

## STUDENT PACKET

Please complete and return the attached packet at least 3 weeks PRIOR to your scheduled rotation at Meadowview Regional Medical Center.

If you have questions please call 606-759-3112.

Thank you.

Stacey Cropper  
Administration Assistant

## MEADOWVIEW REGIONAL MEDICAL CENTER

### MEDICAL/AHP STUDENT ROTATIONS POLICY

#### POLICY

It is the policy of Meadowview Regional Medical Center to establish and enforce the procedure for Medical/ AHP student rotations.

#### PURPOSE

It is the purpose of this policy to ensure a uniform and standard procedure for medical student rotations in the hospital under physician supervision.

#### SCOPE

This policy covers all Medical/AHP students during their rotation while at MRMC.

#### SCOPE OF PRACTICE

Students are not licensed and, therefore, are not legally or ethically permitted to practice. A student may be involved in assisting in the care of a patient, but only at the direction and guidance of a licensed physician. Students will have an opportunity to accompany their supervising/sponsoring physician while making hospital rounds, perform history and physicals, participate in patient care, utilize their skills in diagnosis, principles, practice and treatment, and be generally introduced to hospital routine. Students may attend medical staff department meetings related to their rotation service.

#### RESPONSIBILITIES

It is the responsibility of the MRMC Medical Staff to ensure compliance with the provisions stated within this Policy.

Physicians are responsible for medical care of the patient and for approving and countersigning all history and physicals, orders, progress notes, etc. written by the student.

#### PROCEDURES

The supervising/sponsoring physician will notify Administration when a student rotation is planned.

Prior to the student accompanying a physician in the hospital, the following items need to be on file in the Administration Office:

- a. Current Affiliation/Externship Agreement for School on file
- b. Immunization records of student (include TB & Drug Screen)
- c. Signed confidentiality agreement
- d. Proof of Liability Insurance coverage on file
- e. Signed Code of Conduct Statement
- f. Signed Background Authorization forms
- g. Signed Information/Education Acknowledgment
- h. Name Badge with photograph (upon arrival)

Following receipt of above items, a memo will be sent to the various hospital departments and the medical staff informing them of the student's presence and will outline the time frame of the student's rotation.

Originated: 3/08

Reviewed: 5/12

SPONSORING PHYSICIAN

Name of Student: \_\_\_\_\_

Dates of Student Rotation: \_\_\_\_\_

\* \* \* \* \*

Sponsoring Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Number: \_\_\_\_\_ Type of Practice: \_\_\_\_\_

Dates of Student Rotation: \_\_\_\_\_

During this student's rotation it is understood that the student, at all times, will be under my direct guidance and supervision.

\_\_\_\_\_  
Sponsoring Physician's Signature

\_\_\_\_\_  
Date

**MEADOWVIEW REGIONAL MEDICAL CENTER  
MEDICAL STUDENT  
INFORMATION FORM**

Full Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**Premedical Education:**

College or University	Degree	Date of Graduation
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**Physician Assistant Education:**

College or University	Degree	Anticipated Date of Graduation
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**Medical Education:**

Medical School	Complete Address	Anticipated Date of Graduation
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Current Year in Program: (Please Circle)      1      2      3      4

**Status of CPR Certification:**

Date Issued	Location	Expires
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**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER:**

- A) Have you ever been charged with a criminal offense other than a minor traffic violation?  
 Yes    No
  
- B) Do you require special accommodation to perform the essential functions of the position?  
 Yes    No

I hereby certify that the information contained in this information form is true and correct to the best of my knowledge. By signature on this information form, I agree to abide by the policies and procedures governing medical students at Meadowview Regional Medical Center. Specifically, that medical students are allowed to examine patients, review charts and write orders in a patient's chart, but the orders must be countersigned by the supervising physician before the orders are carried out. I further agree to abide by all rules, regulations, policies and procedures of Meadowview Regional Medical Center during my preceptorship at said facility.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Preceptor(s)

\_\_\_\_\_  
Dates of clerkship/rotation

\_\_\_\_\_  
Name of Preceptor(s)

\_\_\_\_\_  
Dates of clerkship/rotation

\_\_\_\_\_  
Name of Preceptor(s)

\_\_\_\_\_  
Dates of clerkship/rotation



# Meadowview

REGIONAL MEDICAL CENTER

*Bridging the Future of Healthcare*

**TO: CREDENTIALS COMMITTEE  
C/O MEADOWVIEW REGIONAL MEDICAL CENTER  
989 MEDICAL PARK DRIVE  
MAYSVILLE, KENTUCKY 41056**

**RE: MENTAL & PHYSICAL COMPETENCE**

I have known \_\_\_\_\_ personally and professionally, and can attest to the fact that the above practitioner is mentally and physically competent to carry out his/her responsibilities for the privileges with which he/she has requested. I therefore recommend his/her appointment/reappointment to the Allied Health Professional staff of Meadowview Regional Medical Center.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print or Type Name & Title

1995  
1998  
1999  
2001  
2002  
**100**  
**SPOTLIGHT**  
TOP HOSPITALS

989 Medical Park Drive  
Maysville, Kentucky 41056  
(606) 759-5311

## Disclosure

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We ( \_\_\_\_\_ ) will obtain one or more consumer reports or investigative consumer reports (or both) about you for employment purposes. These purposes may include hiring, contract, assignment, promotion, re-assignment, and termination. The reports will include information about your character, general reputation, personal characteristics, and mode of living.

We will obtain these reports through a consumer reporting agency. Our consumer reporting agency is General Information Services, Inc. GIS's address is P.O. Box 353, Chapin, SC 29036. GIS's telephone number is (866) 265-4917. GIS's website is at [www.geninfo.com](http://www.geninfo.com).

To prepare the reports, GIS may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources.

You may inspect GIS's files about you (in person, by mail, or by phone) by providing identification to GIS. If you do, GIS will provide you help to understand the files, including trained personnel and an explanation of any codes. Another person may accompany you by providing identification.

If GIS obtains any information by interview, you have the right to obtain a complete and accurate disclosure of the scope and nature of the investigation performed.

The Federal Trade Commission provides a summary statement of your rights on its website at [www.ftc.gov/credit](http://www.ftc.gov/credit).

Please sign below to acknowledge your receipt of this disclosure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name



## Authorization

**Authorization:** By signing below, you authorize: (a) General Information Services, Inc. ("GIS") to request information about you from any public or private information source; (b) anyone to provide information about you to GIS; (c) GIS to provide us ( \_\_\_\_\_ ) one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. GIS may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge receiving the Federal Trade Commission's "Summary of Your Rights under the Fair Credit Reporting Act." You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

**Personal Information:** Please print the information requested below to identify yourself for GIS.

Printed name:

\_\_\_\_\_

First	Middle	Last	Maiden
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Other names used: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Current and former addresses:

_____	current	_____	_____
from Mo/Yr		Street	City, State & Zip

_____	_____	_____	_____
from Mo/Yr	to Mo/Yr	Street	City, State & Zip

_____	_____	_____	_____
from Mo/Yr	to Mo/Yr	Street	City, State & Zip

Some government agencies and other information sources require the following information when checking for records. GIS will not use it for any other purposes.

_____	_____
Date of birth	Social security number

_____	_____
Driver's license number & state	Name as it appears on license

**Professional Licensure/Certifications:**

_____	_____
Professional License Held	License Number and State Issued

_____	_____
Professional License Held	License Number and State Issued

**Education (Please provide level completed):**

_____	_____
High School	City, State

_____	_____	_____	_____
Dates Attended (MO/YEAR)	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	GED or Diploma	Name while attending

_____	_____
Institute/College/University Name	City, State

_____	_____	_____	_____
Dates Attended (MO/YEAR)	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Degree Earned	Name while attending

**Employment to cover up to 7 years** (attach additional page if needed) - If employed through an Agency, please provide the Agency name instead of the company name or hospital.

May we contact your current employer?  Yes  No

Employer Name	City, State	Phone Number	Supervisor
Dates: To / From (MO/YEAR)	Job Title	Reason for Leaving	
Employer Name	City, State	Phone Number	Supervisor
Dates: To / From (MO/YEAR)	Job Title	Reason for Leaving	
Employer Name	City, State	Phone Number	Supervisor
Dates: To / From (MO/YEAR)	Job Title	Reason for Leaving	

**Professional References (Please provide 3 references):**

Reference Name	City, State	Phone Number	Alt Phone Number
Reference Name	City, State	Phone Number	Alt Phone Number
Reference Name	City, State	Phone Number	Alt Phone Number

**Report Copy:** If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: .

Signature \_\_\_\_\_ Date \_\_\_\_\_

Para informacion en espanol, visite [www.ftc.gov/credit](http://www.ftc.gov/credit) o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

### A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for additional information.

- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need—usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.ftc.gov/credit](http://www.ftc.gov/credit).
- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identify theft victims and active duty military personnel have additional rights. For more information, visit [www.ftc.gov/credit](http://www.ftc.gov/credit).

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center – FCRA; Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency; Compliance Management, Mail Stop 6-6; Washington, DC 20219; 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Consumer Help (FRCH); P O Box 1200; Minneapolis, MN 55480; Telephone: 888-851-1920; <a href="http://www.federalreserveconsumerhelp.gov">www.federalreserveconsumerhelp.gov</a> ; Consumer-Help@FederalReserve.gov
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision; Consumer Complaints; Washington, DC 20552; 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration; 1775 Duke Street; Alexandria, VA 22314; 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation; Consumer Response Center, 2345 Grand Avenue, Suite 100; Kansas City, Missouri 64108-2638; 877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation; Office of Financial Management; Washington, DC 20590; 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture; Office of Deputy Administrator – GIPSA; Washington, DC 20250; 202-720-7051

## CONFIDENTIALITY AGREEMENT

As a member of the medical staff, I recognize that effective credentialing, peer review and performance improvement cannot be achieved unless the confidentiality of all discussions, deliberations, record and other information generated in connection with these activities is maintained. I further recognize that such confidentiality is necessary to ensure the candid participation of staff members in these activities which is critically important for the evaluation and improvement of the quality of care rendered in the hospital.

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and information related to these activities. I agree not to disclose voluntarily any such information to anyone, except to persons authorized to receive it in the conduct of the medical staff affairs or as directed by the medical executive committee or the hospital's board. If I have any questions regarding whether information is confidential, I will consult the Chief of Staff and the hospital administration prior to disclosing it.

I understand that the hospital and its medical staff are entitled to undertake such action as deemed appropriate to ensure that this confidentiality is preserved. I further understand and acknowledge that any breach of this agreement, or threatened breach of this agreement, may subject me to legal action to prevent disclosure as well as corrective action under the medical staff bylaws.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For help with a privacy related concern or to report a complaint or possible violation of the Patient Privacy Program, please contact your supervisor, another member of local management, your local facility privacy officer, the corporate privacy officer, or the corporate ethics line at: **1-877-508-LIFE (5433)**.

- P** - Protect patient health information (PHI) as if it were your own information.
- R** - Respect patient requests regarding how their information should be used and disclosed.
- I** - Inform patients of how you will use and disclose their individually identifiable information.
- V** - Verify the identity of all persons that may request access to protected health information.
- A** - Assess access to the minimum necessary amount of information needed to do your job.
- C** - Comply with the standards for Patient Privacy explained in the Patient Privacy Program Brochure.
- Y** - You, are responsible for how you use and disclose patient information - Remember, We care about our patient's and their right to privacy.

# Acknowledgment

I acknowledge that I have received LifePoint Hospitals' Code of Conduct. I understand that it represents mandatory policies of the organization, and I agree to abide by it.

Signature \_\_\_\_\_

Position \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Facility \_\_\_\_\_

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# Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality, integrity and availability of their patients' health information. Additionally, the Company must assure the confidentiality, integrity and availability of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I agree that it is not acceptable to discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company. I will also return all Company access, authentication, and identification devices.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that actions in violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, termination of authorization to work within the Company, and/or civil liability or criminal prosecution.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, position screens away from public view and securing the workstation by logging off or (electronically/technically) locking it when not in use.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
  - a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
  - b. Use only approved licensed software.
  - c. Use devices in accordance with Company policies, procedures and standards.
15. I will never:
  - a. Share/disclose user-IDs, passwords or tokens.
  - b. Attempt to use tools or techniques to break/exploit security measures.
  - c. Connect to unauthorized networks through the systems or devices.
16. I will immediately notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if I have reason to believe my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I understand that should my personal patient records become part of the confidential information stored within this Company's information systems that access to these records using CPCS may not allow me to view my entire medical record. I understand many portions of the medical record are NOT available in PCI or other software systems and some documents may only be accessible via the paper record. I understand the PCI record is not the legal patient record and access to the legal patient record can be obtained only from the Health Information Management Department.

The following statements apply to physicians using Company systems containing patient identifiable health information:

18. I agree that I will only access information systems to review patient records of patients for which I am participating in their treatment. If I should need to access a patient record without being listed as a participating provider, I will document the access and attempt to acquire provider privileges as soon as possible.
19. I will ensure my office staff, who access the Company software systems and Confidential Information, are trained on issues related to patient confidentiality and access.
20. I will cooperate fully with any disciplinary action required as a result of inappropriate access to the Company software systems and Confidential Information by my employees.

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

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name and COID	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	

**MEADOWVIEW REGIONAL MEDICAL CENTER  
REAPPOINTMENT INFORMATION/EDUCATION PACKET**

I have received and reviewed MRMC's Reappointment Information/Education Packet which includes information pertaining to:

- Corporate Compliance & Ethics, Rights & Responsibilities
- Performance Improvement
- Confidentiality/HIPAA
- Core Measure Quality Initiatives
- Advance Directive
- National Patient Safety Goals
- Patient's Rights & Perception of Care
- Risk Management
- Infection Prevention & Control
- Pharmacy
- Pain Management Tools
- Medical Staff Code of Conduct
- Do Not Use Abbreviations
- Life Safety
- Illness & Impairment Recognition
- Medical Records

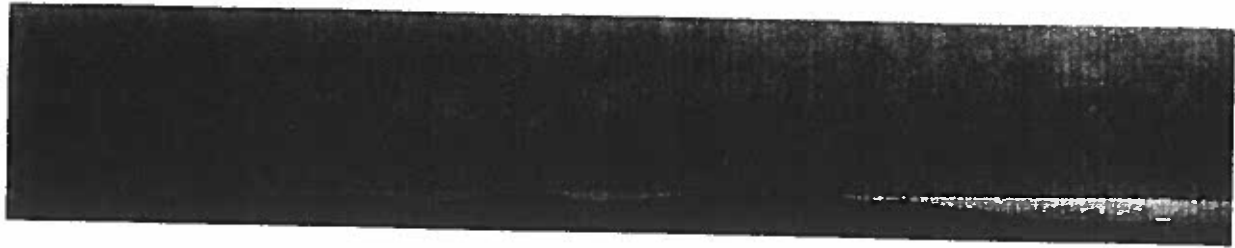
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Physician's Signature

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Date





I acknowledge that I have received training for LifePoint Hospital's Patient Privacy Program. I understand that it represents mandatory policies of the organization and my facility, and I agree to abide by it.

Signature \_\_\_\_\_

Position \_\_\_\_\_

Printed Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date \_\_\_\_\_

Facility \_\_\_\_\_

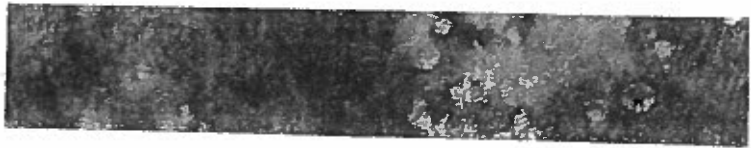
# Acknowledgment

## Patient Privacy Program

LifePoint  
Hospitals, Inc.

For help with a privacy related concern or to report a complaint or possible violation of the Patient Privacy Program, please contact your supervisor, another member of local management, your local facility privacy officer, the corporate privacy officer, or the corporate ethics line at: **1-877-508-LIFE (5433).**

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- C** - Comply with the standards for Patient Privacy explained in the Patient Privacy Program Brochure.
- Y** - You, are responsible for how you use and disclose patient information - Remember, We care about our patient's and their right to privacy.



# Acknowledgment

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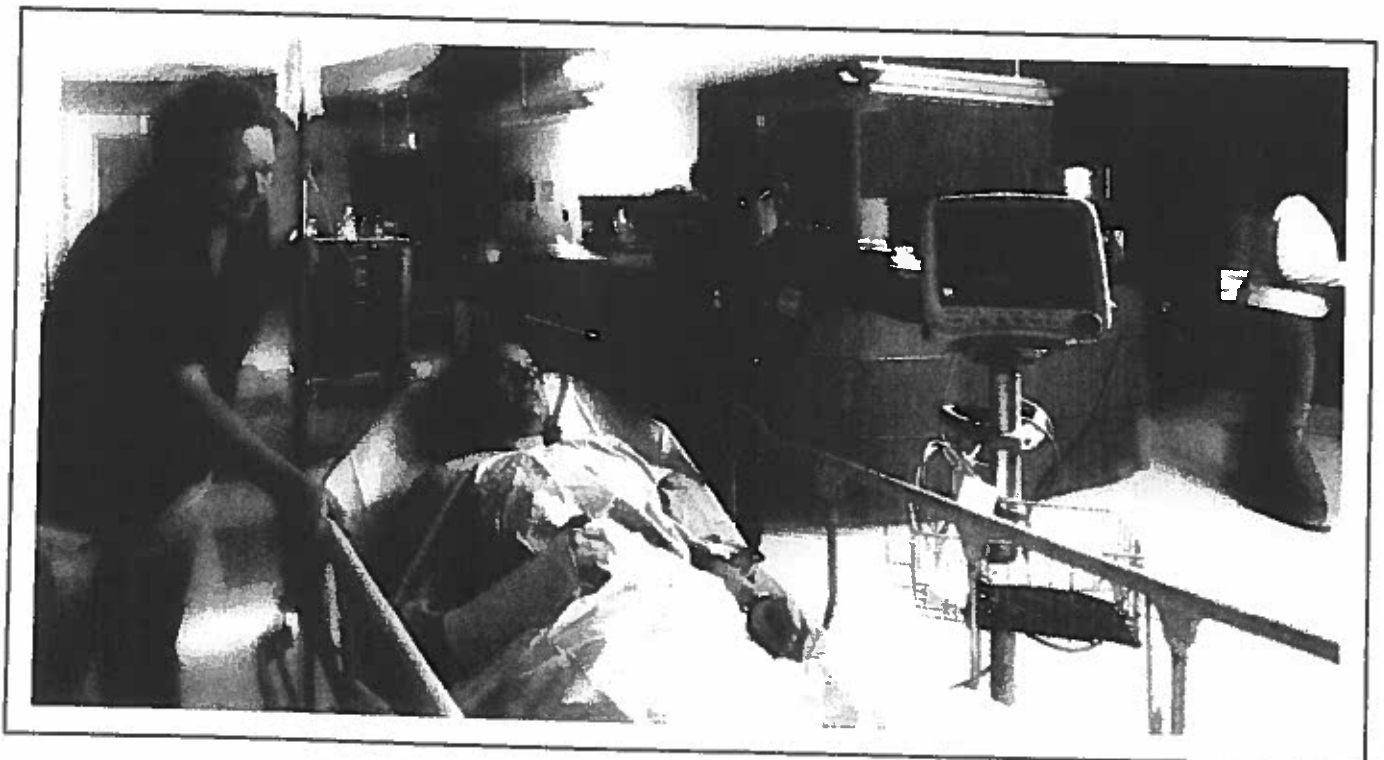
Signature \_\_\_\_\_

Position \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Facility \_\_\_\_\_



# MEDICAL STAFF EDUCATION

## OUR 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 the following value statements are essential and timeless.

We recognize and affirm the unique and intrinsic worth of each individual.

We treat all those we serve with compassion and kindness.

We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.

We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

## STRATEGIC GOALS FOR OUR ORGANIZATION VALUES

Meeting goals is critical to the fulfillment of our vision. Achieving excellence in quality, service and community positions us as a leader in providing patient-centered care. The High Five Guiding Principles are:

- Delivering high quality patient care
- Supporting physicians
- Creating excellent workplaces for our employees
- Strengthening the hospital's role in community
- Ensuring fiscal responsibility

## LEADERSHIP

The governing body is ultimately accountable for the safety and quality of care, treatment and services of Meadowview Regional Medical Center. The medical staff is responsible for overseeing the quality of care provided by individuals with privileges. Leaders from different groups (governance, medical staff, and senior management) bring different skills, experiences and perspectives to MRMC. Working together, leaders from all groups have the opportunity to participate in discussions and have their opinions heard.

## CORPORATE COMPLIANCE & ETHICS, RIGHTS & RESPONSIBILITIES

It is the policy of Meadowview Regional Medical Center to comply with all applicable federal, state and local laws and regulations (civil and criminal). The Corporate compliance program applies to anyone associated with MRMC. Anyone who has knowledge of activities that he or she believes may violate the law or appear to be improper business conduct has an obligation to report the matter to the hospital's Ethics & Compliance Officer (Diana Kennedy). They may also make an anonymous report via the Corporate Ethics Line (1-877-508-5433).

## PERFORMANCE IMPROVEMENT

Performance Improvement is the process utilized to monitor and improve the safety and quality of care, treatment and services provided by MRMC. It is a continuous process and involves collecting and analyzing data and identifying changes which will enhance performance and improve patient outcomes.



## CONFIDENTIALITY/HIPAA

Patient information should only be shared with other healthcare providers on a "need to know" basis and should be shared in a confidential manner. Sharing patient information with facilities/agencies involved in providing care to the patient does not violate HIPAA regulations. Providing patient information as follow-up for quality of care or outcome is not a violation of HIPAA regulation.



## CORE MEASURE QUALITY INITIATIVES

Core measures are national standards of care for patients undergoing certain surgical procedures or having certain medical conditions. The measures are based on scientific evidence which is constantly evaluated by healthcare experts and researchers to ensure the measures and guidelines are kept up-to-date. The four core measure categories include Heart Failure, Acute MI, Pneumonia and the Surgical Care Improvement Project.

Compliance with the use of these standardized measures is reported to the Center for Medicare and Medicaid Services (CMS) and The Joint Commission. The results are compared to other hospitals across the country. The comparative data is reported publicly through CMS. The medical staff collaborates with other disciplines to improve processes of care to improve compliance with these core measures.

## **ADVANCE DIRECTIVE**

An Advance Directive is a legal document instructing physicians and other caregivers as to what treatment the patient wants (or does not want) to receive if he/she becomes unable to give instructions. There are three types of documents to communicate patient wishes: Advance Directives, Living Will and Durable Power of Attorney for Healthcare.

A valid Advance Directive is completed by an individual to express his/her wishes. Family members cannot complete the patient's Advance Directive but can represent the patient by acting as the surrogate decision maker. The Advance Directive is not a Do Not Resuscitate Order. Additionally, an Advance Directive does not go into effect until the patient can no longer speak for him/herself, and the treatment is considered to be life sustaining, but the condition is not curable.

## **ADHERENCE TO NATIONAL PATIENT SAFETY GOALS: 2013**

- Reduce the risk of patient harm resulting from falls.
- Reduce the risk of surgical fires
- Improve the effectiveness of communication among caregivers
- Read back verification of critical test results and verbally reported values. (Critical tests results should be reported to the physician within one hour of receipt)
- Accurately and completely reconcile medications across the continuum of care.
- Hand hygiene to decrease the spread of infection.
- Rapid Response Team (RRT) encourages early recognition and appropriate response and intervention to changes in patient's condition.
- The use of standardized practices for anticoagulation therapy which include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin and warfarin.
- Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).\*
- Patient Identification
- Surgical Safety in the OR

## **PATIENTS' RIGHTS & PERCEPTION OF CARE**

Meadowview Regional medical Center recognizes and respect the dignity and individuality of each person admitted or treated within our facilities. Some patient's rights include:

- To be treated with respect, honesty and hospitality.
- To be informed and involved in the care to be provided and made aware of the risk, benefits and alternatives to any procedure being performed. (The person performing the procedure should be the one to explain the risk, benefits and alternatives).
- To refuse care or treatment, and to know the outcome of their care – even when it was not the expected outcome.

Patient satisfaction is formally measured through the use of the HealthSteam telephone survey. Surveys are conducted on inpatient, outpatient testing and emergency, ambulatory and surgery patients. Benchmark data from other LifePoint hospitals is used to determine percentile ranking of performance in patient satisfaction.

Meadowview also conducts the required survey submitted to the CMS and publicly reported. This survey of Medicare patients, referred to as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), is used to compare patients' perceptions of care among all hospitals and across the country.

Root Cause Analysis: A Root Cause Analysis (RCA) is a process used for identifying causal factors of an actual occurrence or "near miss" caught before an error occurs. The analysis focuses on systems and processes – not individual performance. Information gained and improvement strategies implemented are reported through medical staff committee and to the Governing Board.

Failure Mode Effect & Criticality Analysis (FMEC): FMEC is a systematic, proactive technique used to identify and address problems before they occur. The technique analyzes a process to identify the possible ways it might fail, the effects of failure and the possible causes of the failure. A FMEC may be conducted on a high risk process or a newly implemented process or procedure. Results are communicated to medical staff committees and the Governing Board.

## **Risk Management**

MRMC proactively pursues risk reduction and encourages everyone to report any safety or quality concerns to a supervisor, Administration or the Risk Manager (Tammy Mastin). If you feel your concern has not been resolved, you may contact The Joint Commission's Office of Quality Monitoring without fear of retaliatory action at: (800) 994-6610.

### Disclosure of an Adverse Event to Patient or Surrogate Decision

Maker: An event, occurrence or situation involving the clinical care of a patient resulting in death, compromising patient safety or resulting in an unanticipated injury requiring the delivery of additional health services to a patient should be disclosed to the patient or their surrogate decision maker. The attending physician or a



designated employee will communicate with the patient or representative. The disclosure should state only the facts of the occurrence, and should not include any suppositions or incrimination of another party. Serious events may be reportable to regulatory or accrediting services under the direction of Administration.

## **Infection Prevention & Control**

Meadowview Regional Medical Center has a coordinated prevention program for healthcare associated infections, surveillance efforts, policies, and public reporting issues. Policies are based on prevention guidelines published by CDC and other recognized authorities.

Physicians are considered in all areas of infection prevention, including the following:



- Standard precautions for patient care, hand hygiene, personal protective equipment, cleaning and disinfection, and waste management.
- Management of exposure control; airborne illness and exposures to blood or other potentially infectious body fluid which may be reported to the Infection Control Nurse. Pharmacy maintains emergency stock of anti-retroviral recommended for possible HIV exposure.
- Vaccination is offered at no cost; current vaccinations include Hepatitis B, Influenza, Varivax, and Tdap, as well as Td.
- Tuberculosis control with PPD skin testing and respirator fit testing are available at no cost; each facility has negative pressure rooms to house patients that are suspected to have pulmonary TB.

Focuses on infection prevention include close observations on best practices for the following conditions:

- Central Line Associated Blood Stream Infection
- Surgical-Site Infections
- Multi-Drug Resistant Organism Infections (MDRO) and C-difficile infections

### Pharmacy

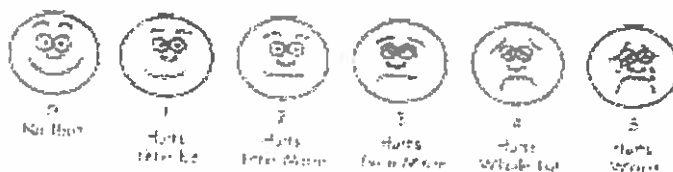
The Pharmacy Department communicates medication shortages and outages to the medical staff and provides education regarding anticoagulation therapy to staff, patients and families and the medical staff. Medication substitution protocols for shortages or outages are communicated through the Department of Medicine/Pediatrics.

### Pain Measurement Tools

Pain assessment is documented, as applicable, on the appropriate pain monitors including admission history, admission assessment, shift assessment and nursing diagnosis. An appropriate pain scale rating will be utilized in conjunction with physiological data to guide pharmacological management of pain. The Pain Management Policy provides visual examples of pain rating scales.

**Standard Scale:** This 0-10 numeric pain intensity scale is used to assess an adult patient's pain level if they display appropriate cognitive and verbal skills. It is a visual numeric scale (VAS) and consists of a straight line with end points identified as 0 (No Pain) to 5 (Distressing pain) to 10 (Unbearable pain).

**Wong Baker Faces Pain Rating Scale:** This pain scale will be considered for pediatric patients as well as those with impaired cognitive and communication barriers.



**FLACC Pain Scale:** The FLACC (Face, Legs, Activity, Cry & Consolability) scale should be used with ANY patient who is unable to use the VAS or FACES scale. This includes non-verbal patients, patients on a ventilator or patients with limited English proficiency (LEP). Each of the five categories is scored from 0 – 2, which results in a total score between zero and ten. Teaching patients and families (when appropriate) methods of pain management is part of their treatment.

### Medical Staff Code of Conduct

All Medical Staff and Allied Health members practicing at MRMC must treat others with respect, courtesy and dignity and must conduct themselves in a professional and cooperative manner. The Medical Staff Unprofessional Conduct addresses conduct that does not meet this standard. Negative statements about another care provider should not be written on the patient record. Concerns should be reported through the proper channels.

**Impairment:** Issues of impairment relating to members of the medical staff are referred to the Physician Advisory Committee ("PAC") which is the Executive Committee. If any individual has a concern that a member of the medical staff is impaired in any way that may affect his or her practice at the hospital, a written report shall be given to the Chief Executive Officer, or Chief of Staff/President of the Medical Staff, the Department Chairman, or any member of the Physician Advisory Committee.

### Do Not Use Abbreviations

Abbreviation	Preferred Term
U, u (for unit)	Write "unit"
IU (for international Unit)	Write "international unit"
Q.D., QD, q.d., qd	Write "daily"
Q.O.D., QOD, q.o.d., qod	Write "every other day"
Trailing zero	Never write a zero after a decimal
Lack of a leading zero	Use a zero before a decimal
MS	Write "morphine sulfate"
MS04	Write "morphine sulfate"
MgS04	Write "magesium sulfate"
Ug (microgram symbol)	Write "mcg" or "microgram"
gr (for grain)	Write "grain"
Ad, AS, AU	Use "right ear", "left ear", or "each ear"
TIW or tiw	Cannot be used for "3 times a week"



## LIFE SAFETY

Code Red

Code Yellow

Code Blue

Code Brown

Code Orange

Code Black

Code White

## Emergency Codes

Fire

Internal/External Disaster

Respiratory/Cardiac Arrest

OB emergency

Abduction

Aggressive/Violent Behavior

Haz Mat Spill/Release (Internal/External)

Bomb Threat

Hostage/Weapon

Severe Weather/Tornado (Watch or Warning)

**Emergency Management:** The Emergency Management Plan is designated to care for a large number of victims resulting from a disaster. Medical staff participation is part of the plan on an "as needed" basis. After evaluating the situation, the emergency department physician will determine the number and specialties needed to assist.

### Fire Safety:

**In case of fire**

**R**emove the patient

**A**ctivate plan

**C**ontain fire

**E**xtinguish flame if safe to do so

**Fire Extinguisher**

**P**ull pin

**A**im at base of fire

**S**pray

**S**weep



**Hazardous Materials:** A Material Safety Data Sheet (MSDS) is printed material concerning a hazardous chemical. It is located in the House Supervisor's office and includes (1) first aid procedures, (2) chemical make-up and (3) chemical handling and disposing protocol. If you identify a hazardous spill, remain at the site to keep other from coming into contact with the substance. Information is also available online (Facility Share).

**Electrical Safety:** **RED** is the color indicating emergency power for outlets and light switches. Cell phones, walkie-talkies and all other radio frequency producing devices should not be used within 5 feet of medical equipment!

our hospital  
meadowview regional

[www.meadowviewregional.com](http://www.meadowviewregional.com)

## LifePoint IT&S Security Access Form (Facility)

Applicant Last Name		Applicant First Name		MI or "NA"	Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> PRN	Start Date
Work Address 989 Medical Park Drive			City, State, Zip code Maysville, KY 41056		Request Number	
Phone Number 606-759-		EXT.	Date of birth - - 19		SS# of User - -	
User Type <input checked="" type="checkbox"/> Life Point <input type="checkbox"/> Contractor Company name & phone # required for Contractor/Vendor <input type="checkbox"/> Vendor					Exp. Date for Contract or Vendor	
<b>Expiration and Approval Requirements</b>			Expiration date must be supplied in field 10 for "Contractors" and "Vendors". The expiration date should be the end of the contract or engagement period.			
Department #		Department Name			Job Title	
Universal ID		Network login if different from UID Same			Domain LPNT	
Applicant Signature			(19) E-Mail Address			(20) Date
<b>Authorizing Security Coordinator Statement</b>		By signing this request I am stating that I have reviewed the above information for completeness and it is accurate to the best of my knowledge. Also I have reviewed the Information Security Agreement and verified that it has been completely filled out and signed. Also that I verify this request and authorize its processing. 2 signatures required.				
(21) Director/Administrative Rep Signature		(22) Security Coordinator Signature			(23) Date	
(24) Director/Administrative Rep Printed Name		(25) Security Coordinators Printed Name			(26) Phone Number of HDIS / LSC 606-759-3234	

Applicant has Information Confidentiality & Security Agreement on file  Yes  No

Action:  New  Add  Change  Delete  Terminate Effective Date:

Access Granted By HDIS/LSC	Level	Other Comments
<input checked="" type="checkbox"/> Meditech		
<input type="checkbox"/> Discharge 1-2-3 – ER		
<input type="checkbox"/> Kronos		
<input type="checkbox"/> NT/AD Account		
<input type="checkbox"/> Exchange Email	Nickname?	
<input type="checkbox"/> Remote VPN Connectivity		
<input type="checkbox"/> Secure ID Card		
<input type="checkbox"/> VPOM Access	<input type="checkbox"/> HR <input type="checkbox"/> Payroll <input type="checkbox"/> General	
<input type="checkbox"/> FTP Access	<input type="checkbox"/> HR <input type="checkbox"/> Payroll <input type="checkbox"/> Budget	
<input type="checkbox"/> FAS PC Best		
<input type="checkbox"/> Stars		
<input type="checkbox"/> TMS		
<input type="checkbox"/> Medselect		
<input type="checkbox"/> 3M Coding		
<input type="checkbox"/> Passport		
<input type="checkbox"/> HPS System	.....	
<input checked="" type="checkbox"/> PACS		

Provider Type:  MD  PA  NP

Comments: