Accreditation / Certification Requirements

Medical Staff Education Packet
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION</td>
<td>3</td>
</tr>
<tr>
<td>ROLE IN THE EVENT OF A FIRE</td>
<td>3</td>
</tr>
<tr>
<td>RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT</td>
<td>3</td>
</tr>
<tr>
<td>ROLE IN EMERGENCY MANAGEMENT</td>
<td>3</td>
</tr>
<tr>
<td>INFECTION PREVENTION/CONTROL</td>
<td>4</td>
</tr>
<tr>
<td>STANDARD PRECAUTIONS</td>
<td>4</td>
</tr>
<tr>
<td>HAND HYGIENE</td>
<td>4</td>
</tr>
<tr>
<td>ISOLATION</td>
<td>4</td>
</tr>
<tr>
<td>MULTI-DRUG RESISTANT ORGANISMS</td>
<td>5</td>
</tr>
<tr>
<td>PREVENTING CENTRAL LINE INFECTIONS</td>
<td>5</td>
</tr>
<tr>
<td>PREVENTING CATHETER ASSOCIATED URINARY TRACT INFECTIONS</td>
<td>5</td>
</tr>
<tr>
<td>C. DIFFICILE PREVENTION</td>
<td>6</td>
</tr>
<tr>
<td>PREVENTING SURGICAL SITE INFECTIONS</td>
<td>6</td>
</tr>
<tr>
<td>INFLUENZA VACCINATION PROGRAM</td>
<td>7</td>
</tr>
<tr>
<td>USE OF RESTRAINT</td>
<td>7</td>
</tr>
<tr>
<td>PAIN MANAGEMENT</td>
<td>8</td>
</tr>
<tr>
<td>PHYSICIAN IMPAIRMENT</td>
<td>8</td>
</tr>
<tr>
<td>ANTICOAGULANT THERAPY</td>
<td>9</td>
</tr>
<tr>
<td>DOWNTIME PROCEDURE FOR ELECTRONIC DOCUMENTATION</td>
<td>10</td>
</tr>
<tr>
<td>ANTIBIOTIC STEWARDSHIP PROGRAM</td>
<td>10</td>
</tr>
<tr>
<td>CLINICAL ALARM SAFETY</td>
<td>12</td>
</tr>
<tr>
<td>STROKE TIPS</td>
<td>12</td>
</tr>
<tr>
<td>CHEST PAIN ACCREDIATION</td>
<td>14</td>
</tr>
<tr>
<td>SEPSIS MANAGEMENT</td>
<td>14</td>
</tr>
<tr>
<td>EMTALA &amp; MEDICAL SCREENING EXAMINATIONS</td>
<td>15</td>
</tr>
<tr>
<td>ATTESTATION STATEMENT</td>
<td>18</td>
</tr>
</tbody>
</table>
INTRODUCTION
Good Samaritan Medical Center is accredited by The Joint Commission (TJC) – a non-profit organization that sets minimum standards for quality and safety in healthcare organizations. TJC is also a deemed-status agency authorized by the federal government to certify healthcare organizations as meeting Medicare Conditions of Participation.

TJC standards require that physicians, other licensed independent practitioners, and other members of the medical staff receive education on selected topics. This packet has been developed to meet these requirements.

Please review the information contained in this packet. Upon conclusion, please sign the accompanying attestation record indicating that you have reviewed and understand the information contained herein. Return the signed attestation along with your appointment / reappointment application.

TOPICS

REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION
Members of the medical staff have the right to report a concern regarding the quality or safety of treatment, care, and service rendered by Good Samaritan Medical Center directly to TJC without fear of reprisal or disciplinary action.

ROLE IN THE EVENT OF A FIRE
In the event of a fire, please take the following actions:
If you discover or are at the origin of the fire:
• Remove yourself and others from immediate danger
• Alert the nearest staff member of the fire or pull the nearest fire alarm and dial 55
• Confine the fire if you are able by closing doors and windows
• Extinguish the fire if you are able, or take appropriate direction from staff.

If you are away from the origin of the fire:
• Take appropriate direction from staff in the area.

RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT
If you become aware of an unsafe or potentially unsafe situation, please report it immediately to the supervisor of the care or work area. If an incident occurs, please take actions necessary to protect yourself and others from harm and report the incident immediately to the supervisor of the care or work area. You may also file an incident or unusual occurrence form.

ROLE IN EMERGENCY MANAGEMENT
Good Samaritan Medical Center has established a comprehensive plan to respond to a variety of emergency situations. In the event of a significant emergency (disaster), members of the medical staff will be responsible for providing medical care and support. This may involve such activities as:
• Determining which patients under your care could be discharged to make room for emergency admissions.
• Staffing triage and secondary care areas depending on your discipline and specialty.
• Providing medical direction to care units.

Remember R.A.C.E.
During an emergency, members of the medical staff will be assigned to posts, either in the Hospital, an auxiliary hospital, or a mobile casualty station in the event of a mass disaster. The practitioner shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Medical Staff Director (assigned the day of the event) changes the assignment.

INFECTION PREVENTION/CONTROL

Standard Precautions
Assume all blood and body fluid is infectious (blood borne pathogens include HIV, Hep B, and Hep C)
- Hand hygiene at least before and after patient contact
- Wear PPE based on the risk for exposure (gloves, gown, mask, face shield)
- Use safe injection practices to perform injections in an optimally safe manner for patients, healthcare providers, and others
- Safe handling, cleaning/disinfecting of potentially contaminated equipment and surfaces
- Respiratory hygiene/cough etiquette

Hand Hygiene
- Our goal is 100% compliance
- We follow CDC guidelines for hand hygiene and use the phrase “Clean hands and gloves (if needed) for clean tasks and clean supplies”
- Minimum expectation per our policy is “Clean In, Clean Out”
  - Use hand sanitizer or soap and water upon entry to a patient room or approaching a patient stretcher and again upon exiting the patient room or leaving the patient stretcher
  - If a patient is in Special Precautions isolation for *C. difficile* or Norovirus, soap and water hand hygiene must be used when exiting the isolation room (alcohol based hand sanitizers do not kill the C. diff spore)
  - If hands are visibly dirty, contaminated or soiled, wash with soap and water
- Artificial nails are prohibited for those in direct patient care

Isolation
- To order isolation, select “isolation panel” and choose the appropriate isolation type
- On the EMR banner bar:
  - The type of isolation will be visible if the Isolation Panel has been ordered.
  - The Infection section will show the reason for isolation (click on it for more information)
- No PPE in the hallway, including gloves or masks hanging around your neck
- For the perioperative area see the Peri-op Isolation Tip sheet (found in the peri-op area)

<table>
<thead>
<tr>
<th>Type of Isolation</th>
<th>Specific Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact e.g. MDROs, MRSA, ESBL</td>
<td>Gown and gloves</td>
</tr>
<tr>
<td>Droplet e.g. Influenza, Pertussis</td>
<td>Surgical mask covering nose, mouth, and chin</td>
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<tr>
<td>Airborne e.g. TB, Measles, Primary Varicella, and Disseminated Shingles</td>
<td>N-95 mask (covering nose, mouth, and chin) or PAPR This patient needs to be in a negative airflow room</td>
</tr>
<tr>
<td>Special e.g. <em>C. difficile</em>, and Norovirus</td>
<td>Gown and gloves, wash hands with soap and water when exiting, wipe equipment with bleach wipes.</td>
</tr>
</tbody>
</table>
Multi-drug Resistant Organisms

Periodic assessments are performed to identify the risk of acquisition and transmission of multi-drug resistant organisms (MDRO). The following MDRO are determined to be of epidemiologic importance:

- MRSA (methicillin resistant Staphylococcus aureus)
- VRE (vancomycin resistant Enterococcus)
- ESBL (extended-spectrum beta-lactamases)
- CRE (carbapenem resistant Enterobacteriaceae)

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures have been employed:

- Standard precautions as stated above and for positive MRSA in the nares or axillae, or past infection with MRSA, VRE, or ESBL
- Isolation precautions: Patients with CRE (both colonized and infected) shall be placed on contact precautions for the duration of their present admission and any future admissions to the hospital. Patients with a new culture this hospitalization with MRSA, VRE, or ESBL from any source (other than nares or axillae) or an open wound and previous positive culture growing MRSA, VRE, or ESBL are placed in Contact precautions for the duration of their present admission. Patients may be removed from isolation with the approval of the Infection Preventionist.
- Appropriate antibiotic use: The selection and ordering of antibiotics may be restricted as determined by the Antibiotic Stewardship Committee. All antibiotics should have a documented reason and duration.

Preventing Central Line Infections

Central line associated bloodstream infections (CLABSI) are reportable through the National Healthcare Safety Network (NHSN) and can cause significant morbidity and mortality. Good Samaritan Medical Center implements evidence based practices to prevent CLABSI including, but not limited to:

- Avoidance of central lines and removal when no longer medically necessary
  - The “vascular access eval and treat” order allows the vascular access team to determine if a central line or midline is more appropriate for the patient
  - Review necessity for central lines daily and remove as soon as possible
- Insertion following the CDC’s central line insertion bundle
  - Hand hygiene performed
  - Appropriate skin preparation—first choice is CHG for individuals ≥2 months of age
  - Skin prep agent is completely dry prior to insertion
  - Maximal sterile barriers used—sterile gloves, sterile gown, cap, mask, and large sterile drape
- Proper maintenance of central lines
  - Order the “central venous catheter insertion and maintenance panel” after placing a central line to ensure follow up by the vascular access team
  - Dressings are changed weekly and as needed
  - All IV ports must be cleaned prior to access
- Only order cultures if suspicious for bloodstream infection—avoid pan culturing for a temperature spike; two peripheral draws is the default

Preventing Catheter Associated Urinary Tract Infections

Catheter associated urinary tract infections (CAUTIs) are reportable through the National Healthcare Safety Network (NHSN). Good Samaritan Medical Center implements evidence based practices to prevent CAUTI including, but not limited to:

- Insert catheters only for appropriate indications (below); assess daily and remove when no longer medically necessary
  - Acute urinary retention or bladder outlet obstruction
  - Hourly assessment of urinary output in critical care (decisions are made hourly based on urine output)
  - Perioperative use for selected surgical procedures:
- Patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract
- Anticipated prolonged duration of surgery (catheters inserted for this reason should be removed in PACU)
- Patients anticipated to receive large-volume infusions or diuretics during surgery
- Need for intraoperative monitoring of urinary output
  - To assist in healing of open sacral or perineal wounds in incontinent patients (stage III or IV only)
  - Patients requiring prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures)
  - To improve comfort for end of life care if needed
- Good Samaritan Medical Center utilizes a Nurse Driven Foley Removal Protocol to allow nurses to remove indwelling urinary catheters as soon as possible, as well as a bladder scan protocol to assist with voiding post catheter removal
- Appropriate culturing
  - Only order urine cultures in the presence of urinary symptoms
  - Best practice is to request a new clean catch midstream (CCMS), not simply voided, or new catheter specimen: add on cultures to a UA are not an inpatient order option
  - If a Foley has been in place greater than 2 days, best practice is to remove the Foley, allow the patient to void and get either a CCMS or catheter specimen

**C. difficile Prevention**
- GSMC follows CDC LABID for surveillance purposes:
  - A positive C. diff test on or after day 4 of hospitalization = healthcare associated CDI, even if the patient was symptomatic on admission.
- Order the C. diff test as soon as there is a suspicion for CDI
  - Unexplained loose stools (could the diarrhea be from stool softeners, laxatives, tube feedings, bowel prep, etc.?)
  - And at least 3 unexpected liquid/loose stools beyond the patient’s known or established baseline within the past 24 hours
- Order is an auto discontinue in 24 hours

**Preventing Surgical Site Infections**
Select surgical site infections (SSIs) are reportable through NHSN. Please note the following evidence based practices to prevent SSI:
- Patient preparation
  - When possible, treat infections remote to the surgical site before elective procedures
  - For surgeries involving implants, CHG bathing along with CHG mouth rinse and nares decolonization is utilized
  - Do not remove hair at the operative site unless it will interfere with the operation; if hair must be removed, use clippers instead of shaving, prior to the operating room
  - At the intended incision site, clean and perform antiseptic skin preparation prior to incision
  - Prophylactic antimicrobial therapy should be utilized in accordance with the most updated CDC guidelines
  - Implement glycemic control with target blood glucose levels less than 200mg/dl
  - Maintain perioperative normothermia
- Operative personnel guidelines
  - Nails should be kept short; artificial nails, gel, or shellac are not allowed in the OR
  - Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic
  - A surgical mask that fully covers the mouth and nose must be worn when entering the OR
  - Only hospital laundered scrubs should be worn in the OR and hair should be covered
INFLUENZA VACCINATION PROGRAM
It is an organizational expectation that each individual will be vaccinated or formally decline vaccination due to medical or religious exemption.

Annually, prior to the start of the flu season, the organization will notify Medical Staff of the availability of the influenza vaccine. The exact timing of such notification and vaccination will be based upon CDC recommendations and the availability of the vaccine from suppliers.

If the vaccination is declined or medically contraindicated then the following requirements will be required in order to prevent the spread of infection:

- A surgical mask will be worn from the time the staff member reports to work, to the time they leave work. The mask can be removed to eat and use the restroom.

USE OF RESTRAINT (Seclusion is not done at GSMC and therefore not addressed in policy)
Policy Statement & Patient Rights
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint, of any form, imposed as a convenience, or retaliation by staff. Restraints may only be imposed to ensure the immediate physical safety of the patient, staff member(s), or others and must be discontinued at the earliest possible time.

Good Samaritan Medical Center will work to actively decrease the use of restraints. When restraint is necessary, such activity will be undertaken in a manner that protects the patient’s health and safety and preserves his or her dignity, rights, and well-being. The use of restraints is a last resort, after alternative interventions have either been considered or attempted.

Training Requirements for LIPs and AHPs
All licensed independent practitioners or allied health professionals that manage patients placed in restraints will have a working knowledge of the hospital policy. Reference policies: Restraint – GSMC which includes Restraint Decision Tree – GSMC- Supporting Document.

Prohibitions to Use of Restraints
The use of restraints for the following reasons is strictly prohibited:
- Use that is based solely on a patient’s prior history and/or behavior.
- Use as a convenience to staff.
- Use as a method of coercion or as punishment.
- Use as a method for the prevention of a fall.

Requirements for Patient Assessment & Ordering of Restraints
The use of restraints must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient. The attending physician must be consulted as soon as possible if the attending physician did not order the restraints.

Orders for the use of restraints must never be written as a standing order or on an as needed basis (PRN).

Each order for restraints must contain at least the following information:
- The name of the patient being restrained
- The date and time of the order
- The name of the LIP ordering the restraints
- The type of restraint to be applied
- The time limit (duration) of the restraint

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order.
To protect the physical safety of the non-violent or non-self-destructive patient, restraint orders are for each episode. If the restraint is discontinued and subsequently needed again, a new order must be given.

Each order for restraints used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be ordered / renewed in accordance with the following limits for up to a total of 24 hours:

- Four (4) hours for adults age 18 and older;
- Two (2) hours for children and adolescents ages 9 to 17;
- One (1) hour for patients under age 9.

After 24 hours, before writing a new order a physician or other LIP who is responsible for the care of the patient must see and assess the patient.

When restraints are used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a physician or other LIP. The purpose of the face-to-face evaluation is to assess the patient’s immediate situation; the patient’s reaction to the intervention; the patient’s medical and behavioral condition; and the need to continue or terminate the restraint.

PAIN MANAGEMENT

Patient Rights

Patients have the right to pain management. It is the policy of our organization to do the following:

1. Conduct an appropriate assessment and/or reassessment of a patient’s pain consistent with the scope of care, treatment, and service provided in the specific care setting in which the patient is being managed.
2. Require that methods used to assess a patient’s pain are consistent with the patient’s age, condition, and ability to understand.
3. Assess the patient’s response to care, treatment, and service implemented to address pain.
4. Treat the patient’s pain or refer the patient for treatment.

Treatment of Pain

In general, inpatients shall receive treatment for any active pain issue (acute or chronic), when intensity exceeds their acceptable level. Treatment shall be consistent with the patient’s clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient’s needs. Treatment is to be provided in a timely manner.

Patient Refusal of Pain Management

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient’s medical record.

Decision Not to Treat Pain

If a decision is made not to treat a patient’s pain and/or refer the patient for treatment, then the clinical justification for that decision should be documented in the patient’s medical record.

PHYSICIAN IMPAIRMENT

Physician impairment is a serious issue. The following may be signs that you or a colleague are impaired.

Personal

- Deteriorating personal hygiene (e.g. over-use of cologne or mouth wash, disheveled appearance).
- Multiple physical complaints
- Personality and behavioral changes (moods swings, emotional crises, irritability, loss of compassion)
Physical symptoms (blackouts, sweating, tremors)
Preoccupation with mood altering agents (hiding or protecting supply, using more than intended)

Friends and Community
- Personal isolation
- Embarrassing behavior
- Legal problems (e.g. drunken driving, speeding tickets)
- Neglect of social commitments
- Unpredictable, out of character behavior, such as inappropriate spending

Professional
- Change in work pattern (more or less hours), or disorganized scheduling
- Frequent "breaks" or absence
- Inaccessibility to patients and staff
- Excessive drug use (samples, prescriptions, etc.)
- Complaints by patients regarding physician’s behavior
- Alcohol on breath
- Rounding at inappropriate times
- Deteriorating relationship with staff, patients, and/or colleagues
- Deteriorating performance

If you suspect that a colleague may be impaired, it’s important that he or she gets the help they need. The medical staff has established avenues where physicians can seek assistance in a safe and confidential way. Refer to medical staff policies for further information.

ANTICOAGULANT THERAPY
Establishment of an Anticoagulant Management Program
Patients receiving anticoagulant therapy shall have these medications ordered, prepared, dispensed, administered, and monitored in accordance with guidelines and requirements established in this policy. The following requirements govern the overall approach to managing patients on anticoagulant therapy:
- There must be a clear and appropriate indication for use.
- The particular type of anticoagulation used shall be the most appropriate and clinically indicated for the condition or reason for use.
- Where appropriate, patients’ laboratory values will be monitored while on anticoagulant therapy.
- Pharmacy will review orders for anticoagulant therapy against normative and patient specific information regarding indications for use, dosage, route, frequency, contraindications, duplicative therapy, and drug/drug interactions. Issues or concerns will be brought to the attention of the prescribing practitioner for appropriate resolution (unless in emergent situations) before the medication is dispensed.

Management of Patients Placed on Warfarin Therapy
The following shall be required for patients placed on warfarin:
- The patient shall have a baseline International Normalized Ratio (INR) measured at the start of therapy.
- There shall be a current INR for the duration of therapy which shall be used to monitor and adjust therapy as warranted.
• The patient’s baseline and current INR shall be available to Pharmacy for the duration of therapy and shall be reviewed prior to dispensing of warfarin. Issues or concerns will be addressed with the prescribing practitioner prior to the medication being dispensed.
• Authoritative resources shall be used in managing potential food / drug interaction.

Management of Patients Placed on Heparin & LMWH
• An aPTT or unfractionated heparin level will be drawn 6 hours after the initial dose of heparin and 6 hours after any dose adjustment. This frequency may be modified based on the clinical circumstances and presentation of the patient. The physician will be contacted and informed of the aPTT or unfractionated heparin level result if warranted.
  o This does not apply to the use of heparin for the purpose of maintaining patency of lines and catheters
• A baseline platelet count should be obtained on patients placed on LMWH. Further monitoring of a patient’s platelet count should be based on the clinical circumstances and presentation of the patient.

Education of Patients and Families
Patients and – as appropriate – families will be educated on anticoagulant therapy. This education shall include – but not necessarily be limited to – the following:
• Importance of follow-up monitoring,
• Compliance issues,
• Dietary restrictions,
• Potential for adverse drug reactions and interactions.

DOWNTIME PROCEDURE FOR ELECTRONIC DOCUMENTATION
The hospital’s Information Management Plan describes the process for maintaining documentation when there is either an interruption in power or information system components. The plan includes the use of downtime forms created to facilitate paper documentation until systems can be restored. These forms are located in each unit’s downtime kit. Information regarding the status of the electronic systems will be communicated should an outage occur.

ANTIBIOTIC STEWARDSHIP PROGRAM
Background: It is estimated that 20-50% of all antibiotics prescribed in the US acute care hospitals are either unnecessary or inappropriate. Antibiotics can have serious side effects and cause adverse drug reactions. This misuse of antibiotics has also contributed to the growing problem of antibiotic resistance, which has become one of the most serious threats to public health. Unlike other medications, the potential for spread of resistant organisms means that the misuse of antibiotics can adversely impact the health of patients who are not even exposed to them. Therefore, improving the use of antibiotics is an important patient safety and public health issue as well as a national priority.

In 2007, the Infectious Diseases Society of America (IDSA) published guidelines for the development of institutional antimicrobial stewardship programs. These programs are aimed at providing appropriate antibiotic selection, dosing, route and duration of antimicrobial therapy and are supported by various national organizations. In 2013 the CDC highlighted the need to improve antibiotic use as one of the four key strategies required to address the problem of antibiotic resistance in the US. In addition, in 2017, the Joint Commission, CMS and Leapfrog have all adopted Antimicrobial Stewardship as a “core measure” initiative for participation.
A growing body of evidence shows that hospital based Antimicrobial Stewardship Programs (ASPs) dedicated to improving antibiotic use can both optimize the treatment of infections and reduce adverse events associated with antibiotic use. ASPs have been shown to decrease hospital length of stay, health care costs, and antimicrobial resistance while maintaining equivalent clinical and microbiological outcomes through increased cure rate, reduced treatment failures and increased frequency of correct prescribing. They can also help to significantly reduce hospital rates of CDI and antibiotic resistance. ASPs can often achieve these benefits while saving money for the health system.

**Facts about Antibiotic Resistance & Prescribing: Attitudes, Behaviors, Trends, and Cost**

- Antibiotic resistance has become one of the world’s most pressing public health problems.
- Overuse and misuse of antibiotics threatens the usefulness of these important drugs. Decreasing inappropriate antibiotic use is a key strategy to control antibiotic resistance.
- It is estimated that over half of antibiotics prescribed for patients who visit a clinic in the United States are inappropriate.
- Antibiotics cause 1 out of 5 emergency department visits for adverse drug events.
- In 2009, $10.7 billion was spent on antibiotics in the United States, including $6.5 billion among patients who visit physician offices and $3.5 billion among hospitalized patients.

**Good Samaritan Medical Center Specific Strategies:** GSMC’s antimicrobial stewardship program allows the optimization of antimicrobial therapy through review by clinical experts. A pharmacist, in conjunction with an infectious disease physician, review antibiotic usage and microbiologic results daily (Monday through Thursday) for all hospitalized patients. The Antimicrobial Stewardship Team conducts daily discussions with physicians and medical staff regarding the appropriate use of antimicrobial agents through dedicated review of guidelines and hospital resistance patterns as well as patient specific parameters.

**Goals:**
1. To collaborate with physicians in provision of care as related to infections and antimicrobial use
2. To optimize antimicrobial use
3. To improve clinical outcomes
4. To minimize unintended consequences of antimicrobial use
5. To improve patient care and safety
6. To reduce costs associated with antimicrobial use

**Team and Structure:**
- Consultative Groups:
  - ID Physicians (Kaiser Permanente)
    - Dr. Ryan Oyer
    - Dr. Amy Duckro
    - Dr. Carla Saveli
  - Western Infectious Disease
  - ID Pharmacists
    - Catherine Hebert, PharmD BCPS
    - Cisco #: 303-689-6009

**Additional information**
- Antibiogram location – In eSummit go to weblinks at top of screen click on antibiograms then pick GSMC antibiogram
  - “Initial Antibiotic Guide” part of Antibiogram
- Automatic ID consult for all Staph aureus bacteremias or fungemias
- Restricted Antibiotics (requires approval by ID prior to use):
  - Daptomycin
  - Ceftaroline
- Tigecycline
- Anidulafungin
- Voriconazole (unless continued from home)

**Pharmacy Services related to ASP**
- All Kinetics consults are automatic pharmacy consults
  - Vancomycin
  - Aminoglycosides
- IV/PO Switch Program (additional non-ASP agents as per IV to PO Policy)
  - Azithromycin (Zithromax) – including duration of 3 days (500 mg daily)
  - Levofloxacin (Levaquin)
  - Fluconazole (Diflucan)
  - Voriconazole (Vfend)
  - Metronidazole (Flagyl)
  - Linezolid (Zyvox)
- Renal Dose monitoring/adjustment on all patients with CrCl <50 (additional non-ASP agents as per Renal Dose Guidelines available under “Weblinks” within eSummit)
  - Amikacin
  - Amoxicillin
  - Amoxicillin/Clavulanate
  - Ampicillin
  - Ampicillin/Subactam
  - Cefazolin
  - Cefepime
  - Ceftaroline
  - Ceftriaxone
  - Cefazolin
  - Ertapenem
  - Gentamicin
  - Penicillin (PO)
  - Pipercillin/Tazobactam
  - Tobramycin
  - Vancomycin

**Antibiotic therapy guideline reference available per request, contact ID pharmacist**
- UTI
- Organism identification
- Skin and Skin Structure Infections

**CLINICAL ALARM SAFETY**
Good Samaritan Medical Center has a Clinical Alarm Management policy for managing alarms designed to alert clinicians of an actual or potential life threatening condition, which can be found on PolicyTech. This policy addresses the following:
- Clinically appropriate settings for alarm signals
- That alarm signals can never be disabled.
- When alarm parameters can be changed
- Who in the organization has the authority to set alarm parameters
- Who in the organization has the authority to change alarm parameters
- Who in the organization has the authority to set alarm parameters to “off”
- Monitoring and responding to alarm signals
- Checking individual alarm signals for accurate settings, proper operation, and detectability
Please note that if an alarm is sounding, please do not touch, and notify nursing.

**STROKE TIPS**
**Stroke Protocols:**
- Activate Stroke Alert process for any person developing new neurological deficits (dial 55)
• FAST (Face, Arm, Speech, Time) to assess for anterior stroke symptoms
• 5 D’s- to assess for posterior stroke symptoms
  o Dizziness- Balance disturbance, vertigo, dizziness
  o Diplopia
  o Dysarthria- Difficulty speaking or understanding
  o Dystaxia
  o Dysphagia
• Severe, sudden headache without known cause

• **Call “55” in the hospital for any person exhibiting stroke signs/symptoms for stroke alert activation**

• Call a stroke alert for any patient exhibiting above symptoms with a last known normal (baseline neuro status) **< 12 hours**
• May be candidate for IV tPA if recognition occurs within 3 hours of last known normal or up to 4.5 hours in select patients
• Goal--IV-tPA within 60 minutes of arrival to ED or time of recognition if on inpatient unit
• If outside this window may still be eligible for intra-arterial (IA) intervention – consider neurology consult

• Major contraindications for IV-tPA
  • Anticoagulants, including Novel Oral Anticoagulants (INR > 1.7)
  • Non-compressible, active bleeding site.

• Must use Stroke Order set for any patient being evaluated for stroke/TIA:
  • It is a stand-alone admission order set
  • Use of stroke order set ensures that all performance measures needed are addressed
  • It is designed to make your life easier and to provide evidence based care to patients following clinical practice guidelines

**Stroke Order Sets Include:**

**Evaluation:**
• **Stroke Acute Evaluation** for acute ED or in-patient evaluation of new onset stroke symptoms
• **Alteplase Administration for Stroke**—**MUST** be used for any patient receiving tPA

**Admission:**
• **Stroke Admission without Alteplase** –
• **Stroke Admission Post Alteplase Administration**—**MUST** be used for any patient receiving tPA
• **Hemorrhagic Stroke**- designed for intracerebral and non-traumatic hemorrhagic stroke patients
• **Subarachnoid Hemorrhage**

• Patients should be admitted to a designated stroke unit for care
  o Nursing staff on these designated units have additional education and training to care for these patients
• **Remember it’s a stroke until proven otherwise!**

**Did you know?**
• Stroke is now the 5th leading cause of death in the United States but remains the leading cause for long-term disability
  • 87% are ischemic strokes
  • Patients who arrive at the emergency room within 3 hours of their first symptoms tend to have less disability 3 months after a stroke than those who received delayed care
• All three Denver SCLHS site are Primary Stroke Centers. Primary Stroke Center Designation recognizes hospitals that meet standards to support better patient outcomes for stroke care.
CHEST PAIN CENTER ACCREDITATION/ACS CARE
National Jewish/Saint Joseph is a chest pain center accredited hospital by The American College of Cardiology. As such, we have a robust ACS program that extends from pre-hospital care (EMS) to discharge into our cardiac rehab facility. The hospital is committed to providing superior cardiac care to all of our patients as well as using percutaneous coronary intervention (PCI) as our primary reperfusion strategy. The hospital also has a resuscitation program that provides out of hospital cardiac arrest patients, as well as in-house cardiac arrest patients, with a focused targeted temperature management strategy.
A multi-disciplinary team known as the Chest Pain Center Committee has developed comprehensive algorithms that encompass the detailed workflow for our ACS/rule-out ACS patients. These algorithms are to be used in conjunction with chest pain order sets to provide comprehensive cardiac care including best practice recommendations and core measures that are required to meet our accreditation standards.
Highlights of the chest pain center program include:

- Protocols with EMS, clinics and other hospitals to bring/transfer acutely ill patients to SJH for comprehensive cardiac care
- The use of the HEART Score to risk stratify and treat r/o ACS patients
- ACS Triage, Low-Intermediate Risk, Abnormal exercise stress test, Unstable Angina/NSTEMI, STEMI in the Emergency Department, In-Hospital STEMI and Cardiac Arrest algorithms
- (found on each unit &/or ask your preceptor for more information)
- Order sets including: Acute Chest Pain, Low Risk ACS, UA/NSTEMI, Post PCI, TTM, Heparin and general admission order sets that prompt comprehensive orders for the ACS patient
- The use of TIMI scores to risk stratify ischemia versus invasive treatment for the UA/NSTEMI patient
- 24/7 availability of the cardiac catheterization lab for emergent and urgent patient needs
- Non-invasive stress testing available 7 days a week; outpatient non-invasive testing scheduling prior to discharge also available
- Comprehensive and personalized discharge information via the After Visit Summary for patients and families
- Cardiac Rehab as well as an intensive cardiac rehab program for every ACS patient

The Chest Pain Center Committee is committed to providing education to our associates and surrounding community members on early heart attack care and healthy lifestyle options. Above all else, SJH strives to be the premier destination for ACS/Cardiac care. The Chest Pain Coordinator is available to answer any questions as is our physician leads on the CPCC.

SEPSIS MANAGEMENT
We endeavor to provide the best possible care for our patients who are being treated for sepsis. There are several tools available to you to help identify and manage individuals who have life-threatening infections.

Best Practice Alert (BPA)
This will appear on your computer screen when you enter a patient’s chart who may have sepsis based on SIRS criteria. Several options are available to you that will be displayed on this screen. You can choose to ignore if patient is not septic, or you have several other options to pursue if patient appears to have an active infection.

Sepsis Order Set
There is an ICU order set, a non-ICU order set, and an ED order set available for use. Simply type in
“sepsis” under order sets and a dropdown will appear for you. This encompasses the needed orders to fulfill SEP-1 criteria for the appropriate management of sepsis. This includes:

1. Blood Cultures X2
2. Appropriate antibiotics on our formulary for specific infection sites
3. Serial lactate levels to be followed
4. Appropriate volume resuscitation – 30 cc/kg ideal body weight

These must be performed within the first 3 hours of the identification of sepsis. If the patient remains labile from a hemodynamic point of view there are additional orders in these sets regarding pressor options as well as options to assess adequacy of volume resuscitation.

Caveats

A lactate of 4 or greater suggests the need for a higher level of care. Do not hesitate to contact the ICU physician on call if questions arise.

EMTALA

SCL Health complies with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA), codified at 42 U.S.C. § 1395dd, and the regulations implementing EMTALA, found at 42 C.F.R. § 489.24.

The Detailed Policy can be found in Policy Tech, as a System Policy “Emergency Medical Treatment and Labor Act (EMTALA) - SCL Health”

Policy:

It is the policy of the Hospital that it shall:

1. Provide an Medical Screening Exam (MSE) by a physician or other Qualified Medical Personnel/Person (QMP) to any individual who comes to the Emergency Department to determine if the individual has an Emergency Medical Condition (EMC); and
2. If it is determined that the individual has an EMC, provide the individual with such further medical examination and treatment as required to stabilize the EMC within the capability and capacity of the hospital or to arrange for an appropriate transfer of the individual to another medical facility in accordance with the procedures set forth in the policy.

Medical Screening Examination (MSE) – What is it and What is Required

General Requirement

- When an MSE is required pursuant to the procedures set forth in the policy, the Hospital shall perform the MSE to determine if an EMC exists. It is not appropriate to merely “log in” or “triage” an individual and not provide an MSE. The purpose of the MSE is to determine whether an EMC exists. The MSE shall be documented in the medical record.

- To Be Performed by a Physician or QMP
An MSE shall be performed by the emergency room physician, by another physician, or by a QMP. The MSE must include all ancillary Hospital services routinely available to the Designated Emergency Department (DED). This may require the use of an on-call physician.

- Location Where MSE Should be Performed

- Presents to DED. In cases in which the individual presents to the DED, the MSE shall be performed at the DED. If the individual’s condition requires transfer to another department located on the campus of the Hospital in order to determine whether an EMC exists, the individual may be transferred to that department to receive further screening. Appropriate
medical personnel must accompany the individual.

- **Presents to Hospital but not at DED.** If an individual who requires an MSE presents to an area of the Hospital’s campus other than the DED, the Hospital shall start the MSE at the place at which the individual presents. To the extent the individual’s condition permits, the individual shall be transferred to the Hospital’s DED or another department located on the Hospital’s campus, as appropriate, in order to provide the individual with the MSE within the capability of the Hospital’s DED, including ancillary services routinely available to the DED. If the individual is transferred within the Hospital’s campus, appropriate medical personnel shall accompany the individual.

- ** SHALL be Performed within Capability of DED.** Regardless of where the MSE is performed, the Hospital shall perform the MSE within the capability of its DED to the extent necessary to determine whether an EMC exists.

- **Transfer to Complete MSE.** The decision of whether to transfer the individual to another department on the Hospital’s campus to complete the MSE shall be made by the physician or QMP providing the initial screening. The decision to transfer an individual shall be based strictly on whether such transfer is medically necessary, and in no event shall such decision be based in any way on the individual’s insurance status or ability to pay.

**No Delay in Screening or Treatment Permitted**

- Neither the MSE nor any required stabilizing treatment for an EMC shall be delayed to inquire about the individual’s method of payment, insurance status, or prior authorization from a health plan or insurance company. Under no circumstances shall an individual be required to complete a financial responsibility form or make payment of a co-payment prior to receiving an MSE and/or necessary stabilizing treatment.

- **Registration.** So long as it does not delay or otherwise adversely affect the MSE and/or treatment to stabilize an EMC, the Hospital may inquire as to the individual’s demographic information and insurance information as reasonably necessary to properly register the individual at the Hospital. Notwithstanding the foregoing, the Hospital shall not adopt or implement a registration process that unduly discourages individuals from remaining for further evaluation.

- **Prior Authorizations.** The Hospital shall not seek prior authorization, as may be required by an individual’s health plan or insurance company, until after the Hospital has provided the MSE and initiated any treatment necessary to stabilize an EMC if found to exist. In the case of an individual with an EMC, once the Hospital has initiated stabilizing treatment, the Hospital may seek authorization for all services from the plan, including post-stabilizing services, so long as doing so does not delay or otherwise affect the outcome of the care necessary to stabilize the individual, regardless of the insurer’s decision.

- **Consultations / Contact with Personal or Previous Treating Physician.** A physician, QMP, or other QMP may contact the individual’s personal physician or previous treating physician at any time to seek advice or information regarding the individual’s medical history and needs that may be relevant to the MSE and/or treatment of the individual, so long as such consultation does not inappropriately delay the required screening services or stabilizing treatment.

**Appropriate Level of MSE to be Determined on a Case by Case Basis**

- The Hospital shall provide an appropriate MSE within the Capability and Capacity of the Hospital’s DED, including ancillary services routinely available to its DED, to the extent necessary to determine whether an EMC exists. This does not mean that all MSEs must be equally extensive. Rather, each individual must be given an MSE of the quality that is appropriate in order to determine whether that individual has an EMC, based on his or her presenting condition. The objective of the MSE is to determine whether or not an EMC exists.

- Depending on the individual’s presenting condition, the MSE may range from a simple process involving only a brief history and physical examination (when, for example, the nature of the individual’s request makes it clear that his or her medical condition is not of an
emergency nature) to a complex process that also involves performing ancillary studies and procedures. The level of the MSE shall be dictated by what is required to determine whether the particular individual has an EMC.

- The Hospital shall administer MSEs in a non-discriminatory manner. The level of MSE for a particular individual shall be the same level of MSE for any other individual that comes to the Emergency Department of the Hospital with similar signs and symptoms, regardless of the individual’s ability to pay or insurance status.

Non-Emergency Conditions (After MSE)
- The physician or QMP providing the MSE shall determine whether an EMC exists. If the physician or QMP providing the MSE determines that an EMC does not exist, the Hospital’s EMTALA obligations end. In such case, the Hospital shall assess the nonemergency condition and provide reasonably necessary care to the individual within the nature of the non-emergency condition. If appropriate, this may include sending the individual to his or her primary care physician for follow-up care if such action would not cause a deterioration of the individual’s medical condition.

EMCs (After MSE) – What is Required
- If the physician or QMP providing the MSE determines that the individual has an EMC, the Hospital shall either:
  1. Provide the necessary stabilizing treatment for the EMC within the capabilities and capacity of the Hospital’s medical staff and facilities; or
  2. Under the limited circumstances set forth in the EMTALA Policy, provide an appropriate transfer of an unstabilized individual to another medical facility.
Medical Staff Education Packet
Attestation Statement

Please sign, date and return this form with your application for membership/reappointment

My signature indicates that I have received and reviewed the information provided below as part of my initial appointment or reappointment to the Good Samaritan Medical Center Medical Staff

REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION
RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT
ROLE IN EMERGENCY MANAGEMENT
INFECTION CONTROL / HAND HYGEINE
MULTI-DRUG RESISTANT ORGANISMS
PREVENTING CENTRAL LINE INFECTIONS
PREVENTING CATHETER ASSOCIATED URINARY TRACT INFECTIONS
PREVENTING SURGICAL SITE INFECTIONS
INFLUENZA VACCINATION PROGRAM
USE OF RESTRAINT OR SECLUSION
PAIN MANAGEMENT
PHYSICIAN IMPAIRMENT
ANTICOAGULANT THERAPY
DOWNTIME PROCEDURE FOR ELECTRONIC DOCUMENTATION
ANTIBIOTIC STEWARDSHIP PROGRAM
CLINICAL ALARM SAFETY
STROKE TIPS
CHEST PAIN ACCREDITATION
SEPSIS MANAGEMENT
EMTALA & MEDICAL SCREENING EXAMINATIONS

Signature________________________________________ Date__________________________

Print Name