Cornerstone
HEALTHCARE GROUP

Agency Staff Orientation Packet 2015

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WELCOME TO CORNERSTONE HOSPITAL SEAZ

The information in this booklet is designed to help orient you to the policies and procedures that apply to the nursing units at Cornerstone Hospital. However, standards for specialty areas vary. Please consult the clinical educator or House Supervisor for questions or clarification.

Nurses at Cornerstone maintain primary responsibly for the care of our patients and are expected to comply with Cornerstone's standards of care, policies and procedures.

SECURITY AND ID BADGES

All agency nurses and must wear photo IDs, provided by their Agency, at all times while on Cornerstone premises.

PARKING

Agency staff may park in the west lot. Use the door marked "Employee Entrance" located by the loading dock and generator. If you arrive before 0600 or after 2000 you must use the front entrance and call the House Supervisor using the phone located on the wall.

TIME SHEET

It is the Agency Staff's responsibility to provide a time sheet. It is your responsibility to enter the times you arrive and leave on your sheet. The House Supervisor will sign your Timesheet on a daily basis.

IMPORTANT PHONE NUMBERS

- Central Staffing Office (staffing issues) 520-901-5503
- Hospital Operator 520-901-5500
- After hours issues 520-901-5520

MISSION, VISION, VALUES, & PHILOSOPHY

Mission

Our mission declares our purpose as a company.

To advance and nurture healing, provide hope to patients and families, and make a difference in the lives of those we serve.

Vision

Our vision describes what we aspire to accomplish as an organization.

To be the leading provider of complex acute and post-acute healthcare in our communities by delivering superior, cost-effective patient care at the right time, in the most appropriate setting. We WOW patients and their families with our quality of care and responsive service. We attract the best physicians who desire to affiliate with the market leader. We engage employees to create a high-performance culture and extraordinary, rewarding careers.

Values

Our values define the attitudes and behaviors that will be required to make our Vision a reality.

Passion

We are passionate about delivering superior patient care.
We share a desire to make a meaningful difference in the lives of our patients.
We strive to make every personal interaction a positive experience.

Purpose

We perform our job with a sense of purpose and pride, according to clear priorities.
We act with a sense of urgency to accomplish our immediate priorities.
We are resourceful and persevere to achieve goals.

Operational Excellence

We continuously strive for improved performance.
We constructively challenge the status quo to achieve performance excellence.
We are flexible, adaptable and embrace change as a key element of our future success.

Teamwork

We work as a team, each of us taking personal accountability, to deliver superior results.
We believe that teamwork and collaboration leads to improved outcomes.
We assume personal responsibility for addressing issues with a positive, “can do” attitude.

Respect

We treat each other with respect to promote and sustain a trusting culture.
We treat others as they wish to be treated, with courtesy, politeness and kindness.
We engage in a beneficial, positive dialog to achieve desired outcomes.

Integrity

We are candid, truthful and ethical in our words and actions.
We tactfully communicate in an open, honest and direct manner.
We always perform our jobs in a responsible and conscientious manner.

JOB DESCRIPTION & EXPECTATIONS

POSITION OBJECTIVE
Contributes to the provision of high-quality, cost-effective health care as a provider of direct and indirect patient care and by effective collaboration with other members of the health care team. Functions as a competent member of the health care team.

Within the scope of this job the individual will be exposed to blood-borne pathogens and hazardous materials. The individual will be required to utilize personal protective equipment in accordance with universal precautions.

KNOWLEDGE/EXPERIENCE
Current licensure as a registered nurse or licensed practical nurse by the Arizona Board of Nursing or Compact Licensure.

WORKING CONDITIONS/PHYSICAL REQUIREMENTS
Medium work: Exerting up to 50 pounds of force occasionally, and/or up to 20 pounds of force frequently, and/or up to 20 pounds of force constantly to move objects. The above is intended to describe the general content of and requirements for the performance of this job. It is not to be construed as an exhaustive statement of duties, responsibilities or requirements.

ENVIRONMENT OF CARE / SAFETY MANAGEMENT

Overhead page phone is 8888 on any phone
All emergency codes are to be announced overhead
State the type of code and location three (3) times
During emergency codes please restrict phone use to emergent information only

FIRE OR SMOKE IN YOUR AREA (CODE RED)

1. Locate the fire extinguishers and red fire alarm pull boxes on your unit. In case of fire or smoke in your area, do not shout “FIRE!” stay calm.
2. **R.A.C.E.:**

a. **RESCUE** - Get everyone away from immediate danger.

b. **ALARM** - Activate the alarm by pulling lever on nearest red alarm box. Or using nearest phone: Dial 8888 and page three times CODE RED

c. **CONFINE** - Close doors and windows to keep fire and smoke from spreading.

d. **EXTINGUISH** - Attempt to extinguish the fire if it’s small and confined.

3. Use the fire extinguisher properly (**PASS).**

a.a. **PULL** the pin.

a.b. **AIM** the extinguisher low, point the nozzle at the base of the fire.

a.c. **SQUEEZE** handle to release extinguishing agent.

a.d. **SWEEP** back and forth as you walk backward away from the area.

ELECTRICAL EQUIPMENT SAFETY

1. Check connections and cords for the following:
   a. Be alert for damaged cords, plugs, and outlets.
   b. Avoid using extension cords.
   c. Keep cords out of the way of traffic.
2. Use Equipment Safety:
   a. Read and follow all instructions posted on equipment.
   b. Don't put anything wet on electrical equipment.
   c. Turn equipment off before unplugging.
   d. Always unplug by pulling the plug, not the cord.
   e. Don't use any equipment that sparks or gives the slightest shock.
   f. Never try to repair equipment - contact Biomedical or Engineering.
3. Electrical equipment brought in by patients, i.e. hair dryers, razors, etc.
   a. Any equipment brought in from home by patients must be assessed by the Engineering department for safety prior to patient using item.

SAFETY DATA SHEETS (SDS)

1.MSDS sheets describe the hazards of the chemicals that an employee uses on the job.

2.If a MSDS sheet is required, ask a House Supervisor for the copy of the MSDS you want.

3. If more information is needed, check with Safety Officer.

HAZARDOUS MATERIAL/SPILL RESPONSE PLAN

1. Call Code Orange by overhead page, repeat page 3 times if:

a. you are unfamiliar with clean-up procedure.
b. spilled material is listed on the Hazardous Materials and Waste Management Plan and Policies located on SharePoint.
c. chemical spill is over one gallon.
d. chemical is highly toxic/volatile.

2. Spills are contained by using the "Think **C.L.E.A.N**. Plan"

a. **C**ontain the spill.
b. **L**eave the area.
c. **E**mergency: eye wash, shower, medical care.
d. **A**ccess spill procedure.
e. **N**otify Housekeeping via overhead page.

3.Chemical Spills - All chemical spills are contained according to OSHA guidelines

following procedures as outlined on the MSDS sheet.

4. Biohazard Spills

a. Use personal protective clothing and equipment.
b. Contain spill and prevent splashes by covering with paper towel or chux.
c. Pour generous amounts of disinfectant onto the contaminated surface.
d. Allow disinfectant to sit on spill for at least 10 minutes.
e. Broken glassware should be removed carefully with disinfectant soaked gauze and placed into an impervious sharps container.
f. Carefully wipe up and dispose of contaminated material into marked Biohazard waste container. Rinse area with soap and water. Dry with mop or paper towel.

BOMB THREAT

When a call is received in a work area, have a co-worker notify the following center that a bomb threat is in progress:

1. Page [redacted] 3 times overhead.
2. Call 911.

Get as much information about the caller as possible.

a. Time bomb is set to explode.
b. Where located.
c. What kind of bomb.
d. Why is he/she doing this?

Note the following details: sex, accent, speech impediment, age, background noises, and unusual phrases.

INTERNAL DISASTER EVACUATION PLAN (CODE TRIAGE INTERNAL)

1. Internal disaster within the building
2. All healthcare staff are to respond immediately to the announced location
3. Precautions should be announced or taken based on the nature of the disaster
4. Additional assistance may be needed from outside resources.

EXTERNAL DISASTER PLAN (CODE TRIAGE EXTERNAL)

To respond to mass casualties as a result of any manmade or natural disaster in the community that will exceed the normal capacities of the facility. The plan is intended to provide emergency medical services with a minimum amount of interruption to the routing patient services of the medical center. Upon hearing “Disaster Plan now in effect” over the overhead paging system:

1. External disaster for the city, county or state
2. Designed to accept limited number of patients for observation or treatment
3. Limit phone use to emergency calls only

4. All staff are expected to perform their assigned duties until relieved

SMOKING POLICY

It is the intent of Cornerstone to provide a safe, healthy environment for patients, visitors, employees, volunteers and medical staff. The designated smoking area is located outside and just north of the Employee Entrance. Please note E-cigarettes are not allowed to be "smoked" inside the building at any time.

CORNERSTONE HOSPITAL EMERGENCY OPERATIONS PLAN Can be found on SharePoint>>Shared Documents>>Emergency Management Plans and Policy.

PATIENT SAFETY

TITLE		POLICY #
Patient Identification		
MANUAL	EFFECTIVE DATE	REVISE DATE
Nursing	**9/2004**	**January 2010, May 2013**
SCOPE:	REFERENCE	
Tucson, Arizona		

PURPOSE:

- To reduce the risk of medical error by correctly identifying patients.
- To comply with TJC National Patient Safety Goal.

POLICY

Two unique approved patient identifiers (neither to be the patient's room number) will be used to identify the patient prior to any high-risk patient care activity. This includes:

- When drawing blood or collecting specimens
- When administering medications
- When administering blood
- Prior to any test, procedure or treatment
- When taking verbal reports (critical values) or placing hard copy reports in records

The patient/representative is educated that the facility uses two identifiers for patient safety.

APPROVED PATIENT IDENTIFIERS

The following identifiers are acceptable for patient identification:

- Patient name (interactive process preferred if the patient is competent to participate in the identification process before drawing blood, collecting specimens, administering medications, blood and prior to any procedure or treatment)
- Patients medical record number

Identifiers will also be checked on the patient's identification bracelet.

Missing identification bracelets shall be replaced immediately, again using the two-identifier system.

Additional identifiers may become necessary to correctly and safely identify the patient, depending on the patient care activity. Examples of these identifiers include:

- Date of Birth

- Social Security Number

PROHIBITED PATIENT IDENTIFIERS:

Use of the following as a unique patient identifier is prohibited at Cornerstone Hospital of Southeast Arizona:

- Patient Room Number

Physician Orders

PURPOSE:

To clearly communicate and safely deliver medical care to a patient as ordered by a physician.
The purpose is to provide an accurate and current medical plan and record.

PROTOCOL:
All orders for patient care are written or pre-printed on the "Physician's Order Sheet."
Use of prohibited abbreviations in clinical documentation and in preprinted forms is prohibited.

All orders are to be transcribed in the orders medication administration record (MAR), and treatment record.

Typed orders (standardized orders), if used, must be individualized for the patient and signed by the physician before they are carried out.

Telephone Orders: These orders will be accepted only by licensed personnel.

Telephone orders must be read back to the ordering physician for validation and clarification of the orders.

Every effort will be made to have all orders written by the physician.

Physician must countersign orders as soon as possible.

To note a physician order you must sign, date, time and write "NOTED" on the order sheet.

PROCEDURE:

Transcription of Orders

The order is signed off and entered and a copy is made to give to licensed staff member treatment record by the charge nurse. It is to be countersigned and acknowledged on the Physician's order sheet by a Registered Nurse or Licensed Vocational Nurse. Each must note the date, time, and title after their full signature as well as writing the word "NOTED".

Telephone orders are written in black ink on the "Physician's Order Sheet". The order must state if it was a verbal or telephone order.

Example: Haldol 5 mg. IM now telephone order by Dr. John Jones / Sally Smith, R.N.

All telephone orders will have documented "read back" after they are recorded by the licensed staff receiving them to confirm accuracy of the order. This will be documented in the record.

Copies of orders are to be sent to the appropriate departments, i.e. med orders to pharmacy, nutrition orders to dietary, etc. Copies may be placed in departmental boxes, located at each nurse's station or faxed.

Clarification of Orders

When an abbreviation or a question of clarity, illegibility or appropriateness exists, the nurse

will verify the order with the appropriate physician. An order is considered illegible if it cannot be read by two nurses.

When acknowledging a written order in the physician's order sheet, the nurse must review the original order for accuracy.

General Information
Chart checks are to be performed every 3 hours.
If new orders are written the chart will be placed in the rack designated for this purpose. The chart wheel will indicate the priority of the order. Green indicates new Nursing order, Yellow indicates other orders, Red indicates STAT order.

PHARMACY POLICIES

Cornerstone HEALTHCARE GROUP

TITLE		POLICY #
Medication reconciliation Across the Continuum of Care		**PH-201**
MANUAL	**EFFECTIVE DATE**	**REVISE DATE**
Pharmacy	**08/01/05**	**10/06/06; 04/25/07; 03/07/08; 06/22/09; 08/01/12**
SCOPE:	**REFERENCE**	
Pharmacy, Clinical	**JCAHO NPSG and MM**	

POLICY:

It is the policy of Cornerstone Hospital to reconcile medications for every patient accurately and completely upon admission and across the continuum of care.

PROCEDURE:

1. When a patient is approved for admission, the admitting nurse from information from the previous facility will generate a Medication Reconciliation and Physician Order Form. The information recorded on this form may come from the patient, family members, the patient's medication containers, previous medical records, the patient's pharmacy or the patient's physician. The recording nurse will date and sign the form at the top in the spaces provided

2. The form will be filled out entirely to include the patient allergies, type of reaction, complete medication list, and source of the list.

3. The medication list shall include prescription medications, over-the-counter medications, and herbals including appropriate medication name, the dose, the route, the frequency, and the time taken. Space may be utilized on the second page if necessary and the box "Continued on second page if checked" will be marked.

4. Upon admission, Nursing will verify completion or receipt of the Medication Reconciliation and Physician Order Form. The nurse verifying the Medication Reconciliation and Physician Order Form will immediately clarify questions relating to the patient's medications against the Medication Administration Record (MAR).

5. Nursing and the admitting physician will review the Medication Reconciliation and Physician Order Form. The physician will indicate which medications are to be continued and discontinued, or changed on the Medication Reconciliation and Physician Order Form by circling "C" for continue, "DC" for discontinue, or "CH" for change according to the physician's decision for each medication. Changes will be written immediately to the right of the listed medication in the space provided.

6. A copy (both pages if applicable) of the completed and signed form will be sent to Pharmacy to process and review and the original form shall be placed in the chart.

7. Once processed, any orders will be written on a Physician Order form as a new order or a clarification. The Pharmacist will enter the medication onto the patient's profile if "C" is circled, take no action if "DC" is circled, and enter the changes by the physician into the patient's profile as written.

8. The Physician will sign in the "Physician Signature for Review Only" or "Physician Signature for Ordering" area.

9. The admitting Physician will write additional admissions orders separately on a Physician Order Form based on his or her review of the Medication Reconciliation and Physician Order Form, the previous MAR, if applicable, previous medical records, and the patient's current medical condition.

10. A Nurse will compare the Physician's admission orders with the Medication Reconciliation and Physician Order Form and will immediately clarify discrepancies with the Physician. The Nurse will then sign in the Noted By: area.

11. If the patient is transferred to another department within the same facility, previous medication orders will be reviewed alongside new orders and plans for care. Any discrepancies will be immediately reconciled with the Physician.

12. When the patient is discharged from the facility, the discharge nurse will reconcile the Medication Reconciliation and Physician Order Form, the patient's current MAR and the physician's discharge orders. Any discrepancies will be fully reconciled with the Physician prior to discharge.

13. Case Management or Nursing will communicate complete list of the patient's medications to the patient's next provider of services and document this communication in the chart.

14. The Medication Reconciliation and Physician Order Form will remain as a permanent part of the chart, will be filed in front of the Physician Order section of the chart, and will not be thinned.

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Title		Policy #
Medication Errors: Preventative Measures		**PH-149**
Manual	**Effective Date**	**Revise Date**
Clinical Services, Nursing, Pharmacy	**1/7/92**	**06/02/94, 04/14/03, 11/20/10**
Scope:	**Reference**	
Organization - Wide		

POLICY:
In order to reduce the number of errors committed by nursing and Pharmacy, the following preventative measures will be followed.

PURPOSE:
To outline the procedures for prevention of medication errors.

PROCEDURE:
1. Personnel Who Administer Drugs:
   a. Oral orders are put in writing promptly in the patient's medical record and authenticated by the prescriber.

b. Orders are communicated promptly to the pharmacy.
c. Double-checking the accuracy of orders transcribed onto MARs by comparing transcriptions with original orders.
d. Check the label and appearance of the produce provided by the pharmacy and contact the pharmacy if there are obvious discrepancies.
e. Clarify ambiguous drug orders or questionable administration with the prescriber before administrating the drug. Document the clarification and all changes made in the order.
f. Question all orders that call for an unusual number of dosage units (e.g., more than two tablets or more than one ampule or vial).
g. Consult drug information and drug administration references as needed.
h. Contact the pharmacy when drugs are unavailable for administration. The order may have been discontinued and the discontinuation not noted on nursing records. In addition, borrowing from other patients may result in omitted doses for those patients.
i. Prepare drugs for administration in an area that is free from distractions and interruptions.
j. Prepare doses for one patient at a time.
k. Check mathematical calculations (e.g., dosage and flow rates) with another qualified individual (e.g., a pharmacist or a nurse).
l. Ensure that the patient is identified accurately (e.g., by checking the patient's wristband) immediately prior to drug administration.
m. Double-check the name of the drug and strength on the label with the drug and dose prescribed.
n. Check the drug and drug order if the patient questions the administration of the drug. This reduces the likelihood of administering a wrong drug or administering a duplicate dose of a drug.
o. Use the proper administration equipment (e.g., controlled-infusion device) and technique.
p. Use standardized administration rate charts to determine the IV flow rate of solutions of critical-care drugs dosed in mcg/kg/min (e.g., dobutamine).
q. Observe the patient after administering oral drugs to ensure that he or she swallows the drugs.
r. Record the administration of drugs soon after their administration. Prompt recording leads to complete and accurate documentation and reduces the likelihood of omitted doses and administering duplicate doses.
s. Return all discontinued drugs and unneeded drugs to the pharmacy promptly.
t. Continuously review the system for ordering, dispensing, and administering drugs to identify ways to improve the system and thus reduce the potential for medication errors.
u. Participate in improving the drug distribution system (e.g., by improving policies and procedures, standardization, and education).

2. Personnel Who Dispense Drugs:

a. A unit-dose distribution system may be the single most effective measure for preventing medication errors. A unit-dose system permits identification of the drug up to the point of administration.
b. Use unit-dose packaging to the extent possible (even when the distribution system is not fully unit dose).
c. Ensure that personnel are familiar with policies and procedures and understand the importance of following them.
d. Enforce the policy that a pharmacist reviews the original order (or a direct copy) and the

patient's drug profile prior to dispensing the first dose of a drug.

e. Review orders carefully. Clarify ambiguous and incomplete orders and inappropriate dosages with the prescriber prior to dispensing.
f. Compare orders with patient information on pharmacy patient profiles for duplicate therapy, drug interactions, and allergies.
g. Question all orders that call for an unusual number of dosage units (e.g., more than two tablets or more than one ampule or vial).
h. Ensure correct transcription of orders in the pharmacy.
i. Minimize the use of abbreviations in patient profiles and use only standard abbreviations approved for use in the institution.
j. Keep pharmacy patient profiles current and accurate.
k. Reconcile pharmacy patient profiles with MARs regularly.
l. Require a double-check on all calculations (especially pediatric dosage calculations). Incorrect calculations may result in significant under dosing or serious overdosing of patients.
m. Use of standardized concentrations of drugs to minimize the need for calculations and necessity to compound drugs.
n. Triple-check labels on drug containers (i.e., when removing from shelf, before dispensing, and when returning to the shelf).
o. Prepare one order at a time.
p. Compound drugs carefully and correctly. The compounding process must ensure that:
    1. All entries in compounding records are correct.
    2. Products (drugs, excipients, etc.) used are as ordered.
    3. Amounts used are correct.
    4. Compounding equipment is used correctly.
    5. In process checks (e.g., inspection of products and checks of calculations) are performed.
q. Label drugs clearly and accurately. All drugs must be labeled with a minimum of:
    1. Drug name and strength.
    2. Patient name, if applicable.
    3. Expiration date (and time if applicable).
    4. Lot number and manufacturer (if applicable).
    5. Ancillary precaution labels that will decrease the risk of drug administration errors (e.g., "For the Ear" and "Not or Injection").
r. Dispense pass prescriptions in containers that meet the requirements of the Poison Prevention Packaging Act of 1970. Label these prescriptions in accordance with State Board of Pharmacy and Federal regulations.
s. Ensure that technicians have their work checked by a pharmacist.
t. Arrange drugs in an orderly fashion in patient's unit-dose cassette drawers to minimize errors in retrieving drugs for administration.
u. Deliver filled orders to the patient-care area promptly (to reduce haste in preparing drugs for administration and lessen the likelihood of omitted doses).
v. Organizing drug storage and work areas to minimize the potential for dispensing errors (i.e., keep them uncluttered and free from distractions and interruptions).
w. Provide floor stock and night stock and ensure that an on-call pharmacist is available to provide drugs that cannot be obtained from floor stock and night stock.
x. Limit floor stock and night stock to emergency and essential drugs.
y. Do not store drugs with similar names or containers with similar labels together (to minimize the chance of choosing the wrong drug).

z. Arrange floor stock to minimize error in retrieving drugs (e.g., by storing ampules and vials of drugs intended for irrigation and respiratory therapy separately from ampules and vials for parenteral use, and by storing drugs and products intended for external use separately from injectables and drugs intended for internal use).
aa. Store dangerous drugs in an isolated area or segregate then from other drugs.
ab. Avoid stocking particularly dangerous drugs and unsafe concentrations of drugs that can be lethal if given undiluted (e.g., potassium chloride concentrate).
ac. Provide cautionary warnings for drugs with a narrow margin of safety (e.g., concentrated lidocaine solutions).
ad. Inspect floor stock areas regularly to ensure that drugs are labeled properly and stored to minimize the likelihood of a medication error. Deteriorated, expired, and otherwise unusable drugs must be removed immediately.
ae. Provide drug information references (including standard dosage charts and standard flow rate charts) to personnel who dispense and administer drugs.
af. Participate in aspects of the institution's quality program that aim at detecting and preventing medication errors.
ag. Continuously review the system for ordering, dispensing, and administering drugs to identify ways to improve the system and thus reduce the potential for medication errors.
ah. Participate in improving the drug distribution system (e.g., by improving policies and procedures, standardization, and education).
ai.

Cornerstone HEALTHCARE GROUP

TITLE		POLICY #
Unacceptable Abbreviations and Dose Expressions		**PH-146**
MANUAL	**EFFECTIVE DATE**	**REVISE DATE**
Clinical Services, Nursing, Pharmacy	**7/01/12**	**08/12**
SCOPE:	**REFERENCE**	
Organization - Wide	TJC IM.02.02.01	

POLICY:

All entries written or printed in a patient chart shall comply with standardized abbreviations, acronyms and symbols.

PURPOSE:

To assure that all medication orders have "the degree of accuracy, completeness, and discrimination necessary for their intended use",

PROCEDURE:

A. A list of unacceptable abbreviations will be posted in all nursing units and physician dictation areas.

B. Medical staff will be presented with any changes to the listing below for approval.

C. If an unacceptable abbreviation is used, the order will be verified with the prescriber prior to its being filled.

D. Use of unacceptable abbreviations by staff or physicians will be reported to the Director of Quality. Education will be provided regarding the list of unacceptable abbreviations, avoiding miscommunications, and the prevention medication or provision of care errors.

E. **Unacceptable Abbreviations (per The Joint Commission IM.02.02.01):**

1. U,u
2. IU
3. QD, Q.D., qd, q.d.
4. Q.O.D., QOD, q.o.d., qod
5. Trailing Zero (X.0mg)
6. Lack of Leading Zero (.Xmg)
7. MS
8. MSO4
9. MgSO4

Cornerstone HEALTHCARE GROUP

TITLE		POLICY #
Medication Administration		**PH-201A**
MANUAL	**EFFECTIVE DATE**	**REVISE DATE**
Pharmacy	**01/01/05**	**01/01/10; 08/01/12**
SCOPE:	**REFERENCE**	
Cornerstone SEAZ	**Institute for Safe Medication Practices (ISMP)**	

PURPOSE:

To establish consistent times for those medications prescribed on a scheduled frequency. The goal is to achieve and maintain therapeutic blood levels over a period of time.

Appropriate medication administration times will take into account the nature and types of medications, the clinical situations in which they are administered; and the needs of the patients receiving them.

PROCEDURE:

All repetitive drug doses will be given using established scheduled times, unless otherwise prescribed by the physician or unless otherwise contraindicated by incompatibilities with nutrients or other medications. One time dose, now or stat doses or prn doses will not follow the standard administration times.

A. Time-critical scheduled medications are those designated in Table B
    1. Meds in this category will be given no sooner than 30 minutes before or 30 minutes after the scheduled time due to potential negative impact on the therapeutic effect. The total administration time window is one hour.
    2. The nurse will strike through the time on the MAR and write the exact time the med was administered.
        a. If medication is not administered at the designated time the variance must be documented and the physician notified, if clinically indicated.

B. Non-time-critical scheduled medications are prescribed more frequently than daily, but less frequently than every four hours.
    1. Meds in this category will be administered within one hour before or one hour after the scheduled administration time. The administration window will not exceed a total of two hours
    2. Examples include: antihypertensive medications, probiotics, topical creams or ointments and diuretics.

C. Non-time-critical scheduled medications are given as daily, weekly, or monthly.
    1. Meds in this category will be administered within two hours before or two hours after the scheduled time for a total window will not exceed four hours.
    2. Examples include: multivitamins, laxatives and erythropoietin stimulating agents.

Table A

Medication Administration Times Schedule

QAM	0900	TID w/meals	0800, 1200, 1700
Q daily	0900	Q12H	0900, 2100
BID	0900, 2100	Q8H	0600, 100, 2200
TID	0900, 1500, 2100	Q6H	0600, 1200, 1800, 2400
QID	0900, 1300, 1700, 2100	Q4H	0100, 0500, 0900, 1300, 1700, 2100
AC	0730, 1130, 1630	Q3H	0300, 0600, 0900, 1200, 1500, 1800, 2100, 2400
HS	2200	Q2H	0600,0800, 1000, 1200, 1400, 1600, 1800, 2000, 2200, 2400, 0200, 0400

PC	0900, 1300, 1800		

Table B

Critical Timed Medication *

Medication/Therapeutic Class	Administration Times	Examples
Medications which should be administered with food.	TID w/meals OR with nutritional supplements (See PH-159A for a more complete list of these medications) or daily w/breakfast, etc.	Posaconazole, aspirin, carvedilol, amiodarone, allopurinol, etc.
Medications which should be administered on an empty stomach.	30 minutes before breakfast, BID ac, etc. (see PH-159A for a more complete list of these medications)	Pantoprazole, alendronate, levothyroxine, loratadine, etc.
Scheduled pain meds	Schedule based on physician order	Oxycontin, morphine SR, tramadol, etc.
Scheduled medications given Q4hr or more often	See scheduled medication administration times in Table A	Inhaled treatments (e.g. acetylcysteine, albuterol, etc.),Ciprofloxacin eye drops, etc.
Intravenous antibiotics	Scheduled based on time of first dose administered and concurrent use of other IV medications/fluids	Penicillin, ceftazidime, daptomycin, vancomycin, etc.
Insulins	Time based in physician order but may include TID w/meals, Q12 hours, sliding scale, etc. If ordered with meals the med must be given at time of meal.	Novolog, Novolin, Lantus, etc.
Anticoagulants	Daily, Q8 hours, BID	Wafarin, heparin, fragmin, etc
Immunosuppressants	Daily, BID, TID w/meals, etc.	Mycophenolate, tacrolimus, cyclosporine, prednisone, etc.
Anticonvulsants	Daily, BID, TID, etc.	Felbamate, gabapentin, divalproex, phenytoin. Levetiracetam, clonazepam, etc.

**Critical Time Medications based on recommendations from ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications.* 2011.

Parenteral Nutrition AKA, Total Parental Nutrition (TPN), will be hung at 1800. Although these medications may be considered by some to be a daily administration, due to the lengthy time of administration, 12 to 24 hours, parenteral nutrition will be considered a critical medication.

A "NOW" dose means the patient will receive the dose as soon as it is readily available, but not necessarily immediately. The nurse should administer the medication as soon as it becomes available.

A "STAT" dose means the pharmacy will prepare and label the drug immediately, and the patient will receive the dose immediately upon receipt from the pharmacy.

RESTRAINTS

Cornerstone HEALTHCARE GROUP

TITLE		POLICY #
Behavioral Management Restraints		**CL-6.2**
MANUAL	EFFECTIVE DATE	REVISE DATE
Clinical Services; Administrative	**09/02/2013**	**10/01, 01/11, 8/12, 12/12, 09/02/2013, 2/14**
SCOPE:	REFERENCE	
Organization - Wide	**CMS, TJC** See end of Policy****	

PURPOSE:

To delineate the responsibilities of and procedural steps to be followed by clinical and medical staff in the use of restraints and alternatives to restraints as an integral component of patient care in behavior management situations.

POLICY:

Cornerstone Healthcare Group Hospital's restraint program shall comply with the requirements set forth by the Joint Commission (TJC) and the Center for Medicare and Medicaid Services (CMS). State laws that are more restrictive will override this policy. Cornerstone Healthcare Group Hospital Leadership will support limited and justified use of restraints through its Performance Improvement Program and through ensuring staff competency.

Seclusion will not be used at Cornerstone Healthcare Group Hospitals

An appropriately trained RN may initiate use of restraints in the case of an emergency wherein:

a. An acute change in a patient's mental status that results in unexplained, unanticipated and non-redirectable agitation, confusion, or aggressive behavior injurious to the patient or caregivers, and less restrictive measures have proven ineffective.
b. The emergency is of such intensity that there is not sufficient time to telephone the attending physician or LIP. The order must be obtained during the emergency application or immediately (within minutes) after the restraint is applied.

1. Restraints shall not be written or entered as a standing or PRN order. A restraint ordered for behavioral management is time limited to four (4) hours.
2. The attending physician must be consulted as soon as possible if the restraint was ordered by another LIP.
3. Within one (1) hour of initiation of use of restraints for the purpose of behavior management, the LIP will assess the patient face-to-face, even if the patient's behavior subsides, and the need for restraints is no longer evident. The evaluation includes the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition that warranted the use of restraints, and the need to continue or terminate the restraints. This information should be documented in the medical record.
4. After the original order expires, the LIP must see the patient and assess before issuing a new order.
5. Restraint use must be in accordance with a written modification to the patient's plan of care, in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques and only when less restrictive measures have been found to be ineffective.
6. The patient's condition must be continually monitored, assessed and reevaluated in an effort to end the restraint as soon as is safely possible.
7. The RN shall collaborate with the attending physician to develop a plan of care required to meet the patient's needs until discharge to a more appropriate level of care can be arranged.

NOTE: All reports, including the above, of any unexpected events while a patient is in restraint, shall be reported immediately to the Director of Quality Management (or their designee).

DEFINITIONS OF RESTRAINTS:

A. There are two major categories of restraints:
   1. A **physical restraint** is any manual method, or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, and that restricts freedom of movement or normal access to one's body.
   2. A **chemical restraint** is a drug used as a restriction to manage or restrict the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

B. **NOTE:** The following are not considered as restraints:
   1. A **voluntary mechanical support** used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such mechanical support is not considered a restraint (i.e., splints, prosthetic devices, lap trays, adult special walkers, etc.).
   2. A **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize during medical, dental, diagnostic, or invasive procedures is not considered a restraint.

3. **PRN Medications**: Medications ordered on an "as needed" basis to address a patient's specific behaviors are not considered a chemical restraint. These are part of the patient's regular medication regime, even if their use is to control ongoing behavior.

CLINICAL JUSTIFICATION:

The following conditions may warrant the initiation of restraint use:

1. An acute change in mental status that results in unexplained, unanticipated and non-redirectable agitation, confusion, or aggressive behavior injurious to the patient or caregivers.
2. An attempt to or actually has hit staff or attacked others.
3. Thrashing about in bed and attempting to harm self.
4. Combative behavior that poses danger to self or others.
5. Alternative methods to modify the patient's behavior pattern have been attempted and found to be ineffective.

ALTERNATIVES to RESTRAINTS:

Potential alternatives to use of restraints may include but are not limited to:

1. Regular reorientation to environment
2. Closer proximity and visibility to the nurses' station
3. Auditory stimulation
4. Relaxation techniques
5. Encourage family presence
6. Effective pain management
7. Structured and consistent daily routine
8. Unrestrained mittens
9. Diversionary activities
10. Utilization of the night light
11. Provide for scheduled ambulation, toileting, and activity
12. Pharmacy consult to evaluate medication

PROCEDURE FOR USE OF RESTRAINTS:

Registered Nurse (RN)

A. Conduct an initial assessment of the patient and document findings in the medical record.

B. Initiate use of restraints in an emergency behavioral situation involving acute changes in a patient's mental status that results in non-redirectable agitation, confusion, or aggressive behavior potentially or actually injurious to the patient or caregivers.

C. Apply restraint according to manufacturer's directions, and ensure that the restraint is properly and safely applied. This includes, but is not limited to:
   1. Restraints must be placed so that the patient's circulation is not compromised by the restraint.
   2. Apply the restraint gently and fasten securely to the bed frame. Fasten using a quick release tie. Restraint should never be fastened using a knot. Never tie to the side rails or lower section of the bed frame when the head of bed (HOB) is raised; the patient can be hurt by the restraint since it is attached to a non-moving section of the bed.
   3. The call bell must be accessible to the patient even with the restraint applied.

D. Notify the attending physician (either directly or if they cannot be reached by telephone, via pager) of the patient's change in mental status. Immediately upon initiating restraints, or within minutes, obtain a restraint order from the attending physician, or if they are unavailable, another LIP or the Medical Director. Orders are time limited up to 4 hours.

E. Notify the attending physician as soon as possible if the restraint was ordered by another LIP.

F. Notify the family/significant other that restraints have been applied after less restrictive measures have been deemed ineffective.

G. Develop a plan of care to include:
   1. Desired outcomes.
   2. Interventions including attempts to use alternatives to restraints.
   3. Discharge to an appropriate level of care capable of providing behavioral management services.

H. A patient in restraints as a result of having met the behavioral management criteria shall be observed face to face every fifteen (15) minutes by the RN. The RN shall document their observations in the medical record.

I. To determine if continued use of restraints is necessary, re-assess the patient's need for restraints every four (4) hours. If yes, notify the physician (prior to the expiration of the four (4) hour time-limited order) to renew the order.

J. Document findings of the initial assessment and reassessments and include, at a minimum, the following:
   1. The actual behavior observed – reason(s) for initiating restraint.
   2. Determination that the patient's behavior is potentially injurious to themselves or others.
   3. Alternative methods attempted to avoid restraint and the effectiveness of those methods.
   4. Discussion with the patient and/or family concerning the risk and benefits regarding the use of restraints and education provided.
   5. The patient's response to the use of restraint

K. After 24 hours, before writing a new order for restraints for behavioral management, a physician or LIP who is responsible for the care of the patient, must see/assess the patient, face to face.

L. Adhere to the following safety measures to decrease opportunity for the patient to inflict injury to self, staff or others:
   1. Closely observe the patient; practice one-to-one nursing care as needed.
   2. Create a safe environment for the patient removing objects, which could be potentially harmful.
   3. Provide patient with plastic flatware and plates, if appropriate.
   4. Frequently orient the patient to person, place, and time of day/evening, if indicated.
   5. Assist patient during self-care or toileting.
   6. Carefully observe to ascertain that patient swallows medications prescribed by staff physician.

M. Make every effort to preserve the patient's rights and dignity during the period that they are restrained.

N. If findings from the reassessment demonstrate that the restraint criteria are not met, the restraint may be removed from the patient.

O. If within the same four (4) hour period that the restraints were removed, the patient exhibits the same behavior that led to the restraint initiation, a new order must be obtained prior to reapplying the restraints and the requirements restart.

1. Document observations and care provided. Include, at a minimum, the following every 15 minutes;
   a. Fluids are offered during waking hours.
   b. Mental status of the patient
   c. Toileting needs addressed during waking hours.
   d. Circulation and skin integrity of the restrained limb observed immediately after application and ongoing.
   e. Nutritional needs addressed.
   f. Personal hygiene is addressed.
   g. Vital signs (including respiratory and cardiac status) and intake and output are assessed.

      Note: Any member of the health care team trained in restraint use (e.g., Nursing, Rehab, Respiratory Therapy, Nutrition Services, etc.) may document the above items.

P. Evaluate the need to continue restraints (including the patient's reactions to the restraints and alternatives attempted). Discontinue use of restraints as soon as possible, based upon findings of re-assessments and re-evaluations of the patient's condition.

Note: Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered prior to the introduction of more restrictive measures).

Medical Staff (Physician and LIP)

A. Within one (1) hour of initiation of use of restraints, assess the patient face-to-face, even if the patient's behavior (see Clinical Justification for details) subsides and the need for restraint is no longer evident.

B. Document:
   1. The events leading to the use of restraints, and
   2. The clinical justification.
   3. Review of: Systems, Behavior, Patient's history, drugs and medications and lab values to determine possible other contributing factors to the patient's behavior.

C. Enter the documentation at the time of writing/entering the restraint order, or in the case of giving the order via telephone, at the time the order is countersigned. Include the following required elements on the order:
   1. Statement that the order is time-limited to not exceed twenty-four (24) hours
   2. Specify which part(s) of the patient's body is/are to be restrained
   3. Specify that only "soft" restraints are to be used

D. Do not write a restraint order as a standing or PRN order.

E. Determine the need for psychiatric evaluation of the patient and decide upon the most appropriate setting required for meeting the patient's needs.

F. In the event that the patient's behavior meets the criteria for extending the restraint for more than four (4) hours, document the continued need for restraints and renew the order.

G. The LIP is not required to perform another face-to-face assessment of the patient after four (4) hours. Prior to the expiration of the original order, the RN must telephone the LIP; report the results of their most recent assessment, and request that the original order be renewed.

H. If within the same four (4) hour period that the restraints were removed, the patient exhibits the same behavior that led to the restraint initiation, a new order must be obtained prior to reapplying the restraints and the requirements restart.

I. The LIP conducts a face-to-face re-evaluation at least every eight (8) hours.

A. **Hospital Organization:**

1. The Hospital, through its Performance Improvement Program, identifies opportunities to reduce risks associated with restraint use and whenever possible, minimize the use of restraints through innovative, less restrictive methods of protecting the patient's well-being.
   a. The measurement and assessment process related to restraint use seeks to:
      1) Understand the root cause for restraint use;
      2) Incorporate this understanding into the organizational plan, prioritize, evaluate, and if appropriate, reduce usage; and
      3) Advance this understanding by assessing aggregate data on restraint usage when appropriate; i.e. on units, by shifts, and for purposes for which restraints are used.
   b. Examples of items for the organization to assess, monitor and trend to identify performance improvement opportunities may include but are not limited to:
      1) Event reports to determine if incidents and accidents occur more frequently and are of greater severity with restrained patients.
      2) Number of patients who are restrained on weekends, holidays, at night, on certain shifts; when contract nurses are used; in one unit more than other units as compared to typical weekday use.
      3) Compliance of physician orders specifying the reason for the restraint as well as the type and duration of restraint.
      4) Consideration of environmental factors as a potential cause for restraint needs.
2. Training is to be provided to staff (employees and contract staff) during initial orientation and competency reassessment is to be conducted annually for staff (employees and contracted) having direct patient care responsibilities or contact. At a minimum, physicians or LIPs authorized to order restraints must have a working knowledge of the hospital's policy regarding the use of restraints. Training will include:
   a. The proper and safe use and application of restraints.
   b. Behaviors, event or environmental factors that may trigger circumstances that require the use of restraints.
   c. The use of techniques and least restrictive measures, including non-physical interventions to protect and maintain the well-being of patients.
   d. Clinical indications or specific behaviors that indicate restraints are no longer necessary.
   e. Monitoring requirements of the patient in restraints, and how to respond to recognize signs of physical and psychological distress.

B. **Outcome Measurement:**

In efforts to decrease restraint utilization and eliminate potential harm to patients, Cornerstone Healthcare Group Hospital will perform ongoing monitoring of restraint utilization to include, but not limited to: restraint utilization episodes, daily orders, least restrictive methods, restraint injuries, and assessment and documentation compliance.

C. **Reporting:**

The Director of Quality Management (DQM), or designee, must submit a report to the CMS regional office of **any death occurring during or within 24 hours of discontinuation of 2-point soft, cloth like restraints used in combination with other restraints**

or
deaths associated with the use of other types of wrist restraints, such as a 2-point rigid or leather wrist restraint
or
any death where the restraint intervention may have contributed to the death.
The report is submitted to CMS via telephone, facsimile, or electronically, no later than the close of business following the day the hospital knows of the patient's death.
The report must include basic identifying information related to the hospital, the patient's name, date of birth, date of death, name of attending physician/practitioner, primary diagnosis(es), cause of death (preliminary, in case a final, official cause of death is not yet available), and type(s) of restraint or seclusion used. CMS makes a standard form available for hospitals to use in submitting the required reports.
When **the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials**, the hospital staff must record in an internal log or other system, the following information:
(i) Any death that occurs while a patient is in such restraints.
(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

A. For deaths described in paragraph above, entries into the log or other system must be documented as follows:
(i) Each entry must be made not later than seven days after the date of death of the patient.
(Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c), medical record number, and primary diagnosis(es).
The death report log or tracking system entry must include:
• The patient's name;
• Patient's date of birth;
• Patient's date of death;
• Name of the attending physician or other licensed independent practitioner who is responsible for the care or the patient;
• Patient's medical record number; and
• Primary diagnosis(es).
B. The staff must document in the patient's medical record the date and time the death was:
Recorded in the internal log or other system, or reported to CMS for deaths described above.
C. The information must be made available in either written or electronic form to CMS immediately upon request.

REFERENCES:

CAMH: PC.12.10, PC.12.20, PC12.30, PC12.40, PC.12.50, PC.12.60, PC.12.70, PC.12.80, PC.12.90, PC.12.100, PC.12.110, PC.12.120, PC12.130, PC.12.140, PC.12.150, PC.12.160, PC.12.170, PC.12.180, PC.12.190,, PC.11.10, PC.11.20, PC.11.30, PC.11.40, PC.11.50, PC.11.70, PC.11.100, HR.2.10, HR.2.30, HR.3.10: COP 482.13 (e)

Cornerstone HEALTHCARE GROUP

RESTRAINT ASSESSMENT/MD ORDER

Non-Behavioral Management Restraint Assessment **DATE:** _____

A **REGISTERED NURSE** must complete the assessment on this form at the time of the application of non-behavioral restraints Documentation of monitoring patients on restraints will be performed on this form. Restraints must be ordered daily.

I. **Pre-existing medical condition or any physical disabilities that would place the patient at greater risk during restraint.**

❑ Yes; ❑ No ❑ Unable to determine
describe_____

II. **Description of patient's medical signs & symptoms leading to application of restraints. (Check all that apply)**

- ❑ Attempting to dislodge medically necessary lines, tubes, and or drains
- ❑ Attempting unsafe activities due to inability to follow directions
- ❑ Other_____

III. **Less restrictive intervention(s) attempted prior to restraints. (Checking all measures that apply indicates that said measures have failed and that restraints usage is appropriate)**

- ❑ Verbal redirection
- ❑ Reorientation
- ❑ Reduced environmental stimuli
- ❑ Diversional techniques, i.e. TV, Visitors
- ❑ Moved closer to staff supervision
- ❑ Cover essential lines/tubing with protective coverings
- ❑ Pain relief/comfort measures taken
- ❑ Increased frequent observation
- ❑ Family/significant other notified (name, date, time)_____
- ❑ Other_____

IV. **Type of restraint (Check all that apply)**

- ❑ Soft limb restraint
- ❑ Full side rails
- ❑ Waist restraint
- ❑ Other: _____
- ❑ Enclosure bed
- ❑ Medication: _____
- ❑
- ❑
- ❑ _____
- ❑ Wrist restraint(s) ❑ Right ❑ Left
- ❑ Ankle restraint(s) ❑ Right ❑ Left

V. **Education given to patient and/or patient representative regarding use of restraint/seclusion.**

❑ Patient ❑ Patient representative _____
(Name) *(Relationship)*

- ❑ Patient and/or patient representative verbalizes understanding.
- ❑ Additional education provided (specify): _____

RN Signature: _____

Date of Order: _____ Start Time: _____ End Time: _____

MD Signature: _____

RESTRAINT FLOW SHEET

DATE: _____

NOTE: Assessment of circulation, comfort, hygiene, safely in restraints, hydration, nutrition, elimination, skin integrity, ROM, and continued need for restraint must be done q 2 for non-behavioral patients in restraints.

Assessments/interventions on the flow sheet with a " " need to be "√" marked to verify that the activity was done. Other assessments/interventions are documented utilizing the following "keys":

Key to MENTAL STATUS/BEHAVIOR
1=Disoriented
2=Confused
3=Quiet/Resting
4=Sleeping
5=Does not follow instructions basic to patient's safety
6=Pulling at lines, tubes, dressings, etc.
7=Other

Key to NUTRITIONAL/FLUID NEEDS
1=Assisted with meal/snacks
2=Released to feed self
3=Fluids offered
4=Other (specify)

Key to COMFORT/POSITIONING
1=Turns
2=Chair
3=Ambulate
4=Pain management
5=Reposition

Key to ELIMINATION/HYGIENE
1=Bedside commode
2=Bed pan/urinal
3=Assisted to bathroom
4=Foley
5=Diaper change
6=Oral care
7=Bath

Key to SKIN INTEGRITY
1=Intact
2=Dry
3=Impaired
4=Diaphoretic
5=Cold/clammy
6=Other_____

Every 2 hours enter the appropriate key or "√" the columns as applicable * = see nurses notes for further information

Time	VS q shift and PRN			Nutritional/ Fluid needs	Elimination/ Hygiene	Comfort/ Positioning	Skin Integrity Circulation	Mental status	Remove/ Release*	ROM for Restrained Extremities	Need to Continue	Privacy/ Dignity Maintained	COMMENTS	Initials
	BP	P	R											
0700														
0800														
0900														
1000														
1100														
1200														
1300														
1400														
1500														

1600														
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2200														
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0300														
0400														
0500														
0600														

Restraint Flow Sheet

Date: _____

- The patient currently in restraints requires appropriate assessment and documentation at least every two (2) hours while in restraints; for medical restraints only. V/S at least every 4 hours while awake.

- Only an RN with documented competency on Cornerstone's Restraint Program and Policy may care for a patient in restraints.

Reference

- Initial box if Assessed

Documentation of Assessment & Care Provided

Time Started: _____	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600
Circulation Check												
Fluids/Nutrition												
Toileting Offered												
Hygiene Care												
Comfort Measures CP – Changed Position												
R.O.M. Provided A–Active, P-Passive												
Release												
Care Plan Change A–Assessed,												

C-Changed, U-Updated												

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

SAFE PATIENT HANDLING AND TRANSFERS

Cornerstone HEALTHCARE GROUP

TITLE		POLICY #
TRANSFER PROCEDURES		**REHAB 418**
MANUAL	EFFECTIVE DATE	DATES
REHABILITATION SERVICES	July 1997	Revisions: 11/2007, 01/2010, 07/2012 Reviewed: 07/2012
SCOPE:	REFERENCE	
Cornerstone Hospital of SEAZ		

POLICY: All staff will practice safe transfer procedures by utilizing correct body mechanics, appropriate transfer techniques, and monitoring safety precautions throughout the transfer.

PURPOSE: To maintain the safety of all staff and patients during transfer procedures.

PROCEDURE: The following procedures will be utilized during patient transfers.

1. Review of Body Mechanics – as provided during the General New Hire Orientation
2. Preparation for Transfers
   a. Be aware of and understand all patient medical conditions or precautions related to transfers.
   b. Understand the type of transfer to be performed with the patient.
   c. Gather all necessary equipment before initiating the transfer.
3. Transfer types
   a. Hoyer Transfer
   b. Slide Board Transfer
   c. Stand or Squat Pivot Transfer
   d. Stand and Step Transfer
4. Transfer Procedures
   a. Hoyer Transfer
      1) Hoyer lifts are stored at all times in the small storage room adjacent to room 101. Hoyers with cords are to be plugged into the outlet when not

in use. Hoyers with batteries require an additional battery to be charged at all times.

2) Performance of a Hoyer transfer requires at least 2 people with proper training. Some situations may require additional personnel.
3) Place the Hoyer sling evenly underneath the person by rolling side to side. Stitching is to be on the outside or to the bed side. The vertical band is placed midline under the head and the wide horizontal band is placed under the thighs.
4) Place the Hoyer lift over the bed with the wide width of the hoist horizontal over the person's chest. Attach the four corners of the Hoyer sling to the hoist using double straps.
5) Hoist the person into the air. Position the wheelchair under the person. Tip the wheelchair back about 45°. Slowly lower the person into the wheelchair. To increase patient comfort while sitting in the chair, handle the Hoyer sling near the person's hips and position the hips centered between the armrests and to the extreme back of the seat. Once the person is firmly in the seat, slowly allow the chair to return to the floor, while guarding the person from any sudden forward momentum or from sudden contact with the lift.
6) Remove straps from the Hoyer and complete any additional comfort measures, such as leg rest placement.

b. Slide Board Transfer
   1) Position the wheelchair next to the bed. Allow room between the posterior of the wheelchair and the bed, if one assistant needs to assist at the patient's backside.
   2) Remove inside armrest closest to bed.
   3) Assist the patient, as needed, into a sitting position at edge of bed with feet touching floor. The wheelchair can be positioned more closely after the patient is sitting. Maintain support to the patient as necessary while sitting.
   4) Place one end of the slide board under patient's hip closest to the chair and other end on the chair seat. Use of a chux, pillow case, or other material may be needed to reduce friction and assist the transfer.
   5) Instruct patient to maneuver across the slide board. Or assist the patient by blocking the lower extremities and moving the hips in segments across the board. The person in front of the patient will instruct all others that may be assisting for proper timing and patient safety.
   6) Once the patient is in the chair, remove the slide board, and position the armrest and footrests.

c. Stand or Squat Pivot Transfer
   1) Position the wheelchair near the bed prior to the patient sitting at the edge of the bed.
   2) Assist the patient as needed from supine to sitting position.
   3) Guard the patient while positioning the wheelchair in the desired position next to the bed. Ensure that the wheelchair and bed brakes are locked.
   4) Pre-position the patient at a diagonal to the bed and the feet at a diagonal to each other to create the shortest distance for the transfer. Apply a gait belt, if needed, in the safest location on the

patient so as not to disturb any lines, ostomies, or other medical equipment.

5) Instruct the patient to assist with the transfer by leaning forward, pushing down with the hands and pushing with the feet.
6) Use appropriate body mechanics and hand positions to assist the patient to a partial (squat) or full stand position. Assist with the pivot toward the chair and complete to a sitting position.
7) At NO time should a patient place hands or arms around the staff person's neck for the transfer.
8) Complete the wheelchair set-up with leg rests or other equipment as needed.

c. Stand and Step Transfer
   1) Same procedures as a stand or squat pivot transfer, except that a patient is able to stand fully and able to take steps to the chair. Pre-positioning at the edge of the bed prior to standing may or may not be necessary, depending on the patient's ability level or functional limitations.

5. Safety Awareness
   a. Inspect all wheelchair parts for safety and proper functioning.
   b. Prevent bruising or laceration of extremities.
   c. Protect areas of decubitus ulceration, blistering, or other skin wounds. Avoid shearing forces.
   d. Provide adequate support to patients with postural hypotension, decreased balance, or decreased strength.
   e. Consider the patient's physical and mental condition prior to the transfer.
   f. Use the adequate number of staff for a safe transfer. Discuss the transfer with the involved staff and patient to ensure that all understand the expectations.
   g. Ensure the safety of all of the patient's lines and tubes to avoid dislodging or otherwise compromising equipment or care.
   h. Test the Hoyer unit prior to use to ensure battery power and proper functioning. Know the location of a back-up battery, in case of failure.
   i. A gait belt is provided in each patient's room. However, gait belts are to be used selectively, based on the patient's medical conditions and assistance level.
   j. Apply non-skid footwear to all patients prior to any type of weight bearing transfer. Apply any ordered footwear or braces prior to the transfer.

TITLE	POLICY #	
Falls Mitigation Program	**966**	
MANUAL	EFFECTIVE DATE	REVISE DATE
Risk Management	**May 2012**	
SCOPE:	REFERENCE	
Organization – Wide	**TJC Chapters NPSG, PC, PI, IC, EC, & MM**	

Purpose:

Preventing falls among patients in acute and long term care healthcare settings requires a multifaceted approach. This policy provides the framework for a comprehensive falls prevention program designed to reduce the risk of patient harm resulting from falls and methods to evaluate the effectiveness of the program.

Definitions

1. A fall is defined as a An unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed), or is reported to have landed on the floor (un-witnessed) not due to any intentional movement or extrinsic force such as stroke, fainting, seizure.
2. Accidental falls occur when patients fall unintentionally. For example, they may trip, slip, or fall because of a failure of equipment or by environmental factors such as spilled water or urine on the floor.
3. Unanticipated physiologic falls occur when the physical cause of the falls is not reflected in the patient's risk factor for falls. A fall in one of these patients is caused by physical conditions that cannot be predicted until the patient falls. For example, the fall may be due to fainting, a seizure, or a pathological fracture of the hip.
4. Anticipated physiologic falls occur in patients whose score on risk assessment scales [(e.g. Morse Fall Scale (MFS)] indicates that they are at risk of falling. According to the MFS, these patients have some of the following characteristics: a prior fall, weak or impaired gait, use of a walking aid, intravenous access, or impaired mental status.
5. Falls are classified into the following categories:
   - 1= No apparent injury;
   - 2= Minor- Bruises, or abrasions as a result of the fall;
   - 3= Moderate- Injury that causes tube or line displacement, a fracture or laceration that requires repair;
   - 4= Major- Injury that requires surgery or move to ICU for monitoring of life threatening injury; and
   - 5= Death

Fall Risk Assessment

A. Patients will be assessed for their fall risk:

On admission to the facility

On any transfer from one unit to another within the facility

Following any change of status

Following a fall

On a regular interval, such as daily

B. Assessment Tool (*Attachment B)*

1. The Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling It consists of six variables that are quick and easy to score, and it has been shown to have predictive validity and interrater reliability.

The Morse Fall Scale (MFS)

Item	*Scale*	*Scoring*
1. History of falling; immediate or within 3 months	No 0 Yes 25	_____
2. Secondary diagnosis(more than one diagnosis listed on the patient chart)	No 0 Yes 15	_____
3. Ambulatory aid None/bed rest/nurse assist/wheelchair Crutches/cane/walker Furniture	0 15 30	_____
4. IV/Heparin Lock	No 0 Yes 20	_____
5. Gait/Transferring Normal/bedrest/immobile Weak Impaired	0 10 20	_____
6. Mental status Oriented to own ability Forgets limitations	0 15	_____
TOTAL SCORE MORSE FALL RISK **>=45 High Risk** **25-44 Moderate Risk** **<= 24 Low Risk**		

2. The items in the scale are scored as follows:
   A. *History of falling*: This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as

from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

B. *Secondary diagnosis*: This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.
C. *Ambulatory aids*: This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.
D. *Intravenous therapy*: This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.
E. *Gait*: A *normal gait* is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a *weak gait* (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.
F. *Mental status*: When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the ambulatory order on the chart, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.
G. *Scoring and Risk Level*: The score is then tallied and recorded on the patient's chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, and high risk prevention interventions) are then identified.

C. Risk Level *(Attachment C)*

MFS Score	Risk Level	Action
0 - 24	Low Risk	Environmental prevention measures
25 - 50	Moderate Risk	Implement Standard Fall Prevention Interventions
≥ 51	High Risk	Implement High Risk Fall Prevention Interventions

<u>Interventions and prevention strategies based on Risk Level Scoring</u>

Risk Level	Action

Low Risk	**<u>Prevention: Environmental Rounds</u>** θThe facility management, housekeeping, clinical services and biotech staff perform environmental rounds. Facility management and/or Housekeeping staff confirms: *Hallways and patient areas are well lit* *Hallways and patient areas are uncluttered and free of spills* *Locked doors are kept locked when unattended* *Handrails are secure and unobstructed* *Tables and chairs are sturdy* Biotech staff confirms**:** *All assistive devices are working properly by inspecting them on a regular basis* Nursing Staff confirm: *Locked doors are kept locked when unattended* *Patient rooms are set up in a way that minimizes the risk of falling (see High Fall-Risk Room Set-up in Intervention section)* Everyone confirms: *Unsafe situations are dealt with immediately either by dealing with the situation or notifying the appropriate staff and ensuring that they arrive and correct the situation.*
Moderate Risk	**<u>Implement prevention strategies as above AND Standard Fall Preventions Measures listed below:</u>** <u>Orientation & Environment</u> Orient patient to surroundings and assigned staff. Lighting adequate to provide safe ambulation. Instruct to call for help before getting out of bed. Demonstrate nurses' call system. Call bell within reach, visible and patient informed of the location and use. Light cord within reach, visible and patient informed of the location and use. Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unnecessary equipment). Personal care items within arm length. Bed in lowest position with wheels locked. Instruct patient in all activities prior to initiating. Assign bed that enables patient to exit towards stronger side whenever possible.

	Mobility & Transfer Interventions Rehab team (PT and OT) is to make recommendations for the safest type of transfer i.e. toward the strongest side, use transfer belt, etc. Request PT consult. Ambulate as early and frequently as appropriate for the patient's condition. Non-slip footwear. Transfer towards stronger side. The patient is to ambulate with assistive devices (if applicable). Assess the patient's coordination and balance before assisting with transfer and mobility activities. Communication & Education Educate and supply patient and family with fall prevention information. Actively engage patient and family in all aspects of the fall prevention program. Place an "at risk" indicator on the chart, outside the room and at the bedside Identify patient with a yellow colored wrist band. Place a colored star outside of patient's room. Place a colored star over patient's bed. Consult with pharmacy. Medications reviewed. Instruct patient in medication time/dose, side effects, and interactions with food/medications Comfort rounds (include positioning as indicated; pain management, offering fluids, snacks when appropriate and ensuring patient is warm and dry). Every 4-hours. Every 2-hours. Every 1-hour. Implement bowel and bladder programs to decrease urgency and incontinence. Equipment and assistive devices. Individualize equipment specific to patient needs. Lock movable equipment prior to use Bed alarm

	Wheelchair alarm Check tips of canes, walkers and crutches for non-skid covers. Bedside mat/perimeter mattress. Hill-rom low bed. For risk of head injury consider consult for PT for consideration of a helmet (those at risk of head injury are patients on anticoagulants, patients with severe seizure disorder and patient mechanism of fall is by history to fall hitting head). Elevated toilet seat. Instruct patient in use of grab bars. <u>Rest and Diversion.</u> Request OT consult. Relaxation tapes/music. Diversional activities. Exercise program. Minimize distractions.
High Risk	**<u>Implement Moderate Risk Interventions (above) AND High Risk Fall Prevention Measures listed below:</u>** Consider use of sitters for cognitively impaired Room placement closer to nurses' station. Enclosure bed Restraints Repeatedly reinforce activity limits and safety needs to the patient and family <u>Increase Comfort rounds to every hour</u> (Include positioning as indicated; pain management, offering fluids, snacks when appropriate and ensuring patient is warm and dry).

<u>Post Fall Procedures and Management</u>

Note: There are two key elements of the post fall procedures/management: :Initial post-fall assessment and Documentation and follow-up

A. Initial Post Fall Assessment

1. <u>First priority</u> is to assess the patient for any obvious injuries and find out what happened.

   A. *Patient assessment*

      i. *Injury*

      ii. *Vital signs (temperature, pulse, respiration, blood pressure, orthostatic pulse and blood pressure — lying, sitting and standing)*

      iii. *Probable cause of fall*

iv. *Comorbid conditions (e.g., dementia, heart disease, neuropathy, etc.)*

v. *Risk factors (e.g., gait/balance disorders, weakness)*

vi. *Morse Fall Scale Risk Assessment*

2. The <u>second priority</u> is to find out what happened. Information needed:

A. *Date/time of fall*

B. *Patient's description of fall (if possible; what* was patient trying to accomplish at the time of the fall?

C. *Where was the patient at the time of the fall (patient room, bathroom, common room, hallway etc.)?*

D. *Assess Environment*

E. Bed in high or low position?

- Bed wheels locked?
- Wheelchair locked?
- Floor wet?
- Lighting appropriate?
- Call light within reach?
- Bedside table within reach?
- Area clear of clutter and other items?
    - Side rails in use? If so, how many? How many are on the bed?

F. Assess contributory factors:

- Patient using a mobility aid? If so, what was it?
- Wearing correct footwear?
    - Sensory aids (glasses, hearing aids; was patient using at the time?)
    - Current medications (were all medications given, was a medication given twice?)

G. Was the treatment intervention plan being followed? If not, why not?

3. The <u>third priority</u> is family/guardian and physician notification.

B. Documentation and Follow-up

1. Following the post-fall assessment and any immediate measure to protect the patient:

a. An occurrence report should be completed. All occurrence reports must be forwarded to the Risk Manager

b. A detailed progress note should be entered into the patient's record including the results of the post-fall assessment

c. Refer the patient for further evaluation by physician to ensure other serious injuries have not occurred

d. Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate

e. *Communicate to all shifts that the patient has fallen and is at risk to fall again. Place an "at risk" indicator on the chart, outside the room and at the bedside.*

Responsibilities of Staff

Responsible Party	Actions
Medical Director	The Medical Director is responsible for ensuring that falls and fall-related injury prevention is: *A high priority at the facility* 2. *Promoted across the facility through direct care, administrative and logistical staff* 3. *Adequately funded to provide a safe environment for patients and staff*
Associate Administrator/Director of Nursing	The Associate Administrator / Director of Nursing is responsible for: *Establishing population-based fall risk levels/units/programs* *Deploying evidence-based standards of practice* *Overseeing the policy within the hospital*
Clinical Managers and Education Service	The Clinical Managers are responsible for: *Making fall and fall-related injury prevention a standard of care* 2. *Enforcing the responsibilities of the clinical staff to comply with interventions* 3. *Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with facility equipment experts* 4. *Developing competencies for nursing staff about the falls prevention program* 5. *Ensuring that all nursing staff receive education about the falls prevention program at the facility and understand the importance of complying with the interventions*
Staff and Contract Nurses Including RNs, LVN/LPNs and NAs	Staff Nurses including RNs, LVN/LPNs and NAs are responsible for: 1. *RNs: Completing the fall-risk assessment on admission* 2. *Notifying the care team of any patients assessed as high-risk* 3. *Following the identification procedure for high fall-risk admissions (i.e. specific color armband, ensuring the bed assigned is close to the nursing station, ensuring there is visual cue outside of patient's room and over patient's bed, and applying the appropriate colored socks.* 4. *Ensuring compliance of fall and fall-related injury interventions* 5. *Completing fall-risk assessments on transfers,*

	following a change in status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use 6. *Ensuring that rooms with high fall-risk patients are assessed and corrected as necessary depending on the patient's current fall risks*
Physicians and LIP	Physicians, and LIP are responsible for: 1. *Identifying and implementing medical interventions to reduce fall and fall-related injury risk* 2. *Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls*
Pharmacists	Pharmacists are responsible for: 1. *Reviewing medications and supplements to ensure that the risk of falls is reduced* 2. *Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls*
Physical and Occupational Therapists	Physical and occupational therapists are responsible for: 1. *Conducting balance assessments for all high fall-risk patient referrals* 2. *Developing an intervention program for patients to reduce their fall-risk*
Biomedical Technologists	Biomedical technologists are responsible for ensuring that: *1. Assistive equipment, such as wheelchairs, walkers and canes are checked regularly and equipped with devices to prevent falls*
Quality Management Team	The Quality Management Team is responsible for: 1. *Collecting data to ensure that fall and fall-related injury prevention strategies are effective* 2. *Conducting case-by-case reviews for all falls to ensure that medications are reviewed and prevention measures are recommended* 3. *Providing assistance to interdisciplinary treatment teams when requested to recommend prevention strategies for a patient* 4. *Participating in the Quarterly Falls Aggregate Review*
Facility Management Staff	The facility management staff are responsible for: *Ensuring a safe environment of care by conducting environmental*

	assessment

Evaluation of Program Effectiveness

A. Measurements

1. Rates: The most commonly used statistic to measure and track falls is the "fall rate," which is calculated as follows:

   Number of patient falls x 1000
   Number of patient days

   The fall rate for a specified time period is defined as the total number of eligible falls divided by the total number of eligible patient days, multiplied by a constant or "k" of 100 to create a rate per 1000 patient days. Note that all falls are included in the formula, so that repeated falls experienced by the same patient are included in the numerator.

2. Other rates found in the literature are also used to track and trend fall data and include:

   - The number of patients at risk;
   - The number of patients who fell; and
   - The number of falls per bed.

C. Comparisons

1. Risk adjustment: A variety of rates found in the literature demonstrates the difficulties of comparing studies that use different calculations, and highlight the importance of comparing like rates and determining whether or not they are risk-adjusted. Thompson Reuters utilizes risk-adjusted data for comparisons to other external organizations with "similar" populations.

D. Tracking and Reporting

A. All falls should be reported to the Charge Nurse/Supervisor immediately following the event. Quality management should be notified within 24 hours of the event, and all falls should be discussed during daily Morning Meeting.
B. Each fall incident is investigated and summarized in the Occurrence Log.
C. All falls are reviewed by the Environment of Care (EOC) as they pertain to the environment, the Quality Committee (QC), the Medical Executive Committee (MEC), and the Governing Board (GB).
D. Trending and analysis is accomplished by Thompson Reuter's data integration systems.
E. Quality Management reviews and analyzes fall data to ensure that fall and fall-related injury prevention strategies are effective.

Attachments

A. Attachment A: Fall Risk Assessment Flow Chart

B. Attachment B: Risk Progression

C. Attachment C: Fall Prevention Conceptual Model

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CULTURAL SENSITIVITY

The goal of the health care system is to provide optimal care for all patients. We must keep in

mind that culture and ethnicity are strong determinants in an individual's interpretation or perception of health and illness. Religion,
ethnicity, and culture interweave into the fabric of each response of a particular individual to treatment and healing.

ANA Position Statement

- Knowledge of cultural diversity is vital at all levels of nursing
- Cultural groups often utilize traditional health care providers, identified and respected within the group.
- Concepts of illness, wellness, and treatment modalities evolve from a cultural perspective or world view and are part of the total cultural belief system.
- Recognizing cultural diversity, integrating cultural knowledge, and acting, when possible, in a culturally appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates.

Barriers to Cultural Competence

Equal Treatment Model

All people are treated the same. This is what my parents told me as I was growing up. Melting Pot syndrome- put everyone in same pot together. This could lead to failure to recognize ethnic differences and needs of various patients.

Cultural Dissonance

When the needs of ethnic minority group in the hospital are not recognized this could lead to cultural dissonance. This is when 2 distinctively different cultures are match up to each other. In Nurse/Patient relationship, patient is often labeled as "non-compliant" because the patient's individual or cultural needs are not fully explored.

Ethnocentrism

Belief that one's own culture is better than others. This is often unconscious but pervasive and imposed on the care of the patient. Nurses often believe that their ways (Traditional western views) of health care practices are the best, most moral, and correct.

AGE-SPECIFIC CARE
CARE OF THE ADULT PATIENT

YOUNG ADULTHOOD (20-30)

Young adults seek companionship and love with another person or they become isolated from other people. They are concerned with getting started in an occupation, deciding about military service, developing parenting skills, and the overall development of a personal life style in a social context. Young adults are at the prime of their physical development as characterized by strength, energy and endurance.

Possible Crisis Events:

- failure to graduate from high school/college
- entering military service/avoiding service
- inability to find a satisfactory career

- poor performance in a chosen career
- purchase of a home; marriage
- birth of first child; financial difficulties
- conflict between career and family goals
- discipline problems with children
- illness of a son or daughter; or inability to manage the various demands of the parental role.

Interventions:
- ask the patient if they have any questions or concerns
- give them answers to questions in a factual, non-judgmental manner
- support patient strength, i.e., going to school, getting a job, starting a family
- accept their chosen lifestyle and assist with necessary adjustments relating to health
- support change as necessary for health

MIDDLE ADULTHOOD (30-45)

In normal development, adults are productive, performing meaningful work and raising a family. They are dealing with new responsibilities, increasing productivity and developing socioeconomic consolidation.

In middle age there is a re-examination of earlier life choices (mate, career, and children) and reworking of earlier themes (identity, intimacy). Goals are usually clearer and more specific and the middle age adult can enjoy a rich personal life.

There may be added responsibilities of assisting aging parents. It is a time of re-evaluating and consolidating ones relationship with spouse/significant other and/or adjusting to loss due to death or divorce.

Possible Crisis Events:
- rejection of rebellious adolescent children
- divorce
- setback in career
- conflict at work
- financial concerns
- moving associated with career advancement
- unemployment
- regret over earlier decisions regarding marriage and children
- dissatisfaction with goals achieved
- marital problems/extra-marital affairs

Interventions
- recognize how their health status may affect the patient's role as a parent or spouse, their professional identity and their role as a wage earner
- identify issues associated with separation from young children
- when indicated, supply adequate information to encourage necessary compliance and life style changes in chronic illness

PROBABLE MID-LIFE CRISIS ISSUES (38-45)
- coming face-to-face with one's own mortality
- accepting the discrepancy between life's goals and probable attainment
- acceptance of the limitation of new opportunities
- change in orientation from time lived to time left to live

LATER ADULTHOOD (45-65)

There is a shift in life structure in light of changes in family and work responsibilities and a need to develop mutually rewarding relationships with grown children. There is an increase of leisure time and a desire to use it productively. Likewise, there is frequently an ongoing quest for more knowledge and education which is compatible with the scientific data that IQ scores can increase at least into the mid-fifties.

Possible Crisis Events:

- these adults are concerned with adjusting to physiological changes of middle age as well as adjusting to children reaching adulthood and leaving home.
- they will ultimately have to deal with an "empty nest" syndrome when the last child moves out
- there is a beginning awareness of physical decline, chronic illness of self or spouse, and the death of friends.
- decisions may need to be made regarding retirement, the use of leisure time and/or a new career.
- there may be a change in living conditions such as a home to an apartment or condo.
- there may be conflict with adult children, divorce or death of a spouse
- physical or mental illness may lead to socioeconomic failure, a feeling of hopelessness or even addictions
- they may have to make major decisions about the care of aging parents including prolonged illness and death.

Interventions:

- assist the patient in planning for anticipated changes in life and recognizing risk factors related to health
- understand that hospitalization may exacerbate an older adult's fear of loss of physical strength and debilitation
- focus on their strengths rather than their weaknesses
- try to normalize their concerns.

CORPORATE COMPLIANCE

Basics of Compliance

Who is responsible for ensuring Cornerstone adheres to all compliance related regulations?
What does compliance concern?
Why is compliance important to the company, hospital and you?
Where do I go if I have a compliance question?

Who is responsible for ensuring Cornerstone adheres to all compliance related regulations?

As a corporation, Cornerstone has a Corporate Compliance Officer whose responsibility is to oversee the compliance program and report regularly to the Board of Directors.
Each hospital has a Compliance Officer and Compliance Committee. The hospital Compliance Officer is to implement various compliance programs at the hospital and to report to the hospital Compliance Committee.
As employees we each are responsible to ensure adherence to all laws and regulations.

What is Compliance?

Compliance is a collection of rules and regulations promulgated to eliminate fraud waste and abuse in the healthcare system
Cornerstone is committed to following all rules and regulations

Cornerstone relies heavily upon its employees to help us comply with all legal and regulatory requirements
Why is compliance important to the company, hospital and you?
Healthcare is one of the most heavily regulated industries and following the rules is essential to our success.
Cornerstone is committed to following all applicable laws and regulations, and delivering the best healthcare and service to its patients.
Failure to follow laws and regulations could jeopardize the company, hospital and patients.
As an employee you are expected to conduct yourself in accordance with all rules and regulations.

Where do I go if I have a compliance question?
Cornerstone has a Corporate Compliance Officer who is responsible for monitoring all compliance related activities. If you have a question or concern you can contact the Corporate Compliance Officer directly. Each hospital has a Compliance Officer. The hospital Compliance Officer is generally the Director of Quality Management. It is their responsibility to oversee compliance in the hospital.

Cornerstone maintains a compliance hotline. If you have a concern you can call the compliance hotline anonymously.

Compliance
Fraud is the intentionally making a false statement or submitting a document that is known to be false.

-An example is filing a claim with Medicare for reimbursement knowing the claim is inaccurate or false.

Abuse describes practices or incidents that are inconsistent with sound practices, that result in unnecessary cost.

-An example is a healthcare professional doing testing that is not medically necessary.

Compliance-Rules and Regulations
Code of Conduct
As an employee you are required to annually read, understand, and adhere to Cornerstone's Code of Conduct. The Code of Conduct delineates expectations of you, including:

-Adhere to all laws and regulations.
-Comport yourself in an ethical manner.
-Avoid possible conflicts of interest.
-Protect all confidential information.
-Comply with all rules and regulations concerning patient privacy.
-Respect all patient's rights.
-Report any suspected violation of the Code of Conduct.
-Cornerstone will not tolerate any retaliation against an individual who reports a suspected violation.

Compliance-Education
Continuing education is an important part of compliance. Each year you will be required to complete certain compliance education and affirm that you have read and understand the Code of Conduct. Failure to complete the required compliance education may result in suspension and even termination of your employment.

Compliance-Non-Retaliation Policy
Cornerstone has adopted a policy to protect employees from adverse action when they do the right thing and report a genuine concern.

Reporting a Concern
If you have a concern you should:
Inform immediate supervisor.
Inform hospital compliance officer.
Contact Corporate Compliance Officer, Chris Corrigan- 469-621-6740
Call Cornerstone Compliance Alert line.- 866-478-9319

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.

FINGERSTICK BLOOD SUGAR

Bedside glucose monitoring is performed:
1. Per physician/LIP order
2. Every six (6) hours for patients on Total Parenteral Nutrition (TPN), the times being 0600, 1200, 1800, 2400
3. Before meals and at bedtime for patients on oral intake, the times being 0630, 1130, 1430, and 2100

You may NOT perform a finger stick blood sugar until you have completed training with a designated Trainer, each team has one, or with the RN Educator. Once you have completed training you will be given an ID number to use.

When performing a patient test you must obtain two (2) patient identifiers (See Patient Identification Policy). Scanning the patient's armband alone is not verification of patient identity.

Per Roche, the Accu-Chek Inform II meter can only be cleaned with bleach wipes. Ensure you have 1 minute contact time (the time the meter stays wet). The meter MUST be cleaned between each patient use. **DOCUMENT ON THE METER THAT YOU CLEANED THE METER BETWEEN EACH PATEINT FINGERSTICK***

Procedure for finger stick:

- Wash your hands, don gloves and explain the procedure to the patient
- Obtain two (2) patient identifiers per policy
- Cleanse the fingertip with alcohol or have the patient wash with soap and water

- Perform finger stick
- Wipe away the first drop of blood and collect the second drop
- Clean the machine and add comment that the meter has been cleaned

Insulin Comparison Chart

Insulin Name	When does it start working? (Onset)	When will the effect be the greatest? (Peak)	How long will it lower blood glucose? (Duration)	Notes for Use	Cost Estimate
Rapid Acting					
Lispro (Humalog™)	<15 minutes	0.5-3 hours*	3-5 hours	If mixing with NPH, rapid-acting insulin should be drawn into syringe first. Mixture should be given immediately to avoid effects on peak action	$129.66 (10 ml vial)
Aspart (Novolog™)	<15 minutes	0.5-3 hours*	3-5 hours		$44.44 (10 ml vial)
Short Acting					
Regular (Novolin R™ or Humulin R™)	0.5-1 hour	2-4 hours	4-8 hours	May be mixed with NPH in same syringe. Mixing order should be the clear regular drawn up first, then the cloudy NPH (i.e. "clear to cloudy")	$12.95 (10 ml vial) $11.78 (10 ml vial)
Intermediate Acting					
NPH (Novolin N™ or Humulin N™)	2-4 hours	4-10 hours	10-18 hours	Available in outpatient setting as pen – vial only in hospital	$12.75 (10 ml vial) $11.78 (10 ml vial)
Long Acting					
Glargine (Lantus™)	4-6 hours	Same action throughout the day	24 hours	Do not mix with other insulins. Available as pen in outpatient setting. Duration (clinical trial data): 6 hrs (0.1unit/kg), 12 hrs (0.2unit/kg), 20 hrs (0.4unit/kg), 23 hrs (0.8unit/kg and 1.6 unit/kg)	$183.16 (10 ml vial)
Detemir (Levemir™)	2-3 hours	6-8 hours	Dose-dependent 5.7-23.2 hours		$83.34 (10 ml vial)
Combinations					
Humulin or Novolin 70/30	0.5-1 hour	2-10 hours	10-18 hours	70% NPH + 30% regular insulin. Insulin action includes 2 peaks (1 from each formulation).	$11.78 (10 ml vial) $12.95 (10 ml vial)
Novolog Mix 70/30 Humalog Mix 75/25 or 50/50	<15 minutes	1-2 hours	10-18 hours	Novolog Mix: Aspart protamine 70% + aspart 30% Humalog Mix : 75/25 = 75% lispro protamine + 25% lispro 50/50 = 50% lispro protamine + 50% lispro Insulin action includes 2 peaks (1 from each formulation	$42.44 (10 ml vial) $44.32 (10 ml vial) $44.32 (10 ml vial)

INFECTION CONTROL

Health care-associated infections affect 2 million patients in the US each year and are responsible for 80,000 deaths per year. Transmission of health care-associated pathogens most often occurs via the contaminated hands of health care workers. Nurses, doctors and other health care workers can get thousands of bacteria on their hands through contact with their patients and the patient care environment.

Cornerstone Hospital has **"Zero-Tolerance"** for non-compliance with Hand Hygiene and Isolation Precautions.

CDC Guidelines Hand Hygiene Guidelines
The Centers for Disease Control and Prevention (CDC) and other healthcare-related organizations believe that cleaning your hands before and after having contact with patients is one of the most important measures for preventing the spread of bacteria in healthcare settings.

Wash hands with soap and water if:
- your hands are visibly soiled (dirty)
- hands are visibly contaminated with blood or body fluids
- before eating
- after using the rest room

Washing Your Hands Effectively
When washing hands with plain or antimicrobial soap:
- wet hands first with water (avoid HOT water)
- apply 3 to 5 ml of soap to hands
- rub hands together for at least 15 seconds
- cover all surfaces of the hands and fingers
- rinse hands with water and dry thoroughly
- dry with a paper towel
- turn off the faucet with a paper towel

When should you use an alcohol-based hand rub?
If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands**:**
- before having direct contact with patients
- after having direct contact with a patient's skin
- after touching equipment or furniture near the patient
- after removing gloves

Using Alcohol-based Hand rub Effectively
- Apply 1.5 to 3 ml of an alcohol gel or rinse to the palm of one hand and rub hands together
- Cover all surfaces of your hands and fingers
- Include areas around/under fingernails
- Continue rubbing hands together until alcohol dries
- If you have applied a sufficient amount of alcohol hand rub, it should take at least 10 -15 seconds of rubbing before your hands feel dry.

Artificial Nails Policy
- Nails need to be intact and short, no more than ¼" in length
- Polished nails are acceptable only if nail polish is intact (no chips!)
- Artificial nails are not allowed for those administering patient care or patient-related care, this include nail extenders, gel overlays, etc.

Isolation Precautions:
Please note the isolation signs posted on the patient's door.

Contact-Gel in, Gel out and gowns and gloves every time you enter the room.

Soap & Water-Gel in, gowns and gloves every time you enter the room, hand washing with soap and water when exiting the room.

Droplet-Gel in, Gel out, Yellow surgical mask when in the room, eye protection if risk of aerosolization of secretions.

Airborne-Gel in, Gel out, N-95 or Duckbill (what you were fit tested for) every time you are in the patient room

Airborne and Contact-Gel in, gel out, N-95 or Duckbill, gown and glove every time you enter the room

**When you wear a gown it needs to be tied in the back, if you haven't covered your clothing you have not done enough to protect yourself or your other patients.
**It is everyone's responsibility to hold all staff, including physicians/NP, accountable to do the right thing. When you approach someone who is non-compliant, do so in a non-confrontational and professional manner. If you are reminded to perform hand hygiene it should be accepted in a non-confrontational and professional manner

CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PREVENTION

The bottom line in CAUTI Prevention is:
If your patient doesn't have a Foley catheter they cannot get a CAUTI.

Infections can be caused by colonization of the rectal and genitourinary areas or the lack of proper post insertion care and maintenance. The catheter and tubing form a biofilm from urinary pathogens. Bacteria found in that biofilm can become resistant to the body's natural defenses and resistant to antimicrobials.

Risk Factors:

- Prolonged catheterization
- Female
- Elderly
- Compromised immune system
- Lack of sterile technique with insertion
- Improper post-insertion care and maintenance

Criteria for having a Foley catheter:

- Acute urinary retention, neurogenic bladder dysfunction, suspected or known obstruction
- Accurate measurement of intake and output in the critically ill patient
- Incontinence in a patient with a Stage III or Stage IV pressure ulcer on their trunk
- Prolonged immobilization in a patient with an unstable thoracic or lumbar spine injury
- Comfort care for end of life
- Gross hematuria
- Recent urologic surgery
- Physician order

Methods to Prevent a CAUTI

- Hand hygiene, hand hygiene, hand hygiene
- Strict sterile technique when inserting the Foley
- Cleansing of the perineal area
    - Peri care should be done Q shift
    - Female wipe from the meatus out and wipe towards the rectum. Male wipe from the meatus out
    - When cleansing the catheter wipe from the meatus away from the body, one cloth-one wipe
    - Keep the bag below the level of the bladder. When transferring the patient be sure the bag remains below the level of the bladder ***you may need to place it in a pink bucket on the floor***
    - Keep the tubing straight ***you may need to place it in a pink bucket on the floor***
        - Never lift the tubing to empty the urine into the bag. This dumps dirty urine back into the bladder
        - Do not loop the tubing on the bed
    - Keep the system closed-there is no need to change the bag unless it is damaged, leaking, etc.
        - Flushing only with a physician order
    - Make sure the Foley has a securement device
    - Do not change the Foley at routine intervals
    - Do not let the bag lay on the floor
- **Documentation:**
    - Does the patient meet the criteria to have a Foley? If so, which criteria. If not, have a discussion with the physician/LIP to see if it can be removed.
    - Document the care you provided
    - Q shift any signs and symptoms to include but not limited to:
        - Fever, suprapubic tenderness, flank pain, urgency, any other urinary s/s
        - Urine characteristics, cloudy, odor, color, etc.

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI) PREVENTION

Infection Prevention

- ***Assess the connector each shift for evidence of leakage, damage, and cleanliness.***
- ***Wash hands with soap and water for a minimum of 20 seconds with soap and water or with alcohol gel, enough to cover all surfaces of hands, continue rubbing until dry***
- ***Don non-sterile gloves prior to any access of the connector and/or tubing***
    - ***Giving meds***
    - ***Flushing***
    - ***Changing the connector***
    - ***Connecting or changing tubing***
- ***Scrub the connector, using friction, with an alcohol prep pad for at least 10 seconds and allow it to completely and passively dry, if the product doesn't dry the germs won't die***
- ***Cover all connectors/connections prior to bathing or showering your patient***
- ***All central line dressings are to be covered with a waterproof barrier while showering. This includes any tunneled catheter that is open to air***

Central Line Dressing and Needleless Connector Change

1. Gather your supplies
    a. Central Line Dressing change kit
    b. Needleless connectors
2. Wash your hands
3. Identify patient using two patient identifiers
4. Explain the procedure to the patient
5. Don a mask
6. Place a mask on the patient and anyone in the room
7. Don non-sterile gloves
8. Remove and discard old dressing
9. Remove and discard Statlock ***be careful not to dislodge the central line or cause pistoning of the line (the line moving in and out of the insertion site)
10. Open kit; be sure you maintain your sterile field.
11. Don sterile gloves
12. Activate the Chloraprep swab. Use a vigorous back and forth scrubbing motion to cleanse site for a minimum of 30 seconds. Be sure to cover all surfaces that will be covered by Statlock and dressing.
13. Allow Chloraprep to completely and passively dry, <u>if the Chloraprep doesn't dry the germs won't die, this will take **a minimum of 30 seconds.**</u>
14. Apply skin protectant to area under the Statlock.
15. Use one package of alcohol swabsticks to cleanse the line. Wipe from the insertion site out, never go back to the insertion site, one swipe and discard. ***Retain second pack of alcohol swabs to change the needleless connector.
16. Place the wings of the PICC line in the doors of the Statlock prior to placement of the Statlock on the skin. Once the PICC wings are secured in the Statlock then remove the backing and place the Statlock on the skin.
17. Apply the Biopatch, blue side up, with the slit towards the line.
18. Apply the occlusive dressing
19. Date, time and initial your dressing
20. Use alcohol prep pad to cleanse the connector between the needleless connector and the line, remove connector.
21. Use second pack of sterile alcohol swabs to cleanse the outside of the open hub. Do not get aggressive with cleansing the internal lumen of the catheter.
    ********DO NOT CLEANSE THE OPEN HUB WITH ANY PRODUCT THAT IS NOT STERILE********
22. Place new needleless connector
23. Remove gloves, discard used supplies
24. Document dressing change on the MAR and on the Nursing Assessment Flowsheet.

**Remember that central line dressing are to be changed every seven (7) days, more frequently if the site or dressing is not clean, dry and intact.

**Needleless connectors closest to the patient are to be changed on Tuesday when the dressing is changed.

**All other needleless connectors will be changed when tubing is changed, every 72-96 hours.

**Intermittent tubing and needless connector are to be changed every 24 hours

**TPN Tubing and needleless connector are to be changed every 24 hours

Tubing and Connector Change

- Needleless connector is to be changed every 7 days unless leaking soiled or damaged. At Cornerstone this is done every Tuesday
- Needleless connectors used to infuse TPN should be changed every 24 hours

- Connectors attached to intermittent tubing, bifurcates, etc., should be changed with every tubing change, EVERY 72-96 hours
    - Connector attached to an implanted port, Huber needle, are to be changed with every access of the port/needle change
- Intermittent tubing, tubing that is disconnected for greater than 30 minutes in a day, should be changed every 24 hours.

DRAWING BLOOD SPECIMENS

Correct order of draw
Blood Cultures-ALWAYS draw before any other labs
Red or Gold
Navy
Light Blue (coags)-NEVER draw first. ALWAYS fill to full, short draws will be rejected as the skew results
Green
Lavender/Purple
Pale Yellow
Gray

Peripheral Draw-Non Blood Culture

1. Check the physician order
2. Assemble you supplies
3. Wash your hands
4. Don gloves
5. Explain the procedure to the patient
6. Identify patient using two patient identifiers
7. Use tourniquet to identify your site then release the tourniquet
8. Cleanse the venipuncture site with alcohol using a vigorous back and forth scrubbing motion for 10-15 seconds. Allow the site to completely and passively dry (if the product doesn't dry the germs won't die)
9. Reapply tourniquet
10. Perform venipuncture and collect blood specimen using **correct order of draw** (above)
11. Release tourniquet, remove needle, apply pressure and bandage venipuncture site
12. Dispose of supplies, all sharps in the sharps container
13. Gently invert tubes 8-10 times-do not shake tubes as this can cause hemolysis
14. Label tube in patient room as follows:
    a. Patient name
    b. Patient MRN
    c. DOB
    d. Date and Time of draw
    e. Your employee ID#

Central Line Draw-Non Blood Culture
All blood specimens drawn from a central line MUST have a physician/LIP order

1. Steps 1 thru 6 above

2. Cleanse the needleless connecter at the connection between the connector and the line using friction for 10-15 seconds. Allow site to completely and passively dry (if the product doesn't dry the germs won't die)
3. Luer lock a 10 ml syringe on to the hub
4. Withdraw your blood specimen
5. Place a new needleless connector and flush per protocol
6. Fill tubes using **correct order of draw** (above)
7. Step 12-14

Blood Cultures-Peripheral

1. Check the physician order
2. Assemble you supplies
3. Wash your hands
4. Don gloves
5. Explain the procedure to the patient
6. Identify patient using two patient identifiers
7. Cleanse your blood culture bottles with alcohol pad, discard, cleanse with a second alcohol pad and leave the second pad on until you are ready to inoculate the bottle
8. Use tourniquet to identify your site then release the tourniquet
9. Cleanse the venipuncture site with Chloraprep using a vigorous back and forth scrubbing motion for 30 seconds. Allow the site to completely and passively dry (if the product doesn't dry the germs won't die)
10. Reapply tourniquet
11. Perform venipuncture and collect blood specimen using (2) 10 ml syringes. 20 ml is the preferred volume.
    Ensure that your supplies remain clean, do not lay on any surface unprotected
12. Release tourniquet, remove needle, apply pressure and bandage venipuncture site
13. Dispose of supplies, all sharps in the sharps container
14. Place 10 ml in the green bottle (aerobic) and 10 ml in the orange bottle (anaerobic)
    a. If you have less than 20 ml, put 10 ml in the green bottle and the remainder in the orange bottle
15. Label tube in patient room as follows:
    a. Patient name
    b. Patient MRN
    c. DOB
    d. Date and Time of draw
    e. Your employee ID#
    f. Source-please note that blood is not the source, PERIPHERAL is the source
    g.

Blood Culture-Central Line

All blood specimens drawn from a central line MUST have a physician/LIP order

WE DO NOT DRAW FOR WASTE

DO NOT CHANGE THE MICROCLAVE CONNECTOR EITHER BEFORE OR AFTER YOUR DRAW

1. Steps 1-7 above
2. Use friction to cleanse the needleless connector with Chloraprep for 30 seconds. Allow the site to completely and passively dry (if the product doesn't dry the germs won't die)
3. Access the connector and with (2) 10 ml syringes withdraw your specimen…..Do NOT draw waste.
   Ensure that your supplies remain clean, do not lay on any surface unprotected
4. Flush per protocol
5. Place 10 ml in the green bottle (aerobic) and 10 ml in the orange bottle (anaerobic)

a. If you have less than 20 ml, put 10 ml in the green bottle and the remainder in the orange bottle

6. Label tube in patient room as follows:
    a. Patient name
    b. Patient MRN
    c. DOB
    d. Date and Time of draw
    e. Your employee ID#
    f. Source-please note that blood is not the source, LINE is the source, if the patient has more than one central line be specific

VENTILATOR ASSOCIATED EVENT (VAE) PREVENTION

1. Perform hand hygiene and wear gloves while performing patient care
2. Ensure the HOB is up to at least 30° unless medically contraindicated
3. Assess daily readiness to wean
4. Sedation vacation
5. DVT prophylaxis
6. Oral care Q 4 hours and PRN
7. Avoid gastric distention

BLOODBORNE PATHOGENS AND PERSONAL PROCECTIVE EQUIPMENT

1. Exposure to blood borne pathogens can occur through: contact with broken, chapped, or cut skin; needle stick injuries; and contact with mucous membranes.
2. The medical center maintains a Universal Precautions policy.
3. Personal protective equipment helps you practice universal precautions and is one of your best defenses against exposure to infectious materials. When you use the appropriate personal protective equipment, and use it correctly, you can significantly reduce your risk of infection.
4. When using personal protective equipment, be sure it:
    a. Fits properly each time you use it.
    b. Provides you with the protection you need. It should not allow blood or other potentially infectious materials to pass through our reach your clothes, skin, eyes, mouth, or other mucous membranes.
5. Cornerstone Hospital provides the following personal protective equipment for your safety. For the location of this equipment or if you have any questions, please see your area manager.
    a. Gloves - powered/powder-free/latex-free
    b. Face masks
    c. Particular respirator face masks (to be used with respiratory isolation)
    d. Face shields
    e. Goggles
    f. Impervious gowns

g. Shoe covers
h. Surgical caps
i. ABG needle resheathers
j. Protective IV angiocaths
k. Safety BGM lancets
l. Sheathed syringes
m. Protected butterfly needles
n. Protected vacutainer barrels
o. Plastic blood collection tubes
p. Sharps containers in various sizes
q. Needleless IV system

Occupational Exposure to Blood Borne Pathogens

1. Reportable Exposures

   a. All needle sticks and skin penetrations from sharp instruments.
   b. Splashes involving contact of body secretions with mucosal surfaces.
   c. Skin contact with body secretions.
   d. Accidental ingestion of body secretions.

2. Reporting Procedure - Immediate reporting is essential, since treatment regimens, when indicated, must begin within one to two hours.

3. Report to:

   a. Notify the House Supervisor on duty **AND**
   b. Call the Employee Health Office at ext. 5541 (M - F 7:30 a.m. - 4:00 p.m.) if open **AND**
   c. Call the company you work for **AND**
   d. You will be directed by your Agency for follow up care.

INCIDENT REPORTING

All reportable incidents should be reported to the House Supervisor. An incident report must be completed and placed in the DQM mailbox in the Charge RN office.
Some incidents that require reporting include, but are not limited to

- Patient falls
- Medication errors or near misses Specimen labeling errors
- Missed order for treatment, medication, etc. Narcotic discrepancy
- Removal of a patient's ID bracelet
- Significant delays in treatments or disposition

- **ABUSE POLICY**
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TITLE	POLICY #
Abuse, Reporting Suspected Abuse	**CL-2.5**

MANUAL	EFFECTIVE DATE	REVISE DATE
Clinical	**07/15/95**	**9/11, 5/13, 10/13, 2/14**

SCOPE:	REFERENCE
Patient Safety	**TJC Standard PC.01.02.09**

- **Purpose:**
- To provide criteria for identifying victims of abuse, neglect or exploitation. To provide a procedure for staff to follow when they suspect that a patient has been abused, neglected or exploited.

- **Policy:**
- Hospital staff is trained in the use of identifying criteria to objectively recognize possible victims of abuse, neglect or exploitation. Material is strictly privileged and confidential disclosure to any unauthorized person may constitute an unlawful violation. This policy applies to all hospital staff and non-hospital health professionals who are involved in the care of a patient.

- **Procedure:**
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1) Definitions

i) **Elder** means any person, 65 years of age or older.=

ii) **Dependent Adult** means any person between the ages of 18 and 64 who has physical, developmental, or mental limitations which restrict his or her ability to carry out normal activities to protect including, but not limited to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

iii) **Abuse of an Elder or Dependent Adult** means physical abuse, neglect, intimidation, cruel punishment, abandonment, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

iv) **Physical Abuse** means all of the following as defined in the Penal Code; assault and battery; assault with a deadly weapon or force likely to produce great bodily injury; sexual assault (sexual battery, rape, rape in concert, incest, sodomy, oral copulation, penetration of a genital/anal/ opening by a foreign object); as well as unreasonable physical constraint, or prolonged or continual deprivation of food or water; and use of a physical or chemical

restraint, medication or isolation, including but not limited to, for staff convenience, for punishment, or for a period beyond that for which it was ordered.

v) **Fiduciary Abuse** means a situation in which any person having the care or custody of an elder, dependent adult, or child, or who stands in a position of trust to an elder or dependent adult, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of his or her trust.

vi) **Neglect** means the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care, which a reasonable person in a like position would exercise. Self-neglect must also be reported. Neglect includes, but is no limited to, all of the following;

(vi.1.a) Failure to assist in personal hygiene or in the provision of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.

(vi.1.b) Failure to provide the mental care for the physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(vi.1.c) Failure to protect from health and safety hazards.

(vi.1.d) Failure to prevent malnutrition.

vii) **Abandonment** means the desertion or willful forsaking of elder or dependent adult by anyone having care or custody of that person under circumstances that a reasonable person would continue to provide care and custody.

viii) **Mental Suffering** means deliberately subjecting a person to fear, agitation, confusion, severe depression, or other forms of serious emotional distress, through threats, harassment, or other forms of intimidating behavior.

ix) **Reasonable Suspicion** means that it is objectively reasonable for a person to entertain such suspicion based upon facts that could cause a reasonable person in a like position; drawing when appropriate upon his or her training and experience to suspect abuse.

x) **Caretaker** means any person who has the care, custody, or control of, or who stands in a position of trust with an elder or dependent adult. This term includes the Human Services provider, related or unrelated.

xi) **Care Custodian** is an administrator or employee of public or private facilities when the facilities provide care for elders or dependent adults. The service provider/employee of the in-home supportive services recipient does not fall within the definition of the “care custodian” as a mandated report.

- xii) **Financial Abuse** is a form of mistreatment and fraud in which someone forcibly controls another person's money or other assets.
- xiii) **Financial Exploitation** this involves unauthorized use of an elderly person’s funds or property, either by a caregiver or an outside scam artist.

- **<u>Reporting Procedure:</u>**

xii) Any staff member who reasonably suspects abuse is required by law to report such suspicions.

(xii.1.a) Report possible signs of mistreatment to the Case Manager/Social Worker.

xiii) A clear notation must be placed in the progress notes of the medical record.

xiv) Nursing /Case Management will support the attending physician or one whom he or she designates to inform the family/significant other(s) unless otherwise determined by the interdisciplinary team.

xv) If sexual abuse is suspected, or abuse that will require a chain of evidence, report to the Hospital Administrator or designee and Case Manager/Social Worker.

xvi) The Case Manager/Social Worker will report as follows:

(xvi.1.a) Call the State Department of Elderly Protective Services for those patients age 65 or above.

(xvi.1.b) Call DHH/Bureau of Protective Services, for disabled adults age 18-64.

(xvi.1.c) Contact the Police department or Sheriff for those patients with suspected sexual assault or abuse and arrange transfer to an Emergency Department for collection of evidence.

(xvi.1.d) Complete the form for each incident and each victim of suspected abuse. If any item of information is unknown, write "unknown" beside the item. It is imperative that the reporting party signs this report.

(xvi.1.e) Mail the completed report form to the state agency as requested.

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xvii) A copy will be placed in the patient's chart and the Case Manager/Social Worker will maintain a copy for follow-up.

xviii) Nursing and the interdisciplinary team will be informed by the Case Manager/Social Worker about any protective service investigation or action, which occurs, and clear documentation is recorded in the medical record.

xix) Signatures are not required of police photographers.

xx) If the case is still open at the time of discharge, the protective agency will be notified prior to discharge of patient.

xxi) Protection of privacy can be achieved by use of business cards, ID cards, identification badges, and verification of callers by placing a return call to the agency prior to conversation.

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2) **Possible Signs/Symptoms of Abuse**

i) Dependent Adult/Elder

(i.1.a) Physical Abuse:

i.1.a.i.1. Frequent unexplained injuries such as black eyes, cuts, bruises, and c/o pain with obvious injury.

i.1.a.i.2. Burns/bruises in unusual patterns

i.1.a.i.3. Passive, withdrawn behavior

i.1.a.i.4. Lack of reaction to pain

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(i.1.b) Neglect:

i.1.b.i.1. Obvious malnutrition; begging for food

i.1.b.i.2. Lack of cleanliness; dirty clothes

i.1.b.i.3. Obvious fatigue and listlessness

i.1.b.i.4. Unattended need for medical and dental care

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(i.1.c) Sexual Abuse:

i.1.c.i.1. Evidence of injury to genital area; signs of STD

i.1.c.i.2. Difficulty sitting/walking

i.1.c.i.3. Fear of being alone with a caretaker

- (i.1.d) Exploitation: Evidence of improper use of elderly person's resources for personal gain
  - i.1.d.i.1. Vague with few details
  - i.1.d.i.2. Changes in explanation
  - i.1.d.i.3. Highly unlikely story
  - **i.1.d.i.4.** Discrepancy in history of injury/physical exam
- (i.1.e) Delay in Seeking Medical Care
  - i.1.e.i.1. Delay of over four hours
- (i.1.f) Family/Custodian Behavior:
  - i.1.f.i.1. Lack of concern and interest in patient, the condition, or prognosis
  - i.1.f.i.2. Resistive /irritable when asked for details of the accident
  - i.1.f.i.3. Depressed, preoccupied, limited eye contact
  - i.1.f.i.4. Refusal to consent to diagnostic procedures
- (i.1.g) Financial Abuse
  - i.1.g.i.1. Sudden changes in legal documents such as wills, power of attorney.
  - i.1.g.i.2. Unfamiliar family or friends claiming to have rights to "help" with a person's affairs and/or possessions.

ii) Criteria for Identifying Possible Victims of Domestic Abuse

- (ii.1.a) High Risk History
  - ii.1.a.i.1. Extent or type of injury are inconsistent with patient's explanation
  - ii.1.a.i.2. Delay in seeking medical care
  - ii.1.a.i.3. "Accident prone" patient
  - ii.1.a.i.4. History of children or other family members being abused
  - ii.1.a.i.5. Frequent visits to the Emergency Department
  - ii.1.a.i.6. High stress in the family, i.e., financial, pregnancy
  - ii.1.a.i.7. Drug abuse or alcoholism
  - ii.1.a.i.8. Patient presents with chronic nonspecific complaints
- (ii.1.b) High Risk Findings
  - ii.1.b.i.1. Injuries to face, neck, head and chest, such as blackened eyes, dental injuries, strangulation marks, injuries to the breast
  - ii.1.b.i.2. Lacerations or burns in unusual shapes or locations, such as areas hidden by clothing
  - ii.1.b.i.3. Injuries to areas not proven to be injuries by falls, unusual fractures or dislocations
  - *ii.1.b.i.4. Contusions in varying degrees of healing*
  - ii.1.b.i.5. Injuries to multiple sites
  - **ii.1.b.i.6.** Symmetrical injuries
  - ii.1.b.i.7. Mid-arm injuries (defensive)

ii.1.b.i.8. Problems during pregnancy, such as abdominal injury, bleeding, miscarriage, or multiple miscarriages\

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(ii.1.c) High Risk Behaviors

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ii.1.c.i.1. Patient is evasive and guarded
ii.1.c.i.2. Patient is embarrassed with poor eye contact
ii.1.c.i.3. Patient reports fatigue, anxiety, sleeplessness, and loss of appetite
ii.1.c.i.4. Patient is depressed with injuries
ii.1.c.i.5. Patient denies abuse too strongly
ii.1.c.i.6. Patient minimizes injury or demonstrates inappropriate responses such as crying or laughing
ii.1.c.i.7. Patient displays guarded or fearful behavior with a family member/partner

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- **CODE/RRT**

• TITLE		• POLICY #
• Code Blue		○
• MANUAL	• EFFECTIVE DATE	• DATES
• **Nursing and Pharmacy**	• **10/1991**	• Revisions: 1/10, 6/12, 8/12, 5/13, 8/2013 • Reviewed:
• SCOPE:	• REFERENCE	
• Cornerstone Hospital of SEAZ	•	

- **PURPOSE:**
- To set in operation an organized plan for treating cardiopulmonary arrest.
- **SCOPE:**
- This policy is applicable to all patient care and ancillary service areas.
- **EQUIPMENT NEEDED:**
  1. Crash Cart
  2. Defibrillator
  3. Resuscitation bag
  4. Portable oxygen
  5. Suction
  6. Intubation Box
- **POLICY:**

A. Code Blue is the code used to designate that a patient is in respiratory or cardiac failure that may, or has already, resulted in arrest.
B. Code blue will not be called for a patient who has been recognized as a Do Not Resuscitate (DNR).
C. The Code Blue page is answered by:
   1. A Nurse
   2. A Respiratory Therapist
   3. A Pharmacist, (if available)
   4. A Certified Nursing Assistant (CNA)
D. Any clinical employee trained in Basic Life Support may initiate CPR.
E. All hospital employees will remain aware of procedure for calling a “CODE BLUE” through annual in-services.

F. At least one ACLS certified employee will remain with the patient and initiate the Code Blue procedure.
G. If any Cornerstone employee or medical staff with a higher level of training and proficiency in resuscitative procedures arrives, they may be asked to direct the code.
H. IV access will be established by a qualified member
I. The attending physician or the physician on call will be notified as soon as possible.
J. If needed, critical care transport will be called by a designated staff member.
K. ACLS trained staff will treat patient per American Heart Association (AHA) guidelines using ACLS protocol and algorithms, in addition to communication with physician.
L. When a Physician is not present:
    1. The Zoll M defibrillator has external pacemaker capabilities with the use of two (2) disposable pads that function as ECG electrodes and pacing wires simultaneously. As a result of this feature, ACLS certified staff may perform external pacing in the presence of severe bradycardia without a physician's order.
    2. The Code Blue will be conducted according to the American Heart Association Universal Algorithm for Adult Emergency Cardiac Care, which includes the Ventricular Fibrillation, Pulseless Ventricular Tachycardia, Pulseless Electrical Activity, and Asystole Treatment Algorithms. ACLS certified staff will not need a separate physician's order to perform the functions of these algorithms.

- **PROCEDURE:**

A. Recognize Symptoms of Cardiac Arrest:
    1. Check for pulse by placing fingers directly on carotid artery.
    2. Loss of consciousness:
        a. Determine by physical stimulation, call out patient's name, roughly rub sternum or shake patient to be certain patient is not in a deep sleep. Shake and Shout.
    3. Assess respiration
        a. Gasping or irregular respiration's leading to apnea.
    4. Dilation of Pupils

- B. Initiate "Code Blue":

1. PATIENT'S ROOM: Access the overhead paging system and announce "Code Blue to Room _____", or pull the call bell out of the wall or the emergency cord in the bathroom and announce to the person answering to "Page Code Blue". If there is no response to the call system, shout "Code Blue" and the patient's room number three (3) times. The person answering the call will access the overhead paging system and announce "Code Blue" and the patient's room number three (3) times.

C. Code Blue Team:
    1. The Code Blue Team members will be responsible for handling the procedures during a code situation in a safe, efficient, and timely manner.
    2. The Code Blue Team will consist of at least four (4) Nurses, minimum of one (1) Respiratory Therapist, one (1) Certified Nursing Assistant, and a Pharmacist (if available).
    3. The Team Leader will be ACLS certified. The Team Leader will manage the defibrillator and contents of the Crash Cart or designate another team member to do so. The additional team members will do one of the following:
        a. Make required phone calls (Physician, facility to receive transfer, family).

a.i. The Physician once notified will stay on the phone with the team leader to provide oversight and assistance.

b. Obtain IV access and administer medications (IV push medications will only by administered by the RN).
c. Document the events on the Cardiopulmonary Resuscitation form.
d. Perform CPR.
e. Copy information for EMS if patient is to be transferred. (Code Blue Record Sheet, Face Sheet, most recent lab work, Chest X-ray, EKG strip, H&P, current MAR).
f. The Respiratory Therapist will maintain the airway, obtain ABG's, administer oxygen, intubate if necessary, and set up for ventilator use.

4. Any physician that is in the facility at the time of the code will respond to the code and provide support to the team leader.

- **CARDIO-PULMONARY RESUSCITATION:**
- A. Follow American Heart Association guidelines
- **INTRAVENOUS ACCESS (I.V.)**

A. If needed, a peripheral IV will be started.
B. Central Line may be started by a physician if necessary.

- **CARDIAC MONITOR AND DEFIBRILLATOR:**

A. Apply leads if not already in place, and obtain a rhythm strip.
B. If monitor shows asystole, continue cardiac compression and administer drugs per current American Heart Association ACLS protocol.
C. Based on ACLS protocol, if defibrillation is required:

- ACLS trained staff, who have received appropriate ACLS training may initiate defibrillation. Defibrillation should be performed based on specific defibrillator type and manufacturer's recommendation.

D. Following defibrillation, and based on patient assessment and cardiac rhythm, administer appropriate medication per ACLS protocol/algorithm.
E. See specific American Heart Association ACLS Protocol/Algorithm for treatment of cardiac rhythms.

- **CODE BLUE TEAM TRAINING**
- A. Staff serving on the Code Team must meet the following qualifications:

• Position	• Pre-Requisite
• Team Leader • Arrhythmia recognition	• a. BLS training • b. ACLS training
• Team Member	• a. BLS training • b. Training in airway and ventilation: use of adjunctive airway devices
• Team Member • (cardiac compressions)	• a. BLS training • b. Proficient technique

• Team Member • Medication	• a. BLS training • b. ACLS training • c. RN • d. Proficient at veni-puncture
• Team Member • Recorder	• a. BLS training • b. ACLS training

•In the event of limited staff, team members may assume more than one role.

- B. Eligibility

•A person to be eligible to follow/direct protocols must be a current ACLS Provider.

- C. Advanced Cardiac Life Support Training
  - 1. Basic life support
  - 2. Advanced Cardiac Life Support
  - 3.Use of adjunctive equipment for ventilation and circulation (including endotracheal intubation)
  - 4.Cardiac monitoring for dysrhythmias recognition and control
  - 5.Defibrillation, synchronized cardioversion, and external pacing
  - 6.Establishing and maintaining an intravenous infusion
  - 7.Employing definitive drug therapy (to correct acidosis to establish and maintain cardiac rhythm and circulation)
  - 8. Stabilization of patient's condition.

- **RESTOCK CODE/CRASH CART**

a.A.Charge Nurse: It is the responsibility of each Charge Nurse to insure the crash carts are cleaned and restocked.

a.B.Pharmacy: Pharmacy to replace all medications as needed and maintain seals on code cart.

a.C.At the end of each month, Pharmacy checks the entire cart to ensure all drugs in the cart are in date. Expiration dates are posted with the list of drugs in the cart and this list is kept on the cart.

a.D.The first med to expire is noted, with the expiration date and pharmacist initials on a sticker to be placed on the cart.

a.E.Respiratory Therapy: Replace emergency respiratory equipment and place a seal to alert pharmacy of need for numbered locks.

a.F.Clean and replace all other equipment used. Note: the laryngoscope blades are to be washed with soap and water, and then soaked in Cidex solution for 1 hour. The laryngoscope handle is to be cleaned with a germicidal cloth.

- **INFECTION CONTROL**

- Any multi-patient use equipment must be cleaned with Hydrogen Peroxide wipes when coming out of the room, Bleach wipes if the patient is on Soap and Water Precautions
- The clean Ambu bag will be contained in a closed plastic bag and will hang on the side of the crash cart.
  - B. Maintenance of Defibrillator and Intubation Boxes

- The defibrillator will be checked daily by firing a “test load” and checking for proper performance. In addition, the cart will be inspected to assure lock integrity and medication expiration date. The intubation boxes will be checked at least daily and preferably each shift. Respiratory Care and Nursing Services will assure that all equipment is present and working properly. A current log for these checks will be kept with the defibrillator. Completed records will be kept by the Quality Manager. Problems identified should be reported immediately for correction as follows.
  - 1. All problems to Chief Clinical Officer/ Director of Quality
  - 2. For defibrillator problems – notify Bio-Medical Services.
  - 3. Problems related to O2/intubation equipment - notify Respiratory Care Services

- C. Equipment Checks by Biomedical Engineering
- 1. Each crash cart defibrillator will be checked and certified as Power Safe on its arrival and yearly. Each defibrillator will be checked every six months by Biomedical personnel for safety and performance, according to their specified guidelines. Following this evaluation, a defibrillator calibration sticker should be placed visibly on the defibrillator. A copy of the check sheets should be kept on the floor where the crash cart is located and by Biomedical Engineering.
- 2. If a problem is found during the check, Biomedical personnel should collaborate with the Chief Clinical Officer/Director of Quality providing information on the problem and plans for the correction. If it is necessary to remove a defibrillator for maintenance, arrangements for a replacement unit will be made.
-
- **EMERGENCY RESPONSBILITIES:**
  - All hospitals are required to appraise medical emergencies, provide initial treatment, including code blue activities, and referral when appropriate. A hospital is not in compliance with Medicare Conditions of Participation if it relies on 9-1-1 services as a substitute for the hospitals own ability to provide services.
  - We have the ability to Code a patient in our hospital. We cannot use EMS or others who arrive from an outside agency, in response to a call to transport a patient, to provide direct patient care, including participating in a code while that patient remains in our hospital.
  - Once the transport service has been given permission to take the patient to the designated receiving facility, personnel from that transport service will use their own equipment and take over direct care of the patient. However, should the patient destabilize (code again) in our building the patient remains our responsibility and we provide direct patient care until it is determined that the patient can be transported.
  -
  - **CODE REVIEWS**

A. After a code blue the code team leader will initiate a post code review discussion with all team members present at code and complete the team leader portion of the code review form before the end of shift.

B. The Code Blue Review Form will be forwarded to the Chief Clinical Officer for assessment and follow up. The CCO will conduct an investigation and follow up with any identified problems listed on the Code Blue Review Form.

C. The Code Blue Form and supporting documents will be forwarded to the medical staff assigned to the code review peer reviews.

D. The Medical Staff Code Blue Reviewer will review the code sheet, code blue review form along with the patient's chart and complete the physician review portion of the form.
E. Results of review will be discussed in code blue committee meeting and action plans will be developed.
F. The results of the code blue reviews, physician peer reviews and code blue committee action plans and follow up will be reported to the Quality Improvement Committee for review and discussion.
G. A report of all code blues code blue analyses will be presented to the Medical Executive Committee and the Governing Board

• TITLE		• POLICY #
• Rapid Response Team		○ CHG-L20:10:0
• MANUAL	• EFFECTIVE DATE	• REVISE DATE
• Clinical Services	• 9/14/07	• 10/17/2010, 02/14/2013
• SCOPE:	• REFERENCE	
• Organization Wide		• ***JCAHO CAMH NPSG***

- ○ **PURPOSE**

- To establish a procedure for Rapid Assessment of a patient with acute status changes. The goal of the Rapid Response Team (RRT) is to improve patient outcomes by providing a means for rapid and timely intervention for a declining patient.

- ○ **POLICY**

1. **Criteria Guidelines for Initiating the RRT**

• Any, or all, of the criteria meets the guidelines for initiating the RRT. The key to using the guidelines appropriately, is early identification of the following:

a. Staff member worried/concerned about patient.
b. Acute change in heart rate less than 40 bpm or greater than 130 bmp.
c. Acute change in SPB less than 90 mmHg or greater than 170 mmHg.
d. Acute change in respiratory rate less than 8 or greater than 28 breaths per minute.
e. Acute and persistent change in saturation less than 90%.
f. Acute change in mental status/level of consciousness.
g. Acute significant bleed.
h. Seizures
i. Failure to respond to treatment.
j. Uncontrolled pain.
k. Suspected aspiration.
l. Chest pain – new or onset unrelieved with NTG.

- 2. **RRT Structure**

•The RRT Structure is a group of clinicians who will bring critical care expertise to the declining patient at bedside. The RRT will consist of an ACLS-Trained RN, an ACLS-Trained Respiratory Therapist (RT), and the Floor Nurse caring for the patient. Rapid Response Team assignments will be made each shift.

3. **Activation of the RRT**

a. Any staff member may call for the RRT when Rapid Assessment and Interventionis deemed necessary for a declining patient, based on the guidelines.

b. After a brief assessment, the nurse will verbally notify the Rapid Response Team. The Overhead Paging System may be used, if needed.

c. If the assigned nurse is not in the immediate location, the nurse will be notified ASAP.

d. The RRT will notify the attending or on-call physician immediately following the RRT's Initial Assessment.

4. **RRT Responsibilities**

a. The RRT will respond within two (2) minutes.

b. The Floor Nurse will have prepared for the team:
- The RRT Documentation Tool Form
- Patient Chart
- Current Medication List
- Recent Vital Signs

c. The Floor Nurse must remain at the patient's bedside and assist the RRT.

d. The Floor Nurse should be prepared to provide the following information upon arrival of the RRT:
- What prompted the RRT call?
- Current HR, RR, BP, Temp.
- Interventions already attempted and the results.
- Code Status
- Allergies
- Pertinent Medications
- Pertinent Medical History
- Recent Labs/Diagnostic Tests

e. The RN is deemed the Team leader and will perform the Initial Assessment and assist the Floor Nurse with:
- Physician Communication
- Obtaining Appropriate Orders
- Initiation of Physician Orders

f. The Respiratory Therapist will perform a complete Respiratory Assessment and initiate intervention, as appropriate, per Policy Guidelines.

g. The RRT will:
- Collaborate Assessment findings and recommendation for intervention.
- Immediately implement treatment or diagnostic services, as appropriate, per Policy.
- Call a "CODE BLUE" and initiate ACLS Procedures, if indicated.
- Assist with implementation of Physician Orders.
- Assist with transport of patient, when necessary.

5. **Assessment Guidelines**

a. The RRT RN will perform the Initial Assessment to include and/or consider:
- Vital Signs
- Blood Glucose
- Cardiac Rhythm
- Neurological Status
- Fluid Status
- Skin Condition
- Pain
- Anxiety
- Recent Medication History
- Lab Values
- Diagnostic Test Results

b. The RRT Respiratory Therapist will perform the Initial Respiratory Assessment to include and/or consider:
- Breath Sounds
- Work of Breathing
- Ventilator Pattern and Status
- Chest Assessment
- Oxygenation
- Airway Clearance
- Ventilation
- Recent Respiratory History (Last Treatment Given)
- Past Respiratory History

6. **<u>RRT Immediate Interventions</u>**

a. The RN may initiate the following prior to physician contact:
- Cardiac Monitoring
- Currently Ordered PRN Medications
- Establish Intravenous Access
- Lab Work pertinent to the Assessment Findings

b. The Respiratory Therapist may initiate the following prior to physician contact:
- 12 Lead EKG
- Oxygen Application
- Oral, nasal, tracheal, or artificial airway suctioning.
- Arterial blood gas puncture.
- Placement of an oral nasal airway (intubation will be performed by calling CODE BLUE).
- Hand-held nebulizer (Albuterol 2.5mg and 3ml NaCl x 1).

7. **<u>Post RRT Monitoring</u>**

a. Vitals signs will be taken post RRT every 2 hours for a total of 6 hours. At the end of the 6 hours the patient will be reassessed to decide if the patient is stable and if there is a need to continue to monitor.

8. **<u>RRT Documentation</u>**

a. The RRT will document on the designated Rapid Response Team Record by the RN House Supervisor, Charge RN, or designee.

b. The nurse will properly transcribe physician orders in the patient Chart and MAR, as indicated.
c. The Rapid Response Team Record Form will be filed in the patient Chart under the Nurses Notes Section.
d. A copy of the Rapid Response Team Record Form will be forwarded to the Chief nursing Officer/Chief Clinical Officer.
e. All Rapid Response Team Records will be reviewed by MD in same manner as Code Evaluations to identify opportunities for education and/or improvement.

- 9. **Communication**
  - The RN will communicate the assessment findings and recommendations of the team to the physician
- 10. **Evaluation**
- All RRT's will be evaluated by the Charge Nurse after the RRT. The CNO/CCO or designee will do the follow up within 48 hours of the event and all findings will be brought to quality committees to include QAPI, MEC, and Governing Body.

ADVANCE DIRECTIVES

TITLE		POLICY #
Advance Directives		
MANUAL	EFFECTIVE DATE	REVISE DATE
Nursing	**August 1993**	**January 2011, May 2013, October 2013**
SCOPE:	REFERENCE	
Tucson, Arizona	**CFR 482.13(b)(3)**	

PURPOSE:

Health care providers are required by the Patient Self-Determination Act of 1990 to advise adult patients of their rights to make health care decisions, to formulate advance health care directives, and to accept or refuse medical or surgical treatment. Cornerstone Hospital will inform adult patients with capacity about their options and rights to make their own decisions;

provide support and assistance to individuals desiring advance directives; and educating patients, professionals, and the community. The purposes of this program are to ensure statutory compliance and to enhance patient autonomy and self-determination.

- **POLICY:**

- It is the policy of Cornerstone Hospital to comply with the Natural Death Act, the Durable Power of Attorney for Health Care Act, and the Out-of-Hospital Do Not Resuscitate Order regarding informed consent and the patient's right to accept or refuse medical or surgical treatment. This facility routinely does not provide mental health services. However, in accordance with federal law, it is the policy of Cornerstone Hospital to provide additional written information to all adult inpatients, upon admission, regarding their right to make a Declaration for Mental Health Treatment. Because of these requirements and to honor the wishes of the patient or patient's legal representative regarding medical treatment and the withdrawal or withholding of life-sustaining procedures, it is the policy of Cornerstone Hospital to provide written information to all adult inpatients, with capacity, regarding:

(1) their right to accept or refuse medical or surgical treatments; and
(2) their right to make advance directives

- It is the policy of Cornerstone Hospital to document in each patient's medical record whether or not he/she has executed an advance directive.

- It is the policy of Cornerstone Hospital to allow a surrogate decision-maker, under the specified provisions in the Consent to Medical Treatment Act, to consent to preventative care and medical treatment to maintain the physical and mental condition of an adult patient who does not have the capacity or ability to make health care decisions or who does not have a legal guardian or agent named under the Durable Power of Attorney for Health Care Act.

- It is the policy of Cornerstone Hospital to provide educational opportunities to its staff and the community on issues concerning advance directives.

- Definitions:
- **Advance Directive** is defined as a "living will," a durable power of attorney for health, a "do not resuscitate" (DNR) request, an Out-of-Hospital Do-Not-Resuscitate Order, or a health care treatment directive.

- **Capacity** is defined as the functional ability to (1) comprehend information relevant to the particular decision to be made; (2) deliberate regarding the available choices, considering his/her own values and goals; and (3) communicate verbally or non-verbally his/her decisions.

- **Procedure:**

1. Upon admission, a designee (Admissions Coordinator, case manager, or member of the nursing staff) will present the patients' right brochure to the patient; however, if patient is incapacitated at the time of admission, then the information may be presented to the patient's family or surrogate, but also must be presented to the patient when he no longer is incapacitated (or patient's

representative if patient is mentally incapacitated) and provide them with a copy of the following documents:

A. Life Care Planning Packet (See attachment A)
B. Durable Health Care Power of Attorney (See attachment B)
C. Durable Mental Health Care Power of Attorney (See attachment C)
D. State of Arizona Living Will (End of Life Care) (See attachment D)
E. State of Arizona Letter to My Representative (See attachment E)
F. Pre-hospital Medical Care Directive (Do Not Resuscitate) (See attachment F)
G. Out-of-Hospital Do-Not-Resuscitate Order. (See attachment G)

-
- Patient will be instructed to discuss with attending physician before completing forms regarding advance directives. The patient will be informed that an advance directive is effective until revoked.
-

2. If the patient desires, he/she will complete the Advance Directive to Physicians, Durable Power of Attorney for Health Care or Declaration for Mental Health Treatment. The Out-of-Hospital DNR requires the attending physician's signature and may be completed only if the patient has been qualified as a terminal patient (see definitions). If the patient already has executed an advance directive prior to admission, he/she provides executed original of this, or copy with original signature, to initial hospital contact for filling in medical record. If questions arise as to the validity of an advance directive provided by the patient, these are presented to the director of nursing.
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3. If the patient asserts he/she previously has provided an executed advance directive to the facility as an inpatient, the medical record department should retrieve the document.
-
4. The advance directive is placed in the patient's medical record and appropriate personnel are notified of existence of advance directive.
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5. Chief Nursing Officer or other administrative staff receive questions regarding the validity of advance directives, notifies attending physician of questions, and notifies hospital counsel to resolve questions.
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6. When there is a question of competency or capacity of the patient to issue an advance directive, the attending physician is notified to resolve the question.
-
- 7. a. When a terminally ill adult patient is admitted with an executed Directive to Physicians, the attending physician and one other physician (both of whom personally have examined the patient), both must certify in the patient's medical record that: the patient has an incurable or irreversible condition caused by injury, disease, or illness; this condition would, without the application of life sustaining procedures, produce death; and the application of life sustaining procedures serves only to postpone the patient's death.

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b. If a terminally ill adult patient is incompetent or incapable of communication at the time of admission and has not executed or issued a Directive to Physicians, then the attending physician and legal guardian, and if no guardian, then the physician and the spouse, majority of adult children or parents, may make a treatment decision to withdraw care of the patient. The decision must be documented in the patient's medical record and signed by the attending

physician; the decision does not require the presence of witnesses. Also, if a patient does not have a legal guardian, and if the spouse, majority of adult children or parents are not available, then a treatment decision to withdraw care of a patient who is near death and who previously had not executed or issued a directive must be witnessed by another physician who is not involved in the treatment of the patient.

c. If a patient is admitted with a Durable Power of Attorney for Health Care and lacks the capacity to make health care decisions as certified in writing by the patient's attending physician, then the agent may make treatment decisions on behalf of the patient according to the terms of the power of attorney.

d. If a patient is admitted without a legal guardian or agent named under the Durable Power of Attorney for Health Care Act, and if the patient lacks the capacity to make health care decisions as certified in writing by the patient's attending physician, then certain family members under the Consent to Medical Treatment Act may consent on behalf for preventative care and medical treatment to maintain the patient's physical and mental condition; this act cannot be used to withhold or withdraw treatment.

8. The physician is responsible for the informed consent of the patient regarding advance directives and for abiding by the facility's terminal care policies. In issues of informed consent and refusals of consent, generally, the physician must abide by the policies and procedures of the facility regarding care and treatment of its patients.

9. For patients who have executed an Out-of-Hospital DNR : Upon transport outside of the facility, either the **original** of the Out-of-Hospital DNR form must accompany the patient or the patient must wear an approved Texas DNR identification bracelet as evidence that the individual has a valid Out-of-Hospital Do-Not-Resuscitate Order.

10. In the event that a patient expires while hospitalized at Cornerstone Hospital, the original Out-of-Hospital DNR form will be kept on the patient's medical record.

- **Consciences Objection**

1. Staff members may request not to participate in an aspect of patient care, including treatment, where there is perceived conflict with staff member's cultural values or religious beliefs.
2. Hospital will assure that a patient's care, including treatment, will not be negatively affected if the request is granted.

- **GUIDELINES:**

1. Inform potential employees during the pre-employment process about policies that may influence their desire for employment. Examples of policies may include “withholding of nutrients for brain-dead patients”, “abortions” or “staffing schedules”.

2. Inform employee during orientation that they may request to not participate in an aspect of care because of cultural values, ethics or religious beliefs.

3. If an employee identifies an aspect of care or service in which they do not wish to participate, they should make a request in writing to be excused from participation.

4. Requests should include the cultural, ethical or religious reasons and the aspect of care or service from which they wish to be excused.

5. The unit manager or supervisor will review the request to justify appropriateness and to see if accommodation is possible.

6. If accommodation is possible, the supervisor will notify the employee and others who need to be involved in the accommodation.

7. If events prevent the accommodation at a specific point because of an emergency situation, the employee will be expected to perform assigned duties so they do not negatively affect the delivery of care or services.

8. If accommodation is not possible, the employee will be allowed to explore other job opportunities within the hospital where an accommodation might be possible.

9. If an employee does not agree to render appropriate care of services in an emergency situation because of personal beliefs, the employee will be placed on a leave of absence from their current position and the incident will be reviewed.

DOCUMENTATION BASICS

- **Factual**
- Document only what you see, hear, smell, etc.
- Describe what you see
- Don’t use judgments such as: drunk, confused, violent
- Just the facts
- Don’t say “ate well” or “moderate amount”
- Be specific
- Avoid bias
- If you made an error in charting, draw a single line through the incorrect documentation, date
- and initial the error and re-write the correct information. Do NOT write “error” or “mistake”.
- If you made and error in the care you provided, document it
- What did you do or fail to do?
- What did you do about it?
- What was the response to your interventions?

- ** Order read Dilaudid 1mg IVP, you gave 0.5 mg. Your notes should reflect that you called the physician and the outcome of that conversation. What is your assessment of the patient including pain status. Do not document the words “mistake” or explain how the error occurred. Finally, complete an incident report.
-
- **Accurate**
- Document who gave the care
- Oral Care provided by Jose CNA who states patient complained of a sore tongue
- Document what you did to follow up
- If you are precepting a new employee or have a student and you need to co-sign a note, be sure you carefully review their documentation.
-
- **Complete**
- Change in condition
- Patient response, especially if that response is unusual, undesired or an ineffective response
- Document if you had to use the Chain-of-Command
- Document your communication with the family and patient
- Do not leave blanks, if a question or section does not apply then write N/A
- Do not leave a blank line, this leaves that open to another’s charting or for falsification of the record
-
- **Timely**
- In a negligence or malpractice case the date and time are critical to establish timely care and
- response
- Don’t block chart (0700-1200)
- Use exact times for your care (what time did you empty the Foley, what time did the patient
- Fall, etc.)
- Don’t chart only at the beginning and/or end of your shift
- NEVER, EVER, EVER document in advance of care you provide
- This is falsification of the record
- In a malpractice case if the RN admits to advanced documentation it puts the entire patient
- record in jeopardy.
- Date needs to be on every sheet of the bi-fold and the tri-fold.
- The actual time that the vital signs were taken must be placed in the box for accurate tracking.
- When you complete the shift please total out the Intake and Output so the physicians can adjust medications if needed.
- An accurate percentage of meal intake is needed also so the dietitian and physician can increase the patient’s diet and adjust supplements.
- When filling out the Intake and Output sections of the chart:
    - All intake must be charted. If you are giving a patient blood the amount of blood as well as the amount of normal saline must be placed on the chart.
    - All output must be charted. If the patient has an ostomy or wound V.A.C. you must put the amount emptied from the bag or the canister.
- On each sheet the date needs to be placed in case they pages are separated. This is also part of LEGAL documentation.
- The tri-fold needs to be completed:

    - Do not draw a line through a cell on the assessment. If that section doesn't apply to your patient write "NA".
    - If the patient has a Foley catheter, document the indication for the Foley.
    - If the patient has a Central Line, document the indication for the central line.
    - When doing Central Line dressing changes on Tuesday, you must measure the external length of the catheter. If it has migrated out more than 4 cm you MUST notify the physician (it may no longer be a central line). **If it gets pulled out during the dressing change, do NOT push it back in!!!****
- On each sheet the date needs to be placed in case they pages are separated. This is also part of LEGAL documentation.
- The tri-fold needs to be completed:
    - Do not draw a line through a cell on the assessment. If that section doesn't apply to your patient write "NA".
    - If the patient has a Foley catheter, document the indication for the Foley.
    - If the patient has a Central Line, document the indication for the central line.
    - When doing Central Line dressing changes on Tuesday, you must measure the external length of the catheter. If it has migrated out more than 4 cm you MUST notify the physician (it may no longer be a central line). **If it gets pulled out during the dressing change, do NOT push it back in!!!****
- When documenting a nurse's note **ALL** interventions assessments and the outcomes of the interventions need to be charted.
    - Example: Change in condition: if a patient has a cardiac change, in the note there should be what was assessed, who was notified, how long it took to contact that individual, what interventions were done (Vital Signs, EKG, Etc.), and what the physician ordered done (if anything).
    - This should be in chronological order. If someone else charted during this time than a late entry is appropriate and should be put in as "Late entry 1900…" and the note written after.
- Any intervention that was done to care for the patient needs to be charted on the nurse's note or on the RT notes.
    - Example: If a patient self-decannulates, what was done by both the RT and the RN needs to be charted.
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- **Chart Checks**
- The completion of these chart checks need to be done at change of shift and at midnight.
- The 12 hour chart checks are to include:
    - Ensure that all orders have been accurately transcribed/entered and executed.
    - Make sure that all documentation has been completed.
- The 24 hour chart checks are to include:
    - All required documents for the next shift.
    - Stuffing charts
    - Check the MAR against that days orders and check that they are signed off.
    - Ensure that allergies are placed on the chart and the white book.
    - All test referrals and procedures are transcribed/ordered.
    - All restraint orders are up to date and aren't required to be reordered.
    - All pharmacy yellow sheets are pulled and placed into the pharmacy box.

- Wound care sheets are up to date and completed.
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- **Rounding**
- When Rounding on our patients, chart the 3 P's
  - Position: Which side the patient is on, up in the chair, at therapy, etc.
  - Pain: Address the pain scale.
    - Pain is to be assessed every 4 hours and documented in the pain section of the tri-fold.
  - Potty: Ensure the patient has been offered to opportunity to eliminate bowel and/or bladder.
- Also include the call bell is in reach, bed is in low position, if low boy bed are the mats
- on the floor, and bed is locked.
- Tell the patient when you plan to return.
- Each shift needs to assess fall risk using fall tool (Do NOT copy from the previous shift).
  - Once a risk assessment is done the appropriate level of fall risk assessment needs to be implemented.
  - On the bottom of the fall assessment tool are multiple interventions that can be implemented.
  - Check the correct circle to indicate which interventions you completed.
    -

- **Wound Care**
- When charting on a wound you need to address what was done and what treatments were performed.
- Each shift needs to assess the patient's skin and chart the assessment. If there is a change from the shift or day before the wound care nurse needs to be notified to assess the area. Document you notified the WOCN.
- When charting the wound care treatment, put the time and your initials on the treatment sheet. Please don't chart CDI this is not where that goes, this is to be charted on the tri-fold or nurses note.
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- When you receive a critical lab value you have **30 minutes to call the physician.**
  - **If you do not get a call back from the physician, re-page. If still no call back, use your chain-of-command.**
- Chart when and if any orders have been given for the critical lab.
- If you received the Critical Lab notification, you are responsible for notifying the physician.
- ***DO NOT LEAVE FOR NEXT SHIFT.***
- Critical lab values are found in the nursing policy and procedure book.
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- ***You have reached the end of the agency orientation packet.***
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- ***"Access to the policies is for the sole purpose of fulfilling the clinical work assignment at CHG. The policies are the sol of Cornerstone Hospital and may not be released, forwarded, shared, viewed or re-disclosed to any other individual without permission from the hospital administration risk management office."***

- **Please read, complete, sign and return the following documents to the House Supervisor.**
- **CONFIDENTIALITY & PATIENT RIGHTS**

TITLE	POLICY #

○ **Patient's Rights and Responsibilities**		○ **RA-06-015**
• MANUAL	• EFFECTIVE DATE	• REVISE DATE
○ **Clinical Services**	• **09/01/2012**	○ **8/10/2012, 01/31/13**
• SCOPE:	• REFERENCE	
○ **Organization - Wide**	○ **CFR § 482.13(b)(2) & RI.01.01.01, EP 1,2, & 4**	

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- **PURPOSE:**
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- To define the Patient Rights and Responsibilities and to identify support mechanisms to ensure that patient care is delivered in a manner that respects these rights. In addition, Cornerstone Healthcare Group states that a hospital must protect and promote each patient's rights.
    - **POLICY:**
-
- Cornerstone Healthcare Group Hospital's goal is to educate all clients and family members of their rights as a patient in our hospital and to inform and educate them on those responsibilities.
-
- **GOAL:**
-

A. To have patient/family acknowledge understanding of their patient rights.
-
B. To have patient/family acknowledge receipt of a copy of their patient rights.
-
C. To have patient/family acknowledge understanding of all of their patient responsibilities.
-
D. To have patient/family acknowledge the importance of compliance with the plan of care and to acknowledge that the patient/family is responsible for any outcomes in regards to refusing care.
-
E. To have patient/family acknowledge the importance of the doctors and direct-care staff in being able to obtain a complete medical history determined by the patient's current condition.
-
F. To have patient/family acknowledge their responsibility in ensuring that the hospital has copies of insurance/financial information to file insurance claims.
-
G. To have patient/family acknowledge there responsibility in providing the hospital with a copy of any advance directive.
-
H. To have patient/family acknowledge their obligation in abiding by the hospital rules and regulations.
-

I. To have patient/family acknowledge their obligation in being considerate of other patients, hospital staff, noise levels, and personal property.

- **PROCEDURE:**
- **CONFIDENTIALITY AGREEMENT FOR CORNERSTONE HOSPITAL SEAZ**

A. A written copy of the patients' rights and responsibilities will be given, upon admission, to the patient or a family member (if the patient is determined to be unable to understand). The rights and responsibilities will then be verbally explained to the patient/family member. The acknowledging person will sign a consent stating that the written and verbal information was given.

B. A written copy of the patient's rights and responsibilities will be posted in public view in the hospital setting.

- Patient and employee information from any source and in any form (i.e., print, conversation, electronic) is confidential. I shall protect the privacy and confidentiality of patient and employee information. Access to this information is allowed **ONLY** if I need to know in the scope of my role/function.
- In this function, I may see or hear confidential information on the following:
- Patients and/or Family members
- Such as patient records, conversations, and financials information
- Employees, Volunteers, Students, Contractors, Partners
- Such as employment records, disciplinary actions, salaries
- Business Information
- Such as financial records, reports memos, contracts, technology, strategy and development
- Third Parties
- Such as vendor contracts, computer programs, technology
- Operations Improvement, Quality Assurance, Peer Review
- Such as reports, presentations, survey result
- **Please print the following sheets. The Confidentiality Statement and Acknowledgement need to be read and signed. Give the signed copy to your supervisor so it can be faxed to Deb Ramage, Human Resources at Cornerstone.**
- **Confidentiality Statement for Cornerstone Hospital SEAZ**
- **I Agree THAT**

1) I WILL ONLY access information I need to do in the scope of my role/function.

2) I WILL NOT show, tell, copy, give, sell, review, change, or distribute, or otherwise violate any confidential information unless it is part the scope of my role/function and I will follow the correct department procedure (such as shredding confidential papers before throwing them away).
3) I WILL NOT misuse or be careless with confidential information.
4) I WILL KEEP my computer password secret and I will not share it with anyone.
5) I WILL NOT use anyone else's password to access any hospital operating systems.
6) I AM RESPONSIBLE for any access using my password.
7) I WILL NOT share any confidential information even if I am no longer affiliated with the hospital.
8) I ACKNOWLEDGE that my access to confidential information may be audited.
9) I WILL notify my supervisor if I suspect my password has been comprised or someone else is using my password.
10) I KNOW THAT confidential information I learn while at the hospital does not belong to me.
11) I ACKNOWLEDGE that the hospital may revoke my access at any time.
12) I WILL protect the privacy of our patients and employees.
13) I WILL NOT make unauthorized copies of the hospital's software.
14) I AM RESPONSIBLE for my use or misuse of confidential information.
15) I AM RESPONSIBLE for my failure to protect my password or other access to confidential information.
16) Failure to comply with this agreement may result in the immediate termination of employment or services with Cornerstone Hospital SEAZ, and/or civil or criminal legal penalties.

- By signing this, I agree that I have read, understand, and will comply with this agreement.
-
- Signature _____

- Date_____
- Printed Name _____
- Department_____

Acknowledgement

- **I acknowledge that I have read this packet and am responsible for knowing the content. By signing this, I agree that I have read, understand, and will comply with this agreement.**
-
- Signature _____

- Date_____
- Printed Name _____
- Department_____

- **Name_____Date_____**
- **Bring the following to work on your first day. Your preceptor will complete and return to Human Resources.**

- **BEHAVIORAL COMPETENCIES (to be scored by your Preceptor)**
- **(Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)**
- ___ 1. Communication
- The ability to present ideas and information in a timely, concise, effective and interpersonally appropriate manner through both written and oral forms. This competency is further demonstrated by the ability to receive and effectively process information through appropriate listening skills.
- ___ 2. Commitment to Change
- The demonstrated commitment to contribute to and support effective change in order to enhance organizational performance. This competency is demonstrated by continuously identifying and acting on opportunities to improve AAHS processes and services
- ___ 3. Continuous Self-Improvement
- The demonstrated commitments to identify opportunities, invest time, and participate in activities resulting in a personal and professional development.
- ___ 4. Customer Relations

- The demonstrated ability to develop and cultivate mutually beneficial relationships with both internal and external customers. Customer relations behavior is demonstrated by continually striving to meet or exceed customer expectations, enhancing trust and respect for others.
- ___ 5. Problem Solving/Decision Making
- The demonstrated ability to identify issues and opportunities, collect appropriate information, effectively process information and make timely and effective decisions to improve outcomes.
- ___ 6. Role Model
- The demonstrated ability to be trusting, trustworthy and respectful of myself and others by insuring confidentiality and appreciation for others' time, resources and respect for the dignity of each person.
- ___ 7. Teamwork
- The demonstrated ability to establish and maintain effective relationships with others. Teamwork is characterized by working toward a shared purpose or goals or through cooperating, collaborating and partnering with others.
- ___ 8. Accountability
- The demonstrated ability to take responsibility and ownership for the outcome of all actions and decisions in fulfilling job requirements with special emphasis on customer satisfaction.
- **PROFESSIONAL / TECHNICAL COMPETENCIES /ESSENTIAL (to be scored by your Preceptor)**
- **(Performance Key: 3 = Excellent, 2 = Good, 1 = Fair**
- **Clinical Decision Making/Judgment**
- ___ 1. Demonstrates clinical nursing knowledge and skill in the specialization of the unit.
- ___ 2. Demonstrates the ability to apply the nursing process effectively in the care of culturally diverse patients and families.
- ___3. Demonstrates the ability to utilize all applicable laws, policies, standards, guidelines and evidence-based practice in the provision of patient/family care.

- ___ 4. Organizes and reprioritizes patient care activities based on subtle and overt and/or environmental changes.
- ___ 5. Consistently and thoroughly assesses patients to collect data and identify learning needs according to established standards and policies.
- ___ 6. Utilizes a systematic, continuous and complete analysis of assessment data to develop individualized problem lists for assigned patients.
- ___ 7. Develops and individualizes a plan of care for each patient in accordance with established standards, appropriate prioritization of problems/needs, and mutually agreed upon goals.
- ___ 8. Efficiently implements the patient's plan of care in accordance with applicable standards, policies, procedures and guidelines. `
- ___9. Demonstrates proficiency in medication administration, pain management and other unit or initiative specific skills.
- ___ 10. Continuously evaluates the effectiveness of the plan(s) of care, making revisions and recommendations based on analysis of patient responses to interventions.
- **Nurse-Patient Family Relationships ESSENTIAL (to be scored by your Preceptor)**
- ___ 1. Demonstrates the ability to assess the patient's/family's learning needs, readiness to learn, learning style, and presence of barriers to learning. Demonstrates the ability to develop, implement and evaluate teaching plans for patient populations in unit specialty in accordance with applicable standards.
- ___ 2. Demonstrates the ability to apply knowledge of growth and development across the life span to the care of patients.
- ___ 3. Provides direct patient care to patients and families in a culturally, developmentally and ethically appropriate-ate manner.
- ___ 4. Plans of care address the physical, psychosocial, spiritual and learning needs of the patient/family.

- **Preceptor** **Date**