2019 MEMORIAL HOSPITAL MEDICAL STAFF ANNUAL EDUCATION

INFECTION CONTROL

Prevent the Transmission of Infection

- Adhere to hand hygiene; use soap & water or alcohol-based rub upon entering and exiting patient rooms.
- Utilize standard precautions for all patients & any additional transmission-based precautions. (droplet, contact, airborne) guidelines.
- Stay at home if you are sick.
- Stay up to date on all immunizations.

Immunizations

- Tdap needed for pertussis prevention in those interacting with children/newborns.
- Influenza vaccinations mandatory for 2019-2020 influenza season.

Prevent the Spread of Multi-drug resistant organisms

- Adhere to Contact Precautions for patients with known or suspected MDRO, i.e., MRSA, CRE, VRE etc.
- Gown & gloves required; hand hygiene before and after.
- Avoid taking items into room, i.e., (chart, electronics) etc. Disinfect items after removing from an isolation room, i.e., stethescope, otoscope, etc.

Prevention of Central-line associated bloodstream infections

- Educate patients about CLABSI prevention
- Use central line insertion checklist
- Avoid femoral and jugular sites
- Perform hand hygiene, use full body drape; wear mask, cap, sterile gown and sterile gloves, use CHG skin prep
- Hand hygiene & gloves before changing dressing or accessing port---**Scrub the hub** 15 seconds before all access
- Remove any unnecessary catheters

Prevention of surgical site infections (SSI)

- Educate patients about SSI prevention
- Perform proper surgical scrub on hands
- Use proper antibiotics for prophylaxis at right time
- If hair removal needed , use clippers in pre-op area
- Utilize standardized and hospital recommended surgical site prep.
- Minimize traffic in OR during surgery
- Do not flash sterilize equipment
- Wear only hospital laundered Memorial Hospital scrubs; don a fresh set daily; do not wear surgical scrubs outside of the hospital.

PAIN MANAGEMENT

MHSB respects patients' rights to effective pain management. Pain management is a multidisciplinary process, characterized by continual coordination and communication of the plan of care towards the improvement of patient outcomes: increased comfort, reduced side effects, and enhanced patient satisfaction.

Pain is generally assessed using a 0-10 scale:
0 = No Pain 10 = Worst Pain

For non-verbal patients, a picture scale (Wong-Baker) is available showing various faces indicating pain level. For cognitively impaired patients or patients unable to use numeric or faces scale, pain is assessed by using a non-verbal pain scale.

Pain medication should be ordered with specific details regarding indications and dose. Range orders for medications should be clarified in such a way that nursing staff is knowledgeable about which dose within the range is appropriate. When multiple medications are ordered for pain, specific guidelines for which medication to give for each type of pain should be provided.

Reference Policy: MHSB Medication, Orders with Dose Ranges

ENVIRONMENT OF CARE

"CODE" Calls (Call 44 from hospital phone or 647-1000 from any phone)

Code Red: Fire, or Smoke–
"RACE" - Rescue persons, pull **A**larm & call 44, **C**ontain fire; **E**xtinguish if possible and **E**vacuate if necessary.
"PASS" – Pull the pin, **A**im at base of fire, **S**queeze the handle, **S**weep to extinguish fire.
Code Blue : Cardiopulmonary Arrest

Plain Language for all other events such as system/network failures, weather events, and the following:

Missing Infant, Child, or Adult: monitor immediate area and exits, report suspicious people.
Security Assistance Needed: Disruptive or Combative Person. - Stay back unless specifically trained.
Security Alert-Active Shooter/Armed Intruder**:** Person with weapon/hostage, active shooter – Run, Hide, or Fight. Stay away from area.
Hazardous Material Incident: Hazardous Material Incident/Spill- Evacuate area, prevent access, redirect contaminated persons outside to ECC.
Security Alert-Bomb Threat: Remain calm, report details, avoid cell phone use.
Water Rescue Emergency (EPWORTH)- call 911.

IMPAIRED PRACTITIONER

The term **impaired** is used to describe a practitioner who is prevented by reason of illness or other health problems from performing his professional duties at the expected level of skill and competency. Impairment also implies a decreased ability or willingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety. Some signs of impairment are deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability or neglecting commitments, excessive ordering of drugs, lack of or inappropriate response to pages or calls, decreasing quality of performance or patient care.

MHSB will assist the entry of a suspected or confirmed impaired practitioner into evaluation, appropriate treatment, and/or rehabilitation.

Reference: MHSB Medical Staff Policy on Physician Assistance

DISRUPTIVE BEHAVIOR

Disruptive conduct by a member of the medical staff is behavior which adversely impacts on the quality of patient care, and includes verbal or physical abuse, sexual harassment, and/or threatening or intimidating behavior toward colleagues, team members, or patients/visitors. This conduct will not be tolerated. Any medical/AHP staff member, team member, or agent of the hospital, volunteer, patient/visitor may file a complaint about a practitioner for disruptive behavior. No retaliation will be taken for reporting a concern in good faith. Complaints may be referred to the President of the Medical Staff or Vice President for Medical Affairs (VPMA). Complaints should be in writing and will be maintained by the VPMA.

Reference: MHSB Medical Staff Policy on Disruptive Conduct and the Beacon policy regarding Mutual Respect.

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Prevention of catheter-related urinary tract infection

- Use approved indications for urinary catheter; attempt alternate methods prior to anchoring indwelling catheters.
- Ensure plan for catheter removal
- Remove any unnecessary urinary catheters- discontinue once no longer meets approved indication.

Emergency Plan Activation + Level : Internal/External Disaster - If Level 3 or higher, contact Medical Staff Office 574-647-7920. Be prepared to triage injured persons if needed.

Safety Data Sheet (SDS) Be familiar with the hazards posed by chemicals used in your workplace. SDS information is available on the intranet under general info/ Safety Data Sheet.

Safety Concerns: Report all Safety Concerns to the Safety and Joint Commission Coordinator at 647-2290 or the Safety Hotline at 647-7233.

RESTRAINT and SECLUSION

- A restraint is defined as any manual method, physical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his arms, legs, body, or head freely.
- Restraint devices may only be used after less restrictive alternatives have been tried and documented as unsuccessful.
- 2 categories of restraint: 1) to protect the physical safety of the non-violent or non-self-destructive patient, and 2) to manage violent or self-destructive behavior.
- Prone restraint is not permitted.
- Medical Staff must have a working knowledge of the restraint and seclusion policy.
- Medical Staff may not be involved with applying restraints or seclusion without proper training.
- Restraint requirements for **non-violent or non-self-destructive patient**:
  - A timed/dated order for initiation on green sticker
  - Care plan must be updated to include restraints
  - Every calendar day, the physician or LIP will see and evaluate the patient before writing a new order for restraints. Examination of the patient should be documented in the medical record
- Restraint requirements for **violent or self-destructive behavior**:
  - A timed/dated order for initiation on designated form
  - A **face-to-face evaluation within one hour** of implementation (physician, psychologist, LIP, on designated form)
  - Care plan must be updated to include restraints
  - Duration of orders: ≥ age 18 – 4 hours; age 9-17 – 2 hours; under age 9 – 1 hour
  - Every 24 hours a physician, psychologist, or LIP will see and evaluate the patient before writing a new order.

RAPID ASSESSMENT TEAM (RAT)

The RAT is a patient safety strategy that can "rescue" patients when their conditions deteriorate and reduce the number of Code Blues and the inpatient mortality rate. The RAT is a team of clinicians who come to the bedside to assist with assessment and treatment of an inpatient that has had an acute change in condition. The RAT can be called at **any time** and consists of the patient's primary nurse, an ICU nurse, a respiratory therapist, and the House Resident.

A Rapid Response can be initiated by calling 44 and requesting a RAT team.

- anytime a clinician is concerned about a sudden or ongoing worsening of a patient's condition,
- when Narcan is being administered on a nursing unit (the RAT must be called).
- When a patient is experiencing chest pain the RAT will be called as part of the inpatient STEMI Protocol.

Reference: MHSB Policy Rapid assessment Team

FALLS

- **All adult inpatients and observation patients will be screened for fall risk upon admission using the Johns Hopkins Fall Risk Assessment tool.** Patients will be reassessed every shift and whenever there is a significant change in the patient's condition or after a fall.
- Assessment includes 7 fall risk factors: Age, Fall History, Elimination, Medications, Patient Care Equipment, Mobility and Cognition.
- Three Levels of Fall Risk based on assessment score:
  ≤ 5 = Low, 6-13 = Moderate, > 13 = High
- Paralysis or completely immobilized patients = **Low Risk**
- Seizure within last 6 months, active alcohol withdraw and active brain injury patients = **High Risk**
- Interventions are based on level of fall risk:
  - **Low risk**: standard safety interventions
  - **Moderate**: Moderate risk sign, **Yellow Wrist Band**, Reorient confused patients as necessary
  - **High**: High risk sign, **Yellow Gown**, Bed/Chair Alarm, Gait belt or lift equipment, Caregivers remain while toileting.
- Education of patient and family on fall prevention is important with corresponding documentation in the chart. A post-fall huddle will occur with every fall.
- Reporting and documentation of any patient fall via MHSB Incident Reporting System is essential.
- **All Pediatric inpatients and outpatients will be screened for fall risk upon admission using the Humpty Dumpty Fall Risk Assessment tool.** Interventions will be initiated based on score and patient needs.
- **All adult procedural outpatients** will be screened for falls by utilizing a 4 question form. Patients that

Exam of the patient should be documented in the medical record on designated form.

- Restraints should be discontinued when the patient meets the criteria outlined in the order. The RN will terminate the restraint or seclusion and document the rationale in the medical record.

Reference: MHSB Restraint and Seclusion Policy

screen positive will be identified by an appropriate band and/or yellow socks.

- Adult procedural patients receiving narcotics, pain meds or anesthesia are automatically a fall risk.

Reference: MHSB Fall Prevention Assessment and Interventions Policy

ABUSE AND NEGLECT

All in- and out-patients should be informally screened at admission for signs of abuse and neglect.

- Possible indicators of abuse/neglect may include:
  - patient states that abuse/neglect occurred
  - repeated and/or unexplained traumatic injuries
  - explanation of injuries is vague or refuses to explain
  - patient exhibits fear, withdrawal or unnatural compliance in presence of caregiver
  - suspicious injuries, "doctor hopping," etc.
  - unusual delay in obtaining treatment for injuries.

- If abuse and/or neglect is suspected, you should:
  - report this immediately to CPS or APS
  - document findings, observations and statements made by the patient or family/caregiver(s) which support the suspected abuse/neglect
  - arrange for photographs of injuries if appropriate.

Reference: MHSB Abuse, Treatment and Reporting Policy

REPORTING CONCERNS

Healthcare workers may anonymously report, without fear of disciplinary action, any urgent patient safety or quality concern, as well as any improvement idea through the MHSB Incident Reporting System.

Concerns may also be reported to:
Risk Management at 647-3632
Safety Hotline at 647-7233
Indiana State Department of Health
2 North Meridian Street Indianapolis, IN 46204
(317) 233-1325.

The Joint Commission
Division of Accreditation Operations
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
800-994-6610 or complaint@tjc.org

ANTICOAGULATION

National Patient Safety Goal #3: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. This pertains to patients on long-term anticoagulant therapy where the clinical expectation is that the patient's lab values for coagulation will be outside normal values. Patient education is a vital component of an anticoagulation program including a face-to-face interaction with the professional to explain risks, precautions, and the importance of monitoring. Also key with anticoagulation is the use of approved protocols, baseline labs, and the use of resources to manage potential food and drug interactions.

ORGAN DONATION

MHSB works with Indiana Organ Procurement Organization as well as tissue and eye banks to maintain potential donors while the necessary testing and placement of potential organs takes place in order to maximize the viability of donor organs for transplant. There is an Organ Procurement policy for MHSB on the intranet under policies and procedures to assist when an organ procurement is possible. The nursing staff and spiritual care are available to assist with the families during the request for organ donation and throughout the procedures. It is vitally important for physicians to attempt to request donation whenever appropriate.

Reference: MHSB Organ Procurement Policy

CULTURE OF SAFETY

Leaders create and maintain a culture of safety and quality throughout the hospital. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care. All medical staff signs and agrees to abide by Memorial Medical Staff Code of Conduct at all times. Any deviations from that code will be addressed by the MEC.

Reference: MHSB Medical Staff Code of Conduct

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FIRE SAFETY

The hospital minimizes the potential for harm from fire, smoke, and other combustibles. MHSB is NON Smoking throughout the campus. Physicians and other providers should follow the acronym RACE for fire response: **R**emove people from immediate danger, **A**ctivate the fire alarm and call 44, **C**ontain the fire by closing doors, **E**xtinguish the fire if practical and **E**vacuate if necessary. Fires are announced as Code Red.

Reference: MHSB Fire Safety Policy

ROLE OF LIP IN EMERGENCY OPERATIONS PLAN

In the case of an activation of the Emergency Operations Plan a "Code Yellow activation level 1/2/3/4" will be announced overhead and via the Lynx notification system. When the activation level reaches a 3 or 4 all available physicians are to contact the Medical Staff Office at 647-7920 or in person to notify the staff of your availability and location.

Reference: MHSB DEOP policy

ALTERNATE PROCEDURE DURING DOWNTIME FOR EHR

When the electronic health record system (Cerner) is interrupted MHSB goes into a "downtime" procedure. There are designated computers on each unit that maintain a "snapshot" of the patients record to reference back for labs and radiology results etc. Any new orders that need to be placed will be done on paper during the downtime and the nursing staff on all units will be available to assist you.

Reference: MHSB PowerChart Downtime Policy

DOC HALO

Doc Halo is a communication and notification tool for physicians to contact other physicians who utilize the doc halo platform. It is a secure platform that will allow patient information to be shared without the risk of PHI disclosure. It allows laboratory results, photographs, and radiologic images to be sent from one provider to another. The platform does allow for future additional use of the system for nursing staff, utilization management, and other providers.

OPIOID EDUCATION

There are many resources available to assist with education surrounding opioids. The Indiana Hospital Association can be reached at www.ihaconnect.org, the American Hospital Association at www.aha.org, and the Centers for Disease Control at www.cdc.gov. All of these sites provide robust information about opioid use and abuse as well as current practice guidelines surrounding prescribing.

POWER OF ATTORNEY/CONSENT HEIRARCHY

As of July 1, 2018, Indiana now has a specific hierarchy for who is able to give consent for treatment for an incapacitated patient.
If an adult becomes incapable of consenting for themselves and does not have an appointed health care representative/power of attorney (POA) or the healthcare representative/POA is not available or declines to act, **consent to healthcare may be given in the following order of priority:**

Healthcare Consent Hierarchy (*If there are multiple members at the same priority level, then the majority of available individual controls.):
1) Court appointed guardian
2) A spouse
3) An adult (child)
4) A parent
5) An adult sibling (or majority of adult siblings*)
6) A grandparent (or majority of grandparents*)
7) An adult grandchild (or majority of grandchildren*)
8) The nearest older adult relative in the next degree of

HIPAA/BEACON POLICY GUIDE

In relation to Information Security

1. Authenticated access to Beacon patient systems is by virtue of assigned userID and password. Access to patient information is authorized by following set Beacon procedure. (*1, *2, *3, *6, *8, *9)
   Tips for compliance:
   a. Your password should never be shared with others.
   b. Do not allow others to access systems you are logged in to using your userID and password.

HIPAA/BEACON POLICY GUIDE-continued

Considerations:

A. Beacon is obligated to monitor patient data accesses, monitor system logs, assure the integrity of the patient record, and apply sanctions when breaches of policy are discovered. (*4, *7, *13)
B. Any communication, log, or data record in relation to a legal data preservation request or subpoena could involve such material anywhere, and everywhere, it may exist.

c. If you believe your password, computer or other type of device is compromised, or that any inappropriate access to patient data has occurred, immediately report it to the help desk.

2. Beacon patient data should be created and stored only on approved Beacon patient data systems, (*1, *5).
   Tips for compliance:
   a. Do not use personal email accounts or devices to send/receive/store patient data.
   b. Use DocHalo for secure texting and image capture/transmission involving patients when using your cellphone; (note: Orders cannot be sent via text message).

3. Devices (Workstations) used to access patient data must be protected so as to avoid unauthorized access of patient data, (*5, *6, *10, *11, *12,).
   Tips for compliance:
   a. Logout of applications, or lock the screen (Windows Key + L), when leaving a workstation unattended.
   b. Logout of Beacon applications in use from personal devices when leaving personal devices unattended.
   c. Apply physical safeguards to devices accessing patient data, such as positioning screens away from public view, and preventing unauthorized access to devices containing patient data. (Note: All patient data must be encrypted on devices/workstations or when being transmitted over the internet).
   d. Devices/Media containing patient data, even if just cached information, must be properly processed to irrecoverably destroy sensitive data prior to disposal.

C. Attempting to circumvent security measures at Beacon are against policy. (*1)
D. The Information Security and Privacy offices are here to assist and help resolve issues involving HIPAA and data security/privacy. The following points of contact may be used for questions or to discuss issues/concerns:
   - Help Desk
     helpdesk@beaconhealthsystem.org
     574-647-7254
   - Information Security Official/Bruce Bryner
     bbryner@beaconhealthsystem.org
     574-647-2234
   - Privacy Officer/Carla Wagner
     cswagner@beaconhealthsystem.org
     574-647-7751

Reference: Beacon intranet site
Beacon Health System >> BHS Policies and Procedures >> Beacon Policies >> HIPAA Privacy and Security.

kinship who is not listed above
9) An adult friend who has maintained regular contact with the individual and is familiar with the individual's activities, health and religious or moral beliefs
10) The individual's religious superior if the individual is a member of a religious order

What happens if the healthcare providers need to locate someone who can consent?
Healthcare providers shall make **a reasonable inquiry** as to the availability of individuals who are able to provide healthcare consent. **Reasonable inquire includes** examining the medical records and personal effects. The healthcare provider **shall attempt to contact individuals** who are high in the priority level and able to provide consent by telephone or other means.
Those who cannot provide consent:
1) A spouse who is legally separated or has a petition for dissolution, legal separation or annulment of marriage.
2) An individual who is the subject of a Protective Order or other court order to avoid contact with the incapacitated individual.
3) An individual who is subject to pending criminal charge in which the incapacitated individual was the alleged victim.
It is also important to remember:
1) An adult even with a designated POA or health care representative still maintains the ability to make their own medical decisions until determined and documented to be incapacitated by a physician or the courts.
2) Once we determine a patient is incapacitated, if we do not have paperwork that designates a POA/HCR or a court appointed guardian, the attached hierarchy should be followed to obtain consent for care and to make medical decisions.
3) If we have a family member who is asserting that they are POA/HCR or guardian, staff should defer to the hierarchy until we have copies of the documents that confirm the POA/HCR/Guardian.

		Reference: House Bill 1119 and Indiana Health Care Consent Act