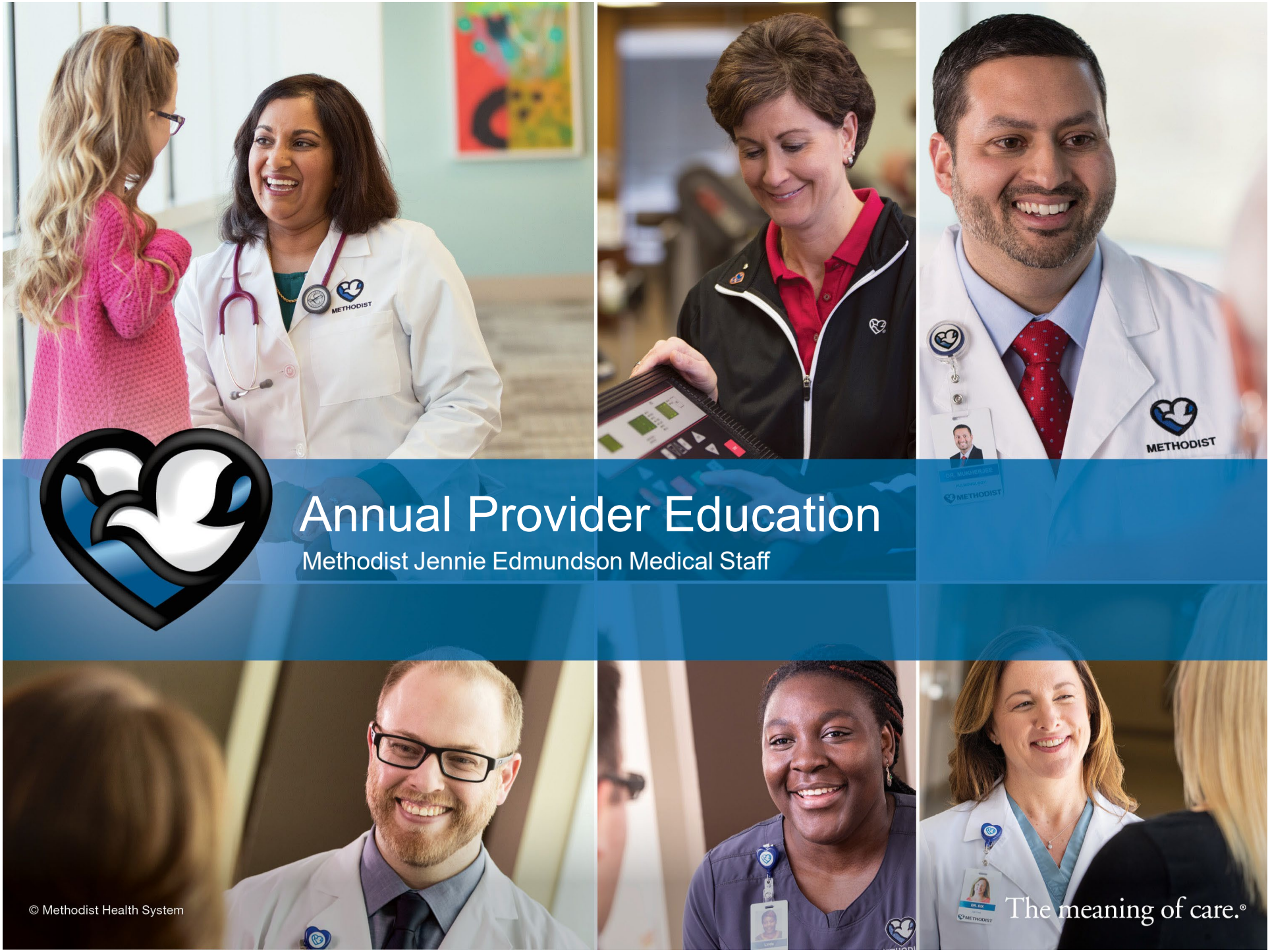


Annual Provider Education

Methodist Jennie Edmundson Medical Staff

Plain Language Messaging

Alert	Meaning
Medical Emergency	Adult Cardiac or respiratory medical emergency
Code Pink	Infant Cardiopulmonary Arrest
Stroke Alert	Patient showing stroke symptoms
Internal or External Disruption/Disaster – Standby	Staff are on alert status to sign-in if event escalates.
Internal or External Disruption/Disaster	Report to Medical Staff Lounge to sign-in.
Armed Intruder (active Threat)	Run – Seek safety by getting away from the attacker Hide – Find a place out of view. Close and lock doors, turn off lights and remain silent. Fight – Fight only as a last resort. Be aggressive and commit to the fight.
Missing Infant or Child (abduction)	Monitor unattended area for announced person.
Missing Person	Adult patient elopement – Monitor area for announced person.
Code Black	Bomb Threat – Isolate and clear area if found; If phone call, document caller details on Bomb Threat Checklist.
Dr. Major (CIT)	Agitated/escalated patient or visitor – Call the hospital operation and ask for Dr. Major for assistance.
Medical Gas Emergency	Oxygen, Medical Gas, or Vacuum failure or shutdown.

Severe Weather

In general, three actions are taken in response to Severe Weather	• **PACKAGE:** Gather items necessary to support the movement of people with little notice. • **PREPARE:** Work within the dept. to identify movement priority, process, and location. • **PROTECT:** Take protective action (shelter in place, relocation point, or staging area).

Severe Weather	Action
Severe Thunderstorm Watch	• Continue normal work routine while aware of changing conditions
Severe Thunderstorm Warning (Act)	• Package patients and supplies • Prepare for potential protection measures
Tornado Watch (Prepare)	• Package patients and supplies • Prepare for potential protection measures
Tornado Warning (Act)	• Package patients and supplies • Prepare for potential protection measures

Severe Weather

Be Prepared

Review Key Weather Terms.
Review Severe Weather Policies.
Locate sheltering locations.
Practice the 3Ps: Prepare, Package, Protect
Be prepared at home with a plan, shelter, and an emergency kit.

Severe Weather Resources

MHS Severe Weather Response Plan
https://powerdms.com/docs/1900250/revisions/2786971

NWS Omaha:
https://www.weather.gov/oax/

National Weather Service Watches and Warnings

Best source for information and guidance

Severe Thunderstorm Watch

Conditions are favorable for severe thunderstorm development in the area.

Severe Thunderstorm Warning

A severe thunderstorm is currently approaching or in the area. Potential to produce >1" large hail and 58+ MPH damaging winds.

Tornado Watch

Conditions are favorable for severe thunderstorms capable of producing tornados.

Tornado Warning

A tornado has been indicated on radar or confirmed by spotters in the area.

High Wind Warning

Expected winds above 40 mph for an extend period, potentially with gusts over 58 mph.

Flash Flood Warning

Sudden, violent flooding in flood prone areas such as low spots or streets is imminent or occuring.

Emergency/ Disaster Response

Response During Emergency/Disaster Event

- As a staff member, your response during a hospital “Internal/External Disaster” is critical to the success in managing the patients’ care.
- Credentialed Medical Staff, except trauma surgeon, will report to the Physicians' Lounge upon hearing the overhead announcement “Internal/External Disaster”.
- Trauma surgeon on-call will report to the ED/Triage area.
- LIPs without clinical privileges will report to the Board Room for Medical Staff credentialing.
- Upon arrival at the lounge, credentialed Medical Staff will sign-in on a pre-established form (name, specialty, and contact cellular phone or pager number) permanently attached to the bulletin board. After signing in, please return to your normal activities, unless your services are requested.
- If event requires your services, the incident commander will facilitate the process of having someone contact you and request your assistance in providing services to care for current or arriving patients.

Environment of Care

Workplace Safety
All areas must meet all regulatory codes for safety. If an accident/injury occurs (i.e. slips, falls, blood/body fluid exposures, needle sticks), report it. Contact Quality/Performance Improvement for a variance report, and Employee Health or Administrative Coordinator on duty for assistance on the Employee Injury/Illness report. If unsure how to report an accident or injury and/or need a form, contact a member of leadership.

Interim Life Safety Measures (ILSM) are a series of actions that must be taken to temporarily compensate for fire protection deficiencies or for hazards created by construction activities.

Crisis Intervention Team Response – Dr . Major
"Dr. Major" is the term used to initiate a crisis intervention team (CIT) response. The CIT's main function is to address the audience and normalize the environment as quickly as possible. If involved, practitioners should visually monitor the patient as well as support the CIT and Security during verbal or physical intervention.

Utility, Elevator, or Medical Gas Failure
In the event of a utility, elevator, or medical gas failure, contact 4-4111 and provide as much details as possible.

Fire

Fire Alarm

Smoke or Fire Sighted: Remember:

"**RACE**" **R**escue, **A**lert, **C**ontain, **E**vacuate

R: Rescue those in danger

A: Alert others, activate the alarm, and call 6-6911

C: Contain the fire by closing doors to the area

E: Evacuate from fire either to the next smoke compartment or down the stairwell to the floor below and to the assigned external collection point or use an extinguisher to control fire if possible. If you think you smell something burning, call the hospital operator. Maintenance and/or Security will come to check your area.

Fire Extinguisher - PASS

Pull the pin

Aim the nozzle

Squeeze the handle

Sweep side to side at the base of the fire

Only utilize a fire extinguisher if safe to do so. Do not use when:

- Fire is rapidly spreading
- There is a risk of inhaling smoke or that exit routes will be cut off
- Your instincts tell you to leave

Rapid Response Team

The Rapid Response Team (RRT) is a patient safety strategy that brings critical assessments, care, and expertise to the patient's bedside at a time when a patient's condition is rapidly changing or is compromised. RRT members at Methodist Jennie Edmundson includes the Critical Care RN or designee, Respiratory Therapist or designee, phlebotomists or designee and the Administrative Coordinator or designee. One call to **6-6911 or utilizing Vocera by stating "call code phone"** quickly brings these team members to the patient's room or location.

When to activate the Rapid Response Team:

- When staff identify an actual or potential clinical crisis situation developing with an individual, additional clinical expertise is warranted.
- Acute change in heart rhythm rate to ≤40 or ≥131 bpm.
- Temp (oral) <95 or >103°F.
- Systolic blood pressure ≤90 or >220 mmHg.
- Mean Arterial Pressure (MAP) <65
- Respiratory rate ≤8 or ≥25.
- SaO2 <90% or increased O2 needs above 6 liters.
- Change in breathing pattern.
- New onset of chest pain.
- Chest pain unrelieved after initiation of treatment.
- Acute change in level of consciousness.
- New signs of stroke: New-onset balance difficulties, eye/vision changes, facial droop, arm/leg weakness, speech changes.
    - Staff may directly initiate a stroke alert if signs of stroke are present
- Patient requires an emergent transfer to a higher level of care.
- Primary Provider not available to provide prompt assistance in an acute situation.
- Change in NEWS Alert level.

Stroke Program

When to activate a Stroke Alert/Stroke Signs & Symptoms:

B.E. F.A.S.T: sudden/new onset of balance difficulty, vision problem, facial droop, arm numbness/weakness, slurred speech/difficulty speaking or understanding

About Stroke: The American Stroke Association reports in the United States, stroke is the #1 cause of disability, the #5 cause of death in Iowa, and approximately 80% of strokes are preventable.

Methodist Health System Mission Statement regarding stroke care: Improve the quality of life of persons who experience an acute stroke and their families through coordinated evidenced based stroke care, education and rehabilitation

Primary Stroke Center: Recertified by The Joint Commission in November 2023.

Treatment Goals include:

- Goal: Door to provider assessment ≤5 minutes
- Goal: Door to CT initiation ≤15 mins
- Goal: Door to CT Interpretation ≤35 minutes
- Goal: Door to administration of TNK for eligible patients ≤60 minutes
- Goal: presentation of stroke s/s to transfer to higher level of care ≤60 minutes
- Goal: Last Time Known Well to administration of IV TNK for eligible patients ≤3 - 4.5 hours
- Goal: Last Time Known Well to Mechanical Thrombectomy for eligible patients ≤24 hours

Stroke Program: Resources

Employee Center: Clinical Resources > Stroke Resources

- Thrombolytic Inclusion/Exclusion Criteria

- **Clinical Practice Guidelines**
  - Ischemic Stroke
    - AHA/AHA: Guideline for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke
  - Hemorrhagic Stroke
    - AHA/ASA: 2022 Guideline for the Management of Patients With Spontaneous Intracerebral Hemorrhage: A Guideline From the American Heart Association/American Stroke Association
  - Subarachnoid Stroke
    - 2023 Guideline for the Management of Patients With Aneurysmal Subarachnoid Hemorrhage: A Guideline From the American Heart Association/American Stroke Association

Documentation Templates

- ED Stroke Note
- Complex Stroke Note
- Stroke Assessment Note

Employee Center: Policies> Power DMS

Order Sets/Power Plans

ER

- ED Stroke, Acute
- ED Hemorrhagic Stroke

TNK

- Thrombolytic Therapy for Ischemic Stroke
- Gen Adm Stroke Post Thrombolytic Therapy
- Thrombolytic Complications

Types of Stroke Admissions to Inpatient Units

- Stroke Under Investigation
- Gen Adm Stroke/TIA
- Gen Adm Hemorrhagic Stroke – *admit to ICU**
- Gen Adm Subarachnoid Hemorrhage – *admit to ICU**

Stroke Alerts

- ER: ED Stroke, Acute
- Inpatient: Stroke Diagnostic Protocol

Telemedicine

- **Teleneurology: Bryan Health/RBI**
  - Available 24/7
  - NE Medicine *OR* Methodist Hospital
    - Contact for transfer for possible Mechanical Thrombectomy patients

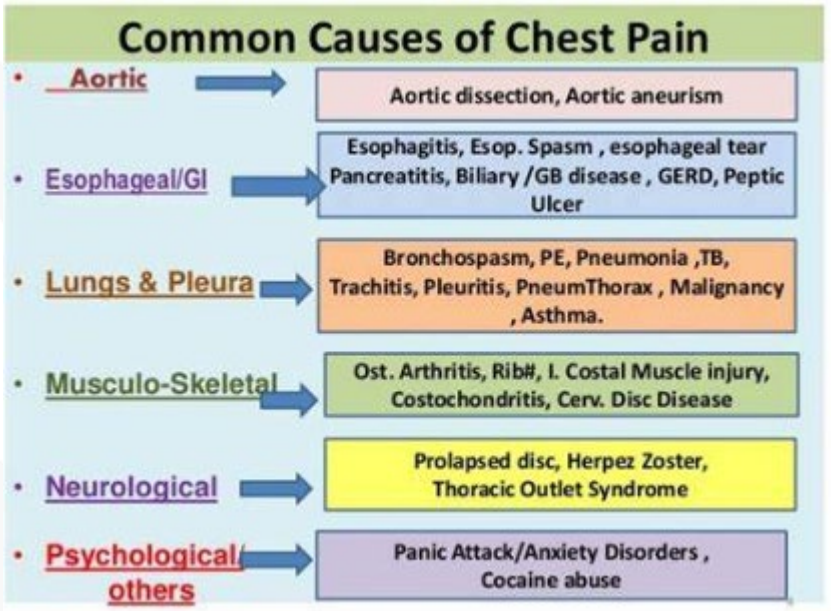
Chest Pain Program

About the program:

- A program based on evidence-based practice providing excellence in cardiac care with quality outcomes to ACS, STEMI, NSTEMI, and chest pain patients as well as promoting community health
- Certified by the Joint Commission. Goal to become Primary Heart Attack Center by 2026.
- Quarterly Chest Pain Core Committee is a multidisciplinary team
  - Medical Director-Dr. J. Ayoub
  - Chest Pain Coordinator- Igor Volk, DNP, MA, RN.
- Chest pain powerplans are protocol-driven by the clinical practice guidelines based on the American College of Cardiology and American Heart Association.
- Powerplans and Chest Pain Policy (protocols) developed, revised (yearly) and are supported by clinical practice guidelines (CPG's) with evidenced-based care

Treatment Goals include:

- HEART Score (risk-stratification tool) MUST be done on every patient experiencing chest pain. Done at time of admit, either in the ED or by the admitting provider if a direct admit.
  - 0-3: Minimal/No Risk for ACS
  - 4-6: Intermediate Risk for ACS
  - 7-10: High-Risk for ACS
- ECG within 10 minutes and interpreted within 10 minutes
- Primary PCI below 90 minutes
- EMS FMC to PCI below 90 minutes
- Arrival a First Facility to Primary PCI below 120 minutes
- Stress test while in the chest pain center or within 72 hours if discharged
- Smoking cessation and cardiac rehab for all NSTEMI/STEMI patients



Chest Pain Program: Resources

Employee Center: Clinical Resources: Accreditation/Certification:

- Chest Pain Resources
- Chest Pain Policies/Protocols (MJE)
  - Chest Pain Protocol MJE
  - STEMI Alert Checklist
  - MJEH AMI Alert Policy
  - Krames Patient Education
  - Clinical Practice Guidelines
  - MJEH Rapid Response Team Policy
  - Heart Score

Order Sets/Power Plans

- Cards ACS MI High Risk-Heart Score 7-10
  - ACS/NSTEMI/STEMI
- Gen Adm Chest Pain ACS Intermediate Risk Heart Score 4-6
  - Chest pain rule out
- ED ACS (STEMI, NSTEMI, Unstable Angina)
- ED Chest Pain
- Found in physician powerplans on Bestcare.org

Clinical Practice Guidelines

- 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR: Guideline for the Evaluation and Diagnosis of Chest Pain
- AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR: Guidelines for the Evaluation and Diagnosis of Acute Chest Pain

Fluoroscopy Provider Education

All physicians involved in a procedure in which radiation is used are required to comply with State Regulations for minimizing exposure to radiation. Please follow the procedural guidelines when utilizing fluoroscopy.

Please wear a radiation dose badge **at all times** upon entering the fluoroscopy suite at the collar level **outside** the lead apron. If you do not have one, contact the site's Radiation Safety Officer.

Procedure:
Only necessary staff and ancillary personnel are to be in the room during a procedure involving radiation. Always remember: **Time, Distance, Shielding**

Time: Minimize the amount of time exposed to radiation. Learn how to employ low dose techniques such as: Last Image Hold, Pulsed Fluoro Mode, Appropriate Collimation, Vendor Specific options, to reduce total radiation exposure time—**for yourself, your patient, and your staff**

Distance: Radiation intensity decreases exponentially with distance: increase your distance from the source, and tell your staff to step away from the table if they are closer than necessary. Also, position the patient such that they are as far away from the source as possible, while maintaining image quality, etc.

Shielding: Use protective lead or lead equivalent barriers such as **aprons/skirts**, **thyroid shields**, **goggles** or **portable stands/shields**. Encourage your staff to utilize the portable shields. Position all individuals including yourself so that only the "area of interest" is struck by the primary beam. Primary exposure to staff will be from scatter on the "entrance side" of patient—position staff/self on exit side of patient, if possible.

Restraint and Seclusion

Definitions:

- **Restraint:** Any manual method, physical or mechanical device, material or equipment involuntarily attached or adjacent to the patient's body that he/she cannot easily remove that its intended use restricts freedom of movement or normal access to one's body.
- **Non-violent restraints** are no longer utilized for "to protect the patient from harm or unsafe mobility". The only time a non-violent restraint can be utilized is to "protect life-saving lines and devices/tubes from accidental dislodgement or removal by patient. If unsafe mobility or harm to selves was a concern they would need violent restraints.
- **Restraint: Violent/Self-Destructive Behavior:** Use of restraint in emergency or crisis situations when unanticipated, severely aggressive or violent/destructive behavior presents an immediate, serious danger to his/her safety or that of others.
- **Chemical Restraints:** Medications that are used to restrict a patient's freedom of movement.
  - If the medications used are a standard part of treatment for the patient's medical or psychiatric condition they are not considered a chemical restraint.
- **Seclusion:** Is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is limited to a highly selective population, in the Behavioral Health Unit only with oversight reflective of its high-risk potential. Seclusion may only be used for the management of violent or self-destructive behavior.

Restraint and Seclusion

Physician Orders for Non-Violent Restraint Use:

- The treating LIP's order written for a specific episode must be obtained for use of any type of restraint
- Orders must be documented in the EMR
- The treating LIP's order cannot exceed a calendar day, and will specify the reason for the restraint use and the type of restraint

Physician Orders for Violent Restraint Use:

- The treating LIP's time-limited order, written for a specific episode must be obtained for use of restraints for violent/self-destructive behavior.
- Written and verbal orders must be documented in the EMR.
- The initial and renewal orders for violent/self-destructive behavior restraints will be for a maximum of 4 hours for adults, 2 hours for children/adolescents (age 9-17) and 1 hour for children under age 9 and will specify the reason for the restraint use and the type of restraint.
- The LIP/Trained RN will perform a face-to-face assessment on the patient's physical and psychological status **within one hour** of the initiation of the restraint. This assessment is performed even in those situations where the person is released early (prior to one hour). The assessment shall include and be documented in the EMR: the patient's immediate situation, patient's reaction to the intervention, patient's medical and behavioral condition.
- If a patient remains in restraints for violent/self–-destructive behavior 24 hours after the original order, the LIP must conduct a face-to face reevaluation before writing a new order for the continued use of restraint.

NO PRN ORDERS ARE ALLOWED FOR ANY TYPE OF RESTRAINT

Pain Management

Methodist Jennie Edmundson respects a patient's right to effective pain management. Pain management is multidisciplinary, characterized by continual coordination and communication.

- Desired outcomes include: optimum pain control, reduced side effects, and enhanced patient satisfaction.
- Effective pain management consists of pharmacological and non-pharmacological treatment options.
- The standard assessment for pain intensity is the numerical scale, 0-10 scale. For those who are cognitively impaired, unconscious, or those unable to otherwise communicate to staff, utilize the Pain Assessment in Advanced Dementia Scale (PAINAD) or the Critical-Care Pain Observation Tool (CPOT) when applicable in addition to signs & symptoms. Staff at MJE does have the option to use these tools in Cerner.
- Range orders CANNOT be used.
- More than one medication may be ordered for pain but specific direction for which medication and/or dose must be included.
- Schedule non-opioid analgesics first, adding opioids for moderate or severe pain. Non-pharmacological options should be incorporated by the treatment team.

Pain Management

Order based on pain intensity:

- **Mild pain (1-3**) – non opioid analgesics, ex. Tylenol or NSAIDS
- **Moderate pain (4-6)** - non opioid analgesics in addition to low dose opioids
- **Severe pain (7-10)** – non opioid analgesics in addition to higher strength opioids

Utilizing a multimodal approach to manage pain can reduce the side effects related to opioid use, potential over sedation, and risk for adverse outcomes.

Use of the following order sets is highly recommended: Pain Constipation Nausea Protocol and the standard PCA and Multi-Modal Preop Analgesics.

In Iowa, prescribers and their designated agents are required to check the Prescription Monitoring Program (PMP) database before issuing a prescription for Schedule II, III, or IV controlled substances, unless the patient is receiving inpatient hospice or long-term residential facility care. This requirement applies to all prescribers using their Iowa license, regardless of where the patient fills the prescription.

Click on the link below for more information:
https://nmhs.service-now.com/esc?id=kb_article&sysparm_article=KB0031537&table=kb_knowledge&searchTerm=pdmp

Infection Prevention

Hand Hygiene: Alcohol hand sanitizer is acceptable for use when hands are not visibly soiled. Use soap and water for visibly soiled hands.

Perform hand hygiene:

- Before and after patient contact
- Before donning and after removing gloves
- Before a clean/aseptic procedure
- After touching patient's surroundings
- After contact with blood or body fluid

Perform hand hygiene between patient encounters. Avoid taking computer or non-dedicated equipment into rooms.

Prevent the Spread of Multi-Drug Resistant Organisms

For patients with suspected or known MRSA, ESBL, or VRE follow standard precautions. Patients with uncontained drainage or history of CRE follow **contact precautions** which include the use of gloves and gown with direct patient or environmental contact.

Special droplet/contact precautions are used to prevent the transmission of COVID-19 infection; this includes respiratory protection (N95 or PAPR) gloves, gowns, and eye protection prior to entering room.

Enhanced Contact Precautions for patients with suspected or known Norovirus, ~~or~~ C. difficile **or Candida auris**; gloves and gown are required prior to entering room and bleach used for surface/equipment cleaning.

Policies for additional information: Isolation Procedures

Infection Prevention

Prevention of Central-Line Associated Blood stream Infections (CLABSI)

- Educate patients about CLABSI prevention PRIOR to line insertion
- Use approved indications for ordering i.e., patients requiring >14 days of IV therapy
- Evaluate need for central line daily, including PICCs, do not maintain for convenience
- Consider alternatives to Central lines such as midline catheters

Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

- Reassess the need for the catheter daily
- Follow approved indications for insertion
- Utilization of Foley Removal Protocol developed using best practice medical indications the order will assist in augmenting the removal by nursing when appropriate
- Consider appropriateness of using an external catheter

Prevention of Hospital Onset Clostridioides Difficile (C. Diff)

- Any positive C. diff test on or after hospital day 4 is considered Hospital Acquired Infection
- C. diff spores can survive on surfaces for up to 5 months.
- Excellent hand hygiene isTesting for CDI.
- Testing for CDI should occur ideally: 1) As soon as patients meet appropriate CDI testing criteria AND 2) prior to hospital day 4 (if possible) to avoid categorization as a HAI.
- Reserve CDI testing for patients who meet the following criteria:
  - New unexplained onset diarrhea occurring at a frequency of ≥3 unformed stools within 24 hours, without recent use of laxatives, oral contrast, tube feeds, or other medications known to cause diarrhea, and/or alternative reasonable explains for diarrhea (e.g. food poisoning, other infectious causes of diarrhea, etc.).
- CDI is a toxin-mediated disease and stool testing at MJE consists of an automatic two-step GDH-antigen test, reflexed to a toxin-test.
- An optional PCR test, is available to order, at provider request, for GDH+/Toxin- cases where diagnosis cannot be determined and CDI strongly suspected.
  - However, available published literature suggests there is no benefit to treatment of PCR+/Toxin- cases.
- Most patients who are toxin-negative, do not have CDI and an alternative cause of diarrhea should be investigated.

Infection Control

Prevention of Surgical Site Infections

- Educate patients about SSI prevention PRIOR to procedure
- Perform proper surgical scrub on hands and don proper surgical attire per policy/procedure
- Use proper antibiotics for prophylaxis prior to incision, including adding anaerobic coverage intra-op when the bowel becomes involved unexpectedly
- If hair removal is needed, use clippers in pre-op area
- Ensure proper surgical site scrub; surgical scrub containing alcohol is preferred
- Minimize traffic in OR during surgery
- Do not flash sterilize equipment
- Use proper hand hygiene before and after caring for a wound

Emergency Care Provider Reporting Significant Exposure

Providers will complete an Iowa Department of Public Health Report of Exposure when the following is involved:

- Needle (sharps) stick.
- Mucous membrane exposure to blood/body fluids.
- Cutaneous wound exposure to blood/body fluids.

Report is then delivered to Employee Health and prophylaxis may be needed if diagnosed with a bloodborne pathogen or other communicable disease.

Falls

Risk Assessment: Age appropriate fall assessments are completed on all patients

- The Morse Fall Scale: Patients who score ≥60 on the MFS are considered **SEVERE RISK FOR FALLS.**
- Humpty Dumpty Scale: Patients who score >12 on the Humpty Dumpty Scale are considered **HIGH RISK FOR FALLS.**
- Nurses assess daily and PRN. Universal fall precautions are initiated on **all** patients admitted.
- The fall assessments are to be completed **within 4 hours** of admission and reassessed every shift and as needed.

Steps Providers can do to help prevent falls:

- Medication review and reduction
- Treatment of postural hypotension
- Treatment of balance and gait problems
- Encourage the importance of early ambulation with your patients (they listen to you best!)
- Consult therapies to encourage proper mobility and movement

Post Fall: If a patient falls while in the hospital, the following will occur per policy:

- RN notifies the attending physician and family.
- Immediate vitals/neuro/injury assessment should be performed prior to moving the patient.
- Implement needed additional measures to prevent further falls.
- Nursing will take vital signs/neuro/injury assessment Q4 hours x24 hours and complete a variance report.
- Pharmacy consult is triggered in EMR for medication review

Note: Diagnostic testing (CT, x-ray, etc.) or additional interventions post fall are determined by the physician based upon his/her assessment.

Falls

Family Refusal of Fall Precautions: If a patient requests not to be on fall precautions, please inform the Primary Nurse or the Charge Nurse to review with the patient/family the purpose of fall precautions. If the patient continues to refuse, the patient must sign a "Referral of Care/AMA" form and document refusal in the EMR. DO NOT write an order to not use fall precautions without documented rationale.

Injury Level Classification Definitions (Developed by NDNQI)

When the initial fall report is written by the nursing staff, the extent of injury may not yet be known. Hospitals have 24 hours to determine the injury level to allow for time waiting for diagnostic test results or consultation reports. The levels are as follows:

- **No Injury:** Patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post-fall evaluation results in a finding of no injury.
- **Minor:** Resulted in application of a dressing, ice, cleaning of a wound, limb evaluation, topical medication, bruise or abrasion.
- **Moderate:** Resulted in suturing, application of steristrips/skin glue, splinting or muscle/joint strain.
- **Major:** Resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall.
- **Death:** The patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).

Antimicrobial Stewardship

- Decreasing antimicrobial resistance and improving correct use of antimicrobials is a national priority. Evidence demonstrates that programs dedicated to improving antibiotic use, known as “antimicrobial stewardship” programs (ASP), can help slow the emergence of resistance while optimizing treatment, reducing harm and minimizing costs. In 2022, The Joint Commission updated the Medication Management Standard: MM.09.01.01 that addresses antimicrobial stewardship at the hospital level.

- The Nebraska Methodist Health System (NMHS) has an ASP supported by a multi-disciplinary team of Laboratory & Microbiology, Clinicians, Infection Prevention, Quality, and Administration/Senior Leadership at both the institution and health system level.

- The NMHS ASP is coordinated by the Infectious Disease Pharmacist (Kevin Sponsel, PharmD) and supported by the Hospitalist Physician Chair, and the Methodist Infectious Disease Physicians.

- The NMHS evaluates local microbiology data and evidence-based best practices to support providers in the diagnosis, treatment, and transition-of-care management for infectious diseases at NMHS.

- Some examples of the content and/or services that the ASP provides:
  - Annual antibiogram publication for each NMHS affiliate
  - Locally informed, evidence-based guidance for diagnosis and treatment of infectious diseases (e.g. CDI, MRSA nasal screens for pneumonia, surgical antimicrobial prophylaxis, etc)
  - Antimicrobial formulary review
  - Antimicrobial order set review and creation
  - CDI, CAUTI, and Sepsis Committee participation and collaboration
  - ID-pharmD prospective audit and review with feedback
  - ID-pharmD ad hoc consultation (available via QliqChat)
  - Review and audit of the restricted antimicrobials

- Information regarding AMS is frequently shared on screen in physicians’ lounge and in-person as needed.

Antimicrobial Stewardship Continued

- An Antibiogram is prepared annually for Methodist Jennie Edmundson Hospital by MHS Microbiology Department. This document can be accessed: 1) within the Patient Chart (PowerChart) in Cerner, 2) On the MHS Intranet at https://mhsintranet/Resource.ashx?sn=MJEAntibiogram. This document provides susceptibility data for various organisms to formulary antimicrobial products and their relative cost. It also includes a chart of Preferred Antimicrobial Therapy for Specific Pathogen.

- All content, education, and guidance document materials that the ASP produces, can be accessed on the intranet at
  - Employee Center > Clinical Resources > Medication Pharmacy > Infectious Disease

- All antimicrobials require an indication:
  - When entering antimicrobial orders in Cerner, an indication needs to be selected. If "other" is selected, a free text indication needs to be entered in the Free-text Indication box.

- Most IV antibiotics have a two-day automatic renewal.
  - This provides a good opportunity to perform an "antibiotic time- out" to assess whether-or-not antibiotic needs to continue, stop, or modify to another agent based upon culture and susceptibility data.

- Several antimicrobials are restricted at MJE, these include:
  - Restricted to ID Service only:
    - Micafungin, Valganciclovir, Daptomycin, Ceftaroline, Ceftolozane/Tazobactam, Ceftazidime/Avibactam, and Omadacycline
  - Others:
    - Ertapenem (ID, Pulmonology/Intensivist, Hospitalist, Internal Medicine, Family Practice, or by indication of SAP for intra-abdominal surgery)
    - Oritavancin, Dalbavancin (ID and ED)
    - Meropenem (ID, Pulmonology/Intensivist, Hospitalist, Internal Medicine, Family Practice)
    - Tigecycline (ID, or by indication of: cSSTI, cIAI, ESBL, severe beta lactam allergy/multiple antibiotic class allergies)
    - Fidaxomicin (ID or GI)
    - Linezolid (ID, Hospitalist, or HAP/VAP PowerPlan)

Antimicrobial Stewardship Continued

- Available Evidence Based PowerPlans in Cerner
  - Cellulitis
  - Community Acquired Pneumonia (CAP)
  - Hospital/Ventilator Acquired Pneumonia (HAP/VAP)
  - OB Group B Strep Prophylaxis
  - Rabies Exposure Protocol
  - Sepsis Advisor (Trialing new PowerPlan approach)
  - Urinary Tract Infection (UTI)

MINDME – The antibiotic creed	
M	Microbiology guides therapy wherever possible
I	Indications should be evidence-based
N	Narrowest spectrum required
D	Dosage appropriate to the site and type of infection
M	Minimise duration of therapy*
E	Ensure monotherapy where appropriate +

HIPAA Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

HIPAA Privacy Rule

- Applies to healthcare organizations, healthcare plans, healthcare clearinghouses, and Business Associates with access to Protected Health Information.
- Applies to data in written format, videos and images containing any individually identifiable health information.
- States PHI can only be disclosed to a third-party with the authorization of the patient, unless the disclosure is related to healthcare treatment, payment for healthcare or healthcare-related operations.
- States Covered Entities must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request.
- The "Minimum Necessary Rule" must be enforced at al times.

Misconduct that may lead to corrective action includes any violation of the HIPAA Privacy rule and/or action threatening the security of the MHS IT Network, including, but not limited to:

- Inappropriately accessing or disclosing information about patients, their families, other employees, organization personnel, or medical affairs of any NMHS entity.
- Forging, altering, or deliberately falsifying any document or computer entry, authorization, or record that is to be used by the facility.

HIPAA Privacy Rule

Breach Notification Rule

Any potential breach needs to be reported immediately to the **MHS Privacy Officer at 402-354-6863**

- The Privacy Officer will investigate the suspected breach and notify the appropriate parties.

Patients have the following rights under HIPAA:

- To review and obtain a copy of their protected health information in their designated record set (Right of Access)
- To request an amendment to their health records (Amendment)
- To request a list of people and organizations who have received his/her health information (Disclosure Accounting)
- To request that we communicate with them by alternative means (Confidential Communications Requirements)
- To restrict use or disclosure of their protected health information (Restriction Request)
- To know what ways a covered entity may use and disclose protected health information and the right to file a complaint with the Department of Health and Human Services (HHS) and/or NMHS (Notice of Privacy Practices)

Misconduct that may lead to corrective action includes:

- Inappropriately accessing or disclosing information about patients, their families, other employees, organization personnel, or medical affairs of any NMHS entity.
- Accessing PHI outside of your job scope; only access information on a “need to know basis.” Accessing PHI without a “need to know” is a violation of the HIPAA Privacy Rule and Methodist Health System privacy policies.

NMHS regularly monitors users’ access to Cerner with a variety of monitoring and auditing tools. Anyone who violates or otherwise fails to observe the Methodist Health System Privacy rules and policies will be subject to disciplinary action, including termination and/or loss of access and privileges.

Policy Review

- https://mhsintranet/Main/Policies/Breach-Notification-11555.aspx
- https://mhsintranet/Main/Policies/Patients-Right-to-Access-Medical-Record-Denial-Pro-10619.aspx
- https://mhsintranet/Main/Policies/Amendment-of-Protected-Health-Information--15201.aspx
- https://mhsintranet/Main/Policies/Accounting-of-Disclosures-15200.aspx
- https://mhsintranet/Main/Policies/Patient-Requests-to-Restrict-Uses-and-Disclosures-10616.aspx
- https://mhsintranet/Main/Policies/Notice-of-Privacy-Practices-16294.aspx

HIPAA Security Rule

The HIPAA Security Rule of 2003

- The Security Rule protects all individually identifiable health information a covered entity creates, receives, maintains, or transmits in electronic form. Referred to as “electronic protected health information” or “e-PHI”. The Security Rule does not apply to PHI transmitted orally or in writing.

Safeguarding PHI

- Do not reply to emails (or phone calls, text or instant messages) requesting protected health information, personal or other confidential information.
- Never send PHI or confidential information to a personal email address.
- Do not store PHI on any work or personal mobile device.
- Do not forward suspicious emails (“phishing”) to others – contact the **IT Operations Center at 402-354-2280.** By reporting suspicious emails promptly, you help protect yourself and the organization from potential cyber threats.
- Encrypt email containing PHI before sending it outside of NMHS walls by typing Encrypt in the subject line or body of the email.
- Only communicate PHI information utilizing a secure platform approved by Methodist Health System IT Department.

Misconduct that may lead to corrective action includes:

- Inappropriately accessing or disclosing information about patients, their families, other employees, organization personnel, or medical affairs of any NMHS entity.
- Forging, altering, or deliberately falsifying any document or computer entry, authorization, or record that is to be used by the facility.

NMHS regularly monitors users’ access and use of IT assets with a variety of monitoring and auditing tools. Anyone who violates or otherwise fails to observe the Methodist Health System Security rules and policies will be subject to disciplinary action, including termination and/or loss of access and privileges.

Always contact IT Operations Center at 402-354-2280/Privacy Officer at 402-354-6863 if medical devices, offered by medical device representatives, will be connected to our servers, and transmit or maintain patient information.

Social Networking/Photography and Recording

Social Networking

- All employees are expected to conduct themselves on any social media platform in a manner that reflects integrity and shows respect and concern for others.
- Never post confidential information, photos of a patient or videos of a patient on any social medial platform, even if it does not include a patient's name. Inappropriate posts can seriously damage Methodist Health System's reputation.
- Never discuss confidential information in public forums, chat rooms, text messages or news groups.
- Be cautious of identifying yourself as an MHS employee on any social media platform.
- Do not discuss workplace frustrations with patients or share workplace related frustrations on any social media platform.
- Do not use MHS logos or trademarks on your personal posts on any social medial platform.
- Refrain from friending patients. Employees should keep their personal and professional life separate. Befriending and interacting with patients online can result in accidental disclosure of PHI.
- Researching patient on any social medial platform to identify health or social concerns, can result in inaccurate information and have a negative effect on the patient care.
- Failure to follow the Social Networking Policy may result in corrective action, up to and including termination of employment.

Policy: https://mhsintranet/3051770a-4fda-43c2-9ca8-7fbcc2e75514/PoliciesAndProcedures.ashx?sn=12_2020-01-09_10-53-18-AM

Photography and Recording

- MHS has a policy titled, "Photography and Recording" that applies to all NMHS affiliates. In general, photography and recording by a patient or visitor is permitted if it does not interfere with patient care. However, photography and recording of a provider/staff without his/her knowledge is prohibited per the policy. You have the right to stop recording or taking photographs if you have not given permission to do so.
- The policy allows providers and staff to utilize photography and recordings for purposes of identification, patient care and treatment, as long as it complies with the provisions in the policy. Personal cell phones or other personal recording devices should not be used. Please review the policy for details.

Policy: https://mhsintranet/6c2efee8-4d25-4db6-8509-2359cd26e62d/PoliciesAndProcedures.ashx?sn=7_2020-10-09_09-06-54-AM

Workplace Violence Prevention

Workplace violence is an act or threat occurring at the workplace that can include any of the following: Verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern.

For assistance in mitigating actual or potentially violent behavior:

- Physical – call Security 6-6211.
- Behavioral Health Intervention Team (BHRT) – call the hospital operator and ask for “BHRT” assistance.
- Anxious and agitated people – Call the hospital operator and ask for “Dr. Major” assistance.

Set limits and maintain healthy boundaries with patients, visitors, contractors, and co-workers. Recognize warning signs that indicate the person’s behavior may escalate and contact Security 6-6211 before the person(s) becomes disruptive or dangerous. If unsure of the situation, call the unit’s manager or Administrative Coordinator for assistance.

It is the policy of the Methodist Health System to prohibit any person from engaging in any act, either on Methodist Health System property or during the performance of work-related duties, which threaten the safety, health, life or well-being of any employee, customer, visitor, patient, physician, volunteer or other guest.

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Disruptive Behavior Medical Staff

- **Disruptive Behavior:** Defined as raised voice, profanity, name calling, throwing things, assault or abusive treatment of patients, employees, other Medical Staff or Allied Health staff members or visitors; sexual or other unlawful harassment; disruption of meetings, repeated violations of hospital policies or rules; or behavior that disparages or undermines confidence in the hospital or its staff. A report should be submitted within one week of the incident directly to the V.P. of Medical Affairs or to another member of the Administrative team.

- **Impaired Practitioner:** 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 willingness to acknowledge the problem or to seek help to recover. If a provider has a concern, they can submit a report to the VP of Medical Affairs.

- If there is enough information to warrant a review, the matter will be referred to the Peer Review Committee who will monitor the affected provider and the safety of patients until rehabilitation or other action is complete.