



FAIRVIEW PARK

HOSPITAL

**CONTRACT/TRAVELER
ORIENTATION MANUAL**

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Welcome to Fairview Park Hospital!

We look forward to working with you as a partner in your professional experience. We strive to provide high quality, patient centered care for each of our patients. Our mission statement is based upon a core set of values & standards which allow us to provide the best patient experience.

This manual contains the information you will need to complete your orientation. Please follow the steps below to complete your orientation experience prior to working at our facility.

- 1. Read the contents of this manual. It provides valuable information to help you care for patients according to Fairview Park Hospital policy & procedure.**
- 2. Save or print a copy of this manual for future reference.**
- 3. Print a copy of the Orientation Exams. Complete the exams using the answer sheet located at the end of this orientation manual. Return the completed Orientation Exams to Keri Justice, Director of Education.**
- 4. Passing test score is 80%.**
- 5. A physical orientation to your assigned unit will be conducted on your first day of staffing.**

Mission

Our mission is to treat our communities as family and meet their health needs by providing compassionate, quality CARE.

Vision

Our vision is to be the provider of choice for comprehensive healthcare services to all Central Georgia.

Values

Integrity

Ethical Behavior
Honesty

Competence

Safe Environment
Appropriate Skill Levels

Accountability

Stewardship
Efficient & Effective Processes
Doing the Right Thing Right

Respect

Diversity
Compassion
Treat others properly

Excellence “in all we do”

Passion
Positive Attitude

Location of Hospital Manuals (Policies & Procedures)

- 1. Clinical Manual-Hospital Intranet**
- 2. Emergency Preparedness-Hospital Intranet**
- 3. MSDS (Material Safety Data Sheets)-Hospital Intranet, HazSoft link at bottom of the page**
- 4. Infection Control-Hospital Intranet, link on left toolbar**
- 5. Nursing Policy & Procedures-View the Lippincott Online Nursing Skills & Procedures link on Hospital Intranet; for hospital specific policies and procedures, view the Nursing P & P Library in Meditech**
- 6. Up to Date-Hospital Intranet, contains information about evidence-based practice and patient education tools**
- 7. Clinical Pharmacology-link on Hospital Intranet, can be used to research drug information and provide patient drug education**
- 8. Environment of Care Manual (EOC)-Hospital Intranet, contains policies and procedures for hospital codes and Emergency Preparedness**
- 9. Georgia Diet Practice Manual-Hospital Intranet**
- 10. Daily Call Sheet-Hospital Intranet, link on left toolbar, shows what physicians are on call/contact information**
- 11. Healthstream-Hospital Intranet, link at bottom of page, contains online education (assigned and elective classes)**
- 12. Lab Manual-Hardcopy manual on all units**

Chain of Command

Fairview Park Hospital Dublin, Georgia	Department: All Departments	
	Standard:	
	Reviewed: 4/87, 5/90, 3/93, 6/96, 3/99, 7/01, 2/02	Revised: 7/1/01, 4/12/07
Title: Administrative Chain of Command	Approved By:	Date Approved: 7/1/01
Page: 1 of 1	Original Effective Date: 4/87	

POLICY:

The fundamental organizational reporting mechanisms of Fairview Park Hospital are depicted in the chart on the following page. Amplification of this basic structure is provided in departmental manuals.

Routinely, all employees are expected to report through established supervisory channels in all but the most exceptional situations. In cases of grave emergency, serious personal conflict, highly confidential information, etc., the employees should exercise his best judgment; and, if necessary, respond with direct contact to Administration.

In the absence of the CEO, the following chain of command shall exist:

1. Chief Financial Officer
2. Chief Nursing Officer
3. Chief Operating Officer
4. Controller
6. Department Heads (according to length of services with the Hospital)

Identification of Patients

1. All patients shall have an identification armband applied on admission. Information on the patient's armband may be used as a means of identifying the patient. When placing the armband on the patient, use two identifiers and ask the patient to verify that the information on the armband is correct for their identification.

2. The armband shall be checked before any treatment or medication. If the armband is used as the sole means of identifying the patient (i.e., unconscious patient), two identifying pieces of information from the armband must be matched, (e.g., the patient's lab requisition form, eMAR record, physician's order, etc.)

3. The armband shall not be removed unless the patient's welfare necessitates such removal.

4. If an armband is removed or comes off, another armband should be obtained and applied immediately.

5. Except in emergency, no procedure is to be done when the patient's identity cannot be verified by armband.

6. Newborn Patients:

A. An identification band is placed on the infant's arm, leg, and mother's arm in the delivery room. All three bands contain the same information (name and sex of child, date and time of delivery, doctor, and pediatrician).

B. On admission to the nursery, the nursery nurse and the nurse who brings the baby from Labor and Delivery will verify that the information on the Hollister Identification Record matches the information on both baby bracelets.

C. At the time of discharge, the mother verifies the infant's identity using the bands. After ascertaining the identity of the infant, the mother signs she has verified the infant's identity and one band is removed and affixed to the infant's medical record.

7. Allergic Arm Bands:

A. A red armband will be available to all patients with allergies.

B. This distinct color will alert all personnel to be cautious regarding any conflict of treatment and any possible allergic condition.

8. Blood Identification Band:

A. Blood ID bands are applied by laboratory personnel when the first cross match is drawn.

B. The Blood ID band is to remain on the patient at all times for crosschecking identification number on unit of blood.

9. ALWAYS USE TWO IDENTIFIERS TO IDENTIFY A PATIENT.

- a. patient name
- b. date of birth
- c. scanned armband with eMAR
- d. medical record number

DO NOT USE THE ROOM NUMBER AS A METHOD OF IDENTIFICATION!!

Abbreviations

Policy: to maintain a list of common abbreviations for reference

A list of common abbreviations used at Fairview Park Hospital will be maintained for reference in the Meditech library.

In order to increase patient safety, a list of DO NOT USE ABBREVIATIONS has been developed. This list is referenced in the policy: National Patient Safety Goals (NPSG): Abbreviations, Acronyms, & Prohibited Symbols located in the Clinical Manual.

Do Not Use Abbreviations

Do Not Use

U
IU
MS
MGSO₄
MS O₄
.1 (lack of leading zero)
1.0 (do not use trailing zero)
Q.D.
Q.O.D.

0.1

Use

Unit
International Unit
Magnesium
Sulfate
Morphine Sulfate
1
Daily
Every other day

MEDICATION ADMINISTRATION

Administration of Medications

Medications are administered to patients only upon an order from a physician who is a member of the Medical Staff. They may be administered by Physicians, Registered Nurses, Licensed Practical Nurses, and student nurses from affiliated schools of nursing under the supervision of their instructors. Radiology techs may administer contrast media. Nuclear medicine tech may administer radioactive contrast media.

Please refer to the Clinical Manual on the Hospital Intranet for policies related to Medication Management and medication administration.

Medications are expected to be administered utilizing the six rights of administration including:

- Right Patient
- Right Drug
- Right Dose
- Right Time
- Right Route
- Right documentation

Medication administration is documented utilizing the hospital eMAR system. All employees are expected to utilize scanning procedures including scanning of the patient armband and scanning of medications within the eMAR system.

Medication Errors: All medication errors including missed doses are to be reported in a Notification form. If you require assistance with completing this form, notify the charge nurse immediately.

Multi-dose Vials:

Use single dose vials for parenteral additives or medications whenever possible. Single dose vials are considered expired after one use and should be discarded.

Multi-dose vials expire 28 days after opening the vial. When opening a new multi-dose vial, it should be dated with the date 28 days from the date of opening to signify the expiration date. Multi dose vials that are found opened and undated should be discarded.

Controlled Substances & Blood Administration

CONTROLLED SUBSTANCE INSERVICE

PROOF OF USE OF CONTROLLED DRUGS

The following rules and regulations of the state of Georgia apply to proof of use of controlled substances. The items listed below are the minimum requirements for documenting controlled substances on proof of use forms.

1. Name of drug, strength, and dosage form.
2. Dose.
3. Name of ordering physician. This shall include, at a minimum, the initial and last name.
4. Given and last name of patient.
5. Date and time of administration to patient.
6. Signature of individual administering, which shall include at a minimum, the initial, last name, and title.
7. Documentation of destruction of all unused portions by two signature verifications.
8. Proof of receipt of medications that bears identifying serial numbers.
9. Date medication was issued and the date that the proof of use form was returned.
10. Any time a count is done, 2 signatures and the time are required.
11. Final count must be on narcotic sheet then transferred to a new sheet. Two signatures are required and should accompany the final count and the transferred count.

RULES OF WASTING CII. AND CIII THRU CV

1. The wasting rules are the same for all schedules for nurses on both oral and parenteral drugs. One nurse signs for administering the dose that is given and a second nurse also signs the same line to witness the destruction of the left over drug.
2. There is no provision for nurses to waste full doses of any scheduled drug.
3. Full, unusable doses of parenteral controlled substances (in any schedule) can be wasted by one pharmacist and two other witnesses. Scenario is the dropped and broken ampule.
4. Full doses of CII oral medications cannot be wasted by nursing or pharmacy.
5. Nurses can waste parts of CII tablets (say giving half of a percocet-5 tablet) in the same manner as parenterals. One nurse signs for administering the dose that is given and second nurse also signs the same line to witness the destruction of the leftover drug.
6. WHAT HAPPENS WHEN THE NURSE HAS ALREADY CRUSHED THE TABLET, PLACED IT IN APPLESAUCE AND THEN THE PATIENT REFUSES THE DOSE? HOW DO YOU DOCUMENT WASTAGE? It should be returned to the pharmacy and held for destruction by a drug inspector. The nurse signs on the sheet for preparation of the dose and the pharmacist signs for receiving the dose into the pharmacy. The quantity is deducted from the nursing floor stock at that time. If a dose is wasted in the bed or sheets, a nurse and witness must sign the narcotic sheet and fill out a notification form.
7. Pharmacists are not allowed to destroy oral controlled substances under any circumstances.

Jan-02

Procedure to Return **Full unusable** injectable or **Whole** Tablets to the Pharmacy for Waste/Destruction

To return a dose of a controlled substance to the pharmacy for waste/destruction, complete the following steps:

- ⇒ Sign the dose back in on the narcotic sheet, place the patient's name to whom the drug was signed out originally and "HOLD FOR RX" in the patient column
- ⇒ Add the dose back to the inventory count so that all doses, usable or **unusable** will be accounted for
- ⇒ Fill out the Narcotic Return Slip
- ⇒ Sign out the "Tamper Evident Plastic Bag" on the sign out form (Be aware that each bag is numbered and match the number of the bag to the number on the form)
- ⇒ Place the dose to be returned and the Narcotic Return Slip in the "tamper evident bag" (Remove adhesive strip and fold over bag to seal)
- ⇒ Place in the narcotic cabinet until picked up by pharmacy personnel

NARCOTIC RETURN SLIP

(Place inside with medication being returned)

BAG # _____

Date: _____

Patient Name: _____

Drug Name: _____

Qty: _____

Reason for return: _____

Signature: _____ LPN/RN

BLOOD ADMINISTRATION

Policy Statement:

This procedure is implemented to establish guidelines for administration of blood and blood components (except albumin) using universal precautions.

Procedure:

Prior to the transfusion:

1. There must be a written order on the patient's chart for a type and cross match and administration of blood or an order for components. A signed consent is necessary.* The "Blood Administration Education" letter addresses commonly asked questions regarding transfusions of blood or blood products and is given to the patient before the consent is signed. Two types of informed consent are available -- Inpatient and Outpatient. Inpatient consents are valid for the current admission; **outpatient consents are valid for 12 months. If a patient refuses to accept a blood transfusion, have the patient sign "Release of Responsibility Form" and notify the physician.

*If no one is available to sign a Blood Consent, a telephone consent with two people listening can be obtained. In an emergency situation, the physician will make the call to proceed with the administration of blood and document in the progress notes.

**Keep a copy of the signed outpatient blood consent forms in a folder on the nursing unit. It will be available for review, copy and placement on the Medical Record with each encounter.

2. Notify the physician if the patient has a temperature of 101o F or above prior to starting the infusion.

3. Enter order for blood/components in CPCS order entry.

4. Lab Tech will apply blood bracelet before drawing blood for type and crossmatch.

5. A patent I.V. with a #18 or #20 gauge catheter and Normal Saline with Blood Y-Set will be present prior to obtaining blood from the Blood Bank. While a larger gauge catheter is preferred, a #22 gauge catheter is acceptable for use with pediatric patients.

6. Blood products, with the exception of platelets and thawed

cryoprecipitate, should be stored in a regulated, monitored blood bank refrigerator until immediately before transfusion. Never store blood on the unit.

7. When ready for the unit, go to the Blood Bank and have the patient's name. No paperwork is needed. Verification of donor unit, blood component, and intended patient identification is performed by blood bank personnel and the licensed nurse obtaining the unit from the blood bank. Verification of donor unit-recipient identity must be completed and documented on the Blood Requisition Form by two authorized individuals (RN/LPN) prior to each blood unit infusion. The Blood Bank retains a copy of the Transfusion Record for their records.

8. Immediately prior to transfusion, the unit is again checked.
- a. Identify the patient recipient by matching the full name and hospital number as it appears on the patient identification bracelet with the same information recorded on the blood requisition form and the blood container.
 - b. Match the blood unit with the accompanying blood requisition form. The donor unit number, ABO Group, and Rh type must be identical on both the blood container and the blood requisition form. Any apparent discrepancy must be resolved and documented in consultation with the Blood Bank prior to the infusion of blood.

Errors associated with identification of crossmatch specimens and donor unit-recipient identity account for the majority of serious immediate transfusion reactions and must be avoided.

9. Two RN's or an RN and LPN must check the blood donor number, type, expiration date, patient name, and hospital number to assure accuracy. Only an RN may hang/start blood. The Blood Bank tape ID number must be checked against the Blood Bank ID bracelet, also.

Administration

1. All blood and blood components must be transfused through a blood filter tubing. Only an RN may start the blood/blood components with a physician order.

2. Vital signs will be checked prior to administration; every 15 minutes times two and then every 30 minutes thereafter. Vital signs are checked one hour after the infusion has ended. These will be recorded in the CPCS intervention Vital Signs. This is done for each unit of blood administered.

3. Rate of infusion:

- a. The rate of infusion depends upon the clinical condition of the patient and the product being transfused.
- b. Patients who are not in congestive heart failure or in danger from fluid overload tolerate the infusion of a unit of whole blood or packed cells in 1.5 to 2 hours.

Discontinuation of blood

Blood is discontinued after the infusion is complete or in the event of a blood reaction.

Completed unit

1. Open clamp on Normal Saline to flush tubing. Remove empty blood bag, and attach cord clamp to opened port. Complete attached blood slip and place chart copy on patient record.

2. Dispose blood bag and tubing.

3. The Blood Identification slip (attached to each unit of blood or component) is to be filled out completely. After the infusion of each unit, complete the canned text "BLOODADMIN" in CPCS Patient Care Notes. Place original Transfusion Requisition on Lab sheet in chart when transfusion is completed.

Discontinuation before complete infusion of unit

1. Close the clamp on the blood set at its most distal end. Do not flush tubing.

2. Disconnect the unit and tubing from the primary I.V. set or INT.

3. In case of suspected transfusion reaction, the blood and tubing must be returned to the Blood Bank in Ziplock bag. The reason for the incomplete transfusion must be documented.

Additional Units to Follow

According to the American Association of Blood Banks (AABC) a blood set can be:

*used for the administration of 2-4 units of blood or;

*4 hours, whichever is less.

Notes:

1. Never add any type of medication to any unit of blood.

2. Blood units should not be warmed except by mechanisms approved by Fairview Park Hospital Blood Utilization Committee. The infusion of warm blood may be indicated in massive transfusions when the infusion rate exceeds 50 cc/min., occasionally in exchange transfusion of the newborn and when the recipient has a potent cold agglutinin. (See "Blood/Fluid Warmer Procedure" and "Cold Auto-Agglutinins".)

3. In the event the unit of blood is not immediately infused, it must be returned to the Blood Bank, no more than 30 minutes after obtained from the Blood Bank.

4. Whole blood is very seldom used. Packed cells have replaced whole blood according to the American Red Cross.

5. Only use Normal Saline solution in conjunction with blood.

6. Do not use medication piggyback with blood.

Approved by Larry Polk, MT (ASCP), MBA, Laboratory Manager, May 1, 2002

For additional information, refer to NURSING PROCEDURES --FOURTH EDITION, pg. 327-332 and the Lab Reference Manual.

revised: 1/93, 4/98, 5/02, 04/05 NPROC:0055B

Reviewed: 4/99, 3/02

****Fairview Park Hospital has integrated the use of the BCTA (Bar Code enabled Transfusion Administration) system into the blood administration process. JCAHO recognizes the use of BCTA as a means of using two licensed personnel to check blood products. If you are not familiar to BCTA, you will receive training regarding this system during your unit orientation.

Medication Reconciliation

PURPOSE: To outline the processes that ensures accurate and complete reconciliation of medications across the continuum of care at Fairview Park Hospital.

POLICY:

Definitions

Reconciliation: Medication reconciliation is the process of creating the most accurate list of all medications a patient is taking. When possible, information gathered should include drug name, dosage, frequency, and route. The process will be comparing that list against the physician's admission, transfer and/or discharge orders.

Medications: defined by the FDA as:

- Prescription medications
- Sample medications
- Vitamins
- Nutraceuticals
- Over-the-counter drugs
- Vaccines
- Diagnostic and contrast agents
- Radioactive medications
- Respiratory therapy-related medications
- Parenteral nutrition
- Blood derivatives
- Intravenous solutions (plain or with additives)
- Any product designated by the FDA as a drug

**does not include enteral nutrition solutions, which are considered food products, oxygen or other medical gases*

GENERAL INFORMATION:

1. The process for obtaining the current list of medications involves the patient and includes a comparison of the medications provided by the facility and those on the patient's list.

ADMISSION/POE RECONCILIATION:

1. A complete list of the patient's current medications (Admission Order Form:

Attachment

A) will be obtained and documented/ entered into Meditech in the Nursing Assessment module under medication history.

a. The medication history includes the name of medications, remedies, and herbal

products and their dosage, frequency, route, time of last dose and an assessment of patient. Pharmacists will review list and notify nursing for clarification of any incomplete information.

b. A report "Current Patients' Med Recon Report" will print a each patient care area nursing station that provides a list of patients' home meds that are either incomplete on missing information.. The report states "No Documentation entered or "Documentation not complete". The patient's assigned nurse will follow steps in C1 below to obtain more complete information.

c. If patient is taking no medications, the nurse will note this on the home medication list by documenting "None".

d. The patient's current "home" list will include any herbals, OTC, and/or cultural practices that might impact pharmacological efficacy and efficiency.

1) In the event a patient is unable to participate in the medication reconciliation process, every attempt will be made to complete the process by using other resources of information (e.g., patient's family pharmacy, medication bottles, physician, or previous medical records).

2) Information not available at the time of admission should be collected within 24-hours where possible.

2. The **Patient's Meds From Home List** (Sample **Attachment A**) will be placed on the chart on top of the most current physician order sheet for the physician to review and either re-order or discontinue.

3. The physician should document that the list has been reviewed on the form or on the admission orders. The physician has the option to write any continuation of home medications or use the form.

4. When the "The Patient's Meds From Home Form" is used to reorder home medications, it will be faxed/scanned to the Pharmacy for final reconciliation.

a. Pharmacy will review the admission orders, enter them into the Meditech Pharmacy Module, and reconcile them with the patients' current medications.

5. Emergent/Urgent Admission/Entry Situations

a. In urgent situations or when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status immediate care takes precedence.

b. At the point when the patient is stabilized, the reconciliation process will be implemented.

c. Documentation in the medical record should reflect an emergent/urgent situation.

6. Outpatient Treatment Areas- These areas are described as Special Procedure Diagnostics(CT, MRI), Pulmonary Function (Respiratory Therapy Department), Stress Testing unit, Same Day Surgery and any other area that would administer medications prior to or during a procedure. A list of home medication will be taken and provided to the Pharmacy for review against medications ordered.

The pharmacist will review the home medication of appropriateness, planned treatments, allergies, duplications and drug interactions.

The department will be notified if/when any clinical issues are detected.

TRANSFER TO ANOTHER CARE GIVER

1. The patient's accurate medication reconciliation will be communicated to the next provider, whether another setting, service, practitioner, or level of care, whether inside or outside Fairview Park Hospital.
2. To assist with this process and eliminate transcription errors, a Meditech Transfer Form will be generated for the physician to review. The Transfer Order Form lists all active medications. (**Attachment B**)
3. The transferring physician will review the **Transfer Order Form** and indicate which medications are to be continued or discontinued. (**Attachment B**)
4. Pharmacy will reconcile existing orders with transfer orders and make changes accordingly in the Meditech Pharmacy Module.

RECONCILING MEDICATIONS UPON DISCHARGE

1. Discharges from Inpatient status-

A Discharge Medication List is printed and available to the physician for review when the decision is made to discharge a patient from Fairview Park Hospital. This list will include a list of current medications as well as the list of home medications taken upon admission.

The discharge medication list will be reviewed against discharge prescriptions upon discharge.

If a medication the patient has been taking at home is not addressed or is not discontinued, nursing will contact the patient's physician to verify whether or not the patient should continue use of the medication.

Prior to discharge, the nurse will provide the Discharge Medication List to the patient along with discharge prescriptions

A copy will be forwarded to the next provider of care either electronically via PCI or faxed if the follow-up physician's office is out of town. A copy will be maintained in the chart.

2. Discharges from the Emergency Department-

Physician/LIP will reconcile home medications list against discharge prescriptions and document on T-chart that this process has occurred.

Nurse will review discharge prescriptions with patient and provide a list that contains the patients' current medications and the discharge medications.

A copy will be forwarded to the next provider of care either electronically via PCI or faxed if the follow-up physician's office is out of town. A copy will be maintained in the chart.

2. Discharges from Same Day Surgery- Discharging nurse will reconcile discharge prescriptions against home medication list upon patient discharge.

Nurse will review discharge prescriptions with patient and provide a list that contains the patients' current medications and the discharge medications.

A copy will be forwarded to the next provider of care either electronically via PCI or faxed if the follow-up physician's office is out of town.

A copy will be maintained in the chart.

**CORE
MEASURES
2012**

What are Core Measures?

- Standardized evidence based performance measures.
- Focus is on actual results or outcomes rather than processes of care.

What Do Core Measures Mean to Me?

- Core Measures reflect the quality and standard of care provided by our hospital.
- Noncompliance reflects substandard care and can affect our accreditation & reimbursement.

Who Uses Core Measures?

- The Joint Commission for accreditation
- Medicare for reimbursement
- Consumers for comparison of different hospitals and services

Inpatient Measures

- Acute Myocardial Infarction (AMI)
- Heart Failure (HF)
- Pneumonia (PN or CAP)
- Surgical Care Improvement Project (SCIP)
- Perinatal Care (PC)
- Venous Thromboembolism (VTE)
- Immunization (IMM)
- ED Throughput

**Acute Myocardial Infarction
(AMI)**

- THE CLOCK IS TICKING!!!
10 minutes door to ECG
- AMI Care Quality Measures

Aspirin at arrival

ALL ED Patients ***Must*** Receive Prior to Transfer to IP Unit

AMI patients without aspirin contraindications receive aspirin within 24 hours before or after hospital arrival.

- AMI Care (cont.)

ED Patients

DO NOT Accept Transfer to IP Unit until it is verified that Aspirin has been given or there is a contraindication!!!!

- Primary Percutaneous Coronary Intervention (PCI) ***within 90 minutes of arrival.***

Door to Ballon (DTB) ≤ 90 min.

- Thrombolytic Medication ***within 30 minutes of arrival.***

Door to Needle (DTN) ≤ 30 min.

- AMI Care (cont.)
- Assessment of Left Ventricular Function (LVF)- Documentation in the chart/record that LVF was assessed before or during hospitalization.
- ACEI or ARB for Left Ventricular Systolic Dysfunction (LVSD)- Patients without contraindications are prescribed an ACEI or ARB at discharge. *LVSD is defined as left ventricular ejection fraction (EF) < 40%.*
- Beta Blocker at discharge AMI patients without Beta Blocker contraindications are prescribed a beta blocker at hospital discharge.
- Adult Smoking Cessation AMI patients with a history of smoking cigarettes are given smoking cessation advice or counseling during their hospital stay.

- **Aspirin at discharge** AMI patients without aspirin contraindications are prescribed aspirin at discharge
- **Statin at discharge** AMI patients without contraindications are prescribed a statin at hospital discharge

**Heart Failure
(HF)**

Heart Failure Quality Measures

Includes anyone who has ever had a diagnosis HF!

- **Assessment of Left Ventricular Function (LVF)**- Documentation in the chart/record that LVF was assessed before or during hospitalization.
- **ACEI or ARB for Left Ventricular Systolic Dysfunction (LVSD).**- Patients without contraindications are prescribed an ACEI or ARB at discharge. *LVSD is defined as left ventricular ejection fraction (EF) < 40%.*

Discharge instructions for Heart Failure must include all of the following:

- Activity level
- Diet
- Discharge medications
- Follow up appointment
- Weight monitoring
- What to do if symptoms worsen

Pneumonia

- **Pneumonia Care Quality Measures**
- Initial antibiotics *given within four hours* of admission.
- Use of the most appropriate initial antibiotic.
- Blood culture performed *prior to first antibiotic dose* given in hospital.
- Pneumonia Care (cont.)

ED Patients

DO NOT Accept Transfer to IP Unit until verification that blood cultures have been collected and antibiotics are started!!!!

- Pneumonia Care (cont.)

Direct Admit

Collect blood cultures STAT!

Give first antibiotic within 4 hours from the time of arrival!

**Surgical Care Improvement Project
(SCIP)**

- The goal of SCIP is to reduce the incidence of surgical complications.
- Surgical Care Improvement Project Quality Measures
- B-blocker during the perioperative period
- *Prophylactic* antibiotics are given within one hour before incision.
- *Prophylactic* antibiotics are stopped within 24 hours of surgery end.
- Recommended Venous Thromboembolism (VTE) Prophylaxis
- Perioperative temperature management
- Hair removal: *Clippers ONLY; never use a razor!!!!*
- *Urinary catheter is removed on POD #1 or POD #2*
- Perinatal Care (PC) Measures

Mother and Baby

- Perinatal Care (PC) Measures
- Patients at risk of preterm delivery at 24-32 weeks gestation receive antenatal steroids prior to delivering preterm newborns.
- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.

- Elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks gestation.
- Exclusive breast milk feeding during the newborn's entire hospitalization.
- Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns.

Immunizations

**Adults
and
Children**

- *Influenza & Pneumococcal*
VACCINATION
- Screen *ALL* In-Patients
- Implement Approved Protocols
- Administer & Document
- Provide Patient with Appropriate Vaccine Information Sheet (VIS)
- Follow-Up / Complete Documentation Prior to Discharge
- VIS (Vaccine information sheet)

Outpatient Measures

- Acute Myocardial Infarction (AMI)
- Surgical Care Improvement Project (SCIP)
- Stroke
- Pain Management
- ED Throughput / Transition Records

Help!

- *Tools & Resources*
- Checklists
- Nurse Driven Protocols
- Measure Specific Order Sets
- Progress Notes
- Core Measure Notebooks
- Intranet Page

Public Reporting

Hospital Compare

A quality tool provided by Medicare

- **What Can I Do To Help?**
- Be aware of initiatives and evidence based practice
- Make core measures a part everyday practice
- Provide patient education
- **DOCUMENT!!!!!!!!!!**
- *Remember!*

Core Measures are an indicator of the Quality of Care WE provide to our patients!!!!!!

CORE MEASURE PATIENT CHECKLIST

****Return forms to Nurse Manager when complete – Do Not Send to HIM!!!!****

NOT PART OF THE PERMANENT RECORD!

All patients regardless of admitting diagnosis or status are to be evaluated for core measure compliance! Measures include AML, Chest Pain, HF, HF History, PN and Stroke.

AMI/CP/ACS:

- Aspirin received during first 24 hours of admission Initial _____
- _____ LVF Assessment by MD Initial _____
- ACE or ARB prescribed at discharge (If EF documented < 40%) Initial _____
- _____ Aspirin prescribed at discharge Initial _____
- _____ Beta-blocker prescribed at discharge Initial _____
- _____ Statin prescribed at discharge Initial _____

PNEUMONIA:

- Blood cultures drawn Initial _____
- _____ First antibiotic given within 4 hours Initial _____

HEART FAILURE:

- LVF has been assessed Initial _____
- _____ LVF findings documented by physician Initial _____
- ACE or ARB prescribed at discharge (If EF documented < 40%) Initial _____

STROKE:

- Statin Prescribed at discharge Initial _____
- _____/____ VTE prophylaxis started by end of ***calendar*** day #2 Initial _____
- _____ PT/OT/Speech or Rehab referral completed Initial _____
- _____ Antithrombotic prescribed by end of ***calendar*** day #2 Initial _____
- _____ Antithrombotic prescribed at discharge Initial _____
- _____/____ Coumadin or Lovenox prescribed at discharge in patients with Atrial Fib/Flutter Initial _____
- _____ Stroke Education complete Initial _____

IMMUNIZATIONS:

APPLYS TO ALL PATIENTS – ADULTS & CHILDREN

- _____ Pneumococcal vaccine status assessed/documentated/administered (year round) Initial _____

- Seasonal Flu vaccine status assessed/documented/administered (Sept-March) Initial

MANDATORY 2 TIER REVIEW PRIOR TO DISCHARGE

- Follow-up appointment/diet/activity level documented Initials
_____/_____
- Accurate medication reconciliation Initials
_____/_____
- Vaccines documented/administered Initials
_____/_____
- EF documented if AMI or HF patient (*can be found from any record source, e.g. MD note, ECHO, Cath Report, NMST - PLACE CURRENT VISIT PT. STICKER ON ALL PRINTED REPORTS!!*)
Initials ____/_____

Patient Label

Admission Date & Nurse _____	
Discharging Nurse _____	
2nd Tier D/C Nurse _____	

PATIENT RIGHTS

- Patients have the right to:
 - expect a response to any reasonable request.
 - considerate and respectful care.
 - End-of-life comfort and dignity.
 - effective pain management and to be informed about pain and pain relief measures.
 - acknowledgment of psychosocial and spiritual concerns regarding death and dying.
 - refuse treatment (to the extent permitted by law).
 - receive information about treatment and illness.
 - the name of their primary doctor and others involved in their care.
 - sufficient information needed to make an Informed consent.
 - voice concerns and be informed of the mechanism for the review and resolution of concerns regarding quality of care.
 - complain to CMS if the hospital cannot resolve their issue by contacting the state agency at 404-657-5726 or Office of Regulatory Services Healthcare Section, 2 Peachtree St., NE, 33rd Floor, Atlanta, GA 30303 or the Joint Commission’s Office of Quality at 1-800-994-6610 or emailing complaint@jcaho.org.
 - participate in the consideration of ethical issues.
 - privacy and confidential treatment.
 - access personal medical record.
 - leave the hospital, even against the advice of the physician.
 - adequate discharge instructions.
 - their bill and to receive an itemized list of charges.

PATIENT RESPONSIBILITIES

- Patients have a responsibility to:
 - provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They must report unexpected changes in their condition to the responsible practitioner. They must report whether they clearly understand a contemplated course of action, and what is expected of them.
 - follow the treatment plans recommended by their physician and other healthcare workers.
 - follow hospital rules and regulations affecting their care and conduct.
 - consider the rights of other patients and hospital personnel, and for assisting in control of noise and the number of visitors. They must respect the property of other persons and of the hospital.
 - ask/discuss what to expect regarding pain and pain management. Patients should ask for pain relief when pain first begins and should help staff members with assessing their pain and pain relief.

Note: PATIENT also refers to the patient's legal representative/durable power of attorney for healthcare.

Culture & Diversity

What is Culture?

That component of our lives including: physical attributes, diet, world-view, language, philosophy or religion.

The melting pot of America works both for and against acculturation. As new immigrants bump elbows with the "American Way", they find themselves challenged to "fit in". However, they could also band together with folks from their homelands and maintain the customs and lifestyle they used to have. These subcultures that maintain cultural differences challenge healthcare providers.

Ethnocentrism

When we view ourselves as the correct culture or 'right' way of seeing the world and see others' behavior or beliefs as weird or bizarre, we prejudice our ability to give appropriate care to our patients of other cultures. This can result in:

Misdiagnoses

Failure to treat appropriately

A feeling of frustration & isolation for patients & families

Cultural Competency

Knowledge and understanding of cultural practices in the geographical area which includes:

**Language
Family Roles
Health Behaviors
Nutrition
Childbearing Practices
Death
Spirituality**

Understanding these areas of a person’s lifestyle can enable us to be better caregivers and improve the wellness of those who come to us for healing. Fairview Park Hospital utilizes a Cultural Tool to facilitate the understanding of characteristics of various cultures. As we strive to provide “Patients First” Customer Service, and abide by the standards of our regulatory agencies, we must also be sensitive to the needs and preferences of our patients and find common ground.

Communication for our non-English speaking patients is facilitated by a telephone interpreter service through AT & T operators. This special phone is available by paging the Nursing Supervisor at any time.

Pain Assessment & Documentation

The patients’ right to pain management is respected and supported. The organization plans, supports, and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately, including but not limited to those outlined below.

- To assess and manage pain properly, the nurse should depend on the patient’s subjective description in addition to objective tools
- Pain intensity ratings are recorded during the admission assessment.
- Several interventions may be used to manage pain, including analgesics, emotional support, comfort measures, and cognitive techniques to distract the patient. Severe pain may require a narcotic analgesic.
- Narcotics and other analgesics require a physician’s order.
- Standing orders for mild analgesics may be utilized as indicated by the degree of pain a patient is experiencing. When standing orders are utilized, the nurse should write the standing order on the patient’s physician order sheet, along with the name of the physician, nurse, date and time the order was written.
- Narcotic analgesics must be administered according to hospital policy.

PROCEDURE:

I. Assessment

a. The nurse should assess the patient’s pain level by asking essential questions

and noting the response to pain. The patient should be asked to describe the duration, severity, and source of pain. Assess for physiologic or behavioral clues to the severity of the pain such as crying, moaning, grimacing, restlessness, withdrawal, insomnia, slow movement, or elevated vital signs. This should be done during every initial assessment, shift assessments, and regular reassessment of pain according to the level of pain.

b. During the initial assessment of all patients, the nurse identifies patients with pain.

c. All patients at admission are asked the following screening or general questions about the presence of pain: Do you have pain now? Have you had pain in the last several weeks or months? If the patient responds “yes” to either questions, additional assessment data are obtained about the following elements:

i. Pain intensity (show patient a Pain Scale appropriate for the patient population and ask them to rate the pain)

Adults: scales of 0 (none) to 10 (worse pain imaginable)

Pediatric: Wong Baker FACES

Newborn: Neonatal Infant Pain Scale (N.I.P.S.)

*If adults cannot understand or are unwilling to use 0-10 scale, the Wong Baker may be used.

ii. Location (ask patient to mark on a diagram or point to the site of pain (there may be more than one site)

iii. Quality, patterns of radiation, if any, character

iv. Onset, duration, variation, and patterns

v. Alleviation and aggravating factors

vi. Present pain management regimen and effectiveness

vii. Pain management history

viii. Effects of pain on daily life

ix. Patients/families pain goal

d. Medicate for pain as described by patient per physician’s order and/or utilize alternatives as appropriate (i.e., distraction, positioning, breathing techniques, etc.)

e. Document time, site, intensity per pain scale, medication administered and route.

f. Reassess every 1 hour. Document response using pain scale, if patient states no change or increase in pain, consider further action (i.e., repositioning, relaxation, technique, additional medication, or notification of physician). If patient reports decrease in pain or pain free every 1 hour, reassess as noted level intensity.

g. Patients and families receive information verbally and in a printed format at the time of initial evaluation that effective pain relief is an important part of their treatment.

h. Explain to the patient how pain medications work together with other pain management therapies to provide relief. Explain that the goal of pain management is to keep pain at a low level to permit optimal bodily function.

i. Develop appropriate nursing diagnoses, such as pain, anxiety, activity

intolerance, fear, potential for injury, knowledge deficit, powerlessness, and selfcare deficit.

- j. Work with the patient to develop and implement a nursing care plan, using interventions appropriate to the patient's lifestyle. Interventions may include prescribed medications, emotional support, comfort measures, cognitive techniques, and education about pain and its management. Emphasize the importance of good bowel habits, respiratory function, and mobility.
- k. Administer prescribed medications as indicated.
- l. Provide emotional support. Allow patient to express his anxiety and frustration.
- m. Perform comfort measures, such as repositioning, providing back massage, performing range of motion exercises, and providing oral hygiene.
- n. Use cognitive therapy techniques such as distraction, guided imagery, deep breathing, relaxation, and controlling room environment.
- o. Evaluate the patient's response to pain management. If the patient is still in pain, reassess and alter the plan of care as appropriate.
- p. Remember that patients receiving narcotic analgesics are at risk for developing tolerance, dependence, or addiction. Assess for symptoms of physical dependence.
- q. Assess for complications of adverse effects of analgesics.
- r. Document each step of the nursing process: the assessment of pain, your nursing diagnosis, implementation of pain relief methods, and the patient's response to pain management techniques.

Advance Directive

POLICY:

To provide guidelines for patients with and without Advance Directives, which may include Living Wills, Durable Power of Attorney for Healthcare, or similar documents covering the patient's preferences. This process is applied to all adult patients registered as inpatients, outpatient surgery patients, or observation patients.

PROCEDURE:

1. The Patient will:

- a. Provide a current copy of the Advance Directive to their physician and hospital staff.
- b. Alert hospital staff and the physician when Advance Directives change or are revoked.

2. Registration Will:

- a. Make the determination whether a patient has an Advance Directive or is interested in executing one.
- b. Review the Advance Directive with the patient to ensure it is current.
- c. Provide the patient with an Advance Directive brochure and inquire if the patient needs assistance with the Advance Directive.
- d. Contact the Social Services Department (extension 3108) if the patient is interested in executing an Advance Directive.
- e. If an Advance Directive is not available, secure the name and telephone number of the person handling the Advance Directive.

f. Attach a copy of the Advance Directive to the patient's medical record. If copying an Advance Directive from Fairview Park Hospital's files, this should be noted and attached to the patient's medical record.

3. Nursing Staff will:

- a. Check the Advance Directive and acknowledge the status of the patient's Advance Directive.
- b. Document attempts to contact the person holding the Advance Directive by telephone if the Advance Directive is not available. If unable to obtain the Advance Directive, the patient may verbalize treatment preferences. The patient may explain the "substance" of his or her original Advance Directive including treatment preferences, preferred surrogates, and state needs regarding the patient's wishes concerning a minimum quality of life. If a patient chooses to verbalize treatment choices, the hospital designee (nurse) documents the conversation in the patient's medical record and informs the patient's family and physician. The physician is to document in the Progress Notes the patient's intention regarding his/her care. At any point the patient may clarify, modify, or reverse the Advance Directive(s). Such conversation should be documented in the patient's medical record and the patient's physician is to be informed. It should be noted, however, that obtaining a verbal description of a written existing Advance Directive is not necessarily the same under any applicable law, as is the possession by the hospital of the actual document.
- c. Inform the physician of the patient's Advance Directive.
- d. Provide a copy of the patient's Advance Directive to any facility to which the patient is transferred.

4. The Physician will:

- a. Forward a copy of the patient's Advance Directive if available from the office when scheduling a patient's admission.
- b. Document in the Progress Notes the patient's intention regarding their care or any direction executed by the patient's surrogate so that healthcare personnel can comply with the patient's or surrogate's wishes.
- c. Write orders to accomplish the patient's Advance Directive. DNR order must be written by the physician; no verbal or phone order.
- d. If physician is unable to meet the requests of patient's Living Will or Advance Directive, physician is to seek transfer of services to a facility or physician who can.

5. Health Information Services will:

- a. Pull previous medical records and assure that any prior Advance Directives are accessible to the patient care personnel.
- b. After the patient's discharge, file the Advance Directive in the current medical record folder and place the "Advance Directives" sticker on the outside jacket.

AGE SPECIFIC CARE

INFANT- BIRTH TO ONE YEAR

TODDLER- 1-3 YEARS

PRESCHOOLER- 3-5 YEARS

SCHOOL AGE CHILD- 6-12 YEARS

ADOLESCENT 13-17 YEARS

YOUNG ADULT 18-45 YEARS

MIDDLE ADULT- 45-65 YEARS

OLDER ADULT- 65 YEARS AND OLDER

INFANT

CHARACTERISTICS

- Rapid growth & development
- Crying is communication
- Sucking shows stress and provides comfort
- Promote social interaction
- Decrease environmental stress
- Older infant will experience separation anxiety

DEVELOPMENTAL TASK

- Trust vs. Mistrust

PHYSICAL GROWTH

- 1-4 MONTHS
 - Development centers around head
 - Smile development
 - Eyes follow objects
 - Begins head control
- 4-8 MONTHS
 - Musculature of trunk develops
 - Rolls over
 - Sits without support
 - Hand grasping begins
- 8-12 MONTHS
 - Distal limbs further develop
 - Begins creeping
 - Stands
 - Walks
 - Purposeful and voluntary movement by six months
 - Birth weight doubles by 4-6 months and triples by one year

IMPLICATIONS

- Allow caregiver to remain with the child as much as possible
- Under six months try to continue the infant's normal routine
- Determine cause for crying instead of simply quieting the infant
- Decrease stress in environment- hold snugly, give pacifier, feed
- Space procedures to allow sucking for comfort
- Feed infant on demand rather than waking to feed
- Use as many observational methods of assessment during sleep
- Encourage toys brought from home- provide colorful toys
- Signs of overstimulation in infant- closing eyes, turning away, increased formation of stool, hiccupping, increased motor activity, hyperalertness

TODDLER

CHARACTERISTICS

- Separation anxiety increases
- Does not understand reason for hospitalization
- Rapid psychosocial growth
- Crying is still a method of communication
- Does have use of a few words
- Comprehends much more than verbal capacity
- Likes control over his/her environment
- Usually the toddler is highly mobile
- Play decreases the toddler's stress
- Learning occurs through play

DEVELOPMENTAL TASK

- AUTONOMY VS SHAME AND DOUBT

PHYSICAL GROWTH

- CYLINDRICAL CHEST DEVELOPS
- PROTRUDING ABDOMEN DUE TO EXTRA SUBCUTANEOUS FAT
- DIAPHRAGMATIC BREATHING IS PRESENT
- HEART SIZE INCREASES
- 60% OF TOTAL BODY WEIGHT IS FLUID
- DECREASED FOOD INTAKE FROM INFANCY

IMPLICATONS

- Allow caregiver to remain with the child as much as possible
- Allow the toddler to "help" with procedures such as removing their dressing or gown
- Provide toys including objects of the hospital environment for creative/imaginative play
- Speak and play with the toddler to reduce stress
- Allow mobility and control by restraining only those extremities directly involved in fluid administration
- In young toddlers, the nurse can place a mitt on the child's hand to prevent the child from grabbing the IV line
- Toddlers react to procedures with resistance.
- The toddler has little concept of danger- increased risk of falls, burns, foreign body aspiration, poisoning, suffocation
- Fluid volume deficit can occur quickly

PRESCHOOLER

CHARACTERISTICS

- May see hospitalization as punishment
- Pain is perceived as punishment
- Preschoolers have many fears that increase stress
 - Separation
 - Abandonment
 - Body mutilation
 - Dark
 - pain
- Attention span is short- give short and simple explanations
- Preschoolers are very imaginative
- Have difficulty distinguishing fantasy and reality
- Death is seen as reversible

DEVELOPMENTAL TASK

- Initiative vs. Guilt

PHYSICAL GROWTH

- Begins to develop fine motor skills
 - Ties shoes
 - Rides two wheel bike
- Large muscle coordination remains far advanced of small muscles
- Develops right or left orientation at 4 years
- At 4 years, shows independent toileting habits
- Posture is more erect
- Older preschoolers may lose baby teeth

IMPLICATIONS

- Allow parents to remain with child as much as possible
- Reassure often that procedure is not punishment
- Whenever possible, allow one nurse to develop a trusting relationship with child and parent
- Encourage use of comforting objects such as a blanket or favorite toy
- Use bandaids to “plug up holes”
- Use toys and replicas of medical equipment with explanations
- Older preschooler prints first name and draws recognizable representations
- Keep explanations short, simple, and logical
- Explain to the child how she can “help”
- Set limits during procedures
- Increased risk of drowning and burns
- Normal heart rate 80-100
- Normal respiratory rate 22-34

SCHOOL AGE CHILD

CHARACTERISTICS

- Strong sense of right and wrong
- Fears include
 - Separation, school failure, disability, death, forced dependency
 - Bodily injury, invasive procedures of the genital area, pain
- Understands cause and effect
- Perceives past and future
- Can deal with several concepts in sequence
- Stress is shown by
 - Regression, anxiety, withdrawal, depression, increased dependency
- Works on building self-esteem

DEVELOPMENTAL TASK

- INDUSTRY VS INFERIORITY

PHYSICAL GROWTH

- SECONDARY SEX CHARACTERISTICS BEGIN
- GRACEFUL AND COORDINATED MOVEMENTS PRESENT
- HAND EYE COORDINATION IS WELL ESTABLISHED
- MOST PLAY IS ACTIVE
- ERUPTION OF PERMANENT TEETH BY AGE 12
- BONES LENGTHEN AND BECOME HARDER
- AVERAGE WEIGHT FOR SIX YEAR OLD BOY IS 48 POUNDS
- AVERAGE HEIGHT FOR SIX YEAR OLD BOY IS 46 INCHES
- HEIGHT INCREASES ABOUT 2 INCHES PER YEAR
- WEIGHT INCREASES ABOUT 7 POUNDS PER YEAR

IMPLICATIONS

- Allow for privacy as much as possible
- Explain to child how he may "help" with activities
- Begin preparation for procedure as soon as possible
- Allow parents and peers to visit as much as possible
- Explain if procedure will hurt, its purpose, how it will make them better and what injury could result
- The school age child believes others die, but not self
- Descriptions may be exaggerated because of stress and heightened fear
- Be aware of nonverbal requests for support
- By age 9, the child can understand simple anatomy and body functions
- Normal heart rate 75-100
- Normal respiratory rate 18-30
- Normal blood pressure 84-120/54-80

ADOLESCENT

CHARACTERISTICS

- Mature level of reasoning
- Understand concept of time as an adult
- Draw inferences and demonstrate problem solving skills
- Fears include
 - Losing control, losing independence
 - Changes in physical appearance
- Are often scared but do not want to show it
- Stress is manifested by
 - Aggression, irrational behavior
 - Fear, rebellion
- Aware death can happen to them

DEVELOPMENTAL TASK

- IDENTITY VS FRUSTRATION

PHYSICAL GROWTH

- Second major growth spurt occurs
- Sexual maturation occurs
- Puberty in female begins between age 10-14
- Puberty in male begins between age 12-16
- Frequent health problems of the adolescent
 - Teen pregnancy, acne, postural defects, fatigue, anemia, respiratory infections, mononucleosis, suicide, alcohol/drug abuse,STD

IMPLICATIONS

- Do not talk down to the individual
- Teach away from peers, roommates, and parents
- Use proper medical terms
- Encourage visits from family
- If a favorite nurse is identified, nursing assignments should reflect this preference
- Respect privacy
- Normal heart rate 60-90
- Normal respiratory rate 12-16
- Normal BP 94-140/62-88

MIDDLE AGE ADULT

CHARACTERISTICS

- Typically more settled than the younger adult
- More financially sound than younger adult
- Increased awareness of losing youthfulness, vitality, their partner's love
- Widowhood is more likely to occur in this stage

DEVELOPMENTAL TASK

GENERAL ACTIVITY VS STAGNATION

PHYSICAL GROWTH

- May see
- Menopause occurs in females
- In the 50s may see a reduction in male potency
- Decalcification of the bones begins to occur
- Basal metabolic rate decreases by 30%
- May see diminished vision
- Decreased elasticity of blood vessels
- May see loss of bladder tone

IMPLICATIONS

- Help maintain intact body images
- Obtain resources to help adapt/accept any loss of function or disability
- Explain procedures and plan of care
- Dependency conflicts are manifested by:
 - Asking for favors
 - Trying hard to please
 - Demanding care
 - Refusing needed assistance
- Support family members who are supporting the patient
- Make sure any prosthetics are available such as glasses, hearing aid, dentures
- Increased risk of cardiovascular disease and hypertension

OLDER ADULT

CHARACTERISTICS

- At the turn of the century, aging was not recognized as a problem
- Today, because of the number of older citizens, the perception toward this group has turned negative.
- Retirement age is expanding 65-70 years
- There are changes in the older person from aging and some from disease.
- Work capacity declines

DEVELOPMENTAL TASK

- EGO INTEGRITY VS DESPAIR

PHYSICAL GROWTH

- MAY SEE MEMORY LOSS/FORGETFULNESS
- CONFUSION IS NOT NORMAL PART OF AGING AND INDICATES DISEASE PROCESS
- DECREASE IN SENSE OF BALANCE AND FINE MOTOR SKILLS
- FEELS COLD MORE EASILY
- PERCEPTION OF AND RESPONSE TO PAIN DECREASES
- SLOWER PERISTALSIS AND ELIMINATIONS
- LOSS OF TASTE BUDS
- DECREASE IN GAS EXCHANGE IN LUNGS
- DECREASE IN CARDIAC OUTPUT
- MAY SEE PROSTATIC ENLARGMENT IN MALE AND PROLAPSE OF FEMALE ORGANS
- KIDNEY EFFICIENCY DECREASES
- BONE MASS BEGINS TO DECREASE

IMPLICATIONS

- Show patience with the older person
- Be willing to listen, explain, orient, reassure, and comfort the older person
- Involve family if possible
- Insure safety mechanisms are in place to prevent falls
- Have any prosthetics such as glasses, hearing aids, dentures in easy reach of the patient
- Assess the older patient frequently when applying hot or cold therapy
- Explain safety risks to the older person
- Provide plenty of fluids, small frequent meals and variety of foods
- Teach to avoid strenuous activity in heat
- Balance activity with rest periods
- Due to decrease in kidney function, may see more adverse drug reactions and need to adjust drug dosages.

Restraint Use

POLICY:

Leadership at Fairview Park Hospital is dedicated to fostering an organizational culture limiting the use of restraint to clinically justified situations only and seeks to reduce, with the ultimate goal of eliminating, the use of restraints through the following mechanisms while maintaining patient safety:

It is the policy of this facility to protect the patient and preserve the patient's rights, dignity, and well being during restraint use by:

- Respecting the patient as an individual
- Maintaining a clean and safe environment
- Encouraging the patient to participate in his/her own care
- Maintaining the patient's privacy, preventing visibility to others, and protecting the patient from harm or harassment
- Ensure the patient has the right to be free from restraints of all forms that are not clinically necessary or imposed as a means of coercion, discipline, convenience or retaliation by staff.
- Provide for a safe application and removal of the restraint by qualified staff
- Monitor and meet the patient's needs while in restraints
- Reassess and terminate restraint use at the earliest possible time
- Require that an LIP and RN shall be responsible for the use of restraints and for following the policy on informing patients of their rights. Only those care providers who are trained and competent may physically apply restraints, and only under the supervision of RN or LIP

Key Points for Restraints

Non-violent Restraints can only be used for a medically necessary reason and after alternatives have been documented and failed.

Violent Restraints can only be used when the patient demonstrates aggressive, combative, violent behavior that places the patient, staff, and others in immediate danger and the restraint is the least restrictive method to protect the patient & others.

Types of Restraints used at Fairview Park Hospital

- Mittens
- Soft wrist/soft ankle
- Roll Belt

Alternatives to Restraints must be attempted and documented as failed prior to the initiation of restraints. Examples of alternatives include:

- Ask family to stay with patient
- Move to room closer to nurse
- Leave door open
- Provide reality orientation/diversion activity
- Change in surroundings
- Quiet area
- Bed alarms, call lights
- Pain assessment, toileting, repositioning
- Use of sensory aides- glasses, hearing aid

Restraints may only be initiated by a Registered Nurse who has demonstrated competency in Restraint Use.

Restraints may only be discontinued after an assessment and determination by a Registered Nurse or LIP.

Restraint Orders must be based on a face to face physician assessment and are time limited to 24 hours

for medical-surgical use and time limited to 4 hours for behavior use for adults, 2 hours for age 9-17 years, and 1 hour for age <9 years. Restraints may NOT be ordered PRN.

- The patient in Medical Surgical Restraints & Behavioral Restraints must be monitored every two hours for the following:
 - Alternatives
 - Type of device & patient response
 - Education & criteria for release
 - Level of consciousness & behavior
 - Signs of injury/skin integrity
 - ROM & circulation
 - Nutrition & hydration
 - Toileting & hygiene
 - Comfort Measures
 - Dignity/Patient Rights & Safety
- The patient in restraints must also be monitored every 15 minutes by RN/LPN/Tech/PCA for safety, dignity, patient rights.
- Four Raised Side Rails on a hospital bed is considered a Restraint and requires a physician order as well as Restraint Monitoring.
 - Alternative: Raise top two side rails or Raise side rails x 3 and activate bed alarm.
- What is NOT considered a RESTRAINT?
 - Stretcher side rails
 - Should always use stretcher side rails as safety device
 - Use of voluntary mechanical support devices
 - Orthopedic appliances or braces
 - Handcuffs used by law enforcement
 - Age or developmentally appropriate protective safety devices
 - Stroller, high chair, swing safety belts, crib siderails, crib covers
 - Recovery from anesthesia in ICU or PACU is considered part of the surgical procedure

Material Safety Data Sheets

Definition: Material Safety Data Sheets (MSDS) are produced by the manufacturer to provide the following information to the users of their product. MSDS are available on all products that contain a caution or warning statement.

MSDS Information

- Name of the Product**
- Ingredients (Scientific Name) and percent representation in the product**
- Handling & Storage**
- Identification of product risks & precautions to be taken by users**
- Treatment for accidental exposure to the product**

MSDS ACCESS

Material Safety Data Sheets are accessible for all products used in the hospital through the HazSoft system. This electronic MSDS may be accessed through the Fairview Park Intranet on any hospital PC.

In the event of computer downtime, HazSoft may be contacted by phone at : 1-877-682-5602

Emergency Codes

HOSPITAL EMERGENCY CODES

CODE BLUE– CARDIOPULMONARY ARREST

CODE GRAY-VIOLENCE/THREAT/NEED ASSISTANCE

CODE GREEN- INTERNAL/EXTERNAL DISASTER

CODE PINK-INFANT/PEDIATRIC ABDUCTION

CODE RED-FIRE

CODE ORANGE-BOMB THREAT

CODE YELLOW-HAZ/MAT: RADIATION/CHEMICAL

WEATHER WARNING-SEVERE WEATHER

TORNADO ALERT-TORNADO SIGHTED

RAPID RESPONSE TEAM- NEED HELP FOR PATIENT WHO IS CLINICALLY DECLINING

CODE S- STROKE ALERT FOR PATIENTS WITH S/SX OF STROKE

CODE BLUE: CARDIOPULMONARY ARREST

- a. If you find a patient who is not breathing adequately or Who has no pulse, please stay with the patient, press the Nurse's Call Light on the bed and ask for help. Dial 3111 and ask for Code Blue. Begin CPR.
- b. Clinical Code Team will respond.

CODE GRAY: VIOLENCE/NEED ASSISTANCE

- a. If you encounter a situation where you need assistance of of security, please maintain your immediate safety and call 3111 and ask for CODE GRAY.

CODE GREEN: INTERNAL/EXTERNAL DISASTER

- a. Please contact your instructor or preceptor for direction.

CODE PINK: INFANT/PEDIATRIC ABDUCTION

- a. All newborns in our nursery have alarm bracelets.
- b. If newborn crib is moved too close to elevators or stairwell, alarm will be activated.
- c. Transportation of newborns only by certain staff.
- d. Newborns must be transported in crib/isolette.
- e. Nursery/Labor & Delivery have secured entrance. Ring doorbell for access to entrance.
- f. When transporting newborn to mother's room, compare Number on newborn bracelet to ID number on mother's ID bracelet.
- g. DO NOT leave newborn with anyone other than person with ID bracelet that matches the newborn bracelet.
- h. If code pink is called, all staff are to report to exits on their respective unit and stop EVERYONE to check for presence of abducted newborn. No employees, students, or visitors, or other staff are allowed to leave the building.

CODE YELLOW: HAZ/MAT

- a. Students do not care for patients or enter the decontamination area.
- b. Call for help to handle any hazardous material spill.
- c. Report any exposure to hazardous materials and obtain the MSDS through the HazSoft System.

CODE ORANGE: BOMB THREAT

- a. Keep caller on the line and obtain as much information as possible.
- b. Notify Nursing Supervisor immediately

WEATHER WARNING

- a. Be alert for bad weather

TORNADO ALERT

- a. Move patients to interior of the building
- b. Stay away from doors & windows

RAPID RESPONSE TEAM

- a. Used for patients who are clinically declining outside of CCU/ED
- b. Used by staff to obtain immediate help for patient
- c. Team consists of patient's nurse, CCU nurse, Nursing Supervisor, Respiratory Therapy

CODE S

- a. Notifies Rapid Response Team to respond for stroke alert
- b. Be aware of rapid stroke assessment
 1. F-Facial Droop on one side of face
 2. A-Arm Drift with eyes closed
 3. S-Speech difficulty including slurred speech, difficulty speaking, absent speech

4. T-Time-obtain treatment immediately to preserve brain function

Fire Safety

FIRE RESPONSE

R.....RESCUE
A.....ALARM
C.....CONTAIN
E.....EXTINGUISH

RESCUE: Rescue any person in immediate danger

- Always use the term Code Red for fire. Never yell "FIRE"
- Stay Calm
- Always check the temperature of a closed door before opening in a fire- if the door is HOT to touch- Do NOT open.
- Keep low and get the victim to the floor ASAP.
- Close the door behind you to contain the fire
- Stop,Drop, & Roll if your clothing or person catch fire.
- Do NOT put yourself in danger to become a victim.

Alarm: Activate the Fire Alarm

- Locate alarm stations on your unit
- Pull alarm immediately in case of fire- no matter how small the fire seems
- Fire doors will automatically close- Do not place equipment in front of fire doors.
- Fans will shut down the ventilation system

Contain: Contain the fire by closing doors and windows.

- Closing doors & windows stops the fire from spreading and protects other spaces from smoke

Extinguish: Extinguish the fire

- Only after rescue, alarm, and if fire is small & contained
- Know location of fire extinguishers
- Smother fire by throwing blanket
- If unable to extinguish, close the door
- Fire Extinguisher use:
 - PASS-Pull the pin
 - Aim the nozzle at the base of the fire
 - Squeeze the handle all the way
 - Sweep back and forth at the base of the fire

Security Tips

The safety & security of students while in the facility is of the utmost importance. Students should engage in activities that promote personal safety & security.

- Do not bring pocketbooks or other valuables to the clinical area as space to securely store these items may not be available.**
- Lock any valuable and personal items in the trunk prior to arriving at the hospital. This includes pocketbooks, CD's, cell phones, that might be visible in your vehicle.**
- Only carry minimal cash on your person.**
- Leave jewelry at home.**
- Always be aware of your surroundings and alert for suspicious activities or persons.**
- Park only in designated areas.**
- When entering or leaving the hospital, you may call security for escort, especially if you are leaving after dark and are alone.**
- Have your keys ready to unlock your car.**

Fairview Park Hospital Parking Map

Please see the attached document for a map of the Fairview Park Hospital campus & parking lots. Due to our “Patients First” philosophy, we ask that you do NOT park in the parking areas reserved for patients including the front visitor lot, Emergency department parking lot, Same Day Surgery parking area.

The employee parking area is located at the back of the main building in the employee parking lot.



Parking.pdf (561
KB)

Fairview Park Hospital Dublin, Georgia Human Resources	<i>Department:</i> All Employees and Contractors	
	<u>Standard:</u>	
Reference Number:	Reviewed:	Revised: January 1, 2012
Title: Tobacco-Free Campus	Approved By: Administration	Date Approved: November 14, 2011
Page: 49 of 1	Original Effective Date: July 18, 1988	

Purpose

Our hospital's purpose is to help sick people get well. Medical evidence indicates that smoking is contrary to this objective. Smoking not only is harmful to those who smoke, but has also been proven harmful to those who inhale the smoke of others. Smoking is also a fire and safety hazard.

Smoking is a major cause of preventable disease and death in this country. For this reason and for the health and comfort of the majority of people who are non-smokers, effective January 1, 2012 employees and contracted employees are not permitted to smoke or use tobacco while on duty.

Procedure

1. Employees are prohibited from using tobacco while on duty at the hospital.
2. Smoking breaks will not be allowed. Breaks will continue to be managed under the "Break and Meal Period" policy.
3. Employees are not allowed to smoke or use tobacco in their vehicle unless they are **clocked out and leaving campus**. Upon returning from an off-campus meal break, the employee should not return with the smell of smoke. The employee should take extra precautions to avoid the smell of smoke on his/her clothing. In addition, all overwhelming smells, such as perfumes, smoke, or body odor should be avoided as per the dress code policy.
4. Electronic (e-cigarettes) cigarettes are also not allowed on hospital property.
5. Smokeless tobacco, including dip and chew varieties, are also not allowed on company property during an employee's work shift.
6. Upon request, tobacco/smoking cessation information and assistance shall be provided to employees.
7. Violations of this policy will be addressed under the Rules of Conduct policy.

Infection Control

Infection Control & Employee Health

Infection Control is a set of recommended precautions implemented to protect healthcare workers and others from the spread of infections within the facility.

Hand Hygiene

Hands are the most common agent for the transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Therefore, hand washing is the single most important procedure for preventing the spread of infection in the hospital. Long and artificial nails may serve as a reservoir for microorganisms, and microorganisms are more difficult to remove from rough or chapped hands. In effect, clean and healthy hands with intact skin, short fingernails, and no rings minimize the risk of contamination, and subsequent spread of infection.

When to clean

1. Before beginning shift duties
2. Before and after direct or indirect patient contact
3. After performing any bodily functions including blowing your nose, eating, or using the bathroom
4. Before and after preparing or serving food
5. Before preparing or administering medications
6. After removing gloves or other personal protective equipment
7. Before and after participating in any sterile or invasive procedures, wound care, and dressing changes
8. Whenever your hands are grossly contaminated
9. Before and after caring for any highly susceptible patient, isolation patient, and newborn
10. After contact with a source that is likely to be contaminated with virulent microorganisms or hospital pathogens
11. After completion of your shift
12. After contact with unclean equipment and work surfaces, soiled clothing, washcloths, and handling raw food

How to clean – Soap or Alcohol gel?

Situation	Soap	Hand Rub
Hands are visibly dirty or contaminated with protein-based material (including blood or other body fluids)	X	
<i>Before</i> direct contact with patients	X	X
<i>Before</i> donning sterile gloves when inserting a central vascular catheter	X	X
<i>Before</i> inserting urinary catheters, IV's, or other invasive devices that do not require a surgical procedure	X	X
<i>After</i> contact with patient's intact skin (e.g., when taking a pulse or blood pressure, & lifting a patient)	X	X
<i>After</i> contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings (Hands are not visibly soiled.)	X	X
When moving from a contaminated-body site to a clean-body site during patient care	X	X
<i>After</i> contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient	X	X
<i>After</i> removing gloves	X	X
<i>Before</i> eating and after using a restroom	X	

After (possible) exposure to spores (e.g. <i>C. difficile</i>)	X	
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Hand Care and Protection:

Nails, Nail Polish and Artificial Nails

- a. For those with direct patient contact, natural fingernails should be kept clean and neat, cuticles free of inflammation, and not exceed 1/4 inch in length. Artificial nails are not acceptable at any time. Nail polish is acceptable, so long as the polish is a single color, not peeling and/or flaking, and without adornments (Flaking and/or peeling polish may harbor bacteria, and nail jewelry can make donning gloves more difficult and may cause gloves to tear more readily). Students with direct patient contact represent the following programs: physical therapists; physical therapy assistants; occupational therapists; occupational therapy assistants; speech-language pathologists; respiratory therapists; radiology techs; OR scrub techs, phlebotomy, nursing (R.N. and LPN), and PCA/CNA's.
- b. For those without direct patient contact, fingernails should be kept clean and neat, cuticles free of inflammation. Artificial nails, and polish are acceptable so long as they are a single solid color without adornments, and no longer than 1/2 inch in length. Nail length for food handlers is limited to 1/4 inch.
- 2. Rings can be worn, so long as appropriate hand washing/antiseptis occurs as outlined above (Rings can make donning gloves more difficult and may cause gloves to tear more readily).
- 3. Lotions are recommended to ease dryness from frequent hand washing, and to prevent dermatitis resulting from glove use. Avoid using oil-based hand creams or lotions when wearing latex gloves, as they may weaken the glove causing deterioration, and increased permeability.
- 4. Glove Usage
 - a. Standard precautions recommend wearing gloves for any known or anticipated contact with blood, body fluids, tissue, mucous membrane, or nonintact skin.
 - b. Gloves should be used as an adjunct to, not a substitute for, hand washing.
 - c. Gloves should be removed and hands washed after each task is completed, when the integrity of the gloves is in doubt, and between patients (gloves may need to be changes during the care of a single patient, for example when moving from one procedure to another).
 - d. Disposable gloves should be used only once, and should not be washed for reuse. Gloves made from materials other than latex should are available for personnel with sensitivity.

Personal Protective Equipment

OSHA defines personal protective equipment (PPE) as “specialized clothing or equipment worn b an employee for protection against infectious materials. It is provided by the facility to protect the employee.

Types of PPE include gloves, gowns/aprons, masks and respirators, goggles, and face shields. PPE in only effective if used appropriately.

A. Selection Factors

- Type of exposure anticipated. This is determined by the type of anticipated exposure, such as touch, splashes or sprays, or large volumes of blood or body fluids that might penetrate the clothing. PPE selection, in particular the combination of PPE, also is determined by the category of isolation precautions used.
- Durability and appropriateness for the task. This will affect, for example, whether a gown or apron is selected for PPE, or, if a gown is selected, whether it needs to be fluid resistant, fluid proof, or neither.
- Fit. PPE must fit the individual user.
- Examples

Giving a bed bath	Generally none
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Suctioning oral secretions	Gloves & mask/goggles or a face shield – sometimes gown
Transporting a patient in a wheelchair	Generally none required
Responding to an emergency where blood is spurting	Gloves, fluid-resistant gown, mask/goggles or a face shield
Drawing blood from a vein	Gloves
Cleaning an incontinent patient with diarrhea	Gloves, may need gown
Irrigating a wound	Gloves, gown, mask/goggles or a face shield
Taking vital signs	Generally none

- B. Gloves are worn during patient care activities, environmental services and any time protection against the environment is needed. Glove materials vary. Examples are vinyl, latex, and nitrile. Sterile and non-sterile gloves are available. Glove selection is based on anticipated use. In situations when tearing is anticipated, the use of thicker or double gloving is indicated. Once contaminated, gloves can become a means for spreading infectious materials to yourself, other patients or environmental surfaces. Therefore, the way gloves are used can influence the risk of disease transmission.
1. Work from “clean to dirty”
 2. Limit opportunities for “touch contamination”, protect yourself, others and the environment.
 - a. Don’t touch your face or adjust PPE with contaminated gloves
 - b. Don’t touch environmental surfaces except as necessary during patient care.
 3. Change gloves
 - a. During use if torn and when heavily soiled (even during use on the same patient)
 - b. After use on each patient
 4. Discard in appropriate receptacle. Never wash or reuse disposable gloves
- C. Gowns or Aprons are worn to protect the clothing and skin of the healthcare worker. Types of gowns or aprons include natural or man-made products, reusable or disposable, and fluid protection varying from minimal to maximum. Gowns and aprons are clean or sterile. Isolation gowns are generally the preferred PPE for clothing but aprons occasionally are used where limited contamination is anticipated. If contamination of the arms can be anticipated, a gown should be selected. Gowns should fully cover the torso, fit comfortably over the body, and have long sleeves that fit snugly at the wrist. Fluid resistance should be considered. If fluid penetration is likely, a fluid resistant gown should be used. Clean gowns are generally used for isolation. Sterile gowns are only necessary for performing invasive procedures, such as inserting a central line. In this case a sterile gown would serve purposes of patient and healthcare worker protection.
- D. Face Protection
1. Masks protect the nose and mouth. The mask should fully cover the nose and mouth and prevent fluid penetration.
 2. Goggles are used to protect the eyes. They should fit snugly over and around the eyes. Personal glasses are not a substitute for goggles.
 3. Face shields protect the face, nose, mouth, and eyes. It should cover the forehead, and extend below the chin and wrap around the side of the face.

E. Respiratory protection devices are used to protect from inhalation of infectious aerosols. PPE types include particulate respirators (N-95 masks), half- or full-face elastomeric respirators, and powered air-purifying respirators (PAPR). Refer to the Respiratory Protection Program for additional information.

F. Key Points About PPE

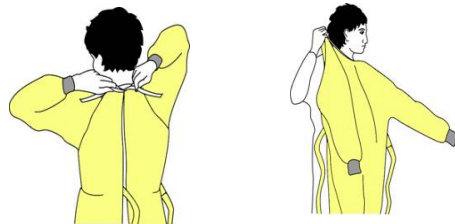
1. Don before contact with the patient, generally before entering the room
2. Use carefully – don't spread contamination
3. Remove and discard carefully, either at the doorway or immediately outside patient room; remove respirator outside room.
4. Immediately perform hand hygiene

G. Sequence for Donning PPE

1. Gown first
2. Mask or respirator
3. Goggles or face shield
4. Gloves

H. How to Don a Gown

1. Select appropriate type and size
2. Opening is in the back
3. Secure at neck and waist
4. If gown is too small, use two gowns. Gown #1 ties in front. Gown #2 ties in back



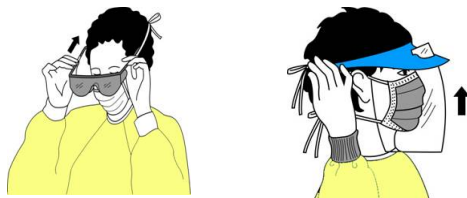
I. How to Don a Mask

1. Place over nose, mouth and chin
2. Fit flexible nose piece over nose bridge
3. Secure on head with ties or elastic
4. Adjust to fit



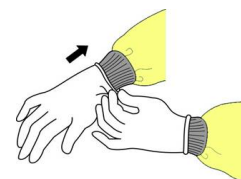
J. How to Don Eye and Face Protection

1. Position goggles over eyes and secure to the head using the ear piece or headband
2. Position face shield over face and secure on brow with headband



K. How to Don Gloves

1. Don gloves last
2. Select correct type and size
3. Insert hands into gloves
4. Extend gloves over isolation gown cuffs (if used)



L. How to Remove PPE

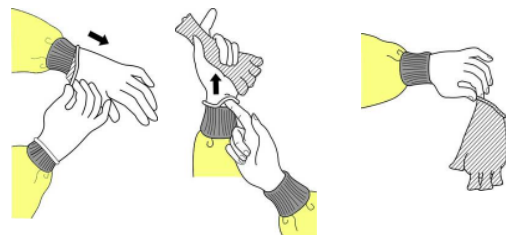
The sequence for removing PPE is intended to limit opportunities for self-contamination. The gloves are considered the most contaminated pieces of PPE and are therefore removed first. The face shield or goggles are next because they are more cumbersome and would interfere with removal of other PPE. The gown is third in the sequence, followed by the mask or respirator.

“Contaminated” and “Clean” Areas of PPE

1. Contaminated areas of PPE have or are likely to have been in contact with body fluids, materials, or environmental surfaces where the infectious organisms may reside. The Outside Front is generally considered contaminated.
2. Areas of PPE that are not likely to have been in contact with the infectious organism are considered clean. The inside, outside back, ties on head and back are generally considered clean.

Sequence for Removing PPE

1. Gloves
2. Face shield or goggles
3. Gown
4. Mask or respirator



M. How to Remove Gloves

1. Grasp outside edge near wrist
2. Peel away from hand, turning glove inside out
3. Hold in opposite gloved hand
4. Slide ungloved finger under the wrist of the remaining glove
5. Peel off from inside, creating a bag for both gloves
6. Discard

N. Remove Goggles or Face Shield

1. Grasp ear or head pieces with ungloved hands
2. Lift away from face
3. Place in designated receptacle for reprocessing or disposal



O. Removing Isolation Gown

1. Unfasten ties
2. Peel gown away from neck and shoulder
3. Turn contaminated outside toward the inside
4. Fold or roll into a bundle
5. Discard



P. Removing a Mask

1. Untie the bottom, the top, and tie
2. Remove from face
3. Discard



Q. Hand Hygiene

1. Perform hand hygiene immediately after removing PPE. If hands become visibly contaminated during PPE remove, wash hands before continuing to remove PPE

2. Wash hands with soap and water or use an alcohol-based hand rub

Transmission Based Precautions

Transmission of infection within a hospital requires three elements: a source of infecting microorganisms, a susceptible host, and a means of transmission for the microorganism.

Standard Precautions were developed to protect HCW's and patients from the transmission of Bloodborne pathogens. Included in these guidelines are hand hygiene and gloves. Gloves should be worn whenever contact with blood, mucous, urine, stool, spinal fluid and other fluids is anticipated.

Airborne Precautions

1. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei. Examples of such illnesses include:
 - Measles (Rubeola)
 - Varicella (including disseminated zoster)
 - Tuberculosis
 - Smallpox
2. SPECIFICATIONS FOR AIRBORNE PRECAUTIONS:
 - Place patient in a private isolation room that has monitored negative air pressure with 6-12 air changes per hour and appropriate discharge of air outdoors or with monitored high-efficiency filtration of room air before the air is circulated to other areas of the hospital.
 - Door must be kept closed and the patient must stay in the room.
 - In general, patients who have active infection with the same microorganism and no other infection may share a room, if needed.
 - Particulate mask must be worn when entering the room of a patient with known or suspected infectious pulmonary tuberculosis.
 - Personnel or visitors susceptible to measles (rubeola) or varicella (chickenpox) should not enter the room if other immune caregivers are available. If susceptible persons must enter the room, they should wear respiratory protection. Persons immune to measles (rubeola) or varicella (chickenpox) need not wear respiratory protection.
 - If transport or movement is necessary, for essential purposes ONLY, place a surgical mask on the patient, if possible.
 - Standard/Universal Precautions MUST be followed.
3. Fit testing for N-95 masks is required prior to entering the room of a patient on airborne precautions.
- 4. STUDENTS ARE NOT TO ENTER THE ROOMS OF PATIENTS ON AIRBORNE ISOLATION.**

C. Droplet Precautions

1. In addition to Standard Precautions, use Droplet Precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include:

Flu, Mycoplasma pneumonia, Diphtheria, Mumps, Rubella Whooping Cough

2. Specifications for Droplet Precautions
 - a. Place the patient in a private room and door may remain open
 - b. Maintain at least 3 feet between the infected patient and other patients and visitors
 - c. A mask must be worn when working within 3 feet of the patient or you may put a mask on prior to entering the room.

- d. Limit the transport of the patient to essential purposes, ONLY. If necessary to transport the patient, a surgical mask must be worn by the patient, if possible to minimize the dispersal of the droplets.
- e. Standard Precautions must be followed.
- f. Discontinue droplet precautions after signs and symptoms have resolved or according to pathogen specific recommendations

NOTE: For patients with suspected SARS or Avian influenza wear both respiratory and eye protection (goggles or face shield)

E. Contact Precautions

- 1. In addition to Standard Precautions, use Contact Precautions for patients known to or suspected to have serious illnesses transmitted by direct patient contact or by contact with items in the patient's environment. Examples of such illnesses include:

- 1. MRSA, VRE, Hepatitis A, RSV, Impetigo, Diphtheria

- 2. Specifications for Contact Precautions

- F. Patient should be placed in a private room. If needed, may place the patient in a room with another patient who has active infection with the same microorganism but no other microorganism.
 - G. Limit the movement and transporting of the patient from the room to essential purposes ONLY. If patient must be transported out of the room, ensure that precautions are maintained to minimize the risk of transmitting the microorganisms to other patients and contaminating environmental surfaces or equipment.
 - H. Whenever possible, limit the use of noncritical patient-care equipment to a single patient (or share with patients that are infected or colonized with the same microorganism) to avoid sharing between patients. If the use of common equipment or items is unavoidable, clean and disinfect them before use on another patient.
 - I. Wear a gown (a clean, nonsterile gown is adequate) when entering the room if you anticipate your clothing to come into contact with the patient, environmental surfaces, or items in the patient's room, or if the patient is incontinent or has diarrhea, an ileostomy or colostomy, or if the patient has a wound draining that is not contained by the dressing. The gown is to be removed before leaving the room. Afterwards, take extreme care that clothing does not come into contact with surfaces to avoid transfer of microorganism to other patients or the environment.
 - J. Gloves MUST be worn (clean, nonsterile gloves are adequate). Wear gloves when entering the room and during the course of providing care for the patient. Gloves should be changed after having contact with infective material (stool and wound drainage). Remove gloves before leaving the patient's room and wash hands IMMEDIATELY with an antimicrobial soap. Afterwards, ensure that hands do not touch contaminated surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or the environment.
 - K. Discontinue Contact Precautions after signs and symptoms have resolved or according to pathogen specific recommendations.
- 3. If reusable items/equipment are taken into the room these items should be cleaned upon exit with an approved germicidal (Virex, PDI Super SaniCloth). Examples of such items includes, but is not limited to:
 - i. Stethoscopes, ink pens, emar carts, Dinamapp, portable x-ray machines, EKG machines, thermometers
 - 4. MRSA (methicillin resistant staph aureus and VRE (vancomycin resistant enterococcus) are examples of multi-drug resistant organisms (MDRO's). These are transmitted by direct patient contact or by contact with items in the patient's environment. Many

patients are colonized with MRSA; some are infected with MRSA. Contact Precautions are used to prevent the spread of this organism.

IV. Bloodborne Pathogens

HIV, Hepatitis B & C are considered bloodborne pathogens. The single most important measure to control transmission of HIV, HBV, and HCV is to treat all human blood and other potentially infectious materials as if they are infectious. Standard Precautions are used to prevent the transmission. These are viruses are transmitted by:

- Needlestick injuries
- Cuts, scrapes, and openings in the skin
- Splashes into the mouth, nose, or eyes
- Oral, vaginal, or anal sex
- Sharing infected drug needles
- Perinatal transmission

V. Bloodborne Pathogen Exposure

Exposure means that you have been exposed to blood and/or body fluids by one of the following ways:

- Your skin has been punctured by a needle or any sharp object contaminated with blood or body fluids.
- A splash that results in blood or body fluids coming in contact with your mucous membranes (i.e. blood splashed into your eyes, nose, mouth)

Remember **W-I-N**

Wash the area thoroughly.

Identify the source – whose blood or body fluid was it? What route was used for your exposure? Needle? Blade? Suction contents?

Notify your instructor that the exposure has occurred. Call Linda Jackson (3580) in the Infection Control/Employee Health office ASAP. Prompt notification of Linda Jackson helps to ensure the lab work from the source is obtained quickly and checked for HIV, Hepatitis B & C. If Linda Jackson is not available, notify the Nursing Supervisor. Notify the department manager.

After any blood and/or body fluid exposure, it is important for you to **report to the Emergency Department (triage)** and tell them you have had an exposure. Baseline lab work will be drawn on you for Hepatitis B & C. The Emergency Room physician will then review the patient information. If the patient is a *known HIV patient or has high-risk behaviors*, the physician will most likely give you medication to reduce your chance of infection. *The sooner PEP (Post Exposure Prophylaxis) is begun, your chances of contracting HIV is significantly reduced.* Due to the severity of the side effects of the medications, the physician will counsel you before initiating therapy. If the source is not high-risk or known to be HIV positive, the physician may recommend that medications are not indicated.

Report to the Health Department within the next few days and inform them you have had an exposure and need to have an HIV test performed. This does not require a physician's order and there is no charge to you. This is to obtain your baseline status. Continue with their recommendations for further testing. We do not do HIV testing of employees at Fairview Park Hospital. This is to protect your privacy.

The **Infection Control/Employee Health** office will contact you about the results of your lab results and those of the source. Recommended follow-up will be included. **A Health Department Representative will discuss your HIV results with you.**

AIM FOR ZERO: STOPPING CENTRAL LINE BSI

- 1. Assesses medical necessity for line daily; removes as soon as not medically necessary**
- 2. Performs hand hygiene before line manipulation or dressing change**
- 3. Use CHG (chlorascrub) and alcohol for skin antisepsis with dressing change**
- 4. Changes gauze dressings every 2 days or semi-permeable transparent dressings every 5-7 days unless soiled, dampened or loosened.**
- 5. Scrubs the Hub (ports) vigorously for 10 seconds before accessing for meds/flushing**
- 6. Limits line access for blood draws to those medically necessary**
- 7. Includes indications and status of lines in handoff report**
- 8. Educates patient & family on care of line and s/sx of infection**
- 9. Notes s/sx of infection & reports to LIP immediately**

******Be sure to utilize the Central Line Bundles available on your unit for insertion/maintenance.**

Patient Satisfaction

AIDET:

- A**- Acknowledge the patient by their name. Knock before entering the room.
- I**- Introduce yourself. Tell your title.
- D**- Duration. Tell how long you will be with the patient. (the whole shift, a few minutes, etc.)
- E**- Explain your role in their care. (I'm your nurse, therapist, to draw your blood, clean your room, etc.)
- T**- Thank the patient for allowing us to care for them. (It was my pleasure to care for you today.)

AIDET is a patient scripting tool to help guide patient interaction and promote patient satisfaction.

Hourly Rounding: Rounding for Outcomes on Patients and Family

****Every patient should be rounded on at minimum once an hour by someone on clinical staff. During these hourly rounds, the clinical staff should be assessing the 4 "P"s: Pain, Potty, Personal Belongings, Position. In addition, clinical staff should use this opportunity to perform service recovery and address any other concerns or questions voiced by the patient or family.**

Questions to Ask During The 4"P" Rounding

Instead of "Do you need to use the bathroom?"

Try, "Let me assist them to the bathroom"

Instead of "Do you need anything?"

Try, "Is everything you need close at hand or within reach?"

Instead of "Are you in pain?"

Try, "How can I make you more comfortable?"

Patient Safety and Patient Satisfaction Meld Here – The last question you ask *the patient* is, “May I get you anything? I have time” and the last question you ask *yourself* is:

HAVE I LEFT MY PATIENT IN A SAFE CONDITION???

White Boards: All patient rooms are equipped with a white dry-erase board which should be utilized to record the date and name/Spectralink phone number of all clinical staff (Nurse, PCA/Tech) and Housekeeper assigned to that patient room. Patients and families should be instructed about the white board upon orientation to the unit and room.

Service with a HEART:

Hear

- * Give your full attention.
- * Make sure your mind is focused on the person speaking
- * Let the person finish speaking before you begin to talk.

Empathize

- * Be aware of what other people are feeling.
- * Appropriate touch communicates empathy.

Apologize

- * Be relaxed. Crossing your arms and pointing fingers puts the person on the defensive
- * Take responsibility. Be sincere in your apology
- * Don't make excuses.

Resolve

- * Stay focused on the facts of the situation
- * Agree with the person on the “plan of action” to achieve resolution.
- * Commit to follow-through.

Thank

- * Always end the conversation with saying “thank you.”
- * Thank the patient for the information they have provided.

Confidentiality/HIPPA

Quality medical care is related to the patient's freedom to disclosed detailed personal information and the healthcare professionals pledge to protect it. All patient information is considered confidential and may be released only to individuals designated by the patient or healthcare providers on a need to know basis. Patient information should not be released or discussed unless it is necessary to serve the patient or required by law. You should never disclose confidential patient information that violates the privacy rights of our patients. Patient information will only be released to persons authorized by law or by the patient's written consent.

Steps to assure Privacy/Confidentiality

- A. All interviews with the patient/family should be conducted in an Area without threat of being overheard. Usually, closing a door Will accomplish this.
- B. Consultation or discussion involving the patient will be done discreetly.
- C. Only individuals designated by the patient will be allowed to participate in decision-making process.
- D. The medical record should be assessable and read only by individuals directly involved in their treatment or handling of records.
- E. All information pertaining to payment are confidential.

HIPPA

What is HIPPA?

- Health Insurance Portability & Accountability Act of 1996
- Federal Law
- Affects all healthcare industry
- HIPAA is mandatory with civil & criminal penalties for failure to comply

HIPPA Key Points to remember

- Patients receive a Notice of Privacy Practices on Admission
- All patient health information (PHI) should be placed in Shred Boxes for disposal
- Patient family members must have passcode to obtain health information
- Patient information should only be accessed if there is a need to know
- Any information that could be used to identify the patient is protected as well all information about medical history & treatment

- **Privacy complaints should be made the Facility Privacy Official: Alison Anderson ext. 3337**
- **Patients have the right to access their medical record by going to medical records to request a copy.**
- **Patients have the right to OPT OUT of the Hospital Directory and will then be know as a CONFIDENTIAL patient. You may NOT acknowledge this patient is in the facility or give information about patient.**
- **Employees, volunteers, or students are NOT allowed to access their own personal medical record or family members medical records in Meditech. Access only the records needed to perform job duties.**
- **Whiteboards in patient care areas should not contain patient full name. It is acceptable to use the first three letters of patient last name and first initial on the whiteboard and patient door tag.**
- **Common reasons for privacy complaints:**
 - **Discussion of patient information in public places such as elevators, hallways, and cafeteria.**
 - **Printed or Electronic information left in public view**
 - **Patient Health Information left in trash**
 - **Records accessed without need to know order to perform job duties**
 - **White boards with full patient name**
 - **Charts left in public view**

2010 NATIONAL PATIENT SAFETY GOALS

WHAT IS A NATIONAL PATIENT SAFETY GOAL?

National Patient Safety Goals were instituted by the Joint Commission of Accreditation of Healthcare Organizations to address patient safety issues. Compliance with these goals is **MANDATORY** in order for our organization to remain accredited and in good standing. These goals are designed to reduce the risk of patient injury and death from errors. Please read these goals and plan to use them during your clinical rotation at the hospital.

1. Accuracy of Patient Identification
 - a. Two patient identifiers
 - i. Patient Name
 - ii. DOB
 - iii. Hospital Account Number
 - b. Use two identifiers in these situations
 - i. Administering Meds
 - ii. Performing Invasive Procedures
 - iii. Collecting Specimens
 - iv. Administering blood

2. Eliminate transfusion errors related to patient misidentification
 - a. Use two identifiers
 - b. Use two person verification at bedside
 - i. RN/RN
 - ii. RN/LPN
 - c. Compare all elements
 - i. Patient name
 - ii. Hospital account number
 - iii. Donor/unit id number
 - iv. Patient blood type/donor unit blood type
 - v. Expiration date
 - vi. Blood identification number/blood ID band

3. Improve effectiveness of communication among caregivers
 - a. Critical Test Results
 - i. Lab to Nurse to Physician
 - ii. Only Licensed Nurses to take results from Lab
 - iii. Document on blue sticker
 - iv. Place sticker in physician progress notes
 - v. Results should be "Read Back" not repeated back
 - vi. Time Limit:
 1. Lab to Nurse: immediately
 2. Nurse to Physician: Page MD, no response after 15 minutes, page MD on call, no response after 30 minutes

from the receipt of the results from the lab, implement chain of command by notifying nursing supervisor

- vii. What is considered a “Critical Result”?
 - 1. see Critical Results policy
 - b. Do Not Use Abbreviations- see list on previous page
 - c. Hand Offs
 - i. Use SBAR format
 - ii. Provide opportunity to ask questions
 - iii. Use Ticket to Ride for transportation for diagnostic tests off the unit
4. Medication Safety
- a. Look-alike/Sound-alike drugs
 - b. Label all meds, med containers on & off the sterile field
 - c. Anticoagulation Safety
 - i. See anticoagulation checklist
 - ii. Anticoagulation Patient Education
5. Reduce the Risk of Healthcare Acquired Infections
- a. Hand Hygiene
 - b. Sentinel event: any death/major loss of function associated with healthcare associated infection
 - c. Evidence Based Practice to prevent HAI associated with MDRO
 - d. Evidence Based Practice to prevent Central Line bloodstream infections
 - i. Maximal Barrier Precautions at time of insertion
 - ii. Documentation in Meditech CVC/PICC Insertion
 - iii. Documentation of daily maintenance in Meditech CVC/PICC Maintenance
 - iv. Dressing Change: gauze/24 hrs
Opsite/96 hrs
 - e. Evidence Based Practice to prevent Surgical Site Infections
 - i. Hair removal: clippers—NO RAZORS
 - ii. Preop antibiotics within 1 hour of cut time
 - iii. Prophylactic antibiotics d/c within 24 hours
 - iv. Appropriate antibiotic selection
6. Medication Reconciliation
- a. Complete list of home meds obtained on admission
 - b. Print home med list on admission
 - c. Physician to complete Home Med list for meds to continue
 - d. Cannot write “Continue Home Meds” as an order
 - e. On Transfer: must print Transfer med list for physician to complete what meds to be continued
 - f. On Discharge: must print Discharge med list—includes Home Meds obtained on admission and current Hospital Meds; physician to complete this list for Discharge Medications
 - g. Discharge meds list must be sent to next provider of service

- i. Meditech
- ii. Fax/Mail
- h. Discharge med list given to patient; meds explained to patient

7. Falls Reduction

- a. Falling Star Program
- b. Falls Risk Alert
 - i. Falling Star Sign on door
 - ii. Yellow Falls Alert Bracelet
- c. Falls Risk Assessment
 - i. Done on all patients on admission and every shift
 - ii. Risk Criteria
 - 1. Alert/Response AND have one or more of the following
 - a. confused at times
 - b. falls history in last three months
 - c. impulsive behavior
 - d. lethargic/sedated
 - 2. OR they are alert/responsive and not following Directions
- d. Falls Risk Interventions
 - i. Global
 - ii. Generic
 - iii. Specific
- e. Falls Risk Education
 - i. MUST BE DONE FOR ALL PATIENTS REGARDLESS OF RISK LEVEL!!!!!!
 - ii. Always done on admission as part of admission assessment
 - iii. Re-educate every shift as needed
 - iv. DOCUMENT, DOCUMENT, DOCUMENT
 - v. Must document Falls Prevention education in record
 - vi. Use Falls Prevention Flyers to teach
 - 1. "Please Help Prevent Falls" flyer over the bed
 - 2. Ways to Help Prevent Falls located behind the door
In each patient room.

8. Patients active involvement in their own care.

- a. SPEAK UP program

9. Identify patients at high risk for suicide

- a. On admission/triage assessment: cue questions to trigger possible Treatment for emotional/mental disorder/thoughts of suicide.
- b. if cue questions are positive, obtain Suicide Risk Screening Tool
- c. Tool is NOT located in Meditech but is a hard copy form on the unit
- d. Complete Risk Screening Tool; scores >12 indicate increased risk of suicide
- e. Patient placed in suicide safe room; mental health evaluation obtained

10. Rapid Response Team

- a. Staff notify RRT when patient's clinical condition is declining or staff is worried about the patient and need help
 - i. Obtain RRT by calling 3111 and ask for Rapid Response Team to patient's room
 - ii. RRT is Nursing Supervisor, Respiratory Therapist, CCU nurse, patient's nurse
 - iii. RRT assists in assessing the patient and notifying physician for orders
 - iv. Complete the Rapid Assessment Tool & Critique and place in manager's door.
 - v. Criteria for notifying the RRT

WAIVED TESTING AND POINT OF CARE TESTING

ANNUAL GLUCOMETER COMPETENCY WAIVED TESTING

- MANDATED BY CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)
- ALL LAB TESTS MUST BE PERFORMED BY CERTIFIED LAB TECHNICIANS
- ONLY EXCEPTION IS WAIVED TESTING AND POINT OF CARE TESTING
- FAIRVIEW PARK HOSPITAL HAS A CERTIFICATE OF WAIVER ISSUED BY CLIA ALLOWING WAIVED TESTING.
- EXAMPLES OF WAIVED TESTING
 - DIPSTICK REAGENT URINALYSIS
 - FECAL OCCULT BLOOD
 - OVULATION TESTS
 - URINE PREGNANCY TESTS
 - **BLOOD GLUCOSE**
- THE ONLY WAIVED TEST APPROVED TO BE PERFORMED AT THE BEDSIDE BY OUR HOSPITAL STAFF IS: BLOOD GLUCOSE MONITORING

POINT OF CARE TESTING (POCT)

- BILICHEK ANALYZER USED BY NURSING STAFF IN NURSERY TO CHECK BILIRUBIN
- CLASSIFIED BY GEORGIA DEPT OF HUMAN RESOURCES (GDHR) AS POCT
- BILICHECK ANALYZER MAY ONLY BE USED BY RN/LPN WHO MEET THE ANNUAL COMPETENCY TRAINING REQUIREMENTS
- ALL POCT MUST BE APPROVED AND UNDER THE SUPERVISION OF A LICENSED LABORATORY.

LABORATORY ACCREDITATION

- LICENSED BY GEORGIA DEPARTMENT OF HUMAN RESOURCES
- CERTIFICATE OF ACCREDITATION BY CLIA
- ACCREDITED BY COLLEGE OF AMERICAN PATHOLOGISTS (CAP)

ACCU-CHECK INFORM GLUCOMETER

- BEDSIDE BLOOD GLUCOSE MONITORING SYSTEM
- REFER TO LAB REFERENCE MANUAL ON INDIVIDUAL UNIT
- REFER TO CLINICAL POLICY: DM- ROCHE ACCU-CHECK INFORM SYSTEM
- USE SYSTEM OPERATOR'S MANUAL FOR DETAILED SYSTEM INFORMATION
- ACCU-CHECK INFORM GLUCOMETER
 - PERFORMS BLOOD GLUCOSE AND QUALITY CONTROLS
 - RECORDS THE FOLLOWING
 - DATE/TIME
 - OPERATOR ID/PATIENT ID
 - CONTROL SOLUTION INFORMATION

- TEST STRIP INFORMATION
- TEST RESULTS & COMMENTS
- ACCU-CHECK INFORM GLUCOMETER
- METER
 - USED TO CHECK BLOOD GLUCOSE
- BASE UNIT
 - ALWAYS PLACE METER IN BASE WHEN NOT IN USE OR AFTER PERFORMING A PATIENT TEST
 - RECHARGES METER BATTERY PACK
 - PROVIDES TRANSFER OF DATA INTO MEDICAL RECORD
- ACCESSORY BOX
 - STORAGE OF SUPPLIES
 - ACCU-CHECK INFORM GLUCOMETER
- QUALITY CONTROLS
 - PERFORMED EVERY 24 HOURS OR AFTER CRITICAL RESULTS (this is a recent change from every 12 hours)
 - MUST RECEIVE "PASS" RATING TO PROCEED WITH PATIENT TEST
 - CONTROL SOLUTION
 - USE TWO CONTROLS- "HIGH" AND "LOW"
 - DATE BOTTLES WITH DATE THAT THEY ARE OPENED FOR USE.
 - CONTROL SOLUTION CONSIDERED GOOD FOR THREE MONTHS. DISCARD CONTROL SOLUTION THREE MONTHS FROM DATE OPENED.
 - CONTROL LOT NUMBER MUST BE CORRECTLY ENTERED INTO METER
- COMFORT CURVE TEST STRIPS
 - STORE AT ROOM TEMPERATURE
 - KEEP IN TIGHTLY CLOSED ORIGINAL VIAL
 - CHECK EXPIRATION DATE ON SIDE OF VIAL
 - DISCARD EXPIRED STRIPS
- COMFORT CURVE TEST STRIPS
 - CODE FOR TEST STRIPS MUST MATCH CODE IN THE METER
 - CODE KEY MUST BE CHANGED WITH EACH NEW VIAL OF STRIPS

BLOOD SPECIMENS

- CAPILLARY
- VENOUS
- ARTERIAL
- NEONATAL CORD BLOOD

COLLECTING A BLOOD SAMPLE

- FINGERSTICK SHOULD BE PERFORMED ON THE SIDE OF THE FINGERTIP FOR ADULTS OR HEEL FOR NEONATES
- IF FIRST DROP IS NOT SUFFICIENT SAMPLE, MAY APPLY SECOND DROP WITHIN 15 SECONDS

CRITICAL RESULTS POLICY:

- Glucometer will read CR HI or CR LO for glucose results of the following:
 - >450 <45 FOR ADULTS
 - >300 <30 FOR NEONATES
 - Critical Results actions:
 - For Symptomatic patients:
 - Initiate treatment according to orders
 - Order Lab blood glucose verification
 - Notify physician
 - For asymptomatic patients:
 - Repeat test
 - If 2nd test is CR HI or CR LO, order Lab blood glucose verification & notify physician.

UNIVERSAL PRECAUTIONS

- USE GLOVES WHEN PERFORMING FINGERSTICK BLOOD GLUCOSE
- USE GLOVES WHEN CLEANING MACHINE
- DISPOSE OF LANCETS IN SHARPS CONTAINER
- DISPOSE OF USED TEST STRIPS AND OTHER MATERIALS WITH BLOOD APPROPRIATELY

EQUIPMENT CLEANING

- MAY USE THE FOLLOWING TO CLEAN THE ACCU-CHECK INFORM GLUCOMETER
 - SANI-CLOTH
 - 70% ALCOHOL
 - WARM SOAPY WATER
 - USE ONLY DAMP CLOTHS- DO NOT EXPOSE THE METER TO EXCESS MOISTURE OR WATER.

DRUG INTERFERENCE WITH ACCUCHEK INFORM RESULTS

- Certain substances in the bloodstream can falsely elevate the blood glucose reading
 - Maltose
 - Galactose
 - Xylose
 - Certain therapies or drugs can cause these substances to enter the blood stream.
 - Drug Interference may result in:
 - False high or false normal blood glucose
 - Inappropriate insulin dosage based on the false reading
 - Failure to administer Glucose to a patient with an actual low blood glucose level

Screening Patients for Potential Drug Interference

- Patients at risk:
 - Undergoing peritoneal dialysis containing Icodextrin (EXTRANEAL). We do NOT use this type of fluid at Fairview Park Hospital.

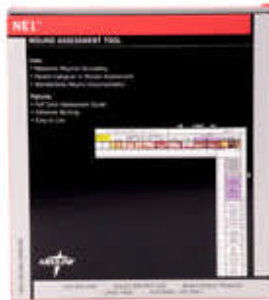
- Patients receiving certain types of IV Immunoglobulin (Ig) that contain maltose.
- Treat the patient, not the glucose meter!
- Careful assessment of patient's symptoms in conjunction with medication history.
- Be aware of possibility with peritoneal dialysis patients. We do not stock the EXTRANEAL (Icodextrin) peritoneal fluid here, but patients could use this type of fluid at home.

ANNUAL COMPETENCY

- PLEASE COMPLETE THE FOLLOWING FOR ANNUAL COMPETENCY
 - OBTAIN THE ACCU-CHECK INFORM GLUCOMETER AND PERFORM A QUALITY CONTROL USING YOUR USER ID. YOU MUST PERFORM A PASSING QC WITHIN THE TIME FRAME FROM JANUARY 2011- MARCH 2011 AS PART OF THE COMPETENCY TRAINING. THIS IS REQUIRED!! IF YOU HAVE NOT COMPLETED A PASSING QC IN THIS TIME FRAME, YOUR GLUCOSE ID NUMBER WILL BE INACTIVATED AS OF MARCH 31, 2011.
 - COMPLETE THE POST TEST INCLUDED IN THE ORIENTATION QUIZ PACKET AND ACHIEVE 80%.

NE1 Can Stage: Skin and Wound Assessment Tool

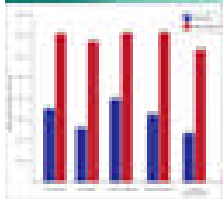
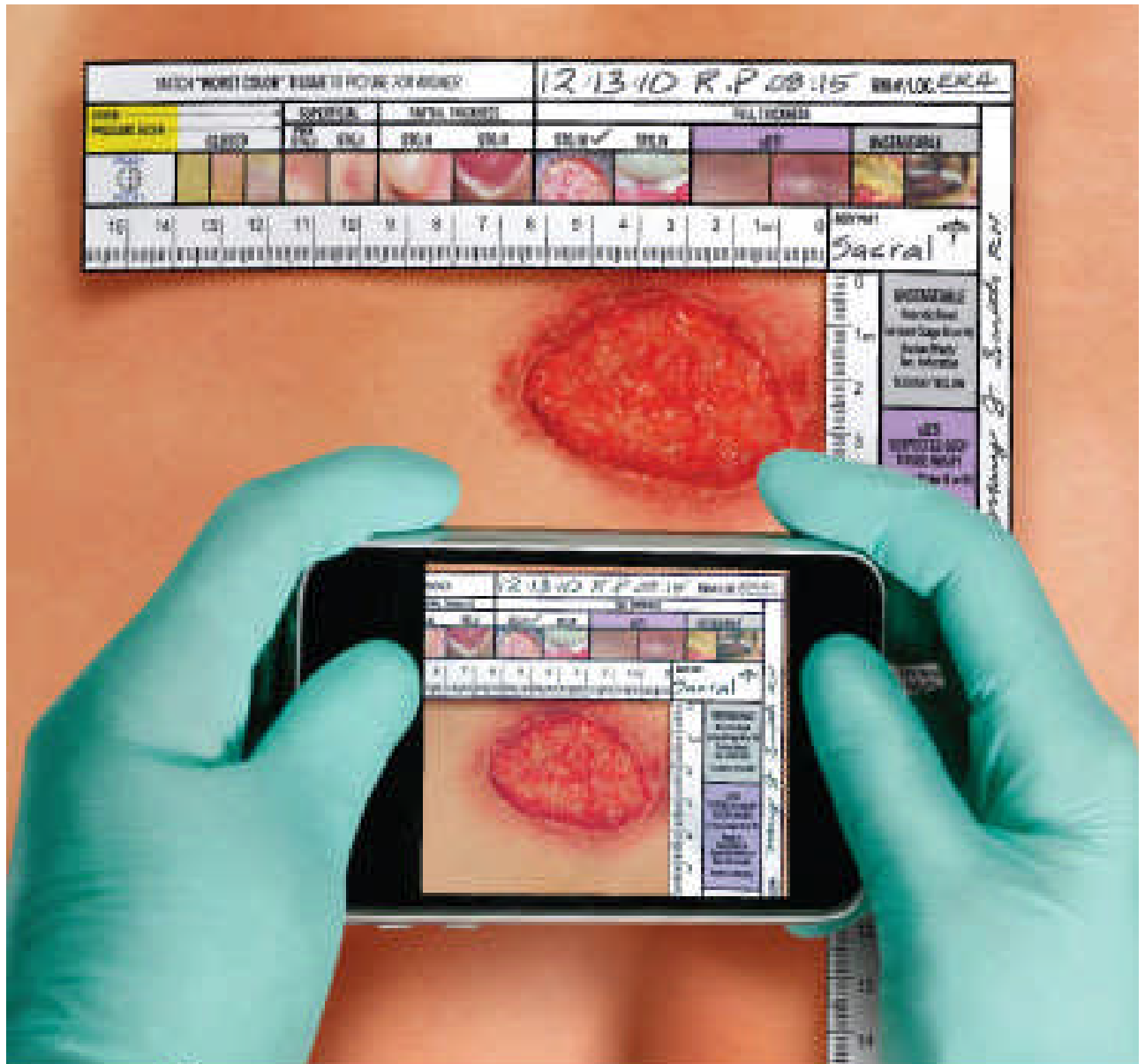
The New Standard for Wound Assessment



[MSCNE1TOOL](#)

Medline Industries Inc. introduces the new standard in wound assessment. The NE1 Wound Assessment Tool is an easy to use method of evaluating wounds, even for clinicians with limited training. The tool helps reduce errors and promotes accurate wound assessment.¹ The patent-pending design provides a consistent and standardized method for assessing and documenting wounds that will help facilities receive appropriate reimbursement for wound care. This tool also helps reduce errors and promotes accurate wound assessment.

- Standardizes wound documentation, which can be used for administrative review and can be of assistance in potential litigation.¹
- Drives appropriate reimbursement due to more accurate wound assessments



Before and after using NE1

[Click Here >](#)

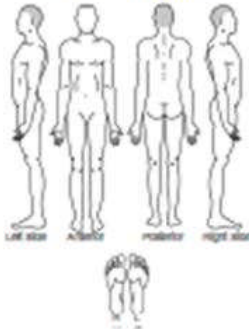
Once the NE1 Can Stage tool has been used to assess the wound/skin, photographic documentation of the wound is to occur per protocol (upon noticing wound, weekly on Mondays, and on discharge) with the photograph printed and affixed to the corresponding NE1 Can Stage Assessment Form (See below).

Style 1/4 1 3/8 c-to-c

NET™ PHOTOGRAPHIC WOUND DOCUMENTATION

LOCATION (ANATOMICAL SITE): _____

Mark Wound Location



Write on the Tool:

- Date
- Patient Initials
- Time
- Room #/ Location
- Wound Location
- Clinician Signature

- 1 Frame the NET Wound Assessment Tool around the wound (12 O'clock Position).
- 2 Do not wrap tool around the body. Keep flat to maintain the tool's 90° angle.
- 3 Camera must be perpendicular to the wound, then take picture.
- 4 Print the picture.
- 5 Delete pictures from the camera immediately after printing.
- 6 On photo, mark the tissue damage edge using horizontal and vertical lines as shown above, then measure length and width.
- 7 Calculate the surface area, (L x W = Surface area).
- 8 Affix the photo in this box.
- 9 Place this document in patient's Medical Record.

WORST TISSUE TYPE:

- | | |
|---|---|
| <input type="checkbox"/> Normal or Closed Skin (Epithelialized) | <input type="checkbox"/> Exposed Muscle/Tendon/Bone |
| <input type="checkbox"/> Red/Pink/Erythema (intact skin) | <input type="checkbox"/> Purple/Maroon/Deep Hues of Red (or blood filled blister) |
| <input type="checkbox"/> Opaque (intact serum filled blister) | <input type="checkbox"/> Yellow (Slaugh) |
| <input type="checkbox"/> Red/Moist/Smooth/Shallow | <input type="checkbox"/> Black/Tan (Eschar) |
| <input type="checkbox"/> Red/Moist/Bumpy (Granulation) | |

WOUND TYPE:

- Pressure Ulcer:
- | | | |
|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Closed | <input type="checkbox"/> Stage II | <input type="checkbox"/> Suspected Deep Tissue Injury |
| <input type="checkbox"/> Pre-Stage I | <input type="checkbox"/> Stage III | <input type="checkbox"/> Unstageable |
| <input type="checkbox"/> Stage I | <input type="checkbox"/> Stage IV | |
- Other:
- | | | | |
|---------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Closed | <input type="checkbox"/> Superficial | <input type="checkbox"/> Partial Thickness | <input type="checkbox"/> Full Thickness |
|---------------------------------|--------------------------------------|--|---|

I have reviewed and agree with the findings above.

Pressure Ulcer: Present on Admission YES NO

Physician Signature _____

Date _____ Time _____

PALPATED: (Touched)

Skin/wound compared to adjacent tissue:

- | | | | |
|--------------|--------------------------------------|---------------------------------|-------------------------------------|
| Temperature: | <input type="checkbox"/> Cool | <input type="checkbox"/> Normal | <input type="checkbox"/> Warm |
| Texture: | <input type="checkbox"/> Intact Skin | <input type="checkbox"/> Boggy | <input type="checkbox"/> Soft |
| | <input type="checkbox"/> Firm | <input type="checkbox"/> Hard | <input type="checkbox"/> Non-Intact |
| | <input type="checkbox"/> Bumpy | <input type="checkbox"/> Bone | <input type="checkbox"/> Muscle |
| | | <input type="checkbox"/> Smooth | <input type="checkbox"/> Tendon |

Blanch Test: (capillary refill of intact skin):

- Blanchable Non-Blanchable

DETAILS:

Diabetic: Y N

Size (cm) (L x W): _____ Depth (cm): _____

Tunneling (cm): _____ Undermining (cm): _____

EXUDATE:

- Foul Odor: Y N
- Type: None Serous Serosanguineous
- Bloody Purulent
- Amount: None Small Moderate Large

Nurse/PT Signature _____

Date _____ Time _____

PATIENT IDENTIFICATION



N6401BC 07/2011

Fairview Park Hospital Dublin, Georgia	<i>Department: Nursing</i>	
	Reviewed: 02/2011	Revised:
Title: Wound Documentation (Photographic)	Approved By: NEC, MEC	Date Approved: 11/2008
Page: 74 of 91	Original Effective Date: 11/2008	

OBJECTIVE:

To provide photographic image of decubitus ulcers or other wound/skin impairment for documentation in the patient's medical record.

POLICY:

This procedure provides established guidelines for obtaining accurate photographic documentation of skin impairments that may be present on admission or occur during hospitalization. The visual image of the wound is used as an enhancement to the written documentation regarding wound care.

PROCEDURE:

1. On admission, the admitting RN will identify any existing decubitus ulcers during the admission assessment.
2. Consent to photograph will be obtained from the patient.
3. A photograph for initial documentation will be taken on the date of admission and placed in the patient's medical record.
4. Photography of the wound does not take the place of documentation in the medical record. The nurse should continue to document the wound assessment in Meditech under the intervention, "Wound Care" with each treatment of dressing change.
5. Subsequent photographs: After the initial photographic documentation on admission, photographic documentation will be performed on a weekly basis occurring each Monday of the week.
6. Discharge: A photograph of the wound should be taken on the date of discharge to document the condition of the wound.
7. Development of a decubitus ulcer during hospitalization: A photograph of any decubitus ulcers that develop during hospitalization will be taken on initial assessment and treatment of the wound and thereafter on a weekly basis occurring each Monday.
8. Photograph Guidelines: To maintain consistency in photographic documentation, use the following guidelines:
 - a. The photograph should be obtained from a consistent distance from the patient.
 - b. A disposable measuring device should be included in the picture by placing it next to the wound.
 - c. Lighting should be adequate to illuminate the wound on the photograph.
 - d. The following documentation should be included on the photograph:
 - i. Patient name and medical record number
 - ii. Date/time the photograph taken
 - iii. Wound location

- e. Photographs should be printed at the time they are taken and then immediately deleted from the digital camera to protect patient privacy.

Orientation Quiz Instructions

Print the following quizzes & answer sheets. Complete the quizzes using the answer sheet and return answer sheet/test form to Keri Justice, Education Director.

PATIENT RIGHTS & ADVANCE DIRECTIVES

TRUE/FALSE

1. PATIENTS HAVE THE RIGHT TO REFUSE TO SPEAK WITH ANYONE NOT OFFICIALLY CONNECTED TO THE HOSPITAL.
2. A PATIENT MAY WEAR A RELIGIOUS SYMBOLIC ITEM AS LONG AS IT DOES NOT CAUSE HARM.
3. A PATIENT'S MEDICAL RECORD MAY BE READ BY ANYONE IN THE HOSPITAL.
4. A PATIENT DOES NOT HAVE TO KNOW THAT A STUDENT IS TAKING CARE OF HIM/HER.
5. A PATIENT HAS THE RIGHT TO REFUSE TREATMENT AND EVEN LEAVE THE HOSPITAL IF HE/SHE CHOOSES.
6. A PATIENT HAS THE RIGHT TO EXPECT HIS/HER PAIN NEEDS TO BE ADDRESSED AND CONTROLLED.
7. ADVANCE DIRECTIVES ARE WRITTEN BY THE NURSE ON ADMISSION.
8. ALL PATIENTS RECEIVE INFORMATION ON ADVANCE DIRECTIVES ON ADMISSION TO THE HOSPITAL.
9. A COPY OF THE PATIENT'S ADVANCE DIRECTIVE SHOULD ALWAYS BE PLACED IN HIS/HER MEDICAL RECORD.
10. ONCE A COPY IS PLACED IN THE MEDICAL RECORD, A PATIENT MAY NOT CHANGE THE CONTENTS OF HIS/HER ADVANCE DIRECTIVE.

PAIN MANAGEMENT

TRUE/FALSE

1. ALL PATIENTS HAVE THE RIGHT TO BE INFORMED ABOUT PAIN AND PAIN RELIEF MEASURES.
2. UNRELIEVED PAIN HAS NO PHYSICAL OR PSYCHOLOGICAL EFFECTS.
3. PATIENTS AND FAMILIES ARE TO BE NOTIFIED DURING THE ADMISSION ASSESSMENT OF THEIR RIGHT TO PAIN RELIEF.
4. PATIENTS ARE RATED FOR PAIN ONLY ON ADMISSION TO THE UNIT.
5. ALL ADULTS ARE RATED ON A 0-10 PAIN SCALE.
6. APPROPRIATE PAIN MANAGEMENT CAN BRING ABOUT QUICKER RECOVERY, SHORTER HOSPITAL STAYS, FEWER RE-ADMISSIONS, AND IMPROVED QUALITY OF LIFE.
7. BEFORE A PATIENT IS DISCHARGED, THEY MUST BE REASSESSED REGARDING THEIR PAIN STATUS.
8. PAIN IS CONSIDERED THE “FIFTH VITAL SIGN.”
9. PAIN RATING SCALES DO NOT NEED TO BE CONSISTENT
10. AS A STUDENT CARING FOR PATIENTS, YOU SHOULD ASSESS YOUR PATIENT FOR PAIN USING THE PAIN SCALE.
11. AS A STUDENT CARING FOR PATIENTS, IF YOUR PATIENT COMPLAINS OF PAIN YOU SHOULD REPORT THIS AT THE END OF THE SHIFT TO YOUR ASSIGNED NURSE.

RESTRAINTS

TRUE/FALSE

1. RESTRAINTS SHOULD ONLY BE USED AS A LAST RESORT, AFTER TRYING ALTERNATIVE METHODS OF CARE.
2. EXAMPLES OF ALTERNATIVES TO RESTRAINTS INCLUDE PROVIDING ACTIVITIES, USING ALARMS, AND MAKING CHANGES TO THE PATIENT'S SURROUNDINGS.
3. IF A PATIENT HAS A HISTORY OF NEEDING RESTRAINTS, THAT ALONE IS REASON ENOUGH TO RESTRAIN HIM/HER FOR NOW.
4. THE PATIENT AND HIS/HER FAMILY MAY HAVE GOOD SUGGESTIONS FOR ALTERNATIVES TO RESTRAINTS.
5. THE POLICY FOR RESTRAINTS AT FAIRVIEW PARK HOSPITAL IS THE SAME FOR MEDICAL-SURGICAL RESTRAINTS AND BEHAVIORAL RESTRAINTS.
6. ONLY CERTAIN STAFF MEMBERS ARE AUTHORIZED TO ORDER RESTRAINT USE.
7. IF A RESTRAINT IS UNAVOIDABLE, YOU SHOULD ALWAYS CHOOSE THE LEAST RESTRICTIVE METHOD POSSIBLE.
8. PATIENTS WHO ARE PROPERLY RESTRAINED, DON'T NEED ANY SPECIAL CARE.
9. EVERY USE OF RESTRAINTS AS WELL AS ALTERNATIVE METHODS TRIED SHOULD BE CAREFULLY DOCUMENTED IN THE PATIENT'S MEDICAL RECORD.
10. ALL RESTRAINED PATIENTS MUST BE MONITORED EVERY TWO HOURS.

CULTURE AND RELIGION

TRUE/FALSE

1. AMERICAN CULTURE IS UNIVERSALLY THE SAME FOR ALL AMERICANS.
2. IF YOUR PATIENT DOES NOT SPEAK ENGLISH, YOU DO NOT HAVE TO COMMUNICATE WITH HIM/HER.
3. DIRECT EYE CONTACT IS NOT ALWAYS ACCEPTABLE.
4. BATHING AND BASIC HYGIENE ARE ACCEPTED PRACTICES OF ALL CULTURES.
5. ALL PATIENTS ACCEPT AND BELIEVE IN MEDICAL SCIENCE AS THE PRIMARY METHOD OF HEALING.
6. SOME CULTURES MAY NOT BELIEVE IN VERBALIZING THAT THEY ARE IN PAIN.
7. IF YOUR PATIENT HAS A SPECIAL FOOD CUSTOM, YOU SHOULD MAKE SURE THAT HIS MEALS HONOR THAT CUSTOM.
8. TOUCH IS ACCEPTABLE FOR ALL CULTURES.
9. IF YOUR PATIENT DOES NOT SPEAK ENGLISH, FAIRVIEW PARK HOSPITAL HAS A METHOD TO PROVIDE COMMUNICATION.
10. IF YOU ARE UNSURE OF A PATIENT'S CULTURAL CUSTOMS, YOU SHOULD ASK ABOUT HIS CUSTOMS.

HOSPITAL EMERGENCY CODES
& DISASTER PREPAREDNESS

MATCHING

- | | |
|--------------------|--|
| A. CODE BLUE | 1. FIRE |
| B. CODE GRAY | 2. BOMB THREAT |
| C. CODE GREEN | 3. INFANT/PEDIATRIC ABDUCTION |
| D. CODE PINK | 4. DANGEROUS WEATHER |
| E. CODE RED | 5. USE "RACE" |
| F. CODE YELLOW | 6. MANN ALL EXITS FROM THE HOSPITAL |
| G. CODE ORANGE | 7. DISASTER |
| H. WEATHER WARNING | 8. CARDIOPULMONARY ARREST |
| I. TORNADO ALERT | 9. KNOW LOCATION OF FIRE
EXTINGUISHERS |
| J. 3111 | 10. HOW TO CALL A CODE |
| | 11. NEED SECURITY |
| | 12. NEED AMBU BAG AND CRASH
CART |
| | 13. USE "PASS" |
| | 14. RADIATION/CHEMICAL SPILL |
| | 15. TORNADO SIGHTED IN HOSPITAL
AREA |
| | 16. BEGIN CPR |
| | 17. VIOLENCE OR THREATENING PERSON |
| | 18. KNOW LOCATION OF OXYGEN CUT OFF
VALVES |
| | 19. STOP EVERYONE FROM LEAVING
HOSPITAL |
| | 20. MOVE PATIENTS TO INTERIOR
HALLWAY/STAIRWELL |

NATIONAL PATIENT SAFETY GOALS

TRUE/FALSE

1. "TIME OUT" IS USED BEFORE ALL SURGICAL/INVASIVE PROCEDURES TO DOUBLE CHECK THE IDENTITY OF THE PATIENT.
2. WHEN IDENTIFYING A PATIENT PRIOR TO ADMINISTERING MEDICATION OR PERFORMING A PROCEDURE, THE ROOM NUMBER IS AN ACCEPTABLE FORM OF IDENTIFICATION.
3. QD IS AN ACCEPTABLE ABBREVIATION AT FAIRVIEW PARK HOSPITAL.
4. STUDENTS SHOULD READ BACK AND VERIFY ALL VERBAL ORDERS FROM A PHYSICIAN.
5. CRITICAL LAB AND TEST RESULTS MUST BE READ BACK AND VERIFIED AND NOTED ON A BLUE CONFIRMATION STICKER IN THE MEDICAL RECORD.
6. ALL MEDICATION MUST BE LABELED WHEN REMOVED FROM ITS ORIGINAL CONTAINER AND NOT IMMEDIATELY USED ON A PATIENT.
7. CLINICAL ALARMS SHOULD BE PLACED IN SILENT MODE.
8. PATIENTS AT HIGH RISK FOR A FALL ARE TAGGED WITH A YELLOW DOT.
9. ANYTIME THERE IS A MEDICAL ERROR OR PATIENT INJURY, YOU SHOULD FIRST CHECK THE SAFETY OF THE PATIENT AND REPORT THIS TO THE CHARGE NURSE AND YOUR INSTRUCTOR IMMEDIATELY.
10. ERRORS AND INJURY ARE REPORTED IN NOTIFICATION FORMS WHICH ARE PART OF THE PATIENT'S MEDICAL RECORD.

VIOLENCE IN THE WORKPLACE

TRUE/FALSE

1. THERE ARE RARELY ANY WARNING SIGNS OF VIOLENCE.
2. IT HELPS TO TALK LOUDLY TO A PERSON WHO SHOWS SIGNS OF VIOLENCE.
3. YOU SHOULD REPORT ALL THREATS AND INCIDENTS OF VIOLENCE
4. YOU CAN IMMEDIATELY TELL THE TYPE OF PERSON WHO IS LIKELY TO BE VIOLENT.
5. IT IS A GOOD IDEA TO CHECK RECORDS FOR A PERSON'S HISTORY OF VIOLENCE.
6. FEAR, STRESS, AND FRUSTRATION CAN BE TRIGGERS FOR VIOLENCE.
7. IF A THREATENING PERSON DEMANDS DRUGS, YOU SHOULD NOT GIVEN THEM TO HIM.
8. MOST THREATS CAN BE TREATED AS JOKES AND IGNORED.
9. PACING, CURSING, AND CLENCHING FISTS CAN BE WARNING SIGNS OF VIOLENCE.
10. IF A VIOLENT EVENT OCCURS IN YOUR AREA, YOU SHOULD SEEK TO MAINTAIN YOUR IMMEDIATE SAFETY AND CALL CODE GRAY.

ERGONOMICS

TRUE/FALSE

1. THE BACK HAS SIX NATURAL CURVES.
2. WRISTS SHOULD BE STRAIGHT AND ARMS AT SIDES WHEN USING COMPUTERS.
3. WHENEVER POSSIBLE, YOU SHOULD PULL INSTEAD OF PUSHING OBJECTS.
4. YOU SHOULD ALWAYS TEST THE WEIGHT OF THE LOAD PRIOR TO LIFTING.
5. POOR BODY MECHANICS IS ONE OF THE KEY RISK FACTORS FOR BACK INJURY.
6. YOU SHOULD USE A CHAIR WITH BACK SUPPORT AND PROP FEET WHEN SITTING IF POSSIBLE.
7. ANYTIME YOU TURN, YOU SHOULD MOVE YOUR BODY AS A WHOLE UNIT TO AVOID TWISTING.

AGE SPECIFIC EXAM

TRUE/FALSE

1. A 14 YEAR OLD BOY WILL NOT BE EMBARRASSED TO DISROBE FOR A PROCEDURE.
2. A TWO YEAR OLD WITH A FAT TUMMY IS PROBABLY CONSTIPATED.
3. THE PARENTS OF A FOUR YEAR OLD CHILD DO NOT NEED TO STAY WITH THE CHILD.
4. A TEN YEAR OLD CHILD LIKES TO “HELP”
5. THE ADOLESCENT IS NOT AFRAID TO SHOW FEAR.
6. THE LEADING CAUSE OF DEATH IN YOUNG ADULTS IS ACCIDENTS.
7. A SIX YEAR OLD BOY IS TOO YOUNG OT HAVE PROCEDURES EXPLAINED TO HIM.
8. A 70 YEAR OLD IS MORE SENSITIVE TO TEMPERATURE CHANGES THAN A 25 YEAR OLD.
9. AN OLDER PERSON HAS LESS PERCEPTION OF PAIN.
10. AN INFANT CRIES TO COMMUNICATE HIS NEEDS.
11. A 16 YEAR OLD GIRL IN THE HOSPITAL WILL NOT WANT TO BE VISITED BY HER FRIENDS.
12. CONFUSION IS A NORMAL PART OF THE AGING PROCESS.
13. A FIVE YEAR OLD BOY MAY PERCEIVE A PROCEDURE AS PUNISHMENT.
14. AN ADOLESCENT CAN HAVE INPUT INTO HIS/HER PLAN OF CARE.
15. A 50 YEAR OLD MALE IS AT INCREASED RISK FOR HYPERTENSION AND HEART PROBLEMS COMPARED TO A 20 YEAR OLD MALE.

TEST
WAIVED/POCT TESTING
ACCU-CHECK INFORM SYSTEM

___ 1. WE HAVE A CERTIFICATE OF WAIVER ISSUED TO OUR HOSPITAL BY CLIA WHICH COVERS WAIVED TESTING.

___ 2. OUR NURSES WHO WORK IN THE NURSERY PERFORM BILIRUBIN TESTS USING THE BILICHEK ANALYZER WHICH IS CLASSIFIED BY THE GEORGIA DEPARTMENT OF HUMAN RESOURCES (GDHR) AS A WAIVED TEST.

___ 3. THE BILICHEK ANALYZER MAY BE USED BY RN/LPN WHO WORK IN THE NURSERY AND MEET THE ANNUAL TRAINING/COMPETENCY REQUIREMENTS.

___ 4. THERE ARE NO REGULATORY REQUIREMENTS FOR WAIVED OR POCT TESTS.

___ 5. BLOOD GLUCOSE IS THE ONLY WAIVED TEST APPROVED TO BE USED BY OUR HOSPITAL STAFF ON PATIENTS.

___ 6. BEFORE RUNNING A PATIENT TEST WITH THE ACCU-CHECK INFORM GLUCOMETER, YOU MUST BE SURE THE CODE NUMBER IN THE TEST STRIPS VIAL CORRESPONDS TO THE CODE NUMBER DISPLAYED ON THE GLUCOMETER.

___ 7. If "QUALITY CONTROL IS DUE" OR "QC DUE IMMEDIATELY" APPEARS IN THE DISPLAY, YOU SHOULD RUN CONTROLS THAT ARE IN RANGE BEFORE PROCEEDING TO DO A PATIENT TEST.

___ 8. THE ACCU-CHECK INFORM SYSTEM CANNOT RECORD OPERATOR OR PATIENT ID INFORMATION.

___ 9. GLOVES MUST BE WORN WHEN PERFORMING BLOOD GLUCOSE OR GLUCOSE CONTROL TESTING AND WHEN CLEANING THE ACCU-CHECK INFORM SYSTEM.

___ 10. WHEN CODING THE ACCU-CHEK INFORM METER, YOU MUST USE THE CODE KEY FROM THE SAME VIAL OF TEST STRIPS THAT YOU ARE USING.

___ 11. THE TEST STRIP IS PLACED IN THE TEST STRIP SLOT WITH THE YELLOW TARGET AREA OR TEST WINDOW FACING UP. (INSERT THE END WITH THE SILVER BARS.)

___ 12. THE PROPER SITE FOR THE FINGER PUNCTURE IS ON THE SIDE OF THE FINGERTIP.

___13. IF THE DROP OF BLOOD IS NOT LARGE ENOUGH TO COVER THE YELLOW TARGET AREA OR TEST WINDOW, IT IS ACCEPTABLE TO ADD ANOTHER DROP ONTO THE TEST STRIP WITHIN 15 SECONDS OF THE FIRST DROP.

___14. GLUCOSE CONTROL SOLUTIONS DO NOT HAVE TO BE DATED WHEN FIRST OPENED.

___15. IF "LO" OCCURS ON A PATIENT TEST, YOU REPEAT THE TEST.

___16. ONLY CAPILLARY WHOLE BLOOD SAMPLES SHOULD BE USED WHEN TESTING WITH THE ACCU-CHEK INFORM SYSTEM AND ACCU-CHEK COMFORT CURVE TEST STRIPS.

___17. THE ACCU-CHEK INFORM METER SHOULD BE DOCKED IN THE BASE UNIT WHEN NOT IN USE.

___18. THE ACCU-CHEK INFORM METER USES A RECHARGEABLE BATTERY.

___19. IF HI OCCURS ON A PATIENT TEST, IT INDICATES THE RESULT MAY BE ABOVE THE READING RANGE OF THE METER.

FILL IN THE BLANKS

20. THE EXPIRATION DATES FOR TEST STRIPS AND CONTROL SOLUTIONS ARE FOUND _____.

21. _____ CONTAINS A COMPLETE TROUBLE SHOOTING GUIDE FOR THE ACCU-CHEK INFORM SYSTEM.

22. CONTROL SOLUTIONS ARE STABLE FOR _____ MONTHS AFTER OPENING.

23. IF PATIENT RESULTS ARE HIGHER THAN _____ MG/DL OR LOWER THAN _____ MG/DL FOR AN ADULT OR LESS THAN _____ OR HIGHER THAN _____ FOR A NEONATE, THIS IS CONSIDERED A CRITICAL RESULT AND A STAT BLOOD GLUCOSE SHOULD BE DRAWN.

24. TEST STRIPS ARE STABLE UNTIL THE EXPIRATION DATE LISTED ON THE _____.

25. THE FOLLOWING BLOOD SPECIMENS MAY BE USED WITH THE ACCU-CHEK INFORM METER.

- a. CAPILLARY
- b. VENOUS
- c. NEONATAL (INCLUDING CORD BLOOD)
- d. ARTERIAL
- e. ALL OF THE ABOVE

Controlled Substance Exam for Nursing

Name: _____

Date: _____

1. Nursing can waste a partial dose of any scheduled drug (CII-CV) as long as there are two signatures, one being the nurse administering the drug and the other the nurse witnessing the wasting.
 - A. True
 - B. False

2. A full unusable dose of a schedule CIII thru CV can be wasted by a nurse as long as a witness signs for the wastage.
 - A. True
 - B. False

3. On the narcotic proof of use sheet, which of the following is (are) required by law to be the minimum requirements:
 - I. given and last name of patient
 - II. date and time of administration to the patient
 - III. name of drug, strength, and dosage form of the drug (description of drug on the narcotic sheet should meet these requirements.
 - IV. Signature of individual administering, which shall include at a minimum the last name
 - V. At a minimum the last name of the patient
 - A. I and III
 - B. II, III, IV, and V
 - C. I, II, and III
 - D. I, II, and IV
 - E. II, III, and V
 - F. All of the above

4. If a Percocet is removed from the blister pack, carried to the patient, and then refused, the nurse can waste it as long as another nurse signs was a witness to the wastage.
 - A. True
 - B. False

5. Which of the following is FALSE?
 - A. A 'beginning' and 'ending' narcotic count must be on each narcotic control sheet
 - B. The final count is also transferred to the new proof of use sheet
 - C. Two signatures are required for all narcotic counts. (shift change, personnel leaving early, etc.)
 - D. If a nurse leaves early from work and it is not shift change, a narcotic count is not required as long as two nurses still remain on the unit.

6. If a full unusable dose needs to be wasted which of the following are TRUE?
 - I. Two nurses may waste the dose as long as both sign the proof of use

Sheet.

- II. Sign the unusable dose back into floor stock inventory with “Hold for Pharmacy”, patient last name, and initial written in the patient column.
 - III. Place unusable full dose in sealed plastic bag with patient name, drug name, reason for wastage, and two signatures.
 - IV. Fill out a notification
- A. I and II C. I and IV E. none of the above
B. II and III D. I, II, and III
7. Full, unusable doses of injectable controlled substances in any schedule may be wasted by one pharmacist and two witnesses.
- A. True
B. False
8. If a dose such as cough syrup (Schedule II thru V) is spilled in the bed sheets, the proper procedure is:
- I. have another nurse verify the wastage and sign as the witness along with a short note of reason on the proof of use sheet
 - II. Fill out a notification
 - III. Gather the linen and send to the pharmacy
- A. I and II C. I, II, and III E. none of the above
B. II and III D. I and III
9. Controlled substances should be signed out on the narcotic proof of use sheet prior to administration of the medication to the patient.
- A. True
B. False
10. It is proper procedure and good practice for a nurse to wait to sign for wastage at the end of his/her shift.
- A. True
B. False

Blood Administration

1. The physician's order reads: "Type and Cross for 2 units of PRBC". According to this order, the nurse should obtain the blood and transfuse the patient.
 - a. True
 - b. False
2. Patients and/or family should sign a consent for Blood Administration prior to administration of blood.
 - a. True
 - b. False
3. When the lab technician draws blood from the patient for the Type and Crossmatch, a yellow blood band is placed on the patient with the identifying blood number.
 - a. True
 - b. False
4. Which of the following IV tubings should be used to administer blood?
 - a. Regular primary IV set
 - b. Vented tubing
 - c. Y set with filter tubing
5. Prior to starting the blood transfusion, identifying information may be checked by:
 - a. RN/RN
 - b. RN/LPN
 - c. LPN/LPN
 - d. LPN/PCA
 - e. A or B
6. Which of the following information should be checked at the bedside to prevent transfusion errors?
 - a. Compare patient full name on hospital ID band and blood requisition form
 - b. Compare hospital ID number on ID band and blood requisition form
 - c. Match the blood unit donor number, ABO group, and Rh type on the actual blood unit and the blood requisition form.
 - d. Check expiration date
 - e. Compare patient blood band ID# with blood requisition form
 - f. All of the above
7. Blood may be administered with:
 - a. 0.9% Saline
 - b. D5W

- c. Other drugs
 - d. 0.45% Saline
8. The rate of infusion of the blood is usually:
- a. One unit over approximately 2-3 hours.
 - b. Dependent upon the clinical condition of the patient
 - c. Slower for patients at risk for fluid overload
 - d. All of the above are true
9. A blood tubing set can be used for 2-4 units of blood or 4 hours whichever is less.
- a. True
 - b. False
10. Signs of a transfusion reaction include:
- a. Fever/chills
 - b. Significant change in vital signs including drop in blood pressure and increase in heart rate
 - c. Back pain
 - d. Itching
 - e. Shortness of breath
 - f. All of the above
11. The most common time for a transfusion reaction to occur is:
- a. At the end of the transfusion
 - b. In the 1st 15 minutes of the transfusion
 - c. About an hour into the transfusion

Orientation Quiz Answer Sheet

NAME: _____

DATE: _____

Patient Rights & Advance Directives

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Pain Management

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____

Restraints

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Culture & Religion

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Emergency Codes & Disaster Preparedness

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____
- 13. _____
- 14. _____
- 15. _____
- 16. _____
- 17. _____
- 18. _____
- 19. _____
- 20. _____

National Patient Safety Goals

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Violence in the Workplace

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Ergonomics

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

Blood Administration

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____

Controlled Substance Exam

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Waive Testing

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 11. _____ | 21. _____ |
| 2. _____ | 12. _____ | 22. _____ |
| 3. _____ | 13. _____ | 23. _____ |
| 4. _____ | 14. _____ | 24. _____ |
| 5. _____ | 15. _____ | 25. _____ |
| 6. _____ | 16. _____ | |
| 7. _____ | 17. _____ | |
| 8. _____ | 18. _____ | |
| 9. _____ | 19. _____ | |
| 10. _____ | 20. _____ | |