Gottlieb Memorial Hospital

2019

IN THE KNOW

Education and Training Information for Medical Staff

WHAT'S INSIDE THIS YEARS EDITION:

Loyola Medicine | Gottlieb Memorial Hospital

INFECTION CONTROL

Hand Hygiene

Performing Hand Hygiene is the single most important step to prevent the spread of infection/ organisms. You must wash your hands with soap and water if your hands are visibly soiled/if the patient is in Contact Plus Precautions.

Gloves are not a substitute for hand hygiene. Perform Hand Hygiene before donning gloves and after removing gloves.

Perform hand hygiene before and after every patient contact or room entry/exit.

Standard Precautions

Applies to all patients receiving care, regardless of their diagnosis or presumed infectious status. Standard Precautions include:

- Proper use of Personal Protective Equipment - mask with face shield, gloves and gowns.
- Prevention of blood borne exposures-Practice sharp safety, engage safety devices and dispose in the nearest sharps containers.
- Report to the ED immediately if you have a blood/body fluid exposure.
- Do not wear Personal Protective Equipment (PPE) in the hallways.

Discard PPE inside room and perform hand hygiene before exiting room. Clean all shared equipment between patients.

Airborne	Perform Hand Hygiene upon entering room. Wear a fit-test N-95 respirator/PAPR in designated negative pressure rooms. Perform Hand Hygiene when exiting. Place patients in Airborne Precautions for TB, Measles, Disseminated Herpes Zoster, etc.
Contact	Perform Hand Hygiene upon entering the room. Wear gloves and gown upon room entry. Perform Hand Hygiene when exiting. Place patients with MDRO's, Bed Bugs, etc. in Contact Precautions.
Contact Plus	Perform Hand Hygiene when entering room. Wear gloves and gown upon room entry. Wash hands with soap and water when exiting. Clean shared equipment/stethoscopes with bleach between patients. Place patients in Contact Plus Precautions when ruling out enteric organisms (ex., C.difficile, Norovirus), all patients with Candida auris and all Nursing Home/Skilled Nursing patients admitted
Droplet	Perform Hand Hygiene when entering room. Wear a surgical mask prior to room entry. Perform Hand Hygiene when exiting. Place patients in Droplet Precautions when R/O Pertussis, Influenza, Mumps, etc.

Surgical Site Infections (SSIs)/Preventions

Implement best practices for preventing surgical site infections including:

- Administer IV antibiotic prophylaxis at the appropriate time as recommended by current guidelines and infection control, redose depending on the antibiotic
- Confer with anesthesia to ensure timely antibiotic administration
- Discontinue prophylactic antibiotics 24 hours after surgery
- Avoid hair removal; if hair removal is necessary, remove hair outside of the operating room using clippers or a depilatory agent

Catheter Associated Urinary Tract Infections/Preventions

Urinary catheters are indicated for:

- Accurate output measurement for the critically ill (ICU)
- Post procedure < 24 hours
- Acute & chronic urinary retention
- Pressure ulcer healing with incontinence
- Terminally ill/comfort measure
- Colorectal surgery/Urogyne surgery
- Prolonged immobility due to spinal surgery trauma
- Epidural/regional anesthesia

Central Line-Associated Bloodstream Infections/Prevention

Perform hand hygiene, don mask/ gown/ sterile gloves/cap, Chlorprep skin prep, and drape site with large sterile barrier. All patients with central lines receive daily chlorhexidine baths. The subclavian is the preferred site. Document central line insertion bundle into Epic. Follow best practice for line maintenance and access.

Any Infection Control questions, please call Robin Larson, RN,BSN MPS at (708) 538-5121 or pager (708) 643-4159.

Please remove Urinary Catheters and all Intravenous lines as soon as possible. Infection Control is Everyone's Responsibility!

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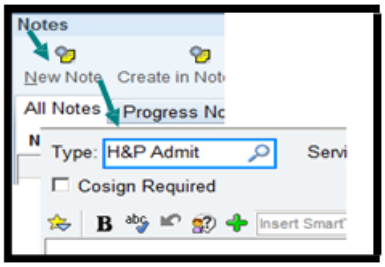
EPIC MEDICAL RECORD

History and Physical (H&P)

An H&P needs to be completed on a patient as follows:



1. Admitting to the hospital

The H&P should include the following: patient identification, chief complaint, history of present illness, review of systems, personal medical and surgical history, including medication and allergies, family medical history, social history, including any abuse or neglect, physical examination, lab and diagnostic findings, assessment and plan.

This document should be completed within 24 hours after admission or before surgery (exception: within 72 hours following admission to TCU).

2. Re-admitted to the hospital

If patient is readmitted within 30 days for the same or different problem, a readmission note should be written in the patient's medical record as well as an updated physical exam, which includes any changes in the patient's current condition.

This documentation should be completed within 24 hours after admission or registration.

3. Prior to outpatient diagnostic testing

The H&P, specific to the affected system, must be in the medical record prior to the procedure.

4. Prior to elective inpatient or outpatient procedures.

The H&P should be **completed no more than 30 days prior** to the procedure and should include an updated examination of the patient. The update must include any changes in the patient's condition since the date of the original H&P that might be significant for the planned course of treatment or state that there have been no changes. Patients will not be allowed into any procedural/surgical areas unless the H&P and pre-procedure/operative diagnosis have been entered into Epic.

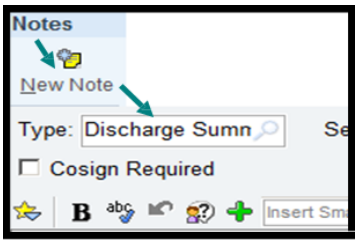
5. Prior to **EMERGENT** surgeries

The H&P examination must be recorded in the medical record before any surgical or other invasive procedure is undertaken, unless the surgeon certifies in writing that:

- The case is an emergency and delay for such a purpose would constitute a hazard to the patient and could potentially result in loss of life or limb.
- If not auto-populated, include patient's heart rate, respiratory rate, and blood pressure.

The attending physician is required to complete and document a history and physical examination immediately Following the emergency procedure.

What?	Time Limit
H&P	24 hours of admission or before surgery
Operative Report	24 hours
Consultation	24 hours
Discharge Summary	7 days after discharge
Verbal & Telephone Orders	24 hours



6. Pediatric patients

The pediatric H&P should include the following: developmental age, length or height, weight, head circumference (if appropriate), and immunization status . This document should also be completed within 24 hours after admission.

Discharge Summary

A discharge summary must be completed for all patients hospitalized for more than 48 hours . A discharge progress note may be used to document the discharge summary for normal obstetrical deliveries, normal newborn infants, ambulatory care patients, and stay less than 48 hours. Furthermore, the discharge summary must be completed within 7 days from the date of discharge and should include the following:

- Relevant past diagnoses and procedures
- Reason for hospitalization
- Any significant findings
- Procedures performed and treatment rendered
- Patient's condition at discharge
- Discharge instructions given to the patient, family or caregiver regarding diet, activity, medications and follow-up.

Ensure there are no home medications included on the discharge summary for expired patients!

As of January 2016
use of an order set is
REQUIRED on all admissions

Gottlieb Memorial Hospital

EPIC MEDICAL RECORD (CONTINUED)

Informed Consent/Brief Operative Note/Operative Reports

1. The surgeon/proceduralist is responsible for obtaining and documenting an informed consent that includes patient identification, date, surgery/procedure/treatment, authorization for anesthesia and blood, if applicable, and potential risks, benefits, complications and options for alternatives.
*Note: The Informed Consent **MUST** be dated and timed!*

2. A brief operative note is documented immediately after a procedure or surgery. This note **MUST** include:
- Surgeons and assistants' names
- Procedure/surgery performed
- Description of findings
- Estimated blood loss as well as no blood loss, if applicable
- Specimens removed as well as no specimens removed, if applicable
- Post-procedure/operative diagnosis
- Signature/date/time

3. A comprehensive operative report must be completed within 24 hours following the procedure/surgery and include:
- Date of surgery/ procedure
- Name of surgeon(s) and assistant(s)
- Preoperative diagnosis
- Postoperative diagnosis
- Surgical procedure
- Type of anesthesia
- Complications
- Description of techniques and findings
- Description or specimens removed as well as no specimens removed, if applicable
- Estimated blood loss as well as no blood loss, if applicable.
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if applicable
- Signature, date, time

Copy & Paste

1.Providers should avoid:

a. Inappropriate use of copy/paste functionality (Example: Copying a previous note without updating the information; plagiarizing a note from another Provider into an encounter without attribution to the originating author).

b. Over-documentation of clinically irrelevant information (Example: Documenting conditions that are not being treated and/or irrelevant comorbidities).

c. Copying redundant information provided in other parts of the EMR (Example: Including the past 7 days of vital signs in the progress note).

2. Providers should avoid cloned notes functionality, such as:

a. When one patient's medical record is cloned (copied) into a different patient's EMR.

b. When a pre-completed note is used by the Provider(s) for all the patients with the same review of systems (ROS) and physical examination pre-documented and not updated with information specific to the patient.

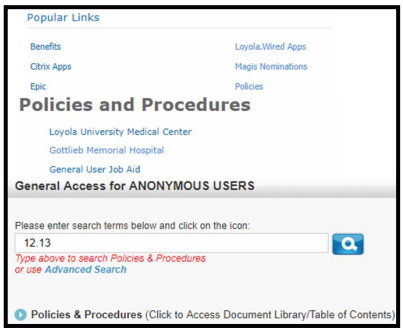
Reference: Administrative Policy: COMP-041 Copy & Paste Functionality in Electronic Patient Records

Chart Completion

Epic In Basket:
Physicians must complete all chart deficiencies and transcribed dictations from the "Hospital Chart Completion " and "Transcriptions" folders. **Deficiency letters will be sent to the "Deficiency Letters" folder** .

GMH Epic Downtime Procedures (P/P #12.13)

In the event of a temporary or



sustained period of Epic downtime the GMH Epic Downtime Policy/Procedures should be followed. The policy/procedure can be found on the Spirit Intranet by click on "Resource" "Policies and Procedures."

- During an Epic downtime all physicians are to follow the GMH Epic Downtime Procedures (Policy # 12.13).
- Physician orders are to be written on the triplicate physician order sheets (#004206) or on a specific order set. Orders will be entered into Epic when the system is live.
- Forms can be found on all nursing units.

For information or assistance with the EMR, please contact Health Information Management at 708-216-2110 or the IS Help Desk at 708-216-2160.

Use standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

Do not use any unacceptable medical record abbreviations and medication dose designations. See the next page for a complete list.

EPIC MEDICAL RECORD—LIST OF UNACCEPTABLE MEDICAL RECORD ABBREVIATIONS & MEDICAL DOSE DESIGNATION

Purpose: Use of certain abbreviations and medication dose designations can be dangerous and lead to treatment errors. This list of unacceptable abbreviations and dose designations identifies specific abbreviations and medication dose designations that have been in use, but have been found to create the potential for error.

THE ABBREVIATIONS AND MEDICATION DOSE DESIGNATIONS LISTED BELOW MAY NOT BE USED.

Abbreviation or Dose Designation	Reason	Acceptable Practice	Rational for Selection
Do not use "U" as an abbreviation for "Units"	"U" can be confused with a "0" or a "4"	Write out the word "Units"	Frequently used, high risk drugs (heparin and insulin) are ordered in units. Identified as unsafe by the ISMP*.
Do not use IU (for international unit)	Mistaken as IV (intravenous or 10 (ten).	Write "international unit"	Identified as unsafe by the ISMP*.
Do not use Q.D., Q.O.D. (Latin abbreviation for once 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".	Write "daily" and "every other day"	Identified as unsafe by the ISMP*.
Do not use "ug" for microgram	Misinterpretation as "mg"	Write "mcg" for microgram	Used frequently for dosing in infants and children. Identified as unsafe by the ISMP*.
Do not use trailing zeros (1.0)	Misread as 10 if decimal is not seen	Write numerals without the decimal point Write 1 mg, not 1.0 mg	Potential for ten-fold dosing errors. Identified as unsafe by the ISMP*.
Do not use leading decimals (.1)	Misread as 1 if the decimal is not seen	Write numerals as 0.1 mg, not .1 mg	Potential for ten-fold dosing errors. Identified as unsafe by the ISMP*.
Do not use MS04 or MS for morphine	Misread as magnesium sulfate	Write morphine	Frequently used in high-risk situations. Identified as unsafe by the ISMP*.
Do not use MgS04 for magnesium sulfate	Misread as morphine sulfate	Write magnesium sulfate (the salt matters)	Frequently used in high-risk situations. Identified as unsafe by the ISMP*.

***ISMP is the Institute for Safe Medication Practices**

Document available at: http://www.luhs.org/internal/clin_res/documents/UnacceptableAbbreviations.pdf

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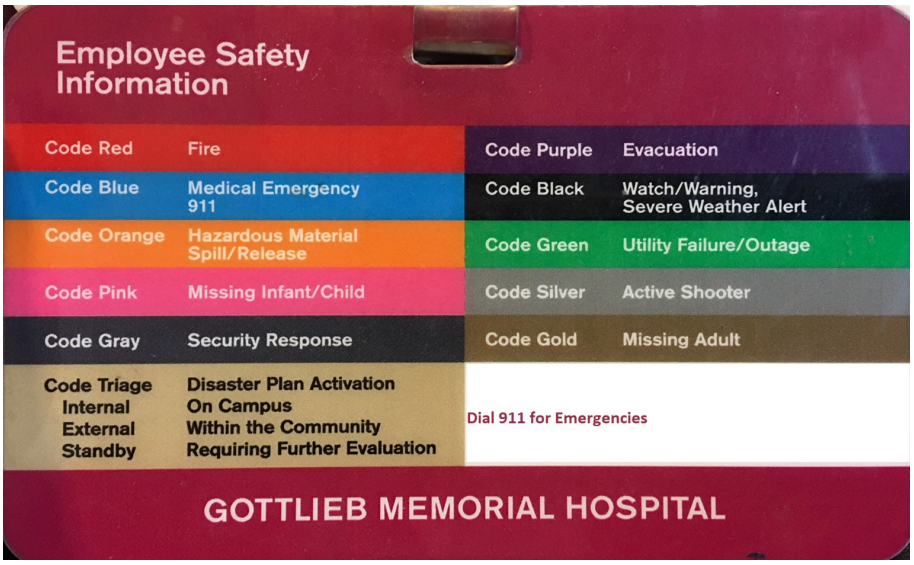
HOSPITAL-WIDE ENVIRONMENT OF CARE



Emergency Preparedness

In addition to the codes on the above badge you should also be aware of five other emergency types:

OB Alert - OB Hemorrhage
Cardiac Alert – STEMI
Stroke Alert - Patient with potential stroke
Sepsis Alert- life-threatening response to infection
Trauma Alert- Trauma I: Traumatic Arrest Penetrating, Trauma II:
Traumatic Arrest-Blunt

Know your codes and your responsibility. Standby for further notice from the Incident Command.

Security Management

All medical and hospital staff members are expected to wear their ID badges in a visible location at all times.
Additionally, remember to lock lockers and vehicles.

General Safety

Bomb Threat

If a bomb threat is received by phone:

- Keep the caller on the line
- Ask caller to repeat the message
- Attempt to record every word spoken by caller
- Immediately report the bomb threat to security
  - Individual receiving the call should remain available until law enforcement arrives

Hazardous Materials and Waste Management

In case of a spill:

- Dial "911"
- Give location of spill and announce "Code Orange" immediately ("Code Orange" is the designated code for a chemical spill at Gottlieb)
- Complete a VOICE report!

Fire Prevention and Response

If a fire is discovered in your area, the following actions should be taken:

R.A.C.E.

Rescue anyone in immediate danger.
Alarm others, call 911 and activate the nearest pull station.
Contain the fire by closing the door.
Extinguish the fire, only if safe to do so.

P.A.S.S.

Pull the pin between the handles.
Aim at the base of the fire.
Squeeze handles together.
Sweep from side to side.

Know location of nearest fire alarm pull box and extinguishers.

Evacuation routes are posted by every elevator. DON'T use elevators unless directed to by Fire Department.

First level of evacuation is horizontal away from the fire and beyond the nearest set of fire doors then vertically down stairways.

GMH Falls Prevention Program

The falls prevention program aims at decreasing the risk of a patient fall with a proactive versus a reactive approach.

Key elements of the Falls Prevention Program include:

1. Patient fall risk assessment is completed upon admission, daily and when there is a change in the patient's condition.
2. After each patient fall a safety huddle is held with participants including the patient's RN, PCA, charge nurse and nurse manager or nursing supervisor within 1 hour of the event.
3. A " huddle" form is completed on all patient falls.
4. Purposeful hourly rounding, including reminding patients to call for assistance is implemented on all units.
5. Falls Prevention Committee meets once a month to review data and identify any opportunities for improvement: members include nursing and ancillary areas.
6. Weekly leadership fall huddles present falls from previous week and identify opportunities.

Pressure Ulcers

All inpatients need a thorough assessment of their skin integrity, especially on admission. Findings from this assessment should be placed in the patient's History and Physical (H&P) and updated as appropriate in daily progress notes. <u>If pressure ulcers are present on admission make sure to also indicate location.</u>

Note the majority of the templates for these documents already include a skin integrity field.

Restraints

Restraints are used only when clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff or others. Patients' rights, dignity and safety are protected and maintained. Restraints are used in the least restrictive, safest, and most effective manner possible. Restraint use is assessed and reassessed per policy and discontinued at the earliest possible time, regardless of the scheduled expiration order.

We need your help ensuring that the order is placed when needed.

<u>Orders for Non-Violent restraints or Non-Self-Destructive Behavior</u>:

- Restraint order is good for 24 hours.
- Assess for continuation with each order renewal; a new order must be obtained, based upon a daily face-to-face exam of the patient by a Licensed Independent Practitioner (LIP).

<u>Orders for violent restraints/self destructive behaviors</u>:

- All LIPs must see the patient within one hour after initiation of the restraints to evaluate the patient's immediate situation, reaction to the intervention, medical condition (including review of systems), behavioral condition, high risk medical issues and need to continue or terminate the restraints.

<u>Time limited order applies and may not exceed:</u>

- Four (4) hours for adults
- Two (2) hours for children and adolescents ages 9-17
- One (1) hour for children under 9 years of age
- Assess for continuation with each order renewal

Pain Management

<u>Ordering practice for PRN:</u>
When two or more PRN medications are ordered for pain, the patient's level of pain will determine which PRN medication is administered based on the pain classification in the order.

- ***Mild Pain (pain scale 1-3)***
- ***Moderate Pain (pain scale 4-6)***
- ***Severe Pain (pain scale 7-10)***

If two or more medications are ordered for the same PRN pain level:

- The prescriber must provide instructions to the nurse regarding which agent to use under what conditions. For example: "may alternate with ___" or "use for pain not responding to ___".
- When multiple routes are ordered – the least invasive route is preferred. If the oral route is not feasible then the next more invasive route can be used.
- If subsequent orders create duplication, the latest order within that pain-medication class will be followed and the earlier order discontinued.

<u>Patient involvement:</u>
The CMS / HCAHPS patient satisfaction survey for 2018 has shifted emphasis away from asking how well pain was controlled. They instead ask about hospital staff activities in pain assessment ("...how often did hospital staff talk with you about how much pain you had?") and patient involvement in pain management planning ("...did hospital staff talk with you about how to manage your pain").

Patient involvement in planning pain management involves information sharing and collaboration between the patient and provider to arrive at realistic expectations and clear goals. This should include education on non-pharmacologic methods as well as opiate and non-opiate medication options.

CLINICAL CARE (CONTINUED)

Advance Directive

Having an Advance Directive provides patients the opportunity to make informed decisions about end-of-life care and services. Encourage patients to have this discussion when they are well so that these decisions are in place when they are faced with illness.

Do Not Resuscitate (DNR)

The Ethics Committee has written and approved the Do Not Resuscitate Policy, DO NOT RESUSCITATE—DNR POLICY #3.11. The policy was also approved by the MEC. This policy addresses issues that were out of date or were not in compliance with Illinois law. The new policy incorporates guidelines from national and international professional societies.

Nurses can now take a DNR telephone order. The older version of this policy required the hospitalist to take the order from the primary care physician and enter the order in Epic.
The policy affirms that if the patient has a valid Illinois POLST form, properly filled out and signed, we are bound to honor that even if there is no DNR order entered into Epic. This is in compliance with Illinois law.

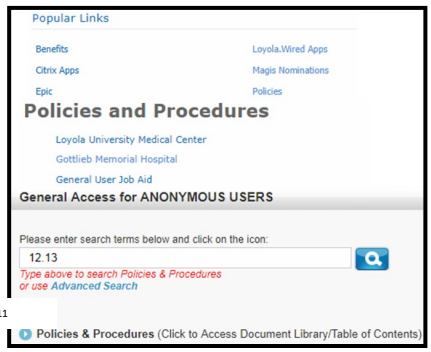
ED physicians can enter a DNR order either based on a discussion with the patient/surrogate or based on a valid POLST.

The section on patients with a DNR order going for surgery or procedures requiring sedation or anesthesia was rewritten to conform to guidelines by the surgical and anesthesia professional societies.

The old version of this policy called for automatic suspension of the DNR order, which did not always comply with the patient's wishes. This policy calls for a more collaborative approach involving the patient/surrogate, the treating physicians and the anesthesia service.

The policy recommends that a referral to the Ethics Committee may be helpful at any time in the process, especially when there is uncertainty or conflict.

Hospice Care



Hospice care is end of life care that provides comfort and support for persons with life-limiting conditions as well as their families. Hospice care aims to control a patient's pain and symptoms for the length of their illness. Specifically, the focus is on caring not curing. Generally, for patients to be eligible for hospice care they must be considered terminal with a life-expectancy of 6 months or less if the disease follows its normal course.
The decision for patient/families to decide on hospice care may be a difficult one. Providing adequate information and having honest discussions with patients /families early on in the disease process can ease some of the difficulty in choosing hospice care.

Visitation Rights

Trinity Health recognizes that a key component in ensuring patient excellence in care involves respecting the rights of patients including their rights to involve family members, domestic partners and significant others in their care or treatment.

Gottlieb Memorial Hospital supports a patient-centered, open visitor policy while striving to maintain a safe and secure environment for patients and their families, support person, visitors, and staff.

General visiting information includes:

- Children between 6 and 16 may visit but must be accompanied by a responsible adult.
- General floor visiting hours are from 11:00 am to 8:00 pm daily.
- Critical and intermediate units have department-specific visiting regulations but exceptions will be permitted based on patient and family needs.
- A family member may remain in the hospital overnight with the approval of the Nursing Supervisor, Nurse Manager or Charge Nurse.

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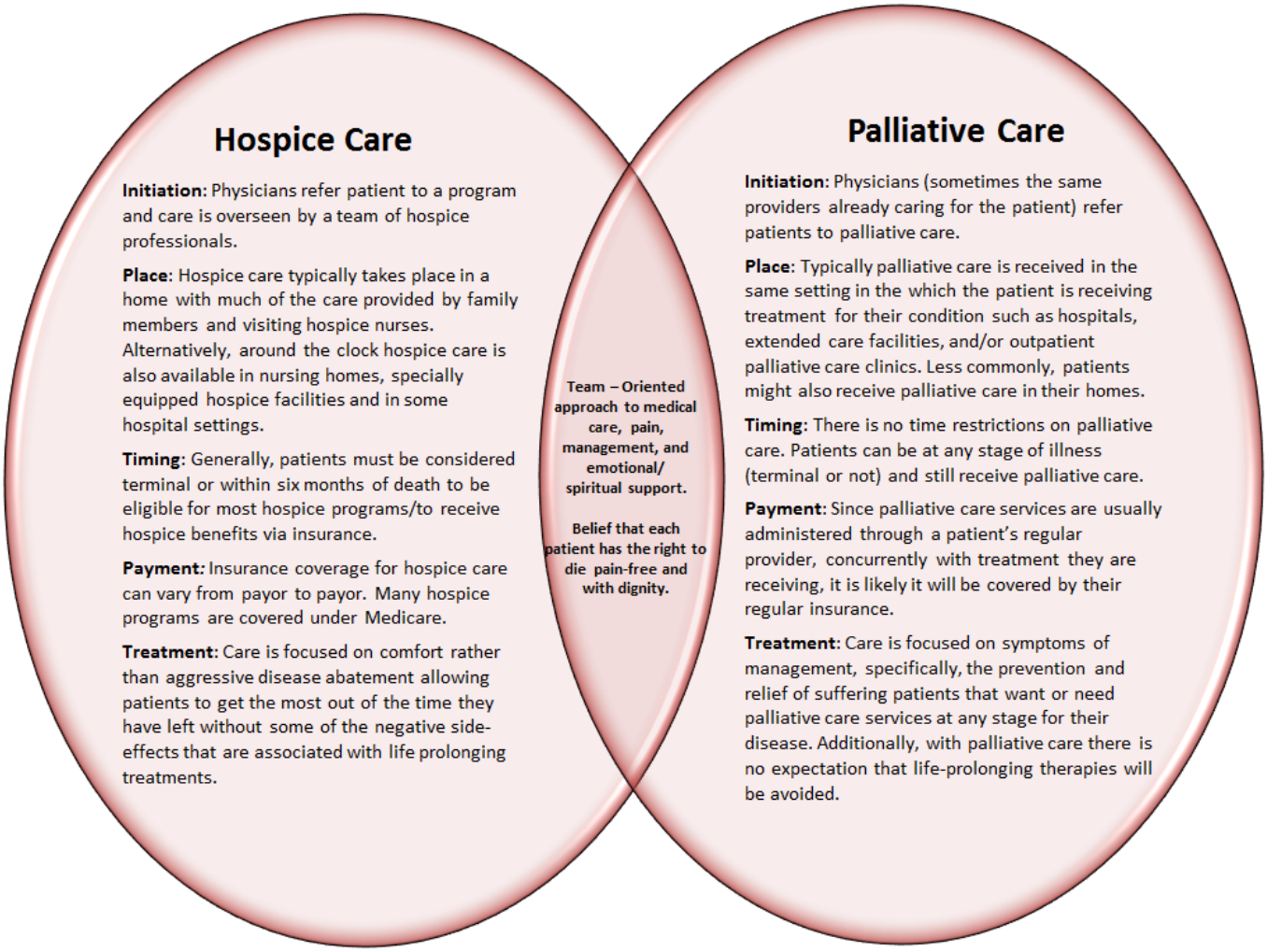
Do you know the general differences and similarities between Hospice Care and Palliative Care?



Sources: http://www.nhpco.org/about/hospice-care, http://www.pbs.org/wnet/onourownterms/articles/versus.html

Palliative Care

Palliative care is defined as specialized medical care for people with serious illnesses. Palliative Care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care can be provided by a team of doctors, nurses, and other specialists who work with a patient's primary doctor to provide an extra layer of expertise. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

For more information or palliative care requests, nurses on each medical unit should contact the manager of case management for assistance..

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ANTIMICROBIAL STEWARDSHIP

Joint Commission Standard:

Joint Commission accreditation requires that hospitals have an antimicrobial stewardship program. This standard (MM.09.01.01) became effective January 1st, 2017.

Antimicrobial stewardship definition:

"Coordinated interventions designed to improve and measure the appropriate use of [antibiotic] agents by promoting the selection of the optimal [antibiotic] drug regimen including dosing, duration of therapy, and route of administration"[1]

Benefits of an antimicrobial stewardship program[2]:

- Improved patient outcomes
- Reduced clostridium difficile infection (CDI) in addition to other adverse drug reactions (ADRs)
- Improved antibiotic susceptibility rates
- Optimized usage of resources

Antimicrobial Stewardship Committee members:

- Infectious Disease
- Pharmacist
- Infection Prevention
- Pharmacy Informatics
- Microbiology/Molecular pathology
- Chief Quality Officer
- Emergency Medicine

Programs to optimize antimicrobial stewardship:

Order sets to assist in therapy selection

- Examples include "Sepsis Adult," Pneumonia", "GMH Preoperative Antibiotic", "Sexually Transmitted Disease or Urinary Tract Infection".
- All order sets may be found on the GMH Guidelines and Order Sets webpage. (Click on the Web icon in Epic then on the link)
- Direct link at http://gmhweb.lumc.edu/content/clinical-protocols

Clostridium difficile Colitis prevention project

- The following interventions are considered for patients identified by Pharmacy as being at high risk for C.diff infection:
  - Discontinue or streamline antibiotic regimen
  - Discontinue proton pump inhibitor
  - Initiate oral vancomycin prophylaxis for duration of antibiotic use

IV to PO

- Once a patient is tolerating other meds or food by the oral or enteral route, pharmacy will automatically switch antibiotics with good bioavailability and
- similar efficacy as IV
  - ◊ Azithromycin
  - ◊ Ciprofloxacin
  - ◊ Doxycycline
  - ◊ Fluconazole
  - ◊ Levofloxacin
  - ◊ Metronidazole
  - ◊ Linezolid

Pharmacokinetic Dosing Service for aminoglycoside antibiotics and vancomycin

- Available upon consultation
- Pharmacy will enter the orders and complete notes in Epic

Prescribing Restrictions:

Drug- Amphotericin B intravenous formulations
Approved Prescribers: Infectious Disease

Drug- Colistimethate
Approved Prescribers: Infectious Disease

Drug– Daptomycin (Cubicin®)
Approved Prescribers: Infectious Disease

Drug– Ertapenem (Invanz®)
Approved Prescribers: All; restricted to one dose (in preparation for outpatient use)

Drug– Linezolid (Zyvox®)
Approved Prescribers: Infectious Disease; Critical Care

Drug– Micafungin (Mycamine®)
Approved Prescribers: Infectious Disease

Drug– Polymyxin B intravenous
Approved Prescribers: Infectious Disease

Drug– Tigecycline (Tygacil ®)
Approved Prescribers: Infectious Disease; Critical Care

Renal Dosage Guideline

- Pharmacists are authorized to adjust medication dosage (including antibiotics) based on renal function assessment and published guidelines

Antibiotic usage tracking

- Tracked by day of therapy (DOT/1000). Reviewed quarterly with benchmarking comparisons to other institutions.

Antibiotic susceptibility tracking

- An antibiogram is compiled annually. This is posted on the Guidelines, Order Sets and Forms page under the ANTIMICROBIAL STEWARDSHIP heading.
- A culture and sensitivity follow-up is performed to ensure that prescribed therapy is appropriate.

Antibiotics Formulary

- List of formulary antibiotic agents is provided to the right.

1. SHEA, IDSA, PIDS. "Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society (PIDS)" *Infect Control Hospital Epidemiologic* 2012;33(4):322-327.
2. IDSA. "Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America" *Clin Infect Dis* 645^{0};^{0} 6(54):e95-e77.

Antibiotics on Formulary

Penicillins	
Penicillin G	Piperacillin/tazobactam
Penicillin V	Amoxicillin/clavulanic acid
Nafcillin	Ampicillin/sulbactam
Dicloxacillin	
Ampicillin	
Amoxacillin	
Cephalosporins	
Cefazolin	Ceftazidime
Cephalexin	Cefdinir
Cefuroxime	Cefepime
Cefoxitin	
Ceftriaxone	
Carbapenems/Monobactams	
Ertapenem	Aztreonam
Meropenem	
Macrolides	
Erythromycin	Clarithromycin
Azithromycin	
Fluroquinolones	
Ciprofloxacin	Levofloxacin
Sulfonamides	
Sulfamethoxazole/trimethoprim	
Glycopeptide/lipopeptide	
Vancomycin	Daptomycin
Oxazolidinone	
Linezolid	
Aminoglycosides	
Amikacin	Tobramycin
Gentamicin	Neomycin
Lincosamide	
Clindamycin	
Tetracyclines/glycylcycine	
Doxycycline	Tigecycline
Nitroimidazole	
Metronidazole	
Miscellaneous	
Fosfomycin	Nitrofurantoin
Antifungal	
Fluconazole	Micafungin
Voriconazole	Amphotericin B
Itraconazole	
Antiviral	
Acyclovir	Valgancyclovir
Valacyclovir	

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CLINICAL CORE MEASURES- Must Do's for Perfect Compliance

Measure	Physician Actions
HBIPS For Geriatric Behav-ioral Health Patients on 3S	• Documentation **MUST** be completed, within the first day of patient's admission, reflecting their tobacco use within the past 30 days and that they have been offered smoking cessation medication (make sure to also document refusal). • Documentation at discharge **MUST** include patient being offered a prescription for smoking cessation medication or the reason why they are not receiving it. If the patient refused tobacco cessation medication during hospitalization, a pre-scription must be offered again at the time of discharge. • If patients are discharged on multiple antipsychotic medications, documentation must address reason why more than one antipsychotic is required. • Appropriate justification for more than one antipsychotic includes: 1. The medical record contains documentation of a history of a minimum of three failed multiple trials o monotherapy. 2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge. 3. The medical record contains documentation of Clozapine. • The medical record may contain documentation of a justification other than those listed in the allowable values 1-3 above, however this will not meet the measurement requirements and the case will not pass the measure.
Metabolic Screen (SMD)	• Documentation **MUST** include that metabolic screen (BMI, BP, Fasting Glucose or HbA1c, and Lipid Panel) was per-formed prior to or during index hospitalization for patients discharged on one or more routinely scheduled antipsy-chotic medications. Specific to Fasting Glucose or HbA1c and Lipid Panel are the following requirements to meet the measure: • The record must contain at least one documented result with a result date within the current patient stay, or 12 months prior to the date of discharge. • If within the medical record there is a Fasting Glucose/HbA1c or Lipid Panel from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test).
Transition Record For Geriatric Behav-ioral Health Patients on 3S	• All patients discharged from the Geriatric Behavioral Health Unit (GBHU) must be provided with a Transition Record that includes/addresses the following elements: ◦ Reason for inpatient admission ◦ Principle diagnosis at discharge ◦ Major procedure and tests, including summary of results ◦ Current medication list ◦ List of studies pending at discharge or documentation that no studies are pending ◦ Directions for patient and/or caregiver to follow upon discharge (ex. medication information, activity restrictions, warning signs/symptoms associated with condition etc.) ◦ Medical and psychiatric advanced directives addressed ◦ 24hr/7-day contact information including physician for emergencies related to inpatient stay ◦ Contact information for obtaining test results pending at discharge ◦ Plan for follow up care that describes treatment and other support services to maintain or optimize health ◦ The name of primary care provider, other healthcare professional or site designated for follow up care
OP-29 Endoscopy/Polyp Surveillance: Appropriate Fol-low-Up Interval for Normal Colon-oscopy in Average Risk Patients	• Documentation in the recommendation section of the final colonoscopy report **MUST** include patient follow up in at least 10 years. • Any other duration other than "at least 10 years" **MUST** be in the report and have the rationale documented e.g. "patient is 85 years old and current guidelines suggest further screening/surveillance after ages 75-80 may not be necessary."
Sepsis	• **USE** the sepsis order set to aid 3hr and 6hr bundle compliance. • **USE** the Sepsis Navigator. • Refer to Sepsis Care at Gottlieb section of this newsletter.

CLINICAL CORE MEASURES—SEPSIS SPECIFICS

Recognition of Sepsis

- Early recognition of sepsis can help save a life. Implementation of 3 hour bundle can reduce progression of sepsis.
- Patients admitted to medical/surgical units can be in acute stages of sepsis; nursing recognition of sepsis will help improve that patient's prognosis and outcomes.
- Septic shock (**red zone**) is one of the most common causes of death in ICUs.
- Early identification and interventions of a septic patient (**green zone**) can prevent the progression to severe sepsis (**yellow zone**) and septic shock (**red zone**).

SIRS = Systemic Inflammatory Response Syndrome

A patient that meets two (2) or more of the following criteria (SIRS) makes them at risk for developing sepsis:

- Temperature >38º (100.4) or <36º (96.8)
- Heart rate > 90/min
- Resp Rate > 20/min or PaCO2<32 mmHg
- Hyperglycemia with glucose > 140 mg/dL in the absence of diabetes—NOT SIRS CRITERIA BUT APPROPRIATE FOR EARLY RECOGNITION OF DEVELOPING SEPSIS.
- Leukocytes >12,000; <4,000 or more than 10% bands

Sepsis MUST DO's for Perfect Compliance

- **MUST** acknowledge MEWS alerts.
- Initiate Sepsis order set if appropriate.
- Documentation **MUST** include source of infection or suspected source of infection. If unknown, **MUST** document "unknown source." SOURCE/SUSPECTED SOURCE OF THE INFECTION NO LONGER REQUIRED.

CLINICAL CORE MEASURES—SEPSIS SPECIFICS–Continued

GREEN Zone Early Identification of **SEPSIS**	**Documentation of Suspected or documented risk of infection or a clinical indication of:** 1. **New or worsening signs of infection** (which may include new onset of pain, respiratory distress, drainage, cloudy urine, etc.) **AND** **2. Two or more of the following symptoms** Temp >100.9 or < 96.8 HR > 90 RR > 20 or PaCO2 < 32mm Hg WBC < 12,000 or < 4,000 or Bands > 10% Blood sugar > 140 (in absence of diabetes) **IF YES: call licensed provider, at risk for developing Severe Sepsis.**	**Orders Required:** 1. STAT labs including serum lactate, CBC w diff. chemistry labs 2. STAT blood cultures PRIOR to antibiotics 3. Other Cultures and Imaging (UA, C&S, sputum, CXR, Ekg, etc.) 4. Obtain IV access. Goal for 2 large bore IV's. 5. Broad Spectrum IV Antibiotics to be started within 3 hrs. of sepsis identification. 6. Insert foley catheter to gravity; strict I % 0 UO > 30ml/hr. 7. Begin 30cc/kg Isotonic Fluid Bolus Stat within 3 hrs. of initial Hypotension or initial Lactate >=4. 8. Monitor vitals, including increased 02 needs. 9. Notify licensed provider if any drop in any of the following: SBP <90 or MAP <65, Change in mental status, change/increase in HR, RR from baseline.
YELLOW Zone Identification of **SEVERE SEPSIS**	**1. Presence of Sepsis (see above) AND** **2. New Onset of End Organ Hypo-perfusion:** • SBP<90, MAP <65 or >40 point drop in SBP from patient's norm • Bilirubin >2mg/dl • Coagulopathy:INR >1.5; aPTT >60 sec or Platelet count <100,000 ul • Serum Lactate >2.0 • Urinary: UO <.5ml/kg for > 2hrs;Creatinine >2 mg/dl **IF YES: Call licensed provider STAT for Severe Sepsis Orders. May Call "RRT: Code Sepsis"**	Provider Severe Sepsis Orders: **Orders Required:** 1. Enter orders as identified in Green Zone if they have not already been completed. 2. Begin 30cc/kg IV fluid bolus STAT within 3 hrs. of initial hypotension, lactate >4or septic shock 3. Repeat STAT serum lactate after bolus infused. 4. Prepare for a possible patient transfer to a monitored unit if patient not responding to therapy.
RED Zone Identification of **SEPTIC SHOCK**	**Septic Shock is defined as:** 1. The presence of severe sepsis and persistent hypotension evidenced by an initial lactate >=4. 2. The presence of severe sepsis and persistent hypotension evidenced by 2 consecutive hypotensive BP's in the hour following the completion of the 30cc/kg bolus (Shock TOP is the time of the 2nd hypotensive BP).	**If patient remains with End organ Hypoperfusion after ALL the above complete then:** 1. Provider to Call intensivist for consultation 2. Provider to consider transfer to a higher level of care 3. Monitor CVP "If available" 4. Vasopressor therapy to maintain SBP >90 and/or MAP >65 5. Consider US to assess fluid status. 6. Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge. 7. Documentation by an LIP within 6 hrs. after TOP for Septic Shock that a fluid reassessment was completed.* * (ex.:"I did the Sepsis reassessment"; "Review of systems completed";" Sepsis re-evaluation was performed") -

Sepsis Bundle Algorithms

01-01-2019 (1Q19) through 12-31-2019 (4Q19)

SEP-1: Early Management Bundle, Severe Sepsis/Septic Shock

Within three hours of presentation of severe sepsis:
- Initial lactate level measurement
- Broad spectrum or other antibiotics administered
- Blood cultures drawn prior to antibiotics

AND received within six hours of presentation of severe sepsis. ONLY if the initial lactate is elevated:
- Repeat lactate level measurement

AND within three hours of initial hypotension:
- Resuscitation with 30 mL/kg crystalloid fluids

OR within three hours of septic shock:
- Resuscitation with 30 mL/kg crystalloid fluids

AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:
- Vasopressors are administered

AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L:
- Repeat volume status and tissue perfusion assessment is performed

MEWS (MODIFIED EARLY WARNING SEPSIS) FOR SEPSIC EARLY GLOBAL DIRECTED THERAPY

A MEWS score of 5 or greater will trigger a Best Practice Alert (BPA) that alerts all members of the care team that the patient might be showing signs of early clinical deterioration. Please remember that MEWS is NOT a sepsis screening tool, but it is a tool that may identify patients who are showing the initial signs of sepsis. Every time a MEWS BPA fires on one of your patients, please ask yourself if this patient could be septic.

At Gottlieb, **when a BPA for a MEWS score of 5 or greater is triggered**, the RN will immediately notify the ICU Intensivist from 7am-7pm at (708) 261-8580 and the Encompass Hospitalist from 7pm—7am at (708) 427-2030 or page (708) 643-4015 for a "**Critical Care Consult to be evaluated for SEPSIS**." After the evaluation, the Intensivist/Hospitalist will communicate with the attending physician via Epic note(s) and/or directly speaking with the
Attending physician. If that patient is septic, the sepsis order set should be used as all the Best Practice Core Measures are identified.

The grid below demonstrates how the MEWS Score is tabulated based on the range of each vital sign documented in the Epic VSS flowsheet.

- Scores range from 0-15 points
- MEWS score of 4 triggers a yellow BPA alert for "Sepsis" MEWS
- MEWS Score of 5 triggers a red BPA alert for "Sepsis" MEWS

GMH Sepsis MEWS Scoring

Points	*3*	*2*	*1*	*0*	*1*	*2*	*3*
Temperature	≤ 34.9	34.5-35.0	35.1-36.0	36.1-37.9	38.0-38.6	38.7-40.5	≥40.6
Pulse		≤40	41-50	51-100	101-110	111-129	≥130
Respiratory Rate		≤8		9-20		21-29	≥30
Systolic BP	≤70	71-80	81-100	≥101			
Level of Consciousness	•Combative	•Agitated •Irritable •Acute Confusion	• Restless	•Alert •Arousable •Asleep •Awake •Eyes open spontaneous	•Drowsy •Eyes open to voice	•Eyes open to pain •Eyes open to Stimulus •Pharmacologically paralyzed	•Comatose •Lethargic •Unresponsive

Universal Protocol

Prior to the start of any surgical or invasive procedure, a final "Time Out" verification is conducted to confirm the correct patient, procedure and site. Additionally, the Time Out provides a final opportunity before any incision is made to ensure the patient has received the recommended prophylactic antibiotics. The Time Out must be an active process that includes all members of the OR/ procedural team. All team members must pause and participate.

Post Operative Venous Thromboembolism (VTE) Prevention

Evidence-based best practices are followed for all patients receiving prophylaxis prior to anesthesia start time and after anesthesia end time.

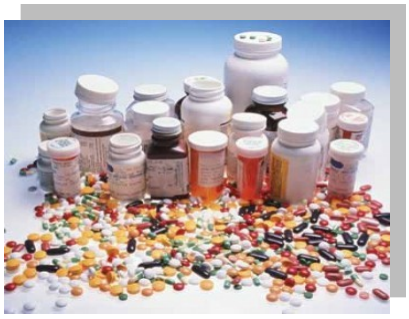
Ensure these orders are in place to help reduce the morbidity/ mortality
resulting from post operative deep vein thrombosis and pulmonary embolisms.

Specimen Management

To ensure all specimens are labelled and managed correctly:

- When the specimen is passed to the scrub or circulating RN, the staff member will repeat the specimen to be sure there is clear communication.
- As the procedure is coming to a close, the circulating RN will do an end of procedure time out where all specimens for the case will be restated and verified by the proceduralist.
- Prior to leaving the room, the proceduralist will review and sign the requisitions for specimens that were not required to be sent prior to the end of the case.

Medication Management



Anticoagulation therapy is a high risk treatment!

- Use Heparin Protocol
- A baseline PTT, CBC and platelet count required. Treatment may begin prior to obtaining results.

Medication Reconciliation

Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting.

Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, and purpose).

Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

Clinical Alarms

Critical alarms must not be deactivated during the duration of their use! Staff members must physically respond to clinical alarms, assess the patient, evaluate the reason for the alarm and take appropriate action. Alarm parameters can only be changed after consulting with the patient's attending physician and obtaining an order. The changes to the alarm parameters should be specific to the patient's needs and only done to reduce the number of false alarms. Furthermore, the volume level of the alarms must be sufficiently audible with respect to the distance and
competing noise to be heard by responsible clinicians which may require alarm volume be adjusted upward at certain times.

In circumstance where the patient room door must be closed and clinical staff can't readily hear alarms, care providers will maintain regular assessment of the room to evaluate alarm status. Arrangements can be made with the Clinical Engineering Department for any individuals in need of further training on any devices which have an alarming system (see Administrative Hospital-Wide: Clinical Alarm Policy & Procedure 19.19 located in Policy Manager).

Gottlieb Memorial Hospital

PATIENT SAFETY (CONTINUED)

Communication

Accuracy of Patient Identification
Hospital-wide Patient Identifiers:

- Name
- Date of Birth

Color-Coded Arm Bands:

White=Generic ID band

Red-Allergy

Purple-DNR

Pink-Do not use limb

Yellow-Fall Risk

Orange-Swallow Precautions

A verbal order (via telephone or in person) for a medication, biological, or other treatment will only be accepted under circumstances when it is impractical for such an order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.

SBAR

SBAR is the recommended standard method of hand-off communication at Gottlieb Hospital.

SBAR
S = Situation
B = Background
A = Assessment
R = Recommendation

Suspected Abuse and Neglect

Abuse and neglect exist in all societies, races, educational backgrounds, and economic levels. Abuse and neglect represent symptoms or expressions of family dysfunction. Abuse may happen not only in the home, but in healthcare settings as well.

Abuse includes:

- Child abuse
- Elder abuse
- Sexual abuse
- Verbal abuse
- Emotional abuse
- Domestic violence
- Financial abuse
- Neglect

Key Elements Which May Indicate Abuse/Neglect Situations

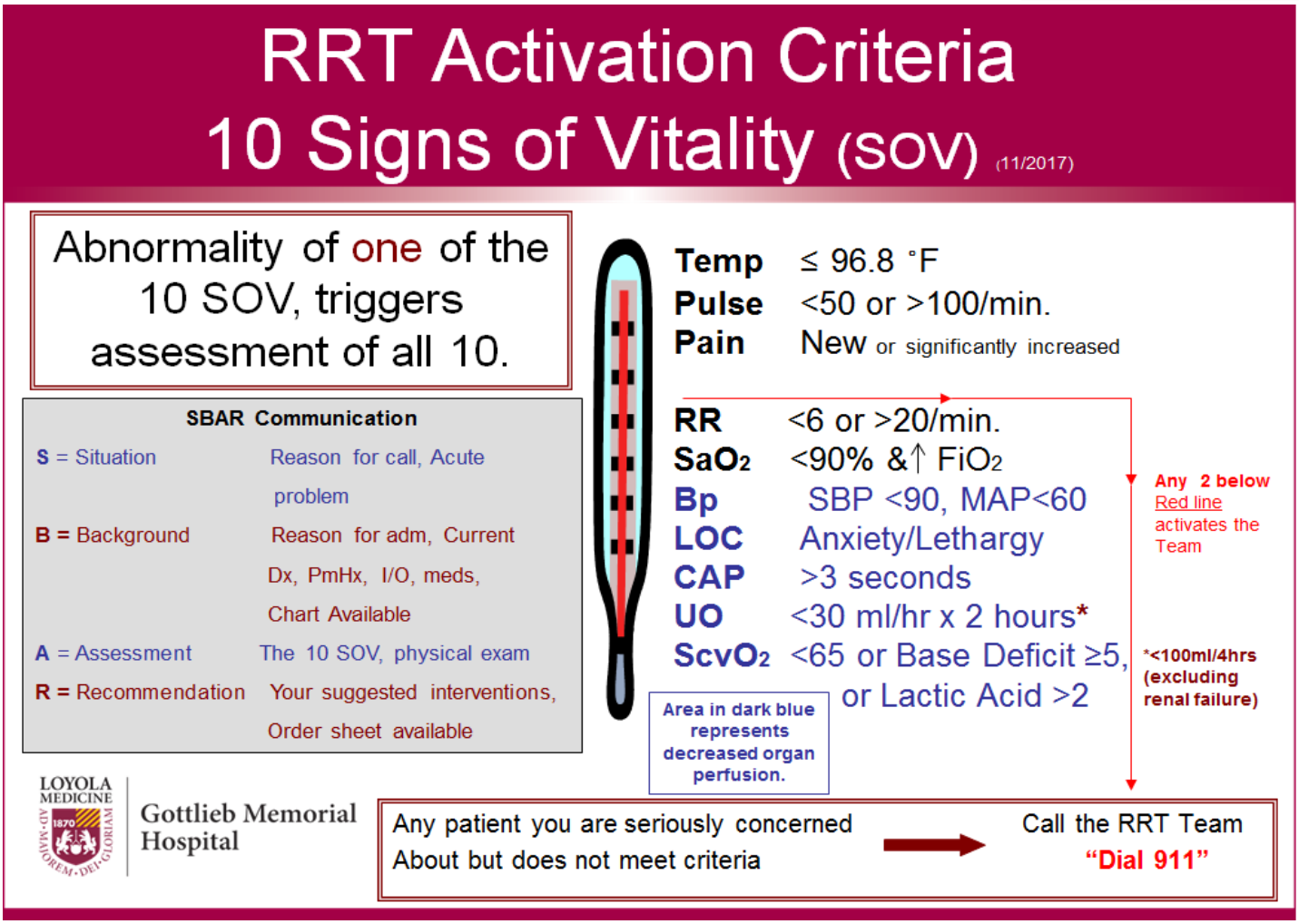
- History of abuse or untreated injuries
- Injuries inconsistent with developmental, physical or cognitive abilities
- Injuries inconsistent with the explanation
- Observation of bruises, bites, burns, fractures, lacerations, pressure sores, poor hygiene
- Shy or withdrawn behavior of patient
- Behavior extremes in caregiver or family members
- Changes in behavior of patient with caregiver/family
- Family answers questions for patient (older child or adult)

When Abuse and/or Neglect is Suspected

The physician and Social Worker will be notified immediately when there is abuse and/or neglect suspected. They will assess the interaction between the patient, family and/or caregivers (including the healthcare staff). This will include the review of medical and social history including history and explanation of injury. The patient should be questioned in a safe environment alone and privately by appropriate designated professional.

If sexual abuse of a child is suspected:

- Interview parents/caregiver outside the presence of the victim by appropriate designated professional
- Interview with the victim should be limited to brief questions related to medical issues only by one designated professional
- A Victim Sensitive Interview (VSI) is to be completed by a designated legal interviewer arranged by DCFS.



Rapid Response Team (RRT)
The team is composed of an (Encompass) Hospitalist, critical care nurse and respiratory therapist who provide clinical support to nursing staff.

Reasons to Call a Rapid Response:

- An acute change in
  - A heart rate <50 or >100
  - Systolic blood pressure <90
  - Respiratory rate <86or >20 breaths per minute
- Non-specific subtle changes identified by family
  - Pulse oximetry saturation <90% despite oxygen administration
  - Change in consciousness
  - Urine output < 100ml in 4 hours (excluding renal failure)
- Staff members worried about the patient

****For all RRTs called outside of the hospital, but on the campus grounds (ie. sidewalks, parking lots, etc.) and any areas that are not part of the main hospital beyond the gift shop (ie. Subway, POB, Eye Center, Fitness Center, ADC, Outpatient Rehab and Human Resources) the RRT team will respond in addition to the Melrose Park EMS.**

Gottlieb Memorial Hospital

NATIONAL PATIENT SAFETY GOALS

THE RIGHT PATIENT
Use TWO patient identifiers (Name and Date of Birth) every time you administer medications and blood, obtain blood and lab samples and do procedures. Label blood and lab samples at the bedside or chair in the presence of the patient.

Before administering a blood transfusion, identify the patient using a two -person verification process at the bedside or chair. Include the patient in this process.

All components of the Universal Protocol must be documented. Confirm with the team the correct PATIENT, SITE and PROCEDURE at each step.

1. A pre-procedure verification process is required to confirm that the required documentation, equipment and supplies are available. Verify the correct patient, site and procedure when the procedure is scheduled, during pre-admission testing, on the procedure day and when the patient is moved from the pre-procedure setting.

2. The MD marks the surgical site BEFORE all procedures when there is more than one possible location for the procedure. Actively involve the patient in the process.

3. Conduct a timeout prior to all surgeries and invasive procedures, actively involving all team members to address the following:

- Correct patient – check name and date of birth
- Correct site – marked and visible
- Correct procedure – matches the consent

EFFECTIVE COMMUNICATION
Report, read back and document all critical test results immediately.

SAFE EQUIPMENT USE
Check individual alarm signals for accurate settings, proper operation and detecting function.

SAFE MEDICATION USE
Label all medications and solutions, including water and saline, on and off the sterile field. Labeling should include:

- Drug name, strength, quantity, diluents and volume
- Expiration date when not used within 24 hrs.
- Expiration time when expiration occurs in less than 24 hrs.

Use standard protocols (EPIC order sets) to initiate and maintain anticoagulation therapy:

- Use unit-dose oral meds, pre-filled syringes or pre-mixed infusion bags. Administer heparin via pump.
- Monitor labs regularly. Obtain baseline and daily INR for all patients on warfarin therapy.
- Educate patients and families on the importance of follow-up monitoring, compliance issues, food-drug interactions and the potential for adverse drug reactions and interactions. Document the teaching in the EPIC Patient Education Module

Reconcile medications

1. On admission, document the patient's complete home medication list in EPIC. Review dose, route and frequency for accuracy of each medication.
2. When a new medication is ordered, compare against the list of current medications. Reconcile and document any discrepancies.
3. Reconcile/check/document medication list at all patient transfers and at discharge. Provide updated medication list to the patient/family and the next provider at discharge.

PREVENT INFECTIONS
Perform Hand Hygiene with antiseptic hand gel or with soap and water for 15 seconds before and after any patient encounter. Use soap and water if visibly soiled or when caring for a patient with Clostridium difficile (C.diff).

Prevent infections from multiple-drug resistant organisms (MRSA, VRE, C. diff, and gram-negative bacteria).
- Wash your hands and use appropriate PPE - gloves, masks, gowns.
- Strictly follow isolation guidelines.

Prevent central line/PICC line infections by following protocols for line insertion and maintenance.

- Insertion: Use insertion checklist, standardized supply kit, maximum sterile barrier, chlorhexidine antiseptic for skin prep, apply BioPatch® disk and swab cap to every port. The subclavian site is preferred.
- Maintenance: Disinfect catheter hubs and injection ports with alcohol swab prior to access. Assess and document use of BioPatch disk with dressing changes.
- Removal: Evaluate need for catheter daily; remove nonessential catheters.

Prevent catheter-associated urinary tract infections by using evidence-based practices and Decath Protocol.

Insertion: Use aseptic technique for site preparation, Foley insertion, equipment, supplies and urine sample collection.

Maintenance: Minimize urinary catheter use and duration. Change only if clinically indicated by infection, obstruction, etc. Maintain the sterility of the collection system. Ensure that the catheter is secure, free flowing and the bag is below the bladder and off the floor. Perform Foley catheter care daily.

Removal: Document daily catheter assessment. Remove nonessential catheters.

Prevent surgical site infections by administering the appropriate antibiotic within 60 minutes of surgical incision; discontinue antibiotics within 24 hrs. of surgery end time (48 hrs. for cardiac surgery).

- ALWAYS use clippers if hair removal is needed— DO NOT use razors.
- Use active warming measures to maintain normal patient temperatures.
- Maintain normal glucose levels in cardiac surgery patients.

Report signs and symptoms of surgical site infection to the Department of Infection Prevention and Control 708-216-3654.

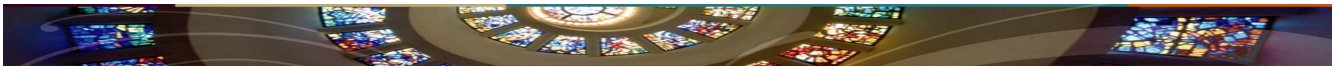
PATIENT ASSESSMENT/EDUCATION
Educate patients and families on infection prevention strategies and document instructions.

Identify patients at risk for suicide and address immediate safety needs. Provide resources for crisis (National Suicide Prevention Hotline: 1-800-273-TALK (8255).

Address home safety risks for patients on oxygen therapy.

Educate patients and families to share their concerns related to quality and safety issues. "Talk to your caregiver and/or call 708-327-SAFE."

Guiding Behaviors



We support each other in serving our patients and communities

- Build collaborative relationships within and across boundaries and levels
- Demonstrate a passion for understanding how to be of service to external and internal customers/constituents, and act accordingly
- Actions are consistent with words publicly and privately
- Make decisions in the interests of the larger community (UEM), not just own function, organization or area
- Once a decision is made, support it publicly and privately
- Focus on the things that unite us (Mission, goals, service), rather than on our differences

We communicate openly, honestly, respectfully and directly

- Listen respectfully to others and value their contribution
- Willingly express point of view directly "in the meeting, not in the hall"
- Communicate respectfully – whether in agreement or disagreement
- Create an environment which values diverse points of view and experience
- Foster an environment of openness without fear of reprisal

We are fully present

- Set aside distractions to be present
- Seek first to understand, then be understood
- Openly appreciate the gifts and contributions of others
- Create a health balance between personal and professional life
- Contribute to a positive, optimistic and fun environment

We are all accountable

- Focus on finding solutions, not blame
- Lead by positive, motivating example
- Accept responsibility for his or her decisions and actions
- Hold self accountable for the success of the larger organizations – across boundaries
- Focus on the high payoff items
- Follow through on commitments

We trust and assume goodness in intentions

- Talk directly to an individual when there is a concern or problem, avoid triangle conversations or hidden agenda
- Assume positive intentions in one another
- Act in a way that earns trust and fosters an environment of trust
- Listen to people and really hear what they mean without being dismissive or defensive
- Build trust through open communication throughout the organization

We are continuous learners

- Consistently demonstrate openness to new possibilities
- Listen with an open mind
- Challenge “the way; it has always been done”
- Provide and accept coaching and feedback
- Encourage new ideas and people to try new ways of getting the job done
- Demonstrate genuine curiosity before judging

LOYOLA MEDICINE Gottlieb Memorial Hospital

Resource List for Employees and Physicians

Reporting Suspected Violations or Patient Safety/Quality of Care Concerns

If you know of or suspect a violation in our hospital's standards of conduct or have concerns with patient safety or quality of care, please contact the appropriate resource from the table listed below. If your concerns are not met, you also are encouraged to contact the hospital's President, Vice President, CMO, Medical Staff department chair or the Integrity Line at (866) 477-4661 without fear of retribution.

Topic/Area of Concern	Contact/Phone Number
Organizational Integrity Examples include billing and coding concerns, conflict of interest, Standards of Conduct concerns, etc.	**Chief Integrity Officer** John Hart Ext. 68351 **Integrity Hotline** (866) 477-4661
HIPAA Release of confidential information, concerns about patient privacy, access to computerized records, etc.	**John Hart** Chief Integrity Officer 708-216-8351 **Chris Yu** Regional Security Officer 734-343-3469
Infection Prevention Ideas to improve infection control processes in your work area or concerns about practice patterns that are inconsistent with current infection control policies.	**Infection Prevention & Control** LUMC: 708-216-3654 GMH: 708-538-5121 MacNeal: 708-783-3389
Environment of Care Ideas to improve work safety in your area or equipment concerns, hazardous materials, and/or staff safety concerns.	**Scott Ando** Interim Regional Director, Public Safety 708-216-4038
Customer Service Physician/hospital staff quality of practice concerns, patient and family complaints, ideas to improve patient care.	**Jeff Kunkel** Manager, Pt Relations LUMC and GMH 708-216-4909
Patient Safety/Risk Management Reporting of adverse events and near misses, patient safety concerns, ideas to improve patient safety.	**Jeff Kunkel** Interim Director, Patient Safety 708-216-4909
Human Resources Discrimination; sexual harassment; labor law violations	**Dianne Zimmerman** Regional Director, Colleague/Labor Relations 708-216-9410

Patient and employee safety concerns that cannot be resolved through the hospital can be reported to The Joint Commission online at the jointcommission.org, by fax to 630-792-5636, or by mail to: Office of Quality and Patient Safety, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL.

CULTURE

Mission

"We Treat the Human Spirit"

The Mission of Loyola Medicine at Gottlieb Memorial Hospital and its affiliated programs is to provide interrelated health programs that will meet the health-care needs of the community to enable people to function at their optimal level. The goal of Gottlieb is to provide coordinated services humanely, effectively, efficiently, and with recognized excellence through collaborative action and the interdependent efforts of our professional and volunteer staff.

Gottlieb is proud of its not-for-profit mission to provide quality health care to all people who need it regardless of ability to pay. Gottlieb will treat all people equitably and with dignity and compassion.

Loyola University Health System/Trinity Values

Our work as a system is guided by our shared, corporate values:

- **Reverence:** We honor the sacredness and dignity of the person.
- **Commitment to the Poor:** We stand with and sever those are poor, especially the most vulnerable.
- **Justice:** We foster right relationships to promote the common good, including the sustainability of the Earth.
- **Stewardship:** We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted in our care.
- **Integrity:** We are faithful to who we say we are.

[3]Just Culture

"A Fair and Just Culture is one that learns and improves by openly identifying and examining its own weaknesses. Organizations with a Just Culture are as willing to expose areas of weakness as they are to display areas of excellence. Of critical importance is that caregivers feel that they are supported and safe when voicing concerns individuals know, and are able to articulate, that they may speak safely on issues regarding their own actions or those in the environment around them. They feel safe and emotionally comfortable while busily occupied in a work environment, able and expected to perform at peak capacity, but able at any moment to admit weakness, concern, or inability, and able to seek assistance when concerned that the quality and safety of the care being delivered is threatened."

[4]Culture of Safety

"The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures."

[5]Provider Impact on High Patient Satisfaction Scores

Press Ganey (a national recognized expert on patient experience and satisfaction) conducted research on attributes of physicians with very high patient satisfaction scores. The following attributes were identified as having significant impact on patient satisfaction:

- Focused on teaching and explanations
- Conveys warmth from the start
- Well planned flow of visit(s) with focus on patient's agenda
- Controlled script with clear part
- Extremely personable-connects with every patient
- Always looking for buy-in from the patient that they fully understand
- Recap the history: "I read your chart…"
- Confident but not arrogant
- Finished dictation and coding each day
- Has clinic staff enter orders and prepare after visit summary

COMMUNICATION—APPROPRIATE PHYSICIAN HANDOFFS

Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety. Effective clinician-to-clinician communication is important to facilitate continuity of care, eliminate preventative errors, and provide a safe patient environment. Communication should be complete, clear, concise, and timely.

One vital and critical communication event is the patient handoff. A handoff may be described as the transfer of patient information and knowledge, along with the authority and responsibility, from one clinician or team off clinicians to another clinician or team of clinicians during transitions of care across the continuum. A handoff may office, during the transfer of care in any several circumstances, including but not limited to the following:

- From one on-call physician to another
- From the office physician to the hospital physician or vice-versa
- From the generalist to the specialist
- From the emergency physician to the inpatient attending, consultant, or intensivist
- From the anesthesiologist to the intensivist
- Between the attending physician and the resident
- Between the attending physician and nursing staff.

Properly executed handoffs are interactive and include the opportunity for questions and answers. Every important aspect of the patient's condition and circumstance must be accurately communicated and acknowledged from one party to the other for a safe and effective handoff to occur. It should include an opportunity to ask questions, clarify, and confirm the information being transmitted. Communication at the time of the handoff should result in a clear understanding by each clinician about who is responsible for which aspects of the patient's care.

- E-mail may constitute an appropriate form of the handoff, if receipt is acknowledge by the recipient.
- Voice mail or other unacknowledged messages, however, do not constitute an acceptable form of handoff.

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