



WELLSPAN®

York Hospital

**NEW PHYSICIAN /APC
MEDICAL STAFF
ORIENTATION MATERIALS**

Our Mission: Working as one to improve health through exceptional care for all, lifelong wellness, and healthy communities



pix2002 www.fotosearch.com

Table of Contents

Contents	Page
Forward	3
Our Values	4
Medical Staff Overview	6
• Medical Staff Bylaws	6
• Medical Staff Rules & Regulations	6
• Credentials Policy & Procedure Manual	6
• Fair Hearing Plan	6
• Disruptive Practitioner Policy	6
• Code of Conduct	6
• Moderate Sedation Documents	6
• Aggressive Behavior Policy	6
• Risk Management COBRA EMTALA Policy	6
• Peer Review Policy	6
Regulatory Compliance (ACT 13/52)	7
Risk Management COBRA EMTALA Policy	7
Center for Exceptional Care (CEC)	8
• Patient Experience	9
• Patient Safety- National Patient Safety Goals (NPSG's)	12
• Performance Improvement	16
• Quality Improvement	17
• Human Resources	19
Ethics/Cultural Diversity	20
Coding & Documentation	21
Disease Specific Information	23
• Sepsis	24
• Trauma	26
• Stroke	28
• Weight Management Program	33
Antimicrobial ordering, dispensing, administration, and monitoring	34
Waived Testing	36
Patient Safety-Restraint and Seclusion	39
Emergency Response	45
Hospital Acquired infection reduction-CLABSI, MRSA, SSI, CAUTI Prevention	53
Pain Management and Opioid Abuse Awareness	85
Hospice Care-Ensuring patient comfort and dignity at end of life	90
Gift of Life-Organ Procurement	91

Forward

Welcome to York Hospital new physician or APC! We warmly welcome you to the Wellspan Family. The purpose of these orientation materials is to clearly identify our mission, values, and culture in support of quality patient centered safe care. Our goal is for you to work in harmony with our operational mission to provide clinically advanced regional hospital and health services offered in a healing and learning environment and coordinated within a comprehensive system of care. It is our hope that you fully commit to being engaged and work cooperatively and professionally with each other and all other hospital employees to this end.

Our goal is to utilize the Just Culture model in concert with our Human Resources and Patient Safety policies and procedures during investigation and management of adverse patient events and other undesirable outcomes (unsatisfactory customer service experiences, employee conflicts, harm to the organization's reputation, etc.) and ensure that we effectively manage both system design and staff behavioral choices. The term "Just" in this model infers that staff will be treated consistently and fairly, and just as management is accountable for system design, staff members are accountable for their choices. Just Culture is a means to design safe systems, manage behavioral choices, and create a learning culture, while ensuring an open, fair, culture.

Please know that we value our Medical Staff members and look forward to working with you to align your area of expertise with our mission, vision and goals.

Our Values



CARE FOR ALL

Everyone deserves essential care delivered in an exceptional manner regardless of race, gender, ethnicity, sexual orientation, age, economic status, or ability to pay

PATIENT AND FAMILY CENTERED

We believe fulfilling our promise to those who entrust their lives and the lives of their loved ones to our care is our highest priority. We consider the patient first in all that we do and work in partnership with the patient and family members they choose to involve in their care. We collaborate with patients and families to improve the delivery of care and service.

WORKING AS ONE

We work as one across professional, organizational boundaries and with patients and communities. We do this by collaborating, coordinating, and sharing expertise, information and resources to meet the needs of those we serve. While our people are highly valued for their individual talents and contributions, we recognize that working together will allow us to improve health more effectively than any one of us working alone.

RESPECT

We honor the dignity and diversity of our patients and communities by treating everyone we serve and work with the way we would want to be treated—with courtesy, compassion and respect.

INTEGRITY

We earn the trust and confidence of the individuals and communities that we serve by doing what's right; acting transparently and honestly; protecting patient and the spirit of all applicable laws, regulations and professional



Our Values

CONTINUOUS LEARNING

As a learning organization, we innovate, seek out and share best practices and adopt new ways of transforming the delivery of health care to make a difference in the lives of our patients. As individuals and teams, we are committed to continuously improving and applying our skills and knowledge.

STEWARDSHIP

We take seriously our responsibility to be good stewards of the resources entrusted to our care. Our constant focus on being an operationally excellent, financially strong and strategically focused organization enables us to control costs, to provide exceptional care, to be the employer of choice, to provide charitable community services and to be a strong health care organization for future generations.

Medical Staff Overview



Medical Staff Bylaws
Medical Staff Rules & Regulations
Credentials Policy & Procedure Manual
Fair Hearing Plan
Disruptive Practitioner Policy
Code of Conduct
Moderate Sedation Documents

Can be accessed via the link below:

<http://www.wellspan.org/for-medical-professionals/physicians/medical-staff-documentation/>

Aggressive Behavior Policy

<https://portals.wellspan.org/sites/yhadmin/Manual%20of%20Administrative%20Policy/316%20-%20Workplace%20Violence%20Response%20Team%2016.pdf>

Policy	Policy Number
Risk Management COBRA EMTALA POLICY	508
Peer Review Policy	621

Access Both Below:

<https://portals.wellspan.org/sites/yhadmin/default.aspx>



Regulatory Compliance (Act 13 & 52)

MCare Act/Act 13



Event Report Types to report to DOH and/or Patient Safety Authority:

- Infrastructure failure or discontinuation of a service
 - An undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety (includes elopements)
- Incident
 - An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care service to the patient.
- Serious Event (Patient Safety Officer to be notified within 24 hours of occurrence)
 - An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.
 - Disclosure required

ACT 52 - MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT - Reduction and Prevention of Health Care-Associated Infection and Long-Term Care Nursing Facilities

Act 52 of 2007 requires certain healthcare facilities in Pennsylvania to report healthcare-associated infections to the Pennsylvania Department of Health, the Pennsylvania Healthcare Cost Containment Council and the Pennsylvania Patient Safety Authority through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) for hospitals Pennsylvania Patient Safety Reporting System (PA-PSRS) an electronic reporting system for nursing homes. The Act is part of the Governor's "Prescription for Pennsylvania" plan to reduce and eliminate healthcare associated infections.

CENTER FOR EXCEPTIONAL CARE TEAM (CEC)

Collaborative approach in which we assist with ensuring that the vision, purpose, guiding principles, related to stewardship, patient experience, quality, safety and exceptional patient care are incorporated by the team by employing engaged employees and utilizing Lean Performance Improvement tools to accomplish goals.



CENTER FOR EXCEPTIONAL CARE TEAM-FOCUS AREAS

Patient Experience

WellSpan Health Patient Experience Definition:

The sum of all interactions, shaped by the patient’s injury or disease process and the organization’s culture that influence patient perceptions across the continuum of care.

WellSpan Health Patient Experience Strategy:

Reduce anxiety so we can effectively communicate and transfer knowledge, which will result in better clinical outcomes, improved safety, and optimize patient engagement.

Aligning Our Behaviors to Clinical Outcomes Examples:

Behavior	Impact	Clinical Outcome
Sit at eye level	<ul style="list-style-type: none"> • Patient perceives more time is spent with them • Increased confidence in physician/APC • Demonstrates active listening 	<ul style="list-style-type: none"> • Decreased anxiety • Transfer of knowledge <ul style="list-style-type: none"> ○ Increased patient understanding ○ Plan to be followed as intended • Increased likelihood of following care plan.
Provide explanations in clear, non-clinical language	<ul style="list-style-type: none"> • Patient understands plan of care and • Trust 	
Acknowledge and empathize with patient’s feelings	<ul style="list-style-type: none"> • Increased confidence • Partnership • Trust 	
Manage up your colleagues	<ul style="list-style-type: none"> • Builds confidence/trust in team • Partnership 	

Physician Communication Best Practice Behaviors:

1. Calling the patient by their first name
2. Introduce yourself with name, role and experience, as appropriate
3. Suit at eye level with the patient and maintain good eye contact
4. Acknowledge others in the room

5. Invite the patient to include his/her primary support person
6. Demonstrate that you are familiar with the patient's medical history
7. Explain what you will be doing, why and how long it will take
8. Provide explanations in clear, non-clinical language
9. Explain to the patient that you are taking notes to capture accurate information
10. Acknowledge and empathize with patients' feelings
11. Use the teach-back method to check for patient's understanding of the information you have provided
12. Look for non-verbal cues such as sighing, frowning, blank looks that indicate uneasiness, nervousness, confusion and fear
13. Manage up your colleagues to the patient
14. Ask "What questions can I answer? I have the time."

Measurement:

HCAHPS Physician Communication Composite:

1. During your hospital stay, how often did you doctors treat you with courtesy and respect?
2. During your hospital stay, how often did your doctors listen to you carefully?
3. During your hospital stay, how often did you doctors explain things in a way that was easy to understand?

Coaching and Data Support:

Beth Rosborough, BSW
Manager, Patient Experience
brosborough@wellspan.org
717-851-3873



What to expect; progressive support:

- Exploration of need, explanation, education (15 mins)
- Preparatory data analysis (as needed)
- Office meeting (assess knowledge, write AIM statement, practice techniques—1 hour)
- Field study (approx. 4 hours shadowing, coaching after each patient encounter)

Patient Safety

PHILOSOPHY/PURPOSE

- Quality and Patient Safety are *everyone's* responsibility
- To improve quality and patient safety, a culture of safety needs to develop which leads to preventing and reducing healthcare errors that result in decreasing patient injury
- Culture of Safety is about:
 - Creating an open and fair culture
 - Creating a learning culture
 - Designing safe systems
 - Managing behavioral choices

EXPECTATIONS

- Look for risks around yourself
- Report errors and hazards
- Help design safe systems
- Make safe choices
 - Follow procedures
 - Make choices that align with organizational values
 - Never sign for something that was not done

Patient Safety History

- 1999 Institute of Medicine Report (IOM)
- PA Legislature
 - Medical Care Availability & Reduction of Error Act of 2002 (MCare Act/Act 13)
 - Health Care-Associated Infection & Prevention Act (Act 52 of 2007)
- The Joint Commission (TJC)
 - National Patient Safety Goals (initiated in 2003)
- PA Department of Health (DOH)
 - Chapter 51.3 Notification
- Patient Safety and Quality Improvement Act of 2005
 - First Federal law passed addressing patient safety – voluntary
- Accountable Care Act
 - Requires participation in a Patient Safety Organization by 2017



CMS Healthcare Acquired Conditions (HAC) Preventable Events for Non-Payment

- Air embolism
- Blood incompatibility
- Foley catheter associated urinary tract infection
- Vascular catheter associated blood stream infection
- Falls with injury and trauma
- Foreign object retained after surgery
- Surgical site infection – mediastinitis after CABG, select orthopedic procedures and cardiac implantable electronic devices
- Stage 3 and 4 pressure ulcers
- Venous thromboembolism (VTE) after hip/knee replacement
- Poor glycemic control
- Pneumothorax with venous catheterization

“Never Events” for Non-Payment

- Surgical Events such as surgery performed on wrong patient, wrong body part, wrong procedure
- Product/Device Events such as death or serious disability related to use of a device, function of a device
- Patient Protective Events such as infant discharged to wrong person, death or serious disability related to patient elopement

“Never Events” for Non-Payment

- Care Management Events such as patient death or serious disability associated with medication error, related to failure to identify and treat hyperbilirubinemia in neonates
- Environmental Events such as death or serious disability related to use of restraints or bedrails, death or serious disability related to a burn incurred from any source
- Criminal Events such as care by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider, abduction of a patient of any age

Reporting Safety and Quality Concerns

- Employees are encouraged to discuss concerns about safety or quality of care with supervisors or the Patient Safety Officer
- However, employees who have concerns about safety or quality of care provided at the WSYH may report these concerns to:
 - Department of Health (DOH) at 1-800-254-5164
 - The Joint Commission (TJC) at 1-800-994-6610
- WSYH will take no discriminatory action because an employee reports safety or quality of care concerns to the DOH or TJC



2018 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

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 the patient 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.

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.



This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

This data is monitored.

Contact Information:

Holly Ricke, BSN, RN
Director Patient Safety/Patient Safety Officer
717-812-2247



Performance Improvement



Our Vision is to seek excellence through 15,000 aligned, engaged problem solvers

- We get there by transforming the culture of the organization through Lean thinking to empower the people to improve the processes that impact patient care
- The elements of Lean thinking include the Lean Daily Management System (LDMS), Strategy Deployment, Visual Management, A3 Problem Solving, and other Lean methodologies
- LDMS is 10 tools that forms the system for improving the way we engage staff and teams to improve patient and family experience
- York Hospital has 6 PI resources that are assigned to support all the surgical, procedural, nursing, and clinical support areas within the hospital
- Our primary work is LDMS implementation, project support, and Lean Leader Training

York Hospital – Performance Improvement Team

What We Do: Support improvement projects, implementation of WellSpan's Lean Daily Management System (LDMS), and provide Lean training

The Team: Srinath Asuri, Dave Miller, Janet Miller, Bill Plappert, and John Young

How We're Are Aligned: Every clinical area has a PI Specialist dedicated to that area to support project work, LDMS, and training

2017, WellSpan Health, All Rights Reserved



4

Contact Information:

Bryan Taylor
Manager of Performance Improvement
717-812-4074

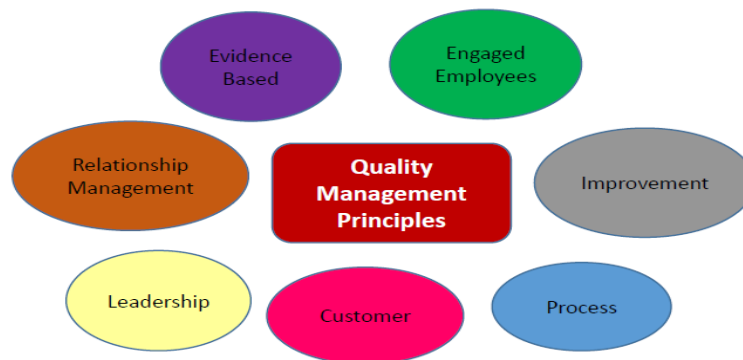


Quality Improvement



Culture of Quality

Leading innovative change strategies that lead to improved patient outcomes, better overall system performance, and improved professional development of the team. How? By using engaged team members to create highly reliable processes that are proactively monitored, analyzed, improved, and sustained.



High Reliability
Expectations
of All Process
Changes

- *No Single Points of Failure with Any Step in the Process*
- *Every Process has a Double Check*
- *Each Process Must have a Check and Balance*
- *All Processes Must have KPI to Measure Success*
- *Every Process Should be Audited*

System and Local Quality Improvement Groups

- Clinical Effectiveness Teams (CET)
Local multidisciplinary disease specific teams that utilized evidence based medicine research to determine best care for patients and lead to improvements for the system.
 - Local subgroups- implement the recommendations and develop communication and sustainability methods to hardwire best practice at the local level.
- Accountability Model
Purpose: To establish a standard, easy to use WellSpan Health accountability model for the elevation and reporting awareness of identified deficiencies in quality reporting, when measures do not meet performance goals.

Public and Regulatory Reporting

- The Quality Improvement department support improvement efforts related and not limited to the Joint Commission, CMS and other quality reporting agencies. This can include Core measures, readmission, complication, length of stay, and mortality reduction efforts.
- The public has access to our performance in these key areas via the website below:
 - <http://www.hospitalcompare.hhs.gov>

Link to system quality improvement initiatives and performance

- Metrics Dashboard

<http://edwrs2/ReportServer/Pages/ReportViewer.aspx?%2fProd%2fReports%2fMetrics%2fDashboardsIndex&rs:Command=Render>

Contact Information:

Tabetha Green, BBA
Director of Quality Improvement
717-812-6719



Human Resources



Your voice matters and we want to hear from you! Your knowledge, skill and dedication are foundational to our ability to provide the very best care for our communities!

- Employee Engagement initiatives.
 - Including an Employee Engagement survey
- Consult on strategic initiatives to meet organizational goals.
- Provides general HR consulting services to operational leaders.
- Ensures compliance with regulatory and legal requirements related to HR activities.
- Oversight of Employee Relations for designated areas of responsibility.

Contact Information:

Kim Wakefield
Regional Director Human Resources
717-851-2290



ETHICS/Cultural Diversity

Ethics

- Ethical Issues
 - Ethics Committee
 - Review policies and procedures with ethical impact
 - Review proposed research
 - Provides advice on requested patient care issues
 - Consultation may be obtained by contacting a member of the Ethics Committee through a department manager, nursing supervisor or Quality & Risk Management Department



Organ Donation

- Gift of Life (GOL) is designated Organ Procurement Organization (OPO)
- Northeast PA Lion's Eye Bank – for eye donation (coordinated through GOL)
- Must notify OPO if death imminent or patient has died
 - Guidelines for imminent death noted in Organ Donation and Procurement policy PC-24
- Consent process: GOL makes initial contact with family
- Important to use discretion and sensitivity



Please feel free to contact **Drs. Bruce Bushwick** bbushwick@wellspan.org or **David Emrhein** demrhein@wellspan.org should you have an ethical concern.

Link to Ethical Diversity Education

<https://portals.wellspan.org/sites/MedicalGroupKnowledgeCenter/Meeting%20Minutes/BUG-RUG%20Meetings/2013/06-12-2013/11%20Interpersonal%20Cultural%20Competence%20Booklet.pdf>

Coding & Documentation



Assistance with the coding and query process can be located on the physician learning home dashboard in Epic

CDI and Coding Query Guides


- v **CDI Query**
 Answering a CDI Query
 Wellspan Physician Pocket Guide
- v **Coding Query**
 Answer a Coding Query

- ❖ **HEART FAILURE:** Always document if it is acute, chronic, or acute on chronic (exacerbation). Always document if it is systolic, diastolic, or systolic and diastolic.
 - o Systolic: can't pump; EF < 40%; HFrEF
 - o Diastolic: can't fill; EF > 50%; HFpEF**Cardiogenic pulmonary edema = heart failure**
- ❖ **SYMPTOMS:** State suspected, likely, or probable cause of symptoms
- ❖ **RESPIRATORY FAILURE:** Document physical findings (working of breathing, pursed lip breathing, accessory muscle use, cyanosis, tripod position) to support diagnosis
 - o Mechanical vent not required, but if patient is on a vent, most likely in acute respiratory failure!
 - o pH<7.35, pH>7.45, pO2<60, CO2>50 RR>28, SaO2 <88
 - o Patient weaning normally
 - o Acute Post-op Pulmonary Insufficiency should be considered in those with respiratory comorbidities
- ❖ **SIRS/SEPSIS/SEVERE SEPSIS/SEPTIC SHOCK:**
 - **SIRS** criteria:
 - o T>100.9 or < 96.8
 - o WBC >12000 or <4000
 - o HR >90
 - o RR > 20
 - **Sepsis** = 2 SIRS due to infection
 - **Bacteremia** = nonspecific lab finding
 - **Severe sepsis** = sepsis with one or more organ failure (must link sepsis and the organ failure)**Organ failure includes:** AKI, acute respiratory failure, critical illness myopathy/polymyopathy, DIC, encephalopathy, hepatic failure, lactic acidosis, or septic shock
 - **Septic shock** = severe sepsis with hypoperfusion not corrected by fluid resuscitation/requiring vasopressors OR Initial Lactic Acid ≥4

- ❖ **Urosepsis** = Does not code to any diagnosis!

- ❖ **RENAL FUNCTION: Document CKD Stage**
 - o CKD = kidney damage or GFR < 60 x 3+ months

Stage I	Kidney damage with normal kidney function	GFR > 90
Stage II	Mildly decreased kidney function	GFR 60-89
Stage III	Moderately decreased kidney function	GFR 30-59
Stage IV	Severely decreased kidney function	GFR 15-29
Stage V	Failure	GFR < 15
ESRD	Requiring long term hemodialysis therapy	GFR < 15
- ❖ **RENAL FAILURE:** Renal insufficiency lacks specificity. Compare current renal function to baseline function in a patient with CKD. If you document *acute renal insufficiency/ARI* when your patient is in acute renal failure, you will not capture severity of illness!
 - o Use the AKIN criteria for acute kidney injury
 - ☞ Increased serum Cr by 0.3 mg/dl over baseline OR
 - ☞ Increased serum Cr by 50% over baseline OR
 - ☞ Reduction in urine output (oliguria) <0.5mL/kg/hr x 6 hours
 - o **Acute Kidney Injury and Acute Renal Failure** can be documented interchangeably.
 - o **Acute Tubular Necrosis** can be toxic (cells exposed to nephrotoxic substances) or ischemic (due to hypotension). Consider this if renal function fails to improve after fluid challenge.



CLINICAL DOCUMENTATION IMPROVEMENT

Gaylynn 812-5796, Debbie 812-5794, Melissa 356-4077,
 Lisa 812-5979, Eileen 812-6958, Leah 812-5998,
 Athena 356-4079, Crystal 812-5999, & Vicky 812-6961
 Manager: Amy Gerhart 812-5795

- o Always document the reason for admission, including possible or suspected diagnoses
- o Always document if the diagnosis is confirmed, resolved, ruled out, or suspected/possible/likely, etc.
- o Always carry through valid diagnoses to the discharge summary
- o Always document all conditions that affect the patient's care or length of stay, including chronic conditions for which medications have been ordered
- o Always document the clinical significance of any abnormal labs, radiology reports, and pathology findings
- o Always document adherence to 2-Midnight Rule, core measures and quality standards

- ❖ **PRESENT ON ADMISSION (POA):**
 - o Ulcers: identify type, laterality, location, & stage
 - o Sepsis if identified after study and not noted on admission
 - o Catheter-associated UTI, central line associated bloodstream infection
 - o Deep vein thrombosis
 - o If currently treating a condition, document it as current and not just "history of"
- ❖ **LINK!!**
 - o Link conditions to underlying cause
 - o Link infections to organisms

Neurology	
Instead of...	think about documenting...
Altered mental status	<ul style="list-style-type: none"> Encephalopathy (septic, toxic, metabolic, etc.) Drug-induced delirium Delirium with dementia with (specified) behavior
Mass effect	<ul style="list-style-type: none"> Cerebral edema Brain compression
TIA	<ul style="list-style-type: none"> Cerebral thrombus/embolus without infarct
Stroke	<ul style="list-style-type: none"> Acuity: acute vs. old Location, vessel, and laterality Cause: hemorrhagic, embolic, thrombosis, stenosis, occlusion Deficits Dominant side
Cardiology	
Instead of...	think about documenting...
CHF	<ul style="list-style-type: none"> Acute, Chronic, or Decompensated Systolic, Diastolic, or Combined OR HFpEF or HFrEF
ACS	<ul style="list-style-type: none"> NSTEMI or STEMI Unstable angina
Cardiomyopathy	<ul style="list-style-type: none"> If there is a component of heart failure Cause: medication, ETOH, ischemia
Troponin leak	<ul style="list-style-type: none"> NSTEMI/STEMI Demand ischemia
Chest Pain or Syncope	<ul style="list-style-type: none"> Suspected or known cause
Accelerated HTN/ HTN Urgency	<ul style="list-style-type: none"> Hypertensive emergency Hypertensive crisis

Pulmonary	
Instead of...	think about documenting....
Respiratory distress/hypoxia/SOB	<ul style="list-style-type: none"> Respiratory failure (specify acute or chronic), with or without hypoxia/hypercapnia
HCAP	<ul style="list-style-type: none"> Gram negative organism Aspiration
Pulmonary edema	<ul style="list-style-type: none"> Acute pulmonary edema If cardiogenic, document heart failure (see heart failure tips)
GI/GU	
Instead of...	think about documenting...
Urosepsis	<ul style="list-style-type: none"> Sepsis due to UTI UTI (if no sepsis)
Renal insufficiency/ ARI	<ul style="list-style-type: none"> ARF/AKI (if acute) CKD with stage (if chronic)
+ UA	<ul style="list-style-type: none"> UTI and causative organism Infection d/t (specified) genitourinary device
GI bleed	<ul style="list-style-type: none"> GI bleed linked to specific cause
Colitis	<ul style="list-style-type: none"> Acute ischemic colitis C. diff colitis/enteritis
Metabolic	
Instead of...	think about documenting...
Cachexia, wt loss, muscle wasting	<ul style="list-style-type: none"> Malnutrition – mild, moderate or severe Underweight if BMI < 19
IDDM or NIDDM Uncontrolled diabetes	<ul style="list-style-type: none"> Type 1 or type 2 With hyperglycemia or hypoglycemia Link DM and osteomyelitis
Fluid overload	<ul style="list-style-type: none"> See Heart Failure tips Link with HD noncompliance Acute Pulmonary Edema

Integumentary	
Instead of...	think about documenting...
I&D	<ul style="list-style-type: none"> Debridement: Excisional or non-excisional Instruments used, tissue description, wound size, & deepest layer debrided
Pressure ulcer	<ul style="list-style-type: none"> Location, stage, and laterality
Hepatobiliary	
Instead of...	think about documenting...
Obstructive jaundice	<ul style="list-style-type: none"> Bile duct obstruction
Hepatitis	<ul style="list-style-type: none"> Type and acuity
Hematology/Oncology	
Instead of...	think about documenting...
Pancytopenia	<ul style="list-style-type: none"> Pancytopenia d/t medication/chemo
Anemia	<ul style="list-style-type: none"> Anemia of acute/chronic blood loss Anemia due to chemotherapy Anemia of CKD Anemia of (specified) chronic disease Anemia due to (specified) nutritional deficit
A few last words:	
<p>POA! For <u>all</u> non-chronic diagnoses, state if suspected to be POA if noted after admission</p> <p>Acuity! EVERY diagnosis should be described as <u>acute, chronic, or acute on chronic</u>, if known.</p> <p>Laterality! If it can be described as left, right, bilateral, or midline please do so.</p> <p>Specificity! If a site can be described down to a more exact location, please do so. If a condition can be described with more details, please do so.</p> <p>Thanks!</p>	

Disease Specific Program Information

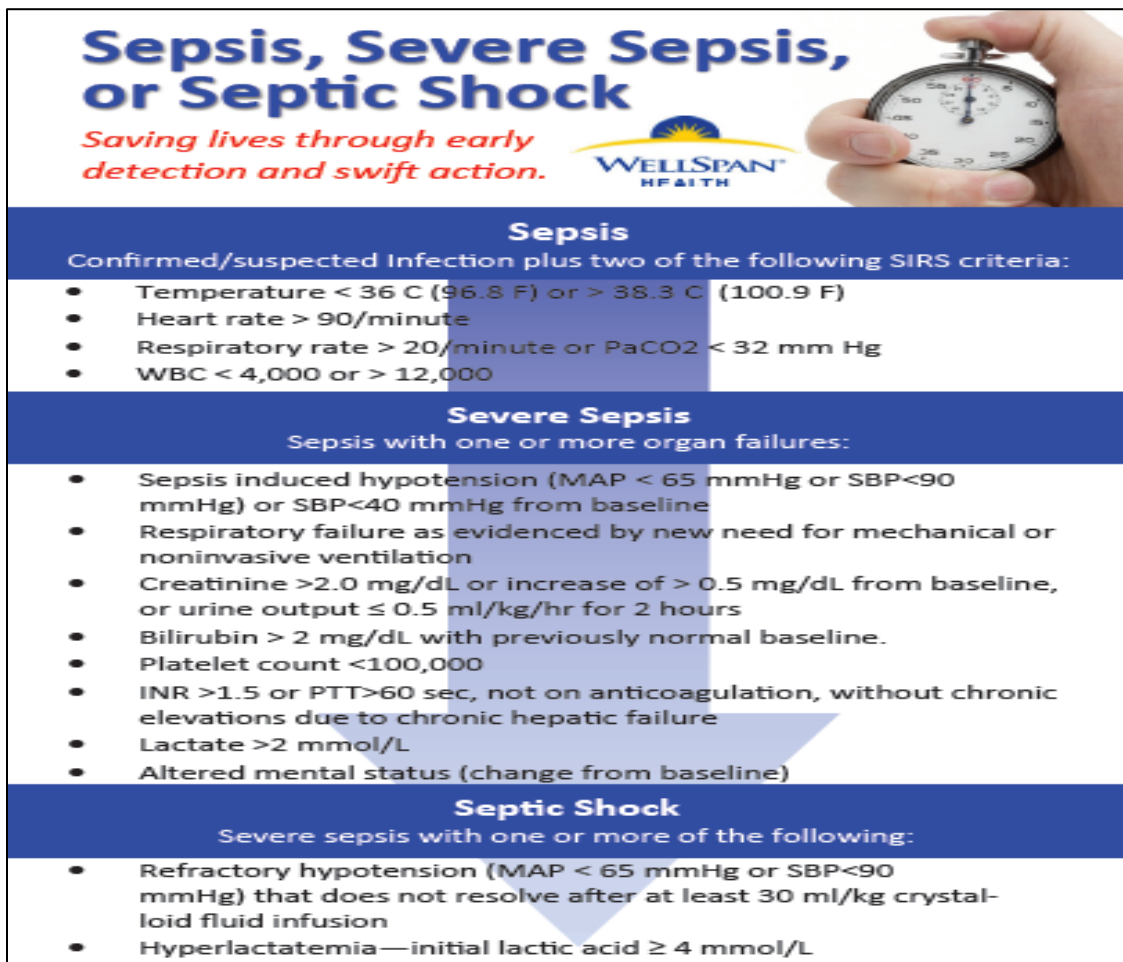
Sepsis

Currently a three year “Wildly Important Goal” (WIG) designed around reducing sepsis mortality beginning in FY 2018.

Improve the clinical reliability of the sepsis care we provide our patients by improving consistency and standardization of care using best practices of treatment. Through consistent implementation of three core strategies, achieve incremental progression in FY 18 of at least 50% toward the target of sepsis mortality rates that are at or below the expected O:E of 1.0, using the Premier Select Comparative Group (top 16% of Premier clients) for the nationally top performing.

Achieving a consistent O:E ratio less than 1.0 will result in over 160 less deaths/year.

Sepsis Definitions and Bundle Metrics



Sepsis, Severe Sepsis, or Septic Shock
Saving lives through early detection and swift action.

WELLSPAN
HFAITH

Sepsis
Confirmed/suspected Infection plus two of the following SIRS criteria:

- Temperature $< 36\text{ C}$ (96.8 F) or $> 38.3\text{ C}$ (100.9 F)
- Heart rate > 90 /minute
- Respiratory rate > 20 /minute or $\text{PaCO}_2 < 32$ mm Hg
- WBC $< 4,000$ or $> 12,000$

Severe Sepsis
Sepsis with one or more organ failures:

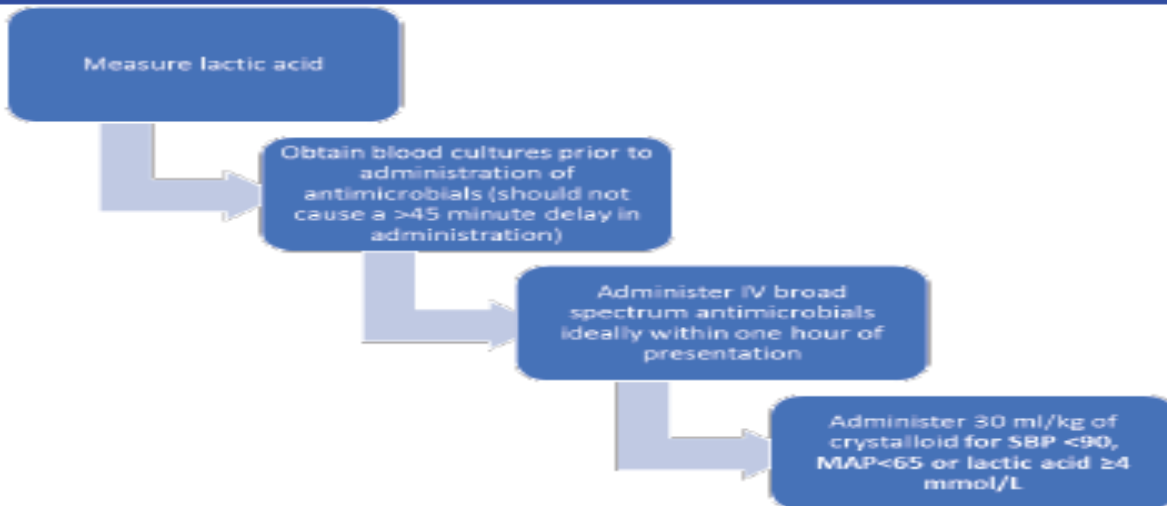
- Sepsis induced hypotension (MAP < 65 mmHg or SBP <90 mmHg) or SBP <40 mmHg from baseline
- Respiratory failure as evidenced by new need for mechanical or noninvasive ventilation
- Creatinine >2.0 mg/dL or increase of > 0.5 mg/dL from baseline, or urine output ≤ 0.5 ml/kg/hr for 2 hours
- Bilirubin > 2 mg/dL with previously normal baseline.
- Platelet count $<100,000$
- INR >1.5 or PTT >60 sec, not on anticoagulation, without chronic elevations due to chronic hepatic failure
- Lactate >2 mmol/L
- Altered mental status (change from baseline)

Septic Shock
Severe sepsis with one or more of the following:

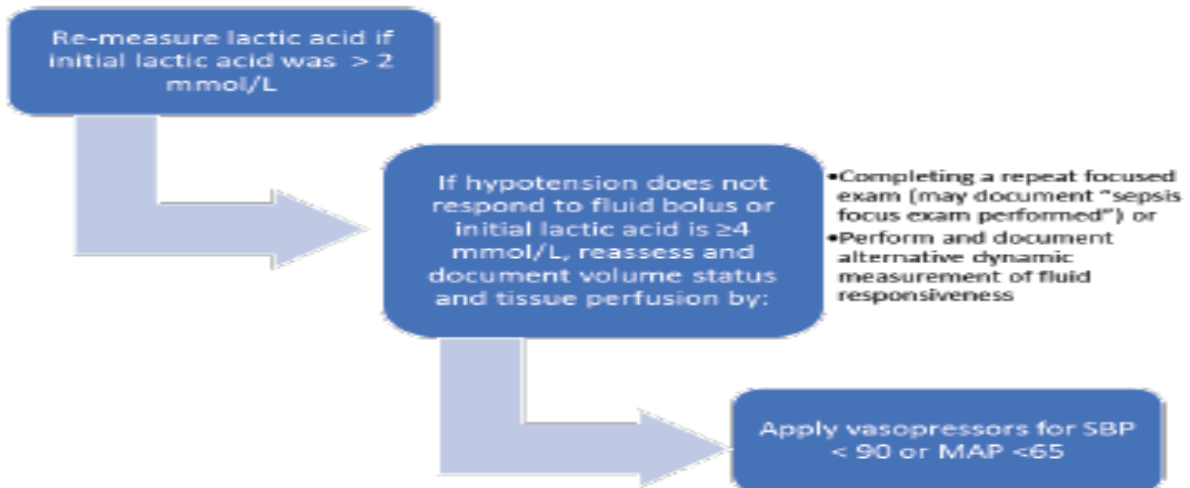
- Refractory hypotension (MAP < 65 mmHg or SBP <90 mmHg) that does not resolve after at least 30 ml/kg crystalloid fluid infusion
- Hyperlactatemia—initial lactic acid ≥ 4 mmol/L

Sepsis Resuscitation Bundle

To be Completed Within 3 Hours



To be Completed Within 6 Hours



Current performance with key leading measures can be accessed via the link below:

<http://edwrs2/ReportServer/Pages/ReportViewer.aspx?/Prod/Reports/Metrics/MetricsDashboard&rs:Command=Render&Dashboard=18>

Sepsis Tools-Virtual Sepsis Alert Notification

There is an electronic sepsis alert that fires on all patients and are monitored by virtual nurses aka Central Alert Team (CAT) who reach out to the Entity nurses to ensure that the bundle is been met and that the sepsis power plan has been initiated in a timely fashion as well as communicate with the Rapid Response Teams (RRT) during times of patient transition from the Emergency Department to the Floor.

There is a weekly report generated by Clinical Quality Improvement detailing performance with bundle metrics in a sampled population and is available by physician / APC responsible for care during the 3-6 hour period.

Sepsis WIG Bundle Summary Report-Weekly
York Hospital
CY 2017

Week Ending	3 Hour Bundle						
	Initial Lactate Level Collected 6 Hours Prior and 3 Hours following Presentation			IV Broad Spectrum ABX administered 24 Hours Prior to or 3 Hours Following Presentation			Blood C Hours Following ABX
	Num	Den	Rate	Num	Den	Rate	Num
9-Jul	22	23	95%	21	23	91%	18
16-Jul	20	21	95%	18	21	86%	13
23-Jul	20	20	100%	18	20	90%	19
30-Jul	14	15	93%	15	15	100%	13
12 Week Rate	76	79	96%	72	79	100%	63

Trauma

Trauma Center FAST FACTS



What is a Level 1 Trauma Center?

Level I Trauma Center – Highest level of Trauma Centers

A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation – including the following services:

- 24-hour in-house coverage by general surgeons and prompt availability of care
- Referral resource for communities in nearby regions
- Provide leadership in prevention, and public education to community
- Programs for substance abuse
- Operate organized teaching and research efforts to help direct new innovations in trauma care
- Meets minimum volume requirement for annual patients observed

What brings a person to a Trauma Center?

Trauma refers to a serious or critical bodily injury. Some types of these injuries include:

- Serious Falls (Most common at WellSpan York Hospital)
- Traumatic Car Crash Injuries (Second most common)
- Gunshot Wounds
- Blunt Trauma
- Stab Wounds
- Major Burns
- Traumatic Brain Injuries

WellSpan York Hospital Specifics

- Trauma 1 Level designation achieved in 2008
- Serves Patients in York, Adams, and Franklin counties in Pennsylvania and upper parts of Baltimore, Carroll and Fredrick counties in Maryland.
- 2,127 patients treated in 2015
- 2,200 patients treated in 2016
- Trauma Team was ranked among the Nation's highest in exceeding expectations in TQIP (Trauma Quality Improvement Program) data for mortality, complications and length of stay.

Community Outreach

Programs designed to educate and meet the needs of the surrounding communities

Matter of Balance:

- Inform and assess fall risks for older adults in community. 100+ adults assessed for risk falls in 2016.

Distracted Drivers:

- Educate on the dangers of distracted driving; namely texting while driving. Over 3,000 downloads of safe driving phone app.

Professional Education:

- Educate and train 200+ healthcare and medical professionals in various trauma topics annually.

Peer Visitor and Support Program:

- Individuals, as well as those close to someone who has suffered a trauma, are able to meet with people that have had similar experiences.



Trauma Research at York Hospital

WellSpan York Hospital has published over 20 articles in the past 3 years.

Publication Sources:

- American College of Surgeons
- American Surgeon
- Journal of Head Trauma and Rehabilitation
- Journal of Trauma Nursing
- Journal of Orthopedic Trauma
- Journal of Emergency Nursing
- Journal of Trauma

Trauma Research Topics:

- A Crew Resource Management Program Tailored to Trauma Resuscitation Improves Team Behavior and Communication
- The Impact of Seatbelt use and airbag deployment on blunt aortic injury
- Does Mechanism Injury Play a Role in Recovery from Concussion?
- Impact of Nursing Education by a Pharmacist on Sedation Practice in a Trauma Surgical Intensive Care Unit (ICU)
- Semi-extended intramedullary nailing of the tibia using a suprapatellar approach
- Bath Salt Abuse: More Than Just Hot Water
- Timing and type of surgical treatment of Clostridium difficile-associated disease

Program Process Improvement

Trauma Leadership Weekly Meeting Topics:

- Evaluate Transfers
- Quality Issues
- Medical Admissions for Traumatic Diagnosis
- System Concerns

Noteworthy cases or areas for improvement are referred to appropriate services or Trauma Services Multidisciplinary Peer Review.

Outcomes Include:

- Education
- Referral to Hospital Quality Assurance Programs
- Guideline Development

Lean Process Improvement Project:

- Transfers in of trauma patients from referring hospitals

Recent Awards

- Gift of Life – Platinum Status
- Drexel University – Teaching Award
- Community Health – Nursing Educator



Stroke

WellSpan York Hospital Stroke Program Mission Statement, Scope of Service, Program Design and Leadership Team

Mission Statement

The WellSpan Health York Hospital Stroke Program is dedicated to working as one, providing the safest and most efficient quality of health care to people with stroke- through patient care, service excellence, educational pre-eminence, and new knowledge and innovation.

The program is designed, implemented, and evaluated collaboratively by all Stroke team members.

The WellSpan Health York Hospital Stroke Program is committed to emergency stroke treatment, stroke prevention and secondary stroke risk reduction.

The target population of the WellSpan Health York Hospital Stroke Program is adult focused. The mean age for stroke is 71.5 years. The gender population for stroke reflects males at 50% and females at 50%. The program is designed to rapidly diagnose, provide emergent treatment, and manage patients with stroke 24 hours a day, seven days a week.

The WellSpan Health York Hospital Stroke Program utilizes six stroke specific clinical practice guidelines from the American Heart/American Stroke Association:

- 2018 Guidelines for the Treatment of Acute Ischemic Stroke
- 2015 Focused Update of the 2013 Guidelines for the Early Management of Patients with Acute Ischemic Stroke Regarding Endovascular Treatment
- 2015 Guidelines for the Treatment of Acute Hemorrhagic Stroke
- 2015 Scientific Rationale for the Inclusion and Exclusion Criteria for Tissue Plasminogen Activator
- 2016 Telemedicine Quality and Outcomes in Stroke
- 2012 Guidelines for Subarachnoid Hemorrhage

The program's focus is on the following domains of stroke care:

- Prehospital Care
- Urgent Care Assessment
- Acute Care
- Risk Factor Reduction
- Secondary Prevention
- Stroke Education
- Research
- Rehabilitation
- Reintegration into the community
- Community Education

Telestroke

The WellSpan Health York Hospital Stroke Program serves as the distant site for Telestroke services. There are currently 4 partner hospitals participating in the program: Gettysburg Hospital, Waynesboro Hospital (Summit Health), Chambersburg Hospital (Summit Health) and York Hospital (off hours).

WellSpan Health York Hospital Stroke Program Goals:

- Rapid identification, triage and treatment of acute stroke
- Consistently meet or exceed the standard to administer tissue plasminogen activator in less than 60 minutes; with an ultimate goal of achieving administration in less than 45 minutes
- Effective prevention of complications
- Aggressive secondary prevention of stroke
- Create individualized patient education, plans of care and discharge plans
- Optimize patient outcomes
- Follow-up Stroke Clinic

Patient Types Treated within the WellSpan Health York Hospital Stroke Program:

1. Small and Large vessel ischemic strokes

- ICU level of care
- Mechanical Endovascular Reperfusion Therapy
- Administration of IV and IA Tissue Plasminogen Activator
- Systemic disease with multi-organ involvement
- High ICP
- Cryptogenic etiology

2. Intracerebral Hemorrhage

- ICU level of care
- Neurosurgical interventions
- Maximization of medical management
- Hemicraniectomy

3. Subarachnoid Hemorrhage

- ICU level care
- Endovascular and neurosurgical therapies (coil and clipping for aneurysm)
- Vasospasm treatments

Advanced imaging capabilities

1. Carotid duplex imaging
2. Catheter angiography
3. CTA

4. MRA
5. MRI
6. TCD
7. TEE
8. TTE

Post hospital care and coordination for stroke patients is available from services provided by: Case Management, Social Services, Palliative Care, Hospice Care, VNA Home Care, Primary Care Provider Practices and Subspecialty Provider Practices including a Multidisciplinary Stroke Clinic.

The Medical Surgical Intensive Care unit has dedicated beds to treat complex stroke patients. An Intensivist Model is utilized to care for, and monitor this patient population. There is a neurology attending on call 24/7.

Tower Three is designated as the preferred unit for patients with stroke. A Hospitalist Model is utilized to care for, and monitor this patient population. Structured Multidisciplinary Bedside Rounding occurs daily (SIBR), and includes the patient and family in planning and decision making. Multidisciplinary Stroke Rounds also occur 4 times per week and include Neurology, Hospitalist provider, Med-Res provider, Therapy representation, Nursing (Stroke Program Coordinators), and WSRH Rehabilitation Liaison.

Leadership Team

Robert Sterling M.D. Medical Director WellSpan Health Stroke Program Medical Director
Catherine Spahr MBA, MA, BSN, RN WellSpan Health Stroke Program Director
Lori Clark VP Neuroscience Service Line
Grant Sorkin M.D. Endovascular Neurosurgery
Leslie Walter BSN, RN Program Coordinator
Judy Failing BSN, RN Program Coordinator

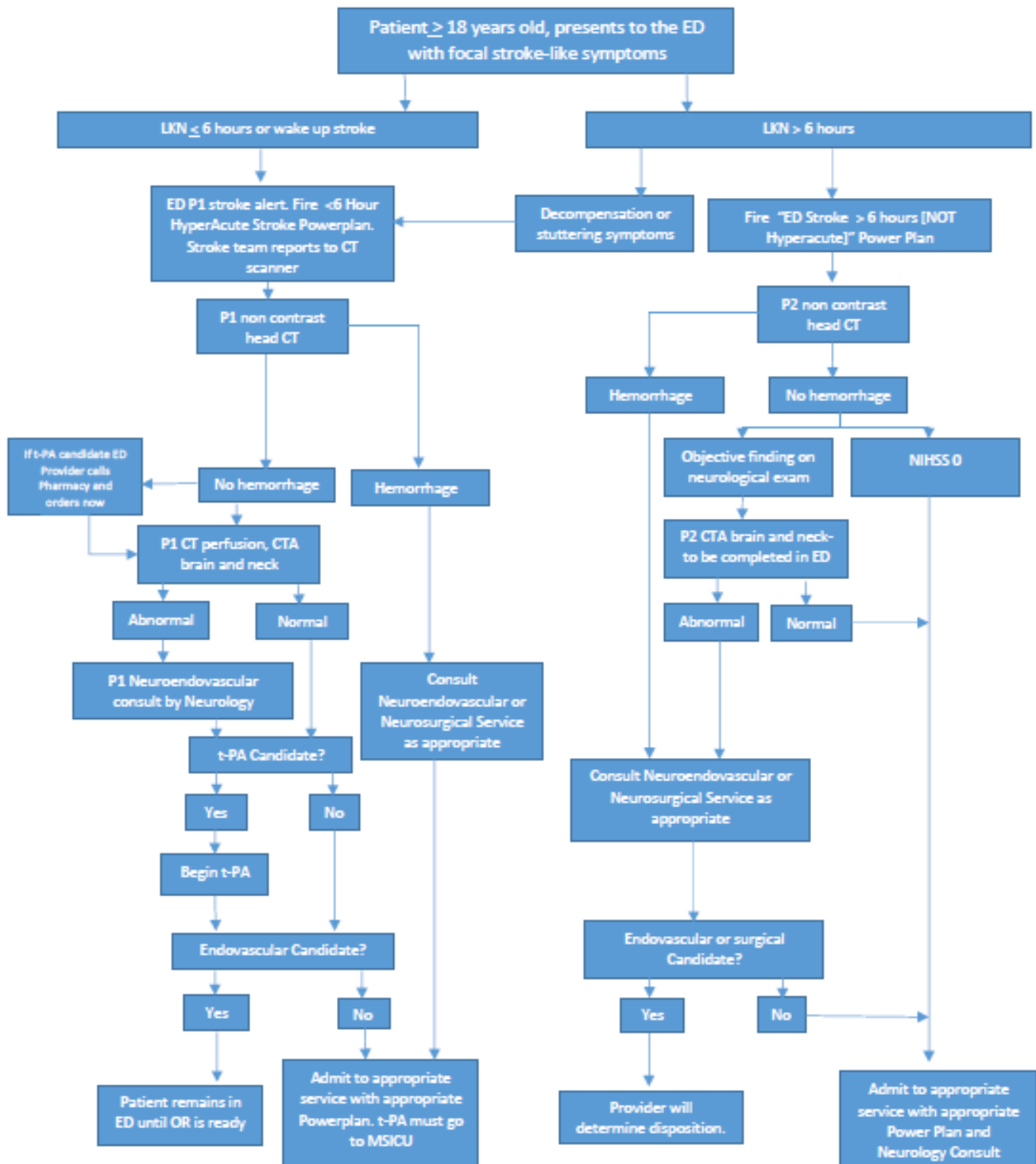
Inpatient Neurology Stroke Team

Robert Sterling M.D.
John Mingle M.D.
Robert Reif M.D.
Debra Kanya CRNP

Endovascular Neurosurgery Team

Grant Sorkin M.D.
John Shank CRNP
Jillian Krebs CRNP

WellSpan York Hospital Hospital HyperAcute Stroke Algorithm



Revised:
5/19/2016
9/20/2016

Comprehensive Stroke Center at York Hospital

Leslie Walter, BSN, RN
Stroke Program Coordinator
lwalter@wellspan.org
851-5860

Judy Failing, BSN, RN
Stroke Program Coordinator
jfailing@wellspan.org
812-3095



Clinical Practice Guidelines

AHA/ASA Guideline

2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Reviewed for evidence-based integrity and endorsed by the American Association of Neurological Surgeons and Congress of Neurological Surgeons

Endorsed by the Society for Academic Emergency Medicine

AHA/ASA Guideline

Guidelines for the Management of Spontaneous Intracerebral Hemorrhage

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists.

Endorsed by the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the Neurocritical Care Society

AHA/ASA Guideline

Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

The American Academy of Neurology affirms the value of this statement as an educational tool for neurologists.

Endorsed by the American Association of Neurological Surgeons and Congress of Neurological Surgeons and by the Society of NeuroInterventional Surgery



The Joint Commission Quality Measures for Disease Specific Care Certification (CSTK)

Set Measure ID	Measure Short Name
CSTK-01	National Institutes of Health Stroke Scale (NIHSS Score Performed for Ischemic Stroke Patients)
CSTK-02	Modified Rankin Score (mRS at 90 Days)
CSTK-03	Severity Measurement Performed for SAH and ICH Patients (Overall Rate)
CSTK-04	Procoagulant Reversal Agent Initiation for Intracerebral Hemorrhage (ICH)
CSTK-05	Hemorrhagic Transformation (Overall Rate)
CSTK-06	Nimodipine Treatment Administered
CSTK-07	Median Time to Revascularization
CSTK-08	Thrombolysis in Cerebral Infarction (TICI Post-Treatment Reperfusion Grade)
CSTK-09	Arrival Time to Skin Puncture
CSTK-10	Modified Rankin Score (mRS at 90 Days: Favorable Outcome)
CSTK-11	Timeliness of Reperfusion: Arrival Time to TICI 2B or Higher
CSTK-12	Timeliness of Reperfusion: Skin Puncture to TICI 2B or Higher



Stroke Order Sets in Epic

- **Rationale:** Standardized order set improve adherence to best practices for treatment of patients with stroke
- **Recommendation:** The use of standardized stroke care order sets is recommended to improve general management (Class 1; Level of Evidence B)
- **In practice:** Order Sets were created with prechecked fields to enhance adherence to standards of care and avoid core measure fallouts
- **Order Sets:**
 - Stroke-Ischemic/Transient Ischemic Attack (TIA)
 - Stroke Ischemic Thrombolytics-tPA
 - Intracerebral Hemorrhage
 - Subarachnoid Hemorrhage
 - Post Carotid Stenting

Jauch, Edward et al.,2013: Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke 915-918.



Weight Management Program



The WellSpan Weight Management Program uses a staged approach to treating overweight and obesity.

Stage 1: Prevention

In this stage, the focus is slowing or reversing a year over year increase in the patient's BMI. Patients with yearly increasing BMI, approaching 25 would be counseling by the primary care provider on healthy eating, exercise, and lifestyle habits. The goal for this stage is the avoidance of further weight gain.

Stage 2: Structured Weight Management in Primary Care

In this stage, the focus is on identifying patients with BMI's between 25-35, with or without obesity related co-morbidities. There are several WellSpan program the primary care provider can refer the patient to: WellFit, A Healthy You, Healthy Living (a WellSpan Medical Weight Management Program embedded within the PCP's office). The goal for this stage is weight loss of 5% of the starting body weight and improvement in health target within 6 months.

Stage 3: Comprehensive Multidisciplinary Intervention / Medical Weight Management

In this stage, the focus is for adult patients with a BMI > 30 with or without obesity related co-morbidities. This intensive medical weight management program uses a multidisciplinary team approach: customized meal planning, meal replacements and/or FDA approved weight loss medications. This is a 24-week curriculum-based approach to weight management, immediately followed by a maintenance program. The goal for this stage is weight loss of 10% of starting body weight and sufficient improvement of health targets within 6 months.

There is also a pediatric program, which approaches weight loss in a similar model, but also including the involvement of the patients' caregiver and over a 13-week curriculum followed by a maintenance program.

Stage 4: Surgical, Tertiary Care Intervention*

In this stage, the focus is for adult patients with a BMI \geq 35 with T2DM*, HTN, hyperlipidemia, cardiomyopathy, OSA, pseudotumor cerebri, obesity-related hypoventilation, arthropathy of spine or weight bearing joints, or hepatic steatosis OR BMI \geq 40. This program is directed by the bariatric surgeon, where the patients follow a bariatric surgery protocol for 3-6 months prior to surgery. The protocol includes evaluations by pulmonology, behavioral health, cardiology (as needed) and intensive patient education. The goal for this stage is loss of 60% of excess body weight. The bariatric surgeons follow these patients for their lifetime.

* Based on national treatment algorithms, it is recommended that bariatric surgery is considered as an early treatment for obese type 2 diabetic patient with poor glycemic control.

Pharmacy Services and Resources

Antimicrobial Stewardship Pharmacist – (717) 851-7946

Available Monday through Friday 7:00-15:30

The Antimicrobial Stewardship (AMS) pharmacist utilizes a monitoring tool to identify patients who may be eligible for antimicrobial intervention including drug-bug mismatches, antimicrobial de-escalation, or duration of therapy recommendations. When an antimicrobial recommendation is available for a patient, the covering physician is paged. Difficult cases are reviewed with an infectious disease physician.

Our Antimicrobial Stewardship Pharmacy team works closely with infectious disease physicians and microbiology to provide an [Annual Antibiogram and Empiric Antimicrobial Recommendations](#)

Pain Management Team – (717) 812-7889

New consults accepted Monday through Friday prior to 14:00. Consults will be completed within 24 hours and those placed after 14:00 will be seen on the next business day.

Clinical pharmacists on the Pain Management Team (PMT) are responsible for hospital-wide pain management consultation, with a focus on acute pain in high-risk patients. The PMT may be consulted for the management of pain or analgesic-related adverse effects. When consulting the PMT, the physician has the option of requesting recommendations only or full pharmacy management via the pain management protocol.

A [Pain Management Reference Card](#) includes information on pain assessment, non-pharmacologic therapies, analgesic use and dosing, side effect management, and opioid conversions.

Pharmacokinetics Consult Services

Pharmacists utilize a Pharmacy and Therapeutics committee (P&T) protocol to automatically adjust vancomycin and aminoglycoside orders on all adult and pediatric patients. Pharmacists adjust doses and order serum creatinine and drug levels as clinically appropriate. All medication changes are documented in the patient's chart. While not automatic, providers may consult a pharmacist to manage and adjust phenytoin dosages by using the pharmacy consult order.

Warfarin Consult Service

Warfarin management can be performed by a pharmacist through a P&T approved protocol. This requires a pharmacy consult, which can be done by selecting “Warfarin (Coumadin) – RX to manage daily” in the orders. With every pharmacy consult, the clinical pharmacists will enter daily warfarin orders, provide patient education if patient is new to warfarin, and perform a transition of care document upon discharge.

Total Parenteral Nutrition (TPN) Consult Services

Deadline for new consults – 11:00 daily

TPN management can be performed by a pharmacist through a P&T approved protocol. This requires a pharmacy consult, which can be ordered through the TPN order set. A nutrition consult is required on all TPNs. With every pharmacy consult, the clinical pharmacist will manage the daily ordering of TPNs as well as electrolyte replacements as necessary.

Renal Adjustments

Pharmacists utilize a P&T protocol to automatically adjust approved renally-eliminated medications. All medication changes are documented in the patient’s chart. Pharmacists also monitor other non-automatic medications and will contact the provider to recommend a change when warranted.

IV to PO Conversion

Pharmacists utilize a P&T protocol to automatically change orders from IV to PO for patients meeting appropriate criteria on approved medications including antimicrobials, gastrointestinal agents, and anti-seizure medications.

Useful Resources

Drug Reference database links:

- [Clinical Pharmacology](#)
- [Micomedex](#)
- [York Hospital IV Guidelines](#)
- [Natural Medicines](#)

Perioperative medication management recommendations (Pre-Hospital Assessment)

- [Perioperative Medication Recommendations](#)
- [Interventional Radiology Medication Recommendations](#)

WAIVED TESTING

All facilities in the United States that perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Waived tests include test systems cleared by the FDA for home use and those tests approved for waiver under the CLIA criteria. Although CLIA requires that waived tests must be simple and have a low risk for erroneous results, this does not mean that waived tests are completely error-proof. Errors can occur anywhere in the testing process, particularly when the manufacturer's instructions are not followed and when testing personnel are not familiar with all aspects of the test system.

Some waived tests have potential for serious health impacts if performed incorrectly. For example, results from waived tests can be used to adjust medication dosages, such as prothrombin time testing in patients undergoing anticoagulant therapy and glucose monitoring in diabetics. In addition, erroneous results from diagnostic tests, such as those for human immunodeficiency virus (HIV) antibody, can have unintended consequences. To decrease the risk of erroneous results, the test needs to be performed correctly, by trained personnel and in an environment where good laboratory practices are followed.

All laboratory testing performed in York Hospital is licensed through the Laboratory under the responsibility of the Laboratory Medical Director. The only Provider-Performed CLIA-Waived tests performed at York Hospital are fecal occult blood (limited to the Emergency Room) and body fluid pH (limited to Labor and Delivery).

Fecal Occult Blood Testing (Inpatient) to be Performed ONLY BY LAB



EFFECTIVE June 3, 2019, all Point of Care fecal occult blood (FOB) testing will be removed from the inpatient units at YH, GH and WSRH. All inpatient FOB testing will be performed on specimens sent to the Main Lab at all hospitals.

This change will assure that all test results are documented and appear as a lab test result in EPIC. The testing performed by the laboratory will meet all of the regulatory and accreditation

standards.

EXCEPTION: The Emergency Departments at YH and GH which will continue to be managed as a POC location performing this test. The nursing staff and physicians performing the test and documenting the results will be held to all the applicable standards and regulations.

How do we order this test in EPIC?

- **Physicians will order “Fecal Occult Blood Screen” which generates 3 labels. Note that this test was originally designed for the 3-card Hemoccult guaiac test.**
- **Nursing staff will collect a stool specimen and label the cup with Specimen #1 Label. The Extra two labels will be placed in the pouch of the Biohazard bag.**
- **Send specimen to the lab.**
- **Lab techs will process the specimen and result the associated Performance Monitors and lot numbers of the test card and developer.**
- **Results will be available in EPIC as a Laboratory result.**

This process mirrors that currently in place at both Ephrata and Good Samaritan Hospitals, and standardizes our process across all WellSpan Hospitals.

Restraint Education for Medical Affairs

WellSpan Health Restraint Policy

<https://portals.wellspan.org/sites/wsnursing/System%20Policies/System%20Policies/Practice%20and%20Quality/SYS-PQ%20Restraint%20Policy.pdf>

Physicians and other Licensed Independent Practitioners must have a working knowledge of the policy regarding the use of restraint and seclusion. The following slides highlight additional information required by regulatory and accrediting bodies.

WellSpan's Philosophy

- WellSpan uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
- Patient's rights, dignity, and well-being will be supported and maintained.
- Restraint or seclusion may not be used as punishment, discipline, staff retaliation, means of coercion, for staff convenience, as a substitute for inadequate staffing or other inappropriate reasons such as solely based upon previous restraint necessity or a history of dangerous behavior.

Strategies

A comprehensive patient assessment must be conducted to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion.

Possible Considerations:

Hypoxia, Hypercarbia
Medication side effects
Delirium
Hallucinations
Substance withdraw

Alternatives/ Least Restrictive Measures

If the situation is not emergent, appropriate restraint alternatives must be attempted or determined to be ineffective before restraints are initiated.

Personal alarms, bed alarms, and low beds

Reorientation or redirection

Distraction and diversional activities, such as folding/sorting activities, magazines, puzzles, music, TV, drawing/coloring

Frequent observation and reminders, moving patient close to the nurse's station

Asking a family member to stay with the patient

Move to a quiet area

Explaining procedures

Encourage physical exercise

Toileting needs addressed

De-escalation

Criteria

- The patient is removing/attempting to remove invasive tubes/catheters that have been identified as integral to the patient's treatment plan. (non-violent)

- Agitation or concerns for safety where the patient's behavior interferes with medical care or healing. (non-violent)

- The patient's present behavior or ideation has the potential to inflict bodily harm to self or others. (violent/self-destructive)

Orders

**see policy for other ordering requirements

- Centers for Medicare & Medicaid Services (CMS) require a physician or licensed independent practitioner (LIP) to order a restraint **prior to (or at the time) of application.**
- In emergency situations, the order must be obtained either during the emergency application of the restraint or **immediately** after (defined by CMS as **“within a few minutes”**) the restraint was applied.
- Orders **MUST** never be written as a standing order or on an as needed basis (PRN).

Face to Face

- A face-to-face evaluation must occur within one (1) hour of initiation of restraint or seclusion for patients with violent self-destructive behavior.
- Documentation of the in-person evaluation includes an evaluation of the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and behavioral condition and the need to continue or terminate the restraint or seclusion.

Discontinuation of Restraints

- Restraints are discontinued at the earliest possible time.
- Restraints may be discontinued by an RN, physician, or licensed independent practitioner.
- Termination of restraint should occur when behavior has improved to the point that alternative measures can be used.
- Examples of criteria for release:
 - Ability to cooperate/ follow instructions
 - Reduction/resolution of the behavior that warranted restraints

Potential Physical Complications Related to Restraint Use

- Abrasions, bruises, dislocations, contusions, numbness, tingling, fracture, and muscle strain
- Prone position increases risk of restraint-related asphyxia
- Supine position without elevating head of bed increases risk of aspiration
- Prolonged restraint and struggling may lead to hyperthermia, lactic acidosis, elevated creatinine kinase levels, DVT.

Potential
Psychological
Complications
Related to Restraint
Use

- Distress and Anxiety
- Fear
- Loss of control
- Flashbacks
- Vulnerability
- Loss of therapeutic rapport with staff
- Humiliation

Debriefing is a key strategy to prevent further psychological complications!!!

Emergency Preparedness

Part of WellSpanYork Hospital's Commitment to Serve The Community

Emergency Management
Dave Michaels, Team Leader

What Hazards do We Face ?



Fire



Roles of Staff

All staff members are required to complete personal safety training during new employee orientation that includes fire safety training. All staff members are required to complete annual area specific fire safety training. The records of this training are maintained by WellSpan Health Organizational Learning & Development.

Staff members have responsibilities in a fire emergency that are defined by where they are located at the time of the emergency.

Roles of Licensed Independent Practitioners (LIPs)

Licensed Independent Practitioners (LIPs) will follow the direction of the charge nurse in the areas they are working.

R.A.C.E.

- RESCUE 
- ALARM 
- CONTAIN 
- EXTINGUISH or EVACUATE  

P.A.S.S.

- PULL
- AIM
- SQUEEZE
- SWEEP



• WHY?

Why are PASS and RACE important?



What actions can we take?

- Prevention - You don't have to fight fires that never start.
- Preparation - What will you do if you can't prevent it?
- Response - How will you take action?

From Fire Emergencies to all Hazards

PREPARE

Prepare Through Training



What to do in an emergency on a hospital campus?

Call the appropriate
Emergency number to
request help.

At York Hospital the number is 66

- What you will need to
know when you call?
1. What the emergency is.....
 2. Where the emergency is.....
 3. Your name
 4. Your callback number



REALITY OR
ULTRA REALITY?

York Hospital (York) - Incident #1227

12. What is the purpose of this document?

A. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

B. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

C. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

D. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

13. What is the purpose of this document?

A. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

B. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

C. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.

D. To provide a checklist for the Security Officer (SO) to use in the event of an armed intruder incident. This document is intended to provide the SO with a checklist of items to check and actions to take in the event of an armed intruder incident. It is not intended to be a substitute for training or experience.



INFANT ABDUCTION

MAN ALL DOORS

INFANT ABDUCTION

EMERGENCY

What to do when you receive a call from a parent who reports a missing child:

1. Stay calm and listen to the caller.
2. Ask for the child's name, date of birth, and last known location.
3. Ask for a description of the child and the person who took the child.
4. Ask for the name and phone number of the person who reported the missing child.
5. Ask for the name and phone number of the person who is currently with the child.
6. Ask for the name and phone number of the person who is currently with the child.
7. Ask for the name and phone number of the person who is currently with the child.
8. Ask for the name and phone number of the person who is currently with the child.
9. Ask for the name and phone number of the person who is currently with the child.
10. Ask for the name and phone number of the person who is currently with the child.

What to do when you receive a call from a parent who reports a missing child:

1. Stay calm and listen to the caller.
2. Ask for the child's name, date of birth, and last known location.
3. Ask for a description of the child and the person who took the child.
4. Ask for the name and phone number of the person who reported the missing child.
5. Ask for the name and phone number of the person who is currently with the child.
6. Ask for the name and phone number of the person who is currently with the child.
7. Ask for the name and phone number of the person who is currently with the child.
8. Ask for the name and phone number of the person who is currently with the child.
9. Ask for the name and phone number of the person who is currently with the child.
10. Ask for the name and phone number of the person who is currently with the child.

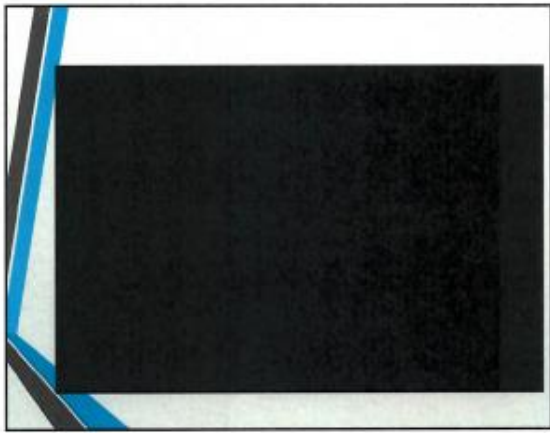
ARMED INTRUDER

Workplace Violence

York Hospital

WELLSPAN

SECURITY OFFICER



ARMED INTRUDER ACTIVATION

If you encounter an individual brandishing a weapon, immediately call:

- **911 AND YORK HOSPITAL SECURITY "851-4444" WHEN SAFE TO DO SO**
- Security will notify Telecommunications to activate **ARMED INTRUDER**
- Hospital monitors will display **ARMED INTRUDER** with location and there will be blue flashing lights at the main entrances.

ARMED INTRUDER

ATRIUM CAFE

DETAILS

Caller should give as much detail as possible:

- Location
- Number of suspects
- Physical description of suspects
- Number and type of weapons
- Injuries if any

DURING AN ARMED INTRUDER

- Quickly determine what is most reasonable to protect your own life
- Visitors are likely to follow the lead of employees and managers during an **ARMED INTRUDER**
- Make sure you understand Law Enforcements response and how you should react

Armed Intruder Responses

- Get Out / Hide / Fight
- Run / Hide / Fight
- Evacuate / Hide Out / Take Action
- Avoid / Deny / Defend

Run

Have an escape route and plan in mind.
Leave your belongings behind.
Help others (patients, visitors etc.)
escape if possible.

KEEP YOUR HANDS VISIBLE.



Hide

- ✓ Get out of view.
- ✓ Block entrances/lock
- ✓ Turn out lights/block windows.
- ✓ Stay away from doors and windows and take cover behind thick objects.
- ✓ Remain calm and quiet.
- ✓ Silence all cell phones.



Fight

This is the last resort and only when your life is in imminent danger, attempt to incapacitate or disrupt the person by:

- Acting as aggressively as possible
- Throwing items or using improvised weapons Yelling, screaming
- Being committed to your actions.



HOSTAGE SITUATIONS VS ARMED INTRUDER


A Hostage Situation is where one or more persons are holding persons against their will in exchange for some type of demands.
 At this point the hostage taker (s) have not engage in the systematic manner of killing or attempting to kill the hostages.

- Forensic Prisoners Attempting to Escape
- Psychotic persons in response to delusional thinking
- Persons unhappy with Healthcare or other Services
- Normal person under abnormal stress
- Domestic Situation
- Criminals who may use hostages as part of a criminal act
- Political Terrorists

Conclusion

- Be aware of your environment and any potential dangers.
- Any situation involving an **ARMED INTRUDER** will be trying and chaotic.
- Develop a "**SURVIVALIST MINDSET**" so you can think clearly during this incident.
- The incident may be over before Law Enforcement arrives.
- Keep your personal safety and the safety of others in mind.
- **DO NOT** hinder Law Enforcement efforts.

BE AWARE OF POTENTIAL VIOLENCE

- VERBAL CLUES - Talking about...
 - Weapons 
 - Losing Control
 - Frustration, Ultimatums, Retaliation
 - Challenging Rules and/or Authority
 - Unreasonable Demands
 - Angry mutterings to self
 - Making Threats, Shouting, Cursing

BODY LANGUAGE SIGNS



BEHAVIORS THAT MAY ESCALATE THE LIKELIHOOD OF VIOLENCE

- Speaking - Overly Official, Condescending Manner
- Failing to Provide Updates or Assurances
- Raising Your Voice, Pointing Fingers
- Ignoring Patients and/or Customers
- Failing to Listen, Being Disrespectful
- Criticizing or Lecturing
- Crowding Someone's Personal Space
- Taking Action Without Explaining the Procedure
- Turning Your Back on Someone During a Conversation
- Using Threats to Gain Compliance



IF SOMEONE SHOWS SIGNS OF LOSING CONTROL...

- Alert Staff, Supervisors and Security
- Stay Calm, Stay Alert
- Keep a Safe Distance from the Person
- Leave Yourself an Escape Path
- Be Supportive, Talk Slowly and Softly
- Avoid Physical Contact
- Offer Choices, Be Flexible
- Use Good Non Verbal Skills



Infection prevention

2018 Central Line Related Blood Stream Infection Prevention

By the Corporate Infection
Control Department

Content contained in this learning was developed by WellSpan Health for educational use by WellSpan Health employees and affiliates. The content may be shared for information purposes. However, use of this content in its entirety is not permitted.

fppt.com

Objectives

At the conclusion of this program, the participant should be able to:

- Identify outcomes associated with a hospital acquired central line associated blood stream infection (CLABSI)
- Identify risk factors for a CLABSI
- Identify strategies used to prevent CLABSI

fppt.com



Risk Factors

Risk factors associated with hospital-acquired CLABSI:

- Prolonged hospitalization before insertion of catheter
- Prolonged duration of catheter use
- Heavy microbial colonization at the insertion site
- Heavy microbial colonization of the catheter hub
- Site of choices (internal jugular has a higher risk than subclavians but femoral lines have the highest risk)
- Neutropenia
- Prematurity (NICU)
- Total parenteral nutrition
- Substandard care of the catheter (excessive manipulation of the catheter, poor technique, and so on)

fppt.com



Proper Technique to Prevent Infection

1. “Time Out” Procedure

Prior to the beginning of the procedure, a time out should be conducted per policy.

2. Use a Checklist

Use a catheter checklist to ensure adherence to infection prevention practices.

If breaches in aseptic technique are noted, the observer should stop the procedure.

fppt.com



Proper Technique to Prevent Infection

3. Do Not Enter

Keep unnecessary traffic out of the room.

Post the sign on the door.

4. Hand Hygiene

After donning mask and cap, perform hand hygiene (everyone in the room).

Use of gloves does not replace hand hygiene.

fppt.com



Proper Technique to Prevent Infection

5. Barrier Precautions (Staff)

Use maximal sterile barrier precautions during CVC insertion, PICC insertion, guide wire exchange, and arterial line insertions in the ICU setting.

A mask, cap, sterile gown, and sterile gloves are to be worn by all the healthcare personnel involved in the catheter insertion procedure.

6. Patient Cap

Place a cap on the patient.

fppt.com



Proper Technique to Prevent Infection

7. Site and Skin Prep

Subclavian site should be used when clinically feasible because it has the lowest incidence of catheter colonization and infection.

Internal jugular site has a higher incidence of catheter colonization and infection than the subclavian (but lower than the femoral) and may be chosen when subclavian access is not feasible.

Femoral is the last site chosen due to increased risk of deep vein thrombosis as well as increased risk of infection.

Use chlorhexidine-based antiseptic (ChloraPrep wand) in a back-and-forth scrubbing motion for skin prep in patients older than 2 months of age.

The antiseptic solution must be allowed to dry before making the skin puncture.

fppt.com



Proper Technique to Prevent Infection

8. Barrier Precautions (Patient) 9. Kit

Apply small drapes followed by a full-body drape on the patient.

Use an all-inclusive catheter cart or kit.

Choose a treated catheter if the patient does not have a sulfa allergy.

fppt.com



Proper Technique to Prevent Infection

10. Dressing

Once insertion is complete, apply initial dressing (gauze if oozing, transparent dressing if not).

Apply a chlorhexidine-impregnated sponge (BioPatch) at the insertion site if no contraindications.

11. Documentation

Complete required documentation **per hospital policy**.

fppt.com



Proper Technique to Prevent Infection

12. After insertion

Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter.

“Scrub the hub” with 70% alcohol and allow to dry, or use SwabCaps where available.

Change dressings and needleless adapters per hospital policy.

13. Removal

Assess the need for continued intravascular access on a daily basis and remove catheters not required for patient care.

Remove nonessential catheters using aseptic technique.

Replace administration sets not used for blood, blood products, or lipids at intervals no longer than 96 hours.

fppt.com



Proper Technique to Prevent Infection

In summary, anyone involved in the process of inserting central lines may “Stop the Line” to protect the patient from incomplete bundle usage.

Central line catheter tips should not be routinely cultured. If a central line-associated bloodstream infection is suspected, “Blood Culture Catheter Related Sepsis” should be utilized to aid in diagnosis.

fppt.com

Multi-Drug Resistant Organisms



Multi-Drug Resistant Organisms

By the Corporate Infection Prevention and Control Department

Content contained in this learning was developed by WellSpan Health for educational use by WellSpan Health employees and affiliates. The content may be shared for information purposes. However, use of this content in its entirety is not permitted.

fppt.com

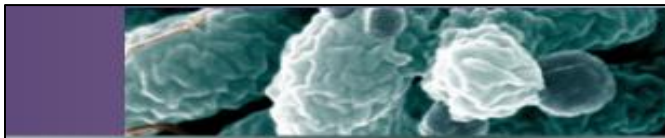


Objectives

At the conclusion of this program, the participant should be able to:

- Define a multi-drug resistant organism (MDRO).
- Describe the importance of MDROs.
- List strategies to prevent the transmission of MDROs.
- Discuss WellSpan's policy regarding criteria to place patients into Contact Precautions.

fppt.com



Introduction

Multidrug-resistant organisms (MDROs) such as MRSA, vancomycin resistant enterococcus (VRE), Clostridium difficile, and resistant gram negative bacteria are increasingly common causes of health care-acquired infections.

Interrupting the transmission of MDROs between patients in the hospital can contribute to dramatic reductions in facility rates of health care-acquired infection.

fppt.com

VANCOMYCIN-RESISTANT STAPHYLOCOCCUS AUREUS

13 CASES
IN 4 STATES SINCE 2002

THREAT LEVEL CONCERNING

This bacteria is concerning, and careful monitoring and prevention action are needed.

SOME STAPHYLOCOCCUS STRAINS ARE RESISTANT TO VANCOMYCIN
LEAVING FEW OR NO TREATMENT OPTIONS

- Rare occurrence, but serious because there are few treatment options available to these patients.
- Risk factors are prior MRSA/enterococcal infections, history of chronic conditions, and previous treatment with vancomycin.
- Pennsylvania is 1 of the 4 states where VRSA was identified.

fppt.com

VANCOMYCIN-RESISTANT ENTEROCOCCUS (VRE)

20,000 DRUG-RESISTANT ENTEROCOCCUS INFECTIONS

1,300 DEATHS FROM DRUG-RESISTANT ENTEROCOCCUS INFECTIONS

66,000 ENTEROCOCCUS INFECTIONS PER YEAR

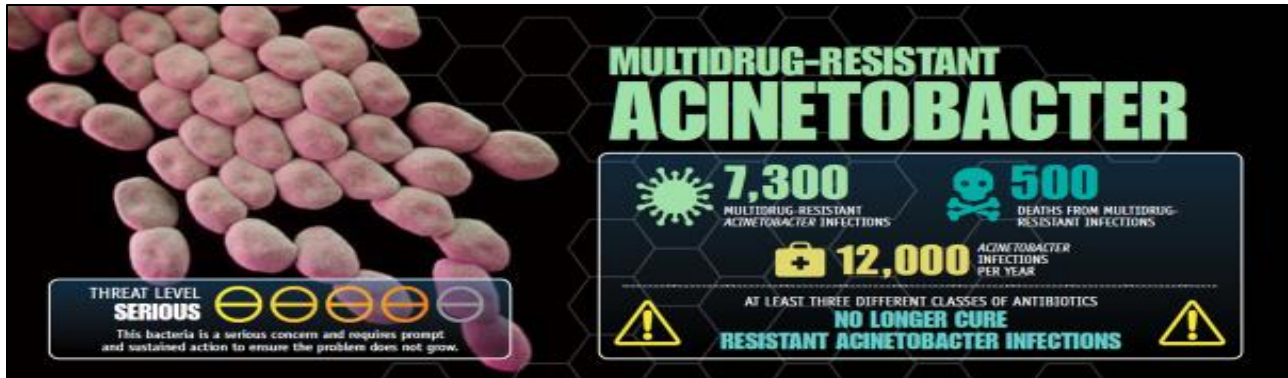
THREAT LEVEL SERIOUS

This bacteria is a serious concern and requires prompt and sustained action to ensure the problem does not grow.

SOME ENTEROCOCCUS STRAINS ARE RESISTANT TO VANCOMYCIN
LEAVING FEW OR NO TREATMENT OPTIONS

- Enterococcus are bacteria normally present in the intestines and female genital tract.
- VRE is a cause of urinary tract infections, bloodstream infections, and surgical site infections.
- Commonly acquired through contact with a healthcare setting, but also found in livestock (especially chicken).
- Patients may be screened for VRE using rectal culture.

fppt.com



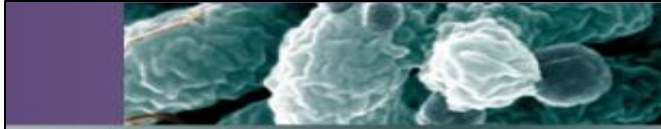
- Causes pneumonia and bloodstream infections in critically ill patients
- Can spread rapidly and be difficult to eradicate among patients on mechanical ventilation
- No screening test available

fppt.com



- “Gut bugs” that are resistant to all or nearly all antibiotics, including carbapenems, which are antibiotics of last resort.
- Half of all patients with a CRE bloodstream infection die from it.
- Screening tests currently in development.

fppt.com



Which bacteria are CREs?

- “CRE” refers to a type of antibiotic resistance, not a specific bacteria.
 - Bacteria such as Klebsiella, E. coli, and Enterobacter MAY acquire this type of resistance, making them a “CRE.”
- Issues encountered in treating CRE infections:
 - Very few antibiotics are effective.
 - Effective antibiotics have significant side effects.
 - Effective antibiotics can be prohibitively expensive.

fppl.com



Many MDROs are able to live on inanimate surfaces for prolonged periods of time.

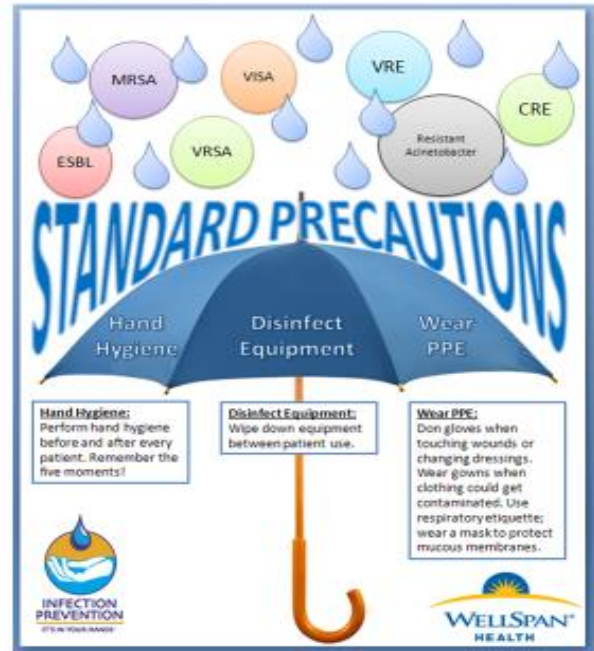
Studies have shown that health care workers' hands are just as likely to become contaminated with MDROs by touching surfaces in the rooms of colonized patients as they are by touching the skin of those patients.

fppl.com



Standard Precautions

- With the increased presence of resistant organisms that may or may not be identified, a standard of care for every interaction is crucial to prevent the spread of infection.



fppl.com



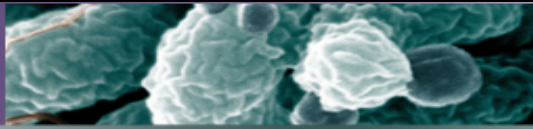
Standard Precautions

- Proper hand hygiene is the single most effective tool to reduce the risk of spreading organisms from a patient and his environment to other patients.
- WSH utilizes the World Health Organization (WHO) guidelines.
- We must insist on adherence to the 5 Moments of Hand Hygiene.

Your 5 moments for HAND HYGIENE



fppl.com



Proper Use of Personal Protective Equipment (PPE)

- Just because a patient is not on enhanced precautions doesn't mean you shouldn't wear PPE.
- Each task poses a risk and there are times PPE should be used to reduce that risk.
- Examples of when PPE should be worn with standard precautions include:
 - Changing dressings
 - Handling patients with open sores or lesions
 - Wound irrigation and debridement
 - Incontinent stool (code brown)

fppt.com



Who goes on Contact Precautions?

Clostridium difficile
Overly resistant MDROs
uNcontained wound drainage
Trach w/ increased secretions
Acute onset diarrhea
inContinent urine MDROs
Think Infection Prevention



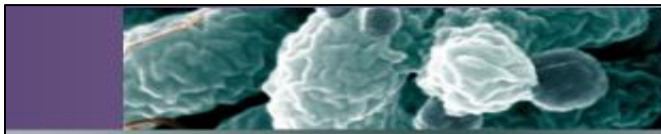
fppt.com



Clostridium difficile

- Patients suspected with or confirmed with C. diff will require contact precautions.
- Once positive, the patient must remain in precautions until cleared by a member of the Infection Prevention Team.
- Test of cure should NOT be performed for the purposes of treatment or to justify discontinuing isolation.

fppt.com



Overly resistant MDROs

- Currently, the following MDROs go into contact precautions regardless of when or where they were cultured:
 - Vancomycin Intermediate or Resistant Staph aureus (VISA/VRSA)
 - Multi-Drug Resistant Acinetobacter
 - Carbapenem-Resistant Enterobacteriaceae (CRE)

fppt.com



uNcontained wound drainage

- This can be a little tricky; what is uncontained?
- When wounds are open and draining and are not contained within a dressing (particularly when infected such as bed sores, ulcerations, and so on.), there is a risk of spread REGARDLESS of the organism.
- This is a clinical decision that needs to be made with nursing and providers.
- Please consult with the Infection Prevention Team as needed.

fppt.com



Trach w/ increased secretions

- Those patients with open trachs and/or open suctioning, that are showing increased secretions require isolation. The offending organism is not the driving factor.
- This is a clinical decision that needs to be made with nursing and providers.
- Please consult with the Infection Prevention Team as needed.

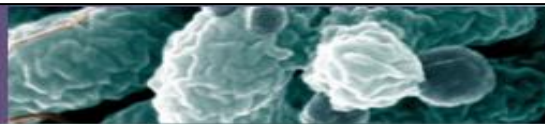
fppt.com



Acute onset diarrhea

- C. diff is not the only cause of acute diarrhea.
- Norovirus (as well as other viruses) may cause acute onset diarrhea and is highly contagious to both patients and staff.
- It is important to separate the normal “loose” stools that some patients may be prone to, from uncontained acute onset diarrhea.
- When seeing an unexplained acute onset diarrhea, place those patients on contact precautions.

fppl.com

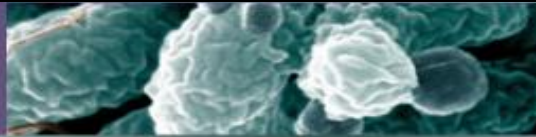


incontinent urine MDROs

For patients with a MDRO in their urine who:

- Do NOT have a Foley catheter
- Are incontinent and urine cannot be contained by a brief

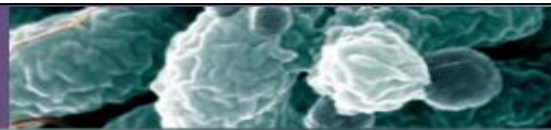
fppl.com



Think Infection Prevention

- No lab finding or algorithm can replace the critical thinking and judgment of a health care professional. There will be times that will seem appropriate to place enhanced precautions on a patient.
- The patient's team needs to be open and discuss concerns to ensure that our patients are safe.
- Anyone (nurse, physician, infection control) can initiate contact precautions.
- When in doubt, do it!

fppt.com



Contact Precautions Components

Introduction

The following steps need to be followed for any patient placed on Contact Precautions, regardless of reason for precautions.



fppt.com



Contact Precautions

- Patients in isolation must be in a private room.
- Place appropriate signage at the door.
- Door may remain open.



Signage for suspected/confirmed C diff patients



Signage for other conditions requiring contact precautions



Contact Precautions

Personal Protective Equipment (PPE)

Gowns and gloves:

- Are mandatory when entering a room.
- Must be changed after contact with material containing high concentration of microorganisms (fecal material and wound drainage).
- Must be removed before leaving the patient room.

Perform hand hygiene before and after glove removal.





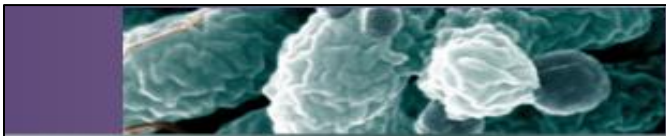
Contact Precautions

Patient Care Equipment

- Dedicate non-critical patient care equipment to a single patient.
- If common equipment is used, wipe it with antimicrobial wipes between patients per standard precautions.



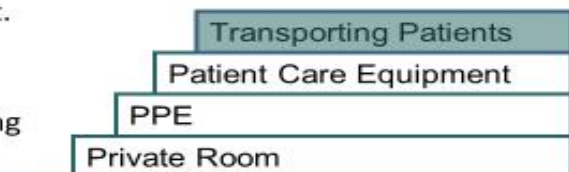
fppt.com



Contact Precautions

Transporting Patients

- Limit the need for transfer of patients on precautions.
- Wear gown and gloves when transferring a patient to a wheelchair or stretcher.
- PPE should NOT be worn in the hall when transporting a patient.
- Once patients reaches their destination, fresh gowns and gloves should be worn if handling patients.
- Notify the receiving area of the precaution.
- Volunteers cannot transport patients on precautions.



fppt.com

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

WellSpan Health is committed to providing staff who are involved in the use of or care for patients with indwelling urinary catheters with education regarding CAUTIs and the importance of infection prevention.

This education may be used for any Licensed Provider, Clinical Staff, Non-Clinical Staff, or Ancillary Staff for CAUTI prevention education as appropriate.

Click Next to continue.

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Catheter Associated Urinary Tract Infection or CAUTI Definition: A catheter-associated urinary tract infection is a symptomatic urinary tract infection that is related to the patient having a urinary catheter in place or recently removed.

Background:

- Any patient with a catheter is at risk for developing an infection.
- Most catheter-associated infections are preventable.
- It is everyone's responsibility to help prevent catheter-associated infections.

Click Next to continue.

<http://www.cdc.gov/nhsn/pdfs/pscManual/7pscCauticurrent.pdf>

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Care of a Patient with a Urinary Catheter:

- Perform hand hygiene before and after touching the catheter or drainage bag.
- Empty the drainage bag prior to any patient transport.
- Keep the drainage bag below the level of the patient's bladder and off the floor.
- Avoid pulling on the catheter.
- Ensure the patient does not lie on or block the flow of urine in the tubing.
- Keep the tubing from kinking or forming loops.

Remember: Hand hygiene is the most important step in preventing infection!

Click Next to continue.

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Background:

- 600,000 patients develop hospital-acquired urinary tract infections per year.
- 80% of these are urinary catheter associated.
- Approximately half of the patients with a urinary catheter do not have a valid indication for placement.
- Each day a urinary catheter remains, the risk of a catheter-associated urinary tract infection (CAUTI) increases 5%.

Goals:

- To decrease CAUTI.
- To improve patient safety.
- To teach clinical providers the indications for urinary catheter use.
- To reduce the unnecessary use of urinary catheters in the inpatient setting.

Modified from original internet citation: Appendix G. Urinary Catheter Project Fact Sheet. Content last reviewed October 2015. Agency for Healthcare Research and Quality, Rockville, MD.

Click Next to continue.

<https://www.ahrq.gov/professionals/quality-patient-safety/hais/cauti-tools/impl-guide/implementation-guide-appendix-g.html>

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Prevention of CAUTI

- The presentation of catheter-associated infection varies from asymptomatic bacteriuria that does not require treatment, to overwhelming sepsis and even death. Clinical manifestations of CAUTI may include such local symptoms as lower abdominal discomfort or flank pain, or systemic symptoms such as nausea, vomiting, and fever. Patients with bloodstream infection may present with fever, confusion, and hypotension.
- A key first step leading to CAUTI is the colonization of the catheter with organisms. Indeed, urinary catheters readily develop biofilm – a collection of microbial organisms on a surface that is surrounded by an extracellular matrix – on their inner and outer surfaces once they are inserted. Such biofilm provides a protective environment for microorganisms.
- Many of the infectious complications of the urinary catheter could be prevented by using the catheter only when necessary and promptly removing it when no longer needed.

Modified from original internet citation: Appendix G. Urinary Catheter Project Fact Sheet. Content last reviewed October 2015. Agency for Healthcare Research and Quality, Rockville, MD.

Click Next to continue.

<https://www.ahrq.gov/professionals/quality-patient-safety/hais/cauti-tools/impl-guide/implementation-guide-appendix-g.html>

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Follow criteria indicated for a urinary catheter:

- Acute urinary retention or obstruction.
- Perioperative use in selected surgeries.
- Assistance in healing of severe perineal and sacral wounds in incontinent patients.
- Hospice/comfort care/palliative care.
- Required immobilization for trauma or surgery.
- Accurate measurement of urinary output in critically ill patients (intensive care).

Remember: Promptly remove unnecessary urinary catheters!

Modified from original internet citation: Appendix G. Urinary Catheter Project Fact Sheet. Content last reviewed October 2015. Agency for Healthcare Research and Quality, Rockville, MD.

Click Next to continue.

<https://www.ahrq.gov/professionals/quality-patient-safety/hais/cauti-tools/impl-guide/implementation-guide-appendix-g.html>

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Education

Follow criteria indicated for a urinary catheter:

- Acute urinary retention or obstruction.
- Perioperative use in selected surgeries.
- Assistance in healing of severe perineal and sacral wounds in incontinent patients.
- Hospice/comfort care/palliative care.
- Required immobilization for trauma or surgery.
- Accurate measurement of urinary output in critically ill patients (intensive care).

Remember: Promptly remove unnecessary urinary catheters!

Click Next to continue. Modified from original internet citation: Appendix G. Urinary Catheter Project Fact Sheet. Content last reviewed October 2015. Agency for Healthcare Research and Quality, Rockville, MD.
<https://www.ahrq.gov/professionals/quality-patient-safety/hais/cauti-tools/impl-guide/implementation-guide-appendix-g.html>

For Medical Staff or APC's performing or assisting with Surgical Procedures:

2019

Prevention of Surgical Site Infections By the Corporate Infection Control Department

Content contained in this learning was developed by WellSpan Health for educational use by WellSpan Health employees and affiliates. The content may be shared for information purposes. However, use of this content in its entirety is not permitted.

Public Health Importance of Surgical Site Infection (SSI)

- A recent prevalence study found that SSIs were the most common healthcare-associated infection (HAI) accounting for 20% of all HAIs among hospitalized patients.
- SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death.
- 2%-5% surgical patients acquire SSI (300-500K per year).
 - SSI is associated with a mortality rate of 3%.
 - Seventy-seven percent of deaths among patients with SSI are directly attributable to the SSI.
 - Many SSI result in long-term disability.
- They prolong hospital stays by 7 to 10 days.
 - Attributable costs vary, depending on the type of procedure and the type of infecting pathogen.
 - Published estimates of costs range from \$3,000 to \$130,000.
 - Most estimates do not account for re-hospitalization, outpatient treatment, post-discharge expenses, quality of life for the patient, or any long-term disability costs.

Strategies to Prevent Surgical Site Infections in Acute Care Hospitals: 2014 Update, Infection Control & Hospital Epidemiology, Vol.35, No.6 (June 2014), pp. 605-627. NHSN Patient Safety Manual, Chapter 9: SSI, p. 1, January 2013.

Click Next to continue.

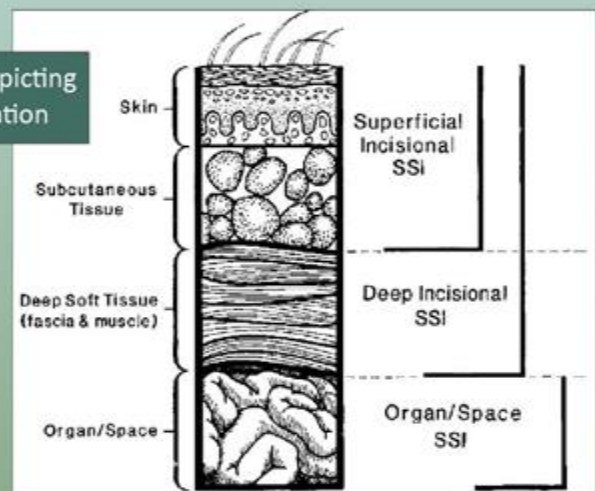
SSI Classification

Surgical site infections can be classified into incisional and organ/space manipulated during an operation.

Incisional infections are further divided into superficial (skin and subcutaneous tissue) and deep (deep soft tissue, muscle, and fascia).

Deep incisional and organ/space are the types of surgical site infections that cause the most morbidity.

Abdominal Wall Depicting
CDC SSI Classification



Click Next to continue.

Preventative Measures: Preoperative

Preoperative preparation of the patient to prevent SSIs:

- Minimize preoperative stay
- Identify and treat remote site infections
- Adequately control glucose in diabetics
- Encourage discontinuation of tobacco for 30 days
- Consider delaying elective procedures in severely malnourished patients
- Identify and treat remote infections – when possible
 - Before elective operation
 - Postpone operation until infection resolved
- No recommendations to taper or discontinue steroids (unresolved issues)
- Preoperative antiseptic showering
- Preoperative hair removal
- Patient skin prep in the OR
- Preoperative hand/forearm antiseptics
- Management of infected or colonized surgical personnel
- Antimicrobial prophylaxis



Click Next to continue.

Preventative Measures: Preoperative (cont.)

- Patients should be instructed to bathe or shower before surgery with either soap or skin antiseptic (CHG) on at least the night before or the day of surgery (AORN, 2018).
- IHI Guidelines for Orthopedic Joint Surgery recommends three CHG baths/wipes because of the cumulative log reduction of bacteria on the patient's skin.
- Do not remove hair preoperatively unless it will interfere with the operation.
- If hair is removed, remove it just prior to surgery with electric clippers.
- Hair removal should be done outside the OR.
- Wash and clean at and around the incision site prior to performing antiseptic skin preparation.



Click Next to continue.

Preventative Measures: Preoperative (cont.)

Shaving/Hair Removal

Hair itself is not “dirty.” Bacteria contained within hair follicles, when released through the friction and micro-cuts caused by shaving, create a sub-clinical local folliculitis.

This is a setup for SSI. It is best not to disturb the follicles at all. Most, if not all, hair removal currently performed preoperatively, is done for the surgeon’s convenience and is not backed by science.

Patients should be counseled not to be “helpful” and shave themselves preoperatively. Do not remove hair preoperatively unless the hair at or around the incision site will interfere with the operation. If hair is removed, remove immediately before the operation, preferably with electric clippers. Multiple studies show that clipping immediately before operation is associated with lower SSI risk than shaving or clipping the night before the operation.

Do not remove hair at the operative site unless the presence of hair will interfere with the operation.

Appropriate:

- No hair removal at all
- Clipping
- Depilatory agent

Inappropriate:

- Razors
- Removing hair, the night before

Click Next to continue.

Preventative Measures: Preoperative (cont.)

Preoperative Skin Preps

- Wash site to remove gross contamination.
- Use appropriate antiseptic agent.
- Use an antiseptic agent with alcohol, unless contraindicated.
 - Povidone-iodine with alcohol (Examples: Prevail, Duraprep)
 - CHG with alcohol (EX: Chloraprep)
- Both chlorhexidine gluconate and iodophors have broad spectra of antimicrobial activity.
 - Chlorhexidine gluconate achieved greater reductions in skin microflora than did povidone-iodine and had greater residual activity after a single application.
 - Chlorhexidine gluconate is not inactivated by blood or serum proteins.
 - Iodophors may be inactivated by blood or serum proteins.

Click the text box to read more about Chlorhexidine.

Chlorhexidine

Click Next to continue.

Larson E. Am J Infect Control. 1995;23(4):251-269.
Mark DG, et al. Lancet. 1991; 338:339-343.

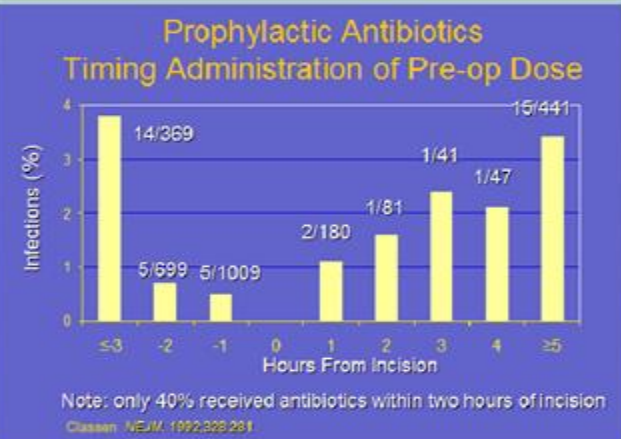
Prophylactic Antibiotics: Timing

- Studies indicate optimum timing for prophylactic antibiotic is within one hour prior to incision.
- When a cuff is used, make sure all antibiotic is infused prior to inflation of the cuff.

NOTE: Because of the longer required infusion times, vancomycin or fluoroquinolones, when indicated for beta-lactam allergy, should be started within 2 hours before the incision.

The graph demonstrates the results of a large study indicating that the effectiveness of prophylactic antibiotics is optimized if the antibiotics are delivered within 0-60 minutes prior to incision time.

When timing and selection are most important, questions often arise regarding re-dosing or increased dosing of prophylactic antibiotics. The definition of a "long" operation may be locally defined, but is usually interpreted as an incision being open for three hours or longer.



Click Next to continue.

Prophylactic Antibiotics: Dosing

- Always give at least a full therapeutic dose of antibiotic.
- Consider the upper range of doses for large patients and/or long operations.
- Use new ASHP/IDSA/SHEA/SIS Antibiotic Prophylaxis Guidelines.
- Repeat doses for long operations, per ASHP Guidelines. Cefazolin should be redosed for surgeries exceeding four hours (open incision time).

Cefaxolin > 80 kg 2 g
≥ 120 kg 3 g

Vancomycin 15 mg/kg

Gentamicin 5 mg/kg
dosing wgt = ideal wgt + 40% of excess wgt

Click Next to continue.

Prophylactic Antibiotics: Duration

- Most studies have confirmed efficacy equal or less than or equal to 12 hrs.
- Many studies have shown efficacy of a single dose.
- When compared, the shorter course has been as effective as the longer course.
- There is no need to continue coverage beyond 24 hours even if a patient has tubes or drains postoperatively.

What is best for our patients?

- Antibiotic prophylaxis is one of many methods for reducing the incidence of SSI.
- There is a lack of evidence that antibiotics given after the end of the operation prevent SSIs.
- There is evidence that increased use of antibiotics promotes antibiotic resistance.

Duration of Prophylaxis Gastrointestinal

Author	Drug	Duration	Infection
Strachan 1977 (biliary)	cefaxolin	1 dose	3%
		5 days	6%
		placebo	17%
Stone 1979 (mixed)	cefamandole	3 doses	0
		5 days	3%
		cephaloridine	5 days
Hall 1989 (mixed)	moxalactam	1 dose	5%
		2 days	6%

Click Next to continue.

Prophylactic Antibiotics (cont.)

- Select appropriate agents based on the surgical procedure, the most common pathogens causing SSI for a specific procedure, and published recommendations.
- Discontinue prophylaxis within 24 hours after surgery for most procedures; discontinue it within 48 hours for cardiac procedures.

Click Next to continue.

Preoperative Prevention of SSIs

Preoperative Preparation of the Surgical Team

- Keep nails short and no artificial nails.
- Wash hands and forearms if visibly soiled with soap and running water before beginning surgical scrub.
- Perform preoperative surgical scrub using waterless alcohol and chlorhexidine product or a traditional 3-5 minute surgical scrub with water.
- Perform preoperative scrub including forearms.
- Do not wear hand/arm jewelry.
- Nail polish should be chip free.
- Clean underneath each fingernail prior to first surgical scrub.
- After performing surgical scrub: keep hands up and away from body; allow water to run from hands to elbows; dry with sterile towel.



Click Next to continue.

Preoperative Prevention of SSIs (cont.)

Surgical Hand Scrubs

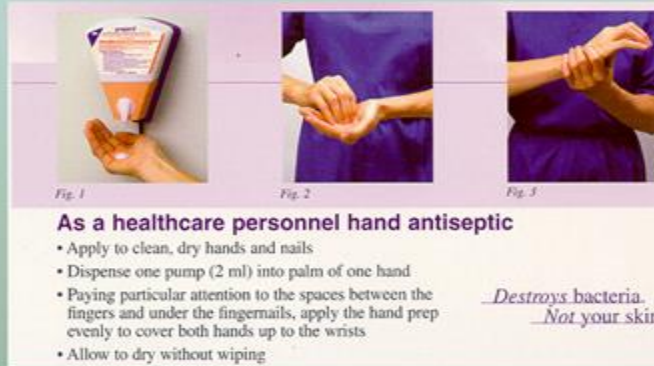
- Surgical hand scrubs should:
 - Significantly reduce microorganisms on intact skin.
 - Contain a non-irritating antimicrobial preparation.
 - Have broad-spectrum activity.
 - Be fast-acting and persistent.
- Studies suggest that neither a brush nor a sponge is necessary to reduce bacterial counts on the hands of surgical personnel to acceptable levels, especially when alcohol-based products are used.
- One study (AORN J 2001; 73:412) found a brushless application of a preparation of 1% CHG plus 61% ethanol yielded lower bacterial counts on the hands of participants than using a sponge/brush to apply 4% CHG.

Click Next to continue.

Preoperative Prevention of SSIs (cont.)

Hand Antiseptic

Example of 3M Avagard Moisturizing Hand Antiseptic (Alcohol & CHG)



Click Next to continue.

Surgical Attire

- Cover the head, hair, ears, facial hair, and nape of neck when entering the semi-restricted and restricted areas.
- Cover non-disposable head coverings with a disposable head cover.
- Launder non-disposable head coverings in a health care accredited laundry facility.

Rationale: Reduction of patients' exposure to potentially pathogenic organisms from clinicians' hair and bare skin (EX: bald head).

Click Next to continue.

Guideline for surgical attire: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc; 2018.

Surgical Technique

Excellent surgical technique is widely believed to reduce the risk of SSI. Such techniques include maintaining effective hemostasis while preserving adequate blood supply, preventing hypothermia, gently handling tissues, avoiding inadvertent entries into a hollow viscus, removing devitalized (necrotic or charred) tissues, using drains and suture material appropriately, eradicating space, and appropriately managing the postoperative incision.

- Removing devitalized tissue
- Maintaining effective hemostasis
- Gently handling tissues
- Eradicating dead space
- Avoiding inadvertent entries into a viscus
- Using drains and suture material appropriately
- Adhere to the principles of asepsis when placing intravascular devices, spinal or epidural anesthesia catheters

Click Next to continue.

Prevention of SSIs

Intraoperative/Postoperative Normothermia

Hypothermia in surgical patients is defined as a core body temperature below 36.C, and may result from general anesthesia, exposure to cold, or intentional cooling such as is done to protect the myocardium and central nervous system during cardiac operations. In one study of patients undergoing colorectal operations, hypothermia was associated with an increased SSI risk. Mild hypothermia appears to increase incisional SSI risk by causing vasoconstriction, decreased delivery of oxygen to the wound space, and subsequent impairment of function of phagocytic leukocytes (EX: neutrophils).

- Hypothermia reduces tissue oxygen tension by vasoconstriction.
- Hypothermia reduces leukocyte superoxide production.
- Hypothermia increases bleeding and transfusion requirement.
- Hypothermia increases duration of hospital stay even in uninfected patients.

Click Next to continue.

Asepsis and Surgical Technique

- Use delayed primary skin closure or leave an incision open to heal by second intention if the surgeon considers the surgical site to be heavily contaminated.
- If drainage is necessary, use a closed suction drain. Place a drain through a separate incision, a distance from the operative incision. Remove the drain as soon as possible.

Hyperglycemia and Risk of SSI

These papers discuss the importance of glucose control in the immediate postoperative period, in both diabetic and non-diabetic patients undergoing cardiac surgery.

Increased risk:

- High HbA1C
- Diagnosed diabetes
- Undiagnosed diabetes
- Post-op glucose > 200 mg% within 48h

Anderson, D. J., Podgorny, K., Berrios-Torres, S. I., Bratzler, D. W., Dellinger, E. P., Greene, L., Nyquist, A. C., Saiman, L., Yokoe, D. S., Maragakis, L. L., ... Kaye, K. S. (2014). Strategies to prevent surgical site infections in acute care hospitals: 2014 update. *Infection control and hospital epidemiology*, 35(6), 605-27.

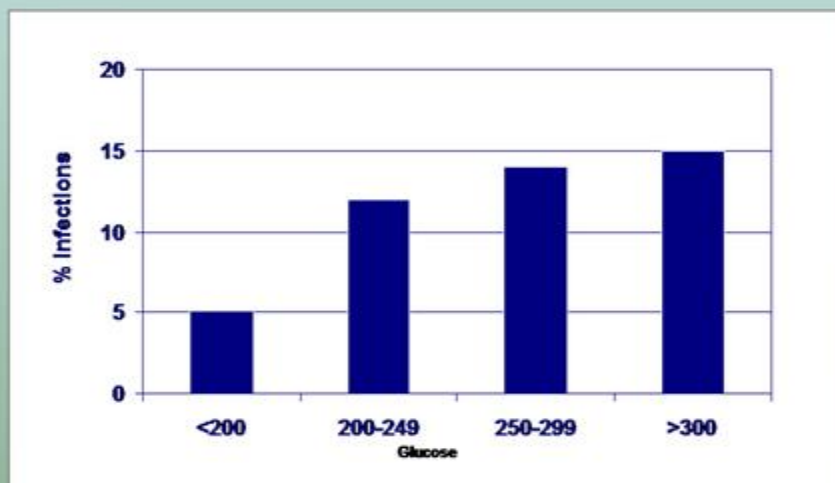
Noam Shohat, Khitam Muhsen, Ron Gilat, Alexander J. Rondon, Antonia F. Chen, Javad Parvizi, Inadequate Glycemic Control Is Associated With Increased Surgical Site Infection in Total Joint Arthroplasty: A Systematic Review and Meta-Analysis, *The Journal of Arthroplasty*, Volume 33, Issue 7, 2018, Pages 2312-2321.e3, ISSN 0883-5403, <https://doi.org/10.1016/j.arth.2018.02.020>

Yang, L., Sun, Y., Li, G., & Liu, J. (2017). Is hemoglobin A1c and perioperative hyperglycemia predictive of periprosthetic joint infection following total joint arthroplasty? A systematic review and meta-analysis. *Medicine*, 96(51), e8805.

Click Next to continue.

Diabetes, Glucose Control, and SSIs

This study found an increasing rate of postoperative infection in diabetic CABG patients depending on the degree of glucose control.



Click Next to continue.

Latham. ICHE. 2001; 22: 607-612.

Preventative Measures: Postoperative

Postoperative Incision Care

- At a minimum, protect with a sterile dressing for 24-48 hours postoperatively. (An incision that has been closed primarily.)
- Maintain sterile dressing as directed.
- Use aseptic technique when changing surgical dressings.
- Wash hands before and after dressing changes and any contact with the surgical site.
- Ensure that patients understand the importance of hand hygiene before and after wound care when they go home.

Click Next to continue.

Preventative Measures: Postoperative (cont.)

Discharge Instructions

- Dressing maintenance
- Proper incision care
- Symptoms and reporting of SSI
- Hand hygiene at home – before and after dressing changes and any contact with the incision site
- Nutritional guidelines
- Medications
- Blood glucose monitoring for diabetics
- Bathing instructions
- Follow-up appointments

Click Next to continue.

Conclusion

- Surgical site infections result in significant patient morbidity and mortality, and increased hospital cost.
- Reduction in surgical site infections can be achieved by strict adherence to standard surgical guidelines.
- Observations have revealed failure to follow standard guidelines.
- Strict adherence to standard guidelines is crucial to reduce SSIs.

Click Next to continue.

Pain Management Policy & Opioid Awareness

https://wellspan.sharepoint.com/:w:/r/sites/yh/_layouts/15/Doc.aspx?sourcedoc=%7BF753BCC4-5C9E-496C-9405-E1932C559C51%7D&file=720-Pain%20Assessment%20Management%202018.docx&action=default&mobileredirect=true

Click Box

What are Opioids?

“Opiates” or “Narcotics”



Morphine
Codeine
Fentanyl
Tramadol
Hydromorphone/Dilaudid
Hydrocodone/Vicodin
Oxycodone/Percocet

Opioids are highly
addictive and
dangerous if not taken
appropriately.

Click Next to continue.

Click Box

What do we know now about opioids?

Annals of Internal MedicineREVIEW

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harmful outcomes. Fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, and other harmful outcomes.

Purpose: To evaluate evidence of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Database of Systematic Reviews, Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2000 to January 2015). We included relevant studies from a prior systematic review (ClinicalTrials.gov).

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

tential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. doi:10.7326/M14-2559
For author affiliations, see end of text.
This article was published online first at www.annals.org on 13 January 2015.

www.annals.org

Click Next to continue.



Too Many People are Dying from Opioids

15
 Pennsylvanians
 die every day of a
 drug overdose.

2017 Overdose Deaths by County

All time high overdose deaths in each of our counties

Adams: 18
 Lancaster: 164
 Lebanon: 29
 York: 121

Increase in Overdose Deaths

In South Central PA:
442% increase in overdose admission due to prescription opioids

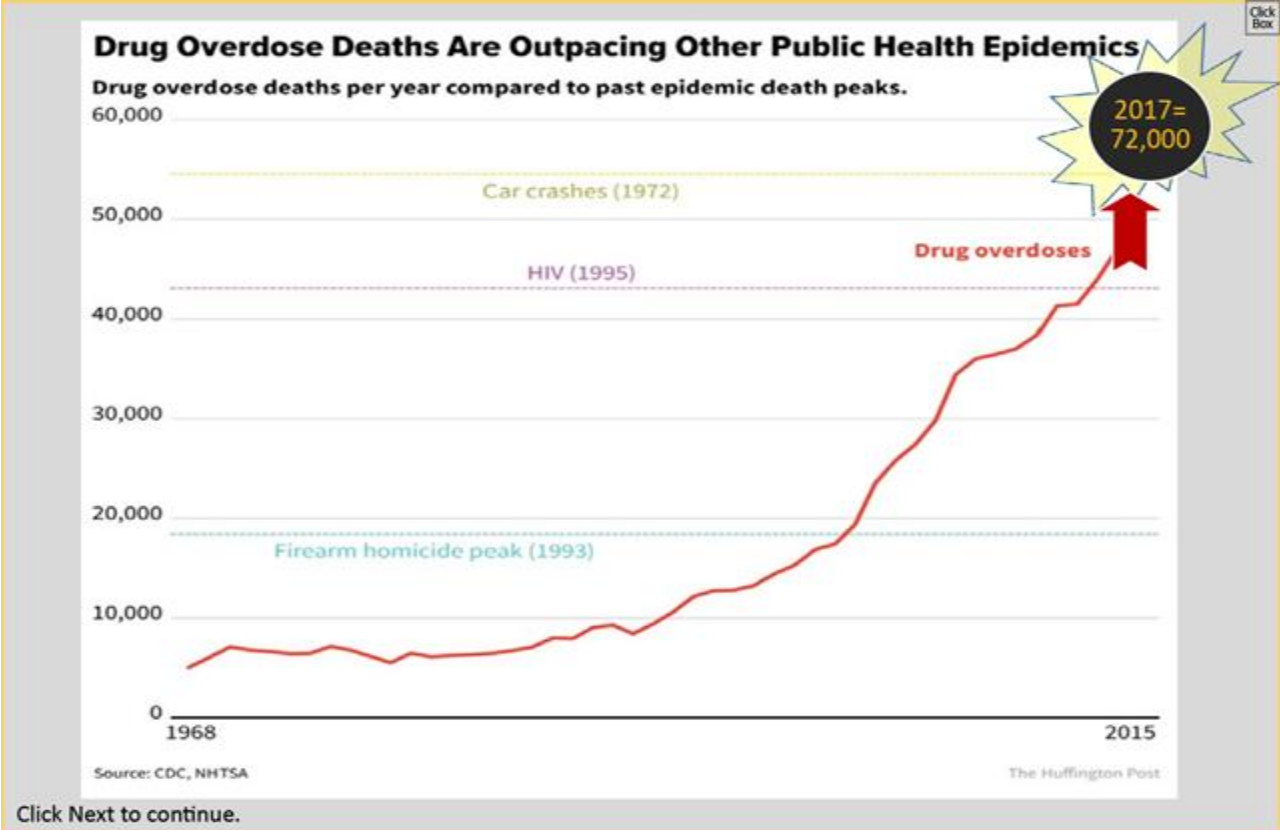
305% increase in overdose admissions due to heroin

Non-Medical Opioid Users

Estimated 825 non-medical users of opioids for every overdose death and that 4 of 5 people that overdose had an opioid pain medicine prescribed to them or a family member.

Opioid Withdraw Cases

Admissions to WellSpan York Hospital NICU for Neonatal Abstinence Syndrome (opioid withdraw) has increased from 10 cases in 2007 to 99 cases in 2015.



WellSpan Endorses CDC Guidelines for Opioid Prescribing

- ◆ Goals
 - Patient and Provider make informed decisions together
 - Safer opioid use, including Narcan prescriptions
 - Consistently monitor all patients on opioids to keep them safe
 - Communicate expectations with patients to avoid conflicts
- ◆ Opioids are not the first line or routine therapy for chronic pain
- ◆ Patient and Provider need to establish and measure goals for pain and function
- ◆ Need to discuss benefits and risks of non-opioid therapies to be used first or in combination with opioid prescribing



Click Next to continue.

What Patients Can Expect When Prescribed Opioids

- ◆ Controlled Substance Agreement videos located at www.wellspan.org/opioid and available on the INET
- ◆ Urine Drug Screens at least once per year
- ◆ Maximize non-opioid pain treatment options
- ◆ Regular (every 3 month at least) re-evaluation
 - Are opioids helping or harming?
 - Are you experiencing side effects?
 - Do you have signs of addiction?



Click Next to continue.

Securing and Disposing of Meds

- ◆ \$10 can save a life.
- ◆ May still steal or break open--but at least you will know it.
- ◆ It is important for you to destroy any leftover medicine.



Click Next to continue.

Safe Disposal of Medicines

Medicines are drugs prescribed by your doctor such as antibiotics, opioids for pain, and other over the counter drugs. They need to be stored in a correct way for use. You should never reuse leftover medicines without talking to your doctor first. There is a right way to get rid of leftover medicines. Look at the medicines you have on hand. Old out dated and unused ones should be thrown away.

How do I safely dispose of drugs and medicines?

Throwing away expired or unused medicines in the right way can protect you and your loved ones from harm. It will also prevent the medicines from getting into someone else's hands for use. Follow the instructions on the label or package inserts to know how to safely dispose of your drugs and medicines. **DO NOT** flush down the toilet or sink unless the label or patient information insert tells you to do this.

Follow these steps before throwing away medicines in the trash:

1. Pour medicine into a plastic bag that seals. Add water to help dissolve the medicine.
2. Add kitty litter, dirt or coffee grounds (something that will make it less appealing for pets and children to eat) to the plastic bag.
3. Seal the plastic bag and put it in the trash.
4. Remove and destroy any personal information (such as the label with your name) from the medicine container before recycling or throwing it away.

Drug Take-back Programs

Drug take-back programs are a good way to get rid of expired, unwanted or unused medicines and drugs from the home. This will lower the risk that others may accidentally take the medicine.

Local drug take-back program information:

Many police stations have drug take-back boxes in their lobbies. To find the nearest take back box:

- Adams County - call 717-783-8200
- Lancaster County - call 717-297-9968
- Lebanon County - call 717-783-8200
- York County - call 717-845-1066

Other resources:

- York County Solid Waste Authority
www.ycswa.com
- PA Dept. of Drug and Alcohol
Programs - Drug Take-back Program
www.ddap.pa.gov

Poison help: 1-800-222-1222

* WellSpan Medical Groups and other facilities **DO NOT** accept medicine or drugs for disposal.

At this time, the following WellSpan Outpatient Pharmacy locations will accept medicines for disposal:

- WellSpan Pharmacy, York Hospital
- WellSpan Pharmacy, Apple Hill Medical Center
- WellSpan Pharmacy, Fairfield
- WellSpan Pharmacy, Good Samaritan Hospital
- WellSpan Pharmacy, Ephrata Community Hospital

Keep all drugs and medicines out of sight and reach of children.

Where do I go if I or someone I know needs help?

My patient: 1-844-PHILHAVEN

My colleague/team member: Talk to your supervisor or call Employee Health

Myself: Employee Assistance Program 1-800-673-2514 or <http://www.wellspaneap.org/>

My family member: Employee Assistance Program 1-800-673-2514 or <http://www.wellspaneap.org/> or 1-844-PHILHAVEN

A friend or neighbor: 1-844-PHILHAVEN

I am concerned that WellSpan is putting a patient at risk with an opioid medication or not recognizing or treating the patient's addiction: Talk constructively with the physician/team members in charge of patient's care. If you feel your concerns are not adequately addressed – talk to their supervisor(s). If you still feel the issue is not adequately addressed and the patient is at risk for harm, talk to Risk Management (717)851-3052 or WellSpan Corporate Compliance (717)851-5444.

NOTE: All resources are located at www.wellspan.org/opioid and on the WellSpan INET by searching for "chronic pain."

Click Next to continue.

General Inpatient Hospice Services

Hospice general inpatient care (GIP) is for pain control or symptom management provided in an inpatient facility that cannot be managed in other settings. The care is intended to be short-term up to 72 hours. Our goal is to provide staff with education around unique patient needs in support of patients and families to prioritize their care with dignity and comfort during the end of life.

Link To Inpatient Hospice Policy

<https://portals.wellspan.org/sites/yhnursing/Policies%20%20Procedures/SC-011-GENERAL%20INPATIENT%20HOSPICE%20.pdf>

https://portals.wellspan.org/sites/sepsiswigfy18/Steering%20Committee/November%202017/Hospice%20%20Community%20Care_General%20Inpatient%20Process%20for%20WellSpan.pdf

Gift of Life Care

- WellSpan Health is encouraging local residents to have a conversation with their loved ones about their wishes about end-of-life medical care, and to develop an advance care plan, in observance of National Healthcare Decisions Day on Tuesday, April 16.
- “Sharing your wishes for end-of-life care with your trusted loved ones is the best gift you can give them,” says Roberta Geidner, WellSpan Coordinator of Horizon Planning. “It comforts and reassures them that they are doing the right thing, at the right time during a difficult period. Families are so grateful for the peace of mind when they know and can carry out their loved one’s wishes about their care. They will realize the true value of this gift after we are gone.”
- WellSpan supports this process through Horizon Planning, a free, self-directed advance care planning program that educates people about how to have these conversations with loved ones and the types of decisions that need to be made.
- The Horizon Planning program offers online resources to help individuals plan, organize and record those decisions. They include tips and suggestions for starting the conversation with loved ones about end-of-life wishes, as well as a living will form, a durable power of attorney for health care form, and information regarding physician orders for life-sustaining treatment.
- The materials are available free on WellSpan’s website at WellSpan.org/Horizon-Planning.
- All advance care planning documents should be submitted to a primary care provider and the person’s hospital to become part of the individual’s health record. WellSpan Health has developed several processes to help patients record their wishes in their electronic medical record.
- The regional health system recently worked with the York County Bar Association to establish a process where attorneys who work with WellSpan patients on their advance care planning can securely transmit the documents to WellSpan’s medical records office.
- WellSpan patients also have access to the Horizon Planning information and forms on the MyWellSpan online patient portal. Patients who log onto their secure portal can watch a video and then organize and plan their wishes, adding documents and naming health care agents for themselves. The information becomes part of patients’ electronic health record, accessible and on file wherever they go within the WellSpan system.

Link to Organ & Tissue Procurement Policy

https://wellspan.sharepoint.com/sites/yh/map/Forms/AllItems.aspx?useFiltersInViewXml=1&FilterField1=Policy_x0020_Category&FilterValue1=600%20-%20Medical%20Affairs&FilterType1=Lookup&FilterOp1=In&id=%2Fsites%2Fyh%2Fmap%2F616%20Organ%20Tissue%20Procurement%2Epdf&parent=%2Fsites%2Fyh%2Fmap