CHI Saint Joseph Health: Agency Nurse Orientation

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Welcome and Introduction

This orientation guide is has been created to help orient you to CHI Saint Joseph Health policies and protocols. This information applies to adult inpatient units. Any protocols for specialty areas such as ED, critical care, HISSU, Cath Lab, PACU, ORs may vary. Contact the charge nurse or nurse manager for your unit for specific information.

- All agency nurses are expected to comply with the CHI Saint Joseph Health standards of care, policies and procedures.

For more information refer to Policy Stat (be sure to select your location)

Resources

- This booklet reviews fundamental elements of CHI Saint Joseph Health policies/procedures. More information about the protocols and procedures summarized in this booklet can be found on the CHI Saint Joseph Health intranet available on all facility workstations. There websites are only accessible via a CHI Saint Joseph Health secure computer.
- We are happy to answer any questions you may have so please do not hesitate to ask. The Directors, Nurse Managers, Charge Nurses, and Clinical Educators are your primary clinical and administrative resources on the nursing units.

Mission, Vision and Values

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Values

Compassion
- Care with listening, empathy and love.
- Accompany and comfort those in need of healing.

Inclusion
- Celebrate each person's gifts and voice.
- Respect the dignity of all.

Integrity
- Inspire trust through honesty.
- Demonstrate courage in the face of inequity.

Excellence
- Serve with fullest passion, creativity and stewardship.
- Exceed expectations of others and ourselves.

Collaboration
- Commit to the power of working together.
- Build and nurture meaningful relationships.

CommonSpirit

Standards of Conduct

To ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment by defining a code of conduct, and to prevent or eliminate, to the extent possible, conduct that:

- Disrupts the operation of the organization;
- Affects the ability of others to do their job;
- Creates or has potential to create a hostile work environment for organization employees or other staff members;
- Interferes with an individual's ability to work effectively; or
- Adversely affects or impacts the community's confidence in the organization's ability to provide quality patient care.

Conversations are to be conducted in a quiet manner, maintaining a quiet, healing atmosphere throughout the hospital. Confidentiality is to be maintained at all times. Patient information of any kind is to be discussed ONLY within the context of the patient care setting.

Interaction with coworkers, visitors, patients, physicians and all others must be considerate and courteous, whether face-to-face or on the telephone.

The following misconduct may result in corrective action up to and including discharge:

1. Violation of CHI Saint Joseph Health's policies, procedures or safety rules.
2. Insubordination or refusal to follow leadership's instructions regarding a job related matter;
3. Falsification or omission of documents and requested information on any CHI Saint Joseph Health record or report, including job applications, personnel forms, timekeeping records;
4. Violation of CHI Saint Joseph Health's EEO Policy or disrespectful conduct toward fellow employees, customers, contractors, suppliers, visitors or other members of the public;
5. Sexual, discriminatory, or other unlawful harassment of another employee, visitor or customer (or potential customer) of CHI Saint Joseph Health;
6. Violation of CHI Saint Joseph Health's Drug and Alcohol-Free Workplace Policy, including possession, use or sale of alcohol during working hours, reporting to work under the influence of alcohol or controlled substances, or unlawful use of controlled substances;
7. Threats or acts of violence, even if meant as a joke or any violation of CHI Saint Joseph Health's Violence-Free Workplace Policy;
8. Theft or unauthorized removal or possession of CHI Saint Joseph Health property, another employee's or contractor's property or the property of any visitor to CHI Saint Joseph Health
9. Gambling on CHI Saint Joseph Health property;
10. Neglect of job duties, unsatisfactory performance or job related incompetence;
11. Release of confidential information without proper authorization about CHI Saint Joseph Health, its customers, or firms that do business with CHI Saint Joseph Health;
12. Inappropriate use of CHI Saint Joseph Health telephones/equipment/computer systems and communications tools (e-mail, fax, PDA's, Bluetooth devices, etc.) This includes excessive personal use of these systems and tools while on duty;
13. Intentional destruction or inappropriate/careless use of CHI Saint Joseph Health equipment/materials;
14. Restricting production or interfering with others in the performance of their jobs.
15. Non-compliance with infection control standards.
16. Conviction for a criminal act that (1) renders the employee unable to perform his/her job due to incarceration, or (2) negatively impacts the employee's ability to safely and adequately perform his/her job.

17. Failure to follow parking guidelines.
18. Horseplay and/or any other unsafe behavior or actions that jeopardize the safety of others on CHI Saint Joseph Health's premises.
19. Willful failure to report an overpayment of wages.
20. Misuse of CHI Saint Joseph Health funds, equipment, credit cards, etc.
21. Unauthorized or inappropriate use or disclosure of CHI Saint Joseph Health's confidential information or trade secrets;
22. Other misconduct as determined by CHI Saint Joseph Health in its sole discretion.

To that end, every CHI Saint Joseph Health employee is subject to the following conditions of behavior:

- Treat all staff, patients, and visitors with courtesy and respect
- Support and follow organization policies and procedures; address dissatisfaction with policies through appropriate channels;
- Use conflict management skills and direct verbal communication in managing disagreements with staff and coworkers
- Cooperate and communicate with other employees in a respectful and dignified manner.
- Address dissatisfaction with and complaints concerning employees with the appropriate leadership.
- Respond promptly and professionally when called upon by fellow workers to provide appropriate information.
- Respect patient confidentiality and privacy at all times; follow all regulations for release of information.
- Treat patient families with respect and consideration while following all applicable laws regarding such relationship (release of information, advance directives, etc.).

The list above should not be considered all-inclusive, and is not intended to limit CHI Saint Joseph Health's intent to address performance or behaviors that are not acceptable, but are not explicitly noted above.

Infractions will result in progress through the CHI Saint Joseph Health's Corrective Action Process. Human Resources will coordinate with leadership and help conduct an investigation of facts related to a potential infraction. The severity of the offense and the employee's corrective action record will normally dictate the level of discipline to be taken. These guidelines do not modify in any way the at-will employment status of employees.

Reference: PolicyStat: Standards of Conduct and Corrective Action

Orientation Information

For agency nursing staff who will be working at CHI Saint Joseph Health, it is expected that the following will have been completed prior to the beginning of employment.

- New Employee Online Orientation
  - **http://www.chisaintjosephhealth.org/orientation**
- Agency Orientation Book
  - Complete and return all forms
- Cerner Documentation Book

Please complete and return all orientation forms to the unit manager or clinical educator.

CHI Saint Joseph Health Nursing Vision

CHI Saint Joseph Health nurses are leaders distinguished by evidence-based practice, exquisite service to others, and safe, effective care. Nationally renowned for our innovative practice environment, our nurses will achieve the highest level of outcomes by partnering with patients, their families, other care providers, and our communities.

Reference: PolicyStat: Plan for Provision of Patient Care Services: CHI Saint Joseph Health Market Services

Confidentiality

Every patient served at CHI Saint Joseph Health has the right to expect that their personal and medical information will be kept confidential. Accessing patient information is only permitted to provide care according to Kentucky Revised Statutes, HIPPA laws, and CHI Saint Joseph policy.

To help maintain patient confidentiality:

- Treat all information regarding patients, residents, medical staff members, employees and the organization, including information accessed through electronic information systems, as confidential.
- Employees are not to access information unless that information is needed to perform the duties of their jobs, including accessing family members or employee's personal medical records.
- Use discretion in discussing any information about patients, residents, medical staff members, employees and the organization. Information should be discussed only with individuals who have a job-related need to know.
- Avoid discussing patients in public places; elevators, hallways, cafeteria.
- Employees may not copy, destroy and/or remove confidential patient documentation from the facility at any time unless authorized to do so by the appropriate parties.
- Protect computer screens by "logging off" when walking away from computer

Reference: CHI Confidentiality Policy, Privacy Safeguards for Protected Health Information, IT Security Standards, and Social Media Standards

Disaster Codes

Event	Code
Fire	Code Red
Bomb Threat/Bomb	Code Black
Immediate Security Assistance	Code Gray
Firearm/Active Shooter	Code Silver
Cardio/Pulmonary Arrest	Code Blue
Missing Infant/child	Code Pink
Internal/External Hazardous Material spill	Code Orange
Internal/External Disaster	Code Yellow
Antepartum/Labor Emergency	Code Green

Missing Adult	**Code Gold**
Medical Assistance Needed	**Rapid Response**
Evacuation	**Code X**

Reference: PolicyStat: Refer to individual Code policies

Dress Code

To ensure that a professional image is presented by all CHI Saint Joseph Health employees, contracted and agency individuals, and students to our patients, families, visitors and other guests. All individuals must adhere to this policy while in the workplace or otherwise while representing CHI Saint Joseph Health on business.

Uniforms

To project a professional image, CHI Saint Joseph Health requires that clinical employees wear scrub colors based on their job title. Some non-clinical employees, based on department guidelines, will be required to wear a uniform. Purchase and maintenance of uniforms is generally the employee's responsibility.

Jackets

Fleece jackets are not allowed in patient care areas. Fleece materials collect and shed lint. Additionally, lint may harbor microbial-laden dust and respiratory droplets. Uniform lab coats or jackets are acceptable.

Sterile Gowns

All isolation/sterile gowns and/or masks, leg and/or show covers and caps must be removed when leaving the work area.

Name Badges

For security purposes and as a courtesy to patients and visitors, all staff shall wear their identification badges at all times while on duty. They are to be worn above the waist and below the neck with the picture visible, not on the sleeve or belt or hat. If the badge is worn from a badge holder or lanyard it must be a breakaway, the badge must be suspended well above the waist. ID badges are not to be displayed unless coworkers are on duty. ID badges must be returned to Human Resources upon termination of employment.

The employee name badge will be issued to all new Employees at orientation or as soon as possible thereafter. There will be a fee associated with replacement of lost or forgotten badges that can be payroll deducted.

Any employee transferring to different job classification/job title is to have a replacement badge made with their new job title. An employee that has changed their name will have a new badge made to match the name on their Social Security card. These changes will be completed at no cost to the employee.

Shoes

Footwear must be of a type that provides safe, secure footing, offers protection and be of material that provides a quiet walking surface appropriate to the uniforms or style of dress worn. Shoes should be

clean and in good repair at all times. Close-toed shoes must be worn by direct patient care providers and departments designated for safety reasons as determined by the department leader. If at any time a non-direct patient care employee is required to go to a patient care area, they must wear close toed shoes.

Hair

Hair must be clean, neatly styled and should not interfere with the job performance. If hair is longer than collar length (patient care providers) it must be tied back to avoid patient contact during patient care and/or transportation.

Beards, sideburns, mustaches and goatees are allowed as long as the facial seal for the care of certain isolation patients is not compromised but must clean and neatly trimmed.

Hair accessories should coordinate (tastefully, professionally) with uniform color. Hair accessories must be simple, such as small conservative clips, barrettes or combs.

Jewelry

Minimal jewelry may be worn but must not interfere with patient care activities or create a safety hazard. Bracelets should not be worn in patient care areas, with the exception of a medical alert bracelet. Long hanging earrings are not acceptable. Wrist watches are acceptable. Ear gauges should be plugged closed with plugs of matching skin tone. Exposed eyebrow, cheek, lip and/or nose piercings are not permitted.

Fingernails

Patient care providers, coworkers who occasionally visit patients and food service coworkers may NOT wear Acrylic Nails, Acrylic Nail tips, Gels, No Chip Polish or Wraps. Nail ornaments are also not allowed. Nail colors should be conservative and well maintained with no chipped polish. Finger nails should be no longer than 1/4 inch long, to permit soap or waterless hand gel/antiseptic rub to reach all areas under the nail. Long nails are not acceptable because they may tear/cut gloves and can provide a place for organisms to hide and grow which could increase the risk of infections.

Personal Hygiene

All coworkers are expected to maintain clean and appropriate oral and body hygiene. Issues involving personal hygiene or body odor should be handled discretely in a private counseling session conducted by the coworker's supervisor.

Fragrance

Cologne or perfume are not to be worn in any areas of the hospital because perfume, cologne, after shave and scented lotions can set off an allergic reaction to our patients and coworkers. Additionally, perfumes and lotions may interfere with the barrier properties of gloves.

Tobacco Smell

This is a smoke free campus and tobacco use is prohibited. Caregivers should not report to work smelling of tobacco. Patients and coworkers can be sensitive to the smell of tobacco. For example, patients or coworkers with respiratory illnesses can have a reaction to the smell.

Hats/Head Wear

Hats, caps, head wraps or skull caps are not permitted unless they are part of an authorized uniform or worn for religious or health-related reasons.

Athletic sweatbands, hats and scarves (with the exception of religiously or culturally required head coverings) are not acceptable head wear.

Tattoos

Non-offensive tattoos are allowed. Tattoos depicting graphic, sexual, violent or distasteful images are not permitted. Anything identified as offensive will be addressed accordingly as per Corrective Action policy. If management recognizes that a tattoo is or can be perceived as offensive to our patients, coworkers, visitors or physicians, you will be asked to cover the tattoo with clothing or concealer.

Amendment for COVID-19 Pandemic: Face Masks:

Homemade masks made of cloth, bandanas and/or head bands to be worn across the face are permitted as long as they are a plain color or patterns in good taste that matches uniform, scrubs or other clothing. Masks should be in good condition and cannot be frayed, torn or soiled. **Cloth items are not a replacement for approved PPE**. Appropriate PPE must be worn during all interactions while at work. Cloth masks may be worn OVER approved PPE.

Reference: Policy Stat: Dress and Appearance Standards

Environment of Care

It is the goal of the Environment of Care Management Program to provide a safe and supportive and effective environment through activities supportive of reducing risk of injury for patients, visitors, employees, contract staff, volunteers, students, physicians and other individuals providing care or services.

Performance Improvement Monitoring activities of the Environment of Care Management Program include:

- Proactive safety and security risk assessments, root cause analyses, gap analysis, proactive risk assessments of high risk processes, and external sources such as Sentinel Event alerts
- Proactive assessments conducted through the scheduled EC Tours
- Fire Drill critiques and aggregated information surrounding staff preparedness
- State and Federal Warning product notices and recalls
- Injuries to patients or others coming to the organization including incidents of property damage
- Patient safety issues and events as they relate to the environment of care
- Occupational illnesses and injuries to staff
- Security incidents involving patients, staff or others within its facilities
- Hazardous materials and waste spills and exposures
- Radiation Safety and Laser Safety
- Fire safety management problems, deficiencies and failures
- Medical and/or laboratory medical equipment management problems, failures and user errors
- Utility systems problems, failures or user errors
- Infection prevention and control reports as they relate to the environment of care
- Inspection results from contractors and external authorities
- Incidents of damage to its property or the property of others

Smoking

The hospital prohibits smoking except in specific circumstances and takes action to maintain compliance with this policy.

Fire Safety

- Keep combustibles (paper, linens, clothing, etc.) away from heat producing devices
- For Fire Safety, know the locations of:
    - Fire alarms and fire extinguishers in your work area
    - Medical gas/oxygen shut-off valves
    - Proper exits for evacuation plan
    - You unit fire zones (the area between two sets of fire doors)
    - Automatic fire doors will close when the fire alarm is pulled. The metal FIRE ZONE doors contain both smoke and fire, and provide a longer length of time to save lives.
    - In addition to the fire doors, all other doors to offices and patient rooms are to be closed for additional protection and fire/smoke containment. Never block the fire doors or prop open.

In the event of a fire, remember R-A-C-E (badge)

- Rescue people who are in immediate danger by moving them away from the area.
- Alarm, pull the alarm and call the in house emergency number. Tell the operator “Code RED and location”
- Contain the fire. Close all doors. Reassure patients who stay in their rooms.
- Extinguish/Evacuate. Fight the fire only if it is small and contained like a wastebasket fire. Use the right fire extinguisher and evacuate as instructed.

To use a fire extinguisher, think P-A-S-S (badge)

- Pull the pin. Twist the pin to break the plastic tie.
- Aim at the base of the fire.
- Squeeze the trigger.

- Sweep from side to side while continuing to aim at the base of the fire.

REMEMBER:
Hospital Emergency Numbers:

- 1111 @ SJH/SJE/SJJ
- 66 @ SJB
- 0 @ SJMS
- 799 @ SJL
- 999# @ Flaget

Know the locations of alarms, exits, medical gas/oxygen shut-off valves, and identify doors that divide the fire zones in your work area. Respiratory Therapy is responsible for turning off medical gas/oxygen shut-off valves in the event of a fire.

Reference: Policy Stat: Environment of Care Program Management and Plans; Code Red

Incident Reporting

The Risk Manager has oversight of all Risk Management functions at CHI Saint Joseph and will maintain and manage all operations of IRIS (Incident Reporting Information System) for reporting and tracking unexpected events related to potential or actual injuries involving patients, visitors/non-patients, and employees.

The purpose is to outline the policy for reporting, analyzing and managing an incident involving patients, visitors/non-patients, and employees. Every incident report offers CHI Saint Joseph Health an opportunity to evaluate care or realign resources to advance the safety of patients, visitors/non-patients, and employees. These reports record accidents or unusual events, which might result in injury or damage to person(s) or property and could involve potential litigation.

Definition of an Incident: An incident is defined as any happening that is not consistent with the routine care of a patient, **including near misses**, or any event that is not consistent with normal operations of the hospital that could have an impact on any patient, visitor/non-patient or employee.

Reference: Policy Stat: Incident and Occurrence Reporting: CHI Saint Joseph Health

Confidentiality, Reporting and Culture

- When an incident occurs or is discovered, an on-line computer report via Incident Reporting **I**nformation System (IRIS) shall be entered by the person who witnessed the incident or to whom the incident was reported. The entry of the incident into IRIS should occur, as soon as feasibly possible, after assuring the safety and wellbeing of the patient, visitor and/or employee is addressed.
- The incident report is a confidential document and should not be added to the medical record.
- All incidents are considered confidential and the information contained in the report should only be shared with hospital personnel that have a need to know the information to perform their duties, to include Quality, Risk, Safety First, Performance Improvement, or Peer Review initiatives.
- Incident reports may be considered a part of the PSES (Patient Safety Evaluation System) for purposes of reporting to the PSO (Patient Safety Organization)

Reference: Policy Stat: PSO Policy for CHI Saint Joseph Health

- Employees may submit an incident report without fear of intimidation or retaliation.
- **Do Not** document in the medical record that an incident report was completed

- The **facts** regarding a patient incident shall be recorded in the medical record. Statements regarding liability, speculation, and/or judgment as to the cause should not be included. Do not include names of individuals - utilize titles only.
- No statements which could lead to discovery of an incident report shall be written in any patient medical records.
- **Do Not** print, copy or otherwise distribute the incident report other than as approved for in hospital policies and procedures. The Risk Manager or designee may make a copy as required for state reviews or audits.
- An IRIS report requested for potential litigation must be provided by the CHI Claims Professional. The Risk Manager will be notified of the request and contact the appropriate individual in the Claims Department for assistance in providing an appropriate document for legal counsel.
- Employees, who desire to remain anonymous, may complete the IRIS report on-line as it does not require the name of the reporter for submission. However, to facilitate the flow of the investigative process one is encouraged to include their name.
- Every effort should be made to preserve all evidence from the incident. Evidence would include all equipment, supplies, medical records, linens, or packaging contents, etc.
- Equipment should be removed from service and placed in a safe locked area until the Performance Manager and/or Bio Med can retrieve it.
- Programmed settings, memory etc. are not to be changed or deleted.
- The name of the equipment, the manufacturer and related serial or control numbers should be documented.
- If tubing or fluids are involved, they are to be saved intact.
    - Syringes, vials, ampules, medications, etc. are to be kept intact.
- Photographs may need to be taken to preserve the evidence and may be electronically attached to the incident in IRIS.

How to Report an Incident

- To access IRIS, use one of two methods: Double click the IRIS Icon on your desktop or Click on the IRIS Reporter located on the CHI Saint Joseph Intranet Home Page or per facility route to IRIS.
- Select the radio button for Patient or Security/Visitor and the page will automatically prompt you to the next fields to be completed
- If unsure of the process on how to access IRIS and submit a report, online help may be accessed by clicking on “HELP” button in the upper right corner of any IRIS screen.
- The hard copy forms “IRIS PATIENT” Incident Reporting Form and “IRIS VISITOR-NONPATIENT” Incident Reporting Form shall be used for incident reporting when the IRIS system is not available. These forms can also be obtained from the IRIS help page. Each department shall have paper copies available for staff to access in case the computerized versions are not available. Completed paper IRIS forms should be hand-delivered to the Risk Manager’s office.

Security Investigation of Visitor Incidents

- Security staff is responsible for the investigation of any incident involving a visitor.
- Security staff shall follow their department policy for investigating a visitor incident.
- Incidents investigated by security staff shall be entered into IRIS.
- If the visitor’s incident is such that the visitor needs to see a physician, the Security officer or attending manager should ask the visitor if he/she wishes to go to the Emergency Department (ED). An employee is to escort the visitor to the Emergency Department if he/she wishes to be seen in

the ED. The visitor has the right to refuse treatment. **Treatment in the ED is therefore optional and the employee must not guarantee that the hospital will pay for the treatment.**

Reference: Policy Stat: Incident and Occurrence Reporting: CHI Saint Joseph Health

Reporting Mechanisms

Safe Medical Devices Act

This law is meant to protect patients and employees from medical devices or products that may potentially cause serious injury, illness, or death by promptly reporting incidents to the FDA.
What to do**:**

- In a patient care incident, remove the equipment or supply.
- Stabilize and treat the patient.
- Notify the physician.
- Notify the Risk Manager (or House Administrator after hours).
- Complete a variance report with the identifying serial numbers or equipment numbers.
- Follow the specific procedure for drugs, supplies or equipment according to what is involved in the event.
    - **Drug Failure** – Retain all packaging, syringes, inserts, serial numbers, and disposable accessories. *Example of drug failure: Unit dose packaging received for your patient is empty,* or AddVantage *product that will not activate.*
        - Notify the Pharmacy via a variance report and deliver the item to the pharmacy.
    - **Supply Failure** – Remove the item from use; retain all packaging and disposable accessories, place in a biohazard bag and deliver to the office of Risk Manager. *Example: After placing the patient to hemovac suction you note the hemovac drain will not maintain suction. You note the drain appears to be defective.*
    - **Equipment Failure**- Attach and complete a variance report and a red "defective sticker", remove the equipment from service and sequester. Leave the equipment set-up as it was when the incident occurred. Do not disconnect the electrical supply and save all items connected to the equipment when the event occurred (fluids, tubing, etc.). *Example of equipment failure: Pump (IV, PCA) fails on free flow protection, administering too much medication to patient or underflows by not administering the proper dose to patient*.
        - Notify Clinical Engineering (Biomed) Department immediately that equipment was involved in a patient incident.

Reference: Policy Stat: Management and Reporting of Medical Device Incidents

Sentinel Events

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

SOME EXAMPLES OF SENTINEL EVENTS:

- Object left in patient after surgery; surgery on wrong patient/wrong body part

- Severe neonatal hyperbilirubinemia
- Patient rape
- Child abduction or discharge to the wrong family

If you feel that a Sentinel Event or "near miss" has occurred, please notify Administration, Risk Manager, or House Administrator IMMEDIATELY.

Your leader will provide the number for the Risk Management Hotline.

Reference Policy Stat: Sentinel Events-Responding to Reporting of, Disclosure of Unanticipated Outcomes, Adverse Patient Event Communication

National Patient Safety Goals 2022

Goal 1: Improve the accuracy of patient identification.

NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment, and services.

--Rationale for NPSG.01.01.01--

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is twofold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Newborns are at higher risk of misidentification due to their inability to speak and lack of distinguishable features. In addition to well-known misidentification errors such as wrong patient/wrong procedure, misidentification has also resulted in feeding a mother's expressed breastmilk to the wrong newborn, which poses a risk of passing bodily fluids and potential pathogens to the newborn. A reliable identification system among all providers is necessary to prevent errors.

Element(s) of Performance for NPSG.01.01.01

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.
2. Label containers used for blood and other specimens in the presence of the patient.
3. Use distinct methods of identification for newborn patients.
   Note: Examples of methods to prevent misidentification may include the following:
   - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples).
   - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
   - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

Goal 2: Improve the effectiveness of communication among caregivers.

NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis.

--Rationale for NPSG.02.03.01--

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Element(s) of Performance for NPSG.02.03.01

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
   - The definition of critical results of tests and diagnostic procedures
   - By whom and to whom critical results of tests and diagnostic procedures are reported
   - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
2. Implement the procedures for managing the critical results of tests and diagnostic procedures.
3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3: Improve the safety of using medications.

NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

--Rationale for NPSG.03.04.01--

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at Standard MM.05.01.09.

Element(s) of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   - Medication or solution name
   - Strength
   - Amount of medication or solution containing medication (if not apparent from the container)
   - Diluent name and volume (if not apparent from the container)
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours

   Note: The date and time are not necessary for short procedures, as defined by the hospital.
4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.
7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
   Note: This does not apply to multiuse vials that are handled according to infection control practices.
8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

--Rationale for NPSG.03.05.01--

Anticoagulation therapy can be used as therapeutic treatment for several conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulant medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications, including improving patient outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy and the precautions they need to take. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, warfarin, and direct oral anticoagulants (DOACs).

Element(s) of Performance for NPSG.03.05.01

1. The hospital uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable.
2. The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
3. The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants.
   Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
4. The hospital has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.
   Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.
5. The hospital addresses anticoagulation safety practices through the following:
   - Establishing a process to identify, respond to, and report adverse drug events, including adverse drug event outcomes

- Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the hospital

6. The hospital provides education to patients and families specific to the anticoagulant medication prescribed, including the following:
   - Adherence to medication dose and schedule
   - Importance of follow-up appointments and laboratory testing (if applicable)
   - Potential drug–drug and drug–food interactions
   - The potential for adverse drug reactions
7. The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
   Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.
8. When heparin is administered intravenously and continuously, the hospital uses programmable pumps in order to provide consistent and accurate dosing.

Introduction to Reconciling Medication Information

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, and services, even in situations where medications are not used.

NPSG.03.06.01: Maintain and communicate accurate patient medication information.

--Rationale for NPSG.03.06.01--

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is

taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Element(s) of Performance for NPSG.03.06.01

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
   Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
   Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.
2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings.
   Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
   Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1)
4. Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.
   Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

Goal 6: Reduce patient harm associated with clinical alarm systems.

NPSG.06.01.01: Improve the safety of clinical alarm systems.

--Rationale for NPSG.06.01.01--

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.

Element(s) of Performance for NPSG.06.01.01

1. Leaders establish alarm system safety as a hospital priority.
2. Identify the most important alarm signals to manage based on the following:
   - Input from the medical staff and clinical departments
   - Risk to patients if the alarm signal is not attended to or if it malfunctions
   - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   - Potential for patient harm based on internal incident history
   - Published best practices and guidelines
3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following:
   - Clinically appropriate settings for alarm signals
   - When alarm signals can be disabled
   - When alarm parameters can be changed
   - Who in the organization has the authority to set alarm parameters
   - Who in the organization has the authority to change alarm parameters
   - Who in the organization has the authority to set alarm parameters to “off”
   - Monitoring and responding to alarm signals
   - Checking individual alarm signals for accurate settings, proper operation, and detectability
4. Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Goal 7: Reduce the risk of health care–associated infections.

NPSG.07.01.01: Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines.

--Rationale for NPSG.07.01.01--

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, monitors compliance, and provides feedback.

Element(s) of Performance for NPSG.07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease

Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines.
2. Set goals for improving compliance with hand hygiene guidelines.
3. Improve compliance with hand hygiene guidelines based on established goals.

Goal 15: The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01: Reduce the risk for suicide.

Note: EPs 2–7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.

--Rationale for NPSG.15.01.01--

Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Element(s) of Performance for NPSG.15.01.01

1. For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
   For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.
   Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).
2. Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.
   Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.
3. Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
   Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.
4. Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.
5. Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reassessment
   - Monitoring patients who are at high risk for suicide
6. Follow written policies and procedures for counseling and follow-up care at discharge for patients

identified as at risk for suicide.

7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the timeout procedures should be as consistent as possible throughout the hospital.
Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

UP.01.01.01: Conduct a preprocedure verification process.

--Rationale for UP.01.01.01--

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are as follows:

- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers

- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Element(s) of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.
   Note: The patient is involved in the verification process when possible.
2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure
     Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.
3. Match the items that are to be available in the procedure area to the patient.

Introduction to UP.01.02.01

Wrong-site surgery should never happen, yet it is an ongoing problem in health care that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In

most cases, that will be the person performing the procedure.

Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These individuals would include the following:

- Individuals who are permitted through a postgraduate education program to participate in the procedure.
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses
- (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

UP.01.02.01: Mark the procedure site.

Element(s) of Performance for UP.01.02.01

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.
2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.
3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
   - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
   - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.
     Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.
4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.
   Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.
5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).
   Note: Examples of other situations that involve alternative processes include:
   - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice

- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01: A time-out is performed before the procedure.

--Rationale for UP.01.03.01--

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

Element(s) of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.
2. The time-out has the following characteristics:
   - It is standardized, as defined by the hospital.
   - It is initiated by a designated member of the team.
   - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.
3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
4. During the time-out, the team members agree, at a minimum, on the following:
   - Correct patient identity
   - The correct site
   - The procedure to be done
5. Document the completion of the time-out.
   Note: The hospital determines the amount and type of documentation.

Reference: https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-national-patient-safety-goals/

Parking

Saint Joseph Lexington Market Campuses

Security may issue temporary hang tags to those not listed as employees- (students, temporary, contract). Drivers with temporary vehicles should place a visible note in the rear dash listing their name and department.

Saint Joseph Hospital

Physicians and Physician Assistants and Allied Health Care Professionals (credentialed by Medical Staff office) will park in the garage in designated spaces.

Otherwise, employees, contract and temporary workers must park in the SJH parking areas as follows:

- Acceptable areas are those not otherwise visibly prohibited in the parking garage; or in the last 2 rows (visible by the blue paint outline) of the visitor main parking lot. The 3rd row (visible by the blue paint outline) from the back of the parking lot will be reserved for Valet parking.
- Employees, contract and temporary workers parking is prohibited where designated for Physicians, Allied Health Care Professionals, volunteers or handicapped individuals.
- Those with special need circumstances (handicapped, injured, pregnant) must contact the Security department for a resolution to their parking needs.
- All qualified as handicapped must provide the Security department with a copy of their handicapped parking paperwork issued by their respective County Clerk's office stating the tag is issued to them.
- All employees with a handicapped parking pass must park in the designated handicap parking spaces in the parking garage.

Parking garage guidelines:

- All vehicles must be centered in each parking space. Be considerate of other vehicles around you.
- Drivers must not back their vehicle into a parking space. Pull in forward facing to the spot.
- The parking garage is a *one-way* driving lane. Follow directional arrows in the garage.

Saint Joseph East

Security may issue temporary hang tags to those not listed as employees (students, temporary, contract). Drivers with temporary vehicles should place a visible note in the rear dash listing their name and department.

All employees, contract and temporary workers must park in the SJE employee parking lot located off Blazer Parkway. No employees are allowed to park in the visitor lot, unless the following exceptions are considered. Employee overflow parking will be in the 3470 Blazer Building parking lot in the spaces along the tree line.

Exceptions:

- Employees, contract and temporary workers with special need circumstances (handicapped, injured, pregnant, etc.) must contact the Security department for a resolution to their parking needs.
- 2nd and 3rd shift staff are permitted to park in the Lexington Clinic parking lot between 6 pm - 7:30am. Associates vehicles must not be present before 6pm and all must be removed before 7:30am.
- All qualified as handicapped employees, contract and temporary workers must provide the Security department with a copy of their handicapped parking paperwork issued by their respective County Clerk's office stating the tag is issued to them.

Saint Joseph Jessamine

Security may issue temporary hang tags to those not listed as employees (students, temporary, contract).

All SJJ employees must park in the designated employee parking areas outlined by the map located in Administration (with the following exceptions)

• Employees, contract, temporary workers with special need circumstances (handicapped, injured, pregnant, etc.) must contact Security for a resolution to their parking needs.

• All qualified as handicapped associates must provide Security with a copy of their handicapped parking paperwork issued by the County Clerk's office stating the tag is issued to them.

Flaget

- Designated Parking Areas
- Employee parking spaces are identified in green on the campus map.
- Towing Policy
    - Violations of this policy may result in a citation and the appropriate supervisor informed.
    - Continued violations may result in the vehicle being towed at the owner's expense.
    - Any vehicle blocking access to lots or entrances may be towed at the owner's expense.
    - Any vehicle parked in a designated "handicap" space without displaying a handicap tag may be towed at the owner's expense.

Saint Joseph London

- Temporary hang tags may be issued to students, temporary employees and employees with temporary vehicles (rental car, borrowed car).
- Parking signs are posted throughout the premises either at the entrance to a parking area or at individual parking spaces to designate where to park.
- Employees with special circumstances (handicapped, injured, pregnant, etc.) must contact Security for a resolution to their parking needs.
- All qualified as handicapped associates must provide Security with a copy of their handicapped parking paperwork issued by the County Clerk’s office stating the tag is issued to them.

Saint Joseph Berea

All Berea employees must park in the designated employee parking lot behind the hospital at the bottom of the hill or the legal spaces on the slant down the hill.

Exceptions to this policy are as follows:

- Employees with special need circumstances may provide an excuse from their medical provider to their manager or security to receive a parking pass allowing them to park on top of the hill, in spaces not designated for handicap or specific departments.
- Employees may park in the upper parking lot, behind the hospital from 4:30pm - 7:30am.
- All employees with handicapped parking tags will provide security with a copy of their handicapped parking paperwork issued by the County Clerk's office stating the tag is issued to them.
- 2nd shift employees may park on top of the hill at the beginning of their shift, so long as it begins at 2:30pm or later.
- All other day shift employees may move their cars up the hill after 4:30pm.

Saint Joseph Mt. Sterling

Staff parking is provided in the front parking lot, only in the three aisles closest to the interstate and in the back lot in any spaces that are not marked with parking specific signage. Exceptions for employee parking policy include handicap parking, SJMS employee of the Quarter, SJMS Leader of the Year, SJMS Employee of the Year, and a few other exemptions with written permission from the Executive Team.

Reference: PolicyStat: Standards of Conduct

Patient Rights and Patient Responsibilities

The organization encourages respect for the personal preferences and values of each individual. We consider patients as partners in their health care. When patients are well informed, participate in treatment decisions and communicate openly with their doctor and other health professionals, they help

make their care as effective as possible.

When you are a patient you have the right to:

1. Receive fair and compassionate care at all times and under all circumstances.
2. Receive comfort, respect and recognition of personal dignity, values and beliefs; including cultural, psychosocial, and spiritual.
3. Be treated equally and receive the same level of care or treatment regardless of your age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.
4. Receive safe and appropriate medical care to the best of the organization's ability.
5. Be informed of your rights before care is provided or discontinued, whenever possible.
6. Be informed of organization rules and regulations that affect your behavior as a patient.
7. Personal privacy and to expect that documents and communication concerning your care will be treated as confidential.
8. Confidentiality of your clinical records and to review or obtain a copy of your medical record within a reasonable timeframe.
9. Access, request amendment to, and obtain information on disclosures of your health information, in accordance with law and regulation.
10. Have family members, representatives and your physician notified promptly of the admission to the facility upon patient's request.
11. Know the name of the physician and/or medical group who has primary responsibility for coordinating your care and the names of other physicians or non-physicians involved in your care.
12. Access religious and other spiritual services.
13. Receive treatment in a safe environment free from neglect, exploitation and abuse, and to be assisted in accessing Protective Services and/or Advocacy Services, as appropriate.
14. Receive personalized treatment through an individualized treatment plan, and for you and/or your personal representative to participate in the development and implementation of your treatment plan. This organization values each patient's cultural, racial, and religious customs as part of their treatment plan.
15. Appropriate assessment and management of pain.
16. Be free from restraints and seclusion of any form that are not necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
17. Patients have the right to information regarding the Organization's policy on resuscitation, as well as the policy regarding withholding or withdrawal of life sustaining treatment.
18. Complete, review and revise an Advance Directive. You have the right to receive assistance in completing an Advance Directive. Your access to care will not be affected if you do or do not have an Advance Directive. Your wishes at the end of life will still be obtained and respected.
19. Know the extent to which the organization is able, unable or unwilling to honor your advance directive.
20. Have your family involved in care, treatment and services decisions to the extent you allow or your surrogate decision-maker, in accordance with law and regulation.
21. Have a designated surrogate decision-maker, someone who is able to make decisions about your care in the event that you are unable to do so. When a surrogate decision-maker is responsible for making care, treatment and service decisions, the organization will respect the surrogate decision-makers right to refuse care, treatment and services on your behalf, in accordance with law and regulation.
22. Have a family member, friend, or other individual be present with you for emotional support during the course of your stay, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. This individual may or may not be your surrogate

decision-maker or legally authorized representative.

23. Participate in ethical decisions regarding your care, including decisions relative to care at the end of life. The dying patient has the right to care that optimizes comfort as well as dignity.
24. The right to receive information including risks, benefits and reasonable alternatives in a language or method of communication that you understand pertaining to your health status, current diagnosis, treatment plan and prognoses in order for you to give informed consent or to refuse consent.
25. Refuse treatment to the extent allowed by law, and be informed of the significant medical consequences of this action.
26. Refuse recording or filming made for purposes other than the identification, diagnosis or treatment of the patient.
27. Wear personal clothing and religious or other symbolic items, provided such items do not interfere with diagnostic procedures or treatment.
28. Receive information from your physician about the outcomes of your care, including unanticipated outcomes and prospects for recovery, in terms you can understand.
29. Request a consult with other physician(s) and/or independent specialist(s), at your own expense.
30. Expect that the organization will make a reasonable response to your request for services. The organization will provide evaluation, service and/or referral(s) as indicated by medical necessity. Only after you have received information about the need for transfer, and it is medically permissible, will you be transferred to another facility. The receiving facility must have agreed to accept your transfer.
31. Receive continuity of care and notification in advance of any health care needs following discharge, including outpatient care options.
32. Timely notification if your insurance will not pay your bill and information about the process to follow if you disagree with your insurance company's determination.
33. Receive an itemized explanation of your bill.
34. Present complaints and expect that corrective action will be taken, when indicated. The right to voice complaints about care without being subject to coercion/intimidation, discrimination, retaliation or compromised access to future care.
35. To expect prompt response to and resolution of a grievance, including a written notice of the organization's decision, the name of a contact person, steps taken to investigate the grievance, the results of the grievance process and the date of completion. As appropriate to the nature of the grievance, the following individuals may assist you in initiating the grievance process: the physician, staff nurse or his/her supervisor, the patient representative, hospital administrator or a social worker.
36. Communicate your problems, concerns or complaints with the organization to the Kentucky Cabinet for Health and Family Services by contacting the Office of the Inspector General, Division of Licensing and Regulation. Per geographic areas of Market facilities, use the following contact information:
    a. Central Office (State Office) 275 E. Main St., 5E-A Frankfort, KY 40621
       Phone: 502-564-7963 Fax: 502-564-6546
    b. Flaget - L & N Building, 10-W 908 W. Broadway Louisville, KY 40203
       Phone: 502-595-4958 Fax: 502-595-4540
    c. London & Berea- 116 Commerce Ave. London, KY 40744
       Phone: 606-330-2030 Fax: 606-330-2054
    d. Lexington, SJJ & Mount Sterling - 1055 Wellington Way, Suite 125 Lexington, KY 40513
       Phone: 859-246-2301 Fax: 859-246-2307
37. Be advised if the organization intends to engage in or perform research, investigation, clinical trials or educational activities which affect your care or treatment so that you may decide if you want to participate or refuse to participate in such activities. You have the right to decline to participate in clinical studies, research or experiments. Refusal to participate will not affect your access to care or

treatment or affect benefits to which you are otherwise entitled.

38. Patients who are dying have the right to receive care that will provide them with comfort and dignity. The dying patient has the right to receive such care, which shall include:
    - Treatment of primary and secondary symptoms responsive to treatment, as desired by the patient or surrogate decision maker
    - Effective management of pain
    - Acknowledgment of the psychosocial and spiritual concerns of the dying patient and his/her family
    - Acknowledgment of the expression of grief by the dying patient and his/her family
39. Receive the visitors designated, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time; the organization will:
    - Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability;
    - Ensure that all visitors chosen by the patient enjoy "full and equal" visitation privileges, consistent with the patient's wishes.

Patient Responsibilities:

The care that you receive as a patient depends partially on your participation and actions with your physicians and organization staff. Therefore, in addition to your rights as a patient, you have the following responsibilities:

1. Provide the facility with accurate and complete information about your present complaints, past illnesses, hospitalizations, medications and any other pertinent matters about your health.
2. Report any safety issues related to your care or about the physical environment.
3. Ask questions when you do not understand what you have been told about your care, your condition, or what you are expected to do regarding your care.
4. Report any unexpected changes in your condition to your physician(s) or other health care providers.
5. Follow any treatment plan recommended by your physician, including the instructions of nurses and other health care professionals as they carry out your physician's orders.
6. Assume responsibility for your actions if you refuse treatment or do not follow the prescribed treatment.
7. Keep appointments given to you at discharge.
8. Treat organization staff, physicians and other care providers with respect and courtesy, avoiding use of profanity and inappropriate or threatening conduct.
9. Inform and provide us with advance directives and the appointment of a surrogate in your behalf.
10. Meet your financial commitments to the organization

Reference: PolicyStat: Patient Rights and Patient Responsibilities

Patient Identification

Before providing any treatment or service, staff must reliably identify the individual as the person for whom the treatment or service is intended through the use of **two patient identifiers** which must be directly associated with the individual, and the same two patient identifiers must also be directly associated with the medication, blood product, specimen container, or other treatments, services, and procedures.

Guidelines

1. The term "identifier" refers to the ways the care recipient is identified. Two identifiers may be in the

same location, such as contained in the information on an identification (ID) bracelet. The hospital will create and place an ID bracelet on each patient.

2. Based on staff assessment of patient condition and circumstances, whenever possible, staff will seek active involvement of the patient or other person familiar with the patient when identifying the patient. Leading questions shall not be asked. Rather, the staff member should actively involve the patient or responsible caregiver by asking them to state their name.
3. Use at least **two patient identifiers** when providing care, treatment and services, which are:
   - The **patient's name**
   - The **patient's medical record number**, and/or
   - The **patient's date of birth**
4. Staff will **not** use the patient's room number or their physical location as a patient identifier.
5. In areas that use ID bracelets, it is **not** acceptable to lay the ID bracelet on the bedside table or tape it to the bed. If placing an ID bracelet around a patient extremity is medically contraindicated, reasonably prudent alternative methods should be utilized. For any circumstance that does not allow an armband to be placed on a patient's body, heavy documentation should be included in the patient medical record, and the MD should be notified. The armband should then be placed in an area where it is on or near the patient at all times.
6. Injured patients who arrive at the hospital through the Emergency Department ("ED"), and who are unaccompanied by family, or who are unresponsive and/or unable to communicate with others will be assigned a temporary "name" (e.g. John Doe) and an ED number or a medical record number. These identifiers may be used to identify the patient and match the individual to specimen labels, blood products, medications, and other treatments and services ordered for the patient.
7. Staff may ask family members, guardians, a spouse, or other person familiar with the patient to identify an individual who is injured, unresponsive, or unable to communicate.
8. If an unresponsive individual is brought to the hospital (on presentation) by a law enforcement officer or emergency medical personnel, and there is no identification with the patient, staff should ask the law enforcement officer or emergency personnel accompanying the patient to positively identify the patient. If law enforcement or emergency personnel cannot make a positive ID, then refer to procedure outlined in line item 6.
9. In all applicable areas, two patient identifiers will be verified prior to placing an ID bracelet on a patient to confirm the reliability of the information on the ID bracelet, and prior to the administration of any medication, blood product, treatment or service.
10. In circumstances where the ID bracelet becomes lost, or damaged, or illegible, nursing staff will print or contact admissions for a new ID bracelet and place it on the patient as soon as possible. Damaged/illegible identification bracelets contain protected health information, and therefore must be shredded/destroyed in accordance with policy.
11. If it is discovered that the patient's ID bracelet contains errors or inaccurate information, nursing staff will contact Admissions for a new ID bracelet. .
12. For patients that arrive in the hospital and request to be identified with an alias name, all paperwork, ID bracelets, and labels will use the alias name and should be used in the patient identification process.

Reference: Policy Stat: Patient Identification

Quality, Safety and Performance Improvement

Purpose:

The organization strives to deliver optimal care which is patient-centered, safe and evidence based while doing so in an environment of perpetual improvement. Quality is described as doing the right thing, for

the right patient, at the right time, in the right setting, by the right provider and using the right resources. To meet this goal, our employees will participate in ongoing and systematic quality improvement utilizing an integrated, inter-disciplinary approach. Our quality improvement efforts will be directed towards care delivery processes, systems and structures that promote patient outcomes and support operational excellence.

Plan / Policy Statement

The Quality, Safety and Performance Improvement Plan provides an organizing framework to ensure that the organization's Board of Directors, administrative leadership and medical, nursing and ancillary staff continuously improve existing systems and processes for delivery of safe, efficient, effective and optimal patient care services. This plan supports the organization's board goals and responsibilities for the quality and safety of care, treatment and services.

Goals and Objectives

The primary objectives of the Quality, Safety and Performance Improvement Plan are to consistently measure, monitor, evaluate and improve the delivery, effectiveness, efficiency and outcomes of clinical care, treatment and service.

A. To define, measure, analyze, improve and sustain an effective culture of quality and safety.
B. To define and implement an ongoing, proactive quality and safety program by monitoring, responding to and improving identified systems and processes impacting performance and accountability.
C. To include all departments and services, including those services furnished under contract or arrangement, and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.
D. To provide education and resources to enhance knowledge and skills related to quality improvement, safety, risk reduction and regulatory requirements.

Reference: Policy Stat: Quality, Safety and Performance Improvement Plan 2021

Safety First

What is SafetyFirst?

In any health care organization, the care that is intended to be given is a direct outcome of the actions and interactions of individuals working within a system. The best outcomes are the result of systems designed to shape and guide human behavior. SafetyFirst methods are based on reliability science – an understanding of human performance in complex systems and the application of this understanding in organizational design. SafetyFirst is a guide for Market-Based Organizations (MBOs) towards comprehensive safety and reliability performance improvement.

Why is SafetyFirst Important?

Safety events are the leading cause of injury and harm to our patients. While we know that no one intends to hurt patients, an outside study of our hospitals and care sites revealed that a serious safety event occurs on average about every eight days. That's why CHI is introducing SafetyFirst, a major initiative to change our organization into one that always puts patient, employee and medical staff safety first.

- Thinking SafetyFirst! It's common knowledge that using a cell phone while driving is unsafe. Yet, we sometimes perform the equivalent of this unsafe behavior at work, multi-tasking to save time. Research shows that it's safer, and usually more effective, to perform one task at a time, while giving that task our full attention.

- Committing to patient, personal and team safety. Pledging to make safety a daily habit.
- Finding and helping fix safety problems and unsafe habits. Timely reporting unsafe situations, workflows or equipment. As more and more of the staff are trained in safety and error prevention techniques, the number of reported safety events will increase. Increased reporting is good. It's a sign that we are improving!

Safety Coaches

Safety Coaches are peer team members (staff and physicians) who provide real-time feedback about practice and compliance with safety behaviors and error prevention tools and who help to prevent events of harm. As a part of their day-to-day work, coaches provide feedback to their colleagues – coaching to reinforce when a colleague does the right thing and coaching to correct when a colleague's practice does not meet expectations, we are making progress!

Safety Huddle

Safety Huddles are a brief time daily to meet with staff & leaders to discuss safety. During this time leaders can share information regarding what is going on within the organization/facility from a safety perspective as well as discuss employees' personal safety concerns. Items of concern related to safety should be identified and action owners assigned to address concerns.

SafetyFirst Expectations and Techniques

Reference: PolicyStat: Quality, Safety and Performance Improvement Plan 2021

Service Excellence

Service excellence is a way of working, a way of interacting and a way of thinking about our jobs as we work together with others. Everything you do from a service aspect impacts our hospital's success.

Although there are many things outside of our control in healthcare, we do have total control over the way we treat our patients and guests. It's about creating positive experiences for customers from the word go, through an endless string of needs understood and promises kept.

Customers who access our services deserve to be treated just like we and our families want to be treated. Important customer needs are feeling welcome, being informed, knowing what will happen next and being treated courteously and respectfully. Customers today demand great service. After all, isn't that what we all want too?

We need to appreciate how our customers perceive us as healthcare providers. Our customers expect us to provide expert care. They expect us to have good technology. They expect quality care. *But what they hope for is compassionate care and service.*

Steps to Create Positive Experiences:

- **Welcome Warmly**
    - **For everyone**
        - Dress professionally according to department/Unit expectations
        - Knock before entering a room or office
        - Introduce yourself, your role, and your purpose (AIDET)
        - When visitors or others approach, make eye contact, smile and greet, stop all personal conversations- give everyone your undivided attention
        - Monitor your workspace and the building's physical environment
            - Make sure it is clean and uncluttered
            - No handwritten signs- be cautious and considerate with the wording on computer generated signs
            - No food, drink, or chewing gum in patient areas
        - Take initiative to acknowledge and greet visitors/colleagues in public areas as well as your work areas
    - **For patient and family interactions**
        - Use patient and family member names as appropriate; ask the patient how they would like to be addressed
        - When interacting with patient and family, maximize your time with them
            - Sit at their level when interacting
            - Avoid answering your phone or pager
        - Introduce the next shift's caregiver
        - Each time you enter a room, acknowledge all individuals at the bedside
        - Share expectations and time frames
        - Take initiative
        - Orient patient and family to the department/unit/hospital using the available resources and individualize as necessary
            - Make appropriate maps available
            - Utilize white boards in patient rooms-individualize and update
- **Welcoming phone standards**
    - **For everyone**
        - When answering the phone, identify yourself, your role, your department/unit, etc.
        - Encourage consistency in phone answering- script your departments/unit's greeting
        - Do not transfer caller to voicemail without permission

        - When transferring a call, announce caller and reason for transfer
- **Take initiative**
    - **For everyone**
        - Anticipate needs of colleagues/patients/families. Act before being asked
        - Demonstrate respect and concern by actively listening
        - Explain next steps to colleagues/patients/families
        - Look for those who appear lost. Offer assistance with directions; take them there
        - If you cannot assist someone- find someone who can
            - Never say "I am new here" or "I don't know where that is"
        - Perform as a team
            - Support each other and other departments/units, "We're taking you to CT scan now. Chris will take really good care of you"
            - If a request is made, follow through
    - **For patient and family interactions**
        - Update families during procedure with status or delays
        - Explain next steps to patients and families
        - When interacting with patient and family, maximize your time with them
            - Sit at their level when interacting
            - Avoid answering your phone or pager
        - Respect privacy of patient and staff. Articulate steps take to protect privacy (ex: pull curtain while discussing personal/sensitive information.) Monitor the level of your voice as well.
        - If a patient or family member appears fearful or withdrawn, assess and intervene as appropriate (compassionate conversation or touch, utilize appropriate resource- chaplain, etc.)
        - Avoid unprofessional comments or excuses that erode the confidence of our patients and families
            - "We're short staffed today"
            - "I'm just so busy today"
            - "I'm new here"
        - Always listen and approach colleagues/patients/families with a positive attitude
- **"Is there anything else I can do for you?"**
    - **For everyone**
        - End each conversation with this statement in both face-to-face and phone conversations
        - If the answer is "no", thank them again
        - If the answer is "yes", listen to the request and follow through with the appropriate information and contacts for questions, information , or concerns

Reference: PolicyStat: Patient Care Bundle - Guidelines for the Patient Experience

Abuse and Neglect

DEFINITION(S):

- **ADULT** - a person eighteen (18) years of age or older or a married person without regard to age, who because of mental or physical dysfunction, or who is the victim of abuse or neglect inflicted by a spouse, is unable to manage his/her own resources, carry out the activities of daily living, or protect self from neglect, hazardous or abusive situations without assistance from others and may be in need of protective services.
- **ABUSE** - the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.
- **NEGLECT** – a situation in which an adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his health or welfare, including self-neglect. Also includes "dependency" – the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult; for example, caregiver becomes ill or disabled.
- **EXPLOITATION** - the improper use of an adult or an adult's resources by a caretaker or other person for the profit or advantage of the caretaker or other person.
- **Types of abuse may include**: neglect, verbal, physical, seclusion (unreasonable confinement), mental, sexual and/or misappropriation of property (improper use of a person's assets or the use of withholding a person's resources)
- **Verbal Abuse:** Is defined as the use of oral, written or gestured language that includes disparaging and derogatory terms (regardless of their age) ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a person, degrading remarks, and name-calling.
- **Sexual Abuse:** Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Rape has occurred when a person has been forced to have sex against their will.
- **Physical Abuse:** Involves hitting, slapping, kicking, shoving, choking, biting, pinching and assault with an object or weapon. It also includes controlling behavior through corporal punishment.
- **Mental Abuse**: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.
- **Caregiver Neglect:** deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult.
- **Misappropriation of Property:** Means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money without the persons consent.
- **Involuntary Seclusion:** Is defined as the separation of a person(s) from other person(s) or from his / her room or confinement to her / his room (* with or without roommates) against the person's will, or the will of the residents legal representative. Emergency or short term monitored separation from other persons will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until a professional staff can develop a plan of care to meet the person's needs.
- **Self-Neglect:** A situation in which an adult who is physically or mentally dysfunctional is unable to provide or obtain for himself / herself that which is necessary to maintain health or welfare.
- **Professionals**: A physician, osteopathic physician, coroner, medical examiner, medical resident, medical intern, chiropractor, nurse, dentist, optometrist, emergency medical technician, paramedic, licensed mental health professional, therapist, cabinet employee, child-care professional, teacher, school personnel, ordained minister or the denominational equivalent, victim advocate or an organization or agency employing any of these professionals. [KRS 209A.020(5)]
- **Victim**: an individual who is or has been abused by a spouse or former spouse or an intimate partner

who is a member of an unmarried couple or is a member of a dating relationship. [KRS 209A.020(6)]

- **Domestic violence and abuse**: physical injury, serious physical injury, stalking, sexual abuse, assault or the infliction of imminent physical injury, serious physical injury, sexual abuse or assault between family members or members of an unmarried couple. [KRS 403.720(1)]
- **Dating violence and abuse**: physical injury, serious physical injury, stalking, sexual abuse, assault or the infliction of imminent physical injury, serious physical injury, sexual abuse or assault between persons who are or have been in a dating relationship. [KRS 456.010(2)]

Reporting Alleged Adult Abuse

When any employee or physician who has reasonable suspicion that an adult patient – whether an inpatient, outpatient, discharged or deceased – has suffered abuse, neglect or exploitation must ensure that a report of the suspected abuse is made to the Cabinet for Health and Family Services (CHFS) Department for Community Based Services (DCBS) in accordance with Kentucky law. **Exception: SEE DOMESTIC/DATING ABUSE/VIOLENCE later in this P&P.**

The following list represents signs and symptoms that MAY indicate abuse, neglect, exploitation, or dependence:

A. Reports of neighbors, EMS, etc.
B. Poor hygiene
C. Multiple and/or suspicious lesions or fractures in various stages of healing
D. Injuries inconsistent with patient's or caregivers descriptions of incident
E. History of family violence
F. Inappropriate partner/caretaker reaction to injury and emergency department care
G. Partner reluctant to allow patient to speak for him/herself
H. Forced by circumstances to care for patient who may be unwanted

Abuse effects all ages, genders, nationalities, and socioeconomic groups, altering normal daily functioning and sometimes advancing to life-threatening situations. The health care professional(s) obtaining the history and assessment should consider the following:

- The victim's reluctance to report abuse.
- The abuser may be present at the time of assessment.
- The interview should be conducted in a private, secure setting.
- The victim may not recognize that abuse is unacceptable and that the abuser is committing a crime.
- The victim often may accept responsibility for the abuse.
- Assessments should be completed without contributing to the victim's risk.

Reporting Alleged Adult Abuse by Persons Who are NOT employees and occurred prior to admission or when not under the direct care of the facility:

Any employee or physician who **knows** or **reasonably suspects** that the patient has been abused by a non-employee must:

A. Notify Adult Protective Services (APS) of the alleged abuse. The Abuse Hot line Number is: 1-877-597-2331. The report to APS must contain the following information, if known:
    1. Name, address, and age of the adult victim
    2. Name and address of any person responsible for his/her care

3. Nature and extent of the abuse, neglect, dependence or exploitation including any evidence of previous abuse, neglect, or exploitation
4. Identity of the perpetrator, if known
5. Identity of the complainant, if possible
6. Any other information that the reporter believes might be helpful in establishing the cause of abuse, neglect or exploitation. The Adult/Child Protective Services Reporting form may be used.

B. Note the report in the medical record. Document in the patient's record in a clear and concise manner the reasons for suspected abuse. Documentation will include any referrals and/or consultations relating to the patient and suspected abuse. Documentation in the medical record should include all concerns relating to the suspected abuse or neglect including content of any conferences held in relation to the suspected abuse or neglect.
C. Additional psychiatric evaluation may be referred to Our Lady of Peace (OLOP) Access Center/Mobile Assessment team by calling 502-451-3333 or 1-800-451-3637. This is a 24/7 help line.
D. The Manager/Charge Person or Designee will work with APS to facilitate the investigation.

Flaget Memorial Specific Guidelines

Any employee or physician who **knows** or **reasonably suspects** that the patient has been abused by a non-employee must:

- If indicators of abuse / neglect are identified, complete the "Abuse / Neglect Reporting" form.
- Report the suspected abuse case to Community Based Services if the alleged perpetrator lives in the household or is a family member. Other cases should be reported to the Police Department (502) 348- 3211. Community Based Services Referral line—Monday-Friday 8:00a.m.-4:30p.m. Call 888-403-5090. Abuse hotline—800-752-6200 call after 4:30pm and on weekends.
- Provide appropriate education/community referrals to the patient / family, i.e., Rape Crisis, Communicare, Spouse Abuse Services, or Victim Advocate.
- Record the assessment findings and interventions in the medical record and notify the supervisor or hospital social worker.
- Send a copy of the form to Health Information Management and fax a copy to Community Based Services.
- Health Information Management will forward a copy of the abuse reporting form to the social worker.
- Upon receipt of the "suspected abuse" form, the hospital social worker will have notation made in the computer system for the purpose of tracking.
- The hospital social worker is available to assist with assessments, intervention and / or reporting.

Reporting Allegations of Adult Abuse within a facility or under a facility's direct care by employees or non-employees:

Any employee or physician who knows or reasonably suspects that the patient has been abused by an employee, medical staff member or other patient must:

A. Immediately notify their manager, who will contact Administration (or Administrator on Call after hours), who will contact the Risk Manager on call.
B. For investigations which can be completed expeditiously, remove the employee alleged of abuse from direct patient care until investigation has been completed. For other investigations, place the employee on administrative leave until the investigation has been completed.
C. The Manager of the involved employee shall communicate the employee's work status change to

the House Manager either in person or by direct telephone contact. If the House Manager places an employee(s) on administrative leave in the absence of the employee's Manager, then the House Manager shall communicate the leave to the employee's Manager and the other House Managers. **All communications of the employee/provider leave shall take place in person or by direct telephone contact with assistance from HR, whenever possible. Employees/providers shall be informed not to return to work at any facility until instructed by designated leader.**

D. The House Manager or designee should alert the appropriate people/departments of all work status changes to ensure that all employees who are placed on work status change are not allowed to work.
E. The employee's manager shall communicate in person or by direct telephone contact to the House Manager the final determination of the employee's work status upon completing his or her investigation. Appropriate departments will be notified.
F. The Manager/House Manager will call Administration or the Administrator on Call (AOC) (after hours). The Administrator on Call will contact the Risk Manager. To promote coordinated and consistent communications, **only the AOC, Risk/Quality Manager, or designee will call Adult Protective Services.**
G. The Risk/Quality Manager will advise the person reporting the abuse that the abuse has been called in.
H. In addition, there will be a consultative discussion between Administration or AOC and the Risk/Quality Manager resulting in a decision of whether to call the OIG. **Only the AOC, Risk/Quality Manager or designee will contact the OIG.**
I. All written or verbal reports of abuse will be handled as grievances per CMS guidelines.

Note: This policy reflects current guidance from the Kentucky OIG. The Directors of Quality will take responsibility for verifying the process for reporting to the OIG whenever there is a change of leadership in the local or state cabinet.

Reference: PolicyStat: Abuse Reporting (Adult) Central East Market

ADULT RAPE OR SEXUAL ABUSE:

WHO: 18 years or older
WHAT: Allegation of rape or sexual abuse on site or recent past
WHAT TO DO:

- Follow steps above for abuse, neglect or exploitation
- Notify Manager or Charge Person who will notify police at (502)574-7111 (Flaget Memorial) OR (859)258-3600 (Lexington) after consulting with administrator
- Notify family member/guardian

PROTOCOL FOR EXAMS FOLLOWING SEXUAL CONTACT:

Any allegation of sexual contact involving penetration or when penetration cannot be excluded based on the available facts and evidence, regardless of whether it was consensual, should be referred by physician order for a legal sexual assault exam at an acute care facility.

Kentucky hospitals and other sexual assault examination facilities must provide SAFE Exams to victims who request such exams, regardless of law enforcement reporting. The victim/patient must be given a choice of whether or not law enforcement will be notified. If the victim chooses to have a SAFE Exam but not report to law enforcement, samples must be stored for at least 90 days in a manner that limits access and in a secure location to allow the victims consider filing a delayed report. There must be proper

storage of samples collected in non-reported cases.

Domestic Violence & Abuse/Dating Violence & Abuse

NOTE: Nothing in House Bill 309 nor this policy and procedure changes anything about the mandatory reporting of child dependency/abuse/neglect or vulnerable adult abuse/neglect/exploitation.

A. Professionals shall **not** report suspected domestic violence and abuse or dating violence and abuse to the Cabinet for Health and Human Services.
B. Professionals must report suspected domestic violence and abuse or dating violence and abuse domestic to Law Enforcement **only after obtaining permission** from the victim.
C. Professionals with a reasonable cause to believe that a victim with whom they have had a professional interaction has experienced domestic violence and abuse or dating violence and abuse must provide the victim with educational materials related to:
    - domestic violence and abuse or dating violence and abuse
    - how to access regional domestic violence programs or rape crisis centers
    - how to access protective orders.
        - Approved educational materials/information is available for download on the KCADV website: www.kcadv.org.
D. Notify the patient of intent to make APS referral unless it contradicts with professional judgment of person making report. Ask patient's permission to contact Spouse Abuse Center for counseling and assisting with discharge resources if it is determined that the patient is a victim of spouse abuse (to make domestic violence report, follow the previous procedure.)
E. Documentation in the patient's medical record will outline the provision of these materials and the agreement or refusal to report to Law Enforcement.
F. If a professional believes the death of a victim with whom he/she has had a professional interaction is related to domestic violence and abuse or dating violence and abuse, the professional must report this to Law Enforcement.

Note:

- Anyone acting upon reasonable cause in compliance with the provisions of applicable state law shall have immunity from civil/criminal liability. Knowing or wanton violation of the law is a class B felony.
- If a patient being treated for substance abuse, you may not divulge information about his/her substance abuse or treatment to the agency whom you report.

Reference: PolicyStat: Management of Alleged/Suspected Sexual Assault Victims

AIDET

AIDET is a framework to communicate with patients and their families as well as with each other. It is a simple acronym that represents a very powerful way to communicate with people who are often nervous, anxious and feeling vulnerable. It can also be used as we communicate with other staff and colleagues, especially when we are providing an internal service.

Always use the components of AIDET during your interactions with patients, family, and coworkers.

A – ACKNOWLEDGE

Greet people with a smile and use their names if you know them. Attitude is everything. Create a lasting impression.

- "Good morning/afternoon, Mr. Smith. Welcome to CHI Saint Joseph Health. We want to make your

visit as convenient as possible. Would you please take a moment to confirm that we have your most current information?"

I – INTRODUCE

Introduce yourself to others politely. Tell them who you are and how you are going to help them. Escort people where they need to go rather than pointing or giving directions.

- "Mr. White, Dr. Williams would like you to have an X-ray in our radiology department. We have an excellent team of radiology technicians who use state-of-the-art equipment. I'm confident you will have a great experience."

D – DURATION

Keep in touch to ease waiting times. Let others know if there is a delay and how long it will be. "Dr. Heart had to attend an emergency. He was concerned about you and wanted you to know that it may be 30 minutes before he can see you. Are you able to wait or would you like me to schedule an appointment for tomorrow?"

E – EXPLANATION

Advise others what you are doing, how procedures work and who to contact if they need assistance. Communicate any steps they may need to take. Make time to help.

- "The test takes about 30 minutes. The first step is to drink this solution and then we'll have you wait 20 minutes before we take a blood sample. Would you like to read while you wait?"

T – THANK YOU

- "Thank you for choosing CHI Saint Joseph Health. It has been a privilege to care for you."
- Thank you for your call. Is there anything else I can do for you? I have the time."

Reference: PolicyStat: Patient Care Bundle - Guidelines for the Patient Experience

Bedside Shift Report

Preparation for bedside shift report:

1. Upon admission to the unit, the nurse should discuss with the patient and family the purpose of bedside shift report. Partnering with patient and families during shift report allows for open dialogue about various health care issues such as medications, diagnostic tests, etc.
    a. Reinforce that this is a time for patients and families to ask questions about their medical care.
    b. Ask if the patient is comfortable having family/visitors remain in the room during report.
        i. With input of the patient, determine sensitive topics and respect patient's privacy.
        ii. Information such as new diagnoses or test results the physician has not yet shared with the patient should not be discussed at the bedside.
        iii. Any other sensitive information should be shared with the on-coming nurse prior to entering the room.

    c. To respect patient confidentiality, refrain from discussing patient information in public areas.
2. What to do if the patient is off the unit or asleep:
    a. Patient preferences for bedside shift report should be obtained on admission and prior to the end of each shift.
    b. If patient is sleeping, the oncoming nurse should observe the patient and quietly check equipment, IV pump, etc.
    c. If the patient is off the unit, the off-going nurse should give a verbal report to the on-coming nurse along with the estimated time of the patient's return to the unit.
    d. Later, the oncoming nurse should review the bedside shift report information with the patient and family if they have missed it.
3. Use the final hourly rounding time to remind the patient and family of upcoming bedside shift report.
    a. To minimize interruptions during bedside shift report, address pain or other medication needs, toileting and any other patient requests at this time.
    b. Ask the patient who they would like to stay and participate in bedside shift report.

Nursing Bedside Shift Report Process:

NOTE: If English is not the patient's preferred language, always use an interpreter or Culturalink phone for communication during bedside shift report.

1. Begin bedside shift report by having the off-going nurse introduce and manage up the oncoming nurse, using AIDET as appropriate.
2. Update patient's communication board with new names and phone numbers for the oncoming shift. Update other whiteboard content (i.e. patient goals and pain management) as needed.
3. Identify the patient using two patient identifiers.
    a. Verify accuracy and presence of patient identification armband.
    b. Replace armband immediately if missing.
4. Explain that you are ready to begin bedside report and ask the patient if they want anyone to step out of the room for privacy.
    a. If there are concerns about the patient being able to answer this honestly with visitors in the room, be sure to address this with the patient ahead of time.
5. Ensure patient is comfortable before proceeding with report.
6. Be sure to be patient-inclusive in your language and communicate clearly using language that the patient can understand.
7. Using the electronic medical record, review the patient's history pertinent to this hospitalization, reason for admission, treatment and procedures, plan of care, discharge planning and any other pertinent patient care information.
8. Encourage the patient and family to ask questions during bedside shift report.
9. Perform a brief, safety-focused assessment:
    a. General appearance
    b. Verify IV medications/infusion rates and IV sites
    c. Wounds/incisions/drains
    d. Review medications
    e. Alarm settings
    f. Call light/telephone in reach
    g. Side rails up and falls precautions in place as indicated
10. Provide patient and family with clarification of information and answer questions as requested.
11. Close by asking, "Is there anything else I can do for you?"

12. Before leaving the room, the off-going nurse should thank the patient and family for allowing you to care for them.
13. The on-coming nurse should also ensure that pertinent patient care information is communicated with other members of the health care team (such as nursing assistants or SWANs) after receiving bedside shift report.

Nursing Assistant Bedside Shift Report Process:

1. Begin bedside shift report by having the off-going nursing assistant introduce the oncoming assistant using AIDET as appropriate followed by transferring handoff-care patient information.
2. Update patient's communication board with new names and phone numbers for the oncoming shift. Update other whiteboard content as needed.
3. Identify the patient using two patient identifiers.
    a. Verify accuracy and presence of patient identification armband.
    b. Replace armband immediately if missing.
4. Conduct a brief verbal report at the patient's bedside using words that the patient can understand. Be sure to address:
    a. Patient diet
    b. Activity status
    c. Any drains, tubes, ostomies, wounds, etc.
    d. Fall risk level and what precautions are in place.
5. Review tasks that need to be done, such as:
    a. Baths
    b. Urine or other specimens that need collected
6. Conduct a focused safety assessment:
    a. Visually assess the room for any physical safety concerns
    b. Fall risk precautions in place and bed exiting alarm activated as needed
    c. Turn or reposition the patient together if needed
    d. Ensure side rails up and call light/phone in reach
7. Close by asking, "Is there anything else I can do for you?"
8. Before leaving the room, the off-going assistant should thank the patient and family for allowing you to care for them.

Example of Bedside Shift Report using SBART

S **Situation**	**Off-going Nurse** "Hello (name). We are here to have change of shift report. I'm going home, and (name) will be your nurse today/tonight. Please listen, and feel free to add anything I may miss". **Oncoming RN** Introduce self. Update white board. Check armband while asking patient to state his/her name and date of birth.
B **Background**	**Off-going RN** Involve patient in change of shift report. Use words the patient and family can understand, give a brief pertinent past medical history, explain any co-morbidities or events that led up to this hospitalization or that are having an effect on the patient's condition at this time. Admitted for…..Pertinent history…..Pertinent labs/test/procedure……Current therapy (meds, tx, monitoring, dressings, drains, tubes, O2), IV lines/sites, Current Vitals, Pain (rating, drug, last dose, follow-up assessment, include patient in discussion)

	Special Needs (precautions, isolations, fall risk, fluid restrictions), Consults (physician, social work, case management, wound care, dialysis), Teaching Needs (diabetic, wound care) Ask the patient. Discharge Plan and Needs Ask the patient. **Oncoming Nurse** Ask the patient if they have any questions
A **Assessment**	**Off-going RN** Inform the oncoming RN of what you assessed and/or noted during your evaluation. (Review of Systems) Include any information or tasks that you completed. Mention what the oncoming nurse will need to complete or follow up on. Be specific about what is going on with the patient now. **Oncoming Nurse** Review chart/ check documentation. Conduct a quick physical assessment and check all IV sites and pumps for accuracy. Assess patient's pain using a pain scale.
R **Recommendation**	**Off-going RN** Review the ordered nursing and medical plan of care with the oncoming RN. (tests, tx, meds, IV sites, drips) Include any relevant meds that have been ordered and any ancillary or support services that are working with the patient such as respiratory, radiology, social worker, etc.) Ask the patient: "Do you have any questions? Is there anything else RN needs to know about caring for you today?" **Oncoming Nurse** Validate orders/ plan of care Ask any questions of off-going nurse
T **Thank You**	Thank the patient **Off-going RN and Oncoming RN** Prior to leaving the room ask the patient, ask the patient the following: Is your PAIN under control? Are you comfortable (position)? Do you need to go to the bathroom? Do you understand your plan of care? Do you know what you are waiting for and what will happen next? Do they have any concerns we can address? **Use Closing Key Words** **Off-going RN** "Thanks for allowing me to care for you today/tonight and Good-bye"- to the patient **Oncoming RN** I will be back to check on you …..

Reference: PolicyStat: Patient Care Bundle - Guidelines for the Patient Experience

Blood Administration

Pre-transfusion Preparation

Ordering of Blood Products:

1. A physician's order for transfusion of blood products is required and must contain:
    - The type of product (packed red blood cells, platelets, FFP, cryoprecipitate, etc.)
    - The amount to be administered, often described as units or packs.
    - Transfusion priority: Routine, Stat, or Timed. Blood products should not normally be requested as Timed unless there are specific clinical indications to do so.

- Product Order/Transfusion Reason: Select from the list provided or choose Other and specify in the Order Comments
- Number of Units Needed
- Date of Transfusion/Surgery
- Complete all other order entry fields as necessary

Patient Consent and Education

Patient consent must be obtained upon initial order of blood or blood product transfusion.

- This consent form is to be used with the initial order of a blood or blood product transfusion. A new consent form is to be completed and signed for the administration of subsequent transfusions only if a different individual will be authorizing the subsequent transfusions.
- The consent for possible transfusion of blood and blood products intra-operatively is included in the surgical consent process. Therefore, completion of the Blood Administration Consent form is not required to be signed with the surgical consent form. However, any blood administered pre or post operatively requires a second, separate, blood administration consent.

Explain to the patient/family the process of blood product transfusion and what his/her role is in the procedure. Instruct the patient in what signs/symptoms to report to the nurse. Specifically: shortness of breath, rash, itch, pain, chills, flushing, hot flashes, and/or any other discomfort. Provide patient education materials as appropriate.

Pre-Transfusion Verification

When the blood product is issued from the Blood Bank it will have a Compatibility Tag physically attached to the product with a Secur-A-Tach fastener. A printed Product Chart Copy (MR-29) will also be attached by rubber band.

1. The Compatibility Tag attached the blood product must not be removed from the product for any reason.
2. The Product Chart Copy is intended to be used in the initial verification process. If Cerner is operational and the blood administration is electronically documented, the Product Chart Copy should be discarded.
3. During Cerner downtime, the Product Chart Copy may be used as the Blood Administration Record (BAR). If used as the BAR, the Product Chart Copy is to be placed in the patient's chart in the Lab section when the transfusion is completed.
    a. **Note:** Any blood product administrations initiated during Cerner downtime are considered pertinent information that must be re-documented in the iView Blood Administration Initiation band once downtime is complete.

All required pre-transfusion preparation and verification steps must be completed and acceptable vital signs obtained prior to initiation of blood product transfusion

1. Two nurses (an RN and RN/LPN), a nurse and a physician; or a nurse and a paramedic (Emergency Department only) must verify the following items at the recipient's bedside prior to initiating the transfusion:
    a. Consent form signed.
    b. Verify MD order to transfuse.
    c. The patient name, patient MR number, BB wristband ID (cellular products only), unit number, component code, and compatibility testing results on the Product Chart Copy must match the information on the blood product label and compatibility tag.

d. The patient name and patient medical record number of the compatibility tag must match the patient name and medical record number shown on the patient's hospital identification wristband.
e. The patient ABO/Rh Type on the Product Chart Copy must match the patient ABO/Rh type on the attached compatibility tag.
f. The unit ABO/Rh type on the Product Chart Copy must match the unit ABO/Rh type on the attached compatibility tag and the blood product label.
g. The unit is appropriate for any Special Needs listed on the Patient Chart Copy.
h. The Blood Bank ID number on the compatibility tag must match the number shown on the patient's Blood Bank wristband. **Note:** A Blood Bank wristband is not required for non-cellular components.
i. The product must be within the labeled dating period (products without a specific expiration time listed expire at 23:59)

2. One individual conducting the identification verification is the qualified transfusions who will administer the blood or blood component to the patient.
3. The individual initiating the transfusion will complete all necessary pre-transfusion documentation in the electronic medical record using the Blood Administration iView band. The individual assisting with the pre-transfusion verifications will sign as the witness in the electronic medical record. Whenever possible, the blood product Donor Identification Number should be recorded electronically using a barcode reader.

Transfusion of Blood Products

1. Transfusion must begin within 30 minutes after the product leaves the blood bank. Only a Registered Nurse or Physician may "hang" the blood and initiate the transfusion.
2. Transfusion must be completed within 4 hours of the time the product was released by the blood bank AND prior to the labeled expiration of the product.
3. DO NOT place blood products in unit refrigerator. If transfusion will not begin within 30 minutes after the blood leaves the blood bank, return the unit to the blood bank until ready to transfuse.

Red Blood Cells

1. All red blood cell transfusions will be administered with a Y type blood set containing a clot filter, available as floor stock. Other special sets or filters (micro aggregate filters or Leukocyte Reduction filters) are supplied through Central Distribution.
    - Change the transfusion administration set/filter after the completion of each unit or every 4 hours. If more than one unit can be transfused in 4 hours, the transfusion set can be used for a 4-hour period.
    - Administer blood products with 0.9% sodium chloride. No other solutions or medications should be added to or infused through the same administration set with blood components.
2. Document the time the transfusion was started, and initiate the red blood cell transfusion at a rate of 50 ml/hr for the first 15 minutes of the transfusion. Remain with the patient during the first 15 minutes and monitor for signs/symptoms of a transfusion reaction.
3. The initial flow rate may be increased if the patient's clinical condition is such that rapid infusion is indicated. If this is the case, extra care must be given to observation for signs/symptoms of a hemolytic transfusion reaction.
4. If there are no indications of a possible problem with the transfusion after 15 minutes, increase the rate to 125 ml/hr unless otherwise ordered or indicated by the patient's condition. Blood may be run faster, if indicated, but must not run so slowly that it will not infuse within the 4 hour limit.

5. If the patient requires a rate that will cause the 4 hour limit to be exceeded with the usual volume in a unit, inform the Blood Bank so that the unit can be divided into smaller amounts.
6. Vital signs should be obtained and documented after the first 15 minutes of the blood transfusion, and then at least hourly during the transfusion.
7. If the patient is to receive two or more units in succession:
    a. The entire verification process must be repeated for each unit
    b. Under normal circumstances, a new administration set is to be used for each unit. If the patient's clinical condition is such that rapid infusion is indicated, then multiple units may be given through the same administration set if the manufacturer's instructions for the administration set in use allows for multiple units for be infused. In no case should the same set be used for greater than 4 hours.
    c. The patient must be closely monitored by the RN during the first 15 minutes of each unit transfused. Vital signs should be obtained at the regular intervals described above.

Platelets, Plasma, & Cryoprecipitate

1. The Blood Bank will send component recipient sets for use with platelets, plasma, and cryoprecipitate. This is a straight set (not a Y type set).

Transporting a Patient Receiving a Blood Product

1. Transportation of a patient to another unit/department during transfusion of a blood product should only occur in an emergency situation.
2. Patients receiving a blood product who require transportation to another unit/department will be accompanied by a nurse.
3. A handoff to the receiving nurse in the receiving unit/department must occur before the transporting nurse leaves.

Completion of Transfusion

1. When the transfusion is completed, document the post-transfusion vital signs, date/time completed, amount transfused, and patient's response in the EMR. Include the amount of blood product transfused and saline infused in the patient's Intake & Output record.
2. If no further units are to be transfused: flush the line with normal saline, disconnect the blood administration set and resume previous fluids, flush the line to lock or discontinue the IV.
3. Discard empty blood bag and tubing in the container on the unit marked for contaminated waste (red Biohazard containers).

Release of Blood Products from Crossmatch

1. Blood is routinely released from crossmatch at midnight on the 3rd day following specimen collection. Blood shortages and other issues may occasionally require earlier release of the product.
2. Orders to "keep ahead X number of units" cannot be honored by the Blood Bank. If the physicians wishes to have a certain number of units in reserve at all times, it is necessary to obtain a physician's order for each of the additional units.
3. The correct procedure for maintaining a specified number of units in reserve is to send the Blood Bank a new order for the number of units required to maintain the reserve as existing units are used.

If a transfusion reaction is suspected:

1. STOP THE BLOOD TRANSFUSION and close the roller clamps on the tubing.
2. Disconnect the blood administration set, and convert the IV to a saline lock.
3. Notify the Blood Bank
4. Notify Rapid Response Team, if necessary.
5. Stay with the patient and notify the attending physician. If the attending physician cannot be reached immediately, notify the physician on call for that service. If the physicians cannot be contacted and the reaction is severe, notify the Unit Manager or House Administrator for assistance.
6. Monitor frequent vital signs and treat the patient per physician's orders until stable and/or symptoms of reaction resolve.
7. A phlebotomist will obtain a blood specimen.
8. Send the following items to the blood bank with the phlebotomist:
    a. All 3 copies of the Transfusion Reaction Report (MR-57)
    b. The blood bag and tubing along with any IV fluids used. Clamp the tubing to avoid leakage. Remove any needles.
    c. The patient's most recently voided urine *since the initial symptoms of a reaction*. Label as "Transfusion Reaction Workup"
9. Continue monitoring patient closely for 48 hours
    a. Monitor intake and output closely. Inspect each voiding for hematuria.
    b. Monitor and record vital signs, including temperature every 2 hours for 12 hours, then every 4 hours for the next 24 hours.
    c. Watch closely for rashes during the 24 hours following the suspected reaction.
10. Document events in the electronic medical record.
    a. Record the type of blood product and the approximate amount transfused. Describe events, actions taken, and the patient's response to interventions.
    b. Complete the Transfusion Reaction Report (MR-57) and send to the Blood Bank

Reference: Policy Stat: Administration of Blood and Blood Products and Transfusion Reaction Procedure

Braden Risk Assessment

Braden Scale for Predicting Pressure Sore Risk: Is a valid and reliable risk assessment tool that assesses the patient's level of risk for skin breakdown (the lower the score, the higher the risk for skin breakdown) based on the categories of:

- Sensory Perception
- Moisture
- Activity
- Mobility
- Nutrition
- Friction and Shear

Scoring is as follows:

- Mild Risk = 15-18
- Moderate Risk = 13-14
- High Risk = 10-12
- Very High Risk = ≤ 9

Patient's Name_____ Evaluator's Name_____				Date of Assessment				
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2 .Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2 . Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2 .Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake incudes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

Reference: Policy Stat: Skin and Wound Assessment and Management

Code Blue

American Heart Association Guidelines:

When you find a patient who has arrested:

- The first person, if qualified and acting within their scope of practice, should begin high quality CPR. Perform chest compressions, compressing the chest at least 5 cm (2 inches) but no more than 6 cm (2.4 inches).
- Maintain continuous chest compressions at a rate between 100 and 120/min.

Rationale: The number of adequate chest compressions delivered per minute correlates with improved neurologic function and survival, but compressions that are too deep and too fast can cause *increased* injury and decreased return of spontaneous circulation.

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- Allow full recoil of chest after each compression; do not lean on the chest after each compression.
- Limit interruptions in chest compressions to less than 10 seconds.

Procedure:

1. Once pulselessness and apnea is determined, begin high quality chest compressions per AHA Guidelines above.
2. Call a Code Blue
    a. Press the Code Blue Button in the patient's room or place a call from an internal phone:
        - Lexington Facilities: Dial 1111
        - Saint Joseph Berea: Dial 66
        - Saint Joseph London: Dial 777
        - Saint Joseph Mount Sterling: Dial 0
        - Flaget: Dial 999
        1. State, "CODE BLUE _____ (unit, room number if known). Do not wait for the operator to answer. The line goes straight through to switchboard. Hospital Operator will page the code.
        2. The first rescuer should continue high quality CPR until the second person has called the Code Blue. When this is done, the second person shall assist with CPR and provide Basic Life Support per American Heart Association recommendations.
3. Unit personnel should initiate emergency procedures immediately
    a. Take Code Blue cart to the scene (room).
    b. Place cardiac board beneath patient's chest area. Board should cover area from neck to waist for maximum effectiveness.
    c. Notify the patient's attending physician, stat.
    d. Take the patient's chart or the mobile workstation to the scene (room). Print the Code Blue Report, if possible, by utilizing Discern Analytics in Cerner (where applicable). This is particularly helpful on the non-critical care floors. The unit clerk should print the report and deliver it to the room. This facilitates communication and provides an overall snap shot of the patient's clinical course during the current admission.
    e. Without interrupting chest compressions, attach electrodes or multi-function pads to the patient for EKG (External Defibrillator/Pacer Monitor). The package and the pads show illustration of proper placement.
    f. Clear the room of visitors, remove obstructing items of furniture, personal items, or durable medical equipment (canes, walkers, bedside toilet) from the area of the patient and team. Continue CPR. Any non-essential staff should exit the area. Family may observe code, if they can remain calm and out of the way, if requested. Chaplaincy may offer support to the family member who wishes to view the resuscitative effort.
    g. Use closed loop communication. Maintain an environment of calm. Assign roles per BLS until Code Team or Rapid Response Team arrive. Ensure high quality chest compressions are minimally interrupted.
4. Prepare Ambu Bag for use
    a. The registered nurse may initiate oxygen therapy in an emergency. Deliver ventilation and oxygen via bag and mask until the Code Blue or Rapid Response Team arrives. The ambu bag should be opened, and the tubing attached to the "Christmas Tree" adapter of the oxygen meter. Turn the oxygen meter all the way up, or "full blast." Deliver breaths per AHA recommendations.
5. If sufficient unit personnel are available to perform CPR, the nurse should ensure existing IV line is

patent and secure, and may also attempt to start another IV line.

a. Use the largest IV catheter possible
b. If IV access is not attainable, the Code Blue/RRT team may place an intra-osseous access.

6. Brief the Code Team
    a. When the Code Blue team arrives, the patient's attending nurse should provide relevant information to the team leader. The team leader, preferably a seasoned clinician, then may assign roles per ACLS guidelines.

**** (If code blue originates in Intensive Care Unit, ACLS may begin immediately, without need to wait for Code Team) *********

Diabetes Management

Glycemic Management of Hospital Patients

Assess and Ask:

What type of diabetes they have been diagnosed with and what medications they currently take for glycemic management?

***Remember*:** Those with Type 1 diabetes MUST have insulin.

Power plans: *MED Blood Glucose Control_KY and MED Hypoglycemia NON PREGNANT Adult Standing Order_KY power plans* are to be initiated at admission on all patients with known diabetes diagnosis. These can also be ordered on those without diagnosis but who have lab glucose levels >180 mg/dl or <70 mg/dl. These are nurse driven power plans and may be ordered per protocol.

Insulin Pumps and CGMs:

MED Insulin Pump_KY powerplan is to be initiated at admission on all patients who present with an insulin pump. Place a consult for the Diabetes Nurse Specialist.
Assess the patient's ability to self-manage the insulin pump and make sure they have their own supplies. If a patient has been admitted with DKA/HHS, is not awake or alert, or is unable to self-manage the insulin pump, it must be completely removed and given to a family member or security.

***Remember*:** If a pump is removed an Alternate insulin delivery must then be ordered. (SQ or IV)

If the patient is currently on their pump while inpatient: On the powerplan Under Medication: Check: non formulary. Fill in "frequency" with ACHS and fill in ""Freetext Dose'' with Diabetes Educator will update with settings. The non-formulary (insulin pump) will show up on the MAR so that the nurse is able to document all boluses given by the patient using the insulin pump.

***Remember*:** A patient may require boluses for carb coverage even if the FSBG does not meet criteria for correction < 140 mg/dL.

The patient will be responsible to provide their own supplies and change the injection site and insulin reservoir every 2-3 days.

A patient may also continue to wear their CGM (Continuous Glucose Monitor), however inform the patient that the Hospital POC Glucose Monitor must still be used, documented and all insulin doses based on the POC FSBS results.

When a patient goes to radiology, the insulin pump and the CGM *cannot* be exposed to the radiologic machines. The CGM must be completely removed. If the insulin pump is a Tubeless system, such as an Omnipod, it must be completely removed. An insulin pump with a tube can be disconnected at the

injection site and reconnected immediately after the radiology test is completed by the patient.

Each shift you must evaluate the injection site and document location and condition.

DKA and Critical Care Insulin Drip:

MED Diabetic Ketoacidosis (DKA) Insulin_KY power plan is to be initiated at admission on all patients with diagnosis of DKA.
Critical Care Insulin drip is used for persistent hyperglycemia but is not DKA.

Follow the protocol for titration, notifying the MD, changing IV fluids and lab draws. Glargine must be ordered and given 2 hours prior to transition off the IV insulin drip.

***Remember*:** Failure to overlap therapy can result in recurrence of DKA or elevated glucose levels.

Inpatient Glucose Goals:

Overall Blood Glucose Goal at SJE and SJH is 70-180mg/dl. The women's hospital at SJE has different blood glucose goals.

Hyperglycemia:

If the patient has POC FSBS levels **>180 mg/dl X 2 in any 24 hour period,** you must discuss with the physician about adding basal insulin (Glargine) or increasing the basal insulin dose if already receiving. Correction insulin (SSI) is NOT recommended as the sole treatment of the hospitalized patient.

***Remember*:** Pay attention daily to your patient's blood glucose pattern, ask for orders during rounds. Persistent hyperglycemia increases length of stay, infections, delays healing and mortality risk.

Types of Insulin:

Basal insulin in the hospital is Glargine. Basal insulin controls blood glucose between meals and nighttime. The Onset of Action time for Glargine is 2-4 hours after injection and it does not peak.
***Remember*:** Basal insulin is not to be held without a physician order even if the patient is NPO. Discuss with the physician and obtain an order if you do not feel comfortable giving the basal insulin for any reason.

Mealtime/Bolus insulin is ordered to be given with meals and should be given within 15 minutes of the meal (15 minutes before, during or up to 15 minutes after the meal).

***Remember*:** If the patient is not eating, then the mealtime insulin is not to be given.

Correction insulin is insulin given to correct an elevated blood glucose level. A correction dose is to be given preferably within 30 minutes after the POC FSBS level is obtained. If longer than one hour has passed since the POC FSBS you are correcting for, you must recheck the POC FSBS level.

Hypoglycemia:

All hypoglycemic events must have a one hour POC FSBS recheck after the hypoglycemia has been corrected.
Mild to Moderate Hypoglycemia: 41-69mg/dl

1. Treat hypoglycemia by giving patients carbohydrates. Use one of the following:
    a. Meal tray if in the room
    b. 4 oz. of juice/regular pop/skim milk
    c. 4 glucose tablets or glucose gel

    d. If patient is not alert or unable to consume treatments by mouth, treat with IV or glucagon as described in Severe hypoglycemia Treatment
2. Recheck FSBS 15-20 minutes after the treatment (step 1) to verify if the treatment corrected the hypoglycemia.
    a. If FSBS still below 70mg/dl, Repeat Step 1. Recheck in 15-20 minutes again. If after 3rd treatment, FSBS remains below 70m/gl, Call the physician.
    b. If FSBS is 70mg/dl or above: Give patient food if able to eat-meal tray or a snack.
3. Recheck FSBS ONE hour after FSBS has come up to 70mg/dl or above in efforts to prevent the patient from having rebound hypoglycemia.

Severe Hypoglycemia: 40mg/dl or below

1. Recheck FSBS within 7 minutes using the same meter to confirm that the hypoglycemia is a critical value. Also confirm with a lab, but DO NOT wait for the lab results before treating.
2. Treat the hypoglycemia using one of the following:
    a. IV available:
        i. Give 1 amp of D50 if patient weighs 100 pounds or more
        ii. Give ½ amp of D50 if the patient weighs less than 100 pounds.
    b. IV not available: Administer 1 mg of Glucagon IM and obtain IV access.
3. Recheck FSBS 15-20 minutes after treatment to verify if the treatment corrected hypoglycemia.
    a. If FSBS still below 70 mg/dl: Repeat step 2. Ensure patient has IV access. Recheck FSBS 15-20 minutes after 2nd treatment and repeat treatment if necessary. Notify physician. Administer no more than 2 doses of Glucagon.
    b. If FSBS is 70mg/dl or above: Feed the patient (if able to eat)-meal tray or snack
4. Recheck FSBS ONE hour after the FSBS has come up to 70 or above in effort to prevent rebound hypoglycemia.

Consult to the Diabetes Nurse Specialist:

Place a consult in the EMR for the Diabetes Educator for any of the following reasons:

- Patient is newly diagnosed with diabetes.
- Patient has an insulin pump and/or CGM.
- Patient is admitted with DKA.
- Patient has an A1C of 9% or greater.
- Patient requests education about diabetes.
- Patient discharging home with new insulin order, never taken insulin before.
- Patient is using their home supply of a concentrated insulin inpatient. (U-200, U-300, U-500)
- Feel free to contact us for any needs or concerns.
- SJH 859-313-2260
- SJE 859-313-5653
- DNC Manager 859-313-1254

Reference: Policy Stat: Please refer to facility specific protocols for Glycemic Management of Hospital Patients.

Nova Stat Glucometer Meter

The Nova StatStrip is intended for point-of-care, *in vitro* diagnostic, multiple-patient use for the quantitative determination of glucose in capillary finger stick, venous whole blood, arterial whole blood, neonate arterial whole blood, and neonate heel stick specimens. It is also intended for use in the

quantitative determination of glucose in venous whole blood, arterial whole blood, neonatal heel stick and neonatal arterial whole blood samples throughout all hospital and all professional healthcare settings. It is not intended for the screening or diagnosis of diabetes mellitus but is indicated for use in determining dysglycemia.

A physicians order is required for patient testing on the Nova StatStrip. Since patient treatment may be based upon results obtained from testing on the Nova StatStrip meter in concert with other patient findings, results reported from this method are considered definitive. Repeat testing is required for critical and/or questionable values with correlation to patient condition before any patient treatment is begun.

The Nova StatStrip quantitatively measures glucose in whole blood both enzymatically and amperometrically. The test strip is designed with an electrode that measures glucose levels. The glucose in the blood sample mixes with reagent on the Test Strip and produces an electric current. The amount of current is proportional to the amount of glucose in the sample.

The bedside unit is equipped with a barcode scanner and a large touch-sensitive display, both of which allow the operator I.D., patient encounter number, and reagent information to be entered. In order to access quality control and patient testing the operator must enter their I.D., which will be the operator's badge number. Operators have been properly trained to use the system and have an operator I.D. programmed into the system.

Only certified operators identified by current operator ID numbers (employee badge number) will be allowed to perform glucose meter testing. Training and certification for glucose meter use will be performed during general nursing orientation upon initial employment or by a qualified trainer on the unit. New employees will initially be certified for six months, regardless of status. Annual recertification will occur each year for all employees using the glucose meter. Employees whose status is full-time or part-time will be re-certified for one year. Employees whose status is casual or pool must be re-certified every six months to continue using the glucose meters.

Use of meter on critically ill patients

For purposes of this procedure **critically ill patients** are defined as those patients whose hemodynamic status is compromised resulting in inadequate peripheral perfusion, regardless of the patient's location in the facility.

The Nova StatStrip is FDA approved for testing all patient populations using capillary samples, including those who may meet the definition of critically ill.

Specimen Collection

A. Patient Preparation
    1. Universal precautions must be observed.
    2. The puncture site should be cleaned and thoroughly dried before obtaining the blood sample.
    3. Capillary blood can be obtained using the lancing device to puncture the fingertips. Alternate site testing (earlobe, forearm, and toes) is NOT allowed. Please refer to Laboratory procedure Venipuncture and Capillary Collections for additional information.
B. Specimen Type
    1. Fresh whole blood—capillary, venous, and arterial may be used. Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake.
    2. Do not use serum or plasma samples.

3. For venous collection: tubes with lithium heparin must be used.
4. Do not use preservatives that contain fluoride or EDTA.

C. Specimen Handling
1. Test the blood sample as close as possible to the time the sample was collected. The test should be performed within 30 minutes of sample collection to minimize glycolysis.
2. If using fresh whole blood in the absence of an anticoagulant, test immediately to prevent clotting from affecting the sample testing method.
3. When whole blood in a test tube is used, care should be taken to uniformly distribute red cells throughout the tube before testing. This can be accomplished by gently inverting the capped tube.
4. Storage of samples on ice is not recommended

D. Sample Volume is 1.2 µL.

Equipment and Materials

Product	Storage Requirement	Comments
StatStrip Glucose Meter Test Strips	**Open expiration 180 days**, or until expiration date printed on label; store at 15C to 30C. Each bottle contains desiccant to keep strips dry Keep away from heat and direct sunlight. Do not refrigerate or freeze the strips. Each bottle must be dated upon opening with an open and expiration date. Once opened, the test strips are stable for 180 days at room temperature or until the expiration date, whichever comes first.	Each strip contains these chemical and biological reagents: glucose enzyme (Aspergillus sp.) > 1.0 IU, mediator > 20 ug and other nonreactive substances Do **NOT** reuse test strips. Single use only. Remove the test strip from the vial only when ready to test. Do **NOT** use after the expiration date printed on the bottle label or if the 180 day stability date has passed. This may cause inaccurate results. Each shipment and/or Lot Number change must have lot to lot comparisons before being put in use.
Control Solution 1, StatStrip (1 bottle per package)	**Open expiration 90 days**, or until expiration date printed on label; store at 15C to 30C. Keep the control solution vial tightly closed when not in use. Each bottle of control solution must be dated upon opening with an open and expiration date. Once opened, the control solution is stable at 90 days or until the expiration date, whichever comes first. Do not use after the expiration date printed on the bottle label or if the 90 day stability date has passed. This may cause inaccurate results.	Each solution is provided as a buffered aqueous solution containing D-glucose, preservative, FD&C dye, viscosity-adjusting agent, and other nonreactive agents. Each control solution contains a known concentration of glucose that reacts with the compounds in the strip. Expected value range is listed on the Nova StatStrip control bottle label. New lots of quality control materials are tested repeatedly to verify ranges established by the manufacturer Test strips and control solution lot

		numbers need to be entered into the system before use.
Control Solution 3, StatStrip (1 bottle per package)	**Open expiration 90 days**, or until expiration date printed on label; store at 15C to 30C. Each bottle of control solution must be dated upon opening with an open and expiration date. Once opened, the control solution is stable at 90 days or until the expiration date, whichever comes first. Do not use after the expiration date printed on the bottle label or if the 90 day stability date has passed. This may cause inaccurate results.	Each solution is provided as a buffered aqueous solution containing D-glucose, preservative, FD&C dye, viscosity-adjusting agent, and other nonreactive agents. Each control solution contains a known concentration of glucose that reacts with the compounds in the strip. Expected value range is listed on the Nova StatStrip control bottle label. New lots of quality control materials are tested repeatedly to verify ranges established by the manufacturer. Test strips and control solution lot numbers need to be entered into the system before use.
StatStrip Wireless Meter	Room Temperature 15C to 40C (59 to 104 F).	For issues regarding the meter, please contact the Laboratory POC staff. If after hours please return meter to Laboratory in exchange for a loaner meter.
Docking Station	Room Temperature 15C to 40C (59 to 104 F).	For issues regarding the docking station, please contact the Laboratory POC staff.
Li-Polymer Battery	Store below 60C (140F). Return to laboratory after expiration date printed on the label for replacement. Batteries must be properly disposed of.	Do not incinerate. For issues regarding the battery, please contact the Laboratory POC staff.

Maintenance

Trained personnel will perform routine care and maintenance.

A. General Care and Cleaning
   1. Clean the meter after each patient use with one of the following products depending on the specific patient population.
      a. Sani-Cloth® Wipe (Purple Cap) - Allow to remain wet for a full 2 minutes and allow to air dry.
      b. Sani-Cloth® Bleach Wipe (Yellow Cap) - Allow to remain wet for a full 4 minutes and allow to air dry.
   2. When cleaning, avoid the barcode scanner and electrical connector. If necessary, wipe the scanner with a soft cloth dampened with water. Dry immediately.
   3. Never immerse meter in any cleaning agent or water. Do not spray the meter with a disinfectant solution.
   4. Keep the unit dry and avoid exposing it to extremes in temperature.
   5. Do not take apart unit.

6. If you drop the unit, inspect it for obvious damage. Perform a quality control test prior to running a patient test.

B. Charging the Meter
   1. Leave the meter in the docking station when finished testing to keep the meter charged and ready to use at all times. If the meter is not docked within 8 hours the battery will need recharging before it can be used.
   2. When the battery LOW symbol displays on the screen, place the meter into the Charging Station. If you have a spare battery that is already fully charged, change the battery.
   3. Changing the battery.
      a. Press the Power button to enter the Sleep Mode. This will allow the operator approximately 20 seconds to change the battery and not lose date/time settings.
      b. Push down on the two cover latches to release the cover. Take the battery cover off the back of the meter.
      c. Push up on the battery latch. Remove the drained battery.
      d. Replace with a fully charged battery.
      e. Replace the battery cover and dock the meter in to the Charging Station prior to use.
      f. Place the drained battery into the Charging Station.

C. Battery Expiration
   1. All Nova batteries are assigned an expiration date which is printed in the upper right corner of the battery label.
   2. Expired batteries should be replaced immediately with a fresh in-date battery.

Quality Control

Quality Control testing must be performed at least every 24 hours of use with two levels of control material: LOW liquid control and HIGH liquid control. If controls have not been performed and 24 hours have passed, a message will appear on the glucose meter screen that reads **QC Lock out L1, 3 GLU QC Required**. When this message appears, the meter will not test patients until all quality control has been performed and has passed. QC and patient results will be evaluated by the Point of Care Coordinator or other designated employee as appropriate.

A. Nova StatStrip Level 1 and Level 3 Control Solutions are to be used to verify the Nova StatStrip System performance.
B. Quality control test should be run under the following conditions.
   1. Required every 24 hours. Patient testing will be locked out until valid QC is ran.
   2. Before using the meter for the first time.
   3. If a patient test has been repeated and the blood glucose results are still lower or higher than expected.
   4. When troubleshooting the system because there are indications that the system is not working properly.
   5. If the bedside unit is dropped to insure meter is still working properly.
C. Results should fall within the range printed on the label and/or control solution insert sheets.
   1. New lots of quality control materials are tested repeatedly to verify ranges established by the manufacturer.
D. Results that fall within the range, when testing in the bedside unit's QC Test mode, are indicated by PASS on the bedside unit display.
E. Results that are not within the range are indicated by FAIL.
   1. If test results fall outside the expected range, repeat the test.
   2. Results that fall outside the expected range may indicate:

a. Procedural error.
b. Old or contaminated control solution.
c. Test strip deterioration, expiration or damage.
d. Unit malfunction.
e. Control solution expired.

Patient Test Procedure

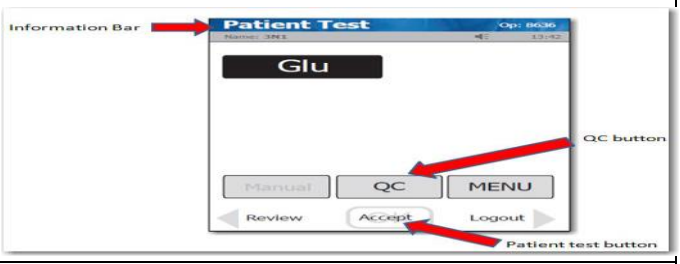
A. Obtain carrying case with meter and supplies. Carrying case should contain: meter, single-use lancets, alcohol pads, gauze or cotton, test strips and control solutions (levels 1 & 3). Necessary testing supplies (except gloves) should be kept stocked in the carrying case. Check the strips for expiration date and proper storage. At SJH and SJE, glucose meter testing supplies are available through Central Distribution. At SJJ, reagent strips and controls may be obtained in the laboratory.

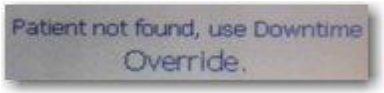
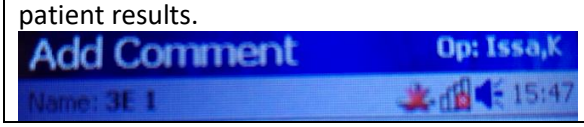
B. Perform quality control tests if necessary. A message will appear prompting you to run controls if they have not been performed in the previous 24 hour period.

C. Wear gloves at all times during the blood glucose test procedure, and dispose of all contaminated materials (strips, lancets, etc.) in an approved biohazard or sharps container.

D. Explain the purpose of the test and steps of the testing procedure to the patient to reassure the patient.

E. Clean with alcohol, allow to air dry before using single-use lancet. Wipe away first drop of blood.
Note: When scanning or manually entering the patient's ID number it is **very important** that the correct number is entered for that patient! Always verify patient's identity by checking both the name and ID number on the patient's armband before performing the glucose test, if patient is able verify all identifiers have verbal confirmation. All manually entered patient ID's will need to be confirmed by re-entering to avoid potential misidentification.

What you do	Comments
Upon entering the patient's room wash hands	Don gloves, and explain your purpose. Follow the Identification of Patients policy to identify the patient.
Wake up the meter by either touching the screen or pressing the button on the top of the meter. The Blue information bar will inform the user of what steps to take.	
Press **OK** to begin testing.	At the middle bottom of the screen.
Press **Scan** to scan the Operator ID or manually enter the numbers on the keypad and press Enter. 	The Operator ID number is the nine-digit employee badge number (If a new badge is given from human resources, the operator will need to contact the Point of Care staff at 3273). The Strip Lot number screen will display.

 Hold meter 4 inches from barcode and align green Scanner over barcode.	Make sure that the test strips have not exceeded the manufacture date, or the 180 open dating. If still good, open vial and remove one test strip.
 Press **Scan** the patient wrist band it will read this number.	The patient ID will be the patient encounter number. Failure to use the encounter number will cause a delay in results being uploaded into the patient's chart.   ADT not found or down? Use this: 
 	Insert strip as shown on the meter screen with the Stat Strip side up and the gold portion of the strip into the meter. Before inserting the test strip, ensure that the port is clean and dry.
Prepare patient's finger. Clean with alcohol, allow to air dry before using single-use lancet.	Wipe away first drop of blood.
Apply a drop of blood to the target area on the test strip. The test starts automatically, as the sample is accepted.  	Do not squeeze finger excessively to obtain drop of blood. Finger may touch strip while applying blood. The test strip must fill completely upon touching the blood droplet. If the test strip does not fill completely, **do NOT touch the test strip to the blood droplet a second time**. Discard the test strip and repeat the test with a new strip.
Wait for the monitor to analyze the sample and display the result.	The test starts automatically, when sufficient sample has been applied. A 1.2 microliter sample is required. The monitor counts down the **6** second analysis time, then displays the test result.
Evaluate the result and enter the appropriate comment into the meter. Comment is required on all patient results. 	A comment is **required**. To enter press  , or **Comment**. Selected comment from options

Remove the test strip from the monitor and discard appropriately.	Please note under the Procedure Limitations section when repeat testing and/or laboratory confirmation testing is required for the result obtained. Repeat testing is required on all critical values, <40 or >450. Confirmation by lab test must be done on critical values unless physician notified of critical result requests that the value is not repeated by lab test or if patient has had a previous critical result during the current visit. Critical results must be reported immediately to patient's attending physician or nurse with 'read back' of critical results required.
Press**: Accept** to perform next patient	If a patient is in isolation, place meter in a biohazard bag to perform testing. Meter must be cleaned after each patient with a Sani-cloth or bleach cloth. Discard gloves, and wash hands before exiting the patient room.
Place meter in docking station to charge the batteries after every test run performed. Patient results will automatically be entered into the patient's medical records through the computer system interface.	**Please remember**: When you access the patient history mode, the previous result the meter shows is only the previous result from testing on that particular meter and may not be the most recent glucose result on that patient if they have had testing performed on a different meter.
Document patient results on appropriate flow sheet or POC progress notes sheet, where applicable	

Nova Stat Errors

Do	Don't
Do push the test strip all the way into the meter before applying the sample to the strip. The screen will change to "Apply Sample" when the strip is inserted all the way. 	**Don't** apply the sample to the test strip until the strip is pushed all the way into the meter and the screen has changed from "Insert Strip" to Apply Sample" 
Do apply the QC sample with QC or sample "nose to nose" at the end of the strip. The strip will take in the sample via capillary action. 	**Don't** place a drop of QC solution or sample on top or on the bottom of the strip. This will cause a FLOW ERROR. 
Do hold the finger/drop of blood or QC solution to the end of the strip until the 6 second countdown begins on the screen. 	**Don't** pull away the finger/drop of blood or QC solution until the strip is fully dosed (when the 6 second countdown begins). Sample cannot be re-added to the strip if partially filled. This will cause a FLOW ERROR. 

Comment Codes

QC Comment Code	When to use QC Comment Code
Daily maintenance performed	QC Passed
QC repeated	QC Failed
Wrong QC used	QC Failed and wrong level of QC was used
Patient Comment Code	**When to use patient comment code**
Art/Ven Spec Used	For Critically ill patients that fingerstick collection is not appropriate
Notified MD RBV	Physician notified of results and read back and verified.
Notified Nurse RBV	RN notified of results, and Read back and verified. Should be used by ancillary staff, if the results is within normal limits
Received Meds	Patient was treated
Confirmed Previously	Critical results from original test, and repeat test previously confirmed by the Laboratory
No Repeat per MD	Critical result repeated on the glucometer and the Physician does not want a laboratory confirmation
Repeat Test	Nova results matched criteria for repeat test
No action required	No action needed
Insulin Drip	Patient treated with Insulin

Additional comment codes for use in the Nursery and NICU at SJE

QC Comment Code	When to use QC Comment Code
Greater 150 Call	Notify the Physician of result
Less 40 Feed Rpt 30m	

Results Reporting

A. Reference Ranges
    1. Blood glucose levels for people without diabetes are as follows:
        - Before meals: 70-110 mg/dL
        - Inpatient Blood Glucose goal: 70-180 mg/dL

B. Reporting Format:
Results are reported in milligrams per deciliter (mg/dL).

C. Reportable Ranges:
10 - 600 mg/dL

D. Critical Results
    1. Critical Results are defined as follows
        - Low Critical ≤ 40 mg/dL
        - High Critical ≥ 450 mg/dL

E. Unexpected results
    1. Check the lot number of the test strips to make sure it is the same as the lot number entered on the meter.

2. Check the expiration date of the strips.
3. Run the control closest to the patient value. If the control is within range, repeat the patient test.
    a. If the new value matches the original value plus or minus 15%, the result is declared valid.
    b. If the repeated test is not within plus or minus 15%, a specimen should be drawn and sent to the laboratory for comparison. These two test must be done relatively at the same time. A delay in time may affect results.
4. If a discrepancy exists between the laboratory value and the Nova StatStrip value, the following Action must be taken.
    a. Sequester the glucose meter so it cannot be used for patient care, place a red equipment tag on the meter.
    b. Notify POC personnel for evaluation of the glucose meter.
    c. Notify immediate supervisor.
    d. Borrow loaner instrument from Laboratory.

Critical Glucose Result Procedure

- **Initial Results** that fall outside the <40, >450 range must be confirmed on the same glucometer, within seven minutes, for each new episode.
    A. Use Comment Code: ***Repeat Test***.
- If the repeat value is still <40, >450, the nurse or physician must be notified and the result read back. Use Comment Code: ***Notified Nurse RBV or Notified MD RBV.*** In addition, a stat lab glucose must be ordered to confirm a result.
- A lab glucose is not required if:
    A. the critical value has been previously confirmed by the lab (Comment Code: ***Confirmed Previously***), or,
    B. The Critical result was reported to the physician who does not want the critical confirmed by the lab (Comment Code: ***No Repeat per MD***).

Policy Stat Reference: Nova StatStrip Glucose Meter

POC Contacts

SJH: Kayla Isaacs 313-3273 Fax: 313-3057
SJE: Serge Charles 967-5119 Fax: 967-5306
Return broken glucometers to the lab for repair/replacement. Loaner glucometers are available.

SAINT JOSEPH HEALTH SYSTEM

Point of Care Testing

CHANGE OF PATIENT ID/RESULT REQUEST

SECTION A: TO BE COMPLETED BY UNIT PERSONNEL

Correct Patient Name (Last, First, M):

_____

Correct Patient ID_____ Place correct ID patient bar-coded label here or enter patient name and ID on

lines provided above

Reason for ID/Result Change (Please be specific):

☐ Incorrect Patient ID Number:

Current Incorrect Patient ID_____

☐ Other:

Incorrect Item/Problem Noted_____

_____

Point of Care Instrument used: Glucose meter _____ I-stat _____

Test Date: ____/ ____/ ____ Time Testing Performed: _____am or pm (circle one)

Operator ID (badge #): _____ Operator Name: _____

FACILITY: SJH SJE CCH (circle one) UNIT: _____
Change Requested By _____ Date _____/ _____/ _____

Send (tube or fax) this form to the Laboratory. Attn. Kayla Isaacs SJH Lab Fax: 313-3057, Serge Charles SJE Lab Fax: 967-5306 Tube Station 112

SECTION B: TO BE COMPLETED BY LABORATORY

Corrected By: _____ Date _____/ _____/ _____
Time _____

Fall Prevention

Definitions:

A. **Fall:** A patient fall is an *unplanned descent to the floor* with or without injury to the patient. Include falls that result when a patient lands on a surface where you wouldn't expect to find a patient. NDNQI–National Database of Nursing Quality Indicators.

B. **Falls Risk Screening:** A brief process to identify those patients with an increased risk of falling who need either increased supervision, teach-back method education, or a detailed falls risk assessment. Example: *BMAT*

C. **Falls Risk Injury Screening**: The process of accessing a patient's risk for injury if they do fall. Example: *ABCs Risk Stratification*

D. **Falls Risk Assessment**: CHI Saint Joseph uses the Morse Fall Risk assessment tool. This is a simple tool, designed to score the patient on the likelihood of having a fall while under the hospital's care.

Universal Fall Precautions

All patient care areas should implement Universal Fall Prevention Intervention on all patients regardless of diagnosis and age.

These include:

- Call light/phone/personal items within reach/orient to surroundings
- Wheels locked/low position in either bed or chair
- Wearing Non-skid footwear (yellow slip-resistant socks)
- Adequate lighting
- Room free from clutter/spills

- Encourage proper use of railing, walker, or other assistance device
- Reminder to call for assistance and ensure patient is educated with teach-back method of using the call bell, as well as frequent reminders and orientation to the call device
- Encourage sensory aids as appropriate (glasses, hearing aids, etc.)
- Fall prevention education and explanation in lay terms the patient can understand and teach-back, in real time.
- Hourly comfort/safety round per patient care bundle expectations
- Document interventions in the medical record, particularly in the patient plan of care (POC). Update goals daily, include the patient and family in the POC planning and revising daily.

Risk Stratification: Tools

Identify and Prevent Risk: Tools to assist clinicians to identify patients at risk of falling and at higher risk for injury from falling

ABC and Morse Fall Screening Tool:

A. **ABCs for Injury Risk Identification** is a screening tool that focuses on patient groups most at risk for injury with a fall. Components include:
   - **A**GE and/or frailty – Individuals who are greater or equal to 85 years old or frail due to a clinical condition
   - **B**ONES – Patients with bone conditions, (i.e. osteoporosis, a previous fracture, prolonged steroid use or metastatic bone cancer)
   - **C**OAGULATION – Patients with bleeding disorders, use of anticoagulants or underlying clinical conditions
   - **S**URGERY – Post-surgical patients, (i.e., recent lower limb amputation or recent, major abdominal or thoracic surgery, minor surgery as appropriate)

B. **The Morse Fall Scale (MFS) Screening Tool for Risk of Falling**

The items in the scale are scored as follows:

History of falling: This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

Secondary diagnosis: This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.

Ambulatory aids: This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.

Intravenous therapy: This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.

Gait: A *normal gait* is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a *weak gait* (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an *impaired gait* (score 20), the patient may have difficulty rising from the chair,

attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.

Mental status: When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the nursing assessment, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing assessment or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.

Scoring and Risk Level: The score is then tallied and recorded on the patient's chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

MFS Risk Level Scores:

- 0-24 Low Risk
- 25-45 Moderate Risk
- 46 or > High Risk

Morse Fall Risk Assessment		
Risk Factor	**Scale**	**Score**
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / Walker	15
	None / Bed Rest / Wheel Chair / Nurse	0
IV / Heparin Lock	Yes	20
	No	0
Gait / Transferring	Impaired	20
	Weak	10
	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

Morse Fall Score	
High Risk	≥ 46
Moderate Risk	24 – 45
Low Risk	0 - 24

Implement Universal Fall Precautions on Moderate Scores up to 45.

For MORSE Fall Scale (MFS) ≥ 46:

Implement ALL Universal Fall Precautions + Moderate-High Fall Risk Prevention Interventions:

- Fall alert indicated by yellow light alert illuminated by call system (where applicable)
- Place non-skid slippers and Fall Risk arm bracelet per facility protocol
- Fall prevention education with patient/family
- Room close to nurse station if possible given census/unit needs
- Elimination needs assessed at least hourly (bi-hourly at night)
- Supervised toileting as indicated (patient privacy will be considered, however, **a patient may not be left during toileting if they are at high risk for falling**).
- Gait Belt
- Physical Therapy consult if applicable
- *Exiting Alarm
- *Specialty low bed
- *One to one observation

Review adult in-patient and out-patients admitted to an in-patient unit, using the ABCs for Injury Risk Identification as well as the Morse Fall Risk Scale and document in the EMR

- On admission
- Every shift
- Change in patient's condition
- Change in level of care
- After a fall event

Special Considerations for Outpatient Departments:

A. Help the patient when applicable. For instance, if assist device in use, ensure patient is adept at using, and a staff member is close by to help observe and assist.
B. Wheelchair use: if the patient appears to need a wheelchair and does not have one, obtain a wheelchair from the registration area and assist the patient to the location in which their care is to take place.
C. Assistance in and out of vehicle: when appropriate, and ensuring adequate help is available, assist the patient in and out of the private or commercial vehicle (cab, taxi, Lyft, etc.)
D. Ask for help: if your outpatient area lacks enough staff to cover high fall risk transfers, call department leadership to obtain help. This may prevent a fall.
E. If a patient does fall: call for assistance based on your existing assistance alert mechanisms (RRT, 911, etc.).

Include additional factors to understand the patient's risk of falling:

Intrinsic risk factors:

Medical History – Review medical history for physiologic alterations that increase the risk for falling: impaired memory and cognition, osteoporosis, osteoarthritis, decreased hearing, decreased night vision, cataracts or glaucoma, orthostatic hypotension, impulsive nature, failure to adhere to instruction, decreased balance, slowed nervous system response, history of stroke or parkinsonism, incontinence, and decreased energy or fatigue.

Medication – Prescribing providers, and/or pharmacist and nursing review patient's history for use of prescription and/or over-the-counter medications that may cause physical or cognitive impairment and lead to falls: nurses are to take special care when patients are given medication that is known to increase

the propensity to fall.

These medications include, but are not limited to:

- new antihypertensives/anti-arrhythmic (causes lower blood pressure, which increases fall risk)
- diuretics (patient will need to increase bathroom usage and will have urgency)
- pain medications (can alter level of consciousness)
- sleep medications
- controlled substances

Nurses and pharmacists should collaborate on both reconciliation of existing medication, as well as when new medications are started in the inpatient setting. Nurses should also advise nursing assistants that patient is on medication that can lead to a higher risk of fall.

Extrinsic factors:

Extrinsic risk factors that may pose a threat to safety:

- improperly lighted room
- obstructed walkway
- clutter of supplies and equipment, such as cords and IV lines, telemetry cords

Bedside Mobility Assessment Tool (BMAT)

The BMAT is a tool designed for nurses to assess patient mobility in acute care. The BMAT allows nurses (and other healthcare workers) to determine the appropriate patient handling and mobility equipment or device to safely move or mobilize the patient.

- Assessment level I : Sit and Shake
- Assessment Level II: Stretch and Point
- Assessment Level III: Stand
- Assessment Level IV: Walk

Each BMAT level safely tests a patient's mobility. The patient must complete all parts of each level of the assessment to pass to the next level. Assessment levels are below.

Assessment Level 1: Sit and Shake-verifies patient has adequate sitting balance and strength	
Sit	Determines whether patient is able to follow commands and has adequate balance and core strength for sitting.
Shake	Determines patient's upper extremity strength and spatial orientation.

Assessment Level 2: Stretch and Point-verifies patient has adequate lower extremity stability and strength	
Stretch	Tests for minimal quad muscle strength to stand. If patient does not have adequate quad strength, it is not safe to ask patient to stand.
Point	Tests for foot drop. If unable to complete, consider asking physician for PT consult.

Assessment Level 3: Stand-verifies patient has adequate upper and lower extremity stability and strength	
Stand	Tests patient's ability to move into standing position and maintain balance for 5 seconds unassisted.

Assessment Level 4: Walk-verifies patient has sufficient strength and balance	
Walk	Marching in place with each leg tests for balance and leg strength and stability in standing. If the patient is unable to complete safely, ask patient to sit.
Advance and return step	Stepping forward and back with each leg tests patient's endurance and ability to shift weight for transfers and walking. Many patients fall because endurance and ability to return to bed or chair is not tested.

Communication:

Communicate the patient's risk of injury and/or risk of a fall across the continuum of care and disciplines as a team approach by using shift huddles, state of the unit reports, leader rounding, and bedside shift report.

Patient/Family Education:

- Determine what patient and/or family knows about risks for falling and steps he or she takes to prevent falls.
- Educate the patient and family members about risk for fall, the interventions in place at the hospital, and interventions to consider for home care; risk of injury from a fall on admission and throughout the hospital stay and their specific role in helping to prevent a fall and potential injury.
- Document education in the EMR.

Process in the event a fall does happen:

- Evaluate the patient and stabilize
- Complete a **Post Fall Huddle**. **To be led by senior nurse at the scene**; staff discusses the fall (whoever found patient, Charge RN, Primary RN, any other staff as appropriate). Evaluation of circumstances and consequences of the fall by primary nurse.
- Complete an incident report in IRIS. Document as many components as possible in a thorough manner. Scan a PDF version of the Post Fall Huddle into the IRIS report or email to unit manager.
- Document Fall in the Electronic Health record in a very thorough manner.
- Notify the provider and family as soon as possible.
- **All falls should be reported as safety events immediately, which includes notification of the manager responsible for the unit 24/7.**

References: PolicyStat: Fall Prevention, Code Fall and Post Fall Care

Health Literacy

Definition: a patient's ability to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Low health literacy is more prevalent among:

- Older adults
- Minority populations
- Those who have low socioeconomic status
- Medically underserved people

Reasons for a Patient's low health literacy:

- Health care providers use words patients don't understand
- Low educational skills
- Cultural barriers to health care
- Limited English Proficiency (LEP)

Instances when patients with low health literacy may have difficulty:

- Locating providers and services
- Filling out complex health forms
- Sharing their medical history with providers

- Seeking preventive health care
- Knowing the connection between risky behaviors and health
- Managing chronic health conditions
- Understanding directions on medicine

Impact on Patients with Low Health Literacy:

- Use fewer preventive services
- Have more hospitalizations
- Have more ED visits
- Have poorer health outcomes
- Show higher mortality rates
- Make more medication errors

Strategies to Improve Patient Understanding

- Identify patients with limited literacy levels
- Use simple language, short sentences and define technical terms
- Supplement instruction with appropriate materials (videos, models, pictures, etc.)
- Ask patients to explain your instructions (teach-back method) or demonstrate the procedure
- Ask questions that begin with "how" and "what," rather than closed-ended yes/no questions
- Organize information so that the most important points stand out and repeat this information
- Reflect the age, cultural, ethnic and racial diversity of patients
- For Limited English Proficiency (LEP) patients, provide information in their primary language
- Improve the physical environment by using lots of universal symbols
- Offer assistance with completing forms

10 Elements of Competence for Teach-Back

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

Examples of Plain Language

Health Care language	**Plain Language**
Annually	Yearly or every year
Arthritis	Pain in joints

Cardiovascular	Having to do with the heart
Dermatologist	Skin Doctor
Diabetes	Elevated sugar in the blood
Hypertension	High blood pressure

When Plain Language isn't enough

To ensure that the intended users of health information understand it, communicators must know how to reach them. Writing and speaking clearly are critical steps to achieve that goal. At the same time, communicators must also be aware of additional barriers to understanding. Intended users of the information may speak a different language or be unfamiliar with the situation; there may be critical cultural differences between sender and receiver; and intended users may have communication or development disorders.

Limited English Proficient speakers – Plain English won't necessarily help individuals who do not speak English as their primary language and who have limited ability to read, write, speak, or understand English. Simply translating health information, such as written medical instructions, into a person's native tongue does not guarantee that non-English speakers will be able to read or understand it. To better ensure understanding, health information for people with limited English proficiency needs to be communicated plainly in their primary language, using words and examples that make the information understandable in their language.

Cultural differences – Culture affects how people understand and respond to health information. In addition to the use of plain language, the cultural competency of health professionals can contribute to health literacy. The Office of Minority Health, U.S. Department of Health and Human Services, defines cultural competency as the ability of health organizations and practitioners to recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations, and apply that knowledge to produce a positive health outcome. Cultural competency includes communicating in a manner that is culturally and linguistically appropriate.

Lack of knowledge and experience – People with limited health literacy skills often also lack knowledge or have misconceptions about critical health topics, such as the body, its functioning, and the nature and cause of disease. Without accurate and appropriate knowledge, they often fail to understand the importance of lifestyle factors—diet and exercise, for example. They may read commonly used directions, like "take on an empty stomach," and not understand what the terms mean. Even with clear directions, if the audience has no context or prior experience, they can still misunderstand. For example, when instructions say, "Give two drops, three times a day for earache," it may not be clear whether the drops should be swallowed or placed in the ear.

Communication and developmental disorders – Plain language and other clear communication techniques may not be effective or appropriate for audiences with communication or developmental disorders. Approximately one in six Americans has a disorder or difference in communication resulting in unique challenges. There are also challenges for individuals suffering with mental health diseases and disorders that impair or obstruct clear communication, no matter how plain the language. These individuals will require strategies that are tailored to their needs and abilities. Developing improved ways

to communicate health information to these audiences is a crucial component to addressing health literacy.

References: https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html; https://www.cdc.gov/healthliteracy/learn/index.html; https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy; https://www.ahrq.gov/health-literacy/index.html

Human Trafficking

Purpose:

The purpose of this policy is to provide guidelines for a consistent approach in the identification, assessment, and referral of human trafficking victims in the inpatient and outpatient settings.

Policy Statement:

1. The organization is committed to recognizing and addressing the impact of human trafficking on patients' overall health status and immediate safety.
2. Patients believed to be victims of human trafficking will be reported to facility appropriate individual(s) for referral to community resources.

Definitions:

- **Abuse** - The infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.
- **Adult:** A person eighteen (18) years of age or older.
- **Child:** A person under the age of 18.
- **Human Trafficking: D**efined by Kentucky Law KRS 529.010 as "criminal activity whereby one or more persons are subjected to engaging in:
    - Forced labor or services; or
    - Commercial sexual activity through the use of force, fraud, or coercion, except that if the trafficked person is under the age of eighteen, the commercial sexual activity need not involved force, fraud, or coercion."

Guidelines:

Adult:

A. When a patient/visitor is suspected of being a human trafficking victim:
    1. **Talk to the patient/visitor in a safe confidential environment.** If the person has a preferred language other than English, utilize only Organization approved interpreter services to ensure accurate and effective communication, as well as cultural appropriateness.
    2. Before questioning a person who may be a victim of human trafficking, separate them from the person accompanying them, since this person may be the trafficker posing as a spouse, family member or employer.
B. If patient/visitor consents to reporting, contact facility appropriate individual: i.e. Administrator on Call, Social Services, or Care Management.
C. If patient/visitor **wishes to report** that they are a victim of human trafficking to police, staff will notify local law enforcement or appropriate authorities.

Child

When a child is suspected of being a human trafficking victim, a report is made to the Cabinet for Health

and Family Services (CHFS) Child Protective Services (CPS), in accordance with Kentucky law.

Potential Signs of Human Trafficking

- Clinical presentation and oral history don't match up
- Oral history is scripted, memorized or mechanical
    - Lying about age
    - False Identification
    - Lack of knowledge of location (due to frequent movement)
- Someone with the patient exerts an unusual amount of control over the visit
- Patient appears fearful, anxious, depressed, submissive, hypervigilant or paranoid
- Patient is concerned about being arrested or jailed
- Patient is concerned for his/her family's safety
- Tattoos or insignia's indicative of ownership
- Evidence that care has been lacking for prior or existing conditions
    - Urgent problems:
        - Malnutrition
        - Dehydration
        - Chemical exposure
        - Traumatic injuries (Traumatic Brain Injuries, old bone fractures, cuts, bruises, punctures, burns)
        - Respiratory problems
        - Skin infections
        - GI problems
        - Withdrawal from addictive substances
        - PTSD
        - Hostility
        - Depression
        - Suicidal ideation
    - Other problems:
        - Headaches
        - Dizzy spells
        - Sexual health problems
        - Memory problems
        - Back pain
        - Fatigue
    - Dental injuries
    - Infectious diseases not usually seen in immunized individuals
        - Polio
        - Measles
        - Tetanus
        - HIV (particularly in young girls)
    - Sexually Transmitted Infections
    - Occupational-type injuries or physical ailments linked to their work
        - Repetitive use injuries

Tips for Working with Trafficking Victims in the Hospital Setting

- Get as much information as you can about the patient.

    - Phone number of “Escort”
    - License plate number (if possible)
    - Photograph patient to document any injuries, if possible
- Separate suspected trafficking victims from anyone accompanying them prior to assessing their safety.
- Consider placing trafficking victim under an alias.
- Notify hospital security of any safety concerns regarding trafficking victims
- Use CHI Saint Joseph Health approved interpreters to communicate with victims of trafficking.
- Ask general questions and then move to questions like:
    - “Are you being controlled by the person who brought you here?”
    - “Are you involved in activities you would like to stop?”

Questions to ask potential victims of human trafficking:

- Who is the person who came in with you today?
- Can you tell me about them?
- Were you ever promised something and it didn’t happen?
- Has anyone taken and kept your passport or other legal papers?
- What are your living conditions?
- Are you able to leave your job and find another job if you desired to?
- Are you able to leave your room when you want or are you locked in?
- Do you have to ask permission to go to the bathroom?
- Are you able to shower or take a bath as often as you would like?
- Are you in any physical danger?
- Has someone threatened you or your family?
- Do you owe anyone any debts?
- Do you have to work or do something you don’t want to do to pay that debt?
- Does anyone ever monitor your conversations with family or friends?
- Do you ever feel pressured to do something you don’t want to do?
    - How do you feel pressured?
- Do you feel you were tricked or lied to?
- Has anyone ever threatened you?
- Has anyone ever physically abused you?
- Have you ever had to trade sex for money or something else you needed?
- Do you have to meet a quota of money each night before you return home?
- Have you ever been told to have sex with someone you don’t want to have sex with?

Reference: PolicyStat: Suspected Victims of Human Trafficking

Intentional Hourly Rounding

Every hour, we will be performing a purposeful, effective, INTENTIONAL hourly round on our patients. During these rounds, we should explain that we are “here for our hourly rounding”.

1. Hourly Rounding Protocol is as follows: hourly, from 7am until 10pm; then every 2 hours from 10pm until 6am.
2. The licensed nurse assigned to the patient will be responsible for ensuring that hourly rounding is completed. While this task may be delegated to a patient care assistant on an every other hour basis,

the nurse should see the patient at least every other hour for the duration of his or her shift. At the beginning of each shift, remind the patient that someone on the unit team should be doing hourly (or bi-hourly during night time hours listed above) rounds. Use team work to accomplish this goal.

3. Each hour, the patient will be rounded on to assure that their needs are met, focusing on the 6 Ps (pain, potty, position, possessions, pump, plan of care). While it is understood that rounds cannot be conducted exactly 60 minutes apart, someone should check on the patient at some point during each hour of the shift.
    - Accurate I/O must be maintained with each hourly rounding. Amounts for all intake and output should be documented at this time. If your patient requires assistance to the restroom, offer assistance. Patients should be offered toileting with each hourly round.
    - Positioning: Regardless of your patient's functional status, patients should be encouraged to change position each hour. If the patient is bedbound, he/she should be repositioned every 2 hours at hourly rounding times.
    - Personal Possessions: Prior to leaving the patient's room, all personal belongings should be secured or within the patient's reach. Also, ensure the bedside table is free of debris (trash, empty bottles, etc.) and that the bedside table is within reach
    - Pump: Prior to leaving the room, all RNs should assess the IV pump. Assess your IV site as well.
4. Use AIDET (announce, introduce, duration, explanation, and thank you) every time you encounter the patient. Scripting example: "Hello Mrs. Jones, I am Mary. I am here to do my hourly rounds and check your needs. Thank you. Is there anything else I can do for you? I have the time."
5. Perform scheduled tasks during your rounds. This allows for inclusion of your scheduled work in the rounding process so that you save yourself time and address needs and tasks concurrently.
6. Use the components of the 6 Ps pro-actively during each round. This will ultimately reduce call lights, patient falls, decubiti, and enhance the patients' sense of comfort. This process is also known as *meaningful or **intentional** hourly rounding*.
7. Always inform the patient when someone will return. This doesn't have to be a precise time, but can be an estimate i.e. "someone should be back in the next 35-40 minutes." This helps the patient begin to cluster their need requests around your rounds.
8. Document the round on the white board if the patient is asleep, incapacitated, out of the room, and/or has no family is in the room. That ensures to both parties that rounds were completed, even if they were sleeping or unaware.
    - Update the Plan of care
9. If the patient is asleep, do not wake the patient up. You should still do the environmental check and document the rounds. Ensure the environment is free of clutter, spills, etc. and that all possessions will be in reach once the patient does awaken.
10. When addressing the pain, update the pain score on the white board to help you and the patient determine the effectiveness of both pharmacological and non-pharmacological interventions. Use the Pain Clock so the patient is aware of when they may ask for additional pain medication. This also shows the patient you are concerned about their pain.
    - Should the patient tell a CNA they are having pain, that CNA should notify the patient's nurse immediately
11. Round in an intentional manner: the RN or PCA doing the rounding should prompt patients for the 6PS. I.e. "Mrs. Smith, you have not been up to the bathroom for a while, shall we go ahead and try to use the bathroom while I am here?" or "Mr. Jones, I see that you are about due for another round of pain medication, how is your pain level now?"

Reference: PolicyStat: Patient Care Bundle – Guidelines for the Patient Experience

Incontinence Guidelines

Moisture control:

A. Perform perineal care as soon as possible after toileting and each episode of incontinence; choosing appropriate skin care products according to patient indication.
B. Institute measures to manage moisture.
    1. Patients who have deep skin folds need increased attention to cleansing of those skin folds and keeping area clean and dry.
    2. Patients who are diaphoretic need increased attention to keeping the skin clean and dry.
C. Institute measures to control and contain incontinence.
    1. Fecal management systems as appropriate
    2. Urine management systems as appropriate
    3. Do not use diapers except for ambulation of incontinent patients. Remove when patient is placed back in bed.

Incontinence Guidelines	

	**Episode of Incontinence**
	• Use Aloe-Vesta 3-in 1 Cleansing Foam to cleanse the skin with each episode of incontinence, dry well.
	• If patient experiences multiple episodes of incontinence in 24 hours, if skin appears red or breakdown is observed, apply a thin layer of Aloe Vesta 3 Protective Ointment after cleansing.
	  ○ If fungal infection observed, replace Aloe-Vesta 3 with Antifungal Cream or Powder
	  ▪ Requires MD order
	• For severe Incontinence Associated Dermatitis replace Aloe-Vesta 3 with Remedy Calazime Skin Protectant with Zinc

	**Moisture Control** • Use one disposable underpad and draw sheet under the patient (Limit layers of linen). • Provide frequent incontinent checks (recommend minimum Q2H) • If increased moisture noted to skin folds, Cut to fit InterDry Ag. Place in the skin folds, leaving a 2" overhang to wick moisture. Change Q5 days and PRN. Do not rinse textile.
	**Fecal Incontinence** • Consider bowel training as able • Consider application of Rectal Pouch • Consider Fecal Management System (FMS) if patient has frequent liquid stool. ○ MD order required

	• Urinary Incontinence
	• Consider bladder training as able (scheduled toileting)
	• Consider toilet substitutes such as urinals and commodes.
	• Consider Purewick
	  ○ Does not require MD order-Refer to policy
	• Consider Condom Catheter
	  ○ Does not require an MD order-Refer to policy
	  ○ To be changed Q24 hours and PRN

References: PolicyStat: Catheter Associated Urinary Tract Infection (CAUTI); External Female Catheter Device; External Male Catheter (Condom Catheter); Skin and Wound Assessment and Management

Informed Consent

To ensure that patients and their physician or other health care providers engage in a collaborative relationship to support and foster informed consent for **any and all medical procedures and treatments**.

Decision-making capacity: the ability of a patient to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions and to evaluate them in relation to personal preferences and priorities, i.e., the ability to understand the nature and severity of one's illness, the potential benefits, risks, and side effects of the proposed treatment, reasonable alternatives to the proposed treatment and their risks, benefits, and side effects, and the risks related to not receiving the proposed treatment. Decision making capacity is contingent:

- **Task specific.** Deciding if the patient is decisional means weighing the degree to which the patient has decision making capacity against the objective risks and benefits to the patient. Some decisions are more complex than others, requiring a higher level of decision-making capacity. Thus a moderately demented patient may be able to make some decisions (e.g. antibiotics for pneumonia) but not others (e.g. chemotherapy for metastatic lung cancer). This sliding scale view of decisionality holds that it is proper to require a higher level of certainty when the decision poses great harm.
- **Time specific**. e.g., when encephalopathic, a patient may not be decisional; after treatment decisionality may be regained.

I. A patient is presumed to possess decision-making capacity, except in those circumstances where exceptions apply (see Section 6). If there is a question or concern regarding a patient's decision-making capacity, the patient's primary physician is responsible for determining whether the patient has the capacity to make health care decisions. The following may be helpful to a physician to deem a patient 'decisional,' a physician must be satisfied that a patient is able to do three tasks:

   a. Receive information,
   b. Evaluate, deliberate, and mentally manipulate information, and
   c. Communicate a treatment preference.

Commentators suggest that physicians look for:

a. Understanding. Does the patient adequately understand the information about the risks, benefits, and alternatives of what is being proposed? The patient does not have to agree with your interpretation, but should be able to repeat what you have said. Ask, Can you repeat to me the options for treating X I have just discussed with you? Can you explain to me why you feel that way? What is your understanding of what will happen if we don't do Y?

b. Logic. Is the logic the patient uses to arrive at the decision "not-irrational"? One wants, as much as possible to make sure the patient's values are speaking, rather than an underlying mental or physical illness. Note: Severe depression or hopelessness will make it difficult to interpret decisionality; consult psychiatry for assistance with this or other complex cases.

c. Consistency. Is the patient able to make a decision with some consistency? This means not changing one's mind every time one is asked. Is the decision consistent with the patient's values? If there is a change in the patient values, can the patient explain the change?

II. If a patient is determined to lack decision-making capacity, the patient's best interests are to be protected. To the extent possible, the patient will be included in the informed consent process because people with impaired decision-making capacity may still possess some ability to comprehend, communicate, and express a preference.

If an adult patient whose physician has determined that he/she does not have decisional capacity has not executed an advance directive, or to the extent the advance directive does not address a decision that must be made, any one of the following responsible parties, in the following order of priority if no individual in a prior class is reasonably available, willing, and competent to act, shall be authorized to make health care decisions on behalf of the patient:

a. The *judicially-appointed guardian* of the patient, if the guardian has been appointed and if medical decisions are within the scope of the guardianship;
b. The attorney-in-fact named in a *durable power of attorney*, if the durable power of attorney specifically includes authority for health care decisions;
c. The *spouse* of the patient;
d. An *adult child* of the patient, or if the patient has more than one (1) child, the majority of the adult children who are reasonably available for consultation;
e. The *parents* of the patient;
f. The *nearest living relative* of the patient, or if more than one (1) relative of the same relation is reasonably available for consultation, a majority of the nearest living relatives.

III. The ordering physician (or anesthesia provider, in the case of administration of anesthetic) discusses with the patient (or surrogate for health care decisions, when applicable):

a. The patient's proposed care, treatment, and services;
b. Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation;
c. Reasonable alternatives to the patient's proposed care, treatment, and services;
d. Risks, benefits, and side effects related to the alternatives; and
e. Risks related to not receiving the proposed care, treatment, and services.

I. Personal interaction between the patient and the physician or other health care provider is necessary for good communication so that decisions are based on mutual understanding and are not made wholly by the patient or by the physician. The process of informed consent is enhanced by:

- Establishing trust between the patient and the health care provider
- Presenting medical information in a concise and understandable manner
- Eliciting the patient's personal goals and values
- Allowing the patient time to assimilate information
- Encouraging questions and expression of feelings
- Repeating information, as needed, to achieve understanding
- Being alert to obstacles to understanding, e.g., stress of hospitalization, limited intellectual capacity, hearing limitations, primary/preferred language, cultural or religious preferences.
- Assessing the patient's understanding of the information, e.g., by asking the patient to summarize and/or repeat back.

II. If the patient's preferred mode of communication is other than English, a hospital-approved medical interpreter will be made available to provide interpretation in the patient's preferred mode of communication. This interpretation may be in person or via a certified interpretation service phone; whichever form is most readily available per Provision of Services for Limited-English Proficient (LEP), Deaf/Hard of Hearing, and Blind/Visually Impaired Individuals
Most Consent forms are available in Spanish and, when available, are to be provided to those whose preferred language is Spanish along with the services of a hospital-approved medical

interpreter. The English-language consent form is the version to be completed, signed and included in the patient's medical record along with documentation of interpreter use.

III. Documentation of informed consent process

a. All discussions, consultations, and decisions are executed by the licensed independent provider and be clearly documented in the patient's medical record.

b. The completed consent form is a permanent part of the medical record.

   i. Consent for surgical or medical procedure may be obtained by the provider prior to the patient being admitted to the hospital or in the PASS/PAT clinic, providing the consent is obtained within 30 days from the time of the procedure.

   ii. A physician order to set-up blood and/or blood products must be in the patient's medical record prior to obtaining the patient's (or surrogate for health care decisions, when applicable) consent.

   iii. A physician order to obtain consent for surgical or medical procedure **should NEVER be given as a verbal order and should always be entered in the medical record by the physician.** The consent form should have the procedure clearly written, with no abbreviations used.

c. Documentation, in the patient's chart or on the consent form, will include evidence that the patient (and/or surrogate for health care decisions, when applicable) has been given and understands the following information:

   i. the full name of the physician ordering the procedure/treatment;

   ii. the full name of the health care provider who discussed the procedure with the patient (and/or surrogate for health care decisions, when applicable);

   iii. If utilized, the full name of the certified medical interpreter; if utilizing a face to face medical interpreter, document the interpreter full name and language used, if using a phone interpreter, document the interpreter ID number and language used.

   iv. if applicable, the presence of any vendors/observers who may be present during the procedure/treatment for observation and/or verbal instructional purposes only (e.g., other physicians, nurses, nursing students, participants in authorized educational and training program and/or vendors);

   v. the patient's proposed care, treatment, and services - written in full; abbreviations are **not** used;

   vi. potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation;

   vii. reasonable alternatives to the patient's proposed care, treatment, and services;

   viii. risks, benefits, and side effects related to the alternatives; and

   ix. Risks related to not receiving the proposed care, treatment, and services.

d. The patient's (or health care surrogate's) signature, date, and time of signing is required on written consent forms. The signature is witnessed by the physician conducting the informed consent discussion (or the physician's designated physician assistant or advance practice registered nurse) or by a hospital clinical staff person. Note that the hospital clinical staff person is only witnessing to the patient (or health care surrogate) signing the form.
   If the patient has decision-making capacity but is unable to write, he or she may indicate consent by making an "X" on the consent form in lieu of signature; in such a case, two (2) witnesses are necessary and must sign the form as witnesses.

IV. Exceptions to obtaining informed consent **prior** to medical treatment / procedure

a. The patient should **not** be administered any medications such as narcotics, sedatives, or hallucinogens for four (4) hours prior to giving consent. If, however, in the judgment of the practitioner, the patient is deemed to have decision-making capacity despite receiving medications, the patient may then give his/her own consent. Such exceptions must be documented in the progress notes and noted on the consent form itself.
b. An emergency is a situation in which immediate medical treatment is necessary to prevent jeopardy of life, health, limb, disfigurement or impairment of faculties. It also applies where unanticipated conditions discovered during the course of a procedure, which, if not immediately corrected, would threaten life or health of the patient, and the consent of the patient or authorized patient representative is not obtainable at the time.
c. Consent is "implied" when emergency treatment is necessary. Kentucky statutes indicate that "in an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services, there is no requirement that a health care provider obtain a previous consent" [KRS 304.40-320].
d. Attempts must be made to obtain consent prior to proceeding with any treatment. In an emergency situation where consent cannot be obtained, the health care provider must document in the patient's medical record the emergency nature of the patient's condition, including the ramifications to the patient's care and urgency of proceeding without consent.

V. Consent by Telephone

Consent via telephone is obtained only when it is necessary to obtain consent from the legally authorized representative or next of kin and the designated individual is physically unable to be present to sign the consent form prior to the treatment or procedure. Two (2) hospital personnel must listen to the oral consent by telephone, document on the consent form that it was obtained via telephone and sign as witnesses. At least one of the hospital personnel must be a licensed health care professional.

VI. Patient's Right of Refusal

A patient who has capacity for decision making (and/or surrogate for health care decisions, when applicable) has the right to refuse or withdraw consent for any medical treatment or procedure. A patient's (and/or surrogate for health care decisions, when applicable) refusal or withdrawal of consent must be honored and adhered to. The healthcare provider will be notified of the patient's (and/or surrogate for health care decisions, when applicable) refusal or withdrawal of consent.

Reference: PolicyStat: Consent and Informed Decision Making

Interpretive Services

Provision of Services for Limited-English Proficient (LEP), Deaf/Hard of Hearing, and Blind/Visually Impaired Individuals

As a federal fund recipient under the Title VI of the Civil Rights Act of 1964, Executive Order 13166 and TJC Standard **RC.02.01.01**, **CHI Saint Joseph Health** is required to offer limited English- proficient patient **and** their families free and qualified language services. Once a patient/family member is identified as needing an interpreter, they are presented with a form that explains their right to a free, qualified/licensed interpreter. They are free to choose an interpreter of their own as long as the person is 18 years of age or older. The hospital is responsible for the quality of that interpretation and

employees should feel free to call interpretative services as needed. **Only under emergency circumstances should a child under the age of 18 be used.**

When a limited-English proficient or deaf/hard-of-hearing patient presents for registration, the following procedure should be followed:

- The Patient Access Registrar will determine the primary language of the patient, by using Culturalink phone services, if the patient does not present with an English-speaking representative.
    - The Registrar will ask the Patient "In what language do you prefer to receive your health care?" through the English interpreter present and/or through the Culturalink phone services, using the patient primary language.
    - If the answer is other than English, the patient will be asked in his or her preferred language "Do you want a trained medical interpreter available to you?"
- If the Patient refuses the hospital language services, the registrar will have the patient sign the Services for Limited-English Proficient Patients and/or Services for Deaf/Hearing Impaired Waiver Form, available in (English and Spanish), which explains these services are free of charge, and if they use the services of another person they must be at least 18 years of age, etc.
- All patients whose preferred language is other than English and have requested hospital language services, a (Blue) Interpreter Needed Form with the language identified will be place along with their paperwork.
- If the Patient preferred language is other than English, the registrar will be required to place a (Blue) dot on the patients ID band, identifying the preferred language. (Using the Language Abbreviation listing).
- The Registrar must contact Interpretive Services to obtain the appropriate language interpretive service for the patient.
- The Registrar must contact Interpretive Services to obtain the appropriate language interpretive service for the patient.
    - For Medical Interpretation in Spanish: Call Lynn Fors, Ext. 1510, Beeper 599, Monday – Friday from 9 a.m. – 5 p.m.
    - All other hours: Refer to the Language Line Services at 1-800-874-9426.
    - For all other languages refer to the Language Line Services at 1-800-874-9426.
    - For all Deaf Inquiries refer to the Deaf or Hearing Impaired procedure on the N drive.
    - The Registrar will be required to entering the corresponding code in the (Staff Alert (LEP/Limited English Proficiency), on in the miscellaneous page is STAR Processor. To identify All Limited English Proficient preferred language needs in Star Navigator.
- All Waiver Forms will need to be scanned in Cerner scanning system under the Consent for Treatment folder. Original copies will be attached to the patient paper work.
- With Telephone Interpretive Services, routine issues can be dealt with in a matter of minutes and it may be the only way when it comes to less common languages
- With Telephone Interpretive Services you have immediate access to an interpreter Face to Face interpretation is more economical when it comes to teaching situations that will last one hour or more On-site interpreters may be more appropriate when dealing with cultural issues or in circumstances that are sensitive in nature such as worsening medical conditions, end-of-life care and decision-making, and fetal demise.

To arrange for a face-to-face interpreter within the same day or in less than 24 hours, please call CHI Saint Joseph Health Language & Interpreter Services at 859.313.4556.

To schedule a face-to-face interpreter 48 hours ahead, fill out the Interpreter Request Form.

In an email request to Language Services, include all of the following appointment details:

- Date
- Time
- Duration
- Facility/practice name
- Facility/practice address
- Type of appointment
- Language needed
- Patient's name
- Patient's date of birth

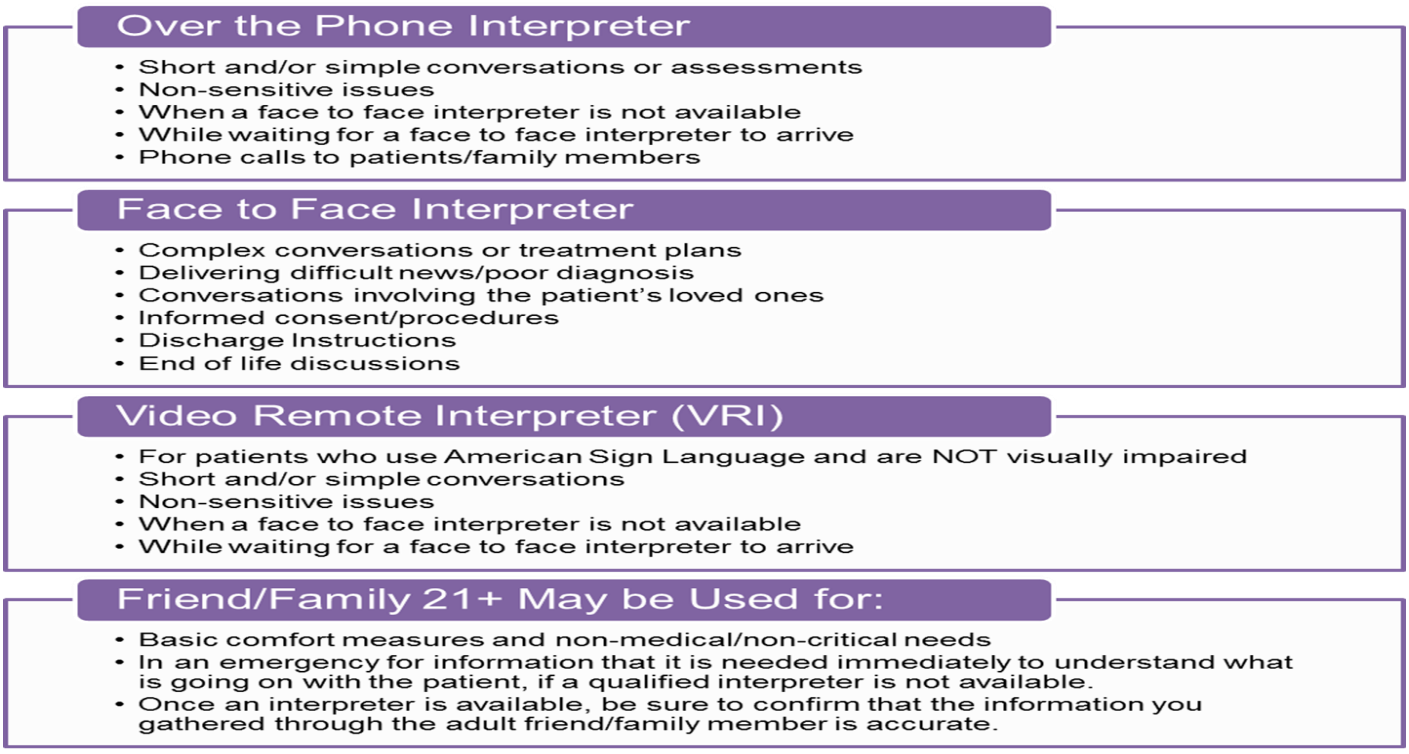
You can access an over-the-phone interpreter 24/7 by calling:

- Primary over-the-phone interpreter line (Culturalink): 1.888.243.0699 (access code assigned to your department).
- Backup over-the-phone interpreter line (LSA): 1.877.274.9745 access code 1004655

FOR FLAGET ONLY:

- Language Services – FMH calls the following
- Over The Phone Primary: 1-844-350-0198
- Over the Phone Backup: 1-877-274-9745 Access code 1004655
- Face to Face: 1-859-313-4556 (Dot Kerr)

Reference: PolicyStat: Communicating with the Limited-English Proficient (LEP) patient

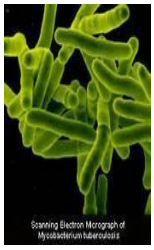


Infection Control

Blood-borne Pathogen Control Plan:

Prevention of blood borne pathogen exposures is the responsibility of all healthcare providers. The routine use of hospital standard precautions and work practice and engineering controls, such as personal protective equipment and sharp safety products ensure your safety.

- Perform Hand Hygiene before and after each contact with patient or patient's environment (see CHI Saint Joseph Health Hand Hygiene Policy in PolicyStat for additional information)
- Use Standard Precautions for all patients (see Policy Stat Isolation: Standard and Transmission Based Precautions)
- Use sharps safety products properly and place all sharps in the sharps containers
- Place medical waste in labeled red bags and contain when transporting
- Wear personal protective equipment (PPE) such as gloves, gown, and eye protection when there is a possibility of exposure to blood or any body fluids: remove prior to leaving area and perform hand hygiene
- Do not eat-drink-or apply lipstick/lip balm in areas when there is a possibility of exposure to blood or body fluids
- Handle soiled linen with care to prevent personal or environmental contamination
- Clean all patient care equipment between uses and patient environment regularly
- Contain and clean up any spill immediately
- Complete your Hepatitis B virus immunizations



Tuberculosis Control Plan:

The TB control plan applies to all healthcare settings of CHI Saint Joseph Health. Mycobacterium Tuberculosis causes tuberculosis that is spread through inhalation of droplet nuclei.

Prompt Detection

- All patients with suspected or confirmed active tuberculosis shall be placed in airborne infection isolation rooms (AII) as soon as possible or instructed on respiratory hygiene- cough etiquette
- Airborne infection isolation rooms meet AIA guidelines for negative pressure and exhaust. Monitors for each room allow all entering to ensure appropriate conditions are in place. **Doors are to be closed when in use.**
- Airborne precautions signs, outlining precaution steps, including PPE are posted on the isolation room door when in use
- Particulate filter respirators certified by NIOSH, N-95 masks are provided to healthcare workers. **Be sure to complete your Fit Testing each year as required.**
- Transport of patients with tuberculosis shall be kept to a minimum. During necessary transport, the patient shall be fitted with a surgical mask.
- Infection Control coordinates activities with outside agencies regarding tuberculosis case screening and evaluation of Healthcare Personnel at Risk for TB disease or exposure to *M. tuberculosis*

Hand Hygiene

Hand hygiene is the single most effective deterrent to the spread of infection. Hand hygiene includes hand washing, alcohol based hand cleansers, and the care of the skin, hands and nails. Partnering with

our patients and families is encouraged to enhance hand hygiene performance and increase the safety of our patients.

Healthcare workers will perform hand hygiene as follows:

A. Soap and water
   - Should be used primarily and whenever hands are visibly soiled or contaminated with blood or body fluids. Washing with soap and water requires a process that includes wetting the hands, applying soap with friction for at least 15 to 20 seconds, rinsing with water, and patting dry with clean paper towels.
   - Before Eating
   - After personal use of the toilet
   - After contact with stool, after caring for patients with ***Bacillus anthracis,*** *Clostridium difficile,* or active diarrhea

B. Alcohol-based Hand Sanitizer
   - Should be used if hands are not visibly soiled. Apply the appropriate amount (see manufacturer's recommendations) in the palm of the hand and rub hands to coat all surfaces. Rub until dry.

C. Non-oil or petroleum based hand lotions or creams
   - May be used by healthcare providers to minimize the occurrence of skin irritation.

D. In addition, hand hygiene must be performed:
   - Upon arrival at work, leaving and returning to work area
   - Before and after any direct patient contact
   - After contact with patient environment or equipment (Bedrail, bedside table, bedside commode, etc.)
   - When moving from a dirty patient care task to a clean task
   - Before caring for patients with severe neutropenia, or immune suppression
   - Prior to invasive procedure
   - Before and after eating, drinking, or smoking
   - Before and after gloves are used

Other Aspects of Hand Hygiene:

- Gloves should be used as an adjunct to, not a substitute for, hand hygiene.
- Gloves should be changed after patient care activities or procedures.
- Change gloves during patient care if moving from a contaminated body site to a clean body site. Perform hand hygiene.
- Remove gloves after patient care activity or procedure.
- Hands should be cleaned or decontaminated when gloves are removed and the hand-contaminating activity is completed.
- Disposable gloves are used only once and should not be washed for reuse.
- Keep natural nail tips neatly groomed and trimmed to ¼ inch in length.
- Do not wear artificial fingernails or extenders when having direct contact with patients.

Isolation: Standard and Transmission Based Precautions

Airborne Infection isolation Room(AIIR) - is a single-patient room that is equipped with special air handling and ventilation capacity that meet the American Institute of Architects/Facility Guidelines Institute (AIA/FGI) standards for AIIRs (i.e., monitored negative pressure relative to the surrounding area,

12 air exchanges per hour for new construction and renovation and 6 air exchanges per hour for existing facilities, air exhausted directly to the outside or recirculated through HEPA filtration before return).

Definitions:

- Blood - human blood, human blood components, and products made from human blood.
- Bloodborne Pathogens - pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Human Immunodeficiency Virus (HIV).
- Body Substance Isolation - is a system of barrier precautions for all body fluids developed in 1985 to protect HCP from known and unknown infectious risks. Precautions should be taken with all blood and body substances.
- CDC - Centers for Disease Control a federal government organization
- Contaminated - means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.
- Colonized - A person cultures positive with an organism, but has no disease or infection caused by the organism.
- Contaminated Laundry - means laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.
- Contaminated Sharps - means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.
- Decontamination - the use of physical or chemical means to remove, inactivate, or destroy microorganisms on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.
- Disinfect - means the use of a chemical procedure that eliminates virtually all recognized pathogenic microorganisms but not necessarily all microbial forms on inanimate objects.
  There are three levels of disinfection:
  - **High level** which kills all organisms, except high levels of bacterial spores with a chemical germicide sterilant per FDA
  - **Intermediate level** which kills mycobacteria, most viruses and bacteria with a chemical germicide registered as a tuberculocide by the EPA
  - **Low level** that kills some viruses and bacteria with a chemical germicide registered EPA disinfectant.

Standard Precautions

Standard Precautions combine the features of universal precautions and body substance isolation into a single set of procedures that apply to all patients regardless of their diagnosis or suspected infection status. Standard Precautions recognize the pathogenic importance of all blood, body fluids, secretions and excretions (except sweat), non-intact skin, and mucous membranes and are to be used in the care of all patients to reduce the risk of transmission of microorganisms from recognized and unrecognized sources of infection. Standard Precautions include the following:

- Hand Hygiene Hand hygiene is the single most important method of reducing the transmission of microorganisms. Hands will be washed/cleaned using soap and water or alcohol hand rub as promptly and thoroughly as possible between patient contacts and after contact with blood, body fluids, secretion, excretions, and contaminated equipment or articles. See Hand Hygiene policy for additional information.
- Personal protective equipment (PPE) - PPE provides a barrier to reduce the risk of infection in HCP

and to minimize HCP exposure to infectious agents or blood/body fluids that may contain infectious agents. PPE includes gloves, masks/respirators, gowns, face shields, eye protection and other protective items. PPE is available in patient care areas and is provided by the facility. All PPE will be removed prior to leaving the work area and will be disposed of appropriately. Any contaminated PPE will be removed as soon as possible after exposure.

- Patient Care Equipment - All patient care equipment that is soiled with blood, body fluids, secretions or excretions shall be handled and enclosed in containers or bags in a manner that will prevent skin and mucous membrane exposures. Single use, disposable items will be handled, transported, and disposed of in a manner that reduces the risk of transmission of microorganisms and decreases environmental contamination. Covered carts will be used to transport refuse to the collection area. Reusable critical medical devices or patient care equipment and semi-critical medical devices or patient care equipment and non-critical care equipment will be cleaned, sterilized or disinfected appropriately prior to use on another patient.
- Environmental Controls - All patient care areas and furnishings are routinely cleaned and disinfected using EPA registered products.
- Linen - Linen soiled with blood, body fluids, secretions and excretions will be handled, transported and processed in a way that prevents skin and mucous membrane exposure, contamination of clothing and the transfer of microorganisms to other patients and the environment.
- Sharps HCP will avoid injury when using needles, scalpels and other sharp instruments. Safety products will be utilized where possible. Used needles will not be bent, broken, manipulated, or recapped. All contaminated needles, syringes, scalpel blades and other sharp items will be placed in designated puncture resistant containers.
- Emergency resuscitation: HCP will not do mouth-to-mouth resuscitation. They will use mouthpieces, resuscitation bags, or other ventilation devices that are available in the facility.
- Patient Placement: Patient rooms are private and semi-private with hand washing and toilet facilities. The facility may cohort patients based on infection or disease. The pathology and laboratory departments will provide prompt, accurate patient results and notification of epidemiologically significant organisms.
- Respiratory hygiene and cough etiquette: cover mouth and nose with tissue when coughing or sneezing, provide masks and tissue as appropriate, complete hand hygiene after contact with respiratory secretions and contaminated objects/materials.
- Safe injection practices: HCP will follow recommended safe injection practices which include aseptic technique, hand hygiene, one time only use of needles and syringes to include finger stick devices. As available needleless system, single-dose/single use vials should be implemented. Follow medication handling guidelines for all single-dose/single use vials and multiple dose vials to include transporting, storing, preparing and administering medications, solutions and related supplies.

Transmission Based Precautions

Transmission based precautions are designed for patients documented or suspected to be infected or colonized with transmissible or epidemiologically important organisms for which additional precautions beyond standard precautions are needed. Standard precautions are always used in addition to the necessary transmission based precaution. Transmission based precautions contain adequate precautions for infections transmitted by the airborne, droplet or contact routes of transmission. Empiric use of transmission based precautions may be appropriate based on the clinical presentation and will be maintained until a definitive diagnosis is made. Transmission based precautions may be combined for a

disease that has multiple routes of transmission. Patient movement and transport of the patient is limited to essential purposes only. If the patient is transported out of their room, the appropriate transmission based precaution will be maintained to minimize the risk of transmission of microorganisms and contamination of environmental surfaces or equipment. Transmission based precautions include standard precautions plus the following:

Airborne Precautions

Airborne precautions are designed to reduce the risk of airborne transmission of infectious organisms or particles less than 5 microns in size by utilizing special air handling, ventilation and respirators. AIIR (formally negative pressure rooms) and rooms with HEPA filtration should have 6-12 air exchanges per hour. The AIIR room air is filtered prior to release to other areas of the hospital or is directly discharged outside. Airborne precautions are to be used for patients with suspected or diagnosed pulmonary tuberculosis, SARS, Varicella and rubeola viruses or other infectious agents.

Droplet

Droplet precautions are used for patients known or suspected to have serious illnesses transmitted by large particle droplets (larger then 5um in size) containing microorganisms. Transmission occurs when droplets containing microorganisms generated from the source person during coughing, sneezing, and talking or during procedures such as suctioning are deposited on the HCPs conjunctivae, nasal mucosa, or mouth. Because the droplets do not remain suspended in air and travel short distances (approximately 3 feet), no special air handling or ventilation is necessary. Masks are worn by HCP when working within 3 feet of the patient.

Contact/Contact Containment/Enteric

Contact/Contact containment/Enteric precautions are used for specific patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient or indirect contact with environmental surfaces or patient-care items in the patients' environment. Gloves and gowns will be used as a barrier to reduce the transmission of potentially infectious microorganisms. Additional prevention interventions maybe implemented for emerging pathogens, MDRO or Clostridium difficle See IC Management of Patients with MDRO or *Clostridrioides difficle* infection policies for additional information.

Empiric

Empiric use of airborne, droplet, and contact precautions is necessary for patients with certain clinical syndromes and conditions that have a high risk of epidemiology significant organisms. The empiric precautions will remain in place pending confirmation of diagnosis.

Transport of patients on Transmission based precautions:

Limiting the movement and transport of patients on transmission based precautions and ensuring that such patients leave their rooms only for essential purposes reduces the opportunity for transmission of microorganisms.

Signage:

Signs will be placed when transmission based precautions are in place. The Contact, Contact Containment, Enteric, Droplet and Airborne signs will be used as indicated to inform all HCP taking care of

the patient of the need for precautions. Patient, family and visitor education regarding precautions and the proper use of personal protective equipment will be provided.

References: PolicyStat: Bloodborne Pathogens Exposure Control Plan; Tuberculosis Protocol; Isolation: Standard and Transmission Based Precautions; Hand Hygiene; See Guidelines for Pregnant Healthcare Personnel for additional information about pregnancy and healthcare personnel

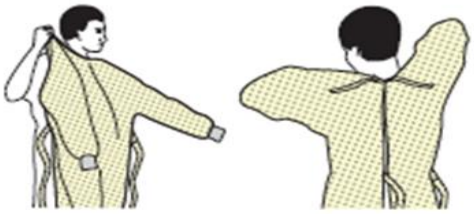
Donning and Doffing PPE

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

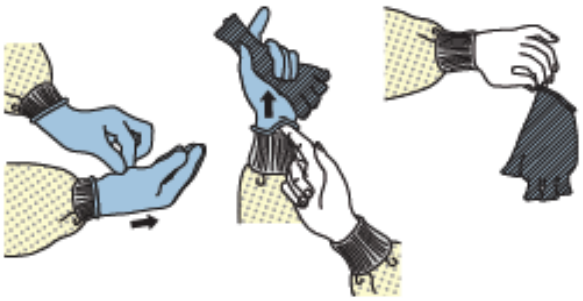
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)
EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

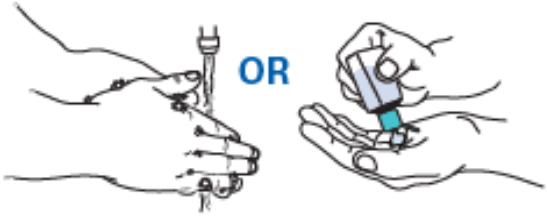
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

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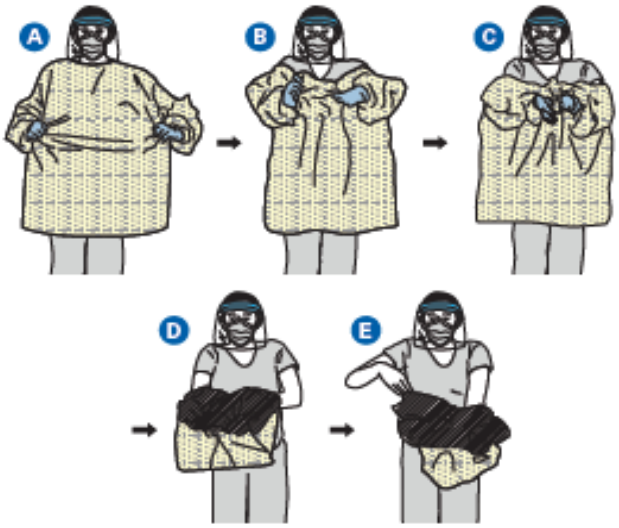
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



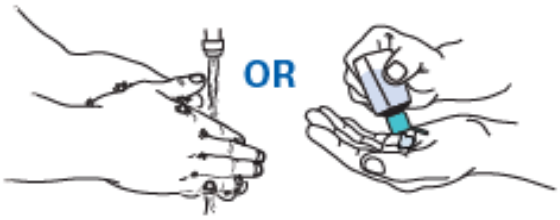
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

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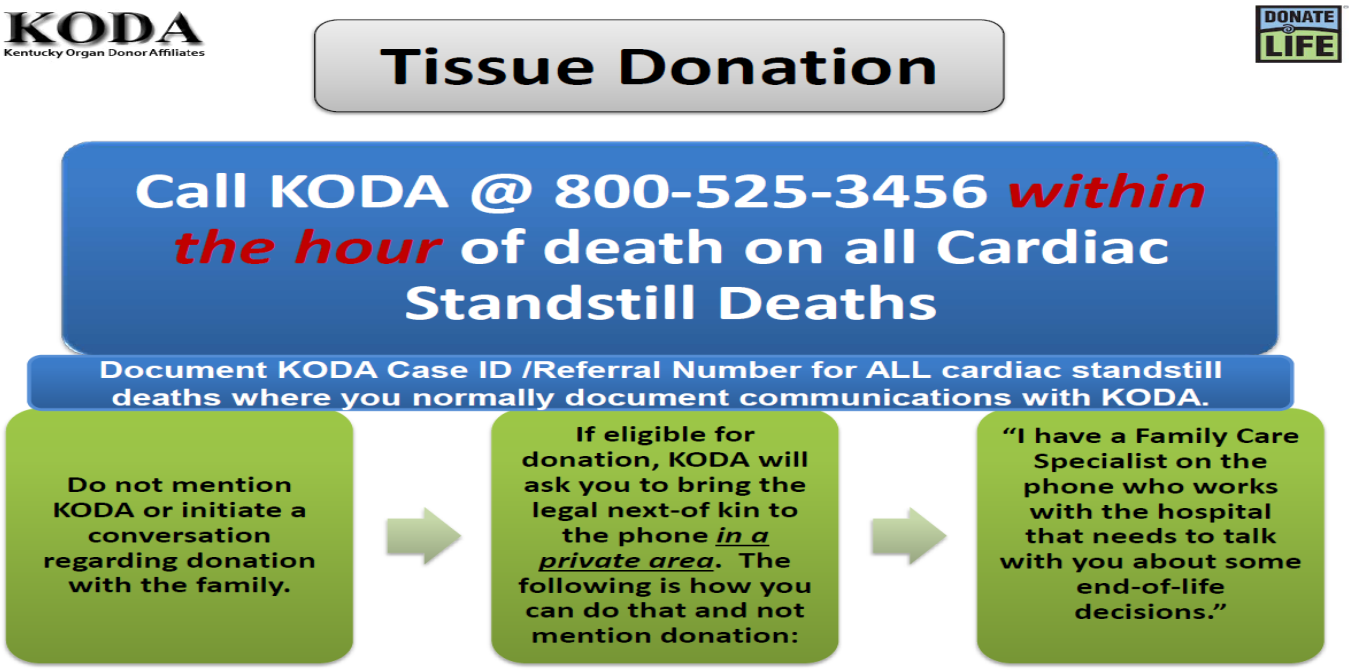
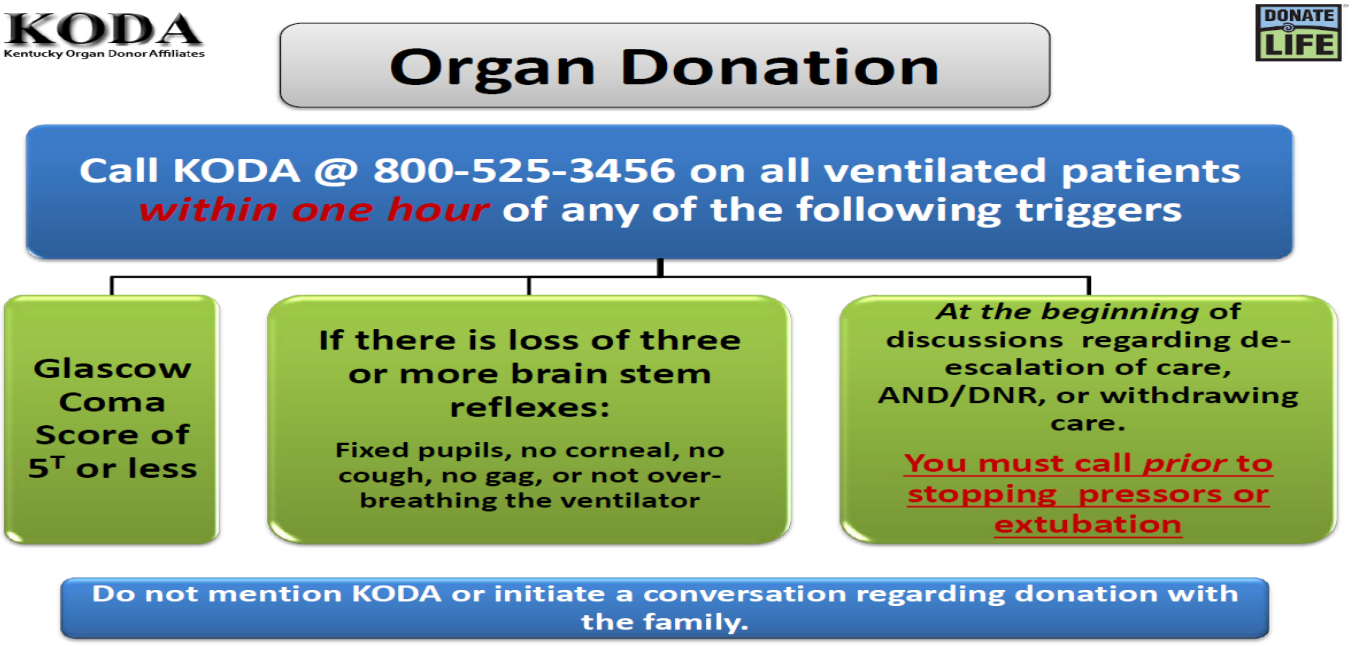
Reference: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

KODA

CHI SAINT JOSEPH HEALTH embraces a commitment to our guiding principles associated with the delivery of patient care and the protection of patient and family rights. In keeping this commitment, the needs and rights of every patient and family will remain paramount throughout the organization's compliance with state and federal laws and TJC guidelines specific to organ, tissue, and eye donation. These laws require hospitals to consider every death as a potential organ or tissue donation. All families are to be given the opportunity to donate.





Latex Allergy

Latex is a natural rubber product made from the milky sap of the rubber tree. Latex can cause minor skin irritations or SEVERE allergic reaction of our employees and patients. **Individuals at HIGH RISK for Latex Allergy include:**

- Patients who have multiple operations.
- Children with spina bifida who require numerous surgeries and need urinary catheterization.
- Individuals with breathing allergies such as hay fever or asthma, and who have multiple allergies.
- Individuals with certain food allergies:
    - Avocado
    - Apple
    - Celery
    - Carrot
    - Papaya
    - Kiwi
    - Banana
    - Melon
    - Tomato
    - Potato
    - Chestnut
- Symptoms can appear FAST and SEVERE when a person is experiencing a life- threatening anaphylactic shock (SEVERE ALLERGIC REACTION).
- Swollen eyelids, lips, and face/swelling or "tightening" of the throat.
- Reaction can occur after direct contact to a latex product or from inhaling latex particles.
- Anaphylactic shock (MOST SEVERE REACTION) is not common and is seldom the first sign of latex allergy.

Other allergic reactions to latex can include: Skin rash, itching, hives, swollen red skin, tears, burning eyes, shortness of breath, dizziness, fainting, stomach pain, nausea, and diarrhea.

Latex Products and Labeling: The US Food and Drug Administration **(FDA)** requires ALL medical devices containing natural rubber latex to be labeled.

Treatment of Latex Allergy Anaphylactic Shock (SEVERE REACTION):

- The onset of a SEVERE reaction that is life-threatening will usually occur 20 to 60 minutes after exposure to latex:
- Symptoms will continue to worsen and will include a drop in blood pressure, rash, difficulty breathing. Without treatment, the individual will DIE.
- Immediately stop or remove the latex contact.
- Give a shot of epinephrine.
- Maintain airway with 100% oxygen.
- Do not leave the victim, call for assistance.
- Arrange for immediate transfer to Emergency Department if an associate, visitor, volunteer, etc. is the victim:

A "Latex Free" Cart is available for all patients with latex allergies. A latex cart can be obtained by

calling Central Distribution.

An OR "Latex Free" cart is available to the OR and PACU where the latex sensitive patient is having the surgical procedure done.

Latex Sensitivity Prevention for Healthcare Workers

- Wear gloves only when needed. Consider non-latex gloves when appropriate. For glove sensitivities, synthetic (non-latex) gloves are available for employee use.
- If latex gloves are worn they must be powder-free. If latex gloves contain powder, rinse any powder from your hands prior to handwashing.
- Take care of hands – use non-oil-based lotions as needed to prevent drying. Protect hands from cold. The employee must be screened per Employee Health prior to product changes and for evaluation of skin problems that do not resolve.

Reference: Policy Stat: Management of Patients with a known Latex Allergy, or Patients at High Risk for Reactions to Latex

Medication Administration

Timing of Medication

Medications *not eligible* for scheduled dosing times: These are medications that do not require exact or precise timing of administration, based on diagnosis type, treatment requirements, or therapeutic goals. The policy for administration of these medications shall be hospital-wide.

- **Stat doses:** Administration shall occur within 1-hour of entry onto the medication administration record.
- **First time or loading doses:** Administration will be governed by nursing staff judgment as to whether the medication is a home medication or a newly prescribed medication. Home medications must have consideration as to the timing of the most previous dose. Newly prescribed medications shall be administered within 4-hours of entry onto the medication administration record.
- **One-time doses:** Administration shall occur within 4-hours of entry onto the medication administration record.
- T**ime-sequenced doses; doses timed for serum drug levels.**
- **Investigational drugs:** Administration per specific study guidelines and/or guidance from Research Coordinator.
- **Drugs prescribed on an as needed basis (prn doses):** Shall be administered as the patient requests or the clinical condition indicates, and according to the ordered dose frequency

Medications *eligible* for scheduled dosing times: These are medications prescribed on a repeated cycle of frequency to achieve and maintain therapeutic blood levels of the prescribed medication over a period of time.

- **Time-critical scheduled medications:** Will be administered within 30-minutes before or after their scheduled dosing time, for a total window of 1 hour. This includes medications scheduled for administration more frequently than Q12H and medications which have an administration time

specified by the physician or by policy (e.g. insulin or anti-diabetic medications ordered bid, warfarin ordered daily).
- **Non-time-critical scheduled medications** – will be administered within 2-hours before or after the scheduled dosing time, for a total window that does not exceed 4-hours. This includes medications prescribed ≥ Q12H.

Administration of eligible medications outside of their scheduled dosing times and windows

- **Patient temporarily away from the nursing unit:** Nurse to administer medication as soon as possible upon patient return to nursing unit.
- **Patient refusal:** Nurse to document patient refusal and notify physician.
- **Patient inability to take the medication:** Physician shall be notified for alternative treatment options.
- **Problems related to medication availability:** Administration guidance shall be offered by the pharmacist.
- **Other reasons:** Nursing staff to use own judgment regarding the rescheduling of missed or late dose. Late or missed doses shall be reported as a medication error in the IRIS error reporting system.
- **IV Medications initiated between standardized dosing times:** Nursing to utilize the medication stagger schedule

Evaluation of medication administration timing policies & adherence

- The medication administration timing policy and staff adherence will be evaluated regularly to determine whether safe and effective medication administration is assured.
- Medication errors related to the timing of medication administration will be tracked and analyzed to determine their causes. Late or missed doses shall be reported as a medication error in the IRIS error reporting system.

Reference: Policy Stat: Timing of Medication Administration; Schedule of Medication Administration Times

High Alert Medications

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error.

Class/Categories of "High Alert Medications" that may result in death or serious injury including specific medications of concern:

- Adrenergic agonists, IV (e.g. epinephrine)
- Adrenergic antagonists, IV (e.g. propranolol)
- Anesthetic agents, general, inhaled and IV (e.g. propofol)
- Cardioplegic solutions
- Chemotherapeutic agents, parenteral and oral
- Colchicine injection
- Concentrated Electrolytes (potassium chloride, potassium phosphate, sodium phosphate)
- Dextrose, hypertonic, 20% or greater

- Dialysis solutions for Continuous Renal Replacement Therapy
- Epidural or intrathecal medications
- Glycoprotein IIb/IIIa inhibitors
- Heparin and Low Molecular Weight Heparins (enoxaparin)
- Hypoglycemics, oral and Insulin IV and SQ
- Inotropic medication, IV (e.g. digoxin, milrinone)
- Liposomal forms of drugs
- Moderate sedation agents, IV (benzodiazepines – midazolam, lorazepam)
- Methotrexate, oral (non-oncologic use)
- Narcotics/Opiates, IV and oral
- Neuromuscular blocking agents
- Sodium Chloride solutions, concentrations above 0.9%
- Thrombolytics/Fibrinolytics, IV
- Total Parenteral Nutrition solutions
- Warfarin
- Oxytocin

New "High-Alert" medications may be added to this as identified through the Failure Mode and Effects Analysis formulary procedure conducted by the SJHC Pharmacy and Therapeutics Committee.

The availability of "high-risk" medications is restricted. There is a heightened awareness of these medications, and appropriate safeguard policies are followed in the ordering, storage and administration of the identified "high-risk" medications.

1. Adrenergic agonists are limited to Automated dispensing cabinets, Cardiac emergency boxes, Anesthesia carts, and Cardiac Code carts. Standardized concentrations and initial infusion rates are utilized for ordering, preparation and administration of adrenergic agonists via continuous infusion.
2. Adrenergic antagonists are limited to Automated dispensing cabinets, Cardiac Code carts, Cardiac Emergency boxes, Anesthesia carts, and AMI ED Kits. Standardized doses, concentrations and infusion rates are utilized for ordering, preparation and administration of adrenergic antagonists.
3. Anesthetic agents are limited to OR areas and Automated dispensing cabinets. Utilization of these agents for conscious sedation is limited to appropriately credentialed prescribers. Propofol is available to be used for sedation in the intensive care units per the Analgesia/Sedation/Delirium protocol.
4. Cardioplegic solutions are only available from the pharmacy. At SJH, small supply will be stored in the Surgery Stock area.
5. IV chemotherapeutic agents must be ordered utilizing the Chemotherapy order form. Prior to order entry, a pharmacist will double-check the drug, dose (mg/kg or mg/m^2), route, frequency, infusion rate/solution, total 24-hour dose, and total doses. Prior to admixture, two pharmacists will verify the entered order (including pre-medications) and double-check the drug, dose, volume, solution, tubing, and labels prepared by the pharmacy technician. Chemo compounding logs will be maintained on each patient receiving IV chemotherapeutic agents.

   Oral chemotherapeutic agents may be ordered on any hospital Physician Order form. Prior to order entry, a pharmacist will double-check the drug, dose (mg/kg or mg/m^2), route, frequency, total 24-hour dose, and total doses.

   Oral medications requiring special handling, such as chemotherapeutic and hazardous drugs, are

identified with alert stickers attached on the unit dose packaging for dispensing of first and subsequent doses and with MAR alerts for continuing dosages.

6. Concentrated potassium chloride, potassium phosphate, and sodium phosphate injections are NOT floor stock on nursing units.
7. Magnesium sulfate injection is not considered a concentrated electrolyte or high-risk medication but is limited to Cardiac Code Carts, OR Perfusion Boxes and Automated cabinets outside of the pharmacy.
8. Large volume hypertonic dextrose solutions 20% or greater are NOT floor stock on nursing units and are only stored in the pharmacy. Large volume hypertonic (>20%) solutions are utilized for IV admixture in the pharmacy and not for direct patient administration. Small volume hypertonic dextrose solutions (e.g - Dextrose 50% 50mL Lifesheild Syringes) have limited access on the nursing units via Automated dispensing cabinets, OR Perfusion Boxes or Cardiac Code Carts for use in emergent hypoglycemia or emergent hyperkalemia.
9. Continuous Replacement Renal Therapy (CRRT) for the Citrate Protocol Dialysate Replacement Fluids will be compounded in the pharmacy.
10. Medications for epidural administration are limited to the pharmacy and automated dispensing cabinets. Analgesics administered via epidural pump are only prepared in a yellow Deltec cassette to encourage differentiation from IV analgesic cassettes. Syringes for Intrathecal administration are labeled appropriately prior to dispensing.
11. Protocols for the standard prescribing, dosing, concentrations, and administration of the GP IIbIIIa inhibitors are available to minimize medication errors with these agents.
12. Protocols for the standard prescribing, dosing, concentrations, and administration of heparin and enoxaparin are available to minimize medication errors with these agents. Available concentrations of heparin are limited. Administration of IV heparin rate changes or enoxaparin therapeutic doses will be double-checked by a second nurse.
13. Insulin preparations and doses are to be double-checked by at least two members of the nursing staff prior to patient administration. Initial hang of continuous insulin infusions are also to be double-checked by at least two members of the nursing staff.
14. Digoxin is limited to automated dispensing cabinets and Cardiac Code carts.
15. Milrinone is NOT floor stock on nursing units.
16. Formulary liposomal agents are limited in number. These agents are NOT floor stock on nursing units and are only available in the pharmacy. Storage of liposomal agents is such that they are segregated from the non-liposomal counterparts in order to minimize medication errors.
17. Benzodiazepines are limited to automated dispensing cabinets outside the pharmacy.
18. Oral Methotrexate (non-oncologic use) may be ordered on any hospital Physician Order form. Prior to order entry, a pharmacist will double-check the drug, dose (mg/kg or mg/m^2), route, frequency, total 24-hour dose, and total doses. An alert is built into the pharmacy computer system prompting the pharmacist to verify all dosages with the appropriate indication and recommends typical PO doses of 2.5 to 7.5mg per week (doses should not exceed 20mg per week).
19. Narcotic/Opiate agents are limited to automated dispensing cabinets outside the pharmacy.
20. Neuromuscular blocking agents are only available in secure pockets of automated unit based cabinets in nursing units. Protocols and standing order sets are available, which standardize prescribing, dosing, concentrations, and administration of these agents in order to minimize medication errors.
21. Alteplase is only available outside the pharmacy in the Emergency Department and Heart Cath Lab (at SJH) automated dispensing cabinet. Reteplase is only available outside the pharmacy in automated dispensing cabinets or the AMI kit drug box. Protocols and standing order sets are available, which standardize prescribing, dosing, concentrations, and administration of thrombolytics in order to

minimize medication errors.

22. Sodium chloride solutions above 0.9% are NOT floor stock on nursing units. These agents are not used routinely.
23. Adult Total Parenteral Nutrition must be ordered utilizing the Adult TPN Order form in Cerner OneCare. Prior to order entry, a pharmacist will double-check the electrolyte concentrations, infusion rate/solution, and total 24-hour dose. Prior to admixture, two pharmacists will verify the entered order and double-check the admixture concentrations, TPN volume, solutions, and labels prepared by the pharmacy technician. Compounding logs will be maintained on each patient receiving TPN.
24. To avoid free-flow incidents that may result in serious injury or death in the course of intravenous infusion therapy, "high-risk" medications are administered by an electronic infusion device with anti-free flow fail-safe mechanisms.
25. Alaris-Medley IV Pumps are utilized to apply guard-rails for administration of intravenous medications.
26. Warfarin will not be stocked outside the pharmacy.
27. Oxytocin is only available outside the pharmacy in the Emergency Department and Labor and Delivery (at SJE) automated dispensing cabinet.

Reference: PolicyStat: High-Alert Medication Safety

Nurse Witness Required for Medication Administration

The following procedures/medications shall be double-checked by two licensed nurses or a licensed nurse and a physician (unless noted specifically otherwise) prior to administration. Both nurses' signatures (or the nurse's signature and the physician's signature) will be documented on the MAR indicating all applicable parameters have been verified and are correct.

1. The following MUST be double-checked by two registered nurses or a registered nurse and a physician:
    - Chemotherapeutic agents (IV and Oral)
    - Intrathecally administered medications
    - Epidural medications for analgesic purposes (including such medications as morphine sulfate, bupivacaine and sub-anesthesia dosages of Ketamine Hydrochloride). *The administration of such medications via intraspinal route for the intrapartum patient in labor is not within the scope of practice of the registered nurse.*[1]*The administration of medication for the purpose of anesthesia per spinal, epidural or caudal routes is not within the scope of practice of the registered nurse.*[1]
2. The following require a nurse double-check for initial product evaluation (comparison of product label against physician order for content, dose, concentration, fluid, etc).
    - Total Parenteral Nutrition (TPN)
    - Initial infusion set-up and all bag changes for IV insulin
    - Any handwritten label on an IV product
    - PCA medications for analgesic purposes
3. The following require a nurse double-check for *each dose and/or infusion rate change:*
    - All PCA and epidural pump program changes/settings (Epidural needs two registered nurses)
    - Administration of all doses of subcutaneous insulin
    - IV insulin infusion rate changes greater than or equal to 15 units/hour must be double-checked by a second nurse (Rates less than 15 units/hour do not require a double-check)
    - Administration of all IV heparin including boluses, infusion rate/dose calculations, and pump program changes/settings

- All enoxaparin (Lovenox®) weight-based doses (mg/kg)
- All fondaparinux (Arixtra®) doses
- Alteplase Recombinant (Activase) doses

Reference: PolicyStat: Nurse Witness Required for Medication Administration

Controlled Substance Wasting

All controlled substance waste must be witnessed by two nurses or healthcare providers (HCP) that are licensed to prescribe, dispense or administer drugs. All controlled substance waste should be disposed of in the Cactus Smart Sink or the Stericycle Rx Service container, if one is available. In Kentucky, Pharmacists are not eligible to waste, but may witness waste.

- Unused, unopened medications removed from the AcuDose will be returned as soon as possible, using a witness as required.
- Excess medication should not be carried or placed in medication drawers for later use or disposal
- Controlled substance waste should occur immediately after removing the medication from the AcuDose.
    - Dispensing RN should be the first to log in to the AcuDose for recording waste. RN/ HealthCare Provider should not enter their ID/password to record waste of controlled substance without visually witnessing the waste.
    - Un-witnessed waste requests need to be reported to charge nurse and Unit Manager or House Manager.
    - Exception to immediate waste upon dispensing: Urgent/Emergent situations (i.e. Code Blue, anesthesia, PACU) when controlled substances are required, waste documentation shall occur at the completion of the event.

Reference: PolicyStat: Controlled Substances Wasting

Medication Safety

Adverse drug reactions (ADR)

An adverse drug reaction is not considered a medication error. The definition of an adverse drug reaction is any unintended response, an undesired response or excessive response to a medicine that requires discontinuing the medicine, changing the medication therapy, modifying the dose, admission to a hospital, prolonged stay in a health care facility or supportive treatment.

- Reportable ADR
    - A significant, serious, or unexpected reaction to a drug which is not typical (in kind or degree) of most patients who receive the same drug. These reactions require immediate intervention and a change in patient management.
- Non-Reportable ADR
    - An unintended but generally anticipated reaction to a drug which is relatively minor in nature and degree. Such reactions occur in a significant percentage of persons who receive the drug but are considered to be acceptable in view of the therapeutic benefit gained from use of the drug.
- ADR Reporting
    - Any physician or hospital employee responsible for ordering, dispensing or administering medications who suspects a reportable adverse drug reaction should

take the following actions:

- promote the safety and comfort of the patient
- inform attending physician (if applicable)
- document in patient's chart
- report an ADR using either:
- a variance report located on the

CHI Saint Joseph Health intranet call pharmacy and give patient's name, computer number and suspected ADR.

Medication Errors

A **medication error** is any event that resulted in or may have resulted in or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Medication errors will be reported and trends noted via the performance improvement activities of the organization as part of the **CHI Saint Joseph Health** Quality Improvement processes and quality control monitoring.

Medication Error Reporting:

Medication errors, as defined above, are to be documented in the Incident Reporting Information System (IRIS), located on the hospital intranet homepage. Only the FACTS of the incident are to be reported. **CHI Saint Joseph Health** fosters a non-punitive reporting system.

- The attending physician is to be notified (within a reasonable amount of time), normally by the incident reporter or designee.
- As with any medication administered, medications administered in error are to be documented on the patient's medication administration record (MAR).
- Medication error(s) reported through IRIS will be forwarded to the appropriate department director(s) for evaluation.

Common Sources of Medication Errors:

- Unavailable patient information prior to dispensing or administering a drug (lab values, allergies, etc.)
- Unavailable drug information (written resources)
- Miscommunication of drug orders (similar names, use of zeros, inappropriate abbreviations, poor handwriting)
- Problems with labeling, packaging
- Drug standardization, storage (stocking multiple concentrations of the same drug, look-a-like containers)
- Drug device use and monitoring (lack of standardization in drug delivery devices, unsafe equipment)
- Environmental stress (distractions, noise during transcription or dispensing, too long shifts)
- Limited staff education (on problem prone drugs)
- Limited patient education
- High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error.

Dangerous Abbreviations and the Appropriate Terms:

To minimize the potential for error and to maximize patient safety, the following list of dangerous abbreviations and phrases are not to be used in any form of clinical documentation in the patient medical record:

Dangerous Abbreviation	Appropriate Term
U	Unit
IU	International Unit
QD	Daily or Every Day
QOD	Every Other Day
Trailing Zero (X.0 mg)	No Zero After a Decimal Point
No Leading Zero (.X mg)	Use Zero Before a Decimal Point
MS and MSO4	Morphine or Morphine Sulfate
MgSO4	Magnesium or Magnesium Sulfate
Ug (Microgram)	Use mcg
TIW	Three Times Weekly
Cc	ml

Look Alike/Sound Alike Medication Safety (Refer to PolicyStat) Pharmacy will review annually a list of look-alike/sound-alike drugs used within the organization and will take action to prevent errors involving the interchange of these drugs. Annual review will include the following:

- Look-alike/sound-alike drug combinations currently on the organizational listing
- Look-alike/sound-alike drug combinations to be added to the organizational listing
- Specific actions to prevent errors involving the interchange of these drugs, including but not limited to:
    - Computer strategy
    - Storage strategy
    - Prescribing strategy
    - Formulary strategy
    - Nursing strategy

- *New "Sound-alike Look-alike" medications may be added to this as identified through the Failure Mode and Effects Analysis formulary procedure conducted by the CHI Saint Joseph Health Pharmacy and Therapeutics Committee.*

Reference: PolicyStat: Medication Errors

Medication Reconciliation

Medication reconciliation is performed to clarify any discrepancies between the patient's actual medications and the most recent record of prescribed medications. This will allow the physician to review the information and order the appropriate medications and dosages for patients on admission to CHI Saint Joseph Health.

This process will also reduce adverse drug events (ADE) and potential adverse drug events (PADE), which may cause harm or potential harm to patients. The admission medication reconciliation

process will be completed by the nurse and will be used to perform medication reconciliation. Medication reconciliation is an interdisciplinary process between the patient, physician, pharmacy and nursing designed to decrease ADEs and PADEs on all nursing units and provide the most therapeutic outcome for the patients.

Reference: PolicyStat: Medication Reconciliation

MEWS (Modified Early Warning Score)

The purpose of the Modified Early Warning Score (MEWS) is to provide the bedside nurse with a quick and easy assessment tool to help identify adult patients with the potential for clinical deterioration and promote early initiation of the Rapid Response Team (RRT). The MEWS score uses physiologic data that is already recorded by the nurses in the medical record. Determining the MEWS score involves assigning a number between 0 and 3 to each of the five vital sign parameters **(Level of Consciousness, Respiratory Rate, Heart Rate, Systolic Blood Pressure, and Temperature).** The MEWS tool provides a quickly calculated score that is easily understood.

Score	3	2	1	0	1	2	3
Central Nervous System (CNS)- Level of Consciousness		Confused or agitated		Alert	*Drowsy/ Respond to voice or newly confused*	Respond to pain	Unresponsive
Respiratory Rate (breaths/min)		< 8		9 - 14	*15 - 20*	21 - 29	≥ 30
Heart Rate (Beats/min)		≤ 40	41 - 50	51 - 100	101 - 110	111 - 129	≥ 130
Systolic Blood Pressure (mmHg)	< 70	71 - 80	81 - 100	101 - 199		≥200	
Temperature (F)		≤ 95.0⁰		95.1⁰ – 101.2⁰		≥ 101.3⁰	

MEWS Action Algorithm	
Total MEWS	Inpatient Action (EXCLUDES DNR/Comfort Care /Hospice Patients) **Note: Nurses may notify RRT for any score at their discretion.*
0 – 2	Continue routine/ordered monitoring
3	Increase VS frequency to every 4 hours X 3; Calculate the MEWS each time. Inform charge nurse.
4	At first reading, inform charge nurse to assess patient. Increase VS frequency to every 1 hour X 3; include pulse oximetry-Calculate MEWS each time. Strict I & O – call if UOP <100mL/4 hrs; if Foley catheter present, observe UOP< 30 mL/hr. If score is 4 at change of shift, re-evaluate to determine if this score is patient's baseline.
5	**Call RRT.** Increase VS frequency to every 1 hour include pulse oximetry-Calculate MEWS each time. Strict I & O – call if UOP <100mL/4 hrs; if Foley catheter present, observe UOP< 30 mL/hr. Inform physician. If patient remains "5" for three consecutive readings, request order for possible transfer to higher level of care. Is end-of-life discussion with patient/family indicated
≥6	**Call RRT and physician stat.** Recommend transfer to higher level of care. Is end-of-life discussion with patient/family indicated?

Reference: PolicyStat: MEWS (Modified Early Warning Score)

MRI Safety

- The MRI magnet effects medical equipment within the patient's body. No one with a pacemaker or other internal device is allowed to enter the restricted magnetic area.
- No one is to enter the MRI area without approval of MRI trained personnel.
- No metal objects are permitted to be in, or on, a person when entering the restricted magnetic field area.
- Only oxygen tanks, regulators, wheelchairs, IV poles, stretchers, and fire extinguishers that are MRI safe and are labeled with MRI Safe stickers are permitted in the MRI area.
- All patients must have an informed consent signed prior to entering the MRI scan area
- Employees should be aware of foil-backed medication patches that could result in a burn during MRI.
- Magnetic strips such as those found on credit cards and employee badges will be erased if taken into an MRI scan room.
- Certain equipment (e.g. buffing machines, chest tube stands, clip boards/patient charts, hairpins, hearing aids, identification badges, keys, medical gas cylinders, mops, nail clippers and nail files, pulse oximeters, pacemakers, pagers, paper clips, pens, and pencils, IV poles, shrapnel, sandbags with metal filings, steel shoes, stethoscopes, scissors, staples, tools, vacuum cleaners, watches, housecleaning carts or mop buckets, gurneys, oxygen cylinders, prosthetic limbs, wheelchairs, anesthesia carts) can cause a potential for injury resulting in death if taken into an MRI scan room.
- If a Code Blue occurs while the patient is in the MRI Scan, the patient will be transported to the MRI holding area prior to announcing a CODE BLUE.

Nursing Standards of Practice: Nursing Intervention Minimum Frequency and Documentation

The Standards of Practice for adult core nursing (Medical Surgical, Telemetry, Orthopedic, Oncology, and Acute Rehab) serve as guidelines for the provision of nursing care and professional performance expectations. The affected areas include the above listed areas, as well as all patients with these admission status boarding in areas outside of these departments, such as the ED, ICU overflow, ect.

Nursing Intervention	Frequency
Assessment	
Focused Assessment	• Within 30 minutes of admission • PRN according to patient condition/ LIP order • Every 4 hours post op/ post procedure x 24 hours
Vital Signs	• Upon admission (within 30 minutes) • Approximately every 8 hours • Telemetry patients: every 4 hours while awake, minimum of every 6 hours • Within 1 hour before discharge
History	• Started within 30 minutes of admission (chief complaint) • Completed within 24 hours of admission • Updated PRN when new information obtained
Physical Assessment	• Upon admission (within 4 hours) • Every shift (within 4 hours) • PRN according to patient condition/LIP order

Screenings (skin, fall, sepsis, and mobility)	• Upon admission (within 4 hours) • Every shift (within 4 hours)
Suicide Screening	• Upon admission (within 4 hours)
Valuables and Belongings	• Upon admission • With transfer • At discharge
Planning	
Plan of Care	• Every Shift
Implementation- Health Teaching and Promotion	
Patient/Family Education	• Every Shift
Implementation- Care Delivery	
Activity and Positioning	• Every 4 hours • Out of Bed • PRN
Consults	• PRN
Hygiene	• Every Shift
IV Access	• Every Shift • With Each Use • Insertions • Discontinuation • Dressing change
Intake and Output	• Every shift • Intake is recorded when patient completes meal
Medication Administration	• At time of medication administration
Pain	• Upon Admission • Every Shift • PRN • Before administration of pain medication • After administration of pain medication
Patient Handoff	• Shift change • Transfer • Caregiver transitions
Weights	• Upon Admission • Daily (if ordered or patient condition warrants)

Reference: PolicyStat: Core Nursing Standards of Practice

Oxygen Safety

PLEASE NOTE: The only cylinder gas tank that you should find in patient care areas is oxygen. You may encounter helium tanks in critical care and the operating room. If you find any other tank gas, please call Respiratory Care immediately.

Handling of Oxygen Cylinders:

- Avoid dragging or sliding cylinders, even for short distances. Cylinders should be moved by

using a suitable hand cart or truck. An approved oxygen holder attached to a bed may also be used.

- Never drop cylinders or permit them to strike each other violently.

Storage of Oxygen Cylinders:

- **ALWAYS store oxygen in a secure, upright position.**
- Always secure in a rack, a stand, or attached to a cart.
- Never leave cylinders unsecured on a bed, stretcher or under a bed or stretcher.

Safety Considerations:

- Keep cylinders protected from excessive temperatures by storing them away from radiators or other sources of heat.

Pain Management

CHI Saint Joseph Health and its entities recognizes a patient's right to pain relief and supports a holistic and interdisciplinary approach to pain assessment and management. The identification and management of pain is an important component of patient centered care.

The patient is the definitive voice in identifying and defining his/her pain. Therefore, pain is defined as "whatever the experiencing person says it is, and exists whenever he/she says it does" and requires an individual approach towards its management, including use of pharmacological and non-pharmacological techniques. The treatment of pain has a strong scientific basis, which is acknowledged by a variety of national and international organizations, including The World Health Organization, The American Pain Society, The Agency for Health Care Policy and Research and the Joint Commission. This being noted, CHI SJH also enforces opioid stewardship and safe pain management practices. For patients with ongoing pain control issues, the patient should be referred to pain management modalities to ensure adequate and ongoing pain management is achieved in a safe and effective manner.

Assessment

1. All patients admitted as inpatients and/or presenting to the emergency department shall be questioned as whether or not they are experiencing pain. Other ambulatory patients need not be assessed for the presence of pain unless **a)** pain is commonly associated with the condition for which they are seeking care or **b)** pain may be induced by subsequent treatments or interactions (for example, patients undergoing an outpatient invasive procedure or potentially painful therapy).
2. Obtain a pain assessment/history when pain is present upon initial screening or upon the first report of pain, whichever comes first.
    1. An **assessment** and /or **reassessment** for pain consists of an interaction with the patient, when relevant, that includes **intensity** (per the patient's perception and statement), **impact of interventions** (is the method of pain relief working), **progress toward comfort** (amount and intensity of pain lessening), **effect of pain on the patient's functionality and ability to achieve sleep/rest.**
    2. A comprehensive pain assessment shall be performed at least once every 12 hours for inpatients and extended-stay outpatients and following any intervention intended to lessen the patient's pain (for example, administration of pain medications, application of cold packs, or repositioning). The care provider renders a conclusion from the patient conversation/ interaction about pain and documents the conclusion. For example, reassessment and documentation of a successful pain intervention may be as simple as

"patient able to sleep comfortably following pain medication", or "patient states pain management is working." There is no requirement for specific pain scale or answers to all pain interaction elements (although these may be used); the goal is a conclusion from the conversation/interaction about the patient's pain management regimen with each reassessment.

3. Reassessment following pain intervention shall take place within a clinically appropriate time frame in relationship to the pain intervention provided, and documented by the end of the care provider's shift. (Example: PO-60-90 minutes; IM/SQ- 60 minutes; IV 30 minutes; non-pharmacologic-60 minutes). It is NOT necessary that the results of such post-intervention reassessment be documented in a concurrent note. Reassessment after pharmacologic intervention includes assessing for the presence of analgesic side effects.
4. Assess pain using a pain measurement tool(s) consistent with the patient's age, condition, language and ability to understand. Patient self-report is utilized whenever possible.
    a. **PAIN MEASUREMENT TOOLS:**
        a. NIPS (well-baby nursery: term, preterm)
        b. FLACC (2 months to 7 years of age)
        c. Wong-Baker Picture Face Scale (3 years of age and older)
        d. 0-10 Numeric Pain Intensity Scale in Adult and verbal school-aged or older age group.
        e. Critical Care Pain Observation Tool (CPOT) for ventilated and/or nonverbal patients in the critical care setting
5. Assess and document pain including location(s), quality, onset, intensity, character, description, frequency, duration, aggravating/relieving factors, satisfaction with relief and presence/ severity of side effects.
6. Assess and document history of previous pain medications used.
7. Consider the patient's personal, cultural, spiritual, and/or ethnic belief system/values regarding pain and pain management
    a. Use interpreting service for non-English speaking or deaf/HOH patients. Do not use family, friends or untrained SJH associates to do medical interpretation.
    b. Complete a Cultural Pain Assessment (see attached) as appropriate
8. Assess for pain in non-verbal patients or those with impaired communication and recognize that the following patients require specialized pain assessment: infants; young children; *children and/or adults with special needs;* adults with cognitive impairment; altered level of consciousness; severe emotional disturbance; dementia; delirium; or psychoses; the elderly; patients who speak a different language and/or have different educational or cultural background from those of the health care team. See Pediatric Pain Management Policy.
9. Assess for pain in patients who cannot self-report.
    a. Document why self-report cannot be used.
    b. Assess for conditions and procedures that may cause pain.
    c. Observe for behaviors the patient demonstrates that may indicate pain; use the behavior scale Checklist of Nonverbal Pain Indicators (CNPI) or a checklist of behaviors indicative of pain, if appropriate. (See attached).
    d. Ask others who know the patient well to identify behaviors that may indicate pain in the patient. Ask about preexisting painful conditions.

e. **Conclusion**: if pain is suspected based on items b, c, or d, assume pain is present. Document APP (Assume Pain Present).
f. Plan - Consider an analgesic trial if analgesia has not been started. Use recommended starting doses of a non-opioid when pain is estimated to be mild to moderate or an opioid for more severe pain.
g. Evaluate response to analgesia by observing changes in behaviors, if present.
h. Make appropriate adjustments such as increases in dose or addition of other analgesics if behaviors indicative of pain persist or increase, or additional potentially painful pathology or procedures occur. In patients who are unresponsive, no change in behavior can be seen to guide evaluation of analgesic effect; therefore, continue the same dose.
i. Ongoing care for all patients: medicate prior to a painful event. For continuous, persistent pain, consider the use of a continuous infusion or scheduled, around the clock analgesic doses and supplemental doses for breakthrough pain and prior to painful procedures.

A. Assess for presence of respiratory depression/sedation/satisfactory pain relief post administration of all pain medications and sedatives. Reassess for changes in sensorium, sedation, (POSS sedation scale or RASS scale) respiratory rate (minimum of 10 per minute), quality of respirations (depth) and patient/significant other report of satisfactory pain relief. Nursing judgment may dictate the utilization of portable pulse oximetry to assess O2 saturation.

1. Symptoms of narcotic induced respiratory depression should be treated with titration of IV administered naloxone (Narcan) to effect as prescribed.

Interventions:

1. Patients receive prompt, effective management of their pain and any analgesic side effects, if relevant to the visit.
2. Pain management plans are individualized and include consideration of clinical condition, developmental, social, spiritual and cultural concerns of the patient/family/proxy.
3. Assist the patient with selecting a realistic comfort/function goal and document in the medical record. The comfort/function goal is the **patient's pain rating** that would be acceptable or satisfactory to him/her, considering the activities required for recovery or for maintaining a satisfactory quality of life. Use this goal to monitor effectiveness of the pain management plan. Provide interventions to keep patient's pain rating at or below the comfort function goal. Document if the patient is unable to determine and state his/her goal.
4. Pain management plans may include both pharmacologic (non-opioid, opioid, and adjuvant analgesics) and nonpharmacologic strategies (i.e., massage therapy, physical therapy, heat, cold, relaxation, meditation, music, distraction, and biofeedback).
5. Pain scores unacceptable to the patient or pain that interferes with function, activities of daily living, treatment, self-care, play or sleep are addressed promptly, as appropriate.
6. The pain management plan is reviewed and revised as needed based on patient needs.
7. Notify the MD if the patient's pain relief is not satisfactory with the current plan.
8. Consider dosing around-the-clock (ATC) if pain present is greater or equal to12 hours out of 24 hours. It may be appropriate to wake the patient to administer pain medications to maintain continuous therapeutic levels of pain medications. Titration of pain medications shall be based

upon patient response, not dose required.

9. Transitioning routes of administration should utilize equianalgesic dosing concepts.
10. IM injections are not recommended.
11. Encourage the gradual tapering of opioids rather than abrupt discontinuation for those patients who have utilized opioids for 7 days or longer to decrease the risk of physical withdrawal symptoms.
12. Include pain management in discharge plan if appropriate.
13. Placebos are not used in the management of pain unless within the boundaries of a clinical research trial that includes informed consent.
14. Notify the MD if the pain medications are held for any reason.
15. A referral to a pain specialist should be considered for patients with poorly controlled pain.

Reference: Policy Stat: Pain: Assessment and Management

Patient and Family Centered Care (PFCC)

Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control.

This perspective is based on the recognition that patients and families are essential allies for quality and safety—not only in direct care interactions, but also in quality improvement, safety initiatives, education of health professionals, research, facility design, and policy development.

Patient- and family-centered care leads to better health outcomes, improved patient and family experience of care, better clinician and staff satisfaction, and wiser allocation of resources.

Core Concepts:

- **Dignity and Respect**. Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing**. Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation**. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation; in facility design; in research; and in professional education, as well as in the delivery of care.

Reference: https://www.ipfcc.org/about/pfcc.html

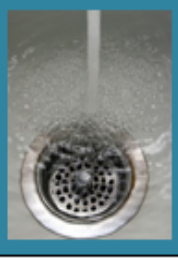
Pharmaceutical Waste Management

Red Bag Waste: Blood, Other Potentially Infectious Material, Items with Caked or Dried Blood, or Items with Visible Blood Contamination dispose of in biohazard containers.

Empty Sharps: Needles, Syringes, Scalpels, Culture Slides, Culture Dishes, Broken Capillary Tubes, Broken Rigid Plastic, Exposed Ends of Dental Wires dispose of in red sharps containers.

Narcotics: Scheduled Drugs, Controlled Substances, DEA Controlled Items dispose of according to current hospital policy.

Plain IV Solutions: Lactated Ringers, Dextrose, Saline, Potassium, Electrolytes, Sodium Bicarbonate dispose of in the sanitary sewer.

	NOT Labeled / Identified			
Sort Code	No Code		No Code	No Code
Waste Class	Chemotherapy Rx Waste		Maintenance IV Solutions (No Medications)	Sharps / Infectious Waste
Description of Wastes	**BULK** • Chemo Agents • IVs with Residual Chemo Agents • Chemo Spill Cleanup Debris • Containers with Residual Chemo Agents • Tablets	**TRACE** • Empty Vials • Empty Syringes • Gowns • Gloves • Goggles • Wipes • Empty IVs / Tubing	**Items that can be cut and poured down the drain.** • Maintenance IV Solutions Containing: – Potassium Chloride – Potassium Phosphate – Sodium Phosphate – Calcium – Sodium Bicarbonate – Dextrose – Saline	• Needles • Empty Syringes • Empty Ampoules • Other infectious wastes that are not hazardous
Container				

		Labeled / Identified Hazardous by Pharmacy	
Sort Code	**No Code**	**BKC or PBKC**	**SP, SPO, SPC**
Waste Class	**Non-Hazardous Rx Waste**	**Hazardous Rx Waste**	**Incompatible Hazardous waste**
Description of Wastes	**All Rx wastes without a code default to the blue container. Any waste with the potential to leak must be placed in a Ziploc bag. It is not permitted by the DOT to transport free fluids.** **Examples of Non-RCRA Waste:** • Antibiotics • Tylenol • Aspirin • IV's with medication left. Keep tubing attached and place in Ziploc bag. • Creams Ointments capped or in Ziploc bag • Meds soaked in Sponges or paper towels place in Ziploc Bag • Pills & Tablets • Vials and ampoules with Medication **2 Gallon Black Sharps Container** Syringe, ampoule or sharp with medication left (bulk), with or without a needle - *is not a* controlled substance	**BKC** • Allergenics • Antiseptics • Gums & Lozenges • IV & Other Compounded Solutions • Lotions, Creams, Ointments & Pastes capped or in Ziploc baggie • Medicinal Liquids contained • Pills & Tablets • Rx Delivery Devices / Tubing • Transdermal Patches • Unidentified Medications • Vials & Ampoules **2 Gallon Black Sharps Container** Syringe, ampoule or sharp with medication left (bulk), with or without a needle - *is not a* controlled substance **PBKC (acutely hazardous)** **Capture empty packaging for this waste stream.** • Nicotine / Nicotrol • Coumadin / Warfarin 	**These wastes are sent to pharmacy in Ziploc bags for proper disposal.** **Incompatible Rx wastes require segregation to satisfy DOT, safety & disposal facility requirements.** **Aerosols** • Inhalers **Corrosives** (Examples) • Glacial Acetic Acid • Sodium Hydroxide **Oxidizers** (Examples) • Potassium Permanganate • Unused Silver Nitrate
Container		 	**Bag and Send Back to Pharmacy**

Rapid Response Team Notification

The Rapid Response Team is a team of clinicians who bring critical care expertise to the patient bedside. The rapid response team has several key roles. The team assists the staff member in assessing and stabilizing the patient's condition and organizing information to be communicated to the patient's physician. The rapid response team consists of a critical care nurse and a respiratory therapist who is available 24 hours a day 7 days a week.

Criteria for Calling the Rapid Response Team includes, but not limited to:

Nurse, family, or patient feels uncomfortable with patient situation

- **Respiratory distress**:
  RR < 10 or > 30
  SpO2 < 90% despite increasing FiO2 requirements
- **Acute change in**:
  Systolic BP > 190, < 90 or Diastolic > 110
  Heart Rate < 45 or > 130
  Or
  20% change in vital signs from patient's baseline
- **Urine output** < 50 ml in 4 hours (without urinary retention or history of renal dysfunction)
- **Acute change in level of consciousness**:
  Glasgow Coma Scale decrease by 2 or more from previous assessment (consider recent narcotics/sedative and hypoglycemia/hyperglycemia)

- Seizures (New, repeated, or prolonged)
- Significant bleeding
- Failure to respond to treatment
- Agitation or delirium
- Uncontrolled pain
- Acute decreased capillary refill > 2 seconds with visual evidence of decreased tissue perfusion
- Modified Early Warning Score (MEWS) 5 (five) or greater

Notification and Process Implementation:
The Rapid Response Team should be notified by dialing 1111. The operator will then page the Rapid Response Team. SJB – will call 66.

The rapid response team should educate/coach the primary RN on their assessment findings, impressions, and recommendations. The primary RN's knowledge of the patient and their history is critical and should be communicated to the team. In Cerner facilities, the Handoff Report may be utilized to further facilitate sharing of patient health information.

In addition to Primary Nurse contacting RRT Team at 1111, the attending physician should be paged to collaborate with the Team related to the change in the patient condition. This will allow for additional orders the patient may need.

SBAR stands for **S**ituation- **B**ackground-**A**ssessment-**R**ecommendation and is the communication method that should be used when conversing with the physician regarding the patient's condition.

If at any time during the rapid response process the patient has a respiratory or cardiac arrest a Code Blue should be called per facility protocol.

Guidelines for Notifying Physician/Provider of Changes in Patient Condition

The physician/provider may need to be notified for changes in vital signs, patient condition, etc., differing from those described below and depending upon the individual patient. Notify the physician/provider of significant changes in the patient's condition or of abnormal findings as determined by nursing assessment.

Criteria for notifying a physician/provider includes but is not limited to;

1. If a physician/provider requests or orders to be notified of specific patient assessment findings or clinical situations
2. Cardiac or respiratory arrest.
3. Physiological condition has deteriorated unexpectedly as evidenced by the nursing assessment.
4. Response to medication, blood, or treatment is abnormal.
5. Urine output < 50 mL in 4 hours (or < 30 mL/hr. x 2 hours in Critical Care patients) without urinary retention or history of renal dysfunction.
6. Concerns regarding output from surgical drains, chest tubes, etc.
7. Acute changes in level of consciousness.
    - Glasgow Coma Scale decrease by 2 or more from previous assessment.
    - Consider recent narcotics/sedatives and hypo/hyperglycemia.
8. Acute changes in blood pressure (Systolic > 190, < 90 or Diastolic >110 and no current orders for PRN medications.
9. Acute changes in heart rate based on previous patient baseline and no PRN medication orders.
10. Hemodynamic pressures are abnormal and/or significantly different from previous readings and no order for prn medication/boluses.
11. Temperature 101° (oral) or higher and no order for PRN medication and/or blood cultures have not been obtained.
12. Oxygen saturation trending decreases below 90% despite increasing oxygen requirements.
13. Patient has any signs/symptoms of respiratory distress (including increased respiratory rate).
14. Life threatening arrhythmias are noted in Critical Care or Telemetry monitored patients. Exception may be made if patient had arrhythmia previously or if orders written to treat arrhythmias/standing orders implemented and patient responds positively to therapy.
15. Significant bleeding.
16. For patients experiencing <u>hypoglycemia</u> report the following:
    a. If after 45 minutes of unresolved hypoglycemia treatment (less than 70mg/dl), call the physician who is managing the patient's diabetes for further orders.
    b. If the patient is experiencing severe hypoglycemia (less than 40mg/dl) call the physician AFTER the hypoglycemia protocol has been implemented.
17. For patients experiencing <u>hyperglycemia</u>, follow the *Blood Glucose Control PowerPlan* and report the following:
    a. If FSBG remains greater than180mg/dL X2, call the physician for potential basal/bolus insulin orders.
    b. If FSBG greater than 350mg/dL at any time, call the physician unless otherwise ordered.
18. Critical lab values, except if similar lab results were obtained previously and physician is aware of previous values.
19. Arterial, Swan, and/or central venous lines are not functional and the RN cannot return the lines to functional status.
20. Patient falls.
21. Any medication error.
22. Adverse drug reactions requiring medical interventions.
23. Patient reporting pain and no current orders for analgesic, or patient reporting pain unrelieved after analgesic has been administered.
24. Other pertinent information, based upon the nurse's assessment/judgment.

Method for notifying physician/provider

The nurse is to determine which physician/provider should be notified about changes in patient's condition, concerns, etc. Contact the consulting physician for specialty focus problems. The attending and consulting physicians should be notified in the event of cardiac/respiratory arrest and/or death.

Medical Patients:

- Call the attending physician/hospitalist unless there is a consulting physician for the specific concern.

Surgical Patients:

- Call the surgeon or their representative (Resident/PA/APRN) with any surgery-related concerns/complications.
- Call the consulting physician if the concern/complication affects that specific body system (ex. pulmonary, renal, etc.).
- Call the hospitalist/internal medicine MD (if applicable) for general medical management concerns

Procedural Patients:

- Call the interventionalist physician with any concerns/complications
- Call the consulting physician if the concern/complication affects that specific body system (ex. pulmonary, renal, etc.).
- Call the hospitalist/internal medicine MD (if applicable) for general medical management concerns

Prior to calling the physician/provider:

1. Assess the patient yourself.
2. Consult Charge Nurse, RRT, or other resources as appropriate
3. Read the most recent physician Progress Note and nurses' documentation from the previous shift.
4. Review the patient's chart to determine the appropriate physician to call.
5. Check to determine if there are standing orders to cover this situation.
6. Have the patient's chart open in front of you or easily accessible in order to communicate the following pertinent information:
    - Patient's name, room number, date of admission, diagnosis, and code status
    - List of current medications, IV fluids and allergies
    - Date of any interventions, procedures, or surgeries performed.
    - Patient's most recent vital signs and Intake & Output
    - Pertinent labs, radiology results, EKG, finger stick blood glucose, and other test results
7. Obtain the appropriate "on call" schedule and determine the physician on call for the physician group. Also determine if there is a resident covering for this physician.
8. In non-emergency situations, check with the Charge Nurse before attempting to contact physician to coordinate multiple calls to the same physician.
9. Use the following modalities according to physician preference, if known.
    - Direct page
    - Physician's Call service (Exchange)
    - The physician's office (during weekdays)
    - Physician's personal cell phone
10. Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. If you are having difficulty contacting a physician during an emergency, notify the House Manager.

When calling the physician/provider (SBAR)

Situation: *What is the situation you are calling about?*

- Identify yourself, unit, patient, and patient's room number
- Briefly state the problem: What is it; when it happened or started, and how severe

Background: *Pertinent background information related to the situation could include the following:*

- Admitting diagnosis and date of admission
- Code status
- List of current medications, allergies, IV fluids
- Most recent vital signs
- Lab results: provide date and time the test was done and results of previous tests for comparison
- Other pertinent clinical information

Assessment: *What is your assessment of the situation?*

Recommendation: *What is your recommendation or what do you want the physician to do?*

Reference: Policy Stat: Guidelines for Notifying Physician/Provider for Change In Patient Condition

Restraints

CHI Saint Joseph Health aims to create an environment which minimizes circumstances that give rise to restraint use and maximizes safety. Restraint is the least preferred method of managing patients who present risk of harm to themselves or others and/or interferes with medical/surgical healing. Less restrictive interventions shall be explored initially. Restraints are implemented in the least restrictive manner possible and are stopped at the earliest possible time. Restraint(s) is limited to clinically appropriate and adequately justified situations. Orders for restraint use are never written as a prn order or as a standing order.

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion is the involuntary confinement of a patient in a room or an area, which the patient is physically prevented from leaving.

Forensic and Correctional Restriction is the use of restrictive devices or measures (for example, hand cuffs or police guard) applied and monitored by law enforcement for custody, detention, and public safety. Therefore, these measures are not involved in the provision of Health System and are not governed by this policy.

It is the philosophy of that all patients have the right to be free from restraints. The organization's philosophy and commitment is to:

1. Prevent, reduce, and strive to eliminate the use of restraints;
2. Prevent emergencies that have the potential to lead to the use of restraint;
3. Implement nonphysical interventions as the preferred interventions;
4. Limit the use of restraint to emergencies in which there is an imminent risk of a patient physically harming himself/herself or others;

5. Facilitate the discontinuation of restraint as soon as possible;
6. Preserve the patient's safety and dignity when restraint is used;
7. Provide education to increase awareness of the physical, psychological, and emotional effects restraint has on patients and/or families.

The principle of least restrictive intervention is observed in all cases involving the use of restraint devices. **Use the least restrictive device necessary to provide for the safety of the patient and others!**

Determine Need for Restraint	A licensed Nurse or Licensed Independent Practitioner (LIP) assesses the patient and concludes that use of restraint is indicated to protect the patient from injury or to promote the patient's well-being or healing.
Licensed Independent Practitioner Order for Restraint	Licensed Independent Practitioner provides an order for each restraint event, based on the risk of actual or potential harm to self or others or the need to maintain the well-being and health of patient. The order may be verbal, written or conveyed by telephone.
Time Limits for Medical Restraint	1. The licensed nurse must notify the MD as soon as possible to obtain the restraint order. If due to the individual situation, the restraint initiation and application was maybe necessary prior to obtaining the physician order. 2. If a patient was recently released from restraint and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required. The licensed nurse must notify the MD as soon as possible to obtain the restraint order if, due to the individual situation, the restraint re-initiation and reapplication was necessary prior to obtaining the physician order. **However, a temporary release that occurs for the purpose of caring for a patient's needs (But not limited to/during certain treatments/procedures.)--For example, toileting, feeding, and range of motion is not considered a discontinuation of the invention**. 3. **Restraint orders must be renewed daily.**
Explain Use of Restraint Devices to Patient and/or Family	Explain to patient and family why restraints are in use. Document education provided to patient and family in the medical record.
Power Plan	Plan of care for the restrained patient is individualized and documented by the assigned licensed nurse at all times.
Apply Restraint Devices	1. Inspect patient's skin condition before applying restraints and document findings. a. WHENEVER POSSIBLE, AVOID APPLYING RESTRAINT DEVICES PROXIMAL TO IV SITES.

	b. Apply restraints according to manufacturer's directions in a way that allows for quick removal by staff. c. Attach restraints to a secure, solid part of the bed or chair. d. DO NOT SECURE RESTRAINT DEVICES TO BED RAILS OR HEAD OF BED, RATHER, SECURE THEM TO BED FRAME. Assure that restraint devices are loose enough to allow circulation to distal extremity.
Documentation of Restraint Device Justification and Use	Document in the medical record: 1. Less restrictive interventions attempted/considered prior to the restraint(s) 2. Reason for the restraint(s) 3. The type of restraint devices applied Criteria for discontinuation of restraint
Patient Monitoring/ Documentation	Patients in restraints are monitored at least every 2 hours according to need. Monitor: • The patient's physical and emotional well being • That the patient's rights, dignity, and safety are maintained. • Whether less restrictive methods are possible. • Whether patient continues to exhibit behavior that necessitates continuation of restraints. • Changes in the patient's behavior or clinical condition needed to initiate the removal of restraints. • Whether the restraint has been appropriately applied, removed, or reapplied. Check the following at least every **2 hours** & document: • Circulation and skin integrity of involved extremities • Toileting, food and fluids are offered. • Perform ROM and rotate restraint sites, if patient condition permits. • Position Changes • Vital Signs These may be performed based on scope of practice
Discontinuation of Restraint Devices	The licensed nurse releases the patient from restraint as soon as possible, based on assessment and reevaluation of the patient's condition
Reinitiating the Restraint(s)	Based on assessment and re-evaluation of patient's condition, the licensed nurse is to document the criteria to reinitiate. **NOTE**: If the restraint is discontinued for any reason other than meeting

	patient's personal (i.e. toileting, feeding) or ROM needs, a new physician order must be obtained.

Medical Seclusion/Violent Restraints

Used only in emergencies when nonphysical interventions are ineffective or not viable and when there is an imminent risk of a patient physically harming him or herself, staff, or others. Use the least restrictive intervention necessary to provide for safety of the patient and others. Restraint is never permitted for coercion, discipline, convenience, or retaliation by staff. The use of restraint is not based on a patient's restraint history or solely on a history of dangerous behavior.

The principle of least restrictive intervention is observed in all cases involving the use of restraint devices

Determine Need for Restraint Use: Emergency Power Plan	• Emergency: severely aggressive/destructive behavior • Behavior places staff/others in imminent danger • Behavior places patient in imminent danger A Licensed nurse or Licensed Independent Practitioner (LIP) assesses the patient and concludes that the patient's behavior is destructive, aggressive or violent and presents an immediate threat of harm to self or others. In emergency situations, a qualified licensed nurse may restrain a patient prior to receiving an order from a Licensed Independent Practitioner. A Licensed Independent Practitioner must see and evaluate the patient within one hour of the time restraints are started***. If a physician is not available to perform a face-to-face evaluation within one hour, then contact a House Manager or RRT to perform the face-to-face evaluation***. .
Time Limitation of Orders	Orders are limited to: • 4 hours for adults 18 years of age and older • 2 hours for adolescents and children ages 9-17 • 1 hour for children less than 9 years of age. If restraints are discontinued prior to the expiration of the original order, a new order is required before restarting the use of restraint regardless of whether or not the time frame of the original order has been exceeded.
Order Renewal/Continuation	The original order may be renewed ***one time*** (4 hour increments for adults and 2 hours increments for adolescents) by telephone or verbal order. Use beyond the one time renewal requires a new order. A qualified licensed nurse contacts the LIP by telephone, communicates findings of the most recent assessment of the patient, and requests the original order be renewed. Order renewals are entered in the medical record. A LIP must complete a face-to-face evaluation of the patient

	before writing a new order. Orders for restraint use are never written as a prn order or as a standing order.
Restraint Type	Consider the intended purpose of restraint in deciding what device to use.
Patient/Family Education	Explain to patient and family why restraints are in use. Provide support for family/significant other. Document any education provided to patient and family in the medical record.
Apply Restraint Devices	1. Inspect patient's skin condition before applying restraints and document findings. 2. WHEN POSSIBLE, AVOID APPLYING RESTRAINT DEVICES PROXIMAL TO IV SITES. 3. Apply restraints in a way that allows for quick removal by staff. 4. Attach restraints to a secure, solid part of the bed or chair. 5. DO NOT SECURE RESTRAINT DEVICES TO BED RAILS OR HEAD OF BED, RATHER, SECURE THEM TO BED FRAME. Assure that restraint devices are loose enough to allow circulation to the distal extremity.
Monitoring/ Documentation	Continuous means uninterrupted observation of that patient for as long as the restraint is used. In-person means that the observer must have direct eye contact with the patient. However, this can occur through a window or through a doorway, since staff presence in the room in which the patient is restrained could be dangerous or add to patient agitation. Assess the patient at the initiation of restraint and every 15 minutes thereafter. The assessment includes the following, as appropriate: • Distal circulation and skin integrity of involved extremities • Offer toileting, hygiene, food and fluids • Perform ROM and rotate restraint sites, if patient condition permits • Physical and psychological status and comfort • Readiness for discontinuation of restraint. • VS based on individual patient needs Documentation includes, but is not limited to: 1. Specific behavior requiring restraint 2. Less restrictive interventions considered and/or attempted 3. Patient response to intervention 4. Patient behavior and condition at least every shift

	5. Basic care delivered Patient response to weaning from restraint

Reference: Policy Stat: Restraints

Safe Patient Handling and Movement

At CHI Saint Joseph Health, the Safe Patient Movement and Handling policy is one part of a comprehensive program to prevent musculoskeletal injuries to all patient care employees, one of our most valuable resources. The policy recommends guidelines to ensure that the handling and movement needs of all patients are assessed. The patient should be encouraged to assist in their own transfers and handling aids must be used whenever they can help to reduce the risk of injury to the patient care worker and the patients, if the aids are not contrary to their condition or need. All patient care employees responsible for the movement and /or transferring of patients shall be aware and trained on the correct procedures for moving and handling patients. Adherence to this policy ensures that patients are being moved safely while encouraging patient mobility and independence.

A Safe Patient Movement System for patient care employees will be implemented for all patient care units, including the following key elements:

A. A Safe Patient Handling and Movement Team will be established to develop Safe Patient Handling and Movement policies, procedures, and guidelines for all patient handling tasks and use of all equipment and transfer devices/aid; monitor and evaluate the System through incident and injury review, action plan review, equipment utilization and ensure continuous training and education programs, updating as needed. The team will include patient care workers, non-managerial nurses, nursing leaders and safety leaders.

B. There will be a Mobility Coach/Safety Champion to provide resources, options, equipment review/analysis, and training assistance for implementation and continuance of the safe patient handling and movement activities on each unit/facility.

C. Patient handling and movement processes that support a Culture of Safety.

D. The use of evidence based approaches and research to provide information regarding the technology needed for the ongoing success of the Safe Patient Movement and Handling Policy.

E. Safe patient handling is an essential part of every patient's plan of care. The patient's abilities and needs are continuously assessed and communicated from admission through discharge to establish compliance with that patient's safe handling.

Definitions

A. **High Risk Patient Handling Tasks**: Patient handling tasks that have a high-risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring tasks, lifting tasks, repositioning tasks, bathing patients in beds, making occupied beds, dressing patients, turning patients in bed, and tasks with long duration.

B. **High Risk Patient Care Areas:** Inpatient hospital wards with a high proportion of dependent patients, requiring full assistance with patient handling tasks and activities of daily living.

Designation is based on the dependency level of patients and the frequency with which patients are out of bed.

C. **Manual Lifting:** Lifting, transferring, repositioning, and moving patients using the patient care worker's body strength without the use of lifting equipment/aids to reduce the forces on the patient care worker's musculoskeletal structure.

D. **Mechanical Patient Lifting Equipment:** Equipment used to lift, transfer, reposition, and move patients. Examples include portable base and ceiling track mounted full body sling lifts, stand assist lifts, and mechanized lateral transfer aids.

E. **Patient Handling Devices/Aids:** Equipment used to assist in the lift or transfer process. Examples include gait belts with handles, stand assist aids, sliding boards, and surface friction-reducing devices.

F. **Culture of Safety:** Describes the collective attitude of employees taking shared responsibility for safety in a work environment and by doing so, providing a safe environment of care for themselves as well as patients.

G. **Direct Patient Care Employees**: An individual involved in the provision of care to another individual and who works for the employer at any level in the continuum of care. Examples of healthcare workers, include, but are not limited to: nurses, nursing assistants, resident assistants, home health aides, direct care workers working in community settings, occupational therapists, physical therapists, therapist assistants, radiology technologists, infection control practitioners, peer leaders, social workers, emergency medical technicians, paramedics, and transporters, physicians, educators, and students engaging in clinical practicums.

H. **Technology**: The assistive tools used to facilitate the healthcare workers performance of safe patient handling, movement, and mobility tasks. These tools, in most instances, should minimize the risk of injury to the healthcare recipient and the healthcare worker. Technology may include equipment, devices, accessories, software, and multimedia resources.

Safe Patient Movement Requirements

A. Assess all patient handling and movement tasks, avoiding hazards whenever possible.

B. Assess each patient's strength and assistance ability prior to beginning any patient lift, handling, repositioning, or movement.

C. When indicated, use mechanical lifting devices and other approved patient handling devices/aids for ALL patient handling and movement tasks except when absolutely necessary to the provision of emergency patient care procedures.

D. Use mechanical lifting devices and other approved patient handling devices/aids in accordance with instructions and training.

E. See attached Safe Patient Handling and Movement algorithms.

Education and Training

A. Proper training on use of each piece of lifting and transfer equipment should be completed for all new patient care employees upon hire and on an ongoing basis to support proper

use/understanding and competency of safe patient handling and movement equipment and aids/devices.

B. The clinical education department provides assistance in the coordination of on-going, on-unit, or other trainings in conjunction with mobility coaches and nurse leaders.

C. Each patient care department/unit should have an employee designated as the trainer (Mobility Coach) for their area.

D. New patient care employees should receive training during department-specific orientation from the Mobility Coach in their unit/department at which time a skills checklist will be completed. During training, this policy will be available for the employee to review.

E. No new, temporary, agency or transferred patient care employee should use lifting and transfer devices without completion of the skills checklist.

F. Annual observed competency will be required of any patient care employee using lifting and transfer equipment. Retraining should be recommended and completed for employees using transfer/lift equipment as indicated.

G. All patient care employees should complete and document Safe Patient Handling and Movement training incorporating the components in the Safe Patient and Handling Movement Module and Culture of Safety initially on hire, with competency review annually and as required to promote proper use/understanding of safe patient handling and movement equipment, transfer aids/devices.

Patient Assessment

A. Upon admission, an assessment should be performed by the nurse assigned to the patient to determine the need for mechanical lift. The nurse should use the Admission History to determine which equipment may be necessary. Any change in the patient's condition may change the need for equipment, and a reassessment should be performed and documented.

B. When evaluating the use of the lifts, the condition of the patient, their capabilities, their medical condition and their cognitive abilities should be reviewed. The admitting nurse should assess to determine if the patient requires assistance for transfer or lifting. Patients who require a mechanical lifting or transfer device should be identified by documentation of recommended equipment in the medical record.

C. The Nurse Manager or Mobility Coach may be consulted when deciding any change in a patient's mandatory transfer/lifting status. Assessment input may also be acquired from Physical Therapists.

D. See attached Safe Patient Handling and Movement algorithms.

E. Patient refusal: the mentally competent patient does have the right to refuse handling and the use of the lift equipment. However, if the patient refuses the use of lift equipment deemed necessary to provide a safe mechanism for staff to handle the patient, the staff, who believe in good faith they could be exposed to risk of injury, are entitled to refuse to engage in the handling of the patient. Safety of both staff and the patient are ultimate goals of this guideline, and the refusal of a patient to allow staff to safely engage in their work is not conducive to the goal of the Safe Patient Handling and Mobility Program. This should be heavily documented in the patient record, and an incident report should be filed, as well as immediate notification of the Risk Management team. The patient's physician and family should be notified of the patient’s refusal to comply with the plan of care. The patient

should be educated about the risks of refusal of treatment, and every attempt to encourage the patient to comply with the plan of care should be utilized.

Patient Lift/Transfer

A. Every precaution is used to safeguard the patient when making a mechanical or manual lift, transfer or move.

B. Plan any lift, transfer or move ahead of time. Have the proper equipment or personnel on hand. Ensure everyone involved in the task understands his or her role in the transfer, lift or move.

C. Arrange the environment as necessary. Make sure there is appropriate space to maneuver and work in to ensure a safe lift, transfer or move.

D. Explain all lifts, transfers and moves to the patient involving mechanical equipment or a manual lift. Enlist as much help from the patient as possible.

E. Mechanical lifting and transfer equipment is available for use by trained associates. The lifting and transfer equipment will be located in accessible areas on the applicable nursing unit. The equipment will be returned to the location upon completion of a lift.

F. Prior to using a mechanical lifting and transfer device the nurse will ensure that proper planning for the transfer/lift has been accomplished and will request assistance when required for any difficult lift/transfer.

G. Physical Therapy or Occupational Therapy, when appropriate, may work with the unit to adjust lifting and transfer protocols for a patient when a change is warranted.

H. Extremely combative patients require a minimum of two employees to assist in lifts and transfers.

Mechanical lifting equipment and other transfer devices/aids:

A. **Storage**
   1. The lifts will be located in accessible areas on applicable nursing units. (see attached list of available equipment) The equipment will be returned to the designated spot following usage to ensure availability for the next lift/transfer.
   2. Lifts will not leave the floor in which they are assigned without permission of the Nurse Manager or designee.
   3. Disposable slings should be assigned to a patient upon identification of need and kept in the patient's room for the duration of the patient's stay.
   4. Reusable slings (<u>for Tenor lift only</u>) should be kept with the Tenor lift.
   5. Slide sheets should be located on each unit/department.

B. **Equipment Maintenance**
   1. All lifting and transfer equipment including slings should be inspected as required.
   2. Any lift found to be non-operational should be tagged with a Clinical Engineering tag and Clinical Engineering should be notified immediately. For equipment still under manufacturer's warranty, or as indicated by Clinical Engineering, a repair technician should be contacted.
   3. If any lift is removed from the unit/department for maintenance, arrangements should be made to ensure a lift is made available when needed.

C. **Batteries and Chargers**

1. Each battery operated lift is equipped with two batteries and one battery charger. The battery charger should be located in an assigned location on the nursing unit.
2. The charger should remain plugged in and there is no danger of "overcharging" the battery.
3. The batteries should be switched out a minimum of once per day and possibly more dependent upon level of usage.

D. **Slings**
1. Disposable (single patient use) slings should be used except in certain circumstances. Disposable slings should be ordered per each unit/department.
2. In the event that a reusable sling is required (due to weight of patient/use of Tenor lift), the sling should be laundered per the Rehab policy.

E. **Infection Prevention**
1. All patient lifting equipment, slings, and assistive devices should be cleaned and laundered to comply with the facility's invention control procedures and policies. Disposable slings should be used on all patients. If reusable slings are used, store the sling at the patient's bedside and have laundered per Rehab policy when no longer needed.
2. Lifting and transfer equipment should be disinfected with hospital-approved disinfectant after each use by wiping down the seat, support pads, handrails, etc. Cleaning the equipment should be done by the person using the equipment after the lift has been completed and prior to it being placed back in its parking position. Refer to Infection Prevention and Control policy.
3. Slide sheets are single patient use.

Lift Selection

B. **If patient can stand, pivot and walk with no physical assistance from associate with NO risk of falling:** No lift needed.
C. **Patient cannot stand, pivot or walk without physical assistance from staff:**
1. Consider **Sara Steady** if:
   - Patient is able to pull himself into a standing position.
   - If patient weights less than 401 lbs.
2. Consider **Sara Steady Plus** if:
   - Patient weighs less than 420 lbs.
   - Patient can bear weight on at least one leg
   - Patient is able to grip with at least one hand
   - Patient is able to follow instructions
   - Patient can sustain moderate pressure to lower back.
3. Consider **Maxi Move (if not appropriate for Sara)** if:
   - Patient weighs less than 503 lbs.
   - Patient needs to be lifted from the floor, bed or stretcher
   - Patient cannot bear weight on legs
   - Patient can undergo a semi reclined position

4. Consider **Tenor** if:
   - Patient weighs less than 705 lbs.
   - Patient needs to be lifted from the floor, bed or stretcher
   - Patient cannot bear weight on legs
   - Patient can undergo a semi reclined position
5. Consider **Maxi Lite** if:

- Patient weighs less than 350 lbs.
- Patient needs to be lifted from the floor, bed or stretcher
- Patient needs to be assisted in or out of vehicle
- Patient can undergo a semi reclined position

6. Use **Slide Sheet** if:
   - Patient cannot move self in bed
   - Patient requires assistance with moving up in bed or turning
   - Patient requires assistance with lateral transfer

Skin and Wound Assessment and Management

The skin assessment and risk assessment for skin breakdown should occur within 4 hours of admission, within 4 hours of the start of each shift, when transferred from another unit/department, and when indicated by a change in patient condition.

1. The Registered Nurse (RN) will have a second licensed clinician (RN, Licensed Practical Nurse (LPN), Licensed Independent Practitioner (LIP)) then verify that initial assessment within four hours of the patient's arrival, upon discovery of a suspected pressure injury, and when transferred from another unit/department.
2. The primary RN will document the assessment in full, while the second licensed clinician (RN, LPN, LIP) will indicate verification of the initial assessment by verifying that they agree with the primary RN's assessment.
3. An individualized plan of care will be developed based on the initial assessment and revised based on the ongoing assessment by the RN.

All patients will receive individualized multidisciplinary goal-directed care to prevent skin breakdown and promote healing.

- The Braden scale will be used to assess risk for skin breakdown.
- All interventions and protocols and guidelines will be evidence-based.
- Based upon advanced preparation, staging performed by a wound care nurse will supersede the staging by a registered nurse.
- The staging assigned by a physician will supersede the staging performed by any registered nurse.

Definitions:

Braden Scale for Predicting Pressure Sore Risk: Is a valid and reliable risk assessment tool that assesses the patient's level of risk for skin breakdown based on the categories of: Sensory Perception, Moisture, Activity, Mobility, Nutrition and Friction and Shear; and which results in a score indicating the level of risk (the lower the score, the higher the risk for skin breakdown). Scoring is as follows:

- Mild Risk = 15-18
- Moderate Risk = 13-14
- High Risk = 10-12
- Very High Risk = ≤ 9
- Addressing each subscale should be considered.

Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by

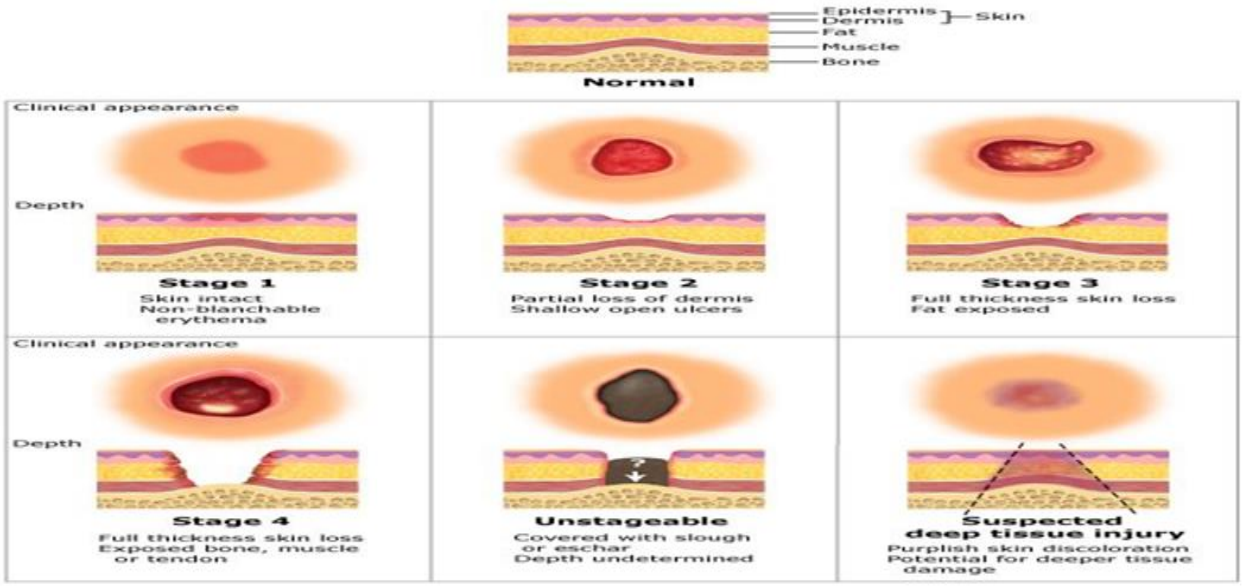
microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

Pressure Injury (Ulcer) Staging System: Standard method of defining the progressive characteristics of pressure ulcers: Pressure ulcers will be assessed according to the following definitions:

- **Stage 1 Pressure Injury (Ulcer)-Non-blanchable erythema of intact skin**
  Intact skin localized area of non-blanchable erythema (redness), which may appear differently in darkly pigments skin. Presence of blanchable erythema (redness) or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
- **Stage 2 Pressure Injury (Ulcer)- Partial-thickness skin loss with exposed dermis**
  The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI) or traumatic wounds (Skin tears, burns, abrasions).
- **Stage 3 Pressure Injury (Ulcer) –Full-thickness skin loss**
  Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
- **Stage 4 Pressure Ulcer-Full thickness skin and tissue loss**
  Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury.
- **Unstageable- Obscured full-thickness skin and tissue loss**
  Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 Pressure Injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
- **Suspected Deep Tissue Pressure Injury (DTPI)- Persistent non-blanchable deep red, maroon or purple discoloration**
  Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic or dermatologic conditions.
- **Medical Device Related Pressure Injury (MDRPI)**
  Medical device relate pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or

shape of the device. The injury should be staged using the staging system.

- **Mucosal Membrane Pressure Injury**
  Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged.



Non-Pressure Related Wounds

- **Partial-Thickness Wounds**: Involve the loss of the epidermis and possibly part of the dermis. Partial thickness wounds appear very shallow/superficial and are painful. They repair by regeneration.
- **Full-Thickness Wounds:** Involves destruction/loss of all skin layers (epidermal and dermis). The base of the wound could reveal subcutaneous tissue, fascia, muscle, or bone. None of these layers can regenerate and must heal by scar formation (granulation tissue).
- **Examples of non-pressure related wounds:**
  - **Skin Tear:** A traumatic wound resulting from separation of the epidermis from the dermis.
  - **Lacerations:** is a type of injury in which skin and or tissue is torn, cut or punctured.
  - **Surgical Wound:** A wound caused by surgical means which is typically re-approximated unless it has been intentionally left open to heal by secondary intention or has dehisced.
  - **Burns:** A burn is an injury that may be caused by heat, cold, electricity, chemicals, light, radiation, or friction. Burns can vary in depth of the tissue destruction.
  - **Abrasions:** A wound consisting of superficial damage to the skin (partial thickness skin loss) from traumatic injury.
  - **Arterial Ulcers:** Occur as a result of inadequate blood flow. Usually are small, deep, dry or with minimal exudate, are pale or may have necrotic tissue, punched out appearance and located distally on the body (e.g., ankle, toes)
  - **Venous Stasis Ulcers:** Occur as a result of impaired return of venous blood from the tissues to the heart. Located around the medial malleolus, shallow exudative ulcer, with dark red wound base or thin layer of yellow slough, irregular wound edges, periwound maceration, crusting, scaling or hemosiderin staining.
  - **Neuropathic/Diabetic Ulcers:** Occur typically from traumatic injury secondary to insensate foot and resemble a puncture, laceration or blister. Wound base may be pink or necrotic with well-defined smooth edges, small to moderate amount of exudate. Periwound skin often presents with callus.

- **Ischemic Wounds/Dry Gangrene:** Wounds caused by lack of perfusion to distal extremities usually the toes, presenting with dry, shrunken and dark black tissue, resembling mummified flesh.

Procedure:

I. Assessment

A. Assessment of Skin:

1. Assess and document wounds on admission, upon discovery, every shift, and with any change in wound status.
2. Complete a 2-licensed clinician skins assessment within 4 hours of admission, upon discovery of a suspected pressure injury, and when transferred from another unit/department.
3. Photograph all wounds and pressure injuries on admission, weekly (Measurement Mondays), upon discovery, prior to discharge, and/or with any change in status.
4. Assess the skin and identify abnormalities and include, but is not limited to:
    a. Presence of rash, bruises, scars, sores or pressure ulcers.
    b. Abnormality of Skin condition
    c. Abnormality of Skin color
    d. Abnormality of Skin turgor
    e. Identification of all abnormalities on an anatomical figure
    f. Moisture

B. Assessment for Risk of Skin Breakdown:

1. Complete the risk assessment using the Braden Risk Scale within 4 hours of admission, within 4 hours of the start of each shift, and PRN for change in patient condition.
2. Include the risk factors listed and address each subscale, if applicable:
    a. Sensory Perception
    b. Moisture
    c. Activity
    d. Mobility
    e. Nutrition
    f. Friction and shear

C. Wound specific assessment:

1. Complete an assessment of all wounds within 4 hours of admission, within 4 hours of the start of each shift, upon first discovery of the wound, weekly (Measurement Mondays), with a change in wound status, when the wound has resolved, upon transfer, and upon discharge.
2. Include in the assessment of wounds, as applicable:
    a. Location
    b. Size (length, width, and depth)
    c. Color of wound bed
    d. Drainage type
    e. Drainage amount
    f. Odor
    g. Peri-wound skin
    h. Tunneling or undermining
    i. Assessment of pressure related wounds will include stage.

3. Consult the wound care nurse to assist with staging as needed. If assistance required please contact via computer system or by phone.
4. Consult the wound care nurse when the wound is a suspected hospital acquired pressure ulcer.
    a. Complete an IRIS report for any pressure ulcer that develops while the patient is in the hospital for quality monitoring purposes.

D. Photographic Documentation
1. Photograph all wounds and pressure injuries on admission, weekly (Measurement Mondays), upon discovery, before discharge, and/or upon any change in status.
2. Post any photographs on the "Photographic Wound Documentation Form" and file under the Doctor's Orders section of the patient's chart by date

E. Physician Notification
1. Notify the physician of the presence of any impaired skin integrity.
2. Obtain specific physician orders for wound/skin care if the physician wishes to supplement wound care guidelines.
3. Follow the physician orders as they always supersede the guidelines.

II. Consultations

A. **Wound Care Consultation**: The Wound Care Nurse will provide recommendations for the treatment of the patient's wounds.
1. Consult the wound care nurse based on patient need including the following situations
    a. Patients admitted with pressure injuries (ulcers)
    b. Patients with hospital acquired pressure injuries (ulcers)
    c. Patient's wound is deteriorating or not improving
    d. Patients with skin/wound issues not easily identified
    e. Patient wound in need of treatment not addressed by guidelines or physician.
2. Contact Physician (i.e. surgery, podiatry etc.) directly, for any wounds being addressed by the physician. When wound care treatment is directed by the physician, it is not necessary to consult the wound care nurse, unless ordered by the physician or in the event that the nurse has a question or a concern.

B. **Registered Dietitian**: Request Dietary Consult for the following situations:
1. All patients with stage 2, Stage 3, stage 4, DTPI, or unstageable pressure injuries (ulcers)

C. **Diabetes Educator** Request consult for patients who have diabetes with actual pressure injury (ulcer), neuropathic ulcer and/or high risk of skin breakdown and require education on care or treatment.

D. **Respiratory Therapy** will routinely see patients on non-invasive ventilation therapy, high flow oxygen therapy, and O2 nasal cannula with pressure injury (ulcer) or high risk for skin breakdown.
1. Devices will be moved and/or removed at least once a shift to assess skin integrity.
2. Respiratory Therapy will perform rounds at least once a shift and document assessment and actions in Cerner.
3. Patient/family shall be informed of the potential for skin breakdown with the use of respiratory devices and the life-saving benefits of the treatment.

E. **Physical or Occupational Therapy** Request Consult for patients who have skin or risk problems related to mobility or activity if indicated. (Physician order required)
F. **Specialty physicians**: Request consult (Physician order required)
    1. Surgery or infectious disease if the wound appears infected
    2. Podiatry if the wound is on the foot
G. **Wound Care Center** Request consult if the patient is going home with a wound and requires treatment post-discharge. (Physician order required)

III. Treatments
A. Coordinate and modify the treatment in collaboration with the physician and other members of the healthcare team including, but not limited to wound care team, nutrition, respiratory therapy, occupational therapy and physical therapy.
B. Continue the treatment (whether physician orders, Wound Care Nurse recommendations, Pressure Injury (Ulcer) Prevention and Treatment Guideline or Skin Tear Guidelines if the wound shows improvement, as evidenced by:
    1. Decrease in size (depth, width or length)
    2. Decrease in necrotic tissue/slough,
    3. Increase in granulation (beefy, red, moist tissue)
C. Notify the physician and/or wound care nurse for change in treatment orders if the wound is deteriorating as evidenced by:
    1. Increase or no change in size (i.e. not healing or improving)
    2. Increased necrotic tissue/slough
    3. Increase or change in odor
    4. New peri-wound redness/induration/warmth
    5. New tunneling/undermining
    6. New exposure of a deep tissue structure
D. Dressing selection
    1. Select dressings based on presence or absence of exudate, wound depth, presence of tracts or tunnels and volume of exudates. All wounds require a moist wound environment to heal.
    2. Dressings are divided into two categories: Filler dressings and Cover dressings.
        a. Filler Dressings: are placed inside the wound bed to fill depth of wound, undermining and tunnels
        b. Cover Dressings: are placed on top of the wound
    3. Dressings are either absorptive or hydrating: base selection of dressing on volume of exudate produced by the wound
        a. Dry wounds require moisture
            a. Excludes dry, stable intact eschar to the heels and feet
            b. Excludes arterial ulcers in the presence of poor perfusion
        b. Wet (exudating) wounds require absorption
        c. Wounds with depth greater than 0.5cm require a filler dressing and a cover dressing
        d. Wounds with depth less than 0.5cm require only a cover dressing.
E. Removal of necrotic tissue
    1. In the presence of adequate perfusion, necrotic tissue can be removed by autolytic (using patient's own immune system) or enzymatic debridement
    2. Sharp debridement by qualified professional when indicated

IV. Prevention Interventions: PUPP (Pressure Ulcer/Injury Prevention Program)

A. Pressure redistribution
    1. Turn and reposition the patient at least every two (2) hours and as needed unless contraindicated by patient's condition.
        a. Frequency of position changes should be adjusted for the individual patient and is determined by evaluation of their skin status after progressively lengthening intervals between position changes.
        b. Increase the frequency if redness develops.
        c. Use Left-Right-Back for turning schedule.
        d. Use 30 degree side lying position when positioning the patient on the left or right. Avoid positioning patient directly on their hip bones.
            a. Modify repositioning for critically ill patients as indicated
    2. Ensure pressure redistributive surfaces are functioning properly.
    3. Offload heels off the bed as appropriate, may consider offloading boots.
    4. Place pillows between knees and bony prominences as needed.
    5. Consider heel relief functions on bed if available.
    6. Remove anti-embolism hose, heel protective boots, sequential compression devices or any other device that obscures the complete assessment of skin and assess the patient's skin integrity every shift.
B. Patient Mobility/Activity/Friction and Shear:
    1. Perform range of motion to all joints if not contraindicated daily as tolerated.
    2. Use a lift and/or Sally Slide Sheet to position patient.
        a. Using a Sally Slide Sheet will prevent friction and shearing and decrease the need for manual lifting. Please remove slide sheet between repositioning.
        b. Limit layers of linen
    3. Use lift equipment as appropriate to reduce friction and shear.
    4. Apply a trapeze bar to the bed to facilitate independent patient movement as appropriate.
    5. Keep the head of the bed at or below thirty degrees if not contraindicated to prevent shearing forces.
    6. Encourage ambulation as ordered
    7. Reposition chair-bound patients Q1H, consistent with overall goals of care
    8. Encourage patients who are able to reposition independently to shift weight every 15 minutes.
C. Moisture control (Refer to Incontinence Guidelines):
    1. Perform perineal care as soon as possible after toileting and each episode of incontinence; choosing appropriate skin care products according to patient indication.
    2. Institute measures to manage moisture.
        a. Patients who have deep skin folds need increased attention to cleansing of those skin folds and keeping area clean and dry.
        b. Patients who are diaphoretic need increased attention to keeping the skin clean and dry.
    3. Institute measures to control and contain incontinence.
        a. Fecal management systems as appropriate
        b. Urine management systems as appropriate
        c. Do not use briefs except for ambulation of incontinent patients.
            a. Remove the brief when patient is placed back in bed, unless the

patient specifically requests the use of the brief.

D. Nutrition
    1. Consult the Dietitian for individual patient assessment and assistance with optimizing nutrition.
    2. Use flexibility and creativity in accommodating the patient's food preferences.
    3. Provide adequate hydration, calories and protein.
    4. Monitor lab values (serum albumin, pre-albumin).
    5. Encourage intake of dietary supplements as ordered.
    6. Monitor patient weight as indicated

E. Device related prevention strategies (refer to medical device guidelines)
    1. Remove and/or move devices Q shift to assess skin integrity.
    2. Avoid placing devices over sites of existing or prior pressure ulceration.
    3. Choose the correct size of medical device to fit the patient.
    4. Confirm that devices are not placed under a patient who is immobile or bedridden.
    5. Cushion and protect the skin with dressings in high risk areas (nasal cannula, BiPap etc.)
    6. Ensure appropriate stabilization and fixation of devices.

F. Respiratory Prevention (refer to medical device guidelines)
    1. Apply a dressing between the mask and/or straps of the cannula or mask and the skin.
    2. Apply E-Z wrap to nasal cannula tubing/venti-mask straps to protect the ears
    3. Lift mask/strap and dressing every two hours to assess underlying skin.
    4. Change dressings every three days and PRN.

G. Sacral Pressure Injury (ulcer) Prevention
    1. Apply Silicone Border dressing
    2. Peel back Q shift to assess skin integrity and reapply
    3. Change dressing Q 3 days and PRN.

H. Heel Pressure Injury (Ulcer) Prevention
    1. Apply Silicone Heel Dressing
    2. Peel back Q shift to assess skin integrity and reapply
    3. Change dressing Q3 days and PRN

V. Education
    A. Provide appropriate education related to pressure injury (ulcer) prevention and treatment of wounds will be provided to the patient, family or caregiver.

VI. Documentation
    A. Plan of Care
        1. Include the multidisciplinary team, rounds and/or family meeting when developing the Plan of Care.
        2. Document the plan of care for wounds in Cerner as appropriate for each patient.
        3. Incorporate the specific risk factors identified during risk assessment into the plan of care.
    B. Risk Assessment
        1. Document a Risk assessment within 4 hours of admission, within 4 hours of the start of every shift, and as needed.
    C. Skin assessment
        1. Skin assessment and reassessment will be documented within 4 hours of

admission, within 4 hours of the start of the shift, upon transfer, when indicated by a change in patient condition or treatment, and upon discharge

D. Wound specific assessment
    1. Interventions/Treatments for all wounds whether they are from the treatment guideline, WOCN recommendations or physician orders, will be documented in Cerner under wound assessment and treatment
    2. Reassessment of Actual Wounds/Pressure Injury (Ulcer) shall be done every shift.

E. Patient refusal to turn
    1. Consider a specialty bed for increased pressure redistribution
    2. Educate patient and family on importance of turning to prevent/treat pressure ulcers
    3. Investigate patient's reasons for refusal and attempt to reconcile concerns/fears/misconceptions if possible
    4. Continue to offer to turn patient Q2 hours and PRN
    5. Document attempts and offers to turn patient and patient's reason for refusal to turn
    6. Document patient education on importance of pressure redistribution by turning

Sleep Apnea Assessment (STOP-BANG)

For all patients with whom an Admission History is completed, sleep apnea screening should be completed in the electronic record.

- Adult screening is completed using the S.T.O.P. and BANG screening tool found on the Admission History record.
- Pediatric screening is completed using risk indicators found on the Pediatric Admission History record.

Nursing Procedure:

1. Complete the S.T.O.P. and B.A.N.G. sleep apnea risk assessments in the Sleep Apnea tab of the Admission History in the electronic health record.
2. If the score indicates that the patient is at high risk for sleep apnea, the nurse will place end tidal monitoring on the patient.
3. If the ETCO2 monitor's high alarm triggers indicating apneic periods the nurse will contact the physician to obtain a physician's order for PAP therapy and enter it in the electronic medical record.
4. **Note: There is a Power Plan in the electronic record for Sleep Apnea at Risk that is available for the physician to order. (recommended)**

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel TIRED, fatigued, or sleepy during daytime?	YES	NO
Has anyone OBSERVED you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood PRESSURE?	YES	NO
BANG		
BMI more than 35 kg/m2	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference > 16 inches (40cm)?	YES	NO
GENDER: Male?	YES	NO

Reference Policy Stat: Sleep Apnea Assessment and Intervention for Hospitalized and Procedural patients

Suicide Precautions

The patient, despite age, presenting to with behavioral health complaints requires a focused assessment to determine risk to self and others. The RN should directly ask the patient "Are you thinking of harming yourself?" The overall biopsychosocial assessment includes suicidal ideation (SI), plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

The patient should be assessed by a Registered Nurse upon arrival to the Emergency department. The tool used at CHI Saint Joseph Health is the Columbia-Suicide Severity Rating Scale. The tool should be used on every patient aged 10 years and older who presents to the facility, regardless of presenting complaint.

General consent for treatment includes all scales and screens utilized by nursing staff as applicable, for all age ranges.

In the event that the patient appears to be violent, the Brøset Violence tool should be initiated and security should be notified immediately for any patient showing signs of violence.

Reference Policy Stat: Suicidal Patients: Assessment and Interventions

Violence Free Workplace

The primary goal of a violence free workplace is to provide a safe and secure environment for our employees, patients, business associates and visitors. To help achieve this goal, we have a policy of **zero tolerance for violence**. Each and every act or threat of violence will result in an immediate and firm response.

Violence is defined as any hostile or harmful behavior that directly and personally threatens an employee or other person with harm, physical attacks, unwanted or hostile personal verbal or physical contacts, or malicious damage to property. The policy applies to acts committed by employees, medical providers, patients, visitors, volunteers or business partners.

Examples of workplace violence include, but are not limited to: harassment, stalking, sabotage, intimidation, bullying, purposely withholding information necessary to perform work, verbal threats of harm or abusive verbal outbursts, assaults, bringing an unauthorized weapon to company premises, or other similar actions. Workplace violence includes oral or written threats and offensive jokes or comments. The violence above can be either covert or overt. Employees are required to immediately report any of the above to their immediate supervisor or other readily available leadership.

Non-emergency situation - defined as no imminent threat, such as intimidation or harassment by any person (including patients, visitors, hospital employees),

Team members faced with immediate danger due to impending in a non-emergency situation the employee who has reasonable cause to anticipate the above situation(s) may occur, or who has been subjected to any of the behaviors listed above, should immediately:

1. Report the incident to your direct supervisor
2. Inform the patient (if applicable) primary care physician.

3. Report the incident to the House Manager if your direct supervisor is not present. The House Manager will notify your direct supervisor and if indicated the hospital administrator-on-call.
4. If an employee is victim, they may enter an IRIS. If unable, direct supervisor should complete an IRIS report. Witnesses to the event should be utilized to help provide an account of the event in order to document the scenario clearly. If a patient is a victim, document an IRIS and contact Risk Management for further instruction.

All reports of violations will be kept as confidential as possible. No person will be retaliated against for reporting any violation in good faith.

Reference: Policy Stat: Violence Free Workplace

Saint Joseph Health System Automated Dispensing Cabinet User Authorization

[ ] Flaget Memorial Hospital [ ] Saint Joseph Hospital [ ] Saint Joseph East [ ] Continuing Care Hospital [ ] Saint Joseph Berea [ ] Saint Joseph Jessamine [ ] Saint Joseph Mount Sterling

EMPLOYEE NAME_____,_____ _____
Last First Middle Initial **(Required)**

UNIT_____SHIFT_____

Check your appropriate position:

___ **Registered Nurse**
LPN
Patient Care Tech (OR tech, Rad Tech, etc.)
Agency Nurse – Per Diem
Agency Nurse – Specify Contract Expiration Date:
Instructor – Specify Expiration Date:

☐ **Registered Nurse Applicant**
☐ **Physician**
☐ **House Administrator**
☐ **Other- Specify:**

___

Password Verification Statement for the Automated Dispensing Cabinets

I understand that my password, in combination with my User ID code, will be my electronic signature for all transactions to the Automated Dispensing Cabinets (ADC). All of my transactions on the ADC will be permanently recorded with my User ID and a time stamp and date. These records will be maintained and archived as per the policies of the hospital and will be available for inspection by the Drug Enforcement Agency (DEA), the State Board of Nursing, and the State Board of Pharmacy, as is presently done with my hand-written signature for controlled substance records.

I also understand that to maintain the integrity of my electronic signature, I must not give my password to any other individual. Sharing of passwords will result in disciplinary action, up to and including termination.

_____ _____

(Signature of Automated Dispensing Cabinet user) (Date)

_____

(Please print full name)

Access authorized by:_____Date: _____
(Nursing Manager/Clinical Educator)

BELOW INFORMATION TO BE COMPLETED BY PHARMACY:

USER ID:_____USER INACTIVE DATE: _____

Entered by:_____Date entered: _____

CHI Saint Joseph Health

Acknowledgment of Orientation Completion

Instructions: *Please print, sign, and date this form and return to HR or email to jennifersmith3@sjhlex.org.*

I hereby acknowledge that I have reviewed the Agency Orientation Booklet and the Clinical Orientation Packet in its entirety.

I understand that if I have any questions about the training, materials presented or information not addressed in the training, or if I encounter any problems, it is my responsibility to seek clarification from the designated Human Resources Liaison and/or Human Resources, the Unit Manager, or the Clinical Educator.

Employee Name (print): _____

Employee Signature: _____

Department Name: _____

Date: _____

Name: _____ Date: _____

Agency Nurse Orientation Quiz

Must be turned into Education Department before start of first shift

1. Concepts of Patient and Family Centered Care (PFCC) include all of the following except;
    a. Dignity and Respect
    b. Information Sharing
    c. Participation
    d. Unprofessional excuses
2. The P's of hourly rounding include the following except;
    a. Pain
    b. Position
    c. Potty
    d. Participation
3. One of the National Patient Safety Goals for 2020 is to improve staff communication. Ways to improve staff communication include all of the following except;
    a. Use repeat backs and read-backs
    b. Ask one or two clarifying questions
    c. Sending patient to a procedure without giving SBAR report
    d. Timely reporting of critical results
4. As part of the dress code nurses can wear galaxy blue tops and bottoms or galaxy blue top and black bottoms. True or False?
5. Code Silver indicates what kind of emergency?
    a. Active Shooter
    b. Fire
    c. Missing Adult
    d. Bomb Threat
6. Which is not part of the acronym R-A-C-E in case of a fire?
    a. Rescue
    b. Run
    c. Alarm
    d. Contain
7. The suicide screening scale used at CHI Saint Joseph Health is?
    a. Columbia-Suicide Severity Rating Scale
    b. Broset Violence Tool
    c. Sad Faces tool
    d. MEWS
8. Reasons to call Rapid Response team include all of the following except;
    a. Systolic BP of 105
    b. Systolic BP of 80
    c. Diastolic BP of 125
    d. 20% change in vital signs from patient's baseline
9. The 5 categories of the Modified Early Warning System (MEWS) are Level of Consciousness, Respiratory Rate, Heart Rate, Systolic Blood Pressure and Temperature
10. The assessment used at CHI Saint Joseph Health for Sleep Apnea is the Stop-Bang questionnaire.
11. The A in BANG for the Stop-Bang questionnaire stands for?
    a. Address

b. Age
c. Angle
d. Ability

12. A score of 11 on the Braden Scale means the patient is what level of risk for developing a pressure ulcer?
    a. Mild
    b. Moderate
    c. High
    d. Very High
13. When obtaining a finger stick using the Nova StatStrip Glucose Meter the nursing care tech reports that the patient has a critical low of 29. The nurse knows the next step is to;
    a. Repeat the finger stick on the same glucometer to verify the result.
    b. Call Rapid Response
    c. Give D50 intravenously
    d. Call Doctor
14. To prevent rebound hypoglycemia the nurse delegates the nursing care tech to repeat a finger stick in how much time after a patient has reached 70 mg/dl?
    a. 15 minutes
    b. 20 minutes
    c. 45 minutes
    d. 60 minutes
15. The initial flow rate for red blood cell transfusion is?
    a. 200 ml/hr.
    b. 50 ml/hr.
    c. 100 ml/hr.
    d. 75 ml/hr.
16. Blood transfusions must be complete in how much time after receiving from blood bank?
    a. 2 hours
    b. 4 hours
    c. 6 hours
    d. 8 hours
17. A patient has been placed in non-violent restraints. How often should vital signs be obtained and documented?
    a. 2 hours
    b. 3 hours
    c. 4 hours
    d. 8 hours
18. You would consider using a Sara Steady Plus lift for all of the reasons except;
    a. Patient weighs less than 420 lbs.
    b. Patient can bear weight on at least one leg
    c. Patient is unable to follow instructions
    d. Patient can sustain moderate pressure to lower back
19. An antibiotic has been ordered stat. How long does the nurse have to hang it?
    a. 15 minutes
    b. 20 minutes
    c. 45 minutes
    d. 60 minutes
20. A second nurse witness is required for the following medications except;

a. TPN
b. PCA
c. IV Heparin
d. IV antibiotics

2020 Nova Statstrip Glucose Meter Learning Assessment

Name of Trainee (Please print) _____

Please complete and give to Unit Educator.

More than one incorrect answer: retraining and retake of assessment required.

True/False

_____1. The glucometer must be disinfected after each patient use with soap and water, alcohol or ammonia based cleaners, such as, Sani-Cloth wipes or bleach wipes.

_____2. Always verify the patient's name, date of birth and ID number on the patient's armband before performing a glucose test.

_____3. The correct patient ID number to use with the glucometer is the encounter number.

_____4. The low and high controls need to be run on the glucometer once every 8 hours.

_____5. The glucometer should be kept in a horizontal position when performing a test.

_____6. A comment code is not required for critical glucose results.

_____7. It is not necessary to enter the letter in the encounter number when manually entering the patient ID.

Multiple Choice

1. A new bottle of control solution is opened. What expiration date do you write on the bottle?
    a. None
    b. 90 days after the bottle is opened
    c. 2 weeks after the bottle is opened

2. Which of the following statements are true with regard to critical glucose values?
    a. The initial test must be repeated on the glucometer and a lab test ordered if the repeat is critical.
    b. The result must be read back when reporting it to a nurse or physician
    c. The glucose value is <40 or >450.
    d. All of the above

3. If a patient glucose test needs to be repeated, the patient will only be charged for one test if:
    a. The repeat test is done within 7 minutes
    b. The same glucometer is used for the repeat
    c. The patient ID is entered in the same manner
    d. All of the above

4. A new bottle of strips are opened. What expiration date do you write on the bottle?
    a. None
    b. One month
    c. 180 days

CHI Saint Joseph Health

2020 Nova Statstrip Glucose Meter Operator Training Checkoff Sheet

NAME OF TRAINEE (Please print): _____

BADGE ID NUMBER: _____ TRAINING DATE: _____

FACILITY: SJH SJE CCH SJJ (circle one) UNIT: _____

EMPLOYEE STATUS: FULL-TIME/PART-TIME _____ CASUAL/POOL _____ Agency _____

SIGNATURE OF TRAINEE: _____

New and Casual/Pool, PRN, Agency employees certification expires in 6 months. Full-time/ part time employees expire in one year.

☐ **On-Line Hub Module Completed or NOVA Glucometer Operator Learning Assessment Completed.** Take this check off sheet and quiz to designated trainer to complete the practical portion of the training session. Once checkoff is completed with designated trainer, sheet must be returned to Point Of Care office.

☐ **2. Perform a low and high control test.**
States policy frequency of control solution testing and demonstrates proper handling of control solutions.
Demonstrates proper scanning for controls and test strip barcodes.
Successfully performs control solution tests and enters appropriate comment code.
States St. Joseph policy for corrective action for failed controls.
Can locate troubleshooting information for failed controls.

☐ **3. Perform a patient test.**
Demonstrates knowledge of St. Joseph blood sample collection procedure.
Understands that the patient armband should be scanned for patient ID
Understands that the correct patient ID for the glucose meter is the patient encounter number
Understands only single-use, auto-disabling lancets are used for capillary blood collection
Understands that if a patient is "Critically ill" or has poor peripheral blood flow that a venous stick or arterial blood should be performed instead of a capillary blood collection.
Applies sample to test strip correctly. WARNING: *The test strip must fill completely upon touching the blood droplet. If the test strip does not fill completely,* ***do not*** *touch the strip to the blood droplet a second time. Discard the test strip and repeat the test with a new strip.*
Successfully performs patient test and enters appropriate comment code.

☐ **4. Reviewed procedure and procedure limitations that may affect patient results**
Understands the procedure limitations section of the Nova StatStrip meter's written procedure and the actions that should be taken when an obtained result is questionable because of the meter's limitations.

Understands laboratory policy for the required repeat and/or confirmation of any patient results that are listed under procedure limitations including (but not limited to) critical values and certain patient conditions. This includes the repeat of an initial critical result on the glucometer within seven minutes, a lab confirmation if the result is still critical, and if previous lab hasn't already been performed for each new occurrence.
Can state critical limits for glucose testing (<40 mg/dl, >450 mg/dl).

☐ **5. Recall patient results.**
Can recall patient results and look up patient to review on-board test data.

☐ **6. Data upload.**
Understands procedure for data upload via download station and required frequency of data upload in case of wireless being down.
Understands the importance of returning the meter to the Docking Station to automatically upload new operators, and to charge the battery.
Knows how to access patient information in the Glucose Management system on the SJH intranet.

☐ **7. Troubleshooting and Maintenance.**
Knows how to change the meter batteries.
Knows where to locate meter supplies.
Understands glucometer must be disinfected after each patient use, per Hospital Infection Control policy

SIGNATURE OF TRAINER: _____

Take this check off sheet and quiz to designated trainer to complete the practical portion of the training session.

Once check off is completed with designated trainer, the sheet must be returned to Point Of Care office. **Failure to give POC a copy of the completed check off sheet will result in the glucometer account being locked out**.

SJH Fax 3057
SJE Fax 5306
SJJ fax 6701