MultiCare

BetterConnected

Provider Handbook

5-2014, Web Edition

MultiCare Health System provides services across the health care continuum. We are dedicated to quality patient care with excellent clinical outcomes. Our physician partners are essential in achieving excellence in service and quality. We thank you for your contribution to patient safety and quality patient care.

MultiCare Mission: Quality Patient Care

Vision: To create a seamless, easy, valued and sustainable continuum of health care that enhances the experience of our patients, providers, caregivers, and employees.

Values: Respect, Integrity, Stewardship, Excellence, Collaboration, Kindness

Good Samaritan Hospital Mission:
We provide quality health care in the compassion and spirit of Christ's love. We meet individual and community needs as a team, reflecting our belief that health is wholeness in body, mind, and spirit.

CONTENTS

Safe patient care is everyone's concern. Please review this information about how you can contribute to safe care at MultiCare in an Emergency.

Medical Staff members are provided a plastic card to attach to the MHS ID badge that lists all emergency codes and phone numbers. Take a moment to familiarize yourself with the STATEWIDE Emergency Codes.

Code Red: FIRE

RACE = Rescue, Activate, Control, and Extinguish PASS = Pull, Aim, Squeeze, Sweep

Code Blue: CARDIAC OR RESPIRATORY ARREST Assist
until the Code Team arrives and you are relieved.

Code Orange: HAZARDOUS MATERIAL SPILL/RELEASE
Material Safety Data Sheets (MSDS) are on the MHS Intranet. For major spill cleanups, call Security.

Code Gray: **COMBATIVE PERSON** Security will respond.

Code Silver: **WEAPON/HOSTAGE SITUATION** Stay away
from the announced location.

Code Bravo (BOMB THREAT): Remain calm and involve
Security

Amber Alert: INFANT/CHILD ABDUCTION Observe
for the missing infant/child

External Triage: EXTERNAL DISASTER
Physicians report to the Medical Staff Lounge and sign in; wait for direction of Incident Commander.

Internal Triage: INTERNAL EMERGENCY/BOMB THREAT More information will follow. **Code**

STEMI: Rapid response treatment of Segment T elevation MI within 60 minute window. **Code NEURO:**

Rapid response to onset of stroke symptoms.

Armbands: Red= allergy, Yellow= fall risk, Orange= skin risk, Purple= DNR, Pink= limb alert

Rapid Response Team

- Staff, patients, and family may call 5555 and ask for a Rapid Response Team for immediate response to inpatient clinical situations where the patient's condition is perceived to be deteriorating.

- The call will summon a respiratory therapist, a critical care experienced nurse, pharmacist and a hospitalist at Tacoma General, Mary Bridge and Auburn Medical Center.

- The RRT is available at hospitals and Baker Center procedural areas.

Medical Equipment

- All Medical equipment has a dated preventive maintenance (PM) sticker. Do not use equipment if the date on the PM sticker has passed.
- Do not use any malfunctioning piece of equipment but set it aside and report it to the supervisor in charge.
- If the equipment is involved in a patient incident, it must be kept intact and impounded for investigation.
- Essential electrical medical equipment must be plugged into a red outlet to continue to function on generator back-up in the event of a power failure.

Medication Safety

- **Do not leave drugs, syringes or sharps unattended. Store in a secured area.**
  All errors are reported electronically via "MeQIM" found online via MHS Intranet. Adverse drug reactions are also reported via MeQIM.

- **Do not use unsafe abbreviations: Refer to the online MHS policy for more details. These are the most dangerous abbreviations noted from the Institute for Safe Mediation Practices (ISMP)**
- "unit," "International Unit" (not u, IU)
- "mcg," "microgram" (not ug)
- "daily," "every other day" (not QD, QOD)
- "morphine sulfate," "magnesium sulfate" (not MS, MSO4, MgSO4)
- Completely spell out Chemotherapy drug names
- Use the metric system, not "dram," "grain"
- NEVER use a trailing zero after a whole number (5.0 – no)
- ALWAYS use a leading zero before a decimal   (0.5 – yes)

Labeling Meds / Solutions

- Label medication or any solution when transferred from original packaging (unless immediately administered and used by the one who transferred it). DO NOT label prior to adding Medication or Solution.
- Applies to medications, contrast, reagents, skin prep solutions, etc.
- Discard any unlabeled meds/solutions

National Patient Safety Goals

- Identify patients with two patient identifiers such as name and medical record number
- If no ID wristband, identify with name and DOB
- Label specimen in presence of the source patient-no pre-label of container
- Label medicines and solutions in containers before a procedure
- Implement evidence-based practice to prevent healthcare-related infections due to multi-drug resistant organisms, central line associated bloodstream infections, catheter associated urinary tract infections and surgical site infections
- Follow CDC Guidelines for hand hygiene
- Reduce the potential for harm from anticoagulation therapy
- Reconcile medications across the continuum of care
- Identify patients at risk for suicide and intervene appropriately
- Report critical test results on a timely basis
- Follow "Universal Protocol" as defined below:

  "Universal Protocol" to prevent wrong patient/wrong procedure/wrong side-site.
  This three-part protocol applies to all surgical and nonsurgical invasive procedures.

1. **Verification**
   - In the pre-procedure processes, verify the correct patient, correct procedure, correct site
   - If there is inconsistency, the surgeon/ proceduralist must resolve it

2. **Site Marking**
   - Prior to the procedure, the site is marked with the initials of the surgeon/ proceduralist when there is more than one possible location for the procedure, with patient involvement if possible.
   - Marking must be done by the LIP who is accountable for the procedure and will be present when the procedure is performed
   - Marking may be delegated in limited circumstances to a medical resident supervised by the proceduralist, or to a PA or ARNP in a collaborative/supervisory agreement with the proceduralist. The medical resident, PA, or ARNP must be familiar with the patient and present at the procedure.

- An alternative marking process is in place for premature infants, teeth, mucosal surfaces, perineum, and for interventional cases where the catheter/instrument insertion site is not predetermined.

3. **"Time Out"**

- A designated time period for final verification of the correct patient, procedure, site, position, and availability of implants or other essential supplies and pre-incision antibiotics have been started.

- It must be conducted in the location where the procedure will be done prior to starting the invasive procedure or making the incision.

- It must have the participation of everyone participating in the procedure

- A second time-out takes place when there is a subsequent procedure with a change in proceduralist **Hand-off**

Communication

- The MHS standardized method of hand-off communication is **S**ituation-**B**ackground-**A**ssessment-**R**ecommendation (**SBAR**).
- Include up-to-date information about care, treatment, services, condition, and recent or anticipated changes.
- Allow an opportunity for questions and answers.

Patients with Elevated Fall Risk

- Nurses assess inpatient fall risk at admission and regularly thereafter using the standardized "Morse Fall Risk Assessment" tool that is integrated into MultiCare Connect.
- Ask patients to report their history of falls.
- Yellow ID band and yellow socks = an elevated fall risk

PHYSICIAN CLINICAL DOCUMENTATION

Physician clinical documentation should support the following goals:

- Accurately and succinctly document patient care
- Be timely, complete and CMS compliant
- Promote patient safety and quality care
- Improve communication and efficiency for all members of the health care team
- Support population chronic disease management
- Support research efforts
- Support institutional quality improvement programs
- Support billing & coding services
- Support an accurate medical legal record

Accessing MultiCare Connect, MultiCare's Electronic Health Record- for Community Physicians

- Call the MultiCare Service Desk at 403-1160 and request the User Registration Form and Confidentiality Statement.
- Fill out the forms and get appropriate signatures; FAX them to 253 459-7395.
- When the Service Desk receives the completed forms a tracking ticket will be created. This will trigger the creation of NT (Network) and MultiCare Connect (EPIC) accounts and passwords and a security token will be issued as needed.
- A log-in packet containing the user name, password and additional security information will be delivered to the physician.
- This process may take up to two weeks depending on the level of requests to the security team.
- Most password resets can be accomplished ONLINE. For assistance with passwords re-set, to report a lost token, or for questions related to accessing MultiCare Connect, contact the Service Desk at 403-1160.
- If you are using a personal phone, tablet, laptop or storage device you must use the MHS Public Wireless network and MultiCare approved tools such as Citrix to gain access to patient information. Using or attempting to access patient information without utilizing approved tools is a violation of MultiCare Information Security policies and can result in the personal device being confiscated, remotely wiped or additional legal action.

Please contact the MHS Institute for Learning Development to schedule free MultiCare Connect training and for reference material at (253) 403-1280.

Physician Online Documentation "Field Manual"

When documenting using an electronic health record, there are a few key recommendations to help you succeed:

1. "Less is More" - Omit extraneous text and data and focus on the IMPORTANT clinical information and medical decision making.

2. Refer to REVIEWED laboratory findings, radiology reports, and other information in your documentation WITHOUT COPYING THEM VERBATIM INTO YOUR NOTE. If you MUST include lab or other data, be brief and selective. **TIP: Consider using the .COMMONLABSIP or .LAB24R SmartLinks**

3. Always avoid abbreviations that others may not understand or worse, misconstrue. Use ONLY approved abbreviations (Abbreviations-Do Not Use policy found on MHSnet). To reduce the need for abbreviations, providers are able to easily access an online medical dictionary with common medical abbreviations spelled out provided by the National Library of Medicine at: http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

4. When using "note templates" (e.g. SmartTexts or personal note SmartPhrases), if any section does NOT apply to your patient, delete it. When using templated lists and exams (SmartLists or standard SmartPhrases) build in "checks" or "wild card stops" that force you to review the data for accuracy

5. Use "Copy Forward" function (same author) JUDICIOUSLY and ALWAYS review your notes before signing.

6. Whenever you use "copy forward", HIGHLIGHT CHANGES from one day to the next and avoid describing events. Instead, specify the date and time of critical events (e.g. chest tube removed today Dec 7 at 10 AM).

7. AVOID CLINICAL PLAGERISM - DON'T COPY OTHER PROVIDER'S NOTES

8. If you do copy portions of another provider's note, make sure the reader knows what YOU observed and does not confuse it with the documentation of ANOTHER PROVIDER recorded at a different time. Always be sure to specify the contributions of other providers that are included in your note (correct attribution).

9. Strive to make your notes visually attractive, informative and easy to read. Consider using novel note formatting to enhance relevance and readability. One example is the "APSO" format: place the Assessment and Plan sections at the top of your note followed by the Subjective and Objective portions. Readers can then quickly see your impressions and plans when first "loading" of the report.

10. Always review and sign your notes promptly. "PENDED" or incomplete notes are available only to YOU but NOT to other members of the care team

11. Documentation Errors in EPIC inpatients-immediately notify on call IS analyst.

Additional Resources:

Centers for Medicare and Medicaid Guidance
http://www.cms.hhs.gov/MLNEdwebGuide/25EMDOC.asp

AHIMA "Copy Functionality Toolkit"
http://www.ahima.org/infocenter/documents/copyfunctionalitytoolkit.pdf

Off the Record- Avoiding the Pitfalls of Going Electronic, P Hartzband & J Groopman, NEJM, 2008, Volume 358; 16, p 1656-1658.

Documentation Bad Habits, C. Dimick, Journal of AHIMA 2008; Volume 79:6, p 40-43.

The Elements of Electronic Note Style, T Payne, JV Hirschmann, SH, Journal of AHIMA, 2003; Vol.74:68, p 70.

Top Ten Physician Clinical Documentation Tips That Support Quality and Coding

1. Never pre-document!

2. Use "possible" or "probable" if appropriate

3. "Insufficiency" is OUT, "Failure" is IN

4. When a patient is admitted with a chronic condition, please consider "ACUTE on Chronic", if applicable

5. Consider "ENCEPHALOPATHY" vs. delirium/confusion/ AMS

6. Specify CHF: Acute or chronic? Systolic, Diastolic, both?

7. Excisional debridement is a recognized surgical procedure
   - document "Excisional debridement"
   - documentation must reflect a definite cutting outside or beyond the wound margin of devitalized tissue

8. ACS=angina. Be specific and document underlying cause
   - NSTEMI
   - CAD as the underlying cause of angina
   - Possible Myocardial Infarction within last 8 weeks
   - Psychogenic angina

9. Sepsis criteria (2 or more with possible source of infection)
   - Relative hypotension
   - Tachycardia >90
   - Tachypnea >20
   - Temp < 96.1F/36C or > 100.4F/38C
   - Leukocytosis/leukopenia WBC > 12K or < 4K or Bands> 10%
   - Metabolic /lactic acidosis
   - AMS
   - Oliguria
   - Hyperglycemia with absence of diabetes

10. Always update the Problem List. Specify "Hospital" versus non-hospital problems, "RESOLVE" inactive problems and "DELETE" erroneous entries. Remember, the Problem List is SHARED WITH ALL PROVIDERS. ICD-9 Codes are NOT NECESSARY for Problem Lists included within notes.

Tip: Use the SmartLink .PROBHOSP

E-Clarification

If it isn't documented, it hasn't been done. *"Concise medical record documentation is critical to providing patients with quality care as well as to receiving accurate and timely reimbursement for furnished services".* CMS

Clinical documentation Improvement (CDI) is a concurrent review process used by MultiCare Health System to assist physicians to more accurately document patient diagnoses, co-morbid conditions, complications, other secondary diagnoses and procedures.

- Please review requested documentation in **RN-CDI Note**
- If you agree, please document in your progress note/Discharge summary.
- We will follow up with you if we do not see a response within 24 hours (text page, phone call or fax to office).
- **Declining the question is ok** – clarifications are recommendations based on clinical indicators, risk factors and treatment.

The physician understands that the documentation clarification (RN-CDI Note) is a communication tool regarding the documentation of specific diagnoses, co-morbid conditions, complications and procedures based on clinical indicators, risk factors and treatment. The documentation clarification is in no way intended to diagnose or replace the physician's documentation in the medical record. It is the responsibility of the physician to review each clarification independently and make their determination of whether or not the clarification is appropriate to document in the medical record.

Documentation that will prompt clarification

- Dysfunction, insufficiency, syndrome, chest pain
- Absence of a diagnosis, diagnosis not connected with "PRESENT ON ADMIT" (POA), or symptom as the primary diagnosis
- "Blood loss anemia"- Please state "ACUTE" if appropriate

Rules for Importing and/or Copying Text

ACCOUNTABILITY: The authors are liable for the content of copied items within the notes they authenticate. As part of the health record review function, use of copy and paste functionality must be monitored, and where violations occur, findings must be reported to the appropriate Medical Staff Committee for disciplinary or other adverse action.

- Copied information should be brief, selective, and pertinent to the care provided during the current visit.
- Copied text and findings must be integral, relevant and medically necessary to the current encounter.
- Any imported object, dialog, etc., if used, must be reviewed and corrected at the source as well as in the document if there is any inaccuracy.
- The original source (person and date) must be cited and quotation marks placed around the information that was copied.
- Authors are responsible and accountable for information in their authenticated (signed) notes, including information that was copied and pasted from the work of others.
- Copy functionalities may be appropriate when copied information is:
  - Based on external and independently verifiable sources, such as basic demographic information that is stable over time.
  - Clearly and easily distinguished from original information.
  - Not actually rendered as part of the record until after a re-authentication process and is auditable for identifying actual origination.
- Never copy problems and medication that are no longer active.
- Never copy the signature block into another note.
- Never copy data or information that identifies a healthcare provider as involved in care if they are not.
- Do not copy entire laboratory findings, radiological reports, or other information in the record verbatim into a note when it is not specifically addressed or clearly pertinent to the care provided.

H&P Elements (Included in most SmartText)

- Chief Complaint: Concise statement of the reason patient sought care
- History of Present Illness: Include location, quality, severity, duration, timing, context, modifying factors, associated signs & symptoms, associated co-morbidities
- Social / Family History and Contributing Emotional, Behavioral and Social Factors: Smoking history, alcohol, drugs?
- Psychosocial Needs, Appropriate to Age
- Risk for and/or signs and symptoms for abuse and neglect
- Other Significant Medical / Surgical History
- Allergies / Intolerances: Drugs, food, dyes, latex, other
- Current Medications: Include all OTCs, herbals, vitamins - include name, dose, frequency, route and reason
- Physical Exam: Review of body systems, Procedure area (if doing a procedure)
- Admitting or pre-procedure diagnosis
- Plan of Care: Includes: testing, treatment, procedures
- Immunization status in pediatric patients

A Current H&P is:

- Dated not more than 30 days prior to admission and updated prior to surgery or sedation, or within 24 hrs of admission, whichever is first.

- In case of emergency procedure the H & P may be deferred no more than 24 hours following the procedure.

- Current progress note qualifies as the pre-op update when the inpatient has a current H&P.
- You may use the Pre-Operative H&P Update SmartText within MultiCare Connect to update your original H&P before surgery.
- Do not write "no change." **Minimally write:** "reviewed H&P, examined patient, no changes" per CMS requirement.

Admission Note (may be reflected in H & P)
- Reason for admission and condition of patient

- **Medically Necessary Admission:** Patient must have a condition that can only be treated or undergo a procedure that can only be performed in an acute care setting
- Attending Physician (if not the admitting Physician)
- Advance Directives
- Individualized plan of care with expectations and treatment goals
- Discharge planning if possible

Present on Admission vs. Hospital Acquired Condition

CMS in collaboration with CDC has deemed the following conditions reasonably preventable and therefore subject to reimbursement reduction unless documented by the PHYSICIAN/PROVIDER as PRESENT ON ADMISSION:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Fall with injury
- Poor glycemic control
- Mediastinitis after CABG

- Catheter-associated UTI
- Central line infection
- DVT/PE
- Surgical site infection

Progress Notes
- Acknowledge consultant's report/ findings
- Determine significance of ancillary test results
- Response to treatment
- Complications, Hospital-acquired infections
- Eliminate or add working or differential diagnosis
- Residents document continuous supervision
- Do NOT use Progress Notes to criticize the care of others or to express risk management issues or quality concerns
- Credentialed Allied Health Practitioners (ARNPs and PA-Cs) may document progress notes with authentication by the attending physician

Immediate Post Procedure Notes must include:
- Name(s) of primary surgeon(s) and assistant(s)
- Name of procedure performed
- Description of procedure
- Pre and post op diagnosis
- Findings and complications
- Specimens removed
- Anesthesia given
- Estimated blood loss
- Medication, blood components, products and fluid replacement
- Drains and implants

Summary Problem List

- All outpatients and ambulatory patients receiving continuing services are required to have a "Summary Problem List" by the third visit.

- While the Summary Problem List completion can be delegated to those authorized to make medical record entries, licensed independent practitioners are responsible for completion and accuracy of contents.

- The Summary Problem List includes**:**

  - Significant medical diagnoses and conditions

  - Significant operative and invasive procedures

  - Adverse and allergic reactions

  - Any Medications known to be prescribed for or used by the patient (including current prescriptions, over-the-counter drugs and herbal preparations)

Best Practice Use of the Problem List / Intelligent Medical Objects (IMO)

Expectations for Problem List Documentation in our electronic health record, MultiCare Connect (EPIC), is outlined in the policy, "Electronic Health Record Etiquette: Best Practice Use of the Problem List." The Problem List is a patient level shared list of active problems that informs and influences clinical decision making during current and future encounters. The Problem List can serve as the "Table of Contents" for a patient's medical narrative and communicates the important clinical aspects of a patient's ongoing care to the entire medical care team over time. Given the importance of the Problem List and to assist in finding appropriate clinical terminology, Intelligent Medical Objects (IMO) is a tool within MultiCare Connect (Epic) to help select visit/encounter **diagnoses** or cross encounter **problems** more easily and more precisely.

Please access the complete policy, "Electronic Health Record Etiquette: Best Practice Use of the Problem List" via the MHS Intranet under "Policies".

- Please access the educational video for IMO and the Problem List via the following link: http://mhsbv5/Education/IMO/videolauncher/

Discharge

- Discharge whenever patient is ready, whatever time of day (don't wait for next morning).
- The hospital must provide a discharge planning evaluation to the patients identified and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
- Consider discharge orders with criteria written the day/evening before.
- Discharge of Patients from ED setting requires documentation of "Condition at Discharge".
- The Discharge Summary should be **completed within 4 days** and be sufficient to justify the diagnosis and warrant the treatment and disposition.
  - Admitting Diagnosis; Discharge Diagnosis
  - Condition at discharge
  - Pending studies and reports
  - Review of hospital course
  - Significant test results
  - Disposition and mode of transportation
  - Any consultations, referrals, or communications
  - Discharge instructions and medications
  - Follow up plan and providers

Discharge Criteria

Discharge from Acute Care Screening elements:
- Temperature is in the normal range (< 38.0) and ALL other vital signs (pulse, respiratory rate and blood pressure) are unchanged from last physician review
- No ongoing need for cardiac/respiratory monitoring (NO significant arrhythmias noted)

- No active bleeding
- Pain is adequately controlled
- Patient can maintain adequate hydration with no ongoing and uncontrollable vomiting
- Patient is voiding adequately or has catheter in place.
- The patient is neurologically stable
- If the patient has had surgery, they have fully recovered from anesthesia
- The location of discharge care is known and all equipment will be available
- Medication reconciliation is complete and the patient understands their discharge medication plan
- The patient understands who and when to call for any post discharge problems or complications
- The patient has received and signed a completed After Visit Summary. (This may also be faxed to the PCP)

Process: The Nurse performing the discharge will document that the discharge screening has been performed on the Discharge flow sheet prior to preparing and reviewing the "After Visit Summary" form. If the patient fails the screening, the nurse will contact the provider with the pertinent information. Before discharge occurs, the Nurse should request that the provider re-evaluate the patient either in person or (at a minimum) review the patient's clinical information in MultiCare Connect before final discharge.

Admission Orders

- Admission status: (Inpatient, Ambulatory or Observation for:...")
- Admitting location
- Vital signs
- Allergies/reactions/intolerances
- Admitting diagnosis
- Diet/NPO status and Activity (up ad lib, bed rest, etc)
- Lab / diagnostic studies/ procedures / treatments
- Orders: IV, medication (see Medication Safety), code status, consults, discharge needs, etc.

<u>Unacceptable</u> Admission Orders:

- Admit overnight (must have reason) or Admit 23'59"
- Patient may stay overnight if she/he wishes
- Admit for 3 days for admission to SNF (Patient must meet Inpatient criteria for 3 days to qualify for SNF)

Orders

- Each order is dated, timed, authenticated and legible
- **Telephone /verbal orders must be authenticated within 48hrs. Any physician who is providing care for the patient may authenticate (sign) a T.O/V.O.** <u>These orders can be reviewed and authenticated by selecting the "Cosign Orders" section of the rounding navigator or via your In Basket.</u>
- Each imaging and PRN order must include the reason for the test or for PRN dosing (diagnosis, signs/ symptoms, indication) Example: Chest X-ray for chronic cough. Example: Tylenol 325 mg po Q 4 hrs for mild pain.
- No double-range orders. Do not write, "300-500 mg Q 4-6 hrs". Include criteria and parameters for dose administration.
- No therapeutic duplication order.
- An order is required for every episode of treatment or care.
- For safety, it is suggested that there are no more than two choices for the following: analgesics, antiemetics, sleep aid.
- Orders must be entirely reviewed whenever a patient transfers to a different level of care (do not write "resume all orders").
- Medication and dose for pediatric and adolescent patients: indicate mg/kg/dose and provide a total medication dose. For adults with weight based dosing, also provide a total dose.
- Reconcile medications when the patient is admitted, discharged, or transferred to a different level of care.
- **Avoid using "MD TO RN COMMUNICATION" orders for medication orders, laboratory testing or other diagnostic tests/procedures**

Dictation: Dial 253-403-3000

To dictate:
1. Enter your Epic ID followed by #
2. Enter the 2-digit work type followed by the # sign

00= Echocardiogram	13= Radiation Onc	45= Transfer of Care
01= Preop H&P	16= Inpt Progress Note	71= EEG
02= H&P	21= Letter	84=NursingNote w/o Encounter
03=Op/Procedure Notes	22=Letter/Consult Combo	85=NursingNote w/Encounter
04= D/C Summary	25= Non-patient Letter	95=Telephone Encounter
05= Consultation	29= Miscellaneous	
06= ER Dept Note	35- CTA	
09= Clinic Note	44=Other/Additional Notes	

3. Enter Contact Serial Number followed by #
4. Begin dictation at prompt (or press 2)
5. At end of report press 5 to hear confirmation number and dictate another report or 9 to disconnect
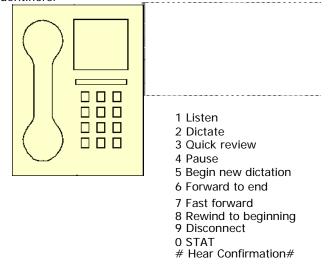6. Press 0 to make report STAT (this is a toggle)

To listen:
1. Enter your Epic ID followed by #
2. Press 3 to access listen line
3. To listen by confirmation number press 1, by contact serial number or account number press 2, or by work type press 3
4. Enter appropriate number of followed by #.

For assistance call Transcription at 253-697-7171.

During MultiCare Connect downtimes, when you do not have access to the patient's Contact Serial Number (CSN) you may enter "eight 9's" (99999999) and within your dictation identify the patient by name and other key identifiers.

1 Listen
2 Dictate
3 Quick review
4 Pause
5 Begin new dictation
6 Forward to end
7 Fast forward
8 Rewind to beginning
9 Disconnect
0 STAT
Hear Confirmation#

Electronic Authentication of Transcription via MultiCare Connect

1. Click on the In Basket button on the MultiCare Connect user toolbar
2. The In Basket opens, allowing access to three folders:
   Transcriptions/Authentication, Chart Deficiencies, Transcription/ Review
3. Click on Transcriptions/Authentication folder, then select desired patient to review the transcription.
4. Click on the Edit button to view and/or edit the current selected transcription.
5. After you have reviewed and/or made changes to the transcription text, click Accept.
6. Click on Authentication button on the activity toolbar and follow the prompt to file the transcription to the patient record. Associated chart deficiencies drop when you authenticate.

Contact Dictation Services to establish access to this function (253-697-7161). Contact Health Information Management (253-697-7047) for additional authentication assistance.

Patient and Family Education

- All members of the healthcare team, as well as the patient and families, are responsible for learning and education.
- Assess and document specific needs and barriers to learning: learning preferences, language barriers, literacy, or other limits (hearing, visual, cognitive, and developmental, etc.).
- Teaching should be tailored to the patient and family learning needs, preferences, styles and strengths.
- Address and document how you address each barrier (use translator, use pictures vs. text, etc.).
- Evaluate and document the outcome of patient education. Were they able to verbalize or demonstrate understanding?
- The education plan should be revised as the patient and family needs change.

Involve Patients in their Care and Safety

- Encourage patients to ask questions and be actively involved in their care.
- Tell them what their medications are for and what side-effects to report. Involve patients in medication reconciliation.
- Ask them to discuss their history of falls.
- Tell parents about infant/child security measures.
- Patients have access to copies of the MHS Patient Safety adult and pediatric brochures.
- The MHS booklet for inpatients, Patent and Family Information Guide, also offers suggestions for increasing the safety of healthcare

Culturally Appropriate Care

- Consider cultural differences and disabilities in planning patient care.
- Familiar behavior may have different meanings.
- Cultural differences include: dietary restrictions, modesty boundaries, rituals of birth and death, willingness to report pain and to ask questions.
- Don't assume that what you meant is what the patient and family understood, or that what you understood is what was meant by the patient or family.
- Avoid using jargon or idiomatic expressions and long sentences when speaking in English with a patient of limited English proficiency.
- If someone seems not to understand your speech, speak slower not louder.
- Certified translators are required for patient education and informed consent, and are accessible by contacting Interpretive Services at 253-403-6691.

Pain Management

Every patient has the right to be involved in his/her plan for pain management.
- Ask the patient what level of pain he/she would be comfortable with (i.e. 4 on a scale of 10). Use the 0-10 pain scale, and other methodologies for patients who cannot communicate, are unconscious, or are pediatric patients.
- Discuss and document pain management whenever appropriate, particularly at admission and discharge. Education about pain includes the patient and family.
- If the patient reports pain, assess and document:

  - Intensity, location, duration, frequency, quality
  - Impact on quality of life and activities of daily living
  - Treatments used
  - Write the analgesic order with an indication for use, such as "for moderate pain" or "for severe pain". Do not write double range orders such as "....2-4 mg IV Q3-4 hrs.

Surveyors will evaluate our pain management

- They will ask the patient how well he/she feel his/her pain is being managed.
- They will ask what the patient and family were told about pain and pain management.
- They will ask the patient designated spokesperson and family if they were involved in the plan.

Advance Directives (Living Will, Durable Power of Attorney, Physician Order for Life Sustaining Treatment)

- Adult patients are asked about their AD at the time of hospital admission and given AD information.
- If a patient has an Advance Directive, every attempt will be made to obtain a copy.
- Ask your patient about their wishes and document the conversation. Incorporate the wishes into the plan of care.

Organ Donation

- A member of the health care team must contact the Organ Procurement Agency (OPO) when death is imminent (prior to determination of brain death or withdrawal of life support) to determine if the patient may be a candidate for organ donation.
- If the patient dies suddenly, a call to the OPO is still required to determine suitability for tissue and eye donation after death.
- If the OPO determines that a patient is a candidate for organ donation, a trained OPO specialist, working with the health care team, will approach the family regarding organ donation.

Informed Consent

- The physician obtains informed consent for any invasive procedure or treatment, except in emergencies.

- Invasive Procedure is defined as a procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to:
  - surgery, biopsy
  - bronchoscopy, endoscopy
  - cardiac catheterization
  - radiation therapy
  - sedation/ anesthesia
  - PICC line insertion

- Examples that do not require informed consent include, but are not limited to:
  - venipuncture or simple phlebotomy
  - peripheral intravenous access, arterial puncture
  - PAP smears
  - skin testing
  - ultrasound procedures, plain film radiography
  - bladder, nasal, or gastric catheterization
  - examination of an orifice
  - closure of minor lacerations
- Washington State law requests that informed consent include:
  - nature and character of the proposed procedure,
  - anticipated results,
  - recognized risks, complications,
  - benefits of the proposed treatment, and
  - recognized alternatives, including non-treatment.

- **Family members may not serve as translator.** Call for an official translator by contacting the MHS Operator.

- At MHS the provider obtains informed consent and includes a conversation of informing the patient of the risks, benefits, and alternatives to the procedure as well as the probability of success. The conversation regarding the informed consent is documented in the patient's medical record. The provider may obtain the patient's signature on the informed consent form or a staff member can witness the patient's signature attesting to the consent to the procedure on the consent form.

Abuse and Neglect Reporting

- Healthcare workers are mandated by law to report suspected or actual **abuse, neglect, abandonment, or exploitation**.
- Contact Social Work to assist you in notification of authorities.

HIPAA/ Confidentiality

- Patients have the right of access to their healthcare information - send patients to Medical Records for proper paperwork.
- When leaving a conference room, remove all materials, x-rays, etc. that contain patient information.
- Discard wastepaper with patient identifiable information in blue bins (for destruction).
- Protect computer monitor from public viewing. Log off from the computer when finished. Never share your computer password(s).
- Don't discuss patient sensitive information in public places.
- Protect patient records, patient lists, etc., by keeping information secure, under a cover or in a notebook.

If Restraints are Required

- **Restraint Orders:**
  - Time limited; PRN orders are not permitted
  - Order identifies the type of restraint:

Restraint, for safety and protection	Restraint, for Emergency Violent or Self-destructive Behavior
Supports medical healing; to prevent harm from patient behavior (pulling lines, tubes, etc) when the patient is unable to comprehend or comply with instructions.	For violent or self- destructive behavior that jeopardizes the immediate safety of the patient or others, regardless of underlying "medical issues"
The RN may initiate restraint, but a phone or written order is obtained within 12 hrs. LIP (Licensed Independent Practitioner) exam the patient w/in 24hrs and write order, even if the restraint has been d/c'd.	LIP notified ASAP after restraints initiated. LIP in-person evaluation w/in 1hr and write order at that time. Evaluate patient situation, condition, and response to restraint. Work with patient/staff to identify ways to help patient regain control. Revise plan of care as needed.
In-person LIP exam every 24hrs	In-person LIP evaluation + rewrite order Q 4hrs pt < 18yrs, Q 8 hrs pt ≥ 18yrs
Each order duration is limited to the time period the assessment determines alternative non-restrictive interventions are ineffective.	Unless LIP is present, RN evaluate + phone LIP for renewal order Q1 hr < 9 yrs, Q2 hrs 9-17, Q4 hrs ≥18 yrs

- The use of restraints has the potential for physical or psychological harm and even death.
- Restraint is the last resort after the use or consideration of preventative and/or alternative strategies.
- The method of restraint must be the least restrictive intervention that is effective, and removed at the earliest possibility.
- **Restraints are not:** age or developmentally appropriate safety interventions, stretcher rails, orthopedic appliances, forensic restrictions imposed by law enforcement authorities, positioning or immobilization for procedure and care, sedatives or hypnotics in standard doses used to treat medical conditions.

- CMS requires nurses and physicians to have education about restraint use and dangers. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

- Deaths occurring while restrained are reported to CMS by the MHS Patient Safety Officers. Also, deaths occurring within 24 hours of restraint use, or within one week of restraint use if the restraint was contributory must be reported to CMS. Contact the MHS Patient Safety Officer with any concerns or questions in this area.

Infection Prevention

- **Infection prevention policies:** Policies can be found on MHSnet under "Policy" tab on the Home Page.
- **Hand Hygiene:** Wash/gel hands when entering/leaving a patient room– always, even if you did not touch anything! Wipe off your stethoscope or other equipment that touched the patient.
- **Infectious Waste:** Infectious waste (bloody, body fluid soaked materials) must be placed in red bags. Nothing else should go in these bags! Sharps must be placed in sharps container BY THE USER (except OR.)
- **Standard Precautions:** All patients are on Standard Precautions. Glove for contact with all patient's blood, body fluids, moist body surfaces; gown if soiling is likely; mask & eye protection if spraying or splashing is likely.
- **Contact Precautions:** Patients with MRSA, VRE, ESBLs, and other multidrug-resistant organisms are placed on Contact Precautions. Patient records are flagged so isolation can be implemented for subsequent admissions. Only Infection Prevention can unflag these patients. Once flagged as MRSA, always flagged as MRSA. Gowns and gloves are required to enter the room for inpatients and for wound care in outpatients.
- **Contact Enteric Precautions:** Used for patients with diarrheal diseases such as C. difficile. Gowns and gloves are required to enter the inpatient room and hand hygiene requires soap & water.
- **Droplet Precautions:** Used for viral respiratory diseases and require a mask with eye protection, gloves and gown for inpatients, mask with eye protection and gloves for outpatients.
- **TB Precautions** - Patients are placed on Airborne Respirator Precautions in an Airborne Infection Isolation (negative airflow) room. A PAPR - Powered Air Pressured Respirator or half-face respirator - is required to enter the room. Gowns and gloves are only needed if indicated for Standard Precautions. TB patients are not managed in the outpatient setting. They are referred to an appropriate provider.
- **Airborne Contact Precautions:** Used for patients with measles, chickenpox or disseminated zoster. All MHS providers are required to be immune to mumps, measles, rubella and varicella. The patient is placed in a negative pressure room, gowns and gloves are required; PAPRs, masks are not.
- Refer to MHS Policy, **"Needlestick and Body Fluid Exposures,"** for details of procedure in the event of exposure to potentially infectious material. On the source patient, order Hep B surface antigen, Hep C and Rapid HIV. **Immediately report to the nearest MHS ED.** Consider hand carrying source patient labs to TG.
- **MRSA must be noted on a death certificate** if it is the cause or a contributor to the death. Colonization does not need to be noted.
- Washington State Law specifies that all patients newly diagnosed with a MRSA infection receive verbal and written instructions on how to prevent transmission in their home. Please ensure that patients are provided with this information. The booklet "Living with MRSA" is an excellent written resource and is available on the nursing units.

- **Preventing Central Line Infections:** MultiCare has adopted the central line "bundle" of best practices for insertion of central venous catheters to help prevent infections. This includes hand hygiene prior to insertion, use of CHG to prep the site, use of maximal barriers during insertion (clinicians use of hair covering, mask, sterile gown and gloves, and large drape covering the patient) and avoidance of use of the femoral site wherever possible.

Sedation for Procedures

- To perform sedation, the privilege must be requested and approved.
- **A documented pre-sedation evaluation is required and includes:**
-
  - History of prior sedation or anesthesia use
  - Physician exam with evaluation of airway
  - Assessment that the patient is suitable for the planned level of sedation (ASA assessment)
  - Informed consent
  - **An airway assessment immediately prior to sedation performed by licensed independent practitioner with sedation privilege**

- **Moderate sedation** ("conscious sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

- **Elective:** ASA Category I or II patient undergoing painful or anxiety-producing procedure or who requires cooperation for diagnostic or delicate therapeutic procedures.

- **Emergent:** May include patients beyond ASA Category II or those with other pre-existing physiological or psychological deficits.

- Post procedure assessment and documentation is required.

Unusual/Adverse/Sentinel/Never Events

- **"Unusual event"** is defined by MHS as an incident or hazardous condition inconsistent with routine operations or routine care. They include events that are termed by third parties as adverse, never, and sentinel events.

- **"Adverse Events"** are defined by WA State regulations <u>and are reported to the State Department of Health.</u>

- **"Never Events"** is the term used by the Leapfrog Group for the same events the State calls "adverse." They are events for which <u>costs directly related to the event are waived.</u>

- **"Sentinel Events."** are defined by the Joint Commission, and are basically the same as Adverse and Never Events. We do not report any events to the Joint Commission.

- Adverse and Sentinel events and serious "near-misses" have a team of involved staff assigned to complete a Root Cause Analysis within 45 days. Quality Management works with the team to complete the RCA and implement improvements.

- Quality Management staff manages event reporting to external agencies.

Examples of Adverse, Sentinel and Never Events
- Surgery performed on the wrong body part or patient, or the wrong procedure performed
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intra-operative or immediately post-operative death in an ASA Class 1 patient
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with
  - Failure to identify and treat hyperbilirubinemia in neonates
  - Intravascular air embolism, while patient is being cared for in a healthcare facility

- Failure to follow up or communicate laboratory, pathology or radiology tests
- Medication error or ABO incompatible blood products
- Fall, electric shock, burn, toxic substance, restraints, or malfunctioning medical equipment, while in the care of a healthcare facility

Reporting Adverse, Sentinel, and Never Events

MultiCare Health System supports and encourages the reporting of actual and potential Adverse, Sentinel, and Never Events through our online reporting system in order to learn from events and promote patient safety.

- Log onto MultiCare's Intranet Web page: MHSNet for MultiCare Employees
- Click on "MeQIM" in left hand column (**M**idas **e**lectronic **Q**uality **I**mprovement **M**emo)
- Click on "Enter" and then select the type of event you wish to report
- Complete the required fields and save/submit.

The MeQIM will be reviewed and processed by Quality Management staff.

Disclosure of adverse, sentinel or never events to patients and their families

- **When?**

Whenever an adverse event has occurred, or the event has actual or potential clinical significance, or an unintended act or substance reaches the patient.

- **Who?**

The Attending Provider, Medical Director, Clinical Director, MMA Regional Manager, and/or other healthcare team member(s) deemed appropriate.

- **Where?**

When possible the meeting should be pre-scheduled and arranged in a private area conducive to confidentiality and the feelings of the patient and family.

- **What?**

Focus on what happened and how it will affect the patient including immediate effects and the prognosis.
- Acknowledge the event, express regret, and explain what happened.
- Limit discussions to known facts and avoid speculation or assigning blame.
- If an obvious error was made, it should be admitted, responsibility should be taken, apology given and commitment made to finding out why it occurred.

Refer to policy, "Critical Event Management and Disclosure"

IMPROVING OUTCOMES

MHS Performance Improvement Plan

- The MHS hospital quality forum is the MultiCare Integrated Quality Committee.
- Our performance improvement plan defines how MultiCare plans, measures and improves quality.
- We are guided by our strategic plan, annual focus objectives and ongoing analysis of aggregated data on key metrics related to care, treatment and services.
- Our methodology for reviewing and improving performance is "**PLAN-DO-CHECK-ACT"** within the Baldridge framework and using LEAN principles..
- Performance Improvement is in partnership with our Board of Directors, Executive and Leadership Teams and the Medical Staff.
- High risk, high volume, and problem prone functions are performance improvement priorities
- The Medical Staff structure does its PI work via interdisciplinary services. Everyone is responsible for quality. Know how you fit into the PI program and what your area is measuring.

Evidence Based Care and the Medical Staff

- As part of our requirements for participation in Medicare/Medicaid, as well as to maintain our accreditation to the Joint Commission, we publically report how well we provide evidence based care in the areas listed.
- All reports are available for comparison to other facilities to the medical staff and any consumer of health care by visiting www.cms.gov or www.jointcommission.org.
- Thorough documentation of care, contraindications to care and education of the patient, you will assist us in meeting the indicators required for reporting, as well as usage of order sets.

Publicly Reported Data Indicators-Core Measures
 * Joint Commission

*Acute MI Care	
*Pneumonia Care	
Heart Failure Care	
*Surgical Infection Prevention	
*Pediatric Asthma Care	Mortality for selected Surgical Procedures (composite)
Hospital Outpatient Surgery Care	
Hospital Outpatient Chest pain	Death Among Surgical patients with treatable complications
30 day Mortality for AMI, HF, and Pneumonia	
Hospital Stroke Care	Hospital VTE Prophylaxis
Immunizations influenza pneumococcal pneumonia	Health care worker influenza immunizations
Elective delivery prior to 39 weeks	Hospital wide all cause unplanned 30 day risk standardized readmission rate
Inpatient psychiatric care	Ambulatory Surgery Center patient safety
Hospital Patient safety (composite)	
MRSA Bacteremia	C. Difficile SIR
30 day All Cause Re-admission rate for AMI, HF and Pneumonia	Patient Satisfaction Results including provider care
Ventilator Associated Pneumonia in ICU patients	Central Line associated blood stream infections in ICU patients
ED Throughput	Total Hip/Total Knee 30day risk standardized complication and readmission rates

Focused Professional Practice Evaluation (FPPE)

- A time-limited period during which the organization evaluates and determines a practitioner's professional performance of privileges.
- FPPE will occur in all requests for new privileges (both new appointments and current medical staff)
- FPPE will occur when there are concerns regarding the provision of safe, high quality care by a current medical staff member as recognized through the peer review process.

Ongoing Professional Practice Evaluation (OPPE)

- A process to ensure that there is sufficient information available to determine whether to continue, limit, or revoke any of a practitioner's existing privileges.
- Data is to be reviewed every eight months and at the time of reappointment by the practitioners and the service committee chairs.
- OPPE reports are sent via the provider's multicare.org e-mail address.

Accreditation and Survey Readiness

- Compliance with accreditation standards improves patient safety and quality of care.
- MHS hospitals and hospital-based services are accredited by multiple agencies, including the Joint Commission.
- Periodic unannounced surveys by the Joint Commission and the State Dept of Health are made to see that we are in continuous compliance.
- MHS complies with the regulations of the Centers for Medicare and Medicaid Services (CMS).
- Surveyors "trace" care of selected patients through the organization.
- Patients and families are interviewed.
- Any employees, physicians, and services with direct or indirect patient contact may be interviewed.
- Questions a surveyor may ask a physician
  - *How are medical guidelines approved?* Interdisciplinary medical staff committee
  - *How are nurses and care providers aware of the privileges granted to physicians and other LIPS?* Information is available on MHS Intranet (ECHONet)

- When speaking with a surveyor:
  If you don't know the answer to a surveyor's question, say, "I don't know but I will find out."
  Answer "yes" or "no," if appropriate.

During a survey it is counterproductive to complain to the surveyor about regulations or the survey process (You may do so directly through their website, www.jointcommission.org). **The MultiCare Difference** is each employee and physician delivering the ideal patient experience.

Safety: Protect patients and other customers 100% of the time.

Clinical Outcomes and Customer Service: These cannot be separated. There are many current studies that show how patients feel will affect their healing and clinical outcomes. It is no longer acceptable to provide good outcomes or work alone. We must do so in a way that shows respect and creates a positive experience.

Clinical Outcomes:
- Provide the best possible care
- Continuously improve care
- Measure what you do

Cost Effectiveness: The Cost Effectiveness standards are not so much about financial performance as they are about the processes and systems that touch our patients and customers. Creating and improving processes that are smooth and easy for our patients and for our staff is important to delivering the Ideal Patient Experience.

E T H I C S

MHS Code of Ethical Behavior

Our promise is to put patients' health first. Admission, transfer, and discharge of patients will occur based on patient needs, rights, extent of available services and other resources appropriate to the individual. All business practices will be conducted with integrity.

Refrain from unlawful harassment or discrimination against any person (including any patient, System employee, Hospital independent contractor, Medical Staff Member, volunteer, or visitor) based upon the person's age, mental disability, medical disability, marital status, gender or sexual orientation, religion, race, ancestry, color, national origin, health status, physical disability, ability to pay, or source of payment. See Medical Staff Bylaws for additional information.

Patient Rights

All patients receive a written copy of their rights and responsibilities upon hospital admission. Copies can be obtained from the hospital information desk, the billing office, and at clinics. You will also see Patient Rights - Responsibilities posters throughout the hospital. Patient rights include:

- Personal privacy and safety
- Information about treatment and alternatives
- Designate a spokesperson on their behalf.
- Participation in their care and refusal of treatment
- Pain assessment and management
- A second opinion
- Pastoral care, culturally appropriate care
- Billing information
- Their healthcare providers' names and roles
- **Adolescents have specific rights** related to mental health, reproductive health, and substance abuse treatment.
- **For our hearing impaired or non-English speaking patients,** Video Teletype Devices are available through the hospital operator. Translator services are available through (telecommunications) 24hrs a day.

Patient Complaints, Grievances

1. **Listen** so that the patient and/or family feel heard. Acknowledge the concerns.

2. Immediately **correct** the situation if you are able. If unable to correct the situation, report the situation to someone who can.

3. **Report** the complaint to MHS management. Resolution is not achieved until the patient and/or family is satisfied.

- Patients may complain verbally or in writing to an employee or call the Customer Service Line: 1-866-247-2366 or 253-403-1739. Our formal Grievance/Complaint policy is found on our MHS Intranet.
- Patients and family may contact the Joint Commission, DOH, CMS, or Qualis, with a concern for patient safety or quality of care, although our hope is that we first have the opportunity to respond to the concern.

Your Concerns about Quality and Safety of Care

- If you have a concern about the quality or safety of patient care, please promptly report it to applicable MHS leadership.
- If your concern is not adequately resolved, you may contact your Medical Director or Christopher Kodama, MD, Medical Vice President or Lester Reed, MD, Senior Vice President of Quality.
- MHS supports the "Just Culture" concept ensuring that employees and medical staff may report serious, unresolved patient care concerns to the Joint Commission without fear of reprisal or retribution. Contact the Joint Commission at www.jointcommission.org or (630) 792-5000.

Program Director Clinical Standards and Accreditation: Mona Bontemps 253-403-4768

Joint Commission, DOH, and Survey information: Beth Herner 253-403-7741

> Katie Bellarin 253-697-1717 and Stephanie Thomas-Murphy 253-333-2652

Performance Improvement/Core Measures: Lois Catts 253-697-1888

Medical Staff Bylaws and Rules/Regulations are available on MHSnet, under "Policy" tab
> Medical Staff Services: 253-403-1085

> Medical Staff Services: Marji Tate 253-403-3300

Patient Safety Program Director: Kathleen Bruttomesso 253-403-2536

 MHS Policy: 253-403-2786

MHS Connect Remote Access: IS Service Desk 253-403-1160
Technology/System Educator: Diane Ness 253-403-1280
Clinical Resources, web and Wagner Library: 253-403-4521

This booklet prepared by the MHS Quality Management Department and distributed by Medical Staff Services.

Quality first; caring always