STUDENT NURSE ORIENTATION MANUAL

Department of In-service Education

ORIENTATION FOR NEW HIRES, AGENCY STAFF AND STUDENTS

I. What is the purpose of orientation?

Welcome to the Valley Presbyterian Hospital (VPH) Orientation Module. This module has been developed to provide future employees, students and agency staff with a brief overview to some of Valley Presbyterian Hospital's Standards and routines. This information applies to most inpatient units. Further details and unit specific information will be provided during onsite hospital orientation.

All VPH standards are available in their entirely to hospital employees via the in-hospital computer intranet system. This intranet site can be accesses in all patients care units and departments.

II. What are the principles for practice at VPH?

A. Hospital Core values
VPH Administration has established the following Core Values.

Our mission is accomplished through a system of guiding care values:

- *Respect for each other's worth.*
- *Compassion for the feelings of others.*
- *Intensely personalized service.*
- *Efficiency in meeting customer expectations.*
- *Excellence in all we do.*
- *The highest order of integrity and ethics.*
- *Taking personal responsibility for our actions, attitude and decisions.*
- *Being trustworthy-keeping promises we make to our customer groups.*

B. Hospital Mission Statement

We exist to improve the quality of health care provided to our community...within an environment of dignity; respect and compassion...while addressing diverse cultural needs...and applying human and financial resources as prudently as possible.
We promote a supportive team environment in which each employee undergoes continual professional growth.

C. The department of Nursing Philosophy

The Department of Nursing (DON) believes that the patient has biological, spiritual and psychological needs that are best met through assessment, intervention, and instruction and support. We believe the patient has the right for independence of expression, involvement in self-care, and to be treated with respect and dignity.

D. VPH delivery of care based on Policy and Procedures

Valley Presbyterian Hospital provides a system and philosophy for defining professional practice as well as managing the facility, department, unit, practitioners, and patient care. We focus on utilizing the nursing/patient care process to assure positive patient outcome and care.

The general principles of the delivery of care methodology are based on the state defined RN and LVN scope of practice regulations:

1) A registered nurse will be responsible and accountable for the nursing process by way of prescribing care.
2) Support personnel will be utilized in an efficient manner as the result of the appropriate delegation of tasks by registered nurse.
3) A registered nurse will assume responsibility for the continuity and consistency of care by way of standards compliance and coordination.
4) The responsibilities outlined for a licensed vocational nurse or for a nursing assistant will presuppose as their foundation the competencies exhibited by the staff and the levels of care required by the patients.
5) The assignment of a caregiver to a patient will be based upon the DRG and LOS classification to the patient, the current point in the hospital stay, the proximity to discharge, the degree of independence, the quantity and levels of protocols.
6) The Charge Nurse or the RN Team Leader will assume responsibility for validating the work of the licensed vocational nurse by:
    a) Making rounds on the patients assigned to the care of the licensed vocational nurse at least once per shift.
    b) Discussing the protocols in effect for the patient at the beginning of the shift and at the end of the shift.
    c) Reading the documentation of the licensed vocational nurse and entering a validation signature on the Assessment Flow sheet at the end of shift, which indicates that the patient received care in an appropriate and accurate manner?
7) The role of the licensed vocational nurse (LVN) will be maximized through the delegation of data collection and psychomotor skill and will not include the exercise of independent judgment, the selection or modification of standards, or the securing of physician orders without collaboration with the responsible registered nurse. The LVN can only take verbal and/or telephone orders from physicians for procedures/treatments/interventions that fall within their scope of practice.

III. What is the central information that I need to know?

A. Emergency Response

The staffs are responsible for recognizing an emergency and notifying the hospital switchboard of the type of emergency and its location. The emergency phone number is "4444"

The following is a list of emergency codes at VPH:

Code Blue: Cardiopulmonary Arrest (Adult)
Code Gray: Security
Code Red: Fire
Code Green: Injured or Ill Individual (non-patient/staff)
Code Pink: Missing/Abducted Newborn
Code Purple: Missing/Abducted Child
Code Silver: Weapon/Hostage
Code White: Cardiopulmonary Arrest (Pediatrics)
Code Yellow: Bomb threat
APAGAR: Baby born needing immediate resuscitation
STEMI: Heart attack in the ER
Orange: Hazardous materials released
Triage Internal: Disaster plan activation, internal
Triage External: Disaster plan activation, external (may include mass casualty)
Rapid Response Team: Patient needing response team for change in status
HERT: Hospital emergency response team

Please review the Structure Standards for more complete information.

B. Security
Security can be called at ext. 1078, 24 hours a day, 7 days a week, if the safety of staff, patients or visitors is compromised.

C. Parking
Parking is free to students and available in the Noble Street parking Structure.

D. Cafeteria
The cafeteria is open Monday - Friday 7:00am until 6:00pm and weekends from 8:00am – 2:00pm. The cafeteria is located on the first floor in the west tower.

E. Dress code
The hospital's professional atmosphere is maintained, in part, by the image that employees present to patients, visitors, physicians and vendors. Students in all areas should therefore utilize good professional judgment in determining their dress appearance

The following standards apply to all Indirect Patient Care Services, Direct patient Care Services and department of Nursing personnel:

a) Students are required to wear shoes and hose or socks at all times. Thongs, open-backed clogs/shoes, cowboy boots, sandals, spike heels, casual or unprotected footwear are not acceptable. Shoes must be clean at all times.
b) Hair must be clean, hair styling must be kept neat and in good taste. Moderate jewelry can be worn (watch, ring, etc.). No chains will be worn that could create an unsafe work practice. One or two earrings per lobe of appropriate size (only small loops) so as not to cause unsafe situations is acceptable. No other rings or studs (i.e., nose, lip, tongue or eyebrow) will be accepted.
c) Wearing elaborate make-up, perfume, body oils, strong scented lotions or powders is not acceptable. Appropriate deodorant will be utilized as well as maintaining good oral hygiene.
d) Fingernails must be appropriate in length and color, clean, well trimmed and without jewelry studs. All nails will be of the same color.
e) Student name badge must be worn and with picture visible at all times. Wearing of isolation or patient gowns as "cover-ups" is prohibited. Surgical boots or head covers will not be worn outside of surgery.
f) Students not wearing uniforms must wear a white lab coat when in patient care areas.

F. Role of the Student Nurse

1) Shift Reports

Students are required to participate in the beginning of shift report and to understand its entire content. If the student is present at the end of the shift reports, then participation is also required.

2) Staff Communication

Students will inform the responsible team leading RN and patient caregiver of any changes in the patient's status, care needs, or in the event of any adverse outcome. The student will also provide a patient status update to the team leader and patient caregiver prior to break/meal times and the completion of their shifts.

3) Direction/validation

Validation of the decision-making process or correct selection of direction will take place between the student and instructor as much as possible. The nursing staff will serve as an occasional resource when appropriate.

4) Educational Boundaries

The instructor and student are responsible for verifying that the patient assignment is within the student's appropriate/current educational boundaries. If at any time the student feels that the

patient assignment or patient care required exceeds their current level, they will inform the instructor immediately.

5) Psychomotor skill limitations
Students that the instructor and student evaluate to be within the student's educational boundaries may perform psychomotor skills.

a. The instructor must observe the student perform the skill the first time to verify the student's ability/appropriateness for independent performance.
b. The student will participate in the patient's education as indicated in the Patient Teaching Protocols.
c. The student nurse will administer medication to the patients via routes within the current educational boundaries and as indicated as appropriate by the instructor.
d. The student's role in intravenous therapy is based upon the student's current educational boundaries. The level of responsibility identified by the instructor will be communicated to the team leading RN/IV certified LVN.
e. The code/emergency standards are included in the student's orientation. The student will be expected to perform as indicated in the standards.

6) Documentation
The student will be expected to comply with all documentation forms as described in the guidelines. The team leading RN and patient caregivers will review documentation. However, it is the responsibility of the student and instructor to assure appropriate and adequate documentation.

IV. How are medications administered?

A. Delivery System
The current system of medication delivery to patients is centralized out of the Pharmacy Department 24 hours every day and delivered via the unit dose/cart system. The Pharmacy performs the IV additive preparation services. The Pyxis machines located on Patient Care Units throughout the hospital are utilized for floor stocks and controlled substances.

B. Obtaining Medication Orders
Medication orders are obtained from physicians by way of written, faxed or telephone orders. All medication orders are changed and new orders must be written. Never write the change on the original order. If the doctor orders for the patient to take his or her own medications, you must obtain a specific MD order for each medication from the doctor. In addition, the pharmacy must inspect and identify the medications prior to administration.

C. Personnel
Only LVN's and RN's may administer medications upon the successful completion of the Pharmacology exam and demonstration of appropriate skills during orientation.

D. Medication procedures
The actual technique for giving medications via different routes is defined in three major nursing procedures: IV, Parenteral and Non-Parenteral.

E. Administration Times
Medications are administered by physician orders in concert with definitions and time frames established by nursing in collaboration with the medical staff. While STAT drugs are given immediately (within 15 minutes of the order), routine drug times are determined in such a way as to promote optimum blood levels but interfere as little as possible with patient rest and change of shift routines. Refer to the CMAR guidelines for specific times.

F. Automatic Stop/Renewal Orders
Automatic stop/renewal orders exist as follow: narcotics/hypnotics- 3 days; Antibiotics- 7 days; and all other medications- 21 days. Upon reaching the stop/renewal date, a physician's order to discontinue or renew the order must be obtained. The nurse may not automatically discontinue or renew the order independently.

G. Double Checking Medications
Due to the high risks associated with the administration of insulin, heparin and PCA, two licensed nurses are required to check for the correct medication, concentration, dose/rate and route upon initial administration, rate changes, or change in patient care unit. The nurse administering the IV or sq heparin, insulin or PCA is required to have another licensed nurse validate the above and initial the MAR.

H. Intravenous Fluid Administration

I. All IV's require the labeling of the site, tubing and solution. IV's with and without additives are recorded on the Scheduled MAR and initiated at the time of each bag change.

V. How do I document in the patient's medical record?

A. The patient Medical Record
The Patient Medical Record is a compilation of data from 3 main areas: the Main Chart at the unit's nursing station, the Bedside Chart kept outside of the patient's room, and the Medication Administration Record (MAR) kept in a book on the Medication Cart.

The majority of the nursing and interdisciplinary documentation forms are kept in the Bedside Chart.

B. Guidelines
All forms require Guidelines that are written instructions and direct employees on how to complete the form. These guidelines are placed on the hospital wide Intranet with a hard copy maintained in the Nursing Office for use in the event of computer down time.

C. Abbreviations
The official abbreviation list is developed by an interdisciplinary task force based on hospital documentation needs and reference/literature review. This list is utilized hospital wide by all Direct Patient Care Service (DPCS) for documentation and communication purposes. The list is updated with each Support Service review/revision on an ongoing basis and is available on the hospital-wide Intranet.

D. Patient Care Documentation System
The Department of Nursing (DON) believes that the interdisciplinary patient care documentation system must be professional standards and based on nursing/patient care process. It is to be concise, focused on patient outcomes and in compliance with regulatory agencies and adequate to address legal requirements. The system addresses the following eight critical points: Admission, Reassessment, Condition Change, Caregiver, patient Education, Evaluation of Effectiveness, Unit Transfer and Discharge.

E. Documentation Tools

1. Major Components of Charting System for Documenting The Nursing/Patient Care Process:

PDB — Initial Assessment-The initial assessment/evaluation is divided into two areas, past/current medical history and physical assessment. The past/current medical history is documented on the Patient Data Base (PDB) by the DON staff and appropriate DPCS. The physical assessment is documented on the Assessment Flowsheet/Interdisciplinary Progress Record (AFS/IPR) by the responsible RN and LVN.

AFS/IPR — Reassessment-Reassessments, as determined by the Unit Specific Performance Standards, the patient's condition, and patient care interventions and evaluations of effectiveness are documented by all licensed/professional DON/DPCS staff on the AFS/IPR.

SOC/ — Nursing Diagnosis/problem Identification and Patient Care

PROTOCOLS Required-Pre-printed Standards of care (SOC) based on specific patient population groups and protocols based on specific treatments/interventions are selected according to the data collected upon admission and related to the patient's medical diagnosis (DRG) and care required. The protocols to be initiated are also driven by the SOC. All initiated SOC and protocols are documented on the Standards Flowsheet (SFS)

SFS Documentation of care given- The documentation of care given occurs by the staff recording, which SOC/protocols are being, followed on the Standards Flowsheet (SFS) each shift. Any deviations from the SOC/protocols require professional modification by the professional DON/DPCS staff and documentation in the IPR.

PTP Documentation of patient Education- For issues that alter the patient's activities of daily living, the education plans, outcome standards, due dates, who provided the education, patient/SO response, effectiveness of education and required follow up are documented on the interdisciplinary Patient Teaching Protocol.

IPR Documentation of Effectiveness of Care- The patient's response to care, with positive or negative changes in patient's condition are documented on the Interdisciplinary Progress Record (IPR).

DIF Documentation Instruction Form- the home care activities required at the time of discharge and necessary follow up is documented on the Discharge instruction Form.

2. Minor Components of Charting System Supporting the Nursing/Patient Care Process. Supportive documentation tools exist to accomplish the following roles:

   - Intake/Output Record- All fluids given via any route to the patient and all patient drainage/excretions via any route are documented on the I&O Record.
   - Vital Signs/Graphic Sheet- The patient's routine temperature, pulse, respiration, pain rating scale, weight, percentage of meal eaten, type of diet taken, number of BM's, 24 hours and I&O totals, if applicable, are documented on the V/S Graphic Sheet.
   - Frequent Vital Signs/Neuro Check Sheet- Vital signs and pain rating taken more frequently than every four hours and all

neuro checks are documented on the Frequent Vital Signs/Neuro Check Sheet.

- Computerized Medication Administration Record (CMAR), scheduled and PRN- All routine and time dose medications administered via any route are documented on the Scheduled MAR. All non-routine and prn, administered by any route are documented on the Unscheduled MAR. The medication dose/frequency and route, initials of the nurse who administered the medication and time administered are documented for all medication administered. Refer to CMAR Guidelines for full instructions.
- IV Heparin Administration Record - The IV Heparin Administration Record is initiated for all patients receiving IV heparin and/or Coumadin. The prothrombin time (PT) and level and anticoagulant medication, dose, route and time of administration are documented on this record.
- Physical Restraint Flow sheet - The Physical Restraint Flowsheet is initiated for all patients who have restraints applied under the Medical/Surgical Intervention or Behavioral Restraints categories. The initial assessment, physician communication, patient/SO instruction, validation of continued need, every two-hour evaluation/patient care and every 15 minutes observation is recorded on this flowsheet.
- Blood Product Transfusion Record- The blood Product transfer record is used to document the entire process of blood product verification and administration including patient vital signs. The record is provided by the Blood Bank at the time of blood pick-up.

VI. What right does the patient have?

A. Bill of Rights

The patient has the right to have equitable and humane treatment at all times and under all circumstances:

1) The patient's privacy and individual dignity shall be maintained in all areas of examination and treatment within the hospital.
2) The confidentiality of the patient's disclosures, within the law, shall be accorded the patient. This right of confidentiality shall include the right of the patient to decide to participate in the clinical training programs and/or the gathering of data for research purposes. The level of this participation shall not be related to the nature of the source of payment for his or her care except as provided by law or third party contacts.
3) The patient has the right to know from those responsible for his or her care:

- The identity of the physician who is primarily responsible for his or her care. He or she should know the identity of all individuals participating in his or her care.
- The nature and extent of the medical problem.
- The planned course of treatment.
- The prognosis.
- Adequate instruction in self-care in the interim between visits to the hospital or to the physician.
- Alternatives for care or medical treatment where medically significant.
- Information necessary to give informed consents prior to the start of any procedure and/or treatment significance of the same.
- The probable duration of the hospital stay.
- Right to participate in ethical issues that may arise in the provision of his/her care.

4) Communication between the patient and the physician or the hospital should accommodate, where possible, the ethnic, cultural and language variations of the patient.
5) In compliance with the patient Self-Determination Act of 1990:
    - Adult patient have the right to control the decisions relating to the rendering of their own medical care, including the right to accept or refuse medical or surgical treatment (and to be informed of the possible medical outcomes of his or her action) and have the right to formulate advance health care directives.
    - No patient shall be discriminated against or have care conditioned on whether or not advance health care directives have been executed.
    - Valley Presbyterian Hospital will comply with state and federal laws governing healthcare Directives. Protection of this right shall not be construed to condone or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as defined by statute.
    - Adult patients have the right to designate a surrogate decision-maker in the event on incapacitation.
6) From the hospital, the patient has the right to expect:
    - A reasonable response to his or her request for services within the capacity of the hospital.
    - Evaluation, service and/or referral as indicated by the urgency of his or her case.
    - Complete information and explanation concerning the needs for and the alternatives to his or her transfer to another institution when medically permissible.
    - Information concerning the relationship of his or her hospital to other health care and educational institutions insofar as his or her care is concerned.

B. Conflict/Complaint Resolution

Patient/families have the right to complain without fear of reprisals about the care/services rendered, and to request that the hospital address these issues.

1) If conflict should occur, the patient/family can request that the physician, Charge Nurse, or Nurse Manager serve as the patient/family advocate.
2) The patient advocate will be responsible for:
    a) Clearly defining the problem and/or issues.
    b) Bringing together the parties involved in the conflict for the purposes of communication and resolution.
    c) Recommending corrective action to the appropriate authority who will approve, or obtain approval, to implement the corrective measures; and
    d) Forwarding a copy of the written report describing the conflict to the quality Improvement manager, to the VP of Operations, and to the attending physician, if applicable.
3) If the concerns or conflicts appear related to ethical implications of care, these can be addressed to the Ethics Committee by contacting the unit manager.

C. Public Relation (PR)

The patient has the right to limited public knowledge of his admission and condition. Under the confidentiality of Medical Information Act, state law allows the Health care provider to release general patient information, unless there is a specific written request by the patient to the contrary. This general information is defined as the patient's name, address, age and sex; general description of the reason for treatment; general nature of the injury, burn, poisoning or condition and the general condition of the patient as good, fair, serious or critical. When the patient has requested that general information not be released, a public figure is involved, or the media is requesting information, only the Public Relations Manager or Vice President of Corporate Development can determine what information is released and how it will be released.

D. Hospital Visiting Hours

The visiting regulations attempt to balance the need of the patient to have the comfort of their family/SO while providing the patient the ability to get the rest delivered for recovery as well as the safety needs of the hospital. The general hospital visiting hours are from 2:00 pm to 8:00 pm every day.

VII. What legal/Ethical issues are important?

A. Healthcare Directives

A Healthcare Directive is a formal document, written in advance of an incapacitating illness or injury, in which people can provide for decision making about medical treatment if they become unable to make their own

decisions. The hospital supports a patient's right to participate in healthcare decision making.

B. Consents
Every patient has the right to "informed consent" which means that the patient has the right to full explanations of diagnostic/therapeutic interventions by a knowledgeable person, as well as the right to give approval or refuse to participate in therapy. Professional nurses share in the legal and moral obligation to see that all patients are adequate information about their rights of informed consent.
The nurse's role in the consent process is limited to verifying that the patient's informed consent has been obtained by the physician and obtaining the patient's signature on the Operative/Invasive Procedure Consent form before the physician performs the medical procedure.

C. Organ/Tissue transplant Information
The department of Nursing (DON) supports the hospital-wide organ/tissue donor philosophy by assisting in the identification of possible donors, referring/collaborating with the One Legacy Organ Procurement Agency and facilitating the procurement process.

D. Reporting Suspected Child/Dependent Adult/Elder Abuse or Neglect
The term abuse/neglect includes physical, psychological and financial forms of mistreatment.

Physical abuse involves intentionally inflicting, or allowing someone else to intentionally inflict bodily injury or pain. It includes such things as slapping, kicking, shaking, throwing, biting, pinching, twisting extremities, and burning, as well as sexual abuse.

Neglect is more common than physical abuse. Forms of physical neglect include the withholding of food, medication, drink, clothing, hygiene, or shelter. Emotional neglect occurs when nurturing or psychological needs are not met or ignored.

VPH has established criteria for the identification of abuse. The penal Code requires practitioners to report suspected or confirmed abuse or neglect. The Patient and family Service Department or Nursing Supervisor is informed and a written report completed.

E. Resuscitation Status of patients
The resuscitation status of patients will be designated by assignment of the terms "Full Code", "No Code", "Do Not Resuscitate" (DNR), or "Meds Only Code" to each patient admitted to the hospital. Any patient who does not have a designated resuscitation status will be considered to be a "Full Code".

The following terminology will be utilized regarding patient resuscitation status:

- "No Code" or "Do Not Resuscitate" (DNR) will imply that no cardiopulmonary resuscitation measures are to be instituted in the event that a patient experiences a cardiopulmonary arrest. These measures include basic Cardiac Life Support (BCLS) and Advanced cardiac Life Support (ACLS) as defined by the American Heart Association (AHA).
- "Full Code" will imply BCLS and ACLS (as defined by the AHA) will be initiated immediately in the event that a patient experiences a cardiopulmonary arrest.
- "Meds Only Code" will be applicable to telemetry monitor units in the hospital and will imply that medication be administered for resuscitative purposes, but that no intubation, CPR or artificial respiration will be administered in the event of cardiopulmonary arrest. Re-designation of code status will be done by the primary care physician or designee at the time of transfer to a non-monitored unit.

Patients who are designed as "No Code" or "DNR" status will have the universal symbol of a rectangle with a circle in the middle placed on their medical record, communication board outside the patient's room and nursing station census board.

F. Incident/Occurrence Reports

The incident/occurrence reports or CARE Hotline are utilized to report all occurrences throughout the hospital. Occurrences are defined as any event or situation which is inconsistent with the routine operations of the facility; is potentially a compensable event; or has a significant positive or negative impact on the safety, security or satisfaction of a patient, family, employee or other.

VIII. How is conscious sedation managed?

Conscious Sedation is produced by administration of pharmacologic agents by any route for the purpose of short-term sedation for planned therapeutic, diagnostic or surgical procedures. Moderate or conscious sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Patients undergoing conscious sedation are at risk for respiratory depression/apnea, hypotension, unarousable sleep or a paradoxical response such as agitation/combativeness. Please refer to the Conscious Sedation Management Protocol for details regarding patient care before, during and after sedation and required documentation.

IX. What is VPH's position on the use of physical restraint?

VPH supports a restraint-free environment. Restraints are not applied to prevent patient falls. Restraints are only applied after the patient demonstrates a serious behavioral threat to themselves or others and all alternatives have failed.

A physical Restraint is any manual method or physical-manual device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove, that restricts freedom of movement or normal access to one's body. Devices used for orthopedic treatment are not considered restraints, i.e., casts, splints). The regulatory agencies divide restraint use into 2 categories, Acute medical/Surgical Intervention and Behavioral Management.

Acute Medical/Surgical Intervention is defined as a restraint used when the primary reason for use directly supports medical healing. In acute medical and post surgical care, a restraint (i.e., soft splint) may be necessary to ensure that (for example) a tracheostomy, endotracheal tube or NG tube will not be removed. Medical restraint may be used to a medical or post-surgical procedure.

Behavioral management is defined as a restraint used when the patient demonstrates unexpected, severely aggressive, destructive and violent behavior, which presents an immediate and urgent threat to the patient or hospital personnel. Behavioral healthcare reasons for the use of restraint are primarily to protect the patient against injury to self or others and because of an emotional or behavioral disorder.

Only RN's who have completed and are current in the restraint education program may validate the patient assessment and determine the appropriate restraint device. These RN's may delegate tasks to patient caregivers (i.e., application of restraint and physical hygiene/comfort measures). Restraints are never used as a punishment to the patient or for the convenience of staff. Please refer to the physical Restraint Management protocol for details regarding the prevention and use of restraints including physician orders and documentation.

X. What special consideration is there regarding blood products administration?

Blood products are administered to replace or correct hematological abnormalities. All efforts to minimize blood transfusion risks must be performed and include the following: patient identification, blood product/group and Rh type, and transfusion of blood products which must be started within 30 minutes from the time obtained from blood bank, never placing blood products in unit refrigerators (except PACU), and using a filter with all blood products. Transfusions may be initiated by licensed nurses with a physician order, informed consent, and patient consent signed. The nurse must present the completed Physician Informed Consent Documentation Record and patient Authorization/Consent to the Blood Bank at the time of blood pick up. Blood administration must be <u>thoroughly</u> documented utilizing the Blood Products Administration Records including all vital signs. Please refer to the Blood Products Administration Procedure and Protocol for details. NOTE: At the time of

admission, if the patient indicates on the "Patient Rights" form that they are unwilling to accept a transfusion, a yellow band stating "No Blood Products" is placed on the patient's wrist.

XI. What are the special issues related to lab?

A. Point of Care Testing
The lab testes that can be performed directly on the patient care unit, point of care testing, include blood glucose, fecal occult blood, activated clotting time, urine protein and glucose, and urine multi-stix.

The nurse's responsibilities regarding point of care testing include the following: performing quality control, calibrating equipment, cleaning equipment, maintaining adequate supplies, collecting specimens, performing the test and documenting the results of the test.

Staff competency in point of care testing must be validated prior to performing any test.

B. Critical Lab/Elevated Therapeutic Drug Values
Critical and toxic lab values are determined by the Clinical Laboratory and the medical staff based on references.

Upon verification of a critical or elevated test value, the laboratory technologist or pharmacist will stamp a "critical value" stamp, fax to unit where patient located, and follow-up with a phone call to nurse responsible for the patient's care. The technologist/pharmacist must use the term "critical or elevated test value" when reporting the abnormal result.

The RN is then responsible for following the established process for result verification, physician communication, patient care and documentation utilizing the appropriate stamp or sticker. The critical value is then placed under the "critical value divider" in patient's chart.

XII. What are VPH's general safety practices?

A. Patients with the same Name
Patients with the same name are identified by the admitting department and patient care units. When the patient is a scheduled admission a "Name Alert" label is placed on the admission jacket by the admitting department staff. As well, this label is placed on the front of the appropriate charts and on the patient census board by the patient care unit staff.

B. General Body Mechanics

Good body mechanics is the efficient, coordinated and safe use of the body to produce motion and maintain balanced during activity. Proper movement promotes body musculoskeletal functioning, reduces the energy required to move and maintain balance, therefore reducing fatigue, and decreasing the risk of injury. Good body mechanics is essential to both patients and nurses to prevent strain, injury and fatigue. Good body mechanics involve good body alignment or posture, good body balance or center of gravity and coordinated body movement. The principles of body mechanics when moving objects are: spread your feet to provide a wide base of support; place your feet appropriately in the direction in which the movement occurs; keep objects to be moved close to your body; push, pull, roll or slide objects, use the body's weight to counteract the weight of the object; avoid twisting the spine by pushing or pulling objects directly away from or toward the body and squarely face the direction of movement and when lifting objects, distribute the weight between large muscles of the legs and arms.

C. Side Rails/Bed Wheel Locks/Bed Position

To decrease risk of fall and patient injury care must be taken in managing side rails, bed wheel locks and bed positioning. Two to three side rails may be in the "up" position when the patient is left unattended and/or during any period of time the nurse/physician assesses their need to provide a safe environment. These times may include: at night when the patient is settled for sleep, postoperatively until the patient's completely active and responsible, after administration of an analgesic or hypnotic or when the patient is disoriented or restless. If four raised side rails are required, the Restraint management Protocol must be followed. Bed wheel locks may be unlocked only to move the bed. The bed position may be raised only during patient procedures, treatments or when rendering care. Otherwise, the bed must remain in the low position at all times.

D. Special Needle/Syringe Precautions

All unused needles and syringes are locked in the Medication Room or Medication carts. All used syringes and needles are disposed of in sharps containers located in each patient room, on each medication cart, in the medication room and in the clean/dirty supply room.

E. Preventing Exposure to Blood Borne Pathogens

Valley Presbyterian Hospital is concerned with exposure to blood-borne pathogens (BBP). It is our intent to eliminate or minimize employee exposure to blood-borne pathogens such as HIC, HCV, and HBV in accordance with the criteria of California Occupational and Safety Administration (Cal/OSHA) Blood-borne pathogens Standard.

F. Special Consideration for Radiation

Radiation is a health hazard and VPH is concerned specifically with those radioactive materials used in diagnostic and therapeutic procedures. Radioactive materials are used for procedures such as radiography, fluoroscopy and nuclear medicine. Radiation injury can occur from over exposure or from exposure to radiation that treats specific issues and at the same time injuries other tissues.

Often nurses help care for patients treated or diagnosed with radioactive substance. The patient diagnosed through radiography or fluoroscopy generally receives minimal exposure, and few precautions are necessary. The nurse assisting with any of these procedures must wear a lead apron. Patients with radioactive implants are a source of radiation to the immediate environment. The nurses who are in close contact with such patients such as in the radiation department or medical/surgical/oncology unit must wear a radiation badge to measure their exposure.

Nurses must deal safely with radioactive body discharges by wearing gloves and in some instances placing excreta in containers for special disposal. The nurse must wash hands well before and after removing the gloves and place contaminated materials in a special container for disposal. The Radiology Department will provide necessary instructions for the care of the patient.

G. Special Considerations with Hazardous Waste

VPH recognizes the risks that hazardous waste materials pose. The staff must be trained in the hazardous materials that they work with, how to handle them, what protective measures are required and how to utilize the Material Safety Data Sheets. Material Safety data Sheets (MSDS) are written preprinted information concerning Students should immediately report exposure incidents to enable timely medical evaluation and follow up.

H. Electrical Precautions

The Staff/student must only utilize equipment that is grounded and in good working order. The electrical plug of grounded equipment has three prongs. The two short prongs transmit the power to the circuits or stray electric currents. Faulty electric spark near certain anesthetic gases or oxygen can cause serious fire. The engineering department must be notified with anything tagged with an equipment repair notice. The equipment must not be used until after repair.

The staff/student may also reduce electrical hazards by complying with the following: check cords for fraying or other signs of damage before using equipment and do not use if damage is apparent; avoid overloading outlets; always pull a plug from the wall outlet by firmly grasping the plug and pulling it straight out; never use electrical equipment near sinks, bathtubs, showers or other wet areas.

Emergency Codes-Effective 1/1/09

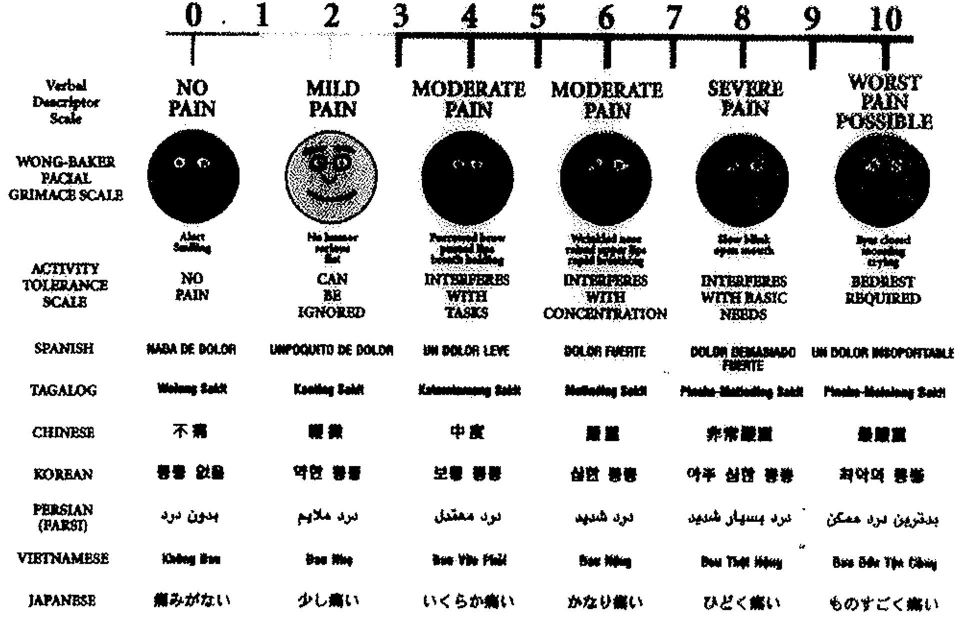
DIAL 4444 TO INITIATE

Emergency Codes:	
Red	Fire
Blue	Cardiopulmonary Arrest - Adult
White (PEDIATRIC)	Cardiopulmonary Arrest - Pediatric
APGAR	Newborn needing immediate resuscitation
STEMI	Heart Attack in the ER
Pink	Missing / Abducted Newborn
Purple	Missing / Abducted Infant / Child
Green	Injured or ill individual (non-patient / staff)
Gray	Combative Person
Silver	Person with weapon [illegible]
Yellow	Bomb threat
Orange	Hazardous material released
Triage Internal	Disaster plan activation - Internal
Triage External	Disaster plan activation - External
Rapid Response Team	Change in patient status
HERT	Hospital Emergency Response Team

MODERATE

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



FLACC Behavioral Pain Assessment

Categories	Scoring 0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position moves easilyl	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry, (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractable	Difficulty to console or comfort

Each of the five categories is scored from 0-2, resulting in a total score between 0 and 10.
The FLACC scale was developed by Sandra Merkel, MS, RN, Terri Voepel-Lewis, MS, RN, and Shobha Malviya, MD, at C. S. Mott Children's Hospital, University of Michigan Health System, Ann Arbor, MI.
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National patient Safety Goals for 2009

Goal 1 – Improve accuracy of patient identification

Goal 2 – Improve effectiveness in communication among caregivers

Goal 3 – Improve safety in using medications

Goal 7 – Reduce risk of healthcare associated infections

Goal 8 – Accurately and completely reconcile medications

Goal 9 – Reduce risk of patient harm due to fall

Goal 10 – Reduce risk of influenza and pneumococcal disease in institutionalized older adults

~~**Goal 11** – Reduce risk of surgical fires~~

Goal 13 – Encourage patient involvement in own care

Goal 14 – Prevent health care associated pressure ulcers

Goal 15 – Identify safety risks in our patient population

Goal 16 – Improve recognition and response to changes in patient's condition (Rapid Response Team)

Universal protocol expectations

"DO NOT USE" ABBREVIATIONS, ACRONYMS AND SYMBOLS

The following must not be used for writing orders or documenting in the medical record

Abbreviation	Intended Meaning	Misinterpretation	Corrective Measure
IU	International Unit	"IV" (intravenous) or the number "10"	Write "International units"
MgSO4	Magnesium sulfate	Morphine sulfate	Write the complete drug name
MSO4	Morphine sulfate	Magnesium sulfate	Write the complete drug name
MS	Morphine sulfate Magnesium sulfate Multiple scleroses	Magnesium sulfate Morphine sulfate	Write the complete drug name or diagnosis
Q.D.	Latin abbreviation for "once daily"	"QID" (four times a day) "QOD" (every other day) The period after the Q can be mistaken for an "I" or "O".	Write "daily"
Q.O.D.	Latin abbreviation for "every other day"	"QID" (four times a day) "QOD" (every other day) The period after the Q can be mistaken for an "I" or "O"	Write "every other day"
U or u	Units	Misread as a "zero" or as a four "4", causing a ten-fold or greater dose increase Example: "4U" seen as "40" or "4U" seen as "44"	Write "units"
Trailing zero ("Zero" after the decimal point) Example: 5.0 mg	Example: 5 mg	Decimal point is missed Example: 50 mg	Never write a zero by itself after a decimal point
Lack of leading zero (No "zero" before the decimal point) Example: .5 mg	Example: 0.5 mg	Decimal point is missed Example: 5 mg	Always use a "zero" before a decimal point

Prescribers will be phoned to clarify any orders containing the above abbreviations, acronyms, or symbols

Customer Service

1. **Be courteous and respectful to my customers by:**
   - Speak with a soft tone of voice and friendly facial gestures
   - Introduce myself
   - Escort customers to their destination when possible
   - Greet and address customers by name and/or title
   - Use appropriate department script
   - Deliver the same treatment as I would expect
   - Say "Thank You"
   - Do not discuss customers in public areas.
2. **Be sincere and compassionate by:**
   - Recognize and address all customers' concerns and needs seriously
   - Constantly round/check on all customers
   - Follow through on promises
   - Engage patient and family in conversation during procedures in patient's room
3. **Demonstrate positive attitude by:**
   - Verbally greet anyone within five feet
   - Make eye contact and smile toward anyone within ten feet
   - Show interest in my job
   - Offer assistance
4. **Display professionalism by:**
   - Dress appropriately per hospital's dress code
   - Keep personal issues separate from employment issues
   - Take responsibility for my actions
   - Report to work on time, prepared to work
   - Wear my ID badge at all times
   - Maintain my own payroll accurately
5. **Practice effective communication with others by:**
   - Practice politeness and honesty
   - Listen to our customers concerns during rounds
   - Keep customers informed by explaining procedures
   - Deal effectively and promptly with unhappy customers
   - Not hold personal conversations in front of customers.
6. **Strive for Excellence by:**
   - Take pride in my work and in my hospital.
   - Perform to the best of my abilities.
   - Keep up with the knowledge and skills in my areas of practice.
   - Support the hospital's mission, goals, and values
   - Be a team player