtain clinical consultation with at least one other licensed physician to confirm the need for such intervention.

    b) Consent for emergency treatment is implied so long as:

        i. No representative previously withheld consent; or
        ii. A representative previously withheld consent, but the minor's condition has changed in a material and morbid way and no representative is available, authorized, and willing to consent for treatment.

    c) The nature of the emergency and the need for treatment must be clearly documented in the medical record.

2. Non-Emergent Treatment for Minors

    A parent/representative or caregiver must consent for medical treatment of minors except as described below.

    If the parent/representative or caregiver is unable to or refuses to consent for treatment, and none of the situations described in Sections 2, 3, or 4 below exist, call Risk Management for assistance.

    a) Minors with Capacity to Consent to Medical Treatment. Certain minors may consent to medical or surgical care on their own behalf without parental consent. These include patients who are:

        i. Married; or
        ii. Have a child and are actively parenting that child (if a minor, then, may consent for herself/himself and the child); or
        iii. Self-sufficient (i.e. lives on own).
        iv. Pregnancy and Pregnancy Prevention Care (except abortions)

    b) Minors May Consent to His/Her Own Medical Treatment for following:

        i. Drug or Substance Abuse
        ii. Communicable Diseases

    There may be situations involving very young minors or mentally impaired minors that may lack capacity to understand the proposed treatment and the risks and

[3] Emergency is defined as: when, in competent medical judgment, the proposed surgical or medical treatment is immediately or imminently necessary and any delay occasioned by an attempt to obtain consent would reasonably jeopardize the life, health or limb or result in disfigurement or impairment of faculties.

benefits of the proposed health care plan**. Call Risk Management to assist in those situations.**

c) Minors who are in Foster Care or have a Court-Appointed Guardian. In these situations, it is important to view the documents to determine decision-making authority. Any court papers must expressly grant the authority to consent for medical care and treatment. Call Risk Management to assist in these situations if there are questions about the decision-making authority.

3. Adult (18 years or older or minors who are deemed to have capacity to consent – see Section 2 above) Patients With Capacity To Make Health Care Decisions

a) If a patient has the capacity to understand the nature of the proposed treatment or procedure, the risks and benefits of that procedure and the ramifications of not going through with the procedure, the patient is deemed to have the capacity to consent to or refuse the treatment.

b) Generally, a physician or LIP shall assume that an adult patient presenting for treatment has the capacity to make health care decisions, unless there is evidence to the contrary. The capacity to consent is required at the time the consent is given.

4. Adult (18 years or older or minors who are deemed to have capacity to consent – see Section 2 above) Patients **Who DO NOT Have** Capacity To Make Health Care Decisions

When non-emergent medical or surgical treatment is required for incompetent adults or adults who lack capacity to give informed consent, informed consent should be obtained from the following person(s) (in this order):

a) Legal Representative

i. Guardian. A court may appoint a guardian of the patient's "person" to consent to care on behalf of the patient. The guardianship papers must expressly grant the authority to consent for medical care and treatment. For admission to a mental health facility for mental health treatment, the guardianship papers must say the guardian has the power to make mental health treatment decisions;
ii. If no court appointed guardian exists, ask if the patient has a Durable Power of Attorney for Health Care (DPAHC). Individuals may execute a DPAHC authorizing another person to act as an "attorney-in-fact" to make health care decisions on their behalf.

b) Family Members: If a patient has no guardian or DPAHC, consent for treatment may be obtained from the patient's closest available relative in the following order of priority and limited to: spouse, adult children, parents, adult brothers/sisters, and adult grandchildren. If there are questions about the situation (i.e., capacity, motive or patient's wishes), contact Risk Management.

II. Issues with Informed Consent

A. What is the Duration of an Informed Consent?

Informed consent should be obtained and documented no longer than 60 days prior to a procedure, surgery, or treatment. In addition, as noted above in Section I.B, informed consent can also be valid for the duration of a continuous course of treatment.

B. **What if the Patient/Parent/Caregiver Refuses To Consent To Medical Treatment?**

An adult patient with capacity, or a parent/care giver of a minor child, or the minor child if he/she is deemed to have capacity to consent generally has the right to refuse medical treatment.[4] If the patient/parent/caregiver refuses specific treatments and/or therapies, notify the patient's physician or licensed independent practitioner so that risks of refusing the treatment and/or therapies can be reviewed with the patient/parent/caregiver. Document in the medical record the refusal and the explained consequences of such refusal. Include in the documentation the name of the physician or licensed independent provider notified and date and time of when notified.

C. What if the Patient/Parent/Caregiver Refuses to Consent to the Administration of Blood and/or Blood Products?

If a patient 18 years or older or a minor who is qualified to consent on his/her own behalf refuses to consent to administration of blood or blood products, then no such products will be given.

If a parent or caregiver refuses to consent for the administration of blood or blood products, such refusal should be handled as follows:

a) If an emergency situation currently exists and the treating physician(s) deem blood or blood products necessary to avoid death or permanent disability, blood/blood products shall be administered.
b) If the emergency situation is only potential *(e.g. the patient needs immediate surgery and more likely than not the patient will need blood during surgery)* and the parent or caregiver does not consent to the administration of blood, the parent or caregiver should be informed of the right to seek legal recourse. Should the emergency situation arise, blood/blood products shall be administered unless there is a court order prohibiting the administration of blood/blood products.
c) The treating physician(s) should document in the medical record the emergent situation, the conversations with the parent or caregiver and decision to proceed with blood/blood product administration given the risks of death and/or permanent disability.

If there is a definite and clear need for future or recurring blood/blood products and the parent or caregiver refuses

- The treating physician or his/her representative shall contact SLCH Risk Management who will coordinate with Social Services and BJC Legal to obtain a court hearing and attempt to obtain a court order allowing the administration
- Social Services shall ensure the family is informed of the proceedings and the ability to access the Juvenile Court.
- Any documentation from the Juvenile Court should be placed in the medical record.

III. Documentation of Informed Consent

[4] Sometimes there may be issues when multiple parents and/or caregivers are not in agreement about consent. In those circumstances, contact Risk Management for assistance.

A. Consent should be obtained using forms approved by SLCH and/or BJC Legal Services.

B. The physician or licensed independent practitioner must document the consent in the medical record. If consent is not obtained, e.g. in an emergency, the reason for such failure should also be documented in the medical record.

C. A copy of any papers authorizing a legal representative to consent to treatment on behalf of the patient (e.g., DPAHC, Letters of guardianship) should be filed in the patient's medical record.

D. Consent for Surgery or Diagnostic Procedure Form is available for use at the hospital. If the patient will undergo a Surgery or Other Procedure that requires use of this document, it is the expectation of the hospital that all blanks be filled in prior to the Surgery or Procedure being performed. If there is not a separate note available verifying the consent discussion between the physician or LIP and the patient, it is the responsibility of the physician, LIP or AHP to specify the operation or procedure on the Procedure Consent form. It is the responsibility of hospital staff to ensure that the Consent Form is completed and in the patient chart prior to the treatment being performed. The form may be completed in advance (at a clinic or office visit prior to the surgery) and forwarded to the hospital by the LIP or AHP.

E. A process must be in place in every area in the hospital that uses this form to ensure that the form is properly executed and is in the patient's medical record prior to the surgery (except in the case of an emergency Surgery or Procedure. The pre-procedure verification for all areas is set forth in the hospital policy entitled, "Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery.

IV. Communication Barriers

When language barriers, hearing or speech impairments impede informed consent, communication must be facilitated with appropriate support for interpretation. Whenever possible, trained spoken language and sign language interpreters will be available through the Center for Diversity & Cultural Competence by calling 747-5682. The medical record should indicate who acted as interpreter and the language used.

A physician or licensed independent practitioner obtaining consent from a patient who may have difficulty with communication because of a physical handicap must arrange for consent discussions to take place using a communication medium in which the patient is fluent. In the rare event that trained interpretation is not available due to the rarity of the language or the physical inability of the patient/family to use telephone interpretation, documentation should show that all alternatives were considered and rejected as less effective in that situation than the use of self-described, bilingual family members or staff.

Exhibit #2

ST. LOUIS CHILDREN'S HOSPITAL
DETERMINATION OF DEATH BY NEUROLOGICAL CRITERIA
(BRAIN DEATH)

PURPOSE:

The occurrence of death shall be determined in accordance with usual and customary standards of medical practice, provided that death shall not be determined to have occurred unless the following minimal criteria are met:

1. When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation; or
2. When respiration and circulation are artificially maintained and there is total and irreversible cessation of all brain function, including the brainstem, and such determination is made by a licensed physician.

GUIDELINES

Examination by a Medical Staff Member who is a neurological specialist (medical neurology or neurosurgery) shall be obtained to determine whether death by neurological criteria is present. A second Medical Staff Member, usually the patient's neonatology or critical care attending physician, shall also perform the exam. The exams by both physicians shall be documented in the patient's medical record using St. Louis Children's Hospital Death by Neurological Criteria Examination form. The exams by the two physicians do not need to be done in a particular order. The neurological specialist may perform the first or second exam.

Age and recommended observation periods

- Neonates (37 weeks gestation to term infants 30 days of age): Two examinations recommended to be separated by 24 hours.
- Infants and children (>30 days to 18 years): Two examinations recommended to be separated by 12 hours.
- Adults (> 18 years): Two examinations, recommended to be separated by 12 hours.

It is possible that unusual circumstances may require an alternate period of observation. In some circumstances, a shorter interval may be preferred. In this situation, the reason for an alternate period of observation should be clearly documented and affirmed by at least one of the physicians performing the determination of death by neurological criteria.

Elements of Diagnosis

1. Whenever possible, the patient must be known to have a disease or injury which can cause death by neurological criteria. Cause must be structural disease or other known irreversible cause. Recoverable disorders, such as drug poisoning, toxin, metabolic disorder, severe electrolyte disturbances, hypothermia (temperature 35ºC or lower), or shock should be excluded. In certain situations, such as can occur with cases of cardiac arrest or severe traumatic brain injury, assessment of neurological function may be unreliable immediately. In such situations, if there are concerns about, or inconsistencies in, the examination, evaluation should be deferred for 24-48 hours or longer.
2. Sedative and anti-convulsant medication levels should be low or mid-therapeutic range. Neuromuscular blocking drugs (NMBDs) should be discontinued and recovery of neuromuscular transmission monitored with a conventional peripheral nerve stimulator. If there is uncertainty regarding such potential confounds, an ancillary test should be performed. Alternatively, the evaluation can be deferred.
3. There must be complete loss of brain function:
    a. There must be no brain-mediated motor responses. The patient must have no spontaneous movement or vocalization, and the patient must not move or vocalize to noxious stimuli. Noxious stimuli should consist of pressure upon the patient's supraorbital ridges. If this is not possible (e.g. facial fractures), can also use noxious stimuli such as nail bed or trapezius pressure. There must be no decorticate or decerebrate posturing.
    b. There may be rudimentary spinal reflex responses such as deep tendon reflexes, plantar reflexes, triple flexion of the legs, superficial abdominal reflexes, erection of penis or nipple. Reflexive movements such as hip flexion with elevation of one or both upper extremities have also been described. These reflexes do not contradict the diagnosis of death by neurological criteria.
    c. The pupils may be either widely dilated or midway between constriction and dilation. Stimulation with a bright light must fail to produce any pupillary constriction.
    d. The eyes must be motionless. Oculocephalic ("doll's eye") and oculovestibular (ice water caloric) responses must be absent.
    e. The gag, cough, sucking, and rooting reflexes must be absent.
    f. Spontaneous ventilatory efforts (including agonal breaths) must be absent. An apnea test (Appendix 2) should be performed, if there is no contraindication.

Ancillary Tests

Ancillary studies can support the diagnosis of death by neurological criteria, but have their own inherent limitations. Unlike the remainder of the clinical exam, ancillary tests do not need to be performed in duplicate.

Ancillary tests can be used to assist the clinician in making the diagnosis of death by neurological criteria in the following situations:

1. To reduce the observation period or interval between examinations;
2. When components of the examination or apnea testing cannot be completed safely as a

result of the underlying medical condition of the patient; if an apnea test cannot be performed, an ancillary test is required;
3. If there is uncertainty about the results of the neurologic examination;
4. If a medication effect may interfere with evaluation of the patient an ancillary test should be performed.

Specific ancillary tests must be interpreted by an attending physician and include:

1. Nuclear medicine perfusion scan. This test may be preferred when medications that may suppress the EEG are present (i.e. pentobarbital).
2. Percutaneous catheter cerebral angiography.
3. EEG. If performed, EEG must be carried out according to an electrocerebral silence protocol (protocol available in the SLCH EEG lab).

Documentation of Death by Neurological Criteria

1. Each of the two examining physicians specified in the guidelines section (page 1) must be present during their respective examinations and should certify in writing in the patient's chart that death by neurological criteria is present using the St. Louis Children's Hospital documentation form (form available in *Forms on Demand*).
2. To facilitate consensus and acceptance of the concept of death based on neurological criteria, support from Spiritual Care and Social Work may be sought. Death by neurological criteria will be pronounced/declared by the physician who has performed the second exam while the respirator is still ventilating the patient. The pronouncement/declaration and time of death will be entered into the progress note section of the patient's chart using the St. Louis Children's Hospital death by neurological criteria examination form. The patient's family is not asked to participate in or to make the decision that the patient is dead. The family is informed when the diagnosis is confirmed and the declaration/pronouncement is made. A reasonable amount of time should be allowed for the family to visit prior to removal of the ventilator.

ORIGINAL AUTHOR: Critical Care Subcommittee members; Children's Medical Executive Committee

REVIEWER: Matthew Goldsmith, MD

EFFECTIVE DATE: January 9, 2023

REFERENCES

Banasiak KJ, Lister G. Brain death in children. Curr Opin Pediatr 2003;15:288-93.

Guidelines for the determination of brain death in children. Task Force for the determination of brain death in children. Neurology 1987;37:1077-8.

Levesque S, Lessard MR, Nicole PC, et al. Efficacy of a T-piece system and a continuous positive airway pressure system for apnea testing in the diagnosis of brain death. Crit Care Med 2006;34:2213-6.

Monterrubio-Villar J, Cordoba-Lopez A. Barotrauma during apnoea testing for brain death determination in a five-year-old boy. Anaesth Intensive Care 2008;36:462-3.
Rowland TW, Donnelly JH, Jackson AH. Apnea documentation for determination of brain death in children. Pediatrics 1984;74:505-8.

Nakagawa TA, Ashwal S, Mathur M et al. Guidelines for the determination of brain death in infants and children: an update of the 1987 Task Force recommendations. Crit Care Med. 2011 Sep;39(9):2139-55.

Practice parameters for determining brain death in adults (summary statement). The Quality Standards Subcommittee of the American Academy of Neurology. Neurology 1995;45:1012-4.

Report of special Task Force. Guidelines for the determination of brain death in children. American Academy of Pediatrics Task Force on Brain Death in Children. Pediatrics 1987;80:298-300.

Wijdicks EF. The diagnosis of brain death. N Engl J Med 2001;344:1215-21.
Young GB, Shemie SD, Doig CJ, Teitelbaum J. Brief review: the role of ancillary tests in the neurological determination of death. Can J Anaesth 2006;53:620-7.

St. Louis Children's

DEATH BY NEUROLOGICAL CRITERA

APPENDIX 1

RECOMMENDED PROCEDURE FOR OXYGENATED APNEA TESTING (OAT)

The OAT is a test of the respiratory response to significant hypercapnea; it is not intended to test the response to hypoxemia. During the OAT, for patients with initial $pCO_2 < 40$ mmHg, arterial pCO_2 must increase from baseline to > 60 mmHg; or for patients with an initial $pCO_2 > 40$mmHg, pCO_2 must increase at least 20mmHg higher than baseline. The OAT must be performed with each examination. If the OAT cannot be completed, an ancillary test is required.

Prior to interrupting the ventilator, the patient should be ventilated with 100% oxygen for 5-10 minutes. Blood gas analysis should be performed and the following criteria should be met before the apnea test can be initiated: pH > 7.30, pCO_2> 35 mmHg, pO_2> 100 mmHg. If any of these criteria are not met, it may not be possible to perform apnea test without hypoxia or hypotension developing.

If the above criteria have been met, the patient may be disconnected from the ventilator and connected to a non-self inflating resuscitation bag (CPAP bag as used by anesthesiology). Self-inflating bags are not to be used for this purpose. The bag should be set up to administer 100% oxygen and continuous positive airway pressure (CPAP) that matches the patient's current positive end-expiratory pressure (PEEP) as set on the ventilator. The patient will then be observed continuously for ~10 minutes, or sufficient time to allow the pCO_2 to rise as outlined above. Observation of respiratory effort may be facilitated by use of continuous capnometry. If no spontaneous ventilatory effort is observed, the test is interpreted as consistent with absence of brain stem function. If circulatory instability occurs at any time, the patient should be reconnected to the ventilator. Pulse oximetry must be performed throughout the test. Arterial blood gas determination at the termination of the test is necessary to determine adequate hypercapneic stimulation (see above).

Criteria for discontinuation of the apnea test:

Oxygen saturation decrease to <85%; hypotension; any arrhythmia associated with hemodynamic instability; presence of respiratory effort. The presence of respiratory effort will be determined by the attending physician performing the apnea test.

CONSIDERATIONS IN USE OF OAT

1. Failure to preoxygenate will lead to hypoxia.

2. Leaving the patient attached to the ventilator during the test may result in small "blips" on the monitor screen (caused by lung compression from cardiac activity or auto-triggering of the ventilator). This may confuse staff or family. The patient should be separated from the ventilator. Oxygen and CPAP are to be provided through a non-self inflating resuscitation bag, and direct visual observation of chest movement or capnometry used by the examining attending physician as the end point.

3. Hemodynamic instability, most commonly caused by severe hypoxic myocardial dysfunction or hypovolemia, in combination with hypercapnea (which is an essential factor of the OAT) may compromise systemic perfusion. The OAT should not be attempted if, in the judgment of the examining physician, the patient will not remain stable throughout the test.

4. Hypercapnia (>60 mmHg) may not always be present after ten minutes of apnea since the rate of CO_2 production varies. The fifteen minute test may be elected if the patient is stable and oximetry confirms acceptable (SaO_2> 85%) oxygenation at ten minutes. The use of ABG's to document pCO_2 at ten and fifteen minutes, is required.

Exhibit #3

PROVIDER DOCUMENTATION POLICY: SYSTEM

EXCLUSIONS

None

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POLICY STATEMENT

A complete and accurate medical record must be maintained on every patient receiving care, treatment, and services in a BJC HealthCare facility. It is the responsibility of the Medical Staff to ensure providers document accurately, timely, and legibly, which is a basic tenet of providing safe patient care throughout the continuum of care, in support of high reliability systems. Documentation translates into publicly available information that drives hospital reputation, accreditation/regulatory compliance, and risk reduction of revenue loss.

This policy is intended to serve as a system expectation for provider documentation to supplement each HSO's Medical Staff Rules and Regulations, establishing minimum documentation requirements for providers across the system. This policy does not cover documentation requirements related to billing for services provided. Appropriate guidance from other parties regarding billing documentation compliance, could at times set additional or more detailed requirements, but does not diminish documentation expectations set within this policy.

New, revised, or deleted regulatory requirements require updates to the policy to ensure ongoing compliance and regulatory readiness. Policy updates of this nature will be reviewed and approved by the CMO Council and become effective immediately.

Source: TJC ~ RC.01.04.01 EP1; MS.05.01.03 EP3; CMS ~ 482.24(b); 482.24(c)(1)

POLICY

1) GENERAL MEDICAL RECORD DOCUMENTATION REQUIREMENTS

a. It is the responsibility of the Admitting Licensed Practitioner, or their designee (House Staff or APP in collaborative practice), to maintain the medical record. A complete, current, legible, and pertinent medical record to support the patient's diagnosis(es)/conditions and course of care, treatment, and services provided is expected.

b. The author of each entry is identified in the medical record.

c. All entries in the medical record are dated and timed.

d. All entries in the medical record are authenticated by the author, including dictated/transcribed reports. Refer to 1) j) (table), for countersignature requirements.

   i. Authentication can be verified through electronic signatures, written signatures or initials, or computer key.

   ii. For paper-based records, signatures are dated and timed. For electronic records, electronic signatures are date and time stamped.

e. All medical records should be completed as soon as practically possible after discharge, but no later than thirty (30) days after patient's discharge.

f. Medical Student documentation must be completed as follows:

   i. A medical student's notes may be recorded in the patient's chart and signed by the student with a notation after the student's name to identify their level of learning.

   ii. All student notes must be countersigned and amended, if necessary, by the responsible licensed preceptor physician, who is either a member of House Staff or the Responsible Physician.

   iii. Nursing staff should not implement medical student written or electronic orders until countersigned and amended, if necessary, by the responsible licensed preceptor physician.

g. Providers utilizing a Scribe must document in accordance with Compliance Policy 26, "Scribe". See Scribe Policy - Compliance Policy 26: System

h. All medical records are the property of the Hospital and may only be removed by court order, subpoena, for scanning or digitization, or for offsite storage. Members of the medical staff and APPs who provided care to the patient may review medical records of those patients. Providers may have access to medical records for bona fide study and research consistent with preserving the confidentiality of the patient.

i. Medical records may not be permanently filed incomplete without approval from the Medical Executive Committee or other designated Committee as assigned by the Medical Executive Committee.

j. Entries in the medical record require countersignature as indicated in the table below. Individual HSO's may have additional countersignature requirements.

PROVIDER	**MEDICAL STAFF**	**ADVANCED PRACTICE PROVIDER (APP) (NP/PA/MIDWIFE) ANESTHESIA ASST.**	**HOUSE STAFF**	**CRNA**	**MEDICAL STUDENTS**
ENTRY	***COUNTERSIGNED BY:***				
Admission Order	Provider with Admission Privileges				•Medical Student notes must be countersigned, and amended, if necessary, by the responsible physician, who can either be a member of House Staff or Responsible Physician who is a Medical Staff member.
Comprehensive H&P	N/A	Collaborating Physician or designee	Attending/Supervising Physician	N/A	
Operative Note		Attending Surgeon	Attending Surgeon	N/A	
Procedure Note**		Collaborating Physician or designee N/A (if performed independently)	Attending/Supervising Physician N/A (if performed independently)	N/A	
Brief Operative Note		N/A	N/A	N/A	
Consultation Note		N/A	Attending/Supervising Physician	N/A	
Discharge Summary		Collaborating Physician or designee	Attending/Supervising Physician	N/A	

Orders		N/A (within scope of practice)	N/A	N/A (within scope of practice)	•Refer to individual HSO policies related to medical student documentation. •Refer to 1) f) i-iii above for additional requirements.
Progress Note		N/A	Attending/Supervising Physician	N/A	
Pre-Anesthesia Eval		Anesthesiologist	Anesthesiologist	Anesthesiologist*	
Post-Anesthesia Eval		Anesthesiologist	Anesthesiologist	Anesthesiologist*	

*May be countersigned by Supervising Surgeon if allowed by local Bylaws/Rules & Regulations.
**Procedure Note – Procedure performed under a local or with use of minimal to no sedation.

Source: TJC ~ RC.01.01.01 EP1,5,7, 13; RC.01.02.01 EP1 – 5; RC.01.03.01 EP1,2

Source: CMS ~ 482.24, 482.24(b); 482.24(b)(6); 482.24(c); 482.24(c)(1); 482.24(c)(2); 482.24(c)(3)(iii); 482.53(d); 482.53(d)(2)

2) DOCUMENTATION COMPLIANCE: SURGICAL HISTORY AND PHYSICAL (H&P)/PRE-PROCEDURE ASSESSMENT

a. Prior to the start of any surgery or procedure requiring moderate/deep sedation or anesthesia, a comprehensive History and Physical must be documented in the medical record.
   i. When the comprehensive H&P is completed within thirty (30) days prior to admission/surgery, an update note must be documented, including physical examination and any changes in the patient's condition or physical exam, prior to the start of surgery or procedure.
   ii. The comprehensive H&P may be completed by an APP/House Staff under the supervision of the responsible licensed practitioner and must be validated or countersigned by the licensed practitioner prior to the start of the surgery/procedure.
   iii. A comprehensive H&P is complete when signed or attested to by a member of the medical staff.
   iv. When a comprehensive H&P has not been documented in the medical record prior to the start of any surgery or procedure requiring moderate/deep sedation or anesthesia, surgery or procedure must be delayed or cancelled until the H&P is documented. If the nature of the surgery is emergent, the emergent nature of the surgery must be documented, and a comprehensive H&P must be documented within 24 hours of admission.
   v. The comprehensive History and Physical includes, at a minimum:
      1. Reason for admission/Chief Complaint
      2. Initial Diagnosis/Diagnostic Impression/Condition of Patient
      3. Allergies or reference allergy list
      4. Physical Exam
      5. Assessment and Plan of Care

b. For procedures performed with the use of minimal sedation or regional anesthesia, a licensed provider must document a Pre-procedure Assessment in the medical record. This includes, at a minimum:
   i. Diagnosis/indication for procedure
   ii. Allergies or reference allergy list
   iii. Pertinent physical exam, to include at a minimum:
      1. Patient's mental status
      2. Heart, lungs, vital signs

c. For procedures performed with the use of local anesthetics, a licensed provider or qualified clinician performing the procedure must document a Pre-Procedure Assessment in the medical record, which includes, at a minimum:
   i. Patient's diagnosis
   ii. Allergies or reference allergy list
   iii. Pertinent physical exam

d. When the procedure is performed by a dentist or podiatrist, the H&P/Pre-Procedure Assessment should be completed as follows:
   i. Prior to the start of a procedure utilizing moderate/deep sedation or anesthesia performed by a dentist or podiatrist, a Licensed Practitioner, including Anesthesia, credentialed to perform History and Physical exams must document a H&P. The dental or podiatry licensed practitioner is responsible for documenting a history and physical specific to their specialty and procedure being performed.
   ii. Patients undergoing a procedure utilizing local anesthesia performed by a dentist or podiatrist, do not require a full H&P performed by a licensed practitioner credentialed to perform a H&P.

The provider (dentist or podiatrist) must document a Pre-Procedure Assessment that minimally includes diagnosis, any allergies, and a pertinent physical exam in the medical record prior to the start of the procedure.

Source: TJC ~ RC.02.01.03 EP2; RC.02.01.03 EP3; PC.01.02.03 EP4, EP5, EP7; MS.03.01.01 EP19

Source: CMS ~ 482.51(b)(6); 482.24(c)(4)(i)(A); 482.24(c)(4)(i)(C); 482.51(b)(1)(iii); 482.22(c)(5)(iv); 482.22(c)(5)(v); 482.22(c)(5)(v)(A); 482.22(c)(5)(iii)

3) DOCUMENTATION COMPLIANCE: INPATIENT ADMISSION NOTE/HISTORY AND PHYSICAL (H&P)
   a. A comprehensive H&P must be completed within 24 hours of admission and is complete when signed or attested to by a member of the medical staff.
   b. A comprehensive H&P may be completed within 30 days prior to admission if updated to note examination of the patient and any changes to the patient's condition or physical exam within 24 hours of admission.
   c. A comprehensive H&P may be completed by APPs/House Staff under the supervision of the responsible licensed practitioner and must be validated or countersigned by the licensed practitioner within 24 hours of admission.
   d. The Medical History and Physical Exam includes:
      i. Reason for admission/Chief Complaint
      ii. Initial Diagnosis/Diagnostic Impression/Condition of Patient
      iii. Allergies or reference allergy list
      iv. Physical Exam
      v. Assessment and Plan of Care

Source: TJC ~ RC.01.03.01 EP3; PC.01.02.03 EP4, EP5; RC.02.01.01 EP2; PC.01.03.01 EP23

Source: CMS ~ 482.61(a)(5); 482.61(b)(2); 482.51(b)(1)(ii); 482.23(b)(3); 482.23(b)(4); 482.24(c); 482.24(c)(4)(ii); 482.24(c)(4)(iii)

4) DOCUMENTATION COMPLIANCE: CONSULTATIONS

Consultation reports should be documented in a timely manner, in accordance with the clinical urgency of the request. For emergent consultation requests, a full consultation note must be entered in the medical record as soon as possible upon completion of consultation. If a full consult note cannot be entered immediately, a short update note will be written and signed after initial evaluation, including preliminary findings and recommendations. In all cases, a full consultation note should be entered by the end of the calendar day following the consultation request unless an alternative timeframe was communicated when consultation was requested.

5) DOCUMENTATION COMPLIANCE: OTHER CLINICAL DOCUMENTATION

The following must be included in the medical record:
   a. Findings of assessments and reassessments.
   b. Diagnoses or conditions established during the patient's care, treatment, and services, including complications and hospital-acquired infections.
   c. A description or record of any emergency care, treatment, and services provided to the patient prior to their arrival.
   d. Treatment goals and plan of care.
   e. Results of diagnostic and therapeutic tests and procedures.
   f. Progress Notes are documented by Medical Staff members or their designees, to include observations and patient's response relevant to care, treatment, and services provided.

Source: TJC ~ RC.02.01.01 EP2; PC.01.02.01 EP1

Source: CMS ~ 482.24(c); 482.24(c)(4)(ii-iv); 482.24(c)(4)(vi); 482.24(c)(4)(viii); 482.26(d); 482.53(d); 482.57(b)(4); 482.56(b)(1); 482.61(a); 482.61(a)(2); 482.61(a)(3); 482.61(a)(4); 482.61(a)(5); 482.61(c)(1)(i-ii); 482.61(c)(1)(iv-v); 482.61(c)(2); 482.61(d); 482.23(c)(6)(i-ii)(E); 482.23(c)(3); 482.43(a)(3)

6) DOCUMENTATION COMPLIANCE: DISCHARGE SUMMARY
   a. A Discharge Summary may be written by Medical Staff members, House Staff, or APPs in collaborative practice. Discharge Summaries documented by APPs and House Staff must be countersigned according to above table,1) j.).

b. A Discharge Summary should be completed by end of calendar day following discharge. The Discharge Summary includes the following, at a minimum:
    i. Discharge Diagnosis
    ii. Reason for Hospitalization
    iii. Procedures performed
    iv. Summary of care, treatment, and services provided
    v. Patient's condition and disposition at discharge
    vi. Information provided to patient and family
    vii. Provisions for follow-up care
    viii. When a patient is hospitalized for less than forty-eight (48) hours, a final progress note may be substituted for the Discharge Summary. The final progress note includes the outcome of hospitalization, disposition of the case, and provisions for follow-up care.
c. Discharge paperwork, i.e., After Visit Summary (AVS)/Post-Acute Transfer Report (PATR), must be completed at the time of discharge; to include at a minimum:
    i. Hospital problem list
    ii. Information provided to patient and family
    iii. Follow-up plan/appointments (as applicable)
    iv. Discharge medication list
d. Records of deceased patients additionally include:
    i. Date and time of death
    ii. Autopsy consent
e. Against Medical Advice (AMA) Discharges:
    i. In accordance with hospital policy, patients who wish to sign out against medical advice of his/her Responsible Physician, will be asked to sign the "Against Medical Advice" form.
    ii. Based upon the patient's length of stay, a Discharge Summary or final progress note, that includes the patient's condition upon release as well as the elements noted above, must be documented in the medical record.

Source: TJC ~ RC.02.04.01 EP3; RC.02.01.01 EP2; PC.01.02.03 EP6

Source: CMS ~ 482.24(c)(4)(vii); 482.61(e); QSO-23-16-Hospitals

7) DOCUMENTATION COMPLIANCE: SURGICAL PATIENTS
This section applies to any operative or other procedure requiring administration of moderate/deep sedation or anesthesia.
a. A Licensed Practitioner documents the provisional diagnosis in the medical record before any operative procedure is performed.
b. A History and Physical must be documented in the medical record in accordance with above sections, 2) Pre-Procedural and Surgical History and Physical/Physical Assessment and 3) Inpatient Admission Note/History and Physical.
c. Informed Consent of the patient must be obtained prior to surgery or a procedure.
    i. Informed Consent must be authenticated, dated, and timed by the patient prior to surgery or procedure.
    ii. Reference Facility Informed Consent Policy(s) for documentation requirements and responsibility for obtaining consent.
d. Any unanticipated events or complications and the management of those events must be documented in the medical record.
e. An abbreviated ("brief") or complete Operative/Procedure Note should be documented upon completion of the procedure and before the patient is transferred to the next level of care. For purposes of this requirement, The Joint Commission considers Pre-Op, O.R., and PACU areas to be same level of care because the clinical team is essentially intact across the areas. If a brief Operative Note is documented immediately after the procedure and before the patient is transferred to the next level of care, the complete Operative Report should be documented by end of calendar day following the procedure. If the licensed practitioner performing the operation or procedure accompanies the patient from the operating room to the next unit or area of care and provides a verbal hand off, the provider may document the brief or complete Operative Note in that unit or area. The complete Operative Note includes:
    i. Name of primary surgeon(s) performing procedure and any assistants
    ii. Name of procedure performed
    iii. Description of procedure
    iv. Findings of procedure
    v. Estimated blood loss; may be documented as:
        1. Numeric value
        2. Qualitative note of minimal/negligible or none

3. For cardiothoracic surgery, “Cardiopulmonary Bypass” or “CPB” when used in procedure

Note: “Per Anesthesia” is not acceptable documentation of estimated blood loss.

vi. Specimen(s) removed, if applicable

vii. Postoperative diagnosis

f. When a complete Operative Note cannot be documented in the medical record immediately after the operation or procedure, an abbreviated or “brief” operative note must be documented in the medical record before the patient is transferred to the next level of care. For the purposes of this requirement, the Joint Commission considers the Pre-Op, O.R., and PACU areas to be the same level of care because the clinical team is essentially intact across the areas. If the provider performing the operation or procedure accompanies the patient from the operating room to the next unit or area of care and provides a verbal hand off, the provider may document the Brief Operative Note in that unit or area. The Brief Operative Note includes:

i. Name of primary surgeon(s) performing procedure and any assistants

ii. Name of procedure performed

iii. Description of each procedure finding

iv. Estimated blood loss; may be documented as:

1. Numeric value
2. Qualitative note of minimal/negligible or none
3. For cardiothoracic surgery, “Cardiopulmonary Bypass” or “CPB” when used in procedure.

Note: “Per Anesthesia” is not acceptable documentation of estimated blood loss.

v. Specimen(s) removed, if applicable

vi. Postoperative diagnosis

g. Inpatient procedures or minor outpatient procedures for which local anesthesia or anxiolytics/analgesia is used, a routine procedure note shall be documented immediately but no later than the end of the calendar day following the procedure that minimally includes:

i. Name of provider performing the procedure and any assistant(s)

ii. Indication for procedure

iii. Post Procedure Diagnosis (may omit if unchanged)

iv. Procedure performed

v. Procedure technique

vi. Findings of procedure

vii. Specimens removed, if applicable

Source: TJC ~ RC.02.01.01 EP4; RC.02.01.03 EP1, Ep2, EP3, EP5, EP6, EP7, EP8; PC.01.02.03 EP4, EP5

Source: CMS ~ 482.24(c)(4)(i)(A); 482.24(c)(4)(iv); 482.51(b)(2); 482.51(b)(6); 482.52(b)(2)

8) DOCUMENTATION COMPLIANCE: ANESTHESIA SERVICES

This section applies to patients receiving general, spinal, or other major regional anesthesia or moderate/deep sedation that may result in loss of protective reflexes. The medical record contains:

a. Pre-anesthesia evaluation is completed by an Anesthesiologist (or designee, APP, Resident/Fellow, CRNA) within 48 hours prior to surgery or procedure requiring anesthesia services and countersigned according to above table, 1) j.).

b. When a pre-anesthesia evaluation is completed prior to date of surgery by APPs or telephonically, evaluation by the Anesthesiologist on day of surgery is required. The Anesthesiologist should perform and notate an exam in their attestation to the previously documented pre-operative assessment, along with any new information obtained from examination of patient.

c. An Anesthesia assessment is conducted by the Anesthesiologist or sedation-privileged provider (or their designee) and countersigned according to above table, 1) j.), before moderate/deep sedation or anesthesia is administered.

d. Reevaluation of patient is conducted immediately prior to administration of anesthesia or moderate/deep sedation.

e. Post-anesthesia evaluation is completed by an Anesthesiologist, or a member of the anesthesia team (CRNA, Resident, or Fellow) within 48 hours post-surgery. Post-anesthesia evaluations are countersigned according to above table, 1) j.)

f. Inpatients undergoing therapies for pain management, should be rounded on daily or as clinically indicated, (telephone or in person), note documented in Epic.

Source: TJC ~ PC.03.01.03 EP1, EP8, EP18; PC.03.01.07 EP7, EP8; RC.02.01.01 EP2

Source: CMS ~ 482.52(b); 482.52(b)(1); 482.52(b)(3)

9) DOCUMENTATION COMPLIANCE: OBSTETRIC RECORDS
    a. When possible, prenatal records should be provided to Labor and Delivery Unit by 37 weeks gestation along with any subsequent updates. The prenatal record, including a complete medical and obstetrical history of the patient, should be available and updated within 24 hours of admission and/or prior to delivery or scheduled induction of labor.
    b. The comprehensive History and Physical, including medical and obstetric history, must be documented prior to delivery or in the event urgent/emergent delivery does not allow for documenting prior to delivery, within 24 hours of admission.
    c. A delivery note must be documented as soon as possible following delivery of the newborn.
    d. Patients undergoing C-Section must follow documentation requirements of Surgical Patients; noted in 2) Pre-Procedural and Surgical History and Physical/Physical Assessment, above.
    e. In the event the patient's labor is redirected toward C-section, a brief explanation of the clinical course and indication for C-Section must be entered by the attending physician in accordance with requirements noted above in 2) i.).

    Source: IL Hospital Licensing Requirements ~ Title 77 Ch1 250.1830

10) DOCUMENTATION COMPLIANCE: NEWBORN CARE RECORDS
    Newborn records contain:
    a. History of the maternal health and prenatal course
    b. Complete physical exam within 24 hours of birth
    c. Daily physical exam
    d. Physical exam within 24 hours prior to discharge
    e. Clinical note regarding status at discharge

    Source: IL Hospital Licensing Requirements ~ Title 77 Ch1 250.1830

11) DOCUMENTATION COMPLIANCE: EMERGENCY CARE RECORDS
    a. The Emergency Department record contains, at a minimum:
        i. Time and mode of patient arrival
        ii. Medical Screening Exam; to include a physical exam, pertinent history, and allergies
        iii. Diagnosis
        iv. Conclusions reached at termination of care, treatment, and services; including final disposition, condition, and instructions for follow up care, treatment, and services
        v. Indication patient left against medical advice, when applicable
        vi. Information made available to providers or other health care entities providing follow-up care, treatment, and services.
    b. The Emergency Department record should be completed at the time of patient transition/discharge but no later than 24 hours after transition/discharge from the Emergency Department.

    Source: TJC ~ RC.02.01.01 EP18

12) DOCUMENTATION COMPLIANCE: PROVIDER QUERIES
    Providers shall appropriately address clinical documentation clarification queries in a timely manner. Outstanding queries are subject to record completion escalation processes as needed.

13) DOCUMENTATION COMPLIANCE: USE OF APPROVED/PROHIBITED ABBREVIATIONS
    a. Providers adhere to the Abbreviation Policy and list of prohibited abbreviations, acronyms, symbols, and dose designations. The list of Prohibited Abbreviations includes the following:
        i. U, u
        ii. IU
        iii. Q.D., QD, q.d., qd
        iv. Q.O.D., QOD, q.o.d., qod
        v. Trailing zero (X.0 mg)
        vi. Lack of leading zero (.X mg)
        vii. MS
        viii. MSO4
        ix. MqSO4

b. A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
c. The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.
d. Refer to local HSO policies and/or Abbreviation Manual for a list of approved abbreviations.

Source: TJC ~ IM.02.02.01 EP 2, EP3

Source: MO Licensing Regulations: 19 CSR 30-20.021 (3)(D)(4)

14) ORDERS
a. General Rules
All orders are dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and who is authorized to write orders.
b. Order to Admit
Patients are admitted only by order from a member of the medical staff with privileges to admit patients to the hospital. Admission orders must be signed by a member of the medical staff with active admitting privileges.
c. Order to Discharge
Patients shall be discharged on order of the Responsible Physician or his/her designee (including House Staff, or APP).
d. Standing Orders/Clinical Treatment Protocols
    i. Standing Orders
        1. Standing orders are defined as pre-approved orders that are initiated by authorized staff without a specific provider order to do so, in response to explicitly defined circumstances that permit interventions for urgent/emergent or time-sensitive, necessary patient care.
        2. Standing orders must:
            a. Be authenticated by the appropriate provider as soon as possible following implementation.
            b. Have explicitly defined circumstances for use, preferably identified by the title of the order, i.e., Chest Pain Standing Order.
            c. Have clearly stated interventions which may contain "if/then" styled directives to account for various anticipated scenarios or clinical presentations.
    ii. Clinical Treatment Protocols
        1. Clinical treatment protocols (aka "protocol orders") are defined as pre-approved, explicit instructions ordered by a provider and implemented by authorized clinicians to manage designated clinical conditions or scenarios in an ongoing manner, in non-urgent/non-emergent situations.
        2. Protocols are initiated either directly when ordered or when designated criteria stated within the protocol are met.
        3. An order to implement a protocol must:
            a. Be entered and authenticated by the provider before initiated.
            b. Have clearly stated interventions which may contain "if/then" styled directives to account for various anticipated scenarios or patient responses.
        4. Additional orders entered when criteria-based parameters of a protocol are met to fulfill a specific component of the protocol do not require countersignature.
    iii. Standing orders and clinical treatment protocol orders must align with nationally recognized standards of care/practice or evidence-based guidelines.
    iv. Standing orders and clinical treatment protocols must be approved in accordance with each HSO's policy.
e. Telephone and Verbal Orders
    i. Refer to "BJC System Telephone and Verbal Orders Policy" for additional information and process steps for giving and accepting/recording TO/VOs. Telephone and Verbal Orders: System
    ii. Telephone and Verbal Orders shall be used only in situations where immediate written or electronic ordering is not feasible, and the patient's condition is determined to warrant immediate action for the benefit of the patient.
    iii. Verbal Orders (VO) shall be limited to urgent situations (example: when the physician is physically present but unable to enter/write orders due to clinical situation, i.e., performing a procedure, scrubbed in, code, rapid response, etc.) VOs are not to be used for the convenience of the ordering provider.

iv. Telephone orders (TOs) may be taken in these situations when the provider is not present.
v. TO/VOs will not be accepted over e-mail, text message, or secure chat in the EMR.
vi. Telephone and Verbal Orders are authenticated, dated, and timed per state regulations.
    1. IL FACILITIES: The ordering provider will sign the VO before leaving the unit/area where the order was given. TOs will be signed no later than 72 hours after the order was given. It may be signed by the treating provider if the ordering provider is not available to sign the order.
    2. MO FACILITIES: The ordering provider will sign the TO/VO promptly. It also may be signed by the treating provider if the ordering provider is not available to sign the order.

Source: TJC ~ RC.02.01.01 EP2; RC.02.03.07 EP1, EP2, EP3, EP4, EP6

Source: CMS ~ 482.23(c)(3); 482.23(c)(3)(ii); 482.24(c)(2)

Source: IL Hospital Licensing Requirements Title 77 Ch1 250.330

DEFINITIONS

Advanced Practice Provider: A healthcare provider who is certified and licensed to practice to the highest level of autonomy within their individual state practice acts. Advanced Practice Providers include Nurse Practitioners (NP), Physician Assistants (PA), Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA), and Certified Nurse Midwives (CNM).

Anesthesia and sedation: The administration to an individual, in any setting, for any purpose, by any route, of medication to induce a partial or total loss of sensation for the purpose of conducting an operative or other procedure. Definitions of four levels of sedation and anesthesia include the following: 1. Minimal sedation (anxiolysis): A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. 2. Moderate sedation/analgesia ("conscious sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. 3. Deep sedation/analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. 4. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. Monitored Anesthesia Care (MAC) is a specific anesthesia service in which the anesthesiologist has been requested to participate in the care of the patient undergoing a diagnostic or therapeutic procedure; does not describe the continuum of depth of sedation. The purpose of MAC is to complete the procedure at the level of sedation that is safest for the patient; the patient could be fully awake or require general anesthesia.

Clinical treatment protocol (aka "protocol orders"): Pre-approved, explicit instructions that align with nationally recognized standards of care/practice or evidence-based guidelines ordered by a provider and implemented by authorized clinicians to manage designated clinical conditions or scenarios in an ongoing manner, in non-urgent/non-emergent situations.

- Protocols are initiated either directly when ordered (e.g., bronchodilator protocol) or when designated criteria stated within the protocol are met (e.g., electrolyte repletion protocol).
- An order to implement a protocol must:
    - Be entered and authenticated (signed) by the provider before initiated
    - Have clearly stated interventions which may contain "if/then" styled directives to account for various anticipated scenarios or patient responses.
- When criteria-based parameters of a protocol require additional order entry to fulfill a specific component (e.g., ordering a specific dose of potassium according to a designated lab result), the order mode, *"Per protocol: no co-sign required"*, is used.

Confidentiality: Protection of data or information from being made available or disclosed to any authorized person(s) or process(es).

Credentials: Documented evidence of licensure, education, training, experience, or other qualifications.

Dentist: An individual who has received either a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is licensed to practice dentistry in the State (MO/IL).

Discharge: The point at which an individual's active involvement with a HSO ends, and the HSO no longer maintains active responsibility for the care of the patient. Discharge occurs at the point at which any encounter or episode of care ends.

Executive Committee/Medical Executive Committee: Executive Committee of the Medical Staff.

Health Information: Any information, oral or recorded, in any form or medium, that is created by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of health care; or payment for the provision of health care to an individual.

HSO (Hospital Service Organization): Refers to each or collectively all hospitals within the BJC HealthCare system.

Licensed Preceptor Physician: Defined as "either a member of the House Staff or the Responsible Physician".

Licensed Provider/Licensed Practitioner: Any individual permitted by law and regulations to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Unless otherwise expressly provided, any Physician, Dentist, or Podiatrist who has either (a) applied for appointment to the Medical Staff and for Clinical Privileges; or (b) been granted an appointment to the Medical Staff and holds specific delineated Privileges; or (c) has applied for or has been granted temporary Privileges to the Medical Staff.

Medical Staff: Licensed Practitioners (LP), such as Physicians, Dentists, and Podiatrists, who receive membership status and Clinical Privileges allowing them to attend to patients and/or to provide other diagnostic, therapeutic, teaching or research services in the Hospital.

Medical Staff Rules and Regulations: Rules and regulations adopted by the Medical Staff and approved by the Board to communicate various professional practices and activities in the Hospital.

Order set: A set of orders, usually evidence based, that includes menu style selections to individualize use for a patient. Order sets may also include orders to implement specific protocols.

Physician: Individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently a fully licensed physician and surgeon in the state (MO/IL), including requirements established for such licensing by the State Board of Registration for the Healing Arts.

Policies: Clear, simply worded, nonnegotiable statements consistent with applicable regulatory and/or accreditation requirements describing how an organization intends to approach business and practices.

Podiatrist: Individual who has received a Doctor of Podiatric Medicine degree and is currently fully licensed to practice podiatric medicine in the State (MO/IL).

Responsible Physician: A "designated member of the Medical Staff" who is responsible for the patient's care.

Standing Order: Pre-approved orders that align with nationally recognized standards of care/practice or evidence-based guidelines and are initiated by authorized staff without a specific provider order to do so, in response to explicitly defined circumstances that permit interventions for urgent/emergent or time-sensitive, necessary patient care.

- Standing orders must:
    - Be authenticated (signed) by the appropriate provider as soon as possible following their implementation.
    - The authorized individual entering the standing order will use the order mode "standing order, co-sign required."
    - Have explicitly defined circumstances for use, preferably identified by the title of the order (e.g., Chest Pain Standing Order).
    - Have clearly stated interventions which may contain "if/then" styled directives to account for various anticipated scenarios or clinical presentations.

Telephone Order: Orders transmitted by a licensed provider over the telephone to staff authorized to accept them. Orders communicated are written down then read back to obtain verification of accuracy from the provider.

Verbal Order: Orders given verbally (face-to-face) by a licensed provider to staff authorized to accept them. Orders are written down whenever possible or verbally repeated back to obtain verification of accuracy from the provider.

RELATED POLICIES, STANDARDS, DOCUMENTS

- Medical Staff Bylaws/Rules and Regulations

Hospital	Link to Medical Staff Rules & Regulations
Alton Memorial Hospital	Medical Staff Rules and Regulations
Barnes-Jewish Hospital	Medical Staff Rules & Regulations
Barnes-Jewish St. Peters Hospital	BJSPH Rules and Regulations
Barnes-Jewish West County Hospital	BJWCH Rules and Regulations
Christian Hospital	CH Rules and Regulations
Memorial Hospital Belleville and Shiloh	MHB/MHS Bylaws/Rules and Regulations
Missouri Baptist Medical Center	Medical Staff Rules and Regulations
Missouri Baptist Sullivan Hospital	Medical Staff Rules and Regs
Parkland Health Center	PHC Rules and Regulations
Progress West Hospital	PWH Rules and Regulations
St. Louis Children's Hospital	SLCH Rules and Regulations

- CMS Conditions of Participation
- The Joint Commission Standards: Information Management (IM), Medical Staff (MS), Provision of Care, Treatment, Services (PC), and Record of Care (RC)
- IL and MO State Regulations
- BJC System Scribe Policy - Scribe Policy - Compliance Policy 26: System
- BJC System TO/VO Policy - Telephone and Verbal Orders: System

REFERENCES

Policy Statement:

Source: TJC ~ RC.01.04.01 EP1; MS.05.01.03 EP3; CMS ~ 482.24(b); 482.24(c)(1)

General Medical Record Documentation Requirements:

Source: TJC ~ RC.01.01.01 EP1,5,7, 13; RC.01.02.01 EP1 – 5; RC.01.03.01 EP1,2

Source: CMS ~ 482.24, 482.24(b); 482.24(b)(6); 482.24(c); 482.24(c)(1); 482.24(c)(2); 482.24(c)(3)(iii); 482.53(d); 482.53(d)(2)

Surgical History and Physical/Pre-Procedural Assessment:

Source: TJC ~ RC.02.01.03 EP2; RC.02.01.03 EP3; PC.01.02.03 EP4, EP5, EP7; MS.03.01.01 EP19

Source: CMS ~ 482.51(b)(6); 482.24(c)(4)(i)(A); 482.24(c)(4)(i)(C); 482.51(b)(1)(iii); 482.22(c)(5)(iv); 482.22(c)(5)(v); 482.22(c)(5)(v)(A); 482.22(c)(5)(iii)

Inpatient History and Physical:

Source: TJC ~ RC.01.03.01 EP3; PC.01.02.03 EP4, EP5; RC.02.01.01 EP2; PC.01.03.01 EP23

Source: CMS ~ 482.61(a)(5); 482.61(b)(2); 482.51(b)(1)(ii); 482.23(b)(3); 482.23(b)(4); 482.24(c); 482.24(c)(4)(ii); 482.24(c)(4)(iii)

Clinical Documentation:

Source: TJC ~ RC.02.01.01 EP2; PC.01.02.01 EP1

Source: CMS ~ 482.24(c); 482.24(c)(4)(ii-iv); 482.24(c)(4)(vi); 482.24(c)(4)(viii); 482.26(d); 482.53(d); 482.57(b)(4); 482.56(b)(1); 482.61(a); 482.61(a)(2); 482.61(a)(3); 482.61(a)(4); 482.61(a)(5); 482.61(c)(1)(i-ii); 482.61(c)(1)(iv-v); 482.61(c)(2); 482.61(d); 482.23(c)(6)(i-ii)(E); 482.23(c)(3); 482.43(a)(3)

Discharge Summary:

Source: TJC ~ RC.02.04.01 EP3; RC.02.01.01 EP2; PC.01.02.03 EP6

Source: CMS ~ 482.24(c)(4)(vii); 482.61(e); QSO-23-16-Hospitals

Surgical Documentation:

Source: TJC ~ RC.02.01.01 EP4; RC.02.01.03 EP1, Ep2, EP3, EP5, EP6, EP7, EP8; PC.01.02.03 EP4, EP5

Source: CMS ~ 482.24(c)(4)(i)(A); 482.24(c)(4)(iv); 482.51(b)(2); 482.51(b)(6); 482.52(b)(2)

Anesthesia Services:

Source: TJC ~ PC.03.01.03 EP1, EP8, EP18; PC.03.01.07 EP7, EP8; RC.02.01.01 EP2

Source: CMS ~ 482.52(b); 482.52(b)(1); 482.52(b)(3)

Obstetric Records:

Source: IL Hospital Licensing Requirements ~ Title 77 Ch1 250.1830

Newborn Care Records:

Source: IL Hospital Licensing Requirements ~ Title 77 Ch1 250.1830

Emergency Care Records:

Source: TJC ~ RC.02.01.01 EP18

Use of Approved/Prohibited Abbreviations:

Source: TJC ~ IM.02.02.01 EP 2, EP3

Source: MO Licensing Regulations: 19 CSR 30-20.021 (3)(D)(4)

Orders:

Source: TJC ~ RC.02.01.01 EP2; RC.02.03.07 EP1, EP2, EP3, EP4, EP6

Source: CMS ~ 482.23(c)(3); 482.23(c)(3)(ii); 482.24(c)(2)

Source: IL Hospital Licensing Requirements Title 77 Ch1 250.330

APPENDIX

N/A

Exhibit #4

ST. LOUIS CHILDREN'S HOSPITAL

Policy # 13770

PATIENT CARE

Title: Orders – Nursing/Pharmacy

Purpose
To provide a consistent and accurate method for receiving and activating provider orders.

Policy Statements

A. Orders may be prescribed by physicians, advance practice nurses (APNs) within the scope of their collaborative practice agreement, physician assistants with a supervision agreement, and dentists.

B. Orders may be accepted by the following licensed clinical professionals when the specific order falls within the scope of care provided by that discipline, as documented in the discipline's professional practice act:
- APN
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Registered or Certified Respiratory Therapist (RT)
- Speech Therapist
- Occupational Therapist
- Physical Therapist
- Audiologist
- Psychologist
- Dietitian
- Pharmacist
- Perfusionist
- Paramedics (Transport Team or Emergency Department)
- Radiology Technologist

C. Verbal and Telephone Orders

Verbal and telephone orders should be limited to emergency or special situations where electronic or written communication is not feasible and initiation of therapy should not be delayed prior to the time in which an order can reasonably be entered/written by the physician or practitioner.

1. Verbal and telephone medication orders may only be accepted by:
   - APN
   - RN
   - Respiratory Therapist
   - Pharmacist
   - Perfusionist
   - Paramedics (Transport Team or Emergency Department)
   - Radiology Technologist
2. Verbal orders will not be accepted from medical students.
3. Verbal/telephone orders are accepted at the discretion of the clinical staff member and will be co-signed by the responsible provider or his/her designee within 48 hours of the order being given.

F.

D. Range Orders

1. Range orders for time are not acceptable (i.e. 3 - 4 hours).
2. Range orders for dose are not acceptable, except for the following:
   a. volume varies per port: for example, heparin flush, indwelling heparin, antibiotic lock therapy, normal saline flush and indwelling normal saline orders to meet the needs of the volume required for each catheter or IV port.
   b. clear parameters included in order which define conditions for administration: for example, insulin correction, naloxone, and titratable infusions.

E. Standing Orders

Standing orders are a set of evidence-based clinical directions or instructions **AND**

- Are implemented by authorized and designated clinical professionals **AND**
- Are used for well-defined clinical situations as either
  - A part of an emergency response or
  - A part of an overall treatment plan to expedite or advance patient care where it is not practical or timely to obtain an order or care is time sensitive, such that a delay may reduce optimal outcomes.

1. Standing orders will be approved by the appropriate sub-committee of the Children's Medical Executive Committee (CMEC) as reflected in the minutes. The process will be coordinated by the Practice Excellence department.
2. Standing orders that include a medication must be approved by the Pharmacy, Diagnostic & Therapeutics sub-committee.
3. Standing orders are available via standardized order sets in the electronic order entry system.
4. Standing orders require a provider order to be implemented except in the case where a delay in medical treatment may result in harm. The RN, RT or Rad Tech will apply clinical judgment to determine the appropriateness of use of the protocol and depending on clinical indications may determine alternative approaches or different orders are needed from the physician.
5. If not included in an order set, a copy of the standing order must be placed in the patient's medical record.

F. Hematology/Oncology Treatment Protocols

Only authorized providers will initiate Hematology/Oncology Treatment Protocols. Order activation will follow the process outlined below in Procedure C.

G. Transplant Treatment Protocols

Only transplant program assistants, nurse coordinators, advanced practice providers, and physicians trained in the use of SLCH-defined transplant protocols for labs or diagnostic testing may place orders for transplant patients pursuant to (1) physician-approved protocols, or (2) the physician, nurse practitioner, or other provider's request is documented in the patient's chart. Order activation will follow the process outlined below in Procedure D.

Procedure

A. Verbal/Telephone Orders

1. The clinician receiving the order must be logged into the patient's electronic medical record in the Order Entry tab prior to taking the verbal or telephone order. The prescriber must remain in continuous contact with that clinician until the electronic order entry is completed and the receiving clinician reads back the order in its entirety ("read back") with all numbers called out individually.
2. A Code Blue is an exception to the verbal order process. During a code, the verbal order(s) clinicians receive from providers for medication and IV fluids will be repeated back then documented on the Code Sheet by the recorder.
3. The prescriber or his/her designee will authenticate all verbal and telephone orders within 48 hours of the order entry.

B. Standing Order Initiation

When ready to implement a standing order, the clinician will:

1. Verify presence of an active order to initiate the standing order.
2. Enter the appropriate elements of the order set for the stated protocol on behalf of the provider with a source of "Standing Order: Cosign Required."
3. Complete the order and document appropriately.

C. Hematology/Oncology Treatment Plans

1. Orders for oncology specific treatment will be placed in the Oncology Treatment plan by an oncology provider
2. Only Beacon trained staff have access to view these orders once they are placed
3. Beacon trained staff will release the orders daily or as needed
4. Once orders are released from the Oncology Treatment plan, they will flow to the active orders tab and will be viewable by all staff with Epic access
5. Once released from the Oncology Treatment Plan, consult with an authorized oncology provider before modification.

D. Transplant Team Lab Protocols

1. Orders for labs or diagnostic testing pursuant to physician-approved protocols, or at the request of a physician, nurse practitioner, or other provider, which is documented in the EMR, may be placed by transplant program assistants or nurse coordinators in order to avoid delays in care.
2. A transplant provider will sign orders within 24 hours.

Reference

BJC HealthCare. (2019). PolicyTech policy and procedure reference card - Overview of document definitions at BJC.

Exhibit #5

St. Louis Children's Hospital

DO NOT RESUSCITATE (DNR) POLICY

Resuscitative measures deemed appropriate by hospital staff who are present at the time of cardiorespiratory collapse will be carried out unless there is a "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only –Do Not Resuscitate (DNR)" order in the chart.

INSTRUCTIONS

1. An order ("Limited – No CPR" or "Comfort Care Only –DNR" or "Limited – Pediatrics") defining resuscitative efforts to be carried out, and those which will not be done, should be written by an active member of the medical staff who is, or who is acting for, the patient's attending physician.

2. An order defining resuscitative efforts may be written in exceptional circumstances by a resident physician only if the resident physician has spoken with the patient's attending physician at the time the order is written, and documents that discussion in the progress notes.

3. In these instances, the attending physician must sign that order within twelve hours of the order being entered or immediately following patient demise if the patient dies prior to signing it.

ORDER SPECIFICS

1. **Limited – No CPR:** Aggressive medical management before a full cardiopulmonary arrest occurs will be provided, including initiating a Rapid Response, if appropriate. Use of antibiotics, IV fluids, and medical treatment will be performed unless specifically selected below:
    a. No intubation
    b. No non-invasive ventilation
    c. No cardioversion
    d. No internal/external pacemaker
    e. No vasopressors

2. **Comfort Care Only – DO NOT Resuscitate**: To allow natural death with dignity.
    a. Patient will be kept clean, warm, and dry.
    b. Medication by any route, positioning, wound care and other measures will be used to relieve pain and suffering.
    c. Oxygen, suction and manual treatment of airway obstruction as needed will be used for comfort.
    d. Transfer patient only if comfort needs cannot be met in current location.

3. **Limited – Pediatrics:** Based upon comprehensive discussion between the patient and family and the healthcare team, the patient and family and attending physician (or his/her designee) are in agreement that the following explanation best describes the patient's and family's current goals. (Can select one, multiple, or all of the options below, as cited in the EPIC order set.
    a. No bag-mask
    b. No cardioversion/debrillation
    c. No chest compressions
    d. No intubation/mechanical ventilation
    e. No resuscitative medications
    f. Other (specify)

CONCURRENT CARE CONCERNS

When appropriate, the physician should also include directions concerning:

1. Adjustment of sedatives/analgesics.
2. Suctioning.
3. Intubation.
4. Antibiotics, antiviral and immunosuppressant agents.
5. Frequency of vital signs and laboratory tests.
6. Blood products.
7. Dialysis.
8. Hydration.
9. Nutrition.
10. Hospice environment in hospital or outside hospital.

DOCUMENTATION OF FAMILY DISCUSSION

1. At the time a "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only – DNR" order is written, a note must be placed in the progress note section of the medical record which documents the discussion(s) with the patient, parent, or guardian of the medical and other considerations underlying the condition and prognosis.

2. The note should further state that the patient, parent or guardian understands that if resuscitative measures are not undertaken, there is a high likelihood that the patient will die.

3. It is recommended that the note be signed by the physician who is writing the "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only – DNR" order and cosigned by a nurse, social worker, or a second physician who was present for the discussion. The attending physician may choose to have the patient, parent, or a guardian also cosign this note.

All patients with imminent or impending death must be considered for organ and/or tissue donation. Refer to Anatomical Gifts policy.

DURATION

1. The duration of the order will be indefinite unless a specific duration is written or it is countermanded by a later order.

2. If the patient is discharged and readmitted, the order must be rewritten at the time the patient re-enters the hospital if the special resuscitation status is to be maintained.

ADVANCE DIRECTIVES

Advance directives, if provided by the patient, 18 years of age or older, will be reviewed by the attending physician, and, after clarification and/or confirmation by discussion with the patient or his/her proxy (person authorized by the patient to have power of attorney for health care decision making in the event the patient is not able to speak on their own behalf), the attending physician will enter an order in the patient's medical record which defines the resuscitative efforts to be carried out or not attempted and covers the appropriate concurrent care concerns.

CONFLICT WITH ADVANCE DIRECTIVE

1. If the attending physician finds him/herself unable or unwilling to write such an order, he/she must proceed with appropriate steps to resolve the problem immediately. These steps should include notification of the chief of the service of which that attending physician is a member and the administrative supervisor.

2. Arrangements to transfer care of the patient to a consenting attending physician should also be completed as soon as possible.

EMERGENCY UNIT

1. The staff of the Emergency Unit will respond to cardiopulmonary collapse with resuscitative efforts unless the parent/guardian/patient presents a document signed by the parent/guardian/patient and a member of the St. Louis Children's Hospital active medical staff, defining the resuscitative measures which they have agreed will be, and those which will not be, employed.

2. The orders contained in this document should be confirmed by either the patient's physician and/or family member at the time of arrival in the Emergency Unit, or prior to that time, if possible.

3. If there is no such document, an active medical staff member of the hospital may enter a “Limited – No CPR”, “Limited-Pediatrics”, or “Comfort Care Only- DNR” order in the patient's chart as described previously. If the physician cannot be present in the Emergency Unit at the time of the patient's arrival, he/she may ask the Emergency Unit attending physician to enter the order.

4. If the Emergency Unit attending physician does so, the order must be cosigned by the child's physician as soon as he/she or his/her designee can reach the Emergency Unit.

PROCEDURES UNDER ANESTHESIA

1. When a patient with a “Limited – No CPR”, “Limited-Pediatrics”, or “Comfort Care Only- DNR” order is scheduled for anesthesia and/or surgery, the anesthesiologist and surgeon shall discuss with the primary physician, patient's guardian and patient (if appropriate), the issues involved in order to best balance the desires and rights of the patient with the potential physiologic instability resulting from the planned procedure, surgery and/or anesthetic.

2. A medical progress note should document such discussion and any decisions reached. The patient/patient's family should understand that in addition to hemodynamic and respiratory instability as a result of the surgical procedure, any anesthesia or sedation carries the potential for significant untoward physiologic responses to pharmacologic interventions.

3. In most situations reversal is quickly and easily accomplished, but may involve airway manipulation (endotracheal intubation), pharmacological intervention, and brief periods of closed chest compressions.

4. These interventions should not be construed as "resuscitation" if performed for reversal of an unplanned and undesirable response to anesthetic agents or to surgical manipulations. Should reestablishment of adequate vital functions not be readily attainable, the physician caretakers, in consultation with the patient's guardians, will determine the extent of any further support efforts.

5. Patients undergoing emergent anesthesia and/or surgery, when sufficient time for such discussion has not taken place, will have the “Limited – No CPR”, “Limited-Pediatrics”, or “Comfort Care Only- DNR” order suspended prior to induction of their anesthetic.

6. Should a life-threatening event occur during the anesthetic/procedure, the extent of any resuscitative effort will be decided by the physician caretakers in consultation with responsible guardians if possible.

7. The suspended “Limited – No CPR”, “Limited-Pediatrics”, or “Comfort Care Only- DNR” order may be reinstated on the patient's discharge from the Post Anesthesia Care Unit, (PACU) or admittance to the Intensive Care Unit if PACU is not used.

REVERSAL OF DNR ORDER

A request by parent, guardian, or patient to revoke all or part of a “Limited – No CPR”, “Limited- Pediatrics”, or “Comfort Care Only- DNR” order will be honored.

PATIENTS IN MISSOURI CHILDREN'S DIVISION OR ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES CUSTODY

Request for "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only- DNR" Status

The hospital social worker must be notified immediately if the healthcare team wishes to present medical information to support a request for "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only- DNR" status for a patient in Missouri Children's Division (formerly Division of Family Services) or Illinois Department of Children and Family Services custody. The hospital social worker will contact the Family Courts to facilitate communication regarding a resuscitation status. The final decision regarding resuscitation status will be made by the court system and will be communicated to the healthcare team in the form of a legal document that shall be kept in the Medical Record.

Existing DNR Status

Legal documentation of resuscitation status as determined by the court system shall be kept in the Medical Record. "Limited – No CPR", "Limited-Pediatrics", or "Comfort Care Only- DNR" orders will remain in effect unless a new court order signed by a judge is obtained.

RECOMMENDED/APPROVED BY: Patient Care Services

EFFECTIVE DATE: February 2, 2022

Exhibit #6

Restraints: Management of Violent and Self-Destructive Behaviors: Core (SLCH)

EXCLUSIONS

BJC Home Care, BJC Behavioral Health, BJC Medical Group

TABLE OF CONTENTS

POLICY STATEMENT

The purpose of this policy is to establish standardized decision-making criteria and practical procedures for the use and discontinuation of violent restraint and seclusion (including physical hold – refer to definition) to protect the patient's health and safety and the safety of others, as well as to preserve the patient's dignity, rights, and well-being. Devices applied by law enforcement ("forensic restraints") to patients from correctional institutions are not clinical restraints for purposes of this policy. See local policy regarding management of prisoners. **Prisoners**

Restraint application should only occur after restraint alternatives have been considered and/or attempted, deemed unsuccessful, and if needed to ensure the immediate safety of the patient and/or others.

1. Behaviors that precipitate the decision to restrain should trigger further investigation aimed at understanding and eliminating the cause(s) of the behavior(s).
2. Restraints are not to be used as a means of coercion, discipline, convenience, or staff retaliation.
3. Violent restraints or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
4. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation. Staff must assess and monitor the patient's condition on an ongoing basis to ensure that the patient is released at the earliest possible time, regardless of the expiration of the order.
5. Chemical restraints are medications used to restrict the patient's freedom of movement or their behavior and are not a standard treatment or dosage for the patient's condition. See definitions section for more detail and examples.

PROCEDURE

Considerations Prior to Restraint Use:

1. Identify the patient's risk for injury. Determine if the risk of using less restrictive measures poses a greater risk than the risk of using a restraint. Consider risks associated with vulnerable populations (e.g., history of abuse or trauma, cognitive or physical limitations, medical conditions such as COPD, pregnancy, asthma, seizures, pressure ulcer risk, or surgery) (See Appendix 1: Restraint Algorithm).
2. Identify patient behaviors/condition that might trigger the use of restraints and determine the cause of the patient's behaviors whenever possible (external: such as excess noise, visitors or roommate issues, lack of communication, long waits, staff attitudes; internal: such as pain, delirium, history of depression/abuse/trauma, stroke, steroid use) and changes needed to help eliminate the causes.
3. Assess the need for least restrictive intervention and effectiveness of restraint alternatives (See Appendix 2: Considerations and Strategies Prior to Restraint).
4. Determine if the patient is a candidate for restraint when alternative measures fail to prevent imminent harm to the patient or other persons.
5. Explain the following to the patient, family or guardian, as appropriate before or after application based on patient situation:
    a. Restraint to be used and rationale
    b. Behavior changes that will allow for release or discontinuation
6. Inspect the area where the restraint is to be placed. Avoid interference with the functioning of medical devices/tubes/lines.
7. Inspect the patient's environment. Prevent patient access to potentially harmful items (e.g., lighter, matches, pillow, phone cord) by removing them from the restrained patient's room or person. Remove patient's shoes, tight clothing, contents of pockets, and eyeglasses when necessary for safety.
    a. **Patient Contraband: System**
    b. **Environmental Assessment Tool for Management of Suicide and/or Non-Suicidal, Self-Injurious Behaviors: System**
    c. **Behavioral Health-Environmental Risk Assessment**
    d. **Environmental Assessment Tool for Management of Suicide and/or Non-Suicidal, Self-Injurious Behaviors: System**
8. Assess and document the patient's need for bedrails. Indications for bedrail use as a protective measure (not a restraint) include but are not limited to:
    a. During patient transport
    b. Recovery from moderate/deep sedation or anesthesia
    c. Patient on seizure precautions
    d. Patient on specialty beds
    e. Crib with raised rails

Application

1. **Choose the least restrictive restraint that provides the best approach to maintain the safety of the patient and staff while considering the patient's physical and psychological needs.**
2. Obtain order for restraint (See Orders Section).
3. Ensure proper application of the restraint to ensure that the restraint is not too tight, which

may cause discomfort, agitation, and constriction of body parts, or too loose a restraint which may result in asphyxiation or other injury and/or escape.

4. Ensure the safety of the patient and team members when placing the patient in restraint. Request assistance from other staff as needed.
    a. Apply and secure the approved and prescribed restraint device properly. Allow for some movement of the extremity and provide for adequate circulation. Secure/lock restraints and verify integrity by tugging on the belt and lock.
    b. Always keep the locked restraint key accessible, when applicable.
    c. **When not in active use, do not leave restraint devices attached to the bedframe or in the patient's room.**
    d. Do not tie restraint straps to bedrails or use a knot to secure the device.
    e. **Application & Removal of Locked Limb Restraints - Standard Work** (Locked Restraints)
5. Place the patient in a comfortable and aligned position to avoid the risk of aspiration or injury (e.g., head of bed elevated, side lying for Obstructive Sleep Apnea patient). KEY POINT: Patients using noninvasive ventilation (NIV) in combination with mittens or limb restraints that are unable to remove mask creates aspiration risk.
6. Avoid placing the physical restraint over areas of impaired skin integrity (e.g., surgical incisions, abrasions). Padding the area where the restraint is to be applied may be necessary.
7. Observation requirements:
    a. If simultaneously using physical restraint AND seclusion, the patient must be continually monitored by trained staff, either through 1:1 observation or through the use of both video and audio equipment while in close proximity to the patient.
    b. *Trained staff will provide direct, continuous observation of the patient in restraints to ensure safety and to render and/or request immediate interventions. The observer will not leave the patient unless relieved by another qualified observer. An RN, PSA, MHC, PCT, EMT, EMT-P, or other staff trained to observe a violent/self-destructive patient can perform this observation.*

Personnel:

1. Only the trained Registered Nurse (RN), Physician, and/or Allied Health Professional (AHP) may determine the need to initiate the application and removal of restraints and seclusion.
2. The following *SLCH Restraint trained* staff may apply or remove restraints/begin and end seclusion under the direction of the RN:
    a. *Patient safety assistants (PSA)*
    b. *Mental health coaches (MHC)*
    c. *Patient care technicians (PCT)*
    d. *Emergency medical technicians (EMT)*
    e. *EMT-Paramedics (EMT-P)*
    f. *Public Safety*
3. The following *SLCH Restraint trained* staff may remove existing violent and self-destructive restraints and reapply to perform therapeutic intervention under the direction of the RN:
    a. *Patient safety assistants (PSA)*
    b. *Mental health coaches (MHC)*
    c. *Patient care technicians (PCT)*
    d. *Emergency medical technicians (EMT)*
    e. *EMT-Paramedics (EMT-P)*
    f. *Public Safety*

Orders:

1. An order by the physician or AHP responsible for the management and care of the patient is required at the time of initiation and at time frames specified below in 1.b.

a. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
b. The order must include the behavior(s) requiring the patient to be restrained, type and location of the restraint, and time limit for restraint:
    i. Less than or equal to 4 hours for ages 18 and older
    ii. Less than or equal to 2 hours for ages 9-17
    iii. Less than or equal to 1 hour for ages 8 years and younger.

2. In an urgent or emergent situation, staff with validated restraint competency, under the direction of the RN, may initiate physical restraints in advance of an order. Notify the provider once the patient's safety is secured to obtain an order for the restraint.
3. A new order is required whenever:
    a. The restraint reason, behavior (e.g., becomes non-violent), restraint type and/or location changes from current order.
    b. Restraint needs to be re-applied after discontinuation, regardless of current order is still active.
    c. Patient requires continuation of restraint intervention beyond current order time limit.
4. If the attending physician is not the person who ordered the restraint, they shall be notified the restraint was applied during the next rounding visit.
5. If the restraint is removed prior to the assessment, a face-to-face evaluation of the patient by the physician, AHP, or qualified Registered Nurse (see Definitions) is still required (See Assessment/Re-Assessment Section).

Assessment/Re-Assessment

1. A physician, AHP, or qualified RN will perform a face-to-face assessment of the patient in restraints on initiation (within 1 hour).
    a. If the face-to-face is conducted by a qualified RN, the qualified RN must consult the attending or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the assessment.
    b. A face-to-face assessment is not required with each order renewal up to a total of 24 hours of continuous restraint use.
    c. If restraint type changes, a new order and face-to-face assessment (within 1 hour of initiation) is required.
2. *While a patient is in restraints or seclusion, provide 1:1 direct, continuous in-person observation of the patient's behavior while in restraint to ensure safety and to render and/or request immediate interventions. The staff observer will not leave the patient unless relieved by another team member that has appropriate training.*
    a. *Reminder seclusion should only be used in approved ED or psychiatric preferred space.* ED Seclusion Policy Self-Releasing Lock Guideline
3. The nurse will evaluate and document the continued need for restraint at a minimum of hourly intervals, with the goal of discontinuing the patient from the restraint at the earliest possible time.
4. Visual checks of the patient in restraints (e.g., circulation, skin integrity) will be documented initially and at least every 1 hour thereafter, or more often if the patient behavior/condition warrants.
5. Release restraints to provide physical care needs (e.g., ROM, fluids, elimination, food/meal) and document releases approximately every 2 hours, or more often if the patient behavior/condition warrants.
    a. When the restraints are temporarily removed to meet care needs, they must remain with the patient to ensure patient safety.

Evaluation/Documentation

Initiation

1. On initiation of restraints, the following will be documented on the Restraint (V) Flowsheet:
    a. Restraint alternatives attempted
    b. Restraint order, Pre-application assessment
    c. Restraint Reason
    d. Education (discontinuation criteria, criteria explained, family notification, patient/caregiver response)
    e. Restraint monitoring section (e.g., visual check, circulation, skin integrity)
    f. START for each restraint type (V) initiated
2. Document Violent/Self-Destructive Restraint Care Plan on the Care Plan Activity.
    a. At SLCH: Emergency Department is excluded from Care Plan requirements.

Continued Use

1. If monitoring the patient in locked mechanical restraints and/or seclusion, have key readily accessible at all times.
2. Document the following on the Restraint (V) Flowsheet at the outlined frequencies:
    a. Restraint Monitoring Visual Checks (e.g., visual check, circulation) hourly and Restraint Monitoring- physical care needs (e.g., ROM, fluids, elimination, food/meal) every 2 hours.
    b. 'Restraint Type' document CONTINUED for each restraint type (V) every one hour, indicating patient behaviors support continued need for device.
3. Inspect the patient for any signs of physical injury, such as hazards of immobility and report the following conditions to the patient's treating provider immediately:
    a. Any significant change in patient behavior or condition
    b. Ineffectiveness of restraints in controlling behavior and/or increase in agitation
4. Evaluate and document progress towards outcomes and approaches to care on the Restraint Violent/Self-Destructive Care Plan at least daily.
    a. At SLCH: Emergency Department is excluded from Care Plan requirements.

Discontinuation

1. A temporary, directly supervised release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint or seclusion intervention. If the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.
2. Indications for discontinuation may include the following:
    a. Improved mental status
    b. Ability to adhere to instructions
    c. Alternative or less restrictive measures are effective
    d. Patient has met release criteria
    e. Patient is asleep or appears to be asleep
3. Document the following when restraints are discontinued:
    a. Under 'Restraint Type' enter DISCONTINUED for each restraint type removed indicating patient now able to corporate with care.
    a. The RN will resolve Violent Restraint Goals in the patient's care plan.
    b. If applicable, document less restrictive measures and/or restraint alternatives utilized.
4. Inspect the patient for any signs of physical injury, such as hazards of immobility and report the following conditions to the patient's treating provider immediately:
    a. Any significant change in patient behavior or condition
    b. Ineffectiveness of restraints in controlling behavior and/or increase in agitation

5. A physical restraint is a prescriptive device and is not to be sent home with the patient/family.

Adverse Outcomes and CMS Death Reporting

1. A process to assess and monitor the use of restraint or seclusion will be implemented and actions taken to ensure compliance with the policy, including appropriateness of use.
2. Report any adverse outcome (e.g., injury or death) that occurs to a patient while in restraint. The nurse will include details about the incident, to include the type and location of the restraint and immediately notify the following:
    a. *Charge nurses and Administrative Supervisor (314-713-0931)*
    b. *The Administrative Supervisor will notify Risk Management.*
    c. *The supervising physician, if not already aware, who will notify the patient's attending physician.*
    d. Place in Safety Event Management System (SEMS)
3. Regulatory agency reporting requirements will be completed by *Regulatory Compliance/Risk Management Department.*
4. The CMS Regional Office will be notified of each death that occurs:
    a. While a patient is in restraint or in seclusion, except when no seclusion has been used and the only restraint used was two-point soft limb wrist restraints.
    b. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was two-point soft limb restraints; or
    c. Within one week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time.
5. Required reports will be submitted to CMS Regional Office by the close of the next business day following the day in which the hospital knows of the patient's death.
6. *Regulatory Compliance/Risk Management Department* documents the following in the patient's medical record the date and time the death was:
    a. Reported to CMS for deaths required to be reported directly
    b. Recorded in the internal log or other system for deaths that are required to be logged and not reported directly to CMS.

Education and Training

1. Safe and effective use of restraint devices will be demonstrated initially and validated as part of orientation (before participating in the application of restraints) and at least annually for staff members who apply/remove, monitor, assess and provide care to patients in restraints.
2. Training content shall include, at a minimum, the following:
    a. Techniques to identify staff and patient behaviors that may trigger use of restraint
    b. The use of nonphysical intervention skills
    c. Choosing the least restrictive intervention
    d. Safe application and how to recognize and respond to physical and psychological distress
    e. Identification of behavioral changes that indicate restraint is no longer needed
    f. Monitoring physical and psychological well-being of restrained patient
    g. The use of first aid techniques, certification in the use of cardiopulmonary resuscitation (BLS – Basic Life Support) and appropriate code/emergency response
3. Physicians and AHPs authorized to order restraint must have a working knowledge of the hospital restraint policy.
4. Qualified RNs (who perform face-to-face assessments) receive all content outlined above

and additional education to include:

a. Content to evaluate the patient's immediate situation, the patient's reaction to intervention, the patient's medical and behavioral condition (e.g., systems assessment, behavioral assessment, review and assessment of the patient's history, medications, lab results), and the need to continue or terminate the restraint or seclusion.

DEFINITIONS

1. **Authorized physician, clinical psychologist, or other Licensed Independent Practitioner**: An individual primarily responsible for the patient's ongoing care who is legally authorized to practice by the state of *Missouri* and who is acting within the scope of his or her license when they order restraint or seclusion.
2. **Debriefing**: A debrief held following an episode of violent and self-destructive restraint for team members to critically assess the effectiveness of the intervention and to determine strengths and opportunities for improvement. A patient debriefing re-establishes therapeutic rapport and identifies patient-stated alternatives to future escalation.
3. **Drugs Used as Restraint (Pharmacologic/Chemical Restraint):** A drug or medication used for management of a patient's behavior or to restrict the patient's freedom of movement and is **not** a standard treatment or dosage for the patient's medical or psychiatric condition. A drug is a standard treatment for a patient's condition and therefore not a restraint when:
    a. It is within parameters approved by the FDA and manufacturers
    b. It follows national professional practice standards
    c. It treats a specific condition (examples: sedation for asynchronous ventilation, neuromuscular blockade agents).

    Example of a medication that is NOT a chemical restraint: A patient is in a detoxification program. The patient becomes violent and aggressive. Staff administers a PRN medication ordered by the patient's physician or other AHP to address these types of outbursts. The use of the medication enables the patient to better interact with others or function more effectively. In this case, the medication used for this patient is not considered a "drug used as a restraint" or "chemical restraint." The availability of a PRN medication to manage outbursts of specific behaviors, such as aggressive, violent behavior is standard for this patient's medical condition (i.e., drug or alcohol withdrawal). Therefore, this patient's medication does not meet the definition of "drug used as a restraint" since it is a standard treatment or dosage for the patient's medical or psychiatric condition.

    Example of a chemical restraint: An elderly post op hip patient that is found wandering in the halls is prescribed and administered a higher-than-normal dose of Haldol because this behavior is disruptive to the nursing staff. The patient cannot stay awake enough to eat their next meal due the sedating effects of the medication.
4. **Forensic Devices:** Devices applied by law enforcement officials to the legally /correctional restricted patient (e.g., handcuffs, shackles). These are not clinical restraints to be managed by the clinical care team. See *Local Policy on Management of Forensic Patients.* Prisoners SLCH Main Campus only-Care of Prisoners in the Surgery Area
5. **Locked Limb Restraints**: Used to control the behavior of a strong, violent and aggressive patient who could injure self, other patients and/or staff.
6. **Non-restraint devices-** Any device used for the reasons of medical immobilization, adaptive support or protection. Examples include:
    a. **Medical Immobilization-** mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures/ tests that are considered a routine part of such procedures/ tests (e.g., arm board for IV, papoose/ mummy restraint for infants/children, safety straps in procedural areas, bedrail(s) raised

while Continuous Passive Motion (CPM) device attached to affected side(s), bedrail(s) raised for patients on specialty beds).

   b. **Adaptive Support-** mechanisms intended to support the patient's posture and permit a patient to achieve maximum normative bodily functioning (e.g., braces, casts, special wheelchairs).
   c. **Protective Device-** mechanisms intended to compensate for a specific physical deficit or minimize safety hazards not related to cognitive dysfunction (e.g., bumper pads, helmets, bedrails used during transport, bedrails raised for seizure precautions or for patients recovering from sedation or anesthesia in the recovery room or ICU).

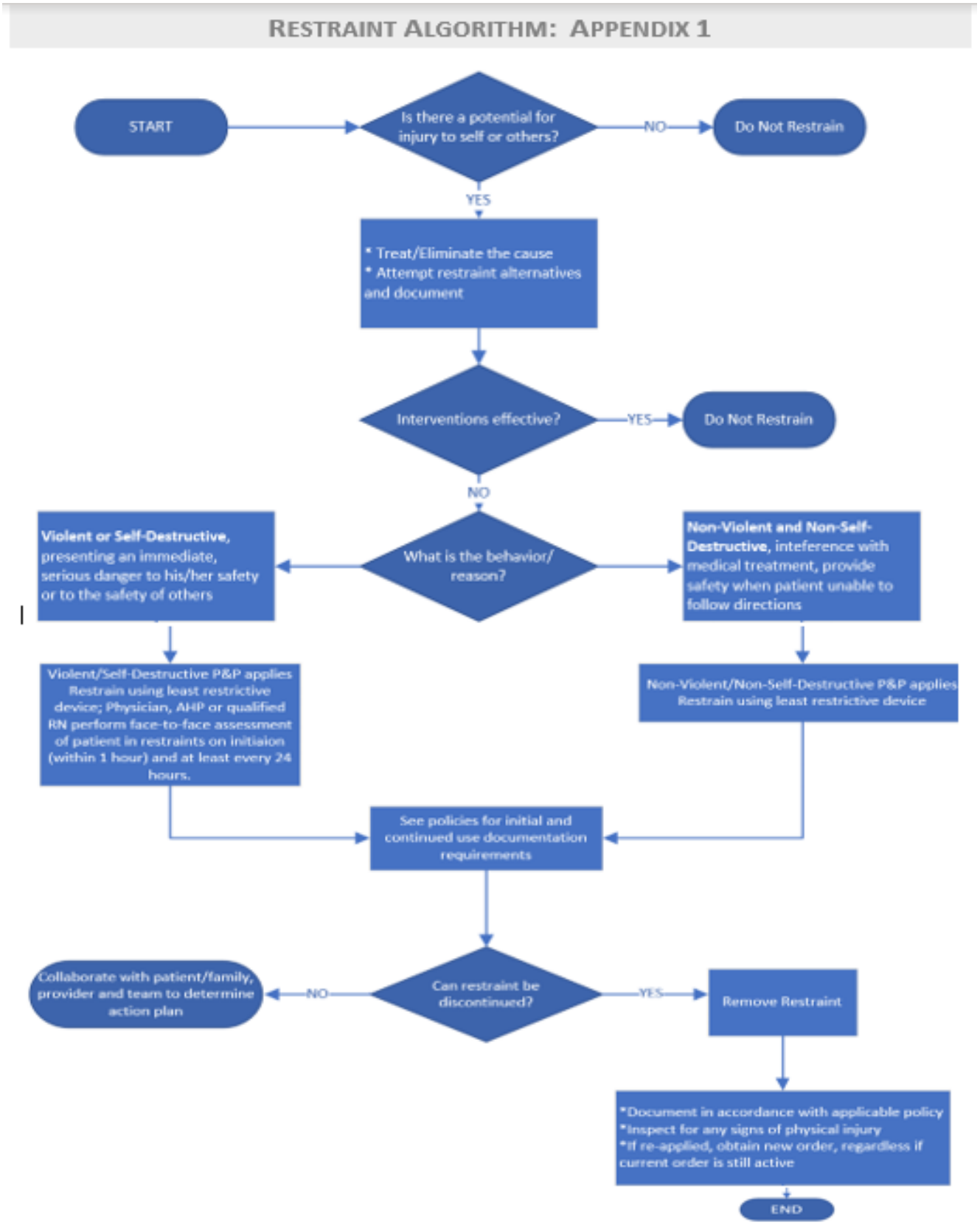
7. **Physical Restraint:** Any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body or head and cannot be easily removed by the patient.
   Examples include:
   a. 4-point soft limb restraints used to temporarily control the behavior of a patient that is kicking and punching at staff.
   b. Locked limb restraints used to control the behavior of a strong, violent and aggressive patient who could injure themselves, other patients and/or staff.
   c. Devices such as bedrails and geri-chairs serve multiple purposes. These devices are a restraint when used to restrict movement and cannot be easily removed by the patient.
   d. Physically holding a patient to administer a medication against the patient's wishes (previously referred to as "therapeutic holds").
   e. Enclosure beds are not an approved violent restraint device. Enclosure Bed-Posey
8. **Qualified Registered Nurse:** Registered Nurses are nurses that are authorized to conduct face-to-face assessments when they receive specific training outlined in **Education and Training** section of this policy.
   a. All registered nurses in the pediatric behavioral health unit will be trained as a part of orientation and annually thereafter.
9. **Seclusion:** The involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. Seclusion may only be used for violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others. (Restricted to inpatient psychiatry units, identified psychiatric preferred areas and Emergency Departments with the capability of providing a safe space for seclusion).
   a. **Timeout:** is not considered seclusion. A procedure used to assist the individual to regain emotional control by removing the individual from his/her immediate environment to a designated quiet area or unlocked room for an agreed upon timeframe (no more than 30 minutes) from which the patient is not physically prevented from leaving.
10. **Therapeutic hold**: Physically holding a patient in a manner that restricts the patient's movement and is against the patient's will. Therapeutic hold can only be applied by staff *trained in Crisis Prevention Institute (CPI) techniques* and are used in circumstances where the safety of the patient, staff and others is jeopardized. Physically holding a patient during a forced psychotropic medication administration is considered a restraint.
11. **Violent and Self-Destructive:** An emergent, crisis situation where a patient's behavior becomes violent or self-destructive presenting an immediate, serious danger to his/her safety or to the safety of others.

REFERENCES

Centers for Medicare & Medicaid Services (CMS) Conditions of Participation; State Operations Manual for Hospitals, Appendix A (Rev. 200, 02-21-20).
Joint Commission Comprehensive Accreditation Manual for Hospitals, January 2022.

APPENDICES

1. Restraint Algorithm: System
2. Considerations and Strategies Prior to Restraints
3. Guidelines for the Use of Restraint and Restraint Alternative Products
   Larger Image of Algorithm: Restraint Algorithm: System
4. Washing Instructions for Locked Limb Restraints



Appendix 2: Considerations and Strategies Prior to Restraints

For specific device information refer to Use Of Restraint & Restraint Alternative Products.

Risk Factor	Alternative Approaches to Try	Specific Devices
Agitation/ restlessness	*Identify cause of the behavior. Is it associated with bladder or bowel urgency, fecal impaction, or urinaryretention? Does it occur at certain times of the day, during noisy or stressful situations? Are sensory impairments present? Is there a pathological basis (anemia, hypoxia, electrolyte imbalance, steroids)? *Reduce physical discomfort: non-pharmacologic pain relief, treat medical illness, constipation or urinaryretention, re-position, adjust toileting schedule, back rubs, massage *Use distraction and/or repetitive motion activities (e.g., folding, sorting, coloring, playing cards) *Reduce excess stimulation, don't leave music or TV on all the time *Provide for the patient's normal sleep patterns *Provide for periods of activity/exercise (e.g., taking a walk, taking a shower/bath). Consider PT/OT consult *Provide for periods of rest/ relaxation *Offer culturally sensitive spiritual/ religious items for comfort *Make sure glasses or hearing devices are in use. *Adjust lighting and/ or temperature in the room *Involve the patient in decision making *Speak calmly and use simple sentences; be aware of nonverbal communication *Offer listening to music of choice, food/fluid or phone call to friend/ family *Give the patient something soft to hold or a familiar object from home * Evaluate the need for Behavioral Health, Psychiatric, Geriatric or spiritual care consult	Diversional activity
Acting out	*Verbal intervention *Redirection *De-escalation -Maintain a safe personal space with patient and ensure access to an exit is available -Assess the situation: What does the patient need/ want? What are the stressors? -Look for a solution to the patients need and/or stressor -Be empathetic and show concern for the patient -Avoid power struggles; be honest and give clear options -Stay calm and confident, use calm, clear tone of voice -Be assertive, not aggressive in voice, posture,	

	and non-verbals -Maintain patient's self-esteem and dignity *1:1 time with staff *Time out in room *Routine or PRN treatment medications specified for control of tension, anxiety or thought disturbance * Evaluate the need for Behavioral Health, Psychiatric, Geriatric or spiritual care consult	

Appendix 3: Guidelines for the Use of Restraint and Restraint Alternative Products

Note: The intent of these guidelines is to provide patient care providers with reference material concerning the use of physical restraints and restraint alternatives. Guidelines are not all inclusive. Manufacturer's Instructions for Use should be used and referred to when there are questions on application of these devices.

PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION
Peek-a-boo Mittens **Restraint Alternative OR** **Restraint** (when patient is unable to self-release or used in conjunction with a limb restraint, roll belt, or wrap belt) 	Floor stock in select inpatient units. May be ordered through Epic or by calling supply directly.	Patients who are picking or pulling at tubes/lines or skin, interfering with medical devices/treatment, or hitting self or others.	To prevent interference with medical treatment or injury to self or others. Maximize limb movement (when untethered) Promote patient safety	*Refer to manufacturer's instructions for use for full details *Insert patient's hand into mitt & put strap around smallest part of wrist *Bring straps over top of wrist; adjust tightness allowing for two fingers. *Check integrity of skin & fingers under device after application & at least every 2hrs for redness, swelling, color change, & temperature. *Hands sweat under mittens; wash & dry hands with each

				release & PRN. *If used in combination with soft limb restraint, devices should not overlap as this will loosen fit.
Diversional activities **Restraint Alternative**	Unit supplies, Occupational Therapy, Child Life	Patients demonstrating behavioral abnormalities such as verbal irritability, physical aggressiveness, wandering, hallucination, delusions, night time awakenings, or boredom	Provide tactile stimulation to calm & soothe Provide distraction Involve patient in meaningful activity Enhance mental stimulation	*Keep items in a central location *Utilize family/friends to determine patient preferences or needs. Examples: Stuffed animal, pillow, Koosh ball, puzzles, sewing card, music, reading materials, folding towels
Soft Limb **Restraint** 	Adult standard size is stocked on most units. *Posey Soft Foam Limb Holder #2532* Neonatal sizes stocked in NICU. *Posey Soft*	Cognitively or judgment impaired patients who require reminder to rest limb, not pick at skin, tubes or lines, hit self or others.	When all alternatives to restraint have been considered/employed and application of the limb restraint is needed to protect the patient or others from injury. To promote patient safety	See manufacturer's instructions for use. *If 1 upper & 1 lower extremity, apply on opposite sides of body. Unilateral application should not occur as could

	Pediatric Limb Holder #4733 May also order through central supply.		To promote the safety of others To facilitate medical treatment	result in patient dangling from bed. *DO NOT ATTACH TO SIDERAILS.
Twice as Tough Locked Limb Restraints Restricted to Violent & Self-Destructive Behaviors **Restraint** 	Units with Psych preferred rooms must keep these available for use. Ordered directly through central supply. *Posey Twice as Tough (TAT) Cuffs #2798 & #2799*	Acutely psychotic, and/or patients who pose immediate threat of injury to self or others. When manifested behavior indicates the need for a stronger device than the soft limb holder	Acute episodes of hostile behavior, which must be immediately controlled. To promote patient safety and safety of others. To facilitate treatment/provide for evaluation.	*Read package instructions prior to use. *Complete Locked Limb Restraint SKILLS CHECKLIST prior to use *Blue cuff = wrists, red cuff = ankles or larger wrists *Device is single patient use unless cleaned per manufacturers' instructions. *Do not extend elbow above the shoulder. *Do not place device over open wounds, fractured/ dislocated limbs or IV site. *Pad the restraints only if needed. *Slide 1 finger between cuff & strap. *Allow some slack so limb is not completely immobilized. *Provide direct continuous observation. *Check integrity of skin and

				circulation q 1hr. *Provide ROM approximately q 2 hours *Ensure key is readily accessible to staff at all times (e.g., should not be carried by any one person).

Appendix 4: Cleaning Instructions for Locked Limb Restraints

Blue: Wrist Restraint; **Red** Ankle Restraint

LAUNDERING INSTRUCTIONS:

1. Locked limb restraints are not disposable and should be cleaned when soiled and between use on different patients.
    a. Strongly recommend having an extra set of clean restraints available while the soiled restraints are being laundered.
2. Fasten all buckles and locks to reduce risk of damage during wash and dry
3. cycles.
4. Launder in a laundry bag or pillowcase with the end secured.
5. Hook-and-loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the “hook” to the “loop” before laundering to help prevent lint buildup. As needed, use a stiff-bristle brush to remove lint from the “hook” side.
6. Wash on hot for 25 minutes.
    a. Laundering in hot water for 25 minutes is acceptable by CDC guidelines for material soiled with blood or bodily fluids.
7. Air dry. DO NOT place in dryer.
8. When dry, store in clean container.

Restraints: Management of Non-Violent and Non-Self-Destructive Behaviors: Core - SLCH

EXCLUSIONS

BJC Home Care, BJC Behavioral Health, BJC Medical Group

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POLICY STATEMENT

The purpose of this policy is to establish standardized decision-making criteria and practical procedures for the use and discontinuation of restraints in order to protect the patient's health and safety and the safety of others, as well as to preserve the patient's dignity, rights and well-being. Devices applied by law enforcement ("forensic restraints") to patients from correctional institutions are not clinical restraints for purposes of this policy. See local policy regarding management of prisoners.

6. Restraint application should only occur after restraint alternatives have been considered and/or attempted, deemed unsuccessful, and if needed to ensure the immediate safety of the patient and/or others.
7. Behaviors that precipitate the decision to restrain should trigger further investigation aimed at understanding and eliminating the cause(s) of the behavior(s).
8. Restraints are not to be used as a means of coercion, discipline, convenience, or staff retaliation.
9. Non-violent restraints may be considered if a patient's behavior is disruptive in a way that interferes with medical treatments (e.g., risk of dislodging artificial airways, vascular access lines, compromising surgical sites). The primary purpose of restraints for the non-violent/non-self-destructive patient is to promote; healing. The use of restraints or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff

member, or others and must be discontinued at the earliest possible time.

10. The use of restraint must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation. Staff must assess and monitor the patient's condition on an ongoing basis to ensure that the patient is released at the earliest possible time, regardless of the expiration of the order.
11. Chemical restraints are medications used to restrict the patient's freedom of movement or their behavior and are not a standard treatment or dosage for the patient's condition. See definitions section for more detail and examples.

PROCEDURE

Considerations Prior to Restraint Use

9. Identify the patient's risk for injury. Determine if the risk of using less restrictive measures poses a greater risk than the risk of using a restraint. Consider risks associated with vulnerable populations (e.g., history of abuse or trauma, cognitive or physical limitations, medical conditions such as COPD, pregnancy, asthma, seizures, pressure ulcer risk, or surgery) (See Appendix 1: Restraint Algorithm).
10. Identify patient behaviors/condition that might trigger the use of restraints and determine the cause of the patient's behaviors whenever possible (external: such as excess noise, visitors or roommate issues, lack of communication, long waits, staff attitudes; internal: such as pain, delirium, history of depression/abuse/trauma, stroke, steroid use; **pediatric: developmental age, cognitive understanding, fear**) and changes needed to help eliminate the causes.
11. Assess the need for least restrictive intervention and effectiveness of restraint alternatives (See Appendix 2: Considerations and Strategies Prior to Restraints).
12. Determine if the patient is a candidate for physical restraint when alternative measures fail to prevent imminent harm to the patient or others. Examples include:
    a. Confused, disoriented or restless to the degree that the patient is not responsible for safe decision-making and may harm self.
    b. Behaviors leading to attempts to remove life support devices (ET tube, IV, GI/GU tubes).
13. Explain the following to the patient and/or family, as appropriate before or after application based on patient situation:
    a. Restraint to be used and rationale
    b. **The use of the call light and rounding/ care routines while in restraints.**
    c. Behavior changes that will allow for release or discontinuation
14. Inspect the area where the restraint is to be placed. Avoid interference with the functioning of medical devices/tubes/lines.
15. Assess and document the patient's need for bedrails. Indications for bedrail use as a protective measure (not a restraint) include but are not limited to:
    a. ED stretcher
    b. During patient transport
    c. Recovery from moderate/deep sedation or anesthesia
    d. Patient on seizure precautions
    e. Patient on specialty beds
    f. Crib with raised rails

Application

1. Choose the least restrictive restraint that provides the best approach to maintain the safety

of the patient and staff while considering the patient's physical and psychological needs. (See Appendix 4: Degree of Restrictiveness Grid).

2. Obtain order for restraint (See Orders Section).
3. Ensure proper application of the restraint to ensure that the restraint is not too tight, which may cause discomfort, agitation and/or constriction of body parts; or that the restraint is not too loose, which may result in asphyxiation or other injury and/or enable potential for self-removal.
4. Apply and secure the approved and prescribed restraint device properly. Allow for some movement of the extremity and provide for adequate circulation.
5. Do not tie restraint straps to bedrails or use a knot to secure the device.
6. Evaluate the patient's ability to use call light and place needed items within reach. Identify an alternative method (e.g., soft touch call light, bell, 1:1) if patient unable to demonstrate use of call light.
7. Place the patient in a comfortable and aligned position to avoid the risk of aspiration or injury (e.g., head of bed elevated, side lying for Obstructive Sleep Apnea patient). KEY POINT: Patients using noninvasive ventilation (NIV) in combination with mittens or limb restraints that are unable to remove mask creates aspiration risk.
8. Avoid placing physical restraint over areas of impaired skin integrity (e.g., surgical incisions, abrasions). Padding the area where the restraint is to be applied may be necessary.
9. Apply bed exit alarm device or engage built-in bed exit alarm for patients in physical restraints, when appropriate. Ensure that bed exit alarm is activated and functional.

Personnel

4. Only the trained Registered Nurse (RN), Physician, and/or Allied Health Professional (AHP) may determine the need to initiate the application and removal of restraints.
5. The following trained staff may apply or remove restraints <u>under the direction of the RN</u>:
    a. a. Patient safety assistants (PSA)
    b. b. Mental health coaches (MHC)
    c. c. Patient care technicians (PCT)
    d. d. Emergency medical technicians (EMT)
    e. e. EMT-Paramedics (EMT-P)
6. The following trained *staff may remove existing* non-violent and non-self-destructive restraints and reapply in order to perform therapeutic intervention <u>under the direction of the RN</u>:
    a. Child Life
    b. Occupational Therapist, Aide or Assistant
    c. Operating Room Technician
    d. Physical Therapist, Aide or Assistant
    e. Respiratory Therapist
    f. Speech Therapist

Orders

6. An order by the provider responsible for the patient's care is required at the time of initiation and each calendar day following the evaluation of continued need. Refer to #6 for exception to calendar day order in the ICU setting.
7. Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
    a. **Exception**: repetitive self-mutilating behaviors.
        If a patient is diagnosed with a severe chronic medical or psychiatric condition and engages in repetitive, intractable self-mutilating behavior, a PRN order for restraint is acceptable with specific parameters established in the treatment plan.

- Psychiatry consult is recommended.
- Assessments will be performed at intervals defined for non-violent restraints.
- Documentation must include patient's inability to understand criteria for restraint removal.

8. In an urgent or emergent situation, staff with validated restraint competency may initiate physical restraints in advance of an order. Notify the provider once the patient's safety is secured to obtain an order for the restraint.
9. A new order is required whenever:
    a. The restraint reason, behavior (e.g., becomes violent), type and/or location changes from current order.
    b. Restraint needs to be re-applied after discontinuation, regardless if current order is still active.
10. If the attending physician is not the person who ordered the restraint, they shall be notified that the restraint was applied during the next rounding visit.
11. ICU Non-Violent Restraint Order is entered at time of initiation only and is effective until the patient no longer meets criteria as follows:
    a. Inability to adhere to instructions preventing continuation of medical treatment and risks the safety of lines/tubes/drains/devices/dressings AND
    b. Restraint type may only include a single or combined application of upper soft limb, mittens used as a restraint, and/or wrap or roll belts (any other restraint type requires use of regular non-violent restraint order that is renewed every calendar day)
    c. Discontinuation Criteria: Improved mental/cognitive status resulting in consistent ability to adhere to instructions, permitting continuation of medical treatment and safety of lines/tubes/drains/dressings.

Assessment/Re-Assessment

6. The nurse will evaluate and document the continued need for restraint at a minimum of every two-hour intervals, with the goal of discontinuing the patient from the restraint at the earliest possible time.
7. Visual checks of the patient in restraints (e.g., circulation, skin integrity) will be documented initially and at least every 2 hours thereafter, or more often if the patient behavior/condition warrants.
8. Release restraints to provide physical care needs (e.g., ROM, fluids, elimination, food/meal) and document releases approximately every 2 hours, or more often if the patient behavior/condition warrants.
    a. When the restraints are temporarily removed to meet care needs, the caregiver must remain with the patient to ensure patient safety.

Evaluation/Documentation

Initiation

3. On initiation of restraints, the following will be documented on the Restraint NV Flowsheet:
    a. Restraint alternatives attempted
    b. Restraint reason
    c. Education (discontinuation criteria, criteria explained, family notification, patient/caregiver response)
    d. Notification of family/representative
    e. Restraint monitoring section (e.g., visual check, circulation, skin integrity)
    f. START for each restraint type (NV) initiated
4. Document Non-Violent Restraint Care Plan on the Care Plan Activity.

Continued Use

1. Document the following on the Restraint NV Flowsheet at a minimum every two (2) hours:
    a. Restraint monitoring sections (e.g., visual check, circulation)
        i. KEY POINT: If patient is off the unit, document 'Patient off unit' under 'Visual Check'.
    b. 'Restraint Type' document CONTINUED for each restraint type (NV) indicating patient behaviors support continued need for device.
2. Inspect the patient for any signs of physical injury, such as hazards of immobility and report the following conditions to the patient's treating provider immediately:
    a. Any significant change in patient behavior or condition
    b. Ineffectiveness of restraints in controlling behavior and/or increase in agitation
    c. Patient/family refusal of restraints
3. Evaluate and document progress towards outcomes and approaches to care on the Non-Violent/Non-Self-Destructive Care Plan at least daily.

Discontinuation

1. A temporary release under the direct supervision of the staff member that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) where the staff member is serving the same purpose as the restraint; or alternating between the wrap belt while in chair and roll belt while in bed, is not considered a discontinuation of the restraint intervention.
2. Indications for discontinuation may include the following:
    a. Improved mental status
    b. Ability to adhere to instructions
    c. Discontinuation of tubes/lines/devices/dressings
    d. Elimination of restrictions in activity
    e. Alternative or less restrictive measures are effective
3. Document the following when restraints are discontinued:
    a. Under 'Restraint Type' enter DISCONTINUED for each restraint type removed indicating patient now able to cooperate with care
    b. The RN will resolve Non-Violent Restraint Goals in the patient's care plan.
    c. Ensure restraint order is discontinued.
    d. If applicable, document the less restrictive measures and/or restraint alternatives that will now be utilized along with patient/family education.
4. Inspect the patient for any signs of physical injury, such as hazards of immobility and report the following conditions to the patient's treating provider immediately:
    a. Any significant change in patient behavior or condition
    b. Ineffectiveness of restraints in controlling behavior and/or increase in agitation
5. When not in active use, do not leave restraint devices attached to the bedframe or in the patient's room
6. A physical restraint is a prescriptive device and is not to be sent home with the patient/family.

Adverse Outcomes and CMS Death Reporting

1. A process to assess and monitor the use of restraint will be implemented and actions taken to ensure compliance with the policy, including appropriateness of use.
2. Report any adverse outcome (e.g., injury or death) that occurs to a patient while in restraint. The nurse will include details about the incident, to include the type and location of the restraint and immediately notify the following:
    a. Charge nurses and Administrative Supervisor (314-713-0931)
    b. The Administrative Supervisor will notify Risk Management.

c. The supervising physician, if not already aware, who will notify the patient's attending physician.
d. Enter in Safety Event Management System (SEMS)

3. Regulatory agency reporting requirements will be completed by *Regulatory Compliance/Risk Management Department.*

4. The CMS Regional Office will be notified of each death that occurs:
    a. While a patient is in restraint or in seclusion, except when no seclusion has been used and the only restraint used was two-point soft limb wrist restraints;
    b. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was two-point soft limb wrist restraints; or
    c. Within 1 week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time
2. Required reports will be submitted to the CMS Regional Office by the close of the next business day following the day in which the hospital knows of the patient's death.
3. After reviewing Regulatory Compliance/Risk Management Department documents the following in the patient's medical record the date and time the death was:
    a. Reported to CMS for deaths required to be directly reported and;
    b. Recorded in the internal log or other system for deaths that are required to be logged and not reported directly to CMS.

Education and Training

5. Safe and effective use of restraint devices will be demonstrated initially and validated as part of orientation (before participating in the application of restraints), and at least annually for staff members who apply/remove, monitor, assess and provide care to patients in restraints.
6. Training content shall include, at a minimum, the following:
    a. Techniques to identify staff and patient behaviors that may trigger use of restraint
    b. The use of nonphysical intervention skills
    c. Choosing the least restrictive intervention
    d. Safe application and how to recognize and respond to physical and psychological distress
    e. Identification of behavioral changes that indicate restraint is no longer needed
    f. Monitoring physical and psychological well-being of restrained patient
    g. The use of first aid techniques, certification in the use of cardiopulmonary resuscitation (BLS – basic life support) and activation of appropriate code/emergency response
7. Physicians and AHPs authorized to order restraint must have a working knowledge of the hospital restraint policy.

DEFINITIONS

12. **Authorized physician, clinical psychologist, or other Licensed Practitioner**: An individual primarily responsible for the patient's ongoing care who is legally authorized to practice by the state of Missouri and who is acting within the scope of his or her license when they order restraint or seclusion.
13. **Drugs Used as Restraint (Pharmacologic/Chemical Restraint):** A drug or medication used for management of a patient's behavior or to restrict the patient's freedom of movement and is **not** a standard treatment or dosage for the patient's medical or psychiatric condition. A drug

is a standard treatment for a patient's condition and therefore not a restraint when:

a. It is within parameters approved by the FDA and manufacturers
b. It follows national professional practice standards
c. It treats a specific condition (examples: sedation for asynchronous ventilation, neuromuscular blockade agents, pre-procedure sedation).

Example of a medication that is NOT a chemical restraint: A patient is in a detoxification program. The patient becomes violent and aggressive. Staff administers a PRN medication ordered by the patient's physician or other AHP to address these types of outbursts. The use of the medication enables the patient to better interact with others or function more effectively. In this case, the medication used for this patient is not considered a "drug used as a restraint" or "chemical restraint." The availability of a PRN medication to manage outbursts of specific behaviors, such as aggressive, violent behavior is standard for this patient's medical condition (i.e., drug or alcohol withdrawal). Therefore, this patient's medication does not meet the definition of "drug used as a restraint" since it is a standard treatment or dosage for the patient's medical or psychiatric condition. The same applies to pediatric patient's patients with behavioral health needs. Medications that are part of the patient's treatment plan to address anxiety, aggression or other symptoms are not considered a chemical restraint.

Example of a chemical restraint: An elderly post op hip patient that is found wandering in the halls is prescribed and administered a higher-than-normal dose of Haldol because this behavior is disruptive to the nursing staff. The patient cannot stay awake enough to eat their next meal due the sedating effects of the medication.

14. **Forensic Devices:** Devices applied by law enforcement officials to the legally /correctional restricted patient (e.g., handcuffs, shackles). These are not clinical restraints to be managed by the clinical care team. See Prisoners or SLCH Main Campus only-Care of Prisoners in the Surgery Area.

15. **Non-Violent and Non-Self-Destructive Restraint:** Implemented for medical or surgical purposes and applied when the primary reason for use directly supports medical healing and to allow medical treatments to continue without disruption, prevent pulling out necessary tubes or drains, and/or provide safety when the patient is unable to follow directions.
    a. See Restraints: Management of Violent and Self-Destructive Behaviors: St. Louis Children's Hospital and CPI - Crisis Prevention Institute Response Plan for emergent, crisis situations where a patient's behavior becomes violent or self-destructive, presenting an immediate, serious danger to his/her safety or the safety of others.
16. **Non-restraint devices-** Any device used for the reasons of medical immobilization, adaptive support or protection. Examples may include but are not limited to:
    a. **Medical Immobilization, Positioning or Securing Devices-** Medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize a patient during a medical, dental, diagnostic, or surgical procedure is not a restraint. Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures/ tests that are considered a routine part of such procedures/ tests include but are not limited to: arm board for IV, papoose/ mummy restraint for infants/children, gait belts when used for safe ambulation, safety straps in procedural areas, bedrail(s) raised while Continuous Passive Motion (CPM) device attached to affected side(s), bedrail(s) raised for patients on specialty beds. Developmentally appropriate positioning and holding of infants, toddlers, pre-school and some school-age children for medication administration and in all patients for phlebotomy, IV or nasogastric insertion, or other procedures is not a restraint.

b. **Adaptive Support-** mechanisms intended to support the patient's posture and permit a patient to achieve maximum normative bodily functioning (e.g., braces, casts, special wheelchairs, positioners).
c. **Protective Device-** mechanisms intended to compensate for a specific physical deficit or minimize safety hazards not related to cognitive dysfunction (e.g., seizure pads, highchair, infant seat, crib rails, bumper pads, helmets, bedrails used during transport, bedrails raised for seizure precautions or for patients recovering from sedation or anesthesia in the recovery room or ICU).
d. **Environmental Safety** – Based on the developmental age of pediatric patients, certain types of protective equipment are age-appropriate and used for patient safety: bed and stretcher siderails, crib covers, highchairs, infant seats, swings, safety belts on wheelchairs, etc.

17. **Physical Restraint:** Any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body or head and cannot be easily removed by the patient.
Examples include:
    a. A soft limb restraint applied to the arm to prevent a patient from pulling out an IV.
    b. Bedrails used to inhibit the patient's ability to get out of bed at will when he/she desires.
    c. Geri-chair with tray locked in place.
    d. Devices such as bedrails and geri-chairs serve multiple purposes. These devices are a restraint when used to restrict movement and cannot be easily removed by the patient.

    Physical hold of extremities or persons, previously referred to as "therapeutic holds."

REFERENCES

Centers for Medicare & Medicaid Services (CMS) Conditions of Participation; State Operations Manual for Hospitals, Appendix A (Rev. 200, 02-21-20). Joint Commission Comprehensive Accreditation Manual for Hospitals, July 2022

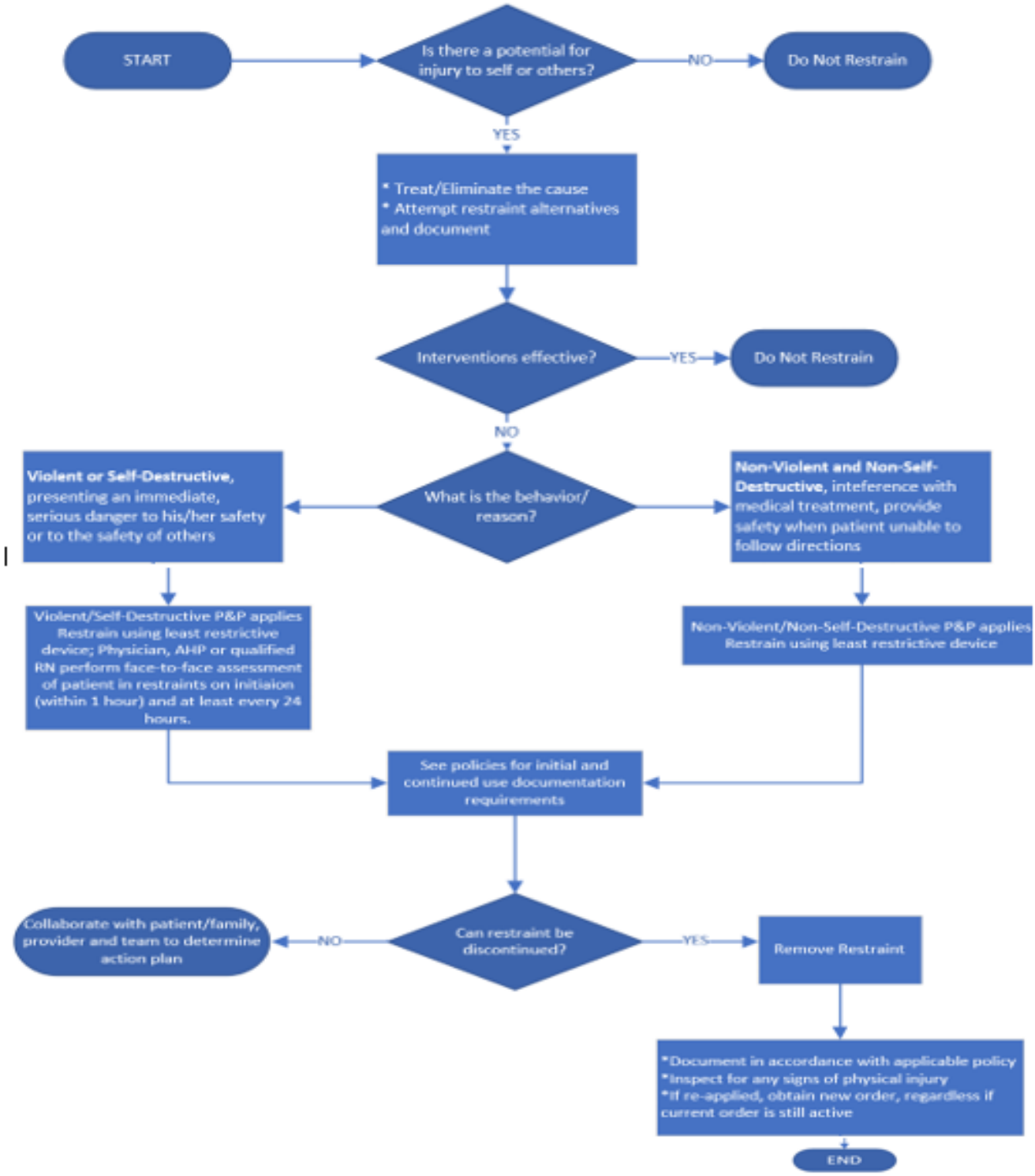
APPENDICES

Restraint Algorithm: System
5. Considerations and Strategies Prior to Restraints
6. Guidelines for the Use of Restraint and Restraint Alternative Products

Degree of Restrictiveness Grid

Larger image of Algorithm: Restraint Algorithm: System

RESTRAINT ALGORITHM: APPENDIX 1



Appendix 2: Considerations and Strategies Prior to Restraints

For specific device information refer to Use Of Restraint & Restraint Alternative Products.

Risk Factor	Alternative Approaches to Try	Specific Devices
Risk of falling during ambulation (Refer to Fall Prevention Policy)	*Assess patient's gait, balance and ability to walk safely *Evaluate the need for PT consult *Evaluate the need for an ambulation assistive device *Schedule every 2-3 hour toileting rounds or as often as needed *Orient the patient to the environment *Ask patient to demonstrate how to use the call light on the bed & in the bathroom *Keep the bed in low position with wheels locked *Adjust the bedside commode to fit the height and comfort of the patient *Place the call light & personal items within easy reach *Leave at least one lower side rail down on patients preferred bed exit side *Instruct patient to sit on the side of the bed for a few minutes before standing *Reinforce the need to call for help before getting out of bed if dizzy or weak *Maintain a clear walking path to the bathroom *Place IV pump on patient's preferred exit side of bed and over bed table on opposite side *Leave a night light on during evening/ night hours *Review medications which may cause sedation, or postural hypotension	Low Bed Floor mat Slip resistant matting Ultimate Walker Walker Cane Bedside commode Non-skid footwear Bed/chair exit alarm Roll belt Wrap belt
Wandering/ trying to get out of bed	*Identify the cause of wandering such as hunger, thirst, discomfort, need to use the bathroom, need for exercise, sensory deprivation or over-stimulation, worsening confusion due to dehydration, infection, CHF or medication effects *Reduce physical discomfort (e.g., non-pharmacologic pain relief, positioning, temperature adjustment, back rubs/ massage) *Orient to the environment and use visual cues as a reminder *Maintain familiar routines & caregivers as much as possible *Reduce excess sensory stimulation *Use gentle touch and simple, clear language *Tell the patient what you want him/ her to do, not what you don't want *Avoid confrontation or arguing, acknowledge concerns and gently redirect *Allow for wandering in a safe, enclosed area *Provide regular outlet for exercise * Evaluate the need for Behavioral Health, Psychiatric, Child Life or Spiritual Care consult.	Diversional activity Door gate Geri-chair Ultimate Walker Activity Apron
Agitation/	*Identify cause of the behavior. Is it	Diversional activity

restlessness	associated with bladder or bowel urgency, fecal impaction, or urinaryretention? Does it occur at certain times of the day, during noisy or stressful situations? Are sensory impairments present? Is there a pathological basis (anemia, hypoxia, electrolyte imbalance, steroids)? *Reduce physical discomfort: non-pharmacologic pain relief, treat medical illness, constipation or urinaryretention, re-position, adjust toileting schedule, back rubs, massage *Use distraction and/or repetitive motion activities (e.g., folding, sorting, coloring, playing cards) *Reduce excess stimulation, don't leave music or TV on all the time *Provide for the patient's normal sleep patterns *Provide for periods of activity/exercise (e.g., taking a walk, taking a shower/bath). Consider PT/OT consult *Provide for periods of rest/ relaxation *Offer culturally sensitive spiritual/ religious items for comfort *Make sure glasses or hearing devices are in use. *Adjust lighting and/ or temperature in the room *Involve the patient in decision making *Speak calmly and use simple sentences; be aware of nonverbal communication *Offer listening to music of choice, food/fluid or phone call to friend/ family *Give the patient something soft to hold or a familiar object from home Evaluate the need for Behavioral Health, Psychiatric, Child Life or Spiritual Care consult.	Ultimate walker Activity Apron
Acting out	*Verbal intervention *Redirection *De-escalation -Maintain a safe personal space with patient and ensure access to an exit is available -Assess the situation: What does the patient need/ want? What are the stressors? -Look for a solution to the patients need and/or stressor -Be empathetic and show concern for the patient -Avoid power struggles; be honest and give clear options -Stay calm and confident, use calm, clear tone of voice -Be assertive, not aggressive in voice,	

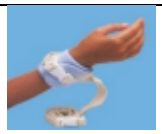
	posture, and non-verbals -Maintain patient's self-esteem and dignity *1:1 time with staff *Time out in room *Routine or PRN treatment medications specified for control of tension, anxiety or thought disturbance Evaluate the need for Behavioral Health, Psychiatric, Child Life or Spiritual Care consult.	
Interference with life support/medical treatment	*Identify the reason the patient is interfering with the treatment. Is the device uncomfortable? Does it restrict mobility? Is it purposeful or as a result of confusion or restlessness? *Evaluate site/device, pain level, and readiness to discontinue *If appropriate, consider covering device to limit access *Provide education and frequent reminders of the device purpose *Consult with provider to escalate concerns, discontinue device, or explore alternative therapy.	Diversional activity Dummy tube Undergarments Pajama pants Skin sleeve Mitten Abdominal binder Sitter or Virtual Patient Observer

Appendix 3: Guidelines for the Use of Restraint and Restraint Alternative Products

Note: The intent of these guidelines is to provide patient care providers with reference material concerning the use of physical restraints and restraint alternatives. Guidelines are not all inclusive. Manufacturer's Instructions for Use should be used and referred to when there are questions on application of these devices.

PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION
IV House  *Restraint Alternative*	Stocked in nursing units.	Pediatric patient population	When protection of an IV is necessary to maintain catheter placement and to maximize limb movement	*Apply device directly over IV site. *Vent holes should be positioned so that they face away from the direction of the insertion site. *Secure device to the patient's skin using clear tape so the IV tubing and catheter can be visualized. *Avoid taping too tightly causing kinking of the IV tubing. *Check integrity of skin under device and observe for redness or irritation.
PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION

Peek-a-boo Mittens Restraint Alternative OR Restraint (when patient is unable to self-release or used in conjunction with a limb restraint, roll belt, or wrap belt)	Stocked on some units. May be ordered through Epic or by calling supply directly.	Patients who are picking or pulling at tubes/lines or skin, interfering with medical devices/treatment, or hitting self or others.	To prevent interference with medical treatment or injury to self or others. Maximize limb movement (when untethered) Promote patient safety	*Refer to Manufacturer's Instructions for Use for full details. *Insert patient's hand into mitt & put strap around smallest part of wrist *Bring straps over top of wrist; adjust tightness allowing for two fingers. *Check integrity of skin & fingers under device after application & at least every 2hrs for redness, swelling, color change, & temperature. *Hands sweat under mittens, wash & dry hands with each release & PRN. *If used in combination with soft limb restraint, devices should not overlap as this will loosen fit.
PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION
Diversional activities Restraint Alternative	Unit supplies, Occupational Therapy, Child Life.	Patients demonstrating behavioral abnormalities such as verbal irritability, physical aggressiveness, wandering, hallucination, delusions, nighttime awakenings, or boredom	Provide tactile stimulation to calm & soothe Provide distraction Involve patient in meaningful activity Enhance mental stimulation	*Keep items in a central location *Utilize family/friends to determine patient preferences or needs. Examples: Stuffed animal, pillow, Koosh ball, puzzles, sewing card, music, reading materials, folding towels
PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION
Soft Limb *Restraint*	Adult standard size is stocked on most units. "Posey Soft	Cognitively or judgment impaired patients who require reminder to rest	When all alternatives to restraint have been considered/employed and application of the limb	See Manufacturer's Instructions for Use standard adult size. Or Manufacturer's Instructions for Use -

	Foam Limb Holder #2532” Infant size stocked in NICU. “Posey Soft Pediatric Limb Holder #4733” May also order through supply.	limb, not pick at skin, tubes or lines, hit self or others.	restraint is needed to protect the patient or others from injury. To promote patient safety To promote the safety of others To facilitate medical treatment	Pediatric Limb Holders
PRODUCT	HOW to get	WHO is it for	WHEN and WHY it is used	APPLICATION
Pedi Wraps Elbow immobilizers *Restraint*  Pedi-Wrap with Thumbhole	Stocked on some units. May also order through supply.	Pediatric patient population.	To control arm movement To prevent pulling NG tubes, IV lines, Tracheostomy Prevents putting objects into mouth, scratching bandages, injuries or skin Prevents self-inflicted injury	Measure patient’s arm to determine the correct size of immobilizer. • The device should be long enough to reach from the axilla to the thumb. Apply the immobilizers by wrapping around each arm and overlapping the Velcro to secure it. Buckle the shoulder strap. • The shoulder strap must be removed during sleep. To discontinue the restraint, remove the immobilizer from both arms. • This device is washable/reusable for a single patient.
Posey Bed	To obtain	Refer to policy:	When all	See manufacturer’s

Canopy / Bed Enclosure Restraint 	an enclosure bed, place a supply order in Epic **AND** call the supply departmen t, select the option for “equipmen t & specialty beds”.	Enclosure Bed-Posey **Note this is for non-violent patients only.**	alternatives to physical or chemical restraint have been considered/employ ed and a restraint is needed to protect the patient or others from injury. To promote patient safety To promote the safety of others Allows freedom of movement within a protected environment To reduce the side effects caused by other restraint devices.	instructions for use for full details. Posey Bed 8070 User Manual Posey Bed 8070 Quick Check Guide

Appendix 4: Degree of Restrictiveness Grid for Non-Violent Restraints

*Restraint alternatives must be attempted and documented prior to the use of a restraint
*Always begin with the least restrictive restraint device necessary to protect patient/ others.

Least Restrictive	Restraint type	Guidelines/ Rationale
	4 side rails in the up position	Is a restraint when the intent is tokeep the patient in the bed Considered protective measure (non-restraint) during some situations, including but not limited to: • ED stretcher • crib with raised rails • patient transport • recovery from sedation/anesthesia • seizure precautions • bed with specialty mattress
	Mitten(s)	Is a restraint when the patient cannot self-remove or used in conjunction with a limb restraint, roll belt, or wrap belt
	Bed Canopy	Is always considered a restraint. Patient is never to be in an enclosed bed canopy with sides unzipped while unattended. No other restraints or alternative devices can be used with bed canopy.
	Geri chair	Is a restraint when the trayin place with the intent of keeping the patient in the chair
	Roll belt	Is a restraint if patient cannot self-remove buckle and/or Velcro; or if used in conjunction with a limb restraint or mitten
	Wrap Around belt	Is a restraint if patient cannot self- remove Velcro or if Velcro is placedbehind the chair; or if used in conjunction with a limb restraint or
↓ Most Restrictive	**Freedom Splints:** • Freedom splint or Pediatric Elbow Immobilizer (one extremity) • Freedom splint or Pediatric Elbow Immobilizer (both extremities) • Limb (one extremity) • Limb (two extremities) • Mitten with Soft Limb (one or two extremities) • Limb (three or four extremities)	Freedom splint is not a restraint when used as a single IV arm board andpatient can self-remove

Exhibit #7

Administrative Policy
St. Louis Children's Hospital

ADVANCE DIRECTIVES

POLICY The hospital will respect and strengthen the role of the adult patient in health care decision-making. Staff will comply with current standards, regulations and laws which apply to advance directives. This policy applies to adult patients 18 years of age or older.

DEFINITIONS

1. An **ADVANCE DIRECTIVE** refers to a document(s) in which an individual statesstates his or her desire for medical care and treatment should he or she be unable to physically or mentally communicate care decisions and/or designates another individual to express his or her desires for medical care and treatment**.**

   A. **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** (**DPOA**) Is a document in which an individual names someone else (an "agent" or "attorney-in-fact") to make health care decisions in the event the individual becomes unable, either physically or mentally, to make decisions for himself or herself. The DPOA may include instructions concerning specific choices/identified circumstances for making health care decisions for the agent.

   A valid Durable Power of Attorney for Health Care must be:

   1) In writing;
   2) Titled "Durable Power of Attorney for Health Care";
   3) Include a provision to the effect that "THIS IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND THE POWER OF MY ATTORNEY IN FACT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I BECOME DISABLED OR INCAPACITATED";
   4) Signed at the end, dated, and
   5) Notarized.

   B. **HEALTH CARE DIRECTIVE** is a document that permits a patient to state, in advance, his/her wishes regarding the use of life prolonging procedures. It may be relied upon when an individual is unable to communicate his/her health care decisions provided such expressions are clearly stated. It can be accepted if notarized or signed by two (2) witnesses, or both.

   C. **LIVING WILL (or sometimes referred to as DECLARATION) is** a document executed in accordance with Missouri Law in which a person, called a Declarant, states his or her wishes regarding the withdrawal or the

withholding of medical treatment if they are diagnosed as terminally ill and is not able to make treatment decisions. Living Wills do not allow for withhold or withdrawal of artificially supplied hydration and nutrition, do not cover persistent vegetative state conditions and will have no effect if a Declarant is pregnant.

A valid Living Will must be:

1) In writing;
2) Signed by the person making the Living Will ("Declarant"), or by another person in the Declarant's presence and by his/her express direction.
3) Dated; and
4) If not entirely in the Declarant's handwriting, signed in the presence of two (2) or more witnesses at least eighteen (18) years of age.

(**Note:** An individual who signs a Living Will at the request of the Declarant cannot also act as a witness).

2. **ADULT** means a person who is 18 years of age or older.

3. **AGENT** refers to a person appointed to make decisions for another individual, such as an attorney in-fact under a durable power of attorney for health care.

4. **DECISION-MAKING CAPABILITY** means the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment and the ability to reach and communicate an informed decision in the matter.

POLICY STATEMENTS

1. Employees and staff physicians must honor an individual's Advance Directives unless the directives require a provider to break the law or a provider is unable to follow the directive as a matter of personal conscience.

2. Any employee who is unable to comply with an individual's Advance Directive may withdraw from care of the individual upon the transfer of care of the individual to others. (Refer to policy "Refusals in Patient Care/Treatment")

3. Any physician on the staff of the hospital who is unwilling or unable to comply with an individual's Advance Directive shall make arrangements for the transfer of the patient's care to another physician. Health care providers can not disregard a Declarant's wishes (pursuant to a Living Will) without serious reasons in the best interest of the patient and must document in the medical record.

4. The adult patient's wishes, as expressed in an Advance Directive will direct the patient's care even if the family's wishes are contrary. Any conflict with end of life care decisions should be immediately referred to the Hospital/Medical Ethics Subcommittee.

5. **Situations involving pregnancy**:
   a) In the event a pregnant woman presents an Advance Directive, the Hospital Medical Ethics Subcommittee and BJC Legal Services will be contacted.

b) Declarations of Life Support under a Living Will have no effect during the course of a Declarant's pregnancy. In the event that there is an unresolvable conflict between a patient's or designee's instructions and the hospital's policy, the hospital staff will assist the patient/family in a transfer to a more compatible provider.

6. **Emergency situations**: It may be impossible for health providers to be certain whether or not a treatment will lead to a significant recovery. Treatment will continue until the provider makes a determination consistent with the Advance Directive and the patient is not able to make treatment decisions.

7. **Do Not Resuscitate Orders (DNR):** Adult patients always have the right to direct their own health care. If a patient requests a specific treatment limitation, it may be written as part of a DNR order. In some instances, the hospital may request additional consent forms should a patient request a continuation of his or her DNR orders in the operating room or other interventional area. (Refer to policy "Do Not Resuscitate" (DNR) Policy)

8. **Surgical Procedures:** When a patient with an Advance Directive is scheduled for anesthesia and/or surgery, the anesthesiologist and surgeon will discuss with the primary physician, patient's representative/guardian and patient (if appropriate), the issues involved in order to best balance the desires and rights of the patient with the potential physiologic instability resulting from the planned procedure, surgery and/or anesthetic. A medical progress note should document such discussion and any decisions reached. (Please refer to the Do Not Resuscitate Policy for additional information.)

   a) Patients undergoing emergent anesthesia and/or surgery, when sufficient time for such discussion has not taken place, will have their Advance Directive suspended prior to induction of their anesthetic.

   b) Should a life threatening event occur during the anesthetic/procedure, the extent of any resuscitation effort will be decided by the physician caretakers in consultation with the responsible guardians, if possible.

   c) The suspended Advance Directive may be reinstated on the patient's discharge from the Post Anesthesia Care Unit, (PACU) or admittance to the Intensive Care Unit if the PACU is not used.

PROCEDURE

1. At the time of hospital admission and/or registration, hospital registration will ask patients if they have an advance directive, including whether they have appointed a Durable Power of Attorney for Health Care or if they need information concerning his or her rights under state and federal law to make care and treatment decisions, including the right to formulate an Advance Directive concerning life sustaining

care. The registrar completes form CN3-7400-589 (Addendum A to the policy) and places it in the patient's medical record.

2. If the patient has an Advance Directive from a state other than Missouri or Illinois, Registration will contact BJC Legal Services to determine its validity in Missouri.

3. If the Advance Directive requests services not provided at SLCH, the patient and/or family or agent (under a DPOA) will be advised as soon as possible by the attending physician.

4. If an Adult patient is incapacitated or unable to receive Advance Directive information, such information may be given to family or a representative. Advance Directive information will be provided to the patient as soon the patient has capacity or ability to receive such information.

5. No individual shall be discriminated against or have care conditioned on whether or not an individual has executed an Advance Directive.

6. A copy of the Advance Directive shall remain a part of the individual's permanent record. Return the original Advance Directive to the patient/family.

7. Advance Directives will be effective during the patient's admission unless revoked by the patient in accordance with applicable law. Upon subsequent admissions (if any), hospital registration will update the patient's information concerning Advance Directives consistent with this policy.
   a) It is the responsibility of the patient or attorney-in-fact to provide a copy of any updated Advance Directive to the hospital.
   b) If this is a readmission, hospital registration will contact Health Information Services (unless otherwise electronically available) to obtain a copy of the patient's Advance Directive and ask the patient if the Advance Directive remains current. If not current, hospital registration will contact the Chaplain for the Chaplain to discuss the Advance Directive with the patient and/or family.
   c) All Advance Directives provided to the hospital must comply with applicable law to be valid. Contact BJC Legal Services or hospital Risk Management if there are any questions concerning the validity of an Advance Directive.

8. If an individual presented an Advance Directive during a previous admission and is now incapacitated and unable to communicate care and treatment decisions, physicians and staff should speak with the Agent (attorney-in-fact) or family to determine whether the patient has rescinded or amended the Advance Directive or created a new Advance Directive. If there are concerns about the validity of the document, contact hospital Risk Management or BJC Legal Services.

9. The patient has the right to review, change, or revoke an Advance Directive at any time.

10. If an adult patient does not have an Advance Directive, then the patient may communicate health directive information to his or her physician, registered nurse, or others with such communication having evidentiary weight or validity in determining the patient's wishes; provided the communication is given by the patient.

11. For assistance with any Advance Directive need and/or issue, contact the Chaplain on call.

12. A patient may revoke his/her Advance Directive at anytime by either oral or written communication. If revoked, contact the Attending Physician and the Chaplain on call.

PATIENT TEACHING

1. Patients who need information may receive written information on Advance Directives from the Patient Registration Department or Chaplain.

2. In-service regarding these policies shall be available to any employee and attendance required for Patient Registration; Department of Clinical Social Work and Chaplaincy; Administrative Supervisors; registered nurses; and physicians from active staff and house staff.

3. Education of our community shall be accomplished by providing written information, consultation from internal resources and providing external presentations on request.

REFERENCES:

Missouri Attorney General Inside Life Choices, March 2009
Missouri Revised Statutes Chapter 459. R.S.Mo and Section 404.800 et seq. RS MO
Medicare Conditions of Participation 42 CFR §482.13(b)(3).

RESOURCE/CONTACTS:

Chaplaincy, Hospital Registration Department

RECOMMENDED/APPRAOVED BY: Patient Care Services

EFFECTIVE DATE: April 5, 2018
REVIEWED: February 21, 2022