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Wesley website: www.wesleymc.com
Abbreviations that are unacceptable

<table>
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<th>Unacceptable</th>
<th>Correct</th>
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<tr>
<td>I.U. or IU</td>
<td>international unit unit</td>
</tr>
<tr>
<td>U or u</td>
<td>every day</td>
</tr>
<tr>
<td>Q.D. or QD</td>
<td>every other day</td>
</tr>
<tr>
<td>Q.O.D. or QOD</td>
<td>magnesium sulfate</td>
</tr>
<tr>
<td>MgSO₄</td>
<td>morphine sulfate</td>
</tr>
<tr>
<td>MS</td>
<td>morphine sulfate</td>
</tr>
<tr>
<td>MSO₄</td>
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Dose expressions

<table>
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<tr>
<th>Zero after decimal point (1.0 mg)</th>
<th>Correct</th>
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</thead>
<tbody>
<tr>
<td>No zero before decimal (.5 mg)</td>
<td>1 mg</td>
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Abuse and neglect

**Children:** When there is reasonable suspicion that a child under 18 years of age is being or has been physically, emotionally or sexually abused or neglected, the physician is required by state law to report it. To report, contact the departmental case manager or call the Case Management Department at 962-2300. The case manager will implement the reporting process.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D090.

**Adults:** When there is reasonable suspicion that a dependent adult is or has been a victim of domestic violence, physically, emotionally or sexually abused, neglected or exploited, the designated case manager shall be notified. If a case manager is not on duty (such as on evenings and weekends) the house supervisor shall be notified and he/she will notify the Wesley Security Dept. The case manager or Security officer will notify Adult Protective Services.

Dependent adult is defined as an individual 18 years of age or older who is unable to protect his/her own interest. Abuse includes neglect by omission or willful deprivation of services by others; the intentional infliction of physical or mental injury; unreasonable confinement; financial exploitation; cruel punishment; mental anguish; rape or sexual assault; harassment; domestic violence.

Advance directives

Physicians need to be aware of their patients’ intent regarding a Living Will and/or Durable Power of Attorney for Healthcare Decisions. If a patient has provided these documents to the hospital, copies will be in the chart. If a patient has not completed these documents, nursing and/or case management will make them available upon admission and at any point during their care.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D091.

**Anticoagulation**

Wesley Pharmacy’s Anticoagulation Service is available to assist in the managing and monitoring of inpatients 24 hours daily. A patient referral may be made to the Anticoagulation Service either in writing (using the Physician’s Order Sheet) or verbally to an Anticoagulation Service pharmacist. Call the Pharmacy at 962-2380 and ask to have the Anticoagulation Service pharmacist-on-call paged. The prescriber shall provide the indication for anticoagulation and therapeutic goal.

Warfarin preprinted order sets are available. With the exception of orthopedic orders #438, #439 and #440, use of the preprinted order set will be implemented any time Warfarin is ordered. The physician can deviate from these orders due to patient-specific reasons.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, E36.

**Blood transfusions**

All orders to transfuse a blood product need the completion of the preprinted order form. It is available on the Intranet, in Meditech, at all nursing stations, and in the operating room.

Please follow these steps to complete the form:
• Indicate the number of units of a given product to be transfused and whether or not they need to be irradiated.

• Mark the indication as to why the blood product is being given. If the indication is not listed, please write the reason in the space marked “Other.”

• Sign and date the order sheet.

This preprinted transfusion order form is only to be completed when blood is actually to be transfused. If you are ordering a Type and Screen or a Type and Hold, please indicate this on the “regular” Physician Order Sheet.

Remember: Transfusions require informed consent. For more information, see Wesley internal Intranet, Policies and Procedures and search Blood Transfusions.

Body fluid exposure and needle sticks

• Wash and rinse wound area thoroughly with germicidal soap.

• Obtain source patient information and account number.

• Report to the Employee Health Office immediately (Level G, Medical Arts Tower, from 9 a.m. to 3:30 p.m.). If Employee Health is closed, report to the Emergency Department for treatment.

• Residents and medical students should complete HNS form located on the Wesley Intranet or call Ext. 23361 for assistance.

• Treatment for individuals who have an HIV-positive exposure must occur within two hours.

The Caring Model

Wesley supports a culture of caring by consistently practicing behaviors that have been proven to improve the patient’s perception of care. The behaviors are:

• Introduce yourself to the patient and discuss your role in his/her care that day.

• Always call the patient by his/her preferred name.

• Sit at eye level at the patient’s bedside to plan and review the patient’s care.

• Use touch appropriately (a handshake or a touch on the arm).

• Speak positively about another caregiver in the patient’s presence.

• Always smile.

• Always answer any call light you see.

• Always help patients and visitors find their way in the hospital.

*Catheter-associated UTIs

Wesley has taken several steps toward decreasing catheter-associated urinary tract infections (CA UTIs), including general education to all staff who handle urinary catheters. Measures can be taken to reduce CA UTI’s if indicated. Indicators include:

• Relief of urinary tract obstruction

• Prostatic hyperplasia

• Acute or chronic urinary retention

• Drainage of hypotonic bladder

• Neurogenic bladder

• Critically ill patients

• Management of urinary incontinence when all other measures are not applicable

• Pre- and post- pelvic surgery

• Accurate measurement of output

• Empty bladder during labor

• Clot retention

• Chemotherapy intervention

• Prevention of skin breakdown in the incontinent patient

• Cytotoxic therapy for papillary carcinoma

Measures to be taken:

• Remove the indwelling catheter when no longer indicated.

• Do not routinely change the catheter at regular intervals. There is little to no research regarding changing the catheter once a UTI is identified.

• Do not irrigate unless medically necessary. If urinary retention is suspected, scan the bladder first. If patient is retaining urine for unknown cause, a catheter change should be considered before irrigation due to the high probability of biofilm build-up on the catheter tip.

• Ensure the catheter is placed using sterile and appropriate technique.

• Do not write “Foley PRN.” Indicate why an indwelling catheter should be placed and write parameters for use of an indwelling catheter.

WMC Infection Control staff and clinical nurse specialists are working with nursing to ensure these guidelines are followed.

When a CA UTI has been identified, the physician will be accountable to agree or disagree with the decision. If the physicians agrees, he or she must make note of this in progress notes and at dismissal so that this event can be coded correctly for billing purposes.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, C110.

*Central line infections

Studies show that hospital-acquired central line infections can be prevented by utilizing a set of guidelines developed by the Centers for Disease Control. The central line insertion bundle has five components: hand hygiene, maximum barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection (the subclavian vein is the preferred site for non-tunneled
catheters in adults), and daily review of line necessity with prompt removal of unnecessary lines.

At Wesley, an antimicrobial patch is applied to the catheter exit site at insertion and with every dressing change.

A nurse can provide the Central Line Checklist. Emergency catheterization, blood coagulation disorder, severe hypoxemia, temporary dialysis catheter access, and inability to access IJ or subclavian sites are reasons for femoral line insertion. The reason should be documented in the provider’s procedure note.

**Conscious sedation**

Contact the Medical Staff Office (962-2025) for information on obtaining credentials for conscious sedation, including a learning packet and information on credentialing. AMA PRA Category 1 credits are offered.

Drugs that require privileges for conscious sedation include, but are not limited to, ketamine, propofol, dexmedetomidine and midazolam.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, E34.

*Critical results received timely*

You should be notified of critical lab/exam results within 30 minutes.

**Cultural diversity**

Population-appropriate care refers to our ability to meet the distinct needs of patients, families, and co-workers with respect to cultural, spiritual and developmental needs. Knowledge and considerations for each population include communication approaches, personal space, time orientation, social organization, spirituality, education, safety, and environmental interventions.

Incorporate the patient’s beliefs into the treatment plan when possible.

If you have questions, contact the unit's case manager or the Case Management Department at 962-2300.

**Death and dying**

Wesley supports the following Kansas Medical Society resolution on physician involvement in the dying process:

• The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment by patients who possess decision-making capacity.

• There is no ethical distinction between withdrawing and withholding life-sustaining treatment at the patient’s request.

• Physicians who care for patients with terminal illness should seek to educate themselves about end-of-life care and to promote the dignity and autonomy of dying patients in their care, including providing palliative treatment even though it may foreseeably hasten death; and

• When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should not decrease.

Wesley has a Palliative Care Order Set (H705). See also the sections on Advance Directives and Pain Management in this guide. If you have questions, contact the unit’s case manager or the Case Management Department at 962-2300.

**Emergency medical screening (EMTALA)**

When an individual comes to Wesley and a request is made on his/her behalf for an examination or treatment for a medical condition, or a prudent layperson observer would believe that the individual presented with an emergency medical condition, an appropriate medical screening examination, within the capabilities of the hospital's Emergency Department (including ancillary services routinely available and the availability of on-call physicians), shall be performed by an individual qualified to perform such examination to determine whether an emergency medical condition (EMC) exists. With respect to a pregnant woman having contractions, the examination is performed in Labor and Delivery to determine whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Such stabilization treatment shall be applied in a nondiscriminatory manner (e.g., a different level of care because of diagnosis, financial status, race, color, national origin, or handicap).

Wesley maintains a list of physicians on its Medical Staff who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual receiving treatment for an EMC. The cooperation of the Medical Staff members with this policy is vital to the Wesley’s success in complying with the on-call provisions of EMTALA. Wesley must have on-call lists for all of the following specialties:

- Anesthesia
- Cardiology
- Emergent endoscopy
- General surgery
- Hyperbaric medicine
- Maxillofacial surgery

- Cardiovascular surgery
- Family practice***
- Hand surgery
- Internal medicine***
- Neonatology

* National patient safety goal
Fall reduction

Every year an estimated 35 to 40 percent of patients aged 65 and older fall. Unintentional injuries are the fifth leading cause of death in older adults, and falls constitute two-thirds of these deaths.

At Wesley, nursing staff assess patients upon admission and then daily or upon change in condition. They use a fall scale that rates the patient’s gait, transferring ability, need for an ambulatory aid, mental status, recent fall history, and whether IV or other lines are present.

Interventions should be based on the scale results, as well as individualized to the patient. Physicians should consider the need for assistive devices, a change in medications, orders for physical therapy or other orders that can reduce fall risk.

A yellow armband and a “falling star” magnet on a patient’s door frame identify the patient as at high risk for falls.

Medications such as sedatives, antipsychotics, antidepressants and other central nervous system agents increase the fall risk in elderly patients, with the risk of falling doubling for each psychotropic added to the drug regimen. For a complete list of fall risk medications, please visit the Fall Risk Medications link on Wesley’s Intranet under Clinical Tools/References.

As part of the HCA Corporate Fall Prevention Initiative, Wesley’s Pharmacy Department implemented a Pharmacist Fall Prevention Program in March 2011. Pharmacists evaluate every patient aged 65 and older currently receiving two or more fall risk medications, and provide evidence-based recommendations to decrease patient fall risk. Pharmacists check to see that medications are dosed appropriately for the patient’s age, renal function and hepatic function.

Physicians are to be notified if their patient experiences a fall, and all falls and precautionary measures should be documented. The physician is accountable for the assessment following a fall.

For more information, see Wesley internal Intranet, Policies and Procedures, Administrative, E74-E74.5

*Health-care-acquired infections (HAIs)

Surgical site infections, central-line-related bloodstream infections, ventilator-associated pneumonia, health-care-acquired pneumonia, multidrug-resistant organisms, clostridium difficile, and Foley-related urinary tract infections are all HAIs. Each is determined by definitions published by the Centers for Disease Control through the National Healthcare Safety Network (NHSN). Most involve the infection appearing 48 hours after admission with no sign of incubation of the infection on admission. HAIs have been in the news, as interventions known as “bundles” appear to help prevent them. Consumers express concern that health-care professionals don’t take these infections seriously enough, and government agencies now refuse payment for infections that occur during a hospital stay.

The most important way to prevent any HAI is by practicing hand hygiene — every patient, every contact, every time.

Also see sections in this guide:
• Catheter-associated UTIs
• Central line infections
• Personal protective equipment
• Surgical site infections
• Ventilator-associated pneumonia

Hold hours

“Hospital hold hours” is a throughput metric used to track the flow of patients out of the Emergency Department into hospital beds. The goal is to move patients within 59 minutes of the time a disposition to admit has been made. If you need to go to the Emergency Department to assess and evaluate your patient, please be mindful of the 59-minute goal and work with the Emergency Department RN to move the patient as soon as an inpatient bed becomes available.
Inpatients occupying emergency beds prevent waiting patients from being seen by a physician.

**Lab testing reimbursement**

Physicians are advised by CMS to order only those tests and/or services which are medically necessary. A specific diagnosis, sign, symptom, or ICD-9-CM code must be provided when ordering tests or services.

When ordering tests or services that do not meet criteria for medical necessity, physicians should explain to the beneficiary why the test is being ordered and that Medicare may not pay for the test. The patient must sign an Advance Beneficiary Notice (ABN). The guiding principle to determine whether an ABN must be obtained is **not** whether you, as a physician believe that the test or service is medically necessary, but whether the patient’s diagnosis, signs, or symptoms are included in an Local Coverage Determination (LCD) and/or National Coverage Decisions (NCD) for the specific test or service being ordered. Signed ABNs should be forwarded to the ancillary service department performing the tests or services.

To limit the potential risk for both physicians and ancillary departments, Wesley has adopted the OIG Model Compliance Plan for Laboratories and several policies related to Medicare billing. We offer only laboratory panels which are approved by the CMS or order sets (profiles) requested by and approved by the Executive Committee of Wesley’s Medical Staff. There are instances when abnormal values for specific tests warrant additional testing. Therefore, we have created Reflex-testing guidelines.

For more information, Wesley internal Intranet, Clinical Tools/References, Lab Handbook, and choose Compliance Policies.

**Labels required**

On and off the sterile field, all syringes must be labeled when drawing up medications; all basins must be labeled as to contents.

**Level of care/status**

The admitting physician must decide the placement for patients. A physician order must specifically state one of the following:

- Admit as inpatient
- Outpatient observation
- Outpatient procedure

Patients must meet medical necessity for the level of care you order. Wesley utilizes InterQual criteria. If you have questions about InterQual, talk with an RN case manager on your unit.

Observation cannot be routinely written following an outpatient procedure. This can only occur when a complication arises following the normal 4-6 hours expected recovery time. The reason for observation must be documented in the context of the order at the time the complication develops or in the progress notes.

For more information, see Wesley internal Intranet, Policies and Procedures, Administrative, E79, or call the Case Management Department at 962-2304.

**Medical emergency/Code Blue**

Code Blue refers to patients; Medical Emergency refers to nonpatients, such as visitors, employees, etc., who are in the hospital.

Wesley has three Code Blue teams: adult, obstetric, and pediatric. They are activated by calling extension 23131 and stating a Medical Emergency/Code Blue, and giving the building and room number of the exact location. The Communications Department then initiates a group page to the appropriate team. The Code Blue button may be used where available.

The resident in charge of the Code Blue is responsible for managing the medical emergency/resuscitation process and the decision to terminate the code.

For more information, see Policies and Procedures, Clinical Practice, sort alphabetically, Go, choose “Medical Emergencies/Code Blue.”

For care to prevent a Code Blue, see “Rapid Response Team” in this guide.

**Medication reconciliation**

All patient medications must be reconciled upon admission, inpatient transfer, and dismissal. Reconciliation involves comparing the patient’s list of medications to the physician’s admission, transfer, and/or discharge orders.

Wesley has a computerized system that captures all three components and produces a printed list for the patient at discharge. Discharge dictation and computerized discharge patient medication instructions should always match.

The Medical Staff Office has CDs available that explain this process and show the actual documents. Call 962-2025 to have one sent to you.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, E43.

**Organ and tissue donation**

Our policy is to request staff from Midwest Transplant Network (MTN) to provide the initial approach to families of all potential organ and tissue donors. Physicians should not approach the patient or family.

The physician notifies the nurse or case manager to contact MTN after the patient and/or next-of-kin, along

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* National patient safety goal
with the attending physician, have made the decision to terminally wean and/or disconnect a ventilator in order to allow death to proceed unobstructed by medical measures. The referral to MTN shall be made prior to disconnection of the patient from the ventilator and/or initiation of the terminal weaning process.

Appropriate candidates for donation:
- The patient has a non-recoverable neurological injury and the attending/consulting physician has determined that the patient’s medical condition is inconsistent with life and the patient’s family has begun discussion to withdraw life support/ventilation.
- Cardiorespiratory death will likely occur within one hour following withdrawal of life support.

The attending physician or designee continues full responsibility for the patient until the patient’s death is pronounced, and is the individual who pronounces death in the operating room at the discontinuation of ventilator support and/or removal of the ET tube.

Comfort measures are to be provided as deemed appropriate by the physician per hospital policy and guidelines.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D025.

**Pain management**

Wesley is committed to achieving optimal pain management. Pain is assessed and documented at admission, every tour of duty, and prn, to include location, quality and intensity. Pain assessments are to be done on all patients at all levels of care. A plan of care with the goal of patient comfort and reduction of complications should be implemented.

For more information about pain management, see:
- Patient Care Policies, Clinical Practice, D66, “Pain Management”
- Patient Care Policies, Clinical Practice, D70, “Palliative Care”
- Adult Patient Controlled Analgesia (PCA) Preprinted Orders #550
- Palliative Care Order Set #705
- KU Hospitalist (Med 1) Admissions Orders #419
- Admission Orders #480
- Epidural Orders — WAC/MCAC (Pain Management — Nonobstetrical) #670
- Continuous Infusion Epidural Block for Labor Analgesia Mid-Continent Anesthesiology Cht., #45

**Patient Action Line (PAL)**

Any patient or family member can call Wesley’s Patient Action Line (Ext. 27277) to voice a concern. The caller will receive a visit from the director on call within 15 minutes, who will seek to resolve the concern. All patients are educated on how to place a PAL call.

**Patient identification**

It is the policy of Wesley Medical Center to verify the identification of all patients during communication about patients and prior to the provision of care, including diagnostic testing and treatment. A minimum of two identifiers are used to identify patients. The primary patient-specific identifier is the patient’s first, middle and last name as stated on the patient’s armband. If this identifier is correct, a second identifier such as account number, medical record number, or birth date on the armband can be compared with orders, labels, requisitions, etc. Prior to the start of a procedure, ask the patient to state his/her name and date of birth. If the patient is unable to participate in the identification process, ask a relative or another caregiver to identify the patient. Never use a room number.

For more information, see Wesley internal Intranet, Policies and Procedures, Administrative, E76.

**Patients at risk of suicide**

All inpatients, outpatients receiving observation services, outpatient procedure patients and Emergency Department patients are to be screened upon admission for risks concerning suicide or harm to self.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D038.

**Personal protective equipment**

Standard precautions protect you from infections. Use personal protective equipment (PPE)—gloves, mask, gown and/or eye protection—whenever needed to prevent exposure to blood, body fluids, excretions or secretions. Always perform hand hygiene before and after seeing each patient.

Contact precautions require that you put on a pair of gloves EVERY time you enter the contact precaution room and remove them every time you exit the room. Put on a gown if your clothes are going to come in contact with the patient or the patient environment (side rails, bedside table and chair). Always use Alcare or wash your hands after you remove and dispose of your gloves and gown. Gloves should not be worn in the hallway.

Droplet precautions require that you put on a procedure mask whenever you are within three feet of a patient that is infectious or potentially infectious. We encourage staff to wear a mask whenever they enter the patient room.

Airborne precautions require that the patient be in a negative pressure room and that everyone entering the room wear an N-95 mask. Fit testing is provided by the Employee Health Office.
Physician notification/chain of command

This policy outlines a formal line of communication for hospital staff who have concerns regarding a prescribed treatment plan (or the lack thereof) or a medical decision or act.

If unable to contact physician, or there are concerns about the physician's orders or treatment plan, staff are to contact their immediate supervisor for consultation and support.

If staff remain uncomfortable with the plan of care after consultation with their immediate supervisor, they are to progressively activate the following chain of command: notification of department manager, department director or director on call, administrator on call.

Management staff will assist with activation of the physician chain of command by progressively notifying the following: attending physicians or designee, medical director of the department, chief medical officer, chair of section.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D110.

Point-of-care testing (waived testing)

The only people who can perform waived tests or any point-of-care tests are those who have successfully completed a competency assessment within the last 12 months. Therefore, physicians may not perform any point-of-care lab test, including occult bloods, vaginal pH's, and urine dipsticks, unless they have completed the annual competency assessment and this information is documented in their credentialing files.

For additional information, contact the laboratory point-of-care coordinator at 962-2828.

Rapid Response Team

Sixty percent of inpatients who experience cardiac or respiratory arrest show signs of deterioration up to six hours beforehand. Wesley's Rapid Response Team (RRT) helps nurses recognize these signs and take preventive action. The patient, family, or other interested person may also initiate the RRT by calling the Patient Action Line.

Available to all adult units 24 hours every day, the team is comprised of an experienced RN from the Medical Intensive Care Unit and a respiratory therapist. They respond to a call from a nurse (through the emergency page operator, Ext. 23131) or Patient Action Line within five minutes. They help the nurse assess the patient, make recommendations for appropriate action, and assist with stabilization, support, or transfer if necessary. The team also contacts the admitting physician for orders and a report. The internal medicine resident provides secondary support if the attending physician is unavailable.

Reasons to activate the team include a drop in blood pressure, heart rate, oxygen saturation or respiratory rate; chest pain; and a change in neurological status.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D075.

Restraint and seclusion

Wesley is dedicated to fostering a culture that supports a patient's right to be free from restraint or seclusion. Restraint use is limited to clinically justified situations, and the least restrictive restraint is used with the goal of reducing and ultimately eliminating the use of restraints.

The staff nurse performs an assessment when a patient exhibits behavior that may place the patient at risk. Patients who are found to be at risk and may need restraint will have alternative options initiated promptly. If the RN determines that alternatives to restraint have failed and that the patient will be safer with restraints than without, management will review the need for restraint and the physician will be called.

An order for restraint must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint. The order must specify clinical justification for the restraint, the date and time ordered, duration of use, type of restraint to be used and behavior-based criteria for release. An order for restraint may not be written as a standing order, protocol or as a PRN (“as needed”) order. If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.

Orders for restraint or seclusion must not exceed:
- 4 hours for adults aged 18 years and older
- 2 hours for children and adolescents aged 9 to 17 years, or
- 1 hour for children under 9 years

The patient in restraint/seclusion is evaluated frequently and the intervention is ended at the earliest possible time.

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D067.

Surgical and invasive procedure safety

Wesley endorses the Universal Protocol for preventing wrong patient identity, wrong procedure, and wrong site prior to invasive procedures. Key elements include:
- Active participation with quality and effective communication among all members

* National patient safety goal
- Confirmation of correct patient identity, procedure, side/site and position
- Marking the intended site prior to surgery/procedure
- Time out: a final assessment immediately before the surgery/procedure verifying that the correct patient, site, positioning, and procedure are identified and that all relevant documents, information, and equipment are available

For more information, see Wesley internal Intranet, Policies and Procedures, Clinical Practice, D065.

*Surgical site infections*

Risk factors for a surgical site infection include diabetes, nicotine use, steroid use, obesity, malnutrition, prolonged preoperative stay, preoperative nares colonization and perioperative transfusion.

Recommendations:
- Antimicrobial prophylaxis (appropriate choice, timing and duration) (Order Set #347)
- No hair removal, or hair removal by clippers only
- Control serum blood glucose levels and avoid hyperglycemia perioperatively
- Effective skin prep (require patients to shower/bathe with an antiseptic agent preoperatively)
- Surgical scrub and hand hygiene, surgical dress attire/drapes
- Inspect sterile items for contamination before opening


**Transfer of patients**

To transfer a patient to Wesley, call the RN transfer coordinator at Wesley’s One Call Transfer Center at 962-2485 or 800-362-3292. Request either a physician consult or transfer and admission. Once physician acceptance has been verified, the transfer coordinator will request basic patient information and make a bed assignment. Fax patient face sheet to 962-2622.

**Vaccine assessment**

Adult influenza and pneumococcal vaccine assessment is automatically performed by nursing within Meditech. If the patient is eligible for the vaccines, an order is sent electronically to Pharmacy and an order is placed on the chart.

Pediatric vaccine assessment is done via an order set. For the Pediatric Influenza Vaccine Order, go to Wesley internal Intranet, Clinical Tools/References, Order Sets, Category Set, #201.

**Vancomycin dosing and monitoring**

To evaluate vancomycin therapy, the following protocol is suggested:

1. Serum concentration monitoring is generally only recommended in the following patients:
   - Patients receiving IV vancomycin only (PO vancomycin has poor bioavailability)
   - Patients receiving >4 days of therapy
   - Patients in whom optimal concentrations are critical (e.g. meningitis, endocarditis)
   - Patients in whom dosing may be difficult (e.g. obese patients, patients with fluctuating renal function)

2. For these patients, trough concentrations are recommended to be drawn either:
   - 30 minutes prior to the fifth dose (patients with a dosing interval <24 hours)
   - 30 minutes prior to the third dose (patients with a dosing interval ≥24 hours)

3. Vancomycin dosing should be adjusted based on the desired trough for each specific indication:
   - Troughs of 10-15 mcg/mL are generally recommended for cellulitis.
   - Troughs of 15-20 mcg/mL are generally recommended for pneumonia, osteomyelitis, and endocarditis.
   - Troughs of 20-25 mcg/ml are generally recommended for meningitis.

4. Any patient receiving vancomycin therapy should have a serum creatinine drawn at a minimum of every three days.

5. In patients receiving long-term therapy, troughs are generally recommended on a weekly basis.

Note: Each vancomycin trough drawn at Wesley costs $320 (patient cost).

**Ventilator-associated pneumonia**

Ventilator-associated pneumonia (VAP) is a subset of hospital-acquired pneumonia and can occur for any period of time until 48 hours after mechanical ventilation is stopped. VAP causes significant morbidity, mortality, cost and utilization of health-care resources.

A VAP bundle has been developed using multiple studies and sources. It consists of:
- Oral care with toothbrush and CHG oral rinse
- Elevation of the head of the bed to at least 30 degrees unless there is a contraindication
- Use of a daily sedation vacation to assess readiness for extubation
- DVT and stress ulcer prevention
Two preprinted order sets are available: Mechanical Ventilation #370 and Suspected VAP #375.

For additional information, see:
- http://www.shea-online.org/about/compendium.cfm
- CDC Guidelines for the prevention of health-care acquired pneumonia.
Adverse event reporting

If a significant event is reported to the Risk Management Department, an investigation is initiated. When the event occurs, the priority is to take care of those affected by the event, i.e. the patient, employees, physicians, and family. Once all immediate patient-care needs have been addressed, a hospital notification form must be submitted. Nursing staff submits all notifications through Meditech. Physicians have the opportunity to submit any occurrence that they desire to be investigated further. Notification of such occurrences can be done by contacting a member of the Risk Management Department, reporting the concern anonymously through the Safe Line at 962-SAFE (7233) or by submitting a Physician Requested Notification Form which can be completed and deposited in the designated box in the physician lounge at the physicians’ entrance.

Various levels of review are completed for events submitted to Risk Management. Lower-level reviews are sent to the appropriate management to review. Events involving residents are reviewed by the program chairperson for each appropriate service.

A “sentinel event” is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. The Joint Commission has outlined criteria which have specific definitions regarding such events and for any sentinel event that should occur. A Root Cause Analysis (RCA) must be completed. An RCA requires team members that were involved to develop action plans to address process issues.

Often, events occur that do not meet the sentinel event definition but are considered significant; these events necessitate thorough analysis and require an investigation or an RCA. Following an RCA, an action plan is developed and each plan is evaluated through its established measure of success (MOS). The continual monitoring of MOS is imperative to patient safety processes. All Risk Management activities are protected pursuant to Kansas Law.

Continuing medical education

Wesley offers many continuing education conferences for students, residents and members of the medical staff; AMA PRA Category 1 Credit™ is available. Copies of the monthly calendar are placed in a box near the bulletin board at the physicians’ entrance. The calendar and more detailed information are available at www.wesleymc.com, under “For Physicians.” You may also contact Tiffany Stepien, CME program administrator, at 962-3304.

Computer downtime procedures

For information, see Wesley internal Intranet, Policies and Procedures, Administrative, G09.

Conflict management

The Conflict Mode Workshop for use with the Thomas-Kilmann Conflict mode instrument is available through Human Resources by request. The phone number is 962-2600.

Device/product malfunction or failure

Any member of the Medical Staff who suspects that any piece of medical equipment, device or product is not working correctly is obligated to report his/her suspicion to a Wesley employee and/or to the Clinical Engineering Department for follow-up and verification that the equipment is functioning correctly.

For more information, see Wesley internal Intranet, Policies and Procedures, Administrative, F15.

Disaster response

In the event of a community disaster, communication regarding the disaster’s scope and the response of the Medical Staff must be timely. If you are in the hospital, at your office or home and become aware of a pending or an in-progress disaster impacting our community, you can acquire timely information and instructions by doing any of the following:

• Call the Wesley Disaster Line at 962-2005 for a recorded announcement with general information about the event and needed response by all Wesley employees and Medical Staff; or
• If you need to speak with someone, call the Wesley main number 962-3030 and ask the operator to connect you to the WMC Incident Command Center if it is activated. Otherwise, the operator can connect you to an administrator; or
• Go directly to the physician’s lounge adjacent to the physician’s entrance and report to the chief medical officer or designee.
• Do not report directly to the Emergency Department unless you are instructed to do so.
Disruptive physician behavior

It is Wesley’s policy that all individuals be treated courteously, respectfully, and with dignity. To that end, Wesley requires all individuals, employees, physicians, and other independent practitioners to conduct themselves in a professional and cooperative manner in the medical center. Inappropriate behavior should be reported to the clinical service department chairperson, the chief medical officer or the chief executive officer.

For more information, see Wesley internal Intranet, Department Pages, Medical Staff Services, Policies, Medical Staff Rules and Regulations 1.6.

Documentation requirements

Failure to maintain timely records can be detrimental to patient care, compensation, and legal issues, and it endangers the physician’s privileges and possibly licensure.

Failure to complete medical records within the specified time frame shall result in a delinquent episode unless the physician has given prior notice to the Health Information Management Department of a vacation, illness or other valid reason for not completing records.

A delinquent episode is the failure to complete one or more medical records that are greater than seven days old from date available.

For more information, see WCGME policy on delinquent medical records.

Ethics and compliance

Business ethics:

Information about the HCA Code of Conduct was provided to you at orientation. This code provides guidance and assistance with carrying out daily activities within appropriate ethical and legal standards. To view the HCA Code of Conduct, go to http://hcaethics.icu.ehc.com/CPM/HCA Code English 1110.pdf. This site can also be accessed from the Intranet page on Ethics and Compliance.

If you have questions about business ethics or the Code of Conduct, call Deb McArthur, Ethics and Compliance Officer, at 962-2463, or the HCA Ethics Line at 800-455-1996.

Clinical ethics:

For assistance with ethical concerns related to patient care, contact a case manager (Case Management Department: 962-2300) or a chaplain (962-2725 or page the chaplain-on-call at 962-3030). They can arrange a consultation with the Ethics Committee within 48 hours, if needed. Clinical ethics policies can be found:

- Intranet: General Policies, Administrative, E26 “Ethical Issues”
- Intranet: Patient Care Policies, Clinical Practice, D72 “Determination of Death”
- Intranet: Patient Care Policies, Clinical Practice, D87 “Do Not Resuscitate”
- Intranet: Patient Care Policies, Clinical Practice, D88 “Withdrawal of Life Support”
- Intranet: Patient Care Policies, Clinical Practice, D95 “Resolution of Conflicts Regarding Care Decisions”

See also “Advance directives” and “Patient rights and responsibilities” in this guide.

HCAHPS hospital survey questions

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The purpose of this survey is to provide comparable data on the patients’ perspective of care. After their hospital stay patients are randomly selected by a contracted company to complete the survey. The data comparing hospital results is available at www.hospitalcompare.hhs.gov. Most questions are answered using the following scale: never, sometimes, usually, always.

The “always” response is what is reported on the comparative data. The questions are:

- How often did nurses treat you with courtesy and respect?
- How often did nurses listen carefully to you?
- How often did nurses explain things in a way you could understand?
- After you pressed the call button, how often did you get help as soon as you wanted it?
- How often did doctors treat you with courtesy and respect?
- How often did doctors listen carefully to you?
- How often did doctors explain things in a way you could understand?
- How often were your room and bathroom kept clean?
- How often was the area around your room quiet at night?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
- How often was your pain well controlled?
- Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

You must sign, date and time all orders. Include your provider number and indication/reason on orders. Telephone orders must be signed, dated and timed within 48 hours of giving them.
• Did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
• Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
• Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
• Would you recommend this hospital to your friends and family?

**Ill and impaired licensed independent practitioners**

Physicians may encounter challenges that impair their ability to practice medicine, such as drug or alcohol addiction, mental or physical disability, or even the aging process. The Medical Advocacy Program (MAP) is designed to help physicians travel the road to recovery. This twenty-five year-old program is grounded in a fundamental philosophy of confidentiality for its participants and for those who report physicians. Except in a criminal action, any information acquired is confidential and may not be disclosed without written consent.

To contact Kansas MAP, call the program director, Judy James, at (785) 235-2383 or email james@kmsonline.org. All requests for information are held in strict confidence.

**Wesley’s process**

Wesley has a process to address licensed independent practitioners who have physical, psychiatric or emotional illness that facilitates confidential diagnosis, treatment, and rehabilitation.

Concerns regarding a practitioner can be relayed to the Wesley house supervisor, a director or administrator-on-call, chief medical officer or other member of the senior management team. Confidentiality must be maintained at every step.

The credibility of the complaint will be evaluated. The practitioner will be informed that a concern regarding impairment has been received. If the concern is substantiated, the practitioner will be referred for evaluation. Then he or she may be asked to voluntarily enter a rehabilitation program and request medical leave of absence or restrict his or her privileges pending rehabilitation. A monitoring program will be initiated and followed.

Any practitioner who is not safe to practice or refuses help will be referred to the Corrective Action Plan, and emergency suspension may be initiated.

For more information see Wesley internal Intranet, Departments, Medical Staff Services, Policies, Medical Staff Corrective Action and Fair Hearing Manual, 2.0 and WCGME Policy Manual.

**In-hospital emergencies**

**Fire, smoke, or suspected fire:**
Move patients from immediate danger. Call 23131, say “Dr. Red,” give location and identify yourself. If no phone is available, pull the closest fire alarm.

**Cardiac or respiratory arrest:**
Call 23131, say “Code Blue,” give location and identify yourself.

**Security emergency:**
Call 23131 for Security, give location, identify yourself and the problem.

**Hazardous material spill:**
Call 23131, say you have a hazardous material spill, give the location and identify yourself.

**Patient out of control:**
Call 23131, say you have a patient out of control and need help, give location and identify yourself.

**Severe Weather Plan enacted:**
Move patients to interior rooms and corridors; if unable to do so, cover patients with blankets or mattresses and move them as far from windows as possible. Close all doors and windows, pull down window shades and blinds. Move to interior rooms. Do not leave the building.

Further information about emergency procedures, emergency conditions and systems failure can be found in the back pages of the Wesley Medical Center telephone directory.

**Joint Commission and physicians**

The Joint Commission is a private, not-for-profit organization dedicated to continuously improving the safety and quality of care provided to the public. The Joint Commission is the nation’s principal standards setter and evacuator for a variety of health-care organizations.

The Joint Commission’s Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as one of its top strategic priorities.

With an ability to serve as a bridge between patients and staff and staff and management, physicians play a unique leadership role in fostering improvements in care.

Physician leadership and involvement are critically important to the success of The Joint Commission’s patient safety improvement efforts, including:
• Standards review
• National patient safety goals
• Health-care summits
• Sentinel event alert topics

The Physician Engagement Advisory Group advises The Joint Commission on expanding physician participation in the accreditation process and broadening physician engagement in quality of care and patient safety.
Medical Staff membership obligations

— Excerpt from the Medical Staff Bylaws 1.5.2 Basic Obligations Of Individual Staff Membership:

“Each member of the Medical Staff, regardless of his/her assigned Medical Staff category, and each practitioner exercising interim privileges under these Bylaws, shall:

(a) Provide his/her patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as the Medical Center in this or similar communities;

(b) Abide by the Medical Staff Bylaws, the Medical Center Bylaws, and all other lawful standards, policies and rules of the Staff and Medical Center;

(c) Discharge such Staff, Committee, Service, and Medical Center functions for which he/she is responsible by Staff category assignment, appointment, election or otherwise;

(d) Prepare and complete the medical and other required records for all patients he/she admits or in any way provides care to in the Medical Center facilities in accordance with these Bylaws and related manuals;

(e) Pledge to provide or arrange for appropriate and timely medical coverage and care for patients for whom he/she is responsible;

(f) Comply with all state and federal laws and regulations;

(g) Provide health care in a manner cost-efficient for the hospital and patient;

(h) Report any disciplinary action taken by a state licensing agency, peer review organization, federal agency or professional association; suspension, restriction, limitation or voluntary surrender of any hospital privileges, any adverse judgment, award or settlement paid resulting from a professional liability claim; found guilty or pled no contest to any felony or Class A misdemeanor or have suffered any impairment which would affect his/her ability to safely practice must be reported to the Medical Staff Office within five (5) working days. Other changes such as name, business address or phone number, home address or phone number, board certification or recertification or loss of certification, must be reported to the Medical Staff Office.

“Failure to satisfy any of these basic obligations is grounds for such action as deemed appropriate by the final action of the Medical Staff or Board of Trustees pursuant to Section 1.6 of these Bylaws, and the Corrective Action and Fair Hearing Plan Manual.”

For more information see Wesley internal Intranet, Departments, Medical Staff Services, Policies, Medical Staff Bylaws.

Patient privacy (HIPAA)

All health-care providers are obligated to take reasonable safeguards to protect patient privacy. HIPAA (Health Insurance Portability and Accountability Act) regulations govern providers’ use and disclosure of health information, and grant patients rights of access and control. They also establish civil and criminal penalties for violations of patient privacy. Fines ranges from $100 to $50,000 for each episode. When privacy violations occur, disciplinary action will be taken.

Health-care providers’ obligation to protect patient health information includes all formats: written, electronic and oral communication.

Protected health information (PHI) may not be discussed in front of a patient’s family, friends and/or visitors without the patient’s permission. There are two exceptions to this portion of the rule: professional judgment and emergency situations.

In normal situations, you should ask individuals to momentarily leave a patient’s room while you discuss the patient’s health information/condition with the patient. Other situations when you should be especially aware of protecting verbal disclosures occur with reports, educating students, voice messages, telephone conversations, discussions in waiting rooms or semiprivate rooms. When discussing health information with another provider or the patient, use reasonable safeguards to prevent others from overhearing. Place patient walk lists in one of the hospital shredding bins rather than the trash. When using images for presentation, remove information that may identify the patient.

Hospital employees may request your Wesley Medical Staff identification number when questioning your identity on a telephone call requesting PHI.

Physicians may only access, use or disclose protected health information when they have a legitimate need to know in order to perform their job function, regardless of the extent of access provided to them.

For more information, see Wesley internal Intranet, Policies and Procedures, Administration, H. You can

You must sign, date and time all orders. Include your provider number and indication/reason on orders. Telephone orders must be signed, dated and timed within 48 hours of giving them.
also contact Wesley's privacy officer, Jo Jurgensen, director of Health Information Management, at 962-7770.

Patient rights and responsibilities

Upon admission, all patients are given a copy of “Patient Rights and Responsibilities.” A copy is presented to physicians at orientation; the list can also be found under Policies and Procedures, Administrative, sort alphabetically. Go, choose “Rights and Responsibilities of Patients.”

Patient rights include the right to accept or refuse any procedure, drug or treatment.

Inpatients also have the right to appeal their dismissal.

Physician immunizations

Physicians and allied health professionals working at Wesley are required to provide documentation of immunization against vaccine-preventable diseases and identification of susceptibility to infectious disease, as a condition of appointment, reappointment and continued affiliation, in accordance with the Joint Commission Infection Control Standards. This screening, vaccination and assessment are an essential part of Wesley’s infection control efforts to protect patients and safeguard co-workers from possible infection.

Wesley’s Employee Health Dept. will initiate, at no cost to the practitioner, testing for antibody titers as indicated to complete these requirements. The administration of any other immunizations to practitioners will be determined according to community prevalence and by Infection Control.

In the event of an outbreak with new public health recommendations, an announcement will be made and education and instructions will be provided. Annual vaccination with influenza vaccine will be offered to all practitioners working within the facility.

Physician Relations and Outreach Department

The Physician Relations and Outreach Department is a valuable resource for facilitating communication between Wesley and physicians throughout the state. The department’s staff members work with Wesley’s administrators, Medical Staff Office, and Continuing Medical Education Department to coordinate various services for physicians and their staff members. For more information, call the department at 962-2071.

Physician IT support

For assistance with computer issues, call the Information Systems Help Desk at 962-7800. Wesley’s physician support coordinator, Vinay Madur, is available at 962-7037 for issues such as Meditech and Simplified Remote Access (SRA). SRA provides physicians and their office staff with access to Wesley documentation modules such as Meditech when physicians are not in the hospital.

A tab entitled “For Physicians” on Wesley’s website (www.wesleymc.com) is a resource for helpful information and guidelines.

Quality and safety

Wesley has systems and programs in place to monitor and evaluate the quality of patient care and patient safety and to identify and address actual or potential risks.

Areas of focus are determined by hospital leadership in collaboration with the Medical Staff. Publicly reported data include core measure performance (see below) patient satisfaction data (HCAHPS), infection rates, and other specific project areas such as cardiothoracic surgery outcomes and care. We are committed to delivering excellent care based upon evidenced-based guidelines which are accepted at a national level.

The Medical Staff Office presents quarterly Quality Forums (which offer CME credit) that include hospital quality and patient safety information, speaker presentations on performance improvements at Wesley and updates on national patient safety goals and other regulatory reports. Make sure the Medical Staff Office has your email address so you can be invited to the Quality Forums, and check the bulletin board at the physicians’ entrance for forum dates and times.

The phone number for Wesley’s Quality Department is 962-3230. The number for Wesley’s Safety director is 962-2046.

Core Measures: Physician Responsibilities

AMI
ASA on admission
PCI within 90 minutes
Discharge meds: ASA
ACEI or ARB for LVF<40%
Beta blocker

Pneumonia (Order Set #243)
Correct abx within 6 hours
Blood cultures prior to abx
Pneumococcal and influenza vaccines

SCIP (Preoperative Order Set #347)
Correct abx within 1 hour of incision
DC abx within 24 hours (48 for CV surgery)
DC Foley within 48 hours
VTE prophylaxis

HF
LVF noted
ACEI or ARB for LVF<40%

CAC (childhood asthma)
Steroids during hospitalization
Home management plan completed

Stroke
VTE
tPA or why not
Anticoag for a-fib
Antithrombix rx by end of day 2
Discharge meds: antithrombotic, statin

Perinatal Core Measures 2010

- **PC-01: No elective delivery at >= 37 and < 39 weeks of gestation completed**
  Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed is to be a “never” event.

- **PC-02: Cesarean section rate**
  Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section

- **PC-03: Antenatal steroids:**
  Patients at risk of preterm delivery at 24-32 wGA receiving antenatal steroids prior to delivering preterm newborns

- **PC-04: Health-care-associated bloodstream infections in newborns**
  Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns

- **PC-05: Exclusive breast milk feeding**
  Exclusive breast milk feeding during the newborn’s entire hospitalization

Root cause analysis

Root cause analysis learning is offered as needed with regular updates through the Quality Forum CME programs which are usually held the third Thursday of each month. (See adverse event reporting in this guide.)

Interpreters

Patients, families and guests who do not speak English or who are deaf must be offered interpreting services for critical medical information. Critical medical information includes informed consent, symptoms, health history, tests/procedures, condition update, diagnosis/prognosis, treatment options and discharge planning/instructions. This practice is mandated by Title VI of the Civil Rights Act, the ADA of 1990 and Executive Order #13166.

Family and friends of non-English-speaking and deaf patients may not serve as interpreters for critical medical information unless specifically requested by the patient. Anyone under 18 years of age is not allowed to interpret, even if requested by the patient, as stated in the federal mandates mentioned above.

Telephonic interpreting is the first choice for providing interpreters for patients who have limited English. Speaker phones are provided in all departments.

To request an interpreter, page 123-0971 during weekdays; call Admissions at Ext. 22565 for interpreter services during evenings, nights, and weekends.

Reporting safety or quality concerns

Any concerns about the safety or quality of care provided at Wesley may be reported to The Joint Commission. No disciplinary action will be taken if concerns are shared with The Joint Commission. Reporting methods are:

- Toll-free Complaint Line: 800-994-6610
- Online: www.jointcommission.org/GeneralPublic/Complaint.
- Email: complaint@jointcommission.org
- Fax: Office of Quality Monitoring, 630-792-5636
- Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, Ill. 60181
Leadership

Wesley administration
President and CEO.................................Hugh Tappan
Chief Operating Officer .......................Steve Edgar
Chief Medical Officer .........................Francie Ekengren, MD
Chief Nursing Officer .........................Kathy Neely
Chief Financial Officer .......................Matt Leary
Associate Administrator ......................Jeff Sollis
GME Office Coordinator ......................Teresa Johansen — 962-2210
Coordinator .........................Greg Gawlik

Medical Staff Executive Committee
Steven Penner, MD ..................President
John Knudtson, MD ..................Secretary-Treasurer
David Norris, MD ..................Chair, Anesthesia
William Park, MD ..................Chair, Internal Medicine
Thomas Estep, MD ..................Chair, Surgery Service
Sam Felt, MD ..................Chair, Medical Director/Pathology
Thalia Lopez, MD ..................Chair, Ob/Gyn Service
Mark Mosley, MD ..................Chair, Medical Director/ED
Paul Pappademos, MD ........ Chair, Orthopedic Service
Joseph Parra, MD ..................Chair, Family Medicine Service
Lindall Smith, MD ..................Chair, Pediatric Service

Ex-Officio
Valerie Creswell, MD ..................Chair, Infection Control Committee
Robert McKay, MD ..................Mid-Continent Anesthesiology
William Palko, MD ..................Chair, Transfusion Committee

Medical Directors
Air Ambulance Transport ..................Francie Ekengren, MD
Anesthesia (WAC) ..................Michael Mueller, MD
Anesthesia (MCAC) ..................Robert McKay, MD
BirthCare Cntr & Birthrooms ........ Travis Stembridge, MD
Cardiac Rehab ..................Assem Farhat, MD
Cardiovascular ICU ..................Paul Uhlig, MD
Cardiovascular Lab ..................Wassim Shaheen, MD
Chest Pain ..................Wesley Kirk, MD
Community Liaison ..................Charlotte Kim, MD
Coronary Care ..................Barry Murphy, MD

Wesley Medical Education Department
Administrative Director: Cindy Ainsworth — 962-3361
GME Office Coordinator: Teresa Johansen — 962-2210
Visiting Medical Students: Rhonda Fransen — 962-2245
Medical Librarians: Leslie James and Jane Tanner — 962-2715
Audiovisual Services — Alyson Boor and Gene Haigler — 962-7130

Residency Program Program Director/Assoc. P.D. WMC Residency Coordinator
Anesthesiology Robert McKay, MD Rhonda Fransen — 962-2245
Family Medicine Paul Callaway, MD Katie Kellerman — 962-3976
Ruth Weber, MD Janell Vulgamore — 962-2212
Internal Medicine Garold Minns, MD Elaine Kleeb — 962-3182
Eli Brumfield, DO John Knudtson — 962-2210
Medicine/Pediatrics Robert Wittler, MD Teresa Johansen — 962-2210
Obstetrics/Gynecology Travis Stembridge, MD Jessica Johnston — 962-2269
David Grainger, MD Tara Shirley — 962-2269
Orthopaedics George Lucas, MD Becky Mann — 962-2211
Douglas Pence, MD
Pediatrics Robert Wittler, MD
Radiology Kamran Ali, MD Rhonda Fransen — 962-2245
Dan Davis, MD
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Patient color-coded wristbands

- Purple for do not resuscitate
- Red for allergies
- Yellow for fall risk
- Green for latex allergy
- Pink on limited extremity
- Bright lime green for pacemakers or internal defibrillators
- Orange for hazardous or cytotoxic drugs
- Rose pink insert inside clear armband for infection control

Employee uniform colors

- Nurses: maroon
- Support staff: navy blue
- Imaging: black
- Lab: maroon top with blue or black pants
- Pharmacy: granite
- Rehabilitation: hunter green
- Respiratory care: royal blue

CLEAN HANDS SAVE LIVES
Protect patients, protect yourself

Alcohol-rub or wash before and after EVERY contact

www.cdc.gov/handhygiene