Nurse Agency Information
CMH Mission- to provide quality inpatient & ambulatory health care to people of Southern Md that is accessible, cost effective, compassionate
The CMH nursing philosophy states that we believe that nurses should practice within scope of Md Nurse Practice Act and they are empowered to make decisions within scope of practice and are assigned to care for patients based on competency, patient need & patient’s self care demands

Patient Care- We value:
1-Collaboration with health care team in the shared goal of achieving max self care capacity for the patient
2-Role of the nurse as patient advocate
3-Patients’ & families’ right to participate in decision making by involving patients and family in formulating their own plan of care

Delegating to Unlicensed Assistive Personnel
Delegation is defined as transferring to a competent individual the authority to perform a selected task in a selected situation, while retaining accountability for the results
Delegation- typically involves the assignment or transfer of selected aspects of a job to selected persons in selected situations; the responsibility can be delegated but ACCOUNTABILITY for that task remains with the delegator

Considerations Before Delegating
1-Potential for Harm
2-Nature of the Task
3-Complexity of the Task
4-Degree of Problem Solving
5-Goal of the Task
6-Predictability of the Outcome

Four Rights of Delegation
1-Right Task- One within scope of subordinate’s job description
   There is documented competency by subordinate in task
   Does not jeopardize patient or staff safety
   Makes more efficient use of nurse’s time
Delegatable tasks are routine, do not involve modification, can be performed with predictable outcomes and does not involve ongoing assessment and interpretation of data

Tasks Which Should Not Be Delegated
1-Requiring specialized or advanced knowledge the subordinate does not possess
2-Outside scope of subordinate’s job description
3-which may jeopardize patient safety
4-which involve a high level of confidentiality or security
5-which demand close supervision when this degree of supervision is not available

2- Right Person- You must match Knowledge, Skills, Experience & Job Description, Competency, Quality of Work, Reliability, Sense of Accountability, Strengths & Weaknesses

3- Right Communication- Specific Task to be Completed, any additional information that is relevant, directions on how to obtain assistance When warranted- Time frame in which the task must be completed

4- Right Feedback After Delegating to include:
   a) Pertinent Outcomes of task
   b) UAP’s Performance of Task
       Positive Feedback- confirms and reinforces effective and efficient performance and can be done publicly
       Constructive Feedback-identifies and corrects deficient performance and should be done privately

Supervision- the process of directing, guiding and influencing another person’s performance of a task. The more difficult, complex, potentially dangerous the task and the less knowledge, skilled or experienced the subordinate, the closer the degree of required supervision.

**SBAR- TEAM COMMUNICATION**

Studies across the nation clearly identify communication failure as the **LEADING** root cause of Sentinel events; particularly communication failures between “HAND-OFFS” when the patient’s care is being transferred to another staff member or department.

Members of the CMH healthcare team are expected to communicate essential patient related information in a timely and effective manner. Use of “SBAR” is one method that can be used as a guide to enhance this communication.

SBAR is a methodology to present information in a brief, organized manner, and avoid irrelevant information. It is especially useful to communicate information when time is critical.

**SBAR Definitions**

S= Brief description of **Situation**
B= Pertinent **Background** information
A= Brief healthcare provider’s **Assessment** of the situation
R= Brief description of the healthcare provider’s **Recommendation**

**When is SBAR Used?**

   Examples of the times the SBAR Communication will be used are:

   1- Nurse to Physician
2- Nurse to Nurse  
3- Nurse to STAT Team  
4- Physician to Physician  

HOW SBAR IS USED? Nurse to MD  
**Situation** – State what is happening at the present time that has warranted the SBAR communication.  
State your name and your unit  
“I’m calling about: (Patient name and room #)  
“The problem I am calling about is: _______

**Background** – Explain circumstances leading up to this situation. Put the situation into context for the reader/listener.  
Include previous patient assessment that lead up to this situation  
A brief synopsis of the treatment to date

**Assessment** – What do you think the problem is?  
Have the most recent vital signs & know if there have been trends  
Know that the patient is on oxygen or not  
Any changes from prior assessment: vital signs, mental status, rhythm changes, lungs, skin, pain, wound, GI/GU, fluid balance, musculoskeletal

**Recommendation** – What would you do to correct the problem?  
-Transfer to ICU  
-Lab testing

**Additional Communication for Use with Temporary Patient Transfers.**  
**Ticket to Ride**

CMH utilize a Ticket to Ride to communicate between departments to ensure safe temporary care. Ticket to Ride will be used when patients leave inpatient units and go to Radiology, Nuclear Medicine, CT, MRI, Cardiopulmonary, and Dialysis.

This form should be used IN CONJUNCTION with the Interdepartmental (SBAR) form for those patients going to Surgery, Endoscopy, or another Inpatient Unit. Ticket to Ride Includes…

- Mode of Transportation  
- Patient’s Cognitive or Communication Barriers  
- Isolation  
- Fall Risk  
- Presence of IV  
- Need for Oxygen  
- Current Medication List  
- Allergies  
- Recent Vital Signs
For Radiology, Nuclear Med, CT, MRI, and Cardiopulmonary the ticket is to be printed, reviewed, and brought to the unit by Radiology or staff person transporting the patient. Once reviewed it is placed in the front of the patient’s chart.

For Dialysis the staff member transporting the patient for treatment should print the Ticket to Ride and place in front of chart.

For patients going to the OR, Endoscopy, or another inpatient unit the ticket is printed by the patient’s nurse and stapled to the Interdepartmental Transfer (SBAR) form

Ticket to Ride is available for you to print at any time.

Print via Order Entry Screen
-Select **Print Ticket to Ride** Option

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**Patient Care & Safety Concerns**

**Chain of Command for Reporting & Documenting Concerns**

CMH Clinical Staff and the Medical Staff together assure the delivery of the highest quality patient care. All CMH staff participating in patient care use this chain of command for reporting patient concerns or problems

Patient concerns may include life-threatening problems or the potential for patient complications

**Procedure for Patient Care Issues**
1. Contact Attending Physician to obtain clarification of orders or treatment
2. If still concerned about the patient’s safety or treatment plan or unable to reach the Attending Physician, notify Charge Nurse, Dept Director or Clinical Coordinator on even/nights weekends
3. Document in pt’s record calls made including phone #s, date/times, response times & reasons for calls procedure for Patient Care Issue
4. Monitor patient’s status, perform actions necessary to stabilize patient. Document in pt’s chart
5. The Charge Nurse, Dept Director or Clinical Coordinator investigates and call the physician to resolve the issue
6. If unresolved, the VP for the Dept or the Administrator on Call is notified
7. If needed, the physician’s Dept Chairman or the Chief of Staff is notified.

If Medical Staff has a Concern Re: Patient Care by CMH Staff
1. Physician will discuss the issue with the Staff Member in charge of the patient’s care
2. If not resolved physician will notify the Charge Nurse
3. If needed the Dept Director, or the Clinical Coordinator, the VP of the Dept or the Administrator on Call will be notified
4. If unresolved the physician will contact CMH’s Chief Executive Officer

CMH Staff are expected to take all necessary actions to make sure that safe quality patient care is provided at all times. All clinical staff and physicians are encouraged to
resolve patient care issues on a one to one basis. All significant patient care concerns are reported to the Director of Quality Management

**Nursing Process & Documentation**

On admission, the patient admission record & patient assessment will be completed within 12 hours.

Assessments are performed by the nurse:
- On admission
- At the beginning of each shift
- When changes in condition occur
- Prior to discharge or transfer from the hospital
- Post surgical and procedure
- One hr post pain medication
- Hourly pediatric IV assessments
- Every 4 hours for ICU patients
- Additional assessments as per unit specific standards
- Assessments are completed using documentation by exemption

- Nursing will document patient assessment at a minimum once every 24 hours. Intensive Care Unit patients must have a documented assessment every 4 hours.

Day Shift: The daily assessment will be completed and documented before 1200 hrs (noon) each day.

Night Shift
a- Will review the daily assessment and perform patient assessment. If there are no changes from the previous assessment the night shift nurse will indicate so in their daily “canned text” reassessment note.
b- Any alterations from the previous daily assessment will be noted by documenting a reassessment focused on the affected system on the MS Reassessment Form.
c- An outcome (goal) note will be written for each assigned patient documenting progress of previous 24 hours.

- On admission at least one nursing diagnosis/ patient problem will be selected by the nurse and appropriate standard of care initiated
- Interventions are documented on the patient’s standard of care.
- A patient note will be written on admission and at a minimum every shift and if there is a change in the patient status
- Night shift completes every 24 hrs. A goal note is that which assess the patient’s progress in terms of the goals established in the care plan. Addendums/ anecdotal notes may be used if the information does not relate to the plan of care and the information is not found anywhere else in the patient’s record
Medical Surgical Physical Assessment Screens include
1- Braden Scale - Less than 17 initiate Impaired Skin integrity care plan
2- Falls Risk Assessment Tool (FRAT)
3- FRAT Scale - If score 10 or greater initiate Falls Care Plan
4- CIWA Assessment Tool initiated for patients with Alcohol Withdrawal

Patient Education
Following the patient education assessment on initial assessment, the nurse will initiate the educational process. The nurse will use patient education materials approved by the CMH Patient Education Advisory Board to assure quality & accuracy of content. The nurse will document all aspects of the patient education process including the patient/family response to the teaching.

Discharge of a Patient
Doctor’s order is required for all discharges. Any patient leaving without an order should be reported to the supervisor - a Leaving Against Medical Advice form (AMA) & a variance will be initiated. All patients having procedures requiring sedation/anesthesia will be required to have a responsible adult provide transportation home. Discharge instructions will be reviewed with the patient/family & signed & will include information such as return Dr. visits, medications, activity level & any special instructions. Security will return personal valuables & the pharmacy will return any patient medications they brought in upon admission.

**Restraint & Seclusion Competency 2011**
CMH Is Committed to:
1- Preventing, reducing and striving to eliminate the use of restraints/seclusion
2- Preserving the individual’s safety and dignity when restraints are used
3- Use of alternative measures as PREFERRED INTERVENTIONS
4- Use the least restrictive methods of restraint first
5- Facilitate discontinuation of restraints as soon as possible
6- Limit use of restraint for emergencies when imminent risk of harm to self or others
7- Prevent emergencies that potentially lead to the use of restraints

Risks Associated with Restraint
Joint Commission revealed that there have been sentinel events resulting in death or severe injury due to restraint use.
- Increased agitation
- New onset pressure ulcers
- Pneumonia
- Nerve injury

Definitions of Restraint
Restraint- (Dr’s Order Required) Any manual method, physical or mechanical device or equipment that immobilizes or reduces the ability of a person to move arms, legs, head or body that cannot easily be removed by the person. Patients under the age of 13 are NOT permitted in restraints.

**Restraints**
Application of restraints require a physician order. Physicians/RNs may make the decision to restrain a patient based on individual patient assessment. Emergency application of restraints can be implemented only after a patient assessment is conducted by a qualified RN and the physician order obtained ASAP or within one hour.

**Restraints include:**
- Four bed siderails in the up position are considered a restraint
- Physical Holding for forcing medications is considered a restraint and requires a face to face assessment within one hour by a trained Behavioral Health RN or LIP.
- Physical Escort includes a light grasp to escort the patient to a desired location. If the patient would not be able to escape the grasp, this would be considered a restraint.
- Drugs as Restraints- Medication is considered a restraint if it meets one or more of the following criteria:
  1. Is given to restrict patient’s freedom of movement
  2. Is not a standard treatment for patient’s condition
  3. Is not a standard dosage for patients condition

IF the medications are used to treat a symptom that will improve the patient’s ability to function and interact with his environment, it is not considered a restraint.

**At CMH, We DO NOT use medications to restrain patients.**

**Restraints do NOT include:**
- Handcuffs or other restrictive devices used by law enforcement
- Use of hospital security staff to ensure the confinement of persons that are Emergency Petitioned or involuntarily admitted until transferred to a locked secure unit
- Positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, dental, diagnostic, surgical or invasive procedures i.e. papoose, holding for IV administration
- Situations in which time-out is used
- Age or developmentally appropriate safety interventions (strollers, safety belts)
- Protective equipment (helmets)
- Therapeutic holding of children
- Physical support devices i.e. non-locking tabletop chairs, orthopedic devices, side rails (as long as patient can exit the bed)

**Restraints approved for use at CMH are in order of least to most restrictive:**
1. Roll Belt for Bed
2. Roll Belt for Chair
3. White Padded Mitts
4. Soft Limb Restraints
5-Locked Limb Restraints
6-Seclusion (ONLY on Level 5)

**Vest restraints are not used due to increased risk of injury and death.**

Transitional Care Unit Restraint follows same guidelines with the EXCEPTION of:
1-Roll belts are the only restraint devices used & require every 7 days order renewal
2-Only Non Behavioral Health Restraints are used

**Restrainment Device Info**
Must be applied according to manufacturer’s directions by staff trained in applying
restraints.
1-Appropriate selection for patient condition
2-Appropriate Size
3-Straps should be loose enough to slide your open hand (flat) between the device and
the patient
4-Appropriate Slip Knot to allow for easy release
5-Tied to the correct area of the bed or wheelchair.
6-Patient is to be restrained with arms at sides bilaterally in a supine position. At no time
is a patient to be restrained in the prone (face down) position. Only exception would be if
the patient was placed MOMENTARILY in the prone position for the purpose of
administering IM injection or positioning the patient for placement in restraints

**Decision for Restraint/ Seclusion**
Knowing the risks, restraint and/or seclusion require a physician order and is a
physician/nurse decision based on patient assessment to include
1. Physical Assessment
2. Medical Conditions
3. Cognitive/ Behavioral Assessment

1. Physical Assessment
   - **Pain Management** - Effective pain management could decrease and/or alleviate the
     patient’s need for restraints.
   - **Nutrition** - Reversing malnutrition and/or dehydration can improve the individual’s
cognitive status
   - **Toileting Needs** - Attempts to get out of bed or restraints are often motivated by
toileting needs. Anticipating these needs and offering Q 2 hour toileting could
eliminate need for restraints
   - **Medications** - Multiple or combination medication regimes can cause dizziness,
sleeplessness, impaired balance, increased agitation. Alerting the physician to change
medications could decrease agitation and eliminate need for restraints

2. Medical Conditions - Patient assessment should take into consideration Medical
   Conditions that could be the cause of behaviors such as:
   - Decreased Oxygenation
• Abnormal Blood Glucose level
• Liver Disease
• Hyper/ Hypothyroidism
• Epilepsy
• Head Trauma

3. Behavioral Assessment- Behaviors that are indicative of potential for harming self/others

   **Posture** - Sitting tensely? Leaning forward? Hands on hips? Jabbing a finger in a particular direction?

   **Speech** - Voice loud and strident? Verbal threats?


   **Past History** - Of Violence? Poor social, functional, or interpersonal skills?

Behavioral Risk Factors

1. History of aggressive episodes or criminal activity
2. History of confusion or brain damage
3. Drug and alcohol consumption
4. Age & Developmental considerations
5. Gender Issues (i.e. young males)
6. Past history of restraints during psychiatric hospitalizations.
7. Low socio-economic status
8. Social Isolation
9. Personality disorder
10. Hx of sexual or physical abuse

Alternatives to Restraint- After the nurse completes assessment, alternatives to restraint are considered & include

1. Maintaining Medical Therapy – Ways to maintain medical therapy may include
   a. Cover IV with gauze to be out of pt’s sight
   b. Place IV poles out of pt’s sight
   c. Use of Mitts without straps and allows finger movement
   d. Indwelling urinary catheter- Consider having patient wear pajama bottoms or sweat pants or discontinuing catheter and starting bladder training program

2. How to Manage Behavioral Problems?

Patient who are agitated or angry, we should:

• Project calmness; move, speak slowly, quietly
• Focus our attention on him and let him know you are interested.

Patients who are aggressive, we should

Project calmness; move, speak slowly, quietly Encourage patient to talk. Listen patiently

• Give patient choices and offer alternatives
• Avoid confrontational poses (hands on hips, waving hands or pointing fingers

Code Green should be called when an individual becomes violent and/or combative and
additional personnel are needed for safe management of the person by dialing telephone #8222

When Non Behavioral Health Restraints are Implemented:
Non Behavioral Health Restraints are used for non-violent or non-self destructive patients who are interfering with the healing process or compromising life support. These behaviors include:
- Confusion or disorientation with risk for injury
- Inability to follow directions regarding treatment or safety

Examples:
- Patient is confused and has to remain on bedrest for medical surgical healing. The use of less restrictive alternatives has been evaluated and were unsuccessful. Restraint use in this situation would be governed by the Non Behavioral Health standard.

Patients whose primary language or method of communication is nonverbal will have continuous observation provided for monitoring for signs of distress with documentation every 15 minutes by a qualified assigned staff member and documented reassessed at least every 2 hours or more frequently as necessary by a licensed nurse.

Examples: Restraining patients who are deaf or aphasic.

Patients in restraints are monitored by certified nursing assistant, mental health tech, mental health counselor, or nurse who has completed restraint education and CPR training. Non Behavioral & Behavioral Health Restraint Flowsheet is used to document the patient monitoring of:
- Maintaining Rights & Dignity
- Circulatory status
- Behavior exhibited - 
- Increased agitation, combative threatening etc
- Toileting Needs
- Offer toileting
- Fluid & Nutrition Needs
- Range of Motion completed
- Removal/ Repositioning of a Restraint


Restraints/Seclusion & Behavioral Health Standards-
Behavioral Health Restraints are used for the patients demonstrating violent or destructive behaviors to self or others
These behavior include
- Severe agitation
- Combative
- Threatening staff/ patients/other
• Threatening self abuse

Example:

Patient with behavioral health diagnosis of Manic Depression becomes so agitated & aggressive that he physically attacks a staff member. He cannot be calmed by other alternatives. He presents a danger to himself and to others. Medical causes of the behavior have been ruled out. The use of restraint in this situation is governed by Behavioral Health Standard.

Behavioral Health Restraint

Patients in four point restraints will have continuous 1:1 observation and is considered a Behavioral Health Restraint. It is important to remember that if a patient has been completely released from all restraint devices or seclusion and begins to exhibit the same behavior that initiated the restraint, a new order is required to initiate the restraint. Patients should never be left alone when restraints are loosened or removed to perform treatments or procedures.

Any death or injury that occurs while a patient is restrained must be immediately reported to Risk Management and Administrative Staff.

Suicide Assessment for Non Behavioral Health Patients

Purpose of Suicide Assessment is to ensure patients identified as at risk for self harm/suicide will remain safe through accurate & appropriate follow up care.

Patients who are identified as depressed or at risk for self harm/suicide will have a SAD scale assessment completed by the nurse:

- Upon admission to medical unit following suicide attempt or suspected suicide attempt
- When referred to Emergency Psychiatric Services for evaluation
- If need is identified during hospitalization
- On going basis with frequency depending on need/risk identification
- Prior to discharge from inpatient setting

On Med Surg Assessment, Protocol may be viewed within the process intervention screen by selecting “view protocol”.

SAD Scale and Risk Factors include one point for each risk factor as determined by SAD scale:

- Male
- Less than 18 yrs
- Greater than 45 yrs
- Previous Suicide Attempt
- Alcohol Abuse
- Irrational Thinking
- No Spouse
- Social Support Lacking
- Organized plan for suicide attempt
Sickness

SAD Score Scale Risk Points

- Low Risk 1-3 points
- Moderate Risk 4-6 points
- High Risk 7-9 points

Interventions
1- Patients with a SAD Score of 3 or less would continue to be assessed by nursing each shift.
2- Patients with a SAD Score of 4-6 would be assessed each shift for specific suicide plan
   (If patient expresses a specific plan it must be documented in the comment field below the SAD score – in MS Physical Assessment)
3- All patients at risk for suicide would have the following environment interventions:
   - Remove unsecured sharps from room
   - Replace plastic trash liners with paper
   - Remove all strings from linens
   - No cleaning items or medications
   - No belts of luggage straps
   - Remove all harmful object
   - Notice posted (all staff/visitors must check with nursing prior to entering room) on patient’s door
   - Staff would monitor items brought to patient from visitors
   - Nurse/ CAN would observe minimally every hour
   - Nurse to consult Social Work

Social Work to provide B-Safe Suicide Prevention Module

A SAD Score of 4 or more will generate a Social Work Consult via a pop up at the completion of the MS Physical Assessment.
- Order must be completed
- Order must include the SAD score in the comment field

Patients with a SAD Score of 7-9 would have in addition to previous interventions:
- One to One Sitter
- Private Room
- Psychiatric Consult
- Belongings searched and if indicated body search conducted by security
- Patient reassessment would be conducted:
- Reassess every shift & prior to discharge for
  1- ‘Red Flags” – Sudden shifts in behavior/mood
  2- Patient exhibits/expresses suicidal behavior or thoughts
**Patient Identification**

Prior to performing any specimen collection, treatment, procedure or medication administration, staff members are to **positively identify patients with at least two patient-specific identifiers.** These should be the patient name & date of birth when the information is available. NEVER USE: ROOM or BED numbers.

Staff are to check the patient’s name & date of birth on the armband. Actively involve the patent or family member (if the patient is unable to participate.) If the name & DOB agree, proceed with treatment, procedure, etc. If no armband, confirm the patient’s name & DOB with the patient or family, when possible and place an armband on the patient. Confirm by asking the patient/family member to tell you the name and DOB.

If no armband is present in the case of newborns or pediatrics, the name & DOB should be confirmed with the parent/guardian.

If information does not match, determine the reason for discrepancy by involving the supervisor and correct the issue. Apologize & reassure the patient that this identification process serves as a safety check.

**Patient Belongings Policy**

- Patients will be encouraged to send property/valuables home with family or store with security. Items essential to ADL (dentures, hearing aids, glasses, prosthetics) will remain at the bedside and Unit staff are responsible for the proper care and security of those items. Complete inventory on admission on the Patient Belongings Inventory Log. This log will be signed by patient/family as well as staff conducting inventory and disposition of valuables.
  - White copy – sent to Medical Records
  - Pink copy- give to Patient
  - Yellow copy- send with belongings to security

This inventory will be conducted every time the patient is transferred to another room by the receiving unit staff. This will also be done when patients move to a different room on the same unit. At discharge- final inventory log check will be completed and patient/family or transport crew member will sign the log.

Personal Belongings will ONLY be placed in CMH Patient Belongings Bags.

In the event it becomes necessary to cut the patient’s clothing off of an E.D. patient, those articles must be placed in a Patient Belongings Bag, inventoried, clothing listed on inventory log and sent to security.

**Informed Consent**

Consents are needed for all of the following:

- Surgical procedures involving skin incision or puncture
- Experimental procedures, medications or treatments
- Invasive imaging
- Abortion
- Administration of blood or blood products
- ECT
- Radiation therapy
- Anesthesia
- Procedures involving moderate to deep sedation
- Diagnostic procedures that carry significant risk
- Vaccines
- Autopsy
- Organ donation
- HIV testing
- Chemotherapy

Informed consent must be obtained:
- Before the procedure is in effect
- If there is a significant deviation from treatment plan to which patient originally consented
- If there is a significant change in the patient’s condition warranting another discussion so the patient has new facts to make an informed decision.
- If the patient revokes consent, verbally or in writing.

Consent forms signed up to 30 days preoperatively are considered valid. Adult over the age of 18 with decision-making capacity may give consent for treatment and may also delegate their decision-making authority in writing to another person. This must be documented in medical record & witnessed by two licensed personnel/LIPs. If a patient is lacking decision-making capacity, two clinicians must document in medical record patients inability to: demonstrate awareness of his/her health situation; understand information provided regarding treatment especially risks & benefits; verbally or nonverbally communicate a clear decision regarding the treatment based on that information.

Patient’s representative may be:
1- Health care agent (HCA) appointed by MD law
2- Legal surrogate when the patient cannot make informed decisions and does not have an appointed HCA.
In order of priority:
1- Court appointed guardian
2- Patient’s spouse or domestic partner
3- Adult child of patient
4- Parent of the patient
5- Adult brother or sister of the patient
6- Friend or relative of the patient who is competent & has an affidavit from the attending physician.
Minors younger than 18 years of age is presumed NOT to have legal capacity to make health care decisions, therefore, such decisions must be made by a parent/guardian/other adult or agency with legal custody.

Those younger than 18 years of age who has legal capacity to give consent in MD (emancipated minor) include parent of living child, married or living apart from parents or legal guardian and is self-supporting.

MD law allows minors to request treatment for: Contraception, STD services, prenatal care, abortion, adoption, Alcohol & drug rehab, Outpatient mental and emotional services (>16 yrs of age), Sexual assault services, Blood donation (17 yrs of age).

Verbal/Telephone Consent
Two hospital employees must listen to a telephone or verbal consent & document conversations. One must be a hospital RN or physician. The names of the person giving and receiving consent must be documented in the medical record. If person giving telephone consent is unable to visit the hospital during the patient’s stay, they are requested to verify their consent for treatment in writing, fax, telegram or email.

AFFIDAVITof DECISION MAKER must be filled out by ALL surrogates with signature And must be signed and witnessed.

Consents should have no abbreviations and must include the
- Doctor’s/LIPs signature, date & time
- Patient signature, date & time
- Witness signature, date & time

**Universal Protocol**

- This is a safety process to verify correct patient, procedure, site, and side before the procedure is performed to prevent Wrong site Wrong procedure Wrong person procedures.

CMH Site Verification Process involves all healthcare providers to include nurses, LIPs, radiology staff. It applies to all operative and invasive procedures and includes procedures performed in settings other than the operating room. Universal protocol does not include routine procedures such as venipunctures, PICC insertion, NG tube insertion or foley catheter insertion.

The Universal Protocol site verification process requires that the correct person, procedure & site is checked:
- At the time the surgery/procedure is scheduled
- At the time of preadmission and admission or entry to CMH
- Before the patient leaves the pre-procedure area or enters the procedure room
- Anytime the responsibility for care of the patient is transferred to another caregiver
- Before the patient leaves the pre-op area or enters the procedure/surgical room
- With the patient involved, awake & aware, if possible
UNIVERSAL PROTOCOL CHECKLIST/DOCUMENTATION is used to verify the following are available and match the patient. The relevant documentation (H&P, orders, nursing assessment, pre-anesthesia assessment) is completed with signed procedure consent. The chart is checked to ensure correct diagnostic & radiology test results as appropriate, and properly labeled and in the OR the staff ensure the required implants, devices, special equipment and Blood products are available.

SITE MARKING

The site is marked by LIP performing the procedure while patient is awake and aware using LIP’s initials or other unambiguous mark at or near the incision site using a permanent marker. The mark must be visible after the site is prepped & draped and will include right or left, multiple structures (fingers, toes), or levels (spine). For spine procedures, radiographic markings of the specific level occurs intra-operatively in addition to preop skin marking of the general area and it also should be visible after site is prepped and draped. Pelviscopy for lateralized organs (ovaries) are marked near the incision site & laterality is noted.

Verification of site marking, if applicable, is documented on the universal protocol checklist. If patient refuses, LIP & another caregiver must validate site and document refusal.

EXEMPTIONS from site markings:

- Cases involving a single organ (cesarean birth, cardiac surgery, appendix, gall bladder) and endoscopies with out intended laterality (hysteroscopies, colonoscopies, lap choles, EGD)
- Epidurals/spinals/lumbar punctures/blood patch
- Interventional cases which insertion site is not predetermined (cardiac cath, pacemaker insertion)
- Teeth (operative tooth/teeth must be indicated on documentation)
- Infants whom the mark may cause a permanent tattoo
- Single obvious wound, lesion or injury
- Single obvious wound, lesion or injury (cast, open fracture, needle localization wire - if they are the solitary injury or lesion)
- Bedside procedures in which the practitioner performing the procedure is at the patient’s bedside from the moment of the decision to perform through the actual performance of the procedure

Alternative processes

- For procedures which site marking is not required or technically or anatomically impossible, there MUST be an alternate site verification method
- Site & side are verified with the patient & physician in writing preoperatively no the Universal Protocol Site Verification Checklist in lieu of marking the site. Examples:
- Cystoscopy, ureteroscopy for lateralized treatment of an organ, teeth extraction, procedures with laterality on mucosal surfaces or genitalia and sinus endoscopy & bronchoscopy with lateralized lung treatment
Pre-Procedure Verification
- Performed by the pre-procedure RN, the procedure RN and the anesthesia provider
- Pre-procedure RN will complete the pre-procedure component of the universal protocol checklist. If no pre-procedure RN, the procedure RN or unit/floor nurse preparing the patient will complete the pre-procedure section of the checklist that includes:

Verifying patient identification
Consent forms, schedule, orders, medical record documentation agree with patient identification & scheduled procedure
• Confirm procedure, site & side w/ pt or guardian
• Confirm any ordered blood products are available
• Consent is signed by patient, physician and witnessed
• Procedure site is marked
• Implant materials/hardware & other special equipment is available
• Radiological images are available

Alternate process
If patient is unable to confirm & legal guardian is not available, confirm procedure, location or site by matching information on patient ID band, patient labels on consent, medical record information/orders, schedules, diagnostic reports and x-rays (all that apply If at ANY time during this process, there is a discrepancy, the process STOPS until clear resolution is achieved & documentation of resolution is complete

“TIME OUT” is a verbal confirmation process that includes:
• Patient (name & date of birth) from the chart is verified with the patient’s armband upon entry to the suite
• Confirmation of procedure from an accurate consent form
• Confirmation that the accurate side & site are marked
• Appropriate antibiotics have been administered in the appropriate time frame if applicable & confirm allergies with the team
• Confirm the alcohol based surgical prep is dry

End of Procedure Validation
- RN caring for the patient will confirm with physician performing procedure and the remainder of the operative team and document in the operative record
- Actual procedure performed
- Specimens taken if any
- Confirm sponge/sharps/instrument counts
- Confirm any instrument/equipment issues
- Document on the universal protocol checklist the time & date of end of procedure verification

Surgical Site Infection Prevention
The FACTS- Surgical site infections are the second most commonly reported hospital associated infections making up 22% of all such infections
SCIP #1
• Prophylactic antibiotics are to be started 1 hour (or less) prior to incision for preoperative patients or within 2 hours prior to incision if Vancomycin or Levaquin is required for prophylaxis. Optimum antibiotic administration is achieved when the infusion is completed at the time of incision to ensure a therapeutic level of antibiotics when the incision is made (and before the tourniquet is inflated in orthopedic cases)

SCIP #2
• Prophylactic antibiotic selection for surgical patients is based on current guidelines for each procedure. Cephalosporins are the drugs of choice for most surgeries since they have broad spectrum activity against Gram-positive and Gram-negative bacteria.

SCIP #3
Prophylactic antibiotics should be discontinued within 24 hours after surgery end time. Evidence shows that discontinuing antibiotics beyond the 24 hours after incision closure offers no additional benefits and can lead to C-Difficile infection.

SCIP #4
SCIP #4 speaks to monitoring of cardiac surgery patient blood glucose levels to reduce infections and this will not be a focus at CMH as we do not care for these types of patients.

SCIP #5
No hair removal for surgical patients unless with an electric clipper with a disposable, single patient use cutting head. Preop shaving has been linked to increased risk of SSIs for skin associated bacteria in addition to nicks and scrapes.

SCIP #6
Colorectal Surgery patients with immediate postoperative normal body temperature (97F-100F) within the first hour after leaving the OR decrease incidence of Surgical Site Infections. Even though this applies to only colorectal surgery patients, all surgical patients should maintain temperatures close to this range & we monitor this at CMH.

IV THERAPY
○ Use smallest gauge & shortest length device for therapy
○ Select distal areas of upper extremities
○ Subsequent venipuncture should be proximal to previous
○ MD order is required for placement in lower extremity

1-Site Prep -
   Use Chloroprep prior to venipuncture scrub for 30 seconds
   Allow to dry 30-60 seconds
   Unsheath catheter & rotate 360 degrees

2-Confirm integrity of catheter
3-Insert needle bevel up
4-Backflash indicates vein penetration
5-Slowly advance catheter over stylet then push white button on top to automatically sheath stylet & prevent needlesticks
6-Withdraw blood sample if ordered, remove tourniquet & connect saline lock
If resistance is met or cannula will not advance DO NOT FORCE
7-Apply transparent dressing
8-Document Site, Size of catheter & Location of IV

Peripheral IV sites are visually evaluated every 4 hours and HIGH RISK PATIENTS SUCH AS DIABETICS, RECEIVING CHEMO, RENAL FAILURE, OR TAKING STERIODS require more frequent evaluation.

The following are changed every 72 hours:
• IV site
• Op Site Dressing
• Primary IV tubing
• Piggyback sets that remain attached to the primary IV set
  Once detached it needs to be changed every 24 hours
• Saline lock adapter

IV Site changes every 72 hours unless signs of infection then change immediately
If there is medical reason for maintaining site beyond 72 hour
  - Notify physician & obtain order
  - Evaluate site Q 4 hours

All units have CMH IV Medication Administration Lists on the medication carts/medication rooms. This list specifies the type of monitoring that must be available to administer the IV drug ordered. The categories of medications are listed below.
Category 1 drug - unmonitored bed
Category 2 drug - monitored bed
Category 3 drug - administer in SCU, OR, PACU or ER
Category 4 drug - Physician must be present on unit

ALWAYS Trace all IV lines/tubing from the patient back to the originating device before making the connection and ALWAYS recheck connections each time they are disconnected and reconnected, not just at arrival or during your hands off process
DO NOT spike IV bag until time of use and IV infusions must be started within 1 hour of spiking bag

TPN
TPN orders are to be written daily on the TPN order forms. Orders received by pharmacy after 1300 will not be filled until the next am.
Before initiation the physician should order blood tests to determine lab values.
These orders shall be written for a 24 hour supply only
The infusion pump must be used to ensure proper volume of solution is administered at
the proper rate and TPN must be infused through central line. TPN MAY NOT be infused through peripheral line. Flow rate of TPN solution via central line should begin at 40 ml/hr for the first 24 hours and gradually increase to 100 ml/hr as determined by patient’s need and requirements. Individual TPN solutions are not to hang longer than 24 hours. Tubing is changed with each solution. The micron filter is to be placed between IV tubing and catheter site. Strict Intake and Output are to be monitored on all patients. Daily weights should be monitored on all patients. Notify physician immediately of fever above 102, chills, change in mental status, blood glucose above 200mg/dl or respiratory distress. Glucose should initially be monitored every 6 hours until stable, thereafter, it should be monitored daily. The TPN line is not to be used for any purpose other than nutritional support. No blood specimens are to be drawn from the TPN line. If the TPN solution must be interrupted for any reason, immediately begin an infusion of 10% Dextrose in water through any available line at the previous central line rate.

**Peripheral Parenteral Nutrition (PPN)**

Initiation rates of PPN are not restricted as in administration of TPN. Nursing care of the peripheral IV site for PPN should be identical to standard protocol for peripheral IVs. Laboratory studies prior to therapy are the same as for TPN. Tubing for PPN should be changed every 24 hours along with the filter. A 1.2 Micron filter will be sent with each TPN/PPN bag. PPN can be ordered on the TPN order sheets and a continuous sequence of bottle numbers should be maintained (i.e., bottle #1, #2, #3, etc.). Only solutions containing 10% or less dextrose (final concentration) plus amino acids can be infused into a peripheral vein. A solution with a higher percentage of dextrose must be infused via a central line.

**Management of CVADs**

Dressing Changes for CVADs:
- Nontunneled (Single, Dual, or Triple Lumen Subclavian or Jugular), PICC - 24 hrs post insertion, then Q 5-7 days with transparent dressing
- Implanted port (Mediport) - Weekly for needle and transparent dressing
- Tunneled (Hickman, Groshong, Broviac) – Newly inserted is to be changed 24 hours post insertion, then every 5-7 days

Once these sites have healed completely there may not be a dressing present.

Intermittent Use for Nontunneled, PICC & Hickman Catheters:
Administer:
- 5 ml of normal saline
- Medication
• 5 ml of normal saline
• 3 ml of Heparin (100 units/ml)
• Use 10 ml syringe for flushing all central catheters

Intermittent Use for Implanted Ports
Administer:
• 5-10 ml of normal saline
• Medication
• 5 -10 ml of normal saline
• 5 ml of Heparin (100 units/ml)
• Use 10 ml syringe when flushing any central catheter

Intermittent Use for Groshong Catheters
Administer:
• 5-10 ml normal saline
• Medication
• 5-10 ml normal saline
• NO HEPARIN REQUIRED

Flushing when not in use for nontunneled, PICC lines & Hickman:
• Heparin 100 units/ml insert 3 ml/day (each lumen)
• Flushing when not in use for implanted port:
• Heparin 5-10 ml weekly
• Flushing when not in use for Groshong:
• Normal Saline 5-10 ml weekly
• Cap Change Weekly for all types

Obtaining Blood Samples without an Infusion for Nontunneled, Tunneled, and PICC (except Groshong)
• Administer 5 ml normal saline
• Withdraw & Discard 1st 3 ml – 5ml of blood
• Withdraw blood for samples
• Administer 10 ml normal saline
• Administer 3 ml of Heparin (100 units/ml)

Obtaining a Blood Sample with an Infusion for Nontunneled, Tunneled, and PICC
• Stop ALL Infusions and Disconnect
• Administer 10 ml normal saline
• Discard 5 ml of blood
• Withdraw blood for sample
• Administer 10 ml of normal saline
• Reconnect and Continue Infusion

No BP or Phlebotomy should be performed on an extremity with a PICC line
If there is no blood return upon aspiration, or resistance is met during flushing, notify the physician. Only physicians can declott CVADs. Nurses may remove a nontunneled CVAD, with an MD order. Only physicians and specially trained nurses may discontinue PICC lines.

Procedure for removal of Nontunneled CVAD

- Check physician order & PTT & PT. If prolonged, notify physician.
- Place patient in supine or Trendelenberg position
- Create sterile field & don sterile gloves
- Instruct patient to turn head in opposite direction
- Culture any purulent drainage
- Clean site with ChloraPrep
- Ask patient to perform valsalva maneuver as you slowly remove the catheter
- If any resistance is encountered during withdrawal, do not exert force to extract it as this could cause breakage and embolism.
- Instruct patient to breathe normally after removal
- Apply pressure for 15 minutes and inspect Q 5 minutes for bleeding
- Inspect catheter and measure length
- If catheter appears ragged or damaged in any way, cut 2 inches of catheter tip, using sterile scissors and drop into sterile specimen container and send to lab for analysis.
- In the event of a catheter fracture, apply direct pressure over the site and notify the physician immediately. Position patient in Trendelenberg position left side down. If the catheter fragment is palpable, apply additional direct pressure proximal to the catheter to prevent migration.
- If an air embolism is suspected, turn patient left side down, in Trendelenberg position. Administer 100% oxygen and notify physician.
- Always document the procedure, condition of catheter and insertion site, any problems and interventions taken and the dressing used to occlude the site.

PCA

PCA Standing Orders can be written by the attending/consulting Physician, nurse practitioner, Anesthesia practitioner or clinical pharmacist (when consult ordered by LIP). It is recommended that only one practitioner take responsibility of pain management orders. Patients should be properly instructed in the use of PCA prior to initiation by the RN.

Two nurses are to verify the PCA was properly programmed & reconciliation of tubing from connection site to syringe
- At time of initiation
- Receiving a patient from another unit
- Change of shift
- PCA settings are changed
Verification includes checking the orders with the VMAR and the VMAR with the pump settings. Patient is to have a dedicated IV access whenever possible to avoid potential incompatibilities.

LPN Scope of practice allows for patient monitoring only while on PCA therapy.

PCA Monitoring includes vital signs (including respirations), level of pain and sedation, effectiveness of meds Q15 X4, Q 1 hr X4, then every 4 hrs unless change in condition warrants more frequent monitoring. Continuous pulse oximetry is required on all patients, readings are recorded every 4 hours.

Patient on PCA should not receive supplemental narcotics unless ordered by the physician. PCA weaning: supplement narcotics or non-narcotic analgesics (oral) are appropriate during this time but should be accompanied by decreasing the PCA dose (increasing lockout period, reducing bolus dose, or reducing the dose limits)

PCA syringe and tubing is changed every 24 hours & documented on the MAR / VMAR. When syringe is changed or PCA d/c’d- The old syringe must be immediately removed from the room and the contents wasted as with any other narcotic. It must be witnessed and both nurses sign for the waste on the MAR/VMAR

- PCA orders must be renewed every 48 hours.
- Pain Assessment must be completed every 4 hours and prn
- Routine hours would be:
  - 0800-1200-1600-2000-2359-0400
- PCA log and settings must be verified at that time & documented

The Nurse Should Notify Physician for:
- Resp rate less than 10
- Inadequate pain relief
- Acute alteration in mental status
- Infusion has stopped
- Pulse increases more than 20 beats per min
- BP drops more than 20 mm/Hg
- Sedation score= 3

If sudden decrease in LOC or respiratory rate below 10 administer Narcan as follows:
- add 1ml of .4 mg/ml Narcan to 9 mls of NSS in a syringe. Administer 1 ml every minute until return of level of consciousness. Narcan is the antagonist for Opioids

**Narcotic Usage with PCA**

MS used most often. Dilaudid & Demerol may be used

Demerol is used with restrictions such as NOT:
- Pts over 65 yrs of age
- Pts w/ acute/chronic renal failure
- Pts hx of seizure disorder
- Contraindicated in patients receiving MAO inhibitors, SSRI, and Isoniazid.

Demerol can be used with patients who have:
- True allergy to MS or Dilaudid
- Rigors in PACU
- Endoscopy Procedures
Rigors cause by Amphotercin B – Demerol can be used to treat rigors associated with Amphotercin B administration. No more than 600 mg in 24 hour period with automatic D/C of Demerol after 48 hours.

Epidural Analgesia

Anesthesia is responsible for the maintenance of the catheter and Epidural orders. All Epidural Analgesia are administered using PCEA Pumps. Syringe bolus injections and catheter removal are to be ONLY performed by Anesthesia. After the Epidural catheter has been injected by the Anesthesiologist in the PACU, the patient is to stay in the PACU at least 30 min after the last injection, unless the patient is in L&D. The labor patient remains in the labor room. Upon transfer 2 RNs ensure the prescribed program agrees with the physician order & line reconciliation from connection site to bag or syringe.

Epidural Analgesia- Monitoring protocol
The patient should be monitored per protocol – Non Obstetric Patient
- Vital Signs every 15 min X 4 then every hr X2, then every 4 hrs for PCEA duration
The patient should be monitored per protocol – Obstetric Patient
- Vital Signs every 5 min X 6, every 15 min X 2, every 30 min (hourly if sleeping) until infusion is complete
- Continuous Fetal Heart Tone per OB Protocol
Assess pain level, sedation and upper/lower body sensation every 4 hrs
  Use Sedation Scale
  0= alert
  1= drowsy, easily aroused
  2= very drowsy, arousable
  3= somnolent, difficult to arouse
  S= normal sleep, easily aroused

Straight Cath for urinary retention if no void in 8 hrs
Continuous Pulse Oximeter
Oxygen @ 2 liters/min via nasal cannula or mask prn to maintain Oxygen saturation greater than 90%
Epidural Site Inspection Every 12 hrs

Side Effects
1- Respiratory depression - Narcan should be given per Epidural Order Set & and intubation equipment must be readily available
2- Urinary Retention-
3- Pruritis-
4- Motor & sensory block-If this occurs while the patient is receiving the infusion, the infusion must be discontinued immediately and Narcan administered.
5- Nausea and Vomiting-
6- Monitor epidural catheter site for leakage, puffiness, redness, signs of infection & notify anesthesia if these appear.
7- Epidural medication bag and tubing must be changed Q 24 hours
8-Pts should not receive an anticoagulant for 12 hours prior to the removal or they should have normal PT and PTT results.

9-Narcan and Ephedrine must be readily available

**Anesthesia must be notified of any side effects to include:**
- Resp rate under 10 per min
- Inadequate pain relief after checking pump & tubing
- Acute alteration in mental status
- Tubing malfunction such as kink or obstruction
- Decrease in BP over 20 mm
- Oxygen saturation less than 90%
- Increase heart rate over 20 beats per min
- Weakness of upper or lower extremities
- Sedation scale= 3

**Patient Safety Initiatives-ALARMS**
- Medical Equipment Alarms are meant to provide for patient safety
- An alarm is only effective if it can be heard
- The patient’s safety is maintained only if we respond to that alarm
- Patient Safety Should Not Be A Gamble
- It is everyone’s responsibility to keep our patients safety
- Each patient will be instructed about their medical equipment such as IV Pumps, Monitors, PCA Pumps and Bed Alarms
- This education will start at admission & continue through their stay
- They will also be told to “call the nurse” if their alarms go off.

If you are in a patient’s room and an alarm goes off it is important to check the equipment to find out the cause of the alarm.

**Blood Administration**

* Administered by RN or physician only
* Requires physician order and patient consent (one per hospitalization)
* Procedure for Packed Cells/Whole Blood

  - After obtaining the patient consent, ensure the blood has been typed and cross matched

* Procedure for Packed Cells/Whole Blood

  - When the blood is drawn for type and cross match, to insure the correct patient is being drawn, the lab will draw a 2nd specimen for verification. A 2nd signature is not needed when obtaining the initial pink top tube
  - Blood products must be infused in dedicated line – do not mix with medications or D5W
  - Establish IV with #18 or #20 gauge catheter (22 gauge for pediatric or geriatric clients) if needed.
  - Hang saline and blood administration tubing and check IV patency prior to obtaining blood from blood bank
- Upon notification that blood is ready for pick up, take patient’s TPR and BP. Notify physician of temperatures above 101. In the blood bank you will check blood slip and patient info with the blood bank staff. The unit of blood should be given to the patient within 30 minutes from leaving the blood bank. If there is going to be a delay, the unit should be returned to the blood bank within that 30 minutes

**Infusion Rate**

- **ADULTS:** Routinely 2 to 3 hours. Not to exceed 4 hours per unit of blood.
- **Peds:** 2 to 5 ml/kg per hour. Not to exceed 4 hours per unit of blood.

Packed red blood cells can be ordered **STAT** (available in one hour) or **ROUTINE** (available in four hours)

- Platelets: special order, available in 3 to 5 hours.
- Apheresis platelets: infuse in 20 to 60 min. Not to exceed 4 hrs/unit.
- Pooled platelets: infuse in 20 to 60 min. Not to exceed 4 hrs/unit.

Note: Do not use the infusion pump or a pall filter.

Cryoprecipitate: special order routinely available in 3 to 5 hours

Fresh Frozen Plasma (FFP) routinely stocked in lab, thawing takes 30 minutes. Infusion rate: 15 to 60 minutes. Can be ordered **STAT** (available in 1 hr) or routine (available in 4 hrs.)

**Two nurses must check the blood prior to transfusion (one must be an RN) must check:**

- Patient’s name and birth date
- The H#, M#, Unit # and Date of Expiration
- The blood ABO and RH compatibility with the bag label, tag, medical record and transfusion record. Also the expiration date is checked.
- Must wear gloves when handling blood products

The unit should be started slowly and increased depending on patient condition using a dedicated line for blood administration ONLY. Minimum time for blood to infuse on a med surg unit is 1 hr. The blood transfusion can not infuse for longer than 4 hours

**In emergent condition, under direct physician supervision blood may be administered in less than 1 hr in any clinical setting**

The patient should be assessed by the nurse during the first 15 min. TPR and B/P are taken frequently, at 15 min after starting the transfusion and hourly or more frequently during the transfusion. Administration sets are changed with each unit of blood

When transfusion is complete, the original of the transfusion record is placed in the pt’s chart and the copy is set to lab.

- All areas for signage MUST be complete on the blood administration record
- Blood testing should be done no earlier than 2 hours after the blood transfusion is completed.

If there is a Transfusion Reaction
- Discontinue transfusion & monitor patient
- Notify physician
- Start new infusion of normal saline
- Obtain urine specimen/draw blood bank tube
- Complete blood transfusion reaction form
- Return unused blood to blood bank & Copy of blood transfusion sheet
- Examine blood unit label and all pre-reaction records for possible errors.

**Bed Weights**

Several illnesses such as: congestive heart failure, renal failure, and malnutrition etc... have treatments which are dependent upon accurate weights. Based on the patient's weight; their medications are adjusted; their dialysis settings are determined; the type of diet ordered or the intravenous nutrition may be dependent upon their weight.

When do you perform a weight?
- Upon admission
- Daily if ordered... always at 0600
- Pre/post dialysis
- As needed

Who weighs the patient?
CNA’S, ACG’S, MST’S, GNA’S (document in care fusion)
Nurses (document in meditech) should review weights daily to assess for fluctuations

How to use Hillrom Advanta Bedscale
Prepare the bed for weighing
Bed in low position
Limit items on bed to:
- Fitted sheet
- Flat sheet
- Pillow with pillow case
- Blanket
Always remember to remove extra items BEFORE weighing
Scale is most accurate if bed is not touching anything
No one touch the bed or footboard when scale is operating

Procedure for preparing Bed to Weighing:
1. Turn scale on (turns off automatically after 5 min)
2. Press and hold the “zero” key
3. Release key when display “000.0” stops flashing
4. “CALC” will appear. Do not touch bed until “CALC” stops flashing and a beep sounds.
5. Place the patient on bed; lying still and centered.
6. Scale will display weight.
BEDSCALE CONTROL PANEL
Special considerations:
Air mattress—if applied or added, you must “zero” the bed again with air mattress on bed. If patient unable to get out of bed; zero bed by raising the patient using lifting equipment, add mattress, re-zero bed, and return patient to bed for weight calculation. Maximum bed weight=450 lbs; use Viking lift on TCU for patients wt 450 lbs to 660 lbs. Instructions are on the foot board of every bed!

Needs of the Dying Patient and Organ Donation

All staff should ensure every patient’s comfort at all times. When we have patients who are approaching the end of life, there are special physical, spiritual, emotional and social considerations that must be addressed.

Physical Needs
1- Pain can be difficult to assess due to absence of verbal or physical signs so nurse must pick up on nonverbal cues & provide pain medication as ordered. Some non verbal cues of pain are: restlessness, furrowed brow, moaning, and guarding
2- Decrease Appetite or Thirst can be relieved with good oral hygiene, glycerin swabs & petroleum jelly on the lips
3- Peripheral circulation changes may result in cold, clammy skin and mottled or blue color to skin. Warm blankets, ice & antipyretics can help with these symptoms.
4- Mental Status changes causes by dehydration and/or decreased renal function can be revealed with restlessness or hallucinations. Medications can be given to relieve these symptoms and non pharmacological approaches can be implemented to include dim lighting, soft music or repositioning.

Social Needs
Patients may spend more time sleeping and withdrawing & decrease in responsiveness
Family and Friends can be reminded that hearing is the last sense that is lost so they should continue to talk to the patient in normal and natural tones. They should also be reassured that this is a natural part of the dying process and not a sign of depression or rejection.

Psychosocial Process
Patients responses to impending death may vary (anger, sadness, hurt, fear)
The healthcare provider should provide a SAFE environment and listen to the patient and educate the family on the importance of family “quietly sitting with the patient & how this can be of great comfort to them.
Patients of different cultures may respond differently based on their cultural beliefs and healthcare providers need support dying patients within their culture beliefs and practices.

Organ Donation
After a patient death, the nurse will:
1- Contact Living Legacy within 1 hour of recorded time of death
2- Contact Living Legacy for every VENTILATED patient within 2 hours of meeting any of the following indicators
a. Glasgow Coma Scale ≤ 5 OR b. Prior to discussion of withdrawal of the ventilator OR c. Conversation of Organ Donation initiated by Family

Hospital staff SHOULD NOT initiate the donation conversation with families. The nurse should document on the death record:
- Date & Time of call to Living Legacy
- Name of responding LLF Coordinator
- LLF Coordinator’s follow up actions

In cases of sudden death due to casualty, accident or possible criminal activity; contact the Medical Examiner prior to organ removal

The TRC Coordinator will
- 1-Evaluate patient for suitability for donation
- 2-Respond to the hospital within 90 minutes if patient is appropriate for donation
- 3-Will approach the family about donation and obtain consent
- 4-Will coordinate the care of the donor after the patient has been pronounced. All requested tests and Lab Work will ordered STAT.

**Resuscitation Policy:**

**Full Code:** Patients are assumed to be "Full Code" unless placed in another classification by means of the procedures outlined within this policy. Full Code patients are to receive all resuscitative efforts to reduce mortality and morbidity.

**DNR** means that at the time of cardiac and/or respiratory arrest patients are to receive no resuscitative efforts. At the time of arrest, dying is permitted to progress naturally:
- Code Blue" is not activated
- CPR, mechanical ventilation or tracheal intubation are not performed
- Ventricular defibrillation is not performed
- No medications are administered.
- No intravenous access is attempted

All code status orders must comply with the hospital approved orders. DNR-A and DNR-B are not appropriate for in-patient use. These orders apply only to patients being transported by EMS personnel.

Life-enhancing care, sometimes referred to as Care and Comfort Only, involves the provisions of high quality, but non-heroic medical care until death occurs naturally. Important examples of life-enhancing care include administration and monitoring of medications, carrying out other measures to control pain, comfort measures such as bathing and massage and offering food and fluids

The attending physician is to write an order for Full Code, DNR or Care and Comfort & document in medical record. A telephone order (“NO CODE”) is acceptable when the primary physician is not in the hospital at the time of the Code Blue. The telephone order must be witnessed by 2 nurses or another physician attending the patient at that time.
STAT TEAM

- The purpose of the STAT TEAM is to help prevent Code Blue situations outside of the Intensive Care Unit. The STAT Team will consist of the following personnel:
  - ICU RN
  - Respiratory Therapy
  - Clinical Coordinator
  - Primary Care Nurse

The Primary Care Nurse or other unit staff member, as directed, will dial 8222 & request the STAT Team to respond to a specific inpatient room. Primary Care Nurse will have a STAT call placed to the attending physician. The Primary Care Nurse will explain to the attending physician precipitating events leading up to STAT Team mobilization.

Code Blue Procedures

1. Initiate Code Blue announcement by pressing Code Blue Button at bedside or dialing ext 8222 “Code Blue Room #”
2. Initiate and maintain CPR according to American Heart Association Standards.
3. ACLS Standards are to be maintained for the duration of the resuscitation process

A RESPONSIBILITIES OF CODE BLUE TEAM MEMBERS:

1. Hospitalist or patient's physician if present.
   a) Directs all operations for entire CODE
   b) The Hospitalist or attending physician will remain in charge of code unless he relinquishes control to another physician.
   c) Hospitalist will give verbal report to attending physician post code.

2. Clinical Coordinator
   - Assists the team and helps to maintain the unit as indicated.
   - Direct any unauthorized persons to leave the area. If family present, escort them from code areas and arrange for a member of nursing service to stay with them if possible and keep them informed, if possible.

Phlebotomy

- Use Standard Precautions with each Patient
- Handwashing- must be done before and after collection of blood or any specimen
- Waterless hand cleansing gel can be used.

THIS IS THE #1 WAY TO PREVENT THE SPREAD OF INFECTIONS.
- Gloves must be worn during all specimen collection and all handling of specimens
Needle and lancet and glass disposed in the wall mounted sharps receptacle & Vacutainer disposal container

**Disinfection**
- Use 10% bleach on blood spills
- Disinfect Trays weekly with 10% bleach
- Discard Barrels after each use
- Disinfect tube racks with 10% bleach weekly
- Use one tourniquet for each patient

**How to Handle a Needlestick**
- Immediate first aid
- Notify the supervisor
- Immediately squeeze the site and force it to bleed. Wash the site thoroughly with disinfectant soap per CMH Policy
- Contact Employee Health Immediately
- Complete a Blood and Body Fluid Exposure Report Form & Safety Net report
- Immediately report to Employee Health Nurse Practitioner
  - Monday- Friday 8a-4p
  - After hours have the ER Registration clerk Page the EHN
  - Follow directions of the Employee Health Nurse Practitioner
  - Initiate the confidential protocol if directed
  - Go to Emergency Dept if directed

**Venous Collection Procedure**
- Initiate Test Request
- Process begins when the physician orders a test on a patient
- Computer requisitions- contain labels to be placed on a specimen
  - Must contain pertinent patient identification
  - May include the type of tube needed for specimen
  - Must have barcode information

**PREPARATION**
- Identify yourself w/ name, dept. & that you are there to collect blood specimen
- Ask patient to state his/her name & date of birth
- Follow Care fusion process
- ID Band must match information on the label

**ER Identification Procedures**
- Receives unconscious or confused pts or patients with no identification
- Given ID bands with Jane/John Doe with H #s
- **Identification of infants & young children**
  - ID band located on ankle
  - Commonly identified as Baby Girl Jones
  - Twins are often given designation A & B
• Never rely on name card on the bed – ALWAYS CHECK THE ID BAND ON THE PATIENT

Routine Venipuncture Procedure

• Cleanse the site
• Recommended antiseptic is 70% alcohol
• Blood cultures require chloraprep solution
• It will not sterilize the site
• Clean the site using a circular motion, starting at the center of the site and moving outward in ever widening concentric circles
• Allow the area to dry for 30 seconds
• Do Not recontaminate the site by drying the alcohol and do not blow on the site
• If necessary to touch site again, clean with alcohol wipe again.
• Verify the equipment and tube selection
• Assure that correct tubes and other equipment have been selected for the tests ordered
• Place the blood collection tray on paper towels on the patient’s bedside table

• Fill the Tubes
  ○ Mix tube with additives immediately by gently inverting 5 to 8 times
  ○ When the last tube has been filled, it must be removed from the holder and mixed before the needle is removed from the arm.

Routine Venipuncture Procedure

Label the Tubes at the Bedside
  • Follow the carefusion process for specimen labeling
  • Do Not Leave the Room before labeling the tubes
  • Do not print labels if unable to obtain specimen

Labeling the Tubes
  • Pink topped tubes, used for type and screen (T & S) for patient blood products require a 2nd blood draw
  • Lab will draw the 2nd specimen
  • A 2nd signature is not required on the initial pink topped tube

Syringe System Order of Draw

Sterile specimens: (ie, blood culture tubes or bottles).

Light blue stopper: sodium citrate or other citrate-containing tube or tubes for coagulation studies.

Lavender stopper: EDTA (K3 or Na2).

Green stopper: heparin.

Gray stopper: oxalate/fluoride.

Red stopper or red/gray stopper: Non-additive and gel separator, respectively.
Life Scan SureStep Flexx Meter

Hypoglycemia Protocol
• This was developed so the nurses could treat hypoglycemia immediately and then notify the physician
• Notify the nurse immediately of a blood sugar <70
• CNA/ACG/MST can assist with this protocol by taking vital signs, drawing blood and rechecking Glumeters at certain intervals

Lifescan Glumeter Procedure
• Wash hands, explain procedure to patient & allow for questions
• Turn machine on
• Scan operator bar code
  — Check operator ID to verify & hit OK
• Scan patient’s ID band
  — Check H number to verify correct pt & hit OK
• Choose lot number for test strip
• If performing controls need lot number from solution also.
• Choose appropriate lancet-blue & white lancet is used most
• If patient has tough skin use gray/blue lancet
• Put on gloves
• Select puncture site, preferably middle finger
• Cleanse finger with alcohol wipe, let dry
• Perform puncture perpendicular to the fingerprints
• Do not stick finger pad or tip of finger
• Wipe away first drop—contains large amount of tissue fluid and will give false low result
• Avoid milking finger—will also give false low results
• Obtain blood specimen & place on test strip
• Insert into test strip holder
  — You have 2 min. to insert strip
• Hold 2x2 on puncture site or have patient hold pressure
• Machine will display results on screen
  — Takes 30 second
• Discard lancet in sharps container
• Clean up equipment & dispose of properly
  — Do not use alcohol to cleanse glumeter
• Turn off and dock the meter in cradle (data will be transferred to Meditech automatically)
  — MUST BE DOCKED WITHIN 1 HOUR

Glumeter
• If reading says “HI”
  – Blood sugar is greater than 500
• If reading says “LOW”
  – Blood sugar is less than 40
• If either is displayed, nurse is to be notified immediately, vital signs should be checked and a green or gray tube draw stat

**Red Panic Value Test & Critical Findings Reporting**

Red Panic values are Lab & Cardiopulmonary test results that may significantly change patient outcome and treatment where URGENT notification and response is important. Critical Findings are Radiology findings/results that may significantly change patient outcome and treatment where URGENT notification and response is important. When using existing orders or protocol such as sliding scale insulin, clinician notification is NOT REQUIRED. The relevant order serves the purpose of being able to act upon the results.

**Panic Values Reporting Procedure**

1- **Laboratory will**:  
   Notify the unit charge nurse or nurse caring for the patient of the red panic value within one hour

2- **Nurse will**:  
   Write down and then read back to testing dept and ask if correct  
   Notify physician/LIP order the test within one hour of receipt  
   Interrupt physician from their duties if necessary to report  
   Document notification in patient record

3- **Cardiopulmonary will**:  
   Notify the physician / LIP of a cardiopulmonary red panic value within one hour and document notification

**Radiology will**  
Radiologist notifies prescribing physician of any radiology critical findings within one hour. Radiologist documents notification in dictated test interpretation.

**Cardiopulmonary Panic Values**
- pH less than 7.3 or greater than 7.6
- pCO2 less than 15 or greater than 60mm/hg (if pH not 7.35-7.45)
- pO2 – Arterial less than 50 mm/hg
- pO2 – Capillary less than 30mm/hg

**Lab Panic Values**
- Glucose less than 60 or greater than 350 mg/dl
- Hematocrit less than 21%
- Hemoglobin (0 days – 1 month) less than 10 or greater than 23g/dl
- Hemoglobin (Older than 1 month) less than 7 or greater than 20g/dl
Potassium (0 – 59) less than 2.8 or greater than 5.7 mEq/l
Potassium (Age 60 Y/older) less than 3.0 or greater than 5.7 mEq/L
Sodium Less than 120 or greater than 160 mEq/L

**Radiology Critical Findings**

- Pulmonary embolism
- Tension Pneumothorax
- Mal-placement of ET Tube
- Cerebral hemorrhage or infarction
- Ectopic pregnancy
- Aortic dissection/aortic aneurysms of significant size (5cm or greater)
- Free air under the diaphragm/ruptured viscera
- Testicular or ovarian torsion
- Spinal cord compression
- Acute or significantly progressive intracranial hemorrhage
- Large territory acute brain stroke or hemorrhagic stroke
- Large mass with significant mass effect or herniation
- Depressed or basal skull fracture
- Acute dural venous thrombosis
- Aneurysm or dissection

**Medication Administration**

All orders that contain meds & IV fluids are to promptly be scanned to pharmacy

- Assure ALL order sheets contain patient height weight, patient label, date, time & physician’s signature. Pharmacy will then enter all medications & IV solutions into the computer. Once in the system, the administering department (RN, RT, …)
is to verify the VMAR entry against the written order. **ALL** medications & IVs **MUST** then be acknowledged by the administering department **BEFORE** the first dose is given or after any edits. If incorrect, put the medication on hold & enter a comment for the pharmacist (please call pharmacy to notify them at this time). If all is correct, “noted” is to be written on the physician’s order sheet with date, time & signature of the person verifying. Once in the system, administering department will “acknowledge” that the medication order is correct on the VMAR. This must be completed prior to administering first dose. Night shift is to review transcription of all orders. The nurse will then date, time & sign the orders signifying this check. If any discrepancies, appropriate corrections will be made at that time.

**VMAR-Routine & PRN meds will be documented in the VMAR**

- You will be prompted to respond to required fields i.e. BP, HR, BS
- If a medication is missed, delayed or not documented (more than 60 minutes), you will be required to enter a reason code in VMAR (this provides valuable information & is not punitive) Examples: refused, pt off unit, med not available

**Routine Med Times**
- Daily--1000
- BID--1000-2200
- TID or q8hours--0600-1400-2200
- 4xdaily--0600-1200-1800-2400
- Q3hours-0000-0300-0600-0900-1200-1500-1800-2100
- Q4hours—0000-0400-0800-1200-1600-2000
- A.C. 30 minutes prior to meal arrival
- P.C. 30 minutes after meal
- H.S.—2200

**Insulin Sliding Scale Times**
- A.M. Insulin 0830
- BID 0830-1730
- TID or AC 0830 1230 1730
- 4 times a day 0830 1230 1730 2200
  or AC & HS
- Q 6 hr 0000 0600 1200 1800

**DOCUMENT GLUMETER READINGS PRIOR TO ADMINISTRATION**

If administration time change is needed, the person giving the medication will notify pharmacy, who will then make the necessary adjustment. Nurses cannot make this change on the VMAR. Pyxis may display medications that are not due i.e. if meds are due q3d. Therefore, always check the VMAR. VMARs orders ALWAYS supersede the PYXIS.

**Mixing of Medications**
- All continuous & intermittent infusions of KCL will be mixed by pharmacy
- Maximum concentration of large volume KCL is 80mEq/1000ml
- Maximum concentration for K runs (adult)
  - 10mEq/100mL over 1 hour-unmonitored setting
  - 20mEq/100mL over 1 hour-monitored setting
  - Infusion pump required for all K runs
**High Alert Meds are to be checked by 2 RNS and they include:**

- PCA & PCEA
- Chemotherapy
- Insulin (IV push & drips)
- Thrombolytics (except catheter clearance)
- Heparin drips
- TPN/PPN
- Magnesium (High Dose) for L & D (40 grams in 1000 ml)
- Magnesium 4 gram bolus in 100 ml for L & D
- Neuromuscular blockers - Succinylcholine (Anectine), Vecuronium, Rocuronium (Zemuron), Cisatracurium (Nimbex) if **drawn up by nursing only**

**Adverse Drug Reactions**

- Report to pharmacy
- Complete Adverse Drug Reaction Report
- Document in the nurses notes the reaction & include interventions implemented
- Pharmacist will assess level of severity of the reaction & conduct an investigation

**Bar Coded Medication Administration**

- Scanning includes:
  - Nurses ID badge
  - Patient’s armband
  - Medication barcode

Assessment of Pain Medications must be documented within 60 minutes of administering the medication.

**Medication Reconciliation**

Who is responsible for Medication Reconciliation?

**Nurse** is to collect & verify the accuracy of the medication list through:

- Patient/ Significant Other
- Written Lists, Medication Bottles, Patient’s Physician Office, Emergency Dept Record, Transferring Institution

**Pharmacist** is to review the home medication list prior to entering in the VMAR &/or releasing the medications to the patient care unit for administration

**Physician** is to review and correct any discrepancies on admission & when the patient is transferred from one level of care to another or discharged

When is Medication Reconciliation Performed?

**ALL PATIENTS WHO ARE::**

1. Patient admission to inpatient or outpatient settings
2. Intra-hospital transfers-transfers to another level of care within the hospital
3. Discharge from Hospital Care

Where to obtain information?

- Patient’s written list
Inpatient Direct Admissions
On admission, the nurse collects the Home Medication list & places in Meditech within the Admission History Assessment as soon as possible. This section can be updated during the patient’s hospitalization if addition/new information is provided regarding patient’s home medications. These updates should be scanned to pharmacy. The pharmacists will provide secondary review and clarify with physician if necessary. Upon completion of the admission history and assessment, the Home Medication & Discharge Medication Reconciliation Form will automatically print. Scan or fax a copy to pharmacy with admission orders. (No routine medications will be released by pharmacy until pharmacy receives this scanned list & performs their medication reconciliation.) Place a copy in the physician’s order section of the chart. This Admission Medication Reconciliation Form will serve as the reconciled medication list up to the point of transfer or discharge.

Inpatients Admitted from the Emergency Dept
The ER Nurse will enter patient’s medications into Allscripts database. If the patient is already in the system, the nurse will verify the medications. The Hospitalist and Pharmacy will review the medications in All Scripts. The ED will send a home medication list from Allscripts for the admitting nurse to review. The receiving Inpatient nurse will review the Home Medication List with the patient that was generated from All Scripts. This Home Medication List will be placed into Meditech by the inpatient nurse within the Admission History Assessment as soon as possible & no longer than 12 hours of admission from the ED. The report will automatically print. A copy will be scanned to Pharmacy then placed under “HOME MEDS” tab section of the chart for the physician for reconciliation. This Admission Medication Reconciliation Form will serve as the reconciled medication list up to the point of transfer or discharge.

IMPORTANT NOTE
● The Home Medications & Discharge Medication Reconciliation will automatically print when the list of home medications is updated or revised after the admission assessment has been completed & filed. The unit secretary or designee, will put the updated reports in the patient record, replacing the previous version.

Transfer Medication Reconciliation Form
Transfer Medication Reconciliation Form will be printed by the nurse & placed on the medical record prior to a patient transfer. The Physician/LIP at the receiving site will review the Transfer Medication Reconciliation Form & note / order changes to the medication regime as a result of the transfer, procedure, or medication received. The
receiving physician may defer review of the Transfer Medication Reconciliation Form to an attending physician by writing an order to do so. Upon receipt of this order the nurse will contact the attending physician to conduct the medication reconciliation and document any changes on the form.

Pharmaceutical Wastes

Pharmaceutical waste is when the total amount of the medication was not administered, leaving you with a full or partially full vial or syringe or IV or a portion of a pill. Some medication packaging is also considered pharmaceutical waste (ex: Coumadin & Nicotine items). Medication vials and syringes that are EMPTY will continue to be discarded in the RED SHARPS container. IV bags, tubing and MOST pill packages that are EMPTY will continue to be discarded in the trash can per current procedure.

Non Hazardous Pharmaceutical Waste Use 8 Gallon Non – Hazardous Reusable Waste (Blue) Non Hazardous pharmaceutical waste are medications that can be placed in the same container without a danger of a chemical reaction
All Non Hazardous pharmaceutical waste are discarded in a BLUE CONTAINER unless it is in a syringe or ampule. Any waste in an IV bag with the potential to leak should be placed in a re-closable bag prior to discarding in the blue container. Examples of Non Hazardous Pharmaceutical Waste
Antibiotics
Aspirin
Tylenol
Full or partial IVs with medication instilled ( keep tubing attached and placed in reclosable bags
Prescription Creams, lotions, ointments- ( must be capped or placed in reclosable bag)
Pills
Tablets
Full or partial filled vials

92% of all non hazardous wastes will be disposed of in the blue container.
NO items with a waste code of BKC, PBKC or SP should be in blue container

Hazardous Pharmaceutical Waste Use
8 Gallon Compatible Hazardous Reusable (Black)
2 Gallon Black Sharps

Hazardous pharmaceutical waste are medications that cannot be placed in the same container because it may cause a dangerous chemical reaction. These medications will be labeled in Pyxis or VMAR with BKC or PBKC.
Medications labeled with PBKC indicates that the medication package is also required to be discarded in the Black Container. Examples are Coumadin and Nicotine patch … All medications with BKC OR PBKC will be discarded in a 8 gallon BLACK CONTAINER. Some examples are:

- Allergenics
- Antiseptics
- Coumadin
- Nicotine Gum and Lozenges
• Full or partial IVs with insulin
• Transdermal patches
• Nitroglycerin
• Lidocaine with Epinephrine
• Epinephrine

All Syringes or ampules with or without a needle containing left over medications will be placed in the 2 gallon Black Sharps Container when the hazardous medication is:
1-Not a controlled substance
2-Has not come into direct contact with the patient

Items discarded down the Drain or Sewer System are:
• Maintenance IV solutions- Sugar / Salt Water IVs
• Potassium Chloride
• Potassium Phosphate
• Sodium Phosphate
• Calcium
• Sodium Bicarbonate
• Dextrose
• Saline
• Controlled Substances- oral, injectable, liquids, epidurals and PCAs. Fentanyl patches should be cut in ½ and flushed down the toilet.

No IV solutions with medications instilled (other than those noted above) can be disposed of down the drain or sewer system incompatible rx waste (send to pharmacy) these wastes are sent to pharmacy in a reclosable bags for disposable. these medications will be labeled in pyxis/vmar as sp, spo, spc, splp.some examples include:
  AEROSOLS- Inhalers
  CORROSIVES- Glacial Acetic Acid & Sodium Hydroxide
  OXIDIZERS- Potassium Permanganate & Unused silver Nitrate

*This list is not conclusive *

Pain Management-

Pain is subjective—it is whatever the patient says it is…BELIEVE THEM!
Utilize a standard pain assessment tool
Physiological signs of pain include: tachycardia, hypertension, diaphoresis, pallor
Pain must be re-assessed after pain relief measures within 60 minutest for IV, IM and PO analgesic

Nursing Pain Assessment includes:
• Location
• Intensity-use pain scales based on recommended age & developmental ability of patient
• Quality-patient’s description using their own words
• Frequency-constant or intermittent
• Contributing and Relieving Factors-what makes it better or worse

**Pain Scales**
Numerical Pain Scale- Rate pain on scale of 1-10, 0 means no pain, 10 is the worst pain
Wong-Baker faces-Used for children or adults who cannot understand the numerical scale
FLACC-used for infants and children who cannot verbalize pain
Nurses are required to educate the patient on the importance of reporting pain & effectiveness of medications AND use scripting to ensure patients are given consistent information from all caregivers
What is scripting?
Scripting provides carefully considered details as a plan of action to ensure patients have good experiences & positive outcomes
Scripting involves identifying common situations, activities, and questions
Teaching staff how to answer questions appropriately to project the caring, professional image of a staff member

**Anticoagulation Therapy**
Anticoagulation Therapy is used to prevent or treat Deep Vein Thrombosis (DVT)
DVT places patients at high risk for pulmonary embolism
Risk Factors for DVT include:
Increased Age
Obesity
Smoking
Hx of DVT
Acute Illness
Central Venous Catheters
Estrogen Therapy
Varicose Veins
Surgery
Cancer / Cancer RX
Inflammatory Conditions
Acute Infectious Processes
Heart Failure
Chronic Lung Disease
Stroke

Patient Education
■Foods Containing Vitamin K can reduce anticoagulation effects of Coumadin
□Asparagus, Beans, Broccoli, Cabbage, Cheese
    Fish, Milk, Rice, Spinach, Yogurt
■Alcohol can alter therapeutic levels of coumadin

**Wound Care**

**Prevention Measures**
Recognize Risk
Decrease Pressure
Assess Nutritional Status
Reduce Friction & Shearing
Preserve Integrity of the Skin

#1 - Recognize Risk
Sensory Perception, Moisture, Activity, Mobility, Nutrition, Friction & Shear

Braden Score Results:
- Not at Risk: 19-23
- Mild Risk: 15-18
- Moderate Risk: 13-14
- High Risk: 10-12
- Very High Risk: Less than or equal to 9

#2 - Decreasing Pressure
Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. Decrease pressure by:
- Limit bedrest and avoid immobility if possible.
- Turn & Reposition every 2 hours when in bed.
- Turn & Reposition every 15-60 minutes when in a chair.
- Use of Pressure Relieving Devices.
- Keep HOB at lowest level possible (No higher than 30 degrees unless medically indicated).

#3 Nutritional Assessment
Patients malnourished at hospital admission are twice as likely to develop pressure ulcers than nonmalnourished patients. Nutritional deficiencies, anemia's, and metabolic disorders can all contribute wound/ulcer development.
Diet: needs to have sufficient calories, protein, iron, Ascorbic Acid (Vitamin C) Vitamins A & B, Zinc, Sulfur
Consider alternative feeding methods if the patient is NPO or has poor PO intake.
Dietician Consult

#4 Reduce Friction and Shearing
Friction is the resistance to movement that occurs when two surfaces are moved across each other. Shear is created by interplay of gravitational forces (forces that push the body down) and friction.
Friction and Shearing can be caused when a patient slides down in bed or is dragged across a surface. Sacrum and heels are the most susceptible

#5 Preserving Skin Integrity by
Adequate Hydration
Bathing Schedule
Minimize force and friction during bathing.
Use sensitive, ph balanced cleansers and moisturizers.
Use absorbent pads, dressings, or briefs.
Cleanse at time of soiling.
Establish a bowel and bladder program.
Use topical agents that provide a barrier against moisture.
NO massaging reddened areas.

Ulcers that are found on mucus membranes caused by medical devices are not to be classified as pressure ulcers, but as device related ulcers, as they can not be assessed by the same criteria as a pressure ulcer. This would include NG tubes, suprapubic catheters, foley catheters, endotracheal tubes, oxygen tubes etc.

Pressure Ulcer Definition
A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Pressure Ulcers are staged

Stage I
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.
Stage I may be difficult to detect in individuals with dark skin tones.

Stage II
Partial loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Presents as a shiny or dry shallow ulcer without slough or bruising.
This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury.

Stage III
Full thickness tissue loss. **SUBCUTANEOUS FAT MAY BE VISIBLE, BUT BONE, TENDON OR MUSCLE ARE NOT EXPOSED.**
Slough may be present but does not obscure the depth of tissue loss.
May include undermining and tunneling.
The depth of a stage III pressure ulcer varies by anatomical location.
The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow.
Bone/tendon is not visible or directly palpable.

Stage IV
Full thickness tissue loss with exposed bone, tendon or muscle.
Slough or eschar may be present on some parts of the wound bed.
Often include undermining and tunneling.
Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow.

Stage IV
Unstageable
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.*

UNSTAGEABLE wound example would be a fluctuant eschar that is movable in the wound bed, and feels as if it were literally floating on a bed of fluid.

Suspected Deep Tissue Injury
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Other Wound Types
Arterial Wounds
Complete or partial arterial blockage may lead to tissue necrosis and / or ulceration. Characteristics of these wounds are that they are found on the feet, heels or toes. Frequently painful, particularly at night in bed or when the legs are at rest and elevated. This pain is relieved when the legs are lowered with feet on the floor as gravity causes more blood to flow into the legs. The borders of the ulcer appear as though they have been “punched out”. Associated with cold white or bluish, shiny feet. There may be cramp-like pains in the legs when walking, known as intermittent claudication, as the leg muscles do not receive enough oxygenated blood to function properly. Rest will relieve this pain.

Venous Wounds
A venous skin wound, also called a stasis leg ulcer, is a shallow wound that develops when the leg veins do not move blood back toward the heart normally.
Characteristics of Venous Wounds are that they are located below the knee, most often on the inner part of the ankles. Relatively painless unless infected. Associated with aching, swollen lower legs that feel more comfortable when elevated. Surrounded by mottled brown or black staining and/or dry, itchy and reddened skin.

Diabetic Wound
Diabetic wounds are caused by the combination of arterial blockage and nerve damage. Although diabetic ulcers may occur on other parts of the body they are more common on the foot. The nerve damage or sensory neuropathy reduces awareness of pressure, heat or injury. Rubbing and pressure on the foot goes unnoticed and causes damage to the skin and subsequent ‘neuropathic’ ulceration. Diabetic ulcers have similar characteristics to arterial ulcers but are more notably located over pressure points such as heels, tips of toes, between toes or anywhere the bones may protrude and rub against bedsheets, socks or shoes. In response to pressure, the skin increases in thickness (callus) but with a minor injury breaks down and ulcerates.

SKIN TEARS
A skin tear is a traumatic wound which occurs most often on the extremities of older adults, as a result of friction alone, or shearing and friction forces.

Category I Skin Tear: appears as incision or has 100% of skin flap present.
Non-draining Skin Tear treatment would be to cleanse with normal saline. Straighten flap over wound bed with saline moistened Q-tip. Apply steri strips. Cover with Cuticerin and light foam dressing. Change every 2-3 days and PRN.
Draining Skin Tear treatment would be to cleanse with normal saline. Straighten flap over wound bed with saline moistened Q-tip. Cover with Mepilex Foam. Change every 2-3 days and PRN.

Category II/III Skin Tear: has 0-75% of skin flap present.
Non-draining Skin Tear Category II/III, would be to cleanse with normal saline. Apply Cuticerin and light foam dressing. Cover with 4x4 and secure with Kling, paper tape. Change every 2-3 days and PRN.
Draining Skin Tear Category II/III would be to cleanse with normal saline. Apply Mepilex Foam. Cover with 4x4 and secure with Kling, paper tape. Change every day to every other day.

HIDDEN WOUNDS
If there is any type of appliance/tube cannula in place, then the skin should be checked for evidence of breakdown as part of your assessment.

Measuring Wounds
Wounds should be measured length, width & depth
Length-measure wound edge from head to toe.
Measure wound edge from fingertip to fingertip
Measurements documented on admission, every 3 days and at discharge

Specifics of wound measurement
Imagine that the wound is the face of a clock.
The top of the wound is towards the patient’s head – or 12 o’clock.
The bottom of the wound is in the direction of the patient’s feet – or 6 o’clock.
LENGTH : Is measured in centimeters from 12 to 6 o’clock at the longest point.
WIDTH : Is measured in centimeters from 9 to 3 o’clock at the widest point.
DEPTH : Is always measured in centimeters by inserting a cotton tip applicator into
the deepest part of the wound bed.
TUNNELING : Is measured in centimeters by inserting a cotton tip applicator into
the tunneled area of the wound.
UNDERMINING : Is described by using the face of the clock to determine location
of undermining in wound bed.

WOUND CARE FORMULARY

TOPICAL DRESSINGS
Helpful Hints for ALL Wounds
Cleanse all wounds with normal saline.
Cleanse surrounding skin as necessary.
Protect intact skin with barrier cream.
Moisturize intact dry, skin.
Apply skin prep to intact skin if adherent dressing is to be used.
Change dressing more frequently if maceration occurs even with appropriate
dressing. Transparent films should be changed when a “bubble” of exudates forms
under dressing or drainage leaks out from under it.

ALGINATES
Calcium or Calcium Sodium salts
Derived from seaweed
Sodium ions in the wound exchange places with the Calcium ions of the dressing
Wound fluid is absorbed and the dry sheet or rope is changed to a hydrophilic gel
Calcium Alginate should be changed when it has formed a gel. Discontinue alginate
if wound is dry. Calcium Alginate dressings are used for wounds that have a moderate
to large amount of drainage, over bleeding sites for 24 hours to promote clotting
And over infected wounds
Calcium Alginate always require a secondary dressing, they can not be used alone.

HYDROGELS
Donate moisture to the wound
Are 30 to 90% water, depending on the brand.
Have minimal absorptive capacity
Prevent drying of tendon, bone, ligament and new tissue forming in the wound.
Are mixed with drugs for topical delivery into the subcutaneous tissue
Can be used if the wound is infected and must be changed daily.

HYDROCOLLOIDS
Provide moisture to the wound in the form of a soft gel mass when the wound fluid comes into contact with the dressing.
CANNOT be used on deep wounds or wounds with moderate to large exudate
CANNOT be used if there is infection present
Should be used at CMH only for creating bridging or building up around an ostomy if there is leaking. Duoderm is a (Hydrocolloid)

FOAMS
Are made to be absorbent
Should be used when wound fluid is not contained in a dressing over a 24 hour period
Used at CMH include: Mepilex Lite and Border Lite and Mepilex, Mepilex Border
Are silicone based and can be used over friable skin and also skin that has age related changes and has high potential for breakdown or tearing.
Also be used over boney prominences if friction is an issue for the patient.
Foam Dressings include Maxorb Ag, Silvasorb Gel

Wound Contact Layer: Cuticerin
Is made to be applied directly over the wound bed.
Is an impregnated gauze made of acetate and mesh and is water repellent.
Does not allow adherence of new granulation tissue
Is permeable to air and exudate
Decreases pain at the time of dressing change.
Is also helpful in softening non viable tissue with the presence of petroleum in the dressing that is present in the wound if used over time.

Cuticerin
Antimicrobial Barrier: Acticoat
Is two layers of silver coated high density polyethylene mesh enclosing a single layer of non woven fabric of rayon and polyester. Silver is applied to the mesh forming metallic silver, the dressing then becomes an antimicrobial barrier
Should be MOISTENED WITH STERILE WATER PRIOR TO APPLICATION
May be trimmed to fit the wound size DARK BLUE SURFACE should be TOWARD the skin. Secondary dressing will be required
Acticoat can remain in place for up to 3 days, depending on the wound drainage

ENZYME DEBRIDEMENT: SANTYL
Collagenase (Santyl + Petrolatum)
Used to destroy unwanted collagen and slough in a wound.
Once daily application. Can be applied with gauze for shallow wounds or tongue depressor/Qtip for deeper wounds.
Must cover with a secondary dressing, this can be of any type depending on the wound and drainage.
WOUND CULTURE PROCESS
Gently dry the wound with sterile gauze.
Obtain culturette, dip the tip of the culturette into sterile saline to moisten and promote adherence of any organisms.
Rotate the swab over a 1 cm squared area with enough pressure to express wound drainage onto the tip of the culturette.
Return culturette to it’s container and label per hospital policy.
PLEASE DO NOT CULTURE SLOUGH, ESCHAR, OR ANY OTHER NON VIVABLE TISSUE!!!!

CARE OF THE PATIENT WITH ALCOHOL WITHDRAWAL
Alcohol withdrawal refers to symptoms that may occur when an alcoholic, including binge drinkers, suddenly stops drinking.
Symptoms can occur within 5-10 hours after the last drink, or up to 7-10 days later. The more heavily a person drinks, the more likely that person will develop alcohol withdrawal symptoms when they stop.
Symptoms could be mild, or severe
Withdrawal symptoms may be more severe if a person has other medical problems.
Appropriate treatment is imperative to assure safety of staff and family.

PSYCHOLOGICAL SYMPTOMS with ALCOHOL WITHDRAWAL
  Jumpiness/nervousness
  Shakiness
  Anxiety
  Irritability
  Easy excitability
  Rapid emotional changes
  Fatigue
  Difficulty thinking clearly
  Bad dreams
  Depression

PHYSICAL SYMPTOMS with ALCOHOL WITHDRAWAL
  Headache
  Sweating
  Nausea and vomiting
  Loss of appetite
  Insomnia
  Pallor
  Rapid heart rate
  Dilated pupils
  Clammy skin
  Tremor of the hands
Involuntary, abnormal movements of the eyelids

_SEVERE ALCOHOL WITHDRAWAL SYMPTOMS_

Physical assessment includes:
- Tachycardia
- Tachypnea
- Fever
- Abnormal eye movements
- Tremors of the hands or body
- Arrhythmias
- Internal bleeding
- Liver failure
- Dehydration

_TREATMENT_

Follow Alcohol Detoxification & CIWA Orders set

Use CIWA scale to determine patient’s severity of withdrawal
Medicate based on scale results

FALLS MANAGEMENT PROGRAM

Prevention is the Key & begins with Assessment of the Patient

Falls Risk Assessment Tool (FRAT)
The scoring is based on:
1- Age
2- Hx of Falls in the last 6 months
3- Mental Status
4- Toileting
5- Mobility
6- Sensory Impairment
7- Substance Abuse
8- Medications Ordered
9- Change in meds within the last week
10-PCA pump in use

How do we assess patients for Fall Risk?
FRAT Score 10+, the nurse must initiate the Falls Risk Care Plan by inserting “Y” on Meditech.
FRAT Score <10, the Falls Risk Care Plan does not need to be initiated UNLESS the nurse initiates the Falls Risk Care Plan by inserting “ Y “ in Meditech.

When is a FRAT scale completed?
On admission.
Transfer from another unit
Once a shift (q12hours) except:
TCU every 24 hours &
Behavioral Health will be reassessed according to condition
Any change in mentation. (Including sedation and general anesthesia)
Change in condition that may put patient at risk.
If anticonvulsants, tranquilizers, psychotrophics or hypnotics are added.

**Patient/Family Education**
The basic Falls Safety brochure is in the admission kit booklet. Refer to it. Use it.
Instruct patient/Family to ask for assistance when getting in/out of bed or chair etc.

**Prevention measures for all Patients**
Keep bed in low position.
Lock all wheels (beds, wheelchairs, geri-chairs etc).
Keep call bell and personal care items within patient’s reach.
Keep assistive devices, glasses, etc within reach. Use them when caring for patient –
including gait belts etc. when getting pt OOB or ambulating etc, even if patient is
confused.
Evaluate and treat pain.
Answer call bells promptly.
Encourage use of non-skid footwear.
Be alert to environmental issues (wet floors, broken wheel locks, etc & report or fix
immediately!).
Keep patient rooms clutter free.
FRAT 10 or Greater we will initiate Falls Risk Care Plan and continue all prevention
measures plus place:
1. **Yellow** FALLS armband on patient
2. **Yellow** ALERT block on door frame.
3. **Yellow** non-skid socks on patient
4. **Yellow** sticker on door name tag
5. Use bed exit alarms
6. Visual patient checks every 2 hours.
7. Initiate a toileting program
8. Re-educate patient/family regarding the safety measures. Clear understanding
helps prevent falls.

**What to do if the patient falls?**
1. Assess your patient.
2. Complete the Post Fall Assessment.
3. Document a new FRAT.
4. **If Unwitnessed or there is evidence that the patient may have struck** their
   head in the fall ---**Do Post Fall Head Injury assessment.**
5. Repeat every hour for 2 hours then every 4 hours for the balance of 24 hrs. (Head
Injury is the leading cause of death post fall

6. Immediately notify the doctor – Notify the physician and remind him/her if the patient was on ASA, Heparin, Coumadin or Plavix Notify Clinical Coordinator
6. Notify family if patient is not alert & oriented (pre or post fall) or At the patient’s request

Any diagnostic labs or x-rays ordered due to a fall are to be ordered as “STAT”.
If the patient is not on a Falls Risk Care Plan – Place them on it regardless of your Post Fall FRAT. Document document document – do your assessments and record.
Re-educate patient & family & document!