



FAIRVIEW PARK

HOSPITAL

**FACULTY & STUDENT CLINICAL
AFFILIATION ORIENTATION MANUAL**

Table of Contents

<u>Welcome</u>	3
<u>Instructions for completing orientation</u>	3
<u>General Guidelines/Expectations of Students</u>	4-5
<u>Dress Code</u>	6
<u>Mission & values Statement</u>	7
<u>Identification of Patients</u>	8-9
<u>Abbreviations</u>	9
<u>Medication Administration</u>	10
<u>Medication Error Reporting</u>	10
<u>Patient Rights</u>	11
<u>Culture & Diversity</u>	12
<u>PAIN: Assessment & Documentation</u>	13-14
<u>Advance Directives</u>	15-16
<u>Age Related Care & Risk Hazards</u>	17-24
<u>Restraint Use & Guidelines</u>	25-26
<u>Material Safety Data Sheets</u>	27
<u>Emergency Codes & Fire Safety</u>	28-30
<u>Security Tips</u>	31
<u>FVP Parking Map</u>	32
<u>Smoking Policy</u>	33
<u>Infection Control</u>	34-40
<u>Confidentiality</u>	41
<u>HIPPA</u>	41-42
<u>2011/2010 FVP National Patient Safety Goals</u>	43-47
<u>Sepsis: Early recognition and treatment</u>	48-53
<u>Violence in the Workplace</u>	54-55
<u>Body Mechanics (Ergonomics)</u>	56-60
<u>Student Quiz Instructions</u>	61
<u>Student Quiz Packet</u>	62-70
<u>Orientation Quiz Answer Sheet</u>	71
<u>Clinical Agreement & Confidentiality Statement</u>	72
<u>Faculty Instructions</u>	73

Welcome to Fairview Park Hospital!

We look forward to working with you as a partner in your clinical education. 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 clinical at our facility.

- 1. Read the contents of this manual. It provides valuable information to help you care for patients according to policy & procedure.**
- 2. Save or print a copy of this manual for future reference.**
- 3. Print a copy of the Student Orientation Exam. Complete the exam using the answer sheet at the end of the exam or using a scannable test form provided by your school.**
- 4. Passing test score is 80%.**
- 5. Print the Clinical Agreement & Confidentiality Statement, read and sign and return to your instructor.**
- 6. A physical orientation to your assigned unit will be conducted prior to or on the first day of clinical rotation.**

Fairview Park Hospital **Student Guidelines & Expectations**

Welcome to Fairview Park Hospital! We are happy to provide a clinical setting that will assist you in your growth and development as a healthcare provider. You are our future!

Below are general guidelines and expectations for all students who are completing a clinical rotation within our facility. Please review prior to your first clinical rotation at our hospital.

Should you encounter any staff who you feel are extraordinary in their role and/or ability to mentor new nurses, please take a moment prior the end of you semester to share that information with us so that these individuals may be recognized. Likewise, if you encounter an employee that is not supportive of you during your time at our facility, please let us know as soon as possible so that we can correct the situation.

Guidelines:

1. Adhere to the facility's policies & procedures.
 - Clinical policies may be found online on each unit on the Fairview Park Hospital Intranet Page.
 - Nursing Procedures are located on the hospital intranet as well within the Lippincott Nursing Procedures and Skills Reference Library link.
2. Review and adhere to our Standards of Behavior.
3. Use the chain of command.
 - Your instructor is the primary chain of command at Fairview Park Hospital. Any incident or situation should be discussed with your instructor.
 - If you need to discuss a situation with a representative of the hospital, you may contact the Inservice Education Coordinator, Keri Belflower at 274-3176.
4. Every patient is under the direct care of Fairview Park Hospital Staff. Students are under the supervision of their clinical instructor and contribute to patient care according to hospital policy. Please communicate issues with the primary clinical staff in a timely manner.
5. Complete routine assigned care with considerations of the patient's age, spiritual, cultural needs and patient rights.
6. Give a detailed, current report on your assigned patients to the appropriate nurse responsible for the patient **before leaving the unit** for break, lunch, or the end of shift.

7. Review and be accountable for providing care utilizing the 2011 National Patient Safety Goals.
8. Ensure patient safety and welfare while providing patient care by adhering to all Environment of Care guidelines and related policies and procedures.
 - a. Report all chemical spills/hazards and handle hazardous chemicals in accordance with the MSDS maintained in HazSoft system.
 - b. Report malfunctioning equipment
 - c. Recognize and be able to report hospital “Codes”
 - d. Observe radiation precautions
 - e. Practice safe ergonomic work habits to prevent injury
 - f. Any student, staff, or patient injury, medication error, or other unusual occurrence must be reported in a Notification Form.
The notification system is located in the Meditech System and can be accessed by hospital staff to complete the notification process. Report any student or patient injury, medication error, or other unusual occurrence immediately to the staff on your unit and your instructor.
9. Identify yourself appropriately by name and title when answering the phone.
 - DO NOT take phone/verbal orders from physicians or other providers.
 - DO NOT take critical test results from the lab. These calls should be directed to the nurse responsible for caring for the patient or the charge nurse.
10. Only smoke in designated areas outside the hospital.
11. Maintain patient confidentiality according to HIPPA guidelines.
12. Utilize the Point of Use system (scan ALL supplies) for supply management.
13. Adhere to the infection control policies & standard precautions.

Dress Code and Conduct Guidelines:

1. Students must abide by their respective school dress code guidelines.
2. Students must wear your school picture ID badge above the waist and clearly visible at all times while in the facility. *Students receive a discount in the cafeteria with their school name badge.*
3. Students must wear personal underclothes that are appropriate for clinical and cannot be seen through your uniform. No jeans are allowed.
4. Students must wear socks or hose with your uniform shoes.
5. Students must wear shoes that cover your toes/feet. No sandals or open toed shoes.
6. No tattoos or body piercings should be visible. No more than one pair of earrings for females. Males are not allowed to wear earrings.
7. No perfume or cologne due to patient allergies.
8. No smoking inside the facility. Smoke in the designated smoking area only.
9. Make-up should be simple and not overdone. No chewing gum while on duty.
10. No eating or drinking in the Nurse's Station or patient care areas. Please take your assigned break on the unit area designated for eating or in the cafeteria. Please keep your voices at a low tone.
11. When using charts, please make sure that charts are easily available for the physicians and nurses on the unit. Keep the physician dictation area available for physician use.
12. Cell Phone use is not allowed within the facility.
13. Do NOT distribute or share security access codes to secure areas of the building such as the Emergency Department, Critical Care Unit, or Labor & Delivery.

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

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.

Students & Faculty are to 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 students and faculty are expected to utilize scanning procedures including scanning of the patient armband and scanning of medications within the eMAR system.

STUDENTS ARE NOT ALLOWED TO TAKE VERBAL OR TELEPHONE ORDERS.

Medication Errors: All medication errors including missed doses are to be reported in a Notification form. Students and Instructors should report errors to the patient's assigned nurse or 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.

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 LSA systems (Language Service Associates). This special three-way phone is available on all units, or 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 and peers
- 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 student parking area is located at the back of the main building in the employee parking lot. Students should park in the back of the employee parking lot near the Fairview Therapy Center.



Parking.pdf (561
KB)

Fairview Park Hospital Dublin, Georgia Human Resources	<i>Department:</i> All Employees and Contractors	
	Standard:	
Reference Number:	Reviewed:	Revised: January 1, 2012
Title: Tobacco-Free Campus	Approved By: Administration	Date Approved: November 14, 2011
Page: 33 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

Student Orientation – 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	
<i>After</i> (possible) exposure to spores (e.g. <i>C. difficile</i>)	X	

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 1/4inch 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 ½ inch in length. Nail length for food handlers is limited to ¼ 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.

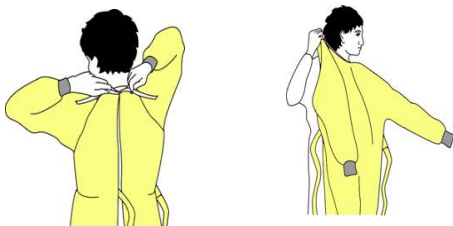
Types of PPE include gloves, gowns/aprons, masks and respirators, goggles, and face shields. PPE in only effective if used appropriately.

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
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 headband
2. Position face shield over face and secure on brow with

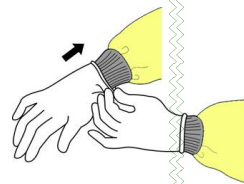


ear pieced or
headband

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

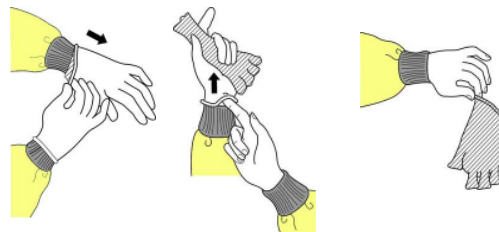
The sequence for removing PPE is intended to limit opportunities for self-contamination. The gloves are considered the most contaminated pieces of PPE and are therefore removed first. The face shield or goggles are next because they are more cumbersome and would interfere with removal of other PPE. The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

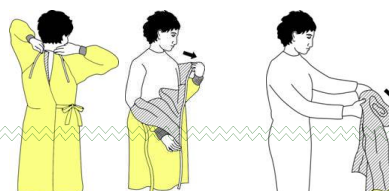
N. Remove Goggles or Face Shield

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

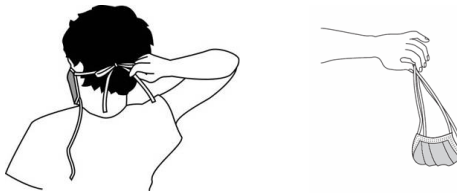
1. Unfasten ties



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 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 HBC 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 you 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.**

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**

*******STUDENTS MAY ACCESS MEDICAL RECORDS FOR LEARNING PURPOSES AND IN THE COURSE OF CARE OF THEIR ASSIGNED PATIENTS. STUDENTS MAY NOT TAKE ANY PRINTED PATIENT INFORMATION OUT OF THE HOSPITAL.**

2011 Hospital National Patient Safety Goals

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.

Additional information regarding these goals can be found at www.jointcommission.org.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01

Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01

Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01

Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

Check Patient Medicines

NPSG.08.01.01

Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines.

NPSG.08.02.01

Give a list of the patient's medicines to their next caregiver. Give the list to the patient's regular doctor before the patient goes home.

NPSG.08.03.01

Give a list of the patient's medicines to the patient and their family before they go home. Explain the list.

NPSG.08.04.01

Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.

Identify patient safety risks

NPSG.15.01.01

Find out which patients are most likely to try to commit suicide.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

Review of 2010 National Patient Safety Goals

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

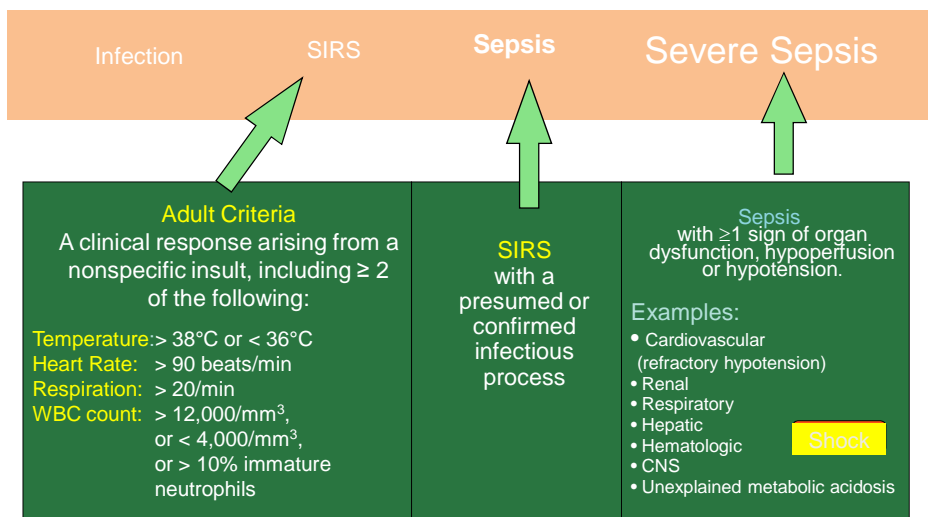
Sepsis: Early Detection and Appropriate Management

Sepsis: Human and Financial Impact

Severe Sepsis: A Growing Healthcare Challenge

- #1 cause of death in non-coronary ICU
- 11th leading cause of death overall
- 28-day mortality: 30-50%
- >750,000 US cases annually
- Incidence growing faster than overall population
- \$17.0 billion cost of treatment in the US(30 billion)

Severe Sepsis: Defining a Disease Continuum



SIRS = Systemic Inflammatory Response Syndrome
 Bone et al. *Chest*.1992;101:1644-1654.

Early Identification Can Help Improve Survival

Mortality rates increase as organ dysfunctions increase:

- **21.2% — 1 organ dysfunction**
- **44.3% — 2 organ dysfunctions**
- **64.5% — 3 organ dysfunctions**
- **76.2% — 4 or more organ dysfunctions**

Occult Tissue Hypoxia

- Tissue hypoxia is often occult, reaches an advanced and lethal stage before its presence is known and resuscitation is attempted.
- Vital signs are inadequate for detecting global tissue hypoxia and not adequate as a resuscitation end point.
- Up to 50% of patients resuscitated from shock may have continued global tissue hypoxia (elevated lactate and decreased ScvO₂) despite normalized vital signs and central venous pressure.

Why Do You Need to Have a Screening Process?

- **TIME IS TISSUE!!**

- Similar to trauma, AMI, or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence outcomes.¹
- To screen effectively, it must be part of the nurses' daily routines— i.e., part of admission and shift assessment
- Severe sepsis screening begins on admission.
- Re-assess every 12 hrs
 - Shift Assessment
- Re-assess as needed

The Severe Sepsis Bundles: Surviving Sepsis Campaign/IHI*

Resuscitation Bundle

(To be accomplished as soon as possible and scored over **first 6 hours**):

- ✓ Serum lactate measured
- ✓ Blood cultures obtained prior to antibiotics administered (1C)
- ✓ Perform imaging studies promptly to find source (1C)
- ✓ Administration of broad- spectrum antibiotics within 1 hour of diagnosis of septic shock (1B) and severe sepsis without septic shock (1D)
- ✓ For hypotension and/or lactate > 4 mmol/L:
 - ✓ Deliver an initial minimum of 20 mL/kg of crystalloid (or colloid equivalent) (1C)
 - ✓ Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain MAP \geq 65 mmHg. (1C)
- ✓ For persistent hypotension despite initial fluid resuscitation (septic shock) and/or lactate > 4 mmol/L (1C)
 - ✓ Achieve CVP of 8 -12 mmHg & MAP \geq 65 mmHg & UO >0.5mL/kg/hr
 - ✓ Achieve ScvO₂ of \geq 70% or SvO₂ \geq 65%.
 - ✓ if ScvO₂ not \geq 70% blood or dobutamine (2C)

Management Bundle

(To be accomplished as soon as possible and scored over **first 24 hours**):

- ✓ Low-dose steroids administered for septic shock in accordance with a standardized ICU policy. (Given to patients who respond poorly to fluids or vasopressors) (2C)
- ✓ Drotrecogin alfa (activated) administered in patients with severe sepsis and clinical assessment of high risk of death (2B, except 2C for postoperative patients)
- ✓ Glucose control maintained to < 150 mg/dL (8.3 mmol/L). (2C)
- ✓ Tidal volume 6 mL/kg (1B) Inspiratory plateau pressures < 30 cmH₂O for mechanically ventilated patients. (1C)

Adapted from Dellinger PR et al. SSC: International guidelines for management of severe sepsis and septic shock: 2008. *Crit Care Med.* 2008;36(1):296-327.

Initial Screening

===SEVERE SEPSIS SCREENING===

LAST 6 SIRS CRITERIA ENTRIES (searching past 1 days)

Date	Time	T (F)	T (C)	P	R

Temperature: Temperature:
Temp > or = to 100.4 F
or less than or equal to
96.8 F

Heart Rate:

Respirations:

WBC Count:

If Y to 2 or more of above, proceed to next section:

Programming Criteria

- If 2 or more are answered with a Y, further screening is required.
 - Add'l screening questions will appear.
- If 1 or more in Infection are answered with a Y –
 - Proceed to the next section
- If 1 or more in Organ Dysfunction are answered with a Y –
 - Patient is POSITIVE for Severe Sepsis

Infection/Organ Dysfunction

===INFECTION===

Suspected/Documented Infection:

Antibiotic Therapy (Not Prophylaxis):

If Y to 1 of the above, proceed to next section:

===ORGAN DYSFUNCTION===

Respiratory: <input type="checkbox"/>	Hematologic: <input type="checkbox"/>
Cardiovascular: <input type="checkbox"/>	Hepatic: <input type="checkbox"/>
Renal: <input type="checkbox"/>	CNS: <input type="checkbox"/>
Metabolic: <input type="checkbox"/>	

If Y to 1 of the above, positive for severe sepsis:

Infection/Organ Dysfunction

===INFECTION===

Suspected/Documented Infection:

Antibiotic Therapy (Not Prophylaxis):

If Y to 1 of the above, proceed to next section:

===ORGAN DYSFUNCTION===

Respiratory: <input checked="" type="checkbox"/>	Hematologic: <input type="checkbox"/>
Cardiovascular: <input checked="" type="checkbox"/>	Hepatic: <input type="checkbox"/>
Renal: <input type="checkbox"/>	CNS: <input type="checkbox"/>
Metabolic: <input type="checkbox"/>	

Renal:
Urine output < than 0.5ml/kg/hr
after fluid resuscitation:
creatinine increase of >
than 0.5mg/dl from baseline

If Y to 1 of the above, positive for severe sepsis:

Infection/Organ Dysfunction

===INFECTION===

Suspected/Documented Infection: Y
 Antibiotic Therapy (Not Prophylaxis): Y
 If Y to 1 of the above, proceed to next section: 2

===ORGAN DYSFUNCTION===

Respiratory: Y Hematologic:
 Cardiovascular: Y Hepatic:
 Renal: Y CNS:
 Metabolic:
 If Y to 1 of the above, positive for severe sepsis: 2

CNS:
 Altered consciousness (unrelated to primary neuro pathology);
 Glasgow coma scale less than or equal to 12.

Error
 Positive for Severe Sepsis - Contact Physician/PA/ARNP
 Ok

Plan of Care

Interventions	Sts	Directions	Doc	Src	D	C/N	KI	Prt
<<-ASSESS/MONITOR/OBSERVE->>								
-Blow Glove: Monitor	A		21h	PS				
<<-ROUTINE NURSING CARE->>								
-Severe Sepsis Screening	A			PS				

Plan of Care

Problems					(→ Goals)
Mnemonic	Description	⌘ for functions menu	Status	Text	Prot
1 P.SIRS	PROBLEM: High Risk Severe Sepsis		A		
2					
3					

Goals				
Description	⌘ for functions menu	Status	Text	Target Date
1 The patient will show evidence of		A		
2				
3				
4				
5				

Interventions				
Description	⌘ for functions menu	Status	Text	Prot
→ 1 HIGH RISK: Severe Sepsis		A		
2				
3				
4				
5				
6				

E/E Text		
→ 1	Date	Time D
2		
3		

resolving infection by becoming afebrile, decreasing WBC.

Prevent infections and the risk of sepsis thru high compliance with evidence based practices

- Surgical infections and post surgical pneumonias
- Catheter associated urinary tract infections
- Reducing MDRO transmission and infections (MRSA, *C. difficile*, highly resistant gram negative bacteria)
- Ventilator pneumonia infections
- AIM for Zero Central Line Associated Bloodstream infections
- Hand Hygiene

Violence in the Workplace: *Violence can Strike anywhere, any time, and in any department.*

Violence in Healthcare Facilities May result in one or more of the following:

- Lives lost
- Serious injury
- Pain and suffering
- Financial costs
- Low moral
- Fear, anger, and grief

What is Violence?

- The use of force or the threat of force to cause harm.
 - Threats (verbal or written)
 - Stalking or bullying
 - Robbery
 - Hitting
 - Using weapons
 - Kidnapping
 - Suicide
 - Rape or sexual assault
 - Murder
 - Property damage

Who commits violence in healthcare facilities?

- There is not one type of person who commits violence. However, certain traits are linked with violence.
 - History of violence or aggression
 - Family conflict or abuse
 - Alcohol or drug abuse
 - Gang membership
 - Head injury or chronic pain
 - Brain disorders or mental illness
 - Low self esteem or feeling of powerlessness

Verbal Signs

- Talking about weapons
- Angry or threatening tone of voice
- Shouting, screaming, or cursing
- Making threats or sexual comments
- Challenging rules or authority
- Making unreasonable demands
- Expressing irrational thinking

Physical Signs

- **Having a weapon**
- **Nervous pacing, restlessness**
- **Clenching fists, jaw, or tightly gripping objects**
- **Violent gestures, pounding on or breaking objects**
- **Angry looks or staring**
- **Acting drunk or under influence of drugs**
- **Major change in appearance or habits**

What should I do?

- **If someone shows signs of losing control**
 - **Alert security and other staff**
 - **Dial 3111- call Code Gray**
 - **Stay calm and alert**
 - **Keep safe distance from person**
 - **Leave yourself an escape path**
 - **Listen to the person**
 - **Be supportive**
 - **Talk slowly and softly**
 - **Offer the person choices**
 - **Avoid touching the person**

What should I do?

- **If violence strikes:**
 - **Take immediate action to protect yourself**
 - **Sound the code- 3111- CODE GRAY**
 - **Help remove patients and visitors from the area**
 - **Give the person what he/she wants if you can**
 - **Do not try to take away the person's weapon**
 - **Do not try to restrain the person by yourself**
 - **Use physical restraints only as a last resort**

Body mechanics (Ergonomics)

Introduction

Many patient care activities require the nurse to push, pull, lift, and carry. By using proper **body mechanics**, you can avoid musculoskeletal injury and fatigue and reduce the risk for injuring patients. Correct **body mechanics** can be summed up in three principles:

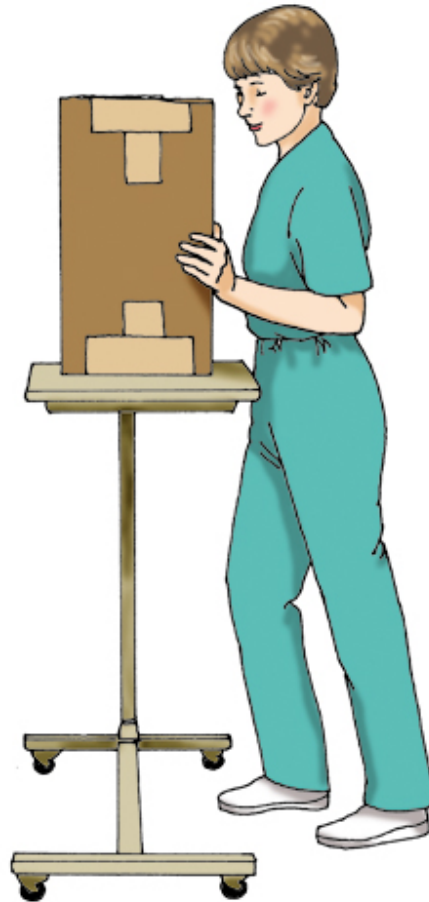
- Keep a low center of gravity by flexing the hips and knees instead of bending at the waist. This position distributes weight evenly between the upper and lower **body** and helps maintain balance.
- Create a wide base of support by spreading the feet apart. This tactic provides lateral stability and lowers the **body's** center of gravity.
- Maintain proper **body** alignment and keep the **body's** center of gravity directly over the base of support by moving the feet rather than twisting and bending at the waist. Keep the back, neck, pelvis, and feet aligned.

■ Implementation

Follow the directions below to push, pull, stoop, lift, and carry correctly.

Pushing and pulling correctly

- Stand close to the object, and place one foot slightly ahead of the other, as in a walking position. Tighten your leg muscles and set your pelvis by simultaneously contracting the abdominal and gluteal muscles.



- To push, place your hands on a stable part of the object and flex your elbows. Lean into the object by shifting weight from your back leg to your front leg, and apply smooth, continuous pressure.
- To pull, grasp the object and flex your elbows. Lean away from the object by shifting weight from your front leg to your back leg. Pull smoothly, avoiding sudden, jerky movements.
- After you've started to move the object, keep it in motion; *stopping and starting uses more energy.*

Stooping correctly

- Stand with your feet 10" to 12" (25.5 to 30.5 cm) apart and one foot slightly ahead of the other *to widen the base of support.*
- Lower yourself by flexing your knees, and place more weight on your front foot than on your back foot. Keep your upper **body** straight by not bending at the waist.

- To stand up again, straighten your knees and keep your back straight.



Lifting and carrying correctly

- Assume the stooping position directly in front of the object *to minimize back flexion and avoid spinal rotation when lifting.*
- Grasp the object, and tighten your abdominal muscles.
- Stand up by straightening your knees, using your leg and hip muscles. Always keep your back straight *to maintain a fixed center of gravity.* Keep the weight of the object as close to your **body** as possible.
- Carry the object close to your **body** at waist height — near the **body's** center of gravity — *to avoid straining your back muscles,* as shown in the illustration below.



■ Special Considerations

- Wear shoes with low heels, flexible nonslip soles, and closed backs to promote correct **body alignment**, facilitate proper **body mechanics**, and prevent accidents.
- When possible, pull rather than push an object *because the elbow flexors are stronger than the extensors*. Pulling an object allows the use of hip and leg muscles and avoids the use of lower back muscles.
- When doing heavy lifting or moving, remember to use assistive or mechanical devices, if available, or obtain assistance from coworkers; know your limitations and use sound judgment.
- Mechanical and other assistive devices have been shown to significantly decrease incidences of low back injury in nursing personnel.¹⁴

References

1. Collins, J., and Owen, B. "NIOSH Research Initiatives to Prevent Back Injuries to Nursing Assistants, Aides, and Orderlies in Nursing Homes," *American Journal of Industrial Medicine* 29(4):421-24, April 1996.
[Abstract](#) | [Complete Reference](#)
2. Craven, R.F., and Hirnle, C.J. *Fundamentals of Nursing: Human Health and Function*, 6th ed. Philadelphia: Lippincott Williams & Wilkins, 2009.
3. Nelson, A., and Baptiste, A.S. "Evidence-based Practices for Safe Patient Handling and Movement," *Online Journal of Issues in Nursing* 25(6):366-79, November-December, 2006.
4. Viera, E.R., et al. "Low Back Problems and Possible Improvements in Nursing Jobs," *Journal for Advanced Nursing* 55(1):79-89, July 2006

Orientation Quiz Instructions

Print the following quizzes & answer sheets. Complete the quizzes using the answer sheet and return answer sheet/test form to the assigned personnel (your school instructor). School Instructor will return to the hospital Education Director, who will verify successful completion of tests.

Print the confidentiality statement on the next page and sign and return to your instructor with the answer sheet.

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. BENDING AT THE WAIST INSTEAD OF FLEXING AT THE KNEES/HIPS EASES THE TRANSFER OF PATIENTS AND OBJECTS.
2. THE USE OF AVAILABLE ASSISTIVE DEVICES IS ALWAYS ENCOURAGED FOR TRANSPORT OF PATIENTS/OBJECTS WHEN POSSIBLE.
3. WHENEVER POSSIBLE, YOU SHOULD PUSH INSTEAD OF PULLING 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. FREQUENT HEALTH PROBLEMS IN ADOLESCENCE INCLUDE: Teen pregnancy, acne, postural defects, fatigue, anemia, respiratory infections, mononucleosis, suicide, alcohol/drug abuse,STD.
7. A SIX YEAR OLD BOY IS TOO YOUNG OT HAVE PROCEDURES EXPLAINED TO HIM.
8. A 70 YEAR OLD ISMORE 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.

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. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Emergency Codes & Disaster Preparedness

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

National Patient Safety Goals

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

Violence in the Workplace

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

Ergonomics

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

Age-Specific Exam

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

Fairview Park Hospital
Student Clinical Agreement & Confidentiality Statement

Student Name: _____

School Name: _____

I have read the contents of this orientation manual and agree to abide by the policies & procedures of Fairview Park Hospital during my clinical rotation at the facility. I understand that Fairview Park Hospital staff maintains responsibility for care of the patient and that I am allowed to participate in the care of patients under the supervision of the school clinical instructor and/or hospital staff.

I understand that all information relating to patients, either written or oral is to be held in strictest confidence. This restriction applies to information regarding diseases and treatments. These confidential matters will be discussed only with those persons involved in the care of the patient. I also recognize that similar diligence is to be observed in protecting the confidence of information concerning hospital employees, medical staff, and hospital financial data.

Signature _____

Date _____

Submit this form to your instructor

For Faculty/Instructor Use:

1. Contact the department manager/director of the respective department in which student will be performing clinical at least two weeks prior to the date student will need to start clinical. Nursing faculty will continue to use the Education Director as the point of contact for Nursing clinicals.
2. Submit student background checks using the appropriate spreadsheet to the Director of Human Resources at least two weeks prior to the date student is to begin clinical.
3. Students should access the Hospital Orientation Manual online, print or save a copy of the manual, and complete the orientation exams.
4. Students should print and sign the confidentiality statement at the end of the manual
5. Verification of the student's successful completion of the orientation exam (>80%) along with the confidentiality statement should be submitted to the hospital Education Director before the first day of clinical.
6. Institution Clinical Instructors and/or hospital preceptors should provide the student with a unit orientation prior to or on the first clinical day.