MORRIS HOSPITAL
& HEALTHCARE CENTERS
People You Know. Extraordinary Care.

Morris Hospital & Healthcare Centers

NON-EMPLOYEE (STUDENT) GENERAL ORIENTATION 2024

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Morris Hospital & Healthcare Centers Mission Statement:

To improve the health of area residents

Vision: Transforming Healthcare to Support Healthier Living

Morris Hospital & Healthcare Centers strives to provide an environment where customers(internal and external) are treated with respect and dignity. All employees, contractors, volunteers, board members, medical staff members, and suppliers (collectively, "Morris Hospital Associates") must adhere to the highest standard of customer service to promote the principles, ideals and mission of the hospital.

Values

The values to which employees, medical staff, and board members of Morris Hospital & Healthcare Centers subscribe are as follows:

CARE

C = Compassion

A = Accountability

R = Respect

E = Excellence

Customer Interaction

The Huron principle of AIDET is used when interacting with our patients and customers.

AIDET

- **A**cknowledge
- **I**ntroduce
- **D**uration
- **E**xplanation
- **T**hank

AIDET Framework of Communication

Acknowledge

- In person, with your body:
  - Smile ☺
  - Make eye contact
  - Use open body language
- On the telephone, with your voice:
  - Smile ☺
  - Give the person your undivided attention

Introduce

- First Generation
  - Name
  - Department
- Next Generation
  - Self, Skill Set, Experience & Certification
  - Co-Workers
  - Other Departments
  - Providers

AIDET Framework of Communication

Duration

- How long will the test, procedure, appointment or admission take?
- How long will the patient need to wait before they can go home, return to work…?
- When should they expect results or a returned phone call from you?

Explanation

- Why are we doing this?
- What will happen and what should you expect?
- What questions do you have?
- Use understandable language

Thank

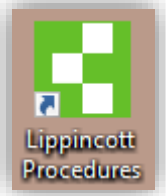
Thank them for choosing YOU!

Additional AIDET Measures

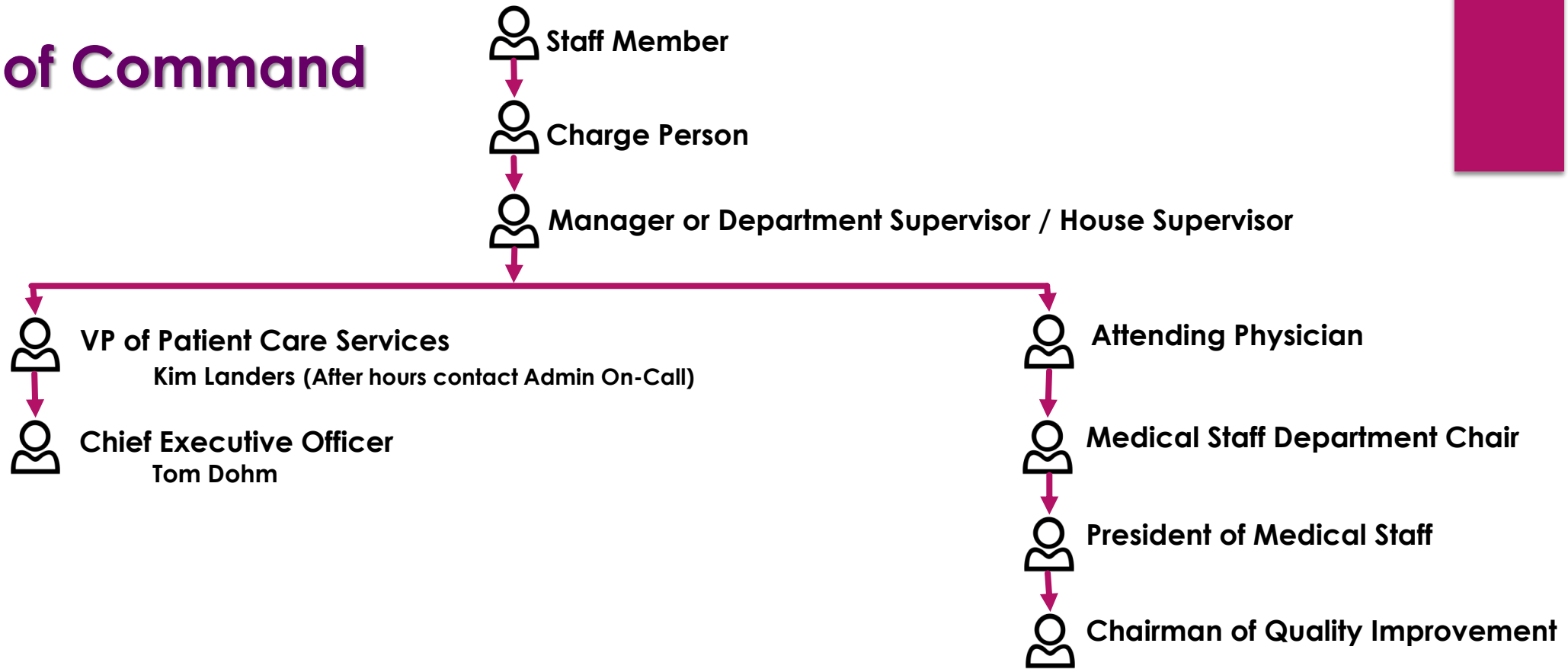
- Discuss hand hygiene with patients
- Close door/curtain for privacy (inform patients of this)
- Bedside Shift Report / Hand Off Communication
- Managing Up
- Call Backs
- Writing thank you notes
- What is your ONE thing?
- White communication boards in patient rooms
- Discuss new medications and their side effects with patients
- Immediate response to call lights
- Rounding
  - Inpatient – Hourly
  - ED – Every 30 minutes
  - OP & Clinics – Every 15 minutes

Accessing Policies / Forms / iShare

- iShare is the Morris Hospital home page for the intranet
- iShare is a communication hub where the following can be accessed:
  - Policies & Procedures
  - Standing Orders
  - MH Forms
- If the computers are not working and internet access in unavailable, hard copies of Policies & Procedures are kept in Administration & the House Supervisor's Office
- iShare can be accessed from any hospital computer simply by accessing the internet
- Pages - iShare (morrishospital.org)
- If you do not have computer access, please ask a MH employee to assist you with accessing the information needed
- Lippincott Procedures icon on desktop



Chain of Command



Please Note: *When calling, let the person know you have instituted the Chain of Command. If an employee feels their concern is not addressed at any level they may go on to the next level*

Plain Language Codes

2024

Plain Language Codes

Medical Alert	
Adult Code Blue	MEDICAL ALERT + ADULT CODE BLUE + LOCATION
Pediatric Code Blue	MEDICAL ALERT + PEDIATRIC CODE BLUE + LOCATION
Stroke	MEDICAL ALERT + STROKE+ LOCATION
Trauma	MEDICAL ALERT + TRAUMA + LOCATION
Stemi	MEDICAL ALERT + STEMI + LOCATION
Rapid Response	MEDICAL ALERT + RAPID RESPONSE TEAM + LOCATION
Infusion	MEDICAL ALERT+ MASSIVE TRANSFUSION + LOCATION
Decon Team	MEDICAL ALERT + DECON TEAM + LOCATION

Facility Alert	
Fire Alarm	FACILITY ALERT+ FIRE ALARM+ LOCATION
Evacuation	FACILITY ALERT+ EVACUATION+ LOCATION
Nuclear	FACILITY ALERT+ NUCLEAR
Network Failure	FACILITY ALERT+ NETWORK FAILURE + DESCRIPTION
Disaster Plan	FACILITY ALERT+ DISASTER PLAN+ DESCRIPTION
Management Team	FACILITY ALERT+ MANAGEMENT TEAM + LOCATION
Utility Failure	FACILITY ALERT+ UTILITY FAILURE + LOCATION

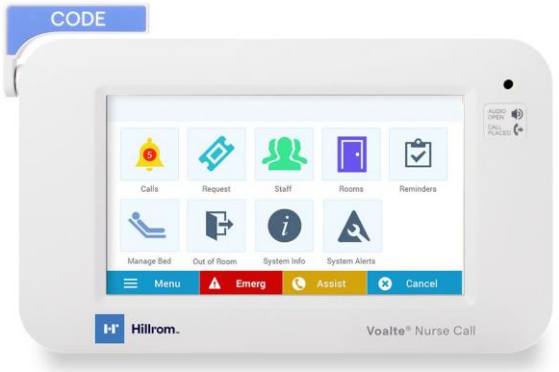
Security Alert	
Armed Intruder	SECURITY ALERT + ARMED INTRUDER + LOCATION
Assistance Needed	SECURITY ALERT + ASSISTANCE NEEDED + LOCATION
Missing Person	SECURITY ALERT + MISSING PERSON + DESCRIPTION + LOCATION LAST SEEN
Lockdown	SECURITY ALERT + LOCKDOWN

Weather Alert	
Severe Thunderstorm Warning /Tornado Warning	WEATHER ALERT + SEVERE THUNDERSTORM WARNING/ TORNADO WARNING+ INSTRUCTIONS

All Clear	
All Clear	ALERT TYPE+ ALL CLEAR

Medical Alert: Adult Code Blue
Cardiac Arrest Procedure

- Call for help and/or pull the 'Code' lever in the room
- Page overhead by dialing 3515, announce "Medical Alert + Adult Code Blue + Location" at least twice
- In the areas that have the computer icon, page the 'Code Blue Team' or in areas that do not have the computer icon, call the Operator at ext. 0), and ask them to page the 'Code Blue Team' on the computer
- Access the "Codes" icon found on computer desktop in addition to calling overhead page.
- Begin CPR
- In the event the internet can not be accessed:
  - Page the 'Code Blue Team' by telephone (815) 851-7777 and include the department extension where the code is taking place and 7777 followed by the # sign to send the message (Example: 11597777#)



Medical Alert: Pediatric Code Blue

- 'Medical Alert: Pediatric Code Blue' is the term used for a pediatric resuscitative emergency at Morris Hospital & Healthcare Centers
- The staff member identifying the emergency will immediately call a 'Medical Alert + Pediatric Code Blue + Location' overhead (ext. 3515) and initiate the appropriate Basic Life Support (BLS)
- Please refer to the Cardio-Pulmonary Resuscitation Policy on iShare for detailed information specific to your work area

Medical Alert: Stroke or STEMI

- **Purpose:** To ensure a person experiencing stroke symptoms is recognized as a medical emergency, receiving medical/nursing care in a prompt and appropriate manner
- Establishes the process that the team will use when responding to an acute stroke emergency
- 'Medical Alert + Stroke + Location' will be called by the Nurse or the Provider
- Medical Alert: Stroke will be utilized for Inpatient and Emergency Department Stroke patients
- Medical Alert: STEMI is utilized for Inpatient and Emergency Department Heart Attack patients

Medical Alert: Rapid Response Team

Adult Emergencies include:
(this list is not all inclusive)

- Staff member or licensed provider concerned about a subtle change
- New onset chest pain
- New neurological findings
  - If a patient presents as a possible stroke, dial 3515 and announce "Medical Alert + Stroke + Location" without calling a Rapid Response
- Symptomatic bradycardia
- Symptomatic hypotension
- Acute respiratory distress
- Acute change in mental status or seizures
- Acute significant bleeding
- Acute change in blood oxygen saturation
- Failure to respond to treatment for an acute problem/symptom
- A MEWS Score of 5 or greater

Medical Alert: Pediatric Rapid Response Team

- The Rapid Response Pediatric Team is a team of experienced clinicians who bring their expertise by rapidly responding to pediatric emergencies to rescue the patient with a change in status
- A pediatric rapid response may be initiated by a licensed provider, employee, patient, visitor, or family member
- Pediatric patients are anyone less than 17 years of age (excluding newborns in the Family Birthing Suites)
- Pediatric emergencies include:
  - Acute changes in heart rate, blood pressure or respiratory rate
  - Hypoxia
  - Mental status changes/seizures
  - Staff and/or family concerns

Facility Alert: Fire Alarm

Facility Alert + Fire Alarm + Location

R = Rescue anyone in immediate danger
A = Activate the fire alarm
C = Contain the fire (close all doors and windows)
E = Extinguish the fire

It is the responsibility of every employee to know:

- Fire prevention and fire safety in their areas
- What to do if a fire is discovered
  - In the hospital
  - In their department specifically
  - What to do if a fire alarm is sounded
- How to evacuate patients, visitors, and employees with disabilities

Fire Extinguisher

P = Pull the pin
A = Aim the nozzle at the base of the fire
S = Squeeze the handle
S = Sweep side to side at the base of the fire

Fire Extinguisher ABCs

- **Class A:** for ordinary combustibles such as paper, plastic, and wood
- **Class B:** for flammable liquids such as gasoline, oil, grease, etc.
- **Class C:** for energized electrical equipment
- **HALON:** used to put out the same types of fires as an A, B, or C extinguisher
- **Class K:** for kitchen appliances, electrical equipment

Fire Watch: Not an Overhead Announcement

To watch the building for fires when the fire alarm system is down

Implementation:

- Fire Watch will only be sent via email when the fire alarm system is down either for repairs or testing
- When the 'Fire Watch' is emailed all departments must watch for fires in an around their area
- The Maintenance Department will notify via email when the fire alarm system is back up and running using "Fire Watch, All Clear"
- If a fire occurs in your area, notify the operator immediately
  - The operator will turn in the call to the fire department
  - The operator will announce overhead "Facility Alert + Fire Alarm + Location"
  - We will follow our normal fire procedures
    - R.A.C.E.
    - P.A.S.S.

Severe Weather: (such as Tornado or Thunderstorm)

When severe weather is imminent in the hospital's location, the operator or designee will announce "Weather Alert + Severe Thunderstorm Warning/Tornado Warning + Instructions

IMMEDIATELY RESPOND TO THIS PROCEDURE

- Hospital is in imminent danger. Tornado is in immediate area and headed for the hospital
- Every effort should be made to physically protect the patients, visitors and yourself the best that you can

Patient Care Areas

- Move all ambulatory patients to inner utility rooms, etc., that do not have windows. Instruct them to shield self from flying debris
- Move as many non-ambulatory patients' beds as possible into the inner corridor
- If unable to fit all the beds into the inner corridor, push beds as far away from windows as possible, pull curtain between beds, position patient facing away from window and shield head with pillow
- Clear visitors from waiting rooms with windows to inner corridors or waiting rooms without windows
- Close doors to rooms

Severe Weather continued…

ED staff will notify Administration when the watch/warning has been cancelled, and the switchboard will be notified to announce "Weather Alert, All Clear"

- **Family Birthing Suites**
  - Nurse must stay with labor patient
  - Move to inner corridor if possible
- **Nursery**
  - All babies are to be taken to inner corridor
  - Give baby to mother if possible
  - Nurse to stay with mothers and babies
- **ICU**
  - Pull drapes between beds
  - If patient's condition permits, move patient to the hallway
- **Surgery**
  - Remain in surgery suite unless patients can be moved to inner corridor
- **ED**
  - Move patients to inner corridor
  - If patient can not be moved, close door to room and remain with patient
- **Non-Patient Care Area – Ancillary Departments**
  - All patients, visitors, and employees should move into the inner corridor or rooms without windows
  - Close all doors to hallways
  - Operator stays at switchboard – shield self under desk

Facility Alert: Disaster Plan + Description

- Provide definitive medical treatment to a large number of casualties with minimum delay
- Utilize existing hospital facilities to minimize the disruption of regular hospital activities
- Announce overhead "Facility Alert: Disaster Plan + Description"
- Initiate plan as per policy in your work area
- Refer to Emergency Operations Plan on iShare

Medical Alert: Decon Team + Location

- Chemical/biological Event:
  - Interior: Evacuate immediate area; close all doors
  - Exterior: Prepare for patient decontamination and triage

* Contact the House Supervisor (ext.7490) who will page out accordingly

Facility Alert: Evacuation + Location

- Evacuation Procedure
  - A designated person will keep the department schedules and log employees out
  - Evacuation of ambulatory patients will be given first priority
  - Non-ambulatory patients will evacuated next followed by critical patients
  - Employees will be evacuated after patients
  - Destination of the evacuees will be determined by the situation

Security Alert: Armed Intruder + Location

- Indicates there is a person on hospital or healthcare center campuses in possession of a weapon and threatening to use it
- Please refer to the Armed Intruder policy for department and personnel response required for this type of event

Facility Alert: Nuclear

- Nuclear Disaster Procedure:
  - The hospital will be notified by Emergency Services and Disaster Agency (ESDA)
  - At the time of notification, follow the guidelines specific to your area
  - Status of the situation will be communicated at all times
  - Depending on information communicated from ESDA, Morris Hospital will either be used as a shelter or be evacuated

Security Alert: Assistance Needed + Location

- Violent Situation Procedure:
  - When an employee or physician perceives a situation may be or has become threatening, verbally or physically, they should call the hospital operator
  - State "Security Alert: Assistance Needed and Location"
  - All available personnel will respond to the location on a 'stat' basis (immediately)
  - Activate the emergency response alarm if indicated in your work area

Security Alert: Missing Person + Description + Location Last Seen

- Abduction Procedure:
  - If 'Security Alert: Missing Person + Description + Location Last Seen' is overhead paged:
    - All personnel will immediately secure all exits and stairwells
    - No person should leave the building unless the police have authorized them to leave or a 'Security Alert: Missing Person ALL CLEAR' has sounded

Facility Alert: Network Failure + Description

- This overhead page indicates an unscheduled downtime of the computer system
  - Immediately initiate your department computer downtime procedures
  - When the computer system is back up 'Network Failure: ALL CLEAR' will be overhead announced

Medical Alert: Trauma + Location

- Trauma Team Activation:
  - If this is overhead paged, the trauma team automatically responds to the announced location
  - Trauma team responds ‘stat’ upon arrival of a walk-in trauma patient who meets criteria

Medical Alert: Massive Transfusion + Location

- Physician determines need for Massive Transfusion Protocol
  - Patient requires urgent transfusion for the treatment of life threatening hemorrhage
  - Massive Transfusion Protocol (MTP) initiated
  - Protocol available on iShare

Security Alert: Lockdown

- Total Site Lockdown
  - This is the highest level of facility and perimeter security
  - During a total lockdown, all perimeter doors and exterior barriers are secured and no one is allowed to enter or exit the facility
  - Security or designees will be deployed to key entry/exit point areas
- Partial Lockdown
  - During a partial lockdown, all perimeter doors are secured and Security or designees are deployed to all public entrances and exits
  - Each person attempting to enter/exit would be screened and escorted as needed

*The House Supervisor or the Administrator On-Call is the only one authorized to call a total or partial lockdown

Facility Alert: Management Team + Location

- If this alert is overhead paged, the Management Team is to respond to the location given

Alert Type: ALL CLEAR

- This alert will be overhead paged whenever any alert has been mitigated and threat has been resolved

Employee Health

2024

Back Safety

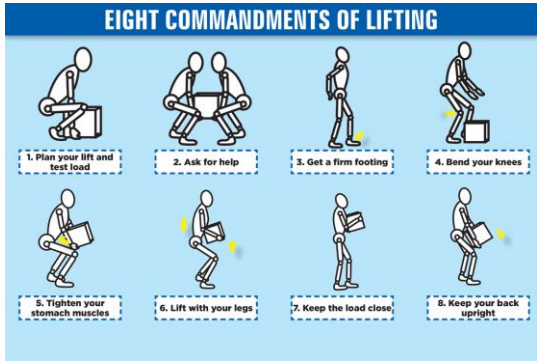
It is the responsibility of Morris Hospital, the Managers and the Employees to ensure back safety is a priority

Body Mechanics & Lifting Safety:

- Before you start
  - Plan ahead
  - Clear your path
  - Determine the best way to perform the lift
- Before lifting the object
  - Inspect the object
  - Size up the load
- Ask for help if needed

Back Safety: Proper Lifting

- Stand with your feet should width apart
- Bend with your knees keeping your back straight
- Lift the object using your legs
- Keep the object close to your body



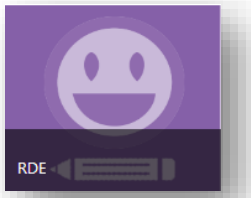
- Always turn your feet in the direction you are moving
- Avoid twisting your body when carrying an object
- Avoid bending at your waist with your knees straight
- Avoid overhead lifting

Reporting Injuries: Utilizing the Visitor Incident Report

If an injury occurs while you are working at MHHC, report it to your immediate supervisor and a Visitor Incident Report shall be completed. This form is utilized for incidents involving visitors, students & non-employed Physicians / Advanced Practice Professionals. The injury shall also be reported electronically through Remote Data Entry (RDE) on iShare. Notify your company/school of the incident.

- On-site injuries
  - The supervisor/employee with knowledge of, or who discovers the incident should immediately notify security, who initiates the Visitor Incident Report Form
  - Security notifies the House Supervisor of the incident
  - A picture of the location where the injury occurred should be taken and printed out to attach to Security's Report
- Off-site injuries
  - The supervisor shall complete the RDE and document the injury on a Visitor Incident Report
  - A picture of the location where the injury occurred should be taken and printed to attach to the Incident Report

For body fluid exposure/needlestick injuries, please refer to the 'Needlestick and Blood Borne Pathogen Exposure to Patient, Non-Patient & Non-Employee' policy on iShare



Patient Rights

2024

Patient Rights & Organizational Ethics

- A copy of Patient's Rights is given to all patients (inpatients, outpatients, and clinic patients)
- The complete Statement of Patient Rights & Responsibilities is available on iShare (Form #208)

Patient's Right to respect, privacy & safety:

- Please knock before entering the patient's room
- Identify yourself and your department
- Address patient by the name they wish to be addressed by
- State your reason for being there
- Maintain a safe environment and report any safety issues

- The Morris Hospital & Healthcare Centers (MHHC) presents a statement on the patient's rights and responsibilities with the expectation patients have a fundamental right to considerate and respectful care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values
- Understanding and respecting these values guide the Physician/Advanced Practice Professional (APP) in meeting the patients' care needs and preferences and will contribute to more effective patient care and greater satisfaction for the patient, their Physician/APP, and the hospital organization
- MHHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex, sexual orientation, gender identity or gender expression
- It is recognized that the basic rights of human beings for independence of expression, decision and action take on a new dimension during sickness, and especially in an organizational structure
- It is in recognition of these concerns that MHHC affirms its responsibility to endeavor to assure that these rights are preserved for patients
- MHHC respects a patient's right to delegate their right to make informed decisions to another person (as allowed under State Law)

Patient or Their Representative's Rights

- To participate in the development and implementation of their plan of care
- To make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right is not a mechanism to demand treatment or services deemed medically unnecessary or inappropriate.
- To personal privacy
- To receive care in a safe setting
- For being considerate of the rights and safety of other patients and hospital personnel, and helping control of noise and disturbances, following smoking policies and limiting the number of visitors.
- To formulate advanced directives and to have hospital staff and Physician/APP who provide care in the hospital comply with these directives
- To have a family member or representative of their choice and their own Physician notified promptly of their admission to the hospital. MHHC will make reasonable efforts that the system sends notifications to al applicable post acute care service providers identified by the patient as their Physician/APP
- To the confidentiality of their clinical records
- The patient is responsible for being respectful of the property of other persons and of the hospital
- For outcomes if they do not follow the care, service or treatment plan

Patient or Their Representative's Rights

- To be free from all abuse or harassment, including those based on gender identity or gender expression
- To access information contained in their clinical records within a reasonable time frame
- To be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff
- To know the relationship(s) of the hospital to other persons or organizations participating in the provision of their care
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible
- For following hospital rules and regulations concerning patient care and conduct
- To be fully informed of and consent or refuse to participate in any unusual, experimental or research project without compromising his/her access to services
- To know the professional status of any person providing their care/services
- To know the reason for any proposed change in the professional staff responsible for their care
- To know the reasons for their transfer either within or outside the hospital
- Of access to the cost, itemized when possible, of services rendered within a reasonable period of time
- For notifying healthcare providers of the patient's Durable Power of Attorney for Healthcare or Living Will and its amendment or revocation. This document must be presented

Patient or Their Representative's Rights

- To be informed of the policies and procedures of the hospital regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation
- To be informed of the source of the hospital's reimbursement for their services, and of any limitations which may be placed upon his/her care
- To be informed of the right to have pain treated as effectively as possible
- Of informed consent for donation of organs and tissues
- To inform the patient (or support person), where appropriate, of the right, subject to their consent, to receive the visitors whom they designate, including, but not limited to, a spouse, a domestic partner (including same sex domestic partner), and other family member, friend, and their right to withdraw or deny such consent at any time
- Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability
- To ensure that all visitors enjoy full and equal visitation privileges consistent with patient preference

Patient or Their Representative's Rights

- The safety of healthcare is enhanced by the involvement of the patient as a partner in the healthcare process. A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility for reporting perceived risks in their care and unexpected changes in his/her condition to the responsible Physician/APP. A patient is responsible for making it known whether they clearly comprehend a contemplated course of action and what is expected of them. The patient and family help the hospital improve its understanding of the patient's environment by providing feedback about service needs, expectations and safety issues.
- For following the care, service or treatment plan recommended by the Physician/APP primarily responsible for their care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible Physician/APP's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do. The patient should express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment. The patient is responsible for keeping appointments and when they are unable to do so for any reason, for notifying the responsible Physician/APP or the hospital.

The parents or legal guardians of neonatal, pediatric and adolescent patients shall assume the aforementioned rights and responsibilities on their behalf

Patients will be made aware of their right to voice concerns and complaints in the following manner via the Patient Rights and Responsibilities handout including:

The hospital takes quality of care very seriously and encourages patients or patient representatives to contact hospital management with any concerns as soon as they arise. Please feel free to contact the manager of the department, or the Director of Risk Management, Compliance Officer at 815-705-7701 if you have any concerns about safety or quality of care issues. The House Supervisor can assist you during the evening and midnight shifts.

If concerns cannot be resolved through the hospital, contact may be made to the Illinois Department of Public Health, Central Complaint Registry, at 1-800-252-4343, (for hearing impaired use TTY 1-800-547-0466) or write to the Illinois Department of Public Health, Division of Healthcare Facilities, 525 W. Jefferson St., Springfield, IL 62761-0001 or fax 217-782-0382.

A Medicare beneficiary may call the Medicare Quality Improvement Organization at 1-888-524-9900 (for hearing impaired use TTY 1-888-985-8775).

Patient or patient representatives can also file a civil rights complaint with the U.S. Department of Health and Human Services, office for Civil Rights electronically at https://orcportal.hhs.gov/ocr/portal/lobby.jsf by mail at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DE.C. 2021 or by email at OCRComplaint@hhs.gov

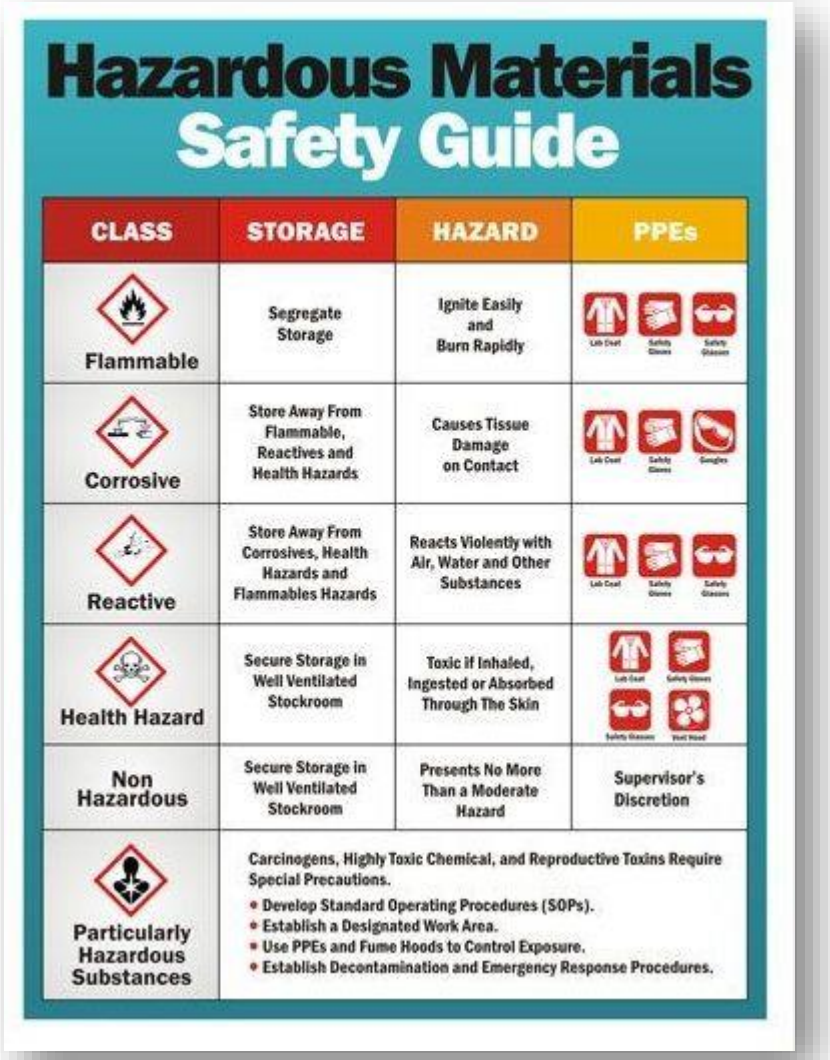
For DME concerns related to Orthopedics and Sports Medicine Product, that have not been resolved by your provider office, you may contact ACHC directly at 1-855-937-2242 or refer to their website at www.achc.org

Interpretive Services

- Morris Hospital & Healthcare Centers provides language interpretation 24 hours a day at no cost to the patient
- These services are available upon request or as identified by a healthcare provider
- If you need these services, contact any staff member, or call 1-815-705-7490 for the MHHC House Supervisor for assistance

Hazardous Waste & Material Safety

2024



Hazardous Waste & Materials Safety

- Hazard communication programs help reduce the risk of workers being exposed to chemicals because employees may work with chemicals as part of their jobs
- The hazard communication program requires healthcare facilities to:
  - Keep a list of chemicals stored by workers
  - Train employees about these chemicals
  - Use labels, signs, and detailed chemical information provided on the SDSs
- Healthcare facilities must comply with the hazard communication programs as required by ACHC, CMS, and OSHA
- OSHA's revised Hazard Communication Standard reduces confusion in the workplace, facilitates safety training, and improves understanding of hazards
- The Globally Harmonized System of Classification and Labeling of Chemicals (GHS) provides a single set of harmonized criteria for classifying chemicals according to their health and physical hazards and specifies hazard communication elements for labeling and safety data sheets
- Knowing these criteria will help chemical manufacturers determine hazardous chemicals and explain how to prepare labels or safety data sheets

Hazardous Waste & Materials Safety

Hazard Classification

- Identifying and evaluating available scientific evidence to determine if a chemical is hazardous and the degree of the hazard is called hazard classification
- It involves the following three steps:
  - 1. Identification of relevant data regarding the hazards of a substance or mixture
  - 2. Subsequent review of those data to ascertain the hazards associated with the substance or mixture
  - 3. A decision on whether the substance or mixture will be classified as a hazardous substance or mixture, and the degree of hazard, where appropriate, by comparison of the data with agreed hazard classification criteria

Hazard Communication Standard Labels

- All labels are required to have:
  - A signal word
  - Pictograms
  - Hazard and precautionary statements
  - Supplier identification
  - Product identifier

Hazardous Waste & Materials Safety

There are nine pictograms under the Globally Harmonized System

Figure 2. Hazard Communication Standard pictograms and hazards

Health Hazard	Flame	Exclamation Mark
		
• Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity	• Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self-Reactives • Organic Peroxides	• Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non-Mandatory)
Gas Cylinder	**Corrosion**	**Exploding Bomb**
		
• Gases Under Pressure	• Skin Corrosion/Burns • Eye Damage • Corrosive to Metals	• Explosives • Self-Reactives • Organic Peroxides
Flame Over Circle	**Environment (Non-Mandatory)**	**Skull and Crossbones**
		
• Oxidizers	• Aquatic Toxicity	• Acute Toxicity (fatal or toxic)

Source: U.S. Department of Labor, Occupational Safety & Health Administration

Hazardous Waste & Materials Safety

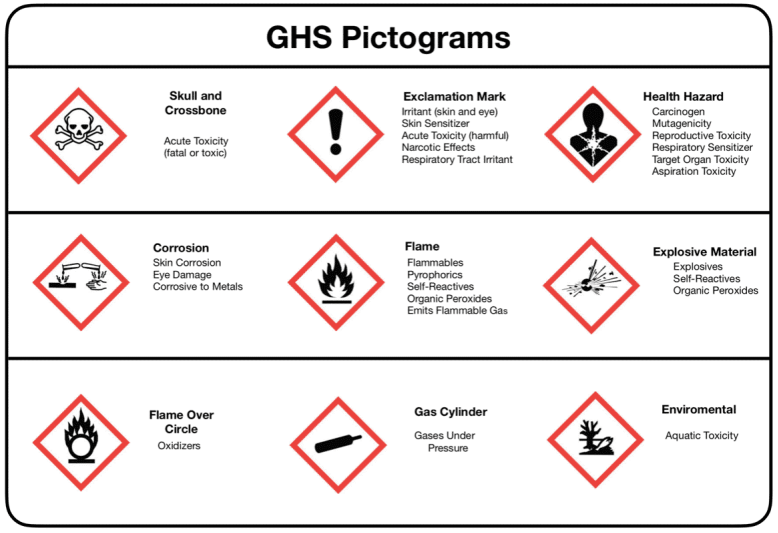
- Chemical manufacturers and importers are required to evaluate the hazards of the chemicals they produce or import, and to provide information about them through labels on shipped containers and more detailed information sheets called safety data sheets (SDSs)
- The Globally Harmonized System requires that all SDSs follow the same format and contain 16 standard pieces of information

Figure 3. Safety Data Sheet (SDS)—required information

1.	Identification of the substance or mixture and of the supplier
2.	Hazards identification
3.	Composition/information on ingredients
4.	First aid measures
5.	Firefighting measures
6.	Accidental release measures
7.	Handling and storage
8.	Exposure controls/personal protection
9.	Physical and chemical properties
10.	Stability and reactivity
11.	Toxicological information
12.	Ecological information
13.	Disposal considerations
14.	Transport information
15.	Regulatory information
16.	Other information including information on preparation and revision of the SDS
Source: U.S. Department of Labor, Occupational Safety & Health Administration	

Chemical Labeling

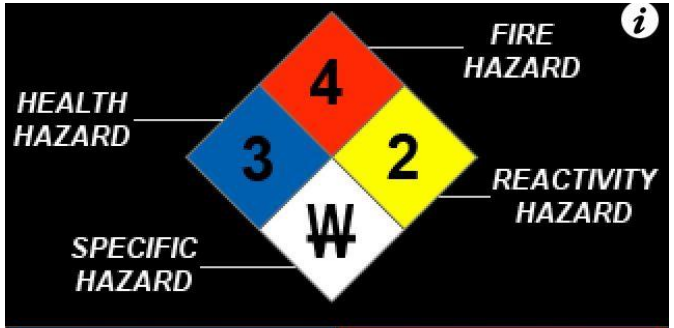
- All hazardous chemical containers must have labels so that the content can easily be identified and to let employees know about any hazard warnings
- The labels must include pictograms



- Chemicals currently must be labeled with:
  - Common name
  - Chemical name
  - Fire, spill, and leak instructions
  - Handling and storage instructions
  - Hazard statement explaining the physical and health hazards of the chemical
  - Instructions in case of exposure
  - Name, address, and phone number of the manufacturer
  - Precautions to be taken when working with the chemical
  - Signal word (such as warning, caution, or danger)

Hazardous Material Placard System

- A hazardous material placard system is used to assist in identifying a hazardous chemical during use, storage, shipping, and transport
- The external labeling placard system requires that symbols be posted in visible locations to warn and assist emergency responders in case an accident occurs
- The labeling on the different placards is as follows:
  - Fire hazards are signified with a red diamond
  - Reactivity hazards are indicated by a yellow diamond
  - Specified chemical hazards are signified with a white diamond
  - Health hazards are indicated by a blue diamond



HEALTH HAZARD	FIRE HAZARD
4 - Deadly	FLASH POINTS: 4 - Below 73°F
3 - Extremely Hazardous	3 - Below 100°F
2 - Hazardous	2 - Below 200°F
1 - Slightly Hazardous	1 - Above 200°F
0 - Normal Material	0 - Will Not Burn
SPECIFIC HAZARD	**REACTIVITY HAZARD**
OX - Oxidizer	4 - May Detonate
W - Use No Water	3 - May Detonate with Heat/Shock
	2 - Violent Chemical Change
	1 - Not Stable if Heated
	0 - Stable

Advanced Directives

2024

Advanced Directives in Illinois

Power of Attorney for Healthcare

- A signed document which specifies a person (agent) to make healthcare decisions for a patient (principal) upon a specific date or when the principal becomes unable to make decisions

Living Will

- A signed, witnessed document that allows a patient to issue a declaration instructing his or her physician about withdrawing or withholding certain death-delaying procedures when the patient is in a terminal condition and unable to communicate his/her wishes

Advanced Directives in Illinois

Illinois Mental Health Treatment Declaration

- A document that expresses a patient's wishes and consent to treatment measures for psychiatric diagnoses
- If a patient presents with this document it shall be placed on the medical record

(POLST) Physician Order for Life Sustaining Treatment Form

- A physician order that reflects a patient's wishes about receiving cardiopulmonary resuscitation in the event the individual's breathing and/or heart stop
- If a patient presents with this form it shall be honored
- See Resuscitation Status – DNR Policy

An individual may revoke his or her living will or power or attorney for healthcare at any time, without regard to his or her mental or physical condition

IDPH POSLT Form

■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*	**ORDERS FOR PATIENT IN CARDIAC ARREST.** Follow if patient has NO pulse.	
	☐ **YES CPR: Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)	☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**
B *Section may be Left Blank*	**ORDERS FOR PATIENT NOT IN CARDIAC ARREST.** Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)	
	☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.	
	☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.	
	☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.	
C *Section may be Left Blank*	**Additional Orders or Instructions.** These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]	
D *Section may be Left Blank*	**ORDERS FOR MEDICALLY ADMINISTERED NUTRITION.** Offer food by mouth if tolerated. (When no selection made, provide standard of care.)	
	☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.	
	☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.	
	☐ No artificial nutrition or hydration desired.	
E *Required*	***Signature of Patient or Legal Representative.*** *(eSigned documents are valid.)*	
	X Printed Name ***(required)***	Date
	Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.* X	
	Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)
F *Required*	***Qualified Health Care Practitioner.*** Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)	
	X Printed Authorized Practitioner Name ***(required)***	Phone
	Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* X	Date ***(required)***

■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

*****THIS PAGE IS OPTIONAL – use for informational purposes*****

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

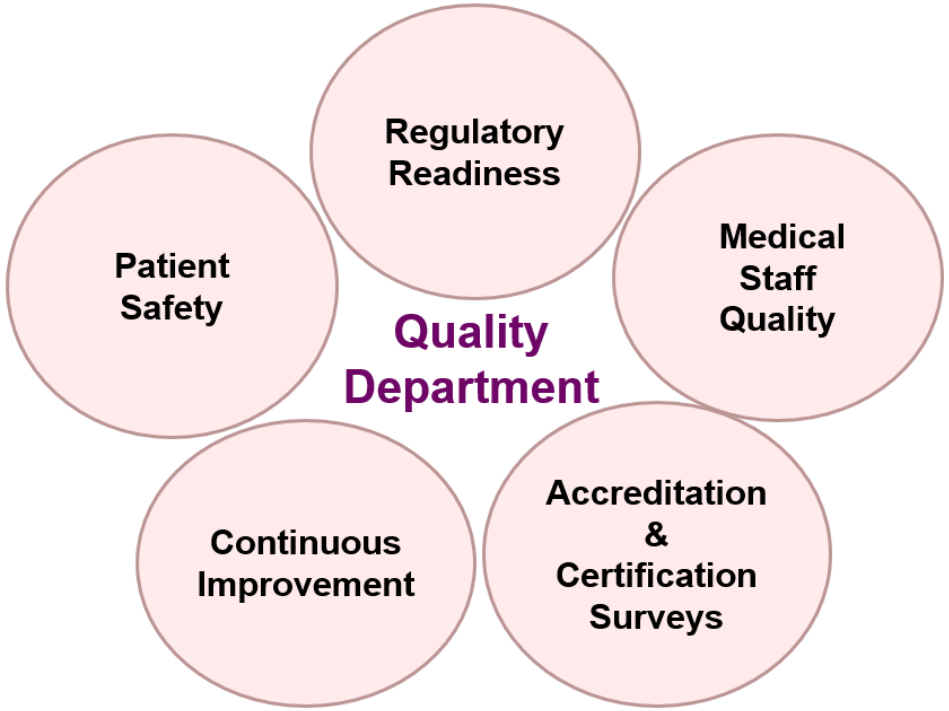
1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Quality

2024



What is Quality & Patient Safety?

Quality

- Quality is what is done and how well it is done to provide care and services to customers
- It ensures safe, effective, patient-centered, timely, and efficient, equitable (IOM)

Patient Safety

- Patient Safety refers to reducing risk from harm and injury
  - Medication Errors
  - HOSPITAL Acquired Infections (HAI)
  - Hospital Acquired Conditions (HAC)
    - Falls
    - VTE
    - Pressure Injuries

What if We Don't Measure Up?

Patients
- Errors/defects
- Lower quality care/poor patient outcomes

Employees
- Re-work
- Morale

Financial (bottom line)
- Medicare reimbursement based on our performance
- Increase costs associated with re-work

Reputation
- Healthcare is consumer driven.
- Almost all of our data is publically reported

Improvement Requires a Team Approach

Coming Together is a Beginning

Keeping Together is Progress

Working Together is Success

- Henry Ford

Culture of Patient Safety

- Healthcare is a **high-risk** and **error prone** environment
- All employees share responsibility for risk reduction and patient safety
- We must be vigilant and **proactive**

Improvement Requires a Team Approach

No role in healthcare is too small to either positively or negatively impact the patient!

Teamwork is **ESSENTIAL**!!

Three Guiding Principles for Improvement:

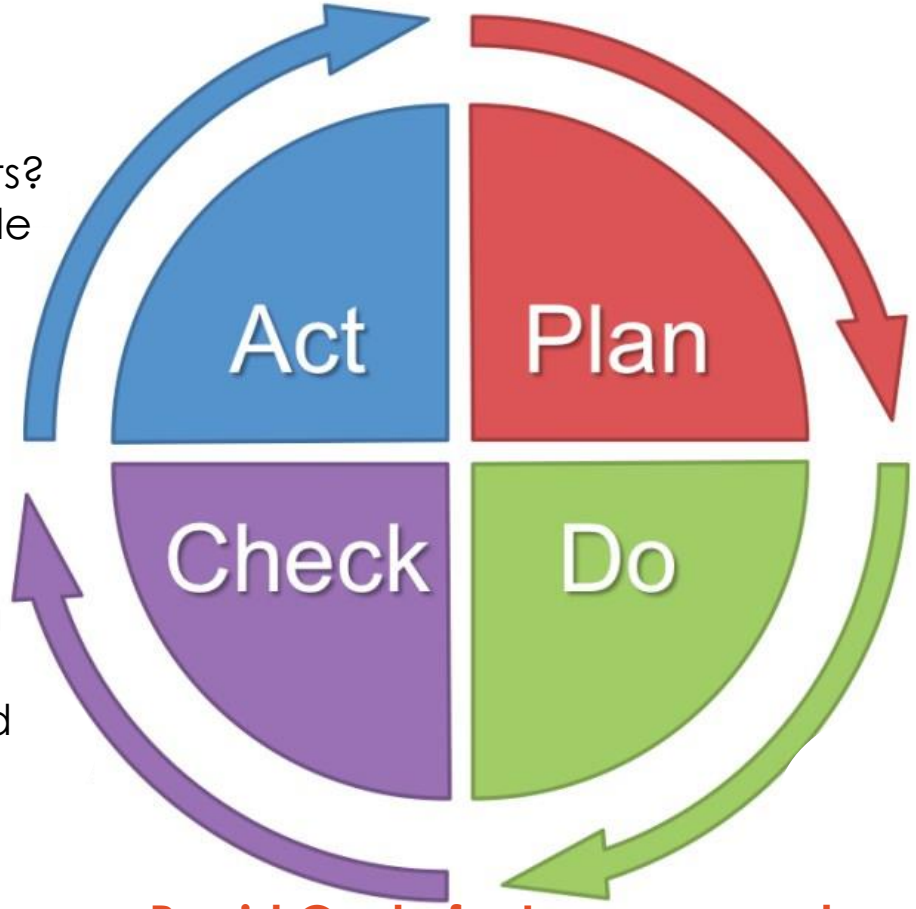
- Standardize
- Create Independent Checks
- Learn From Deficits

Now how do we fix the problem?...

PCDA

Act
- Any Adjustments?
- Begin Next Cycle

Plan
- For a Team
- Define Objectives
- Develop Plan
- Collect Baseline Data



Check
- Analyze Data
- Is Data Meeting Objectives?
- Lessons Learned

Do
- Implement Plan
- Collect Data

Rapid Cycle for Improvement

Reporting is part of a Patient Safety Culture…

Each error or near miss is an opportunity for us to improve

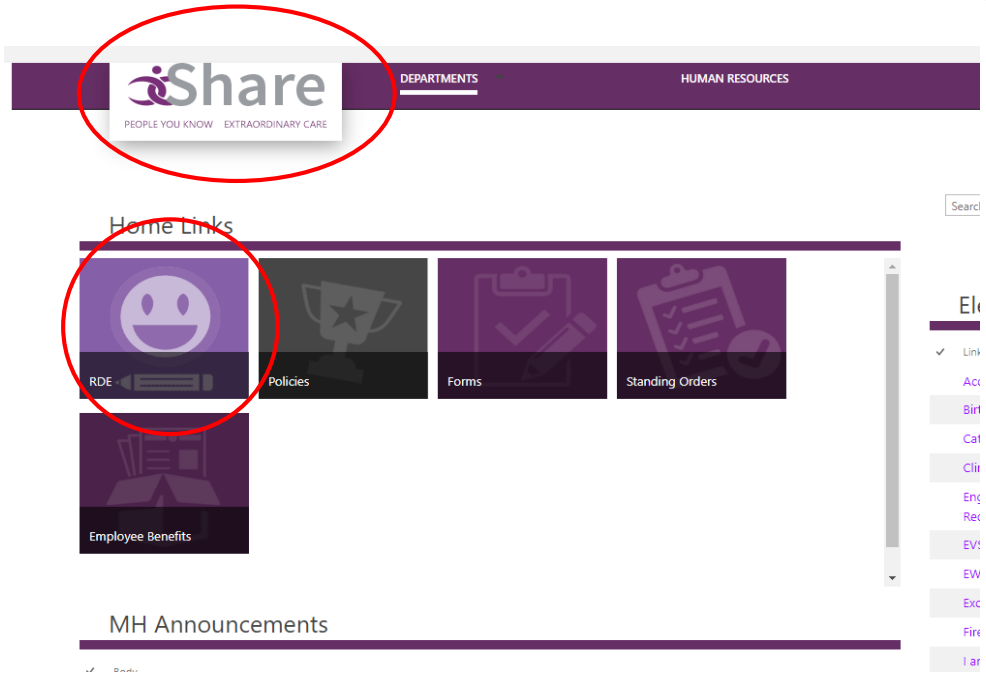
- Errors and near misses (an event that did not reach the patient, but could have harmed them if it did)
- Reporting these are critical to ensure patient safety

We report only to find ways to continuously improve,
not for punitive reasons!

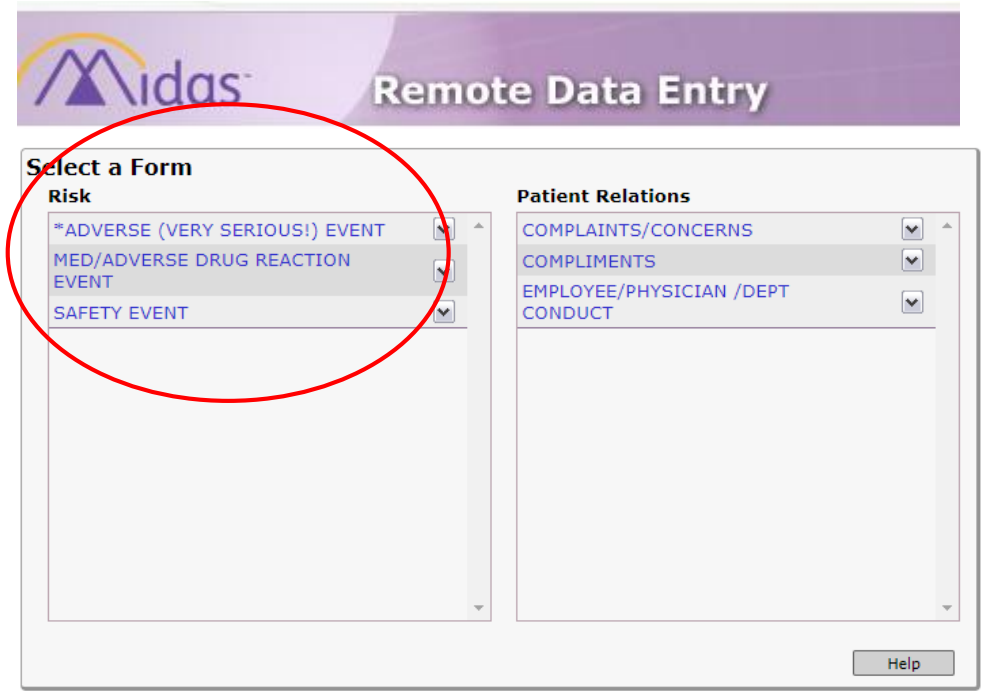
Things You Would Report in an RDE

- All Falls
- Medication issues
  - Additional doses or omissions
  - Monitoring errors
  - Wrong med/strength/frequency
  - Duplicate meds on chart
  - Wrong patient
  - Wrong IV rate
  - Adverse drug reactions
- Communication issues
- Delays in patient care
- Any issue effecting patient safety

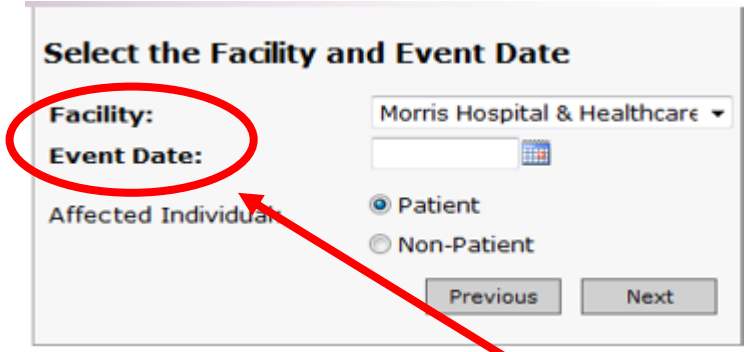
Risk/Patient Safety Reporting

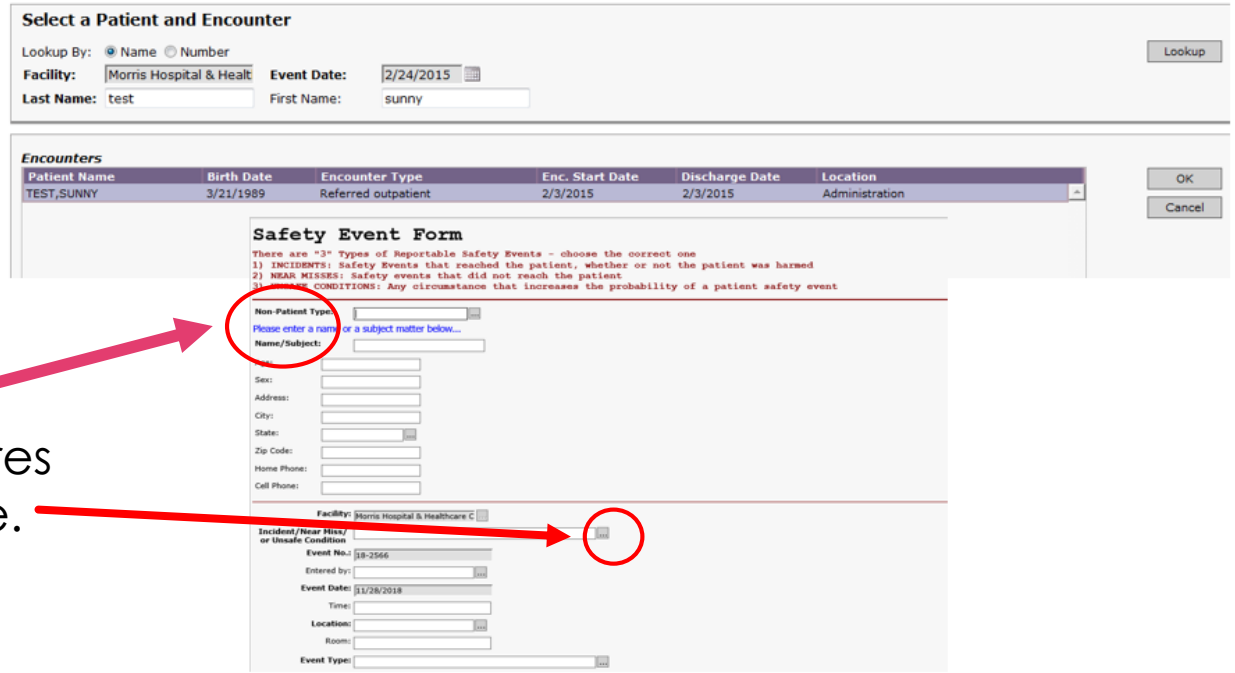


To report an event or near miss go to iShare
And click RDE smiley face- this opens up the Midas Remote Data Entry forms- select event type



Risk/Patient Safety Reporting





Mandatory fields are in bold print. Squares indicate drop down selections available.
State FACTS of event (not opinions or judgements) in comment fields.
Events can be entered anonymously.

Risk Management

2024

Service Philosophy

The Standards of Conduct hold employee's accountable to the ethical standards and serves as the cornerstone for the organization's activities, its principles, philosophies, mission and vision. The Standards of Conduct provide the foundation for a culture of excellence. Morris Hospital & Healthcare Centers is judged by the actions of the individual staff members with whom customers come into contact and the obligation to the community we serve is taken very seriously.

- **Professionalism**
- **Communication**
- **Teamwork**
- **Customer Service**
- **Patient Privacy**

Business Code of Conduct

The Corporate Compliance Program Includes:

- **Reporting** any perceived violation of any law, regulation, policy or governmental guidance to their supervisor, through RDE, to the Compliance Officer or through the **confidential** mechanism – **Alertline (1-844-621-0574).** Morris Hospital & Healthcare Centers does not condone or allow any retaliation towards anyone who reports a concern.

- **Quality of Patient Care and Professionalism** – Treating patients, employees, physicians, and visitors with dignity, respect and courtesy. Acting in a professional manner at all times, utilizing hospital assets wisely to protect against loss, theft or misappropriation.

- **Protecting Confidential Information** – Not accessing, using, or disclosing any patient or confidential business information except to perform professional business job duties.

- **No Discrimination or Harassment** – Strictly prohibits discrimination based on age, race, color, religion, gender, sexual orientation, disability, national origin, or any other legally protected category.

- **Compliance Plan** – The Compliance Plan is located on iShare and outlines all of the aspects of the Compliance program.

Compliance Responsibilities

- **Board/President and CEO/Administration**
  - Oversight role to insure the development and implementation of Compliance/Privacy/Confidentiality policies at Morris Hospital are consistently applied
- **Compliance Officer- Michael Lawrence, Privacy Officer- Kahla Boe**
  - Investigation/resolution of potential Compliance/HIPAA/Privacy violations
  - Develop and implement policies and procedures
  - Administer corrective action.
- **Directors/Managers**
  - Implement policies and procedures
  - Document alleged violations and administer corrective action.
- **Staff**
  - Know and follow policies and procedures especially the **Business Code of Conduct.**
  - Respect the patient's right to privacy/confidentiality.

The Office of the Inspector General (OIG)

Oversees Healthcare Compliance and investigates suspected fraud

Reference websites for OIG: www.oig.hhs.gov

Examples of Healthcare Fraud:

- Billing for services not rendered
- Falsifying certificates of medical necessity
- Billing for services not medically necessary

Compliance Related Laws Associated with the Business Code of Conduct

- **The Patient Self-Determination Act** encourages patients to make choices about the types and the extent of medical care that they want to accept or to refuse, should they become unable to make those decisions due to illness
- **The Emergency Medical Treatment & Active Labor Act (EMTALA)** is a federal law that was enacted to ensure public access to emergency services regardless of ability to pay
- **Anti-Kickback Statute** prohibits anyone from knowingly and willfully soliciting or receiving payments, in cash or in kind, in return for referring patients for services that are payable by the Medicare or Medicaid programs
- **The Stark Law** prohibits any physician from referring Medicare patients to any entity with which the physician (or an immediate family member) has a financial relationship, for the furnishing of any designated health service (which includes inpatient and outpatient hospital services), unless an exception applies
- **Red Flag Rule** is a law passed to prevent and minimize identity theft in connection with a new patient, or a breach of an existing account
- **The False Claims Act** is a federal law that holds anyone who conducts business with the federal government responsible for dealing with the government honestly and in conformity with regulations
- **The Illinois False Claims Act** holds anyone who conducts business with the State of Illinois responsible for dealing with the government honestly and in conformity with regulations
- **The False Claims Act Whistleblower Provision** encourages individuals to come forward and report misconduct involving false claims. The act entitles whistleblowers certain protections such as employment reinstatement, back pay, and protection from retaliation
- **Health Insurance Portability and Accountability Act (HIPAA)** is a law passed to protect patient's protected health information

Code of Conduct

Morris Hospital & Healthcare Centers Code of Conduct expectations includes the following:

- Mission, Vision, Values Statement and Standards of Conduct Policy outlines the:
  - **Mission** - To improve the health of area residents
  - **Vision** – Transforming Healthcare to Support Healthier Living
  - **Values** – Compassion, Accountability, Respect, Excellence
- Each employee signs the Standards of Excellence Agreement and is expected to maintain the highest standard of:
  - Professionalism
  - Common Courtesy
  - Patient Privacy
  - Communication
  - Customer Service
  - Confidentiality

Business Code of Conduct describes the following Corporate Compliance Program conduct expectation for employees:

- **Reporting** any perceived violation of any law, regulation, policy or governmental guidance to their supervisor, through RDE, to the Compliance Officer or through the confidential mechanism - Alertline (1-800-93ALERT). Morris Hospital & Healthcare Centers does not condone or allow any retaliation towards anyone who reports a concern.
- **Quality of Patient Care and Professionalism** 'Treating patients, employees, physicians, and visitors with dignity, respect and courtesy. Acting in a professional manner at all times, utilizing hospital assets wisely to protect against loss, theft or misappropriation.
- **Protecting Confidential Information** - Not accessing, using, or disclosing any patient or confidential business information except to perform professional business job duties.
- **No Discrimination or Harassment** - Strictly prohibits discrimination based on age, race, color, religion, gender, sexual orientation, disability, national origin, or any other legally protected category.
- **Corporate Responsibility** - Employees should understand and comply with the Corporate Compliance Program that is found in the Compliance Plan.

Organizational Ethics

- We will resolve conflicts fairly and objectively through established mechanisms (Human Resources, Administration, and Ethics Committee)
- We maintain confidential information (for our patients and for the hospital) in accordance with the law and standards of governing bodies
  - Log-off computer when not in use to deter anyone with malicious intent
  - Users should minimize screens when a situation presents potential viewing of ePHI (electronic personal health information)
  - Locate workstations and monitors away from public view
- Maintain a Compliance Program that seeks to assure that the activities of the hospital and personnel comply with legal, regulatory, ethical and institutional standards
- Report any suspected illegal or improper conduct through the appropriate channels
- Enhance safety, improve patient care and increase organizational effectiveness

A Just Culture

Acknowledges that competent professionals make mistakes when the mistakes are system related

Acknowledges that unhealthy norms such as short cuts or routine rule violations are to be avoided

Zero tolerance for reckless behavior:	3 Expected Duties of Just Culture:	These principles and duties should be performed while maintaining organizational and individual values such as:
• Reckless behavior includes total disregard for policies, patient safety goals, practices, and actions that potentially may result in harm to a patient or staff	• 1. The duty to avoid causing unjustified risk or harm • 2. The duty to produce an outcome • 3. The duty to follow a procedural rule	• Safety • Cost Effectiveness • Equity • Dignity • Productivity

Risk Management

Reminder:

Patient Safety is everyone's responsibility!

Please remember the following:

- **Distraction Reduction**
  - Care-givers should not be interrupted when performing patient related tasks, such as medication preparation and administration
- **Communication and Documentation**
  - It is important that timely and accurate communication and documentation occurs in order to prevent care-related events

Patients in Restraints for Non-Nursing Staff

- At times, patients will be put into physical restraints to keep them from pulling out tubes or wires or to keep them from harming themselves or others
- Restraints are NOT to be removed by non-clinical staff
- Restraints can ONLY be released by the patient care team members: PCT, CNA, RN
  - PT & OT can remove medical non-violent restraints only
- If a patient in restraints appears to be in any distress, notify the RN/Charge RN immediately

Information Management

2024

CONFIDENTIALITY, COMPUTER ACCESS, & MEDICAL RECORDS CONFIDENTIALITY

Health Insurance Portability & Accountability Act (HIPAA)

HIPAA Privacy & Security

Federal Regulations – Privacy Regulations effective April 2003; Security Regulations effective April 2005

Office of Civil Rights (OCR) – Federal Agency oversees and enforces Federal Privacy Regulations

Privacy Regulation

Protects the security and privacy of all Medical Records and other health information that is used or shared in any form, whether on paper, electronically or verbally by healthcare facilities, employees and their business associates

Notice of Privacy Practice (NOPP) – Morris Hospital provides each new patient with a Notice of Privacy Practice regarding how their health information will be used

Security Regulation

Safeguards the confidentiality, integrity and availability of Electronic Protected Health Information (ePHI)

Minimum Necessary / Need to Know – Each employee is responsible to access **ONLY** the health information that is required for them to complete their job

Privacy & Confidentiality

- Privacy and confidentiality are important patient rights
- Each patient has the right to:
  - Expect privacy and freedom from intrusions or disturbances regarding his or her personal affairs
  - Expect that all communications and records concerning his or her care will be treated as confidential. Information will only be shared with those who need to know the information to perform their duties on behalf of the patient
  - Review the records pertaining to his or her medical care

Maintaining Patient Confidentiality

- Maintaining patient confidentiality means keeping information about a patient's healthcare private
- Only people who need to know information should receive it and only to the extent needed to perform duties for the patient
- Maintaining patient confidentiality requires that any information about a patient cannot be repeated to anyone who is not directly involved with the care of that patient
- One of the greatest forms of communication and connectivity in the twenty first century is social media
- You should never post any information regarding patient care on any form of social media

Maintaining Patient Confidentiality

Healthcare staff have an obligation to safeguard patient information. Measures that safeguard this information include:

- Shredding transitory documents containing PHI
- Leaving phone messages or sending mail reminders for appointments
  - Only the date and time should be given, never the reason
- Keeping fax machines in secure locations
  - The use of preprogrammed fax numbers will help eliminate sending information to incorrect sources
- Verifying the identities of all involved in the care of each patient
- Secure storage of permanent records containing PHI

Safeguarding Electronic Records

Healthcare staff has access to confidential information via electronic records. The confidentiality of these electronic records must be safeguarded through the following actions:

- Computer workstations should be secured at all times
- Passwords should **NOT** be shared
- Access to electronic information should be limited to those who have a need to know the information
- Computer workstations should always be logged off at the end of each session

Infection Prevention & Control

2024

Hand Hygiene

Handwashing 

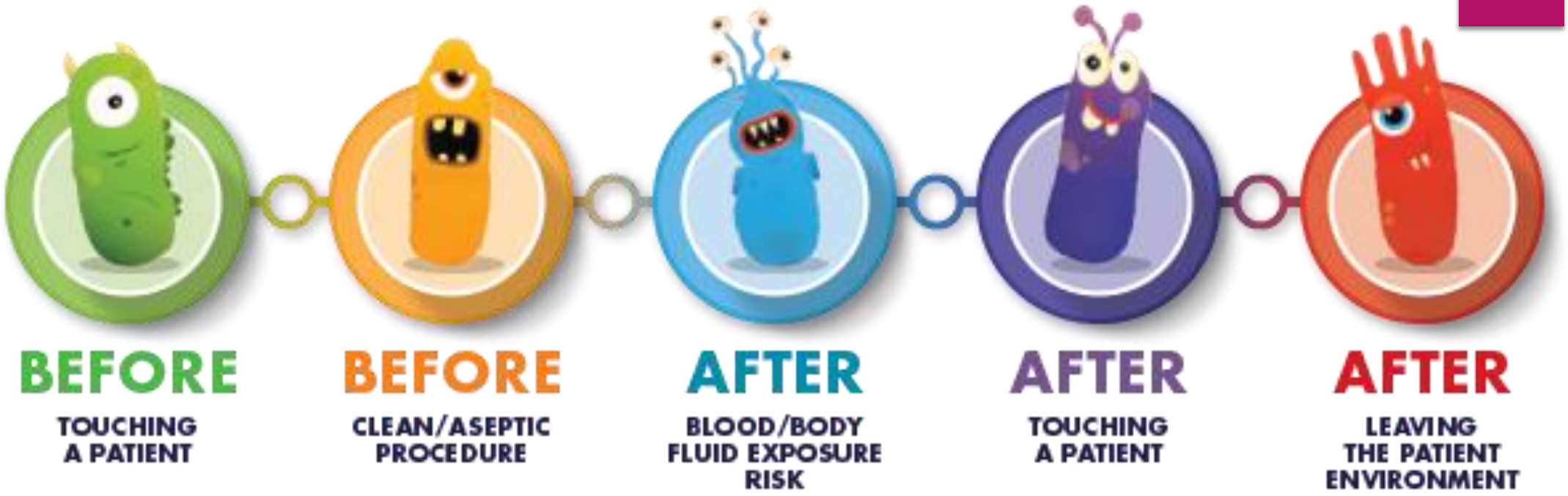
- Rubbing together all surfaces of your hands for 15-20 seconds
- Use any time hands are visibly contaminated
- Use when caring for a patient with diarrhea
- Most often missed spots on the hands
  - Wrists
  - Between the fingers
  - Around the nail beds

Alcohol based hand rub (Purell) 

- Rub all surfaces of the hands together until dry, takes about 20 seconds
- Use when hands are NOT visibly contaminated
- Do NOT use when the patient has diarrhea

Often the preferred method as it is most accessible to healthcare workers

Hand Hygiene is the single most important thing that you can do to prevent the spread of infection!



5 Moments of Hand Hygiene

It takes just 5 Moments to change the world

Clean your hands, stop the spread of drug-resistant germs!

Fingernails

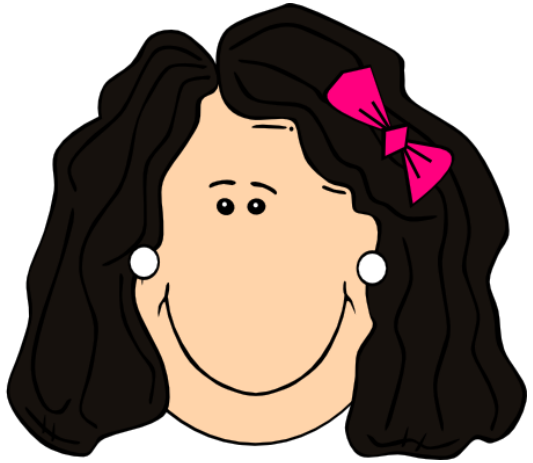
Artificial nails **NOT** allowed for employees who:

- Have direct patient care duties
- Work in areas where end product reaches the patient (including but not limited to):
  - Nutrition Services
  - Environmental Services
  - Pharmacy

Fingernails cannot be over ¼ inch past the fingertip

Piercings

- Gauges on exposed parts of the body and other visible body piercings (e.g. eyebrows, lips, nostrils), other than of the earlobes, are not permissible.



Blood Borne Pathogens

2024

Blood Borne Pathogens

Standard Precautions help protect us from Blood Borne Pathogens

Each of us can prevent disease caused by contact with germs found in blood and other potentially infectious materials (OPIM)

Infection prevention and control measures, put into place by this facility, can protect healthcare workers

Each healthcare worker must be aware of these infection control measures and his or her role in order to protect themselves and others

Contact with blood or body fluids may subject healthcare workers to viruses.

Diseases caused by the following three pathogens are of major concern to healthcare workers

- Human Immunodeficiency Virus (HIV)
- Hepatitis B Virus (HBV)
- Hepatitis C Virus (HCV)

These are three diseases caused by these viruses:

- HIV / Acquired Immunodeficiency Syndrome (AIDS)
- Hepatitis B
- Hepatitis C

Occupation Safety & Health Administration (OSHA) Blood Borne Pathogen Standard

Standard Number: 1910:1030 Blood Borne Pathogens

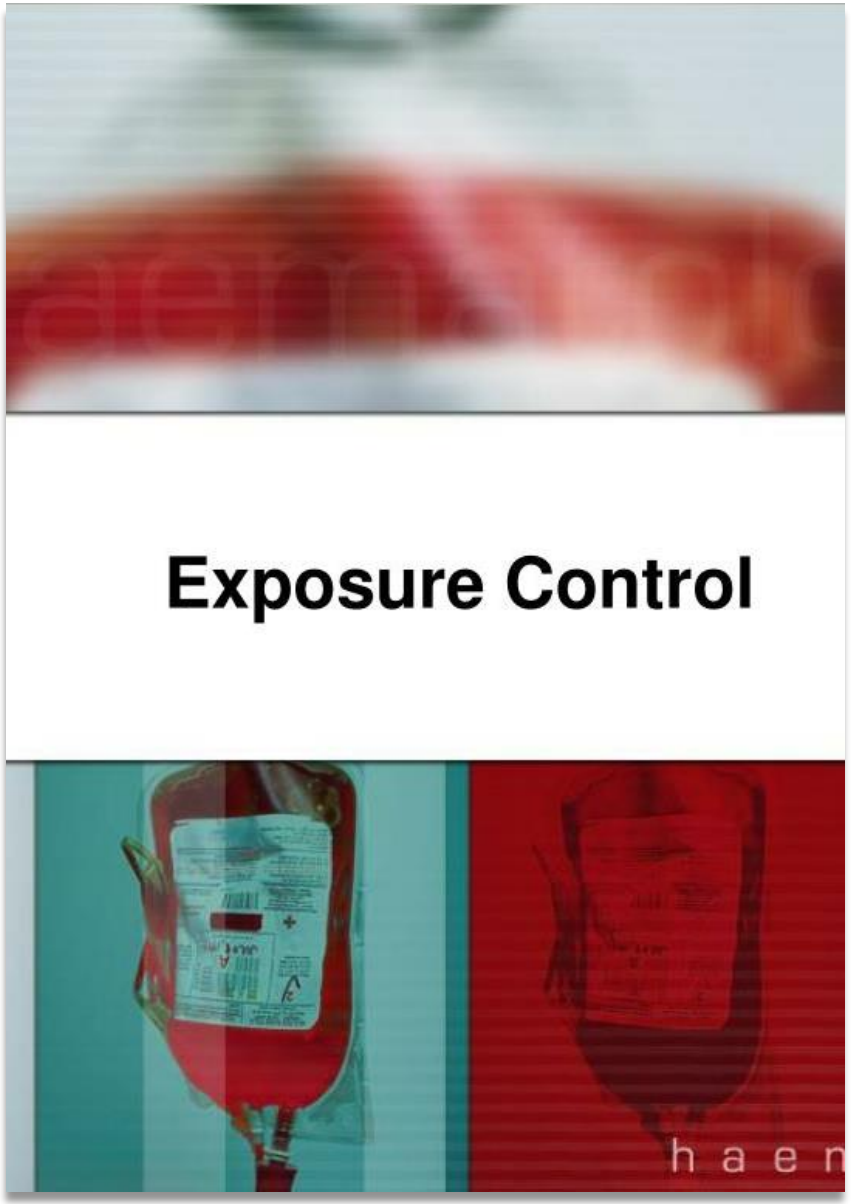
- A copy of the Blood Borne Pathogens Standard can be retrieved online at www.osha.gov

OR

- Employee Health
- House Supervisors
- Infection Preventionist

This Standard Requires Hospitals to have an Exposure Control Plan

- This plan outlines the actions designed to eliminate or minimize employee exposure to blood or body fluids
- Additional information regarding this plan can be found in iShare



This Standard Requires Hospitals To:

- Use safety devices and needleless systems to reduce the risk of blood borne pathogen exposures and **never recap needles**
  - One needle, one syringe, one time
- Maintain an updated exposure control plan
- Maintain a sharps injury log with detailed information
- Use input of Healthcare Providers for the evaluation / selection of new devices and equipment
- Exposure incidents **must** be reported and are reviewed by Risk Management, Safety Committee, and Infection Control Committee

Standard Precautions

An infection control practice where **all** patients and **all** blood and body fluids are considered potentially infectious.

- Wear Personal Protective Equipment (PPE) to prevent exposure to potentially contaminated body fluids
  - Gloves
  - Gowns
  - Masks
  - Protective Eyewear / Faceshield

In addition to Standard Precautions we use

Transmission Based Precautions

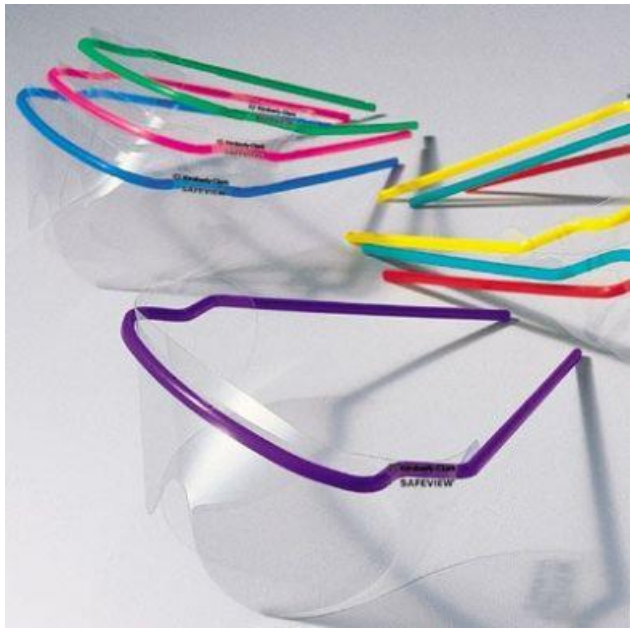
to prevent the spread of other infections

Over door caddy on 2E and 2S

Wheeled cabinet for ICU sliding glass doors

FUN FACT:

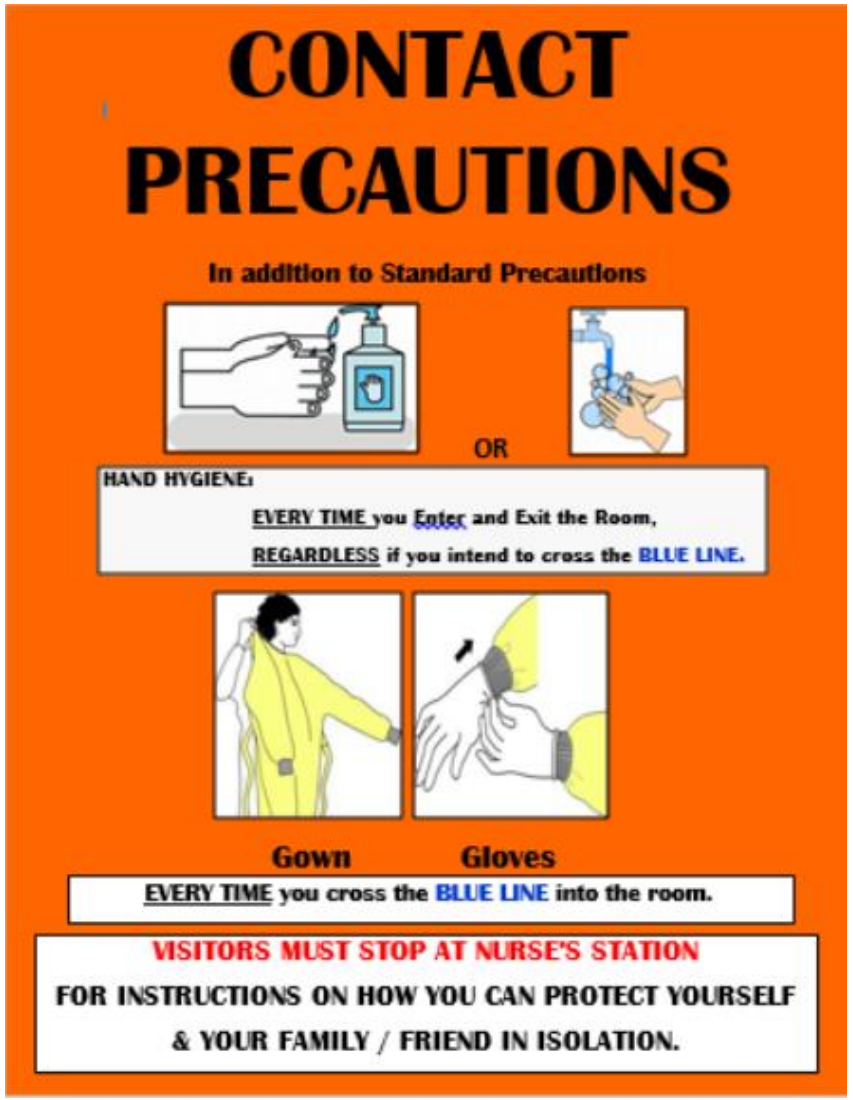
Eye Protection is the most overlooked piece of PPE



Contact Isolation Precautions

Common conditions:

- Multi-Drug Resistant Organisms (MDROs):
  - MRSA
  - VRE
  - ESBL
  - CRE
- Scabies
- Respiratory Syncytial Virus (RSV)
- Wounds or abscesses with uncontained drainage



Minimum PPE: Gown & Gloves

Enteric Contact Isolation Precautions

USED TO ISOLATE PATIENTS WITH LOOSE OR LIQUID STOOLS (3 or more within a 24 hour period)

This includes:

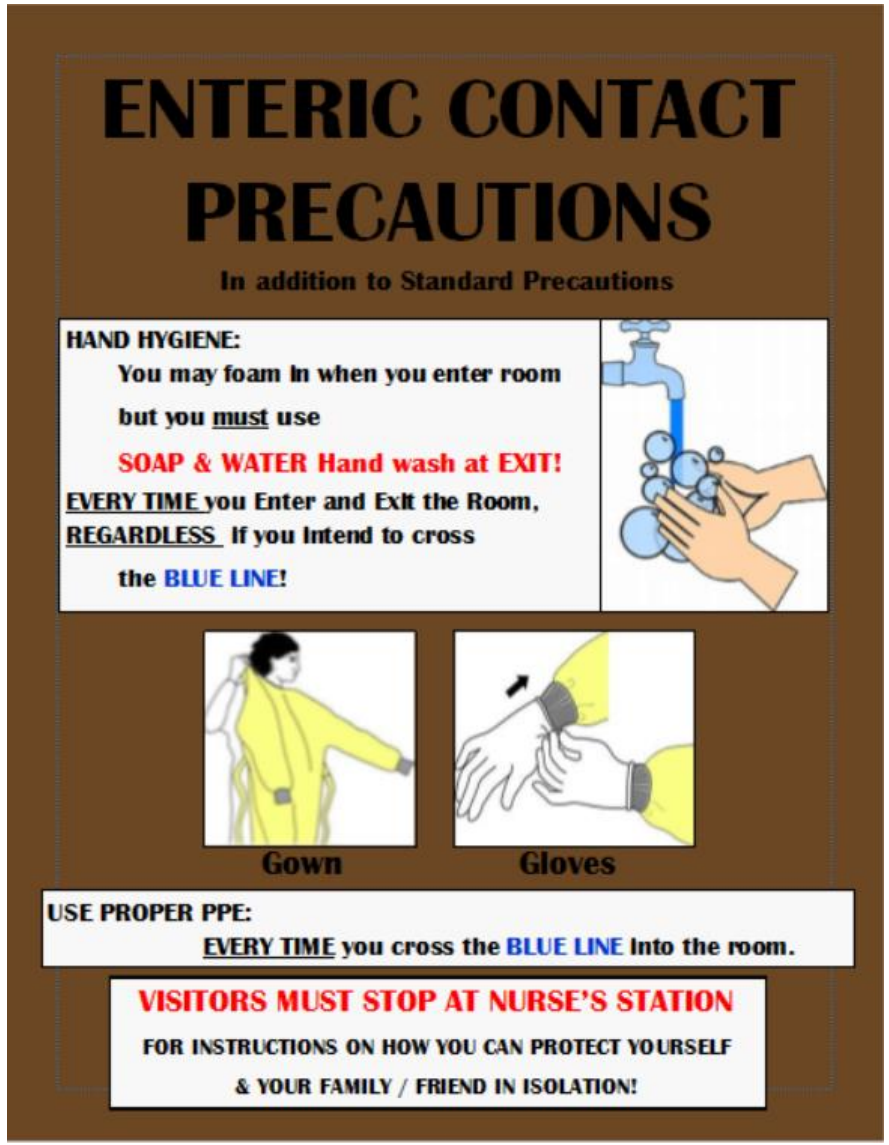
- Patients pending C. diff, Norovirus, etc. (until ruled out)
- Patients with confirmed C. diff
- Patients admitted with C. diff still receiving treatment

PATIENTS REMAIN IN ISOLATION FOR THE DURATION OF THE ILLNESS:

- Until they have completed treatment

AND

- Are free of diarrhea or loose stools



Minimum PPE: Gown & Gloves

Enteric Contact Isolation Precautions

DON'T FORGET…

- ✓ **Hand Hygiene:** Soap & water Only during care and on exit
- ✓ **Disinfectant:** Clorox wipes.
- ✓ **Nurse Driven Protocol for C diff testing**
- ✓ **Stools must be Type 6 or 7 meaning the sample must confirm to the contain. If it does not, lab will reject the specimen.**

Protective Isolation Precautions

Protecting the patient from us!

For patients who are severely **immunocompromised** and at a high risk for infection

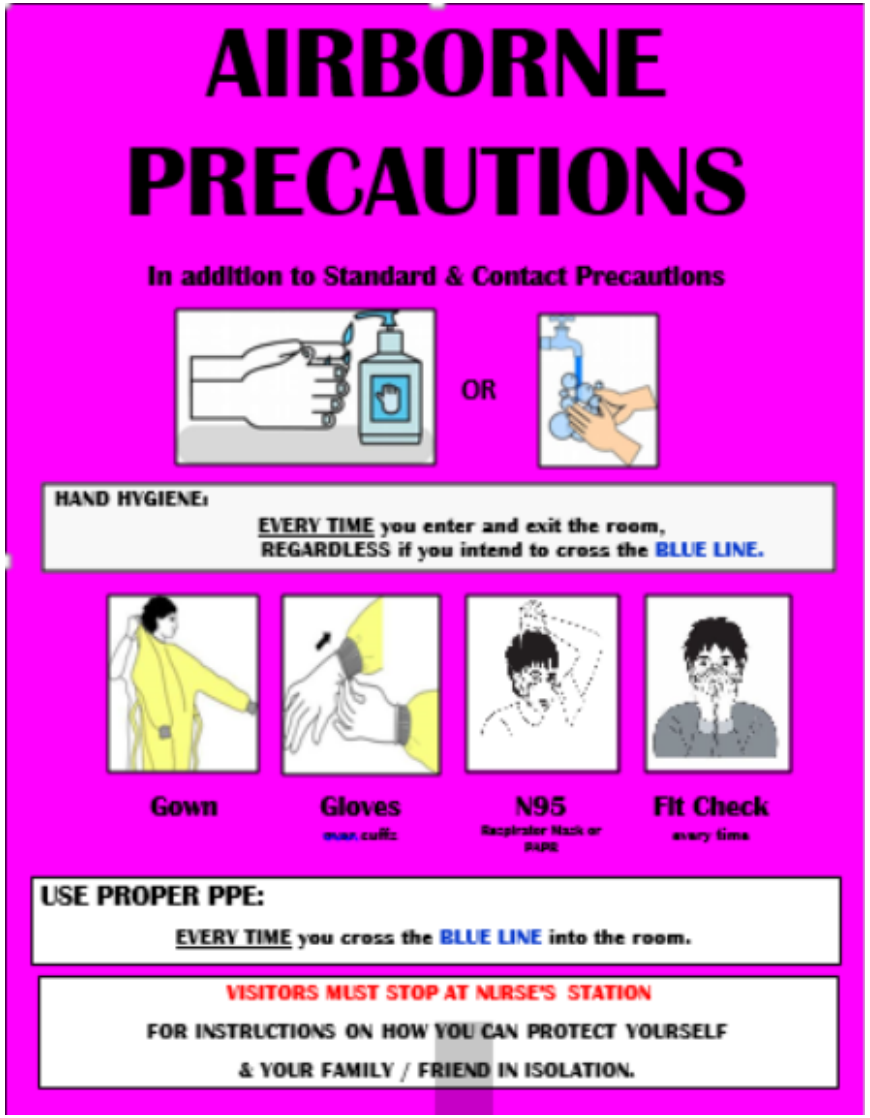
DON'T FORGET:

- Wash hands with soap and water every time you enter and exit
- No persons with infections my enter
- No live plants or flowers

Airborne Isolation Precautions

COMMON CONDITIONS FOR AIRBORNE PRECAUTIONS:

- Tuberculosis
- Chickenpox
- Disseminated Herpes Zoster (Shingles)
- Localized Shingles in an immunocompromised patient
- Measles (Rubeola)



Minimum PPE: N95 Respirator Mask (or PAPR), Gown & Gloves

Airborne Isolation Precautions

Patient will be in a **negative pressure room**.

Keep door closed!

- **2E (Room 251, 259, 260, and 272)**
- **2S (Room 221)**
- **ICU (Room 206)**

Negative Pressure Rooms Require Monitoring

- Daily, when in use for Airborne Precautions
- Monthly, when not in use
- Monitoring is done by Facilities

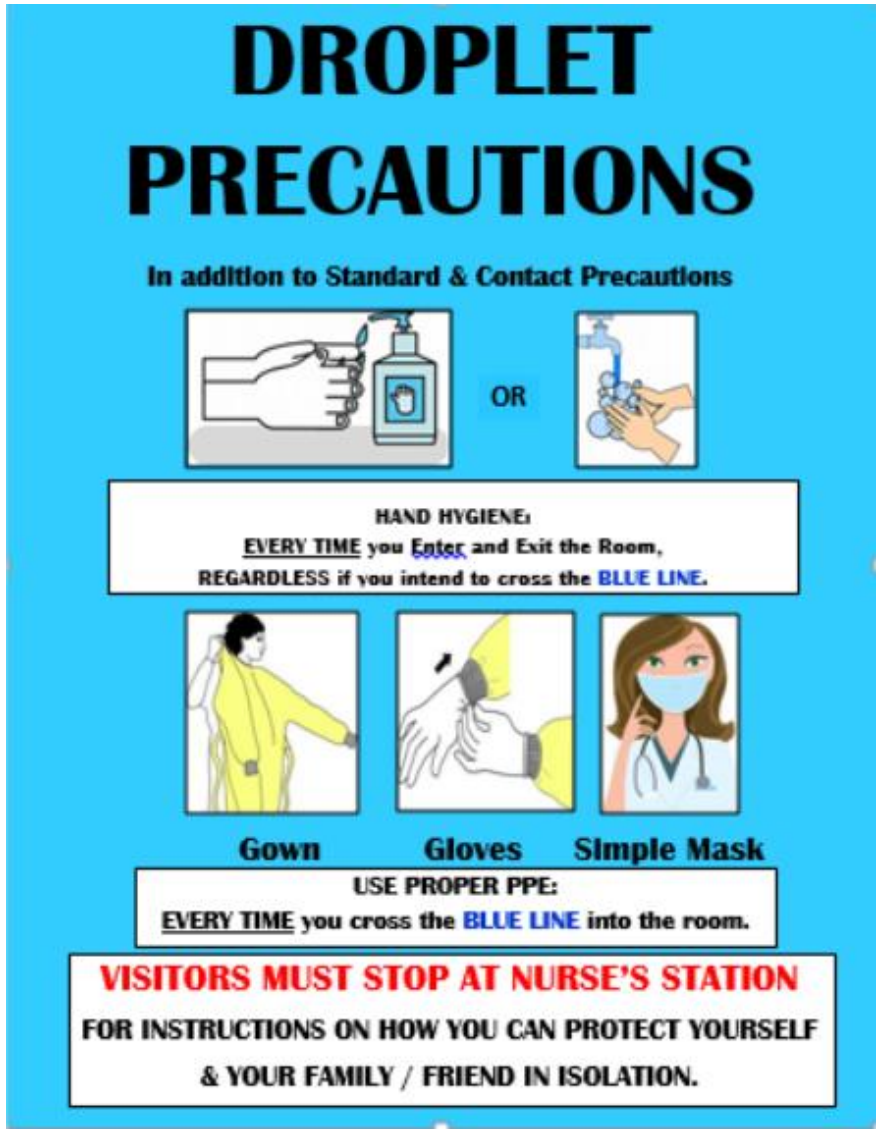
IMPORTANT

Nursing staff should notify Facilities immediately when a patient is placed in Airborne Precautions

Droplet Isolation Precautions

COMMON CONDITIONS FOR DROPLET PRECAUTIONS:

- Influenza
- Meningitis
- Pertussis (Whooping Cough)
- Respiratory viruses



Minimum PPE: Surgical/Procedure Mask, Gown & Gloves

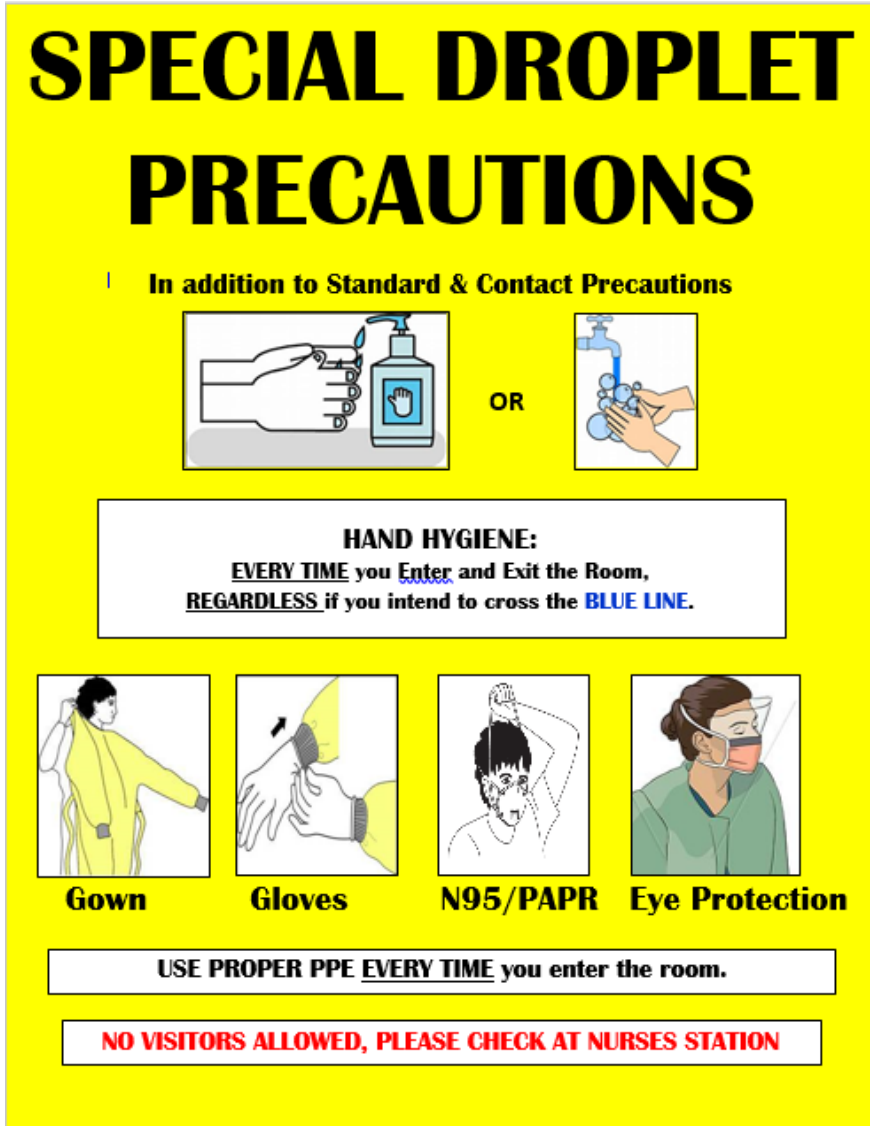
Special Droplet Isolation Precautions

PRECAUTIONS FOR COVID PATIENTS OR SUSPECTED COVID PATIENTS (PUIs)

DON'T FORGET…

- Disinfectant: Clorox wipes

Even when not it Special Droplet N95 Respirator Mask or PAPR is required for activities that generates droplets into the air such as suctioning, respiratory therapy procedures, and oxygen bubblers.



Minimum PPE: N95 Respirator Mask (or PAPR), Face Shield or Eye Protection, Gown & Gloves

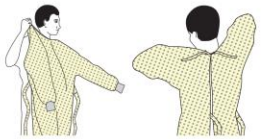
Donning & Doffing PPE

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

1. GOWN

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



2. MASK OR RESPIRATOR

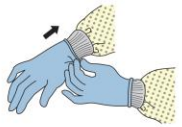
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



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

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

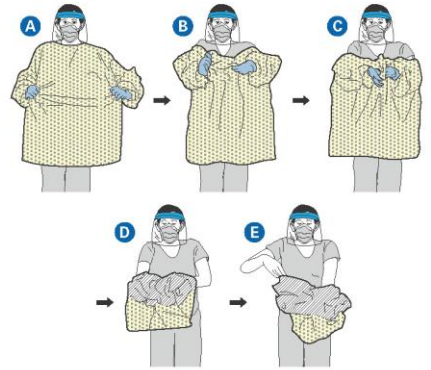
CS250672-E

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

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

1. GOWN AND GLOVES

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

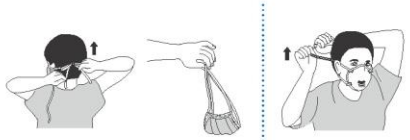


2. GOGGLES OR FACE SHIELD

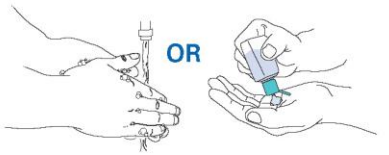
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles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

3. MASK OR RESPIRATOR

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



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



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

CS250672-E

Know Your Disinfectant Wet Contact Time!

1 Minute

Wet Contact Time

3 Minute

Wet Contact Time

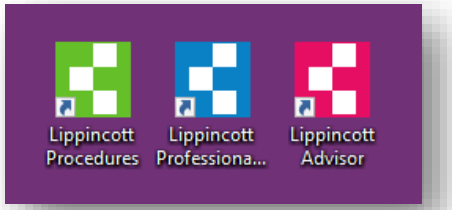
Student Clinical Orientation

PROCEED IF YOU WILL BE WORKING IN A CLINICAL SETTING

2024

Policy and Procedure

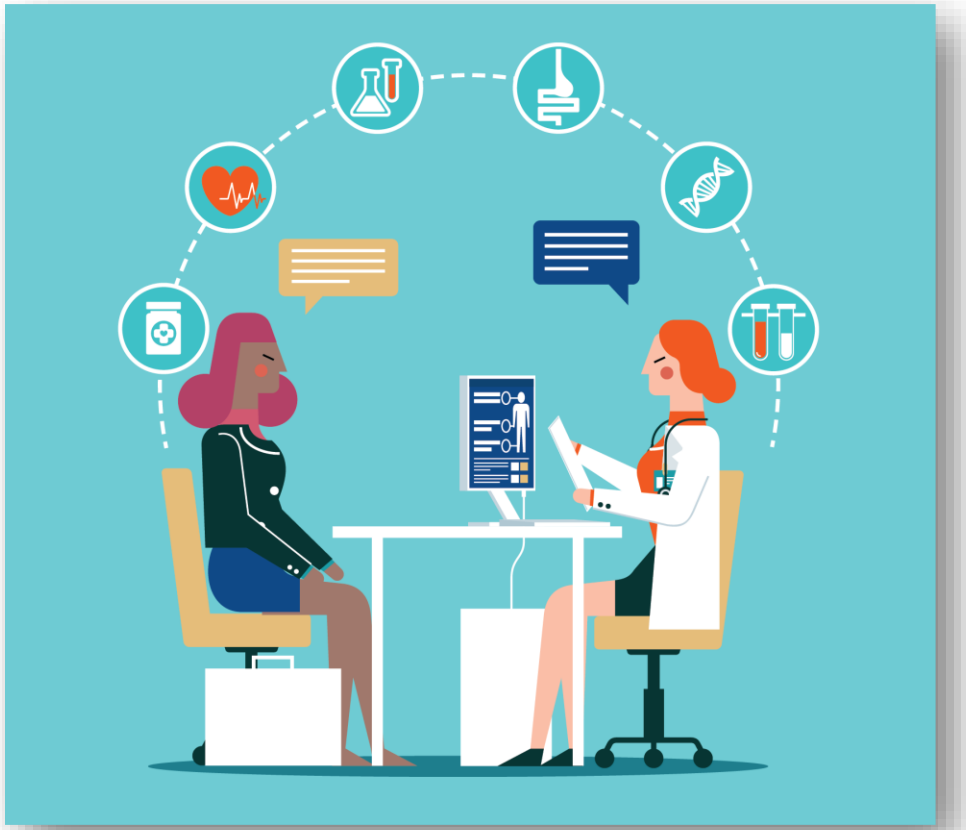
- iShare
  - Morris Hospital specific policies



- Lippincott Procedures
- Lippincott Advisor
- Lippincott Professional Development

Patient Communication

2024



Screening for Health Literacy

- Watch for behaviors that may signal poor health literacy.
  - These include incompletely or incorrectly filled out health questionnaires, frequently missed appointments, noncompliance with the medication regimen, and a lack of follow through with laboratory or other tests
- When a patient claims to be taking medication as prescribed, yet the laboratory test results or physical signs don't change as expected
- When given written information, a patient with poor general literacy may say something like, "I forgot my glasses. I'll read this when I get home," or "I forgot my glasses. Can you read this to me?"
- Patients who cannot name their medications, explain their medication regimen, or explain what their medications are for may have low health literacy
- The 2 questions that can most accurately screen for health literacy are:
  - "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"
  - "How confident are you in filling out medical forms by yourself?"
- Be sure you screen in a safe, supportive, and private environment.
  - Treat the patient with respect
  - phrase questions in a neutral, nonjudgmental fashion
  - use a nonjudgmental tone of voice

Health Literacy

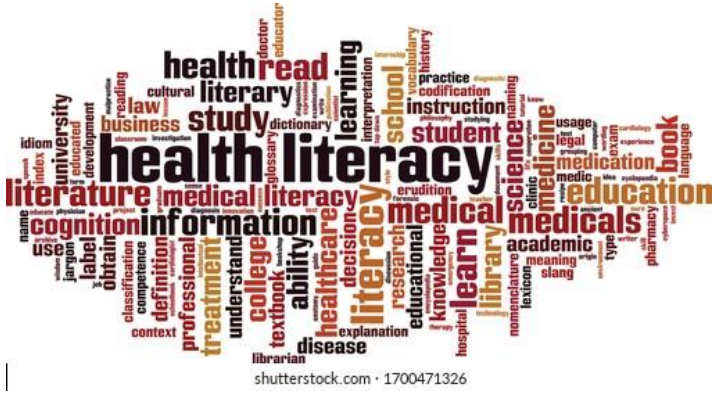
Don't blame the patient for not understanding information

Anyone, no matter how educated, can misunderstand medical information, particularly if the information is complex or the situation emotional

Be aware that patients with low health literacy often don't understand or are unaware of basic concepts about their disease

Patients with low health literacy often don't understand common medical terms, including bowel, colon, rectum, lesion, polyp, growth, tumor, screening, and blood in the stool

Patients with low health literacy have difficulty navigating the health care system



Health Literacy & Communication

- Sit down so that you are on the same level as the patient and speak slowly
- Replace medical jargon with common, everyday words
- Use the active rather than the passive voice
  - For example, instead of saying, "This medication should be taken with food," say, "Take one of these pills when you eat breakfast every morning."

- Use visual images to augment what you're saying, or draw pictures
- Limit the amount of information that you provide at one time and organize information so that the most important points come first
- Even if the patient has good general literacy skills, ensure that any written information is clear and easy to understand
  - Materials written at a sixth-to eighth-grade level seem to be effective for most patients

- To confirm that the patient has understood, don't simply say, "Do you understand?" which requires only a "yes" or "no" answer
  - Instead, use the teach-back technique, in which you ask the patient to demonstrate or explain back to you what you just explained
- Encourage the patient to ask questions
  - Create a shame-free environment in which the patient feels comfortable asking questions
- Encourage the patient to bring someone along to medical visits to witness firsthand what the practitioner is saying

Stages of Growth & Development

2024

Healthy Growth & Development
Providing Age Specific Care

Stages of Growth & Development

- Human growth and development is a continuous and complex process
- There are important age related variations to take into consideration when developing an appropriate plan of care for a patient:
  - Physical Changes
  - Psychosocial Changes
  - Cognitive Changes
  - Health Risks
  - Health Promotion

Infants (1 month – 1 year)

Rapid physical growth and change occur

Vision and hearing continue to develop

Physical Changes: Gross-motor skills that involve large muscle activities are developing (holding head up, rolling over, crawling). Fine motor skills developing (able to grasp rattle briefly at 2 months to placing objects into containers at 10-12 months).

Cognitive Changes: Infants proceed from crying, cooing, and laughing to imitating sounds, comprehending the meaning of simple commands and repeating words with knowledge of the meaning.

Psychosocial Changes: Separation and individuations. During their first year infants begin to differentiate themselves from others as separate beings capable of acting on their own. At 2-3 months infants begin responsively rather than reflexively to smile. Close attachment to their primary caregivers, most often parents, usually occurs by this age.

Health Risks

Injury Prevention: Injury from motor vehicle accidents, aspiration, suffocation, falls, or poisoning are a major cause of children 6-12 months old. Ensure the child's safety and comfort (crib rails, car seat, toys)

Child Maltreatment: Children from any age can suffer from intentional physical abuse or neglect, emotional abuse or neglect, and sexual abuse. More children suffer from neglect than any other type of maltreatment. Screen/assess for warning signs.

Health Promotion

Nutrition: The quality and quantity profoundly influences the infant's growth and development. Breastfeeding is recommended for infant because breast milk contains essential nutrients of protein, fats, carbohydrates, and immunoglobulins that bolster the ability to resist infections. However if breast feeding is not possible or if the parent does not desire it, an acceptable alternative is iron-fortified commercially prepared formula. The need for supplements depends on the infant's diet.

Immunizations: Educate parents about the need for checkups, screenings and immunizations

Toddlerhood (12 months – 36 months)

Physical Changes: Each year average growth of 6.2 cm (2.5inches) in height average weight gain 5-7 pounds. Rapid growth of motor skills allows child to participate in self care activities (feeding, dressing and toileting, moves from scribbling to drawing circles and crosses).

Cognitive Changes: Recognizes they are separate beings from mother. Imitate behaviors. Reason based on experience of an event. Moves from using 10 words to learning 5-6 new words a day and using simple sentences.

Psychosocial Changes: Sense of autonomy emerges. They strive for independence. Their strong wills are frequently exhibited in negative behaviors when caregivers attempt to direct their actions. Strongly attached to their parents and fear separation. Play expands the child's cognitive and psychosocial development.

Health Risks

The newly developed locomotion abilities and insatiable curiosity of toddlers make them at risk for injury.

Poisonings occur frequently because children near 2 years are interested in placing any object or substance in their mouth.

Toddlers' lack of awareness of danger puts them at high risk.

Limit setting is extremely important for toddler safety.

Creating an environment that supports parents helps greatly in gaining the cooperation of the toddler.

Establishing a trusting relationship with the parents often results in toddler acceptance of treatment.

Health Promotion

Nutrition: Childhood obesity and the associated chronic disease that results are a great concern for healthcare providers. Serving finger foods help them to satisfy their need for independence and control. Small nutritional servings allow toddlers to eat all of their meals.

Toilet Training: Recognizing the urge to urinate and or defecate is crucial in determining the child's readiness for toilet training. Patience, consistency, and a nonjudgmental attitude, in addition to the child's readiness, are essential to successful toilet training.

Preschooler (3-5 years)

Physical Changes: Physical development begins to stabilize. Average weight gain 5 pounds per year. Average growth 6.2 to 7.6 cm (21/2-3 inches). Large and fine muscle coordination improve.

Cognitive Changes: Maturation of the brain continues with most rapid growth in frontal lobe areas. Ability to think more complexly by classifying objects according to size or color and by questioning. Increased social interactions. Become aware of cause and effect relationships. The greatest fear of this age-group appears to be bodily harm; this is evident in children's fear of the dark, animals, thunderstorms, and medical personnel. Preschoolers will be more cooperative if they are allowed to help with care.

Psychosocial Changes: Their world expands beyond family. Curiosity and developing initiative lead to actively exploring the environment, developing new skills, and making new friends. Sources of stress can include changes in care giving arrangements, starting school, the birth of a sibling, parental marital distress, relocation to a new home, or an illness. During these times of stress, they sometimes revert to bed wetting, or thumb sucking and want parents to feed, dress and hold them. The play of preschool children becomes more social after the third birthday as it shifts from parallel to associative play. By age 4, children play in groups of 2 or 3.

Health Risks

Guidelines for injury prevention in the toddler apply to the preschooler.

Close supervision of activities.

Preschoolers are great imitators; thus example is important. For instance, parental use of a helmet while bicycling sets an appropriate example for the preschooler.

Health Promotion

Parental beliefs about health, children's bodily sensations and their ability to perform usual daily activities help children develop attitudes about their health.

Nutrition: Average daily intake is 1800 calories. Quality of food is more important than quantity. Preschoolers consume about half of the average adult size portion. Finicky eating habits are characteristic of the 4 year old; however, the 5 year old is more interested in trying new foods.

Sleep: Preschoolers average 12 hours of sleep at night and take infrequent naps.

Vision: Vision screening begins. Early detection and treatment of strabismus are essential by ages 4-6 to prevent amblyopia, the resulting blindness from disuse.

School-age Children (6-12 years)

During these 'middle years' of childhood, the foundation for all adult roles in work, recreations, and social interaction is laid.

Physical Changes: Growth rate is slow and consistent. Child appears slimmer as a result of changes in fat distribution and thickness. Many children double their weight during these years, and most girls exceed boys in both height and weight.

Cognitive Changes: Able to think in a logical manner about the here and now and to understand the relationship between things and ideas. Their thoughts are no longer dominated by their perceptions, their ability to understand the world greatly expands.

Psychosocial Changes: Group and personal achievements become important to the school age child. Success is important in physical and cognitive activities. Prefers same-sex peers. Stress comes from parental expectations, peer expectations, the school environment, or violence in the family, school or community. Deep breathing techniques, positive imagery, and progressive relaxation of muscle groups are interventions that most children can learn.

Health Risks

Accidents are a major health problem affecting school age children.

Motor vehicle injuries as a passenger or pedestrian and bicycle injuries are most common in this group.

Health Promotion

Identity and self concept become stronger.

Child becomes more modest and sensitive about being exposed.

Provide privacy and offer explanations of common procedures.

Focus health education on how the choices they make will affect their body is important.

Stress the importance of annual health maintenance visits for immunizations, screening and dental care with parents.

Provide education about safety measures to prevent accidents and encourage child to take responsibility for their own safety.

The availability of snacks and fast food restaurants make it difficult for children to make healthy choices.

Promote healthy life style choices, including nutrition. School age children need to participate in educational programs that enable them to plan, select and prepare healthy meals and snacks.

Adolescents (13-17 years)

Adolescence is the period during which the individual makes the transition from childhood to adulthood. The term adolescent usually refers to psychological maturation of the individual, whereas puberty refers to the point at which reproduction becomes possible.

Physical Changes: Increased growth rate of skeleton, muscle, and viscera. Sex specific changes such as changes in shoulder and hip width. Alteration in distribution of muscle and fat. Development of the reproductive system and secondary sex characteristics.

Cognitive Changes: Develop the ability to determine and rank possibilities, problem solve and make decisions through logical operations. Now able to think in terms of the future rather than just current events.

Psychosocial Changes: The search for personal identity is a major task for this group. Teenagers establish close peer relationships or remain socially isolated. Initial development of sexual identify. Adolescents seek a group identify because they need esteem and acceptance. Popularity with opposite-sex and same-sex peers is important. Healthy adolescents evaluate their own health according to feelings of well-being, ability to function normally, and absence of symptoms.

Health Risks

Accidents remain the leading cause of death. Motor vehicle accidents most common cause of unintentional deaths and are often associated with alcohol intoxication or drug abuse. Feelings of being indestructible lead to risk prone behaviors.

Violence and homicide is second leading cause of death in the 15-24 year old group, and for African American teenagers, it is the most likely cause of death.

Suicide is third leading cause of death for adolescents 13-19 years of age.

All adolescents are at risk for **experimental or recreational substance abuse**, but those who have dysfunctional families are at more risk for chronic use and physical dependency.

Eating Disorders such as anorexia nervosa and bulimia appear in adolescents.

Sexually Transmitted Infections affect 3 million sexually active adolescents. Making screening for STIs imperative.

Pregnancy: the U.S. has the highest rate of teenage pregnancy and childbearing annually compared with other industrialized nations.

Health Promotion

Maintain privacy and confidentiality.

Be sensitive to emotional cues from adolescents before initiating health teaching to know when the teen is ready to discuss concerns.

Young Adults (18-34 years)

Young adulthood is the period between the late teens and mid to late 30s. In recent years this group has been referred to as part of the millennial generation.

Physical Changes: Usually physical growth completed by the age of 20. Usually quite active, experience severe illnesses less commonly than older age groups and tend to ignore physical symptoms and often postpone seeking healthcare.

Cognitive Changes: identifying an occupational direction is a major task of young adults.

Psychosocial Changes: The emotional health of the young adult is related to the individual's ability to address and resolve personal and social tasks. Trends and patterns include: Ages 23-28 the person refines self-perception and ability for intimacy. From 29-34 the person directs enormous energy toward achievement and mastery of the surrounding world.

Health Risks

Health risk factors for a young adult originate in the community, lifestyle patterns and family history. The lifestyle habits that activate the stress response increase the risk of illness.

Risk Factors include:

- Family History of disease
- Personal hygiene habits
- Substance abuse
- Violent death and injury
- Sexually transmitted disease
- Environmental or occupational factors

Health Promotion

Healthy lifestyle (diet, exercise, stress control, smoking cessation, etc.).

Encourage adults to perform monthly skin, breast, or male genital self-examination.

Middle Adults (35-64 years)

In middle adulthood the individual makes lasting contributions through involvement with others.

Ages 35-43 are a time of rigorous examination of life goals and relationships.

Physical Changes: most visible changes are graying hair, wrinkling of the skin and thickening of the waist. The most significant physiological changes during middle age are menopause in women and climacteric in men.

Cognitive Changes: These are rare except in cases of illness or trauma.

Psychosocial Changes: Involve expected (children moving away) and unexpected (divorce or death of a friend) events. Changes often are related to career transitions, sexuality, family transition (empty nest), marital transitions, and care of aging parents.

Health Promotion & Stress Reduction

When adults seek healthcare, nurses focus on the goal of wellness and guide patients to evaluate health behaviors, lifestyle and environment.

Counseling related to physical activity and nutrition is an important component of the plan of care for overweight and obese patients.

Health teaching and counseling focus on improving health.

Assess for anxiety and depression.

Older Adults (65 years & up)

Age 65 is considered to be the lower boundary for "old age" in demographics and social policy within the United States.

However many older adults consider themselves to be "middle-age" well into their seventh decade.

The care of older adults poses special challenges because of great variation in their physiological, cognitive and psychosocial health.

Myths & Stereotypes

"Some people stereotype older adults as ill, disabled, and physically unattractive ... Some people believe older adults are forgetful, confused, rigid, bored, and unfriendly and that they are unable to understand and learn new information."

"In a society that values attractiveness, energy, and youth, myths and stereotypes lead to the undervaluing of older adults."

Facts

"Specialists in the field of gerontology view centenarians, the oldest of the old, as having an optimistic outlook on life, good memories, broad social contacts and interest, and tolerance for others. Although changes in vision or hearing and reduced energy and endurance sometimes affect the learning process of learning , older adults are lifelong learners.“

"It is important for you to assess your own attitudes toward older adults; your own aging; and the aging of your family, friends, and patients. Nurses' attitudes come from personal experiences with older adults, education, employment experiences, and attitudes of co-workers and employing institutions. Giving the increasing number of older adults in health care settings, forming positive attitudes toward them and gaining specialized knowledge about aging and their health care needs are priorities for all nurses."

Older Adults (65 years & up)

Developmental Tasks for Older Adults

Adjusting to decreasing health and physical strength.

Adjusting to retirement and reduced or fixed income.

Adjusting to death of a spouse, children, siblings, or friends.

Accepting self as an aging person.

Maintaining satisfactory living arrangements.

Redefining relationships with adult children and siblings.

Finding ways to maintain quality of life.

Health Promotion & Maintenance

Participation in screening activities (e.g., blood pressure, mammography, Pap smears, depression, vision and hearing testing, colonoscopy).

Regular exercise.

Weight reduction if overweight.

Eating a low-fat, well balanced diet.

Moderate alcohol use.

Regular dental visits.

Smoking cessation.

Immunizations for seasonal influenza, tetanus, diphtheria, pertussis, shingles, pneumococcal disease, and COVID 19.

Principles for Promoting Older Adult Learning

Make sure that the patient is ready to learn before trying to teach. Watch for clues that indicate the patient is preoccupied or too anxious to comprehend the materials the patient physically well enough to be taught? Is he or she in pain? Sit facing the patient so he/she is able to watch your lip movements and facial expressions. Present one idea or concept at a time. Emphasize concrete rather than abstract material. Give the patient enough time in which to respond because older adults process information slower than younger persons. Keep environmental distractions to a minimum. Provide appropriate lighting and a comfortable setting. Defer teaching if the patient becomes distracted or tired or cannot concentrate for other reasons. Invite another member of the household to join the discussion. Use audio, visual, and tactile cues to enhance learning and help the patient remember information. Ask for feedback to ensure that the patient understands the information (TEACH BACK METHOD). Use past experience; connect new learning to previous knowledge.

Safe Patient Handling & Mobility Equipment

2024

Purpose

- To support the safety of patients and employees, through the proper use of lifting and handling equipment during all patient movement and mobility.
- Mechanical lifting equipment and/or other approved patient handling aids should be used to prevent injury from the lifting and handling of patients, except when absolutely necessary, such as in a medical emergency.

Stedy/Sara Stedy

- Stedy is used for a limited assist, weight bearing patient and assists the patient from sitting position (chair, bed, or toilet) to a standing position for transfers, toileting, and fall prevention.
- Family Birthing Suites also utilizes a Sara Stedy.

Stedy Weight Limit: 120.20 kg/265 lbs
Sara Stedy Weight Limit:181.44 kg/400 lbs

Maxi Lift

- Maxi Lift is a mechanical lift for dependent, non-weight bearing patients and is used for transferring from bed to chair, chair to bed, off of the floor, and to and from a gurney.

Weight Limit: 226.80 kg/500 lbs

****2 trained individuals are required for use**

EZ Lift

- EZ Lift is a mechanical lift used for transferring the immobile patient between positions.

Weight Limit: 453.59 kg/1000 lbs

****2 trained individuals are required for use**

Ceiling Lift

- Ceiling Lift is a motorized device attached to the ceiling used for transferring from bed to chair, chair to bed, off of the floor and to and from a gurney, in rooms equipped with lift.

****2 trained individuals are required for use**

Weight Limit: 272.16 kg/600 lbs

HoverMatt

- Hover Matt is a cushion of air used to transfer and reposition patients.

****2 trained individuals are required for use**

Weight Limit: 545.45 kg/1200 lbs

Slide Sheets (Orange Z-Sliders)

- Slide Sheets (Orange Z-Sliders) are for patients needing assistance from bed to gurney, repositioning back up in bed, and on turning schedules.

****2 trained individuals are required for use**

Weight Limit: 136.01 kg/300 lbs

Slide Board / Roller Board

- Slide Board is used as a bridge for 2 uneven surfaces.

****2 trained individuals are required for use**

Comfort Glide Sheets

- For use in: transfer of patients needing assistance from bed to gurney, repositioning back up in bed, and on turning schedules.
- These sheets may remain under the patient and can be used to safely reposition, turn, boost, and transfer patients.
- These are single patient use and costly. They will be kept in the 2-south manager's office so they can be retrieved at any time
- Contact house officer or security to obtain the device after hours and on weekends.
- These comfort slide sheets should be used in place of the z-slider only for those hard to reposition patients such as those with decreased mobility, paralysis, contractures, and so on.

****2 trained individuals are required for use**

Weight Limit: 260 kg/575 lbs

Gait Belt

- Used in transfer of patients needing assistance, weight bearing patient from sitting position (chair, bed, or toilet) to a standing position for transfers, toileting, and fall prevention during mobility.

Med Sled

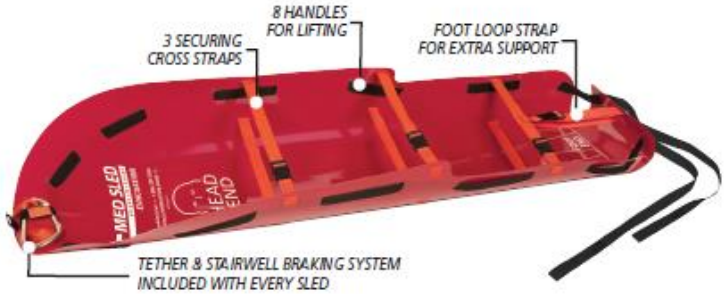
- For use in evacuation of non-ambulatory patients horizontally and vertically to safety.

****2 trained individuals are required for use**

Weight Limit: 453.59 kg/1000 lbs

MED SLED
NO ONE LEFT BEHIND
EVACUATION

MS28, MS36, MS48 INSTRUCTIONS



When using the Med Sled® Evacuation Sled to transport humans every precaution should be used to secure the person to the sled properly ensuring they remain on the sled during transport. The directions below outline the proper way of using and securing a patient to the sled. ARC Products takes no responsibility for injuries sustained in an emergency rescue situation.

1. When transporting a patient from a hospital bed, lock wheels of bed.
2. Pull sheets from both sides and cover patient in bedding. Include pillows for head.
3. Unroll sled and approach patients upper body. **(See Figure 1.)**
   a. If sled begins to roll back up, fasten or tighten the foot cross strap.
4. Put patient on sled.
   a. Roll Patient on their side away from door and slide Med Sled® Evac Sled under head and shoulders then slide remaining sled under buttocks and legs.
   b. Make sure sled is completely on the bed's mattress.
   c. Roll patient back onto sled and slide bedding and patient to middle of sled.
   d. Add any external devices between patient's legs and along sides. IV bags, oxygen, etc.
   e. Secure patient to sled by fastening all three cross straps. Tighten snugly. **(See Figure 2.)**
   f. Ensure ankle strap is tightened until sides meet foot pad.
5. Foot loop strap should be used at all times. **(See Figure 3.)**
   a. Strap should be above patient's feet from cross strap to foot pad.
   b. Cross strap should be connected and tight.
   c. Tighten foot loop strap until foot pad touches sled sides.
6. Taking sled off bed:
   a. If power exists, lower bed to lowest position.
   b. For non-attached mattresses you can grab entire mattress at foot end and rotate mattress toward door.
      1. Make sure sled is in middle of mattress.
      2. Standing on inside of mattress, guide sled down mattress in a "slide" fashion. **(See Figure 4.)**
   c. For attached mattresses, tables or gurneys, spin sled so the foot of sled is extended off the end side of mattress toward the door.
      1. Position people on each side, holding perimeter tether near head of evacuee.
      2. Push foot end to floor. As sled slides off mattress, use a single knee or leg drop to lower head of sled to the floor.

(continued on back)

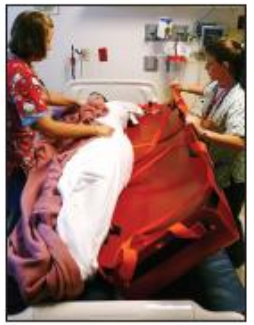


FIG. 1

FIG. 2

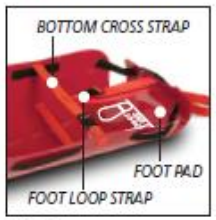


FIG. 3

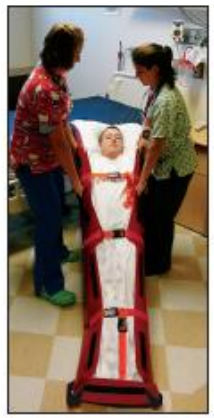


FIG. 4

(continued from front)

7. Grab end strap and pull toward door. The Med Sled® Evac Sled will easily slide down mattress to floor.
8. One or Two employees will pull patient toward emergency exit from the foot strap. **(See Figure 5.)**
9. Open exit door and pull patient to top of steps feet first. **(See Figure 6a.)**
   a. Patient should be pulled over the first step no further than the knees.
10. Approach head of sled and secure large spring hook (carabineer) to the OUTSIDE railing bracket connected to wall. **(See Figure 5a.)** Connect spring hook to railing bracket. **(See Figure6b.)** Do not hook to railing below bracket as hook will slide down with patient. Firmly grab loose tether and take out slack, making sure the tether is wrapped once completely around spring hook.
    a. Employee on lower landing is now ready to pull foot strap. **(See Figure 6c.)**
    b. Upper landing employee lets out tether as the sledding action lowers patient. The spring hook provides a friction breaking system.
11. At bottom landing upper employee unhooks spring hook and walks it to lower landing while taking up tether slack.
    a. Both employees turn patient on landing to repeat process.
12. **Cleaning and Rerolling your Sled** - *Follow medical protocols for bodily fluids on the sled up to and including disposal if contamination is involved.*

    When reusing, rewind the braking tether and attach spring hook and tether to front of sled with Velcro. Reroll the sled tightly starting at the foot of the sled. The final roll should be less than 9" in diameter. Wrap the cinch strap around and Velcro. Slide back into carry bag.

    Care should be taken to keep the product dry, out of direct sunlight and extreme climate/environmental conditions.

Indications

Extrication of a patient from a building to an alternative care site, waiting ambulance or wheeled stretcher

Contraindication

Maximum load for the Med Sled® evacuation devices is 992 lbs. (450 kg.) This limit must not be exceeded

Complications

Pressure points, misalignment of the spine, pain and discomfort

PRODUCT WARNINGS
- Never leave patient unattended.
- Not intended for persons under 100 lbs. or 48" without proper inserts or youth sled.
- If sled is torn or damaged discontinue use.
- Sled may slide on uneven surfaces.

CAUTION
- This apparatus requires 2 qualified persons to operate.
- Risk of falling in the use of this product.
- Danger of serious physical injury if said product is not used or maintained properly.
- Safety straps produce danger of strangulation.

Instructions for taking EQUIPMENT with the patient

a. If the patient is on oxygen (O2), put the O2 tank between the patient's legs, valve up towards groin. We can put a pillow under the tank to protect the patient.
b. Secure under the cross straps.
c. IV bags are placed between the arm and torso, close to the pit of the arm.
d. Monitors and pumps will be secured under cross strap, between the patient's legs and resting on pillow or blanket. If the pump or monitor has a handle, the cross strap can be placed through the handle.
e. Bariatric Sleds (MS48) work best for Critical, or Post OP that maybe connected to equipment. The MS48 is 12" wider than the standard sled.

FIG. 5

FIG. 6a

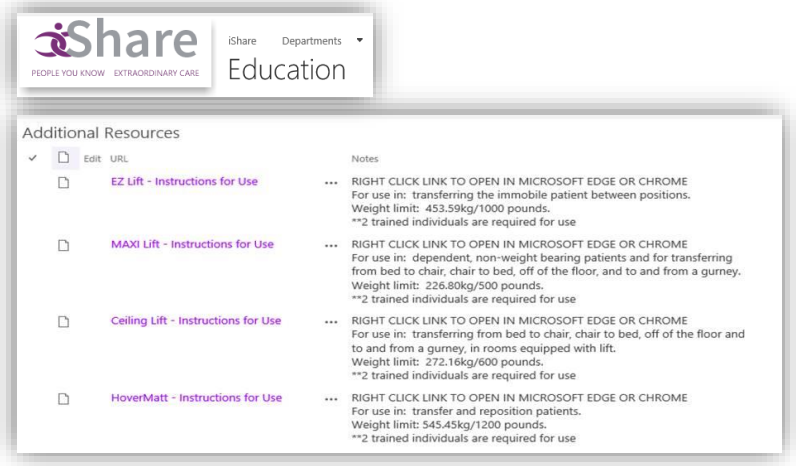
FIG. 6b
Closeup of hook attached to railing bracket

FIG. 6c

Manufactured in the U.S.A.
CE GSA

Additional Resources

Instructional Videos on the use of all the lift equipment are located on the iShare Education page under ‘Additional Resources’



Lift Equipment Instructions for Use Resource Guides are located in each department. These cards are also attached to individual lift equipment.

Determination of Proper Transfer Technique

- Bedrest: Call physician to upgrade activity orders before mobilizing
- Full weight bearing bilateral lower extremities and steady on feet:
  - Independent transfers
- Full weight bearing bilateral lower extremities and unsteady on feet:
  - Use Gait Belt
  - Assess the need for additional help and/or assistive device

Determination of Proper Transfer Technique continued….

- Full weight bearing bilateral lower extremities and unable to stand without moderate assistance x 2 or is unable to take any steps:
  - Stedy, Maxi Lift or Ceiling Lift
- Full weight bearing on 1 lower extremity only, able to stand and maintain weight bearing status:
  - Use Gait Belt
  - Use Walker or Crutches
  - If unable to take steps, but can stand, do a standing pivotal transfer or use the Stedy
  - Request PT/OT consult
  - Assess the need for additional assistance

Determination of Proper Transfer Technique continued….

- Full weight bearing on 1 lower extremity only, unable to maintain weight bearing status or unable to take steps:
  - Request PT/OT consult
  - Slide Board transfers
  - Maxi Lift, Ceiling Lift or EZ lift
- Non-weight bearing on bilateral lower extremities:
  - Request PT/OT consult
  - Slide Board transfers
  - Maxi Lift, Ceiling Lift or EZ Lift

Lateral Transfer To and From the Bed to the Stretcher

- Patient is independent and up ad lib, no assist needed.
- Pt is not independent or unable to stand:
  - Under 300#: Slide Sheet or Slide/Roller Board
  - 300-500#: Hover Matt, Maxi Lift or Ceiling Lift
  - 500-600#: Hover Matt, EZ Lift or Ceiling Lift
  - 600-1000#: Hover Matt or EZ Lift
  - 1000-1200#: Hover Matt

Repositioning in Chair or Wheelchair

- The patient can reposition independently:
  - Allow patient to reposition
- The patient needs assist:
  - Recline the chair if possible
  - Use two care providers
  - Patient weighs less than 300#:
    - Use a Slide Sheet and the draw sheet to lift the patient back into the chair
  - Patient weighs more than 300#:
    - Use the Maxi Lift to reposition using the sling

Repositioning in Bed

- The patient can reposition independently:
  - Allow patient to reposition
- The patient needs assist:
  - Under 300#: Slide Sheet or Slide/Roller Board
  - 300-500#: Hover Matt, Maxi Lift or Ceiling Lift
  - 500-600#: Hover Matt, EZ Lift or Ceiling Lift
  - 600-1000#: Hover Matt or EZ Lift
  - 1000-1200#: Hover Matt

Patient Safety

2024

Identification Bands/Clips for Patient Safety

- **White Band** - Patient Identification Band
- **Red Alert Clip** - Allergy Band
- **Yellow Alert Clip** - Fall Risk
- **Purple Alert Clip** - Do not Resuscitate (DNR)
- **Green Band** - Blood Unit Band
  - Do not remove – call Lab for removal
- **Pink Alert Clip** - Limb Alert
- Security Tags - Security tags are placed on ALL pediatric patients (0 to 17 years of age) and newborns

MORRIS HOSPITAL & HEALTHCARE CENTERS

Pharmaceutical Waste Stream Management

Labeled or Identified as Hazardous / Incompatible Rx by Pharmacy

Items NOT to be Collected in the Containers	Controlled Substances	Non-Hazardous Rx Waste No Messaging	Hazardous Rx Waste "SPECIAL Disposal Required - Black Container"	P-Listed Rx Waste "Special disposal required- "Coumadin/Nicotine Wrappers" bins"	Incompatible Rx Waste "Special Disposal Required - Return to Pharmacy"
Plain Maintenance Solutions such as: • Potassium chloride • Saline • Sodium phosphate • Calcium • Sodium bicarbonate • Lactated Ringers • Magnesium Sulfate	**Controlled Substances Such as:** • Morphine • Fentanyl • Norco **Tablet, Liquid and Patch** 	**Leftover medication such as:** • Most Antibiotics • Lidocaine • Heparin 	**Leftover medication such as:** • Insulin • Some Multivitamins • Neo-synephrine •Bulk Chemo 	**Leftover medication AND its packaging such as:** •Coumadin plus the empty blister pack •Nicotine 	**Leftover medication such as:** **Aerosols** •Inhalers with canister **Oxidizers** (Examples) •Unused Silver Nitrate ***Place in a clear zip lock bag***
Follow Current Hospital Policy for Proper Disposal of these Items	**Dispose in CsRx Container**	**Dispose in Blue Container**	**Dispose in Black Container**	**Place packaging in Special Coumadin/Nicotine only containers**	**Bag and Return to Pharmacy**

Stericycle
Protecting People. Reducing Risk.

SHARPS	Red Bag Waste	REGULAR TRASH	Chemo
• Empty needles and broken Ampoules • Empty syringes • Broken Glass	•Semi-liquid blood or other potentially infectious materials •Contaminated items that would release blood or other potentially infectious materials	•Empty vials	•Gloves, Gowns, Syringes , empty Bags and other trace material that contacted Chemo Drug

Patients Under Legal Custody Policy

- Patient population under legal or correctional restrictions imposes special circumstances in the provision of care and treatment:
  - Prisoner patients shall follow established visiting rules of the law enforcement agency and hospital room assignment procedures
  - Prisoners may be wearing controlling devices such as hand cuffs and/or leg shackles
    - These are the responsibility of the law enforcement officers and are exempt from the Restraint Policy

Missed Alarms Can Have Fatal Consequences

- Failure to recognize and respond to an actionable clinical alarm condition in a timely manner can result in serious patient injury or death
- Patients are put at risk when:
  - An alarm condition is not detected by a medical device
    - Physiologic monitor
    - Ventilator
    - Infusion pump
  - A condition is detected, but not successfully communicated to a staff member who can respond
  - A condition is communicated to clinical staff, but not appropriately addressed
    - whether because staff fail to notice the alarm, choose to ignore an alarm that warrants a response, or otherwise respond incorrectly

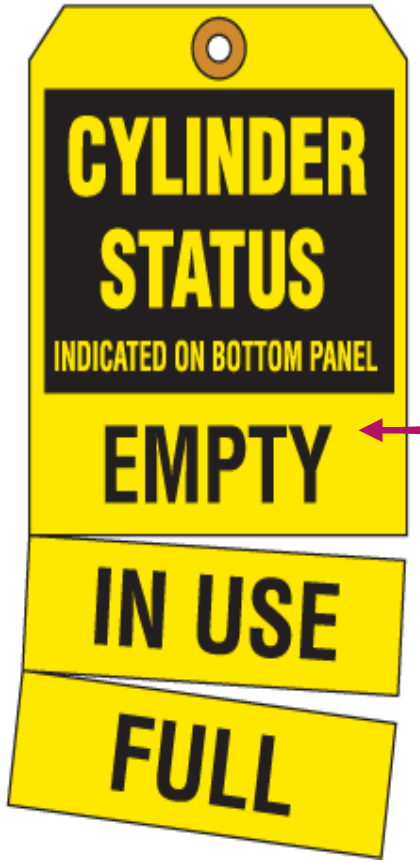
Reducing Alarm Fatigue

- Familiarize yourself with your equipment. Know how to set alarm parameters and know the parameters that equipment defaults to when turned on for a new patient.
- Regular assessment of your patient and customizing the alarm parameters with that patient so when an alarm does sound it is more likely to be meaningful.
- Attend to your alarms. Don't just silence an alarm, glance at your patient and walk away. Take a few seconds to trouble shoot. Does the pulse oximeter need re-fixing? Has an EKG electrode fallen off? Or is there a subtle warning here of some impending catastrophe? Proactively seek to null out any future nuisance alarms.
- Try to maintain some situational awareness throughout the shift for any critical alarms or changes in the texture or tempo of constant background noise that engulfs you during the shift.

(ECRI Institute, 2020)

Oxygen Cylinder / Tank Safety Guidelines:

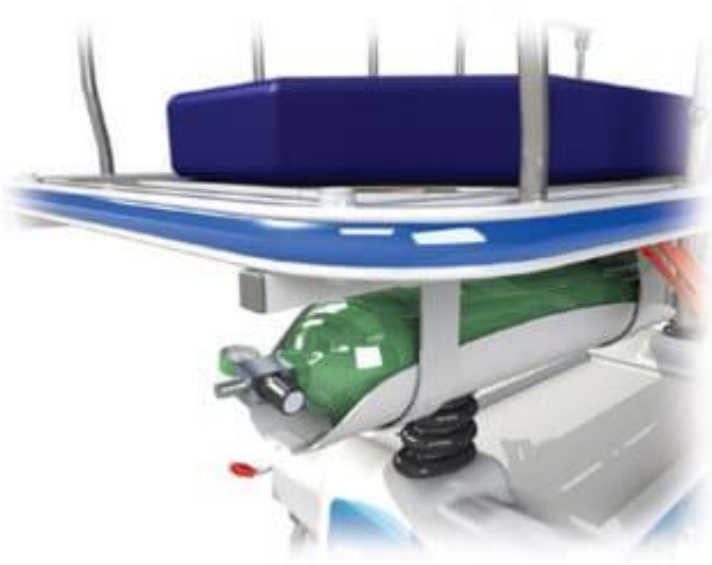
- When the cylinder/tank is empty, place in 'empty' holders in respective department (2 South, 2 East, Pulmonary, ED, & Radiology have their own 'empty' holders)
- Empty and Full cylinder tanks should **NOT** be stored in the same area
- Ensure oxygen tanks are turned off when not in use and secure at all times
- Mishandled cylinders/tanks may rupture violently, release their hazardous contents or become dangerous projectiles
- If a neck of a pressurized cylinder/tank should be accidently broken off, the energy released would be sufficient to propel the cylinder/tank



- Morris Hospital places tags on any compresses gas tanks
  - i.e. oxygen, helium, CO, nitrous, etc.
- This is an ACHC requirement
- These tags will have the cylinder status on them
  - **EMPTY**, **IN USE**, **FULL**
- When a new tank is received or taken from the tank room downstairs and placed in use, please tear off the **FULL** portion so that the **IN USE** is the bottom tag
- When empty, please tear off the **IN USE** portion to show **EMPTY** before taking it to the empty tank area downstairs

Guidelines For Oxygen Transport

- When transporting the patient, the oxygen cylinder must be properly secured in a moveable cart or in an attached cylinder holder under the bed or stretcher
- Do **NOT** lay oxygen cylinder/tank on top of the bed/stretcher as you are transporting a patient
- When arriving at the patient's destination, if wall oxygen is available transfer the patient's device to the wall and turn off the cylinder/tank flow
- If you have any questions, problems, or concerns with transporting a portable cylinder/tank, please call the Pulmonary Services Department at ext. 7655



Emergencies

2024

Medical Alert: Rapid Response Team

- The Rapid Response Team is a team of experienced clinicians who bring their expertise to a patient's bedside by rapidly responding to a call for adult emergencies
- For the adult Rapid Response Team, the team is comprised of an Intensive Care Unit (ICU) RN, Respiratory Therapist, Manager/House Supervisor, Hospitalist, if available, and an ED RN
- Applies to all adult patients, visitors, and employees of Morris Hospital
- The Rapid Response Team will be available 24 hours a day, 7 days a week as a resource for assistance in situations where an adult is experiencing early signs of distress
- To activate the Rapid Response Team dial 3515 and page: "Medical Alert + Rapid Response Team + Location"

Rapid Response Team Adult

Adult Emergencies include: (this is not an all inclusive list)

- New onset of chest pain
- New neurological findings (changes added to policy)
  - Mental status changes, confusion
  - Numbness or weakness of arm, leg or face
  - Trouble speaking, hearing or understanding
  - Loss of vision
  - Trouble walking or loss of balance
- Symptomatic bradycardia (low heart rate)
- Symptomatic hypotension (low blood pressure)
- Seizures
- Significant bleeding
- Acute change in oxygen saturation
- Acute respiratory distress (trouble breathing)
- Failure to respond to treatment
- MEWS Score 5 or greater

Rapid Response Team Broselow (Pediatric)

- The Rapid Response Team Broselow is a team of experienced clinicians who bring their expertise to a patient by rapidly responding to a call for pediatric emergencies.
- A pediatric patient is anyone under 17 years of age, excluding newborns in the Family Birthing Suites.
- Pediatric Emergencies include:
  - Acute changes in heart rate, blood pressure or respiratory rate
  - Hypoxia (difficulty breathing)
  - Mental status changes or seizures
  - Staff and/or family concerns

Adult Code Blue & Pediatric Code Blue

- Assess responsiveness
- Call for help/pull code blue alarm
- **Start CPR**

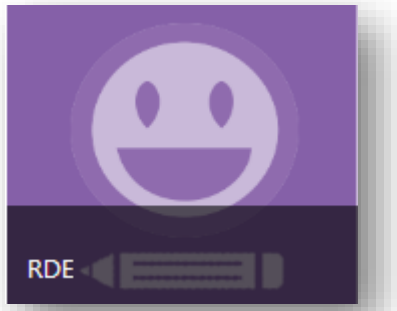
Initiating Code Blue

- Dial 3515. After beep announce “Medical Alert Adult Code Blue” or “Medical Alert Pediatric Code Blue” followed by Location.

Patient Care Improvement Report

Completed electronically through RDE on iShare

- Goal
  - Decrease Risk to patient
  - Improve patient care
  - Improve patient safety
- Responsibilities
  - Employee reports incident
  - Quality Manager coordinates follow-up and prepares report
  - Report is communicated to Quality Committee



- Procedure
  - Incident involving patient
  - Incident involving missing articles or damaged property
  - Incidents involving equipment
- Key Points
  - Complete form thoroughly by recording facts as observed
  - Notify security department (may need to obtain photo documentation
  - Do not document in patient medical record that Patient Care Improvement Report was completed
  - Do NOT inform patient or family that Patient Care Improvement Report was completed

Abuse

2024

Abuse

What is abuse?

- Abuse is anything that causes harm to an individual
- Abuse can be physical, sexual, psychological/emotional, or economic/financial

Morris Hospital Policy

- Healthcare workers are mandated reporters of abuse
- Any staff person who witnesses abuse shall immediately notify security, Charge RN/Manager, and House Supervisor
- Any staff person who suspects abuse of a patient shall notify appropriate service agencies, Social Services, Manager, and/or House Supervisor
- Reporters of abuse are provided, by law, with immunity from criminal and civil liability and professional disciplinary action
- A reporters name may be released only with the reporter's written permission or by Court Order
- Reporter needs to notify VP of Patient Care Services or designee, and/or House Supervisor of any reports to outside agencies

Mandated Reporters at Morris Hospital

- A professional while engaged in social services, law enforcement, and/or education
- A person who performs the duties of coroner or medical examiner, or a person who performs the duties of a paramedic or emergency medical technician

- Any of the occupations required to be licensed under the Medical Practice Act of 1987:
  - Social worker
  - Dentist
  - Dietitian
  - Nurse/Advanced Practice Nurse
  - Occupational Therapist/Physical Therapist/Speech Therapist
  - Optometrist
  - Pharmacist
  - Physician/Physician Assistant
  - Respiratory Care Therapist
  - Audiologist

Elder Abuse & Neglect

- In the U.S. alone, more than half a million reports of abuse against elderly Americans reach authorities every year, and millions more cases go unreported
- Types of Elder Abuse:
  - Emotional Abuse
  - Sexual Abuse
  - Neglect or Abandonment
  - Financial Exploitation
  - Healthcare Fraud and Abuse

- General:
  - Frequent arguments or tension between the caregiver and the elderly person
  - Changes in personality or behavior in the elder
- Physical Abuse:
  - Unexplained signs of injury such as bruises, welts, or scars, especially if they appear symmetrically on two sides of the body
  - Broken bones, sprains, or dislocations
  - Report of drug overdose or apparent failure to take medication regularly (a prescription has more remaining than it should)
  - Broken eyeglasses or frames
  - Signs of being restrained, such as rope marks on wrists
  - Caregiver's refusal to allow you to see the elder alone

Signs & Symptoms of Abuse

Emotional Abuse

- Threatening, belittling, or controlling caregiver behavior that you witness
- Behavior from the elder that mimics dementia, such as rocking, sucking, or mumbling to oneself

Sexual Abuse

- Bruises around breasts or genitals
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained or bloody underclothing

Signs & Symptoms of Abuse

Neglect by Caregivers or Self-Neglect

- Unusual weight loss, malnutrition, or dehydration
- Untreated physical problems, such as bed sores
- Unsanitary living conditions: dirt, bugs, soiled bedding, and clothes
- Being left dirty or unbathed
- Unsuitable clothing or covering for the weather
- Unsafe living conditions (no heat or running water; faulty electrical wiring, other fire hazards)
- Desertion of the elder at a public place

Financial Exploitation

- Significant withdrawals from the elder's accounts
- Sudden changes in the elder's financial condition
- Items or cash missing from the senior's household
- Suspicious changes in wills, power of attorney, title and policies
- Addition of names to the senior's signature card
- Unpaid bills or lack of medical care, although the elder has enough money to pay for them
- Financial activity the senior couldn't have done, such as an ATM withdrawal when the account holder is bedridden
- Unnecessary services, goods or subscriptions

Healthcare Fraud & Abuse

- Duplicate billings for the same medical service or device
- Evidence of over-medication or under-medication
- Evidence of inadequate care when bills are pain in full
- Problems with the care facility such as any of the following:
  - Poorly trained
  - Poorly paid
  - Insufficient staff
  - Crowding
  - Inadequate responses to questions about care

Suicidal-Homicidal Precautions & Sitters for Patient Safety

2024

PURPOSE

- To provide guidelines for assessment of patients who may be at risk for suicide/homicide
- To establish a safe environment for a patient who has attempted to take his/her own life, threatened harm to others, is at risk of self-injury, or expressed suicidal ideation.

Signs & Symptoms of the Suicidal Patient:

- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty, hopeless, or having no reason to live
- Making a plan or looking for a way to kill themselves, such as searching online, stockpiling pills, or buying a gun
- Talking about great guilt or shame
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable pain (emotional pain or physical pain)
- Talking about being a burden to others
- Using alcohol or drugs more often

Signs & Symptoms of the Suicidal Patient Continued:

- Acting anxious or agitated
- Withdrawing from family and friends
- Changing eating or sleeping habits
- Showing rage or talking about seeking revenge
- Taking great risks that could lead to death, such as driving extremely fast
- Talking or thinking about death often
- Displaying extreme mood swings, suddenly changing from very sad to very happy or calm
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, making a will

The Main Risk Factors for Suicide Are:

- Depression, other mental disorders, or substance abuse disorders
- Certain medical conditions
- Chronic pain
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Having recently been released from prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers, or celebrities

SUICIDAL THOUGHTS OR ACTIONS ARE A SIGN OF EXTREME DISTRESS, NOT A HARMLESS BID FOR ATTENTION, AND SHOULD NOT BE IGNORED!

Important Community Resource Hotline Numbers

- National Suicide Prevention Lifeline
  - (1-800) 273-TALK (8255)
- Samaritans, Inc.
  - (1-877) 870-HOPE (4673)
  - For those who are alone, depressed or in crisis
- Samariteen
  - (1-800) 252-TEEN (8336)
  - For teens in despair

Suicide Precautions

The patient/patient representative will be informed and educated that the patient is under suicide/homicide precautions:

- Precautions should be taken to keep the patient safe at all times. The patient will be dressed in paper scrubs.
- All patient belongings will be removed from the room (cell phones, matches, bags, medications, lighters, cigarettes, all clothing, and shoes). Security will inventory, document, and secure patient belongings.
- The patient has the right to communicate with other people in private, without obstruction, or censorship by the staff. This right includes mail, telephone calls, and visits. There are limits to these rights. Communication by these means may be reasonably restricted (such as, the sitter remaining in sight of the patient at all times) to protect the patient or others from harm, harassment, or intimidation.
- Remove all sharp objects from the room.
- Remove all potential hazards from room (tubing, cords, drawstrings, glass, plastic bags, gloves, breakable objects, hangers).
- Remove all non-essential, non-medical electrical appliances.
- Verify that medications are NOT left in the patients room. If there is a restroom in the room, the door must remain open at all times and/or patient observation maintained if the door is closed.
- Family and visitors are not to bring in personal belongings, including but not limited to cell phones, jewelry, keys, purses, bags, backpacks, or coats/jackets into the patient room.

Code Safety Alert

- There is a Code Safety Alert initiated when suicidal/homicidal behavior is exhibited by a patient.
- Suicide/homicide precautions will be initiated by nursing staff and a 1:1 sitter will be put in place at this time.

Sitter Policy

Purpose: To provide sitters for patients who require close, visual monitoring for safety reasons and those at risk of harming self or others.

- The sitter will report promptly to the assigned area to receive handoff and relieve the off going individual. Tardiness to the area after anticipated arrival time may be grounds for disciplinary action.
- The on-coming sitter will be given a report on patient status from the off-going sitter utilizing Sitter Handoff Form (MH #1620).
- The sitter is required to know the patient's physical limitations and needs (e.g. ambulation, number of assists, lifting equipment, the ability to complete activities of daily living, dietary restrictions, etc.).

Sitter Policy continued…

- The sitter will maintain appropriate infection control procedures.
- The sitter will be relieved for breaks.
- Break times are determined according to the Time and Attendance policy.
- The RN, Charge RN, or House Supervisor may initiate a sitter for a patient at any time.
- Sitters for Fall Risk patients do **not** require a physician order.
- Sitters for Safety, which includes patients at risk for harming self/others (suicidal/homicidal), may be initiated without physician order, but **do require** an order to be obtained upon contacting the patient's physician and also require a **physician's order** to discontinue.

Sitter Policy continued…

- If initiating a sitter for fall risk, the Sitter Decision Algorithm (MH #1378) will be utilized to determine sitter need.
- Sitters for Safety may be a clinical staff member or another staff member with complete sitter training.
- Sitters complete a one hour sitter competency prior to sitting with a patient.
- Sitters complete annual education.
- Patients in restraints must have a clinical staff member as a sitter who has been trained and educated in first aid, CPR and de-escalation training.

Patients at Risk for Harming Self/Others Procedure

- When sitting with patients at risk for harming self, the sitter needs to comply with the following:
  - Room must be made safe by removing hangers, cords, sharp objects, pens, pencils, glass, plastic bags, gloves, belts, shoe laces, drawstrings, panty hoses, breakable objects, telephone, trash bags, non-essential non-medical electrical appliances, over bed table with mirror, and any other items which are potential for harm.
  - All patient belongings must be removed from the patient's room (matches, lighters, cigarettes, personal clothes including undergarments, shoes, cell phones, keys, medications, bags, wallet, purse, etc.) and secured by security.

Patients at Risk for Harming Self/Others Procedure continued…

- When sitting with patients at risk for harming self, the sitter needs to comply with the following continued:
  - Patient must be in hospital paper scrubs.
  - Never leave the patient alone. Patient must remain in their room unless there is a physician ordered activity or going for a test.
  - The door to the patient's bathroom must remain open when in use, especially in the Emergency Department.

Patients at Risk for Harming Self/Others Procedure continued…

- When sitting with patients at risk for harming self, the sitter needs to comply with the following continued:
  - Remain in visual contact of the patient and attention is focused on patient's activity. Sitter is not to read books/magazines or use other personal devices such as cell phones/iPads or other electronic devices, unless used for patient care purposes.
  - Position yourself between the patient and the hallway door for your safety. Maintain at least four feet of "reactionary distance" from the patient in order to be able to defend yourself should they become violent. Do not make physical contact with the patient unless assisting nursing staff with patient care activities, if within scope of practice.
  - Travel with patient for all tests and maintain visual contact.

Patients at Risk for Harming Self/Others Procedure continued…

- When sitting with patients at risk for harming self, the sitter needs to comply with the following continued:
  - Remain in the room with the patient during visiting and observe the patient's interactions with visitors. Families and visitors cannot be responsible for watching the patient, nor can they bring in personal purses, bags, backpacks, coats/jackets, or any outside food/drinks into the patient room.
  - No medications will be stored in patient room.

Patients at Risk for Harming Self/Others Procedure continued…

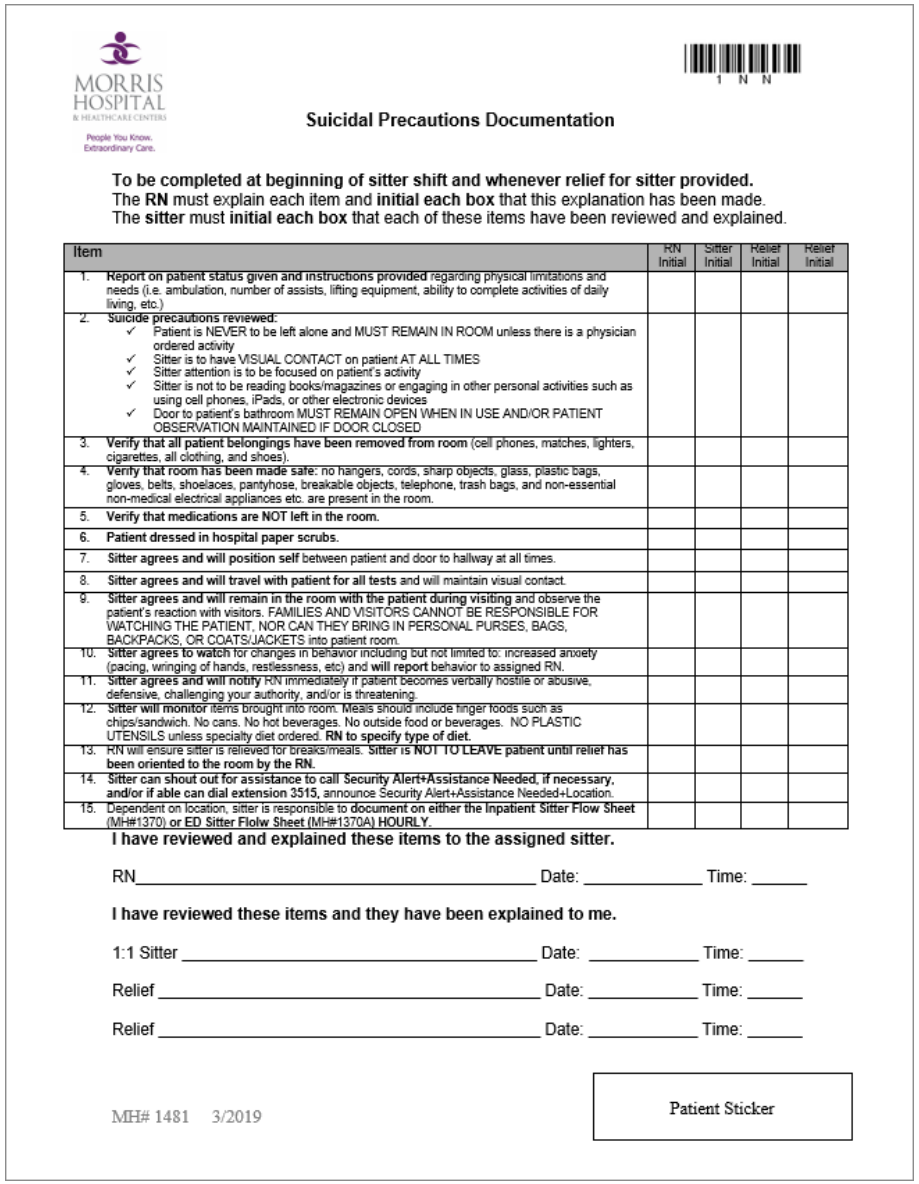
- When sitting with patients at risk for harming self, the sitter needs to comply with the following continued:
  - Watch for changes in behavior including, but not limited to: patient becoming increasingly anxious (i.e., pacing, wringing of hands, restlessness, etc.) and report any changes in behavior to the assigned RN. Notify the RN immediately if the patient becomes verbally hostile or abusive, defensive, challenging your authority or is threatening.
  - In an impending violent situation, dial extension 3515 and announce "Security Alert + Assistance Needed + Location". Shout for assistance if unable to dial.
  - **DO NOT** put your personal safety at risk to prevent an elopement

Patients at Risk for Harming Self/Others Procedure continued…

- When sitting with patients at risk for harming self, the sitter needs to comply with the following continued:
  - Sitters need to be relieved before going on breaks or meals. Relief sitters must remain in the room with the patient. The unit Charge RN is responsible for arranging and ensuring sitter breaks are covered.
  - RN to contact nutritional services for a "safe tray". Safe tray meals should include finger foods, no cans, no hot beverages, and no utensils unless patient has special diet that requires utensils. If patient is using utensils for special diet, the sitter is to be observant and at patient's side while eating.

Patients at Risk for Harming Self/Others Procedure continued…

The Suicidal Precautions Documentation Sheet (MH #1481) is to be completed at beginning of sitter shift and whenever relief for sitter is provided. The RN and Sitter will initial each box as explanation of content has been completed. Keep as part of permanent record.



MORRIS HOSPITAL & HEALTHCARE CENTERS
People You Know. Extraordinary Care.

I N N

Suicidal Precautions Documentation

To be completed at beginning of sitter shift and whenever relief for sitter provided.
The **RN** must explain each item and **initial each box** that this explanation has been made.
The **sitter** must **initial each box** that each of these items have been reviewed and explained.

Item	RN Initial	Sitter Initial	Relief Initial	Relief Initial
1. **Report on patient status given and instructions provided** regarding physical limitations and needs (i.e. ambulation, number of assists, lifting equipment, ability to complete activities of daily living, etc.)				
2. **Suicide precautions reviewed:** ✓ Patient is NEVER to be left alone and MUST REMAIN IN ROOM unless there is a physician ordered activity ✓ Sitter is to have VISUAL CONTACT on patient AT ALL TIMES ✓ Sitter attention is to be focused on patient's activity ✓ Sitter is not to be reading books/magazines or engaging in other personal activities such as using cell phones, iPads, or other electronic devices ✓ Door to patient's bathroom MUST REMAIN OPEN WHEN IN USE AND/OR PATIENT OBSERVATION MAINTAINED IF DOOR CLOSED				
3. **Verify that all patient belongings have been removed from room** (cell phones, matches, lighters, cigarettes, all clothing, and shoes).				
4. **Verify that room has been made safe:** no hangers, cords, sharp objects, glass, plastic bags, gloves, belts, shoelaces, pantyhose, breakable objects, telephone, trash bags, and non-essential non-medical electrical appliances etc. are present in the room.				
5. **Verify that medications are NOT left in the room.**				
6. **Patient dressed in hospital paper scrubs.**				
7. **Sitter agrees and will position self** between patient and door to hallway at all times.				
8. **Sitter agrees and will travel with patient for all tests** and will maintain visual contact.				
9. **Sitter agrees and will remain in the room with the patient during visiting** and observe the patient's reaction with visitors. FAMILIES AND VISITORS CANNOT BE RESPONSIBLE FOR WATCHING THE PATIENT, NOR CAN THEY BRING IN PERSONAL PURSES, BAGS, BACKPACKS, OR COATS/JACKETS into patient room.				
10. **Sitter agrees to watch** for changes in behavior including but not limited to: increased anxiety (pacing, wringing of hands, restlessness, etc) and **will report** behavior to assigned RN.				
11. **Sitter agrees and will notify** RN immediately if patient becomes verbally hostile or abusive, defensive, challenging your authority, and/or is threatening.				
12. **Sitter will monitor** items brought into room. Meals should include finger foods such as chips/sandwich. No cans. No hot beverages. No outside food or beverages. NO PLASTIC UTENSILS unless specialty diet ordered. **RN to specify type of diet.**				
13. RN will ensure sitter is relieved for breaks/meals. **Sitter is NOT TO LEAVE patient until relief has been oriented to the room by the RN.**				
14. **Sitter can shout out for assistance to call Security Alert+Assistance Needed, if necessary, and/or if able can dial extension 3515,** announce Security Alert+Assistance Needed+Location.				
15. Dependent on location, sitter is responsible to **document on either the Inpatient Sitter Flow Sheet** (MH#1370) **or ED Sitter Flow Sheet** (MH#1370A) **HOURLY.**				

I have reviewed and explained these items to the assigned sitter.

RN_____ Date: _____ Time: _____

I have reviewed these items and they have been explained to me.

1:1 Sitter _____ Date: _____ Time: _____

Relief _____ Date: _____ Time: _____

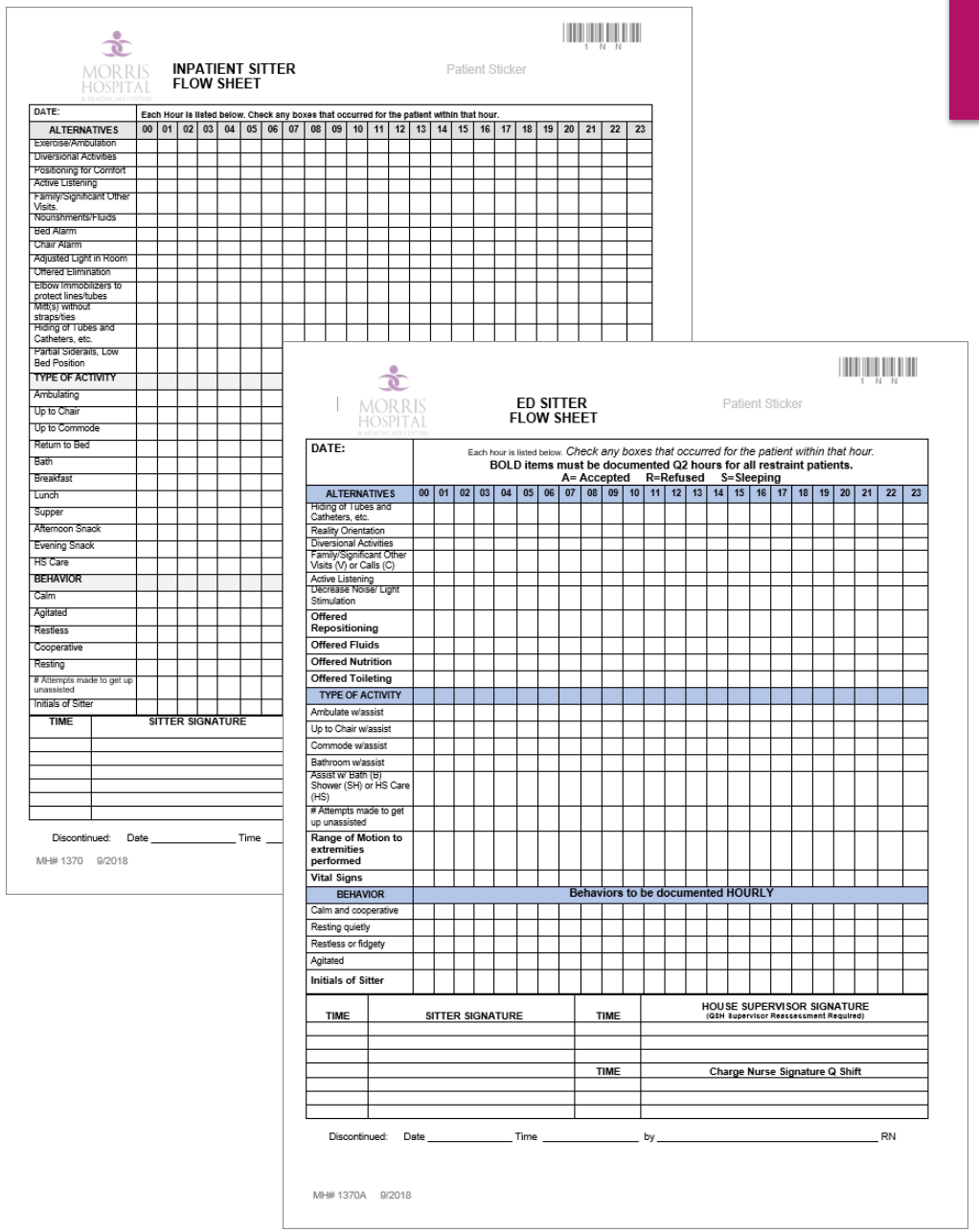
Relief _____ Date: _____ Time: _____

MH# 1481 3/2019

Patient Sticker

Patients at Risk for Harming Self/Others Procedure continued…

The sitter documents on the appropriate Sitter Flow Sheet (MH #1370 or MH#1370A) hourly and the House Supervisor signs every eight hours.



MORRIS HOSPITAL

INPATIENT SITTER FLOW SHEET

Patient Sticker

DATE:	Each Hour is listed below. Check any boxes that occurred for the patient within that hour.																							
ALTERNATIVES	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Exercise/Ambulation																								
Diversional Activities																								
Positioning for Comfort																								
Active Listening																								
Family/Significant Other Visits																								
Nourishments/Fluids																								
Bed Alarm																								
Chair Alarm																								
Adjusted Light in Room																								
Offered Elimination																								
Elbow Immobilizers to protect lines/tubes																								
Mitt(s) without straps/ties																								
Hiding of Tubes and Catheters, etc.																								
Partial Siderails, Low Bed Position																								
TYPE OF ACTIVITY																								
Ambulating																								
Up to Chair																								
Up to Commode																								
Return to Bed																								
Bath																								
Breakfast																								
Lunch																								
Supper																								
Afternoon Snack																								
Evening Snack																								
HS Care																								
BEHAVIOR																								
Calm																								
Agitated																								
Restless																								
Cooperative																								
Resting																								
# Attempts made to get up unassisted																								
Initials of Sitter																								

TIME	SITTER SIGNATURE

Discontinued: Date _____ Time ___

MH# 1370 9/2018

MORRIS HOSPITAL

ED SITTER FLOW SHEET

Patient Sticker

DATE:	Each hour is listed below. *Check any boxes that occurred for the patient within that hour.* **BOLD items must be documented Q2 hours for all restraint patients.** A= Accepted R=Refused S=Sleeping																							
ALTERNATIVES	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Hiding of Tubes and Catheters, etc.																								
Reality Orientation																								
Diversional Activities																								
Family/Significant Other Visits (V) or Calls (C)																								
Active Listening																								
Decrease Noise/ Light Stimulation																								
Offered Repositioning																								
Offered Fluids																								
Offered Nutrition																								
Offered Toileting																								
TYPE OF ACTIVITY																								
Ambulate w/assist																								
Up to Chair w/assist																								
Commode w/assist																								
Bathroom w/assist																								
Assist w/ Bath (B) Shower (SH) or HS Care (HS)																								
# Attempts made to get up unassisted																								
Range of Motion to extremities performed																								
Vital Signs																								
BEHAVIOR	Behaviors to be documented HOURLY																							
Calm and cooperative																								
Resting quietly																								
Restless or fidgety																								
Agitated																								
Initials of Sitter																								

TIME	SITTER SIGNATURE	TIME	HOUSE SUPERVISOR SIGNATURE (Q8H Supervisor Reassessment Required)
		TIME	Charge Nurse Signature Q Shift

Discontinued: Date _____ Time _____ by _____ RN

MH# 1370A 9/2018

Recognition of Behavior Escalation

Anxiety

- Noticeable change in behavior
- An involuntary reaction or response to something that happens
  - Patients exhibiting anxiety need support such as:
    - Listening
    - Comfort
    - Supportive Communication

Emotional Confrontation

- Testing phase of communication with signs such as:
  - Yelling
  - Belligerent
  - Cursing
  - Finger Pointing

Physical Aggression

- Physical violence or losing control physically
- Patients exhibiting emotional or physical aggression need an assertive response by:
  - Maintaining Eye Contact
  - Calm Voice
  - Reinforce or Setting Limits with Reasonable Consequences

Protecting Yourself

- Recognize signs of anxiety, emotional confrontation, and physical aggression
- If you feel threatened, call for help immediately
- Always maintain distance of 4 feet or more between yourself and the patient if at all possible
- Always stay between doorway and patient for escape route
- Keep mentally prepared and aware of potential aggressive situations

Patients at Risk for Falls Procedure

- When sitting with patients at risk for falls, the sitter needs to comply with the following:
  - Never leave the patient alone.
  - Maintain visual contact with patient.
  - If necessary, travel with patient for tests so that visual contact is maintained.
  - Focus on the patient at all times, no reading books/magazines or other personal activities allowed such as using cell phones/iPads or other electronic devices, unless used for patient care purposes.

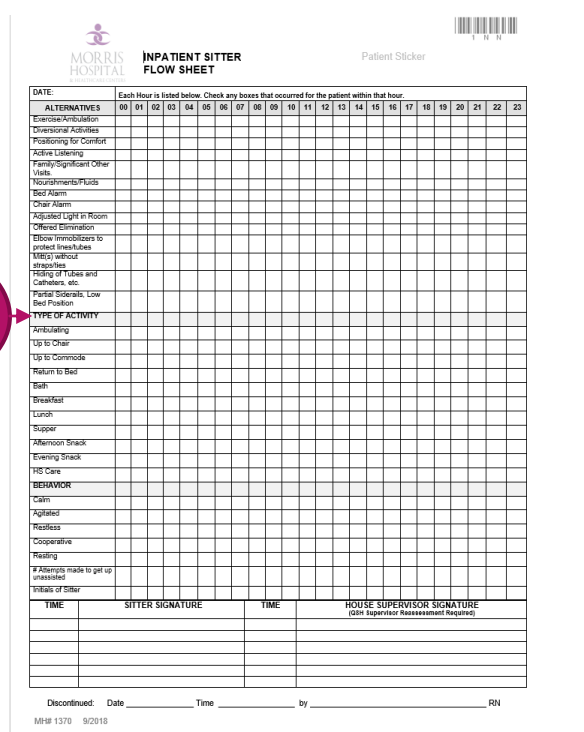
Patients at Risk for Falls Procedure continued…

- When sitting with patients at risk for falls, the sitter needs to comply with the following continued:
  - Watch for changes in behavior including but not limited to: confusion, agitation, and/or inability to follow instructions, and report any changes in behavior to the assigned RN.
  - Sitters need to be relieved before going on breaks or meals. Relief sitters must remain in the room with the patient. The Unit Charge RN is responsible for arranging and ensuring sitter breaks are covered.
  - Encourage family to sit with the patient, if present.
  - Assist/complete Activities of Daily Living (ADL), if within scope of practice.

Patients at Risk for Falls Procedure continued…

Document alternatives, type of activity, and behavior on appropriate Sitter Flow Sheet (MH #1370 or MH#1370A) hourly and House Supervisor signs every eight hours.

Inpatient
MH#1370



MORRIS HOSPITAL

INPATIENT SITTER FLOW SHEET

Patient Sticker

DATE:	Each Hour is listed below. Check any boxes that occurred for the patient within that hour.																							
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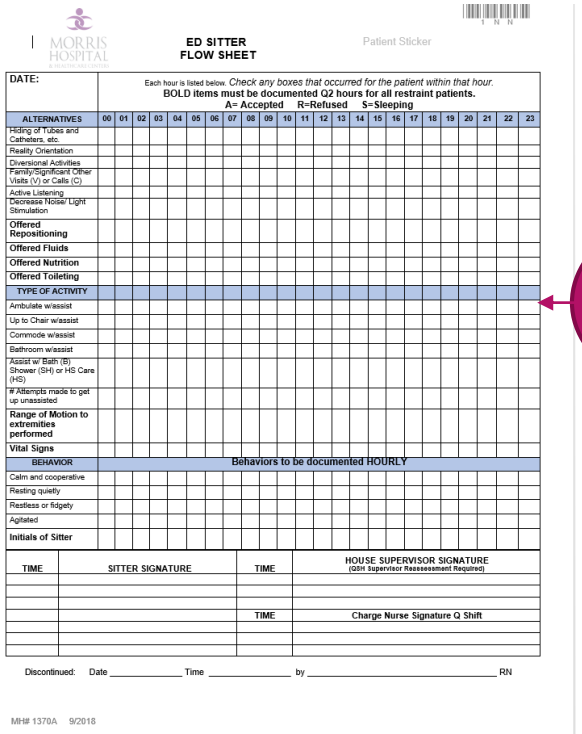
Resting																								
# Attempts made to get up unassisted																								
Initials of Sitter																								

TIME	SITTER SIGNATURE	TIME	HOUSE SUPERVISOR SIGNATURE (Q8H Supervisor Reassessment Required)

Discontinued: Date _____ Time _____ by _____ RN

MH# 1370 9/2018

Emergency Department
MH #1370A



MORRIS HOSPITAL

ED SITTER FLOW SHEET

Patient Sticker

DATE:	Each hour is listed below. *Check any boxes that occurred for the patient within that hour.* **BOLD items must be documented Q2 hours for all restraint patients.** A= Accepted R=Refused S=Sleeping																							
ALTERNATIVES	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
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Initials of Sitter																								

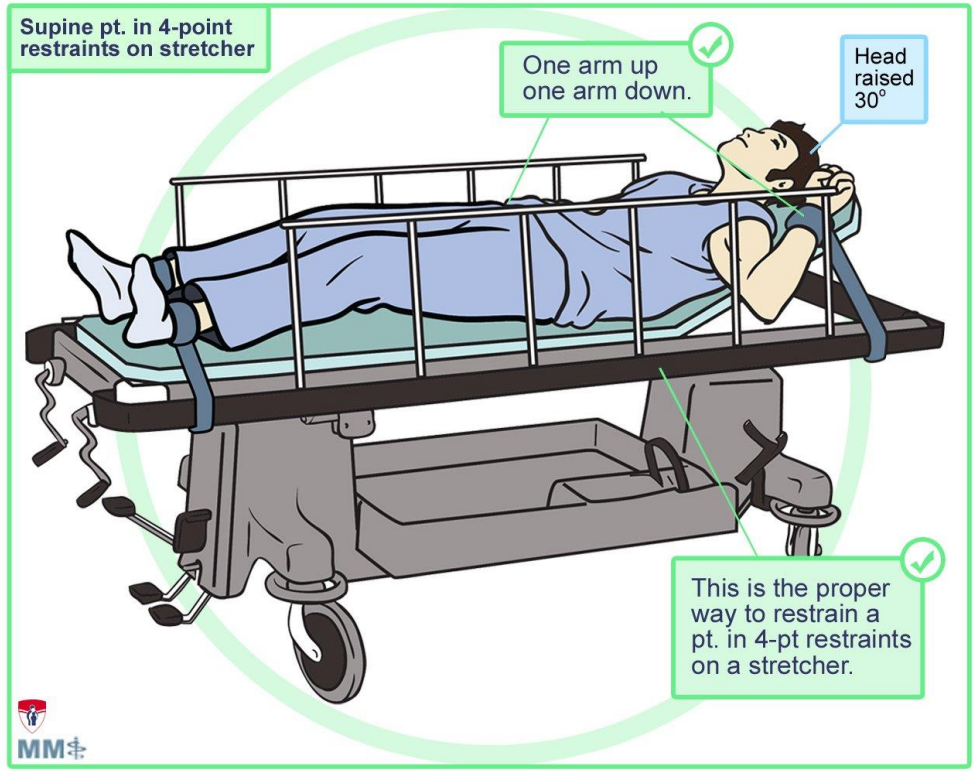
TIME	SITTER SIGNATURE	TIME	HOUSE SUPERVISOR SIGNATURE (Q8H Supervisor Reassessment Required)
		TIME	Charge Nurse Signature Q Shift

Discontinued: Date _____ Time _____ by _____ RN

MH# 1370A 9/2018

Restraint Management

2024



Purpose

- To establish guidelines for the safe and appropriate use of medical/non-violent and violent/self-destructive behavior restraints
- When restraints are necessary, care will be provided that preserves the rights of the patient
- A commitment to prevent, reduce or eliminate the use of restraint is our organizational philosophy

Definitions (per CMS)

- **Restraint** – Any manual method, physical or mechanical device, material or medication/chemical, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.
- **Medical-Nonviolent Restraint** – The use of restraints in medical and post surgical-medical/nonviolent care when it may be necessary to limit mobility or temporarily immobilize a patient. The primary reason for use directly supports the medical healing of the patient. These include soft limb and mitts that are secured to the bed.
- **Violent/Self-destructive Restraint** – Restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others. These include soft limb, Posey Quick Release Limb Holder, Posey Soft Chest Quick Release, or medication.
- **Medications/Drugs used as restraints** – a drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- **Seclusion** - the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. This is not used at Morris Hospital.
- **Non-restraint** - a restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm. If a patient can easily remove a device, that device would not be considered a restraint.

Instructions for Use for Both Medical/Non-Violent and Violent/Self-Destructive Restraint

- Restraints may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time.
- Use of restraint for purposes of coercion, discipline, convenience, or retaliation is never acceptable.
- The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. Morris Hospital does not practice seclusion.
- Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff member or others from harm.

Instructions continued…

All measures as alternatives for restraints will be attempted first, including, but not limited to, the following:

- Redirecting patient's focus/verbal interventions
- Employing verbal de-escalation
- Treat pain
- Bed alarms/application
- Companionship/Family Involvement/Sitter Use
- Diversion/Decrease Stimulation/Noise Reduction
- Exercise/activities
- Move patient to a room closer to Central Station
- Repositioning
- Snacks/beverages
- Bowel/bladder assessment
- Physiologic assessment
- Medication review with Registered Pharmacist (RPh)
- Ongoing reality orientation
- Active listening/therapeutic communication
- Other measures as ordered by physician, considering the patient's condition

Instructions continued…

- The use of non-physical interventions is the preferred intervention.
- Mechanical restraint options at Morris Hospital include: soft limb restraint, Posey Quick Release Limb Holder, Posey Soft Chest Quick Release, and mitts secured to bed frame. Restraints shall be used in accordance with manufacturer's instructions. When Quick Release Limb restraints are used, no key is necessary. Restraint devices are not sent home with patient/family or transferred with the patient.
- Medications administered to manage a patient's behavior or restriction of the patient's freedom of movement that is not a standard treatment or dosage for the patient's condition can only be ordered as a one-time "stat" administration. Each additional dose or other medication for the same purpose shall require separate orders from the provider.

Instructions continued…

- Restraints are considered a temporary intervention to a situation and may be initiated by a Registered Nurse (RN) after observation and assessment of the patient. **If the RN initiates the restraint, a physician's order must be obtained within 15 minutes of imposing the restraint**. Provider notification must be immediate if restraint is being applied due to a significant change in the patient's condition. **The attending provider must be consulted as soon as possible if the attending provider did not order the restraint**.
- Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN). When a staff member ends an ordered restraint, the staff member does not have authority to reinstitute the intervention without a new order.
- A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint because the staff member is present and is serving the same purpose as the restraint. RNs, Patient Care Techs, and Certified Nurse Assistants (CNAs) may perform the temporary directly-supervised release during the provision of care.

Instructions continued…

When restraint is used, there must be documentation in the patient's medical record of the following:

- Description of the patient's behavior
- The intervention used
- Alternatives or other less restrictive interventions attempted (as applicable)
- The patient's condition or symptom(s) that warranted the use of the restraint
- The patient's response to the intervention(s) used including the rationale for continued use of the intervention.

Orders from the ordering provider who is privileged to order restraints, **must include** the following:

- The reason the restraint is used
- The type of restraint used
- The duration for restraint use

Instructions continued…

- When a restraint is implemented, the patient's plan of care must be modified to reflect this change. The plan of care shall be updated every calendar day and upon discontinuation of restraint.
- The patient's family/representative/significant other shall be notified promptly when restraints are initiated and this shall be documented in the medical record. The patient and his/her family/representative/significant other shall be informed of the Morris philosophy on the use of restraint to the extent that such information is not clinically contraindicated. The patient, and in accordance with Health Insurance Portability and Accountability Act (HIPAA) laws, the family/representative/significant other shall be involved in alternative behavioral management decisions that could help minimize the use of restraint and the decisions and activities that relate to the use of restraint. If the family/representative/significant other refuse the restraint, the physician will be notified and alternatives will be discussed and documented in the medical record.

Instructions continued…

- Restraints must be discontinued by an RN at the earliest possible time that appropriate criteria are met, regardless of the length of time identified in the order.
- Restraints will be discontinued by the RN once the behaviors or situation that served as the basis for the restraint are no longer present, and the safety of the patient and others may be assured through less restrictive means. Documentation includes patient behaviors exhibited and any alternatives to restraint that are in place as appropriate.

Additional Instructions for Medical/Non-violent Restraints

- The medical non-violent restraint will be **ordered each calendar day as applicable**.
- Assessment and monitoring for patients in medical/non–violent restraint shall include **documentation**, including, but not limited to, the following nursing interventions minimally **every two hours, unless ordered otherwise by a physician:**
  - Restraint release and skin assessment of extremity (RN)
  - Circulation assessment of restrained extremity (RN)
  - Range of motion for restraints (RN or CNA)
  - Vitals signs (RN or CNA)
  - Repositioning (RN or CNA)
  - Fluids and/or nutrition offered (RN or CNA)
  - Toileting offered (RN or CNA)
  - Assessment of behaviors (RN)
  - Reaction to restraint (RN)
  - Less restrictive interventions (RN or CNA)

Additional Instructions for Violent/Self-Destructive Restraints

For restraints used for management of violent/self-destructive behavior, a physician, trained House Supervisor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA) must perform and document in the medical record a **face-to-face evaluation within one hour** after the initiation of the intervention to assess the patient's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate the restraint.

If the face-to-face evaluation is conducted by a trained House Supervisor, the Attending Physician, or Advanced Practice Professional (APP) who is responsible for the care of the patient must be consulted as soon as possible after completion of the one hour face-to-face evaluation to provide a condition report.

Each order for restraint used for the management of violent/self-destructive behavior may only be renewed in accordance with the following limits for up to a total of 24 hours:

Adult age 18 + years: 4 hours

Adolescent age 9 – 17 years: 2 hours

Children under 9 years: 1 hour

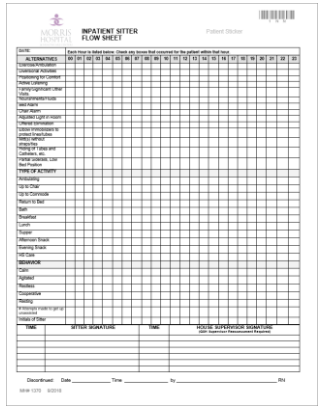
Additional Instructions for Violent/Self-Destructive Restraints

- After 24 hours, before entering a new physician order for the management of violent/self-destructive behavior, the ordering provider who is responsible for the care of the patient and authorized to order the restraint, must see and assess the patient in person.

- Assessment and monitoring for patients in violent/self-destructive restraint shall include **documentation**, including, but not limited to, the following nursing interventions **minimally every two hours, unless ordered otherwise by a physician**:
  - Restraint release and skin assessment of extremity (RN)
  - Range of motion for restraints (RN or CNA)
  - Vitals signs (RN or CNA)
  - Repositioning (RN or CNA)
  - Fluids and/or nutrition offered (RN or CNA)
  - Toileting offered (RN or CNA)

Additional Instructions for Violent/Self-Destructive Restraints

- Assessment and monitoring for patients in violent/self-destructive restraint shall include **documentation**, including but not limited to, the following nursing interventions minimally **every 30 minutes, unless ordered otherwise by a physician**:
  - Circulation assessment of restrained extremity (RN)
  - Assessment of behaviors (RN)
  - Reaction to restraint (RN)
  - Less restrictive interventions (RN or CNA)
- Patients in violent/self-destructive restraint may have a sitter at the bedside for continual 1:1 observation. Depending on location, care shall be documented on the Sitter Flow Sheet MH#1370 or MH#1370A. This may be in addition or in conjunction with the assessments and care documented by the RN/CNA.


INPATIENT SITTER
FLOW SHEET


ED SITTER
FLOW SHEET

Reporting Restraint Related Deaths

- The House Supervisor will notify the Quality Department and the Vice President of Patient Care Services/CNE of any death in a restraint the next business day
- Morris Hospital must and shall report deaths associated with the use of restraint to the CMS Regional Office

- The following information **must** be reported:
  - Each death that occurs while a patient is in restraint, **excluding** those in which only 2-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of their death.
  - Each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
  - Each death referenced in this section must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
  - Staff must document in the patient's medical record the date and time the death was reported to CMS.

Reporting Restraint Related Deaths continued…

- Death of a patient that has been restrained with a soft limb restraint for medical/nonviolent reasons, will not be reported to CMS, but the following patient information will be recorded on the internal restraint log maintained in the Quality Department:
  - Patient's name, dates of birth and death, and medical record number
  - Name of attending physician or other LIP who was responsible for the care of the patient
  - Primary diagnosis(es)

RN / Student Nurse Specific Orientation

PROCEED IF YOU'RE AN RN
OR STUDENT NURSE

2024

IV Therapy

2024

Timeframes

Type	Change Frequency
IV Site	96 hours
IV Tubing (except for lipids or blood products)	96 hours
Blood Tubing	After each unit or every 4 hours
IV Solution with no additives	48 hours
IV Solutions with additives	24 hours
PICC Line Dressing	Every Wednesday or sooner if dressing integrity is compromised, if moisture or blood is present or s/s of infection are present. Every 2 days if gauze present
VAD Dressing	Every Wednesday or sooner if dressing integrity is compromised, if moisture or blood is present or s/s of infection are present. Every 2 days if gauze present
VAD Needle	7 days

IV Therapy Procedure

- Utilize Lippincott for all IV procedures
- A RN or competencied hospital staff member is responsible for insertion and maintenance of IV's
- Fluids, tubing, and dressing changes will be checked during each bedside shift report.

- Equipment:
  - IV start kit
  - IV solution with label
  - IV tubing with pigtails and tubing label
  - In-line filter (if indicated)
  - Angiocath
  - IV pump (if continuous infusion)
  - Prefilled saline flush (if indicated)
  - Heparin lock flush (if ordered) 10 units/ml 1ml flush

Procedure - Preparation

Preparation of IV Pump:

- Obtain IV Pump
  - Call Agiliti ext. 7548
- Enter correct profile and patient account number **(DD#)**
- Select the appropriate solution from the Guardrail menu and program the rate as ordered by provider. **DO NOT** choose Basic Infusion.

Preparation of IV Solution:

- Check provider order with type of solution
- Verify type, volume, and expiration date of solution, after obtaining solution from pyxis or designated storage area
  - Check solution for discoloration or cloudiness (if present, **DO NOT** use)
- Check compatibility of meds and solution
- Close clamp on IV tubing
- Remove protective cap from IV solution and insert spike from tubing into bag
- Squeeze chamber on tubing until half full, then open clamp until solution flows through tubing

Procedure - Preparation

Preparation of IV Solution continued:

- If attaching in line filter to the tubing, follow manufacturer's guidelines for filling and priming
- Label solution with proper label, which should include the following:
  - Date & Time
  - Patient name
  - Hours to run or mL per hour
  - Type of solution
- Label IV tubing with proper label to include date and time
- If non-vented bottle:
  - Remove cap
  - Wipe stopper with approved antiseptic
  - Push spike of clamped tubing through center of rubber stopper
  - Open vent on tubing after spiking
- Squeeze drip chamber until half full and prime tubing

Procedure – IV Insertion

Review Lippincott Procedure Prior to IV Insertion:

- Verify patient's identity using two patient identifiers
  - Patient's name
  - Medical record number **OR**
  - Date of birth
- Neither can be a room number
- Scan patient and IV solution
- Hang IV solution with attached tubing on IV pole
  - Not applicable for saline/Heparin lock
- Explain the procedure to the patient
- Select the site:
  - If long term therapy anticipated, start with vein at most distal site
  - If a CT scan with IV contrast is anticipated, the best site for IV access is the right antecubital fossa. This site provides a combination of optimal safety plus a good point to time delivery of contrast in studies such as cardiac CTA and pulmonary embolism studies. The left antecubital fossa would be the second choice. The 18g angio is preferred. A 20g angio is an acceptable alternative. IV's started in the hands or wrist require a slower injection rate and also require more time to reach the heart. Pulmonary Embolism studies, CTA of the carotids, renal arteries, lower extremities (runoff), and aorta all require at least a 20g IV. Coronary studies require an 18g angio.
- Choose an appropriate size angiocath after locating a vein

Procedure – IV Insertion continued…

- Place patient in comfortable position
- Apply single use tourniquet about 6 inches above site
  - Leave on no longer than 3 minutes
- Don gloves
- Cleanse site with an approved antiseptic
- Grasp canula between thumb and forefinger (bevel facing up)
- Use thumb of non-dominant hand to stretch skin tought below puncture site if needed to stabilize vein
- Tell patient you are ready to insert catheter
- Insert needle at approximately a 25-45 degree angle
- Push through skin into vein in one smooth motion
- Check hub for flashback to signify placement, slightly advance needle, then advance cannula
- Remove tourniquet
- Hold cannula in place while withdrawing needle
- As you withdraw needle, press lightly over catheter tip to prevent bleeding
- Attach tubing and begin infusion or flush
- Secure IV access with tape and transparent semi permeable dressing
- Label site with date, time, and initials
- Engage needle safety device and dispose of needle in sharps container

Procedure – Peripheral IV Line Maintenance

- Perform site care as needed if dressing becomes wet or un-occlusive or after 96 hours if patient refuses IV restart
- If patient IV was a field start, the IV site should be changed as soon as possible. If unable to change sites, be sure to document reason why it was not done
- Explain procedure to patient
- Open supplies
- Don gloves
- Remove old dressing
- If site is intact, stabilize cannula and carefully clean around insertion site using an approved antiseptic
- Allow area to dry
- Cover with transparent semi permeable dressing
- Frequently assess site for:
  - Infection – redness or pain at puncture site
  - Infiltration – coolness, blanching, or edema at site
  - Thrombophlebitis – redness, firmness, pain along path of vein, and edema
- If any signs present, D/C IV and restart on another appropriate IV site
- Change IV site every 96 hours
- All IV dressing options described in this procedure such as tape, transparent semi-permeable dressing, and latex-free cohesive wrap should be from a single use roll. At times a multiple use roll may be used. This roll should not come in contact with the patient's skin, linens, or personal items. **ONLY** the portion that is needed is taken to the bedside.

Procedure – Changing IV Solution

- Plain IV solutions should be changed when infused or every 48 hours
- IVs with additives should be changed when infused or every 24 hours
- Inspect solution container for leaks, cracks or other damage
- Check solution for discoloration, particulates
- Note date & time if solution was mixed along with the expiration date, and place new label on the bag
- Scan the patient and the solution to document administration in the eMAR
- Clamp tubing when inverting to prevent air from entering tubing
- Keep drip chamber half full
- If replacing a bag, remove seal from new bag and remove old bag from pole
- Remove the spike
- Insert it into new bag and adjust flow rate
- If replacing a bottle, remove cap and seal from new bottle
- Swab rubber port with an approved antiseptic wipe
- Clamp line
- Remove spike from old bottle and insert spike into new bottle
- Hang up new bottle and adjust rate
- Bottle should be labeled by pharmacy
  - Plain IV solutions are not labeled by pharmacy

Procedure – Changing IV Tubing

- Clamp IV solution
- Disconnect tubing from needleless pigtail
- Invert IV bag
- Remove spike and discard old tubing
- Cleanse around opening of IV bag
- Spike bag with new tubing
- Prime new labeled tubing
- Cleanse needleless pigtail with an approved antiseptic
- Reconnect new tubing and set to ordered flow rate
- If IV tubing is used intermittently, a sterile cap must attached to the end of the tubing.

Procedure – Removing Peripheral IV Line

- Don gloves
- Clamp IV tubing and gently remove transparent dressing and all tape from skin
- Have gauze pad and tape or adhesive bandage within reach
- Hold gauze pad over puncture site with one hand; use other hand to withdraw cannula slowly and smoothly
- Use the gauze pad and apply firm pressure over puncture site or until bleeding stops
- Clean site if necessary
- Apply adhesive bandage or gauze pad with tape
  - If oozing at site, apply pressure dressing

Procedure – Documentation

- Document IV insertion, site care, and IV solution with rate
- Document when changing solution or IV bag
- The number of attempts at venipuncture, the site of each attempt, patient teaching, evidence of patient understanding, and name of person who performed the venipuncture
- At the end of each shift and upon D/C of patient, document amount infused

Procedure - Considerations

- TKO or KVO rate shall be defined as 10mL/hour for adult patients
- If saline lock ordered, flush with 3mL normal saline every 8 hours
- If heparin lock ordered, flush with 3mL normal saline and 1mL 10units/ML heparin every 8 hours
- Needleless system should be used
- If patient going home with peripheral line or intermittent infusion device, teach patient how to care for IV site and identify complications
- Don't start an IV on extremity which has the following, unless provider order allows:
  - Vein graft, shunt, or AV graft
  - Infiltration
  - Burns
  - Infected extremity
  - Mastectomy
- If IV solution is shut off (per RN), blood may be drawn from vein proximal to IV site
- Explain the cause of IV pump alarms

Procedure – Alaris IV Pump Reminders

- Ensure the correct DD number, Profile setting, and appropriate Guardrail infusion are being used
- There is a way to change the DD number without turning off the pump
  - If you push the Options button, the second choice on the screen is Patient ID
  - From there, you can change the DD number
    - Example: DD123456 – the zeros are eliminated
- Sterile caps should be in place when IV tubing is not in use
- Remember to clear your IV pump at the end of each shift and document all intravenous intake on the IV spreadsheet
- Use appropriate label or flow strip on IV bottles or bags
- Use appropriate label on primary & secondary tubings and ensure they are not expired

Procedure – Phlebitis Scale

- Assess the IV site every 8 hours or as needed for any signs of phlebitis
- Score the IV site according to the phlebitis scale and take appropriate action according to assessment findings
- A score greater than 2 will be reported to the provider

Site of Observation		Score	Stage/Action
Intravenous site appears healthy.		0	No signs of phlebitis
One of the sign is evident.	- Slight pain near cannulated site. - Slight redness.	1	Possible first sign of phlebitis. - Observe cannula
Two of the signs are evident	- Pain - Redness	2	Early stage of phlebitis - Resite cannula
All of the following signs are evident	- Pain - Redness - Swelling	3	Medium stage of phlebitis - Resite cannula - Consider treatment
All of the signs are evident	- Pain - Redness - Swelling - Palpable venous cord.	4	Advanced stage - Resite cannula - Consider treatment
All of the signs are evident	- Pain - Redness - Swelling - Palpable venous cord. - Pyrexia.	5	Advanced stage - Resite cannula - Consider treatment

Blood Transfusions

2024

Definitions of Whole Blood & Blood Component Products

Whole Blood & Packed Red Blood Cells (PRBCs)

Whole blood & Packed Red Blood Cells (PRBC) transfusions replenish the volume and oxygen-carrying capacity of the circulatory system by increasing the mass of circulating red blood cells.

Platelets

Platelets are necessary for blood coagulation; an inadequate platelet count or nonfunctional platelets increases bleeding risk and can be responsible for severe, uncontrolled hemorrhage.

Platelets are supplied as a Platelet Pheresis product, collected from a single donor using mechanical apheresis technology, and are normally leukocyte-reduced.

Plasma

Transfusion of fresh frozen plasma (FFP) refers to the IV administration of plasma and all of its components, including plasma proteins and clotting factors.

Plasma and the clotting factors contained within it are vital to blood coagulation; insufficient plasma coagulation factors increase bleeding risk and can lead to severe, uncontrolled hemorrhage.

Special Considerations for Blood Transfusions

- Obtain informed consent for blood transfusions with the Blood Consent-Refusal form and place in the medical record
  - For non-surgical patients, one transfusion consent is valid for the entire hospital visit
  - For surgical patients, the blood transfusion consent is included in the "Authorization for the Performance of Surgical and Other Procedures/Treatments" and is effective during the authorized procedure, the post anesthesia recovery period, and 24 hours after post-anesthesia care discharge
- Blood and blood products must be initiated within 30 minutes of release from the lab
- If feasible, delay transfusion if patient temperature exceeds 101. 7 degrees Fahrenheit (38. 7 degrees Celsius) and notify provider immediately
- Before transfusion, verification must take place by 2 RNs or RN /Licensed Independent Practitioner at the patient's bedside - one person verification is not acceptable
- Verify appearance of the unit
  - Check the bag for abnormal colors, PRBC clumping and/or gas bubbles prior to spiking the blood
  - Platelets should be straw colored
    - Platelets are agitated during storage, bubbles are normal, but the bag should not be swollen - which can occur from bacteria gases
  - Check for normal appearance and color
    - Thawed FFP is translucent and yellow or light green in color
    - The FFP should not be clumped and should not have bubbles

Special Considerations for Blood Transfusions continued…

- Using the Transfusion Administration Record, scan the patient ID band and complete the patient checklist and co-signature sections
- Scan the blood band, the unit number, product, and blood type
- If the Transfusion Administration Record gives a warning that something does not match, the blood/blood product will not be given and returned to the lab
- For any situations the Transfusion Administration Record is not used, the verification process between 2 RNs is still required for the blood/blood product transfusion
- The following are the ONLY patient situations where it may be acceptable to not scan blood or blood products or the patient identification at the time of administration:
  - Medical Alert Code Blue/Rapid Response
  - Surgical Procedures/Emergency Room Transfusions
  - Patient emergency: During a patient emergency when any delay may further deteriorate the patient's already compromised clinical status, the RN may bypass scanning the blood/blood procedures and patient identification (ID) band. The RN will document why the blood/blood product was not scanned
  - Barcode scanning technology failure due to system downtime/ overall system failure of all scanners

Special Considerations for Blood Transfusions continued…

- The RN will remain with the patient for the first 15 minutes of the blood/blood product to monitor for signs of a transfusion reaction
- After the first 15 minutes of the transfusion, record the patient's initial vital signs and adjust the flow rate as needed
- After the initial 15 minutes, assess the patient every hour and more frequently, depending on the patient's health status, recording initial vital signs every one hour and again at the completion of each unit
- Outpatients will be given the Morris Hospital and Healthcare Centers 'Patient Education - Blood Products Transfusion Information' form
- Inpatients will be given the 'Blood Transfusion Information' sheet
- Transfusion reactions are documented in the Transfusion Administration Record Reaction Assessment

Procedure – Transfusion of Blood & Blood Products

- Verify the provider's order and confirm that the order addresses:
  - Indication for transfusion
  - Preparation of the product
  - Administration requirements - including the start time and rate of infusion
- Confirm that the order and the medical record are labeled with the patient's first and last name and unique ID number – DD#
- Unless the transfusion is an emergency, confirm that informed consent has been obtained and that the signed consent form is in the patient's medical record before initiating the transfusion

- Gather and prepare the necessary equipment and supplies:
  - Blood or blood product administration set
  - IV pole
  - Gloves
  - Blood or blood product
  - Preservative-free normal saline solution
  - 3-mL syringe
  - Antiseptic pad - chlorhexidine, povidone-iodine, or alcohol
  - Disinfectant pad
  - Stethoscope
  - Vital signs monitoring equipment
  - Blood request form

Procedure – Transfusion of Blood & Blood Products continued…

- Perform hand hygiene
- Confirm the patient's identity using at least 2 patient identifiers
- Provide Privacy
- Verify that the patient's religious beliefs don't prohibit blood transfusion therapy
- Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation
- Perform hand hygiene
- Put on gloves to comply with standard precautions
- Ensure that the patient has adequate venous access with an appropriately sized catheter (for short peripheral catheters, 20G to 24G based on vein size and patient preference; 18G to 20G if rapid transfusion is required)
  - Verify patency by aspirating for blood return
  - Insert an IV catheter, if necessary (See the "IV catheter insertion" procedure)
  - A central venous catheter is also an acceptable option for blood transfusion
- Remove and discard your gloves
- Perform hand hygiene

Procedure – Transfusion of Blood & Blood Products continued…

- Obtain the patient's vital signs immediately before initiating the transfusion to serve as a base-line for comparison
- Assess the patient's breath and heart sounds, skin color, and current lab results, such as hemoglobin level and hematocrit
- Identify any conditions that may increase the risk of a transfusion reaction, such as fever, heart failure, kidney disease, and risk of fluid volume excess
- Question the patient about the presence of signs and symptoms that may later be mistaken for signs and symptoms of a transfusion reaction, such as chills, itching, rash, hematuria, muscle aches, and difficulty breathing
- Assist the patient to the bathroom, if necessary, before beginning the transfusion
- Help the patient assume a comfortable position either in a chair or bed
- Providing patient comfort before the transfusion helps reduce the number of manipulations of the blood and tubing during the course of the procedure
- If the patient is in bed, raise the bed to waist level before providing care to prevent caregiver back strain

Procedure – Transfusion of Blood & Blood Products continued…

- Obtain the blood or blood product from transfusion services.
- When receiving the blood or blood product from the transfusion services representative, verify:
  - Patient's two independent identifiers
  - ABO group and Rh type
  - Donor identification number, ABO group, and (if required) Rh type
  - Interpretation of crossmatch tests (if required)
  - Special transfusion requirements (if applicable)
  - Expiration date and time (if applicable)
  - Date and time of blood issue
- Wear gloves or transport the blood product units in a container that prevents direct contact with the blood unit bag
- Remove and discard your gloves, if worn for transport
- Perform hand hygiene
- Put on gloves and, as needed, other personal protective equipment to comply with standard precautions
- Use a two-person verification process in the presence of the patient to match the blood or blood product with the provider's order and the patient to the blood product.
  - One of the people conducting the verification must be qualified to administer the blood or blood product and is usually a registered nurse.
  - The second person conducting the verification must be qualified to participate in the process, as determined by your facility.
- Each employee must independently compare the information, as follows:
  - Compare the name and identification number on the patient's wristband with those on the blood bag label
  - Check the blood bag identification number, ABO blood group, Rh compatibility, and interpretation of compatibility testing
  - Compare the patient's transfusion services identification number with the number on the blood bag
- Check the expiration date on the blood bag, and observe for leaks, abnormal color, clots, excessive air or bubbling, and unusual odor
  - Return expired or abnormal blood to transfusion services

Procedure – Transfusion of Blood & Blood Products continued…

- After checking all of the identifying information, sign the transfusion form to indicate that the identification was correct and that you're the person starting the transfusion; other items that may be included on the transfusion form include:
  - Name and volume of the blood product
  - Blood product's identification number
  - Date and time of the transfusion
- If your facility uses bar-code technology, use it as directed by your facility.
- Prime the blood administration set according to the manufacturer's instructions.
  - If you're using a Y-type set, prime the tubing with normal saline solution as ordered.
  - When using a straight set, prime the administration set tubing with the prescribed blood product
- Perform a vigorous mechanical scrub of the vascular access device hub for at least 5 seconds using an antiseptic pad
  - Allow it to dry completely
- Trace the blood administration set tubing from the patient to its point of origin before beginning the transfusion to make sure that you're connecting the tubing to the correct port and then attach it to the venous access device
  - Route the tubing in standardized direction if the patient has other tubing and catheters having different purposes
  - If multiple IV lines will be used, label the tubing at both the distal (near the patient connection) and proximal (near the source container) ends to reduce the risk of misconnection
- Start the blood transfusion at a slow rate for the first 15 minutes, and increase he rate as prescribed if no signs of a reaction occur to ensure completion of the transfusion within 4 hours
- Remain near the patient during the first 15 minutes to monitor for signs and symptoms of a transfusion reaction because, if a major incompatibility exists or a severe allergic reaction such as anaphylaxis occurs, signs and symptoms usually appear before transfusion of the first 50mL of the unit
- Assess the patient's respiratory status (including breath sounds and oxygen saturation if indicated), skin appearance, and urine output

Procedure – Transfusion of Blood & Blood Products continued…

- If no evidence of a transfusion reaction occurs within the first 15 minutes of the transfusion, increase the infusion rate to the prescribed rate
- Before leaving the room, instruct the patient and family to report anything unusual immediately
- Observe the patient periodically during the transfusion to identify early signs and symptoms of a possible transfusion reaction
- Monitor vital signs hourly (or more often depending on condition) during the transfusion
- Closely monitor the flow rate and inspect the IV insertion site for signs of infiltration
  - If you observe signs of infiltration, immediately stop the transfusion, disconnect the administration set, and aspirate fluid from the catheter using a small syringe
  - Remove the catheter and estimate the volume of fluid infiltrated
  - Notify the practitioner and insert a new IV catheter in a different location to prevent an interruption in transfusion therapy
- Remove and discard your gloves and, if worn, other personal protective equipment
- Perform hand hygiene
- At the completion of blood product administration, obtain the patient's vital signs and compare them with baseline measurements to detect signs of a possible transfusion reaction
- If you must administer additional units, repeat the procedure
- Follow manufacturer's instructions regarding changing of transfusion administration set and filters
- If no additional units are prescribed, perform hand hygiene, put on gloves, and reconnect the original IV fluid, saline lock the catheter, or discontinue the IV infusion, as prescribed
- Return the bed to the lowest position, if applicable, to prevent falls and maintain the patient's safety
- Discard used infusion supplies in an appropriate container, and discard the blood bag, tubing, and filter in an appropriate hazardous waste container
- Clean and disinfect your stethoscope using a disinfectant pad
- Remove and discard your gloves.
- Perform hand hygiene.
- Continue to assess and monitor the patient for signs and symptoms of a delayed transfusion reaction for 4 to 6 hours after the transfusion
  - If the patient isn't under direct observation after the transfusion (for example, if the patient receives a transfusion as an outpatient), provide patient teaching about the signs and symptoms of a delayed transfusion reaction and the importance of reporting them
- Document the procedure

Procedure – Transfusion of Blood & Blood Products continued…

Documentation:

- Record the date and time of the transfusion
- Confirmation that informed consent was obtained
- The indications for the transfusion
- Any premedication administered
- The donor identification number
- The type and amount of transfusion product transfused
- The amount of normal saline solution infused
- The patient's vital signs before, during (if required), and after the transfusion
- Your check of all identification data
- The patient's response
- Document any transfusion reaction, the name of the practitioner notified, time of notification, interventions performed, and the patient's response to those interventions
- Document teaching provided to the patient and family (if applicable), their understanding of that teaching, and any need for follow-up teaching

Blood Transfusion Reaction

What is a Transfusion Reaction?

- A transfusion reaction is any unfavorable event that occurs a patient during or after transfusion of blood or a blood component that can be related to that transfusion
- When caring for a patient who has received a blood or blood product transfusion, health care providers should consider any adverse change in the patient's condition a possible symptom of a transfusion reaction and evaluate the patient promptly to prevent further complications
- Utilize the 'Blood and blood product transfusion reaction management' procedure in Lippincott for further information

The following are specific to Morris Hospital:

- During the blood transfusion and up to six hours after the transfusion, monitor for signs and symptoms such as fever, chills, hives, dyspnea, chest pain, fluctuation in blood pressure, shock, and tachycardia
- If the only symptoms are hives and itching, the transfusion may be paused and antihistamines administered per physician order
  - Once the symptoms have dissipated, the transfusion may be resumed and laboratory workup need not be initiated
  - If the symptoms do not subside or are accompanied by other complications, the transfusion reaction procedure should be followed

Blood Transfusion Reaction continued…

The following is in addition to the Lippincott blood transfusion reaction procedure:

- If a blood transfusion reaction is suspected, immediately stop the transfusion and perform a double check.
  - Compare the information on the form attached to the unit of blood with the unit label and the patient wristband to ascertain whether the right blood is being transfused to the right patient
- Notify the blood bank immediately
  - A lab technician or phlebotomist will report to the patient's bedside to perform an additional check of accuracy and obtain a post-transfusion blood sample
- After a blood transfusion reaction has occurred, collect the next urine sample and send to the lab **labeled with the patient's name and POST-TRANSFUSION**
  - Lab will take responsibility for ordering appropriate testing
- If you suspect a transfusion reaction, stop the transfusion immediately; don't allow the blood remaining in the filter and tubing to infuse
- Trace the blood administration tubing from the patient to its point of origin, disconnect it from the IV catheter, and cover the hub with a sterile cap
  - **DO NOT** discard the administration set or the blood product
- Prime a new IV administration set with normal saline solution, attach the administration set to the IV catheter, and infuse normal saline solution at a keep- vein-open rate (10mL/hour)
  - Trace the tubing from the patient to its point of origin to make sure that you've connected the tubing to the correct port
- Remain with the patient, and notify the patient's provider and transfusion services personnel immediately
- Verify that the patient received the correct blood by comparing the patient's identifying information on the blood bag, attached tag, and the patient's wristband
  - If the information does not match, notify the blood bank to help prevent further mismatching

Blood Transfusion Reaction continued…

- Monitor the patient's vital signs closely for signs of shock
  - Monitor oxygen saturation level using pulse oximetry, and assess cardiac and respiratory status frequently as indicated by the patient's condition and the type of reaction
- Administer treatment, as prescribed, to provide symptomatic relief
- Place the blood bag (even if it's empty), attached IV fluids, and administration set with the related forms and labels in a laboratory biohazard transport bag and return them to transfusion services because transfusion services personnel will test these materials to further evaluate the reaction
- Perform a venipuncture (phlebotomist will come draw) in a different vein and obtain a blood sample for laboratory testing to inspect for hemolysis; obtain blood sample for repeat ABO group determination and direct anti-globulin test as ordered
- The practitioner may order additional laboratory testing, such as blood cultures, if bacterial contamination is suspected
- The practitioner may also order blood urea nitrogen and creatinine levels to monitor renal function as well as coagulation studies, such as prothrombin time, partial thromboplastin time, fibrinogen level, and D-dimer, to identify red blood cell destruction and monitor for disseminated intravascular coagulation
- Notify the provider of critical test results within your facility's established time frame to ensure prompt treatment

Transfusion Reaction Procedure

- Label all samples in the presence of the patient to prevent mislabeling
- Complete and send the appropriate documentation, usually a transfusion reaction report form, to the laboratory along with the samples in a laboratory biohazard transport bag
- Discard used supplies in appropriate receptacles
- Return the bed to the lowest position to prevent falls and maintain the patient's safety
- Remove and discard your gloves, if worn
- Perform hand hygiene
- Monitor intake and output closely
  - Insert an indwelling urinary catheter, if ordered, to monitor urine output in a critically ill patient
  - Note evidence of oliguria or anuria because hemoglobin deposits in the renal tubes can cause renal damage
- Make sure that the patient is comfortable
- Reassure the patient and family as needed
- Clean and disinfect your stethoscope using a disinfectant pad
- Perform hand hygiene
- Put on gloves, as needed
- Clean and disinfect other reusable equipment according to the manufacturer's instructions to prevent the spread of infection
- Remove and discard your gloves, if worn
- Perform hand hygiene
- Document the procedure

Safe Medication Administration

2024

Safe Medication Administration Measures

- Utilize the Medications Administration, Ordering, Standardized Dosing policy on iShare
- Medication shall be administered by those personnel whose licensure includes medication administration and according to hospital policy
  - Medications shall not be self-administered by the patient, with the exception of an implanted medication device
- Administering personnel shall remain with the patient until oral medication has been taken
- Medications from pyxis shall be removed just prior to administration
- Medications may be transported from pyxis to patient bedside in medication cart
- Two patient identifiers shall be used to identify the patient - patient name, date of birth, medical record number
- Refer to Lippincott Online Procedures regarding different routes of medication administration
- Bedside medication verification shall be performed in applicable units using an electronic medication administration record (eMAR)
- The nine rights of medication administration shall be observed
  - Right patient
  - Right medication
  - Right dose
  - Right route
  - Right time
  - Right documentation
  - Right action (appropriate reason)
  - Right form
  - Right Response
- Nursing and pharmacy shall provide patient education regarding the purpose and side effects of new medications prescribed
- Following administration of medication, the patient shall be monitored as indicated per individual drug product recommendations
- In the healthcare center setting, a Medical Assistant may administer oral, intramuscular, subcutaneous, topical or nebulized medication as ordered according to their scope of education and training, provided a licensed care provider is on site to provide assistance
  - The Medical Assistant shall not administer intravenous or narcotic medications
  - All non-unit dose medications shall be double-checked by a licensed care provider with the Medical Assistant

Special Considerations

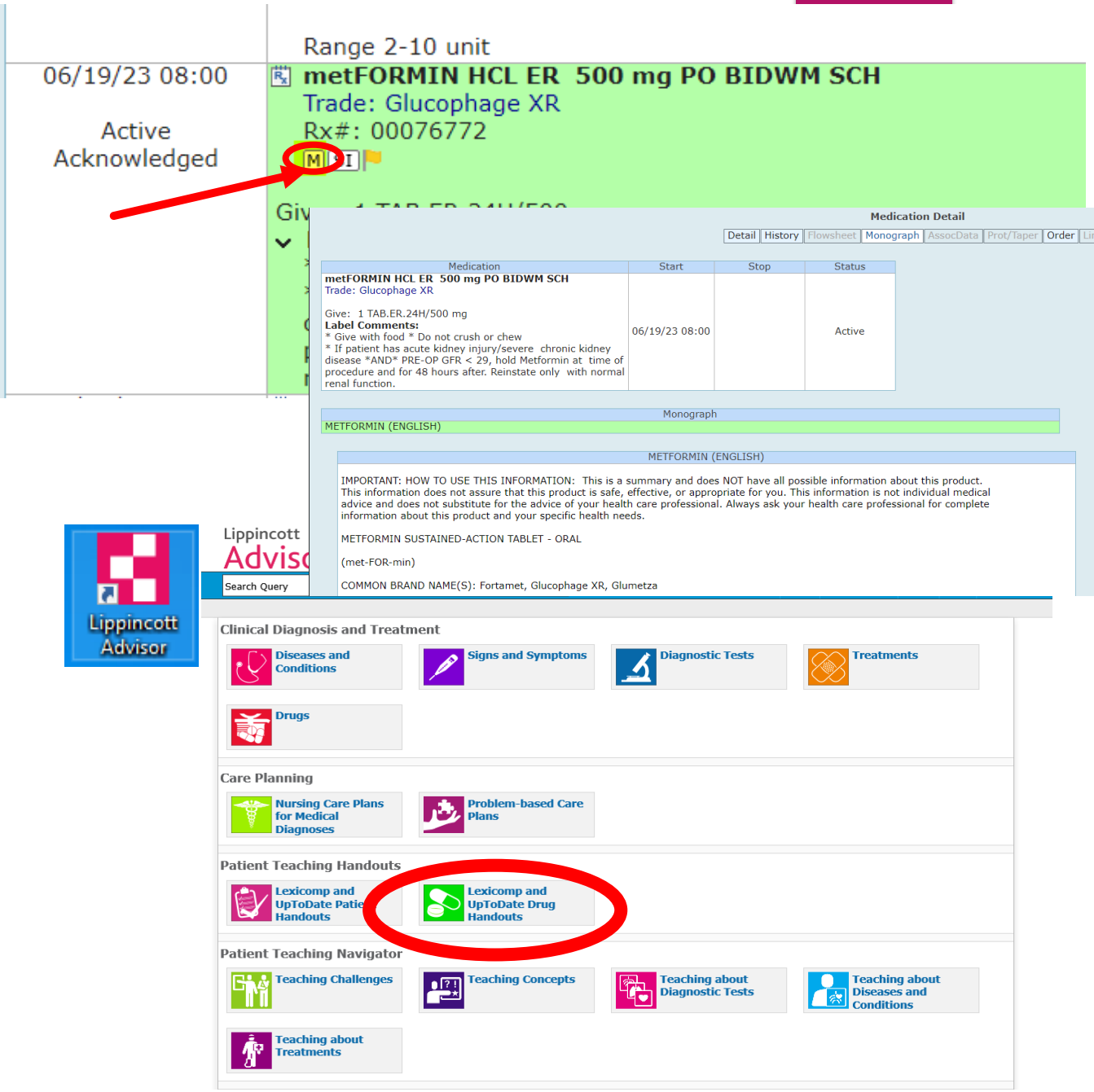
- Medication orders shall be put on hold when a patient goes to surgery having general, spinal, or monitored anesthesia care
  - They shall be reordered by the physician upon transfer back to the medical unit
- Medications shall not be recorded before they are administered
- Medication carts shall be locked when unattended
- Patients shall be assessed for medication reactions when receiving a new medication
  - If an adverse reaction occurs, licensed care provider shall document details of reaction and medication information via remote data entry (RDE) and notify provider
  - Nursing and Respiratory Therapy shall provide patient education regarding the purpose and side effects of all medications upon administration of each dose
  - Pharmacy shall provide additional patient education regarding the purpose and side effects of medications
- Distractions shall be minimized when removing medications from pyxis or administering medications
- A list of high alert medications shall be made available and updated as necessary
  - Refer to High Alert Medication policy on iShare
- When administering heparin or insulin, medication route and dose shall be verified by two licensed personnel
  - A pharmacist may witness and co-sign in the absence of a second RN
  - This may include, but not limited to, all forms of insulin (pens and vials), enoxaparin (Lovenox), fondaparinux (Arixtra), heparin, Argatroban, abciximab (Reopro), and eptifibatide (Integrilin)
- To Keep Open (TKO) or Keep Vein Open (KVO) rate shall be defined as 10 mL/hr

Improving transitions in care & knowledge of medications is part of the **Morris Hospital's strategic initiatives for quality patient care**.

- The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks medication specific questions.
- The following are the questions:
  - When I left the hospital I clearly understood the purpose for taking each of my medications.
  - During the hospital stay before giving you any new medication, how often did the hospital staff tell you what the medication was for? And how often did the hospital staff describe possible side effects in a way you could understand?

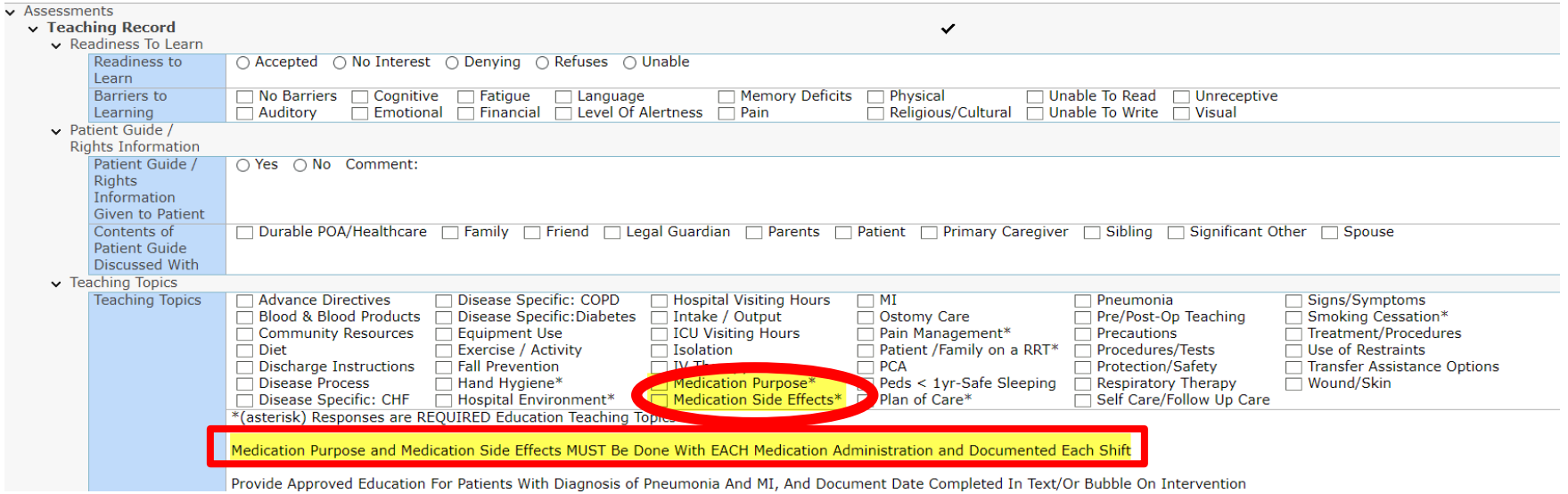
Nursing Process

- On every medication pass, the Nurse must educate the patient on the purpose & side effects of **ALL** meds.
- Monographs and Lippincott Advisor can be utilized to provide education on medication side effects and its purpose upon patient request.
- Example: Mrs. Smith, the purpose of your metoprolol is to help with your heart and/or blood pressure. Some side effects may include dizziness, headaches, drowsiness, and fatigue. Please let me know if you would like more information on this medication.



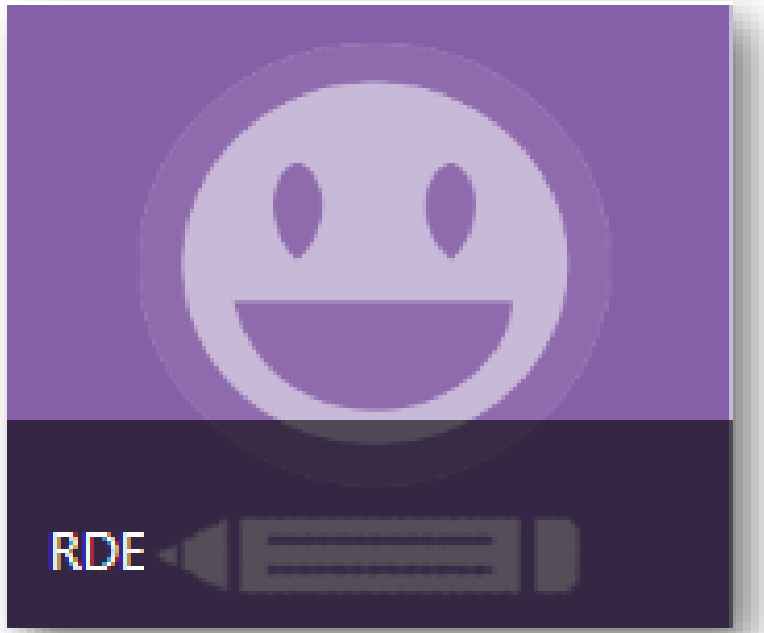
Nursing Documentation

- The medication purpose and side effects education will then be documented in the Meditech Intervention "Education Record" at least once per shift.
- For supplemental patient medication education needs, a referral can be made to the Pharmacist on the unit.
- The Pharmacy extension will be listed on each patient's white communication boards, please remind the patient of this resource also!



Adverse Drug Reaction

- Defined as any response to a drug that is noxious and unintended; that occurs at doses in humans for prophylaxis, diagnosis, or therapy; excludes failure to accomplish the intended purpose (includes hypoglycemia)
- Immediately report to Pharmacy a potential adverse drug reaction at ext. 7614
- Complete the Medication Variance/ADR report through RDE on iShare



Reporting Medication Errors

- Types of medication errors include, but are not limited to:
  - Wrong: drug, dose, route, or time
  - Omission (not administered before next schedule dose due)
  - Unordered dose
- When a medication error occurs, four things should occur in this order:
  - Evaluate the patient and notify the provider and family
  - Record the medication as given in the medical record
  - Report the error in detail with a Medication Variance Report form through RDE on iShare
  - The practitioner who identifies an error will document all relevant information on the Medication Variance Report form
- All Medication Variance Report forms evaluated will be summarized at the Minimizing Medication Variance Meeting
  - Trends and highlights are taken to the Pharmacy and Therapeutics Committee
- All medication errors reported will identify the process affected:
  - Ordering/prescribing
  - Preparation/dispensing
  - Administration
  - And/or monitoring effects of medication

* Personnel involved in a medication error will be notified by their supervisor. All parties will analyze the error to identify breakdowns in current processes or deviation from current procedures that contributed to the error occurrence. If necessary the process will be changed to prevent future occurrences. Repeated deviations from current processes will be handled under the standard disciplinary process and can result in reassignment or dismissal *

THE END

Please Complete Your Written Test

MORRIS
HOSPITAL
& HEALTHCARE CENTERS

People You Know. Extraordinary Care.