Orientation: Clinical Faculty

Partners on the Road to Success
Version 7.1
Revision Date: May 2013
Dear Clinical Faculty,

Welcome to MedStar Franklin Square Medical Center, a Magnet designated hospital. We are pleased you have chosen our hospital for your nursing clinical rotation and look forward to another exciting semester with your nursing students. Here at MedStar Franklin Square Medical Center, our vision, mission and values are centered on our patients and community and we invite your nursing students to join in helping us fulfill our commitments to our patients and community.

We need your assistance to continue to be able to offer high quality clinical placements. As an organization, we must ensure that we are continuously in compliance with regulatory agencies’ and accrediting bodies’ standards, as well as legal statutes set forth by the State for clinical instructors and students that access our facility for educational experiences. It is essential that we have knowledge of all students and instructors working at our facility and that we have ensured that the students and the instructors are properly vetted and oriented prior to caring for our patients.

Please note that clinical faculty and students will only be allowed on the nursing unit once all paperwork is received and verified for accuracy. If the clinical faculty does not abide by the requirements set forth below, the clinical faculty and the students will be asked to leave the unit and will not be allowed to work on the nursing unit until requirements are met. Please use the attached checklist to ensure each of the following items has been completed.

**MFSMC Requirements for Clinical Placement**

We require the following BEFORE the students or the clinical instructors are allowed into the facility for clinical experiences:

1. **New** clinical instructor has met with me and received orientation to the facility and computer system.

2. **New** clinical instructor has spent a minimum of 4 hours orienting on the unit where they will have their students. If the clinical instructor is not new to the facility but new to the unit, this orientation requirement must be completed prior to bringing students to the unit. Some units require more time e.g. Pediatrics, Women’s.

3. Student and clinical instructor names and school IDs are provided electronically in attached Excel format to me a minimum of two weeks **prior** to the first day of the clinical rotation for computer access IDs and passwords. It requires a week to 10 days to obtain IDs and passwords from IT Security. Your students will not have access to the charts if the completed spreadsheet is not received prior to the start of the clinical rotation.

4. Clinical instructors must complete MedConnect computer documentation training at a MedStar facility prior to the clinical rotation (eight hour course). Instructors who have **not** completed this training are not allowed to bring their students to our facility per Medstar policy.

5. All required paperwork **must** be completed and returned to me **before** students care for patients.
   a. Acknowledgement Agreement
   b. Clinical instructor Pyxis System Password/Non-Disclosure Statement
   c. Documentation Summary - All clinical instructors need to provide an updated CV. Current course objectives are required as well.
   d. Student Roster
   e. Student Skills check-off list
   f. Confidentiality Form
g. Verification of Flu Vaccine (October thru March)
h. User Confidentiality Agreement and Acknowledgement of Responsibilities
i. Safety Information Signature Sheet (from Environment of Care Handbook)
j. Medication Administration / Patient Identification Signature Sheet
k. Joint Commission, Patient Identification, Infection Control and Medication Administration Instructor/Student Signature Sheet

If you would like additional observation experiences for their students, please make this request in writing to me no later than the first week of the student clinical rotation. In the past, student observational experiences have included the ED, OR, IV Therapy, Interventional Radiology, Physical Therapy, NICU, ICU, Adolescent Psychiatry, and outpatient practices. Students must be pre-scheduled by me to take advantage of these learning opportunities. Clinical instructors are NOT to contact the managers or educators of these areas to pre-schedule their students.

Please review the Faculty Orientation Manual. Included are mandatory forms that must be completed and returned before the start of your clinical rotation. Please read the forms carefully and complete as directed. Course objectives and each clinical instructor’s CV need to be provided as soon as possible. Computer access will be issued once the instructor’s CV has been provided and the MedStar computer training has been completed.

The forms and required paperwork should be returned as soon as possible to the Nursing Professional Development Coordinator, in the Nursing Administration Office on the second floor of the original building, or paperwork can be left with the administrative assistant in the Nursing Administration Office. Please make sure the forms are clearly marked for delivery. At the end of the semester, student and faculty evaluations of the clinical experience must be completed and the same process followed to return them.

Access badges will be available for all instructors and students. Please see the Nursing Professional Development Coordinator to pick up your access badge. If you are unable to pick them up, please indicate the number you will need for your students and they will be left on the unit for you to pick up. Access badges must be signed for and it will be your responsibility to ensure the students return all access badges to you and that you return them to me. These cards cost the facility approximately $10 each and we have well over 350 students per semester so it is important they are returned.

Thank you and we are looking forward to working with you this coming semester!

Sincerely,

Betsy Rudolf, MS, RN, CNE, CPN

Betsy Rudolf, MS, RN, CNE, CPN
Nursing Professional Development Coordinator
Nursing Administration
MedStar Franklin Square Medical Center
Elizabeth.b.rudolf@medstar.net
443-777-7173
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MedStar Franklin Square Medical Center
Leadership, History & Vision

History
- Founded in 1898, MedStar Franklin Square Medical Center has 300+ beds, and is a full service, acute care community teaching hospital.
- It is the 5th largest hospital in Baltimore and one of the busiest hospitals in cardiology, emergency medicine, general medicine, obstetrics, and oncology.
- The hospital provides a full spectrum of care for the family including behavioral health, orthopedics, primary care and pediatrics. Our state of the art Sleep Center has received full accreditation.
- Franklin Square Hospital, a reputational Magnet facility, received Magnet designation in 2008, the third hospital in Baltimore to obtain this prestigious nursing recognition.

Mission
Franklin Square Medical Center, a member of Medstar Health, provides the highest quality healthcare and education to our communities.

Vision
The Trusted Leader in Caring for People and Advancing Health.

SPIRIT VALUES
The SPIRIT values ensure that we meet our patient care goals. Our fundamental goal is to give each of our patients an excellent service experience at MedStar Franklin Square Medical Center. SPIRIT values focus on Service, Patient, Integrity, Respect, Innovation and Teamwork

- Service: We strive to anticipate and meet the needs of our patients, physicians and co-workers.
- Patient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- Integrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- Respect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- Innovation: We embrace change and work to improve all we do in a fiscally responsible manner.
- Teamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.

Always/Zero
MedStar Franklin Square Medical Center is actively creating the culture of Always Zero.
This is a simplified way of communicating the merging of Quality and Service – meaning Always Excellent Patient Service with Zero Avoidable Harm to the Patient. As part of our Always Zero initiative, Hourly Rounding was instituted. You will find more information about how this is done in our inpatient units later in this manual. Please see the attached FAQs about Always Zero.
A Culture of Always/Zero
FAQ’s

What does a Culture of Always/Zero mean?
It’s just a simplified way to communicate the joining of Quality and Service. It means Always Excellent Service with Zero Avoidable Harm to Patients.

What does Zero Avoidable Harm to Patients mean?
Zero Avoidable Harm to Patients represents our commitment to quality and the safety of our patients. Avoidable harm means preventing occurrences such as falls, medication errors, central line infections, delays in treatment, error in performance of operations, etc.

Does avoidable harm to patients happen often?
A 1999 study by the Institute of Medicine (IOM) found that 44,000 to 98,000 deaths occur annually in hospitals due to preventable medical errors. These errors are usually caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them. These errors are costly, not just financially, but also in terms of the physical and psychological pain and suffering patients and families experience. Medical errors also result in an overall loss of trust in the healthcare system and diminished satisfaction by both patients and health professionals.

How will we achieve a Culture of Always/Zero?
We’ll start by ensuring that everyone in the organization is focused and committed to doing what is necessary to improve patient outcomes and their experience with us. On January 5, 2009, Hourly Rounding on Patients and Responding to Call Lights by hospital staff will be required on all inpatient units. Studies show that by simply intensifying efforts in these areas, preventable harm is reduced and can be eliminated due to increased interactions with patients. This high level of focus also positively impacts the patient’s perception of their overall experience at the hospital.
In addition, there will be multiple teams looking at specific events/factors associated with harm to patients such as a falls team, teams addressing medication safety and pressure ulcer prevention. None of what we are doing is a new initiative. We are refocusing on a variety of factors that contribute to harm and that get in the way of always providing an optimal experience for our patients.

What if I don’t work on an inpatient unit?
You will still be required to answer call lights while on an inpatient unit. Your manager will share information on how you should respond. Inpatient clinical care is not the sole focus of Always/Zero. Employees from outpatient areas or who provide support services will work with their manager and fellow employees to identify ways to contribute to Always/Zero in their respective departments. For example, if someone’s job is to clean equipment, then doing that without error each and every time (without defects) will help to keep our patients and staff safe and free from hospital acquired infections.
Focus On the Patient Experience

Our goal is to be the healthcare leader for the communities we serve, distinguished by excellence in all we do. In our HCAHPS patient surveys, we strive to receive an “Always”. The areas we focus on include:

**Communication with Doctors:** This aspect of the survey asks patients about the treatment received from the doctors at their facility. Patients are asked if they were treated with courtesy and respect, if the doctors listened carefully, and if they could clearly understand what the doctors explained to them during their stay.

**Communication with Nurses:** This portion of the HCAHPS survey asks patients about the treatment they received from the nurses at their facility. Patients are asked how often they were treated with courtesy and respect, how often the nurses listened carefully and how often they could clearly understand what the nurses explained to them during their stay.

**Discharge Information:** This composite asks questions about how often the hospital staff helped the patient prepare to leave the hospital; e.g., was discharge information about symptoms to look for at home in writing and did the staff ask about help at home.

**Pain Control:** This aspect of the survey asks patients to comment on how often the hospital staff did everything they could to help control pain and how often their pain was actually controlled.

**Communication about Medicines:** This feature of the survey focuses on how often the hospital staff discussed side effects of medications and how often the staff explained the medications’ purposes, including new medications.

**Responsiveness of Hospital Staff:** This aspect of the survey asks the patient about the responsiveness of staff when the patient used the call button and if the patient received necessary help to the bathroom or timely help when using the bedpan.

**Cleanliness and Quietness of the Hospital Environment:** This section asks about how quiet the hospital was, especially at night, and whether the room, and specifically the bathroom, was kept clean during their stay.

Our expectation is that student nurses will incorporate these Patient Experience foci into their practice as they learn to care for patients.
Health Insurance Portability and Accountability Act (HIPAA)

While working at MedStar Franklin Square Medical Center, you may have access to confidential information. Confidential information includes, but is not limited to any of the following information or materials owned by or in the possession of MedStar Franklin Square Medical Center or created or received during your association with MedStar Franklin Square Medical Center:

All information relating to -
- Business, financial, strategic and operational policies and procedures
- Personnel information
- Quality improvement
- Utilization management
- Risk management
- Patient data – including medical records
- Current and future promotional and marketing programs and trade secrets
- Billing and financial data
- Testing data and results
- Computer passwords/access rights
- Technical, scientific or economic affairs of MedStar Franklin Square Medical Center

You are expected to:
- Ensure confidentiality of all confidential information to which you will have access
- Comply with applicable laws
- Maintain patient privacy
- Only review or access the materials and information necessary to fulfill your obligations to MedStar Franklin Square Medical Center
- Inform MedStar Franklin Square Medical Center should there be a breach in confidentiality or if you are requested to reveal any confidential information relating to MedStar Franklin Square Medical Center

Photocopying or reproducing patient files is NOT allowed at MedStar Franklin Square Medical Center
Directions to MedStar Franklin Square Medical Center

9000 Franklin Square Drive
Baltimore, MD 21237
443-777-7000 (main number)

MedStar Franklin Square Medical Center is located in Baltimore County, Maryland, near the intersection of Interstate 95 (JFK Expressway) and Interstate 695 (Baltimore Beltway), approximately 10 miles northeast of Baltimore City.

From Belair Road and Putty Hill Road
Take either Ridge Road or Fitch Avenue from Belair Road to Rossville Blvd.; Continue East on Ridge Road to Gum Spring Road to the end and turn left onto Rossville Boulevard. The hospital is across the JFK Expressway, .2 miles past Essex Community College on Franklin Square Drive.

From Pulaski Highway (U.S. 40)
Take U.S. 40 (Pulaski Highway) to intersection approximately ½ mile North of Interstate 695 (Baltimore Beltway); Turn west Rossville Boulevard and continue to Franklin Square Drive.

From the North
Take Interstate 95 (JFK Expressway). Take Interstate 95 South (JFK Expressway) to 695 Essex. Proceed to Exit 34 (Rosedale). Turn left onto Philadelphia Road (Route 7). Proceed to 2nd traffic light. Turn left onto Rossville Boulevard. Proceed to Franklin Square Drive. Turn right to Franklin Square Hospital Center.

From the South
Take Interstate 295 (Baltimore-Washington Parkway). Take Harbor Tunnel or Fort McHenry Tunnel. Follow signs to 95 North. Proceed to Essex Exit 64A (695 East) to Exit 34 (Rosedale). Turn left onto Philadelphia Road (Route 7). Turn left onto Rossville Boulevard. Turn right onto Franklin Square Drive.

Students are strongly encouraged to Carpool and MUST park in upper area outlined in red (East Employee Lot). Lot is gated. There is a button at the gate. Push the button and tell the security guard that you are a student and they will open the gate.
Access badges will also provide access to the parking lots.
Student Parking

General Information

Identification
All instructors & students must wear their school I.D. badge and MedStar Franklin Square Medical Center access badge. Identification badges must be visible, readable and worn above the waist line.

Parking at Franklin Square
Instructors and Students should park in the East Lot on Franklin Square Drive. After turning on Franklin Square Drive from Rossville Blvd, you will proceed past the hospital and the Cancer Institute. On the left, you will see a sign for the East Lot, Employee Parking. Turn left onto Schindelar Drive. There is an intercom directly to Security at the security gate. Please tell the officer that you are a student or faculty and the officer will open the gate. Please Car Pool! Do not leave purses and personal belongings visible in cars. Door access badges for faculty and students can be obtained from the Professional Development Coordinator.

Instructors and Students are encouraged not to leave purses and personal belongings in the clinical area or in unit conference rooms. Valuables such as bankcards, extra cards, credit cards, etc. should not be brought to the hospital.
**Hospital Chapel**
The Chapel is open 24 hours-a-day. Located on the first floor off of the Tower Lobby, the Chapel provides a quiet place for meditation and prayer.

**Medical Library**
The Medical Library provides clinical information both in the physical space and at the point-of-care for all of MedStar Franklin Square Medical Center’s clinical staff and employees. The clinical resources include search databases, journals and books (both print and electronic), and audiovisual materials. Many of these resources are available both onsite and offsite.
The library is staffed Monday – Friday from 8:00 A.M. – 5:00 P.M.

For more information regarding Library policies and resources, please contact the Manager of the Medical Library, at Ext 7363.

- **Medical Library Website** – The website contains a core collection of electronic knowledge-based resources available through StarPort (Medical Library - Quick Links) on all networked computers within the hospital. Among the networked resources are 140 full-text electronic books, 600 full-text electronic journals, Cochrane Library, MDConsult, OVID, PubMed, ePocrates Disease Index, Access Medicine, Access Surgery, and Procedures Consult.

- **Offsite Access** – Many of the library resources are also available offsite through the Clinician Portal – [www.emedstar.net](http://www.emedstar.net) or Athens - [http://www.openathens.net](http://www.openathens.net). Contact the library for more information regarding offsite access.

**Cafeteria**
The Cafeteria is located off of the main hallway in the original building on the first floor.
Open weekdays from 6:30 a.m.-10:30 a.m./11:00 a.m.-7:30 p.m.
Open weekends from 7:00 a.m. to 6:30 p.m.

**Vending Machines**
Vending Machines are located in the main building in the cafeteria and are available 24 hours.

**ATM Machine**
An ATM (Automated Teller Machine) is located on the first floor in the 1 East hallway, near Security.

**Visiting Patients in the Hospital**
MedStar Franklin Square Medical Center welcomes visitors at any time at the discretion of the patient and their healthcare team, with the exception of the following units:
*Critical Care Unit*: 11 a.m. - 6 p.m.; 7:30 p.m. - 9 p.m.
*Psychiatric Unit*: 5:30 p.m. - 7:30 p.m. Monday-Friday
1 p.m. - 2 p.m.; 5:30 p.m. - 7 p.m. Saturday and Sunday

**Smoking**
Smoking is NOT permitted anywhere on the FSHC campus.

**Telephone Usage**
Personal phone calls are not allowed. Personal cell phones MUST be turned OFF while on duty and should not be used while providing patient care or while on the unit. Use of personal cell phones must be limited to time off of the unit.
Additional Information for Clinical Faculty

Pre-Clinical Meetings
Returning instructors **must** arrange to meet with the appropriate nurse manager and/or educator prior to the first day of the clinical experience to discuss instructor/student expectations as well as staff expectations. **All new instructors must arrange for a clinical orientation to the unit prior to students’ first day at MedStar Franklin Square Medical Center. Plan to spend a minimum of four hours on the unit. You must orient to each new unit where you supervise students. (Peds requires a minimum of 8 hours of orientation to the Peds unit).**

Every instructor will provide an updated copy of their CV, a copy of course objectives, and a list of skills that the students may perform, with and without direct supervision, to the Office of Nursing Practice and Research prior to the first day of clinical rotation.

MedConnect
Student and clinical instructor names and school IDs are provided on an Excel spreadsheet to the Professional Development Coordinator a minimum of two weeks PRIOR to the first day of the clinical rotation for computer access IDs and passwords. Clinical instructors must complete MedConnect computer documentation training at a MedStar facility prior to the clinical rotation (eight hour course). Instructors who have NOT completed this training will NOT be allowed to bring their students to our facility. Instructors are responsible for providing their students with MedConnect training using the resources provided to them in their training. A MedStar Franklin Square Medical Center Computer classroom can be reserved by calling 443-777-7492 and asking to reserve a room for training. Instructors are responsible for signing off on ALL student documentation.

For OB Instructors
Documentation is done via the IPROB system in L&D and to a lesser extent, Mother-Baby. An ID and Password will be issued to the instructors and students. Basic instruction in using the system will be provided for the instructor. The instructor is responsible for assisting the student with any documentation that needs to be done.
**MedStar Intranet – StarPort**

**StarPort** is MedStar Franklin Square’s intranet. Anyone may access the intranet by doing the following:

1. Click on the Internet Explorer icon on the computer. This will take you to the MedStar Franklin Square Home Page, titled **MY Franklin Square**.
2. On the left hand side of the page you can click on any one of the topics to preview additional information. The areas you may need to access are:
   - **Policies and Procedures** – There are several policy and procedure manuals located on line. When you click on the menu selection, you can choose the manual pertinent to the information you need. The Clinical Manual contains the Policies governing how our patients are cared for.
   - **Occurrence Reporting** – This system was developed to help make reporting patient and visitor occurrences simple and easy. This system is designed to assist in tracking and monitoring occurrences and provide opportunities for changes in systems, if needed. Once a report is submitted, it automatically sends a copy of the occurrence to the area manager where the occurrence occurred. If there is harm to the patient, then the Patient Safety Manager is automatically notified by email. The Department of Quality, Risk, and Safety is the owner of the system.

**Nursing > Nursing resources** – This menu button will give you access to the Nursing Policies and Procedures, Nursing Code of Ethics, and Mosby’s Nursing Skills.

**On-Line Occurrence Reporting**

**Occurrence:** Anything that happens that is not part of the routine operation of the hospital or the care of a patient. All occurrences, patient, visitor, & potential occurrences are reported in the on-line reporting system. Near misses should also be reported. When more information is tracked, it leads to better opportunities to develop safer patient and employee systems. This is an on-line, anonymous, non-punitive system.

**What to do if there is an occurrence:**

- Offer help as needed
- Report the occurrence as soon as possible to the appropriate charge nurse/manager/supervisor.
- Provide all the facts related to what happened
- Assist the assigned nurse in the on-line Occurrence Report

The on-line occurrence reporting system can only be accessed by a MedStar employee, please have the charge nurse assist you in making an occurrence report. Occurrence Reporting can be selected from the menu on the left side of the page. From this page you will have two options:
- **General Occurrence Report** – Make this selection for all occurrences that are not related to employee injuries or medications.

- **Medication Report** – Make this selection for any occurrences relating to medication administration.

After making your selection fill in the boxes on either form with the information requested and submit.

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**Pressure Ulcer Prevalence Study**

MedStar Franklin Square Nursing conducts a quarterly Pressure Ulcer Prevalence Study on all in-patients. Nursing students are invited to participate as part of the data collection team. This is a great opportunity for students to hone their assessment skills and learn the importance of skin care interventions in preventing ulcers. We require all participants to complete all four modules of the NDNQI Pressure Ulcer training at: https://www.nursingquality.org/NDNQIPressureUlcerTraining/Default.aspx

Please contact Betsy Rudolf for more information.

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**For MedStar Franklin Square Medical Center Policies**

**Please go to the StarPort Intranet page**

**Policies and Procedures**

**Patient Identification for Clinical Care and Treatment:**

Hospital Policy Manual

**Medication Policy:**

Clinical – Clinical Policies and Procedures Manual

**High Risk Medications:**

Clinical – Clinical Policies and Procedures Manual

**Nursing Students and Faculty:**

Clinical – Nursing Policies
Clinical Chain of Command

The clinical chain of command is established to assure staff has 24 hour access to physician and patient care services administration for purposes of assisting in clinical problem solving and/or administrative decision making as needed.

All staff involved in patient care will access the chain of command in the following circumstances and at any time there is a perceived clinical or administrative need:

- Unresolved clinical issues among the team of physicians and nurses or personnel in how to provide care to specific patients
- For clarification on how to interpret and apply clinical protocols and policies
- Potential quality issues secondary to process and outcome concerns

Staff may independently access the physician component of the chain of command, but may utilize the Nurse Manager and/or Service Line Administrative Director to assist in the process. Communication between Patient Care Services and physician staff is encouraged and expected. If the issue revolves around a clinical dilemma, both the nursing and the physician chain of command may be accessed simultaneously until resolution is attained.

Access the Patient Care Services chain of command as follows:

- Level I  Staff Member
- Level II  Unit Charge Nurse of the shift
- Level III Nurse Manager or designee
- Level IV  Service Line Director or designee
- Level V  VP for Patient Care Services/CNO

Access the Physician chain of command as follows:

- Level I  Resident and supervising upper level resident or physician assistant as assigned
- Level II  Attending physician
- Level III  Section chief (i.e. Chief of Cardiology)
- Level IV  Department Chair or designee
- Level V  Vice President – Medical Affairs

There is an administrator on-call during evening hours, on weekends and holidays. Please call the hospital switchboard operator to access the administrator on-call.
Nursing Leadership

Larry Strassner PhD, FACHE, RN, NEA-BC
VP Patient Care Services
Chief Nursing Officer
(443) 777-7590

Deborah E. Hall, MSN, RN, CCRN, CCNS
Medical Service Line Administrator
(443) 777-8097

Debbie Kisner PhD RN
Surgical Service Line Administrator
(443) 777-7934

Jo-Ann Kerschner, BSN, RN
Director of Nursing Operations
(443) 777-8141

Joan Warren PhD, RN, NEA-BC
Director Nursing Research
(443) 777-7957

Barbara Shimaitis, RN
Director Behavioral Health
(443) 777-7009

Cheryl Wood, BSN, RN, NP-BC, NE-BC
Director Nursing Women’s and Children
(443) 777-7840

Michael Clancy, RN
Nurse Recruitment
(443) 777-6320

Sharon Bonner, MS, RN
Director Clinical Informatics
(443) 777-8133

Deborah Biewer, BSN
Director of Patient Care Services, Ambulatory Nursing
(443) 777-8460
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<th>Manager</th>
<th>Ext</th>
<th>Unit Ext</th>
<th>Pager</th>
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<tr>
<td>Nursery, 1CB, Pod C (Mother-Baby)</td>
<td>Shirley Kowalewski</td>
<td>72713</td>
<td>77428</td>
<td>932-6538</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>Jennifer Smith</td>
<td>78406</td>
<td>78272</td>
<td>932-7332</td>
</tr>
<tr>
<td>NICU (Neonatal Intensive Care Unit)</td>
<td>Geri Petit</td>
<td>77840</td>
<td>77050</td>
<td>932-8065</td>
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<tr>
<td>Ante-Partum (Women’s Pavilion Outpatient OB Clinic, Antepartum testing &amp; Perinatology)</td>
<td>Shirley Kowalewski</td>
<td>72713</td>
<td>78272</td>
<td>932-7332</td>
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<tr>
<td>Pediatrics</td>
<td>Shirley Steagall</td>
<td>77653</td>
<td>777012</td>
<td>932-8330</td>
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<tr>
<td>2SB/CAPS (Adult &amp; Adolescent Psychiatry)</td>
<td>Becca Landreth</td>
<td>78449</td>
<td>7632 adult 7077 CAPS</td>
<td>932-7072</td>
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<tr>
<td>PACU (Post Anesthesia Care Unit)</td>
<td>Bev Stiles</td>
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<td>ASC (Ambulatory Surgery Center)</td>
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<td>OR (Operating Room)</td>
<td>Beth Leilich</td>
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<tr>
<td>Tom Maykrantz, MSN, RN</td>
<td>Special Projects Coordinator</td>
<td>(443)777-7006</td>
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<tr>
<td>Betsy Rudolf, MSN, RN, CNE</td>
<td>Professional Development Coordinator</td>
<td>(443) 777-7173</td>
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<tr>
<td>Carol Esche, DNP, RN, NE-BC</td>
<td>Clinical Nurse Specialist</td>
<td>(443)777-7037</td>
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<tr>
<td>Ngozi Azuogu, MSN, RN</td>
<td>Informatics Nurse Specialist</td>
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<td>Liz Jesada, MSN, RN</td>
<td>Wound Ostomy NP WOCN</td>
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<td>Deborah Biewer, BSN</td>
<td>Director, Quality Management/Education</td>
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<tr>
<td>Kari Bunting, MS, RN</td>
<td>Professional Development Specialist Labor &amp; Delivery</td>
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<tr>
<td>Karen Corson, RN, MBA</td>
<td>Professional Development Specialist Mother-Baby</td>
<td>(443)777-8287</td>
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<td>Education Specialist NICU</td>
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<tr>
<td>Tracey Pearson, MS, RN</td>
<td>Professional Development Specialist Pediatrics</td>
<td>(443)777-7541</td>
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<tr>
<td>Arlene Jenkins, MSN, RN</td>
<td>Professional Development Specialist 1 Tower</td>
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<tr>
<td>Lisa Rose, BSN, RN</td>
<td>Professional Development Specialist 2 Tower</td>
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<td>Octavia Coit, BS, RN</td>
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<tr>
<td>Betheen Weed, MSN, RN</td>
<td>Professional Development Specialist 4 Tower</td>
<td>(443)777-8346</td>
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<td>Professional Development Specialist 5 Tower</td>
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<td>Barbara Lynch, BSN, RN</td>
<td>Professional Development Specialist Surgical Service Line</td>
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<tr>
<td>Kelly Kingsbury, MS, RN</td>
<td>Professional Development Specialist ASC/PACU</td>
<td>(443)777-2102</td>
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<tr>
<td>Regina Straw, BSN, RN</td>
<td>Education Specialist OR</td>
<td>(443)777-8413</td>
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<tr>
<td>Rebecca Coleman, BSN, RN</td>
<td>Orientation Specialist Emergency Dept.</td>
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National Patient Safety Goals

National patient safety goals are identified each year by JCAHO to help accredited organizations address specific areas of patient safety. Identified goals include evidence- or expert-based recommendations.  

Policy Manual link – http://starport4.medstar.net/FSH/PP/Pages/C_CPaPM.aspx

Franklin Square is addressing the following goals:

1. Improve the accuracy of patient identification.

(Policy: Patient Identification)

In order to assure that every patient receives appropriate care, MedStar Franklin Square Medical Center has developed a patient identification policy. The key points of this policy are outlined below.

- Every health care worker has the responsibility to ensure the patient is properly identified prior to performing any procedure (i.e. administering medications, performing phlebotomy, starting IVs, etc.)
- Every patient must have an identification band in place.
- Verify information by asking the patient using the two “hospital identifiers”
  - “Can you tell me your full name?” (Do not ask “are you John Smith?”)
  - “Please spell your last name.”
  - “What is your date of birth?” (Do not ask “were you born July 7, 1933?”)
- Confirm all information is correct by comparing information given, to the patient’s identification band and all printed sources of documentation (i.e. optio labels, lab labels, etc.).
- Collection of specimens requires the two patient identifiers prior to the collection. All specimens are labeled in the patient’s presence with the patient’s correct two patient identifiers.
- Patients with a DNR order will wear a purple armband.
- Patients with a Falls risk will wear a yellow armband and yellow slipper socks.
- Patients who are at risk for elopement will wear a gray armband.
- Special consideration must be given to patients in the following areas:
  - Neonatal Intensive Care and Stork Nursery
    - Confirm the patient’s name, date of birth, mother’s name and assigned number with all printed sources of documentation
  - Psychiatry
    - Each patient admitted to the adult and adolescent/child unit will have his/her picture taken. A copy of the picture is placed on the patient’s observation flow sheet and medication kardex to visually confirm the patient’s identification.
    - Additionally, confirm each patient’s identify by confirming the patient’s name and date of birth with all printed sources of documentation.
- Inform patients and family members to insist health care workers use their name before any procedures; inform them of how they can reduce medical errors.
Passport to Surgery  (Policy: Universal Protocol)
Prior to any invasive procedures (OR procedures, central line, chest tubes etc.) performed on a patient, or if the patient is transported to the OR for surgery the following forms must be completed:

- Passport to Surgery (for patients going to the OR)
  - The nurse assigned to care for the patient is responsible for completing the designated areas prior to the patient’s transport to the operating room.
  - Guidelines for required testing are located on the back of the Passport to Surgery form.
  - Each space on the checklist must be initialed.

- Universal Protocol Checklist
  - Write the date, time and procedure in the upper left hand corner.
  - Prior to the start of the procedure verify the patient, site, side, and availability of x-rays, implants and/or special equipment.
  - Each space on the checklist must be initialed.

Elimination of Transfusion Errors  (Policy: Blood Administration Policy)
The following steps are critical to ensure the safe administration of blood and blood components.

- A physician order is required specifying component type, volume or number of units, and flow rate.
- Informed consent for the administration of blood and blood products must be evident in the medical record prior to the infusion of the blood or blood product.
- An identification check must be performed prior to the administration of blood or blood products.
  - Verify blood or component unit number, ABO, and Rh type on blood tag.
  - Identify patient by name and medical record number.
    - Two individuals must perform the identification check.
    - One must be a physician or RN.
    - A LPN may witness the identification check.
  - Compare blood bank identification band number on unit of blood to blood bank number on patient’s bracelet.
  - Check expiration date and time on blood product.
  - Establish base line vital signs.
- Blood products are to be used immediately.
- All information is to be documented on the Transfusion Record.

2. Improve the Effectiveness of Communication Among Caregivers

Telephone & Verbal Orders  (Policy: Nursing Students and Faculty)
Verbal Orders should only be accepted during emergent situations. Nursing faculty and students are not permitted to accept verbal or telephone orders.

Receiving Lab & Test Results by Telephone  (Policy: Critical Values, Reporting of)
- All critical lab results must be taken and documented on the Critical Values/ABG form by an RN.
Read back what you have written to the caller; sign your name on the 1st signature line.
Write the date and time you receive the results.
Give the form to the nurse assigned to care for the patient.
The nurse will call the provider who ordered the lab/test.
Have the provider repeat back the result you have given him/her.
Print the name of the provider to whom you have given the results.
Sign your name on the 2nd signature line. Date and time the form.
Check off the appropriate follow-up action.
Place the Critical Test Results form on the appropriate patient’s chart.

Communication with Patients
Communication is an important aspect of care at MFSMC. A white board is located in each patient’s room to enhance communication by identifying members of the health care team. It is the responsibility of each care provider to write their name on the patient’s white board at the beginning of their shift. Students and their instructors are encouraged to write their names on the White Board at the beginning of the shift.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
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<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero or cc</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international units)</td>
<td>Mistaken as IV (intravenous) or 10</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D. Q.O.D. (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I” or ignored if poorly written</td>
<td>Write “daily and “every other day”</td>
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<tr>
<td>Trailing zero (X.0 mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0X.mg)</td>
</tr>
<tr>
<td>MS, MSO4, MgSO4</td>
<td>Confused for one another</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>AS, AD, AU, OR, OD, OU</td>
<td>May be confused &amp; mistaken for each other.</td>
<td>Write out: left ear, right ear, or both ears; left eye, right eye or both eyes</td>
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<tr>
<td>TIW</td>
<td>Mistaken as “3 times a day”</td>
<td>Three times weekly</td>
</tr>
<tr>
<td>Ug</td>
<td>Mistaken as “mg”</td>
<td>Mcg is ok</td>
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</table>
Unapproved Medication Abbreviations & Legibility. (Policy: Medical Record – Unacceptable Abbreviations)

Prescribers who use unapproved medication abbreviations or write illegibly should be contacted by the nurse to remind them that the medication order must be rewritten. No orders will be accepted that use the unapproved medication abbreviations or are written illegibly and no verbal orders will be accepted to correct these violations, the prescriber must return to the unit to rewrite the order.

Fatal mistakes can be prevented just by writing legibility. It is not acceptable to scribble an order and assume that nurses or the pharmacy will “figure it out” or worse assume that “the reader will know what I mean”. It is imperative that orders be written clearly and succinctly. An identified list of dangerous abbreviations, acronyms, and symbols were developed by Joint Commission. These abbreviations are not to be used for any documentation.

Communication of Critical Situations

It is imperative that communication of critical patient situations is clear and understood by the receiving practitioner. SBAR is a communication tool developed as a result of studies done that identified the need to improve communication between practitioners and nurses.

SBAR stands for:

- **S = Situation**
  - What is going on with the patient?
  - What is the critical situation?

- **B = Background**
  - What is the clinical background information that is pertinent to this specific patient at this specific time?

- **A = Assessment**
  - What is the nurse’s assessment of the situation?

- **R = Recommendation**
  - What is needed from the practitioner and in what time frame

All of the following information should be readily available before you give report or handing off patient care:

- Patient Name
- Age
- Diagnosis
- Medication List
- Allergies
- Vital Signs
- Lab Results
- IV Fluids
- Code Status

3. Improve the Safety of Using Medications  (Policy: Medication Policy)

In order to prevent medication errors of sound alike/look alike drugs, Franklin Square requires that all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions be labeled.
PYXIS MEDSTATION ACCESS

Instructors requiring access to the Pyxis Medstation for the purpose of supervising medication administration by students will be given access effective the first clinical day. The expiration date for access to PYXIS will be the last clinical day for each semester/school year. A new code will be assigned each semester/school year.

Instructors must complete the Pyxis Medstation Password Verification/Non-Disclosure Statement located in your Orientation Manual in the Forms section and deliver it to Betsy Rudolf prior to the first clinical day. The ID is made up of the initials for the school and the last four digits of the instructor’s social security number eg. CCBC0000. A temporary password is issued to the instructor until the instructor signs into the Pyxis Medstation the first time and changes the password.

High risk medications (heparin, insulin, etc) require an independent double check as described below from the Policy: High Risk Medications:
An independent second check is a procedure where two individuals (preferably two licensed practitioners) separately check each component of the work process. An example would be when one person performs a medication dosage calculation for a patient and another individual independently performs the same calculation with matching results. Simply verifying the calculation is NOT considered an independent second check.

Clinical Faculty will utilize another RN to provide the independent double check of these medications prior to allowing student to administer a high risk medication.

Medications are stored in a secured area on each unit. Medications removed from the Pyxis should be selected for one patient at a time and administered immediately. Barcode technology is used to match the drug with the patient. The MAR is now on-line and documentation occurs when the medications are signed in the system. Please see your MedStar eMAR and CareMobile Participant’s Manual for further instructions.

4. Reduce the Risk of Health-Care Associated Infections (Policy: Infection Control Policy)

Hand Hygiene:

Hand hygiene is the most effective way to prevent infections. Hand hygiene is important whether your job involves patient care, lab work, food preparation, environmental cleaning, clerical tasks or any other kind of work. Practicing hand hygiene is simply part of doing your job well.

Wash your hands with soap and water:
- When hands are visibly dirty or contaminated with any materials including blood and other body fluids.
- After using the bathroom, toileting a patient or changing a diaper.

Wash your hands with soap and water or decontaminate with an alcohol-based hand sanitizer:
- In and out of every patient room.
- Before having direct contact with a patient.
- Before donning sterile gloves when inserting invasive devices that do not require a surgical procedure.
- After contact with a patient’s intact skin (taking a pulse or blood pressure).
- After contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled.
- When moving from a contaminated-body site to a clean-body site during patient care.
- After contact with inanimate objects in the immediate vicinity of the patient.
- After removing gloves.

**Hand Hygiene using Soap and Water:**
Wet hands with warm water
Apply soap and rub hands together, vigorously for 15 seconds. Rinse well.
Dry hands with a paper towel.
Turn off faucet with the paper towel.

**Hand Hygiene using an Alcohol-based Hand Sanitizer:**
Apply product to palm of one hand.
Rub hands together, covering all surfaces of hands & fingers until hands are dry.

**Respiratory Etiquette**
Practicing “respiratory etiquette” helps to prevent the spread of many viral and bacterial respiratory pathogens such as the flu, the common cold, respiratory syncytial virus and even SARS. All associates are expected to practice respiratory etiquette. Encourage patients and visitors to also comply with the following respiratory etiquette practices:
- Cover your mouth and nose when coughing or sneezing. If possible, use a tissue.
- Dispose of used tissues, as soon as possible, in an appropriate receptacle.
- Always perform hand hygiene after sneezing, blowing your nose, or coughing and after touching used tissues. Use soap and water or an alcohol-based hand sanitizer.

Patients entering the Emergency Room or other outpatient areas, with symptoms of respiratory illness, should be separated from other patients or asked to wear a mask.

**Standard Precautions**
In order to reduce the risk of transmission of germs from both recognized and unrecognized sources of infection, all healthcare workers should practice Standard Precautions. Standard Precautions are the primary strategy for successful nosocomial infection control and should be used for all patients regardless of risk factors.

Standard Precautions should be used whenever there is a chance that you will be exposed to blood, any other bodily fluids, secretions or excretions (except sweat), broken skin or mucous membranes. By using protective barriers such as gloves, gowns, masks and protective eye wear, you can greatly reduce your exposure to germs and infection when you are providing care or interacting in any way with the patient.
Personal Protective Equipment and Protective Procedures

1. Wear Gloves:
   - when any contact with blood or body fluids is anticipated.
   - when touching any mucous membrane or broken skin.
   - when handling items or surfaces soiled with blood or body fluids.
   - when drawing blood or starting an IV
Gloves are to be changed between each patient. Remove gloves promptly after use and before touching noncontaminated items and environmental surfaces.

Gloves do not eliminate the need for hand hygiene.

2. Use masks and eye protection or protective face shield if there is any chance that blood or other body fluids may splash into your mouth, nose or eyes.

3. Wear a gown if splashing of blood or other body fluids is likely. Change the gown at the earliest opportunity if it becomes soiled or wet.

4. Practice hand hygiene.

5. Cover open wounds and broken skin. Refrain from all direct patient contact and from handling patient care equipment without protection. If you have weeping dermatitis or sores with a discharge, report the condition to your instructor.

6. Use resuscitation bags, mouthpieces or other devices for rescue assisted breathing when possible.

7. Use sharps safely to prevent needle sticks.
   - Always have sharps disposal containers readily available.
   - Use hospital-approved safety needles.
   - Always have help with uncooperative patients.
   - Never startle anyone holding a needle.

8. Dispose of sharps properly.
   - Do not recap, bend or break needles after use.
   - Dispose of sharps in a puncture resistant container immediately after use.
   - Do not overfill sharps disposal containers. Change container when contents reach the “full” line. Call Environmental Services at ext 77666 for a new container.

9. Clean up spills promptly using the hospital-approved disinfectant. Clean your work surface after you’ve completed your work and any time it’s contaminated with blood or other body substances.

10. Bag soiled linen where it was used and close the bag securely.

11. Handle, label and package specimens carefully. Treat every specimen of blood or body fluid as infectious and transport it in a sealed bag.
12. Handle contaminated waste carefully. Dispose of contaminated waste in RED bags/containers for easy identification and to ensure proper handling of this waste. Never reach into a waste container to retrieve any items. If necessary, empty the container and use your eyes to inspect the waste.

13. Dispose of non-infectious waste in clear bags.

**Transmission Based Precautions**

When patients are known or suspected to be infected with highly transmissible diseases or infections it is important to take Standard Precautions a step further and use Transmission Based Precautions in addition to Standard Precautions. Diseases that would require the use of Transmission Based Precautions include tuberculosis, chickenpox, neisseria meningitis, whooping cough, skin or wound infection, RSV in children, and multi-drug resistant organisms (MDROs) such as MRSA and VRE.

There are three types of Transmission Based Precautions that must be used depending on the type of infection. These are Airborne, Droplet and Strict Contact. Enteric Precautions will soon be added to the list and will be used for infections transmitted through stool, such as *Clostridium difficile*. A combination of these precautions may be used for diseases spread by multiple routes.

**Airborne Transmission**

This precaution is designed to reduce the risk of airborne transmission of infection agents. Airborne transmission occurs by the dissemination of either airborne droplets or evaporated droplets that remain suspended in the air for long periods of time, or dust particles that contain the infectious material. These microorganisms can be carried in air currents and may be inhaled or deposited on a susceptible host within the same room or over a longer distance, depending on environmental factors. Consequently it is important that special air handling and ventilation (such as negative airflow rooms) be used to prevent transmission.

**Droplet Transmission**

This precaution is used to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the mucous membranes of the nose or mouth of susceptible patients with large-particle droplets. These large particle droplets are generated when someone coughs, sneezes or talks. Transmission by large particle droplets requires close contact between the source and recipient person because large particle droplets do not stay suspended in the air and generally only travel short distances of up to three feet or less.

**Contact Transmission**

This precaution is used to reduce the risk of transmission of microorganisms by direct or indirect contact. Direct contact involves skin-to-skin contact and physical transfer of the microorganisms to a susceptible host from someone who is infected or colonized. An example is holding hands.

Indirect contact involves contact of a susceptible host with a contaminated intermediate object in the patient’s environment. An example is a blood pressure cuff, an electronic thermometer or over-bed tray.
REQUIRED ELEMENTS FOR TRANSMISSION-BASED ISOLATION PRECAUTIONS

<table>
<thead>
<tr>
<th></th>
<th>STRICT CONTACT</th>
<th>DROPLET</th>
<th>AIRBORNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private room</td>
<td>Preferred *</td>
<td>Preferred *</td>
<td>Yes**</td>
</tr>
<tr>
<td>Door closed</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Teal “Precautions” Bracelet on patient</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mask</td>
<td>No</td>
<td>To enter room (surgical mask)</td>
<td>To enter room†</td>
</tr>
<tr>
<td>Gown</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Gloves</td>
<td>Yes</td>
<td>When handling items contaminated with secretions</td>
<td>When handling items contaminated with secretions</td>
</tr>
<tr>
<td>Large reusable items: wash with approved germicide <em>Read label for required “wet” time.</em></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Linen: leak resistant bag at bedside</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Disposable BP cuff</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disposable stethoscope</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Special Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable meal tray</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Change cubical curtain at discharge</td>
<td>Only if visibly soiled</td>
<td>Only if visibly soiled</td>
<td>Only if visibly soiled</td>
</tr>
<tr>
<td>Indicate isolation on Ticket to Ride</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

When a private room is not available, place the patient in a room with a patient having the same infection/colonization (cohort); OR when a private room is not available, place in a semi-private room with no roommate.

** Requires a room designed for negative pressure and there is appropriate discharge of air outdoors.

† Respiratory protection can be either the Powered Air-Purifying Respirator (PAPR) or the N95 mask depending upon which has been issued to your department and your N-95 fit testing status. *Persons using N-95s must be fit tested within the previous 12 months.*
<table>
<thead>
<tr>
<th>Infection/Condition</th>
<th>Airborne Precautions</th>
<th>Strict Contact Precautions</th>
<th>Droplet Precautions</th>
<th>Duration/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox (same as varicella zoster)</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Until lesions dry and crusted. Susceptible HCWs should not enter room if immune caregivers are available.</td>
</tr>
<tr>
<td>Clostridium difficile (C. diff)</td>
<td></td>
<td>x</td>
<td></td>
<td>Duration of illness</td>
</tr>
<tr>
<td>Conjunctivitis – acute viral</td>
<td></td>
<td>x</td>
<td></td>
<td>Duration of illness</td>
</tr>
<tr>
<td>Diarrhea – known, suspected or rule out C. diff</td>
<td></td>
<td>x</td>
<td></td>
<td>Until C. difficile ruled out</td>
</tr>
<tr>
<td>Epiglottitis (Haemophilus influenzae, type B)</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Hepatitis A – diapered or incontinent</td>
<td></td>
<td></td>
<td>x</td>
<td>Maintain in infants and children &lt;3 years of age</td>
</tr>
<tr>
<td>Herpes simplex – mucocutaneous, disseminated or primary, severe</td>
<td></td>
<td></td>
<td></td>
<td>Until lesions dry and crusted</td>
</tr>
<tr>
<td>Herpes simplex - neonatal</td>
<td></td>
<td></td>
<td>x</td>
<td>Duration of illness</td>
</tr>
<tr>
<td>Herpes zoster (varicella-zoster) (shingles):</td>
<td></td>
<td></td>
<td></td>
<td>Duration of illness. Susceptible HCWs should not enter room if immune caregivers are available.</td>
</tr>
<tr>
<td>Disseminated in any patient OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized disease in immunocompromised patient until disseminated infection ruled out</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td>7 days after onset of symptoms</td>
</tr>
<tr>
<td>Lice (pediculosis)</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Measles (rubeola)</td>
<td></td>
<td></td>
<td>x</td>
<td>4 days after onset of rash. Duration of illness in immunocompromised</td>
</tr>
<tr>
<td>Meningococcal disease: sepsis, pneumonia, meningitis</td>
<td></td>
<td></td>
<td></td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Meningitis: Haemophilus influenzae OR</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Neisseria meningitidis (meningococcal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection/Condition</td>
<td>Airborne Precautions</td>
<td>Strict Contact Precautions</td>
<td>Droplet Precautions</td>
<td>Duration/Comments</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Meningitis:</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Haemophilus influenzae OR Neisseria meningitidis (meningococcal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multidrug-resistant organisms (MDROs):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESBL</td>
<td>x</td>
<td></td>
<td></td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>MRSA</td>
<td>x</td>
<td></td>
<td></td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>VRE</td>
<td>x</td>
<td></td>
<td></td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>VISA (Vancomycin Intermediate S. aureus)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>Other MDROs *</td>
<td>x</td>
<td></td>
<td></td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>Mumps (infectious parotitis)</td>
<td></td>
<td>x</td>
<td></td>
<td>9 days after onset of symptoms</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td></td>
<td>x</td>
<td></td>
<td>Until 5 days of treatment</td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
<td>x</td>
<td></td>
<td>Duration of illness</td>
</tr>
<tr>
<td>RSV (respiratory syncitial virus) in infants, young children and immunocompromised adults</td>
<td></td>
<td>x</td>
<td></td>
<td>Duration of illness. Wear mask per Standard Precautions.</td>
</tr>
<tr>
<td>Rubella (german measles)</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 7 days after onset of rash</td>
</tr>
<tr>
<td>SARS (severe acute respiratory syndrome)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Duration of illness plus 10 days after resolution of fever</td>
</tr>
<tr>
<td>Scabies</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Shingles – see “Varicella Zoster”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Strep” throat (Group A) – infants &amp; children</td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment</td>
</tr>
<tr>
<td>Tuberculosis, known or suspected</td>
<td></td>
<td></td>
<td>x</td>
<td>See “Tuberculosis Control Plan”</td>
</tr>
<tr>
<td>Varicella Zoster</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Until lesions dry and crusted. Susceptible HCWs should not enter room if immune caregivers are available</td>
</tr>
</tbody>
</table>

* Other MDROs include – Resistant *Acinetobacter*, Any *Klebsiella pneumoniae* Carbapenemase-Producing Organism, Imipenem-resistant *Pseudomonas aeruginosa*
5. Accurately and completely reconcile medications across the continuum of care.  
(Policy: Medication Reconciliation)

The clinician that completes the Admission Database is responsible for obtaining a complete medication history. All medications and pertinent patient history will be included as well as last dose taken and current and past prescription history. The medical provider is responsible for reconciling the medications at each transition in the patient’s care and on discharge.

6. Reduce the risk of patient harm resulting from falls
(Policy: Falls Prevention: Patient Safety)

Fall Management
MedStar Franklin Square Medical Center is committed to patient safety & the reduction of falls and injuries related to falls.

Hospital Wide Strategies
- All patients admitted will have a comprehensive fall assessment completed.
- All patients regardless of risk will have interventions individualized and implemented.
- The nurse will identify the appropriate interventions and strategies and incorporate these into the plan of care.
- Hourly Rounding

Fall Assessment Tool
The fall assessment tool is completed at the time the patient is admitted to the hospital, transferred, and every 12 hours. See Fall Risk Assessment and Prevention Tool (Morse Fall Scale or unit specific form). Each patient is evaluated for the following:

The fall assessment tool is completed at the time the patient is admitted to the hospital, transferred, and every 12 hours. See Fall Risk Assessment and Prevention Tool (Morse Fall Scale). Each patient is evaluated for the following:

- History of Falling
- Secondary Diagnosis
- Ambulatory Aid
- IV or IV Access
- Gait
Mental Status
Based on the assessment, patients’ fall risk is established. A score of 25 or above indicates the patient is at risk for falling and Fall Prevention Interventions need to be initiated.

Fall Prevention Interventions
All patients with a score of 25 or more will automatically be given a yellow armband and yellow slipper socks, a falling star magnet is placed on the patient’s door, a review of the fall education pamphlet and evaluated for orthostatic hypotension every 24 hours.

Interventions are individualized based on the patient’s fall assessment risk. Individualized fall prevention interventions may include:

- Low Bed
- Bed Alarm
- Chair Alarm
- PT/OT Consult in SMS
- Self Release Belt
- Psychiatric Liaison Nurse Consult
- Geriatric Consult (if ≥ 65 years old)
- MD evaluation for causes of cognitive impairment/delirium
- Intake & Output
- Bedside commode
- Prompted toileting every 2 hours, while awake
- Pharmacy consult for comprehensive medication review
- Sitter
- At risk patients placed close to the Nurses’ Station

If a Fall Occurs  (Policy: Falls: Patient Care Protocols Post-Fall)

- Refer to the policy manual for documentation guidelines.
- An Occurrence Report must be completed for ANY fall.
- Documentation should include:
• Objective facts related to the incident.
• Vital signs.
• Patient status before and after fall.
• Description of any injuries.
• Diagnostic tests and procedures post fall.
• Name of physician or P.A. notified.
• Time and name of family member or significant other notified.

**Hourly Rounding – The Franklin Square Way**

**Our Process – Inpatient:**

- Introduce self, “I’m here to do my hourly rounds”
- Address 4Ps and 4Rs
  - Pain, Position, Potty, Pump and Medication Needs (Rx), Reach, Respond, Reassure
- Assess the environment (clean up trash, ensure things are in reach of the pt)
- Departing words “Is there anything else I can do for you before I leave? I have time.”
- Tell patient when someone will be back.
- Document what was done in computer or on handheld device.

**Rounding Rules**

- Never wake up a patient unless for a treatment
- Round every hour
- If it isn’t documented, it wasn’t done
- Let patient’s nurse know about medication needs – pain, nausea, etc.

See the Unit Charge Nurse for unit specific Hourly Rounding criteria.

7. **Additional Patient Safety Precautions**

**Restraints** (Policy: Restraints, Use of (Non-Behavioral Health))

**Definition:** A restraint is a method of involuntary physical restriction of a person’s freedom of movement, physical activity or normal access to his or her body. Restraint also includes medications which are used to control behavior or to restrict the patient’s freedom of movement, and which are not a standard treatment for the patient’s medical or psychiatric condition.

- A Licensed Independent Practitioner (physician, resident, midwife, nurse practitioner or physician assistant) must write an order for restraints.
• All orders must include the following: date & time, specific type of restraint to be used and time limit for the physical restraint.

• A restraint order for the protection of therapeutic lines and tubes must be renewed every 24 hours. An order for restraint must be obtained within one hour of application. If the order for the restraint is obtained from someone other than the attending physician, the attending physician must be contacted as soon as possible. Patients in restraints must be assessed every two hours and the RN should periodically evaluate the continued need for restraints.

• A face-to-face evaluation and signed order must occur within 24 hours by the Licensed Independent Provider.

• The patient’s family MUST be notified of the initiation of restraints.

**Elopement  (Policy: Elopement Prevention and Response (Code Grey))**

**Definition:** Elopement occurs when an adult patient admitted or under the care of a physician, leaves the hospital without completion of care and signing out Against Medical Advice.

• Every patient admitted to FSHC will be assessed for elopement using the Patient Safety Screen.

• A patient who is assessed as being “at risk” for elopement will receive a gray wristband.

• If an identified “at risk” patient is determined to be missing a code Gray will be called.

• PLEASE review this entire policy for more detailed information.
The physicians and staff of MFSMC believe that all patients have a right to pain relief. Optimal pain management begins with how the patient defines pain, the patient’s awareness of potential or actual pain, effective communication with the member of the health care team about it and the administration of appropriate therapy to avoid pain or provide pain relief. The assessment and management of pain should be based on a thorough understanding of what is causing the pain, as well as the individual patient’s personality, culture, ethnicity, coping style, and emotional, physical and spiritual needs. The plan for pain management will be evaluated and revised as needed to strive to meet the patient’s pain relief goals.

Each patient admitted to MFSMC will have a complete pain assessment done and will identify, when able, a pain goal on admission and each day. It is the nurse’s responsibility to assess and reassess the patient’s pain status after the administration of pain medication and throughout their shift, and to document their findings according to policy.

**Patient Controlled Analgesic Pump**

IV Patient Controlled Analgesic (PCA) is managed by the attending physician or the assigned health care team. Documentation is made in the computer on the Pain Management Flow Sheet upon initiation of the medication, every 15 minutes x2, every one hour x1, every 4 hours during infusion and 30 minutes x1 after all dose/program changes. It is the nurse’s responsibility to complete the PCA flow sheet according to hospital policy.

Patient Controlled Epidural Analgesia (PCEA) is managed by anesthesia only. There is a specific epidural order sheet that must be completed every day by anesthesia. The nurse is responsible for completing the PCA flow sheet according to hospital policy.
RAPID RESPONSE TEAM
(Policy: Rapid Response Team (RRT))

The Rapid Response Team (RRT) can be called if an inpatient is having signs of deterioration in status or the staff feels “something is not right”. Family members can also request the nurse to contact the RRT.

Responders include the critical care nurse, PA or resident and a respiratory therapist. The team includes the responders plus the primary nurse and other staff on the floor caring for the patient.

To activate team: DIAL 5555 and inform the operator of the exact location and the type of Rapid Response required (Adult, Pediatric, or Obstetric).

Members of the RRT will arrive within 15 minutes.

*Notify attending physician that team has been activated as soon as possible.*

In Preparation for RRT Arrival:

- Have the patient’s chart and medication admin record readily available
- Have the most current labs
- The patient’s assigned nurse must remain with patient

CALL A CODE BLUE IF THE PATIENT:

- Becomes pulse less
- Becomes apneic
- Develops an unstable rhythm

*Push Code Blue button in the patient’s room or DIAL 5555 and give operator your exact location.*

Advance Directives
(Policy: Advance Directive)

An advance directive is a document that states the preferences about future medical care and designates someone to make healthcare decisions if the patient cannot make his/her own decisions.

What is Required?

- All patients over the age of 18 must be asked if they have an advance directive.
- Case Management is available to assist patients who request an advance directive.
- Ask patients who have an advance directive to bring a copy to the hospital as soon as possible.
- Place the advance directive in the designated area of the medical record.
Spirituality & Cultural Diversity

(Policy: Spirituality/Cultural Care)

The patient has a right to, and receives care that is considerate and respectful of his or her personal values or beliefs. Patient assessment considers not only the physiological status but also psychological and social considerations. A patient’s cultural and family contexts are important factors in his or her response to illness and treatment.

- Developing cultural competence begins with self-awareness
- The expression of patient’s values and beliefs must be supported
- Patient care should demonstrate an awareness of the spiritual and cultural beliefs of the community served
- Psychosocial and spiritual needs of the patient are met through hospital resources
- Health care workers at MFSMC are expected to respond to patients special needs which may include but are not limited to:
  - Food preferences
  - Visitors
  - Gender of healthcare workers
  - Medical care preferences
  - Gender roles
  - Eye contact and communication style
  - Authority and decision making
  - Alternative therapies
  - Prayer practices
  - Beliefs about organ/tissue donation

**Meditation Room**

The Meditation Room is located on the first floor of the new Tower off the Lobby.

Pastoral Care Resources can be reached at the following numbers:

Director: (443)-777-7827

Parish Nurse (443)-777-7931
Patient Documentation
DOCUMENTATION
(Policy: Documentation: Nursing)

For detailed information on completion of documentation forms, please review the on-line policy and utilize the unit Charge Nurse as a resource. You will find Charting Location Lists in the Documentation section of this manual to provide you with a complete list of forms and where to find them for Pediatrics, Psychiatry and Adult Health. The following is a guide only. Follow the practice of the unit you are working on. All charting is done under the Iview/I&O on the menu bar unless otherwise noted.

Nursing Admission Data Base - this is completed from the Care Compass task list

- Must be completed within 24 hours of admission
- Initial patient assessment must be completed by a Registered Nurse
- Patient allergies and reactions must be documented and validated with the patient by a Registered Nurse (“NKA” may be documented by the Patient Service Associate working in the newborn nursery)
- Include Braden Skin Assessment and Morse Fall Scale as part of initial assessment

Adult (Pediatric) System Assessment – upon admission and once a shift

- Routine assessments are performed and documented
- Reassessments shall be performed and documented at the time they are performed

Adult (Pediatric) Skin-ADL Nutrition – upon admission and once a shift

- Braden Skin Assessment (Pediatrics – Humpty Dumpty Scale)
- Activities of Daily Living – activity, hygiene, safety, Morse Fall Scale

Adult (Pediatric) Education

- Must be initiated at the time of admission and maintained throughout the patient’s stay
- All patient education must be documented on this record

Medication Administration Record (eMAR)

- All medications received by the patient must be documented using the tethered scanner or handheld devise
- Special parameters or considerations for administering the patient’s medications must be documented on the eMAR
- Medications administered by injection must have the site recorded
- Patient response to PRN medications and untoward responses to standing and stat medications must be documented
- Complete infusion Billing for ALL IV medications and IV fluids (patient’s chart, EMAR, Infusion Billing icon)
Medication Reconciliation Tool
- MD/LIP or RN/LPN responsible for completing this form

Interdisciplinary Plan of Care document under Orders on the menu tab – choose Document in Plan tab
- Must be initiated by the Physician, Nurse Practitioner, Physician Assistant, Nurse Case Manager or RN and the patient/significant other within 24 hours of admission
- The Plan of Care is updated and documented each shift

Clinical Pathways
- Pathways are developed based on evidence in the literature or expert consensus to favorably impact the quality or safety of patient care
- Documents are developed that will support the implementation of the clinical practice guidelines and may include prescriber order sets, mechanism to measure outcomes, and patient education materials
- Documentation should be made daily on the pathway and outcome measures form

Discharge Instructions - charting is done under the Transition Care on the menu bar
- An order for discharge must be completed by the physician
- Each patient must be given a written copy of his/her discharge instructions prior to leaving the hospital – **the signature page must be retained for medical records**
- Ensure the patient has any valuables and medications brought in from home
- All patients must be escorted to the departure area (including those leaving against medical advice - AMA)
- If a patient leaves AMA, all efforts must be made by the nurse to obtain signature of the patient or responsible person on the “Statement of Patient Leaving Against Medical Advice” form. An Occurrence report must be completed
- Staff must stay with and help the patient into the car/taxi
- Patients discharged by bus or to a homeless shelter must be escorted to the departure area
- Pediatric patients must be escorted by a staff member, and may be discharged via wagon, wheel chair or be carried by a parent

Patient Transfers
- Information must be provided to the receiving unit or nursing facility concerning the status of the patient and routine care provided to the patient on the day of transfer
- A physician’s order is required to transfer a patient to a different level of care (i.e. medical surgical to critical care) however; an order is not required to transfer a patient from one medical surgical unit to another.
Handoff of Care Communication must be completed for all transfers. This can be under the Iview/I&O on the menu bar – choose the Adult (Pediatric) Quick View tab.

The transferring nurse must give report to the receiving nurse and include information that includes but is not limited to: diagnosis, current condition, vital signs, fall risk, assessment, current medications and treatments, and safety issues.

**Influenza and Pneumococcal Vaccination Protocol**

- All adult (≥18 years of age) admitted medical patients must be screened using the Influenza and Pneumococcal Protocol.
- The nurse will administer inactivated influenza vaccine and the pneumococcal polysaccharide vaccine to appropriate patients according to the protocol.
- The nurse will document screening and vaccine administration and lot number on the “Influenza and Pneumococcal Vaccination Protocol” and on the eMAR.

**Two nurse signatures are required for the following forms:**

- * Heparin Administration Flow Sheet
- * Blood Administration
- * Pain Management Flow Sheet when initiating PCA and any pump/bag/tubing change
- * Discarding Schedule II substances

**Patient Valuables – Paper Documentation**

- Valuables are listed on the valuable sheet
- Must be signed by the patient, family or significant other
The Supervising Clinician/Instructor selects this Pending Validation task from their task list and they are taken to the activity view documented by the student.

There will be an icon in the top toolbar of Interactive View for the Supervising Clinician or Instructor to select to review unauthenticated results.

If charting a Pending Validation Task, selecting this icon will open the authenticate window with the activity view data to be authenticated.
### MEDCONNECT INPATIENT DOCUMENTATION

#### HOURLY

- **O₂, SATs/HR** – document in I-View under Adult Quick View (Vital Signs) if pt. is on con’t O₂, sat monitoring)
- **IV SITE ASSESS** – If pt. has IV infusing: document Iview under Adult Lines/Tubes/Drains (Peripheral IVs)
- **IV AMOUNT** – document in I-View/I&O under Intake and Output (If pt. is receiving IV fluids) – exact amt. infused
- **HOURLY ROUNDING** (Handheld Documentation) – document on handheld or from Care Compass – handheld documentation
- **I & O** – document in I-View/I&O under Intake and Output

#### CARE COMPASS – monitor Care Compass routinely throughout the shift for new orders, results

- **HANDOFF OF CARE COMMUNICATION** – Adult Quick View, Handoff of Care Communication (complete with every handoff of patient care, ie. Shift change, transfer)

#### Clinician Notification/Communication – Adult Quick View, document all critical values received and any communication with providers

- **Weight** – document in I-View under Measurements

#### ADMISSION

**COMPLETE ADMISSION DOCUMENTATION FROM CARE COMPASS TASK LIST OR APPROPRIATE AREA IN POWERCHART:**

- **VITAL SIGNS- in I-View under Adult Quick View**
- **Adult Patient Database** – document from Care Compass task list
- **Review Allergies** – go to patient’s chart, Allergies/Intolerances (enter new allergies or Mark as reviewed, as appropriate), document Done on Care Compass task list
- **Review and Add Medications** – in → patient’s chart, go to orders, then Document Medication by Hx
- **Review Problem List** (past medical problems) and Diagnosis (current problem/s) – patient’s chart under Diagnosis & Problems; document Done on Care Compass task list
- **Pneumococcal Vaccination Screening & Influenza Vaccination Screening form** (on paper)
- **Ongoing assessment** (head-to-toe assessment within 4 hours of admission including integumentary assessment with Braden/Braden Q) – in I-View: Adult System Assessment, Adult Skin/ADL/Nutrition; document Done on Care Compass task list
- **Pain assessment** – in I-View under Adult Quick View
- **ACTIVITIES OF DAILY LIVING**- Adult Skin/ADL/Nutrition
- **SAFETY ADLS** - CR monitor & pulse ox alarm parameters
- **Hygiene ADLS** – manage moisture/incontinence - CHG bath
- **MORSE FALL RISK ASSESSMENT & INTERVENTIONS** – document from Care Compass task list – takes you to iView complete assessments

#### DOCUMENT FROM CARE COMPASS task list)

- **document**

#### Document from Care Compass task list

- **Patient/Family Education** – document in I-View under Adult Quick View
- **IV SITE ASSESS** – If pt. has saline lock - document from Care Compass under Adult Lines/Tubes (Peripheral IVs)

### ONCE A SHIFT

**REVIEW PROBLEM LIST** (past medical problems) and **Diagnosis** (current problem/s) – patient’s chart under Diagnosis & Problems click on Mark all as reviewed at top of page; document Done on Care Compass task list

**ONGOING ASSESSMENT** (head-to-toe assessment) – document from Care Compass task list (Ongoing Assessment Adult, Adult Skin, ADL-Nutrition) - takes you to iView complete assessments

**ACTIVITIES OF DAILY LIVING** under Adult Skin/ADL/Nutrition

**SAFETY ADLS** - CR monitor & pulse ox alarm parameters

**Hygiene ADLS** – manage moisture/incontinence - CHG bath

**MORSE FALL RISK ASSESSMENT & INTERVENTIONS** – document from Care Compass task list – takes you to iView complete assessments

**PAIN ASSESSMENT** – in I-View under Adult Quick View

**FOCUSED ASSESSMENT** – every 4 hours (and prn) after initial full systems assessment at beginning of shift (I-View: Adult, System Assessment, Adult Skin/ADL/Nutrition)

**VITAL SIGNS** – in I-View under Adult Quick View

**IV SITE ASSESS** – If pt. has saline lock - document from Care Compass under Adult Lines/Tubes (Peripheral IVs)

### DISCHARGE

**IV DISCONTINUED** – remove IV, document in I-View under Adult Lines/Tubes (Peripheral IVs)

**CARE COMPASS** – complete all overdue tasks under **Overdue** task list

**Depart Process** – go to pt’s chart, **Transition Care, Depart**

**Process:**

- **Patient Education and Medication Leaflets** (in Discharge Instructions section). If not using ExitCare, print 2 copies of learning materials – one copy remains with the paper chart for scanning (place patient labels on each printed page).
- **Review**

**Review** **Plans of Care** - go to patient’s chart, under Orders, Document in Plan – will be done/not done or met/not met; (document Done on Care Compass task list)

**CARE COMPASS** – complete all overdue tasks under **Overdue task list** prior to end of shift

### EVERY 4 HOURS

**PAIN ASSESSMENT** – in I-View under Adult Quick View

**FOCUSED ASSESSMENT** – every 4 hours (and prn) after initial full systems assessment at beginning of shift (I-View: Adult, System Assessment, Adult Skin/ADL/Nutrition)

**VITAL SIGNS** – in I-View under Adult Quick View

**IV SITE ASSESS** – If pt. has saline lock - document from Care Compass under Adult Lines/Tubes (Peripheral IVs)

### INFUSION BILLING

**BILLING for all IV medications and IV fluids** (patient’s chart, eMar, Infusion Billing Icon)

### INPATIENT DOCUMENTATION

<table>
<thead>
<tr>
<th>MEDCONNECT INPATIENT DOCUMENTATION</th>
<th>ONCE A SHIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOURLY</strong></td>
<td><strong>REVIEW PROBLEM LIST</strong> (past medical problems) and <strong>Diagnosis</strong> (current problem/s) – patient’s chart under Diagnosis &amp; Problems click on Mark all as reviewed at top of page; document Done on Care Compass task list</td>
</tr>
<tr>
<td><strong>O₂, SATs/HR</strong> – document in I-View under Adult Quick View (Vital Signs) (if pt. is on con’t O₂, sat monitoring)</td>
<td><strong>ONGOING ASSESSMENT</strong> (head-to-toe assessment) – document from Care Compass task list (Ongoing Assessment Adult, Adult Skin, ADL-Nutrition) - takes you to iView complete assessments</td>
</tr>
<tr>
<td><strong>IV SITE ASSESS</strong> – If pt. has IV infusing: document Iview under Adult Lines/Tubes/Drains (Peripheral IVs)</td>
<td><strong>ACTIVITIES OF DAILY LIVING</strong> under Adult Skin/ADL/Nutrition</td>
</tr>
<tr>
<td><strong>IV AMOUNT</strong> – document in I-View/I&amp;O under Intake and Output (If pt. is receiving IV fluids) – exact amt. infused</td>
<td><strong>SAFETY ADLS</strong> - CR monitor &amp; pulse ox alarm parameters</td>
</tr>
<tr>
<td><strong>HOURLY ROUNDING</strong> (Handheld Documentation) – document on handheld or from Care Compass – handheld documentation</td>
<td><strong>Hygiene ADLS</strong> – manage moisture/incontinence - CHG bath</td>
</tr>
<tr>
<td><strong>I &amp; O</strong> – document in I-View/I&amp;O under Intake and Output</td>
<td><strong>MORSE FALL RISK ASSESSMENT &amp; INTERVENTIONS</strong> – document from Care Compass task list – takes you to iView complete assessments</td>
</tr>
<tr>
<td><strong>CARE COMPASS – monitor Care Compass routinely throughout the shift for new orders, results</strong></td>
<td><strong>PAIN ASSESSMENT</strong> – in I-View under Adult Quick View</td>
</tr>
<tr>
<td><strong>HANDOFF OF CARE COMMUNICATION</strong> – Adult Quick View, Handoff of Care Communication (complete with every handoff of patient care, ie. Shift change, transfer)</td>
<td><strong>FOCUSED ASSESSMENT</strong> – every 4 hours (and prn) after initial full systems assessment at beginning of shift (I-View: Adult, System Assessment, Adult Skin/ADL/Nutrition)</td>
</tr>
<tr>
<td><strong>Clinician Notification/Communication – Adult Quick View, document all critical values received and any communication with providers</strong></td>
<td><strong>VITAL SIGNS</strong> – in I-View under Adult Quick View</td>
</tr>
<tr>
<td><strong>Weight</strong> – document in I-View under Measurements</td>
<td><strong>IV SITE ASSESS</strong> – If pt. has saline lock - document from Care Compass under Adult Lines/Tubes (Peripheral IVs)</td>
</tr>
</tbody>
</table>

### ADMISSION

**COMPLETE ADMISSION DOCUMENTATION FROM CARE COMPASS TASK LIST OR APPROPRIATE AREA IN POWERCHART:**

- **VITAL SIGNS- in I-View under Adult Quick View**
- **Adult Patient Database** – document from Care Compass task list
- **Review Allergies** – go to patient’s chart, Allergies/Intolerances (enter new allergies or Mark as reviewed, as appropriate), document Done on Care Compass task list
- **Review and Add Medications** – in → patient’s chart, go to orders, then Document Medication by Hx
- **Review Problem List** (past medical problems) and Diagnosis (current problem/s) – patient’s chart under Diagnosis & Problems; document Done on Care Compass task list
- **Pneumococcal Vaccination Screening & Influenza Vaccination Screening form** (on paper)
- **Ongoing assessment** (head-to-toe assessment within 4 hours of admission including integumentary assessment with Braden/Braden Q) – in I-View: Adult System Assessment, Adult Skin/ADL/Nutrition; document Done on Care Compass task list
- **Pain assessment** – in I-View under Adult Quick View
- **ACTIVITIES OF DAILY LIVING**- Adult Skin/ADL/Nutrition
- **SAFETY ADLS** - CR monitor & pulse ox alarm parameters
- **Hygiene ADLS** – manage moisture/incontinence - CHG bath
- **MORSE FALL RISK ASSESSMENT & INTERVENTIONS** – document from Care Compass task list
- **Patient/Family Education** – document in I-View under Adult Quick View
- **Valuables/Belongings/Home Meds form** - document from Care Compass task list, type in “see Valuables/Clothing List in paper chart”; have pt/caregiver sign the Clothing List sheet, then place form in patient’s paper chart
- **Update Order Entry Details form** - document from Care Compass task list
- **Nurse Review of orders** - document on Care Compass → Hourly rounding- document on handheld or from Care Compass task list
- **Initiate Medical Power Plans** – go to patient’s chart, under Orders, right click on the Medical Plan order, click Initiate
- **Review Plans of Care** – go to patient’s chart, under Orders, Document in Plan
- **Review Suggested Plans of Care** – go to patient’s chart under Orders. If appropriate, choose to accept/modify/customize the plan to meet the unique needs of the patient, then **Initiate any Quality Measures.**
CERTIFICATION: INFORMED CONSENT - OPERATIONS AND OTHER PROCEDURES

PERMISSION FOR SURGERY AND INVASIVE PROCEDURES

I hereby certify that I have discussed the following procedure(s) with patient, (1) ____________________________ (Identify the procedure(s); specify any limitations requested by the patient.) (2) ____________________________ The above named patient, legal guardian, or nearest relative, as appropriate, has requested that the named procedure(s) be performed by Dr(s) (3) ____________________________ and other doctors of my (our) choice who may be required.

PERMISSION FOR NECESSARY ADDITIONAL PROCEDURES: The named patient has also given their permission for the performance of additional procedures that are considered necessary on the basis of findings during the course of the original operation except for any limitations specified above.

AUTHORIZATION FOR DISPOSAL OF TISSUE AND SPECIMENS: The named patient has also authorized Franklin Square Hospital Center to retain, photograph, preserve, dispose at their convenience, or use for scientific teaching purposes, any specimens or tissue taken from the patient during the operation. Authorization is also granted to take videos/photographs of the procedure(s) for teaching.

DISCUSSION OF REQUIRED INFORMATION

I further certify that I have discussed the following information with the patient named above:

1) The nature of the condition which has led to the need for the procedure;
2) The nature and benefit of the proposed procedure(s) named above;
3) Alternative methods of treating the condition;
4) The risks involved in each method of treatment; and
5) The known consequences or complications which will or may result from each method of treatment.
6) Potential for transfusion of blood/blood products
7) Other ____________________________

CERTIFICATION

I hereby certify that I have discussed all the above with the named patient and have secured their permission and consent as outlined above.

SIGNATURE OF PHYSICIAN SECURING THE PATIENT’S CONSENT

DATE/TIME

I certify that a member of the Department of __________________, has explained to me the risks, benefits potential complications and available alternative treatments. I certify that I have had an opportunity to ask questions and have made an informed decision to consent to the procedure.

WITNESS ____________________________

DATE/TIME

PATIENT ____________________________

DATE/TIME

PATIENT'S DESIGNEE OR SUBSTITUTE ____________________________

RELATIONSHIP TO PATIENT ____________________________

DATE/TIME

T30110-18 (9/05)

Consent
CERTIFICATION/PROGRESS NOTE FOR OBTAINING INFORMED CONSENT FOR THE ELECTIVE TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

PERMISSION
I hereby certify that I have discussed the transfusion of blood or blood products with patient, (1) ____________________________________________
Or legal guardian, or family member (if applicable) (2) ____________________________________________
The patient: _______ Has decision making capacity
_______ Does not have decision-making capacity (refer to Health Care Decisions Policy. See references.)
Others present ____________________________________________ (relationship)

Patient's clinical information related to need for transfusion ____________________________________________

Description of treatment: (Circle one) Transfusion of: PRBC's FFP Platelets

Indication for treatment: see indication guidelines on back.

SOME RISKS AND BENEFITS OF TRANSFUSION
(SHOULD BE DISCUSSED IN RELATION TO PATIENT'S EDUCATION AND INTEREST LEVEL):

RISKS
- Febrile reaction - 1:200
- Immunization to WBC's or platelets - 1:100
- Delayed Hemolytic reaction (occurs 2-14 days after transfusion)
  - Hemolytic 1:4,000
  - Serologic (mild usually not clinically important) 1:183
- HIV 1:450,000-660,000
- Hepatitis C 1:10,000-100,000
- Hepatitis B 1:50,000-250,000

ALTERNATIVES
- No transfusion.
- Using your own blood (Autologous transfusion)
- Having family or friends provide the blood. (Has not been shown to be safer than blood from our hospital or Red Cross supply)
- Using other medication instead of transfusion.
  1. Dependent on underlying cause of anemia.
  2. FSHC Bloodless Medicine Program (see references).

BENEFITS
I. PACKED RED CELLS
- Correcting anemia resulting from kidney failure, malignancies, gastrointestinal bleeding.
- Replacing blood loss from trauma or surgery.
- Improving symptoms of shortness of breath, chest pain, postural hypotension when anemia is contributing to these symptoms.

II. FRESH FROZEN PLASMA
- Replacing clotting factors in patients with coagulation factor deficiency.
- Correcting the effect of Warfarin in preparation for surgery, when patient is bleeding or is at high risk for bleeding.
- Correcting the coagulation factor deficiency in certain disease states if there is a high risk for bleeding.

III. PLATELETS
- Correcting low platelet counts in disease states or during therapy that places the patient at a high risk for bleeding.
- Reducing the risk for bleeding in patients undergoing major surgery.
- Control bleeding in patients with deficiency in platelet number or function.

Likely outcome of no treatment ____________________________________________

T:52311-1 (11/00)
DISCUSS YOUR QUESTIONS AND CONCERNS BEFORE YOU AGREE TO HAVE ANY BLOOD TRANSFUSION.

REFERENCES: 1) Health Care Decisions, Hospital Policy Manual for issues such as
- Determining Competency for Consent
- Agents, Surrogates, Advance Directives
- Disagreements and Disputes
2) Refusal of Blood Products Policy, Hospital Policy Manual
3) Consultation for Bloodless Medicine Program. Call 443-777-8280 or 443-777-8048.
4) Patient Care Advisory Committee - contact Case Management or administrator on call.

CERTIFICATION
I hereby certify that I have discussed all the above with the named patient and have secured that permission and consent as outlined above.

Signature of Physician securing the patient’s consent  Date / Time

Patient Signature  Date / Time

Witness  Date / Time

INDICATION GUIDELINES FOR TRANSFUSION OF BLOOD/BLOOD PRODUCTS

PLEASE CIRCLE ALL THAT APPLY

I. PACKED RED CELLS
   A. Bleeding with symptoms and signs of hypovolemia*
      *Systolic BP < 90 mmHg or acute drop systolic BP > 30 mmHg, Hct < 30, Hgb < 10 grams, estimated blood loss of
      20% or > 750 ml.
   B. Hgb < 10 grams prior to surgery except in patients with significant cardiac and/or pulmonary disease.
   C. Symptomatic anemia Hgb < 10, Hct < 30 whatever the cause if no other therapy is likely to correct the anemia,
      i.e., falling hematocrit, postural hypotension
   D. Obvious acute massive hemorrhage with signs of shock

II. FRESH FROZEN PLASMA
   A. Prolonged prothrombin time (PT) or progressively increasing PT over patient’s previously normal PT (PT > 16)
      or a factor assay indicating a clinically significant coagulation factor deficiency.
   B. Reversal of Warfarin effect in clinically urgent circumstances.
   C. Patients with thrombotic thrombocytopenic purpura.
   D. Transfusion of 10 or more units of blood within 5 hours with an abnormal PT.
   E. Patient requires whole blood due to massive hemorrhage, but only red cells are available and must be supplemented.
   F. Severe liver disease with abnormal enzymes SGPT, LDH, SGOT, elevated PT and Hypoalbuminemia.
   G. Abnormal prothrombin time (PT) in patients with clinically significant bleeding prior to a procedure.
   H. Elevated partial thromboplastin time (PTT) with active bleeding or history of congenital coagulopathy.

III. PLATELETS
   A. Non-immune thrombocytopenia with platelet count < or equal to 10,000 when receiving chemotherapy with or
      without active bleeding.
   B. Non-immune thrombocytopenia with platelet count < 50,000 with evidence of active bleeding.
   C. Platelet count < 100,000 in patient undergoing major surgery.
   D. Massive transfusion with evidence of thrombocytopenia.
RESTRAINT / SECLUSION
INITIATION / TERMINATION

Initiation of Restraint/Seclusion:
Date: ____________ Time in: ____________ Licensed Physician/PA: ____________

1. Document behavior: Specify how the patient's behavior constitutes a danger to self, others, or presents a serious disruption to the community.
   □ Self removal of lines or tubes that promote healing. Describe behavior: ____________________________
   □ Danger to self. Describe behavior: ____________________________
   □ Danger to others. Describe behavior: ____________________________
   □ Severely disruptive. Describe behavior: ____________________________

2. Document less restrictive interventions utilized and the patient response to such interventions:
   □ Reality Orientation □ Limit setting □ Time out in room
   □ Diversion/Distraction □ Appropriate medications
   □ Verbal De-escalation □ Decrease milieu stimuli

Patient Response: ____________________________
Intervention: ____________________________ Seclusion: ____________________________ Restraint: ____________________________ Type: ____________________________

3. Disposition of patient's belongings while secluded/restrained: ____________________________

Patient wearing own clothes: □
Hospital clothing provided: □ Explain: ____________________________

4. Physical assessment of the patient at the time of restraint/seclusion (i.e., alert, mobile, restricted mobility, speech or hearing impaired, balance deficit, injured, etc.): ____________________________

5. Patient furnished with an explanation as to why he/she is being restrained/secluded and the staff role in observing and assisting him/her: □
   Explanation of release criteria discussed with patient: ____________________________

6. Notification of family: □ Yes □ No If no, please explain: ____________________________
   Brief description of restraint/seclusion process (how many staff assisted/who assisted, Security called, holds used, etc.): ____________________________

7. Licensed Physician/PA Evaluation within one hour: □ Yes □ No ____________________________

8. Attending physician notified: □ Yes □ No If no, please explain: ____________________________

   Time: ____________________________

   ________________

   RN Signature:

Termination of Restraint/Seclusion:
Date: ____________ Time: ____________

Behavior criteria for release:
□ Calm, quiet
□ No longer exhibiting behaviors that justified use of restraint/seclusion
□ Able to follow direction of staff
□ Able to participate in debriefing process

Debriefing (Patient/family and staff):
□ Discussed behavior that led to restraint/seclusion
□ Alternatives that were attempted
□ Therapeutic counseling provided if needed
□ Recommendations for treatment plan

Nurse's overall impression of patient's response to debriefing: ____________________________

Injuries sustained while in restraints/seclusion: □ Yes □ No

If yes, describe: ____________________________

RN Signature/Title:

White - Medical Records
Canary - Manager
## ALLERGIES:

### DOCTOR'S ORDER AND SIGNATURE

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>DOCTOR'S ORDER AND SIGNATURE</th>
<th>Orders Recorded</th>
<th>Complete or Discontinued Date</th>
<th>Time</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>☐ RESTRAINT</td>
<td>☐ SECLUSION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>☐ RESTRAINT TYPE: ☐ Side Rails</td>
<td>☐ Geri Chair</td>
<td>☐ No/Yes</td>
<td>Freedom Splint</td>
<td>☐ Mittens</td>
<td>☐ Bed Net</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Wrist</td>
<td>☐ Soft</td>
<td>☐ Hard</td>
<td>☐ R</td>
<td>☐ L</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>☐ Ankle</td>
<td>☐ Soft</td>
<td>☐ Hard</td>
<td>☐ R</td>
<td>☐ L</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>☐ 4 Point</td>
<td>☐ Soft</td>
<td>☐ Hard</td>
<td></td>
<td></td>
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<tr>
<td>6.</td>
<td>☐ 6 Point</td>
<td>☐ Straight Jacket</td>
<td>☐ Transport Bag</td>
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</tbody>
</table>

### RATIONALE FOR APPLICATION OF RESTRAINT

8. ☐ Harmful to self or others
9. ☐ Violent/destructive behavior
10. ☐ Protect essential lines and tubes
11. ☐ Identify lines/tubes: ____________________________
12. ☐ Other

13. **TIME LIMIT:** ____________ hours (For Behavior Management begins at initiation of restraints not to exceed 4 hours for adults; 2 hrs. for age 9 to 17; 1 hr. for under age 9) **Medical/Surgical protection of lines or tubes or promote healing, must not exceed 24 hours.**
14. Initiation Termination record reviewed
15. Initiate 15 minutes checks for Behavioral Management
16. Enter patient into SMS restraint screen
17. RN to reassess if needed; request order after verbal consult with Physician (For Behavior Management: 4 hrs. for adults; 2 hrs. for age 9 - 17; 1 hr. for under age 9.) L.I.P. will re-evaluate patient and re-write order q 8 hours if needed. **Medical/Surgical – 24 hours**
18. Physician/L.I.P. Signature ________________________ Date: __________________________

**DOCTOR:** TIME AND DATE YOUR ORDERS.
# NURSE STANDING ORDERS: PNEUMOCOCCAL AND INFLUENZA VACCINATION PROTOCOL

Patients in the following groups should receive PNEUMOCOCCAL POLYSACCHARIDE VACCINE:

### Exclusion Criteria

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
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</table>

- Patient already administered pneumococcal vaccine within 5 yr
- Patient has a severe allergy (i.e., anaphylactic allergic reaction) to previous pneumococcal vaccine

### Inclusion Criteria

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
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</table>

- Patient is aged ≥ 65 years
- Patient has a chronic health problem: heart disease; kidney disease; lung disease; diabetes; anemia; blood disorders
- Patient is a resident of a nursing home or long-term care facility
- Patient is immunocompromised with HIV infection, leukemia, lymphoma, Hodgkin’s disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, damaged or no spleen, organ transplant, alcoholism
- Patient is immunosuppressed by chemotherapy, radiation therapy or long-term systemic corticosteroids
- It is more than 5 years since this high-risk patient received their last pneumococcal vaccination

When unsure whether the patient has ever been given the pneumococcal vaccine, the CDC recommends giving the vaccine

Ref: MMWR 1997; 46:RR-8:1-24

When the patient meets ANY inclusion criteria and has NO exclusion criteria, scan this order to pharmacy to request the vaccine and then administer pneumococcal polysaccharide vaccine

<table>
<thead>
<tr>
<th>Recorded</th>
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</thead>
<tbody>
<tr>
<td>Time</td>
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<tr>
<td>Initial</td>
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</tbody>
</table>

- ☐ Order Pneumococcal polyvalent vaccine 0.5 ml subcutaneous now (scan to pharmacy)
- Document Pneumococcal polyvalent vaccine 0.5 ml subcutaneous (immunization) (LOT #__________)

Documentation of why withheld required if pneumococcal vaccine not ordered. Please check:
- ☐ Screening reveals not indicated in this patient
- ☐ Vaccine not available
- ☐ Patient refuses

Patients in the following groups should receive INACTIVATED INFLUENZA VACCINE:

ONLY in months OCTOBER THROUGH MARCH

### Exclusion Criteria

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</table>

- Patient already administered influenza vaccine this season
- Patient has a severe allergy (i.e., anaphylactic allergic reaction) to hens’ eggs or to previous influenza vaccine
- Patient previously had onset of Guillain-Barré syndrome during the 6 weeks after receiving influenza vaccine

### Inclusion Criteria

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- Patient is aged ≥ 50 years
- Patient has a chronic health problem: heart disease; kidney disease; lung disease; diabetes; anemia; blood disorders
- Patient is a resident of a nursing home or long-term care facility
- Patient is immunocompromised with HIV infection, leukemia, lymphoma, Hodgkin’s disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or is on immunosuppressive chemotherapy or long-term systemic corticosteroids
- Patient will be pregnant during influenza season
- Patient is a household contact or out-of-home caretaker of infants from 0-23 months or high risk groups
- Patient wants to reduce their chance of catching influenza


When the patient meets ANY inclusion criteria and has NO exclusion criteria, scan this order to pharmacy to request the vaccine administer influenza vaccine

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
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</tr>
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</tr>
</tbody>
</table>

- ☐ Order Inactivated influenza virus vaccine 0.5 ml IM now (scan to pharmacy)
- Document Inactivated influenza virus vaccine 0.5 ml IM (immunization) (LOT #__________)

Documentation of why withheld required if influenza vaccine not ordered. Please check:
- ☐ Screening reveals not indicated in this patient
- ☐ Vaccine not available
- ☐ Patient refuses

RN/LPN

<table>
<thead>
<tr>
<th>Signature</th>
<th>Printed Name</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-20718-35 (ORDERS)</td>
<td>WHITE – Medical Record</td>
<td>CANARY – Give this copy to PATIENT</td>
<td>48</td>
</tr>
</tbody>
</table>
FACULTY FORMS
MedStar Health

MedStar Franklin Square Medical Center
9000 Franklin Square Drive
Baltimore, Maryland 21237

Acknowledgement Agreement

I have read and understand the information provided in the Clinical Faculty Orientation Resource Manual, Version 7.1. I agree to comply with the presented information.

Name: __________________________________________

Print

Signature: _______________________________ Date: ____________
Name of School: _____________________________________  
Instructor’s Signature: ________________________________  Instructor’s Initials ______

*Submit this summary and all the starred items before the 1st clinical. All other items must be initialed and dated prior to the start of the clinical rotation.

<table>
<thead>
<tr>
<th>Document</th>
<th>Date</th>
<th>Instructor’s Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Course Objectives</strong></td>
<td></td>
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<tr>
<td><strong>Instructor’s Bioform/CV</strong></td>
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<tr>
<td>List of skills students can do with &amp; without the instructor</td>
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<tr>
<td><strong>Instructor’s PYXIS Form</strong></td>
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<tr>
<td><strong>Instructor and Students’ Confidentiality Statement</strong></td>
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<tr>
<td>Joint Commission, Patient Identification, Medication Administration, Infection Control Signature Sheet*</td>
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<tr>
<td>Medication Administration Patient Identification Signature Sheet for Instructors*</td>
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<tr>
<td>Safety Information Signature Sheet* (from Environment of Care Manual)</td>
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<tr>
<td><strong>Students’ Roster</strong></td>
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<tr>
<td>Instructor Cerner/MedConnect Training Room reservation for training students</td>
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<tr>
<td>Instructor/Student Request for Access Badges</td>
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<tr>
<td>Instructor’s Orientation to Facility &amp; Unit</td>
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<tr>
<td>Request for Instructor’s Computer Access Code/Student’s Access Code in Excel Spread Sheet</td>
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<tr>
<td>HIPAA Training</td>
<td>On file at school</td>
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<tr>
<td>Instructor’s CPR Card</td>
<td>On file at school</td>
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<tr>
<td>Instructor’s Health Screening</td>
<td>On file at school</td>
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<tr>
<td>Instructor’s License</td>
<td>On file at school</td>
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<tr>
<td>Instructor’s Mandatory Training (Blood borne Pathogens, etc.)</td>
<td>On file at school</td>
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<tr>
<td>Students’ CPR Card</td>
<td>On file at school</td>
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<tr>
<td>Students’ Health Screening</td>
<td>On file at school</td>
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<tr>
<td>Students’ Mandatory Training (Blood borne Pathogens, etc.)</td>
<td>On file at school</td>
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<tr>
<td>Students’ RN License (RN-BSN or Masters Student)</td>
<td>On file at school</td>
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</tbody>
</table>
Acknowledgement Agreement

I have read and understand the information provided in the Nursing Student Orientation Resource Manual, Version 3.1. I have read and understand the Environment of Care Manual. I agree to comply with the presented information.

____________________________________  ______________________________________
Print Name                                Signature

____________________________________  ______________________________________
Print Name                                Signature

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Print Name                                Signature

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Print Name                                Signature

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Print Name                                Signature

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Print Name                                Signature

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Print Name                                Signature

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Print Name                                Signature

____________________________________  ______________________________________
Print Name                                Signature

Date _____________________________
**Documentation Summary**

**Addendum**

**Verification of Flu Vaccine**

Name of School: ____________________________________________

Instructors Signature: _____________________________________

Date Submitted: __________

*This form must be submitted to the Clinical Placement Coordinator between October 15 and March 15, for all students attending clinicals at a MedStar facility.

<table>
<thead>
<tr>
<th>Document</th>
<th>Date</th>
<th>Instructor's Initials</th>
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<tbody>
<tr>
<td>Student’s Flu vaccine</td>
<td>On file at school</td>
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</tr>
<tr>
<td>Instructors Flu vaccine</td>
<td>On file at school</td>
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</tbody>
</table>
Acknowledgement Agreement

I have read and understand the information provided in the Nursing Student Orientation Resource Manual, Version 3.1. I have read and understand the Environment of Care Manual. I agree to comply with the presented information.

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Print Name: ___________________________ Signature: ___________________________

Date: ________________________________
PATIENT CONFIDENTIALITY AGREEMENT

EXHIBIT C

I, ____________________, as an enrolled Student or Faculty at _________________________, understand that as part of my clinical experience at any MedStar affiliated organization (“Affiliate”), I may come in contact with medical records. I understand that under Maryland law, the unauthorized disclosure of medical record information is unlawful and could subject myself to civil and criminal penalties. I, therefore, pledge to each Affiliate and to MedStar that I will not reveal the name, address or any other pertinent information that exists on any medical record or that I otherwise come in contact with during the course of my clinical experiences.

This one form is sufficient for the instructor’s and student’s printed name and signatures in each clinical group.

______________________________  ____________________________
Print Name                      Signature

______________________________  ____________________________
Print Name                      Signature

______________________________  ____________________________
Print Name                      Signature

______________________________  ____________________________
Print Name                      Signature

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Print Name                      Signature

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Print Name                      Signature

______________________________  ____________________________
Print Name                      Signature

______________________________  ____________________________
Print Name                      Signature

Date __________________________

55
To: All Nursing Instructors
Re: Medication Administration / Patient Identification Signature Sheet

Thank you for choosing MedStar Franklin Square Medical Center for your clinical rotation. We know you have a choice in where you teach your clinical rotations, and we’re pleased that you’ve chosen to share your time, talent and expertise with your students here.

At MedStar Franklin Square Medical Center we strive to provide our patients with the very best and safest of care. Medication administration has been identified as being an activity prone to errors, despite the fact that nursing students receive close supervision by their instructors. In order to minimize this possibility we require the following:

- that you and your students are familiar with our patient identification policy;
- that the patient identification policy is followed every time a medication is administered;
- that you and your students are familiar with our medication administration policies and high alert medications. It is our policy that medications are administered within 30 minutes of ordered time. Actual administration time must be documented;
- that you do an independent second check as described in the High Alert Medications Policy for all high alert medications;
- Instructors must administer medications with their students and confirm patient identification;
- when administering medications, the handheld device is taken to the bedside for all patients to confirm and document medication;
- that medications for only 1 patient at a time are removed from the Pyxis;
- that you remain in constant communication with the FSHC nurse that has been assigned to your patients.

This document is intended to reinforce and clarify patient safety expectations at MedStar Franklin Square Medical Center. Please don’t hesitate to ask questions or request assistance. We are striving toward a mutually rewarding relationship. We consider you and your students a welcomed and important part of the patient care team.

________________________________________________________________________
Signature of Nursing Instructor Date

By signing this document I acknowledge receipt, understanding and willingness to comply with this information.

All MedStar Franklin Square Medical Center Administrative and Clinical Hospital Policies may be found online on the Starport page (http://starport.medstar.net/wps/portal/fsh). Patient Identification and Medication Administration Policies are included in this manual.
Please ask for assistance if you have any problems accessing this information
This document is the application for your individual password to the PYXIS System. It can be used to access patient medications on your approved nursing unit(s) only. After reading the following statement, please sign below to verify that you have read and understand its contents. After completion, please place this form into a sealed envelope and send to the Pyxis System Manager in the Department of Pharmacy Services.

Attached is my password application to the PYXIS System. I understand that I will be issued an initial temporary password that must be changed when logging onto the Medstation for the first time. It is my responsibility to maintain my password and to establish my Bio-ID. I understand that in combination with my Medstar Employee ID number, this will serve as my electronic signature for all transactions in the system. It will be used to track all of my transactions within the system and will be permanently attached to those transactions with a date and time stamp. These records will be maintained and archived as per the policies of Medstar Franklin Square Medical Center, and will be available for inspection by the Drug Enforcement Agency (DEA) and the Maryland Board of Pharmacy.

I also understand that to maintain the integrity of my electronic signature, I must not disclose this password to any other individual. The disclosure of any access code to another individual to assist that individual to obtain unauthorized access, or the utilization of another individual’s access code, may result in my immediate termination of employment from Medstar Franklin Square Medical Center.

Signature __________________________________________________________________________ Date ________________

Print Name __________________________________________________________________________ Witness __________

If you have any reason to believe that another employee has learned your password, you should immediately notify Unit manager and Betsy Rudolf and change your password in the Pyxis machine.

Name: ________________________________________________________________________________

Last __________________________________________________________________________ First __________________________________________________________________________ Middle initial

SS#: _________ _________ _________ you may use 000 00 your last 4 digits if you prefer

Email address: __________________________________________________________________________

School of Nursing: __________________________________________________________________________ Unit for Clinical Rotation: __________________________________________________________________________

Semester/School year dates: Beginning __________________________________________________________________________ Ending __________________________________________________________________________

School of Nursing Address: __________________________________________________________________________

School of Nursing phone number: __________________________________________________________________________

Password: A temporary password will be provided. You will be required to change your password the first time you log into Pyxis.

All Blanks must be completed to receive Pyxis access
User Confidentiality Agreement and Acknowledgement of Responsibilities

MedStar Health, Inc. and its subsidiaries (collectively, MedStar Health) are committed to the physical, technical and administrative security of its information technology resources. By my signature below, I understand that my access and use of all MedStar Health information technology resources, including but not limited to, access and use of the MedStar Health network, hardware, and software (collectively “systems”) is a privilege and that such access and use are subject to all applicable legal requirements as well as all applicable MedStar Health policies, procedures, and requirements and the applicable policies, procedures, and requirements of the MedStar subsidiary which authorizes my system access and use.

As a condition of my access, I agree to maintain the confidentiality of all MedStar Health confidential business information which I may have the ability to access, including but not limited to, all personnel information, billing and financial information, patient data or medical information, promotional and marketing program information, strategic planning data, business plans, computer passwords/access rights, privileged materials, trade secrets, intellectual property, and other proprietary information relating in any way to MedStar Health.

I further understand and agree that even though I may be granted access to systems which contain large quantities of data as part of my job responsibilities or role within MedStar (“Role-Based Access”), I am only permitted to access, use, disclose specific information as necessary to perform my job function or complete my responsibilities. I understand this means that I am not permitted to access or use any component of the system if I do not have a legitimate professional need to have such access and it is my responsibility to terminate access to any systems I do not need.

In addition, I understand that I am only permitted to access, use and disclose information from the system and its components, or its connected systems, if it is for a purpose permitted under applicable laws and policies (“Purpose-Based Access”). I understand this means that even if when my role would permit me to have access to the system, I am only permitted to access, use, or disclose the information if it is for an authorized and permissible purpose.

I understand that these obligations apply whether the information is held in electronic or any other form, and whether the information is used or disclosed electronically, orally, or in writing.

Acknowledgement of Responsibilities. I understand and agree that:

Administrative, Technical, and Physical Safeguards

- The User ID and Password assigned to me are unique and non-transferable and that I will not share my User ID or password with any other individual, permit another person to perform any functions while logged into a system under my User ID or Password, nor will I perform any function using a system under another person’s User ID or Password.
- I will take appropriate measures to protect my User ID and Password and that I am responsible for all information accessed, used, or altered with the use of my User ID and Password.
- I understand that my approved access and use of MedStar’s systems is limited to only those systems necessary to perform my job duties or as permitted because of my role and that I must request deactivation of any systems not necessary to perform my duties or responsibilities.
- I agree to logoff the system when I leave a workstation and to take such other reasonable steps as are necessary to maintain the physical security of my workstation to ensure that unauthorized persons cannot view or access any confidential, proprietary, or identifiable patient information that I may have access to by virtue of my responsibilities or access rights.
- I understand that my approved access and use may be actively recorded, monitored, and/or audited without prior notice (including Internet and e-mail account usage) and that MedStar Health reserves the right to monitor, review, and record individual user system activities (including, but not limited to, the use of personal e-mail accounts). MedStar Health may permit other business partners or law enforcement to monitor, uses, or record such information as permitted or required by law.

Acceptable Uses and Disclosures

- I agree that acceptable use of MedStar Health systems and the disclosure of information from those systems include only those activities which foster MedStar Health’s clinical, research, educational, and business purposes in a manner which promotes the vision, mission and values of MedStar Health and are consistent with MedStar’s Code of Conduct and legal requirements.
- I agree to access, use, or disclose system information only in the performance of my duties, where required by or permitted by law, and only to persons who have the right to receive that information.
- I agree that I will not copy, download, print, transmit information in any format, for myself or for any other person, except as
I am required to fulfill my responsibilities.

- When using or disclosing information, I will use or disclose only the minimum information necessary.
- I understand that prohibited uses of MedStar’s systems (including e-mail and Internet use) include, but are not limited, to any use that:
  - Involves illegal activity or threatens MedStar, its users, or its systems in any way,
  - Interferes with the acceptable use of other MedStar users,
  - Is in violation of any MedStar Health policy, procedure or requirements.
- I understand that acceptable personal uses of MedStar systems (including e-mail and Internet use) are severely limited to:
  - Activities:
    - Incidental to an acceptable MedStar business use (such as coordinating work and family schedules),
    - That do not cause MedStar to incur additional expenses or interfere with my productivity, or any other clinical or business activities,
    - That does not violate any MedStar policies, procedures or requirements.

**Training and Education**
- I understand that system education and training may be mandatory for each system accessed and that it is my responsibility to fulfill all mandatory training and education requirements necessary for my role as a condition of my system access.

**Reporting Requirements**
- I agree to immediately notify my supervisor and the MedStar Health Information Systems Security Office via the Help Desk (1-410-933-HELP)
  - If I suspect that someone has gained unauthorized access to my User ID or Password.
  - If any hardware or software used to access MedStar systems is lost or stolen.

By my signature I understand and agree that my rights to access and use MedStar’s system may be immediately terminated without further notice for breaching any terms of this agreement and that such a breach may result in personal liabilities, including but not limited to (as applicable): disciplinary actions up to and including termination of employment, loss of professional privileges, criminal prosecution, civil litigation, referral to appropriate law enforcement authorities, referral to regulatory or licensure authorities, or other remedies as deemed appropriate by MedStar Health.

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<thead>
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<th>Print Name</th>
<th>Signature/Date</th>
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**Print Name (Instructor)**

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**School**

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<th>Unit</th>
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MedStar Franklin Square Medical Center
Joint Commission, Patient Identification, Infection Control and Medication Administration
Instructor/Student Signature Sheet

School/Agency:______________________________

Instructor______________________________ Course________________

I have read and reviewed and understand all the Joint Commission, Patient Identification, Infection Control and Medication Administration information presented to me. I am fully aware of the need to comply with this information.

<table>
<thead>
<tr>
<th>Name (Please Print)</th>
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<td>SKILL</td>
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<td>Vital signs Adult</td>
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<td>Assessments</td>
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<td>Initial (beginning of shift)</td>
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<td>Ongoing</td>
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<td>IV</td>
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<td>Pain</td>
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<td>NG Tube</td>
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<tr>
<td>Placement</td>
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<td>Feed</td>
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<td>Removal</td>
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<td>Peg tube/ G tube Care</td>
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<tr>
<td>Feeding</td>
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<td>Dressing change</td>
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<tr>
<td>Sterile gloving/field</td>
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<td>Dry sterile dressing</td>
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<td>Sterile Dressing with Drain (JP, Hemovac, Davol)</td>
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<td>Moist to Moist Dressing</td>
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<td>Moist to Dry Dressing</td>
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<td>CVAD Dressing</td>
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<td>Wound Care</td>
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<td>Packing a wound</td>
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<td>Obtain urine sample</td>
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<td>Remove catheter</td>
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<td>NGT/GT</td>
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</table>
Under the direct supervision of the clinical faculty, nursing students may administer medications **WITH THE FOLLOWING EXCEPTIONS:**

- IV push medications (including central line flushes);
- Cardioactive medications (diltiazem, procainamide, dobutamine, etc.);
- Continuous medication infusion (including but not limited to heparin, oxytocin, dopamine, insulin and magnesium sulfate);
- Controlled substances for infants less than two years of age;
- Initiation of transfusion blood or blood products (excluding Rhogam);
- Initiation, programming, and reprogramming (PCA) pumps.
# MedStar Franklin Square Medical Center
## Student Assignment Form

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Patient Assignment</th>
<th>Unit RN</th>
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This form is part of the Staffing permanent record. Please give this form to the Unit Charge Nurse.

*Reference: JCAHO Standard HR 1.20*