Orientation: Nursing Students

Partners on the Road to Success
Version 3.1
Revision Date: May 2013
Dear Nursing Student,

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 an exciting semester with you as you learn to care for patients. Here at MedStar Franklin Square, our vision, mission and values are centered on our patients and community and we invite you to join in helping us fulfill our commitments to our patients and community.

Please review the Nursing Student Orientation Manual prior to your first day on the unit. Maps are provided to guide you in getting around on our campus. Our philosophy of patient care is included as well as our approach to providing the safest care for our patients.

We have provided an overview of policies that are considered important in providing safe, comprehensive care for our patients. We have provided a link to our policy and procedure manual. I invite you to review these policies to increase your knowledge and to ensure you provide the best care possible for our patients during your clinical time here.

We are looking forward to working with you this coming semester!

Sincerely,

Betsy Rudolf  MS, RN, CNE, CPN

Betsy Rudolf, MS, RN, CNE, CPN
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Nursing Administration
MedStar Franklin Square Medical Center
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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedStar Franklin Square Medical Center Leadership, History and Vision</td>
<td>1</td>
</tr>
<tr>
<td>Always Zero FAQs</td>
<td>2</td>
</tr>
<tr>
<td>Focus on Patient Experience</td>
<td>3</td>
</tr>
<tr>
<td>Health Insurance Portability and Accountability Act (HIPAA)</td>
<td>4</td>
</tr>
<tr>
<td>Directions to MedStar Franklin Square Medical Center</td>
<td>5</td>
</tr>
<tr>
<td>Parking Map/Entry and Exit Directions/Floor Maps</td>
<td>6</td>
</tr>
<tr>
<td>General Information</td>
<td>6 – 7</td>
</tr>
<tr>
<td>MedStar Intranet-Starport</td>
<td>8</td>
</tr>
<tr>
<td>Online Occurrence Reporting</td>
<td>8 – 9</td>
</tr>
<tr>
<td>National Patient Safety Goals</td>
<td>9 – 23</td>
</tr>
<tr>
<td>• Improve the accuracy of patient identification</td>
<td>9 – 11</td>
</tr>
<tr>
<td>• Improve effectiveness of communication among caregivers</td>
<td>11 – 13</td>
</tr>
<tr>
<td>• Improve the safety of using medications</td>
<td>13 – 14</td>
</tr>
<tr>
<td>• Reduce the risk of healthcare associated infections</td>
<td>14 – 21</td>
</tr>
<tr>
<td>• Accurately and completely reconcile medications across the</td>
<td>22</td>
</tr>
<tr>
<td>continuum of care</td>
<td></td>
</tr>
<tr>
<td>• Reduce the risk of patient harm resulting from falls</td>
<td>22 – 23</td>
</tr>
<tr>
<td>Additional Safety Precautions</td>
<td>24 – 25</td>
</tr>
<tr>
<td>Pain Management</td>
<td>26</td>
</tr>
<tr>
<td>Rapid Response Team</td>
<td>27</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>27</td>
</tr>
<tr>
<td>Spirituality &amp; Cultural Diversity</td>
<td>28</td>
</tr>
<tr>
<td>Patient Documentation</td>
<td>29 – 42</td>
</tr>
<tr>
<td>• Requirements</td>
<td>29 – 32</td>
</tr>
<tr>
<td>• Misc. Forms Samples</td>
<td>33 – 42</td>
</tr>
<tr>
<td>Policy information</td>
<td>43</td>
</tr>
</tbody>
</table>
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 Community College of Baltimore County (Essex) 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 MedStar Franklin Square Medical 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 must Carpool and park in upper area outlined in blue. This lot is gated. There is a button at the gate. The first time you come you can push the button and tell the security guard that you are a student and they will open the gate. You will receive a badge from your clinical instructor to access the lot in the future. Please see attached maps for entry into the new building.
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 MedStar 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 Schindlar 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 Betsy Rudolf.

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.

Health Sciences 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 Kristen Chapman, Manager of the Medical Library, at Ext 77363.

- **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 lobby 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**: 12 noon. - 6 p.m.; 8 p.m. - 10 p.m. (requested, but still available)
- **Psychiatric Unit**: 5:30 p.m. - 7p.m. Sunday – Saturday and 1 p.m. - 2 p.m. Saturday and Sunday

Smoking
Smoking is **NOT** permitted anywhere on the MedStar Franklin Square Medical Center’s 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.
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 be accessed by clicking on the on-line occurrence icon or by clicking the internet explore icon. You will be directed to MedStar Franklin Square’s intranet, StarPort. The
MedStar Franklin Square home page will appear on the screen. 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.

### 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.

### National Patient Safety Goals

National patient safety goals are identified each year by The Joint Commission 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

MedStar 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. opting 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 licensed 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 MedStar Franklin Square. 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.

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.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<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>
</tr>
<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 pint (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>
</tr>
<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>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Age</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication List</td>
<td>Allergies</td>
<td>Vital Signs</td>
</tr>
<tr>
<td>Lab Results</td>
<td>IV Fluids</td>
<td>Code Status</td>
</tr>
</tbody>
</table>

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

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

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.
PYXIS MEDSTATION ACCESS

Medications are stored in a secured area on each unit. Most units use the Pyxis. Medications removed from the Pyxis should be selected for one patient at a time and administered immediately. Pyxis Medstation access is limited to licensed personnel only. Students are not given access to the Pyxis Medstation and will be closely supervised when administering medications to MedSatr Franklin Square patients. 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.

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 four types of Transmission Based Precautions that must be used depending on the type of infection. These are Airborne, Droplet, Strict Contact, and Enteric Precautions (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.

**Enteric Precautions**
This precaution is used for diseases that are spread through the fecal-oral route of transmission, such as *Clostridium difficile*.

Hand sanitizer does not kill *Clostridium difficile* spores, therefore hands must be washed with soap and water before leaving the Enteric Precautions Room.
REQUIRED ELEMENTS FOR TRANSMISSION-BASED ISOLATION PRECAUTIONS

<table>
<thead>
<tr>
<th></th>
<th>STRICT CONTACT</th>
<th>ENTERIC</th>
<th>DROPLET</th>
<th>AIRBORNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private room</td>
<td>Preferred *</td>
<td>Preferred *</td>
<td>Preferred *</td>
<td>Yes**</td>
</tr>
<tr>
<td>Door closed</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Mask</td>
<td>No</td>
<td>No</td>
<td>To enter room (surgical mask)</td>
<td>To enter room† (N-95 or PAPR)</td>
</tr>
<tr>
<td>Gown</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Gloves</td>
<td>Yes</td>
<td>Yes</td>
<td>When handling items contaminated with secretions</td>
<td>When handling items contaminated with secretions</td>
</tr>
<tr>
<td>Cleaning &amp; Disinfection – equipment</td>
<td>Super Sani Cloths</td>
<td>Hospital approved sporicidal – used by EVS</td>
<td>Super Sani Cloths</td>
<td>Super Sani Cloths</td>
</tr>
<tr>
<td>Linen: leak resistant bag at bedside</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Disposable thermometer</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disposable BP cuff</td>
<td>Yes</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>
<td>Yes</td>
</tr>
<tr>
<td>Special Transport</td>
<td>Cover patient, (including hands and arms) with clean sheet or place isolation gown on patient</td>
<td>Cover patient, (including hands and arms) with clean sheet or place isolation gown on patient</td>
<td>Patient in surgical mask</td>
<td>Patient in surgical mask</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 with appropriate discharge of air outdoors.

The following are designated negative pressure rooms:

<table>
<thead>
<tr>
<th>TOWER</th>
<th>MAIN HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED/Peds: Pod A: 1 and 11 Pod B: 17 and 18 Pod C: 24 and 34 Pod D: 40 and 41</td>
<td>Autopsy Room</td>
</tr>
<tr>
<td>T1 1104, 1116, 1133, 1145</td>
<td>Labor &amp; Delivery LDR 103</td>
</tr>
<tr>
<td>T2 2103, 2104, 2115, 2116 2127, 2128, 2139, 2140</td>
<td>Operating Room OR 9 and 10</td>
</tr>
<tr>
<td>T3 3104, 3116, 3133, 3145</td>
<td>PACU 2057</td>
</tr>
<tr>
<td>T4 4104, 4116, 4133, 4145</td>
<td>4CB 422, 423</td>
</tr>
<tr>
<td>T5 5104, 5116, 5133, 5145</td>
<td></td>
</tr>
<tr>
<td>T6 6104, 6116, 6133, 6145</td>
<td></td>
</tr>
</tbody>
</table>

†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.
## Type and Duration of Precautions Needed for Common Infections and Conditions

(all patients are on standard precautions)

<table>
<thead>
<tr>
<th>Infection/Condition</th>
<th>Airborne Precautions</th>
<th>Strict Contact Precautions</th>
<th>Enteric Precautions</th>
<th>Droplet Precautions</th>
<th>Duration/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Bugs</strong></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>See policy “Bed Bugs – Prevention and Control” for management of confirmed or suspected bed bugs.</td>
</tr>
<tr>
<td><strong>Chickenpox (same as Varicella Zoster)</strong></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>Until lesions dry and crusted. Susceptible HCWs should not enter room if immune caregivers are available.</td>
</tr>
</tbody>
</table>
| **Clostridium difficile (C. diff)** |                      |                             | x                   |                     | Minimum of 1 week after appropriate antibiotic treatment is initiated AND no longer having unformed stools. Use disposable thermometer, BP cuff and stethoscope. Wash hands with soap and water upon exiting room. EVS to clean patient room with hospital-approved, spore-killing disinfectant. (See policy “Clostridium difficile Infection Prevention Guidelines”)
<p>| <strong>Conjunctivitis – acute viral</strong> |                      |                             |                     |                     | Duration of illness.                                                                                                                              |
| <strong>Diarrhea:</strong>             |                      |                             |                     | x                   | Until C. difficile has been ruled out and/or the CDT Gene test is negative.                                                                     |
| - Unknown etiology        |                      |                             |                     |                     |                                                                                                                                                |
| - Suspect or rule out C. difficile |                      |                             |                     |                     |                                                                                                                                                |
| <strong>Epiglottitis (Haemophilus influenza, type B)</strong> |                      |                             |                     | x                   | Until 24 hours of effective treatment.                                                                                                           |
| <strong>Hepatitis A – diapered or incontinent</strong> |                      |                             |                     | x                   | Duration of hospitalization for infants and children &lt; 3 years of age.                                                                           |
| <strong>Herpes simplex:</strong>       |                      |                             |                     | x                   | Until lesions dry and crusted.                                                                                                                  |
| - Mucocutaneous, disseminated or primary severe |                      |                             |                     |                     |                                                                                                                                                |
| - Neonatal                |                      |                             |                     |                     |                                                                                                                                                |</p>
<table>
<thead>
<tr>
<th>Infection/Condition</th>
<th>Airborne Precautions</th>
<th>Strict Contact Precautions</th>
<th>Enteric Precautions</th>
<th>Droplet Precautions</th>
<th>Duration/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Herpes zoster</strong> (varicella zoster)</td>
<td></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>(shingles):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Facial and/or on the head – any patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Disseminated in any patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Localized disease in immunocompromised patient until disseminated infection ruled out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Influenza</strong> – Human (seasonal influenza)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 days after onset of symptoms. Duration of illness in immunocompromised.</td>
</tr>
<tr>
<td><strong>Lice</strong> (pediculosis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Until 24 hours of effective treatment. See policy “Care of the Patient With Pediculosis”.</td>
</tr>
<tr>
<td><strong>Measles</strong> (rubeola)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>4 days after onset of rash. Duration of illness in immunocompromised. Susceptible HCWs should not enter room if immune care providers are available.</td>
</tr>
<tr>
<td><strong>Meningitis</strong> - known or suspected:</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment.</td>
</tr>
<tr>
<td>- <em>Haemophilus influenzae</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <em>Neisseria meningitidis</em> (meningococcal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal disease</strong>:</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment.</td>
</tr>
<tr>
<td>- Sepsis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Meningitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multidrug-resistant organisms (MDROs)</strong></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>See “Control and Prevention of Multi-Drug Resistant Organisms” policy.</td>
</tr>
<tr>
<td>(MDROs): (ESBL, MRSA, VISA, VRE, Other MDROs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mumps</strong> (infectious parotitis)</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 9 days after onset of symptoms.</td>
</tr>
<tr>
<td>Infection/Condition</td>
<td>Airborne Precautions</td>
<td>Strict Contact Precautions</td>
<td>Enteric Precautions</td>
<td>Droplet Precautions</td>
<td>Duration/Comments</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>Until 5 days of treatment.</td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Duration of illness.</td>
</tr>
<tr>
<td>RSV (respiratory syncytial virus):</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td><strong>Wear mask per Standard Precautions.</strong></td>
</tr>
<tr>
<td>- Infants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Immunocompetent</strong> patient: until 5 days after onset of symptoms if the respiratory symptoms have resolved.</td>
</tr>
<tr>
<td>- Young children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Immunocompromised</strong> patient: until a negative RSV test is obtained after respiratory symptoms have resolved (no sooner than 5 days after onset of symptoms).</td>
</tr>
<tr>
<td>- Immunocompromised adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (German measles)</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 7 days after onset of rash. <strong>Susceptible HCWs should not enter room if immune caregivers are available.</strong></td>
</tr>
<tr>
<td>SARS (severe acute respiratory syndrome)</td>
<td>x</td>
<td>x</td>
<td></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></td>
<td>x</td>
<td>Until 24 hours of effective treatment.</td>
</tr>
<tr>
<td>Shingles – see “Herpes Zoster”</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment.</td>
</tr>
<tr>
<td>“Strep” throat (Group A streptococcus):</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>Until 24 hours of effective treatment.</td>
</tr>
<tr>
<td>- Infants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Young children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis, known or suspected</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td><strong>See policy “Tuberculosis Control Plan”.</strong></td>
</tr>
<tr>
<td>Varicella Zoster (same as Chickenpox)</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>Until lesions dry and crusted. **Susceptible HCWs should not enter room if immune caregivers are available.</td>
</tr>
</tbody>
</table>

21
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 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 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.
   - Hourly Rounding
   - The nurse will identify the appropriate interventions and strategies and incorporate these into the plan of care.

   **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). 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 30 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 and initiate post fall huddle.
- 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 – MedStar 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 on rounding form or 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.
Pain Management

(Policy: Pain, Assessment and Management Policy)

The physicians and staff of MedStar Franklin Square 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 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 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 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. See form in Documentation section of this manual.

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 context is 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 MedStar Franklin Square 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 of the Lobby.

Pastoral Care Resources can be reached at the following numbers:

Director: (443)-777-7827
Parish Nurse (443)-777-7931
Patient Documentation
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
This symbol means the documentation must be authenticated (co-signed) by your clinical instructor.
**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
- HURDLY ROUNDED (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 & Influenza Vaccination Screening form - (on paper)
- Ongoing assessment (head-to-toe assessment within 4hours of admission including intagumentary 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 I-View 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
- Patient/Family Education - in I-View under Adult Education
- 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.

**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 view complete assessments
- ACTIVITIES OF DAILY LIVING I-View 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 view
- ORDER ENTRY DETAILS – review form from Care Compass task list, click document, review, then sign (even if you did not make changes)
- PATIENT/FAMILY EDUCATION - document in I-View under Adult Education
- 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)

**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 all Plans of Care - go to patient’s chart, under Orders, Document in Plan (ALL Plans of Care – planned & initiated - are discontinued at Discharge)
- Review Problem List – change appropriate problems to resolved
- Nursing Discharge Summary – complete appropriate sections
- Valuables/Belongings/ Home meds -obtain Clothing List from pt’s chart and have pt/caregiver sign that all items returned, then you sign
- Place checkmark next to Patient/family/caregiver verbalizes
- Understanding of instructions given (in the lower left side of the window).
- Sign and Print discharge instructions when patient is ready to leave the hospital. Write“Take Next Dose” on all meds listed. Have pt/caregiver sign the printed instructions. Add signature page to the patient’s paper chart.
- Quality Measures – verify Quality Measure are complete – go to patient’s chart, Inpatient Summary, Quality Measures

**INFUSION BILLING** – complete infusion
- Billing for all IV medications and IV fluids (patient’s chart, eMar, Infusion Billing Icon →
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) (4) __________________________________________ 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

PATIENT

DATE/TIME

PATIENT'S DESIGNEE OR SUBSTITUTE

RELATIONSHIP TO PATIENT

DATE/TIME

37
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
A. No transfusion.
B. Using your own blood (Autologous transfusion)
C. Having family or friends provide the blood.
   (Has not been shown to be safer than blood from our hospital or Red Cross supply)
D. 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
A. Correcting anemia resulting from kidney failure, malignancies, gastrointestinal bleeding.
B. Replacing blood loss from trauma or surgery.
C. Improving symptoms of shortness of breath, chest pain, postural hypotension when anemia is contributing to these symptoms.

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

III. PLATELETS
A. Correcting low platelet counts in disease states or during therapy that places the patient at a high risk for bleeding.
B. Reducing the risk for bleeding in patients undergoing major surgery.
C. 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.

<table>
<thead>
<tr>
<th>Signature of Physician securing the patient’s consent</th>
<th>Date / Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Signature</td>
<td>Date / Time</td>
</tr>
<tr>
<td>Witness</td>
<td>Date / Time</td>
</tr>
</tbody>
</table>

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: _______
   - Distractor/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: □ Yes □ No If no, please explain: ________________________

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 Time: _______
   □ No If no, please explain: _____________________________________________________________

RN Signature: ____________________________________________________________

--------------------------------------------------------------
Termination of Restraint/Seclusion: Date: _______ Time: _______

Behavior criteria for release:
□ Calm, quiet
□ Able to follow direction of staff
□ No longer exhibiting behaviors that justified use of restraint/seclusion
□ 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
### PHYSICIAN'S ORDER SHEET

#### RESTRAINT

**ALLERGIES:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>DOCTOR'S ORDER AND SIGNATURE</th>
<th>Orders Recorded</th>
<th>Complete or Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

1. ☐ RESTRAINT  ☐ SECLUSION

2. RESTRAINT TYPE: ☐ Side Rail ☐ Bed Net ☐ Vest ☐ Soft Seat ☐ Other
   Freedom Splint ☐ Mitten ☐ Rollbelt

3. ☐ Wrist ☐ Soft ☐ Hand ☐ R ☐ L

4. ☐ Ankle ☐ Soft ☐ Hand ☐ R ☐ L

5. ☐ 4 Point ☐ Soft ☐ Hand

6. ☐ 5 Point ☐ Straight Jacket ☐ Transport Bag

7. RATIONALE FOR APPLICATION OF RESTRAINT
   ☐ Harmful to self or others
   ☐ Violent/destructive behavior
   ☐ Protect essential lines and tubes
   ☐ Identify lines/tubes: __________________________
   ☐ 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 age 9 and under) (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 and if needed, request order after verbal consult with Physician. (For Behavior Management - 4 hrs. for adult, 2 hrs. for age 9 - 17, 1 hr. for age 9 and under) 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.**

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T-0241 (03/01) WHITE – Medical Record CANARY – Nursing Education
NURSE STANDING ORDERS: PNEUMOCOCCAL AND INFLUENZA VACCINATION PROTOCOL

Patients in the following groups should receive PNEUMOCOCCAL POLYSACCHARIDE VACCINE:

Exclusion Criteria
Yes No
☐ Patient already administered pneumococcal vaccine within 5 yr
☐ Patient has a severe allergy (i.e., anaphylactic allergic reaction) to previous pneumococcal vaccine

Inclusion Criteria
YES NO
☐ 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

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
Yes No
☐ 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
YES NO
☐ 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

Ref: MMWR 2004; 53-50; 1183; AND MMWR 2004; 53:RR06; 1-40

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

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

Signature Printed Name Date Time
RN/LPN

T-20718-35 (ORDERS) WHITE – Medical Record CANARY – Give this copy to PATIENT

#12071835
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