<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Core Measures</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Sensitive Indicators</td>
<td></td>
</tr>
<tr>
<td>CAUTI Skin Integrity &amp; Pressure Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Fall Assessment &amp; Prevention</td>
<td>4</td>
</tr>
<tr>
<td>Restraints and Restraint Alternatives</td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>6</td>
</tr>
<tr>
<td>Ventilator Associated Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>7</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td></td>
</tr>
<tr>
<td>Nursing Clinical Review</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>8</td>
</tr>
<tr>
<td>AcuDose Rx Medication Dispensing System</td>
<td>9</td>
</tr>
<tr>
<td>Blood Administration</td>
<td></td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>10</td>
</tr>
<tr>
<td>Point of care testing</td>
<td>11</td>
</tr>
<tr>
<td>Stroke Care &amp; Dysphagia Screening</td>
<td></td>
</tr>
<tr>
<td>Time Out / Pause for Cause</td>
<td>12</td>
</tr>
<tr>
<td>Critical Lab Values</td>
<td>13</td>
</tr>
<tr>
<td>Intravenous Therapy &amp; IV Pump</td>
<td>14</td>
</tr>
<tr>
<td>Hazardous Medication</td>
<td>17</td>
</tr>
<tr>
<td>Infectious waste</td>
<td></td>
</tr>
<tr>
<td>Bariatric Patients</td>
<td>20</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td></td>
</tr>
<tr>
<td>RESOURCE LIST</td>
<td>21</td>
</tr>
</tbody>
</table>

Revised 5.2013
**CMS Measures**

HealthEast participates in monitoring care for the following CMS Measures:

<table>
<thead>
<tr>
<th>CMS Measures</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction (AMI)</td>
<td>Primary PCI within 90 minutes of arrival</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>Discharge instructions covering: activity, diet, follow-up, medications, symptoms worsening, weight monitoring</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Blood culture in ED prior to initial antibiotic</td>
</tr>
<tr>
<td>Surgical Infection Prevention (SCIP)</td>
<td>Antibiotic given within one hour of incision</td>
</tr>
<tr>
<td></td>
<td>Antibiotic selection</td>
</tr>
<tr>
<td></td>
<td>Antibiotic discontinued within 24 hours</td>
</tr>
<tr>
<td></td>
<td>Cardiac patients with controlled 6 am blood glucose</td>
</tr>
<tr>
<td></td>
<td>Beta blocker prior to admission &amp; perioperative</td>
</tr>
<tr>
<td></td>
<td>VTE prophylaxis (mechanical &amp; medication) ordered within 24 hours</td>
</tr>
<tr>
<td></td>
<td>VTE prophylaxis (mechanical &amp; medication) given within 24 hours prior to and post</td>
</tr>
</tbody>
</table>

**Catheter Associated Urinary Tract Infections (CAUTI)**

Catheter duration is the most important risk factor for UTI.

**DAILY catheter assessment required for necessity.**

Urinary catheter removal second post op day. MD order required if not removed.

**Symptoms of UTI**

- (*) Urine culture with >100,000 microorganisms/cc of urine AND one of the following:
  - Fever >100.4 F
  - Urgency
  - Frequency
  - Dysuria
  - Suprapubic tenderness
  - In the elderly, new confusion

**NOT Symptoms of UTI**

- Cloudy urine
- Foul smelling urine
- Urine with sediment

Not recommended to ‘test’ the balloon before insertion. Catheter balloons can undergo changes when deflated resulting in a ridge formation; increasing diameter size when deflated.
SKIN INTEGRITY & PRESSURE ULCER PREVENTION

**Braden** - Complete on admission and daily, using drop down options on electronic medical record. Chart interventions as needed for low subscale areas. Bethesda: First 24 hours, every shift and the first inspection is done by 2 RNs for verification, cosign in EWHR.

**Skin inspection** – Complete skin inspection on admission and then as follows: (*exception - if Braden score ≤ 12, skin inspection to be done every 8 hours.) Bethesda - First 24 hours, done every shift

**NOTE:** Medical devices put skin at risk for breakdown! Check under collars and other equipment to monitor skin. Bethesda: inspect q shift. under equipment.

---

**Frequency of head-toe skin inspection (Daily with change in condition)**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care M/Surgical and ICU Population</td>
<td>Daily</td>
</tr>
<tr>
<td>Mental Health Units</td>
<td>Daily, only if admission Braden &lt; 19</td>
</tr>
<tr>
<td>Maternity Care Units</td>
<td>Daily, only if admission Braden &lt; 19</td>
</tr>
</tbody>
</table>

---

**Wound Assessment** - Done on all wounds:
- Upon admission
- When new wound identified
- With each dressing change by staff nurses or WOC
- Upon discharge

---

**Pressure Ulcers**

*Stage I pressure ulcer = non blanchable redness over bony prominence or area with pressure from any device. Intervention: Reposition to remove pressure.*

For Stage II, III, IV and other complicated or high risk patients obtain MD order for Wound Ostomy Continence (WOC) nurse consult; Referral line (651) 232-2676

---

**Resources:** INFONET: Clinical Services > Nursing > Tissue Integrity > Tissue Integrity Resource Manual
POLICY: HENSA S-13: Pressure Ulcer Prevention & Managing Skin Integrity
SKIN RESOURCE FLIP CHART: Located in the supply/med room or at nursing desk
HealthEast uses the Morse Fall Scale to assess and reassess patients for their potential of falling.

Morse Assessment is completed:
- On admission
- Daily on day shift
- When the condition of patient changes
- When medication changes that could increase fall risk
- Upon Transfer from one unit to another
- After a fall event has occurred.

Procedure:
1. Complete scale and document on FALLS tab in electronic chart or Morse Fall Scale Assessment Form in paper charting.
2. Determine low, med., or high risk level.
3. Implement interventions that correspond with the patient’s fall risk.

Patient Falls - What do I do?

Clinical leader:
- Initiates post fall huddle (instructions on infoNET)

RN caring for patient:
- Make sure patient is safe.
- Debrief with team using huddle tool
- Complete occurrence report
- Update Morse Fall Risk score

USE OF RESTRAINTS

Philosophy: Patients have a right to be free from restraints of any form that are not necessary. A restraint will be used only when less restrictive interventions have been determined to be ineffective.

DISCONTINUE RESTRAINT USE AS SOON AS IT IS SAFE TO DO SO

Non-Violent / Medical Justification:
- Pulling at invasive lines or tubes and does not respond to verbal/nonverbal redirection.
- Impulsive behavior, poor safety judgment when other less restrictive interventions/devices are ineffective.

Violent / Behavioral Justification:
- Need to manage violent or self-destructive behavior that jeopardizes the immediate safety of the patient, staff or others.
- Cannot be effectively de-escalated.

DOCUMENTATION (Paper and electronic)

Complete all sections:
- Monitoring for safety
- Cares provided/needs met
- Alternatives tried every shift
- Regular reassessment of the ongoing need for restraint
- Restraint is discontinued

“Face to face” exam by treating physician is required EVERY DAY PRIOR to order writing.
- Treating physician is to direct restraint use.
Restraint Resources:

Flow sheets for Non-violent and Violent Restraint Processes and Equipment Information Sheets can be found on Lippincott Nursing Procedures under “RESTRAINTS”

Table below documents the alternative to restraints algorithm for the Short Term Acute Care sties, STACH, there is a different algorithm for Bethesda (LTACH).
Patients in every health care setting are at risk for systemic inflammatory response syndrome, sepsis, severe sepsis, and even septic shock. The progression of sepsis is subtle, rapid, and often deadly.

Call MD for orders/transfer to ICU with any of the Criteria to the right.

**SEPSIS**

**SEPSIS CRITERIA**

<table>
<thead>
<tr>
<th>Known/Suspected Infection</th>
<th>AND</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 out of 4 of the following:</td>
<td></td>
</tr>
<tr>
<td>Temp &gt;100.4 or &lt;96.8</td>
<td></td>
</tr>
<tr>
<td>WBC &gt;10000 or &gt;12,000</td>
<td></td>
</tr>
<tr>
<td>RR &gt;20</td>
<td></td>
</tr>
<tr>
<td>PaCO2 &gt;32</td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>Lactic Acid &gt;4.0</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>SBP &lt;90 (systolic blood pressure)</td>
<td></td>
</tr>
<tr>
<td>MAP &lt;65 (mean arterial pressure)</td>
<td></td>
</tr>
</tbody>
</table>

Other considerations include:
- CAP Refill <3 weeks
- Mental Status Changes
- Low pH
- HCO3 <10
- UO <30cc/2 hrs

**SEPSIS 6 hour Bundle:**
- Sepsis lab panel: Heme1, CMP, PTT, INR, Lactic acid
- Blood cultures prior to antibiotic
- Antibiotic within 2 hours
- Fluid resuscitation
- Pressors for BP not responding to fluids
- Insertion of central line for pressor administration and refractory BP
- Steroid with Levophed rates >5mcg/min or multiple pressors

**SEPSIS 24 hour Bundle:**
- Completion of 6 hour bundle
- SVO2 level with Levophed rates > 5 mcg/min
- Glucose control monitoring and treatment to maintain BG<150
- Measurement of CVP with septic shock

**VENTILATOR ASSOCIATED PNEUMONIA (VAP)**

The physician’s order sets are excellent resources with step-by-step directions. Physician orders:

- ICU Admissions Physician Order PO#1650
- Ventilated Order Set PO#1654
- Ventilator Sedation Order Set PO#1652

DOCUMENTATION: Electronic charting > HED under VAP bundle (protocol tab) or Ventilator section of the flow sheet.

**VAP prevention bundle:**
1. HOB >30degrees
2. Daily DVT prophylaxis
3. Daily SUD prophylaxis
4. Daily wean assessment
5. Daily sedation reduction/sedation vacation/wake-up trial
6. Oral care q 4º

**CONGESTIVE HEART FAILURE (CHF)**

Order set #1017 Highlights:
- Vital Signs: ICU q 1 hour, Telemetry q 4 hours and MS q shift
- Cardiac Monitor: document every 4 hours & PRN with changes, mount in chart
- Document: Education
- Saline Lock
- Labs: Renal Profile and BNP
- Tests: CXR, EKG, ECHO if not done previously
- Notify Dietitian/Cardiac diet, Cardiac rehab and get copy of last ECHO
- Smoking Cessation information if required-chart if patient refuses
- Activity per MD
- Daily Weights and Strict I&O’s

Discharge: Must have all for National Quality Forum (NQF/JCAHO measures)
1. Medication Reconciliation
2. LVF assessment and ACE inhibitor or ARB (if contraindicated document)
3. Activity
4. Diet instructions
5. Medication instructions
6. Symptoms worsening
7. Weight monitoring
**DVT + PE = Venous thromboembolism (VTE)**

Over 2 million Americans will be affected with a DVT each year. As many as 600,000 will subsequently develop a PE.

**Why not just put everyone on anticoagulation therapy?** Using anticoagulation therapy depends on patient’s risk for VTE and contraindication for its use. Central lines are a risk factor.

**DVT/PE assessment:**
- **Calf/arm:** pain, swelling, warmth, erythema/discholoration
- **Respiratory:** RR> 20, dyspnea, HR>100, central chest pain

**Patient Education Resources:**
- DVT education handout: give upon admission for at risk pts
- Lovenox kit with patient education sheet
- Coumadin education sheet: from Pharmacy with first dose

**Document instruction and handouts on Education Tab in Horizon Clinical Documentation.**

---

**Pulmonary Embolism** is the 3rd most common cause of hospital-related deaths in the U.S.

---

**Order Set: PO#1012 Coronary Artery Disease Orders**

MD should assess for Chest pain observation according to protocol on orders
- Assess for ASA on admission
- Vital signs: ICU q 1 hour, Telemetry q 4 hours if stable, more often if needed
- Cardiac monitor: document every 4 hours and PRN with changes and mount in chart
- Document: Education
- Saline lock
- Labs: Troponin I at 6 and 12 hours
- Notify: Cardiac Rehab, Dietician, evaluated smoking/tobacco use provide information
- Activity per MD

---

**Discharge Instructions:**

Must have all for National Quality Forum (NQF/JC measures)

1. Medication Reconciliation
2. Aspirin at time of discharge
3. Beta Blocker
4. ACE Inhibitors or ARB (or documentation of Contraindication)
5. Adult smoking cessation education
Pain assessment and reassessment is documented on a regular and consistent basis in the patient’s chart. Patients and families are included in the plan to manage pain.

Pain assessment is to be documented once every 8 hours, unless otherwise ordered. Pain will be assessed on admission or initial contact with the patient, prior to and after any intervention.

Assess pediatric patients for pain, at least once every 4 hours with each assessment.

Pain reassessment and documentation is to be completed within ONE hour after administering a medication.

Documentation should include:
- Time of initial assessment, including intensity, location, quality/characteristic and pain scale.
- Justification for variation from stated guidelines to determine dose, frequency and route.
- Justification for changes from previous therapies administered.
- Cognitive-behavioral interventions such as relaxation, biofeedback, imagery.

For pediatric patients, the same pain assessment scale will be used consistently. If the scale needs to be changed, it will be communicated within the healthcare team and documented on the patient care plan and EHR (electronic health record). Care management rounds will include plan for pain control.

Pain management needs will be addressed in the discharge planning and education process.

Pain scales to be used:
- Numeric Scale 0-10
- Neonatal Infant Pain Scale (NIPS): Infants < 1 year
  - Faces, Legs, Activity, Cry, Consolability (FLACC): 2 months-7 years
  - The Faces Scale

Complementary Therapies

Multiple complementary therapies are available throughout HealthEast. These are healing methods not usually provided by traditional Western Medicine practitioners.

Common therapies used:
- Aromatherapy with Essential Oils (Nursing intervention)
- Healing Touch (Nursing intervention)
- Meditation
- Message therapy
- Music Therapy
- Acupuncture

Medication information can be found on the Infonet using Micromedex or Krames Patient education.

AcuDose Rx will provide patient information on medications.
AcuDose-RX

ACU DOSE RX AUTOMATED MEDICATION DISPENSING SYSTEM

The Acudose machines are located in the med rooms, find them during your unit tour.

USE OF THE MACHINE:
Login:
Type your user ID and touch NEXT button.

PROFILE dispense
Select patient and touch

INV dispense
Select drugs to dispense

STAT - override button
Select drugs to dispense

Touch dispense
Touch dispense

Enter # of doses
Enter # of doses

Touch open drawer
Touch open drawer

Touch OK to close drawer
Enter, Edit, or verify

Touch OK to close drawer

Steps for Safe Blood Administration

1. Check MD’s order for blood.
2. Obtain consent using surgical and blood consent form.(MR8733S)
3. Confirm correct patient using 2 identifiers: Name & medical record number on patient’s wristband. 2nd nurse required for verification (could be an LPN).
4. Compare blood bank number on the blood bag, blood type, and Rh compatibility. Date of Expiration on bag as well.
5. Document and Co-sign with witnesses name.

DOCUMENTATION

Pre-Infusion Assessment with complete vital signs, using the adverse reactions list.

FIRST 15 MINUTES: slow infusion rate and assess toleration.

VITAL SIGNS every 15 minutes for first 30 minutes. Then every hour until blood is completely infused. And one hour after infusion.
DIABETES MANAGEMENT

Check out the infonet for information on management of diabetes.

CLINICAL SERVICES > DIABETES CARE

POLICIES:

PHARMACY/NURSING

HEPN H-2: Hypoglycemia/Insulin reaction

HEPN I-7: Insulin administration

HEPN M-10: Med. Management of U500

NURSING

HENA B-7: Blood glucose monitoring

HENA B-6: Patient’s glucometer use

HYPOGLYCEMIA

An insulin reaction is typically a blood glucose level below 70, which may or may not be accompanied by symptoms.

SYMPTOMS:

Impaired mental function; confusion, poor concentration, disorientation

Physical symptoms: blurred vision, fatigue, shakiness, slurred speech, seizures, loss of consciousness

INSULIN USE

Evaluate insulin doses daily. Adjust to prevent hyper or hypoglycemia.

Know the Red flags that calls to Diabetes Educators and Physicians are recommended.

Use the scanner feature to enter the patient information into the glucometer to improve patient safety.

Glycemic targets at HealthEast

<table>
<thead>
<tr>
<th>Situation</th>
<th>Target Range (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-ICU Inpatient Patient Care Areas</td>
<td>70-180</td>
</tr>
<tr>
<td>ICU</td>
<td>80-180</td>
</tr>
<tr>
<td>Brain Injuries</td>
<td>100-150</td>
</tr>
<tr>
<td>Continuous Tube Feeding or TPN</td>
<td>120-160</td>
</tr>
</tbody>
</table>

HealthEast Insulin products reference guide can also be found on the Diabetes page. This guide identifies the product, how quickly it will react, peak, duration and expiration of the medication. There is also a photo for identification and directions for storage. It is grouped by rapid acting/bolus, Basal and Premixed Basal insulin.

INSULIN PRODUCTS REFERENCE GUIDE

<table>
<thead>
<tr>
<th>Product</th>
<th>Onset</th>
<th>Peak</th>
<th>Duration</th>
<th>Expiration</th>
<th>Photo</th>
<th>Storage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novolog® U-100</td>
<td>10-20 min</td>
<td>1-3 h</td>
<td>2-5 h</td>
<td>20 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1mL multi-dose vials stored in ADC (AccuDose). Nurse dispenses by “unit” with barcode label from AccuDose. Bevenda Exception: Bevenda utilizes patient-specific 1mL multi-dose vials stored in patient-specific drawer on patient care unit.</td>
</tr>
<tr>
<td>Novolog® U-100 (regular)</td>
<td>30 min</td>
<td>2.5-5h</td>
<td>4-12h</td>
<td>28 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1mL multi-dose vials stored in ADC (AccuDose). Nurse dispenses by “unit” with barcode label from AccuDose. Bevenda Exception: Bevenda utilizes patient-specific 1mL multi-dose vials stored in patient-specific drawer on patient care unit.</td>
</tr>
<tr>
<td>Humulin® U-500</td>
<td>30 min</td>
<td>2.5-5h</td>
<td>6-24h</td>
<td>28 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient-specific dose dispensed by Pharmacy in Tuberculine syringe and stored in patient-specific drawer on patient care unit. **See also HEPN M-10</td>
</tr>
</tbody>
</table>

Basal Insulin

| Lantus®           | 3-4 hours | No peak | 24h      | 28 days    |       |         |
|                   |          |         |          |           |       | Patient-specific dose dispensed |
Point of Care testing (POC) is done at the bedside or in areas other than the lab. Special training (validation) is required for any point of care testing done by nursing staff.

For bedside testing (other than glucometer) CALL LAB:

JOES: 2-3136
JOHNS: 2-7136
WOODWINDS: 2-0136
BETHESDA: 2-2136 (Phlebotomy only; for lab testing call JOES)

**HealthEast Nurse Practice**

**Neuro Assessment Expectations**

**Neuro Standard**

*Key Principle:* The choice of a documentation tool is driven by the patient’s clinical status, not geographical location.

To be included with the head-to-toe assessment performed and documented every 8 hour shift;

- *Hensa A-4 defines that a Neuro Assessment includes:*
  - Mental Status, Pupil Size, Shape, Reactivity and Motor Strength

*ALL INPATIENTS*, including those in maternity care, medical-surgical areas, orthopedics, or any other patient who does not have a primary neurological diagnosis are to be assessed with Neuro Standard.

**Glasgow Coma Scale – for use in primarily in ICU**

Performed every shift as defined every eight hours

If < 7 perform the Coma Assessment for the remainder of the shift

If > 7, use the NIHSS and abbreviated NIHSS or Neuro Standard – depending on diagnosis – for the remainder of the shift

**Coma Assessment – for use primarily in ICU**

These assessments provide more specific information about the depth of the patient’s coma.

Performed at the frequency specified by MD order, usually every 2-4 hours, or according to nursing judgment

**Patients with a diagnosis of stroke**

National Institutes of Health Stroke Scale (NIHSS) + Pupils Abbreviated NIHSS (aNIHSS) + Pupils

NIHSS + Pupils performed in full at the beginning of every shift

The aNIHSS + Pupils to be used for the intervening neuro assessments every 2-4 hours based on order

Resources include a detailed manual at the charge desk, hover text, and Lippincott
HEALTHEAST STROKE CARE: DYSPHAGIA

**Remember:** Patient’s with diagnosis of a stroke or stroke symptoms should have the Stroke order set initiated for stroke: PO#1016

Nursing must assess swallowing by doing Dysphagia screening before giving anything by Mouth!

Follow up with Speech Therapist for Swallow evaluation and study should be done for both pass and fail Dysphagia Screening.

**PASS Screening:** Pills with sips of water, continue until follow up with speech and further orders are received.

**FAIL Screening:** Keep NPO until speech follows up and orders are received.

**DOCUMENTATION “Must Haves”:**
1. Dysphagia screening
3. DVT / PE assessment & education.

**Physician Order main points:**
- Consult: Primary MD or Hospitalist
- Consult: Neurologist
- Notify for evaluation / treatment: PT, OT, Speech / Language for bedside swallow
- Consult: Dietician, -Social Work, -Chaplain

---

**TIME OUT / PAUSE FOR THE CAUSE**

HealthEast began conducting Time Out (Pause for the Cause) years ago. The Time Out process is a final check to verify correct patient, correct site, and correct side, and or procedure.

**Time Out before Incision or Start of an Invasive Procedure**

**Surgeon initiates:** “Let’s do the Time Out”
**Team ceases all activity (radio off)**

**Circulating Nurse reads from the informed consent form:**
- Patient Name
- Procedure
- Laterality (and level) as appropriate

**Anesthesia Care Provider(s):**
- Reads the patient’s name from the anesthesia record
- States shorthand version of the procedure

**Surgical Technician:**
States shorthand version of the procedure he/she has set-up for Verbal confirms he/she can see the site marking (if applicable)
(If anatomical diagram is used in lieu of physical site marking, circulating nurse and team use diagram to verbally acknowledge site of procedure)

**Surgeon:**
States patient name
Complete procedure
Site (laterality if applicable)
Reporting Critical Lab Values
Ordering LIP is notified of critical value within 50 minutes of result by lab

POLICY: Upon identifying the need for notification, the licensed care provider (RN) will ensure the ordering LIP acknowledges critical laboratory values within 30 minutes upon receiving the critical value result from laboratory technologist. The RN will document the acknowledgement from the LIP or the rationale of why the LIP was not notified.

LABORATORY
1. Lab personnel result and identify critical values from established list
   - Lab will not call unit with subsequent CKMB, Total CK, Troponin, and certain labs for oncology patients
2. Critical value called to nurse within 20 minutes
3. Lab personnel will remind nurse of the 30 minute time frame
4. Lab personnel document = date, time and person to whom he/she spoke.
   - For example, “Critical pH called to Tracy, RN at 0715 with read back”

NURSE
1. Reads back critical value to lab personnel
2. Notify LIP of ALL INITIAL critical values within 30 minutes
3. RN documents notification in the patient medical record
4. For subsequent critical lab values, will determine if call is needed:

NO CALL/TEXT PAGE NEEDED IF:
1. LIP has an order in place that addresses critical value e.g. protocols for K+ etc., RN will implement orders
   OR
2. LIP previously ordered not to be notified of subsequent values

CALL/TEXT PAGE NEEDED IF:
1. No orders to cover the critical value
   - TEXT PAGE—“Call John’s ICU 2-7132 for critical lab. Cindy, RN.”
   - *do not include the critical value itself
2. Patient condition/status is not as expected despite previous orders

IF NO RESPONSE TO CALL/TEXT PAGE WITHIN 30 MINUTES:
RN will immediately take action/s based on patient’s condition:
- Attempt to contact another LIP that is caring for/covering for the patient
- Attempt to contact house officer/physician and/or hospitalist
- Call the Rapid Response Team

Monitor labs & renal function as ordered
Protocols for Potassium and Magnesium (ICU only)
**PUMP USE FOR PATIENT SAFETY**

**Drug library** is divided by clinical care area (CCA):
- Anesthesia
- BH 5W
- Catheter Lab
- Critical Care
- Medical / Surgical
- Oncology Inpatient
- Obstetrics (OB)
- Neonatal
- Pediatric
- Emergency
- Mental Health/Addiction
- OR
- Pre-op PACU/SAU
- Radiology

Keep the pump plugged in, machine will wake up every 6 hours to accept new updates.

CLEAR intake at the end of EACH shift and document in the EHR for accurate I & O.

**Double check** required on high risk IV medications:
- IV Infusions
  - Heparin
  - Insulin
  - Chemotherapy
  - Narcotics on PCA’s
  - Thrombolytic
  - 3% Saline
  - Argatroban

**IV Tubing Change Schedule**
- Primary/Secondary Tubing and Pressure Tubing: at least every 96 hours
- TPN/PPN Tubing: at least every 96 hrs (except if given with Lipids, then every 24 hrs)
- Lipid Tubing: new tubing for each bottle/bag (hang time of 24 hours)
- Propofol (Diprivan) Tubing: change every 12 hours

**Peripheral IV’s**

Personnel using intra dermal anesthesia must have a validated competency.

Minimum of 20 gauge catheter is required for all blood products.

Document site, size of catheter, type of dressing and number of attempts to place IV.

Label IV tubing with date/time/initials.

Print date and time on all IV site dressings.

Peripheral IV placed pre-hospital must be changed within 24 hours.

To prevent bloodstream infections scrub the hub with alcohol or CHG vigorously for 15 seconds before injection.

Use minimum of 2.5ml normal saline for saline lock every 8 hours.

If maintenance fluid is running, DO NOT flush line between medications.

**INTRAVENOUS THERAPY**

**Central Line Insertion & Maintenance**

1. Biopatch® is placed after insertion of central line and changed every 7 days & PRN with dressing.

2. Place a neutral pressure cap on all central venous catheters. Scrub the Hub for 15 seconds with alcohol prior to injection.

3. Inspect and document site every shift.

4. Flush line per order set on non-running lines at least every 8 hours.

**Blood Sampling from a Central Venous Line**

**MUST HAVE PROVIDER ORDER**

1. STOP ALL infusions via ports for 2-5 minutes prior to blood draw to avoid dilution of blood sample.

2. DO NOT flush line with normal saline prior to lab draw.

3. Scrub the hub for 15 seconds before accessing.

4. Using a vacutainer or 10 mL syringe, withdraw 6 mL of blood (waste tube) to clear catheter of dead space and diluted blood.

5. Remove waste tube from Luerlok blood device or 10 mL syringe and discard. Attach blue tube and draw labs in the following order: - Blood Culture, - Blue top, - Red top, - Green top, - Purple top, and - Gray top

6. After draw is completed, flush catheter with 20 mL normal saline using pulsatile, start -stop motion, create maximum turbulence to clear cap and line.

7. Caps do not require change after every lab draw.

**PICC Lines (Internal valve)**

1. A Biopatch® is applied after insertion.

2. Change dressing every 7 days and PRN.

3. Measure arm circumference with dressing change 10 cm above the antecubital fossa.


5. Flush according to order set. Flush with 10ml normal saline after medications and 20 ml after blood administration or draws.

6. Line will be flushed with heparin upon discharge.

**Implanted Ports**

1. If blood cannot be withdrawn from port, flush 10 mL normal saline, have patient raise arm on the same side as port, cough, sit up or take a deep breath. DO NOT USE PORT if unable to draw without agreement from physician.

2. Access with Gripper needle, changed every 7 days, if put in under optimal conditions; otherwise within 24 hours.

3. Place neutral pressure cap on all implanted port lines. Flush with 10 ml normal saline after medications and 20 ml after blood draws.

4. Line will be flushed with heparin on discharge.
POINTS TO PRACTICE

1. PREPARATION
   - Make sure all items are accessible throughout the procedure
   - Prepare site according to your facility’s policy and procedure
   - Prior to venipuncture hold catheter hub and rotate barrel 360 degrees
   - Make sure catheter is seated back in the notch

2. VENIPUNCTURE
   - Approach vein slowly at a low angle
   - Observe early flashback along the catheter (20, 22, 24 gauge only)
     In larger gauge sizes observe flash behind white button

3. ADVANCEMENT
   - Upon flashback visualization, lower catheter almost parallel to the skin
   - Advance entire unit slightly before threading catheter
   - Thread catheter into vein while maintaining skin traction

4. NEEDLE REMOVAL
   **Before Pressing the Button**
   - Release tourniquet
   - Apply digital pressure beyond the catheter tip
   - Gently stabilize catheter hub
   - Press the white button

5. SECUREMENT
   - Secure catheter and apply sterile dressing according to your facility’s policy and procedure

CAUTION REMINDERS
- Do Not withdraw needle from catheter hub before pressing the white button.
- Needle should be retracted prior to disposal in a puncture-resistant, leak-proof sharp container.
- Never Reinsert Needle into the catheter as this could shear the catheter.
- Do Not Use Scissors at or near the insertion site.

Refer to package insert for complete instructions for use.
TIPS FOR SUCCESS

INSERTION SUCCESS
- Make sure tip seal is released before insertion, by rotating the barrel 360°
- Make sure catheter is seated back in the notch
- Slow down the speed of insertion
- Use less force to penetrate the skin
- Lower the initial insertion angle keeping the elbow low
- After flash, lower the angle and advance 1/8 inch

SEEING THE FLASH
- Trust your instinct and take a pause
- Look for the flash along the catheter
- Be aware of patient factors such as small veins, small patient, blood pressure, condition of vein, dehydration, etc., that may impact flash

THREADING WITH EASE
- After flash, lower the angle and advance 1/8 inch
- Avoid the push-pull technique when advancing
- Make sure tip seal is released before insertion, by rotating the barrel 360°
- Maintain traction on the skin

RETRACTING THE NEEDLE
- Make sure tip seal is released before insertion, by rotating the barrel 360°
- Make sure to place digital pressure beyond the tip of the catheter
- Make sure needle is not being inadvertently bent while attempting to activate the button

MINIMIZING THE BLOOD
- Release tourniquet before pressing the button
- Place digital pressure beyond the catheter tip
- Have IV connector or tubing close by and ready

AVOID EARLY ACTIVATION
- Be aware of where your fingers are
- Remove needle cover in a straight, outward motion

BD Medical
Sandy, Utah 84070
BD, BD Logo, Autoguard and Insyte are trademarks of Becton, Dickinson and Company. ©2004 BD. D10067-2 E6(04)
P - Listed Medications

Pharmaceutical chemical products that are ACUTELY hazardous when unused for people or the environment.

P Listed Medications are identified by any of the following ways; AcuDose message, Unit dose label message, and E-MAR message.

Common P-Listed Medications: Physostigmine, Phentermine, Warfarin >0.3%, Nicotine

DISPOSAL PROCEDURE:
- Remove any patient identifiers to patient.
- Seal in Ziploc bag with packaging and Silent Knight bags, if used with crushing of medication. Note: Crushing of warfarin is not recommended. Dissolving medication in syringe is preferred.
- Label contents
- Dispose in the white hazardous bin

WHITE HAZARDOUS BINS or SATELLITE PHARMACY WASTE are found in the med room and must be kept closed at ALL times. Use the trolley foot pedal to open.

DISPOSAL EXCEPTIONS:
- Plain electrolyte solutions with no pharmaceutical additives
- Controlled substances must be sewer ed per DEA rules & documented with a witness in the automated dispensing cabinet.

Call housekeeping for removal/replacement with clean bin.

U - Listed and Other Hazardous Wastes

Other pharmaceutical chemicals that are hazardous when unused are primarily CHEMOTHERAPY AGENTS; all antineoplastic and immunosuppressive medications, including Arsenic Trioxide both P & U Listed medication.

DISPOSAL PROCEDURE:
Empty IV bags, tubing’s, and vials are discarded into the YELLOW TRACE BUCKET found in the patient’s room or dirty utility room

OTHER HAZARDOUS WASTE
Alcohol > 24% (Inhalers & aero-sols), Acids/Bases, Centrum Silver, Vaccines, Ophthalemic, Nasal, Insulin, Hormones, anti-virals

INFECTIOUS WASTE

Infectious waste includes:

- Disposable sharps - engage safety device before disposing.
- Visibly contaminated materials with blood or body fluid.
- Microbiology waste
- Pathology waste - includes placentas (HEPS P-2 Placenta handling & disposal)

Handling:
Wear gloves and other appropriate PPE
Red bag items and place into red bio-hazardous waste barrel, double bag when needed.
Hovermatt Air Transfer System
Uses a bed of air to assist with transfer for patients up to 1200 lbs.
Requires a 2 person minimum for use

Directions: 1. Explain procedure to patient.
2. Place Hovermatt under patient, feet symbol at the bottom.
3. Snap air supply in place on either side at bottom.
4. Close belts around patient loosely fitting around patient, (it will tighten as it inflates).
5. Turn on air by touching button on canister.
6. With staff on either side of mattress, carefully move patient with one side guiding the movement across and the other lightly pulling toward self.
7. Once patient is in correct position, deflate mattress by pushing in button on canister once more.

Hovermatt Air Transfer System
for lateral transfers and repositioning

ZOOM Cart Motorized Stretcher
for transporting patients safely

Prior to Use: 1. Unplug cart and press and hold buttons on handles to confirm readiness. (Holds charge for 6 hours).
2. Engage DRIVE wheel and verify that switch is ON.

For Use: 1. Always make sure side rails are up, backrest engaged, and IV pole is secure prior to moving.
2. Cart is powered by your walk/pace. Maintain good control by anticipating corners, stopping a starting.

After Use: Clean/disinfect between patients, Make sure the zoom cart is plugged in for charging.

TROUBLESHOOTING HOVERMATT USE:
- Make sure that air supply is securely snapped in place.
- MRI / CT Compatible
- Never operate with less than 2 people

Risk factors related to staff injury:
- Forceful exertion - amount of force used and how long it is sustained.
- Repetition - performing the same motion over and over again.
- Awkward postures - repeat bending, twisting, reaching, or holding.
- Lack of teamwork or coordinated effort.
Equipment Use:
- Determine by patient’s level of mobility
- Task needed to be performed
- Provide clear, simple directions to patient for their assistance, when possible.
- Apply brakes firmly and properly.
- Use your legs to do the work, saves work on your back.
- Clean as recommended. Replace soiled or broken equipment and pieces immediately.

Ceiling Lifts for transfers and repositioning are available throughout the HealthEast facilities

Determine the correct sling size for the client and task.
Standard sling - up to 625 lbs.
Bariatric sling - up to 800 lbs. (St. Joseph’s 4500 Unit)

Repositioning Sling for boosting and transferring to cart (flat sheet with loop handles)

Chair Sling for transfers (crisscross straps in front, between legs, shorter loops by head so patient is in reclined position).

Procedure:
1. Explain procedure to client.
2. Place sling under client, careful not to twist.
3. Position and lower ceiling lift over client.
4. Attach color coded loops to 4 point hook up. (Color codes correspond to different client positions).
5. Use remote to raise patient.
6. Position patient over chair/bed.
7. Using remote control, lower patient onto bed/Chair.
8. Disconnect straps from support hooks.
9. Move ceiling lift away from patient.
10. Remove sling from patient.

Troubleshooting ceiling lifts

EMERGENCY: Continually pull red cord and patient will lower.

Lift does not work; check to see if red emergency cord is pulled. Manually push it in if pulled and lift should function.
Use a minimum of 2 employees
* Always dock when not in use for charging (white box on wall is power pack)

* Problems? Call Engineering or Occupational Health
St. Joseph’s Hospital is a Bariatric Center of Excellence; You may see patient who have had bariatric recent or past surgery (such as: gastric bypass, LapBand, or sleeve gastrectomy) at any of the HealthEast facilities. Our care model is RESPECT.

General tips for working with patients:

- All bariatric patients are at risk for falling & impaired skin integrity.
- All bariatric surgery patients have minimal physiological reserve. If something goes wrong, it happens quickly. Don’t wait and watch - call the bariatric surgeon.
- Vomiting is NEVER normal.

ELECTRONIC MEDICATION RECONCILIATION (E-Med Rec)

HealthEast uses electronic medication reconciliation for all patient medication orders.

Upon admission all medications are entered into the medication form on the computer by an RN within 8 hours of the patient's (pt's) admission.

Assure that the Med Rec Report is printed, placed in the chart and signed by the provider as an order within 16 hours of the pt’s admission.

When a transfer occurs assure that the Med Rec Report is printed and on the chart before the pt goes to surgery or to the ICU.

Upon discharge assure that the discharge med orders are updated by an RN and signed by the provider.

Print the discharge medication list and review the medications with the patient and family.

Have the patient sign one copy for the chart and give one copy to the pt with the summary of discharge instructions.

Resources:

HealthEast Nursing Procedure number NUR 1853H “Medication Reconciliation: Electronic process (e-Med Rec) for inpatient care in an acute hospital, or outpatient setting within the hospital.

HealthEast Policies and Procedures Manual Nursing Service Administration number HEPN M-9 “Medication Reconciliation”.
# Clinical Resources

## RESOURCES | PHONE NUMBER
---|---
Compliance Hotline | 2-5420
EMERGENCY - In-Hospital | 2-1111
IT Help Desk | 2-1227
In House Central Interpreter Scheduling | 2-5649

### Infection Prevention & Control

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Joseph’s Hospital</td>
<td>2-3058 or 6-3254</td>
</tr>
<tr>
<td>Saint John’s Hospital</td>
<td>2-7097</td>
</tr>
<tr>
<td>Woodwinds Hospital</td>
<td>2-0023</td>
</tr>
<tr>
<td>Bethesda Hospital</td>
<td>2-2198</td>
</tr>
</tbody>
</table>

### Injury Hotline

| | 2-2939 |

### Laboratory

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Joseph’s Hospital</td>
<td>2-3136</td>
</tr>
<tr>
<td>Saint John’s Hospital</td>
<td>2-7136</td>
</tr>
<tr>
<td>Woodwinds Hospital</td>
<td>2-0136</td>
</tr>
<tr>
<td>Bethesda Hospital</td>
<td>2-2136</td>
</tr>
</tbody>
</table>

### Organ, Tissue, and Eye Donation

| | 1-800-247-4273 |

### Social Work (Healthcare Directives)

| | 2-3338 |

### WOC Nursing

| | 2-2676 |

---

**HealthEast INFONET Resources**

- **This week @ HealthEast**
  - *It's camping time again - sign up by August 26 – Register now for a new 10-week session of yoga classes beginning September 2 and going through November 4. Classes are open to all HealthEast employees and take place on Thursday mornings from 6:30 am in Midway's Country Conference Room.*
  - *The community at large is welcome to attend. Space is limited and the $10 registration fee is non-refundable after August 30. Call IT Help Desk for more information.*

- **This month @ Bethesda**
  - *Bethesda June newsletter update – The amount paid out depends on meeting the following quotas:
    - *Submit 50 online prescriptions per month*
    - *Submit 100 online referrals per month*
    - *Submit 100 online consults per month*
    - *Submit 100 online referrals per month*

  - *The Bethesda Hospital Foundation's focus this month is on residents. Bethesda encourages their patients to be healthy and carefree! Look for the new Bethesda newsletter online!*

**Policies and Procedures - Lippincott**

- **Quick links**
  - *Caliber Menus*
  - *Classifieds*
  - *Forms*
  - *In-House HealthCast*
  - *In-House HealthCast*
  - *Policies and Procedures*

- **Policies and Procedures**
  - *EPA Recommendations for Handling 'Sharps'*
  - *Recent updated News*
    - *New Marketing Campaign*
Intraspinal/Epidurals (Gemstar Epidural Pump)