RED RULES

Measure	Measure Definition	How Physicians Comply
Red Rules	Rules that CANNOT be broken- by anyone Associated ONLY with processes that can cause harm Must be followed exactly (regardless of rank or role) Management and Medical Staff Leaders will **ALWAYS** support **STOPPING** to prevent a **RED RULE** from being violated Red Rules are in place to empower the ENTIRE workforce to take action if a critical rule is about to be broken.	Speak up and STOP work that will or is violating a **RED RULE** **RED RULES in place** **Physician and Nursing** 1.Two Patient Identifiers: Name and Date of Birth 2. Time Out: Must be led by physician preforming procedure 3. Professional Interactions: No verbal assaults or inappropriate physical contact **Nursing** 4. Five Rights of Medication Administration 5. Falls Bundle

*** Failure to follow **RED RULES** will be reviewed and handled accordingly***

Measure	Metrics	How Physicians Comply
Retained Foreign Body (RFB)	1. A RFB is anything unintended (material/object) left in the body at completion of skin closure (**ALL** Incidents are State reportable, regardless of harm)	1. Count prior to incision 2. Fully explore the wound prior to closing 3. Verify manual count is correct prior to closing 4. If the manual count is incorrect **STOP** and **Do Not** close the incision. Re-examine the surgical site/wound for missing equipment/material. Examine all areas and recount before closure. Utilize the RF surgical technology. 5. If count is still incorrect then: a) If the patient's condition permits, perform an intraoperative x-ray with radiologist read prior to skin closure b) In the event of a missing needle, document the size and type of needle(s) no x-ray is necessary because the needle would not likely show on x-ray.
Wrong Site Surgery (WSS)	A WSS is defined as a surgical or other invasive procedure performed on the wrong patient, or on the wrong body part or on the wrong side or site of the patient or implanting the wrong material or substance. (ALL Incidents are State reportable, regardless of harm)	1. Perform a **(Mandatory)** standard time out (initiated by surgeon) with at least the following included: Correct Patient, Correct Site, Correct Procedure (When the same patient has two or more procedures: If the person performing the procedure changes, another time-out needs to be performed before starting each procedure). **All activity should STOP during the time out and everyone should participate in the time out.** 2. When possible, involve the patient in the verification process. 3. Mark the procedure site prior to the procedure being performed and before pt. is taking into procedure area when applicable.
VAP Bundle (IHI Evidenced Based Protocol For preventing VAP's) This is an all or nothing measure, all indicators must be met or contraindications must be documented. *** Utilize Pulmonary Order set***	1. Head of Bed up 30 degrees 2. Peptic Ulcer Disease Prophylaxis 3. Deep Venous Thrombosis Prophylaxis 4. Daily Oral Care with Chlorhexidine 5.Sedation Vacation	1. Order HOB up 30 degrees or document a contraindication 2. Order a PUD prophylaxis to reduce stress related gastro-intestinal mucosal disorder 3. Order mechanical or pharmacological DVT prophylaxis at the time vent is ordered 4. Nursing function : Oral Care is done Q2-4 hours 5. Collaborate with nursing and respiratory to develop a patient centered care plan for weaning off ventilator.

Measure	Metrics	How Physicians Comply
Code Blue Documentation	1.Physician Signatures	1. Code physician is responsible to review and sign the code blue EMR documents. Please review documentation as this serves as the orders for the code team.

Example

Physician Signature _____ Date:_____ Time:_____

Physician SIgnature Signifies Approval of above medications and treatments

Before skin incision »»»»»»»»»»»»»»»»»»»»»»

TIMEOUT (Operating Room)

<<<<<<<<<< STOP >>>>>>>>>>

ALL ACTIVITY IS SUSPENDED & MUSIC SILENCED

NEW SURGEON / PROCEDURE - REPEAT TIMEOUT

SURGEON: ***INITIATES TIMEOUT***

- ☐ **ALL TEAM MEMBERS INTRODUCE THEMSELVES BY NAME & ROLE OR TEAM CONFIRMS NO CHANGES FROM PREVIOUS CASE**

SURGEON: Verbalizes

- ☐ ***WHO IDENTIFIED THE PATIENT?***
- ☐ PATIENT NAME, PROCEDURE, SIDE/SITE **(CONFIRMATION FROM CONSENT)**
- ☐ STATES WHETHER IMAGES ARE NEEDED AND AVAILABLE
- ☐ ANTICIPATED CRITICAL EVENTS OR MAJOR CONCERNS

ANESTHESIOLOGIST: Verbalizes

- ☐ PROPHYLACTIC ANTIBIOTICS GIVEN ON TIME, IF APPLICABLE
- ☐ ALLERGY STATUS CONFIRMED
- ☐ BLOCKS / REGIONALS / EPIDURALS DISCUSSED, IF APPLICABLE
- ☐ CONCERNS OR ANTICIPATED CRITICAL EVENTS (INVOLVING MEDICATION, HISTORY, INDUCTION, OR AIRWAY CONCERNS)

SCRUB PERSON: Verbalizes

- ☐ INSTRUMENT & IMPLANT STERILITY CONFIRMED
- ☐ MEDICATIONS & SOLUTIONS ON FIELD LABELED

CIRCULATOR: Verbalizes

- ☐ EQUIPMENT / DEVICES / IMPLANTS / BLOOD PRODUCTS AVAILABLE IF NEEDED
- ☐ FLUIDS FOR SPECIAL IRRIGATION AVAILABLE

INTRODUCTION OF ANY ANCILLARY STAFF & THEIR ROLE

<<<<<<<<<< STOP >>>>>>>>>>

- ☐ **SURGEON: ASKS: ANY CONCERNS? AGREE? (ALL MUST VERBALIZE AGREEMENT)**

Date: 8/25/2016

Example of poster located in procedural

Quality Measure Overview

Measure	Metrics	How Physicians Comply
Tobacco Cessation	1. Adult Tobacco Cessation Counseling to anyone who has or is currently using within the last 12 months.	1. Document smoking cessation education and treatment offered in H&P or progress notes.
VTE	1. VTE-6 Potential Preventable VTE's.	1. Screen all admissions for VTE risk and score and treat appropriately
Acute Myocardial Infarct (AMI)	1. Aspirin (ASA) on arrival. 2. Aspirin (ASA) at discharge 3. ACE or ARB at discharge for LVSD 4. Beta Blocker RX at discharge 5. Statin at discharge. 6. Primary PCI Reperfusion w/in 90 min. of hospital arrival. (Nursing staff required to record and follow Door to balloon time line) Internal Goal ≤ 75 mins 7. Fibrinolysis Therapy received w/in 30 minutes of hospital arrival. (If indicated)	1. Order ASA in the EMR on arrival or document contraindication 2-5. Physician must order the below medications as part of discharge medication list or document a contraindication in progress notes: ASA, ACE or ARB, Beta Blocker, and Statin Document all discharge medications including: prescription and OTC medications that you want the patient to take 6. A code STEMI page is utilized by Emergency room physicians and staff. This process pages the physician, Cath Lab, admitting and X-ray. Physicians are required to respond to a STEMI page w/in 8 minutes and see the patient within 20 minutes or the ED staff will escalate to the Interventionalist on call. 7. Alternative to PCI when it is not available

These measures/processes are subject to change based on Facility/CMS/Joint Commission requirements.

Quality Measure Overview

Measure	Metrics	How Physicians Comply
Heart Failure (HF)	1. Written discharge instructions addressing the following: discharge medications, diet, activity level, follow-up appt. within 7 days of hospital discharge, weight monitoring and what to do if symptoms worsen. 2. Consult the navigation team for this patient population if discharging to home 2. Left Ventricular Systolic Function Assessment. 3. ACEI or ARB prescribed at discharge for patients with LVSD (left ventricular systolic function (LVSF) documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction).	1. Clearly address discharge medications, including home medications in discharge orders. *Finalize D/C Orders*. All heart failure patients must have a follow-up appointment: a physician visit within 7 days of discharge. The discharge nurse provides patient with the Heart Failure Self Care Booklet which includes written teaching regarding diet, medications, weight monitoring, follow-up, what to if symptoms worsen, and activity. 2. Document in the record that left ventricular systolic function (LVSF) was assessed either prior to arrival, during hospitalization, or is planned for after discharge or document a reason for not assessing LVSF (Document this in the progress notes). 3. If ACEI or ARB not prescribed at discharge, document BOTH a reason for not prescribing an ACEI at discharge AND a reason for not prescribing an ARB at discharge.
Community Acquired Pneumonia (PN)	1. Appropriate Antibiotic selection (See PN admission orders) 2. Blood Culture prior to antibiotic administration. (BC required for ICU patients)	1. Utilize/use PNE admission order-set. (Mandatory) 2. Order Blood Cultures for any PN patients admitted to ICU within 24hrs.
PSY	HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed HBIPS-2: Hours of physical restraint use HBIPS-3: Hours of seclusion use HBIPS-4: Patients discharged on multiple antipsychotic medications HBIPS-5: Patients discharged on multiple antipsychotic medications HBIPS-6: Post discharge continuing care plan created HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge patient Strengths completed 8. Substance Use & Tobacco Use	1. Document appropriately 2.Nursing 3.Nursing 4. Must document a medical reason for this 5. Must document a medical reason for this 6. Appropriate order and documentation 7.Social Worker or CM will do this after your documentation is complete 8. Screening appropriately and plan of cessation

These measures/processes are subject to change based on Facility/CMS/Joint Commission requirements.

Quality Measure Overview

Measure	Metrics	How Physicians Comply
Surgical Care Improvement Project (SCIP)	1. Prophylactic ABX delivered w/in 0-60 min. prior to surgical incision. (Anesthesia administers) Vancomycin and Levaquin are to be given w/in 0-120min. (Nursing administers).	1. Order antibiotics to be given in OR by anesthesia. Order Vancomycin and Levaquin on call to OR.
	2. Appropriate Prophylactic ABX.	2. Order Appropriate Prophylactic ABX Infections or possible infections must be documented prior to surgical incision on H&P, Pre-op assessment, or Progress notes.
	3. Prophylactic antibiotics discontinued w/in 24 hrs., 48 hrs. for Cardiac/Vascular procedures (Cardiac pts. receive 5 doses post-op up to 36 hrs., Orthopedic procedures with an implant receive 2 post-op doses up to 18 hours, all other procedures receive one dose unless approved by order-sets committee.)	3. Discontinue prophylactic ABX w/in 24 hrs. & 48 Cardiac/Vascular OR Document continue antibiotics for an infections or possible infection
	4. Cardiac Surgery Patients with controlled Post-Operative Blood Glucose. (< 200)	4. Utilize Immediate Post-op CABG orders to meet this measure
	5. Surgical patients with appropriate Hair Removal.	5. Only approved methods: Clippers, Depilatory or no hair removal
	6. Urinary catheter removed on Post-op day 1 or 2 with day of surgery being day zero.	6. Remove urinary cath on POD 1 or 2 OR document rational to continue.
	7. Perioperative Temperature Management. ≥ 96.8 F or ≥ 36 degree C. (All patients are provided warming in the interop., unless otherwise directed)	7. Document temperatures, and active warming methods. If warming is contraindicated then document intentional hypothermia.
	8 Patients on Beta-Blocker therapy prior to arrival who received a Beta-blocker during the Perioperative Period. (Perioperative period is defined as 24 hrs. prior to surgical incision through POD 2).	8. Instruct patients to take their prescribed Beta-blocker prior to surgery, (they may take the morning of surgery with a sip of water). For Inpatients resume home Beta-
	9& 10. Patient received appropriate Venous Thromboembolism prophylaxis and timely (w/in 24 hrs. of admission through 24 hrs. after surgery end time).	9&10. Screen all admissions for VTE risk and score and treat appropriately

These measures/processes are subject to change based on Facility/CMS/Joint Commission requirements.

Quality Measure Overview

Measure	Metrics	How Physicians Comply
Hospital Inpatient Immunization	1. IMM-1a- Pneumococcal Immunization- Overall Rate 2. IMM-1b- Pneumococcal Immunization- Age 65 and older 3. IMM-1c- Pneumococcal Immunization- High Risk Populations (Age 6 through 64 years) 4. IMM-2- Influenza Immunization	1-3. IMM-1a-1c Nursing protocol in which nursing will assess to see if the patient meets the criteria for vaccine status. If the patient does meet the criteria then the patient will receive the vaccine the prior to discharge. 4. Same nursing protocol as above
****If there is valid medical reason a patient should not be vaccinated please document the reason in the progress notes as well as dc order for the vaccine.****		
Emergency Department Inpatient Quality Measures	1. ED-1a-Median Time from ED Arrival to ED Departure for Admitted ED Patients- Overall Rate ED-1b-Median Time from ED Arrival to ED Departure for Admitted ED Patients- Reporting 2. ED-2a- Admit Decision Time to ED Departure Time for Admitted Patients- Overall ED-2b- Admit Decision Time to ED Departure Time for Admitted Patients- Reporting ED-2c- Admit Decision Time to ED Departure Time for Admitted Patients- Psychiatric/ Mental Health Patients	1. These are timing metrics, so accurate documentation in the medical record is essential. Capture the time in which you preformed the medical intervention vs the time in which you are documented it.
Stroke (STK) Inpatient	1. STK-1: VTE Prophylaxis 2. STK-2 : D/C'd on Antithrombotic Therapy 3. STK-3 : Anticoagulation Therapy for Atrial Fib/ Flutter 4. STK-4 : Thrombolytic Therapy 5. STK-5 : Antithrombotic Therapy by End of Hospital day 2 Dc'd on Statin 6. STK-8 : Stroke Education 7. STK- 10: Assessed for Rehabilitation	1. Stoke Activation &Consult the Stoke Team for CMC only 2. Utilization of Stroke Order set

Quality Measure Overview

Measure	Metrics	How Physicians Comply
SEP 1 Bundle 3 hour bundle completion ≤ 3hrs. of symptomology 6 hour bundle completion ≤ 6hrs. of symptomology	**Severe Sepsis:** Early Management Bundle, Severe Sepsis/ Septic Shock 1. Lactate Level ≤ 3 hrs. 2. Blood Cultures Drawn Prior to ABX ≤ 3 hrs. 3.Broad Spectrum Antibiotic ≤ 3 hrs. **Septic Shock:** Early Management Bundle, Severe Sepsis/ Septic Shock 1. Lactate Level ≤ 3 hrs. 2. Broad Spectrum Antibiotic ≤ 3 hrs. 3. Blood Cultures Drawn Prior to ABX ≤ 3 hrs. 4. Fluid resuscitation 30ml/kg crystalloid fluids ≤ 3 hrs. or documentation of exact amount of IV bolus and why deviation from EBP of 30ml/kg 5. Reassess volume status and tissue perfusion "Must be done by medical provider" 6. If still hypotensive after fluid resuscitation then initiate Vasopressors 7. Document volume status and tissue reperfusion post bolus ***Lactate level redraw within 6 hrs. for all results > 2* (6hrs. Starts with Sepsis time)	1. Sepsis Order Set Utilization- Will aid in EBP and gold standard of care and improved outcomes/reimbursement 2.Documetation when deviating from recommendations 3. Utilization of Sepsis documentation with smart phrase ".sepsisdoc" Serial Lactic order is incorporated in the Sepsis Order Set
PC	PC-01 Elective Delivery prior to 39 weeks PC-02 Cesarean Section-Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section PC-03 Antenatal Steroids PC-04 Health Care-Associated Bloodstream Infections in Newborns PC-05 Exclusive Breast Milk Feeding	1. Elective Deliveries prior to 39 weeks must have an appropriate medical necessity documented in the record. "Tired of pregnancy" or "I want to deliver on this date" is not appropriate 2. Measurement of all C-Sections in this population 3. Appropriate order and documentation of antenatal steroids. 5. Encourage breast feeding

These measures/processes are subject to change based on Facility/CMS/Joint Commission requirements.

Quality Measure Overview

Measure	Metrics	How Physicians Comply
Children's Asthma Care (CAC) **Children's Hospital only** **Children's Metrics ≤ 17 yrs. old**	CAC-1 Inpatient asthma admissions ages 2-17 received a reliever/bronchodilator during hospitalization.	CAC-1 Order Reliever/Bronchodilator to relieve and gain control of acute asthma exacerbation and reduce severity as quickly as possible.
	CAC-2 Inpatient asthma admissions ages 2-17 received systemic corticosteroids	CAC-2 Order Systemic corticosteroids to gain control of acute asthma exacerbation and reduce severity as quickly as possible
	CAC-3 Inpatient asthma admission ages 2-17 Home Management Plan of Care (HMPC)	CAC-3 HMPC
	1. Arrangements for Follow-care have been made (physician/clinic phone number, address, and appointment information.)	1. Physician is responsible for making sure nursing staff is given follow up information so they can make the arrangements and provide appropriate, complete documentation
	2. Control/mitigation of environmental and other triggers.	2. Physician is responsible for ordering Asthma education to be done (this is automatic if Asthma Admission Order Set is utilized).
	3. Asthma Action Plan part of the HMPC. All the following must be addressed: Use of Controllers, Use relievers, and what steps to follow if initial treatment does not improve patient's respiratory state.	3. Physician is responsible for filling out the Asthma Action Plan or providing the information needed for the nurses to fill out prior to dismissal. *See Asthma Action Plan*
	**CAC-3 is an all or none initiative. Failure to provide any of the steps above will result in failure of the measure.*	

Measure	Metrics	How Physicians Comply
Outpatient Surgery		1. Follow all the SCIP measure as the apply 2. Order Appropriate ABX *** **Pre-op infections must be documented prior to incision.** (H&P, Pre-op assessment, or Progress notes.) Infections or possible infections are the only acceptable deviation.
Emergency Department Out patient Quality Measures	**OP-18-Median Time from ED Arrival to ED Departure for Discharged ED Patients** **OP-19-Transition Record with Specified Element Received by Discharged Patients** **OP-20- Door to Diagnostic Evaluation by a Qualified Medical Personnel** **OP-22- Left Without Being Seen**	1. Documentation of time you see the patient 2. Documentation of time of each order
Pain Management of Long Bone Fracture	**OP-21-Median Time to Pain Management for Long Bone Fractures**	1. Order correct pain medication or document a reason why no pain medication was ordered
Stroke	**OP-23- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED arrival**	1. Order/Interpret evaluation test timely **2. Document last known well.**

Other Out Patient Measures include: AMI, Chest Pain
Endo

Goals of Care "GOC"

All ICU patients with a length of stay ≥ 5 days must have a documented GOC in the electronic medical record.

GOC must contain the below information in the specific EMR fields (Smart phrase or Advanced Care Plan Tab):

1. Who was present
2. Goals and plan of care
3. Details of discussion

Example:

Epic Optimization: Integrated GOC SmartPhrase

The Integrated GOC tool makes it very easy to document a goals of care conversation:

- **.goc** or **.goalsofcare**
- **Either can be used within ANY note type**

Goals of Care
Brief goals of care conversation
{Who was present:20410:::1}
{Goals and plan of medical care:28467:::1}
Details of discussion: ***

Highlighted items must be present to meet new Quality Goals of Care Standards

{Goals and plan of medical care:28628}

Primary goal of prolonging life by all medically effective means.
Primary goal is attaining patient's acceptable quality of life by a trial of all medically effective means.
Primary goal is achieving patient's acceptable quality of life by selective medical treatments balanced with avoiding burdensome treatments.
Primary goal of maximizing comfort and allowing a natural death.

Providence
Institute for Human Caring

humancaring@providence.org

What you need to know about the ICU Goals of Care Effort

System Goal

ICU admissions (5+ days) should have a documented goals of care (GOC) conversation using a traceable and reportable method

Why are we focusing on this?

To be able to standardize GOC documentation, which allows for:

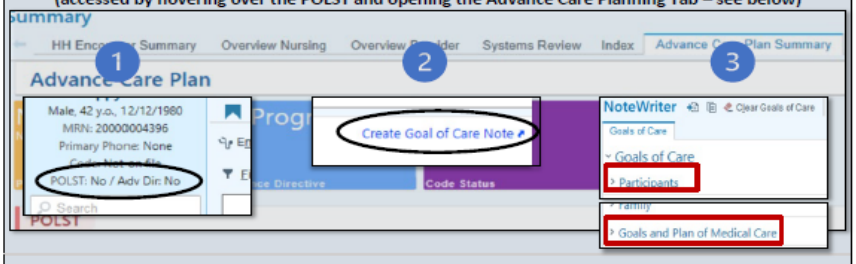
- **The ability to quickly find prior GOC documentation, so we can honor our patient's wishes.**
- **Reliably demonstrating the quality and efforts of clinicians in discussing and honoring patient's wishes.**
- Measuring and responding to healthcare quality outcomes, such as health equity gaps.
- Providing departments, service lines, ministries, and individuals access to their data so they can optimize inter-disciplinary team collaboration.

Preferred Method

Type the SmartPhrase
".GOC" or ".goalsofcare"
into ANY note type

Goals of Care
Brief goals of care conversation
Who was present -
Goals and plan of medical care -
Details of discussion: ***

(Or use the comprehensive notewriter template)
(accessed by hovering over the POLST and opening the Advance Care Planning Tab – see below)



Using either method, the GOC conversation elements outlined in red MUST be completed in order for the documentation to be included in metric measurements

Commonly Asked Questions

Does a GOC conversation documented during a previous admission count? No. When a patient is admitted to the ICU, their GOC often change. Thus, a GOC conversation must be documented during the same hospital encounter, but it can be done at any time during that admission. A conversation documented before day 5 of an ICU admission will count, as it is helpful to have GOC conversations documented during critically ill patients' entire hospitalizations.

Who can document a GOC conversation? Anyone who talks to the patient, and documents their encounter in Epic, can document a GOC conversation; this can be a chaplain, a case manager, social worker, nurse, physician and so on.

Can we copy/paste a GOC conversation? No, when you copy/paste a SmartPhrase, you lose the metadata that "tells" the conversation where to go. A best practice is to include the SmartPhrase in your note templates and if GOC is not addressed during an encounter, the SmartPhrase will disappear.

Updated 03/20/2023

Readmissions

Readmission Reduction Act: Governmental program that assesses Hospitals 30 readmissions in high risk cohorts: AMI, HF, PN, COPD, and TKA/THA

The following evidence base practices have shown effective in decreasing readmissions

1. A 3 to 7 day follow-up with a medical provider
2. Complete Discharge Instructions
    a. Diet
    b. Activity status post discharge
    c. Complete and accurate discharge medication list
    d. Disease specific discharge education
    e. Transition of Care-Navigation, Home Health Services, SNF, IP or OP Rehab
        *Cardiac discharges should receive a Cardiac Rehab referral prior to discharge
        *Pulmonary discharges should be evaluated for pulmonary rehab services

Name, Doctor Name, Doctor Phone Number & Date **must** be filled out

Must check which control med the patient is being sent home with

Complete premedicate box with reliever med information

Must match home med reconciliation sheet. Patient may be on Albuterol inhaler and Xopenex nebulizer or vice versa. Patient must have a reliever med

Take Quick Relief Med every 20 minutes may or may not be selected by doctor

Peak flow is optional but good information if available.

For school nurse is optional. This allows the child to carry their inhaler with them at school.

Please make sure all medications match Home Med Reconciliation Form, Doctor's Discharge Orders and Prescriptions!

Asthma Action Plan

Covenant Children's Hospital - Home Management Plan of Care

Date

Name | Doctor's Name | Doctor Office Phone

GREEN ZONE — **TAKE THESE MEDICATIONS EVERYDAY**

Child feels good:
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night
- Able to do usual activities

GO

Peak flow above: _____

CONTROL MEDICATION	STRENGTH	HOW MUCH	WHEN TO TAKE IT
☐ Budesonide (Pulmicort)			
☐ Fluticasone (Flovent)			
☐ Advair			
☐ Montelukast (Singulair)			

☐ Premedicate 20 minutes before EXERCISE or EXPOSURE TO KNOWN TRIGGER

Medicine	Strength	How much

YELLOW ZONE - NOT FEELING WELL — **CONTINUE TO TAKE EVERY DAY MEDICATIONS**

Child has *any* of these:
- Cough
- Wheeze
- Tight chest
- Waking up at night
- Can do some, but not all, usual activities.

CAUTION

Peak flow between: _____ to _____

Step 1: Add Quick Relief Medication

QUICK RELIEF MEDICATION	STRENGTH	HOW MUCH	WHEN TO TAKE IT
☐ Albuterol (Ventolin)			
☐ Levalbuterol (Xopenex)			

Step 2: Monitor your symptoms:
- If symptoms GO AWAY quickly, return to GREEN ZONE
- If symptoms CONTINUE or return within one hour of the Quick Relief Medication, THEN

√ Take Quick Relief Medication every 20 minutes for total of 3 treatments
√ **Call your healthcare provider within 2 hours of modifying your medication routine**
☐ Change your Control Medications by _____

RED ZONE - MEDICAL ALERT — **EMERGENCY TREATMENT**

Child has *any* of these:
- Breathing hard and fast
- **Quick Relief Medications** have not helped
- Cannot walk or play
- Cannot talk easily
- Retractions

STOP

Take your Quick Relief Medication now and call your physician

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE: Call 9-1-1 or go to the nearest emergency room and continue using your Quick Relief Medication

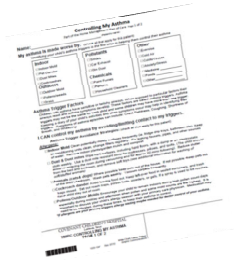
If skin color changes or your lips turn blue, seek immediate medical attention, CALL 9-1-1!

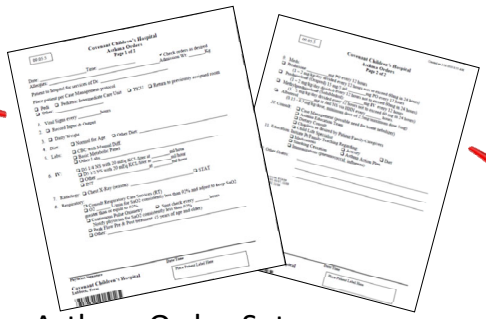
Peak flow below: _____

FOR SCHOOL NURSE: This child is capable of carrying and administering the above Quick-Relief Medication for asthma.
☐ YES ☐ NO (Texas Inhaler Law) _____ MD SIGNATURE _____ DATE/TIME
☐ My child has my permission to self-administer the above Quick Relief Medication at school _____
Name of School child is currently attending _____ GRADE _____

COVENANT CHILDREN'S HOSPITAL
LUBBOCK, TEXAS
HMPC ASTHMA ACTION PLAN
PAGE 1 OF 3

WHITE- Patient; CANARY- Chart; PINK- School Nurse/PCP
1225-151* 04/12 Graphic Communications



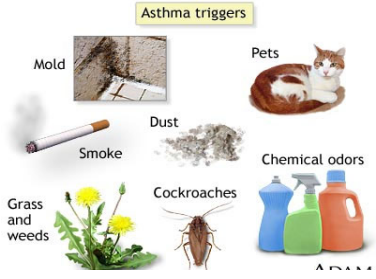


Asthma Order-Set

Asthma Core Measures

Completed Home Management Plan of Care (HMPC)

colored copy given to patient/caregiver



Relievers/ Corticosteroids

Evaluation/Education

Contact List

Clinical Excellence		
Department	**Contact**	**Phone Number**
Quality Management	QM Main Number	806-725-0489
Adult Quality Contact:	Cherry Orr, RN	806-725-1488
Pediatric Quality Contact:	Sara McMenamy	806-725-6404
Infection Prevention	Infection Prevention Main Phone Number	806-725-4334

Adult ED CMC		
Department	**Contact**	**Phone Number**
AED/Trauma/ BH Director	April Hayes, MSHA, BSN, RN	806-725-0609 OR April.d.hayes@covhs.org
AED Manager	Vanessa Milam	806-725-4445

Specialist		
Department	**Contact**	**Phone Number**
Stroke Coordinator	Sarah Hancock, MSN, RN, SCRN, ASC-BC	Office 806-725-1630 Cell 806-438-2992 Email hancocks1@covhs.org
Sepsis Coordinator	Kaysh Eades, MSN, RN	Office 806-725-0623 or Cell 806-999-6317 Email kaysha.eades@covhs.org
Trauma Program Manager	Jessica Martinez, MSN, RN	Email: martinezj10@covhs.org Cell: 806-577-9953

Blood Management/Transfusion Safety:

- Blood transfusion is the most commonly performed procedure in the hospital inpatient
- The Joint Commission National Patient Safety Goal 16.01.01 includes the evaluation for overuse and inappropriate use of RBC transfusions
- St. Joe's as a system started Blood Management/Transfusion Safety Program in 2013
- **The Goal of Blood Management is to Reduce Transfusions and Have Better Outcomes for our Patients**
    - According to studies only about 11% of transfusions are beneficial to the patient
    - **Each unit** transfused increases morbidity and mortality significantly; this is significant for even ONE unit *(ONE dose – Pedi: 10-15mLs/Kg)*
    - Each unit can increase the risk of complications (infection, transfusion reaction, etc) by 50%
- **The goal is not to eliminate transfusions but give the *Minimum Effective Dose***
    - Assess each patient clinically not just transfuse to a number (Hgb)
    - Give one unit and re-assess the patient to see if they really need more to get over their symptoms
- Guidelines in place:
    - Hgb <7.0 g/dL, <8g/dL with ACS; *Neonates Hgb<10g/dL*
    - Plt < 10,000 with marrow failure, <20,000 with bleed, <50,000 going for procedure, <100,000 for neuro procedure
    - INR ≥ 2.0
    - Again these are guidelines and each patient should be assessed for symptoms

If you have any questions about transfusion or possible transfusion reactions you can contact:

[redacted]

Blood bank: 725-4256 (CMC), 725-6914 (CCH)

*** We strongly encourage you review the below educational links regarding ordering and documentation practices for Blood and Blood Products to ensure the safety of our patients. ****

Placing Orders for Blood Products (Inpatient Focus) (providence.org)

Enter Orders for Massive Transfusion Protocol (MTP) (providence.org)

Anesthesia Provider User Guide (providence.org)

Lab Order Explanation

Type and Screen	Type and Cross Match
The blood bank staff will perform all necessary testing on the patient's sample. Until a request is received for blood, units will not be crossmatched and set aside in the blood bank for that patient. However, once a request for blood is received, blood can be made available. This order should be used when the likelihood of the patient needing a blood transfusion is slight.	The blood bank staff will perform all necessary testing on the patient's sample AND crossmatch the number of units requested. In the blood bank, these units will be set aside for the patient and are immediately available once the physician determines there is a need to transfuse the patient

Neonatal Protocol: A type and screen will be performed when admitted to the NICU. Protocol is good until patient is 4 months of age unless there is maternal antibody present. If antibody is present then type and screen will have to be repeated (specimen is good for 3 days) until the antibody clears the patients system. Once antibody has cleared, patient can go on protocol.