# FAIRVIEW HEALTH SERVICES

# JOINT COMMISSION/CMS
## Physician and Allied Health Education

2017

FAIRVIEW

# Joint Commission/CMS Educational Requirements

- The following information is provided to all credentialed providers.
- Located throughout The Joint Commission chapters are standards that specify the need to educate physicians and allied health staff about various topics.
- The following PowerPoint presentation covers required education materials for 2017.
- We appreciate your review of this educational information. If you have questions please contact the Medical Staff Office (contact information listed on the last page).

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# Fairview's Mission

*Fairview is driven to heal, discover and educate for longer, healthier lives.*

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# Code of Professional Behavior

All medical staff and allied health staff of Fairview Health Services acknowledge the guiding code for our professions, and as part of the credentialing and privileging process commit to:

- Place the patient at the center of all we do
- Apply the best science we know
- Model the highest level of professionalism
- Actively engage as a collaborative member of the care team
- Be aware of, and comply with the Bylaws, Rules and Regulations and applicable Policies of the entities within which we work

# Place the patient at the center of all we do

- I am readily available and approachable
- I discuss medical conditions and medically appropriate treatment choices available with each patient
- I advocate for the patient
- I collaborate with other members of the care team to coordinate care.
- I respect patient confidentiality
- I respect patient diversity
- I encourage questions and respond to them openly
- I respect the important role of family and friends
- I will do my best to meet patient needs within the constraints of science, ethics and available resources.

# Apply the best science we know

- I maintain professional knowledge by attending continuing education, reading and learning from colleagues
- I avoid treatment and procedures that are not in keeping with the latest science
- I consult with experts in all professions and I don't provide care outside my area of expertise
- I acknowledge by my actions and words that I am an educator for patients, family and colleagues and I have a duty to apply the best possible science to that role.
- I disclose real or potential conflicts of interest that may create the perception of bias.

# Model the highest level of professionalism

- I share information and knowledge proactively with other members of the care team
- I communicate effectively with colleagues and avoid rude or confrontational behavior
- I maintain a respectful manner
- I challenge the professional judgment of others in a polite manner and I do not speak negatively of other health providers to patients and families
- I model appearance and deportment in a way that provides confidence and comfort to the patients.
- I will refrain from sexual contact or romantic relationships with a patients.
- I refrain from conduct and activities that may impair professional judgment and ability to act competently

# Actively engage as a collaborative member of the care team

- I actively participate in team conversations, meetings and rounds related to care
- I am willing to actively engage in medical staff committees
- I am willing to share helpful information
- I listen to others
- I communicate effectively with referring physicians
- I respond to colleagues and staff in a timely manner
- I manage hand-offs well

# Be aware of and comply with the rules

- I have an obligation to understand and follow pertinent Fairview policies
- I help create and sustain standards of care delivery
- I monitor my own behavior and the behavior of others
- I provide honest feedback and coaching to others when needed

# Reporting Concerns

- **Environmental / Safety** - Contact facility operations director at your location

- **Patient/ healthcare concerns**
  - Contact facility representatives at your location or
  - Office of Health Facility Complaints
    Suite 300, 85 East 7th Place
    St. Paul, MN 55101
    651-201-4200 or

  - The Joint Commission
    Office of Quality Monitoring
    One Renaissance Boulevard
    Oakbrook Terrace, IL 601811-800-994-6610

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Prevention of Healthcare Associated Infections

# Hand Hygiene

National Patient Safety Goal

- **Health care workers are expected to perform hand hygiene using soap and water or alcohol rubs:**
  - Before touching a patient
  - After contact with a patient
  - After contact with the patient environment
  - When removing gloves
  - When changing from dirty to clean procedures; includes procedures with the same patient.
  - Before invasive procedures (i.e. inserting indwelling urinary catheters, IV devices)
  - When contamination with body substances has occurred
  - Before touching own eyes and mouth
  - After toileting, using soap and water and turning faucet off with paper towel
  - Before eating
- **Alcohol rubs are effective and are the preferred method for routine hand hygiene.**

**NOTE:** These products may not be used if hand skin is visibly soiled nor when exiting an enteric isolation room. In these instances, use of soap and water for hand hygiene is required

Prevention of Healthcare Associated Infections

# Prevent: Central Line Bloodstream Infections (CLA-BSI)

- **Aseptic Insertion of Vascular Catheters:**
  - Hand Hygiene prior to insertion and before any line manipulation
  - Standardized protocol through use of kits/carts/checklists
  - Use of maximal sterile barriers (cap, mask, sterile gown, sterile gloves and large sterile drape)
  - Chloraprep for skin antisepsis (except infants < 1000 gm – use Betadine solution)
  - Avoid the use of femoral vein unless other sites are not available

**Educate the patient/family prior to catheter insertion and document in the patient's medical record.**

- **Appropriate Maintenance of Vascular Catheters**
  - Protect catheter site with sterile dressing; use biopatch disc according to the policy.
  - Regularly assess dressing to ensure that it is clean, dry and intact. Change dressing when damp, loosened or soiled, or every 7 days (transparent dressing) or every 48 hours (gauze dressing).
  - Perform hand hygiene before accessing line or changing dressing.
  - Scrub (don't just wipe) the hub and allow to dry before accessing ports.
  - **Do daily evaluation of central line necessity, and remove when less invasive option can be used.** Document evaluation in patient's medical record.

# Prevent: Surgical Site Infections (SSI)

**Educate patient/family on strategies to prevent SSI including:**

- Not smoking
- Pre-op showering with an antiseptic agent the evening before and the morning of surgery. Clean towels, clean sheets on the bed and clean clothing after showering are also important.
- Proper hand hygiene
- Following surgeon's instructions on wound care

**Staff to follow best practices for:**

- Antibiotic dosing
- Surgical Site Preparation
- Follow/support all perioperative guidelines and policies

Prevention of Healthcare Associated Infections

# Antimicrobial Stewardship

- Burden of Antimicrobial Resistance in the Untied States
  - Center for Disease Control (CDC) estimates that more than two million people are sickened every year with antibiotic-resistant infections, with at least 23,000 dying as a result.
- Four Core Actions to Fight Antimicrobial Resistance
  - Prevent Infections- Prevent the spread of resistance through immunizations, handwashing and using antibiotics as directed
  - Tracking-
    - Information gathered by the CDC helps experts to develop specific prevention strategies
  - Improving Antibiotic Prescribing/Stewardship
    - Change the way antibiotics are used. Up to half of all antibiotic use is unnecessary and inappropriate.
    - Commit to always use antibiotics appropriately and safely- only when needed to treat disease, and to choose the right antibiotics to administer them tint he right way every time.
  - Develop New Drugs and Diagnostic Tests
    - Antibiotic resistance occurs as part of a natural process in which bacteria evolve. It can be slowed but not stopped. Therefore, new antibiotics are always needed to keep up with resistant bacteria

## Prevention of Healthcare Associated Infections

# Antimicrobial Stewardship

- What You can do-
  - Promote Antibiotic Best Practices
    - Ensure all orders have a dose, duration and indication
    - Get cultures before starting antibiotics
    - Take an "antibiotic timeout" reassessing antibiotics after 48-72 hours
  - Help patients understand that "less is better" for antibiotics
  - Practice good hand hygiene
  - Be collaborative with your Antimicrobial Stewardship Teams
    - Fairview System Stewardship Efforts
      - Formal Antimicrobial Stewardship Programs have been established at 3 hospitals
        - » Joint efforts between Infectious Disease Providers, Pharmacists and Infection Prevention
        - » Active intervention with real-time feedback
      - System Antimicrobial Subcommittee
      - Order sets developed with antimicrobial best practices in mind

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Prevention of Healthcare Associated Infections

# Multiple Drug Resistant Organism Prevention

National Patient Safety Goal

## ISOLATION

- **Contact Isolation** for care of the patient with MRSA, VRE, CRE, ESBL, and other MDROs.
- **Enteric Isolation** for care of patients with diarrhea-associated *Clostridium difficile*, norovirus or any other diarrhea type illness.
  - Alcohol rubs and foams may not be used if hand skin is visibly soiled **or when exiting an enteric isolation room**.
  - In these instances, use of soap and water for hand hygiene is required.

## EDUCATION

Educate patient and families regarding their MDRO status. Patient education materials are located in Krames On-Demand through the Fairview Intranet and EPIC.

Document patient education in EPIC. Documentation is how we monitor our compliance for providing patients and their families with education.

Prevention of Healthcare Associated Infections

# Isolation Practices

## Contact Isolation

- Requires Glove & Gown to enter: Past the swing of the door.

- Required for all staff – CDC & MN. Statue
  - Includes all care providers, physicians, nurses, ancillary staff and volunteers

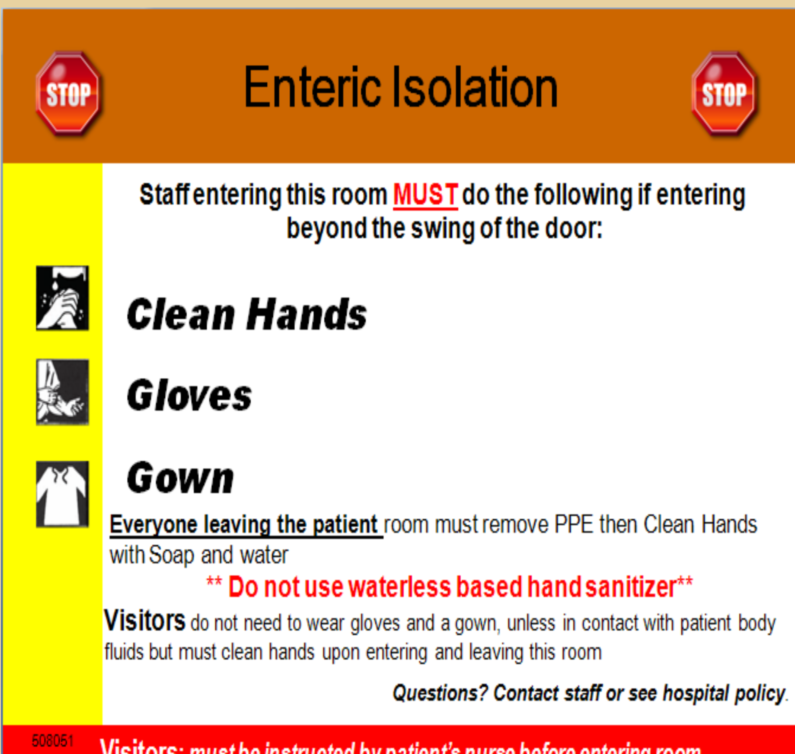
# Isolation Practices

## Enteric Isolation

**NEW**

<u>Use for patients with diarrhea</u>

- To identify potential or known C-difficile patients
- Noro-like viral gastroenteritis, rotavirus, etc.
- Stresses Hand Washing with Soap & Water



Prevention of Healthcare Associated Infections

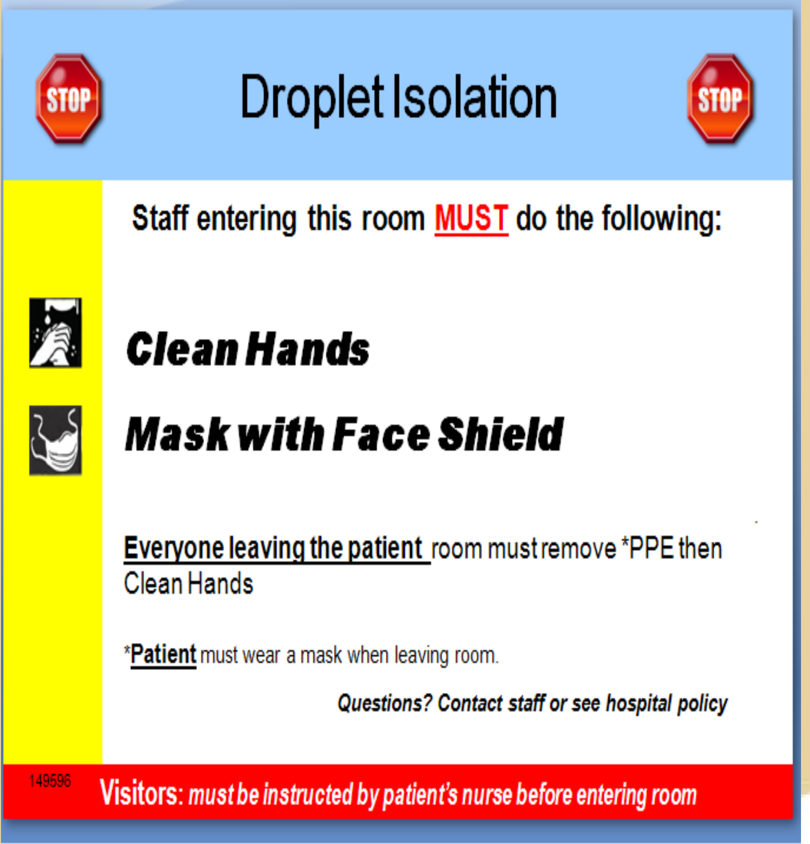
# Isolation Practices

## Droplet Isolation

Mask with face-shield is required to enter the room

- Use for suspect or known acute respiratory infections:

  (e.g., Influenza, RSV, Pertussis, Adenovirus, Parainfluenza, and N. meningitis)



Prevention of Healthcare Associated Infections

# Isolation Practices

## Airborne Isolation Safe Practice

**TB:** Requires a respirator to enter the room.

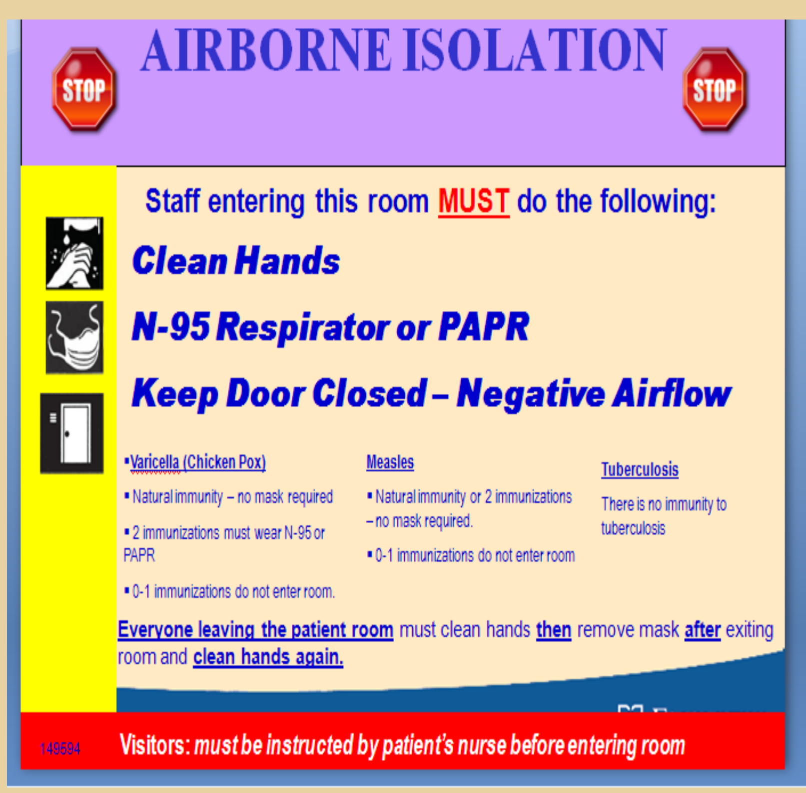
**Measles:** Requires immunity to enter.

**Chickenpox & Disseminated zoster:**

**Requires a respirator to enter**: if immunity is by vaccination (**2 vaccines**),

And: if 0-1 vaccine – Do not enter

Natural immunity- respirator not required.



# Influenza

- Annually,  the Center for Disease Control (CDC) provides the current recommendation for seasonal influenza vaccination.
- The  Fairview Health System Infection Prevention Committee provides recommendations specific to our hospitals and clinics based on CDC and Minnesota Department of Health recommendations.
- All Medical Providers and Allied Health Professionals are required to receive the influenza vaccination yearly or complete a declination .

# Influenza

- **When should health care providers start and stop vaccination efforts?**
  - Vaccination should begin as soon as flu vaccine is delivered. Manufacturers distribute vaccine as production is completed. Distribution of vaccine can begin in August and continue through the fall. Most seasons, vaccine distribution is completed by January.
  - Flu vaccines may be offered to patients when they are seen by health care providers for routine care or as a result of hospitalization.

# Fire Safety

*What if I discover a fire? (R-A-C-E) Rescue-Alert-Confine- Extinguish/Evacuate*

- **Rescue** any person from immediate danger.
- **Alarm/Alert**
  - Pull the emergency fire alarm.
  - Call the emergency number for your site.
  - Be prepared to tell them:
  - Who you are.
  - Where you are.
  - How large is the fire.
  - What type of fire it is.
  - If people are in danger.
  - Stay on the line until the operator ends the call, unless in immediate danger.

# Fire Safety continued

- **Confine** the fire
  - Close all doors and windows.
  - Turn on all lights.
  - Clear the hallway.
  - Stop movement in/out of area.
- **Extinguish** the fire if it is safe and you know how to use the fire extinguisher or **Evacuate** if you are in danger or are directed by the fire response personnel.

- ***What do I do if I hear a Code Red?***
  - **STOP** – Do not go through smoke doors unless needed for immediate patient care.
  - Stop pedestrian traffic where alarm is sounding.
  - Restrict use of hospital telephones to emergencies only.
  - Do not use elevators in building where alarms are sounding.

# Unacceptable Abbreviations

| DO NOT USE | ACCEPTABLE |
|---|---|
| QD, Q.D., qd, q.d.<br>QOD, Q.O.D., qod, q.o.d. | Write “daily,” “every other day” |
| MS, $MSO_4$, $MgSO_4$ | Morphine Sulfate or Magnesium Sulfate |
| U or u | Units |
| IU | International Units |
| Trailing zero: 1.0 | 1 |
| Lack of leading zero: .1 | 0.1 |
| µg | Microgram or mcg |
| Chemotherapy abbreviations. | Spell out all chemotherapy drug names |
| Abbreviations for ear: au, as, ad<br>Abbreviations for eye: ou, os, od | Spell out “ear” and “eye”<br>Spell out “both,” “left,” and “right” |

# Pain Management Strategies

**The fundamentals of safe and effective pain management in the hospital include the following steps:**

1. Identify the type of pain to treat and
2. Use the correct co-analgesic for that type of pain. Do not rely solely on opioids to treat pain. Opioids are rarely totally effective when used alone.

| Type of Pain | Co-analgesic |
|---|---|
| Inflammatory | NSAID |
| Muscular | Muscle Relaxant |
| Neuropathic | Gabapentin |
| Bone | NSAID |

# Pain Management Strategies
cont'd

3. Account for patient's home analgesics when planning for a change in analgesics:

   *E.g. Oxycontin 60 mg po* Q *12 hrs + oxycodone 15mg PO Q* 4 *hrs PRN= total of 210 mg oxycodone/day.*

   *This is equivalent to hydromorphone 15.75 mg IV/day.*

   *Could be administered as hydromorphone 1-2 mg IV Q3Hrs PRN or*

   *0.5 mg/hr infusion +0.3 mg Q 10 minutes PRN via PCA*

4. Use only one scheduled long acting/continuous Opioid infusion and one short acting PRN Opioid together. Using multiple long acting and short-acting Opioids increases the risk of drug side effects, and does little to improve pain relief.

# Pain Assessment Tools

## When Patients can self-report

| Domain | Coded Documentation |
|---|---|
| Comfort | • Intolerable<br>• Tolerable with discomfort<br>• Comfortably manageable<br>• Negligible pain |
| Change in Pain | • Getting worse<br>• About the same<br>• Getting better |
| Pain Control | • Inadequate pain control<br>• Partially effective<br>• Fully effective |
| Functioning | • Can't do anything because of pain<br>• Pain keeps me from doing most of what I need to do<br>• Can do most things, but pain gets in the way of some<br>• Can do everything I need to |
| Sleep | • Awake with pain most of night<br>• Awake with occasional pain<br>• Normal Sleep |

### Pain Assessment Tool

Do you have pain? How much pain do you have? Choose one of these three scales to measure your pain.

| Scale | Description | Faces |
|---|---|---|
| 10 | Pain as bad as it could be | 10 Hurts worst |
| 9, 8 | Extreme pain | 8 Hurts whole lot |
| 7, 6 | Severe pain | 6 Hurts even more |
| 5, 4 | Moderate pain | 4 Hurts little more |
| 3, 2 | Mild pain | 2 Hurts little bit |
| 1, 0 | No pain | 0 No hurt |

# Pain Assessment Tools:

## When Patients are unable to self report

When patients are unable to self-report, use one of the following scales:

### FLACC Pain Scale

| | Scoring | | |
|---|---|---|---|
| | 0 | 1 | 2 |
| F – Face | No particular expression or smile | Occasional grimace or frown, withdrawn, disinterested | Frequent to constant quivering chin, clenched jaw |
| L – Legs | Normal position or relaxed | Uneasy, restless, tense | Kicking, or legs drawn up |
| A – Activity | Lying quietly, normal position, moves easily | Squirming, shifting back and forth, tense | Arched, rigid or jerking |
| C – Cry | No cry (awake or asleep) | Moans or whimpers, occasional complaint | Crying steadily, screams or sobs, frequent complaints |
| C – Consolability | Content, relaxed | Reassured by occasional touching, hugging or being talked to, distractible | Difficult to console or comfort |

| | 0 | 1 | 2 | Score |
|---|---|---|---|---|
| Breathing (independent of vocalization) | Normal | Occasional labored breathing, short periods of hyperventilation | Noisy labored breathing, long period of hyperventilation, Cheyne-stokes respirations | |
| Negative vocalization | None | Occasional moan or groan, low level of speech with a negative or disapproving quality | Repeated trouble calling out, loud moaning or groaning, crying | |
| Facial expression | Smiling or inexpressive | Sad, frightened, frowing | Facial grimacing | |
| Body language | Relaxed | Tense, distressed, pacing ,fidgeting | Rigid, fists clenched, knees pulled up, pulling or pushing away, striking out | |
| Consolability | No need to console | Distracted or reassured by voice or touch | Unable to console, distract or reassure | |
| | | | | Total |

# Pain Assessment Tools cont.

System Pain policy with additional tools can be found at:
http://intranet.fairview.org/Policies/Category/PatientCareClinicalGuidelines/S_071242

## CAPA® Tool (modified)

The conversation leads to documentation- not the other way around.

| Question | Response |
|---|---|
| Comfort | •Intolerable<br>•Tolerable with discomfort<br>•Comfortably manageable<br>•Negligible pain |
| Change in Pain | •Getting worse<br>•About the same<br>•Getting better |
| Pain Control | •Inadequate pain control<br>•Partially effective<br>•Fully effective |
| Functioning | •Can't do anything because of pain<br>•Pain keeps me from doing most of what I need to do<br>•Can do most things, but pain gets in the way of some<br>•Can do everything I need to |
| Sleep | •Awake with pain most of night<br>•Awake with occasional pain<br>•Normal Sleep |

# Rapid Response Team Activation

- The Rapid Response Team brings critical care skills to the bedside. They will respond expeditiously to a decline in a patient's condition.
- If you have concerns about a patient and feel they need immediate and urgent help, please contact the nursing staff and they will call a Rapid Response team.
- Families and patients are also instructed to contact a Rapid Response Team in the event of a need for emergency or urgent help.

# Restraints for Nonviolent Patients

- Orders: Restraints must be ordered by an MD, DO, PA, or NP who has completed restraint education and is involved in the care of the patient. In an emergency, RNs may apply restraints, but an order must be obtained as soon as the situation that required the application of the restraint is addressed and the patient is determined to be safe and stabilized (at least within 1 hour).
- The attending physician must be notified as soon as possible if s/he did not order the restraint.
- Standing and PRN orders are not allowed.
- **Restraint orders must be re-written each calendar day.** The provider must examine the patient prior to reordering restraints each day and write a note specific to the patient's condition that requires continued restraint.
- Telephone orders may be accepted for initial application of restraints.

# Restraints/Seclusion for Violent Or Self-Destructive Patients

- An order must be obtained immediately after the restraint has been applied.
- One Hour Exam: **Within 1 hour** of placing the patient in restraints or seclusion, the **patient must be examined by the physician, PA or NP**
- The ordering practitioner must review the patient's physical and psychological status with staff, determine whether restraint or seclusion should be continued, and help identify ways to assist the patient to regain control.
- Documentation of the evaluation must discuss the patient's immediate situation, reaction to the intervention, medical/behavioral condition, and the need to continue or terminate the restraint/seclusion.

# Restraints/Seclusion Cont'd

- **Orders** for Violent or Self-Destructive patients are **time-limited and expire** in:
  - 4 hours for adults (age 18 and older)
  - 2 hours for adolescents (ages 9 through 17)
  - 1 hour for children under age 9
  - If restraint/seclusion needs to continue beyond the expiration of the previous order, a re-evaluation must occur and the practitioner must give a new order. The re-evaluation may be done by the practitioner or other trained staff. However, the physician must reevaluate the patient at the bedside at least every 8 hours for patients aged 18 or older and every 4 hours for patients aged 17 and younger.

**For Behavioral Health Patients**

- A debriefing about each episode of restraint/seclusion occurs as soon as possible, but no longer than 24 hours after the episode.

# Anticoagulation

**Heparin**

- Pharmacists are typically consulted to dose and manage heparin infusions.
- Heparin infusions are monitored using heparin 10a levels. Heparin 10a levels are monitored every 6 hours after initiation or rate change and then daily once in therapeutic range.
- There are three protocols – low intensity for cardiovascular indications (heparin 10a level goal is 0.15-0.35), low dose/fixed rate (this is a very low, fixed rate drip that is used in patients with very high bleeding risk, heparin 10a goal is <0.15) and high intensity for venous thromboembolism (heparin 10a level goal is 0.3-0.7).
- Platelets are monitored at least every 3 days to watch for heparin-induced thrombocytopenia in patients receiving intravenous or subcutaneous heparin. The provider will be notified if platelet count decreases by 50% or is less than 100,000.

**Enoxaparin (Lovenox)**

- Enoxaparin is not recommended in patients with creatinine clearance < 15 ml/min. Pharmacists will make dose adjustments per policy when creatinine clearance is 15-30 ml/min.
- Monitoring of Anti-Xa levels is recommended in patients with creatinine clearance 15-30 ml/min, patient weight < 40 kg or ≥ 165 kg, or pregnancy.
- Per Fairview policy, platelets are monitored at least every 3 days to watch for heparin-induced thrombocytopenia in patients receiving enoxaparin. If platelet count decreases by 50% or is less than 100,000, provider will be notified.

# Anticoagulation

**Warfarin**

- In the inpatient setting, Warfarin doses must be ordered each day (after that day's INR lab value has been evaluated)
- All Fairview hospitals have a pharmacy warfarin dosing service. Prescribers can utilize this service by ordering the "Pharmacy Warfarin Consult" panel in EPIC.
- A baseline INR must be available prior to first inpatient dose of warfarin.
- Pharmacists or Nurses will educate all patients that receive warfarin in the hospital prior to discharge.
- No dietary adjustments are made for patients on warfarin in the hospital.
- For supratherapeutic INRs, refer to the Vitamin K reversal protocol which may be managed by pharmacist by consult.

**Fondaparinux** (Arixtra) – inhibits Factor X, by inhibiting factor Xa, fondaparinux attenuates thrombin generation and fibrin formation.

- Alternative to argatroban in patients with suspected or history of heparin-induced thrombocytopenia (HIT).
- Use with caution in patients with creatinine clearance < 50 ml/min, not recommended in patients with creatinine clearance < 30 ml/min.
- Platelets are monitored at least every 3 days (or daily if acute HIT). Serum creatinine is required at least 2 times/week while on fondaparinux.

# Anticoagulation

**Dabigatran (Pradaxa) -** binds to and inhibits thrombin (Factor IIa).

- Medication is not recommended in patients with creatinine clearance < 15 ml/min.
- Pharmacists make dose adjustments when creatinine clearance is 15-30 ml/min and serum creatinine should be monitored at least 2 times/week.

**Argatroban** - binds to and inhibits thrombin (Factor IIa).

- Pharmacists are typically consulted to dose and manage argatroban infusions
- Pharmacists follow aPTT for dosing adjustments. Typical goal is aPTT 1.5-2x baseline aPTT or 50-70 seconds.
- aPTTs are checked every 2 hours after initiation and rate changes, then daily once stable. Platelets are monitored at least every 3 days. For acute HIT, daily platelet monitoring is recommended.
- For patients being transitioned to warfarin, the chromogenic factor X level (goal < 45 %) may be used for warfarin dose adjustments as there is a false elevation of INR with argatroban. Once argatroban is stopped, the INR will be used for warfarin monitoring.

# EPIC Downtime Procedure

**DEFINITIONS:**

- **Scheduled Downtime:** A planned period of time during which Epic will be unavailable to end-users.
- **Unscheduled Downtime:** An unplanned, unexpected interruption in connectivity, during which Epic is unavailable to end-users.

Is the Downtime scheduled?

- ☐Yes - Preparatory internal communication procedure is initiated to alert the staff and providers
- ☐No – Begin using downtime procedures at direction of charge nurse or supervisor, based on patient care needs. Unit may switch to downtime procedures immediately if necessary for patient care

# EPIC Downtime Recovery

- **Do not attempt to use Epic until communication is received that the system is live and available for use.**
- For patient safety reasons, it is essential that Hospital Registration and Pharmacy complete ADT/Registration functions and medication orders before other users access the system.
- Continue with Downtime Procedures until notification is received that the system is available.

# Health Care Directives

- Often created before serious illness
- Used to communicate person’s wishes to family, physician and other providers
- Completed and signed by person and witnessed or notarized
- Used to prevent legal and moral problems
- Person can assign a Health Care Agent to speak on person’s behalf should they not be able to communicate
- Minnesota also has available an Advanced Psychiatric Directive which applies only to treatment with neuroleptic medications and ECT (electro-convulsive therapy)

# Surgical Time Out

- An interactive, standardized, prescriptive Time Out that cognitively engages each team member (surgeon, circulating nurse, scrub and anesthesia care provider) will be performed after the surgeon has scrubbed and just prior to incision/procedure start.
- During the Surgical Time Out, all activity will stop and all team members will focus on the Time Out.
- If, at any point in the verification process a discrepancy is discovered, the procedure is stopped and does not continue until the discrepancy is resolved with all members of the procedural team.
- Any team member is able to express concerns about the procedure verification.
- Culture of Safety: describes the collective attitude of employees taking shared responsibility in a work environment and by doing so, providing a safe environment of care for themselves as well as patients.

# Site Marking

- Applies to any surgical and non-surgical invasive procedure involving **laterality, level or multiples** (toes, fingers, etc.)
- Site marking must be with **initials**, not an X
- Site marking is done with the patient awake and aware.
- It occurs before the patient is moved to the location where the procedure is performed

# Sedation and Analgesia for Procedures System Policy Highlights

- Prescribing providers must be privileged for the appropriate level of sedation/analgesia
- Anytime deep sedation/analgesia or anesthesia is anticipated **appropriately privileged** practitioners must be **in attendance**
- Sedation and Analgesia can be performed in any location where competent personnel and the required equipment are available.

# Sedation Continuum

Minimal (Anxiolysis) Moderate (Conscious Sedation) Deep Anesthesia

- Patients may quickly move between sedation levels
- The patient's sedation level is not determined by the **drug, drug dose** but by the **patient's response** to the medication(s).
- Procedures utilizing sedation/analgesia require careful assessment of the patient prior to administration of the medications, during **administration** of the medications and during **recovery** from them.

## Sedation Continued-

# Privileged Practitioner Responsibilities

- **Sedation specific examination and documentation** are required (Use Epic Sedation Navigator)
- **Ordering medications**, including dose and route
- **Recognition of emergencies**, then directing and providing interventions as needed

## Sedation Continued-

# Personnel

- An appropriately privileged provider performs the procedure
- **Another dedicated competent provider administers the medications** under the direction of the appropriately privileged provider and monitors the patient during the procedure and Phase I Recovery - **this person must be separate from the one performing the procedure.**

# Emergency Management

- In time of emergency or disaster do not report to work unless already scheduled to work or directed to do so by your supervisor.
- Follow the site based emergency operations plan and contact your supervisor for further direction.

# Accommodating Deaf or Hard of Hearing Patients

- If you recognize or have any reason to believe that a patient, relative or close friend or companion of a patient is deaf or hard of hearing, you must advise the person that auxiliary aids and services will be provided free of charge. These aids and services include sign language and oral interpreters, TTYs, note takers, written materials, telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, closed caption decoders and open and closed captioning of most hospital programs.

- If you are the responsible health care provider, you must take reasonable and necessary steps to ensure that such aids and services are provided when appropriate. All other hospital personnel should direct that person to interpretive services. This advice and offer must also be made in response to requests from patients and their families for auxiliary aids or services.
- For metro assistance, contact interpretive services at 612-273-3780.

FAIRVIEW

# Medical Staff Governing Documents

- Policies and Governing Bylaws can be accessed on a Fairview computer and are found on the Fairview Intranet at: intranet.fairview.org/business/CredentialingMedicalStaff/index.htm
- Bylaws
  - Each hospital has it's own governing documents including
    - Bylaws
    - Rules and Regulations
    - Credentials and Hearing policy
  - It is the responsibility of each medical staff member to be familiar with the rules and expectations outlined in these documents.
  - If a practitioner applying for privileges would like a copy of the governing documents prior to becoming a member of the medical staff, he/she may contact the Medical Staff Office at the applicable hospital, which is listed on the last page of this document.

# Medical Staff Policies

- Proctoring Policy-
  - Providers who do not meet competency measures identified on privilege forms may be eligible to request proctoring in order to meet the criteria.
  - Proctoring must be requested and approved through the credentialing process prior to performing a procedure for which proctoring is being requested.
  - Proctoring request forms are located at: http://www.fairview.org/fv/groups/internet/documents/web_content/s_112565.pdf
- Practitioner Health Policy-
  - Identifies a process and instructions for assistance with health issues or rehabilitation for practitioners with clinical privileges who may have impairment or health-related concerns.
  - Identifies that the VPMA or Medical Director may be contacted for assistance on health matters and must be notified of:
    - Enrollment in a rehabilitation program
    - Leave of absence greater than 90 days
    - Reinstatement of privileges after a leave due to an impairment

# Medical Staff Office Contacts

- Fairview Lakes Hospital- 651-982-7432
- Fairview Northland Hospital- 763-389-6304
- Fairview Ridges Hospital- 952-892-2103
- Fairview Southdale Hospital- 952-924-5109
- University of Minnesota Medical Center- 612-273-1945
- Maple Grove Ambulatory Surgery Center- 763-898-1438