Accreditation / Certification Requirements

Medical Staff Education Packet
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INTRODUCTION
Saint Joseph Hospital 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 Saint Joseph Hospital 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:
- 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 and incident or unusual occurrence form.

ROLE IN EMERGENCY MANAGEMENT

Remember
R.A.C.E.
Saint Joseph Hospital 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 Saint Joseph Hospital and the specific precautions that must be taken:

<table>
<thead>
<tr>
<th>Type of Isolation</th>
<th>Specific Precautions</th>
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<tr>
<td>Contact Ex: MRSA, CRE, CF patients, and ESBL</td>
<td>Wear gowns and gloves when entering the patient’s room. Remove and dispose before exiting the patient’s room.</td>
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<tr>
<td>Droplet Ex: Mumps, Influenza, Bacterial Meningitis, Pertussis, and Strep</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>
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<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>
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Ex. TB, Measles, Varicella, and Disseminated Shingles

| Special Ex. C. difficile, and Norovirus | Wear gowns and gloves when entering the patient’s room. Remove and dispose before exiting the patient’s room. 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, Saint Joseph Hospital 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 Enterobacteriaceae

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 Saint Joseph Hospital 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.

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**PREVENTING CENTRAL LINE INFECTIONS**
It is the policy of Saint Joseph Hospital 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**
Saint Joseph Hospital 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 gowns/ 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 Saint Joseph Hospital 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 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 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. Restriction 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.

Saint Joseph Hospital 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 Restriction for Non-Violent/Non-Self Destructive Behavior – SJH, and Restriction and/or Seclusion for Violent/Self-Destructive Behavior – SJH, 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**

Saint Joseph Hospital 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.

**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 Antibiotic 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.

**Saint Joseph Specific Strategies:** SJH antimicrobial stewardship program allows the optimization of antimicrobial therapy through review by clinical experts. A pharmacist, in conjunction with an infectious diseases physician, review antibiotic usage and microbiologic results daily for all hospitalized patients. 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
    - Dr. Miguel Mogyoros
    - Dr. Dan Mogyoros
    - Dr. Janet Kuhns
  - ID Pharmacist
    - Kelly Kuk PharmD BCPS
    - Pager 303-897-0304

**Additional information**
- **Antibiogram location** – In Esummit go to weblinks at top of screen click on antibiograms then pick SJH antibiogram
- **Pharmacy Services related to ASP**
  - All Kinetics consults are automatic pharmacy consults
    - Vancomycin
    - Aminoglycosides
  - **IV/PO Switch Program**
    - Azithromycin (Zithromax)
    - Levofloxacin (Levaquin)
    - Fluconazole (Diflucan)
    - Voriconazole (Vfend)
    - Metronidazole (Flagyl)
    - Linezolid (Zyvox)
  - **Renal Dose monitoring on all patients with CrCl <50**
    - Amikacin
    - Amoxicillin
    - Amoxicillin/ Clavulanate
    - Ampicillin
    - Ampicillin/ Sulbactam
    - Cefazolin
- Cefepime
- Ceftaroline
- Cephalexin
- Ertapenem
- Gentamicin
- Penicillin (PO)
- Piperillin/Tazobactam
- Tobramycin
- Vancomycin

- Antibiotic therapy guideline cards and formulary cards available per request, contact ID pharmacist
  - Pneumonia
  - Intra-abdominal infection
  - Antibiotic Formulary
  - UTI
  - Organism identification
  - Cellulitis diabetic foot infection

**CLINICAL ALARM SAFETY**
Saint Joseph Hospital 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 Policy Tech. 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**
Saint Joseph Hospital is a Primary Stroke Center as accredited by The Joint Commission. This designation recognizes hospitals that meet set standards to support better patient outcomes for stroke.

**Stroke Detection:**
- 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
  - Dysstaxia
  - Dysphagia
- Severe, sudden headache without known cause
Dial “55” in the hospital for any person exhibiting new stroke signs/symptoms for stroke alert activation

**Stroke Alerts:**
- Activate a Stroke Alert for new neurological deficits!!!
  - Facial weakness, arm or leg weakness
  - Difficulty speaking or understanding
  - Balance disturbance, vertigo, dizziness
  - Severe, sudden headache without known cause
- Call a stroke alert for any patient exhibiting above symptoms with a last known normal < 12 hours
- IV-tPA if recognition occurs within 3 hours of last known normal, 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
  - Joint Commission requires that 50% of eligible tPA patients receive tPA in 60 mins or less
  - The earlier the tPA is started, the greater the benefit and the lower the risk.
- If outside this window may still be eligible for intra-arterial (IA) intervention
  - Patients with contraindications to IV-tPA may still be IA candidates
- Major contraindications for IV-tPA
  - Anticoagulants, including Novel Oral Anticoagulants (INR > 1.7)
  - Non-compressible, active bleeding site
  - Recent surgery is not an absolute contraindication to IV therapy, and not at all for IA treatment
- Other information:
  - Everything will happen faster if the Stroke Alert is active when a stroke is suspected or possible
  - There is a yellow stroke binder on/near the code cart to assist with evaluation and process
  - Stroke TeleMedicine must be notified at the beginning of process, the stroke alert does not automatically notify them

**Stroke Order Sets**
- Stroke Order Sets must be used with 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
  - Order sets are designed for ease of placing orders and to provide evidence based care to patients following clinical practice guidelines
- **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:
  - Intensive Care Unit
  - Intermediate Care Unit
  - Medical Cardiology
Nursing staff on these designated units have additional education and training to care for these patients. Remember: IT’S A STROKE UNTIL PROVEN OTHERWISE

Patients should be admitted to a designated stroke unit for care: Intensive Care Unit, Intermediate Care Unit, Medical Cardiology

Relevant Performance Measures

<table>
<thead>
<tr>
<th>Hyperacute Performance Measures</th>
<th>Ischemic Strokes/TIA</th>
<th>Hemorrhagic Strokes</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>t-PA administered by 3 hours in patients that arrive by 2 hours</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>t-PA administered by 4.5 hours in patients that arrive by 3.5 hours</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>t-PA within 60 minutes of arrival</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Dysphagia Screen prior to ANY PO</td>
<td>x</td>
<td>x</td>
<td>&gt;85%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Performance Measures</th>
<th>Ischemic Strokes/TIA</th>
<th>Hemorrhagic Strokes</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTE Prophylaxis</td>
<td>x</td>
<td>x</td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Antithrombotic administered by end of hospital day 2</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Initial/admission NIHSS reported</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By Discharge Performance Measures</th>
<th>Ischemic Strokes/TIA</th>
<th>Hemorrhagic Strokes</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged on antithrombotic</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>A-fib and discharged on anticoag</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Patients with LDL &gt; = x70x are discharged on statin</td>
<td>x</td>
<td></td>
<td>&gt;85%</td>
</tr>
<tr>
<td>LDL Documented during hospitalization</td>
<td>x</td>
<td></td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Patient education performed AND documented</td>
<td>x</td>
<td>x</td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Smoking cessation counseling performed AND documented</td>
<td>x</td>
<td>x</td>
<td>&gt;85%</td>
</tr>
<tr>
<td>Rehab(PT/OT/ST) considered AND documented if not needed</td>
<td>x</td>
<td>x</td>
<td>&gt;85%</td>
</tr>
</tbody>
</table>

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 department within 3 hours of their first symptoms tend to have less disability 3 months after a stroke than those who received delayed care
- All four Denver SCLHS sites are Primary Stroke Centers.
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. Serveral 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.

ADVANCED DIRECTIVES

When patients are admitted:
- Discuss resuscitation status with the patient/family. Document the decision in a note in the medical record. Enter an order for resuscitative interventions per patient/family wishes.
- Discuss Medical Durable Power of Attorney (MDPOA) with patient family: “If you were unable to make medical decisions for yourself, who would you want to make medical decisions for you?” Document the decision maker in a note in the medical record. If the patient does not have a completed MDPOA form and would like to complete one, page the chaplain on call at 303-897-2629 and he/she will help patient/family complete one.

Any Patient Having a Procedure Under Sedation:
- Needs a designated medical decision maker (MDPOA). Discuss with patient/family as above, document in a note in the medical record. Page a chaplain at 303-897-2629 for assistance completing a form. If patient does not have decision making capacity, page a chaplain to start the process for appointing a proxy decision maker as required by Colorado State law.
- With a Known CPR Directive (DNR status): The provider who is responsible for sedation must document the discussion of advance directive status prior to procedures using the Patient Wishes About Do Not Resuscitate Directive During Surgery or a Procedure form, or document in a note. The form is located on the Landing/Facility-Forms-By Department/ Surgical Services, or can be obtained from clinical department staff.
- NOTE: This includes any area in which sedation is used that might cause the patient to lose their airway when a patient has a Do Not Resuscitate directive.
- If a patient’s DNR status is suspended for a procedure, it should be reinstated after the procedure. Timing for reinstating DNR status should be discussed with patient/family.
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 Saint Joseph Hospital 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
CHEST PAIN CENTER ACCREDITATION
SEPSIS
EMTALA & MEDICAL SCREENING EDUCATION
ADVANCED DIRECTIVE

__________________________________________  ______________________
Signature                                      Date

____________________________________________
Print Name