SWEDISH
Extraordinary care. Extraordinary caring.℠

medical staff news

PUBLISHED FOR THE MEDICAL STAFF OF SWEDISH MEDICAL CENTER

Guidelines for Authors
medicalstaffnews@swedish.org

June 2018

News
Kudos
PolicyWonk
Epic Hints
Philanthropy
CME

NEWS

Swedish Cardiovascular Services Names Department Chief
The Swedish medical staff cardiovascular services department has ratified the appointment of Ming Zhang, M.D., as chief to complete the unexpired term of Joshua Buckler, M.D., who resigned and is relocating out of the area. Dr. Zhang is board certified in interventional cardiology and cardiovascular disease. He is affiliated with the Swedish Heart & Vascular Institute and has been on the medical staff since 2011.

What Consent You Need When Ordering a Blood Transfusion *by Peggy Hutchison, M.D., Swedish system chief of staff*
Every patient receiving a blood transfusion must have a standard transfusion consent signed prior to the transfusion, unless it is an emergency and the patient can't sign the consent. In the standard surgical consent there are three lines the patient may initial when it comes to the possibility of needing blood. Continue reading.

Key Issues for Use of Interpretation with Patients
Currently, King County is experiencing unique challenges for obtaining interpretation, especially for rare or hard-to-serve languages, which have impacted the ability to fill interpreter requests, especially at the last moment. Healthcare organizations are also under close scrutiny by federal and regulatory surveyors to assure that we always provide effective communication for all patients. Continue reading.

CAUTI Prevention Matters!! *by Janice Lew, M.D., campus chief of staff, First Hill*
During her presentation in April at the Swedish medical staff retreat at Suncadia, Amy Compton-Phillips, Providence-St. Joseph's chief clinical officer, poignantly reflected, "Patients do not come to the hospital to avoid an infection, they come to the hospital to get better." At the beginning of the year, Chris Dale, M.D., Swedish's chief quality officer, set a goal of no CAUTI (catheter-associated urinary tract infection) events for the Swedish system for 2018. Unfortunately, Swedish has 15 CAUTI events year-to-date; 10 of them occurring in patients at First Hill. Continue reading.

Opioid drug shortages and heparin protocol updates
The ongoing, long-term shortage of IV opioids has made utilization of PO or enteral options imperative and strategies to combat the shortage are provided. Heparin order set updates are scheduled to go live June 5. Lidocaine 4% patches replace the 5%. Guidance for use of vasopressin in sepsis have been updated. Read the May newsletter or visit the P&T website to learn more.

Correction
A notice in the March edition titled "Non-physician Admit Notes" contained an error by indicating admission notes must be signed prior to discharge. It is the admission order, not the notes, which must be signed prior to discharge. Orders written by an APC must be authenticated by the supervising physician prior to discharge. These are CMS requirements.

Welcome New Medical Staff Members
Welcome practitioners who joined the Swedish medical staff in May.

EPIC HINTS

Epic Optimizations Go Live June 26 *by Jeff Wolff-Gee, M.D., chief medical informatics officer, and Jud Simonds, MSN, R.N., executive director, clinical informatics, Providence St. Joseph Health*
On June 26, a new package of Epic optimizations (called a wave) will go live at Swedish. The goals for these new features are to improve patient safety, quality and the usability of the Swedish instance of Epic. See the executive summary highlighting the scope of the June wave release and timeline. Continue reading.

PPI Indications: Epic Change June 26 *by Jack Brandabur, M.D., Digestive Health Institute physician chair*
Please be aware of the following ordering changes for proton-pump inhibitors (PPIs) which are intended to improve prescribing practices for PPIs and to reduce the incidence of C difficile infection: Continue reading.

KUDOS

Diggs, Pauk Receive 2018 Rod & Nancy Hochman Physician Leadership Endowment Awards


Naomi Diggs, M.D., and John Pauk, M.D., are the recipients of the 2018 Rod & Nancy Hochman Physician Leadership Endowment Awards. Established in 2013 in honor of the Hochman's leadership at Swedish, the award recognizes physicians who have significantly enhanced the culture of safety and collaboration at Swedish. Nominations came from members of Swedish leadership. Continue reading.

Medical staff members may submit news about awards, recognitions, published articles, media reports, and other professional achievements for consideration in "Kudos" by emailing Medical Staff News.

POLICYWONK

Board Approves Boarding Guidelines Policy
The Board has given final approval to a new set of boarding guidelines approved earlier by the Edmonds and Swedish MECs. The guidelines were designed to improve quality of care by addressing the timelines for providers to assume active management of patients. The new policy appears in Rules and Regulations. More information is also available in "New Guidelines for Boarding Admitted Patients in our Emergency Rooms," published in the March edition of *Medical Staff News*.

New/Updated Standards
Click here for a summary of Clinical Standards recently adopted or amended and links to each Standard. Standards are published as soon as possible after final adoption. All Swedish Standards are accessible at http://standards.swedish.org or by going to the Swedish intranet page and clicking on "Standards."

PHILANTHROPY

Community Donates More Than $520,000 for Brain Cancer Research and Clinical Trials

More than 2,400 people gathered for the 11th Annual *Seattle Brain Cancer Walk* on Sun., May 6 at Seattle Center. Thank you to the 100+ caregivers from the Swedish teams that collectively raised more than $3,600. Since the inaugural fundraising walk in 2008, more than $5.5 million has been raised to benefit brain cancer research and clinical trials at The Ben & Catherine Ivy Center for Advanced Brain Tumor Treatment at the Swedish Neuroscience Institute. You can view the event photos or donate to the walk through Dec. 31.

Join Us at the *Swedish SummeRun & Walk for Ovarian Cancer* on July 15!

Register now for the 25th Annual *Swedish SummeRun & Walk for Ovarian Cancer* on Sun., July 15 at the Swedish First Hill Campus. Funds raised benefit the Rivkin Center for Ovarian Cancer and its work supporting ovarian cancer research, high-risk prevention and early detection screening, and ovarian and breast health education in an effort to save women's lives. Celebrate and support those affected by ovarian cancer by joining one of our largest teams: Team Swedish/Team Mehta, or one of the many incredible Swedish teams! If you are unable to attend, you can still show your support by registering as a virtual participant. Register today!

CME

Swedish Continuing Medical Education Opportunities

Swedish offers a variety of accredited CME events, including full-day conferences, online courses and regularly scheduled series. Check out these upcoming events and visit www.swedish.org/cme for a complete list:

June 15-16 Metabolic Health and Nutrition Across the Lifespan

June 22 14th Annual PsychoOncology Symposium: Promoting Resilience in Cancer Care

SWEDISH
Extraordinary care. Extraordinary caring.℠

Medical Staff News: swedishmedicalstaffnews@swedish.org
Swedish Home Page: http://www.swedish.org
Physician Profiles: http://www.swedish.org/for-health-professionals/professional-resources/managing-your-physician-profile
Swedish for Medical Professionals: http://www.swedish.org/for-health-professionals
Current CME Listings : http://www.swedish.org/cme
Swedish Foundation: http://www.swedishfoundation.org/

Swedish Medical Staff News is produced by Swedish Medical Staff Services.
Subscribe/Update Information | Medical Staff News Archives

At Your Service: The Physician Assistance Program
The Swedish Physician Assistance Program is a confidential, outside resource available to medical staff members and their families at no cost to support members in addressing:

- Family or marital concerns
- Substance abuse
- Work-life balance issues or other problems
- Grief and loss
- Home ownership consultation
- Emotional or behavior issues
- Compulsive behaviors
- Caregiver burnout
- Management coaching

The program is always confidential and available 24 hours a day, seven days a week at 800-777-1323. Benefits also include free legal services, childcare and eldercare referrals, identity theft/fraud services and debt management assistance.

Check out the online tools and resources. Enter your username, swedish, in order to access the library of work/life tools, trainings, and webinars available to you.

And So Forth…

Blood Transfusions

#1 Blood transfusion is not expected to be necessary for this procedure and no pre-transfusion testing is being done.

- This is not a consent for blood. It means no blood was expected and so no standardized transfusion consent has been done. If you have a patient with this marked on the surgical consent who subsequently needs blood during an admission, you need to get a standard transfusion consent (#397073) before the blood can be given.

#2 Blood transfusion may become indicated and a type and screen is ordered. To document consent for transfusion use form #397973. This additional form is the Transfusion consent. When this section is marked, it means transfusion consent needs to be done at the time of the surgical consent and placed in the record so a transfusion may be given if needed.

#3 The patient does not want a blood transfusion under any circumstances. These patients should be enrolled in the bloodless program.

Transfusion consent is valid for the entire admission (inpatient) or one year for outpatient care.

Interpretation with Patients
Failure to do so, or by using non-qualified communication such as with patient family members, children, or non-assessed bilingual providers, can cause patient harm and put Swedish into non-compliance status.

Here are some key issues to review:

- We must *always* use a qualified interpreter with patients who need interpretation. Not using interpretation or using unqualified interpretation is a violation of federal and regulatory requirements and can expose a provider and the organization to penalties, as well as cause patient safety risk. In addition, the Department of Justice could impose rigorous monitoring, documentation and reporting for up to three years which is extraordinarily labor- and time-intensive.

- If a patient refuses an interpreter or insists on using their family member/friend instead, we message that they are welcome to do so, but the provider will *always* continue to use a qualified interpreter for patient's safety. The provider can use video (VRI) or telephonic interpretation instead if the patient is very adamant about not having an in-person

interpreter present, but we still must utilize qualified, certified interpreters for patient safety and liability reasons. Use your qualified interpreter to "back interpret" what patient and family member/friend are communicating so that you are aware that all information has been properly communicated. You should document this process along with your progress notes.

- For rare or hard-to-serve languages, you may need to prepare by "pre-scheduling" a telephonic or video interpreter. Contact the vendor and request the necessary language/dialect before the scheduled appointment. Make sure you have a confirmation, and if not, contact Linguistic Services 24-48 hours in advance for assistance. Please note: not all VRI languages are available 24/7; please see the VRI Interpreter Availability Schedule for availability and plan accordingly.

- For emergent requests for rare or hard-to-serve languages, or if unable to locate an interpreter at any time, you may use non-qualified interpreters, family members or friends *only in cases of "an emergency involving an imminent threat to the safety or welfare of the patient" and if the patient requests this, and it's "appropriate under the circumstances"*– document your attempts to first locate necessary interpretation by all three modalities: VRI, telephonic and in-person. Then, follow up after the encounter at the first available opportunity to obtain an interpreter and communicate with patient to summarize the treatment plan, follow-up, and/or diagnosis to assure patient had effective communication.

- If you are bilingual, you must be tested for accuracy and fluency, and become "qualified" prior to using your bilingual communication skills with patients. This is for patient safety and liability reasons. Please review the Bilingual Staff and Alternate Language Services policy for guidance. You may use your bilingual skills for conversational communications, but must be qualified to use your bilingual skills for critical, high risk communications such as exams, informed consent, and discharge planning.

- Some patients may have both sensory loss and a need for interpretation. Review the patient's EMR to see if you will need to add an assistive device (Menu of Assistive Devices for Patients with Hearing and Vision Loss) when you communicate with your patient. This population must be treated with equal skill and accommodation.

- Patients who are deaf, deaf blind and/or hard of hearing require specialty sign language interpretation. Due to low availability of sign language interpreters, please submit requests ASAP to assure confirmation. At times, there may be the need to have two or more sign language interpreters to meet the patient's unique communication needs, or you may need to also add a spoken language interpreter with a sign language interpreter. Be prepared that such encounters will take longer for communication. Please note: ASL and a certified deaf interpreter (CDI) is available on the VRI cart, but only use if appropriate (See Video Remote Interpretation Decision Tree - Deaf and Hard of Hearing Patients).

- We may not reschedule a patient's appointment if we are unable to locate interpretation for them. Try all options for scheduling interpretation, and call for assistance if needed (206-225-7399 or 206-265-9512). You may have to default to writing for understanding, using non-verbal cues or graphics to communicate. Document all attempts and the manner of communication you used in Epic. Follow up with patient at first opportunity of obtaining an interpreter to assure comprehension.

CAUTI Prevention

Case example:

63-year-old female admitted for recurrent falls was found to have rib fractures and a pneumothorax. Upon admission, she also had polyuria and confusion; a Foley catheter was placed for these reasons. Her medical history included depression, insomnia and migraines. The Foley catheter was replaced after four days. The second Foley was removed 16 days later. With no signs of infection, a urinalysis with reflex culture was sent with catheter removal. Urine reflex culture results were positive. A CAUTI event was recognized for the system. *(The case specifics have been changed to protect patient privacy).*

Learning Points:

1. Use urinary catheters only when necessary and in patients with clear indications (See Table A below).
2. Consider urinary catheter alternatives (e.g. in female patients consider the PureWick® device; the Female External Urinary Catheter (PureWick®): Adult and Adolescent Pediatric Clinical Job Aid.
3. Use appropriate technique when inserting a Foley (Foley/Indwelling Urinary Catheter Insertion job aid).
4. Verify a urinary catheter order (#NURS0191) is in place to trigger the removal protocol.
5. Remove the catheter as soon as it is no longer indicated and within 24-48 hours if possible.
6. Use appropriate maintenance technique (Urinary Catheter Maintenance Bundle for CAUTI prevention).
7. Order urine culture testing only when there is a significant probability the patient is experiencing a symptomatic infection. A common problem leading to over diagnosis of CAUTI and inappropriate treatment with antibiotics is when testing is done for changes in urine appearance or smell. These should never be indications alone for urinary testing in patients with a catheter. Appropriate urine testing recommendations can be found here.
8. For appropriate specimen collection technique when sending urine to evaluate for infection see Urine: Specimen Collection: Midstream Clean Catch and Indwelling Urinary Catheter job aid.
9. If the catheter is in place for more than five days, replace the Foley before sending a specimen for culture.

Table A. Indications for Continuing a Urinary Catheter in Pediatrics and Adults

- Difficult/traumatic catheter insertion
- Urinary retention or obstruction
- Accurate I/O for critically unstable (includes neonates)
- Sacral and perineal wound healing in an incontinent patient
- Pelvic surgery - RN consults LIP after 48 hours
- Epidural or spinal anesthesia within first 24-48 hours (thoracic epidural for surgery 48 hours)
- Unstable vertebral or pelvic fractures with prolonged immobilization
- End of life comfort care
- Continuous bladder irrigation
- Order to maintain a chronic, long-term catheter
- Peds/PICU - VCUG urology procedures
- Selected obstetric patients
- Urinary catheter temperature

CAUTI Facts

CAUTI may seem like a minor condition but the facts demonstrate that CAUTI events have a significant impact on patient safety and outcome.

CAUTI events are the most commonly reported hospital-acquired condition. The rates of CAUTI continue to rise. More than 560,000 patients develop CAUTI each year, leading to extended hospital stays, increased health care costs, and patient morbidity and mortality. Other facts about CAUTI include*:

1. CAUTI is the 2nd most common cause of nosocomial bloodstream infection
2. Approximately 3 percent of all patients with a catheter will develop bacteremia
3. Incidences of sterile urine conversion to bacteriuria occurs at a rate of 3-10 percent per day
4. Each year more than 13,000 deaths are associated with UTIs
5. CAUTI increases morbidity and mortality by 2.8 fold
6. CAUTI increases hospital length of stay by one to three days
7. Approximately 80 percent of all UTIs are associated with indwelling Foley catheters

**From Catheter Associated Urinary Tract Infections: Fact Sheet. Retrieved February 9, 2010 from http://www.wocn.org/pdfs/WOCN_Library/Fact_Sheets/ca.*

For more information
Swedish has a CAUTI steering committee leading the effort to reduce CAUTI events. For more information please contact John Pauk, M.D., medical director, Infectious Disease; Janice Lew, M.D., campus chief of staff, First Hill; Helen Yee, continuous process improvement consultant; or Christina DiFerdinando, quality management system program manager.

Epic Optimizations
Some enhancements included in the June wave will require changes for our clinical operations, so we are enhancing communication and training for our Swedish teams to ease the impact. We also have cross-collaborative workgroups working to make sure our clinics have the training aids and details well ahead of time.

In addition to CIS weekly briefings we'll be sending out regular communications via NewEpicUpdates@swedish.org with the subject line "EPIC CHANGES JUNE 2018: Please Review." We will make these communications actionable, informative and brief. Please take a close look and keep yourself and teams well informed.

Please direct any questions you may have about this release to your local:

- (Ambulatory) clinical informatics representative at SwedishAmbulatoryCli@swedish.org;
- (Inpatient) clinical informatics representative at SwedishInpatientClinicalInformatics@swedish.org
- (Inpatient) provider support team at SwedEpicInptProvider@swedish.org

PPIs
1. Require indications for PPI inpatient orders (Note: this will not affect outpatient PPI orders). For stand-alone PPI orders, providers will be required to enter an indication to order a PPI. There will be embedded decision support to advise the provider when there is a high risk for C. difficile infection (i.e. concomitant use of PPI with high risk antibiotics or recent history of C. difficile). These indications will also assist providers in determining when a PPI started in the hospital can be discontinued at the time of discharge.

2. Removal of PPI orders from order sets where they do not meet approved indications. Where appropriate, in order sets, PPI orders will have a pre-checked indication for ease of use.

Background and rationale:
PPIs remain the leading evidence-based therapy for a variety of upper gastrointestinal disorders, including gastroesophageal reflux disease, dyspepsia, peptic ulcer disease, and acute upper GI bleeding. Commonly used in the ICU for stress ulcer prophylaxis in addition to other acute care scenarios, they are sometimes continued inappropriately at the time of discharge. This has led to the overutilization of PPIs. There is growing evidence of long-term consequences of PPI usage to include an increase in C. difficile infections, and an increase in recurrence of C. difficile despite appropriate therapies. Review of PPI utilization within our health system revealed that 20-30 percent of PPI orders are inappropriate, with a substantial financial impact as well.

These changes have been approved by the Infectious Disease Clinical Decision Team, the Medication Clinical Decision Team, the Inpatient Medicine Clinical Decision Team, the Emergency Department Clinical Decision Team, the Critical Care Clinical Decision Team, and the C. difficile Collaborative.

REFERENCES: Kwok CS, et al. Am J Gastro. 2012; 107:1011-1019; Rane PP, et al. Res Social AdmPharm. 2016 Aug 9.; Lessa FC, et al. N Engl J Med 2015; 372(9):825-834.; Dubberke ER, et al. Clin Infect Dis 2012; 55:S88-92; Barletta, J, Sclar, D, Critical Care 2014, 18:714; Gordon,D, Young, L, et al, Jnl of Hosp Infect, 2016, 92: 173-177; Linsky, A, Gupta, K, et al Arch Intern Med, 2010;170:772-778

Hochman Award

Dr. Diggs was selected for her valued contributions at Swedish and her leadership potential. She will receive tuition support toward earning her MBA through an executive development program.

Dr. Pauk received the Rod & Nancy Hochman Physician Alignment Award, a $5,000 honorarium, for his work on reduction in C. diff and CAUTI rates.

CEO Guy Hudson, M.D., presented the award to Drs. Diggs and Pauk at the annual medical staff retreat in late April.