Resource Packet (Tap a topic)

RCH Campus Map

Visitation Practices

Policy Location Intranet

Scrub Colors

COVID-19 Specimen Collection & Nasopharyngeal Swab

Bloodborne Pathogen Exposure Control Plan

Fire Safety

RCH Radiation Safety

Standards of Care/Practice Guidelines

Intravenous Medication Administration Restrictions by Patient Care Area

IV Drip Titration Documentation

Heparin Drip Documentation

Emergency Department

PEWS – Pediatric Early Warning System
MEWS- Modified Early Warning System-
All Areas Quality Indicators:

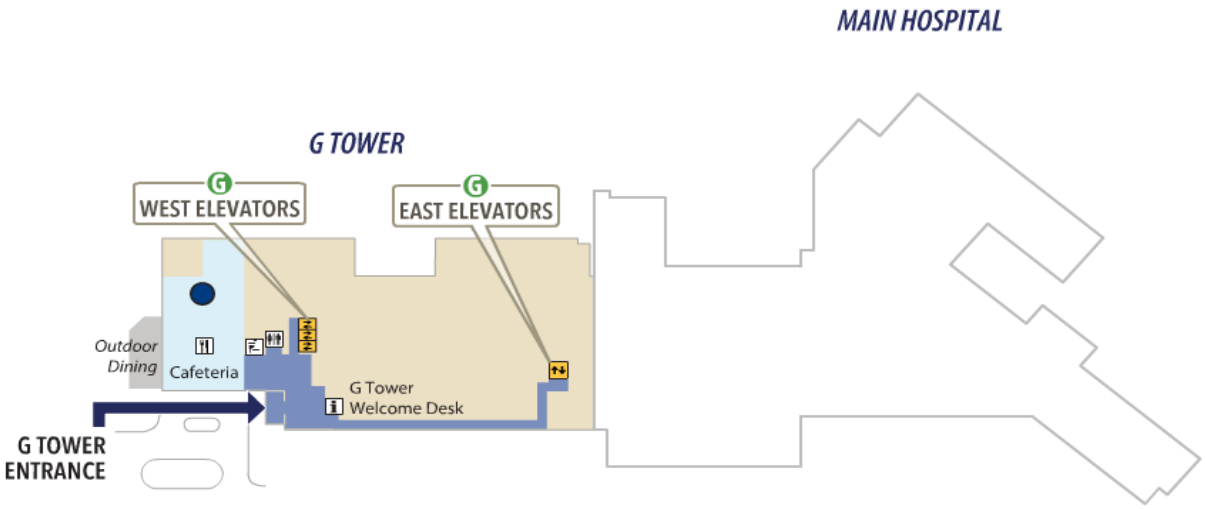
- ✓ **Stroke**
- ✓ Acute MI

Salem Sump Tube with Multifunctional Port and ENFit connection
Keofeed / Dobhoff Tube
Kangaroo Feeding Pump Quick Programming Tips
Blood Transfusions
OneLegacy: Your important role in Organ, Eye and Tissue Donation
Nutritional Services/FNS
Supplies
Advance Directives
Patient Personal Property

Isolation No Passing Zone/Hourly **Rounding Falling Stars** Post-Fall Management **Fall Assessment Prevention Poster** Hand Off Reminders **CareView- Monitoring System** I-TRACE **IV Therapy** Cactus Sink **Controlled Substance** Hand-off Time Out **CHG Bathing** Patient Education **Emergency CODES** iPhones/iMobile **Language Line** End of Life
Lift Equipment: • Z-Slider • **Stedy** • Arjo Opera
Alaris Infusion Pump System • **Alaris Pump and Guardrails** • PCA Pump
MRidium IV Pump for MRI use
Blood Glucose Monitoring (Nova)
Midas First Time User Login (Case Manager)
Dysphagia Screening
Equipment Cleaning
Medtronic LIFEPAK 20 Defibrillator
Welch Allyn Connex Spot Monitor
Restraint Basics
Suicide Safe Environment Readiness Checklist
Wound documentation
Sepsis Prevention & Optimization of Therapy (SPOT)
Missing Medication Notification

RCH Campus Map

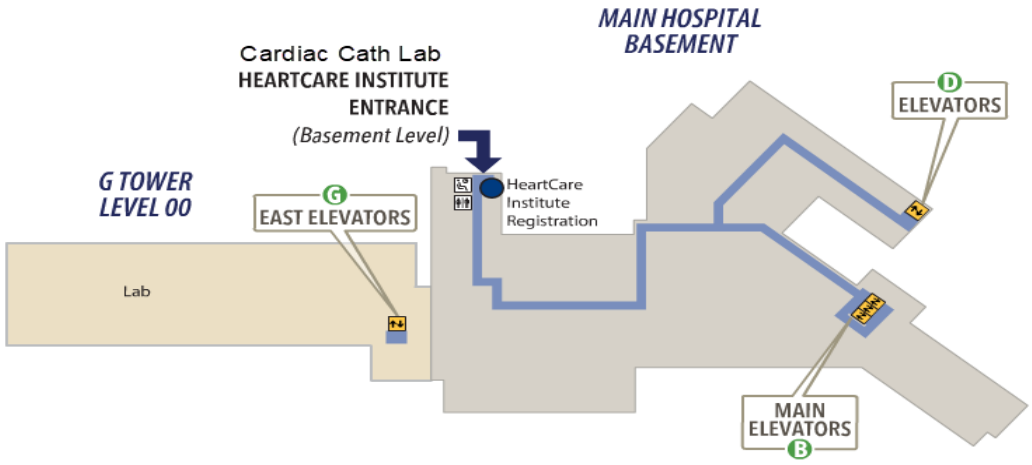
GROUND LEVEL



MAP KEY

Information | Elevator | Restrooms | Cafeteria | Vending

BASEMENT LEVEL / LEVEL 00

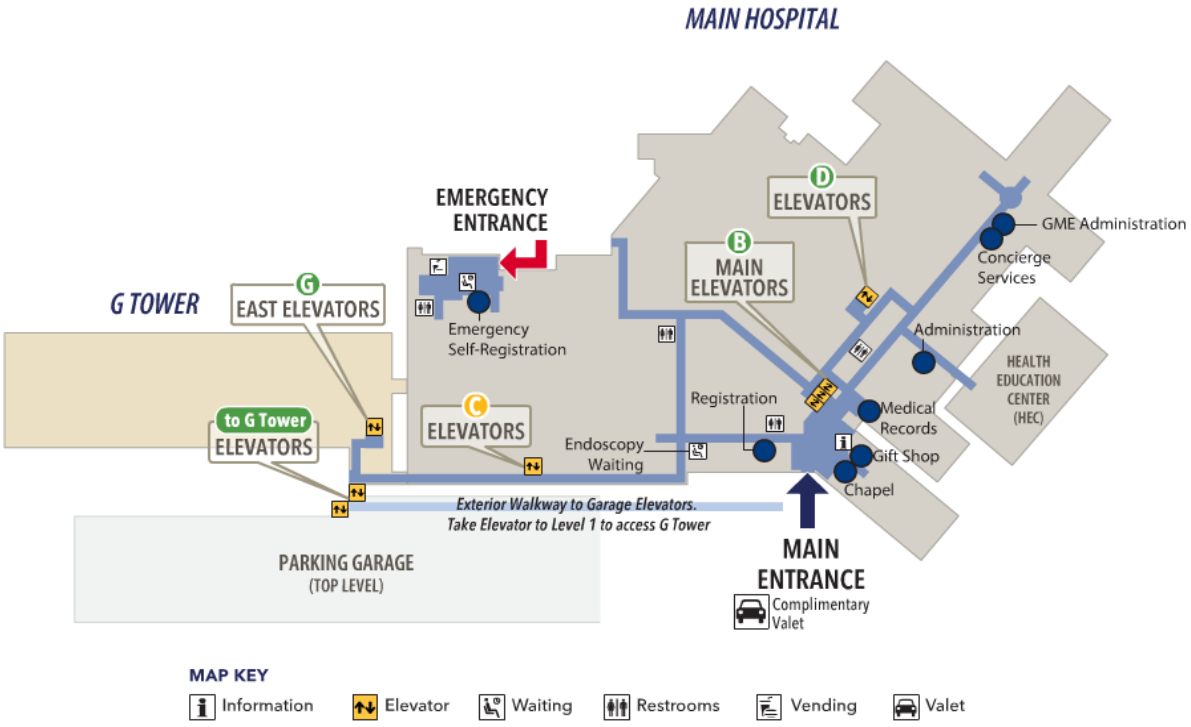


MAP KEY

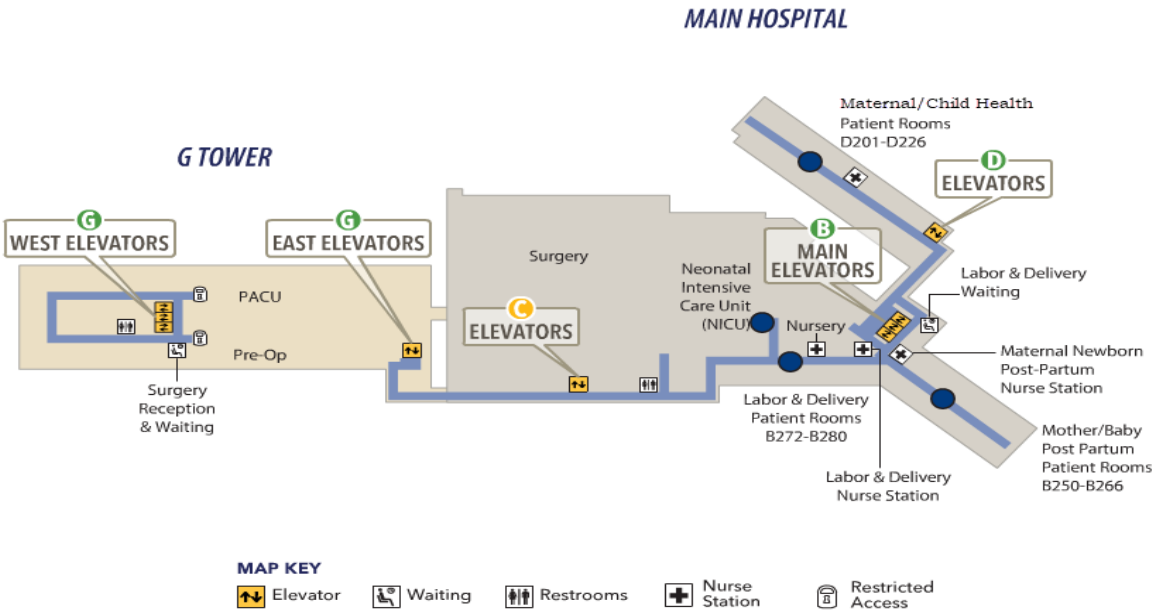
Elevator | Waiting | Restrooms

RCH Campus Map

FIRST LEVEL

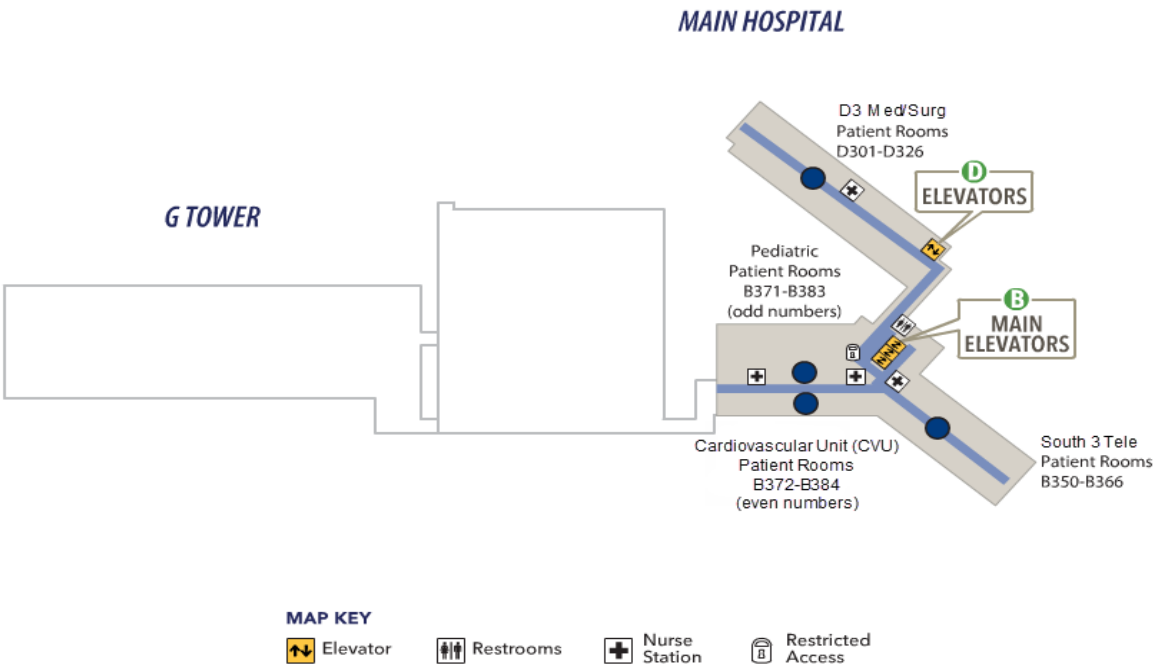


SECOND LEVEL

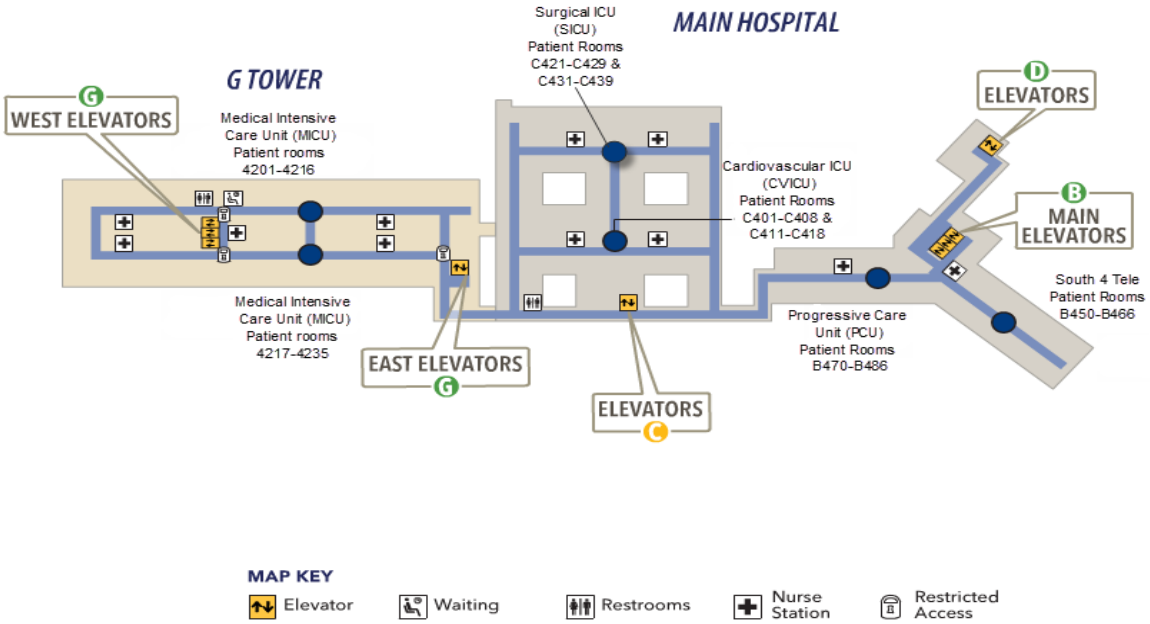


RCH Campus Map

THIRD LEVEL

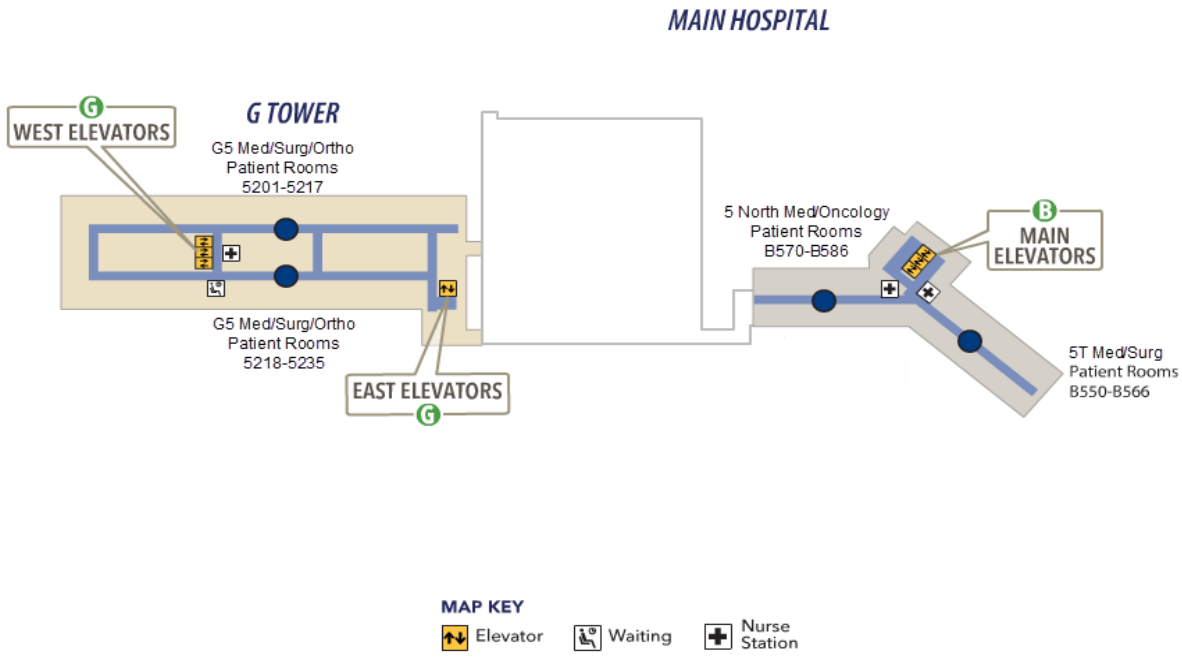


FOURTH LEVEL



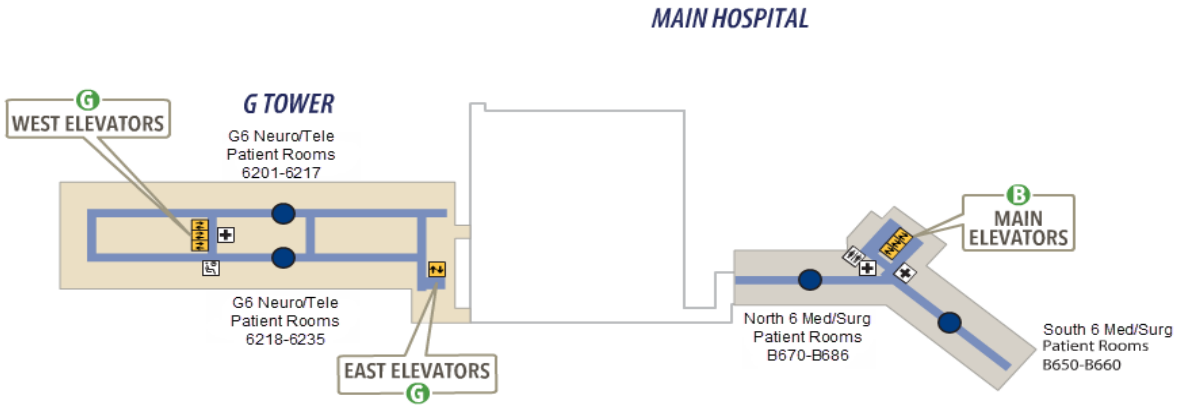
RCH Campus Map

FIFTH LEVEL



MAP KEY
Elevator Waiting Nurse Station

SIXTH LEVEL



Return to TOC

MAP KEY
Elevator Waiting Restrooms Nurse Station

RIVERSIDE Community Hospital

Section B. General Visitation Guidelines: Visiting Guidelines Policy RI.135

1. General visiting hours are between the hours of 7:00 AM – 9:00 PM. If a patient's medical, condition requires that visitation occur beyond the stated visitation hours, visitation may be granted by the Charge Nurse or the Nurse Liaison.
2. Visitors will be limited to two (2) per patient at a time. Additional visitors may be granted by the Charge Nurse or Liaison depending on the condition of the patient and the patient's roommate if in a semi-private room.
3. Visitors will access through the hospital lobby and be required to check in at the front desk.
4. Family members are encouraged to actively engage in the patient's hospital experience to aid in the delivery of safe patient and family-centered care, including participation in bedside report.
5. Family members and visitors should collaborate with the nursing staff to coordinate visitation as directed by the patient.
6. The length of the family members or visitors stay is at the discretion of the patient and the nurse to ensure that the patient and any roommates are achieving adequate rest.
7. The hospital will not restrict, limit or otherwise deny family presence or visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.

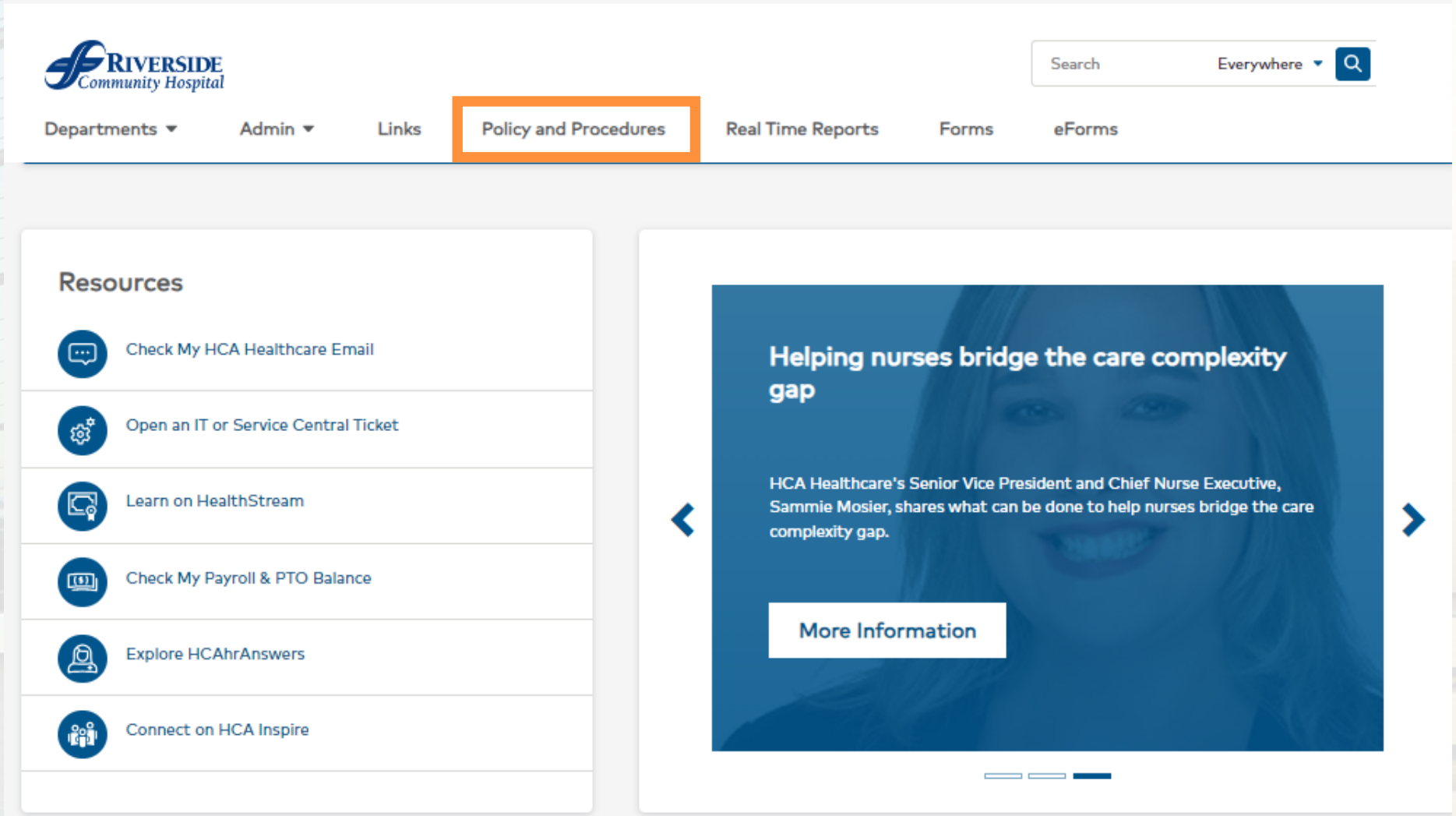
8. Families and visitors whose presence are disruptive or infringes upon others rights or safety; interferes with the care of the patient; or who are medically or therapeutically contraindicated, will be asked to leave (example: visitors who are under the influence of drugs or alcohol).
9. If the patient allows---families are encouraged to be present and participate in nurse handoff communication to promote improved patient outcomes.
   - If the patient does not wish for family to be present or participate in handoff communication, they will be asked to wait in the respective waiting room.
10. To assure privacy for all patients, families and visitors are to remain in patient rooms or in the visitor's lounge and not in unit hallways.
11. Semi-private rooms require special consideration for privacy and quiet.
12. All visiting parties are asked to speak in low tones, maintain confidential information and honor the wishes of all patients in shared rooms.
13. Children over the age of 12 may visit when supervised by an adult family member. Restrictions may be imposed during influenza/RSV season, to prevent the spread of viral illnesses.
14. All children allowed to visit must be directly supervised by a parent or designated adult (other than the patient) while in the hospital.
15. The supervising family member should make certain that the experience is positive and developmentally appropriate for the child/children.
16. A maximum of one (1) family members may stay with a patient overnight if it is a private room.
17. If it is a semiprivate room, families are requested not to stay overnight in consideration to the patient sharing the room.
    - The charge nurse can make exceptions to this based on the needs of the patient and the patient or roommate's condition.
18. Overnight guests are limited to adults.
19. Overnight families and visitors are requested to use designated sleep chairs in their patient's room and not sleep on the floor or in the waiting or lounge area.
20. Clergy or spiritual advisor is welcome to visit at the patient or family member's request.

Note:

The charge nurse or the Nurse Liaison may approve an exception to the policy when extenuating circumstances exist (parents/legal guardians of a hospitalized child, who are under 12 years of age, or the adolescent child of an adult patient). This includes limiting visits based on a patient's deteriorating or critical condition. Families are asked to prepare the child/children for the visit and to ensure that the child/children's behavior supports the patient's rest and recovery as well.

Policy Location...

Facility Intranet



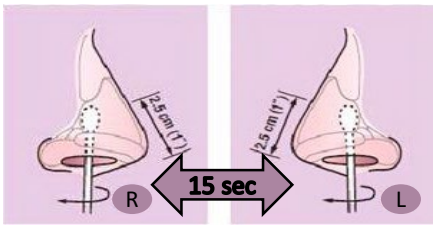
COVID-19
SPECIMEN COLLECTION

Obtain a sterile *Rayon* Tipped Applicator from the lab

Wash Hands

Don PPE
N95
&
Face Shield

Insert swab 1 inch into the nostrils, swabbing each for 15 seconds



Place the swab back in the package. Fill out patient label

Send the specimen to the lab

RIVERSIDE Community Hospital

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.

Bloodborne Pathogen Exposure Control Plan (RCH IC-301)

- 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

RCH Policy Standard and Transmission Base Precautions (IC 202) states:

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

Sharps Safety and Needlestick Prevention

- Used sharps will be disposed of in a safe manner in a rigid, puncture-proof container, which shall be labeled with a biohazardous sign. **Sharps containers will be changed when ¾ full.**
- Sharps containers are located in each patient room and shall be readily available in patient care areas. Sharps containers will be placed to assure that visibility of contents allows for safe disposal.

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

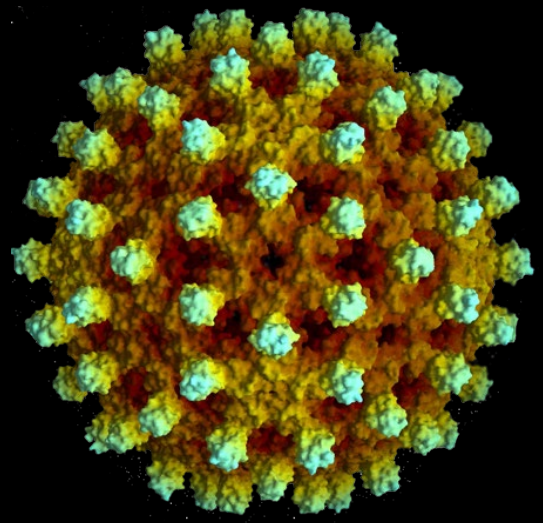
- Should you be exposed to blood or other potentially infected materials by needle stick, by sharps injury, or by splashes to mucous membranes (eyes, nose, mouth), <u>report the incident IMMEDIATELY to your supervisor and Employee Health!</u>

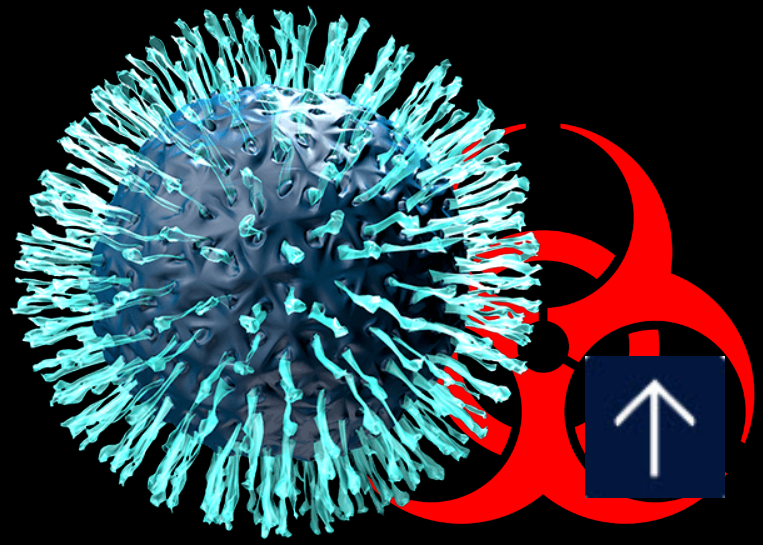
Sharps Injury Statistics

- 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

- Hepatitis B – 6% - 30% after needle stick
- Hepatitis C – 0.5% - 10% after needle stick
- HIV 0.03% after needle stick





Sharps Safety Begins with YOU!

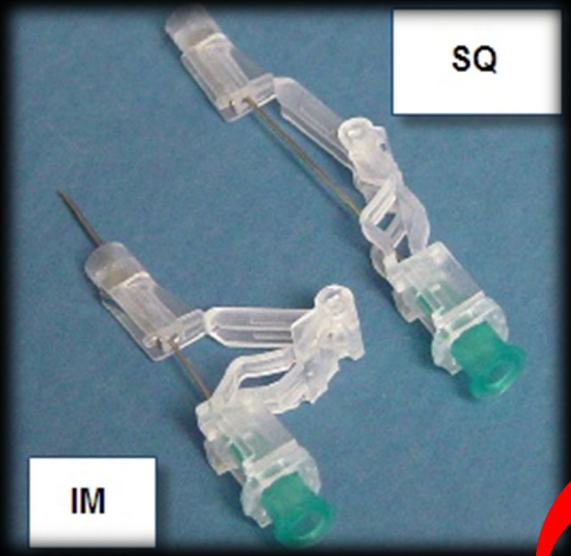
RCH Bloodborne Pathogen Exposure Control Plan (IC.301) states:

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

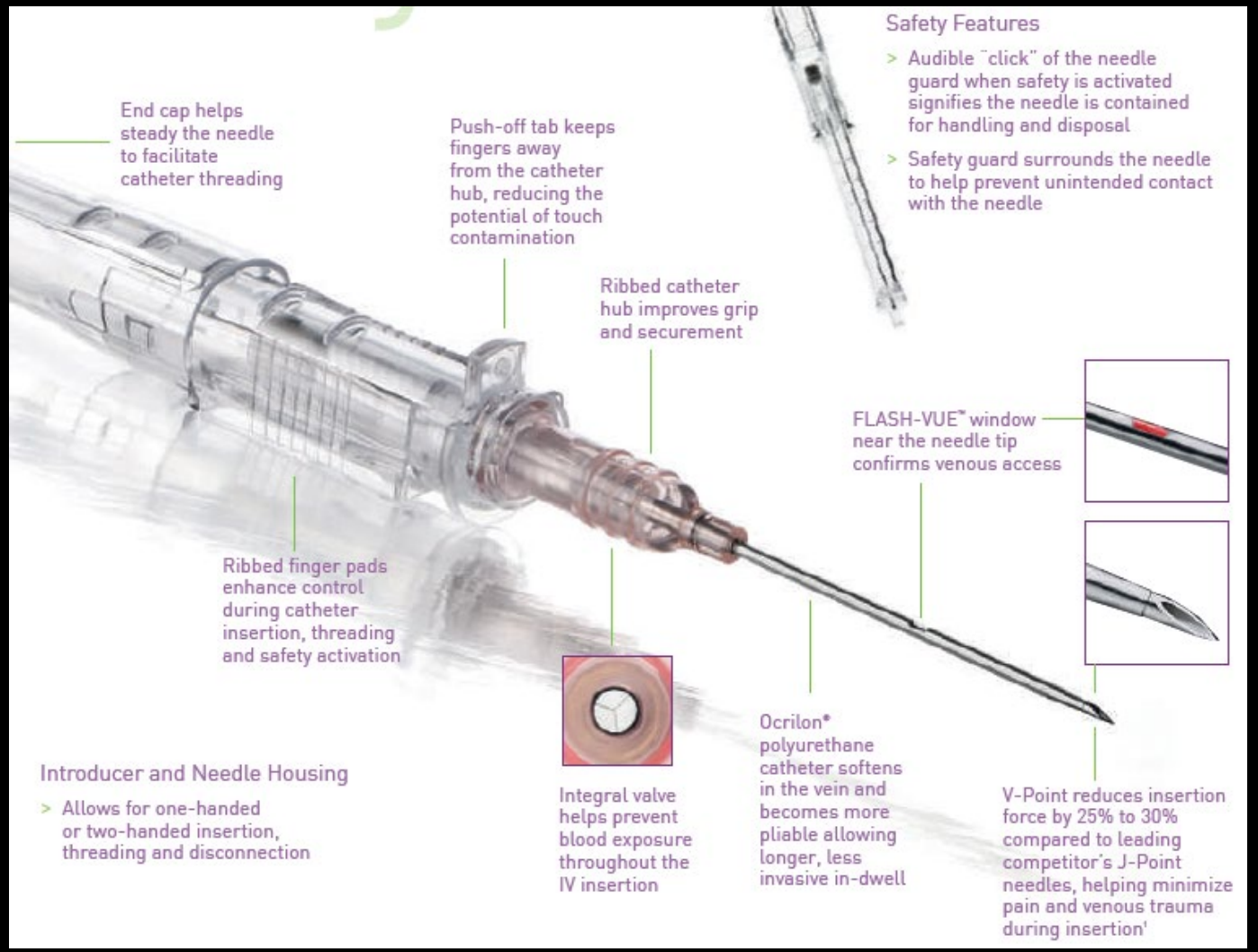
- Withdrawal of body fluids
- Accessing a vein or artery
- Administration of medications or fluids
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available

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

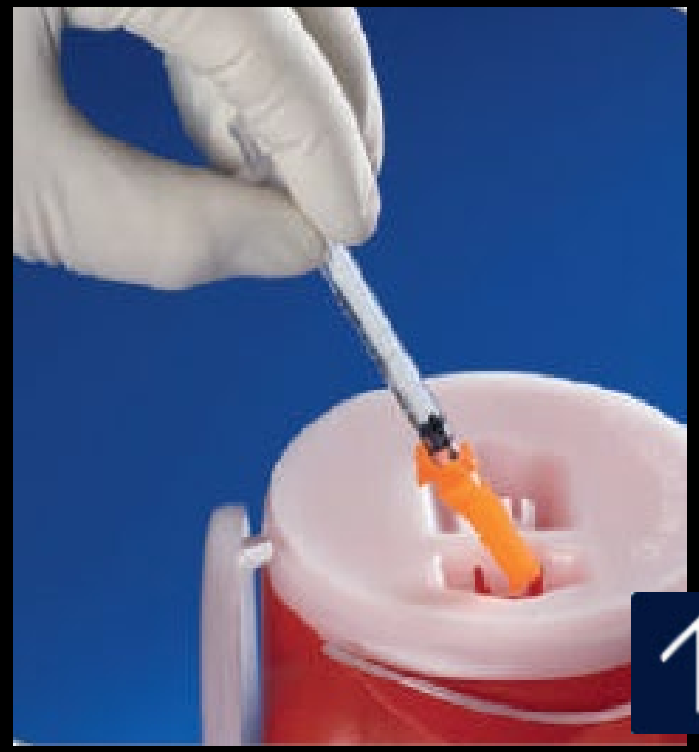


Smiths Medical Hypodermic Needle-Pro Fixed Needle Syringe for Insulin and TB Injections

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.

SAFETY Tips ...

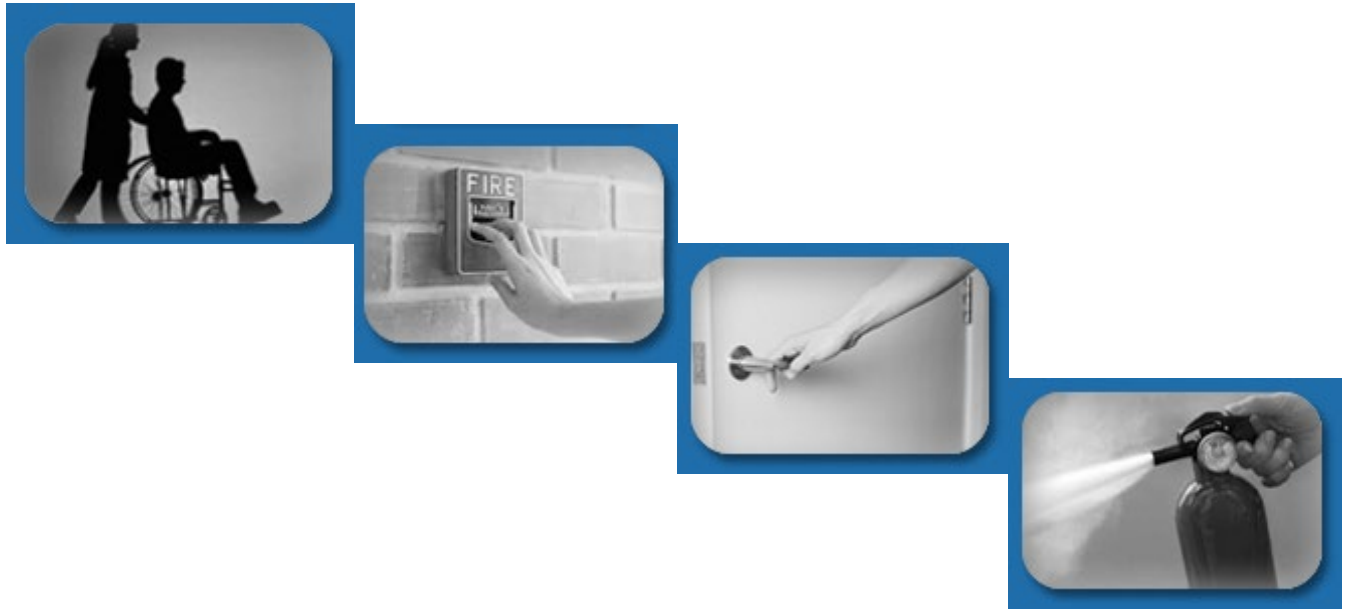
Fire safety is a responsibility we all share!

- 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…

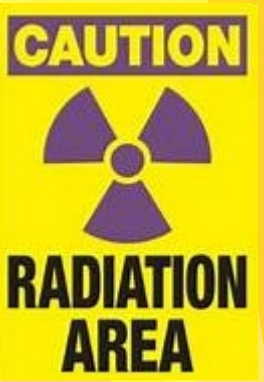
PASS…

- **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

CSG.MI.001
CSG.MI.003
OR.221
Dept. Mgr.

RCH 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

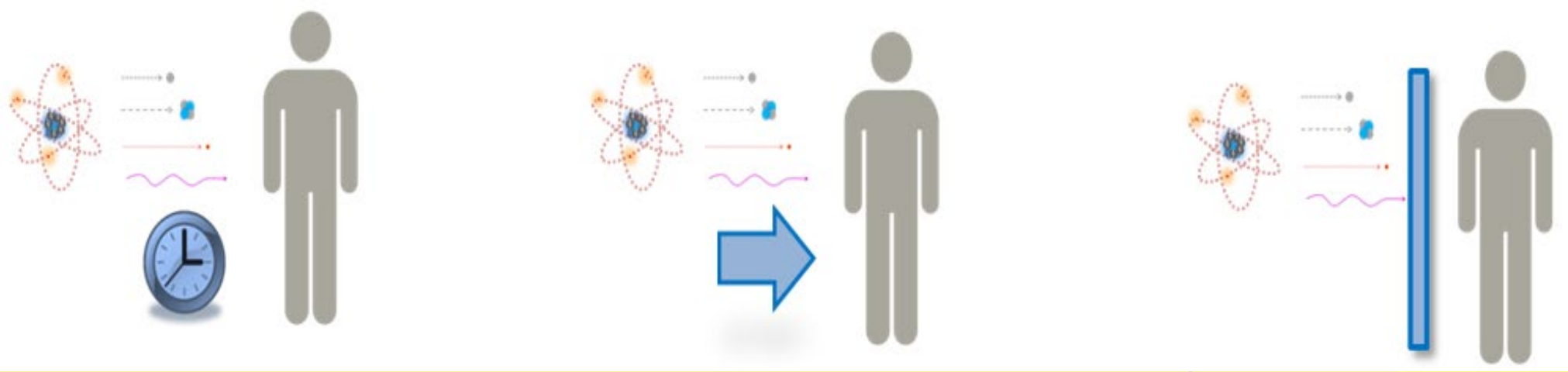
Minimize time around radiation source

Distance

Maximize distance from radiation source

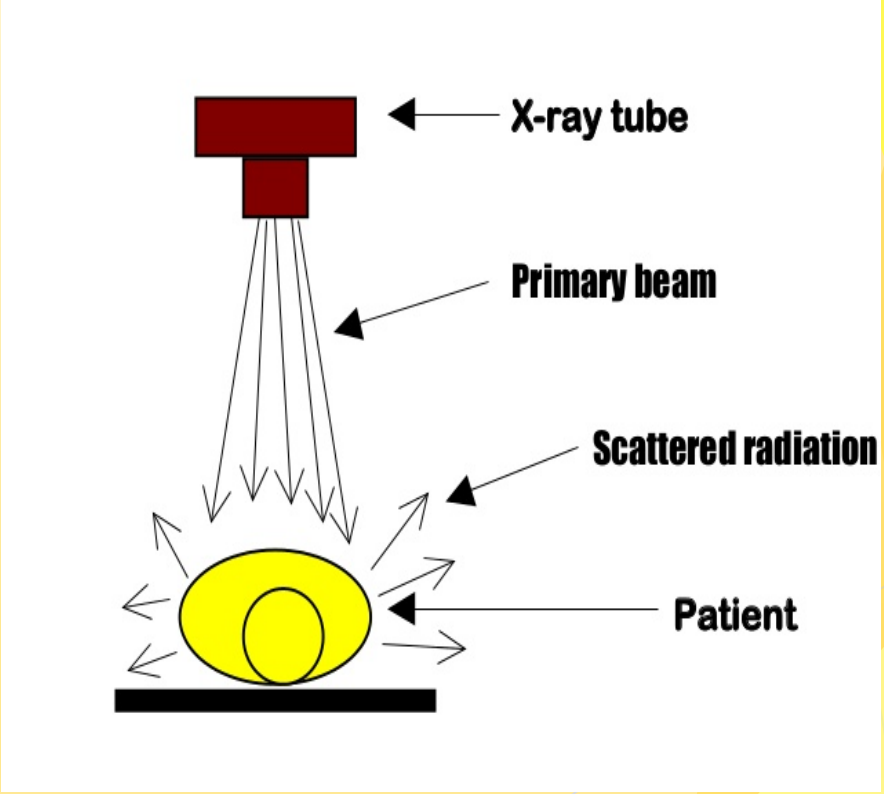
Shielding

Use shielding to minimize exposure

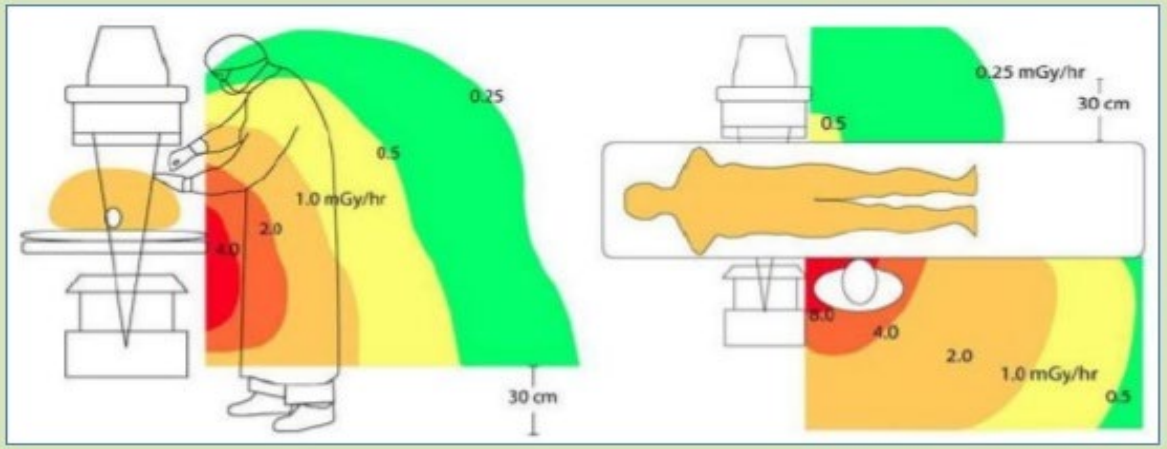


Scatter…

- 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.

RCH Staff Responsibilities…

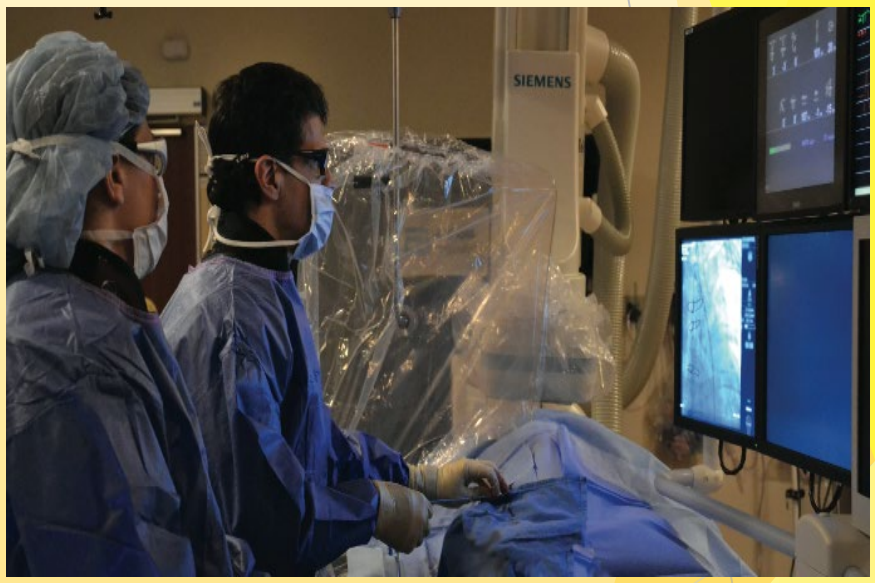
- All personnel involved in fluoroscopic procedures must wear **protective lead aprons**. Personnel who may have to stand with their backs to radiation beam must wear wrap-around aprons to decrease risk of exposure. **Thyroid shields must** be worn to protect thyroid whenever there is a risk of prolonged 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.

RCH 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.

RCH *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.



RCH *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!

RCH 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 for Riverside Community Hospital is Dr. Sharifi.
- 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

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 (MIC, SIC & N4-ICU)	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

CVU, 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 (S3 & S4)	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 (S5, S6, D3, D2)	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

RIVERSIDE Community Hospital

POLICY & PROCEDURE

Specific Vital Signs

	Bedside Procedures	Sedation Analgesia	Post-op	Angio and Heart Cath	PCA	Epidural and Intrathecal Analgesia
All Departments **Exclusion: See PC.222 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

RIVERSIDE Community Hospital

Intravenous Medication Administration Restrictions by Patient Care Area

MM.99 (aka "RCH IV Manual")

Medication	Approved for care area category = X					notes / exceptions
	Adult ICU, ED, Procedural, Code Blue	Step down (IMC)	Telemetry	NICU	General Nursing Floor	
adenosine (Adenocard)	X	X*		X		*Physician must be present on unit for this medication to be given on PCU/CVU level of care. .
abciximab (Reopro)	X	X				
alprostadil (Prostin)	X			X		
alteplase (TPA) (Activase)	X					No area restrictions for Cathflo catheter clearance
amiodarone (Cordarone)	X	X	X*			Allowed in Telemetry units only as a non-titrated drip when a Rapid Response Team RN monitors the patient throughout the first hour of infusion with q15 min vitals *Telemetry units with centrally monitored hardwired cardiac monitors can initiate
atracurium (Tracrium)	X					
atropine	X	X	IVP only			Atropine can be given as IVP in Telemetry per Cardiopulmonary Emergency Protocol
cisatracurium (Nimbex)	X					
dantrolene (Dantrium)	X					
dexmedetomidine (Precedex)	X					
diltiazem (Cardizem)	X	X	X			Allowed in Telemetry units as a non-titrated drip only = NOT IV PUSH
dobutamine	X	X		X		

PROCEDURE /GUIDELINES

General Floor Nursing = drugs may be administered by rapid response registered nurses while the patient is transferred to a critical care area

Medication	Approved for care area category = X					notes / exceptions
	Adult ICU, ED, Procedural, Code Blue	Step down (IMC)	Telemetry	NICU	General Nursing Floor	
dopamine	X	X	X*	X		Includes non-titratable infusion (less than or equal to 5mcg/kg/min) on stepdown and *Telemetry units with centrally monitored hardwired cardiac monitors can initiate
epinephrine (Adrenalin)	X			X		
epoprostenol (Flolan)	x	x				Per RCH Policy MM.136: • Per prostacyclin competent RNs • ICU admission for initiation • if initiated in another area, a prostacyclin competency trained nurse must be present. Once patients are stabilized on the drug, they may be transferred to the PCU or Cardiovascular Units
eptifibatide (Integrilin)	X	X				
esmolol (Brevibloc)	X	X				
fenoldopam (Corlopam)	X					
fentanyl (Sublimaze)	X			X		exception for PCA, epidural
haloperidol (Haldol)	X *telemetry monitored*	X *telemetry monitored*	X *telemetry monitored*		X *telemetry monitored*	• haloperidol intravenous administration restricted to telemetry monitored patients only
ibutilide (Corvert)	X	X*				*Physician must be present on the unit when given on PCU/CVU level of care
ketamine (Ketalar)	X					
isoproterenol (Isuprel)	X					
labetalol (Trandate)	X	X	X		**L&D/PP Only** X	- Allowed in Step Down and Telemetry units - Allowed in Labor & Delivery and Maternal Newborn (PP) units
lidocaine (Xylocaine)	X	X				
methyldopate (Aldomet)	X					

PROCEDURE /GUIDELINES

metoprolol (Lopressor)	**X**	**X**	**X**			Allowed in Step Down and Telemetry units
General Floor Nursing = drugs may be administered by rapid response registered nurses while the patient is transferred to a critical care area						

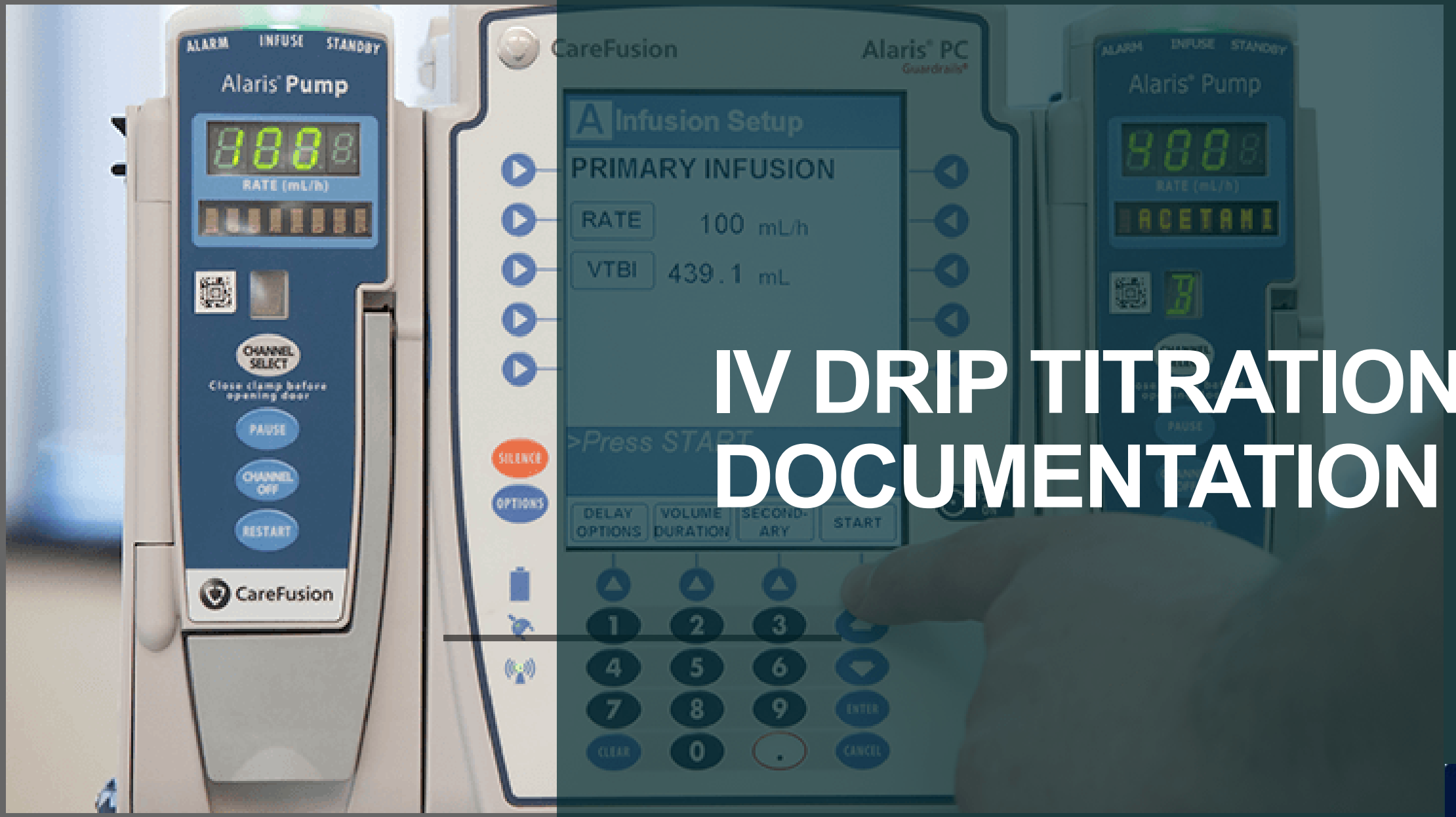
Medication	Approved for care area category = X					notes / exceptions
	Adult ICU, ED, Procedural, Code Blue	Step down (IMC)	Telemetry	NICU	General Nursing Floor	
midazolam (Versed)	**X**	**X**		**X**		Can only be given on stepdown level of care when care is being withdrawn and the patient is a DNR.
milrinone (Primacor)	**X**	**X**				
nicardipine (Cardene)	**X**	**X**				
nitroglycerin (Tridil)	**X**	**X**				
nitroprusside (Nipride)	**X**					
norepinephrine (Levophed)	**X**					
pancuronium (Pavulon)	**X**			**X**		
papaverine	**X**					
pentobarbital (Nembutal)	**X**					
phenylephrine (Neo-synephrine)	**X**					
procainamide (Pronestyl)	**X**	**X**				
propofol (Diprivan)	**X**					
propranolol (Inderal)	**X**	**X**				

PROCEDURE /GUIDELINES

General Floor Nursing = drugs may be administered by rapid response registered nurses while the patient is transferred to a critical care area

Medication	Approved for care area category = X					notes / exceptions
	Adult ICU, ED, Procedural, Code Blue	Step down (IMC)	Telemetry	NICU	General Nursing Floor	
rocuronium (Zemuron)	X					
succinylcholine (Anectin, Quelicin)	X					
sufentanil (Sufenta)	X					
tenecteplase (TNKase)	X					
vasopressin (Pitressin)	X					
vecuronium (Norcuron)	X					
verapamil (Isoptin)	X	X				

General Floor Nursing = drugs may be administered by rapid response registered nurses while the patient is transferred to a critical care area



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.”

IV DRIP TITRATION

Time

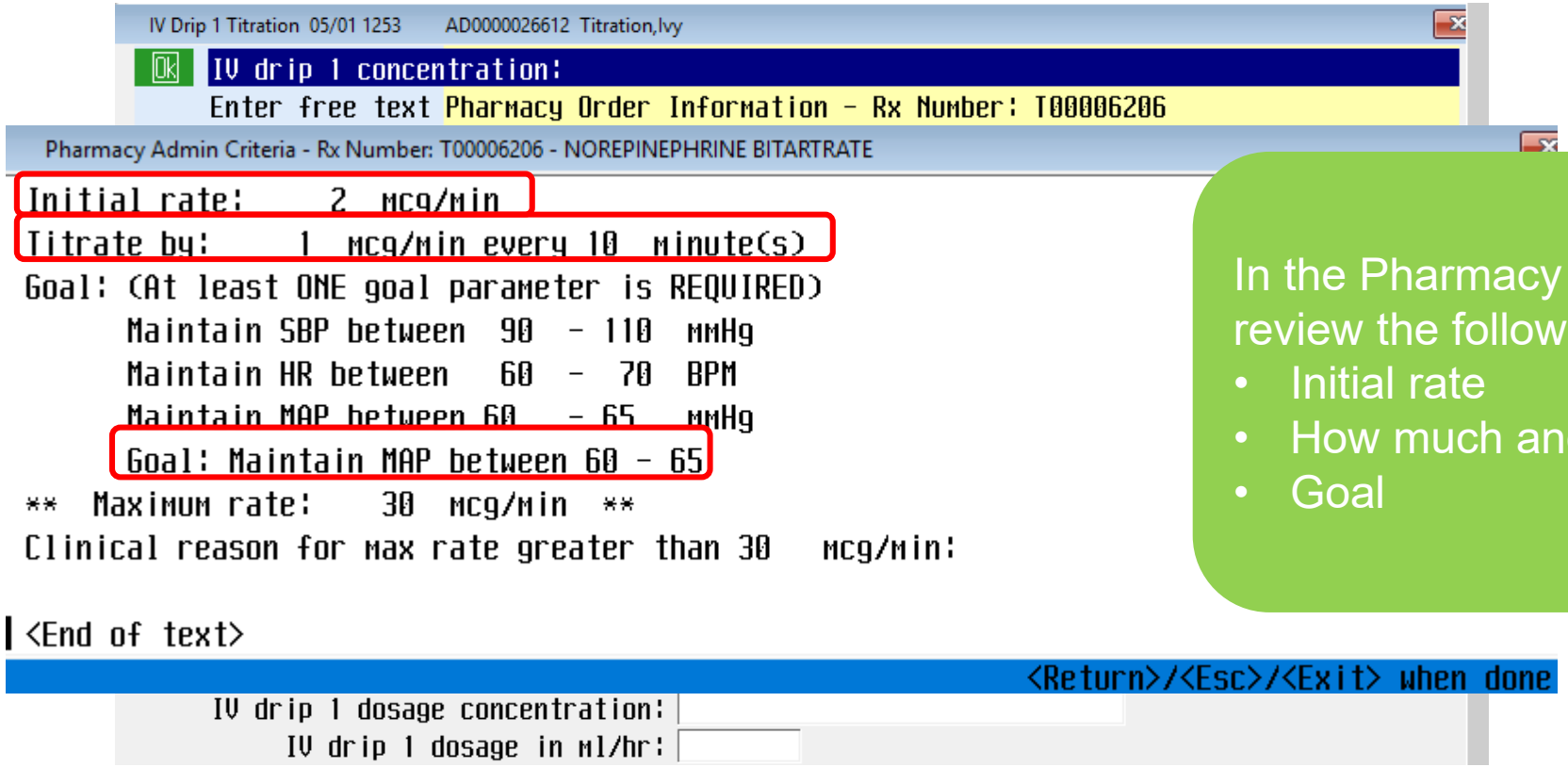
Documenting titrations in real time can be difficult and time consuming.

Patient safety is the number one priority.

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

IV DRIP TITRATION

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



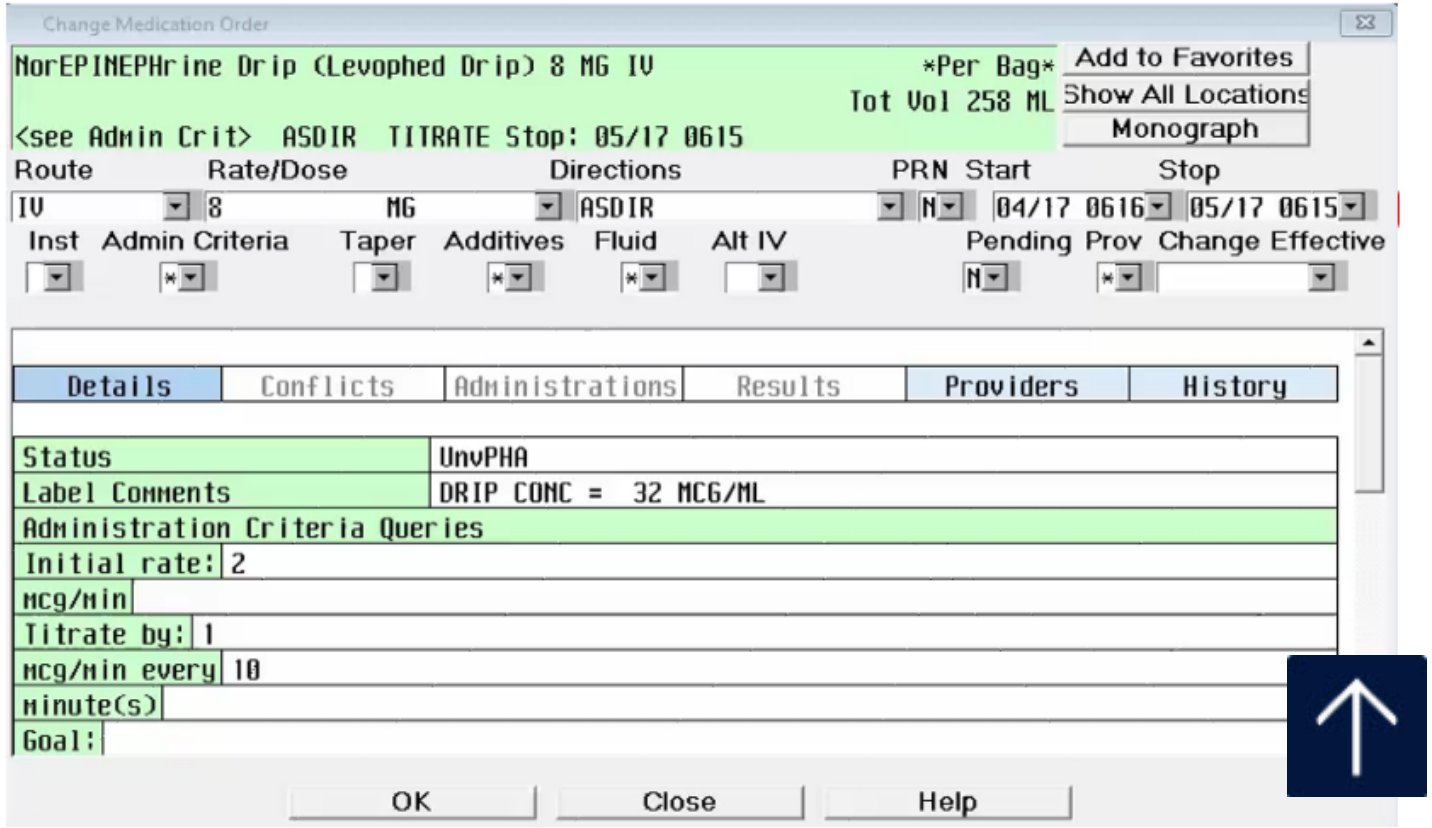
In the Pharmacy Admin criteria box you should review the following instructions:

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

IV DRIP TITRATION

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

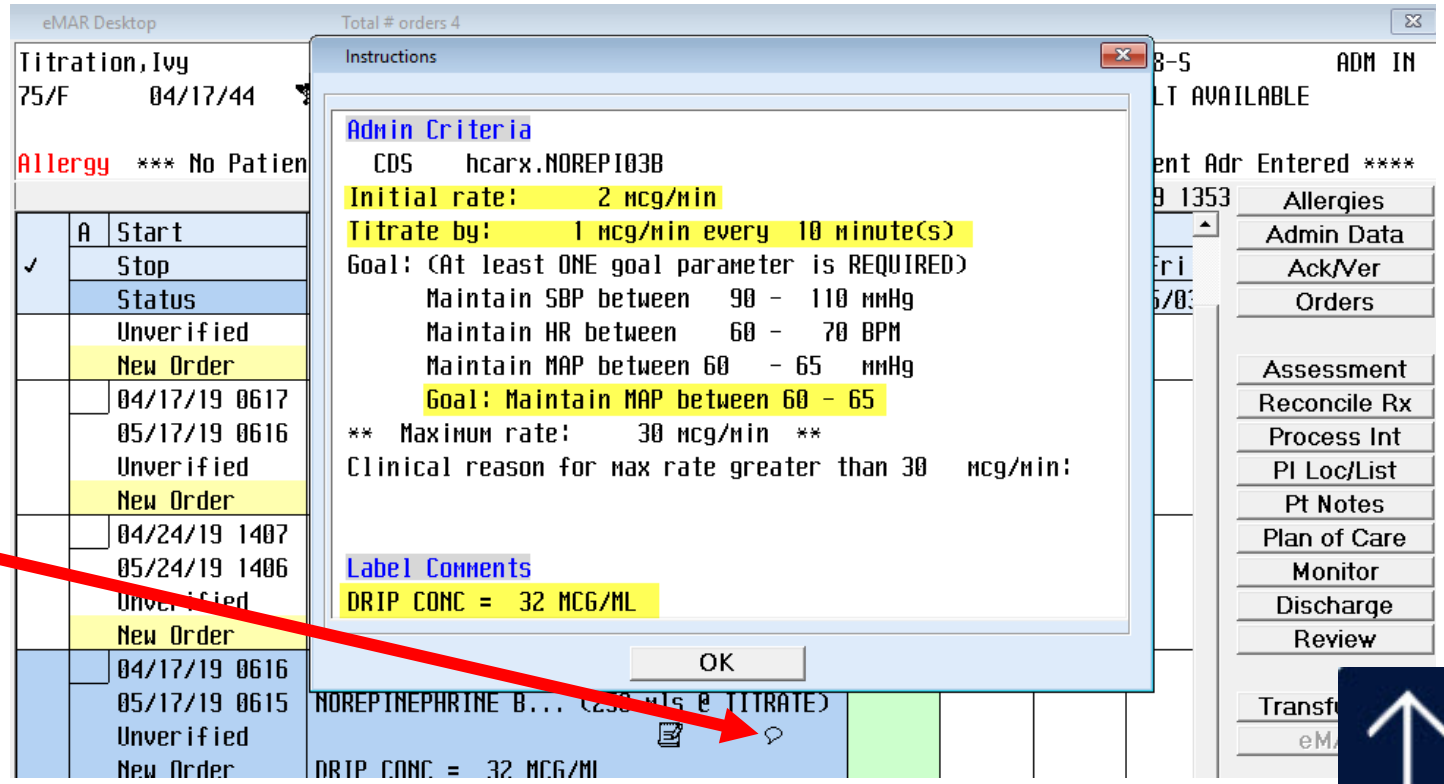
If you scroll up and down, you will find details about the initial rate, frequency of titration and parameter goal.



IV DRIP TITRATION

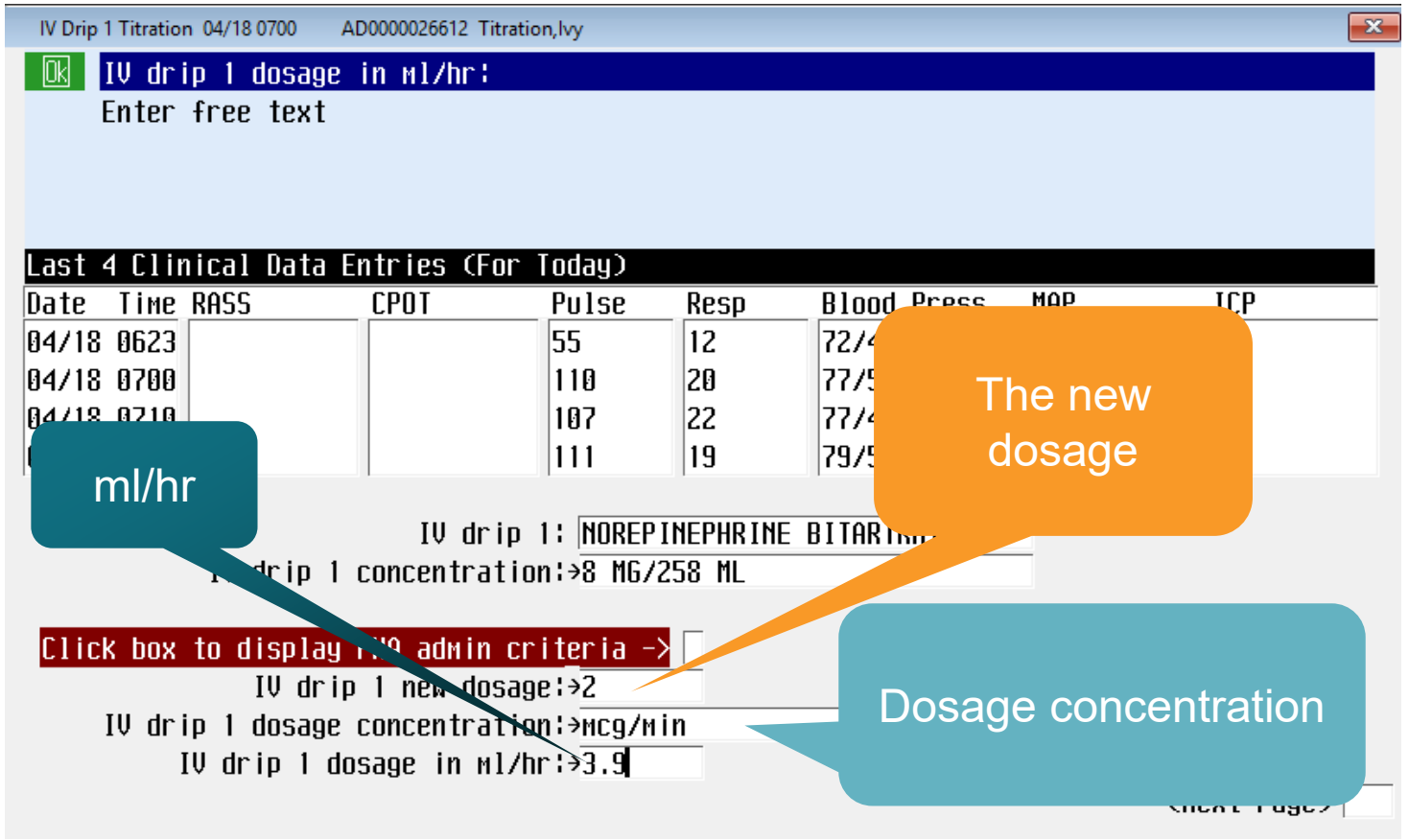
Documentation – Reviewing the Order

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

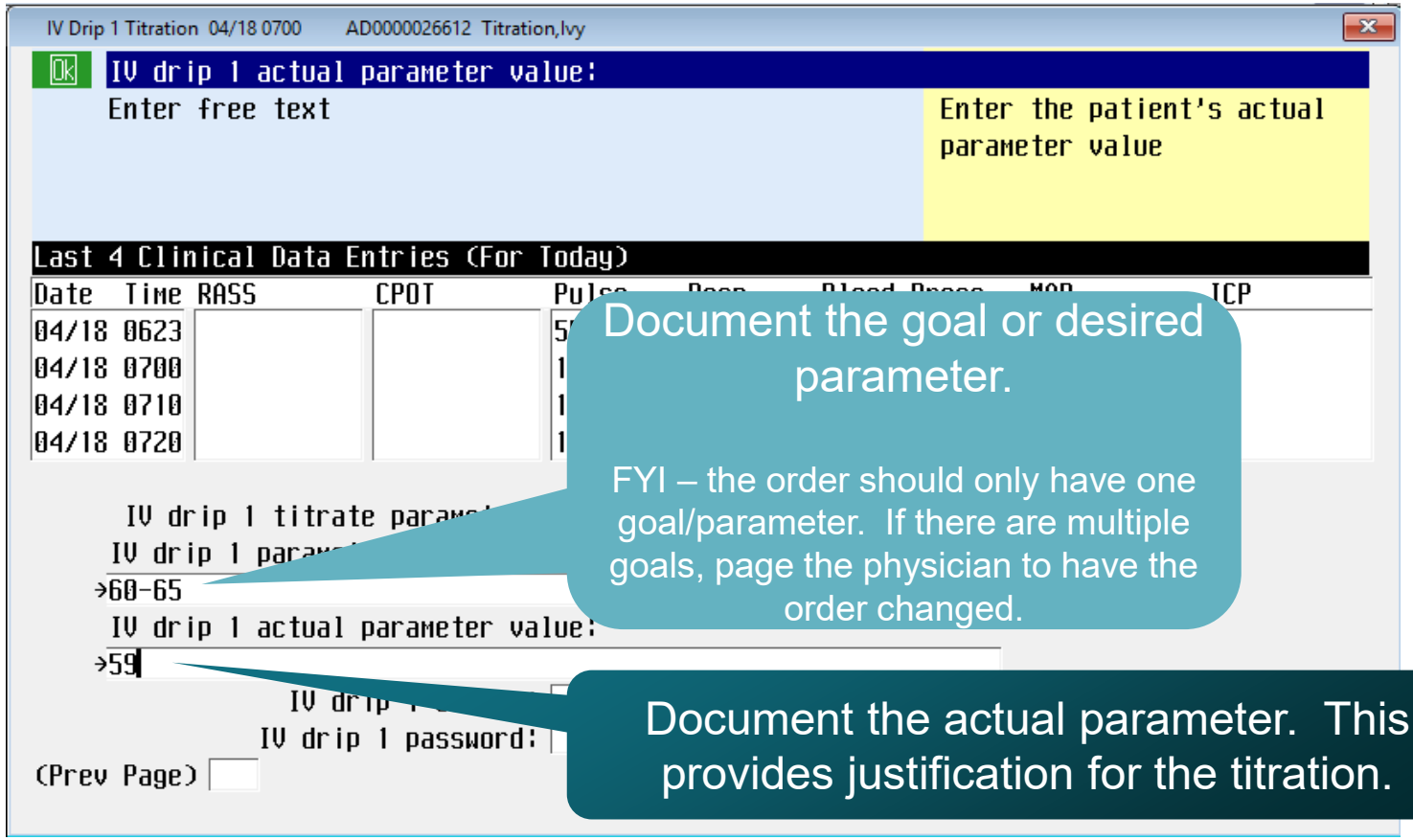


Let's review what must be documented with each titration.

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



Document the goal or desired parameter.

FYI – the order should only have one goal/parameter. If there are multiple goals, page the physician to have the order changed.

Document the actual parameter. This provides justification for the titration.

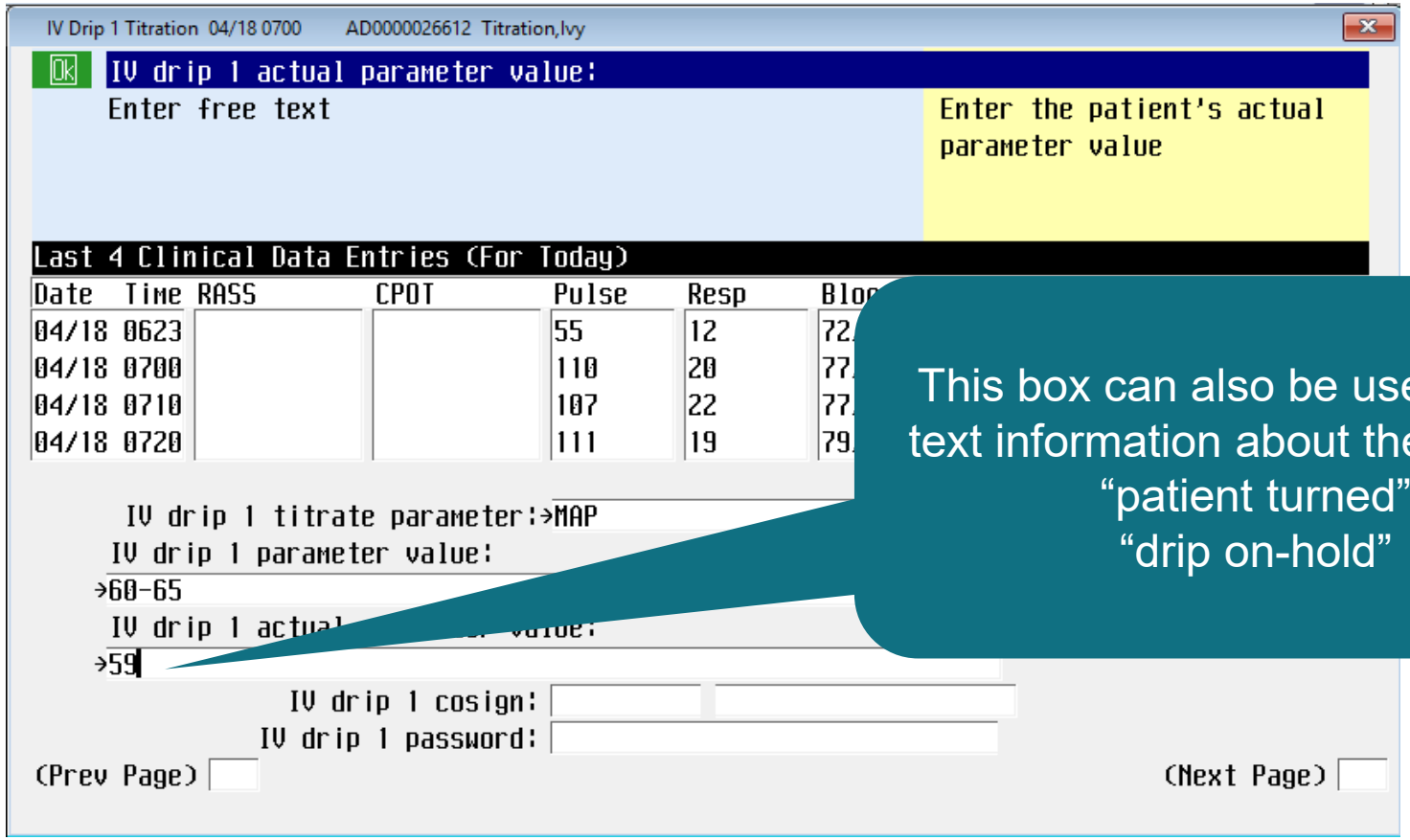
Remember, each documented titration must have an:

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

Documenting both parameters justifies the titration.

IV DRIP TITRATION

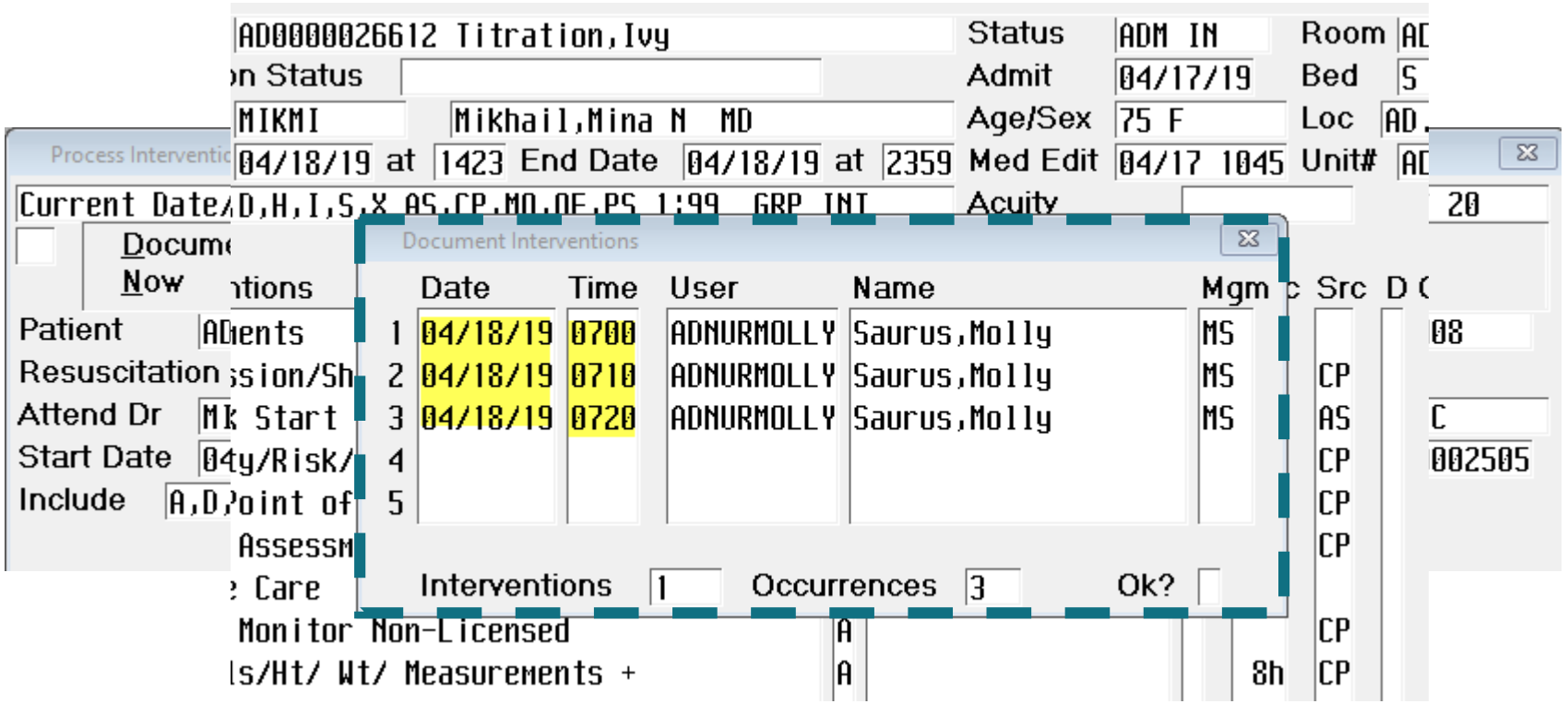
Documentation – Required Fields



This box can also be used to free text information about the drip, i.e.
"patient turned"
"drip on-hold"

IV DRIP TITRATION

Quick Tip

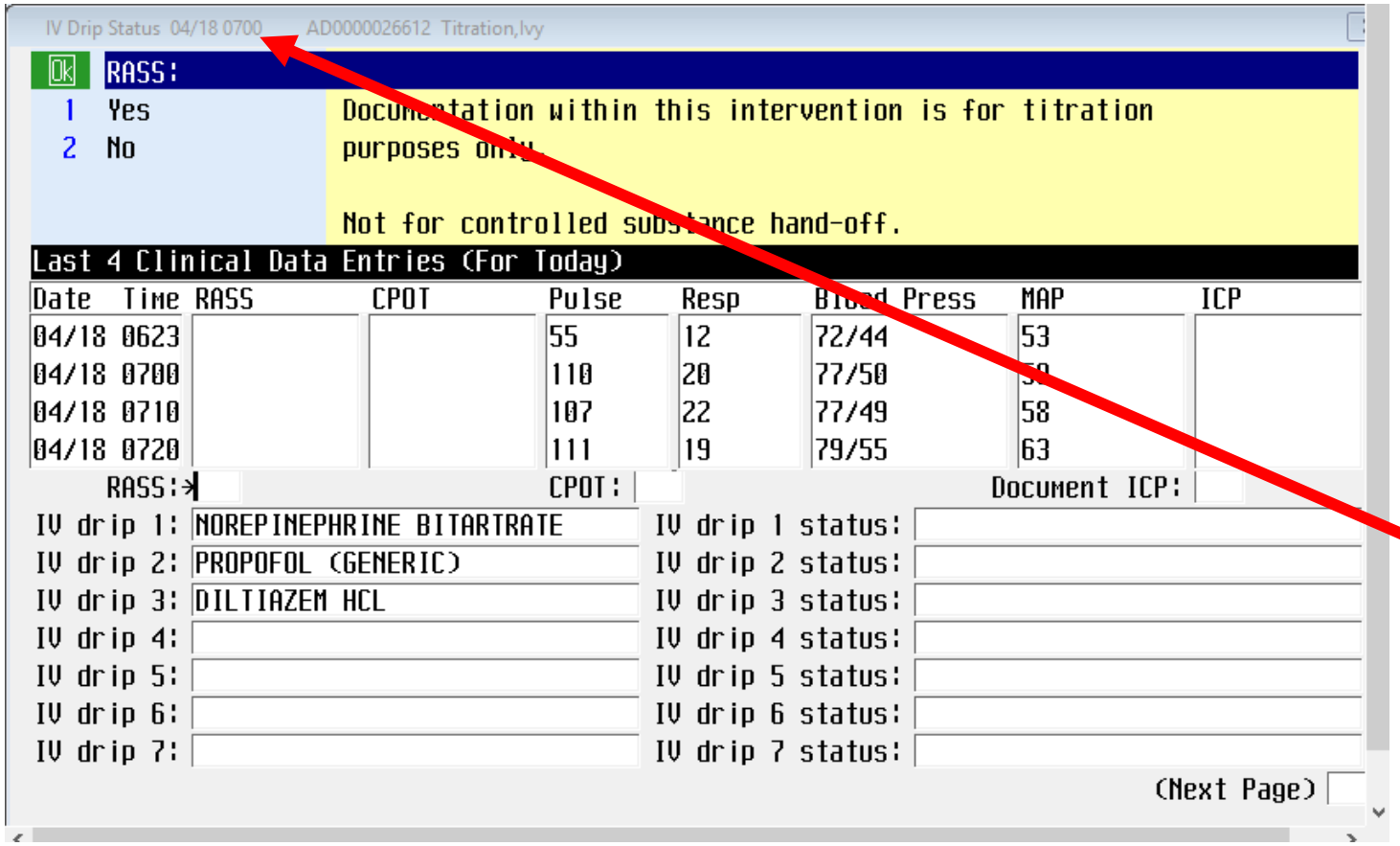


Type in the date and times that you titrated your drip(s).

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.

IV DRIP TITRATION

Quick Tip

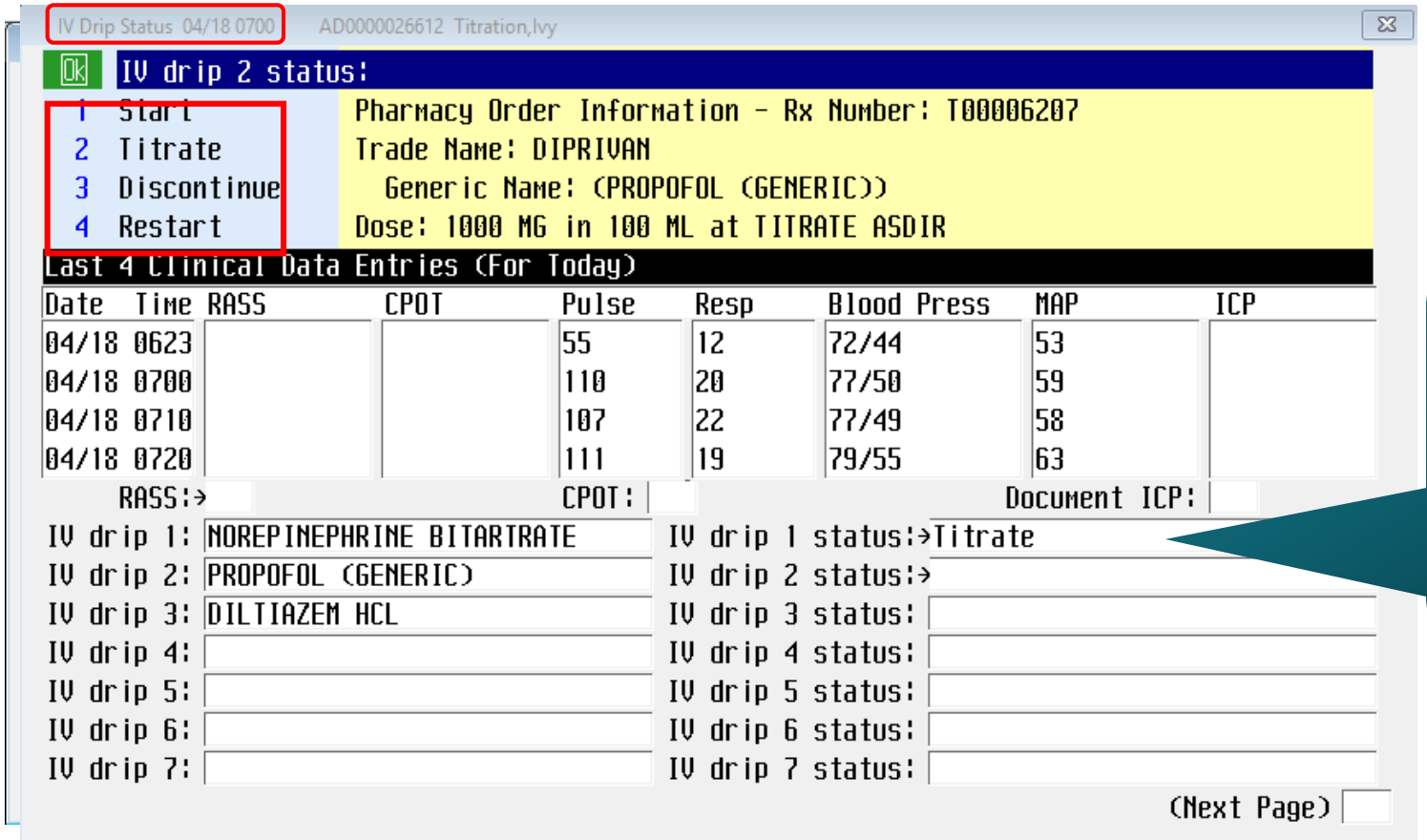


Here, we will document that we titrated the Levophed drip 3 times or every 10 minutes until we reached the ordered goal - MAP 60-65.

The first time stamp is 0700.

IV DRIP TITRATION

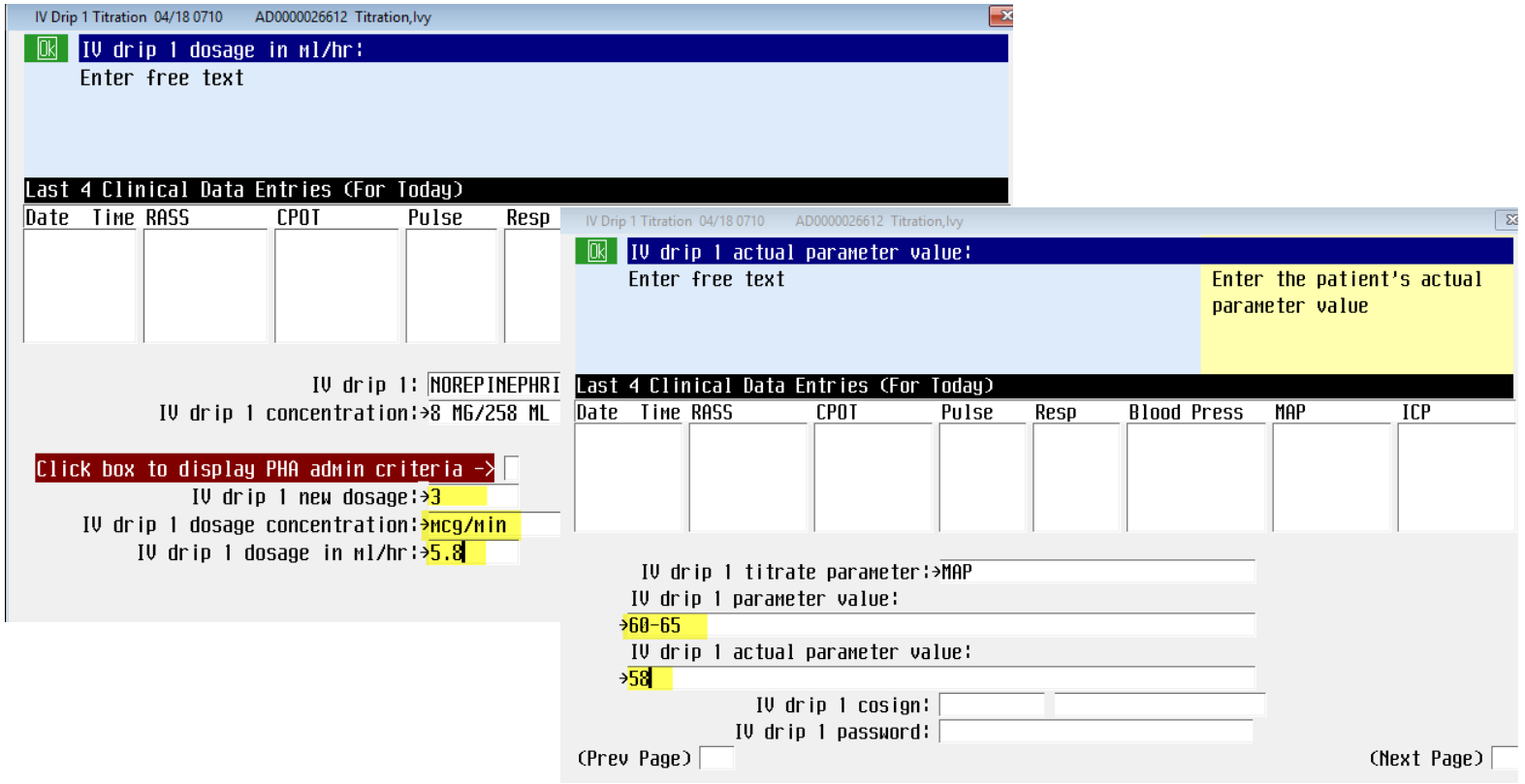
Quick Tip



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

IV DRIP TITRATION

Quick Tip

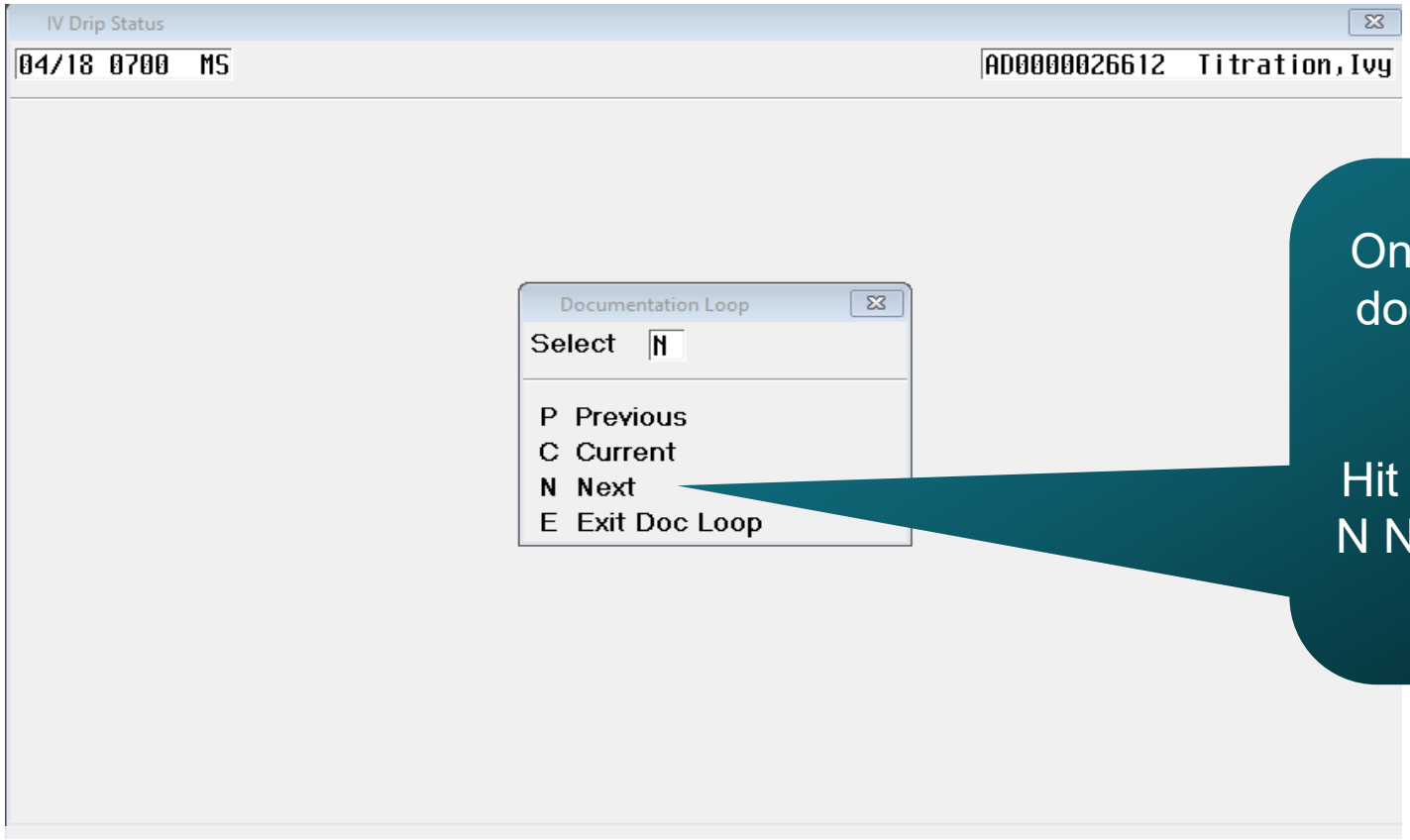


Fill in the required fields.

Then “file”

IV DRIP TITRATION

Quick Tip

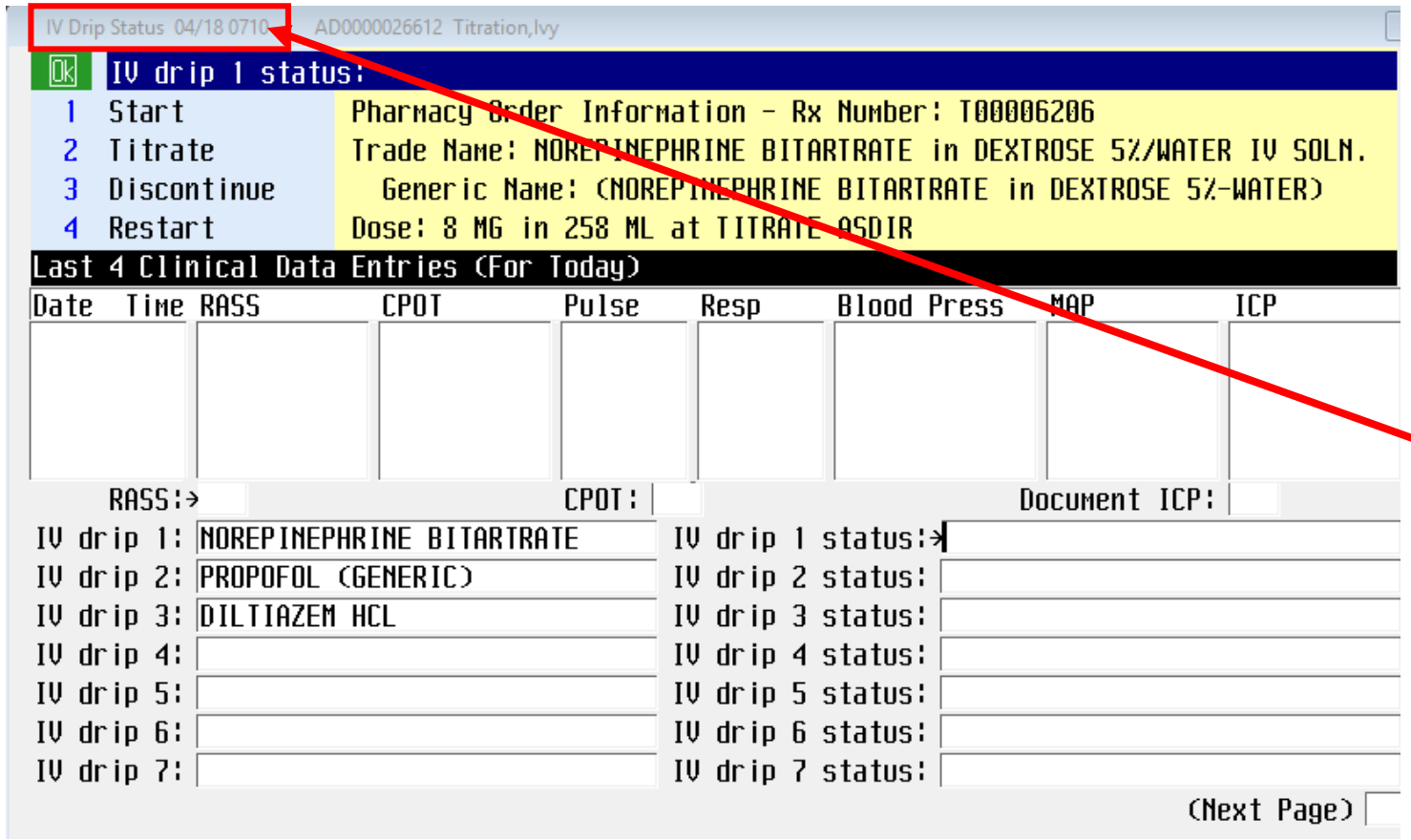


Once you have filed the documentation this box will pop-up.

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

IV DRIP TITRATION

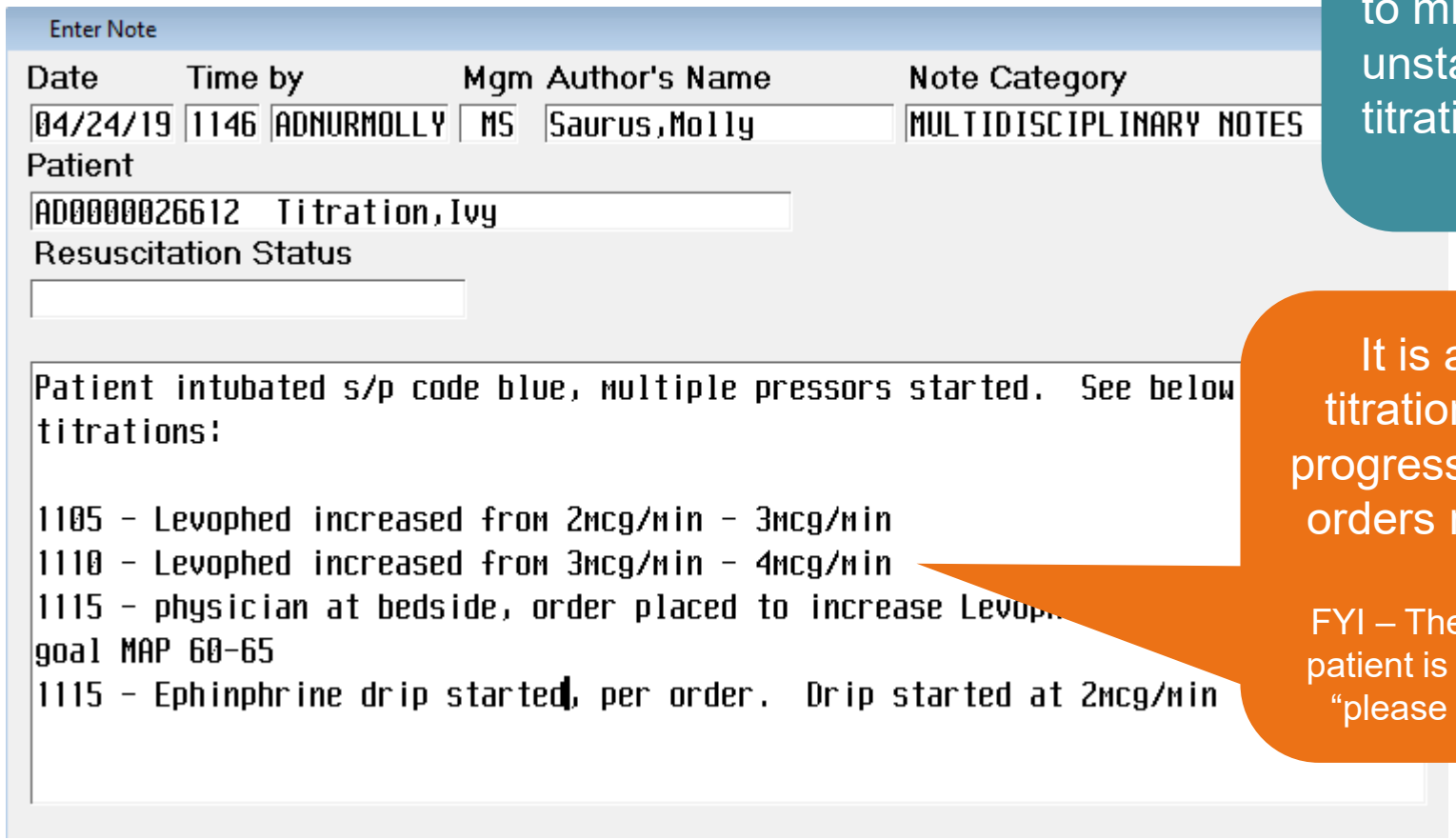
Quick Tip



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

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.


Enter Note

Date | Time by | Mgm | Author's Name | Note Category

04/24/19 | 1146 | ADNURMOLLY | MS | Saurus,Molly | MULTIDISCIPLINARY NOTES

Patient

AD0000026612 Titration,Ivy

Resuscitation Status

Patient intubated s/p code blue, multiple pressors started. See below titrations:

1105 - Levophed increased from 2mcg/min - 3mcg/min
1110 - Levophed increased from 3mcg/min - 4mcg/min
1115 - physician at bedside, order placed to increase Levoph goal MAP 60-65
1115 - Ephinphrine drip started, per order. Drip started at 2mcg/min

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.

TAKEAWAYS

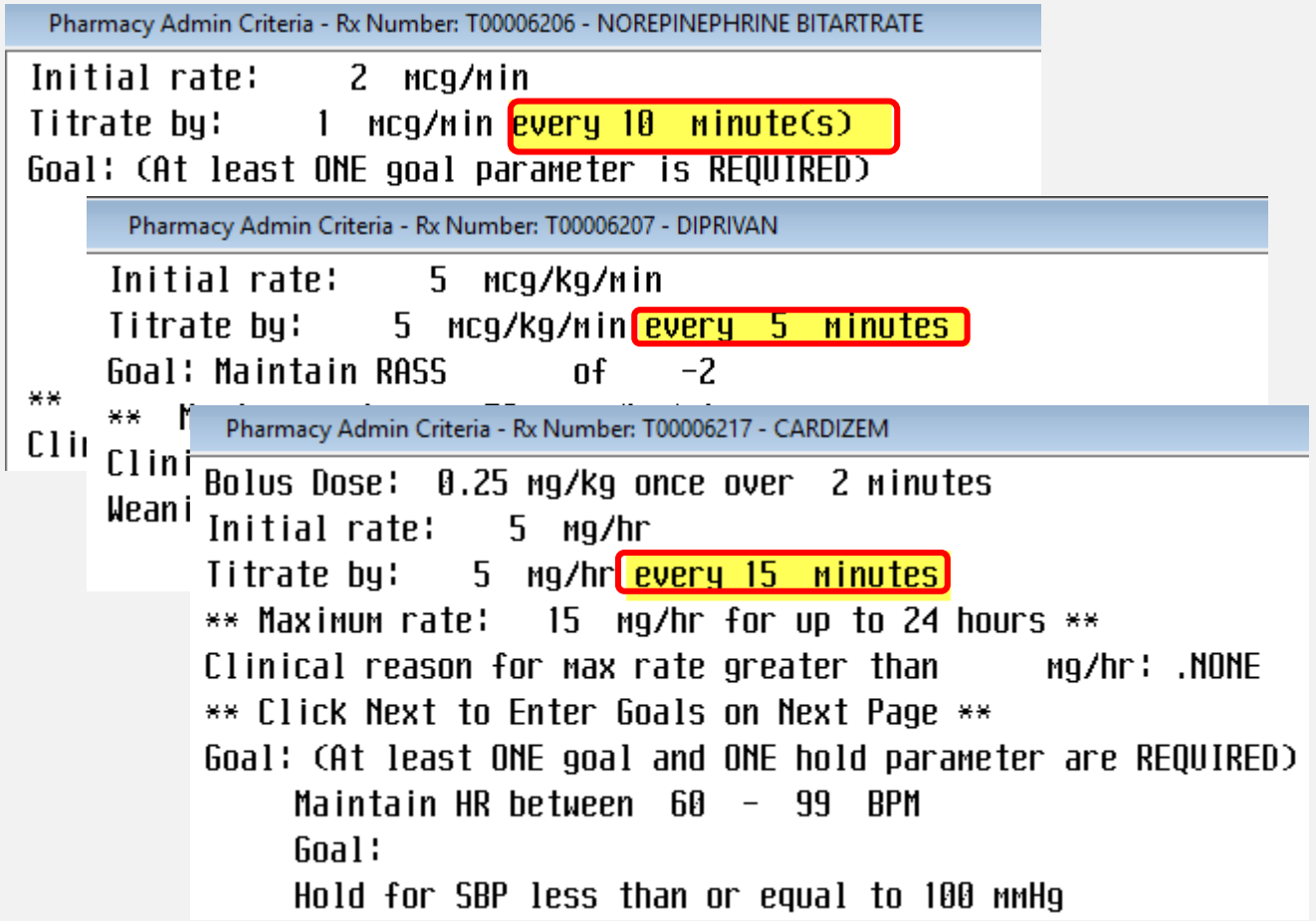
With EACH Titration Document:

- 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.

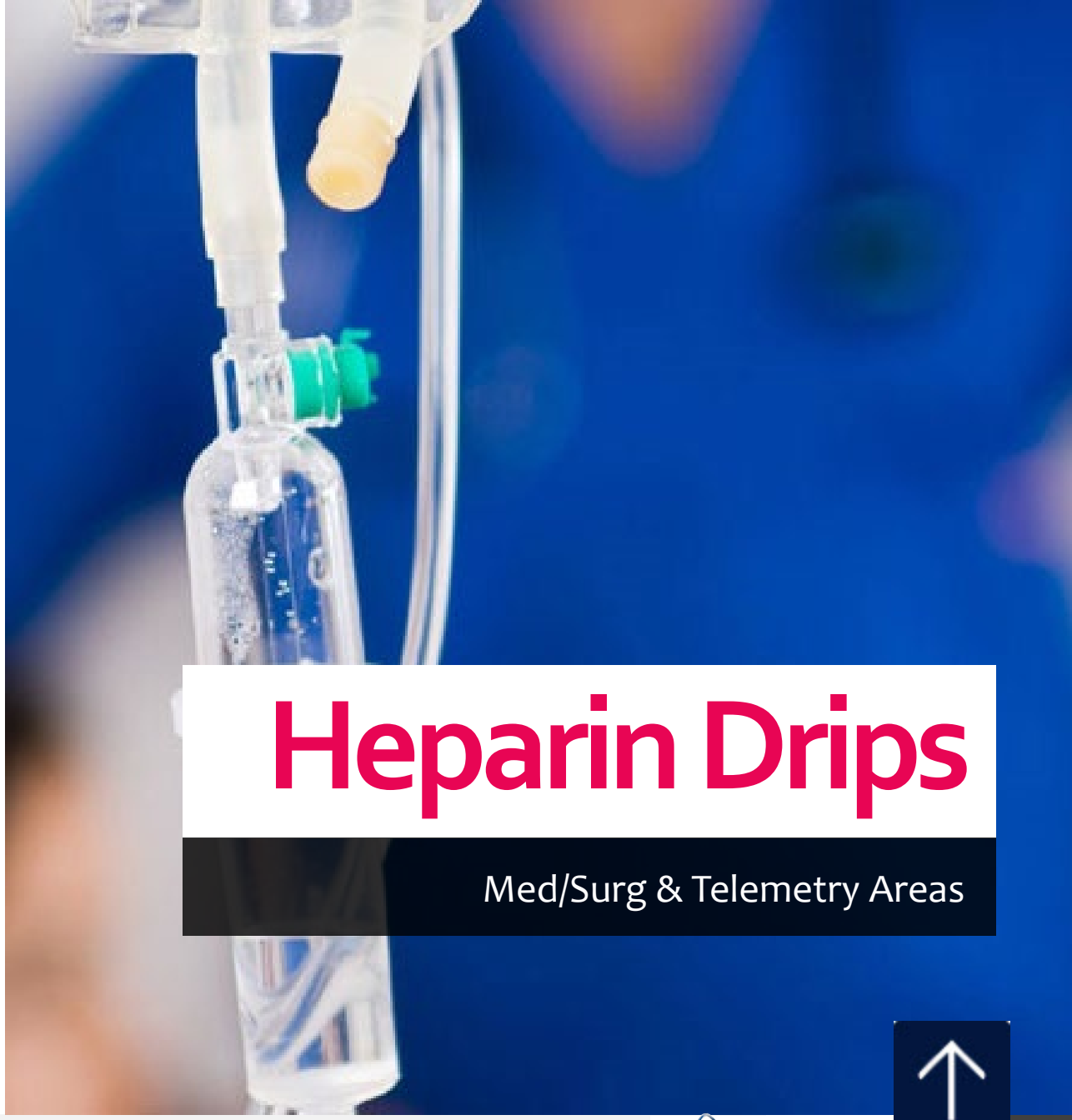
ALL DRIPS MUST BE DOCUMENTED UNDER "IV DRIP TITRATION," not just in I/O

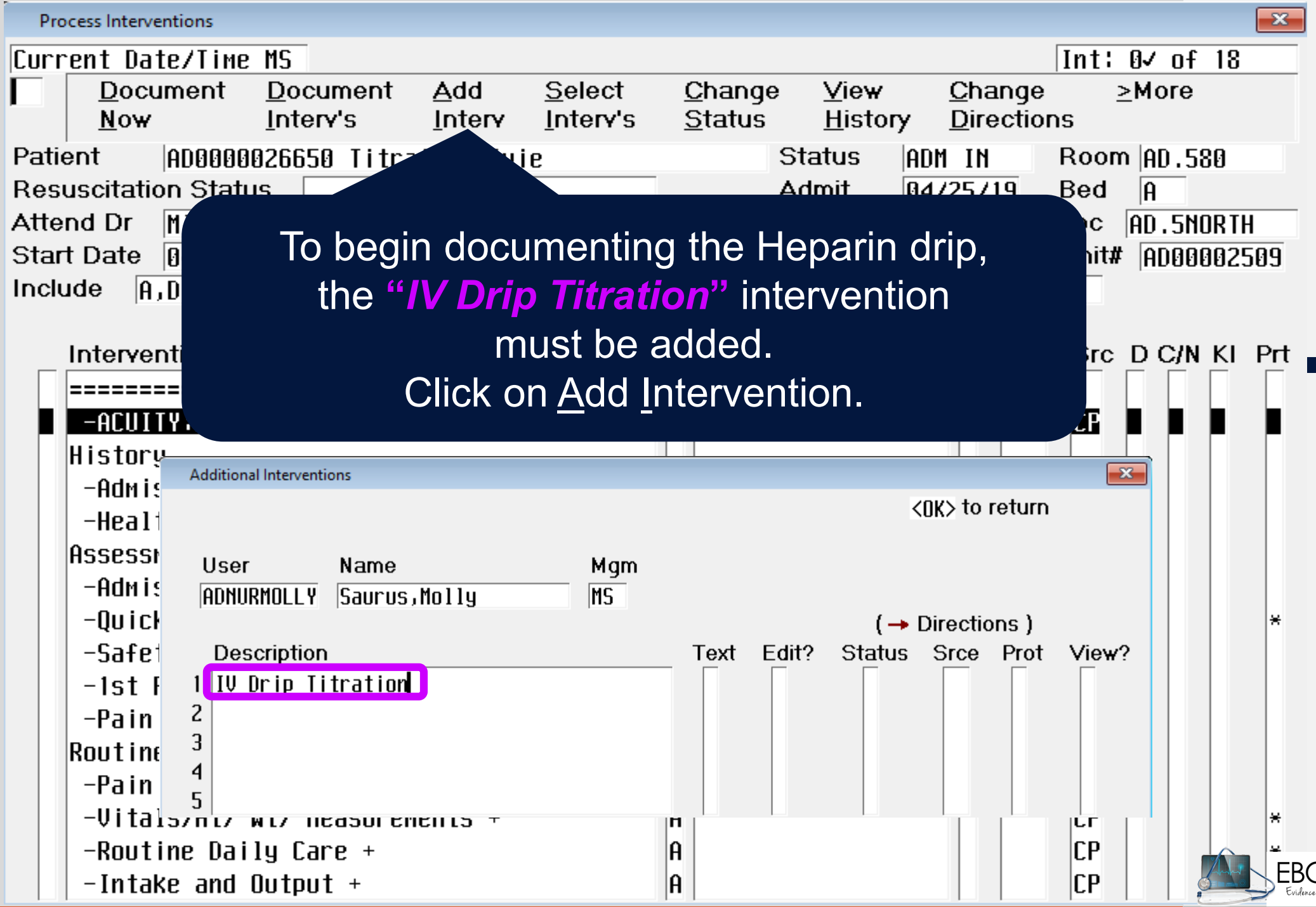
New Process

- Any patient with IV Drips that need titrating will use the new stand alone intervention, "IV Drip Titration."

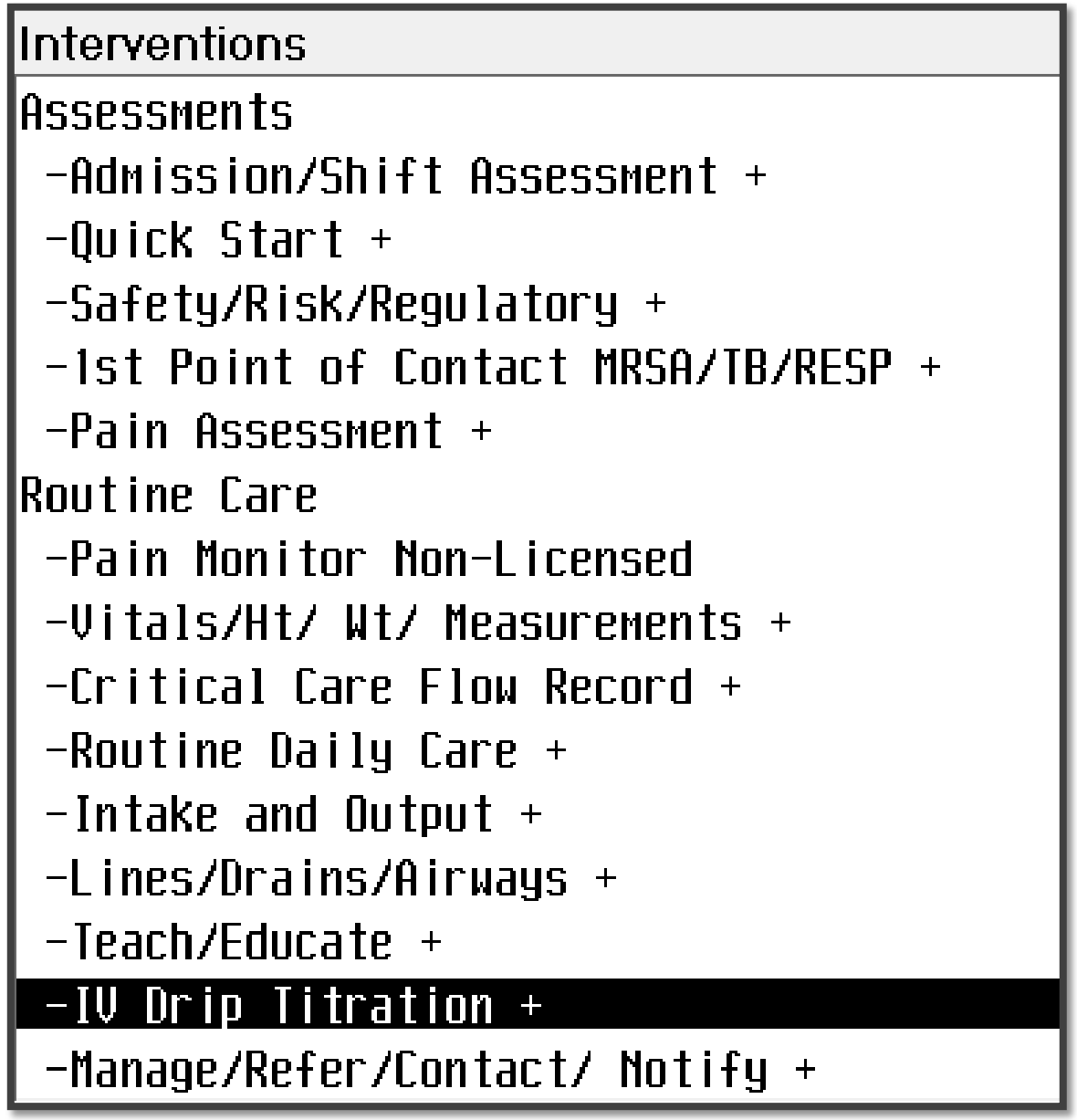
- **This is not just for critical care nurses**, all Heparin drips, or other infusions that may be titrated, **must** be documented using the IV Titration screens.

- **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.





To begin documenting the Heparin drip, the "*IV Drip Titration*" intervention must be added.
Click on Add Intervention.

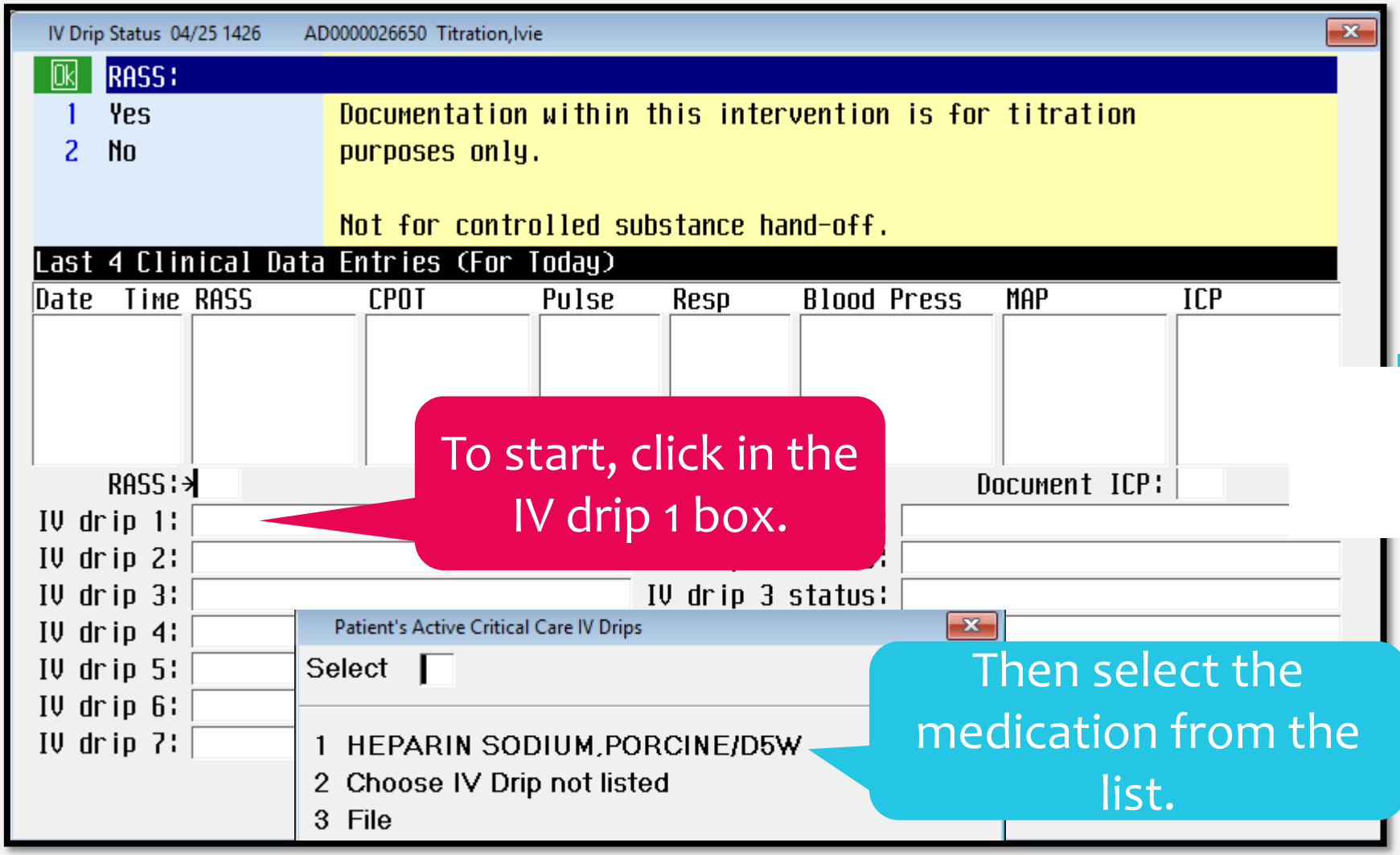


IV Drip Titration

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.

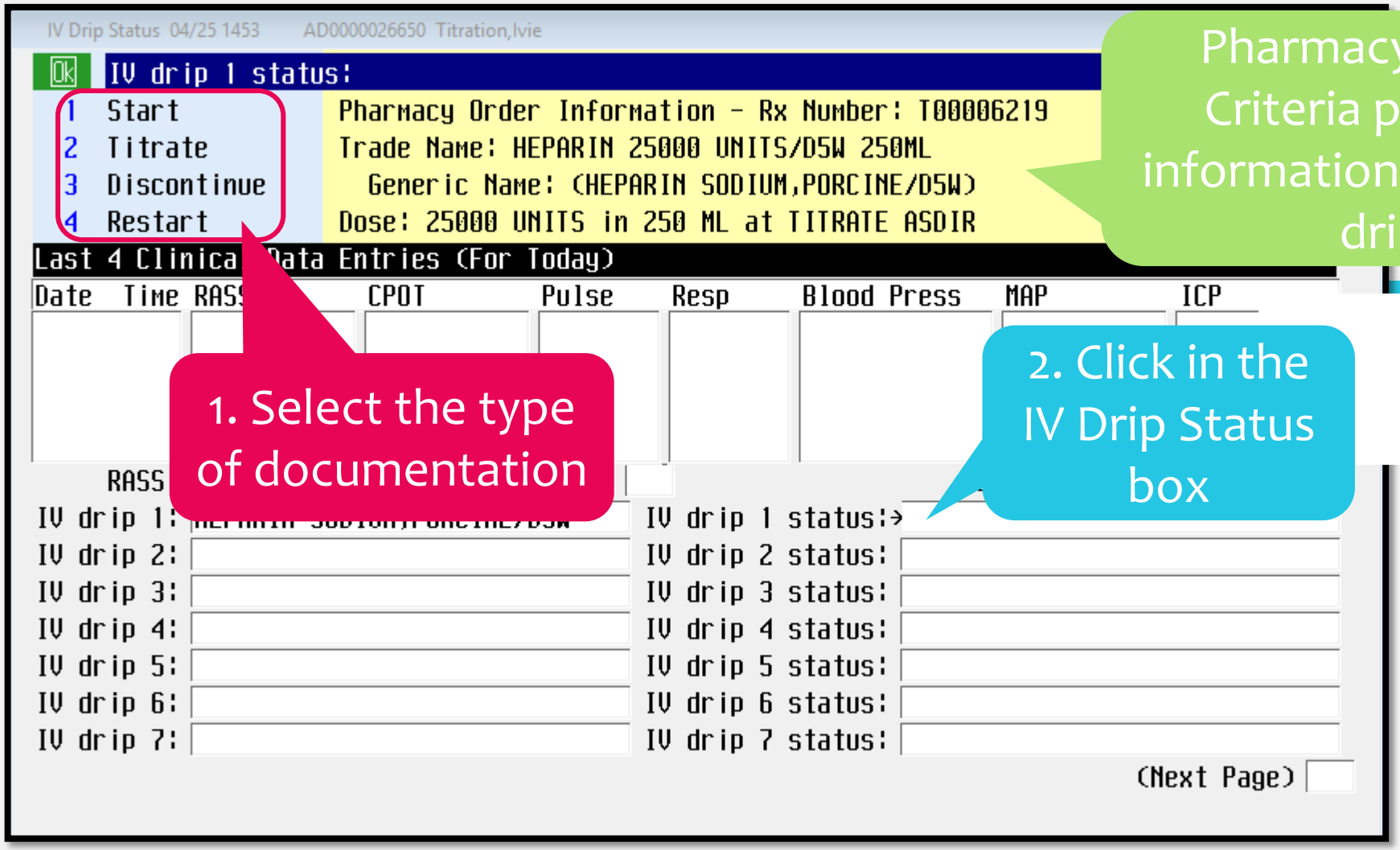


To start, click in the IV drip 1 box.

Then select the medication from the list.

Start

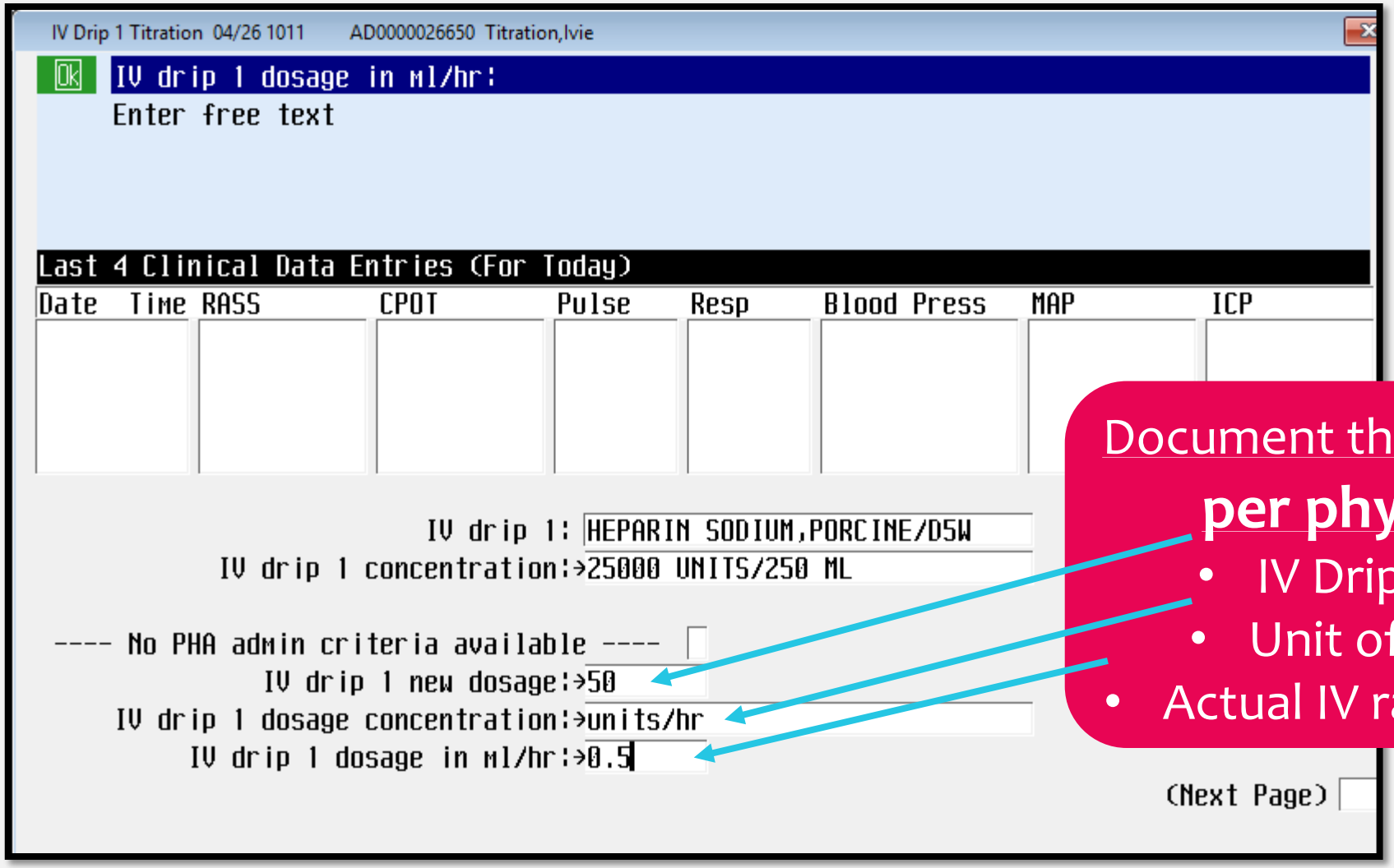
IV Drip 1



Pharmacy Admin Criteria provides information about the drip

1. Select the type of documentation

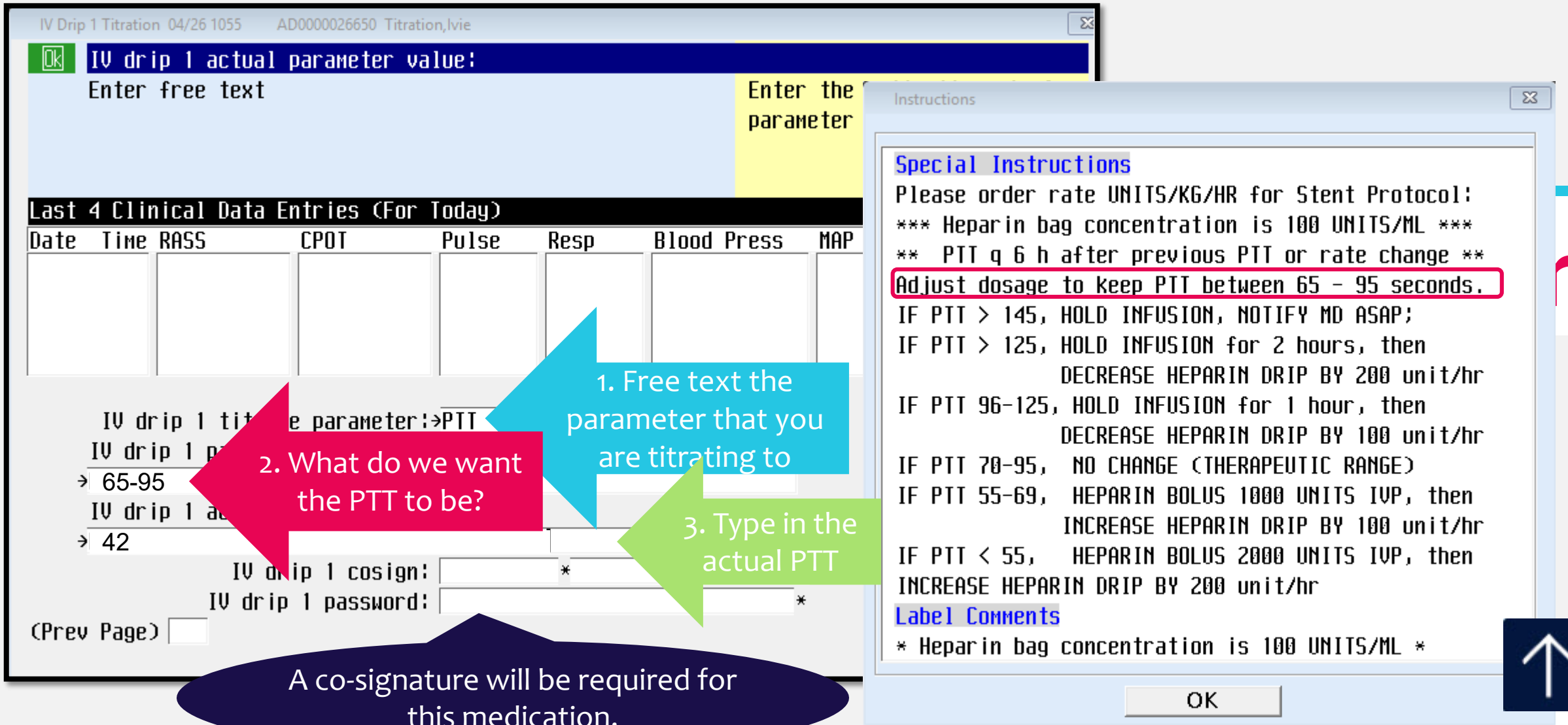
2. Click in the IV Drip Status box

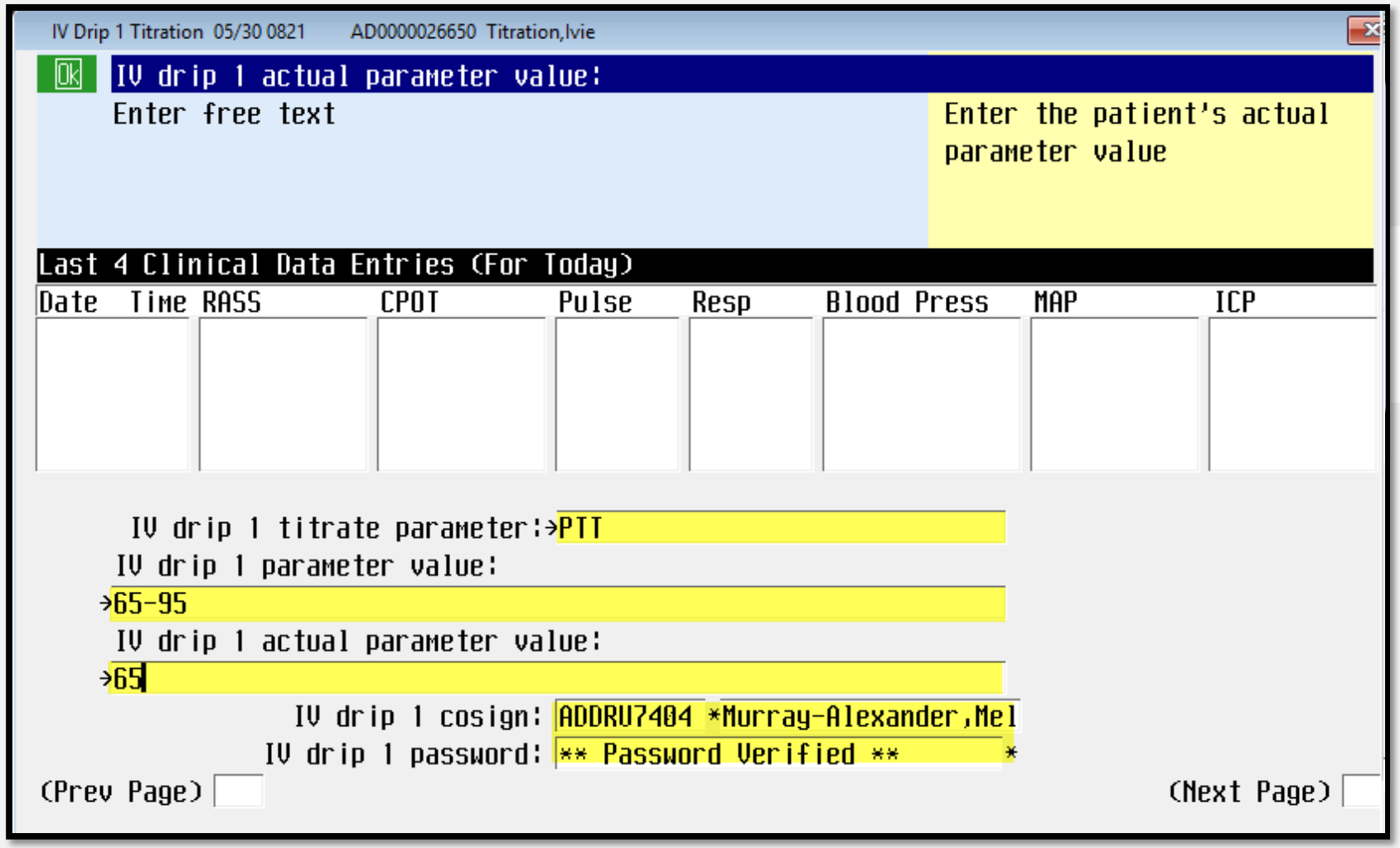


Document the following q6h **or**

per physician order

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

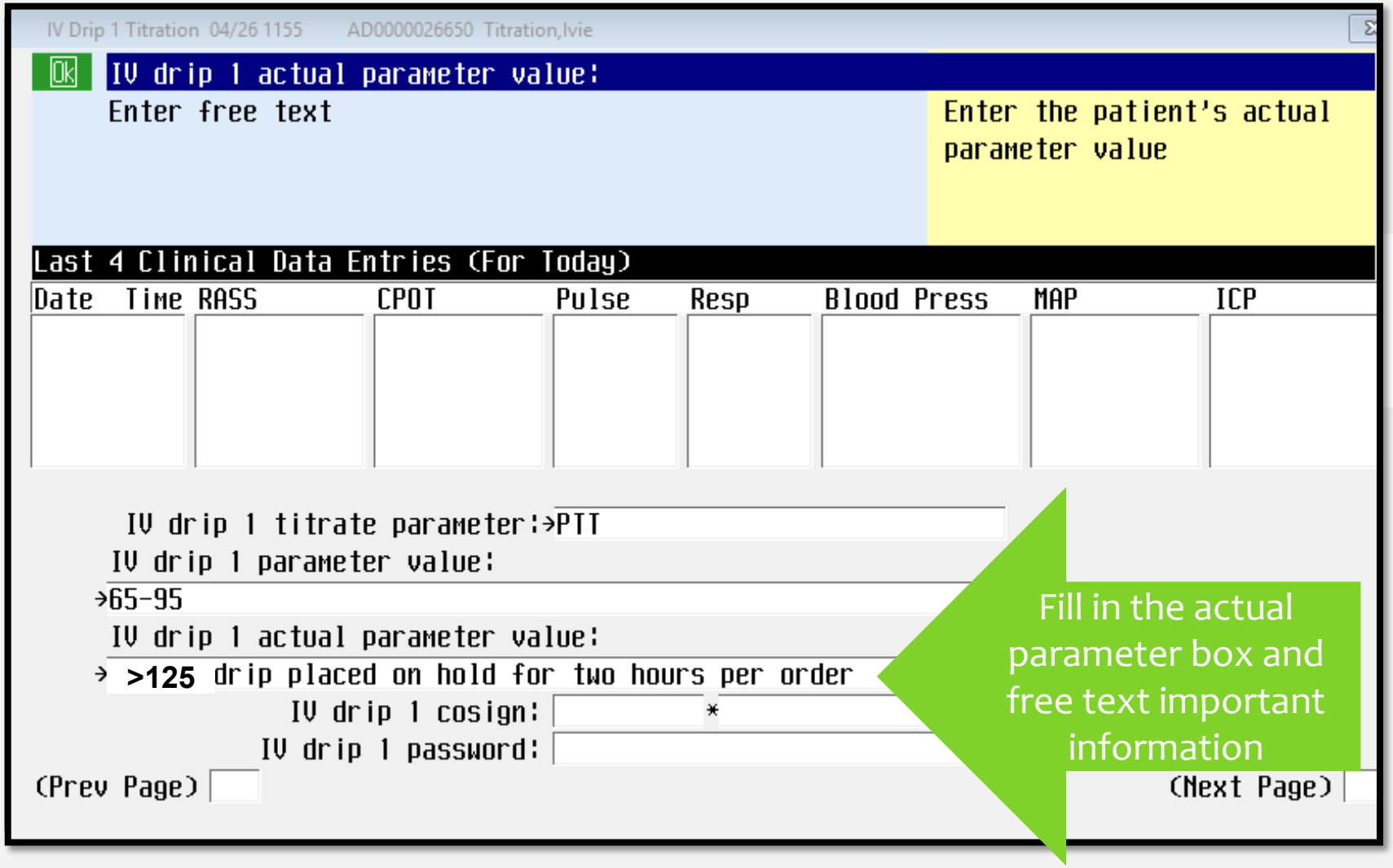

IV Drip 1 Titration 04/26 1055
AD0000026650 Titration,Ivie
IV drip 1 actual parameter value:
Enter free text
Enter the
parameter
Last 4 Clinical Data Entries (For Today)
Date Time RASS CPOT Pulse Resp Blood Press MAP
IV drip 1 tit e parameter:→PTT
IV drip 1 p
→ 65-95
IV drip 1 a
→ 42
IV drip 1 cosign:
IV drip 1 password:
(Prev Page)
1. Free text the parameter that you are titrating to
2. What do we want the PTT to be?
3. Type in the actual PTT
A co-signature will be required for this medication.
Instructions
Special Instructions
Please order rate UNITS/KG/HR for Stent Protocol:
*** Heparin bag concentration is 100 UNITS/ML ***
** PTT q 6 h after previous PTT or rate change **
Adjust dosage to keep PTT between 65 - 95 seconds.
IF PTT > 145, HOLD INFUSION, NOTIFY MD ASAP;
IF PTT > 125, HOLD INFUSION for 2 hours, then
DECREASE HEPARIN DRIP BY 200 unit/hr
IF PTT 96-125, HOLD INFUSION for 1 hour, then
DECREASE HEPARIN DRIP BY 100 unit/hr
IF PTT 70-95, NO CHANGE (THERAPEUTIC RANGE)
IF PTT 55-69, HEPARIN BOLUS 1000 UNITS IVP, then
INCREASE HEPARIN DRIP BY 100 unit/hr
IF PTT < 55, HEPARIN BOLUS 2000 UNITS IVP, then
INCREASE HEPARIN DRIP BY 200 unit/hr
Label Comments
* Heparin bag concentration is 100 UNITS/ML *
OK



q6h Documentation

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

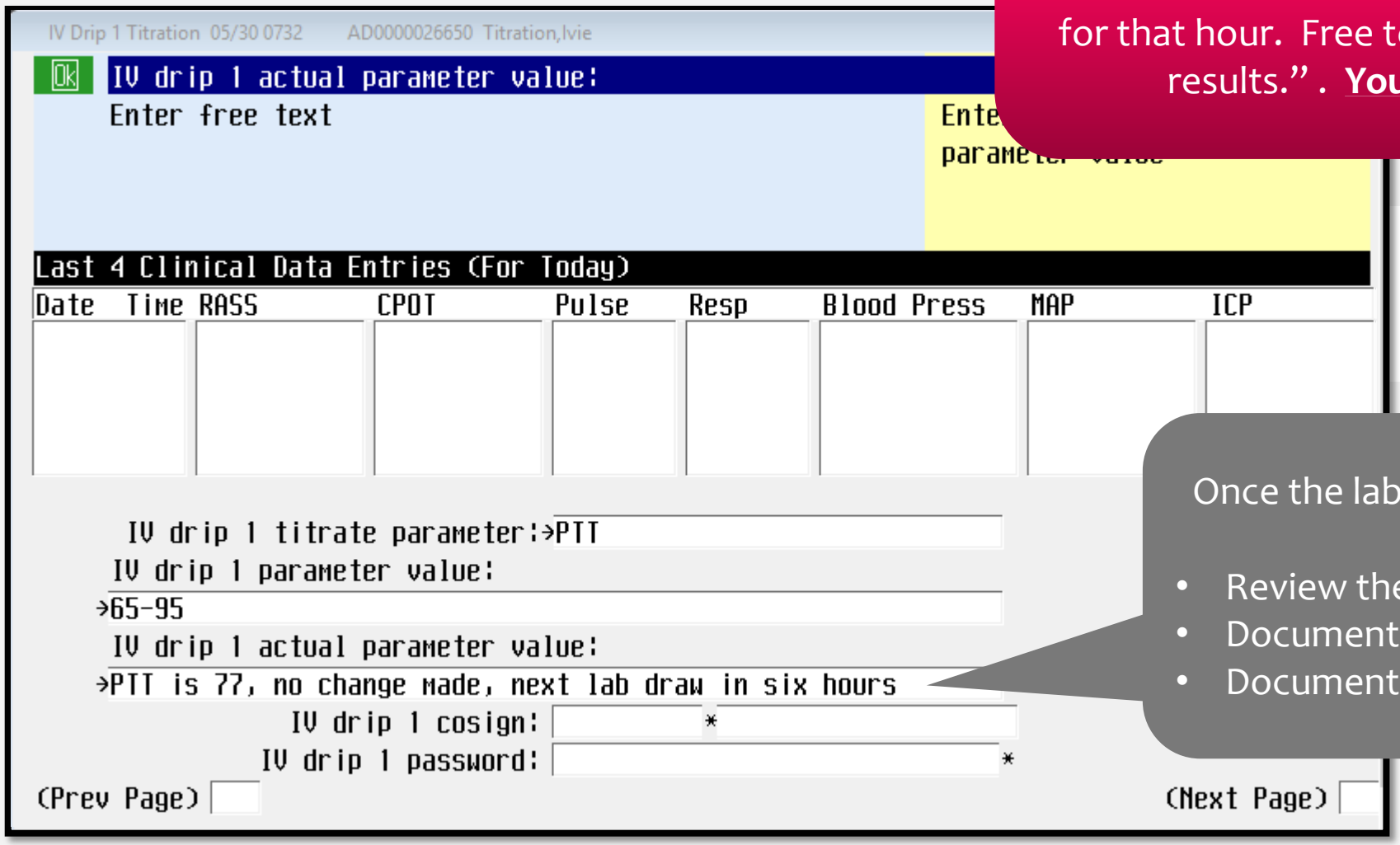


Fill in the actual parameter box and free text important information

Late Lab Draw

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.**

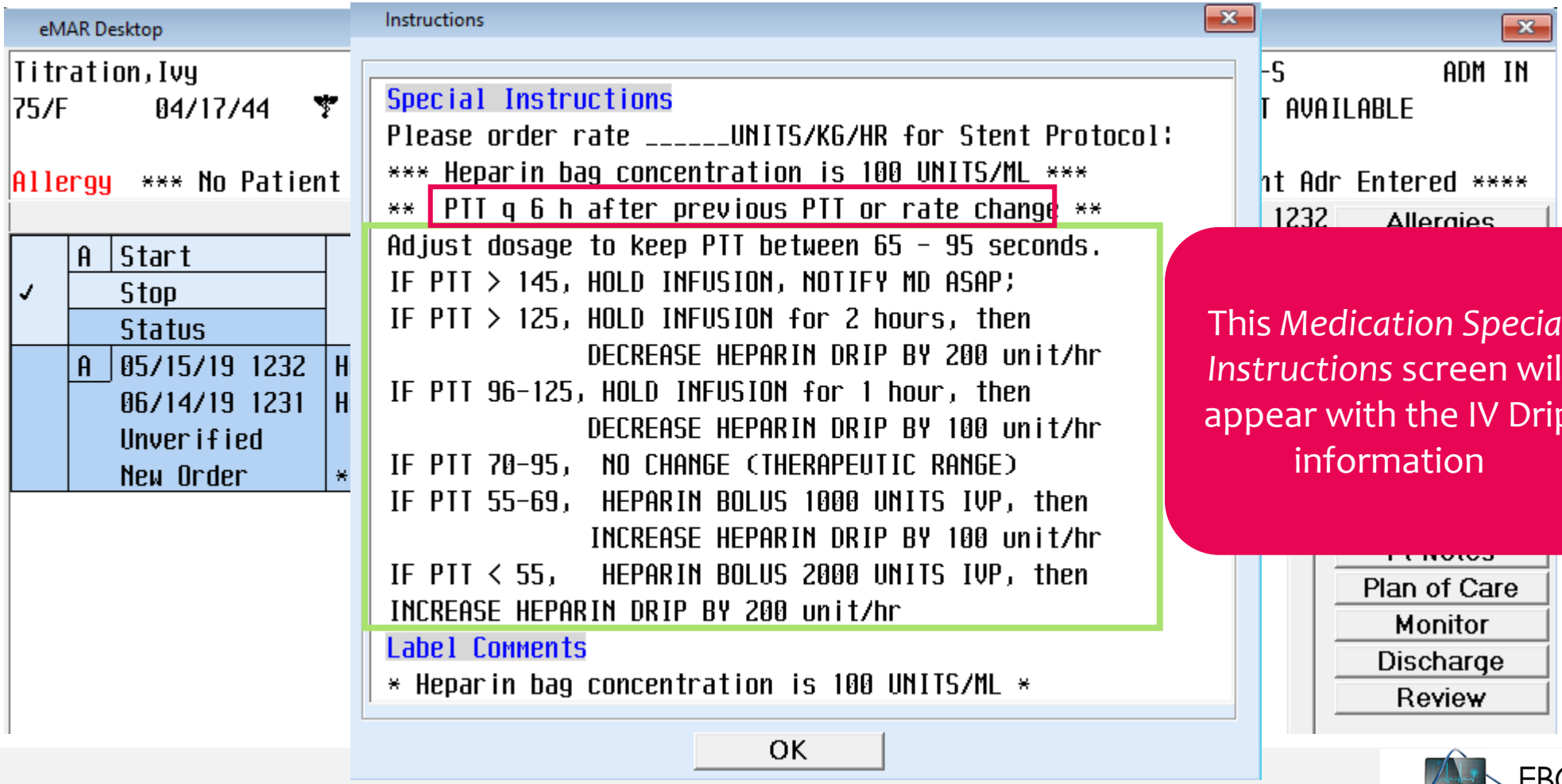


Once the lab results are available, do the following:

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

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.



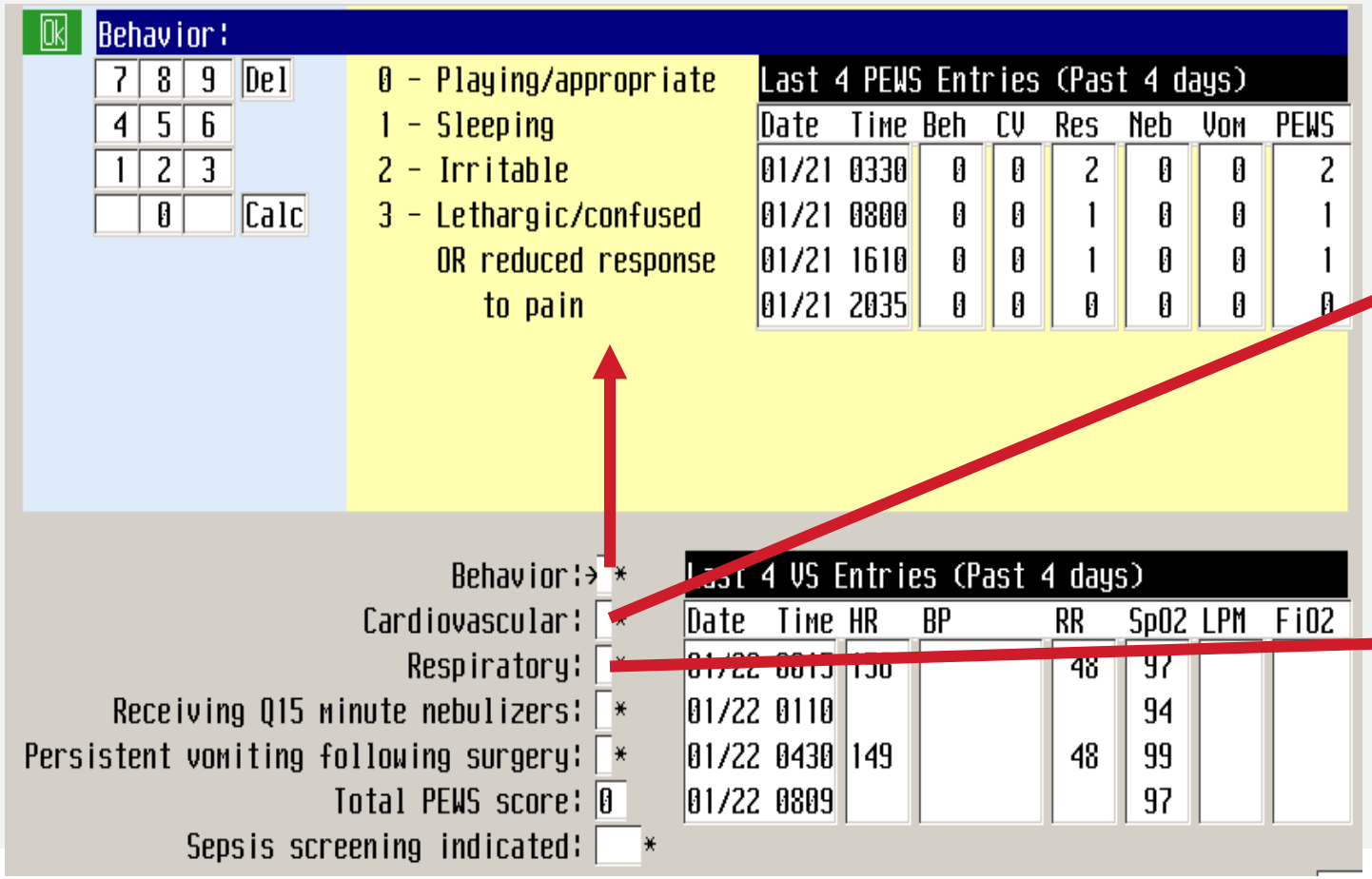
This *Medication Special Instructions* screen will appear with the IV Drip information

Pediatric Early Warning System (PEWS)

Utilized in the Emergency Department

- 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

MEWS – *Modified Early Warning System*

The Modified Early Warning System (MEWS) is a tool used to:

- Identify patients at the earliest signs of decompensation
- Increase critical thinking at the bedside
- Promote early interventions for deterioration
- Prevent Code Blue episodes
- Promote patient safety

The MEWS score is calculated based on:

- Systolic Blood Pressure
- Heart Rate
- Respiratory Rate
- Temperature
- Neurologic status/Level of Consciousness (AVPU: **A**lert – Responds to **V**erbal – Responds to **P**ain – **U**nresponsive)

The Registered Nurse's responsibility/action:

- Obtain and enter into Meditech complete Vital Signs and MEWS score every 4 hours.
- Monitor MEWS score and trending of score. When the MEWS score is **5 or greater**, or there is a **2 point increase** from previous recorded score, **REASSESS** the patient, and **notify the Charge Nurse** for consultation and/or reassessment. Know what parameters have changed and increased the MEWS score. Know the patient's baseline. Does the MEWS score reflect the patient's condition?
- Activate Rapid Response Team (RRT) if **INDICATED** by patient condition.
- Notify Physician as needed.
- Document on Meditech, when 1) RRT is NOT indicated and RRT is NOT called and the reason why, or when 2) RRT IS called.

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

Meet the Stroke Team!

Neurointerventionalist Team

Dr. Stout
Neurointerventional Medical Director

Dr. Teitlebaum
Neurointerventionalist

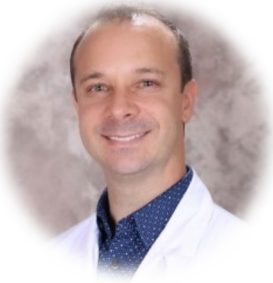
Neurology Team

Dr. Dekermenjian
Neurohospitalist

Dr. Girgis
Neurohospitalist

Meet the Stroke Team!

Nurse Practitioners



Shawn Hurley, NP
Lead Operations
Neurointerventional Practitioner

Lorena Ruiz, NP
Lead Education
Neurointerventional
Practitioner

Shoko Nitta, NP

Rhea Mulvina, NP

Travis Petrick, NP

Meet the Stroke Team!

Program Management

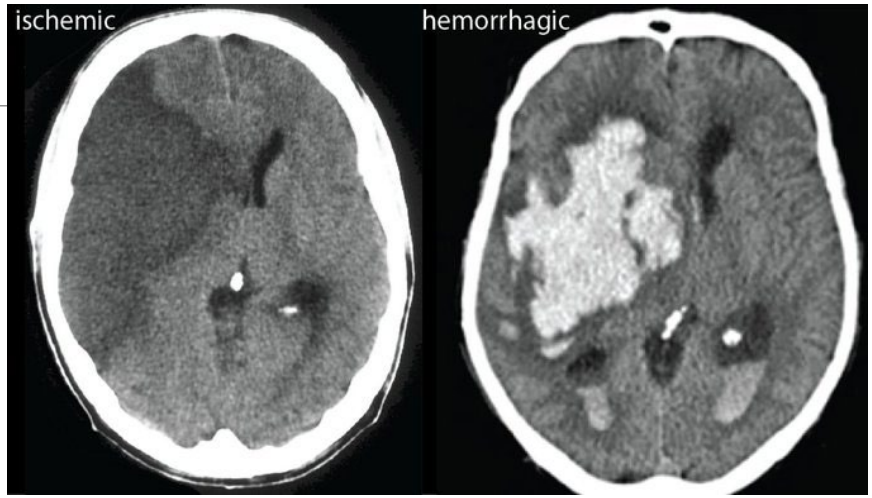
Luke Hopps BHSA, RN
Neuroscience
Director

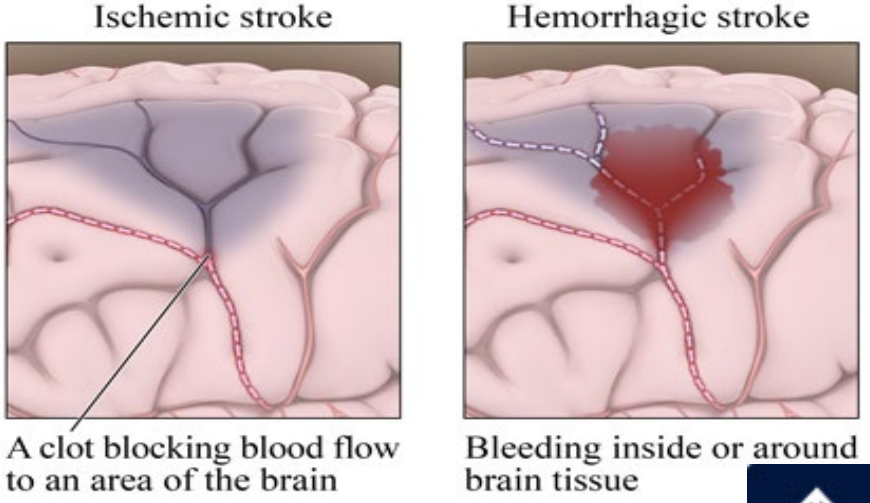
Jon Annand BSN, RN
Neuroscience
Coordinator

Elaina Romero BSN, RN
Neuroscience
Data Analyst

What is a Stroke?

- A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or plaque, or bursts.
- When this happens, this part of the brain cannot get the adequate amount of blood or oxygen, leading to the death of these brain cells.

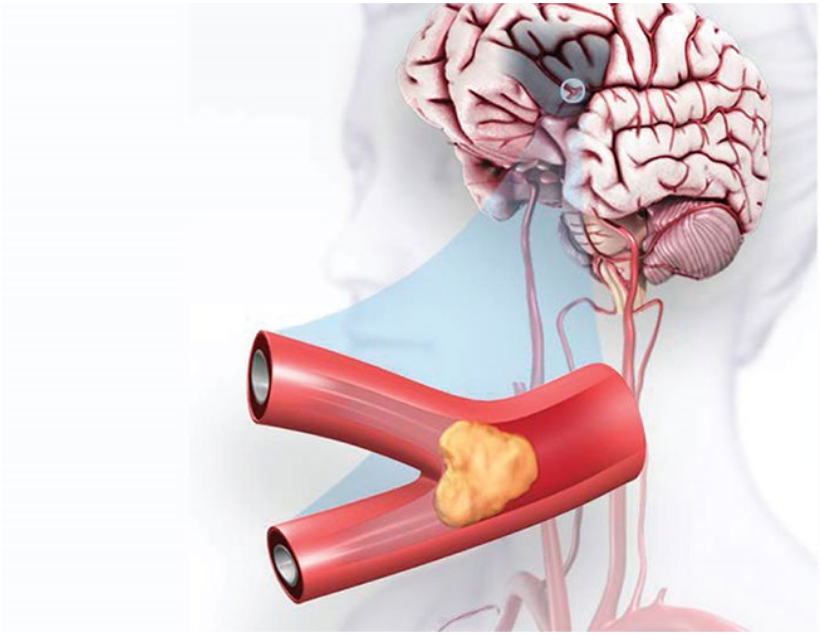


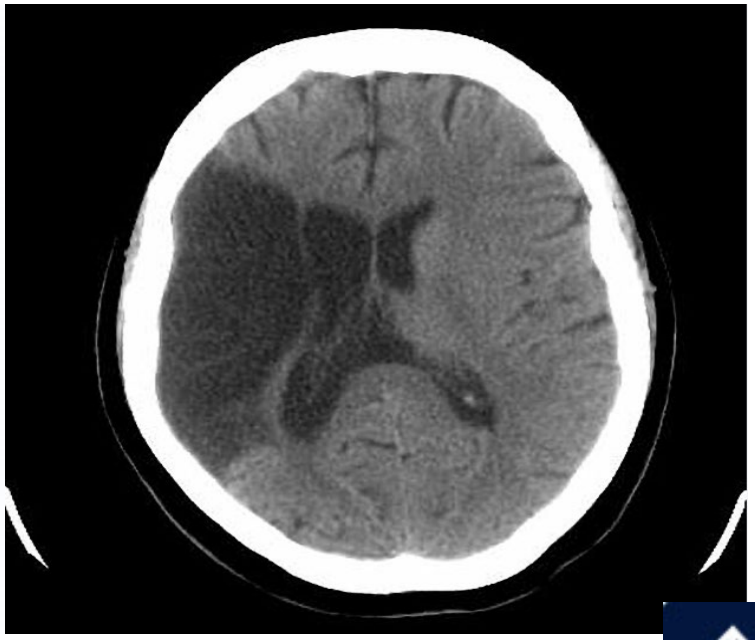


Ischemic Stroke

-Ischemic stroke occurs when a vessel supplying blood to the brain is obstructed. This can either be from a blood clot or plaque build up.

-Ischemic Strokes account for about 87 % of all strokes.





Ischemic Stroke *contd.*

The underlying condition for this type of obstruction is **atherosclerosis**. These fatty deposits can cause two types of obstruction:

- **Cerebral thrombosis-** refers to a thrombus that develops at the clogged part of the vessel

- **Cerebral embolism-** refers to a blood clot that forms at another location in the circulatory system (usually the heart and large arteries of the chest and neck) that breaks loose and travels through the bloodstream to the brain until it reaches vessels too small to pass.

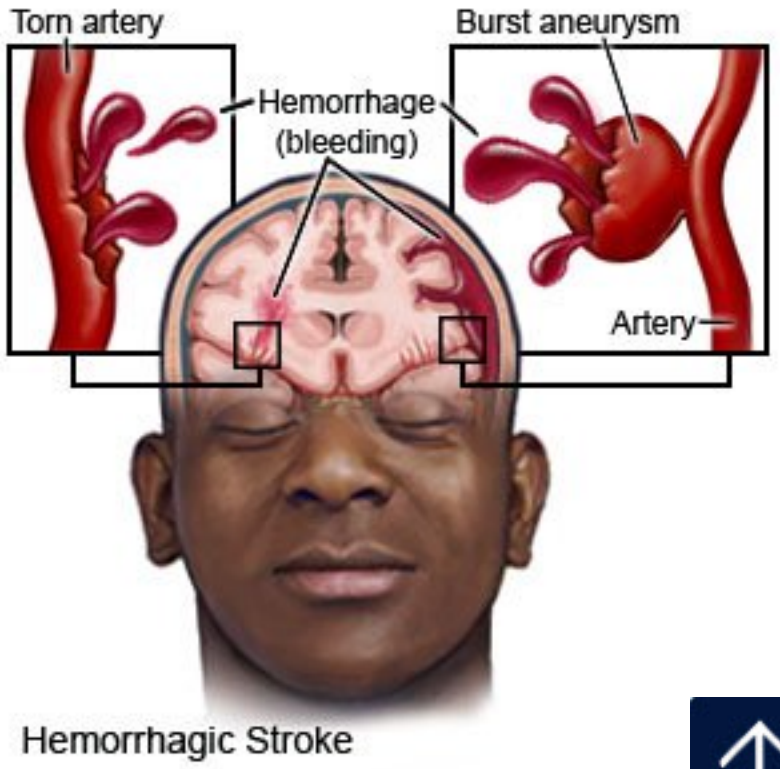
(AHA, 2018)

Hemorrhagic

-Rapidly developing signs of neurological dysfunction related to a focal collection of blood within the brain, subarachnoid space or ventricular system that is not caused by trauma.

-Types of Hemorrhagic Strokes

- Intracerebral hemorrhage
- Subarachnoid hemorrhage
- Hemorrhagic conversion of infarction



Hemorrhagic Stroke

Hemorrhagic *contd.*

-Results from a weakened vessel that ruptures and bleeds into the surrounding brain.

-Types of weakened blood vessels:

- **Aneurysm** is a ballooning of a weakened region of blood vessel. If left untreated, it will continue to weaken until it ruptures and bleeds into the brain.
- **Arteriovenous malformation (AVM)** is a cluster of abnormally formed blood vessels. Any one of these vessels can rupture, causing bleeding into the brain.

(AHA, 2018)

Transient Ischemic Attack (TIA)

"Warning Stroke" or "Mini Stroke"

-Transient episode of neurological dysfunction caused by focal brain, spinal cord or retinal ischemia **WITHOUT** acute infarction.

-Most resolve within one to two hours.

-No permanent residual neurological deficits.

-Prognosis

- 10% stroke in 2 days
- 14% stroke in 30 days
- 16% stroke in 90 days
- * improved outcomes when TIA is aggressively treated

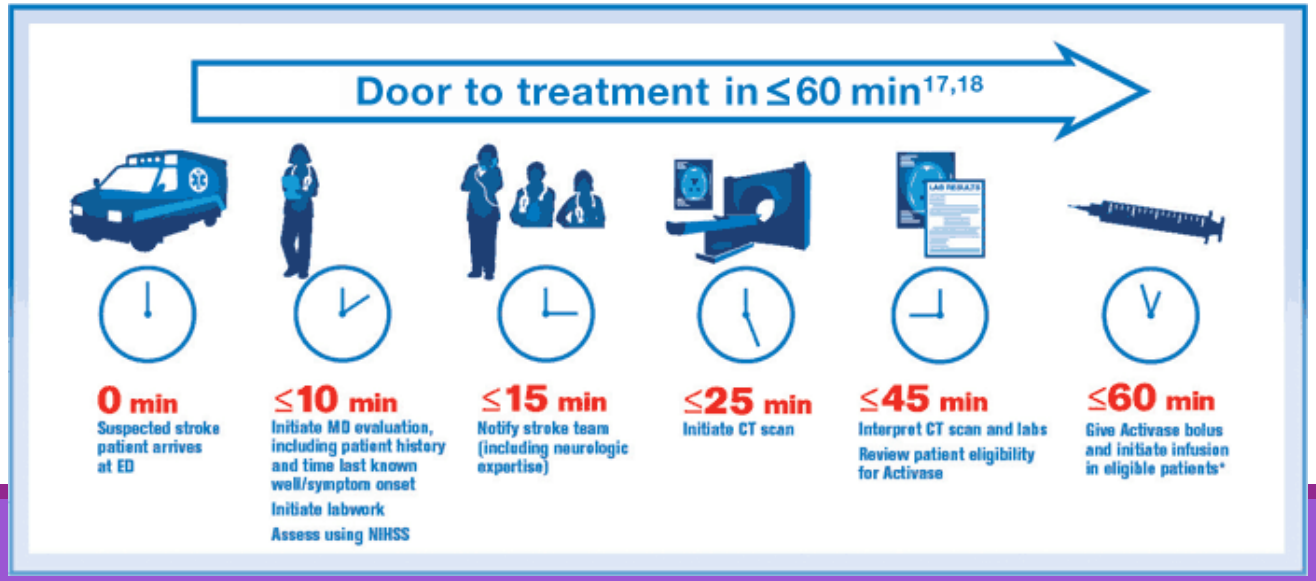
Code Stroke: What is the Purpose?

-The purpose of activating a Code Stroke is to expedite the assessment process to determine if a stroke patient is eligible for TNK administration and/or thrombectomy!

-Goal is for door to CT time to be under 20 minutes!

-Goal is for door to needle time to be under 30 minutes!

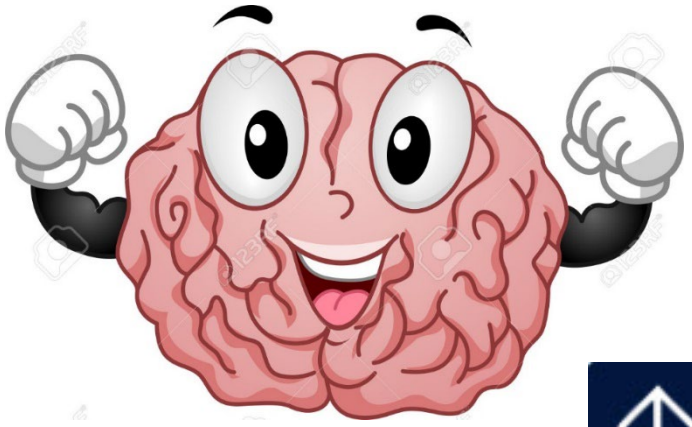
-Goal is for door to groin time to be less than 60 minutes!



When Should a Code Stroke be Activated?

- Patient has a focal neurological deficit.
- Any BEFAST Signs or Symptoms!
- Anybody can activate a Code Stroke!!!

84911 – Code Stroke!



What Happens During a Code Stroke?

Team Members Responding:

NIR NP (Stroke team lead)

Stroke Coordinator*

CT tech

Phlebotomist

X-ray tech

Pharmacy

NIR attending (in person or phone)

Neurosurgery (in person or phone)

Neurology resident

ED or Intensivist Physician

*when in house

Tasks Completed:

CT head

Vital Signs
- BP <185/110 prior to IV thrombolytic

Labs

Chest x-ray

NIHSS

Blood glucose
- Must have BG 50>400

Accurate patient weight
- Transfer board in CT can weight patient

Stroke Tracking Goal Times (Tracking Tool)

Inclusion Criteria: Patients with acute neurologic deficit

Stroke Onset Determination:

Stroke Onset Date: _____ ☐ Self reported

Stroke Onset Time: _____ ☐ Witnessed

Last Known Well: _____

Responders: ☑ ED/Critical Care MD ☐ Neurology ☐ X-Ray ☐ Pharmacy ☐ Lab ☐ EKG ☐

Door to tPA GOAL: ≤ 45 minutes

*For in-patient Code Strokes: Door=Code Activation

Arrival Date/Time: Triage/RR Time:

GOAL Door to Completion	INDICATOR	TIME	COMMENTS
Within 5 MINUTES	Quick Registration		
	ED/ Critical Care MD		
	Transfer Center (877-922-3648)		
Within 10 Minutes	Patient Weight		Weight:
	CT Scan		
	Neurologist Consult		
	Physician led NIHSS		
	Lab Draw (i.e. INR GLU)		Glucose: INR:
Within 30 Minutes	CT Interpretation		
	tPA Order		
Within 45 Minutes	tPA Bolus (7m in from order)		
	CTA/ CTP (as needed)		
If Transporting to NIR	to NIR		
If Remaining in ED	X-Ray		
	EKG		
Additional Comments			

Completed by: (Print Name)

The purpose of this form is to ensure everything is being performed in a timely manner during code strokes, as well as giving Nurses an area to document until they can log onto meditech!

What about Inpatient Code Strokes?

PRIMARY RN

-Identifies **NEW** focal neuro deficits in patients, activates Code Stroke or calls Rapid Response RN.

-Performs glucose check/Vitals/and weighs patients.

-Speaks to Stoke Team about patient's medical hx, medications, and the LKW time.

RAPID RESPONSE NURSE

-Assesses patient for Code Stoke eligibility.

-Activates Code Stoke.

-Ensures patient has proper diagnostic tests performed.

-Accompanies patient to CT.

-Administers t-PA/TNK if ordered.

IV thrombolytic Exclusions

- Evidence of hemorrhage.
- Recent (within 3 months) intracranial or intraspinal surgery, serious head trauma, or stroke.
- Multi-lobar infarction
- Recent major surgery within two weeks.
- HX of intracranial hemorrhage.
- Uncontrolled HTN (>185/110) at time of treatment.
- Active internal bleeding
- Patient taking novel anticoagulants
- INR greater than 1.7.
- PT greater than 15 seconds.
- Heparin given within the last 48 hours **AND** elevated aPTT
- Platelet count less than 100,000 per mm.
- LKWT >4.5 Hours

What's Next?

-Once all information is gathered, Thrombolytic eligibility can be determined.

-Pharmacist will start mixing Thrombolytics, given Neurointervention gives the green light!

(Notify pharmacy right away if the neurologist orders Thrombolytics and isn't present during code stroke)

-NIR provider will go over risks, benefits, and alternatives with patient.

-Consent is **NOT** needed*.

Calling a CODE FAST

-Can only be called by NIR team

-Indicates that patient needs NIR intervention

- Thrombectomy or coiling

-Calls NIR team to action!

-Nurse accompanies patient to NIR suite to transition care / give report

IV Thrombolytics

-Tenecteplase (TNK) or Alteplase (tPA)

-Works by dissolving the clot and improving blood flow to the part of the brain being deprived of blood flow .

TNK Dosing

-0.25 mg/kg (max 25 mg)

-Flush line with NS before administration.

-Single bolus administration of TNK (5 seconds)

-Flush line with NS after administration.

Administering IV Thrombolytic

-Prior to administration:

- BP <185/110
- BG >50
- Patient not on anticoagulants

-Pharmacist will mix dose!

-Dose will be double verified prior to administration.

During Administration

Watch for the following:

Adverse Effects:	Intracranial Hemorrhage	Angioedema	BP Fluctuations
S/S:	Acute neurological deterioration, new headache, acute HTN, N/V.	Swelling that occludes the airway.	SBP>180 or <100 DBP >110 or <60
Next Steps:	1.Stop Thrombolytics 2. Plan to go to CT Draw labs for PT/INR, PTT, Platelets, Fibrinogen 4. Plan to administer FFP	1. Stop Thrombolytics 2. Prepare to administer IV Benadryl OR Epinephrine 3. Prepare to intubate as necessary	**HTN:** STOP Thrombolytics Administer Labetolol x2, Cardene drip for refractory HTN **Hypotension:** NS Bolus
	* Higher risk for NIHSS >22	* African Americans and patients on ACE inhibitors are at Higher risk	

Post IV thrombolytic Monitoring

-Q 15 min. VS and neuro checks for the first 2 hours

-Q30 min. VS and neuro checks for the next 6 hours.

-Hourly VS and neuro checks for the remaining 16 hours to encompass a total of 24 hours post infusion.

-Every spot must be filled out on flowsheet and care plan.

And make you sign!

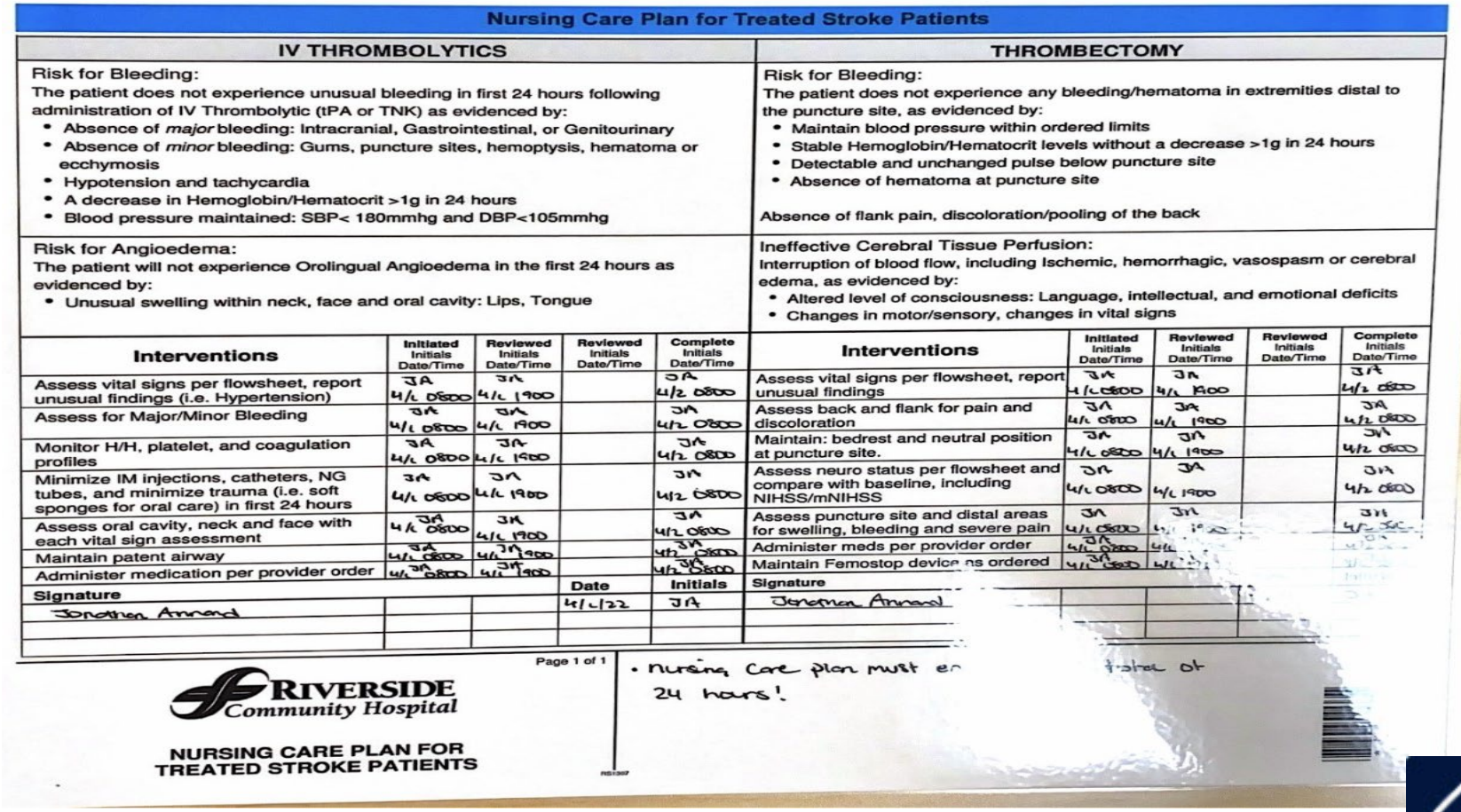
Post stroke intervention Documentation IV thrombolytic, Thrombectomy, Coiling

Frequent Neuro Check Flowsheet

I. Score Maximum points for comatose patients. Comatose patients are defined as making no movement (other than reflexive posturing) in response to noxious stimuli.
II. "T = 0" indicates the time IV t-PA is started or the time of vascular access site closure after NIR procedure

Date: Initial NIHSS: Initial VS: BP____ HR____ O2____ Resp___	START T = 0	+15 m	30m	45m	1hr	1hr 15m	1hr 30m	1hr 45m	2hrs	2hrs 30m	3hrs	3hrs 30m	4hrs	4hrs 30m	5hrs	5hrs 30m	6hrs	6hrs 30m
Actual Time																		
O2 Sat																		
Heart Rate																		
Blood Pressure *Initial BP less than 185/110 *Maintenance BP less than 180/105 for post t-PA *Review BP orders for post thrombectomy patients																		
LOC Questions 0 = Both Correct, 1 = One Correct, 2 = Neither Correct																		
LOC Commands 0 = Performs Both Correct, 1 = One, 2 = Neither																		
Lateral Gaze - 0 = Normal side to side movement, 1 = partial gaze palsy, 2 = no side to side movement																		
Visual Fields - 0 = Normal, 1 = Upper OR lower field blindness, 2 = Upper AND Lower field, 3 = Blind Both Eyes																		
Arm Weakness - 0 = No Drift, 1 = drift w/in 10 sec, 2 = Hits Bed, 3 = Shrug, 4 = No Movement	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Leg Weakness - 0 = No Drift, 1 = Drifts in 5 sec, 2 = Resists Fall to Bed, 3 = Attempt, 4 = No Movement	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Sensory - 0 = Normal, 1 = Abnormal, 2 = No sensation																		
Speech - 0 = Normal, 1 = Mild Aphasia, 2 = Severe Aphasia, 3 = Mute																		
Neglect - 0 = Normal, 1 = Mild, 2 = Severe																		
*Full NIHSS at 2 hrs & Q shift **Total Score**									*									
BP Management- Medication:_____																		
(NIR patients only) Vascular Access Site Assessment D = Dry, A = Active Bleeding, O = Oozing, H = Hematoma																		
(NIR patients only) Distal Pulse Assessment P = Palpable, D = Doppler, A = Absent																		
Other Complications D = Dizzy, V = Double Vision, H = Headache, N/V = Nausea/Vomiting, LOC = Altered mental status, AE = Angioedema, NIH increase																		
Provider Notified																		
Examiner's Initials																		

Post stroke intervention Documentation IV thrombolytic, Thrombectomy, Coiling



Nursing Care Plan for Treated Stroke Patients

IV THROMBOLYTICS

Risk for Bleeding:
The patient does not experience unusual bleeding in first 24 hours following administration of IV Thrombolytic (tPA or TNK) as evidenced by:

- Absence of *major* bleeding: Intracranial, Gastrointestinal, or Genitourinary
- Absence of *minor* bleeding: Gums, puncture sites, hemoptysis, hematoma or ecchymosis
- Hypotension and tachycardia
- A decrease in Hemoglobin/Hematocrit >1g in 24 hours
- Blood pressure maintained: SBP< 180mmhg and DBP<105mmhg

Risk for Angioedema:
The patient will not experience Orolingual Angioedema in the first 24 hours as evidenced by:

- Unusual swelling within neck, face and oral cavity: Lips, Tongue

Interventions	Initiated Initials Date/Time	Reviewed Initials Date/Time	Reviewed Initials Date/Time	Complete Initials Date/Time
Assess vital signs per flowsheet, report unusual findings (i.e. Hypertension)	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Assess for Major/Minor Bleeding	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Monitor H/H, platelet, and coagulation profiles	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Minimize IM injections, catheters, NG tubes, and minimize trauma (i.e. soft sponges for oral care) in first 24 hours	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Assess oral cavity, neck and face with each vital sign assessment	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Maintain patent airway	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Administer medication per provider order	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Signature			**Date**	**Initials**
Jonathon Annand			4/1/22	JA

THROMBECTOMY

Risk for Bleeding:
The patient does not experience any bleeding/hematoma in extremities distal to the puncture site, as evidenced by:

- Maintain blood pressure within ordered limits
- Stable Hemoglobin/Hematocrit levels without a decrease >1g in 24 hours
- Detectable and unchanged pulse below puncture site
- Absence of hematoma at puncture site

Absence of flank pain, discoloration/pooling of the back

Ineffective Cerebral Tissue Perfusion:
Interruption of blood flow, including Ischemic, hemorrhagic, vasospasm or cerebral edema, as evidenced by:

- Altered level of consciousness: Language, intellectual, and emotional deficits
- Changes in motor/sensory, changes in vital signs

Interventions	Initiated Initials Date/Time	Reviewed Initials Date/Time	Reviewed Initials Date/Time	Complete Initials Date/Time
Assess vital signs per flowsheet, report unusual findings	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Assess back and flank for pain and discoloration	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Maintain: bedrest and neutral position at puncture site.	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Assess neuro status per flowsheet and compare with baseline, including NIHSS/mNIHSS	JA 4/1 0800	JA 4/1 1900		JA 4/2 0800
Assess puncture site and distal areas for swelling, bleeding and severe pain	JA 4/1 0800	JA		JA 4/2
Administer meds per provider order	JA 4/1 0800	4/1		
Maintain Femostop device as ordered	JA 4/1 0800	4/1		
Signature				
Jonathon Annand				

Page 1 of 1

RIVERSIDE Community Hospital

NURSING CARE PLAN FOR TREATED STROKE PATIENTS

• Nursing Care plan must en… total of 24 hours!

Interventions for Acute Ischemic Stroke

-For patients that meet exclusion criteria for t-PA **OR** do not respond to IV t-PA treatment **OR** have large vessel/ basilar artery infarctions.

-Opens up the window for treatment to **24 hours**.

-Intra-arterial Thrombolysis

-Delivers t-PA directly to the clot.

- Catheter is inserted into the femoral artery and guided to the site of infarction.
- Less t-PA needed.

-Thrombectomy- ***24 hour treatment window***.

- Endovascular procedure that uses a mechanical device at the end of a catheter to physically pull out all or part of a clot.

Acute Ischemic Stroke: Medical Management ONLY

-Goal is to resuscitate the penumbra and prevent disability.

-Blood Pressure Management

- Permissive HTN in acute phase.
- Keep BP <220/120 OR according to MD ordered parameters.
- Normal saline for hypotension.

-Antithrombotic (ASA, Plavix etc.)

- Recommended within 24-48 hours after onset.

Acute Ischemic Stroke

Cardiac Monitoring

- Watch for Afib (Common cause of stroke).
- Anticoagulant medication should be considered for all A-fib patients before discharge.

Oxygen

- Maintain oxygen saturation >94%.

Hyperglycemia treatment

- Target range is 140-180mg/dl.
- Hgb A1C should be drawn on all stroke patients.

Acute Ischemic Stroke

Statin administration

- High intensity statins should be considered for all stroke patients when not contraindicated.

Monitor for changes in status

- Vital sign changes
- Headache/vomiting
- Decreased consciousness or worsening of symptoms

Ensure as the Primary Nurse you are giving **AND** Documenting Stroke Education to Patient.

*Changes in patient status can indicate a hemorrhagic transformation or cerebral edema. The attending physician and/or the neurologists should be made aware of any neuro changes!

Acute Hemorrhagic Stroke

Goal is to prevent continued bleeding, as well as mitigate the impact of cerebral edema.

Neurosurgery will be Consulted by NP

Blood pressure management.

- AHA guidelines state the target SBP is to be <180mm Hg.
- Aggressive lowering of SBP has been found to be beneficial.
  - Ask MD for ordered parameters.

Reverse Coagulopathies.

- Fresh Frozen Plasma.
- Prothrombin Complex Concentrate.

Acute Hemorrhagic Stroke

-Procedures may need to be performed on some of these hemorrhagic stroke patients. Other interventions are also available.

-Low Stimulation

-Dark area or room of possible

- Patient should not be walking!

-HOB 30 degrees

-Described as quick onset and worst headache of ones life!

-If patient on any Titratable Drip, 30 mins. **Minimum** full Vital Signs!

-Ensure we are Education patients on Stroke Education, provide Stroke Education Booklet

Nimodipine

- **VERY TIME SENSITIVE!**
- Must be given within 30 minutes of scheduled time!
- Although Ca Channel Blocker assists with BP , main purpose is to prevent Vasospasms!
- Ask MD for parameter, usually help if SBP <100

Trans Cutaneous Doppler Ultrasounds to monitor for Vasospasms

- Daily (typically for 21 days)

Dysphagia Screen

ONE and DONE

-NPO until patient **passes** dysphagia screen!

-Order Speech Therapist Evaluation if patient Fails.

-Dysphagia Screen one and done! Should be performed ASAP in ED or ICU

Who you gonna call?

-CNCs

- Under Neuro/Stroke Coordinator: Jonathan Annand

  iMobile: 951-512-4283

  Cell: 951-751-9394

  Email: **Jonathan.Annand**@hcahealthcare.com

-Rapid Response Team

24/7 Stroke NPs!

- **Search NIR NP**
- **In house 24/7/365**
- **For any neuro changes/post procedure issues/critical results**

ED at RCH...

- Level I Trauma
- STEMI
  - Chest pain center.
  - People are flown in from all over the inland empire to be treated in our cardiac Cath lab.
- STROKE
  - Comprehensive Stroke Center.
- Volume
  - 310/day
  - 113,000/year

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.***

Salem Sump Tube with Multi-Functional Port and ENFit connection

Riverside Community Hospital

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.

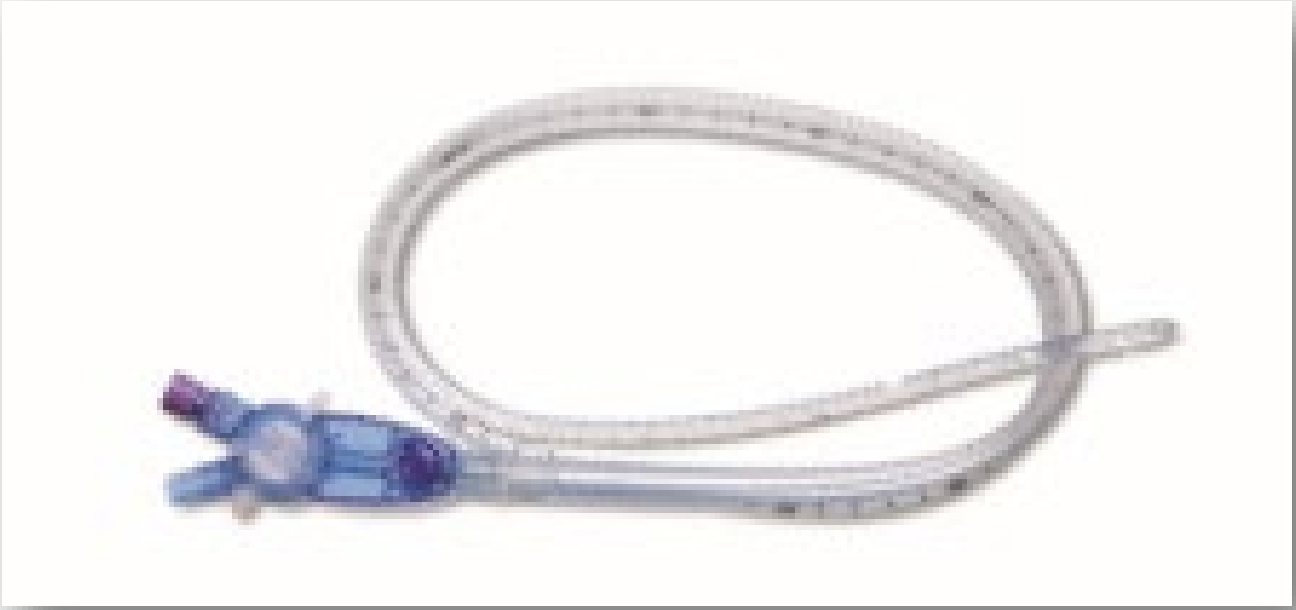
Irrigate

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.



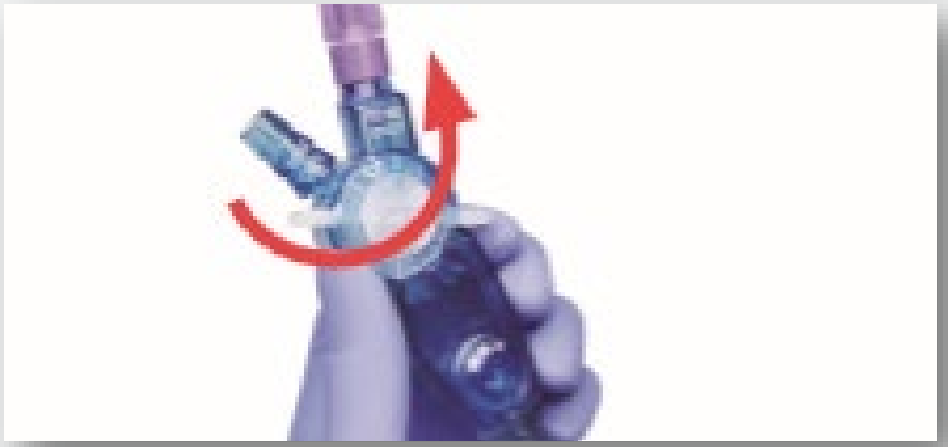
Suction

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”

Riverside Community Hospital

HCA Healthcare

Policy *PC.179* 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

Policy *PC.179* 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.

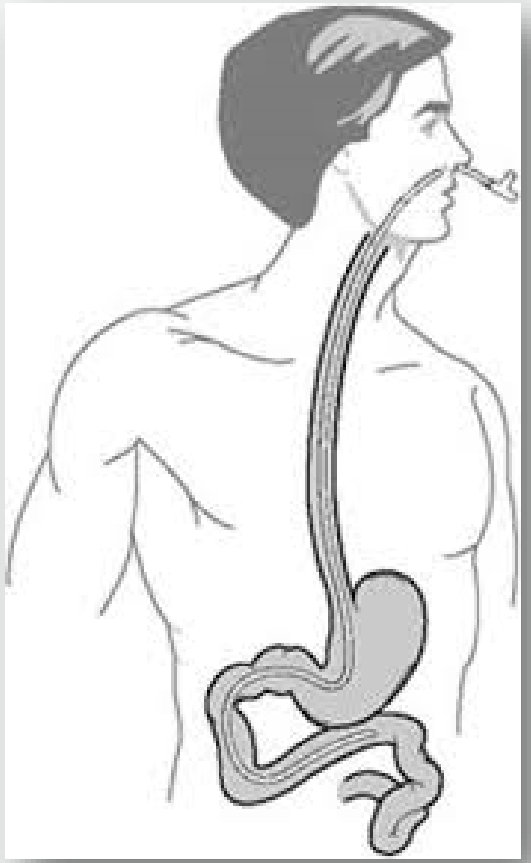
Policy *PC.179* Specifics for Duodenal Feeding Tube (continued)

- 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)

Policy *PC.179* 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: DO NOT REINSERT WIRE INTO TUBE WHILE TUBE IS IN PATIENT – poses risk of esophageal perforation**

Kangaroo Feeding Pump Quick Programing Tips

Riverside Community Hospital

HCA Healthcare

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

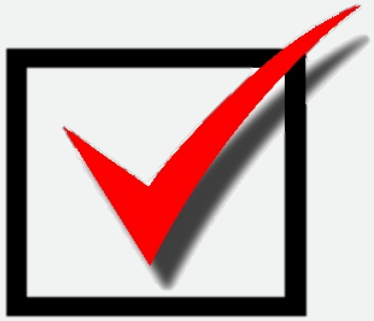
- Power the pump on. Select “Clear Settings” or “Keep Settings”
- Press the “Auto-prime” or “Prime Pump button + “done”
- Set the Feed Rate + “enter” + “done”
- Set the Flush Rate + “enter” + “done”
- Select “Run” to start the feeding

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 Transfusion Orders



A physician's order is

ALWAYS

required to transfuse blood!

*PC.176 Massive transfusion protocol

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:

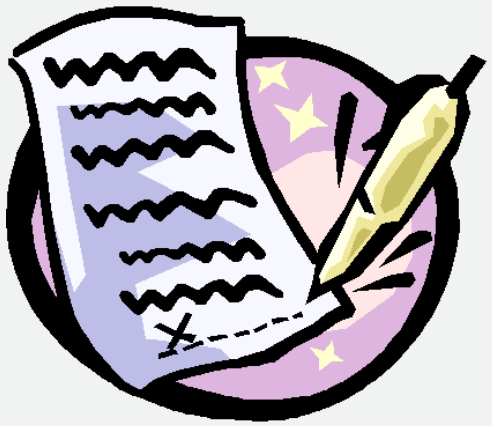
ACUTE INPATIENTS WITH LIMITED (AND PRE-PLANNED) TRANSFUSION THERAPY

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).

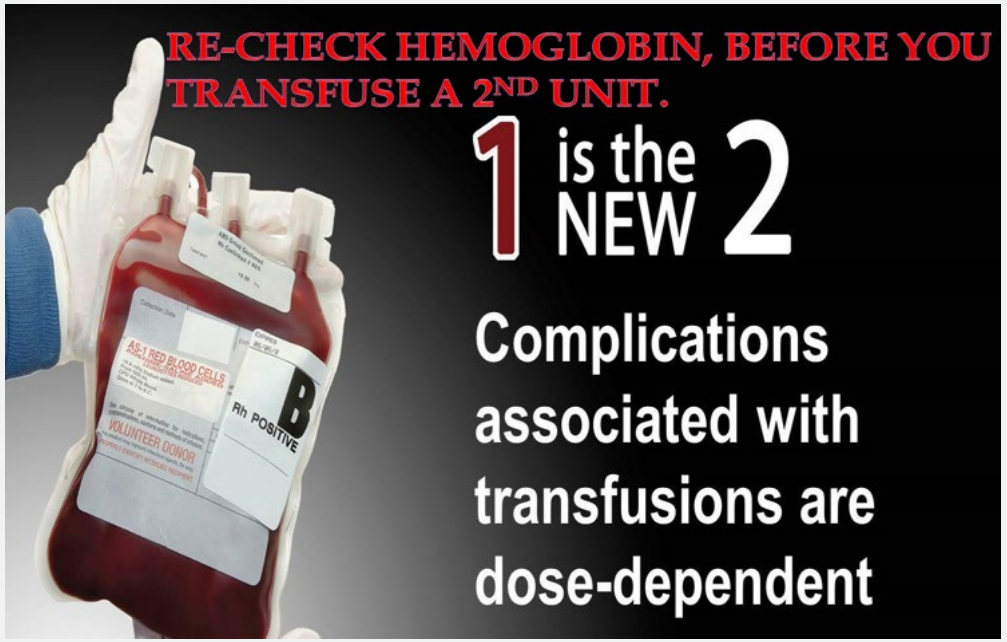
- The **"Refusal to permit Blood Transfusion"** should be signed by the patient and witnessed by a nurse.

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 º F (1º C) above the patient's baseline
- Wheezing
- Bronchospasm
- Itching
- Hives
- Generalized flushing
- Chest or back pain/pressure

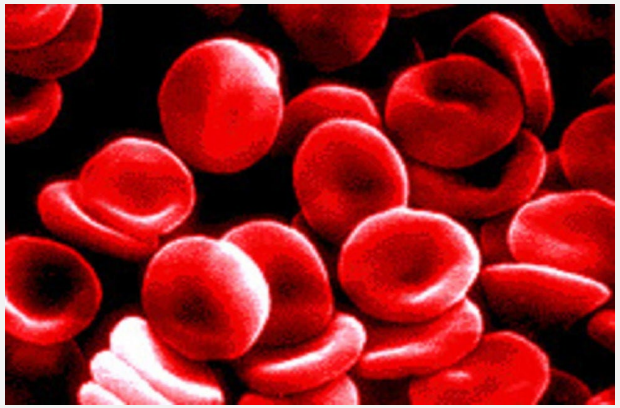
Reactions…

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.

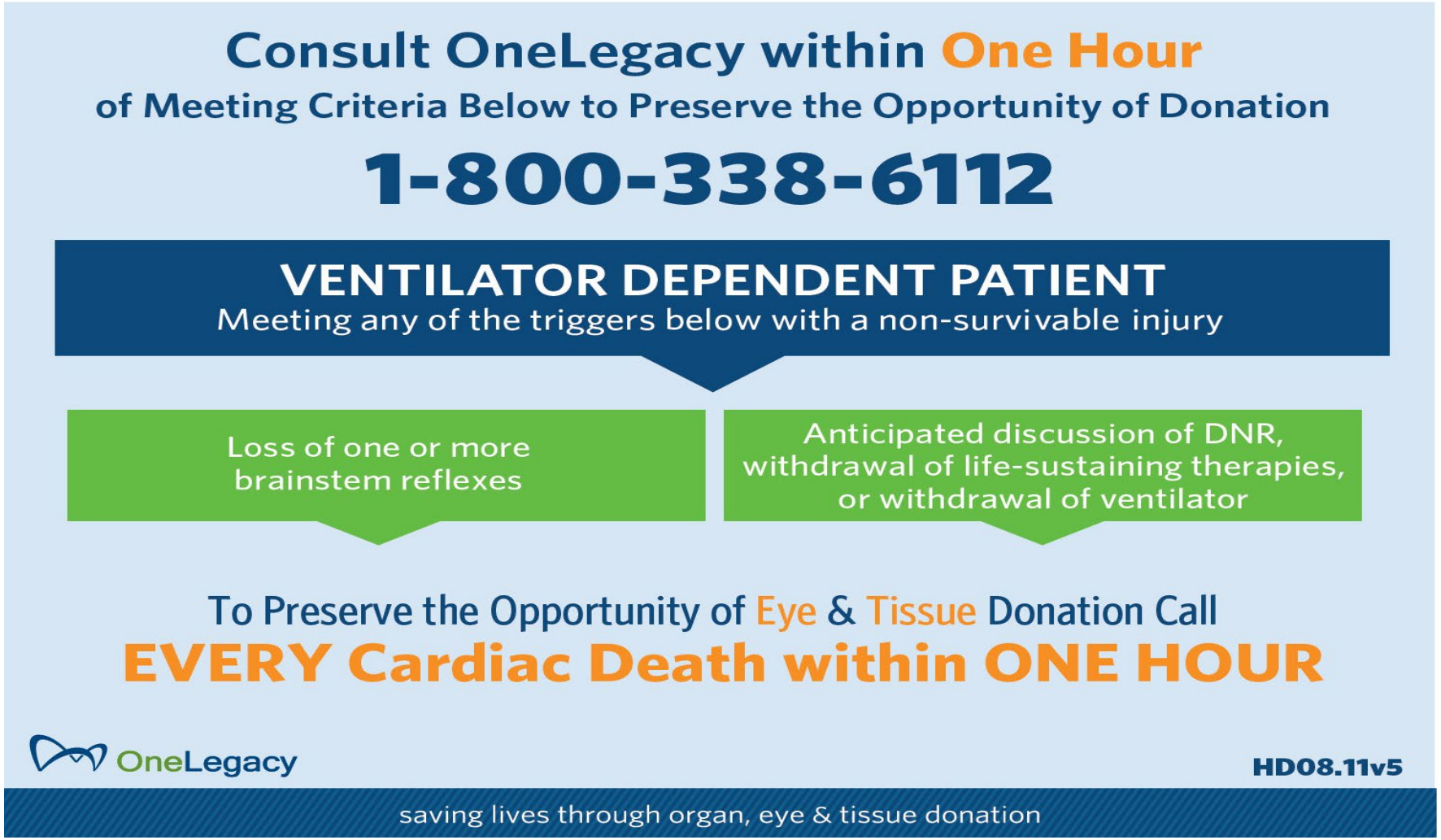
- **Do not tube autologous or directed donor units** via pneumatic tube. Autologous and directed donor units must be checked out in the blood bank.

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.****

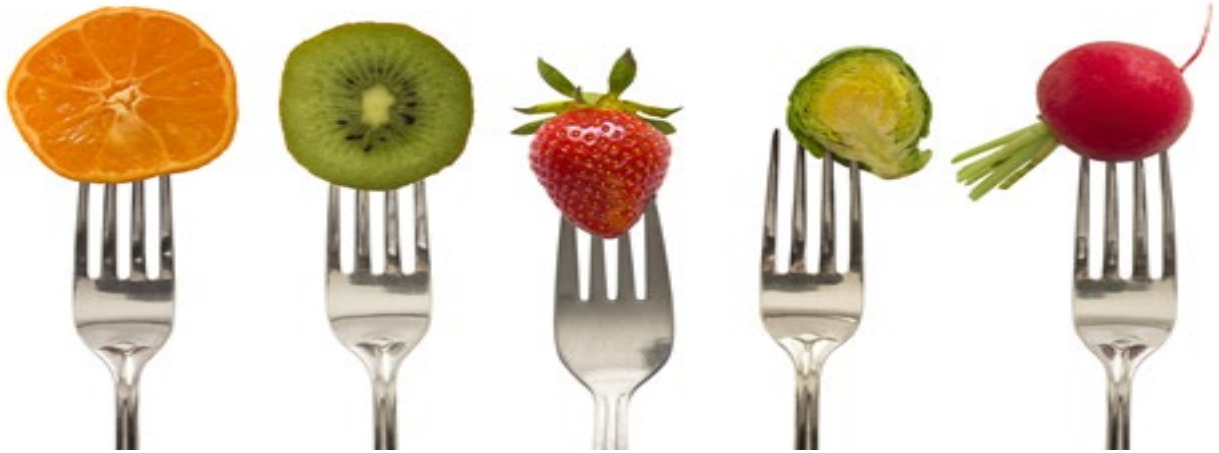
** CMS 42. CFR 482.45
Joint Commission, HRSA, Hospital Policy

Nutritional Services

HCA Healthcare

Where do I get food?

- Cafeteria Hours: 7am – 9:00am Breakfast
- Lunch: 10:30 am – 2:00 pm
- Dinner: 4:30 pm – 7:00 pm
- Night: 8:00pm – 10:00 pm
- Coffee Shop – 24/7 (Vintage tower)



How does my Patient Get Food?

- Menu is placed on bedside table by EVS after room is cleaned
- Patients can call in their meal choices *8FOOD/83663
- Meals are delivered by a Room Service Team member
  - Broadcast are sent to RN/CNA on units notifying them meals are heading up for delivery
  - Isolation trays are delivered to nursing station

What is Your Role?

- Ensure patient has a menu.
- Ensure patient has a phone in room.
- Educate patients on the menu system. *83663 to order their food (83663 = 8FOOD).
  - If no phone in patient rooms, please call (951)788-3663
- Ensure tray tables are cleared for meals (urinals); pick up trays after meals.
    - **Trays are not delivered by Dietary if patient is on any type of Isolation precaution

Nutrition Consult

- Registered Dietitians (RD) will complete nutrition assessment on all patients.
- RDs complete follow up assessments.
- You can request a dietitian consult at any time for your patient.
  - Enter an order in Meditech under “Nutrition Consult.”

❑ 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

KEY PLAYERS IN NUTRITIONAL SERVICES

- Dietitian Coverage = 7 days/week
  - Typical hours are M-F 8 am–5 pm;
    weekends 8 am – 4 pm.
  - A dietitian is assigned to cover each unit daily.
  - Dietitian office *83123
  - Clinical Nutrition Manager *83426
  - Director Food & Nutrition *83625
  - For food related issues, call FNS main line
    Supervisor: 951-512-4040 Room service: *83663

SUPPLIES

WHY IS SCANNING FOR SUPPLIES IMPORTANT?

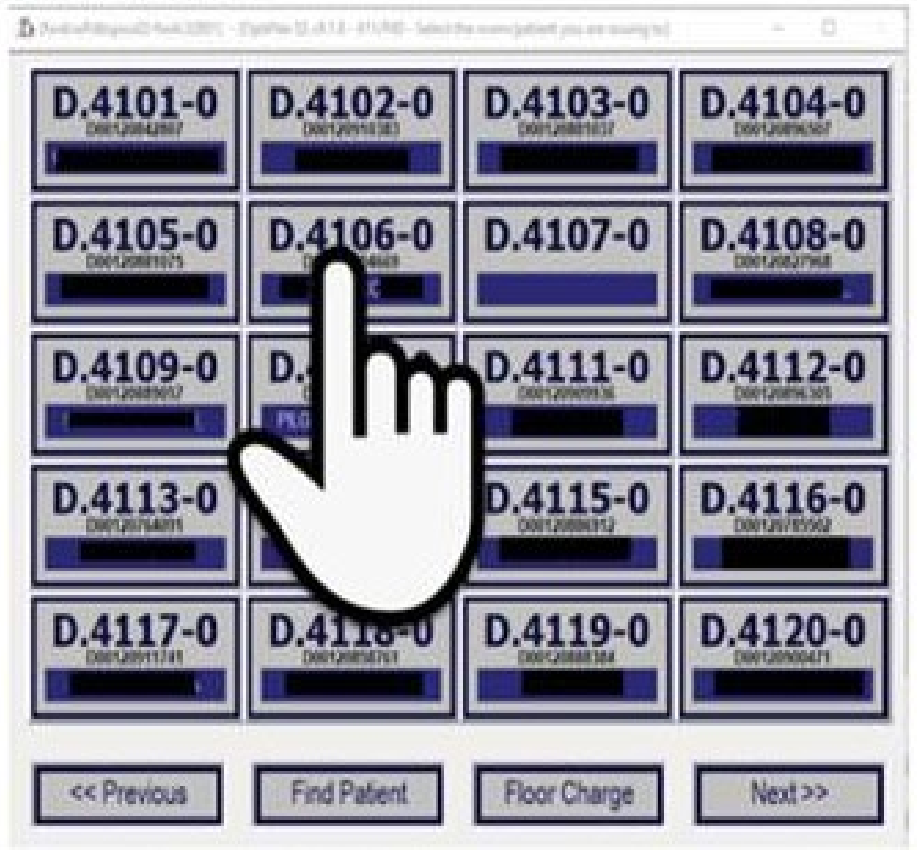
In addition to billing, it keeps the items in your supply room stocked and resupplied based on the amount you use.

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

STEP 1…

Identify the room/patient you are getting supplies for and touch the Optiflex screen.

You can also scan a patient barcode.

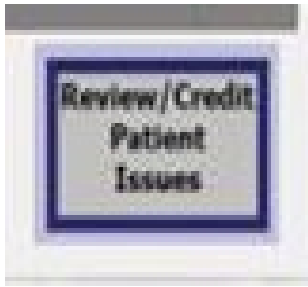


STEP 2…

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.

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.

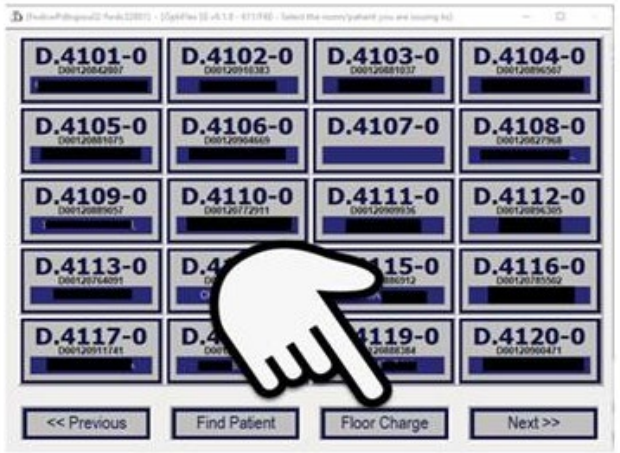
STEP 4…

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

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”.

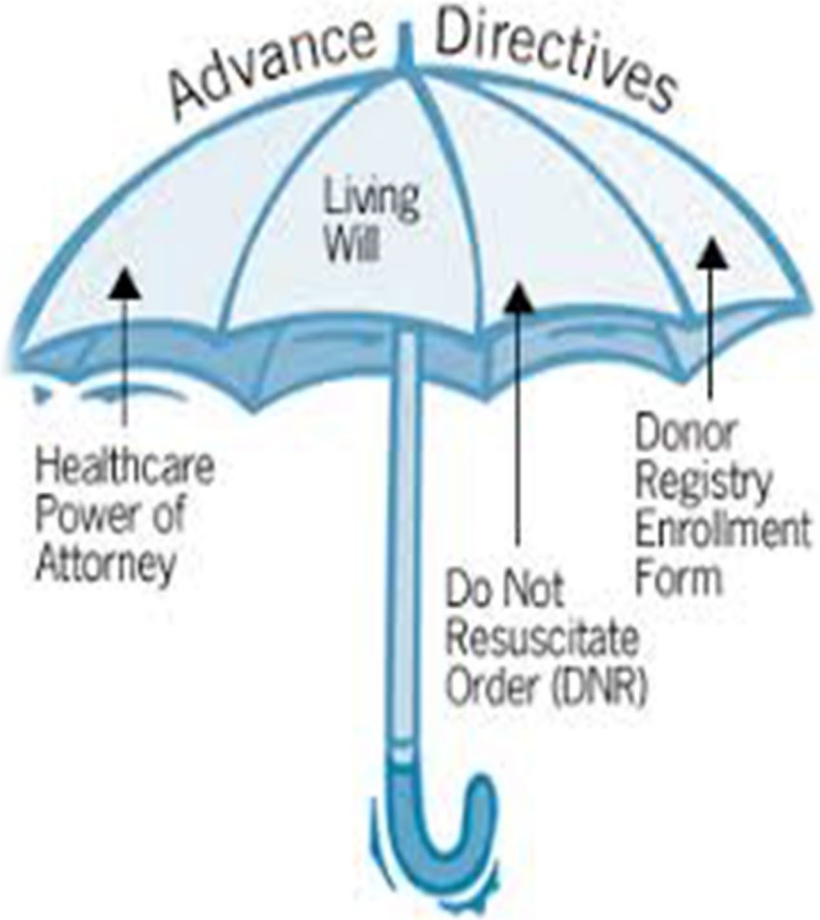


Our Staff Colors…

- RNs = Navy Blue
- Women's Services = Royal Blue +
- CNAs/Clerks = Caribbean Blue
- Resp Therapy = Black
- PT/OT/Speech = Ceil Blue
- ECHO/ECG/Techs = Gray
- Lab/Phlebotomy = Charcoal
- Radiology = Hunter Green
- Pharmacy = Olive
- EVS = Wine

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.

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.**

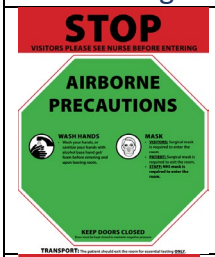
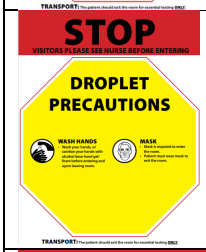
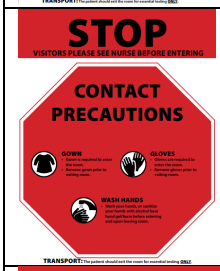
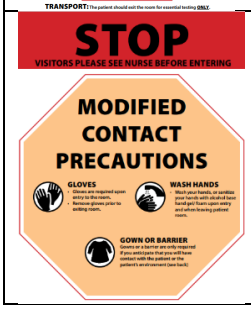
Isolation…

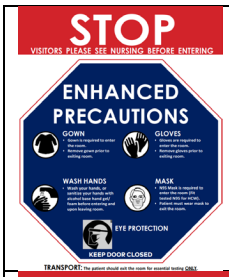
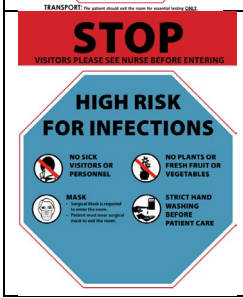
- Supply carts are located on each unit.
- When a patient is placed in isolation, a carts is moved to the hallway outside the patient's room.
- The various isolation signs are kept in the top drawer.
  - They are to be posted outside the room.
- Patients, family members and visitors must be instructed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

Isolation and PPE Education

For patients with a condition that requires isolation precautions, the appropriate isolation sign must be placed at the entrance to the patient's room and the appropriate PPE must be worn at all times. The front of isolation signs at RCH explain PPE and steps that need to be taken. The back of the sign includes conditions that require isolation.

Here is a breakdown of RCH's isolation signs and what they mean:

Isolation Sign	Conditions	Things to Know
	• TB • Measles • Disseminated shingles	• Staff must wear fit tested N95 mask • Door should remain closed at all times • Patient should be placed in a negative pressure isolation room • Visitation limited
	• Influenza • Meningococcal • Infection • RSV	• Staff should wear a mask at all times • If going to have close prolonged contact with patient, eye protection is recommended
	• ESBL • MRSA (infection) • CRE • MDR- ACB • VRE	• Gown and gloves should be worn every time you enter room (even if you do not plan on touching on anything) • Thoroughly clean all items that must be shared after patient use (i.e. glucometer, vital signs machine)
	• C. auris • C. Difficile • Norovirus	• Gown and gloves should be worn every time you enter room (even if you do not plan on touching on anything) • Thoroughly clean all items that must be shared after patient use (i.e. glucometer, vital signs machine) with bleach • Wash hands with soap and water
	• MRSA (colonization)	• Only gown when anticipating direct contact of your body with the patient and/or their surroundings (i.e. turning, bathing, ambulating, etc.) • Gloves and hand hygiene for every entry into the room

	• COVID-19	• N95, gown, gloves, and eye protection whenever entering the room • Keep door closed at all times
	• Neutropenic patients	• Wash hands thoroughly and wear a mask to prevent spreading infections to high risk patients • No fresh fruit or veggies, no flowers • Only healthy visitors

Key Isolation/PPE Points:

- Hand hygiene prior to donning PPE is essential
- Always wear the appropriate PPE for the type of isolation precaution every time you enter the room even if you do not plan on touching anything
- **NEVER** reuse PPE
- Consult with the infection prevention department before removing a patient from isolation precautions
- Always communicate isolation status upon patient hand off (shift report and during location changes such as to radiology or to another unit)
- If you see staff or students not utilizing PPE; speak up
- Help staff caring for patients under isolation with supplies or other needs to eliminate unnecessary PPE changes
- Carefully dispose of PPE in the trash bin and ensure it is not overflowing out of the trash bin

For any questions regarding isolation please call the Infection Prevention Office at 951-788-3482.

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

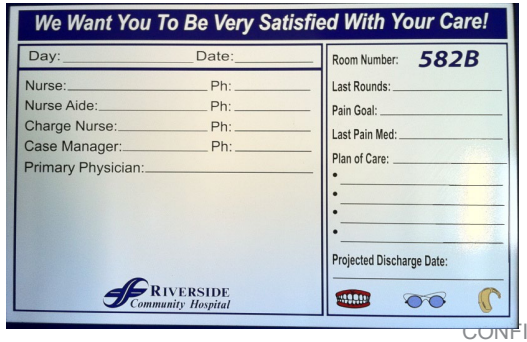
Hourly Rounding

(every hour on days & 2 hours on nights)

The 4 "Ps":

- Pain
- Personal needs (toileting, washing, etc.)
- Position
- Possessions (within reach)

- This may also be a good time for a teaching moment
- Don't forget to update the White Board



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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 G Tower.

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.

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

HCA Healthcare
Center for Clinical Advancement

CareView Huddle Card

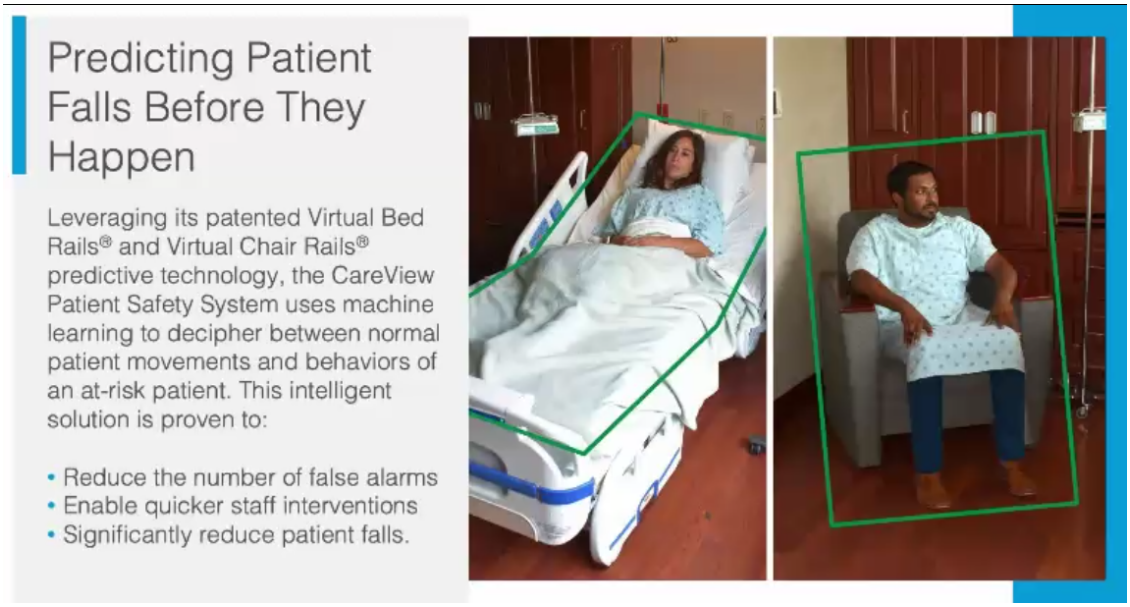
Riverside Community Hospital Process Flow:

Camera Allocation	Facility Camera Allocation based on NATE PSA Data + Leader Input	27 + 2 = (29)
	Number of fixed cameras	0
	Number of mobile cameras	29
Mobile Camera Inventory Process	Where cameras will be stored if not in use?	We can store 2-3 in the main monitor room and then we have additional storage space in the S6 storage room located adjacent to the monitor room
	How would they be charged?	There are plugs located in the storage room
	Who will clean them?	Policy is that staff clean them prior to returning to the monitor room
	Who will deploy camera to location when needed?	When the camera is approved the unit deploys a PCT to retrieve the camera from the monitor room
	How will you track which patients have which camera?	The camera is signed out from the monitor room and assigned/logged by the monitor tech
	How will you track when patient move with camera?	When a patient is moved the RN calls the monitor tech and shares the new room and number and then when they arrive at the new room they re-establish a connection. As a part of the connection, the RN and Monitor Tech complete a virtual hand off of information

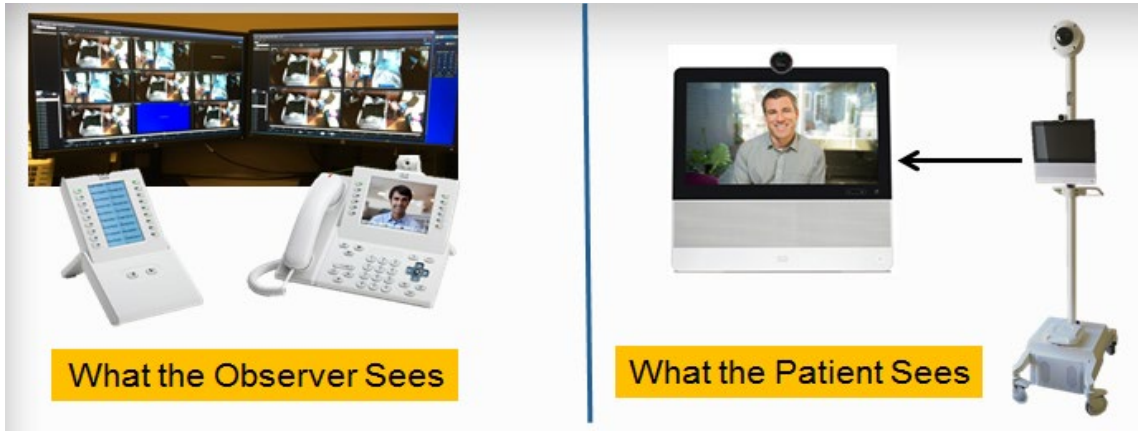
Escalation Pathway:

There are 4 levels of intervention by the PSA. Evaluation of levels are based on failure of the previous level's intervention. If at any point in the escalation process the patient's situation **worsens**, the virtual PSA will pivot to the appropriate escalation level.

Level 1	PSA to Patient in Camera Room	1. Immediately when patient is attempting to get out of bed/chair 2. PSA communicates with patient via 1- or 2-way audio to redirect the patient 3. If behavior continues, proceed to Level 2
Level 2	PSA to Immediate Care Team Assignment	1. PSA will immediately send a broadcast with room number via CareView and iMobile to the patient's care team 2. Any available staff will go to the room to assist the patient 3. If no response within 1 minute of second broadcast, proceed to Level 3
Level 3	PSA to all Unit Healthcare Personnel	1. PSA will immediately send a broadcast with room number via CareView and iMobile to the patient's Care Team 2. Any available staff will go to room to assist the patient 3. If no response within 1 minute of second broadcast, proceed to Level 4
Level 4	PSA to PBX (Private Branch Exchange) Operator	1. PSA will call PBX Operator and activate a Medical Alert PSA Level 4 with room number 2. PBX Operator will send an overheard page 3. In the event a Medical Alert PSA Level 4 is initiated, the House Supervisor and all available personnel on the unit are expected to respond to the patient's announced room number to ensure the patient's safety 4. The RN responding to the patient will notify the Virtual PSA once the patient has been assessed and give an update on patient status 5. The PSA will record the notification(s) on the approved log



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.

I-TRACE

As part of the handoff communication, develop a standardized "line reconciliation" process. Components of the line reconciliation process include:

- re-checking tubing and catheter connections.
- tracing all patient tubes and catheters to their sources for correct route.
- labeling all tubes and catheters at the point(s) of connection.

Trace all lines from the patient to the source before making any connections or reconnections, administering medications, solutions, or other products.

IV Therapy

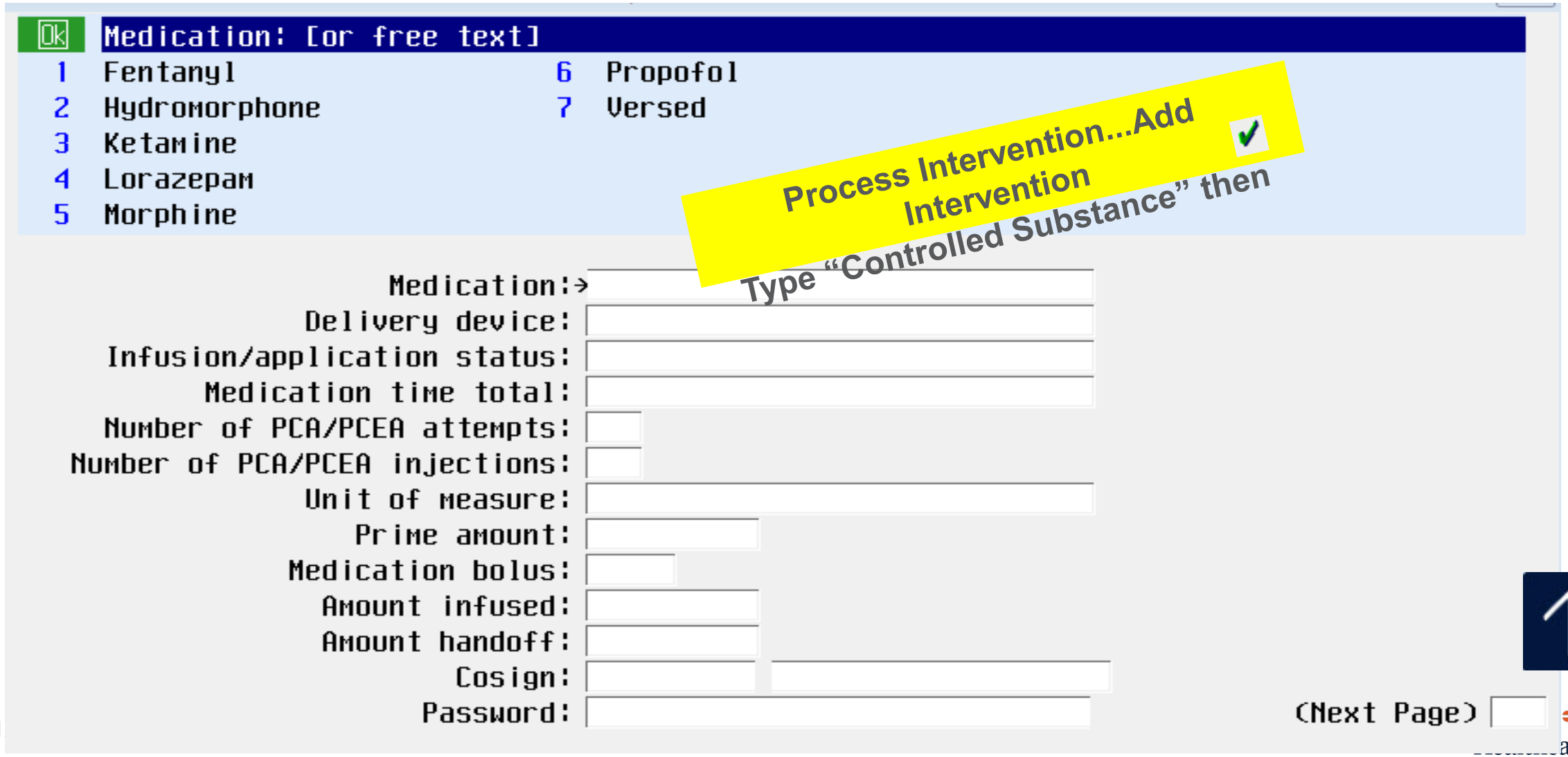
- If you cannot obtain an IV after 2 attempts ask another nurse.
- Patients going to surgery must have at least an 18 gauge.
- 1% lidocaine w/o epi can be used intradermal prior to sticking patient.
- IVs started in the AC must be changed within 12 hours.
- IVs started under emergency conditions must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

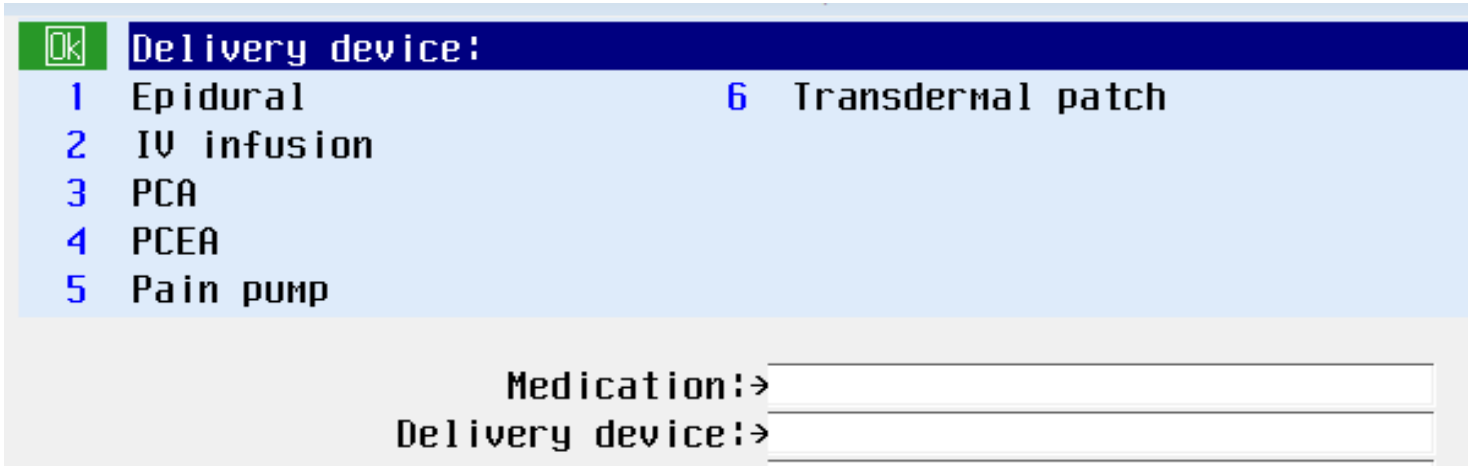
IV Therapy

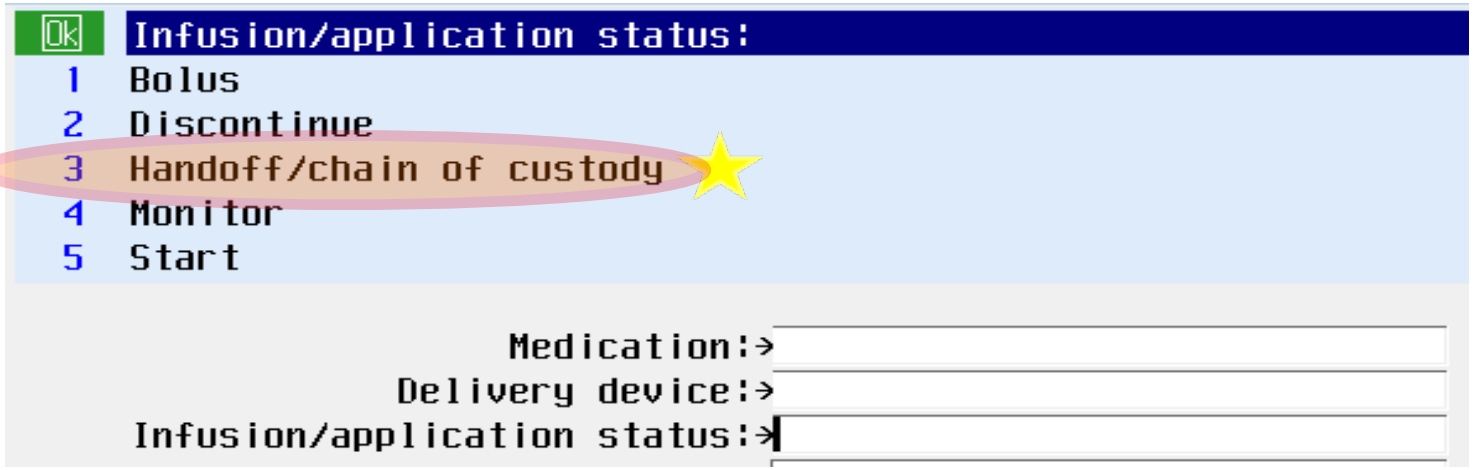
- IV sites, dressings, end caps and tubings are changed every 96 hours.
- TPN tubing and filter – 24 hours.
- Propofol – 6 to 12 hours.
- CVAD dressings are changed every 7 days or sooner if needed.
- ChloraPrep is used to prep the site.

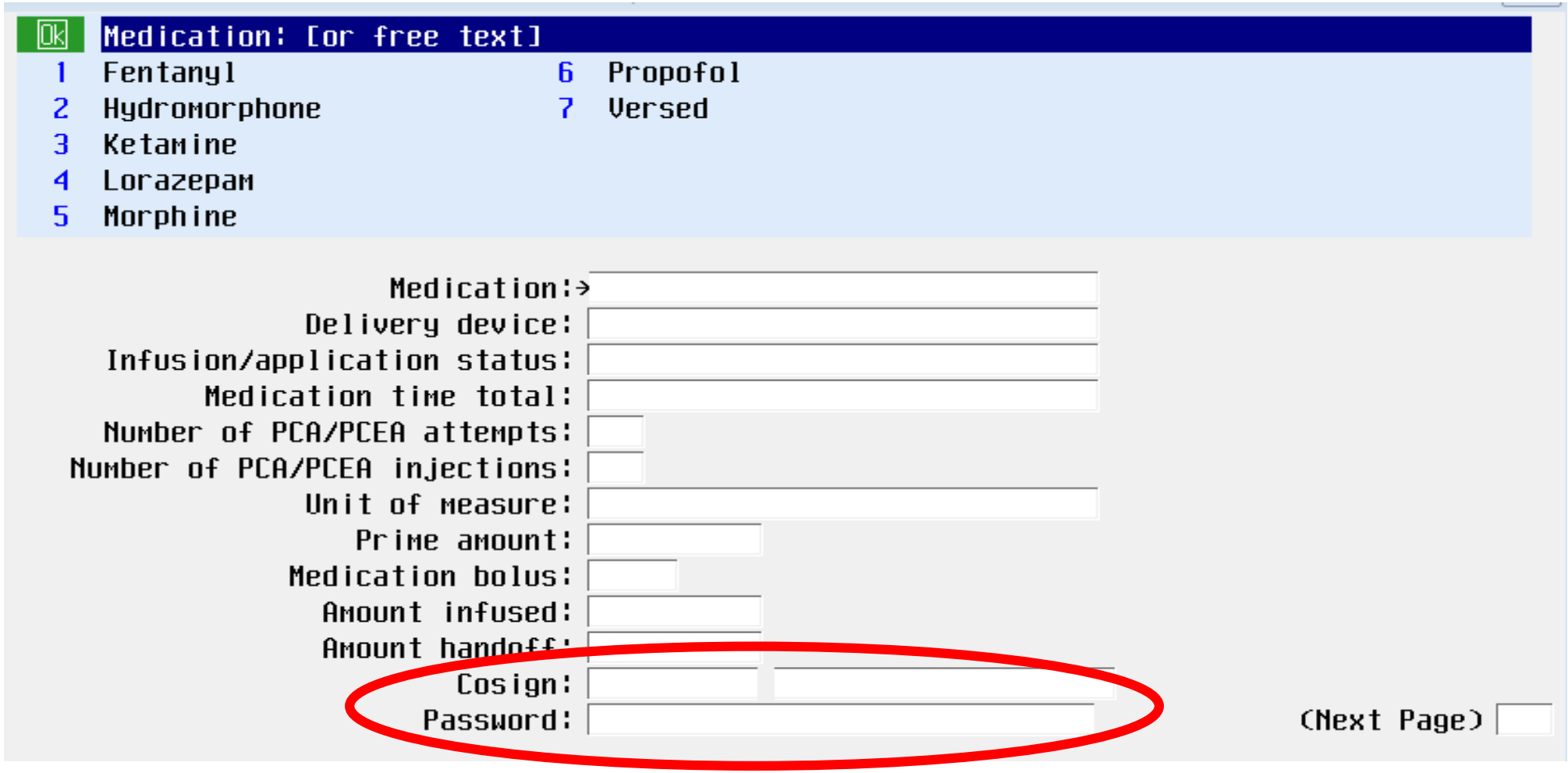
Cactus Sink Instructions – Controlled Substances Only

Control Substance Handoff









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”.

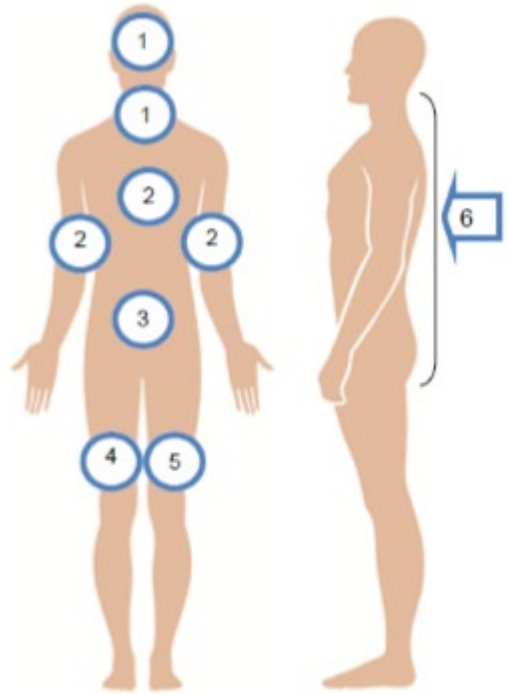
The Charge Nurse or Manager visits with the patient and family to ensure they:

- 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.



New Wipes & Change in CHG Protocol

CHG BATHING

NOW ONLY FOR:

- ✓ ICU patients
- ✓ Patients with CVADs
- ✓ Pre-op Patients

Keep in Warmer

Do NOT Flush!

General Bathing

- Bathing for all other patients
- *Keep in Warmer*
- *Do NOT Flush!*

Incontinent Care

- *Do NOT keep in Warmer*
- *Do NOT Flush*

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Patient Education

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

- ✓ RCH CONNECT (Intranet) - *links*:
  - ➢ Krames on Demand (Intranet, Links)
  - ➢ Clinical Pharmacology
  - ➢ EBSCO
    - ➢ Nursing Reference Center - Patient education
    - ➢ Patient Education Reference Center
- ✓ RCH CONNECT – *EDUCATION:*
  - ➢ Diabetes – handouts for the classes on TV
  - ➢ Channels 60 & 61

OVERHEAD EMERGENCY ALERTS

Group + Event + Location + Instructions

FACILITY ALERT

EVENT	RECOMMENDED PLAIN LANGUAGE
Incident Command Activation	Facility Alert + Incident Command Activated + Instructions
Decontamination	Facility Alert + Decontamination + Location + Instructions
Evacuation/ Relocation	Facility Alert + Evacuation + Location + Instructions
Fire	Facility Alert + Fire Alarm + Location + Instructions
Hazardous Material Release	Facility Alert + Hazardous Spill + Location + Avoid the area
Mass Casualty	Facility Alert + Mass Casualty + Location + Instructions
Utility/ Technology Interruption	Facility Alert + Utility/ Technology Interruption + Instructions
Weather	Facility Alert + Weather Event + Instructions

SECURITY ALERT

EVENT	RECOMMENDED PLAIN LANGUAGE
Armed Subject	Security Alert + Active Shooter + Location + Instructions
Bomb Threat	Security Alert + Security threat + Location + Instructions
Civil Disturbance	Security Alert + Security threat + Instructions
Controlled Access/ Lockdown	Security Alert + Controlled Access + Location + Instructions
Missing Person	Security Alert + Missing Person + Description + Instructions
Security Assistance	Security Alert + Security Assistance + Location
Suspicious Package	Security Alert + Suspicious Package + Location + Avoid the area

MEDICAL ALERT

EVENT	RECOMMENDED PLAIN LANGUAGE
Medical Alert	Medical Alert + Descriptor (Code Blue) + Location

ANNOUNCEMENT EXAMPLE

Facility Alert, Fire Alarm, 4th Floor West, Please evacuate impacted area and shelter in place.

HCA Healthcare

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.

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.

HCA Healthcare
Center for Clinical Advancement

Using CulturaLink on an iMobile Device

- Accessing **Audio** Remote Interpretation via the iMobile Device:

- 1. Log in to the Mobile Heartbeat application, then select your unit and patient.
- 2. Scroll down to the CulturaLink app and click on it to begin your session.
- 3. The language selection screen will appear, tap the language you are looking for.
  - **NOTE:** ASL does not function on the iMobile. Please use an iPad or call **1-888-695-1001.**
- 4. Tap the **Audio** tab to select an **audio only** interpreter.
- 5. The display will show the call screen connecting to an interpreter.
- 6. Audio call screen will confirm the call is connected to an interpreter.
  - The Interpreter will request: MRN; Provider Name; and Dept. placing the call.
  - **To end the call, press the END icon at the top of the screen.**
- 7. Rate the interpreter to complete the session.
- 8. Contact local IT with any iMobile /CulturaLink issues.

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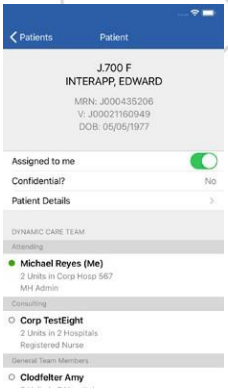

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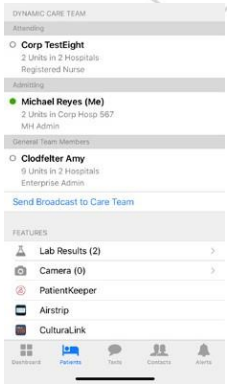

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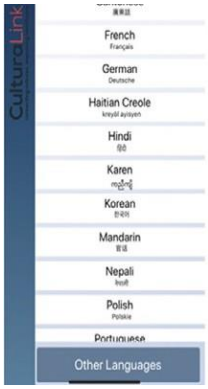

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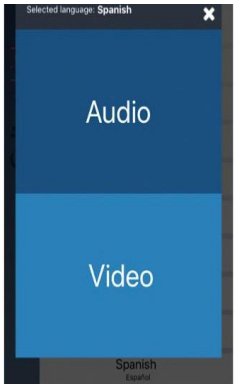

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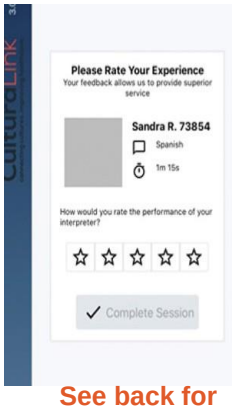

See back for additional guidance

HCA Healthcare
Center for Clinical Advancement

CulturaLink VRI

Accessing Video Remote Interpretation via the iMobile Device:

- 1. Log in to the Mobile Heartbeat application, then select your unit and patient.
- 2. Scroll down to the CulturaLink app and click on it to begin your session.
- 3. The language selection screen will appear, tap the language you are looking for.
  - **NOTE:** ASL does not function on the iMobile. Please use an iPad or call **1-888-695-1001.**
- 4. Tap the **Video** tab to be connected to a **video** interpreter.
- 5. Next, you will be prompted to choose the individual's preferred interpreter gender (or select "first available").
- 6. The next screen will show the call being connected to an interpreter. You can also cancel the interpreter request on this screen.
- 7. Once the session has started, make sure the patient is visible to the interpreter. The interpreter will request the patient's name, MRN or patient ID, and department placing the call.
- 8. A privacy feature is available that will suspend the video feed only. You can turn this on or off from the lock icon in the upper right hand corner.
- 9. To end the call, press the "end call" at the top of the screen.
- 10. Now rate the interpreter to end the session. Be sure to document the encounter, including the interpreter ID number in the EHR.
- 11. Please contact your local IT Support Specialist for any issues with your iMobile device. Be prepared to provide them with appropriate details.
- **NOTE:** *Please refer to HCA Healthcare's "Equity of Care: Ensuring Access to Services" Huddle Cards for information on policy and procedure requirements and best practices for use of Audio or Video services.*

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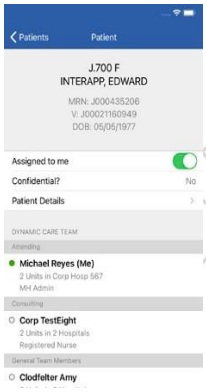

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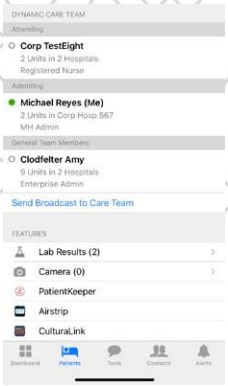

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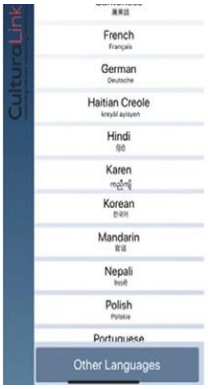

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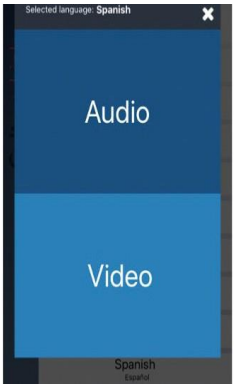

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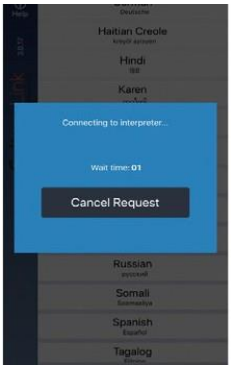

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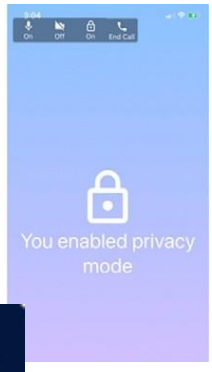

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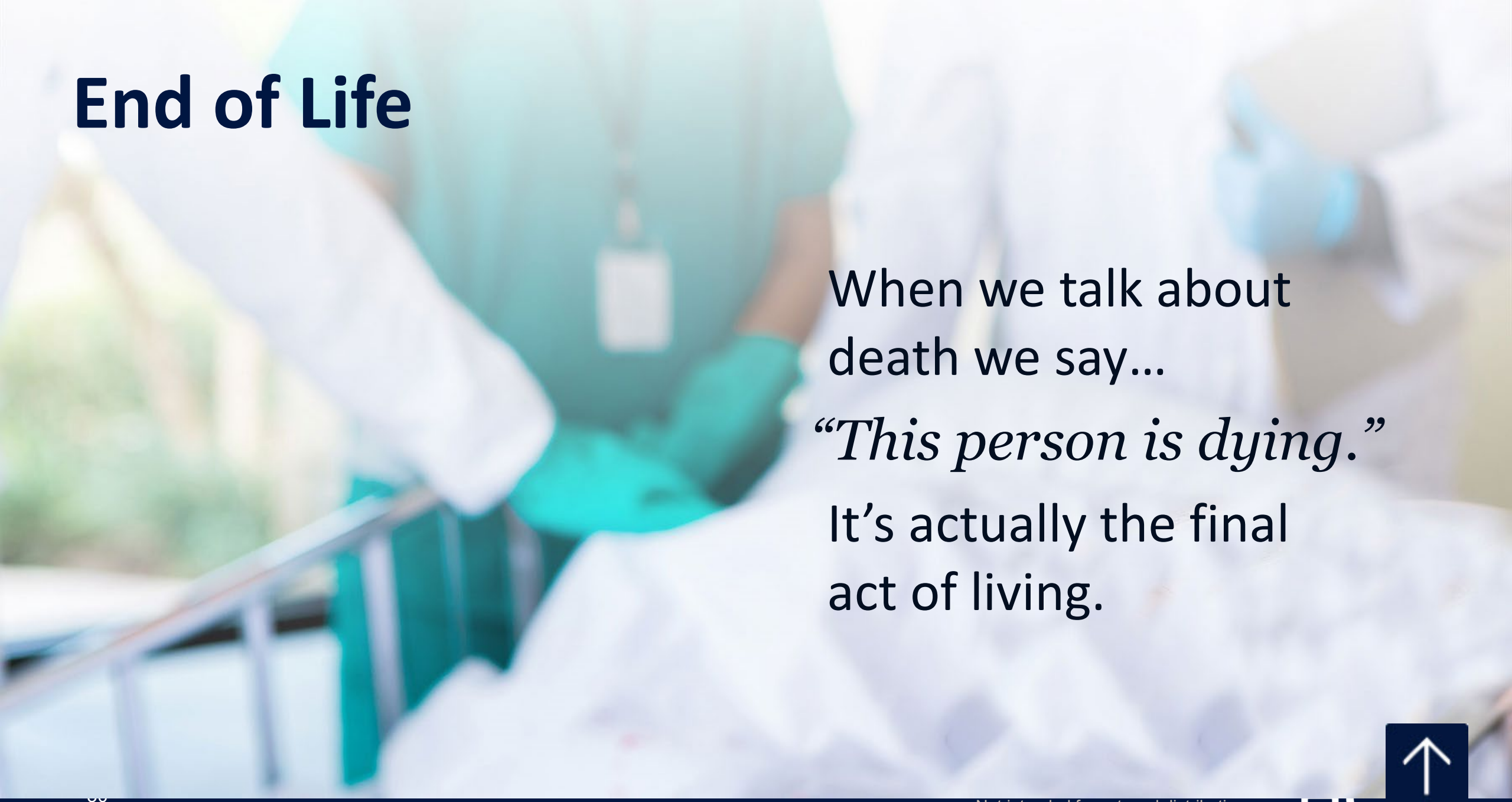
End of Life



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.

At RCH...

- 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.

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

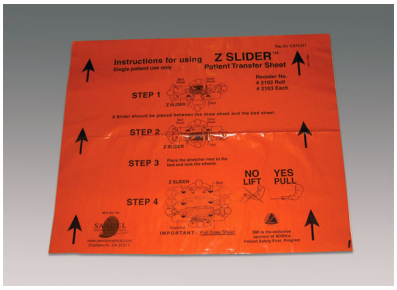
Z-SLIDER: No weight limit.

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:

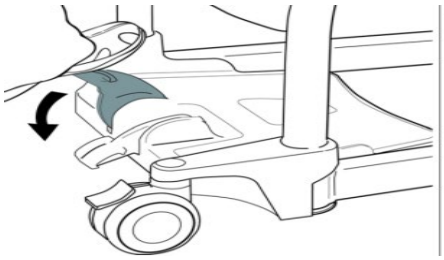
1. Instruct patient to grip the cross bar using both hands to pull self to standing position
2. Put seat up
3. Instruct patient to gently sit on new location (bed, chair, wheelchair, toilet, etc)
4. Release the brakes, remove the Stedy
5. Assure patient safety, place call light within reach

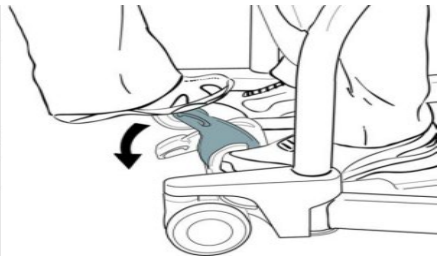
General Information:

- 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

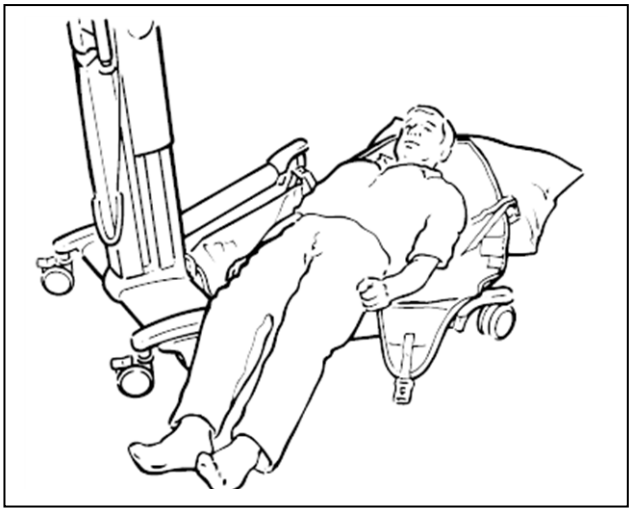
- Open the chassis legs to move the Opera near the chair
- Lower the patient to the chair in the sling
- Be sure patient is in a comfortable sitting position before releasing the shoulder and thigh straps
- Move Opera away from chair
- Leave sling in place for future transfer back to bed
- Ensure patient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

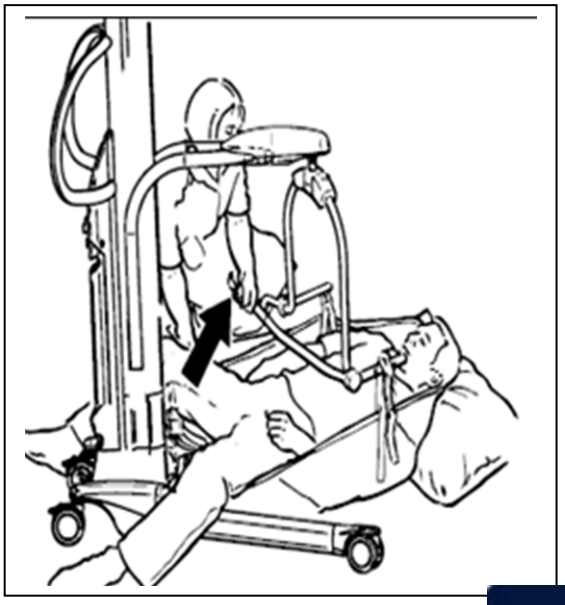
Transfer from a chair to bed

- 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

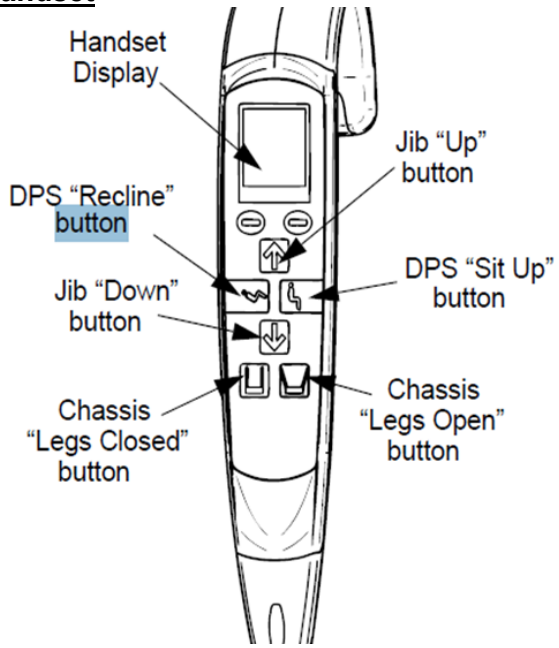
Cleaning process for the sling attachments

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

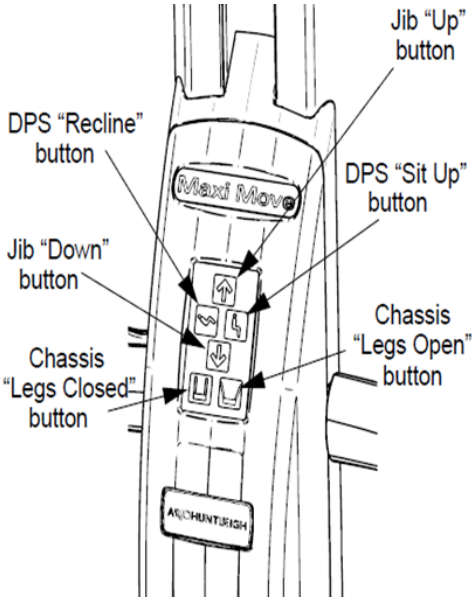
Maxi Move Lift Device (in G building):

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

Alaris Pump

- Must select profile for each patient – what unit is the patient on.
- Never enter the patient ID # only the cost center.
- 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.

HCA Healthcare®

MM.135 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

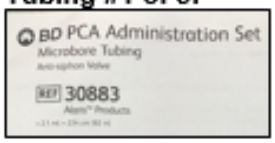
PCA Tubing

When starting a patient on PCA therapy, you must obtain the following three (3) tubing from the Supply Room:

1. PCA Tubing
2. PCA Anti-Reflux Y Set
3. $EtCO_2$ Monitoring Nasal Cannula

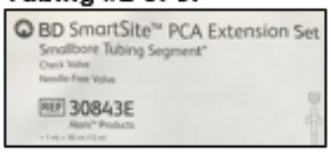
To prevent errors, these 3 tubing will be placed in 1 kit/packaging in the Supply Room. Look for this new kit!!

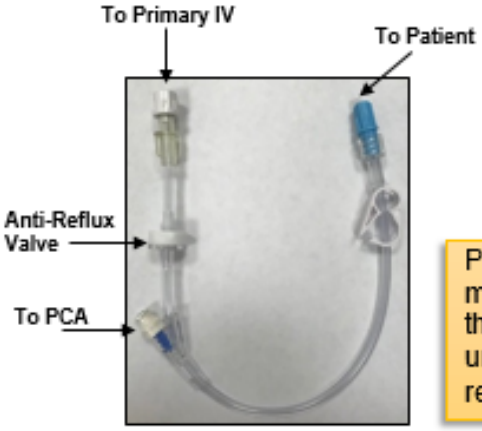
Tubing #1 of 3:



- Attach PCA syringe to this PCA tubing, and prime manually or through the PCA pump. Tubing length of 92 inches = ≈ 2.1 ml
- Place the syringe & tubing to the PCA pump **PRIOR** to connecting it to the patient.
- Program the PCA pump
- Connect the PCA tubing to the PCA port of the Y Set which is already connected to the patient and primed with primary maintenance fluid
- Start the PCA

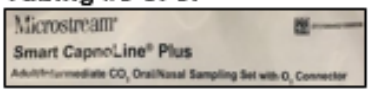
Tubing #2 of 3:





- Connect the Primary IV tubing to the Anti-Reflux Valve port of the PCA Y Set. Prime with the primary IV maintenance fluid.
- Connect tubing to patient
- Connect the PCA tubing that's already primed, placed in Pump, and correctly programmed to the PCA port of the Y Set (the shorter port)
- Press Start on PCA pump

Tubing #3 of 3:



Patient will wear the $EtCO_2$ monitoring nasal cannula throughout the PCA therapy or until an MD order to D/C is received

The purpose of the Anti-Reflux Y-set is to avoid medication from PCA tubing/syringe to travel up to the Primary IV.
To achieve this goal, the primary IV and the PCA tubing must be attached to the **CORRECT** ports:

- Primary IV must be attached to the port <u>with the anti-reflux valve</u>
- PCA tubing must be attached to the shorter port (*"The broken arm gets the medication"* 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) every 4 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:
  - o START ----- At start / initiation of therapy
  - o MONITOR ----- Every 4 hours
  - o DISCONTINUE ----- At end of therapy
  - o 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

PCA Pump

- Hospital staff, family or spouses cannot push PCA button.
- End tidal $C0_2$ monitoring is required throughout therapy.
- 0_2 can be bled through the $ETC0_2$ cannula.
- Two RNs required to set up.
- Controlled substance handoff tool must be added to process intervention to document.
- **PCA syringe is changed every 24 hours**

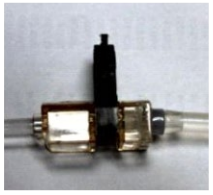
Source Document

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

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

PERFORMANCE CRITERIA AND KEY ELEMENTS

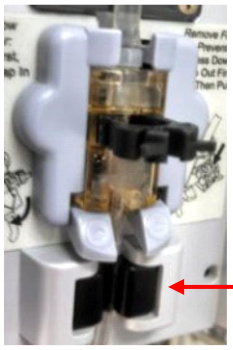
1. Attach the Alaris tubing to the **MRidium Extension Tubing (Ref 1058)**
2. **Prime** the extension tubing (open the valve preventer by pushing it forward: When done, **close** the valve preventer and roller clamp



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

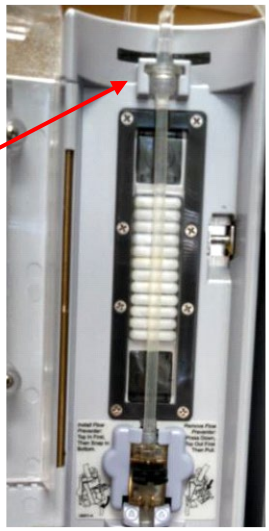
   a. **To open the door:** press the purple button downward and pull the silver lever forward
   b. Press the alignment disc into the alignment chamber
   c. Do not stretch or pull the silicone part of the tubing (similar to Alaris)
   d. Insert the valve preventer into the square area shown in the picture. 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



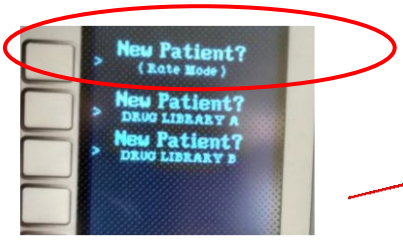
Valve Preventer ←

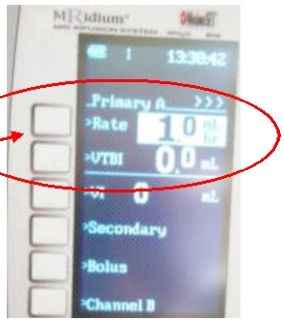
Bubble/Air Detector ←

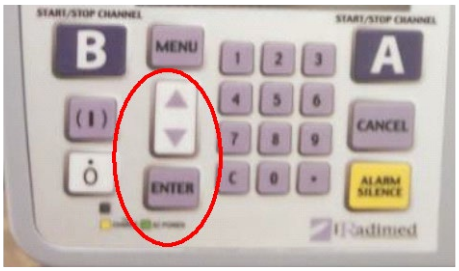
Alignment disc ↗



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)

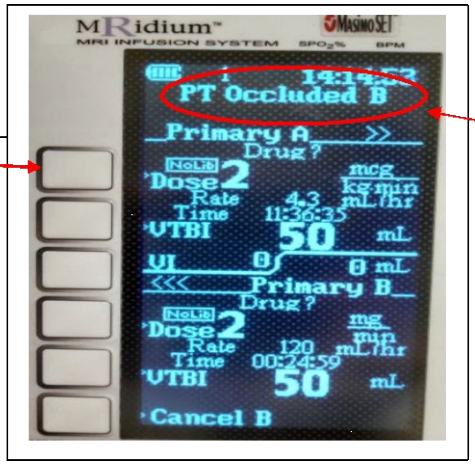
c. If you have a 2nd drip:

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.

For example:

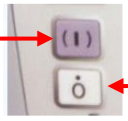
Press the soft white key To change the dose of Channel A – then press ENTER



Alert

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

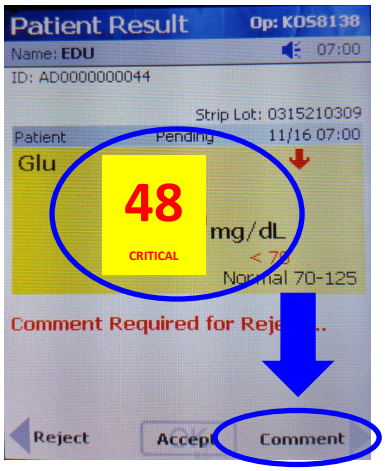
Clinical Alerts:

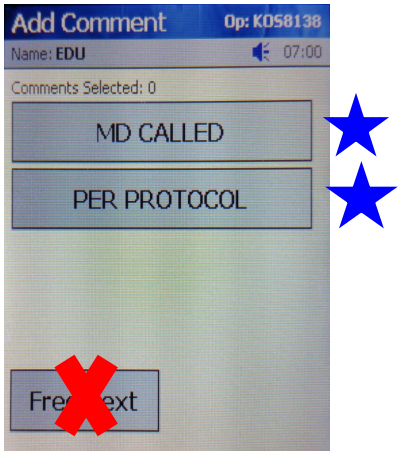
- If you question a result based on the patient's clinical assessment, repeat the test.
- If the result falls below 10 mg/dL or above 600 mg/dL, the meter will read "Lo" or "Hi".
- Capillary, arterial, or venous blood samples can be used for testing.

Critical Value Documentation:

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

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.

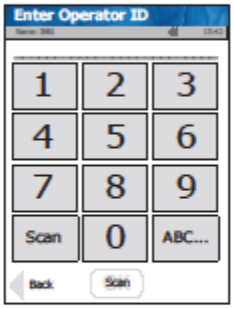
However, if emergency testing is needed for a non-registered patient (no ID band) in specialty areas (ED, NICU or L&D), enter the YYYYMMDDTIME format in lieu of scanning a patient ID band. Once the patient is registered, contact the Lab to update the information to transfer the results to the patient's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

References:

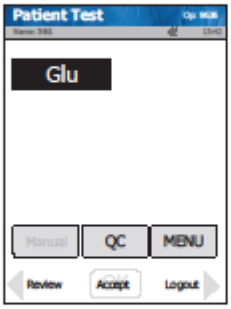
Riverside Community Hospital Policy PC 160 Glycemic Control
Riverside Community Hospital Policy WT 120 Glucose Point of Care Testing Nova

Glucose Monitoring System Quick QC Guide

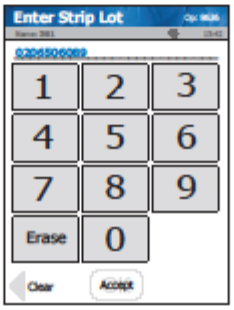
1 From Home screen, press **Login**.



2 Enter or scan Operator ID and press **Accept**.

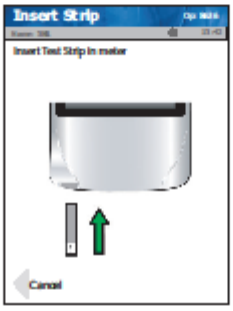


3 From Patient Test screen, press **QC**.



4 Check Strip lot no. and press **Accept**.

5 Enter QC lot no. and press **Accept**.

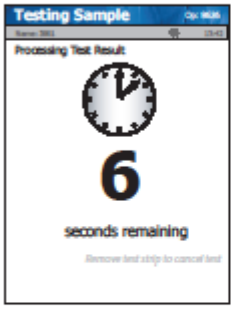


6 Insert Test Strip into Meter.

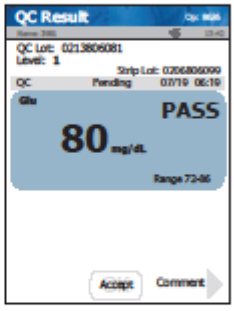
7 Touch drop from QC bottle to strip. Result will appear within 6 seconds.

8 *Warning!*

*The test strip must fill completely upon touching the QC droplet. **Do not add a second QC drop to the test strip.** Discard the test strip and repeat the test with a new test strip.*



9 Result will appear within 6 seconds.



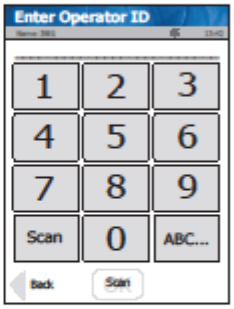
10 To accept result, press **Accept**.

Nova Biomedical, 200 Prospect Street, Waltham, MA 02454
Tel: 800-545-6682 • www.novabiomedical.com

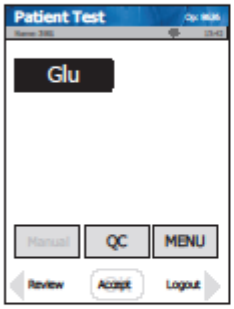
Stat Strip

Glucose Monitoring System Quick Operating Guide

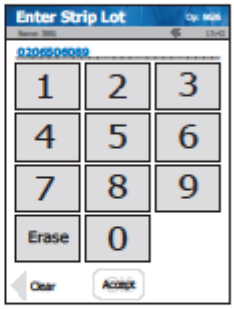
1 From Home screen, press **Login**.



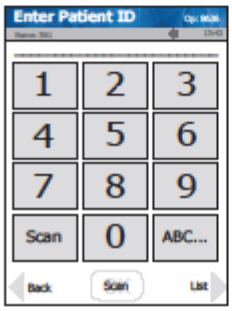
2 Enter or scan Operator ID and press **Accept**.



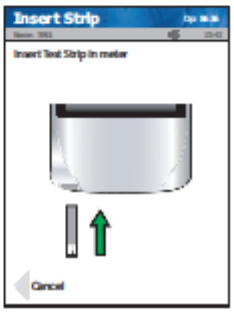
3 From Patient Test screen, press **Accept**.



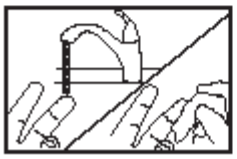
4 Check Strip lot no. and press **Accept**.



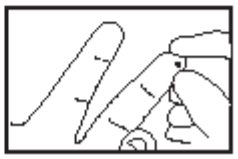
5 Enter or scan Patient ID and press **Accept**.



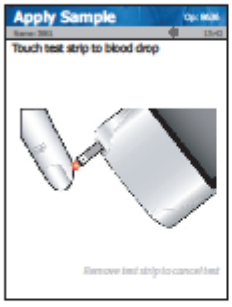
6 Insert Test Strip into Meter.



7 Wash patient's hand thoroughly and massage finger to stimulate blood flow.



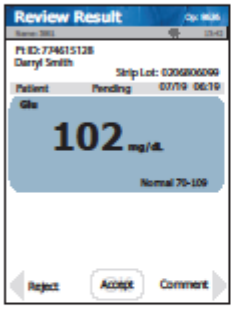
8 Use safety lancet to puncture finger / squeeze finger to form blood drop. Wipe away the first blood drop.



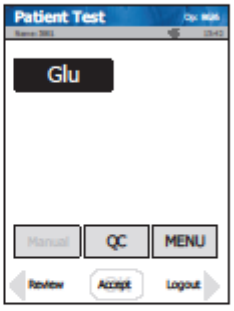
9 Touch strip to blood drop. Result will appear within 6 seconds.

10 *Warning!*

*The test strip must fill completely upon touching the blood droplet. **If the test strip does not fill completely, do not touch the blood droplet a second time.** Discard the test strip and repeat the test with a new test strip.*



11 To accept result, press **Accept**. To reject result, press **Reject**.



12 To review other results, press **Review** from Patient Test screen.

nova biomedical

Nova Biomedical, 200 Prospect Street, Waltham, MA 02454
Tel: 800-545-6682 • www.novabiomedical.com

RESTRAINTS

- ALTERNATIVE MEASURES FRIST
  - ✓ 4 SIDE RAILS ARE CONSIDERED RESTRAINT
- ALWAYS REQUIRE AN MD ORDER
  - ✓ CANNOT EXCEED 24 HOURS
  - ✓ VIOLENT RESTRAINTS..."EYES ON" by Provider with 1 hr of application (intial application only).
- CHARGE NURSE 2ND TIER REVIEW
- Q15 MINUTE MONITORING FOR SAFETY AND DIGNITY
  - ✓ On paper at the bedside; can be done by CNA/PCT.
- RN ASSESSES PATIENT EVERY 2 HOURS – FOR SAFETY AND NECESSITY OF RESTRAINTS

15-Minute Restraint Monitor for Non-Violent Use of Restraint
Riverside Community Hospital, Riverside, California

Date: _____

	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00
Patient's Safety/Rights and Dignity Maintained (3-4 times/hour check). *Write Y / N followed by your Initials* Any "N" entries require further documentation in Patient's Notes	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45

	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00	___:00
Patient's Safety/Rights and Dignity Maintained (3-4 times/hour check). *Write Y / N followed by your Initials* Any "N" entries require further documentation in Patient's Notes	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45	00 15 30 45

Note: Every 2 hour documentation of assessment/monitoring must be entered on *Meditech*

PRINT NAME	INITIALS	PRINT NAME	INITIALS	PRINT NAME	INITIALS

Page 1 of 2

RIVERSIDE Community Hospital

15-MINUTE RESTRAINT MONITOR
FOR NON-VIOLENT USE OF RESTRAINT

Form RP0229 Rev. 03/12

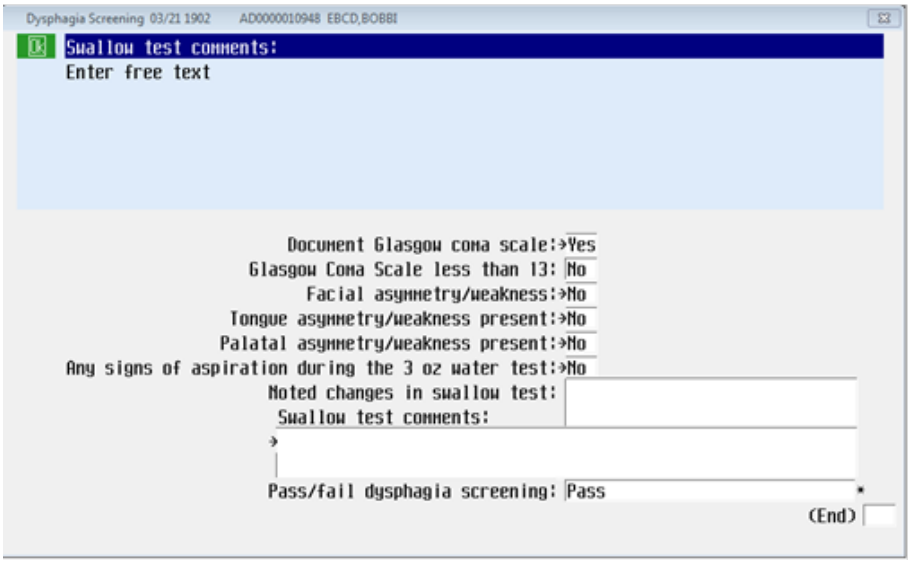
HCA Healthcare®

Quick Guide to Dysphagia Screening Process…….

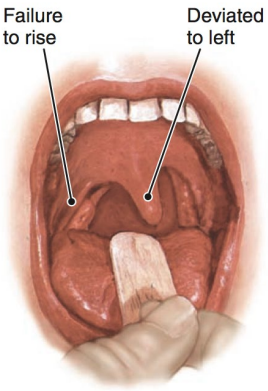
Patients who are NOT candidates for Dysphagia Screening:

- 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 and an order should be obtained for a Dysphagia Evaluation (Bedside Swallow) from the Speech La Pathologist (Speech Therapist).**

Source Document

Competency Title:		
General Equipment Cleaning	**ORIGINATED**	9/2018
	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:

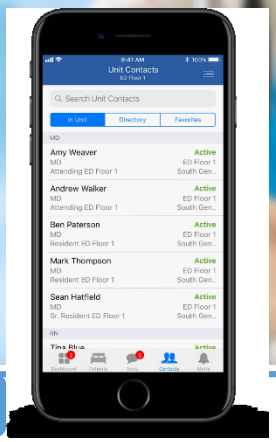
- Clean hands and don gloves before beginning to clean.
- Wipe the exterior surfaces of equipment (including any cords). Use cotton applicators/pipe cleaners for hard to reach areas.
- All surfaces must remain visibly wet for the full amount of dwell time as indicated on the wipes container.
- If the 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.


Sani-Cloth
GERMICIDAL DISPOSABLE WIPE
Prime
LARGE WIPE
DISINFECTS IN 1 MINUTE
KEEP OUT OF REACH OF CHILDREN
WARNING
CONTAINS: 160 Wipes


A11402609 EXP 11/2015
BLEACH
GERMICIDAL DISPOSABLE WIPE
ACTIVE INGREDIENTS:
Sodium Hypochlorite
OTHER INGREDIENTS
KEEP OUT OF REACH OF CHILDREN
CAUTION
Net Contents
75 Large Wipes 6.0 x 10.5 in (15.2 x 26.6 cm)
Net Wt. 1.0 lb 14.0 oz (853g)

Mobile Heartbeat™

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 [illegible]m.
When using wipes, please wear gloves to protect your hands from exposure to disinfectant chemicals.

Medtronic LIFEPAK 20 Defibrillator

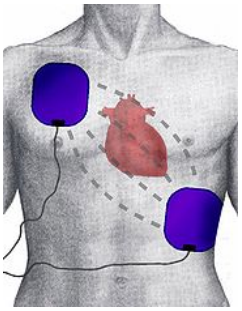
(AED operation, Daily Testing, Manual operation)

AED (Automated External Defibrillation)

Early defibrillation has become the standard of care for patients with either pre-hospital or in-hospital cardiac arrest. The most frequent initial rhythm in sudden cardiac arrest in adults is ventricular fibrillation (VF), and the most effective treatment for VF is timely electrical defibrillation. The speed with which defibrillation is performed is the major determinant of success of resuscitative attempts.

Upon finding a patient non-responsive, not breathing, no pulse:

1. Press Code Blue button
2. Initiate CPR
3. When crash cart is by bedside, use/operate the AED on patient



IMPORTANT THINGS to remember:

- When applying the electrode (Quick-Combo) pads on patient's chest –
  - Ensure chest is dry and without excessive hair.
  - Ensure pads are within expiration date, and moist.
  - Avoid placement over the nipple, bony prominences, dressings, implantable defibrillators or pacemakers, or the diaphragm if possible. If patient has Nitro paste on chest, wipe them off.
  - Apply the pads by smoothing the pads from one end to the other, removing all air.
- AED mode –
  - During the ANALYZE and SHOCK phases, do **NOT** touch the patient, bed or equipment.
  - If shock advised, ensure that no one is touching the patient, bed or any equipment connected to the patient. Say "All Clear", **BEFORE** pushing the SHOCK button.
- Keep the therapy cable connected to the Test Plug at all times, when not in use. This will enable the defibrillator to do its own self-testing automatically at 3 AM daily.
- When using the defibrillator on a patient, remove connection from the Test Plug, and connect it to the electrode (Quick Combo) pads cable.

AED – Automated External Defibrillation Operation

1. Push the **ON** button (#1).
2. Place electrode pads on patient (Sternum electrode below patient's right clavicle, lateral to the sternum, Apex electrode lateral to patient's left nipple with the center of the electrode on the left midaxillary line).
3. Remove therapy cable from Test Plug, and connect to electrode pads cable.
4. Press **ANALYZE** (#2).
5. Follow the voice prompts, *do NOT touch the patient during the analyze or shock phases.*
6. If shock advised, assure that no one is touching the patient, or touching equipment that is touching the patient – say "ALL CLEAR" then push the **RED SHOCK** button (#3).
7. Begin CPR immediately (beginning with chest compressions) after shock delivery.
8. After 2 minutes of CPR, begin at step #1 and repeat sequence.

Daily Testing (unplugged)

1. Assure that the electrode pad cable is connected to the electrode cable test plug.
2. Unplug LIFEPAK 20 defibrillator/AED.
3. Open front panel door.
4. Press the **ON** button.
5. Press the **Energy Select** button (converts AED into Manual mode – for testing).
6. Press the **OPTIONS** button.
7. Select User Test by turning the front speed dial knob.
8. Push in the **Speed Dial** knob.
9. Turn speed dial knob to YES.
10. Push the **Speed Dial** knob to begin the manual test.
11. Plug the LIFEPAK 20 back into the wall.
12. Close the front panel door.

Manual LIFEPAK 20 operation

- Push the ON button
- Place electrode pads on patient (sternum electrode below patient's right clavicle, lateral to the sternum, Apex electrode lateral to patient's left nipple with the center of the electrode on the left midaxillary line)
- Observe heart rhythm on monitor

Defibrillation

a) press ENERGY SELECT button for desired level
b) press CHARGE button
c) say "ALL CLEAR" – observe that no one is touching the patient or any objects that are touching the patient
d) press the RED SHOCK button

Cardioversion

a) press the SYNC button (assure that the pacer function is turned OFF, sync will not work with the pacing function on)
b) press ENERGY SELECT button for desired level
c) press CHARGE button
d) say "ALL CLEAR" – observe that no one is touching the patient or any objects that are touching the patient
e) press AND HOLD the Red SHOCK button until electricity is delivered (expect a slight delay)

Pacing

a) press the PACER button (assure that the SYNC button is OFF, pacer mode will not work when SYNC is on)
b) place the 3 lead cable and electrodes on chest in a Lead II configuration (RA on right shoulder, LA on left shoulder, LL on lower left chest)
c) press the RATE button to select pacer rate
d) press the CURRENT button to select milivolts of electricity. Continue to increase milivolts until "capture" is achieved (spike followed by QRS complex)

Sepsis Prevention & Optimization of Therapy

SPOT Alert

Sepsis Prevention and Optimization of Therapy (SPOT) is an application/algorithm that monitors all patient labs and vital signs in real time and uses the information to identify patients who are at risk for Sepsis.

- SPOT reviews chart for Vital signs the last 6 hours, WBC over 24 hours, Antibiotics and Blood Culture over 48 hours, Sepsis Order Sets, Positive sepsis screen.
- SPOT provides earlier identification.
- Early recognition and immediate treatment of severe sepsis/septic shock decreases the risk of mortality and long-term complications.

When you get a SPOT alert:
Complete a Sepsis Screening in 5 minutes!

SPOT is designed to NOT trigger alerts on the following patients:

- Labor & Delivery
- Post-surgery (24 hours)
- Sepsis Order Set usage (72 hours)
- Positive severe sepsis screening (72 hours)

SPOT, an internally built and sepsis coordinator inspired tool

- Algorithm queries for Sepsis (SIRS + Suspicion of infection) in the background in real time

SPOT's Algorithm Simplified

SIRS (2 of the following):

- Temp (> 38.3°C; < 36°C)
- Pulse (> 90 beats per minute)
- Respiratory rate (> 20 breaths per minute)

} 6 Hour window

- WBC (> 12000/µL; < 4000/µL)

} Last 24 hours

And

Suspicion of Infection (1 of the following):

- Order for a non prophylactic ABX (last 48 hours)
- Order for blood culture (last 48 hours)

Within 5 mins of a SPOT Alert text or call, you MUST go assess your patient and do

HCA Healthcare®

RIVERSIDE Community Hospital
Education Department

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.

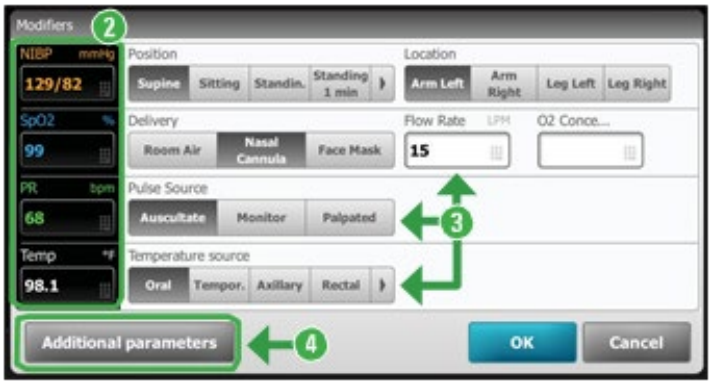
Taking a Temperature

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



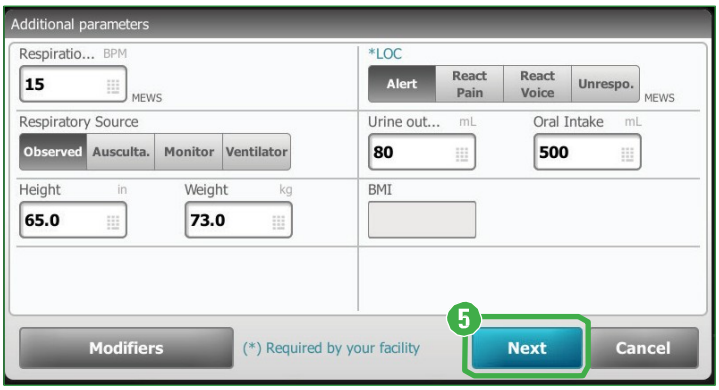
① Touch the modifiers frame on the Home tab.

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

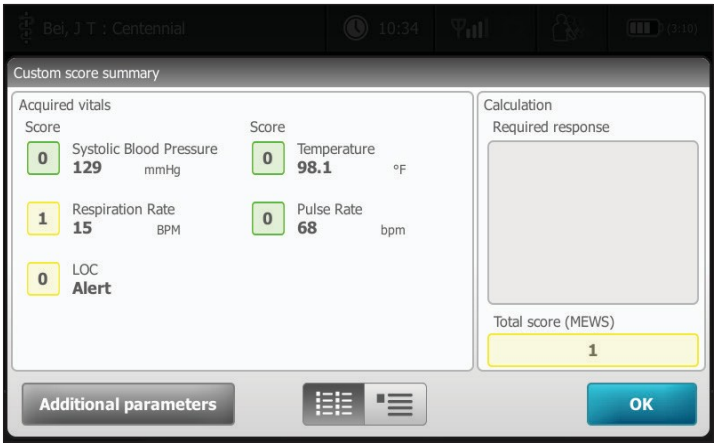
③ Select the desired modifiers from list (touch to expand some lists), or manually enter readings.

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.



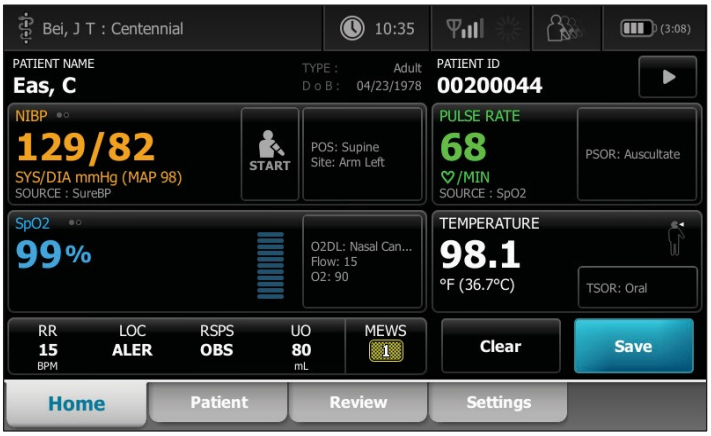
Early Warning Scores



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**.

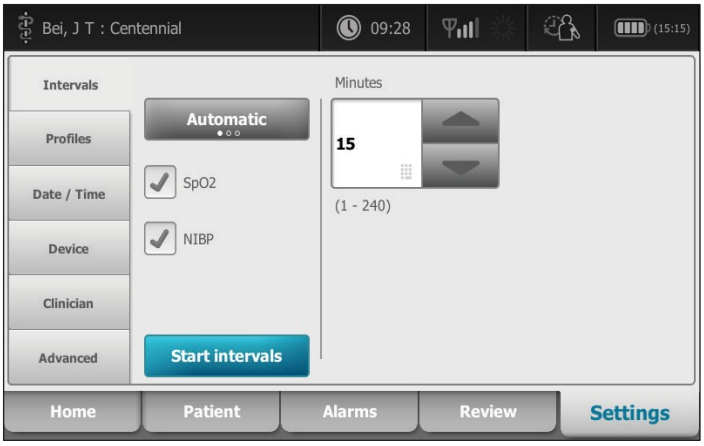
④ **Stop intervals**
1. On the Home tab, touch 

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:

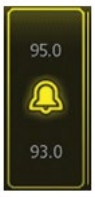


1. Properly size the blood pressure cuff and position it around the patient's bare upper arm.
2. On the Home tab, touch  . The Intervals tab appears (shown)
3. Toggle the intervals type button until it displays **Automatic**. (Options are **Automatic**, **Program**, and **Stat**)
4. Adjust the desired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

For <u>Program</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 **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.

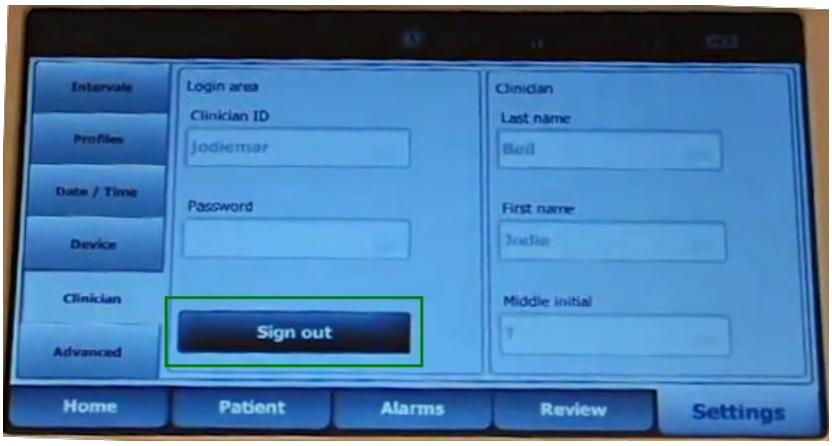
Save Interval Data to EMR – Electronic Medical Record (Meditech)

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.










Date:_____

Suicide Safe Environment Readiness Checklist

WARNING!!!!!! This patient is identified as an imminent or high risk for suicide. The registered nurse must be responsible to implement the following precautions immediately:

The list below includes interventions that will help guide you to implement an improved safe environment for your patient.

Your Initial next to the intervention will be the documented attestation that you have implemented the intervention. Any exception for not implementing must be documented in the space provided at the bottom of this form.

___ **All linen (sheets, blankets, Pillowcases) are counted in the patient room**
___ Patient is placed in a patient gown with snaps (absent of strings)
___ ALL patient clothing, shoes jewelry and belongings are secured (preference is to give belongings to a loved one if patient agrees)
___ Patient will be checked for any metal/sharps/weapons in their possession
___ Visitors are not allowed to give any items to the patient unless approved by registered nurse
___ Staff must have arms length contact with the patient during toileting and grooming activities
___ Room placement is not near exit or exit stairwell or fire pull station if possible
___ Removed plastic liners from trash cans
___ Room must not have windows that can be opened
___ All cords not needed for ongoing patient care are to be removed
___ All sharps containers are removed; use rolling sharps container as needed
___ All glove boxes/gloves are removed
___ Secure all supplies in the room such as sharps/plastics/ligature-prone
___ Notify dietary to use paper and plastic utensils only and no knives

Document reason(s) why any interventions above could not be implemented:

_____

_____

_____

_____

Staff initial	Staff Signature

RIVERSIDE Community Hospital

SUICIDE SAFE ENVIRONMENT READINESS CHECKLIST

HCA | case management

First Time User login and Midas Setup

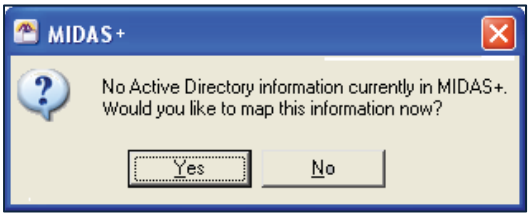
A Guide to assist Users logging in to Midas and nH Discharge for the first time

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

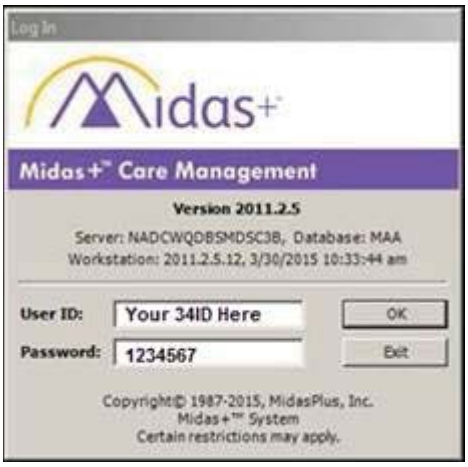
The following steps describe the Active Directory initial login process.

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



Required Skin Integrity Documentation

Key Points

Assessments/Measurements/Photos

- ❑ Accurate documentation of skin assessment is completed EACH SHIFT, including description and measurement of each alteration *(Meditech: Admission/Shift Assessment)*
- ❑ Assessment of risk for pressure ulcer/injury is performed EACH SHIFT *(Meditech: Safety/Risk/Regulatory)*
- ❑ Photos and measurements are taken of skin injury with documented staging (if appropriate) using the NE1 tool, on admission, change in condition, upon transfer, weekly, and at discharge
- ❑ If patient condition or patient refusal does not allow photos / measurements or assessments to be done, document it in patient notes at least ONCE PER SHIFT until it can be completed *(Meditech: Patient Notes)*
- ❑ Upon finding stage 3/4/unstageable skin injury, document 2nd RN's verification of skin injury

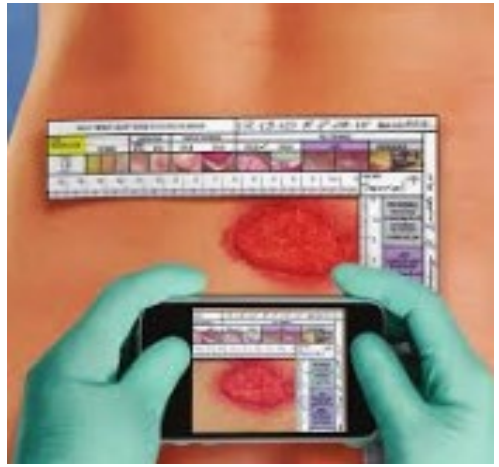
Care Plan/Interventions

- ❑ Individualized care plan is updated EACH SHIFT to include presence of skin injury present on admission, change in condition and condition of wound at time of transfer *(Meditech: Plan of Care)*
- ❑ Appropriate interventions are implemented for patients admitted with existing skin injury or at risk for skin injury, to prevent progression of development of injury
- ❑ Patient is turned or repositioned at least every 2 hours when patient is in bed and this is documented every 2 hours *(Meditech: Routine Daily Care)*

Notification/Education

- ❑ Patient/family and physician are notified of skin injury within 24 hours of identification, and notification documented in patient record *(Meditech: Manage/Refer/Contact/Notify)*
- ❑ Patient/Family are educated on existing skin condition, progression and prevention of injury *(Meditech: Teach/Educate)*
- ❑ Report to Unit Leadership (or Liaison after hours) upon discovery o acquired stage 3/4/unstageable pressure injury

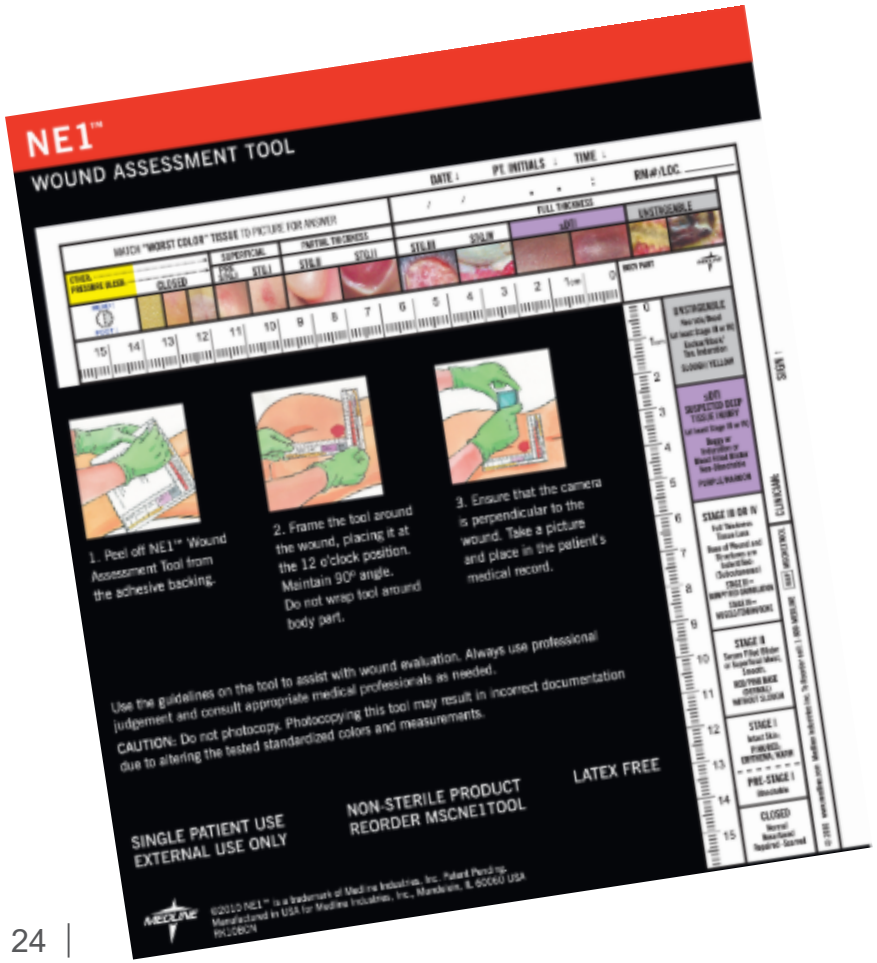
Wound Care…



- Yellow Skin Assessment sheet completed on admission.
- Pictures are taken:
  - Within 4 hours of admission.
  - Upon transfer to another unit.
  - Weekly (Thursdays).
  - When there is a change in the condition of the skin/wound
  - Upon discovery of a new skin alteration.
  - Upon discharge from the hospital.

Photos now taken on iMobile Phone App: GE Media Manager

Wound Documentation…



- Physician notification.
- Patient and family notification/DPOA notification.
- Correct size and staging in Assessment/Reassessment:
  - ✓When first discovered.
  - ✓When dressing is changed.
  - ✓When picture are taken.
- Care must be updated and individualized to include turning.
- Position change documented every 2 hours.

HCA Healthcare®

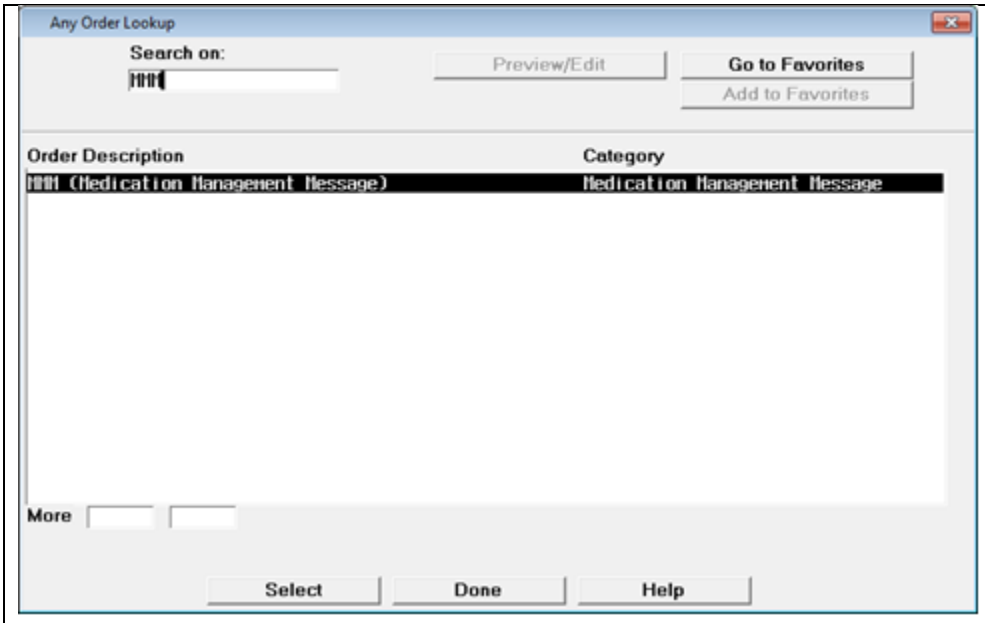
New – Developed On Unit...

- Complete RIR
- Notify Manger/Director
  - Ulcers other than stage 1 or 2 must be reported to CDPH
- Use Stryker (waffle) mattress, specialty bed, etc.

Effective: 10/27/20

Medication Management Message (MMM)

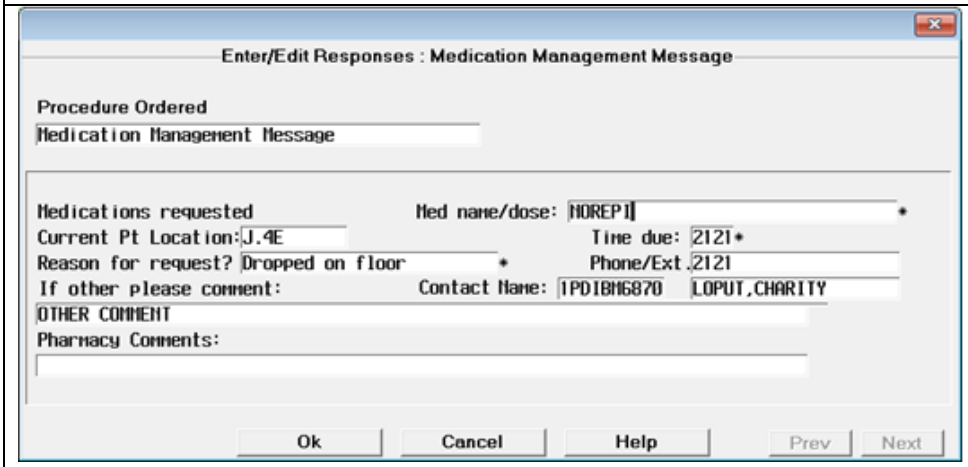
*(*Formerly PHA-NUR MESSAGE TO PHARMACY)*

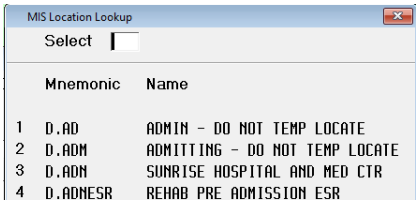


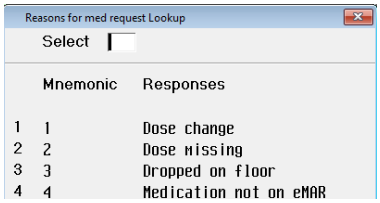
The intent of Medication Management Message order is for sending **missing medication** requests to Pharmacy.

The message is "one way" meaning notification only goes to Pharmacy. Nurses are not notified if Pharmacy updates the message comments. (See below)

Nurse will search for "MMM" under "Orders" and select the order to proceed.





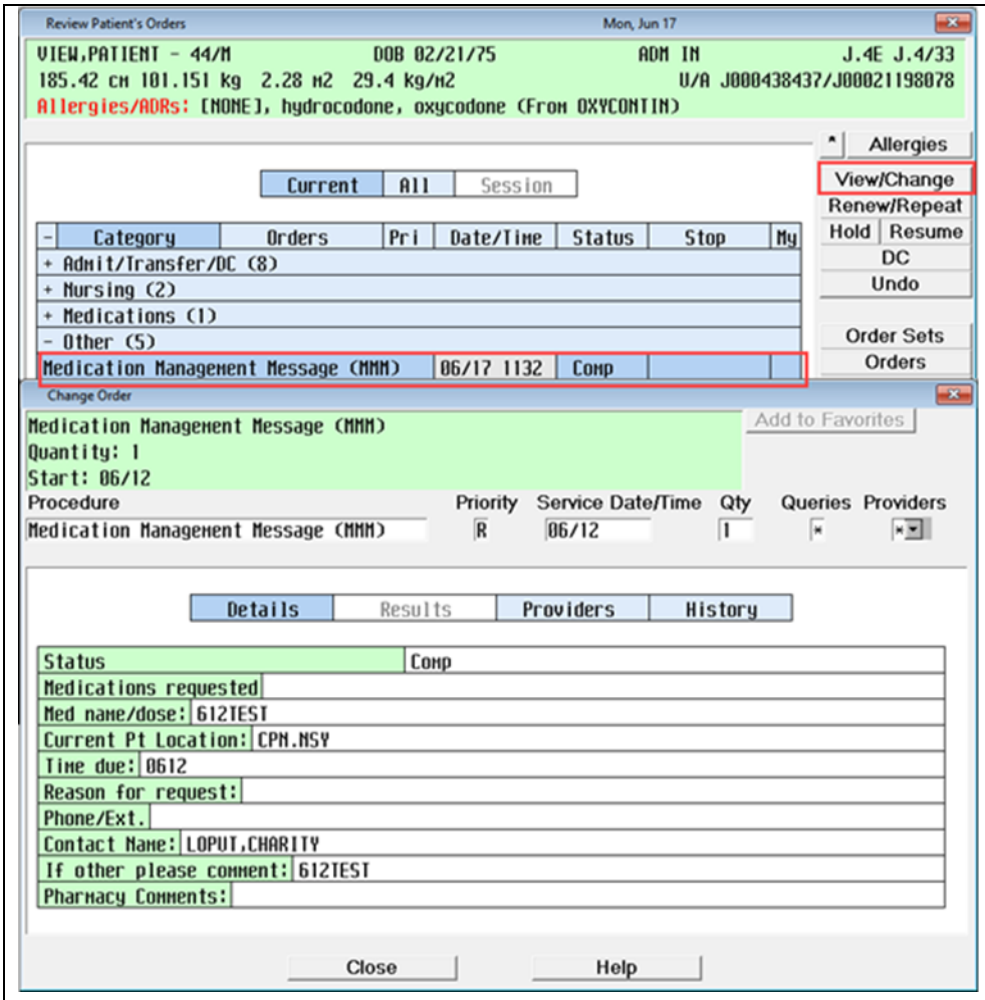


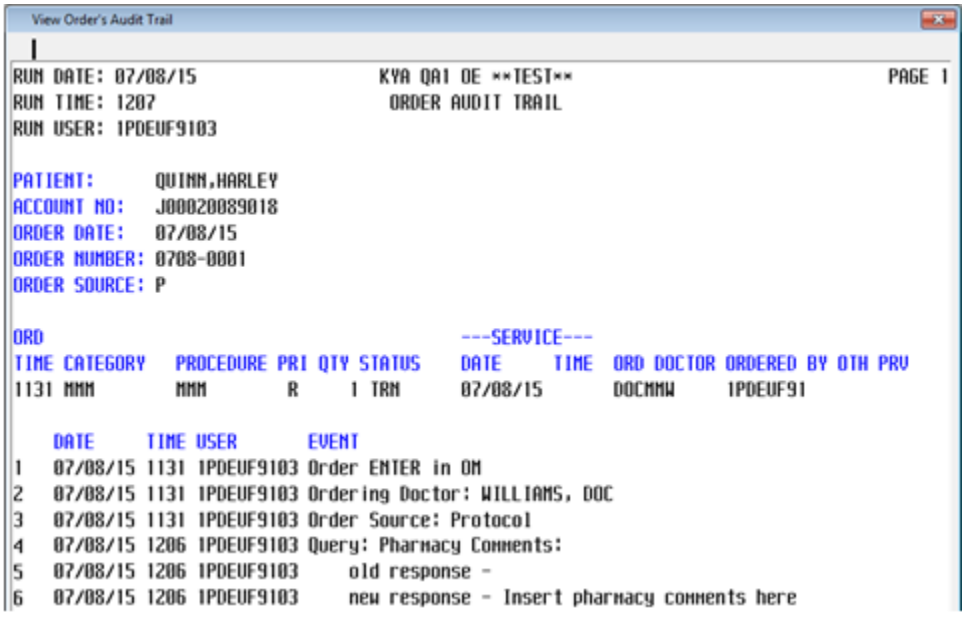
After selecting the order, the nurse will fill out the screen. Fields with an asterisk are required.

Current patient location can be used if patient is temporarily in a location other than admitted.

Both Current Pt Location and Reason for request have canned text in a drop down using F9 key.

After submitting order will appear on the Pharmacy tracker for processing.





Comments can be entered from pharmacy to nursing, but no alert will be given to the nurse.

In Clinical Review:

Highlight the order, then click “View/Change” to see the full order details, which will include any pharmacy comments added.

The print order Audit Trail for the order will also reflect any comments added by pharmacy.