Cornerstone Hospital of Austin

Mandatory Agency
Mini Orientation 2011

2011
Joint Commission
National Patient Safety Goals (NPSG)

#1 Improve the accuracy of patient identification.

- Use two patient identifiers when providing care, treatment, or services.

#2 Improve the effectiveness of communication among caregivers.

- Read back orders or critical test.
- Report critical test results on a timely basis.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- The Situation Background Assessment Recommendation (SBAR) is used to communicate information to other care providers.

#3 Improve the safety of using medications.

- Annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- Label all medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on & off the sterile field.
- Reduce the likelihood of patient harm associated with anticoagulation therapy.
- Maintain awareness of look-alike and sound-alike drug names as published by various agencies.

#7 Reduce the risk of healthcare-associated infections.

- Comply with CDC hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Education of new and current employees regarding hand hygiene.
- Convenient availability of alcohol-based disinfectant and sinks with soap/water.
- Reinforcement of not having long or artificial fingernails.

#8 Accurately and completely reconcile medications across the continuum of care.

- There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the hospital.
- A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to patient on discharge from the facility.
- The MAR from the previous facility is compared to admission orders to ensure all medications are continued as needed.

#15 The organization identifies patients at risk for suicide.

- Suicide Precautions Policy
- Preadmission screening and nursing admission assessments that address psychosocial issues are performed on each patient.
- Suicidal patients are not routinely admitted to this facility.



Cornerstone Hospital of Austin

INFECTION PREVENTION AND CONTROL

IC BUNDLES

Hand Hygiene

Wash your hands - it's the single most important method of controlling infection!

- **What is the right way to wash your hands?**
  - Wet your hands with clean running water (warm or cold) and apply soap.
  - Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers, and under your nails.
  - Continue rubbing your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
  - Rinse your hands well under running water.
  - Dry your hands using a clean towel or air dry.
- Washing hands with soap and water is the best way to reduce the number of germs on them.
- If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol. Alcohol-based hand sanitizers can quickly reduce the number of germs on hands in some situations, but sanitizers do **not** eliminate all types of germs.
- **Hand sanitizers are not effective when hands are visibly dirty.**
- When using alcohol foam – dispense a palm-full (golf ball size) spread over both hands up to ½ inch above wrists and allow to dry.

Hand Hygiene – Nails

This policy applies to all staff who provide care, supervise, or prepare products.

- Nails are to be kept short (1/4 inch of white visible above the quick).
- Nails are to be kept clean.
- Artificial fingernails and enhancements are prohibited.
- Nail polish in good repair is permitted.

Standard Precautions

- **Standard Precautions** should be used for the care of all patients, regardless of their diagnosis or presumed infection status.

- **Standard Precautions** apply to 1) blood; 2) all body fluids, secretions, and excretions, *except sweat*, regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes. Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

- Standard precautions includes the use of: hand washing, appropriate personal protective equipment such as gloves, gowns, masks, whenever touching or exposure to patients' body fluids is anticipated.

Transmission Based Precautions

- **Transmission-Based Precautions** (i.e., Airborne Precautions, Droplet Precautions, and Contact Precautions), are recommended to provide additional precautions beyond Standard Precautions to interrupt transmission of pathogens in hospitals.

- Transmission-based precautions can be used for patients with known or suspected to be infected or colonized with epidemiologically important pathogens that can be transmitted by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. These precautions should be used in addition to standard precautions.

Contact Precautions

- **Contact Precautions** used for infections spread by skin to skin contact or contact with other surfaces
- Think "I'm coming into contact…"
  - **Gloves**: **Always**
  - **Gown**: Required when physical contact with patient **or** environment
  - **Masks**: MDRO in sputum

Droplet Precautions

- **Droplet Precautions** used for infections spread in large droplets by coughing, talking, or sneezing
- Large particles that can only travel 3 feet "then drop"
  - **Gloves**: Follow standard precautions
  - **Gowns**: If soiling is likely
  - **Masks**: Within 3 feet of patient

Airborne Precautions

- **Airborne Precautions** used for infections spread in small particles in the air
- Small particles can travel long distances and remain suspended in air
- Think “Always in the air”
  - N95 Respirator: ALWAYS
  - Gloves
  - Gowns

- Must place patient in negative air pressure room
- Must keep door closed at all times
- Ante room for donning & removing PPE

Infection Control Bundles

What is a bundle?

Bundles are groupings of best practices with respect to a disease process that individually improve care, but when applied together result in substantially greater improvement.

Central-Line Bloodstream Infections (CLBSI)

1. **Hand Hygiene**
2. **Maximal Barrier Precautions**
3. **Chlorhexidine skin antisepsis**
4. **Optimal catheter site selection, with the subclavian vein as the preferred site for nontunneled catheters**
5. **Daily review of line necessity**

Catheter-Associated Urinary Tract Infection (CAUTI)

1. **Hand Hygiene**
2. **Check catheter connections and secure with a leg strap**
3. **Patient awareness of their role in the prevention of UTIs**
4. **Empty drainage bag every shift into a clean container**
5. **Daily review of the need for the urinary catheter**

Ventilator-Acquired Pneumonia (VAP)

1. **Oral Hygiene**
2. **Elevation of the head of the bed**
3. **Peptic Ulcer Disease Prophylaxis**
4. **Daily “Sedation Vacation” and assessment of readiness to extubate.**




Cornerstone Hospital of Austin

SENSITIVITY TO CULTURAL DIVERSITY

ABUSE/NEGLECT PREVENTION

Cultural Sensitivity

- As an employee of Cornerstone Hospital of Austin you are fortunate to work alongside culturally diverse staff, patients, patient families and physicians. Each culture is unique and can influence ones values, beliefs, behaviors and other factors. Being sensitive and informed about other cultures can improve communication and can improve patient care.
- Looking for common elements in a culture can help to guide you in your interactions. It is important to be aware of stereotypes and to remain aware that each individual is different even within one culture.
- **Lack of cultural understanding can lead to…**
  - Miscommunication
  - Misunderstanding
  - Misinformation
  - Mistrust
- **Become culturally competent by…**
  - Increasing your awareness of other cultures
  - Acquiring knowledge on/about other cultures
  - Developing and maintaining cross-cultural skills

Cultural Sensitivity
Nonverbal Communication

- It is important to focus on what the person says and be cautious when interpreting forms of nonverbal communication. Some forms of nonverbal communication that can vary across cultures are:
  - *Facial Expressions* – Avoid using a person's facial expression to gauge their level of emotional or physical comfort.
  - *Eye Contact* – Do not force a person to make direct eye contact. Do not assume that a person who does not make eye contact is hostile or uninterested.
  - *Head Movement* – Do not assume that a head movement means "yes" or "no". Always ask for verbal clarification if possible.
  - *Arm/Hand Gestures* – Some gestures considered friendly in one culture can be vulgar in another. Try not to use hand/arm gestures when communicating cross-culturally.
  - *Personal Space* – Being close is considered commonplace in some cultures while others find this offensive. Follow the person's lead.
  - *Touching* – Certain cultures are comfortable with casual contact, while others are not. Follow the person's lead.

Cultural Sensitivity
Verbal Communication

- When a translator is needed, Case Management, Nursing Administration, or Hospital Administration will be responsible for contacting CyraCom International. You may not use a patient's friend, family member, or another patient as a translator. This ensures confidentiality of information and accuracy of communication.
- When caring for someone with limited English proficiency be sure to avoid yes/no questions. Start questions with the words who, what, where, when, why, or how. Their answer should clarify whether they understand the question asked, and if not, to rephrase your question in a way they may better understand.

Abuse and Neglect

In the hospital setting, all healthcare workers are responsible for reporting signs of abuse, neglect and exploitation to the RN House Supervisor or Case Management.

Signs/Symptoms of Abuse and Neglect:

- **Physical injuries** – bruises, imprint injuries, rope or cigarette burns, broken bones or sprains that are not explained or an inconsistent with the explanation.
- **Lack of physical care** – poor hygiene, dehydration, malnutrition and weight loss. Signs may be manifested as bed sores and comments about being mistreated.
- **Unusual behaviors** – changes in emotional state, such as agitation, withdrawal, fear, anxiety or reports of being mistreated.
- **Unaccounted for financial changes** – including missing money or valuables, unexplainable financial transactions, unpaid bills despite available funds, disconnected utilities or reports of being exploited.
- All staff members shall be legally responsible for reporting suspected abuse. However, the house supervisor shall coordinate members on the nursing unit.
- The physician will be notified by the CCO, Case Management or Social Worker.
- The Department of Family and Protective Services will be called and a written report initiated if requested. The number to call is **1-800-252-5400** 24 hours a day, 7 days a week.

  Abuse, neglect and exploitation is against the law and so is failure to report it. You are required to report it immediately !

When a case of abuse is called in the social worker will be notified Monday – Friday from 0800-1600 and follow up with the Department of Family and Protective Services.

- The case manager will act as the patient advocate in investigative complaints.

Types of Abuse Defined

- **Physical Abuse** is the act that involves physical force, such as hitting, shoving, shaking or any form of physical contact that is used with the intent of inflicting injury or causing pain.
- **Sexual Abuse** is any form of sexual contact that the elderly individual does not consent to or is not mentally competent to consent to. This can be an act of sexual intercourse, rape, inappropriate touching or pornographic photography
- **Emotional Abuse** is the use of harassment, insults, intimidation or threats that cause emotional or mental anguish or isolation.
- **Financial Abuse** is financial or material exploitation involving inappropriate use of an elderly person's resources for the benefit of another person without the consent of a competent elder. It may take the form of stealing, trickery or misuse of government checks.

Neglect Defined

- **Neglec**t occurs when a caregiver fails to provide the adequate level of care to avoid mental and physical harm. This would include food, water, shelter and personal hygiene.
- **Self – neglect** may occur when an elderly individual deprives themselves of medication, food, water or personal hygiene. This often occurs in elderly people with failing health, drug or alcohol abuse issues and depression.

Abuse and Neglect Policy

- An employee of, or any other person associated with Cornerstone Hospital of Austin, who believes or who knows of information that would reasonably cause a person to believe that Cornerstone Hospital, or an employee of, or healthcare professional associated with Cornerstone, has, is or will be engaged in conduct that is or might be illegal, unprofessional, or unethical shall as soon as possible, report the information supporting the belief to the Texas Department of Health and Human Services
- Employee to inform the administrator on call so they may contact the TDH
- This will trigger an immediate visit from the state.
- Any individual who in good faith reports under this policy shall be immune to civil liability actions in accordance with section 161.132 of Texas Senate Bill 210.

Abuse and Neglect Charting

- Observations of the patient upon admission and throughout hospital stay will be recorded in the nurses notes, as well as pertinent statements made by the patient of incident.
- Interactions between parents/guardian and patient, including length of visit.
- Times of physician and DHS notification and responses of the same.
- Visitors – their length of stay and relation to the patient.
- Results of all tests, x-rays called to physician as received by the charge nurse.

  Note: Any deaths occurring from suspected abuse/neglect shall be reportable to the medical examiner

Cornerstone Hospital of Austin

KEY HOSPITAL SAFETY
CODES
FIRE SAFETY
PARASLYDE/BARASLYDE

Cornerstone Hospital of Austin
CODES

- Dr. Leo – Medical Emergency
- Code Red – Fire Alert
- Code Gray – Severe Weather
- Code White – Disaster
- Code Orange – HAZMAT Spill
- Code Purple – Threatening Person or Workplace Violence
- Code Black – Bomb Threat
- Code Expo – Exposure (Bioterrorism)
- Code Down – Visitor Emergency

Code Purple
Threatening/Violent Visitor

Strategies to de-escalate threatening behavior:

- Project calmness, move and speak slowly, quietly and confidently
- Encourage the person to talk; listen closely and maintain a relaxed but attentive posture
- Position yourself at an angle to the person rather than directly in front
- Arrange yourself so your access to emergency exits is not blocked
- Acknowledge person's feelings
- Ask for small, specific favors such as asking the person to calm down, such as offering a drink of water (in a paper cup)
- Point out choices, break big problems into smaller ones
- Avoid sudden movements and maintain 3-6 foot distance
- Call 911 when it is safe to do so

Notification of Code Purple

How is staff notified of Code Purple (threatening or violent visitor):

- Code Purple announced overhead.
- Hospital administration will respond during normal business hours. House Supervisor will attempt de-escalation strategies if after-hours.
- Secure surroundings; ensure that staff and visitors are escorted from the immediate area.
- Call 911 if not successful.

Code Down
Visitor/Employee Emergency

- The goal of the Code Down is to improve and sustain outcomes by providing a means of intervention for a declining visitor or employee.
- Any staff member can overhead page a ‘Code Down’.
- Criteria that meets a ‘Code Down’:
  - Acute change in mental status/level of consciousness
  - Acute, significant bleed
  - Seizure
  - Suspected aspiration and/or airway obstruction
  - Chest pain
  - Anaphylactic shock (Call 911 immediately)
  - Apparent fracture
  - Fall with injury

Code Down
What To Do

- Visitor or employee can be transferred to treatment room on 1st floor (across from bathrooms) in main hospital entrance if it is determined there is no cervical or neck injury.
- No invasive testing.
- Monitor HR, RR, temperature, oxygen saturation, blood pressure. House Supervisor will act as team leader.
- Notify 911 emergency services and communicate assessment findings.

Fire Safety
Patients First

- In case of a fire:
  - R—Rescue patient from danger.
  - A—Alarm nearest manual pull station
  - C—Control fire. Close windows and doors.
  - E—Extinguish fire.
- To use a fire extinguisher:
  - P—Pull the pin.
  - A—Aim nozzle.
  - S—Squeeze the handle.
  - S—Sweep.

Fire Drill

Everyone must identify the location of the fire by looking at the Fire Panel (these are located at each nurses station and by the front door)

Nursing/Pharmacy/Lab/Radiology

- RN Supervisor to get patient census and needs.
- Close all doors and windows to patient rooms and standby for further instructions via overhead paging system.
- **Pharmacy to secure elevator on 2nd floor.**

Respiratory Staff

- Stand by nearest oxygen shut off stations.

Administrative Staff

- Secure all entrances to facility, elevators and stairwells
- Human Resources to secure first floor elevator.
- Business office to secure Medical Records entrance.
- Operator to page fire location, secure front door and direct fire department to fire.
- Operator/backup must answer phone for call from ADT and fire department.

Dietary Staff

- Secure Back entrance to facility.

Rehab Staff

- Report to Unit Secretary areas for further instruction.
- Secure 3rd floor elevator.

Materials Management

- Secure Physician Entrance to facility.

All staff must stand by for overhead page for additional directions.

Transporting a patient using Paraslyde/Baraslyde

- The patented ParaSlyde/BaraSlyde is an emergency sled for safely evacuating non-ambulatory residents or patients weighing up to 500 pounds (ParaSlyde) or 800 pounds (BaraSlyde) from any multi-floor building using the stairway. ParaSlyde/BaraSlyde is durable and designed to efficiently speed the evacuation while maintaining organized communication and control.

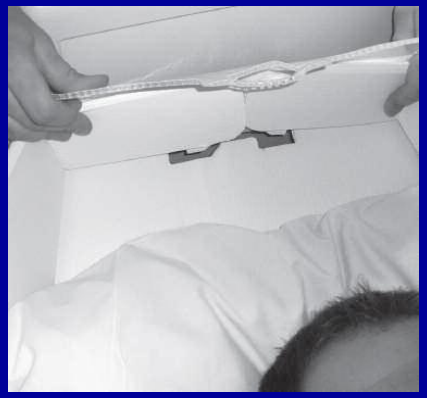
To transport a patient:

- 1. If the patient is currently in bed, place the bed in its lowest position, and lock the bed wheels, if applicable.
- 2. Wrap the bed sheets around the patient from both sides. Include pillows or blankets for the patient's head and feet.
- **Note:** Use items such as pillows, sheets or blankets to provide additional patient comfort.

1

2

3a

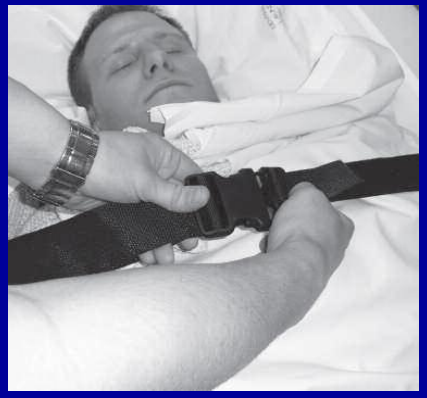


3. Unfold ParaSlyde/BaraSlyde as shown in Figure 1.
4. Log roll the patient onto their side.
5. Place ParaSlyde/BaraSlyde underneath the backside of the patient as shown in Figure 2.
6. Roll the patient onto ParaSlyde/BaraSlyde and place them in the middle of ParaSlyde/BaraSlyde.
7. Construct the head end and foot end as shown in Figure 3a and Figure 3b.
8. Fasten and tighten the safety straps.

WARNING

- The safety straps should be fastened diagonally, where possible, to prevent strangulation of shorter patients as shown in Figure 4a and Figure 4b.
- Always use all restraint straps to secure the patient to ParaSlyde/BaraSlyde. An unrestrained patient may fall from ParaSlyde/BaraSlyde and be injured.
- The patient must be secured on ParaSlyde/BaraSlyde before transferring ParaSlyde/BaraSlyde from the bed to the floor.

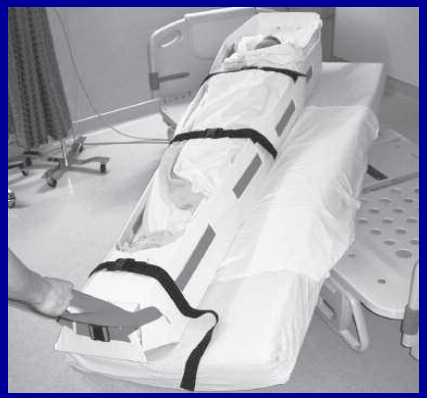
3b



4a

4b

5



6

7

TRANSFER PARASLYDE/BARASLYDE FROM THE BED TO THE FLOOR

9. Pull the foot end of the mattress to the floor to create a ramp as shown in Figure 5.
10. While keeping your back in a neutral, ergonomic upright position, slide ParaSlyde/BaraSlyde down the mattress to the floor.

Note: If the mattress is attached to the bed frame, use the device side handles to ease the patient to the floor by lowering the foot end first followed by the head end.

PULL PARASLYDE/BARASLYDE FROM THE PATIENT ROOM TO THE NEAREST EMERGENCY EXIT

11. Two operators may pull from the foot end by using the two handles as shown in Figure 6.
12. A belay system harness may also be used to pull the patient. Attach the belay system harness to the two handles on the foot end by using a carabineer as shown in Figure 7.

Descending the stairs using Paraslyde/Baraslyde

WARNING

- To reduce the risk of injury, transporting the patient on stairs requires a minimum of two operators.
- To reduce the risk of injury to the patient and/or operator, operators should never attempt to transport patient loads greater than what they can safely lift.

During post evacuation, make sure that the patient is stable on a level surface.

8

9

Two Person Descent

a. The foot end operator and the head end operator grasp both handles firmly as shown in Figure 8.

b. The foot end operator pulls ParaSlyde/BaraSlyde three quarters of the way off of the first stair as shown in Figure 9.

c. The head end operator leans back to support the patient's weight as shown in Figure 10.

d. Descend the stairs at a controlled speed. Stay toward the inside rail of the stairs to allow for an easier turn on the landing as shown in Figure 11a.

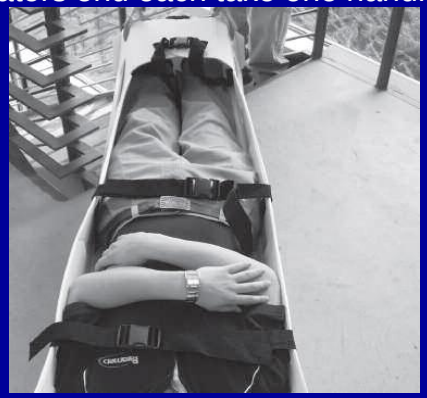
e. Begin turn once ParaSlyde/BaraSlyde is halfway on the landing. Reference the patient's hip as a pivot point as shown in Figure 11b. Repeat the process on the next set of stairs.

Three Person Descent

a. Similar to the two person descent, except that the two head end operators end each take one handle.

10

11a



11b

Cornerstone Hospital of Austin

REPORTING ADVERSE EVENTS

FALL REDUCTION AND PREVENTION

How to Report an Adverse Event

- When an incident/accident is discovered, the employee making the discovery is required to timely notify his/her immediate supervisor.
- Notification is made to the patient's attending physician, family or responsible party and to the Chief Executive Officer or Administrator on Call when the event is categorized as high risk and requires administrative action.
- The incident/accident report form is completed and routed to Director of Quality/Risk Management.
- The facility risk manager is responsible for directing the investigation and appropriate follow up of the incident. All actions will be reported timely to the Chief Executive Officer or designee.
- The facility risk manager is responsible for regularly reporting details collected and analyzed from the incident/accident reports to the Quality Improvement Committee and at least annually to the Medical Executive Committee and Governing Board.

Fall Risk Factors

- Poorly maintained or improperly used assistive devices
- Unfamiliar environment
- Performing unusual activities
- Slippery or wet floors, rugs, loose carpeting, cords and wires
- Surface irregularities, cluttered room
- Unstable furniture
- Poor and dim lighting
- Bathrooms; low toilets, absence of grab bars, lack of non-skid strips
- Poor fitting clothing
- Improper shoes
- Presence of tubes: IV lines, feeding tubes, catheters, etc.

Fall Risk Assessment

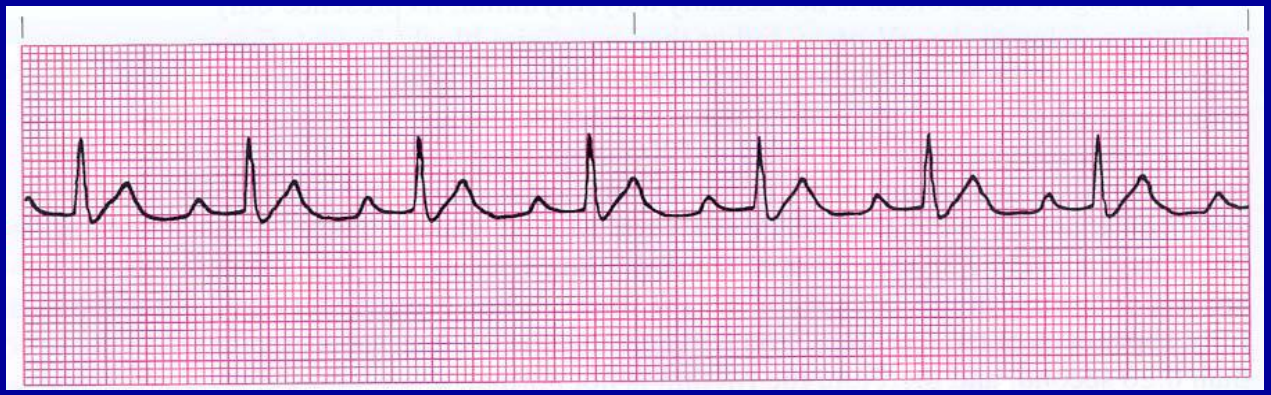
- Fall Risk Assessments are completed upon admission, after a fall, and weekly thereafter.
- After completion of the Fall Risk Assessment, the nurse will place the appropriate colored bracelet on the patient:
  - Yellow wristband - Fall Risk
  - White wristband - Independent, or signed release

Universal Fall Precautions

- Orient the patient to surrounding
- Ensures the patient wears eyeglasses, if applicable
- Ensure patient is wearing appropriate footwear
- Keep bed in low position
- Lock wheels on all wheelchairs, beds, commodes, and stretchers
- Clean up spills immediately
- Ensure adequate lighting at night
- Assure nurse call system, telephone, and personal items are accessible at all times
- Medication review by pharmacy
- Physical Therapy evaluation for safe ambulation and transfer techniques

When a patient falls

- Assess the patient for injury *before* moving
- Use a mechanical lift when possible, to get patients off the floor
- Notify MD of fall, and current assessment
- Document assessment, vital signs, and any other pertinent information
- Complete Patient Fall Incident Report
- Notify the patient's family
- Notify your House Supervisor



Cornerstone Hospital of Austin

ASSESSING AND MANAGING PAIN

RAPID RESPONSE

DR. LEO

Pain Management Concepts

- The patient is the authority on his/her own pain.
- An adequate pain management plan includes physiological, psychological and emotional responses.
- Changes in vital signs do not occur with all patients who are experiencing severe pain
- Patients with pain, even severe pain, can be distracted from thinking about their pain, and may even be able to sleep.
- The patient has the right to expect a rapid and effective response to a complaint of pain.
- Treat the pain, reassess frequently, and continue to treat until the patient is comfortable or side effects prevent further treatment.
- A history and physical examination of the pain is very helpful. Details of the pain's location, duration, radiation, and character often provide valuable clues about how to treat the pain most effectively
- Medications are best given orally for long-term management of pain. For short-term management, like post-op pain, the IV route is preferred.
- Most pain medications have side effects. Effective pain relief is often accompanied by at least some of these side effects. Be prepared to treat the side effects of opioids if they occur.
- A balanced approach to pain management combines nonpharmacologic and pharmacologic therapy, and frequently utilizes multiple analgesics which work by different mechanisms.
- Chronic pain patients are usually on a specific regimen of pharmacologic and nonpharmacologic therapy. This regimen must be continued during their hospitalization. Superimposed acute pain should be treated with additional opioids.

Pain Assessment and Documentation

- A health care professional should identify the presence of pain with every patient encounter.
  - Patients are to be assessed for pain every shift.
  - Patients are to be assessed for pain when it is identified.
  - Patients are to be assessed for pain every time a pain med is given. This assessment should be completed regardless of whether the med is scheduled or PRN.
  - Patients will be reassessed for pain after each intervention.

Changes in Condition

- Staff member worried or concerned about a patient
- Changes in heart rate less than 40 bpm or greater than 130 bpm
- Changes in SBP less than 90 mmHg or greater thant 170 mmHg
- Changes in respiratory rate less than 8 or greater than 28 bpm
- Acute and persistent changes in oxygen saturation less than 90%
- Changes in mental status/ level of consciousness
- Acute significant bleed
- Seizures
- Failure to respond to treatment
- Uncontrolled pain
- Suspected aspiration
- Chest pain- new or onset unrelieved with NTG

Rapid Response Team

- To establish rapid assessment of a patient with acute status changes.
- The goal of the RRT is to improve patient outcomes by providing rapid and timely interventions for a declining patient.
- The RRT consists of :
  - ACLS trained RN
  - ACLS trained Respiratory Therapist
  - The floor nurse caring for the patient
  - *Rapid Response Team assignments will be made each shift*
- Any staff member may call for the RRT when Rapid Assessment and Intervention is deemed necessary for a declining patient

RRT Roles

- The Floor Nurse is to remain at the patients bedside and assist with the RRT
- The Floor Nurse should provide:
  - What prompted the call?
  - Current VS, and FSBG
  - Code status, Allergies, pertinent medications and history
  - Recent labs, or diagnostic tests
- The Team Leader is the House Supervisor
- Team Leader Roles
  - Physician Communication
  - Obtaining Appropriate Orders
  - Initiation of Physician Orders
- The Respiratory Therapist performs a complete respiratory assessment and initiates interventions, as appropriate, per policy.

Rapid Response Documentation

- Complete the RRT Record
- The RRT record is to be filed in Chart under Nurses Notes
- A copy of RRT is forwarded to nursing supervisor and CCO.

Dr. Leo
Medical Emergency

PURPOSE:

- To provide complete advanced medical care in accordance with current American Heart Association guidelines for patients experiencing cardiopulmonary arrest or sudden death. Assignments made each shift.

Dr. Leo
Discovery of Patient

- “Shake and shout” - confirm unresponsiveness
- Recognize code status of patient; initiate Dr. Leo for patients with Category I and II.
- Activate the overhead paging system as follows: “Attention, Attention; Dr. Leo Floor # ___, Room # ___.” Repeat announcement a second time. Announcement should be made loudly, clearly, and distinctly.

First Responders:

- Those staff members who arrive first at the victim’s side shall initiate BLS according to the guidelines endorsed by the American Heart Association. Depending upon the situation, one or two man CPR will be performed by those staff certified to deliver such treatment.
- Upon arrival of the ACLS Dr. Leo Team, the BLS providers will turn over the direction of resuscitative efforts to the ACLS providers. The first responders will continue to act in any supportive roles needed.

Code Team
Roles and Responsibilities

- **Team Leader:** Maintains calm and orderly control of the Dr. Leo environment and team members, further delegating responsibilities as need arise. *Staff qualifications : Physicians'/ ACLS certified RN*
- **Compressor:** Performs chest compressions. Must verbalize fatigue and need to switch out in advance to allow for timely replacement.
- *Staff qualifications: BLS certification*
- **Airway Management:** Provide bag/valve/mask ventilation monitoring oxygen saturations and/ or CO2 detector following intubation by Physician or certified individual. *Staff qualifications: Respiratory Therapy Department/ ICU Nurse/ Physician*
- **Medication Nurse:** Ensures adequate IV access. Administers IV push or ET tube medications and titrates IV vasoactive drips as indicated by Physician or team leader. *Staff Qualifications: RN*
- **Recorder:** Documents all Dr. Leo activities. Times intervals between medication administrations. *Staff qualifications: Licensed Nurse*
- **Runner:** Obtains additional equipment and supplies as needed. Assists in notification of physicians and family as needed. *Staff Qualifications: Any Staff Member*
- **ICU Relief:** Fills in for the ICU nurse participating in Dr. Leo. *Staff Qualifications: ICU staff Nurse/ Charge Nurse*
- Personnel not assigned a specific task during the code, will ensure that the remaining patient care is adequately covered.

Dr. Leo Documentation

- After completion of the Dr. Leo, the record sheet shall be completed, documentation of the event shall be made in the patients chart, and the code evaluation report will completed. All paperwork, including rhythm strips, will be turned in to the charge nurse according to the code packet checklist.

PICC Lines

- PICC lines are a frequent medical device used at Cornerstone.

- ***Note:*** **Agency staff are not permitted to clear occlusions from PICC lines.**
- **Agency staff are not permitted to remove PICC lines.**
- If orders are received to perform these actions, notify the House Supervisor for completion of these orders.

PICC Lines- Blood Specimen Collection and Flushing

- Blood specimen collection from a PICC line is performed for all routinely collected blood samples
  - Procedure:
    - Wash hands, obtain blood collection tubes. Use Aseptic technique and observe Standard Precautions throughout the procedure.
    - Wipe port with alcohol for 15 seconds and allow to dry
    - Attach syringe and slowly aspirate until positive blood return to confirm patency. Withdraw at minimum 5 ml of blood (aspirate) as waste, and discard.
    - Using a second syringe, aspirate the amount of blood needed for sample collection.

PICC Lines- Blood Specimen Collection and Flushing (Continued)

- Attach pre-filled saline syringe and flush line with a pulsatile motion. PICC line flushing must be performed with at least a 10ml syringe, and use of the pulsatile flushing is necessary to assist in keeping the PICC line patent.
- After all lab draws, the PICC caps must be changed. This includes all lumens. ALL caps must be changed.

PICC and Midline Dressing Changes

- Initial dressing changes are performed 24 hours after a PICC or Midline is inserted. This dressing change is routinely performed by the PICC team.
- Scheduled dressing changes are performed weekly on Sunday, and anytime the dressing is non-intact, wet, soiled, or loose.
- PICC and Midline dressing changes may be performed by an RN or LVN with documented competencies.
- Dressing changes are to be performed with sterile technique, and the StatLock ® must also be changed with every dressing change, or if noted to be loose and non-adhesive. Failure to change a non-adhesive StatLock ® may result in line migration and complications.

PICC Line and Midline Dressing Changes (Continued)

- Central Line Dressing Change Procedure:
  - Perform Hand Hygiene
  - Gather Supplies: Central Line dressing change tray, Needleless Ports (Hubs), Stat Lock ®, Extra Mask for Patient
  - Explain procedure to patient, place mask on patient (if patient unable to tolerate mask, have patient turn head away from site)
  - Don gloves, and remove old dressing. Discard glove and dressing.
  - Open dressing change tray, and drop StatLock ® into sterile tray.
  - Put on mask, and sterile gloves from dressing change kit.
  - Inspect site for redness, drainage, pain and swelling.
  - Alcohol swab and unclamp old StatLock ® pad from catheter wings, opening one clamp at a time.
  - Using sterile technique cleanse area around catheter insertion site with Chloroprep ® with back and forth strokes for approximately 30 seconds. Allow the Chloroprep ® solution to air dry completely.
  - Apply new StatLock ®. Remember no to place any tape over catheter at or near the site. Tape placed over catheter may result in damage to catheter and possible catheter or air embolus.

PICC Line and Midline Dressing Changes (Continued)

- Apply Bio Patch at the insertion site. Cover the site with a transparent dressing. Do not apply ointment or gauze under the dressing.
- Change needleless valve on each catheter hub.
- Discard all waste in appropriate receptacles.
- Record date, time and initials on dressing label and adhere it to the outer aspect of the dressing.
- Perform hand hygiene.
- Document site appearance and dressing change on the nursing flow sheet, and PICC Line maintenance form.

Wound Care Protocols

- All wounds are assessed and have an individualized plan of care developed by the Wound Care Department. If a wound is found by the nursing or nursing support staff, a protocol is available to assist the nurse in providing appropriate treatment for the wound until the wound care team is able to assess the wound and develop the correct plan of care.
- The Wound Care Protocol is located in the central supply areas of all floors.

Clinical Report

- ***Huddles*** are staff meetings that occur at the beginning of each shift. These begin at 0645 and 1845 for both shifts. Assignments are given, and any announcements pertinent to the care of patients are given. This meeting lasts approximately 5 minutes and the staff are released to the floor to begin receiving report. These meetings occur in the 3rd floor conference room. Staff are required to be on time, and attend these meetings.
- All staff members are expected to give oncoming shift thorough and appropriate reports. This is necessary to ensure the care of our patient is maintained at a high level.

Clinical Documentation

- Chart Checks are to be performed every shift. The day shift performs a 12 hour chart check, and the night shift performs a 24 hour chart check. Chart checks are co-signed by the oncoming and off-going nurses. By signing the chart check, is stating that the orders from the last 12 hours or 24 hours have been reviewed and completed.
- Ensure all necessary documentation is completed prior to leaving the facility. This includes signatures where necessary.
- Critical Labs received during the shift must be documented with the critical lab sticker and placed in the progress note for the physician. Physicians must be notified of critical labs within 30 minutes, and documented on the critical lab sticker.

Clinical Communication

- All nursing and nursing support staff are required to use radios (walkie talkies) to ensure adequate communication between staff members. These are located at the nurses station on all floors.
- Customer Service is extremely important. When leaving a patient's room for any reason, it is expected that the staff will ask " Is there anything else I can help you with before I leave"? This empowers the patients to participate in their healing and allow them some control in uncontrollable situations.

No Pass Zone

- Cornerstone Hospital uses a *No Pass Zone* philosophy to care for our patients.
  - All Staff are required to STOP and respond to all call lights, phones, and patients requests. If the patients request are not within a staff members scope, notify the primary care team for the patient or the house supervisor.
  - If agency staff members are unsure how to use the phones or call lights, notify the house supervisor and education and training will be provided.

Staff Parking

- Staff are required to park on the street along the Hospital and park.
- The parking lot in the front of the Hospital is for visitor parking only.
- The parking lot in the back of the Hospital is for Physician and Administrative staff only.

Oh, No!! Please Don't Go!!!

What to do if your patient wants to leave

AMA

What Do I Do ?????

1. Notify Physician and House Supervisor
2. Talk to the patient about risks of leaving
3. Offer solutions or alternatives, especially if there is a complaint involved
4. If patient and family are insistent on leaving, they must sign the Leaving Against Medical Advice Form
5. If they refuse to sign the document, or you are unable to obtain a signature from them before they leave, the nurse must document this in the medical record.
6. The House Supervisor will review situation and report findings to the Administrator on call.
7. Cut off the patient armband if possible

Cornerstone HEALTHCARE GROUP			
TITLE			POLICY #
AMA DISCHARGE (AGAINST MEDICAL ADVICE)			**DP-09-003**
MANUAL	EFFECTIVE DATE	REVISE DATE	
Clinical Services- Discharge Planning	**08-01-2007**	~~**07-10-2009**~~ **02-25-2010**	
SCOPE:	REFERENCE		
Organization – Wide			

PURPOSE:
To provide guidelines when a patient leaves against medical advice. (AMA).

GUIDELINES

Once the patient expresses the desire to leave AMA, the nurse shall:

1. Notify the Physician promptly, giving him/her the opportunity to inform the patient of the benefits/risks that may be involved in his leaving.

2. Advise the patient or responsible other to seek medical attention elsewhere if choosing to leave against medical advice.

3. Complete and have the patient or responsible other sign the *Release from Responsibility for Discharge* form

4. Attach form to patient chart to become a part of the medical record.

5. In the event that the patient/responsible other refuses to sign the form, this fact shall be documented on the chart.

6. Charge nurse will review situation or contributing factors or problems and will report findings to the Administrator on Call and/or the CNO.