

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Sleep –Wake cycle	Disturbed/cycle reversed	Fragmented	Disturbed, usually early morning awakening
Associated features	Variable, affective changes, s/s autonomic hyperarousal, exaggeration of personality type associated with acute physical illness	Affect tends to be superficial, inappropriate and labile; attempts to conceal deficits in intellect, personality changes, aphasia, agnosia may be present, lacks insight	Affect depressed, dysphoric mood, exaggerated and detailed complaints, preoccupied with personal thoughts, insight present, verbal elaboration
Assessment	Distracted from task, numerous errors	Failings highlighted by family, frequent "near miss" answers, struggles with test, great effort to find an appropriate reply, frequent requests for feedback on performance	Failings highlighted by individual, frequently answers "I don't know", little effort frequently gives up, indifferent toward test, does not care or attempt to find answer

(Meilillo & Houde, 2011)

try this:

general assessment series

Best Practices in Nursing
Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 13, Revised 2012

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The Confusion Assessment Method (CAM)

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WHY: Delirium is present in 10%-31% of older medical inpatients upon hospital admission and 11%-42% of older adults develop delirium during hospitalization (Siddiqi, House, & Holmes, 2006; Tullmann, Fletcher, & Foreman, 2012). Delirium is associated with negative consequences including prolonged hospitalization, functional decline, increased use of chemical and physical restraints, prolonged delirium post hospitalization, and increased mortality. Delirium may also have lasting negative effects including the development of dementia within two years (Ehlenbach et al., 2010) and the need for long term nursing home care (Inouye, 2006). Predisposing risk factors for delirium include older age, dementia, severe illness, multiple comorbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Precipitating risk factors include acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction, and exposure to high risk medications. Delirium is often unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes. Therefore, patients should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.

BEST TOOL: The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment. There is also a CAM-ICU version for use with non-verbal mechanically ventilated patients (See *Try This*® CAM-ICU).

VALIDITY AND RELIABILITY: Both the CAM and the CAM-ICU have demonstrated sensitivity of 94-100%, specificity of 89-95% and high inter-rater reliability (Wei, Fearing, Eliezer, Sternberg, & Inouye, 2008). Several studies have been done to validate clinical usefulness.

STRENGTHS AND LIMITATIONS: The CAM can be incorporated into routine assessment and has been translated into several languages. The CAM was designed and validated to be scored based on observations made during brief but formal cognitive testing, such as brief mental status evaluations. Training to administer and score the tool is necessary to obtain valid results. The tool identifies the presence or absence of delirium but does not assess the severity of the condition, making it less useful to detect clinical improvement or deterioration.

FOLLOW-UP: The presence of delirium warrants prompt intervention to identify and treat underlying causes and provide supportive care. Vigilant efforts need to continue across the healthcare continuum to preserve and restore baseline mental status.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGerIRN.org.

The Hospital Elder Life Program (HELPE), Yale University School of Medicine. Home Page: www.hospitalelderlifeprogram.org/

CAM Disclaimer: www.hospitalelderlifeprogram.org/private/cam-disclaimer.

Useful websites for clinicians including the CAM Training Manual:

www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf

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Wei, L.A., Fearing, M.A., Eliezer, J., Sternberg, E.J., & Inouye, S.K. (2008). The confusion assessment method (CAM): A systematic review of current usage. *JAGS*, 56(5), 823-830.

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The Confusion Assessment Method Instrument:

1. **[Acute Onset]** Is there evidence of an acute change in mental status from the patient's baseline?
- 2A. **[Inattention]** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?
- 2B. **(If present or abnormal)** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?
3. **[Disorganized thinking]** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. **[Altered level of consciousness]** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)
5. **[Disorientation]** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?
6. **[Memory impairment]** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
7. **[Perceptual disturbances]** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?
- 8A. **[Psychomotor agitation]** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?
- 8B. **[Psychomotor retardation]** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?
9. **[Altered sleep-wake cycle]** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: *Acute Onset or Fluctuating Course*

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: *Inattention*

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: *Disorganized thinking*

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: *Altered Level of consciousness*

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable]

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

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Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegel, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine*, 113(12), 941-948.



A series provided by The Hartford Institute for Geriatric Nursing,
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GERIATRIC NURSING RESUME: www.ConsultGerIRN.org

WHAT'S WRONG WITH THIS PATIENT?

ASSESSING ALTERED LEVEL OF CONSCIOUSNESS

Overnight this elderly patient became confused and lethargic. Can you determine why?

BY EDWINA A. MCCONNELL, RN, PhD,
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MARIE JACKSON, 82, IS ADMITTED to your unit from the ED with decreased level of consciousness (LOC) and general weakness, lethargy, and confusion. She appears to be sleeping but arouses easily when you speak to her. Although she knows her name, she responds slowly and has limited spontaneous movement.

Mrs. Jackson's daughter accompanies her. After orienting them to the room, you check the doctor's orders: complete blood cell (CBC) count, electrolytes, blood urea nitrogen (BUN), creatinine, computed tomography (CT) scan, and clear liquid diet. Mrs. Jackson's vital signs are: temperature, 99.4° F (37.4° C); pulse, 100 and regular; respirations, 20; and blood pressure, 132/64.

1. To assess Mrs. Jackson's neurologic status, you should first
 - a. ask her to tell you the time.
 - b. check her pupils.
 - c. check her oculomotor responses.
 - d. evaluate her fine motor coordination.

Mrs. Jackson is confused about the time and place, but her breathing pattern and pupillary, oculomotor, and motor responses are normal.

2. As you're assessing Mrs. Jackson her daughter says, "I'm really concerned about my mother. I hope this is nothing serious." What's your best response?
 - a. "Don't worry—she'll be fine."
 - b. "Many people her age become confused."

- c. "What concerns you most?"
- d. "What do you think is wrong with her?"

Because Mrs. Jackson can't provide a coherent history, you ask her daughter to supply it.

3. Which of the following would elicit the most useful information about her mother's current problem?

- a. "How long has your mother been confused?"
- b. "Is she usually confused?"
- c. "Tell me about the development of these symptoms."
- d. "How long has your mother been lethargic?"

Her daughter explains that Mrs. Jackson lives in a retirement village and that they talk on the telephone daily. "Yesterday Mom said she was tired and going to take a nap," she says. "When we spoke today, she sounded exhausted. She thought it was 1980 and that I was my sister Dorothy, who lives out of state." Immediately after that conversation, the daughter drove to Mrs. Jackson's place and called the doctor.

"My mother's never behaved like this," she tells you. "She still drives her car and stays very active, even though she's had her share of health problems."

4. Now that you have this information, which would be the best question to ask next?
 - a. "Does your mother take any medications?"
 - b. "Has she fallen recently?"
 - c. "What kind of activities is she involved in?"
 - d. "What health problems has she had?"

The daughter provides a wealth of information. Mrs. Jackson has a history of rheumatoid arthritis, diverticulosis, and severe hypertension. Five years ago she had a modified mastectomy. Eight months ago she was hospitalized for deep vein thrombosis, and she's been taking anticoagulants ever since.

Her daughter gives you a list of all

Mrs. Jackson's oral medications: warfarin (Coumadin), 5 mg daily, except Wednesday and Saturday; ramipril (Altace), 10 mg every other day; ranitidine (Zantac), 150 mg b.i.d.; docusate sodium, 100 mg, with casanthranol, 30 mg (Peri-Colace), one tablet daily; and amiloride, 5 mg, with hydrochlorothiazide, 25 mg (Moxlurctic), once daily.

A history of hypertension and anticoagulant use puts Mrs. Jackson at risk for a stroke and she may have developed brain metastases from her breast cancer, but the CT scan reveals neither. Her CBC count results are: hemoglobin, 12 grams/dl; hematocrit, 38%; red blood cell count, 4.8 million cells/microliter; and white blood cell (WBC) count, 9,200 cells/microliter. The WBC differential is normal. The other blood levels are: glucose, 114 mg/dl; BUN, 14 mg/dl; creatinine, 0.8 mg/dl; calcium, 9.3 mEq/liter; sodium, 123 mEq/liter; potassium, 4.3 mEq/liter; and chloride, 94 mEq/liter.

5. Based on these data, the most likely cause of Mrs. Jackson's decreased LOC and increasing weakness, lethargy, and confusion is
 - a. acute renal failure.
 - b. hyperglycemia.
 - c. hyperkalemia.
 - d. hyponatremia.

▼ ANSWERS ▼

1. a. Although assessing motor function and pupillary response helps pinpoint cerebral or brain-stem dysfunction, LOC remains the most critical index of central nervous system function. If a patient has altered LOC, memory dysfunction causes disorientation to time, then to place, and finally to person. You've already determined that Mrs. Jackson knows her name. Now you need to find out whether she knows where she is and what time it is.

Exhibit #6

GEROPSYCH INSERVICE

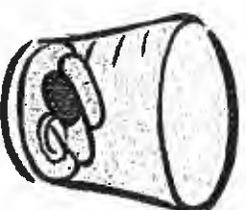
LADONNA CHIRPAS

ANTIPSYCHOTIC MEDICATIONS

Justification of Antipsychotic Medication

Treatment for Bipolar Disorder D/O, Schizophrenia, Psychotic D/O and Severe Agitation

- Dosage individualized due to individualized response to meds
- AIM
 - Lowest effective dose
 - Least amount of side effects



(Stahl, 2013)

ANTIPSYCHOTIC MEDICATIONS

1st Generation Anti-psychotics

- Navane
- Haldol
- Mellaril
- Thorazine
- Trilafon

2nd Generation Anti-psychotics

- Clozaril
- Risperdal
- Zyprexa
- Seroquel
- Abilify
- Geodon

(Stahl, 2013)

ANTIPSYCHOTIC MEDICATIONS

Common Side Effects

Fatigue	Increased Appetite	URI	N/V	Insomnia
Somnolence	Cough	Constipation	Urinary incontinence	
Abdominal Pain	Dizziness	Hyperglycemia	Fever	Dystonia
Extrapyramidal symptoms	confusion	photosensitivity	headache	Anxiety
Impaired body temperature regulation	gynomastia	dry mouth	Tremor	
Dyslipidemia				

ANTIPSYCHOTIC MEDICATIONS

Severe Adverse Reactions

- | | |
|--------------------------------|------------------|
| Severe Hypotension | Stroke |
| Tardive Dyskinesia | QTc Prolongation |
| Neuro Malignant Syndrome (NMS) | Anaphylaxis |
| Severe Hyperglycemia | CBC Changes |
| Seizures | Agranulocytosis |
| Priapism | Neutropenia |
| Extrapyramidal Symptoms | |

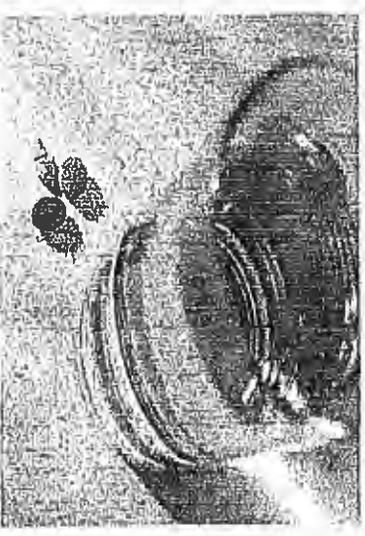
Black Box Warning: Increased Risk of Stroke in patients with Dementia

ANTI-DEPRESSANT MEDICATIONS

- **Justification of Anti-Depressant Medication**
- Selective Serotonin Reuptake Inhibitors (SSRI) are the first line treatment choice for mild-moderate Depression, Dysthymia, Anxiety D/O, and Impulsive and Aggressive Psychiatric Patients with no mental health problems?????
- SSRIs take 4-6 weeks to work in the average adult but may require as much as 12 weeks to work in the elderly adult or with a patient with Dysthymia.

ANTI-DEPRESSANT MEDICATIONS

SSRI	SNRI	TCA	Other Antidepressants
Zoloft	Effexor	Elavil	Wellbutrin
Celexa	Cymbalta	Doxepin	Trazodone
Prozac	Pristiq		Remeron
Paxil			
Lexapro			



ANTI-DEPRESSANT MEDICATIONS

Common Side Effects

Nausea Dry mouth Agitation Impulsivity
Insomnia Mild Tremor Fatigue Headache
Weight Gain Sexual Dysfunction Full like symptoms
Mental/Emotional dullness

ANTI-DEPRESSANT MEDICATIONS

Severe Adverse Reactions

Hyponatremia	EPS
SIADH Syndrome of Inappropriate Antidiuretic Hormone	NMS
Seizures	Priapism
Vasculitis	Hypotension

Black Box Warning: May cause Suicidal Ideation, especially in patients under age 25

ANTI-DEPRESSANT MEDICATIONS

Withdrawal Syndrome

Symptoms

Dizziness Muscle Weakness Pain Nausea Loose Stools

Visual disturbance Irritability Insomnia Headaches

Worsening Mood Odd Sensations in Limbs Brain Zaps

DO NOT STOP MEDICATION ABRUPTLY ALWAYS TAPER OFF MEDICATION

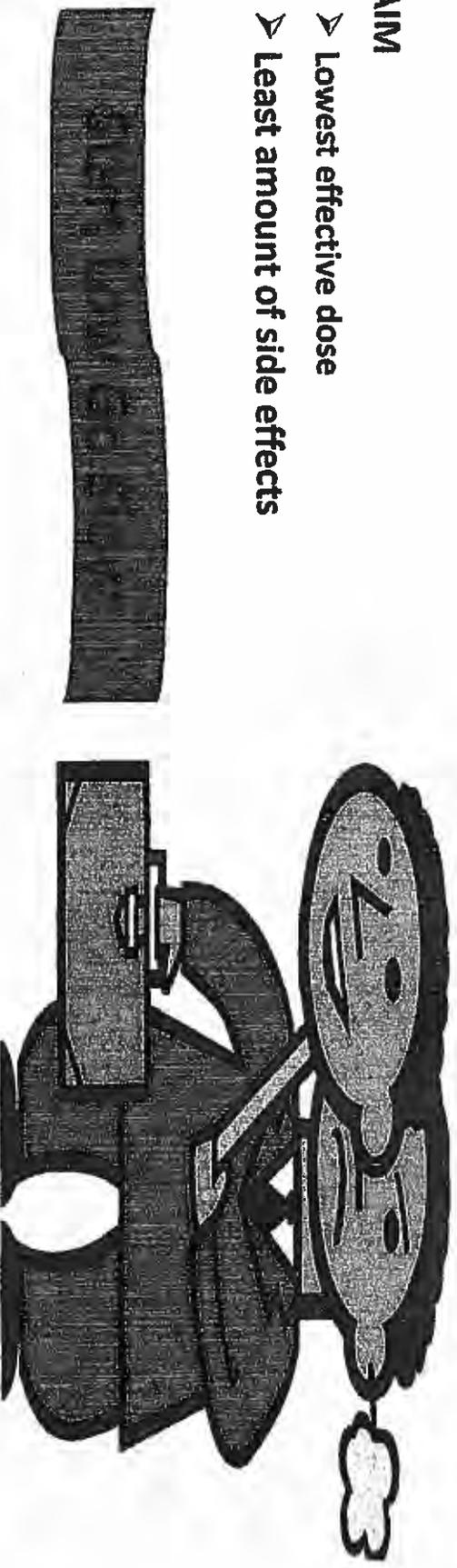
Withdrawal syndrome is worse with Effexor and Cymbalta

MOOD STABILIZERS

Justification of use of Mood Stabilizers

Mood stabilizers are indicated for use in treating Bipolar Disorder

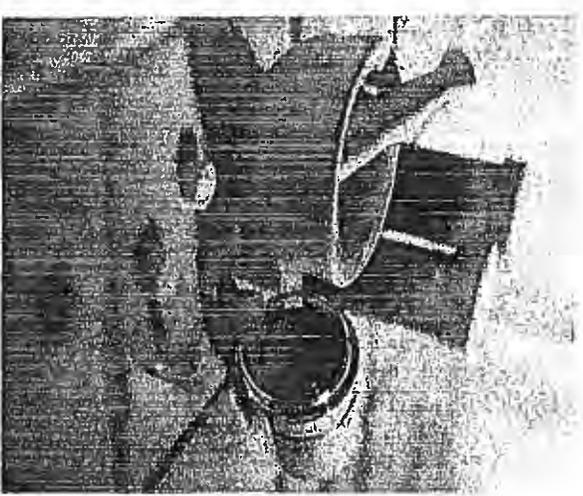
- Dosage individualized due to individualized response to meds
- AIM
- Lowest effective dose
- Least amount of side effects



MOOD STABILIZERS

- Lithium
- Anticonvulsants used for mood stabilization
 - Valproate (Depakote)
 - Carbamazepine (Tegretol)
 - Lamotrigine (Lamictal)
 - Oxcarbazepine (Trileptal)
 - Toprimate (Topamax)

Medication Level Monitoring is required for Lithium, Depakote, and Carbamazepine



MOOD STABILIZERS

Common Side Effects

Sedation	Dizziness	Headache	Ataxia	Fatigue
Nystagmus	Abnormal Gait	Confusion	Nervousness	
Nausea	Vomiting	Abdominal Pain	Dyspnea	
Diplopia	Vertigo	Abnormal Vision	Tremor	
Dyspepsia	Weight Gain	Hyperinsulinemia	Thyroid goiter (IIC03)	

MOOD STABILIZERS

Severe Adverse Reactions

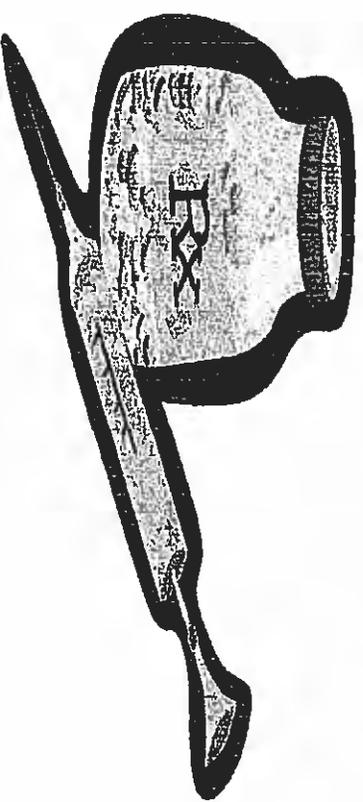
Rash Stevens Johnsons (Lamictal) (Carbamazepine)

Hepatotoxicity Pancreatitis (Valproate)

Hyponatremia (Trileptal)

Lithium Toxicity/ Renal Impairment/DM Insipidus/Arrhythmia (Lithium)

Withdrawal Seizures (Lamictal)



ANXIOLYTICS

Justification for Use of Anxiolytics

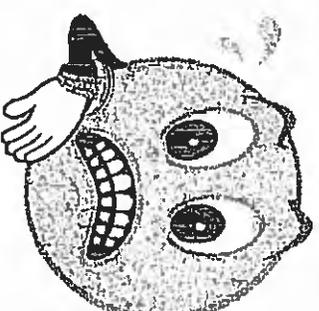
Anxiolytics are used for the treatment of anxiety.

SSRI Antidepressants are 1st line medication for the treatment of Anxiety

Benzodiazepines are 2nd line medications for the treatment of Anxiety and are used as short term adjuncts to SSRI.

- Dosage individualized due to individualized response to meds
- AIM
- Lowest effective dose
- Least amount of side effects

Start Low Go Slow



ANXIOLYTICS / SEDATIVE HYPNOTICS

Anxiolytics

SSRI

Prozac

Zoloft

Paxil

Celexa

Lexapro

Effexor

Benzodiazepines

Alprazolam (xanax)

Lorazepam (Ativan)

Clonazepam (Klonopin)

Chloradiazepoxide (Librium)

Oxazepam (Serax)

Other

Buspirone (Buspar)



ANXIOLYTICS

Review Side
Effects and
Adverse
reactions of
SSRI

Common Side effects

Benzo's

Sedation Fatigue Depression Dizziness (Falls) Ataxia Weakness
Slurred Speech Forgetfulness Confusion Hyperexcitability
Nervousness Hypersalivation



ANXIOLYTICS/SEDATIVE HYPNOTICS

Severe Adverse Reactions

Respiratory Depression in combo with CNS Depressants

Hypotension

- Rare
 - Hepatic Dysfunction
 - Renal Dysfunction
 - Blood Dyscrasia
 - Hallucination



SEDATIVE HYPNOTICS

Non Benzodiazepine Non Barbiturate	Dizziness Weakness GI Irritation Blurred Vision Headache Sleepiness *** Develops Tolerance
Chloral Hydrate	
Zolpidem (Ambien)	
Zaleplon (Sonata)	
Eszopiclone (Lunesta)	
Benzodiazepines	Daytime Sedation Psychomotor Impairment Delirium
Flurazepam (Dalmane)	
Quazepam (Doral)	
Temazepam (Restoril)	
Triazolam (Halcion)	



(Melillo & Houde, 2011)

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HRMC RN/LPN
NURSING REFRESHER SKILL CHECKSHEET

Exhibit 47

Employee Name _____ Date Given to Employee _____
 Skills Verified By _____

	Discussed and/or Demonstrated	Performed Satisfactorily
1. Oxygen Therapy		
A. Nasal cannula		
2. Foley Catheterization		
A. Daily catheter care		
B. Irrigation		
C. Insertion procedure		
D. Foley catheter kits		
E. Obtaining specimens		
3. Medication Administration		
A. Intravenous		
1. Admixtures		
2. Direct pushes		
3. Irrigation of hep locks		
B. Location of piggybacks		
C. Advantage system		
D. Order transcription		
1. Noting physician's order		
2. MAR		
3. Nursing protocols		
4. Physician's care sets		
E. Obtaining medications		
1. Faxing order		
2. Obtaining med from Pharmacy		
3. Pyxis system		
4. Obtaining drugs after hours		
5. Pharmacist on-call		
F. Medication errors		

1.	How to report		
G.	Injections		
1.	Intradermal		
2.	Subcutaneous		
3.	Intramuscular		
4.	Z-track		
4.	IV Therapy Technique		
A.	Angiocaths		
B.	Heparin locks		
C.	Blood product		
1.	Blood transfusions		
2.	Platelet infusions		
3.	Fresh frozen plasma		
4.	Albumin		
D.	Addition of fluids to present IV		
E.	Documentation		
F.	IV infusion pumps		
G.	PCA's		
H.	Site care		
5.	Sterile Dressings		
A.	Reinforcement		
B.	Changing dressings		
C.	Montgomery straps		
D.	Care of staples		
E.	Removal of staples		
F.	Wound drains		
G.	Exit site care for dialysis cath		
6.	Tympanic Thermometer and Dinamap		
A.	Use of equipment		
7.	Isolation Techniques		
A.	Different types		
1.	AFB - rooms		
2.	Respiratory		

3.	Enteric		
4.	Wound and skin precautions		
B.	Disposition of linens		
C.	Disposition of trash		
D.	Signs for doors		
E.	Fitting of mask for AFB		
8.	Glucometer		
A.	Use of glucometer		
B.	How to enter results in EMR		
C.	How to do controls high-low		
D.	Recording of information on correct form		
E.	Cleaning of glucometer		
F.	Problem shooting and corrective action		
9.	Specimen Collection, Labeling		
A.	Clean catch urine		
B.	Urine cultures		
C.	24-hour urine		
D.	Stool specimens		
E.	Sputum		
F.	Throat culture		
1.	Aerobic		
2.	Anaerobic		
G.	NP culture		
10.	Post Mortem Care		
A.	Release of body consent		
B.	Location of morgue		
C.	Autopsy		
D.	Shroud pack		
11.	Safety		
A.	Bed rail policy		
B.	Falls		
C.	Use of restraints; restraint policy/protocol		

D.	Fire regulations		
1.	Reporting		
2.	Floor exits		
3.	Fire extinguishers		
4.	Evacuation plan		
12.	General Med-Surg Policies and Procedures		
A.	Admission of a patient		
1.	Admin. data collection forms adult		
2.	Placement of patients on floor		
3.	Transfer of patients room to room		
B.	Discharge of patients		
1.	Discharge instruction		
2.	Transfer forms		
C.	Visiting hours		
D.	Care of patient clothing and valuables		
E.	Smoking policy		
F.	Minister on-call		
G.	Administrator on-call		
H.	Clinical Manager on-call		
I.	House Supervisor		
J.	Private duty nurses/sitters		
K.	Accident and incident reporting		
L.	Dietary services		
1.	Requisitioning of floor stock		
2.	Obtaining late trays		
3.	Serving trays		
4.	Requesting diet instruction		
13.	Documentation		
A.	Nurses notes (including Initial and Daily assessments)		
B.	Skin assessment (including documentation and skin care protocols).		
C.	Patient Education documentation & materials		
D.	Care plans		

14. Miscellaneous		
A. Documenting I&O (documenting IV fluids)		
B. K-pads		
C. Bed scales		
D. Abdominal binder		
E. TED hose		
F. Sitz bath		
G. Code Blue (documentation, supplies, etc.)		
H. Crash cart checks		
I. Ambu bag		
J. Air Mattress		
K. Obtaining supplies after hours		
L. Location of floor manuals		
1. Policy/Procedure		
2. Infection Control		
3. Fire/Disaster Plan		
4. Hazardous Waste		
M. Physician call schedule		
N. Use of intercom system		
O. Calling Code Blue		
P. Suicide Precautions		
Q. Patient Lifts		
R. Disposal of Sharps Containers		
16. Personal Protective Devices		
A. Location		
B. How to put on/removal		
C. Disposal of		
17. Pain Management		

I have completed my refresher obligations

Employee signature: _____

Preceptor signature: _____

Manager signature: _____

Education signature: _____

Highlands Regional Medical Center *Policies and Procedures*

Subject:	Medication Administration Policy	Department: Nursing/Pharmacy
Scope:	Nursing, Pharmacy, Respiratory, Physical Therapy, Radiology, Cardio Diagnostics	Original Policy Date:10/86
Regulatory Standard:	DNV MM.1 (SR.2)	Revision Date: 4/11,3/07,4/97, 9/90,1/04,11/05, 8/12, 5/13, 1/14, 4/14
Location of Signed Original:	Administration	Page:1 of 10

Author:

Vylinda Howard, PharmD., Director of Pharmacy Signature & Date

Approval Signature:

P&T Chair Representative Signature & Date

Approval Signature:

Susan Ellis RN, VP of Patient Care Services Signature & Date

Approval Signature:

Chris Hoffman, COO Signature & Date

Purpose:

For a medication regimen to be most effective, medications must be administered appropriately. Medications are administered pursuant to a prescriber's order; to the patient for whom they were ordered; by the route ordered; and at times appropriate to the indication, clinical situation, and needs of the patient. All medication administration is documented on the Medication Administration Record (MAR) and kept in the patient's permanent medical record.

Policy:

I. Personnel authorized to administer medications

- a. All medications are to be administered to the patient by a staff person who has the authorization to do so unless a prescriber's order allows the patient to perform self-administration of medications with supervision.
 - i. Medications will be administered by:
 1. Licensed independent practitioners
 2. Licensed Practical Nurses (LPNs): all routes within scope of practice (includes oral, intramuscular, subcutaneous, intradermal,

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- external, piggyback admixtures, select intravenous medications, transdermal, rectal, vaginal, topical, ophthalmic, otic, and nasal)
3. Registered Nurses (RNs): all routes within scope of practice [may administer medications via the intravenous route, intraspinal and intraosseous in addition to all routes listed in the LPN section]
 4. Certified Registered Nurse Anesthetists, Nurse Practitioners, and Clinical Nurse Specialists: all routes within the scope of practice
 5. Physician Assistants: all routes within the scope of practice as delegated by their supervising physician
 6. Physical Therapists: topical medications used within scope of practice
 7. Respiratory Therapists: respiratory therapies only
 8. Radiographic technologists: approved medications and contrast media medications. A physician must be immediately available for assistance.
 9. Nuclear Medicine Technologists: Radiopharmaceuticals
- ii. Students of accredited schools of medicine, nursing, and allied health fields such as physical or respiratory therapy may administer medications only under the direct supervision of a registered health care professional who has ultimate responsibility for the medication administration process.
 - iii. The person administering the medication is responsible for documenting the administration in the patient's medical record.
 - iv. The following medications may be administered only by persons who have received special training and have demonstrated competence to do so:
 1. Intravenous chemotherapy agents
 2. Conscious sedation medications

II. Primary Responsibility

- a. The nurse has primary responsibility for:
 - i. The administration of all routine oral, intramuscular, subcutaneous, intradermal, rectal, intravenous, and vaginal doses.
 - ii. The hanging of piggyback IV admixture doses.
- b. The nurse assumes primary responsibility for the application of routine externally applied or instilled medications (creams, ointments, aerosols, ophthalmic ointments and drops, otic preparations, and nasal preparations).
- c. To ensure "Stat" and "PRN" orders are administered.

III. Medication storage area

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- a. Medication Rooms, if applicable, will be kept locked at all times. Areas will be kept clean and neat at all times.
- b. Medications will be stored in the automatic dispensing cabinet (ADC), emergency cart, medication rooms or medication cabinets, and refrigerators.

IV. Responsibilities while administering medications

- a. The primary nurse is directly responsible to the Clinical Manager, Charge Nurse and/or Unit Shift Supervisor concerning all matters that relate to:
 - i. Distribution
 - ii. Procurement
 - iii. Storage
 - iv. Administration of medications
 - v. Proper documentation on the MAR
- b. Questions on any of these activities are to be directly communicated to the Clinical Manager or Charge Nurse and Pharmacist(i.e. reporting):
 - i. Possible side effects
 - ii. Allergies
 - iii. Adverse patient response to medication therapy

V. Evaluating the nurse's performance while administering medications:

- a. The Clinical Manager, Charge Nurse and/or Unit Shift Supervisor will perform randomized inspections observing:
 - i. Medication administration techniques
 - ii. Documentation on the MAR

VI. Relaying pertinent information to Pharmacy:

- i. The primary nurse is responsible for the communication of all pertinent patient information to the Pharmacy Department if the information is not available in the electronic medical record (EMR).

VII. Intra-hospital transfer of patients:

- a. When a patient is transferred to a different nursing unit, the primary nurse is responsible for the delivery of the patient's medications, and IV fluids to the new unit.
- b. Pharmacy is notified via an automated report after Admissions as entered the transfer.

VIII. Appropriate charting on the medication administration record (MAR):

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- a. All medications will be administered and documented using the electronic medical record (EMR).

Regular Schedule	
Daily or qAM	1000
qHS	2200
Before Meals/AC	0730-1130-1630
After Meals/PC	0900-1300-1800
BID or q12h	1000-2200
TID or q8h	0800-1600-0000
QID or q6h	0600-1200-1800-0000
Q2H	0100-0300-0500-0700-0900-1100-1300-1500-1700-1900-2100-2300
Q3H	0200-0500-0800-1100-1400-1700-1800-2300
Q4H	0200-0600-1000-1400-1800-2200
Exceptions	
Levothyroxine (daily)	0600
Oral Bisphosphonates (daily)	0630
Diuretic (daily)	0600
Diuretic (twice daily)	0600-1800
Intermediate Acting Insulin	0700-1700 with breakfast and dinner
Rapid or Short Insulin	0700, 1100, 1600
Diabetic Oral Agents Daily *sulfonylureas and biguanides	0800 with meal
Diabetic Oral Agents BID *sulfonylureas and biguanides	0800-1700 with meal(s)
Nitrates BID	0800-1300
Nitrates TID	0800-1300-1800
Bile Acid Sequestrants	0800-1700
Coumadin dosing	1600

- b. Order written outside scheduled times:
- i. Since it is recognized that there will be times when an order is initiated at a time that is not convenient with the standard schedule, a procedure of how to adjust first doses must be established.
 - ii. Schedule of adjustment to be followed:
 1. If the time to the next dose is greater than half the dosing interval, the dose should be given as soon as it is available. If the amount of time to the next dose is less than half of the dosing interval, the dose should be held until the next scheduled pickup except when

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otherwise noted by a physician. Doses should not be doubled when the previous dose is missed (i.e., Cymbalta daily ordered at 1400 would be given immediately and then daily at 1000.

Cymbalta ordered at 0200, first dose would be given at 1000 unless otherwise ordered by the physician.

- iii. The primary unit measurement designating drug dose and strength will be the metric system.
 1. If the apothecary system or household measures are written by the physician, the metric equivalent will be placed in parenthesis after the ordered dose.
- iv. The actual drug to be administered to a patient must be indicated in parenthesis if it is different from that ordered by the physician (i.e., generic equivalent products, physician writes for multi-vitamin, etc.).
- v. Timing of medication administration
 1. The timing of medication administration takes into account the nature of the prescribed medication, specific clinical applications, and patient needs. Medications will be classified as not eligible for scheduled dosing times or eligible for scheduled dosing times. Those that are considered eligible for scheduled dosing times are further classified as time-critical and non time-critical.
 2. Medications considered **not eligible for scheduled dosing times** require exact or precise timing of administration. (See Appendix A).
 3. **Time-critical scheduled medications** must be given within 30 minutes before or after their scheduled dosing times. (See Appendix B).
 4. **Non-time-critical scheduled medications** prescribed no more frequently than every three (3) hours must be given within one (1) hour before or after their scheduled dosing times. (See Appendix C).

IX. Techniques and procedures for administration of medications in areas using Bar Code Medication Administration (BCMA):

- a. Nursing areas using BCMA: Emergency Department (ED), Critical Care Unit (CCU), Medical Surgical Units (2A and 4A, aka MedSurg), Obstetrics (OB), Post-Partum (PP), and Behavioral Health (BHI or 3A).
- b. The nurse, or other staff authorized to administer medications, will identify the patient using two patient specific identifiers.
- c. The nurse or authorized individual will read each entry in the patient's MAR and select the appropriate medication from Automated Dispensing Machine (ADM).

- If nursing personnel has any doubts about the medication name, strength, route of administration, allergy, or contraindication, the prescriber and/or pharmacist will be contacted before administering the medication. All IV admixture medications should be visually examined for particulates or discoloration and the ensure that the medication in not past the expiration or beyond use date and time.
- d. The nurse, or other staff authorized to administer medications, will use the following steps to access the barcode scanning feature in the EHR.
 - i. To use CareAdmin
 1. Logon to Cerner
 2. Access Patient's Chart via Powerchart application
 3. Launch Medication Administration Wizard (MAW) in patient's chart.
 4. Pair scanner to workstation.
 5. Scan patient's wristband.
 6. Scan the unopened medication(s) to be given. If medications are appropriate, give to patient. If medications are not appropriate, do not give to patient.
 7. Click sign button on MAW.
 8. Check MAR to verify completion.
 - e. The prescriber will be notified when administration of scheduled medication doses is prevented by changes in a patient's status, level of cooperation, or response to a medication. Examples are: inability to take oral medications due to nausea and/or vomiting; patient refusal to take medications.
 - f. Medications prescribed for one patient are not to be administered to another patient, regardless of circumstances. "Borrowing" of medications from one patient for another is prohibited because to do so bypasses the checks and balances of the medication distribution process; often results in inappropriate charges being assessed to both patients; and may result in "missing" medications later in the day. If a medication is unavailable in the patient's medication drawer/cabinet/peg or in the ADC (non-override), the medication shall be obtained from the pharmacy, from floorstock, or ADC (override).
 - g. Medication cups are used only for patient convenience or measuring doses that are less than the unit dose container delivers.
 - h. Medications to be administered are selected from the ADC or medication cart/cabinet/peg and taken to the patient's rooms. Medications are to remain in original packaging until in the patient's room. This assures proper identification and minimizes waste when medications are refused.
 - i. If patient refuses medication, the medication will be returned for credit. Medication will be returned by the following process(es):

1. If medication removed from Pyxis, then the medication will be returned to Pyxis. Process: Log onto Pyxis, Select Return function, Select Patient's Name, Select Medication to return (if medication is not present, Select Override Med and pick from list). Place medication in Pyxis Return Bin.
 - a. If product will not fit into Pyxis Return Bin, call Pharmacy to secure medication (or House Supervisor if after Pharmacy hours).
 2. If medication sent from Pharmacy, then the medication will be returned to Pharmacy. Item should be placed in Pharmacy Return Bin (refrigerated items need to be placed in Pharmacy Return Bin located in Refrigerator). Pharmacy is responsible to post credit if necessary.
 - i. The nurse or other staff authorized to administer medications shall remain at the patient's bedside until the dose (by mouth route) is taken.
 - j. The nurse or other authorized individual will provide information to the patient or if appropriate the patient's family about any potential clinically significant adverse reactions or other concerns about administering a new medication. The nurse will document education was provided for the first dose medications and Coumadin (warfarin). The nurse may use printed material from Carenotes or equivalent.
- X. Techniques and procedures for administration of medications in areas NOT using Bar Code Medication Administration (BCMA) or in the event BCMA is not functioning:**
- a. The nurse, or other staff authorized to administer medications, will identify the patient using two patient specific identifiers by checking the Medication Administration Record (MAR) with the patient's identification wristband before administering any medications.
 - b. The nurse or authorized individual will read each entry in the patient's MAR and select the appropriate medication. The name of the medication, the dosage strength, the route of administration, and the dosage schedule including the time of administration are verified before administering the medication, If nursing personnel has any doubts about the medication name, strength, route of administration, allergy, or contraindication, the prescriber and/or pharmacist will be contacted before administering the medication. All IV admixture medications should be visually examined for particulates or discoloration and the ensure that the medication in not past the expiration or beyond use date and time.
 - c. The medication labels are read and verified as follows:
 - i. When the medication is selected from the patient's drawer/peg/cabinet or ADC (review for correct drug, dose and dosage form)

- ii. Before administering the medication to the patient identify the patient using two patient identifiers, compare the selected medication to the MAR.
- d. The prescriber will be notified when administration of scheduled medication doses is prevented by changes in a patient's status, level of cooperation, or response to a medication. Examples are: inability to take oral medications due to nausea and/or vomiting; patient refusal to take medications.
- e. Medications are charted in the MAR as the medications are administered. Charting may not be done ahead of or at the completion of the medication administration round. Medications that are not administered as ordered are noted on the MAR with an explanation.
- f. Medications prescribed for one patient are not to be administered to another patient, regardless of circumstances. "Borrowing" of medications from one patient for another is prohibited because to do so bypasses the checks and balances of the medication distribution process; often results in inappropriate charges being assessed to both patients; and may result in "missing" medications later in the day. If a medication is unavailable in the patient's medication drawer/cabinet/peg or in the ADC (non-override), the medication shall be obtained from the pharmacy, from floorstock, or ADC (override).
- g. Medication cups are used only for patient convenience or measuring doses that are less than the unit dose container delivers.
- h. Medications to be administered are selected from the ADC or medication cart/cabinet/peg and taken to the patient's rooms. Medications are to remain in original packaging until in the patient's room. This assures proper identification and minimizes waste when medications are refused.
 - i. If patient refuses medication, the medication will be returned for credit. Medication will be returned by the following process(es):
 - 1. If medication removed from Pyxis, then the medication will be returned to Pyxis. Process: Log onto Pyxis, Select Return function, Select Patient's Name, Select Medication to return (if medication is not present, Select Override Med and pick from list). Place medication in Pyxis Return Bin.
 - a. If product will not fit into Pyxis Return Bin, call Pharmacy to secure medication (or House Supervisor if after Pharmacy hours).
 - 2. If medication sent from Pharmacy, then the medication will be returned to Pharmacy. Item should be placed in Pharmacy Return Bin (refrigerated items need to be placed in Pharmacy Return Bin located in Refrigerator). Pharmacy is responsible to post credit if necessary.

- i. The nurse or other staff authorized to administer medications shall remain at the patient's bedside until the dose (by mouth route) is taken.
- j. The nurse or other authorized individual will provide information to the patient or if appropriate the patient's family about any potential clinically significant adverse reactions or other concerns about administering a new medication. The nurse will document education was provided for the first dose medications and Coumadin (warfarin). The nurse may use printed material from Carenotes or equivalent.

XI. Reporting medication errors:

- a. The primary nurse, or the nurse discovering the error, is to notify the Charge Nurse or Unit Shift Supervisor immediately and complete an Occurrence Report Form describing the error.
- b. The Charge Nurse/Unit Shift Supervisor will:
 - i. Contact the attending physician immediately. If the attending physician is not available, then the physician on-call is to be contacted.
 - ii. The Charge Nurse/Unit Shift Supervisor will see that an occurrence report describing the incident is completed and forwarded to the House Director.

XII. Medications brought from home

- a. Patients and families are to be discouraged from bringing medication at any time, unless specifically requested by the physician or pharmacist. (The patient may take personal medication only on the specific order of a physician.)
- b. Medications brought from home are to be sent back home with a family member or locked up in Security with patient's personal belonging.
- c. If the Pharmacy is unable to obtain a medication which has been ordered for the patient, medications which are brought from home may be used provided there is a written physician's order and the medication is properly labeled. The medication will be stored in the designated medication storage area (cabinet, cart, ADC, or medications).

XIII. Medication to visitors

- a. Medications are not to be administered to visitors. Visitors requesting the nursing staff to contact a physician for a medication order are to be directed to the Emergency Department for evaluation and treatment.

Revision Date	Responsible Person	Description of Revision
01/16/2014	Josh O'Bryan	Changed to New Format

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4/7/2014	Vylinda Howard	Updated to include BCMA procedures. Updated to include return medication process.

Appendix A

Not eligible for scheduled dosing

Require exact or precise timing [examples]:

- Stat doses
- First time or Loading doses ordered by the physician to be given “Now”
- One-time doses ordered by the physician to be given “Now”
- Doses timed for procedures [ex: Antibiotics On-Call to Surgery]
- Time-sequenced dose [ex: Digoxin loading]
- Doses timed for serum drug levels [ex: vancomycin, amnioglycosides (gentamicin, tobramycin, amikacin)]
- PRN doses

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Appendix B

Scheduled dosing time-critical

Must be administered within 30 minutes before or after the scheduled dosing time [examples]:

- Antibiotic: 1st dose of therapy
- “Loading dose” terminology used in the order and Stat/Now not specified
- First dose of therapy where physician specifies a administration time for the initial dose
- Every 2 hour dosing frequencies
- Immediate release Carbidopa/Levodopa (Sinemet) tablets
- Insulins: within 30 minutes after a meal
 - Regular (Novolin R)
 - Aspart (Novolog)

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- Novolog Mix 70/30
- Medications that must be administered separately from other medications or food/nutritional products due to binding issues.
 - Examples:
 - Antacids and Levofloxacin or Ciprofloxacin
 - Fiber containing products [psyllium (Metamucil)]
 - Cholestyramine
 - Phenytoin with enteral feedings

Appendix C

Medications eligible for scheduled dosing times and not time critical

Medications prescribed on a repeated cycle of frequency (examples: daily, BID, TID, QID, q3 or more hours, etc) are to be administered within 1 hour before or 1 hour after the scheduled dosing time

- All medications orders with a repeated cycle of frequency that are NOT “Scheduled Dosing Time Critical”.



Exhibit 411

March 27, 2014.

BHI STAFF:

New Items have been added to the New Admission Report that we receive from outside facilities.

The additional items are as follows:

1. The last 4 bowel movements, to quicker establish a bowel pattern.
2. A dietary intake history
3. If the patient has been treated for nausea, vomiting, diarrhea or infection in the last 30 days.

Please take note of the changes:

Thanks

Bruce M. Fletcher, R.N.

Bruce M. Fletcher

New Admission Report

Patients Name _____ **Phone #** _____

Nurse receiving report _____ **Date** _____ **Time** _____

Nurse/Person providing Information _____ **Phone #** _____

Primary Care Physician _____ **Phone #** _____

Referring Physician _____ **Phone #** _____

Allergies (Meds/Foods) _____

Code Status _____ **Living Will** _____

Will PT return to current living situation _____

Last Hospitalization _____ **Where?** _____

Medications _____

Meds/Crushed/Apple Sauce _____

Diet _____ **Feeder** _____

% of Meal Intake History _____

If Diabetic last B/S _____

Ambulation/Transfer/Feeding/ADL (assist of 1, 2, +) _____

Fall Risk? _____ **Recent Falls** _____

Cont/Incont _____ **Last 4 BM'S** _____

Skin Breakdown? _____

Wound? _____ **Treatment** _____

Treated In past 30 Days for N/V/D or Infection? _____ **YES** **NO** _____

Infection process _____ **Treatment** _____

Foley Cath. _____ **Insertion Date** _____ **IV** _____ **Insertion date** _____

Ostomy _____ **Oxygen Therapy** _____ **Liters** _____ **VIA** _____

Turn schedule _____

Diagnosis _____

Recent Labs _____

Pain? _____ Where _____ Pain Control _____

Smoker _____ Smokeless Tobacco _____ Packs Per day _____

Recent weight loss/gain _____ Weight _____ Height _____

Pacemaker / Other Device _____

Flu Inj. _____ Date _____ Pneumonia Inj _____ Date _____

Legal Status (POA / Guardian) _____

Phone # _____ Voluntary/ Involuntary _____ 72HR _____

Copy of Papers Provided? _____ If no give reason _____

Support Person _____ Phone # _____

W/C, Walker, Cane, Other _____

Reason for Referral and any other information

DON'T FORGET TO TAKE PHOTO AND INVENTORY ALL PERSONAL BELONGINGS UPON ADMISSION TO UNIT.

Exhibit #12

CONTINUING MEDICAL EDUCATION CERTIFICATE

Medscape

certifies that

wayne edwards, MD
KY 41501

has participated in the enduring material titled

**Beliefs and Communication Practices Regarding Cognitive Functioning Among
Consumers and Primary Care Providers in the United States, 2009**

April 10, 2014

and is awarded 1.00 *AMA PRA Category I Credit(s)*™.

Medscape, LLC designates this Journal-based CME activity for a maximum of 1.00 *AMA PRA Category I Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Director, Continuing Medical Education
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KY 41501

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Participatory Medicine: Provider-Patient Communication

April 10, 2014

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KY 41501

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April 11, 2014

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Department of Continuing Medical Education

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KY 41501

has participated in the educational activity titled

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*an online enduring material, on April 11, 2014,
and is awarded 0.50 AMA PRA Category 1 Credit™.*

Physician Certificate of Credit



Steve Smith
President and COO



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Exhibit #13

MEMO

March 19, 2014.

BHI STAFF:

An additional area has been added to the Adult On-Going Assessment. On the Gastrointestinal Tab a box has been added to document whether a patient's bowel movement was observed or reported by the patient. This box is to be used for documentation of whether staff observed the bowel movement or the patient reported it to staff.

Note that staff is to observe a bowel movement at least every three days. If a bowel movement is reported by patient make sure to reinforce education to the patient to notify staff of a bowel movement before flushing.

Bruce M. Fletcher, R.N.

PATIENT RIGHTS IN-SERVICE

APRIL 22 & 24, 2014

Highlands Regional Medical Center

Exhibit # 14

I. Introduction to Subject: Patient Rights and Responsibilities

II. Objective: Staff will receive verbal and written instruction on Patient Rights and Responsibilities to include: Informed Consent, Protected Health Information, and voluntary/involuntary admission with patient legal status .

III. Goal: Staff will have a complete understanding of Patient Rights.

Security of patient information is EVERYONE'S job! We owe it to our patients!

IV. Definitions:

- a. Patient Rights
- b. Privacy
- c. Confidentiality Authorization
- d. Breach Confidentiality
- e. HIPAA

V. Discussion of Rights:

VI. Funding:

VII. Informed Consent:

VIII. Nurses' Response to Patient's Request to Stop Treatment:

IX. Request for PHI:

X. What is Protected Health Information (PHI)?

XI. PHI includes:

XII. Patient authorization for release of PHI must be obtained in the following situations:

XIII. PHI can be used/disclosed without authorization:

XIV. Notice of Privacy Practices

XV. Protections for Health Information

XVI. Faxing Guidelines

a. When you fax to outside offices:

XVII. HITECH

XVIII. Voluntary and Involuntary Admission

a. Patient Legal Status

PATIENT RIGHTS AND RESPONSIBILITIES



- Objectives:**
- › Understanding Patient Rights
 - › The Kentucky Regulations
 - › What Pt. Rights encompass
 - Informed Consent, Protected Health Information, Voluntary, Involuntary admission, Patient legal status.
 - › When & How to Inform Patients of their Rights
 - › The Patient's role in their Rights
 - › Patient Communication Needs & their Rights
 - › Legal Aspects

- Definitions:**
- › Patient Rights-The patient has the right to privacy, quality medical care without prejudice, the right to make informed decisions regarding care and treatment options, and the right to refuse treatment.
 - › Privacy – state of being concealed; secret
 - › Confidentiality – containing secret information (medical record)
 - › Authorization – to give permission for; to grant power to, give consent for.

Definitions Continued:

- **Breach of Confidentiality – to break an agreement, to violate a promise.**
- **HIPAA- Health Insurance Portability and Accountability Act.**
- **PHI-Personal health Information- When a patient gives personal health information to a healthcare provider, it becomes Protected Health Information (PHI).**

**908 KAR 3:010. Patient's rights.
Kentucky Regulations**

- **RELATES TO: KRS Chapters 202A, 202B**
- **Section 1. Definitions.**
- **Section 2. Right to be Adequately Informed.**
- **Section 3. Right to Assist in Treatment Plan.**
- **Section 4. Right to Refuse Treatment.**
- **Section 5. Right to Personal Effects.**
- **Section 6. Right to Receive Visitors.**
- **Section 7. Right to Receive Compensation for Work Done.**
- **Section 8. Right to De Novo Review.**
- **Section 9. Use of Seclusion and Restraint.**

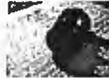
PATIENT RIGHTS

&

*The Nurse's
Role*

The Right to:

1. Informed Consent.
2. Privacy and Confidentiality.
3. Free from Discrimination
4. Be Treated with Dignity and Respect.
5. Participate In Decision Making.
6. Participate in Development of their Treatment Plan.
7. Refuse treatment. **
8. Voice Grievances.



The Right to:

Continued

8. Psychotropic Drug Consents.
9. Receive visitors and a minister of one's own faith.
10. Free from Abuse & Mistreatment.
11. A Safe Environment
12. Receive treatment in the least restrictive setting.

1. The Right to Informed Consent:

- The patient gives consent for treatment after receiving information that has been explained to them in a clear, concise & understanding manner using:
 - Patient's native language
 - Handwriting
 - Printed forms/braille
 - Sign language
 - Pictures

An explanation of all treatment offered will include the possible:

- ❖ Side Effects
- ❖ Risks
- ❖ Complication
- ❖ Long Term Effects
- ❖ Benefits

2. Privacy and Confidentiality

Privacy- is the right of individuals to keep information about themselves from being disclosed. Patients are in control of who has access to their information, and decide who, when, and where to share their health information.

Confidentiality is how personal information is treated once it has been disclosed to healthcare staff.



3. Free from Discrimination
Patient will not be denied services based on:

<input type="checkbox"/> Race	<input type="checkbox"/> National Origin
<input type="checkbox"/> Sex	<input type="checkbox"/> Disability
<input type="checkbox"/> Age	<input type="checkbox"/> Source of Payment
<input type="checkbox"/> Religion	<input type="checkbox"/> Sexual Orientation
<input type="checkbox"/> Color	<input type="checkbox"/> Martial Status



3. Dignity and Respect

- › Treat with Dignity
- › Listen to patient
- › Involve in Decisions
- › Include patient in Conversation
- › Provide Body coverage during Personal Care
- › Treat with Respect
- › Be polite
- › Be respectful in addressing patient
- › Keep them informed
- › Meet their needs
- › Ensure their privacy

4. Participate in Decision Making

- › The right to formulate advance directives, submit them to hospital staff, and rely on practitioners to follow them when within the parameters of the law.
- › Make Decisions Regarding Treatment or Services.
- › Personal Choices help promote self respect.

5. Participate in Development of Treatment Plan

- ✓ Attend Treatment Team Meeting with Physician, Therapists, Nurse and Others making decisions about Treatment Plan
- ✓ Opportunity to talk with Therapists and Nurses regarding Treatment and changes in Treatment Plan.

6. Refuse treatment:

- › Right to refuse treatment
- › Courts have battled back and forth on the issue of a competent adult patient having the right to decline any and all forms of medical intervention, including life-saving or life prolonging treatment.
- › Refuse experimental treatments and/or to participate in research.

7. Voice grievances:

- › Make official complaints without reprisal from staff, physicians or hospital administration.
- › Right to meet with family and legal representatives in private.



8. Psychotropic Drug Consent

- › Consent—Full disclosure of all documented risks of any proposed drugs.
- › Consent to be given for:
 - New Medications
 - Change In Medication Doses



9. Receive visitors and a minister of one's own faith.

- › Right to:
 - Receive Visitors:
 - Family and Ministers.
 - Privacy with regard to all personal correspondence to and from anyone.
 - Make and receive telephone calls.



10. Free from Abuse & Mistreatment.

- › Strange Marks or Bruises
- › Sexual, Physical & Verbal Abuse
- › Withholding Food & Water
- › Depriving of Goods or Services
- › Not Assisting to Bathroom
- › Patient withdraws from certain staff members
- › Tension noted between Patient and Family

› Patients shall not be required to perform services for the hospital that are not included for therapeutic purposes in the plans of care.



11. A Safe Environment.

› Nurse Role:

- ❖ Identify Patients who are at:
 - Risk for Violence
 - Risk for Suicide Ideation
 - Assaulting other patients or staff
 - Secure unit
 - Operational Equipment
 - Clean, Comfortable & Hazardous free



12. Receive treatment in the least restrictive setting.

› Free of Restraint and Seclusion

- Except when necessary to protect the patient from injury to himself or to others.

Protected Health Information

Requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of written & electronic protected health information.

Legal Status

- › Voluntary
- › Involuntary (treatment without consent)
 - ☐ Power of Attorney
 - ☐ Guardian

Involuntary Treatment

- › For involuntary treatment to be delivered outside of an acute emergency, the doctor and hospital must petition a court to order it.
- › Laws vary from state to state and, of course, no two judges are alike.
- › Generally, judges rule in favor of well-prepared documentation from doctors and hospitals that show the treatment is necessary for safety and recovery.

Involuntary Treatment-*Continued*

- › Judges look to see that:
 - ❖ All efforts at voluntary treatment were exhausted;
 - ❖ Family and others were engaged to help persuade the patient to accept care (and were not successful).
 - ❖ The benefits of treatment are likely to outweigh its risks.

REVIEW

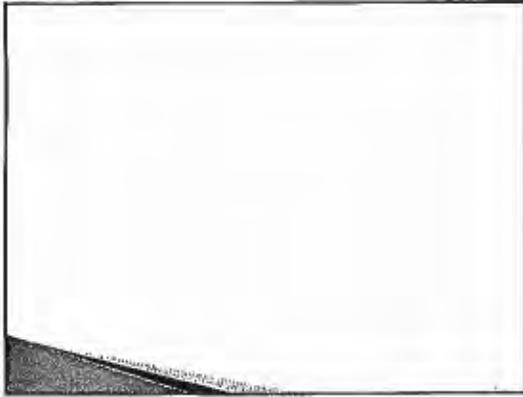
What are Patient Rights

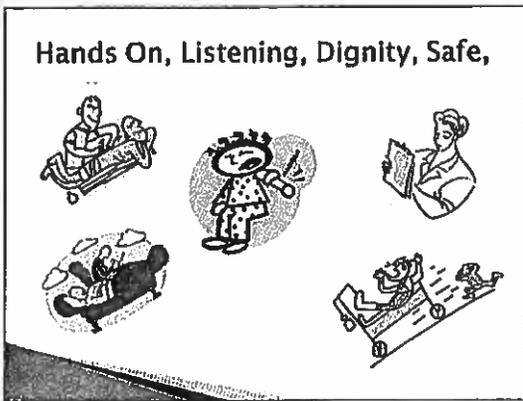
"Review of Rights"

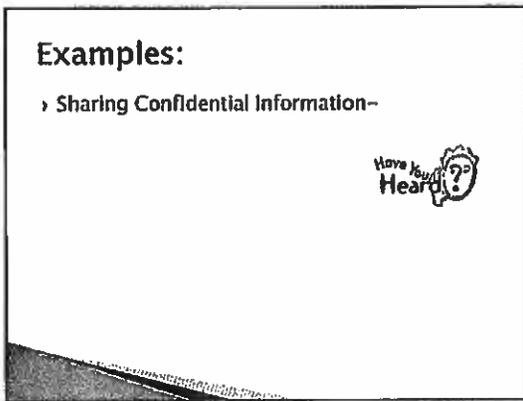
› Consents- 	Privacy- 
› Dignity- 	Decisions 
› Particlparte- 	Refuse- 
› Grievance- 	Psychotropic- 
› Visitors- 	Abuse 

"Review of Rights"

- › Safety- 
- › Restraints 







Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 180005	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/1/2014
Name of Facility HIGHLANDS REGIONAL MEDICAL CENTER	Street Address, City, State, Zip Code 5000 KENTUCKY ROUTE 321 PRESTONSBURG, KY 41653	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0131</u> Reg. # <u>482.13(b)(2)</u> LSC _____	Correction Completed <u>04/24/2014</u>	ID Prefix <u>A0385</u> Reg. # <u>482.23</u> LSC _____	Correction Completed <u>04/30/2014</u>	ID Prefix <u>A0395</u> Reg. # <u>482.23(b)(3)</u> LSC _____	Correction Completed <u>04/30/2014</u>
ID Prefix <u>A0396</u> Reg. # <u>482.23(b)(4)</u> LSC _____	Correction Completed <u>04/30/2014</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/>	Reviewed By <u>MH</u>	Date: <u>05/06/14</u>	Signature of Surveyor: <u>manu burbenz</u>	Date: <u>05/06/14</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>3/20/2014</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
--	--



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
<http://chfs.ky.gov/os/oig>

Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

May 6, 2014

Ms. Kristen Fugate
1087 Canoe Road
Jackson, Kentucky 41339

Re: Highlands Regional Medical Center - KY21455

Dear Ms. Fugate:

As discussed during a conversation on March 14, 2014, with a representative of the Office of Inspector General, Division of Health Care, an investigation of your concerns regarding the care provided by Highlands Regional Medical Center was completed on March 20, 2014. The purpose of this letter is to summarize the findings and action taken by the agency.

The investigation was conducted in accordance with KRS 216B.042 (2), which states that the Cabinet for Health and Family Services may authorize its representatives to enter upon the premises of any health care facility for the purpose of inspection.

Observations, interviews, and/or record reviews were utilized to obtain information during the investigation. The purpose of the investigation was to determine if the facility was in compliance with regulatory requirements and to determine if the allegation was substantiated (the allegation was verified by evidence) or unsubstantiated (no evidence or insufficient evidence to verify the allegation).

The evidence obtained from the investigation verified that the allegation was substantiated with regulatory violations.

Ms. Kristen Fugate
May 6, 2014
Page Two

Thank you for bringing this matter to our attention. If you have any questions, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Sandy Goins Rpm/PM". The signature is written in a cursive style.

Sandy Goins
Regional Program Manager

SG:jm:lk



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

May 6, 2014

Mr. Harold Warman
Highlands Regional Medical Center
5000 Kentucky Route 321
P O Box 668
Prestonsburg, Kentucky 41653

Dear Mr. Warman:

The Division of Health Care conducted a revisit at your facility on May 1, 2014 to determine compliance with the Medicare Conditions of Participation.

As a result of this visit, it was determined that your facility is in compliance with all Medicare Conditions of Participation and standard level requirements. This office will recommend to the Centers for Medicare & Medicaid Services (CMS) that deemed status be restored.

If you have questions, please contact our office.

Sincerely,

Sandy Goins
Regional Program Manager

SG:nm:lk

Enclosure



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

April 3, 2014

COURTESY COPY via ELECTRONIC MAIL (bwarman@hrmc.org)

Mr. Harold Warman
Highlands Regional Medical Center
5000 Kentucky Route 321
P O Box 668
Prestonsburg, Kentucky 41653

Dear Mr. Warman:

The Division of Health Care completed a complaint investigation at your facility on March 20, 2014. It was determined that the hospital was not in substantial compliance with federal certification requirements. The following federal Condition(s) of Participation was not met:

42 CFR 482.23 Nursing Services

These findings have been reported to the Centers for Medicare and Medicaid Services. **A courtesy copy of your Statement of Deficiencies is enclosed.** You may contact our office if you have any questions concerning this matter.

Sincerely,

Sandy Goins
Regional Program Manager

SG:jm:lk

Enclosure



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

April 3, 2014

Mr. Harold Warman
Highlands Regional Medical Center
5000 Kentucky Route 321
P O Box 668
Prestonsburg, Kentucky 41653

Complaint Investigation: KY21455

Dear Mr. Warman:

On March 20, 2014, the Division of Health Care completed a complaint investigation at your facility. This survey was conducted to determine the facility's compliance with state licensure requirements as it relates to the allegation(s) of the complaint. Although the investigation determined the incident occurred, your hospital was found to be in compliance with state requirements with no deficiencies cited.

Enclosed you will find the Statement of Deficiencies as it relates to the findings of this complaint investigation.

If you should have questions regarding this information, please contact our office.

Sincerely,

Sandy Goins / OB

Sandy Goins
Regional Program Manager

SG:jm:lk

Enclosure