M Health Fairview

JOINT COMMISSION / CMS
Medical Staff Education

2024

Joint Commission / CMS Educational Requirements

- The following information is provided to all credentialed practitioners.
- 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 2024. As a member of the medical staff, it is imperative that you review this educational information.
- If you have questions, please contact Medical Staff Services.

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M Health Fairview Mission, Vision, and Values

Fairview's mission

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

Our vision

Fairview is driving a healthier future.

Our values

- *Dignity*: We value the uniqueness of each person and work to ensure everyone's right to privacy. We respect the cultures, values, beliefs and traditions of others and honor their talents and contributions.
- *Integrity*: We say what we mean and do what we say. We communicate openly and honestly and behave ethically. We demand the best of ourselves and accept shared accountability for our actions.
- *Service*: We work to make a difference in people's lives and in our communities. We strive for excellence by anticipating, meeting and exceeding expectations. We continually improve our programs and skills through learning and innovation. We responsibly manage our resources.
- *Compassion*: We recognize and respond to the emotional, spiritual and physical needs of all the people we serve. We create a caring environment, conducive to healing, growth and well-being for all.
- *Innovation*: We support clinical research that leads to tomorrow’s cures. We advance new business models that will change health care. From the bedside to the call center, we are committed to continual improvement. Innovation is part of who we are.

Medical Staff
Code of Professional Behavior

All medical staff members are expected to follow and adhere to the Medical Staff Code of Conduct as well as the Fairview Health Services Code of Conduct.

All medical staff and allied health staff of M Health Fairview 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 practitioners 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.

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.

Be aware of and comply with the rules

- I have an obligation to understand and follow pertinent M Health 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.

Diversity & Cultural Competency

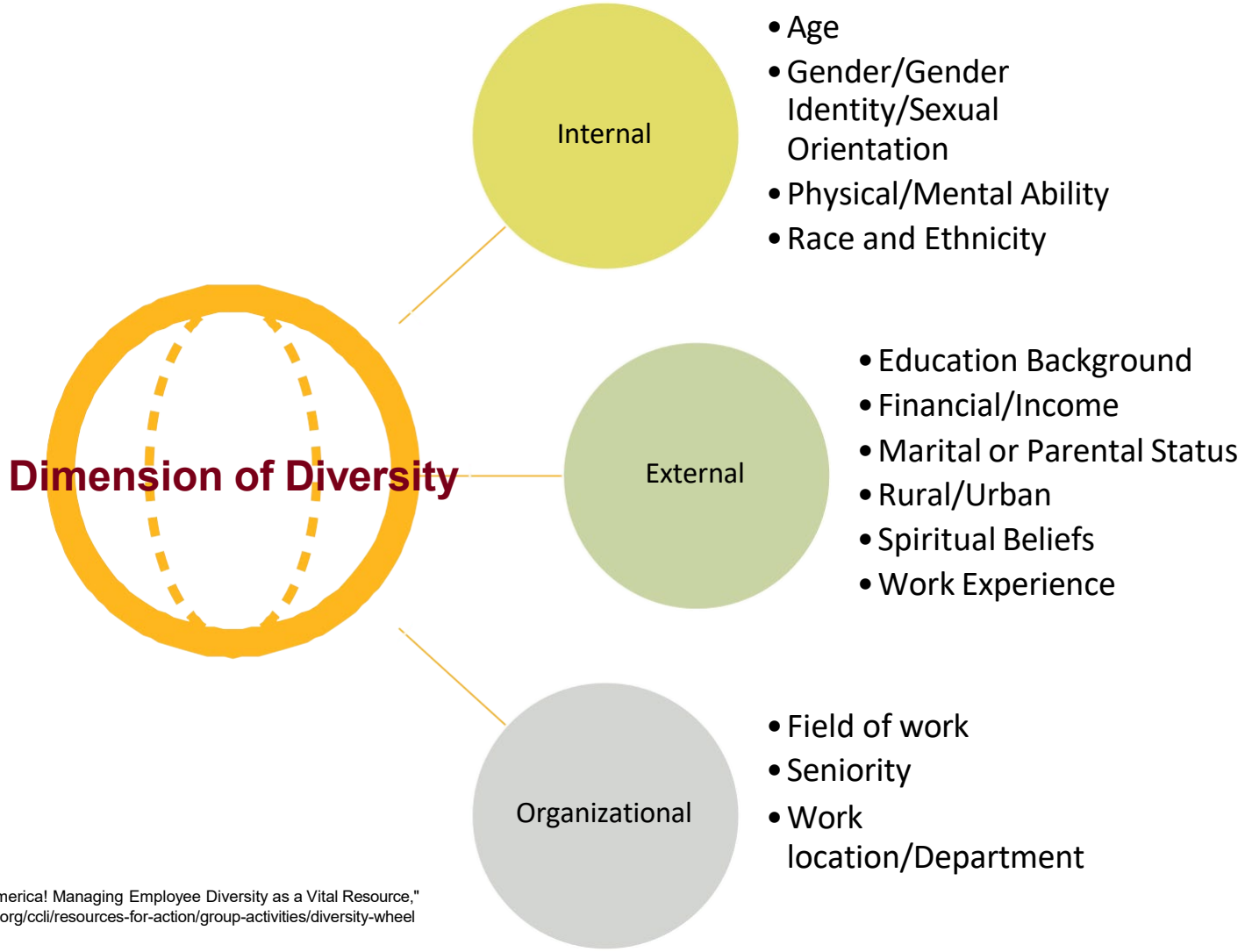
- Knowing that our patients and community populations are increasingly diverse, it is important we **understand how culture impacts the work we do** and **how we can increase our cultural awareness and understanding.**
- For instance, many ethnic cultures have cultural beliefs and it can impact how patients interpret and perceive pain*.
- For more information and resources, visit the Fairview Diversity, Equity, and Inclusion intranet pages.

* Source: The Importance of Cultural Competence in Pain and Palliative Care, Giver, Bhatt, Maani-Fogelman, May, 2023 https://www.ncbi.nlm.nih.gov/books/NBK493154/

Defining Diversity, Equity, and Inclusion

Fairview encourages and supports an inclusive workplace that promotes and values diversity. We define:

- **Diversity** is differences and similarities which affect how we work and live together in society.
- **Equity** is a fair treatment and opportunity; getting what is needed to improve the quality of the situation.
- **Inclusion** is providing equal access and opportunities for all, and everyone has an impactful voice.



Adapted from: Loden, Marily & Rosener, Judy, "Workforce America! Managing Employee Diversity as a Vital Resource," McGraw-Hill Professional Publishing, 1990. https://community.astc.org/ccli/resources-for-action/group-activities/diversity-wheel

**This graph does not represent all dimensions of diversity*

Defining Culture and Its Impacts

Culture is a set of beliefs, values, and behaviors of a designated or a particular group. It is dynamic, learned, and shared. 10% can be seen, but 90% cannot.

"It can be defined by group membership, such as racial, ethnic, linguistic, or geographical groups, or as a collection of beliefs, values, customs, ways of thinking, communicating, and behaving specific to a group. We learn much about our own culture from our family and environment we grow up with which shapes our world view and norms."

Culture is changing and evolving.

Source: CDC

- Facial Expressions & Body Language
- Gender Identity
- Notions of Modesty
- Concept of Cleanliness
- Emotional Response Patterns
- Social Norms
- Child Rearing Practices
- Decision Making Processes
- Approaches To Problem Solving
- Concept of Justice
- Value Individual Vs. Group
- Conversational Patterns
- Sense of Time
- Perceptions of Mental Health, Illness, Disabilities

Cultural Competency

"Cultural Competence" and "**Culturally Responsive**" care refers to- the ability of health care systems and individuals to respond respectfully and effectively to people of all cultures, provide a safe & welcoming environment and acknowledging culture's profound effect on health outcomes.

Key behaviors to support cultural competence:

- Ask questions that focus on social and cultural factors.
- Seek to understand the patient's health beliefs and use of alternative treatments.
- Explore the patient's expectation of care.
- Provide appropriate interpreter services.
- Learn about culturally-based "family" dynamics which guide decision making.

We recognize and respect the unique and different backgrounds of all our patients. We make our best efforts to learn about those differences in order to serve others as they wish to be served. *Acknowledging differences* and *being willing to learn about them* are keys to cultural competence.

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 Event Reporting System- Compass. Link found on the Fairview intranet SharePoint site
  - Office of Health Facility Complaints
    Suite 300, 85 East 7th Place
    St. Paul, MN 55101
    651-201-4200
  - The Joint Commission
    Office of Quality Monitoring
    One Renaissance Boulevard
    Oakbrook Terrace, IL 601811
    www.jointcommission.org

- **Fairview Compliance Hotline: 1-800-530-4694**

Any individual who provides care, treatment and services can report concerns about safety or the quality of care without retaliatory action from the hospital.

Recognizing Illness and Impairment in Practitioners

Working in a healthcare setting can be difficult and stressful. It is important to be able to recognize if someone exhibits signs of impairment. Keeping patients and each other safe are top priorities for Fairview.

Impairment is defined as a state or condition that prevents or restricts one's ability to perform their activities or duties.

Impairment conditions may include, *but are not limited to*:

- Pharmacological Issues (Alcohol, Drugs)
- Mental Health issues (Stress, fatigue)
- Physical Health issues (Illness, medication side effects)

Signs of impairment may include:

Personality Changes

- Negative attitude
- Loss of enthusiasm
- Becoming isolated
- Angry outbursts

Change in Appearance

- Looking tired, foggy or sweaty
- Smell of alcohol or strong cologne/perfume
- Look upset or anxious
- Slur or stammer with their words

Changes in work habits:

- No longer returning call/pages
- Missed meetings
- Procedural and clerical errors (wrong dates, word reversals)
- Changes in normal work habits or routines
- Erratic productivity with crazy hours
- Inability to perform their job duties

Addressing Illness and Impairment in Practitioners

If comfortable, talk with the individual about what you have noticed. The person may feel comfortable sharing.

If uncomfortable talking with the individual, contact the one of the following to voice your concerns:

- Supervisor or trusted leader
- Human Resources
- Vice President of Medical Affairs (VPMA)
- Hospital Administrator

Internal Support Resources

Resources are available to anyone struggling with personal health and wellbeing issues or difficulties that can interfere with happiness at home or work. Fairview's **Employee Assistance Program (EAP)** supports employees and their families before these issues/difficulties develop into larger problems.

- Fairview's EAP offers short-term counseling, referral, and support services for employees and their families.
- Fairview employs a full team of counselors who provide free, confidential, in-person and telephonic assistance for all types of work, family, and personal concerns.
- **Contact Information:**
  - 612-672-2195 or 1-800-CALL-EAP
  - eap@fairview.org

External Support Resources

Physicians Wellness Collaborative is a program of Physicians Serving Physicians which provides independent, confidential counseling and peer support resources for all Minnesota physicians, advanced practice practitioners, residents, medical students, and their families at no cost.

Nurses Peer Support Network of Minnesota is a peer support group for nurses with substance use disorders in a safe environment with the purpose of giving hope and healing for the individual nurse. NPS Network also provides education and outreach about Substance Use Disorder in nursing to promote safety to the public.

Prevention of Healthcare Associated Infections

Hand Hygiene

National Patient Safety Goal

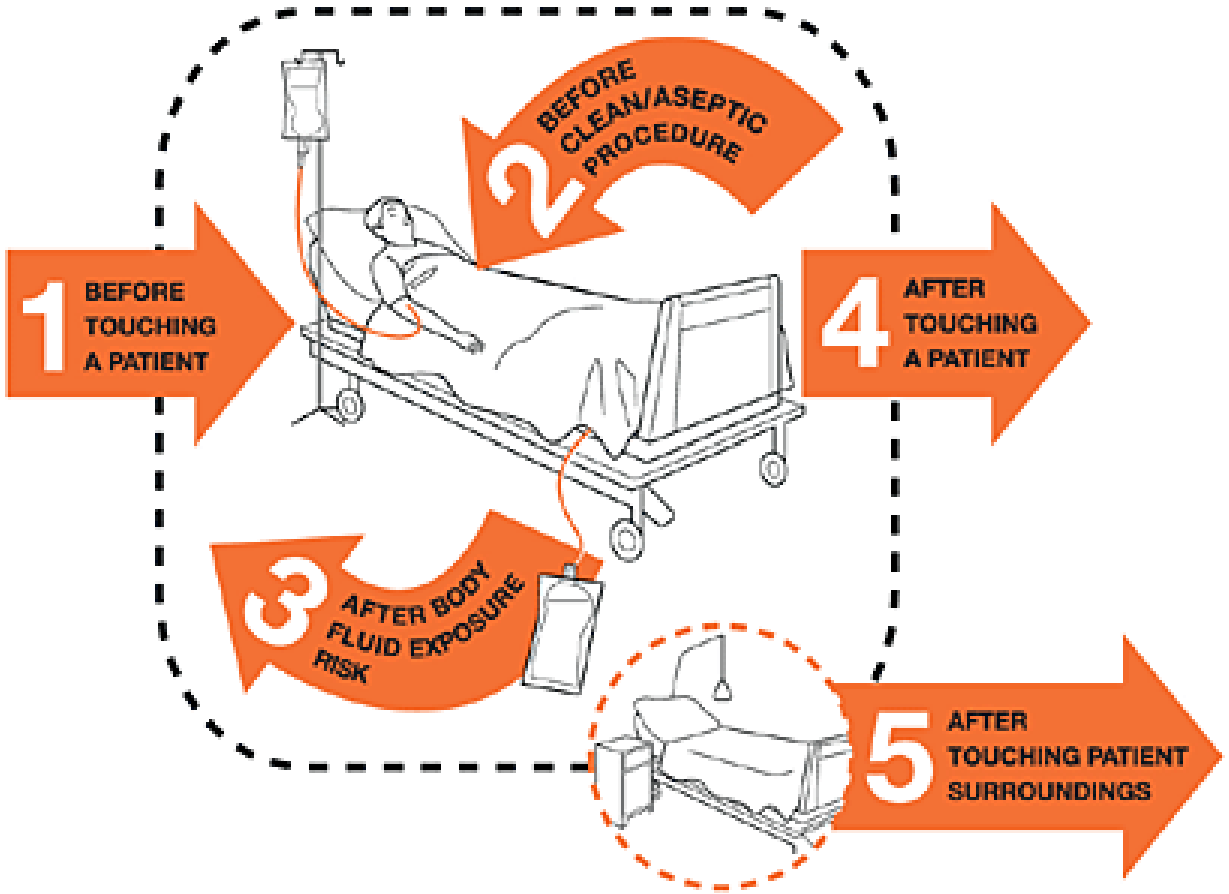
Staff are expected to perform hand hygiene:

- Before entering and after leaving a patient care area (i.e., patient room), commonly referred to as Foam In/Foam Out or Gel In/Gel Out
- Before and after donning gloves
- At the five moments indicated in the diagram

Alcohol-based hand rubs are effective and are the preferred method for routine hand hygiene.

Washing hands with soap and water (in addition to or instead of alcohol-based hand rub) is required:

- When hand are visibly soiled.
- When caring for patients with nausea, vomiting, and/or diarrhea, including patients in Enteric Precautions.
- After using the restroom.
- Before eating



Prevention of Healthcare Associated Infections
Central Line Associated Bloodstream Infections

Aseptic Insertion of Vascular Catheters:

- Hand Hygiene and don sterile gloves prior to insertion.
- Standardized protocol through use of kits/carts/checklists
- Use of maximal sterile barriers for insertion (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 prior to catheter insertion and document in the patient's medical record.

Follow Central Line Maintenance Bundle Elements:

- **LINE NECESSITY**
  - Necessity of all venous and arterial lines will be discussed daily and removed as early as possible
- **HAND HYGIENE and GLOVES**
  - Hand hygiene will be performed, and gloves will be donned just prior to touching tubing, dressings, and/or site, and before accessing lines
- **VASCULAR ACCESS SITE DISINFECTION**
  - Active or passive vascular access site disinfection will be performed prior to EVERY central line access, including sequential accesses
  - Active disinfection times may differ depending on product used for scrubbing the hub
    - Alcohol: 15 second scrub; air dry
    - Green Prevantics: 5 second scrub; 5 second dry
- **DRESSING CARES: clean, dry intact; Dressing Changes every 7 days and PRN**
- **CATHETER HUB CARE**
- **TUBING CARE**
- **LAB DRAWS**
  - Central line access for blood collection will be minimized as much as possible
- **CHG BATHING**
  - All patients with central lines will have daily CHG bath and linen change (if not contraindicated)
  - Pediatric patients not able to do daily CHG bathing will get routine standard bath.
- **PATIENT/FAMILY EDUCATION**

Prevention of Healthcare Associated Infections
Catheter Associated Urinary Tract Infections

- Refer to the M Health Fairview Urinary Catheter Management Guidelines for appropriate indications for insertion and continued use.
- Consider alternatives to indwelling catheters if appropriate.
- Maintain aseptic technique during urinary catheter insertion.

Urine Specimen Ordering

- **Only order a urine culture when clinically appropriate**
  - Avoid pan-culturing; order symptom-specific tests
- Order a urinalysis with reflex to urine culture (certain populations excluded).
- Assess patient for signs and symptoms of UTI, and document fever, flank pain, suprapubic tenderness, urinary urgency, frequency, or dysuria.
- **Cloudy urine, foul-smelling urine and urinary sediment alone are not appropriate reasons for ordering a urine culture.**
- **If ordering a urine specimen for a patient with a catheter in place 7 days or longer, exchange the catheter before collecting urine (special populations excluded).**

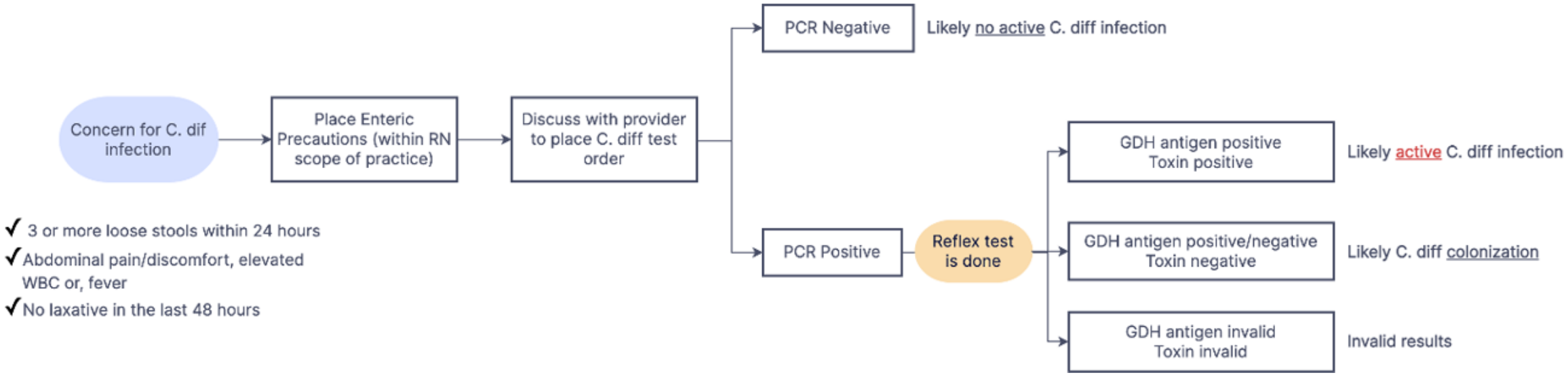
Maintenance of Urinary Catheters

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

Prevention of Healthcare Associated Infections

Prevent: *Clostridioides difficile* Infection (*C. diff*)

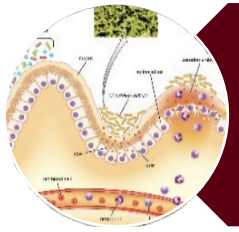
Reflex testing for *C. diff* can help to distinguish active *C. diff* infection from colonization. Antibiotic treatment is generally not indicated for patients with *C. diff* colonization. Reflex testing that is "Toxin negative" still requires Enteric Precautions.



Prevention of Healthcare Associated Infections

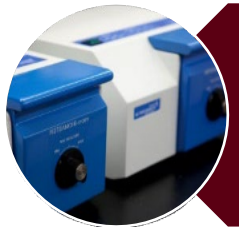
Prevent: *Clostridioides difficile* Infection (*C. diff*)

1/3 of hospitalized patients develop diarrhea.

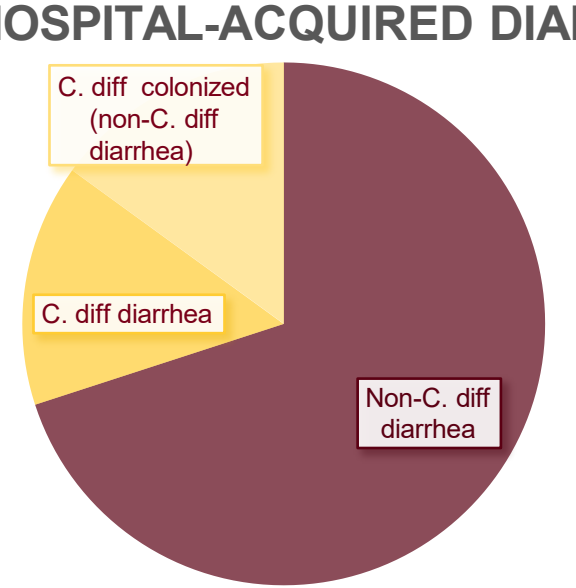


Depending on population 0-50% of patients may be colonized with *C. difficile*, but not infected

- These patients have a positive *C. diff* PCR!



In a patient with clinical suspicion for CDI who is PCR toxin positive, GDH and Toxin A/B ELISA can aide in distinguishing colonization versus infection.



*No laboratory testing can replace clinical acumen.
Only order *C difficile* lab testing if clinically indicated:

- 3 loose/watery stools per day with CDI symptoms
- Not on other laxatives

	PCR +	PCR -
Toxin A/B +	***C diff* diarrhea**	**Non-*C diff* diarrhea**
Toxin A/B -	**Colonization with non-*C diff* diarrhea**	

Prevention of Healthcare Associated Infections
Prevent: Surgical Site Infections (SSI)

Educate patient/family on strategies to prevent SSI including:

- Not smoking
- Glucose management
- Pre-op showering/bathing with chlorhexidine gluconate 4% the evening before and the morning of surgery for patients who meet criteria. Clean towels, sheets on the bed and clothing after showering.
- Patient education for post op wound care, including hand hygiene.

Staff to follow best practices for:

- Antibiotic dosing: Give Ancef/Cefazolin to all patients for procedures that require an antibiotic, unless the patient has a specific Ancef/Cefazolin allergy. Add additional coverage for certain procedures. See the Pharmacy resource page for additional information including the Periprocedural Antibiotic Dosing Guideline
- Surgical Site Preparation
- Follow/support all perioperative guidelines and policies
- Normothermia

Prevention of Healthcare Associated Infections
Antimicrobial Stewardship

Burden of Antimicrobial Resistance in the United 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.

Prevention of Healthcare Associated Infections
Antimicrobial Stewardship

What You can do-

- Promote Antibiotic Best Practices
  - Ensure all orders have a dose, duration and indication
  - When indicated collect 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 practitioners, Pharmacists and Infection Prevention
    - Active intervention with real-time feedback
    - System Antimicrobial Subcommittee
    - Order sets developed with antimicrobial best practices in mind

Prevention of Healthcare Associated Infections
Multidrug-Resistant Organism Prevention

Multidrug-resistant organisms (MDRO) are bacteria or fungi that are resistant to one or more class of antimicrobial agents. Some of the most common MDROs are MRSA, VRE, ESBL, and CRE.

In addition, there is an increase of carbapenemase- producing, carbapenem-resistant organisms (CP-CRO) and Candida auris.

Since these organisms are easily transmissible in healthcare environments, patients with a MDRO should be place in Contact Precautions.

PATIENT EDUCATION

- Educate patient and families regarding their MDRO status. Patient education materials are located in Epic.
- Document patient education in Epic. Documentation is how we monitor our compliance for providing patients and their families with education.

Prevention of Healthcare Associated Infections

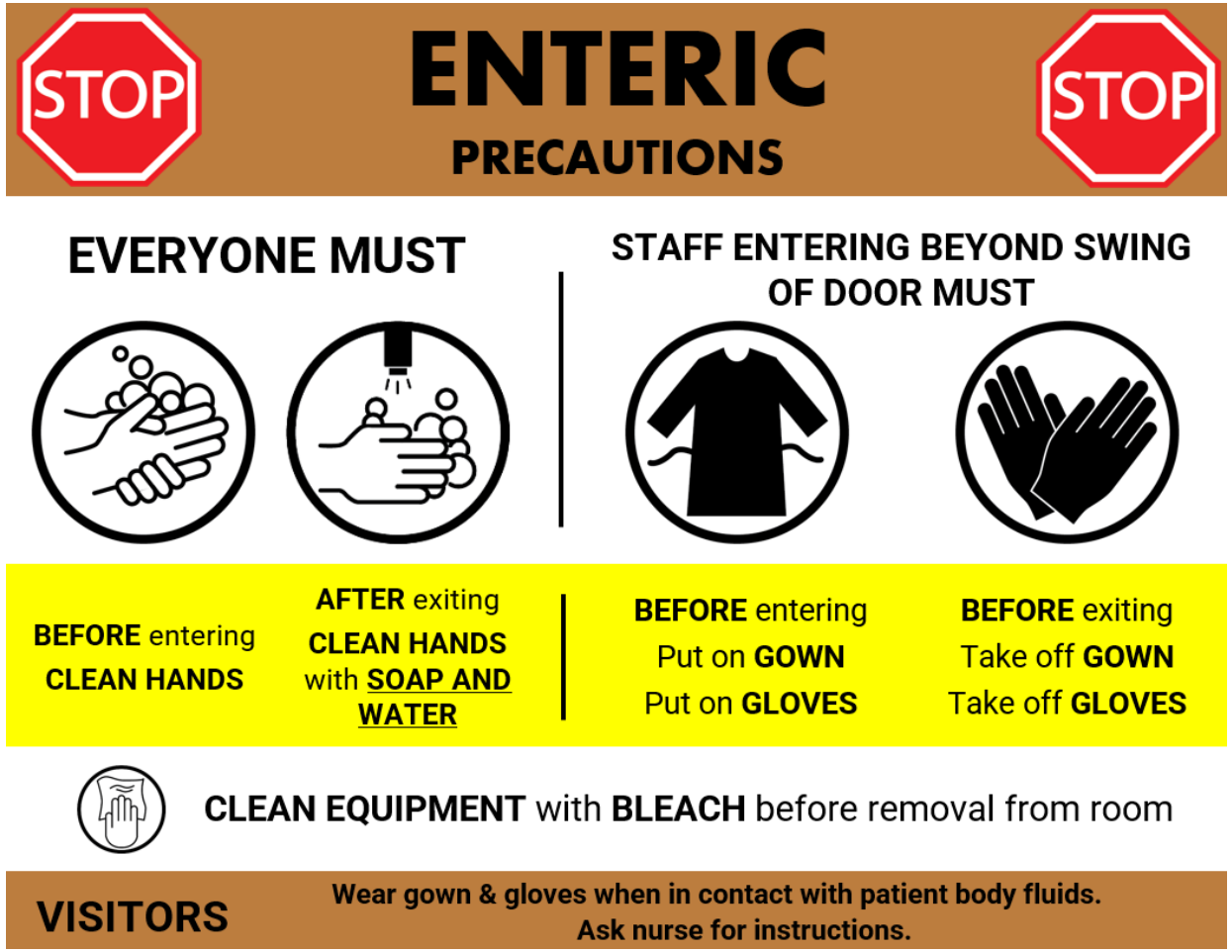
Transmission-based Precautions

Most used for:

- Organisms spread by direct or indirect contact.
- Patients with suspected or confirmed MDROs.
- Patients with uncontrolled body fluids, regardless of diagnosis.

Prevention of Healthcare Associated Infections

Transmission-based Precautions Practices



Most used for:

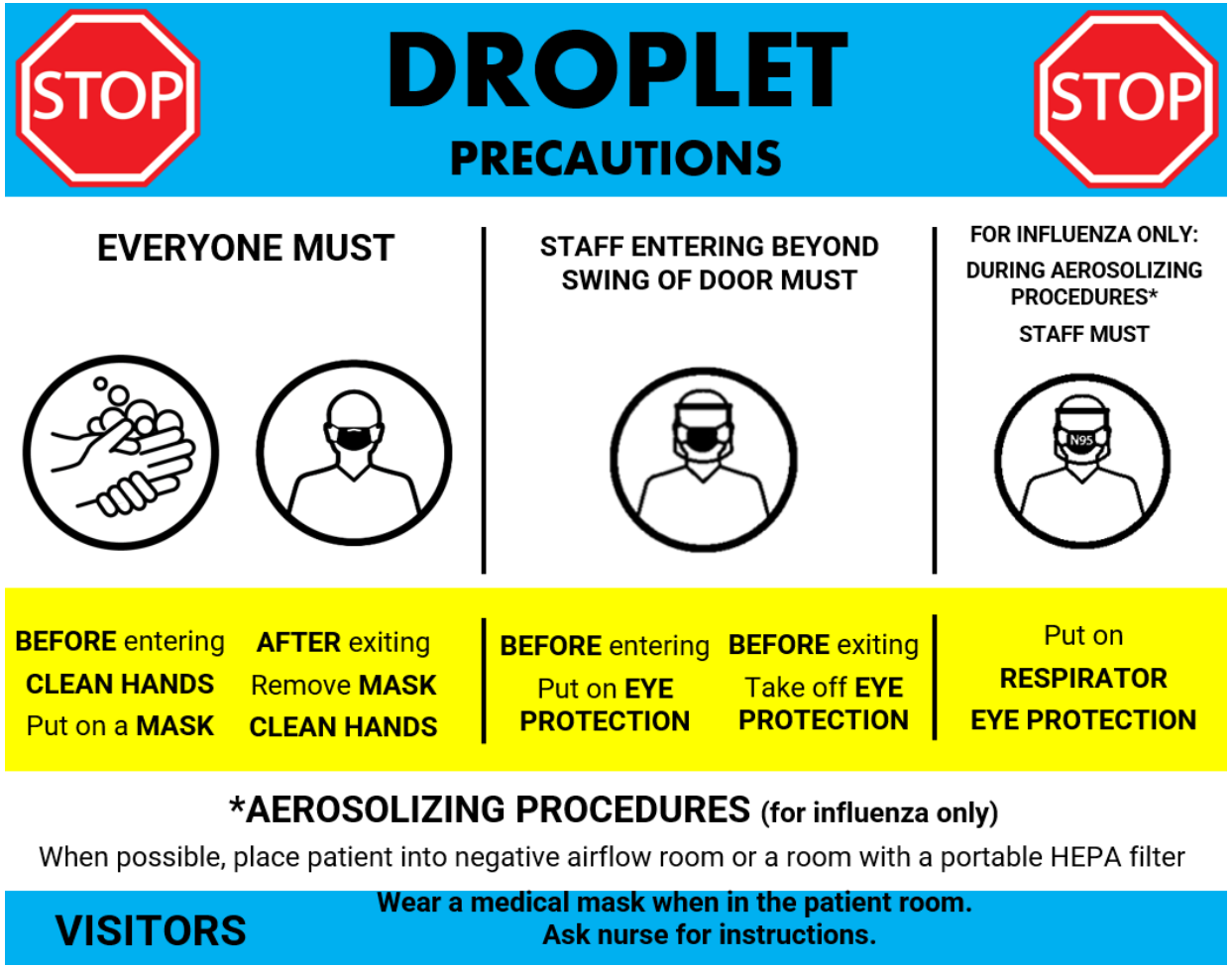
- Organisms spread by direct or indirect contact.
- Patients with *C. diff*, norovirus, rotavirus, hepatitis A, or patients with uncontained diarrhea.

Prevention of Healthcare Associated Infections

Transmission-based Precautions Practices

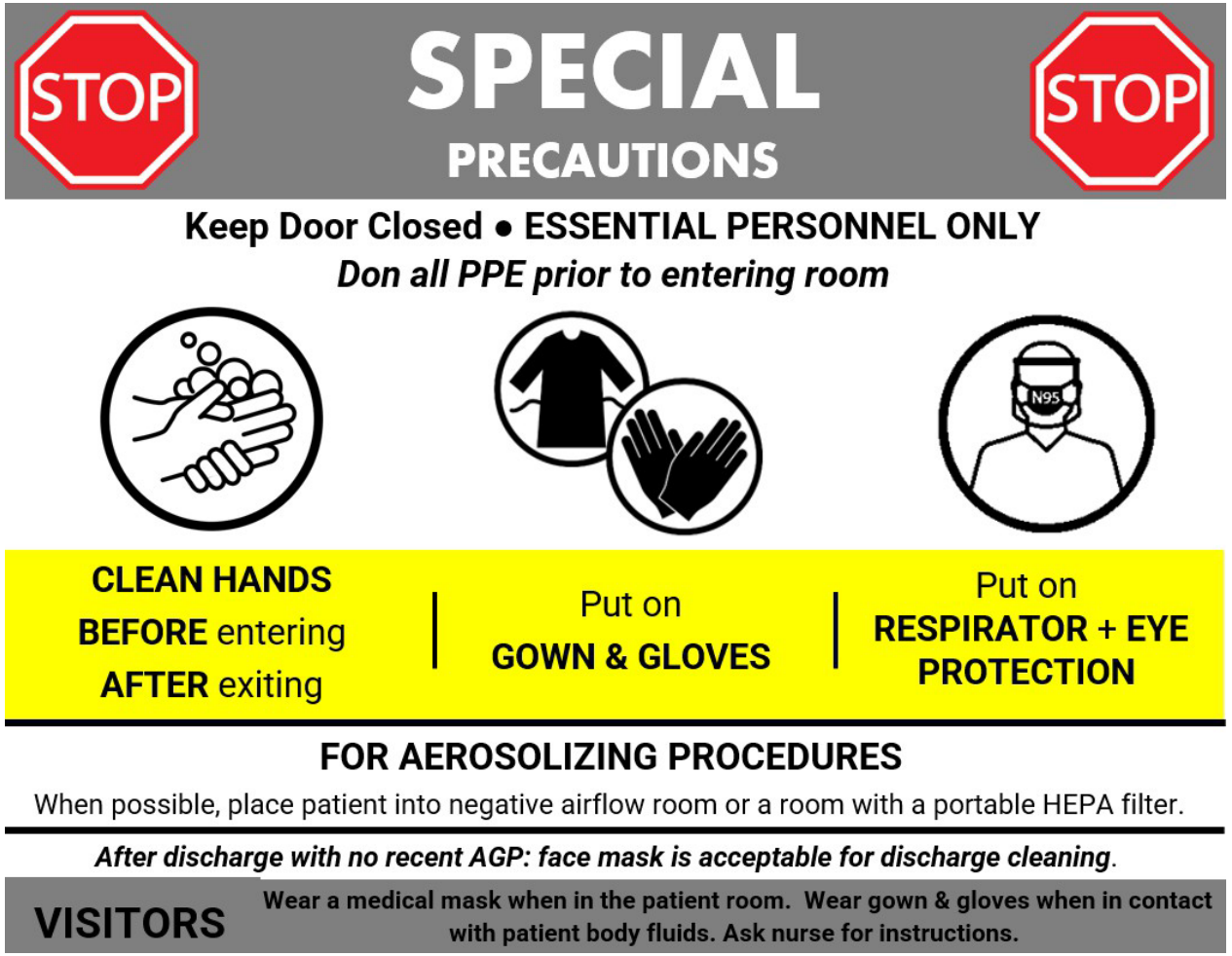
Most used for:

- Organisms spread by large-particle droplets (>5µm).
- Patients with suspected or confirmed influenza, pertussis, bacterial meningitis, or other respiratory illness.



Prevention of Healthcare Associated Infections

Transmission-based Precautions



Most used for:

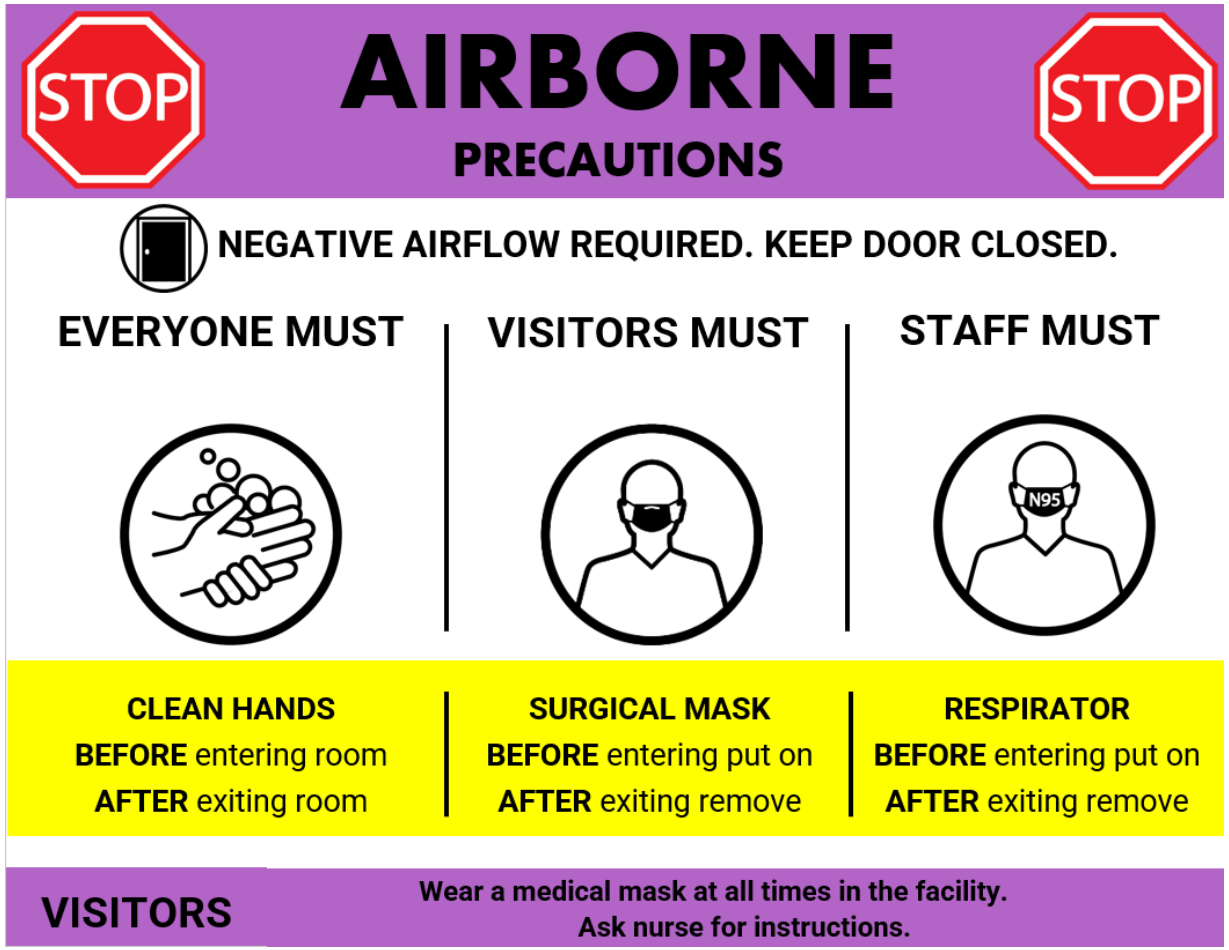
- Patients with suspected or confirmed COVID-19 or mpox.

Prevention of Healthcare Associated Infections

Transmission-based Precautions

Most used for:

- Organisms spread by airborne droplets.
- Patients with suspected or confirmed active pulmonary tuberculosis (TB), disseminated shingles, or measles.



Prevention of Healthcare Associated Infections

Transmission-based Precautions

Full Barrier has been split into 2 categories to align with Minnesota Department of Health recommendations for high consequence infectious disease (HCID).

Full Barrier Precautions - Level One and Level Two are used for infectious conditions and diseases that require a high level of protections and newly emerging infectious diseases where the route of transmission is unknown.

Prevention of Healthcare Associated Infections
Transmission-based Precautions

Most used for:

- Patients with suspected or confirmed “dry” viral hemorrhagic fever (VHF).
  - “Dry” patients are clinically stable with no bleeding, vomiting, or diarrhea.

Prevention of Healthcare Associated Infections

Transmission-based Precautions

Most used for:

- Patients with suspected or confirmed “wet” viral hemorrhagic fever (VHF) or pox virus.
  - “Wet” patients are clinically unstable with bleeding, vomiting, or diarrhea.
- A Level One VHF patient that is having an aerosol-generating procedure performed.

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 practitioners and Allied Health Professionals are required to receive the influenza vaccination yearly or complete an accommodation (Fairview) or exemption (M Physicians) request. Universal masking is required (even when mandatory universal masking is lifted) for those receiving accommodations/exemptions.

Influenza

When should health care practitioners 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 practitioners for routine care or as a result of hospitalization.
- The influenza vaccine and COVID-19 vaccine can be given at the same visit for those eligible to receive both.

Fire Safety

Rescue
Alert
Confine
Extinguish/**E**vacuate

- **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.
- **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.

Pain Management

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

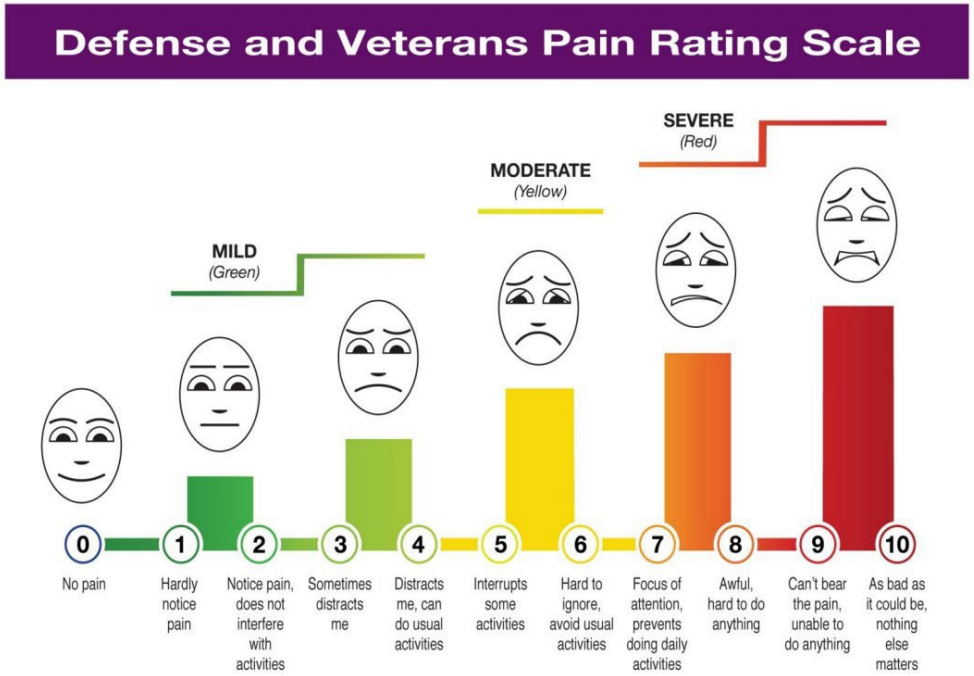
- **Establish, measure, and document pain and function** goals such as improvement in pain, sleep, return to work, and activities of daily living (ADLs).
- **Prescribe non-pharmacologic therapies and non-opioid medications** as first-line for treatment of acute and chronic pain.
- **Discuss potential side effects** of opioid and nonopioid medications with patient.

Pain management plan documentation in the electronic health record is required for compliance with The Joint Commission pain management standards.

Please review the Pain Management policy in PolicyTech for additional information.

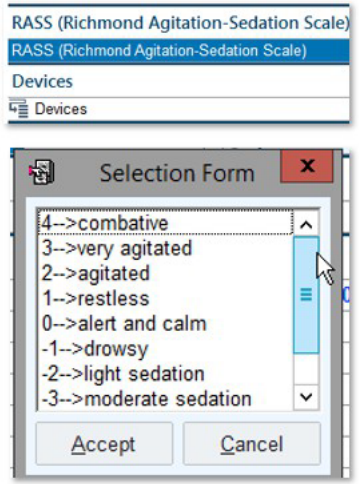
Pain, Function, and Sedation Assessment

There are many tools available for pain assessment. Selection of an assessment tool should be appropriate for the patient's age and cognitive ability.



The Richmond Agitation and Sedation Scale (RASS) is used for documentation of sedation after opioid administration.

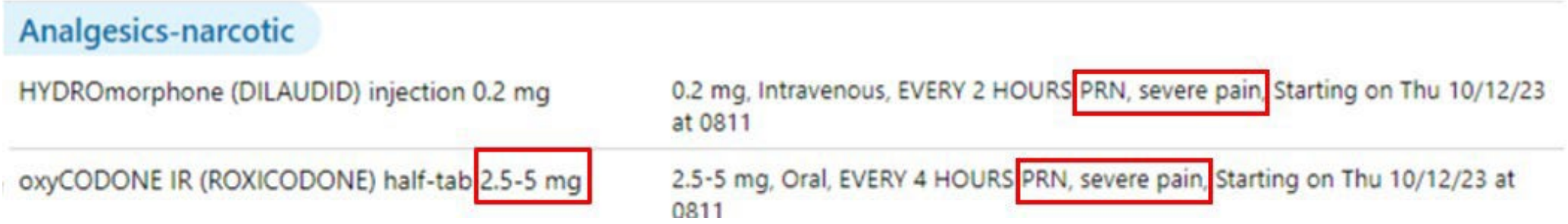
+4	Combative
+3	Very agitated
+2	Agitated
+1	Restless
0	Alert/calm
-1	Drowsy (Eye contact >10 seconds)
-2	Light sedation (Eye contact <10 seconds)
-3	Moderate (No eye contact)
-4	Deep (Physical stimulation required)
-5	Unarousable (No response even with physical stimulation)



Sedation parameters on RASS range from 0 (alert) to -5 (Unarousable)

Therapeutic Duplication and Range Orders

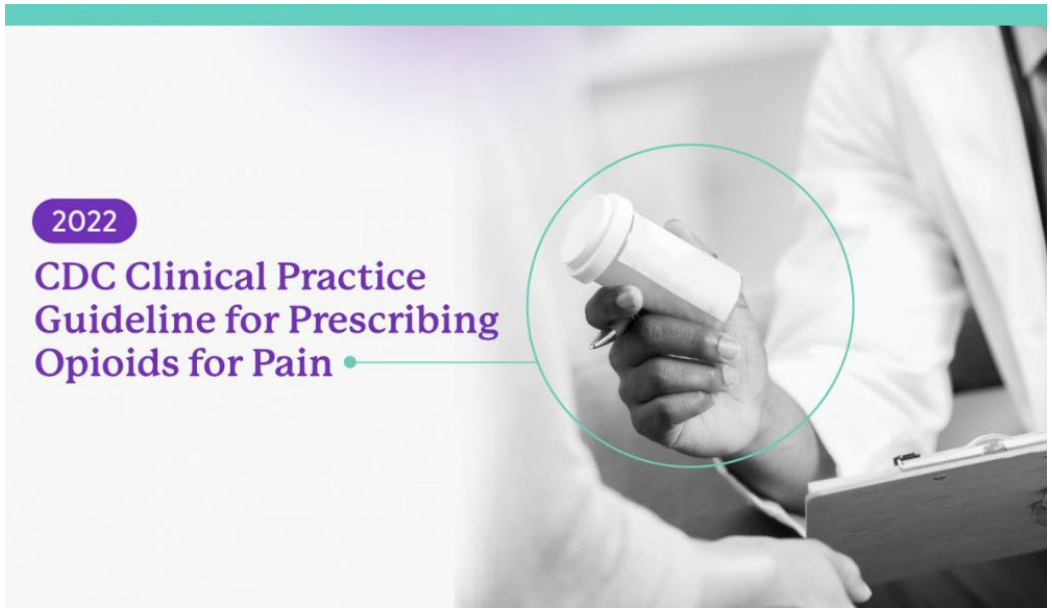
- The Joint Commission medication management standard 04.01.01. pertains to clarity of PRN orders and range orders for dose administration linked to a specific monitoring parameter, symptom, or patient response.
- **The order example below would be cited for non-compliance by the Joint Commission because**:
  - Severe pain PRN reason is duplicated for oral oxycodone and intravenous hydromorphone with no indication on which medication to give first.
  - Oxycodone range order has two different doses both indicated for severe pain.



To make these orders in the example compliant, **change** the **oxycodone** to separate orders with **2.5mg for moderate pain** and **5mg for severe pain**. Add a comment to **intravenous hydromorphone "if patient unable to take oral"**.

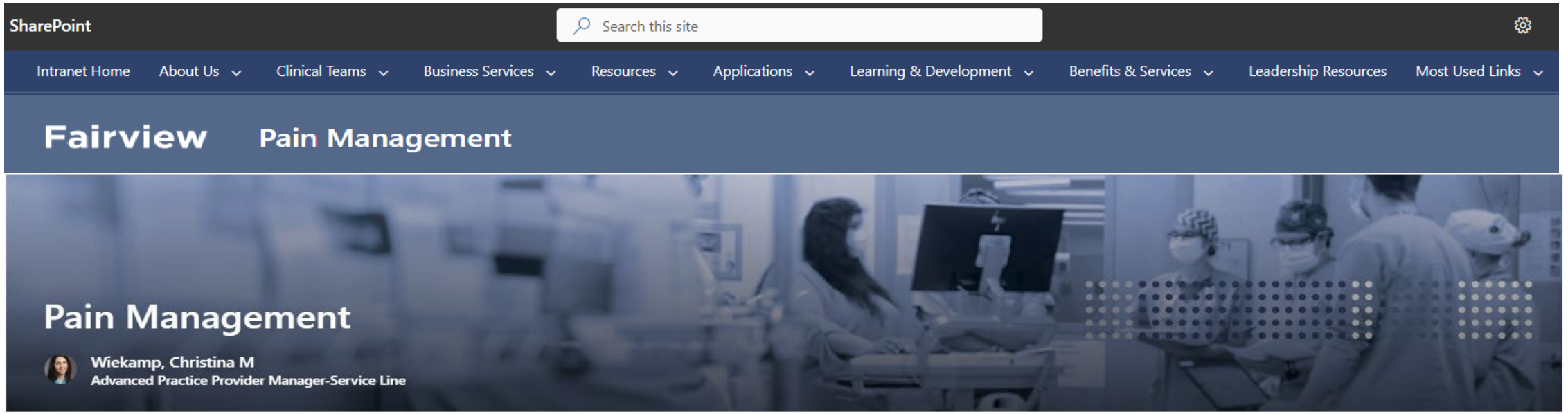
Safe Opioid Prescribing

- Joint Commission provision of care standard 01.02.07 pertains to assessment and management of the patient's pain while minimizing risks associated with treatment
- Pain treatment plan is based on evidence-based practice
  - If you offer opioid therapy for acute, subacute, or chronic pain, use immediate release opioids when initiating therapy instead of extended release and long-acting (ER/LA) opioids
  - Start with the lowest effective dose for opioid naïve patients
  - Use extreme caution when prescribing opioids and benzodiazepines concurrently



CDC Clinical Practice Guideline for Prescribing Opioids for Pain–United States, 2022

SharePoint Pain Management Resources



Pain Management
This page includes resources for pain management, opioid prescribing, patient, and provider education.

For more education to improve pain assessment, pain management, and the safe use of opioid medications click here for more CME information.

- The Pain Management Share point site includes helpful information
- Resource Links:
  - Education and Clinical Tools
  - Assessment Tools and Timing
  - Summary Guides
  - Clinical References for Safe Opioid (and nonopioid) Prescribing
  - Information regarding available services for consultation and referral of patients with complex pain management needs. Click here

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

Critical Alarm 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

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 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

Restraints or Seclusion

- Fairview Health Services recognizes the unique needs associated with the care of the patient whose actions pose a safety risk to self or others. The use of restraint or seclusion poses an inherent risk to the physical safety and psychological well-being of the patient and staff.
- Patients have **a right to be free from restraints or seclusion**. Least restrictive alternatives / interventions and environment are the first choice unless safety issues demand an immediate physical response.
- When restraints or seclusion are used, they are **discontinued at the earliest possible time.**
- When restraint or seclusion is used, particular attention is given to **preserving the patient's safety and dignity**. Patient dignity and privacy is maintained by protecting the patient's modesty and limiting the visibility by others.
- The use of restraint or seclusion for coercion, discipline, convenience or retaliation by staff is not permitted.
- Restraint or seclusion for violent/self-destructive behavior is used only in an emergency, when there is imminent risk of a patient physically harming self, a staff member or others.
- **PRN Restraint or Seclusion orders are prohibited.**

Nonviolent Restraints

- Orders: Restraints must be ordered by a physician or licensed practitioner 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 for restraint are not allowed.
- **Restraint orders must be re-written each calendar day.** The practitioner 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.

Violent or Self-Destructive Restraints or Seclusion

- An order must be obtained immediately after the restraint has been applied.
- **<u>One Hour In-Person Face to Face Assessment</u>: Within 1 hour** of placing the patient in restraints or seclusion, the **patient must be examined by the physician or NP** (Physician Assistant cannot do the face to face unless they have had additional training).
- 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.
- Documented using the .restraintfacetoface note.

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. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed practitioner who is responsible for the care of the patient, must see and assess the patient.
  - **For Behavioral Health Patients** A debriefing about each episode of restraint/seclusion occurs as soon as possible.

Anticoagulants

Overview of anticoagulants available at M Health Fairview

IV/SubQ

COMMON
- Enoxaparin (Lovenox®) SQ
- Heparin drip/SQ

RARE
- Argatroban drip
- Bivalirudin drip
- Fondaparinux SQ

Oral

- Apixaban (Eliquis®)
- Dabigatran (Pradaxa®)
- Edoxaban (Savaysa®)
- Rivaroxaban (Xarelto®)

DOACs (direct oral anticoagulants)

- Warfarin (Coumadin®)

Anticoagulants-General 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 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	Yes	Yes	NO	NO
Onset	Immediate	Immediate	3-4 hours after first dose	2-4 hours after first dose	IV infusion= 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	No reversal agents available Can try Prothrombin Complex Concentrate (Kcentra®)			Protamine	

"Low-molecular weight heparin is the anticoagulant of choice for pregnancy and for active cancer and the primary choice of physicians for treatment of VTE in the outpatient or home setting due to ease of use and low incidence of side effects. Low-molecular weight heparin is used in most cases except when a patient has renal dysfunction or a creatinine clearance less than 30 mL/min." (Hillegass 2016)

"Unfractionated heparin is indicated for individuals with high bleeding risk or renal disease." (Hillegass 2016)

Anticoagulants: Heparin Drips

- Heparin drips are ordered through an order set in EPIC entitled "*Heparin Infusion ADULT- Provider Initiation*". Within the set, you will choose monitoring method:
  - **Heparin Anti-Xa is the PREFERRED lab for most Heparin infusions**
  - PTT should be used in patients who have taken apixaban/rivaroxaban within last 3 days.
- <u>There are 3 dosing options within the heparin set</u>:
  - **HIGH INTENSITY:** used for ACTIVE clots (deep vein thrombosis/pulmonary embolism)
  - **LOW INTENSITY:** used for CV indications (acute coronary syndrome, AFib, valves)
  - **LOW DOSE/FIXED RATE** (300-500 units/hour): This is a low, fixed rate drip that can be used in post-surgical patients at very high bleeding risk
- Once the order set is placed, heparin labs & dose titrations are managed by nurses.

Anticoagulants:

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

- Enoxaparin and fondaparinux are subcutaneous anticoagulants that can be used in both the inpatient and outpatient environments
- Fondaparinux is a non-heparinoid anticoagulant that is typically reserved for patients with heparin intolerance and/or history of HIT.
- Both enoxaparin and fondaparinux are cleared by the kidneys:
  - Enoxaparin should not be used in patients with a CrCl LESS than 15 mL/min
  - Fondaparinux should not be used in patients with a CrCl LESS than 30 mL/min
  - **Neither drug should be used in patients on dialysis**
- Pharmacists will ensure that appropriate labs are drawn for both agents

Anticoagulants

Argatroban/Bivalirudin Drips

- Argatroban and bivalirudin are ***non-heparinoid*** anticoagulants that are typically reserved for:
  - Patients who are NOT candidates for heparin or enoxaparin (e.g., HIT, heparin allergy)
  - Patients who have failed treatment with heparin or enoxaparin treatment
- Argatroban and bivalirudin must be ordered through order sets in EPIC. These sets provide dosing, required lab work and instructions for dose adjustments.
- Depending on the hospital, argatroban dose adjustments will either be managed by pharmacy or nursing.

! **CAUTION: Argatroban and Bivalirudin can cause the INR lab test to substantially elevate.** When administering argatroban/bivalirudin with warfarin, you will need to use “factor 10 chromogenic ” in place of INR to monitor warfarin. Contact pharmacy to assist you! !

ORAL Anticoagulant Comparison

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban	Warfarin
Onset	1-2 hrs after dose	2-4 hrs after dose	3-4 hrs after dose	1-2 hrs after dose	4-5 days
Duration	48 hours	24-48 hours	24-48 hours	24 hours	4-5 days
Bridging with parenteral anticoagulants?	**Do NOT "bridge" with an intravenous or SubQ anticoagulant.** **The novel oral anticoagulants have very fast onset!** **FULL anticoagulation occurs 1-4 hours after the first oral dose**				"Bridging" with a concomitant IV/SQ anticoagulant **IS** necessary for active clots and those at moderate-severe risk for clotting
Reversal for Severe Bleeding	Idarucizumab (Praxbind®)	4 Factor Prothrombin Complex Concentrate (PCC, Kcentra®) can be used for most hemorrhages *For life-threatening intracranial/intraspinal hemorrhages, Andexxa (recombinant factor Xa) can be utilized.* *MUST be approved by a staff neurosurgeon/neurologist/stroke team*			• Vitamin K • Fresh Frozen Plasma • Prothrombin Complex Concentrate *(PCC, Kcentra, Balfaxar)* Use "Warfarin Reversal" order set- it will help guide you!

Anticoagulants:
Warfarin

Ordering

- Pharmacists manage most warfarin regimens in the hospital setting.
- Warfarin is ordered through an EPIC order panel entitled "*Warfarin Pharmacy Consult*":
  - Within this consult, you must fill in a diagnosis and a coagulation lab goal
  - Once the consult is received, the pharmacist will order warfarin doses per policy

Monitoring

- Before the first dose of warfarin can be given in the hospital, a baseline INR is required *(this is a Joint Commission requirement)*
- While most warfarin patients are monitored with an INR lab test, certain patient populations may require a "factor 10 chromogenic" level instead

Elevated INRs/Reversal

- A "*Warfarin Reversal*" order set is available in EPIC.
- A policy entitled "*Anticoagulant, Antiplatelet and Lytic Reversal*" is also available in PolicyTech

Holding Anticoagulants and Other Medications Prior to Surgery

- **Patients receiving anticoagulants must be carefully managed prior to surgery!**

- M Health Fairview has a policy entitled "Preoperative Guidelines for Adult Patients" which provides guidance for how to manage the following medications prior to surgery:

  - ✓ Anticoagulants
  - ✓ Antiplatelets
  - ✓ NSAIDs
  - ✓ Cardiovascular medications
  - ✓ Diabetes medications
  - ✓ Estrogens
  - ✓ GI Medications
  - ✓ Neurologic/Psychiatric Medications
  - ✓ Respiratory Medications
  - ✓ And many other miscellaneous meds!

EPIC Downtime

Procedure

DEFINITIONS:

- **Scheduled Downtime:** A planned period 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.

Is the Downtime scheduled?

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

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 practitioner.
- Practitioner 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).

Surrogate Decision Makers:

Person(s) authorized to make health care decisions for a person who lacks decisional capacity

Do not presume/document someone is a decision-maker until validated by Honoring Choices (or Risk Management if urgent and Honoring Choices is not available). Validated decision makers are identified in Epic Code/ACP tab.

Adults are presumed to have capacity unless evidence or reason to believe otherwise

Minors are presumed to lack capacity unless exception per state law (see informed consent policy for more information)

Possible Surrogates for Adults:

- **Legal Guardian**: Appointed by a judge who determined person lacks competence to make decisions. Authority granted can vary.
- **Health Care Agent**: Appointed by person in Health Care Directive. Active ONLY when patient lacks decisional capacity. Legal Guardian takes precedence over Health Care Agent however wishes in document should still be considered.
- **Power of Attorney :** For financial/property authority ONLY. Do not use the term POA for a Health Care decision maker.

Possible Surrogates for Minors:

- **Parents:** A parent without legal custody still has rights to PHI unless rights have been terminated or denied by court order.
- **Legal Custodian:** Court ordered . Order must be reviewed to determine rights. Custodian may be county or relative/other person.
- **Foster Parent:** Authority for decisions specified by the county or court.
- **Delegated parental authority:** Parents with legal custody may elect to SHARE their parental authority. Designation DOES NOT replace parental rights.

If no validated decision makers: Continue to provide appropriate medical care as decision makers are determined.
Contact Risk Management for assistance in considering other possible decision makers in the absence of a legal document.

Surrogate Decision Makers

Decisional Capacity-ADULTS

- **Decisional capacity is presumed unless there is evidence to the contrary**
- **Determined & documented by a Physician/APRN when capacity/lack of capacity is unclear**
- **Assessments, not presumptions (i.e: diagnosis), are necessary**
- **Decisional capacity can wax and wane, be situational/partial/intermittent**
- **Adults committed under the MN Civil Commitment & Treatment Act retain capacity for any decisions not related to commitment order**

In general, a person **has** the capacity to make healthcare decisions if they:

- Demonstrate a general awareness of his/her/their health situation and the recommended medical treatment or procedure, and
- Understand the factual information provided about the recommended medical treatment or procedure, including the risks and benefits, and
- Can communicate, verbally or nonverbally, a clear decision regarding the recommended medical treatment or procedure based on that information

Surgical/Procedural Time Out

- An interactive, standardized Time Out that engages each team member (surgeon or any other practitioner performing a procedure, circulating nurse, scrub and anesthesia care practitioner 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 practitioner is finished.

Site Marking

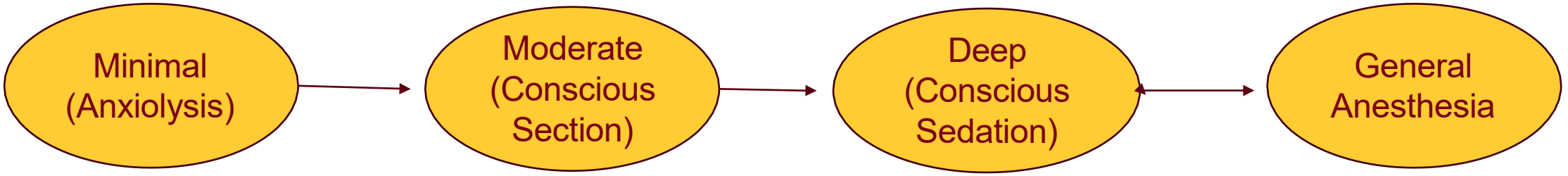
- Applies to any surgical and non-surgical invasive procedure involving **laterality, level (e.g., spine), or multiples** (toes, fingers, bilateral structures, etc.)
- Must be with **initials**, not an X
- Is done with the patient awake and participating, as able
- Occurs before the patient is moved to the location where the procedure is performed

Sedation and Analgesia for Procedures

System Policies
related to Moderate and Deep Sedation can be found in PolicyTech

- Prescribing practitioners 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.

Sedation Continuum



- Patients may quickly or inadvertently move along the continuum of sedation levels.
- The patient's sedation level is not determined by the **drug or 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

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 .**
  - (Use Epic Sedation Navigator where available)
- **Understand relevant sedation medications**, including dose, route, timing, side effects, etc.
- **Recognize over sedation or airway emergencies**, and how to apply appropriate interventions.

Sedation

Personnel

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

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.

Language Services

Language Services provides free communication services and aids to patients and families, responsible parties, and those supporting patients in their care.

Responsible health care practitioners 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.

Contact Information:

- 612-273-3788, option 2
- interpreterscheduling@fairview.org

Suicide Risk Assessment and Prevention

TJC National Patient Safety Goal: Reduce the risk for suicide

- High-risk and highly surveyed standard

Nursing screens *all patients* 11 and older for suicide risk using Columbia Suicide Severity Risk Screen (C-SSRS)

- Patients < 11 are screened if they present with self-injury or mental health primary concern
- Those who screen positive need a full assessment performed by DEC Assessor prior to discharge
- Moderate or high-risk patients will also be rescreened BID

Must document the overall level of risk for suicide and plan to mitigate risk

- NEW: Order set (launching February 2024):
  - Provider must enter an order to identify level of risk
  - Interventions to implement by risk level (low, moderate, high)
- NEW: Storyboard/Track-board identifiers to show risk level

NEW: **Suicide Timeline report**

- Report available to show screening results and interventions documented over time

Suicide Screening, Assessment, and Mitigation of Risk v.3 (policytech.com)

Patients At Risk for Harm to Self or Others - Environmental Modification and Monitoring v.3 (policytech.com)

R3 Report published by The Joint Commission: National Patient Safety Goal for suicide prevention

HEALTH FAIRVIEW

Additional Education Topics

TOPIC	POLICY	RESOURCES
Organ Donation	Donation and Procurement of Organ, Tissue and Eye *Includes Guidelines for Donation table*	• Care and Communication at the End of Life *Includes Advance Care Planning & Advance Directives, and Surrogate Decision-Makers* • Informed Consent • Vitaltalk
Patient Visitation Rights	Facility Access and Visitor Management	• Facility Access and Visitor Management Procedure • Facility Access and Visitor Management Front Door Guide
Recognizing & Reporting Abuse & Neglect	Investigation of Abuse, Neglect, Harassment of Patients or Visitors	• Investigation of Abuse, Neglect, Harassment of Patients or Visitors, procedure • Maltreatment of Minors *Includes reporting procedure* • Vulnerable Adults, Identifying and Reporting Suspected or Actual Maltreatment *Includes reporting procedure*
Workplace Violence	Workplace Violence and Aggression Reduction, Intervention and Response	• A Workplace Accident & Injury Reduction & Ergonomics Program • Threat Assessment Team • Respectful Workplace • Disruptive, Abusive or Violent Behavior by Staff • Active Threat Response • Workplace Violence - Three Identifiable Levels of Behavior and Response Options

Medical Staff Governing Documents

- Policies and Governing Bylaws can be accessed on a Fairview computer and are found on Fairview SharePoint.
  - 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, they may contact Medical Staff Services .

Thank You

for taking the time to review this important information

If you have questions, please contact Medical Staff Services at MedicalStaffServices@fairview.org