CalvertHealth

New Provider Orientation

Outline

- Communication Assistance (Policy GA-31)
- Services for the Visually Impaired (Policy GA-039)
- Nutritional Care (Policy FNS4001)
- SBAR and AIDET
- Patient Satisfaction Surveys
- Abuse/Neglect/Exploitation
- Suicide Prevention
- Critical Findings:
  - Red Panic Values
  - Radiology findings/results

Communication Assistance, Policy GA-031

- All patients are assessed for communication barriers.
- If the patient or the patient's support person is deaf or hard of hearing and/or non-English speaking, visually challenged and/or cognitively challenged, hospital personnel will implement a mechanism to provide effective communication to obtain clinical information.
- Interpretive services must be provided using the communication method preferred by the patient and/or support person free of charge. The use of an interpreter must be documented in the medical record and include the date, time, and interpreter ID number.
- **Bilingual family members and hospital staff may not be used for medical interpretive services.**
- Interpretive services may be provided in person, or using telephonic and video remote interpreting (TVRI): TVRI
- The individual requiring the services of an interpreter should be informed (via TVRI) that the live interpreter could take a minimum of four hours to be present and that care should not be delayed if an emergent condition is assessed.

Communication Assistance, Policy GA-031

- In person certified interpreters are not available on site 24/7 but should be requested as soon as possible and based on patient or family request.
- The Case Management office (X8235) or the Clinical Coordinator can assist with requesting an in-person interpreter.
- Assistance Devices available are:
  - **SLUSA** – Sign Language USA – CHMC has multiple iPads within the hospital for video interpretation on all inpatient and outpatient units.) For telephone interpretation: Please dial 718-838-9317, Enter Pin: 9044 221#, Press*, say the language needed (Example: Spanish, Vietnamese, etc.)
  - **CyraCom** – Blue CYRACOM iPads are available in the hospital as back-up devices for video interpretation
  - **For phone interpretation**: Please call ext. 5900 from any hospital phone or dial 1-800-481-3293 and follow the prompts. Blue CYRACOM iPads stored throughout the hospital for video interpretation
  - **Language Line Solutions** - For telephone interpretation: Please dial 1-844-292-7019 and indicate the language desired

Services for the Visually Impaired, Policy GA-039

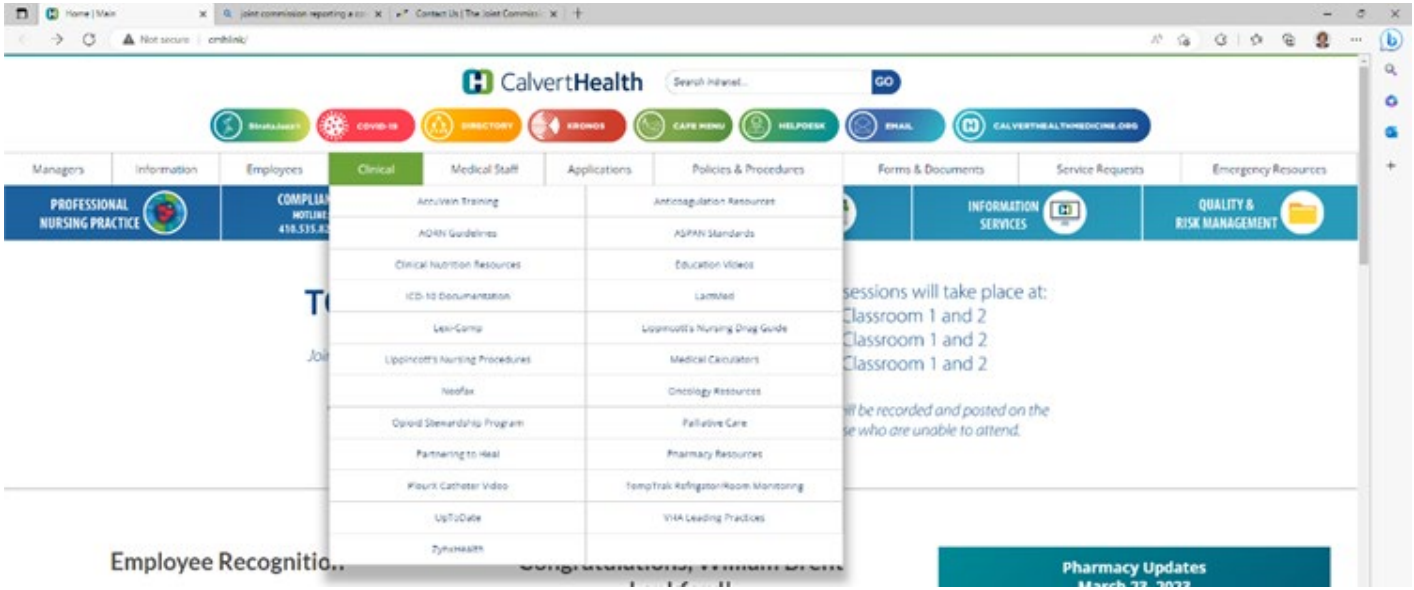
- Upon admission, the hospital will be responsible for providing the necessary resources to assure accurate communication and comprehension on the part of the patient and patient's family.
- Hospital staff providing visual aid support will document their actions in the medical record.
- Please refer to Policies GA-039, Services for the Visually Impaired and GA-136, Service Animals, Therapy Animals, and Pet Visitation for additional information

Nutritional Care Manual, Policy FNS4001

- Discusses the standardized nutrition care practices throughout the facility. Food and Nutrition Services uses the Nutrition Care Manual (NCM) and The Pediatric Nutrition Care Manual (PNCM) to guide in the development of nutrition care policies throughout the facility. The NCM and PNCM are the approved diet manuals of the institution.
- Clinical Nutrition staff use the approved manuals for evidence-based practice guidelines, patient assessment, menu planning and patient education. Physicians, dietitians, and ancillary staff use the manuals as references regarding nutrition support, enteral product formulary and diet order reference.

Nutritional Care Manual, Policy FNS4001

The Nutrition Care Manuals are provided via the intranet throughout the facility. In the event of computer downtime, Food and Nutrition Services should be contacted as a resource for diet orders and education. Clinical Nutrition keeps a backup PDF copy of the nutrition care manual for extended downtime use.



Communication – SBAR and AIDET

- Communications failure is the leading cause of adverse events in healthcare
- SBAR and AIDET are our chosen tools
  - They provide a framework for consistent communications among and between practitioners, nurses and staff
  - They ease patient anxiety by ensuring they know what is happening to and around them
  - SBAR is part of the CalvertHealth effort to ensure clear, appropriate communications among healthcare teams and with patients

SBAR Process

- **S**ituation: briefly describe the situation
  - Identify patient and unit
  - Briefly state problem, when it happened/started, how severe
- **B**ackground: provide background information specifically related the current situation
  - Admitting diagnosis and admission date
  - Current list of meds, allergies, IV fluids
  - Most recent vital signs
  - Key diagnostic results
  - Code status
  - Other pertinent clinical information
- **A**ssessment: describe what is thought to be the problem or healthcare provider's assessment
  - i.e., "the problem seems to be cardiac"
- **R**ecommendation: Describe what you think needs to be done
  - i.e., lab work, new medication or change in medication, assessment by another physician or specialist, etc.

AIDET

A **ACKNOWLEDGE**
- Greet the patient by name (if an adult, use Mr. or Mrs. Or Ms., not first name)

I **INTRODUCE**
- Always tell patient and family your name
- Tell them what your role is
- Talk up the team

D **DURATION**
- Give a specific time expectation
- How long will a procedure/test take?
- When can I expect results?

E **EXPLANATION**
- Enlist patient and family in care plan
- Describe what will take place, what they can expect
- Use terms the patient and family can understand

T **THANK YOU**
- For choosing us
- For trusting us

Patient Satisfaction Surveys

- CHMC has engaged PressGaney to measure the patient's perception of the hospital experience.
- **HCAHPS:** Hospital Consumer Assessment of Healthcare Providers and Systems Survey
- HCAHPS Rates Specific areas such as:
  - *Physician Communication
  - *Nurse Communication
  - *Responsiveness of Staff
  - Explanation of new Medications: possible side effects, discharge instructions, plan of care for recovery and continuation of previous medications
  - Environment of care
  - Likelihood the patient would recommend CHS to friends and family.

  *Scores related to Physician Communication, Nurse Communication, and Responsiveness of Staff are the top priorities, and are reported to the Board of Directors
- Survey results are posted publicly, allowing potential patients to make choices about which organization they will use for their healthcare. This directly affects our revenue, paychecks, equipment purchases - even Medicaid and Medicare reimbursement.

Suspected Abuse, Neglect or Exploitation

- **As a healthcare provider you have a responsibility to report suspected abuse, neglect or exploitation to the appropriate authorities**
- Suspicion of abuse, neglect or adult exploitation ***does not require proof*** that abuse, neglect or exploitation has occurred
- Make verbal report to the Department of Social Services as soon as possible if abuse/neglect/exploitation is suspected after contact, examination, treatment or other circumstances

Who is Vulnerable?

- Vulnerable individuals exist in every patient population
  - Children, Teens, Adults, Elderly – ALL AGES!
  - White, African American, Asian – ALL RACES!
  - Christian, Jewish, Muslim, Buddhist – ALL RELIGIONS!
  - Single, married, divorced, partnered, parent, child, grandchild, step-child, spouse – ALL RELATIONSHIPS!
  - Heterosexual, homosexual, transgender – ALL SEXUAL ORIENTATIONS!
- Abuse, neglect and exploitation exist in every population demographic
- It is **YOUR JOB** to put your own biases aside and identify vulnerable patients

What to Look For: Physical Indicators of Physical Abuse

- Unexplained bruises, welts, burns, lacerations, or abrasions in various stages of healing
- Unexplained or previously undocumented, suspicious, or multiple fractures/dislocations
- Head injuries
  - Subdural hematomas (due to hitting or shaking)
  - Retinal hemorrhage or detachments (due to shaking)
- Internal injuries
- Duodenal or jejunal hematomas
- Rupture of the inferior vena cava

What to Look For: Behaviors Associated With Physical Abuse

- Hyperactivity, impulsivity
- Extreme behaviors, either aggressiveness or withdrawal
- Nervous habits or movements
- Excessive requests for food and tokens of affection
- Distrust of adults
- Display of adult responsibilities
- Frequent school absences or lateness
- Guarded responses when questioned regarding an injury or home life

What to Look For: Signs of Physical Neglect

- Failure to thrive (non-organic)
  - Chronic malnutrition, wasting of subcutaneous tissue, poor growth
- Consistent lack of supervision especially in dangerous activities or for long periods (child ages 0-12)
- Unattended serious physical problems or medical needs
- Abandonment
- Repeated ingestions of noxious substances
- Poor hygiene resulting in serious infections or disease
- Improper clothing resulting in hypothermia or heat exhaustion
- Living in a home without minimal health, nutrition and fire standards

What to Look For: Behaviors Associated With Neglect

- Flat affect and/or depression
- Extreme behaviors, either aggressiveness or withdrawal
- Nervous habits or movements
- Excessive requests for food and tokens of affection
- Distrust of adults and display of adult responsibilities
- Frequent school absences or lateness
- Guarded responses when questioned regarding an injury or home life

What to Look For: Physical Signs of Sexual Abuse

- Difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Pain, swelling, or itching in genital area
- Pain on urination
- Bruises, bleeding or lacerations in external genitalia, vaginal or anal areas
- Vaginal/penile discharge
- Venereal disease, especially in pre-teens
- Poor sphincter tone
- Pregnancy
- Swollen or red cervix, vulva, perineum
- Internal scarring of genitalia
- Recurrent urinary tract infections

What to Look For: Behaviors Associated With Sexual Abuse

- Clinging to adults or wary of adult contact
- Expressing affection inappropriately
- Unusual knowledge of sexual matters and sophisticated sexual play
- Refusing to undress in physical education class
- Passivity during a pelvic examination
- Isolation/poor peer relationships and/or withdrawal
- Difficulty concentrating/poor academic progress
- Regressive or aggressive behaviors
- Poor self-concept
- Flat affect
- Recurrent nightmares, disturbed sleep patterns, fear of the dark
- Use of drugs and delinquent acts e.g., running away

Violence in Intimate Relationships

- Also known as partner abuse, spouse abuse, or battery
- Refers to violence occurring in intimate relationships, regardless of marriage or whether it is a current relationship
- Screen patients ages 18 years and older and emancipated minors
- Be aware of high-risk indicators

Violence in Intimate Relationships
What to Look For: Physical Signs

- Injuries to the head, neck chest, breast, abdomen, or genitals
- Explanation of injury does not seem plausible
- Contusions, abrasions, sprains, lacerations, as well as fractures
- Numerous injuries at multiple sites unless another explanation is obvious, auto accident or other catastrophe
- Repeated or chronic injuries
- Gynecological problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Physical symptoms related to stress
  - Suicide attempts or gestures, alcohol and drug abuse, depression, anxiety, sleep disturbances, panic attacks, heart palpitations, atypical chest pain, chronic headaches

Violence in Intimate Relationships
What to Look For: Clinical Clues

- Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- Delay in seeking medical care
- Frequent use of prescribed minor tranquilizers or pain medications
- Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality
- Partner accompanies patient, insists on staying close, and answers all questions directed to patient
- Reluctance of a patient to speak or disagree in front of partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for partner's violence

Violence in Intimate Relationship: What to Do

- Record information on standardized intimate partner violence screening tool in patient database.
  - Attempt to screen patient in private
  - Notify patient's primary nurse/physician of self-reported or suspected intimate partner violence.
- Further assess and treat physical injuries when indicated.
  - Notify patient's physician or (if outpatient) Emergency Department if physical injuries require treatment.
- **Do not document name or telephone number of referrals on discharge form**

Violence in Intimate Relationship: Resources Available to Provider

- Security – notify to be on standby in immediate area if patient indicates they feel unsafe or if alleged abuser displays threatening behavior
- Police – if appropriate of if patient requests it
  - Recognize that police involvement may increase risk and intensity of battering
- Police notification not mandatory UNLESS
  - Patients Request
  - Assaults involving a deadly weapon (inform patient and report to police).
  - Suspected abuse and/or neglect is of a child
- SAFE Nurse
  - RN specially trained to collect forensic evidence in suspected cases of physical and/or sexual abuse

Violence in Intimate Relationship: Resources Available to Patients

- Refer patient to the following resources if they request them:
  - CHMC Case Management Department, ext. 4858
  - Calvert County Crisis Intervention Center (24 hours daily) 410-535-1121
- If patient requests follow-up after discharged refer to:
  - Calvert County Crisis Intervention Center, 410-535-1121
  - Walden Counseling Center, St. Mary's County, 301-863-6661
  - Center for Abused Persons, Charles County, 301-645-3336

Suicide Prevention

- CalvertHealth assesses for suicide risk following the Columbia Protocol which is a nationally recognized standard and guideline that supports suicide risk assessment.
- Nurses complete a Columbia Suicide Screening ("Screening") at the time of admission and every 12 hours.
  - Per protocol, nursing safety bundles initiated, and provider notified of medium and high-risk screening results.
- Social workers complete a longer assessment called the Columbia Suicide Rating Scale ("Assessment") for medium and high-risk patients.
  - The results of the Assessment are shared with the hospitalist.
  - The Social Worker also collaborates with the psychiatrist (when Psych is consulted).
- Hospitalists orders needed:
  - To lower the initial risk level based on the Assessment
  - The order must have a rationale for changing the risk level
  - Psychiatry consult (if needed)
  - Social work consult (if not already entered by the nurse per protocol)
  - To lift visitor restrictions for high-risk patients (typically in the ICU)

Suicide Prevention

Risk levels and interventions:

- Negative: No intervention required
- Low: Social worker provides community behavioral health resources prior to discharge
- Medium:
  - Continuous Visual Monitoring (CVM), Convert to one-to-one patient observer if CVM is not appropriate
  - Social Worker performs bed search if inpatient psychiatric services recommended
  - Social worker completes safety plan with the patient prior to discharge to the community setting
- High:
  - One-to-one patient observer
  - Nurse removes objects from room that pose a risk for self-harm
  - Patient placed in safety attire
  - Safety diet
  - Visitor restrictions
  - May not leave AMA without clearance
  - Social Worker performs bed search if inpatient psychiatric services recommended
  - Social worker completes safety plan with the patient prior to discharge to the community setting

Emergency Petitions/ Involuntary Psych Admissions awaiting medical clearance may not leave AMA without clearance/ placement & safety plan

Critical Findings: Red Panic Values

Laboratory will notify the unit via telephone of RED PANIC VALUE results. Results must be given to nurse caring for the patient. Results must be written down by the RN/LPN, and then read back to testing department to verify.

RN/LPN will notify practitioner within one hour of receipt. If needed, practitioner may be interrupted from their duties. Acknowledgement by practitioner is required.

RN/LPN is responsible for documenting RED PANIC VALUE notification in patient record, including:
1.time of receiving results from Lab
2.time of practitioner notification

TEST	Red Panic <	Red Panic >	Units
Blood Gas:			
pH	7.3	7.6	mm/Hg
pCO2	15	60	mm/Hg
	(if pH not 7.35-7.45)		
pO2-arterial	50		mm/Hg
pO2-capillary	30		mm/Hg
Glucose	60	400	mg/dl
Hematocrit	21		%
Hemoglobin 0Day- 1Mnth	10	23	g/dl
Hemoglobin >1Mnth	7	20	g/dl
Potassium 0-59Y/O	2.8	5.7	mEq/L
Potassium >60Y/O	3.0	5.7	mEq/L
Sodium	120	160	mEq/L
Lactic Acid		3	mmol/L

Critical Findings: Radiology findings/results

✓ Pulmonary embolism (PE) or Deep Vein Thrombosis	✓ Acute or significantly enlarging pneumothorax	✓ Free air under the diaphragm/ruptured viscera
✓ Tension Pneumothorax	✓ Free intraperitoneal air (pneumoperitoneum)	✓ Testicular or ovarian torsion
✓ Mal-placement of ET tube	✓ Acute saddle pulmonary embolism	✓ Spinal cord compression
✓ Cerebral hemorrhage or infarction	✓ Acute aortic aneurysm, ruptured aortic aneurysm	✓ Acute or significantly progressive intracranial hemorrhage
✓ Ectopic pregnancy	✓ Traumatic aortic tear or other vascular injury/extravasation	✓ Large territory acute brain stroke or hemorrhagic stroke
✓ New/progressing aortic dissection/aortic aneurysm	✓ Traumatic organ or urinary bladder injury	✓ Large mass with significant mass effect or herniation
✓ Depressed or basal skill fracture	✓ Acute Dural venous thrombosis	✓ Abnormal tube/line positions
✓ Perforated appendicitis or diverticulitis	✓ Ischemic bowel disease and/or portal venous air	✓ Acute spinal fracture
✓ Epidural hematoma or abscess	✓ Mets to spine with extrinsic or impending cord compression	✓ Suspected battered child syndrome
✓ Arterial occlusion	✓ Placenta abruption	✓ Cord tumor or infarction