FAIRVIEW HEALTH SERVICES

JOINT COMMISSION/CMS
Physician and Allied Health Education

2019

⊞ FAIRVIEW

Joint Commission/CMS Educational Requirements

- The following information is provided to all credentialed providers.

- Located throughout The Joint Commission chapters are standards that specify the need to educate physicians and allied health staff about various topics.

- The following presentation covers required education materials for 2019. As a member of the medical staff, it is imperative that you review this educational information. If you have questions please contact the Medical Staff Office (contact information listed on the last page).

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Fairview's Mission

Fairview is driven to heal, discover and educate for longer, healthier lives.

Code of Professional Behavior

All medical staff and allied health staff of Fairview Health Services acknowledge the guiding code for our professions, and as part of the credentialing and privileging process commit to:

- Place the patient at the center of all we do
- Apply the best science we know
- Model the highest level of professionalism
- Actively engage as a collaborative member of the care team
- Be aware of, and comply with the Bylaws, Rules and Regulations and applicable Policies of the entities within which we work

Place the patient at the center of all we do

- I am readily available and approachable
- I discuss medical conditions and medically appropriate treatment choices available with each patient
- I advocate for the patient
- I collaborate with other members of the care team to coordinate care.
- I respect patient confidentiality
- I respect patient diversity
- I encourage questions and respond to them openly
- I respect the important role of family and friends
- I will do my best to meet patient needs within the constraints of science, ethics and available resources.

Apply the best science we know

- I maintain professional knowledge by attending continuing education, reading and learning from colleagues

- I avoid treatment and procedures that are not in keeping with the latest science

- I consult with experts in all professions and I don't provide care outside my area of expertise

- I acknowledge by my actions and words that I am an educator for patients, family and colleagues and I have a duty to apply the best possible science to that role.

- I disclose real or potential conflicts of interest that may create the perception of bias.

Model the highest level of professionalism

- I share information and knowledge proactively with other members of the care team

- I communicate effectively with colleagues and avoid rude or confrontational behavior

- I maintain a respectful manner

- I challenge the professional judgment of others in a polite manner and I do not speak negatively of other health providers to patients and families

- I model appearance and deportment in a way that provides confidence and comfort to the patients.

- I will refrain from sexual contact or romantic relationships with all patients.

- I refrain from conduct and activities that may impair professional judgment and ability to act competently

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Actively engage as a collaborative member of the care team

- I actively participate in team conversations, meetings and rounds related to care
- I am willing to actively engage in medical staff committees
- I am willing to share helpful information
- I listen to others
- I communicate effectively with referring physicians
- I respond to colleagues and staff in a timely manner
- I manage hand-offs well

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Be aware of and comply with the rules

- I have an obligation to understand and follow pertinent Fairview policies

- I help create and sustain standards of care delivery

- I monitor my own behavior and the behavior of others

- I provide honest feedback and coaching to others when needed

Reporting Concerns

- **Environmental / Safety** - Contact facility operations director at your location

- **Patient/ healthcare concerns**
  - Contact facility representatives at your location or enter an event in the Safety Reporting Systems, ICare and RL Solutions.
  - Office of Health Facility Complaints
    Suite 300, 85 East 7th Place
    St. Paul, MN 55101
    651-201-4200 or
  - The Joint Commission

    Office of Quality Monitoring

    One Renaissance Boulevard

    Oakbrook Terrace, IL 601811

    800-994-6610 or 630-792-5000

Hand Hygiene

National Patient Safety Goal

- **Health care workers are expected to perform hand hygiene using soap and water or alcohol rubs:**
  - Before touching a patient
  - After contact with a patient
  - After contact with the patient environment
  - When removing gloves
  - When changing from dirty to clean procedures; includes procedures with the same patient.
  - Before invasive procedures (i.e. inserting indwelling urinary catheters, IV devices)
  - When contamination with body substances has occurred
  - Before touching own eyes and mouth
  - After toileting, using soap and water and turning faucet off with paper towel
  - Before eating
- **Alcohol rubs are effective and are the preferred method for routine hand hygiene.**

  NOTE: These products may not be used if hand skin is visibly soiled nor when exiting an enteric isolation room. In these instances, use of soap and water for hand hygiene is required

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Central Line Associated Bloodstream Infections (CLABSI)

- **Aseptic Insertion of Vascular Catheters:**

  - Hand Hygiene prior to insertion and before any line manipulation

  - Standardized protocol through use of kits/carts/checklists

  - Use of maximal sterile barriers (cap, mask, sterile gown, sterile gloves and full body sterile drape)

  - Chloraprep for skin antisepsis (except infants < 1000 gm – use Betadine solution)

  - Avoid the use of femoral vein unless other sites are not available

Educate the patient/family <u>prior</u> to catheter insertion and document in the patient's medical record.

- **Appropriate Maintenance of Vascular Catheters –** Protect catheter site with sterile dressing; use CHG disc according to the policy.

  - **Do daily evaluation of central line necessity, and remove when less invasive option can be used.** Document evaluation in patient's medical record.

Catheter Associated Urinary Tract Infections (CAUTI)

- **Insert urinary catheters only for appropriate indications and leave in place only as long as necessary. Consider alternatives to indwelling catheters when appropriate.**

- **Please refer to the Fairview Urinary Catheter Management Guidelines for appropriate indications for insertion and continued use.**

- **Aseptic Insertion of Urinary Catheters:**
  - Hand hygiene prior to insertion and before any manipulation of the catheter device or site.
  - Standardized protocol through use of Foley insertion kits.
  - Secure catheter after insertion to prevent movement and urethral traction.

- **Educate the patient/family <u>prior</u> to catheter insertion and document in the patient's medical record.**

- **Appropriate Maintenance of Urinary Catheters**
  - Maintain a closed system. If red seal has been broken, sterility of system is compromised. Replace whole system as appropriate.
  - Ensure urine flow is not obstructed (no kinks or loops) and that the bag is not touching the floor.
  - Empty bag frequently to avoid obstruction and backflow.
  - Catheter care should be performed at least once per day.
  - **Do daily evaluation of Foley catheter necessity, and remove when no longer indicated.** Document evaluation in patient's medical record.

  Cloudy urine, foul-smelling urine and urinary sediment should not alone be an indication for culturing urine.

- **Assess patient for signs and symptoms of UTI and document**
  - Fever, flank or costovertebral tenderness
  - Foley removed day of or day before first sign/symptom: include with above urgency, frequency, dysuria.

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Prevent: *Clostridioides difficile* Infection (CDI)

- **Enteric Isolation should be utilized when *C. diff* is suspected.**
  - Don gown and gloves upon room entry.
  - Hand Hygiene with soap and water upon room exit.
  - Bleach cleaning of the patient room and equipment after use.

- **Due to the sensitivity of the *C. diff* PCR, the test cannot differentiate between asymptomatic colonization and true infection, so testing stewardship is necessary.**
  - Antibiotic treatment is NOT indicated for patients with *C. diff* colonization and can drive antibiotic resistance.

- **A two-part BPA was developed to to encourage testing stewardship.**
  - Part 1: Looks for recent *C. diff* PCR results.
    - Testing for cure or repeat testing is not recommended.
  - Part 2: Helps to differentiate between current *C. diff* infection or possible asymptomatic colonization.
    - ≥ 3 loose/watery stools in a 24 hour period.
    - No administration of laxatives in the last 48 hours.
    - Associated *C. diff* infection symptom (fever, elevated WBC, and/or abdominal pain).
  - Providers may override the BPA if they have strong clinical suspicion of CDI.

FAIRVIEW

Prevent: Surgical Site Infections (SSI)

Educate patient/family on strategies to prevent SSI including:

- Not smoking

- Pre-op showering with an antiseptic agent the evening before and the morning of surgery as applicable. Clean towels, clean sheets on the bed and clean clothing after showering. Proper hand hygiene

- Following surgeon's instructions on wound care

Staff to follow best practices for:

- Antibiotic dosing

- Surgical Site Preparation

- Follow/support all perioperative guidelines and policies

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Antimicrobial Stewardship

- Burden of Antimicrobial Resistance in the Untied States
  - Center for Disease Control (CDC) estimates that more than two million people are sickened every year with antibiotic-resistant infections, with at least 23,000 dying as a result.

- Four Core Actions to Fight Antimicrobial Resistance
  - Prevent Infections- Prevent the spread of resistance through immunizations, handwashing and using antibiotics as directed
  - Tracking-
    - Information gathered by the CDC helps experts to develop specific prevention strategies
  - Improving Antibiotic Prescribing/Stewardship
    - Change the way antibiotics are used. Up to half of all antibiotic use is unnecessary and inappropriate.
    - Commit to always use antibiotics appropriately and safely- only when needed to treat disease, and to choose the right antibiotics to administer them the right way every time.
  - Develop New Drugs and Diagnostic Tests
    - Antibiotic resistance occurs as part of a natural process in which bacteria evolve. It can be slowed but not stopped. Therefore, new antibiotics are always needed to keep up with resistant bacteria

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Antimicrobial Stewardship

- ## What You can do-
  - Promote Antibiotic Best Practices
    - Ensure all orders have a dose, duration and indication
    - Get cultures before starting antibiotics
    - Take an "antibiotic timeout" reassessing antibiotics after 48-72 hours
  - Help patients understand that "less is better" for antibiotics
  - Practice good hand hygiene
  - Be collaborative with your Antimicrobial Stewardship Teams
    - Fairview System Stewardship Efforts
      - Formal Antimicrobial Stewardship Programs have been established at all Fairview Hospitals
      - Joint efforts between Infectious Disease Providers, Pharmacists and Infection Prevention
        » Active intervention with real-time feedback
      - System Antimicrobial Subcommittee
      - Order sets developed with antimicrobial best practices in mind
    - HealthEast Stewardship Efforts
      - Antimicrobial Stewardship Program (ASP)
      - Joint efforts between infectious disease providers, pharmacists and infection prevention
      - Active intervention with real-time feedback

FAIRVIEW

Multiple Drug Resistant Organism Prevention

National Patient Safety Goal

ISOLATION

- **Contact Isolation** for care of the patient with MRSA, VRE, CRE, ESBL, and other MDROs.

- **Enteric Isolation** for care of patients with diarrhea-associated *Clostridium difficile*, norovirus or any other diarrhea type illness.

  - Alcohol rubs and foams may not be used if hand skin is visibly soiled **or when exiting an enteric isolation room**.

  - In these instances, use of soap and water for hand hygiene is required.

EDUCATION

Educate patient and families regarding their MDRO status. Patient education materials are located in Krames On-Demand through the Fairview Intranet and EPIC. HealthEast documents on the Infonet. Document patient education in EPIC. Documentation is how we monitor our compliance for providing patients and their families with education.

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Isolation Practices

STOP **Contact Precautions** **STOP**

Staff entering this room must do the following if entering beyond the swing of the door:

Clean Hands

Gloves

Gown

<u>**Everyone leaving the patient**</u> room must remove PPE and Clean Hands

Visitors do not need to wear gloves and a gown, unless in contact with patient body fluids but must clean hands upon entering and leaving this room

149597

Visitors: must be instructed by patient's nurse before entering room

- Organisms spread by direct or indirect contact
- MRSA, VRE, ESBL, CRE
- Policies regarding Contact precautions will be integrated between LFV and LHE in 2019. Expect slight variations between facilities and refer to signage for instructions.

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Isolation Practices

- Spread by contact
- C diff, norovirus, rotavirus

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Isolation Practices

Droplet Precautions STOP STOP

Staff entering this room must do the following:

Clean Hands

Mask with Face Shield

- Visitors entering: Must clean hands and are advised to wear surgical mask
- Visitors exiting: Remove mask and clean hands
- Staff exiting the room must remove PPE and clean hands
- Patients must wear a surgical mask when leaving the room

When performing the following aerosol-generating procedures:
Intubation, extubation, bronchoschopy, open suctioning, or sputum induction (Does not include nebulizers)
- Place patient into negative airflow (HEPA filter required if patient room is not a negative airflow room)
- Wear N95 respirator and visor, or PAPR (NOT a regular mask)

149596

- Spread by droplets size >5um
- Influenza, bacterial meningitis, mumps
- Policies regarding Droplet precautions will be integrated between LFV and LHE in 2019. Expect slight variations between facilities and refer to signage for instructions.

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Isolation Practices

Patients with varicella and measles should be cared for by staff with evidence of immunity. CDC recommends ALL healthcare providers wear N95 or CAPR respiratory protection to enter the room, regardless of their immune status
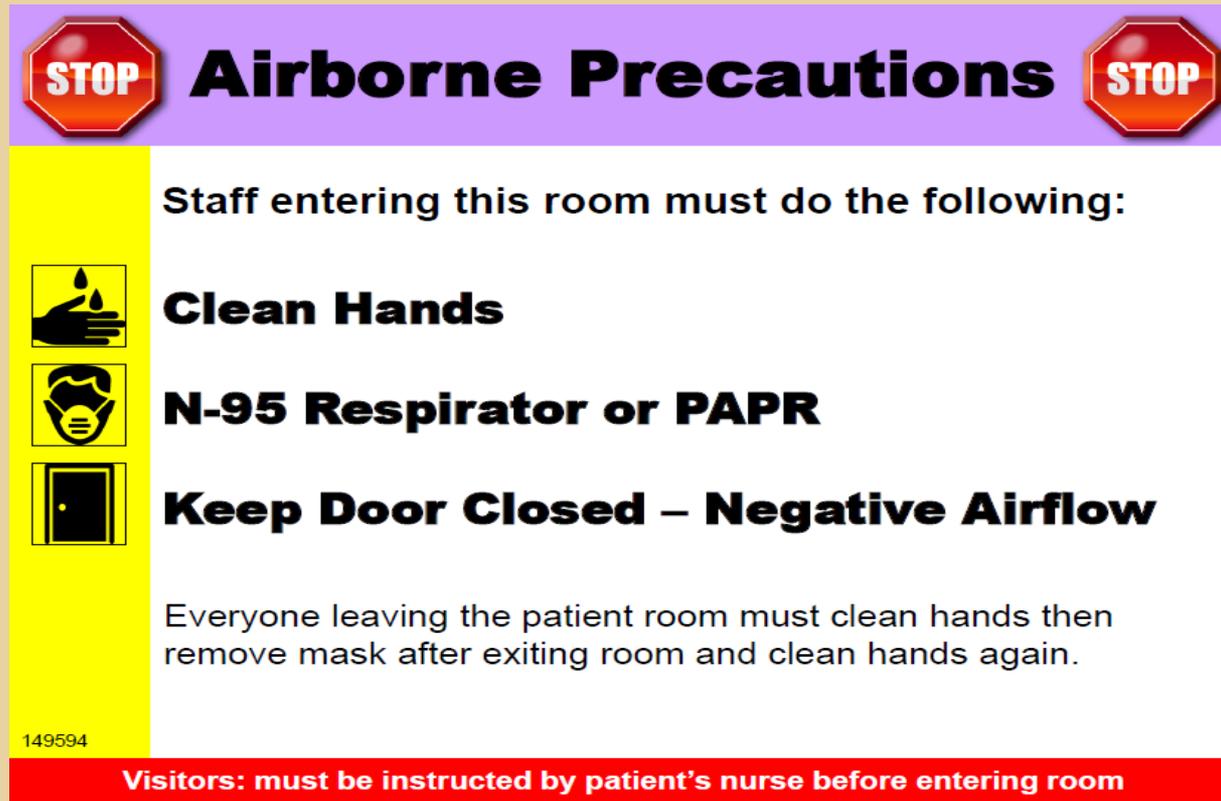
STOP Airborne Precautions STOP

Staff entering this room must do the following:

Clean Hands

N-95 Respirator or PAPR

Keep Door Closed – Negative Airflow

Everyone leaving the patient room must clean hands then remove mask after exiting room and clean hands again.

149594

Visitors: must be instructed by patient's nurse before entering room

- Spread by aerosolized particles <5um
- TB, varicella zoster, measles
- Policies regarding Airborne precautions will be integrated between LFV and LHE in 2019. Expect slight variations between facilities and refer to signage for instructions.

FAIRVIEW

Influenza

- Annually, the Center for Disease Control (CDC) provides the current recommendation for seasonal influenza vaccination.

- The Fairview Health System Infection Prevention Committee provides recommendations specific to our hospitals and clinics based on CDC and Minnesota Department of Health recommendations.

- All Medical Providers and Allied Health Professionals are required to receive the influenza vaccination yearly or complete a declination .

- HealthEast Medical Staff- if declination of immunization is completed, provider must wear a mask.

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Influenza

- **When should health care providers start and stop vaccination efforts?**

  – Vaccination should begin as soon as flu vaccine is delivered. Manufacturers distribute vaccine as production is completed. Distribution of vaccine can begin in August and continue through the fall. Most seasons, vaccine distribution is completed by January.

  – Flu vaccines may be offered to patients when they are seen by health care providers for routine care or as a result of hospitalization.

Fire Safety

What if I discover a fire? (R-A-C-E) Rescue-Alert-Confine- Extinguish/Evacuate

- **Rescue** any person from immediate danger.

- **Alarm/Alert**

  – Pull the emergency fire alarm.

  – Call the emergency number for your site.

  – Be prepared to tell them:

    • Who you are.

    • Where you are.

    • How large is the fire.

    • What type of fire it is.

    • If people are in danger.

  – Stay on the line until the operator ends the call, unless in immediate danger.

Fire Safety continued

- **Confine** the fire
  - Close all doors and windows.
  - Clear the hallway.
  - Stop movement in/out of area.
- **Extinguish** the fire if it is safe and you know how to use the fire extinguisher or **Evacuate** if you are in danger or are directed by the fire response personnel.

- *What do I do if I hear a* **Code Red at Fairview or Fire Alarm and location at HealthEast?**
- **STOP** – Do not go through smoke doors unless needed for immediate patient care.
  - Stop pedestrian traffic where alarm is sounding.
  - Restrict use of hospital telephones to emergencies only.
  - Do not use elevators in building where alarms are sounding.

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Unacceptable Abbreviations

DO NOT USE	ACCEPTABLE
QD, Q.D., qd, q.d. QOD, Q.O.D., qod, q.o.d.	Write "daily," "every other day"
MS, MSO_4, $MgSO_4$	Morphine Sulfate or Magnesium Sulfate
U or u	Units
IU	International Units
Trailing zero: 1.0	1
Lack of leading zero: .1	0.1
μg	Microgram or mcg
Chemotherapy abbreviations.	Spell out all chemotherapy drug names
Abbreviations for ear: au, as, ad Abbreviations for eye: ou, os, od	Spell out "ear" and "eye" Spell out "both," "left," and "right"

FAIRVIEW

Pain Management Strategies

The fundamentals of safe and effective pain management in the hospital include the following steps:

- Opioids are not always first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

FAIRVIEW

Pain Management Strategies

The fundamentals of safe and effective pain management in the hospital include the following steps:

1. Identify the type of pain to treat and

2. Use the correct co-analgesic for that type of pain. Do not rely solely on opioids to treat pain. Opioids are rarely totally effective when used alone.

Type of Pain	Co-analgesic
Inflammatory	NSAID
Muscular	Muscle Relaxant
Neuropathic	Gabapentin
Bone	NSAID

Pain Management Strategies
cont'd

3. Account for patient's home analgesics when planning for a change in analgesics:

    E.g. Oxycontin 60 mg po Q 12 hrs + oxycodone 15mg PO Q 4 hrs PRN= total of 210 mg oxycodone/day.

    This is equivalent to hydromorphone 15.75 mg IV/day.

    Could be administered as hydromorphone 1-2 mg IV Q3Hrs PRN or

    0.5 mg/hr infusion +0.3 mg Q 10 minutes PRN via PCA

4. Use only one scheduled long acting/continuous Opioid infusion and one short acting PRN Opioid together. Using multiple long acting and short-acting Opioids increases the risk of drug side effects, and does little to improve pain relief.

Pain Assessment Tools

When Patients can self-report (Its more than a number)

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

When assessing pain in the patient that can self-report, consider asking more than just, "What is your pain level?"
Consider the following assessment questions:
1. Can you sleep through the pain?
2. Can you walk/ambulate?
3. Can you tolerate this level of pain?
4. Is your pain getting better?

Pain Assessment Tools:

When Patients are unable to self report

Behavioral pain scale

Item	Description	Score*
Facial expression	Relaxed	1
	Partially tightened (eg, brow lowering)	2
	Fully tightened (eg, eyelid closing)	3
	Grimacing	4
Upper limb movements	No movement	1
	Partially bent	2
	Fully bent with finger flexion	3
	Permanently retracted	4
Compliance with mechanical ventilation	Tolerating movement	1
	Coughing but tolerating ventilation for most of the time	2
	Fighting ventilator	3
	Unable to control ventilation	4

* Score ranges from 3 (no pain) to 12 (maximum pain).

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Pain Assessment Tools

When Patients can self-report

Domain	Coded Documentation
Comfort	• Intolerable • Tolerable with discomfort • Comfortably manageable • Negligible pain
Change in Pain	• Getting worse • About the same • Getting better
Pain Control	• Inadequate pain control • Partially effective • Fully effective
Functioning	• Can't do anything because of pain • Pain keeps me from doing most of what I need to do • Can do most things, but pain gets in the way of some • Can do everything I need to
Sleep	• Awake with pain most of night • Awake with occasional pain • Normal Sleep

Pain Assessment Tool

Do you have pain? How much pain do you have? Choose one of these three scales to measure your pain.

10	Pain as bad as it could be	10 Hurts worst
9 / 8	Extreme pain	8 Hurts whole lot
7 / 6	Severe pain	6 Hurts even more
5 / 4	Moderate pain	4 Hurts little more
3 / 2	Mild pain	2 Hurts little bit
1 / 0	No pain	0 No hurt

FAIRVIEW

Pain Assessment Tools:

When Patients are unable to self report

When patients are unable to self-report, use one of the following scales:

FLACC Pain Scale

	Scoring		
	0	1	2
F – Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
L – Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
A – Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
C – Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
C – Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

	0	1	2	Score
Breathing (independent of vocalization)	Normal	Occasional labored breathing, short periods of hyperventilation	Noisy labored breathing, long period of hyperventilation, Cheyne-stokes respirations	
Negative vocalization	None	Occasional moan or groan, low level of speech with a negative or disapproving quality	Repeated trouble calling out, loud moaning or groaning, crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frowing	Facial grimacing	
Body language	Relaxed	Tense, distressed, pacing ,fidgeting	Rigid, fists clenched, knees pulled up, pulling or pushing away, striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				Total

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Pain Assessment Tools cont.

System Pain policy with additional tools can be found at:

http://intranet.fairview.org/Policies/Category/PatientCareClinicalGuidelines/S_071242

CAPA® Tool (modified)

The conversation leads to documentation- not the other way around.

Question	Response
Comfort	• Intolerable • Tolerable with discomfort • Comfortably manageable • Negligible pain
Change in Pain	• Getting worse • About the same • Getting better
Pain Control	• Inadequate pain control • Partially effective • Fully effective
Functioning	• Can't do anything because of pain • Pain keeps me from doing most of what I need to do • Can do most things, but pain gets in the way of some • Can do everything I need to
Sleep	• Awake with pain most of night • Awake with occasional pain • Normal Sleep

FAIRVIEW

CDC Updates regarding pain management

- "Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose, and death." (CDC, 2017) For full guideline visit the CDC webpage.
  https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf
  - Review of prescription drug monitoring program (PDMP) data
  - Urine drug screening
  - Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

FAIRVIEW

2018 JC Standards on Pain Assessment and Management

Effective Jan. 1, 2018, new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited hospitals.

1. Opioid safety is a priority.

2. We provide nonpharmacological pain treatments and modalities. See your respective site lead for services and availability.

3. Please consult the pain team for further point of care education. They also have additional educational resources and programs to improve pain assessment, management, and can give more details on safe opioid use.

4. If needed consult the pain team with complex patients. 651-471-5675 (John's and Woodwinds only).

5. If you need to help your patient with opioid treatment programs you can find them at: http://dpt2.samhsa.gov/treatment/directory.aspx

6. We have facilitated the ease of Prescription Monitoring Program checks and you will now find a link in EPIC that routes you to the PMP.

7. See the Health East Adult Pain Management Policy and Fairview System Pain Management Policy for further information.

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2018 Joint Commission Standards Continued….

8. It is important that you always involve the patient in the pain management plans. This can be as simple as developing realistic goals with your patient and discussing the goals (i.e., improvement in functioning, deep breathing, walking, sleep).

9. Opioid Stewardship – The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment – this is done daily via formal opioid stewardship rounds. Patients deemed highest risk (e.g., patients with sleep apnea, those receiving continuous intravenous opioids, or those on supplemental oxygen) are monitored first. We track adverse events such as respiratory depression, naloxone use trends, and prescribing patterns.

10. We collect data regarding the safe use of opioids in the hospital, if you have a specific concern please report any safety events related to opioids in RL solutions for HealthEast and ICare system at Fairview.

FAIRVIEW

Rapid Response Team Activation

- The Rapid Response Team brings critical care skills to the bedside. They will respond expeditiously to a decline in a patient's condition.

- If you have concerns about a patient and feel they need immediate and urgent help, please contact the nursing staff and they will call a Rapid Response team.

- Families and patients are also instructed to contact a Rapid Response Team in the event of a need for emergency or urgent help.

Alarm Management: Clinical Equipment Alarm Systems

- **Critical alarms:** will not be turned off except for brief silencing during alarm situations or intervention.
  - "Critical Alarms" are when their activation is indicating a potentially life-threatening situation
  - Critical alarms include, but are not limited:
    - **Physiologic monitors**: Cardiac, Oximeters, Capnography, Apnea monitors
    - **Life-sustaining equipment**: ventilators, balloon pumps, ventricular assist devices, defibrillators
    - **Infusion pumps**: IV pumps, feeding pumps, PCA
    - **Central monitoring systems**: telemetry, fetal monitoring

- **Non-critical alarms:** may be silenced and/or turned off if continually alarming and require troubleshooting. Once the cause of the continual alarm is discovered and corrected, the alarm must be reactivated and alarm parameters individualized as required.
  - "Non-critical alarms" are when their activation is indicating a non-life-threatening situation or are located within equipment that is not necessary to sustain life.
  - Non-critical alarms include, but are not limited to:
    - pneumo boots and bed alarms.

FAIRVIEW

Restraints for Nonviolent Patients

- <u>Orders:</u> Restraints must be ordered by an MD, DO, PA, or NP who has completed restraint education and is involved in the care of the patient. In an emergency, RNs may apply restraints, but an order must be obtained as soon as the situation that required the application of the restraint is addressed and the patient is determined to be safe and stabilized (at least within 1 hour).

- The attending physician must be notified as soon as possible if she/he did not order the restraint.

- Standing and PRN orders are not allowed.

- **Restraint orders must be re-written each calendar day.** The provider must examine the patient prior to reordering restraints each day and write a note specific to the patient's condition that requires continued restraint.

- Telephone orders may be accepted for initial application of restraints.

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Restraints/Seclusion for Violent Or Self-Destructive Patients

- An order must be obtained immediately after the restraint has been applied.

- <u>One Hour Exam:</u> **Within 1 hour** of placing the patient in restraints or seclusion, the **patient must be examined by the physician, PA or NP**

- The ordering practitioner must review the patient's physical and psychological status with staff, determine whether restraint or seclusion should be continued, and help identify ways to assist the patient to regain control.

- Documentation of the evaluation must discuss the patient's immediate situation, reaction to the intervention, medical/behavioral condition, and the need to continue or terminate the restraint/seclusion.

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Restraints/Seclusion Cont'd

- **Orders** for Violent or Self-Destructive patients are **time-limited and expire** in:
  - 4 hours for adults (age 18 and older)
  - 2 hours for adolescents (ages 9 through 17)
  - 1 hour for children under age 9
  - If restraint/seclusion needs to continue beyond the expiration of the previous order, a re-evaluation must occur and the practitioner must give a new order. The re-evaluation may be done by the practitioner or other trained staff. However, the physician must reevaluate the patient at the bedside at least every 8 hours for patients aged 18 or older and every 4 hours for patients aged 17 and younger.

For Behavioral Health Patients

- A debriefing about each episode of restraint/seclusion occurs as soon as possible, but no longer than 24 hours after the episode.

FAIRVIEW

Anticoagulants

IV/SubQ	ORAL
• Argatroban drip • Bivalirudin drip • Enoxaparin (Lovenox®) SQ • Fondaparinux (Arixtra®) SQ • Heparin drip/SQ	• Warfarin (Coumadin®) Direct Oral Anticoagulants (DOACs) • Apixaban (Eliquis®) • Betrixaban (Bevyxxa®) • Dabigatran (Pradaxa®) • Edoxaban (Savaysa®) • Rivaroxaban (Xarelto®)

General Anticoagulation Safety

- The risk for anticoagulant-associated bleeding goes up in:

    - **The elderly and those who are a high fall risk**: consider reducing the dose or choosing an anticoagulant that is more easily reversed. Get PT/OT involved early for high fall risk patients!

    - **Patients with hepatic and/or renal disease**: Make sure the anticoagulant is the appropriate choice and that the dose is adjusted

    - **Patients taking additional antithrombotics/NSAIDs**: Hold NSAIDs during anticoagulant therapy

    - **Patients with a history of bleeds** (especially GI): Consider giving a GI protectant

    - **Patients with hypertension, heart failure, cerebrovascular disease or diabetes**

- Anticoagulant use during pregnancy should only be considered if the potential benefit outweighs the potential risk. All women of child-bearing age/potential should receive counseling on the risk for pregnancy related hemorrhage and/or emergent delivery.

Anticoagulation and Spinal Hematoma

Patients receiving anticoagulants are at higher risk for developing an epidural or spinal hematoma. This can lead to long-term or permanent paralysis. Factors that can increase this risk in anticoagulated patients include:

- Use of indwelling epidural catheters

- Those undergoing spinal/epidural puncture

- Those with a history of spinal deformity or spinal surgery

- Use of concomitant NSAIDs, platelet inhibitors, or being on additional anticoagulants

- A history of traumatic or repeated epidural or spinal puncture

Contact anesthesiology for assistance with any of the above scenarios to help develop a plan. (this may include holding antithrombotic therapy during catheter placement/pulls)

Parenteral Anticoagulants: A Comparison

	Argatroban Drip	Bivalirudin Drip	Fondaparinux SQ injection	Enoxaparin SQ injection	Heparin IV/SQ
Safe to use in patients with HIT* and/or heparin allergy?	YES			NO	
Onset	Immediate	Immediate	3-4 hrs after 1st dose	2-4 hrs after 1st dose	IV drip= Immediate SQ = 20-30 min
Duration*	3-4 hours	1-2 hours	24-48 hours	24-48 hours	1-2 hours
Reversal for severe bleeding	4 Factor Prothrombin Complex Concentrate (Kcentra®)			Protamine	

*HIT= heparin induced thrombocytopenia

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Heparin Drips

- Heparin drips are dosed based on "Heparin-10a" levels and ordered through an order set in EPIC. In general, there are 3 dosing schemes available:
  - **HIGH INTENSITY:** used for active clots/VTE
  - **LOW INTENSITY:** used for CV indications
  - **LOW DOSE/FIXED RATE** (300-500 units/hour): This is a very low, fixed rate drip that can be used in post-surgical patients at very high bleeding risk
- Depending on the hospital, heparin protocols are either managed by pharmacists or nurses.
- In the inpatient setting, platelets will be ordered/monitored to watch for heparin induced thrombocytopenia (HIT).

Enoxaparin *(Lovenox®)* & Fondaparinux *(Arixtra®)*

- Enoxaparin and fondaparinux are SQ anticoagulants that can be given inpatient or outpatient.

- Fondaparinux is a <u>non-heparinoid</u> anticoagulant that is typically reserved for use in patients with heparin intolerance and/or HIT.

- Both enoxaparin and fondaparinux are cleared by the kidneys and must be used with caution in patients with renal dysfunction:

  - Enoxaparin should <u>not</u> be used in patients with a CrCl < 15 mL/min
  - Fondaparinux should <u>not</u> be used in patients with a CrCl < 30 mL/min
  - Neither should be used in patients on dialysis

- Inpatient required lab work:
  - Both enoxaparin and fondaparinux patients will have serum creatinines drawn to ensure appropriate clearance.
  - Enoxaparin patients will also have platelet counts drawn to assess for heparin-induced thrombocytopenia.

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Argatroban/Bivalirudin Drips

- Argatroban and bivalirudin are *non-heparinoid* anticoagulants that are used in patients who are not candidates for heparin or enoxaparin (e.g. heparin induced thrombocytopenia and/or a heparin allergy).

- Argatroban and bivalirudin should be ordered through order sets in EPIC. These order sets will provide a starting dose, necessary lab work and instructions for dose adjustments.

- Depending on the hospital, argatroban dosing/adjustments are either managed by pharmacy or nursing staff.

- **Caution: argatroban and bivalirudin both cause the INR lab test to falsely elevate.** If "bridging" with argatroban/bivalirudin over to warfarin, you will need to use chromogenic factor 10 in place of INR to monitor warfarin. Contact pharmacy to assist you!

Oral Anticoagulant Comparison

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban	Betrixaban	Warfarin
Onset	1-2 hrs after dose	2-4 hrs after dose	3-4 hrs after dose	1-2 hrs after dose	3-4 hours after dose	4-5 days
Duration	48 hours	24-48 hours	24-48 hours	24 hours	19-27 hours	4-5 days
Bridging with parenteral anticoagulants?	**Do NOT "bridge" with a parenteral anticoagulant.** **The new oral anticoagulants are very fast-acting** **FULL anticoagulant effect typically occurs 1-4 hours after the first oral dose!**					"Bridging" with a concomitant IV/SQ anticoagulant necessary for existing clots and/or those at moderate-severe risk for clotting
Reversal for Severe Bleeding	**Idarucizumab (Praxbind®)**	**4 Factor Prothrombin Complex Concentrate (Kcentra®)** ***Recombinant Factor Xa (Andexanet alfa / Andexxa®)*				Vitamin K Fresh Frozen Plasma Kcentra®

**Not available, currently being considered for Formulary

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Warfarin

- Warfarin is an oral anticoagulant that works by blocking vitamin-k dependent clotting factors.

Ordering:

- Pharmacists manage the majority of warfarin regimens in the hospital setting
- At Fairview hospitals, prescribers should order "*Pharmacy Warfarin Consult*" via EPIC:
  - Within this consult, you will be asked to fill in a diagnosis and coag lab goal range.
  - Once the consult is received, the pharmacist will evaluate the coagulation lab(s) and will order warfarin doses per policy

Monitoring:

- Before the first dose of warfarin can be given in the hospital, a baseline coagulation test is required
- While the vast majority of warfarin patients are monitored with an INR lab test, certain patient populations may need to be monitored with a "chromogenic factor X" level instead

Elevated INRs/Reversal:

- At Fairview Hospitals, a "*Warfarin Reversal*" order set is available in EPIC
- At HealthEast Hospitals, an "*Anticoagulant, Antiplatelet and Thrombolytic*" reversal order set is available in EPIC.

Holding Anticoagulants Prior to Surgery

Anticoagulant	Minimum Time Suggested To HOLD Anticoagulant Before Surgery
Apixaban	• Low bleeding risk: hold for 24 hrs • Moderate/High bleeding risk: hold for 48 hrs
Argatroban	Hold for 4 hours prior
Betrixaban	• CrCl > 30 mL/min: Hold 3 doses prior • CrCl< 30 mL/min: Hold 6-8 doses prior
Bivalirudin	• CrCl ≥ 50 mL/min: Hold 3 hours prior • CrCl< 50 mL/min: Hold 5 hours prior
Dabigatran	• CLcr ≥ 50 mL/min: Hold 1-2 days prior • CLcr < 50 mL/min: Hold 3-5 days prior
Edoxaban	• Hold at least 24 hrs prior
Enoxaparin	• Q12H Dosing: Hold for 12 hours prior • Q24H dosing: Hold for 24 hours prior
Fondaparinux	• CLCr ≥ 50 mL/min: Hold 2-3 days prior • CLCr < 50 mL/min: Hold 3-5 days prior
Heparin	• Drips: hold for 4 hours • SubQ: Hold 12 hrs for Q12H dosing, Hold 8 hrs for Q8H dosing
Rivaroxaban	Hold at least 24 hrs prior
Warfarin	Hold 5 days prior. Check INR on the AM of the procedure

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EPIC Downtime Procedure

DEFINITIONS:

- **Scheduled Downtime:** A planned period of time during which Epic will be unavailable to end-users.

- **Unscheduled Downtime:** An unplanned, unexpected interruption in connectivity, during which Epic is unavailable to end-users.

<u>Is the Downtime scheduled?</u>

- ☐Yes - Preparatory internal communication procedure is initiated to alert the staff and providers

- ☐No – Begin using downtime procedures at direction of charge nurse or supervisor, based on patient care needs. Unit may switch to downtime procedures immediately if necessary for patient care

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EPIC Downtime Recovery

- **Do not attempt to use Epic until communication is received that the system is live and available for use.**

- For patient safety reasons, it is essential that Hospital Registration and Pharmacy complete ADT/Registration functions and medication orders before other users access the system.

- Continue with Downtime Procedures until notification is received that the system is available.

Health Care Directives

- Legally and morally binding document to extend patient autonomy. Often created before serious illness

- Allows person to:
  - appoint agent as a substitute decision-maker in case of decisional incapacity
  - convey health-related values and preferences relevant to decision making

- Must be completed and signed by person and witnessed or notarized

- Agent may not be the person's current health care provider

- Provider should review with person to assure consistency with law and reasonable medical practice

- Minnesota also has available an Advanced Psychiatric Directive which applies only to treatment with neuroleptic medications and ECT (electro-convulsive therapy)

Surgical/Procedural Time Out

- An interactive, standardized Time Out that engaging each team member (surgeon or any other provider performing a procedure, circulating nurse, scrub and anesthesia care provider or other team members in procedural areas) will be performed just prior to starting the procedure or incision.

- During the Surgical/Procedural Time Out, all activity will stop and all team members will focus on the Time Out.

- If, at any point in the verification process a discrepancy is discovered, the procedure will not continue until the discrepancy is resolved with all members of the procedural team.

- Any team member with concerns or questions regarding procedure verification should express them.

- Culture of Safety**: All employees have a shared responsibility in providing a safe environment of care** for patients, coworkers and themselves.

- A Briefing should occur with the team before the start of a procedure as well as a De-Briefing after the provider is finished.

Site Marking

- Applies to any surgical and non-surgical invasive procedure involving **laterality, level (e.g. spine),or multiples** (toes, fingers, bilateral structures, etc.)

- Site marking must be with **initials**, not an X

- Site marking is done with the patient awake and participating, as able.

- It occurs before the patient is moved to the location where the procedure is performed

Sedation and Analgesia for Procedures System Policy Highlights

- Prescribing providers must be privileged for the intended level of sedation/analgesia

- Anytime deep sedation/analgesia or anesthesia is anticipated **appropriately privileged** practitioners must be **in attendance**

- Sedation and Analgesia can only be performed in certain locations where competent personnel and the required "rescue" equipment are available.

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Sedation Continuum

Minimal   Moderate   Deep   Anesthesia

(Anxiolysis)   (Conscious Sedation)

- Patients may quickly or inadvertently move along the continuum of sedation levels

- The patient's sedation level is not determined by the **drug, drug dose** but by the **patient's response** to the medication(s).

- Procedures utilizing sedation/analgesia require careful assessment of the patient **prior** to administration of the medications, during **administration** of the medications and during **recovery** from them.

Sedation Continued-
Practitioner Responsibilities

- Ensure you have followed the proper steps for credentialing and privileging and understand your role

- Understand role/limitations of ancillary help

- **Perform Sedation specific pre-examination and documentation** are required(Use Epic Sedation Navigator where available)

- **Understand relevant sedation medications**, including dose, route, timing, side effects, etc.

- **Recognize oversedation or airway emergencies**, and how to apply appropriate interventions

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Sedation Continued-
Personnel

- An appropriately privileged provider performs the procedure

- **Another dedicated competent provider, with current ACLS training, administers the medications** under the direction of the appropriately privileged provider and monitors the patient during the procedure and Phase I Recovery - **this person must be separate from the one performing the procedure.**

HIPAA

HIPAA requires that we safeguard patient information. Our patients expect privacy, and there are personal and business consequences for failing to comply with HIPAA and privacy policies.

<u>What you need to know about HIPAA:</u>
- ✓ Covers protected health information (PHI) in any form: written, electronic, oral
- ✓ Limits the unauthorized use and release of PHI
- ✓ Gives patients the right to access their PHI and to be informed of any breaches of their PHI
- ✓ Limits most disclosures of health information to the minimum necessary for the intended purpose
- ✓ Gives patients the right to amend or correct inaccurate health information
- ✓ Requires data security safeguards such as encrypting devices, sending secure emails, locking file storage, and shredding paper

Minnesota has stricter privacy laws than HIPAA. We capture patient consent to share information for treatment and payment via the Consent for Service signed at registration.

<u>What you can do to protect patient privacy:</u>
- Never access or disclose any patient information unless it is needed to complete your assigned job duties. "Snooping" into a medical record out of curiosity is strictly prohibited.
- Be mindful of your surroundings and take precautions (lowered voice, use of privacy curtains) to prevent unintended disclosures.
- NEVER post anything about a patient, no matter how small, on social media.
- Treatment-related photos of patients can only be taken through Haiku/Canto.
- Lock up papers and ensure that any electronic devices or communications are encrypted.
- Limit identifiers (such as room numbers instead of initials) in texting and paging.
- Report concerns and breaches through ICare, RL Solutions, the Privacy Office, or Compliance Hotline.

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Emergency Management

- In time of emergency or disaster do not report to work unless already scheduled to work or directed to do so by your supervisor.

- Follow the site based emergency operations plan and contact your supervisor for further direction.

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Limited English Proficiency & Deaf or Hard of Hearing

- We provide free communication services and aids to patients and families, responsible parties, and those supporting patients in their care.

- Language and communication needs are identified at the initial point of contact.

- As the responsible health care provider, you must take reasonable and necessary steps to ensure communication services and aids are provided when appropriate.

SERVICES & AIDS

- Interpreter services are available 24/7 through in-person, phone and video interpreters.

- Communication aids such as pocketalkers, videophones, and TTYs are available.

- Select documents are available in other languages or translations can be requested.

- Document the offer, request, and use of any communication services and aids for the patient and/or companion in the patient's electronic medical record.

- Effective communication is a shared responsibility. For assistance, call:
  - Fairview Language Services **612-273-3780**
  - East Region Language Access **651-232-5649**

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Medical Staff Governing Documents

- Policies and Governing Bylaws can be accessed on a Fairview computer and are found on the Fairview Intranet at: intranet.fairview.org/business/CredentialingMedicalStaff/index.

- HealthEast Bylaws and Polices can be found on the HealthEast Infonet: https://healtheast.policytech.com/

- Bylaws

  - Each hospital and the combined HealthEast hospitals have their own governing documents including

    - Bylaws

    - Rules and Regulations

    - Credentials and Hearing policy

  - It is the responsibility of each medical staff member to be familiar with the rules and expectations outlined in these documents.

  - If a practitioner applying for privileges would like a copy of the governing documents prior to becoming a member of the medical staff, he/she may contact the Medical Staff Office at the applicable hospital, which is listed on the last page of this document.

Medical Staff Policies

- ## Proctoring Policy*-

  – Providers who do not meet competency measures identified on privilege forms may be eligible to request proctoring in order to meet the criteria.

  – Proctoring must be requested and approved through the credentialing process <u>prior</u> to performing a procedure for which proctoring is being requested.

  – Proctoring request forms are located at: http://www.fairview.org/fv/groups/internet/documents/web_content/s_112565.pdf

- ## Practitioner Health Policy*-

  – Identifies a process and instructions for assistance with health issues or rehabilitation for practitioners with clinical privileges who may have impairment or health-related concerns.

  – Identifies that the VPMA or Medical Director may be contacted for assistance on health matters and must be notified of:

    - Enrollment in a rehabilitation program
    - Leave of absence greater than 90 days
    - Reinstatement of privileges after a leave due to an impairment

- * See HealthEast infonet for East Region specific policies https://healtheast.policytech.com/

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Medical Staff Office Contacts

- Fairview Lakes Hospital- 651-982-7432

- Fairview Northland Hospital- 763-389-6304

- Fairview Ridges Hospital- 952-892-2103

- Fairview Southdale Hospital- 952-924-5109

- University of Minnesota Medical Center- 612-273-1945

- Maple Grove Ambulatory Surgery Center- 763-898-1438

- HealthEast-651-232-3180 or 651-326-5029