Accreditation / Certification Requirements

Medical Staff Education Packet
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INTRODUCTION
Lutheran 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 understood 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 Lutheran 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
Lutheran 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.

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 changes the assignment.

INFECTION CONTROL & HAND HYGIENE

Standard Precautions

Standard precautions are the standard precautions that are to be taken with any patient to prevent the spread of infection. Basic universal precautions consist of:

• **Hand Hygiene** - Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to perform hand hygiene between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

• **Gloving** - Wear gloves (clean nonsterile gloves are adequate) when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens.

• **Mouth, nose, eye protection** - Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. For example, a bronchoscopy would require the use of eye, nose and mouth protection.

• **Safe Injection Practices** - Recent investigations undertaken by state and local health departments and the Centers for Disease Control and Prevention (CDC) have identified improper use of syringes, needles, and medication vials during routine healthcare procedures, such as administering injections. These practices have resulted in one or more of the following:
  - Transmission of bloodborne viruses, including hepatitis C virus to patients
  - Notification of thousands of patients of possible exposure to bloodborne pathogens and recommendation that they be tested for HCV, HBV, and HIV
  - Referral of providers to licensing boards for disciplinary action
  - Malpractice suits filed by patients

Isolation

Certain patients may require isolation. The table below lists the various types of isolation used in Lutheran Medical Center and the specific precautions that must be taken:

<table>
<thead>
<tr>
<th>Type of Isolation</th>
<th>Specific Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>Wear gowns and gloves when entering the patient’s room. Remove and dispose before exiting the patient’s room.</td>
</tr>
<tr>
<td>Ex. MRSA, CRE, CF patients, and ESBL</td>
<td></td>
</tr>
<tr>
<td>Droplet</td>
<td>Wear a surgical mask when entering the patient’s room. Remove and dispose before exiting the patient’s room. Ensure the mask covers the nose mouth and chin.</td>
</tr>
<tr>
<td>Ex. Mumps, Influenza, Bacterial Meningitis, Pertussis, and Strep</td>
<td></td>
</tr>
<tr>
<td>Airborne</td>
<td>Wear an N-95 mask or PAPR. Remove and dispose upon exiting the patient’s room. Ensure the mask covers the nose mouth and chin.</td>
</tr>
<tr>
<td>Ex. TB, Measles, Varicella, and Disseminated Shingles</td>
<td></td>
</tr>
<tr>
<td>Special</td>
<td>Wear gowns and gloves when entering the patient’s room. Remove and dispose before exiting the patient’s room.</td>
</tr>
<tr>
<td>Ex. C. difficile, and Norovirus</td>
<td></td>
</tr>
</tbody>
</table>
Hands must be washed with soap and water since hand sanitizer is not effective against these pathogens. The environment must be cleaned with bleach or yellow-top wipes.

**Hand Hygiene**
Washing your hands is the single most effective way of preventing the spread of infection among staff and patients. Our organization adheres to the CDC recommendations for good hand hygiene:

Wash hands or use the gel / foam sanitizer:
- Prior to direct contact with patients
- Before donning sterile gloves for procedures
- After having contact with a patient's skin
- After contact with blood or body fluids
- After having contact with equipment near the patient
- After removing gloves
- You must wash your hands with soap and water for any of the following:
  - Engaged in food preparation
  - After using the restroom
  - If your hands are visibly soiled
  - Caring for a patient with C-Difficile

**MULTI-DRUG RESISTANT ORGANISMS**
Periodic assessments are performed to identify the risk of acquisition and transmission of multi-drug resistant organisms (MDRO). Based on this assessment, Lutheran Medical Center has identified the following MDROs to be of epidemiologic significance:

- **MRSA** (*methicillin resistant Staphylococcus aureus*)
- **VRE** (*vancomycin resistant Enterococcus*),
- **CDI** (*Clostridium difficile*)
- **CRE** (Carbapenem Resistant Enterobacteriacae)

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

**Hand Washing**
See above

**Patient Placement**
When possible, patients should be placed in a private room. When a private room is not available, patients with a MDRO infection may be placed with other patients with active infection in the same site and organism and no other infection. Patients with colonization may be placed with other patients with colonization, as long as neither patient is being treated.

**Isolation Precautions**
Patients (both colonized and infected) shall be placed on contact isolation (precautions). Droplet isolation (precautions) should be instituted if the patient has known or suspected positive respiratory cultures.

Patients with positive cultures should remain in appropriate isolation (precautions) for the duration of their present admission and any future admissions to the hospital. Patients may be removed from isolation with the approval of the treating physician or Infection Preventionist.

**Use of Personal Protective Equipment**
Gloves, gowns, and masks should be worn as appropriate to the specific MDRO being treated. Consult appropriate infection control policy if you have any questions.

**Use of Antibiotics**
The selection and ordering of antibiotics may be restricted as determined by Lutheran Medical Center and medical staff. Adherence to these restrictions is expected.

**Patient Transport**
As much as possible, necessary treatments and procedures should be performed at the patient’s bedside. If essential tests must be performed in another area, the department should be notified that the patient has an MDRO prior to transporting the patient to the department.

**PREVENTING CENTRAL LINE INFECTIONS**
It is the policy of Lutheran Medical Center to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

**Equipment & Supplies**
Lutheran Medical Center has assured that equipment and supplies are available when a central line is inserted. At a minimum this includes:

- Central venous catheter
- Central venous catheter insertion kit
- Sterile drapes
- Barrier protection as outlined in this policy
- Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations
- Line maintenance anticoagulant appropriate to the line type and patient age / presentation
- Site dressing

**Central Venous Catheter Insertion**
Whenever a central venous catheter is inserted, the following shall occur:

1. If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
2. Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion
3. Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning / gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site.
4. If body hair needs to be removed, it should be clipped rather than shaved if possible
5. Only approved antiseptic skin preparations should be used.
6. Catheters should not be inserted into the femoral vein unless other sites are not available
7. Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
8. Confirmation of proper placement (e.g. x-ray or other test) may be performed.
Accessing Central Venous Catheters
To reduce the risk of infection, accessing central venous catheters should be limited to necessary use. Catheter hubs and injection ports must be appropriately disinfected prior to use.

Dressing Changes
Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters
Catheters should be evaluated daily and removed as soon as the patient’s clinical status and needs will allow. Non-essential catheters should be removed.

PREVENTING SURGICAL SITE INFECTIONS
Our organization is committed to reducing the incidence of surgical site infections. Please note the following evidence-based practices:

Preparation of the Patient
Whenever possible, infections remote to the surgical site should be identified treated before elective procedures. Elective procedures should be postponed – if necessary – until the remote infection has resolved.

Consideration should be given to having patients shower or bathe with an antiseptic agent on at least the night before the operative day.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should be done in accordance with accepted standards of care.

The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. Alcohol-based, chlorhexidine-based, and iodine-based are acceptable for use as antiseptics. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

Administration of Prophylaxis Antimicrobial Therapy
Prophylactic antimicrobial agents should be administered only when indicated, and selected based on its efficacy against the most common pathogens causing SSI for a specific operation and published recommendations.

Antisepsis for Operative Personnel
Nails should be kept short. Artificial nails, gels, shellac, etc. should not be worn. Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows. After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.
Surgical Attire and Drapes
A surgical mask that fully covers the mouth and nose must be worn when entering the operating room if an operation is about to begin or already under way, or if sterile instruments are exposed. The mask is to be worn throughout the operation. A cap or hood to fully cover hair on the head and face must be worn when entering the operating room. Sterile gloves must be worn by all scrubbed surgical team members. Surgical gowns and drapes that are effective barriers when wet (i.e., materials that resist liquid penetration) should be used. Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials should be changed out.

Asepsis and Surgical Technique
Principles of asepsis should be adhered to when placing intravascular devices (e.g., central venous catheters), spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs. Tissue should be handled gently, maintain effective hemostasis, minimize devitalized tissue and foreign bodies (i.e., sutures, charred tissues, necrotic debris), and eradicate dead space at the surgical site. A delayed primary skin closure should be used or leave an incision open to heal by second intention if the surgeon considers the surgical site to be heavily contaminated (e.g., Class III and Class IV).

If drainage is necessary, a closed suction drain should be used. The drain should be placed through a separate incision distant from the operative incision, and removed as soon as possible.

Postoperative Incision Care
For an incision that has been closed primarily, the site should be protected with a sterile dressing for at least 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be deployed. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

PREVENTING CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)
The CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections, 2009 recommends the following:
- Insert catheters only for appropriate indications, and leave in place only as long as needed.
- Minimize urinary catheter use and duration of use in all patients, particularly those at higher risk for CAUTI or mortality from catheterization such as women, the elderly, and patients with impaired immunity
- Avoid use of urinary catheters in patients and nursing home residents for management of incontinence.
- Use urinary catheters in operative patients only as necessary, rather than routinely.
- For operative patients who have an indication for an indwelling catheter, remove the catheter as soon as possible postoperatively, preferably within 24 hours, unless there are appropriate indications for continued use.

Of note, there is a Lutheran Medical Center nurse driven protocol urinary catheter removal protocol.

Examples of Appropriate Indications for Indwelling Urethral Catheter Use
- Patient has acute urinary retention or bladder outlet obstruction
- Need for accurate measurements of urinary output in critically ill patients
- 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
• Patient requires 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

Examples of Inappropriate Uses of Indwelling Catheters
• As a substitute for nursing care of the patient or resident with incontinence
• As a means of obtaining urine for culture or other diagnostic tests when the patient can voluntarily void
• For prolonged postoperative duration without appropriate indications (e.g., structural repair of urethra or contiguous structures, prolonged effect of epidural anesthesia, etc.)

INFLUENZA VACCINATION PROGRAM
It is an organizational expectation that each individual will be vaccinated or formally decline vaccination.

Annually, prior to the start of the flu season, the organization will notify each Medical Staff Member and Allied Health Practitioner 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 form the time the staff members reports to work, to the time they leave work. The mas can be removed to eat, and use the restroom.

USE OF RESTRAINT OR SECLUSION
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 or seclusion, of any form, imposed as a convenience, or retaliation by staff.
Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Lutheran Medical Center will work to actively decrease the use of restraint or seclusion. When restraint or seclusion 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 restraint/seclusion is a last resort, after alternative interventions have either been considered or attempted.

Training Requirements for LIP’s and AHP’s
All licensed independent practitioners or allied health professionals that manage patients placed in restraint or seclusion will have a working knowledge of the hospital policy. Reference policies Restraint for Non-Violent/Non-Self Destructive Behavior - LMC, and Restraint and/or Seclusion for Violent/Self-Destructive Behavior – LMC, located in Policy Tech for more information.

Prohibitions to Use of Restraint or Seclusion
The use of restraint or seclusion 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 Restraint or Seclusion
The use of restraint or seclusion 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 restraint or seclusion.

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

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

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 restraint or seclusion 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 restraint or seclusion is 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; or RN or PA who has been trained in accordance with the requirements of this policy. 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 or seclusion.

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 is 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.
  - 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.

*Evaluation of the Anti-Coagulant Therapy Program*

Lutheran Medical Center shall – at least annually – evaluate safety practices associated with the management of patients placed on anticoagulant therapy. This evaluation may take the form of:
• Analyzing medication errors and adverse drug reactions associated with the use of anticoagulant therapy
• Adherence to protocols developed to address specific conditions or indications for use
• Provision of education to patients/families
• Other measures as may be deemed appropriate

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.

ANTIMICROBIAL STEWARDSHIP

Medical Director: Dr. Jeff Desjardin, Western Infectious Disease Consultants
ID Pharmacy Specialist: Stacy Volk, Pharm.D., Lutheran Medical Center
Program Hours: Monday – Friday, 8am – 430pm
ASP Phone: 303-403-3532
Interdisciplinary ASP Team Meetings: 2nd Wednesday of every other month (Feb start), 12p-1p, LMC Learning Center #1
Team includes: ID Physicians, Hospitalists, Intensivists, Surgery, Infection Preventionist, Microbiologist/Pathologist/Lab Director, Clinical Pharmacy Staff, Nursing
Shared Governance: ASP -> Pharmacy and Therapeutics -> Medical Executive Committee -> Board of Directors
Program Established (Full time pharmacist and ID MD with contract devoted to ASP): June 2010
Background: The Centers for Disease Control (CDC) suggests that 1 in 2 antibiotics given in the hospital are inappropriate. Because of this and the exponential increase in the frequency of antimicrobial-resistant bacteria being detected in healthcare facilities, the CDC has had a sustained effort over the last 10 years to improve the prescribing of antimicrobials across the country. In 2017, the Joint Commission developed a new medication management standard related to Antimicrobial Stewardship Programs in acute care settings (MM 09.01.01). The standard includes many well-accepted stewardship practices defined by the Infectious Diseases Society of America (IDSA), the Society of Infectious Diseases Pharmacists (SIDP), the Society for Healthcare Epidemiology of America (SHEA), and the Centers for Disease Control (CDC). Our program is designed to maximize the patient care impact of stewardship efforts implemented by devoted pharmacy personnel, as well as, all LMC prescribers and to meet the standards defined by the Joint Commission.

Goals:
1 - Optimize antimicrobial use ->
   * Utilize the appropriate drug, at the recommended dose, for the syndrome-specific, evidence-based duration
2 - Reduce unintended consequences of antimicrobial use -> Prevent development of resistance at the patient, hospital, and community levels
3 - Improve patient safety -> Reduce development of Clostridium difficile and major adverse drug events
4 - Reduce costs -> Review and validate utilization of high cost antimicrobials
5 - Improve clinical outcomes -> Reduce ID-related readmissions and mortality
II. Pharmacy Strategies:

1. **Prospective audit and feedback** -> ID pharmacy specialist reviews all systemic antibiotic orders daily and makes recommendations regarding drug, dose, or duration as needed during program hours.
2. **Restricted formulary** -> LMC has very few restrictions on antibiotics. Primarily, our restrictions are those that are mandated by the SCLHS system P&T committee.
3. **Development of infectious disease related order sets** -> for empiric therapy based on supported literature and antibiogram data.
4. **Pharmacy to dose** -> All vancomycin and aminoglycoside doses are ordered and monitored by pharmacy per protocol. Clinical pharmacy staff may also be consulted to dose any antibiotic on the formulary by using the “pharmacy to dose” CPOE entry.
5. **Clinical pharmacist automatic dose adjustments** -> Dosing changes will be made per protocol by clinical staff as deemed necessary based on indication, patient demographics, organism identified, reported MICs, or organ dysfunction.
6. **IV to PO substitutions** -> Clinical pharmacists will change per protocol defined agents from IV to PO based on pre-specified inclusion and exclusion criteria in order to enhance the utilization of highly bioavailable antimicrobials.
7. **Automatic ID physician consultations** are implemented for the following: *Staphylococcus aureus* bacteremia, ESBL/MDRO bacteremia as defined per policy/MEC approval, including vancomycin-resistant *enterococcus*, and all fungemias.
8. Implement routine pharmacy staff and provider ASP education.

III. All LMC Physician/Prescriber ASP Responsibilities:

1. Define indication for all antibiotics prescribed.
2. Include plan for all antimicrobials in daily progress note.
3. Define duration of therapy as soon as definitive diagnosis is made.
4. Utilize appropriate infectious disease related order sets for empiric therapy (including pre-op and post-op sets for surgery).
5. Formulary change and order set change requests should be first addressed to ID Pharmacist who will then take to appropriate committees for discussion.
6. Peer-to-peer communication engagement -> The ASP Medical Director / ID physician is the responsible party for the utilization of all antibiotics at LMC. As part of this responsibility, the ASP Medical Director may initiate peer-to-peer feedback regarding individual practitioner antimicrobial prescribing habits.

IV. Areas of Focus:

1. The LMC ASP recommends AGAINST routinely ordering urine cultures on patients without urinary symptoms. This leads to the treatment of patients with asymptomatic bacteriuria which is NOT recommended for most patients (exceptions include: pregnancy and patients undergoing urologic procedures with mucosal bleeding risk). Surgery itself is not seen as an automatic indication for urine cultures.
2. **Gram-negative coverage** (aka – ceftriaxone, ertapenem, levofloxacin) for cellulitis is almost never indicated. Cefazolin for non-purulent (usually *Strep spp.*) or vancomycin for purulent (*Staphylococcus aureus*) infections are routinely recommended. Necrotizing fasciitis is an obvious exception. Failing outpatient cephalaxin is NOT in indication for IV vancomycin.
3. **LMC is committed to sparing the utilization of carbapenems.** There is no indication for ertapenem prophylaxis for surgery or treatment of a gram-negative infection that is susceptible to other beta lactam therapies (i.e. – penicillins or cephalosporins). Patients with KNOWN history or ESBL or other MDROs are an exception and very rare at LMC.
4. **Discontinuation of IV vancomycin or IV anti-pseudomonal agents (meropenem, cefepime)** after 48 hours of empiric therapy with negative culture data is strongly
**encouraged in immunocompetent patients.** If you want to continue IV vancomycin or IV antipseudomonal agents after this time, your rationale should be included in the progress note. One out of four blood bottles of coagulase-negative Staph spp. is not considered an appropriate use of vancomycin.

**Utilizing appropriate duration of therapy.** Using shorter courses of therapy is greatly preferred to longer courses due to unnecessary selective pressure that drives antibiotic resistance. Please use evidence-based durations when possible.

### Table

<table>
<thead>
<tr>
<th>Disease</th>
<th>Treatment, Days</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-acquired pneumonia&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>3-5</td>
<td>7-10</td>
</tr>
<tr>
<td>Nosocomial pneumonia&lt;sup&gt;c&lt;/sup&gt;</td>
<td>≤8</td>
<td>10-15</td>
</tr>
<tr>
<td>Pyelonephritis&lt;sup&gt;10&lt;/sup&gt;</td>
<td>5-7</td>
<td>10-14</td>
</tr>
<tr>
<td>Intrabdominal infection&lt;sup&gt;11&lt;/sup&gt;</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Acute exacerbation of chronic bronchitis and COPD&lt;sup&gt;12&lt;/sup&gt;</td>
<td>≤5 ≤5</td>
<td>≥7 ≤7</td>
</tr>
<tr>
<td>Acute bacterial sinusitis&lt;sup&gt;13&lt;/sup&gt;</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Cellulitis&lt;sup&gt;14&lt;/sup&gt;</td>
<td>5-6</td>
<td>10</td>
</tr>
<tr>
<td>Chronic osteomyelitis&lt;sup&gt;15&lt;/sup&gt;</td>
<td>42</td>
<td>84</td>
</tr>
</tbody>
</table>

Abbreviation: COPD, chronic obstructive pulmonary disease.

FAST (Face, Arm, Speech, Time) to assess for anterior stroke symptoms
- 5 D’s- to assess for posterior stroke symptoms
  - Dizziness- Balance disturbance, vertigo, dizziness
  - Diplopia
  - Dysarthria- Difficulty speaking or understanding
  - Dystaxia
  - 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.

--- END --
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 Lutheran 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 HYGIENE
MULTI-DRUG RESISTANT ORGANISMS
PREVENTING CENTRAL LINE INFECTIONS
PREVENTING SURGICAL SITE INFECTIONS
PREVENTING CATHETER ASSOCIATED URINARY TRACT INFECTIONS
INFLUENZA 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

______________________________________________   __ _________________
Signature        Date

______________________________________________