PLAN FOR PROVIDING PATIENT CARE

PURPOSE

This plan describes the multidisciplinary and collaborative approach used to allow care to be delivered according to patient needs and to the hospital's scope of services. This approach is focused on optimal patient outcomes, service quality, and safety.

Why we are:

We are dedicated to protecting and promoting the health of the people who seek our services or attend our wellness programs. We actively work with other local providers and community organizations to promote health and encourage a healthy lifestyle.

PLAN

Mason Health's mission statement and set of core values provides the guiding principles for delivering patient care. Detailed plans and individualized patient care plans can be found in individual department/services, policy and procedure manuals, and standards of care and protocols.

Who we are:

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Mason Health (MH) is part of Mason County Public Hospital District No. 1 which is comprised of Mason General Hospital (MGH) and Mason Clinic (MC). MGH is a designated Critical Access Hospital (CAH) working closely with the Medical Staff to achieve our mission and vision. We offer a selected, broad range of services and selected technologies with quality of care for the patient as our primary focus. Our mission is ***'United Community, Empowered People, Exceptional Health'*** and our vision is '***Provide the best patient centered care in the Pacific Northwest***'. Our values of relationships and service is fundamental.

Inpatient and outpatient services are provided in patient care areas including, but not limited to: Intensive and Coronary Care Unit (ICCU), Emergency Department (ED), Medical-Surgical/Pediatrics (MSP), the Birth Center (BC), Surgical Services (SS), and Ambulatory Care Services (ACC). Detailed information for the patient care areas can be found in individual department scopes of practice.

Multidisciplinary and supportive services departments include, but are not limited to, pharmacy, physical therapy, laboratory, respiratory therapy, diagnostic imaging, case management,, diabetes education, Wound Care, and nutrition services.

MH has a Medical Executive Committee (MEC) that oversees and guides the Provision of Care and Services. Other governing bodies which include LIP guidance include but are not limited to: Pharmacy and Therapeutics, Physician Council, general Medical Staff meetings, independent clinic staff meetings.

The Organizational Structure consists of, but is not limited to: A Chief Executive Officer who reports directly to the Board of Hospital Commissioners (BOHC). The executive team also consists of a Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Development Officer (CDO), Chief Operating Officer (COO), Chief Compliance Officer, and Chief Nursing Officer (CNO) (see Organizational Chart for further details). The COO or CMO acts as Chief Nursing Officer when the CNO is away from the facility.

MGH has designated hospitalist's 24/7, 365 days a year. In addition, our ED is staffed 24/7, 365 days a year with board certified Emergency Medicine practitioners. For a list of providers, please see: Provider Call Schedules on the internal SharePoint site.

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Process for accepting patients:

Patients will be assigned to the appropriate department depending on their medical needs and regardless of their ability to pay, type of insurance, national origin, race, physical disability, religion, and sexual orientation. The physical environment will be maintained to provide a safe environment for our patients.

Patients arrive at MGH via one of the following: direct admission from provider offices, Licensed Independent Providers (LIP) referrals for services, and/or entry through the ED. MGH follows written procedures for registration, admission, and services. MGH provides a wide range of services including: inpatient, outpatient, operative, and other invasive procedures. The Medical Staff Office (MSO) maintains the information on LIP's with admission privileges to MGH. Patients who require admissions through the ED are assigned to the designated hospitalist for the required services.

Referral relationships are maintained by the MSO with a mix of specialty providers who attend patient care needs in one or more of the following ways: 1- Referral to a facility which provides the specialty services needed (ex. Dialysis, Cardiac Surgery, burn victims, etc.), 2- attend to the patient's needs during their hospital stay (ex. Pulmonology, Cardiology, Gastroenterology, etc.), and/or 3- by consult appointments arranged as part of post-discharge follow-up with such specialties.

Patients who may be under legal or correctional restrictions are accepted from the Mason County Jail and the Washington State Corrections Center (WCC). Policies and procedures for the continuing care, treatment, and services including the possible restrictions of rights and need for security/seclusion are maintained in collaboration with the correctional institutions. More information can be found by accessing MC Policies and Procedures site. **Patient Assessments**

In order to deliver the appropriate care, treatment, and services to our patient population, comprehensive patient assessments are conducted with admission and reassessments are done throughout the course of care, treatment, and services. These include, but are not limited to history, physical, nutritional, functional, medication history and reconciliation, psychosocial, cultural, social history, pain, fears and anxieties, family history, and spiritual assessments. Key elements for assessments and reassessments can be found in the individual service areas scope of

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care documents (see Department Specific Assessment policies/procedures).At a minimum, the need for further assessment is determined by the care, treatment, and services sought; the patients presenting condition(s); and whether the patient agrees to the recommended care, treatment, and services. Nationally recognized authoritative sources are used for defining specific data elements collected for the provision of individualized services(American Academy of Pediatrics, American Nurses' Association, World Health Organization, American College of Obstetricians and Gynecologists, etc.). In addition, processes are in place to provide a higher level of care if a change in the patient's condition warrants, e.g. Rapid Response Team or various patient-care related Codes. (Adult Code Blue; Code Stroke Protocol; Rapid Response Team RRT).

Information is, ideally, collected from previous patient history, and direct patient interview. As needed, and with the patients consent, the patient's family and other care providers may be accessed for essential information. The Patient Rights and Responsibilities Policy and the Advance Directives Policy (Patient Rights- Management; Advance Directive Policy and Procedure) delineate the accepted processes for accessing information when a patient is unable to speak for themselves.

In the direct patient care areas, Registered Nurses (RNs) are responsible for the initial assessment, the plan of care, and reassessments. Licensed Practical nurses may be delegated some of this data gathering activity. Focused assessments include, but are not limited to, pain, fall risk (Falls Prevention policy, Pain Management policy) system based reassessments, and skin integrity . Assessment and reassessment information includes the patient's perception of medication effectiveness and/or any side effects related to the patient's medications (see Medication Administration policy). Nationally recognized tools for assessment of pain, suicide risk, falls risks, and skin, for example, are utilized and the relative risks are communicated to all essential personnel. Referrals for support services are made based on those assessments, such as for Wound Care Services, Nutrition services, physical therapy, and case management /social services. Pastoral services are available by a number of community-based resources and any religious or spiritual preferences are part of the registration and admission process. As part of the MH continuum of care, the needs and requests of end-of-life care patients are honored as a priority. Patients identified (by self, family/friends, or nursing staff) as at risk for or showing signs of abuse and/or neglect are referred to Case Management, and to legal authorities as appropriate. Those with suspicion of domestic violence are supported, educated, and provided resources and

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referrals, and are encouraged to ensure safety in their homes (Adult Abuse; Child Abuse; Domestic Violence).

Mandatory annual education for all nursing staff includes adult and pediatric resuscitation, cultural awareness, abuse and neglect, domestic violence, skin assessment, suicide prevention, and developmental stages of life and their impact on delivery of care, among other targeted education.

Plans of care are individualized and updated as an ongoing process throughout the provision of care and services. Provider history, physical, rounding requirements, and progress notes, including pre-operative and procedure notes, are provided, maintained, and updated as prescribed in the Medical Staff bylaws.

Diagnostic Testing

MGH provides a wide range of diagnostic testing, both internally and through an extensive network of referral services. LIP orders are entered and a determination is made for which department or referred service provider is to be notified and with which the service should be scheduled. Results are provided either by internal systems or by our outside agencies. Normal value parameters are defined and reported by the service departments. Critical value results are defined and reported as outlined in the Critical Value policy (Critical Values and Critical Test Result Notification).

Plans of Care

Multidisciplinary plans of care, also referenced above, are based on, and modified by, the data from history, assessments, reassessments, testing results, and patients' responses to care and services provided. Patients and families are encouraged to participate in their plans of care and treatment as they are able to. Care plans include goals for treatment, timelines, patient's current status within the process, and plans for further care, treatment, and services needed to achieve the desired outcomes. Nursing plans of care are assessed and outcomes are documented every shift and as needed dependent on patient need. Need for further care, treatment, and services may result in planning for transfer to a higher level of care facility, transfer to a skilled nursing or

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rehabilitation facility, discharge to home with home services or other support, or discharge to home after meeting care goals.

Care, Treatment, and Services

MGH provides care, treatment, and services as ordered and/or prescribed, following all relevant state and federal regulations, as well as per MGH policies, procedures, and bylaws. All care treatment and services are provided in an interdisciplinary, collaborative manner. More complex patients receive a more formalized care conference (Multidisciplinary Care Conference).

Physician orders are either entered in the patients' electronic medical record (EMR) via computerized physician order entry (CPOE), or can be verbally or telephonically given (Computerized Order Entry; Provider Order Types).

MGH maintains and provides medical equipment, supplies, and medications, including emergency supplies (Adult Code Blue; Code Stroke Protocol; Rapid Response Team RRT), for all services and care within the MGH scope of license and services.

If patients or families have questions about the care, treatment, and/or services provided, information is posted and/or provided as part of their admission packet. This includes how to report concerns to the Washington State Hotline, The Joint Commission, DNV, and how to access the MGH Compliance Officer.

Investigational-Clinical Trials or Research

MASON GENERAL HOSPITAL does not conduct research, investigations or clinical trials involving human subjects. If the patient is already involved in a clinical trial through an outside agency, we will participate, as requested by the patient, by submitting required documentation per the guidelines in the clinical trials and/or research

Coordination of Care

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MGH provides many opportunities for multidisciplinary services and referrals. Coordination of care is provided and monitored through several disciplines and communication modes. The district wide shared EMR assists in coordination of scheduling and reporting of results. Intra- and inter-departmental reporting tools are used (Patient Care Communication). Patients are assisted with scheduling of services prior to discharge. Follow up appointments are scheduled within 3-5 days of discharge with the patients primary care provider (PCP). If the patients does not have a PCP, MGH will assist and schedule with the PCP on call. MH's Health Information Management department has processes in place for information requests and sharing of information with health care providers outside of our organization to ensure smooth transitions and accurate information.

Food and Nutrition

Dietary orders are entered into the electronic ordering system, and are based on physician order and any specific patient needs as identified during the nursing assessments (included: cultural, religious, ethnic considerations). Most patients are eligible for ordering from a select menu. Appropriateness of their order in relation to their ordered diet is monitored by the dietary technicians and Nutrition (Dietician) Services (Nutrition Care Plans- Interdisciplinary). Education and counseling are provided as needed. Consults are also available for those patients whose assessment reveals they have difficulty in swallowing.

If a patient is unable or unwilling to take oral nutrition, substitutes are provided of equal nutritional value, e.g. Total Parenteral Nutrition, health shakes. Patients also may opt to eat food provided by family or other outside sources; nursing assists with storage and labeling of food, as well as assessing appropriateness of the food in relation to the ordered diet (Visitors Bringing in Food for Inpatients).

We offer a wide variety of food options, including ethnic food.

Patient Education and Training

In order to equip the patient to provide for self-management, MGH assesses for learning needs and provides education and training, using various modes, depending on the patient's level of understanding, preferred learning methods, and needs.

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Patient preferred learning modes are obtained during the admission assessment, and are evaluated throughout the patient's stay. Cultural factors, emotional barriers, motivation and readiness to learn, physical and/or cognitive limitations, and barriers to communication all are taken into consideration. The Patient Admission handbook contains general health information including, but not limited to: hygiene, VTE prevention, smoking cessation, pain control, falls prevention, infection control, etc. Detailed information about specific patient education can be found in the patient-specific education record and in diagnosis-specific educational materials. Medication reconciliation and education processes receive separate and focused attention due to the importance of managing medications and outcomes (Medication Reconciliation). Patient education, information, follow-up appointments, and referral resources are included in a comprehensive discharge process and packet.

For patients who are unable to manage their own self-care independently, alternate caregivers are encouraged to participate in the discharge planning and teaching process. Specific procedures are verified by return demonstration and repeat-back modalities, whether it be by the patient or other caregiver. Patient satisfaction scores related to patient understanding are analyzed on a quarterly basis and process improvement activities are conducted if needed.

Sedation and Anesthesia

Procedures requiring moderate or deep sedation or anesthesia are performed in various areas of MGH. Anesthesia services are available 24/7 and are provided by CRNAs or MDAs. The conscious sedation policy (Procedural Sedation) describes the process by which specific staff members receive additional education and practice in order to safely administer moderate to deep sedation. All anesthesia and sedation procedures are performed in controlled environments with safety and rescue equipment immediately available.

Patient assessments by LIPs (CRNA or MDA) prior to anesthesia, sedation, or other high risk procedures are performed as recommended by authoritative sources, such as the Association of Operating Room Nurses, and are documented as required by Medical Staff bylaws in the patients record.

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Patients receive 1:1 or better care during all procedures with anesthesia or moderate/deep sedation, including all ventilated patients. Electronic vital signs monitoring for heart rate, respiration's, blood pressure, and oxygenation is employed.

Post-procedure monitoring is based on the agents used, the patient condition, and the stage of anesthesia recovery at time of entry into post-procedure care. All Stage 1 recovery occurs in either the Post-Anesthesia Care Unit (PACU) or in ICCU. Please refer to the previously mentioned Conscious Sedation policy and procedure, as well as PACU policies and procedures.

Restraints

Restraints are used for acute non-behavioral health situations for clinically appropriate and justified situations, in order to protect the patient's health and safety while respecting dignity and rights. Measures to prevent use of restraints are primary for optimal patient well-being.

The least restrictive modes of restraint are used in a planned manner, as described in the comprehensive Restraint Policy (Restraint Policy). Staff receives annual education about restraint policy and use. Restraint usage is audited for appropriateness, justification, and adherence to evidence-based criteria; the data are reported to clinical leadership, medical leadership, and administration.

Continuing Care After Discharge or Transfer

Transfer: Patients may be transferred to a higher level of care, or to a facility that can provide skilled nursing care and/or rehabilitative care as necessary. The Discharge Planning department plays a key role in working with LIPs and nursing for discharge planning when ongoing care needs are identified and the LIP plans to order transfer to skilled nursing or rehabilitative facilities. The patient's medical record contains the rationale for transfer, evidence of the patient's condition and needs, and ongoing plans for care. See specific policies for details on the processes for external transfer, care coordination at time of transfer, and reporting to the receiving facilities Transfer to an Intensive Care Hospital, Transfer to Skilled Nursing Facility).

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MGH has a philosophy that patient education is on a continuum throughout the patients stay. Discharge education is an ongoing event from the time of admission. Prior to discharge or transfer, MGH educates patients and their designated support persons about their recommended follow-up care, treatment, and services. Information includes the reasons for the recommendations, alternatives, diagnoses, readiness for discharge/transfer, and goals of care. Patients and their designated support persons are involved in the decisions and planning. Discharge instructions and educational demonstrations are provided, including providing written instructions at a level the patient or other caregivers can understand. Information is given about community resources, and detail is provided about any referrals and appointments. Interpreter services are used as needed.

In addition, MH provides a patient portal service. Customers of MH have access to relevant care information, lab results, etc. via this portal. Opting in to the portal is by patient preference.

Service providers for care post-discharge/transfer are provided with a summary of care, treatment, services, progress, history, and status at discharge/transfer. The hospital shares relevant test results and other chart information as requested or needed for ongoing care (see Release of Information).

Referenced Documents

See individual policies and procedures for further references.

Collaborators: Dr. Douglas Lindahl, DO- Lead Hospitalist.

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