Documentation

H&P: Surgical, Procedural, or Admission
A complete H&P must appear in the patient's medical record within 24 hours of admission or prior to any procedure or surgery.
An H&P completed within the 30 days prior to an admission, surgery, or procedure is acceptable for use if:

- The patient is re-assessed *AND*
- The H&P is reviewed/updated *AND*
- Verbiage is documented to the H&P prior to the surgery or procedure indicating both steps above have been completed.
- If used for admission, the "update process" must occur within 24 hours of admission or registration and prior to surgery.

Universal Protocol & Patient Safety

- Procedural site labeling – including laterality must be performed by the proceduralist physician. This is NOT an option. This CANNOT be delegated.
- Procedural Time Outs – all activity in the room needs to STOP and attention MUST be focused on the Time Out process.
- An immediate re-assessment of the patient MUST occur and be documented prior to administering anesthesia.
- When performing a bedside procedure, the Universal Protocol form and the BEDSIDE consent form MUST be completed.

Pre-Procedure Note

A pre-procedure note must be documented in the patient's EMR (Cerner) by the service performing the procedure at least 48 hours prior to surgery. The H&P update will suffice if performed the day of the procedure by the performing service.

Immediate Post-Op Requirements

1. An immediate post-procedure note MUST be entered following all procedures and must include:
   - Names of the primary surgeon and assistants
   - Preoperative and postoperative diagnosis an entry in the "patient condition" field

Immediate Post-Op Requirements *(continued)*

   - Technical details of procedure
   - EBL
   - Specimens removed
   - Description of findings
   - Condition of the patient at the end of the procedure
2. A dictated operative note must be completed within 48 hours of the procedure.
3. A post anesthesia evaluation must be performed and documented in the medical record after the patient has had the opportunity to recover from the anesthetic and within 48 hours of the procedure ending.
4. All elements from the immediate post-operative note must be included in the dictated operative note.

O.R. Consent
All procedural consents MUST include:

- Procedure
- Name of Treating Practitioner
- Patient's name either printed or labeled on the consent
- Patient or patient's representative sign, date, and time consent
- Treating practitioner's signature, date and time.
- If an interpreter is used for obtaining a consent, the interpreter must also sign the consent form.

General Inpatient Documentation

- Date and Timing of medical record entries is REQUIRED in progress notes and orders.
- If using paper to document care, all entries must be dated, timed, and include credentials.
- Inpatients require DAILY progress notes by the Staff physician(s).
- Additions to the patient's active problem list are required during hospitalization.

Verbal & Telephone Orders
To minimize the number of verbal/telephone orders, these orders are only taken when:

- It is an emergent/urgent situation
- The physician is performing a procedure
- The physician is out of the hospital

Verbal or telephone orders must be signed within 48 hours. Access Cerner to perform this action.

Restraint Orders
Continuous use of restraints requires a **daily** restraint order.

A new order is required **each and every time** a restraint is restarted: A "trial off" period may not be written into a restraint order.

Quality

Provider Performance Monitoring Processes

Ongoing	**F**ocused
Professional	**P**rofessional
Practice (Performance)	**P**ractice
Evaluation	**E**valuation

OPPE is performance monitoring of Medical Staff in relation to measures identified by each service.

FPPE is the process for monitoring new Medical Staff Members; existing Members granted new privileges; incident reviews; and/or identified trends through the OPPE process.

The Medical Staff Office coordinates these activities with the Medical Staff Quality and Performance Review Committee, Professional Standards Committee, Credentials Committee, the Medical Staff Executive Committee, and the Service Co-Chiefs.

Identified Improvement Opportunities

- Reduce Hospital Acquired Infections: CAUTI, CLABSI, VAP, C. diff., MRSA, SSI.
- Reduce Post-op Respiratory Failure, DVT, PE
- Reduce hemorrhage associated with anticoagulation.
- Reduce average Length of Stay, Readmission Rates, Mortality Rates.
- Improve Patient Satisfaction.

A Quality and Safety Plan was developed and is being implemented across the AHC. Lean Transformation work is underway on Value Streams to improve care of Medical, Surgical, and ED patients at adult hospitals, and Medical and

Top 5 Infection Control Issues

1. **Perform Hand Hygiene—this is the best way to prevent infections.**
   Use the Moments that Matter
   - Prior to touching a patient
   - Prior to putting on gloves
   - Prior to touching invasive devices
   - After body fluid exposures
   - After touching a patient

   Alcohol based hand rub is the preferred method. Soap and water must be used after care of a C.difficile or Norovirus patient and when hands are visibly soiled.
2. **Follow Isolation Precautions**
   Follow signage posted outside of patient rooms. The correct order for donning and doffing PPE is illustrated. Everyone entering the room is expected to follow the Precautions regardless of contact with the patient. Signs are universal.
   Observe Standard Precautions anytime you may be exposed to blood or other body fluids regardless of the patient's isolation status.
3. **Discontinue Foley Catheters and Central Lines as soon as they are no longer needed.**
   Also seek alternatives to these devices when possible. The longer a device is in place, the more risk it is for infection.
4. **Culture Patients and Use Antibiotics Wisely**
   Increased rates of C.difficile-associated diarrhea and increased numbers of multidrug-resistant organisms are being attributed to over-prescribing of antibiotics.
   Avoid culturing patients unless you truly suspect an infection at that given site (Note: Asymptomatic bacteriuria, in general, does not warrant antibiotic treatment).
5. **Clean Reusable Equipment (such as your Stethoscope) Between Patients**
   Use a Sani-wipe cloth and wipe all surfaces: Let it dry as indicated.

Safety & Security

You do not have to remember the detailed responses to safety, security, or disaster preparedness as long as you know where to access key information. Call security (IU Health AHC Police Department) dispatch @ 962-8000 (Methodist) or 944-8000 (UH/Riley).

Three resources are available for you:

1. **Your Emergency Reference Hang Tag** (Available at Security)
   Worn with your hospital I.D. Badge, this quick reference provides essential safety information such as:

Emergency Response Codes

- Medical Alert—Code Blue Response required
- Fire Alert—Follow RACE procedures
- Abduction Alert—Missing infant/child

Fire Plan Actions	Extinguisher Operation
Rescue	**P**ull
Activate	**A**im
Contain	**S**queeze
Extinguish if trained or Evacuate as required	**S**weep

2. **The Emergency Procedure Guide**
   Found in each department or posted in key areas, this guide details response plans.

   Check the publish date is on the front cover to ensure you have the latest version.

3. **MSDS – Material Safety Data Sheets**
   Found on the Pulse Page under *"Employee Tools"*, sheets provide information about chemicals used in the hospital: their toxins, antidotes, and treatments for accidental exposure.

Provider Compliance Quick Facts

Essentials of Continuous Readiness for Patient Quality and Safety

This pamphlet is designed to be a quick reference. Further details and additional information may be found in corresponding Policies and Procedures linked from the PULSE page.

Indiana University Health

Medication Management

PRN Pain Medication Orders

A PRN pain medication order must include only ONE reason or indication for use (no more or less).

Inappropriate Order

- Ibuprofen 200mg, 2 tabs, po, Q8H prn pain or headache
- Hydrocodone-acetaminophen 5mg-325mg, 2 tabs, po, Q4H prn pain
- Morphine 2 mg, IV Push, Q4H prn pain

Appropriate Order

- Ibuprofen 200mg, 2 tabs po, Q8H prn mild pain
- Hydrocodone-acetaminophen 5mg-325mg, 2 tabs, po, Q4H prn moderate pain
- Morphine 2 mg, IV Push, Q4H prn severe pain

American Pain Society Clinical Practice Guidelines for pain assessment and management
Americanpainsociety.org/resources/content/apsclinicalpracticeguildelines.html

Labeling Requirements for Sterile Procedures

Medications that are drawn into a syringe must be labeled immediately after removing the needle/syringe from the vial. Solutions poured into a container must be labeled.

An indelible sterile marker is available for use during sterile technique.

Label requirements:

- Medication Name
- Medication Strength or Concentration
- Medication Quantity (if not apparent from the container
- Preparation
- Expiration Date

May NOT pre-label syringe prior to drawing up medication.

Titration Orders

Titration orders must contain this information:

- Starting rate
- Increase rate
- Frequency of increase
- Parameters for the increase
- Maximum rate

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Procedural Sedation Oversight

Only Practitioners with Procedural Sedation Privileges are allowed to direct procedural sedation.

Patients must have a pre-sedation assessment conducted by the procedural sedation practitioner. The documentation must also include the level of sedation planned.

An immediate re-assessment of the patient must occur prior to administering sedation.

A note assessing the patient reaction to deep sedation must be entered in the record within 48 hours of the procedure.

Do Not Use Abbreviations

Indianapolis Coalition for Patient Safety in Hospitals "DO NOT USE" Abbreviations	
DO NOT USE	**APPROVED ALTERNATIVE**
U	Units
I.U.	International Units
$MgSO_4$, MAG	Magnesium Sulfate or Magnesium
MSO_4, MS	Morphine Sulfate,
µg	mcg
QD	Daily
QOD	Every other day
cc	ml
A.S.	Left ear
A.D.	Right ear
A.U.	Both ears
O.S.	Left eye
O.D.	Right eye
O.U.	Both eyes
Ambivalent Duration	Indicate specific number of doses or days
Do **NOT** write a zero **AFTER** a decimal (Example:	Write a whole number without a decimal (Example: 2)
Do **NOT** leave a blank space **BEFORE** a decimal (Example: .25)	Write a zero BEFORE a decimal (Example: 0.25)

Ensuring patient safety and preventing medication errors is the goal of avoiding dangerous abbreviations.