Children’s Professional Staff Reappointment Education Module

Updated May 2015
Introduction

This education module is designed to provide practitioners holding clinical privileges at Children’s with information pertinent to patient care provided at Children’s, and to meet regulatory requirements on provider education.

To meet the requirements for biannual reappointment and qualify for continuing education credit, a practitioner must review this module and complete the ten (10) quiz questions at the end with a score of 80% or higher.

Thank you for all you do every day to provide outstanding care to your patients and for taking the necessary steps to keep them safe.
Introduction and Disclosures

Children’s Professional Staff Reappointment Module
Activity No.: EM2015-013    ADB No.:1055
Credit: 1.0

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CME Credit

Approved Credit
Children's Healthcare of Atlanta is accredited by the Medical Association of Georgia to provide continuing medical education for physicians.

Children's designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To receive CME credit for this module, practitioners must:
1. Complete this CBT
2. Complete the 10 quiz questions throughout the CBT with a score of 80% or higher

Target Audience
Pediatricians, nurse practitioners, physician assistants, others involved in managing care of children

Copyright and Privacy
Children's owns the copyright for, or has received permissions for use of, materials within this CME activity. In addition, the Physician Education Department follows the Children's privacy policy outlined on the Children's website as well as its privacy policy related to Internet CME Activities.

Estimated time to complete activity: 1 hour

For questions related to this activity, please email continuinged@choa.org.
For additional resources related to this activity, please contact continuinged@choa.org.

Objectives

After completion of this CBT, the learner will be able to:

- Recognize signs of both physical and sexual child abuse
- Identify compliance related expectations
- Follow CDC guidelines for infection prevention
- Articulate HIPAA and PHIA compliance requirements
- Identify behaviors that undermine a culture of safety within the Children’s organization
- Outline medication safety standards for labeling medications on and off the sterile field
- Recognize signs of suicide risk in patients
- Identify instances in which an occurrence notification should be submitted to Risk Management
Child Protection
Child Abuse:
Forms of 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

- **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)
Child Abuse: Possible Signs of Physical Abuse

• A child may be a victim of physical abuse if one or more of the following exist:
  – Unexplained bruises, welts or bruises that resemble objects, bruises in multiple stages of healing or not over bony prominences
  – Fractures (skull injuries) in infants under 1 year of age
  – Burns that show a uniform depth of burn and a distinct border or sock/glove-like appearance, overlapping burns, burns on both feet
  – Behavioral changes, fear of certain people or places, including regression to previously outgrown behaviors
  – A caretaker who delays in seeking medical attention for a child
  – 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 Abuse:
Possible Signs of Sexual Abuse

• A child may be a victim of sexual abuse if s/he experiences:
  – Pain, itching, bleeding, or discharge in genitals or anus
  – Sexually transmitted infections (STIs)
  – Pregnancy or miscarriage
  – Depression, suicidal ideation, self-injurious behaviors, alcohol/drug abuse, aggression/rebellion, eating disorders, change in normal behavior
  – In children - inappropriate sexual knowledge or experimentation, overtly sexualized behaviors, excessive masturbation
    • Psychosomatic ailments (headaches, stomach aches)
    • Regressive behaviors (bedwetting, thumb sucking)
  – In teens - promiscuous behaviors, acting out sexually, sexual interest in younger children
• Disclosure: Just because a child does not tell right away or recants does not mean that the abuse did not happen.
Child Abuse:
Required Reporting of Suspicions Of

• Under Georgia Code 19-7-5, all Children’s practitioners, regardless of job or title, are required to report reasonable suspicion (you do not need proof) that a child has been:
  – physically abused
  – sexually abused or exploited
  – neglected
• Reports should be made to a Children’s social worker, who will conduct an assessment and make any needed reports to appropriate outside agencies.
• Reports made in good faith are immune from criminal and civil liability.
• Willfully failing to report knowledge of abuse or neglect may result in misdemeanor charges.
• For more information, contact cpctraining@choa.org or call 404-785-5004.
Compliance
Compliance: 
Physician 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.
Compliance:
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.
Compliance:
Stark and Anti-Kickback

• Federal and state laws (Stark and Anti-Kickback) govern relationships between hospitals and physicians who may refer patients to the hospital.

• These laws prohibit making payments to physicians or immediate family members in exchange for referrals to Children’s.
  – This includes ordering services unless an exception or safe harbor is met.
  – Also includes any type of monetary and non-monetary compensation perks.

• Payment by Children’s to a physician not employed by Children’s must be made under a written agreement.
  – This includes honorariums, stipends, instructor fees, medical director compensation, hosted meals and reimbursement for approved/ requested expenses.
  – The agreements must set out the services to be provided in exchange for compensation based on quality measures, and must be consistent with fair market value and reasonable within the marketplace.
Compliance:
Stark and Anti-Kickback

• Stark has an exception for non-monetary gifts made to non-employed physicians. The amount changes each year but is currently $392 a year.

• Children’s is able to provide certain benefits to physicians on the Professional Staff such as free parking and free meals when physicians are at a Children’s site seeing patients as incidental benefits.
Compliance: Disclosure of Interest

• Children’s has a responsibility to require that business conducted at Children’s is not improperly influenced by a practitioner’s financial relationship with any of our current or requested vendors.

• Any real, potential, or perceived conflict of interest must be disclosed on the Conflict of Interest form.

• 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
Compliance:
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.
Compliance:
HIPAA

• HIPAA stands for Health Insurance Portability and Accountability Act of 1996.
  – Designed to protect private health information
  – “Protected Health Information” or PHI is anything that identifies a patient such as name, address, account number, medical record number, Social Security number, photos, etc.
  – Requires protection of patient privacy, whether transmitted electronically, on paper, or orally.
  – Governs when you can access, use, and disclose PHI, and for what purpose.

• HITECH stands for Health Information Technology for Electronic and Clinical Health Act of 2009.
  – Increased criminal and civil penalties as well as sanctions and disciplinary actions for HIPAA breaches.
Compliance: PHI and HIPAA

• Do not post, share or discuss PHI of a Children’s patient on social media sites such as Twitter or Facebook.
  – This includes patient medical or health information, patient contact information, pictures or stories of patients or families.
  – Communication with patients and/or patient family members should be kept to a minimum and at all times remain professional.

• Communicating PHI through email is used only to accomplish Children’s business.
  – Email is not always a secure means of communication, so utilize email only if you have no other means to meet the business need.
Compliance:
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.
Emergency Preparedness
Emergency Preparedness:
Emergency Procedures

• Fire Safety:
  – If a fire is suspected or detected, use the RACE procedure.
  – Rescue, Alarm, Contain, Extinguish

• To use a fire extinguisher, use the PASS method.
  – Pull the pin.
  – Aim the hose at the base of the flame source.
  – Squeeze the handle.
  – Sweep the nozzle from side to side.
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Emergency Preparedness:
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
  – PURPLE = Patient/Family Threatening Behavior or Violence
Emergency Preparedness:
Physician’s Role in Emergency Preparedness

• In the event of an emergency, Children’s requests that physicians 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 physicians 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.
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Infection Prevention and Epidemiology: Preventing Healthcare Acquired Infections (HAIs)

- 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.
Infection Prevention and Epidemiology:
Personal Protective Equipment (PPE)

- PPE includes:
  - Gloves
  - Gowns
  - Masks
  - Face and eye protection (personal eye glasses are not considered eye protection)
  - Any barriers preventing contact with blood and body fluids

- Only wear PPE when providing direct patient care. Remove PPE when in halls/nursing station.
  - Wear clean PPE during transport only if patient intervention is necessary (e.g., constant suctioning, bagging).
Infection Prevention and Epidemiology: Exposure to Blood or Bloodborne Pathogens

- In the event you are exposed to high risk fluids, either through skin (needle stick) or mucous membrane (eye, nose, mouth):

  - Obtain immediate first aid:
    - For splash into eyes – go to eyewash station, remove contact lenses, and flush with lots of water for 15 minutes.
    - For needle stick, cut, wound, or splash to mucous membranes other than eyes – wash with lots of soap and water.
      - DO NOT squeeze the area.

  - Contact the house supervisor.
    - Blood will be processed from yourself and the source patient.

  - Report all incidents to the Needlestick Hotline at 5-7777.
    - Leave a direct call back number.
Infection Prevention and Epidemiology: Hand Hygiene

- **Hand washing** with soap and water instead of alcohol-based products should be done:
  - After using the restroom or 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 Infection Prevention Department
Infection Prevention and Epidemiology: Hand Hygiene

- Gloves are NOT a replacement for hand hygiene.

- Proper hand hygiene is **the** single most important means of preventing infection for you and others.

- Good hand hygiene includes:
  - Soap and water wash with friction for 15-20 seconds
  - Alcohol-based foam or gel
  - No artificial nail surfaces
Infection Prevention and Epidemiology: Respiratory Etiquette

• Cover YOUR cough/sneeze with your elbow, sleeve, or tissue.

• Practice hand hygiene.

• Mask 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.

• Restrict visitors (adult and siblings) who are ill.

• Be aware of visitation limits during respiratory season (Typically October 1 to April 15) and as deemed by Infection Prevention and Epidemiology.
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Infection Prevention and Epidemiology: Multiple Drug-Resistant Organisms (MDROs)

- MDROs include organisms such as Methicillin Resistant Staphylococcus Aureus, Vancomycin Resistant Enterococcus, Clostridium Difficile, and Klebsiella Pneumoniae.

- Please follow these guidelines which were adapted from CDC Standard Precautions and Transmission-Based Contact Precautions in an effort to prevent the spread of MDROs:
  - Gloves
  - Facial protection: masks should be worn
  - Protective apparel: gowns should be worn
  - Hand hygiene: hand washing with soap and water
Infection Prevention and Epidemiology: 
HAIs – Reducing Infection Through Bundling

• Bundles are a set of evidence-based practices that, when grouped and implemented together, reduce HAIs and promote best outcome with a greater impact than if performed separately.

• At Children’s, the central line insertion bundle is required for inserting and maintaining central lines, including PICCs:
  – Hand hygiene
  – Appropriate site dressing
  – Maximum barrier protection must include gown, large drape, mask, cap, sterile gloves
  – Sterile technique
  – Chlorhexidine skin prep

• The insertion “checklist” must be documented in the patient record after central lines have been inserted.
Infection Prevention and Epidemiology: HAIs – Reducing Infection Through Bundling

• Surgical site infection 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

• 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
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.
Medical Record Documentation: 
Patient History and Physical Exam Requirements

- Patients who receive general anesthesia, receive care in the operating room, or receive moderate/deep sedation, require a history and physical (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.
Medical Record Documentation

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.
  – 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 practitioner 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.
Medical Record Documentation: Transfer of Care, 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.
Medical Record Documentation: 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.
Medical Record Documentation: 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.
Medical Record Documentation: 
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
Medical Record Documentation: 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.

• 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.
Patient Care
Patient Care:
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:
  – 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.

• Requests for these considerations will be handled by the campus medical director in consultation with the Chief Medical Officer.

• 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.
Patient Care:
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.
Patient Care:
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
Patient Care:  
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.
Patient Care:
Pain Assessment and Management

• Physicians 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.
Patient Care:  
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  
  – Child abuse  
  – Intracranial hemorrhage  
  – Malrotation with volvulus  
  – Intussusception  
  – Feeding tube in airway  
  – Diffuse cerebral edema  
  – Pneumoperitoneum  
  – Testicular or ovarian torsion

• 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.
The following can be considered warning signs that a patient may be contemplating suicide:

- 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
- 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
## Patient Care: 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.
Patient Care:
Patient Restraints

• The two types of restraints, Medical and Behavioral, are used
  – Only to protect the immediate safety of the patient, staff, or others
  – Only when less restrictive form of restraints have not met with success

• Restraints are not used as a means of coercion, discipline, convenience, or staff retaliation.

• Use of restraints is discontinued at the earliest possible time, regardless of the scheduled expiration date.

• Medical Restraints
  – Used to protect patients with life-sustaining devices (airway adjuncts, indwelling catheters, tubes, lines, suture sites, etc.)
  – An order must be placed within 24 hours of initiation of restraints.
  – Orders must be renewed every calendar day; PRN orders are not permitted.
Patient Care:
Patient Restraints

- **Behavioral Restraints**
  - Used in an emergency when there is an imminent threat of the patient hurting himself or others due to behavioral reasons
  - Requires a physician’s *face-to-face* evaluation within one hour of the initiation of restraints and an order entered into the medical record
    - Evaluation includes
      - Medical and behavioral condition
      - Need to continue or terminate restraint
      - An evaluation of the patient’s immediate situation
      - Reaction to the intervention
  - Orders are time-limited and based on patient’s age.
    - 4 hours for adults 18 years of age or older
    - 2 hours for children and adolescents 9 to 17 years of age
    - 1 hour for children under 9 years of age
  - Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.
Patient Care:
Fall Prevention

• Children’s is committed to preventing falls in our pediatric patients.
  – Falls cause more injuries in 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
  – Applying a yellow armband or signage posted on exam/room door
  – Patient and family education regarding fall prevention.
  – Patients identified as a high fall risk require additional interventions above the standard prevention strategies noted above.
Patient Care:
Pressure Ulcer Prevention (PUP)

- Accurate diagnosis is based on physician 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.

- Physician 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.
Patient Care:
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.
Patient Care:
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
Patient Care:
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 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
How Children’s Partners with You to Protect Patients and Prevent Codes

Rapid Response Team (RRT)
- RRT will respond to staff or family requests for assessment when there are worrisome changes in vital signs or level of consciousness
- RRT will assist with communication to the physician and with care and transfer if necessary

Pediatric Early Warning Score (PEWS)
- PEWS is a clinical status score.
- The higher the score, the sicker the patient.
- PEWS can detect signs of deterioration 6-8 hours prior to the code.
Patient Safety: One Is Not Zero

• Patient harm can be caused through:
  • failure to escalate/failure to communicate
  • hospital acquired infections
  • medication errors
  • risky behaviors.

• In a Just Culture we manage fairly and consistently when a person’s actions deviate from performance expectations.

• At Children’s, everyone makes a personal commitment to safety, is accountable for clear and complete communication supporting a questioning attitude, and is:
  • proactive and stop an unsafe act or behavior
  • discreet and provide corrective feedback in a private manner
  • helpful and recognizes good behaviors and correct unsafe behaviors.
Patient Safety: Safe Medical Device Act

• Medical devices include any item, other than drugs, used in patient care.

• Medical Device Report (MDR) must be completed when a medical device may have contributed to the serious injury, serious illness, or death of a patient.

• 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 Clinical Engineering.

• Complete a notification to Risk Management via the Occurrence Notification System (ONS) or contact Risk Management directly (via pager at 404-785-7475).
Patient Safety: 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.
Patient Safety: Medication Reconciliation

• Joint Commission National Patient Safety Goal:
  • Accurately and completely reconcile medications across the continuum of care
  • Medication Reconciliation is a process that begins upon admission and continues through transfer and discharge.

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.
Patient Safety: 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.
Patient Safety:
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.
Professional Staff
Professional Staff Citizenship: 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) 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 testing and influenza vaccination.
Professional Staff Citizenship: 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.
Professional Staff Citizenship:
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 to be addressed through the Professional Staff Health Committee.

• 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.
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.
Professional Staff Citizenship: 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.
Professional Staff Citizenship:
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.
Professional Staff Citizenship: Delegating to an Advanced Practice Professional

• 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.
Professional Staff Citizenship: Physicians In Training

• Residents and Fellows are members of an ACGME-accredited training program and
  – are not members of the Professional Staff.
  – are 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.
Professional Staff Citizenship: 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.
Quality and Performance Improvement
Quality and Performance Improvement:  
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 404-785-7465.
  – 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.
Risk Management
Risk Management:  
Occurrence Notification System (ONS) 

- ONS is an anonymous, non-punitive process to report occurrences and activate resources needed in critical situations.

- An unplanned event or occurrence should be reported via the Occurrence Notification System (ONS) located on Careforce.
  - Sequester all tubing, packaging, and equipment related to the event. When possible, include the serial #, manufacturer, and lot number in the ONS report.

- Submit an URGENT ONS if patient harm has occurred or if the event requires immediate notification; a Clinical Risk Manager will contact you.

- For events requiring disclosure, contact Risk Management via pager at 404-785-7475 (ext. 5-RISK) for assistance.
Risk Management: 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
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.
Risk Management:  
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
Evaluation

Click the following link to complete the evaluation and receive your certificate of participation.


*If the link does not open, copy and paste the address into your web browser.*

If you have questions, please email: ContinuingEd@choa.org