

2018 ANNUAL REQUIRED PHYSICIAN EDUCATION

Main Line Health

<u>Annual Physician Education</u>	<u>INFLUENZA & VACCINE</u>	<u>IMPAIRED PROFESSIONAL</u>
<p><i>Please take some time to review this important educational content that is provided to all medical staff members on an annual basis per Joint Commission standards. There is useful information on a wide variety of topics.</i></p>	<ul style="list-style-type: none"> • MLHS has a Mandatory Flu Vaccination Policy for all health care personnel, unless medical or religious exemption granted • Flu Vaccination is available for all eligible patients during Flu season • MLH goal-100% compliance <p align="center"><i>Clean hands are the single most important factor in preventing the spread of dangerous germs and antibiotic resistant organisms in healthcare setting</i></p> <p>Use soap and water when hands are visibly soiled, when a patient has diarrhea, before and after eating and before and after using the bathroom . Otherwise, alcohol based hand sanitizers are appropriate for performing hand hygiene.</p>	<p>The term impaired is used to describe a practitioner who is prevented by reason of illness or other health problems from performing his/her professional duties at the expected level of skill and competency. Impairment also implies a decreased ability or unwillingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety. Some signs of impairment are deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability or neglecting commitments, excessive ordering of drugs, lack of or inappropriate responses to pages or calls, decreasing quality of performance or patient care.</p> <p>The Medical Staff Physician Health Committee (PHC) will assist the entry of a suspected or confirmed impaired practitioner into evaluation, appropriate treatment and/or rehab. The PHC is the identified body to which information and concerns about the suspected or confirmed impairment of a Medical Staff member can be referred for evaluation. Referrals can be from a physician or hospital staff member.</p> <p>Reference: Medical Staff Bylaws</p>
<p align="center"><u>COMPUTER DOWNTIME</u></p> <ul style="list-style-type: none"> • In the event of downtime, electronic downtime system “Mini Chart” is available to obtain most recent patient clinical information such as vital signs, medication lists, recent results, active orders. • For assistance, contact MLH Help Desk: 484-596-4357 		
<u>REPORTING CONCERNS</u>	<u>ENVIRONMENT OF CARE-Roles</u>	<u>DISRUPTIVE BEHAVIOR</u>
<p>Healthcare workers may anonymously report without fear of disciplinary action/retaliation any urgent pt. safety or quality concern as well as an improvement idea to: MLH Pt. Safety Hotline: 484-337-8888</p> <p>Concerns may also be reported to the Department of Health or the Joint Commission.</p> <p><u>PA Department of Health</u> Division of Acute and Ambulatory Care Room 532 Health and Welfare Building 625 Forster Street Harrisburg, PA 17120 1-800-254-5164 www.health.state.pa.us/complaint</p> <p align="center">or</p> <p><u>Joint Commission</u> Office of Quality and Patient Safety One Renaissance Boulevard Oakbrook Terrace, IL 60181 Phone: 1-800-994-6610 or E-mail: patientsafetyreport@jointcommission.org</p>	<p><u>Fire Safety</u> – if you see a fire: <u>RACE</u> Rescue/Remove persons(s)/patients/staff in immediate danger. Alarm—pull hospital fire alarm and dial 711 from a campus phone. Code Red is announced to the location by the operator. Contain/Confine the fire. Close all doors and windows. Extinguish the fire, if possible. If not, evacuate the area. Right-To-Know Staff should be familiar with the hazards posed by chemicals used in their workplaces. Read the label; check the Safety Data Sheet, available on the MLH employee intranet; questions, contact your <u>Safety/Security Department</u> <u>Infectious Waste</u>: proper disposal, red bag trash: sharps, including needles, syringes, lancets, scalpel blades, blood transfusion bags, etc.; pathological waste Contact the Safety/Security Department or Patient Safety Specialist/Risk Manager to report safety concerns <u>Internal/ External Disaster (Code Orange)</u></p> <ul style="list-style-type: none"> • Routine drills • A page is sent to medical staff, “type of disaster” • Further instructions to follow via page/overhead and who/where to report to in the event of a disaster • Report to the Physician Labor Pool Leader if instructed and further instructions will be provided <p>Please see the Individual Facility Emergency Operation Plan for further details. This can be found on the MLH intranet.</p>	<p>Disruptive conduct by a practitioner is behavior which adversely impacts on the quality of patient care, and includes verbal or physical abuse of colleagues, hospital personnel or patients, sexual harassment and threatening or intimidating behavior exhibited during interactions with colleagues, hospital personnel or patients. Behaviors that do not promote a culture of safety are considered disruptive and are not in accordance with the values of this organization. This conduct will not be tolerated. Any Medical/SHP staff member, employee or agent of the hospital, or patient may file a complaint against a practitioner’s disruptive conduct. No retaliation will be taken for reporting a concern in good faith.</p> <p>Complaints may be referred to the CEO (or designee), MEC Chair, applicable Department Chair, the CMO or other Medical Staff leader.</p> <p>Complaints should be in writing, although not required.</p> <p>Reference: Medical Staff Bylaws</p>

<u>CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIS)</u>	<u>SURGICAL SITE INFECTIONS (SSIS)</u>
<p>Risk Factors: Elderly, groin insertion site, number of lines inserted, multiple sticks during insertion, ventilated patient, history of congestive heart failure, surgery, diabetes, hypotension</p> <p>Prevention:</p> <ul style="list-style-type: none"> - Education and effective surveillance - Hand hygiene and aseptic technique (insertion and maintenance) - Chlorhexidine/gluconate skin antisepsis and let it DRY - Maximal barrier precautions for insertion (full barrier drape, hat, gown, gloves, mask) - Optimal catheter site selection-subclavian vein preferred or PICC - IV teams will perform daily assessment of site, dressing changes as needed - Restrict blood draws through central lines to emergent situations only - Adequate staffing - Discuss with the patient and the family the risk of infection associated with central line - Daily review of necessity/prompt removal if unnecessary 	<p>Risk Factors: Elderly, COPD, obesity, diabetes, smoking, hypothermia, hyperglycemia, wound class 3 (contaminated) or 4 (dirty), systemic steroid use, poor nutritional status</p> <p>Prevention:</p> <ul style="list-style-type: none"> - Treat remote infections prior to surgery - Appropriate hair removal with clippers, not razors - Good blood sugar control - Pre-operative antiseptic shower - Proper skin antisepsis - Proper pre-operative surgical scrub - Appropriate prophylactic antibiotics given at right time - Limit immediate use (flash) sterilization. Allow enough time for full processing of specialty/outside instruments (recommend day in advance of planned procedure) - Perform surveillance and give feedback of surgical site infections to providers - Maintain normal body temperature
<u>OTHER HEALTHCARE-ASSOCIATED INFECTIONS</u>	<u>MULTI-DRUG RESISTANT ORGANISMS (MDROs) AND CLOSTRIDIUM DIFFICILE (C. DIFFICILE)</u>
<p style="text-align: center;"><u>Catheter-Associated Urinary Tract Infections (CAUTIs)</u></p> <p>Risk Factors: Elderly, diabetes, post-partum, severe underlying illness, elevated serum creatinine, duration of catheterization</p> <p>Prevention: Trained personnel to insert catheters, hand hygiene, alternatives to catheterization, limited duration of use and use only when necessary, closed draining system, use antimicrobial-impregnated catheters</p> <ul style="list-style-type: none"> - Educate patient and family on the risk of a foley catheter - Evaluate the need of the catheter daily - remove when no longer necessary - External catheters in men should be considered - When possible consider intermitting catheterization rather than an indwelling catheter <p style="text-align: center;"><u>Ventilator-Associated Pneumonia (VAP)</u></p> <p>Risk Factors: Pre-existing pulmonary disease, multiple organ system failure, trauma or admission for burns, hemodialysis, corticosteroid use, multiple intubations, tracheostomy</p> <p>Prevention:</p> <ul style="list-style-type: none"> - Hand hygiene - Appropriate ventilator management - Assess readiness to extubate - Head of bed up 30-45° - Oral care <p>In the State of Pennsylvania Act 52 requires disclosure of any health care associated infection acquired during the patient's admission. A disclosure letter will be sent to your patient if an infection is identified that meets the CDC-National Health Safety Network surveillance definition. For questions related to the practice please call Infection Prevention or the Patient Safety Officer.</p>	<p>Risk Factors for MRSA: Dermatological conditions (eczema, psoriasis, non-healing ulcers), diabetes, IV drug use, contact with healthcare system, daycare, or prison</p> <p>Risk Factors for C. difficile: Elderly, CHF, COPD, cancer, longer length of stay, use of proton pump inhibitors, prior antibiotic use, tube feeding</p> <p>Prevention of MDROs and C. difficile:</p> <ul style="list-style-type: none"> - Judicious antimicrobial selection/use - Proper and frequent hand hygiene - Compliance with contact precautions education - Enhanced environmental cleaning - Decreasing hospital stays - Communication between facilities of patient's MDRO or C. difficile status <p>Patients are placed in isolation precautions to prevent the spread of communicable diseases. If your patient is in precaution you are expected to wear the designated personal protective equipment (PPE) when entering the room. There will be a sign posted on the patient's door with directions on the appropriate PPE. Removal of all PPE before exiting the room and perform hand hygiene. If you have questions regarding the isolation precautions, please call Infection Prevention.</p>

<u>HAND HYGIENE</u>	TWO METHODS FOR HAND HYGIENE: ALCOHOL-BASED HAND SANITIZER VS WASHING WITH SOAP AND WATER
<p>Risk Factors: 2 million patients are infected with healthcare associated infections (HAI). Hand Hygiene is the single most important role in preventing HAIs.</p> <ul style="list-style-type: none"> - Upon entering and leaving the patient room - Before and after having direct contact with a patient’s intact skin (taking a pulse or blood pressure, performing physical examination, lifting the patient in bed) - After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings - After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient <p>If hands will be moving from a contaminated-body site to a clean-body site during patient care:</p> <ul style="list-style-type: none"> - After glove removal - After using a restroom - Before eating 	<p>Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.</p> <p>When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting.</p> <p>Soap and water are recommended for cleaning visibly dirty hands.</p> <p>Soap and water should be used for hand hygiene when caring for a patients with suspected C. diff or Norovirus.</p> <p>When using alcohol-based hand sanitizer:</p> <ul style="list-style-type: none"> - Put product on hands and rub hands together - Cover all surfaces until hands feel dry - This should take around 20 seconds <p>Techniques for Washing Hands with Soap and Water</p> <ul style="list-style-type: none"> - When cleaning your hands with soap and water, wet your ands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15-20 seconds, covering all surfaces of the hands and fingers - Rinse your hands with water rand use disposable towels to dry. Use a towel to turn off the faucet. - Avoid using hot water to prevent drying of skin

ANTIMICROBIAL STEWARDSHIP PROGRAMS

Improving antibiotic use is a public health priority and the responsibility of all prescribers

- 20-50% of antibiotics prescribed in hospitals are either unnecessary or inappropriate
- Antimicrobial use and misuse is the key driver of resistance
- Resistance leads to increased likelihood of hospitalization, mortality, length of stay, and healthcare costs

MLHS has implemented antimicrobial stewardship programs at each hospital with a pharmacist and ID physician. Each program will provide education and updates related to antimicrobial stewardship throughout the year as needed.

Antimicrobial stewardship is defined as the optimal selection, dosage, and duration of antimicrobials.

Optimal outcomes include:

- Clinical cure
- Reduced length of stay
- Avoidance of toxicity and other adverse effects such as *Clostridium difficile*
- Avoidance of the emergence or propagation of antimicrobial resistance

Stewardship Interventions for Healthcare Providers:

- Be aware of antibiotic resistance patterns in your facility and community
- Do NOT treat asymptomatic bacteriuria, contamination, or colonization
- If a virus is identified and superinfection ruled out, stop antibiotics
- Review antibiotic therapy 2-3 days after it is started based on the patient’s clinical condition and microbiology culture results:
 - Rapid de-escalation based on culture and sensitivity results
 - Evaluate if shorter durations are possible (i.e. 3-5 days for uncomplicated cystitis, 5-7 days for CAP upon resolution of signs and symptoms, etc.)

- When possible convert intravenous to oral antibiotics
- Optimize dosages of antimicrobial agents:
 - Renal dose adjustments
 - Therapeutic drug monitoring when indicated– vancomycin, gentamicin, tobramycin levels!
- Remember to follow clinical guidelines when prescribing antibiotics, this includes:
 - Right antibiotic
 - Right dose
 - Right duration
- Enforce 24 hour time limits for surgical prophylaxis
- Detect and prevent antimicrobial drug-drug interactions and adverse events
- Talk to patients and families about when antibiotics are not needed and discuss possible harms (allergic reactions, *C. difficile*, antibiotic resistance)
- Prevent unnecessary overlap in antimicrobial coverage

References:

- Fishman N. *Am J Med*; 2006; 119(6A): S53-S61
- George et al. *Pharmacotherapy* 2012;32(8):707-721.
- Dellit T.H.et al. *Clin Infect Dis*. 2007;44:159-177.
- CDC. Atlanta, GA 2013. <https://www.cdc.gov/drugresistance/pdf/ar-threats-2013-508.pdf>

ORAL ANTICOAGULANT USE

The relatively new group of oral anticoagulants consists of 2 classes: Factor Xa inhibitors (i.e. Apixaban (Eliquis[®]), Edoxaban (Savaysa[®]), Rivaroxaban (Xarelto[®])) and Direct Thrombin Inhibitor (dabigatran (Pradaxa[®])). Collectively this group is commonly referred to as Direct Oral Anticoagulants (DOACs). DOAC is the preferred abbreviation since NOAC has been misunderstood to mean “No anticoagulation”. An advantage of the DOACs as opposed to warfarin is that the DOACs have no food interactions and fewer drug interactions. Of note, P-Glycoprotein (p-GP) inhibitors and dual p-GP and CYP 3A4 inhibitors/inducers will require a dose adjustment or avoidance of concomitant use of the DOAC.

Dosing for the DOACs is a fixed dose but is dependent on indication as well as creatinine clearance (CrCl). Renal function should be evaluated prior to making a decision about use and dose of DOACs. In the non-valvular atrial fibrillation (NVAf) trials for dabigatran, rivaroxaban and edoxaban (RE-LY, ROCKET-AF and ENGAGE-TIMI, respectively), all excluded patients who had a CrCl < 30 mL/min. However, dabigatran dose may be reduced to 75mg BID if CrCl is between 15-30mL/min which is based on pharmacokinetic data, and rivaroxaban and edoxaban may also be used at a reduced dose for patients with CrCl between 15-50mL/min as shown in the table below. In apixaban’s NVAf trial (ARISTOTLE) patients were excluded if CrCl was < 25mL/min or SCr > 2.5mg/dL. However, according to the package labeling a reduced dose may be used for NVAf patients if certain criteria are met. When used in NVAf patients, apixaban can also be used in patients with end-stage renal disease (ESRD) at a full-dose (if no other age or weight criteria are met) – however, this was based off of a single dose pharmaco-kinetic/-dynamic study. All VTE trials for the DOACs excluded patients with CrCl < 30 ml/min (and CrCl 25ml/min or SCr > 2.5mg/dl for apixaban) but offer no further guidance/dose reduction recommendations for this indication. The 2016 CHEST guidelines recommend warfarin as the preferred anticoagulant in patients with renal disease and CrCl < 30ml/min.

Theoretically, because of the rapid onset of these agents, there is no need to bridge with heparin or low-molecular weight heparins (LMWHs). However, because of the design of the VTE trials for dabigatran and edoxaban – patients starting on these agents for VTE treatment must first use a parenteral anticoagulant and then switch to dabigatran or edoxaban (with NO overlap of therapy), as opposed to apixaban or rivaroxaban which can be started without initial parenteral therapy.

In terms of special populations, pregnant patients were excluded from clinical trials and therefore DOACs are not recommended in this population. Warfarin is teratogenic and should only be considered for high-risk pregnant patient with mechanical heart valves if benefit outweighs the risk. LMWHs (i.e. enoxaparin, etc.) are the anticoagulant of choice in a pregnant patient. VTE is the leading cause of mortality in patients with malignancy. LMWHs are recommended based on superiority compared to vitamin K antagonists (VKAs) and DOACs. A recent meta-analysis of 6 randomly controlled trials for DOACs (n=1,132) showed that DOACs are at least as effective and safe as treatment with VKAs for prevention of VTE recurrence. In regards to obese patients, DOACs display decreased plasma concentrations as BMI increases but this is not clinically significant in obesity and therefore, no dose adjustment is warranted. Of note, data is limited with extreme weights (i.e. < 50kg or > 150kg/Grade 3 obesity) and caution should be used when evaluating DOAC appropriateness.

If a patient presents with a serious/life-threatening bleed, a reversal agent may be administered. When reversing warfarin, vitamin K along with 4-factor prothrombin complex concentrate (4F-PCC) (dose dependent on INR at presentation) may be given along with supportive care. Dabigatran is the only DOAC with an FDA approved reversal agent which is idarucizumab. At MLH, the recommended reversal agent for factor Xa inhibitors is 4F-PCC at a fixed dose of 50 units/kg, along with supportive care. Other reversal agents are projected to hit the market sometime this year.

RESTRAINT CARE-PHYSICIANS

Physicians and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) must have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

Restraints: Medical/Surgical Care	Restraints: Patients Exhibiting Violent/Destructive Behavior
<ul style="list-style-type: none"> • The licensed independent practitioner (LIP) (the physician or 2nd & 3rd year resident) will complete the order for each episode of restraint. • LIP determines the need for reordering restraints based on the reassessment. • Completion of a written order by the licensed independent practitioner is required to reinstitute restraints beyond the initial episode. • LIP will participate in the daily review and restraint reduction measures. <p><u>Assessment, Restraint Criteria</u></p> <ul style="list-style-type: none"> • The patient is assessed by the registered nurse or physician to determine if the patient is at risk for interfering with medical treatment, including: <ol style="list-style-type: none"> 1. Pulling at medical appliances; 2. An assessment reveals a condition or symptom that indicates the need for an intervention to protect the patient from harm. <p><u>Implementation and Orders</u></p> <ol style="list-style-type: none"> 1. There must be a written, time-limited order by a physician for restraints. The order may not be written by a PA, CRNP, or first year resident. 2. The time-limited order must include: Start date and time, stop date and time, reason for use, and type of restraint. 3. Standing orders or PRN (also known as "as needed") orders for restraint or seclusion are prohibited. 4. Staff may not discontinue a restraint and then restart it under the same order. This would constitute a PRN order. 5. If a physician is not available to issue such an order, restraint use may be initiated by a registered nurse on an <u>emergent basis</u>. In that case, a physician is notified during the emergent application or <u>immediately after</u> the restraint has been applied. A verbal or written order is obtained from that practitioner and entered into the patient's medical record. Verbal orders for initiating restraints must be co-signed, dated and timed according to MLH policy for authentication. 6. <u>Re-application of Restraints</u>: If a patient was recently released from restraints and exhibits behavior that can only be handled by the reapplication of restraints, a NEW order is required. 7. Restraints may be <u>released to care</u> for patient needs – for example toileting, feeding and range of motion – this is not considered a discontinuation of restraints; therefore, no new order is needed. 8. Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient (formerly, med/surg care) are <u>renewed every calendar day</u> as warranted based on the continuing need for restraint. <ul style="list-style-type: none"> • <u>Death Reporting Requirements</u>: The hospital must report to CMS each death (with the exception of soft wrist restraints) that occurs while a patient is in restraints at the hospital. 	<p><u>Assessment, Restraint Criteria</u></p> <p>When the restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member(s), or others, a physician must see the patient <u>face-to-face within 1 hour</u> after the initiation of the restraint. This physician must evaluate and document:</p> <ul style="list-style-type: none"> • The patient's immediate situation; • The patient's reaction to the intervention; • The patient's medical and behavioral condition; • The need to continue or terminate the restraint. <p>If the face-to-face evaluation is conducted by a physician <u>other than the attending</u> physician, the attending physician who is responsible for the care of the patient must be consulted as soon as possible after completion of the evaluation.</p> <p><u>Implementation and Orders</u>:</p> <p>When restraint or seclusion is initiated for behavioral health purposes, the physician does the following:</p> <ul style="list-style-type: none"> - Reviews with staff the patient's physical and psychological status. - Determines whether restraint or seclusion should be continued. - Guides staff in identifying ways to help the patient regain control. <p>There must be a <u>written, time-limited order</u></p> <p>Four hours for patients ages 18 and older Two hours for patients ages 9 to 17 One hour for patients under age 9</p> <ul style="list-style-type: none"> • When restraint or seclusion is initiated <u>without an order</u> by a physician, within one hour, qualified staff does the following: <ul style="list-style-type: none"> - Notifies the physician as soon as possible - Obtains an order (verbal or written) from a physician. - Consults with the physician about the patient's physical and psychological condition. • The physician who is primarily responsible for the patient's ongoing care conducts <u>face-face re-evaluation in 24 hours</u> • At the time of the <u>in-person evaluation</u> of the patient who is in restraint or seclusion for behavioral health purposes, the physician does the following: <ul style="list-style-type: none"> - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion

Pain Management

The hospital respects the patient's right to effective pain management. Pain management is a multi-disciplinary process, characterized by continual coordination and communication of the plan of care towards the improvement of patient outcomes: increase comfort, reduced side effects, and enhanced patient satisfaction.

Opioid analgesics rank among the drugs most frequently associated with adverse drug events. Adverse effects associated with opioids include: an increased risk of respiratory depression (especially in opioid naïve patients, elderly, history of obstructive sleep apnea, history of smoking, pre-existing respiratory or cardiac disease); drug-drug interaction (i.e. with co-administration of benzodiazepines or cardiac medications); improper prescribing and administration of multiple opioids and modalities of opioids (oral, parenteral, and transdermal); and inadequate monitoring of patients on opioids.

Formal pain consultations may be performed for any patient with pain (requires a physician's order). Pain consultations are done by specially trained staff. Assistance with dose conversion is also available through pharmacy and pain expert, as well as an opioid converter tool and pain pocket guide in Smart Chart available via Links.

Some other key reminders include:

a. Dilaudid 1 mg IV is equal to 7 mg of Morphine IV

- b. Consider oral opioids as first line treatment for pain, if patient tolerating p.o.
- c. Consider using Tylenol or NSAIDs as an adjunct to opioids

Clinical Alarms Safety

- Main Line Health maintains alarms with manufacturer default settings; however, to reduce alarm fatigue, SPO2 alarm has been decreased from 90-88%, as well as a 15 second delay before alarming. Low heart rate has also been decreased from 50 to 48 (adult population in Tele/ICU)
- Staff, within their clinical expertise, may adjust alarm settings from MLH alarm parameters when it is safe to do so and will reduce non actionable alarms
- No one is permitted to disable/defeat alarms at Main Line Health

ASAP METHOD

The Surgical Clinical Environmental Workgroup at Main Line Health has developed the below handling process to be utilized whenever specimens are extracted

A AWARENESS / Awareness of the anticipated specimen(s)

GOAL: In the Time Out, build awareness of the potential specimen(s), necessary containers and labels

S STOP / Extract and stop

Goal: A moment when the entire team is engaged around specimen extraction.

Action: Surgeon-driven hard stop communication to the team that the specimen has left the body

A AREA / An assigned specimen location to prevent loss

Goal: To provide a well-defined in the room for specimen handling

Action: Movement of the specimen(s) from the surgical field to the assigned location with repeat back for each specimen

Note: Reconciled by Surgeon and Circulator

P POSITIVE IDENTIFICATION / Visualize, Finalize, Sign-off

Goal: A debrief process by which specimens are successfully collected and cannot be lost

Action: Visualization of the specimen, verification or proper labeling and requisition of proper labeling and requisition information with repeat back

RED RULE

An act having the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time.

“Red” designates the rule as a **safety absolute** with the highest priority for *exact compliance*

Highlighting this ‘safety absolute’ is meant to elevate specific **acts to ingrained work habits** to achieve highest level of compliance and reliability.

Our MLH RED RULE is Patient Identification

- Physician will ask alert* patient to state name and date of birth in the following instances:
 - At the time of initial patient introduction in a hospital or procedural setting
 - When obtaining blood or other specimens from the patient
 - Diagnostic/therapeutic procedures
 - Obtaining informed consent

* If not alert the wrist band will be used for identification

HEPATITIS C SCREENING (PA ACT 87)

Q: Who gets screened?

A: Baby Boomers (born between 1/1/1945-12/31/1965) who receive health services as an inpatient in a hospital or receive primary care services in an outpatient department of a hospital. Exceptions: Individuals being treated for a life threatening emergency; have been previously tested and/or lack capacity to consent to the test.

Q: Where can I find education on Act 87?

A: There is a hyperlink on the Admission Assessments. The location for the CDC education sheet: “*Hepatitis C Why Baby Boomers Should Get Tested*” is located on the Patient Family Education Site (PFE) on the intranet.

Hospital Process: If the patient (a) qualifies based on RN screening, (b) requests screening, and (c) the provider will be contacted to order a *HEPATITIS C ANTIBODY*.