



2016 Medical Staff Pocket Pal

Our Mission

Our communities expect and deserve superior medical treatment, compassionate care and expert guidance in maintaining their health and well-being. At Carroll Hospital, we offer an uncompromising commitment to the highest quality health care experience for people in all stages of life. We are the heart of health care in our communities.

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Our Vision

Founded by and for our communities, Carroll Hospital will help people maintain the highest attainable level of good health throughout their lives. We strive to be the best place to work, practice medicine and receive care. Our commitment is to be the hospital of choice.

Our Spirit Values

Our actions and decisions are guided by these core values.

SERVICE . . . exceed customer expectations.

PERFORMANCE . . . deliver efficient, high quality service
and achieve excellence in all that we do.

INNOVATION . . . take the initiative to make it better.

RESPECT . . . honor the dignity and worth of all.

INTEGRITY . . . uphold the highest standard of ethics and
honesty.

TEAMWORK . . . work together, win together.

Strategic Priorities: The Pillars of Excellence

Service	People	Quality
Financial	Growth	Community

Leadership

Leslie Simmons, R.N., F.A.C.H.E., President

Tracey Ellison, VP of Human Resources

Kevin Kelbly, Chief Financial Officer

Ellen Finnerty Myers, Chief Development Officer and
VP of Corporate Development

Mark Olszyk, M.D., Chief Medical Officer and VP of
Medical Affairs

Stephanie Reid, R.N., Chief Nursing Officer, and VP of
Patient Care Services

Sharon Sanders, VP of Clinical Integration

Role of the Medical Staff in Regulatory Surveys

Consumers have become very knowledgeable about contacting federal, state and other regulatory agencies. Consequently, there has been a sharp increase in unannounced surveys for cause to investigate consumer complaints. Carroll Hospital has adapted a continual survey readiness strategy.

The role of the Medical Staff is essential for continual survey readiness. You can help by:

1. Understanding how important our success is to patients, staff, physicians and the hospital's survival.
2. Agree to actively participate if requested.
3. Heighten your awareness of best practices and patient safety during the visit to decrease the chance of citations and to show that we practice quality medicine at all times.

Tips for Survey Success

For success with our next unannounced survey:

1. Welcome the surveyors. Maintain a positive/friendly attitude.
2. Answer only the questions that are asked; do not offer extra information.
3. Be confident, direct and concise!
4. Provide examples when appropriate. Mention quality improvement teams, patient safety projects or committees, and process improvement work. Emphasize teamwork.
5. In patient care areas be sure:
 - Confidential patient information is out of public view
 - To use two patient identifiers when doing procedure/treatment
 - Prescription pads are secured
 - Syringes are labeled with an expiration date
 - To use the Universal Protocol checklist for invasive procedure
6. Wear your badge.

Performance Improvement & Quality Data

Quality Dashboard: The Quality Dashboard can be found on the intranet home page and in the display case by the cafeteria under the “Quality” Pillar of Excellence. The dashboard helps us keep track of our performance on all priority indicators using a color-coded stop light approach as follows:

Green= Target met

Orange= Improving/Near target

Red= Unmet target

Indicators are reviewed at least annually to assure we are measuring and tracking all regulatory required indicators as well as organizational priorities based on our mission, vision, values and strategic priorities.

Improving Performance: The organization embraces a culture of continuous improvement in which everyone plays an integral role. We use the **PDSA** (Plan, Do, Study, Act) method to identify opportunities, implement and then evaluate changes.

Tips for Success:

1. Know what your department’s priorities are
2. Know where to find the data
3. Know how to interpret the results
4. Know what you are doing to improve

Allied Health Staff

The Medical Staff is a self-governing and collegial body accountable to the governing body for oversight of the quality of care, treatments and services delivered by credentialed and privileged practitioners at the hospital. Within this framework, it is our goal to provide a culture of excellence and to serve our community by providing the highest quality of care consistent with the values of service, performance, innovation, respect, integrity and teamwork.

Copies of the Medical Staff Bylaws are available electronically on the Medical Affairs resource page, or by contacting the Medical Affairs office.

Credentialing and Privileging

The Credentials office maintains the credentials and privileges of all physicians and licensed independent health care practitioners with privileges to work at Carroll Hospital.

Medical Staff Resources

The Medical Staff Resource page includes the most up-to-date information for medical staff and should be checked frequently.

The Resource page is found at:
resource.CarrollHospitalCenter.org

Focused Professional Practice Evaluation (FPPE)

FPPE is a process to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competency performing the requested privilege.

A period of FPPE is implemented for all initially requested privileges.

This process is also used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

FPPE is a time-limited period during which the practitioner's professional performance is evaluated.

Information used for FPPE may include:

- Chart review
- Monitoring clinical practice patterns
- Proctoring (concurrent or retrospective)
- External peer review

For more information on the FPPE process, refer to the Medical Staff Quality Policy.

Ongoing Professional Practice Evaluation (OPPE)

An ongoing professional practice evaluation (OPPE) allows us to assess a practitioner's clinical competence and professional behavior. The information gathered is factored into decisions to maintain, revise or revoke existing privilege(s) prior to or at the end of the two-year reappointment cycle.

Criteria used in OPPE includes:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Length of stay patterns (Utilization review)
- Morbidity and mortality data
- Core measures (e.g. AMI, CHF, Pneumonia, SCIP, Children's Asthma Care, etc.)

The information used in the OPPE may be acquired through the following:

- Coding information reported to payers
- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, and nursing and administrative personnel

Code of Conduct

The Code of Conduct for Carroll Hospital and Affiliates, Medical Staff Code of Conduct and Carroll Hospital Compliance Program govern the professional conduct of members and others with clinical privileges. These documents are found on the Medical Affairs Resource page. The policies define disruptive and inappropriate behaviors and their management.

Examples of disruptive and inappropriate behaviors include:

- ◆ Repeatedly acting in a rude, insolent or demeaning manner
- ◆ Verbal and physical threats, intimidation or coercion
- ◆ Deliberate destruction or property damage
- ◆ Actual physical abuse or unwanted touching

For more information on the policies, contact the director of Medical Affairs at 410-871-6899.

Illness and Impairment Recognition

The Medical Staff, Administration and Board of Directors have an obligation to protect patients, fellow physicians, Associates and other persons from harm. It is also their responsibility to ensure that members of the Medical Staff are physically and mentally competent to perform their designated responsibilities. The Medical Staff Health policy provides a means to identify impaired practitioners and facilitate their treatment. The policy is found on the Medical Affairs resource page.

Patient Satisfaction

We use Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results for our customer service feedback process. The physician communication item is rated on a four-point scale based on frequency as opposed to satisfaction. The “always” responses are the only responses that count. Performance is then compared between hospitals in a percentile rank.

Suggestions for Improving Patient Perception of Care:

- Ask to review any questions the patient has and sit down when answering. This gives the perception of spending more time.
- Give patients time to “tell their story”; try not to interrupt. Listen carefully and empathetically.
- Ask open-ended questions; before leaving, ask if they have any more questions.
- Try to make yourself available, especially to family members who often complete the survey.
- Round on your patients with the Patient Care Coordinator (PCC) and/or nurse to keep them up-to-date on the plan of care; they can communicate this in your absence.
- Offer a physical gesture of kindness-touching patients.
- Be receptive to staff inquires to patient concerns; they will help you with service recovery.
- Communicate well, assuring the entire team (staff, consultants, patient and family) knows the treatment plan. Give the patient/family your business card so they know how to contact you.

Patient Ethics Process

Several resources are available when patients, family members and health care workers need assistance with health care decisions:

- A family or team meeting is an effective means to manage these situations.
- When there is not a clear right or wrong answer, when parties are in conflict, or when the patient wants more guidance, a Patient Care Advisory Committee (PCAC) consult is an option.

PCAC Consultants are:

- ◆ Spiritual Care Manager (Charles P. Leger) at x6679
- ◆ Patient Representative (Heather Shilts) at x6259
- ◆ Case Manager (Jen Bell) at x6814
- ◆ CCU Nurse (Stephanie Bankert) at x6724
- ◆ Internist (Dr. Abel) at x5696
- ◆ Palliative Care Coordinator (Jennifer Ballas) at x7890
- ◆ Risk management (Christine Mulligan) at x6592

Other resources include the Shift Coordinator at x6938 who will contact the on-call chaplain.

Confidentiality/Privacy

Only share information with persons who have a “need to know.” It is our responsibility to keep patient information confidential. HIPAA rules define the requirements for privacy and security. We respect a patient’s right to privacy by:

- ◆ Keeping all patient data (paper or electronic) secure.
- ◆ Sharing information only with those who need it to provide care and/or services.

Compliance Program

Maintaining an ethical workplace and environment is essential. The Compliance Program addresses being aware of, identifying and reporting concerns related to:

- ◆ Quality of Care
- ◆ Billing and Coding
- ◆ Conflict of Interests
- ◆ Protection of Property
- ◆ Business Practices
- ◆ Communication
- ◆ Compliance with Laws & Regulations
- ◆ Proper Consideration of Human Resources
- ◆ Inappropriate Financial Reporting Practices

For concerns about our organization in any of these areas, call the Corporate Compliance Hotline at x6807, the toll-free Compliance HelpLine at 844-732-6233 or the Compliance Officer at x6701.

Conflict of Interest

The Conflict of Interest policy can be found on the intranet. Examples of conflict of interest include:

- ◆ Influencing the purchase of equipment, materials or services from a private firm in which you or a family member has a financial interest
- ◆ Unauthorized disclosure of patient or hospital information for personal gain
- ◆ Improper use of hospital resources for personal financial gain
- ◆ Accepting compensation or free services from a hospital vendor or contractor when the medical staff member can influence the hospital's purchase for these persons

If a physician is in a situation where there may be a conflict of interest, contact the Chief Medical Officer, the Medical Staff President and/or the Compliance Officer at x6701.

Just and Learning Culture

Health care is complex and high risk. We cannot stop all errors. Most medical errors and near misses are due to problems with systems, not people. The best (i.e. highly reliable organizations), all excel at the following:

◆ Teamwork Pillars:

1. Speaking up when things don't feel right, ask questions, seek feedback, discuss errors, ask for help, offer suggestions
2. Collaboration- cooperation, mutual respect, share goals, share info and perpetually seek input and feedback
3. Experimentation- expect not to be right the first time and to learn from your actions
4. Reflection- critically examine and assess results of actions and uncover new ideas (daily rounds, huddles, debriefings)

◆ Effective Communication

Use structured communication– formal handoff processes such as SBAR and safety checklists

◆ Coordination of Care

Processes are designed around the patient's needs

Rounds communicate the plan of care to all team members

◆ Accountability

When an error occurs, Medical Staff are responsible for:

- Making good choices
- Recognizing when situations are high risk
- Following policies, procedures and your training
- Focusing on the task at hand
- Learning from mistakes

We have to constantly learn from our near misses and errors so they never happen again.

Patient Safety and Incident Reporting Process

- ◆ Incident reports are for internal use only and protected from release outside the hospital.
- ◆ Enter an incident into the Incident/Safety Reporting button on the hospital intranet or call the Patient Safety Coordinator at x6591 to report significant, untoward or events not planned in the normal course of care.
- ◆ Reports are used for trending for improvement and to report significant cases to our insurer.
- ◆ Do not document in the medical record that you filed a report with Patient Safety Coordinator. Document in the record the facts of the event as appropriate.
- ◆ Serious events are investigated and addressed through a Root Cause Analysis process mandated by regulatory agencies.
- ◆ The goal of Root Cause Analysis is to identify opportunities to improve care and services to avoid recurrence.
You may be asked to participate in one.
- ◆ You are free to call the director of risk management, the patient safety coordinator, or senior risk and claims specialist.

Contact Information:

Safety Hotline at x6909
Patient Safety Coordinator at x6591
Risk Manager and Privacy Liaison at x6592
Director of Enterprise Risk and Insurance
at 410-601-0973

If you continue to have concerns about safety or quality issues after reporting them as above, you can contact The Joint Commission without retaliation from the hospital. The Joint Commission can be contacted at 1-800-994-6610.

15 **Patient Safety Goals**

2016 National Patient Safety Goals (NPSG)

We are committed to upholding the National Patient Safety Goals. Each Associate should identify how his/her job supports these goals.

Identify patients correctly

NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01 Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve staff communication

NPSG.02.03.01 Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01 Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure patients knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

2016 National Patient Safety Goals (NPSG)

Use alarms safely

NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01 Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01 Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01 Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01 Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify patient safety risks

NPSG.15.01.01 Find out which patients are most likely to try to commit suicide.

Prevent mistakes in surgery

UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.

Patient Assessment and Handoffs

Patient Assessment and Reassessment

Assessment of patients and care planning are interdisciplinary efforts to assure appropriate care is planned and provided by qualified individuals throughout the patient's stay. Reassessment of patients is continuous throughout all phases of care.

Handoffs

SBAR is our handoff process between shifts, when transferring or transporting patients, calling physicians, switching providers, etc.

Situation

Background

Assessment

Recommendation

During handoffs be sure to allow time for questions and to verify that the receiver understands the patient information.

Victims of Abuse

A victim can be anyone: male or female, including the elderly, the disabled or a child. State law requires that the hospital report all situations of abuse and neglect to appropriate authorities. For assistance with suspected inpatient abuse cases, contact the shift coordinator. For assistance with suspected victims of abuse in the Emergency Department (ED), contact the ED social worker.

Pain Management

Freedom from pain is a patient right. Pain is extremely subjective, hence, the patient is the best judge of the intensity and relief. Assessment tools used to evaluate the patient's perception of pain include the Wong faces and, when patients are unable to report their pain, the Functional Pain Scale or the Scale for Assessment in Nonverbal Patients.

Patient Rights

All patients are informed of their rights and responsibilities while they are here.

Medical Decision Maker for the Patient

- ◆ By Maryland law patients are considered competent and capable of consent unless properly declared incompetent or incapacitated to make medical decisions.
- ◆ Inpatients: two in-house physicians can declare a patient unable to make medical decisions for a specific time period not to exceed that of hospitalization.
- ◆ Use the appropriate form to document the certification.
- ◆ Seek the assistance of the hospitalist if needed.
- ◆ Ascertain if the family is notified for patients from a nursing facility.

Advance Directives

Verbal Advance Directive:

- ◆ Is verbal direction by the patient regarding health care treatment, which is documented in the medical record by the physician and signed by a witness.
- ◆ Any competent patient can make a verbal advance directive authorizing the providing, withholding or withdrawing of life-sustaining procedure or to appoint a health care agent.
- ◆ Verbal advance directives have the same effect as written directives if made in the presence of the attending physician and one witness, and documented in the medical record.
- ◆ Both the attending physician and the witness date and sign the document in the medical record.

Note: For assistance applying Advance Directives, contact the chaplain at x6679, social worker/case manager or risk manager.

Informed Consent

- ◆ Informed consent is the role of the Medical Staff.
- ◆ The hospital has its own consent form and encourages you to use it.
- ◆ If you have your own consent form please give a copy to the director of medical records to process.
- ◆ Hospital associates cannot obtain informed consent. They can only witness a patient's signature.

Withholding or Withdrawal of Life-Sustaining Treatment

- ◆ Maryland law stipulates two physicians must certify the patient is terminal or end-stage prior to discontinuing life-sustaining treatment in the absence of a patient decision or that of a legally assigned health care agent.
- ◆ Life sustaining treatment includes ventilation and can include antibiotics or pressors if they are maintaining life.
- ◆ Exceptions to the two physician rule are noted in the policy.
- ◆ Call Risk Management at x6592 if you need assistance.

DNR

- ◆ Document DNR orders on a DNR order sheet.
- ◆ Blank DNR order sheets indicate the patient is a full code.

Protecting Patient Anonymity

The hospital has a directory which includes certain limited information about patients while they are here such as the person's name, location in the hospital and general condition. However, patients may elect to opt out of the directory at any time in order to protect their anonymity. Contact the ED (x6700), Admitting Office (x7100) or Risk and Insurance Department (x6592) regarding patients scheduled for admission who may be a victim of abuse or in danger.

Patient Complaints

- ◆ On admission all patients receive a copy of the Patient Bill of Rights and Responsibilities.
- ◆ As per regulations we provide patients with the address and phone number of the state Office of Health Care Quality where they can file a complaint.
- ◆ The Risk Management Dept normally coordinates the investigation of these complaints.
- ◆ Your assistance and input may be needed with the investigation.
- ◆ The Chief of each medical staff department may be called on to assist in resolution if needed.
- ◆ The patient complaint resolution process includes an appeal process to a Patient Grievance group.

The Patient Representative can be reached at x7099.

Transfusion Consent:

- ◆ All transfusions, except emergencies, need a consent.
- ◆ You may use either the:
 1. Transfusion Consent form
 2. Invasive Procedure consent
- ◆ The transfusion consent form also has a refusal section.

Organ Donations:

- ◆ All deaths are expected to be reported to the Living Legacy Foundation (LLF) for patients at the end of life.
- ◆ Federal law states only LLF staff may approach a patient's family about organ donation.
- ◆ Once contacted, LLF will assess the patient for donation potential.
- ◆ LLF staff will contact the family and work with you and hospital staff to manage a donor until harvest staff arrive.

Autopsies:

- ◆ To determine when an autopsy is needed consult the Autopsy Policy and/or consult the pathologist on call.
- ◆ If the family refuses or it is not necessary, document the rationale.
- ◆ Regulatory agencies mandate the review of the documentation of refusal.
- ◆ All physicians must complete death certificate electronically using the Maryland Electronic Death Registration System (MD-EDRS).

Medical Examiner:

Contact the medical examiner if a death is suspicious for any reason. When in doubt call the Medical Examiner.

Transferring Patients

To Another Hospital:

- ◆ Federal regulations stipulate patients can be transferred only when a service is needed that is not available here (done here and no bed), or the patient requests a transfer.
- ◆ Complete the Patient Transfer form.
- ◆ Document the reason for the transfer, risks and benefits, patient consent, name of the accepting facility and physician, and date and time of acceptance.
- ◆ Violation of the federal regulations subjects the hospital and the physician to large fines and penalties.

To Another Physician:

You remain the attending physician of record until care is transferred to another physician.

- ◆ Verbally discuss the handoff of care with the other physician
- ◆ Write an order to transfer care
- ◆ Staff will complete the paperwork for the transfer on your written order that the new attending has accepted the patient's case.

Consultations:

The need for a consult must also be handled verbally between the two physicians and then with an order as in the transfer process above. Consults must be done within 24 hours of the order.

Leaving AMA

- ◆ Speak with patients directly. Do not expect staff to do so.
- ◆ Present all options to patients expressing a desire to leave prior to treatment completion.
- ◆ Maintain an environment of helpfulness by attempting to arrange an aftercare plan.

The Hospital Intranet is the home page found when you open up a browser from any hospital computer. The home page contains easy access to information.

Quick Links Include:

Physician Documents with information about physician order sets and protocols, policies, core measure “cheat sheets,” and the Pocket Guide for Severity.

Portal and Remote Portal for access to the electronic medical record.

Buttons Include:

Policies and Procedures: Policies, procedures and care guidelines are stored and updated on the Intranet. Click the link to search for the policy or procedure desired.

On-Call Schedule and Phone Directory: The electronic directory contains on-call schedules and phone numbers for departments, Associates and physicians.

When electronic medical records are not available, our procedure is:

1. A unit patient roster is printed and distributed to managers and patient care coordinators.
2. During expected downtime lab values, radiology results and transcriptions are printed and available on each patient’s paper medical record.
3. During unexpected downtime, each patient’s nurse will have VS, I &Os, and medications on his or her clipboard/ notes.

Infection Prevention and Control

We strive to ensure that infections are not passed from person to person.

Hand Hygiene

- ◆ Hand washing or sanitizing is the most effective way to prevent passing infection from one person to another.
- ◆ Sanitize with a hospital-approved waterless alcohol hand sanitizer before and after patient contact, after removing gloves, or contact with contaminated equipment or surfaces.
- ◆ Wash hands with hospital-provided soap 10 to 15 seconds when hands are visibly soiled, after using the bathroom, or when instructed by infection control to prevent the spread of *Clostridium difficile*.

Standard Precautions

Using *Standard Precautions* means we assume that all blood and body fluids are infectious.

- ◆ Everyone who works in patient care areas should always follow standard precautions and wear the appropriate personal protective equipment (PPE) when working with patients, based on anticipated exposure to blood and body fluids.
- ◆ When special isolation precautions are needed, a sign is posted on the door to the patient's room. Follow the appropriate measures for each transmission-based precautions type.
- ◆ Respiratory etiquette means not coughing on another person or allowing others to cough on you. Cough into your elbow, sneeze into your sleeve.

Preventing Health Care-Associated Infections

Central line-associated Bloodstream Infections (CLABSI)

- ◆ The MD Health Care Commission requires hospitals to report all CLABSI in ICUs

Preventing Health Care-Associated Infections (continued)

- ◆ Hospital policy requires completion of a best practices checklist every time a central line is placed. See Central Line Procedure Progress Note, Form #6010076

Multiple Drug Resistant Organisms—MDRO

- ◆ Two new mechanisms of resistance, extended spectrum beta-lactamase (ESBL) and Carbapenem resistant *Enterobacteriaceae* (CRE), are being seen. These patients must be strictly isolated in contact precautions. See Associate Health/Infection Control page on the hospital Intranet.

Surgical Site Infections (SSI)

- ◆ We conduct surveillance for SSI in total hip and total knee replacement surgeries. Surgical Care Improvement Project (SCIP) measures are monitored and Chloraprep is primarily used for skin antisepsis.

Influenza

- ◆ The hospital provides influenza vaccine to patients, Associates and physicians. Contact Associate Health (x6846) for information about availability.
- ◆ Patients admitted for community-acquired pneumonia are offered the flu vaccine per best practice standards.

Catheter-associated Urinary Tract Infections (CA-UTI)

- ◆ Documentation of the need for Foley catheter use and continuing justification is part of the daily assessment of patients throughout the hospital. See I-forms in CPOE.

Medications

Medication Errors/Adverse Drug Reactions

Any error or unplanned response to a medication is considered an adverse drug event. The hospital tracks the events for trending purposes and to identify opportunities for improvement.

Medication Error/ADE Reporting

Report medication errors online under Incident/Safety Reporting or call the Safety Hotline at x6909.

Medication Reconciliation

The admission, transfer and discharge reconciliations are completed by nursing and physicians. The role of the medical staff is to review the admission, transfer and discharge list for discrepancies, i.e. omissions, duplications or contraindications, and make needed changes. Order the reconciled medications on admission and transfer. Upon discharge, all inpatients are given a complete list of current medications, and a list is sent to the next provider of care.

High Alert Drug List

We maintain a High Alert Drug List. The High Alert Medications policy found online includes a list of high risk drugs and actions to lessen the risk. We use the acronym A -CHICKEN to identify our high alert medications: **A**ltephase, **C**oumadin and others, **H**eparin, **I**nsulin, **C**hemotherapy, **K**Cl, **E**noxaparin and **N**arcotics.

Verbal Orders: Federal regulators discourage using verbal orders because of potential miscommunication. Use verbal orders sparingly.

Unsafe / Prohibited Abbreviations	What to use instead
U (for unit)	Write "unit"
IU (for international unit)	Write "international units" or "I. Units"
Q.D. (for once daily) Q.O.D. (for every other day)	Write "daily" or "q day" Write "every other day"
Trailing Zero (LEAD DON'T TRAIL)	Write e.g. "5 mg" , not 5.0 mg
Lack of a Leading Zero (LEAD DON'T TRAIL)	Write e.g. "0.5 mg" , not .5 mg
MS MSO4	Write out the drug name "morphine sulfate" or "morphine"
MgSO4	Write out the drug name "magnesium sulfate" or "magnesium"

Restraints

Restraints are to be used only in situations where other alternatives to restraints have failed.

Alternatives to restraints include:

- ◆ Orientation to environment
- ◆ Companionship
- ◆ Diversion
- ◆ Familiar possessions
- ◆ Increase or decrease of lighting/stimulation
- ◆ Concealment of tubing and/or dressings, etc.

Behaviors that may lead to restraint use include:

- ◆ Unsafe mobility
- ◆ Hazardous wandering
- ◆ Manipulating lines or other medical devices
- ◆ Being agitated or combative
- ◆ Violence
- ◆ Threat of imminent harm to self or others

Although a registered nurse may initiate restraints, a physician's order and evaluation is always required within one hour of initiation. Use the restraint order sheet for all patients placed in restraints.

RESTRAINT Quick Reference:	
Standard	A. Medical: Restricting movement to promote healing and prevent treatment interference.
Licensed Independent Practitioner (LIP) order	Within 1 hour of application and good for up to 24 hrs
Initial LIP Assessment	Within 24 hrs of application
Nursing Assessment and Documentation	RN Assessment: At least every 2 hrs Every 1 Hour: Fluids offered Every 2 hours: Toileting, Neurovascular checks, exercise & ROM, turned/repositioned, and skin care Attempt less restrictive measures as appropriate
LIP Face-to-Face Reassessment	Every 24 Hrs
New LIP Order	Once each 24 hrs after face-to-face exam by a physician
One-on-One Monitoring	No
Debriefing	Not required. Patient or family feedback on prevention is helpful.

Refer to the full policy for further details.
B. Behavioral: Restricting movement in an emergent situation when there are physical threats or a risk to others, to self or a severe disruption to the environment.
ASAP, and no longer than 1 hour after application. Orders are good for: Adults= 4 hrs; 9-17 yo= 2 hours; <9 yo= 1 hr Order includes justification for restraint.
In-person evaluation to be done immediately (within 1 hour)
RN Assessment: At least every 2 hrs Face-to-face continuous monitoring Every 15 minutes: Behavioral observations Every 1 Hour: Fluids offered, verbal interactions Every 2 hours: Toileting, Neurovascular checks, exercise & ROM, turned/repositioned, and skin care Attempt less restrictive measures as appropriate
In-person evaluation within 4 hrs for adults and 2 hrs for under 9-17 years old and 1 hour for under 9 years old
Adults= Q 4 hrs 9-17 years old = 2 hrs <9 years old = 1 hr
Yes Document observations every 15 minutes.
Required using the Debriefing Care Guidelines

Laboratory Testing

Critical Values

Critical values are considered potentially life threatening. Provider follow-up is essential. The laboratory reports all critical values to the nurse caring for the patient with the exception of therapeutic drug values and blood gases. Therapeutic drug values are phoned to Pharmacy and blood gases to Respiratory Care. A nurse, pharmacist or respiratory care therapist will contact you with the critical results and for direction on appropriate follow-up.

Refer to the Critical Laboratory Values policy for a complete list of values identified as being critical.

Point of Care Testing

Point of care tests are those tests performed outside the laboratory by hospital associates and Medical Staff but supervised by the Lab (such as Fern testing in FBP). Only trained personnel may perform these tests. There needs to be an order for point of care testing, such as glucose monitoring and urine hcg tests performed by associates.

Environment of Care

The hospital works to ensure our grounds, and buildings are safe for our patients, visitors, other customers and ourselves. We have several plans to address specific environmental risks, such as Life Safety & Emergency Management.

The bright yellow Quick Reference Guide in each department contains detailed information about the plans and contains department specific plans for the work area. This information is also available on the hospital's Intranet.

Life Safety

The Life Safety Management Program is designed to protect patients, associates, visitors, medical staff and property from fire, smoke and/or fumes. We conduct fire drills and ongoing assessments of fire safety features as a part of the Life Safety program.

Security

- ◆ Always wear your name badge while working.
- ◆ Know the number to call to report security emergencies:
 - ◆ Routine Calls x7033
 - ◆ Emergency Calls **x4444**
- ◆ Always be aware of your surroundings in parking lots and other areas of campus.
- ◆ Always lock your vehicles and secure all valuables in your office and/or in your vehicle out of sight.
- ◆ Officers are available for late night escort to your vehicle.

Incident Command/ Emergency Management Code Yellow

The Hospital Incident Management System is initiated in internal or external emergency situations. The hospital may see an influx of patients or have difficulty caring for the current patients. The individual "in charge" of the incident is called the Incident Commander. This person is usually the Chief Nursing Officer or the Shift Coordinator on off-hours. Medical staff may be assigned a specific job associated with the emergency.

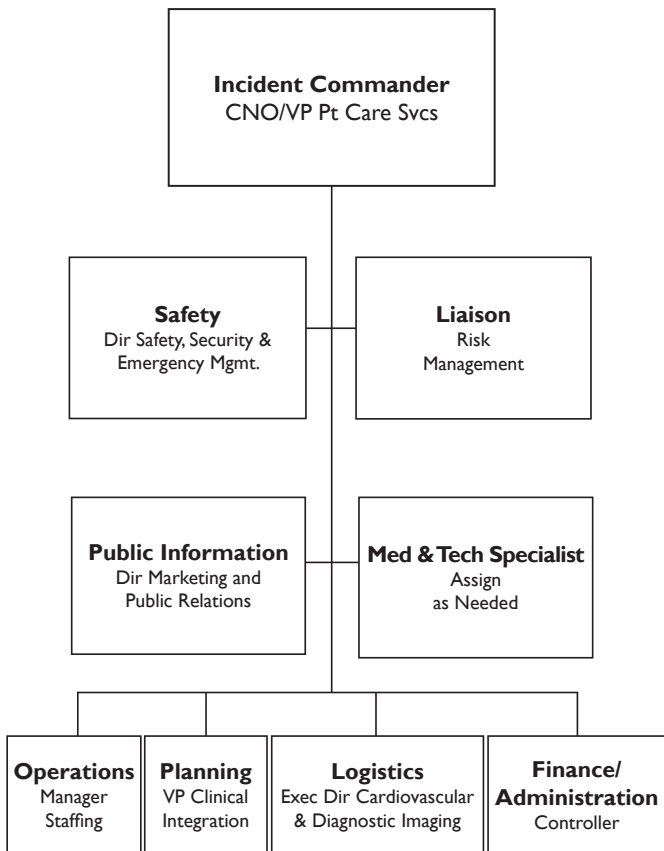
During an emergency, report to the Physician's Lounge. Specialty specific instructions will be taped to the door depending on the nature of the emergency.

Refer to the Quick Reference Guide to know how to respond to the emergencies that might impact our business of caring for patients. All areas have plans in place for security, weather, and other disasters. These plans allow us to continue providing care during emergencies.

The next page shows the top layers of the Incident Command Structure.

Page 34 shows the event classification levels.

Incident Command Structure



Code Yellow Levels		
Level	Event Phase	Definition – Level of impact on facility operations
1	Alert/ Notification	Situation or event that may have an impact on facility operations; weather watch or warning, mass casualty incident, fire alarm (fire not confirmed), ED holding admitted patients
2	Minor Impact	20 patients from single event ED wait > 4 hrs or Census > 50% Partial facility system failure > 15% Associate Absenteeism
3	Moderate Impact	25-30 Pts from single event or 5 requiring surgery or CCU admission ED wait > 8 hrs or Census > 100% In-pt census 20-30 pts above licensed bed count Facility mission critical system failure > 25% Associate Absenteeism Level 2 event lasting > 12 hours
4	Severe Impact	50 patients from single event ED wait > 12 hours or census > 200% > 30 patients admitted over licensed bed count Physical plant or utility disruption affecting multiple areas or systems > 40% Associate Absenteeism Critical shortage of essential items Complete evacuation of building Level 3 lasting > 24 hours

NOTES:

Phone Numbers

All Emergencies (Codes)	4444
Administrator on Call	6938
Carroll County Sheriff	410-386-2900
Chief Medical Officer	6010
Compliance Help Line	844-732-6233
Emergency Command Post	6090
Emergency Management & Environmental Safety	6756
Emergency Dept.	6700
Hazardous Material Spill	6756
Infection Control	6846
Interpreter Services	4300
IS Help Desk	6809
Accreditation Manager	6221
Medical Affairs Office	7506
Patient Relations	7099
Patient Safety Manager	6591
Quality Dept.	6956
Risk Dept.	6600
Safety Hotline	6909
Security	7033
Shift Coordinator	6938
Snow Emergency Command Post	6843

Emergency Codes: Dial 4444

Overhead Page	Description
Yellow	Emergency Action Plan
Purple	Weapons Risk
Orange	Hazardous Material Spill
Pink	Infant/Child Abduction
Red	Fire Response Team
Gold	Bomb Threat
Blue	CPR Emergency
Green	Aggressive Person
Grey	Elopement
Silver	Active Assailant
COT	Emergency Consult (Inpatient)
Emergency Response	Emergency Assistance Required (Non-Inpatient)
O2	Oxygen Emergency

Fire Safety

- R** Rescue
- A** Alarm
- C** Contain
- E** Extinguish or Evacuate

Fire Extinguisher Use

- P** Pull
- A** Aim
- S** Squeeze
- S** Sweep