MERCYHEALTH

Medical Staff
Allied Health Professional
Orientation & Annual Education

Adam Groshans

Springfield Market President

Mercy Health-Springfield Regional Medical Center

Mercy Health–Springfield Regional Medical Center

OPEN 24 HOURS

100 Medical Center Dr,
Springfield, Ohio 45504
937-523-1000

SRMC	2019
Acute Admissions	13,527
Deliveries	1,198
Inpatient Surgeries	2,173
Outpatient Surgeries	1,697
ER Visits	63,958

Mercy Health-Springfield Regional Medical Center (SRMC) is a 254-bed facility and is our community's only full-service hospital.

On April 19, 2004 the boards of Community Hospital and Mercy Health Partners signed a definitive agreement to consolidate. Calling for the construction of a new regional medical center, the agreement made possible an exciting new level of state-of-the-art health care for our community. For over 130 years, SRMC has provided comprehensive medical services for residents of Clark County and surrounding communities. As Springfield's only full-service hospital, we offer complete care including 24/7 emergency services, interventional cardiology, cardiothoracic surgery, maternity services, critical and intensive care, and surgery— all provided by skilled doctors and highly trained health professionals.

Jamie Houseman

Hospital Administrator

Mercy Health-Urbana Hospital

Mercy Health-Urbana Hospital

OPEN 24 HOURS
904 Scioto St
Urbana, Ohio 43078
(937) 653-5231

Urbana Hospital	2019
Acute Admissions	820
Psychiatric Admissions	172
Inpatient Surgeries	79
Outpatient Surgeries	451
ER Visits	14,389

Mercy Health-Urbana Hospital is a 25-bed facility and is the community's Critical Care Access Hospital. It is the only local hospital dedicated to serving the health care needs of residents of Urbana and Champaign County, Ohio.

Since 1951, Mercy Health – Urbana Hospital, formerly known as Mercy Memorial Hospital has delivered quality, comprehensive, compassionate care. With a broad range of inpatient and outpatient services, skilled staff and state-of-the-art equipment, the hospital provides for much of local residents' medical and surgical needs.

Mercy Health-Urbana Hospital provides comprehensive medical, surgical and emergency care. In addition to family medicine and pediatric care, features include general and orthopedic surgery and rehabilitation, emergency services, a full range of imaging and laboratory services, digital mammography, and more.

EXECUTIVE LEADERSHIP TEAM

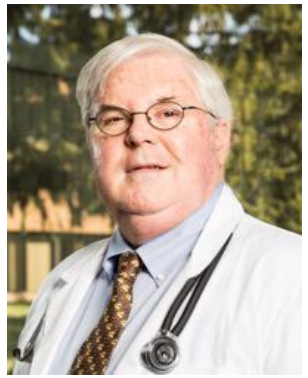
Marianne Potina
Vice President
Mission Integration

Chris Howe
Vice President
Operations

Rhonda Beane
Chief Nursing
Officer

Jenelle Zelinski
Chief Financial
Officer

Tyler Walters
Vice-President, Operations
Mercy Health Physicians



Paul Buchanan, MD
Co-Chief Clinical Officer

Joseph Morman, MD
Co-Chief Clinical Officer

Medical Staff Governance 2021-2022

Faiq Akhter, MD
Past-Chief of Staff

Pradeep Gujja, MD
Chief of Staff

Colleen Alexander, MD
Chief of Staff-Elect

Surender Neravetla, MD
Chair, Department of Surgery

Akber Mohammed, MD
Chair, Department of Medicine

Michael Jopling, MD
Chair, Credentials Committee

Aamir Khan, MD
Chair, Peer Review Committee

Medical Staff Governance 2021-2022 Cont'd

Members-at-Large

2020-2021

Rubeal Mann, MD ('21)
Jyothi Challa, MD
Luke Onuorah, MD
Chandra Palla, MD

2021-2022

Amit Arora, MD
Annick Edon, DO
Stephen Oehlers, MD
Moin Ranginwala, MD

Medical Staff Governance 2021-2022 Cont'd

Department of Medicine – Section Chiefs

Cardiology	**Faiq Akhter, MD**
Gastroenterology	**Alan Gabbard, MD**
General Medicine (FM/IM)	**Ajaz Umerani, MD**
Hospice/Palliative Medicine	**J. Kevin Ahern, MD**
Hospital Medicine	**Atul Kutwal, MD / Ammar Alahmar, MD**
Nephrology	**Pius Kurian, MD**
Oncology	**Filix Kencana, MD**
Pediatrics	**Larry Daykin, MD**
Neonatology	**Sarah Van Nostrand, DO**
Neurology	**Michelle Noel, DO**
PM&R	**Douglas Porter, MD**
Psychiatry	**Jonathan Lazzara, MD**
Pulmonary	**Moin Ranginwala, MD**
Radiology	**Michael Martin, MD**

Medical Staff Governance 2021-2022 Cont'd

Department of Surgery – Section Chiefs

Anesthesiology / Pain Management	**Michael Jopling, MD**
Emergency Medicine	**Rubeal Mann, MD**
Cardiac Thoracic & Vascular Surgery	**Surender Neravetla, MD**
General Surgery	**Terry Carman, MD**
OB/Gynecology	**Shawn Osterholt, MD**
Ophthalmology	**Larry Fish, MD**
Oral Maxillofacial Surgery	**James Maxwell, DDS**
Orthopedics	**Gregory Carozza, DO**
Otolaryngology	**Ronald Smith, MD**
Pathology	**Lakshmy Parameswaran, MD/Jeffrey Rogers, MD**
Podiatry	**Philip Cain, DPM**
Urology	**Vlada Mardovin, MD**

Medical Staff Office (MSO): The Medical Staff Office is on the Ground Level located between the physician's lounge and Administration.

Mary Harger, MBA, CPMSM, CPCS	Manager	937-284-3839
Sandy Shaffer	Medical Staff Coordinator	937-523-5062
Christy Smith	Medical Staff Coordinator	937-523-5522
Main Line		937-523-5060
Fax		927-523-5978

An updated event and meeting calendar and any announcements are located by the physician's lounge entrance.
Mailboxes are available upon request and are located by the coat room next to the lounge.
Direct any questions you may have for committee chairs or medical staff governance to the Medical Staff Office.
Demographic Updates: Contact the MSO if your home address, cell, etc changes.

Physician's Lounge: The physician's lounge is located on the Ground Level adjacent to the Medical Staff Office. There are six (6) computer work stations, complimentary food/beverages and a television area.

Assistance:	Computer Help Desk	833-691-4357
EPIC Assistance :	Janene Pearson	937-471-2411 cell / 937-523-5383 ofc
	Hayley Baker	937-450-2772 cell / 937-523-5441 ofc

Medical Staff Members Photo Identification Badge:

Obtain a photo identification badge from the Security Office during business hours. This must be worn above the waist at all times in the hospital. An extra tab identifies you as a physician or advanced practice clinician. The badge contains a chip that allows entrance to the physician lounge, restricted hospital areas, the physicians parking lot and external doors after hours.

Physician Parking:- Convenient parking is available to the right of the main entrance. You will need your badge to open the gate.

Monthly Medical Staff Meetings

Regional Board Credentialing Subcommittee	3rd Tuesday
Medical Executive Committee	2nd Tuesday
Credentials Committee	1st Friday
Peer Review Committee	2nd Friday
Medical Quality & Patient Safety Council	2nd Thursday

Quarterly Meetings

Cancer Committee	3rd Tuesday
Department of Surgery	3rd Wed (Mar-Jun-Sep-Nov)
Department of Medicine	3rd Thurs (Mar-Jun-Sep-Nov)
General Medical Staff Meeting	Apr-Aug-Dec

SRMC Nursing Units and Other Patient Care Areas

UNIT NUMBERS (937) 523-_ _ _ _		Charge Nurse	Manager
Control Desk	3 2400	n/a	n/a
Anesthesia	3 2404	n/a	n/a
SDS & Pre/Post Op	3 2300	3 43216	3 2335
Surgery Waiting	3 2099	n/a	n/a
PACU	3 3070	3 2407	3 2335
PICC	3 4060	n/a	3 8641
Emergency Room	3 1400	3 1902	3 1408
ARU	3 1001	3 1900	3 1062
1 North	3 1100	3 1901	3 1131
2 East	3 2000	3 2903	3 2174
3 East	3 3000	3 3902	3 3031
3 North	3 3100	3 3903	3 3131
4 East	3 4000	3 4900	3 4031
4 North	3 4100	3 4901	3 4131
Birthing Center	3 3200	3 2900	3 3244
CVICU	3 2050	3 2902	3 2069
ICU	3 2100	3 2904	3 2131
Infusion	3 3160	3 3165	3 8641
Pathology	3 5182	n/a	n/a
Wound Care SRMC	3 4061	3 9179	3 9178
Endoscopy	3 2070	3 2071	3 2335
CV Holding	3 2200	n/a	3 2241
Heart Center	3 1300	3 1099	3 2241
Main Pharmacy	3 5300	n/a	3 5302
Urbana Emergency Dept	4 3210	n/a	4 6386
Urbana Inpatient	4 6144	4 6168	4 6109
Urbana Senior Behavioral	4 6211	n/a	4 6216
Urbana Surgery	4 3216	4 6385	4 6538

COVID-19

All **Physicians, Allied Health Professionals and staff members are required** to self monitor for symptoms of COVID-19 prior to the start of each assigned shift. If you present with multiple symptoms that you feel concerned may represent COVID-19 as outlined below, you will not report to the hospital.

Known COVID-19 symptoms include:

- Fever (100.0°F or above)
- Chills
- Cough
- Shortness of breath or difficulty breathing
- Muscle or body aches
- Fatigue
- New loss of taste or smell
- Sore throat
- Nausea or vomiting
- Diarrhea

Emergency Codes: MH Legacy Facilities in Ohio

Event	Ohio Emergency Codes
Fire	**Code Red**
Infant / Child Abduction	**Code Adam**
Bomb / Bomb Threat	**Code Black**
Severe Weather	**Code Gray**
Hazardous Material Spill / Release	**Code Orange**
Medical Emergency	**Code Blue (Adult)**
Medical Emergency: Pediatric	**Code Pink**
Internal / External Disaster	**Code Yellow**
Violent Patient / Person	**Code Violet**
Hostage / Weapon Situation	**Code Silver**
Missing Adult Patient	**Code Brown**

Concerns about safety and quality of care

- Any **LIP or staff member** with concerns regarding safety or quality of care issues:

✓ Encouraged to speak to someone within our organization (Chain of Command).

✓ Enter a report into our computerized reporting systems (ie-SafeCare)

✓ If not satisfied with the response, you may directly report to our accrediting bodies without fear of disciplinary or punitive action

PerfectServe Clinician to Clinician

The PerfectServe mobile app lets users:

- Access any medical staff member
- Access, acknowledge and reply to secure text and voice messages with attachments
- Select from predefined contact and notification processes
- View lists of inbound and outbound communications
- Call patients while protecting call ID and overcoming caller ID block
- View and modify call schedules
- Trigger different routing, contact & notification processes based upon conditional availability
- Contact PerfectServe Help Center 24/7/365
  - www.perfectserve.com
  - 1-877-844-7727

SafeCare

SafeCARE is our safety event reporting tool. This is for all Bon Secours Mercy Health facilities, providers, and off-site entities. SafeCARE is where you can report any and all safety events including near miss events, complaints, professional conduct events, associate injuries, falls, medication errors, HIPAA, surgical complications, medication errors, adverse drug reactions, etc. This system is non-punitive system used for any incident reports and can be anonymous, if desired. No User ID is required.

Modified Early Warning System (MEWS) – Early Detection of Patient Deterioration

A nurse may call and mention the MEWS score, which is a scoring system that identifies high risk patients. The score is calculated based on heart rate, blood pressure, respiratory rate, temperature, and neurologic status. The score is calculated in Epic to enable nurses to identify patients who are deteriorating and who need urgent intervention and may call for a Rapid Response Team. To review the policy go to: https://hub.health-partners.org/sites/Toledo/defiance/PCU/Shared%20Documents/Forms%20and%20Lists/Mews%20score.pdf#search=MEWS%20score%20policy

Rapid Response Team

The Operator overhead pages "Rapid Response Team" and location three times. Respondents include the Hospitalist, ICU Charge RN, and Respiratory therapist. Others like Radiology or EKG tech may be called as needed. This is intended for "pre-codes" or significant change in status requiring an immediate evaluation. Staff, patients, family members or visitors can activate the Rapid Response Team by calling the operator. Staff call mandatory Rapid Responses for any new onset of chest pain and/or if there are new onset stroke symptoms. We do this as a part of our accreditation for our heart and stroke programs.

House Nursing Supervisor

Shifts: 8a-8p and 8p-8a. They cover the hospital 24/7
Location: Their office is located in Nursing Administration on the Garden Level across from the Medical Staff Office.
Phone: 937-523-5910

Primary responsibilities: The Nursing Supervisor is primarily responsible for throughput. They do all patient bed placement using EPIC. The access center is responsible for inputting direct admit patients in EPIC so physicians can perform order entry. They manage all staffing and adjust staffing levels every 4 hours based on the hospital needs. They are the primary nursing responder to all **Rapid Response Teams and Code Blues**. They are responsible for initiating the chain of command when there is an issue that needs administrative assistance. They call in all OR teams and Cath Lab teams for acute issues. Night shift supervisors do an in-house restraint log and are responsible for locating any equipment or supplies that might be needed throughout the house.

EPIC Electronic Medical Records and Physician Order Entry

The hospital provides a fully electronic environment for physicians including the EPIC electronic medical records, physician-order entry, digital radiology and remote access. All physicians are required to attend EPIC physician training prior to caring for patients. You will receive your login at that time. EPIC may be used for all documentation and is fast and easy with customization, dictation is still permitted.
EPIC Access from Home or Office. The website for OUTSIDE the hospital is https://chpEconnect.health-partners.org. Best to use Windows Explorer or Firefox. Only works with Firefox on the Mac (not Safari). Does NOT work on an iPad.

Three Methods for Order Authentication

The Ohio Board of Pharmacy requires a secondary authentication for any medication orders. That's why we must use the RF-ID "tap" to sign orders or the challenge questions or RSA token outside the hospital. Away from the hospital, the RSA token is used as secondary authentication when ordering any medication. This must be activated and a PIN number

Antimicrobial Stewardship

- Prescribe correctly
- Avoid treating viral syndromes with antibiotics, even when patients ask for them
- Pay attention to dose and duration: prescribe the right antibiotic at the right dose for the correct duration
- Be aware of antibiotic resistance patterns
- Re-assess within 48 hours of starting the antibiotic-check culture results to ensure appropriate medication ordered
- Collaborate with each other and patients
- Talk to patients about appropriate use of antibiotics
- Include microbiology cultures when ordering antibiotics
- Work with pharmacists to ensure appropriate antibiotic use to prevent resistance and other adverse events
- Use resources from the CDC and Society for Healthcare Epidemiology Stop the Spread
- Follow hand hygiene and other infection control measures

Ethical and Religious Directives for Catholic Health Care Services – The *Directives* are a set of principles that inform the provision of health services under Catholic sponsorship. These standards are conclusions drawn from a faith-inspired vision of the human person and the experience gained from providing holistic health care. As a Catholic health care ministry, Mercy Health Springfield is committed to complying with the Ethical and Religious Directives for Catholic Health Care Services (ERDs). The ERDs provide guidance on all aspects of our ministry.

To find out more about the ERDs, follow this link: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf

Fire: Life Safety Program

Life Safety = Fire Safety

Everything we do to protect lives from the risks of the effects of smoke and fire:

- Fire alarms, heat/smoke detectors, pull stations, and sprinklers are unblocked and in working order
- Education, Orientation and Competencies, Code Red Plan and Policy
- Construction: Pre-Construction Risk Assessments (PCRA), Interim Life Safety Measures (ILSM)- *things we do to stay protected when systems aren't fully functional*, Above ceiling work permits
- Doors should close and latch
- No holes in ceilings and walls
- Do not block fire doors, fire extinguishers or medical gas valves
- Hallways are clear to fire exits

Steps to take in a Fire (handout on table)

What would you do if there was a fire here and now? Remember R.A.C.E.!

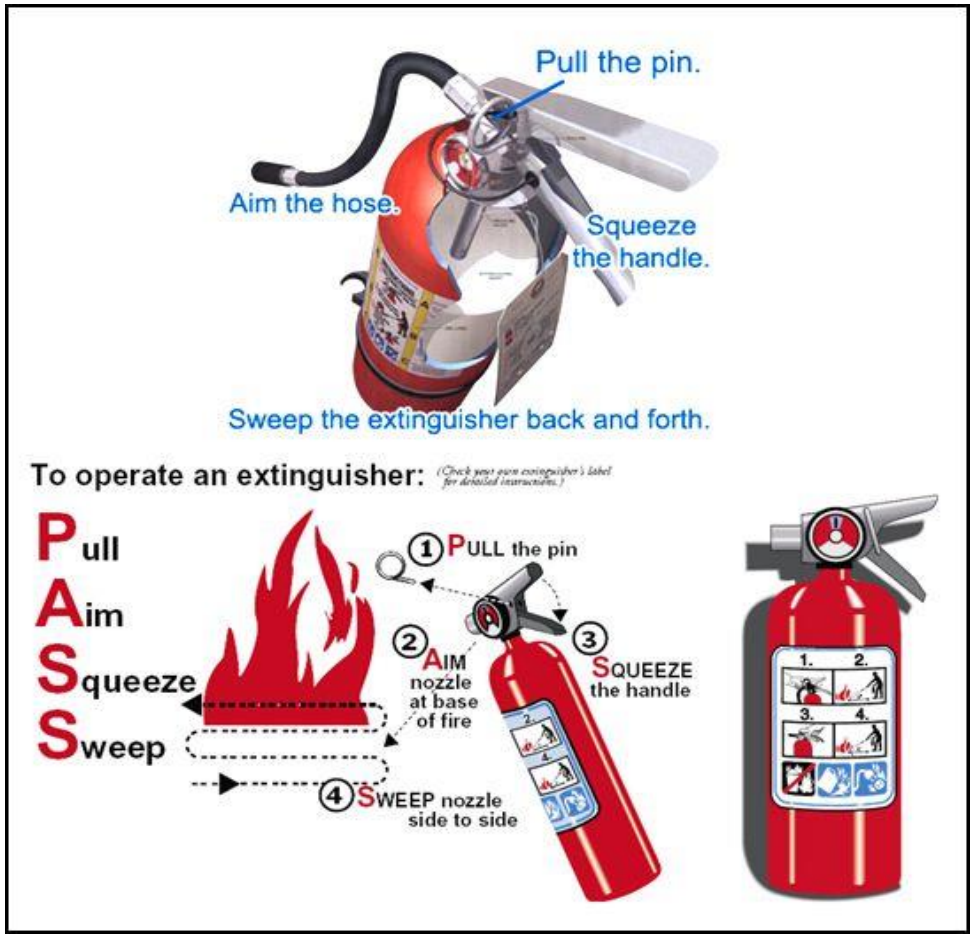
Rescue/**R**emove – Help those in danger of exposure to smoke and fire move to safety.

Alarm/**A**lert – Call **9999 (SRMC) or 7777 (MHUH)** on a facility phone, pull the fire alarm, alert those in the area

Confine/**C**ontain – Keep the smoke and fire from spreading. Close all doors.

Extinguish/**E**vacuate – If safe to do so, extinguish the fire, otherwise evacuate the area. (*Extinguishing may necessitate the use of Fire Extinguishers. To operate remember **PASS**- **P**ull, **A**im, **S**queeze, **S**weep*)

Using a Fire Extinguisher Safely



Did you know there are different types of Fire Extinguishers?

- Their use and placement is determined by where the type of fire (fuel - paper, grease, electrical) is likely to occur and safety considerations (such as near an MRI entrance).
- These include (but not limited to) “ABC”, “K”, and “CO2,” “non-ferrous/MRI-safe” type extinguishers.

Regardless of the type of fire extinguisher, PASS (Pull, Aim, Squeeze, Sweep) is used to operate the extinguisher.

When the Fire Alarm is Activated

- Follow your Code Red (Fire) Policy and Plan
- Fire area or smoke doors will close to create smoke compartments or "Zones of Safety." Exercise caution when evacuating from zone to zone
- Your location relative to the fire determines your response, but the Policy and Plan are implemented for the entire building
- All persons are alerted to a fire in the building but not all areas are immediately responsible for additional actions → think: those in the area of the fire, above it, below it, and adjacent (next) to it

Missing Person- Infant/Pediatric or Adult

- **Follow Policies, to include but not limited to: Code Adam/Amber, Missing Infant/Pediatric Patient, Infant/Pediatric Abduction, Code Brown/Missing Adult Patient**
- Should a patient be identified as missing from their location, staff may initiate an alert to search for the patient
- Monitor persons in the vicinity, and at entrances/exits, for persons matching description of missing person or suspected abductor
- Alert staff and Protective Services (Security) if person is identified to obtain assistance
- **Do not attempt to hold or restrain the individual**; you may follow at a safe distance

Bomb Threat

- **Follow Policy for Bomb Threat**
- Person receiving a bomb threat:
  - Keep calm and keep the caller talking. Ask questions about the bomb such as location, time of explosion, description of bomb, type of detonator. Pay close attention to details such as voice, accent, background noise, music, etc.
  - Get the attention of your co-worker. Have them contact Protective Services (MH Police or Security)
  - Employees will work with Law Enforcement to search
  - If a suspect package is found, evacuate the area in a routine and orderly fashion. **Do NOT touch the package!**
  - Do not use cell phones, radios, or other electronic devices near a suspicious package

Severe Weather

- **Follow Policy for Severe Weather**
- Alerts align with National Weather Service warnings May include:
  - Tornado (Watch or Warnings)
  - Severe thunderstorm (Watch or Warnings)
  - Winter storm, Blizzard, Snow/Ice advisories

Watch *(MAY occur)-* ***Warning*** *(WILL occur/has been spotted)*

- Move or cover patients to protect them from wind and debris. Close drapes and doors.
- Essential staff should consider plans for getting to/from work during weather emergencies and making back-up arrangements for family care.

Hazardous Materials and Waste Management: Information

- Hazardous Materials may include: Chemicals, Medications, Chemotherapy, Infectious Waste, Radiation, etc.
- Every employee has a “Right to Understand” label on all products used during their workday
- Information about these are available on the Safety Data Sheet (SDS) on “MSDS on-line” through the HUB (under Policies)
- SDS provides:
  - Name of chemical, including alternate or generic names
  - Chemical’s contents/ingredients
  - Purpose and proper use
  - Information on how to cleanup spills
  - Any hazards with the chemical

Hazardous Materials and Waste Management: Labeling

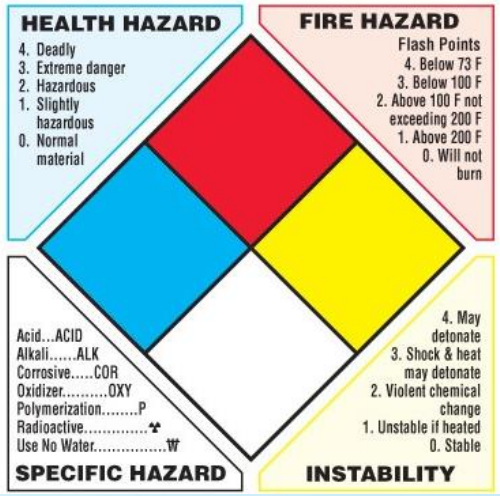
•All containers must be labeled with what they contain- even water!

•Must include a signal word (“danger” or “warning”), pictogram, hazard statement, & precautionary statement for each hazard class & category.

•When a chemical product is transferred to a second container, you must attach a label to the new container.

•This sign is posted in areas containing hazardous chemicals.

- Health Hazards = blue diamond
- Fire Hazards = red diamond
- Reactivity hazards = yellow diamond
- Information purposes = white diamond



Hazards Pictograms

Health Hazard  ▪ Carcinogen ▪ Mutagenicity ▪ Reproductive Toxicity ▪ Respiratory Sensitizer ▪ Target Organ Toxicity ▪ Aspiration Toxicity	**Flame**  ▪ Flammables ▪ Pyrophorics ▪ Self-Heating ▪ Emits Flammable Gas ▪ Self-Reactives ▪ Organic Peroxides	**Exclamation Mark**  ▪ Irritant (skin/eye) ▪ Skin Sensitizer ▪ Acute Toxicity (harmful) ▪ Narcotic Effect ▪ Respiratory Tract Irritant ▪ Hazardous to Ozone Layer (non-mandatory)
Gas Cylinder  ▪ Gases under Pressure	**Corrosion**  ▪ Eye damage ▪ Skin Corrosion/burns ▪ Corrosive to metals	**Exploding Bomb**  ▪ Explosives ▪ Self-Reactives ▪ Organic Peroxides
Flame over Circle  ▪ Oxiders	**Environment (Not Mandatory)**  ▪ Aquatic Toxicity	**Skull and Crossbones**  ▪ Acute Toxicity (fatal or toxic)

Hazardous Materials and Waste Management: Spills or releases

- **Follow policies for Hazardous Material Spill or Release, including Code Orange**
- What to do
  - Restrict access to areas of spill/release and evacuate
  - Notify individuals specified in policy/procedure
  - Identify spilled/released material. Obtain SDS.
  - Can you clean this up per SDS and policy?
    - If Yes → Clean up using appropriate methods and Personal Protective Equipment (PPE). Properly dispose.
    - If No → Contact appropriate leader to arrange for clean-up by qualified personnel.
  - Complete an incident event report; SafeCARE

Medical Emergencies

- **Follow Policies, to include but not limited to: Code Blue, Code Pink, Cardiac Arrest/Respiratory Arrest**
- May be called for a person experiencing an event (patient, employee, visitor), in a variety acute care facility settings
- Intended to quickly obtain professional medical support and supplies
- May begin as a Rapid Response Team (RRT) event and escalate. Response personnel and actions may differ
- Only those required to assist should present to the event location, help keep non-essential personnel clear of area
- Be ready: Keep Crash Carts and other emergency medical supplies available and checked for readiness. Know how to activate a response team at your facility.

Internal or External Disaster

- **Follow Policies for Internal/External Disasters, Surge Plans**
- These may be small or large scale, man-made or natural, internal to the organization or in the community
- Event provides the opportunity for:
  - A high volume of deaths, injuries, or illnesses. *You may exercise your Surge Plan*
  - Extensive Property damage. You may have building or property damage, and access issues (blocked roads and doors).
  - Loss/disruptions of routine utility systems. You may need to use alternative methods to provide these
- Event may initiate use of your Emergency Operations Plan (EOP), Hospital Incident Command System (HICS), Incident Command, and Labor Pool
  - See course on “Emergency Management” for more information specific to your facility

Medical Staff Assignments During a Disaster

- Immediately upon notification of a disaster, the Hospital Incident Command System (HICS) will be initiated.
- The HICS Medical Staff Director will oversee the assignment of Medical Staff to patient care & treatment areas.
- In a mass casualty disaster beyond the capability of available Medical Staff, the Chief of Staff or his/her designee and the President of the Hospital or his/her designee may grant immediate temporary emergency privileges to a volunteer practitioner under specific conditions defined in our policy.
- The volunteer practitioner is assigned to an appropriate clinical Department Chief or his/her designee to oversee his/her performance by either direct observation or review of medical records.

- Temporary emergency privileges will be re-evaluated after 72 hours to determine whether the privileges should continue.
- On call surgical, medical and orthopedic practitioners report directly to the ER.
- Practitioners normally assigned to specialty areas (ED, Psychiatric Unit, Radiology, Lab, Hospice, Rehab & Occupational Health), should continue to report to those areas.
- All other practitioners report directly to the Incident Command Center for assignment.
- If a practitioner thinks that help may be needed & he/she is unable to contact the hospital, it should be assumed that help is needed and the practitioner should report to the Incident Command Center for assignment.

Workplace Violence

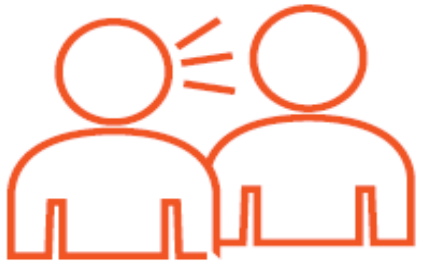
- **Workplace Violence** is the use (attempted use) of physical force against a person; or a statement or behavior that is reasonable for another person to interpret as a threat to use physical force in a workplace, that causes or could cause physical injury to another person
- Bon Secours Mercy Health is committed to providing a safe and secure environment for all persons and will work to maintain an environment that is free from harmful and disruptive behavior.
- The Joint Commission (TJC) has made reduction in violence against healthcare workers from patients and their families a priority (see TJC's infographic, next 2 slides)
- These may result in activation of plans or codes for violent/combative situation or for a hostage or weapon situation

Take a stand: No more violence to health care workers

Forms of violence to health care workers

- Biting
- Kicking
- Punching
- Pushing
- Pinching
- Shoving

- Scratching
- Spitting
- Name calling
- Intimidating
- Threatening
- Yelling



- Harassing
- Stalking
- Beating
- Choking
- Stabbing
- Killing

See ***Sentinel Event Alert*** Issue 59, "Physical and verbal violence against health care workers," for more information.

The Joint Commission

Factors associated with perpetrators of violence

- Altered mental status or mental illness
- Patients in police custody
- Long wait times or crowding
- Being given "bad news" about a diagnosis
- Gang activity
- Domestic disputes among patients or visitors
- Presence of firearms or other weapons

What to do when violence occurs

Report it! Notify leadership, security and, if needed, law enforcement.

See ***Sentinel Event Alert*** Issue 59, "Physical and verbal violence against health care workers," for more information.

The Joint Commission

What to do in an active violence situation…

COPING

WITH AN ACTIVE SHOOTER SITUATION

- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any facility you visit
- If you are in an office, stay there and secure the door
- Attempt to take the active shooter down as a last resort

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

PROFILE

OF AN ACTIVE SHOOTER

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area, typically through the use of firearms.

CHARACTERISTICS

OF AN ACTIVE SHOOTER SITUATION

- Victims are selected at random
- The event is unpredictable and evolves quickly
- Law enforcement is usually required to end an active shooter situation

CALL 911 WHEN IT IS SAFE TO DO SO

(Homeland Security 1 of 2)

…. Run…. Hide… Fight…

HOW TO RESPOND

WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. RUN

- Have an escape route and plan in mind
- Leave your belongings behind
- Keep your hands visible

2. HIDE

- Hide in an area out of the shooter's view
- Block entry to your hiding place and lock the doors
- Silence your cell phone and/or pager

3. FIGHT

- As a last resort and only when your life is in imminent danger
- Attempt to incapacitate the shooter
- Act with physical aggression and throw items at the active shooter

CALL 911 WHEN IT IS SAFE TO DO SO

HOW TO RESPOND

WHEN LAW ENFORCEMENT ARRIVES

- Remain calm and follow instructions
- Put down any items in your hands (i.e., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming or yelling
- Do not stop to ask officers for help or direction when evacuating

INFORMATION

YOU SHOULD PROVIDE TO LAW ENFORCEMENT OR 911 OPERATOR

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons held by shooters
- Number of potential victims at the location

(Homeland Security 2 of 2)

Utilities Safety and Failures

- Utility Systems may include: Gas, Electric, Water, HVAC (Heating and Air conditioning), Water, Medical Gasses and Vacuum, and Elevators
- Loss of any utility system, in part or in whole, may pose a risk to our ability to safety deliver care
- Always use Red Plugs for Critical Patient Care Equipment. These are on Generators and when electric is loss the generators restore power seamlessly or within seconds
- Electrical Panels cannot be blocked; clearance 36 inches in front of panel, to allow access in an emergency
- Plant Operations/Facilities will provide guidance in the event of planned or unplanned loss of utility systems use

Oxygen and Medical Gas Safety

- For piped (in wall) Medical Gases
  - Ensure access panels for shut-off valves is unblocked
  - Shut-off valves should be labeled for what area(s) they shut off
  - Learn who may shut-off the valve and when. This may be labeled at the shut-off valve or in policy
- For Medical Gas cylinders
  - Cylinders must be secured and stored in a rack when not in use
  - “Grab and Go” Style cylinders may be carrier to their destination for use (see picture)
  - Cylinder Segregation- Racks must be labeled to separate tanks Full/In-use/Partial (available for use) and Empty (do not use). *See your facility policy for details*
  - Medical Gas use requires a provider’s order. Only qualified personnel may adjust settings

Culture of Safety

- Culture of Safety is the sum of everything we do to pursue and ensure safety
- Promptly report any safety concerns in your environment; including near-misses/close calls, no harm events, adverse events, and unsafe conditions
- This may mean:
  - Notifying fellow staff of a safety issue
  - Placing a work order for repair
  - Completing a report in the incident reporting system; SafeCARE
  - Following policies related to safety
- Always follow your policy for Chain of Command for reporting
  - Consider Quality, Accreditation, Risk Services, Corporate Compliance, and/or Legal for additional investigation and support
- Bon Secours Mercy Health supports a Culture of Safety

Limited English Proficiency

- HR.01.01.01 EP 1, note
- Mercy Health bilingual employees will not be used in role of the interpreter
- Bilingual physicians should not interpret for other employees or translate documents
- In the event of an emergency, a physician may interpret for staff until a qualified interpreter is available

Pain Management

- **Key Updates**
- To meet the new and revised pain assessment standards from The Joint Commission, the Pain Management Policy went live in 2019. There is an increased focus on the use of non-pharmacologic pain treatment modalities, as wells as improving pain assessment by concentrating more on how pain is affecting patients' physical function.
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- .

Pain Assessment

- **Pain Assessments**
- •Include the patient's pain goal (what is considered tolerable by the patient)
- •Include functional descriptors to identify how pain is affecting the patient's physical activities
- **Pain Reassessments**
- •Completed on non-pharmaceutical interventions per clinical judgement based on the intervention

Interventions

- **Interventions—**
- •A pain rating ABOVE the patient's acceptable level or if unable to reach functional goal requires intervention.
- •Provide at least one non-pharmaceutical intervention or pain treatment modality, instructing patient and family about the intervention. Examples include but are not limited to, heat, cold, massage, range of motion, repositioning, and relaxation.
- Note: Non-pharmaceutical interventions can assist in minimizing risks associated with opioid use.
- •Evaluate the effectiveness of pain control interventions. The patient's satisfaction with the pain intervention is important

Other Pain Highlights

- Education—
- • Education on storage and disposal of opioids to prevent misuse by others will be provided to the patient and family.
- Special Considerations with use of Analgesics—
- • For patients receiving scheduled pain medications (non-PRN meds), a pain assessment shall be documented at least once per shift. If pain is not controlled with scheduled regimen dose, alert physician. Reassessment will be documented if clinically indicated.
- LIPs are involved in establishing protocols, quality metrics, and reviewing PI data around pain management, opioids via Pharmacy and Therapeutics or othe designated committees.

Nonpharmaceutical Interventions

- Staying home when sick
- Washing hands frequently
- Covering coughs and sneezes
- Routinely cleaning frequently touched surfaces

Communicating Critical Information

- Various ways of communication may be used to share critical information such as information about outbreaks or other emergency situations
- This will include communication with licensed independent practitioners, staff and all others
- Examples may be:
  - Email blasts
  - Huddle Messages
  - Signage on entry doors and in care areas
  - Educational materials in patient care areas

ADVANCED DIRECTIVES

- We support the right, consistent with applicable law and ethical principles, of every competent adult to make decisions about medical care, including the right to accept or refuse health care treatments, services and procedures and to formulate advance directives
- Once the document(s) is received, a copy of the Advance Directive shall be placed in the patient's bedside folder and will be scanned into the EHR to become a permanent part of the medical record. Until a copy of the Advance Directive is provided, the facility cannot presume or act upon its provisions. This should in no way be construed as a prerequisite for admission/treatment.
- Spiritual Care serves as the Advance Directive Counseling Team with support from the Patient Representative and Social Services as needed. If a patient would like to change document(s) and/or formulate an Advance Directive, Spiritual Care Services should be notified
- On request, the chaplains will provide the standard Ohio Advance Directive Packets, free of charge, along with additional information regarding making health care decisions and supplementary resources.

Downtime for electronic information systems

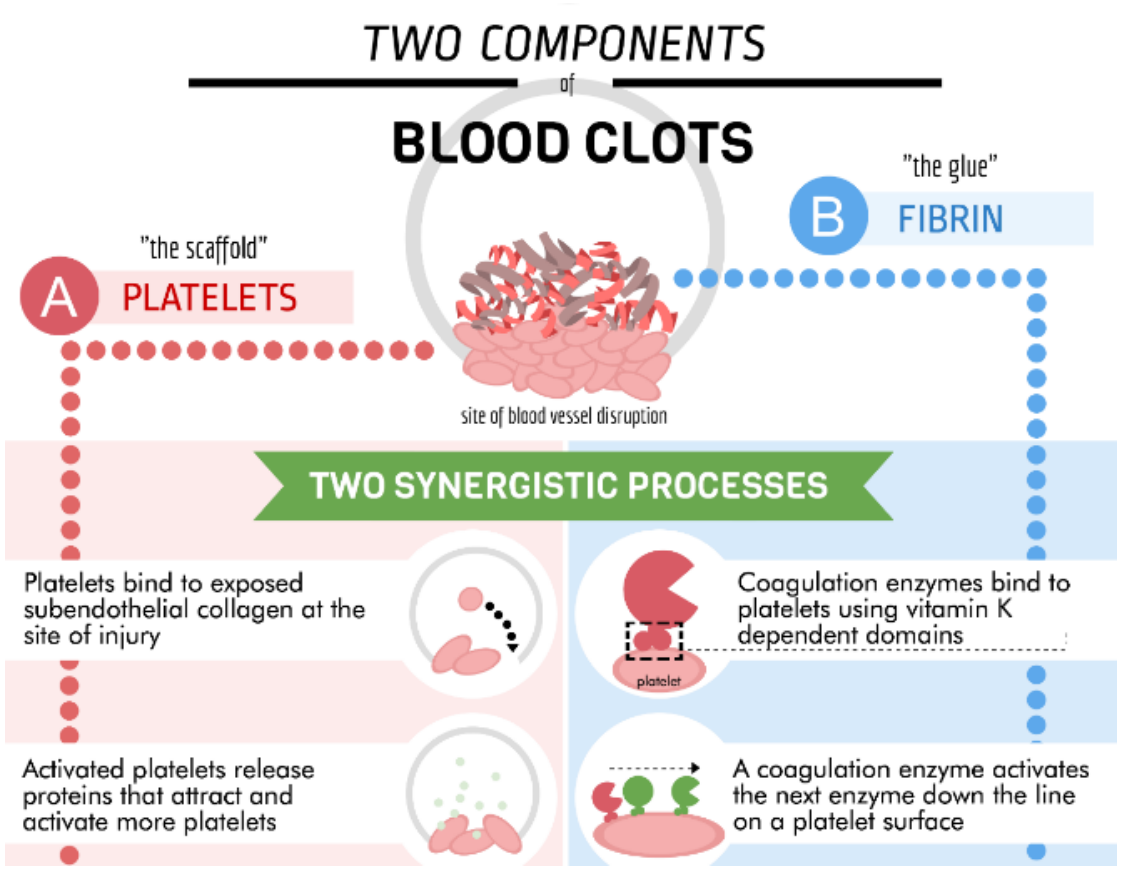
- Paper forms are available on each unit for documentation use during downtime situations
- HIM will scan these documents into the patient care record
- When documenting for care that was provided during the downtime, make sure time accurately reflects the time the care was provided

LIP Impairment

- Expectation is that every LIP treats patients, family, & staff in a professional, respectful and cooperative manner
- Concerns about illness and impairment should be addressed with Department Chair, Chief of Staff, or Chief Clinical Officer
- Symptoms of impairment may include:
  - Change in affect/personality
  - Change in activity
  - Smell of alcohol
  - Poor personal hygiene
  - Disruptive behaviors
  - Slurred speech
  - Abnormal gait
  - Dilated pupils
  - Sexual boundary issues

Continuing Medical Education

- Continuing education is an adjunct to maintaining clinical skills and current competence
- Hospital-sponsored educational activities are prioritized by the medical staff
- Related to care, treatment, and services provided (at least in part)
- Based upon performance improvement activities
- Participation is documented



Anticoagulant Therapy

- Patient/family education includes the following:
  - • The importance of follow-up monitoring
  - • Compliance
  - • Drug-food interactions
  - • The potential for adverse drug reactions and interactions

Purpose and Correct Operation of Alarms

- Red Alarms are never silenced
- Who can adjust alarms and when
- Patients off unit either order to discontinue or remain monitored

INFLUENZA

- Influenza and complications cause approximately 114,000 hospitalizations in the US. Last year alone over 80,000 deaths were related to the flu.
- CDC recommends annual influenza vaccination for everyone 6 months and older with any licensed, age-appropriate flu vaccine (IIV, RIV4, or LAIV4) with no preference expressed for any one vaccine over another
- •CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers get vaccinated annually against influenza.
- •Health care workers include (but are not limited to) physicians, nurses, emergency medical service personnel, students and trainees, contractual staff not employed by the health-care facility, not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from health care workers and patients

Flu Transmission Facts

- •People with flu can spread it to others. Influenza viruses are spread mainly by droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are up to about 6 feet away or possibly be inhaled into the lungs. Less often, a person might get flu by touching a surface or object that has flu virus on it and then touching their own mouth or nose.
- •Most healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Children may pass the virus for longer. Symptoms start 1 to 4 days after the virus enters the body. That means that you may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick. Some persons can be infected with the flu virus but have no symptoms. During this time, those persons may still spread the virus to others.

Flu the impact

- •Since health care workers may care for or live with people at high risk for influenza-related complications, it is especially important for them to get vaccinated annually.
- •Annual vaccination is important because influenza is unpredictable, flu viruses are constantly changing and immunity from vaccination declines over time.
- •CDC recommends an annual flu vaccine as the first and best way to protect against influenza. This recommendation is the same even during years when the vaccine composition (the viruses the vaccine protects against) remains unchanged from the previous season

Preventing and Controlling Infections

- Hand hygiene
- Environmental hygiene-clean and disinfect surfaces and equipment following approved practices
- Screening
- Vaccinations
- Surveillance
- Antibiotic stewardship
- Follow the evidence

Hand Hygiene

- We follow CDC guidelines:
- Hand hygiene is to be done before and after patient contact or contact with any potentially contaminated surface
- Alcohol foam or gel may be used for routine disinfection when hands are not visibly soiled
- Use soap and water:
  - Hands are visibly soiled or contaminated with blood or body fluids
  - Before eating
  - After using the restroom
  - When caring for patients with C difficile

MDRO's

- Prevention of healthcare-associated infections due to multi-drug resistant organisms (MDROs):
- Alerts for patients with history of MDRO, ESBL, CRE, MRSA, VRE, etc via EHR
- Isolation for patients who test positive for any multi-drug resistant organism (MDR) and/or extended spectrum beta lactamase(ESBL) organism, such as MDR Acinetobacter and ESBL E. coli
- Follow instructions on isolation signs
- C-diff patients:
  - Use soap and water for Hand Hygiene
  - Room cleaned with bleach/bleach wipes
  - Send specimen only when appropriate criteria met

Preventing Central Line Associate Bacteremia-CLABSI

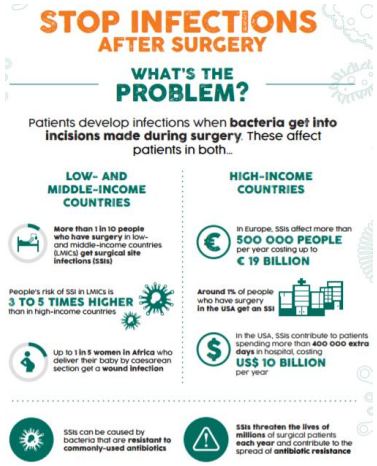
- Prevention of central line associated blood stream infections (CLABSIs):
  - We follow IHI's Central Line Bundle
  - Hand Hygiene performed prior to insertion or manipulation of catheter
  - Maximal barrier precautions in preparation for insertion. Person inserting the line and those assisting are to wear a cap, mask, sterile gown, and gloves. Cover the patient from head to toe with a sterile drape.
  - Chlorhexidine skin antisepsis prior to insertion and with dressing changes
  - Optimal catheter site selection, with subclavian vein as preferred site for non-tunneled catheters in adults
  - Daily review of central line necessity with prompt removal of unnecessary lines

Preventing Surgical Site Infections (SSI)

- We follow SCIP parameters, which include but not limited to:
- Appropriate use of prophylactic antibiotics with the recommended antibiotic for the surgical procedure
- Administer pre-op antibiotic dose within one hour of cut time and or 2 hours for Vancomycin and Gentamycin
- Discontinue antibiotics within 24 hours of surgery; 48 hours in cardiac surgeries
- Controlled serum glucose levels in cardiac surgery patients
- Appropriate hair removal

Other initiatives we follow to prevent SSIs:

- Maintaining recommended temperatures and humidity in OR suites
- Keep traffic in and out of OR suites during surgery to a minimum
- Antibiotic re-dosing



Preventing Catheter Associated Urinary Tract Infections (CAUTIs)

- We monitor the use of foley catheters every shift
  - Alternative attempted
  - Does the patient meet criteria for insertion
  - An order needed for placement
  - Attention to sterile technique
  - Does foley catheter continue to be necessary?

Restraint Education

- An order from a physician or authorized provider is required for all instances of restraints every calendar day
- Orders must be time limited and may extend to midnight of the day after the order is written
- Must be authenticated by the LIP
- PRN orders are not permissible
- Clinical justification for the restraint must be included in the order
- Type of restraint to be used must be designated

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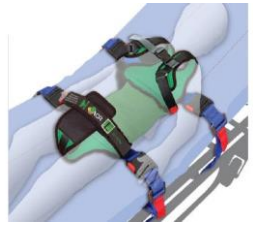
Violent Self-Destructive Restraints

- Primary reason to protect the patient against injury to self or others due to violent, aggressive behavior
- Additional order parameters:
  - Initial order obtained within one (1) hour based on a face to face evaluation (even if restraint or seclusion is removed within that hour)
  - Order renewed (verbal or written) based on age guidelines
  - Every 4 hours for adults, 18 and older for a total of 24 hours
  - Every 2 hours for adolescents age 9-17 for a total of 24 hours
  - Every 1 hour for children under 9 for a total of 24 hours



FACTS on Suicide

- Between 2010 to 2014, the Joint Commission's Sentinel Event database shows 1,089 suicides occurring among patients*
- Patients received care, treatment, and services in a staffed, around-the clock care setting or within 72 hours of discharge
- Includes discharge from a hospital's emergency department
- Admission rates for ages 5 - 17 doubled from 2008 - 2015 for suicide. **
- Estimated 38% sought healthcare assistance within a week before attempting suicide**

*Sentinel Event Alert Issue 56 February 24, 2016

**: High rate of healthcare visits before suicide attempts" (2015). USA Today (May 2017)

Expectations for non-psychiatric units-

- **Mitigate the risk of suicide for patients at high risk for suicide:**
- Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.
- Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation
- Document the patient's risk of suicide and the mitigation plan.

➢ **Our mitigation strategy: 1:1 Monitoring of patients**

High Reliability Principles

- To be a high reliability organization(HRO), safety must be the primary focus and not just exist as an implied assumption. We must vigorously encourage those behaviors which promote a safe environment. There are five basic precepts that HRO exhibit:
- Sensitivity to Operations (Situational Awareness): as understanding of what is going on around us and how the current state supports or threatens safety
- Pre-occupied with Failure: awareness of small signs of impending failure, and after identifying the risk, taking action to minimize or eliminate it
- Deference to Expertise: recognizing the expertise is not in just one person, everyone is able and encouraged to share concerns and are comfortable speaking up
- Reluctance to simplify: seeking a complete understanding of the issue, understanding underlying causative factors rather than just surface explanations