Sutter Medical Center of Santa Rosa
A Sutter Health Affiliate

Physician Education Module 2010

THE JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS (NPSG)

NPSG GOAL 1: IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION

You Must Know!!

- Acknowledge your presence to patient by addressing them by name; introduce yourself to the patient and explain your purpose in the room.
- Patient identifiers at SMCSR are:
  - Name and medical record number if patient has identification band.
  - Name and date of birth **for outpatient areas in which there is no armband** (i.e. rehab)
- Label blood tubes or specimen containers AT the bedside with patient's two identifiers, date and time of collection, your initials.
- When administering blood or blood products, two qualified staff members must conduct a review of the patient's identity and match it with the document accompanying the blood product. One of the qualified staff must be the person administering blood or blood product. **A physician may serve as a "qualified staff member" in this process.**

NPSG GOAL 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS

The following abbreviations MAY NOT be used on written physician orders, telephone orders, or while transcribing orders. Pharmacy will clarify with nursing and/or prescriber when these abbreviations are found in an order. Do Not Use unapproved abbreviations. These DNU abbreviations include:

Abbreviation/Dose Expression	Preferred Term	Mistaken For
U or u for Unit	Unit	Zero (0)
IU for International Unit	Write "international unit"	Mistaken as IV (intravenous) or 10 (ten)
Q.D., and Q.O.D. for once daily and every other day	Write "daily" and "every other day"	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".
Trailing zero (X.0 mg)	X mg.	Decimal point is missed. Never write a zero by itself after a decimal point.
Lack of leading zero -- .X mg	0.X mg	Decimal point is missed. Always use a zero before a decimal point.
MS, MSO_4, $MgSO_4$	Write "morphine sulfate" or "magnesium sulfate"	Confused for one another. Can mean morphine sulfate or magnesium sulfate.
µg (for microgram)	Write "mcg"	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.
T.I.W. (for three times a week)	Write "3 times weekly" or "three times weekly"	Mistaken for three times a day or twice weekly resulting in an overdose.
cc (for cubic centimeter)	Write "ml" for milliliters	Mistaken for U (units) when poorly written

You Must Know!!

- Telephone orders are to be written directly onto the bright pink telephone order sticker and then read back to the issuing provider. Physician must participate in the read back by confirming the order or clarifying it. The order must be authenticated within 48 hours including date, time and signature. Authentication can be accomplished by the physician who gives the order or another physician on the case.
- Nursing tags the telephone order for physician signatures.
- Verbal orders are only allowed in emergency situations.
- The recipient of critical value notification from the Lab and Diagnostic Imaging is required to read back the results. (See Critical Values list attached at the end of this module.) For example, Lab notifies RN, RN records results and reads them back to the Lab. When the RN notifies the physician, the physician writes them down and reads them back to the RN. Once the critical results become available, the licensed staff member will report the results to the physician within 15 minutes. If they are unable to contact the physician within the first 15 minutes, the licensed staff member will make a second attempt to contact the physician. If after a total of 60 minutes there is still no response from the physician, the Chain of Command will be implemented.
- Use SBAR (Situation, Background, Assessment and Recommendation) for patient care handoffs. Ensure recipient has opportunity to ask questions.

MEDICATION SAFETY

1. Clearly identify and distinguish **Sound-Alike / Look-Alike (SALAD)** medications. The table below is a list of SALAD medications - based on Joint Commission National Patient Safety Goal requirements.

Avandia (**rosiglitazone**)	Coumadin (**warfarin**)
CLONIdine (**Catapres®**)	KLONOpin® (**clonazepam**)
FOSphenytoin (**Cerebyx®**)	PHENYtoin (**Dilantin®**)
Hespan® (**hetastarch**)	Heparin
HumaLOG® (**insulin lispro**)	HumuLIN® (**brand name for Lilly human insulin products, e.g. R, N, L, U**)
HydrALAzine (**Apresoline®**)	HydrOXYzine (**Vistaril® or Atarax®**)
HYDROmorPHONE (**Dilaudid®**)	MorPHINE
Lovenox® (**enoxaparin**)	Luvox® (**fluvoxamine**)
NovoLOG® (**insulin aspart**)	NovoLIN® (**brand name for Novo Nordisk human insulin products, e.g. R, N, L**)
OxyCODONE MS Contin® (**extended release morphine**)	OxyCONTIN® (**extended release oxycodone**)
TraMADOL (**Ultram®**)	TraZODONE (**Desyrel®**)
ZesTRIL® (**lisinopril**)	ZyPREXA® (**olanzapine**)

2. Label all medications, medication containers, or other solutions on and off the sterile field in perioperative and other procedural settings.
3. Ensure safe administration and monitoring of all patients receiving anticoagulation therapy.

You Must Know!!

- Look for **"TALL-MAN"** lettering on medication labels. For example: HYDROmorPHONE vs. morPHINE
- Write order legibly and print your name so staff knows who to call for questions.
- Do not carry medications in your pockets or fanny packs! The temperature is not appropriate.
- Label all syringes, basins and medication cups PRIOR to the procedure with the name of the medication (i.e. normal saline, sterile water, Lidocaine, etc.), strength, and amount (and expiration date when not used within 24 hours.)
- Hospital has a policy for safe administration and monitoring of patients on anticoagulation therapy.
- Obtain baseline and ongoing lab results of anticoagulation agents such as heparin and warfarin (Coumadin®) to monitor effects.
- A black box warning is a notice on the packaging of a prescription drug which warns patients and prescribers that the drug has potentially dangerous side effects. This warning system is primarily used by the Food and Drug Administration (FDA).

  Example: Fentanyl patch BBW: should ONLY be used in pts who have demonstrated Opioids tolerance.

  Tolerance: taking Opioids for more than 7 days, more than or equal to 60mg Morphine/day, more than or equal to 30mg oxycodone/day, more than or equal to 8mg Dilaudid oral/day, or any other equianalgesic doses

NPSG GOAL 4: ACCURATELY & COMPLETELY RECONCILE MEDICATIONS ACROSS THE CONTINUUM OF CARE

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You Must Know!!

- Ensure that a complete list of home medications is documented on admission on the Medication Reconciliation Form and the form is reviewed and signed by a physician.
- Update the list if you are aware medications are missing or have been discontinued or changed.
- Refer to the medication reconciliation form when writing admission, transfer or discharge orders so NO medications are missed.
- When transferring patients between units, review the current list of medications on the eMap Transfer Orders Report and reorder as appropriate.
- Reconcile medications on discharge, giving patient a complete and accurate home medication list. Do not use any abbreviations on this list.

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UNIVERSAL PROTOCOL: PREVENT WRONG SITE, WRONG PROCEDURE, WRONG PERSON PROCEDURE OR SURGERY

You Must Know!!

- Pre-operative/pre-procedure verification will include verification of the correct person, procedure and site during the following:
  - At the time the procedure or surgery is scheduled
  - At the time of admission or entry
  - Anytime responsibility of care is transferred
  - With the patient awake and involved, when possible
  - Before the patient leaves the pre-op area
- Physician to mark using ***only*** their **INITIALS** or **"YES"** at or near the incision site.
- Have all members of the health care team pause and participate in a **TIME OUT** led by the physician immediately prior to the procedure. During a Time Out, everyone is to pause and verify the ***correct patient, procedure, and site.***
- If clinically possible, have the patient be awake during the time out.

RAPID RESPONSE TEAM

Because a significant number of critical inpatient events are preceded by warning signs prior to the event, The Joint Commission has mandated a National Patient Safety Goal to **improve recognition and response to changes in a patient's condition.** A majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by a specially trained individual(s) may reduce cardiopulmonary arrests and patient mortality.

GOAL: KNOW THE REASONS FOR WHICH RAPID RESPONSE TEAM MAY BE CALLED

You Must Know!!

Our Rapid Response Team (RRT) is our method for meeting this requirement. The RRT may be called for additional assistance to respond to a change in the patient's condition or a perception of change by the staff, the patient, and/or family. **Patients and families** are educated and encouraged to be **involved in their care** and to report concerns related to care treatment and services and patient safety issues.

Additional efforts to improve early recognition of changes in patient's condition include implementation of screening for signs and symptoms of sepsis in the Emergency Department and for all inpatients every shift. Nursing staff will notify physician of updates or changes and screen for sepsis. A Sepsis Order Set is available to assist the physician in providing evidenced-based, goal directed therapy for the septic patient.

EMERGENCY OPERATIONS PLAN

You Must Know!!

- When you hear a Code Triage # overhead or receive a call from the hospital letting you know that our Emergency Management plan has been activated:
  - Go to the Vesalius Conference Room
  - Bring your ID badge
- We have an up-to-date Emergency Operations Plan in place.
- The Hazard Vulnerability Analysis is updated annually.
- The Medical Staff Office processes disaster privileges to volunteer licensed independent practitioners who present proper documentation, then are paired with credentialed Medical Staff members.
- When shifting to population-based care, medical care is:
  - Coordinated by the Medical Staff Specialists in the Hospital Command Center
  - Implemented by the Medical Care Branch Director

PHYSICIAN WELL-BEING COMMITTEE

You Must Know!!

- The Physician Well-Being Committee is available for Medical Staff members with illness, behavior and impairment issues.
- Alan Baron (707)576-4040 and Ritch Addison (707)576-9813 are Co-Chairs.
- Referrals to the Committee can be made by:
  - Self-referral
  - another Medical Staff or hospital staff member
  - the Medical Executive Committee
- The Committee evaluates the credibility of the referred concern, complaint or allegation.
- The Committee provides advice, counseling, or referrals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.
- These activities are kept confidential, except as limited by law or when the information received by the Committee clearly demonstrates that the health or known impairment of a Member poses a risk of harm to patients or others.

PAIN MANAGEMENT

PAIN IS ASSESSED ON ADMISSION, EVERY 4 HOURS AND PRN USING THE:

Modified Wong Baker 0-10 Pain Intensity Scale

-OR-

Nursing Assessment of Pain Intensity Scale (NAPI) for preverbal children & cognitively impaired adults.

-OR-

The Riley Infant Pain Scale Assessment Tool is utilized for newborns to two (2) months of age.

GOAL: IMPROVE THE QUALITY OF PAIN MANAGEMENT

You Must Know!!

- Pain management is considered a basic right for all patients. Pain assessments and remedies must be tailored to the individual patient's age, abilities, personal, cultural, spiritual, and/or ethnic beliefs.
- The assessment of pain is an interdisciplinary process including input from physicians, nurses, pharmacists, physical therapists and other clinical disciplines involved with the patient's care.
- If pain is still present at discharge, physicians must address pain management as part of the discharge instructions.

Patients who do not achieve satisfactory pain management report less satisfaction with their care in the hospital.

SAFETY / SECURITY / HIPAA

The Joint Commission requires that every person working in a health care facility be familiar with basic safety procedures and practices. The following goals give brief descriptive information on information security, safety management and procedures at Sutter Medical Center of Santa Rosa.

GOAL 1: BECOME COMPLIANT WITH PATIENT PRIVACY, CONFIDENTIALITY, AND HIPAA

- Any information identifying a patient ("Protected Health Information" or "PHI") legally must be used only for patient care, billing, and quality improvement and other operations. Keeping this information private is the legal right of patients, including employees and physicians who are patients. Here are some things you can do to help maintain security, privacy, and confidentiality of information:
- Other than for patient care reasons, do not discuss patient information with any other physician or employee who does not have a need to know this information.
- Be discreet. Do not talk about patient care issues or information on the elevator, in the hallway, in the cafeteria, or any public area.
- Do not bring unauthorized students, children, and other interested persons into the hospital to "shadow you in your medical work." These individuals are not legally entitled to PHI of patients.
- Utilize confidential bins to discard any PHI.
- Do not put patient information on voice mail, message machines, or email, etc.
- Work with your office staff to fax patient information carefully—using a cover sheet, checking numbers, and providing sender information.
- Breaches in patient confidentiality must be reported to the California Department of Public Health within 5 days of discovery.
- Contact the HIPAA Privacy Officer **(Chris Bartel @ 576-4303)** if you believe patient privacy has been or is being breached by any SMCSR practice or if you have any question about HIPAA law.

Goal 2: Know the Different Emergency Safety Codes

Emergency Codes: You may hear the following emergency codes on the attached page announced overhead. Know the significance of ***every code*. YOU** may activate Codes Red, Gray, Yellow, Orange, Pink, Silver, and Blue by **calling x666.**

You Must Know!!

Code RED = FIRE

Remember R-A-C-E-R

Remove, those in immediate danger

Activate Alarm & Dial 666

Contain Fire – close doors

Extinguish fire or **E**vacuate if instructed

Report fire to Command Center (CC), ext. 4005.

Code	Description
Blue	"Code Blue" and location (usually a patient room or hospital department) indicates an ADULT has suffered cardiac or respiratory arrest. Certain employees and physicians are assigned to respond. Activate a Code Blue by calling x666 and giving the location.
Red	"Code Red" followed by a location indicates a fire, e.g. "Code Red: Fourth MS2, East Wing." - Activates the fire response plan, which requires all doors be closed and the use of elevators discontinued. ***Know the acronym "R.A.C.E.R".*** If you discover a fire, pull the closest fire alarm; call x666 and say Code Red and the location of the fire; close doors in the area; contact a staff member of the nearest department. During any Code Red activation, use stairs not elevators. Remain alert for further information/instructions.
Orange	"Code Orange" and a location indicate a hazardous spill. Departments are responsible for cleaning up minor spills. If the spill is NOT minor, call a Code Orange. Engineering will determine whether an external, "expert" response team should be summoned for clean-up. Anyone may call a Code Orange.
Gray	"Code Gray" followed by a location indicates a potentially physically dangerous situation for staff or physician. Designated staff (employees and/or security officers) come to the area to assist. Any person working at the hospital who feels danger from a patient or visitor may activate a Code Gray by dialing x666 and giving the location.
Silver	"Code Silver" should be called into the Code Line when a person displays in a threatening manner a weapon or object capable of great bodily harm or there is a hostage situation. The **Operator** will page the Code Silver and the location, call 911, and will contact the security officer on duty.
Yellow	"Code Yellow" and a location indicates a Bomb Threat. A bomb threat can be received by anyone in the facility. If you receive a bomb threat, try to get as much information as possible, e.g. # of bombs, when it will explode, where is it located, what does it look like, etc.; try to capture details of caller, e.g. voice characteristics, age, sex, background noises; and immediately dial x666 to report threat, location & details.
Triage	"Triage Code" followed by a number indicates the activation of the Emergency Operations Plan and the number of casualties expected at SMCSR. The notification may be by overhead page and/or by the hospital telephone tree. Staff, physicians, and volunteers should report to their department, assigned area, or to the "Labor Pool" located in the Vesalius.
Pink	"Code Pink" alerts the hospital to a possible infant/child abduction. When a Code Pink is announced, staff will go immediately to the nearest exits to observe individuals exiting the building. Anyone working should report a person acting suspiciously or carrying a bag or other container that could possibly conceal an infant. No staff is expected to physically challenge a suspicious person, but notification of security staff is imperative.
Pedi	"Code Pedi" and location (usually a patient room or hospital department) indicates an Pediatric patient has a medical emergency. Activate a Code Pedi by calling x666 and giving the location.
Neo	"Code Neo" and location (usually a patient room or hospital department) indicates an infant medical emergency. Activate a Code Neo by calling x666 and giving the location.
Manpower	"Code Manpower" and location indicates an emergent need for patient transport. Activate a Code Neo by calling x666 and giving the location.

RESTRAINTS

You Must Know!!

1. ALWAYS CONSIDER and DOCUMENT ALTERNATIVES such as reorienting, diversion items, safety education, and/or personal alarms.
2. ASSESS and DOCUMENT FOR UNDERLYING CAUSE of behavior necessitating restraints (i.e. medications, oxygenation, infection, electrolyte imbalance, etc.).
3. Restraint orders shall **never** be written as standing orders or PRN (as needed) orders. If the need for **medical-surgical restraint use extends beyond 24 hours, the physician must reassess the patient daily, before writing new daily order.**
4. Sutter Medical Center Medical Center of Santa Rosa will limit the use of restraints for behavioral management and seclusion only for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. This type of restraint use requires a **face-to-face evaluation** of the patient **conducted by a physician** or other LIP or a registered nurse (RN) or physician assistant (PA) trained in conducting 1 hour face-to-face evaluation, **within 1 hour of the initiation of the restraint**. The face-to-face session must evaluate the following:
   - The patient's immediate situation;
   - The patient's reaction to the intervention;
   - The patient's medical and behavioral condition; and
   - The need to continue or terminate the restraint or seclusion.

   See the Restraint and/or Seclusion Orders for Violent and/or Self-Destructive Behavior Order Sheet for required documentation.
5. Orders for Restraints for violent or self-destructive behavior are limited to 4 hours for adults. The patient must be reassessed for continuation of restraints and a new order obtained at that time. RN can reassess and obtain T.O order at 4, 12 and 20 hours. MD must reassess at 8, 16 and 24 hours.
6. The order for use of **Restraints for management of violent or self-destructive behavior** must be limited to:
   - Four (4) hours for adults
   - Two (2) hours for children 9 - 17
   - One (1) hour for children under 9
7. Drug or medication as a restraint - when used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
8. The hospital must report to CMS **each death:**
   - That occurs while a patient is in restraints or in seclusion at the hospital.
   - That occurs within 24 hours after the patient has been removed from restraint or seclusion.
   - Known to the hospital that occurs within one week after the restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" includes, but is not limited to, death related to restriction of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
   - Physicians should notify nursing staff when this occurs.

INFECTION CONTROL

GOAL: IMPROVE UNDERSTANDING OF INFECTION CONTROL & PROCESSES

You Must Know!!

SOME SPECIFIC REQUIREMTNS AND PREVENTION METHODS	
Hand Hygiene	• As proven over 150 years ago, it is still the **single most important thing you can do to prevent the spread of infection.** • Hand hygiene is to be practiced before and after contact with the patient or their environment and before and after glove use.
Basic Practices for Prevention of Central Line Bloodstream Infections	• Hand hygiene before insertion • Catheter checklist for insertion (CLIP) to ensure compliance with aseptic technique and maximal barrier precautions • Remove catheter as soon as not clinically necessary – assess and document at least daily per regulatory requirements • Maximal sterile barrier precautions (mask, gown, hat, sterile gown, sterile gloves, and patient covered with large sterile drape) • Avoid femoral vein unless no other option (except in children) • Chlorhexadine (CHG) for skin prep (except in babies less than 2 mo.old) *must allow prep to dry prior to puncture* • Disinfect catheter hubs, needleless connectors, and injection ports before accessing catheter *use CHG or 70% alcohol to decrease contamination / scrub the hub* • For non-tunneled catheters use transparent dressings / change dressing and perform site care every 5-7 days (more often if dressing is loose, damp or soiled) • Use antibiotic ointments for hemodialysis insertion sites
Prevention of Surgical Site Infections (SSI)	• Adherence to hand hygiene guidelines • Prophylactic antibiotic received within 1 hour of incision – 2 hours for Vancomycin and flouroquinolones • Antibiotic discontinued within 24 hours of surgery end – unless infection is confirmed or suspected (must be documented) • Clipping of hair, not shaving • Glucose control 6 am post-op • Normothermia • Traffic control in OR's • Surgical hand scrub using an appropriate antiseptic agent; alcohol solution acceptable • Patient skin prep using and appropriate antiseptic agent • Urinary catheters are discontinued by post-op day 2 unless physician documents reason for continuation
Sentinel Event Caused by Hospital Associated Infection (HAI)	• Immediately report to Risk Management any patient who dies or has a permanent loss of function due to an HAI
Multi-Drug Resistant Organisms (MDRO)	• The regulatory requirement is for all physicians to discuss positive MDRO culture results with the patient. • Patients with and MDRO are placed on Contact Precautions throughout their hospitalization. • Regulatory requirement is to provide the patient with education regarding health care associated infection strategies.