YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

The doctors, nurses and staff of the Surgery Center of Santa Fe are committed to meeting your needs as our patient. We are committed to providing the best care available, to respecting your rights and to helping you recognize your responsibilities as a patient. This information has been prepared to help you understand both your rights and responsibilities. We believe that patients who understand and participate in their healthcare are better able to achieve the desired recovery.

YOUR RIGHTS AS A PATIENT:

CARE AND DECISION MAKING - you or your legally authorized representative have the right to:

- receive care regardless of your race, creed, color, national origin, ancestry, religion, sex, marital status, age, newborn status, handicap or source of payment
- be treated with consideration, respect, and recognition of your individuality and personal care, including the need for privacy in treatment
- have the opportunity to participate to the fullest extent possible in planning for your care and treatment
- have your consent obtained before treatment is administered, except in emergencies
- refuse treatment to the extent permitted by law and be informed of the medical consequences of your refusal
- a full explanation, provision for continuing care and acceptance by the receiving institution, and doctor if you are transferred to another facility, except in emergencies
- designate who may be permitted to visit during your stay in accordance with Surgery Center policy
- make decisions regarding your care or select a representative to act on your behalf if you are unable to do so
- make informed decisions regarding your care including being informed of your health status
- consult with a specialist, at your own expense
- formulate advance directives and to have Surgery Center staff and practitioners who provide care in the Surgery Center comply with these directives
- receive reasonable continuity of care within the scope of services offered and staffing of the facility
- receive care in a safe setting
- be free from all forms of abuse or harassment
- be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff

INFORMATION – Your or your legally authorized representative has the right to:

- have your medical records, including all computerized medical information, kept confidential
- access to your medical record
- know the names of your doctors and others who have overall responsibility for your care
- receive from your doctors or the nurses caring for you, information about your illness, course of treatment and prognosis for recovery in terms you can understand
- receive a copy of these rights and responsibilities at the time of admission
- be fully informed and give prior consent for your participation in any form of research or experimentation
- examine and receive an explanation of your Surgery Center bill regardless of source of payment, and may receive upon request, information relating to financial assistance available through the Surgery Center
- be informed of your responsibility to comply with the Surgery Center rules, cooperate in your own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information concerning payment of charges
- ask questions until you are comfortable that you understand an issue regarding your diagnosis or care
- an explanation of any procedure, including an operation, its risks and consequences and available alternatives
- information about any continuing health care requirements
- be aware your physician may have financial interests in the Surgery Center

PROCEDURES FOR PATIENT COMPLAINTS OR GRIEVANCES – You or your legally authorized representative has the right to:

- expect prompt, personal action in addressing a need or concern
- a resolution of a complaint within a short time frame agreed to, by you and the person responding to you
- the attention of a director/cno in the resolution of a complaint regarding your care, without fear of reprisal, should you request it
- express a complaint about your care or treatment; in order to initiate a complaint, you may ask to speak to the center's Coordinator at the location of your surgery or you may address your concerns in writing and send to:

  Surgery Center of Santa Fe
  Attention Director of Surgical Services
  8801 Horizon Blvd NE Suite 360
  Albuquerque, NM 87113
  (505)768-1333

- The Surgery Center Director/CNO shall call or write to the patient acknowledging receipt of the complaint within five (5) working days of receiving the complaint. If the Director cannot resolve the matter, it will be referred to the attention of the Medical Director of the Surgery Center.

Complaints regarding this ASC may be filed with the New Mexico Department of Health at the following address:

Health Facility Licensing and Certification Bureau
2040 South Pacheco
2nd Floor Room 413
Santa Fe, NM 87505
1-800-752-8649

Complaints regarding this ASC may be filed with the Office of the Medicare Beneficiary Ombudsman at the following:

www.medicare.gov/ombudsman/resources.asp
call 1-800-MEDICARE (1-800-633-4227)
www.quickbrochures.net/medicare/medicare-ombudsman-and-complaints.htm

Surgery Center of Santa Fe
Patient Complaints/Grievance Process

PURPOSE:

The Surgery Center of Santa Fe (SFASC) regards the physician-patient relationship to be held in the highest esteem requiring trust, mutual respect and confidentiality. In an attempt to offer quality care on both a personal and professional level, patients will be encouraged to make comments on the care they receive.

POLICY:

If a patient and/or family member offer a complaint, the SFASC will try to resolve the issue to the best of its ability, at the time of the complaint. Complaints may be obtained from the surgical call-backs, post-op questionnaires, feedback from the post-op or attending physician. If there are frequent complaints about the same issue, a quality assessment or process improvement may be initiated.

What is a grievance?

A grievance is a formal or informal written or verbal complaint that is made to the Ambulatory Surgery Center (ASC) by the patient or patient's representative, regarding a patient's care or ASC compliance issue.

If the complaint requires additional actions for resolution (not resolved by the coordinator/charge nurse) or if the person reporting the complaint would like a response in writing then the complaint is now considered a grievance.

The Medical Director, Surgical Services Director or Chief Nursing Officer are the contacts for the SFASC Grievance Process.

All grievances alleging mistreatment, neglect or abuse that are submitted to any ASC staff members, whether verbally or in writing, must be immediately reported to the Surgical Services Director/CNO or the Medical Director. Grievances alleging mistreatment, neglect, abuse, or other behavior that endangers a patient will be investigated as soon as possible, given the seriousness of the allegations and the potential harm to patients. If there is confirmation that the alleged mistreatment, neglect, abuse or other harm took place, then the ASC will report the event to the appropriate local and state authority (see Section 1: General Information, policy 6, 7 and 8).

When an employee receives a grievance (written or verbal) the employee will begin the grievance process by initiating the *Grievance Report* form then forwarding it to the SFASC Coordinator/Manager. The Director/CNO shall call or write to the patient acknowledging receipt of the complaint within five (5) working days of receiving the grievance. The Director/CNO shall also address the subject of the grievance in depth and document appropriately, investigate the grievance and take appropriate action, as indicated. The grievance process will take no more than 30 days from the time the grievance was filed. If there are unusual circumstances that cause the grievance process to exceed 30 days the patient or patient's representative will be notified. The patient will be given written notice of its decision.

If the Director/CNO cannot resolve the matter, it will be referred to the attention of the Medical Director. If the matter is not resolved to the patient's satisfaction, the patient may take the grievance to a representative of their choice. The SFASC will not discriminate or use any coercion or reprisal against a patient or patient's representative for taking action to solve the problem. All complaints/problems and documentation regarding such shall be secured in a file by the Administrator and reviewed quarterly. The process on how to issue a complaint can be found in the **Patient Rights and Responsibilities** form. A copy of the form is posted in the SFASC.

Information on Advance Directives (Living Will)

There may be a time in your life when you are unable to make healthcare choices for yourself. Some serious decisions that people are often called upon to make include treatment choices, artificial life support, and quality of life. You have a choice about medical interventions such as ventilators, CPR, drugs to sustain blood pressure, antibiotics and artificial nutrition (food) and hydration (water).

There are two legal documents which allow you to express your wishes about healthcare decisions. These documents allow you to determine your decision about certain medical treatments and procedures in advance of illness or life threatening circumstances.

An advance healthcare directive consists of a living will and a power of attorney for healthcare. You may complete either or both of these documents.

A living will allows you to decide for yourself how you would address specific end of life decisions. There are three choices that the living will provides:

1) Not to prolong life:

    a) In the case of an incurable and irreversible condition that will result in your death within a relatively short time.

    b) You become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness.

    c) The likely risks and burdens of treatment would outweigh the expected benefits. This choice also allows you to determine if you want to receive artificial food and water based on the conditions listed above. Unless you were to specifically object, this choice would also provide treatment to ease any pain and discomfort.

2) To prolong your life as long as possible within the limits of generally accepted healthcare standards.

3) To make a specific choice yourself but allow a person of your choice (power of attorney for healthcare decisions) to make end-of-life decisions for you.

A power of attorney for healthcare allows you to choose a person to make healthcare decisions for you, should you become incapacitated. You can limit the type of decisions that your agent may make for you, if you choose to do so. This document provides a place for you to list alternative agents, should your original agent be unavailable or unable to act. Your agent's authority becomes effective when your primary physician and one other qualified healthcare professional determine that you are unable to make your own healthcare decisions.

You can also use this form to designate a person to make your current healthcare decisions, even though you are completely capable of making those decisions for yourself. Some persons prefer not to be involved in the decision making process of their healthcare at any stage and designate another person to make current and future decisions for them by completing a power of attorney for healthcare.

You do not have to sign any form if you choose not to do so. If you do not sign a form or tell your doctor about whom you want to make your healthcare decisions (or if someone you identify is not reasonably available), a family member who is reasonably available may act. Family members are selected to act on your behalf in descending order: spouse/significant other, adult child, parent, adult brother or sister, grandparent, close friend.

Advance directives (living will and power of attorney for healthcare) allow you to make your own choices about medical decisions. Making decisions in advance will provide direction and perhaps comfort to family members or agents who may make significant choices on your behalf.

Advance Directive

An Advance Directive Form lets you give instructions about your own health care and/or name someone else (an agent) to make health care decisions for you if you become unable to make your own decisions. You may fill out some or all of this form. You may change all or any part of it, or use a different form. If you have already signed a durable power of attorney for health care and/or a right-

to-die statement (living will), these are still valid. If you wish to combine the health care instructions found in these documents, you may use this optional form.

Please feel free to print and fill out this form making sure to sign and date it. You have the right to revoke (cancel) or replace this form at any time. Give copies of this signed form to your health care providers and institutions, any health care agents you name, and your family and friends.

THIS FORM IS OPTIONAL. You do not have to use any form; instead, you may tell your doctor whom you want to make health care decisions for you. If you have not signed a form or told your doctor whom you want to make your health care decisions, New Mexico law allows these people, in the following order, to make your health care decisions (if these people are reasonably available): 1) spouse, 2) significant other, 3) adult child, 4) parent, 5) adult brother or sister, 6) grandparent, 7) close friend.

You may name another person as your agent to make health care decisions for you if you become incapable of making your own decisions. This is called a durable power of attorney for health care. You should talk to the person you name as agent to make sure he or she understands your wishes and is willing to act as your agent. You may also name alternative agents if your first choice cannot or will not make health care decisions for you. Unless related to you, your agent may NOT be an owner, operator or employee of a health care institution at which you are receiving care. This form has a place for you to limit the authority of your agent. If you do not limit your agent's authority, your agent may make all health care decisions for you.

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NEW MEXICO ADVANCE HEALTH CARE DIRECTIVE FORM

(1) DESIGNATION OF AGENT: I appoint the following person as my agent to make health care decisions for me:

_____
(*name of agent*)

_____
(*address*)

_____
(*city*) (*state*) (*zip code*)

_____
(*home phone*) (*work phone*)

If I revoke my agent's authority or if my agent cannot or will not make a health care decision for me, then I appoint these persons as my alternative agents, to serve in the following order:

_____
(*name of first alternative agent*)

_____

(*address*)

_____
(*city*) (*state*) (*zip code*)

_____
(*home phone*) (*work phone*)

_____
(*name of second alternative agent*)

_____
(*address*)

_____
(*city*) (*state*) (*zip code*)

_____
(*home phone*) (*work phone*)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me AND to make all health care decisions for me, except as I state here:

(Add additional pages if needed)

If you do not limit your agent's authority, your agent will have the right to consent or refuse to consent to any medical care, treatment, service or procedure, such as:

(1) selection and discharge of health care providers and institutions, and decisions regarding hospitalization, nursing care, and home health care;

(2) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate;

(3) directions relating to life-sustaining treatment, including withholding or withdrawing life-sustaining treatment and the termination of life support; and

(4) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care.

(3) AGENT'S RESPONSIBILITY: My agent shall make health care decisions for me based on this durable power of attorney for health care, any specific health care instructions I give and my other wishes to the extent known to my agent. If my wishes are unknown and cannot be determined, my agent shall make health care decisions for me based on my best interest. In determining my best interest, my agent shall consider my personal values to the extent known.
(4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I lack the capacity to make and communicate my own health care decisions.

(5) DURABILITY: This advance directive for health care, including but not limited to the power of attorney, shall remain in effect despite my later incapacity. This advance directive, including but not limited to the power of attorney, remains in effect from the date it was signed unless I revoke it or die.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and **IF**: (a) I have an incurable and irreversible condition that will result in my death within a relatively short time; OR (b) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (c) the likely risks and burdens of treatment would outweigh the expected benefits, **THEN** I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in ***one*** of the following three boxes:

[ ] **(a) I Choose To Prolong Life**: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. ***OR***

[ ] **(b) I Choose NOT To Prolong Life** : I do not want my life to be prolonged. I understand that “NOT prolonging my life” means that I do not want any life support measures. ***OR***

[ ] **(c) I Choose To Let My Agent Decide**: My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above "NOT To Prolong Life," I also specify by marking my initials below:

[ ] I DO Want Artificial Nutrition (food). *OR*

[ ] I DO NOT WANT Artificial Nutrition (food).

[ ] I DO Want Artificial Hydration (water). *OR*

[ ] I DO NOT Want Artificial Hydration (water).

No matter which choices I have initialed in this section, I do want comfort care.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

(*Add additional pages if needed*)

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] **I CHOOSE** to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[ ] **I CHOOSE** to make a partial anatomical gift of some of my organs or tissue as specified below, and artificial support may be maintained long enough for organs to be removed. The following organs and tissue may be donated:

[ ] **I REFUSE** to make an anatomical gift of any of my organs or tissue.

[ ] **I CHOOSE** to let my agent decide.

(10) OTHER HEALTH CARE INSTRUCTIONS OR WISHES: If you wish to write specific instructions about any aspect of your health care and medical treatment, including your end-of-life decisions, you may do so here. I direct that:

(*Add additional pages if needed*)

(11) NOMINATION OF GUARDIAN : I intend by this power of attorney for health care to avoid a court-supervised guardianship. If I need a guardian, I want my agent appointed in this form to be my guardian. If that agent cannot or will not act as my guardian, I want my alternative agents, in the order they are appointed in this form, to be my guardian.

(12) COPIES OF THIS FORM: A copy of this form has the same effect as the original.

(13) REVOCATION: I may revoke my Health Care Instructions (Sections 6-10 of this form) at any time in any way that shows my intent to do so. I may revoke the appointment of an agent under my durable power of attorney for health care (Section 1 of this form) by a signed writing or by telling my doctor. If I revoke any or all of this form, I should promptly notify my doctor, my agent, any health care institution where I am receiving care and any others to whom I have given copies of this

document.

Sign and Date Below:

_____ _____
(your signature) *(date)*

_____ _____
(print your name) *(optional social security number)*

_____
(address)

_____
(city) *(state)* *(zip code)*

(This form does not have to be witnessed to be legally valid. Witnesses are recommended to avoid any concern that this document might be forged, that you were forced to sign it, or that it does not genuinely represent your wishes)

_____ _____
(signature of first witness) *(signature of second witness)*

_____ _____
(print name of first witness) *(print name of second witness)*

_____ _____
(date) *(date)*

_____ _____
(address of first witness) *(address of second witness)*

[This form complies with the provisions of the *New Mexico Uniform Health Care Decisions Act* of 1995, NMSA 1978 Sections 24-7A-1 to 24-7A-18 (1997 Supp.)]