



Claiborne County Hospital and Nursing Home Student Handbook

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*** Please turn the following completed quizzes/forms into your instructor**

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Welcome to Claiborne County Hospital

We look forward to working with you as a partner in your clinical education. We strive to provide high quality, patient centered care for each of our patients.

This manual contains the information you will need to complete your orientation. Please follow the steps below to complete your orientation experience prior to your clinical rotation at our facility.

1. Read the contents of this manual. It provides valuable information to help you care for patients according to policy & procedure.
2. Save or print a copy of this manual for future reference.
3. Print a copy of the following quizzes which are located at the back of the manual: Environment of Care, Infection Prevention, HIPAA and National Patient Safety Goals.
4. Complete the Environment of Care Quiz, Infection Prevention Quiz, HIPAA Quiz & National Patient Safety Goal Quiz.
5. Print the Confidentiality Agreement, read and sign.
6. Give your instructor the signed copies of the Environment of Care Quiz, Infection Prevention Quiz, the HIPAA Quiz; National Patient Safety Goals Quiz & the Confidentiality Agreement.
7. A physical orientation to your assigned unit will be conducted prior to or on the first day of clinical rotation.

General Guidelines, Expectations, & Policies

1. When you are in the clinical setting, you are expected to adhere to the facility's policies and procedures. Clinical policies may be found on each unit of CCH.
2. Your instructor is the primary chain of command at CCH. Any incident or situation should be discussed with your instructor. If you feel that you cannot discuss the situation with your instructor or the incident involves an employee of the hospital you may contact the In-service Education Coordinator, Linda Majors, RN at ext. 2250 or come by the Education Office located in the Education Building.
3. Every patient is under the direct care of CCH staff. Students under the supervision of their clinical instructor may contribute to this care according to hospital policy. Please inform the hospital staff of your patient's needs in a timely manner.
4. Students are expected to wear a hospital issued ID badge whenever in the hospital. You will receive a discount in the cafeteria with this ID badge.
5. Complete routine assigned patient care with consideration of age, spiritual needs, culture & values and patient rights.
6. Give a detailed, current report on your assigned patients to the appropriate nurse responsible for the patient BEFORE LEAVING THE UNIT.
7. Be accountable for The Joint Commissions approved 2011 National Patient Safety Goals.
8. Ensure patient safety and welfare while providing patient care by adhering to all Environment of Care guidelines & related policies & procedures.
 - a. Report chemical hazards/spills and handle hazardous chemicals in accordance with the MSDS maintained in the ER.
 - b. Report malfunctioning equipment
 - c. Recognize and be able to report hospital "Codes" (See Emergency Codes).
 - d. Observe radiation precautions.
 - e. Practice safe ergonomic work habits to prevent injury.
 - f. Any student, staff or patient injury, medication error, or other event must be reported on an Occurrence Report. Report any student or patient injury, medication error or other unusual occurrence immediately to the staff on your unit and your instructor.
9. Identify self appropriately when answering the phone; DO NOT accept phone/verbal orders from physicians or other providers.
10. Park only in designated parking campus areas as instructed by your clinical instructor.
11. Only smoke in designated areas outside the hospital. (See Smoking Policy)
12. Maintain patient confidentiality according to HIPAA Standards. (See Confidentiality)
13. Utilize the Omni cell System for supply management. (See Use of supplies & equipment)
14. Adhere to Infection Prevention policies and standard precautions. (See Infection Prevention Policy).

Dress Code Guidelines

1. You must abide by your school dress code guidelines.
2. You must wear your Claiborne County Hospital picture ID badge on your left upper chest.
3. You must wear underclothes that are appropriate for clinical and cannot be seen through your uniform. No jeans are allowed.
4. You must wear socks or hose with your uniform.
5. You must wear shoes that cover your toes/feet. No sandals or open toed shoes.
6. No tattoo or body piercing should be visible. No more than two pair of earrings for females. For safety purposes earrings must be post or small loop. All jewelry must be MRI compatible or removed prior to entry.
7. No perfume or cologne due to patient allergies.
8. No smoking inside the facility or on designated hospital property. Smoke in the designated smoking area only. Make-up should be simple and not overdone. No chewing gum while on duty.
9. No eating or drinking in the Nurse's Station or patient care areas. Please take your assigned breaks on the unit designated for eating. Please keep your voice at a low tone.
10. When using charts, please make sure that the charts are easily available for the physicians and nurses on the unit. Please keep the physician dictation area available for physician use.
11. Medical Students must always wear their student white coat during all rounding activities.
12. Medical Students must always introduce themselves, or be introduced as Medical Student _____ or Mr. Ms. Mrs. _____, Medical Student.

Welcome to Claiborne County Hospital and Nursing Home

Located in Tazewell, Tennessee. We are committed to improving the health status of all citizens in the rural communities we serve by providing a wide range of high-quality, cost-effective integrated healthcare services in a manner that is convenient and respectful of individual rights.



Mission

Claiborne County Hospital and Nursing Home is a community-owned healthcare organization committed to improving the health of the residents of Claiborne and surrounding counties by providing high-quality and cost-effective health care services.

Values

Our employees, physicians, and board members will continuously strive to conduct themselves according to these values:

Excellence - continually improving the services we offer and the care we deliver.

Service - providing compassionate, individualized service to our patients, community, and each other.

Teamwork - working together to meet the needs of our community.

Integrity - ensuring that honesty and trustworthiness are seen in all we do.

Vision

Claiborne County Hospital and Nursing Home will evolve into a regional provider of a broad spectrum of high-quality, cost-effective health care services. A multi-specialty Medical Staff and a high-performance, customer-focused work force will provide these services. As a responsible steward of the community's assets and as a corporate citizen of Claiborne County, Claiborne County Hospital and Nursing Home will be the facility of choice for residents of the region.

Infection Prevention

Infection Prevention is a set of recommended precautions implemented to protect healthcare workers and others from the spread of infections within the facility.

Hand Hygiene

Hands are the most common agent for the transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Therefore, hand washing is the single most important procedure for preventing the spread of infection in the hospital. Long and artificial nails may serve as a reservoir for microorganisms, and microorganisms are more difficult to remove from rough or chapped hands. In effect, clean and healthy hands with intact skin, short fingernails, and no rings minimize the risk of contamination and subsequent spread of infection.

When to clean

1. Before beginning shift duties.
2. Before and after direct or indirect patient contact.
3. After performing bodily functions including blowing your nose, eating, or using the restroom.
4. Before and after preparing or serving food.
5. Before preparing or administering medications.
6. After removing gloves or other personal protective equipment.
7. Before and after participating in any sterile or invasive procedures, wound care, and dressing changes.
8. Whenever your hands are grossly contaminated.
9. Before and after caring for any highly susceptible patient, isolation patient, and newborn.
10. After contact with a source that is likely to be contaminated with virulent microorganisms or hospital pathogens.
11. After completion of your shift.
12. After contact with unclean equipment and work surfaces, soiled clothing, and handling raw food.

How to clean- Soap or Alcohol gel?

Situation	Soap	Hand Rub
Hands are visibly dirty or contaminated with protein-based material (including blood or other body fluids)	X	
<i>Before</i> direct contact with patients	X	X
<i>Before</i> donning sterile gloves when inserting a central vascular catheter	X	X
<i>Before</i> inserting urinary catheters, IV's, or other invasive devices that do not require a surgical procedure	X	X
<i>After</i> contact with patient's intact skin (e.g. When taking a pulse or blood pressure, & lifting a patient)	X	X
<i>After</i> contact with bodily fluids or excretions, mucous membranes, nonintact skin, and wound dressings (hands are not visibly soiled).	X	X
When moving from a contaminated- body site to a clean-body site during patient care	X	X
<i>After</i> contact with inanimate objects(including medical equipment) in the	X	X

immediate vicinity of the patient		
<i>After removing gloves</i>	X	X
<i>Before eating and after using restroom</i>	X	X
<i>After (possible) exposure to spores(e.g. C. Difficile)</i>	X	

Soap and Water Technique

1. Those involved in direct patient care should not wear rings, however if wearing a wedding ring move the ring up and down your finger to clean beneath it.
2. Wet your hands and wrists with running water, and apply soap from a dispenser (do not use bar soap as it allows cross contamination).
3. Hold hands below elbow level to prevent water from running up your arms and back down, thus contaminating clean areas. (Pay special attention to thumbs, knuckles, sides of fingers, under fingernails, and around cuticles).
4. Work up a generous lather by rubbing your hands together vigorously for 15 seconds. Water reduces surface tension, and this, aided by friction, loosens surface microorganisms, which wash away in the lather.
5. Rinse hands and wrists well, and avoid touching the sink or faucet.
6. Pat hands and wrists dry with a paper towel (avoid rubbing which causes abrasions and chapping).
7. If the sink is not equipped with a knee or foot preventions, turn off faucet by gripping them with a paper towel to avoid recontamination of hands.

Alcohol-based Hand Rub Technique

When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry.

Surgical Hand Antisepsis

1. Remove rings, watches, and bracelets before beginning the surgical hand scrub
2. Remove debris from underneath fingernails using a nail cleaner under running water.
3. Using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes.
4. Refer to department specific procedures for surgical hand scrubs.

Hand Care and protection

1. Nails, Nail Polish and Artificial nails
 - a. For those with direct patient contact, natural fingernails should be kept clean and neat, cuticles free of inflammation, and not exceed ¼ inch in length. Artificial nails are prohibited.
 - b. For those without direct patient contact, fingernails should be kept neat and clean, cuticles free of inflammation. Artificial nails and polish are acceptable so long as they are a single solid color without adornments and no longer than ½ inch in length. Nail length for food handlers is limited to ¼ inch.
2. A ring can be worn; so long as appropriate hand washing/antisepsis occurs as outlined above (Rings can make donning gloves more difficult and may cause gloves to tear more readily).
3. Lotions are recommended to ease dryness from frequent hand washing, and to prevent dermatitis resulting from glove use. Avoid using alcohol based hand cream or lotions

when wearing latex gloves, as they may weaken the glove causing deterioration and increased permeability.

4. Glove Usage

- a. Standard precautions recommend wearing gloves for any known or anticipated contact with blood, body fluids, tissue, mucous membrane, or nonintact skin.
- b. Gloves should be used as an adjunct to, not a substitute for, hand washing.
- c. Gloves should be removed and hands washed after each task is completed, when the integrity of the gloves is in doubt, and between patients (gloves may need to be changed during the care of a single patient, for example when moving from one procedure to another).
- d. Disposable gloves should be used only once, and should not be washed for reuse.
 - Gloves made from materials other than latex are available for personnel with sensitivity.

Personal Protective Equipment (PPE)

OSHA defines personal protective equipment (PPE) as “specialized clothing or equipment worn by an employee for protection against infectious materials.” It is provided by the facility to protect the employee.

Types of PPE include gloves, gowns/aprons, masks and respirators, goggles, and face shields. PPE is only effective if used appropriately.

A. Selection Factors

- ❖ Type of exposure anticipated. This is determined by the type of anticipated exposure, such as touch, splashes or sprays or large volumes of blood and body fluids.
- ❖ Durability and appropriateness for the task. This will affect, for example, whether a gown or aprons selected for PPE, or, if a gown is selected, whether it needs to be fluid resistant, fluid proof, or neither.
- ❖ Fit. PPE must fit the individual user.
- ❖ Examples:

Giving a bath	Generally none
Suctioning oral secretions	Gloves & mask/goggles or a face shield- sometimes gown
Transporting a patient in a wheelchair	Generally non required
Responding to an emergency where blood is spurting	Gloves, fluid resistant gown, mask/goggles or a face shield
Drawing blood from a vein	Gloves
Cleaning an incontinent patient with diarrhea	Gloves, may need gown
Irrigating a wound	Gloves, gown, mask/goggles or a face shield
Taking vital signs	Generally none

B. Gloves are worn during patient care activities, environmental services and any time protection against the environment is needed. Glove materials vary. Examples are vinyl, latex, and nitrile. Sterile and non-sterile gloves are available. Glove selection is based on anticipated use. In situations, when tearing is anticipated, the use of thicker or double gloving is indicated. Once contaminated, gloves can become a means of spreading

infectious materials to you, other patients or environmental surfaces. Therefore, the way gloves are used can influence the risk of disease transmission.

1. Work from “clean to dirty.”
2. Limit opportunities for “touch contamination”; protect yourself, others and the environment.
 - a. Don’t touch your face or adjust PPE with contaminated gloves.
 - b. Don’t touch environmental surfaces except as necessary during patient care.
3. Change gloves
 - a. During use if torn and when heavily soiled (even during use on the same patient).
 - b. After use on each patient.
4. Discard in appropriate receptacle. Never wash or reuse disposable gloves.

C. Gowns or Aprons are worn to protect the clothing and skin of the healthcare worker. Types of gowns or aprons include natural or man-made products, reusable or disposable, and fluid protection varying from minimal to maximum. Gowns and aprons are clean and sterile. Isolation gowns are generally the preferred PPE for clothing but aprons occasionally are used where limited contamination is anticipated. If contamination of the arms can be anticipated, a gown should be selected. Gowns should fully cover the torso, fit comfortably over the body, and have a long sleeve that fits snugly at the wrist. Fluid resistance should be considered. If fluid penetration is likely, a fluid resistant gown should be used. Clean gowns are generally used for isolation. Sterile gowns are only necessary for performing invasive procedures, such as inserting a central line. In this case a sterile gown would serve purposes of patient and healthcare worker protection.

D. Face Protection

1. Masks protect the nose and mouth. The mask should fully cover the nose and mouth and prevent fluid penetration.
2. Goggles are used to protect the eyes. They should fit snugly over and around the eyes. Personal glasses are not a substitute for goggles.
3. Face shields protect the face, nose, mouth and eyes. It should cover the forehead, and extend below the chin and wrap around the side of the face.

E. Respiratory protection devices are used to protect from inhalation of infectious aerosols. PPE types include particulate respirators (N-95 masks), half powered air purifying particulate respirators (PAPR). Refer to the Respiratory Protection Program for additional information.

F. Key Points about PPE

1. Don before contact with the patient, generally before entering the room.
2. Use carefully- don’t spread contamination.
3. Remove and discard carefully, either at the doorway or immediately outside the patient room; remove respirator outside room.
4. IMMEDIATELY perform hand hygiene.

G. Sequence for Donning PPE

1. Gown first
2. Mask or respirator
3. Goggles or face shield
4. Gloves.

H. How to Don a Gown

1. Select appropriate type and size

2. Opening is in the back
3. Secure at neck and waist
4. If gown is too small, use two gowns. Gown #1 tie in front. Gown #2 ties in back

I. How to Don a Mask

1. Place over nose, mouth and chin.
2. Fit flexible nose piece over nose bridge.
3. Secure on head with ties or elastic.
4. Adjust to fit.

J. How to don Eye and Face Protection

1. Position goggles over eyes and secure to the head using the ear piece or headband.
2. Position face shield over face and secure on brow with headband.

K. How to Don Gloves

1. Don gloves last.
2. Select correct type and size.
3. Insert hands into gloves.
4. Extend gloves over isolation gown cuffs (if needed).

L. How to Remove PPE

The sequence for removing PPE is intended to limit opportunities for self-contamination. The gloves are considered the most contaminated pieces of PPE and are therefore removed first. The face shield or goggles are next because they are more cumbersome and would interfere with removal of other PPE. The gown is third in the sequence, followed by the mask or respirator.

“Contaminated” and “Clean” Areas of PPE

1. Contaminated areas of PPE have or are likely to have been in contact with body fluids, materials, or environmental surfaces where the infectious organism may reside. The outside front is generally contaminated.
2. Areas of PPE that are not likely to have been in contact with the infectious organism are considered clean. The inside, outside back, ties on head and back are generally considered clean.

Sequence for Removing PPE

1. Gloves
2. Face Shield or goggles
3. Gown
4. Mask or respirator

M. How to Remove Gloves

1. Grasp outside edge near wrist.
2. Peel away from hand, turning glove inside out.
3. Hold in opposite gloved hand.
4. Slide ungloved finger under the wrist of the remaining glove.
5. Peel off from inside, creating a bag for both gloves.
6. Discard.

N. Remove Goggles or Face Shield

1. Grasp ear or head pieces with ungloved hands.
2. Lift away from face.
3. Place in designated receptacle for reprocessing or disposal.

O. Removing Isolation Gown

1. Unfasten ties.

2. Peel gown away from neck and shoulder.
 3. Turn contaminated outside toward the inside.
 4. Fold or roll into a bundle.
 5. Discard.
- P. Removing a Mask
1. Untie the bottom, the top, and tie.
 2. Remove from face.
 3. Discard.
- Q. Hand Hygiene
1. Perform hand hygiene immediately after removing PPE. If hands become visibly contaminated during PPE removal wash hands before continuing to remove PPE.
 2. Wash hands with soap and water or use an alcohol-based hand rub.

Transmission Based Precautions

Transmission of infection within a hospital requires three elements: a source of infecting microorganisms, a susceptible host, and a means of transmission for the microorganism.

Standard Precautions were developed to protect HCW's and patients from the transmission of Bloodborne Pathogens. Included in these guidelines are hand hygiene and gloves. Gloves should be worn whenever contact with blood, mucous, urine, stool, spinal fluid, and other fluids are anticipated.

Airborne Precautions

1. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei. Examples of such illnesses include:
 - Measles(Rubeola)
 - Varicella-chicken pox (including disseminated zoster)
 - Tuberculosis
 - Smallpox
2. SPECIFICATIONS FOR AIRBORNE PRECAUTIONS:
 - Place patient in a private isolation room that has monitored negative air pressure with 6-12 air changes per hour and appropriate discharge of air outdoors or with monitored high-efficiency filtration of room air before the air is circulated to other areas of the hospital.
 - Door must be kept closed and the patient must stay in the room.
 - In general, patients who have active infection with the same microorganism and no other infection may share the same room, if needed.
 - Hepa-filter mask must be worn when entering the room of a patient with known or suspected infectious pulmonary tuberculosis.
 - Personnel or visitors susceptible to measles (rubeola) or varicella (chickenpox) should not enter the room if other immune caregivers are available. If susceptible persons must enter the room, they should wear respiratory protection. Persons immune to measles (rubeola) or varicella (chickenpox) need not wear respiratory protection.
 - If transport or movement is necessary, for essential purposes ONLY, place a surgical mask on the patient, if possible.
 - Standard/Universal Precautions MUST be followed.

3. Fit testing for N-95 masks is required prior to entering the room of a patient on airborne precautions.
4. Students are not to enter the rooms of patients on Airborne Isolation without their instructor's permission.

Droplet Precautions

1. In addition to Standard Precautions, use Droplet Precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include:
 - Flu
 - Mycoplasma pneumonia
 - Diphtheria-pharyngeal
 - Mumps
 - Whooping Cough
2. SPECIFICATIONS FOR DROPLET PRECAUTIONS
 - Place the patient in a private room and door may remain open.
 - Maintain at least 3 feet between the infected patient and the other patients and visitors.
 - A mask must be worn when working within 3 feet of the patient or you may put a mask on prior to entering the room.
 - Limit the transport of the patient to essential purposes ONLY. If necessary to transport the patient, a surgical mask must be worn by the patient, if possible to minimize the dispersal of the droplets.
 - Standard Precautions must be followed.
 - Discontinue droplet precautions after signs and symptoms have resolved or according to pathogen specific recommendations.

NOTE: For patients with suspected SARS or Avian influenza wear both respiratory and eye protection (goggles or face shield).

Contact Precautions

1. In addition to Standard Precautions, use Contact Precautions for patients known or suspected to have serious illnesses transmitted by direct patient contact or contact with items in the patient's environment. Examples of such illnesses include:
 - VRE/MRSA
 - C-Difficile diarrhea
 - RSV
 - Chicken pox
2. SPECIFICATIONS FOR CONTACT PRECAUTIONS
 - Patient should be placed in a private room. If needed, may place the patient in a room with another patient who has active infection with the same microorganism but no other microorganism.
 - Limit the movement and transporting of the patient from the room to essential purposes ONLY. If patient must be transported out of the room, ensure that precautions are maintained to minimize the risk of transmitting the microorganisms to other patients and contaminating environmental surfaces or equipment.
 - Whenever possible, limit the use of non-critical patient-care equipment to a single patient (or share with patients infected or colonized with the same microorganism)

- to avoid sharing between patients. If the use of common equipment or items is unavoidable, clean and disinfect them before use on another patient.
- Wear a gown (a clean, non sterile gown is adequate) when entering the room if you anticipate your clothing to come into contact with the patient, environmental surfaces, or items in the patient's room, or if the patient is incontinent or has diarrhea, an ileostomy or colostomy, or if the patient has a wound draining that is not contained by the dressing. The gown is to be removed before leaving the room. Afterwards, take extreme care that clothing does not come in contact with surfaces to avoid transfer of microorganisms to other patients or the environment.
 - Gloves **MUST** be worn (clean, non-sterile gloves are adequate). Wear gloves when entering the room and during the course of providing care for the patient. Gloves should be changed after having contact with infective material (stool and wound drainage). Remove gloves before leaving the patient's room and wash hands **IMMEDIATELY** with an antimicrobial soap. Afterwards, ensure that hands do not touch contaminated surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or the environment.
 - Discontinue Contact Precautions after signs and symptoms have resolved or according to pathogen specific recommendations.
3. If reusable items/equipment are taken into the room these items should be cleaned upon exit with an approved germicidal (PDI Super SaniCloth). Examples of such items include:
- Stethoscopes
 - Ink pens
 - Medication cart
 - Dinamapp
 - Portable X-ray machines
 - EKG machines
 - Thermometers
4. MRSA (Methicillian Resistant Staph Aureus) and VRE (Vancomycin Resistant Enterococcus) are examples of multi drug resistant organisms (MDRO's). These are transmitted by direct patient contact or by contact with items in the patient's environment. Many patients are colonized with MRSA; some are infected with MRSA. Contact Plus Precautions are used to prevent the spread of this organism.

Contact Plus

Contact Plus is used for all patients with MRSA and only MRSA. Contact Precautions are followed as outlined in the previous section. Add a mask to the gown and gloves to help prevent colonization of your nose.

Protective Precautions

Protective Precautions are used for immunocompromised patients. Fresh fruits and vegetables are not permitted in room except bananas and oranges when peeled in the room. No plants or flowers allowed. Wear gloves and a mask when in the room.

Bloodborne Pathogens

HIV, Hepatitis B&C are considered Bloodborne Pathogens. The single most important measure to preventing transmission of HIV, HBV and HBC is to treat all human blood and other potentially

infectious materials as if they are infectious. Standard Precautions are used to prevent the transmission. These are viruses transmitted by:

- Needlestick injuries
- Cuts, scraps, and openings in the skin
- Splashes into the mouth, nose or eyes
- Oral, vaginal or anal sex
- Sharing infected drug needles
- Perinatal transmission

Bloodborne Pathogen Exposure

Exposure means that you have been exposed to blood and/or body fluids by one of the following ways:

- Your skin has been punctured by a needle or any sharp object contaminated with blood or body fluids.
- A splash that results in blood or body fluids coming in contact with your mucous membranes (i.e. blood splashed into your eyes, nose or mouth).

Remember **W-I-N**

Wash the area thoroughly

Identify the source- whose blood or body fluid was it? What route was used for your exposure? Needle? Blade? Suction contents?

Notify your instructor-preceptor that the exposure has occurred. Call the Infection Prevention/Employee Health office ASAP. Prompt notification of the Infection Prevention/Employee Health office helps to ensure the lab work from the source is obtained quickly and checked for HIV, Hepatitis B&C. If the Infection Prevention/Employee Health office is not available, notify the Nursing Supervisor. Notify the Department Manager.

After any blood and/or body fluid exposure, it is important for you to report to your immediate supervisor and complete a System Investigative Report. Baseline lab work will be drawn on you for HIV and Hepatitis B&C. The emergency room physician will then review the patient information. The source individual will be tested for HIV and Hepatitis B&C. The HIV test is a rapid results test only on the source individual's blood and results are available in 20 minutes. HIV prophylaxis is available if indicated.

The Infection Prevention/Employee Health office will contact you about the results of your lab results and those of the source. Recommended follow-up will be included.

STAY SAFE

Be sure to activate all safe needle devices after use. The safety device is only as good as the user.

Identification of Patients

1. All patients shall have an identification arm bracelet applied upon admission. Information on the patient's arm bracelet may be used as a means of identifying the patient.
2. Patients admitted through the Admitting Office shall have the arm bracelet applied by the admission clerk while in the Admitting Office.
3. The arm bracelet shall be checked before any treatment or medication. If the arm bracelet is used as the sole means of identifying the patient (i.e., unconscious patient), two identifying pieces of information from the arm bracelet must be matched, (e.g., the patient's lab requisition form, MAR record, physician's order, etc.) This information should be verified with family members.
4. The arm bracelet shall not be removed unless the patient's welfare necessitates such removal.
5. If an arm bracelet is removed or comes off, another arm bracelet should be obtained and applied immediately.
6. Except in emergency, no procedure is to be done when the patient's identity cannot be verified by the arm bracelet.
7. Standardized color coded wristbands will serve as a visual cue to alert caregivers of medical choices or conditions and provide an opportunity to prevent errors related to the following:
 1. Allergies (Red)
 2. Fall Risks (Yellow)
 3. Documented **full** Do Not Resuscitate advanced directives (Purple)

Wristband Color	Communicates
Red	ALLERGY
Yellow	FALL RISK
Purple	DNR

Emergency Delivery

8. Newborn Patients:

An identification band is placed on the infant's arm, leg, and mother's arm in the delivery room. All three bands contain the same information (name and sex of child, date and time of delivery, doctor and pediatrician).
9. Blood Identification Band (Red on White):
 - a. Blood ID bands are applied by laboratory personnel when the first cross match is drawn.
 - b. The Blood ID band is to remain on the patient at all times for the crosschecking identification number on unit of blood.
10. Outpatient Surgery Patients (Green):

- a. All Outpatient Surgery patients shall have an arm bracelet applied upon admission to Outpatient Surgery Unit.
- b. The arm bracelet will be replaced by a regular arm bracelet (white) if the patient is admitted.
- c. The Outpatient Surgery arm bracelet will be green in color to distinguish Outpatient Surgery patients from regular patients.

11. Out Patients:

- a. All outpatients shall have an arm bracelet applied by the outpatient clerk prior to any treatment or testing.
- b. The arm bracelet will be replaced by a regular arm bracelet (white) if the patient is admitted.
- c. The outpatient arm bracelet will be green to distinguish outpatients from Emergency patients or Inpatients.

12. ALWAYS USE TWO IDENTIFIERS TO IDENTIFY A PATIENT

- a. Patient Name
- b. Date of birth

DO NOT USE THE ROOM NUMBER AS A METHOD OF IDENTIFICATION!!!

Medication Administration

Administration of Medications

1. Medications will be administered in this hospital by Registered Nurses, Licensed Practical Nurses, Physicians, Radiology Technicians, Respiratory Therapists, Nursing Students, Medical Students, Physician Assistants, Nurse Practitioners, and Certified Registered Nurse Anesthetists who receives adequate instructions in and orientation to our medication administration system.
2. Medications are not to be administered without a physician's order. The order must be checked and signed by the nurse before administering initial dose.
3. In the Emergency Room, verbal orders may be acted upon in life threatening situations- otherwise all orders must be written.
4. The pharmacist will review all medication orders for appropriateness.
5. Medications are to be transcribed and administered in accordance with the routine hours that have been established for our hospital, example TID (10a-2p-6p). The initial dose is to be given as soon as possible after ordered, then the next dose given as scheduled, unless specific times have been set up, for example: Coumadin given at 5pm unless specifically ordered otherwise.
6. Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible. Verbal or telephone orders must be authenticated by a physician within 48 hours.

Verbal orders for medications may be received by the following:

- Registered Nurse
- Licensed Practical Nurse
- Respiratory Care Practitioner (for respiratory therapy treatment)
- Physical Therapist (for physical therapy orders)
- Dietician(for dietary orders)
- Pharmacist.

When taking a verbal order from the prescriber, the entire order must be written and read back to the prescriber. If there is any question regarding the name of the drug requested by the prescriber, the following safety suggestions are recommended:

- The name should be spelled and read back, stating both brand and generic names and the indication for use. This should be charted with each order, example, T/O Dr. Rose/ C. Brown RN W/R/V @ 11:50am.
- Additional spelling assistance methods , such as S as in Sam, can be used to avoid confusion with drug name modifiers, such as prefixes and suffixes.

- To avoid confusion with spoken numbers, a dose such as 50 mg can be repeated back as “fifty milligrams ... Five Zero milligrams” or 15 milligrams can repeat back as “fifteen milligrams... One Five milligrams”.
- Questions about verbal orders should be resolved prior to preparation, dispensing or administration of the medication.

Students are not allowed to take or give verbal orders.

7. Medication orders should include:

- Date and time of the order.
- Age and weight of the patient, when appropriate.
- Complete name of medication, strength, (concentration- if applicable), and frequency.
- Dosage and/or amount to be given at each administration.
- Rate and/or route of administration for IV medications.
- Duration of number of dosages indicated.
- Signature of physician when written.
- Purpose or indication of the medication for PRN's.
- Name of the individual transmitting the order, if different from the prescriber.
- Name of prescriber and telephone number when appropriate (for example- Hospice patients).

Medications are administered to patients only upon an order from a physician who is a member of the Medical Staff. They may be administered by Physicians, Registered Nurses, Licensed Practical Nurses, and student nurses from affiliated schools of nursing under the supervision of their instructors. Radiology Techs may administer contrast media. Nuclear Medicine Tech may administer radioactive contrast media.

Routine drugs are administered as ordered by the physician according to assigned schedule. In administering analgesic drugs documentation will include:

- a. Need
- b. Location of administration (right deltoid, left deltoid, etc.)
- c. Location of pain (operative side, right shoulder)
- d. Evaluation of effectiveness

All “PRN”, “STAT”, and “one-time only” drugs will be recorded on the supplementary medication record or MAR.

For further information concerning ordering of drugs, etc., refer to the Procedure Manual and to the Pharmacy Manual.

- 8.** A medication order may not be changed by crossing out a word or number. The entire order must be discontinued and order rewritten.
- 9.** Nursing Staff are responsible for safe administration of medication and must be aware of drug implications, proper dosage, etc. Each nurse is responsible for his/her own actions.

The first dose of new medications will be closely monitored by observing for adverse effects, lab results when appropriate, and other measures deemed necessary.

10. The (2) two identifying factors used to administer medication are the patient's name and date of birth; both are printed on the patient's arm bracelet as well as the medication administration record.

11. The medication cart should never be left unlocked when unattended. When giving medication, the cart and MAR should be in eye line view. Medication should never be borrowed from one patient's drawer for another patient. When the cart is not in use, the cart should remain locked.

12. Routine medication must be administered within time period of either 30 minutes before or 30 minutes after the regular scheduled dose. Never back up to administer a missed dose. Never pre set-up medications. The effects of the medications are monitored and documented as appropriate. All "STAT" drug orders are to be called to the pharmacy. If the requested medication is not received on the unit within 15 minutes, licensed personnel should bring a copy of the order sheet to the pharmacy and pick up the medication. At time of order called to pharmacy, nursing will be notified to pick up medication if pharmacy is unable to deliver on "STAT" and "NOW" medications.

"NOW" drugs orders are handled in the same manner but with somewhat less urgency. If the "NOW" medication is not received within 30 minutes, the pharmacy should be notified or the nurse may pick up the medication.

NO DRUG REQUESTS ARE TO BE LEFT ON THE PHARMACY VOICEMAIL.

Nursing home routine medications must be administered timely- within 2 hours of scheduled time of administration (1 hour before or 1 hour after).

13. Medication errors, if indicated, must be reported immediately to the charge nurse and physician and an occurrence report completed. The occurrence is recorded on the patient's chart but not as an "error" or "incident" just the factual data. Do not chart that an "occurrence report was completed". This includes medication that are administered in error and medications administered by physicians.

14. Nursing personnel must be aware of and alert to any signs of Adverse Reaction or drug sensitivity. If any reaction is noted, the medication must be withheld and the physician contacted immediately (see ADR policy)

15. Automatic stop order drugs are as follows:

- Narcotics 72 hours
- Antibiotics 10 days
- Anticoagulants 4 days
- Hypnotics 4 days

All charts are to be reviewed by the 7pm-7am shift and tagged with a sticker on the physician order sheet for reorder. If the physician does not reorder, then the medication is automatically discontinued.

ECF Medications are reordered every 30 days if the resident has a skilled level of care and every 60 days if an ICF level of care.

16. Nurses must be familiar with and adhere to the “ Intravenous Therapy Administration Policy.” All newly employed RN’s and LPN’s will receive instruction in and become qualified to administer IV medication.

Registered Nurses who have demonstrated competency may

- Perform Venipuncture
- Regulate IV Fluids
- Administer IV Medications
- Start IV Fluids
- Administer Blood and Blood Products
- Administer IV fluids containing medication

Licensed Practical Nurses who have demonstrated competency after 40 hour class and at the direction of the Registered Nurse may:

- Perform Venipuncture
- Administer selected IV Medications via IVPB
- Start selected IV Fluids
- Administer selected medications via IV push
- Administer selected IV Fluids containing medications
- Regulate certain IV fluids

IV Medications and products that **MAY NOT** be administered by a Licensed Practical Nurse on the Med/ Surg. floor are as follows:

- Blood and Blood Products
- Chemotherapy
- Central Line Care/ including antibiotics
- Oxytocies/Tocolytics
- Thrombolytics
- Pediatrics < 18 Y.O.
- Titrated Meds
- Moderate sedation
- Anesthetics
- Paralytics
- Investigational drugs
- Experimental drugs
- Adults < 80 lbs.
- OB Patients- pre/ante partum

Each RN and LPN will have the “ authorized to administer IV therapy” signed and placed in their personnel file. Annually, each RN and LPN will demonstrate proficiency in IV therapy. Each RN and LPN will be assessed by their nurse manager and orientation/competency manager.

17. Multi-dose vials- When a multi-dose vial is opened it must be tagged with date the vial is opened, and the unused portion discarded after 30 day. Discard multi-dose vials when empty, when suspected or visible contamination occurs or when the manufacture's expiration date is reached with the exception of insulin which must be dated when opened and the unused portion discarded within 28 days.

18. Narcotics are stored in either the Omnicell or double-locked containers. For surgery, an RN or LPN will carry the key and will be responsible for narcotics during their shift. Only one key will be shared by the RN and LPN that have performed the actual count of narcotics. Medication room doors must be locked at all times. Narcotics must be signed for on the narcotics administration form when the medication is removed from the narcotics box and on the MAR by the person administering the medication. The responsible nurse will count narcotics with the on-coming nurse (RN or LPN) at the end of each shift. Narcotics are kept in the Omnicell medication dispensing machine on all stations. Both nurses must visually count the narcotics. If there is any discrepancy, both nurses will review and follow-up with the charge nurse of the floor, nursing supervisor and pharmacy as required. There is a mandatory cycle count of narcotics after each shift at all stations.

- If a narcotic is missing, cannot be accounted for, or appears to have been tampered with (example, safety seal loose, or broken) the nurse finding the incident should immediately notify the charge nurse of the floor, nursing supervisor, and the pharmacy.
- If waste occurs during surgery, two licensed personnel (the administering nurse and the witnessing nurse) must sign the appropriate space on the narcotics record. The amount of waste must also be documented. If waste occurs at the nursing stations, it is recorded in the Omnicell requiring the same protocol as above.
- Narcotics and quantity of each will be established by the Director of Nursing along with the pharmacy.
- When a narcotic is needed in surgery, the complete narcotic administration form is returned to the pharmacy for replacement.

19. Medication orders are sent to the pharmacy via the yellow carbon copy on the back of the physicians order sheet along with faxing the original copy to the pharmacy. All headings must be completed before sending orders to the pharmacy. Ensure the patient's name, date of birth, room number, bed assignment and hospital number is correct on the copy. Also, make sure the drug order is legible.

- The yellow copy of the physicians order sheet must have the patient's allergies and weight recorded.
- All remaining spaces on the white copy of the order sheet must be crossed out after the yellow copies are removed to prevent orders being missed by the pharmacy (after third copy is removed).

20. The UNIT DOSE MEDICATION SYSTEM is utilized at this hospital. Policy pertinent to this system includes the following:

- Pharmacists check each medication order before the medication goes to the unit and check each medication cart before it leaves the pharmacy.

- The medication cart must be kept current. If a patient is moved; the medication should be moved to the correct drawer in the medication cart. When a patient is discharged, remove all drugs in the discharged patient's drawer and place them in the bottom drawer of the medication cart. The pharmacy personnel will then pick up the medication.
- The nurse is responsible for placing the discharged patient's MAR in the pharmacy bin. The pharmacy personnel will process charges then return the MAR to the unit secretary to file on the charts.
- If more space is needed to write new orders, a blank MAR can be printed. (1 or 2 days as needed).
- The medication administration record sheet must be neat, accurate and legible.
- All medications must be charted after they have been administered. Narcotics must also be signed out in the narcotic book in OR and ECF at the time they have been removed from the narcotic box and before being administered, where applicable.
- When a patient is discharged from the facility, all medications are documented on the Home Medication Assessment and Order sheet along with the patient Medication Education Sheets given with complete instructions for administering in language the patient will understand. All prescriptions written by the physician will be given to the patient or responsible party. The discharge medication may be called to the patient's pharmacy of choice. This may be performed by licensed personnel if written orders do not exist., Schedule II narcotics (CII's) are excluded.
- A copy of each prescription given at time of discharge becomes a part of the medical record.

DRUG SAFETY

- Medications should not be borrowed between patients.
- Unused medications prepared by nursing personnel must be discarded by flushing down the sink/commode.
- Dispose used Duragesic patches in the sharps container in the medication room.
- All medications must be labeled clearly before administration.
- Medication carts must not be left unlocked if unattended.
- Medication must not be left at the patient's bedside.
- The nurse must be certain that the patient has taken the medication before leaving the bedside.
- Read the medication label 3 times before administering the medication.

ALWAYS FOLLOW THE FIVE RIGHTS

1. Right Patient
2. Right Route
3. Right Medication
4. Right Time
5. Right Dose



**DO NOT USE THESE DANGEROUS ABBREVIATIONS
OR DOSE DESIGNATIONS**

ABBREVIATION	POTENTIAL PROBLEM	PREFERRED TERM
μg	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.	Write "mcg"
D/C	Interpreted as discontinue whatever medications follow (typically discharge meds)	Write "discharge"
Q.D. Q.I.D. Q.O.D.	Mistaken for each other. The period after the Q can be mistaken for an "l" and the "O" can be mistaken for "l".	Write "qday or daily" Write "4 times daily" Write "every other day"
U (for Unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (10).	Write "international unit"
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	NEVER write a zero by itself after a decimal point (X mg), and ALWAYS use a zero before a decimal point (0.X mg)
MS MgSO4 MSO4	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine sulfate" or "magnesium sulfate" or "mg sulfate."

Administration of Home Medications

Claiborne County Hospital seeks to provide a safe environment for all patients regarding medication administration.

PROCEDURE:

- 1.** Medications brought from home will be listed in the nursing assessment menu in the HMS computer system. The home medication assessment order sheet will be used to list home medications for patients admitted through the ER.
- 2.** Medication from home will be properly controlled in any of the following ways:
 - a.** Returned to the family of the patient for removal from the hospital.
 - b.** Stored in the safe on west wing properly secured with medication name and quantity written on the outside of the valuables envelope. Two nurses must count and witness (two signatures on outside of envelope) any medication being stored in the safe. Every attempt will be made to return all medications back to the patient. However, any medication left greater than 30 days will be destroyed per hospital policy. Nursing to return to pharmacy for disposition.
- 3.** The disposition of the home medications must be documented in the computer system under the patient care notes section.
- 4.** If the pharmacy cannot obtain a home medication that is ordered, but the patient has their own supply, the patient may use their own medication. The doctor must write an order for the patient to use home medications. The pharmacy must identify/checks visually, evaluates the medication's integrity and label that the medication has been verified. It can be very difficult, if not impossible, to identify and visually evaluate the integrity of liquid medications, such as eye drops, in an unsealed medication container. In these situations, it is recommended that the medication be discarded or returned to the patient, with the understanding that it will not be administered by the staff of the hospital. If the medication can be used it will be placed in the medication cart and the nurse will administer. It should be written on the medication administration record with the notation "Home Medication".
- 5.** NO herbal medications will be continued during the patient's hospital stays.
- 6.** Self administration of medications is prohibited throughout CCH.

Adverse Drug Reactions (ADR)

Definition:

Any response to a drug that is unintended and that occurs at doses within normal limits that result in:

1. An increased length of stay
2. Requires treatment with a prescription medication
3. Temporary or permanent disability
4. Is reported to the FDA
5. Death
6. Hospitalization and/or
7. Is toxic to the patient

Adverse Drug Reactions result in death, permanent disability/loss of limb, and markedly prolonged hospitalization will be classified as severe. All others will be classified as moderate.

Policy:

All adverse drug reactions must be reported to the patient's physician and a suspected adverse reaction reporting form completed.

Mechanisms to identify Adverse Drug Reactions:

1. Physicians or nurses to assess the patient for reaction.
2. Pharmacist review of orders which may indicate significant reaction (i.e., need for Epinephrine, Benadryl, Corticosteroids, etc.)

Procedure:

1. Notify the attending physician.
2. Fill out suspected Adverse Drug Reactions reporting form.
3. Mark patients chart, kardex, computer allergy screen, and MAR with allergy to the medication.
4. Document with complete description of reaction, onset, and interventions in the nurse's notes.
5. Students are to report each ADR to their instructor who will be responsible for reporting to floor/ unit nurse.
6. Report on a quarterly basis all significant Adverse Drug Reactions to the Medical Staff via P&T Committee.

Dispensing of Medication

1. By the Pharmacist or his/her designee, under the supervision of the Pharmacist.
2. Dispensing for hospital, nursing home residents and hospice patients.
3. Pharmacist will receive a faxed or carbon copy of all medication orders for review of appropriateness of the drug, dose, frequency, and route of administration, therapeutic duplications, real or potential allergies, real or potential interactions between prescriptions or food, current or potential impact as evidenced by laboratory values. All concerns, issues, or questions are clarified with the individual practitioner before dispensing of the medication.

There are three exceptions to the above statement:

- a. When a licensed independent practitioner prevents the dispensing and administration of the drug, such as in the Operating room and Emergency room.
- b. Medications ordered “STAT” or “NOW” or when the patient would be clinically harmed by the delay resulting from the Pharmacist review of the order.
- c. In emergency situations.

The above exceptions are reviewed the next workday. The orders are entered into the computer and checked by the RN or LPN before the order is signed off. All carbon copies are sent to the pharmacy and the pharmacist will also verify the orders as well. Medication orders are retained until the patient is discharged.

4. Drugs are ordered, dispensed, or administered only by members having privileges and credentialed to be either an active, courtesy staff member or approved physician agent.
5. All medication will be dispensed out individually for each patient and unit-dose packaging whenever available.
6. Each computer label will have the following information: patient's name, room number, drug name, drug strength, and cautionary statement as appropriate. Any needed information to administer the medication is added to the label for administration, the same information will appear on the Medication Administration Record.
7. Any time one or more medications or solutions are prepared and not immediately administered, the medication container must be labeled. The label should include drug name, strength, amount if not apparent, and expiration date when not used within 24 hours. IV mixture labels must also include the date prepared. When preparing individualized medications for multiple patients or the person preparing is not going to administer the medication, the label must include: patient name, patient location, directions for use, and any precautionary statements.
8. Patient medication profile is maintained in the computer system. It contains: patient name, drug name and strength, date dispensed, quantity dispensed, allergies, age weight, height, sex, pregnant/lactating, diagnosis, and any other information needed for safe medication management. This makes the information accessible to Licensed Independent Practitioners and staff who participate in the management of the patient's medications.

9. The Medication Administration Records are printed for 2 days usage. They are checked for accuracy by the 12 hour chart check by the nursing staff along with the Pharmacist checking each order. The active medication order record report is checked by the Pharmacist daily for duplication of therapy, etc. The medication nurse denotes on the Medication Administration Record the giving of medication by crossing a line through the time and initialing next to it after administration. If the patient refuses the medication or it is not given, the time is circled and the nurse initials next to the time.
10. Medications are stored under proper conditions of temperature and security. Lockable medication carts are used to store unit of use medications in the patient medication dose system. These carts will be locked when not attended.
11. Medication rooms on patient care units used for storage of floor stock medications will remain locked. Access is limited to approved licensed nursing personnel.

Medication Occurrence Policy

Claiborne County Hospital and Nursing Home strive to provide care regarding medication administration in a safe and efficient manner. An Occurrence Report must be written, by the person whom is involved in the occurrence or by the person discovering the occurrence. Any medication occurrence will be immediately reported to the charge nurse or nurse manager as well as the attending physician if the occurrence results in the need for treatment or intervention, then the occurrence report will be completed and submitted to the Department Manager, Director of Risk Management/QMC, and Director of Pharmacy. The report will be reviewed by the P&T Committee.

Purpose:

1. Provide hospital with pertinent information
2. Determine cause and identify means of preventing future errors
3. Determine needs for in-service education
4. Provide information for follow-up counseling

Medication Error Defined as:

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the prevention of the health care professional or patient. Such events may be related to professional practice, healthcare products, procedures, or processes including: prescribing, order communications, products labeling, packaging, compounding, dispensing, distribution, administration, education, and monitoring.

Procedure:

1. Once a medication occurrence is identified, the patient's physician will be notified immediately if the occurrence results in the need for treatment or intervention. If no treatment is needed the physician will be notified at the time the physicians make rounds. The nurse manager or supervisor on duty is to be notified at the time of the occurrence or when it is first discovered.
2. A Medication Occurrence Report is completed and submitted to the Director of Nursing.
3. Upon receiving the report, the Department Manager/Nurse Supervisor will investigate the occurrence and interview the employee(s) involved and appropriate follow-up will be determined after this process by the Director of Nursing or applicable Department Manager. An addendum will be completed by the supervisor along with the employee to aid in preventing future occurrences.
4. The Department Director will then route to the Risk Management Director and the Director of Pharmacy.
5. Occurrences will be categorized due to the levels of severity and trending.

Procedure for Completing Medication Occurrence Report

Reporting an Actual Medication Error

- a. Incidents are documented by utilizing the Medication Occurrence Report by one who actually observed the incident or one to whom the incident was reported.
- b. A Nursing Supervisor Department Manager should be notified to evaluate the situation and to assess the need for immediate medical attention.
- c. Notify the patient's attending physician of the event.
- d. If the patient or visitor is seen by a physician for evaluation following the incident, the physician's findings are to be documented in the "Corrective Actions" section of the Medication Occurrence Report.

Reporting a Non Medication Error event

- a. A visitor requesting or requiring medical attention is to be evaluated by the Nursing Supervisor and then escorted to the Emergency Room.
- b. If the individual refuses medical attention, indicate this on the System Investigative Report.
- c. When completing the System Investigative Report take care to include all details concerning the event, identifying potential witnesses and employees, the area in which the event occurred, lighting, any obstructions to vision or walking, etc.
- d. After completion of a System Investigative report, a Department Director/Nursing Supervisor should be notified for review and follow-up. Early intervention can not occur if occurrences are not reported in a timely fashion. Occurrence notification should take place as soon as an event is discovered.
- e. The Risk Manager is to be notified immediately of any event involving a patient or visitor which could result in a potential claim involving the health care system. This notification should be accomplished by telephone (leave message) or paging for the Risk Manager to discuss the event. Pictures of the site may also be important to the investigation. If the Risk Manager cannot be reached, Administration should be notified.
- f. The Risk manager and/or his/her designee will review all System Investigative Reports for completeness and accuracy and the documentation in the patient's chart, if applicable.
- g. System Investigative Reports /Medication Occurrence Reports will be classified by severity

Pain Assessment & Documentation

The patient's right to pain management is respected and supported. The organization plans, supports, and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately, including but not limited to those outlined below.

To assess and manage pain properly, the nurse should depend on the patient's subjective description in addition to objective tools.

Pain intensity rating is recorded during the admission assessment and with each episode of pain.

Several interventions may be used to manage pain, including analgesics, emotional support, comfort measures, and cognitive techniques to distract the patient. Severe pain may require a narcotic analgesic.

Narcotics and other analgesics require a physician's order.

Standing orders for mild analgesics may be utilized as indicated by the degree of pain a patient is experiencing. When standing orders are utilized, the nurse should write the standing order on the patient's physician order sheet, along with the name of the physician, nurse, date and time the order was written.

Narcotic analgesics must be administered according to hospital policy.

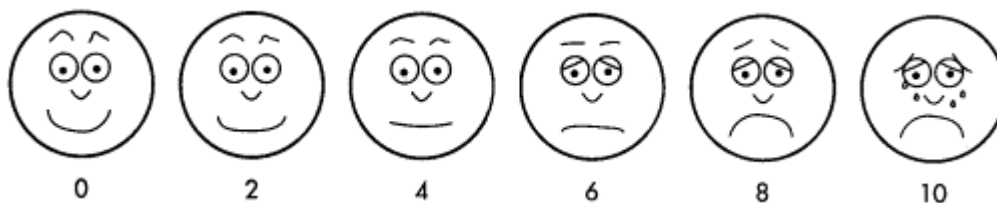
PROCEDURE:

Assessment

1. The nurse should assess the patient's pain level by asking essential questions and noting the response to pain. The patient should be asked to describe the duration, severity, and source of pain. Assess for physiologic or behavioral clues to the severity of pain such as crying, moaning, grimacing, restlessness, withdrawal, insomnia, slow movement, or elevated vital signs. This should be done during every initial assessment, shift assessments, and regular reassessment of pain according to the level of pain.
2. During the initial assessment of all patients, the nurse identifies patients with pain.
3. All patients at admission are asked the following screening or general questions about the presence of pain: Do you have pain now? Have you had pain in the last several weeks or months? If the patient responds "yes" to either question, additional assessment data is obtained about the following elements:
 - a. Pain intensity (show patient a Pain Scale appropriate for the patient population and ask them to rate the pain).
Adults: scales of 0 (none) to 10 (worse pain imaginable)
Pediatrics: Wong Baker FACES
Newborns: Neonatal Infant Pain Scale (N.I.P.S.)
* If adult cannot understand or is unwilling to use 0-10 scale, the Wong Baker may be used.
 - b. Location (ask patient to mark on a diagram or point to the site of pain (there may be more than one site).
 - c. Quality, patterns of radiation, if any, character
 - d. Onset, duration, variation and patterns
 - e. Alleviation and aggravating factors
 - f. Present pain management regimen and effectiveness
 - g. Pain management history
 - h. Effects of pain on daily life
 - i. Patients/families pain goal

4. Medicate for patient as described by patient per physician's order and/or utilize alternatives as appropriate (i.e., distraction, positioning, breathing techniques, etc.).
5. Document time site, intensity per pain scale, medication administered and route.
6. Reassess every 1 hour. Document response using pain scale, if patient states no change or increase in pain, consider further action (i.e., repositioning, relaxation technique, additional medication, or notification of physician). If patient reports decrease in pain or pain free every 1 hour, reassess as noted level intensity.
7. Patients and families receive information verbally and in print format at the time of initial evaluation that effective pain relief is an important part of their treatment.
8. Explain to the patient how pain medications work together with other pain management therapies to provide relief. Explain that the goal of pain management is to keep pain at a low level to permit optimal bodily function.
9. Develop appropriate nursing diagnoses, such as pain, anxiety, activity intolerance, and fear, potential for injury, knowledge deficit, powerlessness and self-care deficit.
10. Work with patient to develop and implement a nursing care plan, using interventions appropriate to the patient's lifestyle. Interventions may include prescribed medications, emotional support, comfort measures, cognitive techniques, and education about pain and its management. Emphasize the importance of good bowel habits, respiratory function, and mobility.
11. Administer prescribed medications as indicated.
12. Provide emotional support. Allow patient to express his anxiety and frustration.
13. Perform comfort measures, such as repositioning, providing back massage, performing range of motion exercises, and providing oral hygiene.
14. Use cognitive therapy techniques such as distraction, guided imagery, deep breathing, relaxation, and controlling room environment.
15. Evaluate the patient's response to pain management. If the patient is still in pain, reassess and alter the plan of care as appropriate.
16. Remember that patients receiving narcotic analgesics are at risk for developing tolerance, dependence, or addiction. Assess for symptoms of physical dependence.
17. Assess for complications of adverse effects of analgesics.
18. Document each step of the nursing process: the assessment of pain, your nursing diagnosis, implementation of pain relief methods, and the patient's response to pain management techniques.

Wong Baker Faces Pain Scale



Restraint Use

Leadership at Claiborne County Hospital and Nursing Home is dedicated to fostering an organizational culture limiting the use of restraint to clinically justified situations only and seeks to reduce, the ultimate goal of eliminating, the use of restraints through the following mechanisms while maintaining patient safety.

It is the policy of this facility to protect the patient and preserve the patient's rights, dignity, and well being during restraint use by:

- Respecting the patient as an individual
- Maintaining a clean and safe environment
- Encouraging the patient to participate in his/her own care
- Maintaining the patient's privacy, preventing visibility to others, and protecting the patient from harm or harassment
- Ensure the patient has the right to be free from restraints of all forms that are not clinically necessary or imposed as a means of coercion, discipline, convenience, or retaliation by staff.
- Provide for a safe application and removal of the restraint by qualified staff.
- Monitor and meet the patient's needs while in restraints.
- Reassess and terminate restraint use at the earliest possible time.
- Require that a physician and RN shall be responsible for the use of restraints and for following the policy on informing patients of their rights. Only those care providers who are trained and competent may physically apply restraints, and only under the supervision of RN or physician under manufacturers' guidelines..

Key Point of Restraints

- Medical Surgical Restraints can only be used for a medically necessary reason and after alternatives have been documented and failed. The least restrictive method is to be used.
- Behavioral restraints can only be used when the patient demonstrated aggressive, combative, violent, behavior that places the patient, staff, and others in immediate danger and the restraint is the least restrictive method to protect the patient & others.
- Types of restraints used at CCH:
 - Mittens
 - Soft wrist/soft ankle
 - Posey vest
 - Leather (**CCU/ICU & ER ONLY**)
- Alternatives to restraints must be attempted and documented as failed prior to the initiation of restraints. Examples of alternatives include:
 - Ask family to stay with patient
 - Move to room closer to nursing station
 - Leave door open
 - Provide reality orientation/diversion activity

- Change in surroundings
 - Quiet area
 - Bed alarms, all lights
 - Pain assessment, toileting, repositioning
 - Use of sensory aids- glasses, hearing aid
- Restraints may only be initiated by a Registered Nurse who has demonstrated competency in restraint use.
 - Restraints may only be discontinued after an assessment and determination by a Registered Nurse or Physician.
 - Restraint orders must be based on a face to face physician assessment and are time limited to 24 hours for medical/surgical use and time limited to 4 hours for behavior use for adults, 2 hours for age 9-17 years, and 1 hour for ages below 9 years. Restraints may NOT be ordered PRN.
 - The patient in medical/surgical restraints must be monitored every hour and patients in behavioral restraints must be monitored every 15 minutes.

Patient Rights & Responsibilities

Patient Rights

Patients have the right to:

- To have impartial access to the medical resources of the hospital.
- To have considerate, respectful care.
- To limit the people who visit you.
- To expect your personal privacy to be respected to the fullest extent consistent with the care prescribed for you.
- To expect all communications and other records pertaining to your care, including the source of payment for treatment, to be kept confidential.
- To know the professional status of the individuals providing your care.
- To hear from your primary care physician, in language you understand, your diagnosis, the treatment prescribed, the prognosis of your illness, and any instructions required for follow-up care.
- To talk openly with your physician.
- To know the reason you are given various tests and treatments.
- To know the general nature and inherent risk of any procedure or treatments.
- To change your mind about any procedure for which you have given your consent.
- To refuse treatment and to be informed of the medical consequences of this action.
- To request consultation or a second opinion from another physician.
- To examine your hospital bill and to receive an explanation of it.
- To have information about the hospital's mechanism for the initiation, review, and resolution of patient complaints.
- To request the Ethics Committee meet to address ethical concerns in your treatment and care.
- To present any complaints you may have regarding your care by contacting the Charge Nurse at ext 2388.
- To have your chosen representative exercise these rights for you if you are not able to do so.

Patient Responsibilities

Patients have the responsibility to:

- To provide accurate and complete information about present complaints, hospitalizations, medications, and other matters relating to your health.
- To report unexpected changes in your condition to your nurse and physician.
- To notify your physician or nurse if you do not understand your diagnosis, treatment, prognosis, or what is expected of you.
- To give cooperation and to follow the treatment plan recommended for you by your Physician, nurse or allied health personnel.
- To present up to date advance directive information upon admission. NO directives can be followed without a copy of these directives being placed on your medical record.

Pediatric Rights and Responsibilities of Parent/Guardian

Patient Rights/Staff Responsibility

In addition to the rights of adult patients, children/adolescents and their parent/guardian shall have the following rights:

- Respect for:
 - Each child and adolescent as a unique individual.
 - The care-taking role and individual response of the parent.
- Provision for normal physical and physiological needs of a growing child to include: nutrition, rest, sleep, warmth, activity, and freedom to move and explore.

Consistent, supportive and nurturing care which:

- Meets the emotional and psychosocial needs of the child
 - Fosters open communication
 - Encourages human relationships.
- Provision for self- esteem needs which will be met by attempts to give the child:
 - The reassuring presence of a caring person, especially a parent;
 - Freedom to express feelings or fears with appropriate reactions;
 - As much prevention as possible over both self and situation;
 - Opportunities to work through experiences before and after they occur, verbally, in play or in other appropriate ways; and
 - Recognition and reward for coping well during difficult situations.
 - Provision for varied and normal stimuli of life, which contributes to cognitive, social, emotional and physical developmental needs:
 - Play, educational and social activities essential to all children and adolescents.
 - Information about what to expect prior to, during, and following procedure/experience and support in coping with it.
 - Participation of children/families in decisions affecting their own medical treatment.
 - Minimization of hospital stay duration by recognizing discharge planning needs.

Family Responsibility

- Parents/family* shall have the responsibility for:
 - Continuing their parenting role to the extent of their ability; and
 - Being available to participate in decision making and providing staff with knowledge of parents/family whereabouts.

* The family consists of those individuals responsible for physical and emotional care of the child on a continuous basis, regardless of whether they are related.

Culture & Diversity

What is Culture?

The components of our lives including: physical attributes, diet, world-view, language, philosophy or religion.

The melting pot of America works both for and against acculturation. As new immigrants bump elbows with the “American Way”, they find themselves challenged to “fit in”. However, they could also band together with folks from their homelands and maintain the customs and lifestyle they used to have. These subcultures that maintain cultural differences challenge healthcare providers.

Ethnocentrism

When we view ourselves as the correct culture or ‘right’ way of seeing the world and see others’ behavior or beliefs as weird or bizarre, we prejudice our ability to give appropriate care to our patients or others cultures. This can result in:

- Misdiagnosis
- Failure to treat appropriately
- A feeling of frustration & isolation for patients & families

Cultural Competency

Knowledge and understanding of cultural practices in the geographical area which includes:

- Language
- Family Roles
- Health Behaviors
- Nutrition
- Childbearing Practices
- Death
- Spirituality

Understanding these areas of a person’s lifestyle can enable us to be better caregivers and improve the wellness of those who come to us for healing.

As we strive to provide customer service and abide by the standards of our regulatory agencies, we must also be sensitive to the needs and preferences of our patients and find common ground.

Communication for our non-English speaking patients is facilitated by a telephone interpreter service through Optimal Language Line operators. This service is available by dialing Optimal Language Line number posted at each nursing station as well as on the hospitals internal web page.

Advance Directives

Policy:

Claiborne County Hospital will have Advance Directive forms available throughout our facilities. Nursing will be available to assist patients and their families any time, upon request.

1. The patient Self-Determination Act of 1990 is a Federal Law. The Right to Natural death Act was signed into law in 1985. These laws state that each person has the right to die with dignity, and that each person can control decisions concerning their medical care. These laws do not allow the withholding of normal food or fluids.
2. Claiborne County Hospital has chosen to make the Advance Care Plan form available to all patients and the community upon request.
3. Each patient who is admitted to CCH will be asked if they have Advance Directives, as mandated by the Federal Law.
4. This information is then documented on the patient's demographic information sheet by Registration Staff.
5. A copy is made of the directive by Registration/Nursing, and placed in the patient's medical record under the tab "patient directives" for reference.
6. If the patient has an Advance Directive, but does not have a copy, the patient will be a "Full Code" and will be afforded all medical intervention that is available, until such form can be produced and a copy made available for the patient's medical record.
7. CCH staff will not discriminate against any patient, regardless of their patient directive status.
8. If the patient's physician is unable to abide by the patient's directives due to ethical reasons, he will explain this to the patient, and he will request the patient locate another physician who will accept the directives and resume patient care.
9. Advance Directives are, and shall remain, patient choice for implementation.
10. The Tennessee Advance Care Plan has combined the Living Will, and the Durable Power of Attorney into one form. This allows patient's the freedom to appoint two people to serve as surrogates to make health care decisions for them if and when they become unable, due to physical or mental incapacity.
11. Staff will be available to assist anyone, upon request, who needs assistance completing these forms.
12. Staff will be available to assist Physicians and their staff who request assistance with Advance Directives, or form availability.
13. Any issues that arise due to following patient directives, or family members who are not in agreement, may be addressed to the Ethics Committee. The Ethics Committee findings will be suggestions only, and will not be legally binding.
14. Patients from other states that have Advance Directives and come to CCH for admission, these directives will be reviewed and # 8 will be followed, if necessary.

Ethics & Compliance Program

Mission and Values and the Ethics and Compliance program

The CCH Mission and Values Statement is as follows:

Mission- Claiborne County Hospital and Nursing Home is a community-owned healthcare organization committed to improving the health of the residents of Claiborne and surrounding counties by providing high-quality and cost-effective health care services.

Values-Our employees, physicians, and board members will continuously strive to conduct themselves according to these values:

Excellence - continually improving the services we offer and the care we deliver.

Service - providing compassionate, individualized service to our patients, community, and each other.

Teamwork - working together to meet the needs of our community.

Integrity - ensuring that honesty and trustworthiness are seen in all we do.

Through the Ethics and Compliance Program, Claiborne County Hospital will create and maintain a culture that promotes the highest standards of Ethics and Compliance. Such standards are designed to ensure that the system, including all hospital facilities and colleagues, operates in a manner that complies with the legal and programmatic requirements of federal, state and private payer health programs. Furthermore, such a culture will ensure that the system meets the obligations set forth in our mission and values statement and affirmed in our fundamental commitment to stakeholders.

Purpose

CCH is committed to a comprehensive Ethics and Compliance program that is guided by the Code of Conduct. The Code, which was developed to ensure that the hospital facilities meet the ethical standards and comply with applicable laws and regulations, defines our obligations related to patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants and one another.

Scope of Services and Objectives

Adherence to the Code of Conduct and our fundamental commitment to stakeholders is a responsibility of all colleagues of Claiborne County Hospital. Consequently, the Ethics and Compliance program is applicable to all departments, services and health care professionals of Claiborne County Hospital.

The objectives of the Ethics and Compliance Program are as follows:

- To establish a culture within the health system that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state laws, and federal, state and private payer health care program requirements.
- To effectively articulate and demonstrate the organization's commitment to the compliance process.
- To establish benchmarks that demonstrate implementation and achievements.
- To provide guidance to all colleagues on ethical and legal standards.
- To provide guidance to the governing body, CEOs, managers, employees, physicians, and other health care professionals on the efficient management and operation of the health system.

- To provide a central coordinating mechanism for furnishing and disseminating information and guidance on applicable federal and state statutes, regulations, and other requirements.
- To identify areas of weakness/non compliance in internal systems and management.
- To create a centralized source for distributing information on healthcare statutes, regulations, and other program directives related to fraud, abuse, and related issues.
- To develop a methodology that encourages employees to report potential problems and concerns.
- To develop a mechanism for early detection and reporting of violations or concerns in order to minimize governmental loss from false claims; thereby reducing the health system's exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion.
- To effectively communicate the requirements, standards, and procedures for ethics and compliance training and education.
- To enforce standards through well publicized disciplinary guidelines.
- To respond to detected offenses and develop corrective action initiatives.
- To audit and monitor compliance.
- To enhance the quality of care provided.
- To comply with applicable laws, regulations, and standards.

<p align="center">Physician Orders for Scope of Treatment (POST)</p> <p>This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.</p>	<p>Patient's Last Name</p> <hr/> <p>First Name/Middle Initial</p> <hr/> <p>Date of Birth</p>
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<p>Section A</p> <p><i>Check One Box Only</i></p>	<p>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.</p> <p><input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitate (DNR/no CPR)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C, and D.</p>
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<p>Section B</p> <p><i>Check One Box Only</i></p>	<p>MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer <u>only</u> if comfort needs cannot be met in current location.</p> <p><input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.</p> <p><input type="checkbox"/> Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.</p> <p><i>Other Instructions:</i> _____</p>
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<p>Section C</p> <p><i>Check One Box Only</i></p>	<p>ANTIBIOTICS – Treatment for new medical conditions:</p> <p><input type="checkbox"/> No Antibiotics</p> <p><input type="checkbox"/> Antibiotics</p> <p><i>Other Instructions:</i> _____</p>
--	--

<p>Section D</p> <p><i>Check One Box Only in Each Column</i></p>	<p>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> No IV fluids (provide other measures to assure comfort)</td> <td><input type="checkbox"/> No feeding tube</td> </tr> <tr> <td><input type="checkbox"/> IV fluids for a defined trial period</td> <td><input checked="" type="checkbox"/> Feeding tube for a defined trial period</td> </tr> <tr> <td><input type="checkbox"/> IV fluids long-term if indicated</td> <td><input type="checkbox"/> Feeding tube long-term</td> </tr> </table> <p><i>Other Instructions:</i> _____</p>	<input type="checkbox"/> No IV fluids (provide other measures to assure comfort)	<input type="checkbox"/> No feeding tube	<input type="checkbox"/> IV fluids for a defined trial period	<input checked="" type="checkbox"/> Feeding tube for a defined trial period	<input type="checkbox"/> IV fluids long-term if indicated	<input type="checkbox"/> Feeding tube long-term
<input type="checkbox"/> No IV fluids (provide other measures to assure comfort)	<input type="checkbox"/> No feeding tube						
<input type="checkbox"/> IV fluids for a defined trial period	<input checked="" type="checkbox"/> Feeding tube for a defined trial period						
<input type="checkbox"/> IV fluids long-term if indicated	<input type="checkbox"/> Feeding tube long-term						

<p>Section E</p> <p><i>Must be Completed</i></p>	<p>Discussed with:</p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Health care agent</p> <p><input type="checkbox"/> Court-appointed guardian</p> <p><input type="checkbox"/> Health care surrogate</p> <p><input type="checkbox"/> Parent of minor</p> <p><input type="checkbox"/> Other: _____ (Specify)</p>	<p>The Basis for These Orders Is: (Must be completed)</p> <p><input type="checkbox"/> Patient's preferences</p> <p><input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown)</p> <p><input type="checkbox"/> Medical indications</p> <p><input type="checkbox"/> (Other) _____</p>	
	<p>Physician Name (Print)</p>	<p>Physician Phone Number</p>	<p>Office Use Only</p>
	<p>Physician Signature (Mandatory)</p>	<p>Date</p>	

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)
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Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

AGE SPECIFIC CARE

INFANTS: BIRTH TO ONE YEAR

TODDLER: 1-3 YEARS

PRESCHOOLER: 3-5 YEARS

SCHOOL AGE CHILD: 6-12 YEARS

ADOLESCENTS: 13-17 YEARS

YOUNG ADULT: 18-45 YEARS

MIDDLE ADULT: 45-65 YEARS

OLDER ADULT: 65 YEARS AND OLDER

INFANT

Characteristics

- Rapid growth & development
- Crying is communication
- Sucking shows stress and provides comfort
- Promote social interaction
- Decrease environmental stress
- Older infant will experience separation anxiety

Developmental Task

- Trust vs. Mistrust

Physical Growth

- 1-4 months
 - Development centers around head
 - Smile development
 - Eyes follow objects
 - Begins head prevention
- 4-8 months
 - Musculature of trunk develops
 - Rolls over
 - Sits without support
 - Hand grasping begins
- 8-12 months
 - Distal limbs further develop
 - Begins creeping
 - Stands
 - Walks
 - Purposeful and voluntary movement by six months
 - Birth weight doubles by 4-6 months and triples by one year

Implications

- Allow caregiver to remain with the child as much as possible
- Under six months try to continue the infant's normal routine
- Determine cause for crying instead of simply quieting the infant
- Decrease stress in environment- hold snugly, give pacifier, feed
- Space procedures to allow sucking for comfort
- Feed infant on demand rather than waking to feed
- Use as many observational methods of assessment during sleep
- Encourage toys brought from home- provide colorful toys
- Signs of over stimulation in infants- closing eyes, turning away, increased formation of stool, hiccupping, increased motor activity, hyper alertness

Toddler

Characteristics

- Separation anxiety increases
- Does not understand reason for hospitalization
- Rapid psychosocial growth
- Crying is still a method of communication
- Does have use of a few words
- Comprehends much more than verbal capacity
- Likes prevention over his/her environment
- Usually the toddler is highly mobile
- Play decreases the toddler's stress
- Learning occurs through play

Developmental Task

- Autonomy vs. Shame and Doubt

Physical Growth

- Cylindrical chest develops
- Protruding abdomen due to extra subcutaneous fat
- Diaphragmatic breathing is present
- Heart size increases
- 60% of total body weight is fluid
- Decreased food intake from infancy

Implications

- Allow caregivers to remain with the child as much as possible.
- Allow the toddler to “help” with procedures such as removing their dressing or gown.
- Provide toys including objects of the hospital environment for creativity/imaginative play.
- Speak and play with the toddler to reduce stress.
- Allow mobility and prevention by restraining only those extremities directly involved in fluid administration.
- In young toddlers, the nurse can place a mitt on the child's hand to prevent the child from grabbing the IV line.
- Toddlers react to procedures with resistance.
- The toddler has little concept of danger- increased risk of fall, burns, foreign body aspiration, poisoning and suffocation.
- Fluid volume deficit can occur quickly.

PRESCHOOLER

Characteristics

- May see hospitalization as punishment
- Pain is perceived as punishment
- Preschoolers have many fears that increase stress
 - Separation
 - Abandonment
 - Body mutilation
 - Dark
 - Pain
- Attention span is short- give short and simple explanations.
- Preschoolers are very imaginative.
- Have difficulty distinguishing fantasy and reality.
- Death is seen as reversible.

Developmental Task

- Initiative vs. Guilt

Physical Growth

- Begin to develop fine motor skills
 - Ties shoes
 - Rides two wheel bike
- Large muscle coordination remains far advanced of small muscles.
- Develops right or left orientation at 4 years.
- At 4 years, shows independent toileting habits.
- Posture is more erect.
- Older preschoolers may lose baby teeth.

Implications

- Allow parents to remain with the child as much as possible.
- Reassure often that procedure is not punishment.
- Whenever possible, allow one nurse to develop a trusting relationship with child and parent.
- Encourage use of comforting objects such as blanket or favorite toy.
- Use Band-Aids to “plug up holes.”
- Use toys and replicas of medical equipment with explanations.
- Older preschooler prints first name and draws recognizable representations.
- Keep explanations short, simple, and logical.
- Explain to the child how he/she can “help.”
- Set limits during procedures.
- Increased risk of drowning and burns.
- Normal heart rate 80-100.
- Normal Respiratory rate 22-34.

SCHOOL AGE CHILD

Characteristics

- Strong sense of right and wrong
- Fears include
 - Separation, school failure, disability, death, forced dependency
 - Bodily injury, invasive procedures of the genital area, pain
- Understands cause and effect
- Perceives past and future
- Can deal with several concepts in sequence
- Stress is shown by
 - Regression, anxiety, withdrawal, depression, increased dependency.
- Works on building self-esteem

Developmental Task

- Industry vs. Inferiority

Physical Growth

- Secondary sex characteristics begin
- Graceful and coordinated movements present
- Hand/ Eye coordination is well established
- Most play is active
- Eruption of permanent teeth by age 12
- Bones lengthen and become harder
- Average weight for 6 year old boy is 48 pounds
- Average height for 6 year old boy is 46 inches
- Height increases about 2 inches per year
- Weight increases about 7 pounds per year

Implications

- Allow for privacy as much as possible.
- Explain to child how he may “help” with activities.
- Begin preparation for procedures as soon as possible.
- Allow parents and peers to visit as much as possible.
- Explain if procedure will hurt, its purpose, how it will make them better and what injury could result.
- The school age child believes others die, but not self.
- Descriptions may be exaggerated because of stress and heightened fear.
- Be aware of nonverbal requests for support.
- By age 9, the child can understand simple anatomy and body functions.
- Normal heart rate 75-100
- Normal respiratory rate 18-30
- Normal blood pressure 84-120/54-80

ADOLESCENTS

Characteristics

- Mature level of reasoning
- Understand concept of time as an adult
- Draw inferences and demonstrate problem solving skills
- Fears include
 - Losing prevention, losing independence
 - Changes in physical appearance
- Are often scared but do not want to show it
- Stress is manifested by
 - Aggression, irrational behavior
 - Fear, rebellion
- Aware death can happen to them

Developmental Task

- Identity vs. Frustration

Physical Growth

- Second major growth spurt occurs
- Sexual Maturation occurs
- Puberty in female begins between age 10-14
- Puberty in male begin between age 12-16
- Frequent health problems of the adolescent
 - Teen pregnancy, acne, postural defect, fatigue, anemia, respiratory infections, Mononucleosis, suicide, alcohol/drug abuse, STDS

Implications

Do not talk down to the individual.

Teach away from peers, roommates, and parents.

Use proper medical terms.

Encourage visits from family.

If a favorite nurse is identified, nursing assignments should reflect the preference.

Respect privacy

Normal heart rate 60-90

Normal respiratory rate 12-16

Normal BP 94-140/62-88

YOUNG ADULT

Characteristic

- Physiological aging begins to overtake the rate of cellular growth.
- Independence, career, intimate relationships, marriage and family are the center of psychological focus.

Developmental Task

Balances Dreams with Reality

Physical Growth

- Achieved full physical maturity by age 20
- A diabetic patient's blood pressure and lipid prevention are held to tighter measures than non-diabetics.
- Women may begin peri-menopause.

Implications

- Realize hospitalization poses a tremendous stress on family especially if the ill family member provides the major source of income for the family.
- Recognize illness of family member necessitates role changes that may also be additional stressor.
- Keep informed of treatment plan and patient's role in care.
- Assess health maintenance needs as identified.

MIDDLE AGE ADULT

Characteristics

- Typically more settled than the younger adult
- More financially sound than younger adult
- Increased awareness of losing youthfulness, vitality, their partner's love
- Widowhood is more likely to occur in this stage

Developmental Task

- General Activity vs. Stagnation

Physical Growth

- Menopause occurs in females
- In the 50's may see a reduction in male potency
- Decalcification of the bones begin to occur
- Basal metabolic rate decreases by 30 %
- May see diminished vision
- Decreased elasticity of blood vessels
- May see loss of bladder tone

Implications

- Help maintain intact body images.
- Obtain resources to help adapt/accept any loss of function or disability.
- Explain procedures and plan of care.
- Dependency conflicts are manifested by
 - Asking for favors
 - Trying hard to please
 - Demanding care
 - Refusing needed assistance
- Support family members who are supporting the patient.
- Make sure any prosthetics are available such as glasses, hearing aid, dentures
- Increased risk of cardiovascular disease and hypertension.

OLDER ADULT

Characteristics

- At the turn of the century, aging was not recognized as a problem
- Today, because of the number of older citizens, the perception toward this group has turned negative
- Retirement age is expanding 65-70 years
- There are changes in the older person from aging and some disease
- Work capacity declines

Developmental Task

- Ego Integrity vs. Despair

Physical Growth

- May see memory loss/forgetfulness
- Confusion is not normal part of aging and indicates disease process
- Decrease in sense of balance and fine motor skills
- Feels cold more easily
- Perception of and response to pain decreases
- Slower peristalsis and eliminations
- Loss of taste buds
- Decrease in gas exchange in lungs
- Decrease in cardiac output
- May see prostatic enlargement in male and prolapse in female organs
- Kidney efficiency decreases
- Bone mass begins to decrease

Implications

- Show patience with the older person.
- Be willing to listen, explain, orient, reassure, and comfort the older person.
- Involve family if possible.
- Insure safety mechanisms are in place to prevent falls.
- Have any prosthetics such as glasses, hearing aids, dentures in easy reach of the patient.
- Assess the older patient frequently when applying hot or cold therapy.
- Explain safety risks to the older person.
- Provide plenty of fluids, small frequent meals and variety of foods.
- Teach to avoid strenuous activity in heat.
- Balance activity with rest periods.
- Due to decrease in kidney function, may see more adverse drug reactions and need to adjust drug dosages.

Material Safety Data Sheet (MSDS)

DEFINITION

Material Safety Data Sheets (MSDS) are produced by the manufacturer to provide the following information to the users of their products. MSDS are available on all products that contain a caution or warning statement.










MSDS information:

- Name of the product
- Ingredients (Scientific Name) and percent representation in the product
- Handling and Storage
- Identification of product risks & precautions to be taken by users
- Treatment for accidental exposure to the product

MSDS Access

Material Safety Data Sheets are accessible for all products used in the hospital in the Emergency Room and in the Plant Engineers Office.

EMERGENCY RESPONSE CODES

	CODE PINK	Abduction
	CODE BLACK	Bomb Threat
	CODE BLUE	Cardiac/Respiratory Emergency
	CODE YELLOW	Disaster
	CODE RED	Fire
	CODE ORANGE	HazMat
	CODE PURPLE	Hostage Situation
	CODE GREEN	Patient or Staff in Danger
	CODE GRAY	Severe Weather
	CODE 13	Weapons Threat

Fire Safety

Fire Response

R **RESCUE**
A **ALARM**
C **CONTAIN**
E **EXTINGUISH**

RESCUE: rescue any person in immediate danger

- Always use the term Code Red for fire. Never yell “FIRE”.
- Stay Calm.
- Always check the temperature of a closed door before opening in a fire- if the door is HOT to touch - DO NOT OPEN.
- Keep low and get the victim to the floor ASAP.
- Close the door behind you to contain the fire.
- Stop, Drop, and Roll if your clothing or person catch fire.
- Do NOT put yourself in danger to become a victim.

ALARM: Activate the Fire Alarm

- Locate alarm stations on your unit.
- Pull alarm immediately in case of fire- no matter how small the fire seems.
- Fire door will automatically close- Do not place equipment in front of fire doors.
- Fans will shut down the ventilation system.

CONTAIN: Contain the fire by closing doors and windows.

- Closing doors and windows stops the fire from spreading and protects other spaces from smoke.

EXTINGUISH: Extinguish the fire

- Only after rescue, alarm, and if fire is small and contained.
- Know location of fire extinguishers.
- If unable to extinguish, close the door
- Fire Extinguisher use:
 - P..... Pull the pin.
 - A Aim the nozzle at the base of the fire.
 - S Squeeze the handle all the way.
 - S Sweep back and forth at the base of the fire.

Security Tips

The safety and security of students while in the facility is of the utmost importance. Students should engage in activities that promote personal safety and security.

- Do not bring pocketbooks or other valuables to the clinical areas as space to securely store these items may not be available.
- Lock any valuable and personal items in the trunk prior to arriving at the hospital. This includes pocketbooks, CD's, cell phones that might be visible in your vehicle.
- Only carry minimal cash on your person.
- Leave jewelry at home.
- Always be aware of your surroundings and alert for suspicious activities or persons.
- Park only in designated areas.
- When entering or leaving the hospital, you may call security for escort, especially if you are leaving after dark and are alone.
- Have your keys ready to unlock your vehicle.

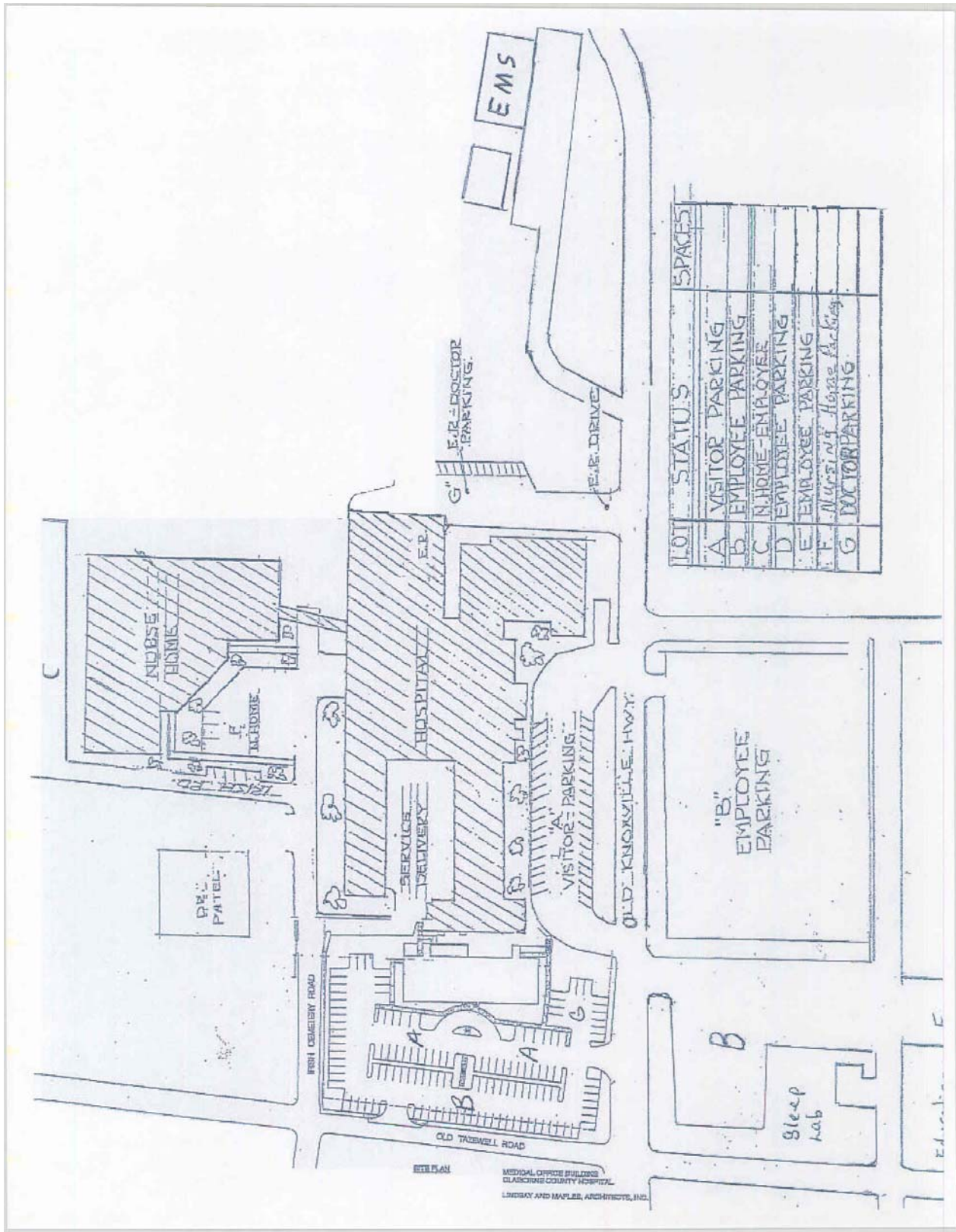
Parking

We require that you do NOT park in the parking areas reserved for patients including the front visitor lot and the Emergency Department parking lot.

The student parking areas are located across the street from the main building, in the lower level of the Medical Office Building along the street, or in the lot located above the Nursing Home. Students may also park in the lot surrounding the Sleep Center.

See the following map showing parking areas.

Claiborne County Hospital and Nursing Home assumes no responsibility for loss, damage, or theft in parking areas.



Smoking Policy

As a community healthcare institution, CCH is concerned not only with the treatment of disease, but also the promotion of wellness. In an effort to provide a safe and healthy environment for all, CCH is a smoke free environment. Smoking within the premises and affiliated hospital sites is prohibited. Visitors and employees may smoke outside in designated areas only.

Effective June 1, 2010, the use of tobacco products, (smoking, chewing, etc.) will be allowed only in private vehicles parked in designated employee parking areas of the hospital.

HIPAA: The Health Insurance Portability and Accountability Act of 1996

Certain laws and regulations require that practitioners and health plans maintain the privacy of health information. A large part of it deals with employees qualifying for health insurance when they change jobs – that is the portability aspect of HIPAA. However, there is much more to HIPAA. Title II of HIPAA is known as Administrative Simplification.

Administrative simplification establishes requirements for the following:

- ❖ Transactions and code sets
- ❖ Security
- ❖ Privacy
- ❖ Timeframes
- ❖ Penalties

In general, privacy is about who has the right to access personally identifiable health information. The rule covers all individually identifiable health information in the hands of practitioners, providers, health plans, and healthcare clearinghouses.

Claiborne County Hospital and Nursing Home and its affiliates¹ (hereinafter referred to as CCH) take HIPAA regulations very seriously. HIPAA impacts students in the following ways:

- ❖ Patient records may not be photocopied or printed from a computer terminal for personal use (i.e. writing care plans or other papers).
- ❖ Students must not release any patient information independently.
- ❖ Any request for patient information should be directed to your CCH preceptor/supervisor.
- ❖ Violations of HIPAA may result in termination of the student experience.

Identifiable Information

The following is considered identifiable information by HIPAA and must not be accessed or shared for any purpose other than patient care.

1. Names
2. Information relating to the individual's geographic subdivision if it contains fewer than 20,000 people.
3. All ages and elements of dates that indicate age of individuals over 89, unless aggregated into a single category of age 90 or older.
4. Telephone numbers
5. Fax numbers
6. E- mail addresses
7. Social Security Numbers
8. Medical record numbers;
9. Health Plans Beneficiary Number
10. Account Numbers
11. Certificate/License Numbers

¹For policy purpose affiliates of Claiborne County Hospital and Nursing Home shall refer to Claiborne County Home Health and Hospice, Claiborne County Rehabilitation and Claiborne County EMS

12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger and voiceprints.
17. Full face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code.

Data that is fully de-Identified no longer requires HIPAA protections or tracking of disclosures. that means CCH can use and disclose de-Identified data freely.

Do not use any of the above elements when writing reports or making presentations. If you feel you need to include any identifiable elements, please check with the HIPAA Coordinator.

Additional steps to protect a patient's privacy

- ❖ Close room doors when discussing treatments and administering procedures.
- ❖ Close curtains and speak softly in semi-privacy rooms when discussing treatment and performing procedures.
- ❖ Avoid discussions about patients in public areas such as cafeteria lines, waiting rooms, and elevators.
- ❖ Safeguard medical records by not leaving the record unattended in an area where the public can view or access the record.
- ❖ If you have logged into a computer system to view an electronic medical record, make sure to log off once you are finished.
- ❖ Before discarding any patient-identifiable information, make sure it is properly shredded or locked in a secure bin to be destroyed later. **Do not place information in a trashcan.**

CCH Facility Patient Directory

Certain patient information may be included in a facility patient directory. Each patient or personal representative should be asked, upon admission, if they wish to be listed in the patient directory, and their preference noted in the computer system. The following protected health information (PHI) may be included in the directory:

- ❖ Patient's name
- ❖ Patient's location
- ❖ Patient's general condition (usually a one word description, such as: undetermined, good, fair, serious, critical, or treated and released)
- ❖ Patient's religious affiliation (optional)

A patient has the right to change their status in the directory at any time throughout their stay. When asked about a patient by name you should **always** check the facility patient directory prior to releasing any information. If a patient has chosen not to be included in the directory then they will not be included although their room will indicate that the room is occupied.

The appropriate response to these inquiries about patients who have opted out of the facility directory will be "I'm sorry but we have no one listed by that name."

Accounting for Disclosures

Privacy regulations grant the patient the right to receive a summary of certain disclosures by CCH.

Therefore, CCH must account for releases of information given to requestors outside of CCH. Specifically, releases made for reasons other than treatment, payment, healthcare operations, or for releases made as the result of an authorization.

Healthcare operations are business activities undertaken by CCH, such as quality improvement studies, peer review, credentialing, medical reviews, and fraud and abuse investigations.

Students must not release any patient information independently. Any request for patient information should be directed to your CCH preceptor/supervisor.

Verification of Identity

When information is requested about a patient, regardless of who is requesting the information (i.e. law enforcement, “parent”, physician’s office) please direct the request to your CCH preceptor/supervisor who will verify identity of the requestor. Students must not release any patient information independently.

Notice of Privacy Practices

The Privacy Rule gives patients the right to be informed of the privacy practices of CCH Healthcare, as well as to be informed of their privacy rights with respect to their personal health information. CCH’s Notice of Privacy Practices is generally distributed to patients on the first day that the patient receives treatment. CCH is required to attempt to obtain written acknowledgment that we offered the patient a copy of the Notice.

HIPAA & Patient Care

Treatment of patients should be essentially unobstructed by the Privacy Rule. For some purposes (such as providing treatment, obtaining payment, and health care operations), the Privacy Rule permits CCH to use and disclose health information without the patient’s permission and with only a few restrictions. CCH may disclose, without the patient’s permission, information necessary for the treatment or payment activities of another health care physician or provider if both entities have a relationship with the patient.

Examples of permitted uses and disclosures include:

- ❖ When sending a specimen to a lab for testing, the physician’s office may send the laboratory the patient’s health plan information so that the laboratory may be reimbursed by the patient’s health plan for services rendered.
- ❖ A physician’s office may send health information to another physician’s office for the treatment of a patient. As long as both have a relationship with the patient, physicians and other providers may share health information as needed for treatment purposes.
- ❖ A physician’s office may send health information to a pharmacy so that pharmacy may fill a prescription for a patient. The physician’s office may also send the patient’s health plan information so that the pharmacy may be reimbursed for filling the prescription.
- ❖ A health plan may share certain member information with another health plan to coordinate benefits. Quality Management Department may abstract data from charts at the facility to conduct a study designed to improve patient care.

Disclosures to Patients’ Family & Friends

Only CCH employees may disclose health information to a family member, other relative, close personal friend of the patient or any other person identified by the patient. This is never the responsibility of the student.

2011 National Patient Safety Goals

Hospital Program

Note: Gaps in the numbering indicate that the Goal is inapplicable to the program or has been “retired,” usually because the requirements were integrated into the standards.

Goal # 1 Improve the accuracy of patient identification.

- 1A Use of two patient identifiers when providing patient care, treatment, and services.
1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures, The patient’s room number or physical location is not used as an identifier.
 2. Label containers used for blood and other specimens in the presence of the patient.
- 1B Eliminate transfusion errors related to patient misidentification.
1. Before initiating a blood or blood component transfusion:
 - Match the blood or blood component to the order
 - Match the patient to the blood or blood component
 2. When using a to-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient
 3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process.

Goal # 2 Improve the effectiveness of communication among caregivers.

- 2A Report critical results of tests and diagnostic procedures on a timely basis
1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
 - The definition of critical results of tests & diagnostic procedures
 - By whom & to whom critical results of tests & diagnostic procedures are reported
 - The acceptable length of time between the availability & reporting of critical results of tests & diagnostic procedures.
 2. Implement the procedures for managing the critical results of tests & diagnostic procedures.
 3. Evaluate the timeliness of reporting the critical results of tests & diagnostic procedures.

Goal # 3 Improve the safety of using medications.

- 3A Label all medications, medication containers, & other solutions on & off the sterile field in perioperative & other procedural settings. (medication containers include syringes, medication cups & basins.
1. In perioperative & other procedural settings both on & off the sterile field, label medications & solutions that are not immediately administered. (This applies even if there is only one medication being used)
 2. In perioperative & other procedural settings both on & off the sterile field, labeling occurs when any medication or solution is transferred from the original

packaging to another container.

3. In perioperative & other procedural settings both on & off the sterile field, medication or solution labels include the following:

- Medication time
- Strength
- Quantity
- Diluent & volume (if not apparent on the container)
- Preparation date
- Expiration date when not used within 24hrs
- Expiration time when expiration occurs in less than 24 hrs

4. Verify all medication or solution labels both verbally & visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered. (An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, & administers to that patient without any break in the process.)

6. Immediately discard any medication or solution found unlabeled

7. Remove all labeled containers on the sterile field & discard their contents at the conclusion of the procedure. (This does not apply to multiuse vials that are handled according to infection Prevention practices)

8. All medications & solutions both on & off the sterile field & their labels are reviewed by entering & exiting staff responsible for the management of medications.

3B Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. (For pediatric patients, prefilled syringe products should be used only if specifically designed for children.)

2. Use approved protocols for the initiation & maintenance of anticoagulant therapy.

3. Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current INR to adjust this therapy. The baseline status & current INR are documented in the medical record.

4. Use authoritative resources to manage potential food & drug interactions for patients receiving warfarin.

5. When heparin is administered intravenously & continuously, use programmable pumps in order to provide consistent & accurate dosing.

6. A written policy address baseline & ongoing laboratory tests that are required for heparin & low molecular weight heparin therapies.

7. Provide education regarding anticoagulant therapy to staff, patients & families. Patient/Family education includes the following:

- The importance of follow-up monitoring
- Compliance
- Drug-food interactions

--The potential for adverse drug reactions & interactions

8. Evaluate anticoagulation safety practices, take action to improve practices, & measure the effectiveness of those actions in a time frame determined by the organization.

Goal # 7 Reduce the risk of health care associated infections

7A Comply with either the current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Prevention & Prevention (CDC) hand hygiene guidelines.

1. Implement a program that follows categories IA, IB, & IC of either the current CDC or the current WHO hand hygiene guidelines.

2. Set goals for improving compliance with hand hygiene guidelines

3. Improve compliance with hand hygiene guidelines based on established goals

7B Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. (This applies to organisms such as MRSA, C-Diff. VRE & multidrug-resistant gram negative bacteria

1. Conduct periodic risk assessments for multidrug-resistant organism acquisition & transmission

2. Based on the results of the risk assessment, educate staff & LIP's about health care-associated infections, multidrug-resistant organisms, & prevention strategies at hire & annually thereafter (The education provided recognizes the diverse roles of staff & LIP's & is consistent with their roles within the hospital.)

3. Educate patients & their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection strategies.

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.

5. Measure & monitor multidrug-resistant organism prevention processes & outcomes, including the following:

-- Multidrug-resistant organism infection rates using evidence-based metrics

--Compliance with evidence-based guidelines or best practices

--Evaluation of the education program provided to staff & LIPs

6. Provide multidrug-resistant organism process & outcome data to key stakeholders, including leaders, LIPs, nursing staff & other clinicians.

7. Implement policies & practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies & practices meet regulatory requirements & are aligned with evidence-based standards.(CDC, etc)

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms (The alert system may use phones, faxes, pagers, automated & secure electronic alerts, of a combination of these methods)

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms (The alert system information may exist in a separate electronic database or may be integrated into the admission system, manually or electronic or a combination of both. The hospital may define its own parameters in terms of time & clinical manifestation to determine which re-admitted patients

require isolation)

7C

Implement evidence-based practices to prevent central line-associated bloodstream infections. (This covers short and long term central venous catheters & PICC lines.

1. Educate staff & LIPs who are involved in managing central lines about central line-associated bloodstream infections & the importance of prevention. Education occurs upon hire, annually thereafter, & when involvement in these procedures is added to an individual's job responsibilities
2. Prior to insertion of a central venous catheter, educate patients & if needed their families about central line-associated bloodstream infection prevention.
3. Implement policies & practices aimed at reducing the risk of central line-associated bloodstream infections. These policies & practices meet regulatory requirement & are aligned with evidence-based standards. (CDC, etc)
4. Conduct periodic risk assessments for central line-associated bloodstream infections, monitor compliance with evidence-based practices, & evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, LIPs, nursing staff, & other clinicians.
5. Provide central line-associated bloodstream infection rate data & prevention outcome measures to key stakeholders, including leaders, LIPs nursing staff & other clinicians.
6. Use a catheter checklist & a standardized protocol for central venous catheter insertion
7. Perform hand hygiene prior to catheter insertion or manipulation
8. For adult patients, do not insert into the femoral vein unless other sites are unavailable
9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters
10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.
11. Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over 2 months of age, unless contraindicated.
12. Use a standardized protocol to disinfect catheter hubs & injection ports before accessing the ports.
13. Evaluate all central venous catheters routinely & remove nonessential catheters.

7D

Implement evidence-based practices for preventing surgical site infections.

1. Educate staff & LIPs involved in surgical procedures about surgical site infections & the importance of prevention. Education occurs upon hire, annually thereafter, & when involvement in surgical procedures is added to an individual's job responsibilities.
2. Educate patients, & their families as needed, who are undergoing a surgical procedure about surgical site infection prevention
3. Implement policies & practices aimed at reducing the risk of surgical site infections. These policies & practices meet regulatory requirements & are aligned with evidence-based guidelines (CDC, etc)
4. As part of the effort to reduce surgical site infections:

- Conduct periodic risk assessments for surgical infections in a time frame determined by the hospital
 - Select surgical site infection measures using best practices or evidence-based guidelines
 - Monitor compliance with best practices or evidence-based guidelines
 - Evaluate the effectiveness of prevention efforts (surveillance may be targeted to certain procedures based on the hospital's risk assessment)
5. Measure surgical site infection rates for the first 30 days following procedures that do not involve inserting implantable devices & for the first year following procedures involving implantable devices. The hospital's measurement strategies follow evidence-based guidelines. (surveillance may be targeted to certain procedures based on the hospital's risk assessment)
 6. Provide process & outcome (for example, surgical site infection rate) measure results to key stakeholders
 7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to evidence-based best practices
 8. When hair removal is necessary, use clippers or depilatories. (shaving is an inappropriate hair removal method)

Goal # 8 Accurately and completely reconcile medications across the continuum of care.

- 8A A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the hospital (this standard is not in effect at this time)
1. At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, & frequency) is created & documented. The patient & as needed the family is involved in creating this list.
 2. The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.
 3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled & documented while the patient is under the care of the hospital
 4. When the patient's care is transferred within the hospital (for example, from ICU to a floor), the current provider informs the receiving provider about the up-to-date reconciled medication list & documents the communication. (updating the status of a patient's medications is also an important component of all patient care hand-off. This element of performance is not in effect at this time)
- 8B When a patient is referred to or transferred from one hospital to another, the complete & reconciled list of medications is communicated to the next provider of service, & the communication is documented. Alternatively, when a patient leaves the hospital's care to go directly to his or her home, the complete & reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of care. (when the next provider of service is unknown or when no known formal relationship is planned with the next provider, giving the patient & as needed the family a list of reconciled medications is sufficient)

1. The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.

2. At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications

8C When a patient leaves the hospital's care, a complete & reconciled list of the patient's medications is provided directly to the patient & as needed the family & the list is explained to the patient &/or family

1. When the patient leaves the hospital's care, the current list of reconciled medications is provided & explained to the patient and as needed to the family. This interaction is documented. (patients & families are reminded to discard old lists & to update any records with all medication providers or retail pharmacies)

8D In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. (it is important for health care providers to know which types of medications their patients are taking because these medications could affect the care, treatment, and services provided.)

1. The hospital obtains & documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, IV contrast media, local anesthesia, antibiotics) & to assess for potential allergic or adverse drug reactions.

2. When only short-term medications (for ex. a pre-procedure medication or a short-term course of antibiotic) will be prescribed & no changes are made to the patient's current medication list, the patient and/or family are provided with a list containing the short-term medication additions that the patient will continue after leaving the hospital.) This list of new short-term medication is not considered to be part of the original, known, & current medication list.

3. In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed

4. In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the patient's current, known long-term medications.

5. In these settings, a complete, documented medication reconciliation process is used when: The patient is required to be subsequently admitted to an organization from these settings for ongoing care.

6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient. & their families if needed, & to the patient's known primary care provider or original provider or a known next provider of care.

Goal # 15 The hospital identifies safety risks inherent in its patient population.

15 A Identify patients at risk for suicide

1. Conduct a risk assessment that identifies specific patient characteristics & environmental features that may increase or decrease the risk for suicide.

2. Address the patient's immediate safety needs & most appropriate setting for treatment.

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide

prevention information (such as a crisis hotline) to the patient & their family

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, & Wrong Person Surgery

The Universal Protocol applies to all surgical and nonsurgical invasive procedures.

The Universal Protocol is based on the following principles:

- Wrong-person, wrong site, & wrong procedure surgery can & must be prevented**
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site**
- Active involvement & use of effective methods to improve communication among all members of the procedure team are important for success**
- To the extent possible, the patient & family if needed are involved in the process**
- Consistent implementation of a standardized protocol is most effective in achieving safety**

UP

Goal #1 Conduct a pre-procedure verification process

UP--A Hospital should always make sure that any procedure is what the patient needs & is performed on the right person. The frequency & scope of the verification process will depend on the type & complexity of the procedure.

1. Implement a pre-procedure process to verify the correct procedure, for the correct patient, at the correct site. (The patient is involved in the verification process when possible)
2. Identify the items that must be available for the procedure & use a standardized list to verify their availability. At a minimum, these items include the following:
 - Relevant documentation (for example, H&P, signed procedure consent form, nursing assessment, & pre-anesthesia assessment)
 - Labeled diagnostic & radiology test results (for example, x-ray images & scans, or pathology & biopsy reports) that are properly displayed
 - Any required blood products, implants, devices, and/or special equipment for the procedure
3. Match the items that are to be available in the procedure area to the patient

UP—B Mark the procedure site

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure & when performing the procedure in a different location would negatively affect quality or safety
2. Mark the procedure site before the procedure is performed and if possible with the patient involved.
3. The procedure site is marked by the LIP who is ultimately accountable for the procedure & will be present when the procedure is performed. In limited circumstances, the LIP may delegate site marking to an individual who is permitted by the organization to participate in the procedure & has the following qualifications:
 - An individual in a medical residency program who is being supervised by the LIP performing the procedure; who is familiar with the patient & who will be present when the procedure is performed

--A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the LIP performing the procedure (that is an advanced practice registered nurse (APRN) or physician assistant (PA) who is familiar with the patient and who will be present when the procedure is performed

4. The method of marking the site & the type of mark is unambiguous & is used consistently throughout the hospital (the mark is made at or near the procedure site & is sufficiently permanent to be visible after skin preparation & draping. Adhesive markers are not the sole means of marking the site).

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum)

Examples of other situations that involve alternative processes include:

--Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice

--Interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)

--Teeth

--Premature infants, for whom the mark may cause a permanent tattoo

UP—C A time-out is performed before the procedure

The purpose of the time-out is to conduct a final assessment that the correct patient, site, & procedure are identified. During time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site & procedure.

A designated member of the team initiates the time-out & it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions & concerns are resolved

1. Conduct a time-out immediately before starting the invasive procedure or making the incision

2. The time-out has the following characteristics:

--It is standardized, as defined by the hospital

--It is initiated by a designated member of the team

--It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, & other active participants who will be participating in the procedure from the beginning

3. When two or more procedures are being performed on the same patient, & the person performing the procedure changes, perform a time-out before each procedure is initiated

4. During the time-out, the team members agree, at a minimum, on the following:

--Correct patient identify

--The correct site

--The procedure to be done

5. Document the completion of the time-out

Environment of Care Quiz

1. Produced by the manufacturer to provide detailed information on a chemical and its hazards. What sheet is this?

2. When using a fire extinguisher, the PASS system stands for:

P _____
A _____
S _____
S _____

3. The cornerstone of the hospital fire program is RACE which stands for?

R _____
A _____
C _____
E _____

4. Code _____ is the code used for disaster.

5. Code _____ is the code used for fire.

6. Code _____ is the code used for a weapons threat.

7. Code _____ is the code used for infant or child abduction.

8. Code _____ is the code used for a bomb threat.

9. Code _____ is the code used for cardiac/respiratory emergency.

Infection Prevention Quiz

Name: _____ Date: _____

1. List four separate occasions when hand hygiene is necessary.
2. True or False: Alcohol hand rub may be used when hands are visibly soiled.
3. What is the minimum amount of time you should wash your hands?
4. When should PPE (personal protective equipment) be worn?
5. True or false: When removing latex gloves it is ok to sling, snap or pop the glove into the wastebasket.
6. Name all five isolation categories used at Claiborne County Hospital.
7. What type of isolation precautions are used for MRSA?
8. True or False: Alcohol hand rub is ok to use after caring for a C-difficile patient.
9. True or False: Airborne requires the door to be closed at all times and all times.
10. True or False: Artificial fingernails are prohibited for all direct patient care.

HIPAA Quiz

TRUE/ FALSE

1. Patients receive a copy of the Notice of Privacy Practice on the first day they receive treatment.
2. Telephone numbers, Medical Records numbers and photographic images are included as protected health information.
3. If a patient chooses to opt out of the facility directory, they are considered to not be in the hospital.
4. Students may take printed information such as hospital census and copies of patient records out of the hospital in order to complete school assignments.
5. The most common privacy complaint by patients/ families is staff talking about patient information in public areas such as hallways, cafeteria, and elevators.
6. CCH is required by law to report certain information such as births, deaths, and suspected abuse.
7. Patient information may be released to family at any time.
8. If someone calls asking about a patient by name what is the **first** thing you do?
 - a. Call the charge nurse
 - b. Check the facility directory to see if they are listed
 - c. Direct them to the patients room
 - d. Ask for identification
9. Which of the following are some common ways you can protect patient privacy?
 - a. Closing patient doors
 - b. Using curtains to shield patients during treatment
 - c. Knocking before entering a patient room
 - d. All of the above
10. It is appropriate to share information with the following without patient authorization:
 - A. Former Physician of the patient's
 - b. Colleague who needs information about the patient to provide proper care
 - c. Friend of patient
 - d. Pharmaceutical salesman offering fee for list of patient names.



Confidentiality Agreement

I understand that Claiborne County Hospital and Nursing Home and its affiliates* (hereinafter referred to as CCH) have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

Additionally, CCH must assure the confidentiality of its human resources, salary information, payroll, fiscal, research, computer systems, and management information (collectively "Confidential Information"). In the course of my employment/assignment at CCH, I understand that I may come into the possession of Confidential Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of CCH's Confidential Information.

(1). I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. In addition, I understand that my personal access code, user ID and password used to access computer systems is also an integral aspect of this Confidential Information.

(2). I will not access or view any Confidential Information, or utilize equipment, other than what is required to do my job.

(3). I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on the shuttle bus, on public transportation, at restaurants, and at social events). It is not acceptable to discuss Confidential Information in public areas even if a patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.

(4). I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.

(5). I will not willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.

(6). In the pursuance of my job I will not use any computer equipment or software that has not been furnished and/or installed by CCH's Information Systems Department.

(7). I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information in CCH's computer system. Such unauthorized transmissions include, but are not limited to; removing and/or transferring Confidential Information from CCH's computer system to unauthorized locations (for instance, home).

(8). I will log off any computer or terminal prior to leaving it unattended.

(9). I will comply with any security or privacy policy promulgated by CCH to protect the security and privacy of Confidential Information.

(10). I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of this Agreement or of any CCH information security or privacy policy.

(11). Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information to CCH.

(12). I agree that my obligations under this Agreement will continue after the termination of my employment.

(13). I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges, in accordance with CCH's Sanction Policy, as well as legal liability.

(14). I further understand that all computer access activity is subject to audit.

CONFIDENTIALITY AGREEMENT

By signing this document I understand and agree to the following:

I have read the above agreement and agree to comply with all its terms.

Signature of employee/physician/student/volunteer

Print name

Date

**For policy purpose affiliates of Claiborne County Hospital and Nursing Home shall refer to Claiborne County Home Health and Hospice, Claiborne County Rehabilitation and Claiborne County EMS.*

NATIONAL PATIENT SAFETY GOALS QUIZ

True/False-circle correct answer

1. The purpose of time-out before surgical/invasive procedures is to conduct a final assessment that the correct patient, site, and procedure are identified.

True False

2. When identifying a patient prior to administering medication or performing a procedure, the room number is an acceptable form of identification.

True False

3. Q.D. is an acceptable abbreviation at Claiborne County Hospital.

True False

4. Anytime there is a medical error or patient injury, you should first check the safety of the patient and report this to the charge nurse and physician immediately.

True False

5. When administering Heparin drip /infusion it is not necessary to use a programmable pump.

True False

6. When a patient is referred to or transferred from one hospital to another, the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented.

True False

7. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (i.e., crisis hotline) to the patient and their family.

True False

8. Critical lab values must be reported within four hours to the physician.

True False

9. Prior to insertion of a central venous catheter, patients and their families should be educated about central line associated bloodstream infection prevention.

True False

10. Students should read back and verify all verbal orders from a physician. True False