LAS PALMAS
DEL SOL
HEALTHCARE

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MEDICAL STAFF ORIENTATION MANUAL

LAS PALMAS
DEL SOL
HEALTHCARE

PHYSICIAN/ALLIED HEALTH PROFESSIONAL ORIENTATION MANUAL

WELCOME

Welcome to Las Palmas Del Sol Healthcare.

This booklet answers frequently asked questions and addresses policies and procedures that all members of the medical staff are required to follow. Please read the information and keep as reference.

Las Palmas Del Sol Healthcare, owned by HCA Healthcare Corporation as a part of HCA's Central and West Texas Division, has had a presence in El Paso since the mid-1960s. It is currently comprised of two major hospitals (Las Palmas Medical Center Campus and Del Sol Medical Center Campus) as well as several off-site locations, and provides a full array of healthcare services for both adult and pediatric patients. Our goal is to be the best at serving our community with high-quality, cost-effective healthcare.

Las Palmas Del Sol Healthcare is committed to providing excellent customer service to enhance patient, physician and employee satisfaction.

We look forward to developing and continuing to build a rewarding relationship with each of you.

MISSION & VALUES

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high-quality, cost-effective healthcare in the communities we serve.

In pursuit of our mission, we believe that the following value statements are essential and timeless:

We ...

- RECOGNIZE and affirm the unique and intrinsic worth of each individual.
- TREAT all those we serve with compassion and kindness.
- ACT with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- TRUST our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

A TRADITION OF CARING — CODE OF CONDUCT

A Message from Las Palmas Del Sol Healthcare's Ethics and Compliance Department (Revised 2018)

Purpose of Our Code of Conduct
Our Code of Conduct provides guidance to all Las Palmas Del Sol Healthcare colleagues and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants and one another.

The code is a critical component of our overall Ethics and Compliance Program. We developed this code to ensure we meet our ethical standards and comply with applicable laws and regulations.

The code is intended to be comprehensive and easily understood. In some instances, the code deals fully with the subject covered. In many cases, however, the subject requires additional guidance for those directly involved with the particular area in order to have sufficient direction. To provide additional guidance, we have developed a comprehensive set of compliance policies and procedures that may be accessed on the Ethics and Compliance site on our Intranet, as well as our external website, hcahealthcare.com. These policies expand upon or supplement many of the principles articulated in the Code of Conduct.

The standards set forth in the code apply to all HCA facilities and employees operating in the United States. These standards are mandatory and must be followed.

To view/print a PDF version of the code, please visit our website, hcahealthcare.com, and view the links under "Ethics and Compliance."

We would particularly call your attention to the following sections:

- **Our fundamental commitment to stakeholders** — Please notice that physicians are some of our most important stakeholders.
- **Patients** — We take our commitment to provide quality care to the patients we serve very seriously; we could not do that without your dedication to the same goal.
- **Physicians** — This section describes the unique relationship between our facilities and the physicians who practice in them. It also describes the laws and regulations that govern that relationship.
- **Ineligible persons** — We have a commitment not to employ, contract with or grant privileges to any individual or entity that is ineligible to participate in federal healthcare programs.
- **Research, investigations and clinical trials** — This section includes important information about our participation in clinical trials.

For any additional information, please feel free to contact the facilities' local Ethics and Compliance Department at the Del Sol Medical Center Campus at 915.621.6551, or the Las Palmas Medical Center Campus at 915.521.1792.

PHYSICIAN RELATIONSHIPS WITH LAS PALMAS DEL SOL HEALTHCARE

Healthcare facilities like Las Palmas Del Sol Healthcare and the organized medical staff reflect a collaboration between those who are part of the company and those who have been credentialed and privileged to practice at Las Palmas Del Sol Healthcare campuses. As in any collaboration, each party has important roles and responsibilities.

We are committed to providing a work environment that is excellent in all respects for physicians and other privileged practitioners who practice in our facilities. Historically, we know that members of our medical staff have interacted with those who work in our hospitals in a respectful and supportive way.

We appreciate this and know that we can expect it to continue. We encourage members of our medical staff to be familiar with this Code of Conduct. There are many portions of this code that pertain to ethical or legal obligations of physicians in hospitals, and this document is likely to be a helpful summary of those obligations for our medical staff members.

Interactions with Physicians

Federal and state laws and regulations govern the relationship between hospitals and the physicians who may refer patients to the facilities. The applicable federal laws include the Anti-Kickback Law and the Stark Law. It is important that those colleagues who interact

with physicians — particularly regarding making payments to physicians for services rendered, providing space or services to physicians, recruiting physicians to the community and arranging for physicians to serve in leadership positions in facilities — are aware of the requirements of the laws and of regulations and policies that address relationships between facilities and physicians.

If relationships with physicians are properly structured but not diligently administered, failure to administer the arrangements as agreed may result in violations of the law. Any arrangement with a physician must be structured to ensure compliance with legal requirements, our policies and procedures, and with any operational guidance that has been issued. Most arrangements must be in writing and approved by the legal department. Failure to meet all requirements of these laws and regulations can result in serious consequences for a facility.

Keeping in mind that it is essential to be familiar with the laws, regulations and policies that govern our interactions with physicians, two overarching principles govern our interactions with physicians:

- We do not pay for referrals. We accept patient referrals and admissions based solely on the patient's medical needs and our ability to render the needed services. We do not pay or offer to pay anyone — colleagues, physicians or other persons or entities — for the referral of patients.
- We do not accept payments for referrals we make. No HCA colleague or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made (or may make) to us.

Extending Business Courtesies and Tokens of Appreciation to Potential Referral Sources
Any entertainment, gift or token of appreciation involving physicians or other persons who are in a position to refer patients to our healthcare facilities must be undertaken in accordance with corporate policies, which have been developed consistent with federal laws, regulations and rules regarding these practices. Las Palmas Del Sol Healthcare colleagues must consult company policies prior to extending any business courtesy or token of appreciation to a potential referral source.

PRINCIPAL LAWS

1. Physician Self-Referral (Stark) Law
   - Do not bill for Medicare services if you have a financial relationship with a physician unless the relationship meets all requirements of an exception.
2. Anti-Kickback Statute
   - Do not pay or offer to pay for referrals.
3. False Claims Act
   - If you violate **1** or **2** and bill government healthcare programs for the services, then you have just submitted a false claim to the government.

Anti-Kickback Statute

- Summary: A hospital cannot pay or offer to pay, *nor* receive or solicit *remuneration*, for referrals.
- This is a criminal statute and therefore must have the intent to violate the statute (generally).
- Anything of value is in play. ANYTHING!
- Both parties are equally subject to the law.
- Applies to much more than just physicians and hospitals.
- If just one of many reasons for paying the remuneration is to influence referrals, then that is a violation of the law.

Explaining Remuneration

- ANYTHING of value. For example: money, food, parking, flowers, tickets or services.
- Free clinical care to physicians and their family members.
- Physician courtesy discounts are an exception.
- A current policy must meet the requirements of LL.018.
- The patient must still be registered appropriately.
- Contract for Exclusive Services: At least one federal court has found that the right to provide exclusive services is remuneration. (U.S. ex rel. Ted D. Kosenske, M.D. vs. Carlisle HMA Inc. — anesthesia)

Stark II

- Summary: If there is a financial relationship between an entity and a physician, the physician cannot refer patients to the entity for provision of designated health services, and the entity cannot bill for such services *unless* the financial relationship fits within an exception.
- There are only **civil** penalties for violating this statute.
- You **must fit within an exception** and your **intent** to comply with the statute **is irrelevant**.
- Strict compliance (similar to speed limits for cars)
- Generally, the only **penalty is to the billing entity**.

Stark Definitions

- "Financial relationship" includes any ownership or compensation arrangement involving remuneration.
- "Referral source": Physician (M.D., D.O., D.M.D., D.D.S., D.P.M., O.D., D.C.) who orders a test/procedure OR who causes a test/procedure to be ordered for which payment may be made under Medicare, including:
  - Anesthesiologists
  - Hospital-based physicians if they order services independently
  - Immediate family members of any of the above individuals

- Referral source — immediate family members — statutory definition is far reaching:
  - Husband or wife
  - Natural or adoptive parent, child or sibling
  - Stepparent, stepchild, stepbrother or stepsister
  - Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law
  - Grandparent or grandchild
  - Spouse of a grandparent or grandchild

Stark Exceptions

- You must meet all of the elements to fit in the exception.
- Commonly used exceptions:
  - Recruitment
  - Professional services agreements
  - Employment
  - Payment by a physician for items or services
  - Rental of equipment/office space
  - Medical staff incidental benefits (less than $33)
  - Business courtesies (up to $392 for CY 2016)
- Common elements in all the exceptions:
  - Written and signed agreement between parties
  - Services are needed and necessary
  - Payments are fair market value
  - Compensation is set in advance
  - Arrangement is commercially reasonable
  - Not based upon the volume or value of referrals
- How do we ensure compliance?
  - Form agreements that incorporate the elements of Stark
  - Establish approval certificates that document the required elements of the exception

Penalties for Stark Violations

- If self-reported:
  - Refund obligations for federal payers
- If CMS finds out that you didn't report:
  - Civil monetary penalties up to $15,000 per offense
  - Assessment up to three times the amount claimed
  - Exclusion from all federal healthcare programs
  - Civil monetary penalties up to $100,000 per circumvention scheme

False Claims Act

- Do not submit a claim to the federal government for payment if you know the claim to be false.
- Includes claims for payment from Medicare and Medicaid (e.g., UB-92)

- Requires certification that the claims are consistent with the law
- If the claim is for services ordered by a physician with whom the hospital has a prohibited financial relationship, it is not consistent with the law.
- Any original source can alert the government when a false claim has been made ("whistleblower lawsuit").
- Original source may receive a monetary percentage of the damages.
- This is how most cases start.
- Many states also have state-specific false claims acts.
- PPACA requires you to promptly refund any overpayments (e.g., Stark issues) within 60 days or it is considered a false claim.

Gifts, Events, Tokens

- Gifts
  - Business courtesies (flowers, newborn gift, golf shirt) can never be solicited by the physician.
  - Tokens of appreciation for committee service, pursuant to a contract.
  - Retreat amenities, pursuant to a contract.
  - Incidental benefits while at the hospital.
- Events
  - One local event per year with entire medical staff.
  - Business courtesies (parties, meals, sporting event tickets) can never be solicited by the physician.
  - Planning or recruitment dinners.
- All are measured at fair market value, not cost.
- None are based on the volume or value of referrals.

Incidental Benefits Requirements

- Less than $33 per occasion for CY 2015
- Related to the provision of medical services at the hospital
- Provided to all members of the medical staff or all members in the same specialty
- Provided on the hospital campus
- Provided while making rounds or engaged in other services benefiting the hospitals and/or patient
- Not based on the volume or value of referrals

Services Agreements

- Fair market value
- Commercially reasonable
- Needed and necessary services
- Signed in advance of services being rendered
- Compensation set in advance

Reporting

- Report any suspected violation of law or policy to Hospital ECO, preferably Ethics Line (1.800.455.1996).
- No retribution for reporting.
- The sooner you report, the sooner the issue can be addressed.

HIPAA

The Health Insurance Portability and Accountability Act's Standards for Privacy of Individual Health Information ("HIPAA Privacy Rule") became effective April 14, 2003. The rule is the first comprehensive federal legislation concerning the privacy of patient information. The rule covers oral, written and electronic communications that involve protected health information.

The rule allows for an option called Organized Health Care Arrangement (OHCA). This arrangement between the hospital and nonemployed physicians will allow the sharing of protected health information, for payment and operations purposes, between the hospital and your practice without requiring the patient to sign separate authorization forms. The arrangement also benefits you because you will not be required to give the patient your Notice of Privacy Practices and have them sign your privacy consent if you interact with them at the hospital.

Because this HIPAA relationship is so beneficial for physicians under the rule, we will assume the OHCA is in place unless you specify that you want to opt out of the OHCA. If you decide to opt out of the OHCA, you will need to request the opt-out form from the facility's privacy official. This form states that you agree to ...

- Provide each patient you see at the hospital your Notice of Privacy Practices, as required under the rule.
- Sign a business associate agreement with the hospital to participate on hospital committees.
- Provide a copy of your Privacy Policies and Procedures, Privacy Notice and/or any document related to the HIPAA Privacy Rule to the facility's privacy official.

HITECH

The Health Information Technology for Economic and Clinical Health Act is a federal law that became effective in 2009 as part of the American Reinvest Act (ARRA). The purpose of this law is to make massive changes to privacy and security laws by increasing penalties for privacy and security violations. Key HITECH changes are sharing of civil monetary penalties with the harmed individual, criminal provisions and private cause of action.

HITECH provisions require the following notification when breaches (as defined in the regulations) occur:

- To the *patient*
- To the *Department of Health and Human Services*
- To the *media* when the breach involves more than 500 individuals in the same state or jurisdiction

Medical staff members should not grant or agree with verbal or written requests for revision. Please direct all requests to the facility's privacy officer (FPO).

For any questions, contact the facility privacy official:

- Del Sol Medical Center Campus — 915.621.6551
- Las Palmas Medical Center Campus — 915.521.1241

ETHICS COMMITTEE

The Ethics Committee is ready to assist you, the hospital staff, your patients and your patients' families. Making decisions about healthcare often involves difficult moral and ethical questions. It can be difficult to know what is the right thing to do.

Your personal beliefs, values and goals may differ from those of your patient or other healthcare providers. For example, decisions regarding withdrawal or withholding of life support can be very difficult ones for your patient or their family. Because your patient's family and other healthcare providers share responsibility to make decisions, disagreements or conflicts may develop about what should be done.

If ethical problems or conflicts cannot be resolved by talking with the patient/family, another physician or hospital staff, you can request a review or consultation with the hospital Ethics Committee. This committee is made up of doctors, nurses, social workers, administrators, chaplains and others who have been trained to deal with these moral and ethical issues. One

of the committee's jobs is to support patients, families and healthcare providers who are trying to make difficult decisions.

The committee does not make treatment decisions. It exists to provide advice and recommendations to physicians, families and staff.

A patient or a member of the family may request consultation with the Ethics Committee by calling the operator and asking for administration or the nursing supervisor.

THE IMPAIRED PHYSICIAN

Las Palmas Del Sol Healthcare is required to provide the mechanisms used to provide education about health issues regarding physician impairment. The information is found in the Bylaws of the Medical Staff. If you have any further questions regarding this policy, please contact the Medical Staff Office of Las Palmas Medical Center Campus at 915.521.1113 or Del Sol Medical Center Campus at 915.263.5220

ADVANCE DIRECTIVES & DO NOT RESUSCITATE

Advance Directives Act — Chapter 166 of the Health and Safety Code provides that an adult patient may make a treatment decision either by oral or written means to refuse life-sustaining procedures when certified with a terminal or irreversible condition. Written information will be provided to all adult patients upon admission to Las Palmas Del Sol Healthcare regarding their right to accept or refuse medical or surgical procedures, and their right to formulate advance directives. These decisions may be made by a competent adult, defined as possessing the ability, based on reasonable medical judgment, to understand the nature and consequences of a treatment decision, the significant benefits and harms, and reasonable alternative treatments.

An advance directive may be any of the following:

- A document voluntarily executed by a competent adult patient in compliance with the provisions of the act.
- A nonwritten declaration by a competent adult patient diagnosed with an irreversible or terminal condition in compliance with the provisions of the act.
- A document voluntarily executed on behalf of a minor patient diagnosed with an irreversible or terminal condition in compliance with the provisions of the act.

Life-sustaining procedure means:

- Treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die.
- Life-sustaining medications and/or artificial life support, such as mechanical breathing machines, kidney dialysis treatment and artificial nutrition and hydration.
- Does not include the administration of pain-management medication or the performance of a medical procedure necessary to provide comfort or alleviate pain.

If a qualified adult patient is incompetent or otherwise mentally or physically incapable of communication and has executed an advance directive, the patient's wishes will be followed.

Do Not Resuscitate (No Code) means that in the event of respiratory and/or cardiac arrest, no resuscitative measures will be taken.

Key Points:

1. The patient representative, risk management or nursing staff will assist any patient to initiate an advance directive.
2. The advance directive is made a part of the permanent medical record.
3. An advance directive may be revoked by a patient at any time, whether competent or not.
4. An attending physician who has been notified of the existence of a directive will certify in writing in the medical record that the patient is "qualified" (diagnosis of a terminal or irreversible condition) under the Advance Directive Act, by documenting or signing.
5. A "Do Not Resuscitate" order must be written by the attending physician. Such orders must be signed, timed, dated and legible. Documentation by the attending physician must be completed in the progress notes in the patient's medical record, including discussion of the patient's condition and treatment alternatives with the patient, guardian or next of kin, with details of who was present and results of the decision.

HCAPS PATIENT ENGAGEMENT SURVEY

The Customer Service Offices at Las Palmas Medical Center Campus and Del Sol Medical Center Campus are designed to serve three separate but interrelated groups.

1. Patients, families and visitors — Customer Service assists in the improvement of organizational processes and staff behaviors that provide exceptional services to persons using our medical centers, making the outcome of the healthcare experience as successful and stress-free as possible.
2. Physicians and office personnel — We provide services, equipment and facilities that make their practice successful for themselves and their patients who come to Las Palmas Del Sol as inpatients or outpatients, or for emergency care or outpatient tests and treatments. Customer Service works to provide our physicians with an organizational environment that respects the unique needs of their practice and encourages increased utilization of Las Palmas Del Sol Healthcare facilities.
3. Medical center staff — Customer Service provides organizational development and process improvement that support staff effectiveness and organizational performance. As part of the Las Palmas Del Sol Healthcare administration's commitment to make the medical centers the employers of choice in our market, Customer Service works to help all employees succeed in a changing healthcare environment and market.

Perhaps the most visible presence of the Customer Service Office is the four patient-satisfaction instruments that survey past patients in four distinct areas:

1. Outpatient surgery.
2. Inpatient services.
3. Emergency healthcare — which is able to improve performance by prioritizing needs.
4. Organizational resources, department services, outpatient tests and treatment. By utilizing both clinical-outcomes data and patient-satisfaction data, Las Palmas Del Sol Healthcare is able to improve performance by prioritizing needs and focusing its organizational resources.

The single largest initiative of the Customer Service Office is the implementation and sustainment of an evidence-based leadership (EBL) model within Las Palmas Del Sol Healthcare. EBL is predicated on the belief that organizational outcomes will improve with minimal variance when leaders behave in ways that are supported by clear management evidence.

At its heart, EBL supports Las Palmas Del Sol Healthcare employees with consistent, predictable leadership behavior that is aligned with organizational outcomes. Not only leaders, but employees, physicians and patients will see that the organization works in ways that will make it succeed because its actions are reliable and consistent.

EBL targets areas of improvement that have surfaced through the four survey instruments, another way that both medical centers support their staff, their physicians and — most importantly — their patients.

Make the connection with open communication:

Acknowledge: Greet the customer using appropriate title.
Introduce yourself: By name, title and specialty.
Duration: Inform the customer of expected length of interaction. Inform of any delays.
Explanation: Procedure, purpose and expected outcome. Avoid technical jargon.
Thank you: Thank the customer for choosing Las Palmas Del Sol Healthcare.

PHYSICIAN SATISFACTION

Physician satisfaction is integral to the success of every hospital. To measure and build satisfaction among physicians, Las Palmas Del Sol Healthcare gathers input from physicians through a satisfaction survey, done anonymously through professional research consultants, and we subsequently incorporate the results of your physician survey into our planning. We believe that physician satisfaction and physician engagement, side by side with employee and patient satisfaction, clearly correlate with quality patient care and improved patient outcomes.

MEDICAL STAFF SERVICES

- Credentialing, privileges, meetings and CME programs for Las Palmas Del Sol Healthcare.
- For medical staff business matters, please call Las Palmas Campus at 915.521.1113, and Del Sol Campus at 915.263.5220.

PHYSICIAN RELATIONS & PHYSICIAN SERVICES

- The Physician Relations Department can be a resource or liaison, and provides information and tours for new physicians.
- For assistance in these areas at Las Palmas Campus, please call 915.521.1158, and at Del Sol Campus, call 915.263.5763.
- ID badges and parking access are obtained through contact with Physician Relations and Medical Staff Services at both campuses.

- Parking access is via a magnetic strip on your badge.
- Your badge also provides access to all hospital areas via badge readers. There is limited access via badge to the maternal and pediatric areas.
- Doctors' lounges are in Surgery and on the main floors of both campuses — complimentary meals and snacks are available in these areas.
- There are other lounges in the maternal/infant areas with snacks and beverages.
- Both campuses have Wi-Fi guest access for laptops anywhere in the main facilities, and there are desktop computers available for use in many areas.

INFORMATION TECHNOLOGY & SECURITY

The following form is being required by the provider who is applying or is being reappointed:

- Confidentiality and Security Agreement

This should be returned to the Medical Staff Office. After access is provisioned, the physician relations director will contact the provider and schedule an appointment for information systems training as part of their facility-orientation process. This must occur prior to the provider's first shift. The physician support coordinator and a member from the Advance Clinical Team will train the provider on all applicable information systems during that time. The physician relations directors may be contacted at 915.521.1158 for Las Palmas and 915.263.5763 for Del Sol.

CORE SERVICE LINES & SPECIAL PROGRAMS — LAS PALMAS

Las Palmas Medical Center
A Campus of Las Palmas Del Sol Healthcare

327 Licensed Beds
1,100 Staff Members
800 Las Palmas Del Sol Physicians

- Total hip and knee replacement "Center of Excellence"
- Pediatric hospitalist
- Pediatric Intensive Care Unit
- Neonatal, pediatric and maternal transport
- Level III Neonatal Intensive Care
- da Vinci Robotic Surgery
- Only kidney transplant center in El Paso — Medicare certified
- Rehabilitation hospital
- LifeCare Center — gym, cardiac rehab, outpatient rehab
- Diabetes Treatment and Education Center
- Women and Teen Resource Centers
- Pathway to Excellence in Nursing
- eMAR
- Accredited Chest Pain Center
- Accredited Stroke Center
- Full-service cardiovascular program
- Only dedicated neuroscience unit in the region (June 2010)
- Limb Salvage Center
- Only NASA-certified hyperbaric chamber
- Radiation oncology
- Full-service emergency department with Level III Trauma designation
- One-call transfers to Las Palmas Del Sol Healthcare 24/7
- Outpatient Diagnostic Center
- Digital mammography

CORE SERVICE LINES & SPECIAL PROGRAMS — DEL SOL

Del Sol Medical Center
A Campus of Las Palmas Del Sol Healthcare

347 Licensed Beds
1,367 Staff Members
800 Las Palmas Del Sol Physicians

- Level III Neonatal Intensive Care Unit
- Neonatal, pediatric and maternal transport
- Maternity services
- da Vinci Robotic Surgery
- Accredited stroke program
- Accredited Sleep Disorders Clinic including pediatrics
- Full-service emergency department with Level II Trauma designation
- One-call transfers to Las Palmas Del Sol Healthcare 24/7
- Bariatric surgery "Center of Excellence"
- Diabetes Education Center
- First El Paso hospital to earn Pathway to Excellence in Nursing designation
- Accredited Chest Pain Center
- LifeCare Cardiac Rehab
- Cardiac Electrophysiology Lab
- Full-service cardiovascular program
- Rehabilitation Hospital
- Women and Teen Centers
- Burn and Wound Management Center
- Regional Oncology Center
- Outpatient Diagnostic Center
- Nurse Navigator Program
- OR hybrid suite
- Per-surgical Assessment

ORGAN & TISSUE DONATION

There is a mechanism in place to assess patients for suitability as candidates for donation, identify the potential organ/tissue donor and assure donation of body parts is achieved in accordance with the Texas Anatomical Gift Act. Las Palmas Del Sol Healthcare endorses organ and tissue donation for transplantation and encourages the utilization of its resources and efforts by its employees and medical staff to ensure that Southwest Transplant Alliance (STA) is notified in a timely manner of individuals whose death is imminent or who have died in the hospital.

Southwest Transplant Alliance serves as the Organ Procurement Organization (OPO).

a. Their 24-hour donor referral number is 1.800.201.0527.
b. SWTA local offices are located at 1733 Curie Drive, Suite 206, El Paso, Texas 79902.

Las Palmas Del Sol Healthcare has a contract with Southwest Transplant Alliance for vascular organs (heart, lung, pancreas, liver, intestine, etc.) and a contract with the American Red Cross (ARC) for tissues (bones, skin, heart valves, etc.). ARC will refer corneal/eye tissue to the West Texas Lions Eye Bank.

Southwest Transplant Alliance works with physicians, staff at hospitals and families for consultations and referrals, questions, and family or clinical support. Physicians should discuss and document the patient's wishes regarding organ donation in their office file. Organ and tissue donation can be supported by physicians and staff through the routine calls made by staff for any death, or by calling Southwest Transplant Alliance to consult if there is potential organ donation when there are situations such as absent cranial nerve reflexes, no spontaneous breathing and the close possibility of death.

Southwest Transplant Alliance staff is trained to work with families around donation, and its role is key in identifying, evaluating, obtaining consent, donor maintenance and funeral arrangements for organ donors.

RENAL TRANSPLANT PROGRAM

Transplant candidates can self-refer or be referred by a nephrologist or dialysis center, and the records are sent to the transplant clinic for review. Las Palmas Medical Center facilitates both live-donor and deceased-donor transplants. Families and potential recipients attend a recipient/donor education orientation class at the transplant clinic. Here, the recipient, donor and family have an opportunity to hear introductory information on transplantation and living kidney donation. They are encouraged to ask questions that will help them make an informed decision. If the recipient or donor wants to continue, tests and interdisciplinary team evaluations are completed, after which each case is presented by the Clinical Coordinator RN to the Transplant Selection Committee. At selection committee, each member of the interdisciplinary team present their findings, and the transplant surgeon and nephrologist make a determination if a transplant is the best option for the recipient and/or donor.

If the patient is using a living donor, potential donors are screened and evaluated. If a deceased donor is used, Southwest Transplant Alliance or any other OPO may be involved in the process. The transplant clinic is located on the sixth floor of the Oregon Medical Building in suite 680, and you may contact the department at 915.521.1828.

PREVENTION OF SURGICAL FIRES

Incidents of surgical fires have been identified nationwide through root cause analysis (RCAs) and occurrence reports. The goal of this national safety initiative is to decrease and prevent surgical fires. About 550 surgical fires occur each year in the United States.

Across the nation, burns were identified as the primary risk issue in 23 claims, valued at $1.1 million in 2008. This represents a national increase of 64 percent in frequency and a 39 percent increase in severity compared to United States statistics for 2007, when 14 claims were reported nationally.

New Changes:

- October 7, 2009 — The Emergency Care Research Institute (ECRI) released new recommendations for controlling oxygen delivery during surgery to prevent surgical fires.

- May 2009 — The American Society of Anesthesiologists (ASA) Task Force on Operating Room Fires developed the guidelines "Practice Advisory for the Prevention and Management of Operating Room Fires."
- Prevent surgical fires from occurring; know what to do in case a fire occurs.
- The ASA recommends to NOT use open delivery of 100 percent oxygen during head, neck, face and upper-chest surgical procedures because oxygen enrichment (OEA) is one of the greatest causes of medical fires. An oxygen-enriched environment is when the oxygen level in the air goes above 21 percent.
- No surgical environment is invulnerable to fire, but the risk is escalated in this situation when oxygen is delivered through a nasal cannula or disposable mask.
- Train all preoperative staff members, including anesthesiologists, CRNAs, surgeons, circulators, scrub techs, X-ray techs or assistants, healthcare industry representatives (HCIR), and students in the prevention of and in the event of a fire in the operating room.
- Oxygen, fuel and ignition source are known as the "Fire Triangle."
- Anesthesiologists need to know their role in a fire situation as they will direct nursing staff when it is OK to shut off the medical gas valves for the affected area.

MEDICAL RESPONSE TEAM

The patient's staff nurse or the patient's family can activate the medical response team. The MRT is not intended to take the place of immediate consultation with the patient's physician if needed.

After consultation with the MRT, a call is placed to the appropriate physician using the SBAR (Situation, Background, Assessment and Recommendation) communication tool. The SBAR tool is a method of communicating between the MRT and the patient's physician after assessment.

The ICU nurse and Respiratory Therapy will do the assessment, call the physician and then make a decision about transferring the patient to a higher level of care.

Criteria for Initiating MRT:

- A staff member or a family member is concerned about changes in patient's medical condition
- Acute change in heart rate or a change of BMP from baseline
- Acute change in systolic blood pressure
- Acute change in respiratory rate or threatened airway
- Acute change in saturation
- Acute change in conscious state
- New onset or prolonged seizures
- Acute significant bleeding

ENVIRONMENT OF CARE

The Joint Commission Standards EOC

1. Safety and security management
2. Hazardous materials and waste
3. Fire safety management
4. Medical equipment management
5. Utilities management

EOC Plans

1. Emergency management
2. Fire safety management
3. Medical equipment management
4. Utilities management
5. Safety management
6. Security management

Types of Hazardous Materials and Waste Exposure Risks for Health Practitioners
Infectious substances: Viruses and bacteria can be transmitted by blood and bodily fluids, equipment, containers, paper goods, glassware, linens and people.

Radioactive Materials

- Use special handling techniques to prevent exposure.
- The most effective methods of radiation protection:
  1. Minimize time of exposure.
  2. Maximize distance to exposure.
  3. Maximize shielding from exposure.

Children and pregnant women should not visit radiation areas.

Flammable Liquids and Gases

- Chemicals, such as ether and alcohol, can burn or explode.
- Exposure can occur over a long period of time before effects are noted.

Routes of Entry

- Inhalation (most common)
- Ingestion
- Absorption
- Injection or puncture wound

Regulatory Agencies
All physicians need to be familiar with knowledge of the proper handling, use, storage and disposal of hazardous chemicals as guided/defined by local, state or federal regulations.

- Occupational Safety and Health Administration (OSHA)

Regulations for blood-borne pathogens, disposal of blood and blood-soaked items.

- Nuclear Regulatory Commission

  Handling and disposal of radioactive waste.

- Other

  Hazardous vapors (e.g., gluteraldehyde, ethylene oxide, nitrous oxide).
  Hazardous energy sources (e.g., ionizing or nonionizing radiation, lasers, microwave, ultrasound).

- The Joint Commission

  Considers infectious waste as falling into this category of materials (hazardous waste). Federal regulations do not define infectious or medical waste as hazardous waste.

Hazardous Waste

- Use biohazardous waste red bags for bulk human blood products and bulk human fluids, and all other potentially infectious material (OPIM). DO NOT include needles, peri pads, trash, urinals or empty IV bags or vials.
- Use biohazardous sharps containers/red bins for syringes, needles and broken vials/glass. DO NOT include controlled substances or trash.
- For all RCRA hazardous waste, use black waste bins. DO NOT include empty containers (except Warfarin and nicotine wrappers). DO NOT include trash, biohazardous waste, aerosols, needles or controlled substances. Fentanyl patches go in the Cactus Sink.
- Isolate spills and call someone who is trained to clean up hazardous spills through PBX *35555 (Del Sol) and 5555 (Las Palmas). DO NOT leave a spill unattended. Use facility-approved products to absorb liquids.

SDS sheets are available on the hospital intranet

- Identification of the substance or mixture and of the supplier
- Hazard identification
- Composition/information on substance/mixture ingredients
- First aid measures
- Firefighting measures
- Accidental release measures
- Handling and storage
- Exposure controls/personal protection equipment (PPE)
- Physical and chemical properties
- Stability and reactivity
- Toxicological
- Ecological information
- Disposal considerations
- Transport information
- Regulatory information
- Other information including information on preparation and revision of the SDS

PPE

- Personal protective equipment (PPE) and ventilation requirements.
- Other precautions for safe handling and use:
  1. Disposal of wastes
  2. Storage
  3. Gloves
  4. Goggles
  5. Masks
  6. Respirator gowns and aprons

7. Footwear
8. Hand hygiene
9. Do not wear PPE out of area (i.e., room or the OR)

Hand-washing Guidelines

- Before entering or leaving patient room and work area
- Before and after contact with patient
- After handling items such as suture kits, intravenous access devices and dressings
- After removing gloves
- After using the toilet, blowing your nose or covering a sneeze
- Before eating, drinking or handling food
- Wash for 15 seconds

Handling Sharps

- Let falling objects fall
- Practice safe-handling techniques
- DO NOT reach into containers
- Dispose of sharps carefully

Avoiding Slips, Trips and Falls

For each step you take, there are many potential hazards.

- Watch your step

  Even common hazards, like water spills and burned-out lightbulbs, can lead to serious, painful injuries and could also limit your ability to respond to emergencies. Protect yourself, your coworkers and your patients by doing what you can to create a hazard-free workplace.

- Clean up wet surfaces

  Any time a spill occurs, clean it up right away. If you can't, mark it with a sign, paper towels or yellow spill pad, and report it to the appropriate person for cleanup.

EMERGENCY CODE RESPONSES — PLAIN LANGUAGE CODES

DIAL 5555 (LAS PALMAS) OR *35555 (DEL SOL) WITHIN FACILITIES.

CODE BLUE

Cardio-Pulmonary Arrest — Adult or pediatric emergency.

(Surge of Infectious Patients) — Medical Alert + Patient Surge + Instructions
A biological event resulting in the influx of infectious patients

CODE RED (Fire)

During a Code Red, the fire alarm system is activated either manually by pulling a fire alarm pull box or automatically by a detection service.

R — Rescue
A — Activate
C — Confine
E — Extinguish/Evacuate

(Assistance Required/Combative Patient) — Security Alert + Combative Patient + Location
Security personnel and other male staff will respond to assist with a combative patient or visitor.

(External/Internal Disaster) — Facility Alert + Type of Event + Instructions
Standby: Remain on shift and prepare carts and call-back trees

(Precipitous Delivery) — Medical Alert + Precipitous Delivery + Location
Emergency response to a precipitous delivery outside of the Labor and Delivery or Emergency departments: give exact location to the PBX operator.

(Pediatric/Infant Abduction) — Security Alert + Infant/Pediatric Abduction + Description of infant or pediatric patient

All hospital personnel are "on alert."

1. Man all entrances/exits.
2. Check restrooms.
3. Man stairwells and elevators. The facility is in complete shutdown mode until the "all clear" is given.

(Hazardous Material/Chemical Spill/Release) — Facility Alert + Hazardous Spill + Location
The Spill Team will respond (Engineering and Environmental Services).

(Bomb Threat) — Security Alert + Bomb Threat + Location
Receipt of telephone warning:

- Bomb threats are usually received by telephone, and although most threats turn out to be hoaxes, each telephone call should be taken seriously.

(Active Shooter/Hostage Situation) — Security Alert + Active Shooter + Location

- Clear the hallway of patients, visitors and physicians.
- RUN if you are far from the incident.
- HIDE: seek immediate shelter.
- Get to an area with a lockable door, block door with heavy equipment if possible, turn off lights and silence cell phone.
- Remain out of public view until the "all clear" announcement is called.

HEART — Medical Alert + Acute Cardiac Event + Location

- An acute cardiac event.

MRT — (Medical Response Team) Medical Alert + Medical Response Team + Location

- Brings critical-care expertise to the patient's bedside before a crisis, such as when cardiac arrest occurs.

BRAIN — Medical Alert + Acute CVA + Location

- Acute CVA.

Hospital CAPACITY — Facility Alert + Bed Capacity + Location

- Hospital at capacity.

TRAUMA — (Level I or II Trauma Patient in the ER) Medical Alert + Trauma Level Red or Yellow (for Del Sol) + Location + ETA
Medical Alert + Trauma STAT/ALERT (for Las Palmas + Location + ETA

- Code called for trauma patients en route to the ER.
- If the trauma pertains to the pediatric or OB population, the ER unit will inform the corresponding department.

PHYSICIAN'S ROLE IN THE ENVIRONMENT OF CARE

1. Safety Management
   Promptly report any safety-related concerns or problems at Las Palmas Medical Center Campus to a safety officer at 915.521.1829, or organization safety officer at Del Sol Medical Center Campus at 915.263.5627.
2. Security Management
   Promptly report any security-related concerns or problems at Las Palmas Medical Center Campus to a safety officer at 915.521.1829 or a coordinator at 915.521.1144. At Del Sol Medical Center Campus, call a coordinator at 915.263.5266.
3. Hazardous Materials Management
   Promptly report any spills of unknown substances that could be potentially dangerous because of the type or quantity of the substance to the hospital operator by dialing 5555 (Las Palmas) and *35555 (Del Sol)
4. Emergency Management
   In cases of an internal or external disaster, contact the nurse director of the department in which you are working. If off premises, contact Las Palmas Medical Center Campus at 915.521.1200, or Del Sol Medical Center Campus at 915.595.9000, and speak with the administrative director of medical staff or one of the hospital executives for further directions on how to assist in the disaster. The Command Center is located at Las Palmas Medical Center Campus in Classroom C, if activated (915.521.1199 and 915.521.2999), and at Del Sol Medical Center Campus in Classroom E (915.263.3240).
5. Fire Prevention Management
   In case of a fire within the area of the hospital where you are physically located, the charge nurse on that unit will give instructions on assistance that may be needed in moving patients to a safe location. If the fire is not in your immediate area, stay where you are and await further instructions from the nursing director or charge nurse.
6. Utilities Management
   Promptly report any concerns or problems with the hospital's utility systems (i.e., electricity, medical gases, telephones, elevators, water, or heating and air conditioning) to the department director, charge nurse or safety officer at 915.521.1829 at Las Palmas Medical Center Campus, or the safety officer at 915.263.5627 at Del Sol Medical Center Campus.
7. Medical Equipment Management
   Campus biomedical maintenance personnel must inspect all medical equipment that is taken into the hospital before it can be used within the hospital without exception. Promptly report any concerns or problems with medical equipment to the department's nurse director, charge nurse or safety officer at 915.521.1829 at Las Palmas Medical Center Campus, or at 915.263-5627 at Del Sol Medical Center Campus. Do not use cell phones or portable two-way radios in areas where medical monitoring equipment is being used, outside the room or next to the monitoring equipment or telemetry devices that operate on radio frequency.

THE COMMUNICATION SYSTEM

Las Palmas Medical Center Campus

The emergency communication system that is utilized at Las Palmas includes cell phones and handheld radios for internal facility communications. Physicians will receive emergency notifications through the Intermedix EMSystems Notification system and/or beeper system.

Del Sol Medical Center Campus

A. The hospital PA system
B. The pocket beeper system
C. The telephone network (portable and landlines)

Assistance Calls

- Dial "0" for hospital operator at Las Palmas. For Del Sol, dial "00"

Internal Calls

- Dial desired extension number at Las Palmas. For Del Sol, extension is 5 digits and must start with *

Outside Calls

- Dial "88" and local phone number at Las Palmas. For Del Sol, just dial the full number to include area code even if it is a local number to call out.

CODE calls: Dial "5555" at Las Palmas. For Del Sol dial *35555
Emergency (RED) phones are located throughout the hospital. These phones are connected to outside lines and will continue to work in the event of an internal phone system outage. Each department has a listing of these emergency phone numbers.

NURSE CALL

Nurse call systems are utilized in all inpatient nursing units and all critical-care areas. Each unit will be receiving training on specifics for operation. The maintenance department will have an operating manual for the system. The system encompasses the individual room notification system, emergency/lavatory stations, and corridor and zone lights to alert a nearby nurse to a call from within the room. Code Blue buttons are located in patient care rooms and a few additional areas, such as the PT gym and procedural rooms. Pressing the Code Blue call will result in the code team being dispatched to your location.

COMMUNICATIONS: SBAR

What is SBAR?

SBAR is an organized and systematic method for communication designed to give patient information from one healthcare provider to another.

S — Situation
B — Background
A — Assessment
R — Recommendations

Implicit in SBAR

- Ready with all relevant information
- Have assessed the patient (or reviewed the chart/lab results)
- Ready to give information

SBAR allows us to ...

- Systematically assess and report findings.
- Ensure that we have not "missed something" that you want to state.
- Relay complete information to the patient, the nurse or another physician, or from another provider to you.

RESTRAINT & SECLUSION POLICY

Las Palmas Del Sol Healthcare is dedicated to fostering a culture that supports a patient's right to be free from restraint or seclusion. Restraint use will be limited to clinically justified situations, and the least restrictive restraint will be used with the goal of reducing and ultimately eliminating the use of restraints.

Las Palmas Del Sol Healthcare does not provide restraints for psychiatric/substance-abuse patients and limits the use of restraints to situations where clinical justification is appropriate.

For assistance from the nursing supervisor, dial:

- 915.521.1161 at Las Palmas Medical Center Campus.
- 915.595.9000 or "00" at Del Sol Medical Center Campus.

PAIN RATING & SEDATION SCALES

Pain scales are used to assess level of pain as follows:

Standard Pain Scale — Las Palmas Del Sol Healthcare uses a "standard numeric pain scale" with zero representing no pain and 10 representing severe pain. The goal of treatment is a pain level acceptable to the patient (usually a score of 3 or lower).

Modified Wong-Baker Faces — The Wong-Baker Faces are an alternative pain-assessment scale for pediatric or cognitively impaired patients. For further pain-scale information, please refer to facility policy relating to pain management

STANDARD PAIN SCALE			
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE
0	1-3	4-6	7-10

FLACC PAIN ASSESSMENT SCALE			
CATEGORIES	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown; withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs; frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to; distractible	Difficult to console or comfort

CRITICAL-CARE PAIN OBSERVATION TOOL			
INDICATOR	DESCRIPTION	SCORE	
FACIAL EXPRESSION	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening and levator contraction	Tense	1
	All of the above facial movements plus eyelids tightly closed	Grimacing	2
BODY MOVEMENTS	Does not move at all (does not necessarily mean absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed	Restlessness	2
MUSCLE TENSION EVALUATION BY PASSIVE FLEXION AND EXTENSION OF UPPER EXTREMITIES	No resistance to passive movements	Relaxed	0
	Resistance to passive movements	Tense, rigid	1
	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
COMPLIANCE WITH THE VENTILATOR (INTUBATED PATIENTS) OR VOCALIZATION (EXTUBATED PATIENTS)	Alarms not activated, easy ventilation	Tolerating ventilator or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2
TOTAL, RANGE			0–8

NEONATAL INFANT PAIN SCALE (NIPS)

Ages Birth–One Year

A score greater than 3 indicates pain.

PAIN ASSESSMENT		SCORE
FACIAL EXPRESSION		
0 — RELAXED MUSCLES BODY MOVEMENTS	Restful face, neutral expression	
1 — GRIMACE	Tight facial muscles; furrowed brow, jaw (negative facial expression — nose, mouth, brow)	
CRY		
0 — NO CRY	Quiet, not crying	
1 — WHIMPER	Mild moaning, intermittent	
2 — VIGOROUS CRY	Loud scream; rising, shrill, continuous (Note: Silent cry may be scored if baby is intubated as evidenced by obvious mouth and facial movement).	
BREATHING PATTERN		
0 — RELAXED	Usual pattern for this infant	
1 — CHANGE IN BREATHING	Indrawing, irregular, faster than usual; gagging, breath holding	
ARMS		
0 — RELAXED/RESTRAINED	No muscular rigidity; occasional random movements of arms	
1 — FLEXED/EXTENDED	Tense, straight arms; rigid and/or rapid extension, flexion	
LEGS		
0 — RELAXED/RESTRAINED	No muscular rigidity; occasional random movements of arms	
1 — FLEXED/EXTENDED	Tense, straight arms; rigid and/or rapid extension, flexion	
STATE OF AROUSAL		
0 — SLEEPING/AWAKE	Quiet, peaceful, sleeping or alert, random leg movements	
1 — FUSSY	Alert, restless and thrashing	

RASS

RICHMOND AGITATION AND SEDATION SCALE (RASS)		
+4	COMBATIVE	Violent, immediate danger to staff
+3	VERY AGITATED	Pulls or removes tube(s) or catheter(s); aggressive
+2	AGITATED	Frequent nonpurposeful movement, fights ventilator
+1	RESTLESS	Anxious, apprehensive but movements not aggressive or vigorous
0	ALERT & CALM	
-1	DROWSY	Not fully alert but has sustained awakening to voice (eye opening and contact ≥ 10 sec)
-2	LIGHT SEDATION	Briefly awakens to voice (eye opening and contact < 10 sec)
-3	MODERATE SEDATION	Movement or eye opening to voice (but no eye contact)
-4	DEEP SEDATION	No response to voice but movement or eye opening to physical stimulation
-5	UNAROUSABLE	No response to voice or physical stimulation

MODERATE SEDATION

Moderate sedation: A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is maintained. All practitioners responsible for the administration of sedation and anesthesia will have delineated clinical privileges in accordance with criteria approved by Anesthesia Services.

KEY POLICIES

AUTOPSY

It is the physician's responsibility to discuss the possibility of autopsy with the patient's family when any of the listed criteria are met or when a family member requests an autopsy. The physician has the right to request an autopsy on any patient. The family of a patient has the right to decline an autopsy except in the case of medical-examiner involvement.

Autopsy criteria:

- Unexpected death occurring during or following procedures and/or therapies.
- All obstetric deaths.
- Any neonatal or pediatric death.
- Death in which the patient sustained or apparently sustained an injury while hospitalized, or as a result of environmental or occupational hazards.
- Death of a patient who participated in clinical trials (protocols) approved by the Institutional Review Board.

CLINICAL RISK MANAGEMENT PLAN

The Risk Management Program at Las Palmas Del Sol Healthcare is an essential component of monitoring performance and patient outcomes.

The purpose of the program is to ...

1. Identify the sources from which losses may arise.
2. Evaluate the financial risk involved in terms of expected frequency, severity and impact in each exposure.

The facility has both an ethical and legal responsibility to provide quality patient care and a safe environment for its patients, employees, visitors, physicians and other healthcare practitioners.

The Risk Management Program is designed to permit the identification of patient, visitor and property risk exposure; to select and implement loss-control measures; and to reduce or prevent exposure. The program manages risks by continual and systematic assessment and action. Risk Management initiates proactive programs to reduce liability. To meet its commitment to provide quality healthcare and to ensure the continuing human, physical and financial integrity of the organization, each campus maintains a comprehensive risk-management program in accordance with the provisions of applicable federal regulations, state statutes and the standards of the Joint Commission and other regulatory agencies.

DNR

Under certain specified conditions, an attending physician can order that no attempt be made at cardiopulmonary resuscitation on his or her patient. Unless an order to withhold CPR is entered on the patient's chart, CPR will be performed on all patients as their conditions require. There are guidelines that primarily address the process of decision-making and are

intended to foster communication between the patient, family, physician, healthcare providers and hospital to provide rational, ethical and humane treatment. No order to withhold resuscitation services will be effective unless there is an appropriate authorization for the order obtained in compliance with the Advance Directives Policy for Healthcare, or other advance directive that may constitute one form of "appropriate authorization" for an order to withhold CPR. In the absence of a known advance directive, Las Palmas Del Sol Healthcare policy is the guide for withholding or withdrawing resuscitative services, otherwise referred to as the Do Not Resuscitate Policy.

EMTALA

Las Palmas Del Sol Healthcare follows the Emergency Medical Treatment and Active Labor Act (EMTALA) in providing an emergency medical-screening examination and necessary stabilization to all patients, regardless of ability to pay, provided we have the capacity and capability. Anyone with an emergency medical condition is treated.

EMTALA is a law that governs when and how an individual may be refused treatment or transferred from one hospital to another when the individual has an unstable medical condition.

1. A hospital that operates an emergency department must provide a medical-screening examination, within the facility's capabilities, to anyone who comes to the hospital property and on whose behalf a request is made for examination or treatment.
2. An emergency medical condition is one that, in the absence of immediate medical attention, could reasonably be expected to seriously jeopardize the health of an individual or unborn child.
3. If the individual has come to the hospital, and the hospital determines that the individual has an emergency medical condition, the hospital may not discriminate in providing further medical examinations and treatment to stabilize the medical condition.
4. An individual with an emergency medical condition may only be transferred to another facility at the individual's request, or if the facility does not have the capacity or capability to meet an individual's medical needs, and appropriate care is known to be available at another facility.
5. If the patient does not have an emergency medical condition or has been stabilized, EMTALA imposes no further obligation of the hospital.

OTHER CONSIDERATIONS:

- Demographic and financial inquiries are not made before the medical exam and treatment if they delay treatment.
- We do not admit, discharge or transfer patients simply on their ability or inability to pay, and regardless of the proposed method of payment, all individuals with an emergency medical condition are treated equally.
- All individuals must be provided information regarding the hospital's EMTALA obligations.
- Where relevant, the medical record must accurately reflect an individual's refusal of an exam and/or treatment, refusal to consent to a transfer or requests for transfers.

- Hospitals that knowingly violate EMTALA provisions may be subject to substantial civil monetary penalties.
- Physicians may be liable for civil monetary penalties as well as other appropriate disciplinary action consistent with the circumstances.

INFORMED CONSENT

Patients have a right to autonomy in healthcare decision-making supported by information concerning the condition, and based on this information, they may provide informed consent or refusal concerning any treatment.

Healthcare providers have a responsibility under Texas Administrative Code and HCFA regulation to provide for adequate informed consent.

Duty to obtain informed consent is on the physician and not the hospital.

- Duty is not delegable.
- Can rely on others to get consent form signed, but not to obtain consent.
- Referring physician does not have duty, but the physician performing procedure does.
- For consent to be informed, the patient and family, when appropriate, is given an explanation of the patient's condition and any proposed treatment(s) or procedure(s).

In addition, for consent for operative, invasive or anesthetic procedures, patients must be provided the necessary information in order to evaluate the risks and benefits, and any alternatives of the proposed treatment or procedure. Before consent is given, the patient must be informed by the physician of the benefits, risks, alternatives and potential complications associated with the treatment(s) or procedure(s) and, as appropriate, the need for and risk of blood transfusion and available alternatives.

The patient must be informed of the risk, as well as the benefits, of not having the procedure. Consent shall be executed prior to the intervention and as close to the time of the intervention as feasible. This must be documented in the medical record. If consent is not documented in the patient record, the intervention shall be postponed until informed consent is obtained.

For information regarding consent by minors or for more details, contact the risk manager at either campus: Las Palmas Campus at 915.521.1200 or Del Sol Campus at 915.595.9000.

PATIENT IDENTIFICATION

The two patient identifiers selected by Las Palmas Del Sol Healthcare are:

1. Full name
2. Date of birth

Clinical staff and physicians must always validate that the verbal identification given by the patient (or their patient representative) matches the information on the patient's wristband before ...

- Carrying out any procedure.
- Administering any prescribed medications.
- Instigating examinations, investigations or treatments as appropriate.

This information should also be consistent with the patient chart.

VERBAL/TELEPHONE ORDERS

All orders for treatment shall be in writing.

Verbal/telephone orders should only be used in the case of an emergency, may be given by a duly privileged M.D., D.O., D.D.S. or D.P.M.

Verbal/telephone orders may also be given by a duly privileged physician assistant and advanced nurse practitioner with counter-signature authentication by the sponsoring physician.

Verbal/telephone orders for treatment should be in writing if dictated to ...

- LVN
- Registered nurse
- Registered respiratory therapist
- Licensed physical therapist
- Licensed physical therapy assistant
- Registered occupational therapist (OTR)
- Certified occupational therapy assistant (COTA)
- Licensed speech language pathologist
- Certified therapeutic recreation specialist
- Registered pharmacist
- Registered dietitian
- Licensed imaging technologist
- Certified laboratory technician
- Certified respiratory therapist
- Registered respiratory therapist
- Certified hyperbaric technologist
- Perfusionist
- Case manager
- Psychologist
- Certified diabetes educator

Mentioned healthcare provider must be functioning within his/her scope of practice and competence, and the responsible practitioner must sign all orders.

Verbal/telephone orders must be signed by the next visit, but no later than 48 hours.

Orders will be signed, dated and timed.

Licensed independent practitioners must participate in read-back and verification of all verbal orders.

PHYSICIAN NOTICE REGARDING MEDICARE NATIONAL & LOCAL COVERAGE DETERMINATION

As an area of increased scrutiny by Medicare, HCA wants to provide complete information about Medicare's Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs) and how these programs interact with our Hospital Notices of Noncoverage and Advance Beneficiary Notices. LCDs and NCDs are coverage decisions at the local and national level that provide specific documentation requirements that must be met for reimbursement to be received. In order to be compliant with CMS regulation, the hospital may ask physicians for additional information when ordering certain services, such as lab and imaging tests, and when scheduling certain surgical or interventional procedures.

It is our goal to facilitate scheduling as expeditiously as possible. However, when Medicare payment is at risk because the LCD/NCD requirements cannot be verified prior to the test or procedure, additional information will be requested from the physician. Often, this provides sufficient information in order to proceed. In the event the service or procedure, as documented, still does not meet the LCD/NCD criteria, the patient must be informed of noncoverage but may still choose to have the service or procedure. If the patient elects to proceed with the ordered service, they will be given an Advance Beneficiary Notification (ABN) for outpatient services or Hospital Issued Notice of Noncoverage (HINN) for inpatient services. Both the ABN and HINN provide the patient advance notice that Medicare may not pay for the test, procedure or service ordered, the amount for which they will be responsible, and how to initiate an appeal.

The guiding principle in obtaining a ABN or HINN is not whether you, as a physician, believe that the procedure or service is medically necessary, but rather whether the patient's diagnosis, signs or symptoms meet the LCD/NCD requirements.

We will work to keep our physicians informed of key LCD/NCD requirements. If you would like more information on LCD/NCD requirements pertaining to services you provide, or if you have questions about this process, please contact Rebecca Posey, R.N., HCA Central and West Texas Division LCD/NCD Coordinator.

CORE MEASURES

WHAT ARE CORE MEASURES?

A major part of the externally driven quality-improvement agenda in the hospital is centered on the core measures, a set of national quality-performance measures. Hospitals began to address a subset of the current core measures nearly 15 years ago as part of hospital accreditation by the Joint Commission. Since then, the core measures have been aligned with CMS quality measurement for the Medicare program and adopted by the National Quality Forum consensus process. Today, they are used broadly to benchmark hospital clinical performance, trend performance and to analyze opportunities and challenges for improvement in patient care.

Core measure results are transparent and posted on public websites, such as Hospital Compare, to facilitate comparison shopping by consumers, and are increasingly linked to reimbursement as part of the Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing and the pay-for-performance programs of many other payers (BCBS, TriCare, Aetna). Core measures track a variety of evidence-based, scientifically researched standards of care that have been shown to result in improved clinical outcomes for patients.

HELPFUL FACTS ABOUT CORE MEASURES

- Set of best-practice standards/evidenced-based medicine that was developed with physician collaboration and has been proven to decrease mortality.
- Numerous preprinted order forms have been developed: preprinted orders and contraindication order form, among others.
- Data is collected concurrently and retrospectively from medical records.
    - » Las Palmas Del Sol Healthcare has core measures reviewers on-site to concurrently review medical records. Our goal is to promote quality care and appropriate medical record documentation to comply with core measures requirements. Please respond to all communication regarding core measures issues in a timely manner and place the response in the progress notes.
- Information is submitted to Joint Commission and CMS, and is publicly reported on the CMS website, hospitalcompare.hhs.gov
    - » Reported at least quarterly to Quality Council, MEC and Board of Trustees.
    - » Measures are continuing to increase. In 2009, there were 30 measures that required data submission. For 2011 and 2012 Reporting Years, there are 44 quality measures: three core measures, three alternate core measures and 38 additional measures.

E-MEASURE	RATIONALE	COMMENTS
AMI		
Primary PCI Received within 90 minutes of hospital arrival.	Acute myocardial infarction (AMI) patients with ST segment elevation or LBBB on the ECG closest to arrival time, receiving primary PCI	Code Heart.
MEASURE	**RATIONALE**	**COMMENTS**
PERINATAL		
PC-03 Antenatal Steroids	Patients at risk of preterm delivery at 24–32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.	The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated corticosteroid courses should not be used routinely because clinical trials show decreased brain size, decreased birth weight and adrenal insufficiency in newborns exposed to repeated doses. Treatment should consist of two doses of 12 mg of betamethasone given intramuscularly 24 hours apart or four doses of 6 mg dexamethasone given intramuscularly every 12 hours. A full course of antenatal corticosteroids should be administered to women with premature rupture of membranes (PROM) before 32 weeks of gestation to reduce the risks of respiratory distress syndrome, prenatal mortality and other morbidities. The efficacy of corticosteroid use at 32–34 completed weeks of gestation is unclear based on available evidence, but treatment may be beneficial, particularly if pulmonary immaturity is documented (Lockwood & Lemons, 2007).

MEASURE	RATIONALE	COMMENTS
PERINATAL		
PC-02 Cesarean Section	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.	Hospitals with CS rates at 15–20 percent have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CS rates continue to rise. This measure seeks to focus attention on the most variable portion of the CS epidemic, the term labor CS in nulliparous women.
PC-01 Elective Delivery	Patients with elective vaginal deliveries or elective cesarean sections at > 37 and < 39 weeks of gestation completed.	According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).
PC-05 Exclusive Breast Milk Feeding	Exclusive breast milk feeding during the newborn's entire hospitalization.	Exclusive breast milk feeding for the first six months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP), and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007).

MEASURE	RATIONALE	COMMENTS
NEWBORN		
PC-04 Healthcare-Associated Bloodstream Infections in Newborns	Staphylococcal and gram-negative septicemias or bacteremias in high-risk newborns.	Healthcare-associated bacteremia is a significant problem for infants admitted into neonatal intensive care units (NICUs) and other hospital units. This is especially true for very low birth weight infants who are at high risk for these infections due to their immature immune systems and need for invasive monitoring and supportive care. Effective preventive measures range from simple hand washing protocols or closed medication-delivery systems to more elaborate multidisciplinary quality improvement plans involving hand washing, nutrition, skin care, respiratory care, vascular access and diagnostic practices.
STROKE (STROKE CERTIFICATION PROGRAM)		
MEASURE	**RATIONALE**	**COMMENTS**
CORE AND E-MEASURE STK-1		
Venous Thromboembolism (VTE) Prophylaxis	Ischemic or hemorrhagic stroke patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission Patients experiencing a stroke that involves a paretic or paralyzed lower extremity are at increased risk of developing deep vein thrombosis (DVT).	Patients with an ischemic stroke or a hemorrhagic stroke will receive DVT prophylaxis by end of hospital day two. Patient exclusions: Less than 18 years of age; have a length of stay less than two days; have a length of stay greater than 120 days; are with *Comfort Measure Only* documented on day of, or day after, hospital arrival; are enrolled in clinical trials; or are admitted for *Elective Carotid Intervention.*

MEASURE	RATIONALE	COMMENTS
CORE AND E-MEASURE STK-2		
Discharged on Antithrombotic Therapy	Antithrombotic therapy should be prescribed at discharge following acute ischemic stroke to reduce stroke mortality and morbidity as long as no contraindication exists.	Patients with ischemic strokes will be prescribed antithrombotic therapy at hospital discharge. Patient exclusions: Less than 18 years of age; have a length of stay greater than 120 days; with Comfort Measure Only documented; enrolled in clinical trials; admitted for Elective Carotid Intervention; discharged to another hospital; left against medical advice; expired; discharged to home for hospice care; discharged to a healthcare facility for hospice care; or a with a documented *Reason For Not Prescribing Antithrombotic Therapy at Discharge.*
CORE AND E-MEASURE STK-3		
Anticoagulation Therapy for Atrial Fibrillation/Flutter	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge. Nonvalvular atrial fibrillation (NVAF) is a common arrhythmia and is an important risk factor for stroke. It is one of several conditions of lifestyle factors that have been identified as risk factors for stroke.	Ischemic stroke patients with atrial fibrillation/flutter will be prescribed anticoagulation therapy at hospital discharge. Patient exclusions: less than 18 years of age; have a length of stay greater than 120 days; with Comfort Measure Only documented; enrolled in clinical trials; admitted for Elective Carotid Intervention; discharged to another hospital; left against medical advice; expired; discharged to home for hospice care; discharged to a healthcare facility for hospice care; or with a documented *Reason For Not Prescribing Anticoagulation Therapy.*

MEASURE	RATIONALE	COMMENTS
CORE AND E-MEASURE STK-4		
Thrombolytic Therapy	Acute ischemic stroke patients who arrive at this hospital within two hours of time last known well and for whom IV t-PA was initiated at this hospital within three hours of time last known well. The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials.	Acute ischemic stroke patients who arrive at this hospital within two hours of time last known well and for whom IV-tPA was initiated at this hospital within three hours of time last known well. Initiate IV-tPA within the recommended time parameters. Acceptable reasons for delay must be clearly documented. Patient-related delays are acceptable/ system- and staff-related delays are not acceptable.
CORE AND E-MEASURE STK-5		
Antithrombotic Therapy by End of Hospital Day two	Antithrombotic therapy should be administered within two days of symptom onset in acute ischemic stroke patients to reduce stroke mortality and morbidity as long as no contraindications exist. Anticoagulants at doses to prevent VTE are insufficient antithrombotic therapy to prevent recurrent ischemic stroke or TIA.	Ischemic stroke patients will receive antithrombotic therapy by the end of hospital day two. Patient exclusions: less than 18 years of age; have a length of stay less than two days; have a length of stay greater than 120 days; are with Comfort Measure Only documented on day of, or day after, hospital arrival; are enrolled in clinical trials; are admitted for Elective Carotid Intervention; are discharged prior to the end of hospital day two; with IV or IA Thrombolytic (t-PA) Therapy Administered at This Hospital or within 24 Hours Prior to Arrival; or with a documented *Reason for Not Administering Antithrombotic Therapy by End of Hospital Day two.*

MEASURE	RATIONALE	COMMENTS
CORE AND E-MEASURE STK-6		
Discharged on Statin Medication	An elevated serum lipid level has been a well-documented risk factor for coronary artery disease (CAD) and reflects on organ-specific manifestation of atherosclerosis. Intensive lipid-lowering therapy using statin medications was associated with a dramatic reduction of the rate of recurrent ischemic stroke and major coronary events	Ischemic stroke patients with LDL greater than or equal to 100mg/dL, or LDL not measured, or who were on lipid-lowering medication prior to the hospital arrival are prescribed statin medication at hospital discharge. All patients with ischemic stroke or TIA should have lipid-profile measurement performed within 48 hours of hospital arrival, unless results are available from within the past 30 days. Patient exclusions: less than 18 years of age; have a length of stay greater than 120 days; with *Comfort Measure Only* documented; enrolled in clinical trials; admitted for *Elective Carotid Intervention*; discharged to another hospital; left against medical advice; expired; discharged to home for hospice care; discharged to a healthcare facility for hospice care; or a with a documented *Reason for Not Prescribing Statin Medication at Discharge*.
CORE AND E-MEASURE STK-8		
Stroke Education	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	Education will include five key factors: how to activate the emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke and warning signs and symptoms of stroke. Patient exclusions: less than 18 years of age; have a length of stay greater than 120 days; with *Comfort Measure Only* documented; enrolled in clinical trials; admitted for *Elective Carotid Intervention*.

MEASURE	RATIONALE	COMMENTS
CORE AND E-MEASURE STK-10		
Assessed for Rehabilitation	Effective rehabilitation interventions initiated early following stroke can enhance the recovery process and minimize functional disability. The primary goal of rehabilitation is to prevent complications, minimize impairments and maximize function.	Patients with ischemic and hemorrhagic stroke are assessed for rehabilitation services by hospital day two. Patient exclusions: less than 18 years of age; have a length of stay greater than 120 days; with Comfort Measure Only documented; enrolled in clinical trials; admitted for Elective Carotid Intervention; discharged to another hospital; left against medical advice; expired; discharged to home for hospice care; discharged to a healthcare facility for hospice care.
CORE AND E-MEASURE CSTK-01		
National Institutes of Health Stroke Scale (NIHSS Score Performed for Ischemic Stroke Patients)	Ischemic stroke patients for whom an initial NIHSS score is performed prior to any acute recanalization therapy (i.e., IV thrombolytic (t-PA) therapy, or IA thrombolytic (t-PA) therapy, or mechanical endovascular reperfusion therapy) in patients undergoing recanalization therapy and documented in the medical record, OR documented within 12 hours of arrival at the hospital emergency department for patients who do not undergo recanalization therapy.	A neurological examination of all patients presenting to the hospital emergency department with warning signs and symptoms of stroke should be a top priority and performed in a timely fashion. Use of a standardized stroke scale or scoring tool ensures that the major components of the neurological examination are evaluated.
CORE AND E-MEASURE STK-OP-01		
Door to Transfer to Another Hospital	Median time from hospital arrival in the emergency department to transfer of a hemorrhagic stroke patient or an ischemic stroke patient to another hospital.	Hemorrhagic stroke is a life-threatening condition caused by a rupture in a weakened blood vessel in the brain. Surgical intervention to repair a ruptured aneurysm may be indicated and necessitate urgent transfer of the patient if the hospital is unable to provide advanced neurological treatments and services.

MEASURE	RATIONALE	COMMENTS
SEPSIS SEP-1		
Early Management Bundle, Severe Sepsis/ Septic Shock	The evidence cited for all components of this measure is directly related to decreases in organ failure, overall reductions in hospital mortality, length of stay and costs of care.	This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement.
EMERGENCY DEPARTMENT ED-2		
ED-2A Admit Decision Time to ED Departure Time for Admitted Patients — Overall Rate **ED-2b** Admit Decision Time to ED Departure Time for Admitted Patients — Reporting Measure **ED-2c** Admit Decision Time to ED Departure Time for Admitted Patients	Median time from admit decision time to time of departure from the emergency department for admitted patients.	Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding.

2019 HOSPITAL NATIONAL PATIENT SAFETY GOALS

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in healthcare safety and how to solve them.

Identify patients correctly
NPSG.01.01.01
Use at least two ways to identify patients. For example, use patient's name (stated) and date of birth (DOB). This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01
Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve staff communication
NPSG.02.03.01
Get important test results to the right staff person on time.

Use medicines safely
NPSG.03.04.01
Before a procedure, label medicines that are not labeled. Label all medication containers, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01
Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01
Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely
NPSG.06.01.01
Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection
NPSG.07.01.01
Use the hand-cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01
Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01
Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01
Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01
Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify patient-safety risks
NPSG.15.01.01
Find out which patients are most likely to try to commit suicide.

Prevent mistakes in surgery
UP.01.01.01
Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01
Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01
Pause before the surgery to make sure that a mistake is not being made.

SAFE PROCEDURAL & SURGICAL VERIFICATION

Las Palmas Del Sol is dedicated to fostering a culture that supports patient safety. Consistent with the requirements of the Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS) and/or other regulatory agencies, processes for reliable performance of safe surgical or invasive procedures includes preprocedure verification, marking the operative or procedural site and a time-out immediately prior to starting the procedure. These processes are consistent and standardized throughout the organization.

The verification process, which starts during the preoperative phase, is conducted throughout all phases of perioperative care and includes the continual sharing of pertinent information to include correct patient, procedure and side/site.

The procedural or operative site is correctly identified and marked by the surgeon/proceduralist performing the procedure. The mark is to eliminate any ambiguity and ensure correct laterality and level, even after the patient is prepped and draped.

A time-out, which is led by the surgeon/proceduralist, is performed immediately prior to starting the procedure by completing a final verification of correct patient, procedure and side/site. Any member of the team may express questions or concerns, and all questions and concerns will be resolved prior to incision/start of the procedure.

PERFORMANCE IMPROVEMENT PLAN

The mission of the Performance Improvement Plan is to contribute to the highest-quality patient care by utilizing performance-improvement methods in the analysis and modification of interdisciplinary systems, using active knowledge of existing and ideal patient-care processes.

We seek to empower employees to be involved in identifying opportunities for improvement and participating in resolution of issues. We promote excellence in patient care by offering physicians, administrators, staff and others as needed objective information that they can use for purposes of review, patient management and quality measurement.

The Performance Improvement Plan provides a framework for the improvement of organizational processes in the support of best practices, best patient outcomes and patient safety. The Performance Improvement Program and Plan encompass all aspects of care, ages and services provided by the organization and includes physicians in actively dealing with quality-of-care issues for the hospital and its practitioners. There are specific individual department indicators of patient-care quality and team projects to enhance the quality of patient care.

Medical staff members participate in interdisciplinary occurrence-analysis teams; investigation of adverse patient events and/or processes that may result in sentinel events; organizational initiatives that seek improvement of health outcomes and reduction of medical errors; and national and local patient-safety initiatives and goals.

SENTINEL EVENTS

A sentinel event is defined by The Joint Commission as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a person or persons, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified under The Joint Commission accreditation policies to help aid organizations in development of root-cause analysis and to assist in development of preventive measures.

The organization is responsible for reporting any sentinel events, which will then be tracked in a database. There is an expectation that the organization adequately analyze any undesirable trends or decreases in performance, and the subsequent mitigation of other such events.

INFECTION-CONTROL PLAN

The infection-prevention and control program has a plan of action designed to identify infections that occur in patients, healthcare workers, visitors and others in the healthcare environment that have the potential for disease transmission.

The program recommends risk-reduction practices by integrating principles of infection control into all direct and indirect standards of practice. Infection-prevention and control

services are provided by the Infection Prevention and Control/Employee Health Department 24 hours a day, seven days a week.

All licensed independent practitioners: One of the National Patient Safety Goals is to reduce the risk of healthcare-associated infections by implementing evidence-based practices.

Surgical-site Infections

- When hair removal is necessary, use clippers or depilatory method.
- Use of razors is inappropriate.
- Make sure your patient understands your post-discharge instructions
- Control blood glucose level during the immediate postoperative period for patients undergoing cardiac surgery: controlled 6 a.m. blood glucose level (lower than 200 mg/dL) on postoperative day one and postoperative day two, with procedure day being postoperative day zero.
- Maintain perioperative normothermia for patients undergoing colorectal surgery.
- Follow appropriate antibiotic-administration protocols.
- All preoperative patients will be bathed/showered with CHG solution at least the night before and the morning of surgery. For patients undergoing certain CV and orthopedic procedures, a MRSA/MSSA nasal swab will be performed. Patients positive for MRSA/MSSA will undergo a five-day course of decolonization to include nasal mupriocin twice daily and daily CHG baths.

Multidrug-resistant Organisms (MDRO)

- Place patients with MRSA colonization or infection on contact precautions to help reduce patient-to-patient spread of the organism within the hospital.
- Wear a gown and gloves on entry into the patient's room. Remove the gown and gloves before exiting the room.
- Use appropriate hand hygiene on entering and exiting the patient's room. Wearing gloves does not eliminate the need for hand hygiene.
- Discontinuation of precautions is ONLY done through the Infection Control Office.
- Call the operator (0) for the campus infection control office to request patient review.

Clostridium difficile

- C. difficile is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD), accounting for 15–25 percent of all episodes of AAD.
- Issues that result from C. difficile infections include pseudomembranous colitis (PMC), toxic megacolon, perforations of the colon, sepsis and death (rarely). Clinical symptoms include watery diarrhea, fever, loss of appetite, nausea and abdominal pain/tenderness.
- The risk for disease increases in patients with antibiotic exposure, gastrointestinal surgery/manipulation, long length of stay in healthcare settings, a serious underlying illness, immunocompromising conditions or advanced age. The infection can usually

be treated with an appropriate course (about 10 days) of antibiotics, including metronidazole or oral vancomycin.

- After treatment, repeat C. difficile testing is not recommended if the patients' symptoms have resolved as patients may remain colonized. DO NOT test for cure.

Please do not use C. diff testing to "screen" possible C. diff patients. Screen only symptomatic patients (abdominal pain, increased white count without another primary source, etc.). Do not test based on stool alone ("Don't treat the stool"). Always ask your patient if they have been on laxatives.

Prevention strategies:

- Use and choose antibiotics judiciously.
- Use contact precautions for patients with known or suspected C. difficile–associated disease.
- Perform hand hygiene using soap and water.
- Use gloves and a gown when entering patients' rooms and during patient care.

Central Line-associated Bacterial Infections

Central Line-associated bacterial infections — Bloodstream Infections (CLABSIs) are blood infections that are not associated with any other cause that develop due to bacteria being introduced into the bloodstream from the central line. An estimated 200,000 CLABSIs occur each year in the United States. Primary bloodstream infections are usually serious infections that typically increase hospital length of stay, cost and risk of death. The population most at risk and followed for this indicator is the patients in the adult Intensive Care Units (ICUs).

Five major risk factors are associated with increased catheter-related infection rates:

1. Cutaneous colonization of the insertion site.
2. Moisture under the dressing.
3. Prolonged catheter time.
4. Technique of care and placement of the central line.
5. Avoid femoral lines.

Insertion of CVCs can lead to serious and sometimes life-threatening complications, whether of mechanical, infectious or thrombotic origin.

Higher rate of infectious complications have been found in studies comparing femoral lines versus subclavian lines.

Evidence-based strategies selected to reduce CLABSIs:

1. Wash hands with soap.
2. Clean patient's skin with chlorhexidine antiseptic.
3. Put sterile drapes on the entire patient.
4. Wear sterile gown and mask.
5. Put sterile dressing over the insertion site.

6. All patients with central lines will receive a daily CHG bath/shower.
7. Line necessity will be reviewed once per shift

Catheter-associated Urinary Tract Infections (CAUTI)
A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters and kidney. UTIs are the most common type of healthcare-associated infection reported to the National Healthcare Safety Network (NHSN)(https://www.cdc.gov/nhsn/index.html). Among UTIs acquired in the hospital, approximately 75 percent are associated with a urinary catheter, which is a tube inserted into the bladder through the urethra to drain urine. Between 15–25 percent of hospitalized patients receive urinary catheters during their hospital stay. The most important risk factor for developing a CAUTI is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed.

Las Palmas Del Sol Healthcare utilizes a Nurse-Driven Urinary Catheter Removal Protocol.

Evidence-based strategies selected to reduce CAUTIs:

1. Wash hands with soap.
2. Insert urinary catheters utilizing sterile technique
3. Catheters are secured to the patient utilizing a securement device.
4. For patients having a urinary catheter greater than 48 hours, always exchange the catheter before ordering a UA for suspected CAUTIs. This prevents sampling catheter biofilm.
5. Catheter necessity is reviewed once per shift.
6. All urinary catheter patients will receive a CHG bath/shower daily.

PREVENTING THE SPREAD OF INFECTION

Careful precautions are the keys to infection control. Without proper precautions, germs can easily spread among patients, visitors, physicians and staff. That's why healthcare facilities take special steps to prevent infection.

Your cooperation is vital. All staff, physicians, students, visitors and patients play a role in preventing the spread of infection.

At Las Palmas Del Sol Healthcare campuses, proper hand hygiene is an expectation. Use and teach respiratory hygiene. You can stop germs by stopping their route of transmission. This is the focus of every healthcare facility's infection-control program.

Standard Precautions
Standard precautions are a central part of the infection-control program. Anyone who has contact with a patient — including visitors — should understand how they work. Standard precautions apply to all patients at all times!

Transmission-based Precautions

In addition, contact, airborne and droplet are utilized as needed with standard precautions. The infection-control manual addresses all precautions very specifically.

Gowns and gloves are required each time you enter a contact-isolation room. This applies in all cases, even if you do not expect to touch a patient or any surfaces in the room.

SEPSIS

We are using evidence-based practices for the Surviving Sepsis Campaign to improve our understanding and caring for our patients with severe sepsis and septic shock. Our goals are to have 8 percent or less severe-sepsis mortality and 30 percent or less septic-shock mortality rates throughout the hospital. In order to meet these goals, we will implement Code Sepsis; sepsis orders sets will be utilized along with compliance of Bundles (B.L.A.S.T.). This will be completed as follows:

WITHIN ONE HOUR OF TIME OF PRESENTATION*:

1. Measure lactate level
2. Obtain blood cultures prior to administration of antibiotics.
3. Administer broad-spectrum antibiotics.
4. Administer 30ml/kg crystalloid initial bolus.

**"Time of presentation" is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.*

WITHIN 3–6 HOURS OF TIME OF PRESENTATION:

1. Maintain IVF between 150 and 200ml/hr for six hours and then adjust rate as needed.
2. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP>65mmHg).
3. In the event of persistent hypotension after initial fluid administration (MAP<65mmHg) or if initial lactate was >2 mmol/L, reassess volume status and tissue perfusion and document findings accordingly.
4. Remeasure lactate. (Must be repeated every two hours until lactate < 2 mmol/L)
5. Sepsis Tissue Perfusion Reassessment must be completed by Physician/PA/NP and must include: vital signs, cardiopulmonary exam, capillary refill evaluation, peripheral pulses assessment and skin assessment, or document two of the following: CVP measurement, ScvO2 measurement, 2D echocardiogram, passive leg raise or fluid challenge. Physician may attest to performing or completing a physical examination, re-perfusion assessment by stating "I did the Sepsis Reassessment", "Sepsis reevaluation was performed", and "I have reassessed tissue perfusion after bolus given".

Please feel free to contact the Sepsis Clinical Coordinator at 915.319.9702 for any questions or assistance.

The purpose of this document is to guide new physicians on HCA/Central West Texas clinical process regarding Sepsis. Please contact your facility's Sepsis Coordinator with any questions or assistance.

<table>
<tr><th>CMS DEFINITION</th><th>CLINICAL EVIDENCE DOCUMENTED IN CHART</th><th>TREATMENT</th></tr>
<tr><td>Sepsis =
SIRS + Suspected Infection</td><td>SIRS Criteria (Any two):
Temp > 100.9 or < 96.8
☐ Heart Rate > 90
☐ Resp Rate > 20
WBC > 12,000 or <4,000
☐ > 10% Bands
<u>Infection:</u>
☐ Suspected/Confirmed
Sourced:</td><td rowspan="3">Blood Cultures prior to antibiotics
Lactic Acid if > 2 repeat is required; if ≥4, patient considered "septic shock"
Antibiotics Administer broad specrum within 1 hr. (7% increase in mortality every hr after)
Saline 30ml/kg crystalloid initial bolus — reassess volume and continue saline at least 250ml/hr until intravascular volume replenishment complete
Time must be completed wthin 3 hr. window

USE SEPSIS ORDER SET

EV1000: application of Edwards noninvasive technology that provides cotinuous real-time advanced hemodynamic information</td></tr>
<tr><td>Severe Sepsis =
Sepsis + New Onset Organ Dysfunction

IMPLEMENT CODE SEPSIS (FACILITY SPECIFIC)</td><td>New/Acute Organ Dysfunction (Any one):
☐ Altered Mental Status
☐ Acute Respiratory Failure (Need for invasive/noninvasive mechanical ventilation)
☐ Hypotension (SBP < 90|MAP <65)
☐ Creatinine > 2 or Urine Output < 30 ml/hr
☐ Total bilirubin > 2 mg/dL
☐ Platelet count < 100,000
☐ INR > 1.5 or PTT > 60 seconds
☐ Lactic Acid > 2 mmol/L
If organ dysfunction not "new or acute", need to document other cause such as:
• Low platelets in patient on chemo
• Elevated lactic in post arrest, post seizure or liver failure
• SBP < 90 secondary to other medication or is patient's baseline</td></tr>
<tr><td>Septic Shock =
Severe Sepsis + Refractory Hypotension
OR
Lactate ≥ 4 mmol/L</td><td>Any one:
☐ Lactic acid ≥ 4mmol/L
☐ Refractory Hypotension (≥2 Consecutive SBP < 90 post 30ml/kg bolus)
☐ Refractory Hypotension (≥2 Consecutive MAP < 65 post 30ml/kg bolus)
☐ SBP drop > 40 mm/Hg post 30ml/kg bolus</td></tr>
</table>

MEDICAL RECORDS

Access to complete records can be obtained electronically through HCARE Portal and Meditech. If you do not have access to HCARE Portal and Meditech, the PSC from the IT department can assist you.

Medical Records — Documentation for Physicians

History and physical documentation compliance must be 100 percent for physicians.

Patient Records

- The patient record must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and result of the interventions, and coordinate interdisciplinary care.

Verbal Orders

- Verbal orders must be signed, dated and timed by the next visit, but no later than 48 hours.
- LIPs must participate in read-back and verification of all verbal orders.

Discharge Summaries

- Discharge summaries shall be dictated within seven days of discharge, dated, timed and signed by the responsible practitioner, with the final diagnosis recorded in full and without the use of abbreviations.
- For newborns with uncomplicated deliveries or for patients hospitalized less than 48 hours with only minor problems, a final progress note may be substituted for the discharge summary. In lieu of discharge summary or final progress note, the physician may document the outcome of hospitalization, the case disposition, provisions for follow-up care and diagnosis on the Operative Report.

Entries in the Medical Record

- Medical record entries are to be legible so that the record may function as a communication tool among healthcare providers.

History and Physicals — Inpatients/Comprehensive

- The primary attending physician is responsible for the history and physical (H&P) of patients admitted under his/her service, which must be in the medical record within 24 hours after admission (including holidays and weekends). H&P must have been performed no more than 30 days prior to admission and may be completed by a duly credentialed LIP and non-LIPs with specifically delineated privileges.
- The H&P must have an updated examination or documentation of any or no changes since the last assessment upon each and every admission, regardless of hospital setting.
- If the patient is having surgery or another procedure that places the patient at risk and/or involves the use of sedation or anesthesia, there must be an update to the patient's condition prior to the start of the surgery or procedure. Surgery/procedure will be held until the H&P is completed.

- A dictated history and physical examination that has not yet been transcribed to the medical record does not meet the Joint Commission intent.
- In an emergency, where life or limb is in jeopardy and there is no time to record the complete H&P, an admission note completed after surgery is acceptable; the note should include a brief history with the preoperative diagnoses recorded in the medical record.

The H&P includes the following elements:

- Date of admission
- Chief complaint
- History of present illness
- Review of systems
- Relevant past medical/surgical history
- Relevant social history
- Relevant family history
- Relevant psychosocial needs
- An age-appropriate physical examination
- Diagnosis or impression
- Plan of care
- Documentation of risks, benefits and alternatives to planned procedure, if appropriate

The H&P may be in the following forms:

- Dictated
- Written on an approved History and Physical form
- Written in the progress notes
- PDOC

Operative Reports

- Operative Reports must be dictated, authenticated within 72 hours of the procedure.

Signature Stamps

- Stamped signatures are not acceptable on any medical record.
- These regulations are pursuant to Condition of Participation and apply to any providers that bill Medicare carriers.

Authenticate, Date and Time All Entries

- Interpretive guidelines for CMS regulation 482.24 (c)(1) explain that all entries in the medical record must be dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

UNAPPROVED ABBREVIATIONS

The unapproved list of abbreviations applies, at a minimum, to all orders and medication-related documentation that is handwritten (including free-text computer entry) or on preprinted forms (including physician office-practice forms).

UNACCEPTABLE ABBREVIATIONS	INTENDED MEANING	MISINTERPRETATION	EXPECTED ACTION
U or u	Units	Misread as a zero (0) or a four (4), causing a tenfold overdose or greater (4U seen as "40" or 4u seen as "44").	Write out the word "units".
IU	For international unit	Mistaken for IV (intravenous) or 10 (ten).	Write out "international unit".
Q.D Q.O.D	Latin abbreviation for once daily and every other day	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for an "I".	Write "daily" And "every other day".
Lack of a leading zero (i.e., 1.0 mg)	0.1 mg	Misread as 1 or 11 mg.	ALWAYS use a zero before a decimal point.
QHS or qhs H.S. or h.s.	At hour of sleep half strength	Mistaken for half strength or hour of sleep. QHS can also be mistaken for Q hour. All can result in a dosing error.	Write out "half strength" or "at bedtime".
Trailing zero (i.e., 1.0 mg)	1 mg	Misread as 10.	Do NOT use trailing zeros after a decimal point.
MS MSO4 MGSO4	Morphine Sulfate Morphine Sulfate Magnesium Sulfate	Confused for one another.	Write out "morphine sulfate" or "magnesium sulfate".

ELECTRONIC ACCESS FROM HOME OR OFFICE TO MEDICAL RECORDS

Electronic access through ITS (Information and Technology Services) via Virtual Desktop Integration (VDI) is available to our physicians with one-time enrollment and compatible with Windows, Mac and iPad. Physicians can sign medical records electronically from home. For information and enrollment, contact 915.621.6622 and ask for VDI to be set up, or visit epremote.com.

CPOE

The CPOE (Computerized Provider Order Entry) Department utilizes the Meditech system for documentation and ordering within the Electronic Health Record (EHR). Training is provided for physicians to enter orders, complete electronic physician documentation (PDoc) and review information within the EHR. The CPOE team, the Director of Physician Relations and Medical Staff at each facility will coordinate a training date and time with you. Working closely with ITS, both departments will coordinate in-house access issues, build order sets based on diagnosis or procedures and coordinate updates/enhancements to Meditech for improvements. The Physician Support Coordinator assists with setting up access on personal devices and preference settings within Meditech. The contact number for the in-house CPOE team is ext. 2763 option #1 for Las Palmas and *32763 option #2 for Del Sol. For out-of-hospital assistance, the number is 915.577.2763 (option #1 for Las Palmas and option #2 for Del Sol). For ITS assistance, please call 915.577.2763 (or in-house EXT 2763 for Las Palmas or *32763 for Del Sol option #3), 7 a.m–4 p.m. MST or the Help Desk afterhours at 915.621.6622 (EXT 6622 for Las Palmas or *36622 for Del Sol in-house) option #1 for physician access, account locked, remote access, etc.

ABOUT CASE MANAGEMENT

Las Palmas Del Sol Healthcare leadership recognizes that Case Management plays a critical role in quality management and patient care, and leading financial indicators such as throughput, reimbursement and length-of-stay management. Our case management teams will work hand in hand with the entire interdisciplinary team.

The role of Case Management staff is to ...

- Assist patients and families, while consistently collaborating with their physicians, to facilitate/direct transition care to the next most-appropriate level based on clinical and psychosocial needs.
- Assure reimbursement for not only current but next level of care by payers.
- Coordinate services necessary post-discharge.
- Provide support for those in crisis and facilitate adjustment to new diagnoses.
- Provide patient advocacy in a compassionate manner that is consistent with the Las Palmas Del Sol Mission and Vision.

Appropriate integration of Case Management within the Las Palmas Del Sol Healthcare system ensures the following:

- Improved quality of care
- More efficient/improved patient throughput
- Appropriate reimbursement for services delivered
- Decreased readmit rates
- Enhanced patient, physician and employee satisfaction

PATIENT EDUCATION PROGRAM

The patient/family/significant other are all involved in the education and learning process in relation to the nature of the patient's illness, the care given in the hospital, what will be expected of the patient/family/SO upon discharge, as well as the community resources that are available.

The patient- and family-education process, and education of each individual patient is developed by an interdisciplinary team. Members include nursing, pharmacy, respiratory, physical therapy, case management, dietitians, ancillary departments and patient educators. Physician input is utilized in all aspects of individual patient-education needs so that the patient and family receive the most comprehensive education possible, both in inpatient and outpatient settings

BILLING REQUIREMENTS FOR PROFESSIONAL SERVICES IN A HOSPITAL FACILITY

CMS requires hospitals to inform physicians/practitioners that when treating patients in a hospital-based department of their hospital, their services are required to be billed with the appropriate place of service code so that correct physician/practitioner payment can be determined by the Medicare Part B Carrier. The following information is being provided as part of the hospital's demonstration that it is complying with the requirement, as stated in the CMS provider-based regulations, 42 CFR 413.65(g)(2).

Medicare Part B pays for services by physicians to Medicare beneficiaries. These services include medical and surgical procedures and other services, such as office visits and medical consultations. Although physicians routinely perform many of these services in a facility setting such as a hospital, skilled nursing facility or community mental health center, certain of the same services may also be performed in nonfacility settings, such as a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting.

Physicians are paid for services based on the Medicare Physician Fee Schedule. An explanation of the payment methodology can be found in 42 CFR 414 Subpart B — Physicians and other Practitioners.

For certain services, Medicare has established two differential RVUs for practice expense to compensate physicians for the cost differences that result from performing a service in a facility as opposed to a nonfacility setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B Carriers for payment. The place of service code is located at field 24(b) of the CMS 1500 claim form. The carrier will pay the physician for the professional component of services provided through the appropriate RVU facility or nonfacility fee schedule rate based upon the place of service code. Certain services will be impacted by "place of service" codes 19, 21, 22 or 23, as they indicate the physician rendered the care to a patient of the hospital, and that the professional component will be reimbursed at the lower RVU facility rate. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service at facilities.

Physicians/practitioners must submit a claim to the Medicare Part B Carrier on CMS form 1500 for the professional services rendered to the patients in a hospital facility with the correct place of service code in order for the carrier to pay the physician/practitioner appropriately. The following place of service codes are required when care is rendered in a hospital setting:

- Place of service code 19 denotes to the carrier that the service was provided to a beneficiary who is treated in an off-campus outpatient department of a hospital. (Effective on or after January 1, 2016).
- Place of service code 21 denotes to the carrier that the service was provided to a beneficiary who is an inpatient of a hospital.
- Place of service code 22 denotes to the carrier that the service was provided to a patient in an on-campus outpatient department of a hospital.

- Place of service code 23 denotes to the carrier that the service was provided to a patient in the emergency department of a hospital either on campus or off.

Off-campus refers to any hospital location where patients are registered as a patient of the hospital, but the location is in excess of 250 yards of a main hospital inpatient building.

- "Place of service" code 11 denotes to the carrier that the service was provided to a beneficiary not registered as a patient of a hospital. ("Place of service" code 11 is never used when services are provided to hospital Medicare patients by the physician.)

Additionally, for certain services/procedures performed at the hospital or hospital-based clinic, the physician will be required to bill the carrier with the modifier "26" to indicate they are only billing for the professional component (i.e., supervision or interpretation). For these services, the physician must not bill the carrier "globally" or use the "TC" modifier for services rendered to either inpatients or outpatients of a hospital.

For additional information, refer to Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the Medicare Claims Processing Manual.

CMS "Place of Service" Codes:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

SMOKING REGULATIONS

In accordance with The Joint Commission and the Surgeon General's guidelines, Las Palmas Del Sol Healthcare prohibits the use of tobacco products and/or e-cigarettes anywhere within its facilities by patients, visitors, medical staff or employees.

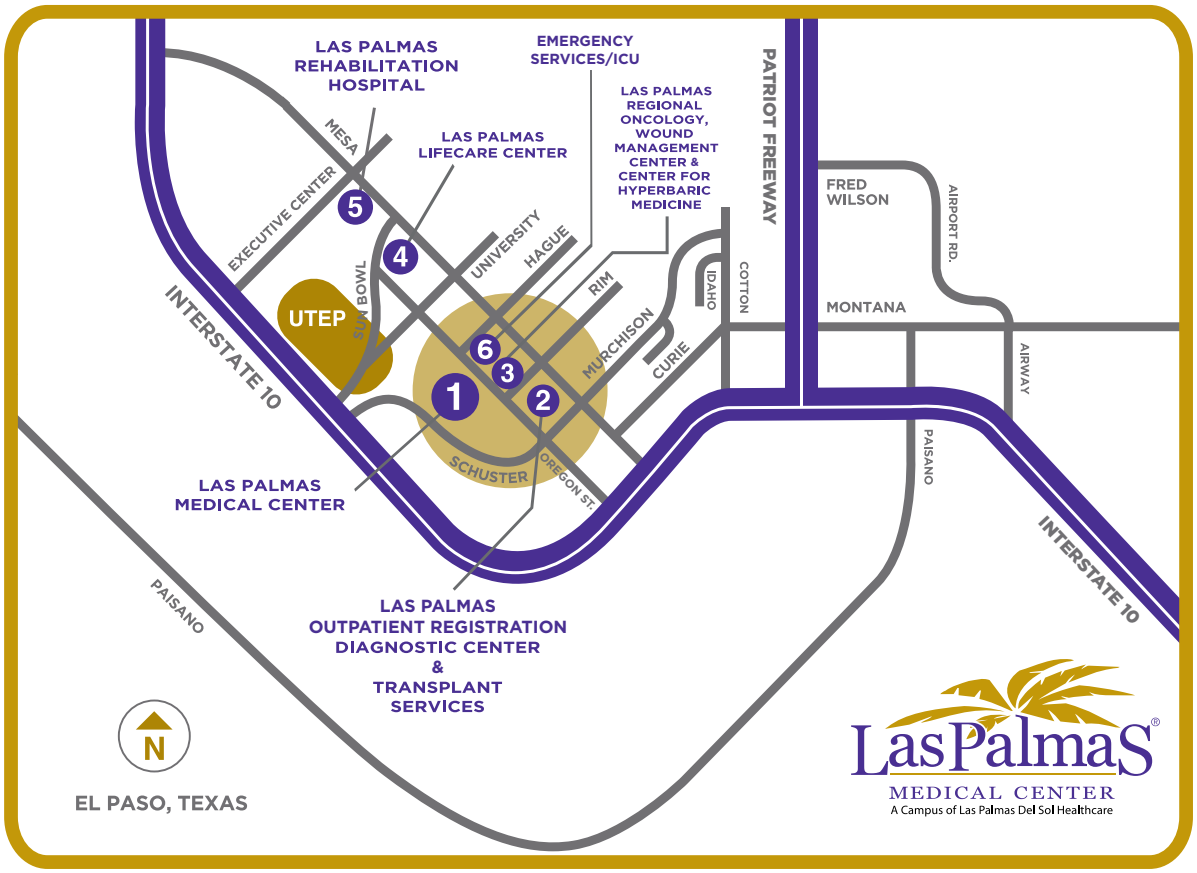
PHONE DIRECTORY

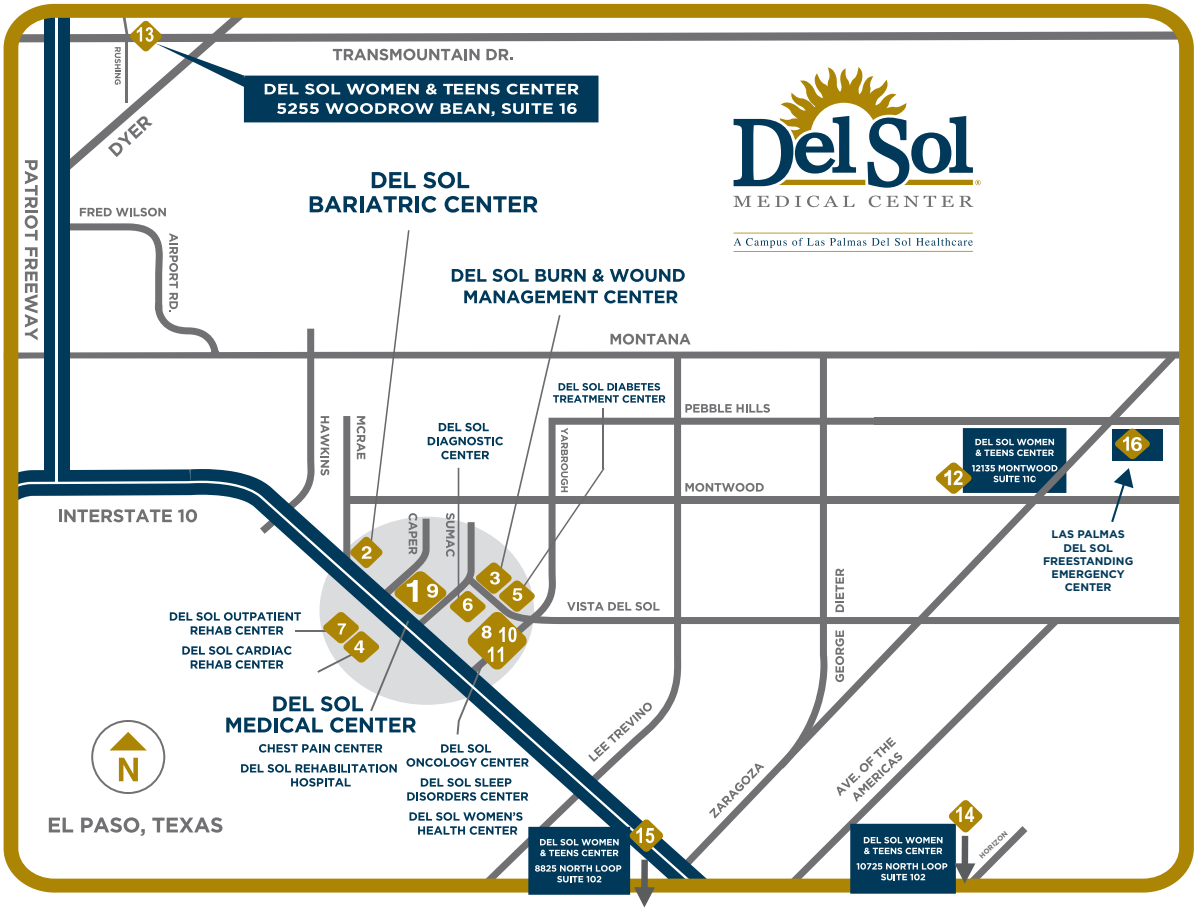
The Las Palmas Del Sol phone directory can be found at laspalmasdelsolhealthcare.com under Patients & Visitors, Helpful Numbers.

LAS PALMAS MEDICAL CENTER (BASIC DIRECTORY)	
ACCOUNTING PAYABLE/RECEIVABLE	1.866.656.9158
ADMINISTRATION	521.1670
ADMIN. NURSING	521.1136
AOD/NURSING SUPERVISOR	521.1136
ADMITTING	521.2976
ADMITTING/REGISTRATION OMB	521.1180
BIO-MED	521.1149
BURN/WOUND CENTER....WOUNDCARE	521.1210
CATH LAB	521.1397
CARDIAC REHAB/LIFECARE CENTER	521.2199
CARDIOLOGY	521.1478
CASE MANAGEMENT	521.1535
CASHIERS DEPT.	521.1185
CHAPLAIN (SPIRITUAL CARE)	521.1117
CONTRACT COMPLIANCE	521.1649
CAT SCAN	521.1197
DIALYSIS DEPT.	521.1745
DOCTOR'S DICTATION LINE	1.866.721.0012
ECHO DEPT.	521.1291
EEG & EMG	521.1176
EKG DEPT.	521.2950
EMERGENCY ROOM	521.1266
EMERGENCY REGISTRATION	521.1188
ENDOSCOPY	521.1423
ENVIRONMENTAL SERV. (HOUSEKEEPING)	521.1248
ETHICS & COMPLIANCE	521.1792
FINANCIAL COUNSELORS	521.1329
FOOD SERVICE	521.2012
GIFT SHOP	521.1284
GREETERS	521.3148
H.B.O. (HYPERBARIC OXYGEN)	521.1322
HEALTH NURSE & INFECTION CONTROL	521.1139
H.L.A. LAB	521.1823
HUMAN RESOURCES (PAYROLL)	521.1469
INJURY HOT LINE (EMPLOYEE)	309.2571
IMAGING SCHEDULING	521.1150
KIDNEY TRANSPLANT	521.1828

LAS PALMAS MEDICAL CENTER (BASIC DIRECTORY)		
LABORATORY	1866.656.9158	521.1171
LAB — OUTPATIENT		521.1570
MAINTENANCE (ENGINEERING)		521.1486
MATERIALS (SHIPPING/RECEIVING)		521.1174
MEDICAL RECORDS		521.1129
MEDICAL STAFF		521.1664
MRI DEPT.		521.1184
NURSING EDU (TRAINING & DEVELOPMENT)		521.1791
OR SURGERY		521.1175
OR SCHEDULING		521.1208
OUTPATIENT SURGERY		521.1214
PACU (RECOVERY)		521.1178
PATHOLOGY		521.1383
PBX OPERATORS		521.1117
PHARMACY		521.1649
RADIOLOGY		521.1197
PBX OPERATORS		521.1200
PHARMACY		521.1260
RADIOLOGY		521.1155
RESPIRATORY		521.1277
SAFETY OFFICE		521.1829
SECURITY DEPT.	.	521.1124
STERILE PROCESSING		521.2478
THERAPY SERVICE		521.1274
VASCULAR DEPT.		521.1261
VOLUNTEERS		521.1699
WAREHOUSE (MATERIALS MGMT.)		521.1699
NURSING UNITS		
EMERGENCY		521.1266
ICU DEPT.		521.1165
ICU NEURO DEPT.		521.1340
TELEMENTRY		521.1390
ANTEPARTUM		521.1410
POSTPARTUM		521.1410
LABOR & DELIVERY (FMS)		521.1493
NEWBORN NURSERY		521.1440
NICU NURSERY		521.1415
MEDICAL		521.1590
SURGICAL/ORTHO		521.1593
WOMEN SERVICES/ONCOLOGY		521.1690
PICU		521.1720
PEDIATRICS		521.1790

DEL SOL MEDICAL CENTER			
ADMINISTRATION	263.5202	MEDICAL RECORDS ROI	263.5245
ADMIN.NURSING	263.5213	MEDICAL STAFF SERVICES	263.5220
NURS.SUPERVISOR/AOD	263.3290	MRI	263.5153
ADMITTING	263.5230	NICU	263.5493
ASU-AMBULATORY SVCS.	263.5080	NEWBORN NURSERY	263.5492
BIO-MED.	263.5248	PHARMACY	263.5100
CATH LAB	263.5052	RADIOLOGY/IR	263.5150
CENTRAL SUPPLY	263.6020	RECOVERY/PACU	263.5040
CHAPLAIN	263.5241	RESPIRATORY	263.5280
CVICU	263.5070	SECURITY	**263.5265**
DIALYSIS	263.6160	STERILE PROCESSING	263.5045
ECHO	263.5192	SURGERY	263.5020
EEG/EMG	263.5182	SURGERY SCHEDULING	263.5044
EKG	263.5060	TRANSPORT/MAIL ROOM	263.5177
EMERGENCY DEPT.	263.5000	VASCULAR/DOPPLER	263.5180
ENDOSCOPY	263.5195	VOLUNTEER DESK	263.5242
FOOD SERVICE	263.6255	3 NORTH — TELEMETRY	263.5392
HEART RECOVERY	263.5175	3 SOUTH — MED/ONC	263.5391
HOTLINE	263.5660	3 WEST — NEURO/ORTHO/SURG.	263.5390
HOUSEKEEPING	263.2254	4 NORTH — MED/SURG	263.5494
ICU	263.5250	4 SOUTH — OB GYN/MOTHER/BABY	263.5491
INFECTION CONTROL	263.6451	5 NORTH — MED/ORTHO	263.5592
LABOR & DELIVERY	263.5490	5 SOUTH — MEDICAL	263.5591
LAUNDRY	263.3084	5 WEST REHAB	263.5590
MAINTENANCE	263.5147	PBX OPERATOR	595.9000
MEDICAL RECORDS	263.5215		


LAS PALMAS REHABILITATION HOSPITAL
EMERGENCY SERVICES/ICU
LAS PALMAS REGIONAL ONCOLOGY, WOUND MANAGEMENT CENTER & CENTER FOR HYPERBARIC MEDICINE
LAS PALMAS LIFECARE CENTER
PATRIOT FREEWAY
FRED WILSON
AIRPORT RD.
MESA
EXECUTIVE CENTER
UNIVERSITY
HAGUE
RIM
IDAHO
COTTON
MONTANA
INTERSTATE 10
SUN BOWL
UTEP
MURCHISON
CURIE
AIRWAY
PAISANO
SCHUSTER
OREGON ST.
LAS PALMAS MEDICAL CENTER
LAS PALMAS OUTPATIENT REGISTRATION DIAGNOSTIC CENTER & TRANSPLANT SERVICES
INTERSTATE 10
PAISANO
N
EL PASO, TEXAS
LasPalmaS
MEDICAL CENTER
A Campus of Las Palmas Del Sol Healthcare


TRANSMOUNTAIN DR.
RUSHING
DEL SOL WOMEN & TEENS CENTER
5255 WOODROW BEAN, SUITE 16
DYER
PATRIOT FREEWAY
FRED WILSON
AIRPORT RD.
DEL SOL BARIATRIC CENTER
DEL SOL BURN & WOUND MANAGEMENT CENTER
MONTANA
DEL SOL DIABETES TREATMENT CENTER
PEBBLE HILLS
HAWKINS
MCRAE
DEL SOL DIAGNOSTIC CENTER
YARBROUGH
MONTWOOD
DEL SOL WOMEN & TEENS CENTER
12135 MONTWOOD SUITE 110
INTERSTATE 10
CAPER
SUMAC
LAS PALMAS DEL SOL FREESTANDING EMERGENCY CENTER
VISTA DEL SOL
DIETER
DEL SOL OUTPATIENT REHAB CENTER
DEL SOL CARDIAC REHAB CENTER
GEORGE
DEL SOL MEDICAL CENTER
CHEST PAIN CENTER
DEL SOL REHABILITATION HOSPITAL
DEL SOL ONCOLOGY CENTER
DEL SOL SLEEP DISORDERS CENTER
DEL SOL WOMEN'S HEALTH CENTER
LEE TREVINO
ZARAGOZA
AVE. OF THE AMERICAS
DEL SOL WOMEN & TEENS CENTER
8825 NORTH LOOP SUITE 102
DEL SOL WOMEN & TEENS CENTER
10725 NORTH LOOP SUITE 102
VONTRON
N
EL PASO, TEXAS
Del Sol
MEDICAL CENTER
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