UNIVERSITY OF MIAMI HOSPITAL AND CLINICS

CLINICAL STAFF

UMHC Annual Hospital Required Education (UAHRE) 2021

Welcome to Provision Of Care 2021

Approximate Duration: 60 minutes

For questions on this subject, please contact the appropriate department:

UMHC: (305) 243-4388

Provision of Care 2021

THIS COMPUTER-BASED LEARNING (CBL) THIS COMPUTER-BASED LEARNING (CBL) MODULE WILL COVER THE FOLLOWING CONCEPTS:

Provision of Care 2021

This computer-based learning (CBL) course outlines important topics regarding the provision of care:

- ✓ Nutrition Screening
- ✓ Pain Management
- ✓ Suicide Risk Prevention Screening
- ✓ Use of Restraints
- ✓ Advanced Directives and **D**o **N**ot **R**esuscitate
- ✓ End of Life Care
- ✓ Organ Donation
- ✓ Impaired Practitioner
- ✓ Antibiotic Stewardship Program
- ✓ Blood Administration
- ✓ Patient Teaching
- ✓ Visitation

PAIN MANAGEMENT

Policy Title: *Pain Assessment and Management*
Link: Click Here

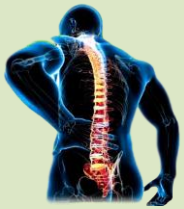
Definitions

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue and/or nerve damage.

Pain Screening Scales: A quantitative rating of the intensity of pain reported by the patient. Standardized instruments for pain assessment are to be utilized.

Patient-Appropriate Pain Assessment Tools: Used to measure patient's pain. They include, but are not limited to:

- ✓ Self-report scales
  - ✓ Numeric Scale
  - ✓ Bake-Wong FACES
- ✓ Behavioral Scales
  - ✓ CRIES
  - ✓ FLACC
  - ✓ NIPS



Pain: Definitions cont.

Acute Pain: Usually acute onset with limited duration and unknown origin. May be mild to extremely disabling/dysfunctional. Acute pain can be easily treated or controlled with immediate interventions and usually resolves when the cause is treated.

Chronic Pain: Defined as the "disease of pain." Its origin, duration, intensity, and specific symptoms vary and may be of unknown origin. Ongoing physical and psychosocial limits, resulting in fatigue, exhaustion, depression, and social isolation.

Chronic Non-malignant Pain: A consequence of different pathophysiologic problems associated with marked life disruption. This pain becomes the disease and depression is often observable.

Chronic Malignant Pain: Multi-causal and multi-focal pain that may worsen over time due to disease progression and treatment.

Pain: Types

Somatic: Pain that is usually aching or throbbing and well-localized. It involves muscle, joints, bone, skin, connective tissue, etc.

Visceral : Pain that can be either Well-localized (Pancreas, GI tract, tumors, etc.) or Poorly localized (Cramping due to intestinal obstruction).

Neuropathic : Includes centrally and peripherally generated pain. Could be intermittent or continuous and occurs when there is abnormal processing of sensory pain input due to nervous system injury or impairment (Trauma, inflammation, metabolic diseases, tumors, etc.)

- ✓ *Peripheral:* Often characterized as numbness and tingling.
- ✓ *Central:* Radiating and/or shooting pain with burning or aching sensation.

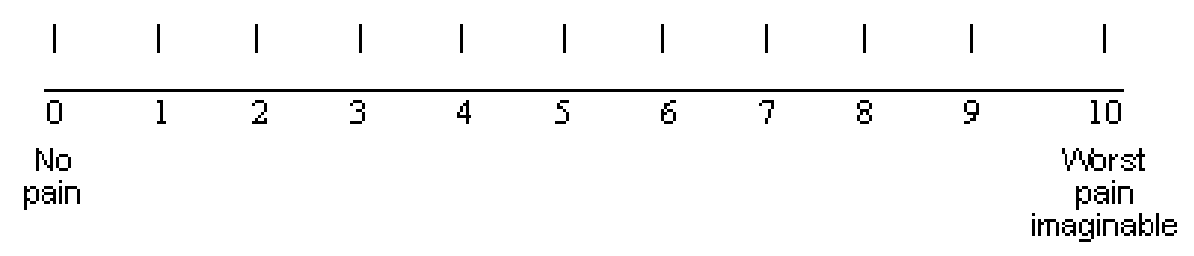
Pain: Assessment

An evaluation of the patient's perception of their pain. The assessment includes, but is not limited, to the following:

- ✓ **History** – origin and occurrence of pain.
- ✓ **Location of pain** – exact location on the patient's body.
- ✓ **Intensity** – based on pain scale/screen.
- ✓ **Description** – i.e. aching, crushing, throbbing, pressure, burning, sharp, dull or unable to describe.
- ✓ **Duration** – length of time that pain has endured.
- ✓ **Radiation** – does pain travel to another part of the body?
- ✓ **Aggravating factors** – what causes pain to increase?
- ✓ **Alleviating factors** – what causes pain to decrease?
- ✓ **Previous therapies** – how was pain treated in the past?

The pain assessment includes the score from the pain screening scale. Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches. Complete elimination of pain (0) is not a reasonable goal or expectation in many clinical scenarios. Therefore, it is crucial to include the patient when developing measurable goals and setting realistic expectations (PC.01.02.07, EP 5)

Pain: Numeric Pain Scale



- ✓ Self-report scale to measure pain intensity
- ✓ Commonly used for adults and children greater than 8 years of age who understand numbers and number order
- ✓ Must understand how to use the scale
- ✓ Utilizes ruler appearing tool to identify pain from 0 (no pain) to 10 (worst pain)

Pain: Wong-Baker FACES Scale

- ✓ Self-report scale to measure pain intensity
- ✓ Commonly used for verbal children over the age of 3 years or non-verbal patients who can point to the most appropriate "face"
- ✓ Utilizes face pictures with different expressions from 0 (no pain) to 10 (worst pain)
- ✓ Child must understand how to use the scale
- ✓ Child identifies the picture that represents how much pain they are experiencing

SUICIDE RISK PREVENTION SCREENING

Policy Name: *Suicide Prevention of Inpatients Protocol*
Link: Click Here

Policy Name: *SOP: Suicide Prevention in the ED*
Link: Click Here

- ✓ Each patient's psychosocial status, including any indications of suicidality, are part of the ongoing nursing assessment process.
- ✓ If patient is currently having thoughts of suicide or if the caregiver is otherwise concerned about the potential for self-harm, immediate interventions should be implemented:
  - Place patient under direct visual supervision (1:1 sitter) while further assessments and treatment planning is completed (person must be continuously monitoring patient at all times)
  - Provide patient with a safe environment
  - Check patient's belonging for contraband
  - Food to be served on a "Safety Tray"
  - Notify immediate supervisor
  - Initiate a referral for further evaluation by a behavioral health specialist (e.g. psychiatric social worker, psychiatric nurse, psychiatrist)
- ✓ Patients being treated by the hospital for behavioral health issues (e.g. patients presenting to the emergency department with behavioral complaints) require a more formal evaluation of potential suicidality.

SUICIDE RISK PREVENTION SCREENING (Cont.)

Any other relevant physical, psychological and/or social needs which are identified by the nursing staff include:

- ✓ Assessment by a RN
- ✓ Every shift patient will be assessed for suicidal ideation
- ✓ Discussion with the physician for the appropriate medical or nursing intervention
- ✓ Documentation in the medical record

NUTRITIONAL SCREENING

Policy Name: *Initial Nutrition Screening, Prioritization, and Assessment*
Click Here

Policy Name: *Malnutrition Criteria in the Hospitalized Patient*
Link: Click Here

- ✓ The goal of nutritional screening is to identify patients who present with malnutrition or due to recent diagnosis, comorbidities, and planned treatment approaches may be at high risk for malnutrition.

- ✓ Malnutrition:
  - Negatively impacts the patient's response to therapy
  - Increases the incidence of treatment-related side effects
  - Extends hospital stay
  - Impairs muscle function, immune function, and quality of life
  - Affects survival

Nutrition: Triggers for Nutrition Screening

- ✓ Recent and/or unintentional weight loss
- ✓ Physical signs and symptoms of malnutrition
- ✓ Difficulty chewing or swallowing
- ✓ Poor oral intake due to decreased appetite
- ✓ Tube feeding/Total Parenteral Nutrition (TPN)
- ✓ Abnormal labs that can impact nutritional status
- ✓ Pressure ulcer or non-healing wound

Nutrition: Types of Patient Meal Service

Bedside Service

- ✓ Patient meal selections are taken at bedside prior to each meal.
- ✓ Patients are visited by an associate 9-12 times per day.

Room Service*

- ✓ Patient meal selections are taken over the phone similar to room-service.
- ✓ Meals prepared real-time and delivered within 45 minutes.
- ✓ Patients and family members can call and place orders throughout the day.

**Currently assigned to designated units only – Heme/Onc*

Nutrition: Services Call Tree

University of Miami Hospital

- ✓ Bedside Service Diet Office (*extension 25495*)
- ✓ Room Service Call Center (*extension 2FOOD or 23663*)
- ✓ Supervisor (*extension 22101*)
- ✓ Dietitian's Office (*extension 23525*)

Sylvester/UMHC

- ✓ Room Service Call Center (*extension 6FOOD or 63663*)
- ✓ Supervisor (*extension 60816*)
- ✓ Dietitian's Office (*direct 305-243-1130*)

ABLEH/BPEI*

- ✓ Sylvester/UMHC Dietitian's Office (*direct 305-243-1130*)

** Clinical coverage at ABLEH/BPEI is provided by the Sylvester Dietitians*

USE OF RESTRAINTS

Policy Name: *Restraint and Seclusion*
Link: Click Here

Restraints: Item, equipment, or medication (chemical) that limits the patient's movement or controls patient's behavior without the patient's consent.

- ✓ Helps to prevent self-injurious behavior or harm to others.
- ✓ Protect the patient and preserve the patient's rights, dignity, and well being during restraint use.
- ✓ Always used as a last resort.
- ✓ Restraints are not part of the treatment.
- ✓ Reassess and encourage the release of restraints as soon as possible.

Restraints: Types of Restraints

Non-violent Behavior Restraints

- ✓ Used to restrict movement when the patient is interfering with medical treatment.
- ✓ Primary reason for use directly supports medical healing.
- ✓ Example: pulling an IV, urinary catheter or dressings.

Violent Behavior Restraints

- ✓ Used to control continuous self injurious behavior or continuous aggressive behavior towards others.
- ✓ Velcro restraints are only used for behavioral management.
- ✓ Physical restraints and seclusion must not be used at the same time.
- ✓ NEVER used as punishment.

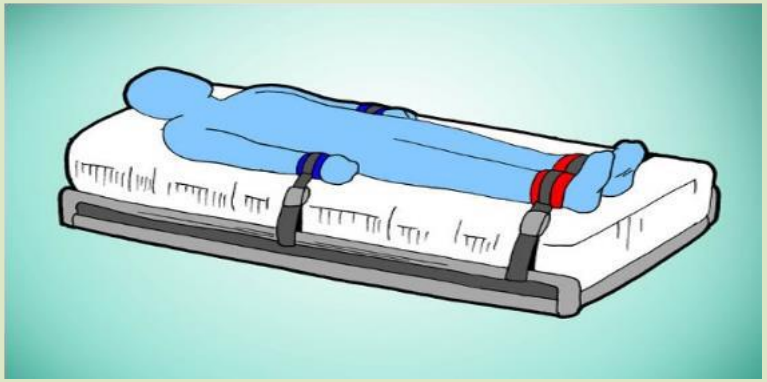
Restraints: Types of Restraints (Cont.)

Non-violent Behavior Restraints

SoftWrist

Mittens

Violent Behavior Restraints



4-point restraints with soft wrist restraints is considered violent restraint

Restraints: Non-violent

- ✓ Monitor Patient Q 2 Hours.
- ✓ Physician must do a face-to-face evaluation within 24 hours of initiation of restraints and sign order.
- ✓ Order needs:
  - Start and stop time.
  - Date.
  - Reason for restraint. Type of restraint used.
  - Renewal order needed at the end of next calendar day.
    - Calendar day is defined as from Midnight to 11:59pm

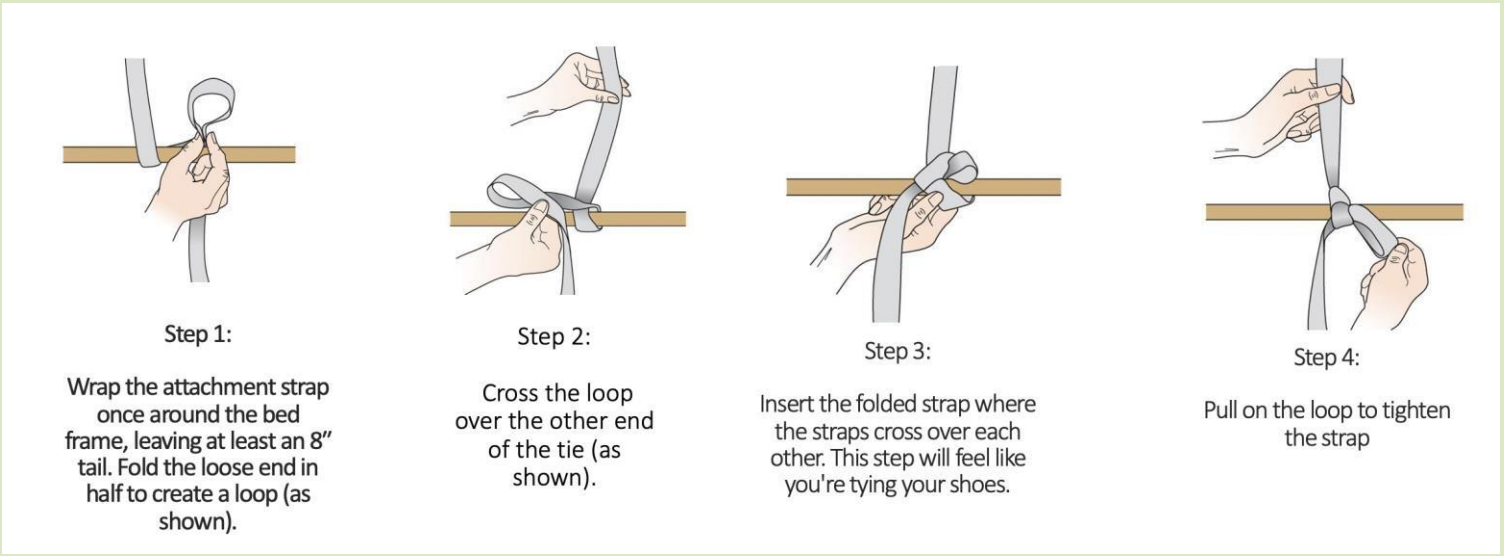
      Example: If the physician ordered a non-violent restraint on July 1st at 10:00 pm, the order would expire on July 2 at 11:59 pm. That is provided that the patient didn't meet criteria for release or discontinuation prior to 11:59 pm.

Restraints: Non-violent Episode

- ✓ A restraint episode:
  - Starts at the time restraints are applied
  - Ends when restraints are discontinued (if the patient does not meet criteria to continue in restraints) or the time has expired for the use of restraints.
- ✓ The order for Non-violent Restraint expires: unless otherwise specified; at the **end of the next calendar day** following a previous (initial or renewal) order.
- ✓ If patient is released from restraints due to not meeting criteria to continue in restraints and there is a decompensation in the patient's behavior, then restraints are reapplied. This action will be considered a separate restraint episode.

Restraints: Soft Wrist Quick-Release

A quick-release knot allows you to quickly release the knot, using one hand, if the patient is in distress or has an emergency.



Step 1:

Wrap the attachment strap once around the bed frame, leaving at least an 8" tail. Fold the loose end in half to create a loop (as shown).

Step 2:

Cross the loop over the other end of the tie (as shown).

Step 3:

Insert the folded strap where the straps cross over each other. This step will feel like you're tying your shoes.

Step 4:

Pull on the loop to tighten the strap

Reference: Lippincott Procedures
http://procedures.lww.com/lnp/home.do

Restraints: Violent

- ✓ Patient on Violent behavior restraint and seclusion has to be monitored Q 15 minutes until the end of the episode and will be placed on 1:1 watch.
- ✓ Patient who received a chemical restraint will be monitored Q 15 minutes for an hour.
- ✓ RN has to monitor the patient on seclusion or behavioral restraint Q 60 minutes until the end of the episode.
- ✓ Violent restraints cannot exceed more than 4 hours, unless a renew order is given.
- ✓ Face to Face within one hour (physician, LIP or RN).

Restraints: Violent Episode

- ✓ A restraint episode:
  - Starts at the time restraints are applied
  - Ends when restraints are discontinued (if patient does not meet criteria to continue in restraints) or time has expired for the use of restraints.
- ✓ *Violent Restraints* order will expire within
  - ✓ **4 hours** of application for adults age 18 and above
    - And:
      - Age 9-17 years of age = 2 hours
      - Children 8 years of age or younger = 1 hour
- ✓ If patient is released from restraints due to not meeting criteria to continue in restraints and there is a decompensation in patient's behavior, then restraints are reapplied. This action will be considered a separate restraint episode.

Restraints: Monitoring and Documentation

Monitoring and assessments shall occur at least every two hours for Non-violent restraints and at least every hour for violent restraint for the following:

- ✓ Condition of skin under restrained areas(s) when loosened/reapplied
- ✓ Circulation/movement/sensation of area(s) restrained
- ✓ Proper wear, fit, body alignment and comfort of the restraint(s)
- ✓ Two fingers between patient and limb restraint
- ✓ Unimpaired breathing with restraint(s)
- ✓ Continued need for restraint(s)
- ✓ Vital Signs
- ✓ Physical and psychological well-being

Restraints: De-escalation

- ✓ Techniques used by mental health professionals to minimize agitation state of a given person.
- ✓ If possible, try to identify patient's trigger for agitation.
- ✓ Allows the patient to regain control and facilitates the introduction of other de-escalation resources (Medication, reduction of stimuli, fluids or food).

De-escalation Tips

- Be empathic and nonjudgmental
- Respect personal space
- Use nonthreatening gestures
- Avoid overreacting
- Focus on feelings
- Ignore challenging questions
- Set limits
- Choose wisely what you insist upon
- Allow silence for reflection
- Allow time for decisions

Restraints: Death Related to Restraints

- ✓ Any significant injury or death related to the use of restraints or seclusion will be reported via the Sentinel Event Policy.
- ✓ Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- ✓ Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time.
- ✓ Excluding those in which only 2-points soft wrist restraints were used and the patient was not in seclusion at the time of death.

References

2014 Baker Act the Florida Mental Health Act User Reference Guide

CMS Standards CMS 42CFR 482.13 (e),(f),(g)

The Joint Commission Standards JC PC.03.05.01 through JC PC.03.05.19

END OF LIFE CARE

While individuals most preferred to die at home and receive a more conservative pattern of end-of-life care

- ✓ Most die in hospitals and receive more aggressive care than they desire
- ✓ Many dying persons fear abandonment and untreated physical distress

Research findings have provided health care staff with a better understanding and awareness of advanced illnesses and the need to provide holistic care for those at the end of life.

- ✓ Included are symptom management, including pain, communication, care giving and medical decision-making.

End of Life Care: Hospice

Philosophy of care

- ✓ Understanding dying is part of life cycle
- ✓ Promotion of quality of living for patient-family system
- ✓ Meticulous management of physical, psychological and spiritual symptoms
- ✓ Relief of distressing symptoms for both patient and family

Part of the palliative care continuum of care

- ✓ Regulated health care benefit
- ✓ Focused on the last phase of life

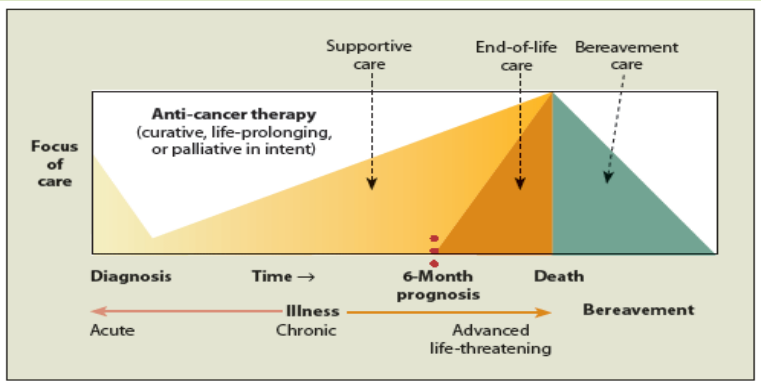


Figure 1: The balance between anti-tumor therapy and palliative care across the continuum of cancer care.

Provision of Care 2021

Some similarities and differences between palliative care and hospice care

Question	Palliative Care	Hospice
Who can be treated?	Anyone with a serious illness	Anyone with a serious illness who doctors think has only a short time to live, often less than 6 months
Will my symptoms be relieved?	Yes, as much as possible	Yes, as much as possible
Can I continue to receive treatments to cure my illness?	Yes, if you wish	No, only symptom relief will be provided
Will Medicare pay?	It depends on your benefits and treatment plan	Yes, it pays for some hospice charges
Does private insurance pay?	It depends on the plan	It depends on the plan
How long will I be cared for?	This depends on what care you need and your insurance plan	As long as you meet the hospice's criteria of an illness with a life expectancy of months, not years
Where will I receive this care?	• Home • Assisted living facility • Nursing home • Hospital	• Home • Assisted living facility • Nursing home • Hospice facility • Hospital

Source: National Institute on Aging, 2021
https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care

Kübler-Ross Theory Grief Process (Cont.)

1. **Denial:** Shock and disbelief
   Interpretation: *"This isn't happening to me! No it cannot be true!"*

2. **Anger:** Hostility and resentment
   Interpretation: *"Why is this happening to me?"*

3. **Bargaining:** Looking for a way out
   Interpretation: *"I promise I'll be a better person if..."*

4. **Depression:** No longer able to deny, patients experience sadness and loss
   Interpretation: *"I don't care anymore!"*

5. **Acceptance:** Acceptance of the inevitability of death with peace and detachment
   Interpretation: *"I cannot change it, but here's what I can do"*

End of Life Care: Assessment, Planning and Implementation

Physical signs and symptoms associated with dying may occur months, weeks, days, or hours before death

Difficulty swallowing

- ✓ Provide alternative routes for essential medications
- ✓ Provide mouth care
- ✓ Offer ice chips to suck if not high risk for aspiration

End of Life Care: Assessment, Planning and Implementation (Cont.)

Nutritional Issues

- ✓ Allow as much or as little intake as patient desires for comfort
- ✓ Favorite foods may not taste the same as taste changes may occur
- ✓ Aspiration precautions
- ✓ Nutritional supplements do not improve quality of life or prolongation of survival
- ✓ Provide education and support about cancer cachexia
- ✓ Weight loss and poor appetite caused by disease is not reversible in advanced stages
- ✓ Avoid use of enteral feeding tubes as does not improve quality of life or survival for those with poor functional status or limited prognosis

End of Life Care: Assessment, Planning and Implementation (Cont.)

Changes in skin temperature and color

- Cold, clammy
- Core body temperature does not drop below normal during dying process
- Believed patient does not experience sensation of being cold
- Use of heating devices and extra blankets are not necessary
- Heavy layers of covers will make work of breathing harder
- Slightly cyanotic, beginning at periphery with progression indicative of imminent death
- Implement good skin care to prevent breakdown
- Discontinuation of routine monitoring of vital signs which may be disruptive and does not change plan of care

End of Life Care:Assessment, Planning and Implementation (Cont.)

Pulmonary symptoms

- ✓ Reposition to lessen laborious breathing
- ✓ Collaboration to treat any underlying causes that may respond to treatments without causing major decrease in quality of life
- ✓ Fluids should be discontinued if attributing to symptoms of circulatory overload
- ✓ Hypoxia - Patients who have required oxygen therapy throughout course of disease will usually continue to need oxygen throughout dying process
  - Those who have not used oxygen may benefit from air blowing on face or via nasal cannula
  - Masks should be avoided since it may contribute to restlessness and agitation

End of Life Care: Assessment, Planning and Implementation (Cont.)

Pulmonary symptoms interventions

- ✓ Provide cool sensation to face - Fan blowing air towards face or cool compress on cheeks
- ✓ Administration of oral or parenteral opioids as needed for dyspnea, and titrate for comfort
- ✓ Provide presence, reassurance and support to lessen anxiety
- ✓ Cheyne-Stokes breathing- additional sign that circulation is slowing
- ✓ Periods of apnea may be difficult for family, especially when prolonged
- ✓ Family needs extra support

End of Life Care: Assessment, Planning and Implementation (Cont.)

Pain

- ✓ Increased pain levels may interfere with patient's ability to speak
- ✓ Behavioral cues such as furrowed brow or stiffened body posture can be used for assessment

Delirium

- ✓ Disturbance in ability to direct, focus and sustain attention
- ✓ Reduced orientation to environment
- ✓ Develops quickly
- ✓ Fluctuates during the day may be due to: Organ failure, Urinary tract infections, or medications

End of Life Care: Supportive Care During the Dying Process

Emotional Assessment

- ✓ Patient and family: anxiety level, guilt, anger, level of acceptance, and identification
- ✓ Major fears: abandonment, loss of control, pain and discomfort, and the unknown

Intellectual Assessment (patient and family)

- ✓ Evaluation of educational level, knowledge, abilities, and expectations they have regarding how and when death will occur.

Social Assessment

- ✓ Assessment of support systems is valuable.
- ✓ Ascertain whether family members desire to assist in the patient's daily care. Never assume they do; many do, others do not.

Chaplaincy (Pastoral Care) Service

UHealth Tower and Sylvester

Contact:

Cancer Support Services Telephone: 305-243-4129
or
Send EPIC Internal Referral/Order No. REF803 for Pastoral Care

References

Heidrich, D.E. (2016). Palliative and End-of Life-care. In Itano, J.K. (Ed), *Core Curriculum for Oncology Nursing (pp515-528).* Pittsburgh: Oncology Nursing Society.

Smith, L. N., & Jackson, V.A. (2013). How do symptoms change for patients in the last days and hours of life? In N.E. Goldstein and R.S. Morrison (Eds), *Evidenced-based practice of palliative medicine* (pp.218-226). Philadelphia: Elsevier.

Witt, S. D. (Eds.). (2015). Cancer. *Palliative Care Nursing* (4th ed. (p. 269). New York, NY: Springer Publishing Co.

Organ Donation

Donation-Related Legislation & Regulations

CMS Conditions of Participation

- Requires hospitals to establish relationship with their federally designated Organ Procurement Organization (OPO)
- Hospitals must establish protocols for identifying and referring potential donors and for informing families of their opportunity to donate

TJC Requirements (Standard PI.02.01.01)

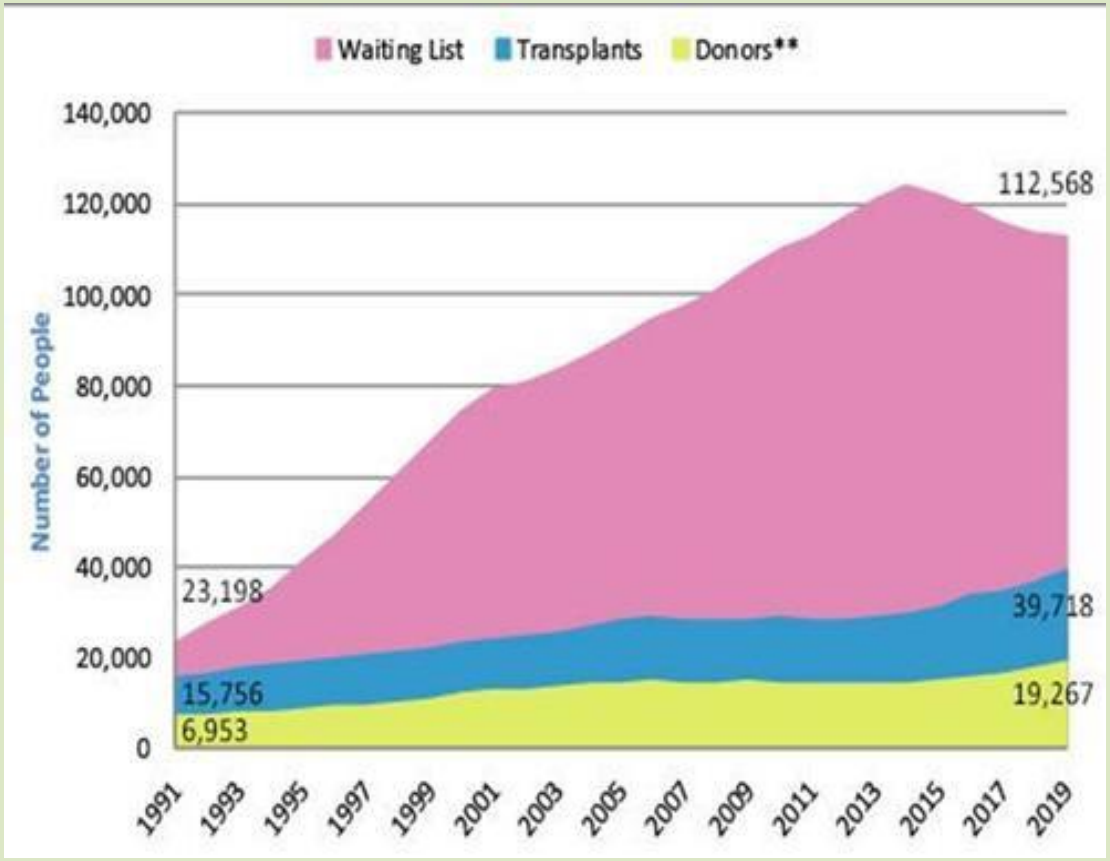
- Requires hospitals to measure the effectiveness of their organ procurement efforts including the conversion rate
- Review donation related data to improve conversion rates

Gift of Life Initiative

- The Organ Donation Breakthrough Collaborative began in 2003 as one of the components of U.S. Dept. of Health and Human Services Gift of Life Initiative.
- **The aim is to dramatically increase the number of organs transplanted.**
- **Best practices include:**
  - Early referral rapid response
  - Preserving the option of donation

Organ Donation

Based on OPTN data as of 8-13-2021
Waiting List
as of 10/25/2019



Type of Transplant	Patients Waiting
Kidney	91,062
Liver	11,880
Pancreas	892
Kidney/Pancreas	1,697
Intestine	210
Heart	3,557
Heart/Lung	52
Lung	1,036
Total	107,728

Organ Donation

Goal: An average donation rate of **75%** thereby saving or enhancing hundreds more lives each year.

Brain Death Law and Determination

Florida Statute 382.085

- Irreversible cessation of brain function including brain stem
- Two board eligible or board certified physicians by clinical exam
- Reversible etiology must be considered and excluded prior to diagnosing brain death
- May confirm brain death by:
  - Negative cerebral flow
  - Flat EEG and/or
  - Apnea test

Donation After Cardiac Death (DCD)

Immediate rescue of organs within the allotted time (60-120 minutes) post extubation after asystole/cardiac death occurs.

Withdrawal of Life Support (WDLS) triggers must be called within one hour to 1-800-255-GIVE

These patients are:

- On mechanical ventilation
- Are terminally ill or have sustained an irreversible brain injury
- Do not meet brain death criteria
- For whom further treatment is deemed futile and are predicted to die
- Families have made decision to withdraw life sustaining therapies

Organ Donation

Donation After Circulatory Determination of Death (DCDD)

- Donation Opportunity offered **After** decision to withdraw life sustaining therapies
- Inform family of process in the event patient does not expire
- Family can be present in **OR** if hospital policy permits
- Pronouncement is made by **Hospital Physician** according to hospital policy
- Withdrawal is done by **Hospital Staff**
- OPO coordinator present to document vitals ONLY
- First incision is made **3-5 minutes** after pronouncement
- **All Organs** can be donated: heart, lungs, liver, kidneys, pancreas, intestine and heart valves.
- There are more than 107,000 people awaiting vital organ transplants, and many more in need of corneas, bone and tissue.
- When you refer a potential donor, you are giving someone the opportunity to save or enhance their quality of life.

LIFE ALLIANCE
ORGAN RECOVERY AGENCY
UNIVERSITY OF MIAMI

ADVANCE DIRECTIVES AND DO NOT RESUSCITATE

Policy Name: *Do Not Resuscitate (DNR)*
Link: Click Here

Policy Name: *Advance Directives*
Link: Click Here

The University of Miami Hospital and Clinics (UMHC) recognize, protect and honor competent adults' rights of self-determination:

- ✓ With multidisciplinary approaches and discussions, UMHC providers assist patients and families with planning for end-of-life decisions to withhold or withdraw treatment, including cardiopulmonary resuscitation and artificial hydration and nutrition, in accordance with state and federal laws and regulatory requirements.
- ✓ Valid consent to or refusal of treatment depends on effective communication among team members, patients and/or their authorized representatives.
- ✓ A Do-Not-Resuscitate order (DNR) applies only to cardiopulmonary resuscitation; other interventions might still be necessary and appropriate, and should be documented in the medical record.

Advance Directives

Refers to a witnessed written or oral statement of a person's end-of-life wishes regarding medical care, treatment, services, designation of a health care surrogate, or declaration of willingness to be an organ donor.

Advance directives include decisions regarding the foregoing or withdrawing of life-sustaining treatments, including artificial hydration and nutrition, cardiopulmonary resuscitation, etc. Advance Directives are made to ensure patients' end-of-life wishes are carried out in case they become unable to communicate or make decisions for themselves due to physical or mental incapacity.

Advance Directives: Definitions

Close personal friends: Any person 18 years old or older who exhibits special care and concern for the patient, presents an affidavit to the health care team stating he/she is a friend of the patient, is willing and able to become involved in the patient's care and through regular contact with the patient is familiar with his health, activities and religious or moral beliefs.

End-stage condition: An irreversible condition that is caused by injury, disease or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

Health care provider: Any person authorized by the state to provide health care as a practitioner through licensure, certification or legal accreditation.

Advance Directives: Definitions (Cont.)

Health care surrogate: A competent adult designated by a patient to make health care decisions on his/her behalf in the event he/she becomes incapacitated.

Incapacitated or incompetent: Describes a patient who is physically or mentally unable to communicate or make health care decisions.

Life-prolonging procedure: Any medical procedure, treatment, or intervention, including artificially administered nutrition or hydration, which sustains, restores, or supplants a spontaneous vital function. This term does not include the administration of medication or performance of medical procedures, which such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

Living will: A witnessed written or oral statement in which a patient voluntarily expresses the patient's instructions regarding life-prolonging procedures.

Advance Directives: Definitions (Cont.)

Persistent vegetative state: A permanent and irreversible condition of unconsciousness in which there is:

(a) the absence of voluntary action or cognitive behavior of any kind, or
(b) the inability to communicate or interact purposefully with the environment.

Terminal condition: Caused by injury, disease or illness from which there is no reasonable medical probability of recovery and which without treatment is expected to cause death.

Advance Directives: Ethics Committee

UMHC is served by an Ethics Committee that is available for education, policy creation and review, and case consultations.

The Committee is available 24/7/365 for case consultations. The Committee is of use, for instance, in cases shaped by end-of-life conflict between or among patients, family members and the care team. The Committee can help sort out ethical issues, resolve conflicts, provide recommendations and otherwise contribute to decision making in cases involving advance directives, surrogate/proxy decision making, withholding or withdrawing treatment, and general end-of-life care (among other issues).

DNR

The decision whether to attempt resuscitation is best made after candid and sensitive communication that includes information about the likelihood of success, risks and alternatives, including comfort measures and hospice care. The details of such communication should be written in the patient's medical record.

- ✓ UMHC adopted the POLST (Physician Orders for Life-Sustaining Treatment) order set and policy to support and document such communication. PolicySTAT Link
- ✓ Seen as an order set, POLST can be used in support of aggressive interventions as well as to document that CPR be withheld or withdrawn and to enter a do-not-resuscitate order.
- ✓ DNRs may be entered using POLST or by other appropriate means in the patient medical record.

DNR (Cont.)

- ✓ DNR orders shall be documented by the patient's attending physician or designee in accordance with the institution's rules and regulations/bylaws.
- ✓ DNR status should be communicated timely to appropriate caregivers via progress notes and nursing report/rounding.
- ✓ Once a DNR order is written, it is valid for the remainder of the inpatient hospitalization unless revoked.
- ✓ In the absence of a DNR order or valid refusal of CPR by a patient, CPR should be initiated.
- ✓ Questions or disagreements about any individual DNR order should lead those in disagreement to request a consult from the UMHC Ethics Committee.
- ✓ When transferring patients with active DNR orders to another healthcare setting, a state of FL Health DNR yellow form may be used.

References

Centers for Medicare and Medicaid Services (CMS), Patients' Rights Condition of Participation (CoP) at 42 CFR 482.102 (a)(1).

Florida Statutes Title XLIV Civil Rights, Chapter 765.

Florida Statute 489.102 Advance Directives - Requirements for providers.

The Joint Commission. (2017) Rights and responsibilities of the individual (RI). *Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)*. Oak Brook, IL: Joint Commission Resources, RI.01.05.01 [1-21].

IMPAIRED PRACTITIONER

Policy Name: *Chemically Impaired Nurses*
Link: Click Here

Policy Name: *Medical Staff Bylaws*
Link: Click Here

The purpose of this module is to:

- Define import concepts/terms
- Provide information on recognizing and assisting the impaired practitioner to minimize the harmful impact and ensure their well-being.

Impaired Practitioner: Definitions

Impairment: Condition that results from the use of mind/mood altering substances, distorted thought processes found in the psychologically impaired or a physical condition that prevents the nurse from providing safe patient care.

Intervention Project for Nurses (IPN): The IPN staff can assist the impaired nurse in obtaining appropriate treatment, continuing care, and ongoing support. If the nurse has violated the Nurse Practice Act, IPN participation is an alternative to disciplinary action by the DOH/BON. If the nurse is already involved in the disciplinary action process through the DOH/BON, an IPN representative will be present. When that nurse's case is heard before the Florida Board of Nursing, IPN can confirm that the nurse is engaged in the recovery process.

Impaired Practitioner (Cont.)

Public health in general cannot be maintained without first ensuring the health and well-being of healthcare practitioners. Therefore, UHealth recognizes that:

- ✓ Practitioners are as susceptible as anyone else to health disorders
- ✓ Some health disorders produce dysfunction, disability, impairment
- ✓ Impairment can pose a risk to the well-being of patients, staff and/or visitors
- ✓ Support for rehabilitation and recovery, not discipline, are the desired responses to impairment
- ✓ All practitioners should know how to respond to a colleague's impairment

Impaired Practitioner (Cont.)

Impairment typically leads to errors in judgment that take the form of incompetence and unsafe or unprofessional behavior.

It is important for all practitioners, as well as hospital employees to recognize and report such behavior to their supervisors.

Reporting an impaired practitioner is an expectation of every healthcare worker.

There are many causes of impairment, some of them are:

- ✓ Physical illness
- ✓ Mental or Cognitive Disorders
- ✓ Emotional – overreaction to stress
- ✓ Psychological Disorders
- ✓ Substance Abuse (Addictive Disorders)

Impaired Practitioner: Signs and Symptoms

It may be impossible to know, or to determine, whether a co-worker is truly impaired. At best, we can be watchful for behaviors which are atypical or unusual. The following signs and symptoms may be indicative of the potential for impairment:

- ✓ Serious mistakes, errors
- ✓ Inadequate fine motor control
- ✓ Unstable balance
- ✓ Speech irregularities
- ✓ Slurred speech
- ✓ Word finding difficulties
- ✓ Swearing, using obscene language
- ✓ Distractibility, inability to concentrate
- ✓ Violating boundaries, i.e. inappropriate sexual advances or demands
- ✓ Frequent weeping

Impaired Practitioner: Signs and Symptoms

- ✓ Excessive irritability
- ✓ Being late, missing deadlines
- ✓ Absences – not coming to work, missing meetings
- ✓ Borrowing money, not paying back
- ✓ Faulty judgment
- ✓ Poor grooming
- ✓ Tiredness, falling asleep while on duty
- ✓ Improbable excuses
- ✓ Blaming others
- ✓ Loud, pressured speech

Impaired Practitioner: Difficulty with Self-Healing

The following are reasons why people resist reporting impaired practitioners:

- ✓ Fear of not being believed or taken seriously
- ✓ Perception of disrespect. Complaining about someone's impairment may seem insulting
- ✓ Fear of retaliation, especially if the impaired practitioner has more power than the reporter
- ✓ Ease; it is more comfortable to fix the person's mistakes or cover up than to "make trouble": *"I don't meddle"*
- ✓ Supervisor's job, not mine: *"I am not a rat"*

Although we recognize that these emotional responses to reporting another exists, we encourage you to remember that by not reporting them you are doing more harm to the impaired practitioner, and possibly to our patients, visitors, and staff. Also, if you are a practitioner yourself, you may have a **legal obligation** to report any peer whom you suspect may be impaired.

Impaired Practitioner: Sources of Confidential Help

At the first sign of concern, practitioners questioning their own health may seek help from any one of the following sources:

- ✓ Faculty and Staff Assistance Program (FSAP),

  (305)-284-6604

- ✓ The University of Miami's employee assistance program offers free and confidential consultation and referral services to UM faculty, staff, and retirees, as well as their domestic partners, spouses and dependents. For more information, http://www.miami.edu/fsap/

Help Lines:

- ✓ Broward County – 211-Broward,

  (954) 537-0211 http://www.211-broward.org/

- ✓ Miami-Dade County – Switchboard 211

  (305) 631-4211 http://jcsfl.org/services/switchboard-211/

Impaired Practitioner: Sources of Confidential Help

- **Mental Health Provider** – These can be found through insurance health plans, or by calling the help lines.

- **Professional Resource Network** (PRN), 1-800-888-8PRN (8776) - One of two programs designated as the State of Florida's Impaired Practitioner Programs (the other is IPN-see below) designed to ensure the public health and safety by supporting ill practitioners in regaining their health. http://www.flprn.org

- **Intervention Project for Nurses** (IPN), 904-270-1620 or 1-800-840-2720 – PRN's counterpart designed for those in the nursing field. For more information, click http://www.ipnfl.org

Impaired Practitioner: Sources of Confidential Help

Twelve-Step Programs, such as:

- Alcoholics Anonymous (AA) https://aa.org/
- Miami-Dade Intergroup: https://aamiamidade.org/
- Narcotics Anonymous (NA) https://na.org/

All UM practitioners (or hospital employees) questioning any practitioner's capacity to function must immediately report their concerns to his or her supervisor.

Impaired Practitioner: Consulting the FSAP (Faculty and Staff Assistance Program)

When a **practitioner/employee** voluntarily consults the FSAP,

the FSAP will:

- ✓ Assess the presenting problem
- ✓ Make treatment recommendations
- ✓ Make the participant aware of available resources for addressing problem(s)

When a **concerned colleague** consults the FSAP, the FSAP will:

- ✓ Listen to the presented concern
- ✓ Recommend a course of action

References

Home. (n.d.). Retrieved August 20, 2021, from http://www.flprn.org/home Home.

Intervention Project for Nurses. (2021, March 17). Retrieved August 20, 2021, from https://www.ipnfl.org/

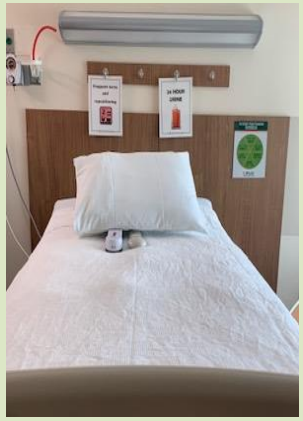
Isolation Sign Placement

- A new infection must prompt the following actions:
  1. Update UCHART by adding the corresponding isolation for the infection
  2. Place isolation sign on the front of the patient's room door (image #1)
  3. Place reverse side of each isolation sign on the back of the room door.
     - The reverse indicates the cleaning protocol for the corresponding infection (image #2)
  4. **Only <u>ONE</u> isolation sign should be posted on the door at any given time.**
     - When **more than one isolation type** is indicated, use the **combination isolation sign** that has been created for that purpose.
  5. All other signs should be posted inside the patient's room at the head of the bed (image #3).

#1

#2

#3



Isolation Sign Placement

- **NOTE**: If signs, other than the isolation sign, cannot be placed at the head of the bed, an alternate placement in the room where the sign can be seen immediately upon entry into the room is acceptable (check with your nursing supervisor)
- Isolation signs are to be removed from the front and back of the door by EVS **after** the room has been **terminally cleaned**

Isolation Sign Placement

Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment (e.g. MRSA, Extended spectrum beta lactamase (ESBL), Vancomycin Resistant Enterococcus VRE), Carbapenem Resistant Enterobacteriaceae (CRE), Carbapenem Resistant Pseudomonas aeruginosa and Acinetobacter baumannii and patient with diarrhea.

*Use Designated Equipment

Isolation Sign Placement

Enteric-Contact Precautions are commonly used for patients with known or suspected with *Clostridiodes difficile* or Norovirus

- In addition to the requirements on the sign, use of designated equipment (e.g. stethoscope, thermometer, BP cuff etc..) is required
- When unable to designate equipment, then disinfect with bleach

Isolation Sign Placement

Droplet Precautions
are used for patients with known or suspected Influenza, invasive *Neisseria meningitidis* disease including meningitis and pneumonia, respiratory diseases as Diphtheria, Pertussis and viral infections.

Isolation Sign Placement

- Airborne Precautions are used for patients with diagnosed or suspected Pulmonary Tuberculosis, & Measles.
- A negative pressure room is required and staff must wear an N-95 respirator when entering the room.

Isolation Sign Placement

This sign is used for patients who have a tracheostomy or who are admitted from a Nursing Home. The isolation requirements are the same as those followed for Contact Precautions. *Both Signs are Yellow

Rationale: Some of these patients may be colonized with *Candida auris*

Isolation Sign Placement

This Combination Sign is used for patient with COVID19 Infection (* Remember that eye protection, either face shield or goggles are required for care of all patients during the Pandemic)

This combinations sign is also used for patients with Chickenpox, and disseminated Herpes zoster (Shingles)

Isolation Sign Placement

Combined Droplet and Contact Precautions Sign

- Combined signs are used for specific conditions that require 2 types of isolation
- May also be used for patients with multiple conditions that require different precautions.

Isolation Sign Placement

Combined Airborne and Contact Precautions Sign

- Combined signs are used for specific conditions that require 2 types of isolation
- May also be used for patients with multiple conditions that require different precautions.

Isolation Sign Placement

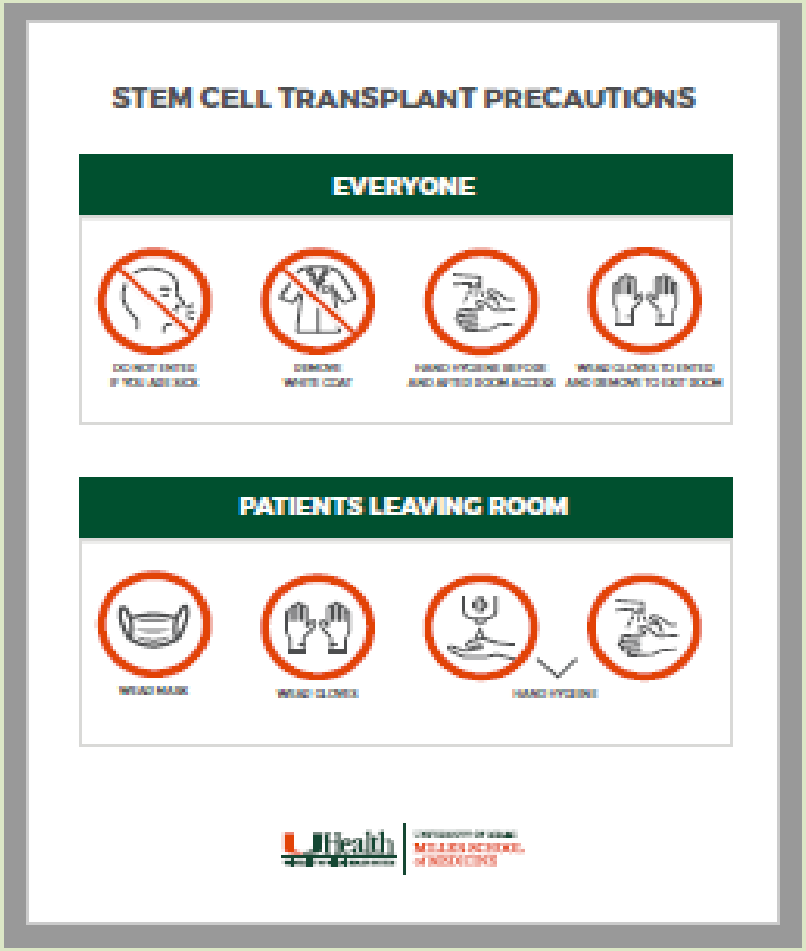
Combined Droplet and Enteric-Contact Precautions Sign

- For patients with multiple conditions that require different precautions (Influenza * r/o C. difficile).

Isolation Sign Placement

Protective Precautions are used for immunosuppressed patients (to protect the patient with impaired resistance to infection)

Isolation Sign Placement



This Type of Precaution is used to protect Stem Cell Transplant Patients

Isolation Sign Placement

Isolation Sign Placement

Candida Auris: A Public Health Threat

Why is Candida auris (*C. auris*) a public health threat:

- *C. auris* is a multidrug-resistant organism (MDRO) that spreads among the sickest patients
- Colonization can last for an indefinite period
- Causes invasive infections
- Contaminates patients' rooms and shared equipment that can lead to outbreaks

Table 1.

C. Auris environmental screening – UMH Location A	
Occupied room with positive patient	
Item	Results
Table	Positive
Bedrail left side	Positive
Counter	Positive
Outside doorknob	Negative
WOW keyboard	Negative
Bedrail right side	Positive

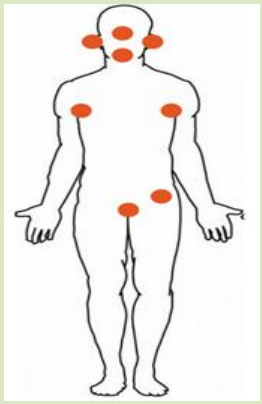
Candida Auris: A Public Health Threat

Risk factors:

- Typically affects the sickest patients with:
  - Tracheostomies
  - Ventilator dependence
  - PEG tubes
  - Colonized with other MDROs

Colonization:

- Duration of colonization is indefinite, even after a negative test
  - Patients who test positive once are considered positive on every admission
  - Thrives in nares and other body sites, including intact skin
- No decolonization process exists. Colonization causes challenges such as:
  - Inability to discharge patient to skilled nursing facilities (SNFs)
  - Increased risk for nosocomial infections with other pathogens
  - Stress to hospital resources/staffing



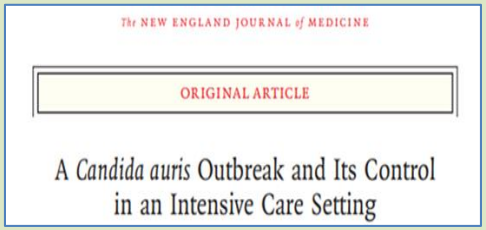
Invasive infections:

- Colonization can lead to invasive infections (e.g., bloodstream infection)
  - The mortality attributed to *C. auris* bloodstream infection is about 30-59%, globally
  - Medical devices can serve as portals of entry for the organism to invade body sites

Candida Auris: A Public Health Threat

Outbreaks:

- Causes outbreaks via **<u>contaminated</u>**:
  - Hands of healthcare workers
  - Equipment
  - Environment


The NEW ENGLAND JOURNAL of MEDICINE

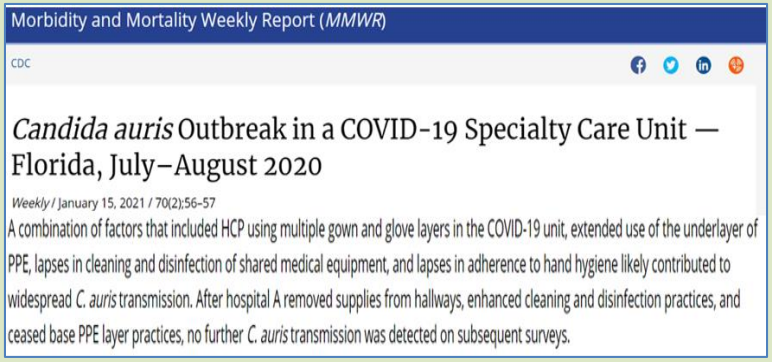
ORIGINAL ARTICLE

A *Candida auris* Outbreak and Its Control in an Intensive Care Setting


The New York Times

With All Eyes on Covid-19, Drug-Resistant Infections Crept In

The spread of other dangerous germs is surging — a result, in part, of the chaotic response to the pandemic.


Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Candida auris Outbreak in a COVID-19 Specialty Care Unit — Florida, July–August 2020

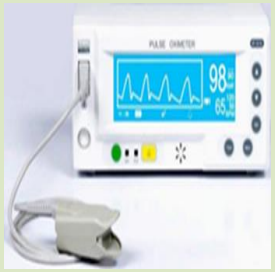
Weekly / January 15, 2021 / 70(2);56–57

A combination of factors that included HCP using multiple gown and glove layers in the COVID-19 unit, extended use of the underlayer of PPE, lapses in cleaning and disinfection of shared medical equipment, and lapses in adherence to hand hygiene likely contributed to widespread *C. auris* transmission. After hospital A removed supplies from hallways, enhanced cleaning and disinfection practices, and ceased base PPE layer practices, no further *C. auris* transmission was detected on subsequent surveys.

Candida Auris: A Public Health Threat

Preventive Measures include:

- **Strict adherence to:**
  - Hand hygiene
    - Keep natural fingernails no longer than a ¼ inch in length
    - Artificial nails are not allowed
  - Maintenance bundles for indwelling medical devices
  - Disinfection of high-touch surfaces
  - Disinfection of shared equipment
  - Contact precautions and appropriate use of isolation signs
  - Appropriate donning, doffing, and disposal of PPE
  - Use of disposable or designated equipment



References

A *Candida auris* Outbreak and Its Control in an Intensive Care Setting: https://www.nejm.org/doi/pdf/10.1056/NEJMoa1714373?articleTools=true

Candida auris: a drug-resistant fungus that spreads in healthcare facilities: https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html

Candida auris Colonization After Discharge to a Community Setting: New York City, 2017–2019: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814391/

Candida auris infection control challenges (cdc.gov): https://emergency.cdc.gov/coca/ppt/2019/slides_062019_C-auirs.pdf

Candida auris Outbreak in a COVID-19 Specialty Care Unit — Florida, July–August 2020 | MMWR (cdc.gov): https://www.cdc.gov/fungal/candida-auris/c-auris-treatment.html

Clinical Outcomes of Patients Treated for *Candida auris* Infections in a Multisite Health System, Illinois, USA: https://wwwnc.cdc.gov/eid/article/26/5/19-1588_article

Treatment and Management of Infections and Colonization: https://www.cdc.gov/fungal/candida-auris/c-auris-treatment.html

With All Eyes on Covid-19, Drug-Resistant Infections Crept In: https://www.nytimes.com/2021/01/27/health/covid-drug-resistant-infections.html

Infection Prevention & Control-
Prevention of Device Associated Infections

- Daily assessment for the continued use of an invasive device is a key element of preventing device associated infections such as central line associated bloodstream infection (CLABSI), ventilator associated events, and catheter associated urinary tract infection (CAUTI).

- Follow evidence-based guidelines for the insertion, and maintenance of these devices.

- Educate the patient/family about measures they should follow to prevent CAUTI (i.e. keep the urine bag below the level of the bladder) and CLABSI (i.e. do not handle the central line dressing and notify your nurse if the dressing becomes soiled or is not sealed).

Zero Harm Initiative

Nursing plays a vital role in reducing patient/hospital acquired harms and is committed to achieving what is known collectively as the Zero Harm Initiative.

Through designated taskforces comprised of subject matter experts and key stakeholders, the Zero Harm Initiative focuses on:

- Implementing improvement strategies based on best practice research
- Evaluation of new products and nursing tools
- Root cause analysis of harm events
- Identification of opportunities and barriers
- Concurrent data collection and monitoring
- Real time auditing and education

Zero Harm Initiative

Current taskforces include:

- Fall Prevention (Inpatient/Outpatient)
- Central Line Associated Blood Stream Infection (CLABSI) Prevention
- Catheter Associated Urinary Tract Infection (CAUTI) Prevention
- Hospital Acquired Pressure Injury (HAPI) Prevention
- Venous Thromboembolism (VTE) Prevention
- Sepsis Prevention

Additionally, nurses who are being onboarded are encouraged to reach out to their leaders, or Practice Councils, for available resources and/or guidance on quality improvement initiatives.

PATIENT TEACHING

Policy Name: *Patient and Family Education*
Link: Click Here

Patient and Family Education

- ✓ Patient/family education is an interprofessional and collaborative process designed to meet the needs of the individual patient throughout the continuum of care.
- ✓ Educational materials may be provided to patients as a reinforcement or resource for teaching and should be provided (when possible) in their preferred language, and with the assistance of an interpreter.
- ✓ Provide a comfortable environment for patient/family education.
- ✓ Set realistic goals for the patient. Involve the patient and the family in goal setting whenever possible.

Patient Teaching: Healthcare Team Responsibilities

- ✓ Assessing the patient's need for information, understanding, and/or skills inclusive of special communication needs, interpreters, etc.
- ✓ Identifying, planning, and coordinating the teaching interventions necessary to meet the ongoing healthcare goals of the patient/family.
- ✓ Initiating interventions designed to address specific learning needs and barriers.
- ✓ Evaluating the learner's response and documenting/communicating the outcome and need for follow up teaching.

Patient Teaching: Assessing Patient's Readiness to Learn

- ✓ Age
- ✓ Education level
- ✓ Language
- ✓ Emotional barrier
- ✓ Physical & cognitive limitations
- ✓ Cultural and religious practice

Patient Teaching: Patient and Family Education

- ✓ Provide patient/family with necessary materials for a better understanding of their procedure and/or illness.
- ✓ Include the family in the teaching plan. Encourage participation in teaching sessions.
- ✓ Assess the patients understanding of the instructions given, by having the patient: return the demonstration, answering questions appropriately, repeating the information accurately.
- ✓ Document patient/family teaching techniques utilized, patient's performance and recommendations.
- ✓ Provide patient with physician's name and phone number he/she may call if any unusual problem develops and any additional community resources.

Patient Teaching: Education Tools

- ✓ Patient teaching materials might include but are not limited to:
  - Lecture or explanation
  - Group or individual teaching
  - Teaching aids (ex: Videos)
  - Demonstration
  - Practice
  - Reinforcement
  - Follow-up

Patient Teaching: Discharge Planning

- ✓ Discharge process starts on admission and shall continue throughout the continuum of care.
- ✓ Patient teaching and discharge shall be updated throughout the continuum of care.
- ✓ Discharge information and patient teaching shall include but is not limited to referrals to outpatient and community resources, follow up appointments, medication reconciliation etc.
- ✓ Safe discharge teaching shall be provided and ensure patient's and family members verbalize understanding of the patient's plan of care and demonstrate any skills when applicable.

Reference

National Patient Safety Foundation (NPSF). Ask me 3: good questions for your good health. NPSG.org Web site. http://www.npsf.org/?page=askme3. Accessed August 24, 2016.

The Joint Commission (TJC). Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace, IL: Joint Commission Resources; 2016.

VISITATION

Policy Name: *Visitation Policy*
Link: Click Here

Policy Name: *SOP: Visitation During Pandemic Events*
Link: Click Here

Patients under the care of the University of Miami Hospital and Clinics have the right to have visitors of their choice subject to reasonable restrictions, as described in the procedures and guidelines below. Visitation privileges shall not be restricted on the basis of the patient's or visitor's race, color, national origin, religion, sex, gender identity and expression, sexual orientation, or disability.

Visitation (Cont.)

- ✓ The patient may limit the visiting privileges of his/her visitors, including providing for more limited visiting privileges for some visitors than those for others.
- ✓ Security measures should be developed as appropriate to the setting (such as security passes, when applicable).
- ✓ The hospital may screen visitors for weapons or other prohibited items.

Visitation: Infection Prevention

- ✓ Visitors should be encouraged through signs, hygiene stations and staff reinforcement to practice hand hygiene before and after interacting with the patient.
- ✓ Visitors should also be encouraged to use respiratory etiquette with tissue technique to cover coughs and sneezes.
- ✓ Visitors with obvious signs of infection or communicable disease should be asked to leave or wait in a non-patient area.
- ✓ Visitors shall observe any posted isolation precautions.

Visitation: Infection Prevention

- Visitation may be limited or paused by leadership for the following areas:
  - ✓ *Inpatient visitation*
  - ✓ *Ambulatory visits*
  - ✓ *Emergency Department*
  - ✓ *Surgical and Procedural*
  - ✓ *CTU*
- Exceptions will be made by leadership at each facility on a case-by-case basis
- Please visit UHealth SharePoint page for the most up-to-date visitation policy and exception criteria

Visitation: During Pandemic - Grievances

If any patient of the Hospital believes that his or her patient visitation rights have been violated, they may file a complaint using the Hospital's internal grievance system by emailing the heretohelp@med.miami.edu

UNIVERSITY OF MIAMI HOSPITAL AND CLINICS

Thank You

UNIVERSITY OF MIAMI HOSPITAL AND CLINICS