Welcome to Children’s Healthcare of Atlanta

New Provider
Clinical Orientation Module
Introduction and Overview

We are excited that you are joining Children’s. The content in this module will review the mandatory topics required for all providers who provide patient care, treatment and/or services.

Next steps:

1) Complete this module prior to your orientation date
2) Complete the attestation provided in the link on the final slide.
3) Ask additional questions at Provider New Employee Orientation.
Objectives

After completion of this orientation module, the learner will be able to:
1) Recognize Children’s mission, vision, and values
2) Identify behaviors that promote a culture of safety
3) Utilize available resources appropriately
4) Describe the provider’s role in complying with the following topics:
   • Professional Staff Citizenship
   • Customer service
   • Patient and family education
   • Cultural diversity
   • Compliance
   • Emergency preparedness
   • Infection prevention
   • Medical record documentation
   • Patient Care
   • Ethics and end of life
   • Patient and Medication safety
   • Risk Management
Children’s Mission, Vision and Values
What is Our Mission?

To make kids better today and healthier tomorrow

• Our mission is the reason **WHY** we exist. It articulates what we want to mean to our patients and to the community **today** and in the **future**.

• Our mission addresses not only how we treat sick kids but also that we are dedicated to prevention and research that will lead to new treatments and cures.
What is Our Vision?

Best Care … Healthier Kids

• Our vision tells us WHERE we are going.

• “Best Care” means providing the highest quality care, resulting in our being acknowledged nationally as a pediatric clinical provider.

• "Healthier Kids" means we have prevented injury and illness and developed new cures and interventions so that children never have to come into our hospitals.
What are Our Values?

Care about People
- Hear what needs to be said/say what needs to be heard
- Invite contributions
- Recognize my unique value
- Help others shine
- Have optimistic intent

Passionate about Kids
- Believe we can make a difference
- Keep the kids close
- Ignite the wonder
- Share the story
- “We” before “me”

Dedicated to Better
- Make it matter
- Build it to last
- Think beyond your badge
- Challenge what is
- Do the right thing
Professional Staff Citizenship
Notice of Changes

• As a stipulation of Professional Staff membership, practitioners agree to inform the System Credentials Chair (or designee) of any change in the practitioner's status or any change in the information provided on the individual's application form.

• This information shall be provided with or without request at the time the change occurs and shall include, but not be limited to, changes in:
  – licensure status
  – professional liability insurance coverage
  – filing of a lawsuit against the practitioner
  – staff status at any hospital
  – eligibility to participate in Medicare or Medicaid
  – ability to safely and competently exercise clinical privileges or perform Professional Staff duties and responsibilities because of health status issues.
Board Certification Requirements

- Professional Staff members are required to achieve and maintain specialty board certification as a condition of staff membership.
  - Physicians and dentists appointed to staff after Dec 8, 1999 must become certified by the appropriate specialty/subspecialty board within seven (7) years of completion of residency or fellowship training.
  - Physicians and dentists appointed to staff after June 20, 2001 must become certified by the appropriate specialty/subspecialty board within seven (7) years of completion of residency or fellowship training AND must maintain certification as a condition of staff membership.
  - Psychologists appointed to staff after Jan 1, 2014 must become certified by the Am Board of Professional Psychology within seven (7) years from the date of approval of their Children’s Professional Staff appointment AND must maintain certification as a condition of staff membership.
Delegating to an Advanced Practice Professional

• Physicians may delegate medical tasks to Advanced Practice Professionals (APP).
  – Delegation is based on the APP’s experience, competence, education, and skill set.

• Responsibilities of a delegating physician include:
  – Remain available at all times by telephone or pager for immediate consultation with the Allied Health Professional
  – Ensures nurse practitioners with prescriptive authority receive appropriate ongoing pharmaceutical education
  – Audit the medical record as required by law
  – Oversee patient care as required by law
Delegating to an Advanced Practice Professional

• An APP may not authorize a patient admission but may convey an order to admit on behalf of the admitting physician.

• An attending physician is expected to be present to examine the child in a timely manner, not to exceed twenty-four (24) hours.
  – An APP may perform the initial assessment on behalf of the attending physician, but the physician still needs to assess the patient within 24 hours and then every 24 hours thereafter.
  – If the patient is admitted after 6:00 PM by anyone other than the physician of record, the Admitting Physician (or resident or appropriately credentialed designee) sees the child by 12:00 pm the following morning.

• Upon admission to an intensive care unit, a patient must be assessed in a timely fashion.
  – An APP may perform the initial history and physical examination on behalf of the attending physician, but the attending physician must review, verify, and update that assessment within 12 hours of the patient's arrival to the intensive care unit.
Delegating to an Advanced Practice Professional (continued)

• A hospitalized child is never to be without an attending physician and is to be assessed daily.
  – An APP may assess a patient in advance of a physician but not in lieu of a physician assessment.

• Any qualified Professional Staff member with clinical privileges at Children's may be called upon for consultation within his or her area of expertise.
  – An APP can fulfill a request for a consultation in lieu of a physician consultation, unless the physician ordering the consultation indicates to the contrary by requesting a physician perform the consultation.

• A discharge summary is required for all patients with stays greater than forty-eight (48) hours and for any patient who is treated in the Intensive Care Unit (ICU), or in the case of a death.
  – An APP Nurse Practitioner (NP) or Physician's Assistant (PA) may dictate a patient discharge summary, which must then be authenticated/co-signed by the Supervising Physician within thirty (30) days of the date of the patient's discharge.
Physicians In Training

• Residents and Fellows are members of an ACGME-accredited training program and are:
  – not members of the Professional Staff
  – authorized to provide patient care only under the supervision of a Professional Staff member.

• The supervising physician must:
  – provide appropriate oversight of the care provided by the resident or fellow
    • oversight must be sufficiently documented in the medical record
  – ensure the resident or fellow practices within their job description
  – immediately address any quality concerns related to the resident or fellow which he/she is made aware of
  – sign the medical record documents: 1) short stay summary 2) history and physical 3) consult note 4) operative notes 5) discharge summary 6) any documentation left unsigned by the physician in training.
Unified/Integrated Professional Staff

• The Professional Staff of Egleston and Scottish Rite Hospitals operate as a system-wide integrated Professional (medical) Staff under one system-wide Medical Executive Committee.

• Regulatory requirements call for education to Professional Staff members of their right to participate in any opt-out vote at the Hospital(s) at which their clinical privileges are effective.
  – Such a vote would call for a separate and distinct Professional (medical) Staff at both hospitals.

• The procedures to facilitate this vote are set forth in Article 10 of the Professional Staff Bylaws.

• An opt out vote may not be held more than once every two (2) years without the prior, written consent of the Children’s Board.
Peer Review Process

• Physician Peer Review evaluates the performance of Professional Staff members in the interest of self-improvement and enhanced patient care.

• The peer review process provides a fair and systematic methodology for evaluation of events related to clinical and behavioral performance.

• When there is question or concern related to physician performance or behavior, call 404-785-7464.
  – Results of referral are confidential and not shared.

• Federal and State laws provide protection for peer review conducted in good faith.
  – Information deemed confidential remains confidential.
  – Individuals and institutions granted immunity.
  – Peer review work product designated privileged and inadmissible in court.
Behavior That Undermines A Culture of Safety

• Children’s has a *NO TOLERANCE* policy for behavior that is disruptive and undermines a culture of safety.

• Such behaviors can interfere with the work environment and/or bring about staff discomfort, thus disrupting the ability to provide quality patient care.

• In addition to verbal outburst and physical threats, the following can be disruptive behaviors:
  – Quietly exhibiting uncooperative attitudes during routine activities
  – Reluctance or refusal to answer questions, return phone calls or pages
  – Condescending language or voice intonation
  – Impatience with questions.

• Every time we let disruptive behavior go unchallenged, it reinforces acceptance and normalizes the behavior.

• Matters of inappropriate conduct by Professional Staff members should be reported to the Professional Staff Peer Review team.
Practitioner Wellness

• Patient care can be compromised if a Professional Staff member has a physical, psychiatric, or emotional condition that impairs their ability to practice medicine safely and competently.

• It is Children’s policy to facilitate rehabilitation, rather than discipline, in matters of impaired ability to practice medicine safely and competently by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection of patients.

• Professional Staff members with a health issue affecting their ability to practice are encouraged to voluntarily bring the issue to their campus Professional Staff President or Chief Medical Officer.

If any individual has reasonable concern that a Professional Staff member has a health issue that may affect their practice within Children's, he or she must report this in writing immediately to the campus Professional Staff President or Chief Medical Officer.
Customer Service
Service Behaviors:


**Smile**
- Address staff, patients, families, and visitors within 5 feet in 5 seconds.
- Look people in the eye and smile.
- Use this interaction to assess their status. Are they lost, or do they look upset?

**Greet**
- Greet colleagues, patients, and families by name if possible.
- Say “good morning” or “hello.”
- Introduce yourself and what you do for the organization.

**Own**
- Introduce yourself.
- Follow through on requests.
- Take it as far as you can.
- Inform and escort.

**Thank**
- Always say “thank you” during or after detailed interactions.
- Consider saying “my pleasure” (when appropriate).
- Let families know that we value their feedback.
Patient Representatives

• Employees who become aware of any complaint should work to immediately resolve the concern whenever possible. If the concern is not resolved, or the patient requests the concern be handled through the formal grievance process, staff should promptly refer the issue to the campus patient representative.

• Patient Representatives serve as a point of contact and liaison between patients, families, medical staff, and the organization for patient complaints and grievances.

• Feedback from patients and families is utilized to continually improve the patient and family experience.
What is considered a “grievance?”

- A written complaint regarding patient care, abuse or neglect, compliance with CMS Conditions of Participation, or a Medicare beneficiary billing complaint
- Written complaints are always considered a grievance when from an inpatient, outpatient, or a patient that has been discharged.
- A verbal complaint regarding patient care that is not resolved by staff at the time of the complaint
- When the patient/parent/legal guardian requests that their complaint be handled through the formal grievance process
- See [Grievance Policy 1.01](#) for more details.

Contact your campus Patient Representatives for assistance with patient complaints/grievances.
Compliance
What is your role in Compliance?

Know your Reporting Options
1-877-373-0126
www.choa.alertline.com
(you can be Anonymous)

Ask Questions –
Be confident in your Compliance knowledge

Know the laws that affect your area

Know Your Chief Compliance Officer
Ellen Light

Use your Compliance Resources

Be aware of potential, real or perceived Conflicts of Interest

Follow the Chain of Command to report concerns

Encourage co-workers to communicate concerns
Coding and Billing

Children’s coding and billing claims submitted to the government and private insurance payors should be truthful, accurate, medically necessary, and conform to federal, state, and local laws and regulations.

**Avoid and correct these types of CODING errors:**

- **Upcoding** (the use of a higher diagnostic code rather than the code the patient documentation supports)
- **Unbundling services** that should be bundled
Avoid and correct these types of BILLING errors:

- Billing for services not supported by clinical documentation
- Billing for physician services when services were provided by another clinician (e.g., NP, PA)
- Billing for services outside the scope of the clinician’s practice
- Billing for services of a non-licensed practitioner
- Billing as the supervising physician without performing the necessary services
- Billing for drug samples
Standards of Conduct

Our Standards of Conduct guide our behavior and support a culture of respect and compliance. We are committed to:

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Some Laws and Regulations that Govern Our Work

• EMTALA

• Anti-Kickback Statute

• False Claims Statute

• Stark Law

• HIPAA/HITECH
Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA requires Children’s to treat patients who come to our emergency departments regardless of their ability to pay.

Our Responsibility:

• Perform a medical screening (separate from triaging)
• Treat the patient to the best of our capability and capacity
• If the patient’s condition is outside the scope of care rendered at Children’s (e.g., burns), we must secure an appropriate and safe transfer to a facility with the necessary capability and capacity.
Anti-Kickback Statute

- Prohibits anyone from offering, paying, or soliciting a benefit of any kind in exchange for referrals or the purchase of items paid for by the federal government. (Medicare of Medicaid)
- AKS applies to hospitals, provider groups, vendors, and their employees.

Examples of activities that may violate AKS if they do not fit squarely within the statute’s “safe harbors”:
  - A vendor providing tickets to concerts or sporting events
  - Providing free space for a vendor to sell medical products to patients
  - A medical device vendor providing free devices/products

- Children’s does not pay physicians for referrals, and we do not accept payment for referrals that we make.
- Children’s business agreements with physicians do not depend upon the volume or value of referrals a physician provides.
False Claims Act

The False Claims Act prohibits any person from intentionally submitting a false or fraudulent claim to the Federal Government.
Stark Law

Prohibits providers from referring patients to entities with which they have a financial relationship, unless it complies with an exception under the Stark Law.

Examples of Financial Relationships:

- Employment
- Medical Director Agreements
- Investments
- Gifts
- Recruitment Arrangements

All financial arrangements with providers must be in writing.
Provider Obligations - Emergency Call

- When paged by an emergency department physician, on-call Professional Staff members are expected to call back as promptly as possible but are required to call back within fifteen (15) minutes. Physical presence in the emergency room for an urgent consult is required to be within thirty (30) minutes from the time the request is made by the emergency department physician.
  - Children’s Professional Staff Policy 13.01, Emergency Call Scheduling, recognizes there may be unavoidable extenuating circumstances that preclude the Professional Staff member from providing a physical presence response within the required 30 minutes (e.g., travel time to the facility).

- Physician assistants and nurse practitioners (APPs) may assist in responding to emergency room call.
  - On a case-by-case basis, the emergency department physician may require that the on-call Professional Staff member respond rather than an APP.
Reporting Concerns to Joint Commission

• Children’s is accredited by the Joint Commission for meeting high standards for quality and safety in the delivery of health care.

• If you have a concern about patient care delivered at Children’s, the Joint Commission’s Office of Quality Monitoring is interested in the details of your complaint and may use your information to identify possible noncompliance with accreditation standards.

• Concerns must pertain to compliance with accreditation. Matters of billing, payment disputes, personnel issues, or labor relations are not within the scope of the Joint Commission.

• To report the details of a complaint to the Joint Commission, email patientsafetyreport@jointcommission.org or mail to Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd, Oakbrook Terrace, IL 60181 or call toll-free (800) 994-6610.
Conflicts of Interest

Children’s Board members, providers, and employees are expected to avoid conflicts of interest or the appearance of conflicts between their private interests and those of the organization.

All individuals associated with Children’s are required to disclose real, perceived, or potential conflicts of interest, with this disclosure being updated as changes occur. Disclosures should be forwarded to the Compliance Office.

Familiarity with the Conflict of Interest Policy 10.20 is expected of all Children’s employees; questions about the policy or exceptions should be directed to the Compliance Office.

Examples of prohibited behavior:
1. An employee accepts a restaurant gift certificate from a vendor who has submitted a bid.
2. A sourcing manager contracts with her brother-in-law to provide vending machine services.
Disclosure of Interest

• Practitioners may ask for particular drugs or devices to be made available at Children’s unless the practitioner has a financial relationship with the company supplying the drug or device, as this might place Children’s in a possible “kickback” situation.

• Children’s needs to know if a Professional Staff member or any member of his/her immediate family has financial interest or ownership rights with a third party vendor.
  – biomedical device manufacturer, durable or other medical equipment company, or pharmaceutical company
  – any company which conducts or wishes to conduct business with Children’s
Disclosure of Interest

• Reportable services or relationships may include
  – receiving compensation for services as a consultant or a speaker’s bureau participant
  – as a director, an owner, or an employee
  – holder of a patent or any interest in a patent which is held, licensed, or utilized by the organization
  – owner of intellectual property

• Professional Staff members are responsible for reporting on an ongoing basis any such financial relationships as they arise outside of the reappointment cycle.
  – Contact Credentialing Services to update the Disclosure of Interest form when necessary.
What is HIPAA?

• The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy and security of an individual’s protected health information (PHI). The HIPAA “Privacy Rule” and “Security Rule” includes mandates that:

  – Require covered entities and their business associates to protect patient privacy, whether transmitted electronically, on paper, or orally
  – Require specific standards for the physical and electronic security of an individual’s PHI
  – Govern when you can access, use, and disclose PHI and for what purpose
  – Require that covered entities post a Notice of Privacy Practices that describes how an individual’s PHI will be used and by whom
  – Provide patients with rights regarding their health information
Updates to HIPAA

• Health Information Technology for Electronic and Clinical Health Act of 2009 (HITECH)
  – Updated HIPAA’s privacy and security standards
  – Defined notifications to the individual, the government (HHS), and potentially the media for a breach or unauthorized use or disclosure of PHI
  – Increased criminal and civil penalties (imprisonment and/or fines) as well as sanctions/disciplinary action for breaches
  – Extended breach liability to Business Associates

• HIPAA Omnibus Rule of 2013
  – Enhanced privacy protections and government enforcement
  – Modified breach assessments
    • ‘Risk of harm’ to ‘low probability of compromise’
The HIPAA Privacy Rule provides patients with the following 5 rights regarding their health information:

• Right to access
• Right to accounting of disclosures
• Right to amend
• Right to request confidential communications
• Right to restrictions

Additionally, patients also have the following rights under the HIPAA Privacy Rule:

• Right to receive a copy of the Notice of Privacy Practices
• Right to receive an electronic copy of their health record
• Right to complain for privacy violations
What is Protected Health Information (PHI)?

• Protected Health Information (PHI) is any individually identifiable patient information, created or received by a covered entity or business associate, that relates to physical or mental health or condition of the individual, provision of health care to the individual, or payment for health care.
  – Includes genetic information
  – PHI can be transmitted in any form – oral, electronic, or written

• Examples of PHI include:
  – Name
  – Address
  – Social security number
  – Health plan or insurance number
  – Payment information including credit card numbers
  – Patient photographs
How can I use PHI?

Employees may use a patient’s PHI internally when necessary for:

- **Treatment**: provision, coordination, or management of health care by one or more health care providers

- **Payment**: healthcare provider obtaining payment or being reimbursed for their services or health plans obtaining premiums, fulfilling coverage responsibilities, or providing reimbursement for the provision of health care

- **Routine hospital operations**: quality improvement activities, training, credentialing, contract of health insurance or benefits contracting activities, business management, and customer service

All other releases need to be done in accordance with Children’s Policies and in adherence to the law.
## How to Protect PHI

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| **Verbal** | • Talk in private.  
• Don’t share PHI with persons not involved in the patient’s care including your family and friends. |
| **Phone**  | • Verify identity before sharing PHI.  
• Request passwords or patient identifiers. |
| **Fax**    | • Use caution - verify number.  
• Use a fax cover sheet.  
• Promptly remove incoming documents from the fax machine. |
| **Paper**  | • Don’t leave documents with PHI on copiers, fax machines, or printers.  
• Pick them up and shred them if not needed. |
| **E-mail** | • All electronic transmission of PHI sent outside of Children’s network must be encrypted. |
| **Computer** | • Lock workstation when away.  
• Log off when done.  
• Don’t share your passwords.  
• Place monitors to prevent viewing by unauthorized passersby. |
Protect Information by Creating a Strong Password

• Passwords should be a minimum of eight characters long and should be changed every 120 days for non-financial roles.

• Use at least 3 of the following 4 characters when creating passwords:
  – Uppercase letters (A–Z)
  – Lowercase letters (a–z)
  – Digits (0–9)
  – Non-alphanumeric characters (!@#$%^&*)

• Do not include personal information in your password (such as your name, bank account PIN, your child’s or pet’s name, etc.).

• Never share your password with anyone, not even IS&T.

If you suspect your password has been compromised contact the Solution Center immediately!
PHI and HIPAA

• It is inappropriate to access a medical record without a legitimate work or business related reason.

• Except in an emergency (any situation that is threat to life or limb), a member of the Professional Staff shall not serve as a caregiver to a member of his/her immediate family who is a patient with the Children’s system.

• Practitioners needing a copy of their child’s medical record must request copies through the Medical Records Department.
  – This helps Children’s comply with Georgia law protecting health information that minors can consent to on their own, such as for STD’s, substance abuse or a female minor’s treatment for pregnancy.

• HIPAA violations are to be reported, in confidence, to the Compliance Hotline at 877-373-0126 or online at www.choa.alertline.com.
Examples of Impermissible uses of PHI

**Snooping:** It is never acceptable for employees to access the medical record (in Chartmaxx, Epic, or hardcopy) of a patient out of curiosity or the medical record of a neighbor, friend, babysitter, celebrity, or co-worker’s child without a legitimate work-related or business need.

**Social Media:** Employees are prohibited from posting, sharing, or discussing PHI of any patient of Children’s on social media sites such as Twitter, Facebook, or others. This includes patient medical or health information, patient contact information, pictures of patients or families, stories, etc.
- Employees’ communication with patients or patient family members on social media sites should be kept to a minimum and at all times remain professional.

**Photography/Videos:** The use of personal cell phones or other personal recording devices by employees to capture patient information, specifically photographs or videos, is strictly prohibited. Using digital cameras or other means to record information about a Children’s patient is only permitted with parent/legal guardian consent and in compliance with our photography policies.
Mobile Devices and PHI

When transporting any device that contains PHI, such as a laptop, smartphone, thumb drives, etc., care should be taken to secure the device.

– Keep devices with you at all times.
– Password protect and encrypt the devices.
– Never leave devices in view or in unsecured vehicles.
– Be mindful of your surroundings, airplane seatmates, or other passersby.
Email and PHI

Communicating PHI through email is used only to accomplish Children’s business. Never send PHI to or from your personal email. Limit your internal communication of PHI over Children’s email or other approved job-related email accounts, and apply the Minimum Necessary Rule. Email is not always a secure means of communication, so utilize email only if you have no other means to meet the business need.

- Use a confidentiality flag and a confidential disclaimer.
- Such communications may need to be filed in the medical record.
Risk Management
Risk and Legal Services

Notify the **Resolution Manager in Legal at 5-7523** if you receive:

- Contact from an **attorney** or an **attorney’s office**
- Parent/legal guardian’s **request for compensation** related to patient care

Notify the **Insurance and Litigation Manager in Risk at 5-7546** if:

- You have been served a **subpoena**
  - Fax subpoena to 5-7513 and keep the original.
Occurrence Notification System (ONS)

• What is an ONS?
  – An anonymous, non-punitive electronic process to report adverse occurrences and near misses. Anyone can submit an ONS through RL, the reporting system we use at Children’s Healthcare of Atlanta.

• Why should I report an ONS?
  – Reporting helps improve patient safety by providing the information needed about events so that they can be analyzed and trended. We can’t fix what we don’t know.

• What to report?
  – Any problems, incidents, or other unexpected events (including near misses, hazardous conditions, property damage, and patient or visitor injury).

If you have any questions, please page Risk Management at 5-RISK
Urgent ONS

• To get immediate assistance in critical situations, submit an Urgent ONS. Select “yes” for the question “Is this Urgent?,” and then page the Risk Management pager at (5-RISK) and the on-call Risk Manager will contact you.

• For events requiring patient disclosure, please contact Risk Management at (5-RISK) for assistance with the process.
ONS Medical Record Documentation

• **Do document**
  - Factually and objectively
  - Parent/legal guardian’s non-compliance with treatment or disruptive behavior

• **Do NOT document**
  - Risk Management or Legal has been notified
    - This could give access to legally protected documents completed by Risk and/or Legal
  - ONS has been submitted
  - Causation, fault, or blame
  - Letters for families addressed “To Whom It May Concern”
    - This could be a potential privacy/HIPAA issue
    - Letters written for families should be addressed to specific individuals or organizations
Response to Unanticipated Events/Outcomes

• Children’s recognizes the right of patients/parents/legal guardians to receive accurate and timely information about a patient’s medical status, treatment, and outcomes to make informed decisions about care.

• Consistent with this approach, Children’s has a process for communicating with the patient/parent/legal guardian regarding unanticipated events/outcomes.
  
  — The communication of unanticipated events is consistent with Children’s core values of trust, integrity, respect, and service excellence.
  
  — It is Children’s goal to have open, honest, and consistent communication with our patients and families.
Legal Services Resources and Support

- Risk Management is available 24/7 at 404-785-7475 (ext 5-RISK)
  - for assistance with disruptive behavior, unanticipated events/outcomes, disclosure
  - any other risk management/legal question you may have.

- Contact Risk Management:
  - If you are contacted by an attorney or attorney’s office about patient care provided at Children’s
  - If you have been served a subpoena in a matter pertaining to patient care provided at Children’s
  - For questions or concerns related to product recall
Employee Health
Immunizations

• The Professional Staff influenza policy requires annual influenza immunization or, with approved exemption, adherence to masking protocols.
  – Documentation proving receipt of current-year influenza vaccine, or the Vaccine Exemption Request form, must be submitted to Children’s Medical Staff Services each year by December 1.
  – Those practitioners with allowed exemption to the vaccine will be required to wear a procedure mask at all times in Patient Care Areas when flu season is officially declared.

• Documentation of current tuberculosis (TB) skin test results must be provided at time of reappointment to the Professional Staff.
  – Documentation must be less than 10 months old.

• Children’s Employee Health is available to provide both TB skin testing and influenza vaccination.
Injuries on the Job

• If you are injured on the job:
  – Contact Employee Health.
  – If you need to see a physician, you will be referred to a doctor on our panel of physicians.
  – It is important that you see one of the panel physicians so that your expenses can be covered completely at no cost to you by Worker’s Compensation.
  – An Illness/Injury Report must be completed and turned in to Employee Health, listing the specifics of the incident.
  – Employee Health will file the first report of injury with our Worker’s Compensation vendor.
OSHA Bloodborne Pathogen Standard

• Examples of blood-borne pathogens are HIV, Hepatitis B, and Hepatitis C.
• Spread by direct contact with blood and body fluids entering the body through an open skin lesion, wound, mucous membrane, or through percutaneous exposure (needles or scalpels)
• Use “Standard Precautions.”
• Get Hepatitis B vaccine.
• For more on how to reduce your risk of exposure to blood and body fluids, refer to the Children’s Exposure Control Plan, Policy 1.16.
What To Do If Exposed?

- In the event that you are exposed to high-risk fluids, either through your skin (needle stick) or mucous membranes (eye, nose, mouth):
  
  1. Obtain immediate first aid:
     - For needle stick cut or wound: wash with lots of soap and water. Cleanse skin with alcohol. DO NOT squeeze the area.
     - If splash is to eyes/mouth: go to eye-wash station, remove contact lenses, then flush with lots of water for 15 minutes.
  
  2. Follow the instructions in the Needle stick Post-Exposure Protocol Manual in your unit.

  3. Contact your supervisor. Blood will be processed from the source patient and from the exposed employee.
What To Do If Exposed? (continued)

4. Complete **Injury/Illness Report** and **Post Exposure Packet** on the forms section of Employee Health’s page on Careforce.

5. Report all incidents to the Needlestick Hotline (5-7777) after blood is drawn and processing in the lab. Once the lab results are completed, you will receive a call back from Employee Health.

6. Leave a direct call-back number. Results will only be given to you, the employee, and cannot be given to anyone else.
Staff Support at Children’s

• Children's Healthcare recognizes the importance of health and wellness for all staff. Caregiving for others comes with its own unique challenges and stressors. Staff Support Services is available to provide confidential and safe emotional and spiritual support to staff when:
  – Daily stressors become overwhelming
  – Difficult patient and family situations arise
  – Grief support is needed
  – Experiencing a difficult personal situation

• For assistance with the Staff Support Main Line at 5-4000.

• The Employee Assistance Program is a counseling and referral service for employees who have family, addiction, financial, or other problems. It is accessible 24 hours a day; service is free.
Emergency Preparedness
Children's Healthcare of Atlanta

Emergency Plans

- All hospital and system-wide emergency response plans can be found on the [Emergency Preparedness page](#) on Careforce.
- Your area may have additional department-specific emergency plans as well. Every employee is expected to know his or her department’s emergency responsibilities.
- The hospital plans periodic emergency response exercises or “drills” to assess the effectiveness of the Emergency Plan. Staff and provider participation allows for improved preparation and performance.
Hospital Incident Command System (HICS)

The Hospital Incident Command System:

- Is a tool Children’s uses to manage emergencies and other incidents that may interfere with normal operations
- Integrates with community emergency plans so Children’s can effectively coordinate with local, state, and federal response agencies
- Is activated when normal methods and operations are overwhelmed
Emergency Numbers

- Dial 5-6161 if you are on the Scottish Rite, Egleston, or Hughes Spalding hospital campuses.
- Dial 9-911 if you are in any other Children’s facility:
  - Office Park
  - Neighborhood locations
  - Meridian Mark Plaza, the Medical Office Building, and 993F at the Scottish Rite Campus
 Provider’s Role in Emergency Preparedness

• In the event of an emergency, Children’s requests that providers follow the direction of staff, listen for instructions over the public address system, and respond accordingly.
  – If you are not actively engaged in patient care, check with the charge person in your primary area of care to see if there is anything you can do to help.

• In the event of a mass casualty incident, all available providers may be asked to report to a personnel pool for possible emergency assignments.
  – In such instances, specific instructions and the location of the personnel pool will be announced overhead.
Emergency Codes

Children’s has 9 Emergency Color Codes:

- RED – Fire
- GREEN – Mass Casualty Incident
- YELLOW – Bomb Threat
- BLUE – Medical Emergency
- PINK – Missing Patient
- WHITE – Winter Weather
- ORANGE – Patient Decontamination
- SILVER – Active Shooter/Hostage Taken
- CODE PURPLE – Patient/Family Threatening Behavior or Violence

Your practice manager will orient you on your role for each code. All policies related to Emergency codes can be found on Careforce.
Workplace Safety and Violence

• Workplace violence can be physical assault, aggressive behavior meant to intimidate, and verbally abusive behavior

• Workplace Safety and Violence Prevention Environment of Care – Policy 2.31

• Be AWARE stands for:
  – Addressing Workplace Violence And Responding Effectively

• All incidents of workplace violence should be reports to Security immediately.

• Refer to the CBT entitled Workplace Violence Prevention” in Aspen for more information.
Fire Safety

• If a fire is suspected or detected, you should use the R.A.C.E procedure.

• R.A.C.E. means Rescue, Alarm, Contain, Extinguish (if the fire is small and manageable) or Evacuate.

• How to use a fire extinguisher (PASS):
  – Pull the pin from the handle.
  – Aim the nozzle at the base of the fire.
  – Squeeze the handle.
  – Sweep the hose from side to side.
Safety
Hazard Communication Standard

• Established by OSHA (Occupational Safety and Health Administration) to give you the right to know about hazardous chemicals in your workplace.

• OSHA requires that all chemicals have labels to identify the chemical and give brief instructions on the chemical's use.

• **Safety Data Sheets (SDS)** contain information on safe use of each chemical. Find these on Careforce Connection “Frequently Used Tools” tab.
Hazard Communication Standard

Standard Labels & Safety Data Sheets (SDS) - Formerly MSDS

Acetone

DANGER
Highly flammable liquid and vapor. Causes severe eye irritation.
Keep away from heat, sparks and flame – No smoking.
Take precautionary measures against static discharge.
Keep from direct sunlight.
Keep container closed when not in use.
Store in a cool/low temperature, well-ventilated place away from heat and ignition sources.
Use only in a well-ventilated area.
Avoid contact with eyes, skin and clothing.
Wear appropriate personal protective equipment, avoid direct contact.
Flush eyes with water for at least 15 minutes while holding eyelids open.

Company Name
Street Address, City, State/Province, Country
Telephone: (Country Code)-####-####
Hazard Communication Standard

Label Elements:
1. Product identifier
2. Signal word
3. Pictogram
4. Hazard statement(s)
5. Precautionary statement(s)
6. Name, address, and phone number of the chemical manufacturer, distributor, or importer
Infection Prevention and Epidemiology
Your Role in Infection Prevention

Reduce the risk of Healthcare Acquired Infections (HAIs) by:

**Practicing Standard Precautions (All patients - All the time)**
- Hand hygiene
- Personal protective equipment (PPE)
- Respiratory etiquette (cover coughs)
- Environmental cleaning using Sani-Wipes

**Infection Prevention Education**
- Provide and document education in EPIC to patients and families on their role in preventing infections.

**Following Transmission-Based Precautions (Isolation)**
- Dress to Protect for Contact, Droplet, and Airborne precautions.
Putting on PPE (Donning)

Depending on PPE required, put on PPE in this order…

1. Gown (then,…)
2. Mask (then,…)
3. Goggles or Face Shield (or apply mask with eye shield combo) (then,…)
4. Gloves

*Don’t forget to perform hand hygiene before putting on gloves!
Removing PPE (Doffing)

Example 1

1. GOWN AND GLOVES
   - Gown front and sleeves and the outside of gloves are contaminated?
   - If your hands got contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp the gown in the front and pull away from your body so that the back layers, touching outside of gown only with gloved hands.
   - While removing the gown, fold or roll the gown inside-out into a bundle.
   - As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container.

Example 2

1. GLOVES
   - Outside of gloves are contaminated?
   - If your hands got contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove.
   - Hold removed glove in gloved hand.
   - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
   - Discard gloves in a waste container.

2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated?
   - If your hands got contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Remove goggle or face shield from the back by lifting head band and without touching the front of the goggle or face shield.
   - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container.

3. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands got contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp bottom ties or elastic of the mask/respirator from the ears at the top, and remove without touching the front.
   - Discard in a waste container.

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.
Hand Hygiene Saves Lives

Proper HAND HYGIENE is the single most important means of preventing infection for you and others.

• All staff performing patient care, treatment, or services must practice hand hygiene
• Hand Hygiene is accomplished by:
  – Using an alcohol-based product (most effective hand hygiene)
    OR
  – Soap and water wash (running water and friction for 15-20 seconds)
  – No artificial nail surfaces (gels, acrylics, overlays)
  – Natural nails should not extend ¼ inch past end of finger or have chipped polish.
  – Use only hospital-provided lotions to improve hand health.
Hand Hygiene Saves Lives

**Hand washing** with soap and water instead of alcohol-based products should be done:

- After using the restroom
- When your hands have body fluids on them, because alcohol doesn’t work well for protein-containing body fluids
- When visibly soiled, because soap and water cleans, while alcohol disinfects
- When patients have *Clostridium difficile* (*C. diff*)
- During special circumstances defined by the Infection Prevention Department
Preventing Healthcare Acquired Conditions (HACs)

- Standard precautions should be used with every patient, whether or not they are known to be infectious.
  - **Contact Precautions:** VRE, MRSA, highly resistant Gram negative pathogens, RSV
  - **Droplet Precautions:** Diphtheria, meningococcal meningitis, influenza, pertussis
  - **Airborne Precautions:** Pulmonary tuberculosis, measles, chickenpox
  - **Contact-Droplet:** Non-specific acute respiratory illness, until identified, adenovirus
  - **Contact Precautions:** HAND WASHING REQUIRED - C. difficile

- Body fluids, blood, excretions, and secretions (including respiratory) are treated as infectious. Use personal protective equipment (PPE) if touching body fluids.
Respiratory Etiquette

• Cover YOUR cough/sneeze with your elbow, sleeve, or tissue.
• Practice hand hygiene.
• Mask all symptomatic patients with acute respiratory illness (rhinorrhea, nasal congestion, sore throat, cough), and mask entire family if patient is symptomatic or has TB or Pertussis. Use a surgical/procedure mask.
• Screen visitors and ALWAYS restrict visitors (adult and siblings) who are ill.
• Be aware of visitation limits during respiratory season (typically October 1 to around April 15 each year and as deemed by Infection Prevention and Epidemiology).
Multi-Drug Resistant Organisms (MDROs)

• MDROs are bacteria that are resistant to antibiotics. These can be fatal for our patients. Common MDROs include:
  – Methicillin-Resistant Staphylococcus (MRSA)
  – Vancomycin-Resistant Enterococcus (VRE)

• Most commonly spread from person to person by hand contact

• How to prevent the spread of MDROs?
  – Frequent hand hygiene
  – Follow isolation protocols
What are Bundles?

Bundles are a set of evidenced-based practices or interventions that, when grouped and implemented together, reduce hospital acquired infections (HAIs) and promote best outcomes with a greater impact than if performed separately.

All or Nothing Approach:
All components of a bundle must be performed to ensure the best patient outcomes.
The following infection prevention bundles are currently in use at Children’s:

• Central Line-Associated Blood Stream Infection (CLA-BSI)
• Catheter-Associated Urinary Tract Infection (CA-UTI)
• Ventilator-Associated Pneumonia (VAP)
• Surgical Site Infection (SSI)
Central Line-Associated Blood Stream Infection (CLABSI) Insertion Bundle

Perform and document the following on insertion of lines:

- Hand hygiene
- Maximum barrier protection (mask, sterile gloves, gown, drape)
- Sterile technique
- CHG prep unless contraindicated (30 sec for dry sites and 2 min for wet sites; let dry completely.)
- Appropriate dressing (e.g., tegaderm with Biopatch) line, directed away from dirty areas such as diaper, draining wounds, or trachs

Occlusive Dressing

Non-occlusive Dressing
CLABSI Dressing Change Bundle

Perform and document the following when changing the dressing:

- Hand Hygiene
- Regular assessment of dressing integrity
- Dressing change using sterile technique every 7 days or when loose, soiled, or damp

  A non-intact dressing should be urgently changed.

- Use CHG for disinfection unless contraindicated.
- Appropriate dressing (tegaderm with Biopatch) with line directed away from dirty areas such as diaper, draining wounds, or trachs
CLABSI Line Access Bundle

Perform and document the following when line accessed or minimum of every 12 hours:

• Hand Hygiene
• Use of gloves with all line access
• Scrub 15 sec/dry 15 sec or use Curos caps
• Connect without contamination
• Limit line entries (Change to oral medication when possible or use drips instead of multiple dosing of IV medication.)
Catheter-Associated Urinary Tract Infection (CA-UTI) Insertion Bundle

- **Hand hygiene, aseptic procedure** for insertion
- **Avoid unnecessary catheterization** by assessing insertion criteria. Does it meet approved indications?
- **Size-appropriate catheter**: smaller size that avoids leaks, larger size for particulate drainage
- Foley securement device **applied**
- Closed drainage system
CA – UTI Maintenance Bundle

• Remove catheter as soon as possible, or if not meeting indication criteria.

• **Hand Hygiene**
  
  • Catheter securement and Closed Drainage System
  
  • Maintain daily hygiene and as needed (prn)
  
  • Keep bag below level of bladder especially during transport.
  
  • Maintain unobstructed flow even during transport. No kinks/clamps, *urine retrograde*, or “uphill climbs”
  
  • Obtain specimens from aseptic port
Ventilator-Associated Pneumonia (VAP) Bundle

- Hand Hygiene
- Daily discussion of extubation readiness or sedation vacation
- Head of bed elevated
- Appropriate oral care every 4 hours
- Suctioning and condensate removal before turning or transport
Surgical Site Infection (SSI) Bundle

- Hand Hygiene
- Bath and shampoo within 24 hours pre-procedure
  - soap and water
  - CHG bath for designated procedures
- CHG operative skin prep unless contraindicated
- Antibiotic(s) administered prior to incision per guideline
- Antibiotic(s) re-dosed per guideline

Other actions to prevent SSIs are clean linens, washing of personal toys and blankets prior to surgery, and patient and visitor hand hygiene.
Medical Record Documentation
Upon Admission

- The attending physician is expected to be present to examine patient within 24 hours of admission. A nurse practitioner (NP) or Physician’s Assistant (PA) may perform the initial assessment on behalf of the attending physician, but the physician still needs to assess the patient within 24 hours and then every 24 hours thereafter.
  - If patient is admitted after 6 pm by anyone other than the physician of record, the attending physician (or resident or appropriately credentialed physician designee) must see the patient no later than 12 pm the following day.

Patient History and Physical Examination (H&P)

- A complete H&P is required within 24 hours of admission for all stays longer than 24 hours or for any patient admitted to ICU.
Patient History and Physical Exam

Requirements

- Patients who receive general anesthesia, receive care in the OR or receive moderate/deep sedation, require a H&P.
- Patients who have a procedure (invasive or non-invasive) that is performed to remedy an injury, ailment, defect, or dysfunction require an H&P.
- Patients must have an H&P completed after registration and prior to the administration of general anesthesia.
  - H&P completed no more than 30 days prior to admission is acceptable if the patient has had no significant changes in their condition.
  - An update must be completed by performing an examination of the patient and documenting that an examination was performed, including documenting any changes in the patient’s condition.
  - Prior to the commencement of surgery, the patient’s medical record must include documentation that the patient was examined for changes since the H&P was initially performed.
Patient Orders

- Patient orders must be:
  - made in writing or by online entry
  - legible, complete, signed, dated, and timed by the ordering physician.
- Texting patient orders within Children’s is **not** allowed because there is no ability to verify the identity of the person sending the text or to keep the original message as validation of what is entered into the medical record.
- Verbal and telephone orders are accepted when the authorized individual is detained from writing an order, and telephone orders are acceptable when the authorized individual is remote from the medical record. Such orders are:
  - Read back to the prescribing provider and then documented that the order was read back and verified, signed, and dated by the authorized individual transcribing the orders at the time they are given.
  - Signed/dated by physician giving the order within thirty (30) days of discharge
Transfer of Care and Progress Notes

• Transfer of Care
  – Except for DNR orders, all orders must be rewritten when a patient is transferred to/from ICU.
  – All orders, including DNR orders, must be rewritten post-operatively.

• Progress Notes
  – Daily progress notes by the attending physician are documented at the time the patient is observed.
  – An NP or PA may assess a patient in advance of a physician but not in lieu of a daily physician assessment.
  – Outpatient clinic notes, diagnosis, and follow-up are present on the medical record and signed within 30 days.
Consultations

• Upon receiving request for consultation, the consultant (or his/her designee) must respond within 24 hours to the patient’s bedside unless a quicker response is requested by the treating physician or the patient’s condition dictates a quicker response.
  – An NP or PA may perform a consultation in lieu of a physician consultation unless the physician ordering the consultation indicates to the contrary by requesting a physician perform the consultation.

• In situations where the consultant (or his/her designee) is unavailable to respond within 24 hours or within the timeframe the patient’s condition warrants, the consultant must so notify the physician ordering the consultation (or his/her designee).

• Consultation reports must be signed as soon as possible after the consult has been completed.
Intensive Care

• A physician credentialed in Critical Care medicine will serve as an attending physician or consultant to the attending physician for all patients admitted to the pediatric intensive care unit.

• The physician identified as the attending physician (or resident or appropriately credentialed physician designee) examines the patient prior to admission, on admission, or within one hour of admission, and at least daily during the critical care stay.

• All current patient orders are reviewed, edited as necessary, and renewed at the time of transfer to the unit and are rewritten by the attending physician or designee.

• A decision regarding transfer of a patient out of the critical care area will be made with collaboration of the physician credentialed in Critical Care medicine and the attending physician.
Operative Report and Discharge Summary

• **Operative Reports**
  – Are dictated immediately after the procedure (before the patient moves to the next level of care)
  – If dictated, transcribed operative reports must be signed and dated by the physician within 30 days of the patient’s discharge.

• **Discharge Summary**
  – Required for all patient stays of 48 hours or more, for any patient treated in the ICU, or in the case of a patient death
  – Short stay summary may be used instead of discharge summary if patient hospitalized less than 48 hours or for day surgery patients
  – Not acceptable for ICU patients or in case of a patient death
Completion of the Medical Record

• **Timeliness**
  – Medical record must be completed as soon as possible after patient discharge and should not exceed 30 days post-discharge.
  – Completion means dictations and signatures, including any required discharge summary or final progress note(s).
  – Use of a signature stamp in medical record documentation is not permitted at Children’s.

• **Clarity**
  – The use of abbreviations is not permitted at Children’s.

• **Delinquency**
  – Records which have been logged with deficiencies for over 30 days are categorized as delinquent.
  – The physician responsible for completing the deficiency will receive notice that his/her admitting and clinical privileges for elective patients have been relinquished.
  – Such relinquishment shall be system-wide and shall continue until all the records of the individual’s patients are no longer delinquent.
Providing Patient Care

This section contains important information from Children’s Policies & Procedures for providing safe and effective care while complying with the Joint Commission Patient Safety Goals
National Patient Safety Goals

1. Improve the accuracy of patient identification
2. Improve the effectiveness of communication among caregivers
3. Improve the safety of using medications
4. Reduce harm associated with clinical alarm systems
5. Reduce the risk of healthcare associated infections
6. Reduce the risk of patient harm resulting from falls.
7. Prevent healthcare associated pressure ulcers
Clinical Alarms

Alarm-equipped devices are essential to providing safe care, but clinicians can become immune to the sounds. In response, clinicians may turn down the volume to the alarm, turn it off, or adjust the volume. **To prevent alarm fatigue:**

- Set alarm parameters utilizing age-specific parameters and/or communicating with the provider
- Change single-use sensors (i.e. pulse ox probe, ECG leads) per manufacturers recommendations
- Don’t depend solely on alarm systems!
- Request training on the device if needed
Admission Policy

Children’s can treat patients until their 21st birthday (18th birthday at Hughes Spalding). Patients who may be considered for admission, diagnostic procedures, or treatment beyond their 21st birthday are: (requests handled by campus medical director in consultation with the Chief Medical Officer)

- those in need of services not offered elsewhere in the state of Georgia;
- those receiving ongoing cancer treatment;
- those in the process of serial or staged surgical procedures;
- those needing cardiac surgical, catheterization, and anesthesia services on the Egleston campus which supports the adult congenital heart disease program;
- those established patients needing compassionate leeway for end of life care.
- Other ongoing treatments and/or therapies will have up to 30 days past the patient’s 21st birthday to complete treatment or to transition to adult care. After 30 days, an approval request will be submitted to the campus medical director for review.

In consideration of diagnosing fetal abnormalities, prenatal fetal imaging on expectant mothers older than 21 years of age does not need approval by campus Medical Directors.
Admission Policy on Pregnant or Psychiatric Patients

• Children’s does not have the capacity to treat known pregnant patients of any age on an inpatient basis.
  – Pregnant patients presenting to the hospital will be stabilized and then transferred to an appropriate facility.

• Children’s does not have the capacity to provide treatment to patients presenting with primary psychiatric problems.
  – If a patient presents for admission with a primary medical need along with an underlying or secondary psychiatric problem, they may be admitted and treated until the patient’s medical condition is stabilized.
  – Once medically stabilized, and if needed, arrangements for transfer and/or referral to an appropriate institution or care provider should be made.
  – If the patient presents for admission with a primary psychiatric problem, and no inpatient medical care is necessary, the patient is evaluated, stabilized, and arrangements for transfer or referral to a more appropriate institution or care provider are made.
Transfer Center

• The Children’s Transfer Center makes transferring patients easy with one phone call to arrange for patient acceptance and admission, and can help facilitate consultations with specialty services.

• Whether the patient is being transferred from an emergency department or other inpatient facility, a specialized registered nurse will assist with:
  – Locating a physician
  – Coordinating ground or air transportation for your patient
  – Arranging for a bed with the appropriate level of care to be ready upon arrival
  – Initiating registration paperwork, including financial information and precertification.

• To transfer a patient anytime 24 hours a day, seven days a week, call locally 404-785-7778 or 888-785-7778, fax 404-785-7779
Pain Assessment and Management

• Patients have the right to assessment and management of pain.
  – Unrelieved pain has negative physical and psychological consequences.

• Children’s is committed to preventing or minimizing pain and distress whenever possible through screening, assessment, interventions, and reassessment. Standard assessment tools include:
  – Infants: CRIES (crying, requires O2, increased vital signs, expression, sleepless)
  – Non-verbal: OPS (observational pain score) or FLACC (faces, legs, activity, cry, consolability)
  – Pre-school/younger school-age children: FACES scale
  – Older school-age/adolescents: 0-10 Linear Analogue Scale
  – N-Pass (neonatal pain, agitation, and sedation scale) is used in the NICU.
Pain Assessment and Management

• Providers may prescribe reasonable dose range, but may not prescribe frequency range to manage pain.
  – Range orders may only include a dosing range.
  – Dosing intervals must be fixed.
• Person responsible for administering the PRN medication utilizes the lower dose ordered unless patient status indicates the need for the higher dose.
• When multiple pain medications are ordered (e.g., morphine and Tylenol), the physician should give direction as to which medication to use and when to use it.
• Children’s Pain Medicine Service/Center for Pain Relief:
  – provides inpatient consultations
  – operates a chronic pain clinic
  – is available for questions and recommendations.
  – Contact 404 785 6220.
Critical Test Values – Radiology & Laboratory

• The following list of diagnoses (significant, unexpected, unsuspected, or newly discovered and/or not corrected on a subsequent study) will prompt immediate communication within one hour of imaging results to the ordering physician or their designated representative:
  – Tension pneumothorax
  – Feeding tube in airway
  – Child abuse
  – Diffuse cerebral edema
  – Intracranial hemorrhage
  – Pneumoperitoneum
  – Malrotation with volvulus
  – Testicular or ovarian torsion
  – Intussusception

• Laboratory critical values are telephoned to the ordering physician or designee within 30 minutes of obtaining the result and read back to the person reporting the results.
Patients at Risk for Suicide - Warning Signs

- Irritability, agitation, or panic
- Refusing visitors
- Restless anxiety (“caged-tiger” look)
- Crying spells
- Decreased emotional reactivity
- Refusing to eat
- Complaining of unrelenting pain
- Putting affairs in order
- Declining his/her medications

- Putting affairs in order
- Declining his/her medications
- Making comments such as: “I won’t be a problem for you much longer” or “You won’t have to worry about me.”
- Suddenly becoming cheerful after a period of depression
Intervening With Patients at Suicide

**Level 1**
- Recent suicide attempt; threatening self harm with plan; not willing to participate in a Suicide Prevention Safety Plan.
- **1 on 1** observation at ALL times.
- Documentation is Q15 minutes

**Level 2**
- Recent attempt, persistent ideation with plan, but is able/willing to complete Suicide Prevention Safety Plan.
- No sitter. Close observation 4 times an hour (10 to 20 minute intervals).
- Documentation at least Q15 minutes.

**Level 3**
- Patient has recently expressed suicidal ideation, but has no current plan and agrees to a Suicide Prevention Safety Plan.
- No sitter required. Routine assessments take place.

Please refer to [Suicide Policy 2.04](#)
Managing Disruptive Behavior

- Children’s employees are encouraged to proactively seek opportunities to establish good communication with parents/guardians/families/visitors in order to minimize miscommunications that could lead to disruptive behavior.

- When good communication does not improve demonstrated disruptive behavior, Children’s will utilize a multidisciplinary team approach to support patient and workplace safety in a timely and decisive manner.

- Actions to mitigate disruptive behavior may include the following:
  - Patient Care Conference
  - Disruptive Behavior Team Conference
  - Individual Behavior Contract (IBC)

When there is a perceived imminent threat at a hospital campus, contact Security at 5-6161. All other Children’s locations should call 9-911.
Code Purple

• What is it?
  – Emergency Code for staff to quickly access a team of support if faced with threatening behavior or violence from patients and/or families *Level Three*

• How to call?
  – Dial 5-6161
  – State “I have a Code Purple” and give location
  – Security will announce location overhead

• Who will respond?
  – Team – Security, House Supervisor, Social Worker, Patient Rep, Chaplain, Uniformed Officer
  – Off hours – May not include Social Worker/Chaplain, Patient Rep
Medical and Behavioral Restraints

The use of patient restraints is a high risk intervention. Children’s protects and preserves patient rights, dignity, and well-being and encourages the least restrictive methods of restrained movement for patients identified at risk. Prior to applying restraints, consider developmental, age-appropriate alternatives, such as Child Life, distraction, or other comfort measures.

- All restraints require a physician order. PRN orders are non permissible!
- The application, removal, monitoring and assessment of the patient in restraints is performed by trained, qualified staff.
- The use of restraints is frequently evaluated and discontinued at the earliest possible time based on the assessment and reevaluation of the patient’s condition.

- Reference Behavioral Restraints Policy 1.15 and Medical Restraints Policy 1.20 for information on ordering, application, monitoring and reassessment guidelines.
Ordering Behavioral Restraints

- If a physician is not available to enter an order, the RN may initiate the behavioral restraint. The RN must notify the physician as soon as safely possible to obtain a verbal order.

- A physician’s **face-to-face** evaluation of the patient is to be entered within **ONE** hour of initiating.

- Behavioral Restraints orders are **time limited**:
  - 1 hour in patients under 9 years of age
  - 2 hours in patients 9-17 years of age
  - 4 hours in patients 18 years or older

- If restraints need to be re-ordered, the physician must conduct a face-to-face re-evaluation at a minimum of:
  - 4 hours for patients 17 years and younger
  - 8 hours for patients 18 years and older
Ordering Medical Restraints

• If a physician is not available to enter an order, the RN may initiate the behavioral restraint. The RN must notify the physician as soon as safely possible to obtain a verbal order.

• The initial and subsequent orders should be renewed every calendar day based on the physician’s examination of the patient.

• If medical restraints are discontinued, a new order must be obtained prior to reinitiating the restraints.
Pressure Ulcer Prevention (PUP)

• Accurate diagnosis is based on provider documentation.
  – *If present on admission, must be indicated in H&P or progress note.*
  – No reimbursement for hospital-acquired Stage III and IV pressure ulcers.

• Braden Q and Neonatal Skin Risk Assessment Scale (NSRAS) used to assess risk for skin breakdown.

• Device-associated pressure ulcer risk includes drains, tubes, cast, c-spine, Bipap/ Cpap.

• Approved beds/mattresses include AtmosAir, Tempurpedic, Geomatt foam.

• Provider order must be written if patient condition does not permit movement; patient must be repositioned/turned/offloaded *at least* every 2 hours.

• Consult the Wound, Ostomy, & Continence Nurse (WOC) for patients presenting with any suspected and/or actual pressure ulcer.
Universal Protocol – Time-Out Process

• During a time-out, activities are suspended immediately before starting a procedure (to the extent possible) so that team members can focus on active confirmation of the correct patient, site, and procedure.

• Applies to all surgical and nonsurgical invasive procedures
  – *Regardless of location where procedure is being performed*
  – Procedure is not started until all questions/concerns resolved.

• The three (3) components of the Time-Out process performed are correct patient, correct procedure, correct site.
  – Site is marked by surgeon using his/her first and last initials and is visible after draping.

**ALL MEMBERS OF THE TEAM MUST BE ENGAGED (ACTIVELY LISTENING) DURING THE TIME OUT PROCESS.**
Surgical Safety Checklist

• The **surgical safety checklist** is utilized to prevent **wrong site**, **wrong patient**, and **wrong procedures**.

• The four stages of the checklist and examples of information:
  – **PREP**: Circulator reviews case with surgeon
  – **SIGN IN**: happens prior to induction
    • Patient identification, weight, allergies, blood products, site marking
  – **TIME OUT**: Intra-op briefing happens prior to cut
    • Team introductions
    • Time-out is performed
    • Review of blood needs, imaging, labs, abx
  – **SIGN OUT**: happens before patient leaves the OR
    • Name of procedures, review post-op care, confirm counts and specimen orders, final wound class
Recognizing Child Abuse

- **Neglect** – failure to provide for a child’s needs for shelter, nutrition, medical care, education, etc. Can also include exposing child to drugs or violence in the home
- **Medical Neglect** – failure or refusal to provide child’s medication or persistent non-compliance with medical recommendations
- **Physical** – hitting, biting, burning, kicking, shaking, etc.
- **Sexual** – enticing or coercing a child to engage in sexual acts, exhibiting genitals, or forcing a child to witness sexual activities
- **Emotional** – constant criticism, threats, rejection; withholding love, support, or guidance (often seen as an indicator of other types of abuse)
- **Munchausen by Proxy** – deliberately making a child sick or convincing medical personnel that a child is sick (includes exaggerating, fabricating, or inducing symptoms)
Possible Signs of Abuse

A child with:

• Unexplained bruises, bruises or welts that resemble objects, bruises in multiple stages of healing, patterned injuries

• Fractures, particularly skull injuries of any kind, in infants under 1 year of age (50% of fractures under age 1 are the result of abuse.)

• Overlapping burns; Scald burns that show a uniform depth of burn and a distinct border, scald burns with a sock or glove-like appearance

• Behavioral changes - the child suddenly is afraid of a person or place, begins to do badly in school or act out
  
  – Includes regression to previously outgrown behaviors such as bedwetting, thumb sucking, or baby talk

Example of intentional scald burn
Possible Signs of Abuse continued

- Depression, eating disorders, self-injurious behavior, suicide attempts
- Redness, irritation, or infection of the genital area or anus; STIs; pregnancy
- Caretaker delays in seeking medical attention for a child
- Note: Children under age 5 are at the highest risk for physical abuse.

Often the BEST indication of possible abuse is the history provided by caretaker or child is inconsistent with the injury or developmental level of the child; and/or the history changes over time, or when told to different medical providers or hospital personnel.
Child Sex Trafficking

• Sexual abuse accompanied by exchange of cash or other things of value to the child or a third party
  • Can also be food, shelter, or for perceived protection
    This is often referred to as “survival sex.”

• Also known as:
  – Commercial Sexual Exploitation of Children (CSEC)
  – Domestic Minor Sex-Trafficking (DMST)

• ~400 female victims in Georgia each month
  – Boys and transgender youth can also be victims.
Child Sex Trafficking: Possible Signs

- Child accompanied by a dominating, older, unrelated adult (male or female)
- Adult may insist on speaking for child
- Child acts fearful/submissive or hostile toward providers
- May not be able to present identification or presents false ID
- May show signs of physical abuse
- Tattoos of someone’s name or nickname
  - Back of neck, underarm, ankle
- Acute medical concern, such as rape, drug intoxication/withdrawal, or serious injury
- History of multiple STIs or pregnancies

“Lay Lows Property”
Mandated Reporting

• Hospital or medical personnel (This applies to all Children’s employees and volunteers, regardless of job description or title) are REQUIRED to report a reasonable suspicion that a child has experienced:
  – Physical abuse
  – Sexual abuse or exploitation
  – Neglect

Children’s Healthcare of Atlanta’s policy and the Official Code of Georgia (19-7-5) require you to make a referral to a Children’s social worker or designated delegate (if your location/unit does not have a designated social worker). Social workers and doctors on call can be found on Careforce. Document the report in the child’s medical record.
Reporting Information

• All employees and volunteers who have reasonable cause to believe or suspect abuse/neglect must **immediately** contact a Children’s social worker or designated delegate.

• A social worker will conduct an assessment and make any needed reports to appropriate outside agencies.

• If there is suspicion or an allegation of potential abuse against a Children’s staff member, report to your immediate supervisor. Your supervisor will then follow the Occurrence Reporting urgent reporting process and also contact Social Work Management and Risk Management.

• If you suspect abuse of a child who is not a Children’s patient, contact Law Enforcement and/or Division of Family and Children’s Services (DFCS).
Pathways, Protocols, Guidelines, Algorithms (PPGA)

• PPGA can be found on Children’s Careforce intranet site under Departments, Quality
  – Know the PPGAs applicable to your specialty area
  – Use the order sets assigned to the PPGA
    • Algorithms are linked to order sets
  – Be aware of the outcome goals
    • Average length of stay
    • Medication usage
  – Algorithms are linked to order sets

Contact the Clinical Effectiveness team in Quality at 404-785-7461 with questions related to PPGA
Patient Safety
Practice Error Prevention Skills, and you will be 10 times LESS likely to experience a human error.

Because Zero is a Real Number!
Error Prevention Skills

Everyone, regardless of their job, can use these tools. These tools have been used in over 100 hospitals, where they have achieved >80% reduction in preventable harm events.

Commitment to Patient Safety
- Know My Team
- Team Member Checking
- Stop, Think, Act, Review (STAR)

Clear and Concise Communication
- SBAR/Standardized Transfer of Care
- Closed-Loop Communication

Support a Questioning Attitude
- Speak UP Using A.R.C.C.
- Stop and Resolve
Safe Medical Devices Act

• It is the responsibility of all employees to provide notification to their immediate supervisor and submit an ONS for any medical device-related event resulting in patient death or serious illness/injury.

• Remove the device from patient-care use. If possible, avoid disassembling any equipment or devices involved in an event. Save any disposable accessories and packaging associated with a medical device incident for Risk Management and Biomed/Clinical Engineering. Complete the red/orange maintenance tag and affix to the device
Fall Prevention

• Children’s is committed to preventing falls among our pediatric patients. Falls cause more injuries to children younger than 15 years of age than any other cause. Every patient at Children’s is evaluated for being at risk for falling. Patients who have been identified as at risk for falls are placed on Falls Prevention, which includes:

  • Documentation in the medical record
  • Apply yellow armband or signage posted on exam/room door, as applicable
  • Patient and family given education regarding fall preventions
  • Patients identified as a high fall-risk require additional interventions beyond the standard prevention strategies, which are outlined in Fall Risk Assessment Policy 2.34
Medication Safety
Medication Safety

Medication Safety is Everyone’s Responsibility.

• **High-Alert** medications - require *independent double-check* prior to administration

• **Five Rights of Medication Administration** - (right drug, dose, interval, patient, and route) applies to every dose administered

• **Distractions and Interruptions** - leading contributory factors to medication error

• Be aware that risks are associated with Look Alike/Sound Alike (LA/SA) medications.

• Observe the **MEDZONE**!
Labeling Medications

• To reduce risk of medication errors, medications need to be labeled every time a medication is transferred from the original packaging to another container if it will not be given immediately and even if only one med is being used.

  – Examples: drawing up Lidocaine from a vial prior to lumbar puncture procedure; pouring Betadine into a sterile bowl.

• Immediately discard any meds found unlabeled.

• Keep original med container(s) available for reference until the conclusion of the procedure.

• Discard all labeled containers on the sterile field at the conclusion of the procedure.
Medication Reconciliation

- **At Admission**: Review prior-to-admission medications screen.

- Review what medications patient is taking at home and then add/remove medications.

- Click **Mark As Reviewed** button in lower left corner.
Medication Reconciliation

- Reconcile Prior to Admission medications.
- Decide whether Prior to Admission medications should be continued during hospitalization (Order), placed on hold for now (Don't Order), or stopped altogether (Discontinue).

- Enter admission orders, including new medication orders.
Medication Reconciliation

- Admission as Inpatient/Observation order
- Be sure to answer question “Has med. reconciliation been done?”
• Review reconciled home medications and new admission orders, and sign or sign/hold, as applicable, based on bed availability.
End of Life Care
Palliative Care, End of Life Challenges & Opportunities

• The pediatric palliative care team identifies and treats patients suffering from life-threatening conditions, and serves as a resource to families and the primary clinical care team. The team focuses on:
  – Addressing challenges in communication related to understanding illness
  – Identifying the family’s goals and values
  – Assisting the family and care team in making decisions for the patient in difficult and emotional circumstances.

• Palliative care can be helpful in helping with the patient’s quality of life even when the child is expected to recover.
  – This is accomplished through expert symptom management, collaboration with the child’s primary care services and compassionate attention to the unique psychosocial needs of each family across all phases of their child’s disease.

• For program information call 404 785 2560
• For patient consultations call 404 785 2240
Resources are available to Support Staff, Patients, and Families on End of Life Issues

- Pediatric Advanced Care Team (PACT)
- Child Life Specialists
- Chaplaincy
- Social Work
- House Supervisor
- Bioethics Committee

Ethical issues are addressed via the Bioethics committee. To access their services and resources, please visit the [Bioethics committee](#) page on Careforce.

**Policy 8.00, Death of a Patient**, outlines the notification priorities, medical examiner/coroner processes, post-mortem care, and death paperwork and documentation guidelines for the bedside care team.
Organ Donation at the End of Life

• It is Children’s number one priority to save lives, however there are times when that is not possible. One person can save up to eight lives through organ donation and up to 50 for tissue donation.

• Children's is federally mandated to “preserve the option of donation for families.” This means that the family of each potential donor is given the opportunity to hear about and choose donation.

There are three scenarios for patients to be an organ and/or tissue donor:
• Patient has already died (cardiac death).
• Patient meets criteria for Neurologic Criteria “Brain Death.”
• Family elects to discontinue the ventilator on patient who is NOT brain dead – Donation After Cardiac Death.
Organ Donation at the End of Life

- Children’s collaborates with LifeLink of Georgia (LLGA).
- **Children’s staff are NOT trained to discuss organ tissue donation with a family and should not do it.**
- The first step is a referral to LLGA. This can be made by any medically trained member of the team, such as an RN, MD, or Supervisor. Ideally, this call is made within 1 hour of identifying patient as a potential candidate.
- Medical suitability for donation is determined on every death with the assistance of the LifeLink of Georgia before the family is presented the option of donation.
- There are no absolute contraindications for eye, organ, and/or tissue donation. All patients, including those undergoing withdrawal of life support, are potential donors and should be referred.
Recognizing and Responding to Deteriorating Patients

- Early recognition and management of shock is integral to the survival and best clinical outcomes of our pediatric patients. Children’s has several tools available for staff to identify deteriorating patients:

  - Pediatric Early Warning Score (PEWS)
  - Rapid Response Team
    - Anyone concerned about a patient can call!
  - Vascular Access Decision Tree
  - Decision Tree for Calling Physician
  - Escalation Process

For more information on these tools, see [Rapid Response Systems Policy 2.37](#).
Family-Centered Care
Patient and Family Education

Upon each admission, nurses perform a Learning Needs Assessment (LNA) for caregivers and developmentally-appropriate patients. The LNA:

• Assesses factors that may lower the ability to understand healthcare information and confirms methods by which each person prefers to learn.
• Puts the focus on each learner and allows you to individualize teaching.
• Is accessible via the Education tab in Epic.

How to access teaching materials on Careforce to individualize your teaching:
http://careforceconnection/PatientCare/SitePages/Teaching%20Sheets.aspx
Cultural Diversity

• Providers should respect the patient’s cultural and personal values, beliefs and preferences.

• Recognizing patient rights directly affects the care that we give. Care, treatment, and services should be provided in a way that respects and fosters the patient’s dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care.

• Because communication (verbal, vision, speech, hearing) is a cornerstone of patient safety and quality care, every patient has the right to receive information in a manner he or she understands.
Interpreting & Translating Services

• Children's provides a variety of interpretation and written translation services. These services are instrumental in the prevention of medical errors. Patients and families who have language barriers run a greater risk of receiving care that is either ineffective or unsafe.

• Children's provides the following resources to assist you in your efforts to ensure positive clinical outcomes:
  – Staff Spanish interpreters
  – Agency foreign-language interpreters
  – Agency sign-language interpreters
  – Phone and Video interpreters
  – Written translation
  – Cultural resources
  – Patient teaching sheets in English and Spanish
Conclusion

This concludes the Clinical Orientation module. Click the following link to attest that you have completed this module.