



ATTACH
PHOTO
(New applicants only)

APPLICATION FOR MEDICAL AND ALLIED HEALTH STAFF APPOINTMENT

Please indicate which staff status you are requesting.

Active Staff: Regularly admits patients to, or is otherwise regularly involved in the care of patients in the hospital. Active staff members are required to be on the emergency call roster.

Courtesy: Allowed 20 admissions per year; 20 inpatient or outpatient procedures per year or 20 invasive diagnostic procedures per year.

Affiliate Staff: Members appointed to the Affiliate Staff may: Refer patients for outpatient diagnostic testing and specialty services provided by the hospital. Refer patients for treatment by a member of the Medical Staff who has admitting privileges. Visit, review medical records and discuss the care with the attending physician of their established patients. Appointees to this category may not write inpatient orders, progress notes, actively participate in the direct provision of patient care, or perform or assist in surgery.

STATUS REQUESTED	
<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Affiliate <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Allied Health Professional	
Signature: _____	Date: _____

KAPER-1 (04/2009)
Part B, Section 1

**For Health Care Providers Desiring Initial
Hospital or Health Care Facility Privileges**

NOTE: Submission and approval of a pre-application for privileges may be required by a health care facility prior to the facility's processing a completed KAPER-1 (04/2009), Part B, Section 1. Therefore, a provider desiring initial health care facility privileges is advised to contact the facility for information relating to any pre-application requirements.

Commonwealth of Kentucky
Instructions - Form (04/2009), Part B, Section 1

A. Uniform Application for Evaluation (Credentialing) Form. Following is the form KAPER-1 (04/2009), Part B, Section 1, developed pursuant to KRS 304.17A-535(5) for evaluation (credentialing) of a health care provider. The form is available on the Web site of the Kentucky Department of Insurance at <http://insurance.ky.gov>. Prior to completing this form, a health care provider who desires initial evaluation (credentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (04/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the health care provider who desires evaluation (credentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (04/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments.

For a Physician, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (04/2009), Part B, Section 1, in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this license, a copy of the application for this license will be accepted until a copy of the license is available for submission.);
2. Current federal drug enforcement agency (DEA) certificate for each state of practice. (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this number, a copy of the application for a DEA number will be accepted until the DEA number is available for submission.);
3. Current state substance registration certificate, if applicable. (If medical, dental or other health care provider, including a psychologist, has applied for but not received this certificate, a copy of the application for this certificate will be accepted until a copy of the state substance registration certificate is available for submission.);
4. Proof of current professional liability insurance, including name, inception and expiration dates and amount of coverage (If medical, dental or other health care provider, including a psychologist, has applied for but not received professional liability insurance, a photocopy of the application for professional liability insurance will be accepted until the proof of current professional liability insurance is available for submission.);
5. Board certification/eligibility verification information;
6. Curriculum vitae (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

For an Allied Health Professional, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (04/2009), Part B, Section 1, in the following order:

1. Current professional license or evidence of licensure (If multiple professional licenses are held by the allied health professional, a copy of each license and/or registration should be attached; for example, registered nurse (RN));
2. Current federal drug enforcement agency (DEA) certificate, if applicable for allied health professional specialty (If allied health professional has applied for but not been issued a DEA number, a copy of the application requesting this number may be submitted until a copy of the actual DEA number is available for submission.);
3. Current state substance registration certificate, if applicable (If allied health professional has applied for but not been issued a state substance registration certificate, a copy of the application requesting this certificate may be submitted until a copy of the actual certificate is available for submission.);
4. Statement of sponsoring health care provider (e.g., physician) or collaborative practice agreement, if applicable;
5. Proof of current professional liability insurance, including allied health professional name, inception and expiration date, and amount of coverage (If allied health professional has applied for but not been issued professional liability insurance, a copy of the application requesting coverage may be submitted until a copy of the approval of coverage is available for submission.);
6. Curriculum vitae or resume (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: Last Suffix First Middle Maiden Name Degree

Medical Staff Allied Health (please specify)

Residence: Phone: Fax:

Primary Office Address: Phone: Fax:

Secondary Office Address: Phone: Fax:

Billing Office Address: Phone: Fax:

Credentialing Address: Phone: Fax:

Credentialing Contact: Credentialing Email:

Preferred Mailing Address: Primary Office Residence Other (please specify)

Phys. Email Address: Prac. Admin's Email: Office Web Address:

Date of Birth: Gender: Place of Birth:

Social Security #: Marital Status:

Citizenship: Spouse:

(If not a US citizen, please complete the next three fields)

Visa Status: Alien Reg. #: Exp. Date:

Language Spoken:

ECFMG #: Pager #: Alpha Digital Voice

Medicare #: Cellular #:

Medicaid #: Answering service #:

UPIN: Are you taking new patients?:

EIN: Taxonomy Code:

NPI #:

Clinical Specialty/Subspecialty:

Other interests in practice, research, etc.:

Name others with whom you are or will be associated in practice:

Nature of association: Solo Group Partnership Corporation Effective Date:

Other: (please specify)

Name of Practice (if applicable):

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: Specialty: Telephone:

Name: Specialty: Telephone:

Name: Specialty: Telephone:

II. EDUCATIONAL DATA

(All periods of time must be accounted for from entrance into medical school to the present)

Please indicate if your name at any educational institution is different than the name listed on your application. Yes No

If YES, please identify other name(s): _____

A. Schools

Undergraduate College/University: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ / _____
From (mm/yy) To (mm/yy)

Medical/Dental/Other College: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ / _____
From (mm/yy) To (mm/yy)

B. Internships

Name: _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

Yes No

Check if more than two internships were begun or completed. Please supply the same information on a separate sheet and attach.

C. Residencies

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Check if more than three residencies were begun or completed. Please supply the same information on a separate sheet and attach.

D. Fellowship and/or Other Postgraduate Training

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Check if more than three fellowships were begun or completed. Please supply the same information on a separate sheet and attach.

E. Other Professional Training

School: _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

School: _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

Check if more than two training programs were begun or completed. Please supply the same information on a separate sheet and attach.

III. TEACHING APPOINTMENTS

Name: _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

Name: _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

IV. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance.

YES NO List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____

Please attach copies of all certificates.

V. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

State:	License #:	Date Issued:	Expiration Date:	Status:	License Obtained by:	
KY State: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity	

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

VI. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VII. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VIII. PROFESSIONAL LIABILITY DATA

(This application cannot be processed without proof of amount of professional liability)

Name of Carrier: _____

Address: _____

City: _____ State: _____ ZIP: _____

Policy #: _____ Amount of Coverage: _____

Date of Inception: _____ Date of Expiration: _____

Name of Agency: _____

CLAIMS MADE OCCURRENCE (Check One)

Please list any other professional liability carriers you have used within the last five (5) years: _____

Answer the following questions:

- 1. Has your professional liability insurance coverage been terminated by action of the insurance company? N/A Yes No
- 2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? N/A Yes No
- 3. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? N/A Yes No
- 4. Have any professional liability suits or claims been filed against you? N/A Yes No
- 5. Have any professional liability suits or claims been filed against you which are presently pending? N/A Yes No
- 6. Have any judgments or settlements been made against you in professional liability cases? N/A Yes No
- 7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund? N/A Yes No
- 8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act? N/A Yes No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

Pending Settled Date: _____

List the allegations: _____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

Amount of jury award or amount awarded by the court: _____

IX. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? Yes No (If not Board admissible, please explain on separate sheet and attach)
2. If yes, list full name of certifying board and date which you obtained certification/recertification:

	Date: _____
	Date: _____
	Date: _____
	Date: _____
3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:

	Date: _____
--	-------------
4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____
5. List date of next required recertification (if applicable): _____
6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. Yes No

X. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1. Are there any actions that have been initiated or are any pending against you by any state licensing board? Yes No
 Pending Resolved
2. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? Yes No
3. Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s). Yes No
4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? N/A Yes No
5. Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed? N/A Yes No
6. If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged? N/A Yes No
7. Have you been named as a defendant or convicted of a felony or misdemeanor? Yes No
8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility? Yes No
9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board? Yes No
10. Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility? Yes No
11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? Yes No

XI. PERSONAL HEALTH STATUS

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1. Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No
2. Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No
3. Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No

XII. PROFESSIONAL SOCIETIES

Membership in local, state, or national medical societies

Dates

Name: _____ From (mm/yy) / To (mm/yy)

Address: _____

City: _____ State: _____ ZIP: _____

Name: _____ From (mm/yy) / To (mm/yy)

Address: _____

City: _____ State: _____ ZIP: _____

Name: _____ From (mm/yy) / To (mm/yy)

Address: _____

City: _____ State: _____ ZIP: _____

Name: _____ From (mm/yy) / To (mm/yy)

Address: _____

City: _____ State: _____ ZIP: _____

1. I would like to use this application for membership in the _____ County Medical Society and the KMA.
A separate dues statement will be sent.

2. I am already a member of my local medical society. Please specify society: _____

XIII. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ From (mm/yy) / To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ From (mm/yy) / To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ From (mm/yy) / To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

B. Affiliations

List in chronological order all professional affiliations since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

XIV. PEER REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, and ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

XV. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____

Date: _____

ACKNOWLEDGEMENT STATEMENT

The following statement is required (by Medicare/Champus regulation) to be signed by each physician when he/she joins the Medical Staff. This must be signed and dated in the physician's own handwriting using his/her legal signature (initials are not accepted).

According to federal guidelines, stamped signatures and typed dates are not acceptable.

MEDICARE/CHAMPUS

"Notice to physicians: Medicare/Champus payment to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal law."

I certify that I have received the above statement.

Signature: _____ Date: _____

Type or Printed Name: _____

NAME: _____ DATE: _____

It is the policy of Frankfort Regional Medical Center to require Tuberculosis Screening of all Medical and Allied Professional Staff at initial appointment and reappointment. Compliance with this screening is important for the safety and well-being of all staff, and patients and is a condition of continued staff membership and privileges.

TUBERCULOSIS SKIN TESTING

TB SKIN TESTING can be obtained in the Laboratory 24/7. TB Skin Test can also be read in the Laboratory.. Self-reading of TB skin tests by nurses or physicians is not an acceptable practice at Frankfort Regional Medical Center.	
PPD TEST RESULTS	
Test Give By: _____	Date Given: _____
Location: () Right Forearm () Left Forearm	
TEST MUST BE READ 48-72 HOURS AFTER ADMINISTRATION OR IT IS INVALID	
Test Read By: _____	Date Read: _____
Test Results: _____ mm of INDURATION _____ NEGATIVE _____ POSITIVE	

ANNUAL HEALTH QUESTIONNAIRE

<p>YOU ARE MEDICALLY UNABLE TO RECEIVE THE PPD TEST, OR HAVE A PREVIOUS POSITIVE TUBERCULOSIS SKINTEST, PLEASE COMPLETE THIS SECTION AND RETURN THE FORM TO THE MEDICAL STAFF OFFICE.</p> <p><i>DO NOT PROCEED WITH TB SKIN TESTING!</i></p>	
<p>_____ I have a medical condition that prohibits me from receiving the PPD skin test.</p> <p><input type="checkbox"/> I am currently taking immuno-suppressant or steroid medication.</p> <p><input type="checkbox"/> Other, (Please explain) _____</p>	
<p>_____ I have a documented positive tuberculosis skin test. I have experienced the following symptoms in the past year.</p> <p><input type="checkbox"/> Productive Cough</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Loss of Appetite</p> <p><input type="checkbox"/> Unexplained Weight Loss</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> None</p>	
<p>I KNOW TO REPORT SIGNS & SYMPTOMS OF TUBERCULOSIS TO THE INFECTION CONTROL OFFICE FOR FOLLOW-UP.</p>	
SIGNATURE: _____	DATE: _____

*SUPERVISING MEMBER AGREEMENT
ALLIED HEALTH PROFESSIONAL*

(To be included with application from the Allied Professional and signed by principal and all designated alternates, where applicable).

In supervising _____ in providing services on Frankfort Regional Medical Center premises,

I agree:

- To accept responsibility for the Allied Health Professional's performance of the duties and acts authorized for him/her while under my supervision;
- To accept responsibility for the Allied Health Professional within the facility, for the Allied Health Professional's observance of all bylaws, policies and rules of the Medical Staff and facility, and for the correction and resolution of any problems that may arise;
- To abide by all bylaws, policies and rules governing the use of Allied Health Professionals in this facility, including refraining from requesting that the Allied Health Professional provide services beyond, or that might reasonably be construed as being beyond, his/her authorized scope of practice in this facility;
- To immediately notify the CEO, or his/her designee, in the event any of the following occur:
 - a) My approval to supervise the Allied Health Professional is revoked, limited, or otherwise altered by action of the applicable licensing board;
 - b) Notification is given to me of investigation of my supervision of the Allied Health Professional by the applicable licensing board and/or certification programs;
 - c) The employment status of the Allied Health Professional changes;
 - d) The Allied Health Professional's authorized scope of services changes, or the Allied Health Professional is under investigation by the applicable licensing board and/or certification programs.

Signature of Supervising Physician

Date



299 King's Daughters Drive, Frankfort, KY 40601
Telephone (502) 226-7681

It is your responsibility to get this form completed and returned with the application.

October 15, 2009

Dear Physician:

Please submit this Activity Verification Form for Appointment to your primary hospital or other clinical setting for completion in order to demonstrate current clinical competency. It will be necessary for us to receive this form in order to process your application for appointment.

I, _____, understand that to qualify for appointment to the Medical Staff, I must provide evidence of sufficient patient contacts (admissions, consultations, procedures) per year to be able to demonstrate current clinical competency.

I understand that it is my responsibility to obtain appropriate verification from another hospital(s) or other clinical setting to document patient activities. Acceptable verification is completion of this form by an appropriate representative from another hospital or other clinical setting who is able to verify the needed information.

Signature

I verify that the above named physician has had the following patient activities at this facility during the time period from _____ to _____ without any quality assurance or peer review problems necessitating any disciplinary actions.

- INPATIENTS:** _____
 - OUTPATIENTS:** _____
 - CONSULTATIONS:** _____
 - SURGERIES:** _____
 - PROCEDURES:** _____
 - MORTALITIES:** _____
- (If available)

Signature: _____ Date: _____

Printed Name & Title: _____

Facility: _____

Facility Address: _____

Phone: _____ Fax: _____

Return to: Medical Staff Office
Frankfort Regional Medical Center
299 King's Daughters Drive
Frankfort, KY 40601
Phone: 502-226-7681
Fax: 502-226-7956

CONTINUING EDUCATION RECORD

Please attach addition sheets if necessary

NAME: _____

Course Name	Date Completed	Number of CME/CEU Hours Granted	Category 1	Other (specify category or type)
Mandatory Education Requirements		TOTAL # OF HOURS THIS REPORT:		
Courses Directly Related to My Specialty and/or Practice		TOTAL # OF HOURS THIS REPORT:		
Other Courses		TOTAL # OF HOURS THIS REPORT:		
TOTAL # OF HOURS THIS REPORT:				

I hereby affirm that I have successfully completed the above continuing education courses as listed above, and I am in compliance with any applicable state laws and rules, requirements of my specialty board (if applicable), Medical staff Bylaws, licensure boards, and any other entity mandating education requirements for my practice, licensure, specialty, and/or certification. I further agree to participate in and maintain at least the minimum education requirements necessary to maintain licensure, board certification and competency in my specialty while on staff. I further understand that failure to meet and maintain such compliance may be considered in the denial, continuation, suspension and/or revocation of my staff appointment and/or clinical privileges at Frankfort Regional Medical Center.

Signature

Date

Physician Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or to the Internet through Company provided systems.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, will only do so for the purpose of delivery of medical services at this facility, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
 - a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
 - b. Use only approved licensed software.
 - c. Use a device with virus protection software.
15. I will never:
 - a. Disclose passwords, PINs, or access codes.
 - b. Use tools or techniques to break/exploit security measures.
 - c. Connect to unauthorized networks through the systems or devices.
16. I will notify my Local Security Coordinator (LSC) or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
20. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
21. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
22. I understand that the Company may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the facility's medical staff, I may no longer use the facility's equipment to access the Internet.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Physician Signature	Facility Name and COID	Date
Physician Printed Name	Business Entity Name	

ELECTRONIC SIGNATURE

TO: HIM DEPARTMENT / IS DEPARTMENT /
MEDICAL STAFF OFFICE / PCI COORDINATOR

FROM: DR. _____

RE: ELECTRONIC SIGNATURE

This is to notify you that I will participate in the use of electronic signature to authenticate documents via the Clinical Patient Care System (CPCS).

I understand the Personal Identification Number (PIN) assigned to me is confidential. I certify that I will not disclose my PIN to another person or permit another person to use it.

I understand failure to maintain confidentiality of misuse, as specified in this policy, will result in revocation of my electronic signature privileges. Misuse, as defined by HCFA, is "that the physician has allowed another person or persons to use his/her PIN." Violations of this policy will be reported to the Medical Executive Committee.

I understand I am responsible for the content of all medical record entries signed electronically.

Print Name

Signature

Date

Requested PIN

Approved: _____
Security Coordinator

Entered By / Date



PHYSICIAN/ALLIED HEALTH PROVIDER INSERVICE PACKET

Please review the attached material and sign that you have read, understand, and agree to abide by the following hospital plans & policies:

I have reviewed, understand, and agree to abide by the hospitals:

- Infection Control and Safety information codes, and my involvement with them. If I have a question regarding these, I will contact the hospital's Infection Control/Nurse and Safety Officer at (502) 226-7896.
- Physician Notice Regarding Medical Necessity and Compliance Pamphlet
- Conditions of Internet Access
- Medical Staff HIPPA Policies
- Reflex Testing Acknowledgement
- Pain Management and Assessment Policy
- Disaster Response Responsibilities & Reporting Instructions
- Medical Staff Bylaws and Rules & Regulations
- HCA Code of Conduct: I certify that I have reviewed the HCA Code of Conduct and understand it represents mandatory policies of the organization. I agree to abide by the Code.

Signature

Date

Print Name

HAZARDOUS MATERIALS – RIGHT TO KNOW – MSDS

OSHA guidelines require the manufacturer to identify information about each chemical and supply Material Safety Data Sheets (MSDS) to the facility purchasing those products. The hospital maintains an inventory of all hazardous chemicals on the intranet site under HazSoft. Each product should be properly labeled with the name of the product, hazardous warnings, name and phone number of manufacturer.

Staff can access MSDS sheets for your if you need information on a chemical.

HAZARDOUS MATERIALS SPILL/LEAK

The following procedure should be followed:

- A. Isolate and make the spill.
- B. Personnel who utilize chemicals should be familiar with spill kits and clean up response.
- C. Chemotherapy spills may be handled on the patient care unit by trained personnel, with the appropriate chemo spill kit. **Only trained personnel may participate in chemotherapy spill clean up.** Chemo Spill Kits are located on 3rd and 4th Floors in the West Nursing Station and in SCU in POD supplies.

- A Formalin spill kits are also located in Histology, OB and OR.
- Blood spill kits are located in patient care areas.

The following spill kits are located in Engineering: Kits for solvents, caustics, acids, formalin and mercury.

ELECTRICAL DISTRIBUTION SYSTEM

The hospital Electrical Distribution System consists of two systems:

1. Normal power supplied by the local electric utility company.
2. Standby power generated by Plant Operations during electrical power interruption.

Both systems supply electricity to power outlets throughout the hospital. Each system is identified by the color of the electrical outlet.

White outlets represent normal power.
Red outlets represent standby power.

Both white and red outlets will supply electricity during normal conditions. Only red outlets will supply power during power outages. For this reason, all critical equipment and life support equipment should be connected to red outlets.

If power outage occurs, the hospital will be without power for 5 – 10 seconds to allow for the generators to start and all transfer switches to operate.

ELECTRICAL SAFETY LOCKOUT/TAGOUT

Lockout tags and devices are used to protect the safety of hospital staff, visitors and patients. These devices are installed at the discretion of the Engineering Staff.

Lockout tags are placed on electrical equipment, utility valves, lighting switches, power receptacles, and circuit breakers to warn all personnel not to energize or operate said equipment or electrical devices. Lockout tags may be used with locking devices, which would further inhibit operations.

Lockout tags are used for the following reasons:

1. Equipment or utility preventive maintenance
2. Equipment or utility failures

Only the person whose name appears on the tag may remove lockout tags.

Disregarding lockout tags may result in the death or injury of hospital staff, visitors, or patients, or damage to equipment or utility. Unauthorized removal of lockout devices is a violation of Federal law.

If you have any questions about lockout tags in your department, call Engineering.

Medical Gas

The following medical gases are supplied to patient care areas:

Oxygen -	Green Outlets
Vacuum	White Outlets
Med Air -	Yellow Outlets
Nitrous Oxide	Blue Outlets

Areas supplied with medical Gas are divided into zones. Each zone has shut off valves to allow the Medical Gas to be terminated in an emergency such as a fire, pipe rupture, etc. These zone valves are easily identifiable and accessible by hospital staff. Each zone valve is labeled with the Medical Gas it controls and the area it serves.

Telephone Outages

If for some reason the telephone system should fail, the Stentofon System can still be utilized for communication within the facility. The Nurse Call System can be used on each floor. Engineering Personnel are equipped with walkie-talkies. Also, you may use the computer e-mail system for communications.

Utility Outages

All elevators work on Emergency Generator Power
Utilize Red wall plugs

INFECTIOUS CONTROL

OSHA (Occupational Safety and Health Administration), has developed a standard that, if followed, is designed to protect you. **STANDARD PRECAUTIONS** is a way for you to protect yourself when dealing with all patients. Our plan for compliance with this OSHA standard is located in the Infection Control Section of the Policy and Procedure Manual.

It is essential that you exercise STANDARD PRECAUTIONS during the care of all patients and while handling patient care equipment.

STANDARD PRECAUTIONS

There are specific procedures you must follow on the job to reduce your exposure to bloodborne pathogens. These include: Handwashing/hand antisepsis safe work practices, such as the use of needleless or sharp are safety devices; proper disposal of needles; and use of protective barriers, such as gloves, gowns, masks, and protective eyewear/masks or face shields.

Handwashing/hand antisepsis is the single best protector from contamination. Alcohol based gel may be utilized for hand antisepsis, unless the hands contain proteinaceous materials. Hand hygiene should be performed before and after contact with a patient or their environment (i.e. entering and leaving a patient's room), and between different aspects of care.

Wash your hands after removing gloves and other protective apparel. Additionally hands should be washed after personal use of the toilet, after sneezing or coughing, before and after eating, after using the bathroom, before beginning duties, and on completion of duties. Good handwashing practices are a must. If you have any questions about hand hygiene, contact the Infection Control Nurse. Soap and water hand washing should be utilized if the patient has Clostridium difficile.

Gloves should be worn for all venous and arterial access, finger and heel sticks.

As an OSHA requirement sharps safety or needleless devices should be utilized whenever available. If a needle must be used, proper needle handling is important to prevent needlesticks from occurring. To avoid needle sticks:

- Do not bend, hand re-cap, or break contaminated needles or sharps
- Place contaminated needles/sharps in an appropriate puncture-resistant, leak-proof container immediately after use
- Resheathers are available for use for recapping when incremental dosing necessary
- A scoop method for recapping is safe but the least desirable method
- Needle boxes should be closed and placed in Infectious Waste Bins when $\frac{3}{4}$ full

Sharps Safety Devices and Personal Protective Equipment (PPE) are provided to you by the hospital to protect you from exposure to infectious materials. Equipment available includes safety needles, gloves (found in patient rooms and throughout patient care areas), masks, gowns, aprons, lab coats, protective eyewear, and resuscitation devices. Protective equipment must be selected based upon specific work and exposure conditions that may be encountered and on the appropriate level of risk. The important point is that the equipment should form an effective barrier. It is important to wash your hands following the use of gloves or other protective equipment.

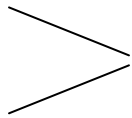
Protective equipment is available and should be used if you are going to be handling blood, body fluids/substance, mucous membranes or non-intact skin. If you are unfamiliar with how the equipment should be applied, contact your supervisor or the Infection Control Nurse to assist you in the correct use of the equipment.

Most PPE is disposable and can usually be discarded in a regular waste can. If an item is heavily soiled with blood or other body fluids, it should be discarded in the infectious waste container. Many protective gowns are re-usable and should be placed in the regular linen hamper after use.

RESPIRATORY PRECAUTIONS/ISOLATION

Diseases requiring Respiratory Isolation:

Tuberculosis
Chickenpox
Measles



Have priority for placement in Isolation Rooms.

Diseases listed below may go in other private rooms if Negative Pressure Isolation Rooms are not available:

Meningitis – Bacterial (Not viral or Aseptic)

Neisseria meningitides

Haemophilus influenzae type b

Respiratory Influenza

Pertussis

Mycoplasma pneumonia

Strep pharyngitis – children only

Mumps

Rubella (German measles)

RSV – Respiratory Syncytial Virus

*Note other diseases in Isolation Policy

1. Use #28 rooms, CCU10, or Trauma or “0” room in the Emergency Department.
2. Inform Infection Control when you place a patient in Isolation.
3. Place Respiratory Isolation signs on patient’s door.
4. Keep door closed.
5. Wear appropriate mask when entering room.
 - A. TB mask – Tuberculosis patient (Must be fit-tested and use the size assigned).
 - B. TB or Routine mask – other respiratory spread diseases
6. Fit mask appropriately for adequate protection. A well fitted mask must be worn to enter the room.

Personnel wearing TB masks must have a formal fit-test procedure performed (contact Infection control).

- **Standard Precautions are still a must.**

Disposal/Re-Use of Masks

1. Discard regular mask just inside or outside (ante-room) of patient door.
 - Masks must be worn during all sputum induction procedures, and bronchoscopes.
 - Patients in Respiratory Isolation must not be transported to other areas of the hospital unless absolutely necessary. If transported, the patient or the entire transport team must wear a mask. The patient must wear the mask the entire time he/she is outside of their room.

CONTACT ISOLATION

Room assignment – Private room unless 2 patients with same organism that can be placed together.

Protective apparel – gloves and gowns – strict hand hygiene. Hand hygiene and donning gowns and gloves must be done upon entering a patient room.

Multi Antibiotic Resistant Organisms:

MRSA – Methicillin/Oxacillin resistant Staph aureus

VRE – Vancomycin resistant enterococcus

Other multi-antibiotic resistant organisms such as ESBL's

Clostridium difficile toxin – positive

Chronic diarrhea or new onset after admission

RSV- Respiratory Syncytial Virus – also use masks

E. coli 0157:H7

Salmonella/Shigella

Hepatitis A – Incontinent or diapered patients/colostomy patients

Rotavirus

Lice/Scabies – until adequate treatment

Major draining wound or decubiti with a lot of drainage

NEUTROPENIC PRECAUTIONS

Must have a physician order.

Place patient in private room. Keep door closed.

Strict hand hygiene.

Wear masks when providing direct patient care.

Screen all visitors for exposure to illness/diseases (especially respiratory spread infections). Have visitors wash their hands and wear masks as necessary.

Standard precautions apply. Procedures that must be performed on these patients or bed baths should be done before other patients.

Personnel with upper respiratory infections or cold sores should not be assigned these patients. (If it is a must they must wear a mask at all times entering the room).

No fresh fruit, flowers or potted plants are permitted.

Do not utilize rectal thermometers, rectal suppositories or enemas.

Physician Notice Regarding Medical Necessity and Compliance

What is a Physician Notice?

This Physician Notice pamphlet has been designed to notify you of Medicare, HCFA, and OIG rules regarding medical necessity and billing compliance in order to protect both you and the hospital from potential liability.

What is Medical Necessity?

Medicare will only pay for those tests and services that it determines to be "reasonable and necessary." Fiscal intermediaries may develop a "local medical review policy" for specific tests and/or services. This local medical review policy indicates which diagnoses, signs, or symptoms are payable for these specific tests and/or services. If a test or service is ordered in which a local medical review policy exists, there must be documentation of medical necessity on the claim in order for Medicare to pay for this test or service. In the case where the Fiscal Intermediary does not have LMRPs, the National Coverage Limitations still apply. Physicians are advised by HCFA to only order those tests and/or services they believe are medically necessary. A specific diagnosis, sign, symptom, or ICD-9-CM code must be provided when ordering tests or services. If a test or service is **not** medically necessary, an Advance Beneficiary Notice (ABN) must be obtained from the patient. Please understand that the guiding principle to determine whether an ABN should be obtained is not whether you, as a physician believe that the test or service is medically necessary, but whether the patient's diagnosis, signs, or symptoms are on Medicare's approved acceptable list for the specific test or service being ordered. Note:

Fiscal Intermediaries and Part B Carriers may have different LMRPs. Our facility will submit Medicare claims to our Fiscal Intermediary, therefore we must follow their LMRPs.

What if I need assistance in ordering tests or services?

The appropriate ancillary department will make available the services of a clinical consultant to assist you when you have questions regarding test or service appropriateness.

What is an ABN & why do we need one?

An ABN is an Advance Beneficiary Notice. The purpose of the ABN is to give the patient advance notice that Medicare will not pay for the test or service ordered. When ordering tests or services that do not meet local medical review policy or National Coverage Limitations, physicians should explain to the beneficiary why the test is being ordered and that Medicare will not pay for the test and therefore an ABN must be signed. Signed ABNs should be forwarded to the ancillary service department performing the tests or services. HCFA considers the billing of non-medically necessary services to Medicare as a False Claim. The False Claim Act states that individuals may be liable for civil penalties up to \$10,000 per claim.

How can we work together?

To limit the potential risk for both physicians and ancillary departments, our facility has adopted the OIG Model Compliance Plan for Laboratories and several policies related to Medicare billing. We realize that it is good medicine to provide certain sets of tests for specific diagnoses and therefore will allow you to define Custom Profiles for use in treating your patients. Please contact our Laboratory for additional information. We have also created Critical Pathway Order Sets for the convenience of ordering groups of commonly ordered tests which are generally accepted by our Medical Staff. Please note, Custom Profiles are for the use of individual physicians while Critical Pathway Order Sets are for generally use by all medical staff. We also realize that there are instances when abnormal values for specific tests warrant

additional testing. Therefore, we have created Reflex testing guidelines which will be updated and approved annually by the Executive Committee of the Medical Staff and published in the Medical Staff Meeting Minutes.

I acknowledge that I have received and read the Physician Notice Regarding Medical Necessity and Compliance Pamphlet.

Attachment to GOS.GEN.002

CERTIFICATE CONDITIONS OF PHYSICIAN INTERNET ACCESS

The undersigned hereby certifies that:

1. I will use the facility's internet access terminals only for the purpose of the delivery of medical services at this facility (*e.g.*, research and review of relevant periodicals, studies and other clinical information).
2. I will not access any restricted information without the appropriate consents being granted (*e.g.*, patient information, restricted hospital information).
3. I will not use the facility terminals to access non-facility email.
4. I have been made aware of and understand the Electronic Communications Policy (IS.SEC.002).
5. I have no intention of varying the volume or value of referrals I make to the facility in exchange for the Internet access service.
6. I have not agreed, in writing or otherwise, to accept such Internet access in exchange for the referral to the facility of any patients or other business.
7. I understand that the facility may decide at any time without notice to no longer provide Internet access to physicians on the medical staff.
8. I understand that if I fail to comply with the above terms, the facility may restrict me without notice from accessing the Internet through its equipment.
9. I understand that if I am no longer a member of the facility's medical staff for any reason, I may no longer use the facility's equipment to access the Internet for any purpose.

MEDICAL STAFF HIPPA POLICY REVIEW

The Policies in the HIPPA binder are to be read and acknowledgment statement signed that you understand the policies. Some key points are listed below. These do not include all of the information regarding the HIPPA policies, but hopefully will provide a better understanding of how these policies affect our Hospital

- BUSINESS ASSOCIATE: This is an entity who provides a service to the hospital but is not a member of our staff, but with whom we do share patient information. The hospital must have a contract with these services and they are listed as a business associate in order for information regarding patients may be shared with them. An example of this association is HOSPICE. If a new service is provided from a business associate we must check to ensure that a contract exists.
- DESIGNATED RECORD SET: All patients have a right to access their entire medical record, not just the information that is maintained in the medical record. This would include Cath Lab CD's, x-rays, etc.
- USE/DISCLOSURE OF INFORMATION: All information that is provided to an external agency regarding a patient must be tracked, this includes to whom the information is released and the type of information that was released. This information is logged and every month reviewed to determine it is present. A patient may request a copy of their disclosures for as long as a 6 year period of time. Example: KODA for death reports, SOCIAL SERVICES for reporting of abuse cases.
- PROTECTED HEALTH INFORMATION: Patient information must be protected at all times, to include past, present and future information. All paper, electronic and oral information must be protected. Oral communication is the biggest problem. Please assure that reports and all patient information is discussed PRIVATELY and not within hearing distance of others. Always assure that charts are not in reach or view of the general public.
- CONDITION OF ADMISSION: The notice of privacy must be distributed and acknowledged by the patient, this is done on the Condition of Admission form. The COA also allows for sharing of Protected Health Information for treatment, payment and operations.
- MINIMUM NECESSARY RULE: Only the minimum amount of information necessary to perform your job, is allowed. This means you would not look through the computer or chart for information that you do not need to know in order to provide care for a patient.
- INDIVIDUAL IDENTITY INFORMATION: Do not display anything that could identify a patient to public view. This includes a patient license plate number, date of birth, social security number, medical record or account number, photo, name, etc. On the units make sure that charts are not left in view of the public.
- PATIENTS RIGHT TO ACCESS RECORD: The patient has the right to access their entire record, according to hospital policies.

- RIGHT TO AMEND: A patient may request that their record be amended, in accordance with hospital policy. The request must be in writing, and reviewed for approval or denial. Some information cannot be amended.
- PRIVACY RESTRICTIONS: All patients have the right to request that certain disclosures of information not be provided. Some disclosures can be denied such as a social service consult for abuse. The hospital may deny this request if it is deemed to be inappropriate. The patient must provide the request in writing to the Facility Privacy Officer.
- Confidential Communication: All patients have the right to request an alternate means of communication. If a patient does not want information regarding medical care sent to their home we must obey the request.
- DISPOSAL OF PATIENT INFORMATION: All hard copies of patient information must be placed in a shredder box, located throughout the hospital. No patient information will be placed in trash cans, IV bags that display patient information should never be placed in trash cans.
- VERIFICATION OF REQUESTOR: Verification of the person requesting patient information is mandatory. The requester should have the patient pass code that is assigned at the time of admission. If a patient requests that the be made confidential, they must understand that they will not be in the directory, will receive no phone calls, flowers, or visitors. The patient may call someone, but the staff may not reveal that the patient is here. Assure that a patient is not in Confidential Status prior to providing any information.
- CLERGY ACCESS: All clergy are required to have a hospital badge, they must present a badge and another form of ID in order to receive a patient list.
- FAXING: Faxing of patient records should only be done in an emergent situation for continuity of patient care. If you must fax records then you must insure that you have: FAX NUMBER (verify), REQUESTOR'S NAME (verify) and VERIFICATION that the Fax was received.

HIM.PRI.001 Patient Privacy – Program Requirements Policy

Establishes general requirements for the patient privacy program, provides pertinent definitions and provides guidance for some aspects of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards). Requires each facility to develop and implement facility-specific policies regarding the privacy of, and access to, patient health information. Attachment A to the policy is a series of Sample Facility Policies.

HIM.PRI.003 Patient Privacy - Protection Policy

Provides guidance regarding each workforce member's responsibility related to using and disclosing only the minimum amount of identifiable patient information to fulfill the purpose of the use or disclosure, regardless of the extent of access provided. This policy covers uses and disclosures of protected health information (PHI) in any form including oral, written and/or electronic mediums. Each individual is responsible for adhering to this policy by using only the minimum information necessary to perform his or her responsibilities, regardless of the extent of access provided or available.

HIM.PRI.004 Patient Privacy – Patients’ Right to Access Policy

Provides guidance regarding patients’ rights to inspect and/or obtain a copy of their PHI as required by the HIPAA Privacy Standards. Provides guidance on patients’ rights to inspect and obtain a paper copy of their PHI that is contained within the designated record set, exceptions thereto, and circumstances when the facility may deny a request.

HIM.PRI.005 Patient Privacy – Patients’ Right to Amend Policy

Ensures patients the right to amend protected health information (PHI) stored in the designated record set as required by the HIPAA Privacy Standards. Provides guidance on patients’ rights to request the facility amend their PHI that is contained within the designated record set for as long as the information is maintained by the facility and exceptions thereto.

HIM.PRI.006 Patient Privacy – Right to Request Privacy Restrictions Policy

Ensures patients the right to request privacy restrictions on the use or disclosure of their PHI as required by the HIPAA Privacy Standards. Provides guidance on patients’ right to request restriction of certain uses and disclosures of their PHI that is contained within the designated record set. Provides guidance regarding exceptions to this right and circumstances under which a request may be denied.

HIM.PRI.007 Notice of Privacy Practices Policy

Ensures that each facility understands the requirement to provide a Notice of Privacy Practices to all patients as required by the HIPAA Privacy Standards. Requires each facility to provide a Notice of Privacy Practices to all patients. Provides that the facility must inform patients of their rights with respect to PHI as well as the facility’s legal duties and that the patient must acknowledge receipt of the notice. All notices must include all the elements in the version attached to the policy and must have the name or title and telephone number of the FPO.

I have read and understand the above HIPPA Policies.

Printed Name

Signature

Date Signed

REFLEX TESTING ACKNOWLEDGMENT

PURPOSE:

The purpose of this Reflex Testing acknowledgment is to ensure that our physicians understand when reflex tests will be performed and how they will be billed to Medicare.

POLICY:

Frankfort Regional Medical Center's Laboratory will automatically perform reflex tests according to the criteria in the attached list when all three of the following conditions are met, unless your order specifically states that you do not want the reflex test performed:

1. An initial test has been performed as ordered;
2. The initial test result meets the criteria for the reflex test; and
3. The hospital's Medical Executive Committee has approved those tests and criteria.

BILLING OF REFLEX TESTS:

The hospital bills for medically necessary reflex tests according to the CPT code listed on the attachment. The Medicare fee schedule amount is listed with each CPT code.

ACKNOWLEDGMENT AND APPROVAL:

By signing this acknowledgment, you acknowledge that you have reviewed the attachment and agree that, whenever the initial test ordered meets the reflex criteria, the corresponding reflex test will be performed, reported and billed.

If in the case of an individual patient, you consider the reflex test unnecessary, you must order the initial test without the reflex. With the exception of those tests required by law, you may order any test without the reflex option.

We recommend that you utilize the hospital laboratory requisition in order to clearly indicate the tests that you want performed.

This acknowledgment may be terminated at any time with written notice to the laboratory director.

Notification of any additions or modifications to reflex tests will be communicated via the Notification of Additions or Modifications for Reflex Testing form as they are approved by the Medical Executive Committee.

FRMC laboratory will perform the following assays reflexed based on positive results.

<i>Test</i>	<i>CPT</i>	<i>Medicare fee schedule</i>
Sensitivity Reflexed if culture is positive	87186	\$12.08
IgG Coombs Reflexed in transfusion reaction	86880	\$ 7.50
Antibody Ident	86870	none listed

Subject: Pain Management	No. PC.082
Provision of Care, Treatment and Services Policy/Procedure	Eff Date: 1/18/99 Rev. Date: 2/14/08
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POLICY:

Recognizing pain as a major, yet largely avoidable, public health problem, Frankfort Regional Medical Center has developed standards that create expectations for the assessment and management of pain. Patients have a right to pain relief. The assessment and regular reassessment of pain enables the staff, patient and family to achieve pain relief. The American Pain Society has endorsed these standards.

PURPOSE:

- Recognize the right of patients to appropriate assessment, reassessment and management of pain;
- Assess the existence and, if so, the nature and intensity of pain in all patients;
- Record the result of the assessment in a way that facilitates regular reassessment and follow-up;
- Determine and assure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff;
- Establish policies and procedures, which support the appropriate prescription or ordering of effective pain medications;
- Educate patients and their families about effective pain management;
- Address patient needs for symptom management in the discharge planning process.

DEFINITION:

Pain is “whatever the experiencing person says it is, existing whenever he says it does”. (McCaffery, 1992).

PRINCIPLES OF PAIN MANAGEMENT:

Family members will be requested to participate in pain management when appropriate. Successful assessment and control of pain depends, in part, on establishing a positive relationship between health care professionals and patients. Patients will be informed that pain relief is an important part of their health care, that information about options to pain control are available, and that they are welcome to discuss their concerns and preferences with the health care team.

The personal successful methods of pain management of the patient, as well as cultural, spiritual and/or ethics/ beliefs are considered when planning the patient’s pain management interventions.

Unrelieved pain has negative physiologic and psychologic consequences. Preemptive management of pain is encouraged. Aggressive intervention before, during, and after surgery can yield both short and long term benefits.

It is not always possible to eliminate all pain. Prevention is better than treatment. Pain that is established and severe can be difficult to control.

Pain intensity and adequacy of relief will be assessed and reassessed at regular intervals.

Patient preferences will be considered when determining methods to be used for pain management.

ROLES AND RESPONSIBILITIES:

The assessment and management of pain is an interdisciplinary process including physicians, nurses, pharmacists and other clinical disciplines involved with the patient's care.

STAFF RESPONSIBILITIES IN MANAGING PAIN:

1. Believe the patient's report of pain.
2. Teach the patient about pain and relief.
3. Know and use analgesic drugs and adjuncts for optimal safety and efficacy.
4. Encourage the use of a wide variety of pain management interventions including nonpharmacologic techniques.
5. Include what the patient believes will be effective in the plan of care.
6. Offer pain medications or interventions frequently and/or as ordered rather than waiting for the patient to ask for relief.
7. Discuss fears and other feelings related to accepting pain management interventions.
8. Request further intervention orders if pain management is ineffective.
9. Incorporate "pain" into the care planning process.
10. Prioritization of pain management through the patient's plan of care.
11. Insuring that unresolved pain present at discharge or transfer is addressed for continuity of care.

POLICY:

Assessment

Pain is assessed in all patients:

- A. Pain assessment on admission includes:
 1. Intensity – Use 0-10 pain intensity rating scale.
Mild pain: 1-3; Moderate pain 4-6 and Severe pain 7-10.
 2. Location.
 3. Quality – Radiation and/or character.
 4. Onset, duration, variations and patterns.
 5. Alleviating and aggravating factors.
 6. Present pain management regimen and effectiveness.
 7. Pain management history.
 8. Effects of pain on daily life, sleep and other ADLs.
 9. Patient's pain goal.
 10. Physical observations of the site of pain.
 11. Pain intensity scales are enlarged and available when appropriate for assessment.

Pain is assessed on admission and minimally every shift or as often as pain needs dictated.

Assessment Tools

The adult patient is assessed utilizing a 0 –10 Pain Intensity Scale.

0 = No Pain; 1 –3 = Mild Pain; 4 – 6 = Moderate Pain; 7 – 10 = Severe Pain

The child or cognitively impaired is assessed utilizing the Wong FACES Pain Rating Baker Scale.

0 = No Pain; 1 –3 = Mild Pain; 4 – 6 = Moderate Pain; 7 – 10 = Severe Pain

The Neonate/Infant or non-communicative patient is assessed utilizing the NIPS Scale.

In addition to non communicative patients, neonates or infants, other patients, may have difficulty communicating their pain require particular attention. This includes patients who are cognitively impaired, psychotic or severely emotionally disturbed, children, the elderly, patients who cannot communicate effectively, patients whose level of education or whose cultural background differs significantly from that of their healthcare team.

III. Assessment Criteria:

ADULT	<u>MILD (0-3)</u> Occasional grimacing No changes in vital signs Restlessness	<u>MODERATE (4-6)</u> Slight increase in B/P, HR Occasional crying Increased restless Guarding of operative site	<u>SEVERE (7-10)</u> Significant increase in B/P,HR Moaning and crying excessively Constant grimacing Unable to relax or agitation
CHILD	<u>MILD (0-3)</u> Quiet, normal body posture No cry to slight wimper "This doesn't hurt too bad" Flat affect expression Direct eye contact	<u>MODERATE (4-6)</u> Fidgety, twisting of extremities Tears to crying "This hurts bad" Facial grimace, frown Limited eye contact	<u>SEVERE (7-10)</u> Kicking, awkward body position Yelling, crying steadily "This hurts really bad" Angry frown Withdrawn, poor/no eye contact

IV. Age specific assessment of pain.

Objective behavioral based data indicating pain:

1. Pre-verbal/infant child
 - a. Facial expressions: brow bulge, eye squeeze, chin quiver
 - b. Restlessness, inability to console, grimacing
 - c. Crying, moaning, screaming
 - d. Torso- shifting, tense, shivering, legs kicking, squirming, kicking, etc
 - e. Touch- reaching but not touching wound, gently touching area, grabbing vigorously at wound.
2. Toddler
 - a. Loud crying, verbalization of pain (ouch, hurt, boo-boo).
 - b. Generalized restlessness.
 - c. Attempt to delay procedures perceived as painful, runs from nurse.
 - d. Guards site and touches painful area.
 - e. Face may show anger, fear, may avoid eye contact, look of sadness.
3. Preschooler:
 - a. May think he is being punished for something "bad" he did
 - b. Cry, kick

- c. Fear body mutilation
 - d. Describe location and intensity
 - e. Regression to earlier behaviors
 - f. May deny pain to avoid a possible injection
 - g. May have been told to be "brave" and deny pain even though it is present.
4. School-age:
- a. Able to describe pain
 - b. Fears bodily harm
 - c. Has an awareness of death
 - d. Non-verbal cues- stiff body posture, withdrawal, crying
 - e. Brings memories of previous pain experience to setting
 - f. Procrastinates or bargains in order to delay procedures
5. Adolescent:
- a. Perceives pain at a physical, emotional and mental level
 - b. Understands cause and effect
 - c. Describes pain
 - d. Increased muscle tension
 - e. Withdrawal and decreased motor activity
 - f. Uses words like sore, ache, pounding, to describe pain
 - g. Confused and uncertain of their roles
 - g. Egocentric and thinks nurse should somehow be aware of the pain that he/she is experiencing. If nurse is unaware, the teen may interpret this as an indication that the pain he/she is having is indeed minimal and that he/she should be able tolerate it.
6. Adult/Geriatric:
- a. Facial expressions: furrowed brow, clenched jaw, generally worries look
 - b. Changes in behavior/gestures: fidgeting,
 - c. Changes in activity/behavior: loss of appetite, no longer doing for self, quiet, withdrawn
 - d. Special risks of pain in the elderly:
 - 1) observe for signs/symptoms of pneumonia
 - 2) plan for mobility and exercise
 - 3) assess for drug interactions and reactions
7. Patients receiving rehabilitative services:
- a. Pain interfering with optimal level of function
 - b. Participation in rehabilitation

V. **Assessment of barriers to reporting pain.**

Barriers to reporting pain from the patient's perspective are assessed on admission:
Barriers can include but are not limited to:

- 1. Fear that pain means disease is worse
- 2. Concern about not being a "good" patient.
- 3. Fear of addiction or being thought of as an addict
- 4. Fear of becoming tolerant to pain meds
- 5. Fear of side effects
- 6. Concern about distracting physician from treatment of underlying disease
- 7. Fear of discomfort associated with medication administration.

VI. **Reassessment:**

- A. Pain reassessment will include:

1. Intensity
2. Location
3. Duration
4. Quality – radiation and/or character
5. Alleviating and aggravating factors
6. Assess effectiveness of medication as needed

B. Re-assessment of Pain:

Each inpatient will be re-assessed for pain throughout the hospital stay. If the initial assessment of pain indicates the patient is pain free, the patient (in-house) will be re-assessed for pain every 12 hours or sooner as needed. The patient being treated in the Emergency Department or Ambulatory Care will be re-assessed for pain every hour or after any pain medication is given, as set forth in this policy and procedure. If the Emergency Department or ambulatory care patient presents pain free, the patient will be reassessed for pain only if the patient indicates a change in the pain status.

C. Any patient will be reassessed for pain with a change in status or condition.

D. Pain reassessment occurs after pain relief interventions are implemented approximately within 1 hour or more frequently if appropriate.

VII. **Education**

A. **Patient/Family Education may include:**

1. The patient's/family role in understanding pain and the importance of effective pain management.
2. Interventions toward alleviating patient barriers or fears to participation in
3. effective pain management.
4. The limitations and side effects of pain treatments.
5. The pain rating scale being utilized.
6. Alternative methods of intervention as appropriate and employed, which may include
7. oral, IM, IV, PCA, Spinal or Intrathecal analgesics.
8. The name, actions, and side effects of pain medications employed.
9. The parental role in assisting with interpretation of behavioral changes of their child that may indicate pain or discomfort.
10. Need to report inadequate pain relief.
11. Use of non pharmacologic interventions.
12. Instruction of possible side effects and to report to staff.
13. Discharge instructions – insure that patient/family understands correct dosage and schedule for medication administration before discharge.

B. **Staff Education will include:**

1. Assessment factors of the verbal and non-verbal patient.
Age-specific factors as appropriate including neonatal, pediatric, and adult geriatric age groups.
2. Pain management therapy/intervention methods including oral, IM, IV, PCA, Spinal or Intrathecal, and the pain medications employed.
3. Recognition and assessment of cultural, religious, and/or ethical beliefs to be incorporated into the pain management process.
4. Barriers that prevent patients from reporting pain and using analgesics.
5. Reportable conditions to physician including: ineffective pain relief, nausea and

vomiting, respiratory depression, rash/itching, urinary retention, constipation and anaphylactic reaction.

6. Management interventions for side effects.

C. **Guidelines:**

1. The clinician will discuss with the patient any previous experience with pain as well as the patient's beliefs concerning pain.
2. The clinician will discuss patient preferences for pain assessment and management techniques.
3. The clinician will provide the patient with information about pain management, therapies that are available and the rationale underlying their use.
4. The clinician and the patient will establish a plan for pain assessment and management. This will be included in the Interdisciplinary Patient Care Plan.
5. The clinician will teach the patient how to use the pain assessment tool.
6. The clinician and the patient will agree upon what level of pain intensity requires further intervention.
7. The clinician will provide the patient with education and information about pain control, including training in nonpharmacologic options such as relaxation, if appropriate. This will be documented on the Patient/Family Interdisciplinary Education Record.
8. The clinician will inform the patient that it is easier to prevent pain than to treat it once it has become established and that communication about inadequately relieved pain is essential. The clinician will emphasize the importance of a factual report of pain, avoiding stoicism or exaggeration.
9. Infants should be closely monitored when they are administered opioids because opioid clearance is prolonged and the blood-brain barrier is more permeable, which increases their potential for opioid-induced sedation and respiratory depression.
10. The elderly are more vulnerable to drug accumulation because of age and require assessment for effects of poly pharmacy.

Management options

A. **Pharmacologic Management:**

Non-steroidal Anti-Inflammatory Drugs (NSAIDS)

A. Examples of NSAIDS:

1. Aspirin
2. Ibuprofen
3. Naprosyn

B. Effectiveness equals that of some opioids

C. Type of pain influences effectiveness of NSAIDS.

1. Most effective for the following types of pain:

- a. Dysmenorrhea
- b. Post-operative orthopedic surgical pain
- c. Some types of cancer pain, particularly bone tumors or metastases.

Opioids

A. Work at central nervous system level.

B. No pain ceiling with opioid analgesics.

C. Routes of Administration:

1. Oral
 - a. Convenient
 - b. Drawback is slow onset (1.5 to 2 hours)
 2. Repetitive IM or SQ injections
 - a. Readily available route
 - b. Drawback is wide fluctuations in absorption from muscle or subcutaneous tissue and injections may be painful.
 3. Intravenous
 - a. Rapid onset with peak effects in 5-15 minutes.
 - b. Limitation is requirement for intravenous access.
 4. Patient controlled analgesia (PCA)
 - a. Intravenous or subcutaneous routes recommended.
 - b. Stable level of analgesia.
 - c. Popular with patients.
 - d. Requires infusion pumps and staff education.
 - e. Limitation is requirement for intravenous access.
 5. Epidural
 - a. When appropriate for patient and surgical procedure performed, provides reliable analgesia.
 - b. Significant risk of respiratory depression and hypotension.
 - c. Requires careful monitoring.
 6. Rectal
 - a. No IV access needed.
 - b. Convenient for patients with compromised GI function.
 - c. Drugs prepared for oral administration can be administered rectally; dosage is the same as oral form.
 - d. May be appropriate for bladder spasm pain.
- D. Doses of opioids should be titrated according to individual responses.
- E. Dosage interval, choice of agent, and route of administration are individualized.

B. Non-Pharmacological Management

- I. Patient education should be documented may include such items as:
 - A. Procedural and sensory information.
 - B. Information about the use of relaxation.
 - C. Cognitive/behavioral interventions including a variety of methods that help patients understand more about their pain and take an active role in pain assessment and management.
 1. Relaxation
 2. Distraction
 3. Imagery
 - D. Physical agents include:
 1. Applications of heat and cold
 2. Massage
 3. Movement
 4. Rest or immobilization
 5. Transcutaneous Electrical Nerve Stimulator (TENS)

C. Alleviating Factors for Pediatric Pain

1. Distraction – to reduce anxiety (pre-school and up)
 - Pain impulses are slower if anxiety can be reduced.
 - An action or thought can refocus child.
 - Have the child say “ouch” when giving the injection.
 - Doesn’t work for severe pain.

- Ex—music, stories games.
- 2. Thought stopping – stop anxious thoughts by substituting a positive or relaxing one. (Pre-school and up.)
 - Requires practice.
 - “It doesn’t take long. The nurse is trying to help me; it’s important to help me get better.”
 - When child begins to become anxious, have him recite.
 - Allows child to ‘feel in control’ of their thoughts.
- 3. Relaxation Imagery (pre-school and up) –
 - Make believe trip to favorite, peaceful place.
 - Slow, deep breathing.
- 4. Guided Imagery – helps child place a non-painful meaning to a painful procedure (pre-school and up)
 - I.e., venipuncture is viewed as a silver rocket ‘probing the moon’ or ‘submarine diving under water to escape’. Be sure child thinks of *specific* image.
 - Elaborate on the image to make it more concrete (color of the rocket).
- 5. Hypnosis – not used frequently in hospital, due to need for previous training with therapist.
- 6. TENS – transcutaneous electrical nerve stimulator.
- 7. Oral analgesics (Tylenol, Codeine, NSAIDS)
- 8. Intravenous analgesics (Morphine, Fentanyl, Hydromorphone)
- 9. PCA Analgesia (Morphine)
- 10. Moderate Sedation (Nembutal, Midazolam, Fentanyl, Miperidien)

VIII. **DOCUMENTATION:**

- Pain Management is integrated into the patient’s plan of care.
- Pain management is reprioritized along with the patient’s other identified problems daily.
- Pain management assessment occurs through the Admission History and through Shift Reassessments.
- Patient/family education.
- Patient response to the pain management regime.
- Document any medications/narcotics/analgesics administered to the patient.
- Documentation of evaluation of pain medication effectiveness occur approximately within one hour of intervention.
- Communications with physicians regarding patient’s reaction to pain management plan.
- Discharge pain management instructions, if applicable.

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Drayer, R.A., Henderson, J., Reidenberg, M. (1999) “Barriers to Better Pain control in Hospitalized Patients”. Journal of Pain and Symptom Management, Vol. 17 (6). p. 434-440



299 King's Daughters Drive, Frankfort, KY 40601
Telephone (502) 226-7681

October 15, 2009

Dear Colleague:

In accordance with Joint Commission standards and Emergency Preparedness planning at Frankfort Regional Medical Center it is my responsibility to communicate the roles, responsibilities, and reporting structure that will be utilized in the event of a disaster affecting Frankfort Regional Medical Center (FRMC).

In the event of an internal or external disaster affecting FRMC, all Licensed Independent Practitioners (LIPs) of Frankfort Regional Medical Center should report to the facility's Emergency Operations Center (EOC) to assist. The EOC will be located in the second floor classroom unless there is structural damage to the facility, in which case an alternate location will be determined by the hospital Incident Commander. The Chief Medical Officer or designee will assume responsibility for assigning practitioners to areas of greatest need, within the scope of practice and privileging of each individual. The Hospital Incident Command (HIC) structure for command and control will be utilized. This command structure is National Incident Management System (NIMS) compliant and is in accordance with the command structure utilized by the local community agencies. In addition, you might be asked to partner with volunteer LIPs to ensure their practice is in accordance with FRMC standards. The full scope of this responsibility is outlined in the Medical Staff Bylaws under "Disaster Response and Recovery". If you have any questions regarding disaster roles, responsibility and response you may contact FRMC's Emergency Preparedness Coordinator, Charlotte O'Neal at 502-226-7992.

Sincerely,

Willis McKee M.D.
Chief Medical Officer
Frankfort Regional Medical Center

WM/tmp