Medical Staff Education

Anticoagulant Therapy

National Patient Safety Goal : Use Medicines Safely- Anticoagulation Therapy

Rationale for NPSG.03.05.01

- Anticoagulation therapy can be used a therapeutic treatment for a number of conditions, the most common of which are:
  - Atrial fibrillation
  - Deep vein thrombosis
  - Pulmonary embolism
  - Mechanical heart valve implant
- It is important to note that anticoagulation medications are more likely than others to cause harm due to:
  - Complex dosing
  - Insufficient monitoring
  - Inconsistent patient compliance

Use Medicines Safely- Anticoagulation Therapy:

- A written policy (900.3207) addresses baseline and ongoing laboratory tests that are required for anticoagulants
- Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
  - Compliance
  - Follow-up monitoring
  - Drug-food interactions
  - Awareness of potential adverse drug reactions and interactions

Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization

900.5863 Transitioning patients to and from direct oral anticoagulants and other anticoagulants.

Indications of Anticoagulation Therapy

Anticoagulants are used to prevent the extension of an existing clot and/or the formation of a new clot. Anticoagulants have no direct effect on an established thrombus, nor do they reverse ischemic tissue damage. Once a thrombus has occurred, the goal of anticoagulant treatment is to:

- Prevent further extension of the formed clot
- Prevent secondary thromboembolic
- 900.5010 Guidelines for reversal of antithrombotic therapy in adults are referenced in this policy.
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Indications of Anticoagulation Therapy

Anticoagulants are used for both treatment and prevention of thrombosis in a number of conditions including the following:

- Atrial fibrillation
- Cerebral vascular accident (Stroke)
- Acute coronary syndromes (ACS) and MI
- Treatment and prevention of venous thromboembolism (VTE)
- Heart disease (valvular) and following valve replacement
- Hereditary clotting disorders
- Cancer-associated coagulopathies
- 900.5863 Transitioning patients to and from direct oral anticoagulants and other anticoagulants

Risks:

These risks/warnings/adverse reactions are common to all anticoagulants
Specific risks/warnings/adverse reactions are discussed within each drug section

LEGACY HEALTH

- Hemorrhage is the chief complication that may result from anticoagulation therapy
- An overly prolonged clotting time or minor bleeding during therapy can usually be controlled by temporarily holding the drug
- Gastrointestinal or urinary tract bleeding during anticoagulant therapy may indicate the presence of an underlying occult lesion, which may require further evaluation

Less common risks include:

- Hypersensitivity reactions (chills, fever, asthma, runny nose, tears, headache, nausea, itching)
- Thrombocytopenia
- Local irritation, redness, ulceration following injectable anticoagulants
- Skin lesions with warfarin
- Interactions with medications or botanical products

Contraindications:

- Any active bleeding from the GI, GU, respiratory tract or cerebrovascular hemorrhage
- Malignant hypertension
- Spinal puncture and other procedure with potential for uncontrolled bleeding
- Recent or impending surgery of the central nervous system, traumatic surgery or certain surgeries of the eye
- Patients with indwelling spinal/epidural catheters require a specific order for concomitant therapy by a physician:
- When neuraxial anesthesia (epidural/spinal anesthesia) or spinal puncture is employed, patients anticoagulated or scheduled to be anticoagulated with LMWH or heparinoids are at risk of developing an epidural or spinal hematoma which can result in long-term or permanent paralysis.
- 900.5011 Periprocedural management of anticoagulation therapy

Better Patient Outcomes
Patient education is a vital component of an anticoagulation therapy. Effective anticoagulation patient education includes:

Face-to-face interactions with *a trained professional who works closely with patient to be sure that they patient understands:*

- The risks involved with anticoagulation therapy
- The precautions they need to take
- The need for regular International Normalized Ratio(INR) monitoring for patients on warfarin

The use of standard practices for anticoagulation therapy that include:

Patient involvement can reduce the risk of adverse drug events associated with:

- Heparin (unfractionated)
- Low molecular weight heparin
- Warfarin
- Direct oral anticoagulants

Clinical Alarm Management

Why are we looking at this?

- There is heightened awareness of alarm fatigue and it has an impact on patient safety
- There is evidence that supports alarm management enhances patient safety
- The efficiency of the bedside health care provider can be enhanced with proper alarm management.
- It is an education requirement from The Joint Commission as of January 1, 2016

There is heightened awareness of alarm fatigue and it has an impact on patient safety:

- Other issues associated with effective clinical alarm system management include:

- Too many devices with alarms
- Default settings that are not at an actionable level
- Alarm limits that are too narrow.

These issues vary greatly among hospitalsand even within different units in a single hospital.

There is evidence that supports alarm management enhances patient safety:

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety.

Efficiency
Many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause

them to miss or ignore alarm signals or even inappropriately disable them.

Responsible Staff
Health care providers are required to monitor and respond to clinical alarms on equipment to which they have been trained

Intended to alert the Healthcare Provider (HCP) of a change in patient condition or when equipment requires attention

Examples include:

- Physiologic monitoring devices
- Continuous Cardiac monitoring devices
- Noninvasive PPV devices
- Continuous pulse-oximeter monitor
- Bed and Chair alarms
- Infusion pumps
- Invasive monitoring devices
- Ventilators

Nuisance Alarms:

- Alarms that do not measure an actual patient condition change
- Two alarms that measure the same thing
- Alarm Limits that are set too tight
- Alarm limits that are not adjusted for patient condition.

Alarm Signal – Audible when in use:

- However, when a signal is duplicated, it is recommended that only one alarm signal be enabled to prevent a nuisance alarm
- When an alarm signal is used to alert the health care provider of a change in patient condition, it should not be disable or turned off.
- Anesthesia providers may disable clinical alarms when providing direct care.

We have to be diligent in responding to alarms:

HCPs must:

- Consider patient safety the top priority when adjusting or modifying alarms
- Confirm alarms are confirmed as active and audible when assuming care of the patient
- Evaluate physiologic parameters at the start of every shift, change in patient condition, and with any change in caregiver
- "End Case" on the bedside or central telemetry monitor after every patient encounter if a patient receives continuous cardiac monitoring in order to reset default parameters (Remember to validate vital signs in EHR before ending case.)

Disabling Alarms + Alarm Fatigue:

- The HCP and/or monitor tech may disable a nuisance or duplicate alarm if there are sufficient alarms enabled to alert the HCP to a change in patient condition (i.e., disabling the irregular alarm on a patient with chronic atrial fibrillation).

- Clinical alarms may be temporarily paused, silenced, or delayed allowing for patient care (i.e., during PA catheter insertion). When leaving the direct area of patient care, alarms should be reactivated.

- Default Parameters: Alarm parameters may be adjusted to fit the patient's physiologic status and according to department policy to reduce duplicate and nuisance alarms.

- Handoff communication: Ensure Handoffs Include Alarm Parameter Status.

Adjusting Alarm Parameters:

- HCP may only adjust alarms on equipment for which they have received training and/or competency to do so:
    - unless there are specific parameters ordered by the LIP.
    - Alarm limits should not be set to such extremes they fail to detect patient condition changes

- If an adjustment is made to an alarm setting by a member of the health care team, it is the responsibility of that team member to alert the direct care provider:
    - For example, an RT notifies the patient's primary nurse that a ventilator alarm has been adjusted.

- Default alarm parameters and settings are set according to or in conjunction with manufacturer's recommendations.

- Never disable life-threatening arrhythmia alarms on cardiac monitors.

Environment of Care

Safety and Security:

Safety/Security Dispatch can be reached 24/7 at 503-413-7911 (X37911).

For off-site locations please dial 9-1-1.

Per Legacy Health policy LH 300.01 Identification of Individuals, all physicians, staff, volunteers and contractors are required to wear photo identification badges at all times while on duty.

Code Red Fire Response:

In the event of a fire, follow the acronym R.A.C.E.R.:
R - Rescue anyone in immediate danger.
A - Alert others by sounding the alarm.
- Call Fire Code line
- Pull alarm pull-station
- Announce "Code Red"

C - Confine the fire by closing all doors
E - Extinguish the fire only if:
- You have an escape route
- The fire is small enough to be extinguished
- You feel comfortable using an extinguisher

R - Relocate all patients from the affected smoke compartment of the fire into the nearest unaffected smoke compartment, exit enclosure or exterior exit.
- Do not take patients past the room of origin when relocating when possible.
- Take an outside route if necessary.

To use a fire extinguisher, follow the acronym P.A.S.S.:
P - Pull the pin.
A - Aim at the base of the fire.
S - Squeeze the handles together.
S - Sweep from side to side at the base of the fire

Safety Data Sheets (SDS): Are you familiar with the hazards posed by chemicals used in your workplace? Safety Data Sheets are available on the MyLegacy intranet.

Violence in the Workplace LH 200.23, Workplace Violence Prevention & Response:
Legacy Health maintains a zero tolerance for violence in the workplace.

What is Violence in the Workplace?

- Physical assault acts
- Sexual harassment and assault
- Intimidation
- Threats
- Aggressive behavior
- Gestures
- Notes
- Domestic Violence and verbal abuse, including use of racial slurs

Contributing Factors to Violence:

- Altered mental status (AMS)
- Drug and alcohol abuse
- Medication concerns
- Failing personal relationships
- Personal loss (family member, job, etc.)
- Inadequate coping skills

* ***Outside of the main campuses, contact 9-1-1.***

When confronted with a violent person or situation:

- Attempt to distance yourself from the person or situation
- Speak calmly and quietly
- Ensure you have an exit/escape route
- Avoid using aggressive body language
- Avoid using ultimatums
- Maintain positive eye contact
- Watch the individual's hands for signs of aggression
- Alert Safety and Security
- If Safety and Security are present at your site, call Dispatch at Ext. 37911
- If Safety and Security is not present at your site, call 911
- Alert a co-worker and ask them to call Safety and Security Dispatch
- Push a panic button if one is available

VIOLENCE
It's Not Part of the Job.

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- Alert Safety and Security
- Alert a co-worker and ask them to call Safety and Security Dispatch
- Push a panic button if one is available

- If you have a Safety and Security presence at your site, contact Security Dispatch at Ext. 37911 or 503-413-7911.

- If you do not have a Safety and Security presence at your site, call 911.

- Complete an ICARE

Victim Assistance:

- Resources are available 24-7 for any staff that have been involved in violent or potentially violent situations
- Workplace Violence toolkits for leaders and victims on the intranet
- Employee Assistance Program (EAP)
- Counseling
  - HR Answer Center x55100
  - Managed Healthcare NW Preferred Provider Directory
- Chaplains & Spiritual Care
- Safety/Security Support
- Social Worker/Clinical Resource Coordinator (CRC)

Emergency Management:

Legacy Health policy 300.09 Emergency Operation Plan, outlines Legacy Health's response to adverse incidents that impact day-to-day operations. In addition, Legacy Health Medical Staff bylaws contain information about expectations of medical staff during emergencies and disasters.

- Code triage internal: An internal/on-campus event that impacts operations.
- Code triage external: An external/off-campus event that impacts Legacy operations.

Your role during a disaster:

- Be familiar with the overall Legacy Health Emergency Operation Plan LH 300.09.
- Know and understand your department/clinic/unit's SPECIFIC emergency response plan.
- Keep current contact information on file with your department/clinic/unit.
- Wear your Legacy ID badge at all times while working and have it with you when arriving to work during a disaster.
- Be familiar with the location of the Emergency Operation Center (EOC) and Labor Pool for the location where you work.
- Ensure your personal preparedness by having a family plan, making a disaster kit, and staying informed about potential emergencies.

Code Amber:

LH 200.08 Abducted, Missing, Eloped or Lost Infant, Child or Adolescent

Infant indicates the missing patient/visitor is a baby less than 1 year of age.
Child indicates the missing patient/visitor is between 1 and 10 years of age.
Adolescent indicates that the missing patient/visitor is between 11 and 18 years of age.
Abduction: The taking of a patient/visitor under 18 by use of fraud, persuasion or force. Any infant/child/adolescent removed from any hospital department without staff and/or the parent/legal guardian's knowledge with the intent of leaving the campus.

Elopement: The voluntary departure by a patient from hospital grounds without knowledge or permission of hospital personnel.

Lost or Missing: Anytime Legacy staff and/or the parent or legal guardian is unable to locate the infant/child/adolescent and there is no reason to suspect an abduction has occurred**.**

In the event a Code Amber is initiated, all staff are expected to:

- Stop all non-critical work
- Proceed to the nearest exit, stairwell, hallway, skybridge, etc.
- Pay attention to your surrounding and report anything suspicious.
- Be an extra set of eyes and ears for Safety/Security.
- Wait for the “All Clear”.

Code Silver:

Monitor:
There is a heightened safety concern on or near campus and access may need to
be limited, controlled and / or monitored. This could be limited to a specific department,
area, building, or the entire campus depending on the situation. **This should be considered an alert only.** A Code Silver, Monitor often does not involve locking any doors and may only result in security officers monitoring specific areas.

Pay attention to surroundings and contact Safety/Security to report any suspicious or criminal activity.

Secure:
There is a serious, potential safety risk on or near campus, **outside** the buildings. Access will be limited, and egress will be allowed in a controlled manner. Staff, patients, physicians, and visitors should remain inside but will not be forced to remain inside. This
could be limited to a specific department, area, building, or the entire campus depending on the situation.

Be sure to have your Legacy photo identification badge with you to gain access into the facility.

Shelter-in-Place:
There is a serious, potential safety risk or risk of imminent harm **inside** the campus buildings or on campus. All personnel should remain behind closed and locked doors. All non-critical work should stop. Access into buildings will be dependent on the location of the incident. Relocation or evacuation of specific areas could be considered. A Code Silver, Shelter-in-Place will include the entire campus.

Active Shooter:
A subject has displayed a weapon in a threatening manner or the weapon is in use anywhere on Legacy Health property. Code Silver, Active Shooter will include the entire campus.

Initiate Run, Hide, Fight response.

Policy: LH 200.21

Available Resources for Environment of Care or Emergency Management:

- Facilities Work Request
- Clinical Engineering Work Request
- Environment of Care Intranet Site
- Inclement Weather Intranet Site
- MyAlert (Emergency Notification System)
- Parking at Legacy Resources

Fall Prevalence

To aid in understanding the impact of falls on our patients, our hospitals, and our community, the following are some national statistics on patient falls in hospitals (AHRQ, 2019)

- Inpatient falls 3-5 per 1000 patient days
- Greater than 50% occur related need to use the bathroom
- 81% are unassisted
- 66% of falls result in no injury
- 44% result in injuries from mild bruising/skin tears to fracture
- Average cost of hospital fall with injury: $30,000

How can we all work to prevent falls?

- Patient & family education
- Provider/staff education & training
- Fall Prevention Best Practice Bundle Interventions

Fall Prevention Best Practice Bundle

- Nursing and Clinical Staff will implement these interventions as a bundle to decrease our patient falls
- Fall Risk Assessment upon admission and first 12 hours:
- Acute Care - MORSE (Adult), Graf-Pif (Pediatrics)
- Unity - Wilson Sims (Adult), Cummings (Pediatrics)
- After first 12 hours: Monitoring the Fall Predictive Index every shift, located as Fall

Risk Score Accordion Report in the Summary tab.
- Banner bar identifies patient as high risk for falling
- Proactive Rounding
- Environmental safety
- Standardized Fall Prevention Interventions
- Post Fall Procedure

Your Role in Fall Prevention

Maintain a safe environment:

- Examples: ensure bed rails are used appropriately, report any spills, ensure floors are kept clear of excessive equipment, wires, etc.

Recognize and implement fall prevention measures:

- Example: Assure personal items are within reach of the patient (glasses, dentures, call light), use of bed alarms, remind families and patients on how to call for assistance.
- If you hear an alarm, respond.

Mitigate clinical risk factors for falls such as: Poor fluid/nutrition intake

- Poor fluid/nutrition intake
- Medication management
- Pain management
- Order therapies (PT/OT) as appropriate
- Cognitive impairment
- Alcohol intoxication and/or withdrawal

WE HAVE DONE EVERYTHING WE COULD TO PREVENT FALLS……now what?

Post-Fall Procedures:

- The nurse will implement the post-fall procedure on the inpatient units.
- ***Anyone*** that witnesses a patient fall, assisted when a patient falls, or may have information about the fall, will initiate and/or contribute to
- the procedure.
- Procedure includes assessing the patient and environment, notifying the physician and patient's family, carrying out doctor's orders for diagnosing injury, completing the Patient Safety Alert (ICare), and implementing further fall prevention interventions.

Culture of Safety and Just Culture

Incident reporting makes a difference in many ways. Reporting helps create a safer environment for patients, visitors, and staff by:
Identifying potential (good catch) or actual safety concerns.Taking steps to prevent harm
Contributing to learning from events so that problem-prone processes can be redesigned.
Relevant Policies:

- Performance Improvement and Patient Safety Program Plan
- Workplace Incident Reporting, Investigation, Tracking
- Anti-Discrimination and Anti-Harrassment Policy

Impact of Reporting:

Reporting helps create a safer environment for patients, visitors, and staff by:

- Identifying potential (good catch) or actual safety concerns
- Take steps to prevent the physical and psychological harm of diverse patients and members of the care team.
- Contributing to learning from events so that problem-prone processes can be redesigned.
- Relevant Policies:
- Anti-Discrimination and Anti-Harassment Policy (policy# 500.504)
- Performance Improvement and Patient Safety Program Plan (Policy # 100.48)
- Workplace Incident Reporting, Investigation, Tracking (Policy # 100.25)

What to Report?

- Anytime something you expect to happen does not.
- When something happens that you did not expect to happen, or nearly happens (Near Miss/Good Catch).
- ***Please note, events that do not reach the patient should still be reported.***

- ***Examples:***

- Medical staff professional conduct incidents (i.e., sexual harassment, racial bias, professional bullying and retaliation, etc.)
- Employee incidents by patients, patient family or colleagues i.e., work injuries, violence or threats, communication breakdown, staffing, etc.)
- Patient or visitor incidents (i.e., falls, medication events, pressure injuries, equipment issues, etc.)

- Your login is your Legacy network username and password. If you do not have a username, please contact the Legacy IS Help Desk at: 503-415-5888

Impaired Practitioner

The term "impaired" is used to describe a practitioner who is prevented by reason of illness or other health problems from performing professional duties at the expected level of skill and competency. Impairment also implies a decreased ability or willingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety.

Some signs of impairment are deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability or neglecting commitments, excessive ordering of drugs, lack of or inappropriate response to pages or calls, and decreasing quality of performance or patient care.

If you have concerns about a colleague or suspect an impairment, file an ICARE or reach out to medical staff services. All information received is kept confidential.

Mandatory Reporting of Suspected Abuse/Neglect:

- As you are aware, providers are mandatory reporters under the law and Legacy's policy.
- As such, if there is a suspected case of abuse/neglect/maltreatment/discrimination of elders, children, mentally ill, or developmentally disabled people, all caregivers, including physicians, have a responsibility to ensure a report is made to the proper authorities.
- Legacy Health policy 900.3312, Mandatory Reporting of Suspected Abuse, provides guidance and procedures for ensuring these reports are made. Reports must be filed in a timely manner.

Legacy One Call Center

- **Patient Placement & Transfer Center for all Legacy Sites**
- **Provides access to all Legacy Specialties for referring physicians / hospitals**

- **Coordinates Admissions for:**
  - Hospital to Hospital Transfers
  - Direct Admits (Physician office to IP Unit)
  - Emergency Department Admits
- **Coordinates Doc-to-Doc conversations for consults and transfers:**
  - Line is recorded for quality purposes
- **All ED referrals are sent through One Call**
  - One Call creates Expected ED encounter for ED doc to note on during doc-to-doc conversation prior to patient arrival.
- **All new admissions (not being scheduled for surgery) requires a phone call to One Call.**
  - External number: 1-800-500-9111
  - Internal number : 503-413-2175
  - https://oncall.lhs.org/smartweb/

Infection Prevention and Control

COVID-19

Transmission-Based Precautions

Use COVID-19 order panel

- Suspect (screening positive) or lab-confirmed COVID-19:
  - Enhanced Droplet/Contact with eye protection
- or
  - Airborne/Contact with eye protection for patients undergoing aerosol-generating procedures
- Screening only:
  - Standard precautions

Discontinuation of Transmission-Based Precautions

- Occurs in accordance with CDC guidelines:
- Mild to moderate illness (at least 10 days) / moderate to severe illness (20 days)
- and
    - At least 24 hours passed since last fever without fever-reducing meds
    - Symptoms have improved

Exposure Prevention

- Personnel must self-screen and are excluded from campus for any unexplained symptoms
- A medical-grade mask must be worn by all personnel when inside healthcare facilities
- Eye protection is recommended during all patient care and required for patients in droplet or airborne precautions

Post Exposure Protocols

- File an ICARE for any possible COVID exposures under 'workplace incident'
- Follow the Return to Work guidelines for possible COVID symptoms or coworker exposures
- Notify COVID-19 Hotline at employeehealth@lhs.org or 503-415-5820 (7am-8p) for possible COVID symptoms or coworker exposures

- Note: most COVID exposures at work occur during an aerosolizing procedure on a patient not yet known to be COVID+
- Note: many COVID exposures at work occur from symptomatic coworkers while both parties are unmasked (break areas, social gatherings)

Hand Hygiene:

Why

- Most important basic practice to prevent transmission of infectious agents and thereby decrease incidence of healthcare acquired infections.

What

- Alcohol hand rub
    - When hands feel clean
- Soap and water
    - When hands are contaminated or dirty
    - When leaving an Enteric/Contact Precautions room

When

- Always when entering and leaving a patient room
    - Regardless of whether you will touch anything
- Before patient contact
- Before aseptic tasks
- When putting on and following the removal of gloves
    - Gloves are never substitute for hand hygiene
    - Remove gloves and clean your hands after caring for one patient
- After contact with patient surroundings or potentially contaminated equipment
- Before eating, after using the restroom, before going home

Prevent Central Line Associated Bloodstream Infections (CLABSIs):

- Evaluate the clinical need for a central line before insertion and during daily rounds. Remove as soon as it is no longer indicated.
- Consult the Vascular Access Team (VAT) prior to inserting a non-emergent line for expert guidance.

- **Follow appropriate indications:**
    - Chemotherapy medications
    - Vesicant medications
    - Hypertonic Saline
    - Long term antibiotics only when a PIV is not appropriate
    - Need for CVP monitoring
    - Potassium in a concentration greater than 20 mEq/50mL
    - TPN
    - Vasoactive medication administration
- **When inserting a central line, follow these best practices:**
    - Follow the central line insertion checklist
    - Follow hand hygiene protocol and remove jewelry before procedure
    - Wear a mask, cap and sterile gown; assistants and the patient (if possible) should also wear a mask
    - Use a pre-packaged tray or pre-filled insertion cart, or box
    - Prepare clean skin at insertion site using CHG and allow to dry

COMPLETELY (Note: Use Betadine instead of CHG for infants less than 28 weeks corrected gestational age)
  - Drape the patient with maximum barrier precautions from head to toe
  - Apply BioPatch and occlusive dressing; do not use iodine ointment at the site
  - Remove unnecessary peripheral or central lines

Prevent Catheter Associated Urinary Tract Infections (CAUTIs):

Evaluate the clinical need for an indwelling catheter before insertion and during daily rounds. Remove as soon as it is no longer indicated.

- **Follow appropriate indications:**

- Assistance in healing of open sacral pressure ulcer/perineal wound healing for incontinent patient
- End of life care
- Management of acute urinary retention and/or urinary obstruction
- Precise urine output impacting changes in treatment
- Unstable spine/pelvic fracture
- Gross hematuria/clots**
- Suspected or established urinary tract injury
- Perioperative use for procedures lasting greater than 2 hours and C-sections

Consider alternatives to the urinary catheter such as the condom catheter, external female device or daily weights etc.

- Communicate the plan for removal during rounds
- Follow urine culturing best practices.
- Culture urine when clinically indicated:
- Based on local findings suggestive of CAUTI
- Prior to urologic surgeries where mucosal bleeding anticipated
- Early pregnancy
- Avoid routine cultures; Avoid pan-culturing
- Treatment is discouraged in cases where a urine culture turns positive in a catheterized patient that has no symptoms or signs of infection

Influenza

Influenza remains one of the top 10 causes of death in the United States despite availability of an effective vaccine to prevent it. From the 2010–11 through 2019–20 seasons, the annual influenza-related disease burden varied from 9–49 million illnesses, 4–23 million medical visits, 140,000–960,000 hospitalizations, and 12,000–61,000 deaths per year. People who are pregnant or who have chronic conditions are at much higher risk for complications from influenza, as are the very young or old. Health care workers are at increased risk of exposure to persons with influenza infection, and if infected can spread the virus between patients, to other staff, or bring it home to their families. Approximately 50 percent of influenza infections for healthy people under age 50 are asymptomatic but still infectious, so it can be spread by someone who does not feel ill. For this reason, The Joint Commission includes flu vaccination rates for health care workers as a measure of patient safety.

Influenza – Provider Roles

Providers are uniquely positioned to help reduce the burden of influenza on our patients and staff.

- All patients will be screened for immunization status upon admission to the hospital (inpatient and observation).

- If a patient meets criteria and does not decline, the vaccine will be given per the approved protocol.
- You can recommend vaccination for your patients and their families. You also can be a role model to your colleagues and health care staff.
- Please support Legacy and your patients by joining our efforts to protect all patients and staff by getting a seasonal influenza vaccination.

The Joint Commission now requires Legacy Health to track and report on the aggregated flu vaccination rates for Medical Staff. If you have gotten your flu

vaccination from somewhere other than Legacy, please email employeehealth@lhs.org or fax to 503-415-5192 and let us know.

For more information on influenza virus or the vaccine to prevent it, visit www.immunize.org/influenza. Flu vaccine clinics can be found by calling 1-800-SAFENET. Legacy medical staff can receive a free flu vaccination at Employee Health offices or from Flu Kickers at each hospital and may bring in guests for their vaccinations. Screening for influenza vaccination status and administering the vaccine when no contraindications exist is performed by the nurse for all Observations and Admitted patients. No additional order/signature is needed from the provider.

Pain Management

Provider Responsibilities:

- Conduct assessment and reassessment of pain upon admission and transfer in all clinical settings
- Involve the patient in the management of pain
  - Establish therapeutic goals, plan of care, patient expectations to manage pain
- Identify patients at risk for over-sedation from opioids
- Include non-pharmacological and pharmacological interventions
  - Multimodal pain management order groups within order sets promote the use of adjunctive non-opioid analgesics administered on a scheduled basis
- Assess opioids prescribed at discharge to assure the most appropriate quantity (or whether opioid therapy is necessary) to offer for safe pain management.

Consider the mantra "minimize pain, maximize function"

Racial Bias in Pain Assessment and Treatment (Recommendations)

- Black Americans are systematically undertreated for pain relative to White Americans.
- There are two potential ways by which racial disparities in pain management could arise. The first possibility is that physicians recognize Black patients' pain, but do not treat it, perhaps due to concerns about noncompliance.
- The second possibility is that physicians do not recognize Black patients' pain in the first place, and thus cannot treat it. Research suggests that racial bias in pain treatment may stem, in part, from a myth that Black people feel less pain than White people.
- If racial bias in pain management and treatment are occurring, report immediately. Implicit bias training and a protocol must be put in place to end the pattern.

Multimodal Pain Management:

- Multimodal analgesia regimens includes scheduled acetaminophen ± a scheduled NSAID ± scheduled gabapentin or pregabalin + an as needed opioid.
- Non-opioid analgesics are more effective when administered on a scheduled basis rather than as needed.
- Keeping the opioids separate from the non-opioids prevents patients who do not require the opioid component from receiving it. This is especially useful in the treatment of acute pain in which less analgesic is required as the pain resolves.

Restraints

Definitions:

- Licensed Independent Practitioner: physicians, nurse practitioners and Physician Assistants (PA) who are permitted by law and by Legacy to provide patient care services without direction or supervision, but within the scope of the individual's license and consistent with the individual's granted privileges.

Restraint:

- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, for managing patient behaviors. This includes enclosure beds.
- A drug or medication used as a restriction to manage a patient's behaviors or restrict the patient's freedom of movement and is not a

standard treatment or dosage for the patient's condition.
- Restraints can be used for Non-Violent Behaviors (NVB) or Violent/Self-Destructive Behaviors (VSD)

Seclusion:
- The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is used only for the management of violent or self-destructive behaviors.

Restraint and seclusion are interventions to:

- Manage patient behaviors that cannot be managed with alternative interventions
- As an adjunct to planned care
- Used in an emergency or crisis situation in response to dangerous behaviors
- Always use the least restrictive method

Restrictions for restraint and seclusion use:

- Cannot be used for coercion, discipline, convenience, or retaliation
- Are not a substitute for inadequate staffing
- Rationale that the patient might fall is NOT an indication for restraint use

Restraint and seclusion use, like other disparities in healthcare, can be impacted by racial bias in clinical encounters.

- Clinician bias is common, with physicians often having positive attitudes toward White patients and negative attitudes toward non-White patients (Hall, 2015).
- A systematic review found that health care professionals tend to associate Black patients with being less cooperative, compliant, and responsible in comparison to white patients (Hall, 2015), while another study found that clinicians tend to associate Hispanic patients with medical non-compliance and partaking in risky behaviors (Bean et al., 2013).
- The lack of standardized thresholds to initiate use of restraints causes the utilization of physical and chemical restraints to be partially determined by the clinician's implicit racial bias.
- For example, one study found that 73% of patients who were physically restrained in the ED were Black (Zun, 2003), and another study determined that even when controlling for confounding variables, such as sex, diagnosis, homelessness, age, and violence, Black patients were more likely to be restrained while in the ED (Schnitzer et al., 2020).

<u>Responsibilities of Providers:</u>

- Order's restraint or seclusion based on collaboration with the RN
- Orders cannot be PRN nor trial release
- Only one order & order type may be active at any time
- Performs and documents 1-hour face-to-face assessment for violent/self-destructive behaviors when restraint or seclusion initiated
- Performs face-to-face at 24 hours of continuous restraint or seclusion for violent/self-destructive behaviors

These racial disparities are consistent even beyond the ED, as a study that used a nationally representative sample of nursing homes in the U.S. found that even when controlling for dementia, fall rate, and ADLs impairments, there is a statistically significant correlation between race and the use of physical restraints (Cassie, 2013).

If racial bias is occurring, follow up immediately with implicit bias mitigation training and protocol to end the pattern.

<u>Orders</u>

The LIP, PA or RN may initiate the use of restraint or seclusion to manage patient behaviors. Implementation will be done upon LIP order, PA order, or by RN with telephone order. If the RN assesses that it is necessary to protect the patient staff members or others from harm, she/he may implement the intervention without the order, provided that the order is immediately obtained from the LIP responsible for the care of the patient.

Orders for non-violent behaviors may be ordered for a specified duration, not to exceed 24 hours (order is default set for 24 hours).

- Orders for violent self-destructive behaviors are based on patient age:
- 4 hours ages 18 and older
- 2 hours ages 9-17 years

- 1 hour ages less than 9 years

- The order will include the indication of the need for restraint or seclusion (clinical justification), method of restraint (device type, number of devices), and duration of the order.
- Any change is device type, number of device(s) and/or clinical justification requires a NEW order.
- A new order will be obtained based on the duration of the previous order. If no order is in place, you must discontinue the intervention. Absence of an active order while the patient is in restraint or seclusion constitutes assault.

Screenshots of the orders are available in the Annual Provider Education PowerPoint slides.

Face-to-face assessment will include:

- Patient's physical and psychological status
- Patient's immediate situation
- Patient's reaction to the interventions, and
- The need to continue or terminate restraint or seclusion
- Dot phrase .F2F captures required elements of this documentation
- No face-to-face requirement for non-violent behaviors
- Unity only: trained RNs may perform the face-to-face

The Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA Background:

- Federal law enacted in 1986 designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer
- The reason for such sweeping legislation grew from an increasing number of complaints over EDs refusing to treat indigent people and/or transferring unstable or medically inappropriate patients, considered "patient dumping"
- Considered one of the most comprehensive laws guaranteeing nondiscriminatory access to emergency medical care and thus to the health care system

EMTALA Obligations:

Hospitals have 3 main obligations under EMTALA:

- Any individual who comes to the ED and requests treatment must receive a medical screening examination (MSE) to determine whether an emergency medical condition(EMC) exists:
    - Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage.

- If an EMC exists, treatment must be provided until the EMC is resolved or stabilized. If the hospital does not have the capability to treat the EMC, an "appropriate" transfer of the patient to another hospital must be done

- Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable EMCs (ex: NICU, Burn)

Definition: "Comes to the ED"

- Includes patients who physically present to a "Dedicated Emergency Department (DED)"
- Includes the main hospital campus, parking lot, sidewalk, driveway, and any building owned by the hospital within 250 yards of the main hospital campus
- Includes patients physically on hospital property who request treatment for what may be an EMC
- Includes patients in a ground/air ambulance on hospital property
- Even if ambulance staff disregard the hospital's diversion instructions
- Diverting an ambulance in route to the hospital without formally being on divert may violate EMTALA

Note: Patients may have a request for treatment made on their behalf; a request for treatment is also considered to exist if a prudent layperson would

believe that the patient's appearance or behavior needs examination or treatment

Definition: Medical Screening Examination (MSE)

- An MSE is an ongoing assessment based on the patient's chief complaint, symptoms, and condition with the intent to determine the presence or absence of an Emergency Medical Condition (EMC).
- For mental health patients, the MSE typically has two steps: (1) an initial exam to rule out organic causes of mental disorder and (2) a psychiatric review.
- Hospital must provide an appropriate MSE to determine whether an EMC exists
- Triage ≠ MSE
- MSE must be performed by a Qualified Medical Person (QMP):
- A physician
- A nurse practitioner, physician assistant, certified nurse midwife, who has demonstrated competency through training and skills verification
- An OB RN who has demonstrated competency through training and skills verification can perform an obstetric MSE

Definition: Stabilized

- Under EMTALA, "stabilized" means that no material deterioration of the patient's condition is likely, with reasonable medical probability, to result from or occur during the transfer or discharge of the patient from the facility.
- Note: "Clinically stable" is different than EMTALA's definition of "stable". Clinically stable is defined as the normalization of the patient's vital signs; however, if the EMC has not been stabilized then EMTALA continues to apply. For example, a patient who is diagnosed with appendicitis might have relatively normal vital signs, but is still in need of surgery, and therefore continues to have an EMC and has not been "stabilized" under EMTALA.
- A pregnant patient in labor is stabilized upon delivery of the child and placenta.
- Acute psychiatric patients that are suicidal or homicidal are considered stable only if they are no longer a threat to themselves or others.
- Intoxicated patients are not stable until sober.

Definition: Capability and Capacity

- Capability means that hospital personnel can provide the services that a patient requires, within their training and scope of professional licenses. Capability also means that the hospital has the equipment, supplies, and specialized services to meet the needs of the patient.

- Capacity means the number or staff on duty, as well as the amount of equipment (including beds) in the facility. Capacity also includes whatever a hospital customarily does to accommodate patients in excess of occupancy limits (i.e., moving patients to other units, borrowing equipment, bringing in extra staff, etc.)

EMTALA: Arranging Transfers

- Patient transfers under EMTALA are reasonable if the hospital does not have the capacity or the capability to manage the patient safely; or the patient requests transfer
- *NOTE: Better insurance coverage at another hospital is NOT an EMTALA-compliant reason for transfer*

The transferring hospital must:

- Provide treatment within its capability until transfer to minimize transfer risks
- Confirm receiving facility has available space and qualified personnel for treatment of the individual and has agreed to accept transfer
- Provide copies of medical records, including the EMTALA transfer form
- Transfer with qualified personnel and appropriate transportation equipment

EMTALA: Accepting Transfers

Legacy is required to accept transfers to the extent that the hospital has capacity and the specialized capabilities (such as a burn, trauma, or NICU) to treat the individual

A hospital must accept appropriate transfers if:

- It has the capacity and capability to treat the individual; and
- The transferring facility does not have these capabilities.
- Qualified Medical Personnel and on-call Physician Assistants are authorized to accept

or reject transfers from another hospital on behalf of Legacy.
    - If an inpatient provider can accept a patient as an ED-to-ED transfer, the inpatient provider should consult with ED providers to assess ED capacity prior to accepting the patient
- Receiving providers need to speak with requesting provider from transferring hospital to establish whether the patient has an EMC that requires transfer.

Tips for Completing the Transfer Form

Complete all elements of the form
Expected benefits and risks must be patient-specific:
- Risks and benefits should be documented (hand-written) on the form
- Example: instead of "deterioration of condition", write "deterioration of asthma" or "increased shortness of breath"
- Insurance coverage should not be included as a benefit for transfer

Transfers by privately owned vehicle (POV)
- POV transfers should only be considered if requested by patient/authorized representative
- If patient/authorized representative requests POV transfer:
- Document recommended transfer by ambulance or other means
- Explain risks of POV transfers (accident, lack of qualified personnel in the event of worsening of condition)
- Although transfer by private vehicle may be appropriate in some cases, it may raise suspicions at the accepting hospital if not clearly documented

On-Call Requirements

- The ED provider determines whether the on-call LIP must physically assess the patient in the ED

- An on-call provider who fails to respond within a reasonable period (30 minutes) is in violation of their ED call coverage contract and may be found to be in violation of EMTALA.

- An on-call provider who is simultaneously taking call at another hospital, or who is delayed, is obligated to attempt to identify alternate coverage from another member of the Medical Staff

Labor and Delivery Patients

Patients who present to the ED for pregnancy-related problem may be directed to L&D for appropriate MSE, after:

- ED asks the pregnant patient for chief complaint, gestational age, and name of OB provider to verify appropriate location of care
- ED must notify L&D
- Patient must be escorted to L&D by qualified staff
- NOTE: If a patient enters through the ED and is simply looking for directions to L&D, staff can direct the patient (wayfinding) to L&D to be triaged
- See Care of Obstetric Patient Practice Guideline: 905.5010

Pregnant patients cannot be discharged if they are considered in labor or unstable

End of EMTALA Obligation

EMTALA obligation ends when a QMP has determined:

- EMC no longer exists,
- EMC exists and the individual is admitted for further stabilizing treatment or refuses further treatment; or
- EMC exists and the individual is appropriately transferred
- Discharging malicious and violent patients
    - EMTALA does not require providers to tolerate violence or risk injury to themselves or their team. Your safety and the safety of your team is more important than tolerating malicious violence. Demanding appropriate behavior is not unrealistic.
    - Once the decision has been made to discharge someone for violent and inappropriate behavior, stick with it. Call for help. Depending on your resources, this may be security, local police, or a crisis team. If you have security around, call them early.
    - Reminder: For a patient in labor, EMTALA obligation ends when the child(ren) and placenta are delivered

Repeat Visitors and "Frequent Flyers"

Repeat visitors have full EMTALA rights on each visit Patients must receive a new assessment on each visit even if:

- Patient was just discharged from the ED a few minutes earlier
- Patient was refusing care or left AMA, but now requests care
- Frequently returning patients must still be assessed fully on each visit
- With proper documentation, it is possible to avoid repeating tests when prior testing is known and nothing of significance has changed

Additional considerations:

- Frequent ED patients may be difficult, or are so well known, making it easy to overlook newly developed problems
- Frequent ED patients are often the source of complaints and lawsuits

Reporting Violations

If you think Legacy received an inappropriate transfer from another facility, or that Legacy violated EMTALA, report the incident to Corporate Compliance as soon as possible:

- Call Compliance directly at 503-415-5555
- Email: ComplianceOfficer@LHS.org
- Report to the Compliance Hotline
- 1-800-820-7478
- https://legacyhealth.ethicspoint.com
- Submit an ICARE (event type Provision of Care)

What is Antimicrobial Stewardship?

- A coordinated multidisciplinary program that
- Promotes appropriate use of antimicrobials
- Reduces microbial resistance
- Prevent collateral damage (i.e., Clostridium difficile infection)
- Decrease spread of infections caused by multi-drug resistant organisms

An effort to reduce patient harm and improve patient outcomes

Drivers of Antibiotic Resistance:

- Unnecessarily broad-spectrum antibiotics
- Unnecessary use of antibiotics
- Prolonged duration
- Incorrect dosing (may result in treatment failure)
- Unnecessary testing (leading to unnecessary antibiotic use)
- Hospital transmissions (i.e., poor hand hygiene)

Role of Primary Provider:

- Determine need for antimicrobial therapy
- Actively consider need 48 hours after starting antibiotics
- Make appropriate antibiotic selection based on guidelines and patient's clinical presentation
- Order tests only when indicated
- Document allergy histories including reaction type and severity
- Collaborate with healthcare team (nurses, pharmacists, etc) to strive to reduce patient harm

Resources:

- Legacy Infectious Diseases and Antimicrobial Stewardship Homepage
  - https://legacyhealth.sharepoint.com/sites/InfectiousDisease
- Antibiotic Dosing Table
  - https://legacyhealth.sharepoint.com/sites/InfectiousDisease/SitePages/Antimicrobial-Dosing.aspx
- Legacy Health Antibiogram
  - https://legacyhealth.sharepoint.com/sites/InfectiousDisease/SitePages/Clinical-Microbiology-%26-Antibiograms.aspx
- CDC Be Antibiotics Aware
  - https://www.cdc.gov/antibiotic-use/index.html

Black Maternal Mortality

Obstetric Hemorrhage / Hypertension

Attend Legacy educational opportunities on obstetric hemorrhage and hypertension

- The United States ranks 65th among industrialized nations in terms of pregnancy- and postpartum-related death.
- Black women are three times more likely to die from a pregnancy-related cause than White women. Multiple factors contribute to these disparities, such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias.
- Because of worsening morbidity and mortality, The Joint Commission evaluated expert literature to determine what areas held the most potential impact. The literature review revealed that prevention, early recognition, and timely treatment for obstetric hemorrhage and severe hypertension/preeclampsia had the highest impact in states working on decreasing these complications.
- As a result of the review, the Joint Commission released new standards, effective January 1, 2021, to address obstetric hemorrhage and hypertension/preeclampsia.

Provider Educational Opportunities

Please Review Relevant Policies and Procedures:

- Obstetric Hemorrhage
- Legacy 915.6150 Massive Transfusion Protocol and Obstetric Hemorrhage practice guideline 911.5051 are evidenced based procedures for treatment of obstetric hemorrhage.
- Management of Hypertensive Disorders of Pregnancy and the Postpartum Period – Including Preeclampsia
- Guideline 911.3162 describes where to find information on related management and procedures.
- This includes an evidence-based protocol to expedite the treatment of acute hypertensive obstetric crises
- Review Joint Commission updated standards
- Review CDC's Working Together to Reduce