THREE RIVERS HOSPITAL

Sonia Ruiz, Medical Staff Secretary/Credentialing Specialist
507 Hospital Way, P.O. Box 577
Brewster, WA 98812
Direct: 509-645-3397 * Fax: 855-814-8423
Email: sruiz@trhospital.net

Dear Provider:

Thank you for your interest in joining the Medical staff at the Three Rivers. Enclosed is an Application for Appointment to the Medical Staff and Clinical Privileges form(s). Also enclosed are the other documents relevant to the credentialing process at this hospital. A copy of the most current Medical Staff Bylaws and Rules and Regulations is also enclosed.

Please be careful to complete this application in its entirety. If sections are left blank, or all required copies of certificates and documents requested in the application are not received, the application will be returned to you for completion, which will delay the credentialing process and your appointment to the medical staff. *We will be contacting each reference listed and do not have the resources necessary to locate addresses, phone numbers, fax numbers, etc. and for this reason we request as much information be provided pertinent to the credentialing process.* Also, please note that the Clinical Privileges must be specifically requested and delineated for all relevant areas of your medical practice.

The following items must be submitted with your application. **We cannot begin to process the application until they are received.**

- COMPLETE application for appointment to Medical Staff and privilege forms. Please include mailing addresses/phone numbers/fax numbers/email addresses of schools, past and current affiliations and peer references
- Copy of current license to practice medicine in the State of Washington (Please list all other states in which licenses are held including the license number)
- Copy of current Drug Enforcement Administration certificate (if applicable)
- Current certificate of malpractice liability insurance coverage (Please include all previous as well)
- Signed Memorandum of Understanding for release of information
- Washington State Patrol Form
- Signed Applicant Disclosure Statement
- Signed temporary privilege form
- Signed Medicare acknowledgment form
- Copies of diplomas
- Copies of internship, residency, and/or fellowship certificates
- Copy of Board Certification certificate
- Copies of CPR/ATLS/ACLS/PALS certificates
- CRNA certification (if applicable)

If you have any questions or require any additional information please contact me at 509-645-3397.

Sincerely,

Sonia Ruiz

Sonia Ruiz,
Medical Staff Secretary/Credentialing Specialist

APPLICATION FOR INITIAL APPOINTMENT TO THE MEDICAL STAFF

Last Name	**First Name**	**Middle Name**	**Social Security Number**	**Birthdate**

Office Name and Address	**Office Phone Number** ( )

Birthplace	**Citizenship in:**	**Marital Status** M S W D	**Name of Spouse**

Home Address	**City**	**State**	**Zip Code**	**Home Phone Number** ( )

CATEGORY OF MEDICAL STAFF MEMBERSHIP: (Please mark appropriate category)

☐ **ACTIVE STAFF** ☐ **ASSOCIATE STAFF** ☐ **CONSULTING STAFF** ☐ **CNM STAFF** ☐ **ARNP STAFF**

☐ **ALLIED HEALTH PROFESSIONAL** ☐ **TELEMEDICINE STAFF**

Practicing with whom and nature of affiliation:

Description of practice:

Solo_____ Partnership_____ Prof.Serv. Corp_____ Hosp.Emp_____

SPECIALTIES AND SUBSPECIALTIES: (Please List)

BOARD CERTIFICATION STATUS:

Name of Board:_____ Status:_____Expires:_____

Name of Board:_____ Status:_____Expires:_____

PREMEDICAL EDUCATION	College or University:	Degree:	Honors:
	Address:		Date Graduated:
MEDICAL EDUCATION	Medical School:	Degree:	Honors:
	Address:		Date Graduated:
INTERNSHIP	Hospital:	Address:	
	Type of Internship:	Dates Attended:	
	Practitioner / Department Responsible:		
RESIDENCIES	Fellowships, preceptorships, teaching appointments, postgraduate education (Chronological order: Dates, locations, and practitioner responsible for performance):		
	Location:		Dates:
	Location:		Dates:

CURRENT AND PREVIOUS HOSPITAL AFFILIATIONS: (Please list all hospital affiliations and medical staff memberships as well as dates involved)

CURRENT MEMBERSHIP IN PROFESSIONAL MEDICAL FELLOWSHIPS, SOCIETIES AND ORGANIZATIONS: (Use separate sheet if needed)

PROFESSIONAL MALPRACTICE INSURANCE CARRIERS: (Please list **current and previous**- **Enclose copy of each coverage justification**).

Name of Carrier:_____ Address of Carrier:_____

Policy #:_____ Amount of Coverage:_____ Expiration Date_____

APPLICATION FOR INITIAL APPOINTMENT TO THE MEDICAL STAFF

PEER REFERENCES: (Include members other than those who might be listed under "affiliations").

1. _____ Address/Email:_____

2. _____ Address/Email:_____

3. _____ Address/Email:_____

LICENSING INFORMATION: (Enclose copies of all certificates for all states**.** Use separate sheet if needed**)**

MEDICAL LICENSE NUMBER:_____ STATE:_____ DATE OF EXPIRATION:_____

MEDICAL LICENSE NUMBER:_____ STATE:_____ DATE OF EXPIRATION:_____

DEA #_____ DATE OF EXPIRATION:_____

_____ **I have met the continued education requirements that are necessary to retain my Washington State License.**

CERTIFICATIONS: (Enclose copies of all that are marked)

☐ **ATLS Exp. Date:**_____ ☐ **ACLS Exp. Date:**_____ ☐ **PALS Exp. Date:**_____ ☐ **BLS Exp. Date:**_____

BILLING NUMBERS: (If applicable, please list all that apply) NPI NUMBER:_____(Please include copy of letter)

MEDICARE:_____ UPIN:_____ DSHS:_____ TAX ID:_____

If you answer yes to any of the following questions, please provide the full information on a separate sheet of paper:

1. HAVE YOU EVER HAD OR ARE YOU HAVING TREATMENT FOR OR PROBLEMS WITH DRUG, ALCOHOL OR SUBSTANCE ABUSE THAT IMPEDED OR MAY HAVE IMPEDED YOUR ABILITY TO PRACTICE MEDICINE IN A REASONABLY SAFE AND SKILLFUL MANNER?
   Yes_____ **No**_____**.**

2. HAVE YOU EVER HAD OR ARE YOU HAVING TREATMENT OR PROBLEMS WITH ANY MEDICAL CONDITIONS OR DISORDERS THAT IMPEDED OR MAY HAVE IMPEDED YOUR ABILITY TO PRACTICE MEDICINE IN A REASONABLY SAFE AND SKILLFUL MANNER?
   Yes_____ **No**_____**.**

3. WAS YOUR MEDICAL STAFF STATUS AND/OR CLINICAL PRIVILEGES EVER REVOKED, SUSPENDED, REDUCED, RESTRICTED, NOT RENEWED OR WERE YOU PLACED ON PROBATIONARY STATUS OR REPRIMANDED AT ANY TIME?
   Yes_____ **No**_____**.**

4. WERE ANY PROCEEDINGS EVER INITIATED THAT COULD HAVE LED TO ANY OF THE ACTIONS LISTED ABOVE?
   Yes_____ **No**_____**.**

5. DO YOU HAVE ANY PENDING MEDICAL MISCONDUCT PROCEEDINGS OR HAVE YOU EVER HAD ANY FINDINGS OR PROFESSIONAL MISCONDUCT IN THIS STATE OR ANY OTHER STATE BY A LICENSING OR DISCIPLINARY BOARD?
   Yes_____ **No**_____**.**

6. DO YOU HAVE ANY PENDING MEDICAL MALPRACTICE ACTIONS OR HAVE THERE BEEN ANY JUDGMENTS OR SETTLEMENTS OF A MEDICAL MALPRACTICE ACTION IN THIS STATE OR ANY OTHER STATE?
   Yes_____ **No**_____**.**

7. DID YOU EVERY VOLUNTARILY TERMINATE YOUR STATUS OR PRIVILEGES OR RESTRICT THEM TO AVOID AN INVESTIGATION OR FORMAL ACTION OR WHILE AN INVESTIGATION OR PROCEEDING WAS GOING ON?
   Yes_____ **No**_____**.**

8. HAVE YOU EVER BEEN DENIED MEMBERSHIP OR RENEWAL THEREOF, OR BEEN SUBJECT TO DISCIPLINARY ACTION IN ANY PROFESSIONAL SOCIETY OR ORGANIZATION?
   Yes_____ **No**_____**.**

9. HAS YOUR DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION EVERY BEEN SUSPENDED OR REVOKED?
   Yes_____ **No**_____**.**

I HEREBY APPLY FOR MEDICAL STAFF APPOINTMENT/RE-APPOINTMENT AND CLINICAL PRIVILEGES AT THE THREE RIVERS HOSPITAL. I UNDERSTAND THAT INACCURATE INFORMATION SUBMITTED BY ME MAY BE JUST CAUSE FOR THE TERMINATION OF THE APPLICATION PROCESS OR FOR SUMMARY SUSPENSION OF STAFF APPOINTMENT AND CLINICAL PRIVILEGES. I ATTEST TO THE ACCURACY OF THE INFORMATION I HAVE PROVIDED.

DATE:_____ **SIGNED:**_____

THREE RIVERS HOSPITAL

P.O. Box 577
Brewster, WA 98812
Phone: 509) 689-2517
Fax: (509) 689-2086

CONTINUING MEDICAL EDUCATION

List all postgraduate activities you have attended, or for which you have received credit for, in the past two (2) years.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

Print Name: _____

THREE RIVERS HOSPITAL

BREWSTER, WASHINGTON 98812

APPLICATION FOR APPOINTMENT/RE-APPOINTMENT TO THE MEDICAL STAFF

MEMORANDUM OF UNDERSTANDING

In making application/re-application for appointment to the Medical Staff of the Three Rivers Hospital in Brewster, Washington, I fully understand that any significant misstatements in/or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment/re-appointment to the Medical Staff of this hospital, I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff and I agree to be bound by the terms thereof if I am granted appointment and clinical or surgery privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted appointment or privileges in all matters relating to the consideration of my application for appointment/re-appointment to the Medical Staff; and further agree to abide by such Hospital and Medical Staff Rules and Regulations as may be from time to time enacted. I therefore pledge to provide continuous care to my patients.

By applying for appointment/re-appointment to the Medical Staff, I hereby signify my willingness to appear for interviews in regard to my application, authorize the hospital, its Medical Staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by other hospitals, its Medical Staff and its representatives of all records and documents at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the privileges requested, as well as my moral and ethical qualifications for staff appointment. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability, any and all individuals and organizations who provide information to the hospital or its Medical Staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for Staff appointment, clinical and surgical privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for Medical Staff appointment/re-appointment, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I will not participate in any form of fee-splitting. Moreover, I pledge myself to shun dishonest money-seeking and commercialism; to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others and to expect the practitioner to obtain his compensation directly from the patient; and to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any medical care for which I am not qualified. Furthermore, I realize that the certification by a Board does not necessarily qualify me to provide certain medical care. However, I believe that I am qualified to provide adequate and proper care for all clinical and surgical care for which I have requested privileges.

Acceptance of the above stated terms and authorization for release of information by other hospitals, Medical Staffs, medical organizations, malpractice insurance carriers and others, shall be signified by the applicant's signature.

A photostatic copy of this original attestation and authorization constitutes my written authorization and request to release any and all supportive documentation regarding this application. Said photostatic copy shall have the same force and effect as the signed original.

_____ _____

DATE SIGNATURE OF APPLICANT

THREE RIVERS HOSPITAL

P.O. Box 577
Brewster, WA 98812
Phone: 509) 689-2517
Fax: (509) 689-2086

CERTIFICATION OF CURRENT MEDICARE PHYSICIAN ACKNOWLEDGEMENT

Notice to Physicians:

Medicare payment to the hospital is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subjected to fine, imprisonment, or civil penalty under the applicable Federal laws.

_____ _____

Physician Signature Date

This acknowledgment is to be filed in the physician's credentials file and remains in effect as long as the physician has admitting privileges at the Three Rivers Hospital.

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633
(360) 534-2000
http://watch.wsp.wa.gov

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

INSTRUCTIONS: PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION BASED ON NAME AND DATE OF BIRTH. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH $16.00 CHECK OR MONEY ORDER. FOR REQUEST BASED ON FINGERPRINTS, MAIL A COMPLETED FINGERPRINT CARD AND FEE OF $38.00. YOU MAY ALSO COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. ***NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST BY NAME AND DATE OF BIRTH FOR $12.00 USING A CREDIT CARD.***

NOTARIZED LETTERS ARE AN ADDITIONAL $10.00 PER NOTARY SEAL ____ **Notarized Letter(s)**

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

A **SUBJECT INFORMATION:** **(Please type or print clearly)**

Applicant's Name: _____
Last First Middle

Alias/Maiden Name: _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

B **REQUESTOR INFORMATION:** **(Please type or print clearly)**

DATE: ____/____/____ Sonia Ruiz, MSS/Credentialing Sonia Ruiz
Mo. Day Yr. (print) Name/Title of Requestor Requestor's Signature

Provide e-mail to receive background results electronically. Phone No. (509) 689-2517

sruiz@trhospital.net
E-mail address

Password (must be at least 8 characters)

REQUESTOR'S ADDRESS: (type or print clearly)

Three Rivers Hospital
Name

PO Box 577
Address

Brewster WA 98812
City State ZIP Code

Subject's Right Thumb Print (Optional)

APPLICANT DISCLOSURE STATEMENT

Pursuant to the requirements of RCW 43.43.834, Three Rivers Hospital must ask you to complete the following Applicant Disclosure Statement. The information will be kept confidential. Please answer fully and accurately.

Note: Three Rivers Hospital will confirm your answers to these questions by:

*(1) Running a **Washington State Patrol** check for criminal convictions;*

*(2) Searching the **Washington Courts** database for civil adjudications as listed below;*

*(3) Searching the **Office of Inspector General** database for participants excluded from participating in Federal health care programs; and,*

*(4) For licensed personnel, checking the **Department of Health** credentials database for disciplinary actions.*

You will be notified of the State Patrol's response within 10 days after we receive the report. We will make a copy of the report available to you upon your request.

1. Have you ever been convicted of a crime?

_____ Yes _____ No

If "yes", please identify the offense(s), provide the date(s) of the conviction(s), the name of the court and the sentence(s) imposed.

_____

_____

_____

2. Have you ever had findings made against you for domestic violence, abuse, sexual abuse, neglect, exploitation or financial exploitation of a child or vulnerable adult in any civil adjudicative proceeding? Civil adjudicative proceeding includes judicial or administrative proceedings, as well as findings by DSHS or the Department of Health, that you have not administratively challenged or appealed.

_____ Yes _____ No

If "yes", please identify the specific finding(s), which agency or court made the finding(s), the date(s) of the finding(s) and the penalty(ies) imposed.

_____

_____

_____

I declare, under the penalty of perjury under the laws of the State of Washington, that the foregoing is true and correct, I understand that if I am hired, I can be discharged for any misrepresentation or omission in the above statement. I also understand if hired, my employment is conditioned on satisfactory results of the background checks listed above; I have signed this Disclosure Statement on the date shown below at _____, Washington.

Date: _____ Signature: _____

Print Name: _____

CONFIDENTIALITY AGREEMENT AND ACKNOWLEDGEMENT OF RESPONSIBILITY

THREE RIVERS HOSPITAL

Applies to all Three Rivers Hospital Healthcare "workforce members" including: employees, medical staff and other health care professionals; volunteers, temporary employees, trainees, students and interns.

I understand and acknowledge that:

- It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all confidential information relating to TRH, its patients, activities and affiliates, in accordance with the applicable laws and Three Rivers Hospital Policy.
- I will access, use or disclose confidential information only in the performance of my TRH duties, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.
- I understand that I may only access patient information in order to perform my job. This includes information for my family and me. If I am treating/caring for a family member, I understand that I must receive a special Release of Information Form.
- I will discuss confidential information for TRH-related purposes only. I will not knowingly discuss any confidential information within hearing distance of other persons who do not have the right to receive the information. I will protect confidential information which is disclosed to me in the course of my relationship with TRH.
- Because special protections by law require specific authorization for release of mental health records, drug abuse records and any and all references to HIV testing, I will obtain such authorization for release when appropriate.
- I understand that my access to all TRH electronic information systems is subject to audit in accordance with TRH policy.
- I understand that all personal computer systems and information stored in these systems are TRH property. I understand that the systems are to be used for business purposes only.
- It is my responsibility to follow safe computing guidelines.
    - I agree not to share my Login or User ID and/or password with any other person. I am responsible for any potential breach of confidentiality resulting from access made to TRH electronic information systems using my Login or User ID and/or password. If I believe someone else has used my Login or User ID and/or password, I will immediately report the use to the Information Technology Department and request a new password.
    - I agree that I will only use mobile computing devices that are able to be encrypted and to ensure that they are encrypted with an approved TRH encryption solution before using them for any purposes involving PHI or other sensitive information. I understand that I may be personally responsible for any breach of confidentiality resulting from an unauthorized access due to theft, hacking or any other means, to PHI stored on my unencrypted device.
- My User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.
- Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to or use or disclosure of patients' confidential information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with TRH**, civil fines for which I may be personally responsible**, and criminal sanctions.
- I have received a copy of TRH's policy entitled "Computer Systems, Equipment and Internet Usage." I agree to follow all of the aforementioned policies concerning the usage of hospital personal computer systems and equipment and I understand that violations may result in disciplinary action, up to and including termination. _____

(please initial to confirm receipt of policy)

I have read, understand and acknowledge all of the above Confidentiality Agreement and Acknowledgement of Responsibility:

_____ _____

Signature Date

_____ _____

Print Name TRH Department

_____ _____

TRH Employee Number Signature of TRH Representative

☐ Non-TRH Employee

_____

Print TRH Representative Name

Revised 4.19.13

Three Rivers Hospital

DEPARTMENT: Information Technology	Page 1 of 4	Effective Date:	REVIEWED	
		Approval Date:	Date	Initials
SUBJECT: Computer Systems, Information, Equipment, & Internet Usage	Department Director Edgar A. Arellano	Date 10/12/12		
	Chief Executive Officer	Date 11/12/13		

PURPOSE:

To inform all Three Rivers Hospital (TRH) computer and network users of the TRH behavioral expectations and requirements:

Definition:

Computer systems, information and equipment, including laptop computers, printers, networks, software, electronic data, electronic mail, video conferencing, and Internet access are provided for Three Rivers Hospital business related use only. It is the responsibility of all employees to see that all hardware/software and associated peripherals of these information systems are used in an efficient, ethical, and lawful manner.

POLICY:

Violations of this policy may result in disciplinary action and or termination.

I. Computer Systems, Information and Equipment

A. All computers are considered to be company property of TRH and are to be used solely for business purposes. Access by employees requires written authorization from a *manager, direct supervisor, or designee*. This authorization can be revised, restricted, or revoked at any time.

B. Employees will only use TRH approved software. TRH Information Technology (IT) employees or designee will install all software. Additionally, employees may not share or distribute computer software with other employees or any party. Regular audits of installed software will be conducted. If unauthorized software is found, a written request to remove the software will be sent to the department manager. If the software is not removed within a reasonable time frame to be decided by management, IT personnel will remove the software. Employees other than IT may not configure or reconfigure (software, operating system, or hardware); or disassemble any PC or other hardware owned by TRH.

C. All information stored in the hospital computer system is to be treated as confidential, proprietary information. The confidentiality of any communication should not be assumed. Even when a message or data is erased, it is still possible to retrieve and read. The use of passwords for security does not guarantee confidentiality. Only certain information printed out to the public correspondence or the like may be considered non-proprietary or non-confidential.

D. All messages composed, sent, solicited, and/or received on the system/network are and remain the property of TRH. Business e-mail will be conducted utilizing accounts and addresses provided by TRH. All transported TRH information will be transported using a TRH IT pre-approved encrypted device.

E. TRH may review, audit, intercept, access, and disclose all messages or files created, solicited, received, or sent through its systems or network, or kept via any other medium such as hard disks, floppy disks, CD's, USB's, etc.

F. The TRH network, including the e-mail system, may not be used to solicit or proselytize for commercial ventures, religious, or political causes, outside organizations, or other non-job related solicitations.

G. The TRH network, including the e-mail system, may not be used to solicit or create any offensive or disruptive messages. Among those that are considered offensive are any messages that contain sexual implications, racial slurs, or any other comment that offensively addresses an individual's age, sex, sexual orientation, religious or political beliefs, national origin, or disability.

H. The TRH network may not be used to send or receive copyrighted materials, trade secrets, proprietary financial information or similar materials in any manner that is a violation of federal or state laws.

I. All TRH Internet web pages shall be reviewed and approved by the management of TRH, who are responsible for ensuring that design and content meet established standards.

J. TRH will provide service for all hospital owned computer systems and equipment. TRH does not provide software and/or service on non-hospital owned computer systems and equipment. The need to create documents, spreadsheets, etc. from home at certain times is understood but needs to be pre-approved by departmental managers in a signed documentation. No data that is created or modified on personal computers is to be transferred from external media to a TRH owned computer prior to verifying the media and its contents are virus free per TRH protocol. If the user has no means of media verification, IT will assist in this process. No electronic Protected Health Information (ePHI) is to be stored on TRH or personal workstations or sent in unsecure email or electronic communication. Electronic transfer of ePHI must be pre-approved by IT.

K. Passwords are required to access networked personal computers. Any power-on and/or screen-saving passwords on stand-alone computers must be registered with the IT department. Users must use their own password while attempting to log on to the network environment. The only exception is designated multiple access computers. Sharing user identifications, passwords, and access codes is prohibited. Employees may be held responsible for misuse that occurs through such unauthorized access. Each user is responsible to lock the computer they are working on prior to leaving it unattended (by holding the windows key and hitting the L key).

1. IT is responsible for managing computer and data security and will assign user name and temporary passwords to each employee or other authorized individuals as requested by appropriate hospital management personnel. The password that is assigned is temporary. The employee/authorized user is responsible for establishing a personalized password. In the event that IT Department staff is unavailable to distribute the user name and password, this information will be given to the employee/authorized user's Department Manager for distribution.
2. Temporary passwords and user names should not be emailed.IT is also responsible for maintaining a current updated security code for all authorized individuals as responsibilities change, and transfers and terminations occur. Any changes to individual security codes require the appropriate management approval.
3. Each member of the hospital management team will determine the unique set of computer functions required by those employees/volunteers/other affiliates under his/her direction. Once determined, this information will be placed on a Spiceworks ticket and submitted to IT for issuance of security.
4. It is also the responsibility of Hospital management to make certain that each person fully understands the confidential nature of both the security code and the data to which she/he has been given access, and the possible consequences of unauthorized use of information or sharing of security codes and passwords.
5. In the event of termination, leave of absence, or transfer of an employee/volunteer/affiliate, it is the responsibility of the manager to notify IT so that the individual's security access can be terminated. When an individual transfers to another department, the new department manager must complete a Spiceworks ticket to request any security access.
6. All employees/volunteers/affiliates will be required to read and sign a Confidentiality and Security Statement as a condition for receiving security access to the Hospital computer systems. Each individual will also be responsible to abide by the conditions outlined in said statement.

L. Data Backup is an essential part of using a personal computer. The IT department conducts backup of all data documents stored on network servers daily. A tape backup of the CPSI Linux Server is performed on a daily basis. A week's worth of backup tapes are kept in a safety deposit box at Wells Fargo Bank downtown. There is also a tape sent to CPSI at the end of the month. A backup of Windows 2003 server is accomplished daily and a full backup weekly on Saturday. The backups are stored on a Network Attached Storage (NAS) device in the IT area. Please note: program files are not backed up. If you require assistance in ensuring that your data documents are backed up, please notify IT.

M. All Network passwords will change on a regular schedule. Those with group User Names such as Nursing, Doctors and Volunteers will be changed by IT. The new password will be given to the director/manager. It is the director/manager's responsibility to get the password to their employees. Individual User Names and Passwords will expire on a regular schedule. The system will prompt the user to create a new password.

II. Internet

A. The Internet is an information-gathering tool providing tremendous benefits to the hospital. Internet access is available during the employee's work hours for business related activities. While it is understood by administration that users will use computers for occasional personal use, TRH prohibits employees from accessing pornographic, gambling-related, and other inappropriate Internet web sites. While accessing the Internet on hospital owned computers, employees will be monitored for misuse.

TRH does not accept liability for any loss or damage suffered by an employee as a result of that employee using the company Internet connection for personal use.

THREE RIVERS HOSPITAL

P.O. Box 577
Brewster, Washington 98812
Phone: (509) 689-2517

TEMPORARY PRIVILEGES

APPLICANTS NAME:_____ DOB:_____

CURRENT OFFICE ADDRESS:_____

DESCRIPTION OF PRACTICE (Specialty)_____

WA STATE PROFESSIONAL LICENSE NUMBER:_____

PROFESSIONAL LIABILITY INSURANCE CARRIER:_____

INSURANCE POLICY NUMBER:_____

PRESENT OR MOST RECENT HOSPITAL AFFILIATION:_____

PHONE NUMBER:_____

(Please attach a copy of your State License, Insurance verification and DEA registration form).

Effective **From**_____**to**_____(or until my credentials have been investigated and acted upon by the Medical Staff and Board of Commissioners). I am requesting the following medical / surgery privileges on a temporary basis:

MEDICAL:	**SURGICAL:**
_____	_____
_____	_____
_____	_____
_____	_____

DATE:_____ **APPLICANT'S SIGNATURE**_____

The above privileges are: _____Recommended _____Not Recommended

Special limitations are:_____

Date:_____Chief of Staff:_____

The above privileges are: _____Recommended _____Not Recommended

Date:_____Hospital Administrator:_____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

The categorized listings include diagnosis/problems which are commonly included in the practice of medicine in that specialty area. Privileges which, because of complexity or unusual risk require special consideration will be listed under own headings. If there are complex or unusual risk conditions which are not included in the listing and you desire to have that privilege to treat, please list at end of clinical listing.

Please specify privileges which are requested, recommended or approved as follows: (See pgs 12-14 of the Bylaws for description):

TYPE I - Unsupervised. **TYPE II** - Consultation required. **TYPE III** - Supervision Required. **TYPE IV** - May assist Only.

0 - Privileges are not requested, recommended or approved.

MD/MID LEVEL EMERGENCY ROOM / OFFICE PROCEDURES & ORTHO PA PRIVILEGES	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
Draw Blood					Remove thrombosed hemorrhoids				
Injections					Prep for cystoscopy				
IV medications					Care of cystoscopic instruments				
Joint Injections or Taps					Urethral dilatation				
Diagnosis					Urinary catheterization				
Remove cysts					Bladder taps				
Remove lesions					Diathermy-Ultrasound				
Remove warts					Spinal taps				
Cauterize warts					Interpret xrays w/suprvsing phys. back-up				
Ingrown toenails					Interpret xrays w/Radiologist back-up				
Sigmoidoscopy					Other: (Please list)				
Biopsies									
I&D of abscess					**EMERGENCY PROCEDURES:**				
Fluorescein staining of the eyes					Obtain history				
Pack nose bleeds					Perform physical examinations				
Wax removal – ears					Diagnosis				
Pierce ears					Treatment and Plan				
Tonometry					Cardioversion				
Suture lacerations					Cardiac resuscitation				
Change dressings					Intubation				
Take EKG's					Poisonings				
Interpret EKG's					Placement of NG tube				
Exercise testing					Burns				
Pulmonary function testing					Reducing fractures				
COMPLETE PHYSICAL:					**ANESTHESIA AGENTS:**				
Acute					Epidural				
Chronic					Local surface agents				
Emergency					Other: (Please list)				
Limited Physical exam					**OB/GYN:**				
School physicals					Prenatal exam				
					Prenatal follow-up				
					Delivery				
					Birth control				
					Routine paps and pelvic examinations				

Ambulatory Care Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT:_____ SIGNATURE:_____ DATE:_____

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Page 2……. MD/MID LEVEL EMERGENCY ROOM / OFFICE PROCEDURES & ORTHO PA PRIVILEGES	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
SURGERY:					**CASTING:**				
Suturing					Spicas				
Removal of sutures					Non-displaced fractures				
ICU care					Sprains				
Pre-operative history					Displaced fractures following reduction				
Pre-operative physical examination					Removing casts				
Postoperative care					Other: (Please list)				
Dressing changes									
Removal skin lesions					**REDUCING:**				
Prep patients					Fractures				
Set up transfusion					Dislocated shoulders				
Other: (Please list)					Dislocated fingers/toes				
					Other: (Please list)				
MINOR SURGERY:									
First Assistant					**HOSPITAL PROCEDURES:**				
Second Assistant					Admit patients				
Other: (Please list)					History taking				
MAJOR SURGERY:					Physical examinations				
First Assistant					Diagnosis				
Second Assistant					Treatment				
Other: (Please list)					Charting				
EMERGENCY ROOM CALL:					Writing orders				
With supervising physician					Make rounds				
Interpret xray w/supervis. Phys. as backup					Write discharge summaries				
Write prescriptions					Order blood or blood components				
Other: (Please list)					Paracentesis				
					Chest tube placement				
ORTHOPEDICS:					Foley catheter insertion				
Physical therapy					Insertion of arterial lines				
Brace fitting					Order IV's				
Remove pins					Change dressings				
Traction equipment					Swan Ganz catheter insertion				
Other: (Please list)					Central Venous pressure line (CVP)				
					Other: (Please list)				

Ambulatory Care Services Director:_____ Date:_____

Chief of Staff: _____ Date:_____

Chairman, Board of Commissioners: _____ Date:_____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

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MEDICAL CONDITIONS	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
Dx./treatment of acute & chronic cardiovascular or circulatory diseases and disorders					Dx. & treatment of acute & chronic endocrine diseases & disorders				
Acute myocardial infarction w/serious arrhythmia CHF, shock or cardiac arrest					Dx. & treatment of acute & chronic nutritional diseases & disorders				
Life threatening cardiac arrhythmia					Dx. & treatment of acute & chronic immunity diseases & disorders				
Acute, severe congestive heart failure					Dx. & treatment of acute & chronic diseases & disorders of the blood & blood forming organs				
Dx. & treatment of acute & chronic pulmonary or respiratory diseases or disorders					Dx. & treatment of acute & chronic mental diseases & disorders				
Acute respiratory failure					Acute, complex, multisystem disease of adult and/or geriatric patients				
Acute pulmonary embolus					Other: (Please list)				
Dx. & treatment of acute & chronic gastrointestinal diseases and disorders									
Acute, severe inflammatory or infectious process, hermorrhage, obstruction									
Acute osteomyelitis									
Acute renal failure									
Dx. & treatment of acute & chronic hepatic disease									
Acute hepatic failure									
Dx. & treatment of acute & chronic genitourinary diseases & disorders					**PROCEDURES:**				
Acute inflammatory or infectious process of any CNS area					Echocardiogram				
Dx. & treatment of acute & chronic neurological diseases and disorders					Treadmill Testing				
Dx. & treatment of acute & chronic musculoskeletal disease & disorders					Thallium Treadmill				
Dx. & treatment of acute & chronic connective tissue diseases & disorders					Pulmonary function testing				
Dx. & treatment of acute & chronic skin & subcutaneous tissue diseases & disorders					EKG reading				
Dx. & treatment of acute & chronic metabolic diseases & disorders					Holter Monitor Reading				

Medical Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

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OBSTETRICS & GYNECOLOGY	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
OBSTETRICS: Dx. & treatment of acute & chronic gynecological diseases and disorders					**SURGERY, OBSTETRIC-GYNECOLOGY:** Abdominal hysterectomy				
Dx. & treatment of acute & chronic conditions of pregnancy, childbirth, & puerperium					Vaginal hysterectomy				
Severe preeclampsia					Uterine suspension				
Eclampsia					Other operations of uterus: Repair, excision of lesion, etc.				
Early labor, after 22 weeks but before 37 completed weeks gestation					Operation of ovaries, including removal				
Elective vaginal delivery following previous cesarean section (VBAC)					Operation of cervix, including removal				
Complicated vaginal delivery, breech extraction, suction extraction, etc.					Dilatation and Curettage				
Fetal distress affecting management of mother					Operations of vaginal wall				
Forceps extraction, high or mid					Operation of Bartholin's gland				
Other: (Please list)					Operations of exterrnal female genitalia and perineum: I&D, repair or excision of lesions, etc.				
					Cesarean section				
					Repair of current obstetric laceration of uterus and/or cervix				
					Repair current OB laceration of bladder and/or urethra				
					Repair of current OB laceration rectum and/or sphincter ani				
					Repair current OB laceration of pelvic floor, perineum or vagina				
					Other: (Please list)				

OB/GYN Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

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PEDIATRIC AND/OR NEWBORN	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.					
Dx. & treatment of acute & chronic diseases & disorders in pediatric patients (under 12 years)									
Acute inflammatory or infectious process of CNS in pediatric patients									
Dx & treatment of conditions of the newborn									
Extreme immaturity of the newborn									
Respiratory disorders of the newborn									
Endotracheal intubation of the newborn									
Major congenital anomalies affecting immediate care of the newborn									
Umbilical catheterization, artery or vein									
Other: (Please list)									

Pediatric Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

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ORTHOPEDIC SURGERY	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
CLOSED REDUCTION OF:					Operations of intervertebral joint structures				
Facial: Nose, mandible, maxilla, zygoma, etc.					Arthroplasty of shoulder				
Shoulder					Arthroplasty of upper limb, excluding hand				
Humerus					Arthroplasty of hand & fingers				
Elbow					Arthroplasty of hip				
Radius & Ulna					Arthroplasty of knee & ankle				
Wrist					Arthroplasty of foot & toes				
Carpals, metacarpals & phalanges					Local excision of tissue or lesion of bone				
Hip					Bone graft				
Femur					Incision & excision of joint structure				
Knee					Arthroscopic incision & excision of joint structures				
Tibia & fibula					Placement of internal fixation device				
Ankle					Removal of internal fixation device				
Heel					Amputation & revision of amputation & disarticulation of phalanges				
Tarsals, metatarsals & phalanges					Amputation & revision of amputation of:				
OPEN REDUCTION OF:					Upper limb				
Facial: Nose, mandible, maxilla, zygoma, etc.					Lower limb				
Shoulder					Coccygotomy/Coccygectomy				
Humerus					Bunionectomy w/ soft tissue correction & osteotomy				
Elbow					Emergency repair of muscle, tendon, fascia & bursa				
Radius & Ulna					Elective operations of muscle, tendon, fascia & bursa				
Wrist					Emergency repair of peripheral nerves				
Carpals, metacarpals & phalanges					Release of carpal tunnel compression				
Hip					Peripheral ganglionectomy				
Femur					Excision of Morton's neuroma				
Knee					Hip pinning				
Tibia & fibula					Replacement femoral head				
Ankle					Other: (Please list)				
Heel									

Orthopedic Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

APPLICANT: _____ SIGNATURE: _____ DATE: _____

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GENERAL SURGERY AND PROCEDURES	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.		Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.
Minor operations of external eye, ear, nose & mouth					Resuscitation, stabilization of trauma patients				
Minor operations of internal eye, ear, nose & mouth					Operations of abdominal wall & peritoneum				
Extensive operation of mouth					Creation, revision & closure of stoma of intestine				
Operations of tonsils, adenoids and pharynx					Operations of spleen, including removal				
Salivary gland surgery					Operations of liver, repair & biopsy				
Excision - neck lymph nodes or lesions					Operations of pancreas				
Radical neck dissection					Operations of stomach				
Thyroid surgery, total or subtotal					Operations of small intestine				
Parathyroid surgery					Operations of large intestine				
Tracheostomy/tracheotomy					Vagotomy				
Catheter embolectomy					Laparoscopes – General				
Aspiration of thoracic cavity					Laparoscopes – Appendectomy				
Placement of temporary pacemaker					Laparoscopes – Gallbladder				
Insert permanent pacemaker					Abdomino-perineal resection of rectum				
Insertion of Swan Ganz catheter					Repair fistula – Recto-vesico-vaginal, Vesicosigmoidovaginal, etc.				
Placement of central venous catheter line					Anorectal surgery: Excision of lesion, repair, etc.				
Bronchoscopy					Intraabdominal vascular surgery				
Esophagogastroduodenoscopy					Peripheral vascular surgery				
Sigmoidoscopy					Simple excision of lymph nodes, excluding neck				
Flexible sigmoidoscopy					Radical excision of lymph nodes, excluding neck				
Colonoscopy					Mastectomy, simple or radical				
Operations on lung, including partial or complete lobectomy of lung					Extensive operations of skin & subcutaneous tissue				
Chest tube placement					Minor operations of skin & subcutaneous tissue				
Trans-abdomino-thoracic operations of esophagus					Other operations of breast				
Operations of gallbladder & biliary tract					Skin grafts				
Diaphragmatic hernia repair – Hiatal					Excision of adipose tissue of abdomen				
Abd. wall hernia repair, ventral, incisional & umbilical					Aspiration of bone marrow				
Groin area hernia repair – inguinal & femoral					Spinal tap				
Appendectomy									

Surgical Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICANT: _____ **SIGNATURE:** _____ **DATE:** _____

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DENTAL SURGERY AND PROCEDURES	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.					
Tooth Extraction									
Root canal resection									
Excision of intraoral lesions									
Intraoral laceration repair									
I&D intraoral abscess									
Repair of fracture, maxilla, mandible, zygoma, etc.									
Other: (Please list)									

Surgical Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL - Brewster, Washington

APPLICATION FOR CLINICAL PRIVILEGES

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ANESTHESIA SERVICES	Requested by Practitioner	Recommended by Dept. Director	Recommended by Med. Staff	Approved by Gov Board Comm.					
General inhalation anesthesia									
General intravenous agents									
Anal / Rectal anesthesia									
Bier Block									
Caudal									
Epidural									
Saddle Block									
Spinal									
Local surface and infiltration agents									
Conscious Sedation (Non-anesthesia providers: Please see attached privileging criteria form)									
Other: (Please list)									
Perform pre & post anesthetic patient evaluations									
Write pre anesthetic drug order (to be co-signed by attending M.D.)									

Surgical Services Director: _____ Date: _____

Chief of Staff: _____ Date: _____

Chairman, Board of Commissioners: _____ Date: _____

THREE RIVERS HOSPITAL

Credentialing Criteria for Conscious Sedation

Conscious Sedation privileges for Non-Anesthesia Personnel

DEPARTMENT OF:_____

❍ Yes ❍ No I, Dr._____, have read and understood and agree to abide by the Hospital Policy for Procedural Sedation.

Instructions

Individuals requesting these privileges must meet the following criteria, please **check** which of the three choices below best describes how you meet these criteria then sign and date the form. Return the completed form to the Medical Staff Services at Three Rivers Hospital.

❒ Demonstrated successful completion of a residency or fellowship training program (within the last 5 years) with at least four (4) weeks exposure to anesthesia (including IV conscious sedation, indications, contraindications, pre-anesthesia assessment, intra-operative care, procedure monitoring and post-anesthesia care);

OR

❒ Previous experience with evidence available to the hospital upon request that the applicant has performed IV conscious sedation;

OR

❒ Evidence of participation in a continuing medical education program devoted to conscious sedation (course certificate to be on file).

_____

PHYSICIAN SIGNATURE DATE

Reviewed and approved by:

_____

DEPARTMENT CHAIRMAN DATE

_____

MEDICAL STAFF PRESIDENT DATE

_____

CHAIRMAN OF THE BOARD DATE

Three Rivers Hospital

DEPARTMENT: NURSING	Page 1 of 13	Effective Date:	REVIEWED	
		Approval Date:	Date	Initials
SUBJECT: PROCEDURAL SEDATION	Chief Executive Officer	Date		
	Chief Nursing Officer	Date		
	Chief of Medical Staff	Date		

I. PURPOSE:

Procedural sedation is used in short-term, therapeutic, diagnostic or surgical procedures. This policy is to establish guidelines for providing safety and continuous monitoring of the patient's physical status during procedural sedation.

II. PROCEDURE:

Candidates for procedural sedation are those who must undergo painful or difficult procedures where cooperation and/or comfort will be difficult or impossible without pharmacologic support. Patients must be screened for potential risk factors when any pharmacologic agents are selected.
All patients receiving procedural sedation will be monitored and drug administration will be given by anesthesia personnel, provider or a sedation certified registered nurse per the provider's verbal or written orders. During procedural sedation, there must be a licensed independent practitioner present who is credentialed by the facility as capable of recognizing and managing airway emergencies.
It is the policy at Three Rivers Hospital that these guidelines apply to all locations in the hospital where procedural sedation may be administered, including ICU/CCU, OR, ER and Radiology/MRI.
The Registered Nurse (RN) managing and monitoring the patient receiving procedural sedation shall have no other responsibilities during the procedure that would leave the patient unattended or compromise continuous monitoring. An additional Nurse or technician must be available to assist the provider. For example, an ER nurse or Charge Nurse must not be assigned as the procedural sedation nurse unless an additional Nurse is available to assist the provider and other ER patients and/or Charge Nurse duties. Drug administration and patient monitoring will be the procedural sedation Nurse's only responsibility. After the procedure is complete and the patient is arousing, a RN will continue to monitor the patient as per protocol and as directed by the provider until discharge criteria is met.
Only a qualified RN will be allowed to do procedural sedation. A qualified RN is one who has completed the certification course annually provided by the hospital. Upon completion of the course, each individual should keep a copy of the completed checklist, give the original to the department supervisor and forward a copy to the Chief Nursing Officer (CNO) and Human Resources (HR) offices. It is ultimately each employee's responsibility to know when their certifications expire and to keep them current.

III. PRE-PROCEDURE:

A. Assessment:

1. The ordering provider will review the risks and benefits of the selected agents with the patient, parent or guardian and document on the informed consent and place in chart. The nurse must verify the presence of this documentation before administration of any medications. Provider documentation should consist of informed consent, copy of the history and physical or progress notes including such information as age, weight, allergies, any previous adverse drug reactions, alcohol or substance abuse, current medications, prior relevant diseases or hospitalizations and/or family history, pregnancy status and physical exam.
2. Nursing physical and baseline assessment parameters should include level of consciousness, anxiety level, full set of vital signs (blood pressure, pulse, respiratory rate, temperature and O2 saturation), skin color and condition, sensory defects, current medications and drug allergies, NPO status, absence of difficult airway and morbid obesity and the patient's perception of the procedure and sedation.
3. The decision to use specific agents will be based on the goals of sedation, type of procedure, condition and age of the patient. Anesthesia should be consulted for patients under age 18 and be present for patients under age 8.
4. Patients will be screened by the ordering provider for risk factors utilizing the American Society of Anesthesiology (ASA) Physical Status Classification. Patients considered appropriate for procedural sedation are ASA Class I or II. Patients who fall into ASA Class III or higher present special medical situations. An anesthesia consultation should be considered.
5. The RN has the right to ask anesthesia to consult for any patient that the RN feels is out of the RN's scope of practice after reviewing the above documentation and the ASA classes.

B. Equipment and Supplies:

1. Gloves;
2. Physicians choice of medications (Demerol, Fentanyl, Versed);
3. Syringes;
4. Needleless system for withdrawal of medication and administration.

Basic and Advanced Airway Management Equipment:

1. Emergency crash cart with defibrillator;
2. Source of compressed oxygen (tank with regulator or pipeline supply with flow meter);
3. Pulse oximeter;
4. Suction machine;
5. Suction catheters (variety of sizes);
6. Yankauer type suction;
7. Face masks and cannulas;
8. Ambu bag;
9. Oral and nasal airways (variety of sizes);
10. Lubricant;
11. Monitor and non-invasive blood pressure monitor;
12. Laryngoscope handles (tested);
13. Laryngoscope blades (variety of sizes);
14. Endotracheal tubes (variety of sizes);
15. Stylet appropriately sized for endotracheal tubes.

Pharmacological Antagonists:
1. Nalaxone (Narcan);
2. Flumazenil (Romazicon).

Emergency Medications:
1. Epinephrine;
2. Ephedrine;
3. Atropine;
4. Lidocaine;
5. Glucose, 50% (10% or 25%);
6. Diphenhydramine.

C. Interventions:
1. Confirm history, allergies and NPO status;
2. Obtain VS and saturation;
3. Verify ride home by a responsible adult, go over and get discharge instructions signed by the patient, driver and nurse;
4. Explain and reinforce provider's instructions; answer any questions;
5. Assemble equipment (listed above);
6. Instruct patient to empty bladder and place in a gown;
7. Establish IV access; fluid type and rate per orders;
8. Administer supplement oxygen as necessary.

IV. PROCEDURE
1. Attach cardiac monitor, blood pressure and pulse oximeter. Begin the procedural sedation record and continually reassess patient throughout the procedure. Record vital signs and level of consciousness at least every 5 minutes, using the Modified Ramsey sedation scale listed top of page 4.
2. Position the patient as required for the procedure preventing peripheral nerve injury and sustained pressure.
3. Administer medications as instructed by provider.
4. Monitor the patient continuously and assist them as needed. Give frequent verbal reassurance throughout the procedure.
5. Notify provider immediately of any untoward reactions or sudden or significant changes in monitoring parameters.
6. Document any reactions and measures taken to resolve.
7. Complete Procedural Sedation Record e-form.

Modified Ramsey Sedation Scale: ***Desired level of sedation is level 2 or 3***

Awake States:
1. Patient anxious, agitated or restless
2. Patient cooperative, oriented, tranquil
3. Patient asleep, brisk response to loud auditory stimulus

Sleep States:
1. Patient asleep, sluggish response to loud auditory stimulus
2. Patient has no response to loud auditory stimulus but does respond to painful stimulus
3. Patient does not respond to painful stimulus

V. POST-PROCEDURE

1. Following the procedure, the patient will be transported to the recovery area via wheelchair or stretcher, depending on the assessment of the RN. The Nurse receiving the patient will monitor and document VS and oxygen saturations upon arrival and every 15 minutes or more frequently as condition warrants. This includes frequency and depth of respirations and level of consciousness. The attending provider should be notified if vital signs change by 20% of baseline and remain without returning to baseline values by the time of discharge.
2. All patients receiving procedural sedation will be monitored until appropriate discharge criteria are satisfied. The duration of monitoring must be individualized depending on the level of sedation achieved, overall condition of the patient and the nature of the intervention for which sedation was administered.
3. The patient must stay at least 2 hours after the last administration of any reversal agent (Naloxone, Flumazenil) to ensure that resedation does not occur. If a reversal agent is used, a Nursing Assistant Certified (NAC) can monitor the vital signs under the direction of the Registered Nurse after 30 minutes and the patient is stabilized. The NAC needs to monitor the vitals every 15 minutes and report to the Nurse. The RN needs to check on the patient every 30 minutes and/or after a report from the NAC of a problem.
4. The RN needs to discharge the patient. The Nurse needs to assess and document the patients discharge status immediately prior to discharge. The following elements will be documented:
   a. Time of discharge;
   b. Blood pressure, pulse, respiratory status, temperature, oxygen saturation and level of consciousness;
   c. Normal or baseline cardiopulmonary and neurological status; if not, specific written notation must be made of abnormalities present;
   d. Gag reflex is intact and tolerates PO fluid and/or is instructed on how to assess gag reflex;
   e. Absence of nausea and vomiting;
   f. Able to ambulate or baseline reached; if not, notation must be made;
   g. Patient given follow up instructions;
   h. A responsible adult who will be providing transportation and care is accompanying the patient; if no driver is available, the patient will be admitted for a minimum of 12 hours or until one can be found.
   i. Copies of the written discharge instructions need to be made. Include in the instructions emergency phone numbers to contact the provider, if any problems arise. Give a copy to the patient and place one in the chart.
   j. Complete the Procedural Sedation Patient Outcome Data Collection Sheet and send to Quality Assurance.

ADDENDUM's referenced and included with this policy:

A. Procedural sedation definitions
B. Patient selection
C. Position statement from NCQAC (Washington State Board of Nursing; Final Draft Revision July 13, 2005) *"Scope of Practice for the Registered Nurse in the Administration of Procedural Sedation and the Management of Patients Receiving of Procedural Sedation"*
D. Procedural Sedation Annual Skills Checklist
E. Discharge criteria
F. Post anesthesia recovery score, Aldrete score
G. ASA physical status classifications
H. Procedural sedation patient outcome data collection sheet

ADDENDUM A Procedural Sedation Definitions

A. Light Sedation:
Light sedation is produced by the administration of medications (usually oral medications) for the reduction of anxiety.
   1. In this stage the following should be present:
      - Normal respirations;
      - Normal eye movement;
      - Intact protective reflexes;
      - Amnesia may or may not be present;
      - Patient is technically awake but under the influence of the drug administered.
   2. Groups of drugs that may be used for this purpose include:
      - Sedative-hypnotics;
      - Anti-anxiety;
      - Benzodiazepines;
      - Antihistamines;
      - Narcotics.

B. Moderate (Procedural) Sedation:
Procedural sedation is produced by the administration of pharmacological agents administered singly or in combination to induce a state that allows a patient to tolerate unpleasant procedures while maintaining cardio-respiratory function.
   1. A medically controlled state of depressed consciousness that:
      - Allows adequate respiratory drive to be maintained;
      - Allows protective reflexes to be maintained;
      - Retains the patient's ability to maintain a patent airway independently and continuously;
      - Permits appropriate response by the patient to physical stimulation or verbal command, for example, "open your eyes".

   Constant observation of the patient by qualified staff is required to avoid deeper levels of sedation and to assure patient safety.

C. Deep Sedation:
   1. Deep sedation is a state of depressed consciousness from which the patient is not easily aroused. Partial or complete loss of protective reflexes, including the ability to independently maintain a patent airway, may occur. Purposeful response to verbal or physical stimuli and normal respiratory drive may be lost. Patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree and are considered to be unconscious. Anesthesia will care for any patient who requires deep sedation.

ADDENDUM B Patient Selection

1. Candidates for procedural sedation are those patients who must undergo painful or difficult procedures where cooperation and/or comfort will be difficult or impossible without pharmacological support. Patients must be screened for potential risk factors for any pharmacologic agents selected. The decision on which agents to use must be based on the goals of sedation, type of procedure and the condition and age of the patient.

2. Patients will be screened by the ordering provider and verified by the RN for risk factors utilizing the ASA Physical Status Classification. Patients considered appropriate for procedural sedation are Class I and Class II. Patients who fall into Class III or above or pediatric patients, age 8-18, present special problems that necessitate a consultation by a member of the Anesthesia Department. Anesthesia needs to be present for pediatric patients under age 8.

ADDENDUM C

Nursing Care Quality Assurance Commission
PO BOX 47864 Olympia Washington 98504-7864
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Scope of Practice for the Registered Nurse

in the Administration of Procedural Sedation

and the Management of Patients Receiving of Procedural Sedation

The Washington State Nursing Care Quality Assurance Commission affirms that it is within the role and scope of practice for the registered nurse (RN) to administer procedural sedation and to manage patients who are receiving and recovering from procedural sedation. Further, the Commission believes that this role is beyond the scope of practice for the licensed practical nurse or the tasks allowed for unlicensed assistive personnel.

Definition
Procedural sedation, also known as conscious sedation, is produced by the administration of pharmacological agents administered singly or in combination to induce a state that allows a patient to tolerate unpleasant procedures while maintaining cardio-respiratory function. A patient under procedural sedation has a depressed level of consciousness, but retains the ability to independently and continuously maintain a patent airway and respond appropriately to physical stimulation and/or to verbal command. Procedural sedation may easily progress to deep sedation or the loss of consciousness, because of the unique characteristics of the drugs used, as well as the physical status and drug sensitivities of the individual patient.

Process
Procedural sedation is used in short-term, therapeutic, diagnostic or surgical procedures.

The registered nurse administers medications to achieve conscious sedation by executing the order of a licensed independent practitioner with authority to prescribe the medications to be administered.

The registered nurse managing and monitoring the patient receiving procedural sedation shall have no other responsibilities during the procedure that would leave the patient unattended or compromise continuous monitoring.

During procedural sedation, there must be a licensed independent practitioner present who is credentialed by the facility as capable of recognizing and managing airway emergencies.

Competency
The administration of procedural sedation requires continuous monitoring of the patient and the ability to respond immediately to deviation from the norm. Procedural sedation should only be provided by an individual who is competent in thorough patient assessment, is able to administer drugs through a variety of routes, is able to identify responses which are a deviation from the norm, and is able to intervene as necessary to cardiac or respiratory rescue for the patient.

To ensure that nurses assisting in procedural sedation receive appropriate and continuous training and support with demonstrated competency, the Nursing Commission recommends that all providers and institutions using registered nurses in procedural sedation have in place written policies and procedures that contain, at a minimum, the following elements:

1. Guidelines for patient selection, monitoring, and drug administration.

2. Protocols for managing potential complications or emergency situations.

3. Specific educational and training requirements with evidence of competency.

4. Specific yearly evaluation and verification of continuing competency requirements.

Excluded from the guidelines in this position statement:

1. Patients receiving inhalation anesthetics (except for the use of Nitronox as an analgesic).

2. Patients who receive analgesia for pain control without sedatives.

3. Patients who receive sedation solely for the purpose of managing altered mental status.

4. Patients who are sedated for the purpose of intubation.

References

Emergency Nurses Association (December 2000). Position Statement Conscious Sedation.

American Nurses Association (September 1991). Position Statement on the Role of the Registered Nurse in the Management of Patients Receiving IV Conscious Sedation for Short-Term Therapeutic, Diagnostic, or Surgical Procedures.

Oregon State Board of Nursing (February 1999). Scope of Practice for the Registered Nurse in the Administration of Conscious Sedation and the Management of Patients Receiving Conscious Sedation.

Original position statement adopted by the Washington State Nursing Care Quality Assurance Commission January 2000.
Final Draft Revision July 13, 2005

ADDENDUM D

Three Rivers Hospital

PROCEDURAL SEDATION ANNUAL SKILLS CHECKLIST

Employee Name: _____
Date of Skills Completion: _____

SKILLS	DATE COMPLETED	OBSERVER'S SIGNATURE
A. Completed procedural sedation module and test in annual review		
B. Current in ACLS		
C. Policies reviewed: procedural sedation; medication administration, safe medication administration		
D. Administers medications appropriately		
E. Monitors patient per policy		
F. Aware of complications and how they would be managed		
G. Documents care throughout procedure on appropriate forms		
H. Identifies emergency resuscitative procedures and equipment use		

A, B, C, G – May be completed by department Supervisor.
D, E, F, H – Requires Anesthesia department to observe and sign.

Comments:

ADDENDUM E Discharge Criteria

A. The patient may be discharged home when discharge criteria has been met. Discharge criteria includes:
   - Completion of the Aldrete score; the score must return to baseline assessment before the patient may be released;
   - Appropriate consciousness/alertness for their age;
   - Appropriate vital signs for their age;
   - No respiratory distress;
   - No nausea or vomiting;
   - Ability to ambulate consistent with baseline assessment, depending on procedure;
   - Ability to demonstrate a gag reflex, depending on procedure (for example, EGD);
   - Ability to retain PO fluids, as appropriate to physicians orders;
   - Minimal pain;
   - Follow up and post procedural instructions are given in writing and verbally and are understood by the patient as well as significant other/friend, etc.;
   - 2 hours have elapsed after the last administration of reversal agents (naloxone, flumazenil) to ensure that patients do not become resedated after reversal effects have abated;
   - Concurrence with pre-arrangement for safe transportation including discharge to the care of responsible adult;
   - THE PATIENT MAY NOT DRIVE THEMSELVES HOME!!
   - The patient will be admitted for a minimum of 12 hours if no driver is available, or until one is found.

ADDENDUM F **Post Anesthesia Recovery Score, Modified Aldrete Score**

Activity:	
Able to move 4 extremities voluntarily on command	2
Able to move 2 extremities voluntarily on command	1
Able to move no extremities voluntarily on command	0
Respiration:	
Able to breathe deeply and cough freely	2
Dyspnea or limited breathing	1
Apnea/Obstructed	0
Circulation:	
BP +/- 20% of preanesthetic level	2
BP +/- 50% of preanesthetic level	1
BP > 50% of preanesthetic level	0
Consciousness:	
Fully awake	2
Arousable on calling	1
Not responding	0
Oxygen Saturation:	
Able to maintain oxygen saturation >92% on room	2
Needs oxygen inhalation to maintain oxygen sat >90%	1
Oxygen saturation <90% even on oxygen supplement	0

Total score = 10. Score 9-10 indicates readiness for discharge.

ADDENDUM G ASA (American Society of Anesthesiology) Physical Status Classifications

Class I – No organic, physiologic, biochemical or psychiatric disturbance. Normal, healthy patient.

Class II – Mild-moderate systemic disturbance, may or may not be related to reason for surgery. (examples: hypertension, diabetes mellitus)

Class III – Severe systemic disturbance. (examples: heart disease, poorly controlled hypertension)

Class IV – Life threatening systemic disturbance. (examples: congestive heart failure, persistent angina pectoris)

Class V – Moribund patient. Little chance of survival. Surgery is last resort. (examples: uncontrolled bleeding, ruptured abdominal aortic aneurysm)

Class VI – Declared brain dead patient whose organs are being removed for donor purposes.

Class E – The letter "E" should follow in cases in which the patient was not scheduled for surgery. Patient requires emergency procedure. (examples: appendectomy, D and C for uncontrolled bleeding)

ADDENDUM H

PROCEDURAL SEDATION PATIENT OUTCOME DATA COLLECTION SHEET

Please complete a form for each episode of Procedural Sedation
Not part of the patient chart, when complete please forward to Quality Department

Procedural (Conscious) Sedation	
A drug-induced depression of consciousness during which patients respond purposely 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 usually maintained.	
Date of Administration:	
Unit Administrating Sedation: (Circle) OR Endo ER AC ICU/CCU Radiology	
Drug and Total dose: Versed _____mg Demerol _____mg Morphine_____mg Fentanyl_____mcg Romazicon_____ Narcan_____	
Physician ordering sedation: _____	
Administered by: RN _____	
Please check all of the following that are appropriate for the patient.	
	Administration of reversal agent: Romazicon _____mg Narcan _____mg
	Airway support required (circle) Oral Airway Chin Lift ET Tube
	Assisted Ventilation required
	Drop in 02 saturation < 90% for 2 minutes, patient instructed to DB, 02 mask applied
	Respiratory and/or cardiac arrest
	Unplanned admission or transfer to a higher level of care related to moderate sedation
	No problems related to moderate sedation
	Other:_____
Additional Comments: _____ _____ _____ _____	