HEALTHTRUST™ Workforce Solutions

Resource Packet (Tap a topic)

1. A - LRH Campus Map
B – WHH Campus Map
2. PPE Update-December update
3. COVID-19 Specimen Collection
4. Yellow Cloth Isolation Gown
5. Bloodborne Pathogen Exposure Control Plan
6. Fire Safety
7. Radiation Safety
8. Standards of Care/Practice Guidelines
9. IV Drip Titration Documentation
10. Heparin Drip Documentation
12 Specific Policies:

- Advance Directives
- Patient Personal Property
- Isolation
- No Passing Zone
- Falling Stars: Flyers
- Virtual Patient Safety Observation (VPSO)
- Post-Fall Management
- IV Therapy
- Alaris Pump/PCA Pump/Cactus
- Controlled Substance Hand-off
- Time Out
- CHG Bathing
- Patient Education
- Emergency CODES
- iPhone/iMobile

13 Orientation Additional Information:

- PEWS – Pediatric Early Warning System (LR Only)
- Quality Indicators:
  - ✓ Stroke
  - ✓ Emergency Department Throughput
  - ✓ Acute MI
  - ✓ Women's Services: Elective delivery, Cesarean Section, Administration of antenatal Steroids, Healthcare Associated Bloodstream Infections in Newborns, Breastfeeding Measure, Pediatric Asthma
- Salem Sump Tube with Multifunctional Port and ENFit connection
- Keofeed / Dobhoff Tube
- Kangaroo Feeding Pump Quick Programming Tips
- USP800
- Blood Transfusions
- OneLegacy: Your important role in Organ, Eye and Tissue Donation
- Nutritional Services
- Supplies

14. Lift Equipment:

- Z-Slider
- Stedy
- Arjo Opera

18. Dysphagia Screening

19. Equipment Cleaning

20. Violence Prevention

21. Suicide Prevention

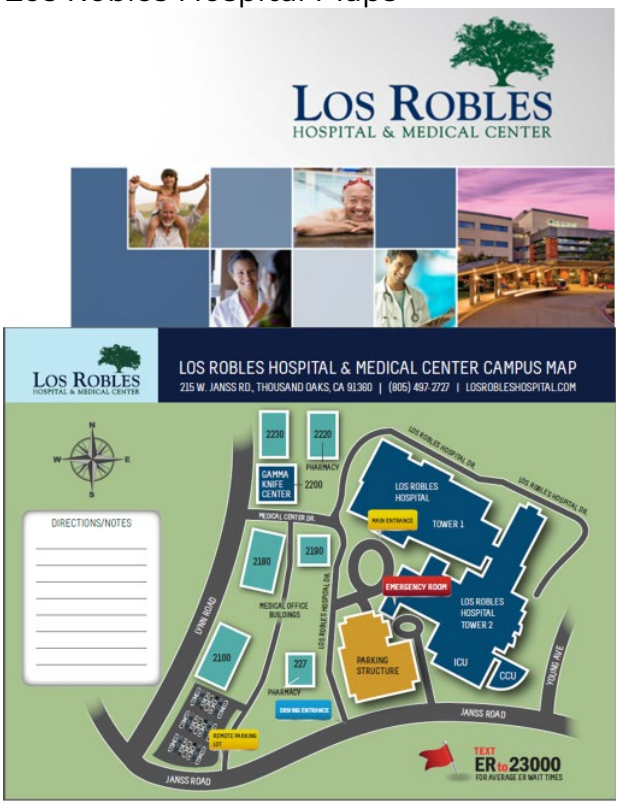
22. Welch Allyn Connex Spot Monitor

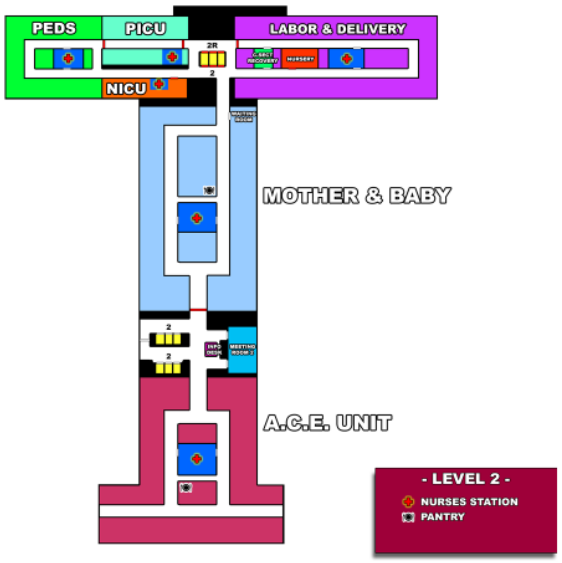
23. Fall Assessment Prevention

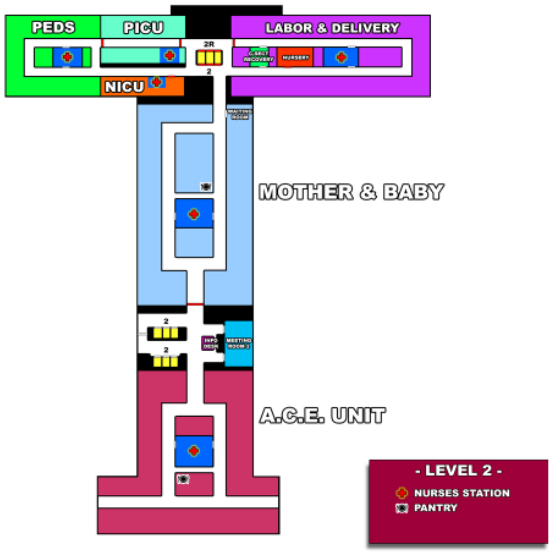
24. Falls and iTrace and iTrace

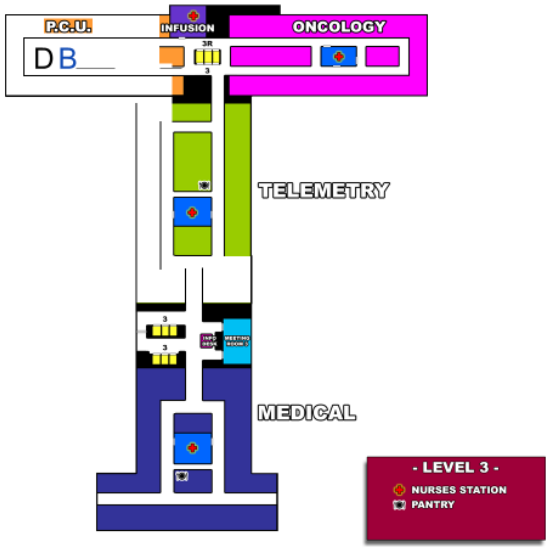
25. Midas First Time User Login (Case Manager)

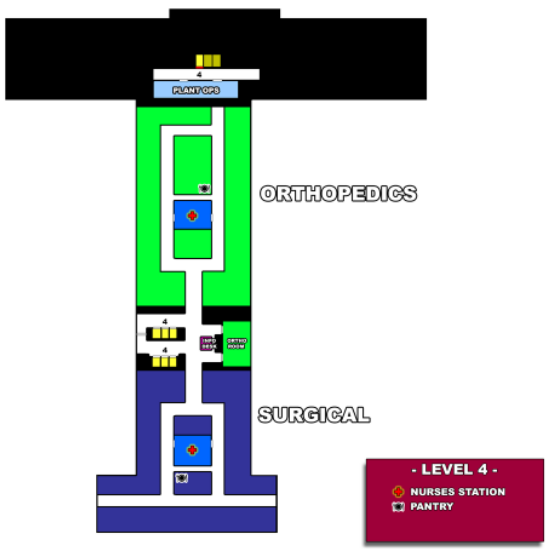
Los Robles Hospital Maps











West Hills Hospital Map

Facility Map

FLOOR	DEPARTMENT	ROOM/LOCATION
1st Floor	Administration	Main Tower
	Admitting	Main Tower
	Emergency Department	New Tower
	Cardiology	Main Tower
	Nuclear Medicine	Main Tower
	Medical Staff	West Tower
	Medical Records	West Tower
	Cafeteria	East Tower
	CPOE	Main Tower
	Gift Shop	East Tower
2nd Floor	ICU	Rooms 8-26 | New Tower
	ICU Overflow	Rooms 1-7 | Main Tower
	BICU	East Tower
	Surgery	Main Tower
	Radiology	Main Tower
	Laboratory	Main Tower
	Cath Lab	Main Tower
3rd Floor	Labor & Delivery | 3 East	East Tower
	NICU	East Tower
	Post-Partum	West Tower
4th Floor	4 West	Rooms 400-418
	Grossman Burn Unit | 4 East	Rooms 450-467
5th Floor	Telemetry | 5 West	Rooms 500-518
	Med/Surg | 5 East	Rooms 550-567
6th Floor	Oncology | 6 West	Rooms 600-618
	Ortho | 6 East	Rooms 650-667

West Hills Hospital
& MEDICAL CENTER

PPE and Enhanced Masking Guidelines

		MASK	FACE SHIELD	GOWN
All Staff who interact with patients & in all patient care areas	Non COVID Patients	✓ Non fit-tested KN95 for non-aerosolizing patient care ✓ Fit-tested N95 for care during aerosolizing procedures	✓ Required within 6 feet of patient	Based on identified isolation *See * below*
	COVID Patients & PUI (Patient Under Investigation)	✓ Non fit-tested KN95 for non-aerosolizing patient care ✓ Fit-tested N95 for care during aerosolizing procedures	✓ Required within 6 feet of patient	✓ Required in room *See * below*
Staff in Non-patient care areas		✓ Level 1 or personal mask		
Patients / Visitors / Vendors		✓ Level 1+/personal mask in common/public areas – reuse multiple days - CA mandate requires a mask when around others -	Currently restricting visitors and vendors	

Aerosolizing Procedures

• Intubation/extubation Team • Manual ventilation • Hi-flow O2 (on Airvo2) • CPAP/BiPAP	• Sputum induction • Open airway suctioning • Tracheostomies	• CPT (Chest Physiotherapy) • Bronchoscopies/TEE • R/O or +TB patients

Med nebs via closed system Circulaire (99.9% filtration rate) – Use KN95 (Fit tested N95 not required)

No Double Masking	• Wearing a mask over an N95 mask may compromise the fit, seal and efficiency of the respirator • Wearing a mask over an N95 mask does not extend the life of the mask	• Wearing two masks of any type does not provide additional protection • Double masking wastes masks that are in short supply around the world

- The model of KN95 masks that we use will switch frequently
- All our KN95 masks have the same FDA/EUA approval and 95% filtration efficiency as our fit-tested N95 masks.
- Each unit will send their mask order to the PPE Depot prior to the beginning of the next shift
  - ✓ Include the 3-4 ID and mask type for each person
  - ✓ Staff will receive their mask from the CNC/designee
- Staff will receive one mask per shift
- Please reuse your level one/personal mask for the entire week for entering and exiting the hospital
- Cloth face masks are allowed for patients/visitors/vendors in all areas, and staff in non-clinical areas
- Valved masks are prohibited in all areas – they do not protect others around you
- *Isolation gowns: Yellow cloth gown for most isolation. Plastic for C. diff / high fluid procedures
- Disinfect and reuse stethoscopes and face shields – they are not disposable

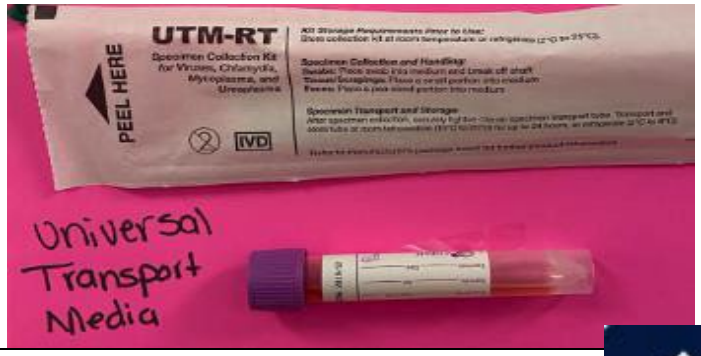
Source Document

Competency Title:	**ORIGINATED:**	March 2020
How to Obtain a Nasopharyngeal Specimen for COVID-19 Testing	**REVISED:**	
	REVIEWED:	
	Author: Education	

PERFORMANCE CRITERIA AND KEY ELEMENTS (Use action verbs that are observable and measurable such as…demonstrates, utilizes, applies, interprets, creates, states, produces, assesses, reports, measures, locates, uses, assists, performs, follows, practices, reports, completes, describes, explains, initiates, etc.)

This procedure is to obtain a specimen for COVID-19.

1. Obtain a **purple top** specimen collection kit from the Lab.
2. Wash your hands and don appropriate PPE ***(gown, gloves, N95 mask, goggles and face shield).***
3. Explain the procedure to the patient – it will be slightly uncomfortable.
4. Have the patient blow their nose to remove any excess secretions.
5. Tilt the patient's head back (the patient may want to close their eyes).
6. Gently insert the swab until you meet resistance.
7. Rotated the swab for 10-15 seconds to ensure you obtain an adequate sample.
8. Place the swab in the specimen collection container.
9. Appropriately remove your PPE and wash your hands.
10. Label the specimen. Send it to the Lab.
11. Document the specimen collection.



Yellow CLOTH Isolation Gowns

Why CLOTH gowns?

The CDC anticipates COVID-19 will continue to be an issue, especially as our communities begin to open up and people become more active. In addition, we may also see an upsurge with this winter's flu season.

HCA has begun ordering and collecting PPE in preparation for the flu season, however suppliers are saying the raw resources that make up the PPE items are in short supply. So, we need to be judicious in the use of our current supply of PPE...like reprocessing our N95 masks and wearing cloth gowns when we can instead of the plastic gowns.

We all want to ensure that everyone has the PPE they need to appropriately care for our patients.

Wear them…

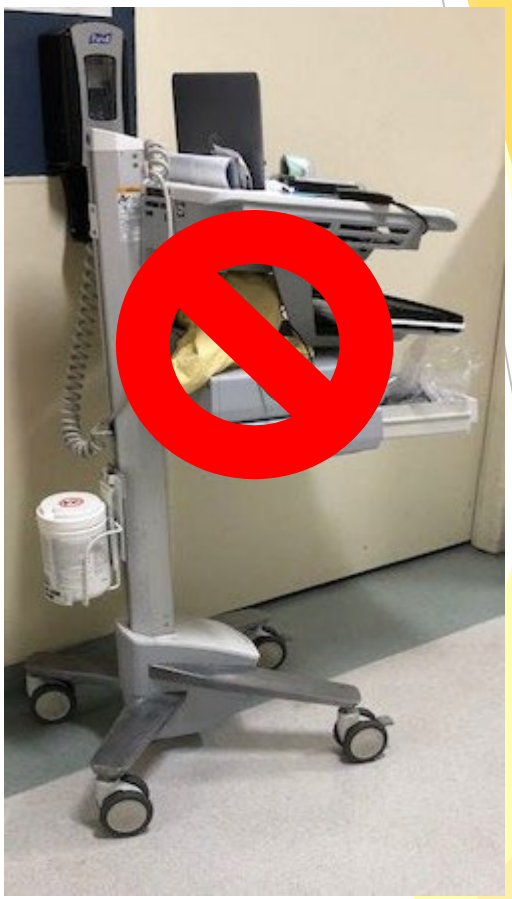
- with ALL isolation patients.
  - *except C Diff or situations with high risk for body fluid exposure, wear a plastic gown.*
- with COVID-19 POSITIVE patients.

Discard them…

- in patient's linen hamper_ <u>BEFORE</u> exiting the room.

Do NOT…

- hang up for re-use.
- drape on a chair.
- wear as a jacket or covering for scrubs.
- …



IF...

your patient has C Diff or you anticipate a situation with high risk for body fluid exposure (trauma, GI bleed, etc.),

wear a plastic gown.

Alone we can do so little; together we can do so much.

Helen Keller

Bloodborne Pathogen Exposure Control Plan -

- This policy applies to all medical, nursing, and ancillary staff who may, in the course of their routine work, have contact with blood and/or other potentially infectious materials (“OPIM”)
- The purpose of RCH IC-301 is to address employee safety specifically related to occupational exposure to bloodborne pathogens.
  - ✓ Bloodborne disease include:
  - ✓ HIV infection/AIDS
  - ✓ Hepatitis B
  - ✓ Hepatitis C

The Bloodborne Pathogen Standard (BPS)

- Helps protect workers from exposure to bloodborne pathogens
- Covers any worker who might come in contact with blood or other potentially infectious materials (OPIM) as part of his or her job
- Requires employers to take certain steps to protect these workers
- One of the key parts of Bloodborne Pathogen Standards is to require the use of Standard Precautions

Sharps Safety and Needlestick Prevention

Policy Standard and Transmission Base Precautions states:

- Needles shall **NOT** be recapped, purposely bent, broken or removed by hand.
- Recapping shall be accomplished only when necessary: this shall be accomplished by a **one-handed scoop method and/or mechanical recapping device.** No two-handed recapping is allowed.

Sharps Safety and Needlestick Prevention

The CDC recommends
replacing sharps containers
when they are 3/4 full.

Sharps Safety and Needlestick Prevention

- The physician, nurse or technician using the needle, syringe or other sharp is responsible for placing it properly into the sharps box after use.
- The contracted reusable sharps container company and Environmental Services are responsible for collecting, storing and disposing of any sharps and pharmaceutical waste per Environmental Services policy. Nursing may also change out full sharps if EVS is detained.

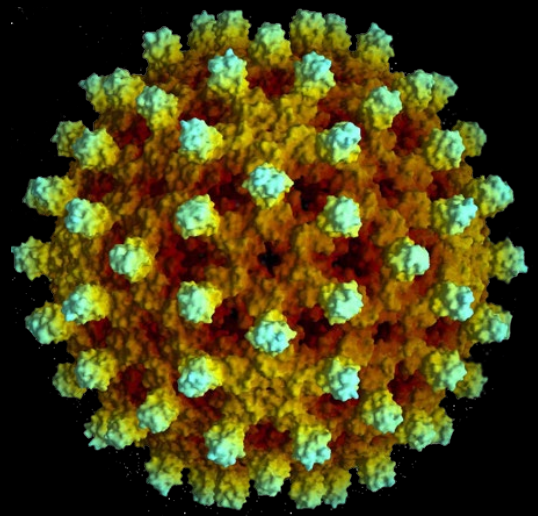
Exposure to Bloodborne Pathogens

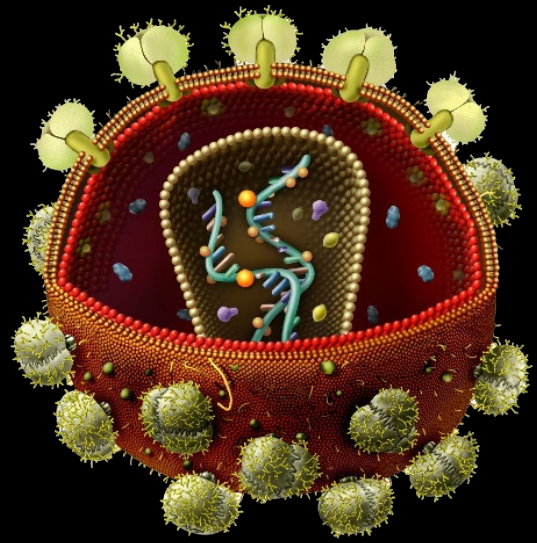
- Should you be exposed to blood or other potentially infected materials by needle stick, by sharps injury, or by splashes to mucous membranes (eyes, nose, mouth), <u>report the incident IMMEDIATELY to your supervisor and Employee Health!</u>

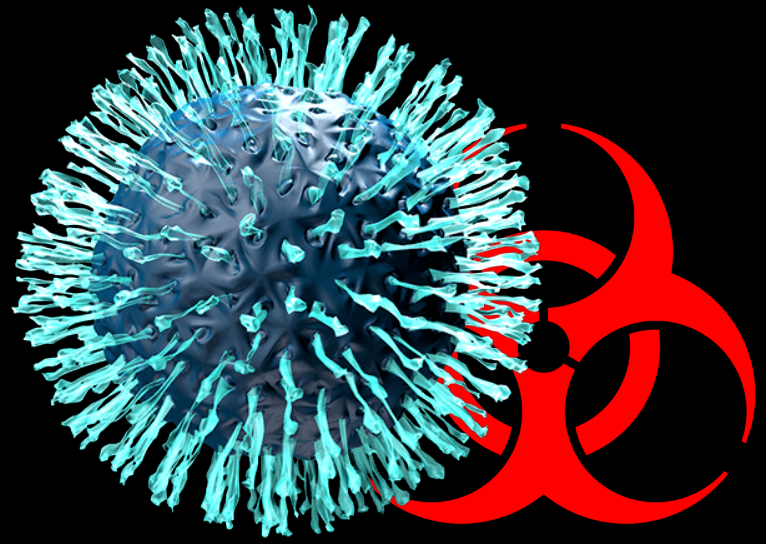
Sharps Injury Statistics

- The CDC says that 385,000 needlestick injuries and other sharps-related injuries are sustained annually by hospital-based healthcare personnel.
- According to unpublished data from the CDC, 40 percent of injuries occur after use and before disposal of sharp devices, 41 percent of injuries occur during the use of sharp devices on patients, and 15 percent of injuries occur during or after disposal

Risk of Infection Transmission & Conversion Rates from Sharps Injuries







Sharps Safety Begins with YOU!

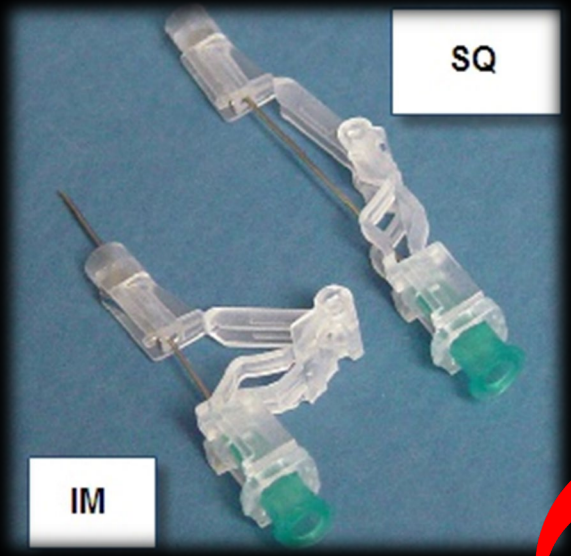
RCH Bloodborne Pathogen Exposure Control Plan (IC.301) states:

Needleless systems or needles with engineered sharps injury protection shall be used for:

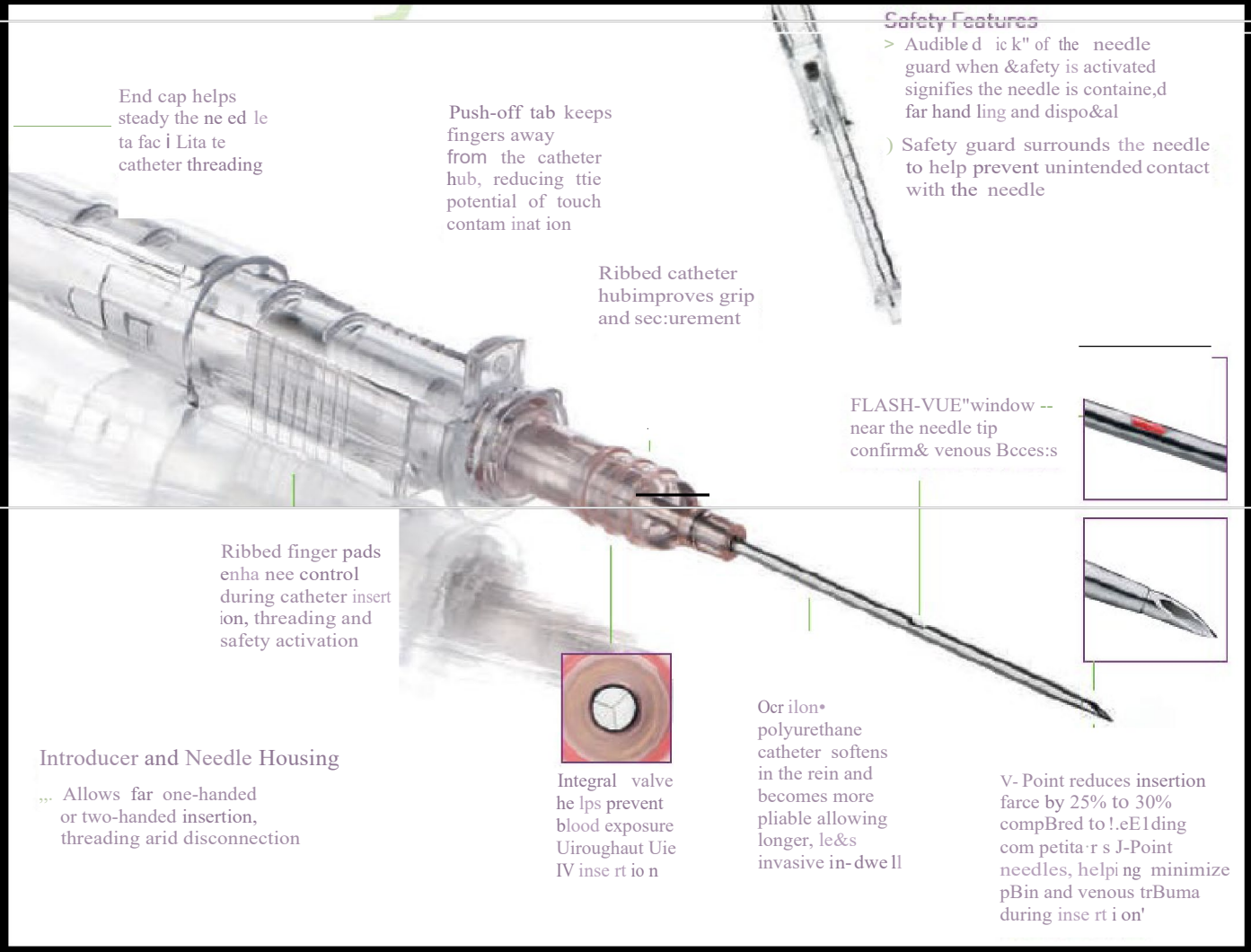
- Withdrawal of body fluids
- Accessing a vein or artery
- Administration of medications or fluids
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available

Sharps Safety Begins with YOU!

- Needles with sharps injury protection are NOT to be used to access IV ports because the patient can move and cause a needlestick. Use a syringe with the needle-free valve to access any injection port on IVs. Use safety engineered needles for IM/SQ injections only. Use safety IV catheters to start IVs.



Smiths Medical ViaValve IV Catheter with Blood Control



Smiths Medical Hypodermic Needle-Pro Fixed Needle Syringe for Insulin and TB Injections

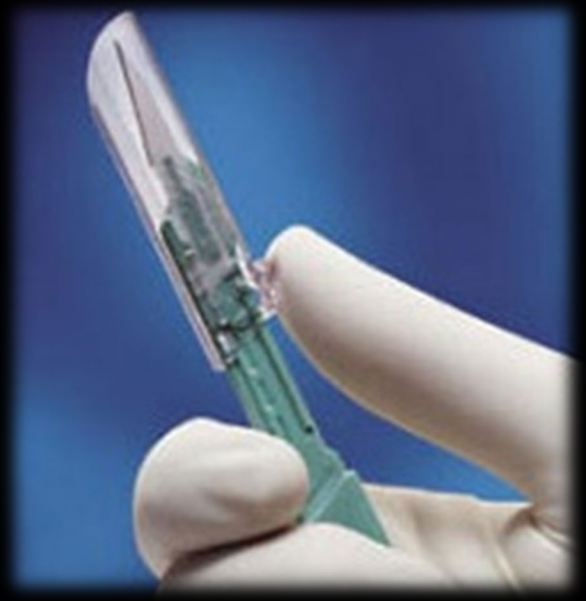
Perform Injection

Press gently on sheath against a flat surface

Dispose of device into a sharps container

Make sure the Safety Mechanisms are fully deployed

Whenever possible, use the scalpel with the protective safety sheath



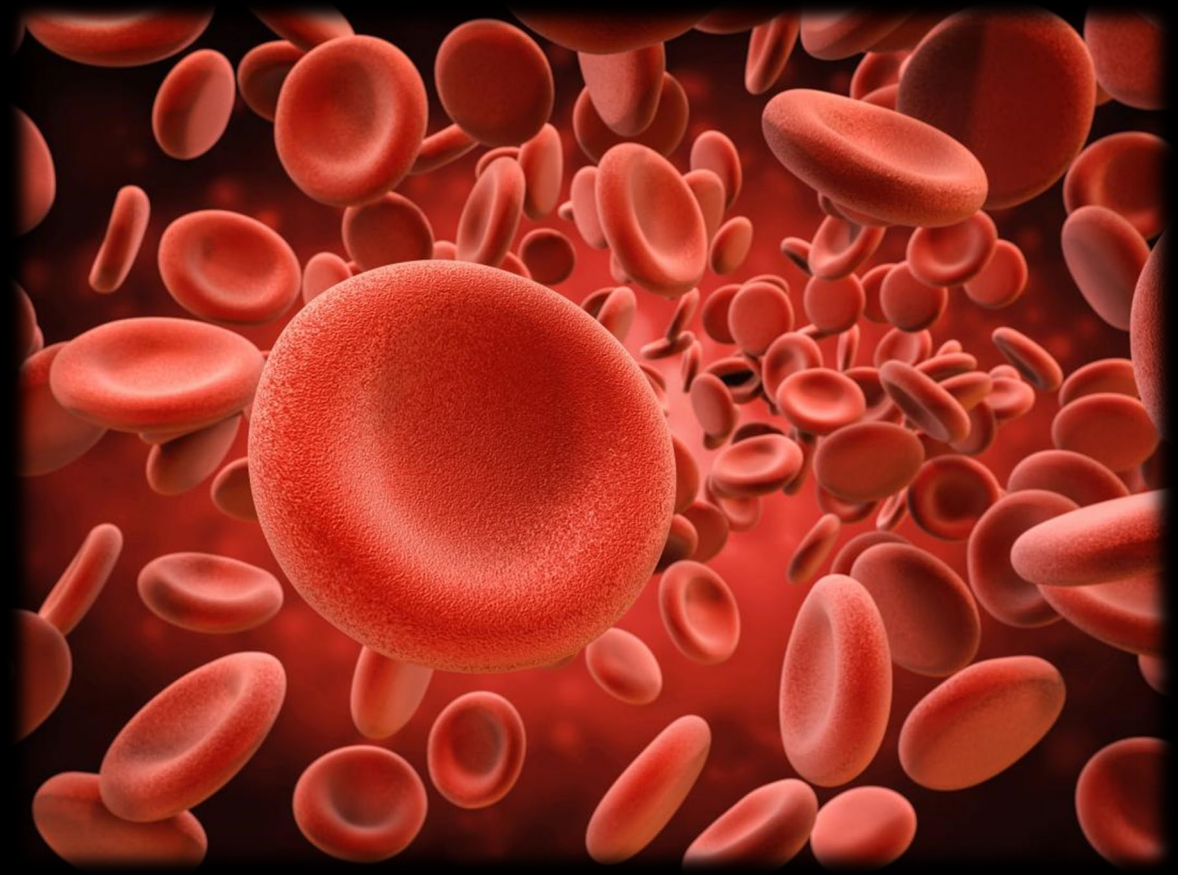
Strategies to Prevent Sharp Injuries

One-Hand Scoop Technique

Strategies to Prevent Sharp Injuries

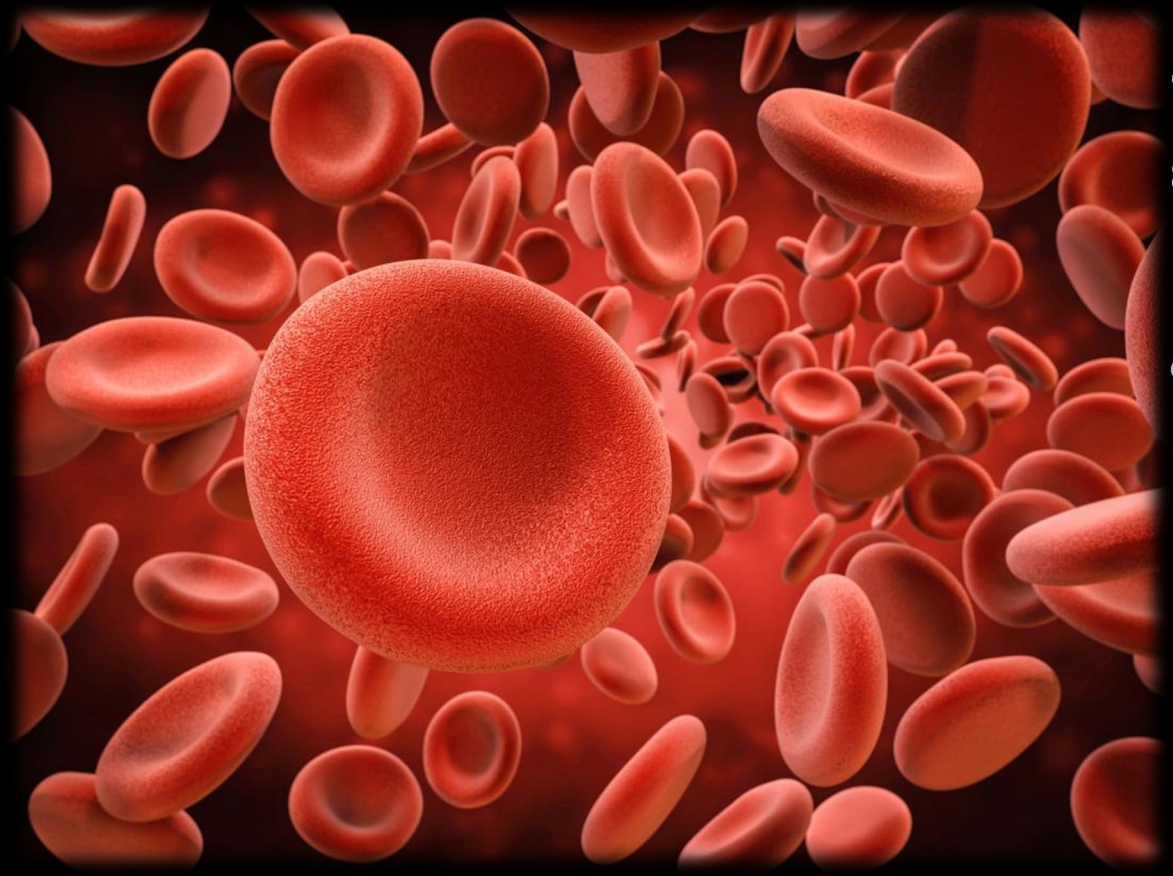
- When working with physicians (during special procedures or during surgery) remain aware of their positioning and movements to avoid accidental contact with sharps.

So….Don’t let this be YOU!
Remember to Always:



1. Assess patient’s capacity for cooperation and request help if needed.
2. Ensure lighting is adequate.
3. Instruct patients to avoid sudden movement.
4. Do not expose sharps/needles until moment of use and keep pointed away from you.
5. Maintain visual contact with sharps during use.
6. Remain aware of positioning of other staff to avoid accidental contact.

Remember to Always

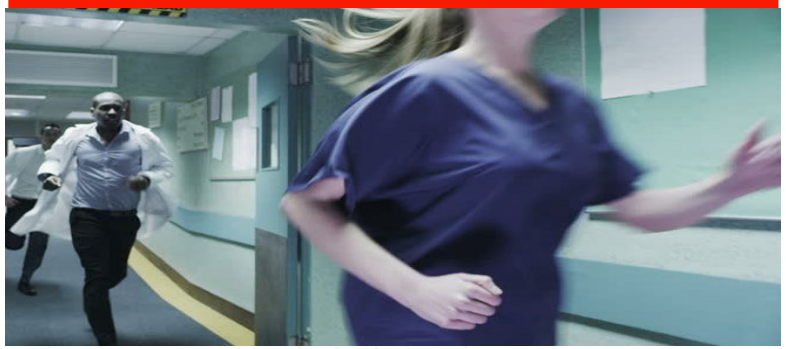


7. Alert staff when placing or retrieving sharps.
8. Immediately post procedure ACTIVATE safety features of sharps and ensure that features are fully activated and dispose of sharps.
9. Ensure all sharps are accounted for and visible.
10. Check trays, linens, waste materials prior to handling for sharps accidentally misplaced or left behind.
11. Keep fingers away from the device when disposing, and avoid placing hands close to the opening of the container.

FIRE Safety

SAFETY Tips …

Fire safety is a responsibility we all share!

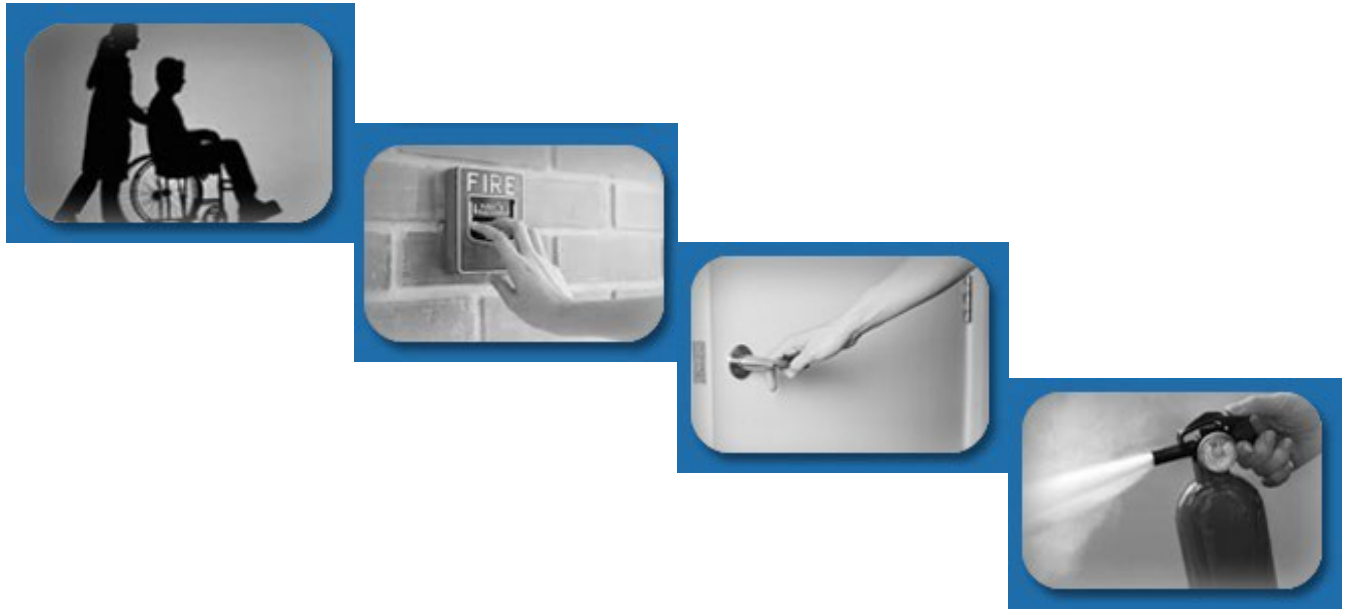


- Keep fire exit doors and exit access corridors clear of equipment and clutter.
- Know the location of the following in your work area:
  - ✓ Fire alarm pull box stations.
  - ✓ Fire extinguisher(s).
  - ✓ Means of egress/exits in case of evacuation.
- In case of a fire or drill,
  - ✓ close all doors.
  - ✓ do NOT use the elevators.
  - ✓ await further instructions.

RACE & PASS...

RACE...

- **R**emove those in immediate danger of fire; call aloud the facility fire code phrase
- **A**ctivate the fire alarm
- **C**onfine the fire
- **E**xtinguish fire with proper extinguisher if safe to do so.



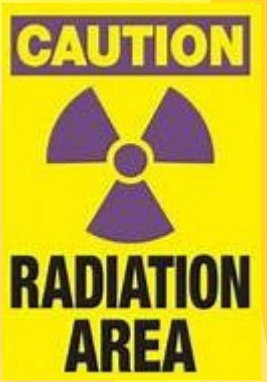
RACE & *PASS…*

PASS…

- **P**ull the pin
- **A**im low (base of fire), stand 6 to 8 feet from fire
- **S**queeze the handle
- **S**weep from side to side

Radiation Safety

For Imaging & Procedural Staff



ALARA…
As Low As Reasonalby Acheivable

The ALARA radiation safety principle is based on the minimization of radiation doses and limiting the release of radioactive materials into the environment by employing all "reasonable methods."

ALARA is not only a sound radiation safety principle, but it is a regulatory requirement for all "radiation protection programs."

The ALARA concept is an integral part of all activities that involve the use of radiation or radioactive materials and can help prevent unnecessary exposure as well as overexposure.

The three major principles to assist with maintaining doses "As Low As Reasonably Achievable" are **time**, **distance** and **shielding**.

Radiation Safety…

The amount of radiation you receive depends on:

- time or duration of exposure
- distance from the radiation source
- shielding between the radiation source and you

Time

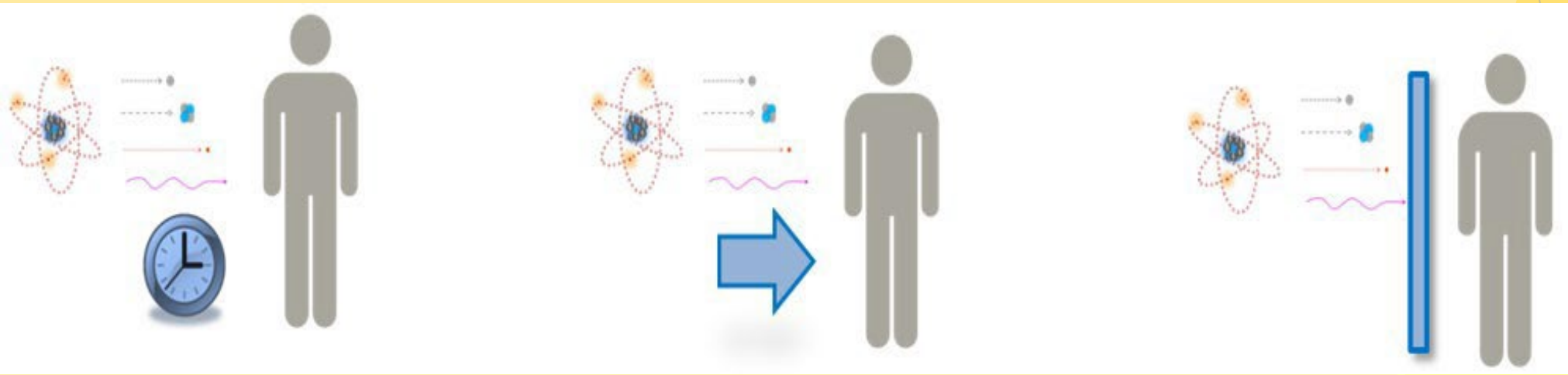
Minimize time around radiation source

Distance

Maximize distance from radiation source

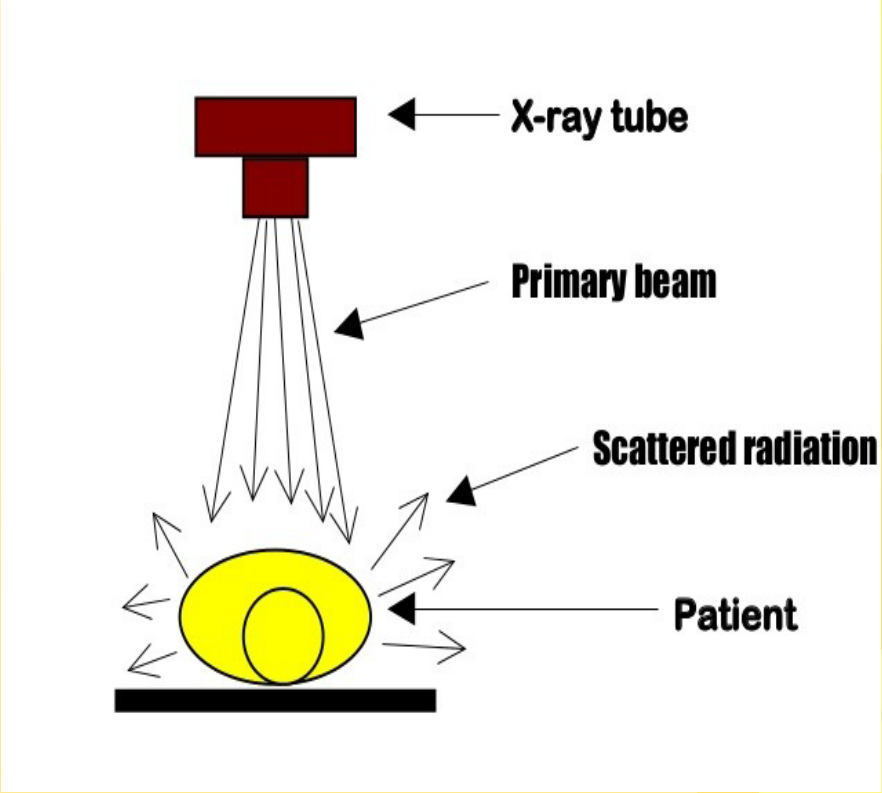
Shielding

Use shielding to minimize exposure

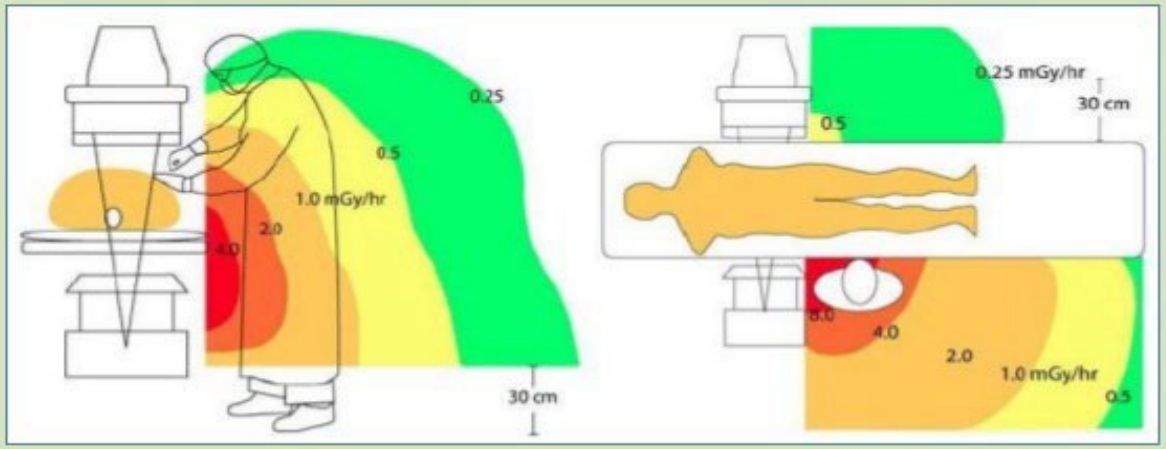


Scatter…

- The primary beam of radiation is centered on the patient's body. Most of the beam's energy is absorbed by the patient's tissues, however, some of the energy is scattered from the body's surface.
- Staff are exposed to these scatter rays.
- Most of staff's occupational exposure comes from scatter radiation.



This is why time, distance and shielding are so important…



The diagrams depict scatter radiation for a C-arm fluoroscopy system with the x-ray tube under the table (left) and in lateral projection on the same side as the operator (right).

- Note the **high dose to the operator** when standing on the same side of the patient as the tube.
- If the operator **stands upright**, scattered radiation to the face is perhaps one-fourth as great as when the operator is **leaning down** toward the patient.
- Short operators receive more radiation to the face than do tall operators. They may wish to stand on a platform.

Staff Responsibilities…

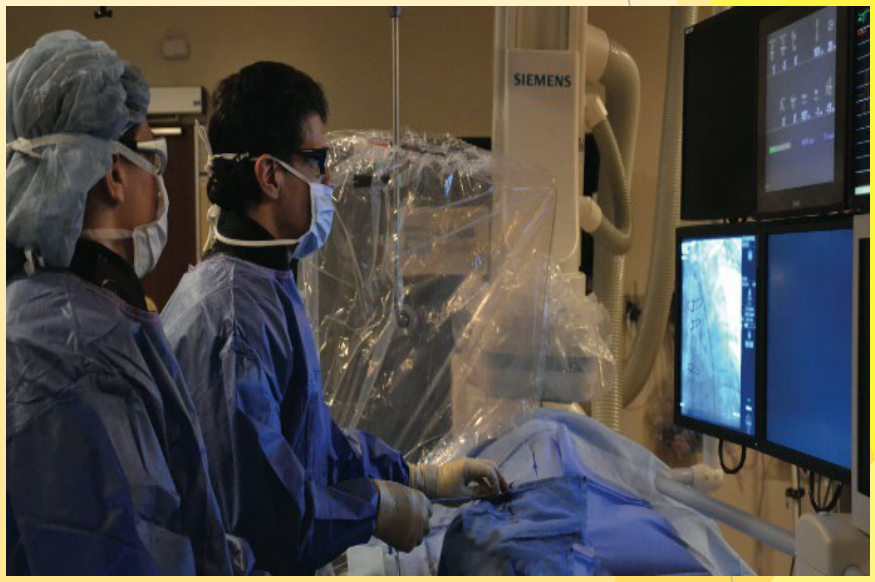
- All personnel involved in fluoroscopic procedures must wear **protective lead aprons**. Personnel who may have to stand with their backs to radiation beam must wear wrap-around aprons to decrease risk of exposure. **Thyroid shields must** be worn to protect thyroid whenever there is a risk of prolonged exposure. **Radiation glasses** are also available.
- Leaded aprons and thyroid shields must be stored flat or hung vertically and not folded.
- Procedure room doors are to remain closed during fluoroscopic and radiographic procedures.
- Personnel must be aware of scatter radiation during radiological and fluoroscopic procedures.
- Personnel not wearing lead aprons during radiographic procedures (portable x-rays) must either leave the room, stand behind a leaded barrier, or stand behind the x-ray technologist at least 6 feet from the x-ray tube during the shooting of the x-ray.
- Never eat, drink or relax in a room with radioactive material.
- Speak up if a safety or dose management barrier(s) exists.
- Participate in annual continuing education and training.

Staff Responsibilities…

- All personnel will be responsible for their dosimeter and will be required to wear it when exposed to radiation.
  - Your dosimeter is to be worn at the neckline and not concealed behind the lead apron.
  - Dosimeters are not to be stored in an area where X-ray is performed.
  - Dosimeters are to be replaced monthly.
    - *It is the individual's responsibility to turn in their dosimeter every month to the appropriate department designee and acquire a new one.*
- If you become pregnant, inform your supervisor to obtain a baby dosimeter.
  - Baby dosimeter must be worn near the abdomen covered by the lead apron.
- Any over-exposure reading will be brought to the attention of the Administrative Director of Radiology and the Radiation Safety Officer.

Rad Tech Responsibilities…

- Identify and manage behaviors that are counter to those outlined above and consequently counter to ALARA principles.
- Provide interventionalist with periodic verbal notifications of exposure levels Air Kerma shall be used exclusively for this purpose where available.
- Provide interventionalist with intra-procedure awareness of the moment substantial radiation dose level (SRDL) has been exceeded.



Rad Tech Responsibilities…

- Reporting and following up on patient procedures for which **a substantial radiation dose level (SRDL) of 3,000 mGy Air Kerma is exceeded** *and* entering comments in DoseWatch for all study alerts where system is available.
  - ***5,000 mGy Air Kerma for neuro-interventional radiology patients.***

- *Complete an RIR in Meditech*
- *Physician informs patient and hands them a letter.*
- *Follow-up call to patient at 48 hours and 1 month post-exposure and documented on form…*

WARNING

By LAW (CA Title 17),
moving or operating fluoro
or other radiation equipment *when in use*,
MUST be done by a
Licensed Radiation Technologist.
NO EXCEPTIONS!

Radiation Safety Program…

- Safety of all radiographic equipment shall be monitored by the Department of Radiology following regulatory guidelines and mandates.
  - Specialty Departments outside the main Radiology Department should notify the company directly for service / repair needs and then notify the Imaging Department Director.
- The Radiation Safety Officer is listed on the hospital intranet.
- The Radiation Safety Committee meets quarterly and as needed. They oversee the radiation safety and quality assurance program, some of which includes:
  - ✓ Licensure and regulatory compliance
  - ✓ Occupational and radiation exposure incidences

If you have additional questions about Radiation Safety, please contact your department leadership.

References…

On Policy Portal on the Hospital Intranet

POLICY & PROCEDURE

Department Specific Time Frames for Assessment of Patient's and Plan of Care Development for the Adult Patient

Department	Initial Assessment Initiated Completed and Documented	Plan of Care Initiated and Evaluated	Shift Assessment and Re-Assessment	VS, O2 Sats and MEWS	Pain	Comments
Emergency Department	Upon Triage Within 2 hours	Care Plan not applicable for ED. ED focus is intervention(s) to determine admission or discharge.	The 5-level CTAS Triage Acuity system Level I-V will be utilized to determine priority for assessment/re-assessment	Category 1: Continuous Category 2: Every 1 hr x 2, then every 2 hrs if clinically stable until medically cleared. Then every 4 hrs and PRN. Category 3: Every 4 hr and PRN if condition necessitates. Category 4 & 5: Reassess if abnormal findings on initial assessment or change in condition.	Same as VS by Category of patient and: Before administration of medication and within 1 hour of treatment	
ED Holding	Patients with admission orders waiting for a bed in ER Hold will be treated under the Time Frame Guidelines of the unit they are admitted to on the physician's order sheet.					
Critical Care						
Critical Care	Upon Arrival Within 8 hours	Within 8 Hours Every Shift	At least every 2 hours & PRN	With titratable drugs—follow titration orders, monitor & document parameter with each titration change and iIf parameter is met/maintained—then document q1 hr . Every 15 minutes If on hypothermia blanket monitor temp every 30-60 minutes.	Every 2 hours and before pain medication/treatment With re-evaluation within 1 hour	Continuous EKG Monitoring, Rhythm strips every 4 hours Change EKG patches daily

Step Down

PCU	Upon Arrival Within 8 hours	Within 8 Hours Every shift	At least every 3 hours & PRN	• Routine VS--every 3 hours—including non-titratable drips. • With titratable drugs—follow titration orders, monitor & document each titration change. If parameter is met/maintained—then document q1 hr thereafter. • If on hypothermia blanket monitor temp every 30-60 minutes.	Every 3 hours and before pain medication/treatment With re-evaluation within 1 hour	Continuous EKG Monitoring, Rhythm strips every 4 hours Change EKG patches daily

Department	Initial Assessment Initiated Completed and Documented	Plan of Care Initiated and Evaluated	Shift Assessment and Re-Assessment	VS, O2 Sats and MEWS	Pain	Comments
Medical Surgical Telemetry						
Telemetry	Upon Arrival Within 12 hours	Within 12 hours Every shift	Every shift & PRN	Every 4 hours If on hypothermia blanket monitor temp every 30-60 minutes.	Every 4 hours and before pain medication/treatment With re-evaluation within 1 hour	Continuous EKG Monitoring, Rhythm strips every 4 hours Change EKG patches daily
Med Surg	Upon Arrival Within 12 hours	Within 12 hours Every shift	Every shift & PRN	Every 4 hours If on hypothermia blanket monitor temp every 30-60 minutes.	Every 4 hours and before pain medication/treatment With re-evaluation within 1 hour	Remote monitoring strips every 4 hours Change EKG patches daily

Specific Vital Signs

	Bedside Procedures	Sedation Analgesia	Post-op	Angio and Heart Cath	PCA	Epidural and Intrathecal Analgesia
All Departments **Exclusion: See Policy For those departments able to administer Sedation Analgesia**	Baseline Every 15 min x4 Every 30 min x4 Every 2 hours x1 And then routine	Prior to administration of medication Every 5 min x3 Every 15 min during procedure Every 15 min until pt returns to pre medication status	Every ½ hour x4 Every 2 hours x4 Then every 4 hours for first 24hrrs. Then per unit routine unless otherwise ordered by MD. Neuro pt to include Pupil check and motor response Ortho pt to include neuro circulation checks of extremity involved	Every 15 min x4 Every 30 min x2 Every 1 hour x4 Then routine Vital signs include pedal pulse and groin checks.	Before starting PCA 5 minutes after Every 30 min x2 Then every 4 hours Must include: ETCO2 until no longer monitoring	Every 4 hours Must include: ETCO2 Value until monitoring is dc'd by Anesthesiologist order

IV DRIP TITRATION DOCUMENTATION

REGULATORY REQUIREMENT

Regulatory Agencies (CDPH, CMS, TJC) require that we document titratable drips, at least hourly, and with every titration. When a drip is titrated, the new rate must fall within the, "parameter value," or goal found in the physicians order. The documented "actual parameter" justifies the titration and must match the ordered "parameter value."

2

IV DRIP TITRATION

Time

Documenting titrations in real time can be difficult and time consuming.

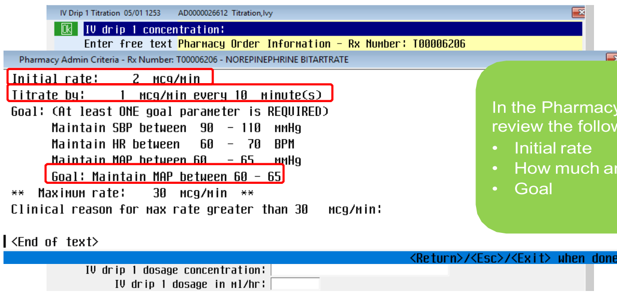
Patient safety is the number one priority.

Here's a way to document all of your titrations accurately and consecutively.

3

IV DRIP TITRATION

Documentation – Reviewing the IV Drip Titration order within the IV Drip Titration intervention



In the Pharmacy Admin criteria box you should review the following instructions:

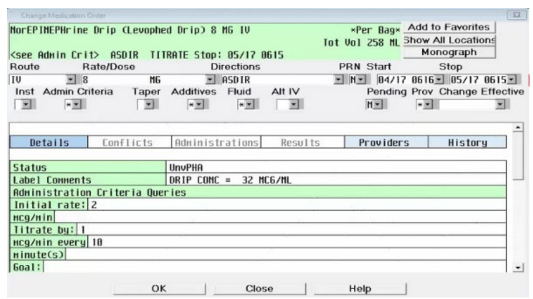
- Initial rate
- How much and how frequent you can titrate
- Goal

You should review the IV drip medication order ... seen within the intervention screen.

IV DRIP TITRATION

Documentation – Reviewing the IV Drip Titration order from the Orders tab

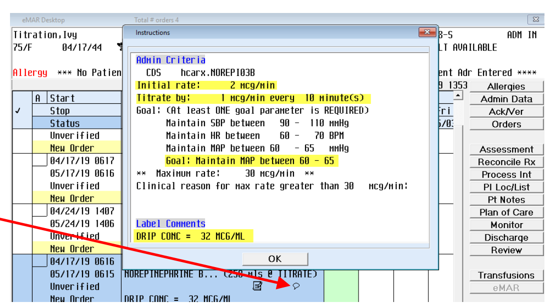
You can also review the details of the IV medication by looking at the medication order. If you scroll up and down, you will find details about the initial rate, frequency of titration and parameter goal.
Click on "View/Change"



IV DRIP TITRATION

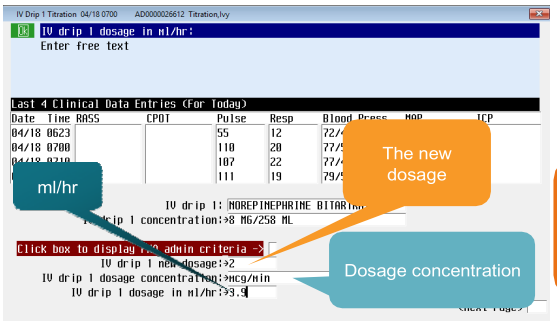
Documentation – Reviewing the Order

You can also review details of the IV Drip Titration order in eMAR. Highlight the medication, then, click on the "comment bubble"



IV DRIP TITRATION

Documentation – Required Fields

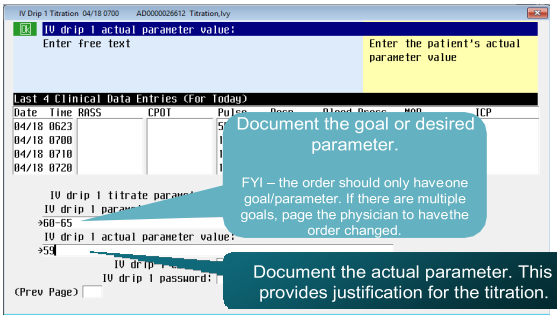


Let's review what must be documented with each titration.

Documenting the drip and IV rate under "intake/output" is not enough. IV drips must also be documented using these screens.

IV DRIP TITRATION

Documentation – Required Fields



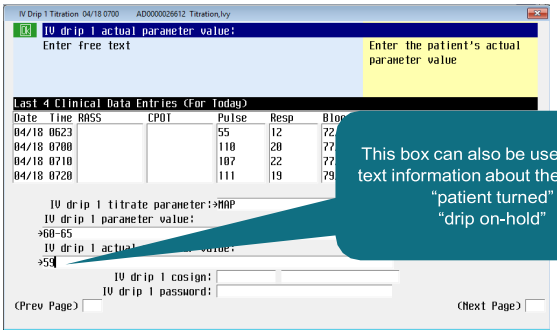
Remember, each documented titration must have an:

- IV drip 1 parameter value
- IV drip 1 actual parameter value

Documenting both parameters justifies the titration.

IV DRIP TITRATION

Documentation – Required Fields

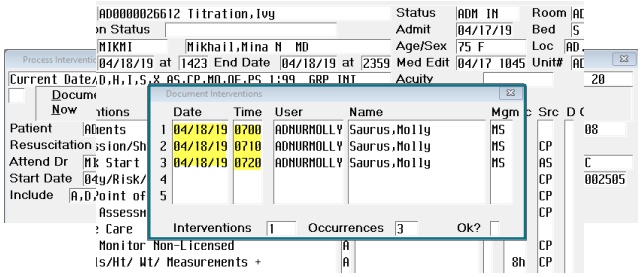


DOCUMENTING DIFFERENT TITRATION TIMES AT ONCE

Quick Tip

IV DRIP TITRATION

Quick Tip



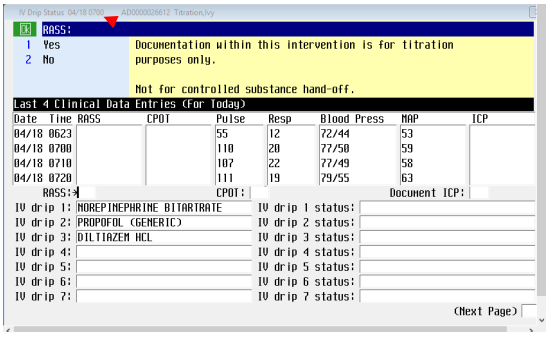
Type in the date and times that you titrated your drip(s).

This example shows that we want to document titrations that occurred at 0700, 0710 and 0720. The time between the titrations must match the order i.e. q 10min, q 15min.

Click on 'Document Interv's

IV DRIP TITRATION

Quick Tip

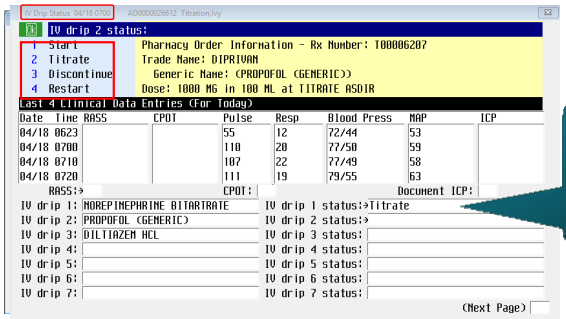


Here, we will document that we titrated the Levophed drip 3 times or every 10 minutes until we reached the ordered goal - MAP 60-65.

- The first time stamp is 0700.

IV DRIP TITRATION

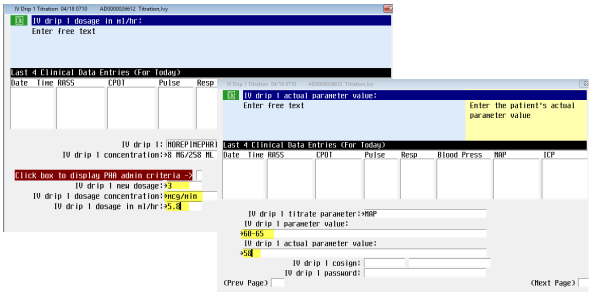
Quick Tip



We will select “Titrate” from the list of options.

IV DRIP TITRATION

Quick Tip

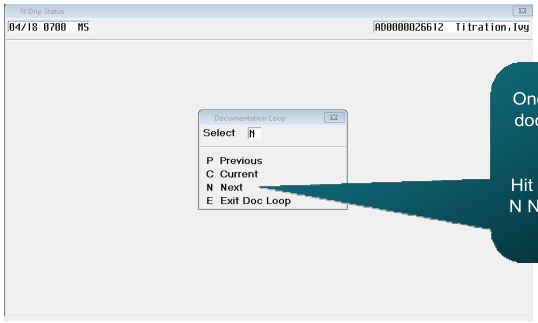


Fill in the required fields.

Then “file”

IV DRIP TITRATION

Quick Tip

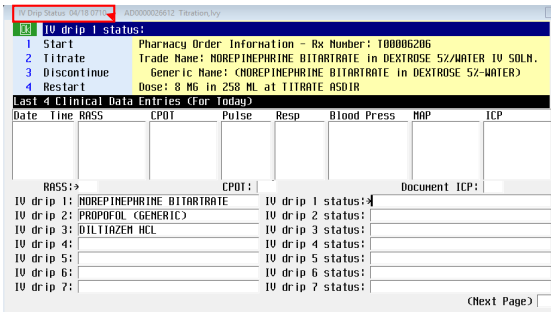


Once you have filed the documentation this box will pop-up.

Hit “enter” or click on the N NEXT to document the 0710 titration.

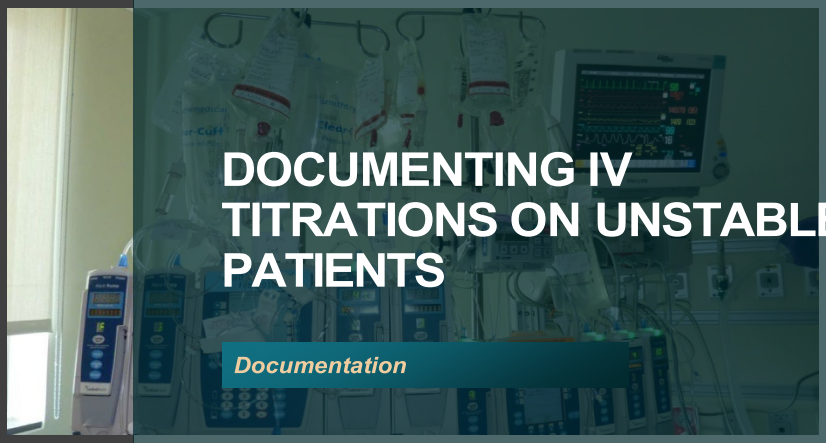
IV DRIP TITRATION

Quick Tip



You will see this screen again. Notice the time stamp has changed and you can complete the titration information for 0710.

16



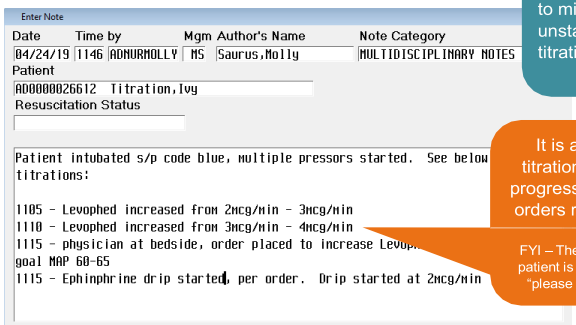
DOCUMENTING IV TITRATIONS ON UNSTABLE PATIENTS

Documentation

17

DOCUMENTING FREQUENT TITRATIONS ON AN UNSTABLE PATIENT

There will be times that it may be impossible for you to document minute to minute titrations if your patient is unstable. Please document your titrations in a progress note.



It is acceptable to document the IV titrations of an unstable patient in your progress note. Make sure the physician's orders reflect your frequency of titration.

FYI – The visual flowsheet is not available after the patient is discharged so making references to it, i.e. "please see visual flowsheet," is not appropriate.

18

TAKEAWAYS

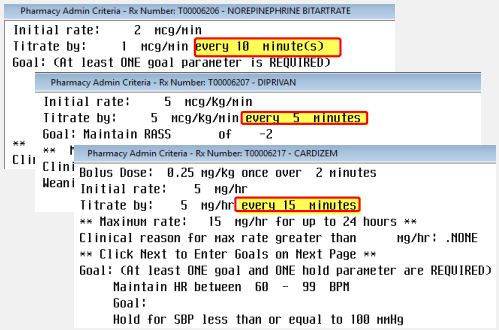
With EACH Titration Document:

- IV Drip 1 New Dose
- IV drip 1 Dose Concentration (will auto-populate)
- IV drip 1 Dose in ml/hr
- IV drip 1 titrate parameter (will auto-populate)
- IV drip 1 parameter value (will auto-populate)
- IV drip 1 actual parameter value (**REQUIRED**: this justifies the titration)

TAKEAWAYS

Using Document Intervention to chart multiple titrations

You can use "Document Intervention" to chart on multiple titrations ***BUT***, make sure that the times stamps match the ordered frequency for titration!



TAKEAWAYS

IV Titration Documentation

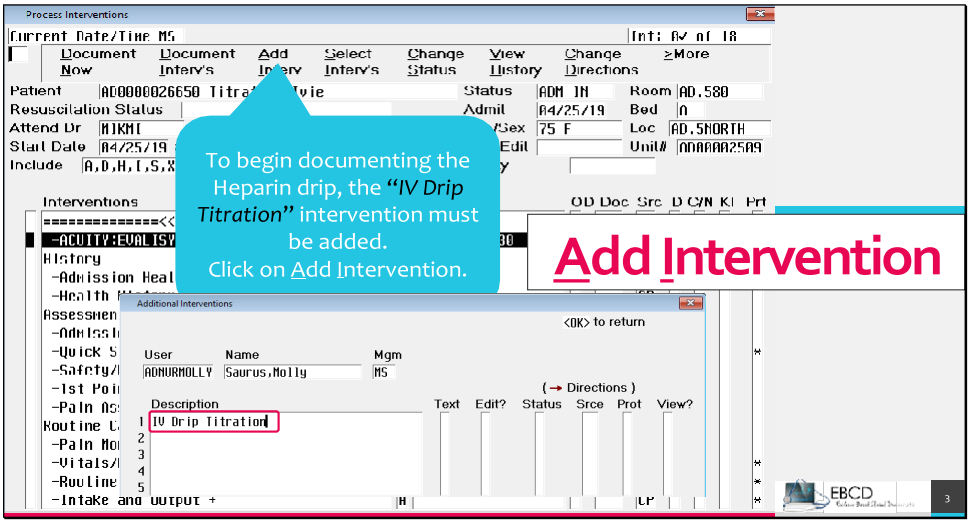
This presentation provided information on what nurses are required to document when titrating medications. There are other methods to document the frequency of titrations i.e. real time, or one by one. What's important to remember is to fill in ALL REQUIRED FIELDS.

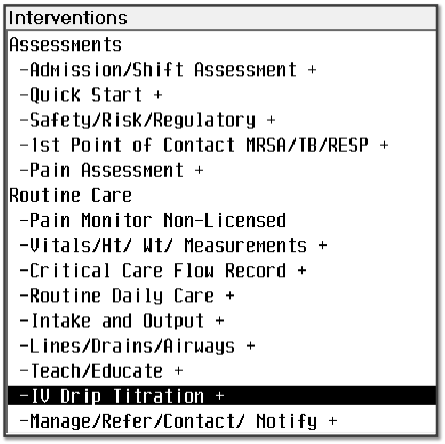
The titrations and documentation ***must match*** the parameters found in the physician's order.

ALL DRIPS MUST BE DOCUMENTED UNDER "IV DRIP TITRATION," not just in I/O

New Process

- Any patient with IV Drips that need titrating will use the new stand alone intervention, "IV Drip Titration."
- **This is not just for critical care nurses**, all Heparin drips, or other infusions that may be titrated, **must** be documented using the IV Titration screens.
- **IMPORTANT NOTE**: IV Drip Titration screens **do not** communicate with the Intake/Output screens. Please continue the current process of documenting the amount of IV fluids infused using the I/O screens.



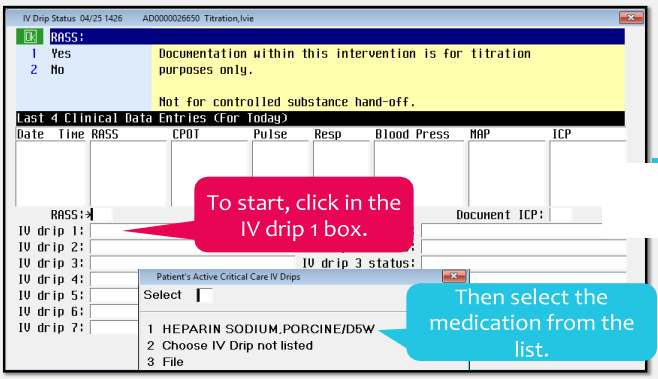


IV DripTitration

Process Intervention

IV Drip Titration

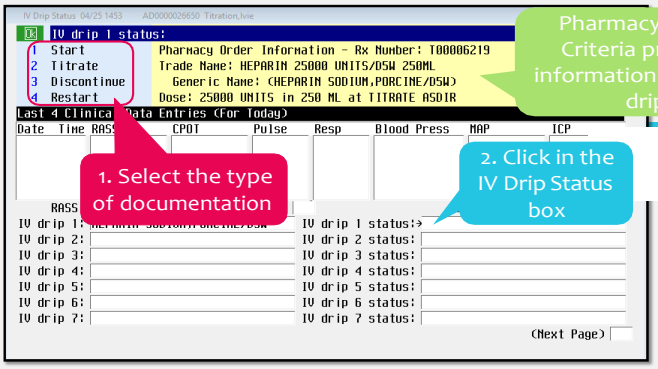
- The new intervention will appear under **Routine Care**.
- Before documenting, please make sure you have an order for a Heparin drip.



To start, click in the IV drip 1 box.

Then select the medication from the list.

Start

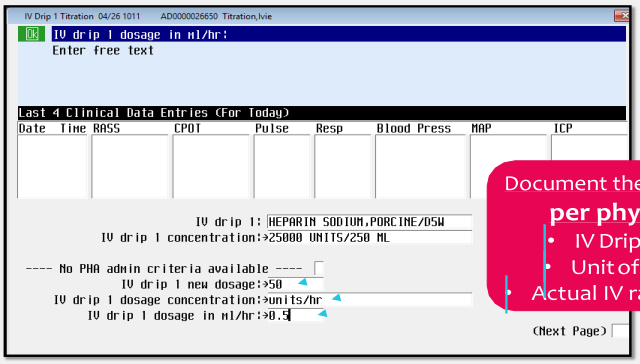


Pharmacy Admin Criteria provides information about the drip

1. Select the type of documentation

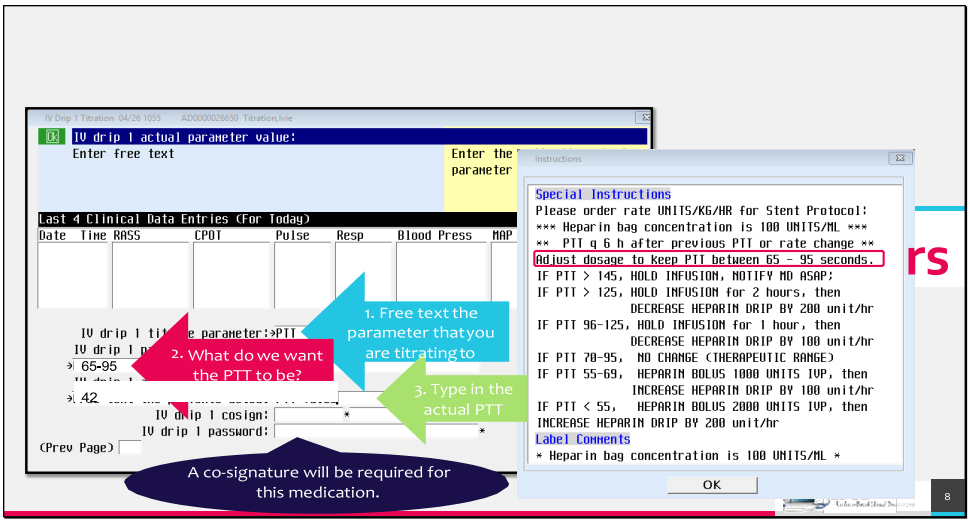
2. Click in the IV Drip Status box

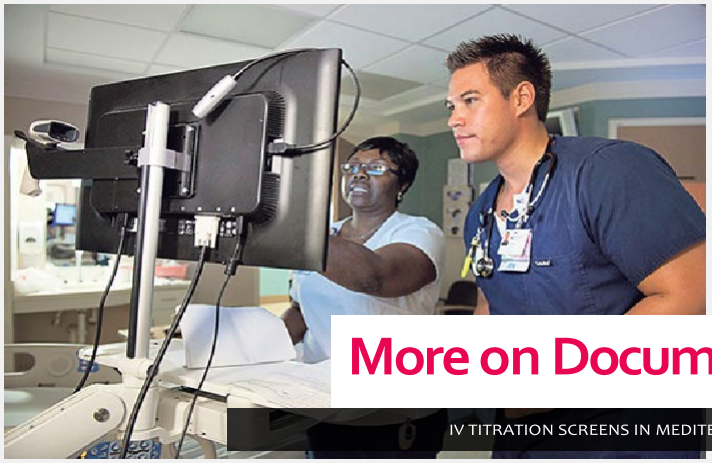
IV Drip1



Document the following q6h **or per physician order**

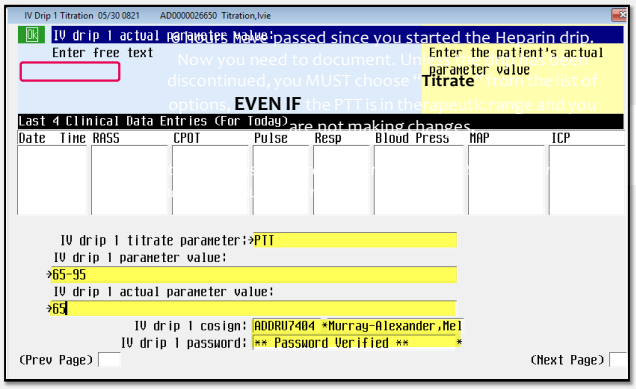
- IV Drip 1 new dosage
- Unit of measurement
- Actual IV rate from the pump





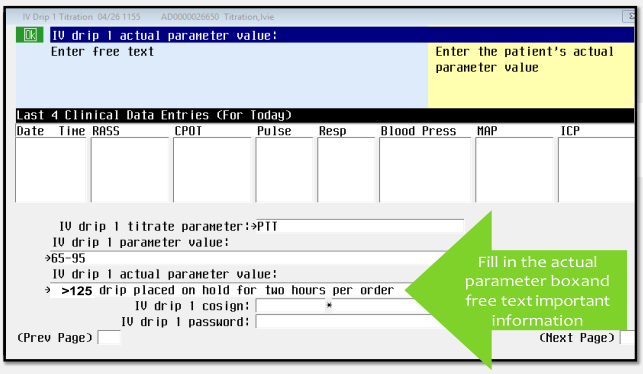
More on Documentation

IV TITRATION SCREENS IN MEDITECH

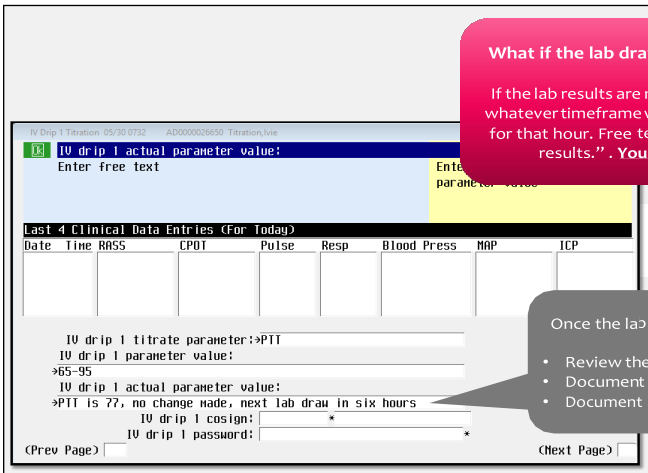


q6hDocumentation

Document in every field every 6 hours or per physician order. Each time you document you will need a co-signer even if no changes were made.



Drip on Hold



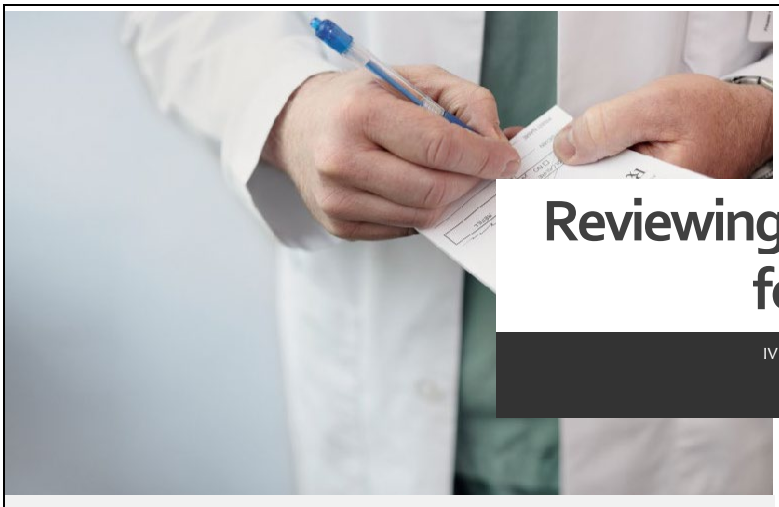
What if the lab draw is late and it is the sixth hour?

If the lab results are not back and it has been 6 hours (or whatever timeframe was ordered), continue to document for that hour. Free text, "lab drawn" or "waiting for PTT results." . **You will need a cosigner for this.**

Late Lab Draw

Once the lab results are available, do the following:

- Review the order
- Document the PTT results
- Document the change, if any

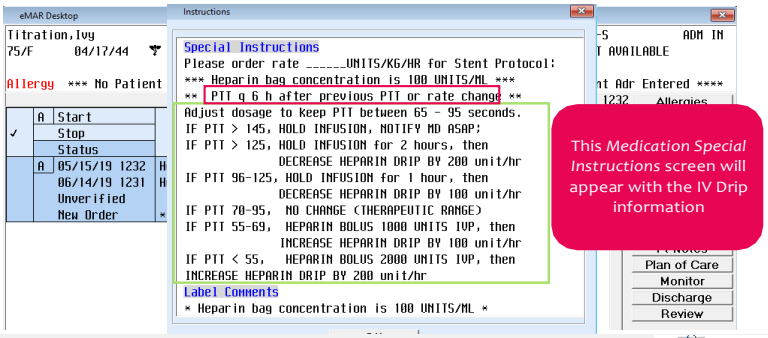


Reviewing Orders for Drips

IV Drip Titration Screens

Reviewing the IV Drip Order

***ALWAYS* follow the *MOST CURRENT* physicians order!** Please review the IV Drip orders during Bedside Shift Report and/or I-TRACE. You can find details of the Heparin order in eMAR.



This *Medication Special Instructions* screen will appear with the IV Drip information

EBCD 14

Takeaways

IV Drip Titration Screens

You are required to document Heparin Drips using the IV Drip Titration screens

Continue to document the volume infused, during your shift, under Intake/Output

Document on the Heparin drip, at least, every six hours, or **per the physicians order** and **with every drip change**

Most fields are "free text" boxes, use them to briefly explain drip changes or holds

Review the IV Drip orders during Bedside Shift Report I-TRACE

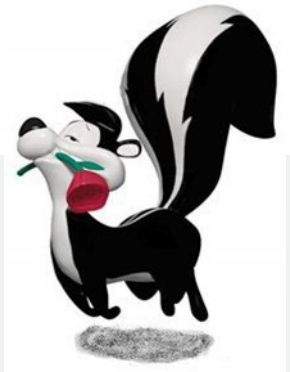
FOLLOW THE PHYSICIANS MOST CURRENT ORDER!!

EBCD 11

Additional Information

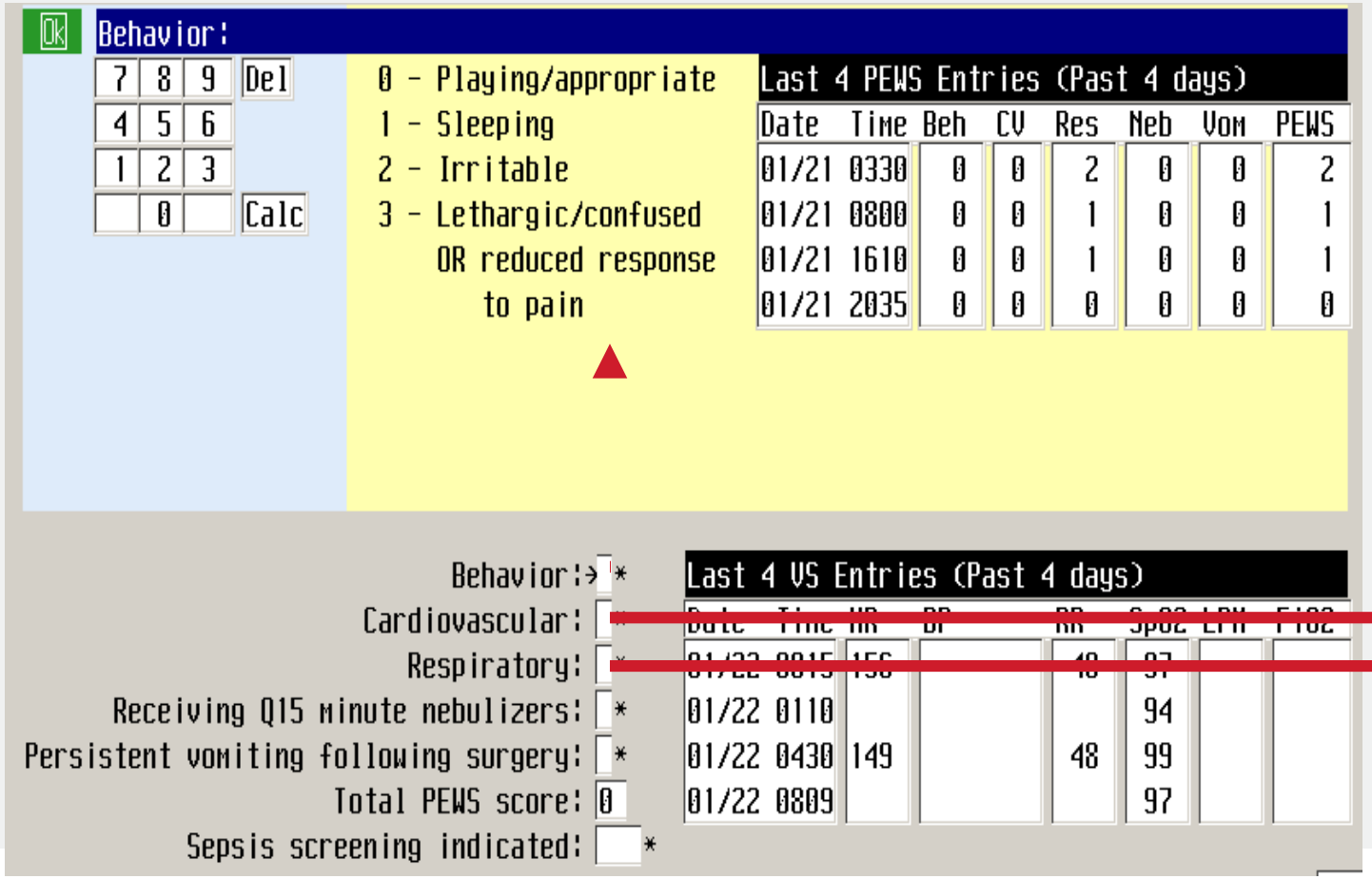
HCA Healthcare℠

Pediatric Early Warning System (PEWS)



- All pediatric patients in Pediatric unit and Med/Surg/Tele units
- Ages 0-17+364 days
- Admission, every four hours with routine vital signs, and with changes in patient condition
- Parameters:
  - **Behavior**
  - **Cardiovascular criteria** (color, capillary refill time and heart rate)
  - **Respiratory rate** (rate and oxygen demand)
- Notify charge nurse if PEWS score is 3 or greater, or there is a 2 point increase
- Notify LIP if PEWS score is 4 or greater. Call RRT anytime
- Consider notification of physician for a score of 3 in any one category
- Meditech documentation: **Add Intervention** (PEWS+); it will appear under Routine Care

PEWS – Pediatric Early Warning System



0 - Pink OR cap refill 1-2 secs
1 - Pale OR cap refill 3 sec
2 - Grey OR cap refill 4 sec
OR tachycardia of 20 above normal rate
3 - Grey and mottled
OR cap refill > 5 sec
OR tachycardia - 30 above normal OR bradycardia

Heart Rate (at rest)

Birth - 12 mos . . 100-180
13 mos - 12 yrs . . 70-110
13 yrs - 17 yrs . . 55-90

0 - RR within normal OR No retracts
1 - RR >10 above normal
OR use of accessory muscles
OR >30% FiO2 OR 3+L/min
2 - RR >20 above normal OR retracts
OR >40% FiO2 OR 6+L/min
3 - RR 5 below normal w/retracts
OR Grunting
OR 50% FiO2 OR 8+L/min

Respiratory Rate (at rest)

(Birth - 1 month). .40-60
(1 - 12 mos). . . . 35-40
(13 mos - 3 yrs). . 25-30
(4 - 6 yrs). 21-23
(7 - 12 yrs). . . . 19-21
(13 - 17 yrs). . . .16-18

Quality Indicators:

Stroke, ED Throughput, AMI, Women's Services

HCA Healthcare℠

Know the STROKE WARNING SIGNS and B.E.F.A.S.T!

BALANCE

B

Loss of balance, coordination or dizziness

EYES

E

Blurred or loss of vision

FACE

F

One side of the face is drooping

ARMS

A

Arm or leg weakness

SPEECH

S

Speech difficulty

THUNDERCLAP HEADACHE

T

Sudden severe headache with no known cause

Moments Matter

Code Stroke

- Who is eligible?
  - Age >18 years
  - Presents with focal neurological deficit sudden in onset
  - Last known well (LKW) ≤6 hours prior to recognition of new neurological deficit
- When to call?
  - Call ***84911** when you suspect a stroke
  - For units other than ED or ICU, a **code Rapid Response** must be called first
- What is the purpose?
  - Expedite the evaluation and decision for treatment

Moments Matter…

Code Stroke Response Team

Responding Team Member	Code Stroke Location
ED Nurses and personnel	ED
ED Physician	ED
Rapid Response/ICU Nurses	In-patient and ED Holding areas
ICU Physician Licensed Independent Practitioner	In-patient and ED Holding areas
Neurologist on-call	Any
Neurology Nurse Practitioner	Any (when on site)
Stroke Coordinator Advanced Practice Nurse	Any (when on site)
Radiology personnel	Any
Laboratory personnel	Any
Pharmacy personnel	Any
Respiratory personnel	Any

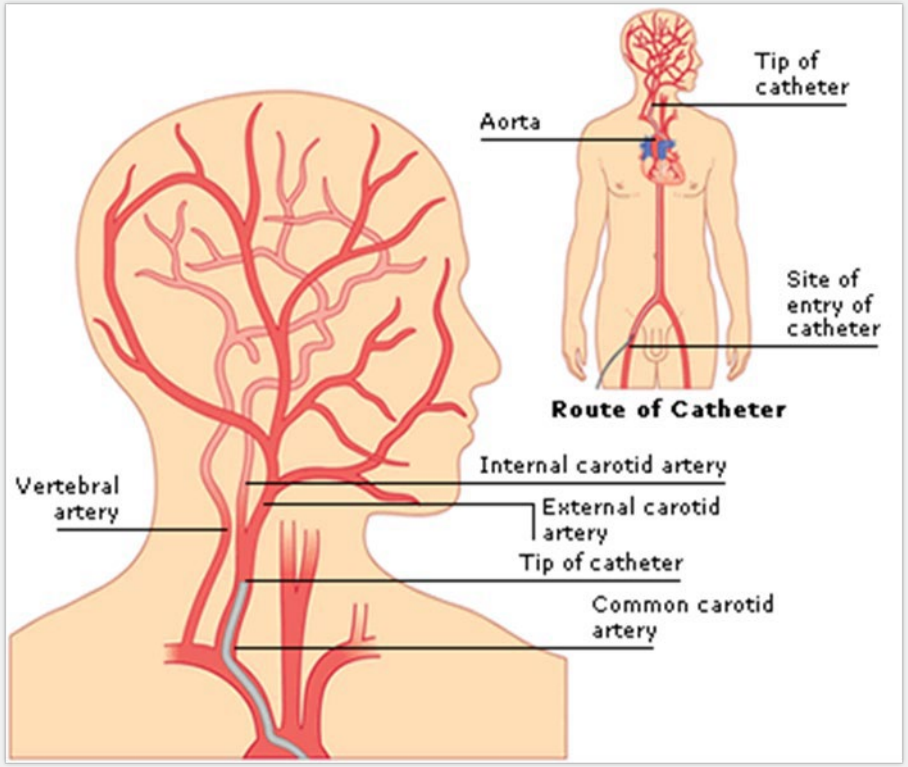
Stroke Treatments

Medication Treatment for AIS

- The only FDA approved medication for treatment of acute ischemic strokes
- Tissue Plasminogen Activator: Tenecteplase(TNK) standard treatment for acute ischemic stroke (AIS) when administered within 3 hours of stroke symptom onset
- Works by dissolving the clot and improving blood flow
- Administered IV as a bolus and an infusion

Stroke Treatments

Mechanical Treatment for AIS

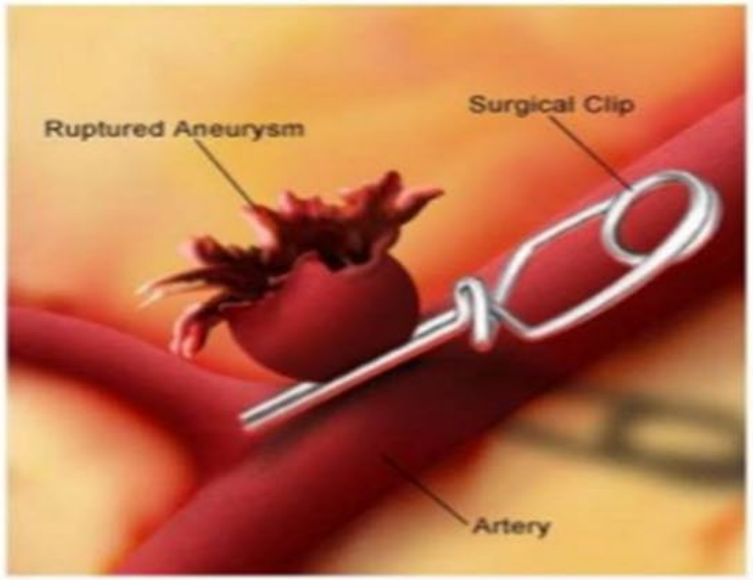


- Known as endovascular procedure or **mechanical thrombectomy**
- The procedure allows physical removal of a large blood clot by the Neurointerventionalist by using a stent retriever device or aspiration

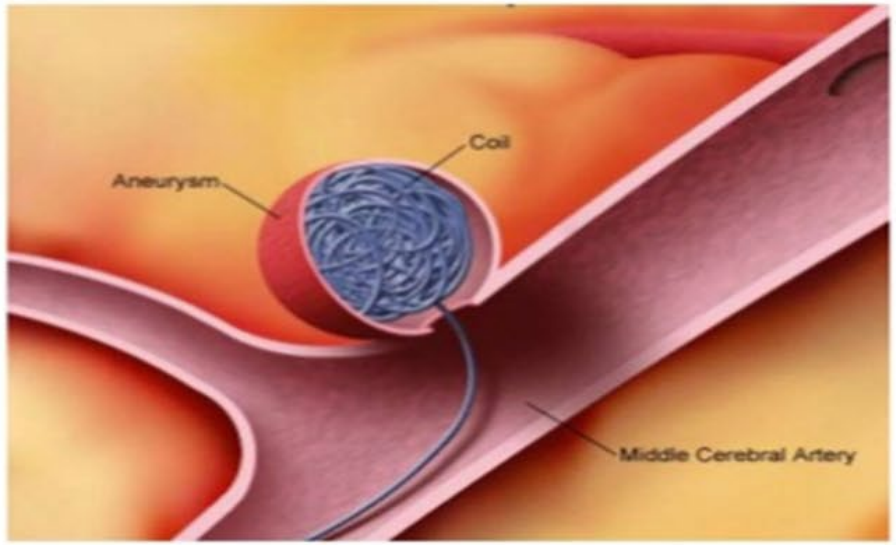
Stroke Treatments

Treatment of Hemorrhagic Stroke

Aneurysm Clipping



Embolization Coiling



Emergency Department

HCA Healthcare℠

ED…

- LR is Level II Trauma
- LR & WH are STEMI
  - Chest pain center.
  - People are flown in from all over the inland empire to be treated in our cardiac Cath lab.
- LR & WH are STROKE
  - Comprehensive Stroke Center.

Key Metrics...

MTD Oct 21st	DLOS	Level 3 DLOS	LA LOS	ALOS	Dispo to Leave (D)	Bed Assigned to Leave	Hold Hours	CT TAT	Blood Ord to Coll	UA Ord to Coll
Current Year Targets	125	160	85	210	25	40		100	15	30
Sunrise Adult	262	193	62	418	148	91	5,700	103	18	58
Sunrise Peds	151	175	103	281	35		140	127	34	39
MountainView	147	163	62	271	36	40	2,240	94	21	46
Lakes FSER	72	79	49	189	14		2	76	10	18
So Hills	116	117	57	189	30	41	331	84	16	37
Good Sam	148	156	54	293	26	79	1,028	95	30	61
Regional	155	187	73	355	27	49	1,782	94	25	48
Los Robles	146	177	62	344	45	62	2,101	88	20	53
West Hills	163	179	68	464	50	46	2,341	103	28	53
Riverside	202	237	80	602	46	48	6,424	155	17	91
Far West Division	171	180	73	375	53	58	22,088	105	23	52
National Group	141	152	74	310	35	51	76,766	-	-	-
HCA, INC	146	157	77	317	33	-	153,993	-	-	-

Why is Throughput Important?

Reducing holding time in the ED improves access to treatment for other patients waiting to be seen.

How can YOU Help?

- We are ALL busy!
- Remember, the patient needs your special care!
- Be proactive.
- Expedite discharges.
- Utilize Discharge Lounge on G5.

Acute MI

AMI Best Practice...

- **Aspirin (ASA)** within 24 hours before or after arrival.
- **Fibrinolytic** within 30 minutes of arrival (if not going to the CCL).
- **Percutaneous Coronary Intervention (PCI)** within 90 minutes of arrival.
- **Aspirin, a Statin (regardless of LDL), a Beta Blocker, and Anti-platelet** therapy prescribed **at discharge** UNLESS there is a physician documented contraindication.
- **Angiotensin converting Enzyme Inhibitor (ACEI) / Angiotensin Receptor Blocker (ARB) at discharge** for LV syst. Dysfunction (LVSD – EF% of 40 or less). If not ordered, MD must document reason.

ASA…

ASA within 24 hours before or after arrival AND at discharge

Must document *WHY* no ASA on admission or discharge, unless there is documentation of allergy, or patient is currently on Coumadin.

- ***If patient took prior to coming in, document "took at home".***
- ***If given by EMS—ensure it is documented on the run sheet.***
- ***If not given at discharge, MD progress note must state why.***

Women’s Services

LRCHM Only

HCA Healthcare℠

Elective Delivery

- Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed.
- Elective induction of labor, elective primary or elective repeat cesarean section for singleton gestations, will only be scheduled for women who have reached 39 completed weeks of gestation (39 weeks)
- **No Elective Deliveries prior to 39 weeks gestation**

Cesarean Section

- **Nulliparous women with term, singleton baby in a vertex position delivered by cesarean section (NTSV CS)**
- NTSV CS is the most variable portion of the CS epidemic
- Some hospitals now have CS rates over 50%; hospitals with 15-20% have infant outcomes that are just as good and better maternal outcomes

Administration of antenatal Steroids

- Patients admitted to Labor and Delivery at risk for preterm birth within 7 days.
- Antenatal Corticosteroids: Medications used between 24-32 weeks gestation with PPROM to improve fetal outcomes for patients at high risk for preterm delivery within 7 days
- Antepartum Steroid Order:

➢ Celestone Soluspan 12 mg IM now

➢ Repeat dose in 24 hours then DC

Or

➢ Dexamethasone 6 mg IM every 12 hours x 4 doses if Celestone not available

Healthcare Associated Bloodstream Infections in Newborns

- Reduce the incidence of healthcare associated bacteremia in the neonatal population
- Effective preventive measures range from simple hand-washing protocols or closed medication delivery systems to more elaborate multidisciplinary quality improvements involving:

- Hand-washing/Bare below the elbow
- Nutrition
- Skin Care
- Respiratory care
- Vascular access
- Diagnostic practices

Breastfeeding Measure

- Exclusive breastmilk feeding during the newborn's entire hospitalization
- This measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the entire hospitalization, and a second rate, a subset of the first, which includes only those newborns that were exclusively fed breast milk during the entire hospitalization excluding those whose mothers chose not to breast feed.
- In the Mother's record, document the following:

➢ Feeding Preference on Admission

➢ If not exclusively breastfeeding, document Final Feeding Preference after Discussion/Education

➢ Date and Time Education provided

Pediatric Asthma- Children's Asthma Care (CAC)

- Use of relievers in pediatric patients (2 to 17 years) admitted for inpatient treatment of asthma
- Relievers administered for Inpatient Admission
- Systemic Corticosteroids administered for Inpatient Admission
- Home Management Plan of Care given to every patient upon discharge completely filled out, signed by caregiver and a copy placed in medical record

Salem Sump Tube with Multi-Functional Port and ENFit connection

HCA Healthcare℠

How the tube works - functions

The Kangaroo Salem Sump Tube with Multi-functional Port is an all-in-one enteral system. The one-function design lets clinicians toggle between functions in a single device

Feed/medicate

The system is designed with an ENFit connection to attach to a Kangaroo feeing set or EnFit syringe

Suction

The universal suction adapter features a universal connection, with no ancillary adapter needed. The integrated anti-reflux valve (ARV) helps prevent stomach wall invagination during suction and reduces gastric reflux.

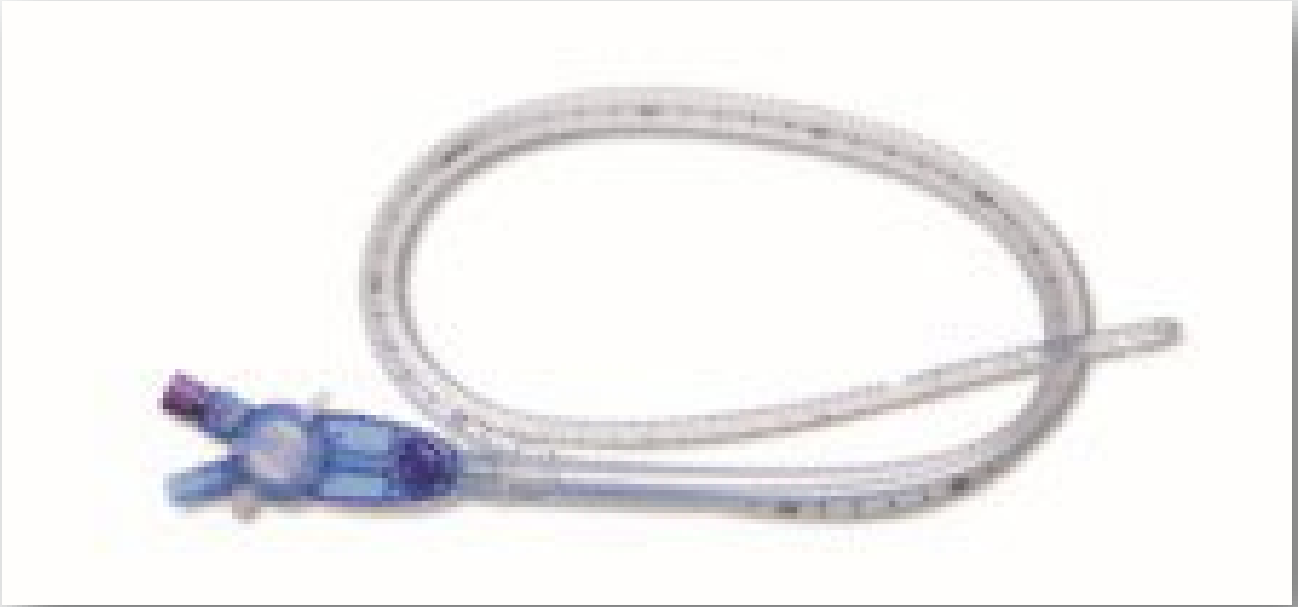
Irrigate

The device also accepts a catheter tip syringe for air or fluid irrigation.

Assembly

Insert the larger diameter post into the larger diameter hole of the suction lumen on the sump tube

The part is properly attached to the tubing when the face of the port is flush with the end of the tube.



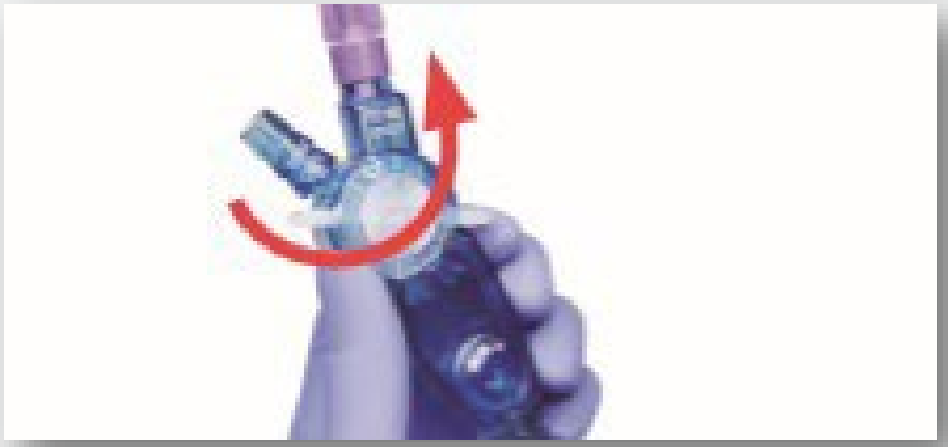
Suction

Using a quarter twist, securely push the suction line over the port.

Turn the selection knob until the indicator line on the knob is aligned with the indicator of the suction port. Begin suctioning.

Feeding

Attach the enteral feeding adapter to the feed port. Secure the Enfit adapter to the port by applying pressure and a quarter turn.



Turn the selection knob until the indicator line on the knob is aligned with the indicator of the feed port. Begin feeding.

Medicating, Irrigating, checking residuals

To medicate, irrigate or check residuals, connect an ENFit syringe and use a quarter turn for a secure seal.

To lock in fluid path mode, slide the center tab toward the ARV port until the padlock symbol appears. To unlock, slide the center tab away from the ARV port.

ARV port

Irrigate the ARV port with AIR using an irrigation tip syringe. Seat with a quarter turn. Always inject 10 to 20cc of air after each saline/water flush to reestablish the air buffer.

CAUTION

DO NOT deliver any crushed or liquid medications, formulas or other liquids into the ARV port

Post Pyloric Duodenal Feeding Tube with guidewire “Keeofeed / Dobhoff tube”

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Specifics for Duodenal Feeding Tube

- Placed distal to the pylorus to avoid reflux
- Must have a Dr.s order to place
- RNs who have completed the educational process may insert the Nasoduodenal tube
- Measure from nose to ear to stomach and add 10-15cm to the distance measured for placement to allow the tube to pass beyond the pylorus (The tube must be at least 40cm at the nares after insertion)
- Tube and guidewire should be inserted at least a full 40-45cm depending on patient's measurement to ensure placement in the stomach

Specifics for Duodenal Feeding Tube (continued)

- Allow the tube to coil in the stomach for initial placement. The excess tubing allows the tube to advance past the stomach into the small intestine.
- Obtain KUB X-ray for “placement of duodenal feeding tube”. Remove stylet after tube position is confirmed with X-ray to be either coiled in the stomach, or located in the duodenum.
- Start feeding at Low Flow (30-40 ml/hr) after the post-insertion KUB X-ray has confirmed placement to be coiled in the stomach. Higher rates of enteral administration can be started once the tube is confirmed to be in the duodenum.
- When tube can be advanced only to the stomach, place patient on right side (unless contraindicated) to facilitate tube advancement.

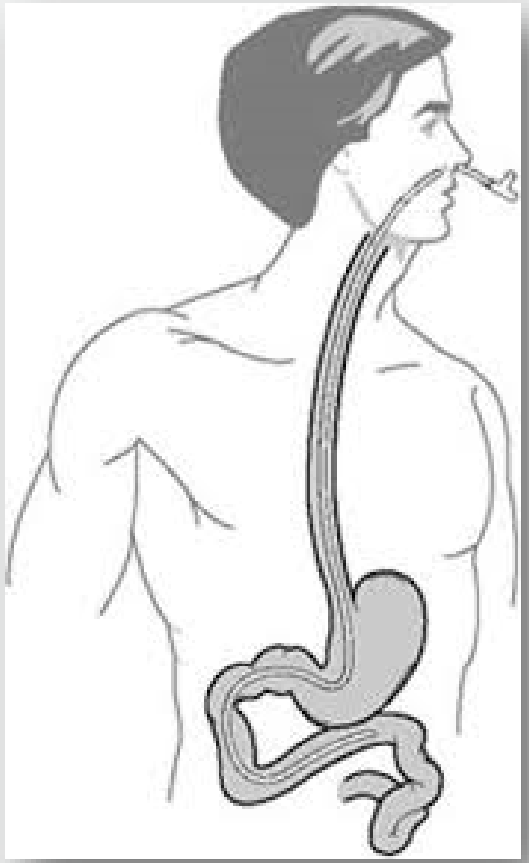
Specifics for Duodenal Feeding Tube (continued)

- Obtain KUB X-ray 24 hours after initial placement to confirm advancement into the duodenum (small intestine). If feeding tube is still coiled in the stomach, order another KUB X-ray in 24 hours to confirm placement into the duodenum. If after 48 hours feeding tube is not yet migrated to the duodenum, notify Physician for further orders.

- After X-Ray confirmation of feeding tube in duodenum is obtained, mark tube at nares with indelible ink, and obtain initial measurement from nares to end of tube in centimeters. Document initial measurement and confirmation of feeding tube location in duodenum, in the electronic medical record. If indelible ink mark in NOT visible, obtain KUB X-ray to assess for location of feeding tube.

- If the tube moves out greater than 2 cm, from the original indelible ink marking, stop feeding and notify physician. (A KUB should be ordered)

Specifics for Duodenal Feeding Tube (continued)



- Aspiration of the tube is not a reliable indication of residual, as the tube will collapse. Clinical indicators of feeding tolerance include: soft, non-tender, non-distended abdomen, active bowel tones, regular bowel movements., absence of nausea or vomiting.

- **RNs: <u>DO NOT REINSERT WIRE INTO TUBE</u> WHILE TUBE IS IN PATIENT – poses risk of esophageal perforation**

Kangaroo Feeding Pump Quick Programing Tips

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Loading the feeding set into the Kangeroo pump

Grasp thumb tab on valve and insert firmly into left pocket, ensure valve is fully seated. Tab should align with raised white line on left

Loading the feeding set – continued….

Grasp black ring retainer, gently wrap tubing around rotor, and insert retainer directly into right pocket.
Do NOT overstretch tubing.

Loading the feeding set – continued….

Once the feeding set is loaded, close the blue door. The pump is now ready for normal operation.

Priming and programing the Kangeroo

- Power the pump on. Select “Clear Settings” or “Keep Settings”
- Press the “Auto-prime” or “Prime Pump button + “done”
- Set the Feed Rate + “enter” + “done”
- Set the Flush Rate + “enter” + “done”
- Select “Run” to start the feeding

Changing Rate or Clearing Volume

To Change Rate or Clear Volume

1. Select ▶ **“Hold”**.
2. Select ▶ **“Clear Vol”** to clear the volume.
3. Select ▶ **“Adjust Settings”** to adjust all settings.
4. Select ▶ **“Run”** to return to normal operations.

Blood Transfusions

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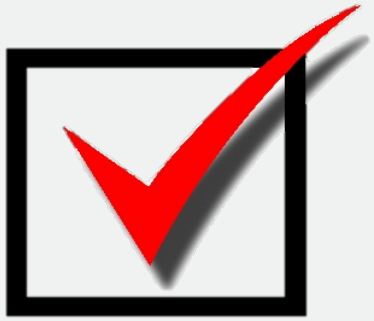
Blood Transfusion Orders



A physician's order is

ALWAYS

required to transfuse blood!

Paul Gann Blood Safety Act...

INTRODUCTION

THE PAUL GANN ACT IS A CALIFORNIA STATUTE REQUIRING A DISCUSSION ABOUT, AND OPPORTUNITY FOR, VARIOUS TRANSFUSION OPTIONS WHEN THERE IS A REASONABLE POSSIBILITY SUCH THERAPY MAY BE NECESSARY AS A RESULT OF AN ANTICIPATED NON-EMERGENT MEDICAL OR SURGICAL PROCEDURE. THE PAUL GANN ACT HAS REQUIREMENTS SEPARATE FROM, AND IS NOT CONSIDERED A REPLACEMENT FOR, THE INFORMED CONSENT PROCESS OF BLOOD TRANSFUSION.

REQUIREMENTS OF PAUL GANN ACT

- A DISCUSSION OF THE RISKS AND BENEFITS OF AUTOLOGOUS, DIRECTED ALLOGENEIC AND NONDIRECTED ALLOGENEIC BLOOD PRODUCTS
- THE PATIENT IS PROVIDED THE LATEST STANDARDIZED EDUCATIONAL BROCHURE PREPARED BY THE CALIFORNIA DEPARTMENT OF HEALTH, "*A PATIENT'S GUIDE TO BLOOD TRANSFUSIONS*," REGARDING THE VARIOUS BLOOD DONATION TYPES
- ADEQUATE TIME IS GIVEN PRIOR TO THE ANTICIPATED TRANSFUSION NEED TO ALLOW FOR AUTOLOGOUS OR DESIGNATED DONATION TO OCCUR (IF DESIRED)
- PAUL GANN ACT REQUIREMENTS MUST BE DOCUMENTED WITHIN THE PATIENT MEDICAL RECORD

FREQUENCY OF PAUL GANN

- FREQUENCY OF THE PAUL GANN ACT PATIENT DISCUSSION AND DOCUMENTATION DEPENDS UPON INSTITUTIONAL PRACTICES AND TREATMENT COURSE. EXAMPLE REQUIREMENTS ARE PROVIDED BELOW:

ACUTE INPATIENTS WITH LIMITED (AND PRE-PLANNED) TRANSFUSION THERAPY

PAUL GANN ACT DOCUMENTATION IS VALID FOR EACH TREATMENT COURSE (E.G., ONCE PER ADMISSION) UNLESS A SIGNIFICANT CHANGE DEVELOPS IN INDICATION OR TRANSFUSION RISK

CHRONIC INPATIENTS OR OUTPATIENTS REQUIRING SERIAL TRANSFUSION THERAPY

PAUL GANN ACT IS VALID FOR MULTIPLE EPISODES (E.G., FOR 12 MONTHS) UNLESS A SIGNIFICANT CHANGE DEVELOPS IN INDICATION OR TRANSFUSION RISK

Blood Consent – 3 in 1

- Patients receiving non-emergency transfusion must sign the **“Informed Consent for Non-Emergency Blood Transfusion”** section.
- A patient who is an autologous donor or as a direct donor must sign the **“Autologous/ Donor Blood Only”** section.
- Patient who refuse to accept transfusions should sign the **“Refusal to Permit Blood Transfusion”** section and have a No Blood band.

Jehovah's Witnesses

- If your patient is a Jehovah's Witnesses it is important to ask if they take blood products. Let the physician know your patient's wishes regarding blood products.
- If your patient does not accept blood products place a **NO BLOOD** armband on the patient (available through blood bank).

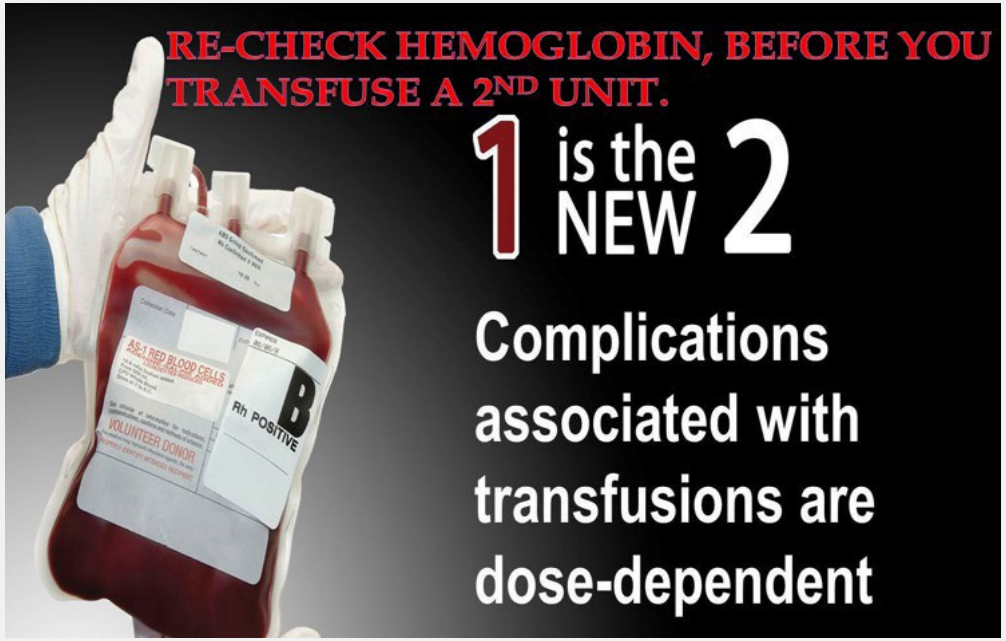
- The **"Refusal to permit Blood Transfusion"** should be signed by the patient and witnessed by a nurse.

Blood Transfusion the Process

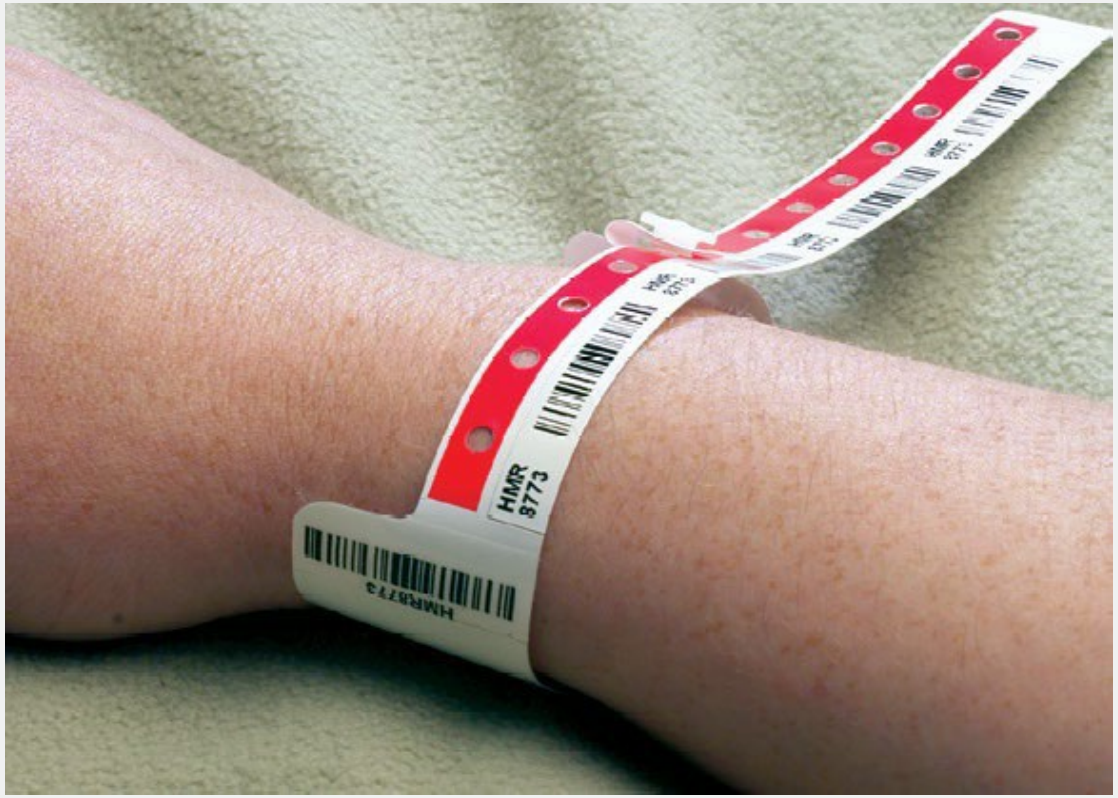
- Patients must have a consent for a non-emergency blood transfusion.
- Whomever collects the blood for the type and cross is responsible for placing a barcoded blood band on the patient.
- When the blood is ready for pick up – 2 RNs must go to the bedside to verify the patient and sign the blood release form.
- A barcode from the blood band will be placed on the blood release form.

New Guidelines…

- No transfusion for Hgb >7.
- Post transfusion Hgb level checked after each unit.
  - Unless initial Hgb <6 – then 2 units may be infused without testing between units.



Barcoded Blood Band

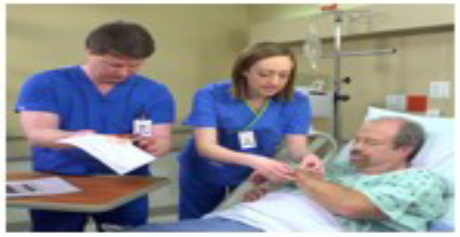


Picking up Blood Products

- Any staff member can pick up blood products from the blood bank provided they have the appropriate paperwork.
  - Students and volunteers *may not* pick up blood.
- A copy of the signed **Informed Consent for Non-Emergency Blood Transfusion** form and the **Authorization for Release of Blood Products** form with the patient information, barcode from the blood band and 2 RNs signatures is required for picking up blood. *NO COPIES!*

Each Blood Product Unit requires verification of patient information TWICE *at the bedside*...

Before obtaining each unit of blood product... 2 licensed nurses at the bedside must verify following information against the information on the Authorization Form:



- ✓ the patient's name and the blood product requested on the Form is consistent with the physician's order.
- ✓ correct patient label is on the Form.
- ✓ the patient has a Blood Bank ID Band.
- ✓ the patient's information on the Form matches the hospital ID band and Blood Bank ID band – verified by reading aloud the MR #, patient name, and date of birth.
- ✓ if all the information is correct, the bar coded sticker from the Blood Bank band is removed and placed on the Form.
- ✓ both RNs sign the Form.
- ✓ ***DO NOT copy this Form for other units!***

***Before administration begins...2 licensed staff* at the bedside (one must be administering the product)** must verify the following information:

- ✓ the patient's name and MR # match both the patient's hospital ID band and the Blood Bank ID band.
- ✓ the patient and the type of blood product are verified by scanning bar codes on the:
  - ➢ patient's hospital ID band
  - ➢ Blood Bank ID band
  - ➢ product unit number
  - ➢ product type
  - ➢ blood type
- ✓ the product's expiration date and time are visually verified.
- ✓ if all the information is correct, the electronic record is co-signed.

Patient Monitoring

- Vital signs must be done < 30 minutes prior to picking up blood.
- The RN must stay in the room from the beginning of the blood product infusion and remain in the room until first set of vital signs are taken. Vital signs are taken:
  - ✓ 15 minutes from the start of the infusion.
  - ✓ every hour thereafter until the transfusion is completed.
  - ✓ at the end of the transfusion.
- Blood should hang no longer than 4 hours.
  - ➢ Tubing must be changed every 4 hours.

Blood Product Safety

- Blood products should always be infused through blood tubing and be on an IV pump.
- Only Normal Saline 0.9 NaCl should be infused with blood products.
- Medications should **never** be administered through the blood tubing with blood.
- The blood infusion should be stopped if the patient develops (fever, SOB, itching, hives, etc). Contact the physician for further orders.

Transfusion Reaction
Common Symptoms

- A temperature increase of 2 ºF (1º C) above the patient's baseline
- Wheezing
- Bronchospasm
- Itching
- Hives
- Generalized flushing
- Chest or back pain/pressure

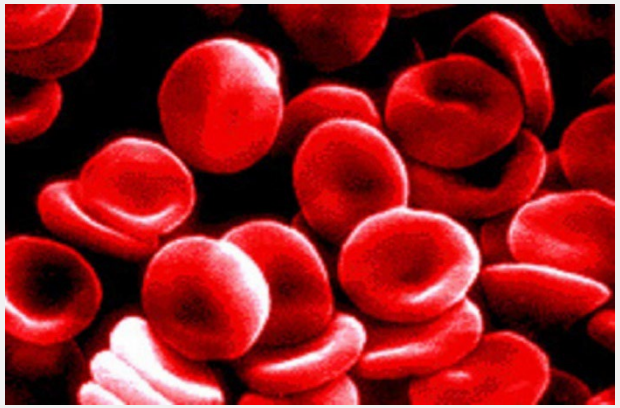
Reactions…

Most serious transfusion reactions, such as acute hemolytic transfusion reactions caused by ABO incompatibility and anaphylaxis, **occur within the first 15 minutes of transfusion.** *Therefore, a slow initial infusion rate with continuous monitoring of the patient during the early stages of a transfusion allows the reaction to be discovered in a timely manner.*

Some other serious reactions, such as Transfusion related acute lung injury (TRALI) and transfusion related circulatory overload (TACO) may occur during or within 1 to 2 hours after transfusion.

Transfusion Reaction: *what to do…*

- ✓Stop transfusion – save blood and tubing, return to Lab.
- ✓Notify MD and treat patient as appropriate.
- ✓Document reaction in Meditech.
- ✓Collect specimens… urine and blood.
- ✓Continue to monitor the patient.



In an *EMERGENCY*…

The pneumatic carrier tube system will allow for the timely delivery of blood units and components to the different areas of the hospital in the event of a ***true emergency…***

> ***an active code blue, excessive bleeding, and / or the physician is actively working on the patient at the bedside.***

Blood or Blood Components may be tubed ONLY to the following areas:

- Operating Room (Recovery Room and OR holding unit is included in OR)
- ED / Trauma
- Labor & Delivery
- MICU & SICU, except during a Massive Blood Transfusion Protocol (MBTP).

In an *EMERGENCY*…

Fill the bottom part of the **Authorization for Release of Blood and Components** form and return the form via tube system to blood bank ASAP.

- ✓NOTE: Received by…put your Name, 3-4 ID, Date, Time and Location.

If the blood transfusion cannot start right away, return the blood to Blood Bank within **30 minutes** or the blood will be wasted.

- **Do not tube autologous or directed donor units** via pneumatic tube. Autologous and directed donor units must be checked out in the blood bank.

PC.176 Massive Blood Transfusion Protocol

OneLegacy

Your Important Role in Organ, Eye and Tissue Donation

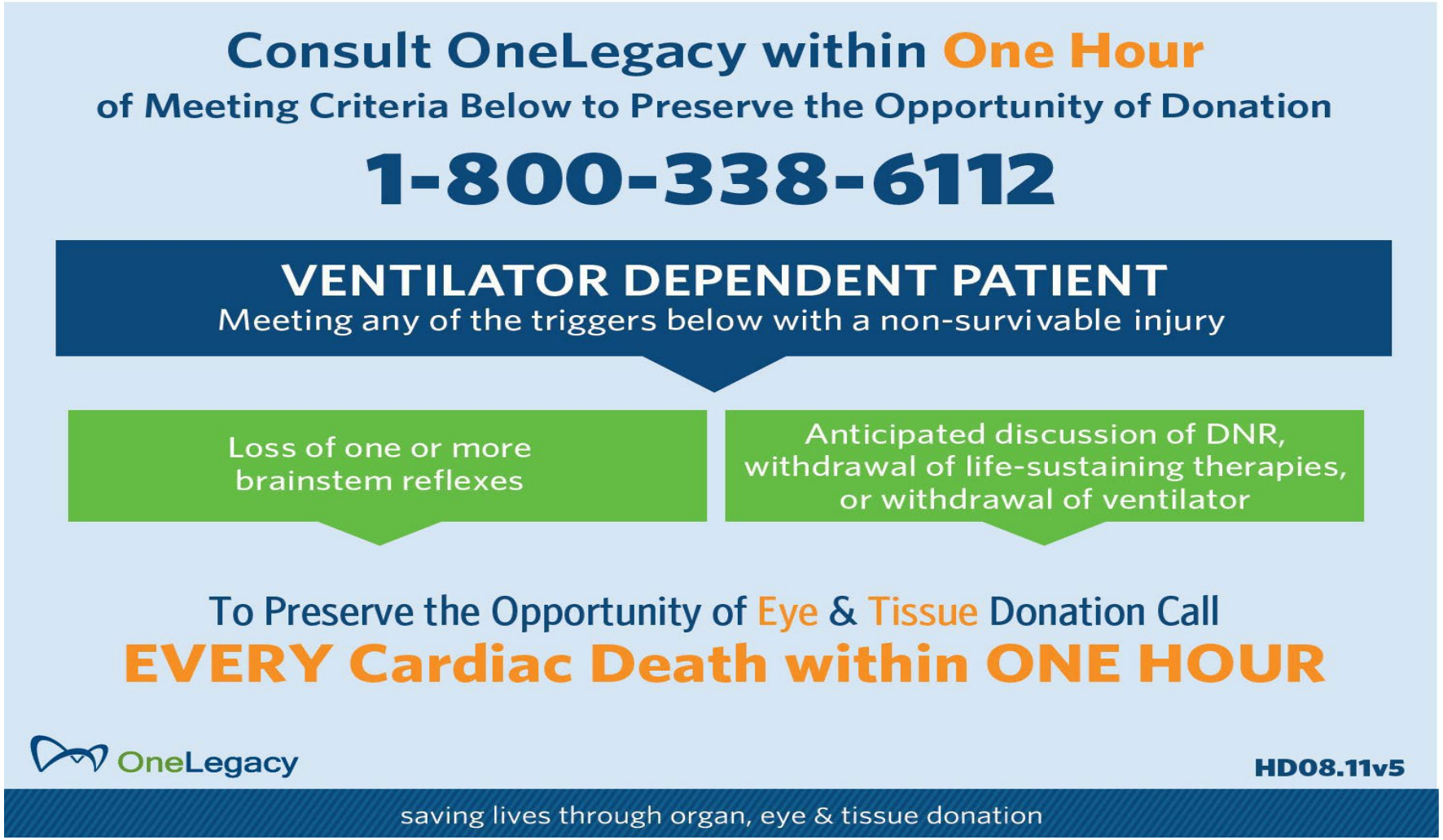
HCA Healthcare℠

Clinical Triggers to Call OneLegacy

Within 60 minutes, reporting of the following is required:

1. Imminent Brain Death
   - Ventilated patient
   - Severe neurological injury
   - Loss of one or more brain stem reflexes
2. Anticipated Withdrawal of Ventilation
   - Ventilated patient
   - Severe neurological injury
   - Anticipated discussion of End of Life decisions such as:
     - DNR
     - Withdrawal of life sustaining therapies
     - Withdrawal of the ventilator
3. Any Death
   - Anywhere in the hospital

Clinical Trigger Card



Organ, Eye & Tissue Donor Criteria

Donation criteria often changes, please refer:

- ✓ all ages
- ✓ regardless of medical history
- ✓ even patients under Sheriff-Coroner's jurisdiction
- ✓ even patients with Advanced Directives (even those objecting to donation)

NO ONE SHOULD BE RULED OUT

24-hour Referral Line (800) 338-6112

HIPAA Privacy Rule on Donation

CFR § 164.512(h) –– Final Rule:

A covered entity may use or disclose PHI to OPOs or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Referral Information

When calling OneLegacy:

- Have patient chart available

- Provide demographic Information
  - Patients name, age, race and gender
  - Medical Record #
  - Admit and Death date and time
  - Hospital name and unit phone number

- Answer clinical questions to further determine medical suitability; will vary by patient

Do Not Mention Donation

Please refrain from mentioning organ or tissue donation to family.

- Prior to brain death testing: may not meet neurologic death criteria.
- Perceived conflict of interest.
- May not be eligible for donation,
- Not appropriate timing.

Family is presented with donation options by trained designated requestor **only.****

** CMS 42. CFR 482.45
Joint Commission, HRSA, Hospital Policy

NUTRITION

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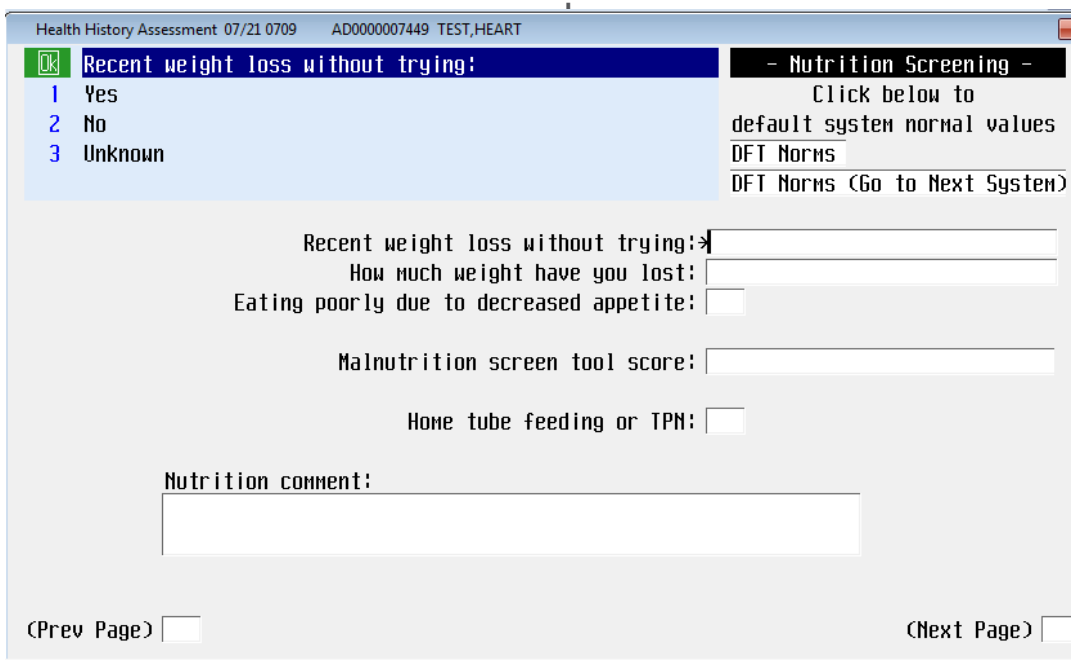
NUTRITION SCREENING

- The RN is responsible for completing the initial Nutrition Screening which is found in the Admission Assessment.
- Any “Y” answer will be treated as a high priority patient; seen by RD within 24 hours.



Nutrition Consult

- You can request a dietitian consult at any time for your patient.
- Enter an order in Meditech under Nutrition Consult.
- Use the Nutrition Screening box on the Assessment Form marked:

  "Dietary Screening"

❑ Appropriate Consults

- ✓ Declining appetite
- ✓ Consistently poor PO intake
- ✓ Patient request
- ✓ Nutrition related knowledge deficit.
- ✓ Weight change
- ✓ Multiple allergies
- ✓ Development of N/V/D/C
- ✓ Change in status that may effect the patients nutritional status/intake
- ✓ Wound

RESOURCES

- What is the Diet Manual and where do I find it?
- What are some typical Diets you will see?
- What tube feedings and supplements do you have?
- Where does the Dietitian document?

The Diet Manual

- The Diet Manual is an essential tool that defines the various diets offered at the facility.
- It provides instruction on which foods to include or limit while on various diets
- When the computer system is down, hard copies of the manual are located in the Diet Office and Liaison's Office

Know how to access the diet manual. Surveyors LOVE to ask nursing staff to locate the facility diet manual!

The New Diabetic Diet
CCD = Diabetic Diets

CCD refers to Consistent Carbohydrate Diet

CCD offers patients more choices and by doing so improves the likelihood of compliance

What influences postprandial blood sugars the most? CHO = CARBOHYDRATES !!

Changes

- Main focus on CHO and the amount of CHO per meal vs protein, fat, starch, dairy, fruit, vegetables, etc
- Not counting exact calories; uses ranges instead
- Allows occasional “sweet” as a CHO choice

CCD Levels

- **CCD Very Low = 1300 cal or less per day**
  - 2 CHO exchanges per meal or ~ 30gms of CHO
- **CCD Low = 1400 -1600 calories per day:**
  - 3 CHO exchanges per meal or ~ 45gms of CHO
- **CCD Moderate = 1700 -1900 calories per day**
  - 4 CHO exchanges per meal or ~ 60gms of CHO
- **CCD High = 2000-2300 calories/day**
  - 5 CHO exchanges per meal or ~ 75gms of CHO
  - HS snack of 1 CHO
- **CCD Very High = 2400 calories and above per day**
  - 6 CHO exchanges per meal or ~ 90gms of CHO
  - 2 PM and HS Snack
- FOR YOUR GESTATIONAL DIABETIC PATIENTS: PLEASE ORDER THE

Diabetic Liquid Diets

- The American Diabetes Association position on liquid diets is to provide 150-200 grams of carbohydrate per day.
- This means that patients may receive regular gelatin, fruit ices, sherbet, ice cream, and puddings for their carbohydrate allowance.
- The carbohydrate grams is listed beside the food item on the menu.

Other Common Diets

- Cardiac Heart Healthy= Low sodium; Low fat; Low Cholesterol; No caffeine
- Anti-GERD Diet = 5 meals (10am + 2pm snacks); very low fat; no spicy or strong flavored foods; caffeine free
- Dysphagia = Modified Textures and Liquids
- Renal Diet = Modified Protein levels; low sodium; low potassium; low phosphorus
- Bariatric Diets = No sugar; no straws; small meals

Enteral Feedings

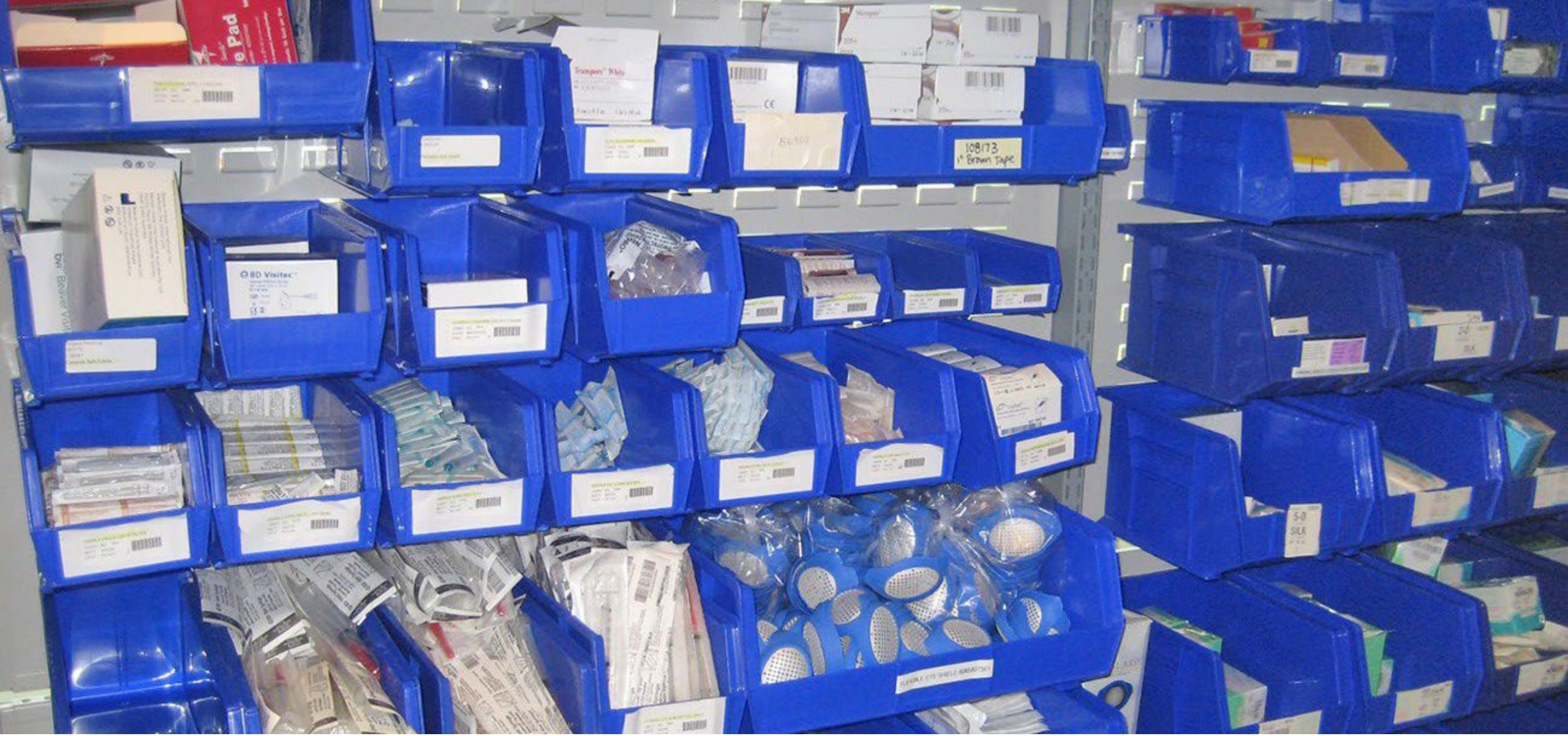
We use ABBOTT brand products for Adults/Peds (excluding NICU)

- Jevity 1.2 ; Jevity 1.5 (contains fiber)
- Glucerna 1.2 and Glucerna 1.5
- Nepro
- Vital 1.2 cal; Vital High Protein
- Oral Supplements:

  Ensure Enlive; Ensure Clear; Pediasure

Dietitian Documentation in Meditech

- Nutritional Assessment Form
- Multidisciplinary Patient Note
- Care Plan



SUPPLIES

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Why is scanning for supplies important?

- In addition to billing, it keeps the items in your supply room stocked and resupplied based on the amount you use.

- For example, if your unit frequently runs out of an item, the par level can be increased to meet the unit's needs.

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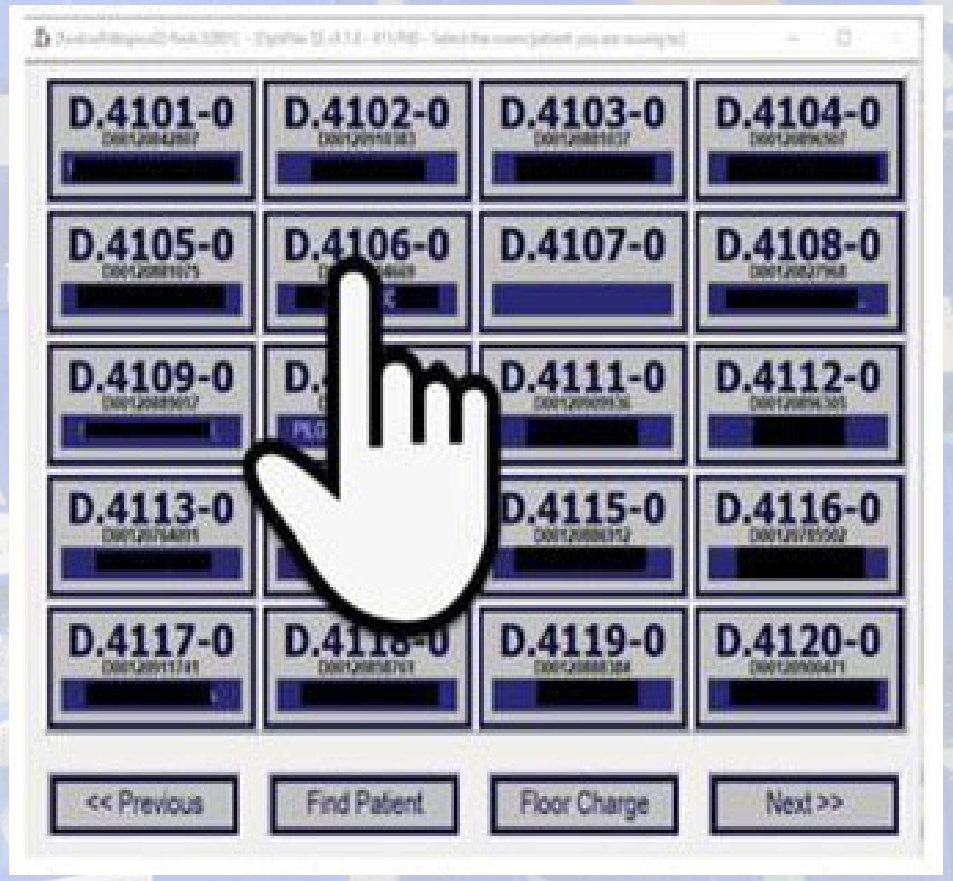
Step 1…

- Identify the room/patient you are getting supplies for and touch the Optiflex screen.
- You can also scan a patient barcode.



HCA Healthcare℠

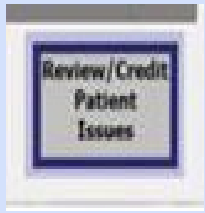
Step 2…

- Locate the supply item you need and scan the barcode on the bin.
- If you are taking 2 items from that bin, scan the bar twice…3…4…etc.

HCA Healthcare℠

Step 3…

- Continue scanning the items you need for that patient.
- If you make a mistake, press the **"Review/Credit"** button on the bottom of the screen to back out that scan.



HCA Healthcare℠

Step 4…

- When you are done getting supplies for that patient, touch the **“Done With This Patient”** button at the bottom of the screen.

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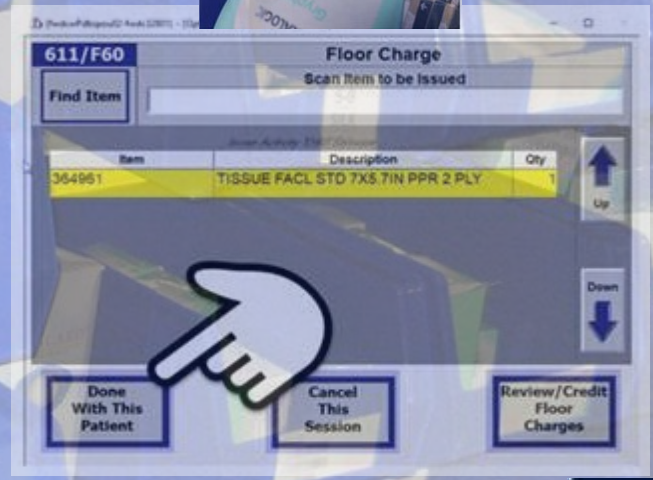
Floor Stock…

- If you are taking supplies not for a specific patient (for example, supplying tissue for the nurses station):
- 1. Touch **“Floor Charge”** at the bottom of the screen.
- 2. Scan the barcode on the supply bin.
- 3. Touch **“Done With This Patient”**.

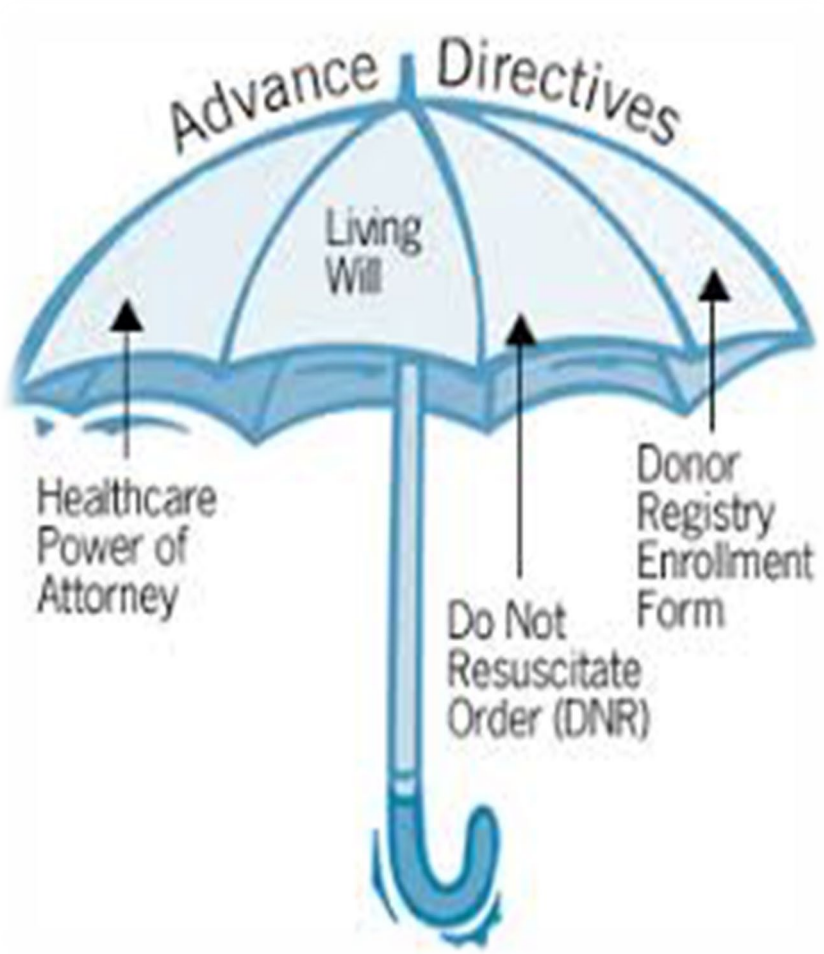


HCA Healthcare

Specific Policies

Advance Directives

- All inpatients/outpatients will be asked if they have an advance directive.
- They need to provide a copy (must ask at least 3 times and document).
- If they need assistance with completing one call social work.
- Only go into effect when a patient loses capacity to make decisions.



POLST

physician orders for life-sustaining treatment paradigm

- It is voluntary, never mandatory.
- It is a portable, actionable medical order that helps ensure patient treatment wishes are known and honored. It helps prevent initiation of unwanted, extraordinary treatment.
- It is not for everyone – it is for those who are battling a serious illness or who are frail. For these patients, their current health status indicates the need for standing medical orders for emergent or future medical care.
- It allows patients to have their religious values respected.
- It requires that ordinary measures to improve the patient's comfort, and food and fluid by mouth as tolerated, always be provided.

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Patient Personal Property

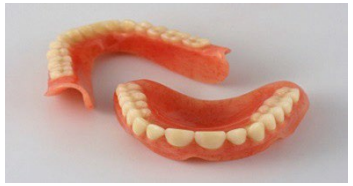
Patients and families are ***strongly*** encouraged not to bring unnecessary property or valuables into the hospital.

Valuables: any money, wallet, keys, jewelry, watches, credit cards, and personal documents.

Personal Property: clothing, books, electronic entertainment and/or communication devices (i.e., laptops, cell phones, and DVD/Blu-ray players).

Personal Assistance Devices: hearing aids, glasses, dentures and ambulatory assistive devices (walkers, wheel chairs and canes).

- If you become aware the patient has any of these items, itemize and describe each item on the patient valuable record. Notify Security/Public Safety to pick up and secure.
- Help the patient keep any personal assistance devices on the bedside table remind patient not to pace any personal items on their meal tray.
- Document any personal assistance devices in the medical record.
- **Notify Security when patient is ready for discharge.**



HCA®

Isolation…

- Supply carts are located on each unit.
- When a patient is placed in isolation, a carts is moved to the hallway outside the patient's room.
- The various isolation signs are kept in the top drawer.
  - They are to be posted outside the room.
- Patients, family members and visitors must be instructed by the staff on the isolation requirements (including hand washing) as outline on the front and back of the signs.

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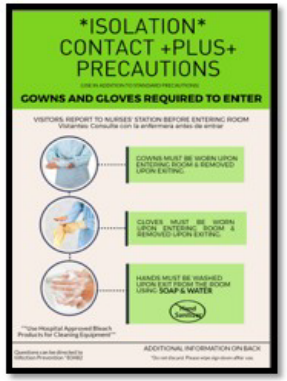
INFECTION PREVENTION ISOLATION SIGNS: Read before you enter!



AIRBORNE ISOLATION	CONTACT +PLUS+ ISOLATION	DROPLET ISOLATION	CONTACT ISOLATION	PROTECTIVE ISOLATION
For diseases such as suspect or active TB, Measles, Chickenpox. Must be in a negative pressure room with door closed. Wash or use hand sanitizer prior to entry. If Chickenpox/measles, know your immune status- if not immune…. Do Not Enter! Staff must wear N95 or PAPR. A SURGICAL/procedural mask should be worn by the patient during transport for exams/procedures. Notify receiving department prior. Visitors wear surgical/procedural masks.	For active/suspect C-Diff. No mask needed! Wash or use hand sanitizer prior to donning PPE. Gowns and gloves required to enter room. Handwashing prior to exiting room should be with SOAP and WATER. All equipment must be cleaned with bleach wipes (orange top). Notify receiving department if patient scheduled for test/procedure prior to transport.	For diseases such as active/suspect Influenza, mumps or meningococcal meningitis. Wash or use hand sanitizer prior to donning PPE. Surgical/isolation mask, gowns and gloves required to enter room. A SURGICAL/procedural mask must be worn by the patient during transport for testing/procedures. Notify receiving department prior to transport.	For diseases such as Scabies or rash of unknown origin, CRE, MDR-Acinetobacter, etc. No mask needed! Wash or use hand sanitizer prior to donning PPE Gowns and gloves required to enter room. Notify receiving department if patient scheduled for test/procedure prior to transport.	For neutropenic or new solid organ transplant patients. Wash or use hand sanitizer prior to donning PPE. Surgical/isolation mask and gloves required to enter room. A SURGICAL/procedural mask must be worn by the patient during transport for testing/procedures. Notify receiving department if patient scheduled for test/procedure prior to transport.

HCA®

No Passing Zone: HEADS UP

Do not pass a light without stopping to help!

- **H**eads up! Look for the light
- **E**nter the room and introduce yourself
- **A**ttend to and inquire as to the patients needs
- **D**etermine what you **can** or **cannot** do
- **S**afety first!
- **U**nderstand what the patient needs
- **P**ass it on if you cannot fill the need yourself

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“Falling Stars”

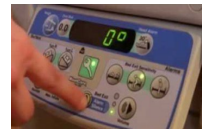
An RN assesses a patient for fall risk on admission, every shift and any change in condition (ie., following a procedure) – Meditech, Process Intervention, Safety/Risk/Regulatory.

If the patient is determined to be a fall risk...

- The patient receives a yellow armband/dot clip to armband.
- The patient receives yellow, non-skid socks.
- A yellow magnetic star is placed on the door frame identifying the patient's bed (A/B) or the Falls Risk pull the tab in the GTower.

Safety Practices:

- Bed in the lowest position.
- Side rails and bed alarms are in use.



- Call light is within patient’s reach.
- Patient knows how to use the call light.
- Personal items are within reach on over-bed table – tissue, water, phone, etc.
- Provide continual reminders not to get up without assistance.
- Answer call light promptly.

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Post Fall Management…

- Assess immediately for injury and perform a basic neurology assessment before moving the patient.
  - ✓ Document a **Nurses' Note**.
  - ✓ Document specifics using the **Post Fall Assessment Screens (Add Intervention).**
  - ✓ Add to **Plan of Care** (musculo-skeletal).
  - ❖ *May now require a higher level of risk and additional precautions.*
- Notify the physician and obtain any necessary orders.
- Gather all the patient and environmental data to complete an **RIR** in Meditech and a **Post Fall Debrief** Form – ask Charge Nurse for assistance.
- Notify the family as appropriate.

RCH Connect

post fall debrief form

RS0606a^PostFallDebrief_p1^FP L
Primary Care Nurse Once Checklist is completed, turn in with the **Post Fall Debrief Form.** RF0085 v4 Rev. 02/18 Page 2 of 2 **POST FALL DEBRIEF** *NNS* RS606b **POST FALL DEBRIEF**
Authors: Lockwood Stacey, Tdedert Date: 2/23/2018 Size: 1MB
http://riverside.farwest.medcity.net/Forms/Documents/0 Patient Forms/Chart Forms/RF Forms/RF0085 v4 **Post Fall Debrief**.pdf

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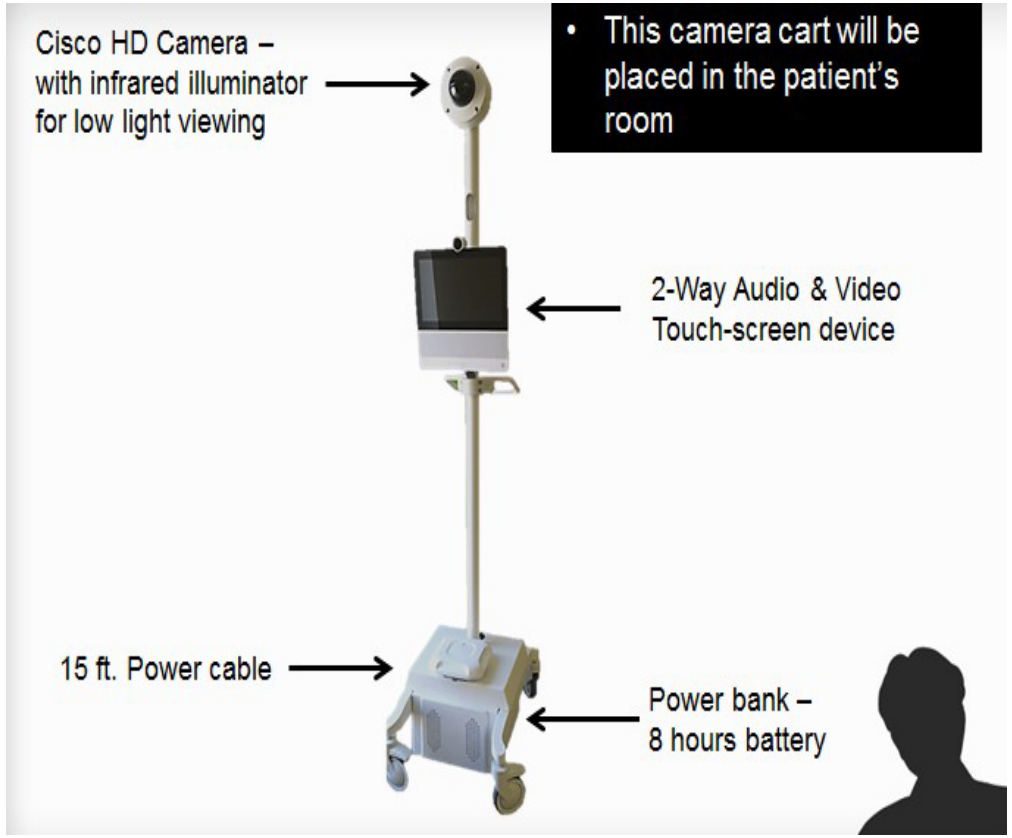
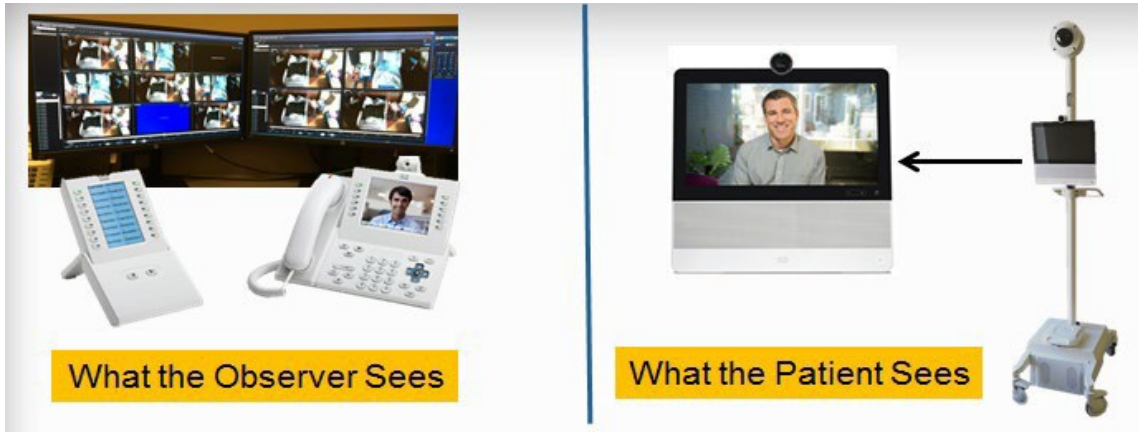
Virtual Patient Safety Observation (VPSO)…



The cameras utilize technology to improve patient safety and increase caregiver efficiency.

- It allows for a centralized observer to monitor multiple patients from a remote location.
- Patients are individually assessed to determine the most appropriate form of observation. If the patient meets the "Virtual Sitter" criteria, a camera is placed in the room.
- Where the VPSO is in use, you will see this sign on the patient's door.

Two-way Communication…



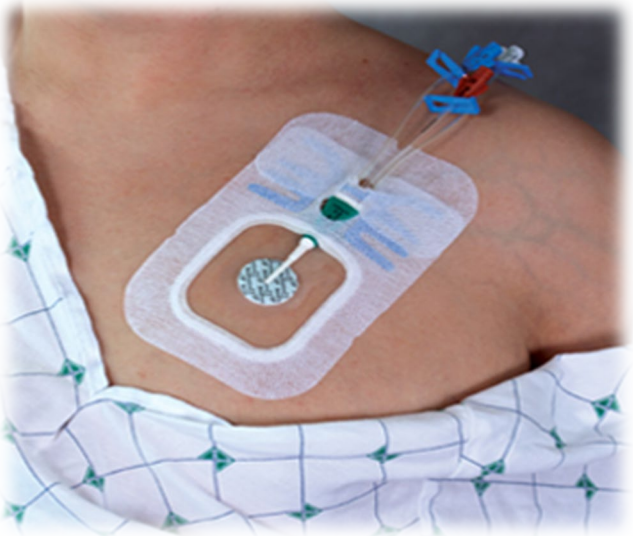
- When the patient exhibits unsafe behavior, the Observer uses the audio/video to redirect the patient while simultaneously alerting the staff via phone to provide physical assistance – go to the room to check on the patient!
- Whenever a ***CODE CAM Alert*** is called, **GO IMMEDIATELY** to the patient's room to assist the patient/staff and ensure the patient is safe.

- The video is live not taped.
- For privacy periods (ADLs, patient care, etc.) or when the patient leaves the area for tests, wave at the camera to notify/talk with the Observer to activate the "privacy mode". Notify them again to resume observation.

IV Therapy

- If you cannot obtain an IV after 2 attempts ask another nurse.
- Patients going to surgery must have at least an 18 gauge.
- 1% lidocaine w/o epi can be used intradermal prior to sticking patient.
- IVs started in the AC must be changed within 12 hours.
- IVs started under emergency conditions must be changed in 12 hours.

IV Therapy



- IV sites, dressings and tubing are changed every 96 hours.
- TPN tubing and filter – 24 hours.
- Propofol – 6 to 12 hours.
- CVAD dressings are changed every 7 days or sooner if needed.
- Bio-patches are used on a CVADs.

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Alaris Pump

- Order under “Z” Order Source – includes Main + 1 side.
  - ➢Additional sides (up to 4/Main) must be ordered separately.
- Must select profile for each patient – what unit is the patient on.
- Never enter the patient ID # only the cost center (ED is 78027).
- Always use the guardrail drug or IV fluid library.
- Never run maintenance fluids under ”basic infusion”.
- Documents volume infused at end of shift, transfer and completion of med.

PCA Pump

- Hospital staff, family or spouses cannot push PCA button.
- End tidal $C0_2$ monitoring is required throughout therapy.
- 0_2 can be delivered through the Y connector on $ETC0_2$ tubing.
- Two RNs required to set up.
- Controlled substance handoff tool must be added to process intervention to document.

Cactus Sink Instructions – Controlled Substances Only

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Controlled Substance Hand-off

- **Process Intervention**
- **Add Intervention**
- **Controlled Substance +**
  - (under Routine Care)

```
Routine Care
 -Pain Monitor Non-Licensed
 -Vitals/Ht/ Wt/ Measurements +
 -Routine Daily Care +
 -Intake and Output +
 -Lines/Drains/Airways +
 -Teach/Educate +
 -Controlled Substance+
 -Manage/Refer/Contact/ Notify +
 -Display Board Information
```

```
Ok  Medication: [or free text]
 1  Fentanyl                6  Propofol
 2  Hydromorphone           7  Versed
 3  Ketamine
 4  Lorazepam
 5  Morphine

                  Medication:→
                Delivery device:
       Infusion/application status:
             Medication time total:
    Number of PCA/PCEA attempts:
  Number of PCA/PCEA injections:
                Unit of measure:
                  Prime amount:
               Medication bolus:
                  Amount infused:
                  Amount handoff:
                         Cosign:
                       Password:                    (Next Page)
```


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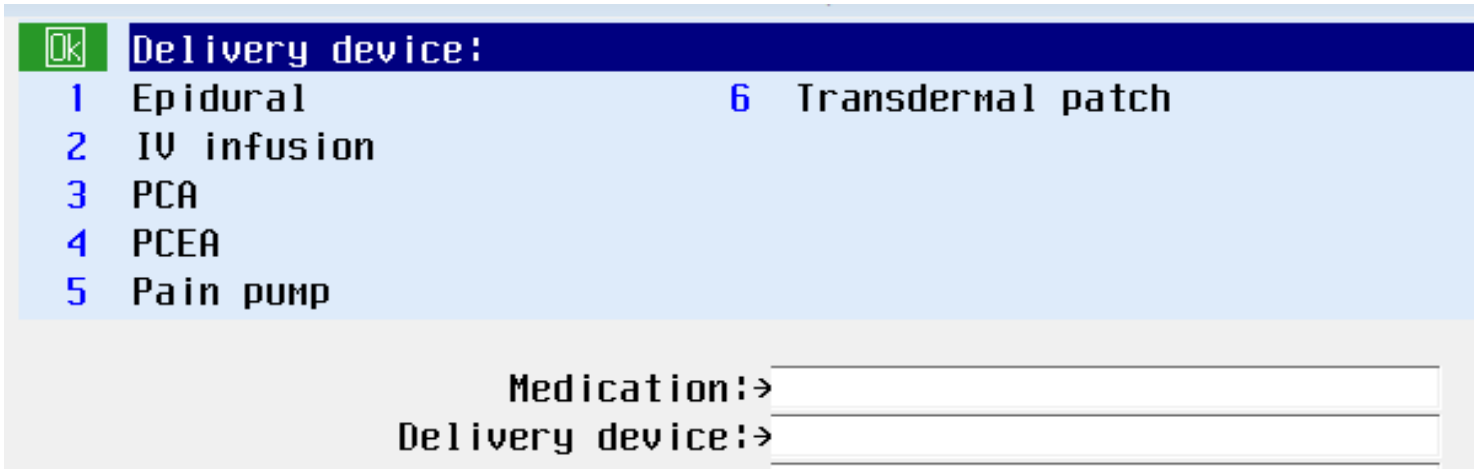

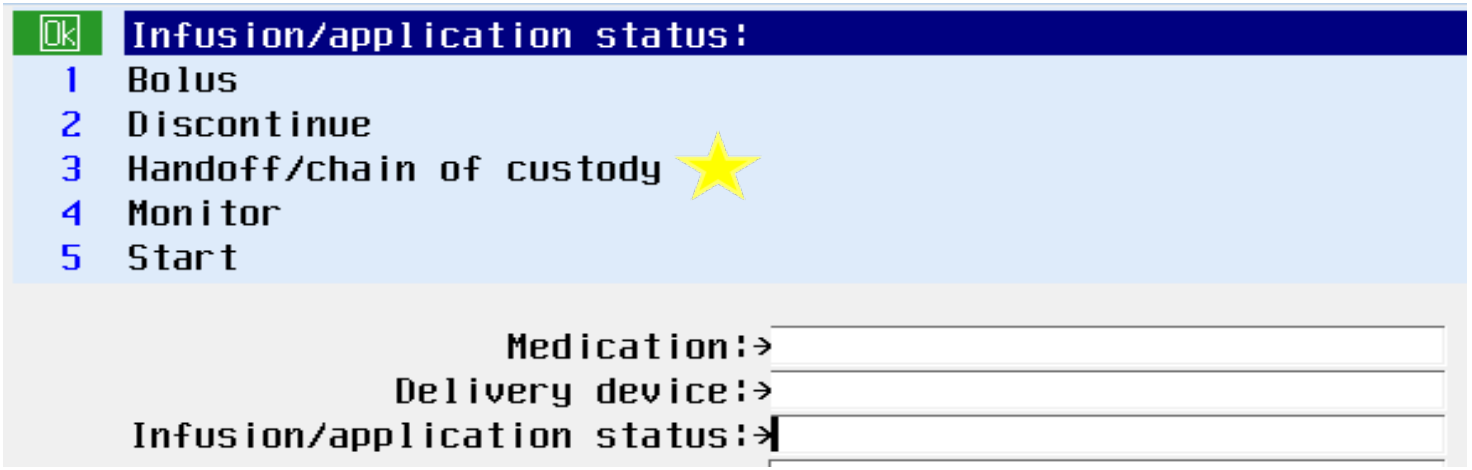

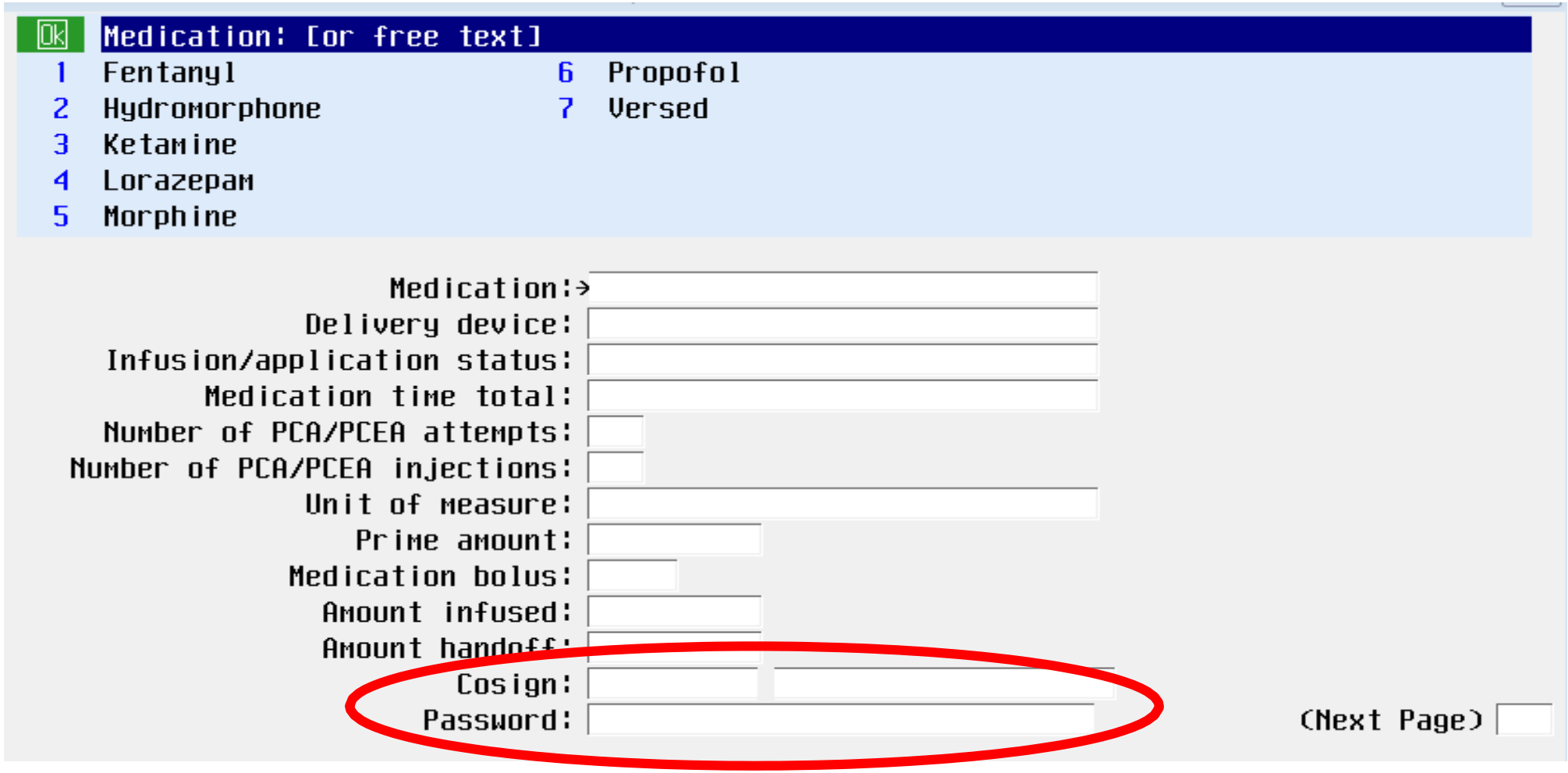

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Time Out…

Universal Protocol

(Procedural Time Out)

- This protocol is intended to ensure the consistent use of a standardized approach to identify the correct patient, the correct procedure, and the correct side or site BEFORE any procedure has begun.
- All team members participate, including the patient/representative.
- The Physician leads the Briefing, Time Out , & Debriefing.
- Any member of the team may express questions/concerns; all questions/concerns will be resolved prior the start of the procedure.

Discharge Time-Out

When the patient is just about ready to leave (meaning dressed and in the wheelchair)….we take a “TIME OUT”.

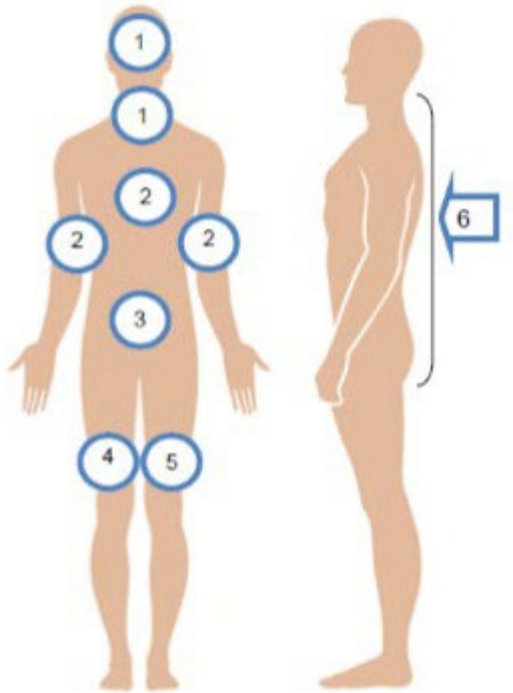
The Charge Nurse or Manager visits with the patient and family to ensure they:

- clearly understand their instructions
- have their prescriptions
- know how and when to follow-up with their physician
- discharge plans are complete (home health, physical therapy, etc.).

It should not take more than a few minutes and ensures the patient knows what to do once they leave the facility.

CHG Bathing

- Chlorhexidine Gluconate (**CHG**) cloths are used for patient bathing in the hospital to help reduce the risk of infection.
- CHG daily bathing reduces CLBSI (Central Line Blood Stream Infection) and patient acquisition of VRE, MRSA and Acinetobacter.
- To ensure consistent application, **Nursing Personnel** will bathe the patient daily with CHG even if the patient is able to self-bathe.
- CHG is safe on drains, G tubes, rectal tubes, EKG leads, Central Lines, and Foley catheters.
- **AVOID** mucous membranes – especially eyes & ear canals.
- Use only Hospital lotions; no deodorants.
- Do not flush the wipes.



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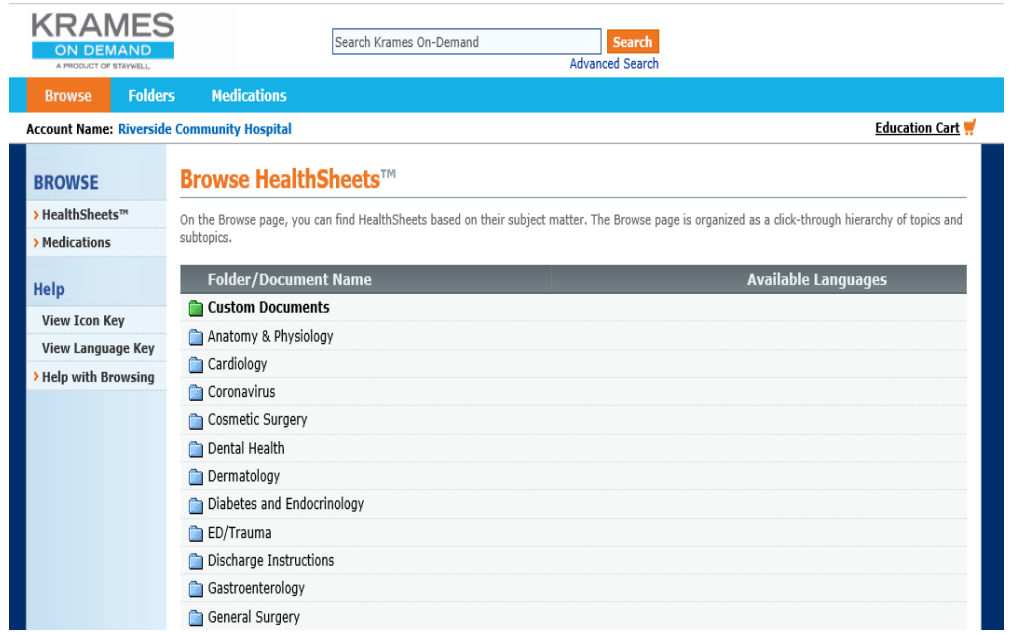
Patient Education

Any interaction with a patient or family member is an opportunity for education

- ✓ KRAMES on Demand – *RCH CONECT under Links*
- ✓ CONNECT - *Links*:
  - ➢ Clinical Pharmacology
  - ➢ EBSCO
    - ➢ Nursing Reference Center - Patient education
    - ➢ Patient Education Reference Center
- ✓ CONNECT – *EDUCATION*:
  - ➢ Diabetes – handouts for the classes on TV
  - ➢ Channels 60 & 61 *(Vintage Tower ONLY)*



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Emergency CODES…

- ***Call *7455(LR) or 6455(WH) all Codes***

HCA Healthcare

Facility Alerts

EVENT	PLAIN LANGUAGE CODE
Decontamination	Facility Alert + Decontamination + Location + Instructions
Evacuation	Facility Alert + Evacuation + Location + Instructions
Fire	Facility Alert + Fire Alarm + Location + Instructions
Hazardous Spill/Response	Facility Alert + Hazardous Spill + Location + Instructions
Mass Casualty	Facility Alert + Mass Casualty + Location + Instructions
Utility Interruption	Facility Alert + Utility/ Technology (interruption type, i.e., EHR, phone, water, medical gas, network, suction) + Location + Instructions
Weather	Facility Alert + Weather (event type, i.e., blizzard, tornado, flood) + Location + Instructions

HCA Healthcare

Security Alerts

EVENT	PLAIN LANGUAGE CODE
Active Shooter	Security Alert + Active Shooter + Location + Instructions
Bomb Threat	Security Alert + Bomb Threat + Location + Instructions
Civil Disturbance	Security Alert + Civil Disturbance (type, i.e., protest, strike, demonstration, riot) + Location + Instructions
Limited Access	Security Alert + Lockout/Lockdown + Location + Instructions
Missing Person	Security Alert + Missing Person + Location + Description (i.e., adult/peds/baby, male/female, age, general characteristics/clothing)
Security Assistance	Security Alert + Security Needed for (i.e., hostage situation, staff assault, imminent threat of harm (operator to call 911) + Location
Suspicious Package	Security Alert + Suspicious Package + Location + Instructions

HCA Healthcare

Medical Alerts

EVENT	PLAIN LANGUAGE CODE
Behavioral Emergency	Medical Alert + Code BERT + Location
Massive Transfusion Protocol (MTP)	Medical Alert + MTP + Location
OB Emergency	Medical Alert + OB Emergency + Location
Post-Partum Hemorrhage	Medical Alert + Maternal Hemorrhage + Location
Rapid Response	Medical Alert + Rapid Response + Location (i.e., PEDs room #, Adult room #, Neonate room #)

EVENT	PLAIN LANGUAGE CODE
Resuscitation	Medical Alert + Adult Code Blue + Location Medical Alert + Pediatric Code Blue + Location Medical Alert + Neonate Code Blue + Location Medical Alert + Maternal Code Blue + Location
Sepsis	Medical Alert + Code Sepsis + Location
Stroke	Medical Alert + Stroke Alert + Location
Telemetry	Medical Alert + Telemetry Alert + Location
Trauma	Medical Alert + Trauma Alert (Level I, II, III) + Location

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iMobile…

RNs carry hospital issued iMobile phones that connect to the patient call system and have the ability to make outside calls to physicians, patient families, Language Line, look up a specific staff member and make department and hospital broadcasts, etc.

- ***The access code to log in is 9517.***
- Log in at the beginning of your shift and out at the end of your shift.

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Language Line Solutions (Interpreting)

HOSPITAL STAFF DO NOT INTERPRET!

- **Language Line interpreters are available via iPhones and Sign Language services are available via webcam 24 hours a day/7 days a week.**
- This service should be used for medical/technical discussions regarding informed consent or other medical decision making, obtaining patient health history or physical assessment information, patient education, and discharge instruction.
- Check with your charge Nurse for assistance.

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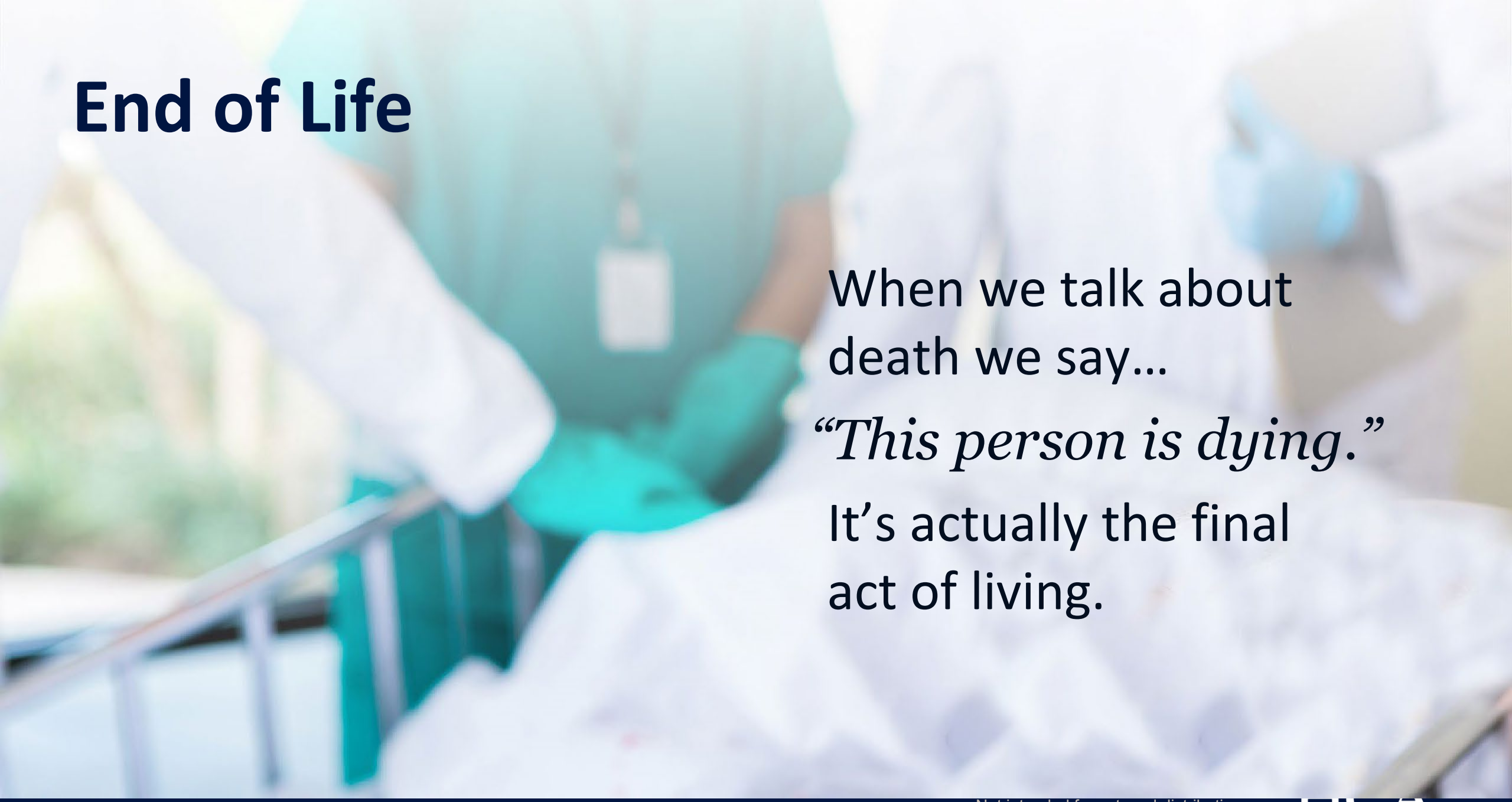
End of Life



When we talk about death we say…

"This person is dying."

It's actually the final act of living.

The butterfly is our universal symbol for actively dying patients.

If you see a colorful butterfly magnet on the doorframe of a patients room, help us create a quite atmosphere of respect, avoid mobile phone use and be prepared to interact with those who are grieving.

Comfort cart...

- Relax visiting hours as appropriate.
- Chaplain services.
- Call the kitchen and ask for the ***Comfort Cart***...a few drinks and snacks for families so they do not have to leave the bedside.
- Offer tissue, blankets, etc.

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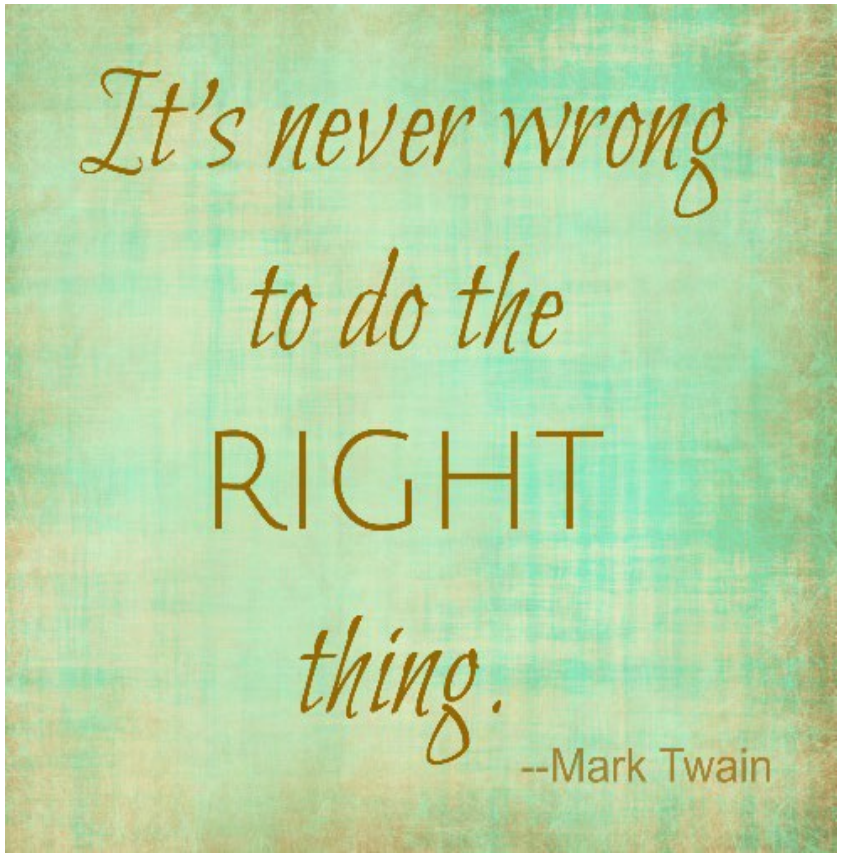


Source Document

Competency Title:	**ORIGINATED:**	February 15, 2012
Z-Slider Transferring Equipment	**REVISED:**	November 7, 2016
	REVIEWED:	December 21, 2017
	Author: Education	

Competency Statement: Designated staff will demonstrate actions to safely transfer a patient with the use of the Z-slider transferring devices.

The Z-Slider is designed to transfer from one flat surface to another flat surface.

PERFORMANCE CRITERIA AND KEY ELEMENTS

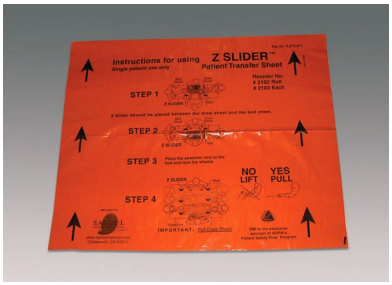
Z-SLIDER: No weight limit.

Transfer of patient from bed to gurney

1. Log roll patient to left or right
2. Place Z-Slider with the arrow pointing to the side where the gurney is, between the draw sheet & the bed sheet
3. Place gurney next to bed & lock wheels. Be sure wheels on bed are locked
4. Pull draw sheet to place patient on the gurney

Transfer of patient up in bed:

1. Log roll patient to properly place z-slider under the patient
2. Place Z-Slider with the arrow pointing towards the head of bed, between the draw sheet & the bed sheet
3. Pull draw sheet to move the patient up in bed
4. Remove Z-Slider
5. Adjust the foot of bed to keep patient from moving down in bed



Other Information when using the Z-Slider:

- No lifting is required
- Only pull the sheet to move the patient
- For single patient use; disposable
- Instructions can be found on the Z-Slider

General Information:

- Patient transfers and accessories should be cleaned and/or disinfected between each patient using the hospital approved germicidal cleaner.

References:

ARJO skills check-off sheets: Stedy, Opera, MaxiSlide
ARJO stedy assembly from packaging and operating instructions
ARJOHUNTLEIGH video: Compilation product in-service DVD
Z-Slider patient transfer sheet instructions

Source Document

Competency Title:		
Stedy Transferring Equipment	**ORIGINATED:**	February 15, 2012
	REVISED:	December 21, 2017
	REVIEWED:	November 7, 2016
	Author: Education	

Competency Statement: Designated staff will demonstrate actions to safely transfer a patient with the use of the Stedy transferring device.

USE: The Stedy is used to quickly transport or transfer patients from one sitting position to another. It is intended for use only by patients who have the ability to stand unaided or who can stand with minimal assistance.

PERFORMANCE CRITERIA AND KEY ELEMENTS

STEDY: **Maximum weight: 265 lbs.**

Placing patient on Stedy:

1. Position Stedy in front of patient with seat halves up
2. Assure patient's knees and feet are properly positioned on the knee and foot board
3. Lock the wheels
4. Instruct patient to grip the cross bar using both hands to pull self until standing
5. Put seat down
6. Instruct patient to gently sit
7. Release the brakes, transport patient to desired location

Removal of patient from Stedy:

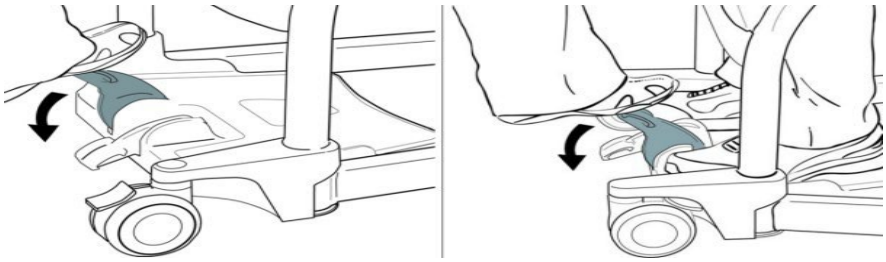
1. Instruct patient to grip the cross bar using both hands to pull self to standing position
2. Put seat up
3. Instruct patient to gently sit on new location (bed, chair, wheelchair, toilet, etc)
4. Release the brakes, remove the Stedy
5. Assure patient safety, place call light within reach

General Information:

- Patient transfers and accessories should be cleaned and/or disinfected between each patient using the hospital approved germicidal cleaner.

SARA STEDY (in G building): Maximum weight: 182 kg/400 lbs.

Placement and removal of patient with the Sara Stedy is the same as with the Stedy. The only difference is the weight limit, and the availability of the foot pedals to open and close the legs of the equipment (press down on the left pedal to open the legs and the right pedal to close the legs).



References:

ARJO skills check-off sheets: Stedy, Opera, MaxiSlide

ARJO Stedy assembly from packaging and operating instructions

ARJOHUNTLEIGH video: Compilation product in-service DVD

Z-Slider patient transfer sheet instructions

Sara Stedy Instructions for Use, 2011

Source Document

Competency Title:	**ORIGINATED:**	March 31, 2011
Arjo (Opera) Lifting Device	**REVISED:**	February 14, 2012 / December 21, 2017
	REVIEWED:	
	Author: Education	

Competency Statement: Designated staff will demonstrate actions to safely transfer a patient with the use of the Arjo (Opera) Lifting Devices. Use: The device is used for totally dependent, non-weight bearing patients to transfer from bed to chair, wheelchair, gurney or floor to bed.

PERFORMANCE CRITERIA AND KEY ELEMENTS

Before approaching the patient ask these questions

- Is the battery pack fully charged?
  a. Locate the service indicator light on the panel above the battery pack
- Is the green reset button, below the dual control panel, pressed in?
- Do I have the appropriate sling size?
  a. All slings are size-coded with different colored edge binding or attachment strap coloring.
  b. Standard Rated slings: M = Yellow; L = green; LL = Purple; XL = blue; XXL = Terracotta
  c. Always refer to the label on the sling being used to make sure of its actual safe working load.
- Have I told the patient what we will be doing?

Weight limits for OPERA: 440 lbs

Transfer from bed to chair

- Log roll patient to place sling into position
- Fold sling in half & place behind back; similar to changing an occupied bed
- Head support area of the sling covers the patient's neck
- Approach bed with the open side of the spreader bar towards the patient's head
- Adjust the chassis legs to maneuver around obstructions
- The Opera spreader bar should be just above, & centrally situated over the patient
  a. Be careful not to lower bar on patient
- Tilt the spreader bar until the shoulder attachment points can be connected to the sling shoulder strap attachment clips using the positioning handle
- Press down on the positioning handle until it is possible to connect the sling leg pieces
  a. The leg pieces are brought under the thighs to connect
  b. Lift one leg at a time to connect
  c. If needed, thigh leg pieces may be attached first
- Be sure the sling attachment clips are fully in position before & during the lifting cycle
- Lock brakes before lifting
- Lift the patient using the handset control & adjust to a comfortable position for transfer
- Turn the patient to face the attachment at approximately normal chair height
- Unlock brakes

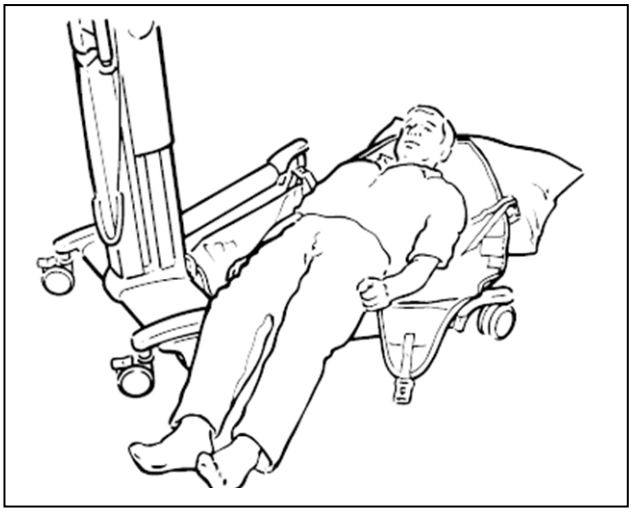
- Open the chassis legs to move the Opera near the chair
- Lower the patient to the chair in the sling
- Be sure patient is in a comfortable sitting position before releasing the shoulder and thigh straps
- Move Opera away from chair
- Leave sling in place for future transfer back to bed
- Ensure patient will be safe while sitting in a chair before leaving unattended

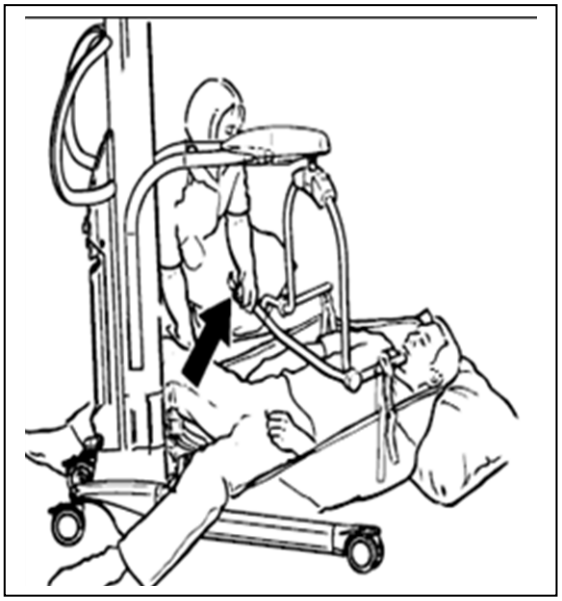
Transfer from a chair to bed

- Explain the procedure to the patient
- Place sling around patient so the base of his/her spine is covered & the head support is behind the head
- Pull each leg piece under the thigh so it is inside of the thigh
- Open the chassis legs to move the Opera close to the chair
- The wide part of the spreader bar is at, or just below, shoulder level
- If the Opera is not close enough to attach the shoulder clip, put the patient's feet on, or over the chassis
- Attach the shoulder strap attachment clip
- Press down on the positioning handle of the spreader bar to attach the leg strap attachment clips
- Be sure the sling attachment clips are fully in position before the lifting cycle
- Lock brakes before lifting
- Raise the patient by operating the handset control
  a. If the handset button is released during lifting or lowering, powered motion will stop immediately
- Unlock the brakes
- Move the Opera away from the chair
- Position the handle until the patient is reclined in the sling
- Turn patient to face the attendant at approximately normal chair height
- Move the Opera to the bed with chassis facing the head of the bed
- Make sure the patient is located in the center of the bed before lowering
- Lower using the handset control
- Move the Opera away from the bed before removing the sling from under the patient

Lift from the floor to a bed

- Explain the procedure to the patient
- Place sling under patient as before; bed to chair
- Approach patient with open part of chassis
- Place pillow under head
- Lift legs over chassis





- Have open part of spreader bar pointing down towards the shoulders
- Attach the shoulder strap clips
- Raise hips & knee into maximum flexion
- Push down on the positioning handle to connect the leg strap attachment clips
- Patient's head & shoulders will be raised slightly
- Make sure sling attachments are connected before lifting from floor
- Lock brakes before lifting
- Raise patient from floor in a semi-recumbent position
- Supporting the head can be comfortable & reassuring for the patient
- Position onto chair, or place in bed
- Note there is a special sling for patients with amputations
- When transferring the patient using the Arjo Opera Lifter, the chassis legs should be parallel (closed) for easier maneuverability
- Apply brakes if leaving the patient unattended

Changing and charging the battery: Opera & Scale

OPERA:

Changing the battery:

- When the battery charge indicator on the control handset displays the low battery icon, complete your lift cycle, then replace the battery. When the battery is low, an audible warning device will make a noise
- To remove the battery push the red button and pull straight out toward you
- Replace with a fully charged one from the charging unit

Charging the battery:

- Turn the main power to the charger unit off before connecting the battery
- Ensure the cable connection plugs that fit into the charger & into the battery are fully inserted before switching on the main electricity
- Orange light = totally discharged battery
- Changed to yellow as approaches full charge
- Green light means fully charged battery
- A discharged battery should be left approximately 8 hrs to totally recharge
- The battery pack may be left connected to the charger when fully charged without being damaged by overcharging
- Disconnect the main power to remove battery from charger
- Insert into the Opera battery position

***BEST PRACTICE**: use a freshly charged battery pack the start of every work day*

SCALE:

Change when battery symbol displayed on scale LCD

  - There is about 1 hour of operation after this message appears
  - If all digits are flashing, battery is exhausted
- Open the battery compartment cover
- Pull out the battery holder; disconnect battery from connector
- Remove existing batteries & add four new 'AA' batteries
  - Batteries inserted incorrectly will not damage the circuit board
- Replace the battery holder
- The display will reset to kg. Change back to lbs by pressing the operating button for a minimum of 10 sec

Cleaning process for the Opera Lifting Device

- Disinfect between each patient use
- Use a hospital approved germicidal
- Clean the spreader bar between & after each patient contact using a rubbing action to effectively disinfect the surface
- Clean other parts of the Opera as needed
- **DO NOT** over wet areas of the Opera which could cause problems with electrical components or internal corrosion
- **DO NOT** use petroleum based solvents; may damage plastic parts

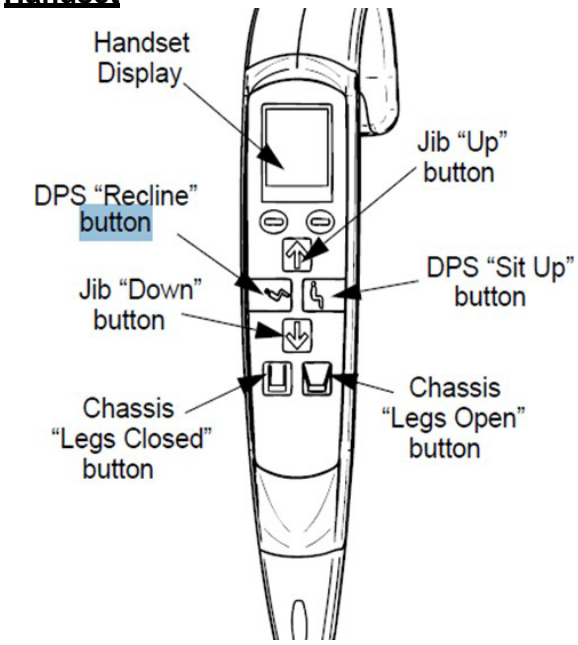
Cleaning process for the sling attachments

- Disposable slings are used at RCH
- **Slings are single patient use only**

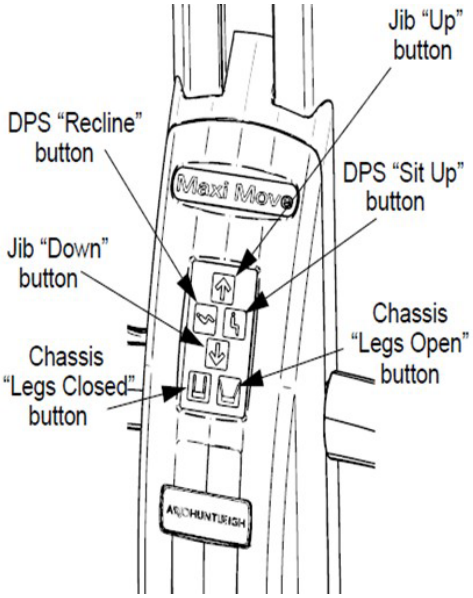
Maxi Move Lift Device (in G building):

Weight limits for the Maxi Move: 500 lbs.
Tilting of the spreader bar (Recline/Sit Up) is now motorized, controlled by the Handset or Control Panel.

Handset



Control Panel



References:

Opera operating & product care instructions manual
Opera operating instructions supplement (scale) manual
Maxi Move Instructions for Use: January 2014

Alaris Infusion Pump System

MM.114 Intravenous Therapy/Intravenous Infusion Pump Infusion System

The following highlighted Policies and Procedures are meant to be a quick reference to our facilities processes. Please take the time to read these policies in their entirety as the information provided here is abbreviated.

Alaris Infusion Pump

- A profile must be selected for each pump at the time it is placed on the patient i.e Telemetry, L&D.
- ✓ The receiving nurse is responsible for assuring the proper profile is selected
- ✓ **When prompted to enter the patient identification number, please enter the cost center number of the unit/department. Example: 614 for South 6. This should be done with all pumps.**
- For any medication or solution delivered using an infusion pump, you must choose the appropriate profile from the Guardrail Drugs or Guardrail IV Fluids library for safer delivery. Do NOT use the Basic Infusion mode routinely, since no safety software exists in this mode.
- ✓ Clinical advisories are clinically important reminder messages set to display on the Alaris Pump. Read the advisory and hit confirm if the reminder has been completed.
- **ITRACE** all lines from patient to pump
- ✓ Document volume infused at the **end of the shift**, **upon transfer** or at the **completion of a medication or blood product**.
- Clear pump totals at the end of shift, and upon transfer.
- ✓ Guardrails is the programming software within the Alaris pump designed to help prevent programming errors.
- Hard limits within the Alaris pump will not allow you to adjust the rate of drug delivery outside of the parameters currently set within the data set.
- ✓ Soft limits within the Alaris pump allow the operator of the infusion system to adjust the rate of drug delivery above the maximum dose or below the minimum dose. When a soft limit is reached, the operator will be asked to review and approve the infusion rate. A visual and auditory prompt will occur.
- ✓ Wild card is an option in the programming that can be used to manually enter nonstandard concentrations of and IV drip.

IV Management

Intravenous Therapy

- For safety, staff **must** use the appropriate profile and the Guardrails Drugs or Guardrails IV Fluid Library, whenever able.
- ✓ RN's may perform venipuncture and administer IV fluids if they have been verified as competent in the performance of 3 venipunctures by an RN who has been verified.
- If a nurse is unable to obtain IV access on a patient after two attempts, they must ask another nurse
- ✓ If a patient is going to surgery, the IV should be started with an 18 gauge or larger
- Lidocaine1% **without** epinephrine may be injected intradermally to anesthetize the venipuncture site prior to starting the IV (check for local allergy to anesthetics).
- ✓ IV's started in the lower extremities are only allowed in cases of emergency or with a physician's order.
- IV solutions must be changed every 24 hours. The IV fluid label should include the following
  - Date
  - Hang time
  - Patients 3/3 initials
  - RN initials
- ✓ TKO rates should be run at 20ml per hour unless order indicates otherwise

IV Site, Dressing and Tubing Change

- ✓ All peripheral IV sites, dressing and tubing's shall be changed and labeled every 96 hours
- ✓ Blood tubing must be changed every 4 hours (if two units of blood are infused within 4 hours the same tubing may be used.
- TPN tubing and filter must be changed every 24 hours
- ✓ Propofol tubing must be changed every 6 – 12 hours
- Minimize contamination risk by wiping any IV access port with an appropriate antiseptic and access the port with only sterile devices.
- ✓ Central Vascular Access Devices (CVAD) includes all devices that provide access to midline or central venous/arterial vessels, including broviacs, swan-ganz and PICC lines.
- Dressing changes on CVAD are performed every 7 days or when loose, wet or soiled and must have a bio-patch and occlusive dressing.
- ✓ All sites, dressing and tubing changes must be documented in the medical record. If no other vein is available, and the site is not changed, please document.
- Any IV inserted under emergency conditions shall be changed within 12 hours
- ✓ Any antecubital IV shall be changed within 12 hours

Patient Controlled Analgesia (PCA) with End-Tidal Carbon Dioxide Monitoring (EtCO2 Capnography)

The following highlighted Policies and Procedures are meant to be a quick reference to our facilities processes. Please take the time to read these policies in their entirety as the information provided here is abbreviated.

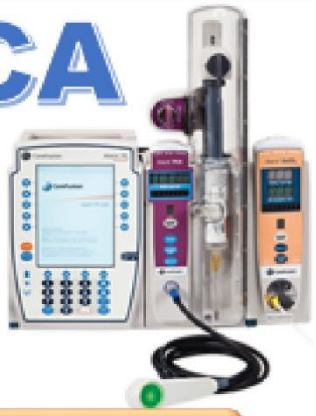
Patient Controlled Analgesia (PCA)

- Hospital staff, family members or signification others are **NOT** allowed to administer PCA doses
- ✓ The PCA pump security code must be disabled whenever a patient is an employee or the family member of an employee. The pump must be then accessed using a key.
  - ➢ An end-tidal C02 monitoring device will be worn by patients on a PCA until an order to discontinue EtCO2 therapy is written by the physician. If a patient requires 02, it may be delivered through the EtCO2 up to a max of 5L/min

PCA Set Up

- Set up can only be done by and RN and co-signed by an RN
- ✓ Educate the patient on the purpose of the PCA and the EtCO2 monitoring equipment
- ✓ Use and IV dedicated for the PCA
- **PCA pump can only be attached to the right of the Alaris pump unit**
- ✓ Verify the analgesic medication with the physicians order at the patient's bedside with another RN
- ✓ PCA tubing and analgesic syringes must be changed at least every 96 hours along with the main IV tubing
- IV fluid must run at a minimum of 20ml/hr
- ✓ The second RN will double check and verify the following before co-signing:
  - ➢ Drug and concentration
  - ➢ Loading dose
  - ➢ PCA mode
  - ➢ PCA dose
  - ➢ Lockout interval
  - ➢ Continuous rate (if ordered)
  - ➢ One hour limit
- ✓ For EVERY INITIATION / START of PCA Therapy (except for PACU) – call G5 or S6 Charge Nurse to request a 2nd RN witness. A G5 or S6 RN staff will be the 2nd RN witness to confirm correct use of equipment, tubing, and programming of pump.

PCA



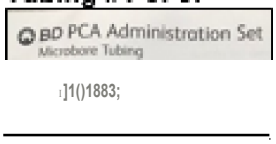
PCA Tubing

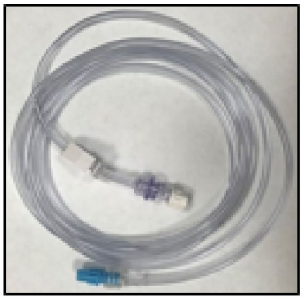
When slartiirig a patie11t on PCA herapy, you musl. obtain he following three (3) rubing trorn tllile S 11.1 pp r Ro om:

1. PCA Tubing
2. PCA .Airl'li-Reftux Y Set
3. CO_2 Mio11il miing Na sal Carmu!a

To prevent errors, these 3 tubing will be placed in 1 kit/packaging in the Supply Room. Look for this new kit!!

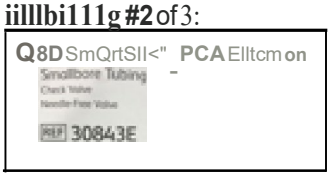
Tubing #1 of 3:

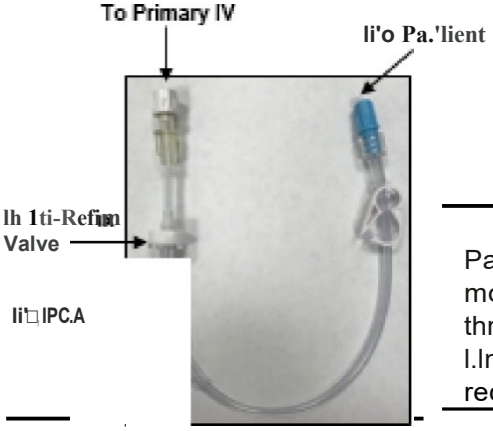




- Attadh PCA syringe to this PCA tubing, and prim e mam.1.ally or through the PCApump. Tubing length of92 inches=:::: 2 .1 ml
- Place the syringe & tubing to the PCA pump **PRKJR** to connecting it to the patient.
- Program the PCA pump
- Connect the PCA tubing to the PCA port of the Y **Set whidh** is **alread y connected** to the patient **and primed with primary maintenanoo fluid**
- **start the PCA**

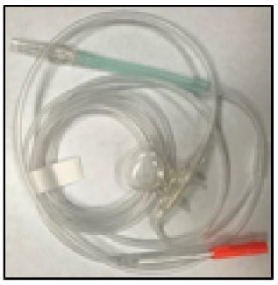
iilllbi111g #2 of 3:





- 6 onn ect the Primary IV tubiri g to the Anti-R,ef LIX V al\lle portof the PCA Y Set. Prime with the primary IV maintenance f uid.
- Connect tubing to patient
- Connect the PCA tubing that's alreadyprimed, plaood in Pump, and correctly programmed to the PCA port ofthe Y Set (the shorter port)
- Press start on PCApump

iilllbi111g #3 of 3:



Patient w ill w ear the EtCG.2 monitoring nasal canm.1la throughol.ltthe PCA therapy or l.Intil an MD orderto D/C is recei ved

The purpose oft ti e An ti-R,efh.ixY-s,et is to avoid medicatiion fr om PCA tubing/syringe to tra \lIel up to the Primary IV.
To achieve this goa l, the primary IV and the PCA tubing must be attachedtothe**CORRECT**ports:

- PrimaryIVmustbeattachedto the port <u>with the anti-reflu x</u> valve
- <u>PCAtubing</u> mustbeattached to the shorter port ("The *broken arm gets the medica* tion"'will help you remember)

Nursing Responsibilities and Documentation

- The nurse will monitor and document baseline vital signs within 30 minutes prior to starting PCA then:
  - 5 minutes after start of PCA
  - Every 30 minutes x 2, then,
  - Every 4 hours
- ✓ Every four hours the RN will document the EtCO2 monitor value. This will continue until therapy is discontinued by a physician's order
  - Normal values: EtCO2 = 30-45mmHg *Notify physician if increase 10mmHg from baseline for longer than 15 minutes
  - Adult RR: 8-24 *RR < 8, d/c PCA and maintain open IV, try to awaken patient, if unable to awaken patient consider Narcan 0.2m slow IV push
  - Pediatric RR – 12-60
- EtCO2 can be suspended while a patient is eating, being transported or ambulating and resumed when finished
- ✓ The RN will document the following PCA activities and monitoring in the "Controlled Substance" intervention in "Process Intervention" (This is an Add Intervention) every4 hours:
  - Infusion Status – Start, Monitor or Discontinue
  - Medication time total
  - Number of PCA/PCEA attempts
  - Number of PCA/PCEA injections
  - Amount infused in milliliters
  - Sensation Level (epidurals only)
  - Motor strength
  - Assess pain
  - Assess vital signs **INCLUDING EtCO2**
  - Document any education under "Teach/Educate"
- ✓ Each PCA Therapy on a patient MUST have documentation of:
  - START------ At start / initiation of therapy
  - MONITOR ----- Every 4 hours
  - DISCONTINUE------ At end of therapy
  - HANDOFF of Controlled Substance ----- Must happen at end of shift and on transfer (e.g. PACU to unit).
    - Document volume of Controlled Substance handed off to the next nurse
    - Review pump program and compare to Physician's order
    - Co-signature required
- ✓ Each time a dosage amount is increased greater than 0.2ml:
  - BP and respirations will be monitored every 1 hour x 2 then,
  - Every 4 hours if stable
- ✓ All PCA changes must be double check and cosigned by another RN
- ✓ Document infusion totals at the end of shift, upon transfer of care or at the completion of medication

Source Document

Competency Title:		
Alaris IV Pump – the use of Guardrails	**ORIGINATED:**	12/2015
	REVISED:	
	REVIEWED:	
	Author: Education	

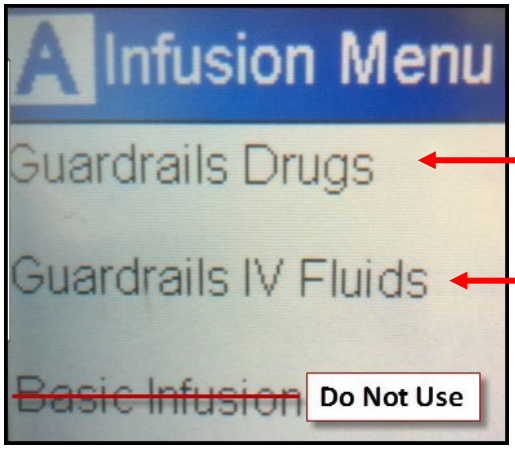
Competency Statement:

Staff will be able to correctly demonstrate operation of the Alaris IV Pump System using the Guardrails Drugs or Guardrails IV Fluids library and profile specific to the location of the patient in order to enhance the safe delivery of intravenous fluids/medications.

PERFORMANCE CRITERIA AND KEY ELEMENTS

- **Guardrails 'Soft Limit':**
  - Allows the operator of the infusion system to adjust the rate of drug delivery above the maximum dose or below the minimum dose. When a soft limit is reached, the operator will be asked to review and approve the infusion rate to assure that an error has not been made before overriding the Guardrails limit. A visual and auditory prompt will occur indicating that the infusion is being delivered above or below the Guardrails limit when a soft limit is overridden. The visual alert will stay visible during the infusion.
- **Guardrails 'Hard Limit':**
  - Does not allow the operator of the infusion system to adjust the rate of drug delivery outside the parameters currently set within the dataset.
- **Profiles:**
  - Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

- A PROFILE must be selected for each Point-of-Care Unit (Brain) that reflects the type of care provided for the patient. When a patient is transferred to another level of care, the Brain must be powered down and a new profile appropriate for the new unit must be selected.
- On initial set-up, when prompted to enter patient identification number, enter the **COST CENTER** of the unit/department. Example: 614 for South 6, 613 for South 4.
- For any medication or solution delivered using an infusion pump, you must choose the appropriate profile from the **Guardrail Drugs** or **Guardrail IV Fluids library** for safer delivery. Do NOT use the Basic Infusion mode routinely, since **no safety software exists in this mode**.
- If a soft limit is met/exceeded, verify the rate/dosage before proceeding; may use double check with another RN or pharmacist when appropriate.
- Obtain and document infusion totals at the end of shift, upon transfer, or at the completion of a medication or blood infusion.
- **Clear pump infusion totals** (Zeroing Out) at the **end of shift**, or upon **transfer**. If you receive a patient and the totals have not been cleared, you must do so at that time.
- Alarms are **never** to be muted/silenced/turned off at any time when the licensed staff is not in the room attending to the patient.



Medications
Antibiotics
Sedation drugs
Titrated Drips
ETC

Maintenance Fluids
Fluids with Additives
Blood Products
TPN/PPN

Powering on the Alaris System:

- System On to turn on
- New Patient? Yes (No = retain previous data)
- Previous Profile? No (Yes = retain previous data)
- Scroll through choices. **Choose appropriate profile**
- Confirm
- Patient ID: **Cost Center** of the unit the patient is on
- Confirm

Programming an IV Fluid:

- Press Channel Select on pump module
- Infusion menu on main screen:
  - Guardrails Drugs
  - Guardrails IV Fluids
  - Basic Infusion (do NOT use this option)
- **Guardrails IV Fluids**- categories – for LR, NS, D5 ½ use Maintenance IV (check out other possibilities, page down key)
- If you make a mistake, press CLEAR button
- **Open clamp**, Press START.
- **Green** Light is good
- Occlusion – kink the tubing, light turns **Yellow**, over 15 second will alarm. (Notice the Black Bar on the main screen – this means that pressure is building up). Will need to press RESTART button (on pump module) after assessing the patient.

Change the Rate of the Infusion:

- Channel Select, press RATE, press CLEAR to erase, enter new rate, press START
- Max Rate: 999
- If you press 9999 by mistake, it will not start. Read blue bar, press CLEAR, enter new rate and press START

Programming a Secondary Infusion:

- Hang primary using the full length of hanger, 9.5”
- Main bag should be 20” above patient
- Channel Select, press Secondary key, U-Z key (for example select Vancomycin, 1 gram/250ml), YES, NEXT to confirm
- Set by pharmacy, VTBI and Duration pre-populated
- Press START

To interrupt the secondary, and switch back to primary:

- Channel Select, SET UP key, press PRIMARY key, press START key, press YES

Non-Standard Concentration:

- Channel Select, SECONDARY Key, choose Drug
- Choose_____gram/_____ml, press YES
- Enter DRUG AMOUNT: e.g. 2GM, DILUENT VOLUME: e.g. 500ml
- You can edit the VTBI and Duration, START
- If patient C/O pain from too fast infusion, change to lower rate or change time to longer time. (Find VOLUME DURATION) – located on hard key at bottom of screen

Clear Volume:

- VOLUME INFUSED, PRI/SEC VOLUME (at bottom left corner)
- Total Volume, Clear All

Programming a continuous drug infusion:

- Channel Select, GUARDRAILS DRUGS, find Drug from alphabet key, YES (read Clinical Advisory), CONFIRM, NEXT,
- VTBI_____, DOSE_____, START
- Titrating the dose:
  - Increase the Dose, press Channel Select, press DOSE, START:
    - Rate will recalculate.
  - If you change the dose to above guardrails soft limit:
    - ↑↑↑ = on the high side
    - LLL = too low
    - Need to bring dose back down acceptable dose

Using the Basic Infusion Mode ☹No protection, Legal issues – should NOT use this routinely. Use ONLY if drug/fluid is not in Guardrails IVF or Drug, or can be used in a Code situation

- Channel Select, BASIC INFUSION
- RATE:___VTBI:_____START
- Green light on, but **NOTHING is scrolling across message bar, means NO GUARDRAILS**
- **Use ONLY if drug/fluid not in Guardrails IVF or Drug, or in Code Situation**
- To change to "Good" (Guardrails) pump: while fluid continues to infuse, Channel Select, OPTIONS, GUARDRAILS IVF, RATE, START
- Find CODE BLUE drugs listed in "ZZ" at bottom of list on Guardrails Drugs

References:

RCH policy MM.114 – Intravenous Therapy, Intravenous Infusion Pumps, Alaris Infusion System
Alaris System Implementation Workbook for Riverside Community Hospital, August 2011

Alaris® PCA Module Guide

Syringe Loading and Set-Up

WARNING: TO PREVENT UNREGULATED FLOW, CLOSE SET TUBING CLAMP BEFORE LOADING OR UNLOADING SYRINGE.

Loading:

1. Open syringe barrel clamp (clear piece) until it clears syringe chamber.
2. Raise drive head (gray) to fully extended position.
3. Insert syringe barrel flange between barrel flange grippers (see drawing).
4. Lock syringe in place by closing barrel clamp.
5. Twist gripper control clockwise, lower drive head, lock plunger in place with plunger grippers.

Priming:

1. If priming using PCA module, this feature is available when viewing Infusion Mode screen during programming of PCA module. At this screen Press **OPTIONS**, then press **PRIME SET WITH SYRINGE**.
2. Once tubing set is primed, close slide clamp.

Note: *At the start of an infusion program, the system prompts to select and confirm syringe type and size. Ensure displayed syringe manufacturer and size correctly identifies the installed syringe*.

Programming Guide

WARNING: DO NOT PRIME WhILE ATTAChED TO PATIENT!

Initial Set-Up:

1. Select administration set and attach set to syringe.
2. If priming manually, express air from administration tubing set.
3. Load syringe with administration set attached.
4. Press **SYSTEM ON** key and select **YES** or **NO** to "New Patient".
5. Select appropriate profile.
6. Press **CHANNEL SELECT** key and set key to "Program" position.
7. Press **CONFIRM** time setting and choose correct syringe type and size.
   Note: *If installed syringe is not listed, press ALL SYRINGES and chose matching installed syringe type and size.*
8. Choose correct medication and concentration.
9. At "Infusion Mode" screen: To Prime, press **OPTIONS** key.
10. Press **PRIME SET WITH SYRINGE**.
11. Press and hold **PRIME** key to prime tubing.
    Note: *Do not prime while attached to patient.*
12. Press **EXIT** when prime is complete.
13. Choose desired Infusion Mode and follow on-screen prompts.
14. Close and lock door and attach administration set tubing set to patient.
15. Review settings and press **START**.

Programming PCA with PCA Pause Protocol Enabled:

1. Perform steps 1-10 of **Initial Set-Up** in previous section and continue with following steps.
2. Review Clinical Advisory "Attach an SPO2 or EtCO2 Module Now".
3. Press **CONFIRM**.
   Note: *If a monitoring module is not attached and started, PCA Pause Protocol WILL NOT activate.*
4. Choose desired Infusion Mode and follow onscreen prompts.
5. Press **NEXT** key to verify medication parameters.
6. Review Clinical Advisory "PCA Pause Limits Should be Reviewed".
7. Press **CONFIRM**.
8. Choose desired Infusion Mode and follow onscreen prompts.

Change Syringe:

1. Press **PAUSE** and close tubing clamp.
2. Use key and unlock door and remove old syringe.
3. Press **SILENCE**.
4. Attach new syringe to tubing and load new syringe.
5. Set key to "Program" position and close door.
6. Press **CHANNEL SELECT** key.
7. Choose correct syringe type and size.
8. Press **CONFIRM**.
9. Press **RESTORE** if same drug and concentration.
10. Verify drug and concentration and current settings.
11. Lock door and open tubing clamp.
12. Review settings and press **START**.

Change Program/Mode:

1. Press **CHANNEL SELECT** key.
2. Press **PROGRAM**.
3. Set key to "Program" position or enter authorization code (if enabled).
4. Choose desired infusion mode and follow onscreen prompts.

Beginning of Shift/Summary Review:

1. Press **CHANNEL SELECT** key and verify settings.
2. Press **START** key.

Patient History/End of Shift/24hr History:

1. Press **CHANNEL SELECT** key.
2. Press **OPTIONS**.
3. Press **PATIENT HISTORY**.
4. Press **ZOOM** key (time interval) as appropriate and review drug totals.
5. To clear patient history press CLEAR HISTORY and press YES or NO.
6. To view 24 hour totals: Press 24 h Totals.
7. Press EXIT then press START.

Operator Precautions: For proper operation of the Alaris® System (formerly Medley®System) the user must be familiar with the features, disposables, administration sets, set-up and programming.
This guide includes selected information and suggestions and is not intended to be comprehensive instructions for the set-up and operation of the Alaris® System. For complete instructions along with Warnings and Cautions, refer to Alaris® System Directions for Use (v8).

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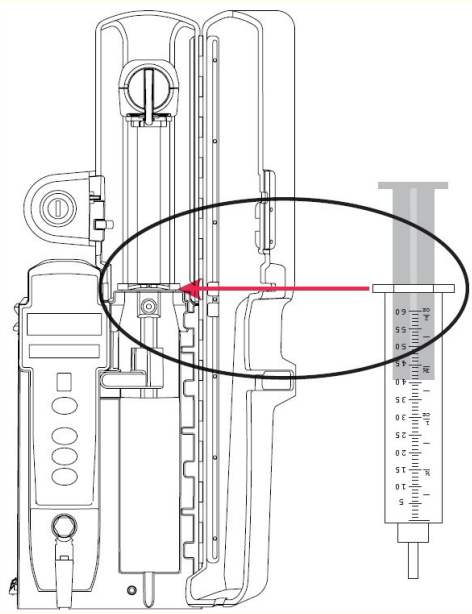

Alaris® EtCO2 Module Guide

Setting Ala irm Lim ts:

1. Press O!ANNB... SB.EC.T key.
2. Press !JMITS..
3. Sell · irrit p.arame"..er be changed
4. Entel a numeric !t!alu e USfig ke:,rpad or fda'lm arrow e-.ys.
5. Press OONIFIRM.
6. Press MAIN SQREEN.

Trend Data:

1. Press O!ANNB.. SElEC.T key.
2. Sel'ect TIIBNIIl
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4. Press ZOO to change tim-eperiod_
5. To [Press EtC:02 n_
6_ Press MAIN SQREEML

I?CA1Etc02 Trend Da

No :te: Th is• oo req ui e-s use of A.Jans'@ PCA modu e.

1. Press O!ANNB. SB..ECT key.
2. Press OPTIONSc
3. Sel'ea PCAliEtC:02 lii"elildl Data Navrgale as described above in section ed rend Data.

4. Toexit pi;ess BC02 Main
!5.. P i1es s MAIN SCREEN.

Cha III ge Waveform Height:

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2. ilEss OffliiilONS.
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4 . Se lect OOmrriHg or QElmnHg
!5.. less MAIN SCREEN.

Cha III ge Waveform Time Scale:

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4 . Se lect !5 or 1 serconds (fur rowar re51Pir atcily rates. select O se oorn:fs }.
!5.. PileSs MAIN SCREEN.

Pire--Silen cing Alairm:

1. PileSs SILENCE to pre--9'ilence m:mtainga rms fur 2 mmrl:es.

***Nob!!:]** al'm!IDS not be .silenced..*

Troutilfeshooting : Alarm s / Messages

H-oh Priority .Alann	Mei1ningif Ci1Uses	Response
No Breath DetecteG	• Patient is not lbrealhin9 " Disposatie is not prapeti .atl.a.ched to palEnt and/or dei.rid 2- " Disposatie is not ru ema1	.. Assess pa:i chec.'k d b'le. .. Consocler usiliJJ different d"tsp0safbe type c0aw hosp.iial prok)oo'.I actions..
H-oh Etc:02	Patient has m.re measurement · ign BtC02 F-e-ver or h,ype:rmetabo ic state	
Low EtCOO	D i e is oot properiy attached low EtCO2 pa :ient to patient or Patient has m.re measurement .• Di e ct 0.:iJFed.Jy dhed se;::urely connected to m:xlule	.. Assess pa':ient, chec.'k d b'le .. Compare value baseline .. cOaw hosp.ii.al prok)oo'.I actions..
High RR	Respiratory Rate is above the specified limit	
	Respiratory Rate is below the specified limit	
LowHR H FiiCOO	Patient iis. inspi ng e CO2 or d ispos.able oot prqperiy atta.ched pa:jent 02 mask may oot be p.r;cparly atlached (if patient is. W:aring an 02 mask:) 02 ilr:M' to ma sk may ve stepped	.. Assess pa ent. check disposable. .. Check 02 ilow .. Check mas'k am:L'or c:fra;pe po:s ::ioo hosp.if.al protocol actioos
Disconnect Occtuded	Drapes or cove:rs may be over palient"s face Pu119 jng cperati:o f ed	.. DISCONNECT OC di'lsposafbe and 1he reatlachi. .. Obtain and attach n reads
Disposable	he d&)l(lsable o::cluded or needs Dbe res.el tained	Monitoring will automatically resume when completed. No intervention is necessary. Cl11DED DISPOSABLE. a new diispoesa'.ble.
.Aufozero lin pr)DEJ essi	The mc:xfite perfoming an autozero ca libra fi.cmi to clear the clogged disposable. will automatically resume monitoring. During this ti:rn"e oo data is o	If unable to clear, the module will go into a DISCONNECT OCCLUDE LE alarm.
Cleani g 1 Disposable	The mc:xfite "b)qng I . the rrn,:Ju le :F m: 11J m ib..,	!!I msPOSAIB

Alaris® System (formerly Medley® System)

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3. Press PCAIM:Onlfa'11rn Trem::I data.
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5. Pless **MA.IN** S CRE E N I.

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2. PlessB olus. IDoa lii.
3. :Sej ley 1D PIDgrii -:Joni ,ore r autholtZa"J::m oode ·, a ed):.

4. Enter bolui. ,dDE-e a motm and loc H. d oor.
5. Press OONF[RMI.
6. • ei.ilew :&etttngs and press STA RT.

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1. Pless CHAN EL SELECT key.
2. Press stop EIOILIIBi'il oacl lil!IJ oc IPCA.
3. Press YES ior I 0.

!Note: Programmed cSei:!i'rlg.5 IIBS flm:'.

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1. Press **CHAN** EL SELECT key.
2. Press OPTIIO:t\lS.
3. Pless "Dose- **ReqUest** Set
4. Ch oose des lrad Dose cord P re. (1 - ll g h l am es , 2- ll g ht ion light
5. Presa **OONF[RMI** a n d pres:; STA/R.T.

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Insert latching conn r, the oord lrr.o **Dose Request Cord attach-ment** oo - PC.A **Ildule.** red marking on the latching connector shllUkl b:!· a'ligned with the red marking on the Dose Request Cord atta::hment

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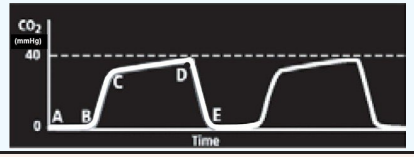
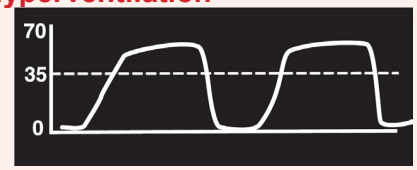
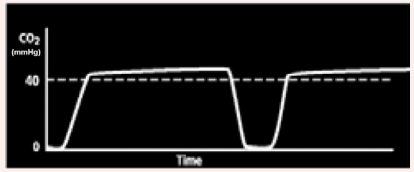
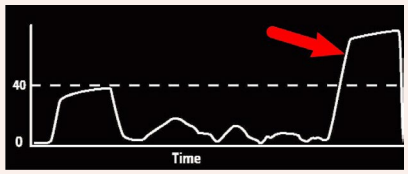
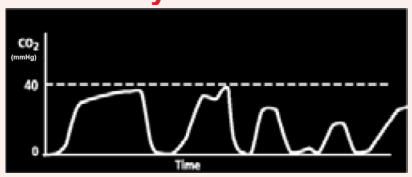
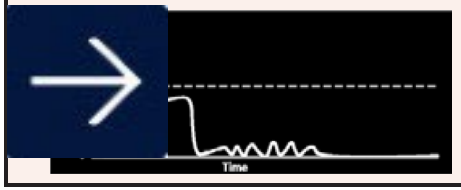
U:5!:! tey D. ·**dDOC** I de *!:ate·* IE-'i'ef and depre66. At lz ID:! **ookl the** CA**lllOOUle**· and ll)(]"li:!'ll'E·OO 'll'E·PiCA 00 · Side<May& · *a*Will)' rnm 'fi'E AlaJIQI PC ?Illm-ar-care . t f' iirtliib PC unit").

Tro leshooting Ale:rt:s a n d] A;la nns [t' OTIE: 1:N11119 .alarm !!rl:a 9 - PCA moot116i D li!!11ger 111rua 111g .

Alanru **Alerts**	**Meaning**	**Response**
Check S -	• tll1J11er gl'fp_pera;c:J ed diil g channel. close mp::**oo** arrecte:1 condition. If security door is closed and syringe is not captured, the system will immediately alarm.	Infusion and then .S. rg(lll='=f5. CtlAJilt'ilEL SEl..E'CT **tey. d** rE-- :&El b ;.rrel damp, and pre66 RES,TART ilia! 11g. Eh&lR amni :xm set [11:ll osed .Se ctl"El:f loot plt.mger gflpp;!r:li !>o'er &yl'[-
PSA Infusion has paused due to a decline in respiratory status.	'fD l! ClC;3te pu.e-ntlal :sl ooling	It.a1Ql=l' arm, Press
PCA. Pause Alarm	pal!Ertl status -	PrE-SSCCIWflRM D ee p,aHent Module to pause. Press **EXIT** and then **START**. adll' **Es:5ed** Pres:;. **RESTART**
Drive Not Engaged	Drive system disengaged during operation.	Open and close plunger grippers. Ensure syringe is properly CH'A t'ilNEL S'El!.IE · rc-ss [] . UG *Ell* 0-
Max Limit Reached	Indicates the maximum amount of drug del on **Maximum Hourly Limit** field.	*R'ff.* . JCJ D DfiD11 'la1Ue CA limit ed.
Module Enforce-ment	A user message will appear on the screen when the PCA module is NOT located directly to the right of the Alaris® PC unit.	Remove the PCA module and attach directly to the right of the Alaris® PC unit Ta SIE@:!Sey aBm - SILENCE Ie'f- ?CA.m:dlile lAt rB!Bn :sl- A:am !Mli . all:ltlOOil*oose*16 re :_j dllli1Jon",,.. „ ,
Near End (NEOI)	**Near End of Infusion** and remaining VTBI will alternate on screen until syringe is empty. Alert message will scroll in channel message display on the PCA module. The PCA module remains functional and will continue infusion	To silence **aam** will remain silent until $; E©:!Sey ast tale, p;es& SILENCE: *kE-'J.* PCilt.rood.IE
Syringe Empty	Alarm message **Syringe Empty** will scroll in channel message display on the PCA module	To silence safety alarm tone, press **SILENCE** key. PCA module will remain silent approximately 2 minutes and will re-sound.

EtCO2 Waveform Examples

The following are examples of common EtCO2 waveforms. The waveform trends are examples only and do not represent all potential abnormal waveforms. Analysis of these waveform trends may provide an early indication of the noted possible causes. The associated possible responses are suggestions only and are not meant to replace current clinical practice or hospital protocols. Always consult hospital protocols. Abnormal waveforms are not always associated with alarms

Normal /Abnormal Waveform	Clinical Findings	Possible Causes	Possible Responses
Normal Waveform (Normal Ventilation; 35-45 mmHg) 	• Normal breathing, Normal EtCO2 A - B: Baseline period of no CO2, End of inhalation B - C: Exhalation begins, Begin rapid rise in CO2 C - D: Sustained exhalation, Alveolar plateau D: End of expiration, end tidal CO2 (EtCO2) value D - E: Inhalation, Rapid decrease in CO2		
Hyperventilation 	• Rapid breathing, Low EtCO2	Increase in pain level or splinting area of pain • Increase in anxiety or fear • Respiratory distress or shortness of breath	Always follow hospital protocols • Treat cause of increased respiratory rate • Assess ABCs (Airway, Breathing, Circulation) • Decrease pain stimulus or encourage calm • Notify RT or MD
Hypoventilation 	• Slow breathing, High EtCO2	• Over medication or increased sedation • Snoring or possible obstruction	• Always follow hospital protocols • Access ABCs • Assess sedation level • Stimulate patient • Notify RT or MD
Hypoventilation with Shallow Breathing 	Slow breathing, Low EtCO2 followed by deep breath (see pointing arrow)	• Over medication or increased sedation • Low tidal volume	• Always follow hospital protocols • Assess ABCs • Maintain patient airway • Encourage patient to take deep breaths • Notify RT or MD
Partial Airway Obstruction 	Irregular breathing, possible audible sound or snoring, EtCO2 may be above or below baseline	• Poor head or neck alignment • Over medication or sedate	Always follow hospital protocols • Assess ABCs • Encourage patient to take deep breaths • Perform a head tilt or chin lift; Check position of cannula • Notify RT or MD
No Breath 	Sudden loss of EtCO2 reading, Very shallow or no respiratory rate pattern observed	• No Breath or Apnea • Very shallow breathing • Over medication or sedate • Displaced cannula	Always follow hospital protocols • Assess ABCs • Stimulate patient • Open airway • Notify RT or MD

References: 1. Capnography in the Management of the Critically Ill Patient, EducationPAK for Critical Care and Procedural Sedation - A Guide to Capnography, CD-ROM - Needham, MA Oridion Medical, 2003.
2. AACN Procedure Manual for Critial Care 4th Ed. (2001). Ed. Lynn-McHale, D.J. & Carlson K.K., American Association of Critical-Care Nurses.
3. Thalan's Critical Care Nursing Diagnosis and Management 4th Ed. (2001) Ed. Urden, L.D., Stacy, K.M. & Lough, M.E., C.V. Mosby

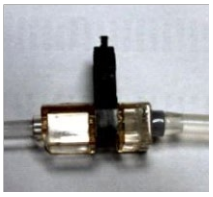
Source Document

Competency Title:		
MRidium IV Pump (To be used in MRI)	**ORIGINATED:**	4/2015
	REVISED:	
	REVIEWED:	12/2015
	Author: Education	

Competency Statement: Able to set-up and program the MRidium IV Pump

PERFORMANCE CRITERIA AND KEY ELEMENTS

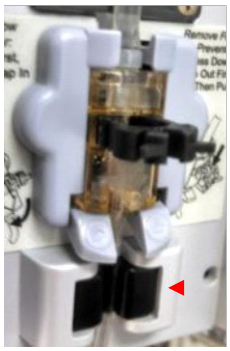
1. Attach the Alaris tubing to the **MRidium Extension Tubing (Ref 1058)**
2. **Prime** the extension tubing (open the valve preventer by pushing it forward: When done, **close** the valve preventer and roller clamp



Flow Preventer in Locked Position →

3. **Turn the pump on** by pressing the purple "I" key on the front panel
4. **Load the tubing**(s) into place

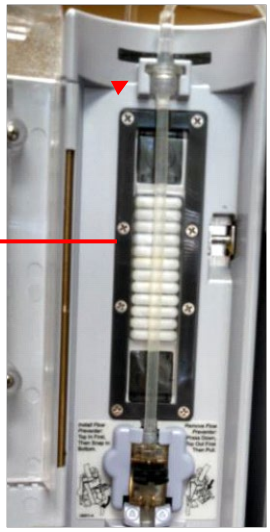
   a. **To open the door:** press the purple button downward and pull the silver lever forward
   b. Press the alignment disc into the alignment chamber
   c. Do not stretch or pull the silicone part of the tubing (similar to Alaris)
   d. Insert the valve preventer into the square area shown in the picture. The flat side goes toward the machine. Push inward and downward to insert it correctly.
   e. Ensure the bottom of the tubing is in the bubble/air detector



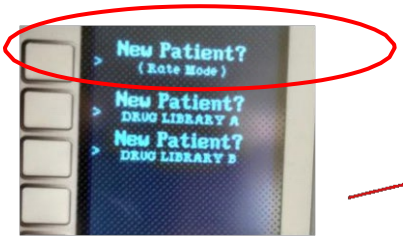
Valve Preventer

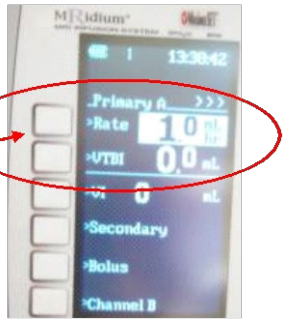
Bubble/Air Detector

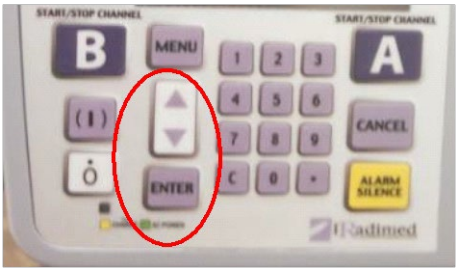
Alignment disc



5. **Program the pump** to deliver the drips needed (maximum is 2)
   a. Select channel
   b. You have two options for programming when using drips
      i. You can select "Rate Mode" or "Drug Library"
         1. **Rate Mode:**
            a. When selecting "Rate Mode" you must input the rate then press enter.
            b. The unit of measure can be changed by using the white key with the purple arrows located on the front panel – you must push enter between each entry
            c. Then put in the VTBI and press enter
            d. You should see a flashing channel key on the screen – push that key and ensure your roller clamp is open – the infusion has begun.







2. Drug Library

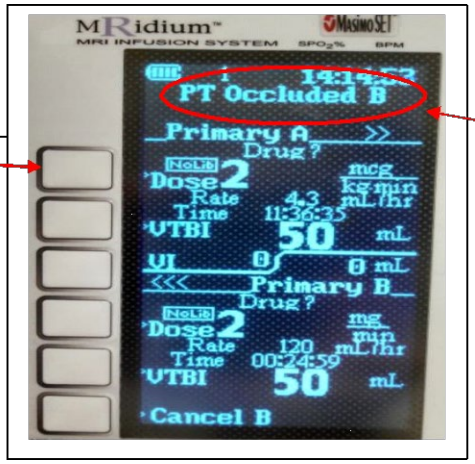
a. Use the white soft key to select the dose and press enter.
b. You must input all the info on the screen ensuring to press enter after each.
c. Once all the info has been entered, you will see the flashing channel key that can be pressed to begin the infusion.

(If it does not start, you may not have Pressed the enter key at the end of Data entry which is required, so do so)

c. If you have a 2nd drip:

i. Press the letter of the appropriate channel (you can again have two options: rate or dose)If using rate, just enter the correct rate and VTBI
ii. If using dose, press menu and select the programming for the appropriate channel by pressing the appropriate white soft key
iii. Enter in the required data as above and press the flashing key to start the infusion

d. When running two infusions, the screen will display both in a split format. If you have to make any changes to the rate, simply select the white soft key next the correct rate, enter the new rate by using the number keys, and press enter.



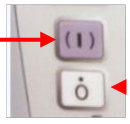
Alert

For example:

Press the soft white key To change the dose of Channel A – then press ENTER

6. When done, please turn the machine off by pressing the white “0” key on the front panel (you must hold if for a moment), and remove the tubing.

On



Off

7. **Troubleshooting:**
   a. Ensure you have entered all required elements
   b. Be sure to push enter after entering data (new or a change)
   c. Look at the top of the screen – alerts may appear to tell you what is wrong (see above: PT Occluded)
   d. Press silence and make the correction for the issue

References:

Source Document

Competency Title:	ORIGINATED:	11/2014
Blood Glucose Monitoring	REVISED:	04/2017; 1/2019; 1/2020
	REVIEWED:	
	Author: Education Department	

Competency Statement: Demonstrate competency on Blood Glucose monitoring and Nova Stat Strip Meter

PERFORMANCE CRITERIA AND KEY ELEMENTS

Hyperglycemia is defined as blood glucose above 180 mg/dl with or without symptoms. Nursing staff will notify the physician if there are no orders to cover hyperglycemia.

Hypoglycemia is defined as blood glucose below 70 mg/dl with or without symptoms or blood glucose between 70-100 mg/dl with symptoms. Hypoglycemia recognition and treatment will be promptly instituted by the nursing staff. Patients will be treated and re-tested with blood glucose meter within 30 minutes.

If blood glucose meter reading is below 50 mg/dl, obtain a STAT serum glucose from the Laboratory and start treatment based on hypoglycemic protocol – use the Comment: "Per Protocol" on the NOVA meter.

High and Low checks:

Nova results are used for screening purposes only. When the results are below or above the Critical Value range:

A. For Adults:

- If blood glucose registers over 500, call Lab for STAT blood sugar prior to treatment.
- If blood glucose registers 50 or below and the patient is symptomatic, call Lab for STAT blood sugar. If anticipated Lab delay, institute treatment.

B. For Neonates:

Follow the same procedures, except that the lower value is 40 mg/dL and the upper range is 150 mg/dL.

Reference Range:
Adults/Peds: 70 – 125 mg/dl
Neonates: 40 – 90 mg/dl

Critical Values:
Adults/Peds: less than 50 or greater than 500 mg/dl
Neonates: less than 40 or greater than 250 mg/dl

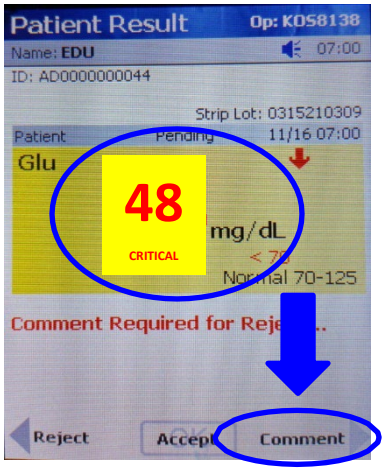
Clinical Alerts:

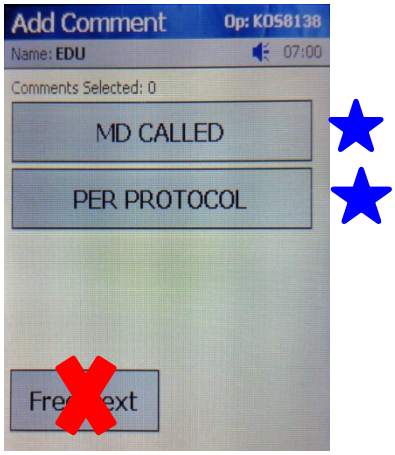
- If you question a result based on the patient's clinical assessment, repeat the test.
- If the result falls below 10 mg/dL or above 600 mg/dL, the meter will read "Lo" or "Hi".
- Capillary, arterial, or venous blood samples can be used for testing.

Critical Value Documentation:

- ***You must enter a Comment for critical values (<50 or >500).*** Press the "Comment" soft key on the Patient Result screen and select one of the pre-formatted options on the Add Comment screen

choose either “MD Called” or “Per Protocol” (do NOT use the ”Free Text” or “Do not Upload” options). Finally, press “Accept” for the result.





- You must also document the result and your interventions in Meditech.

Quality Control Testing:

1. Quality control consists of cleaning the meter, performing Low and High Glucose Control Solution tests, and docking the meter.
2. Meter will not allow patient testing if the quality control has not been performed in the previous 24-hour period. (or if the display reads “Quality Control Due Immediately)
3. Glucose control solutions must be stored at room temperature and are stable for 90 days after opening the bottles, or until the expiration date, whichever occurs first.
4. Glucose test strips are good for 180 days, or until the expiration date, whichever occurs first.

General Notes:

- The meters are to be cleaned with a hospital approved germicidal wipe after each patient use (NO alcohol).
- The meters are for patient testing only - not for visitor or staff use.

ATTENTION:

The ONLY acceptable ID number used for blood glucose testing on the NOVA meter is the scanned/entered patient ID number.

However, if emergency testing is needed for a non-registered patient (no ID band) in specialty areas (ED, NICU or L&D), enter the YYYYMMDDTIME format in lieu of scanning a patient ID band. Once the patient is registered, contact the Lab to update the information to transfer the results to the patient's chart.

References:

Riverside Community Hospital Policy PC 160 Glycemic Control
Riverside Community Hospital Policy WT 120 Glucose Point of Care Testing Nova

StatStrip

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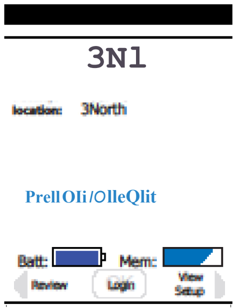

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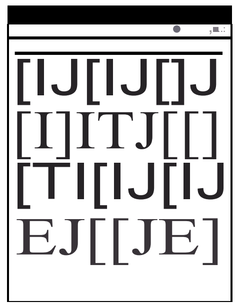

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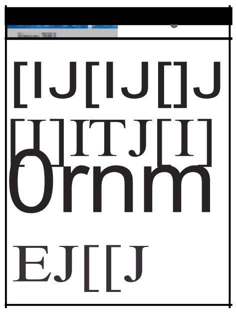

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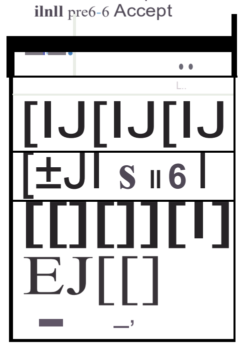

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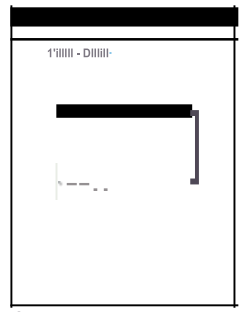

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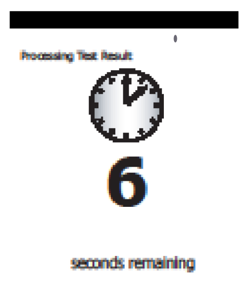

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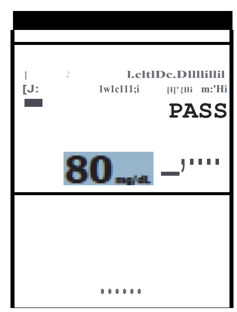

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Novai Biomed ical, 200 Rrospect Street, W.allh am , MA 02454
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StatStrip

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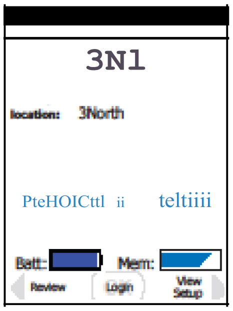

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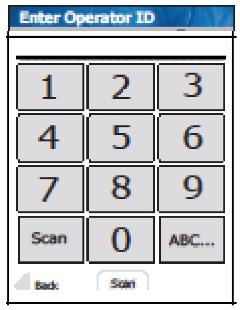

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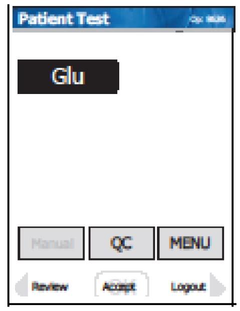

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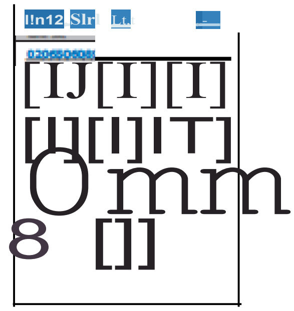

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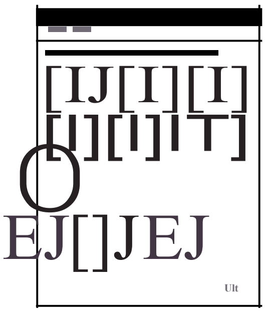

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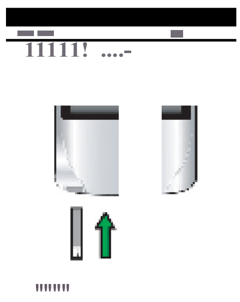

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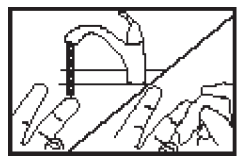

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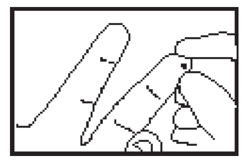

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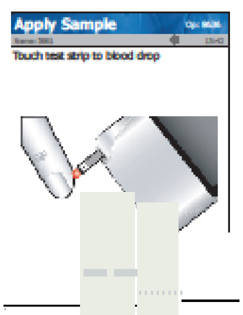

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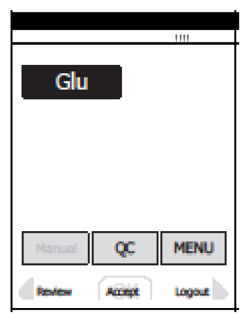

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Source Document

Competency Title:	**ORIGINATED:**	January 2014
Restraint Application and Monitoring	**REVISED:**	December 2017; 1/2020; 8/2020
	REVIEWED:	
	Author: Education Department	

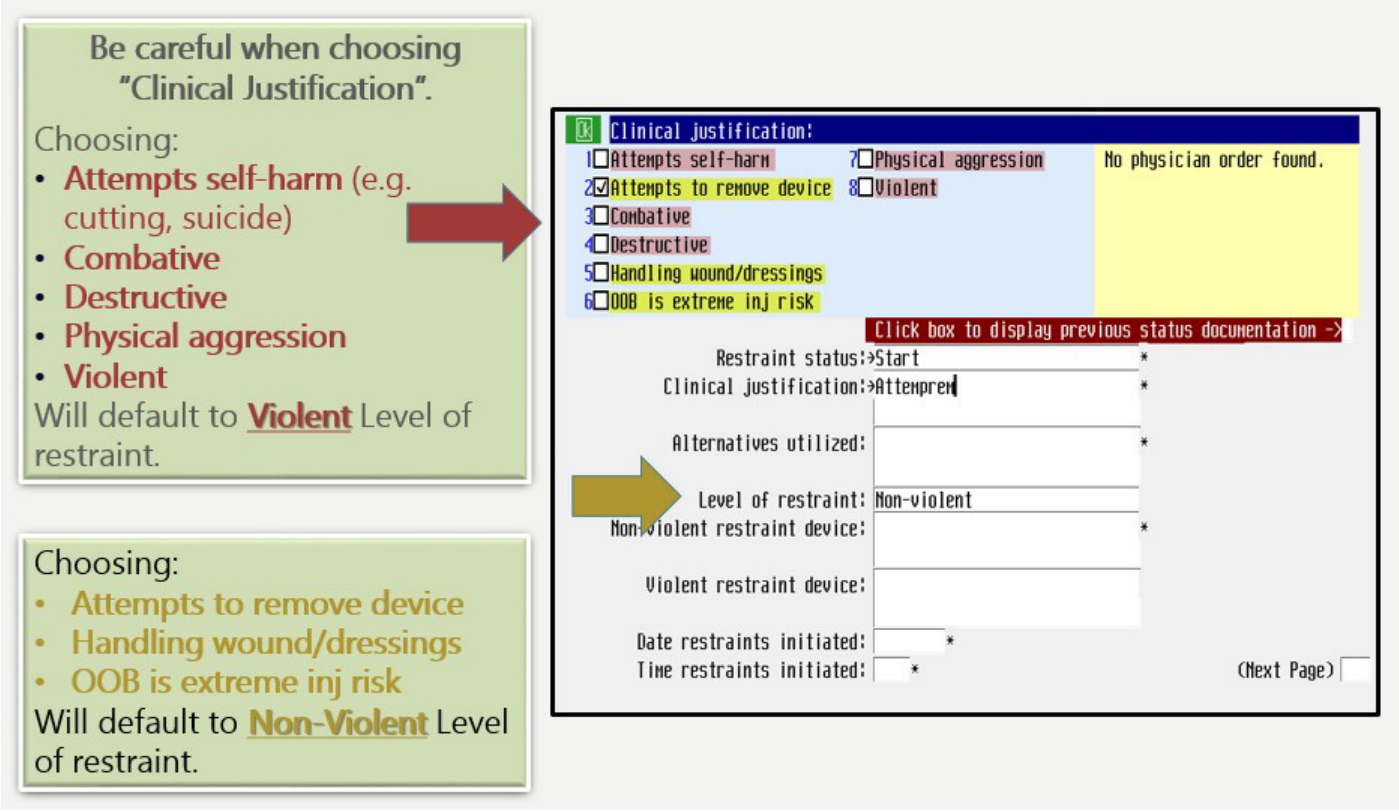
Competency Statement:
RN staff will be able to demonstrate proper placement of soft limb restraints, Secure Sleeve and Finger Control Mitt as well as demonstrating securing straps with a quick release knot. RN staff will be able to articulate the difference between violent and non-violent restraints and articulate the monitoring criteria and frequency of monitoring.

PERFORMANCE CRITERIA AND KEY ELEMENTS

Restraint management involves all members of the healthcare team. Initially, an in depth assessment must be performed by a Registered Nurse to determine the need for a restrictive method to maintain patient safety. Alternatives must first be attempted. Least restrictive methods of restraint must be attempted and documented before more restrictive methods are tried.

Violent vs. Non-Violent Restraints:

The reason for applying the restraint determines whether it is a Violent or Non-Violent Restraint, and this will be determined during the documentation in Meditech.



What is the difference between Violent and Non-Violent restraints?

Violent	Non-Violent

• Orders expire sooner:
  ○ 4 hours for 18 and older
  ○ 2 hours for children 9-17 years
  ○ 1 hour for children under 9 years
• Requires **face to face** by MD/PA/NP **within 1 hour** of application. Documentation required by MD/PA/NP and by the RN
	• Initial Order must be renewed in 24 hours
	• Subsequent renewals are by calendar day

Monitoring:
Both require:

- Every 15 minute Safety Checks (on paper)
- Every 2 hour Monitor/RN Assessment (on Meditech)

All members of the healthcare team must report any risk or safety factors observed to the charge nurse. For instance, observation of incorrect restraint application (too tight, too loose, on backwards, tied to the wrong part of the bed) requires prompt nursing intervention, assessment and documentation. Likewise, if certain procedures require the temporary removal of restraints, notify the patient's nurse or the charge nurse **before** removing restraints. Examples may include the taking of a portable X-Ray, assistance to the bathroom, giving a bath, turning a patient in bed, or simply, the patients' request for the removal of restraints.

Important Points:

- Ensure the patient is positioned correctly in bed.
- Restraints or restrictive devices are correctly applied: i.e. wrist or ankle restraints allow for at least (1-2) finger widths between skin and restraint.
- Restraint or restrictive device ties are out of the patient's reach, but easily untied by staff in case of an emergency, such as a Code Blue, seizure or fire.
- Restraint or restrictive device ties are tied with a quick release knot to the part of the bed which moves with the patient ***NOT*** the side rail or the bottom rung or the bed frame.
- If full side rails are used and the side rails are split in the middle, a sheet or pad must be secured between the side rails to prevent the patient from slipping out between the upper and lower rails.
- Observe patient extremities (hands / feet) for evidence of good circulation / nerve function: capillary refill time less than 2 seconds, patient denies any loss of feeling, tingling, or inability to move, pulses remain strong.
- Trained RN team members may take an active role in collecting data and address attention to needs (i.e., toileting, fluid and nutritional needs as appropriate to their discipline.)
- The following direct and indirect care giver "roles" related to restraint responsibilities apply to the RN:
  - Provides bedside care which may require the temporary release and reapplication of restraints in order to provide treatment, reposition, or transport the patient.
  - Provides patient and family with emotional support during restraint use.
  - Assists with observing patients for signs of safety risks for patients in restraints and reports any of above to the R.N.
  - Documents safety checks at least three times each hour.
- In order to keep the patient safe, the following measures must be maintained:
  - When securing a tied device, the straps must be secured to the bed frame, wheelchair frame, or other non-movable part of the appliance on which the patient has been placed, using a quick release knot.
  - Orders for restraint may never be written as a standing order or on an as-needed basis.
- **Safety checks performed by the trained RN staff must include:**
  - Maintaining the physical and emotional well-being of the patient.
    - Monitoring vital signs
    - Monitoring peripheral circulation below the restraint
    - Meeting any hydration, hygiene, elimination, range of motion, or comfort needs the patient may have (within any restrictions the patient may have).

- Monitoring skin integrity
- Monitoring level of distress and/or agitation
- Monitoring mental status
- Monitoring cognitive functioning

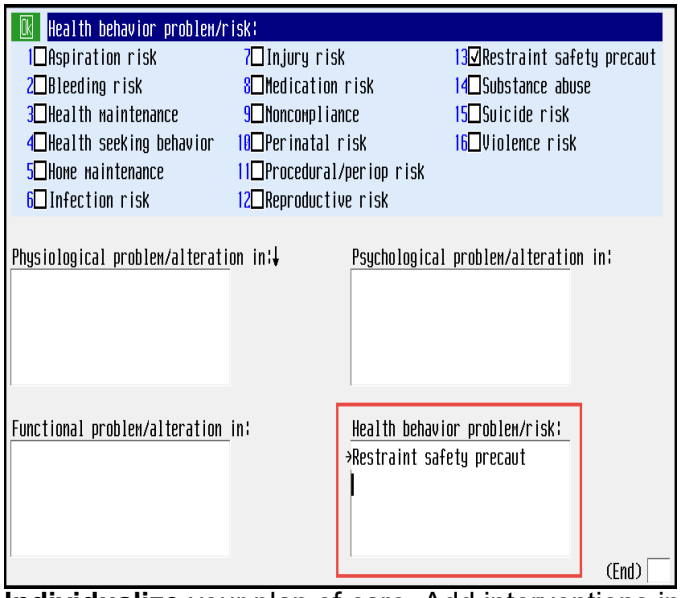
- Maintaining the patient's rights, dignity, and safety.
  - Maintaining patient's Safety/Rights and Dignity, means:
    - Respecting the patient as an individual
    - Maintaining a clean and safe environment
    - Encouraging the patient to participate in his/her own care
    - Maintaining the patient's privacy, preventing visibility to others, and protecting the patient from harm or harassment
    - Ensuring 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.
    - Monitoring and meeting the patient's needs while in restraints
    - Validating with the RN if less restrictive measures are possible
    - Monitoring changes in the patient's behavior or clinical condition required to initiate the removal of restraints
    - Monitoring whether the restraint has been appropriately applied, removed and/or reapplied

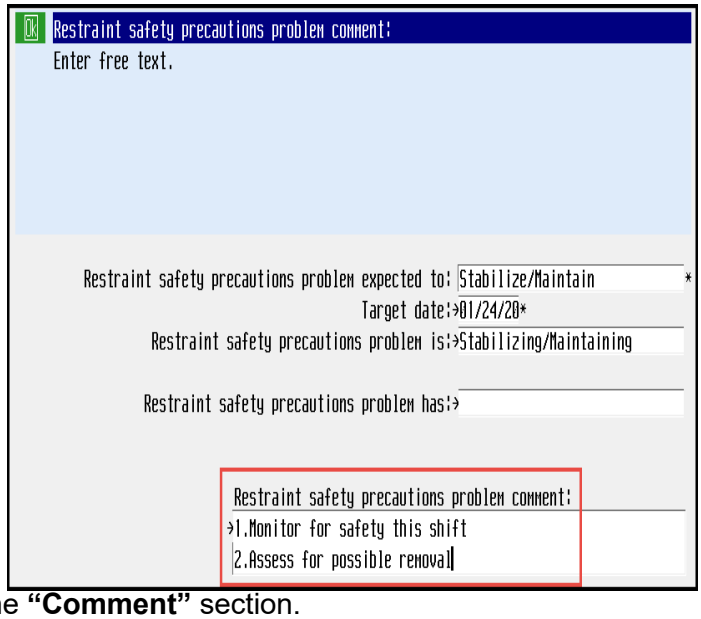
Documentation Requirements:

Initially, Add Intervention (AI) "Restraints Documentation". Document in Meditech under "Restraints Documentation".

- **START** (initiation) or Restraints
- **SECOND TIER REVIEW** – documented by Charge Nurse/Nursing Management (occurs with the initial restraint application)
- **MONITOR/RN ASSESS** – to be documented every 2 hours by the RN
- **SAFETY/RIGHTS/DIGNITY** – on paper: 15-Minute Restraint Monitor form (every 15 minutes)
- **DISCONTINUE** – at discontinuation of restraint
- **FACE TO FACE** – documentation of face to face meeting between MD/PA/NP and patient within 1 hour of restraint application (only with Violent Restraint)

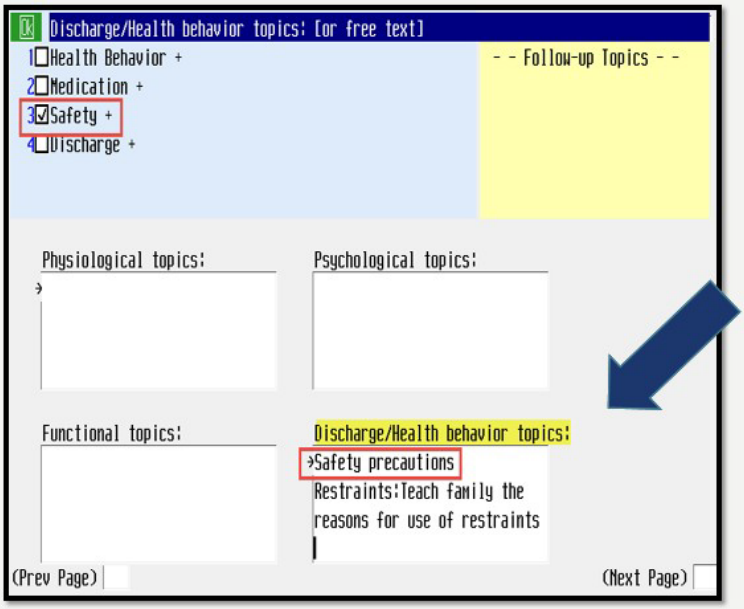
Care Plan:





Individualize your plan of care. Add interventions in the **"Comment"** section.

Restraint Education:



Document restraint education in the **"Teach/Educate"** intervention, under **"Discharge/Health Behavior topics"**. Choose **"Safety"**, and click on **"Safety precautions"**. Also free text other restraints teaching that you did.

REFERENCES (be sure to read prior to coming to Skills Day)

RCH Policy PC.213 Restraint and Seclusion Guidance Policy
EBSCO Dynamic Health Nursing Skills:

- Limb Restraints
- Mitten Restraints
- Elbow Restraints

(f)Posey RESTRAINT ALTERNATIVES

SecureSleeve

- An external hand, wrist, elbow and knee splint.
- Waterproof outer cover.
- Inner lining of soft cotton adds extra comfort against the skin.
- Translucent fabric allows the Splint to remain in place during X-rays.
- Polystyrene bead filling conforms to the limb and helps equalize pressure with comfort and stability.
- Nylon loop may be pinned or clipped to patient's sleeve to prevent sliding off (see clip application).
- Available in infant through adult leg sizes.
- One per package.

Adult SecureSleeve		
Size	Length	Limb Circum.
8168XS	10" (25 cm)	3" - 12" (8 - 30 cm)
81685	11" (28 cm)	3" - 14" (8 - 36 cm)
8168M	13" (33 cm)	6" - 17" (15 - 43 cm)
8168L	14" (36 cm)	8" - 21" (20 - 53 cm)
8169	18" (46 cm)	14" - 27" (36 - 69 cm)

Infant/Pediatric Sleeve		
Size	Length	Limb Circum.
81681	3" (8 cm)	1½" - 4" (4 - 10 cm)
8168IL	4½" (11 cm)	1½" - 4" (4 - 10 cm)
8168P	7" (18 cm)	1" - 10" 8 - 16 cm)

8151Attachment Clip, Metal, l doz.en
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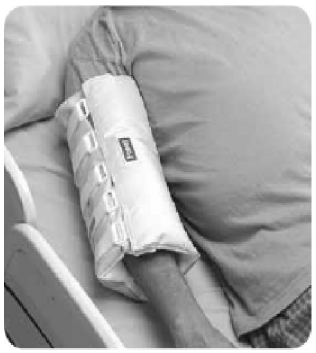


Application Instructions

1. Open the SecureSleeve by releasing the hook-and-loop adjustment strap.
2. Orient the splint so that the plastic buckles are positioned towards the patient. Infant sized splints will orient the strap towards the patient.
3. Adjust the splint to the desired position on the limb. The splint should be centered over the elbow with the opening towards the inside of the arm. For leg application, the splint should be centered over the knee with the opening towards the front of the leg.
4. Secure the splint by threading the hook-and-loop strap through the plastic buckle and securing back onto itself. To secure an infant sized splint, wrap the hook and loop strap around the limb and attach to the corresponding hook and loop strip. Leave enough room to easily insert two fingers between the device and the patient's limb to maintain adequate circulation.

Optional

5. To reduce the splint size [i.e. for a limb that is in between sizes), fold the outside panel with hook-and-loop towards the inner lining, minimizing the splint width. Continue by following steps 2-4 as described above.

Clip Application:

The optional clips (Fig.1) connect the splint to the patient's sleeve and help prevent the splint from sliding off the patient's arm.

1. To open, grasp the prong portion of the clip and twist clockwise (Figs. 2 and 3).
2. Separate prongs (Fig. 4) and insert clip through splint loop (Fig. 5). To close, grasp the prong portion of the clip and twist counterclockwise.
3. Clip to patient's sleeve squeezing sides of clip to open, and release to secure (Figs. 6 and 7).


Fig. 1


Fig. 2


Fig. 3

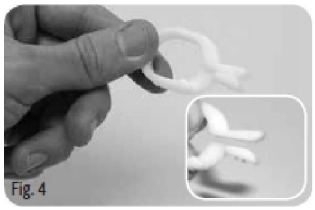
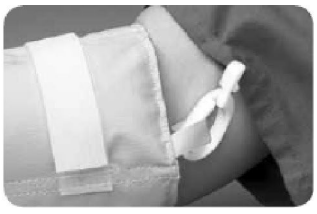


Fig. 4


Fig. 5


Fig. 6


Fig. 7



Monitor skin condition frequently, DO NOT overtighten or impair circulation!

Metal attachment clip may trigger alarm.

NEVER alter or repair this product. ALWAYS inspect before each use: Check for broken stitches or parts; torn, cut or frayed material; or hook and loop fasteners that do not hold securely. DO NOT USE soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

DO NOT allow patients to ingest product material.

Storage and Handling

This device is designed for use in normal indoor environments. This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

Laundering Instructions:

M [Q]

WASH LUKEWARM BLEACH "HASDI E&TED DRY LDRY

Posey Company • 5635 Peck Road. Arcadia. CA 91006-0020 USA • www.posey.com
Phone: 1.800.447.6739 or 1.626.448.1143 • Fax: 1.800.767.1933 or 1.626.443.5014

Posey® Limb Holders 2532, 2551

Application Instructions for Wrist and Ankle

Pose Y

Rx ONLY

DESCRIPJ ON OF PRODUCT: imb holder for limiting timb movement. For bed and stretcher use only.

Indkations f:or Use

- Pa ents assesse:I to be at **risk** of dis rupting life-saving treatme nh (e.g_ pullil"lg tu bes or lines) or in danger of injury to themselves or to others,
- Follo w your h pitafa restrai policies and pmoo::lures which a re in oompli anoe with OMS guidelines and state laws.

Contra indications

Do not se this device with somro ne who hasconti nued highly aggressive oroombati¥e behavior;self-destru· <e behavio r, or deemed to be an im mediate ris k to ot he rs **or** to self.

Applicatiion Instructions

Follo w these stepsto apply device (repeats teps1-7on each side}:

Fig. 1

1a. Attach the female end of the quick-release buckle (,... ortstrap to t e rame th at moves l Mth the patie (Fig, 1), out of t he patie nt's reach (do not afuldh to side rail or head/foo tboord). You may also wrap the connecting strap once around the frame to move lJhe buckle o ut of lJhe patient's reach_ Sect.J reby feeding the female end rough the loop i n e st P-

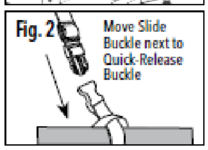


Fig. 2

1h lnserti:h e male e d of the connecting p into the femaleend ofl:he shortstrap. Liste n fo r a "snapping" sound Pull firmly o n the stra ps o ensure a good con ection. Mo ve the s lide buckle next ·o the male end of the quick relea se buckle to prevent the st rap from lo= ing (Fiig. 2).

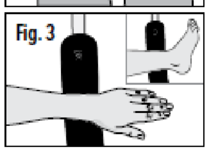


Fig. 3

2 Wrapthe limbho lde r cuff around the patient's wrist/a nkle sothe buokle and connectingstrap is on the ulnarside of the wrist or lai:eral mallro lus of the a kle _ (Fiig 3)_

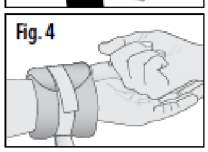
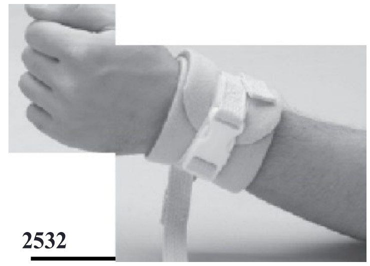


Fig. 4



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Posey Limb Hol!de:rs

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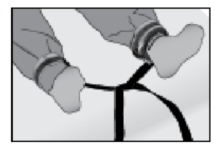
2551 Quid,-Rele.a:ie Quilted Limb Ho lder.,, singlestra with quick-release oonnecting strap

To limit low er Lillilh range of m oti onforlegs:



1. Attach the oufft hat is secured i:o e bottom rights i e o ft he frame i:o the lefl anl-/le.
2. Crisscross lJhe straps and attach the cuff seoured to the bottom leftside of he frame i:o the right an kle.
3. Adjust oon necting st ps as necessary

Precaut ions

- Avoid using on a patien t with a dis locatio n o r fracture on the reslrained limb, or if an 1V o r wom d site could be compromised by the device.
- Check the patient regularly to ensure that oircula on is no impaired. Serio us inj ry may occur if the cuffs restricts ciroulabion when lhe limb holde r is applied.
- **M-w j: l lJ I©** riefore each use, oheck cu ffs and straps for oracks, tears,

Secure e hook-a nd loo p f.astena-:Slid e ONE finger (flat) ba'ween the cuff a nd the inside of the patient's wrist/ankle to ensure proper fit (Fig 4). The strap must be snug, but not compromise circulation.

4. C ose the quick-release buckle on the cuff. Inserl ONE finger (flat) under the buckle and pull the strap snug, but not so tight as to rict cin::ulalion (Fig 5).

5. Re lease the quick-release buckle, twist buckle 180°, and reconnect (Fig 6). Listen for a "snapping" soond.

6. Attach the "hook" end of the cuff strap to ihe "fuzzy backing on ihe ouff to keep the quick-release buckle from sliding (Fig 7).

F=a=J

7. Adjust the sbrap to allow for desired freedom of m01/€IDS7t, without compromising patient or caregiver safety.

To remove cuffs: Unsnap quick-release buckles and release hook-and-loop fastenern.

and/or exoessive wear or stretdh, broken buckles or locks, and/or that hook-and-loop adh esseouretyas llhese may allow patient to remove Cliff []iocard if device is damaged or if unable to lock

- M!N ┘tl /@ Additional or different body a. limb restr.iints may be needed (See P:osey Catalog):
  - If lhe patient pulls violently against the beds traps.
  - To reduce the risk of the patient gelling acoess to the 6ne/ wound/ tube site.
  - To prevent the patient from flailing or bucking up and down and ca Gi ng self-injury.

Bed Safety

Refer to the Food and []rug Adminisi:r-a on (FDA) for the most recent Hospital Bed Safety Guidelines as well as the Bed Manufacturer for U4 r Instructions for U:,e.

ADDm ONA! SA.Fm AN IAUNM J ING INSTRUCTIONS ON OTHER SI E

_._.ull l'osey Products, LLC • !lfil5 Peck Road, Area-dia, CA !M006-00.20 USA
l'hone: 11100 447 6739 • fax: L800.767 39i33 • lwm .posey.com

E o .IRP .lSch P-'DS.SQ mCH D-30_7H,-J"lrnb'.'e:f, (t:

TIDI Support Caregivers. Protect Patients.

192:77 REVC 120318

USP<800> "Handling Hazardous Drugs"

WHY

1. Establishes safety practice and quality standards for handling hazardous drugs
2. Promotes patient safety, **EMPLOYEE SAFETY,** and environmental protection
3. Alerts staff to the safety hazards of handling specific drugs

WHAT

Hazardous Drug Class A

- Use a single pair of nitrile/chemo gloves to administer, cut, crush, or open a capsule
- Use a sealed bag when crushing is necessary

Hazardous Drug Class B

- Use a single pair of nitrile/chemo gloves to administer or adjust the volume
- Wear a gown, mask, and eye protection when there is a risk for splash

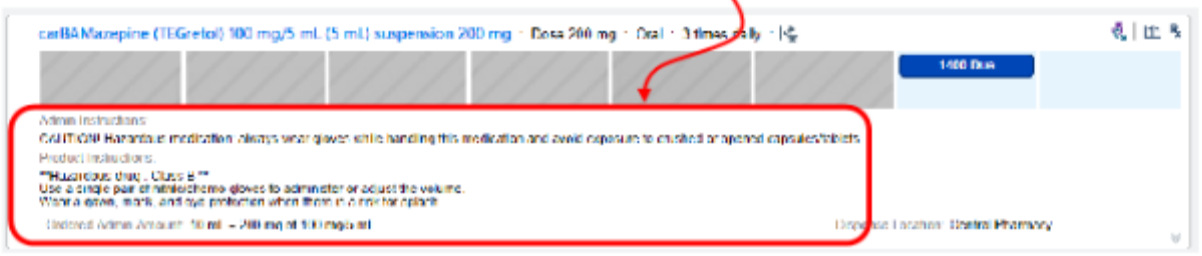
Hazardous Drug Class C

- Use a single pair of nitrile/chemo gloves to administer oral solid drugs in this class
- Wear TWO pairs of nitrile/chemo gloves and a chemo gown when administering any other form of drug in this class
- Wear a mask, and eye protection when there is a risk for splash
- Do NOT manipulate (cut, crush, open, or adjust volume) the final dosage form

HOW

Utilize appropriate PPE when handling Hazardous Drugs:

1. Pyxis prompt will alert staff if a Hazardous Drug is pulled
2. An eMAR "popup" will alert staff to the required PPE for handling and administration of the specific class of Hazardous Drugs that are being given



HCCA USP 800

Background:
"provides standards for safe handling of hazardous drugs to minimize the risk of exposure to healthcare personnel, patients and the environment."

PPE Demonstration

USP800 information

Must know your HCA login credentials to use QR code

USP 800 Standards

Know the location of the following

- Safety Data Sheets
- Policies
- Hazardous Waste Policy (Spills & Waste)
- Appropriate PPE
- Fertility Implications
- KNOW YOUR RESOURCES –
  Hazardous Drug Coordinator

Please watch the provided
PPE Demonstration and USP 800 guidelines

HCA Healthcare | Far West Division

USP 800: Safe Handling of Hazardous Drugs

Category 'A' Category 'B' Category 'C'

Transporting Medication

Category 'A'—Do NOT tube any antineoplastic medication in any form
Category 'A & B'—RN will transport via medication cup/standard packaging while wearing gloves
Category 'C'—RN will transport via transport containers to prevent spillage/leakage

Cleaning Spills

Spill Cleaning Steps
- Prevent spreading- signage and quarantine the area
- Obtain Spill Kit
- Don PPE
- Clean spill using kit contents
- Dispose of spill kit in Black Waste Bins
- Call EVS to clean spill area

Category 'A'—routine cleaning, utilize spill cleaning steps
Category 'B & C'—Less than 5 mls about 3in circle diameter
- Utilize spill cleaning steps
- Call Spill Response Team

Disposal of Medication

Category 'A'—all material into regular trash
Category 'B &C'—place all material in to Yellow HD Bags, then place into the yellow trash bin or black trash bin.
- Yellow Bin—medium and high-risk drugs greater than 3% of original wt/volume remains
- Black "bulk"—medium and high-risk drugs greater than 3% of original wt/volume remains

Donning and Doffing PPE

Category 'B'—2 pairs of chemo gloves will be worn for all dose forms, if risk for splash-wear a gown and eye protection. Wear a mask for handling powder,
Follow CDC standards sequence for donning and doffing PPE.
Wash hands with soap and water

Administration

Category 'A'—wear one pair chemo gloves
- Crushed or split tablets in pharmacy and wear N95 mask

Category 'B'—IV-wear 2 pairs chemo gloves, gown, and Eye protection
- Tablets 2 pair chemo gloves, crushed/split in pharmacy
- Oral Solution- 2 pairs chemo gloves, gown, eye protection

Category 'C'—IV, IM, SubQ, -- 2 pairs chemo gloves, gown, eye protection and mask
- IV Tubing primed and attached in pharmacy, closed system transfer device in use

Miscellaneous

Meditech alerts on the EMAR by expanding the label comments
Location of resources- SDS, Pyxis Clinical Alerts, USP800 P/P

Posey® Double Security Mitts
Application Instructions

Posey®

Rx ONLY

DESCRIPTION OF PRODUCT: Padded mitts without finger separator.,. Co11necti11g straps *(for hospital bed use only).*

Indications for Use

- Patie11ts assessed to be at risk of disrupting life-saving treatme11ts (e.g. , chmnic Me pulling).
- Patie11ts assessed to be at risk of line pulling, wrnich may prevent monitoring of vital sig11s.
- Patie11ts whose pic ing, pulli11g scratching or eeling exacerbates a s ni rnndition, causes self-injmy, orcompmmises wou11d site i11t egriity.

Contraindications

- **DO NOT** use on a patient who is or I:Jemmes highly aggressive, combative, agitated, o, suicidal.
- **NEVER** use mitts 011 a patient
  - IIf an IV or wound silE could Ibe compromised by the device; or
  - With a dislocation or fracturn on the affected! limlb.

See the Posey Catalog fur other ptio11s fur sudl a patiernt.

Adverse Reactions

Severn emotional, psydhobgica'.l, or physical prol:Jlems may occur: if the

app'liedldevice is uncomfortable; o, if it severely limits movement If sym ptoms of these prob'lems ever appear fo, arny Ireaoon, get help from a quali ied medical authority and li11dl a lle ss restrictive pf<Xluct or i11terventio11i.

Application Instructions

(Repeat Steps 1-4 to, each rnittj:

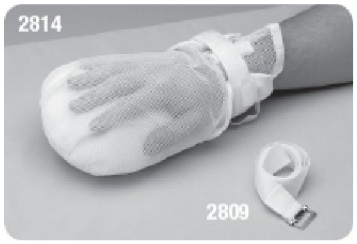
1. Insert tile patient's hand irnto tile mitt, palm down.
2. Wrap the wrist strap around the smallestpart of the patient's wrist over the top of the wrist, tllmugh the plastic rimgi, and secure it ornto iitself.
3. Bri119 the second ho□kstrap over the top of the lo p strap to fu.rna "doul:Jle security" closure.
4. Slide Or.JE finger Ia between the device arnd tile irnside of tile patient's wrist to ensure proper fit. Tne strap must l:Je snug, l:Jut not compromise ci.culatio11.

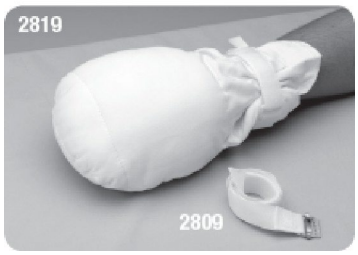
Note: Follow steps 5-6 for use of o,ptional mitt mnrnecting strap !hospital bed use only) to help prevenHhe patient Irom removirng the device or inflicting self-injury:

5. Wrap the strap around the patient's wrist or pass it tllrougll tile l'oops on the mitt.
6. U'se Posey Quick-Release lle (see drawings on reverse) to secl!Jre the erndl of the strap to a movable part m tile bed frame. lle strap at a poirnt midway between tile patiernt's wrist arnd elbow, out of the patient's reach.

fiWi•@ it© ADDrTIONAIL OR DIff IERBNT BODY OR LIMB RESTRP/I:..TS **MAY** BE INBEDBD(See Posey Catalog):

- If the patiem pulls vidlelltiy againrst the bed sl@lls;.
- To reduce the risk of !he patiem getting access to !he line/woundtitube site;
- To prevent the patiem Irom flailing o, bucking up cllidi down and rausing seW-imjury.





Posey FingerControl Mitts

2814 Double SooJilty Mitts
1!!!!!12819 Double IPaddOO I, liil'.lub kl Seourlty Mitts
29J9 Mitt CGnnectlng strap

MONITOR PER FACILITY POLICY. Clileck to ensure llilat:

- Con11ecting straps eamnot slide in amy direction or loosen if tile patient pulls on them, o, if the bed is adjusted;
- Mitts and straps are pmpe,ly secured. If applied too lightly, oirculalim will be restricted; iif applied too loosely, the patient may be able to slip his or her limb from tile device;.
- Mitts are intact, not tom or damaged, and hook arndl loop closes secure'ly. DO NOT allow patients to irngest mitt materia11;
- The patiernt canrnot use his or her teeth or otherwse ramove the device arndl inflict self-injury;
- Monitor closely when tile patient is out of bed. I?atiernts who ambulate while wearing this device may be at risk m imjLHY from a fall.

BED SAFETY

- **ALWAYS** use Hospital Bed Safety Workgroulp (HBSVIJ) (htt :/lwww.fda.gov search keyw,o d "HBSW") compli ants side rails in tile UP posibion and fill All gaps to .educe the isk mentrapme11t.
- U'se side rail rnver., and gap protectors to help prevent the patie11t's body Irom going umder, amund, through or between tile side rails. A faillure to do so may result in serious Injul'Y or death if a patient becomes suspended or ernntrap,ped. Posey offers a full ra11ge of side ralil pads and 1of gap protecto.s to cover gaps.

ADDITIONAL SAFETY AIID LAUNDERIUG rnSTIIUCTIONS ON OTHER SIDE

..u..Jl Posey Comparry • 5635 Pock RoflJ, IIIcadla, CA 91oas-002a USA

• Phone: 11.Ba0.447.6739 • 1 626.443.3143• Fax: 1.8a .767.3933 • www.posey.oom

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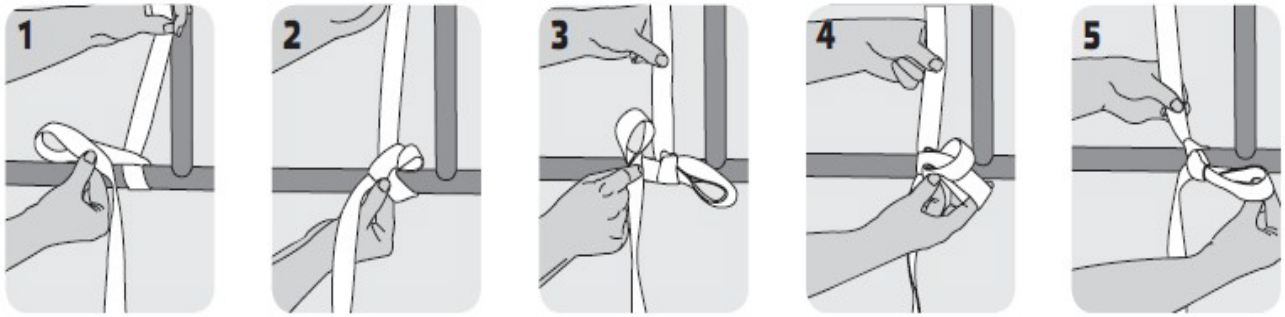
How to tie a quick release knot



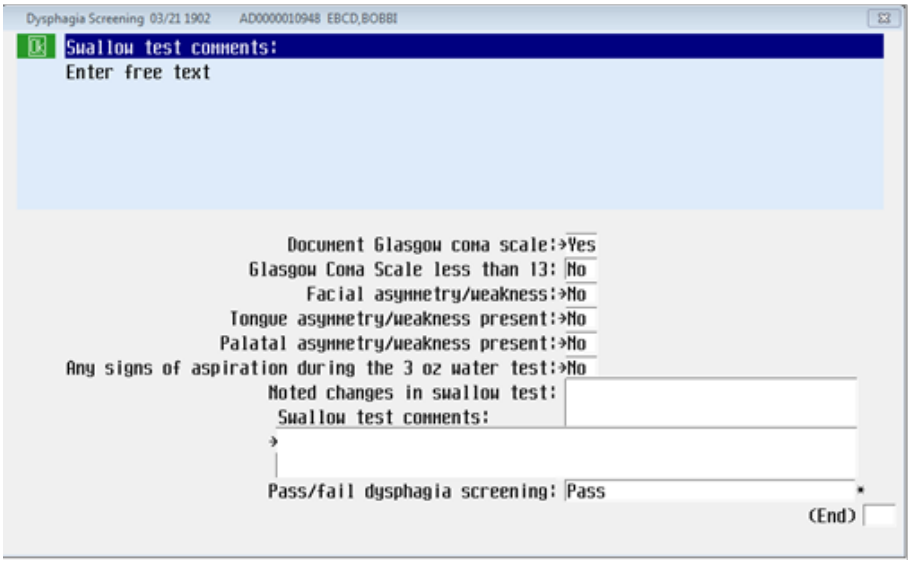
1. Wrap the strap once around a movable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.
2. Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.
6. Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.

Quick Guide to Dysphagia Screening Process…….

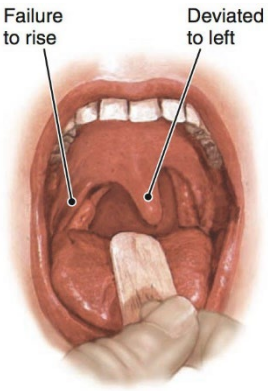
Patients who are NOT candidates for Dysphagia Screening:

- Medically unstable
- Non-responsive
- Intubated
- Patients who have been recently extubated following an intubation time of more than 48 hours
- Patient is unable to remain alert for testing
- Head of bed is restricted to less than 30 degrees
- Patient is currently eating a modified diet secondary to dysphagia
- Patient has a tracheostomy tube in place

Select **"Add Intervention" for "Dysphagia Screening"** in Process Interventions of Meditech……..



- **Assess the Glasgow Coma Scale** – score patient in categories of **Eye opening, Verbal and Motor response**. **If GCS is less than 13, the screening may NOT be performed**.
- To **assess** for **Facial asymmetry / weakness**: have patient smile. Observe for equal facial symmetry
- To **assess** for **Tongue asymmetry / weakness**: have patient stick tongue out and move side to side. Observe for controlled tongue movement and symmetry
- To **assess** for **Palatal asymmetry / weakness**: have patient open mouth and say "Aaah…" Observe for uvula to be midline and NOT pulled over to one side.
- To **assess for Signs/Symptoms of Aspiration during the 3oz. (90ml) water test**: have patient drink 3oz (90ml) of **water only** without taking any breaths in between sequential swallows: observe for:
  - Coughing during or right after drinking
  - Wet or gurgly sounding voice during or after drinking
  - Extra effort or time needed to swallow
  - Liquid leaking from the mouth or getting stuck in the mouth
  - Chest congestion after drinking



Example of Palatal Asymmetry

*** **If patient is unable to pass any part of the screening, this is a *FAILED* screening. The patient should remain NPO and an order should be obtained for a Dysphagia Evaluation (Bedside Swallow) from the Speech Language Pathologist (Speech Therapist).**

Source Document

Competency Title:	**ORIGINATED**	9/2018
General Equipment Cleaning	**REVISED:**	10/2019; 12/20
	REVIEWED:	
	Author: Education	

Competency Statement: Staff will demonstrate proper cleaning of shared equipment using appropriate germicidal wipes, keeping surfaces wet for the appropriate amount of time.

PERFORMANCE CRITERIA AND KEY ELEMENTS

To prevent cross contamination between patients, shared equipment is maintained in good working condition and cleaned after each patient use:

Each piece of equipment is inspected for safety and found to be in good condition (no adhesive or scotch tape) prior to cleaning and patient use.

Cleaning is done with hospital approved germicidal wipes according to the manufacturer's guidelines.

- **Pay close attention to the contact (dwell) time found on each container.*

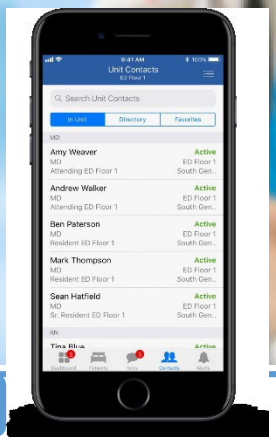
Non-SPD equipment is cleaned with hospital-approved germicidal wipes; for deeply soiled equipment, a germicidal solution is poured onto a cloth for cleaning (dwell or "wet" time should be per manufacturer's recommendation as shown on disinfectant instructions for use) prior to using that machine/equipment with a patient.

Procedure:

- Clean hands and don gloves before beginning to clean.
- Wipe the exterior surfaces of equipment (including any cords). Use cotton applicators/pipe cleaners for hard to reach areas.
- All surfaces must remain visibly wet for the full amount of dwell time as indicated on the wipes container.
- If the surface dries before the end of the dwell time, wet the surface again with another wipe.
- Allow to air dry – do not wipe to dry.
- Examples of equipment: Wheelchair, Lift Equipment, Bedside Commode, Walker, Cane, etc.
- Bleach wipes are used on equipment after contact with a patient in contact plus isolation (C. Difficile). Keep surfaces wet for 5 minutes - you may need to re-wipe the surface to keep it wet for 5 minutes.
  - **NOTE:** the dwell time on the Bleach container is 4 minutes but our policy is a 5 minutes dwell time.
- Certain types of equipment may require cleaning with specialty wipes (green top, gray top, etc.) - check with your leadership to learn if there are any special cleaning requirements in your department.

RCH Policy IC.103 Cleaning Patient Equipment

iMobile Device Cleaning and Disinfection Guidelines



When to Disinfect

- At the start of the shift
- At the end of the shift
- When visibly soiled

Using the device when entering a patient's room? Sanitize **after** hand hygiene and donning gloves

Did you use the device while in the patient's room? Sanitize the device **before** removing gloves

How to Disinfect

Start/End of Shift

- Remove the otter box
- Wipe all surfaces of the otter box cover thoroughly using **SuperSani** Prime or **Bleach Wipes**
- Allow the surfaces to dry completely
- Wipe any residue away
- Replace the otter box

During Shift

- Leave the phone in its cover
- Wipe all surfaces of the otter box cover using Super Sani or Bleach Wipes
- Allow the surfaces to dry completely
- Wipe any residue away

Note: A residual haze or film may reduce visibility and touch friction contact. Remove residue with an alcohol pad.

Isolation Precautions

Disinfection Practices for Patients in Isolation Precautions:

Use in an isolation room is not recommended if it can be avoided. In the event the device must be in use in isolation, follow this guidance:

- If the mobile device is in use upon entry of a patient's room, sanitize the device **after** hand hygiene and donning gloves and gown
- If the mobile device was in use or accessed while in a patient's room, sanitize the device **before** removing gloves and gown

Devices should be regularly disinfected between use in patient rooms or care areas to reduce the risk of tra
When using wipes, please wear gloves to protect your hands from exposure to disinfectant chemicals.

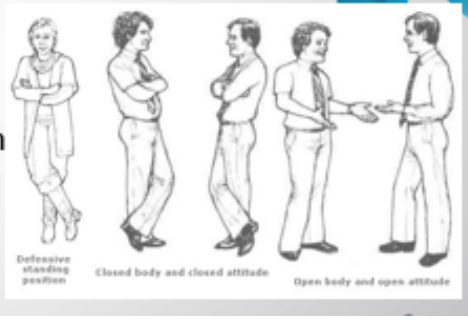
Recognize Potential for Violence

- Look out for various levels of threatening behavior:
  - Intimidating gestures
  - Bullying
  - Harassment
  - Talking loudly, yelling
  - Actual threats of violence
  - Increased agitation or physical signs (staring, clenched fists, etc)

De-escalating a Situation

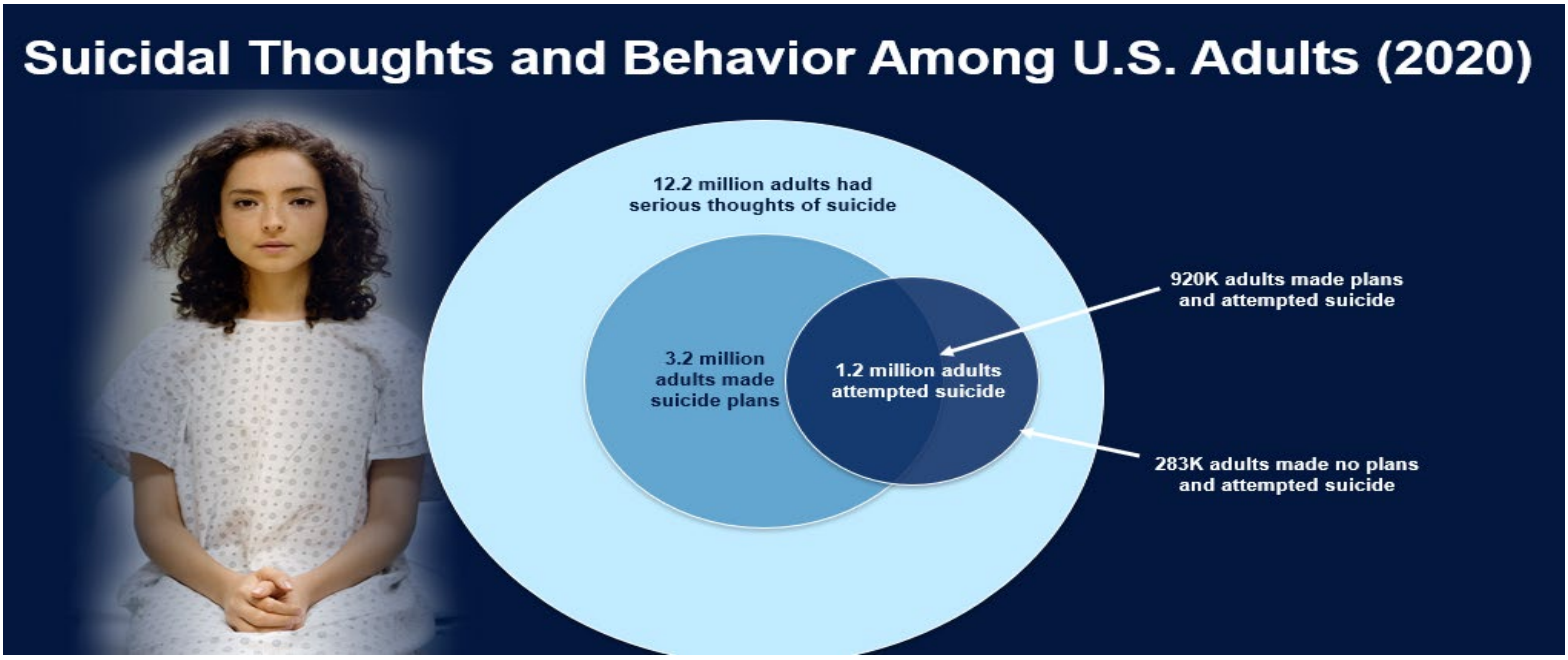
Strategies to Avoid Harm:

- Listen and be empathetic
- Talk slowly and calmly, ask questions to clarify their concerns
- Be aware of your body language
- Avoid arguments and get help from your supervisor
- Call a Security Alert, Security Assistance needed, if unable to de-escalate the situation



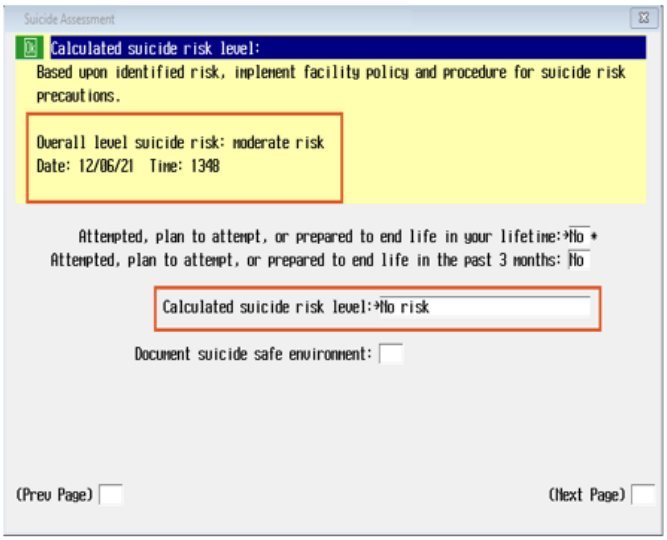
Watch Out / Avoiding Harm

- Always face the person
- If possible, be sure you have a clear path to the exit / door
- Be aware of objects in the area that can be used as a weapon
- Bring help or get another staff member for support
- Call a Security Alert, Security Assistance needed, if unable to de-escalate the situation



Documentation Considerations

- The Overall suicide risk level will appear in the yellow information box or show no data
- New Overall level of suicide risk
- The **Overall suicide risk level** is determined utilizing the *Calculated suicide risk level* and other assessments.
    - It may end up being different than the singular Calculated suicide risk level once all factors have been assessed by the provider



Initial RN screening of a patient being evaluated for a BH chief complaint yields a "positive" result for suicidal ideation. Safety measures (as defined by facility policy) should be appropriately implemented for management of at risk for Patients.

Interventions for Moderate to High Risk Levels

INTERVENTIONS	No-Risk	Low Risk	Moderate Risk	High Risk
Provider/Practitioner Notified		X	X	X
Physical PSA in Place (1:1)				X
Line of Sight/Virtual PSA (if available; if not, escalate to sitter)			X *Only if the ideation is without method/ plan / intent within the past month. Not required if the ideation is within a lifetime only.*	
Re-assessment by the provider daily, with a change in patient condition and prior to discharge		X	X	X
Suicide Safe Environmental Checklist Every Shift and as needed with a Change in Patient Condition			X	X
Suicide Interventions Implemented			X *(See next slide)*	X *(See next slide)*

Additional Interventions for Moderate to High Risk Levels

SUICIDE INTERVENTIONS	MODERATE RISK-LIFETIME	MODERATE RISK-PAST MONTH	HIGH RISK
Suicide Safe Environment Checklist initiated	X (once per shift only)	X	X
Paper scrubs or scrubs without ties		X	X
Remove ligature risks that are not essential to patient care (e.g. unnecessary cords removed gloves removed, nurse call cords secured)		X	X
Electric beds disables/unplugged		X	X
Remove/secure sharp items		X	X
Remove extra bed linens and towels that are not in use		X	X
Remove plastic trash liners in trash cans and obtain paper liners		X	X
Implement dietary safe environment orders (as appropriate)		X	X
Confirm "safe tray" has been ordered for meals		X	X
Curtains removed/secured		X	X
Request behavioral health consult		X	X
Referral to outpatient behavioral health upon discharge		X	X

Source Document

Competency Title:	**ORIGINATED:**	3/2017
Welch Allyn Connex Spot Monitor	**REVISED:**	
	REVIEWED:	
	Author: Education Department	

Competency Statement:
RCH staff members following education will be able to demonstrate the ability to obtain vital signs and transmitting the data to EMR – Electronic Medical Record, utilizing the Welch Allyn Connex Spot Monitor.

PERFORMANCE CRITERIA AND KEY ELEMENTS

Power Button and Battery Status

Power button

- Located on the device housing
- Powers up the monitor
- Opens pop-up dialog with controls to sign out, power down, and enter Sleep mode

Power down

1. Touch the power button.
2. Touch **Power down**.

Battery status

		
Charging	Approximate operating time remaining	Battery removed or not holding a charge

Clinician Login and Patient Identification

Clinician Login

1. Confirm connectivity to Wi-Fi
2. Touch the medical icon 
3. Scan your badge
4. Enter your password and touch **OK**
5. Touch **Sign in** to search for clinician name and return to the Home tab

Patient Identification

Scan the patient's wristband. The patient's name and ID appears at the top of the screen.

Spot Profile – Taking Vital Signs

① **Medical icon**

Touch  to log in as clinician
Scan the patient's wristband.

② **Start/Stop blood pressure**

③ **Modifiers entry**

Touch the modifiers frame to manually enter modifiers or required items

④ **Clear patient data**

Touch **Clear** to delete all measurements from the Home tab without saving them

⑤ **Next/Save**

Touch **Next** to advance to the modifiers screen or to save and send readings after you enter all required information into the device.
Next changes to **Save** following required data entry.

Taking a Temperature

1. Remove the temperature probe from the probe well
2. Insert the probe into a new probe cover and press the probe handle down firmly.
3. Touch the **Temperature site control** to select the measurement site: oral, pediatric axillary, or adult axillary.
4. Hold the probe tip in place at the measurement site. The monitor sounds a tone when the final temperature is obtained (approximately 6 to 15 seconds).

Icon	Description
	Pediatric axillary
	Adult axillary
	Oral

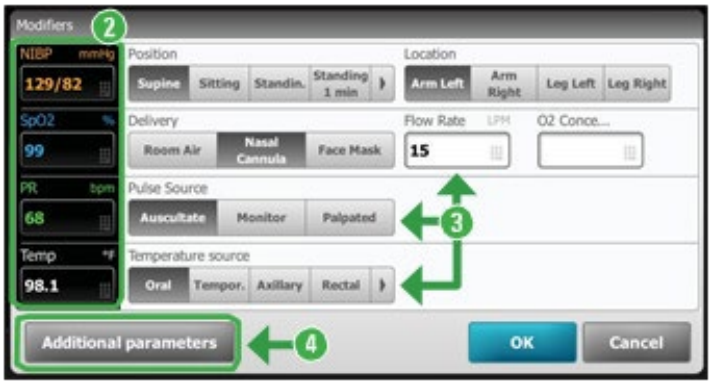
To ensure optimal accuracy, always confirm that the correct mode and site are selected

Enter Required Patient Modifiers, Additional Parameters, and MEWS

① Touch the modifiers frame on the Home tab.

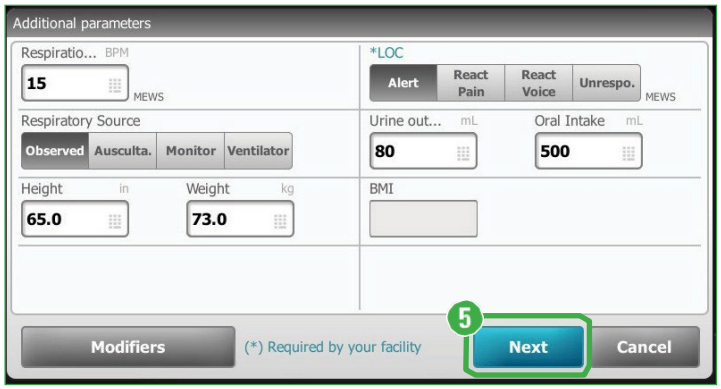
② Touch vital sign reading to manually enter different vital signs readings.

③ Select the desired modifiers from list (touch to expand some lists), or manually enter readings.

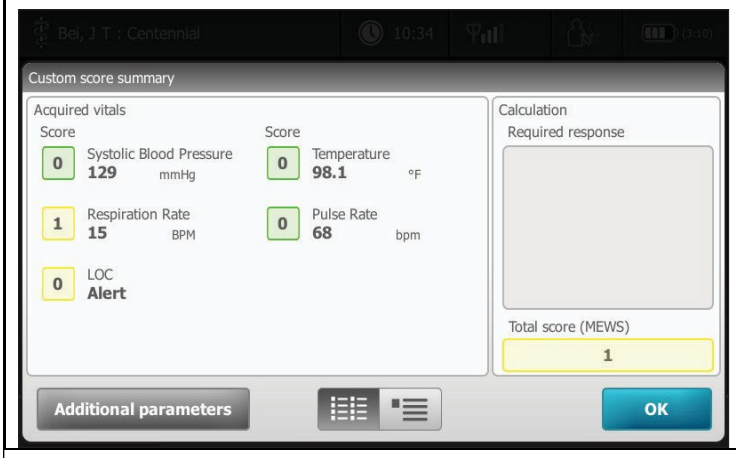


④ Touch **Additional parameters** to include additional parameters and modifiers in the Early Warning Score calculations. Be sure to include any required items.

⑤ Touch **Next** to calculate Early Warning Scores and open the Custom score summary.



Early Warning Scores



The custom score summary appears after you enter modifiers and additional parameters. This screen displays individual parameter scores, an overall patient score, and a clinician message.

Click **OK** to return to the Home tab.

Save Data to EMR – Electronic Medical Record (Meditech)

After you enter all REQUIRED parameters and modifiers and also collect or manually enter patient readings, touch Save on the Home tab to save and send the readings to the Electronic Medical Record – EMR (Meditech)

Interval Mode

① **Change profile**
1. Touch the profile indicator in the Device Status area.
2. Touch the desired profile. The tabs associated with that profile appear across the bottom of the screen.

② **Start/Stop blood pressure**

③ **Start intervals**
1. On the Home tab, touch 
2. Select **Automatic**, **Stat**, or **Program**, and enter or select desired settings.
3. Touch **Start Intervals**.

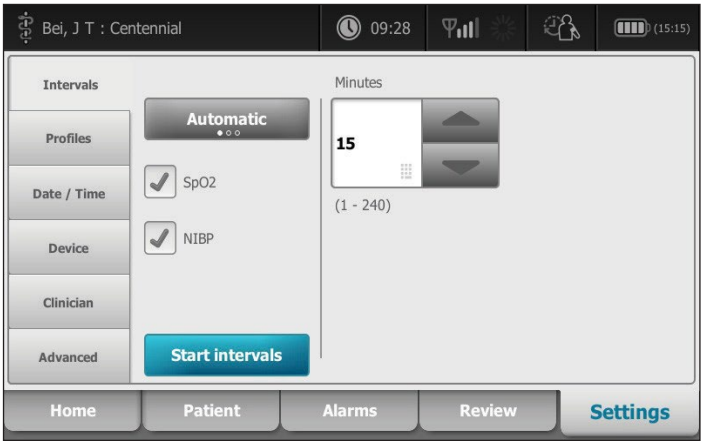
④ **Stop intervals**
1. On the Home tab, touch 

2. Touch **Stop intervals**.

* To access modifiers while in intervals, press and hold any parameter frame.

Start BP Automatic and Program intervals

For <u>Automatic</u> intervals:

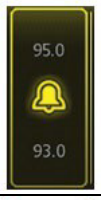


1. Properly size the blood pressure cuff and position it around the patient's bare upper arm.
2. On the Home tab, touch  . The Intervals tab appears (shown)
3. Toggle the intervals type button until it displays **Automatic**. (Options are **Automatic**, **Program**, and **Stat**)
4. Adjust the desired time by using the arrows or touching the box and manually entering the time.
5. Touch **Start intervals**.

For Program intervals:

1. Properly size the blood pressure cuff and position it around the patient's bare upper arm.
2. On the Home tab, touch  . The Intervals tab appears (shown)
3. Toggle the intervals type button until it displays **Program**. (Options are **Automatic**, **Program**, and **Stat**)
4. Select the preselected program or an unassigned one. If unassigned, you can name the program and manually enter the frequency and duration of a different protocol.
5. Touch **Start intervals**.

Alarm indicators and controls

	Alarm off No Visual and audio notifications are enabled.
	Alarm on Visual and audio notifications are enabled.
	Alarm audio off Only visual notifications are enabled.
	Alarm audio paused Countdown timer is active.
	Alarm active Touch to pause or silence.
	Multiple alarms active Touch to pause of silence.
	Medium priority alarm Touch to adjust alarm limits or turn off alarm.
	High priority alarm Touch to adjust alarm limits or turn off alarm.

To adjust high/low alarm settings for pulse rate in the Interval mode

1. In the Interval mode, you can adjust the high/low alarm settings of the BP, Pulse, and SpO2.
2. Press on the Alarm icon, and adjust accordingly.

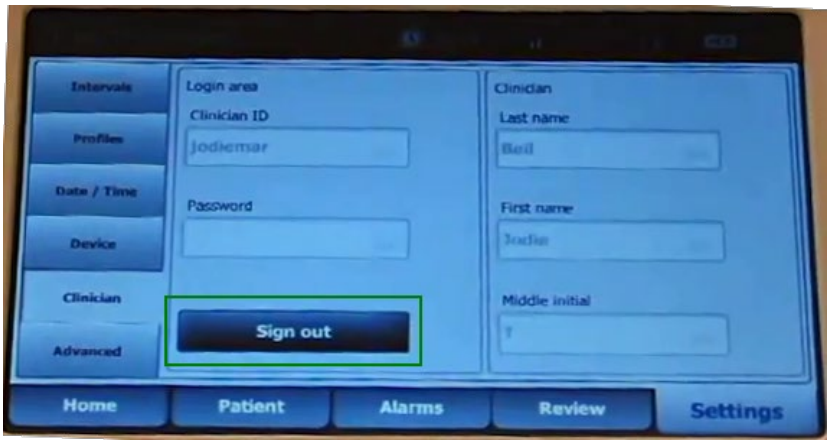
Save Interval Data to EMR – Electronic Medical Record (Meditech)

Patient records can be printed or deleted.

1. Touch the **Review** tab.
2. Select records by touching the check box next to each desired patient name.
3. Touch **Send** to transmit the records to the network or **Delete** to permanently remove the records.

The **Review** tab displays patient data that has been previously captured. Data can be viewed for a single patient or for multiple patients. Patient measurements older than 24 hours are automatically deleted from the patient records list on the Review tab. The monitor will store up to 400 readings in memory.

Logging Off and Turning Off the device



1. Touch the medical icon  on the left upper corner of the Home screen.
2. Press **Sign out**.

You can also touch **Power** button
A dialog box appears with options:

- Sign out
- Power down
- Sleep
- Cancel

Touch one of the options.

Cleaning the Device

Follow the cleaning agent manufacturer's instructions to prepare solution, if applicable, and clean all exposed surfaces of the monitor, Accessory Power Management (APM) work surface, accessory bin(s) and basket, cords and cables, and stand. Wipe all surfaces until no visible soil remains. Change the wipe or cloth throughout the cleaning procedure as needed.

1. Disconnect the AC power cord from the main outlet.
2. Wipe the top of the monitor.
3. Wipe the sides, front, and rear of the monitor.
4. Avoid residual film buildup on the LCD screen by periodically wiping the LCD screen with a cloth dampened with water (following the cleaner/disinfectant wipe) and wiping the screen dry with a clean cloth.
5. Wipe the bottom of monitor.
6. Wipe the APM work surface.
7. Wipe the accessory bins or basket.
8. Wipe the AC power cord and the APM work surface power/USB cable assembly.
9. Wipe the stand from top to bottom.

CAUTION Do not use unapproved cleaning agents. Use of unapproved cleaning agents may cause damage to components.

Cleaning Agent Approved for all Connex Spot Monitor components
Accel INTERVention, Accel TB, CaviWipes, Clinell® Universal Wipes, Oxiver TB, Sani-Cloth® Plus, Super Sani-Cloth®, 70 percent isopropyl alcohol solution Applied to a clean cloth

References:

Welch Allyn Connex Spot Monitor Quick Reference Card 80019624 Ver. A. Revision date: 2014-12
HCA HealthStream course "Welch Allyn Spot Monitor Clinical Training Video" – 3/2017
Welch Allyn User Manual, Ver. M, Revised 2015-10

Fall Risk Assessment/Prevention Guide

(Fall Assessment and Interventions Policy PC.152)

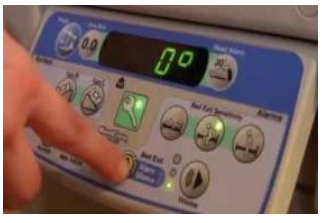
Fall Risk Assessment ***Admission/Every Shift/Change in Condition***	**Fall Prevention**
Consider the following:	**For *EVERY* Patient:**
Previous falls	Bed in lowest position
Reduced vision	Side rails up (3 max)
Unsteady gait muscle atrophy, balance or posture issues	Call light within reach
Mental status confused, understanding or memory issues	Knows how to call for help
Acute illnesses seizure, hypotension, stroke, etc.	Belongings/side table close
Chronic illnesses dementia, arthritis, cataracts, Parkinson's, etc.	Educate about fall risk
Medications (affecting CNS) conscious sedation, pain meds, etc.	Reminders to call for help
Special circumstances ID'd by the RN	

If HIGH fall risk…Falling Star
Yellow non-skid socks
Fall Risk ID band
Star Magnet on Door (Vintage)
Room Placard Pulled (G Tower)
Bed Alarm - ON
Consider room close to Nurse's Station or camera if HIGH Risk

Hand-Off

Don't Forget….AIDET & Update ***Whiteboard***

Fall Prevention	iTRACE
Fall Risk Assessment: ***Admission/Every Shift/Change in Condition***	**Together, trace all lines & tubes from patient outward**
Bed in lowest position	IV site(s): *Peripheral / Central*
Side rails up (3 max)	Bio-Patch in place correctly
Call light within reach	Dressing dry, intact and labeled
Knows how to call for help	Tubing attached correctly
Belongings/side table close	Tubing labeled
Educate about fall risk	Pump set correctly
Reminders to call for help	IVs hanging - correct & labeled
If HIGH fall risk…Falling Star	Foley Catheter secured-*Statlock*
Yellow non-skid socks	Clipped to bed
Fall Risk ID Band	No dependent loops
Star Magnet on Door (Vintage)	Seal intact
Room Placard Pulled (G Tower)	Bag emptied & labeled/dated
Bed Alarm - ON	Foley care documented
Consider room closer to Station or camera if HIGH Risk	Assess other drains/tubes from the patient outward.












Tubing & Line Connection Safety Using

I-TRACE

These recommendations describe actions undertaken by clinicians who initiate, access, maintain, or discontinue invasive lines and tubes. Lines and tubes include, but may not be limited to, parenteral, enteral, respiratory, gastrointestinal, and urinary devices.

I **Illuminate** the patient care area whenever invasive medical lines and tubes are manipulated (initiated, accessed, maintained, or discontinued).

T Perform hand hygiene. **Touch** the line or tube and **Trace** it from the insertion point on the patient back to the point of origin.

R Perform a cognitive **Review**. Think about the purpose and expected outcome of the actions you are about to perform. When line access or connection involves medication delivery, use defined BCMA processes or follow facility guidelines to ensure medication is checked against the medication administration record or prescriber order.

A **Act** if any mismatch between the planned activity and desired outcome is discovered, either through BCMA alerts, independent double checks, or a cognitive review.

C **Clarify** and **Correct**. Concerns expressed by primary caregivers, colleagues, patients, or family member are valid reasons to seek clarification before proceeding with a task involving lines and tubes. Correct any discrepancies before proceeding with the intervention.

E **Expect** to use the I-TRACE Process, each time a line or tube is accessed, manipulated, or discontinued and when care is handed-off to another clinician or care team.

HCA | case management

First Time User login and Midas Setup

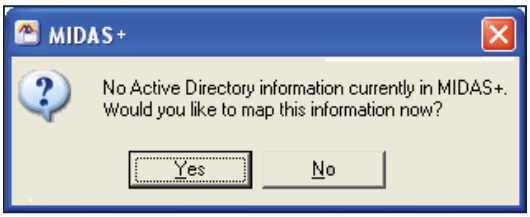
A Guide to assist Users logging in to Midas and nH Discharge for the first time

Steps to login to Midas for the first time (Syncing with AD Single Sign On)

The following steps describe the Active Directory initial login process.

1. At the Midas Login Prompt, enter the Active Directory's, or Windows', UserID and Windows' Password. Click OK.

2. Click "Yes "at the prompt asking "No Active Directory information currently in Midas. Would you like to map this information now?"



3. Enter the Midas User ID and Password provided. Click "OK"
   a. User ID –3/4 ID
   b. Password – 1234567