Welcome to Online Physician Orientation and Annual Retraining

for

Shoals Hospital

July 2010

Orientation Guide

This comprehensive physician orientation includes key information to review prior to practicing in our facility and as annual retraining.

Orientation Guide

Once you have reviewed the orientation guide in its entirety, print and sign the *Physician Orientation and Annual Retraining Certificate* from the previous web page and return to the Medical Staff Services Office at Shoals Hospital.

Physician Orientation Topics

- Mission
- Medical Staff Services
- Hospital Services
- Regulatory & Compliance
- Patient Safety & Quality of Care
- National Patient Safety Goals

Mission

We are a community of compassionate and skilled caregivers devoted to meeting the physical, spiritual, and emotional needs of those we are privileged to serve.

Medical Staff Services

- Shoals Hospital
  - Miranda Riley/Miranda Brown
    - Medical Staff Coordinator/Assistant
    - Phone: 256-386-1603 – Miranda Riley
    - Phone: 256-386-1593 – Miranda Brown
    - Email: mlriley@chgroup.org
    - Email: mabrown@chgroup.org
    - Fax: 256-386-1303

Medical Staff Committees

- Divisions
  - Medicine
  - Surgery
- Credentials Committee
- Executive Committee
- Special Care Committee
- Environment of Care Committee
- Patient Safety/ Performance Improvement Council
- Professional Practice Evaluation Committee
- Pharmacy & Therapeutics Committee
- Infection Control Committee

Hospital Services

Inpatient Wound Care Services at ECM and Shoals

- Assistance with inpatient wound care is provided by a Certified Wound, Ostomy Continence Nurse and the Skin Wound Assessment and Treatment Team.

Wound Healing Center at ECM East

- The Wound Healing Center at ECM East is the only Center of its kind in the region. It specializes in the latest therapies for hard-to-heal wounds – to include hyperbaric therapy.
- Specific conditions or symptoms treated include:
  - Diabetic Ulcers
  - Lower Leg Ulcers
  - Pressure Ulcers
  - Gangrene
  - Radiation Burns
  - Failing Grafts and Flaps
  - Surgical Wounds
  - Foot/Heel Wounds
  - Wounds Not Healed Within 30 Days

The Endoscopy Center at ECM

- ECM has the area's largest Endoscopy Unit.
- The Center offers one-stop service. From registration through recovery, everything is taken care of for the patient within the expanded facility.

Palliative Care at ECM & Shoals

- Palliative Care Suites at ECM are available for patients and families dealing with chronic or end-of-life illnesses.
- The purpose is to relieve suffering and improve quality of life for patients with advanced illness.
- The primary physician is responsible for the patient's care, but may request a consultation from the Palliative Care Service to assist in managing the patient's symptoms.
- Some palliative care is provided at Shoals through the agencies providing inpatient hospice services (GIP) if a patient meets the criteria for that service.

Case Management

- The Department provides the following:
  - Care Coordination – Ensures the patient receives the right care at the right time at the right location.
  - Utilization Review – Ensures the hospital will be appropriately paid for the care delivered.
  - Discharge Planning – Ensures that post-hospital care needs are provided to the patient.
  - Resource Management – Ensures care is delivered cost-effectively.

Case Management

- Case Managers are available to assist the Physician and staff to coordinate the care of the patient.
  - Care Coordinators assist by rounding with physicians, assisting with coordination of test and procedures and other functions as needed as well as assessing the patients' needs and coordinating the services the patient may require post discharge.
  - Social Workers assist with complex discharge issues and psychosocial needs of the patient and/or family.

Sleep Center at ECM East

- The Sleep Center at ECM East is fully accredited by the American Academy of Sleep Medicine. Physicians are board certified by the American Board of Sleep Medicine. The technical staff includes licensed sleep technologists and respiratory therapists with over 40 years of combined experience. The center has private rooms, queen sized beds, and private baths.

Senior Care Unit at Shoals

- The Senior Care Center at Shoals Hospital is the only in-patient acute geropsych treatment program in northwest Alabama.
- The **Center** offers an acute treatment program designed to address a wide range of geropsychiatric disorders that require hospitalization.
- This specialized program provides acute care to patients age 65 and over exhibiting psychiatric symptoms, often in relation to medical disorders.
- The geropsych team is skilled at completing comprehensive assessments and intervening in highly complex cases involving interplay of medical, psychiatric, functional and psychosocial issues.
- Commonly treated diagnoses:
  - *Dementia*
  - *Psychosis*
  - *Mood Disorders, including Depression*

J.W. Sommer Rehabilitation Unit at Shoals

- J.W. Sommer Rehabilitation Unit on the campus of Shoals Hospital, is the only Acute Rehabilitation Unit in Northwest Alabama.
- Our staff works together with patients and families to ensure that their rehabilitation course prepares them to return to functional living.
- An interdisciplinary team approach, specially trained staff, compassionate care, and evidence based treatment complimented by a Board Certified Physical Medicine and Rehabilitation Physician has made for a very successful unit.
- The unit has recently been expanded by 6 beds to allow a 32 bed capacity.

Radiology Services at Shoals

- The following Radiology Services are available at Shoals Hospital.
  - CT
    - 64 Slice CT Scanner (Coronary Package)
    - QCT Bone Density
  - Nuclear Medicine
  - General Radiography
    - Radiology Dept., Emergency Dept, and Surgery
  - Ultrasound
  - Echocardiology
  - Mammography
    - Stereotactic Breast Biopsy System
    - Digital Mammography
  - Open MRI
- The PACS system is used for all imaging modalities.
- There is a Radiologist at Shoals Hospital from 7AM-4-4:30 PM and available by telephone from 4 PM until 8 PM. Teleradiology coverage from 8pm-5am.
- Our goal is to have a final report on all procedures within 24 hours.
- Reports can be auto-faxed or made available through the Meditech system which can be installed in Physician offices.
- The PACS system can also be installed in Physician offices for instant access to images.

Radiology Services at ECM East

- The following Outpatient Radiology Services are available at ECM East, Monday through Friday from 8am-4pm. A Radiologist is on site at ECM East during normal business hours.
  - Digital Mammography
    - Diagnostic
    - Screening
  - Ultrasound
    - General Abd, OB, Small parts, Breasts, Prostate
  - PET/CT
    - 16 Slice CT scanner
- No general radiography, nuclear medicine or invasive procedures are done at the outpatient facility.

Surgical Services at Shoals

- The Shoals Surgical Services Department performs approximately 3991 procedures including Endo cases per year. Surgery has 5 procedure rooms, 1 Cysto and 2 Endo rooms. Normal operating hours are 6:00 AM-5:00 PM, Monday through Friday.
- Shoals has just received the Blue Cross Distinction Award for Hip and Knee Replacement

Critical Care Unit at Shoals

Shoals has available:

- 10 bed Intensive/Coronary Care Unit
- This unit accepts patients who require ventilation support

Reading EKGs at Shoals

- To schedule training for reading EKGs online in the PACs system, contact the Director of Respiratory at 256-386-1620.

Pharmacy Services at Shoals

- Pharmacokinetic dosing and monitoring (daily), including vancomycin and aminoglycosides.
- Nutrition support team that provides TPN/PPN management and monitoring (daily), including complete writing and monitoring of parenteral nutrition therapy.
- Renal dosing for antibiotics and Lovenox, monitored and adjusted according to creatinine clearance as calculated by Cockroft-Gault.
- Miscellaneous drug dosing.
- Drug information or research, etc.
- Protocol or order set assistance.
- The physician would only need to write “Vancomycin dosing per pharmacy”, or “TPN by pharmacy”, to initiate our involvement.
- The entire pharmacy staff is involved in pharmacokinetic dosing and renal dosing, and the following are involved in the nutrition support and all other clinical functions: Pharmacy Director, Clinical Coordinator, and Clinical Staff pharmacist.

Rehabilitation Services at Shoals

- Inpatient Rehabilitation Services include:
  - Physical Therapy
  - Occupational Therapy (J.W. Sommer only)
  - Speech Therapy
- Outpatient Rehabilitation Services include:
  - Physical Therapy
  - Speech Therapy
  - Wound Care (Physical Therapy)

Clinical Lab Services at Shoals

- 24/7 Clinical Lab
- Esoteric testing provided by Quest Medical Clinical Lab.
- Limited Reference and Microbiology lab provided by ECM.
- Blood Bank limited services with antibody ID and antigen screening performed at ECM lab.
- Contracted Pathology and Cytopathology with pathologists readily available.
- Clinical Lab and Anatomical Pathology are accredited by College of American Pathologists (CAP).

Cath Lab at ECM

- The ECM Cardiac Cath Lab cares for approximately 300 patients per month. The department specializes in the care of adults and geriatrics with known or suspected arterial or cardiac disease. The CCL has four procedure rooms. Normal operating hours are 6am-4:30pm, Monday through Friday.
- Services particular to this area include:

Diagnostic:

- Left Heart Cath
- Right Heart Cath
- Graft Angiogram
- Renal Angiogram
- ABD/AO Angiogram
- EP Studies
- Intra Vascular Ultra Sound
- Wave Wire

Interventional:

- PTCA – PTA – PTCRA
- Stents (Cardiac and Peripheral)
- Dialysis Declotting
- Swan Ganz Insertion
- IABP
- Temporary Pacemaker
- Permanent Pacemaker
- Pericardiocentesis
- Cerebral Angiogram
- AngioJet Declotting
- ICD implants
- Bi-Ventricular implants
- Spectranetics Laser
- Carotid Stenting

PICC Lines

- PICC Placement is provided through a request from ECM PICC line team. There is planning for PICC line education at Shoals with a dedicated team.
- Outpatient Infusion Therapy is available Monday through Friday in the Ambulatory Department. Infusions may be scheduled by calling Centralized Scheduling at 256-768-8181. A physician order will be required to initiate therapy. Common infusions are packed RBC platelets, IVIG, iron, Reclast and antibiotics. Other infusions may be available upon request.

Clinical Nutrition

- A nutritional screening is completed on all patients within 24 hours of admission. All patients for whom nutrition consults are ordered by a physician are completed by a member of the clinical nutrition staff within 24 hours. Patients are reassessed on an on-going basis.

Regulatory

Standards of Conduct & Corporate Compliance

- Our hospitals maintain a high standard of legal and ethical behavior. Our values form the foundation of the service that is rendered by employees, physicians, volunteers and contractors.
- Compliance means that we abide by federal and state laws and standards with an emphasis on preventing fraud and abuse.
- Compliance means we have a responsibility to report any behavior that may be considered illegal or unethical.

Standards of Conduct & Corporate Compliance

- Our values are...
  - Integrity
  - Respect
  - Trust
  - Compassion
  - Responsibility
  - Caring
  - Innovations

The Deficit Reduction Act of 2005 and False Claims Act

- The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including Medicare and Medicaid programs.
- Federal law prohibits discriminating against an individual associated with the hospital because the individual initiated or otherwise assisted in a false claims action.

How do I report a concern?

- If you think someone has committed fraud or taken a wrong action, you are required to report it immediately to one of the following:
  - Shoals/ECM Ethics and Compliance Officer, Terrye Liles at 256-768-8086.
  - Ethics Point at 1-888-9CARE91
  - 1-800-HHS-TIPS
  - Compliance @ regionalcare.net
  - Ethics Point @ http://regionalcare.ethicspoint.com

CMS Regulations Regarding Restraint or Seclusion

Public Health Concerns

- Increased risk of morbidity/mortality for all patients who have been restrained. Research has documented that physically restrained patients are more likely to die even though death was not directly related to restraint use.
- At a minimum, physicians who order restraint or seclusion must have a working knowledge of hospital policy regarding use of restraint or seclusion.

Restraints are renamed by CMS

- Non-Violent or Non-Self-Destructive Restraint (formerly Medical-Surgical Restraints)
- Violent or Self-Destructive Restraint or Seclusion (formerly Behavioral Restraints)

CMS Regulations Regarding Restraint or Seclusion

The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.

The hospital uses restraint or seclusion only when less restrictive interventions are ineffective.

The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.

The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

Restraint or seclusion is based on an individual order by physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing orders. Cannot be PRN and if written as such, must have clarification order.

Attending physician contacted as soon as possible if did not write the order.

Orders for restraint used to protect the physical safety of the nonviolent or non-self destructive patient are renewed in accordance with hospital policy. No 24 hours, no calendar day, any length of time defined by policy.

CMS Regulations Regarding Restraint or Seclusion

Violent or Self-Destructive Restraint or Seclusion

- Debriefing is a formal review process for violent or self-destructive restraint or seclusion event to determine causative factors to prevent further occurrences.
- Debriefing should occur within 24 hours after release from violent restraint or seclusion with the staff, patient, physician, and family if appropriate.

Non-Violent or Non-Self Destructive Restraint

- MD order is good as defined by hospital policy.
- If restraint is discontinued for any reason, then a new order is required to restart restraint.

Death Related to Restraint or Seclusion

- The hospital must report each death that occurs while a patient is in restraint or seclusion or 24 hours after restraint or seclusion is ended to CMS by telephone within one working day.
- Death within 7 days of restraint is reviewed and reported only if directly related to the restraint or seclusion.

Disclosure of Unanticipated Outcomes

- Consistent with institution ethical practices, we recognize the importance of maintaining effective communication with patients and their families and providing information which fosters better decision making. This includes informing the patient and/or the patient's family of an unanticipated outcome (a clinical result that differs significantly from what was anticipated to be the result of a treatment or procedure). In the event that the results from treatment or a procedure differ significantly from what was anticipated, the physician shall communicate the outcome to the patient. Professional judgment will determine when and how the information will be communicated

Illness and Impairment Recognition

- In order to protect patients, staff and others from harm and to facilitate and support a practitioner to retain, or regain, optimal professional functioning consistent with protection of patients, employees and Licensed Independent Practitioners will be educated to identify and report matters of individual health for LIP, i.e. illness and impairment issues based on at-risk criteria.
- Concerns will be reported to hospital Administration, Chief of Staff, or Medical Advisor.

Illness and Impairment Recognition

Recognition of at-risk criteria may include but is not limited to:

- Illness
  - Changes in practice patterns or behaviors
  - Changes in personality or behavior
  - Slurred speech
  - Hand/eye coordination
  - Unsteady gait/stumbling/ recent falls
  - Decreased problem solving ability
  - Changes in communication patterns
  - Parkinson-like movements
  - Symptoms of infections
  - Open wounds/sores
  - Impaired hearing or vision
  - Signs of Alzheimer's disease or dementia

Illness and Impairment Recognition

Recognition of at-risk criteria (cont):

- Drug or alcohol impairment
  - Alcohol odor on breath
  - Stumbling, staggering, difficulty balancing, acts in an uncoordinated manner
  - Behaves in an unpredictable manner; behaves erratically
  - Appears sedated, sleepy, over relaxed; droopy eyelids, slurred speech
  - Appears disoriented, confused; seems “spaced out”, paranoid; anxious
  - Acts violently, aggressively
  - Late or absent from work duties
  - Extreme mood swings
  - Slow respiration rate
  - Poor concentration, difficulty focusing
  - Marijuana odor on clothes/hair
  - Nervous, agitated, fidgety (tapping feet, hands), impaired fine motor skills
  - Fresh needle marks on body
  - Scars or tracks over veins in inner arm
  - Overactive, overly excitable; overly talkative
  - Small, constricted pupils
  - Large, dilated pupils
  - Slow, decreased reactions

Patient Confidentiality

Patient privacy is everyone's concern.

- It is a basic part of patient care and a Patient Right. Protected Health Information (PHI) must be kept confidential whether it is in written, spoken or electronic form.

Reminders:

- Only access patient information for your patients. If you are not involved in the care of a patient, do not access the medical information in any format. (Paper, electronic, lab or x-rays results).
- Do not ask a hospital staff member to retrieve information on a patient not assigned to you.
- You must not access the medical information of family members or friends without **written permission from the patient.** This includes the records of spouses and children. You may access your own medical information or ask for reports through Medical Records.
- Be a **patient advocate** and make others aware that conversations are being overheard.

Patient Confidentiality

Reminders:

- Be aware of where you hold conversations when sharing appropriate Protected Health Information. Avoid areas where your discussion may be overheard by staff and/or visitors. Speak in a quiet voice when discussing information about a patient when others may overhear.
- Don't give your computer password to anyone and do not use another person's password. If you feel a password has become known, notify Information Systems at 256-768-9411 or by email through the Work Order System. Change or request a new password if needed.
- If you see any misuse of Protected Health Information, breach of patient confidentiality, or if you identify a process that needs to be improved regarding confidentiality, discuss it with a supervisor, manager or the Privacy Officer, Nancy White.

Urgent/Emergent & Non Urgent/Emergent Care Process for Uninsured Patients

- Patients are screened for possible program assistance (i.e. Medicaid)
- Uninsured Prompt Pay Discounts are available. No payment arrangements are available for Non Urgent/Emergent uninsured planned services.
- A call will be made to Physician Office prior to discussion with patient for Urgent/Emergent clarification.

Urgent/Emergent & Non Urgent/Emergent Care Process for Uninsured Patients

- The Central Business Office (CBO) discussions with patients will not specifically attribute the clarification to the physician in an attempt to avoid return pressure phone calls to the physician offices.
- The CBO will attempt to communicate to the patient before day of procedure in case it has to be postponed until patient is able to secure payment required.
- The need to postpone will be communicated to service department and physician office as soon as the determination is made.
- Physicians may choose to schedule non urgent/emergent uninsured services after financial clearance from Central Business Office.

Patient Safety & Quality of Care

Patient Safety & Quality of Care

- If you have concerns about patient safety or the quality of care given to any patient within our facilities, the options for notification are:
  - Hospital Administrator
    - ECM – 256-768-9413
    - Shoals- 256-386-1701
  - Patient Safety Officer – Stephanie Smith 256-768-8459
  - Chief Quality Officer – Angie Nix 256-386-1889 or 256-768-9498
  - Risk Manager – Kathy Harrison 256-386-1704 or 256-768-8258
  - Patient Care Manager or Hospital Director.
  - The Joint Commission Office of Quality Monitoring
    - 1-800-994-6610
    - complaint@jointcommision.org
- Physicians may report concerns without fear of retaliatory disciplinary action.

Patient Safety & Quality of Care

- It is the desire and obligation of everyone in our organization to make quality of care and patient well-being the priority.

Fire Safety

If you discover a fire (RACE):

- **R**emove persons in immediate danger.
- **A**larm - pull the fire alarm and call the switchboard operator to give location of fire.
- **C**ontain the fire by closing doors and windows.
- **E**xtinguish the fire if possible or evacuate

Fire Safety

To use the fire extinguisher (PASS):

- **P**ull the pin in the handle.
- **A**im the nozzle at the base of the fire.
- **S**queeze the handles.
- **S**weep back and forth at the base of the fire.

You must call the switchboard in conjunction with pulling the fire alarm and give the location of the fire.

Emergency Preparedness

Safety/Security Codes

CODE	CONDITION
Code Green	All Clear (applies to all codes)
Code Amber (with age & location)	Infant/Child Abduction
Code Blue	Cardiopulmonary Arrest
Code Pink	Infant/Child Cardiopulmonary Arrest
Code Grey	Wandering Patient/Elopement
Code Red	Fire Disaster
Code 99	Visitor, Employee, Patient or Security Emergency
Code D	Disaster Plan
Code 4	Bomb Threat
Care Team	Decline in patient, visitor or employee condition

Material Safety Data Sheets

- Hundreds of different chemicals are used daily in healthcare settings. In the event you have a question or a problem with any chemical, the information you need is available on the *MSDS* for that particular product. It contains details about the hazards, possible exposure mechanisms, symptoms of exposure and remediation action to take if you are exposed.

- To instantly access MSDS Information:
  - Open the Intranet Page and click on the **MSDS** link on the left side of the screen.
  - For emergencies call - **1-888-809-3787.**

Sentinel Event

- Sentinel Event: An event that has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition or the event is one of the following:
  - Suicide of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge
  - Unanticipated death of a full-term infant
  - Abduction of any individual receiving care, treatment or services
  - Discharge of an infant to the wrong family
  - Sexual abuse/assault (including rape)
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
  - Surgery on the wrong individual or wrong body part
  - Unintended retention of a foreign object in an individual after surgery or other invasive procedure
  - Severe neonatal hyperbilirubin (bilirubin > 30 milligrams/deciliter)
  - Prolonged fluoroscopy with cumulative doses > 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose.

Sentinel Event

Near Miss: An occurrence that, but for an interruption, may have led to a sentinel event.

Root Cause Analysis: Conducted as soon as possible following the sentinel event or near miss and recommendations and actions shall be reported to pertinent Medical Staff Divisions and committees.

Patient Rights

- Introduce yourself by name to the patient.
- Ask permission to allow students or other approved outsiders to be present while care is being given.
- Obtain informed consent. When a surgical and/or invasive procedure is to be performed, it is the responsibility of the physician performing the procedure to provide information about the procedure to the patient, answer any questions raised by the patient and obtain consent. The patient must also give consent before any filming or recording can be done during procedures and treatments.
- Physicians must wear a name badge with photo facing outward and without obstruction to photo, name or title.

Pain Management

- Pain will be assessed on all patients by appropriate care providers.
- The goal of pain management is to relieve the physical and psychosocial symptoms associated with pain while maintaining the patient's level of function.
- Effective pain management reduces the incidence and severity of the patient’s acute postoperative or posttraumatic pain, contributes to fewer postoperative complications and is linked to overall quality of life for all patients. The single most reliable indicator of the existence and intensity of pain is the individual’s self report.

Performance Improvement

- We participate in and require documentation on the following core measures:
  - Acute Myocardial Infarction (AMI)
  - Congestive Heart Failure (CHF)
  - Community Acquired Pneumonia (CAP)
  - Surgical Care Improvement Project (SCIP) – Outpatient included
  - Outpatient Chest Pain for EKG time and aspirin administration
- A core measure documentation form is placed on every patient chart for physicians to utilize if they desire. It is not required but will assist physicians in documentation.
- The document measures compliance or contraindications/reasons for measure non-compliance.
- Our goal is to be in the top 10% with all our core measure sets.

Performance Improvement

- A Physician Performance Evaluation Committee (PPEC) conducts Ongoing Physician Performance Evaluations (OPPE).
- Physician outcomes related to all the appropriate indicators by specialty are reviewed by the Professional Practice Evaluation Committee on an ongoing basis and at the reappointment periods.
- Areas of review include :
  - Patient Care
  - Medical/Clinical Knowledge
  - Practice-Based Learning and Improvement
  - Interpersonal and Communication Skills
  - Professionalism
  - Systems-based Practice

Present on Admission (POA) Indicators

- POA indicator is a reporting data element required by CMS for patient diagnoses on inpatient visits to reflect whether each diagnosis was present on admission or not.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered present on admission.
- POA indicators are appended to each ICD-9-CM code reported for patients conditions and diagnoses documented in the medical record by physicians/providers.
- POA data will be used for measuring hospital performance, public reporting, and payment.

Present on Admission (POA) Indicators

Physician/Provider Role:

- To clearly document if a diagnosis or condition was present at the time of admission, especially when diagnoses are established at a point of time subsequent to admission but clinical evidence may or may not support the condition was indeed present on admission.
- Consistent, complete documentation in the medical record is imperative.

Patient Satisfaction

- The Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) is designed by the Centers for Medicaid Services (CMS) to give the public access to hospitals' patient satisfaction data. That information is available at www.hospitalcompare.hhs.gov.
- Questions on the Survey related to Physicians:
  - During this hospital stay, how often did doctors treat you with courtesy and respect?
  - During this hospital stay, how often did doctors listen carefully to you?
  - During this hospital stay, how often did doctors explain things in a way you could understand?
- Survey data is reviewed at Med Exec Committee meeting and Division meetings.

Disruptive Behavior

- It is our policy that the work environment be free from all forms of disruptive behavior including harassment, intimidation, and sexual harassment.
- No form of disruptive behavior will be tolerated.
- Any inappropriate or disruptive behavior by an employee, supervisor, manager, physician, visitor or person doing business with the organization that tends to create an intimidating, hostile or offensive work environment is strictly prohibited.
- Disruptive behavior is characterized by intimidation, ridicule, and condescension.
- Disruptive behaviors will be reported to the Human Resource department or to the Professional Practice Evaluation Committee.

Infection Control

Post Exposure Management Program

- If you are exposed to blood or body fluids by a needle stick or other sharps injury, or by a splash to the mucous membranes or non-intact skin:
  - Wash site immediately with soap and water or rinse eye or mucous membrane with water or normal saline.
  - Immediately inform the nursing supervisor and report to the Emergency Department for post exposure follow-up.
  - Follow up with Employee Health located on the ground floor at ECM, within 48 hours.

Tuberculosis

- Patients with a diagnosis of TB are placed on airborne precautions which require use of negative pressure rooms. Doors should remain closed. Patients must wear regular surgical masks when transported out of their room.
- When entering the room of a TB patient, care providers must wear the respirator mask for which they have been fit tested.
- Physicians may be fit tested by the ECM Employee Health Nurse or nursing employees trained to administer the test.
- TB skin testing of all staff will be performed annually.

Advance Directives

- Shoals Hospital will honor a patient's right of personal decision making and individual choice regarding medical treatment and life sustaining measures in keeping with Federal and applicable State Law.
- If the patient has an advance directive but does not have a copy with them, the RN will notify the physician and the physician will discuss the contents of the advance directive with the patient. The intent will be noted in the medical record.
- An advance directive becomes effective only when the patient is terminally ill or when the patient's condition is one of permanent unconsciousness.
- If the patient does not have an advance directive and requests more information, the RN will give the advance directive booklet to the patient. If the patient wishes to execute an advance directive, the Case Manager or Patient Care Supervisor will be contacted.

Age and Cultural Diversity

- We strive to care for our patients with knowledge of age specific and/or cultural needs.
- Age-Specific competencies support care for the individual at every stage of life. A key part is learning to recognize each patient's needs and abilities due to age.

- Cultural diversity is the differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. Differences make each person unique.

Abuse and Neglect

- Shoals utilizes an indicator-driven referral system to identify patients at risk of abuse and neglect.
- Healthcare providers flag cases of potential abuse and forward the referrals to Case Management.
- Case Managers and/or Social Workers will do an assessment and report confirmed or highly suspicious cases to the appropriate authorities.
- Remember...everyone is responsible for identifying potential abuse victims.

Allow Natural Death

- Allow Natural Death (AND) and Do Not Resuscitate (DNR) both mean “continue all reasonable treatment, but no CPR.”
- AND is less negative and more acceptable for the patient and families dealing with a “natural” death process.
- The physician must write a “AND” or “DNR” order in the patients medical record if applicable.

National Patient Safety Goals

Improve the Accuracy of Patient Identification

- Use at least two patient identifiers prior to any procedure, specimen collection, medication administration, transfusion, transport, or treatment. The hospital actively involves the patient, and as needed the family, in the identification and matching process. When active patient involvement is not possible or the patient's reliability is in question, the hospital will designate a caregiver responsible for identity verification.

Improve the Accuracy of Patient Identification

- Patient Identifiers at Shoals:
  1. Patient Name
  2. Patient Date of Birth
  3. Label containers used for blood and other specimens in the presence of the patient.
- Eliminate transfusion errors related to patient misidentification.
  - Match blood or blood component to the order, match the patient to the blood or blood component, 2 person verification process or 1 person with automated identification (bar coding)

Improve the Accuracy of Patient Identification

- The hospital uses white patient identification bracelets. In addition to the white bracelets, standardized color coded wristbands will be used to alert staff to various patient conditions.
  - Red – Allergy Alert
  - Yellow – Fall Risk
  - Purple – DNR/AND (Do Not Resuscitate or Allow Natural Death)
- Color coded stickers that coordinate with the wristbands will be placed on the patients chart when applicable.

Improve the Effectiveness of Communication Among Caregivers

- Critical results of tests and diagnostic procedures are reported on a timely basis.
  - Critical values will be reported by the responsible licensed caregiver to the physician within 30 minutes of obtaining the test values.

Improve the Safety of Using Medications

- Medication orders that are illegible, incomplete, unclear or contain unapproved abbreviations must be clarified by the physician and the order rewritten before administering the medication.

Improve the Safety of Using Medications

Unapproved Abbreviations

USE	DO NOT USE
Unit	U, u
Units	IU or iu
Daily, every other day, 4 times daily, 4 times a day or 4x daily	qd, q.d., qod, q.o.d., QD Q.D., Q.O.D., QOD, or q.i.d.
10 mg	10.0 mg (trailing zero)
0.2 mg	.2 mg (lack of leading zero)
Morphine Sulfate	MS, MSO_4
Magnesium Sulfate	$MgSo_4$

Reviewed 4/2010

Improve the Safety of Using Medications

- For a patient to self administer medications, a physician order is required. The physician order must include:
  - Medication name
  - Strength
  - Frequency
  - Route
  - Directions
  - Medical condition being treated

Medication Reconciliation

Medication reconciliation is the process of creating the most accurate list possible of all medications including name, dosage, frequency and route the patient is taking prior to admission into the facility. The nurse will verify the date and time of last dose with patient. One copy will be placed under the physician orders tab for their review. One copy is placed under the Med Rec tab for use at the time of discharge of the patient. **The physician will review the list and determine which medications the patient will continue.** After the physician signs the order, the list is scanned to the pharmacy and orders will be processed and signed off by the nurse. **Any discrepancies must be verified with the physician.**

Medication Reconciliation

- For patients who present in ED , the most recent medications taken by the patient will be placed into the Med Reconciliation. Upon discharge, any additional medications or changes in routine medications will be documented on the Med Rec form and a copy will be given to the patient.
- If the patient is admitted to the hospital, the Med Rec will accompany the patient to the nursing unit and will be utilized by the RN to update any medications not present on the previous list.
- **Any discrepancies must be verified with the physician.**

- **Daily medication list of current medications taken while in the hospital will be printed daily and placed under the physician's order tab.**
- **This may be utilized daily to make changes to current orders or may be used at the time of discharge. It is not required to be signed each day if no changes are made.**

Reduce the Risk of Healthcare Associated Infections

- CDC hand hygiene guidelines are followed. Use soap and running water, rub hands vigorously for 15 seconds, rinse well and dry hands with a paper towel. If hands are not visibly soiled, an alcohol based foam gel may be used.
- Deaths resulting from healthcare associated infections are treated as a sentinel event. A Root Cause analysis will be conducted to determine how and why the patient acquired the infection.
- When indicated, SCIP initiatives are utilized for surgical patients. The SCIP Core Surgery Measures are listed on the next page.

Reduce the Risk of Healthcare Associated Infections

SCIP Core Measures	Nurse Action/Intervention
Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision *to decrease risk of infection.*	**Prophylactic Antibiotic:** Start antibiotics (eg Vancomycin) only when surgery calls & tells you to start. Spike and send all other antibiotics to surgery for the CRNA to start. Document all antibiotics sent to surgery in the MAR as non-admin.
Recommended Antibiotic Selection	Antibiotic selection verified by pharmacy & anesthesia.
Antibiotics Ended Within 24 Hours of Surgery End Time (48 hours for cardiac surgery patients) to decrease risk of infection.	Antibiotics should not extend beyond 24 hours of surgery end time (48 hours for cardiac surgery patients) unless there is physician documentation of an infection / possible infection. Clarify orders if needed.
Hair Removal by clippers	**Hair Removal**: Document how hair was removed or "none" removed.
Glucose Control for Cardiac Surgery Patients with blood glucose levels maintained less than or equal to 200 mg/dL for post-op day 1 and 2 to decrease the risk of infection.	**SEE HYPERGLYCEMIC PROTOCOL (FOR CABG, VALVE, PERICARDIAL WINDOW)** Obtain blood glucose level and treat per Hyperglycemic Protocol. Keep blood glucose levels less than or equal to 200 mg/dL post-op day 1 and 2. Notify MD if unable to control blood glucose.
VTE Prophylaxis (Mechanical and/or Pharmalogical) Started Within 24 Hours Prior to Surgery Start Time to 24 Hours After Surgery End Time to prevent pos-op complications.	Verify that surgery patients have the appropriate VTE prophylaxis ordered. Start prophylaxis within 24 hours of surgery end time.
Beta-Blockers Perioperatively (within 24 hours of surgery) for all patients on home beta-blockers.	Document the date and time the last Beta-Blocker was taken by the patient on the Pre-Procedure Checklist. Do not hold Beta-Blockers because the patient is NPO. Do not hold Beta-Blockers unless a physician/anesthesiologist order is obtained to hold or unless there is a documented contraindication.
Temperature Control (temperature of 96.8° F or greater) for Post-Op Recovery by Critical Care Units.	Check the patient's temperature upon arrival to the unit and document temperature within 15 minutes after arrival to the unit.
Urinary Catheter Discontinued on Post-Op Day 1 or Post-Op Day 2.	Remove urinary catheters by POD 2 (**if placed in the OR for surgery**). Clarify with physician if orders have not been received by post-op day 2 for removal and either: write orders for catheter discontinuation or write orders of physician reason to continue catheter.

The Organization Identifies Safety Risks Inherent in its Patient Population

- A risk assessment will be conducted on patients. The risk assessment identifies specific characteristics and environment features that may increase or decrease the risk of suicide.
- When a suicidal patient is being treated, the immediate safety needs must be addressed and the patient will be placed in the most appropriate setting.
- Upon leaving the care of the hospital, the patient at risk for suicide and their family will be provided with suicide prevention information.

Universal Protocol

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and as needed, the family are involved in the process.

Universal Protocol

Preprocedure Verification Process

- The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:
- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Universal Protocol

Mark the surgery site.

- Patient/patient's next of kin will be involved in the site identification process.
- **The physician ultimately accountable for the procedure and will be present when the procedure is performed marks the site.**
- The mark(s) should be visible at the time of the procedure/ surgery after the patient is prepped and draped.
- For cases in which the patient refuses site marking or it is technically or anatomically impossible or impractical to mark the site, a temporary blue armband will be placed on the patient's wrist on the side of the procedure by the physician or the physician's assistant performing the procedure. The blue armband will have a patient's sticker affixed with the patient name and date of birth.

Universal Protocol

A time-out is performed before the procedure.

- Prior to the start of an invasive procedure requiring a consent, a time-out is required to verify the following:
  1. Correct patient
  2. Confirmation that the correct side and site are marked
  3. Accurate procedure consent form with MD signature
  4. Agreement on the procedure to be done
  5. Correct patient position
  6. Relevant images and results are properly labeled and appropriately displayed
  7. The need to administer antibiotics or fluids for irrigation purposes
  8. Safety precautions based on patient history or medication use (i.e. allergies or precautions around implantable devices)
  9. The time-out process must be documented

Other Topics

Rapid Response Team

- To improve recognition and response to changes in a patient's condition, Shoals Hospital has a Rapid Response Team which is known as the **CARE Team**. This team is called upon when a patient appears to be declining and allows for early intervention that my prevent a Code Blue outside of the Critical Care Units.

Patient Fall Prevention

To prevent patient falls from occurring, we ask everyone to:

1. Provide assistance for patients who are attempting an unsafe transfer or who are in distress.
2. Request assistance for the patient and stay with them until assistance arrives if you are unable to assist.
3. Report any unsafe patient situations to the charge nurse.
4. Communicate patient fall precaution status to other health care providers.

Patients are identified as high risk for falls by:

- Fall alert signs (Yellow Falling Leaf) on the patient's door
- Yellow Fall Risk armband
- Yellow skid proof socks
- Yellow “Fall Alert” sticker placed on front of medical record

Reducing the Risk of Influenza and Pneumococcal Disease

- Upon admission to the hospital, patients are assessed for current status in regard to influenza and pneumococcal vaccination.
- If the patient meets eligibility requirements, the influenza and pneumococcal vaccines will be offered to the patient prior to discharge.
- The patient has the right to refuse the vaccine(s).

Pressure Ulcers

- To prevent healthcare associated pressure ulcers, chronic wounds/pressure ulcers will be measured on admission and every Wednesday and upon discharge.
- Pressure ulcers will be photographed on admission, on Wednesdays, upon discharge and on an as needed basis. The picture will be mounted on the Wound Photography and Staging Form and posted under the Miscellaneous Tab.

Language Line

- We have the ability to access credentialied translators fluent in over 140 different languages to include American and Spanish Sign Language through *Language Line Services*.
- Language phone is located at the nursing desk on patient care units and instructions for use is on the phone itself and it will be placed in the patient's room for use.

Spiritual Needs

- The spiritual needs of the patient and/or families are identified upon admission as part of the on-going assessment process.
- Hospital pastoral services are available, at a minimum, on an on-call basis 24 hours a day, 7 days a week.
- A non-denomination chapel is located on the First Floor of Shoals Hospital adjacent to the staff elevators.
- Requests for assistance with pastoral care may be made to Patient Care Services, Social Services, or the Patient Representative.

Nursing Leadership

- There is always a nurse leader in the building.
- The Nursing Supervisor is the Administrative Representative after hours and on weekends.
- The Nursing Supervisor can be reached at 256-386-1692 or 256-366-7323.
- Notify the Nursing Supervisor when accepting a patient as a transfer from another facility.
- Notify the Nursing Supervisor when a patient needs an urgent admission to a Critical Care Unit bed.

Physician Online Resources

- *Up-to-Date* & *MD Consult* are available to Physicians through the Intranet.
- *MD Consult* can be made available in Physician offices through individual registration.
- *Up-to-Date* patient information is available through hospital website.
- Contact the Education Department for detailed information and assistance.

Meditech & PACS Training

- Individualized Meditech and PACS System Physician training can be scheduled by calling:
  - Information Systems – 256-768-9411
  - Medical Staff Services – 256-386-1603

Organ Donation

- In cooperation with the Alabama Organ Center (AOC) and the Alabama Eye Bank (AEB), Shoals participates in the Routine Referral Donation Program.
- Staff is trained to contact the AOC and/or AEB when appropriate.

Conclusion

- You have finished reviewing the material for Online Physician Orientation.
- Print and sign the Physician Orientation Certificate and return it to the Medical Staff Services Office at Shoals Hospital.