Accreditation / Certification Requirements

Medical Staff Education Packet
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INTRODUCTION

Saint Mary’s 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 St. Mary’s 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:

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

St. Mary’s 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.

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

INFECTION CONTROL & HAND HYGIENE

Standard Precautions

Standard precautions are the expected precautions that are to be taken with any patient to prevent the spread of infection. Basic transmission based precautions consist of:

- **Hand Hygiene** - Perform hand hygiene before contact with patients and entering patient rooms/exam rooms and 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 or when handling contaminated supplies/equipment. 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. Dispose of gloves at the point of use unless transporting contaminated supplies/equipment. 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** - 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: See the attached CDC Guidelines for Isolation and Respiratory GI Panel Isolation Reference Sheet for SMMC; we will be adding Special & Contact with a new sign for CDiff & Norovirus

Certain patients may require isolation. Hand hygiene is required upon entry & exit. The table below lists the various types of isolation used in SMMC 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 Ex. MRSA, CRE, CF patients, other Multi-resistant organisms (MDRO), and ESBL</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>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>
</tr>
<tr>
<td>Airborne Ex. TB, Measles, Varicella, and Disseminated Shingles</td>
<td>Wear an N-95 mask (only if passed fit testing) or PAPR. Remove and dispose upon exiting the patient’s room. Ensure the mask covers the nose mouth and chin.</td>
</tr>
<tr>
<td>Special &amp; Contact Ex. C. difficile, and Norovirus</td>
<td>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 upon exiting the patient’s room or after</td>
</tr>
</tbody>
</table>
Hand Hygiene
Performing hand hygiene 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 with soap & water or use the alcohol 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 soiled or 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 or performing personal care
- If your hands are visibly soiled
- Caring for a patient with C-Difficile or Norovirus

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, SMMC has identified the following MDROs to be of epidemiologic significance:
- MRSA (methicillin resistant Staphylococcus aureus)
- VRE (vancomycin resistant Enterococcus)
- CRE Carbapenem Resistant Enterobacteriaceae
- KPC (Klebsiella pneumonia carbapenemase (KPC)-producing bacteria)
- Other MDROs

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 shall 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 upon consultation with Infection Prevention/Infectious Disease Physicians. Patients with colonization may be placed with other patients with colonization upon consultation with Infection Prevention/Infectious Disease Physicians, as long as neither patient is being treated. Patients placed on Airborne Precautions are to be placed in Negative airflow isolation rooms (see Suspect TB (Mycobacterium tuberculosis) Patient Protocol and “When and when not to institute Airborne Precautions for AFB”)

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

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 and Infection Preventionist.

Use of Personal Protective Equipment
Gloves, gowns, and masks, protective eyewear/faceshield shall be worn as appropriate to the specific Infection/Communicable Disease 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 SMMC, SMMC Antimicrobial Stewardship and medical staff. Adherence to these restrictions is expected.

Patient Transport
As much as possible, necessary treatments and procedures shall be performed at the patient’s bedside. If essential tests must be performed in another area, the department shall be notified that the patient is on Isolation Precautions & the type prior to transporting the patient to the department.

PREVENTING CENTRAL LINE INFECTIONS
It is the policy of SMMC 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
SMMC 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
- Full body 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 shall be explained to the patient and family. Appropriate consent – if required – shall 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 shall be clipped rather than shaved if possible.
5. Only approved antiseptic skin preparations shall be used.
6. Catheters should not be inserted into the femoral vein unless other sites are not available.
7. Catheters shall 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 shall 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 shall be evaluated daily and removed as soon as the patient’s clinical status and needs will allow. Non-essential catheters shall 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 shall be identified treated before elective procedures. Elective procedures shall be postponed – if necessary – until the remote infection has resolved.

Consideration shall 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 shall be done in accordance with accepted standards of care.

The area around the intended incision site shall 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 shall 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 will be kept short ¼ inch per policy. Artificial nails, gels, shellac, etc. shall not be worn. Personnel shall perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic according to best practice. Hands and forearms shall be scrubbed up to the elbows. After performing the surgical scrub, hands shall 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 shall be dried with a sterile towel and staff shall 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) shall be used. Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials shall be changed out as soon as possible.

Asepsis and Surgical Technique
Principles of asepsis shall 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 shall 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 shall 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 shall be used. The drain shall 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 shall be protected with a sterile dressing for at least 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique shall 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 SMMC nurse partnership 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 shall 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 members 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.
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.
St. Mary’s 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 Restraint for Non-Violent/Non-Self Destructive Behavior – SJH, and Restraint 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**
St. Mary’s 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 heath 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 Mary’s Specific Strategies: SMG 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 attends daily rounds 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 develop pathways for all common infections
3. To reduce days of therapy per 1000 patient days
4. To optimize antimicrobial use
5. To improve clinical outcomes
6. To minimize unintended consequences of antimicrobial use
7. To improve patient care and safety
8. To reduce costs associated with antimicrobial use

Team and Structure:
• Consultative Groups:
  ○ ID Physicians
    ▪ Dr. Sheila Neese
  ○ Intensivist
    ▪ Dr. Garry Lambert
  ○ Pathologists
    ▪ Dr. Rachel LaCount
    ▪ Dr. Tara Marshall
  ○ Hospitalist
    ▪ Dr. Nicholas Blanchard
  ○ Pediatrician
    ▪ Dr. Katherine Joy
  ○ ID Pharmacist
    ▪ Currently recruiting for a new pharmacist

Additional information
• Antibiogram location – SMGs Pharmacy Sharepoint page
• Antibiotic clinical pathways available on SMG pharmacy Sharepoint
  ○ Clostridium Difficile Infection Pathway
  ○ Common Antibiotic Durations
  ○ Inpatient Pneumonia Pathway
  ○ Procalcitonin Pathway – Sepsis
  ○ Procalcitonin Pathway – Respiratory Tract Infection
  ○ Skin and Soft Tissue Infection
  ○ Urinary Tract Infection Treatment
  ○ Urinary Tract Infection Diagnosis
• Pharmacy Services related to ASP
  ○ All Kinetics consults are automatic pharmacy consults unless specified by the ordering provider for physician to manage
    ▪ Vancomycin
    ▪ Aminoglycosides
  ○ IV/PO Switch Program
    ▪ Ampicillin
- Azithromycin
- Cefazolin
- Ciprofloxacin
- Clindamycin
- Doxycycline
- Fluconazole
- Levofloxacin
- Linezolid
- Metronidazole
- SMX-TMP
- Voriconazole

  - Renal Dose monitoring on all patients with CrCl <50
    - Amikacin
    - Amoxicillin
    - Amoxicillin/ Clavulanate
    - Ampicillin
    - Ampicillin/ Sulbactam
    - Cefazolin
    - Cefepime
    - Ceftaroline
    - Cephalexin
    - Ertapenem
    - Gentamicin
    - Penicillin (PO)
    - Piperclillin/Tazobactam
    - Tobramycin
    - Vancomycin

- Provide physician and patient education on antibiotics
- Report quarterly data to Colorado Hospital Association and NHSN
- Track ASP interventions and audit as needed
  - De-escalation
  - Duration
  - Duplicate Therapy
  - Dose Adjustment
  - Inappropriate Coverage
  - IV to PO
  - Indication Unclear

**CLINICAL ALARM SAFETY**

St. Mary’s 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 TIPS
Stroke Protocols:

- Activate Stroke Alert process for any person developing new neurological deficits (dial 55)
  - FAST (Face, Arm, Speech, Time) to assess for anterior stroke symptoms
  - 5 D’s- to assess for posterior stroke symptoms
    - 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) < 6 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 or less 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
- **ED Stroke/TIA order set**: for patients that arrive to the emergency department with stroke

**Stroke Admission order sets-- MUST** be used for any patient being admitted with stroke/TIA or rule out stroke

- **Stroke Admission Post Alteplase Administration**
- **Stroke/TIA Admission without Alteplase**
- **Hemorrhagic Stroke**
- **Subarachnoid Hemorrhage**

- Patients should be admitted to a designated stroke unit for care-at St. Mary’s the two designated stroke units are 9NTS and the ICU.
  - 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
  o 87% are ischemic strokes. 13% hemorrhagic (spontaneous ICH, SAH)
  o 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
• St. Mary’s Hospital is a Primary Stroke Center. Primary Stroke Center Designation recognizes hospitals that meet standards to support better patient outcomes for stroke care.
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 St. Mary’s 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 TIPS

________________________________________________________________________
Signature Date

________________________________________________________________________
Print Name