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Introduction to Providence

Please review the slide deck that follows this page

OUR MISSION

AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

OUR VALUES

Compassion
Dignity
Justice
Excellence
Integrity

OUR VISION

Health for a Better World

OUR PROMISE

"Know me, care for me, ease my way"

Providence

What is a Red Rule?

A red rule <u>MUST</u> be adhered to without compromise because of the high potential for harm and/or error.

If a red rule cannot be followed: **STOP** until it can be followed

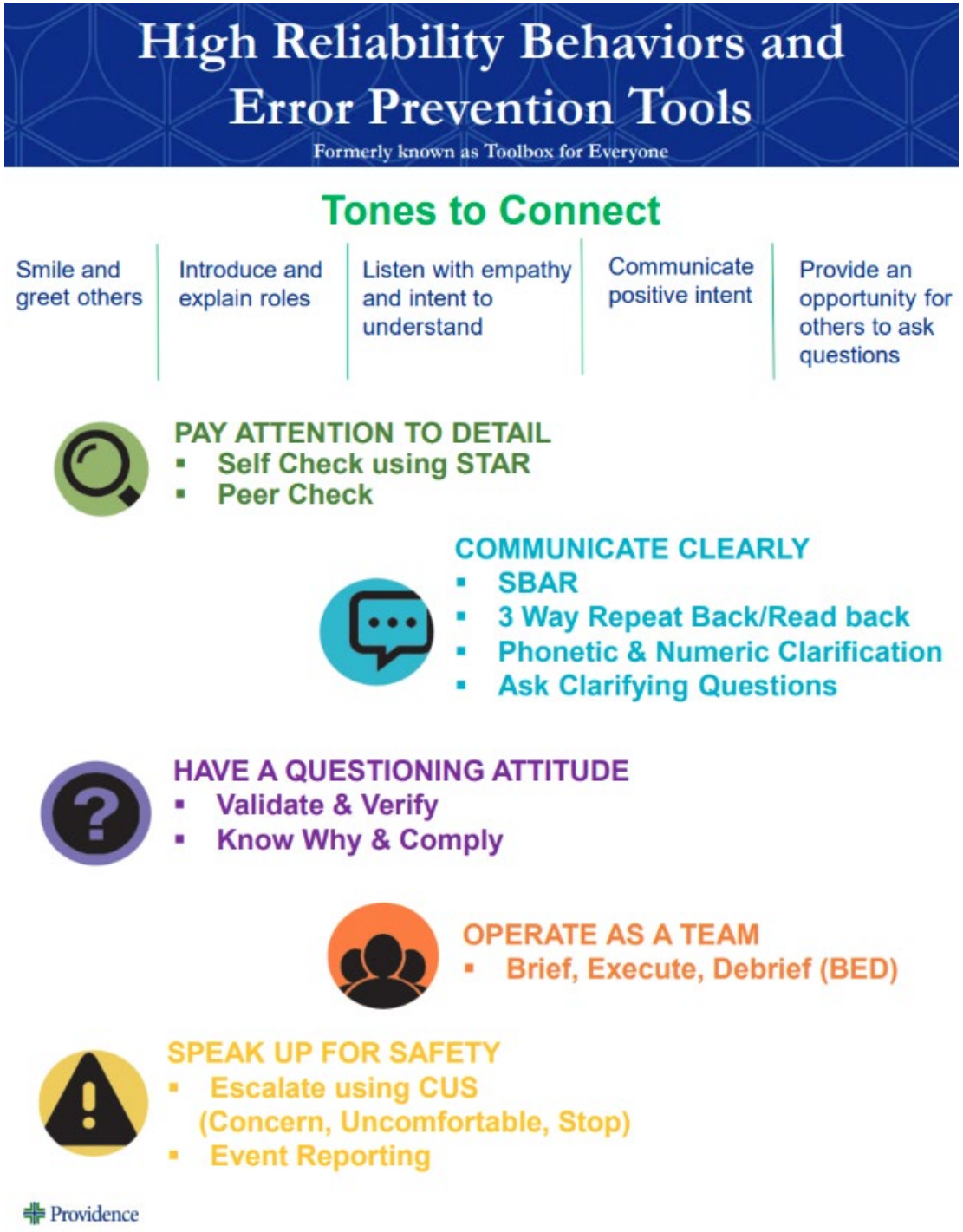
Providence's RED RULE: **<u>MUST</u>** use at least 2 patient identifiers before delivering care of any sort.

Providence

Providence Communication Tools

Caring Reliably

High Reliability: Our Journey to ZERO Preventable Harm



Providence

Accessing High Reliability Platform(HRP)

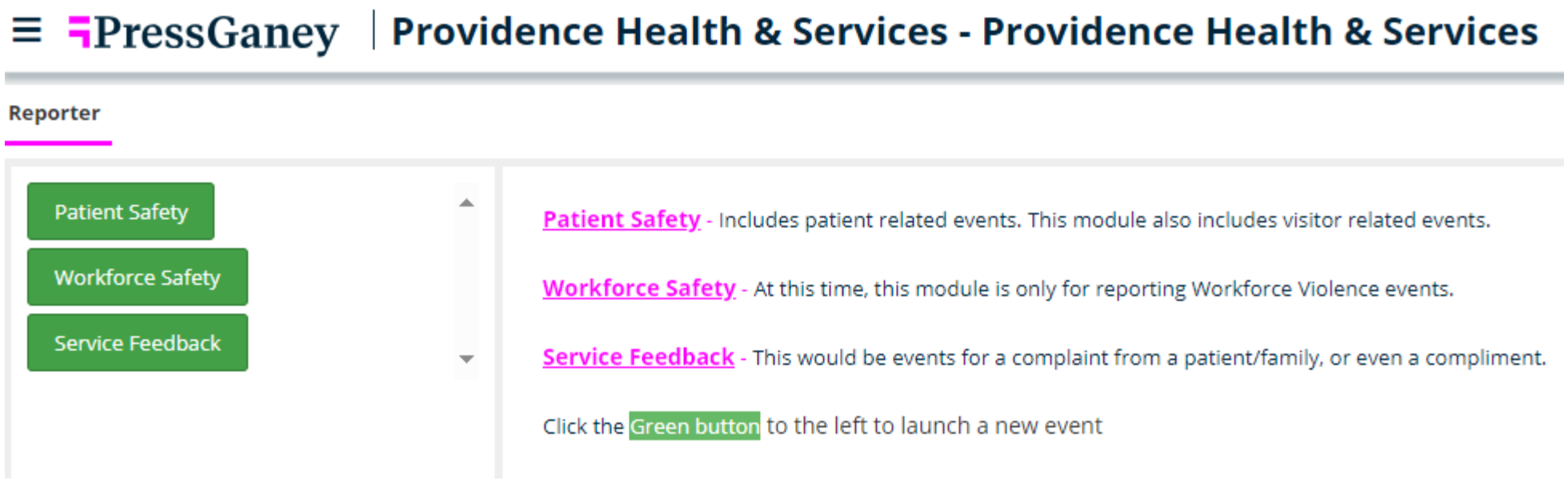
- Report errors, near-misses, and concerns via the HRP tool
- Easiest way is to click on the Speak Up for Safety Icon (located on most Providence computers)
- Can also access via the Division SharePoint site

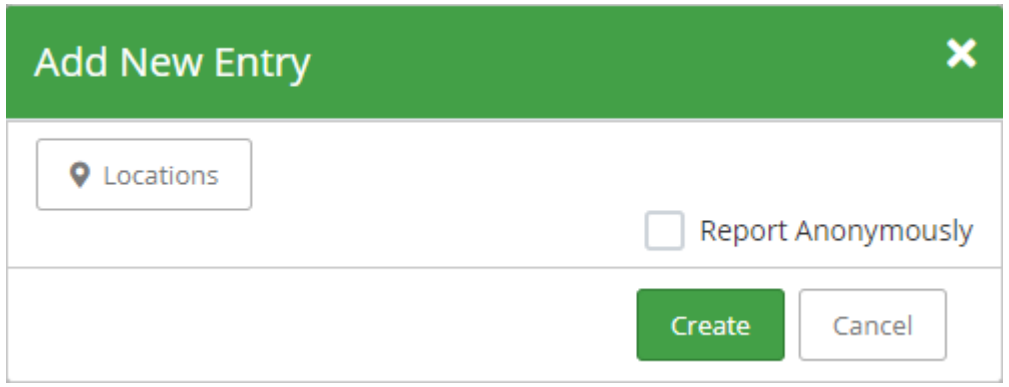
The High Reliability Platform (HRP) is now live!

Click the Speak Up for Safety icon to report an event!

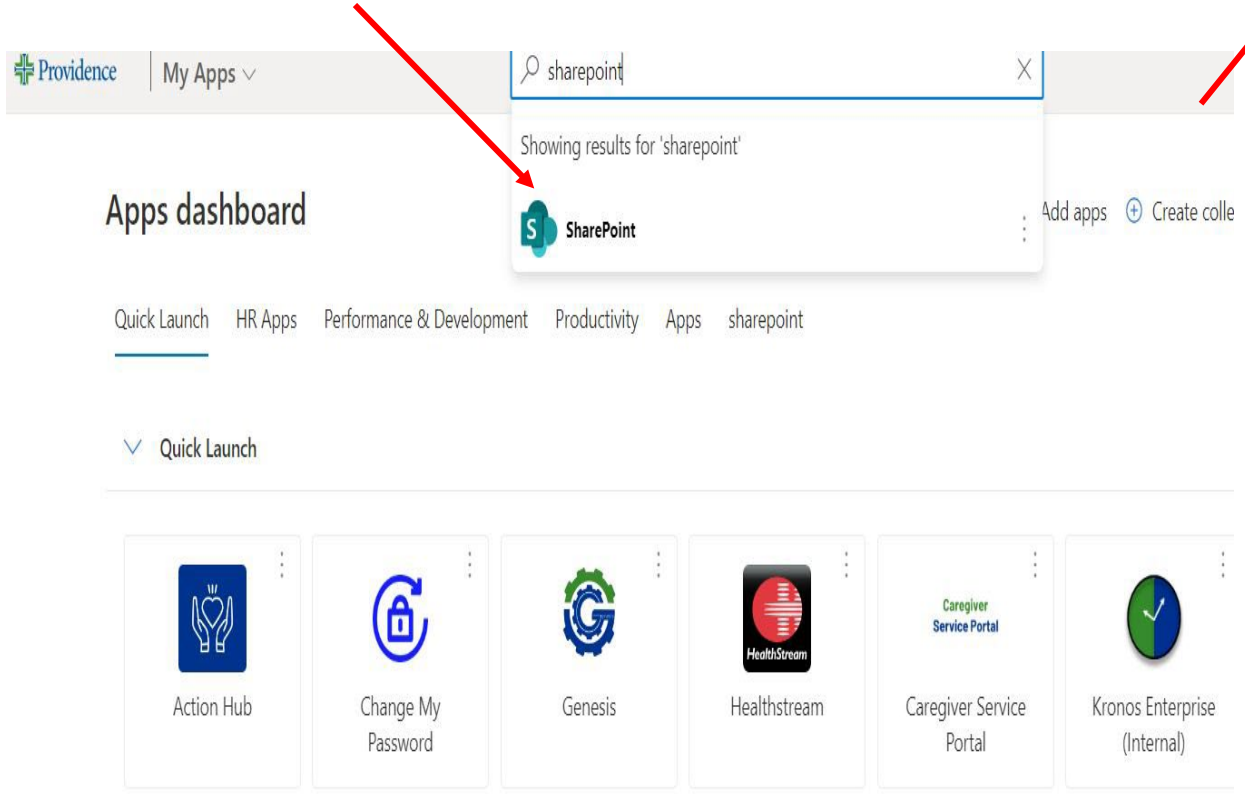
*NOTE: There is a 2 hour delay the first time you log in to set up your account

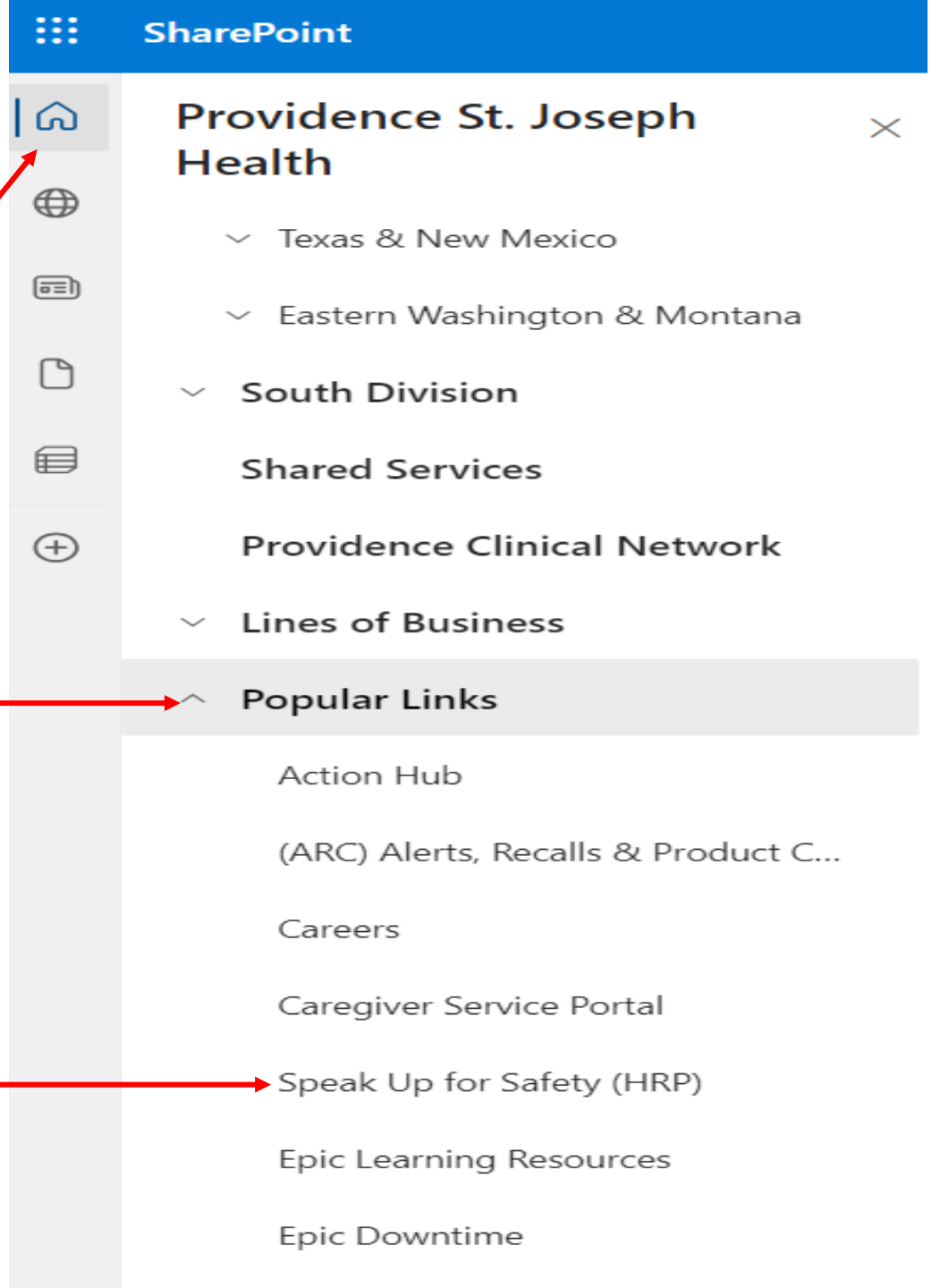
Reporting Events





Submitting an HRP report





Providence

Communication Tools

- SBAR

Situation - Who or what you're calling about, the immediate problem, your concerns

Background - Review of pertinent information, procedures, patient condition

Assessment - Your view of the situation: *"I think the problem is…" or "I'm not sure what the problem is";* urgency of action: *"the patient is deteriorating rapidly - we need to do something"*

Recommendation - Your suggestion or request

- CUS

Speak-up for Safety: Escalation Using CUS and Chain of Command

A responsibility we each have to protect in a manner of mutual respect

Use the lightest touch possible…

I have a **C**oncern…

I am **U**ncomfortable with…

Stop – this is a safety issue

If no success…

Use chain of command

"I have a concern…"

Providence

The Joint Commission

National Patient Safety Goals (NPSG) 2024)

Hospital Patient Safety Goals

Goal 1: Improve the accuracy of patient identification

Goal 2: Improve the effectiveness of communication among caregivers

Goal 3: Improve the safety of using medications

Goal 6: Reduce patient harm associated with clinical alarm systems

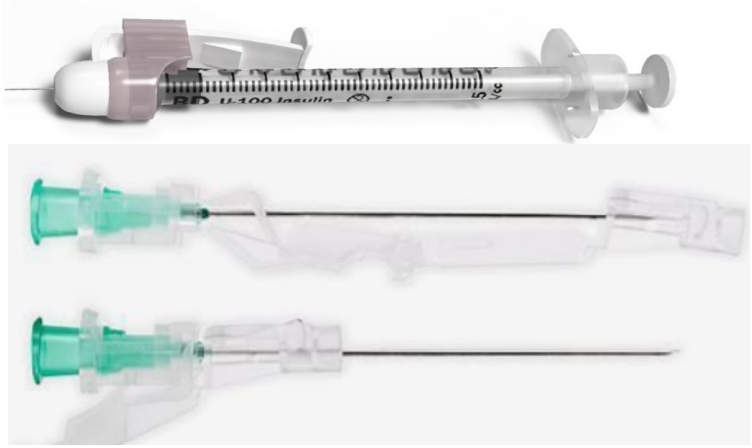
Goal 7: Reduce the risk of health care-associated infections

Goal 15: Reduce the risk for suicide

Goal 16: Improve Health Equity

Insulin needles and Injuries

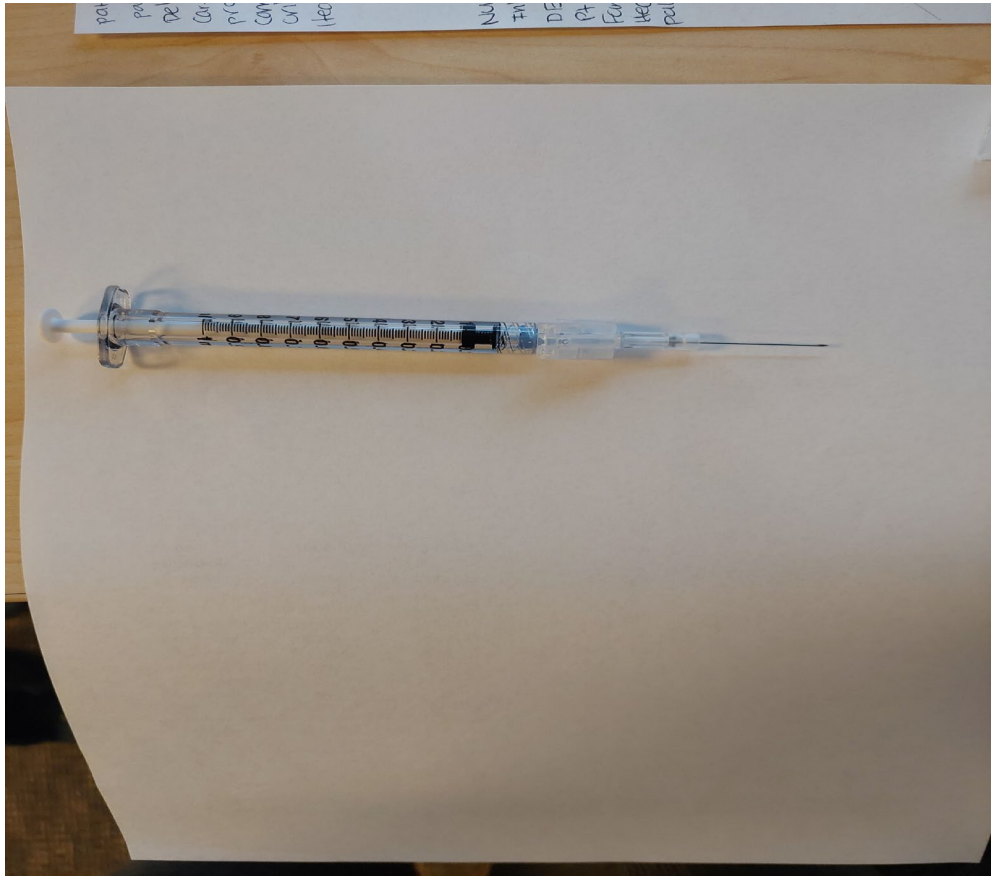
- 20% of needlestick injuries result from insulin needles and occur right after administering insulin (American Nurse Today, Mitchell, 2018)
- Always use Safety Needles
- In chaotic situations (e.g. Code Gray) announce when approaching with a needle **AND** retreating
- **How** we hold the skin when administering insulin is being discussed

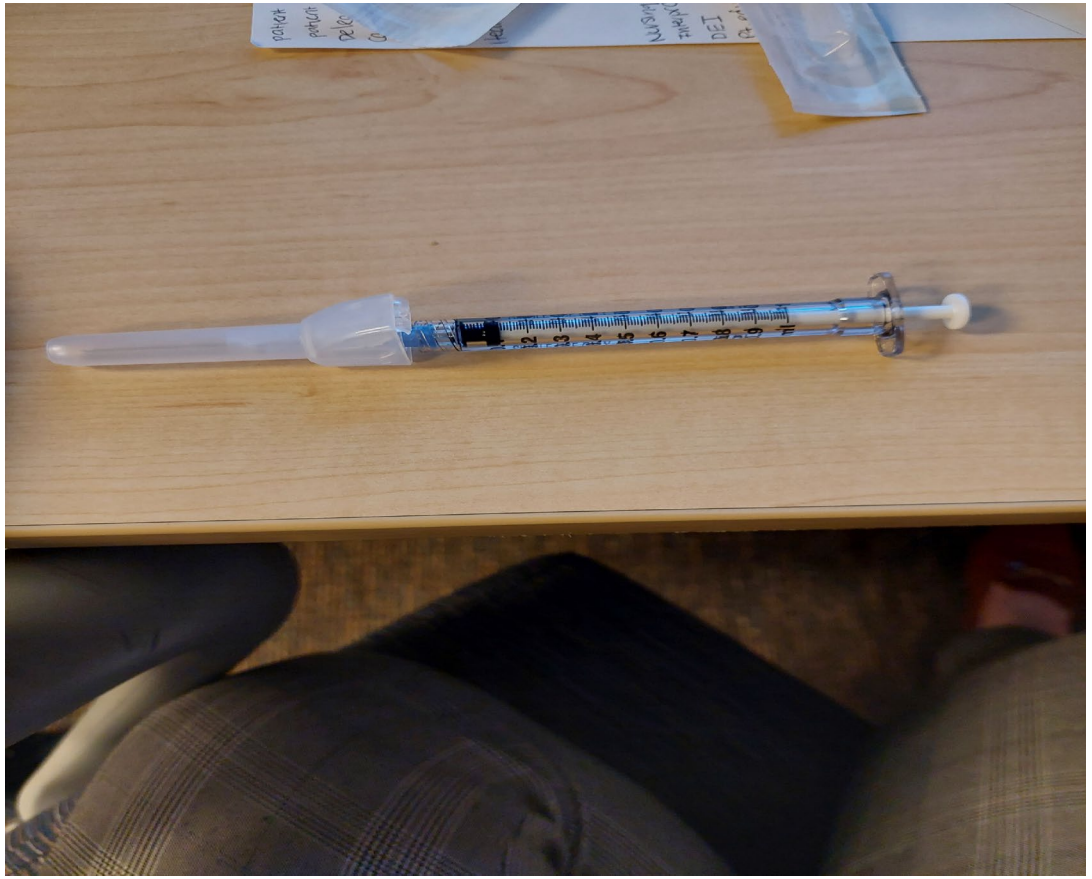


Needle Safety

- Important to always use a safety needle to reduce risk of needlestick
- Current evidence shows up to 20% of needlesticks occur right after administering insulin
- Discussion being held around ***how*** we hold the skin when administering insulin
- When in chaotic situations (e.g. Code Gray) announce when you are approaching with a needle, and when you are retreating with a needle

Examples of Safety Needles





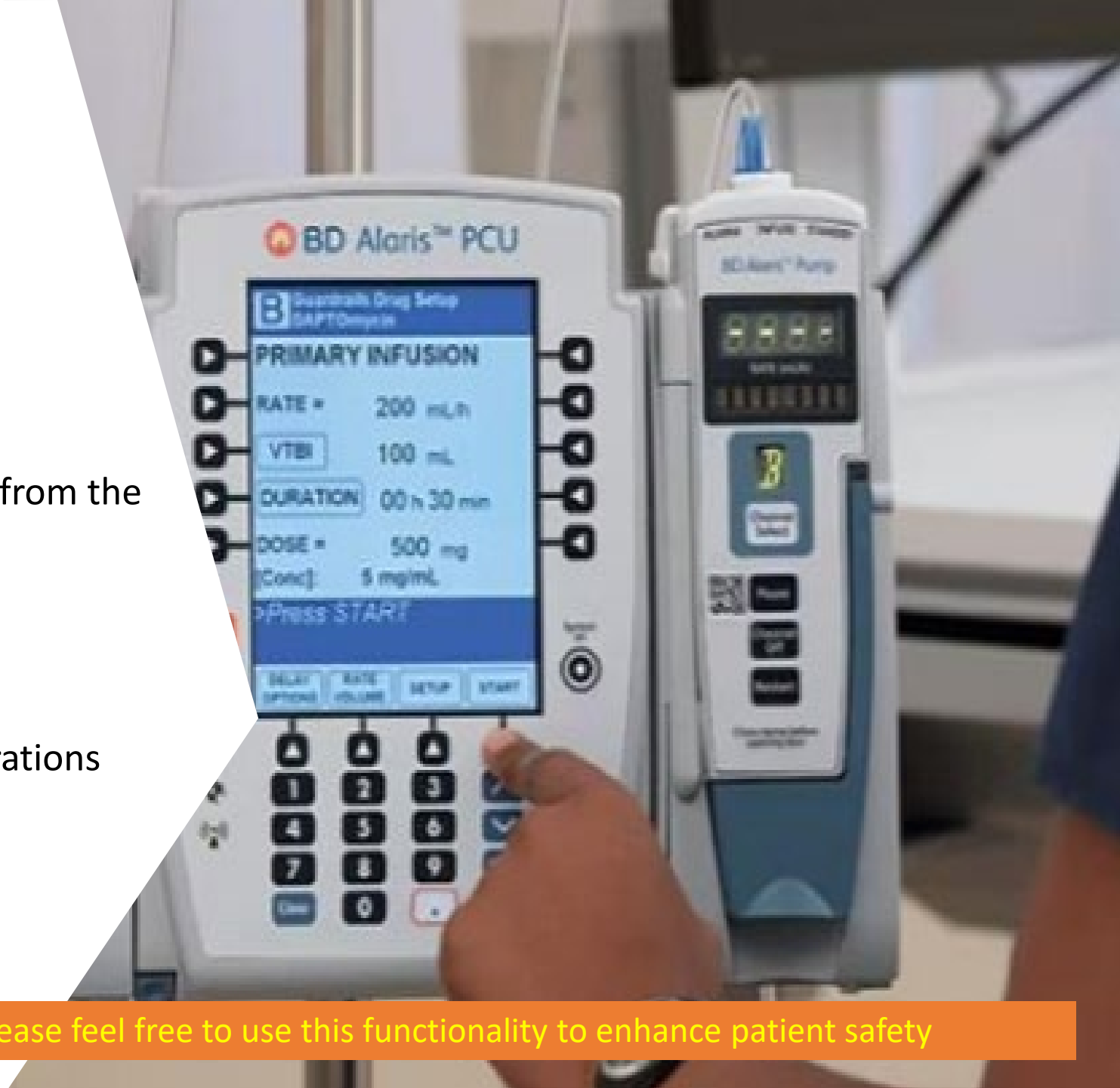
Epic Alaris Pump Interoperability

Reduces Medication Errors:

- It minimizes the chance of manual programming errors
- The infusion parameters pre-populate from the medication orders in Epic

Simplified and Reliable Documentation:

- The infusion status, rate changes,& titrations are sent back to Epic in near real-time
- It decreases documentation time
- It increases time spent with patients

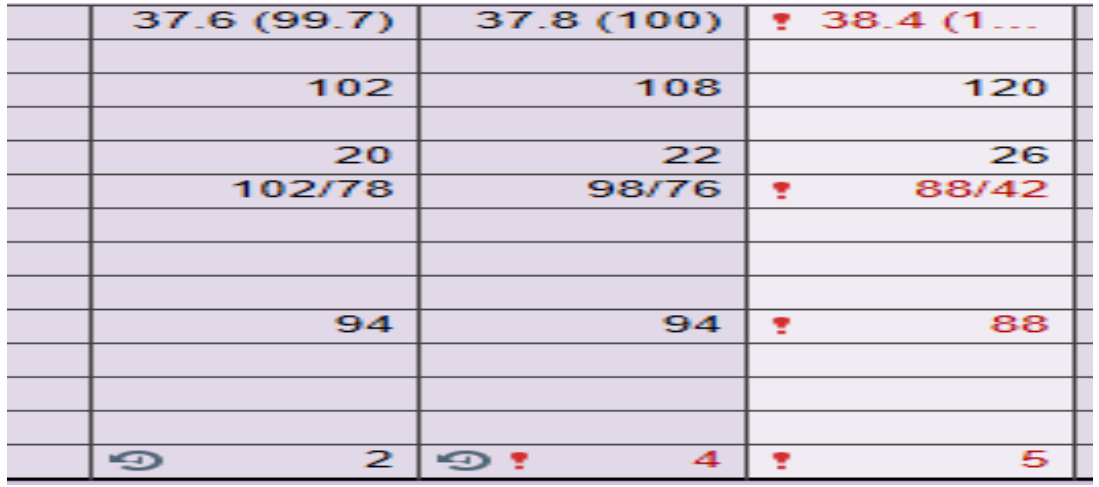


If you know how to use Interoperability, please feel free to use this functionality to enhance patient safety

Clinical Alarm Safety

- Ensure alarms are audible and working
- Respond immediately to alarms
- Individualize alarm parameters
- Assess your patient!!

MEWS: Modified Early Warning System



	37.6 (99.7)	37.8 (100)	! 38.4 (1...
	102	108	120
	20	22	26
	102/78	98/76	! 88/42
	94	94	! 88
	2	! 4	! 5

Modified Early Warning System Score (MEWS)

Score	3	2	1	0	1	2	3
Respiratory rate (RR)	-	<=8	-	9-14	15-20	21-29	>=30
Heart rate (HR)	-	<=40	41-50	51-100	101-110	111-129	>=130
Systolic Blood Pressure (SBP)	<=70	71-80	81-100	101-199	-	>=200	-
Temperture (&degC) (Temp)	-	<=34.9	-	35.0-38.4	-	>=38.5	-

MEWS is a physiologic scoring system that generates a score based upon subtle changes in vital signs that have been found to precede cardiac arrest and death.

MEWS is calculated and displayed in Epic each time vital signs are measured

MEWS alerts are paged to charge RN when MEWS ≥ 5 or MEWS ≥ 4 with SBP < 90 mmHg

NOTE: MEWS alerts are NOT paged when patient is in ICU, ED, L&D, peri-op, hospice (end of life comfort care) care

PHSOR MEWS Algorithm

MEWS ≥ 5 or
MEWS ≥ 4 with SBP < 90 mmHg

Text page to RRT RN
Select Ministries

Text page to Charge RN
Or Ministry equivalent

Text Page Message
MEWS alert room XYZ. Verify repeat VS and LIP notification.

RRT response per Ministry specific protocol
Refer to PHSOR RRT Practice Guideline

PRIMARY RN

Repeat & document vital signs **within 15 minutes**

VS **validated abnormal** for patient's clinical circumstance(s)

YES

Notify provider. Document notification **within 60 minutes** of initial MEWS alert

*Refer to **PHSOR RRT Practice Guideline** for Ministry specific* ESCALATION PROTOCOLS *PRN*

PROVIDER

- Orders *PRN*
- Bedside assessment *PRN*
- Update plan of care *PRN*

PRIMARY RN

- Implement orders
- Implement plan of care
- **Repeat and document vital signs Q1 hr x 2**
  Unless otherwise ordered

Ongoing abnormal VS and/or MEWS alerts

YES

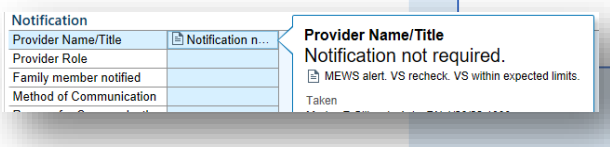
NO

Consider "Second eyes" assessment or RRT activation

NO

Document repeat VS

Document exception to provider notification requirement **within 60 minutes** of initial MEWS alert



Continue routine patient care

Revised 1-28-2022

More Tools for Safety

- CHEWS: Children's Hospital Early Warning System
    - Behavior, Cardiovascular, and Respiratory, Parental Concern
- MEWT: Maternity Early Warning Trends
    - Perinatal and OB
- Severe Sepsis Alert
    - Vitals and certain Labs (ie Lactate)

STROKE

PHS Stroke Program

B	E	F	A	S	T
Balance	Eyes	Face	Arms	Speech	Time

B is for Balance:	E is for Eye:	F is for Face:	A is for Arm:	S is for Speech:	T is for Time:
Does the person have a sudden loss of balance?	Has the person lost vision in one or both eyes?	Does the person's face look uneven?	Is one arm hanging down?	Is the person's speech slurred? Does the person have trouble speaking or seem confused?	

DIAL 88

FOR THE

RAPID RESPONSE NURSE

NOW!

Suspected Stroke Protocol

Initial Response:

- ABCs, VS, Glucose check
- BE FAST exam, NIHSS
- STAT head CT
- ECG
- Labs – platelets, INR
- Accurate weight
- IV access
- NPO - including all meds, until patient passes Bedside Swallow Screen

Goal Times

STAT	< 20 minutes	< 30 minutes	< 45 minutes	< 90 minutes
Door to Stroke Physician	Door to STAT CT	Door to IV thrombolytic	Door to Lab results	Door to Device (thrombectomy)

Head CT is required before any treatment decision!

PROVIDENCE
Brain and
Spine Institute

NIH STROKE SCALE (NIHSS) IN PLAIN ENGLISH

1a. Level of Consciousness	0= Alert 1= Sleepy but arouses 2= Can't stay awake 3= No purposeful response	
1b. Questions (month, age)	0= Both correct 1= One correct /intubated 2= Neither correct	
1c. Commands (Close eyes, make fist)	0= Obeys both 1= Obeys one 2= Obeys neither	
2. Lateral Gaze (Eyes open. Eyes follow examiners fingers/face side-to-side)	0= Normal side-to-side eye movement 1= Partial side-to-side eye movement 2= No side-to-side eye movement	
3. Visual Fields (Both eyes open, count 1/2/5 fingers/detect movement, 4 visual fields)	0= Normal visual fields ⊕ 1= Blind upper **or** lower field one side.  2= Blind upper **&** lower field one side.  3= Blind in both eyes/4 fields ●	
4. Facial Weakness (Smile/grimace, raise eyebrows, squeeze eyes shut)	0= Normal 1= Mild one-sided droop with smile 2= Obvious droop at rest 3= Upper **&** lower face weak	
5a. Arm Weakness– Left **5b. Arm Weakness– Right** (Pt. holds arm at 90^0 if sitting, 45^0 if supine for **10 seconds**)	0= No drift X=Untestable-joint fused/amp 1= Drifts down, does not hit bed 2= Drifts down to hit bed 3= Can move but can't lift 4= No movement	Lt. Rt.
6a. Leg Weakness– Left **6b. Leg Weakness– Right** (Pt. holds leg straight out if sitting, 30^0 if supine **5 seconds**)	0= No drift X= Untestable, joint fused, etc. 1= Drifts down, does not hit bed 2= Drifts down to hit bed 3= Can move but can't lift 4= No movement	Lt. Rt.
7. Coordination Finger-to-nose, heel-to-shin. Score only if not caused by weakness.	0= Normal or **no movement** 1= Clumsy in one limb 2= Clumsy in two limbs	
8. Sensation (feeling) (Pin prick face, arm, leg – compare sides)	0= Normal 1= Decreased sensation 2= Can't feel, no pain withdrawal	
9. Speech (content) Intubated pt can write. Give blind pt objects to name. (name objects, describe cookie picture)	0= Correct full sentences 1= Wrong or incomplete sentences 2= Words don't make sense 3= Can't speak at all	
10. Speech (slurring) Slurring. (Listen to patient read/repeat words)	0= No slurring X= Intubated/physical barrier 1= Slurs but you can understand 2= Slurs and you can't understand **or** mute	
11. Neglect (Ignores one side of body; test vision then test touch on both sides at once)	0= Sees & feels when **both sides tested at once**. 1= Doesn't see **or** feel one side when tested at once 2= Doesn't see **&** feel one side when tested at once	

NIH STROKE SCALE (NIHSS) Scoring Tips

1. **Level of consciousness/questions/commands**. Use patient appropriate questions, commands:
    - Use voice then touch to wake a sleeping patient. May require vigorous stimulation.
    - Intubated or otherwise unable to speak give score a 1.
    - Person with one arm amputated and the other paralyzed can wiggle their toes.

2&3. Eye movement and visual fields:

- If patient cannot open eyes, examiner may gentle lift lids open for exam.
- Test both eyes at same time for movement and fields
- May roll patient's head side to side if not following (oculocephalic maneuver)

4,5,6. Facial and extremity strength:

- If patient not following commands, examiner may show patient what to do (i.e. lift arm) for patient to mimic or maintain position.
- Test each side separately to avoid confusing neglect for weakness.

7. Limb coordination (ataxia):

- Only score if patient is able to move the limb, and the precision of movement is abnormal or out of proportion to weakness.

8. Sensation:

- Test arm and legs; many people have numb hands (carpel tunnel) and feet (diabetic neuropathy).

9. Language:

- Testing for cognitive content of speech, naming objects, fluent sentences.

10. Slurring (dysarthria):

- Testing for clarity of speech, the actual motor function of getting the words out.
- For patients who cannot read, have the patient repeat sentences and words after you state them out loud to patient.

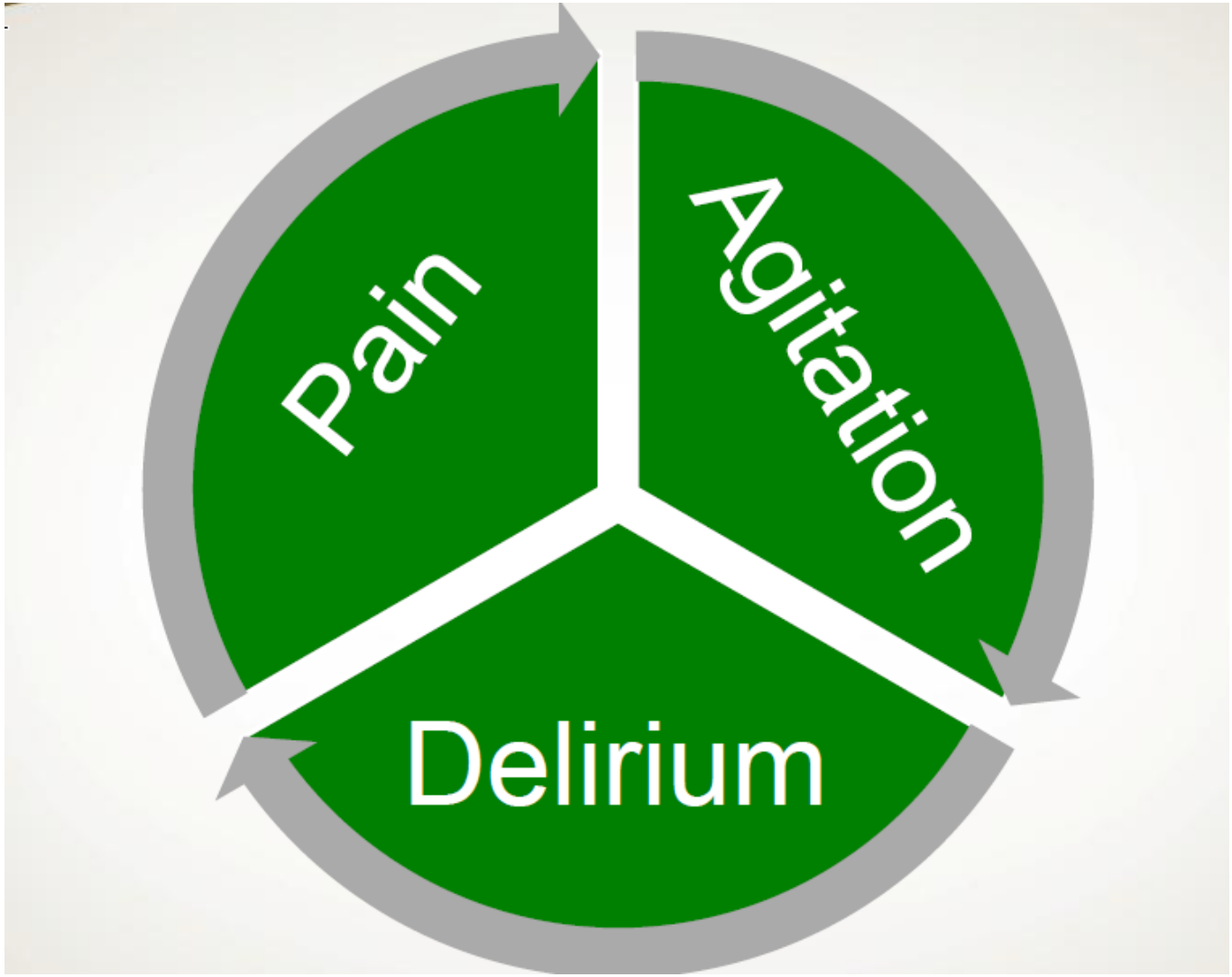
11. Neglect (inattention or extinction):

- Can patient pay attention to stimuli on both sides of the body at the same time?
- Must have some vision in both fields to test: if scores a 2 on #3 (visual fields), cannot score visual neglect.
- Must have some sensation on both sides to test: if scores a 2 on #8 (sensation), cannot score sensory neglect.
- If patient does not acknowledge one side of space (does not recognize own arm when held in their good visual field; does not acknowledge they have any problem with a paralyzed side, etc.) score is 2.

EMERGENCY!!!

Delirium

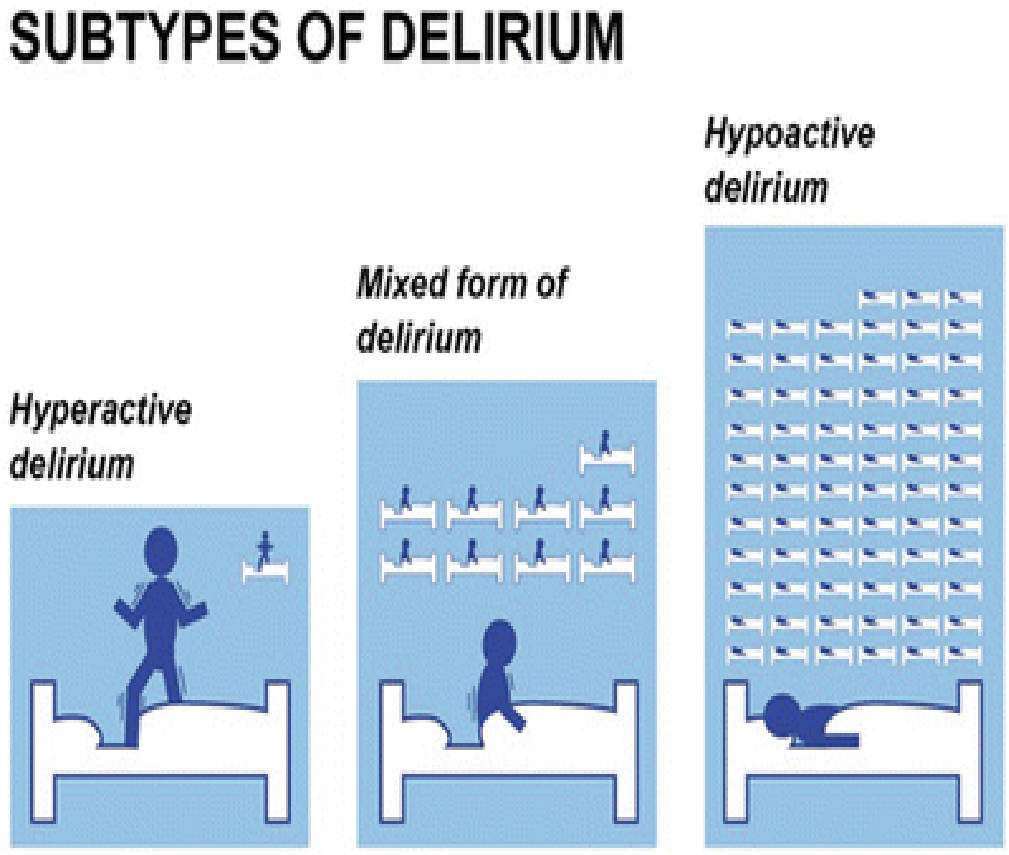
"Disturbance of consciousness with inattention & change in cognition that develops acutely and fluctuates over time."




50-70%
Cognitively Impaired
© rustyrhodes via Flickr
Wolters *Intensive Care Med* 2013; 39: 376
Jackson *AJRCCM* 2010; 182: 183
Girard *Crit Care Med* 2010; 38: 1513


60-80%
Functionally Impaired
Marcel Oosterwijk via Flickr
Latronico *Lancet Neurol* 2011; 10: 931

Delirium Types



Hospital Associated Functional Decline (HAFD)

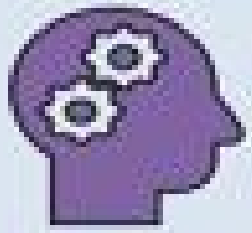
- Medical patients with HAFD, 12 months post-discharge

Risk Factors:

- Age ≥ 80 (OR 2.3)
- Any pre-existing impairments
- Untreated depression
- Sepsis/HF
- Restricted mobility
- Enforced dependence
- Cognitive impairment

Best Practice Reminder

Identify and Communicate Early about Delirium



Delirium:

- increases *risk of injury, morbidity, and mortality* for the patient
- increases *risk of violence* against the care team

Delirium looks like:

- change in mental status, confusion
- sleeping much more (hypoactive)
- agitation, irritation (hyperactive)

Delirium can occur because of:

- Stress of illness, infection
- Stress of hospitalization
- Disrupted sleep-wake schedules
- Medications

PRIORITY:

SAFETY

PRIVACY

Nurses, our providers want to partner with you to treat and reduce the incidence of delirium for your patients

Delirium Assessment: The CAM

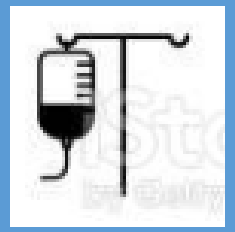
The diagnosis of delirium by the Confusion Assessment Method (CAM) requires the presence of features 1 and 2 *and* either 3 or 4.

Feature	Symptoms	Assessment
(1) Acute onset and fluctuating course	Is there evidence of an acute change in mental status from baseline? Does the abnormal behavior fluctuate (increase or decrease in severity over a 24 hour period)?	Ask a family member or someone who knows the patient well: "Is this the patient's norm or baseline?"
(2) Inattention	Does the patient have difficulty focusing attention, become easily distracted, or have difficulty keeping track of what is said?	Ask the patient to state the days of the week backward and forward, or spell the word "world" backwards. *If unable to do so correctly, meets Feature 2.*
(3) Disorganized thinking	Is the patient's thinking disorganized or incoherent, e.g., rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?	Ask the patient: ☐ Will a stone float on water? ☐ Can you use a hammer to pound a nail? ☐ Does 1 pound weigh more than 2 pounds? ☐ Are there fish in the sea? *Meets criteria if the patient answers 3 or more of the 4 questions incorrectly and is unable to follow commands.*
(4) Altered level of consciousness	Is the patient's mental status anything besides alert (hypervigilant, lethargic, stuporous or comatose)?	*If any other than alert/normal, meets criteria for Feature 4*

When to complete CAM nursing flowsheet?

- On admission
- Change of mental status
- Per provider request

Delirium Medical and Nursing Interventions



Hydration

Pain Control

Allow for rest

Re-orient

Reduce noise

Progressive Ambulation!!!

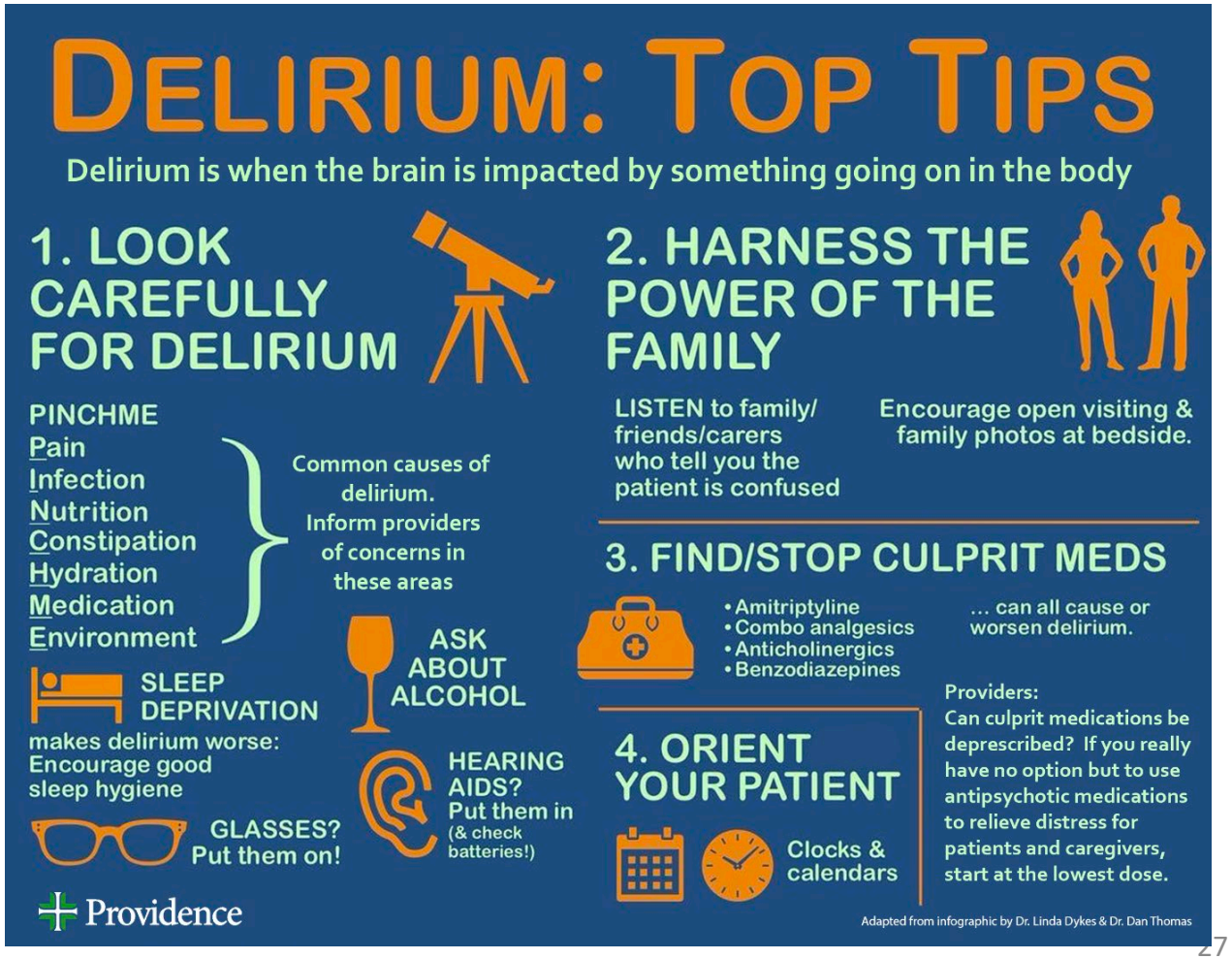
Prevention is our best treatment

Delirium Prevention-In the hospital

- The Yale Delirium Prevention Trial: 850 pt, intervention was HELP (orientation, cognitive engagement, mobilization, hydration) vs usual care
  - Reduced the incidence of Delirium by nearly **40%**
  - Similar interventions also reduced falls by 64%
  - **Importantly:**

1. Once delirium occurred the intervention had no effect on severity → prevention is the most effective strategy

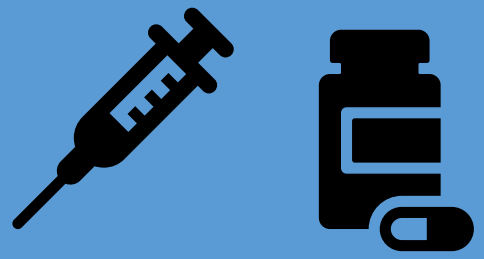
2. Intervention had no adverse effects



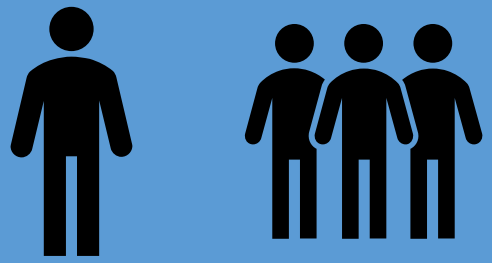
Call or page the patient's provider and document in End of Shift Summary:

- "The patient's CAM score has changed"
- "I am concerned about a change in mentation"
- "Patient showing signs of agitation" (hyperactive delirium)
- "Patient slept all day" (hypoactive delirium)
- "Patient was confused when they awoke" (early signs of delirium)

Alcohol Withdrawal



Meds for management – oral or IV?



Is the patient in the right level of care?

Evolving evidence and protocols:

- Benzodiazepine
- Phenobarbital
- Precedex

Standing/Ambulation

Most fatalities from alcohol withdrawal occur in the early stages of alcohol detox, when the body is shocked by The deprivation of alcohol. During this stage there can be many unpleasant-and even deadly-symptoms

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

PART A: THRESHOLD CRITERIA:	**("Y" or "N", no point)**
Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" blood alcohol level (BAL) on admission?	_____
IF the answer to either is YES, proceed with test:	

PART B: BASED ON PATIENT INTERVIEW:	**(1 point each)**
1. Have you been recently intoxicated/drunk within the last 30 days?	_____
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., inpatient or outpatient treatment programs or AA attendance)	_____
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?	_____
4. Have you ever experienced blackouts?	_____
5. Have you ever experienced alcohol withdrawal seizures?	_____
6. Have you ever experienced delirium tremens, or DT?	_____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates during the last 90 days?	_____
8. Have you combined alcohol with any other substance of abuse during the last 90 days?	_____

PART C: BASED ON CLINICAL EVIDENCE:	**(1 point each)**
9. Was the patient's BAL on presentation ≥ 200?	_____
10. Is there evidence of increased autonomic activity? (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea)	_____

TOTAL SCORE: _____

Notes: *Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS. A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.*

Source: Adapted **Source:** Adapted from Maldonado JR, Sher Y, Ashouri JF, et al. The "prediction of alcohol withdrawal severity scale" (PAWSS): systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol.* 2014;48(4):375-390.

CIWA Scoring (10 assessment areas)

Nausea & Vomiting- Rate on scale 0-7

0- None
1- Mild nausea, with no vomiting
2
3
4- Intermittent vomiting
5
6
7- Constant nausea and vomiting or dry heaving

Anxiety- Rate on scale 0-7

0-No anxiety, patient at ease
1-Mildly anxious
2
3
4-Moderately anxious or guarded, so anxiety is inferred
5
6
7-Equivalent to acute panic-severe delirium-acute schizophrenic reactions

Other assessment include:

Paroxysmal /Sweats- Rate on a scale 0-7
Tremors- Rate on a scale 0-7
Excitation (normal activity, fidgety, pacing, etc.)-Rate 0-7
Orientation and clouding of sensorium- Rate on a scale 0-7
Tactile disturbances (itching, hallucinations, etc.)**-** Rate 0-7
Visual disturbances(sensitivity to light, hallucinations) 0-7
Auditory disturbances (easily startled, hallucinations) 0-7
Headache (mild, moderate, severe, like band around head)

0 to 9 points: Very mild withdrawal

10 to 15 points: Mild withdrawal

16 to 20 points: Modest withdrawal

21 to 67 points: Severe withdrawal

To maintain consistency in assessment, perform CIWA-Ar scoring by using the questions embedded in the Scoring Guidelines

Severity of Alcohol Withdrawal Symptoms and Associated Syndromes

Severity of Symptoms	Alcohol Withdrawal Syndrome	Signs and Symptoms	Onset after last drink
Mild	Minor withdrawal	Tremulous Mild anxiety Headache Diaphoresis Palpitations GI symptoms	6 to 36 hours
Moderate-Severe	Seizures	May have Absent (Petit Mal) seizures or full-blown Tonic/Clonic (Grand Mal) seizures	6 to 48 hours
Moderate-Severe	Alcoholic Hallucinosis	Visual, auditory, and/or tactile hallucinations Orientation may be intact	12 to 48 hours
Severe	Delirium Tremens (DT's)	Delirium Hallucinations Disorientation Tachycardia Fever Diaphoresis	48 to 96 hours

Richmond Agitation-Sedation Scale (RASS)

- Used to assess patients when they are unable to answer the CIWA questions
- The scale runs from a +4 (Combative) to a -5 (unarouable- no response to voice or physical stimulation
- Procedure for performing a RASS assessment is as follows:
    1. Observe patient
        a. Patient is alert, restless, or agitated
    2. If not alert, state patient's name and say to open eyes and look at speaker
        b. Patient awakens with sustained eye opening and eye contact
        c. Patient awakens with eye opening and eye contact, but not sustained
        d. Patient has any movement in response to voice but no eye contact
    3. When no response to verbal stimulation, physically stimulate patient shaking shoulder and/or sternal rub
        e. Patient has any movement to physical stimulation
        f. Patient has no response to any stimulation

+4=Combative | +3=Very agitated | +2=Agitated | +1=Restless | 0= Alert & Calm | -1=Drowsy | -2=Light Sedation

-3=Moderate Sedation | -4=Deep Sedation | -5=Unarousable

Benzodiazepines

- Treats psychomotor agitation
- Prevents progression to more severe withdrawal
- Short-acting: Ativan
- Long-acting: Diazepam and Librium

Symptom-triggered Therapy:

- **Recommended for most patients**
- **Provides medication only when a patient has symptoms**
- **Used with a tool like CIWA-Ar**

Phenobarbital

- Also used for treating alcohol withdrawal symptoms
- An adjunct treatment to manage patients with refractory Delirium Tremens
- Caution when given with Benzodiazepines
- Caution on max dose
- Used with RASS scoring tool

Phenobarbital Treatment Protocol - Inpatient

The provider may order a prophylactic or *loading dose* of phenobarbital based upon their assessment.

Symptom-triggered dosing (either IV or PO) will also be ordered.

Protocol dosing is based on the patient's Ideal Body Weight (IBW), not actual body weight

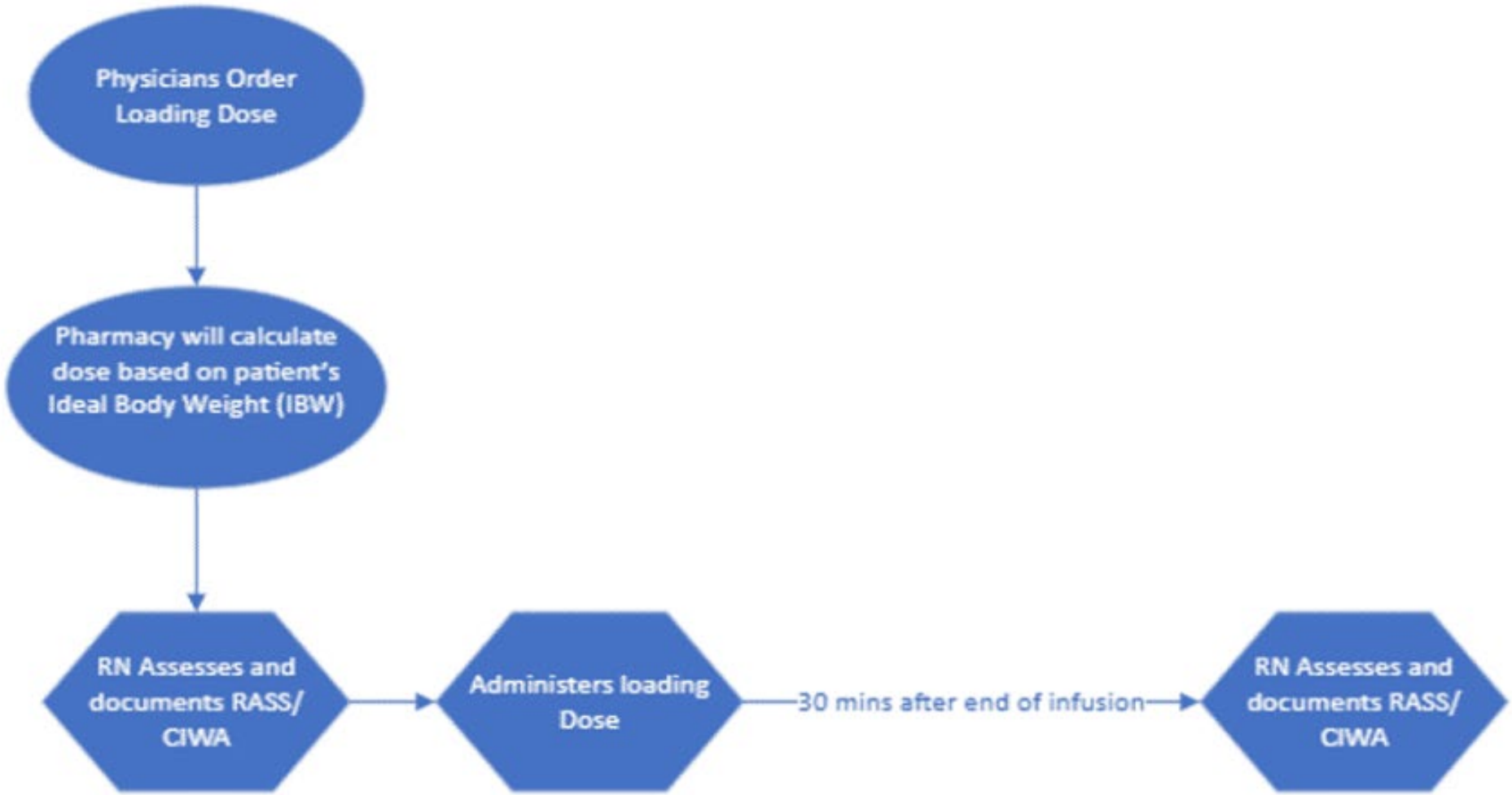
When administering phenobarbital:

- Do not use with other alcohol withdrawal orders
- Do not order any benzodiazepines concurrently
- Do not give phenobarbital if marked hepatic impairment or encephalopathy

> **Nurses should be careful to document patient's accurate height to ensure accurate calculation of IBW.**

Phenobarbital Protocol - Loading Dose

Loading dose is optional and may be given in ED or on unit of admission.



RASS & CIWA

- RASS is an assessment of sedation
- CIWA measures alcohol withdrawal symptoms
- **For consistency of treatment, it is important to use the same assessment scale for the duration of therapy**
- Both RASS & CIWA are required upon protocol initiation
- For the phenobarbital pathway, unless otherwise ordered, **RASS is recommended for ongoing assessment**

Sepsis Defined

1. **SEPSIS:**

- Life-threatening organ dysfunction due to a dysregulated host response to infection

2. **SEPTIC SHOCK:**

- A subset of sepsis marked by profound circulatory, cellular, and metabolic abnormalities
- Refractory hypotension despite adequate fluid resuscitation requiring vasoactive medications to maintain MAP > 65 mmHg and when lactate > 2 mmol/L.

Lippincott (2017); Society of Critical Care Medicine [SCCM](2021)

Sepsis Statistics

- 1 in 3 patients who die in the hospital has sepsis
- Mortality in the United States annually:
  - Sepsis 28%
  - Septic Shock 36%
- Responsible for 12% of hospital readmissions overall
- 1 of 3 Intensive Care Unit patients will experience Sepsis
- Approximately 270,000 Americans die of Sepsis annually

- CDC 2020; Bauer et al (2020)

Sepsis **#1** cause of death for hospitalized patients

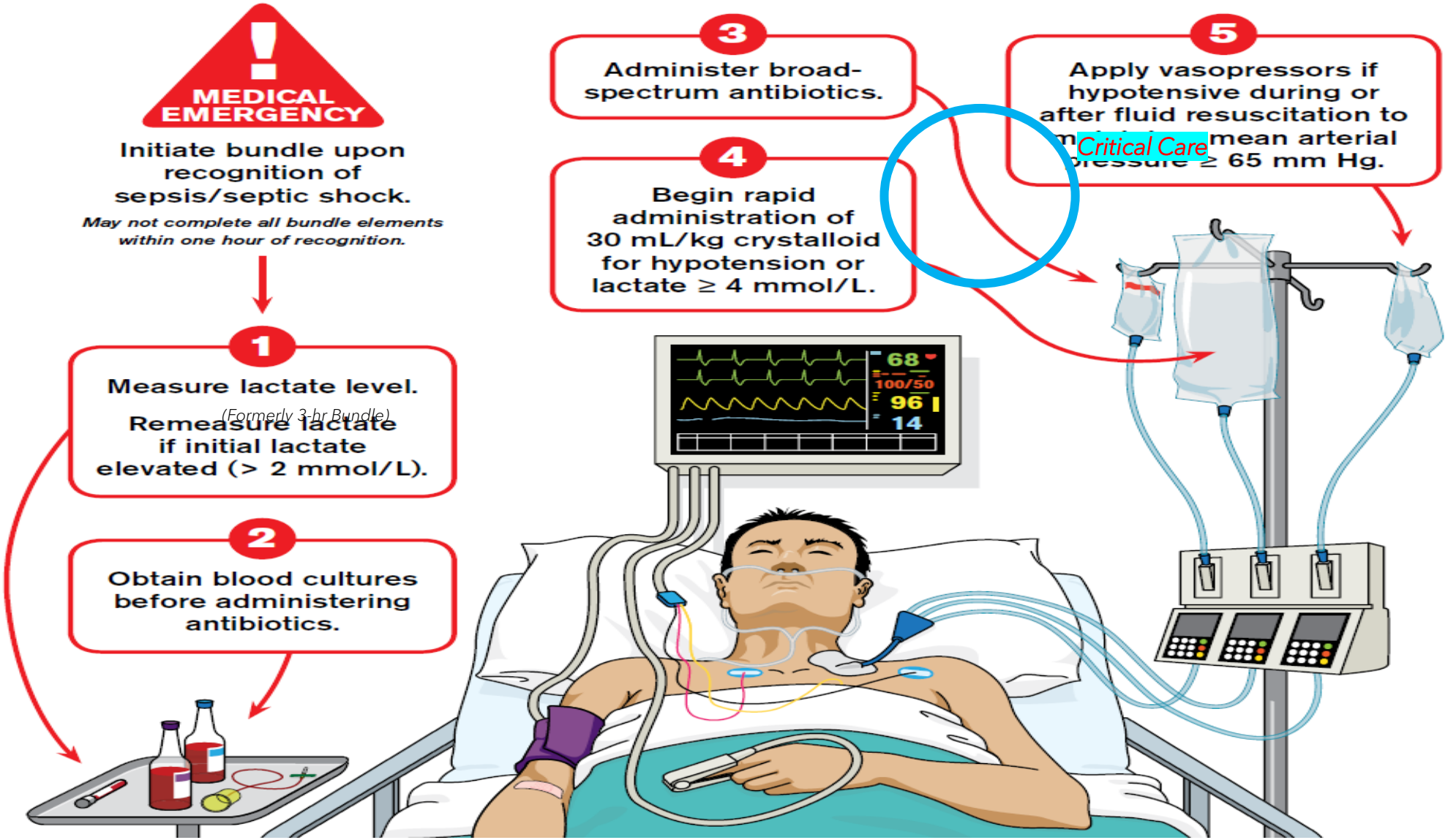
3rd leading cause of death in the US

For **every hour** the antibiotic is delayed, mortality increases by **7%**

Hour-1 Bundle

Initial Resuscitation for Sepsis and Septic Shock

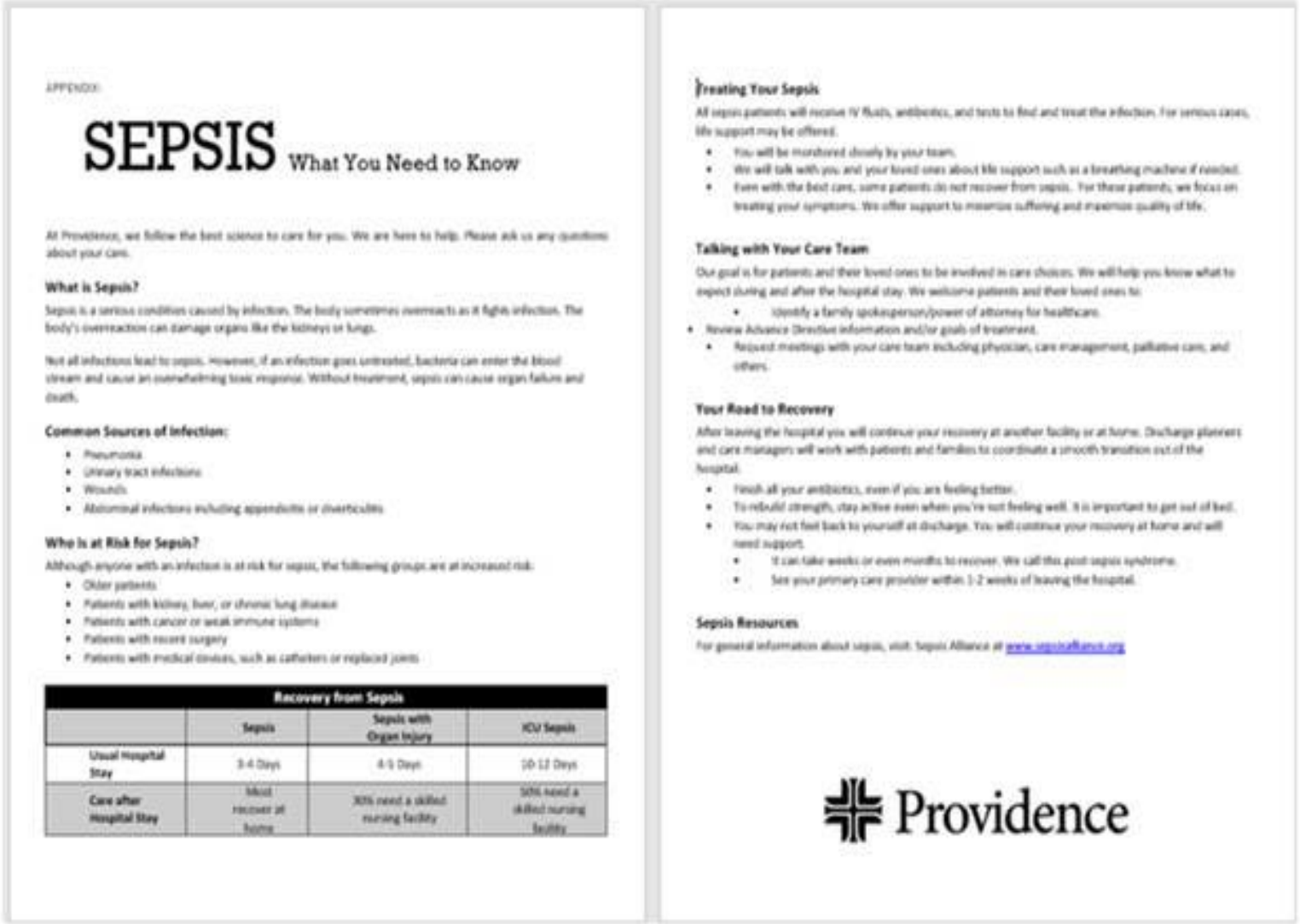
Surviving Sepsis Campaign



Patient Education in 5 Languages

Linked to Epic Sepsis Order set ~July, 2022

RN prints & teaches on Day 2



APPENDIX

SEPSIS What You Need to Know

At Providence, we follow the best science to care for you. We are here to help. Please ask us any questions about your care.

What is Sepsis?

Sepsis is a serious condition caused by infection. The body sometimes overreacts as it fights infection. The body's overreaction can damage organs like the kidneys or lungs.

Not all infections lead to sepsis. However, if an infection goes untreated, bacteria can enter the blood stream and cause an overwhelming toxic response. Without treatment, sepsis can cause organ failure and death.

Common Sources of Infection:

- Pneumonia
- Urinary tract infections
- Wounds
- Abdominal infections including appendicitis or diverticulitis

Who is at Risk for Sepsis?

Although anyone with an infection is at risk for sepsis, the following groups are at increased risk:

- Older patients
- Patients with kidney, liver, or chronic lung disease
- Patients with cancer or weak immune systems
- Patients with recent surgery
- Patients with medical devices, such as catheters or replaced joints

Recovery from Sepsis			
	Sepsis	Sepsis with Organ Injury	ICU Sepsis
Usual Hospital Stay	3-4 Days	4-5 Days	10-12 Days
Care after Hospital Stay	Most recover at home	30% need a skilled nursing facility	50% need a skilled nursing facility

Treating Your Sepsis

All sepsis patients will receive IV fluids, antibiotics, and tests to find and treat the infection. For serious cases, life support may be offered.

- You will be monitored closely by your team.
- We will talk with you and your loved ones about life support such as a breathing machine if needed.
- Even with the best care, some patients do not recover from sepsis. For these patients, we focus on treating your symptoms. We offer support to maximize suffering and maximize quality of life.

Talking with Your Care Team

Our goal is for patients and their loved ones to be involved in care choices. We will help you know what to expect during and after the hospital stay. We welcome patients and their loved ones to:

- Identify a family spokesperson/power of attorney for healthcare.
- Review Advance Directive information and/or goals of treatment.
- Request meetings with your care team including physician, care management, palliative care, and others.

Your Road to Recovery

After leaving the hospital you will continue your recovery at another facility or at home. Discharge planners and care managers will work with patients and families to coordinate a smooth transition out of the hospital.

- Finish all your antibiotics, even if you are feeling better.
- To rebuild strength, stay active even when you're not feeling well. It is important to get out of bed.
- You may not feel back to yourself at discharge. You will continue your recovery at home and will need support.
  - It can take weeks or even months to recover. We call this post sepsis syndrome.
  - See your primary care provider within 1-2 weeks of leaving the hospital.

Sepsis Resources

For general information about sepsis, visit: Sepsis Alliance at www.sepsisalliance.org

Providence

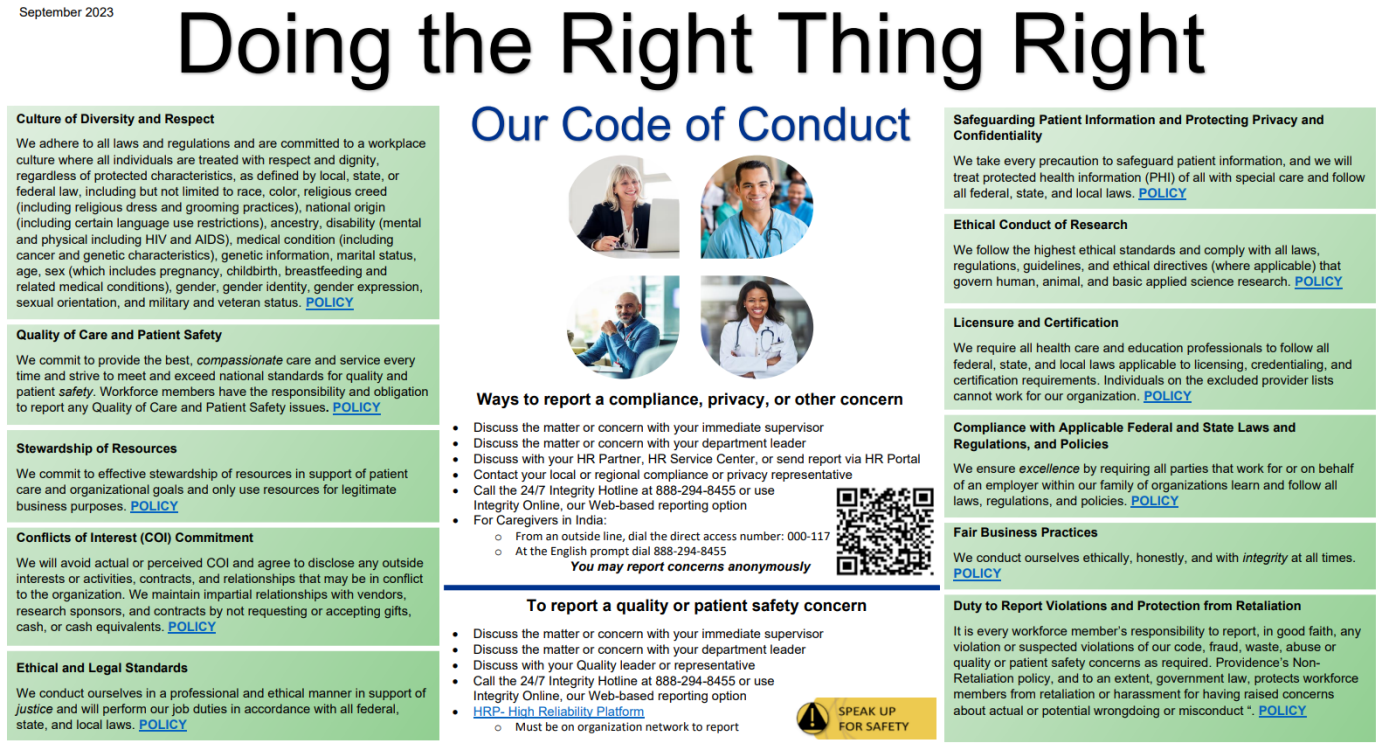
Patient Experience- Privacy & Security

Data privacy and security is an essential component of providing high quality patient care. The following document will outline the policies, processes, and strategies that will support you in keeping data private and secure as a member of the Providence care team.

Compliance Program

The US Department of Health and Human Services Office of the Inspector General (OIG) requires all workforce members to participate in compliance education upon hire and annually. Within Providence, the Compliance Program is part of the division of Risk and Integrity Services (RIS). The purpose of the Compliance Program is to recognize and prevent regulatory risk and in doing so protect our organization, workforce members, patients, and the community.

Compliance Program Functions:
Code of Conduct



Conflicts of Interest (COI)

A COI is a situation where a workforce member may stand to gain from their position within Providence in a way that harms our organization. These gains may include financial compensation, gifts, or use of resources to benefit your own personal interests. The COI program within Providence provides support and monitoring for workforce members who may have a COI or need assistance in navigating a COI. Any workforce member with a conflict of interest must provide a Conflict-of-Interest Disclosure.

COI: Gifts and Entertainment from the Organization

- Gifts given and paid for by the organization that are over $75 are taxable
- Cash or gift cards/certificates of any value are taxable if paid for by the organization.
- Gifts over $75, cash gifts, or gift cards/certificates of any value paid for by the organization must be reported to Payroll.

COI: Gifts and Entertainment from Patients, their families, vendors, or providers

Acceptable gifts:

- Modest, perishable, and infrequent gifts of food or flowers that can be shared among the department.
- Notes, Holiday cards or Thank You cards

If you are uncertain about any potential conflict of interest you might be experiencing you can reach out to your supervisor, the compliance team, or the Integrity Hotline (888-294-8455) to receive guidance and support.

Exclusion Screening Program

Per the Social Security Act, government offices can exclude (remove) and individual or vendor for a certain amount of time based on the following reasons:

- Suspended or revoked license
- Criminal activity
- Conviction due to patient abuse
- Health care fraud
- Default on federal loans or support payments

Excluded individuals or entities are placed on an exclusion list maintained by the federal government. Partnering or hiring with an individual or entity on an exclusion list may result in penalties and possible suspension from participation in government health care programs.

Compliance Related Healthcare Laws	
Physician Referrals (Stark Law)	Prohibits physicians from referring patients to agencies they have a financial relationship with except under specific circumstances.
False Claims Act (FCA)	Prohibits ***knowingly*** submitting false or fraudulent claims for payment.
Anti-Kickback Statute (AKS)	Prohibits providing a reward or inducement for patient referrals.
Fraud, Waste, and Abuser (FWA) Prevention	Prohibits the over-utilization of services or other practices that result in unnecessary costs. *Fraud: intentional deception or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.* *Waste: the unnecessary use or consumption of financial or medical resources.* *Abuse: a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.*
Emergency Medical Treatment and Labor Act (EMTALA)	Ensures equal access to emergency services for everyone. EMTALA requires Medicare-participating hospitals such as Providence with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner, regardless of their ability to pay, insurance status, national origin, race, creed, or color.

Privacy Program

The Privacy Program's main function is to protect our patient's protected health information (PHI). All workforce members have a responsibility to protect and maintain our patient's privacy.

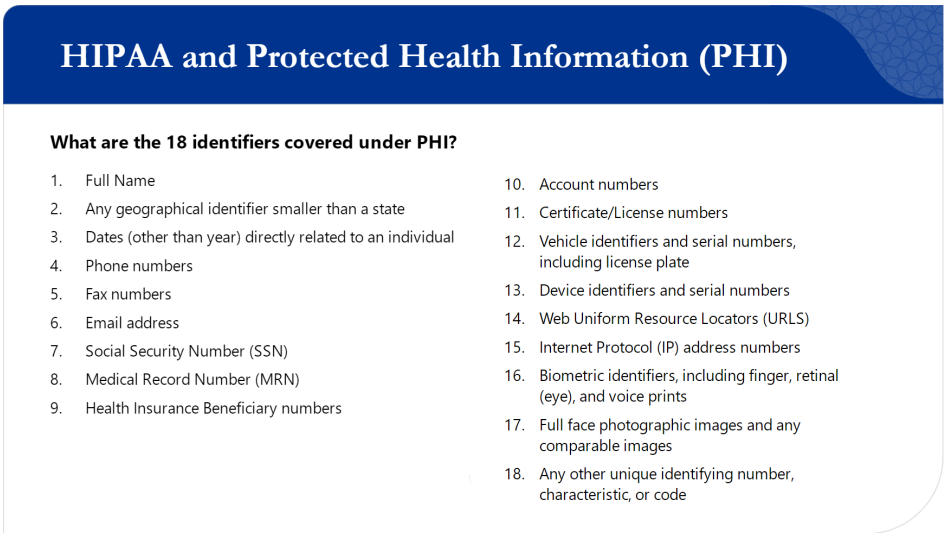
Privacy Related Healthcare Laws	
Healthcare Insurance Portability and Accountability Act (HIPPA)	• Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs. • Reduces health care fraud and abuse. • Mandates industry-wide standards for health care information on electronic billing and other processes • Requires the protection and confidential handling of protected health information.
Health Information Technology for Economic and Clinical Health Act (HITECH)	Promotes the adoption and meaningful use of health information technology as well as strengthening privacy and security protections.

Protected Health Information

PHI is information created or received by a healthcare provider, health plan, or healthcare clearing house and relates to the past, present, or future physical or mental condition of an individual or past, present, or future payment for treatment and care to an individual. Providence's PHI policy states that workforce members may only access, use, or disclose the **minimum necessary** PHI to complete a work-related task. This includes:

- Not accessing a patient's medical record if you are not a part of the patient's care team
- Not accessing your own medical record.

To ensure compliance with PHI laws and policy and in the event of potential concern regarding a breach of PHI protocol, Providence has a proactive privacy monitoring program that provides a review and audit of any workforce member's access to our electronic health record (EHR). Privacy violations may result in disciplinary action including termination of employment and civil and/or criminal penalties/fines against the individual workforce member.



PHI and Law Enforcement

Any caregiver who is approached by law enforcement with a request for patient information (including a subpoena or warrant for medical records) must *immediately notify their supervisor, a department/unit*

core leader, or Admin on Call (AOC). These leaders will ensure that the request for information is handled appropriately through our organization's procedure.

Requirements for disclosure of patient information to law enforcement:

- A written authorization by the patient
- A valid court order
- A valid search warrant

IMPORTANT: Only individual specifically trained in Government requests (i.e.: a supervisor, a department/unit core leader, or Admin on Call) may release PHI to law enforcement per policy.

PHI and Media Requests

Unless it is your job to do so as a Providence workforce member, do not speak to the media regarding business or patient information. Politely decline comments and immediately notify your supervisor.

PHI and Social Media

Any caregiver who shares PHI on social media is subject to disciplinary action.

Information Security Program

The Providence Information Security Program serves to protect Providence information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide confidentiality, integrity, and availability.

Information Security and Personal Devices

- Personal device use must comply with all security policies (password protected, update Operating System (OS) patches, anti-virus, etc.) and the Use of Personal Device HR policy.
- Personal devices that contain Providence applications, programs, and apps are not to be used by or shared with anyone else.
- Only use approved Providence licensed applications, programs, and apps to conduct Providence business, even on your personal devices
    - Never use non-Providence licensed software, this includes free online applications as well as cloud storage.
- Any attempt to circumvent Providence security controls on non-compliance with policies can result in disciplinary action up to and including termination of employment.

Information Security Best Practices

- Keep all work passwords private and secure. Do not share your password with anyone, ever!
    - Providence will **never** ask you for your password, even if you are trying to reset it.
- Lock or log off your computer when you walk away.
- Use #secure# in your subject line when sending confidential information outside of the organization
    - Do not send confidential information to a personal (non-business) email address.
- A vehicle is not considered a secure location and should not be used to store confidential information, mobile computing, or storage devices.
- Texting is not secure. If you must text in an emergency, only provide the minimum necessary PHI
- Always use shredder bins to dispose of confidential information.
- To avoid phishing schemes, do not click on suspicious links or download attachments from unfamiliar senders, especially from external email addresses.

Information Security and Reporting Concerns

Contact the IS Service Desk (844) 922-7548 immediately if you have:

- Lost or had your organization device stolen
- Lost or had your personal device stolen *and it contains Providence information / applications on it*
- Clicked on a phishing link or otherwise responded to a scam

Physical Security

The following are actions you can take to ensure that Providence facilities are secure and workforce members and patients are safe:

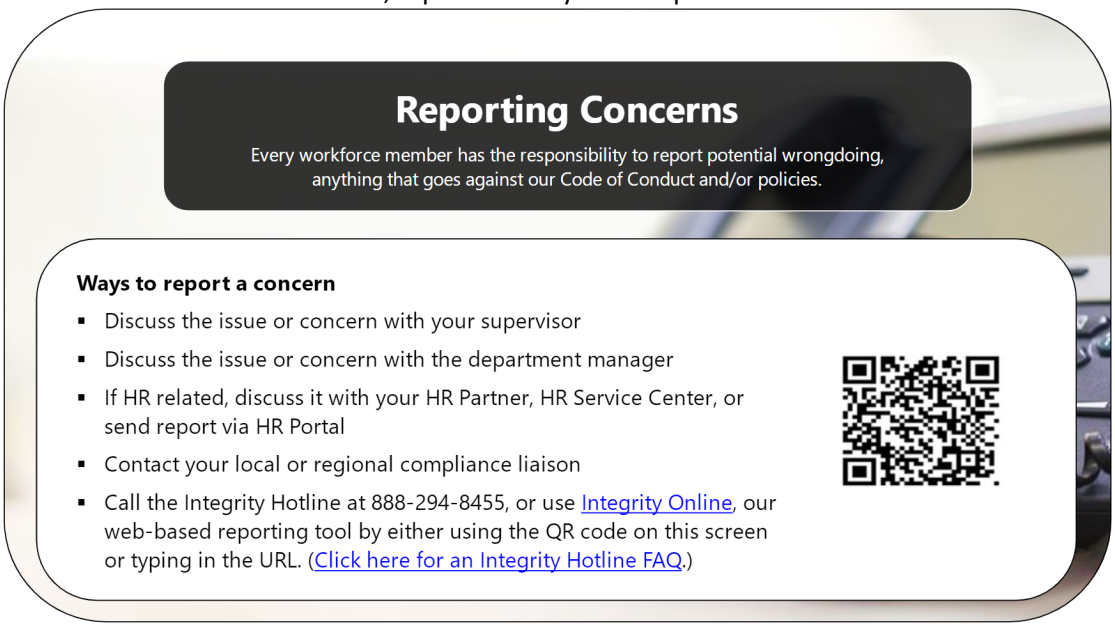
- Always wear our badge on Providence property
- Prevent unauthorized individuals from entering confidential areas within the ministry/facility.
- Do not loan out your keys or access cards; if they are lost or stolen, report it immediately to your local security personnel office.
- Confidential information in hardcopy for must be kept in a locked cabinet/office when left unattended and should be shredded before disposal or placed in a designated shredding bins provided by the local facility.

IMPORTANT: IF you see something, say something. If you observe something that does not look, feel, or seem right, it probably isn't. REPORT IT to your locally physical security department or to the Integrity Hotline (888-294-8455).

Reporting Concerns

Every workforce member has the responsibility to report potential wrongdoing, anything that goes against our Code of Conduct and/or policies.

- Reports can be made anonymously.
- Providence's Non-Retaliation policy and the federal Whistleblower law protect workforce members from harassment or other hostile actions for reporting potential wrongdoing *in good faith*.
- If you feel like someone, including a supervisor or above, is retaliating against you for reporting a concern, report this to your compliance team.



Please review the following policy when you are on campus:
Policy: Code of Conduct
Compliance Policies:

- PSJH-RIS-700 Compliance Program Policy
- PSJH-RIS-711 Fraud, Waste, and Abuse Prevention
- PSJH-RIS-715 Record Retention and Destruction
- PSJH-RIS-722 Code of Conduct Policy
- PSJH-RIS-724 Conflict of Interest in Research
- PSJH-RIS-730 Use of Compliance and Related Titles by Employed Caregivers
- PSJH-RIS-731 Creation of Organization-Wide Policies
- PSJH-RIS-732 Anti-Corruption Compliance Policy
- PSJH-RIS-733 Non-Retaliation
- Policy: PSJH-GOV-208 Conflict of Interest Policy

Policy: Right to Support Persons with Disabilities
Policy: EMTALA
Policy: Reporting Fraud, Waste &Abuse
Policy: PSJH-RIS-850 General Privacy Policy
Policy: PSJH-EIS-950 Information Security Management

Patient Advocacy

Patient Rights

The Patient Rights and Responsibility document affirms Providence's commitment to equity as aligned with Providence's Mission, Vision, and Values.

The Patient Rights and Responsibilities document is provided in the following pages.

Abuse and Neglect

As caregivers and patient advocates, it is important to recognize the many forms of abuse or neglect that a patient may be experiencing.

Physical	• Bruises or abrasions • Broken or fractured bones • Burns or scalds • Bite marks • Sexual abuse
Neglect	Failure of a caretaker to provide the goods and services or care necessary to maintain the health or safety of a vulnerable child or adult. Examples of neglect include: • Abandonment • Imprisonment in the home • Failure to feed a dependent person • Conduct that endangers the person's physical or psychological well-being • Leaving a person sitting or lying in urine or stool
Psychological/Emotional	Verbal harassment, threats, criticism, and isolating behaviors are a form of psychological abuse. Examples include: • Verbal abuse • Threats of physical harm • Cultural shaming • Racial slurs • Threats of abandonment • Social isolation
Financial/Economic	Improper, unauthorized removal of a person's money, property, or possessions. Examples include: • Cleaning out bank accounts • Selling off possessions • Improper use of Power of Attorney or guardianship • Forcing a vulnerable adult to work against his/her wishes
Domestic Violence	A pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks. Economic coercion that adults or adolescents use against their intimate partners is another example. Indicators include: • Overly attentive partner • Delay in seeking medical care • Multiple cuts, scrapes and/or bruises in various stages of healing • Inconsistent description of how injuries occurred • Emergent presentation for medically insignificant trauma

Human Trafficking	Human trafficking is the recruitment, transportation, harboring, or receipt of persons for the purpose of exploitation. Examples include: • Prostitution • Sexual exploitation • Forced labor • Slavery

All caregivers are required to report cases of known or suspected abuse of vulnerable adults and children. In addition to the mandatory requirement to report to the appropriate protective agency, thec aregiver will report to their supervisor or to a nurse supervisor.

Reporting Protocol for Suspicion of Abuse

- Notify person in charge
- Call clinical social worker. If a social worker is unavailable, work with your Core Leader, Charge Nurse, House Supervisor, and Provider to follow the next steps
- Complete report for Adult Protective Services or Child Protective Services

Treating a Victim

When treating a victim of abuse or suspected abuse, including human trafficking, it is important to create an environment where they can feel safe. Have visitors wait in waiting areas, use a calm voice, ask questions without placing blame or judgment, and reassure them that help is available.

Domestic Violence/Partner Abuse

If you believe the patient is a vulnerable adult, please contact a social service clinician, charge nurse or house supervisor to discuss the reporting process. In the Ambulatory environment,
please contact the patient's care provider and clinic manager.

- Interview in private
- Express concern for safety and well being
- Report as appropriate for vulnerable patients (those who do not have decision making capacity and patients under the age of 18 years)
- If a report of harm is made due to the patient’s vulnerability, please discuss with social work/house supervisor and ensure a discussion is had with the patient about the report
- Address patient safety in the discharge plan. This may include letting them know about appropriate community resources from which they could benefit
- Refer to your local policy for specific reporting requirements.

Consent and Refusal of Consent for Procedures

In keeping with the mission and values of Providence Health and Services proceduralists have a professional obligation to obtain permission that is a patient's consent, to administer medically appropriate clinical interventions. Absent an emergency, capable patients, or the appropriate decision-maker, may give, refuse, or withdraw informed consent both to the treating provider (proceduralist) and to the medical center prior to undergoing any treatment, test or procedure for which specific consent is required.

Every competent person has the fundamental right to self-determination over his/her person and property. Individuals who are not competent or incapable of participating in decision-making have the right to be represented by another person who will carry out the individual's known desires and act in their best interest.

Ages of Consent

(ORS 109.610 – 109.695, 433.001 – 433.085, 418.307)

TREATMENT	CONSENT AGE	MAY YOU TELL PARENTS?*	STATUTE	MUST THE PARENTS PAY?
Hospital Care, Medical or Surgical Diagnosis or Treatment by a Physician, physician assistant, nurse practitioner, naturopathic physician, dentist or optometrist ORS 109.640	15	Yes Permitted	ORS 109.650	Statute is silent, so common law kicks in. Parents are liable if the care is necessary.
Outpatient Diagnosis/Treatment for Mental/Emotional Disorder or Chemical Dependency (excluding Methadone Treatment) ORS 109.675	14	Permitted	ORS 109.675	No (ORS 109.690)
		Permitted (inpatient)	ORS 109.680	
Reproductive Health Information and Services ORS 109.675	Any age	Permitted	ORS 109.650	Statute is silent, so common law applies. Parents are liable if the care is necessary.

Sexually Transmitted Infection (Hospital, Medical or Surgical Care, related to Diagnosis or Treatment) ORS 109.610	Any age	The statute is silent	The statute is silent	No (Unless treatment was with parental consent)
HIV Testing ORS 433.045(5)	Any age	No	ORS 433.045(3)	No (Unless the treatment was with parental consent)

* While the law may permit disclosure to parents, caregivers should carefully consider several factors before disclosing sensitive PHI including but not limited to the nature of the information, the patient's preferences regarding disclosure, the potential impact of involuntary disclosure, and other circumstantial details (e.g., if there are concerns about abuse). Cf. "Minor Rights: Access and Consent to Health Care: A resource for providers, parents and educators" by the Oregon Health Authority.

Safe Surrender

A. Any caregiver of Providence Health & Services will accept a newborn at the hospital and medical facility, clinics, or physician's office.

1. The person relinquishing the newborn is not required to provide any identifying information about the newborn or the parents. The caregiver receiving the newborn will ask if the parent is willing to volunteer important medical information for the baby's history and care. The person surrendering the newborn may voluntarily give information.
2. Do not try to identify the person (parent) surrendering the newborn.
3. Perform all reasonable acts to ensure the health and safety of the child including the following:
   a. Check infant for any visible signs of abuse.
   b. Estimate if the infant is 30 days old or younger.
4. If the baby shows signs of abuse or appears much older than 30 days old, call the police and your local Child Welfare Office.
5. If the baby seems to be a newborn and there are no signs of abuse, proceed with the following steps:
   a. Give the parent the Letter for Parents, and
   b. Phone numbers for Child Welfare Offices.

6. Ask if the parent would fill out a voluntary health questionnaire about the infant. The parent can take the questionnaire with them and fill it out and mail it later. (Give the parent a self-addressed stamped envelope).
7. All forms can be found at http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/SafeSurrender/Pages/facility.aspx

Advance Directives

Health care decision-making is based on a collaborative relationship between the patient and health care professionals who are primarily responsible for the patient's care. Discussion with the patient or decision-maker is essential in determining the course of treatment in given circumstances. The patient may choose to delegate his/her decision-making authority. Formal advance directives are documents written in advance of serious illness, which indicates a competent adult's preferences for health care, and/or designate a person to make those choices should the patient become unable to make decisions. Along with the clinical condition of the patient and what is medically appropriate, these preferences should direct the care provided to the patient.

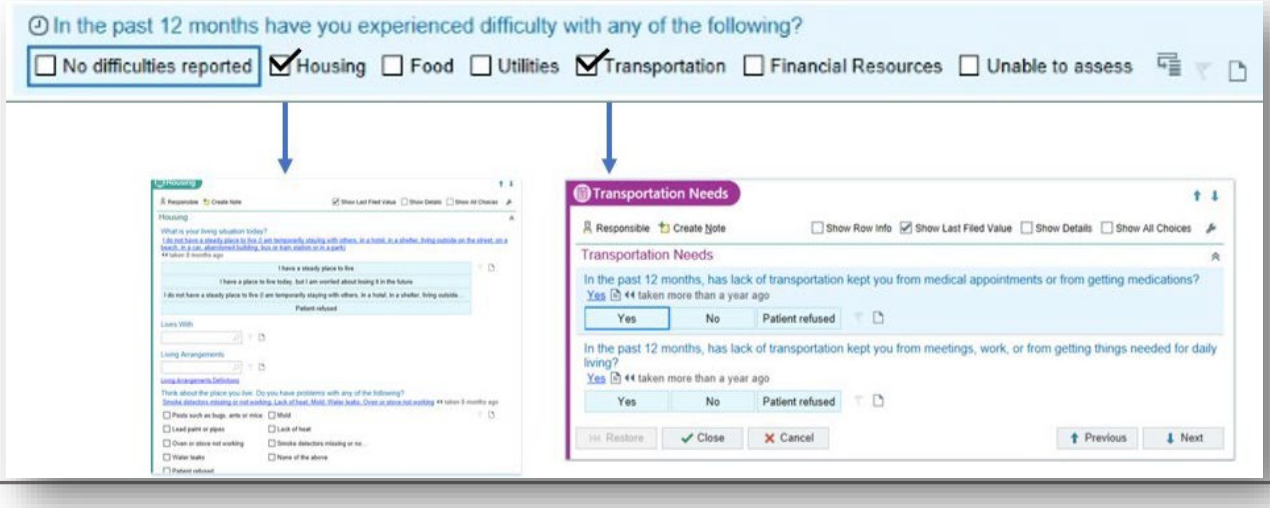
Consistent with the Catholic tradition of its Sponsors, Providence Health & Services recognizes the right of patients to be the primary decision-makers for their own health care, and recognizes its duty to honor such decisions as long as those decisions do not conflict with the Catholic moral and social teachings, as stated in such places as the Ethical and Religious Directives for Catholic Health Care Services, and the policies of Providence St. Joseph Health (PSJH). If it is confirmed that a treatment preference in an advance directive conflicts with the Catholic identity of Providence, the care of the patient will be transferred to a setting where such decisions can be honored.

For those with advance directives, copies of these documents will become part of their medical record. In the event of loss of decision-making capacity, every reasonable effort will be made to honor such written information regarding health care decision-making.

See the policy listed below for additional information on the responsibility of the nurse.

Social Determinants of Health

Nurses are required to screen for social determinants of health upon patient admission. Plans of care during the patient's stay and the plan for safe discharge are informed by knowledge gained from the social determinants of health screening.



Interpreter Services

Unless already approved during their pre-boarding process by your Agency management company as an accredited medical interpreter in another language, agency workers who are multilingual are not eligible to take the medical proficiency assessment and therefore *may not translate medical information* for patients. Additional information is provided in the following pages.

Always use approved interpreter services as directed by our policies (listed below).

Service Animals

Providence Health & Services – Oregon reserves the right to make a reasonable determination as to the necessity of all animals (personal/service), in accordance with Title III of the Americans with Disabilities Act (ADA), within the facility and the safety of allowing such animals into various areas of the facility.

1. Service Animals, as defined by the Americans with Disabilities Act (ADA), are permitted to accompany people with disabilities in all areas where members of the public are normally allowed to go unless the animal's presence or behavior creates a fundamental alteration in the nature of the facility's services in a particular area or a direct threat to the other persons in a particular area.

2. Based upon the Center for Disease Control (CDC) guidelines, service animals should not be excluded from areas within a facility, "…unless an individual patient's situation or a particular animal poses greater risk that cannot be mitigated through reasonable measures. If health-care personnel, visitors, and patients are permitted to enter the care areas (e.g., inpatient rooms, some ICUs, and public areas) without taking additional precautions to prevent transmission of infectious agency (e.g., donning gloves, gowns, or masks), a clean, healthy, well-behaved service animal should be allowed access with its handler. Similarly, if immunocompromised patients are able to receive visitors without using protective garments or equipment, an exclusion of service animals from this area would not be justified."

Additional information is provided in the following pages.

See policy listed below for more information about areas where restrictions on service animals may be appropriate. Collaborate with a Providence nurse leader for assistance.

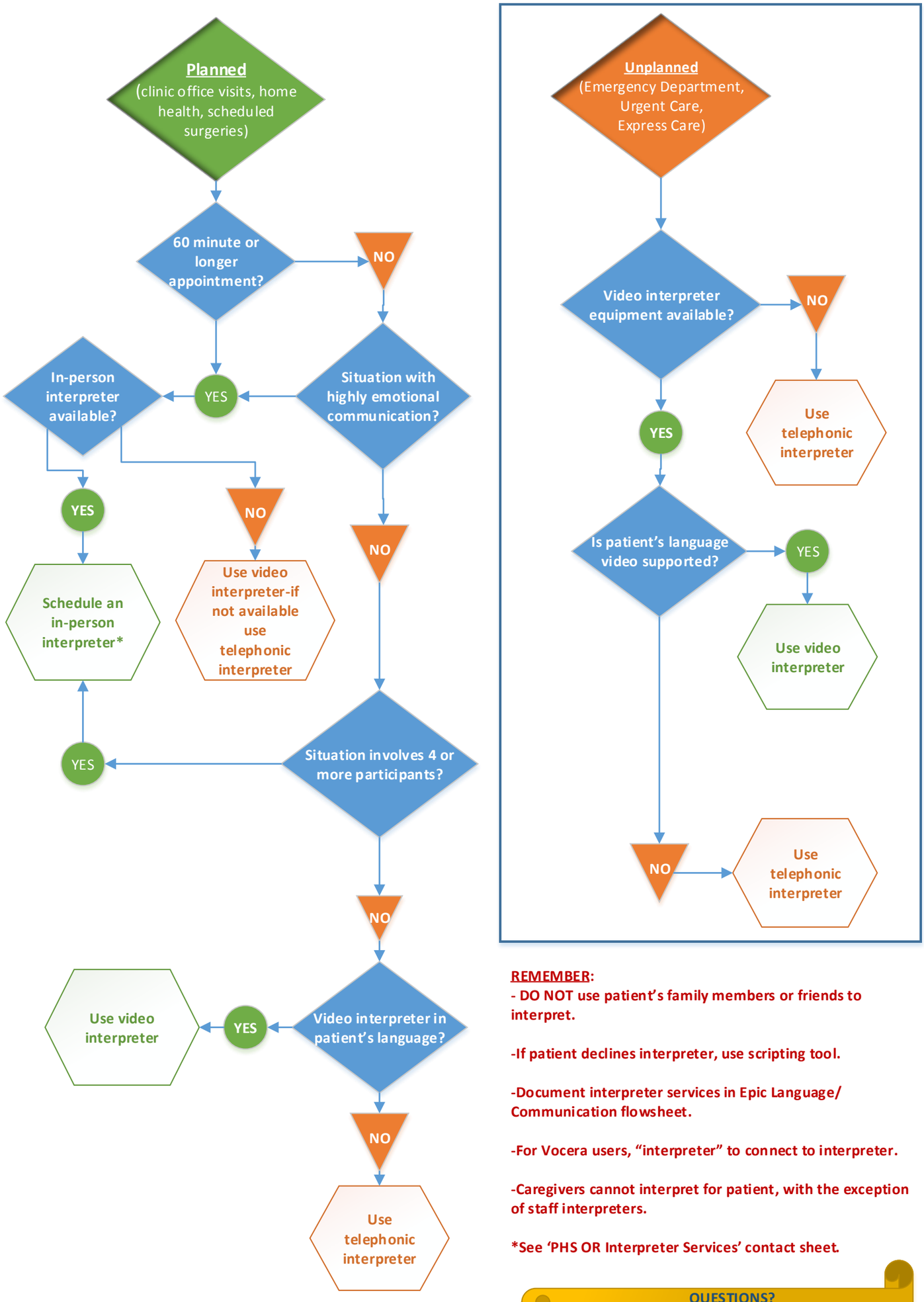
Please review the following policy when you are on campus:

- Policy: System-wide Patient Rights and Responsibilities Policy
- Policy: Safe Surrender of Newborn
- Policy: Abuse Identification and Intervention
- Policy: Interpreter Services for Patients- Spoken Language Interpreter Services
- Policy: Interpreter Services for Patients who are Deaf, Deafblind, or Heard of Hearing
  Policy: Document Translation GOP
- Policy: Animals in Medical Facilities
- Policy: PSJH-EIS-950 Information Security Management
- Policy: Advanced Directives

SPOKEN LANGUAGE Interpreter Selection Decision Tree

PROVIDENCE Health & Services

Should I use an In-Person, Video or Telephonic Interpreter?



REMEMBER:

- DO NOT use patient's family members or friends to interpret.

-If patient declines interpreter, use scripting tool.

-Document interpreter services in Epic Language/ Communication flowsheet.

-For Vocera users, "interpreter" to connect to interpreter.

-Caregivers cannot interpret for patient, with the exception of staff interpreters.

*See 'PHS OR Interpreter Services' contact sheet.

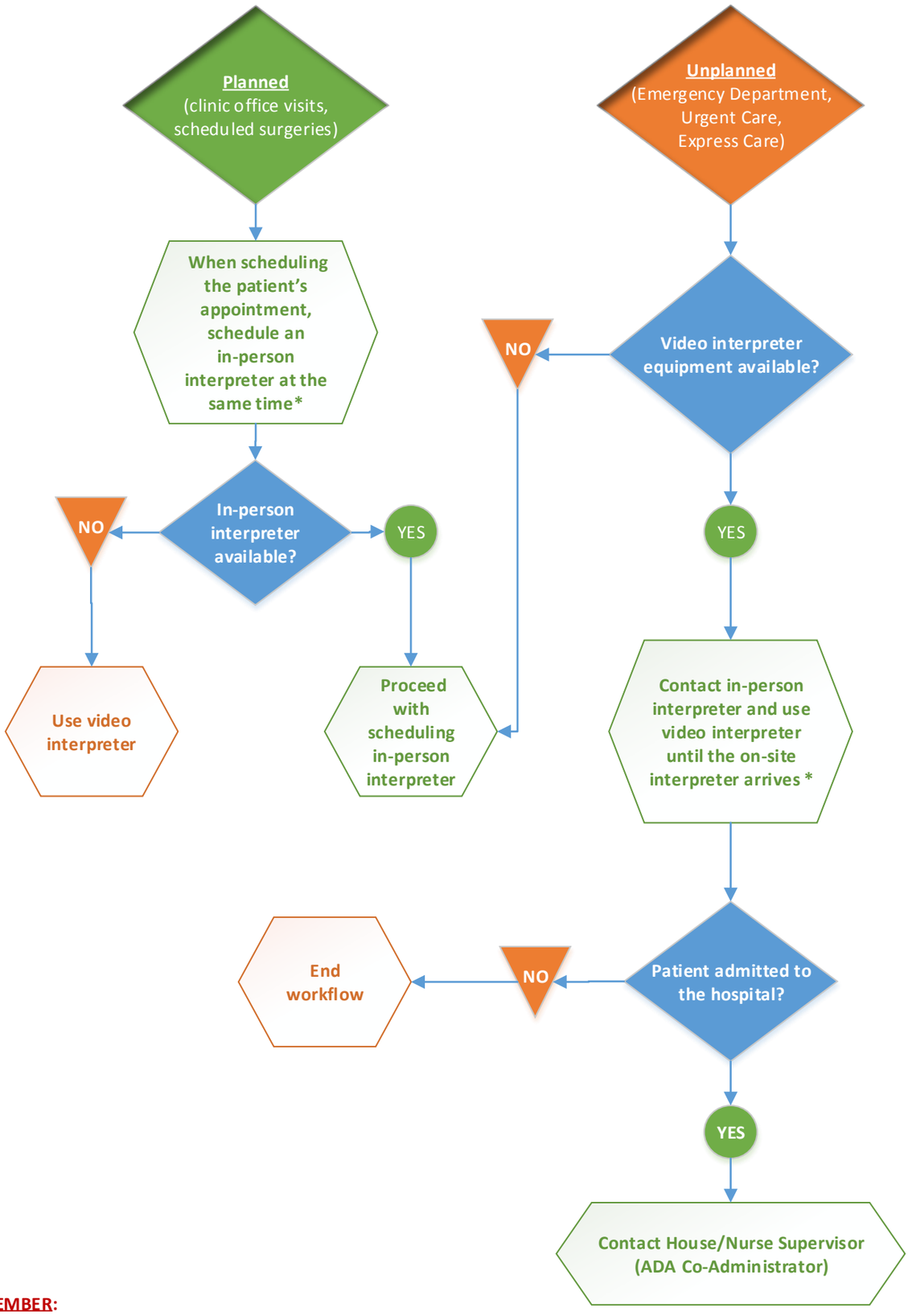
QUESTIONS?
Call 503-215-2147 or e-mail:
ORREG.InterpreterServices@providence.org

This document replaces INDEMAND Decision Tree
v.2 Oct 30, 2019

SIGN LANGUAGE Interpreter Selection Decision Tree

PROVIDENCE Health & Services

Should I use an In-Person or Video Interpreter?



REMEMBER:

- DO NOT use patient's family members or friends to interpret.

-If patient declines interpreter, use scripting tool.

-Document interpreter services in Epic Language/Communication flowsheet.

-If a Vocera user, say "sign language" to schedule an in-person interpreter.

-Caregivers cannot interpret for patient, with the exception of staff interpreters.

*See 'PHS OR Interpreter Services' contact sheet.

QUESTIONS?
Call 503-215-2147 or e-mail:
ORREG.InterpreterServices@providence.org

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v.2 Oct 30, 2019

Providence Oregon Interpreter Services

ACUTE CARE/INPATIENT

	CYRACOM Preferred		LINGUAVA Second choice		NIS National Interpreting Service, Inc.
In-Person **SIGN LANUGUAGE ONLY**	N/A		N/A		(503) 932-8460 -or- **VOCERA COMMAND "SIGN LANGUAGE"**
TELEPHONIC **Spoken Language**	PSVMC	(833) 368-7252	PSVMC	(888) 661-1375	N/A
	PWFMC	(833) 368-7256	PWFMC	(888) 661-1324	
	PMH	(833) 368-7257	PMH	(888) 661-1440	
	PPMC	(833) 719-6824	PPMC	(888) 661-1430	
	PMMC	(833) 368-7254	PMMC	(888) 661-1404	
	PNMC	(833) 368-7253	PNMC	(888) 661-1368	
	PHRMC	(833) 368-5219	PHRMC	(888) 661-1388	
	PSH	(833) 368-5217	PSH	(888) 661-1420	
	-or- **VOCERA COMMAND "CALL INTERPRETER"**				
IN-PERSON **Spoken Language**	N/A		(503) 265-8515; Opt #1 -OR- For online scheduling access, please email: ORReg.InterpreterServices@providence.org		N/A
Document Translations	Please email all requests for written document translations to: Oregon.Translations@Providence.org				

For questions or issues with interpreter services, please email Language Access/Interpreter Services at ORReg.InterpreterServices@Providence.org

Patient Refusal of Interpreter Services – Scripting Tool

In the event a patient refuses interpreter services for any reason, Providence caregivers still have an obligation to ensure that effective communication is taking place, which includes any/all caregivers understanding the patients as well as any conversations between a patient and their family members who may be involved with the patients' care.

There are occasions when a patient may refuse interpreter services; the reasons for this may vary. There may be specific cultural practices/considerations; the patient may be concerned about their privacy and sharing medical information with a stranger or possibly someone they know from the community; the patient may prefer to have a friend or family member interpret; a patient may have concerns about the cost of interpreter services, etc.

In these instances, caregivers should advise patients of the following:

1. Assure patients that interpreters keep patient information private and confidential
    a. If a patient is concerned about the in-person interpreter being of the opposite gender, we can offer telephonic interpreter services
    b. InDemand units also have a "privacy screen" which allows the patient and the interpreter to hear one another without them seeing one another on the screen
2. Assure patients that interpreter services are offered by Providence at no charge to the patient
3. If a patient insists on using a family or friend to interpret, caregivers should use the following statement:

    "We understand that having your [son, daughter, friend, etc.] interpret for you makes you more comfortable. While your [son, daughter, friend, etc.] is interpreting for you, we will use an interpreter for the [doctor, nurse, etc.]."

    Here's one of our safety stories to highlight the importance of using an interpreter for clinical communication

Safety Story
Interpreter for Safety.

A Somali speaking patient arrive with her son-in-law for a CT scan. The patient and her son-in-law were consistent is stating he was the one providing primary interpreting services for her and that is what they always do at doctor's appointments, and they did not want/need an interpreter service.

The patient had an obvious change in her condition after her CT scan. The patient's caregivers felt that there was communication that was not being relayed appropriately and immediately got the Video-on-Demand interpreter. Through this interpreter, it was realized that the patient was having active chest pain and shortness of breath and was transported to the emergency room.

The caregivers explained to the son-in-law that his interpreting services were valued and appreciated, yet they needed to ensure her best safety by using a medical interpreter to ask medically-driven and critical questions. The patient and her son-in-law were understanding and appreciative of the team's efforts.

This story highlights the caregiver's use of the Validate and Verify tool. While having a questioning attitude, the caregivers utilized the proper communication channels to gain the help of a medical interpreter. This validated the caregiver's concerns and verified that the patient was indeed in distress.

Bilingual Proficiency: Frequently Asked Questions

1. How do I get certified to use my language skills at Providence?

We prefer to use the word **proficient** instead of certified. We don't want to confuse anyone with interpreter certification. Oregon and Washington have their own programs to certify interpreters. (See question #3.) To be identified as proficient, fill out an application form on the program's intranet page, **Interpreter & Language Services**. We review your language skills and experience through an application process and refer you to testing if needed. Depending on the outcome, we can give you approval to use your skills. This designation protects you and Providence in case of a Joint Commission audit. This test is not required for social conversation or to obtain patient demographics.

2. Who can apply to take the bilingual proficiency test?

Clinicians (i.e., medical doctors, doctors of osteopathic medicine, registered nurses, physician assistances, nurse practitioners) are eligible to apply for and take the test. If you have eligibility questions based on your role, contact Jennifer Alvarez, ADA/Linguistics Services Program Manager, using the contact information provided at the end of this document.

3. Do I have to test if I am a native speaker?

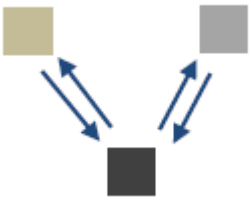
Please know we mean no disrespect to native speakers. Our goal is to have documentation of your skills on record in case of an audit. Please turn in an application to determine if testing is needed. In most cases, native speakers have not needed to test, but there have been a few exceptions. The more details you provide on your application, the better idea we have of your skills and experience.

4. I passed Providence's bilingual proficiency process. Does this mean that I can interpret?

No, you may not interpret. Passing means you are identified as a bilingual proficient clinician and are approved to use your language skills to speak directly to patients in the performance of your job duties only. It does not mean you may interpret for a staff person who needs to ask medical questions of a patient. Oregon and Washington have established programs and laws for interpreters to get certified through the state. We realize the role of a bilingual proficient clinician and an interpreter seems the same, but we separate them into two different roles at Providence.

Bilingual Proficient Clinician:
Just you and the patient talking.

Interpreter: You help two or more people talk to eachother.



5. I have taken a language test at a former employer. Do I have to take another test?

If you have test results or a letter indicating your bilingual proficiency, please send copies to the contact person listed below for review and approval.

6. Who pays for the test?

Providence pays for the bilingual proficiency test. Once you pass, your approval does not expire.

7. What score do I need to pass?

The passing score for the Clinical Cultural and Linguistic Assessment (CCLA) is 80%. To pass the Qualified Bilingual Staff Assessment (QBS), all sections of the test must be passed with a score of 3 or greater. The CCLA and QBS are both validated exams. Please see the ADA/Linguistics Program homepage for more information.

8. I did not pass the exam. When can I take it again?

If you did not pass the exam, you will be asked to come up with a study plan to improve your skills. You can retest no less than 3 months from your original examdate.

9. I did not pass the exam. What does that mean for me?

Not passing the exam means you must communicate through a Providence-approved, medically qualified/certified interpreter or interpreter service for clinical conversations. Clear and accurate communication ensures patient safety.

10. Can I use my bilingual skills for non-clinical communication?

Caregivers and providers regardless of proficiency testing completion may offer sight or written translation and spoken communication in a second/target language to gather patient demographics and to communicate non-clinical information. Caregivers and providers non-clinical communication should not exceed their personal second/target language skills.

11. What's in it for me?

Caregivers and providers who pass the assessment will earn a one-time $150 incentive.

Questions? Please contact:

Jennifer Alvarez
ADA/Linguistics Services Program Manager
Oregon Regional Quality Management & Medical Staff Services
Phone: 503-215-2147
E-mail: ORREG.InterpreterServices@providence.org
SharePoint: Interpreter & Language Services

For specific region versions of the Patient Rights flyer, go to the Providence Patient Rights SharePoint site and refer to PRR Print on Demand to print flyer or Web2Print to order printed flyers. English and translated versions are available on this SharePoint site.

PROVIDENCE

Patient Rights and Responsibilities

OUR COMMITMENT TO YOU, OUR PATIENT:

At Providence, we believe health is a human right. Every person deserves to live their healthiest life. Our mission calls for us to care for all by honoring the dignity and diversity of each person. We welcome you, at every stage of life, and we are committed to providing care that recognizes and affirms you as a whole person. We strive to create a welcoming, safe and respectful environment for you to celebrate life's most sacred moments and for us to stand by you when times are tough. You can count on us to hear you, understand you and work with you to meet your health goals. More than a place of healing and health, we're committed to eliminating health inequities, including giving everyone equitable access to safe, high-quality, effective care. We will not discriminate, and you can expect care that is free of prejudice. We thank you for entrusting us with your care – it is our greatest responsibility and honor.

AS OUR PATIENT, YOU HAVE THESE RIGHTS:

To respect, dignity, and justice

You have the right to receive considerate, compassionate, confidential and respectful care. You will be treated with dignity, and therefore be free from neglect, exploitation, abuse, harassment, racism, or discrimination. All patients have the right to be free from physical or mental abuse, and corporal punishment. Providence will provide high-quality, inclusive care to all that visit us. We see you as the unique person you are, and we will provide your care in a culturally responsive manner.

We are committed to removing the causes of oppression. We respect and diligently care for all individuals accessing services. We welcome people of all races, ages, creeds, ethnicities, cultures, national origins, citizenship, languages and/or immigration statuses, economic statuses, the source of payment for care, religions, traditions, practices, and ancestries. We honor and respect all marital, domestic partnership, or civil unions, appearances and body sizes, sexes, sexual orientations and gender identities or expressions. We welcome and provide equitable care for all physical or psychiatric or intellectual disabilities, handicaps or abilities, medical conditions (including HIV/AIDS status, cancer, genetic, substance use and eating disorders), family medical histories, veteran or military statuses, and any characteristic protected by federal, state, or local law.

To a safe environment

You have the right to receive care in a safe setting, to access protective and advocacy services, and to be free from abuse and harassment.

To be free of restraint or seclusion

You have the right to be free from restraint or seclusion. The use of restraint or seclusion for the following reasons is prohibited: based on the patient's race, color, national origin, age, disability (recognized by anti-discrimination laws), or sex (including pregnancy, sexual orientation, gender identity, and expression), and all other categories protected under the law. Hospital and professional staff members receive education and training (in accordance with statutory and regulatory requirements) on assessment of patients who exhibit behaviors that may inhibit the patient's ability to protect themselves and others from harm or injury.

To your chosen visitors

In accordance with applicable hospital and clinic policies, you have the right to receive visitors of your choice. These visitors include, but are not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. These visitors will not be restricted or otherwise denied visitations privileges because of race, color, national origin, sex, sexual orientation, gender identity or expression, age, or disability. You hold the right to withdraw or deny such consent at any time.

You also have the right to have a family member or representative of your own choice and your own primary care physician notified promptly of inpatient admission to the hospital.

To access medical care responsive to your unique needs

You have the right to access services, treatment or accommodations that are available at our facilities and that are medically necessary. Our goal is to align with your personal health and life goals and take into account all of who you are. In accordance with applicable hospital policies, patients with disabilities have the right to designate at least three support persons, including at least one support person to be present at all times in the emergency department and/or during a hospital stay.

To discuss and participate in your health care decisions

You have the right to discuss, ask questions about, and make decisions regarding your care. You know yourself best, which is why we listen to your health goals and partner with you to achieve them. You will have your personal, cultural and spiritual values, preferences and beliefs honored when deciding about treatment. If you desire, your trusted decision maker or others of your choosing may participate in decisions about your care. You also have the right to request the consultation of a specialist, ethicist and/or chaplain. And, to help ensure you understand the care being given or proposed, interpreter services are available at no cost to you.

To have your wishes honored

You have the right to have your treatment decisions respected. If you become unable to speak for yourself in making decisions about your care, we will respect the decisions of the person you named as your power of attorney for health care, health care agent, or trusted decision maker. If your advance directive or other advance care planning document indicates preferences regarding specific treatments, we will honor your choices within the limitations imposed by your condition. If you do not have an advance directive or similar advance care planning document on file, we will offer to help you in completing one. Providence's focus for care through the end of life is on meeting the needs of patients and their loved ones, alleviating their suffering, and improving the quality of their lives. We will provide access to spiritual care, palliative care and hospice care within a full continuum of care. When appropriate, we will help coordinate donations of organs and other tissues as in accordance with your directives while providing compassionate end-of-life care.

To informed consent and declination of care

You have the right to be informed by your doctor of your diagnosis, treatment and prognosis in a way that you understand, so that you can make informed decisions regarding your care. To the degree possible, this should be based on an explanation of your condition and all proposed procedures and treatments, including the possibility of any serious risks or side effects, problems related to recovery and the probability of success. In addition, you have the right to understand the risks and benefits of not having the proposed procedures and treatment. Your right to receive treatment is not conditioned upon having and advanced directive, POLST, or an order withdrawing or withholding life support such as a Do Not Resuscitate order. Patients and designees have the right, to the greatest extent possible, to participate in decisions concerning their medical care, including any research projects or ethical issues that may arise. This includes the right to decline treatment or leave the hospital, even if advised not to do so by your provider for medical reasons.

To continuity of care

You have a right to receive information that allows you to understand the choices that you have as we assist you in planning for continued health care needs that may exist when you leave our care and facilities. This includes coordinating treatment, evaluations, and if necessary, transferring to another facility.

To adequate pain control

You have the right to have your pain managed while receiving care and services.

To communicate about your care

You are encouraged to learn and ask questions about the treatment you are receiving. If necessary, our staff will obtain an interpreter at no cost to you or provide other means for you to fully understand the care being given to you or proposed. Unless you tell us not to, we retain the right to notify your established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers of your admission, discharge, or transfer from the hospital. Upon your request, we will notify the family member of your choice of your admission, discharge, or transfer from our hospital.

To your medical records

You have right to receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care in terms you can understand. You have the right to access your medical records. You will receive a separate Notice of Privacy Practices that explains your rights to access your records. You have the right to effective communication and to participate in the development and implementation of your plan of care.

You have the right to participate in ethical questions that arise during your care, including issues of conflict resolution, withholding resuscitative services and forgoing or withdrawing of life-sustaining treatment. In addition, you have the right to sign up for the MyChart patient portal. MyChart provides up-to-date information on appointments, medications, health conditions, labs, studies, after-visit summaries, clinical notes and other information in real time with no unique access request. Please visit Providence.org for more information.

To privacy and confidentiality
You have the right to confidential treatment of all communications and records pertaining to your care and stay. You will receive a separate Notice of Privacy Practices that explains your privacy rights in detail and how we may use and disclose your medical information. You have the right to have personal privacy respected. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. You have the right to know the name of the licensed healthcare practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating the care, the names and professional relationships of physicians and nonphysicians who will see the patient and to be told the reason for the presence of any individual.

To voice complaints about your care and receive a response from us
You have the right to voice concerns or complaints about your care and to receive a response from us, without impacting the quality or delivery of your care.

You may report or contact any of the listed leadership agencies below. Further contact information for complaint and grievance reporting is available at your chosen health care facility or location.

To understand your financial responsibility and options for assistance
As our patient, you can request a cost estimate and you have the right to receive a copy of a clear, understandable itemized bill. Upon request, you can also have charges explained. If you are experiencing financial hardship, please contact our customer service center at 1-866-747-2455. You can find out about payment options or whether you qualify for financial assistance, regardless of insurance coverage. We are committed to working with any of our patients who ask for assistance to pay a medical bill.

To information on care facility policies
If requested, you will receive information about our policies, rules or regulations applicable to your care, including the use of service animals in public spaces within care facilities, based on federal law.

AS A PATIENT, FAMILY MEMBER, OR VISITOR YOU HAVE RESPONSIBILITIES:

Providence is a place of healing, where caregivers, patients, family members and visitors alike should feel welcome, safe, and respected. We ask and expect all people who come through our doors or seek care with us to behave in a manner that honors everyone's dignity, and helps us to provide high-quality, compassionate care. Our staff members are chosen for their skill and expertise and their safety is paramount. Harassment or mistreatment of our staff will not be tolerated. While in our care or visiting someone who is, we expect the following of you:

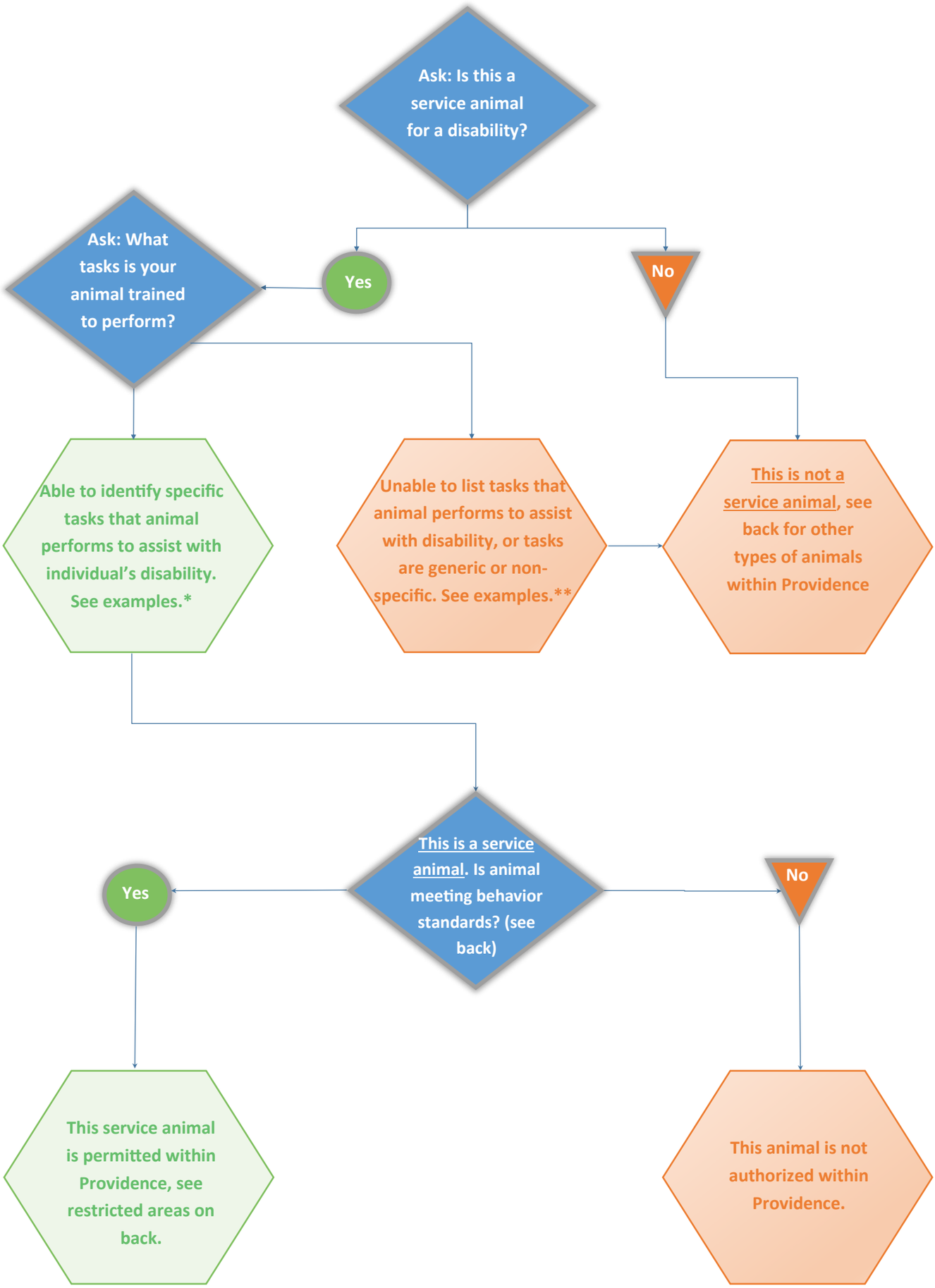
- Be considerate and respectful of those around you, including to those providing care or receiving it.
- Understand that caregivers will not be reassigned for reasons unrelated to their professional role.
- Refrain from using discriminatory and/or derogatory language or behavior of any kind. It will not be tolerated and may result in your exclusion or removal from the facility.
- Inform your provider about your health priorities, so you can create a plan together.
- Provide your medical history and treatment information accurately and completely.
- Report unexpected changes in your condition, take part in decisions, and ask providers questions about your care.
- Consider your providers' advice and follow the treatment plan that is recommended. This includes notifying your providers if you are unable to keep an appointment or follow medical guidance.
- Provide us with a copy of your medical advance directive, living will and/or the identity and contact information of your designated trusted decision maker, if you have one.
- Work with your caregiver to complete a medical advance directive, if you don't have one.
- Understand your financial responsibilities and options for financial assistance.
- Follow care facility policies.
- Leave all personal belongings at home.

ADDITIONAL RIGHTS FOR THE STATE OF OREGON:

If someone with a disability comes to Providence for medical care, they have the following rights:

- To choose at least three support persons to help them communicate and make decisions about their care if they have a physical, intellectual, behavioral, or cognitive impairment, deafness, hearing loss or other communication barriers, blindness, autism or dementia. The support person can be a family member/significant other, guardian, personal care assistant or other paid or unpaid attendant selected by the patient. At least one support person may be at the bedside with the patient all times in the hospital, including the emergency room.
- To have a support person physically present for any discussions regarding hospice care, signing an advanced directive, or making decisions that could mean stopping life-sustaining treatments, unless the patient requests otherwise. Providence will not condition the provision of treatment on a patient having a POLST, an advanced directive, or an order withdrawing or withholding life support, such as a Do Not Resuscitate order.
- If a patient's request for a support person's presence at their bedside is restricted or denied by the hospital, they shall immediately be notified of the opportunity to request a support care conference to discuss the denial and any parameters for permitting a support person to be present. This support conference will be scheduled as soon as possible, but not later than 24 hours after admission or prior to a procedure or operation.
- This notice is available in alternate formats upon request of the patient or the patient's legal representative.

Service Animal Decision Tree



*Examples of acceptable specific tasks performed by service animals for an individual include: turning on lights, offering stability, alerting to oncoming panic attack, offering guidance to patients who are blind, providing an anchor for an autistic child. This is not an exhaustive list.

**Unacceptable examples include generic or broad purposes of the animal, including "helping with anxiety," "gives me comfort," "helps calm me down," or "provides companionship." This is not an exhaustive list.

v.2 Oct 30, 2019

Where do we Permit Animals within Providence Healthcare facilities?

	Service Animals	Animal Assisted Therapy (AAT)	Emotional Support Animals (ESA) and Personal Pets
Identifying features	• Specifically trained (task-trained) • Is a working animal • Trained to assist one person • Does not have to be certified or registered • See decision tree on opposite page to determine if an animal qualifies as a service animal.	• Good temperament and disposition • Reliable and predictable behavior • Does not assist a single individual with activities of daily living	• Their presence has a positive effect • Not trained to perform a specific task or service • ESA's can be recommended or prescribed by a physician or therapist
Does Providence permit this type of animal?	Yes– service animals are permissible by law, under the ADA	Not required to permit under the ADA, but Providence allows AAT through "Pet Partners," which must be coordinated though the Director of Volunteer Services.	Not required to permit under the ADA, but may be allowed if specific criteria are met, including an active physician order and consideration to other patients' allergies and health conditions. This is not a service promoted by Providence. See full Policy for more information.
Where is this type of animal permitted within Providence?	Restricted from: -Any oncology unit or any unit that cares for severely immunosuppressed patients -Any area that requires donning of specific PPE (such as a gown, mask or gloves) -Any critical care unit that restricts access to the general public -Operating Rooms, PACU, and procedural areas -Clinical laboratory -Food preparation areas -Central sterile processing -Areas which store sterile or clean supplies or items -Any area whose service would temporarily incapacitate it's owner (the patient) from being in control of the animal (eg. MRI)	Permitted in areas that are considered accessible to the general public.	Within the patient's room only, door must be closed during visit.

Any animal within Providence must adhere to behavior standards, or dismissal should be considered.

Service Animal Behavior Standards

- If behavior poses a direct threat to the health or safety of others, animal may be dismissed.
- Animal must be under the continuous, direct supervision and control of the owner/handler while in a Providence facility.
- The owner/ handler must be in attendance to care for the animal at all times.
- The care of the animal, including walks outside the facility, for elimination, are solely the responsibility of the owner/handler. Providence caregivers are at no point expected to provide these services.
- If waste is excreted inside the facility, the owner/handler is responsible for clean up. The waste should be deposited into the bathroom toilet, in a hopper in the dirty utility room, or equivalent.
- If the animal is not under control, it may be dismissed.

Safety/Environment of Care

A disaster is a non-routine event that could threaten or overwhelm any hospital resources. This could include natural disasters, technological disasters, industrial and engineering disasters, major transportation accidents, terrorism, biological, chemical, and radiological disasters.

The purpose of emergency management is to provide safety for the patients and staff and to prepare and potentially care for a large arrival of patients from outside the facility.

Providence Oregon has a Regional Emergency Operations Plan (EOP). This policy addresses four phases of disaster preparedness, or emergency management: **mitigation**, **preparedness**, **response**, and **recovery**. The Hospital Incident Command System (HICS) is used during a disaster. Once ON-SITE, please review Providence Oregon Regional EOP for more information (a Providence login is required to access).

Mitigation includes activities that would lessen the impact of a disaster on the facility. Preparedness activities increase readiness and identify resources in case of a disaster. Response includes the activities and how they will be managed during an actual disaster. Recovery includes returning the hospital to its pre-disaster status.

All caregivers must understand the sections of the EOP that affect their duties, describe their responsibilities under the EOP, and know what to do when a disaster code is activated. Every department has a departmental Emergency Response Guide on what to do in an emergency. All caregivers must be familiar with emergency response guidelines.

Emergency Code Responses

Providence is committed to supporting the safety of patients, visitors, and staff in the event of an emergency. See the chart on the next page for standardized overhead paging to support effective communication.

For events listed below, **dial "88"** from any hospital phone and report the following information:

PROVIDENCE Health & Services

EMERGENCY CODE CALLS

For all emergency codes call 88.

CODE RED Fire emergency	▸Seeing smoke or fire ▸Smelling smoke or other burning material ▸Feeling unusual heat on wall, door or other surface
CODE ORANGE Hazardous chemical spill	▸A hazardous chemical spill or release ▸Unsafe exposure to chemical spill ▸Avoid area
RAPID RESPONSE TEAM Medical team needed	A patient's medical condition is declining and needs an emergency medical team *Prior to heart or respiration stopping*
CODE BLUE Heart or respiration stops	An adult, child, or infant's heart has stopped or they are not breathing.
CODE GRAY Combative person	Combative or abusive behaviors by visitors, patients or caregivers. *If a weapon is involved, "CODE SILVER" should be called*
CODE SILVER Weapon or hostage situation	▸At risk or confronted by person with any weapon ▸Hostage situation *A weapon is anything that can cause bodily harm or injury*
CODE SILVER ACTIVE SHOOTER Weapon or hostage situation	▸Active threat on campus ▸Run, hide, fight
CODE AMBER Infant/child abduction	▸An infant or child is missing or abducted ▸Secure all exits
INTERNAL TRIAGE Internal emergency	Internal emergency, including: ▸Computer network down ▸Major plumbing problems ▸Power or telephone outage
EXTERNAL TRIAGE External disaster	External emergencies impacting hospital, including: ▸Mass casualties ▸Severe weather ▸Massive power outages ▸Nuclear, biological and chemical accidents
CODE CLEAR Emergency is over	Announced when emergency is over

Remember: Dial **"88"** to call an emergency code from any hospital phone to be connected with the operator. After your call is placed, you will hear 3 long beeps followed by the type of code and location announced in hospital-wide overhead paging. Remain on the phone with the operator until you hear the overhead page. *If calling a code gray or code silver remain on the phone to be transferred to security dispatch.*

Code Name	Type of Event	Actions to take

Code Red	Fire emergency	**R.A.C.E.R**
		• **R= Rescue**
		  ○ Move patients and assist visitors away from immediate danger of fire/smoke
		  ○ Put at least one closed door between you and the fire
		  ○ Do not use the elevator
		• **A= Alarm**
		  ○ Activate pull station alarm
		  ○ Call in the alarm. Use 88 to activate a CODE RED
		  ○ Notify co-workers
		• **C= Confine**
		  ○ Close all doors and windows
		  ○ Pack all sheets and towels under the doors to contain smoke
		• **E= Extinguish**
		  ○ Select the appropriate fire extinguisher.
		  ○ Use the P-A-S-S technique to extinguish the fire
		• **R= Relocate**
		  ○ Wait for the incident commander to coordinate evacuation efforts.
		  ○ Move patients to staging/assembly area.
		  ○ Account for all evacuated caregivers and patients.
		P.A.S.S. (fire extinguisher)
		• **P= Pull** pin
		• **A= Aim** low at the base of fire
		• **S= Squeeze** handle
		• **S= Sweep** from side to side aiming at the base of the fire

Code Orange	Hazardous chemical spill	Avoid area until appropriate team has cleaned the spill and it is safe to return
Rapid Response Team	Immediate response/intervention needed for a change in patient condition (refer to Rapid Response policy listed below)	Ensure suction, O2 set up, Cardiac monitor, code cart and any other needed equipment are at bedside Provide SBAR to RRT/ Response team
Code Blue	An adult, child, or infant heart has stopped or not breathing (no pulse, no respirations)	• Provide SBAR to code team on arrival • Ensure code cart and other equipment are in the room • Follow facility policy addendum
Code Gray	Combative or abusive patient, visitor, or caregiver	Stay on the line after dialing 88, to be connected with security dispatch to provide additional information PMAB trained caregivers will respond

Code Silver	At risk or confronted with a person with a weapon Hostage situation	Remain on the line to be connected with security Security will respond to area All others avoid area until resolved
Code Silver Active Shooter	Weapon or hostage situation	Run, hide, fight
Code Amber	Infant/Child abduction	If calling, prepare to provide a brief physical description of missing minor or newborn Respond to all exists, stairwells, bathrooms, public areas Security will respond to location
Internal Triage	<u>Internal Emergency:</u> Computer network down Major plumbing problems Power/telephone outage	Follow downtime procedures
External Triage	<u>External Disaster:</u> Mass casualties Severe weather Massive power outage Nuclear, biological, chemical accidents	Designated administration staff will follow protocol and may open an incident command center. Follow directions provided from incident command center.
Code Clear	Emergency Code is over	Announced overhead page when an emergency code is resolved **Does not apply to Rapid Response*

Please review the following policies when you are on campus:

Policy: Emergency Codes for Overhead Paging

Policy: Code Amber- Missing and/or Abducted Minor

Policy: Code Blue Medical Emergency Adult and Pediatric

Policy: PHSOR Adult Rapid Response Team Practice Guideline

Policy: Code Carts

Policy: Code Gray- Pre-Code Gray

Policy: Code External Triage

Policy: Code Internal Triage

Policy: Code Red- Fire Response Plan

Policy: Hazardous Chemical Spill Cleanup- Code Orange

Hazardous Materials

A hazardous material (HazMat) is any item or agent (biological, chemical, radiological, and/or physical), which has the potential to cause harm to humans, animals, or the environment, either by itself or through interaction with other factors.

Labeling of Chemicals/Hazardous Materials

- Hazardous materials are substances that are physical hazards (e.g., flammable), health hazards (e.g., carcinogen, toxic) or both.
- Exposure may occur through inhalation, ingestion, absorption, and injection.
- Hazards may be detected through
    - Odor: Absence of odor does not indicate a substance is harmless
    - Symptom: Red skin, swelling, dizziness, difficulty breathing, coughing, headache, odd taste
- Manufacturers determine the health hazards associated with their products and provide this information to users through product labels and Safety Data Sheets (SDS).
- A SDS contains information to help you manage the product, your risk of exposure and response to emergency situations.

All chemical manufacturers worldwide must place specific labels on containers and supply SDSs to follow the Globally Harmonized System of Classification and Labeling of Chemicals (GHS).

Required components of the label include - Name, address and telephone number of the chemical manufacturer, importer, or other responsible party; Product identifier: Signal words: DANGER or WARNING; Pictogram; Hazard statement; Precautionary statement; Recommended measures in the event of exposure to the chemical

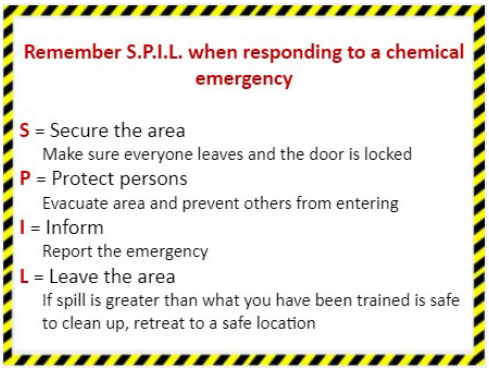
HCS Pictograms and Hazards

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 (harmful) • 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)

If chemicals / products are transferred from the primary container to a secondary container, that secondary container must be labeled to include, at a minimum, the chemical / product name, the hazard, the date transferred and the expiration date.

Handling of Chemicals/Hazardous Materials

- Use caution when handling chemicals. Before using, read the product label and SDS for safe handling precautions and emergency procedures.
    - Access the Emergency Response Guide located on every unit/area. This guide has detailed instructions related to initial response for spills (small & large)
- SDSs can be found on the Providence Oregon Region SharePoint site.
    - Quick links for Oregon or Work resources > Safety data sheets
- Use personal protective equipment specified on product label or SDS.
- Know where the nearest safety equipment (eyewash, spill kit) is located.
- Follow policy on hazardous material disposal.
- Follow policy for any exposure or potential exposure to hazardous materials/chemicals.
- Store hazardous products only in approved, properly identified labeled storage areas and containers. Follow and caution or warning signs of symbols that mark these areas.
- Never:
    - Eat while working with or around hazardous materials/chemicals.
    - Allow chemicals to come into contact with bare skin or mucous membranes (e.g., wipe skin or eyes with materials that have contacted chemicals).
    - Inhale or swallow chemicals.
- Always follow policy for the management of spills.



Electrical Safety

- A hot outlet can be an indication of unsafe wiring:
    - Unplug cords from the outlet.
    - Report the hazard.
- Do not use outlets or cords with exposed wiring. Report damaged outlets or cords. All outside electrical devices (i.e., home medical devices) need to be approved by Facilities and/or Biomedical Engineering.
- Use cords and outlet properly.

MRI Safety

- All caregivers need to be aware of important safety issues when working in or near an MRI treatment area.
- Radio frequency (RF) fields produce heat and interfere with electronic equipment.
- Thoroughly screen all staff and patients prior to entering MRI scan rooms and remove all metallic objects.
- Only use approved, MR safe, fire extinguishers.

Radiation Safety

- The goal of radiation safety is to maintain occupational radiation exposure levels to as low as reasonably achievable (ALARA).
    - Minimize the time you spend near radiation.
    - Maximize your distance from the source.
    - Use lead shielding such as aprons or walls.
    - Wear a dosimeter badge if required when working around radiation.

Medical Gas Safety

- Restrain all cylinders to prevent them from tipping over.
    - A wheeled cart, wall bracket or similar restraint is acceptable.
- Keep EMPTY cylinders separate from full / partial while in storage.

Waste Disposal Guide

Oregon WASTE SORTING GUIDE Rev. 2/23

PROVIDENCE Health & Services

Regulated Medical Waste – KEEP LIDS CLOSED!

Red Bin with Clear Liner (PSV, PPMC, PMH & PWF)

Materials **saturated with blood or body fluid, but not pourable fluid.**
ALL plastic items with patient ID.
Ex.: Patient ID bands, bloody sponges, empty blood transfusion bags and vials.

Red Bin with Black Lid

Pourable volumes of blood or body fluid.
Ex.: Full, partially full, or empty albumin & immunoglobulin bottles, full or partially full blood vials, urine samples, suction canisters, and drains.

Chemotherapy Waste – KEEP LIDS CLOSED!

Trace Chemo - Yellow Bin

Materials contaminated with **3% or less (by volume) of chemotherapy drugs.**
Ex.: PPE (e.g., gloves and gowns), wipes, empty vials, syringes, empty IV bags and tubing used for chemo.

Bulk Chemo - Black Bin

Materials contaminated with **more than 3% (by volume) of chemotherapy drugs.**
NO SHARPS!! KEEP LID CLOSED!
Ex.: Full or partially full vials, ampoules, medicated IV bags and PPE saturated w/ chemo drugs.

Other Waste – KEEP LIDS CLOSED!

Controlled Substances (CsRx)

All controlled substance (liquid, tablets, patches). Continue to witness / waste, per policy.
NO SHARPS, VIALS, OR PACKAGING!!

Hazardous Chemical Waste ..... Contact Safety Manager
Non-Rx Aerosol / Pressurized Gas Containers ..... Contact Safety Manager

Pharmaceutical Waste

Non-Regulated Pharm Waste & Sharps – Blue Bin

Non-regulated pharmaceuticals & sharps.
Ex.: Full or partial medicated IV bags (e.g., **propofol**), empty medicated IV bags w/ patient ID, vials, ampoules, pills, ointments, needles, syringes, scalpels, glass slides / pipettes and all empty medication containers.

Seal spiked IV bags in a clear, plastic bag to prevent leakage.

Regulated Pharm Waste – Black Bin

Regulated pharmaceutical waste.
Refer to the Regulated Pharmaceutical Waste List
NO SHARPS!! KEEP LIDS CLOSED!
Ex.: Full or partial medicated IV bags, vials, ampoules, syringes, pills, ointments, bulk chemo, & **insulin / warfarin.**

Seal spiked IV bags in a clear, plastic bag to prevent leakage.

Regulated Incompatible Pharm Waste

Follow your ministry-specific process for how to waste anything listed in green / yellow / red.

Aerosols

Unused silver nitrate sticks

Hydrogen Peroxide

FOR ASSISTANCE CALL EVS OR SAFETY MANAGER
Hazardous Waste List is in the Regulated Waste Mgmt Policy

Recyclable Waste

Blue Bin with Blue Liner

Hard plastic: Containers/bins, basins/tubs, beverage bottles and plastic utensils.
Soft plastic: Bags, IV overwrap, peel packs, sterile blue wrap, and bubble wrap.
Other: Block Styrofoam, cans, & paper boxes.

NOTE: Material must be clean.

Blue Bin Without Liner

Mixed paper
- **Confidential material is permitted.**
- **All paper is shredded.**

Collect Separately

Collect in separate containers for recycling:
- Batteries
- Glass
- Cardboard

Disposal: Call Environmental Services (EVS)

Trash / Drain

Trash Can with Clear Liner

Plastic IV tubing, empty non-medicated IV bags (not designated for disposal in other receptables and without patient ID), Styrofoam cups, hygiene products / diapers, and **nicotine (and the packaging).**

NO chemicals, pourable liquids, sharps, etc.

Drain

Non-medicated IV liquids and urine.
Ex.: Saline, dextrose, sodium bicarbonate and other maintenance IV solutions.

Pharmaceutical Waste Quick Reference Guide

PROV OR: Disposal Guide for Regulated Pharmaceutical Waste

MEDICATION (BRAND NAME)	PRODUCT
Adalimumab (HUMIRA)	INJ
Albuterol sulfate (PROAIR, VENTOLIN)	AER
Isopropyl Alcohol	LIQ
Alprostadil (CAVERJECT)	INJ
Amantadine HCL (GOCOVRI)	LIQ
Argatroban	INJ
Beclomethasone (QVAR)	AER
Benzocaine containing products (HURRICAINE)	TOP
Benzocaine (CETACAINE SPRAY)	AER
Benzoin tincture	TOP
Betamethasone Dipropionate (DIPROLENE)	TOP
Budesonide/ Formoterol (SYMBICORT)	AER
C1 Inhibitor (BERINERT)	INJ
Carbamide peroxide (MURINE, DEBROX)	LIQ
Calcipotriene (CALCITRENE)	TOP
Ciclopirox (CICLODAN)	TOP
Clindamycin (CLEOCIN)	LIQ
Clobetasol Propionate (CLOBEX)	TOP
Clove Oil	LIQ
Copper Trace Metal	INJ
Crotalidae polyvalent immune fab (CROFAB)	INJ
Cyclosporine (SANDIMMUNE, NEORAL, GENGRAF)	CAP, LIQ
Derazoxane (ZINECARD)	INJ
Desflurane (SUPRANE)	AER
Dexamethasone (DECADRON)	INJ
Diazoxide (PROGLYCEM)	LIQ
Diclofenac (VOLTAREN)	TOP
Digoxin (LANOXIN)	LIQ, INJ
Diphenhydramine/Zinc Acetate Cream	TOP
Doxycycline (DOXY 100)	INJ
Erythromycin (ERYTHROCIN)	LIQ
Ethyl Chloride	
Exenatide (BYETTA)	INJ
Factor IX (BENEFIX)	INJ
Ferric Subsulfate (ASTRINGYN)	TOP
Flurbiprofen Sodium	TOP
Fluticasone (FLOVENT)	AER
Fluticasone/ Salmeterol (ADVAIR HFA)	AER
Glycopyrrolate	INJ
Hydroxyzine HCL (VISTARIL)	LIQ
Hyoscyamine containing products (DONNATAL)	LIQ
Indomethacin (INDOCIN)	CAP, INJ, SUPP
Insulin (All Products except drips) - aspart or lispro (ADMELOG, HUMALOG) - regular (HUMULIN, NPH); glargine (LANTUS)	INJ
Interferon Beta-1a (AVONEX)	INJ
Iodine	LIQ
Ipratropium (ATROVENT)	AER

MEDICATION (BRAND NAME)	PRODUCT
Itraconazole (SPORANOX)	LIQ
Ketorolac Tromethamine (TORADOL)	INJ
Lamivudine (EPIVIR)	LIQ
Levalbuterol HFA (XOPENEX)	AER
Levetiracetam (KEPPRA)	SLN
Levonorgestrel (MIRENA)	IUD
Liothyronine (CYTOMEL)	INJ
Loperamide (IMODIUM)	LIQ
Lopinavir/Ritonavir (KALETRA)	LIQ
Mastisol Liquid	TOP
Multivitamin (THERA M PLUS, AQUADEKS)	TAB, LIQ
Mycophenolate (CELLCEPT)	INJ
Neomycin/Polymyxin Containing Products	TOP
Nimodipine (NYMALIZE)	LIQ
Nitroglycerin (NitroMist)	AER
Nortriptyline HCL (PAMELOR)	LIQ
Nystatin	SUSP
OnabotulinumtoxinA (BOTOX)	INJ
Paricalcitrol (ZEMPLAR)	CAP, INJ
Pegfilgrastim (NEULASTA)	INJ
Permethrin/Pyrethrins (NIX, LEADER LICE)	LIQ
Phenol (CHLORASEPTIC)	LIQ
Phenytoin (DILANTIN)	INJ
Physostigmine	INJ
Potassium Iodide and Iodine (IODINE STRONG)	LIQ
Pramoxine HCL (TRONOLANE)	AER
Pramoxine HCL/Zinc Acetate	TOP
Prednisone (RAYOS)	SLN
Promethazine HCL (PHENERGAN)	LIQ
Prothrombin Complex Concentrate (KCENTRA)	INJ
Salicylic Acid (DUOFILM WART REMOVER)	LIQ
Scopolamine (TRANSDERM SCOP)	TOP
Selenium Sulfide (ANTI-DANDRUFF)	TOP
Sertraline (ZOLOFT)	LIQ
Sevoflurane (ULTANE)	LIQ
Silver Nitrate (GRAFCO)	TOP
Silver Sulfadiazine (SILVADENE)	TOP
Sulfamethoxazole/Trimethoprim (BACTRIM)	INJ
Sulfacetamide/Prednisolone (BLEPHAMIDE)	TOP
Tacrolimus (PROGRAF)	INJ
Tenectaplase (TNKASE)	INJ
Tetracaine HCL (AMETOP)	TOP
Theophylline (ELIXOPHYLLIN)	LIQ
Treprostinil (ORENITRAM)	INJ
Urea (DERMOPLAST)	AER
Vitamin B6 (PYRIDOXINE)	INJ
Warfarin (COUMADIN, JANTOVEN)	TAB
Zinc Sulfate containing products	INJ, TOP

UNIT-BASED BLACK BIN	HAZARDOUS INCOMPATIBLE WASTE (see ministry specific procedures)		
All Hazardous Waste (Flammable/Toxic); Chemotherapy	AEROSOL (SPRAY)	CORROSIVE	OXIDIZER

See PolicyStat and PSJH Entity Hazardous Drug List and Assessment of Risk for disposal of non-antineoplastics (high risk, low risk)

Approved 02/06/2023

- If the drug you want to waste is in BLACK then it gets disposed of in the BLACK Bin
- If the drug you want to waste is in GREEN / YELLOW / RED, then:
  - Aerosols > BLACK Bin w/ GREEN sticker
  - Oxidizers > BLACK Bin w/ YELLOW sticker
  - Corrosives > BLACK Bin w/ RED sticker
    - If specific bin is not available on your dept, then take to Pharmacy Transaction Window
- If the drug you want to waste is NOT on this list then it gets disposed of in the BLUE Bin w/ sharps
- This list DOES NOT include controlled substances. Those drugs are wasted in the CsRx bin per policy.

For any safety / environment of care questions or concerns, please escalate through your chain of command:

- Escalate to your preceptor.
- Escalate to your Core Leader.
- Escalate to your department's Safety Coordinator.
- Escalate to your ministry's Safety and Environmental Health Manager.

Please review the following policies when you are on campus:

Policy: Hazard Communication

Policy: Hazardous Chemical Spill Cleanup- Code Orange

Policy: Hazardous Materials Waste Management Plan

Policy: Regulated Waste Management

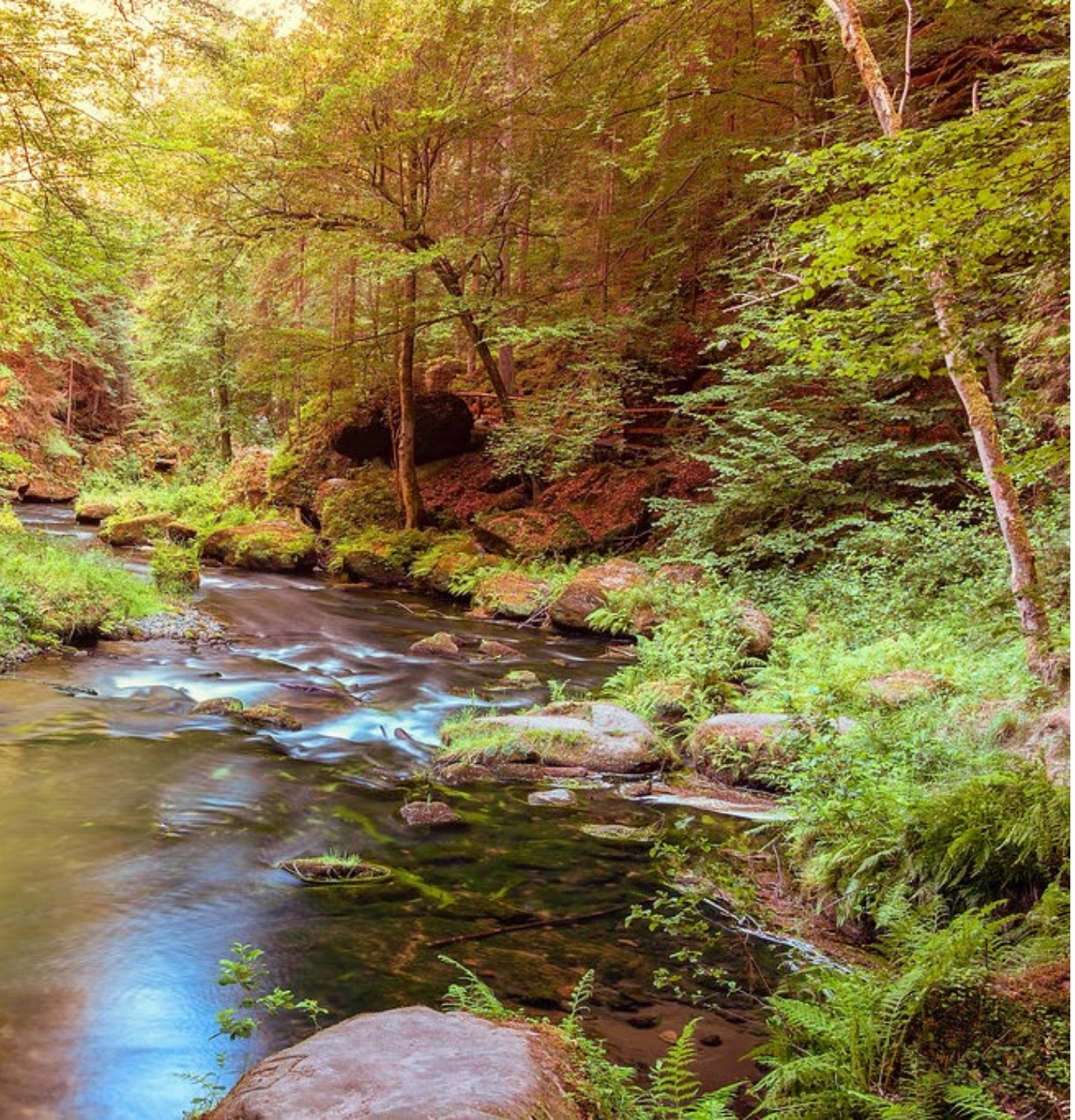
Trauma Informed Care

Providence is committed to providing a trauma-informed approach to patient care and during caregiver and care team interactions

This slide deck provides an overview of Trauma Informed Care

Universal Trauma Precautions

- Awareness of own trauma (ACES)
- Use therapeutic communication
- No room for judgement
- Create a healing environment
- Practice self-care



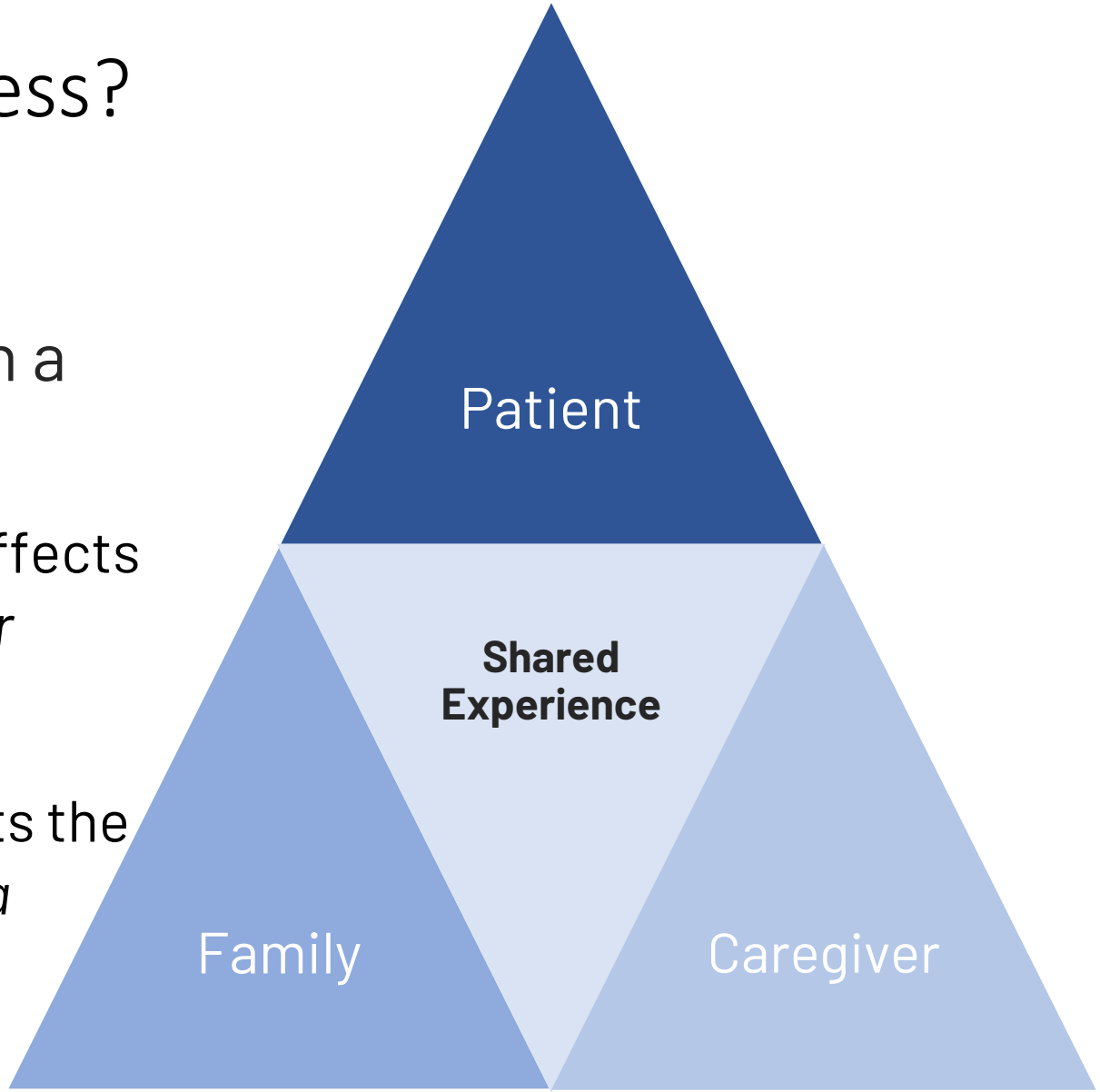
Trauma Informed Approach 3 R's

- **Realize** widespread prevalence & impact
- **Recognize** signs & symptoms
- **Resist** re-traumatizing

What does an escalating patient or situation look like to you?

What is your response to stress?

- Patients, family members and caregivers do not behave or react in a vacuum.
- The patient/family member's behavior affects the caregiver. *We have a reaction to their behavior.*
- Likewise, the caregiver's behavior affects the patient and family members. *They have a reaction to our behavior.*



Managing Escalation

Acknowledge your own response to conflict and stress

Slow down and actively listen

Watch for verbal and non-verbal cues of escalating behavior

Allow for a verbal release of emotion (while maintaining safety)

Do not engage in a power struggle; maintain consistency

Prioritize your own safety

Nonverbal & Paraverbal Communication

Nonverbal Communication

- Personal Space
  - Average need is 1.5 – 3 ft
  - Need varies with situation
  - Invasion increases anxiety
- Body Language (facial expressions, gestures, posture/movements)

Paraverbal Communication

- Tone
  - Emotion in your voice
- Volume
  - How soft or loud
- Cadence
  - Rhythm & speed

Communication in Challenging Interactions

Gain your personal emotional control

Employ broken record technique

Help your patient get emotional control

Seek clarification

Use empathetic listening

Use silence

Workplace Violence Prevention

Providence is committed to preventing workplace violence and to maintaining a safe work environment.

Definition and Caregiver Rights

Workplace Violence (WPV) is defined to include any of the following: verbal, nonverbal, written, or physical aggression (regardless of intent or injury); threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.

Caregivers are prohibited from engaging in violent conduct and/or discussions of violent conduct or the use of dangerous weapons, even in a joking manner. In addition, weapons are prohibited on Providence premises, with certain exceptions for security, military and law enforcement.

No caregiver, or prospective caregiver, will be subject to retaliatory action of any kind or barred from employment because they report violent conduct, participate in an investigation regarding violent conduct, or seek assistance from local emergency services or law enforcement when a violent incident occurs. Reports of violent conduct will be taken seriously and will be thoroughly investigated, and all complaints reported to management will be treated with as much confidentiality as possible.

Communicating about Patient Violence

National data finds that healthcare workers face significant risk of job-related violence while caring for patients. At Providence we believe that workplace violence prevention is a team effort and reliable communication is key. Caregivers are expected to communicate regarding patients at risk for violent behavior at every handover and at every shift change. Do not assume that no information, means there is no risk. On-coming caregivers should ask specific questions about the risk and strategies for caring for the patient safely. Questions to ask:

1. Is there a known violence risk – what type?
2. What are triggers for dangerous behavior?
3. What are warning signs for dangerous behavior?
4. Tips and tricks for caring for the patient safely
5. How to get help when you need it

De-Escalation

The key to de-escalation is recognizing escalation as an unmet physical and/or emotional need. Focus on identifying and treating the underlying causes of the person's agitation.

Focus on the need, not the behavior:

- Treat underlying causes of the agitation: consider hunger, fatigue, confusion, pain, elimination.
- Validate patient's distress as a normal response to a stressful situation.
- What can you do or say to resolve the patient's concern?
- Are there alternatives the team can offer if what the patient wants is not available?

Even when needs are identified, we may not be able to meet them in the way the patient is wanting. Work to align the patient's expectations with what is reasonable and available. Communicate this plan to the care team so everyone is approaching the patient in the same way. This will create predictability and reliability for the patient and potentially decrease their anxiety and attempts to get different responses from different caregivers (also known as "staff splitting").

Be clear with expectations. This should include what the team expects of the patient and what the patient can expect from the team.

Tips and Techniques for Reducing Escalation

Remain calm

- Pause and breathe
- Maintain or lower the stimuli in the environment (low lighting, few people, low noise level)
- Speak clearly, directly, but softly – no arguing

Listen

- Listen more than speak. Allow them to vent frustration
- Validate patient's distress as a normal response to a stressful situation

Focus on the need, not the behavior

- What can you do or say to help resolve the patient's concern
- Comply with patient requests when possible
- Offer alternatives if what the patient is asking for is unavailable
- Keep your message simple

Be Mindful of your body language

- Be aware of your own body language and facial expressions
- Keep your hands visible
- Don't let your "buttons" get pushed
- Respect personal space

Show that you care

- Be patient
- Give your full attention
- Reassure the person that you are here to help
- Empathize

Stay positive

- Expect an optimal outcome for the patient and yourself
- Use positive and helpful statements:
  "I want to help you."
  "What can I do to help you feel more comfortable right now?"

Clinical Violence Alert Sign

We post a sign on the patient's door to communicate with all caregivers, including ancillary caregivers, when a patient or their visitors/family members pose a risk for violent behavior. The sign provides basic information about risk, but ancillary caregivers will still need to check in with the nurse for additional details before interacting with the patient.

The back of the sign provides definitions and recommended responses.

Violence Types:

V = Verbal
S = Sexual
P = Physical

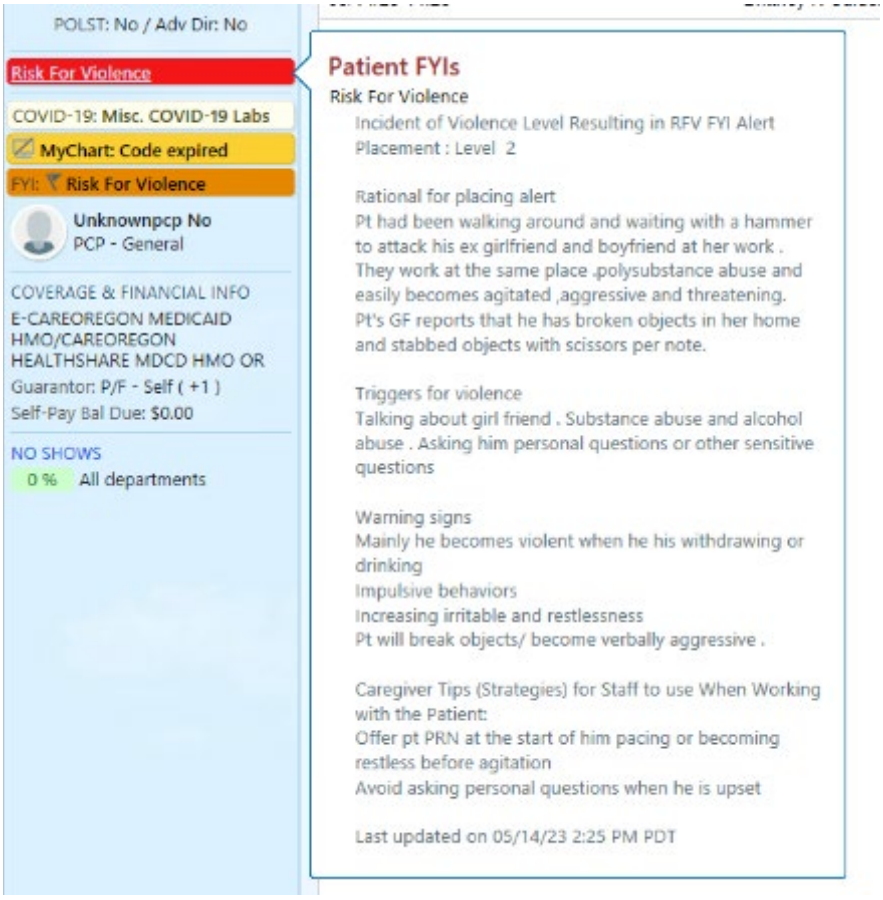
[Clinical Violence Alert Sign - SBAR and Guidelines for Use.pdf]

Violence Levels:

	Level 1	Level 2 Flag	Level 3 Flag
Behaviors & Characteristics	• Past history of violence, not meeting Level 3 criteria. • Risk factors or warning signs for violence: i.e. confusion, intoxication, withdrawal, delirium, etc. • Verbal threat with no physical attack or contact.	• Any direct or imminent threat of assault, without use of a weapon, and with no attack. • Physical intervention to prevent assault, i.e. pre-code gray. • Physically posturing or menacing, i.e. physically puffing themselves up, raising fists, etc. • Inappropriate sexual behavior: i.e. exposure, public masturbation, lewd comments.	• Known history of physical assault, in any setting, regardless of level of injury, harm or intent. • Code Gray with significant resistance to containment. • Damage to physical objects. • Threatened use of weapon. • Possession of prohibited weapon on campus AND display of aggressive behavior. • Known history of non-consensual fondling, verified history of sexual assault or rape. ○ *If this occurred in a healthcare setting (patient or caregiver) ensure this is included in the Risk Mitigation Note.)* • History of murder.

Risk for Violence FYI Flag in Patient's Chart (Epic)

When a patient displays Level 2 or 3 violent behavior, their medical record in Epic should be flagged "Risk for Violence". Contact the nurse manager, associate nurse manager, or house supervisor if you wish to activate a risk for violence FYI flag in Epic.



When a patient's chart is flagged Risk for Violence you will see a red banner at the top of many patient reports, both in and out of the patient's chart.

Hover over the banner or click on the flag icon to see detailed information, including:

- Violence Level
- Rationale for placing the flag
- Triggers for violence
- Warning Signs
- Caregiver Tips and strategies when working with the patient

Note that the violence risk mitigation note in Epic has the same information as those questions to ask at handoff.

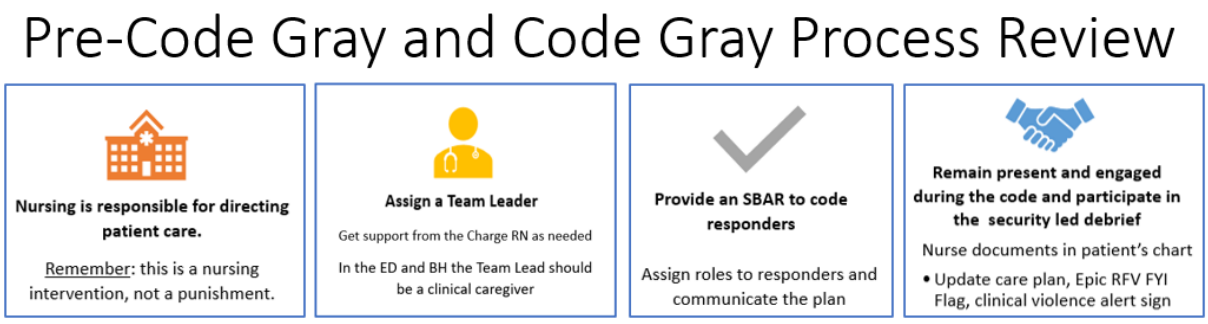
Calling for help: Code Gray and Pre-Code Gray

Security and other staff are available to support caregivers in violent situations.

Pre-Code Gray is called when aggressive behavior is escalating, and prior to a violent incident. It is never too early to call a Pre-Code Gray. The goal is to identify the underlying causes of the escalation and to stabilize the situation with the presence of additional caregivers. Notify the charge nurse who will call Security. The response team is notified by private pager. Pre-code grays are not paged overhead.

If the safety concern is more immediate, call a **Code Gray**. Anyone can call a Code Gray. Dial 88 and say "*I have a Code Gray in [state the specific location, including room number*]." You should hear this paged overhead three times. If it is safe to do so, stay on the line and the operator will transfer you to security dispatch where you can share additional pertinent details. Dispatch officers will relay this information to your officers who are already en route to your location.

Code grays begin with a brief SBAR and the response team assigns roles. Nursing staff needs to stay engaged: the RN remains responsible for directing patient care during the code. Work with the pre-code gray support personnel and code gray responders to develop a plan to restore safety to the situation. The team is there to support you and the patient.



Report Violence:

Caregivers are encouraged to report all events of workplace violence. Violent incidents are taken seriously and thoroughly investigated.

To report violence, click on the "**speak up for safety**" icon on your desktop:


Speak Up for Safety.url

Select "Workforce Safety" from the main dashboard and complete the reporting form. The appropriate core leader will be notified and is required to complete an investigation within 20 days.

The violence report may be used to report all types of workplace violence, also including caregiver-to-caregiver or provider-to-caregiver violence, bullying, intimidation or harassment. If you wish to report anonymously, contact Providence's Integrity Hotline online or call 1-888-294-8455.

More information: Oregon Workplace Violence Prevention - Home (sharepoint.com)

Prevention and Management of Assaultive Behavior

PMAB

Providence is committed to providing a safe environment for caregivers, patients, and visitors. The following slides present strategies for managing situations with higher potential for risk/danger.

Please review the following policy when you are on campus:

Policy: Code Gray – Pre-Code Gray

Prevention and Management of Assaultive Behavior (PMAB)

An Introduction for Agency/Travelers/Per Diem Caregivers

What is PMAB

PMAB is a part of the Providence Workplace Violence Prevention strategy providing training of verbal de-escalation and hands-on techniques to manage situations with a higher potential for risk/danger.

- Similar to programs such as:
  - CPI - Crisis Prevention Institute
  - MOAB - Management of Aggressive Behavior
  - NCVI – Non-Violence Crisis Intervention
  - AVADE

PMAB Focus

- ✓ Early Recognition
  - By recognizing and responding early, many patient needs can be identified and addressed thereby decreasing the experience of anxiety and in many cases, avoiding behavioral crisis
- ✓ Exhausting All Opportunities to De-escalate
  - Recognizing that escalation is most commonly an expression of unmet needs
- ✓ You Are Not Alone
  - Pre-Code Gray and Code Gray process is there to support you and the patient

De-Escalation is Trauma Informed Care

Focusing on early recognition and intervention of patient distress in many cases reduces the need for physical management thereby mitigating the risk of re-traumatization of the patient and care team.

Have a BRAVE conversation

- **B**e willing to engage
- **R**eassure the person that you are here to help
- **A**ctively listen to their concern
- **V**alidate their experience as normal
- **E**xpress understanding and offer comfort measures

Not sure what to say? Try using the 4 RE's .

Evasive/Escape Maneuvers

- Caregivers are expected to use de-escalation techniques in an attempt to defuse potential use of force incidents if they have the time and opportunity to do so and if the circumstances permit it.

- Caregivers may use physical force upon another person in self-defense or in defending a third person to prevent death or serious physical injury. When justified, caregivers will employ ***only the force reasonably necessary*** to protect themselves or others.
  - PHSOR Violence Prevention Policy
  - OR Statute - ORS 654.423

- PMAB Maneuvers

Show of Support – Managing Escalating Situations

Goal – to recognize and respond to patient distress in a way that feels safe for the patient and the caregiving team.

Pre-Code Gray: consulting support staff available to provide nursing care units with the resources to assist with the management of escalating aggressive behavior prior to a violent incident.

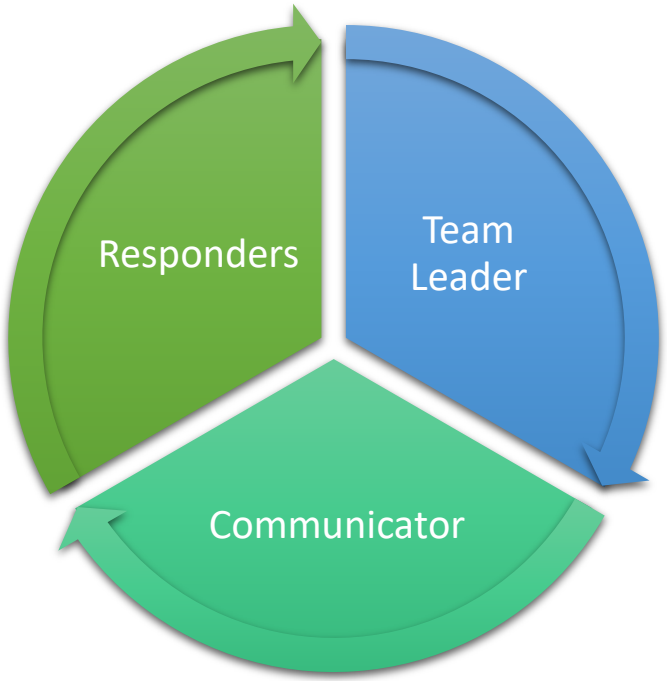
Procedure

- Inform Charge RN of the escalating situation and determine support needs. This could include the manager on duty, social work, house supervisor, the patient's physician, security, etc.
- If security officer(s) are needed and not already present –
  - PWFMC, PMH, PNMC, PMMC – dial 88. This will connect you with the hospital operator who will connect with security and the house supervisor to dispatch to your location.
  - PPMC, PSVMC, PHRMH, PSH – dial x57777 to connect with security directly. Ask for a pre-code gray and give brief description of the need (e.g. ***"We need an officer present for safety while we have a conversation with the patient about leaving the hospital.")***

Code Gray: a violent patient or visitor event which requires the assistance of a trained support team to de-escalate and regain control of the event.

Procedure

- For all locations – dial 88 to connect to the hospital operator. Say: "I have a Code Gray in (state **specific location-** e.g ***ED Red Pod 51.***") Once you disconnect you will hear the Code Gray paged overhead 3 times.
- All available designated responders will respond – this will be a multi-disciplinary team made up of clinical caregivers and Security.
- 1. Assign roles. 2. Communicate plan. 3. Execute plan. 4. Debrief event



Code Gray Roles and Responsibilities

Nurse – as the nurse caring for the patient you are responsible for directing care. Work collaboratively with your Code Gray Team Leader to develop a plan to address the needs.

Team Leader – communicating the plan to the team, monitor the patient for change of status, change the direction of the plan as the patient needs change, oversee all members of the code team. The Team Leader should be a clinical caregiver in the ED and Psychiatric Units.

Communicator - engage/re-engage the patient. Reassure the patient that the team is there to help keep them safe. Continue efforts to de-escalate the situation. **Designated to monitor patient respirations**.

Other Responders - as a responder you may be asked to contain a limb during a Code Gray event, apply a restraint, call the MD for emergency medication orders, or help to monitor the rest of the unit/needs.

Speaking Up For Safety

A Code Gray is crisis that requires us all to recognize and respond to the changing psychological and physical condition of the patient. If you have any concerns about the well-being of the patient or the safety of the event, please speak up.

- Utilize the HRO Tool – CUS
  - I'm Concerned…
  - I'm Uncomfortable…
  - I need you to Stop and listen…
- Observing and reporting any ***Sudden and Profound Changes*** (eg: abrupt silence or stillness)
- Monitoring with vigilance the increased risk for Positional Asphyxia for individuals who are being contained or restrained

At any time during a Pre-Code Gray or Code Gray event a caregiver can be removed if they are not lending to the resolution of that crisis. ***Dr. Armstrong*** scripted language may be used - *e.g.* ***"Dr. Armstrong needs to speak to Nurse John now"*** or if used on oneself, ***"Dr. Armstrong needs to speak to me now."*** This is a cue to both the caregiver and the team that the caregiver is leaving the code.

Important Note: If you are concerned for the well-being of your patient during a Code Gray or a restraint or seclusion event you should communicate it immediately. Nursing intervention should match the current need, which could include providing comfort measures, first aid, resuscitation, and BLS techniques when indicated and within your scope or the authorized duties of your role.

Post-Event Follow Up

If the situation escalated to a Code Gray participate in the immediate post event debrief

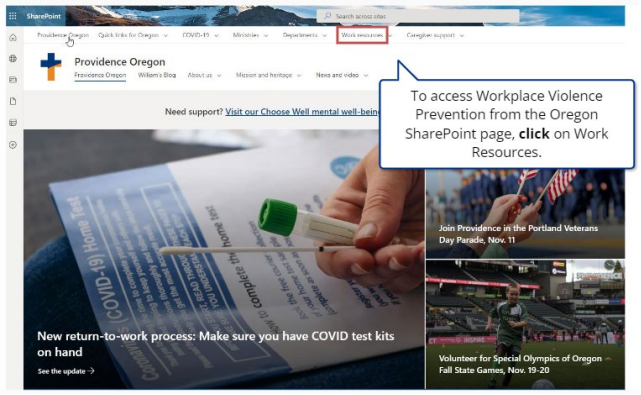
- Special considerations to be determined by nurse leader present
  - Caregiver needs for medical attention
  - Reassignment of duty
  - Release from duty

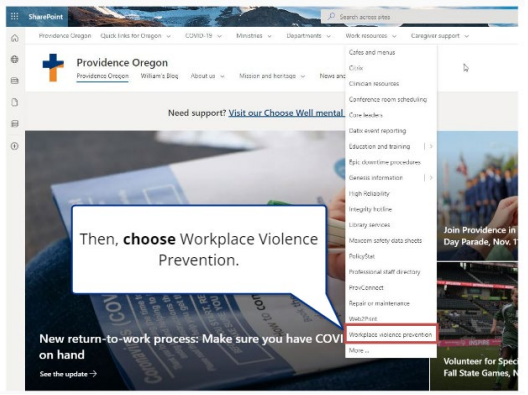
Reporting on Providence Oregon Sharepoint

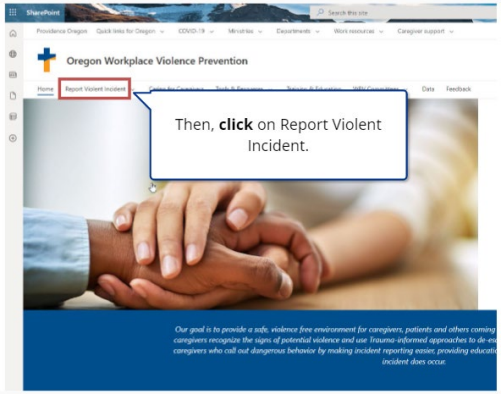
HRP Reporting

- WpV Reporting - Violence toward caregivers
- Patient on patient or patient on visitor

Sedgwick Injury Reporting







Restraint Events

If restraints or seclusion are needed to restore safety, the RN must consider the following decisions:

1. What type of event is this (violent or non-violent)?
   - This only determines order frequency, assessment/reassessment, and observation
2. What device should be used?
   - Consider the least restrictive device is needed to restore safety
3. What position should the patient be placed in?
   - Consider if it is safe to restraint both arms in a down position. Position one arm in an up position if harm could come to the patient or caregivers if the patient has free range of motion of their torso
   - For a violent restraint event, no fewer than 2-point restraints (wrist and opposite ankle) should be maintained so the patient is safe from rolling/flipping off the bed
   - 4-point restraint (wrists and ankles) is the most restrictive position, consider if a less restrictive position is an option

Next up:

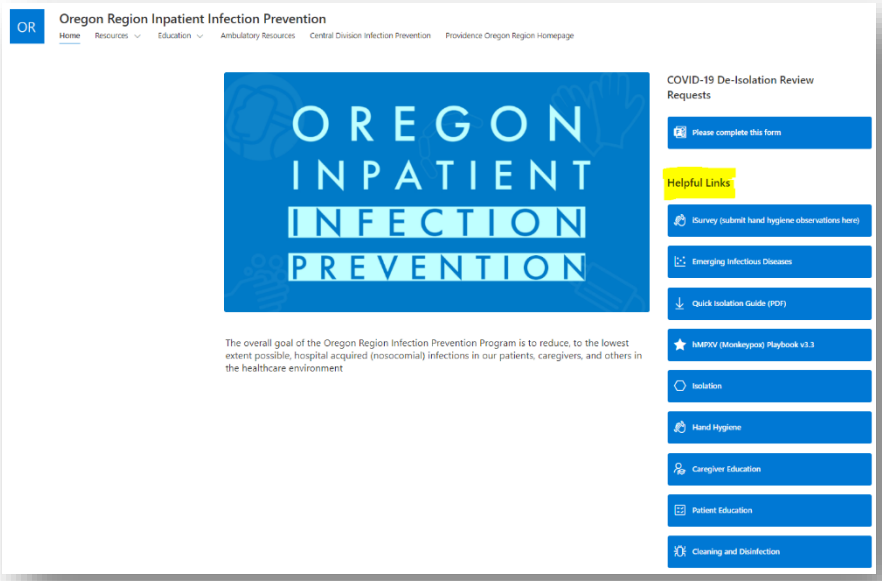
Demonstrate containment and restraints and evaluate locking restraint competency

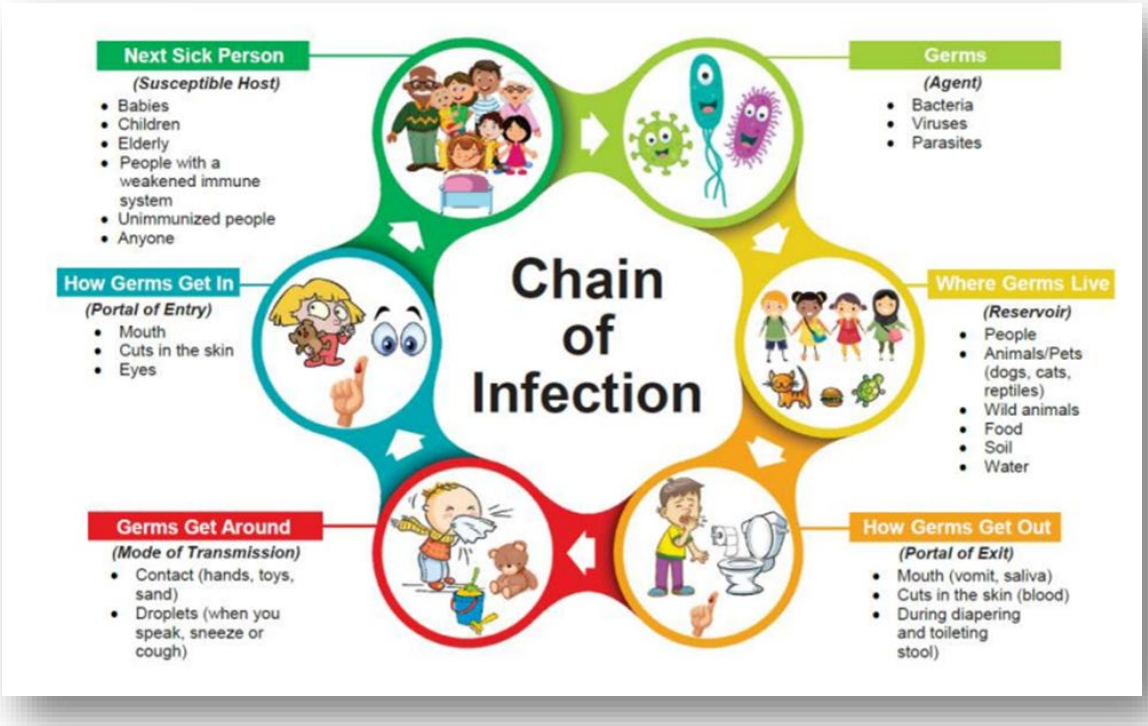

THANK YOU
!!

Infection Prevention

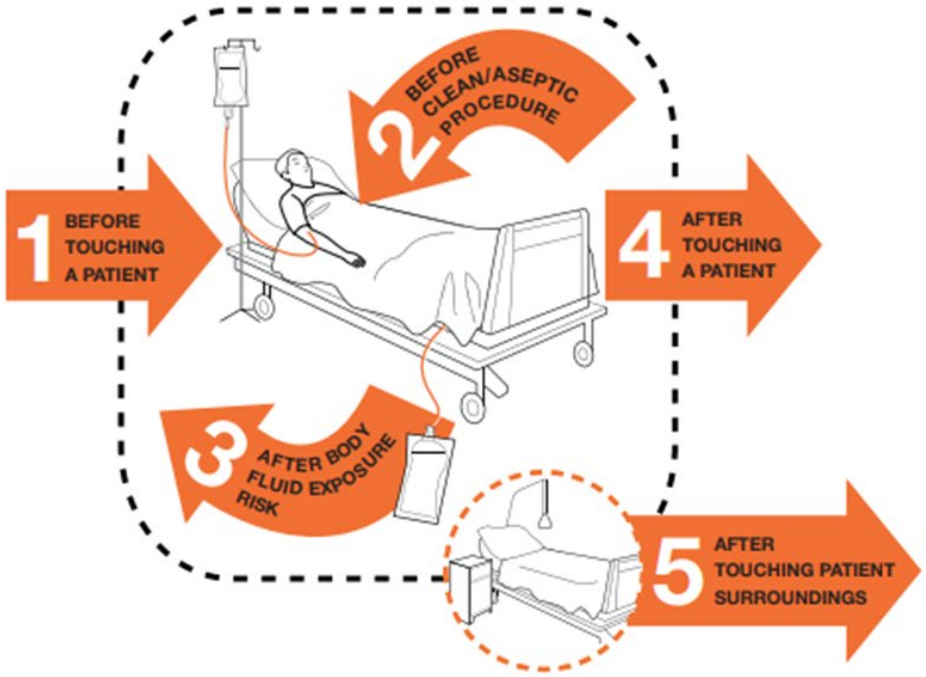
There are many different germs and infections inside and outside of the healthcare setting. Despite the variety of viruses and bacteria, germs spread from person to person through a common series of events. **Therefore, to prevent germs from infecting more people, we must break the chain of infection!**

Oregon Region Infection Prevention Sharepoint Site: Link See the **Helpful Links** section for supporting information





Your 5 Moments for Hand Hygiene



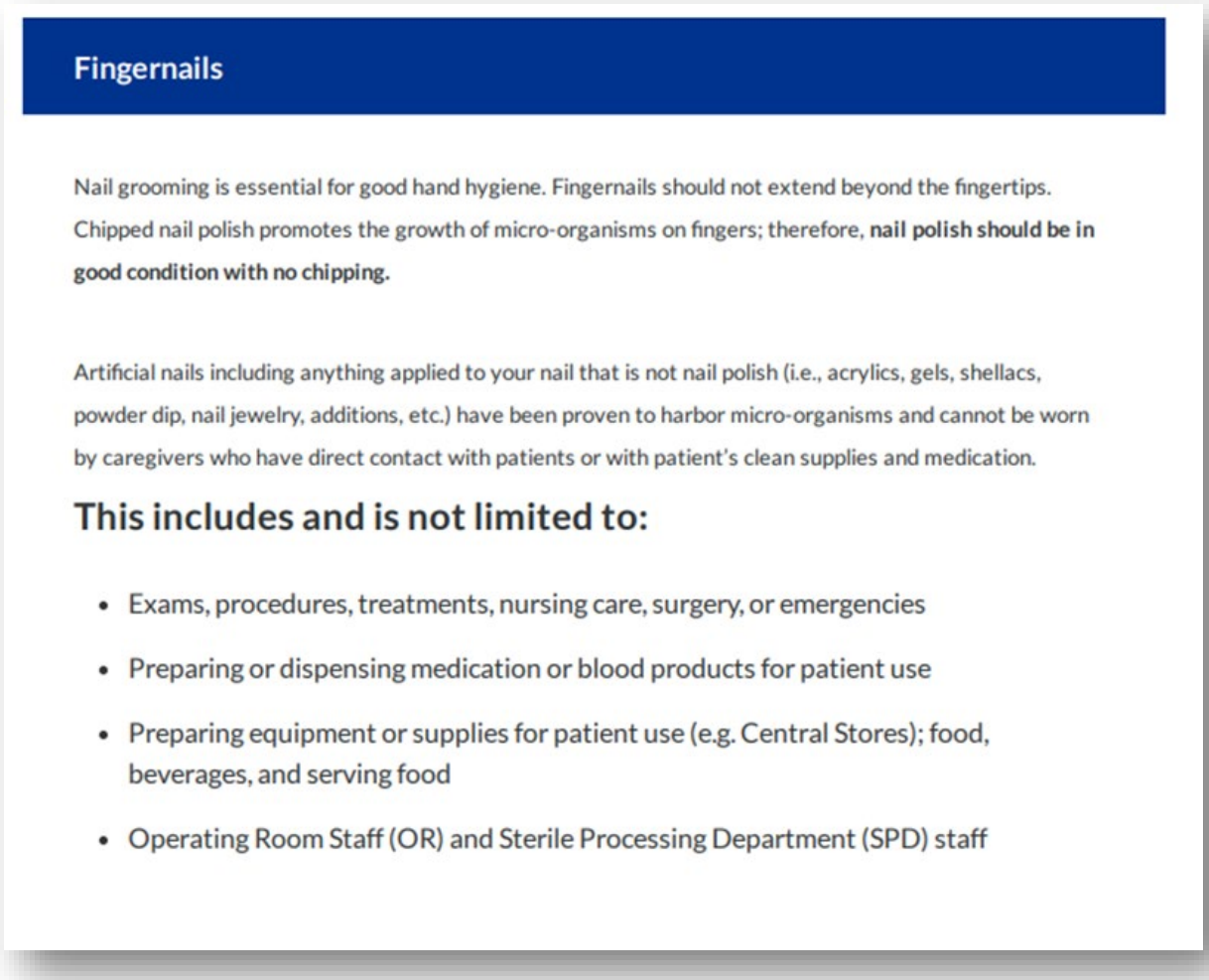
1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009



Fingernails

Nail grooming is essential for good hand hygiene. Fingernails should not extend beyond the fingertips. Chipped nail polish promotes the growth of micro-organisms on fingers; therefore, **nail polish should be in good condition with no chipping.**

Artificial nails including anything applied to your nail that is not nail polish (i.e., acrylics, gels, shellacs, powder dip, nail jewelry, additions, etc.) have been proven to harbor micro-organisms and cannot be worn by caregivers who have direct contact with patients or with patient's clean supplies and medication.

This includes and is not limited to:

- Exams, procedures, treatments, nursing care, surgery, or emergencies
- Preparing or dispensing medication or blood products for patient use
- Preparing equipment or supplies for patient use (e.g. Central Stores); food, beverages, and serving food
- Operating Room Staff (OR) and Sterile Processing Department (SPD) staff

Standard and Transmission-Based Precautions:

- Standard Precautions are guidelines that outline the minimum set of interventions that are required for preventing the transmission of recognized and unrecognized sources of infections. They provide a foundation for infection prevention measures that are to be used for all patients in every healthcare setting.
- All blood, body fluids, secretions, excretions, non-intact skin, and mucous membranes should be treated as potentially infectious.
- Personal protective equipment (PPE) is designed to protect the wearer's skin, eyes, mucous membranes, airways, and clothing from coming in contact with infectious agents. The selection of PPE is made based on the tasks being performed and anticipated level of exposure the employee expects to encounter.
- Goggles/face shields: Should be worn by caregivers to protect the eyes and face of the wearer from sprays of respiratory secretions, blood, or body fluids. They should be worn anytime that there is potential to generate splashes or sprays of blood, body fluids, secretions, or excretions. Personal eyeglasses or contact lenses do not provide adequate protection and are not considered acceptable eye protection. The use of face shields allows caregivers to wear their own personal eyeglasses and increase protection to other areas of the face, including the eyes.

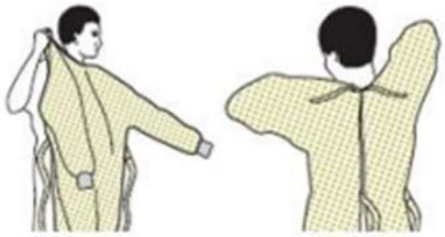
Transmission-based precautions (also known as isolation precautions) are for specific patient conditions and are required in addition to Standard Precautions.

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

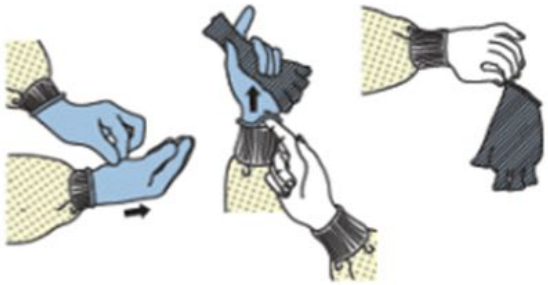
CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **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. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in 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 or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

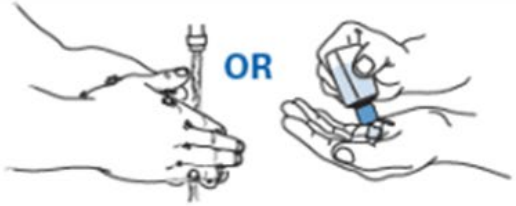
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. 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

5. 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

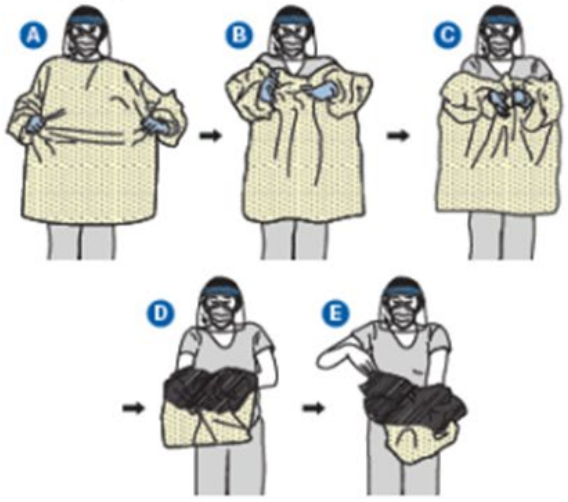
CDC

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

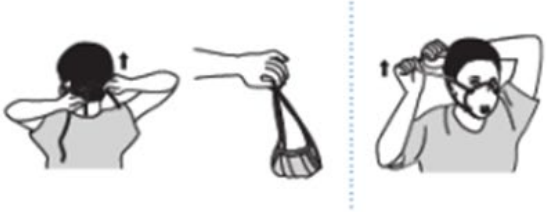


2. GOGGLES OR FACE SHIELD

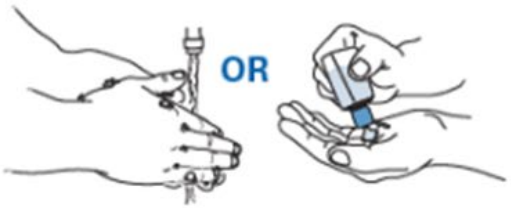
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles 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

CDC

STOP

CONTACT ENTERIC PRECAUTIONS

ALTO

(In addition to Standard Precautions)
Sign to be removed by EVS only

VISITATION BY THOSE 12 YEARS OLD OR YOUNGER IS DISCOURAGED
Check with Nurse before entering room.

NO SE RECOMIENDAN LAS VISITAS DE PERSONAS DE 12 AÑOS DE EDAD O MENORES
Consulte a la enfermera antes de entrar en la habitación.

Everyone Must:

Wash or gel hands when entering room, soap and water upon leaving.

Doctors and Staff Must:

Gown and glove at door

Use patient dedicated or disposable equipment.

Clean and disinfect shared equipment.

STOP

CONTACT PRECAUTIONS

(In addition to Standard Precautions)
Sign to be removed by EVS only

ALTO

VISITATION BY THOSE 12 YEARS OLD OR YOUNGER IS DISCOURAGED
Check with Nurse before entering room.

NO SE RECOMIENDAN LAS VISITAS DE PERSONAS DE 12 AÑOS DE EDAD O MENORES
Consulte a la enfermera antes de entrar en la habitación.

Everyone Must:

Clean hands when entering and leaving room

Doctors and Staff Must:

Gown and glove at door.

Use patient dedicated or disposable equipment.

Clean and disinfect shared equipment.

STOP

DROPLET PRECAUTIONS

ALTO

(In addition to Standard Precautions)
Sign to be removed by EVS only

VISITATION BY THOSE 12 YEARS OLD OR YOUNGER IS DISCOURAGED
Check with Nurse before entering room.

NO SE RECOMIENDAN LAS VISITAS DE PERSONAS DE 12 AÑOS DE EDAD O MENORES
Consulte a la enfermera antes de entrar en la habitación.

Everyone Must:

Clean hands when entering and leaving room

Wear surgical mask

STOP

SPECIAL DROPLET/ CONTACT PRECAUTIONS

ALTO

RESPIRATOR MUST BE WORN BY CAREGIVERS ENTERING ROOM

Clean hands when entering/exiting

Must wear:

-Fit tested N95 or CAPR/PAPR
-Face shield or Goggles
-Gown
-Gloves

KEEP DOOR CLOSED

Use patient dedicated or disposable equipment.

Additional signage (AGP sign) should be placed for all Aerosol Generating Procedures

Last revised 5/5/21

STOP

AIRBORNE RESPIRATOR PRECAUTIONS

(In addition to Standard Precautions)
Sign to be removed by EVS only

ALTO

Family and visitors need approval before entering room.
Check with Nurse before entering room.

Los familiares y visitantes necesitan obtener aprobación antes de entrar en la habitación.
Consulte a la enfermera antes de entrar en la habitación.

Everyone Must:

Clean hands when entering and leaving the room

Doctors and Staff Must:

OR

Wear PAPR or fitted N95 mask prior to entering room

Airborne Infection Isolation Room required (negative pressure).
Keep door closed.

STOP

Aerosol-Generating Procedure In Progress

ALTO

- PPE Per infection isolation precaution practices

*** See back of sign for instructions ***

- Keep door closed unless safety risk prohibits

Place sign at start of AGP
Remove sign when safe to enter.
*** See back for instructions ***

Clear Time:

AGP Door Sign 1/12/23

STOP

ENHANCED PRECAUTIONS

(In addition to Standard Precautions)
Sign removed with Leadership approval

ALTO

***NO VISITORS ALLOWED**

Everyone Must:

- Remove personal uniform: wear hospital or disposable scrubs. Remove personal items.
- Clean hands when entering. Clean hands when leaving room with soap and water.
- Perform frequent disinfection of gloved hands
- Keep door closed.

Trained Observer Must Be Present for Donning & Doffing of PPE

Personal Protective Equipment (PPE):
Follow detailed CDC Guidelines for donning and doffing PPE.

- Single-use (disposable) fluid-resistant or impermeable full gown. No skin should be showing.
- Single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least the knees.
- N95/PAPR/CAPR with disposable hood head cover and full-face shield.
- Single-use (disposable) nitrile examination gloves with extended cuffs. Two pairs of gloves should be worn. Outer gloves should have extended cuffs.

Use airborne infection isolation room (AIIR) if available.

Clean and disinfect shared equipment with designated disinfectant.

Use patient dedicated or disposable equipment.

Version 3, December 2022

Tuberculosis (TB)

Tuberculosis (TB) is caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not
everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist. Latent TB
infection (LTBI) and TB disease.

If not treated properly, TB can be fatal.

Transmission of TB

TB bacteria are spread through the air from one person to another. The TB bacteria are put into the air
when a person with active TB disease of the lungs or throat coughs, speaks, or sings. People nearby may breathe in these bacteria and become infected.

Symptoms of TB

- A bad cough that lasts 3 weeks or longer
- Pain in the Chest
- Coughing up blood or sputum
- Weakness or fatigue
- Weight loss
- No appetite
- Chills
- Fever
- Sweating at night

If a patient is exhibiting signs/symptoms of TB:

- **Ensure appropriate patient placement in an airborne infection isolation room (AIIR)** constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home.
- **Use personal protective equipment (PPE) appropriately,** including a fit-tested NIOSH-approved N95 or higher level respirator for healthcare personnel.
- **Limit transport and movement of patients** outside of the room to medically-necessary purposes. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible, and observe Respiratory Hygiene/Cough Etiquette.

Respiratory Protection (PPE)

Caregivers working in airborne isolation rooms or near patients with known or suspected TB.

Powered air purifying respirators (PAPRs)
N95 respirators after proper training, testing, and certification for use

PAPR/CAPR and N95 respirators need proper training. N95 respirators require fit testing prior to use and fit checking for proper seal before each use. Work with your local supervisor to learn more about fit testing.

TB Testing

New Hire Baseline Process	Annual Testing	Post-Exposure
Upon hire, all health care personnel are screened for TB upon hire. The PSJH TB screening includes: A baseline individual TB risk assessment TB symptom evaluation, A TB test, most often a blood test (e.g., TB blood test or a TB skin test), and Additional evaluation for TB disease as needed, such as a chest x-ray Information from the screening tools above is used to interpret the results. Health care personnel with a positive TB test will receive a chest x-ray to rule out TB disease. Additional evaluation may be needed based on those results. Health care personnel with a documented history of a prior positive TB test receive a baseline individual TB risk assessment and TB symptom screen upon hire.	Annual TB testing is performed where there is evidence of ongoing transmission or a regulatory requirement to do so. Compliance with annual testing is required	Post-exposure testing is performed to help determine if an infection has occurred. A baseline test is performed and testing repeats at 8-10 weeks post last exposure unless directed otherwise by the local health department. Complying with post-exposure testing is required. What happens if a caregiver has a positive TB test? A caregiver with a positive TB test will require further evaluation. This may mean a repeat test, chest x-ray, and likely evaluation by a physician. The TB history, symptom, and risk assessment are all taken into consideration in determining what action is necessary.

If you experience an exposure to Tuberculosis any other ATDs in the workplace, report this to Caregiver Health Services immediately.

KNOW WHY AND COMPLY

Mask Selection Guidelines

- Facemasks are worn for protection of caregivers, patients, visitors to prevent the spread of infections. Providence follows guidance set forth by the American Society of Testing and Materials (ASTM) in selection of the most appropriate facemask for different scenarios.
- To ensure caregiver protection, please ensure you are selecting the appropriate mask to wear for various scenarios.

- **ASTM Level 1 Masks**: Are used as **source control** for caregivers, patients, and visitors. These masks are intended as source control to help reduce the spread of large respiratory droplets from the wearer to other individuals. Examples for use include public spaces, hallways, nursing stations, and during interactions when no exposure to respiratory secretions, blood, or body fluid is anticipated.
- **ASTM Level 2 Masks**: Are used as **personal protective equipment** to protect the wearer from exposure to respiratory droplets and ***small*** amounts of blood or body fluid. Examples for use include when a patient is on droplet precautions or any situation where small exposures to respiratory secretions, blood, or body fluid could occur. In addition, eye protection should be worn if exposure could occur.
- **ASTM Level 3 Masks**: Are used as **personal protective equipment** to protect the wearer from exposure to respiratory droplets and ***large*** amounts of blood or body fluid. Examples for use includes operating rooms, labor and delivery, trauma, or any where exposure to large amounts of blood or body fluid could occur. In addition, eye protection should be worn if exposure could occur.

Caregivers should select an ASTM level mask based on the type of scenario. If you are unsure which mask is appropriate, please default to the ASTM level 3 mask. During any direct patient care, we strongly recommend a minimum of an ASTM level 2 mask.

Approved by Oregon Region Infection Prevention, Caregiver Health Services, and Safety 12/18/2023

Mask Selection Guidelines

Please note: Your ministry may have different manufactured masks than what is pictured. Refer to the specific box for the ASTM rating.

Approved by Oregon Region Infection Prevention, Caregiver Health Services, and Safety 12/18/2023

Quick Isolation Guide is available via the Infection Prevention Share Point site

Created By: Oregon Region Infection Prevention

Quick Isolation Guide

Test Ordered or Positive Result	Isolation Type: Adult	Isolation Type: Pediatric/ NICU/PICU	PPE to enter Room	Other	Duration of Isolation
Multi-drug resistant organism (MDRO): **MRSA and VRE**	None	None	None	Patients with wounds with uncontained drainage are placed in contact precautions. Otherwise, standard precautions required.	N.A
Extended-spectrum beta-lactamase: **ESBL** Multi-drug resistant *Acinetobacter* : **MDR-Acinetobacter** Multi-drug resistant organism *Pseudomonas* : **MDR-Pseudomonas** Carbapenem-resistant *Acinetobacter baumannii* : **CR-Acinetobacter** Carbapenem-resistant Enterobacterales: **CRE** Carbapenem-resistant *Pseudomonas aeruginosa* : **CR-Pseudomonas**	Contact		Gown & gloves	**Add eye protection and mask per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	Duration of stay and a year from last positive. Reference Oregon Region Infection Prevention SharePoint Site for de-isolation protocol and contact IP as indicated.
Carbapenemase Producing Carbapenem-resistant Enterobacterales: **CP-CRE** Vancomycin-resistant *Staphylococcus aureus* : **VRSA** Vancomycin-intermediate *Staphylococcus aureus* : **VISA**	Contact		Gown & gloves	**Add eye protecction and mask per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	Contact isolation must be maintained indefinitely
Lice and Scabies	Contact		Gown & gloves	**No bouffant or shoe covers needed**	For 24 hours after effective treatment
C. difficile	Contact Enteric		Gown & gloves	**Soap & water** hand hygiene when exiting room. **Bleach** clean room and equipment.	Reference Oregon Region Infection Prevention SharePoint Site for de-isolation protocol. Call infection prevention for de-isolation.
Norovirus	Contact Enteric		Gown & gloves	**Add mask & eye protection** if patient vomiting. **Soap & water** hand hygiene when exiting room. **Bleach** clean room and equipment.	May consider de-isolation after 48 hours without symptoms. Call infection prevention for de-isolation.
R/O Gastroenteritis w/ acute diarrhea (incontinent)	Contact Enteric		Gown & gloves	**Soap & water** hand hygiene when exiting room. **Bleach** clean room and equipment. *If unknown infectious etiology	May consider de-isolation after symptoms resolve or stool results are negative or for confirmed alternative diagnosis (i.e. colitis, etc.)
Respiratory pathogen panel ordered	Droplet	Droplet & Contact	Mask; add Gown & Gloves for pediatrics	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled. **Add Contact precautions** (gown & gloves) for infants, young children, and immunocompromised adults	If test positive, refer to specific organism for duration and additional specific isolation type
Influenza	Droplet	Droplet & Contact	Mask; add Gown & Gloves for pediatrics	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled. **Add Contact precautions** (gown & gloves) for infants, young children, and immunocompromised adults	5 days after specimen collection or duration of illness whichever is longer. If immunocompromised, call infection prevention for de-isolation.
Pertussis (includes the following: *Bordetella (B.) pertussis* , *B. parapertussis* & *B.holmesii*)	Droplet		Mask	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	Call Infection Prevention for questions.
Rhinovirus	Droplet	Droplet & Contact	Mask; add Gown & Gloves for pediatrics	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled. **Add Contact precautions (gown & gloves)** for infants, young children, and immunocompromised adults.	5 days after specimen collection or duration of illness whichever is longer$_1$
Adenovirus	Droplet & Contact		Mask, gown & gloves	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	5 days after specimen collection or duration of illness whichever is longer$_1$ Extended for immune compromised patients.
Human metapneumovirus	Droplet & Contact		Mask, gown & gloves	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	5 days after specimen collection or duration of illness whichever is longer$_1$
RSV	Droplet & Contact		Gown and gloves	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	5 days after specimen collection or duration of illness whichever is longer$_1$
Parainfluenza	Standard	Droplet & Contact	Pediatrics: Mask, gown & gloves	**Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	5 days after specimen collection or duration of illness whichever is longer$_1$
Acute Respiratory Virus (not covered elsew					

Adapted from: CDC HICPAC 2007 Isolation

Created By: Oregon Region Infection Prevention

Quick Isolation Guide Continued

Test Ordered or Positive Result	Isolation Type: Adult	Isolation Type: Pediatric/ NICU/PICU	PPE to enter Room	Other	Duration of Isolation
Neisseria meningitidis	Droplet		Mask	**Notify Infection Prevention immediately.** After hours, weekends, and holidays, notify House Supervisor. **Add eye protection per Standard precautions** if respiratory secretions copious or coughing uncontrolled.	After 24 hours of appropriate treatment.
Meningitis: viral, fungal and other bacterial causes	Standard		As needed for standard precautions	Bacteria examples: *Strep* , *Listeria* , *Staph* , *E.coli* Fungal Examples: *Cryptococcus* , *histoplasma* , *coccidioides* Viral examples: Enterovirus	N/A
Measles (rubeola)	Airborne		PAPR/CAPR or N95	To enter room, caregiver must have lab confirmed immunity to measles (rubeola).	4 days after onset of rash, longer if patient immunocompromised.
Tuberculosis (TB) **pulmonary disease** KNOWN & SUSPECTED or R/O	Airborne		PAPR/CAPR or N95	**Place patient** in negative air room and keep door closed. **If patient going to OR** call Infection Prevention. **Patient wears** plain mask if must leave room. **Collect AFB specimens** at least 8 hours apart with 1 specimen collected in the AM.	**Known disease:** requires approval from Infectious Disease or Pulmonary provider to discontinue isolation **Suspected disease:** requires 3 ngeative AFBs OR 2 negative AFBs with 1 negative MTB-NAAT (1 must be AM specimen) **Absence of required number of specimens:** patient is improving on non-TB treatment and provider notes in chart the alternative diagnosis **Consult** with IP and/or ID for questions.
Tuberculosis (TB) non-pulmonary	Situational, see "other" column.		Situational, see "other" column.	Use Airborne isolation (PAPR/CAPR or N95) and Standard precautions (gown/gloves) if wound open & draining or if irrigating wound. **Contact Infection Prevention if patient going to OR.**	Call Infection Prevention for questions.
Tuberculosis (TB) latent	Standard		As needed for standard precautions	Latent= Quantiferon positive or skin test positive but no illness	N/A
Non-TB mycobacterium (NTB)	Standard		As needed for standard precautions	Example: Mycobacterium avium complex (MAC)	N/A
Chickenpox (varicella)	Airborne & Contact		PAPR/CAPR or N95, gown & gloves	**When possible,** patient should be cared for by caregivers with confirmed immunity.	Until all lesions dry and crusted.
Shingles (zoster) **disseminated** or patient is immunocompromised and disseminated is being ruled out	Airborne & Contact		PAPR/CAPR or N95, gown & gloves	**When possible,** patient should be cared for by caregivers with confirmed immunity **Disseminated disease** is defined as multiple lesions outside 1-2 dermatomes and/or lesions that cross the midline of body. **Immunocompromised-** leave in Airborne & Contact until disseminated shingles is ruled out	Until all lesions are dry and crusted over. **Consult with Infection Prevention before discontinuing isolation.**
Shingles (zoster) **localized,** patient with normal immune system, lesions can be covered/contained.	Standard		As needed for standard precautions	**When possible,** patient should be cared for by caregivers with confirmed immunity. **Localized infection=** lesions in only 1-2 adjacent dermatomes and do not cross midline of body. **If lesions cannot be covered** by dressings or clothing, Contact Precautions are required.	Until all lesions are dry and crusted over. Call Infection Prevention for questions.
R/O COVID-19 or COVID-19	Special Droplet/Contact		PAPR/CAPR or N95 and faceshield/ goggles, gown, & gloves	**Negative pressure** room for aerosol generating procedures if available.	**R/O COVID:** After 1 negative PCR test, consult with attending physician prior to discontinuing isolation. **COVID Positive Patients**: consult policy "COVID-19 Workflow: Discontinuing Isolation Precautions (Deisolation, De-isolation) for Patients with COVID-19" **Consult IP/ID for further questions.**

Adapted from: CDC HICPAC 2007 Isolation Precautions and from American Academy of Pediatrics Red Book*: 2015 Report of the Committee on Infectious Diseases. Revised (1/5/2024)

Cleaning and Disinfection

Please adhere to the manufacturer's instructions for use for disinfection of all medical/patient equipment and items. **The instructions for use** for the item being cleaned and the cleaning agent (e.g., disinfectant wipe) **must be followed**.

CHOOSING THE CORRECT SANI-CLOTH

Disinfecting wipes, in pop-up containers, are a great way to keep surface cleaners at the ready, and selecting the right one for the job can be important. **Please note:** The times listed refer to the time a surface must remain wet. This is one of the most common questions a surveyor will ask. With so many choices, this guide will help you pick the right one (guide found on Infection Prevention SharePoint site).

PROVIDENCE Health & Services

Choosing the Correct Sani-Cloth

Disinfecting wipes, in pop-up containers, are a great way to keep surface cleaners at the ready, but selecting the right one for the job can be important.* With so many choices, the following will help you pick the right one:

1 min

Oxivir TB wipes and Spray: *White tops with purple or blue writing. Peroxide based disinfectant.* Contact time: 1 minute. Order # 394833

2 min

Super Sani-Cloth: *Purple top high-alcohol disinfectant.* Contact time: 2 minutes. May be used on alcohol-tolerant, sensitive plastic surfaces and electronics. **May cause irreversible eye damage if splashed in the eye**. Order # 160533

The individually wrapped wipes may hold more liquid than the container wipes.
Use caution when opening them and do so away from your face. Eye protection recommended.

3 min

Sani-Cloth AF3: *Gray top alcohol-free disinfectant. No fragrance.* Contact time: 3 minutes. Alternative when alcohol-free is required for Sensitive plastic surfaces and electronics. Order # 389063

3 min

Clorox Bleach: *Clorox brand bleach-based disinfectant.* Contact time: 3 minutes. This is the ONLY disinfectant that can be used on glucometers. Order # 780879

4 min

Sani-Cloth Bleach: *Orange top bleach-based disinfectant.* Contact time: 4 minutes. To be used for disinfecting areas at risk for *Clostridium difficile* spores and *Norovirus*. Can discolor and fade fabrics - for use only on non-porous surfaces. Order # 394625

NEVER FLUSH WIPES DOWN THE TOILET – These wipes are woven from a material that is not easily broken down in the sewer, and you can clog a toilet with just one wipe.
Please throw these in the regular trash for disposal.

DO NOT USE SANI-CLOTHS ON SKIN! They are for disinfecting non-porous surfaces, not people.

*These wipes are COVID-19 approved.

OR Region Infection Prevention, updated 11/1/23

PROVIDENCE Health & Services

OR REGION REUSABLE INSTRUMENT PRE-TREATMENT PROCEDURE

THIS PROCEDURE APPLIES TO INSTRUMENTS BEING RETURNED TO HOSPITAL STERILE PROCESSING DEPARTMENTS (SPD) FOR DECONTAMINATION AND STERILIZATION.

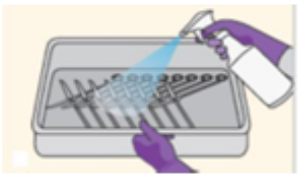
Step 1: Wear gloves when handling contaminated instruments.
It's ok to wear gloves in transport of the dirty instruments to the soiled utility area.

Step 2: Transport contaminated instruments immediately after the procedure from the treatment room to the dedicated soiled space/room in a biohazard labeled, puncture-resistant, closed container. Examples include:

Step 3: Wearing gloves and protective eyewear (faceshield or goggles), open instruments, and remove <u>visible</u> soil with a moist paper towel, gauze or **single-use sponge or brush.** (Eye protection is important when using an enzymatic)

All pre-cleaning must be done in designated "dirty" area, <u>not</u> in exam/procedure room.
It is ok to run the instruments briefly in running water (designated dirty sink).

Step 4: Place instruments in their **open** position in the red biohazard tray. Apply wetting agent* (or other hospital approved pretreatment spray).



*Optipro Gel Instrument Pre-Cleaner is the preferred, low-toxicity wetting agent (Ecolab prod # 6075552, Lawson #362724). Use unless otherwise indicated by the instrument manufacturer.

Step 5: Close and lock biohazard tray when not inserting instruments.

Step 6: Remove gloves and wash hands

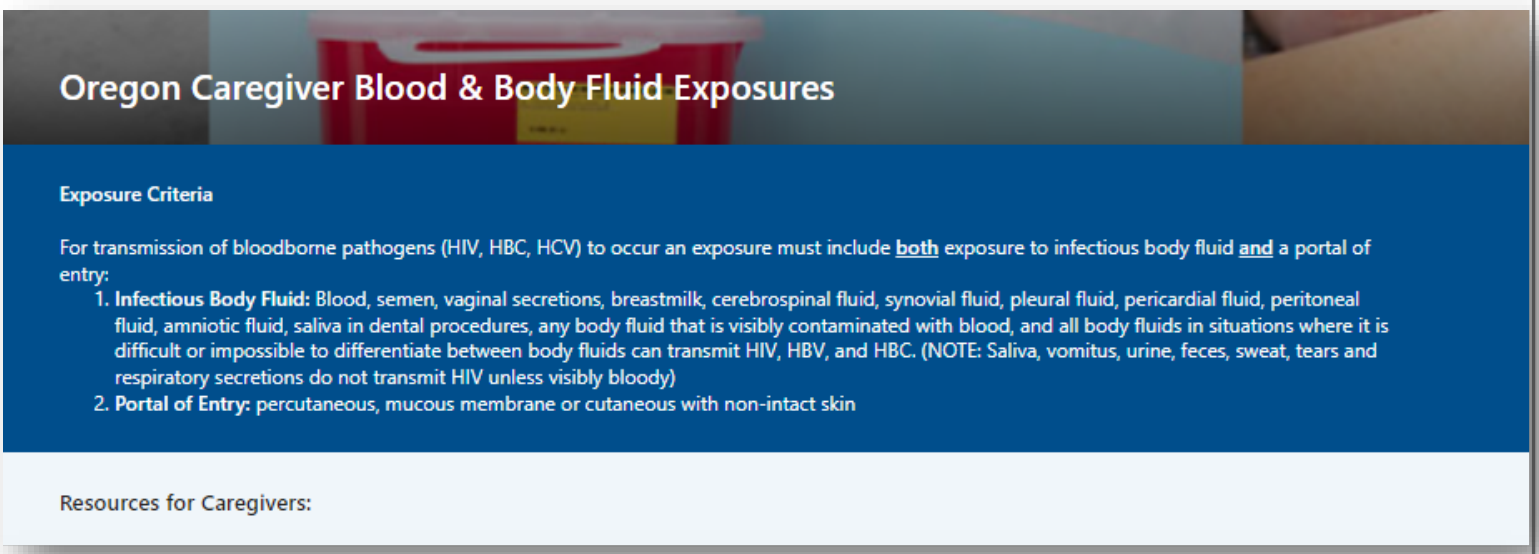
Arrange for pick-up or drop off bins to SPD for sterilization.

Bloodborne Pathogens

Bloodborne pathogens (BBP) are microorganisms that can be present in human blood. BBP can be transmitted through contact with contaminated blood and body fluids via direct contact with broken skin or mucous membranes. BBP are transmitted by sharing needles/syringes, unprotected sexual contact, mother-to-baby, or through sharps injuries/needle sticks.

Employee Blood and/or Body Fluid Exposure (BBFE)

What to do as an Employee who has been exposed?



Contracted Caregivers, Students, and others not directly employed by Providence follow the steps below:

1. Notify your supervisor immediately
2. Call Caregiver Health Services - (503)216-3200, Option 1
   a. Nurses are available on-call 24/7 to help with blood and body fluid exposure follow-up care.
3. Complete exposure packet with Caregiver Health Services and follow all instructions. Source patient testing should be initiated as soon as possible.
4. Complete the Non-employee Incident Form with Caregiver Health Services

When handling sharps, remember:

Sharps Containers are to be used for the disposal of:

- All used needles and syringes
- Syringes removed from their sterile packaging, even if not used

No item classified as a sharp should ever be placed in a recycling container including syringes that can accept a needle.

- Be aware of your surroundings
- Stop if you feel rushed or distracted and focus on the task
- Avoid passing sharps and use verbal alerts when moving sharps
- Watch for sharps in linen, beds, on the floor and waste containers
- Hold bags with linen or medical waste away from your body when lifting or carrying
- Never reach into a sharps container to retrieve a sharp
- Be responsible for the device you are using
- Always activate sharps safety features
- Dispose of sharps in sharps containers only
- Keep fingers back from container opening when disposing of sharps
- Never recap needles
- Don't allow sharps containers to become overfull. Change before the fill line is reached or when ¾ full.

Injection Safety Guidelines

- [ ] Follow proper infection control practices and maintain aseptic technique during the preparation and administration of injected medications (e.g., disinfect skin, perform hand hygiene)
- [ ] Never administer medication from the same syringe to more than one patient, even if the needle is changed
- [ ] Never enter a vial with a used syringe or needle
- [ ] Do not use medications packaged as single-dose or single-use for more than one patient
- [ ] Do not use bags of intravenous solution as a common source of supply for more than one patient
- [ ] Limit the use of multi-dose vials and dedicate them to a single patient whenever possible. Label the syringe and date multi-use vials according to your ministry policies.
- [ ] Always use face masks when injecting material or inserting a catheter into an epidural or subdural space

Oregon WASTE SORTING GUIDE Rev. 2/23

PROVIDENCE Health & Services

Regulated Medical Waste – KEEP LIDS CLOSED!

Red Bin with Clear Liner (PSV, PPMC, PMH & PWF)

Materials **saturated with blood or body fluid, but not pourable fluid.**
ALL plastic items with patient ID.
Ex.: Patient ID bands, bloody sponges, empty blood transfusion bags and vials.

Red Bin with Black Lid

Pourable volumes of blood or body fluid.
Ex.: Full, partially full, or empty albumin & immunoglobulin bottles, full or partially full blood vials, urine samples, suction canisters, and drains.

Chemotherapy Waste – KEEP LIDS CLOSED!

Trace Chemo - Yellow Bin

Materials contaminated with **3% or less (by volume) of chemotherapy drugs.**
Ex.: PPE (e.g., gloves and gowns), wipes, empty vials, syringes, empty IV bags and tubing used for chemo.

Bulk Chemo - Black Bin

Materials contaminated with **more than 3% (by volume) of chemotherapy drugs.**
NO SHARPS!! KEEP LID CLOSED!
Ex.: Full or partially full vials, ampoules, medicated IV bags and PPE saturated w/ chemo drugs.

Other Waste – KEEP LIDS CLOSED!

Controlled Substances (CsRx)

All controlled substance (liquid, tablets, patches). Continue to witness / waste, per policy.
NO SHARPS, VIALS, OR PACKAGING!!

Hazardous Chemical Waste ..... Contact Safety Manager
Non-Rx Aerosol / Pressurized Gas Containers ..... Contact Safety Manager

Pharmaceutical Waste

Non-Regulated Pharm Waste & Sharps – Blue Bin

Non-regulated pharmaceuticals & sharps.
Ex.: Full or partial medicated IV bags (e.g., **propofol**), empty medicated IV bags w/ patient ID, vials, ampoules, pills, ointments, needles, syringes, scalpels, glass slides / pipettes and all empty medication containers.

Seal spiked IV bags in a clear, plastic bag to prevent leakage.

Regulated Pharm Waste – Black Bin

Regulated pharmaceutical waste.
Refer to the Regulated Pharmaceutical Waste List
NO SHARPS!! KEEP LIDS CLOSED!

Ex.: Full or partial medicated IV bags, vials, ampoules, syringes, pills, ointments, bulk chemo, & **insulin / warfarin**.

Seal spiked IV bags in a clear, plastic bag to prevent leakage.

Regulated Incompatible Pharm Waste

Follow your ministry-specific process for how to waste anything listed in green / yellow / red.

Aerosols

Unused silver nitrate sticks

Hydrogen Peroxide

FOR ASSISTANCE CALL EVS OR SAFETY MANAGER
Hazardous Waste List is in the Regulated Waste Mgmt Policy

Recyclable Waste

Blue Bin with Blue Liner

Hard plastic: Containers/bins, basins/tubs, beverage bottles and plastic utensils.
Soft plastic: Bags, IV overwrap, peel packs, sterile blue wrap, and bubble wrap.
Other: Block Styrofoam, cans, & paper boxes.

NOTE: Material must be clean.

Blue Bin Without Liner

Mixed paper
- **Confidential material is permitted.**
- **All paper is shredded.**

Collect Separately

Collect in separate containers for recycling:
- Batteries
- Glass
- Cardboard

Disposal: Call Environmental Services (EVS)

Trash / Drain

Trash Can with Clear Liner

Plastic IV tubing, empty non-medicated IV bags (not designated for disposal in other receptables and without patient ID), Styrofoam cups, hygiene products / diapers, and **nicotine (and the packaging).**

NO chemicals, pourable liquids, sharps, etc.

Drain

Non-medicated IV liquids and urine.
Ex.: Saline, dextrose, sodium bicarbonate and other maintenance IV solutions.

Oregon Pharmaceutical WASTE SORTING GUIDE Rev. 3/23

PROVIDENCE Health & Services

Pharmaceutical Waste – KEEP LIDS CLOSED!

Non-Regulated Pharm Waste & Sharps – Blue Bin

Non-regulated pharmaceuticals & sharps.
Ex.: Full or partial medicated IV bags (e.g., **propofol**), empty medicated IV bags w/ patient ID, vials, ampoules, pills, ointments, needles, syringes, scalpels, glass slides / pipettes and all empty medication containers. **Seal spiked IV bags in a clear, plastic bag to prevent leakage.**

Regulated Pharm Waste – Black Bin

Regulated pharmaceutical waste. Refer to the Regulated Pharmaceutical Waste List
NO SHARPS!!

Ex.: Full or partial medicated IV bags, vials, ampoules, syringes, pills, ointments, bulk chemo, & **warfarin**. **Seal spiked IV bags in a clear, plastic bag to prevent leakage.**

Regulated Incompatible Pharm Waste

Follow your ministry-specific process for how to waste anything listed in green / yellow / red.

Aerosols

Unused silver nitrate sticks

Hydrogen Peroxide

FOR ASSISTANCE CALL EVS OR SAFETY MANAGER
Hazardous Waste List is in the Regulated Waste Mgmt Policy

Hazardous Chemical Waste.....Contact Safety Manager
Non-Rx Aerosol / Pressurized Gas Containers.....Contact Safety Manager

Chemotherapy Waste – KEEP LIDS CLOSED!

Trace Chemo - Yellow Bin

Materials contaminated with **3% or less (by volume) of chemotherapy drugs.**
Ex.: PPE (e.g., gloves and gowns), wipes, empty vials, syringes, empty IV bags and tubing used for chemo.

Bulk Chemo - Black Bin

Materials contaminated with **more than 3% (by volume) of chemotherapy drugs. NO SHARPS!!**
Ex.: Full or partially full vials, ampoules, medicated IV bags and PPE saturated w/ chemo drugs.

Controlled Substances (CsRx) – KEEP LIDS CLOSED!

All controlled substance (liquid, tablets, patches). Continue to witness / waste, per policy.
NO SHARPS, VIALS, OR PACKAGING!!

Trash Can with Clear Liner

Plastic IV tubing, empty non-medicated IV bags (not designated for disposal in other receptables and without patient ID), Styrofoam cups, hygiene products / diapers, and **nicotine (and the packaging).**
NO chemicals, pourable liquids, sharps, etc.

Drain

Non-medicated IV liquids and urine.
Ex.: Saline, dextrose, sodium bicarbonate and other maintenance IV solutions.

Providence

Patient Hygiene

According to the CDC, each day, approximately 1 of every 31 U.S. patients contracts at least one infection in association with their healthcare. One of the key elements to preventing Healthcare Associated Infections (HAIs) is maintaining patient hygiene. Performing hygiene not only cleans a patient's skin but also stimulates circulation, provides mild exercise, and promotes comfort. It also enables assessment of the condition of the patient's skin as well as joint mobility and muscle strength.

At Providence it was identified that significant variance exists within our organization related to patient hygiene. A multidisciplinary group was created including subject matter experts from Nursing, Infection Prevention, Skin Wound Ostomy, and supply chain to perform an extensive literature review and determine a minimum specification guidance document to lead best practice promotion throughout Providence. Local areas may add more detail to this guidance such as specific workflow processes as needed or desired.

Areas identified as out of scope for this document include:

- pediatric and neonatal populations
- pre-surgical bathing/ skin antisepsis practices

Patient Hand Hygiene

While focus on caregiver hand hygiene is well documented, patient hands may also be a significant source of contamination. Patients who are able, will be encouraged to sanitize their hands at frequent intervals including at least upon entry to the facility, upon admission, after utilizing the restroom, before eating, upon entering and exiting the patient room, and when visibly s oiled. Patients who are unable to perform hand hygiene themselves should be assisted by caregivers.

Patient Bathing

All patients who are within the organization, and do not have a contraindication, should be offered bathing/ skin antisepsis at least daily. Patients should be assessed for potential contraindications, allergies, and appropriateness. Bathing and skin care products should be provided by the organization as items have been assessed for contraindications and/or interactions. Wipes may be heated in wipe warmers as available to promote patient comfort and will be used per the manufacturer instructions for use. Wipes may not be microwaved. Wipes should be monitored for expiration and not used if expired. The correct number of wipes will be used for each bath per written protocol. Wipes are to be disposed of in the trash, not flushed in the toilet. The reuse of opened packages of wipes will not be used due to increased risk of contamination.

Patient Shower

Patients will be assessed for the safety and ability to bathe themselves by their care team. For patients who can utilize the shower, should be offered at least daily showering. All devices, wounds, and equipment will be properly secured and covered to maintain the integrity of equipment and related dressings. Patients should be given the appropriate cleansing products and instructed in proper use/methods to ensure safe and effective bathing practices. Per local protocol, patients who require Chlorhexidine gluconate (CHG) may be provided CHG in one of 2 forms per local protocol. Patients may be given a liquid form of 4% CHG for showering. Alternatively, patients may use organization provided cleansing soap in the shower and will be provided with CHG impregnated wipes after showering. The patient should be assessed to determine if they are able to perform the CHG wipes themselves and those who are not will have the CHG wipes performed by a caregiver. Patients who are unable or unwilling to shower should be offered alternative bathing options.

Patient Bed Bath

Patients who will receive hygiene from a caregiver or a "bed bath" will be offered at least daily and as needed. Bathing shall be performed with pre-packaged wipes impregnated with cleansing solution that is provided by the organization. Bathing with a basin, soap and water, or non-organization provided bathing wipes will not be utilized. Therefore, partial packages should be thrown away. To promote workflow and prevent contamination, a linen and hospital gown change should be considered when performing a daily bath per local written protocol.

Chlorhexidine Gluconate (CHG)

Chlorhexidine gluconate (CHG) bathing has been promoted in literature as an effective measure to decolonize the patient skin for up to 24 hours. Patients in intensive care units (ICU) and those with a central line vascular access device will receive a CHG bath/treatment daily. Local determination can be made for daily CHG bathing/ treatment in addition to or in place of cleansing wipe bathing. Avoid the eyes, ear canals, and mouth when administering CHG.

CHG may be utilized on perineal area and indwelling urinary catheters as allowed by the manufacturer and local determination. Consideration may be made to expand CHG hygiene to other populations such as those with indwelling urinary catheters, neutropenic populations, high risk units, etc. A multidisciplinary risk assessment should be performed when deciding additional use of CHG for patient hygiene.

Perineal Care

Performing cleansing of the perineum is imperative to prevent contamination of the patient. Perineal care should be done at least daily utilizing perineal wipes provided by the organization. Perineal care should be completed as soon as possible after episodes of incontinence. The number of wipes utilized will be at least the minimum number to perform all parts of perineal hygiene. For large episodes of incontinence where more than the number of wipes per package will be required, utilization of organization provided foaming cleanser or wipes prior to the use of perineal wipes could be implemented. Unused wipes are to be thrown away. If an indwelling urinary catheter is present this should be cleansed per catheter management protocol and should be documented in the electronic health record.

Documentation, Education and Refusal

Patient Hygiene will be documented in the electronic health record when performed. All elements of bathing should be documented e.g., complete bath, CHG, perineal care, etc.

Patients should be educated regarding the importance of hygiene, especially in the healthcare setting. Patients who receive CHG bathing/skin hygiene should be instructed regarding the additional efficacy of the product and potential for skin feeling sticky until drying is complete.

In the event that a patient or family member refuses patient bathing, the person should be educated regarding the importance of bathing. Documentation of refusal, additional education, and continued refusal should be documented in the electronic health record. Additional attempts to offer bathing should be provided at frequent intervals.

Additional Resources:

- Patient Hygiene Talking Points
- Adult Hygiene Evidence Grid
- **Standard work (please ensure your ministry has approved the below practices):**
  - Patient Bathing with Wipes
  - Patient Bathing with CHG Wipes
  - Patients Showering with 4% CHG Soap
  - Patients Shower Followed by CHG Wipe Treatment
  - Patient Bathing with Bath Wipes & Chlorhexidine
  - Perineal Care
  - CHG Perineal Care

Please review the following policy when you are on campus:

- Policy: Bloodborne Pathogens Exposure Control Plan
- Policy: Emerging Pathogens: Severe Illness Requiring Enhanced Precautions
  Policy: Standard Transmission-Based Precautions
- Policy: Transferring Patients to Facilities with Active Infection/Colonization of MDROs
- Policy: Regulated Waste Management

Antimicrobial Stewardship and Immediate Use Compounding

Antimicrobial Stewardship

Multi-drug resistant organisms are a major public health concern. Antimicrobial stewardship (AMS) is defined as a rational, systematic approach to the use of antimicrobial (antibiotic, antifungal and antiviral) agents to achieve optimal outcomes including cure, and reduction of toxicity, adverse effects, and resistance.
The goal of AMS is to ensure the selection of the:

- RIGHT antimicrobial
- at the RIGHT dose
- and for the RIGHT duration

Providence has an Infectious Disease Clinical Decision Team that provides oversight of AMS through education, policy and guideline development, formulary review, and data collection and analysis. All prescribers and non-prescribers are encouraged to participate in stewardship whether it is by increasing awareness with patients, discussing on rounds, or changing prescribing behaviors.

Immediate Use Compounding

Immediate Use Compounding is defined as “combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance to create a sterile preparation”.

In order to maintain compliance with regulatory requirements for IUC the following criteria must be followed by caregivers performing IUC:

- Aseptic techniques, processes, and procedures are followed to minimize the potential for contamination
- The mixture contains no more than 3 sterile products
- Any unused starting component from a single-dose container must be discarded after preparation is complete
- Single-dose containers must not be used for more than one patient
- Administration begins within 4 hours following the start of preparation or dose must be discarded
- Preparation is labeled unless immediately administered by person who prepared or witnessed preparation

Proper labelling includes:

- Names and amounts of all active ingredients
- Name or initials of the person who prepared the preparation
- Beyond-Use Date (BUD) – maximum of 4 hours

Adult: Admission, Assessment, Assumption of Care, Care Planning

Assumption of Care

When a newly assigned nurse assumes care for an assigned group of patients or a specific patient, if providing 1:1 care.

- can occur within a shift (e.g. census fluctuation), between shifts, or with patient transfer.
- Handover and information exchange will occur between the caregiver handing over care and the caregiver assuming care.
- For meal and rest breaks:
    - Provide a brief handover report to covering nurse containing essential patient safety information or task information that should/may need to be completed during the break.
    - Covering nurse will document care elements delivered during meal and rest breaks (e.g. prn medications or treatments).
    - A focused assessment is not necessary unless the patient's condition changes.

Admission

On arrival to unit, the nurse is to:

- Greet patient and family/support person as appropriate.
- Validate and verify the clinical status and stability of the patient.
- Establish a safe environment. Consider implementation of purposeful/intentional rounding (see table below).
- Release Signed and Held orders as soon as possible, but no longer than thirty minutes after arrival to unit.
- Contact admitting LIP if no orders are held or available on arrival.

Purposeful/Intentional Rounding	
CARES	4Ps
• C: Comfort: Address any pain or comfort issues • A: Anticipate: Anticipate any upcoming needs • R: Reposition: Reposition comfortably • E: Elimination: Check to see if patient needs to use the restroom and provide assistance • S: Sensitivity: Work to answer questions and/or concerns	• Pain: Assess for pain and intervene as appropriate • Potty: Implement toileting plan • Positioning: Make sure the patient is comfortable and turning has been performed as needed • Possessions/Person: Environment free of clutter; Patient's needs met; Call light and personal belongings within reach.

Assessment

Within their scope of practice, the nurse is responsible for performing and documenting a focused and comprehensive assessment.

- Focused, initial assessment of reason for which the patient is admitted **within 4 hours**.

  determined by the reason for admission/chief complaint.

- Complete, comprehensive assessment **within 24 hours**.

  the purpose: establishing nursing, diagnostic statements and developing, implementing, and evaluating a plan of care.

- Post-operative assessment **within 30 minutes** of arrival.
- Individual and population specific needs (specific patient needs or specialty patient population e.g., bariatric, geriatric, neurological, oncology, etc.)
- Ongoing assessment: Individualized, focused assessment with changes in patient condition and upon assumption of care

Care Planning

Admission

- Focused, initial plan of care **within 4 hours**.
- Complete, comprehensive plan of care **within 8 hours**.

Ongoing: Prior to handover (transfer, between shifts) and as needed.

- Comprehensive plan of care for ongoing management
- Plan of care goals will be:
  - Based on patient assessment and problems
  - Individualized and inclusive of the preferences of the patient (patient centered)
- Plan of care goals will include a start date and specific, expected end date for completion.
  - Expected end date may not be "by discharge."

Evaluation: Prior to handover (transfer, between shifts), as needed based on changes in patient condition, discharge.

- Update plan of care goals and interventions to reflect the patient's current condition and needs.
- Document goal outcome summary that evaluates the patient's progress toward goal.

Education

- Complete *Learning Assessment* on each admission
- Identify primary learner and co-learners, assess barriers to readiness to learn and describe preferred method of learning **within 24 hours**.
- Document provided education at the developmental level of the patient as appropriate for the learning style/needs patient/guardian/lay caregiver.

Clinical Instability/Deterioration

Acute change in an adult patient is a medical emergency. Action must be taken to assess, evaluate, and treat changes as needed. Response could include:

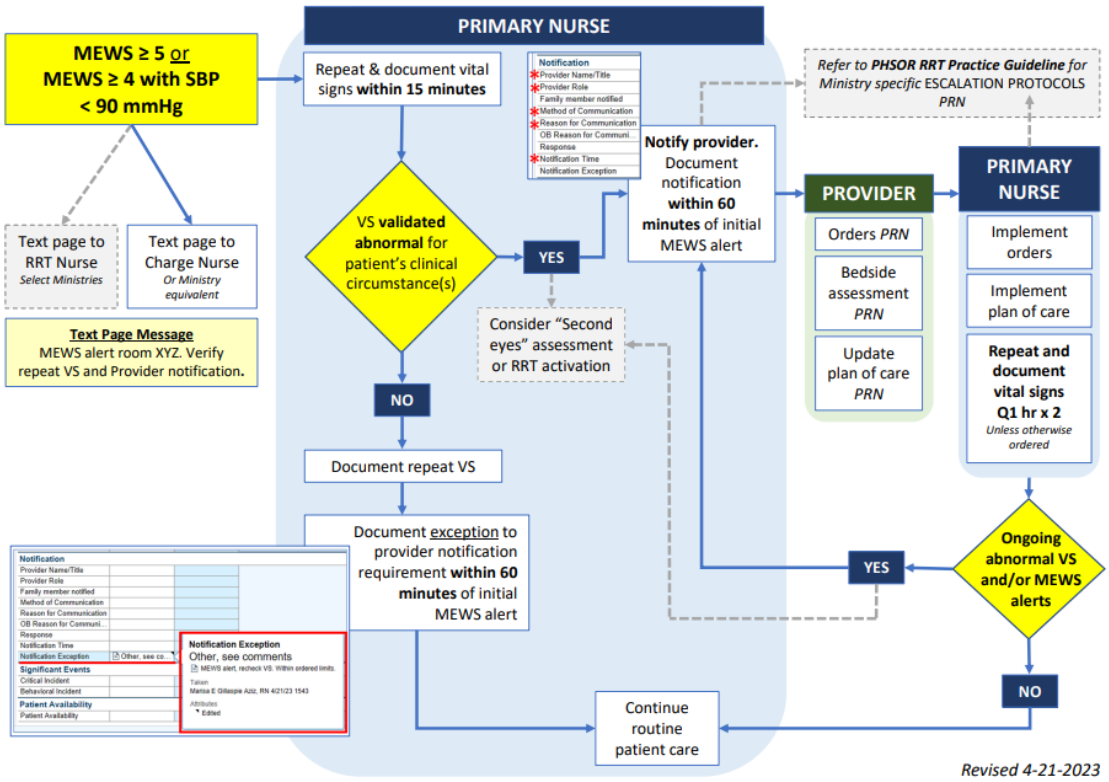
- Notification of the attending provider
- implementation of existing orders
- activation of the Rapid Response Team (RRT)
- other applicable emergency response team (e.g. Code Blue).

Remember: EHR notifications, warning system triggers, and other tools for identification of clinical instability/deterioration cannot address every possible clinical scenario that could be faced by a clinician and must not replace clinical judgment.

Modified Early Warning System (MEWS)

- a physiologic scoring system that generates a score based upon subtle changes in vital signs that have been found to precede cardiac arrest and death. This score is automatically generated based upon protocol logic built into the EHR.
- Calculated and displayed in EPIC each time vital signs are measured.
- MEWS alerts are **paged** when **MEWS ≥ 5** OR **MEWS ≥ 4 with a systolic blood pressure of < 90 mmHg**
    - MEWS alerts are not sent via page when patient is receiving care in critical care, ED, L&D, peri-op areas, has hospital service type of "hospice" or "end of life comfort care" ordered.
- Nurse response to MEWS alert (*unless otherwise ordered by LIP*):
    - Repeat and document vital signs.
    - Notify provider and document provider notification.
    - Repeat vital signs Q1 hour x 2 hours.

PHSOR MEWS Algorithm



End of Care/ Plan of Care Note

Captures:

- The patient's "story" and nursing care;
- Patient's progress toward their goals;
- Relevant details that support individualized patient care, transition in care, and patient safety.

Occurs:

- At the end of care (End of shift, transfer, discharge).
- May also occur with significant changes in patient status.

End of care/ plan of care notes:

- Do not replace required minimum documentation.
- Do not replace documentation of patient's goals, progress toward goals, and outcomes in the Epic care plan.
- Should not simply repeat clinical documentation/ data captured elsewhere in the chart.

Please review the following policy when you are on campus:

Policy: Adult Universal: Admission, Assessment, Assumption of Care, Care Planning

Regional Nursing Minimum Documentation and Notification Reference

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Vital Signs	**Admission**: T, P, R, BP, SpO2 (if indicated by condition) within 4 hrs **Ongoing**: Q8 hrs/per provider order; as condition warrants **Post-op**: T, P, R, BP, SpO2 on arrival; Q30 min x 1; Q1 hr x 3; Q4 hrs x 24, then Q8 hrs	**Admission**: T, P, R, BP, SpO2 (if indicated by condition) **Ongoing**: BID; as condition warrants	**Admission**: T, P, R, BP, SpO2 on admit Ongoing: • Q15 min X 1hr or until stable, then Q1hr for 2hrs then Q4hrs • Temp Q4hrs • SPO2 on admit and always with vital signs as needed	**Arrival**: T, P, R, BP, SpO2, pain (see below for directive on pain assess/reassess) Frequency of vital signs will be based on chief complaints, interventions and change in the patient's condition Abnormal VS on arrival should be reassessed within 1 hour or sooner if intervention provided **Non-behavoral health patient:** VS Q4 hrs and more frequently as patient's condition dictates **Behavioral health patient:** VS Q8 hrs and more frequently as patient's condition dictates	**Arrival**: T, P, R, BP, SpO2, pain (see below for directive on pain assess/reassess) This will be based on chief complaint and any change in condition Abnormal VS on arrival should be reassessed within 1 hour or sooner if intervention provided VS Q4hr and more frequently as pt condition dictates	**Adult Psychiatry:** **Arrival**: T, P, R, BP, SpO2, pain (see below for directive on pain assess/reassess) **Ongoing**: BID and as condition warrants **Pediatric Psychiatry:** **Arrival**: T, P, R, BP, SpO2, pain (see below for directive on pain assess/reassess) **Ongoing**: Once a day and as condition warrants
Height	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: On admit	If ordered by ED provider	None if obtained in ED	**Admission**: within 4 hrs
Weight ACTUAL not reported	Admission: within 4 hrs Ongoing: per provider order	Admission: within 4 hrs Ongoing: Weekly	**Admission**: On admit Ongoing: Per standard of care	**Adults**: Actual weight for patients with stroke like symptoms. **Pediatric patients**: Actual weight in kilograms for all patients 18 years of age and younger.	None if obtained in ED	**Admission**: within 4 hrs

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Prior-to-Admission Medications, Allergies, Immunizations	Admission: Verify within 4 hrs. Nurse is to verify list of PTA medications & allergy data is compiled. Assess for presence of medication patches and document notification of provider if present. Nurse will not delete medications from the list. "Not taking," "taking differently," or "completed," with a comment when applicable, will be documented when a patient reports not taking medication. Provider holds primary responsibility for medication reconciliation.	Admission: Verify within 4 hrs. Nurse is to verify list of PTA medications & allergy data is compiled. Assess for presence of medication patches and document notification of provider if present. Nurse will not delete medications from the list. "Not taking," "taking differently," or "completed," with a comment when applicable, will be documented when a patient reports not taking medication. Provider holds primary responsibility for medication reconciliation.	Admission: Verify within 4 hrs. Nurse is to verify list of PTA medications & allergy data is compiled. Assess for presence of medication patches and document notification of provider if present. Nurse will not delete medications from the list. "Not taking," "taking differently," or "completed," with a comment when applicable, will be documented when a patient reports not taking medication. Provider holds primary responsibility for medication reconciliation.	Within the Triage Assessment prior to treatment ED RN to document PTA medications and allergy data.	Verify within 4 hrs. Nurse is to verify list of PTA medications & allergy data is compiled. Assess for presence of medication patches and document notification of provider if present. Nurse will not delete medications from the list. "Not taking," "taking differently," or "completed," with a comment when applicable, will be documented when a patient reports not taking medication. Provider holds primary responsibility for medication reconciliation.	Admission: Verify within 4 hrs. Nurse is to verify list of PTA medications & allergy data is compiled. Assess for presence of medication patches and document notification of provider if present. Nurse will not delete medications from the list. "Not taking," "taking differently," or "completed," with a comment when applicable, will be documented when a patient reports not taking medication. Provider holds primary responsibility for medication reconciliation.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Initial Focused Assessment (Admission) within 4 hours Comprehensive Assessment (Admission) within 24 hours See Epic Admit Arrival Navigator	Admission: Focused assessment within 4 hrs Ongoing: Individualized focused assessment upon assumption of care and as condition warrants Post-op: Within 30 min of arrival then an individualized focused assessment upon assumption of care and as condition warrants. Comprehensive assessment within 24 hours	Admission: within 4 hrs Ongoing: Q24 hrs	Admission: On admit Ongoing: Q4 hrs or with changes	Upon Arrival: A brief triage assessment will be performed to include: • Chief complaint • Brief history of illness/injury • Allergies • Relevant medical-surgical history • Infectious disease screening • Completed fall risk assessment • Vital signs if ESI level 1-3. • Vital signs on ESI level 4 and 5 per ED RN discretion • For pts 18 yrs. and younger: actual weight in Kg. Complete Focused Assessment should be completed as soon as possible. Repeat Assessment Reassess the patient to evaluate response to intervention. • A discharge assessment is due within 15 min prior to leaving dept for transfers and admits to the Critical Care Unit. • Document mobility status for all discharges.	Admission: Individualized Focus Assessment completed as soon as possible. Repeat Assessment at least every 12 hours or on assumption of care. Reassess the patient to evaluate response to intervention. A discharge assessment is due within 15 min prior to leaving dept for transfers and admits. Mobility for all discharges.	Admission: Focused Assessment within 4 hrs Ongoing: Individualized focused assessment upon assumption of care and as condition warrants. Comprehensive assessment within 24 hours.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Initial Focused Plan of Care (admission) Comprehensive Plan of Care (admission)	Admission: within 4 hrs Admission: within 8 hrs	Admission: within 4 hrs Admission: within 8 hrs	Admission: within 4 hrs Admission: within 8 hrs	Focus plan of care is documented on White Board and communicated with patient Plan of care on admitted pt. NOTE: if patient is boarding in ED for more than 4 hours after decision to admit/orders obtained, follow the documentation for the area to be admitted.	The plan of care is made up of nursing assessment and documentation for each episode of care	Admission: within 4 hrs Admission: within 8 hrs
Comprehensive Plan of Care (on-going management)	Prior to handover of care (transfer or change of shift); Significant change in condition: Document goal/outcome evaluation to include goal/outcome summary, goal status	Prior to handover of care (transfer or change of shift); significant change in condition: document goal/outcome evaluation to include goal/outcome summary, goal status	Prior to handover of care (transfer or change of shift); Significant change in condition: document goal/outcome evaluation to include goal/outcome summary, goal status	ONGOING: update white boards with goals and inform pt of what is pending, bedside report is best practice. Handover to inpt setting. Some facilities approach this with no telephone report. Verbal reports should be consistent with SBAR report of pt condition, abnormal tests, interventions and outcomes, plan for admission, last set of vital signs and pain score.	The plan of care is made up of nursing assessment and documentation for each episode of care Handover to inpt setting. Some facilities approach this with no telephone report. Verbal reports should be consistent with SBAR report of pt condition, abnormal tests, interventions and outcomes, plan for admission, last set of vital signs and pain score.	Adult Psychiatry: Prior to handover of care (transfer or change of shift); significant change in condition: document goal/outcome evaluation to include goal/outcome summary, goal status Pediatric Psychiatry: Day and Evening Shifts: Prior to handover of care (transfer or change of shift); significant change in condition: Document goal/outcome evaluation to include goal/outcome summary, goal status Night shifts: Review nursing plan of care and update goal/outcome status PRN

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Plan of Care (discharge)	Discharge Documentation: Status of each active CPG & goals: For problems in which the goals were not met, document the follow-up services or supports as part of the discharge plan.	Discharge Documentation: Status of each active CPG. For problems in which the goals were not met, document the follow-up services or supports as part of the discharge plan.	Discharge Documentation: Status of each active CPG & goals: For problems in which the goals were not met, document the follow-up services or supports as part of the discharge plan.	Discharge Document RN to document discharge assessment specific to presenting complaint and any other issues during visit, vitals reassessed if abnormal or intervention occurred, mobility of patient at discharge, understanding of AVS and discharge instructions documented prior to discharge. For behavioral health patients: If patient declines the safety plan and/or discharge instructions or is unable to understand the safety plan and/or discharge instructions or refuses to sign any documents required by policy or refuses to be given a copy of the safety plan and/or discharge instructions, the ED RN is to alert the ED physician.	Discharge education specific to presenting complaint will be provided, as well as education for other pertinent, required, post-discharge support.	Discharge Documentation: Status of each active CPG & goals: For problems in which the goals were not met, document the follow-up services or supports as part of the discharge plan.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Pain Assessment	Admission: within 4 hrs • Pain assessment with pain rating, descriptors & assessment tool. • Acceptable comfort level & effects of pain on goal. During first 24 hrs: • Pain assessment every 2-4 hours around the clock. If no pain on admission, evaluate upon assumption of care and as condition warrants. ○ Pain rating ○ IF there is a change in pain and/or change in pain location, include: ▪ Location and description ▪ Onset, duration and variation or rhythm ▪ Nonverbal cues of pain expression ▪ Effects of pain on acceptable comfort level ○ Reassessment is completed according to the patient condition and the expected response to intervention. **After 24 hrs**: • Pain assessment every 8 hours, as condition warrants, and on discharge. If the patient's pain rating is greater than the identified acceptable comfort level or is unacceptable at any time, continue monitoring until an acceptable level is achieved. Thereafter, every 8 hours and as condition warrants. • Pain rating • IF there is a change in pain and/or change in pain location, include: ○ Location and description ○ Onset, duration and variation or rhythm ○ Nonverbal cues of pain expression ○ Effects of pain on acceptable comfort level • Reassessment is completed according to the patient condition and the expected response to intervention. Opioid therapy: Upon initiation, increasing of therapy or combining analgesic regimens based on range order dosing: • Sedation level • Quality of respirations Plan of Care: Initiate appropriate Pain CPG if pain rating > Acceptable comfort level' and unacceptable Acceptable comfort level: Only requires documentation at time of admission AND if discussion with patient/family determines need to establish new goal.			Pain is assessed on arrival and post intervention. • Pain assessment with pain rating, descriptors & use of assessment tool when needed. • If no pain on admission, evaluate upon assumption of care and as condition warrants. • Pain assessment to be documented if there is a change in pain, change in pain location, change in frequency of pain • Reassessment is completed according to the patient's condition.	Pain is assessed on arrival and post intervention. • Pain assessment with pain rating, descriptors & assessment tool. • If no pain on admission, evaluate upon assumption of care and as condition warrants. • Pain rating IF there is a change in pain and/or change in pain location, include: Reassessment is completed according to the patient condition.	Adult Psychiatry: Pain is assessed on arrival and post intervention. • Pain assessment with pain rating, descriptors & assessment tool. • If no pain on admission, evaluate upon assumption of care and as condition warrants. • Pain rating • IF there is a change in pain and/or change in pain location, include: Reassessment is completed according to the patient condition. Pediatric Psychiatry: Pain is assessed on arrival and post intervention. • Pain assessment with pain rating, descriptors & assessment tool. • If no pain on admission, evaluate upon assumption of care and as condition warrants when patient is awake • Pain rating • If there is a change in pain and/or change in pain location, include: Reassessment is completed according to the patient condition.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Pressure Injury Risk Assessment (Braden or Braden Q Scale)	Admission: within 4 hrs Ongoing: Q24 hrs, transfer of care to another department, significant change in patient condition	Admission: within 4 hrs Ongoing: Q shift	Admission: within 4 hrs Ongoing: Q24 hrs, transfer of care to another department, significant change in patient condition	Patients that will be admitted and have been in bed > 2 hrs: Description of any skin impairment to be documented	Admission: within 4 hrs Ongoing: Q24 hrs, transfer of care to another department, significant change in patient condition	Adult Psychiatry: Admission: within 4 hrs Ongoing: Q 24 hrs Pediatric Psychiatry: Admission: within 4 hrs Ongoing: As needed per patient condition
Skin plan of care for Braden ≤ 18 or one sub-score ≤ 2	Within 4 hours of meeting assessment criteria	Within 4 hours of meeting assessment criteria	Within 4 hours of meeting assessment criteria		Within 4 hours of meeting assessment criteria	Within 4 hours of meeting assessment criteria
Head to toe skin survey/assessment Including presence of medication patches. See "prior to admission medications"	Admission: within 4 hrs (Includes 4-eye assessment) Ongoing: On assumption of care, transfer of care to another department, with significant change in patient condition	Admission: within 4 hrs (Includes 4-eye assessment) Ongoing: On assumption of care, transfer of care to another department, with significant change in patient condition	Admission: within 4 hrs (Includes 4-eye assessment) Ongoing: On assumption of care, transfer of care to another department, with significant change in patient condition	Description of any skin impairment to be documented	Admission: within 4 hrs (Includes 4-eye assessment) Ongoing: On assumption of care, transfer of care to another department, with significant change in patient condition	Adult Psychiatry: Admission: within 4 hrs Ongoing: Q 24 hrs Pediatric Psychiatry: Admission: within 4 hrs Ongoing: As needed per patient condition
Fall Risk Assessment	Admission: within 4 hrs Ongoing: On assumption of care & with significant change in patient condition	Admission: within 4 hrs Ongoing: On assumption of care & with significant change in patient condition	Admission: within 4 hrs Ongoing: On assumption of care & with significant change in patient condition	Within the Triage Assessment on all adult patient	Admission: within 4 hrs Ongoing: On assumption of care & with significant change in patient condition	Adult Psychiatry: Admission: within 4 hrs Ongoing: On assumption of care & with significant change in patient condition Pediatric Psychiatry: Admission: within 4 hrs Ongoing: With significant change in patient condition or medication
Disability	Admission: within 24 hrs	Admission: within 24 hrs	Admission: within 24 hrs	Disability to be documented in focused assessment if applicable.	Admission: within 24 hrs	Adult and Pediatric Psychiatry: Admission: within 24 hrs

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Interpreter Services	Document • Patient/family initial request for interpreter • Number of attempts made to schedule an interpreter, in-person or otherwise • Interpreter confirmation time (time confirmed, not time arrived) and agency providing the interpreter • Any situation where unable to provide patient/family requested modality and why (e.g., when in-person interpreter is requested but not available) • Interim services provided when there is a wait for an interpreter (in-person or otherwise) • Initial Interpreter arrival/departure. • Interpreter shift change (e.g., if there are three interpreters to cover a 12-hour shift, document on initial interpreter arrival, document at first shift change, second shift change, and final departure time). • Upon assumption of care, document to the exception if the interpreter is not present when EPIC/patient chart indicates otherwise. • Document modality change (e.g., from video relay cart to in-person interpreter) • Each engagement of patient using a video relay cart in absence of in-person interpreter • Do not need to document: Upon assumption of care if no change in interpreter service/schedule • Do not need to document: Each time a caregiver engages with patient using scheduled in-person interpreter					
Nutrition Risk	**Admission**: within 24 hrs **Ongoing**: On transfer, every 4 days & significant change in condition	**Admission**: within 24 hrs **Ongoing**: On transfer, every 4 days & significant change in condition	**Admission**: within 24 hrs **Ongoing**: As pertinent to patient status	N/A	An assessment will be completed on in-patients residing in an observation unit within 24 hours of conversion to in-patient status	**Admission**: within 24 hrs **Ongoing**: On transfer, every 4 days & significant change in condition
Bedside Swallow Screen – for patients age 80 years and greater and those with recent and/or new stroke	Complete on admission prior to any oral intake (including medications), if not NPO or already completed in ED	N/A	Complete on admission prior to any oral intake (including medications), if not NPO	Complete prior to any oral intake (including medications), if not NPO	Completed on admission prior to any oral intake (including medications), if not NPO or already completed in ED.	Adult Psychiatry: Complete on admission prior to any oral intake (including medications), if not NPO or already completed in ED Pediatric Psychiatry: Complete if clinically indicated.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Confusion Assessment Method (CAM/ICU CAM) Note: If the patient is alert & oriented at time of admission, the screening is considered complete.	**Admission**: within 4 hrs **Ongoing**: with significant change in behavior or condition	**Admission**: within 4 hrs **Ongoing**: with significant change in behavior or condition	**Admission**: within 4 hrs **Ongoing**: with significant change in behavior or condition	Not available ASAP	**Admission**: within 4 hrs **Ongoing**: with significant change in behavior or condition	**Admission**: within 4 hrs **Ongoing**: with significant change in behavior or condition
Alcohol Use Screening	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs
CIWA-aR Scale Ongoing	As needed	As needed	As needed	As needed	As needed	As needed
Pregnancy/ Lactation Screen	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs	Within the Triage Assessment prior to treatment (LMP for all females within childbearing age)	If not done in ED, on admission within 4 hours	
Suicide Risk	**Admission**: within 24 hrs	**Admission**: within 24 hrs	**Admission**: within 24 hrs	Those identified at risk	**Admission**: within 24 hrs	**Admission**: within 4 hours
Latex Screen	**Admission**: within 4 hrs	**Admission**: within 4 hrs	**Admission**: within 4 hrs	N/A	**Admission**: within 4 hrs unless completed in ED	Adult and Pediatric Psychiatry: Admission: within 4 hrs

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Patient Profile items: General Information, Current Health, Mutuality/Individual Preferences, Functional Level Prior/Current, Abuse Screen, Values/Beliefs/Spiritual Care/Social Determinants of Health (SDOH)	Admission: within 24 hrs	Admission: within 24 hrs	Admission: within 24 hrs	Abuse screening is asked of all patients and within the Triage Assessment area.	Admission: within 24 hrs unless completed in ED	Adult and Pediatric Psychiatry: Admission: within 24 hrs
Fluid Balance Interoperability Infusion Verify should be used and documented for all in-scope medication / solution infusions at a minimum of intervals designated	Q8 hrs until 24 hrs after d/c of IV or Foley	Q8 hrs if on I/O or Tube Feedings	Urine output Q1 hr on unstable patients or those with fluid volume imbalances; others Q8 hr	End of visit for all admission to critical care or those who are requiring I/O monitoring. (ie. IV fluids, foley, etc.)	Every eight hours for those who require I/O monitoring (ie. IV fluids, foley, etc.)	N/A
Drainage tubes & lines	Per scheduled shift of nurse and with significant change in connection, patency & placement		Per scheduled shift of nurse and with significant change in connection, patency & placement	D/C all drains/tubes/lines for pt being discharged that are applicable.	Per scheduled shift of nurse and with significant change in connection, patency & placement	Per scheduled shift of nurse and with significant change in connection, patency & placement
IV Administration (large volumes) Interoperability Infusion Verify should be used and documented for all in-scope medication / solution infusions at a minimum of intervals designated	At time of hanging and ending solution, end of shift, rate changes, & d/c solution*	At time of hanging and ending solution, end of shift, rate changes, & d/c solution	At time of hanging and ending solution, end of shift, rate changes, & d/c solution	At time of hanging and ending solution, rate changes	At time of hanging and ending solution, end of shift, rate changes, & d/c solution	At time of hanging and ending solution, end of shift, rate changes, & d/c solution

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Vascular Site Assessment	Every 4 hours, upon assumption of care and with changes in patient condition • Dressing status	Every 4 hours, upon assumption of care and with changes in patient condition • Dressing status	Every 4 hours, upon assumption of care and with changes in patient condition • Dressing status	Peds/Adults—documentation of abnormal findings	Every 4 hours, upon assumption of care and with changes in patient condition	Every 4 hours, upon assumption of care and with changes in patient condition • Dressing status
Critical Value Notification Document critical labs under provider notification in EHR.	Medical Record will reflect date/time critical lab results were reported to provider and/or actions taken.	Medical Record will reflect date/time critical lab results were reported to provider and/or actions taken.	Medical Record will reflect date/time critical lab results were reported to provider and/or actions taken.	Medical Record will reflect date/time critical lab results were reported to provider and/or actions taken.	Per Critical Value Notification Policy. • Each/every call must be documented in the EMR under "Notifications" • If no response within 15 minutes from first call, document under "Notifications," and activate chain of command	Medical Record will reflect date/time critical lab results were reported to provider and/or actions taken.
ADLs	Per scheduled shift of nurse	Q shift per scheduled nurse	Per scheduled shift of nurse and standard of care	PRN Note: Behavioral Health Pt to have ADLs Qshift.	PRN	Adult Psychiatry: Per scheduled shift of nurse Pediatric Psychiatry: Twice a day (days and evenings). Allow patients to sleep at night.

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Nutrition Note: Routine checking of tube feeding residuals is not required nor recommended Refer to policy Calorie Count for patients with order for calorie count	Q meal • Diet type • % eaten Q8 hrs – Tube Feeding • Formula type • Formula strength • Rate	Q meal • Diet type • % eaten Q8 hrs – Tube Feeding • Formula type • Formula strength • Rate	Q meal • Diet type • % eaten Per scheduled shift of nurse – Tube Feeding • Formula type • Formula strength • Rate	PRN	Per physician order.	PRN
Restraints	Non violent, Non self-destructive • On initiation • On-going: Q2 hrs Violent or Self-destructive • On initiation • On-going: Q15 min	Non violent, Non self-destructive • On initiation • On-going: Q2 hrs Violent or Self-destructive • On initiation On-going: Q15 min	Non violent, Non self-destructive • On initiation • On-going: Q2 hrs Violent or Self-destructive • On initiation • On-going: Q15 min	Non violent, Non self-destructive • On initiation • On-going: Q2 hrs Violent or Self-destructive • On initiation • On-going: Q15 min	Non violent, Non self-destructive • On initiation • On-going: Q 2hrs Violent or Self-destructive • On initiation • On-going: Q15 min	Non violent, Non self-destructive • On initiation • On-going: Q2 hrs Violent or Self-destructive • On initiation • On-going: Q 15 min
Cardiac Monitoring on Telemetry Process for printing strips: Per Ministry specific protocol	Frequency of printing strips • Admission • Q 12 hrs • Change in condition/rhythm • Critical/significant event		Frequency of printing strips • Admission • Q 12 hrs • Change in condition/rhythm • Critical/significant event	If placed on Telemetry: Initial rate and rhythm should be documented in Epic. Any change in rhythm is documented.	If placed on Telemetry: Initial rate and rhythm should be documented in Epic (this could be done remotely). Any change in rhythm is documented. Patients who are remotely monitored, additional documentation is completed by Telemetry Technician. Nurse is responsible for reviewing all documentation.	N/A

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Cardiac Monitoring on Telemetry Process for documentation on strips: Per Ministry specific protocol	Frequency of documentation on strips • P-R interval • QRS interval • QT interval		Frequency of documentation on strips • P-R interval • QRS interval • QT interval			
Cardiac Monitoring on Telemetry Clinical documentation: Direct care nurse	With assessment per unit routine (within EHR) • Telemetry monitor on/off • Cardiac rhythm (Rhythm present on monitor) On each strip: • Validate measurements documented on rhythm strip • Document nursing interpretation of cardiac rhythm • Date, time, sign (By signing, you are validating strip measurements)		With assessment per unit routine (within EHR) • Telemetry monitor on/off • Cardiac rhythm (Rhythm present on monitor) On each strip: • Validate measurements documented on rhythm strip • Document nursing interpretation of cardiac rhythm • Date, time, sign (By signing, you are validating strip measurements)			

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Hemodynamics			• Arterial, CVP & PA pressures per standard of care • Cardiac output per standard of care	Hourly monitoring, more frequently if pt condition changes.	N/A	N/A
Vasoactive IV Drug Administration			BP Q1 hr when titrating or per standard of care	Per Provider Order or per protocol	Per Provider Order	N/A
Neuromuscular Blocking Agents			• Initial: Baseline neurological assessment, RASS & Train of Four (TOF) • Ongoing: RASS & TOF: Upon titration; During continuous infusion: Q4 hrs	If used for RSI - per guidelines	N/A	N/A
Temporary Pacemaker			Assessment of patient's underlying rhythm per scheduled shift of nurse	N/A	N/A	N/A
Ventilated Patients			Assessment of lung sounds Q4 hrs & PRN	Assessment of lungs upon intubation, with change in condition, transfer, or Q4 hr if stabilized	N/A	N/A

Charting Element	Medical/Surgical	Acute Rehab	Critical Care	Emergency Department	Observation Units: extension of ED, outpatient status	Adult and Pediatric Psychiatry
Modified Early Warning System (MEWS) MEWS ≥ 5 MEWS ≥ 4 with SBP < 90 mmHg	Repeat vital signs and document Provider notification and document Repeat and document vital signs Q1 hr x2 unless otherwise ordered					
Children's Hospital Early Warning System (CHEWS)						
Changing oxygen demand: • Increasing oxygen by 3 or more liters • Greater than 6 liters of oxygen in use, if a change from baseline or previous assessment and the provider is not already aware.	Provider notification and document		Provider notification and document	Provider notification and document	Provider notification and document	

Please review the following policy when you are on campus:

Policy: Regional Nursing Minimum Documentation and Notification Reference

Patient Identification and Verification

It is the policy of the Providence Health & Services Oregon Region hospitals and clinics to ensure that every patient's identification is verified prior to the initiation of health care services, including, but not limited to, patient registration, order entry*****, medication administration, medical and surgical interventions, discharge and transfer, blood transfusions, diagnostic testing, patient monitoring and emergency care, using at least two unique patient identifiers.

*** Important:** The Patient Identification **Red Rule** applies in all situations *where compliance is actually feasible*, and where it isn't feasible, such as when patients and caregivers are not physically present together but orders must be entered, all caution is expected toward avoiding incorrect order entries, and the responsibility for accuracy lies firmly with the caregiver entering the orders.

Identification:

The responsible caregiver must properly identify the patient by checking at least two unique identifiers to ensure the right patient receives the right services. Typically, the patient's full name and date of birth will be used, but other acceptable identifiers are listed below.

For the administration of blood/blood products refer PH&S Oregon Region Nursing Policy – Blood and Blood Products: Consent, Administration, and Transfusion Reaction – Adult, Pediatric, and Neonate

Acceptable identifiers, each counts as *one* identifier:

1. Full name, first and last
2. Date of birth
3. Full face photo in Epic
4. Last four digits of social security number
5. Patient address
6. Telephone or fax number
7. Photo ID, Government-issued such as state license, ID card, passport
8. Bar code
9. Medical record number
10. Health plan beneficiary number or account number
11. Biometric identifiers, including finger prints and voiceprints
12. Personal email address
13. Any other unique identifying number, characteristic or code
14. Other sources of information as dictated by unit/department policy

Room numbers, diagnosis, patient descriptors or bed location
are ***never*** acceptable identifiers.

Verification:

- All caregivers are responsible to verify that the ordered treatment/procedure is intended for the identified patient by comparing the patient's two-specified identifiers with ideally the same two-specified identifiers found on the order, requisition, MAR, etc.
- Caregivers should use open-ended questions to verify the patient identifiers, for example, ask "What is your name?" or "What is your date of birth?"
- An identification armband is to be placed on every patient as appropriate or per the Regional Access Services policy Access *Services Validation of Patient Identification Number 1220*. Armband must be attached to the patient/resident at all times.

Special Populations:

- Confused or unresponsive patients:
    - Match full name, date of birth and MRN on armband with government-issued ID and photo in Epic, if available
    - Verbal verification may be obtained from department staff, patient's legal guardian/surrogate or family as required
- Unknown Patient
    - If the patient who arrives in the ED is unable to provide basic identification required for registration or when a patient cannot be positively identified, the patient will be registered using the ED Unknown Patients Epic workflow.
    - Once the patient has been positively identified, follow the appropriate Epic record reconciliation process outlined in the *Anonymous Patients* Epic workflow.
- Newborn Mother Identification: See the *Newborn Mother Identification* Policy.

Please review the following policy when you are on campus:

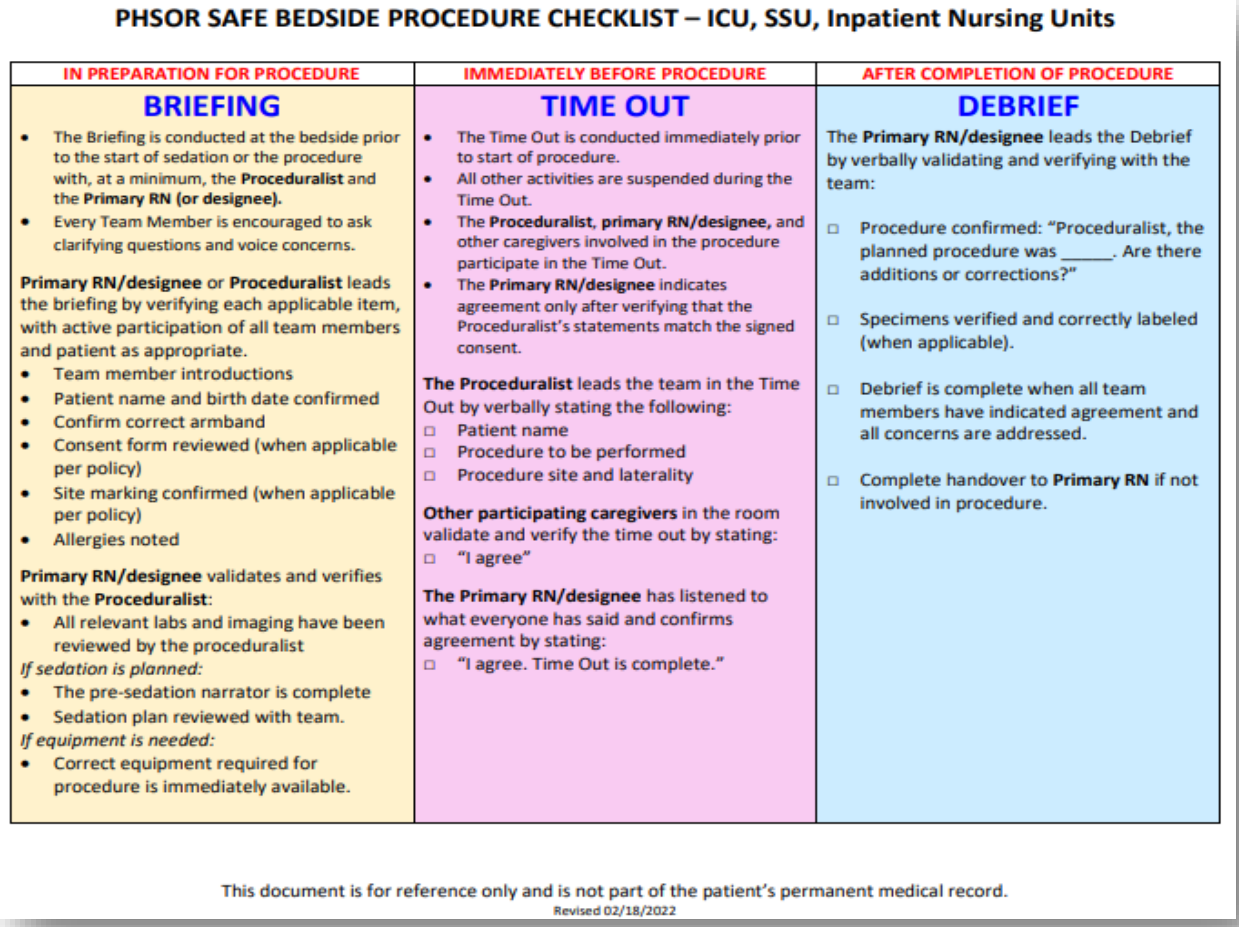
Policy: Patient Identification and Verification

Universal Protocol for Invasive Procedures

All patient care teams in PHSOR will utilize the steps outlined in this policy for site marking and a Safe Procedure Checklist in the care of patients undergoing invasive procedures.

This policy applies to any area in which invasive procedures are performed, including Operating Rooms, Endoscopy Suites, Cardiovascular Labs, Diagnostic Imaging/Interventional Radiology Units, Critical Care Units, Emergency Departments, Labor and Delivery, and all other inpatient and short stay nursing units.

Invasive Procedures in Scope: All procedures involving puncture or incision of the skin or entry into a natural orifice, including surgery, endoscopy, vascular catheterization procedures, regional anesthetic blocks, insertion or implantation of any foreign device in a body part, needle biopsy/aspiration/injection of diagnostic or therapeutic substance (including radiologic contrast material) into body cavities, internal organs, central nervous system, and joints.
For example: Any procedure requiring procedural sedation, any procedure requiring cardiac or oxygen monitoring, any central line placement, tube thoracostomy, thoracentesis, paracentesis, arthrocentesis, lumbar puncture, biopsy
Exempted Invasive Procedures: Certain minor invasive procedures which carry minimal risk are exempted from this policy. Examples of minor invasive procedures include venipuncture for blood collection, peripheral IV placement, oral or venous administration of imaging contrast agents, and insertion of nasogastric tube, rectal tube, urinary catheter, and wound packing.



PHSOR SAFE BEDSIDE PROCEDURE CHECKLIST – ICU, SSU, Inpatient Nursing Units

IN PREPARATION FOR PROCEDURE	IMMEDIATELY BEFORE PROCEDURE	AFTER COMPLETION OF PROCEDURE
BRIEFING • The Briefing is conducted at the bedside prior to the start of sedation or the procedure with, at a minimum, the **Proceduralist** and the **Primary RN (or designee).** • Every Team Member is encouraged to ask clarifying questions and voice concerns. **Primary RN/designee** or **Proceduralist** leads the briefing by verifying each applicable item, with active participation of all team members and patient as appropriate. • Team member introductions • Patient name and birth date confirmed • Confirm correct armband • Consent form reviewed (when applicable per policy) • Site marking confirmed (when applicable per policy) • Allergies noted **Primary RN/designee** validates and verifies with the **Proceduralist**: • All relevant labs and imaging have been reviewed by the proceduralist *If sedation is planned:* • The pre-sedation narrator is complete • Sedation plan reviewed with team. *If equipment is needed:* • Correct equipment required for procedure is immediately available.	**TIME OUT** • The Time Out is conducted immediately prior to start of procedure. • All other activities are suspended during the Time Out. • The **Proceduralist**, **primary RN/designee,** and other caregivers involved in the procedure participate in the Time Out. • The **Primary RN/designee** indicates agreement only after verifying that the Proceduralist's statements match the signed consent. **The Proceduralist** leads the team in the Time Out by verbally stating the following: □ Patient name □ Procedure to be performed □ Procedure site and laterality **Other participating caregivers** in the room validate and verify the time out by stating: □ "I agree" **The Primary RN/designee** has listened to what everyone has said and confirms agreement by stating: □ "I agree. Time Out is complete."	**DEBRIEF** The **Primary RN/designee** leads the Debrief by verbally validating and verifying with the team: □ Procedure confirmed: "Proceduralist, the planned procedure was _____. Are there additions or corrections?" □ Specimens verified and correctly labeled (when applicable). □ Debrief is complete when all team members have indicated agreement and all concerns are addressed. □ Complete handover to **Primary RN** if not involved in procedure.

This document is for reference only and is not part of the patient's permanent medical record.
Revised 02/18/2022

Please review the following policy when you are on campus:

Policy: Universal Protocol for Invasive Procedures

Bedside Swallow Screen

Bedside Swallow Screen is a validated tool to identify dysphagia. At Providence, nurses use the Yale Swallow Protocol to perform Bedside Swallow Screen for patients that are at risk of dysphagia prior to **ANY** oral intake, including medications.

When to perform:

- In the Emergency Department
- On admission to in-patient unit
- With any new risk for aspiration

Indications:

- Possible, recent, or new ischemic stroke or Transient Ischemic Attack (TIA)
- Possible, recent, or new hemorrhagic stroke (Intracerebral hemorrhage or Subarachnoid Hemorrhage)
- Post procedural for: Carotid Artery Stent (CAS), Trans-Carotid Artery Revascularization (TCAR), or Carotid Endarterectomy (CEA)
- All patients age 80 and greater

Additional Considerations:

- After extubation if patient has been intubated for more than 48 hours
- Post-operative anterior cervical surgery
- Any noted swallowing issues or concerns of aspiration
    - Presence of any enteral feeding tube (nasogastric, gastric, or jejunal)
    - Presence of a tracheostomy
    - Altered mental status
    - Hoarse or wet voice

Important: If changes in the patient's clinical status (e.g. Increased lethargy, new weakness, new aphasia, or significant worsening of weakness or aphasia) **AT ANY TIME** result in a new risk for aspiration, the Yale Swallow Protocol must be performed before oral alimentation or medications are administered.

Contraindications/ Deferring Bedside Swallow Screen:

- Unable to remain alert for testing.
- Eating a modified diet (thickened liquids) due to pre-existing dysphagia.
- Existing enteral tube feeding via stomach or nose.
- Head-of-bed restrictions <30°.
- Tracheostomy tube present.
- Nil per os by physician order.

Pass/Fail Criteria:

PASS: Completes uninterrupted drinking of all 3 ounces of water without overt signs of aspiration, e.g., coughing or choking, either during or immediately after completion.

- If patient passes, collaborate with provider to order appropriate oral diet.

FAIL: Inability to drink the entire 3 ounces in sequential swallows due to stopping/starting or patient exhibits overt signs of aspiration, e.g., coughing or choking, either during or immediately after completion.

If patient fails, **keep NPO** (including medications) and discuss referral for **objective swallowing evaluation** by speech-language pathologist with provider.

Documentation:

- Inpatient: Navigate to "Flowsheets." Nursing Bedside Swallow Screen documentation is available on the Stroke Care, Adult PCS, Critical Care PCS, and Pediatric PCS Body Care System flowsheet.
- ED: Navigate to "ED Narrator" and open the Stroke Narrator.

Document:

- Severe risk factors present
- Additional observed signs/symptoms for aspiration risk
- Status: Nursing Bedside Swallow Screen

Please review the following policy (includes EPIC tip sheets) when you are on campus:

Policy: Bedside Swallow Screen

Yale Swallow Protocol

Step 1: Exclusion Criteria

___ Yale Swallow Protocol Deferred due to NO concern for aspiration risk.

Any YES answer to the following risk factors will also defer administration to protocol:

Yes	No	
___	___	Unable to remain alert for testing.
___	___	Eating a modified diet (thickened liquids) due to pre-existing dysphagia.
___	___	Existing enteral tube feeding via stomach or nose.
___	___	Head-of-bed restrictions <30°.
___	___	Tracheostomy tube present.
___	___	Nil per os by physician order.

If the patient's clinical status changes resulting in a new risk for aspiration, the protocol must be readministered before oral alimentation or medications are ordered.

Step 2: Administration Instructions

If patient is deemed an aspiration risk and all exclusion criteria in Step 1 are checked "NO," proceed with protocol:

- Brief Cognitive Screen:

  What is your name?
  Where are you right now?
  What year is it?

- Oral-Mechanism Examination

  Labial closure
  Lingual range of motion
  Facial symmetry (smile/pucker)

- Perform 3-ounce water swallow challenge:

  Sit patient upright at 80-90° (or as high as tolerated >30°).
  Ask patient to drink the entire 3 ounces (90cc) of water from a cup or with a straw, in sequential swallows, and slow and steady but without stopping. (Note: Cup or straw can be held by clinician or patient.) Assess patient for interrupted drinking and coughing or choking during or immediately after completion of drinking.

  Note: Information from the brief cognitive screen and oral mechanism examination provide information on odds of aspiration risk with the 3-ounce water swallow challenge and should not be used as exclusionary criteria for screening.

Step 3: Pass/Fail Criteria

Results and Recommendations

____ PASS: Complete and uninterrupted drinking of all 3 ounces of water without overt signs of aspiration, i.e., coughing or choking, either during or immediately after completion.

- If patient passes, collaborate with MD/PA/LIP to order appropriate oral diet. If dentate, order a soft solid consistency or regular consistency diet. If edentulous, order a liquid and puree diet.

____ FAIL: Inability to drink the entire 3 ounces in sequential swallows due to stopping/starting or patient exhibits overt signs of aspiration, i.e., coughing or choking, either during or immediately after completion.

- If patient fails, keep nil per os (including medications) and discuss with the MD/PA/LIP the need for an objective swallowing evaluation by speech-language pathologist.
- Readminister the protocol in 24 h if patient shows clinical improvement.

(Taken from: Suiter, D.M., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A prospective double-blinded videofluoroscopic study. *Dysphagia, 29,* 199-203.)

Validation Information

1. Three-ounce water swallow test validation first reported on 44 stroke patients by DePippo et al. (1992). Failure required referral for objective (VFSS) dysphagia test.

2. A revised 3-ounce water swallow challenge administered to 3,000 hospitalized patients with 14 distinct diagnoses and referenced with FEES as the standard correctly predicted aspiration 96.5% of the time, with a negative predictive value of 97.9%, and a false negative rate of ≤2.0%. (Suiter, D.B. & Leder, S.B. [2008]. Clinical utility of the 3-ounce water swallow test. *Dysphagia, 23*, 244-250.)

3. Validation study of Yale Swallow Protocol was reported using 25 subjects with categorical diagnoses of esophageal surgery, head & neck cancer, neurosurgery, medical issues, or neurological (CAV, MS, TBI) and using VFSS as the standard reference. Seven participants passed and 18 failed the 3-ounce swallow challenge. Of the 18 who failed, 14 aspirated on VFSS (true positives) and 4 did not aspirate on VFSS (false positives). Sensitivity for the protocol = 100%, specificity = 64%, positive predictive value = 78%, and negative predictive value = 100%. All participants who passed the protocol, i.e., deemed to have no aspiration risk, also did not aspirate during VFSS. (Suiter, D.M., Sloggy, J., & Leder, S.B. [2014). Validation of the Yale Swallow Protocol: A prospective double-blinded videofluoroscopic study. *Dysphagia, 29,* 199-203.)

Hospital Acquired Pressure Injury (HAPI) Prevention

Pressure injuries result in localized damage to the skin and underlying soft tissue. These injuries usually occur over a bony prominence, relate to pressure from devices, or intense and/or prolonged pressure/shear force on any skin surface.

Nursing Responsibilities to prevent and treat HAPI

Prevent wounds from occurring when a patient is in our care	• We use the Braden Scale to assess risk for skin breakdown in adult patients • We use preventative foam dressings • We use air overlays and seat cushions • Keeping the patient's skin clean and dry • Keeping bedclothes clean, dry, wrinkle-free, and unlayered (no folded blankets or multiple sheets under a patient) • Offloading or "floating" bony prominences • Ensuring proper hydration and nutrition • Encourage safe mobility and ensure frequent turning

Identify existing wounds ASAP	• 4-eyes skin assessment within 4 hours of admission to your unit
	  ○ Document any wounds present upon admission
	• 4-eyes skin assessment within 4 hours of transfer to your unit from another unit
	  ○ Document any wounds present upon arrival to your unit
	• Daily Shift Assessment includes skin assessment
	  ○ Especially over bony prominences, under medical equipment, and existing wounds
	  ○ Remove dressing, masks, ted hose, tubing, braces, glasses, clothing to properly assess the skin/wound(s). If you are unable to remove a device and assess, document your rationale in Epic
	  ○ Foam dressings should be dated/timed when applied so they can be removed as per order
	The 4-eyes skin assessment process utilizes two nurses or a nurse and a CNA to thoroughly evaluate the patient's skin condition and identify/document any existing skin injuries.

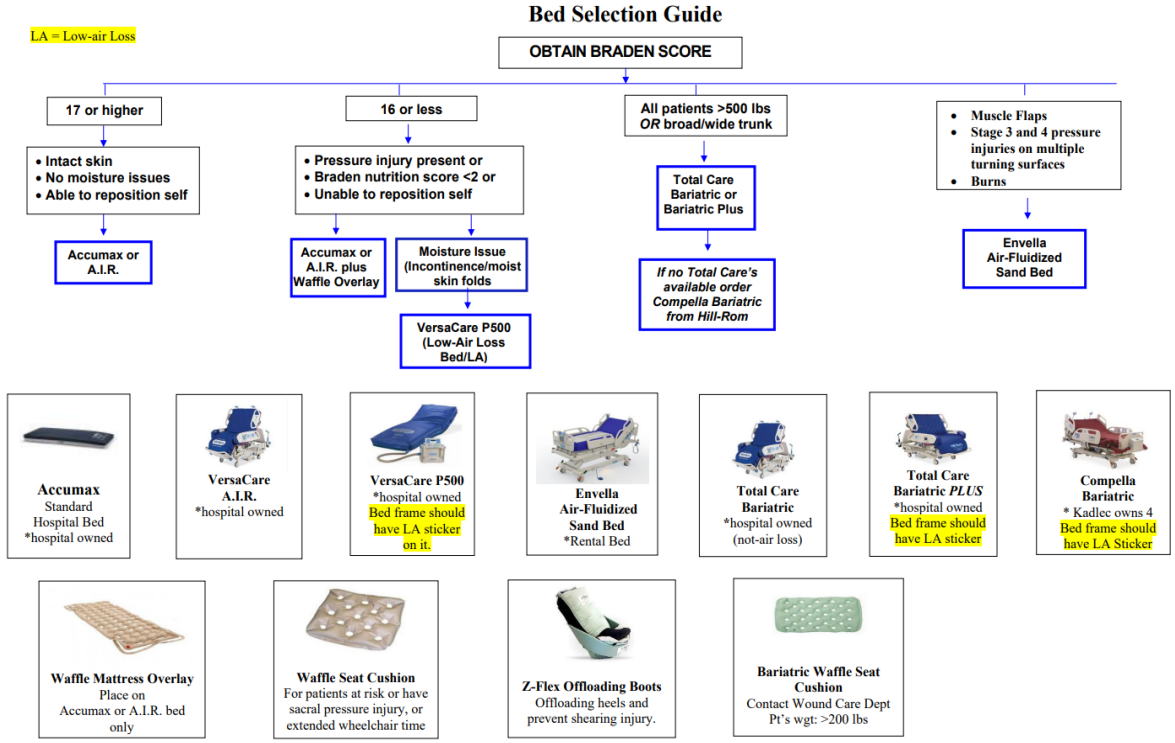
Assess, document, report wounds	• We use EPIC Avatar to place wounds anatomically and chart assessment • We take pictures of injuries using the iPad or iPhone on unit and Haiku. Pictures are used as a supplement and do not replace documentation or assessment
Implement evidence-based best practice treatments for existing wounds	• We use wound care guidelines and high-quality dressings along with evidence-based practice to initiate proper care quickly

Beds, Specialty, and Therapeutic Support Surfaces

Based on the patient's assessed Braden Scale score the patient may require a special bed or support surface to prevent/treat HAPI(s). Please see the Bed Selection Guide below to assist in selecting the appropriate support surface for your patient. As a reminder:

- Air mattress overlay does not substitute turning, repositioning, moisture management, nutritional support, ongoing risk and assessment

- Replace existing mattress with a support surface if patient: cannot be positioned off pressure injury, has pressure injury on two or more turning surfaces, fails to heal despite care, is at high risk for pressure injury
- Bariatric patients require bariatric bed



Wound Assessment Documentation

What to document	When to document wound assessments	When to document wound measurements

• Full visualization of the wound. Remove dressings or other items that obscure your view
• Measurement length (head-to-toe orientation) and width (widest side-to-side portion)
• Assessment of the wound bed and surrounding healthy intact tissue includes:
  ○ Color
  ○ Texture
  ○ Exudate (drainage)
  ○ Margins (edges)
	• Immediately when wound is identified
	• Daily with Shift Assessment
	• At discharge
		• Immediately when wound is identified
		• Weekly thereafter AND
		• When significant changes of wound are noted
		• At discharge

Notify WOCN & MD of any of the following issues:

- Wound with devitalized tissue
- Eschar
- Wound vac
- Diabetic foot ulcers
- Infected wounds
- Pressure injuries

Wound Treatment Goals:

- Preventing injury or pressure insult to the damaged area
- Keep the wound clean
- Keep the wound bed (healthy granulation tissue) moist, do not allow it to dry out
- Keep the wound bed clean by cleansing with a gentle approved wound cleanser or saline
- Keep the peri-wound (surrounding skin) dry, do not allow it to remain wet as this will cause additional breakdown
- Encourage good nutrition, hydration, and rest for the patient
- Follow orders from WOCN that apply to wound care/prevention

Refer to the Wound Care Guidelines Reference Tools for additional information on wound classification and wound care interventions.

Skin Tear Prevention and Management

Prevent skin tears by:	Treat skin tears by:
• Protecting bony prominences • Ensuring proper hydration and nutrition • Keeping skin clean, dry, and moisturized • Avoiding friction and shear	• Cleanse with saline • Approximate (close) skin flap if possible • Dress the tear with a foam or silicone dressing. Be sure to date and initial the dressing. • Secure the dressing with a stretch net. Try to avoid using any adhesive products to secure the dressing • Document the tear in Epic • Submit an HRP even if the skin tear is the result of patient handling, medical device removal, or any other unexpected event in the hospital setting.

Negative Pressure Therapy

- If a patient is admitted to the unit with a wound vac in place consult the provider to determine if the dressing needs to be changed.
- If VAC therapy order is continued, switch from the home unit over to the hospital unit. If possible, send the home unit with the family. If unable to send home unit with family, document what was done with it.
- Notify KCI to put home unit on hold.

Documentation

RN to chart the following:

- Amount of exudate accumulated in the cannister per shift
- Appearance of the dressing
- Current setting
- Appearance of periwound

Additional Considerations
• Wound VAC suction can only be off for 2 hours MAXIMUM • Notify MD of acute heavy bleeding in cannister • Monitor patients with low platelets or who are on anti-coagulants • Wound VAC dressings are MRI safe with the exception of dressings that contain silver, the machine is NOT MRI safe.

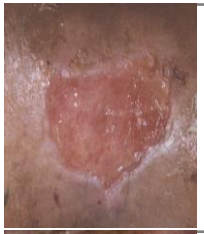
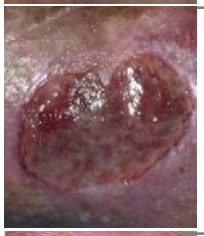
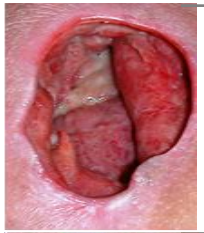
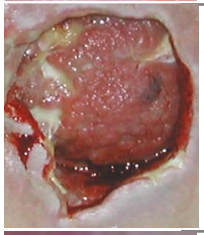
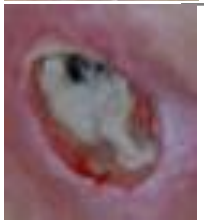
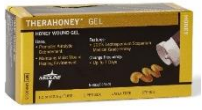
Please review the following policy when you are on campus:
Policy: Clinical Reference Summary Hospital Acquired Pressure Injury(s)-HAPI
Policy: Wound Assessment, Measurement, Care and Photography
Policy: Skin Tear Prevention & Management in Adult Patients
Policy: Negative Pressure Wound Therapy: VAC Device
Reference Tool: Wound Care Guidelines
Policy: Beds, Specialty and Therapeutic Support Surfaces
Reference Tool: Taking Wound Photos Job Aid

Willamette Falls Wound Care Guidelines

Skin Health

PROVIDENCE Willamette Falls Medical Center

Wound Care Guidelines are meant as a starting point for treatment based on wound bed characteristics. As a wound evolves, treatment modalities may change as well.

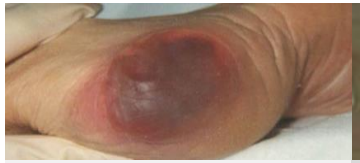
Based on depth of wound and drainage, select from appropriate rows below.	Wound Cleansing Cleanse wound with product shown. Pat dry.	Dressing Choices Chooses from products listed below. See other considerations for specifics on each dressing. Consult wound nurse for any questions.	Other Considerations See specific instructions listed below for each dressing option
 **Shallow & Dry/ lightly draining**	Skintegrity Wound Cleanser 	**Exuderm LP Thin**  OR **Skintegrity Hydrogel**  Cover with Foam Dressing or Bordered Gauze Dressing **Versatel Silicone Contact Layer** 	If using **Exuderm LP Thin**, change Q 3 days and PRN If using **Skintegrity Hydrogel**, cover with Foam Dressing or **Bordered Gauze** and change Q 3 days and PRN If dressing adheres to wound, use Versatel contact layer
 **Shallow & Wet/ heavily draining**	Skintegrity Wound Cleanser 	**Opticell Ag**  OR **Opticell Ag Ribbon**  Cover with Foam Dressing or Optilock and secure	If using **Opticell Ag** or **Optcell Ag rope,** cover with either **Foam Dressing or Optilock** depending on drainage. Change Q 3 days and PRN.
 **Deep & Dry/ lightly draining**	Skintegrity Wound Cleanser 	**Skintegrity Hydrogel**  Cover with Foam Dressing or Bordered Gauze Dressing	Apply **Skintegrity Hydrogel** cover with Foam Dressing or **Bordered Gauze**. Change Q 3 days and PRN If filling depth is needed, apply gel to gauze and loosely fill depth of wound with impregnated gauze. Do not leave dead space unfilled
 **Deep & Wet/ heavily draining**	Skintegrity Wound Cleanser 	**Opticell Ag**  OR **Ioplex**  **Optilock** 	Apply **Opticell** or **Opticell Ag** to fill wound. Cover with **Foam Dressing or Optilock.** Use **Optilock** for excessive drainage Change Q 3 days and PRN
 **Necrotic tissue**	Skintegrity Wound Cleanser 	**Therahoney Gel**  OR **Ioplex**  Cover with Foam Dressing or Bordered Gauze Dressing	Apply **Therahoney Gel or Ioplex** to wound. Cover with either **Bordered Gauze** or **Foam Dressing,** depending on drainage. Change Q 3 days and PRN. Note – drainage may increase with use of **Therahoney Gel**

Wound Classification Guide
National Pressure Ulcer Advisory Panel (NPUAP)
International Skin tear Advisory Panel (ISTAP)

Skin Health

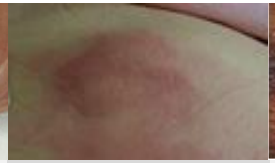
PROVIDENCE Willamette Falls Medical Center

Deep Tissue Pressure Injury



Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Stage I Pressure Injury



Stage 1 Pressure Injury: Non-blanchable erythema of intact skin – Intact skin with an area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

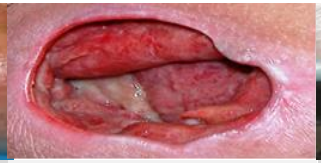
Stage 2 Pressure Injury

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
- Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury

Stage 3 Pressure Injury: Full-thickness skin loss
- Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury

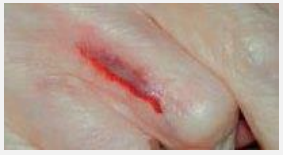


Stage 4 Pressure Injury: Full-thickness skin and tissue loss
- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

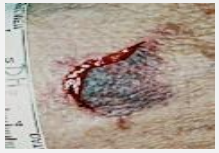
Unstageable Pressure Injury

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed. **NPUAP 2016**

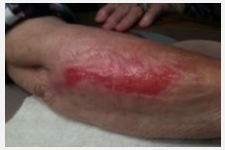
Skin Tears



Type 1: No Skin Loss
Linear or flap tear which can be repositioned to cover the wound bed.



Type 2: Partial Flap Loss
Flap cannot be repositioned to cover the wound



Type 3: **Total Flap Loss**
Entire wound bed is exposed

Fall Prevention

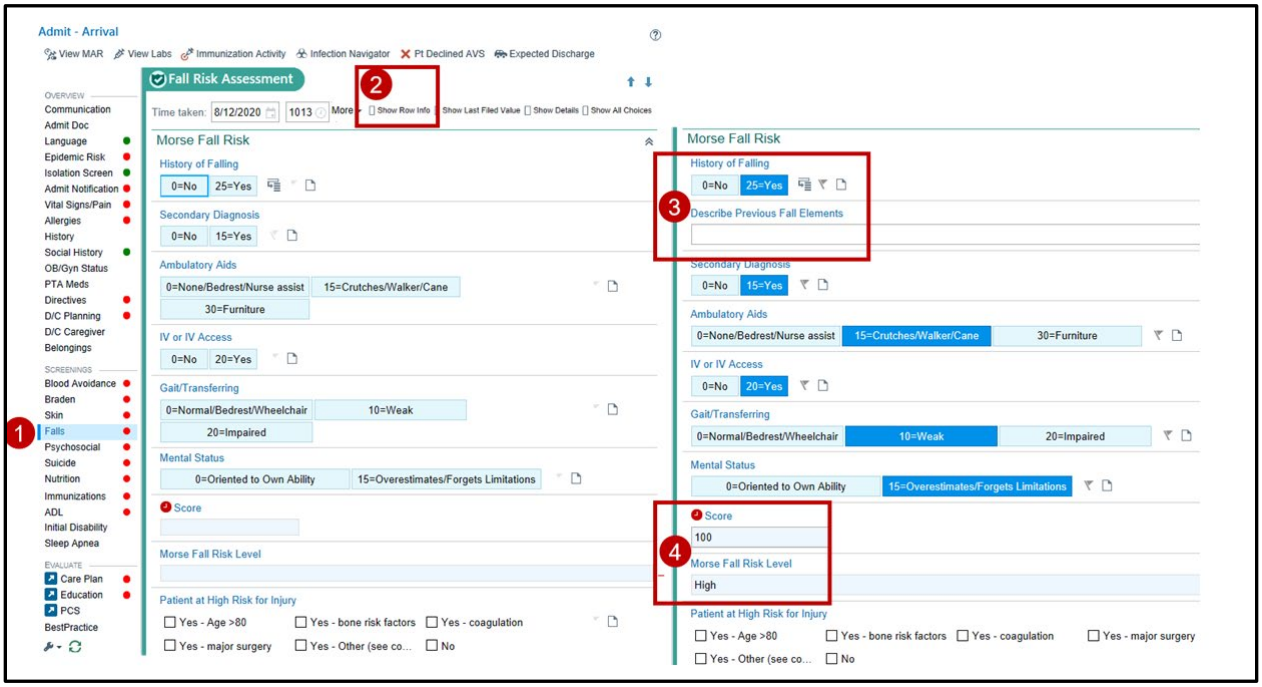
Providence is committed to patient safety, reducing falls and falls with injury. In addition, providing safe working conditions through ergonomic education and prevention of injury using evidence-based practice. A Morse Fall Risk Scale must be documented on all patients (screenshot below):

- Upon admission (within four hours)
- On assumption of care and with significant changes in patient condition

The Morse Fall Scale is an evidence-based fall risk tool. This screening tool indicates the patient's likelihood of falling with a numeric score and a risk level of *high, medium, or low*.

Remember: All items must be completed in Epic screening tool to produce a fall risk score (0-100). A risk of medium or high adds the Fall Injury Risk Care Plan Guide to the patient's care plan.

Documentation



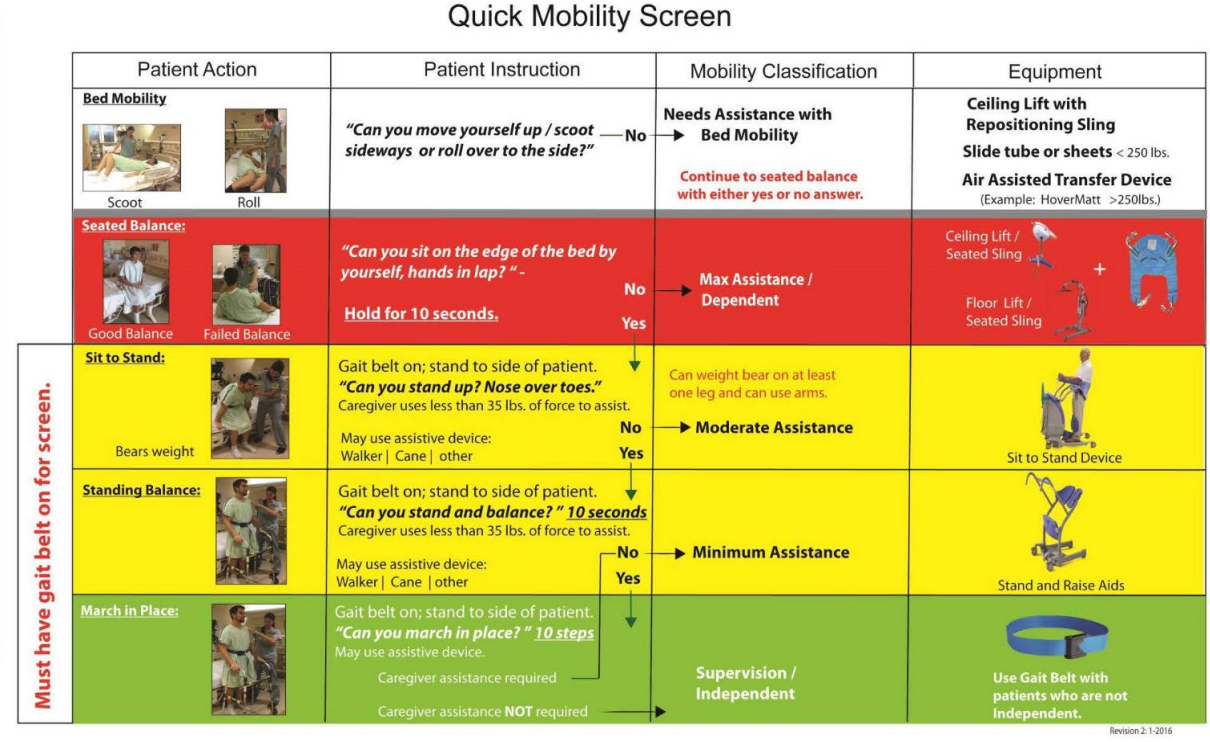
Risk Factors

- History of falling
- Secondary Diagnosis
- Ambulatory Aids
- IV or IV Access
- Gait/Transferring
- Mental Status

Interventions to Mitigate Risk for Falls	
Purposeful Rounding: • Proactively ensuring patient's needs are met: ○ **C:** Comfort: Address any pain ○ **A:** Anticipate any upcoming needs ○ **R:** Reposition comfortably ○ **E:** Elimination: Adress toileting needs ○ **S:** Sensitivity: Work to answer questions	**Environment Safety:** • Brakes "on" when patient in wheelchair • IV poles- wheels roll easily, weight from pumps and IV bags distributed to avoid tipping • Bed in low position, brakes locked, side rails raised (if needed) • Call bell working, audible alarm, lights outside door and alarms at nurses station • Bed alarms plugged in, turned on, audible with correct settings • Appropriate room lighting • Non-skid footwear • Floors clean and dry
4Ps: ○ **P**ain: Assess for pain ○ **P**otty: Implement toileting plan ○ **P**ositioning: Ensure the patient is comfortable and turning has been performed ○ **P**ossessions/Person: Environment free of clutter; Patient's needs met; Call light and personal belongings within reach	

Quick Mobility Screen

- Use this quick mobility screen to assess which type of equipment is needed for safe patient mobility



Please review the following policy when you are on campus:

Policy: Fall Prevention Practice Guideline

Restraints and Seclusion

Important: This document provides an overview of education required initially for caregivers. Hands-on competency documentation is required prior to application of a restraint device.

Restraints are

Any method or device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

- **Non-violent/non self-destructive**: use of restraint to prevent interference with treatment or therapeutic devices (i.e., pulling on intravenous lines, tubes, drains)
- **Violent or self-destructive**: use of restraint to prevent aggressive or destructive behavior that places the patient or others in imminent danger
- **Chemical Restraint**: a drug or medication used to restrict or manage the patient's behavior or movement that is not a standard treatment or dosage for the patient's condition

Seclusion is

The involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving.

- May be used only for the management of violent or self-destructive behavior
- Simultaneous restraint and seclusion is only permitted if the patient is continually monitored

The use of seclusion poses significant risks to the patient and its use is restricted to selected units. Refer to your facility policy.

Are Side Rails a Restraint?

- If the intent of the side rail is to **prevent the patient from voluntarily getting out of bed**, they **are** considered a restraint
- If the intent is to **keep the patient from inadvertently falling** (i.e. during transportation on a stretcher), then they **are not** considered a restraint
- If the patient is **physically unable to get out of bed**, raising 4 side rails does not impact their freedom of movement **is not** considered a restraint

> ⓘ Patients attempting to get out of bed are at greater risk for injury by use of 4 side rails, due to increased height of falling over the rail or entrapment between the bed and side rail.

Chemicals

Drugs or medications used as part of a patient's standard treatment are not considered a restraint. **Chemical restraints are not used in Providence facilities**.

Physical Hold

Holding a patient against their will due to violence (e.g. during administration of emergency medications or a takedown) is considered manual restraint. An order for violent restraints needs to be obtained and this would be documented under degree of restraint.

Note: Therapeutic holding or comforting a child is not considered a restraint.

Causes

Occasionally the need for restraint is triggered when a patient is confused or agitated. It is important we intervene with these patients in a supportive manner and evaluate the potential causes of confusion/agitation.

- Pain Management needs
- Elimination needs
- Feeling disrespected
- Fear, anxiety
- Prior history of abuse or Post Traumatic Stress Disorder
- Medical Issues (hypoxia, hypoglycemia, infection, fever, drug interaction/side effects, drug/alcohol withdrawal, electrolyte imbalance

Alternatives to Restraints

Before restraints are initiated, consider the following options:

- Ask family to stay with patient
- Increase rounding frequency
- Use a 1:1 Constant Attendant/Sitter
- Offer time to discuss concerns and validate feelings
- Modify the environment
- Establish a toileting routine
- Offer pain medication as needed

> ⓘ The RN can initiate restraints and obtain a provider order when clinically justified, choosing the least restrictive intervention based on patient assessment and condition.

A provider/LIP order is required to initiate restraints:

- Initial order can be obtained by telephone before or within a few minutes after application in urgent situations
- Subsequent orders can be entered only after the provider (or other designated staff per policy) assess the patient

> ⓘ **If an order is not obtained the patient must be taken out of restraints.**

Provider Orders

Non-Violent, Non-Self Destructive

- Face to face assessment within 24 hours
- Assessment and orders are renewed once per calendar day

Violent, Self Destructive

- A face-to-face assessment is required ***within one hour*** *(for acute care hospitals)*
- Assessment and order renewal is then based on patient age:
  - Adult (greater than 18 years): q 4 hours
  - 9-17 years: q 2 hours
  - Less than 9 years: every hour

Monitoring

- Monitor patient frequently for signs of physical or psychological distress
- Provide appropriate interventions to prevent patient harm or injury
- Be alert for signs/symptoms of impaired breathing or circulation, or increased agitation- notify provider if signs/symptoms persist
- Provide interventions, including first aid measures as necessary, to reduce patient injury

The RN is responsible for documentation of assessments and interventions every 2 hours (or more often per policy). This includes:

- Orientation, level of consciousness
- Proper application of restraints (adequate circulation, sensation of limbs)
- Prevention of injury (range of motion, repositioning to prevent skin breakdown)
- Supporting physical needs (nutrition, hydration, toileting, pain control and comfort measures)
- Behavior and clinical condition changes that allow for removal of restraints

Please review the following policy when you are on campus:

Policy: Restraints or Seclusion

Safe Medication Administration

Nurses play a critical role in preventing medication administration errors. Providence has implemented several processes, policies, and technology to support nurses in the safe administration of medications. The following document will outline several of the strategies in place to support nurses in preventing medication errors through safe medication administration practices.

The 5 Rights of Medication Administration		**The 3 Safety Checks of Medication Administration**
The 5 Rights of Medication Administration	RN Accountability	• Check when you pull the medication out of Pyxis • Check as you prepare the medication • Check just before you administer the medication
The right drug	The RN must know the action, use, side effects, dosage and proper administration routes and techniques.	
The right dose	Validate and verify that the dose is within the recommended does range. Speak Up for Safety if you are concerned that a dose is not appropriate for your patient.	
The right time	The MAR and pop-up notification within Epic support the timely and accurate administration of medication.	
The right patient	Use of two patient identifiers (name and D.O.B). Where capability exists barcoding should always occur for correct identification of the patient and the correct drug prior to actual medication delivery. Always check to ensure the patient's arm band and order match exactly.	
The right route	Ensure that the route of administration is ordered and appropriate.	

Remember:

- It is important to wear gloves and perform hand hygiene before and directly after administering medications.
- Patient education is an important element of safe medication admin practices. Always explain to the patient:
  - Why they are being given the drug
  - What effects they can expect from the drug
  - What side effects or symptoms they should alert you to as a result of being given the drug
  - Your plan to re-assess for the effects of the drug

Complete Orders

Nurses may only administer a medication that has all of the components of a complete and correct order:

- The date and time of the order
- The name of the medication
- The dose of the medication
- The route of the medication
- If a PRN medication, the indication must be included

Orders with dual ranges, unapproved abbreviations, or illegible handwriting must be corrected by the provider.

Range Orders

Range Order Requirements:

- Drug Name
- Dose Range
- Route of administration
- Specified frequency (the frequency must be a specified amount of time and NOT a frequency range
    - **Unacceptable**: Morphine 2mg IV q 2-5 hours prn pain
    - **Acceptable**: Morphine 2mg IV q 2 hours prn pain

Range Orders and Pain Management

Range orders are often utilized for pain management. When utilizing range orders for pain management the nurse must assess/reassess for symptom relief and adverse effects at:

- Initiation and dose change
- When the drug reaches peak effect.

Approximate peak effects of opiates*:*
IV peak = 30min,
Oral peak = 60min,
IM/SQ/Rectal peak = 60min

For all range orders, the initial dose must be the lowest dose. If the dose is ineffective upon reassessment at peak effect, repeat the lowest dose. For future doses, administer the last effective dose at the next allowable time. The total dose during the interval must not exceed the maximum prescribed dose. If the maximum dose is inadequate, notify the LIP.

Example: Patient is ordered Oxycodone 5-10 mg po q 3 hrs prn knee pain.

- 0900 Patient reports pain is a 7/10 and is given an initial dose of Oxycodone 5 mg.
- 1000 (peak effect) patient reports that their knee pain has not improved. The RN may administer another 5 mg of Oxycodone per the range order (total of 10 mg).
- 1100 patient reports that their pain is now at an acceptable level of 2/10.
- The RN can administer the next dose of Oxycodone 10mg no earlier than 1300 (3 hours from the last effective dose administered in the ordered time range).

NOTE: If a patient is transferred from another inpatient unit or admitted from home you may continue the patient's current dose (if higher) as long as the current dose is included in the range order.

Example: A patient is taking Oxycodone 10mg q 3 hours prn pain at home. The patient is admitted to a hospital inpatient unit with an Oxycodone range order of Oxycodone 5-10mg q3 hours prn pain. The nurse may administer an initial dose of Oxycodone at 10 mg.

Multi-Dose Vials

- When you open a multi-dose vial, document an expiration on the vial. The expiration date is 28 days after the vial is open, unless the manufacturer's expiration date occurs first.
- Never use a multi-dose vial unless the expiration date is written on the vial itself.
- Do not use multi-dose vials for multiple patients in clinical areas.
- Dedicate and label each multi-dose vial for single patient use only.

Glass Ampules

Proper Opening and Preparation of Meds from Glass Ampules

- Tap the top of the ampule with your finger. This sends medication into the body of the ampule.
- Use a sterile gauze pad or an alcohol wipe between your thumb and index finger and the ampule neck. Snap open away from your body (away from face and eyes).
- Use a filter straw or filter needle to draw up the medication. This ensures no shards of glass will be drawn up into the syringe.
- Discard the filter straw or needle into a sharps container.
- Prepare the syringe as you would normally for an IV or IM injection.

Common Mathematical Conversions:

1 Liter = 1000 Milliliters
1 Gram = 1000 Milligrams
1 Milligram = 1000 Micrograms
1 Kilograms = 2.2 pounds

Wasting Controlled Substances

All controlled substances require a second licensed nurse to witness and verify the appropriate waste procedure occurred. To co-sign an opioid waste YOU MUST observe the actual drug wasting.
The verification and waste amounts must be recorded by using one of the following tools:

- PYXIS
- Analgesia Record (PCA, Epidural, IV Medicated Drips)
- Controlled Drug Stock Inventory Form (for units without PYXIS)

Wastage of all controlled substances (tablets/capsules/suppositories/patches and liquids) is placed into Stericycle waste containers

During the waste procedure in PYXIS, the second licensed nurse will be required to log in, placing an electronic date/time/signature stamp as verification.

Please review the following policies when you are on campus:

Policy: Medication Administration - Adult- Pediatric & Neonate

Policy: High Alert Medications

Policy: Patient Controlled Analgesia: Adult & Pediatric

Work Aid: Alaris PCA Pocket Guide

Policy: Medication Range Orders

Policy: PRN Medication Order of Use

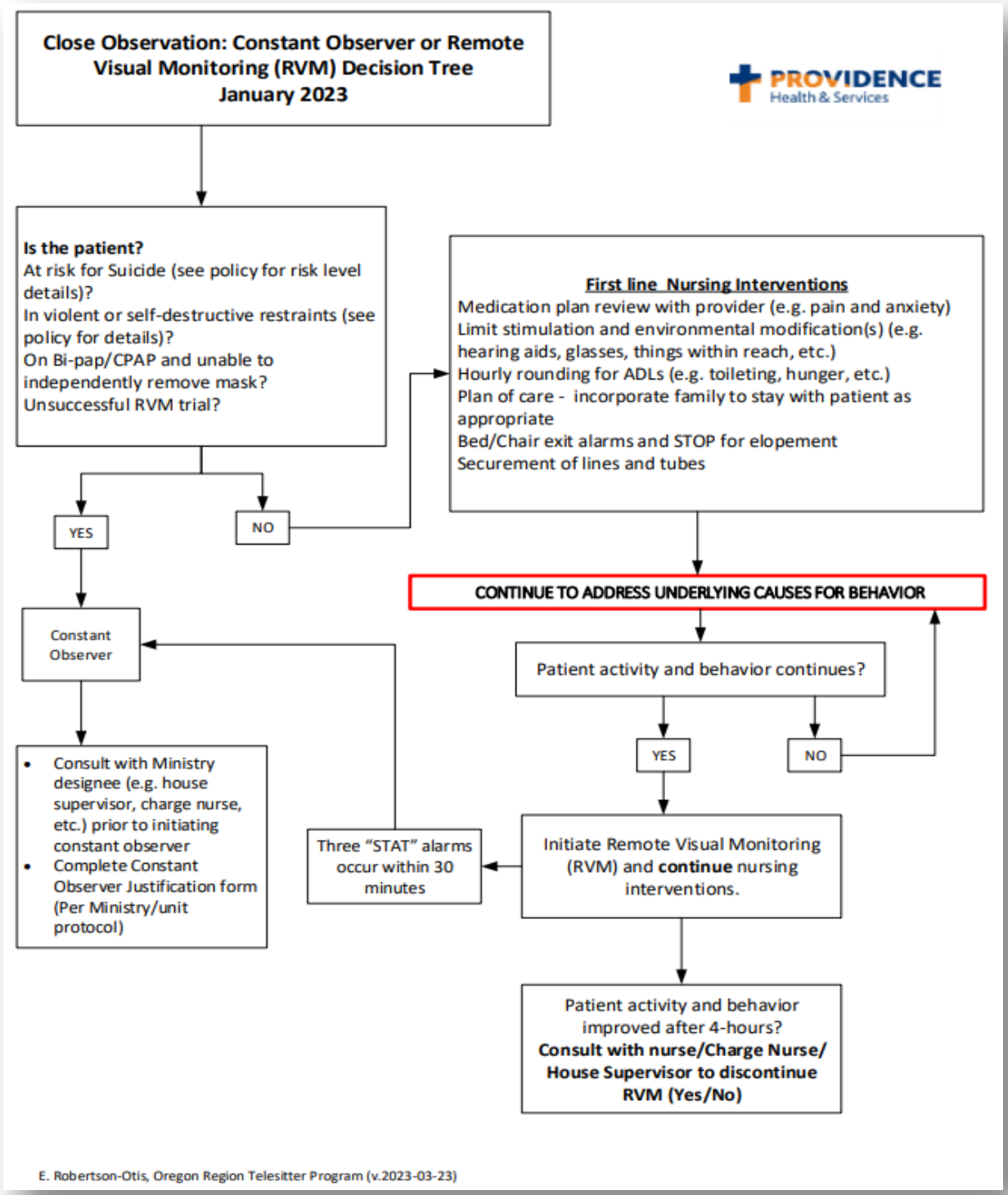
Policy: PSJH Hazardous Drug Handling

Policy: PHSOR Hazardous Drug Handling

Close Observation Remote Visual Monitoring (RVM) or 1:1 Constant Observation

Close observation allows for effective monitoring of the patient's behavior and mental state, while providing an opportunity to enable a rapid response by staff to any change by the patient, or within the environment, that creates unsafe conditions. Safety, privacy, and dignity are crucial aspects in creating a therapeutic environment. Patient observation practices are seen as part of the patient's therapeutic treatment plan and are based on their individual needs.

RVM or constant observer provides continuous, close observation of the patient's behavior and supports rapid staff intervention in response to changes in a patient's behavior or the environment.



Assigned RN Responsibilities	Staff Assigned Responsibility for Patient Observation
• Assess, in collaboration with the interdisciplinary team, potential causes for the behaviors and initiate appropriate nursing interventions to manage the safety needs of the patient. • Document the rationale, justification for constant observation and interventions tried prior to initiation of constant observation. • Every patient who requires one-to-one observation will have the following included in their individualized plan of care. • Appropriate identification of the behaviors of concern or underlying problem. • Nursing interventions to manage the problematic behavior. • The RN assigns appropriate care to the constant observer during face to face verbal report using Constant Observation Report tool. Provides supervision of care. • Patient's RN/Charge nurse remains accountable for the decision to assign and supervise patient observation. • Educate each patient/family member about the rationale for observation, goals, and plan of care. • Ensure all assigned patients are monitored as required based upon ongoing assessment and level of observation required. • Charge RN or RN will ensure that constant observer breaks/meals are provided. • Consider rotating constant observers during each shift to promote their ability to provide active, undivided attention, and direct visualization at all times.	• Staff assigned responsibility for conducting routine or special patient observations are to: ○ Verify identity of each patient assigned. ○ Introduce self to patient at beginning of their assignment for observations. ○ Be knowledgeable of reason for observations for each patient assigned. ○ Routinely observe environment for potential risk factors impacting safety. ○ Maintain continuous visual observation of patient at all times, including when patient is in bathroom. ○ Remain with patient during family visiting, unless directed otherwise by the assigned nurse. • During sleep hours: If patient is in bed, use adequate indirect lighting to allow clear visualization of the patient. ○ Notify patient's RN or charge nurse immediately of any changes in patient's condition or environment that could potentially decrease or elevate the level of observation. ○ Document observations hourly in the medical record. ○ Immediately inform patient's RN or Charge RN/House Supervisor if unable to complete observations as assigned.

Please review the following policies when you are on campus:

Policy: Use of 1:1 Constant Observation for Inpatient, Non-Behavioral Health Units

Policy: Remote Visual (TeleSitter) Patient Monitoring

Blood Administration and Transfusion Reactions Recognition

Blood administration is a highly regulated procedure. Providence has policies and procedures in place guided by recommendations from the Centers for Medicare & Medicaid Services (CMS), College of American Pathologists (CAP), American Association of Blood Banks (AABB), and The Joint Commission to ensure the safe administration of blood and blood products.

Blood Components	
Red Blood Cells	• Contains hemoglobin which carries oxygen to body tissues • Used in the treatment of anemia caused by blood loss or other medical conditions • When separated from plasma, each unit of RBCs has a hematocrit of ~ 60% and a volume of ~ 350 mL
Plasma	• Non-cellular portion of blood, provides maintenance of intravascular volume; contains coagulation factors and other proteins • Separated from red cells and frozen for storage (fresh frozen plasma or FFP) • Must be thawed prior to infusion
Platelets	• Small fragments (thrombocytes) that control bleeding through clot formation • Produced in the bone marrow and live for 5-9 days • Obtained for transfusion by pooling from multiple donors or from a single donor using apheresis • Stored and delivered at room temperature
Cryoprecipitate	• Non-cellular blood component obtained by collecting the precipitate from centrifuged plasma • Contains concentrated levels of fibrinogen and clotting factors • Units are pooled and transfused as one product • Frozen for storage and thawed prior to infusion

All components are administered through straight or Y-tubing sets with a 170-260 micron filter.

Blood Typing and Compatibility

Prior to receiving a transfusion, patients are typed and screened to determine ABO and RhD antigens expressed on RBCS and the presence of antibodies to RBC antigens. Crossmatch testing is done for RBC transfusions on donor and recipient samples to ensure compatibility between the two when the provider orders the product and transfusion in the EMR.

Donor and recipient must have ABO compatible blood types when transfusing RBCs and plasma:

- RBCs are matched for both ABO and Rh
- Plasma needs to be compatible with patient's blood type, but is not crossmatched like RBCs

If donor and recipient are not ABO compatible, an acute hemolytic transfusion reaction (AHTR) is likely to occur

Leukocytes are also present in blood products and can trigger antibody responses in recipients. Our blood banks routinely provide products that are leukocyte reduced to reduce these adverse effects.

Transfusion Process

- ☐ Confirm that the patient has a consent to receive blood and an order to transfuse in their medical record:
  - The provider is responsible for obtaining informed consent for transfusion, describing the procedure, alternatives, risks of receiving or refusing transfusion, and answering questions with the patient and their parent or guardian (when applicable)
  - The nurse is responsible for verifying patient's signature on the consent form
- ☐ Check to see if you have a current Type and Screen. If a type and screen is needed, collaborate with blood bank/provider to ensure appropriate specimens have been drawn. Blood bank regulation requires that the blood bank confirm patient identification by having two determinations of the recipient ABO/Rh, also known as the Second Check sample. This is done by:
  - Comparing with previous records (if available)
  - Testing a second current sample - drawn at a different time than the first

  Before a unit can be released for transfusion a second blood type must be performed if there is no history available, otherwise type "O" will have to be given.
- ☐ Prepare the patient, verify good IV access, and obtain a set of baseline vital signs

Patient Preparation	
Education	Assessment
• Patients should receive education re: transfusion, using resources available in your facility • Teach the patient/caregiver to report any unusual sensations during or after the transfusion • Explain the need for frequent assessments, including vital signs during the transfusion	• Obtain baseline VS prior to transfusion • Ensure patient has adequate IV access (gauge and patency) • Administer pre-transfusion medications if ordered

- ☐ Verification of the recipient and blood component by two license caregivers.
- ☐ Documentation

Recipient and Component Identification

Prior to transfusion patient identification and blood product must be verified by two licensed caregivers using two unique identifiers. The patient's full name and medical record number (MRN) on their ID band is compared with the name and MRN on the blood component. Once the recipient is identified correctly, the blood component should be verified against the blood transfusion record by two licensed caregivers with the following information:

- Donor Unit Identification Number
- Component being transfused matches order and any special requirements (ie: irradiated, washed, etc)
- ABO/Rh of unit is compatible with ABO/Rh of recipient
- Expiration date of unit

Do no proceed unless all items are correct and comparisons match exactly.

Blood Administration Tips: What to do and what NOT to do	
Do	**Don't**
• Always transfuse blood products through filtered blood product tubing; change tubing q 4 hours or more often* • Only saline should be infused with blood products: ○ If using Y-type tubing, spike saline bag and prime tubing. Then use second spike for blood product, flush blood through tubing and hang • When using single lead tubing: spike blood bag, prime filtered tubing and hang • All blood products can be infused using infusion pumps* • Any and all unused blood products should be returned to blood bank as soon as possible*	• Store blood components in an unmonitored refrigerator • Warm the blood using anything other than and approved blood warmer • Piggyback or add medications to the blood bag or line - you could hemolyze or clot the blood

Transfusion Rates

Initial Rate	Duration of Infusion

• Begin non-emergent transfusions slowly for the first 15 minutes:
  ○ Adults 60-120 ml/hr (or per facility policy)
  ○ Peds/NICU 1 ml/kg/hr (or per order / facility policy)
• Before rates are increased you should assess your patient
• If they have renal or cardiac insufficiency, or a positive fluid balance, you may not want to transfuse as fast
	The average duration of infusion of blood products:
	
	RBC: 1.5 – 3 hours or Provider order
	Platelets: 30 – 60 min or as tolerated
	FFP: 30 – 90 min
	Cryoprecipitate (pooled): 30 min or less
	Pedi/NICU: per ordered rate for all products
	
	A transfusion must not exceed 4 hours infusion time

Monitoring

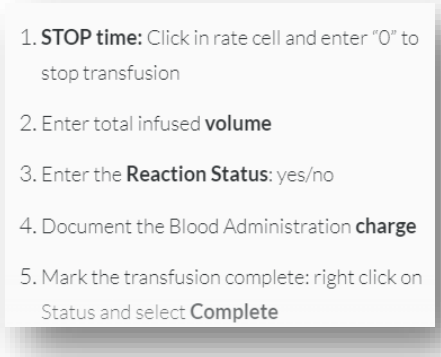
Vital signs should be obtained

- Baseline set prior to transfusion start time (per facility policy)
- 15 minutes after initiating transfusion
- At the end of the transfusion
- If the patient exhibits signs and symptoms of a transfusion reaction.

Documentation

The following elements must be documented in the medical record when the transfusion is complete:

- Vital Signs (pre-, 15 min, completion)
- Start & stop time of infusion
- Volume infused
- Evidence of transfusion reaction (Suspected Reaction - yes/no)



Transfusion Reactions

Signs and symptoms of blood transfusion reactions:

- Infusion site pain
- Itching
- Nausea
- Rash
- Shock
- Shortness of breath
- Tachycardia
- Elevated temp (>1C/1.8F rise)
- Wheezing
- Back/flank pain
- Chills
- Chest pain
- Chest tightness
- Dyspnea
- Flushing
- Hematuria
- Hives
- Hypertension
- Hypotension

If you suspect that the patient is having a transfusion reaction:

- Stop the transfusion
- Replace the tubing and infuse NK TKO to keep IV access
- Notify the Provider and Blood Bank
- Attend to life threatening signs and symptoms
- Return blood product and entire tubing set to Blood Bank
- Initiate transfusion reaction work-up per orders
- Document transfusion reaction symptoms and interventions in EHR
- Monitor patient (VS and I & O) closely for next 2 hour

Possible Transfusion Reactions
• Allergic Reaction • Transfusion-Associated Circulatory Overload (TACO) • Transfusion-Associated Lung Injury (TRALI) • Acute Hemolytic Transfusion Reaction (AHTR) • Hypotension • Febrile Non-Hemolytic Transfusion Reaction (FNHTR) • Transfusion-Associated Graft vs. Host Disease (TAGVHD) • Transfusion Transmitted Infection (TTI)

Any fatality due to transfusion must be immediately reported to the FDA by the Blood Bank
It is very important that any suspicion that a patient's death was caused by or related to a transfusion reaction be reported to the Blood Bank.

Please review the following policies/resources when you are on campus:
Policy: Blood and Blood Products: Consent, Admin, Transfusion Reaction
Policy: Blood Product Transport Training Work Instruction
Work Aid: PHSOR Blood Product Continuous Use Tool

PHSOR Blood Product Continuous Use Tool

Complete and Return to Manager

Patient Label

Blood unit number/sticker

_____
Date/Time of transfusion start

_____
Date/Time of transfusion stop

- ☐ Verify Consent (paper and document verification in EPIC)
- ☐ Complete pre-transfusion vital signs (T, BP, HR, RR)
- ☐ Ensure order for flush product if using double spike Alaris tubing (LIP order or Nursing Protocol: Blood Tubing Prime and Flush)
- ☐ Two RN verification documented
- ☐ Complete set of vital signs 15 minutes after start
- ☐ Documentation of hourly VS during transfusion (T, BP, HR, RR) (Q30 minutes if Peds/NICU)
- ☐ Stop time of transfusion document rate "0"
- ☐ Document volume of transfused product
- ☐ Stop time vital signs (T, BP, HR, RR)
- ☐ Document suspected reaction in EPIC (Yes or No)
- ☐ Document blood administration charge (# of units given) – **Not for ED/Peri-op use**
- ☐ Peer review of documentation _____ (reviewer initials)
- ☐ Complete transfusion in EPIC (Right click on transfusion row and choose complete)

_____
Transfusing RN Name

_____
Receiving RN Name

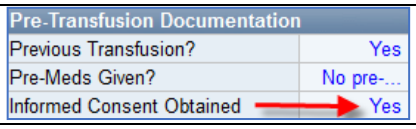
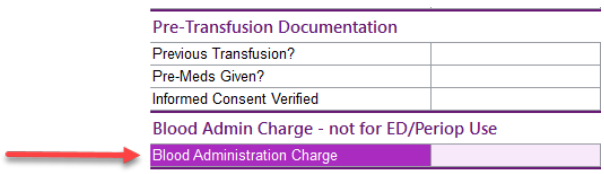
If patient transfers while blood is transfusing:

- ☐ Circle last line item completed prior to transfer & use form to assist with handover
- ☐ Send this form with patient
- ☐ Ensure blood products paper consent form is sent with patient

If patient care is handed off to next shift while blood is transfusing:

- ☐ Off-going RN circles last line item completed & use form to assist with handover
- ☐ RN receiving handoff adds name to this tool, completes transfusion, & turns in to manager

Required Nursing Documentation for Blood Administration – See PolicyStat for more info

Consent	Presence of Consent for Blood Products verified 
Order for Flush fluid (0.9% sodium chloride)	Flush required when using double spike Alaris tubing. Use LIP order or Nursing Protocol: Blood Tubing Prime and Flush
Pre-Transfusion Vital Signs	Full set equals T, BP, HR, and RR Temperature is key to monitor and document at all stages of the transfusion (before, during, and after)
Dual verification	Transfusing RN and qualified second verifier (second RN)
Barcodes	Scan the "W" number barcode (*Donor ID Number*) and the "E" number barcode (*Product Code*) on the Blood Product bag
Start Time/Rate	Transfusion start time is generated by the original rate entry
During Transfusion VS	Full set of VS including temp a minimum of 15 minutes after transfusion is started
Stop Time	Generated by change of rate to "0"
Volume of Transfusion	Per infusion pump or volume listed on blood product bag
Stop Time Vital Signs	Full set of VS including temp when transfusion is stopped
Suspected Transfusion Reaction	Always document "yes" if a reaction is suspected If no reaction is suspected, document "no"
Charge Capture (not for ED or Peri-op)	Enter the number of unit(s) you administered. (charge after each unit complete) 
Complete Transfusion	By right clicking the Doc Flowsheet transfusion row header and choosing "Complete"

Continuous Use Tool Directions:

Not part of the permanent record

Updated 8/14/2023 NB

PHSOR Blood Product Continuous Use Tool

Complete and Return to Manager

1. Blood Bank will send "PHSOR Blood Product Continuous Use Tool" with the blood product being released. *One tool per unit of blood.*
2. RN to place patient sticker, extra sticker from blood bag depicting unit number and RN name on form along with date/time of transfusion start.
3. RN to utilize tool to ensure required documentation is completed:
    a. If patient is transferred to another unit while blood product is transfusing, follow instructions on the tool.
    b. If blood product transfusion occurs through a shift change/handover, follow instructions on the tool.
4. RN turns completed form into unit manager.
5. Manager reviews completed tools against dashboard data and will follow up with individual nurse(s) for any incomplete areas to identify barriers.

Clinical Alarms

It is the policy of PHS-OR leaders and staff members who are responsible for and provide care for patients to abide by safety standards when medical device alarms are in use. Clinical alarms include all patient physiologic monitoring and patient care equipment alarms (e.g., cardiac monitor alarms, fetal monitors, apnea alarms, ventilator alarms, pulse oximeters, bed alarms, infusion pump alarms, and emergency assistance alarms.)

Definitions:

- **Patient care alarm**: Any alarm that is used in patient care to alert healthcare providers of patient safety issues including but not limited to: Cardiac monitors, ventilators, infusion pumps, medical gas alarms, patient call systems, and bed or elopement alarms. Exclusions from this policy would include alarms such as fire alarms, laboratory alarms, refrigerator alarms, and elevator alarms.
- **Medical device**: The technological equipment applied to patients during the delivery of care that assist clinicians in monitoring various aspects of the patient's physiologic condition.
- **Medical device settings**: The parameters that are set on a medical device.
- **Medical device alarm**: The audible sound from a device that is intended to alert a caregiver of potential patient problems.
- **Alarm parameters**: Ranges (numbers) that are pre-set on a medical device based on the individualized patient's clinical condition. It is possible to change the parameters on many medical devices.
- **Alarm management**: The response from the clinicians at the bedside to the parameters that are set on the medical device.
- **Alarm fatigue**: The potential for numerous and various alarm signals to desensitize clinicians in responding appropriately.

Individualized alarm parameters can be adjusted from default settings in two distinctive ways:

- Provider order for individual patient
- Policy with preset parameters for specialty populations with clinical leadership oversight and sign-off from both Medical and Nursing leaders

In an effort to minimize alarm fatigue, it is expected that the care team is selective in types of patients who will benefit from alarmed medical devices and demonstrate judgment in limiting how long the devices will remain in place whenever possible.

Procedure:

- Silencing alarms when taking patients off an alarmed medical device will reduce alarm burden as will pausing alarms during electrode changes or skin preparation in electrocardiogram monitoring.
- Clinical staff is to ensure all alarms are **set to activate at pre-established settings for each patient with each new use** and are audible with respect to distances and competing noises within the care setting.
- Alarm limits are pre-set based on patient population, current condition, and setting; and enabled when the equipment is placed in use and with each new user.
- Alarm signals are **not to be disabled** except in circumstances where it is necessary in providing direct patient care and when the patient is being continuously monitored by clinical staff.
- The hospital staff and/or providers assigned to or treating the patient are expected to **immediately respond** to medical equipment alarms.
- Any trials or proposed changes to parameter settings are to be approved by the specialty population clinical leadership and are reviewed and monitored by the LIP leaders.
- In some instances, monitoring is done remotely such as in the instances of telemetry, which provides ongoing cardiac monitoring in a specific electrocardiogram lead. The Monitor Technician is responsible for continually observing and monitoring the telemetry screens. To ensure patient safety, the Monitor Technician has the responsibility for confirming the communication of emergent alarms that may signal a change in the condition of the patient.
- Clinical Engineering Department is responsible to ensure periodic checking of individual alarm signals for accurate settings, proper operation, and detectability.
- Education is provided to all staff and providers about the purpose and proper operation of alarm systems for accurate settings, proper operation, and detectability. Healthcare providers are to assess for current maintenance status prior to use.
- **Department managers are to be notified of failure of medical device alarms** and faulty equipment must be taken out of services as described in Safe Medical Device Act Response and Investigation Policy to prevent inadvertent reuse.
- On-going education is provided to staff and providers about the purpose and proper operation of alarm systems for which they are responsible.

Please review the following policy when you are on campus:

Policy: Clinical Alarms

Critical Value Notification

The methods used in diagnosing clinical conditions frequently involve testing and procedures. At times, critical values or results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. It is the policy of Providence Health & Services, Oregon Region, to ensure patient safety in communicating these results to the responsible LIP within an established time frame so that the patient can be promptly treated.

Critical result or value: the result or value of a test or procedural that lies outside reasonable physiological limits and may require immediate therapeutic intervention appropriate for the clinical circumstance and is communicated from the Respiratory Therapy, Laboratory or Diagnostic Imaging service to the licensed caregiver.

Receiving Critical Results:

The service conducting the test (RT, Lab, DI) will notify the nursing unit and give the critical result or value to a licensed nurse.

- At PPMC & PSVMC only: In rare instances when a licensed nurse is not available, other nursing personnel (i.e., Technician, Health Unit Coordinator, and Certified Nursing Assistant) may take the result and communicate it to a licensed nurse as soon as possible.

Nursing personnel receiving the critical result will give their full name to the personnel communicating the result or value. Laboratory Services will expect a **read back** of the patient's name, test, and result to validate and verify clear communication.

Reporting Critical Results to LIP:

The licensed caregiver (RN, LPN, or RT) who receives test results that are considered a "critical result" or "critical value," will report to and receive a response from the LIP, **within a maximum of sixty (60) minutes** from the time the testing service (Respiratory Therapy, Laboratory or Diagnostic Imaging) notifies the licensed caregiver.

- The recommended format to communicate critical results is the SBAR(R):
    1. Situation: situation described to provider
    2. Background: briefing on current patient status, i.e., vital signs
    3. Assessment: Assessment/Actions
    4. Recommendation: Response requested (when to call back, expected outcomes, parameters)
    5. Read-back: read back the telephone or verbal orders and receive verbal confirmation.
- **If no response after 15 minutes**, appropriate LIP must be called again. This must be documented.
- If no response after second call, and 30 minutes from the first call has elapsed, notify immediate supervisor for assistance. Activation of a Rapid Response or Code Blue Team, depending on patients' needs, may be required. These actions must be documented.

Reporting Criteria:

The physician will be informed within sixty (60 minutes) when a critical lab value meets the following criteria:

- The value is unanticipated.
- Indicates a deterioration of the patient's condition.
- Requires physician intervention or further intervention.
- All critical microbiology lab results including positive blood cultures, CSF specimen, AFB smear, or unusual pathogens.
- All toxic drug levels.

Anticipated critical results: There are population specific and clinical treatments that have anticipated outcomes that may result in critical values. The LIP may order reporting parameters for these types of labs (e.g. renal function in Chronic Renal Failure). If the LIP is not notified of the critical result, the RN must still document in the EMR that they received the result and comment on the reason the result was not communicated to the LIP. Document under "Notifications" in the EMR.

Documentation:

- Each/every call to the LIP must be documented in the electronic medical record (EMR) under "Notifications".
- Document in the patient medical record the date and time critical lab value results were reported to the LIP and any actions that were taken. Each/every call to the LIP must be documented (as is the case when no response is received within 15 minutes from the first call).

Please review the following policy when you are on campus:

Policy: Critical Value Notification

IV Maintenance Standards (Adult & Pediatrics)

General Infusion Safety

- Unless the patient is allergic to chlorhexadine/alcohol (Chloraprep), all insertion sites should be **prepped with chlorhexadine/alcohol for 30 seconds** (scrub back and forth) and allow to fully dry.
    - For moist sites such as the groin, the prep time per manufacturer's recommendations is 2 minutes (scrub back and forth) and allow to fully dry.
- "Scrub the Hub" before every access to a connector.
- Before connecting any device or infusion, always trace tube or catheter from the patient to the point of origin to ensure appropriate infusion is being administered to the appropriate line. Repeat this step as part of the handover process to a new setting, service or at change of shift.
- Ensure all infusion lines are labeled with date the tubing is to be changed.
- Prefilled normal saline flushes are one time use only. Discard after single use. Reuse of normal saline flushes may lead to infection.
- Inform non-clinical staff, patient and their families that clinical staff must evaluate and assist with all requests to connect or disconnect devices or infusions.

Tubing Change Schedule

	Frequency
Continuous Primary/secondary sets	Every 96 hours
Intermittent Primary/secondary sets	Every 24 hours
Blood/blood products	Every 4 hours
Fat emulsion	Within 24 hours of starting the infusion
Propofol	Every 12 hours

Additional considerations: replace IV tubing whenever the sterile fluid pathway may have been compromised or when a new central line has been placed.

End Cap Change Schedule

- Routine end cap change: No more frequently than every 96 hours, but at least every 7 days
- Prior to obtaining blood cultures
- When blood is visible
- Connector soiled/compromised.
- Lipids and TPN infused through end cap: Change **every 24 hours**.
- Propofol infusion: Change **every 12 hours**.

Peripheral Lines

	Adult	Pediatric	Newborn
Assessment	Assess site at a minimum every 4 hours, upon assumption of care and w/ changes in patient condition. Document assessment and note any signs/symptoms of complications.	Assess site hourly during infusion, and every 4 hours when saline locked; Document assessment and note any signs/symptoms of complications.	
Catheter Changes	When clinically indicated. Determine if IV access is still needed.		
Dressing Changes	Change transparent semipermeable dressing every 7 days or when loose, damp, wet, or soiled.	Change when loose, damp/wet or soiled.	
Flushing Before/After/ Between Intermittent Meds	Flush with NS before, between & after meds with at least 2 times the volume of the access device (Usually 5 mL or less).	3-5 mL NS	2 mL NS
Administration of Medication Incompatible with Continuous Infusions	Flush with 10 mL NS to clear line before and after incompatible meds.	3-5 mL (1.5 times the volume of the access device.)	2 mL NS
Flushing Saline Locks	Flush with 10 mL NS at least every 8hr when not in use.	3-5 mL NS at least every 8 hrs when not in use	2 mL NS
Flushing Before & After Blood	Flush with 20 mL NS before and after blood administration.	Flush with 10 mL NS before and after blood administration.	Enough volume to visibly clear the line (Approx. 2 mL)
Blood Draws	Not recommended in adult population.	Acceptable	

- Vascular access devices placed in emergent situations shall be replaced as soon as possible, preferably within 24 - 48 hours.
- When determining placement for PIV placement, avoid areas of flexion (e.g. antecubital, wrist).

Midlines

A midline is a peripheral catheter that is between 3 and 8 inches long, typically inserted (nu nurse with midline competency validation) in the upper arm. Midline catheters may remain in place 1-4 weeks if there are no complications. **Midline catheters are not inserted in pediatric patients**.

Indication:

- Difficult venous access
- Fluids that are compatible for infusion by peripheral veins including: antimicrobial, fluid replacement, analgesics/PCA, blood products or intermittent infusions.

Midlines are **contraindicated** for infusion of continuous vesicant,TPN, or infusates with > 900 mOsmo/L. Consult with a pharmacist about whether a medication can be administered via peripheral access.

Maintenance:

Action	Frequency
Tubing and cap exchange	Every 96 hours (every 4 hours for blood transfusion)
Dressing change	Every 7 days and PRN (use sterile gloved and mask)
Flushing before/after/between intermittent meds	• Flush with 10 mL NS before medication. • 10 mL NS between medications. • 10 mL NS after medication given.
Administration of medications that are not compatible with continuous infusion	1. Turn off infusion. 2. Flush with 10 mL NS before, between, and after medications. 3. Restart infusion.
Flushing	Flush with 10 mL NS every 8 hr when not in use.
Flushing before and after blood	Flush with 20 mL NS before and after blood administration.
Blood Draws	**Not for routine use**. Discard 1.5 times the volume of the access device (usually 5 mL). **Exception**: Do not discard any blood when obtaining blood cultures. Flush with 20 mL NS after specimens obtained.

Central Lines

Assessment	Assess for redness, swelling, pain, exudates, and intact dressing (minimum of every 8 hours)

Tubing and end cap changes	Change end-caps: Every 96 hrs (Monday and Thursday);
	• **Exceptions**
	  ○ Change every 24 hrs when lipids/TPN infused through end cap.
	  ○ Change immediately: After infusion of blood products or if cap visibly soiled (Scrub the hub beforechange).
	Change administration sets: Every 96 hrs (Monday and Thursday);
	• **Exceptions:**
	  ○ New central line: Use new tubing when a new central ine has been placed
	  ○ Infusion of intermittent piggyback, lipids, or TPN: Change every 24 hrs
	  ○ Propofol: Change every 12 hrs
	  ○ Blood administration: Change every 4 hrs
	Add on device: Disinfection port protector (e.g. CUROS (Green) cap)
	• Single use ONLY for specific patients on approved unit(s).
	• Apply new CUROS cap after each line access.
	• When line not in active use, CUROS can remain in place for 7 days without changing (usually outpatients).

Dressing changes (Central & PICC)	• Initial gauze dressings should be replaced a chlorhexadine-impregnated dressing or transparent dressing and CHG disk within 24 hours of central line insertion.
	  ○ Use chlorhexadine-impregnated dressing OR chlorhexadine-impregnated disk for patients who are greater than 2 months of age.
	• Dressing should be changed every 7 days or when wet, loose or soiled.
	  ○ If CHG impregnated dressing is not used, also change CHG-impregnated disk during dressing change.
	• Wear sterile gloves & mask for dressing changes.
	• Any dressing with gauze under the transparent dressing shall be changed every 48 hours.

Lab draws	**LAB DRAW** • Pause infusion ○ NOTE: Consider specimen collection via direct venipuncture instead of pausing critical medications. • Clamp line. • Wait for 2-3 minutes to clear line of medication.

	• Flush with 10 mL normal saline. Pediatric: Use 3-5 mL NS
	• Aspirate 5 mL blood and discard. Pediatric: Discard 1.5 times the volume of the access device.
	• Obtain blood specimen sample(s).
	• Flush with two 10 mL syringes for a total of 20 mL of normal saline (using "push-pause" technique). Pediatric: Use 2-3 mL NS
	• Resume infusion(s).
	BLOOD CULTURES
	• Obtain paired samples: One from line and one via direct venipuncture.
	• Prior to obtaining blood culture, change end cap.
	• Apply new end cap, scrub the hub and allow to dry.
	• Do not flush line and do not discard any blood prior to obtaining specimen from line.
	• Collect specimen for blood culture.
	• Label bottle to:
	  ○ Reflect the site from which blood was obtained.
	  ○ Reflect volume of blood inserted into bottle.
	BLOOD CULTURES FROM HEMODIALYSIS LINES
	• Refer to considerations for hemodialysis lines

Flushing after blood administration	Flush with two 10 mL syringes of normal saline (Total of 20 mL) using "push-pause" technique. Pediatric: Flush with 10 mL NS
Flushing after TPN	Flush with two 10 mL syringes of normal saline (Total of 20 mL) using "push-pause" technique. Pediatric: Flush with 10 mL NS
Flushing intermittent/ capped lines ****	Flush with 10 mL normal saline before medication, 10 mL normal saline between medication, and 10 mL normal saline after medication. Scrub the hub between each line access. Pediatric: Flush with 2-3 mL NS Flush at least every 8 hours when a lumen is not in use.
Administering medications that are incompatible with continuous infusions	Pause the infusion. Flush with 10 mL. normal saline before, between, and after medications. Then restart infusion. Scrub the hub between each line access.

Catheter-specific considerations:

CATHETERS	PICC* Closed ended & valved	**PICC Open ended**	Non-tunneled Open ended	Tunneled Open Ended***	**Tunneled Closed Ended**	Implanted Ports
CATHETER EXAMPLES	Groshong (arm), Vaxcel with PASV**	Power PICCs, Vaxcel without PASV, Per-Q Catheter	Arrow (multi-lumen), Hohn	Neostar, Hickman Broviac, Cook	Groshong (chest)	Port-a-caths, Power Port, Lifeport, Passport
Clamp	N/A	Requires clamp when not in use	Requires clamp when not in use	Requires clamp when not in use	N/A	Requires clamp when not in use
De-accessing implanted ports (Specially trained nurses only)	N/A	N/A	N/A	N/A	N/A	Flush with 10 mL NS. Follow with 5 mL of 100 units / 1 mL heparin

Considerations for hemodialysis lines:

- Dialysis catheters are accessed only by RNs specially trained to do so.
- The central line maintenance chart above does not apply to dialysis catheters; however, nurses are required to assess dialysis catheters for redness, swelling, pain, exudates, and intact dressing a minimum of every shift, and document assessment. RN will notify dialysis RN, IV therapy, or designee per Ministry protocol for abnormal findings.
- When blood cultures are required from a dialysis catheter, dialysis RN, IV therapy or designee per Ministry protocol will:
    - Identify the approximate lumen volume of the dialysis catheter to determine the volume of any lock/dwell solution present.
    - Do not flush the line.
    - Aspirate and waste only the dwell/lumen volume from the line to remove any locking solution from the catheter.
    - Collect the specimen for blood culture.

Management of Complications

Notify LIP for any items that are **bold** & **underlined** below:

PROBLEM	SYMPTOMS	ACTION
Air Embolus	• SOB • Hypotension • Continued coughing, altered mental status, changes in facial appearance, altered speech, numbness, wheezing, tachyarrhythmias. • Air in line or broken catheter	• **Notify LIP** • Clamp catheter below the break or remove catheter • Place patient on LEFT side in Trendelenburg position • Provide O2 • Activate Rapid Response Team or contact RRT RN
Infiltration/ Extravasation	• Swelling of tissue surrounding IV access area. • Blood return may or may not be present. • IV flow rate may be decreased. • Pump may alarm resistance. • Leaking may occur from exit site. • Infusion stopped.	*Administer test bolus of 20 mL normal saline. Observe for changes. *Do not test bolus chemotherapy or venotoxic agents. They may require other action. Refer to appropriate extravasation procedure. Pediatric: Do not test bolus for infiltrate or extravasation. Consult wound care
Phlebitis	• Redness extending along vein • Tenderness • Erythema • Hard palpable cord along vein	• Warm moist packs four times a day X 20 min each time. • Encourage increased fluid intake as appropriate. • Determine possible etiology; Chemical, bacterial, and/or mechanical. • Implement appropriate interventions for midlines and PICCs. • **Contact LIP for interventions and/or removal of central lines**. Short peripheral catheters should be removed
Localized redness and irritation at entry site	• Erythema • Inflammation • Tenderness	• Discontinue peripheral IV & start a new site. • PICC/Central line: Notify LIP
Possible local infection	• Erythema • Inflammation • Tenderness • Exudate • Elevated temperature • Induration	• **Notify LIP** • When present, exudates from a peripheral or central insertion site should be collected for culture and gram stain to determine causative organism

	• Edema	
Suspected systemic infection	• Elevated temperature • Temperature spike following beginning of infusion • NOTE: Local site symptoms may not be present.	• **Notify LIP** • Blood cultures X2 (one peripheral site and one from line). • If contaminated IV fluid is suspected, stop infusion and send IV bottle/bag for culture.
Venous thrombus formation	• Flow rate and/or aspiration ability may be altered. • Pain and/or numbness of extremity distal to thrombus. • Collateral circulation visible. • Pain in extremity, neck, shoulder, or chest • Edema in the extremity, neck, shoulder or chest	• **Notify LIP** • Venogram or ultrasound may be ordered for PICC, tunneled or implanted catheters.
Central line Occlusion	• Flow rate and/or aspiration ability may be altered.	• Remove dressing and assess for possible mechanical problem. • Prepare for de-clotting procedure.
Catheter Break	• Clear fluid from exit site associated with infusion times. • Clear fluid leaking into dressing • Blood backup for unknown reasons • Profuse bleeding • Air in line (See Air Embolus)	• Suspect hole in catheter. • **If hole is suspected in the tunnel, contact LIP** • Catheters that can't be repaired must be removed or exchanged.
Catheter slippage – out of skin	• Measurements from insertion have changed. • Cuff visible at exit site (on tunneled catheters only)	• Secure catheter with tape and note measurements. • **For tunneled catheter, notify LIP immediately.** • For all other types of catheters, the medication and amount of slippage are considered before further action is taken. An x-ray may be required to verify acceptable tip placement.

Peripheral IV Complications

Phlebitis:

Definition: " Phlebitis is the inflammation of the intima of the vein which occurs as a result of irritation to the endothelial cells of the vein intima creating a rough cell wall where platelets readily adhere. Phlebitis is characterized by pain and tenderness along the course of the vein, erythema, and inflammation with a feeling of warmth at the site, streak formation, and or a palpable cord "

Grading:

Phlebitis is graded according to a standardized scale:

- Phlebitis Grade 0: No symptoms
- Phlebitis Grade 1: Erythema at access site (with or without pain)…may be only slightly pink. In pediatric patients consider removal of peripheral IV.
- Phlebitis Grade 2: Pain at access site with erythema and or edema
- Phlebitis Grade 3: Pain at access site with erythema, streak formation, and a palpable venous cord
- Phlebitis Grade 4: Pain at access site with erythema, streak formation, palpable venous cord greater than 1 inch in length, and purulent drainage.

Phlebitis Treatment:

- Phlebitis grade of 1 requires more frequent assessment of the PIV
- Phlebitis grade of 2, 3, & 4 requires removal of PIV
- Depending on the severity of the phlebitis (grade 3 & 4), the LIP should be notified for treatment and to discuss alternatives to vascular access.

Infiltration:

Definition: "Infiltration is the inadvertent administration of a nonvesicant solution or medication into surrounding tissues"

Grading:

Infiltration is graded according to a standardized scale:

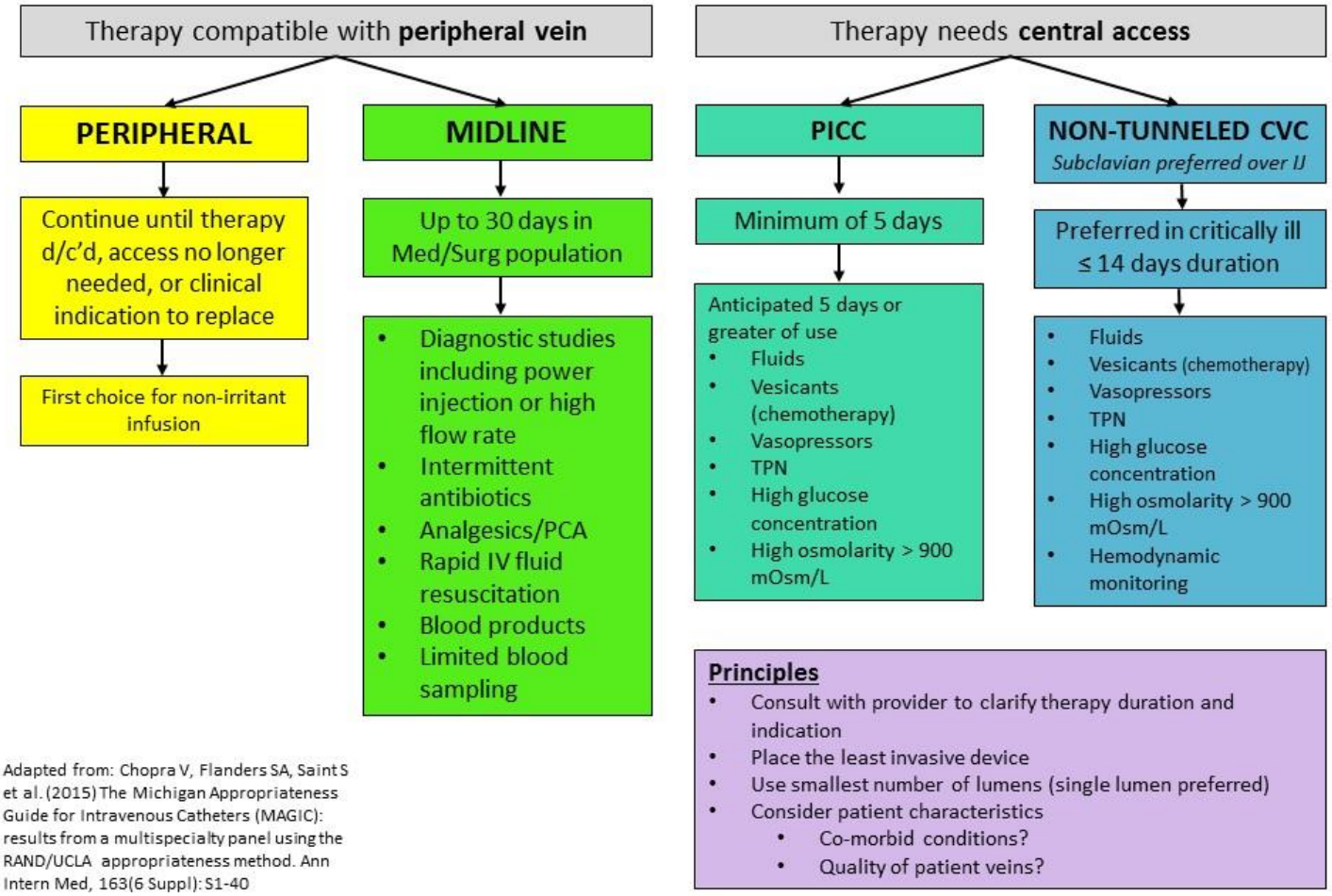
- Grade 0: No symptoms.
- Grade 1: Skin blanched, edema <1 inch in any direction, cool to touch, with or without pain.
- Grade 2: Skin blanched, edema 1-6 inches in any direction, cool to touch, with or without pain.
- Grade 3: Skin blanched, translucent, gross edema >6 inches in any direction, cool to touch, mild to moderate pain, possible numbness.
- Grade 4: Skin blanched, translucent, skin tight, leaking, skin discolored, bruised, swollen, gross edema >6 inches in any direction, deep pitting tissue edema, circulatory impairment, moderate to severe pain, infiltration of any amount of blood product, irritant, or vesicant.
- Depending on the severity of the infiltration, the LIP should be notified for treatment and to discuss alternatives to vascular access.

Infection:

Definition: Invasion of the body with organisms that have the potential to cause disease.

Characteristics: Infection can occur at the insertion site without the presence of phlebitis. Signs and symptoms of infection include swelling and inflammation, tissue discoloration around the site, and purulent drainage. Signs and symptoms may be present before or after the site is removed.

Vascular Access Selection Guide



Adapted from: Chopra V, Flanders SA, Saint S et al. (2015) The Michigan Appropriateness Guide for Intravenous Catheters (MAGIC): results from a multispecialty panel using the RAND/UCLA appropriateness method. Ann Intern Med, 163(6 Suppl): S1-40

Please review the following policy when you are on campus:

Policy: IV Maintenance Standards: Adult & Pediatrics (Peripheral IV, midline, CVC, Central Line, Port, PICC)

Specimen Identity Management

The most critical element of the pre-analytical stage is the accurate identification of the specimen. Improperly identified specimens can result in delayed diagnosis, additional laboratory testing, treatment of the wrong patient for the wrong disease, and severe transfusion reactions. Accurate specimen identification is critical for quality patient care and it is the number one National Patient Safety Goal.

Specimen Labeling Requirements for All Sample Types:

- The patient's full patient name (first and last), a second unique identifier, as defined above, are required to be on the specimen label.
- The label must be affixed to the **primary containers** (tubes, syringes). For specimen containers (i.e. Urine, Stool, Culture, Body Fluid) the label should be place on the side of the container and *not the lid*.
- Specimens submitted on slides must have the patient's last name, and one additional unique identifier on each slide.
- In addition to the patient information, the specimen must also be labeled with the collection date/time and the collector's initials or last name, first name.

Requisition Requirements:

- All specimens received must be accompanied by a matching complete order requisition.
- Verify that the specimen requisition matches the sample labeling upon receipt and prior to test ordering or processing.
- Requisitions (physician orders) are required to contain the following information: patient's first/initial and last name and date of birth, and date/time of collection, the ordering provider, client ID and tests ordered. Collector identification (initials or last name, first initial), where required. (Samples for Transfusion services).
- The patient's last name and first name/initial and second unique identifier must match when the specimen label is compared to the requisition.

Management of Clinical Laboratory specimens not meeting labeling requirements:

- After physician notification, all Clinical Laboratory samples received unlabeled will be discarded. Testing will not be performed. Specimens will be sequestered until notification has been completed. Refer to department policy for storage location.
- All samples, partially meeting labeling requirements, will be forwarded for testing if specimen stability is at risk.
    - Perform testing by following department downtime procedure.
    - Confirmation of patient identity required prior to release of results.
- All samples, partially meeting labeling requirements, where specimen stability is not at risk will be stored until physician notification is completed. Refer to department policy for storage location.
- **Notice to the ordering clinician is required** in all instances when a sample is rejected and the test is not performed.

Please review the following policy when you are on campus:

Policy: Patient Identification and Verification

Neuraxial Care

There are two different levels of neuraxial care: Basic and Advanced

- Basic care includes basic assessment and monitoring of patients receiving neuraxial analgesia/anesthesia
- Advanced care includes basic care as well as advanced skills of setting up the pump administering medication bolus via epidural pump, adjusting medication rate on pump, hanging a new bag, and discontinuing the epidural line when ordered

Important: Hands on competency validation is required prior to providing care for patients who have received/are receiving epidural or intrathecal anesthesia or analgesia.

The following educational content is a preview that will help prepare you for the hands-on competency

What is Neuraxial Analgesia/Anesthesia?

- **Neuraxial** refers to the central nervous system including the spinal cord.
- **Neuraxial analgesia**, therefore, refers to analgesic agents instilled into the central nervous system via the spinal cord.
  - This includes **intrathecal analgesia** and **epidural analgesia**.
- Epidural and intrathecal are very similar. The differences lie within indications for use.

Epidural Space

- Analgesic and/or anesthetic medication can be administered via catheter into the epidural space between the dura mater and the vertebral canal.
- Drugs administered into this space diffuse across the dura and bind to receptors in the spinal cord.
- They also affect nerve roots outside of the dura and are absorbed systemically from blood vessels that are also in the epidural space.
- There may be tissue and fat in this space, but not spinal fluid. Medications are injected at any level of vertebral column.
- Note: Epidural pain management does not ensure that the patient will be completely pain free.

Intrathecal Space

- The intrathecal space is also known as the subarachnoid space— it is the space between the dura and the pia mater.
- Cerebrospinal fluid (CSF) circulates within the intrathecal space.
- They also affect nerve roots outside of the dura and are absorbed systemically from blood vessels in the epidural space.

Neuraxial Analgesia / Anesthesia: Benefits

- Administration of medication close to the site of pain transmission
- Requires less medication, resulting in fewer systemic effects, and thus fewer associated side effects
    - Using the epidural or intrathecal method allows for significantly smaller doses to be used compared to treating pain with oral or IV options, thus pain is controlled well with less side effects
    - This will allow patients to perform ADL's earlier and more independently, therefore avoiding risks of prolonged immobility (e.g. pneumonia, bowel obstruction, DVT)
- Decreased metabolization of the medications
- Not dependent on vascular absorption to reach their destination
- Neuraxial analgesia may decrease cardiac workload and myocardial oxygen demand

Neuraxial Analgesia / Anesthesia: Risks

- Respiratory depression
- Neurotoxicity
- Epidural hematoma potentially resulting in permanent paralysis
- Symptomatic hypotension
- Urinary retention
- Infection
- Risk for alterations in skin integrity due to altered sensation and immobility
- Risk for falls due to altered sensation and weakness

Neuraxial Analgesia / Anesthesia: Cautions

- Only epidural infusion tubing can be used to administer epidural medications
  - Usually identified with a yellow line on the tubing
  - No ports
- Epidural medications must be preservative-free, and labeled as “pf” and “for epidural use only”
- Infection is a serious complication of neuraxial lines
- Only **advanced** neuraxial RNs may manage epidural pumps and tubing
  - Never access the line directly (no "scrub the hub," no use of syringe for administration)
  - Ordered epidural bolus doses must be administered via locked epidural pump

Important: RNs ***do not*** administer intrathecal medications or manage intrathecal pump/tubing. ***Only*** anesthesia providers may provide intrathecal management.

Roles and Responsibilities in Relation to Management of Patient with EPIDURAL Catheter

Anesthesia Provider

- Test dose
- First dose
- Syringe/non-pump bolus
- Dressing changes
- Orders for medications, dosing, management, and catheter removal

Basic Neuraxial RN care

- Patient assessment and monitoring per policy

Advanced Neuraxial RN care

- Patient assessment and monitoring per policy
- Administer ordered medications (infusion, bolus, rate change) via epidural pump
- Change medication bags and tubing
- Reinforce dressing
- Discontinue catheter (per provider order)

Roles and Responsibilities in Relation to Management of Patient with INTRATHECAL Catheter

Anesthesia Provider

- Administers all medication doses
- Orders any additional pain medications that may be needed while intrathecal medication is active

Registered Nurse

- Patient assessment and monitoring per policy
- Confirm medication administered via intrathecal route and its duration of action
- Reminder: do not administer any additional pain medications by any route for the medication's duration of action without an order from an anesthesia provider

DRUG	ONSET IN MINUTES	DURATION	HALF LIFE	PEAK ACTION IN MINUTES	ADVERSE REACTIONS	NURSING CONSIDERATIONS
MORPHINE (Duramorph)	30-90	Up to 24 hrs	2-4 hrs	90-120	N/V, itching, sedation, respiratory depression	Early respiratory depression may occur w/in 2 hrs of loading dose Late respiratory depression may occur as late as 2-12 hrs after loading dose
FENTANYL (Sublimaze)	5-15	2-4 hrs	3-4 hrs	10-20	N/V, itching, sedation, respiratory depression	Respiratory depression w/in 1 hour of dose Elderly/obese most susceptible to effects- consider a dose decrease of 25%
HYDROMORPHONE (PF Dilaudid)	15-30	Up to 18 hrs	2-3 hrs	45-60	N/V, itching, sedation, respiratory depression	Respiratory depression w/in 1-2 hrs of bolus May produce delayed respiratory depression
NALOXONE (Narcan) Opioid Reversal agent	Immediate 1-2	30-60 min	30-80 min	5-15	Rapid admin may cause N/V, HTN, Cardiac Arrhythmias, Pulmonary Edema, severe pain	Mix Narcan 0.4mg w/ 9ml NS in 10 ml syringe. Per orders: For RR<8, give 0.04mg (1ml) slow IV push Q 2 min prn until RR>12, notify provider. For respiratory arrest, give one dose of 0.4mg IV STAT, call Code Blue, notify provider. **Titrate for adequate ventilation & LOC w/o precipitating pain**
BUPIVACAINE (Marcaine)	20 min	1-4 hrs	2.7 hrs	30-45	Respiratory depression, hypotension, bradycardia, cardiac arrhythmias, toxicity	Assess sensory/motor function (Dermatome & Bromage) with vital signs In combination w/ epidural opioid, has synergistic effects
ROPIVACAINE (Naropin)	20 min	1-4 hrs	5-7 hrs	34-43	Respiratory depression, hypotension, bradycardia, cardiac arrhythmias, toxicity	Assess sensory/motor function (Dermatome & Bromage) with vital signs In combination w/ epidural opioid, has synergistic effects

Updated 9/2016

General Safety and Care

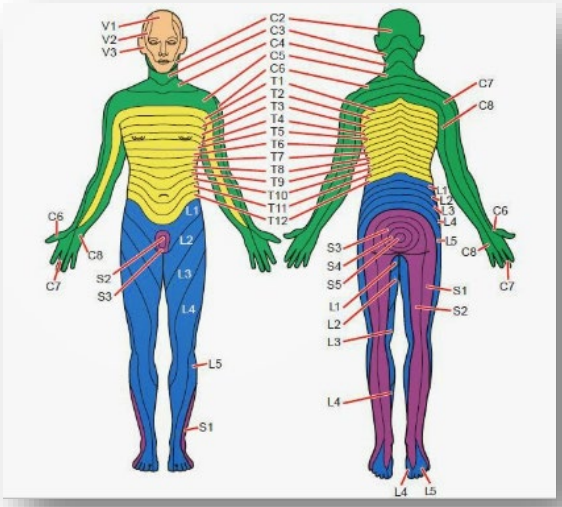
General Safety Notes	Bedside Safety Equipment	• Bag Valve Mask and Oral Airway at bedside
	Anticoagulation Status	• Review anticoagulation status and medications with anesthesia
	IV Status	• Maintain patent IV access for 6 hours after last dose of fentanyl medication • Maintain patent IV access for 24 hours after last dose of hydromorphone or morphine medication
	Reversal Agents	• Ensure reversal agents are available on nursing unit
	Notify Anesthesia	• If the site dressing begins to peel and you need a dressing change • If the patient is experiencing unacceptable pain • If the catheter is severed or disconnected • Trouble with pump alarm or tubing • Removal: If catheter tip in not intact • Any intrathecal pump action

Adult Monitoring Parameters for ALL Epidural/Intrathecal

Assessment	Opioid/ Analgesic	Anesthetic	Frequency
Pulse Oximetry	X	X	Continuous
BP, Pulse, Temperature, Pain	X	X	Per LIP order. No LIP order= q4 hours and PRN
Dressing Site Assessment	X	X	Every 8 hours and assumption of care
Urinary Output/Retention	X	X	Per LIP order. No LIP order= q shift and 24 hours post medication discontinuation
Sedation, Respiratory Rate, Pattern & SaO2	X	X	For bolus, initial dose & rate changes: • q1-hour x 12 hours • q2 hours x 12 hours • Then q4 hours x 24 hrs past last dose of medication/end of infusion • As needed per patient condition unless otherwise ordered.
Dermatomes & Bromage		X	• Prior to administration (infusion/loading dose/bolus) • 30 min after administration with initiation, rate change or bolus • Q4 hrs until 24 hrs after last dose • Before ambulation • PRN patient condition
Assessing Ambulation Safety		X	• The Bromage score should be ZERO to proceed • Sensory Level must be normal on the entire sole of foot to proceed • Assess orthostatic response to dangling on the edge of the bed ○ Do NOT ambulate is there is a systolic drop of 15 mmHg or more • Have the patient stand at the side of the bed and ask them to bend their knees slightly and then straighten them. If they can steadily complete this step you may proceed with ambulation with stand-by assist.
Signs and Symptoms of Toxicity	X	X	• prior to administration • 30 min after administration • Q4 hrs until 4 hrs after last dose • before ambulation • PRN patient condition (Anesthetics Only)

Pediatric Considerations

Anesthetic Medications	• Assessment of sensation for a pre-verbal, non-verbal, or developmental delayed pediatric patient may not be feasible. If the assessment of the child's pain is that it is under control, then the assessment of sensation in unnecessary. • If the pre-verbal, non-verbal, or developmentally delayed pediatric patient's pain assessment is that it is NOT under control, consult the anesthesiologist to assess the patient and direct treatment changes
Opioid Medications	• After an epidural is placed the patient should be monitored q 5min for BP, HR, RR, O2 saturation, and mental status until stable for at least 15 min, then q15min for one hour. Progress to q2h VS. • If a rate change or epidural bolus dose produces hemodynamic instability unresponsive to the fluid challenge per the epidural orders, call the anesthesiologist for orders. • If a rate change or epidural bolus produces hemodynamic instability that is responsive to a fluid challenge, the patient should continue to be monitored q5min for BP, HR, RR, O2 saturation, and mental status until stable for at least 15 min, then q15min for one hour. Progress to q2h VS.
Dermatome Assessment	Q 4 Hours Assessment of sensation for a pre-verbal, non-verbal, or developmental delayed pediatric patient may not be feasible. If the assessment of the child's pain is that it is under control, then the assessment of sensation in unnecessary. If the pre-verbal, non-verbal, or developmentally delayed pediatric patient's pain assessment is that it is NOT under control, consult the anesthesiologist to assess the patient and direct treatment changes
Bromage Assessment	Q 4 Hours Unable to assess Bromage motor function on pediatric patients who are non-ambulating due to age or developmental status
Assessing site for dressing integrity, drainage, and catheter securement	On assumption of care and every 4 hours
Urinary Output Monitoring	Urine output every 4 hrs and assess for symptoms of retention.



Dermatomes

- Lightly touch the patient's upper arm or cheek with an alcohol swab or ice inside nitrile glove
- Ask if it feels cool
- This allows you to determine the patient's ability to sense and differentiate temperature
- Begin sensory testing by cold swiping using horizontal sweeps starting in an area with no sensation
- Ask patient to report when they feel the same coolness they did on upper arm or cheek
- Move in one inch increments on both sides
- When patient is not able to differentiate temperature change (numbness), correlate the anatomical location of return of sensation with the representative dermatome graphic and document

Bromage

Assess motor function by asking patient to:

1. Dorsal/plantar flex
2. Bend knees
3. Move their legs (unless movement is contraindicated)

Bromage Scale for the Degree of Motor Block Associated with Epidural Anesthesia

Able to Move Legs	Able to Flex Knees	Able to Move Feet	Degree of Motor Block	Grade
Yes	Yes	Yes	nil	I
No or minimal	Limited	Yes	partial	II
No	No	Yes	almost complete	III
No	No	No	complete	IV

Urgent and Emergent Care

The pain management benefits of epidural and intrathecal catheters are tremendous; however, there are serious and potentially life-threatening situations that can result from epidural catheters. These include:

Systemic toxicity

- Toxicity-tingling around lips, Tinnitus, slow speech, metallic taste
- Severe toxicity- seizures, bradycardia ventricular tachycardia, ventricular fibrillation, asystole

Hematoma

- Must be recognized and treated immediately to avoid permanent loss of neurologic function
- Ask patients to tell you if there is a change in sensory sensation or heavy/shooting/numb/tingling sensation in either/both legs along with back pain
- The biggest red flag for an epidural hematoma is a prolonged sensory deficit. If the sensory effects of an epidural aren't wearing off after the medication is discontinued, consider the possibility of an epidural hematoma and notify the anesthesia provider.
- Severe pain is not a common finding
- If calling provider regarding concern for a potential hematoma, be sure your SBAR highlights if a patient is on anticoagulant medication as this increases risk.

Neurotoxicity from infused alcohol, antiseptics, and preservatives

Over-sedation

- A thorough and timely assessment is essential in prompt identification and treatment for over-sedation.
- Requires IV reversal agent

Allergic reaction

Epidural catheter line disconnection/dislodgement

- A broken/disconnected catheter is considered contaminated and should not be used/re-connected.

Managing Epidural pumps

	Assessment	Intervention
Respiratory	• RR < 8 or > 20 • Sp02 less than 93%	• Stop infusion • Support with Bag-Valve-Mask ventilation • Administer O2 therapy per order • Administer medications/reversal agents per order • Call RRT or Code Blue
Level of Consciousness	• If unable to arouse the patient • Sedation level Ramsay greater or equal to 4 • POSS greater than or equal to 3	• Stop infusion • Administer reversal agent per orders • Call RRT
Cardiovascular	• BP > 20% from baseline • BP < 89 mmHg systolic • Increased HR > 20 beats/min from baseline • Postural BP drop > 15 mmHgHR > 120	• Follow hypotension orders • Place patient in full supine position • Call provider
Sensory/Motor	• Numbness above dermatome t4 (nipple line) • Continuous progressive rise in dermatome level • Shortness of breath • Inability to bend knees (Bromage 2 or greater) or progressive rise in score	• Stop infusion • Elevate the head of the bed • Call provider
Catheter Related	• Tubing becomes disconnected from catheter • Catheter severed	• If line is disconnected, cap line with sterile cap immediately • If line is severed, place occlusive transparent dressing (Tegaderm) over distal (severed) end immediately • Contact anesthesiology immediately • Convey to anesthesiology: • If disconnected/severed line was witnessed or not • How much time may have elapsed from dislodgement/disconnection to discovery (i.e., establish the "last known normal" time) • Swab a disconnected/severed catheter with an antiseptic agent ONLY when ordered by anesthesiology • Do not reconnect the tubing

Please review the following policy when you are on campus:

Policy: Neuraxial Management and Competency for Adult and Pediatric Non-Obstetric Patients

Point of Care Testing

Glucometer

The following slides present an overview of proper use of the Glucose Accu-Chek Inform II glucometer. Completion of this learning is required prior to hands-on competency documentation.

Both are required prior to performing a glucose POCT test in a Providence facility.

Please review the following policies, if appropriate, when you are on campus:

Policy: POCT Glucose Accu-Chek Inform II Procedure

Policy: POCT Unregistered Patient, Unreadable or Unavailable Bar Code Procedure

Accu-Check Inform II Meter

Operations Manual

The meter has the following elements:

1. Test strip port
   - Insert the test strip here
   - *Scanning Window* (hold 4 - 6 inches away from barcode)
2. Touchscreen (touch-sensitive display)
   - This screen allows you to perform patient tests, perform control tests, and review results
   - To select any of these functions, simply touch the button on the screen
3. On/Off button
   - Press this button to power the meter on or off

To reset meter:

- Press and hold the power button for 20 seconds to RESET the meter. You may have to perform this step twice

Meter Elements | Base Unit | Reagents/Supplies/ Equipment | Quality Control

EXIT COURS

Operations Manual

Base Unit

- Recharges the battery when meter is docked on base unit
- Communicates with data management system
- Meter should remain on the base when it is not in use
- The light on the base should be green (or blue if you are in South Puget Sound Region)
  - If the light is red the connection is not being made to the interface (PMG Clinics/Spokane and Stevens County are not interfaced, so light can be red, blue or green)
  - If the light is off the base, unit is without power

For facilities with wireless capabilities:

- If the wireless system is down, patient results will transmit when the meter is placed on the base unit

Meter Elements | **Base Unit** | Reagents/Supplies/ Equipment | Quality Control

The meter should always be in the base unit "charger" when not in use

Quality Control Checks

Accu-Chek Test Strips

- Strips expire on the manufacturer's date on the bottle
  - Strips are sensitive to light, heat and moisture
  - Use test strips immediately after removing from the container
  - Make sure that the test strip container is tightly sealed and kept at room temperature
- Insert strip with "Accu-Chek" writing face up

Accu-Chek Inform II Quality Control

- Two Levels (Level 1 and Level 2)
- Store at room temperature
- Vials expire 3 months from opening date or on the manufacturer's expiration date, which ever comes first

Quality Control Manual

When should a QC be performed?

- Both levels of quality controls need to be performed daily (every 24 hours) on each meter
- When opening a NEW bottle of strips or NEW lot of strips
- When a bottle of strips is left open
- When the meter is accidentally dropped
- If results are questionable

Oregon Region

At a minimum, the 3-month discard date must be documented on the control vials in MM/DD/YY format either using stickers or permanent marker. When using stickers ensure the sticker does not cover the barcode on the control vial. If using stickers, you may contact the POCT department for the discard date sticker template.

Patient Tests

Finger Stick

- Evaluate Patient for Suitability for Testing with Finger Stick Sample:
  - When peripheral circulation is impaired, collection of capillary blood is not advised
- Examples of impaired peripheral circulation can include, but are not limited to the following:
  - Severe dehydration
  - Hypotension
  - Shock
  - Decompensated heart failure NYHA Class IV
  - Peripheral arterial occlusive disease

If impaired peripheral circulation is established, venipuncture or line draws should be performed.

Finger Sticks | **Specimen Requirements** | **Limitations**

Specimen Requirements:

Acceptable specimens:

- Capillary- whole blood finger stick only
- Venous*
- Arterial*
- Neonatal collected by heel stick only

**Acceptable anticoagulant: EDTA, lithium heparin, or sodium heparin*

Limitations in Testing

If any of these limitations apply, order lab glucose testing. Glucose results will be inaccurate on the meter.

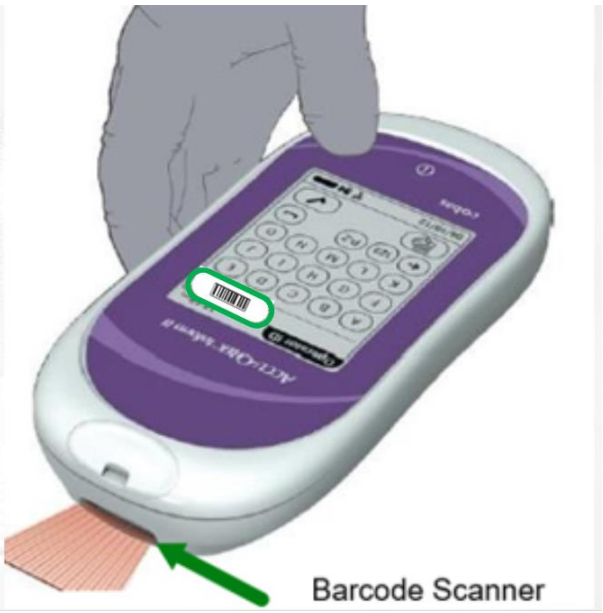
Accu-chek Inform II should NOT be used when:

- Patients who meet your hospital definition of receiving intensive medical intervention or therapy
- HCT less than 10% or greater than 65%
- Patients with galactose over 15 mg/dL (i.e. Hereditary Galactosemia)
- Ascorbic acid over 3 mg/dL
- Triglycerides greater than 1800 mg/dL
- Intravenous administration of N-acetylcysteine (NAC) which results in blood concentrations >5mg/dL

Barcoding

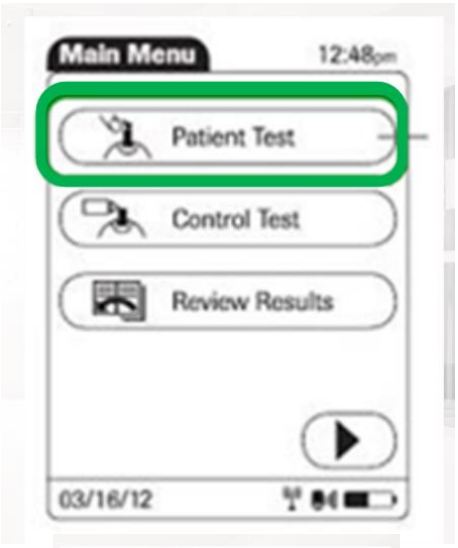
The meter works using barcoding to identify you as the operator and the patient as well as, control solutions and test strips.

Click the button to review more.



To perform patient testing:

- Explain the procedure to the patient.
- Wash your hands and appropriate PPE
- Scan your operator ID from your employee badge
- Select Patient Test from the touch screen
- Select barcode icon and scan patient armband
- Verify correct patient
- Complete finger stick and collect sample
- Clean meter observing wet time
- Place dry meter into docking station to allow for auto documentation of glucose into patient record



Patient Confirmation:

- Confirm with patient the identity information that displays on the meter screen after barcode scanning their armband
- Select ☑ to continue

On rare occasions, Point of Care Testing (POCT) is performed on patients who have not yet been registered (i.e. given an encounter or account number) or POCT is requested STAT when a registered patient's armband bar code is unreadable or unavailable.

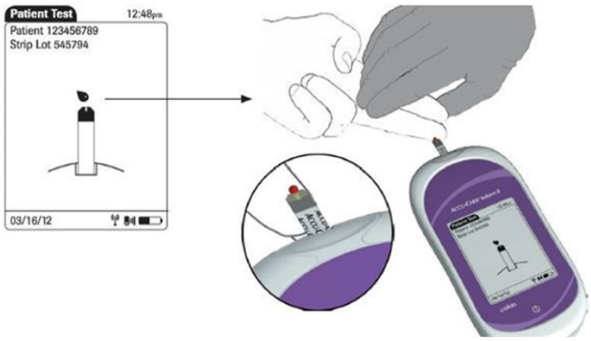
Notify Unit Lead for any needed POCT on an unregistered patient

Patient Testing Steps

1. Clean puncture site with alcohol swab
   - Allow to air dry completely
   - Alcohol at the puncture site must be dry or an error code/inaccurate result may occur
2. Puncture site using single patient use lancet
3. Hold the puncture site downward and gently apply intermittent proximal to distal pressure along finger
   - Avoid milking the finger
4. Wipe away first drop of blood, make sure to use the second drop of blood for testing
   - This is advantageous because it ensure the cleansing agent is dry, it stimulates blood flow and clears interstitial fluid from the sample
5. Apply a well formed drop of blood to front edge of test strip
   - Do not apply to top of strip

Once the meter has detected the test strip, you are prompted to apply an adequate blood sample (about 0.6mL) taken from the side of the fingertip.

- Wait until the flashing drop appears in the display before applying the blood. The meter will beep again.
- Apply the drop of blood to the **front edge** (yellow dosing area) of the test strip. Blood is pulled into the test strip by capillary action.
- Do **not** apply the blood to the top of the strip.

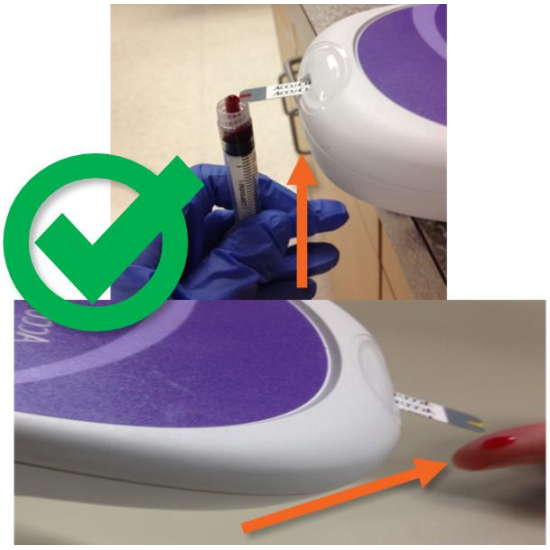


Note: IF YOU DO NOT WAIT for the flashing drop, you will receive an error message.

Collecting a Sample Correctly

Sample must NOT get into the strip port!

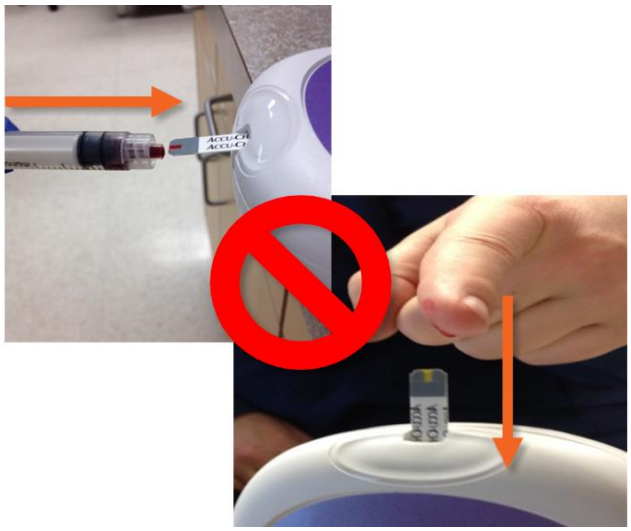
- To keep this from happening, keep the meter flat (horizontal) or with the strip pointed down.
- If blood or QC fluid runs into the port, remove the meter from service and call the repair number according to your facility.

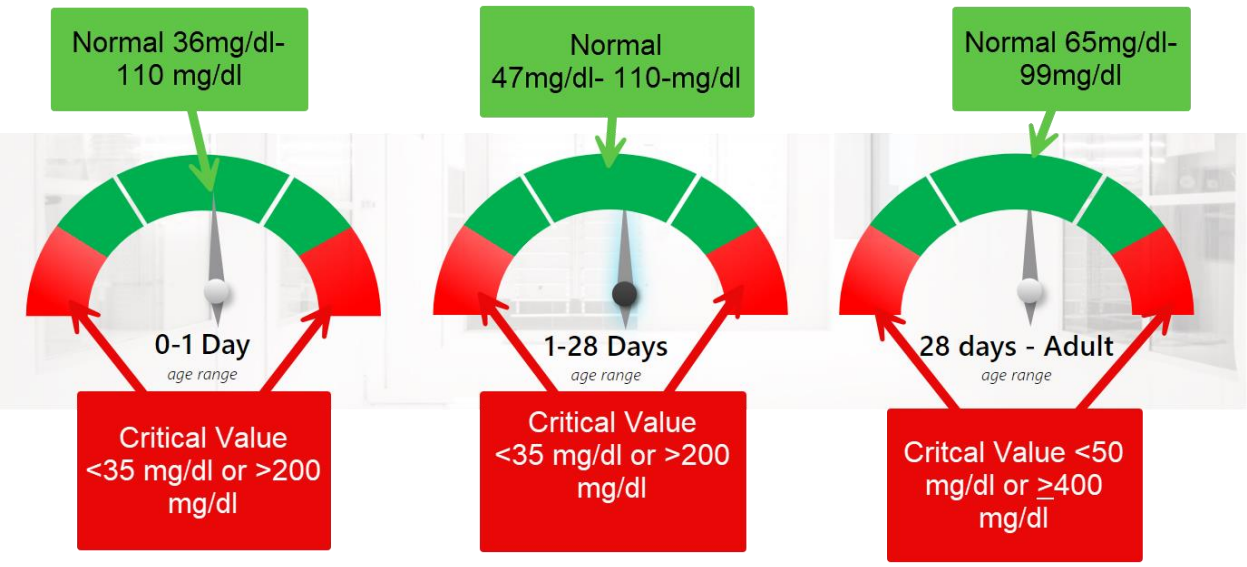


Incorrect Sampling Method

Remember, sample must NOT get into the strip port!

- If blood or QC fluid runs into the port, remove the meter from service and call the Point of Care office (or repair number according to your facility).





Out of Reportable Range

Results outside the meter's Reportable Range display as:

- **"LO"** (result < 10 mg/dL)
- **"HI"** (result > 600 mg/dL)

Treat results outside the reportable range as a critical value.

Actions for Critical Results

Use the scroll bar to view all content.

- Comment entry from the glucose meter is required for all critical values
  - 1 minimum – up to 3 permitted
  - **NOTE:** Once the meter times out or once result is sent – it is not possible to edit the result to add a comment
- "Out of Range Critical" message will display on the screen and require acknowledgement to proceed
  - Press (💬) to record comments
  - Press (✓) again to transmit the result
- Confirm result via repeat testing or with the laboratory if the result is:
  - Not previously verified
  - Inconsistent with the clinical picture

Confirmatory Testing Requirements

Confirmatory testing is required if unexpected results are obtained. Send a venous specimen for confirmation by alternate laboratory method if:

Verified Values	Questionable Results	No Results	Repeated Results
Critical values are obtained and they have not been previously verified (unless provider deems results are consistent with clinical picture).	Results are obtained but are questionable and inconsistent with the patient's clinical picture.	No results are obtained (the instrument displays an error code rather than a numerical value).	Repeated results are similar in value, but results are still inconsistent with the patient's condition.

Questionable Results

1. **Results**

   - Consider whether the result is consistent with the patient's history and clinical presentation

2. **Reliability**

   - Take the following action if you question the reliability of the result for any reason:
     - Add comment (Procedure Error) to the result indicating that the result is in question and should not go in the patient's chart *(Not applicable for Oregon)*
     - Perform quality control testing using the same meter and test strips

3. **New Sample**

   - If quality control test results are within range, repeat the patient test using the same vial of test strips and meter with a new sample from a different finger

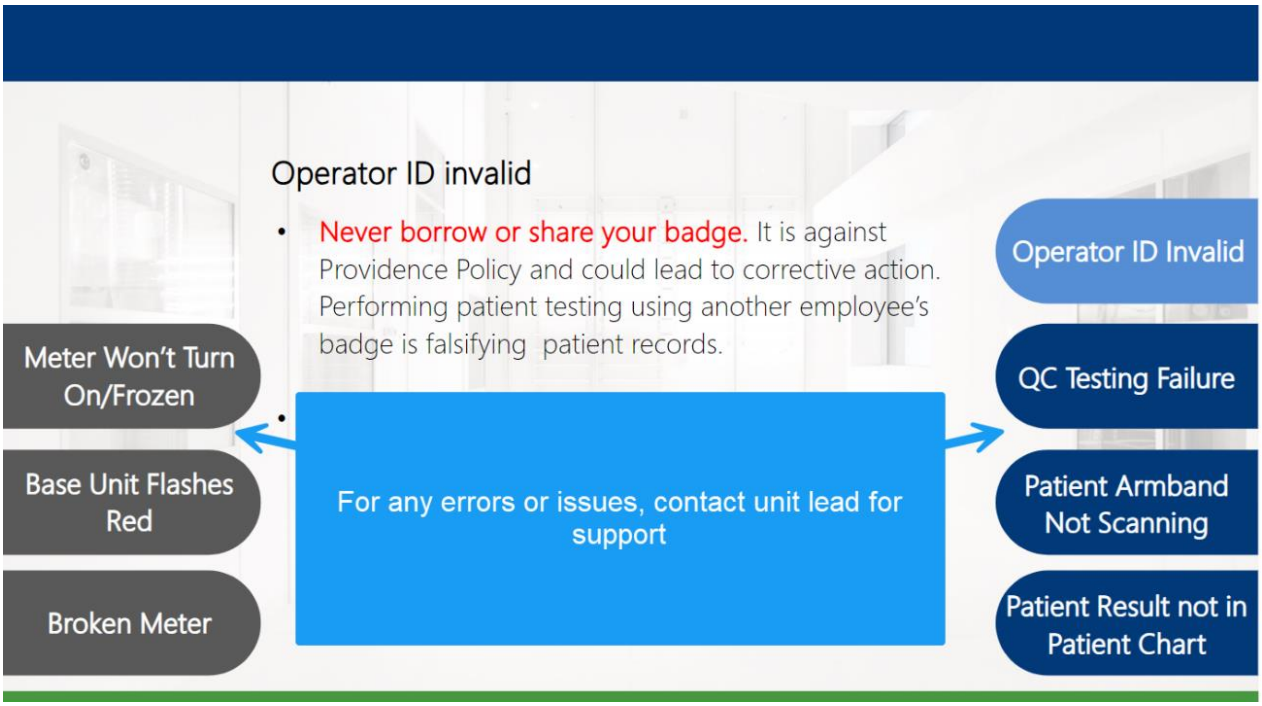
4. **Out of Range**

   - If the quality control tests are not within range, sequester the meter and test strip vial involved and contact the Point of Care Coordinator (Lab) for advanced troubleshooting

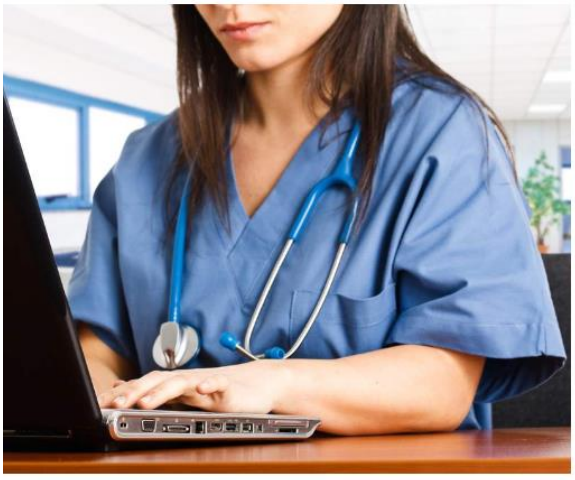
5. **Repeat Testing**

   - Repeat patient testing using another meter and test strip vial that have passed routine quality control testing

Other issues/errors



Result Correction for Interfaced Glucose Meters



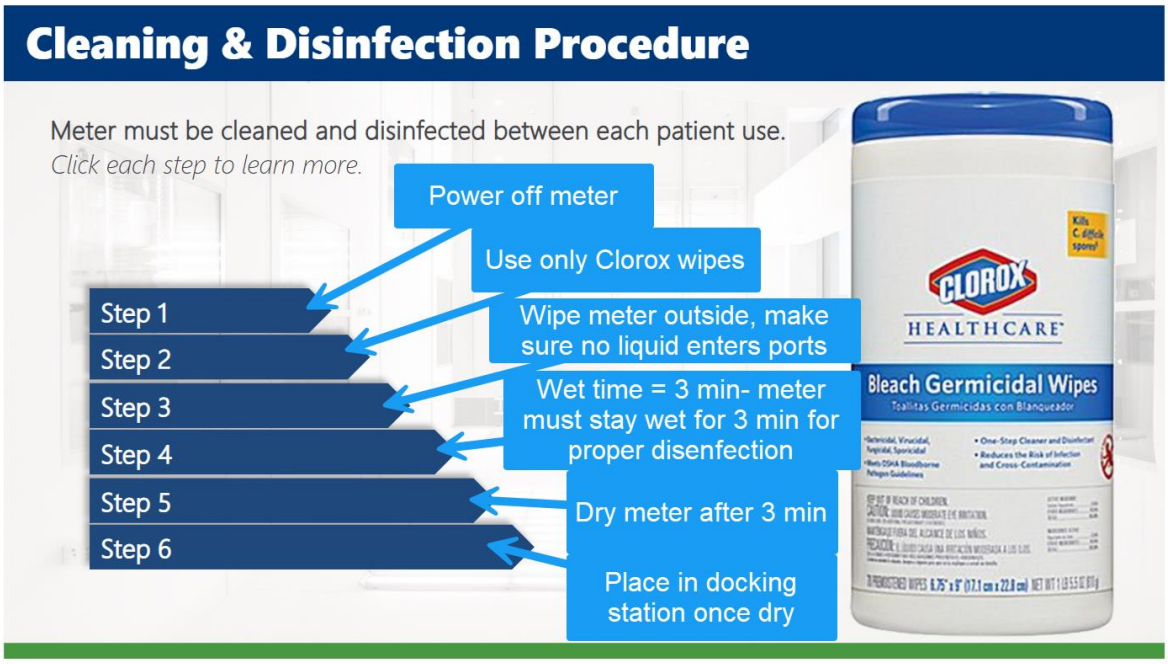
Notify unit lead for support!

If a result is transmitted to the wrong patient chart, complete the following steps.

1. ***Immediately*** complete a datix event
2. Place a ***high*** priority IS ticket
3. Provide as much detail as possible to the IS representative, including the datix number
4. Repeat testing on correct patient as appropriate

Cleaning and Disinfecting

NOTE: Make sure the metallic points located on the back of the meter are completely dry before docking the meter on the base.



Suicide Risk

Providence is committed to providing a safe environment and maintaining the dignity of patients who are at risk for self-injury. To support the early identification of patients with risk factors for suicide, all adult inpatients must be screened for suicide risk by an RN using the Columbia Suicide Severity Rating Scale (screenshot below):

- Upon admission
- Any time the adult patient makes new self-harm or suicidal statements.

Remember: Patients being treated for a medical condition may have unknown behavioral health conditions, a change in prognosis, or psychosocial issues that may precipitate suicidal ideation and/or self-harm behaviors. This is why screening of everyone is so important.

COLUMBIA-SUICIDE SEVERITY RATING SCALE
C-SSRS Screener Tool

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Within Past Month**	
Ask questions that are bold and underlined. Place check in appropriate boxes.	**YES**	**NO**
1) ***In the past month, have you wished you were dead or wished you could go to sleep and not wake up?***	LOW	
2) ***In the past month, have you actually had any thoughts of killing yourself?***	LOW	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"	MOD	
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"	HIGH	
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***	HIGH	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life? (Lifetime)*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	MOD	
If "YES", was it within past 3 months?	HIGH	
Signature_____ Date_____ Time_____		
If the answer is yes to any of the above questions, the C-SSRS Risk Assessment Tool must be completed by ministry designate staff.		

Initial Level of Risk For Suicide ***(based on highest affirmative answer above)*:**

- ☐ **No Risk**
- ☐ **Low Risk**
- ☐ **Moderate Risk**
- ☐ **High Risk**

Providence St. Joseph Health

Screening Results

- If the patient answers "yes" to any of the 6 questions of the C-SSRS Screening Tool, the screen is positive for suicide risk and a comprehensive risk assessment should be completed by ministry designated personnel. In Epic, the C-SSRS screener tool automatically calculates an initial risk level based on the patient responses.
- The provider and clinical team should be notified of patient's initial level of risk (low, moderate or high risk for suicide) and the environment assessed to ensure patient safety.
- Consider whether a psych consult is needed — this may also include notifying the Charge Nurse or House Supervisor per facility policy.

While awaiting further assessment, it is important to implement monitoring and interventions (per policy) to mitigate risk as warranted by the patient's level of risk.

For patients identified at risk re-assessments are completed using the C-SSRS Daily Shift tool every shift or more frequently as needed based on the patient condition or per policy.

Mitigating Risk

Interventions to mitigate risk are determined based on the patient's overall risk level and should be incorporated into the patient's plan of care per order or protocol, depending on the facility policy. Interventions may include:

- Placing the patient under the appropriate level of observation
- Assessing the environment for potential risks and implementing safety precautions
- Engaging other clinicians to assist with development of a safety plan

Suicide Mitigation Plan of Care based on the patient's identified risk level can be found in the Screening And Management Of Non-BH Inpatients At Risk For Suicide – Adult policy Addendum A Suicide Risk Nursing Workflow Job Aid

<table>
<tr><th colspan="2">Possible Interventions to Mitigate Risk for Suicide</th></tr>
<tr><td>Increased Observation:
Patient monitoring (1:1 at bedside or doorway, 2:1 or 4:1)
Frequent checks (q 15 minutes, q 30 minutes or hourly rounding)
Door kept open/closed based on patient need
Place close to nurses' station
Tele-sitter (remote visual monitor)</td><td rowspan="2">Environmental Assessment:
Belongings searched and unsafe items removed
Room risk assessment completed
Removal of ligature risk items not needed for care (e.g., cords, O2 tubing, suction heads/cannisters, phone cord)
Remove sharps container, hand sanitizer, supply cart, plastic bags
Remove matches/lighters/cans/chemicals/meds/sharp items
Remove strings, belts, hoods or neckties
Review and assess need for medical devices
Facilitate changing into colored scrubs/hospital gown
Use breakaway curtains
Use safety tray
Monitor housekeeping items</td></tr>
<tr><td>Communication/Collaboration:
Notify Provider
Frequent communication and building connections
Therapeutic interventions
Safety Planning</td></tr>
</table>

Documentation

The RN will document the following in the patient's Medical Record:

- Results of C-SSRS Screener Tool and C-SSRS Risk Assessment, including initial suicide risk
- Mitigation Plan Interventions including 1:1 monitoring with continuous visual observation
- Physician and interdisciplinary team notification
- Medications given and the response to the medication
- Reassessments via C-SSRS Daily Screening tool, per policy
- Patient/family education and response
- For inpatients, addition of Suicide Risk to the Care Plan and documentation of care goals and strategies
- Discharge and follow-up plan.

Please review the following policy when you are on campus:

Policy: Screening & Management of Non-BH Inpatients at Risk for Suicide-Adult

Organ Donation

Cascade Life Alliance 24-Hour Donor Referral Line:

1-800-344-8916

Providence facilities in Oregon partner with Cascade Life Alliance to support families through the end-of-life process and organ donation. Potential organ donors must meet the following clinical triggers to be considered eligible for organ donation:

Criteria for organ donation eligibility (clinical triggers):

- Donor must have suffered a devastating illness or injury
- Must be intubated, on ventilator in ICU
- Most have a neural injury
- Glasgow Coma Scale (GCS) of 5 or less & loss of brain stem reflexes
- Patient is transitioned to comfort Care

Roles and Responsibilities:

IMPORTANT: Conversations about organ donation with a patient's family may only be done by coordinators from the Organ Donation program (Cascade Life Alliance). There must be NO MENTION OF DONATION by members of the hospital's care team (MD, RN, CNA, etc) .

Direct Care RN: Notifies Cascade Life Alliance of a patient who meets the clinical triggers for referral. Please refer to your unit's charge nurse to discuss your facility's specific process for patient referral to Cascade Life Alliance. Cascade Life Alliance must receive the referral call prior to extubation/withdrawal of care.

Organ Donation Program Coordinator:

- Collaborates with the direct care RN to verify eligibility.
- Speaks with the family about organ donation after brain death is declared
- Provides on-site support/coordination in the case of viable organs. (Eye and tissue donation is coordinated over the phone)

Please review the following policy when you are on campus:

Policy: Immediate Donation after Circulatory Death

Post-Mortem Care (Adult)

The Registered Nurse is responsible for ensuring post-mortem standards and protocols are followed.

Equipment/Forms:

- Clean linen
- Incontinent pads (Chux), if needed
- Consent for Autopsy form, if needed (DocuSource #113495)
- EPIC post-mortem checklist
    - Note: Complete applicable documentation in Epic Post-Mortem flowsheet
- "Record of Expiration/Required Donor Referral Form"
- "Record of Death Form"
- Shroud (body bag)

1. Provider Notification of Patient's Death:

- Determine who will pronounce the patient.
    - People who can pronounce include: any physician on staff, any resident on staff, and nurse under conditions specified in PHSOR policy "Death Pronouncement." If attending physician would like a resident to pronounce (in facilities where residents are present), contact the switchboard to determine available residents.
- Notification of family is **always** the responsibility of the physician.

2. Documentation:

Complete "Post-Mortem Checklist" in Post-Mortem flowsheet in the electronic medical record (EPIC)

3. Hospital Supervisor/ Main Admitting Notification:

Nurse to notify hospital supervisor of expiration. At **PPMC and PSVMC only** nurses call Main Admitting to be notified of patient's expiration. Nurse to call no longer than 30 to 60 minutes of expiration.

> Calling is necessary to notify hospital supervisor and Main Admitting of the patient expiration. The call also provides appropriate information for ME case evaluation.

Provide the following information:

- Patient name
- Room number
- Date of birth
- Date and time of death
- Attending primary care provider
- Medical Record Number
- If the admission was due to an injury or accident; if an accident occurred while the patient was hospitalized, and length of stay.
- If the death was a suicide, homicide, or overdose

- Potential organ or tissue donation
- Request for autopsy
- If there are valuable with the patient or sent with family members
- Name of requested mortuary if known

4. **For facilities without a morgue:**
   Complete Record of Death Form (e.g. #3900) for transfer of remains and belongings to funeral home or with medical examiner.

5. **Notify Pastoral Care:**
   When a chaplain is not on-site, have the operator page the on-call chaplain.

6. **Note Funeral Home:**
   Nurse or Pastoral Services will obtain name of desired funeral home from the family and document in electronic medical in Post-Mortem Notes, under "Funeral Home"

7. **Transportation**

- Facility with morgue: Funeral home will obtain body from the morgue
- Facility without morgue: Funeral Home personnel will assume transportation of the body from the patient's room.
- Request for transportation by person other than a funeral service practitioner
    - If not a medical examiner case, ORS 432.005(25)(a)&(b) allows a person other than a funeral service practitioner (e.g. relative, friend, other interested party) to transport the body of the decedent from the hospital.
    - Transporting individual must contact a funeral home for requirements related to private transportation prior to transportation.
        - Transporting individual must provide house supervisor with the name and contact information of the funeral home contacted.
        - House supervisor will contact funeral home to verify that the requirements for private transportation have been met prior to release of the body.
        - Transporting individual completes and signs applicable section of "report of expiration."

8. **Organ Donation Referral:**

- Arrange for request for organ donation by following the steps within the "Record of Expiration/Donor Referral form".
    - All requests are made by the Donation Agencies
    - May document in the "Record of Expiration/Required Donor Referral". This form does not become part of the permanent record.

9. **Prepare Body** – Personnel should always use PPE (e.g. gloves, gowns)

- Close eyelids.
    - Place dentures in mouth if applicable.
    - Remove all lines and tubes.

Exception: If autopsy is to be done or Medical Examiner case, leave in place all peripheral lines, central lines, epidural line, chest tubes, and any invasive devices. When removing peripheral lines, cover sites tightly to prevent oozing and exsanguination.

- Avoid excessive use of tape on those areas of the body that may be visible during open-casket funeral.
- Assure armband is accurate. COMPARE LABELS TO ARM BAND BEFORE PLACING toe tag and label tied to zipper on outside of bag. Label belongings.
- Assure body placed correctly in size appropriate shroud
- Transportation will take body to morgue (PPMC and PSVMC only) or connect with the assigned Mortuary.

10. Management of Home Medications for Deceased Patients

The patient's own medication shall not be returned to a family member and are disposed via current process to destroy patient own medications.

11. Management of Personal Property for Deceased Patients

- If family is present, all personal property should be sent with family.
    - Any jewelry should be removed from the patient's body and sent with family.
    - The name of that individual should be documented in the medical record.
- If family is not present or able to accept jewelry or valuables, the hospital will assume custody of all valuables until they can be released to the patient or patient representative.
    - Valuables should never be sent with the patient body to the funeral home or morgue.
    - Items should be removed from patient body/belongings prior to Patient Access Services arrival to the unit.
    - Items should be secured per the process outlined in section A(c)(ii) for pickup by patient representative at a later date.
    - Valuables receipt yellow carbon copy should be placed in patient's paper chart to be scanned into the medical record.
- Document in the medical record the items that were sent home with the patient representative or secured in the hospital safe.
- In the event that jewelry cannot be removed from the patient's body:
    - Nursing should document in the Post-Mortem Notes section of the medical record that items were left on the body.
    - Patient Access Services should be informed of items that were unable to be removed.
    - Patient Access Services will note these items on the Record of Expiration form in the mortuary signature section and request that the funeral home representative initial the section.
- Valuables may be released to the patient's next of kin in the following order:
    - Spouse, if married
    - Parents and/or adult children, if unmarried
    - Siblings, if no parents or adult children

- If no spouse, parents, adult children, or siblings, valuables will only be released if the requestor has proof of being executor for the patient.

12. Autopsy

- **Verify whether physician will be requesting an autopsy from family**.
  - It is the responsibility of the physician to discuss the need for an autopsy with the patient's family if indicated according to the autopsy criteria and procedure are outlined in policy Post-Mortem Examinations by Medical Examiner, Pathology & Lab, as well as the Professional Medical Standards.
  - If the physician has obtained permission from the family, have the legal next of kin sign the Consent for Autopsy (form #3100 or #113495). The consent signature must be witnessed by one person. Also, inform bed control personnel of inability to remove jewelry because an autopsy has been ordered.
  - Per Autopsy Consent Form: The legal next of kin is the surviving husband or wife of the deceased. If no surviving spouse, then children of the deceased of legal age (18 years of age or older). If the deceased is unmarried, father and mother (unless one parent has exclusive custody, then that parent). If none of the above, then brothers and sisters of legal age. If none of the above, then nearest of kin.
  - Deliver consent for autopsy to supervisor or main admitting.

13. Medical Examiner cases include all deaths within 24 hours of admission and other cases identified by the Bed control checklist.

14. Medical Examiner's Cases

- All deaths occurring within 24 hours of admission and other deaths as deemed necessary by the medical examiner, including homicide, suicide, overdose, accident, injury, or suspicious death.
  - Not all Medical Examiner cases result in autopsy.
  - Medical Examiner will be notified by Main Admitting (PPMC and PSVMC).
  - The Emergency Department will make direct calls for their patients.
- Nurse to follow same protocol regarding Autopsy/Organ Donation as patient who expires after 24 hours of admission.
- The body needs to be refrigerated within 24 hours of death.

15. Viewing Of the Body Once the Body is in the Morgue (for facilities with Morgue)

- If at all possible, allow family to view body in the patient room prior to moving to the morgue. If this is not possible and family requests viewing call Pastoral Services. In extreme situations may be able to coordinate a viewing with Pastoral Service after hour
  - Contact Pastoral Care or Nursing House Supervisor for availability of staff to facilitate viewing after hours.

16. Viewing of the Body in the Patient's Room

- If at all possible, allow family to view body in the patient room for up to four hours after death.
  - This time may be expanded according to each specific situation and need.

17. Body Fluid Spill

If there is a body fluid spill during the transfer of a body to/from the morgue, the spill should be contained following the Spill Cleanup Standard at each facility.

Please review the following policy and attached forms when you are on campus:

Policy: Post-Mortem Care