Admission/Discharge Folder

The Patient Admission and Discharge Information folder is used to ensure all written material for patient/family are secured in one location. For non-ICU rooms the folder will be kept in the wire basket on the Patient/Family Communication Board. Material located in the book should be explained to the patient and used as resource for information that applies to the patient's care. Tear off sheets located in the book: *Notice to Patients, Patient Valuables Disposition Statement,* and *Patient Education* should be signed and placed in the medical record. Encourage your patient and family members to review its contents before discharge. Remember, planning for a patient's successful discharge begins the moment a patient is admitted.

Advanced Directive

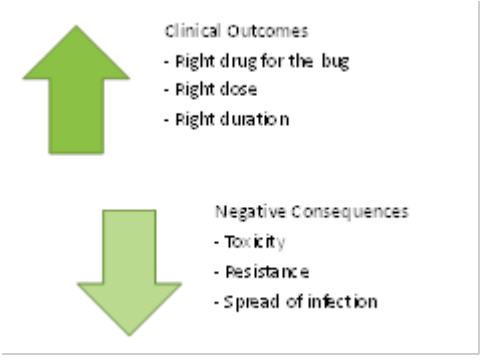
An Advanced Directive is a document or documentation that allows a person to give directions about future medical care or to designate another person to make medical decisions if the individual loses decision-making capacity. Advance Directives may include living wills, durable powers of attorney, etc. In the event the patient has an Advanced Directive, a Living Will, and/or a Durable Power of Attorney for health care, the document or documents must be obtained from the patient or agent appointed by the patient and made a part of the medical record.
Social Workers, Nurses or Case Managers may provide information regarding Living Wills/Advanced Directive for Health Care to patients or their families as requested. The forms are accessible via the Pulse Page- Forms- Advanced Directive booklet. Social Worker, Nurses or Case Manager will document in the patient's Medical Record that the form and instructions were provided. If the patient chooses to sign the Living Will/Advanced Directive for Health Care while hospitalized, the Social Worker or RN Case Manager informs patient / family that two witnesses are required to sign the Living Will/Advanced Directive. Hospital employees are not allowed to sign as a witness. Security can provide a notary if requested.
An Advance Directive does not include DNR/A.N.D (Do Not Resuscitate/Allow Natural Death) orders, right to die, or similar documents - there may be a DNR/A.N.D request, but the DNR/A.N.D. order must be provided by the physician on that admission with a note in the progress notes that the DNR/A.N.D. was discussed with patient/family. This order does not require renewal and remains in effect during the entire hospital stay unless explicitly revoked by the physician or physician's representative in consultation with the patient or patient's surrogate.

Anticoagulation

- Nursing provides educational materials to patients receiving an oral anticoagulant and documents the education in the patient's medical record. Patients on warfarin are educated to keep their diet of vitamin K containing foods consistent. PKS is available for oral anticoagulant education.
- Patients are evaluated each shift for signs and symptoms of bleeding, signs and symptoms of thrombus formation, and appropriate administration of oral anticoagulants.

Antimicrobial Stewardship

- Antimicrobial stewardship is a coordinated program that (1) promotes the appropriate use of antimicrobials, (2) improves patient outcomes, (3) reduces microbial resistance, and (4) decreases the spread of infections caused by multidrug-resistant organisms
- Put simply, it is enhancing clinical outcomes while minimizing negative consequences in patients receiving antimicrobials



How can YOU help? Be antibiotics aware!

Verify penicillin allergy

- Although 10% of the population in the United States reports a penicillin allergy, less than 1% of the population is truly penicillin allergic
- When possible, obtain a more detailed history of the penicillin reaction and review previously prescribed antibiotics

Reassess antibiotic therapy

- Review the patient's microbiology results (e.g., rapid diagnostic tests and clinically relevant cultures)
- Consider stopping or tailoring antibiotic therapy as appropriate

Avoid treatment of asymptomatic bacteriuria (ASB)

- Patients with ASB should not be treated with antibiotics in most cases
- Consider the importance of signs and symptoms consistent with urinary tract infection (UTI) when reviewing positive urine cultures and/or making treatment recommendations

Use the shortest effective antibiotic duration

- Guidelines for treatment duration are available for common infectious diseases such as pneumonia, UTI, and skin and soft tissue infection
- Consider entering stop dates on antibiotics to ensure the shortest effective course for patients

Armbands

Patients are to have a verified hospital patient identification armband in place at all times. This armband is the PRIMARY armband used for verification during medication administration, and prior to treatment or procedure.

- See Policy and Procedure *Patient Identification of Unidentified Patients* located in Patient Care Issues folder in Docushare; if unable to ID patient upon arrival.

If the patient is unable to provide full name and date of birth on arrival, a family member or authorized representative is asked to provide this information. If the information cannot be obtained **"Registering and Updating Doe Patient"** guidelines are followed.

All armbands are placed on the unaffected arm, including a pink "limb alert" armband. NEVER place an armband on an arm with a renal dialysis access, central line or lymphedema. If both arms are affected or the patient only has one arm and it is the "affected" arm, place all of the armbands on one ankle. If the patient is wearing "issue" armbands like "Livestrong" or "Team Pink" etc., the patient is asked to remove the issue armbands while in the hospital. If the patient refuses to remove the issue armbands, the patient is asked to sign the "Patient Refusal to Participate in the Armband Process" form.

Color Coded Armbands (armband color communicates):
Red Allergy
Yellow Fall Risk
Purple DNR/A.N.D.
Pink Limb Alert
Blue Suicide Precaution

Authorization for Procedures

Authorization for Procedure forms are signed by the patient or authorized representative **AFTER** informed consent has been obtained by the physician (including the risks, benefits, and alternatives discussion) and prior to operative/invasive procedures, anesthesia, or pre-procedural sedation being performed (ie. Cath Lab, Nursing Unit, Pain Clinic, etc.).

- See Policy and Procedure *Authorization for Procedure/Anesthesia: Guidelines for Informed Consent)*

In the event of an emergency, when informed consent

cannot be obtained from the patient or authorized representative, the physician makes a note on the progress notes.

The process for completion of an Authorization for Procedure form is facilitated by the nurse. The process is as follows:

1. Check physician's orders for Authorization for Procedure.
2. Review applicable printed procedure or surgery schedule for consistency, notify physician if discrepancy.
3. Use black ink on all Authorization for Procedure forms and fill out form completely.
4. Do not use abbreviations
5. Enter all procedure information and physician's name, (first and last) on the form prior to patient's signature being obtained.
6. Verify patient's identity and procedure.
7. Check patient armband and sticker on form for patient's name and ID number.
8. Ask patient or authorized representative, to state the patient's name and to state what procedure he/she is scheduled for. If the procedure is one with a Right or Left side, verify that the side is correct with the patient, or authorized representative.
9. Verify that the Informed Consent discussion with the physician has occurred and if he/she has any further questions for the physician about the procedure. Only the physician may obtain informed consent.
10. Ask patient or authorized representative to read and sign the appropriate place on the Authorization for Procedure form using his/her legal signature (with his/her full name and title).
11. The licensed employee who witnesses the signing of the authorization for procedure form does not explain the risks, benefits and alternatives of the procedure.

Signed authorization forms are evidence of the oral conversation and consent obtained by the physician. A signed authorization form does not replace the documented discussion between the physician and the patient or the patient's representative about the proposed medical treatment and the risks, benefits, and alternatives.

- Patients may use an "X" to sign in cases of impairment or illiteracy or if the patient has physical impairments that prevent him/her from signing or making a mark, then the licensed employee may document on the Authorization for Procedure form the patient's agreement to the document.
    - When an "X" is used as a patient signature or if the patient has physical impairments that prevent him/her from signing or making a mark, there are **two** licensed witnesses.
- If the patient has received analgesics or sedatives and the nurse assesses that the patient is alert, oriented, and has memory recall the patient will be allowed to sign. If not, seek the authorized representative to sign the authorization.

Note: *Some Sedatives such as Midazolam (VERSED) may have an amnesic effect for several hours after administration.*

- If the nurse assesses that the patient is not alert and/or not oriented and/or does not have memory recall or has recently received a sedative with an amnesic effect seek the authorized representative to sign the authorization.
- If nurse has concerns about the patient's ability to sign and there is no authorized representative available to sign/give telephone consent, contact the physician.

Authorized Representative

When an adult patient is physically or mentally unable to give consent or sign an authorization form, a surrogate, in consultation with the attending physician, may give consent or authorize treatment. Once the appropriate surrogate has been identified, no other persons should be asked to authorize treatment for the patient. The surrogate for adult patient must be a competent adult 19 years of age or older and is to be considered in the following descending order:

1. A judicially appointed guardian
2. An agent appointed by the patient in accordance with an Advance Directive
3. The patient's spouse
4. An adult child of the patient
5. One of the patient's parents
6. An adult sibling of the patient
7. Any one of the patient's surviving adult relatives who are the next closest degree of kinship to the patient.

If a patient or the patient's authorized representative has limited or no English proficiency an interpreter translates the informed consent information from the physician and the information on the Authorization for Procedure form. The interpreter witnesses under second witness and is identified as interpreter. If the Language Line or MARTTI *(My accessible real-time trusted interpreter)* is utilized for translation, this is noted, along with interpreter's name, in the blank provided for the 2nd witness signature.

Blood Transfusion

Blood products include whole blood, packed red blood cells, fresh frozen plasma, platelets, and cryoprecipitate. Blood components include albumin, clotting factors, and immunoglobulin.
Your primary responsibility when administering blood products is to prevent a potentially fatal hemolytic reaction by making sure that the patient receives the correct product. Typing and cross-matching establishes the compatibility of donor and recipient blood. Before administering a blood product, verify that the patient's medical record contains documented RBAs by the provider, a signed Permit for Blood Products, a provider order to transfuse the blood product, and an indication for transfusion. Verify the patient and the blood product information with another qualified health care professional and inspect the product for any abnormalities.
A blood identification armband is placed on patient's wrist when the type and crossmatch blood sample is drawn. This arm band has an alphanumeric code which is also placed on units of whole blood (WB) and RBCs that are cross-matched for transfusion to the same patient. NOTE: If the patient's full name is "cut off" on the collection and blood identification armband labels, write the missing part of the name on both labels so that the FULL LAST NAME, FIRST NAME AND MIDDLE INITIAL ARE ON THE LABELS.
Ensure acceptable vital signs and functional IV site **PRIOR TO** obtaining blood products from the blood bank. Blood products are removed from the blood bank only with the assistance of a lab tech. Registered Nurses, Licensed Practical Nurses, other approved qualified designees, and approved patient care assistants may check out blood from the blood bank or retrieve blood from the Pneumatic Tube System. Blood products for only one patient may be removed at any one time. Unmatched blood products may be retrieved by any designee.

- The transfusionist reads aloud the identification information to the lab tech (patient's name, date of birth, medical record number, donor number and name of provider ordering the blood).
- For WB or RBCs, the unique blood bank identifier, ABO group and Rh status are also read aloud by the transfusionist to the lab tech. The patient and donor blood group and Rh, expiration date, compatibility, and any special requirements such as antigen negative, irradiated, or sickle screen negative are verified. The lab tech repeats back what is said while checking the unique blood bank identifier on the unit of blood.
- If cross-matched platelets are ordered, the ABO type of the donor does not have to be the same type as the patient. Platelet transfusion may be a different type depending upon availability.

Verification at the bedside:

- Two transfusionists identify patient by using two patient identifiers. Patient states name and DOB aloud. Patient name, date of birth, medical record number, and blood bank identification number (if applicable) on the transfusion form attached to the blood bag is compared to the patient's hospital armband and the Blood Bank armband.
- Transfusionists verify aloud that the following information is correct:
  a. Patient ABO-Rh
  b. Donor ABO-Rh
  c. Donor identification number
  d. Compatibility of blood- i.e. state "blood compatible"
  e. Special transfusion requirements, i.e. state unit is “negative for (antigen or antigens)”, "irradiated" or "sickle cell negative"
  f. Expiration date and time
- The verifying transfusionist repeats back what is said while checking the Blood Bank sticker on the unit of blood. Write time, date and signatures on Blood Transfusion Form attached to blood bag when transfusion is started. DO NOT REMOVE PAPERS FROM BAG UNTIL TRANSFUSION IS COMPLETED.

Administration:

- ALWAYS REFER TO POLICY AND PROCEDURES REGARDING CENTRAL LINE OR PERIPHERAL IV CARE and BLOOD ADMINISTRATION.

- Normal Saline is the only IV fluid to use as flush with blood transfusion. An order must be obtained if hanging a NS 1000mL bag of fluids during blood transfusion. No other medications or fluids are to be added to or infused with blood. Blood and blood components are not piggybacked through the side port of another IV line.
- Additional IV sites may be started to administer medications.
- Vital signs are to be checked prior to getting blood, 15 minutes after transfusion and at the end of transfusion.
- Regulate flow rate for first 15 minutes. Observe patient frequently during the transfusion and closely for the first 15 minutes for signs of reaction. Recheck vital signs after 15 minutes. The transfusionist remains with the patient the first 15 minutes. If no symptoms of reaction after 15 minutes, set rate as ordered or as tolerated by the patient to avoid infusing the blood too quickly and to ensure completion of the unit within 4 hour time limit. Transfusions are to be complete within 4 hours from the time it is received from the blood bank due to the risk of bacterial growth. Max time to allow blood product to infuse is four hours from the time checked out of the blood bank. If the provider orders a slower administration rate, request blood bank to divide the unit and keep partial unit until needed.
- If reaction is suspected, clamp off the blood transfusion, begin Normal Saline infusion at 20ml/hr. Symptoms of hemolytic, febrile nonhemolytic, allergic, anaphylactic, and transfusion-related acute lung injury (TRALI) include: hives or urticaria, itching, diffuse rash, flushing, runny nose, angioedema, temperature increase of greater than 1 degrees Celsius above pre-administration temperature, tachycardia, shaking or chills, headache, difficulty in breathing with or without cyanosis, hypoxemia, coughing, frothy sputum, pulmonary edema, red/dark urine, generalized aches and pains, hypotension with shock, chest or back pain, vomiting, confusion, and sometimes death. Symptoms of transfusion-associated circulatory overload (TACO) include: acute respiratory distress, dyspnea, positive fluid balance, left heart failure, elevated central venous pressure, radiographic evidence of pulmonary edema, and elevated BNP usually within 6 hours of cessation of transfusion.
- LPNs may not initiate or discontinue blood product transfusions or blood component infusions to a central line. The only blood components that appropriately trained LPNs may administer are clotting factors. Appropriately trained LPNs may verify blood products, initiate blood product transfusions and clotting factor infusions to a peripheral IV, may monitor patients receiving blood products or clotting factors to include the first 15 minutes of blood product transfusions, and may discontinue blood products and clotting factors transfusing to a peripheral IV.

While the transfusion is being administered, assess the patient for signs of a transfusion reaction, assess the I.V. site for signs of infiltration, and closely monitor for the proper infusion rate. Keep in mind that a delayed transfusion reaction, in which the patient presents with signs similar to acute respiratory distress syndrome, may occur within 6 hours of a transfusion, other signs of a delayed transfusion reaction, including purpura, jaundice, anemia, or fever, may occur a week or more after the transfusion. If a blood reaction is suspected, the provider and the Blood Bank are notified as soon as possible and the transfusion reaction investigation is initiated.

Change in Patient Condition

Clinical staff must be notified anytime a change in the patient's condition is observed. The Rapid Response Team (RRT) may be activated by calling -45555. The Neuro RRT is called if symptoms of a stroke are noted. The NEURO RRT staff may call a STROKE Alert after their assessment of the patient if indicated. RRTs may be initiated with the aid of 1Chart notifications. Through 1Chart documentations, a MEWS (Modified Early Warning System), or PEWS (Pediatric Early Warning System) score is generated and utilized to help identify acuity changes.
Examples of Clinical changes may include:

- MEWS Score 5 or greater
- PEWS Score 5 or greater or initial admission score greater than 3
- Airway problems such as respiratory distress, shortness of breath, change in oxygen saturation.
- Vital Sign changes such as change in Blood Pressure, increase or decrease in Respiratory Rate

- Mental Status changes such as change in level of consciousness, increased confusion, slurred speech, dizziness, sudden weakness
- Antepartum/postpartum Hemorrhage
- Other examples of changes in patient condition might include difficulty to arouse and bleeding.

The Rapid Response TEAM is minimally comprised of a critical care nurse and a respiratory therapist who respond to a specific nursing unit. When calling for RRT, staff may be able to improve patient outcomes by having critical care nurses and respiratory therapists assist in identification of patient problems and acting quickly before a Code Blue occurs. Patient and family members are to be educated during admission process on how to call for help if the patient's condition declines.

Core Measures Best Practices

The Joint Commission introduced four initial core measurement areas for hospitals in May 2001. Standardized and renamed National Hospital Quality Measures, these core measure sets are expected to improve the quality of care for hospital patients while promoting examination of results of the care provided.
* Although Acute MI (AMI), Heart Failure and SCIP are no longer measured, these remain standard of practice throughout Huntsville Hospital.

Acute Myocardial Infarction (AMI)

Acute Myocardial Infarction (AMI) is the number one killer of the male and female population in the United States. Please remember the importance of documentation of the items in the Patient Education Book to include information on:

- Low fat, low salt diet
- Risk factor review
- Physical activity level counseling
- Smoking cessation recommendation
- Instruction regarding Cardiac Rehabilitation availability
- Follow-up appointment
- What to do if you experience chest pain, shortness of breath or other questions or concerns

Heart Failure (HF)

- Discharge Instruction:

1. 2gm sodium diet
2. Fluid restriction of two liters or 2000mL/day unless otherwise instructed
3. Monitoring of daily weights
4. Call the doctor's office if you have a weight gain of 3 pounds in a day or 5 pounds in a week, worsening of swelling or shortness of breath
5. What to do if Heart Failure symptoms worsen or other questions or concerns
6. Physical activity level counseling
7. Follow-up appointment with CHF Clinic and/or provider with date, time, location and phone number of clinic
8. Review of all Discharge medications and side effects
9. Adult Smoking Cessation Advice/Counseling

- Completed Cardiac Quality Measure Worksheet:

1. Complete prior to discharge in order to verify use of guideline driven medical therapy i.e. evaluation of left ventricular function and angiotensin converting enzyme inhibitors (ACE-I) or angiotensin II receptor blockers (ARB) or angiotensin receptor neprilysin inhibitor (ARNI) for left ventricular systolic dysfunction.

2. If you receive a patient with Cardiovascular Disease including Heart Failure and / or Acute MI, please consult the Patient Navigator by calling 256-759-4189 and use the Heart Failure Core Measures Sheet on the Pulse Page under Forms to assist you on how to properly educate, document and care for these patients.

- Downtime:

1. Utilize the Teach Back Validation tool for CHF Education Form to document patient education and response

If you receive a patient with Cardiovascular Disease including Heart Failure and / or Acute MI, please consult the Patient Navigator by calling 256-759-4189 and use the Heart Failure Core Measures Sheet on the Pulse Page under Forms to assist you on how to properly educate, document and care for these patients.

Venous Thromboembolism (VTE)

VTE - 6: This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

Venous Thromboembolism Prophylaxis Process (Nursing Unit Responsibilities)

Nursing unit:

- Maintain stock of VTE order set - double-sided on lavender paper(Lawson #288364)

HUA/Nurse :

- On admission to nursing unit, place a blank copy of the VTE order set on chart under physician's order section for the physician or NP/PA to complete. If the physician has already addressed VTE prophylaxis in the admission orders or on an order set, the lavender sheet does not need to be placed on the chart.
- Enter order set into EMR after completion

Nurse/PCA:

- Apply mechanical methods of prophylaxis, various intermittent compression devices, when ordered
- Document use of mechanical prophylaxis (at least daily); documentation that the mechanical prophylaxis is on the patient is required to meet the core measure
- If ordered mechanical prophylaxis cannot be implemented due to a contraindication (such as edema or lower extremity injury) or the patient refuses the treatment, document the reason for not applying or discontinuing the mechanical prophylaxis (at least daily).

Quality Indicators for Stroke (STK) Core Measures

Data reported to TJC in order to maintain Stroke Program Certification:

STK-1 Venous Thromboembolism (VTE) Prophylaxis

STK-2 Discharged on Antithrombotic Therapy

STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter

STK-4 Thrombolytic Therapy

STK-5 Antithrombotic Therapy By End of Hospital Day Two

STK-6 Discharged on Statin Medication

STK-8 Stroke Education

STK-10 Assessed for Rehabilitation

CSTK-01 NIHSS Score for Ischemic Stroke

Nurse Responsibilities regarding Stroke patients:

- Call Neuro Rapid Response at ext. 45555 at first recognition of new acute Stroke symptoms: Remember BEFAST- Balance, Eyesight, Facial Droop, Arm weakness, Speech, Time to call.
- VTE prophylaxis- document Pneumatic Compression Devices on initiation & maintained each shift.
- Swallow screen performed & documented on all eligible TIA/Stroke patients prior to any PO intake.
- Stroke education every shift to include: type of Stroke, individualized risk factor reduction with teach back and calling 911 for Stroke warning signs. Documented Stroke Patient Satisfaction Survey given to patient/family to complete prior to discharge, faxed to 8N at ext. 52709.

- NIHSS documented each shift, with any change of neuro status, prior to and after any acute recanalization therapy and documented within 12 hours of arrival at the hospital emergency department for patients who do not undergo recanalization therapy.
- Tailor goals on nursing care plan to reflect individualized stroke risk factors.

Surgical Care Best Practices

1. When a patient's vital signs are stable and there is a NPO order for surgery, the daily dose of a beta blocker is still administered during the preop period with a small sip of water.
2. The HUA, RN checking the orders and the pharmacist must use the Anesthesia Stop Time for determining the correct time to administer the first dose of anticoagulant based VTE prophylaxis and administer the last dose of prophylactic antibiotics.
3. Time all doses of prophylactic antibiotics to give the final dose within the 24 hour period after Anesthesia Stop Time (48 hours after Cardiac Surgery)
4. Time anticoagulant based VTE prophylaxis to begin within 24 hours after Anesthesia Stop Time after major inpatient surgery.
5. Maintain mechanical VTE prophylaxis with SCDs or VFPs at all times while patient is in bed or sitting in a chair. If it is not possible to fit SCDs correctly due to patients size VFPs may be used instead if approved by the surgeon.
6. Remove the Foley catheter by POD 2 unless the surgeon specifically orders for it to not be removed and documents a reason to continue past POD 2.

Sepsis Core Measure (SEP)

Emergency Department, Inpatient, observation patients, and outpatient in a bed >18 years of age that are admitted to Huntsville Hospital, Women's and Children's Hospital and Madison Hospital are continually monitored by the Saint John Sepsis Agent (SJSA) via Cerner Electronic Medical Record (EMR) for signs of Systemic Inflammatory Response Syndrome (SIRS), and Severe Sepsis.

- Patient alerts for SIRS/Severe Sepsis in the EMR based on the SJSA algorithm
- The nurse with the established relationship is alerted through the EMR with a discern alert
- The unit charge nurse is alerted through the EMR with a discern alert in the EMR
- The unit charge nurse ensures that the assigned nurse is aware that there is an alert pending in the EMR that requires evaluation
- The staff nurse acknowledges the discern alert in the EMR based on an assessment and the nurse completes the Sepsis Infection Screen powerform in the EMR for SIRS discern alerts
    - If the patient screens negative for infection, the SIRS discern alert is suppressed
    - If the patient screens positive for infection, the nurse initiates the appropriate nurse driven Sepsis Lactate Series from the Infection Screening Tool powerform in the EMR
- The nurse alerts the physician of the lactate level based on the Sepsis MD Notification Guidelines[1] and completes documentation
- For Severe Sepsis the staff nurse acknowledges the Severe Sepsis discern alert in the EMR based on an assessment and verification of accuracy of vital signs
- If the alert is deemed inaccurate, the nurse exits out of the alert and the nurse documents on their task list the reason for dismissing the alert
- If the alert is deemed accurate, the nurse initiates the nurse driven Sepsis Lactate Series in the EMR if the lactate series has not been initiated in the past 6 hours
- The staff nurse notifies the physician of the Severe Sepsis discern alert and the initial lactate level so that the physician can evaluate and complete the Sepsis Advisor and documents on their task list the completed task via the Severe Sepsis Checklist

The SEP-1 Core measure requires that a 3 and 6 hour sepsis bundle be completed for severe sepsis and septic shock. The bundle elements are:

3 Hour Bundle:

1. Measure initial lactate level
2. Obtain blood cultures x 2 prior to administration of antibiotics
3. Administer broad spectrum antibiotics
4. Administer 30mL/kg crystalloid for hypotension or lactate greater than or equal to 4mmol/L. The 30 mL/kg bolus may be given based on actual weight or ideal body weight if the patient has a BMI >30. When the Licensed Independent Practitioner (LIP)orders the fluid resuscitation bolus based on ideal body weight, they must document that the bolus is being given based on ideal body weight for BMI>30. The provider may adjust the bolus based on patient comorbidities such as renal failure and heart failure.

6 Hour Bundle:

5. Administer vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) greater than or equal to 65mmHg
6. In the event of persistent hypotension after initial fluid administration (MAP <65mmHg) or if initial lactate is greater than or equal to 4mmol/L, re-assess volume status and tissue perfusion and a licensed independent practitioner must document findings.
7. Re-measure lactate if initial lactate elevated.

Critical Values

A Critical Value and/or result are defined as a test result that has been determined to be critical to the patient's subsequent treatment decisions. The goal set by the Quality Council for reporting critical values is less than 45 minutes from the time the result is available to the ordering department and the results are communicated to the responsible licensed caregiver (MD, PA, CRNP; the person that can act upon the test results). The responsible licensed care giver can be the bedside nurse when there is a protocol for the nurse & when the physician does not need to be reported the results.

A reference to the current critical values list, which includes not only lab critical values but imaging and telemetry as well, is located on the Pulse Page.

Click by Click instructions:

Pulse/References/policies & Procedures/Organizational Policies and Procedures/Patient Care Issues/Critical Values Policy

Computer Downtime

- Downtime procedures begin when the Electronic Medical Record (EMR) is unavailable for order entry or documentation that may interfere with patient care. Downtime procedures are put into effect if the system is unavailable more than 30 minutes.
- Each unit has a 724 downtime computer. Audits are performed monthly to verify that the 724 downtime viewer is functional.
- Communicate with other departments by phone, fax, and/or Aionex Focus. If Aionex Focus is included in the downtime, utilize alternate communications methods including phone, fax, pneumatic tube system, or courier.
- All orders are faxed to pharmacy.
- Call or page all ancillary departments for STAT, NOW, TIMED, and any other order to be performed during downtime. Complete an Ancillary Back up Form when necessary. The white copies of the Ancillary Back up Forms for the other department and the yellow copy is placed on the chart.
- Refer to the *Computer Downtime-1Chart* policy for detailed guidelines for documentation, communication, and recovery from EMR downtimes.

Departmental Policies and Procedures

Maintaining a working knowledge of the appropriate policies and procedures for your unit is a fundamental responsibility of all employees. Having a working knowledge of the emergency procedures pertaining to patients on your unit is also each employee's responsibility. Reporting patient related incidents through the accepted Huntsville Hospital reporting channels (i.e. Safety Event Reports (SERs), Risk Management Reports, Physician Behavioral Event Reports) is also expected of all staff. Employees can access Departmental, Medical Staff, Organizational Manuals and Nursing Policies and Procedures by going to the Hot List on the Pulse page, scrolling down and selecting 'Policies & Procedures' and then searching by folder or by entering the subject into the Search Box field. Make sure the option of 'This Collection' and NOT 'This Entire Site' is selected in the drop down box. Searching 'This Entire Site' will display outdated policies and procedures.

Documentation

- If you did not chart it, you did not do it.
- All patient care/interventions are documented in the electronic medical record.
- The interdisciplinary plan of care (IPOC) is documented before the end of shift or within twelve (12) hours of admission or transfer to the floor or ICU in the electronic medical record. Each care plan is a working document and part of the permanent record. Problems, goals and interventions are to be consistent with physician's plan for medical care. When changes occur with the patient's condition, the POC is updated. Examples may include placing the patient in restraints or on isolation precautions. Routine updates to the POC occurs towards the end of each shift prior to shift change based on current condition, anticipated.
- To correct an error in the handwritten portion of a patient chart, draw a single line and initial, date and time.
- Patient care orders are required to be entered directly into the electronic medical record (EMR) by the provider. Non-CPOE orders are accepted only in limited circumstances. Once entered, the EMR orders are electronically routed to the appropriate hospital staff for implementation.
- Verbal/telephone orders meeting criteria (non-emergent):
    a. The licensed employee enters order(s) directly into the EMR as verbal/telephone orders under the provider's name. If the provider's name is not listed within the EMR, verbal/telephone orders cannot be accepted. The provider remains physically present or on the telephone until the order entry process and read-back validation is complete.
    b. The licensed employee notifies the provider of any order alerts as they are generated. The provider gives the licensed employee verbal instructions regarding resolution of the alerts.
    c. The licensed employee reads the order(s) back to the provider for verification after the order(s) are entered.
    d. The licensed employee corrects any discrepancies and reads the corrected order(s) back to the provider for verification after the order(s) are entered.
- Ignoring a physician's order in not an option. If there is an order which is consistently not used, consult the physician to revise the order (i.e. activity order).
- All activities of daily living are to be documented each time you complete an activity (for example: turning, ambulating, feeding, dangling

Electrical and Medical Device Safety

How do you know if a piece of medical equipment is safe to use on a patient?

- Visually inspect for obvious damage, i.e. frayed cords.
- Does it boot up successfully and appear to be functioning correctly?
- Biomed Inspections are indicated by a dated sticker. Although medical equipment is inspected at regular intervals, this does not guarantee the medical equipment is functioning properly today.

Huntsville Hospital maintains an ongoing preventive maintenance/inspection program for medical equipment.

Only the operator can determine that medical equipment is safe to use at the time of use, regardless of the date on a sticker.

If you find a piece of medical equipment that is not functioning properly, take it out of service, go to the PULSE page, HotList, Forms, Biomed, and select the form titled "Medical Equipment Failure Report Tag" and print the form. Fill out the form and attach it to the broken piece of equipment,
provide information of the reported failure and take it to the BioMedical Department. Sign the equipment into the log located in the BioMedical Department.

Important Note:

- If the equipment is involved in a known or possible injury, the equipment and accompanying devices, i.e. tubing, etc. must be tagged and removed from service immediately. Incident needs to be reported to immediate supervisor and a safety report completed.
- Take to BioMedical Department as soon as possible. After hours, (after 4pm and before 7am daily) notify your immediate supervisor and take equipment to the BioMedical Department the next morning.

Learn the frequency with which equipment in your department should be checked. For example:
According to Hospital policy, Crash Carts are to be checked daily, with these checks being documented on the Crash Cart log. A Crash Cart log entry should be present for every day including days when the unit/department might be closed.

- Daily checks include the following:

- Defibrillator function test. **Caution**: Accidental Defibrillation may occur. This test is not to be performed in a patient room or at a patient bedside.
- EKG paper supply – make sure it is adequate
- Assure electrodes multifunctional pads on top of crash cart have not expired
- Zoll defibrillator gel
- EKG electrode pads have an expiration date and are only good for 30 days
- Lock number is clearly displayed on the checklist and matches number displayed on the lock.
- O2 tank greater than 1200PSI
- Assure portable suction machine function (where applicable)
- Review tags on drug drawers and supply drawer handles for expiration dates of items
- Drawer 4 is for customized supplies for your floor or specialty area.

- Temperature should be manually checked and documented daily on any hospital refrigerators which are not managed by the AeroScout Wi-Fi monitoring system. Any hospital refrigerator which contains patient food or medications must be checked daily and documented in the refrigerator log. On out of range temperatures, the corrective action taken and a recheck of the temperature should also be documented on the log. A refrigerator log entry should be present for every day including days when the unit/department might be closed. When alerted by the AeroScout system, corrective action must be documented in the "AeroScout temperature software" to assure regulatory compliance.

Remember, you and your coworkers play an important role in ensuring electrical and medical device safety and in acting quickly in an emergency. Here are some important safety tips:

- Make sure the power switch of an electrical device is in the "off" position before plugging it in or unplugging it.
- Make sure air can circulate near the ventilation openings of an electrical device to keep it from overheating.
- Remove equipment from use if it causes even a small tingle.
- Do not use any electrical equipment that is damaged, wet, or in poor repair; that has fallen or been dropped; that emits sparks; or that has a burning odor.
- Do not use electrical equipment in an area that is wet or damp.
- Do not assume an electrical device is safe to use simply because it works.
- Do not overload circuits.
- Do not try to repair or adjust electrical equipment yourself.
- Do not let patients use personal appliances, except in special circumstances. Have the engineering department check the appliances first.
- Do not use extension cords or power strips to plug in patient equipment unless approved by the Biomedical department (Hospital policy).
- Do not ignore electrical problems. Report them to the plant operations department immediately.

End of Life Care

The plan of care should reflect the patient's wishes regarding care at end-of-life. Level of care preferences may include: 1) Full supportive/disease modifying care, 2) Limited/disease modifying care, 3) comfort focused care. Personal, cultural, religious/spiritual beliefs and values shape the patient's individual preferences and experiences at end-of-life. Staff should involve the patient's identified HC POA (legal paperwork), health care proxy (living will) or next of kin/medical surrogate decision maker and support system in goals of care discussions.

- Address and monitor changes in patient communication needs
- Address patient functional status and impact on mobility needs
- Identify patient's personal, cultural, religious/spiritual beliefs, values and preferences and support their right to pursue care accordingly
- Ensure access to patient's chosen support person.
- Provide an environment that promotes comfort

Ethics Committee

Making decisions about care sometimes presents questions, conflicts or other dilemmas for the hospital, the caregiver, the patient, and the family. Anyone can make a referral for an ethics consultation. If you are faced with an ethical dilemma, you may contact the ethics committee representative through Nursing Administration staffing office at 265-8889. For Madison Hospital, please contact the department director or the Administrative Supervisor for after hours or by following up with your unit director.

Patient Falls

National Database of Nursing Quality Indicators (NDNQI) (1Q2016) defines a patient fall as a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can). When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured. All unassisted and assisted falls (see definition below) are to be reported, including falls attributable to physiological factors such as fainting (known as physiological falls).

MORSE FALL RISK ASSESSMENT CHART

Risk Factor	Scale	Points	Patient's Score
History of Falls	Yes	25	
	No	0	
Secondary Diagnosis (Two or more medical Diagnosis/ co-morbid)	Yes	15	
	No	0	
Ambulatory Aid	Furniture (Patient walks clutching onto furniture)	30	
	Crutches/Cane/Walker	15	
	None/Bedrest/Wheelchair/ Nurse assisted	0	
IV Therapy/ IV device	Yes	20	
	No	0	
Gait	Impaired	20	
	Weak	10	
	Normal/Bedrest/immobile	0	
Mental Status	Forgets Limitations	15	
	Orientated to own ability	0	

TOTAL :_____

In order to keep our patient safe we need to be able recognize their fall risk. Use your inpatient Morse Falls Scale to determine your patients risk for falling. All patients are assessed for fall risk on admission,

transfer, post fall, every shift, and whenever their condition changes and a yellow armband is used to indicate inpatients risk for falling.

Low Risk (All Patients) (Point Score of 0-24):
a. Zero out bed scale prior to placing patient on the bed and weigh patient in bed.
This reduces false bed alarms when bed alarm is set.
b. Provide adequate room lighting.
c. Ensure the traffic path in the room is free of clutter and observe for and minimize environmental hazards in patient's room.
d. Place upper side rails up when patient is in bed and instruct patient/family to leave rails up.
e. Place call bell and bed controls within reach. Evaluate whether the patient and family are able to utilize the nurse call apparatus. When orienting a patient to a new location on admission or transfer, test the nurse call apparatus to ensure it is working appropriately.
f. Place telephone and/or personal items within easy reach of patient.
g. Provide appropriately sized non-skid slippers if personal footwear is not equipped with non-skid features.
h. Instruct patient and family about fall prevention strategies. Review educational handouts with patient and family as appropriate. Encourage hand rail/safety bar and sensory support items used.
i. Encourage toileting before administering pain medications to minimize the patient getting up unnecessarily after pain meds administered.
j. Place bed in LOW position when staff is not in attendance and check to verify that bed brakes are locked. Instruct patient/family to leave bed in LOW position.
k. Orient patient to time/person/place as needed.
l. Before leaving patient, ensure iBed is set unless patient is in a specialty area where iBed is unavailable (such as Madison Hospital).
m. Document interventions and education as appropriate.
n. Include fall risk status on Handoff.
o. Utilize purposeful (caregiver) rounding to prevent falls by addressing the following:
1. Items are within reach
2. Pain assessment
3. Personal and bathroom needs
4. Position of patient
5. Bed in low position
6. Room is safe with cords secured wherever possible.
p. Utilize side rails when transported by stretcher.

Moderate Risk (Point Score of 25-45) *Apply all Low risk interventions plus the following:*
a. Private room is preferred if available. Otherwise, if in a semi-private room, the bed closest to the bathroom is preferred.
b. Place a yellow Fall Risk armband on the patient next to the hospital armband. Place a yellow Fall Risk door magnet on the exterior frame of the door to the patient's room.
c. Instruct patients to call for assistance prior to getting out of bed.
d. Consider using a bedside commode for elimination needs.
e. Utilize nursing judgment to consider whether or not to leave the patient unattended when up.
f. Set bed alarm to Zone 1 at night during hours of sleep unless patient is in a specialty area where Bed Alarms/zones are unavailable (such as Behavioral Health)
g. Use Chair alarm at night when patient is allowed to be up in chair unless patient is in a specialty area where chair alarms are unavailable (such as Behavioral Health).
h. Include fall risk status on care plan, and educate the patient and family on moderate fall risk interventions.
i. Communicate fall risk on all handoff including Ticket to Ride.
j. While in ancillary departments, maintain close observation of patient and consider patient at risk for falls.

High Risk (Point Score of >45) *Apply all Low and Moderate risk interventions plus the following:*
a. Move the patient to a room close to the desk when room becomes available.

b. Reminder: Zero out bed scale prior to placing patient on the bed and weigh patient. This appropriately assesses the patient's weight for alarm feature.
c. Set Bed Alarm to **"Zone 2" except for patients weighing less than 50 kg** who then needs to be placed on "zone 3". Rationale: patients weighing less than 50 kg do not trigger alarm on zone 2.
d. Place a sign above the bed indicating high risk for falls.
e. If patient is allowed up to Bathroom, staff is to remain by the bathroom door with the patient while leaving door cracked a few inches so that patient can be monitored as to when assistance needed to arise.
f. Use chair alarms when available when patient is allowed to be up in chair unless patient is in a specialty area where chair alarms are unavailable (such as Behavioral Health).
g. Consult the pharmacist to evaluate polypharmacy or medications that may contribute to falls such as sedatives, antidepressants, and diuretics.
h. Ask the patient's physician to consider a physical therapy consult if balance and mobility is an issue.
i. Include High Fall Risk on iPOC, Handoff, unit huddles and Ticket to Ride.

Pediatric Patients: all patients over age 1 to age 18 will be screened using the Humpty Dumpty Scale. For all patients, regardless of score, the appropriate bed type should be utilized based on age/ developmental level. All families should be instructed on fall prevention strategies. Utilize non-skid socks for ambulation. Maintain bed in lowest position and ensure crib rails are raised. Keep wheels of bed or crib locked. Keep nurse call light within reach of patient or family. If a patient scores as high, the following interventions are implemented:

a. Place yellow armband on patient
b. Utilize bed alarm

Fall Assessment Tool
The Humpty Dumpty Scale

Parameter	Criteria	Score
Age		
	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years old and above	1
Gender		
	Male	2
	Female	1
Diagnosis		
	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments		
	Not Aware of Limitations	3
	Forget Limitations	2
	Oriented to own Ability	1
Environmental Factors		
	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant Toddler in Crib or Furniture/Lighting (Tripled Room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia		
	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage		
	Multiple Usage of: Sedatives(excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives /Diuretics Narcotics	3
	One of the Meds listed above	2
	Other Medications/None	1
	Total	

Fall Risk
Low Humpty Dumpty Score = 7-11
High Risk Humpty Dumpty Score = 12 or above

<u>Infusion Therapy</u> (Central Catheters)

Intravenous therapy is carried out in accordance with Centers for Disease Control and Prevention (CDC) guidelines and Infusion Nurses Society (INS) standards of practice, to provide/maintain hydration, correct electrolyte imbalance, and/or administer medications.

- Central lines (Swan Ganz, Hickmans, Port-a-Caths and CVCs, PICCs, and CVP lines) are inserted by physicians and specially trained RNs/NPs. The provider's order specifies the

fluid, additives, amount and rate of administration.

- Standardized IV keep open rate:
  - 20 mL/hr. (Adult)
  - 10 mL/hr. (Fluid restricted Adult)
  - 5 mL/hr. (Pediatric patient < 10kg)
  - 10 mL/hr. (Pediatric patient >10kg)
- LPNs cannot initiate fluids, discontinue fluids, or change injection caps to central lines. They cannot open the central line system in any way.
- LPNs cannot change a central line dressing. LPNs are to coordinate with RN for Central Line dressing change, and injection cap changes.
- The LPN must have IV therapy experience and attend a required class to be to able to change approved IV Fluids to a to an existing IV line to a central catheter. The LPN has completion of supervised competencies on file.
- Gloves and mask are worn during all central line procedures including giving medications.
- All Central Lines must have physician order to implement the "Adult Central and Peripheral Flush" power plan. Use one syringe, one port, and one time.
- The nurse must flush using the push-pause method and aspirate blood prior to use of central line. If unable to aspirate blood the nurse is to obtain order to declot a partial or total occlusion with altepase.
- If unable to flush or aspirate, RN to obtain order for alteplase and administer using the stop-cock method.
- RN changes IV tubing every **96** hours. If TPN contains lipids the tubing is to be changed every 24 hours. Tubing is labeled with change date. If the drug product's labeling recommends a SHORTER tubing change-out interval, follow the product labeling guidelines (ex. propofol tubing is changed out every 12 hours as recommended by the product labeling). Do not loop IV tubing on itself.
- All central line dressings are to be changed on admission. The staff nurse is responsible for removing, assessing the central line site and applying a new sterile central line dressing. Document in EMR . This includes PICC/Hickmans/Implanted ports/Dialysis catheters.
- The nurse taking care of the patient is responsible for assessing the central dressing site for dressing integrity, bloody or wet. The bedside nurse will perform all routine and PRN dressing changes and document accordingly.
- PRN dressing changes are needed if biopatch is bloody/saturated, dressing is loose or taped down, dressing is no longer occlusive or there is obvious blood under dressing.
- Apply new injections caps if caps are removed, have visible blood after flushing, and with every dressing change.
- Any port not in use should have an alcohol impregnated cap attached to the injection cap. All unused IV tubing ports are to have an alcohol impregnated cap attached.
- Implanted port needles are to be changed every seven days and PRN. If accessed at CCI best practice is to remove and insert new non-coring needle upon admission. If patient refuses then document date inserted so as needle and dressing can be changed 7 days from insertion. Assess implanted catheter for power port or portacath. Insert correct needle. (Huber or Power lock).
- No IV solution is to hang longer than 24 hours (blood only 4 hours from time removed from blood bank).
- Except for certain drugs in an emergency, all large volume IVs are mixed by pharmacy personnel under the laminar flow hood.
- IV fluids given through a central line are administered on an infusion pump. (Exception: Procedural Areas.) When administering IV fluids on a pump the Medication Library and Smart Pump Programming is utilized (if available). Do not use dial-a-flows with a central line.
- The IV infusion is not interrupted for patient showers or to ambulate without a physician order.
- Nurse must obtain physician order for labs drawn via central catheter; in an effort to decrease central line associated bloodstream infections (CLABSIs). Draw routine lab with a physician order ONLY via injection caps using safety devices. Discard a minimum of 6-10mL. Flush with Normal Saline 20 mL using push pause method after each blood draw.
- Draw blood cultures at the hub with physician order ONLY. If the syringe touches the side then it is contaminated. Do not draw cultures via injection cap. Fill the green blood culture bottle then the purple using the safety device.

Infusion Therapy (Peripheral IVs)

Intravenous therapy is carried out in accordance with CDC guidelines and Infusion Nurses Society (INS) standards of practice, to provide/maintain hydration, correct electrolyte imbalance, and/or administer medications.

- LPNS may start IVs after completing the LPN IV Therapy basic class.
- The primary nurse is expected to attempt to establish an IV line before notifying the charge nurse. The charge nurse or designee may attempt once prior to contacting the IV Team nurse. If veins cannot be visualized or palpated, the primary nurse (after conferring with charge nurse) or charge nurse may page the IV Team member without attempting access. If all attempts are unsuccessful, then the charge nurse or evening supervisor is to be notified that the attempt to start a peripheral IV access was unsuccessful and then makes the decision to contact the physician for possible PICC placement.
- Date and initial all IV sites. IV peripheral catheters **inserted outside of Huntsville Hospital** are changed to a new site as soon as possible and no later than 48 hours of admission. Careful consideration is given to patient condition. The catheter is not to be removed until an alternative access is established .
- Rotate IV sites when clinically indicated.
- Change PIV dressing every seven days or if soiled or no longer intact. Date and initial dressing with the date IV inserted and with date dressing changed.
- If resistance is met when attempting to flush, remove the IV catheter. *IV catheters are NEVER force flushed.*
- IV Tubing is changed every 96 hours. Tubing is also changed with initiation of incompatible solutions, or if there is any question about contamination. When disconnected a sterile tip covering is utilized to keep tip sterile-do not loop tubing on itself. If solution contains LIPIDS, tubing is changed every 24 hours.
- Assess and document:
    - every 4 hours for routine patients
    - every 1-2 hours for patients who are critically ill/sedated, have cognitive deficits or are receiving vesicants
    - every 2 hours for neonatal/pediatric patients
- To remove hair use only electric razor with disposable head or clip with disposable single use scissors.
- The intended insertion site is prepped aseptically with 2% Chlorhexidine gluconate in 70% isopropyl alcohol (Chloraprep) **30 seconds and allow to dry.** A patient with moist, diaphoretic skin requires scrub of 2 minutes. Check for allergies before prepping. Use aseptic technique to insert and remove IV catheter.
- Do not stick a patient twice with the same peripheral catheter. They are to be used only once. Activate the needle safety mechanism by pressing the white button and discard the device in a needle box. Assess patient's vein to determine the smallest needle gauge possible. Assess for length of stay and medication to be administered.
- Scrub all injection ports on IV tubing and catheters at least 10-15 seconds with ALCOHOL prior to attaching syringe or tubing. Use one syringe for one time.
- Standardized IV keep open rate:
    - 20 mL/hr. (Adult)
    - 10 mL/hr. (Fluid restricted Adult)
    - 5 mL/hr. (Pediatric patient < 10kg)
    - 10 mL/hr. (Pediatric patient >10kg)
- Always trace a tube from the patient to the point of origin before connecting any new device or infusion to verify you are connecting the IV to the correct site.

Labeling

Any medications or solutions taken from the original container must have the new container labeled as specified below. Receptacles cannot be pre-labeled - the product must be labeled immediately upon placing the drug/solution in it; sterile markers and labels are available for use on the sterile field.

- *IV bags removed from the overwrap* - if an IV bag is removed from its overwrap and not used immediately (generally, within an hour), it must be labeled with a new expiration date (<50 mL = 15 days, >50 mL = 30 days)...be sure to affix a label with this date - do not write directly on the bag with a pen or Sharpie. Do NOT put the date removed from the overwrap on the bag – you must put the new expiration date.

- *Oral liquid bulk bottle* - no need to add a label to the bottle...it can be used through the manufacturer's expiration date unless it appears contaminated - do NOT put the date opened on these products; if you pour the liquid into a cup and transport it to the patient, you must label the cup (or other receptacle) with drug name and strength/amount
- *Oral tablet/capsule* - if removed from its original container and transported to the patient's room, it must be labeled with at least drug name and strength...this includes medications that are crushed or mixed with food/drink; if the drug is taken to the room in its original packaging, it does not have to be further labeled.
- *Multi-dose injectable vials* - generally use once, then discard; if re-used, you must put the new 28-day expiration date on the label (do NOT put the date it was first used on the label – only the new expiration date).
- *Single-dose injectable vials* - no need to add a label...penetrate once, then discard
- *Syringes (and other receptacles, including cups, bins, basins, bowls, etc.)* - must be labeled with a minimum of drug name and strength/amount; if diluted, the name and amount of diluent must be on the label; if it expires in less than 24 hours, the expiration date and time must be on the label [the only exception to labeling of syringes (or other containers into which a drug or solution has been placed) is when the same person who prepares the medication also administers it immediately upon preparation and with no intervening steps]
- *Topical products* - no need to add a label...it can be used through the manufacturer's expiration date unless it appears contaminated; if the container is taken to the immediate patient care area (e.g., the patient's room/bedside), it can only be used on that patient and should not be returned to the med room
- *Warmed items* - medications or solutions placed in a warmer can generally be warmed to 104 degrees F for either 14 days (e.g., mannitol, IV fluids) or 30 days (e.g., contrast). The date that the product is to be removed from the warmer must be affixed to the label (NOT the date it was placed in the warmer).

Latex Allergy

Latex allergy (immediate hypersensitivity) is a systemic type I IgE-mediated response to plant proteins in natural rubber latex (NRL). Symptoms include local swelling, redness, edema, itching, and systemic reactions, including anaphylaxis**.** All employees should be aware of patients and/or employees who may show signs of sensitivity to latex. If the patient says he/she has a latex allergy or you assess high risk and there is no documentation in the H&P regarding latex allergy, you will call the MD to get an order to implement Latex precautions. Document physician notification and orders received to implement or not to implement latex precautions. If the latex allergy is noted in the physician's H&P the nurse proceeds to implement latex precautions without notifying the physician.

Persons at risk for developing a latex allergy include employees who have occupational exposure to latex products, particularly to powdered products such as gloves, or to latex aerosols and patients with a history of oral allergy syndrome or progressive reactions to foods known to cross-react with natural rubber latex including bananas, kiwifruits, avocados, stone fruits, raw potato, tomato, papaya, or chestnuts, or a history of latex glove-associated contact dermatitis

Latex is used in many hospital products, blood pressure cuffs, catheters, etc. Manufacturer products labeling should indicate if the product contains latex ("Natural latex rubber"). Remove items containing latex from the room.

Note: Procedure rooms may have Latex items stocked in cabinets that cannot be removed. Communicate allergy to team members. Place visible latex allergy warning signs on the door and at the head of the bed. Place latex allergy sticker on front of chart. Apply RED allergy armband per Color Coded Armband policy. Inform departments that have contact with the latex sensitive or high risk patient prior to transport to that department per oral report and or by computer when ordering tests / studies. Do not use Latex products in the patient's room or when caring for the latex sensitive or high-risk patient. Read all product packages/labels to determine if latex is present. Use non-latex or synthetic gloves and latex free syringes for preparation of patient's medications and IV fluids. Do not draw up medications through a rubber vial stopper. Remove the stopper prior to drawing up medication. Do not use latex injection ports on IV bags or tubing. If allergic reaction occurs, call the physician immediately. Be prepared to call a Code 0 (Ext. 4-5555) in case of anaphylaxis / shock. List the Latex allergy on the discharge

instructions and instruct the patient, family/companion. Discharge teaching for NRL allergic patients may include the handout on Latex Allergy found in Care Notes.

Magnetic Resonance Imaging (MRI) Safety

Always collaborate with the MRI techs before entering the MRI scan room. There are 4 safety zones in the MRI department. These zones make everyone aware of how close they can be to the magnet. The magnet is always on whether a patient is being scanned or not. Remember no magnetic or ferrous metal objects can be in the MRI room regardless of size. The powerful magnetic field of the MR system will attract iron-containing (also known as ferromagnetic) objects and may cause them to move suddenly and with great force. This can pose a possible risk to the patient or anyone in the object's "flight path." Great care is taken to be certain that objects such as ferromagnetic screwdrivers and oxygen tanks are not brought into the MR system area. All patients need to be screened before entering the MRI room. All metallic belongings must be removed from the patient in advance of an MRI exam, including hearing aids, watches, jewelry, and items of clothing that have metallic threads or fasteners. Additionally, makeup, nail polish, false eyelashes or other cosmetics that may contain metallic particles should be removed if applied to the area of the body undergoing the MRI examination.

The powerful magnetic field of the MR system will pull on any iron-containing object in the body, such as certain medication pumps or certain aneurysm clips. In some cases, certain medical implants can heat substantially during the MRI examination as a result of the radiofrequency energy that is used for the procedure. The magnetic field may damage an external hearing aid or cause a heart pacemaker, electrical stimulator, or neurostimulator to malfunction or cause patient injury. If the patient has a bullet or any other metallic fragment in his/her body there is a potential risk that it could change position and possibly cause an injury.

Malignant Hyperthermia

Malignant Hyperthermia Syndrome is a rare, genetically transmitted, life-threatening complication that may be triggered by anesthesia gases and succinylcholine, which is used by CRNAs, Emergency Medicine Physicians, Intensivists, Hospitalists, residents, and Pulmonologists for rapid sequence intubation. The syndrome begins with a hypermetabolic state with the following signs & symptoms: Tachycardia, Hyperkalemia, Tachypnea, Cyanotic mottling of skin, Profuse sweating, Arrhythmias, Myoglobinemia, Unstable BP, Discolored urine, Elevated CPK, Fasciculations and/or rigidity, Hypercapnia, Metabolic acidosis, Fever - rapid rise, sustained to as high as 108 F (42.2 C) or more, Respiratory acidosis. An episode of malignant hyperthermia can be life threatening. However, early treatment at onset of symptoms is usually successful. Once recognized and diagnosed, future episodes can almost always be prevented by avoiding known triggers.

A Code MH is called for any suspected malignant hyperthermia crisis in non-procedural areas, where anesthesia is not already present. Code MH activation brings a response team and the MH cart to help manage the crisis. MH carts must be available **within 10 minutes** and are located in the following areas: **HH Main**- Old PACU; **W/C**- OR Hallway; **GMT**- PACU; **Madison**- Anesthesia Workroom; **Orthopedic and Spine Tower**- 2nd floor PACU

Treatment:

In case of MH emergency- Contact the 24-HOUR MH HOTLINE 800-644-9737.

- Hyperventilate with 100% oxygen, administer the antidote Ryanodex (dantrolene), Administer Bicarbonate, Cool the patient, Treat Hyperkalemia, acidosis and dysrhythmias,
- Draw labs ASAP: ABG, CBC, BMP, CK, Urine myoglobin, PT/INR, PTT
- Place foley catheter, arterial line, multiple large bore IV's, consider Central Venous Line or PA monitoring as needed.
- When stable, transfer the patient to the ICU for at least 24 hours. Initiate the ANES Malignant Hyperthermia Post Acute Orders powerplan.

- Documentation of MH crisis is completed on the Code MH flow sheet and placed under "Other" tab of chart. Add volatile anesthetics and succinylcholine to patient's list of allergies. A safety event report should be completed on any MH crisis.

Recovery time for MH Susceptible patients undergoing general anesthesia in which they are connected to an anesthesia machine must be recovered in the PACU for a minimum of 1 hour, followed by a minimum of 1 hour in Phase 2 Recovery, unless they are being admitted to the hospital. This applies even if a non-triggering anesthetic was used.

Medication Management

- Medications must be secured (either under lock or constant surveillance by authorized staff) at all times.
- Medications - including saline flushes - are never carried in pockets. There are NO EXCEPTIONS to this requirement!
- Medication orders must be legible if written, contain no unsafe abbreviations, and be complete. All unclear orders must be clarified with the provider before implementation.
- PRN orders must contain a frequency interval, an indication/reason for use (if more than one possible indication for the drug), and (if more than one drug is ordered for a particular indication) clear instructions for when the nurse is to choose one drug over another.
- Range orders are not allowed. Dose range comments are removed from orders and doses default to the dose entered into the dose field. Frequency ranges are converted to the most frequent time in the range.All medication orders must be verified by a pharmacist before administration. The only exceptions are when (1) when a provider controls the ordering, dispensing/preparation, and administration of medications (such as in ER or Endoscopy) or (2) when, in the professional judgement of a clinician, any delay may compromise the clinical status of the patient. If a clinician removes a medication for administration before it has been verified by a pharmacist, it is strongly suggested that the drug be checked by a second clinician. Medications removed from PYXIS on override and administered prior to pharmacist verification are documented in the medical record..
- All sterile products (IV drips) must be made in the Pharmacy, with the following exceptions: registered nurses who have received training in sterile product preparation are permitted to compound and admix sterile medications and intravenous admixtures for immediate use for patients if the situation is deemed emergent or if it is not feasible for pharmacy to prepare due to a medication having poor product stability with a short duration of effectiveness.
- All medications removed from Pyxis on override must be for emergent use or for use in the presence of a physician and must have the reason for override documented in the electronic medical record.
- All medications and solutions (on and off the sterile field) must be labeled unless drawn up and administered immediately by the same person. The label must contain drug name, strength, quantity if not apparent, and diluent if diluted. Pre-labeling is not allowed, neither is 'batching' - prepare one drug for one patient at a time and label it immediately. Note: taping of the vial to the syringe and other shortcuts are *not* acceptable. Non-sterile labels can be printed from Pulse (Rx-for-Nursing) and sterile labels and pens are available from Central Supply.
- When a patient is treated by the hospital in any setting, a complete medication history must be taken and made available in the medical record for provider review.
- When patients are discharged/released from the hospital's care, they must be given a complete list of medications to take at home.
- "Blanket" orders (orders to "resume... " or "continue... " meds from a previous setting) are prohibited - always clarify with the provider and get a complete order.
- Use of the patient's own home supply of medications in the hospital is restricted to medications unavailable from the pharmacy. Requirements for use of the patient's own supply include: (1) approval by a pharmacist; (2) identification of the medication by qualified personnel; (3) secure storage (medication room / if controlled substance, contact pharmacy). If the patient's own medications are not to be used in the hospital, send the medication home with a family member (or treat as a valuable according to the "Patient Belongings and Disposition of Valuables" policy if no family available).
- If a patient is to self-administer a medication, (1) he/she must have a provider's order to do so, (2) patient/family must be educated about appropriate use of the medication and judged competent to self-

administer, (3) patient/family must sign a waiver (available on Pulse), (4) patient/family must keep an in-room MAR (which goes in the chart at the end of each shift). Meds should be kept out of sight (e.g., in bedside table) and the patient/family must be taught safe administration practices, including reporting of adverse drug reactions (ADRs). Staff administration of medications is preferred to patient self-administration of medications.

- Non-sterile products (orals, topicals, etc.) are good through the manufacturer's expiration date unless the product appears contaminated. These products are NOT dated when opened. Sterile multi-dose injectable vials may be used for up to 28 days after opening (however insulin is only good for up to 28 days at room temp, whether opened or not). For most multi-dose vials (other than insulin), it is recommended to **dispose of them after one use** (e.g., lidocaine, heparin vials). If these sterile multi-dose injectable products are kept for 28 days after opening, they must be labeled with their new 28-day expiration date (NOT the date opened!) and disposed of at that time. Products marked "single dose" must be disposed of after one use.

Mobilizing and Transferring the Bariatric Patient

Clinical staff may have special challenges associated with the care of bariatric patients. These challenges include physical differences, mobility, safety, use of specialized equipment and unique skills required to provide a sensitive and dignified care experience.

Steps to Mobilize a Bariatric Patient:

1. Assess the patient's level of independence and capability while carefully planning the safest method of mobilization or transfer. Involving the patient, helps reduce the risk of injury not only for the clinician but for the patient as well. Instruct the patient on proper technique and how he/she can assist in the movement. Understand the importance of providing a sensitive and dignified care experience .Thorough and compassionate instruction to the patient will help in the goal being accomplished without injury to anyone.
2. Watch out for yourself - Ask for assistance. Utilize proper body mechanics and lift equipment. When lifting, keep your back straight or slightly arched. NEVER use your back to lift. Use your legs to do the majority of the lifting. And most importantly, never twist your body while lifting. This causes a huge strain on the back muscles and can cause severe injury. When transporting a patient, be sure to have the appropriate size vehicle. Trying to fit a patient on an inappropriate size transport vehicle can result in injury to you or the patient. Make sure you have the adequate number of assistants as evidenced by your assessment of the situation. Push the vehicle, don't pull. Pulling causes more strain on your muscles and can increase the risk of injury.
3. Use proper equipment. Be familiar with and know the weight capacity of equipment ahead of time. Use "ARJO Tool Box" videos on **Pulse** to identify proper lift equipment. Proper equipment is a must (the right size bed, stretcher, wheelchair, walkers, and lifts such as: Sara Stedy, MaxiMove, Tenor, MaxiSlides, etc.).

Arrange the equipment, furniture, and physical space ahead of time and make sure everyone understands their role prior to beginning the task. Taking the time to plan in advance will improve safety and success.

4. No excuses. Never use obesity as an excuse to not mobilize a patient. Find a way! Get help, get proper equipment, do whatever it takes to protect yourself and the patient from injury to get them moving. Taking your time will help reduce patient discomfort and anxiety. Sensitive emotional support is also a top priority.

Moderate Sedation

Moderate sedation is a safe alternative to general anesthesia for certain procedures. Here are some points to remember:

- There are four levels of sedation: mild sedation, moderate sedation, deep sedation, and anesthesia.
- Moderate sedation provides an altered perception of pain while allowing the patient to maintain his airway and spontaneous ventilation.
- If a patient undergoing moderate sedation becomes unable to speak or has decreasing respirations, he might be moving into deep sedation and might need ventilator support.
- Moderate sedation is used in a variety of procedures, including endoscopy and cardiac catheterization procedures.
- Only those with advanced training (including airway and advanced medication management) and current ACLS, PALS, and/or NRP are qualified to administer moderate sedation.
- Reversal agents are available in the event that a patient becomes over sedated.
- Frequent monitoring of the patient and his vital signs are essential to safe care during and after moderate sedation.

National Patient Safety Goals

The purpose of the National Patient Safety Goals, issued by The Joint Commission, is to improve patient safety. The goals focus on problems in health care safety and how to solve them. All Huntsville Hospital employees are responsible for ensuring a safe environment and safe care for our patients.

**For a detailed version of the NPSG, see handout in the "Learn More" section to the right of each page*.

The Joint Commission

2023 Hospital National Patient Safety Goals

(Easy-To-Read)

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Improve health care equity

NPSG.16.01.01

Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

Opioid-Induced Respiratory Depression

In August 2012, the Joint Commission released a Sentinel Event Report on the safe use of opioids in hospitals. TJC reported that opioids are a common cause of adverse drug events (ADE), with respiratory depression being the most serious ADE. Some of the causes for adverse events associated with opioid use are lack of knowledge about potency differences among opioids, improper prescribing and administration of multiple opioids and modalities of opioid administration (i.e., oral, parenteral and transdermal patches), and inadequate monitoring of patients on opioids. Due to the obvious risks for hypoxic brain injury and death, preventing patient harm associated with opioid use should be a priority.

Characteristics of patients who are at higher risk for oversedation and respiratory depression*:*

- morbid obesity with high risk of sleep apnea
- sleep apnea or sleep disorder diagnosis
- snoring
- older age (>60 year old; highest for >80 year old)
- no recent opioid use (opioid naïve)
- post-surgery (especially upper abdominal or thoracic)
- increased opioid dose requirement (opioid tolerant)or opioid habituation
- longer length of time receiving general anesthesia during surgery
- receiving other sedating drugs such as benzodiazepines, antihistamines, diphenhydramine, sedatives, or other central nervous system depressants
- pre-existing pulmonary, cardiac, renal, or liver disease
- thoracic or other surgical incisions that may impair breathing
- smoker

Monitoring recommendations:

- sedation monitoring -sedation precedes respiratory depression; pay attention to trends in sedation; recognize advancing sedation and intervene before respiratory depression occurs; sedation monitoring using the Pasero Opioid-Induced Sedation Scale (POSS) is used for assessing and tracking sedation on any patient prescribed opioid medication for pain control (any route; adult and pediatric populations) (per HH policy, sedation monitoring is required for patients on PCA pumps). The POSS will be assessed with each pain assessment for patients receiving opioids. .
- continuous pulse oximetry - continuous pulse oximetry is recommended for patients receiving opioids postoperatively; (based on Huntsville Hospital policy, it is required for patients on PCA pumps), however, use care when interpreting O2 sat levels; O2 sat levels may remain in the normal range even when patients are actively experiencing respiratory depression (especially when supplemental oxygen is used); do not rely on O2 sat monitoring alone. If you find a patient sleeping with a low pulse oximetry reading, for example 89, and you awaken that patient and their pulse oximetry climbs to 93 - you must act upon the initial 89 reading.
- depth and quality of respirations - respiratory depression is characterized by an initial period of irregular breathing without affecting the respiratory rate; evaluate the rhythm and depth of respirations in addition to the frequency of respiration. Patients who have received naloxone to reverse respiratory depression or over-sedation require continued frequent monitoring due to the fact that naloxone has a shorter duration of action than most opioid agents; (in other words, the offending drug's effects may last longer than the antidote).

Organ and Tissue Donation

The agencies currently designated as responsible for the coordination and retrieval of organs, tissues, or eyes are Legacy of Hope (LOH) and Advancing Sight Network (ASN). After suitability is determined, LOH or their designee offers the family the option of organ and tissue donation. The family consent is obtained by the LOH coordinator or their designee in conjunction with a member of the hospital staff. Only trained designated requestors should approach families about donation.

- Nursing staff or designated hospital representative notifies LOH/ASN of pending death and/or death, prior to withdrawing care by entering a Legacy of Hope Notification order in 1chart- no cosign required.
- This order will send pertinent information to LOH coordinator. LOH will call the nurse with any questions
- Nurse should verify in Results Review the order went through. If the order did not go through, nurse will call referral in to LOH.
- Suitability is established by the LOH/ASN as to whether the patient is a potential Organ/Tissue/Eye Donor.
- The chart and the body with ID band attached remain on the unit, if applicable, until future instructions by LOH/ASN.

Oxygen

1. Oxygen requires a provider's order. It is administered to help decrease work of breathing, reduce work on the heart, and improve low oxygen levels. Providers also order oxygen for patients before, during, and after certain procedures and tests.
2. Competently trained nurses routinely initiate and adjust nasal cannula oxygen up to 6 liters per minute. The nurse documents the device, liter flow, and oxygen saturation in the electronic medical record (EMR) upon the initial set up of the nasal cannula and each time an adjustment is made. All other supplemental oxygen devices (e.g. non-rebreather, partial non-rebreather, trach mask, venturi mask, oxymizer, high flow therapy, CPAP/BiPAP/Vent) are routinely set up and adjusted by licensed respiratory therapists only.
3. Huntsville Hospital uses oxygen E cylinders to transport patients requiring oxygen. These E cylinders have built in regulators which display how much oxygen is in each tank. It is the responsibility of every clinician to follow all oxygen safety guidelines when using the tank.

   Step 1:

   Verify there is adequate oxygen in the tank to last for the duration of time the tank is needed. Check the amount of oxygen displayed on the tank's regulator. Use the following guidelines to determine whether the tank is full, partially full (in use), or empty:

   - A **FULL** cylinder is one un-opened with all **CAPS** on the outlets with greater than or equal to **2000 PSI**. Full cylinders are un-opened and are kept in areas with signs reading **FULL**.
   - An **IN USE** cylinder is one without CAPS, with **greater than 500 PSI**. These cylinders are partially full and are kept in areas with signs reading Partially Full/In Use Tanks.
   - An **EMPTY** cylinder is one with **less than 1/4 Full or 500 PSI (Red Zone)** and is to be returned to Respiratory Therapy or taken out of service for replacement (e.g. placed in area with sign reading Empty Tanks).
   - Use this formula to calculate tank duration times: The amount of pressure in the E tank) multiplied by (0.28) then divide this # by the # of liters you are running the tank = Total Minutes of use (Example a Cylinder has 1200 PSI and the patient is on 2 LPM. Therefore 1200 x 0.28 = 336 divided by 2 LPM = 168 minutes of total Cylinder time.
   - Cylinders placed on **Crash Carts** must be >1/2 Full or > 1200 PSI. These cylinders are not to be used for general transportation of patients.
   - **Full tanks, Empty tanks, and Partially Full (In use) tanks are to be kept separate**.

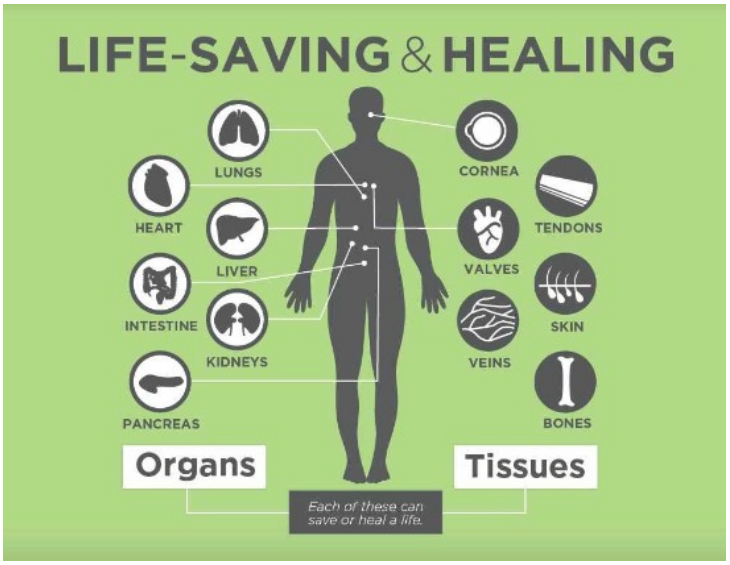
   Step 2:

   Remove the black cap from the tank's outlet and turn the tank on by turning the black rotary dial at the top of the tank clockwise until the patient's ordered liter of flow is displayed in the window. Connect the patient's oxygen device to the tank's outlet.

4. **Some additional oxygen safety guidelines to follow**:
   - Tanks are to be secured at all times in a hospital approved carrier, cart, or bracket holder. Never place a tank in the bed with the patient and never hang a tank on the handles of a wheelchair.
   - When connecting oxygen delivery devices to the wall, make certain that you are connecting it to a flowmeter in a green outlet in the wall.
   - The universal color code for oxygen is green, therefore oxygen outlets are green. The universal color code for air is yellow, therefore air outlets are yellow.
   - Avoid placing Petroleum based products directly on or around Oxygen delivery devices. Avoid storing tanks near electrical outlets.
   - No more than 300 cu ft. of gas (or 12 e-cylinders) can be stored in any given area at a time. Designated tank storage areas are available for tank storage for greater than 300 cu ft. of gas.
   - **In the event of a fire or disaster, medical gas zone valves are controlled by competently trained individuals in each area that are designated as first responders. These individuals receive support from Respiratory Therapist and Plant Operators that help coordinate the back-up supply for oxygen. When shutting off medical gas valves, one should take into consideration all patients in all rooms that are supplied by the zone valve that is being turned off.**
   - Use the AF3 Sani-Cloth Germicidal Disposable Wipes to disinfect the tanks with in between each patient use.

Pain Management

Pain management is a priority for our patients. Frequent communication with the patient/family to make sure their pain is managed appropriately is essential. Pain assessment is completed as part of the initial nursing assessment and occurs with each new report of pain focusing on identifying the cause of pain and developing a pain management plan. With the patient's participation, document the goal pain level that is tolerable to the patient and can be safely achieved. Help the patient set realistic expectations about his/her pain. Non-pharmacological interventions, such as deep breathing, should also be considered, especially if the intervention helps the patient at home.



A patient's pain level is assessed on admission, at least once per shift, whenever the patient's condition changes, whenever the patient complains of pain, and at discharge. The patient's pain level at the time of a pain medication request is documented. Then, the patient's pain is reassessed within 1 hour post prn pain medication administration (30 minutes after IV medication and 60 minutes after oral medication) and documented in the patient's record.

NOTE: Use the same pain assessment scale for assessment and reassessment. Patients on PCA pumps are assessed prior to starting the PCA and at least every 4 hours until PCA is discontinued for pain. Patients receiving scheduled pain medication (e.g., MS Contin), a continuous pain medication IV drip, epidural or implanted pain pumps, and or IV sedation/analgesia are to be assessed for pain level at the time of initiation and at least every (4) hours for the duration of therapy; also pain is reassessed if the patient says pain is not relieved or as the patient's condition changes.

If a patient complains of pain implement nonpharmacologic pain management interventions. Those interventions may be implemented before, concurrently, or subsequent to administration of PRN pain medication.

Complete the pain assessment section on the Patient/Family Communication Board as appropriate. If needed use the "Goal of the Day" section on the Patient/Family Communication Board to address pain management (ex. "keep pain level below 2"). Suggested response when communicating with patient/family regarding pain management: "(Insert patient name), please don't wait until your pain is severe. Call me as soon as it feels like it is becoming uncomfortable (ex: level), so I can help keep it in control." Repositioning can often help relieve pain.
When multiple pain medications are ordered by the provider, the pain level is specified for each medication; i.e. mild, moderate, or severe. Ensure that the medication administered is the correct order for the documented pain level (i.e, give the moderate pain medication if the pain score is 6). Medications ordered for “breakthrough pain” may be given if the maximum dose of the primary PRN medication for the designated pain level has been administered and the patient’s pain is unrelieved upon reassessment or if no primary PRN medication is ordered for the reported pain level. Consider contacting the provider for pain medication order adjustment if more than 2 doses of breakthrough pain medication doses are needed in a day.

Palliative Care

Palliative Medicine is a subspecialty that focuses on improving quality of life for patients living with serious illness from diagnosis forward. Palliative Care providers use specialized communication techniques and an interdisciplinary approach to elicit patient’s beliefs and values in effort to align evidence based medical care with patient preferences. Interventions are aimed at maximizing QOL by alleviating symptom burden and emotional/spiritual distress while providing and extra layer of support for patient and caregiver. The interdisciplinary team is comprised of physicians, nurse practitioners, chaplains, music therapists, and pharmacists. The team collaborates with other medical providers and staff to identify goals/preferred level of care, provide symptom management, coordinate care and support transition plan. Consult Services are available Monday through Friday 0800-1700.

Patient Identification

Every patient is identified upon arrival to the hospital and before care is initiated, using full name (first name, middle name, and last name) and date of birth. Patients are to have a verified hospital patient identification armband in place at all times. This armband is the PRIMARY armband used for verification during medication administration, and prior to treatment or procedure. Prior to placing the armband, ask the patient to spell full name and date of birth, while comparing that information to the armband. Prior to treatment, procedure, and/or medication examine the patient’s armband and ask the patient name and date of birth. Compere the name and date of birth to the document being used. When identifying inpatient newborns for any procedure or treatment, the infant name and medical record number is used as the two unique patient identifiers. For non-communicative patients, or non-reliable historians, check the patient’s armband and compare the name and date of birth to the document that is being used for the treatment or procedure. Doe patients are identified by the Doe name assigned by registration and medical record number until positive identification can be completed. Do not use date of birth as an identifier for the Doe patient. For departments which do not use patient armbands, patients are asked their full name and date of birth, which is compared to the document being used, prior to any treatment or procedure. If the patient is unable to provide full name and date of birth, a family member or anyone accompanying the patient is asked to provide this information. When validating written or electronic patient information that is related to a visit, include all numbers in the account number. When labeling specimens, compare each labeled specimen to the patient’s armband and verify name and date of birth. If at any point during the identification, treatment, procedure or medication administration, the patient or family questions the appropriateness of the procedure or if the armband does not match the documents or the patient or family information, stop the procedure and re-examine all aspects for appropriate patient identification. Upon transfer of patient to any other unit, morgue, or facility, verify the correct patient identification armband is in place.

Patient Rights and Responsibilities

Huntsville Hospital Health System will respect, protect, and promote the following rights of every patient:

- Care shall be provided impartially. Patients are entitled to considerate, respectful and dignified care at all times. Patients have the right to receive care in a safe setting. Patients are entitled to personal and informational privacy as required by law. Patients and/or patients' legally designated representatives have the right of access to information contained in the patient's medical record, within the limits of the law and in accordance with hospital policies. Patients of the Health System have the right to know the identity and professional status of all persons participating in their care. Patients are entitled to know the status of their condition. Patients have a right to share in decisions about their care to the extent permitted by law. Patients have the right to be free from physical restraints which are not medically indicated or necessary. Patients have the right to have their family and physicians promptly notified of their admission, transfer and discharge from the hospital. Patients are entitled to formulate advance directives or a health care power of attorney and appoint a surrogate decision maker to make health care decisions on their behalf, to the extent permitted by law when a patient is unable to make decisions about their care. Patients are entitled to receive an itemized, detailed explanation of charges related to services rendered on their behalf by the Health System. Patients will not be transferred to another facility or location without explanation of the necessity for such action. A patient's guardian, next of kin, or legally authorized responsible person, may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been judged incompetent in accordance with the law, or is found by his/her physician to be medically incapable of understanding the proposed treatment or procedure, or is unable to communicate his/her wishes regarding treatment, or is a minor. Patients have the right to appropriate assessment and management of pain. Patients have the right, subject to the patient's consent, to receive visitors whom they designate. Patients have the right to withdraw or deny any such consent at any time. Patients have a right to meet with the Ethics Committee, Chaplain or Patient Advocate to discuss any ethical issues and policies. The patient's rights to religious and other spiritual services will be respected. Patients have the right to language interpreting and translation services which may include hospital-employed, contracted interpreting services, or trained bilingual staff, and may be provided in person, via telephone, or by video. Patients have the right to the use of a service animal that has been trained to do work or perform a task for people with disabilities. Patients have a right to leave the hospital (as far as the law allows) even if advised against it. Patients have a right to have their complaints handled fairly. The health system will never ask a patient to waive his or her privacy rights as a condition of treatment.

Patients have the following responsibilities:

- Providing the Health System and its practitioners with complete and accurate information regarding past and present illnesses and operations, hospitalizations, medications, insurance and other health-related issues, including any unanticipated changes in their condition. Following recommended treatment plans prescribed and/or administered by their primary practitioner or those assisting him/her, including keeping appointments relative to their care. Asking questions they may have about their treatment and what they need to do to take care of themselves. Patient should inform Health System clinicians if they are concerned or notice any changes in their condition. Ensuring prompt and complete payment of their hospital bills Following hospital rules and regulations relative to patient care and conduct. Providing any living will, power of attorney, or donor forms they may have. Contacting the Health System Compliance and Privacy Department if they are concerned about their privacy. Assuming responsibility for the consequences of their actions if the patient refuses prescribed treatments or does not follow their practitioner's instructions.

Present on Admission (POA) and Hospital Acquired Conditions

Present on admission (POA) is defined as a condition that is present at the time the order for inpatient admission occurs, including conditions that develop during an outpatient encounter, such as in the ED or during observation or outpatient surgery.

In July 2008, the Centers for Medicare and Medicaid (CMS) Final rule listed ten categories of conditions that were selected for the Hospital Acquired Conditions payment provision. Hospitals will not receive additional payment for cases in which one of the 10 selected conditions was not present on admission. The categories selected are:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure injuries
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter Associated Urinary Tract Infections
- Vascular Catheter Associated Infections
- Surgical Site Infections following:
  - Coronary Artery Bypass Graft – Mediastinitis
  - Bariatric Surgery
  - Orthopedic Procedures
  - Deep vein Thrombosis/Pulmonary Embolism

Several of the conditions listed above have been referred to as "never events ." According to the National Quality Forum (NQF), "never events" are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Examples of "never events" include surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure injury" acquired in the hospital; and preventable post-operative deaths. Hospital acquired conditions are considered both quality and financial concerns for the organization.

The importance of complete documentation in the medical record cannot be overemphasized. Documentation from any provider involved in the care and treatment of the patient is helpful in determining the presence of these conditions on admission. Nursing documentation at the time of a patient's admission is key to providing needed information. Clinical Documentation Specialists, Registered Nurses specially trained in documentation, review all documentation in the medical record and confer with the physician for determination of present on admission when the information is unclear.

If a "never event" occurs while the patient is in the hospital, a Safety Event Report (SER) should be completed as timely as possible to allow for prompt follow up. All SERs related to hospital acquired conditions are reviewed by Quality Management and Patient Accounting.

Remember:

- *Complete a thorough initial patient assessment*
- *Document any conditions POA*
- *Include these POA conditions in the patient's care plan*
- *Inform Physician of patient's condition*
- *Complete a SER if patient acquires one of these conditions while in the hospital.*

Radiology Education

In many cases, x-rays are done portably in the patient's room. X-ray technologists receive many hours in radiation safety training and are aware of proper procedures for making such x-rays.

- The technologist is required to use all required safety protection for himself/herself and the patient.
- The radiation beam is to be restricted to the body part being radiographed by automatic collimator or coned down manually to concerned body part, while the x-ray beam is accurately aligned with the patient and image receptor.
- During any exposure, no person or persons shall be permitted in the x-ray room except patients being radiographed or, if necessary, persons assisting in holding the patient with proper shielding attire (lead apron and gloves).
- No individuals exposed to occupational radiation will hold a patient during exposure except during an emergency. If a patient must be held, the individual is to have the proper shielding, and no body part is to be placed in the useful beam.
- The operator shall stand as far as possible (at least 6 feet) from the patient, the tube, and the useful beam; he/she will wear a protective apron or stand behind a suitable shield.
- Mobile or portable equipment should only be used for examinations where it is impractical to transfer patients to permanent radiographic installations.
- Anyone assisting will wear a protective apron and stand as far as possible from the patient. In the close confines of the operating room or the intensive care unit it is sometimes difficult for everyone to be several feet from the patient. Often, a nurse or another clinician must hold uncooperative, unconscious, or mentally agitated patients or those otherwise incapacitated and assist others in maintaining difficult or uncomfortable positions. In such situations, the assistant will be required to be in contact with the patient and shall be provided with a protective apron. In all cases, the direct beam should be avoided. Other persons who must be near the patient should be provided with protective clothing (lead apron) or be located behind a protective screen.

Restraints

A restraint is any method, physical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

- Mitts that restrict use of the hands, tied or untied, with patients other than infants are considered a restraint. Mitts that are pinned with infant patients are considered a restraint. A Geri-chair is considered a restraint when the tray is locked in place and the patient is not actively participating in an activity such as eating a meal, coloring, stacking cups, folding towels, etc.
- Patients (not including patients needing restraints for violent or self-destructive reasons) are restrained for (a) prevention of medical device displacement or (b) impaired cognitive function that interferes with medical treatment. Specific patient populations, such as emergency and pediatric patients who are cognitively or physically challenged, are assessed for risks associated with the application and maintenance of restraints.
- Non-violent restraint is used to ensure the physical safety of nonviolent, non-self-destructive patients for the primary purpose of supporting medical healing.
- Clinical staff is to check vital signs every two hours around the clock on patients in nonviolent restraints. While checking the vital signs, check the patient's clinical condition (circulation, condition of limbs, skin integrity, hygiene, nutrition, hydration, ROM and turning/repositioning) using observation, interaction with the patient, or direct examination to ensure they are being addressed. Non-violent restraints are applied correctly if two fingers can be inserted between the extremity and the restraint, and the restraint is tied to appropriate place on bed frame or clipped to the bed frame (not the side rail) using a quick-release knot or other quick-release mechanism.
- Less-restrictive measures should be exhausted before restraint is used. If restraint is necessary, the least-restrictive method should always be used. The goal is to use restraint only when absolutely necessary and to discontinue it as early as possible.
- Patient monitoring during restraint use is important for many reasons, including maintaining the patient's physical and emotional well-being and protecting the patient's rights, dignity, and safety. Documentation

at the initiation of, during, and discontinuation of restraint is critical to ensure restraints are used only when absolutely necessary and discontinuation of restraint is accomplished as soon as possible.

- A Violent restraint episode is only used in an emergent situation to prevent the patient from harming themselves or others and is performed by a staff member trained in the management of violent restraints. There must be a patient safety attendant assigned to the patient while in a violent restraint episode. Staff assigned to monitor patients in violent restraints must have documented competency in violent restraint management.

Safety Event Reporting (SER)

- Report events that may or may not reach the patient and that could result or did result in harm to the patient; encompasses all types of patient safety events from a **near miss to a sentinel event**.
- Reports are submitted electronically into the Safety Event Manager or initially by telephone (*adverse w/significant consequences*) to Quality Management.
- An electronic SER is completed before the end of the shift.
- Provide brief objective and factual description of event, impact on patient, and immediate interventions.
- Notify and document notification of physician.
- *No reference* to the Safety Event Report, Event Reporting via telephone, Quality Management, Risk Management or Legal Counsel is made in the medical record.
- Briefly objectively document the occurrence in the medical record. The SER does **NOT** take the place of documenting in the medical record.
- Examples of events to report include but not limited to: faulty equipment, medication errors, patient falls, and misidentification/mislabeling of specimens.

Special Considerations

The Hospital serves patients from a community of diverse backgrounds, interests, cultures, and religions, and treats patients with a wide variety of illnesses, conditions, and diseases. Hospital employees are expected to care for all patients to whom they are assigned. However, employees may request not to participate in the care of a patient by making a written request to their manager. If, however, the accommodation cannot be made, the employee must provide the requested care to the patient. Patient care will not be compromised.

Telemetry

- Telemetry Monitors and Leads should be placed in a PLASTIC BAG & SEALED before placing in the tube system
- ALWAYS use TWO pieces of FOAM padding and use the green/clear tube for telemetry monitors; Use empty send and tube will automatically return to telemetry. Please send only one (1) monitor per tube.
- Once Telemetry is placed on the patient, call from the room (52727) to verify signal is being received
- Return the Lithium-ion rechargeable battery with the monitor
- Call the monitoring room (52727) anytime patient is off monitor (bathing, tests, etc.)
- Follow up on “leads off” pages in a timely manner for patient safety!
- Provide the patient’s full name and DOB for rates and rhythms
- Return monitors promptly upon discharge