Annual Review

The following is a review of Catholic Health policy and procedures. Some policies have been updated to reflect changes in practice.
2016 TJC NPSG

- Patient ID
- Staff communication
- Medication safety
- Alarm safety
- Prevent infection
- Patient safety risk
- Surgical mistakes
2 ID sources at all times! Never use room number!

Place name band on only when 2 identifiers are found

Special circumstance
  • Patient unable to speak, unconscious, and no ID, the patient is called Jane or John Doe until ID is completed

Identification is vital!

Adult
  • Name
  • Date of birth

Newborn
  • Name
  • Medical record #
Patient ID: Other Scenarios

Medication administration

• Bar code technology is used
• ID band is scanned prior to med pass

Outpatients

• Patient states full name and date of birth, if able
• Compare information stated to paperwork
Name Alerts

Med host (ED)
- Patients with same
- Name - name will be flashing

Soarian (Inpatients)
- Sign on will alert you of patients with same name

You click on correct name with each sign on
Patient ID Checks Must be Done

- Arrival on unit
- Consent
- Arm band placed
- Charting
- Breast milk
- Patient meals
More Times to Check Patient ID

- Prior to procedure
- Blood draws
- Transfusion
- Telephone order
- Verbal order

- Med administration
- Assessment
- Transport of patient

*Any time you are in contact with a patient!!*
NPSG
Improving Staff Communication
NPSG
Improve Staff Communication

Critical value
• **Test value** that if not acted upon, may result in the patient being compromised medically

The provider
• Should return your call within 60 minute time frame
Who Calls Who?

Lab, xray technician
  • Call RNs for acute site inpatients
  • Call providers for outpatients

RNs at acute sites
  • Call the provider
Critical Value = Abnormal Result

Lab values (Serum)
- Potassium (< 2.8, > 6.0)
- Sodium (< 120, > 160)
- Hct (< 15)
- Hgb (< 6)
- Glucose (< 40, > 500)
- Magnesium (< 1.0, > 6.0)
- WC (< 2.0, > 50)
- Lactic Acid (≥ 30)

Radiology
- Intracranial Bleed
- Pulmonary Embolism
- Pneumothorax
- Abdominal Free air

Echocardiogram
- Tamponade
- Aortic Dissection
- Pericardial Effusion
Cardiology Critical Values

On EKG

- Acute, recent or possible MI
- Current Injury
- Bradycardia with HR ↓40
- Tachycardia with HR ↑150
- 2nd degree Type II Block
- Complete Heart Block
- Ventricular Tachycardia
- Electrical Alternans
Critical Value Follow Up

Provider return call time is not to exceed 1 hr

Document:
- Time of your call
- Provider call back
- Conversation
- Orders
Critical Value

No call back received?

• Follow chain of command
• **Call RRT- 55555** if patient clinically compromised
• Report call back delay to the nurse manager
Speak Up For Safety

You - the patient advocate

• All pt’s needs addressed?
• Offer suggestions to provider
• If provider ignores you, the Nurse Manager or supervisor must be informed of the situation
Event Timing

Time notation

Critical when recording:
- Patient condition changes
- Emergency meds given

Use for notation
- 1st - Computer screen
- 2nd - Phone display
- 3rd - Cell phone
- Use Last - Wall clock
Rapid Response Team

Acute site staff
• Providers
• Critical Care Nurses
• Respiratory Therapists
Call a “Rapid” for Any Significant Change

- Vital signs - HR, BP, RR
- Cardiac rhythm
- Breathing or airway
- Decrease in O2%, despite oxygen usage
- Acute bleed
- Unresolved chest pain
- Level of consciousness change
- Poor response to current interventions
Using Medicines Safely
Medications On or Off Sterile Field

All must be labeled
- Medications
- Med containers
  - Syringes
  - Medication cups
  - Basins
- Solutions

Labeling includes name, dosage & route for drug
If patient specific, must have patient name and DOB
Labeling must occur
- When medication or solution is taken out of it’s original packaging
- Placed into a different container
Medication Reconciliation

Patient

Medication Information
Medication Reconciliation

Process to assess medication usage across the continuum
- Identify meds on admit, or on transfer to another unit
- Track patient’s meds across the continuum to another location

Computerized Provider Order Entry
- Provider identifies whether meds are to be continued, discontinued or changed
- Provider review is done on admission, post procedure, unit transfer or discharge
- Nursing is to verify changes with provider
Medication Safety
<table>
<thead>
<tr>
<th>Abbreviation/ Dose Expression</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Mistaken as a zero (0)</td>
<td>“Unit” has no acceptable abbreviation. Use “unit”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e.g. 4U seen as “40”</td>
<td></td>
</tr>
<tr>
<td>IU</td>
<td>International unit</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Use “units”</td>
</tr>
<tr>
<td>Trailing zero after decimal point (1.0 mg)</td>
<td>1 mg</td>
<td>Mistaken as 10 mg if the decimal point is not seen</td>
<td>Do not use trailing zeroes for doses expressed in whole numbers</td>
</tr>
<tr>
<td>No leading zero before a decimal dose (.5 mg)</td>
<td>0.5 mg</td>
<td>Mistaken as 5 mg if the decimal point is not seen</td>
<td>Always use zero before a decimal when the dose is less than a whole unit</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium sulfate</td>
<td>Mistaken as morphine sulfate</td>
<td>Spell out “magnesium sulfate”</td>
</tr>
<tr>
<td>MSO4, MS,</td>
<td>Morphine sulfate</td>
<td>Mistaken as magnesium sulfate</td>
<td>Spell out “morphine sulfate”</td>
</tr>
<tr>
<td>qd, QD, q.d.</td>
<td>Every day</td>
<td>Mistaken as q.i.d.</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>qod, QOD, q.o.d.</td>
<td>Every other day</td>
<td>Mistaken as q.d. (daily) or q.i.d. (four times daily)</td>
<td>Use “every other day”</td>
</tr>
</tbody>
</table>
Look or Sound Alike Names

Nurses must be vigilant to prevent errors.

Look or sound alike refers to:
- Drug names
- Vial, box or syringe labels

MAK dispensing system uses TALL MAN lettering:
- For example: OxyCODONE or OxyCONTIN
- Be your patient’s advocate and prevent errors!
Indications

Look - Alike/Sound - Alike Meds

Drugs in this category

- Must have the indication for use in the orders

Potential errors

- Hydroxyzine - Hydralazine
- Ephedrine - Epinephrine
- Nalbuphine - Naloxone
- Risperidone - Ropinirole
Patient and Family Education

Patient and family education is an ongoing process.

Safety handout is on CHS Intranet

Patient and families appreciate any information to help them understand the hospital experience.
Verbal Order Read Back Policy

- Order taken verbally
- Stamped (sign/date & time) and flagged
- Co-signed (date and time) within 48hrs

*Text messages are not legal orders*
*Tiger texting – purpose is only for giving information to the provider – and NOT for ORDERS*

Provider orders either by writing order out or to Input into CPOE – verbal orders are as needed only
*CPOE is to be utilized by the providers*
Telephone Order with Read Back

• Order sheet correctly labeled
• ID patient
  • Adult- name & date of birth
  • Peds- name & medical record number
• Obtain and transcribe order
• No orders texted to you are to be utilized in the care of your patient per CHS policy
• You must obtain a verbal or telephone order, or have provider use CPOE for orders to be valid
Nothing By Mouth
(NPO Policy)
Only Acceptable NPO Orders

- NPO no oral medications
- NPO give oral medications
- NPO no oral meds until procedure/test completed
- NPO give oral meds until procedure/test completed
NPSG

Using Alarms Safely
Use Alarms Safely

Initiated in 2014

- **Alarm fatigue** is an issue with the variety of alarms used, even for one patient

- **TJC** developed this goal for patient safety

- Make sure all alarms are heard *and* responded to on time and appropriately
NPSG

Prevent Infection
Can We Prevent?

What can nurses do

- Follow policies
- Follow bundles (EBP)
- Keep up to date
- Vigilant patient monitoring
- Update provider of any patient status changes
How often to wash?

- Before, during, or after any patient contact

- Scrub hands 15-20 seconds with soap and water

- If there is obvious soiling noted on hands, do not use the antibacterial gels.

- You must scrub hands using soap and water
Central Line Infections

Ways to minimize CLABSI

- Education of health care staff
- Pre insertion “Time Out”
- Sterile insertion process
- EBP bundles for
  - Insertion
  - Maintenance
Central Line Insertion Bundle
CLABSI Prevention

- Hand hygiene prior to
- Use of Subclavian/Internal Jugular is preferred
- Femoral use for insertion – not preferred
- Provider must use full barrier precautions
- Assistant to be in full barrier precaution garb when in the sterile field
- Full sterile drape over patient after the Chlorhexidine prep is done to area of insertion
Inserting Provider’s Full Barrier Precautions

- Sterile gown
- Sterile gloves
- Cap
- Mask
- Face shield and/or eye protection
- Scalp, beard, mustache must be covered
Assistant’s Role
During Central Line Insertion

- Cap, mask, gloves, isolation gown, face shield and/or eye protection to be worn

Monitor provider for sterile field breaks
- If provider breaks sterile field, speak up for safety, provide new gloves, gown or whatever is needed

Assistant must be garbed if within the sterile field
Maintenance Bundle

- Hand hygiene
- Scrub access portals prior to usage
- Monitor site & cover dressing, assess daily for continued need of line
- Sterile dressing change q 7 days - unless soiled
- Administration sets changed every 96 hours
Surgical Site Infection (SSI) Prevention Bundle

- Prophylactic antibiotics per physician’s order
- Clippers only for hair removal (no razors)

With cardiac surgical patients, improved wound healing outcomes are noted postoperatively with patient having stable 6am postop blood glucose
CHG Wipes Usage

CHG decolonizes the skin
- Replaces soap & water bath
- Nurses and aides both use
- Only use from neck down

Kept in a warming unit
DON’T microwave
DON’T flush down toilets
Urinary Catheter Usage for CAUTI Prevention

**Used only for**
- Strict I & O
- Retention/Obstruction
- End of life
- Pressure ulcer until reaches a stage 2*
- Long term use
- Preoperative
- Patient monitoring

**Do not use for**
- Nursing convenience
- History of incontinence (UI)
- UI without having Stage 2 or greater skin breakdown
- Doesn’t meet criteria
- No order in chart
Urinary Catheter Bundle

- Appropriate reason
- Wash hands
- Wear gloves
- Meatal hygiene
- Securement device
- Closed system
- Bag below bladder
- No part of system to touch the floor
ii. Specimen Quality and Handling

- Specimen Collection using SoftID
  - Review specimen requirements – note new specimen collection tubes
    - UR Cup - Integrated Collection cup; used for Quest testing requiring large volume
    - UR CLR (No Additive) - Clear top Tube, used for routine analyte testing performed in-house
    - UR GRY C&S (Sterile) - Short Gray Top, urine tube used for culture and sensitivities
    - UR R/Y UA (Random) - Red/Yellow marble top, urine tube used for routine urinalysis

This patient would require 5 specimens –
1. UR GRY top for Culture
2. UR Clear top tube for other randomi analaysis
3. UR Red/Yellow top for UA
Urinary Catheter Sampling Process

ii. Specimen Quality and Handling

1. Open bag
2. Tear off paper backing from the 3M Vacutainer™ 24 Gauge Needleshield™ Access Device package
3. Remove from package
4. Set aside

5. Using gentle technique, position the 3M Vacutainer™ Low-Loss™ Access Device over the center of the sampling port. Push it in and rotate the Access Device so that the 采样 device checks over the sampling port until the needle port is in the center.

6. A. To perform your sample collection, insert the 3M Vacutainer™ Plus Collection Device into the needle port of the Access Device, and push it in.
B. Once the tube is completely filled, remove the tube from the holder.
C. Immerse the tube 5-10 times.

7. After removing the last tube, hold the sampling port and remove the 3M Vacutainer™ Low-Loss™ Access Device by rotating it counter clockwise.

8. Uncapping the drainage tube.

9. Discard the 3M Vacutainer™ Low-Loss™ device immediately into an approved sharps disposal container.
Use Patient Instructions

BD Vacutainer® Urine Collection Cup

Instructions to Patient

Routine Urinalysis

1. Caution: DO NOT REMOVE the label from the top of the BD Vacutainer® Urine Collection Cup. There is a needle under the label.
2. Wash hands thoroughly with soap and water.
3. Unscrew the blue cap.
4. Place the blue cap on counter with "straw" facing upwards. Do not touch inside of cap or straw.
5. Follow mid-stream clean catch directions below if instructed.
6. Replace the blue cap onto the BD Vacutainer® Urine Collection Cup.
7. Return the sample to the healthcare worker.

Mid-Stream Clean Catch Instructions
(This may or may not apply to you. Ask your healthcare worker.)

Female Cleansing Instructions
1. Stand in a squatting position over the toilet. Separate the folds of skin around the urinary opening.
2. Cleanse the area around the opening with the firstcastle soap towelette.
3. Repeat using a second clean towelette.
4. Urinate the first portion of urine in the toilet.
5. As you continue to urinate, bring the collection cup into the midstream to collect the urine sample.
6. Do not touch the inside or lip of the cup.
7. Urinate remainder of urine into the toilet.
8. Replace the blue cap onto the BD Vacutainer® Urine Collection Cup.
9. Return the sample to the healthcare worker.

Male Cleansing Instructions
1. Cleanse the end of the penis with the firstcastle soap towelette beginning at the urethral opening and working away from the foreskin of an uncircumcised male must be retracted.
2. Repeat using a second clean towelette.
3. Urinate the first portion of urine in the toilet.
4. As you continue to urinate, bring the collection cup into the midstream to collect the urine sample.
5. Do not touch the inside or lip of the cup.
6. Urinate remainder of urine into the toilet.
7. Replace the blue cap onto the BD Vacutainer® Urine Collection Cup.
8. Return the sample to the healthcare worker.
HIV Testing Overview

**NYS required screening**
- Ages 13 - 64 must be offered testing
- Verbal consent required
  - Written consent no longer required
- Key points on consent are to be reviewed
- Offered to all ED and in/outpatients
- Patient can refuse
Patient Exclusions from HIV Testing

Patients are not offered testing when

- Life threatening emergent care is needed
- Patient was previously offered testing
- Individual lacks capacity to consent
Prior to consent for testing, patient must have knowledge regarding:

- Explanation
- Treatments
- Prevention strategies
- Voluntary
- Confidential
HIV Testing

Must be ordered by provider
• RN to draw sample using gold top tube
• Answer questions

If HIV positive:
• Counseling, referrals
• HIV specialist is seen, lab f/u is done to determine course of treatment
Hepatitis C

Hepatitis C testing is being offered to individuals who are considered at risk:

- Born between 1945-1965
- Illicit IV drug abuse
- Received clotting factor concentrates made prior to 1987
- Health care workers
Hepatitis C

- Hepatitis C Oraquick test
- Test results 20-40 minutes
- Counseling prior

- If Hepatitis test is positive:
  - Follow up labs
  - Clinical care followed by an infection specialist
Bed Bugs

• Bed bugs hide during day

• If noted on bedding it will be at night time

• Notify environmental department and nursing supervisor
Sepsis

Policy
• Developed to help reduce the impact of sepsis on patients

Sepsis protocol
• Application of the policy. Please see next slide for the Sepsis algorithm
Sepsis Protocol

SIRS criteria:
- Patient has two or more of the following present:
  - Temp >100.4°F or < 96.8°F
  - Pulse > 90 bpm
  - Resp Rate > 20/min
  - WBC >12,000/mm³ or <4,000/mm³ or >10% bands

- Reassess as needed
- Suspected or confirmed infection
- Yes

Within One Hour
- Obtain Appropriate Cultures
- START ANTIBIOTICS
- DRAW LACTIC ACID LEVEL

Within Three Hours
- Administer Fluids 500 ml q 15 min to a total of 36 ml/kg or MAP > 65
- Confirm Antibiotics Given
- VS q 15 min x 90 min then q 60 min
- Repeat Lactic Acid in 3 hrs.
- Start Vasopressors if MAP ≤ 65 after fluids
- See Severe Sepsis / Septic Shock Orders

- WITHIN SIX HOURS
  - Achieve Hemodynamic Stability with Fluids and vasopressors
  - Consider CVP Line if MAP ≤ 65 despite fluid resuscitation or lactic acidosis persists
  - Obtain Source Control for Infection
  - Repeat Physical Exam (must include):
    - Vital signs
    - Cardio-pulmonary exam
    - Capillary refill
    - Peripheral pulses
    - Skin exam (mottled skin etc.)

- 6 HOUR TREATMENT GOALS
  - Hemodynamic stabilization resuscitation
  - Restoring tissue oxygenation
  - Infection identification
  - Control of the infection (antibiotic therapy / source control)
Exclusions from Adult Sepsis Protocol

Sepsis protocol applies to all patients seen in emergency department and acute inpatient settings

Except in these situations

- Clinically contraindicated interventions
- Advanced directives which prohibit interventions
- Patient or surrogate declines interventions
- Enrolled in an IRB approved clinical trial, where the sepsis protocol is inconsistent with the trial protocols
3 Sepsis Levels

- Sepsis
- Severe Sepsis
- Septic Shock

Variables are:
- Patient status
- Lactic acid level
Sepsis Protocol – SIRS Criteria

Does the patient have 2 symptoms?
- T > 100.4 or < 96.8
- P > 90 bpm
- RR > 20/minute
- WC > 12 or < 4

What to do
- RN to review with provider
- Obtain orders - sepsis labs

Evaluate Pt for
- Septic Shock
- Shock/Organ Failure
## Adult Protocol Workup

### Suspected Sepsis Labs/Diagnostic Tests

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber.

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
<th>PRESCRIBER ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LAB STUDIES:**
- Lactic acid **[notify MD if greater than or equal to 36mg/dL]**
- CBC with diff
- INR, PTT
- Amylase/Lipase
- Urinalysis
- Cardiac Enzymes

**Obtain cultures prior to initiating antibiotic therapy:**
- Cultures:  
  - Blood x 2 (peripheral sites) **AND** Blood x 1 Vascular Access Device if present >48 hours
  - Urine
  - Sputum

**Urine:**
- Legionella Antigen
- Streptococcus Pneumonia Antigen

**Stool:**
- C. difficile toxin
- Other: _____________

**Additional Studies:**
- Chest X-ray
- CT Chest with contrast
- CT Abdomen and pelvis with contrast
- EKG
- CT Chest without contrast
- CT Abdomen and pelvis without contrast
- Other studies: ________________
A - Severe Sepsis = Sepsis + Organ Failure
B - Septic Shock = Severe Sepsis + Refractory Hypotension

**A - Symptoms**
- BP < 90/60
- MAP < 65
- P > 120
- RR > 24
- Lactic acid level \( \geq 18 \)
- Cr > 2.0
- Platelet < 100,000
- ARF or UO 0.5 mg/kg/hr
- Hepatic issue with:
  - Bilirubin > 2 or INR > 1.5

**B - Symptoms**
- **All of A**
- Plus
  - BP < 90/60 or MAP < 65, despite adequate fluid resuscitation
  - Lactic Acid level \( \geq 36 \)
Sepsis Protocol Goals
Within 3 Hours

WITHIN THREE HOURS
- Administer Fluids 500ml q 15 min to a total of 30 ml/ kg or MAP > 65
- Confirm Antibiotics Given
- VS q 15 min x 90 min then q 60 min
- Repeat Lactic Acid in 3 hrs.
- Start Vasopressors if MAP ≤ 65 after fluids
- See Severe Sepsis / Septic Shock Orders
Sepsis Protocol Goals
Within 6 Hours

WITHIN SIX HOURS

- Achieve Hemodynamic Stability with Fluids and vasopressors
- Consider CVP Line if: MAP ≤ 65 despite fluid resuscitation or lactic acidosis persists
- Obtain Source Control for Infection
- Repeat Physical Exam (must include):
  - Vital signs
  - Cardio -pulmonary exam
  - Capillary refill
  - Peripheral pulses
  - Skin exam (mottled skin etc.)
Pediatric Sepsis Algorithm

PEDIATRIC SEPSIS TRIAGE SCREENING CRITERIA

Fever ≥ 38°C or hypothermia ≤ 36°C within the last 24 hours either by report or direct measure

PLUS:

HIGH RISK PATIENT
1. Infant < 30 days
2. Immunocompromised
3. On immunosuppressants/steroids
4. On chemotherapy
5. Transplant patient
6. Indwelling medical foreign body:
   - Central line
   - CSF shunt
   - JF drain
   - Foley
   - Tracheostomy
7. Sickle cell disease
8. Asplenia

STANDARD RISK PATIENT
1. Altered Mental Status
2. Poor Perfusion
   OR
3. Ill- Appearing
   OR
4. Excessive tachycardia corrected for temperature (see table)
   OR
5. Hypotension

Provider rapidly assesses patient and decides if Pediatric Sepsis Protocol should be initiated.

Excessive Tachycardia Table

<table>
<thead>
<tr>
<th>Heart Rate for Age</th>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37.8</td>
</tr>
<tr>
<td>&lt; 2 years *</td>
<td>&gt;180</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>&gt;140</td>
</tr>
<tr>
<td>6 - 12 years</td>
<td>&gt;130</td>
</tr>
<tr>
<td>13 - 18 years</td>
<td>&gt;110</td>
</tr>
</tbody>
</table>

*Also qualify if bradycardic:
< 1 month: HR <100
1 - 23 months: HR <90
Pediatric Sepsis Algorithm

**PEdiATRIC SEPISS / SEVERe SEPISS / SEPICTIC SHOCK**

0 – 15 mins
- Initiate Sepsis Protocol
- Place monitor & O2 venti mask
- Verify weight, height, & allergies
- Place IV and obtain labs
- Start 1st IVF bolus using “Push-Pull” with 3 way stop cock, pressure bag if >25kg
- STAT PED Sepsis Orders
  - Cell CHOB to arrange for Transfer
  - LABS: Blood Culture, BMP, VGK, CBC with diff, Lactate
  - VITAL SIGNS: Q 15 mins
  - NEURO CHECKS: Q 30 mins x 2 hours
  - FLUID BOLUSES: NS or LR 20 ml/kg up to and over 60 ml/kg until perfusion improves or unless failure or hepatomegaly develop
  - MEDICATIONS:
    - Correct hypoglycemia & hypocalcemia
    - Antibiotics
    - Consider antipyretics

15 MINUTE GOALS:
- IV placed & 1st Bolus Ordered
- Labs sent STAT
- Antibiotics
- Transfer Arrangements
- Glucose & Calcium addressed

15 – 30 mins
- Recheck Vital Signs
  - Are vital signs normal & patient well appearing and/or Lactate < 5.7
  - Yes
    - MD decision off sepsis protocol
  - NO
    - Consider clotters type & screen, fibrinogen, and Fibrin degradation products
    - Consider catecholamines (see treatment table)
    - Start 2nd then 3rd boluses
    - Place 2nd IV

30 MINUTE GOALS:
- 3rd Bolus Ordered
- Perfusion Improved
- Antibiotics Given
- Recheck Vital Signs
  - Are vital signs normal & patient well appearing and/or Lactate < 5.7
  - Yes
    - MD decision off sepsis protocol
  - NO
    - Fluid refractory shock
      - Begin inotrope IV & tiritate to normalize vital signs
    - Reverse COLD shock
      - Cold extremities, cap refill < 2 sec
      - Tiritate dopamine or, if resistant, tiritate central epinephrine
    - Reverse WARM shock
      - Warm extremities, cap refill < 2 sec
      - Tiritate norepinephrine
    - Catecholamine resistant shock
      - See treatment table
      - Begin hydrocortisone if at risk for absolute adrenal insufficiency
    - Transfer to higher level of care
      - Hand-Off Communication consider using SBAR
**Pediatric Treatment Decision Table**

### Pediatric Sepsis/Severe Sepsis/Septic Shock Treatment Table

**HYPOCALCEMIA**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium gluconate</td>
<td>IV: Dose expressed in mg of calcium gluconate 100mg/kg Max dose 3000mg</td>
</tr>
<tr>
<td></td>
<td>May be given peripherally</td>
</tr>
</tbody>
</table>

**HYPOGLYCEMIA**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dextrose</td>
<td>IV: 10% dextrose 5ml/kg or</td>
</tr>
<tr>
<td></td>
<td>IO/ Central Line: 1-2 ml/kg</td>
</tr>
<tr>
<td></td>
<td>May be given peripherally</td>
</tr>
<tr>
<td></td>
<td>May be given via IO or Central Line</td>
</tr>
</tbody>
</table>

**ANTIBIOTICS**

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Antibiotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously Healthy</td>
<td>Ceftriaxone (Rocephin) 50 mg/kg dose IV x 1 max dose 2000mg IV PLUS</td>
</tr>
<tr>
<td>Immune Compromise</td>
<td>Vancomycin 15mg/kg/ dose X1 max dose 1500mg</td>
</tr>
<tr>
<td></td>
<td>Piperacillin/Tazobactam 100mg/kg/dose Piperacillin component max dose 4.5 grams ( = 4000mg Piperacillin and 500mg Tazobactam) PLUS</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>Vancomycin 15mg/kg/ dose X1 max dose 1500mg</td>
</tr>
<tr>
<td></td>
<td>Azithromycin 10mg/kg/dose IV max 500mg if pneumonia suspected</td>
</tr>
<tr>
<td>Intra-abdominal Source</td>
<td>Piperacillin/Tazobactam 100mg/kg/dose Piperacillin component max dose 4.5 grams ( = 4000mg Piperacillin and 500mg Tazobactam) PLUS</td>
</tr>
<tr>
<td>Neonate</td>
<td>Ampicillin IV 50mg/kg/dose IV PLUS Gentamicin 2.5 mg/kg/dose IV OR</td>
</tr>
<tr>
<td></td>
<td>Ampicillin IV 50mg/kg/dose IV PLUS Ceftazoxime 50 mg/kg/dose IV</td>
</tr>
</tbody>
</table>

**VASOPRESSORS/INOTROPES**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose/Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dopamine</td>
<td>2-20 mcg/kg/min If dose exceeds 10 mcg/kg/min consider adding another agent</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>0.05 - 0.3 mcg/kg/min Doses up to 2 mcg/kg/min have been used</td>
</tr>
<tr>
<td>MIRIVANCE</td>
<td>0.25 - 0.75 mcg/kg/min Loading dose (50mcg/kg) - may cause hypotension</td>
</tr>
<tr>
<td>Norepinephrine</td>
<td>Initial Dose: 0.2 - 0.5 mcg/kg/min IV - titrate q 30 min to target BP</td>
</tr>
<tr>
<td>Vasopressin</td>
<td>0.5 - 2 milli units/kg/min</td>
</tr>
</tbody>
</table>

**ADRENAL INSUFFICIENCY**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose/Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocortisone</td>
<td>IV: 2mg/kg/dose Max dose 100mg</td>
</tr>
<tr>
<td></td>
<td>May be given peripherally</td>
</tr>
</tbody>
</table>

Adapted from [Women & Children’s Hospital of Buffalo](https://wchb.org) and [UB|MD Pediatrics](https://ubmd.org) Sepsis Protocol
Pediatric Algorithm

Pediatric patients at risk:

- Provider makes decision for the transfer to a higher level of care (to WCHOB) within the first hour of noted patient compromise
NPSG

Identify Patient Safety Risks
Suicide Precautions

Protect & prevent harm:

• In the least restrictive environment
• Allows for observation
• Allows for physiologic monitoring
Suicide Precautions - Direct Observation

Direct observation - constant visual contact at all times!

Including:

- In the bathroom
- During showers
- Any off unit activity
- While in their room, even when sleeping

Associates are not to:

- Attend to anything else but the patient
Interventions

• Move or admit patient to a room near the nurse’s station (if able)

• Beginning of each shift or at the start of precautions:
  • 2 staff (one must be an RN) will do a full room search to identify any potentially harmful items
Room Search

- Be professional and thorough
- Remove harmful items
- List all items removed
- Valuables - give to family
- Items found - to security or at nurse’s station (if no family)
- Document
Potentially Harmful Items

**Sharp objects**
- Scissors, nail cutters
- Glass bottles

**Flammable items**
- Alcohol based toiletry
- Matches, lighter

**Personal items**
- Non electric razors
- Medications
- Items with cords
- Torn bed linens
- Dental floss
Suicide Precautions - Contact Other Departments

**Dietary**
- Plastic utensils
- Paper tray
- No metal items

**Environmental**
- Obtain paper bags
- No plastic bags
Suicide Precautions
Communication

Continuing and hand-off communication is expected between all associates who work with this patient. We are all working together to keep the patient safe.

- Providers – Nurses - Aides
- Security staff – Dietary - Environmental
- Nursing supervisory staff
Suicide Precautions Documentation

Assessment
- Potential risk for suicide

Clear descriptions of
- Behaviors
- Changes
- Mood
- Eating
- Sleeping
Lastly

- **Providers** (Medical, Psychiatric)
  - Discuss the potential need for patient transfer to a psychiatric inpatient setting
- **Arrangements** (Voluntarily vs Non) are made
  - **Voluntary**: patient signs their consent for transfer
  - **Non voluntary** (committing): patient sent to psychiatric facility due to mental illness, risk for harm to themselves or others
NPSG

Prevent Mistakes in Surgery
World Wide Initiative

- Surgical & invasive procedure protocol
- Reduces risk of wrong:
  - Procedure
  - Patient
  - Site or side
- **Time out** - the protocol verifies that all the team is in agreement prior to start up
Central Line Insertion - Time Out

Time out is done every time – prior to a central line being placed
Time Out Recap

Team agreement on everything is mandatory

- Patient identification
- Correct procedure
- Correct site marking
- Proper positioning
- Correct antibiotic hanging
- Correct surgical equipment
- Images displayed correctly
- Any safety concerns
Catholic Health
Quality Measures
Quality Care

- Patient satisfaction
- Quality measures
- Palliative care program
Patient Satisfaction
Patient Experience
CHS Patient Survey

- Survey is done by the patient after discharge
- All departments at the acute sites review the results
  - Patient-centered care
  - Holistic approach used
  - Patient’s experience
  - Provider, associate impact
Patient Survey: Nursing Related Questions

- Did the nurses treat you with courtesy and respect?
- How often did the nurses listen carefully to you?
- Did the nurse explain things to you in a way that you easily understood?
- After you pressed the call button, how often did you get help as soon as you wanted it?
- Did the nurses ask your name, check your ID band, and confirm who you are prior to medicating or treating you?
Other Areas Questioned

- Physician or provider
- Environmental
- Experiences during stay
- About discharge
- Overall rating of hospital

- Spiritual needs
- Hospital staff overview
- Your health care
- Your feelings about your care
Purposeful Rounding

• Purposeful rounding is an ongoing practice to assess and reassess patients needs
• Demonstrates to patient and families the CH commitment to quality care

• RN educates patient & family on admission on the hourly purposeful rounding process
• The RN and/or the aide will be checking in on the patient minimally every hour
Nursing Questions for Patients
Purposeful Rounding

- **Pain status** - alerts nursing to address issue
- **Toileting need** - inquire about or offer assistance, to prevent potential falls
- **Positioning/comfort** - pressure relief, patient comfort is addressed
- **Items in reach** - safety concerns, patient satisfaction addressed
- “Is there anything else I can do for you before I leave?”
Quality Measures
Evidence Based Practice
2016 Core Measures Monitored by CMS

Influenza Immunization (IMM-2)
• Compliance with being offered and given?

Acute MI (AMI-7a)
• Fibrinolytic therapy given within 30 minutes of arrival?

Surgical Care Improvement (SCIP-Inf-4)
• Cardiac surgery patients have stable glucose levels postoperatively?

Stroke
• Thrombolytic therapy done?
More Core Measures

Venous Thromboembolism (VTE)
- Hospital acquired VTE?
- Warfarin discharge information given?

Sepsis (SEP-1)
- Sepsis management appropriate, screening done?

For more information on these measures talk with your Manager

CMS website
http://www.medicare.gov/hospitalcompare/search.html
Internal monitoring remains ongoing for these factors

- Falls
- Pressure Ulcers
- Preventable events
Immunizations

Influenza and Pneumococcal

Standing protocols for each vaccine

- All patients screened
- At least one indication
- No documented or known contraindication
- Offered vaccine while inpatient
- Provide patient with vaccine information sheet (VIS)
- Obtain consent, administer and document
Influenza Vaccine

**Indication**

- Age 6 months or greater
Influenza

Contraindications or precautions

- Anaphylactic reaction: eggs, latex
- Allergy or sensitivity to previous Influenza vaccine given
- Already immunized for this season
- History of Guillain-Barre within 6 weeks of receiving another vaccine
- Bone marrow transplant in last 6 months
- Patient declined
Influenza Vaccine Administration Guidelines

9/1/15 to 4/1/16  Flu season
  • Standing order to give
  • No new order needed

4/2/16 to 8/31/16  Offseason
  • **Must** obtain MD order
  • Only then can you give
Pneumococcal Vaccine

Indications

• Age 65 or greater
• Patient any age with long term health problems
  • Cardiac, respiratory, kidney, etc.
• Patient any age with weakened immune system
  • HIV, Leukemia, CRF, etc.
• If received prior to age 65
  • Greater than 5 yrs have elapsed
Contraindications or precautions

- Anaphylactic reaction or allergy/sensitivity to the pneumococcal vaccine
- Previously immunized
- Currently receiving or just received during hospital stay, or within 2 weeks: chemotherapy or radiation therapy
- Bone marrow transplant in last 12 months
- Received shingles (Zostavax) vaccine in last 4 weeks
- Patient declined
Pneumococcal Vaccine Administration Guidelines

May give year round

- Standing order to give
- No new order needed
Immunization Overview

- All inpatients
  - Should be screened
- ICU patients
  - Vaccines not given unless transferring out that day
- CHS goal
  - Immunize all who are at risk
Nurses Administering Vaccines

Must have current BLS certification

In review
Obtain order if needed
  • Print up VIS for patient or family
  • Obtain consent
  • Administer vaccine
  • Document in MAK, pt’s record
AMI Details

ASA
- Ordered on admit, or already on from home
- Must be on at discharge

ACEI or ARB
- On for severe LVSD

Beta blocker
- If not already on, was placed on prior to discharge

Statin
- On at discharge

Fibrinolytic therapy
- Within 30 minutes of arrival

Primary PCI
- Within 90 minutes of arrival

MD documentation
- Why interventions were not utilized
Stroke or TIA

On thrombolytic therapy
Diagnosis of atrial fibrillation or flutter
  • Anticoagulant started, if not already on
Statin therapy prior to discharge
Swallowing screen
  • Prior to any intake by mouth
NIH stroke scale
  • Within 24 hours of arrival
Modified Rankin scale
  • Within 24 hours of discharge
Stroke or TIA

Lipid profile within 24 hrs of arrival
VTE prophylactic or antithrombotic therapy by day #2
  • ASA, Coumadin, Plavix, Lovenox, Heparin
Rehab assessment prior to d/c
Stroke education packet
  • Documentation on education, patient receipt
Palliative Care

• Palliative care is one of the acute site’s functions

• Death with dignity, compassion and patient centered care delivery are all part of the CHS experience
Nurses provide quality care by doing the
• Assessment of patients
• Implementation of orders
• Evaluation of patients
• Documentation of care provided
• Notifications to provider
Informed Consent
Informed Consent

Regarding informed consent

Providers are responsible to initiate
  • Patient or surrogate discussion including the risks and benefits of the proposed treatment or surgery

Questions are answered
  • Patient or surrogate will have the opportunity for all of their questions to be answered fully
Informed Consent for Treatment

- Obtained for *non-emergent* situations
- Providers can’t treat *without consent*
Who Signs Consent for Patients Who Lack Capacity

Health Care Proxy can sign
If no proxy
  • Follow NYS surrogate law

NYSFHCDA
  • NYS family health care decision act is the listing of surrogates regarding health care
NYSFHCDA Surrogate List

- Article 81 Guardian
- Spouse or domestic partner (not legally separated)
- Adult daughter, son
- Parent
- Adult sister, brother
- Close friend
- Ethics committee
Written Informed Consent

A few examples of when it is needed

- Cystoscopy
- Lumbar puncture
- Angiography
- Myelograms
- Surgery
- Radiation
- Blood transfusion

Consent is needed for any procedure/surgery which has more than minimal risk
Valid Consent

Valid consent if

- Used during current admission

Exception:

- When **significant change** in status occurs a new consent for treatment is needed taking patient status into consideration

On readmission, new consent is also needed
Valid Blood Portion of Consent

Valid if

- Need for blood is related to surgical procedure
- Used before, during or after surgical event
- New consent if blood needed for another reason not related to surgical experience
Telephone Consent

Process:
- Physician responsible to obtain consent

Nurse’s Role
- Nurse is the 3rd party to be listening in on phone call
- Provide documents
- Nurse co-signs as 3rd party witness
Nurses and Informed Consent

Role

• Inpatient consent witness
• 3rd party witness for phone consent
• Patient advocate
• Validate & support patient concerns
• Health teaching
Restraints and Seclusion
Restraint and Seclusion Policy

- Protect the patient’s health and safety
- Preserving dignity, rights, and well being of the patient
Physical Restraints

Two uses for specific purposes

• Acute medical surgical patient
• Behavioral management
Some Alternatives for Patients

**Verbal**
- Reassurance
- Redirect

**Environmental**
- Soothing music
- Family

**Physical**
- Snack, toileting

**Diversional**
- Fold napkins
- Activities
Not Considered Restraints

- Handcuffs
- Mechanical/postural support
- Bed rails (2)
- Time-out
- Protective equipment
- Surgical positioning
Least to Most Restrictive Restraints

Utilize the least restrictive first

- 1 Soft limb
- 2 Soft limb
- 4 Soft limb
- Hard limb (leathers) for behavioral patients
Restraint Orders

- Written or verbal order
- Obtained within 1st hr of application
- Never prn or standing order
- If ordered by a provider who is not the primary – you must notify the patient’s primary MD of the restraint application
Orders Should Include

• Date, time
• Reason
• Type of restraint
• Time limit of restraint
• RN signature if verbal or phone order
• Provider signature
Monitoring Patients in Restraints

Process

- Monitoring delegation to aides can be done
- However, the RN maintains the ultimate responsibility
- Monitoring of all bodily systems
- Documentation in medical record of the monitoring
Computer Documentation

<table>
<thead>
<tr>
<th>Restraint Flow Sheet - Acute Medical/Surgical Restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Assess for Readiness for Discontinuation every 4 hours</td>
</tr>
</tbody>
</table>

1. **TYPE OF RESTRAINT:**
   - 1 - Soft Wrist (right)
   - 1 - Soft Wrist (left)
   - 2 - Soft wrists
   - 4 - Soft extremity

2. **Reason for Restraint Utilization:** (check all that apply)
   - Promote medical healing
   - Prevent removing equipment/therapeutic modalities
   - Other

3. **Interventions Attempted to Avoid Restraints:** (check all that apply)
   - Airway Management
   - Pathophysiological
   - Pain Management
   - ADL/Nutrition
Medical Surgical Restraint

Process

- **Nurse requests**
  - Provider must do evaluation **within** 24 hours
- Provider reassessment daily
- Reorder restraints daily
Medical Surgical Restraint Monitoring

**Every 30 minutes**
- Safety checks

**Every 2 hours**
- Turning and positioning

**Every 4 hours**
- Circulation
- Range of motion
- Nutrition, hydration
- Hygiene, elimination
- Level of distress
- Any agitation
- Skin integrity
- Readiness for d/c of the restraint
Medical Surgical Restraints

Every 8 hours
  • Vital signs

Documentation
  • At least every 4 hours
Behavioral Restraint

Process

- **Nurse requests** immediate provider evaluation
- Patient’s behavior is harmful to him or herself or others
- If patient recovers quickly do not remove restraint until seen by provider
- Physician face to face evaluation in less than 1 hour
Behavioral Restraint Use

- Puts provider in control
- Can revise treatment plan if needed during this time
- Provider can focus on treatment plan, and not worry about the patient’s or staff’s safety
Behavioral Restraint
Time Limits

Time limits for orders
• Up to 4 hrs: 18 yrs and older
• Up to 2 hrs: 9 to 17 yrs
• Up to 1 hr: below 9 years of age

When limit expires
• Provider must reorder restraint
Behavioral Restraints or Seclusion

Every 30 minutes
- Safety checks

Every 2 hours
- Circulation
- Range of motion
- Level of distress
- Any agitation
- Turning & positioning
- Readiness for d/c of restraints
Behavioral Monitoring

Every 4 hours
- Nutrition
- Hydration
- Hygiene
- Elimination
- Skin integrity

Every 8 hours
- Vital signs

Documentation
- At least every 2 hours
Restraints and Seclusion

- Either is discontinued as soon as is possible
- *Never* combined
Nursing Documentation on Restraint Use

- Behavior prior to usage
- Interventions used
- Alternatives tried
- Restraint rationale
- Patient response
- Injuries - if any from use
- Patient and family understanding of use
Any patient who is using or has used restraints requires a review of:

- Plan of care
- Alternatives or interventions tried
- Length of usage, attempts to remove
- Injuries or deaths related to use
- All statistics are reportable to federal government agency - CMS
Fall Prevention Program
Fall Prevention Program

Patient’s fall risk is assessed on admit

- Morse falls risk assessment
- Risk level assigned
- Education on fall prevention is provided to patient and/or family
Morse Fall Risk

Done:
• On admission
• Daily
• With a condition change
• After any fall
• With transfer
• Computer gives you total score and fall risk level

• Interventions for the individual patient are then determined after the risk assessment is done
One last question:
Inpatient Fall During this Hospital Stay?
If answer is Y - Implement Fall Risk Interventions for High risk patients
Fall Risk Levels

Risk level:

• Low (0-34) Basic nursing care
• Mod (35-59) Standard prevention
• High (60+) High risk prevention

Consider the patient’s number!
Not just the level they are in
Fall Reduction Program

Fall Risk Reduction Strategies

• Utilize Bed or Chair Alarms as appropriate. These alarms are often indicated for patients who are unaware of their own limitations (will get out of bed without asking for help when told to ask for help).

• If a bed alarm is in use and the alarm needs to be turned off for any reason, keep the flap of the alarm panel UP until the alarm is turned back ON.
Fall Interventions

• **Do not** leave high risk patients alone in the bathroom or on the commode. If you need to walk the patient to the bathroom, they should not be left alone.

• Make sure call light and other personal items are within reach of the patient.
Standard Fall Interventions

Standard Interventions

- Call light in reach
- Nonskid socks
- Bed in low position
- Possessions available
- Areas clear and clutter free
- Provide ambulation assistance as necessary
- Provide fall education sheet
### Falls Assessment

**Interventions**

<table>
<thead>
<tr>
<th>History of Falls (immediate - past 3 months):</th>
<th>IV or IV Access (for infusions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No - Standard Interventions</td>
<td>□ No - Standard Interventions</td>
</tr>
<tr>
<td>□ YES</td>
<td>□ YES</td>
</tr>
<tr>
<td>Yellow Socks</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td>Yellow Blanket</td>
<td></td>
</tr>
<tr>
<td>PT Eval (If not already ordered &amp; has OOB order)</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td>Fall Prevention Education</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td>Instruction to call before getting out of bed</td>
<td>□ Fall Prevention Education</td>
</tr>
</tbody>
</table>

**Diagnosis requiring narcotics, antihypertensive, diuretics, anticoagulation, Antipsychotic:**

<table>
<thead>
<tr>
<th>□ No - Standard Interventions</th>
<th><strong>Gait / Balance</strong> □ Normal/ Immobile</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ YES</td>
<td>□ Weak</td>
</tr>
<tr>
<td>Fall Prevention Education</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td>Instruction to call before getting out of bed</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td><strong>Ambulatory Aide:</strong></td>
<td>□ Do not leave alone when ambulate / in bathroom / on commode</td>
</tr>
<tr>
<td>(Furniture / Cane / Walker / Nurse Assist)</td>
<td>□ Do not leave alone when ambulate / in bathroom / on commode</td>
</tr>
<tr>
<td>□ No - Standard Interventions</td>
<td><strong>Impaired</strong></td>
</tr>
<tr>
<td>□ YES</td>
<td>□ Consider PT Eval (If not already ordered &amp; has OOB order)</td>
</tr>
<tr>
<td>Fall Prevention Education</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td>Instruction to call before getting out of bed</td>
<td>□ Fall Prevention Education</td>
</tr>
<tr>
<td><strong>Ability to follow instructions:</strong></td>
<td>□ Do not leave alone when ambulate / in bathroom / on commode</td>
</tr>
<tr>
<td>□ Understands instructions / not impulsive / uses call light - Standard interventions</td>
<td><strong>Unable to communicate</strong></td>
</tr>
<tr>
<td>□ Does not Understands instructions / impulsive / Does not use call light / Unable to communicate</td>
<td></td>
</tr>
<tr>
<td>□ Yellow Socks</td>
<td>□ Yellow Blanket</td>
</tr>
<tr>
<td>□ Yellow Blanket</td>
<td>□ Do not leave alone when ambulate / in bathroom / on commode</td>
</tr>
<tr>
<td>□ Appropriate ambulatory aide is within reach of patient</td>
<td>□ Bed Alarm / Chair Alarm</td>
</tr>
</tbody>
</table>

- Room Temperature
- Chair Height
- Bed Height
- Bed Alarm / Chair Alarm
### OB-GYN Fall Risk Assessment (FRA)

**Every Patient Receives A ZERO OR FULL SCORE in Each Category**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INDICATOR</th>
<th>POINTS</th>
<th>Time: Initials</th>
<th>Time: Initials</th>
<th>Time: Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Falling</td>
<td>In the past 3 months (include this hospitalization)</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Judgment</td>
<td>Poor judgment, lack of safety awareness, not able to follow instruction</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Medications</td>
<td>Current or recent use of IV analgesics, PCA, narcotics; Sedatives/med mods; Magnesium sulfate; Antipsychotics; Anticonvulsants (i.e. Neurontin, depakote, Klonopin, Tagretol)</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness, Vomigo</td>
<td>Could be related to medication, orthostatic changes, history of anemia defined as Hgb less than 10mg/dL or Hct less than 30% (prenatally) or hypotension</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Mobility</td>
<td>Generalized Weakness (Anesthesia related or not)</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Loss</td>
<td>Postpartum hemorrhage (EBL greater than 500 mL at delivery or within 24 hours). Includes patients with boggy uterus that requires interventions to regulate bleeding and Post Partum patients with moderate to heavy lochia</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Fall Risk Assessment Indicator  | Score 0 - 5 - Low Risk: Initiate Universal Safety Precautions | Score 6 and greater - High Risk: Document intervention and initiate Fall Prevention Program strategies | Indicate level of FRA | |  |

**Total Score:**

**RN Signature**

**RN Signature**

**RN Signature**

CSC #9880 Developed 12/12
After Fall Risk is Determined

What now
- Interventions planned
- Monitoring done
- Documentation in medical record
Let’s Talk about Fall Risk

Hand off communication occurs with any change of personnel

Discuss
- Falls history
- Interventions attempted
- Success/failures
- Current plan

When
- Transfer to another unit
- Shift change
- Break - if warranted
What about Sitters

Process

- Sitters remain with patient
- Can leave after sitter for next shift arrives
- Re-evaluation by RNs of use every 8 hrs
- Must go with patient for any “road trips”
- Sitters effectiveness is documented on by RNs every 12 hours
- Refer any sitter concerns to the RN
Plan of care changes as the patient status changes happen

- Interventions appropriate?
- Education given to patient and family?
- Documentation of all of the above in medical record?
If a Fall Occurs

**Notify**
- Attending or house provider
- Nurse manager or Nursing supervisor
- Patient’s family

**Provider assessment**
They need to know
- Patient meds?
- Direct injury to patient’s head?

**Provider develops plan of care**
Computer Documentation of Fall

Falls Documentation

Date and Time of Fall: 06/11/20 08:00
Unwitnessed Fall

Fall Witness: No
Name of Witness

Location of Fall: bathroom
Who Found Patient: Jane RN

Did the patient strike their head?: No
Yes
Unknown
Is the patient on Anticoagulants?: No
Yes

Statement of event per Patient or Writer:
More Documentation of Fall

Nurses Assessment Post Fall

Mental Status: confused
Temp: 99
O2 sat: 85
BP: 190/90
HR: 100
RR: 24
Describe any injuries: bump on the head

Names of Notifications

Nursing Supervisor: Sue Jones
Date and Time Notify: 06/11/20 08:15

House Physician: Dr Smith
Date and Time Notify: 06/11/20 08:20

Attending Physician: Dr Brown
Date and Time Notify: 06/11/20 08:25

Patients Family: Spouse
Date and Time Notify: 06/11/20 08:25
Post Fall -
Must Redo Morse Scale
Gait / Transferring - The patient is scored according to the gait used when OR if they transfer and ambulate.

- Weak - stooped but able to lift head
- Impaired - difficulty lifting head, poor balance
- Normal - head erect, arms swing freely when transferring
- Immobile - Unable to move out of bed on their own

Patients ability to understand instructions

- Patient understands limitations - will follow instructions
- Patient consistently Does Not Call for assistance - Will not Follow Instructions

Morse Fall Risk Total 105

Hospital Fall - Fall during this Hospital Stay - Patient is a High Risk for Falls

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>MFS Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>0 - 34</td>
<td>Good Basic Nursing Care</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>35 - 59</td>
<td>Implement Standard Fall Risk Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventions</td>
</tr>
<tr>
<td>High Risk</td>
<td>60 +</td>
<td>Implement High Risk Fall Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventions</td>
</tr>
</tbody>
</table>
Oxygen Monitoring and Titration Protocol
Oxygen Monitoring & Titration

Goals:
- Target pulse ox 92-94%
- MD orders override
- Titration protocol follows

NOT applicable to:
- ICU, CCU
- Open heart unit
- Special care nursery

Indications:
- Attempt to get patient off of supplemental 02

Implemented by:
- Registered nurses
- Respiratory therapists
Masimo Monitoring
Monitoring Sp02 and Sp Hg

Masimo PSN (patient safety net) is at
  • Mercy Hospital at Buffalo
  • Kenmore Mercy Hospital – coming soon

System allows for critical monitoring
  • Oxygen saturation
  • Hemoglobin

Respiratory therapy also monitors 02 and Hgb
Oxygen Protocol: Titrating O2

**Nasal Cannula Initial Steps**

**SpO2 > 94%**
- ↓ flow 1 liter
- In 30 minutes
- recheck SpO2

**If SpO2 > 94%:**
- Repeat above steps
- Keep titrating down

**If SpO2 < 92%:**
- Return to previous O2 setting
Room Air Trial
Nasal Cannula

Patient on 1 - 2 L 02
Sp02 > 94%

Room air trial
Remove 02
In 30 minutes recheck Sp02

If Sp02 ≥ 92%
  • Leave on Room air

If Sp02 < 92%
  • Return to previous oxygen liters per minute setting
Cardiac or Respiratory Challenge

ADL challenge for patients with history of
- Cardiac disease
- Respiratory (includes OSA) disease

Allows staff to determine if patient can stay on room air

On room air, have patient do an activity that matches their current status and ability
- Walk about room, or to bathroom and back
- Walk down the hallway
Post Activity ADL Challenge Check

Post activity Sp02 check

**Sp02 ≥ 92%**
- Pt passed challenge: d/c 02, update provider

**Sp02 < 92%**
- Resume previous 02 settings, update provider, monitor patient
- If patient complains of not feeling well, short of breath, Sp02 keeps dropping, **call a RRT and continue monitoring patient**
Nurses Can Switch Patient to Ventimask

If patient's condition is deteriorating, and has a nasal cannula on:

- Nurse can change patient to the venti-mask to attempt improved oxygenation
- Update provider of patient status for any new orders
- Follow protocol, consult with respiratory therapy

For example

- Patient is on 2 liters O2 NC. Per the protocol, 2 liters NC is equal to 28% via the venti-mask
Initial Titration for Patient on Ventimask

Sp02 > 94%
Drop to next lowest:
  - Fi02 setting
  - Match 02 flow

Do a 30 min recheck of patient’s Sp02 on the lowered settings

Follow up Sp02
Sp02 > 94%
  - Continue titration
Sp02 = 92-94%
  - Leave at current settings
Sp02 < 92%
  - Return to previous settings
Patient on Ventimask
Continuing Titration

Presenting with Fi02 of 36% or less:
  • Change to NC
  • Now follow the NC titration portion of the protocol

Presenting with Fi02 of 28% with a Sp02 of 94%:
  • Room air trial
    • 30 min - recheck Sp02
      Sp02 ≥ 92%
        • Keep on room air
      Sp02 < 92%
        • Back to previous 02 settings
Cautions

Continually assess the patient’s status
  • Sp02 ↓ 92%
    • Call provider

Orders may allow COPD pts to have
  • ↑ 2L NC/↑ 28% VM

All other pts to have
  • ↑ 4L NC/↑ 40% VM

Don’t titrate when

Significant changes
  • HR > 120
  • RR > 25

Significant change
  • Mental status
  • Call MD, RRT
Oxygen and Clinical Situations

Oxygen is a medication
Nurse’s aides cannot touch 02 at any time
In emergent situation
  - RRT called
  - 02 2L NC applied

Fire hazard!
  - No petroleum based products or smoking

Things to think about
  - Drying of nares
  - Pressure areas noted
  - 02 setup appropriate
  - Continue monitoring of patient
  - Documenting on any of the above
Cardiac Monitoring
Continuous monitoring is done on specific patients per the telemetry orders/specific provider orders

Monitoring is provided
- In room (intensive care areas, emergency room)
- Telemetry or remote monitoring

Monitoring by
- Charge RNs, remote resource RNs, Telemetry RNs, or Monitor techs
- Ask if you are not sure!
Nurses Responsible for Monitoring

Nurse role in ICU/CCU/ED/OHU/SCN areas:
- All patients have a nurse assigned to monitor them

Telemetry monitoring areas:
- RN or remote resource RN is responsible

Ask your charge nurse or nurse manager if you are not sure of your role with cardiac monitoring
Cardiac Monitoring Start Up

• Apply cardiac leads per order (3, 5 lead)
• Transmitter # and room # on patient’s ID label → bring to monitor bank
• Monitor tech or assigned RN confirms patient data and entry into monitor is done after patient ID is found to be correct
Alarms - Monitoring

- Alarms remain in active mode
- Alarm volume must be audible
- Battery changed prior to each patient usage or when low battery alert signals
- Transmitters and lead wires cleaned between patients
Cardiac Monitoring Orders
24 - 48 - 72 Hours?

Orders for monitoring are for specific length of time
Do not d/c at order end point unless patient is stable

Contact provider when

- Patient is unstable/meets criteria to **not** remove monitoring
SOC Communication

SOC has specific communication routes for the remote telemetry nurse to call care area where patient is located

- **Main street** uses red phone to communicate with the RN assigned to the patient
- **St Josephs** uses cell phone to communicate to the RN assigned to the patient
Patency of the monitoring system is maintained

Nursing staff **must** alert monitoring staff to any changes:

- Patient leaving or returning to area
- Going for shower
- Room changes, discontinuation of monitoring

RN should document transmitter # every shift
RN Role

- **Emergent response** to rhythm and/or rate changes (assess patient and situation) - call Code X (10) or RRT
- Daily, the RN or remote resource RN places a copy of the rhythm report and event review summary in patient’s medical record
- Receive orders for **continued** monitoring, after duration of initial monitoring has expired
RN Role

Transport

• Patient with hardwire monitor (ICU for example) can be moved on monitoring, only with RN who is trained in rhythm analysis

• Patient on telemetry monitoring can be sent for testing treatment or procedure without an RN, with a provider order
Before Removing Telemetry for Transport

Contact the provider to review whether the monitoring should be removed - if the patient has any of the following conditions:

- Heart rate less than 50 or greater than 150
- Documented 2\textsuperscript{nd} degree type 2 heart block
- 3\textsuperscript{rd} degree heart block
- Patient on a continuous anti arrhythmic medication infusion
- Active chest pain or acute change in condition
RNs to Document on Admission, arrhythmia onset, every 12 hrs, or new assignment

- Rate, Rhythm; PR, QRS and QT intervals
- Admission, arrhythmia onset and minimally every 12 hours
- Rhythm report

During RRT or Code 10 or prior to dc off telemetry

- Event summary
Pager Use for Monitor Alarms

Key points

• All patients will have a nurse with an assigned pager/phone given to them by the charge RN
• If you are assigned a phone or pager it is your responsibility
  You **must get coverage for meals and breaks**
• What if the nurse covering is a LPN or a non telemetry trained RN? - **must be a RN who is responsible for the continued monitoring**
Patient With a Life Vest

Zoll Life Vest - a external cardiac defibrillator

If patient admitted with vest on
• Obtain a MD order to leave on
• Telemetry monitoring is mandatory
• Leaving unit - must be accompanied by RN
• If order is to remove, vest must be taken home
Zoll Vest

Emergent situations

• Vest shocks and patient is responsive → call a RRT
• Vest shocks and patient is unresponsive → call Code 10
• Vest is left on until team ready to apply pads
Zoll Life Vest

Patient is admitted without Life Vest – MD now orders
  • Contact phone # is on unit to call to reach a Zoll rep
  • Zoll rep will run baseline ekg and fit the patient
  • The Zoll rep will assist with the initiation of patient education regarding the vest itself

Zoll Life Vest has an audible & visual alarm prior to the defibrillation activity

Website: lifevest.zoll.com
End of Life Care

Spiritual Needs

Advanced Directives
Chaplains

Committed to all faiths:

- Trained professionals
- At all acute sites, some are there 24/7
- Minister to all
- Services to all
- Advanced directive assistance
- Ethics review
Advanced Directives (AD)

- Patient decisions about care they want
- **On admission, RN to note if AD exists**
  - If no AD, notify provider and social worker
- CHS computers have ability to access whether AD already is scanned in our database
Valid Advanced Directives (AD)

- Nurse to verify directives as accurate by having a discussion with patient or surrogate/proxy.
- Health care proxy not valid if the proxy agent has signed off as a witness!
- Revoke the HCP? - patient can do at any time. If patient requests, update provider.
Nurse Documentation

- Whether patient admitted with AD
- Request family (list name) to bring in AD
- Each shift to check if brought in, as follow up
- Spiritual care can help to obtain by calling family if you notify them of need
MOLST
Medical Orders
Life Sustaining Treatment

- **NYS** option for declaring wishes
- Website: [health.ny.gov/professionals/patients/patientrights/molst/](http://health.ny.gov/professionals/patients/patientrights/molst/)
- Legal statement of patient’s wishes
Intention of MOLST

For patients who
- Desire no life sustaining treatments
- Reside in long term facility or receive services
- Variable to poor prognosis
Nursing Admission and MOLST

- Does patient have a valid MOLST form?
- Is there an MD order in place?
  - Order states “Follow MOLST orders”
- Form or copy valid throughout the CH system
More on MOLST

- **Do not need**: DNI, DNR, Limitation of treatment orders if patient has a completed MOLST which covers these issues
- **Developmentally disabled or mentally ill patients need the** supplemental checklist and form for MOLST to be valid
Health Care Agent Actions

Against patient’s wishes:
If changes to MOLST orders are requested
  - Clear, convincing evidence must be presented
  - Ethics committee to review
  - MOLST orders will stand and cannot be changed
  - Follow NYSFHCDA surrogate lists as to who can make decisions for the patient
Do Not Resuscitate

What to do?
- Decision made
- Consent
- **No** to CPR only
- Can be treated for other issues

CH DNR Forms
- Minor patient
- Surrogate
- Adult patient
- Revocation

Proper order is
Do not resuscitate John Smith
NYSFHCDA Surrogate Hierarchy

- Guardian
- Spouse, domestic partner (not legally separated)
- Adult child
- Parent
- Adult sibling
- Close friend
- Ethics committee
Physician Role: DNR and More

• Patient or family should have a full and clear understanding of treatment options, the pros/cons of withholding the resuscitation, and the meaning of the DNR status

• Provider is accountable to obtain the DNR or MOLST, should the patient or family request
Continuation of DNR Order
Patient Admitted With Valid DNR

Admission
- Initial order obtained
- Reevaluated q7d
- MD documents

Transfers
- DNR is binding
- New DNR order obtained

Non-hospital DNR:
- Same as transfer

Surgery suite
- DNR is suspended unless specified on the operative consent
Revocation of DNR

Process

- Patient, surrogate make decision
- Conversation with provider is done
- Physician order needed
- Provider puts diagonal line through DNR form
- Dated, timed, signature
- Revoked DNR stays in chart
Ethics Committee

Addresses:
- Ethical issues
- Concerns
- Supports caregivers
- Resolving conflict
- Policies
- Resource
UNYTS

1998 law to facilitate organ donation

UNYTS verifies qualifiers for any potential donations:
  - Cardiac or Brain death

Nurses only do:
  - Notification of UNYTS
  - Document time call made
All deaths must be referred to Upstate New York Transplant Service (UNYTS) at 853-6671 or 1-800-227-4771

<table>
<thead>
<tr>
<th>Name of UNYTS coordinator contacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, accepted as suitable donor</td>
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<tr>
<td>Yes, no decision</td>
</tr>
<tr>
<td>Yes, declined</td>
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<td>Sudden death when in good health</td>
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<tr>
<td>Other</td>
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Death of a Patient
Death of a Patient

• When a patient expires, we as nurses are to support and comfort the family and/or significant other who now has to deal with the loss
• Remain professional, despite any personal feelings about situation you may have
• Respect the family’s wishes
Follow Policy

- If family not coming in for viewing, then post mortem care is done
- If medical examiner case, everything is left as is
- Document regarding patient expiration and associated details
Death of a Patient Form

- At time of patient death, form is to be completed
- Check with your assigned area - paper or computer form is to be done?
- Form completion facilitates removal of the patient’s remains by the funeral parlor
- System wide process
Autopsy Consent

- Decision for an autopsy can only be made legally by the responsible person.
- Each situation has a responsible person.
  - For example - if married, responsible person is the spouse (if still living).
- HCP is not necessarily the responsible person.
- If a medical examiner case, the autopsy cannot be refused by the responsible person.
Medical Examiner Cases

- Accident
- Homicide
- Suicide
- Sudden death (at home)
- Suspicious cause
- Toxicology concerns
- Dead on arrival in ED
- Infant death
- Death in OR suite
Computer Documentation

Death of a Patient

- Patient expired date and time
- Resuscitation attempt: Yes/No
- OR death: Yes/No
- Patient in restraints past 24 hours: Yes/No
- Please contact QPS if patient in restraints during hospital stay.
- Family present and/or notified: Yes/No/Unable
- Name of family member notified
- Relationship
- Pronouncing physician
- Preliminary cause of death
- Consulting physician notified
- Nursing supervisor/mgr notified
All deaths must be referred to Upstate New York Transplant Service (UNYTS) at 853-6671 or 1-800-227-4771

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If Yes, please call the Erie County Morgue (961-7591)
Adult Heparin Weight Based Protocol
Heparin Anti Xa Level

Protocol

- Measures Anti-Factor Xa
- Level correlates to true serum level in blood
- Not affected by Liver, Coumadin
- Promotes tighter control
- Monitors UFH, LMWH
Initial Considerations

Protocol first steps:
• Any contraindications
  • Allergy or religious objection to pork
• Patient’s current medications
• Update MD of any issues
• Actual patient weight in pounds
• Convert to kilograms: 1 kg = 2.2 lbs.
• Remember protocol is weight based
Initial Laboratory Work Up

Labs:
- CBC
- PTT
- PT/INR
- Heparin
  Anti Xa level
## Screening Labs: Abnormals to Notify Provider about

<table>
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<th>Values</th>
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<td>PTT</td>
<td>100 or &gt;</td>
</tr>
<tr>
<td>INR</td>
<td>2 or &gt;</td>
</tr>
<tr>
<td>Platelets</td>
<td>&lt; 100,000</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>&lt; 9g/dL</td>
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<tr>
<td>Heparin Anti Xa</td>
<td>&gt; 0.9</td>
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</table>
Provider Orders either Low or High Protocol

Low protocol:
- Age > 75
- High risk bleed
- AMI
- Unstable angina
- Stroke
- GP IIb/IIIa Inhibitor infusion (Integrelin)

High protocol:
- VTE event
- Mechanical valve replacement
Start the Protocol

1. Initial bolus table
   - Give bolus dose if ordered
2. Initial infusion table
   - Start infusion
3. Anti Xa level
   - 6 hours after start time
4. Lab will notify the inpatient units if
   - Anti-Factor Xa value is > 0.9
Heparin Infusion Information

25,000 units Heparin
250 ml D5W
100 units/ml

Two RN check is recommended
• With any rate change
• Having to go above safety guardrails range
Heparin Anti Xa Factor

Therapeutic Ranges

Low protocol
- 0.3 – 0.5 units/mL

High protocol
- 0.5 – 0.7 units/mL
Follow Up: First Anti Xa Factor Check

Computerized protocol

- If giving a repeat bolus, use rate adjustment bolus table

If the computer is down

- Print up the 4 page protocol from the forms server, use the rate adjustment table to see if bolus is needed
Other Thoughts
Heparin Protocol

Process
- Warfarin may be started on day 2
- Daily PT/INR monitoring
- Education to patient and family
- Document above in medical record
Blood Sampling per Protocol

• Anti Xa done every 6 hours unless have a higher level
• Continue to follow protocol
• If you have 2 consecutive in range therapeutic Anti Xa values - you can now do testing daily
• CBC every other day
Protocol

Notify provider if
- Level not in a therapeutic after 3 boluses
- Anti Xa is > 0.9 after any draw, especially if infusion has been stopped for 2 hrs, and value was rechecked

Document
- Bolus doses
- Rate changes
- Patient responses
- On the paper Protocol form, or in the EMR
- Any communications with other depts.
Heparin Safety Guardrails

Alaris pump guardrails are set for Heparin at these levels:

- **Soft max**
  - 3000 units/hr

- **Hard max**
  - 4000 units/hr
For Dosing > 4000 u/hr
Nurse Must

- Notify pharmacy, they may suggest you should contact MD to discuss
- Notify the nurse manager or supervisor
- Recommended second RN check prior to starting administration at this higher dose
- Monitor patient
Computer Documentation

- EMR documentation assists the RN with bolus/infusion calculations
- EMR alerts support the RN with real time documentation to manage the Heparin protocol
- When using the computer for the Heparin protocol, use the paper protocol as a guide. You can pull up a paper protocol via a link within the Heparin documentation or from the forms server
- Paper protocol must be used during computer downtime
Open up **Heparin Protocol Orders** and choose either High or Low Dose Protocol *with or without* Bolus Dose.
These Orders will appear on the Orders Tab for all Heparin Drips
Use the Same Blue Well Access Point (High or Low) Over and Over
Input Patient Weight in Pounds

Click here for written Heparin Protocol

Prior to beginning this form review the patient weight, update the weight if not valued.

Weight: 147 lbs, 0 oz

Select one:
- Initiation of Heparin Protocol
- Maintenance of Heparin Protocol

Initiation Heparin Protocol High Standard

- Baseline CBC, PT/INR results reviewed?
- Identified cultural/religious contraindications to pork? Yes, No
- Was a bolus dose ordered? Yes, No

Initial Heparin Infusion Start Date/Time: 03/06/2014 11:00

Education for Anticoagulation Therapy provided.

Collected: 03/06/2014 11:08
Charted for: 
Status: Cmt
Click on the Radio Button to Convert Pounds to Kg
Patient weight (Kg) is in the **Orange** box. Use this weight to select from the drop downs for the correct Infusion Rate and Bolus dosing.
Maintenance Infusion

- Go to Filtered list for Low or High protocol
- Click on: **Maintenance of Heparin Protocol**
- Follow screen prompts
The next screen will appear

- **Verify current weight** as correct
- It needs you to **verify** the most **current** Heparin anti Xa level
- **Input the current** Heparin infusion **rate**
- Computer will then show the **new Heparin infusion rate**

**Screen shot of this is on next slide**
Maintenance Hints

Heparin Protocol High Standard

Entered / Revised by Jessica Thursam

Scheduled N/A

3 units/kg/hr 2 mL/hr

Set Pump Rate to 4 mL/hr Click here if no value is displayed

Compete this section regarding the next Heparin Anti Xa order. Order will be automatically placed when Yes is selected.

Is a Heparin Anti Xa order needed?  Yes No

If a daily order is in place then answer No

Time for next Heparin Anti Xa order: 12/01/2013 16:00

Refer to section below for time of next lab

VERIFY DATE AND TIME BEFORE SAVING

Repeat Heparin Anti Xa lab draws:

Heparin Anti Xa Result < 0.14 through 0.89 - Obtain Heparin Anti Xa in 6 hours after rate change

Heparin Anti Xa Result > 0.89 - Obtain Heparin Anti Xa in 2 hours after rate change

Follow the following for provider notifications:

Notify provider if patient is unable to reach therapeutic dose after 3 boluses

Notify provider if Heparin Anti Xa is greater than 0.9 units/mL after infusion has been stopped for 2 hours and value has been rechecked
Heparin Protocol - Lastly

Computers do not replace your critical thinking skills

- Any changes with patient condition, such as new onset bleeding, must be called to the physician immediately!

Provider, nursing staff and pharmacy are all working together to keep the patient safe
Chest Tube Policy
Initial Post Insertion Thoughts

- Intact chest tube drainage system at all times
- Continuous or intermittent bubbling needs to be monitored for source
- Occlusive dressing does not have to be vaseline gauze
- Start monitoring patient for any change with respiratory status
Chest Tube Set Ups

Water seal or Wall suction
- Hang from bed frame
- No loops, kinks

Some bubbling is noted in these situations:
- Air is displaced by fluid
- Air leak may be present
- Rhythmic with patient’s breathing

- Ocean is considered the “wet” system
- Oasis is considered the “dry” system
Need to Know

Process

- Stopcock open at all times
- Below chest level at all times
- When removing kinks or loops:
  - Release slowly due to changes in pressure
- Post insertion CXR is always done to verify placement
Assessment and Monitoring

Cardiopulmonary status, VS, SpO2:
- 15 minutes x 2
- 30 minutes x 1
- Hourly x 3
- Then every 4 hours
Assessment of Drainage

**Amount, color**
- 15 minutes x 2
- 30 minutes x 1
- Hourly x 3
- Then every 8 hours
Nursing Considerations

Notify provider

- If > 200 ml/hr for 2 consecutive hrs
- Serosanguinous fluid changes to bloody
- Continue monitoring fluid levels, replace drainage unit prn
Chest Tube Patient Care

Monitoring & assessing

- Respiratory, cardiac, vital signs
- New onset pain
- C & DB
- Subcutaneous emphysema
- Pneumothorax

Chest tube itself

- Site
- Dressing
- Migration
- Patency
- Patient self report of pain or discomfort at insertion site
### Other Concerns

<table>
<thead>
<tr>
<th>Changing unit</th>
<th>Obtaining specimen</th>
</tr>
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<tbody>
<tr>
<td>• Clamp tubing 12” from insertion site</td>
<td>• 20 gauge needle</td>
</tr>
<tr>
<td>• Switch to new unit and unclamp asap</td>
<td>• 10 ml syringe</td>
</tr>
<tr>
<td>• 2nd nurse assist</td>
<td>• Obtain through tubing after cleansing with alcohol</td>
</tr>
<tr>
<td></td>
<td>• Remove 5 ml</td>
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</table>
Ambulate or Transporting

**Process**

- Obtain order to d/c wall suction while ambulating
- Do not close stopcock
- Secure attached to cart, below patient
- Resume suction after activity
Chest Tube Nursing Care

**Process**

- Continuing assessment
- Documentation in medical record
- Update provider of any changes
Administration
Blood and Blood Products
Policy & Procedure

Policy

- Obtain informed consent
- Obtain order; ID patient
- Obtain blood
- Administered by RNs, MDs, and at MHB - Perfusionists
- Start IV if no line prior to obtaining blood
- Baseline Vital Signs
ID Patient and Verify
2 Staff

Adult/Infant

On receipt of product - check

• Type of blood product
• Pt’s/donor blood group/
  Rh type
• Unit #
• Expiration date
• Sign record and have a
  2nd person also do
Policy Guidelines – Rate

Orders:
- 60 ml/hour for first 15 minutes
- 120 ml/hour as patient tolerates
- Intensive care per provider
Administration Guidelines

- Product to be initiated no later than 30 minutes from the time it was dispensed by the Transfusion services staff
- **Monitor patient continuously for first 15 minutes**
- If patient leaves floor during the transfusion, a nurse must go with - no exceptions
Leuko-Reduced Blood Products

- When ordered, lab will send product
- If not available, leukocyte filter with non filtered product is the equivalent
Administration Guidelines

- Transfusion needs to be completed within 4 hrs
- Use only 0.9 Normal Saline IV solution
Transfusion Record

Documentation:

- Date/time started, completed
- VS: taken prior to the start, 15 min after, and at completion
- Signatures where required
- Transfusion reaction, symptoms
- Medications (if any used)
- Patient tolerance to transfusion
## Transfusion Reactions

<table>
<thead>
<tr>
<th>Reactions</th>
<th>Clinical symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anaphylactic</td>
<td>• Bronchospasm</td>
</tr>
<tr>
<td>• Allergic</td>
<td>• Laryngeal edema</td>
</tr>
<tr>
<td>• Hemolytic</td>
<td>• Urticarial wheals</td>
</tr>
<tr>
<td>• Febrile</td>
<td>• Rash</td>
</tr>
<tr>
<td>• Circulatory overload</td>
<td>• Weakness</td>
</tr>
<tr>
<td></td>
<td>• Elevated bilirubin</td>
</tr>
<tr>
<td></td>
<td>• Fever, chills</td>
</tr>
<tr>
<td></td>
<td>• Pink frothy sputum</td>
</tr>
<tr>
<td></td>
<td>• Dyspnea</td>
</tr>
</tbody>
</table>
Provide Patient Education

Signs or symptoms to teach patient/family

- Chills
- Low back pain
- SOB
- Dyspnea
- Throat closing
- Nausea
- Sweating, itching, hives
- Anxiety
What To Do If Patient Has a Transfusion Reaction

**Process**
- Stop transfusion
- Put up new 0.9 NS and IV tubing
- Notify provider, blood bank
- Recheck blood numbers and type

**Per orders & policy**
- Treat symptoms
- Send blood, tubing and NS solution to blood bank
- Obtain 1 pink top blood tube and urinalysis - send to lab with blood product left
Age Specific Considerations

Infants, young children:
- Potential for fluid overload

Geriatric:
- Delayed reactions
- HF overload
Emergency Release of Blood
ED-ICU-PACU

Process

• Alert Blood Bank
• 2 units of uncross-matched 0-negative blood is prepared
• Emergency Release form to be done
• Blood bank release form signed by MD
• 10 ml of blood to lab
Venipuncture Policy
**Procedure**

**Process**
- ID patient
- Educate on reasoning behind
- Choose appropriate location
- Antecubital is **not** the preferred site
  - Cephalic or basilic veins are
- This is due to higher rate for infection when repeatedly using the antecubital
- Tourniquet - remove asap
BD Button Needle System

Used for obtaining blood cultures

- Collecting the blood samples is the same
- Use of BD Button Needle allows retraction of needle once the venipuncture process is complete
- Must push the button with the needle still in the patient arm (otherwise will get a blood spray)
- Minimal chance for any needlestick injury to occur
- Remember to do a discard tube first then obtain the samples
Vacutainer Push Button
Procedure

After draw

- Gently invert tube
- Cover site
- Apply Soft ID labels, at bedside
- No more than 2 attempts
- Update MD if unable to obtain sample
Proper Labeling

STEP 2
Visually align the v-notch in the label with the color coded notch on your BD Vacutainer® Blood Collection Tube.

STEP 3
Before you adhere the label, make sure the color coded notch and color coded sidebar on your BD Vacutainer® Blood Collection Tube are clearly visible. Smoothly wrap the label around the tube.

Once your label is fully adhered to your BD Vacutainer® Blood Collection Tube, you should be able to clearly see the color coded notch and the color coded sidebar.
Inappropriate Sites

Do not draw at site if
- Mastectomy - arm
- Edematous area
- Lymphedema
- Hematoma area
- Transfusion arm
- Scarred area
- Fistula or vascular graft
- Dialysis shunt
Drawing Blood from IV Arm

Never draw above the IV site
  • Always draw below the IV site
  • Fluids are shut down briefly, no longer than 2 minutes
  • Heparin infusion is shut down for same (2 minutes)
  • Document on tube - where the sample was drawn from
    • For example: “IV arm draw”
Age Specific Issues

**Pediatric: use**
- Butterfly needle
- Pedi (Bullet) tubes

**Elders: use**
- Butterfly
Obtaining Blood Cultures

Process

• Draw 2 samples
• Different locations
• Attempt peripheral sticks first
• MD order needed for any VAD draw
Obtaining Blood Cultures

- Must use a Butterfly needle
- Same process as Venipuncture
- You must use the larger Vacutainer adapter to have correct fit for the blood culture bottles
IV Insertion and Care
Policy

After obtaining/verifying MD order

- RN or GN
- LPN trained and competent
- Trained technicians
  - May insert a peripheral IV or Intermittent Infusion Device (IID)
IV Specifics

- Check solutions for issues (color, particles)
- **Label IV correctly – date and time**
- All solutions must be on a pump*
  - *Exceptions exist at KMH, MHB, in the Perioperative, Endoscopy, and Urology areas
- All pumps should be locked during use
IV Monitoring

- Orders for IV solutions are continued or discontinued in the computer every 24 hours by provider
- Assess flow, solution, and site q 2 hours
- IV solutions are changed q 24 hours
- IV sites rotated, tubing changed q 96 hours
Document

- If unable to find new IV site and MD notification
- Obtain MD order to leave in current site until further decisions are made about access

Emergency starts are changed within 24 hrs r/t risk of infection
IID/saline traps flushed:
- 3 ml or more NS
- Minimum of every 12 hours
- Pre/post access of site
Insertion Highlights

Need

- Extension tubing
- Injection cap
- Sterile tape
- Transparent dressing

**Once line in either** flush line w/ 3 ml NS or initiate IV infusion

Document procedure and pt response
Safety Guardrails & IV Meds

RN must contact the pharmacy when:
- Hard limit reached
- Prior to taking patient off safety guardrails
- Pharmacy may recommend nursing staff contact provider
Special Considerations
Pediatric Patients

• Insertion by trained personnel only
• NO Chloraprep used if < 2 months of age
• IV fluid management calculated by BSA
• Rate controller use
• IV is left in place, unless problem develops
• Assess every hour
Special Considerations
Geriatric Patients

- Stabilize vein
- Veins more sclerotic
- Smaller, shorter catheters
- Remove tourniquet promptly
Complications

Initially:

- Discontinue IV line
- Update of provider
- Attempt to restart IV in another location, if ordered
- Occurrence report
- Continuing monitoring site
Infiltration

• If noticed within 30 minutes of last check, apply ice directly over site for 5 minutes

• If noticed greater than 30 minutes after last check, apply warm compresses and elevate arm

• If extravasation of a vesicant occurs, notify MD immediately to obtain orders for administration of antidote
Phlebitis Scale

Assess the IV site using the Phlebitis scale

- **Grade 0** - No symptoms
- **Grade 1** - Erythema at access site, with or without pain
- **Grade 2** - Pain at access site with erythema &/or edema
Phlebitis Scale

- **Grade 3**- Pain at access site with erythema &/or edema, streak formation, palpable venous cord
- **Grade 4**- Pain at access site with erythema &/or edema, streak formation, palpable venous cord greater than 1 inch in length, purulent drainage

Then

- Apply warm compresses
Infection

Process

• Obtain orders for interventions
• If culture is ordered, cleanse site with alcohol and obtain fresh drainage for culture
• Blood cultures if ordered
Documentation

Process

- Time of discontinuation of line
- Description of surrounding skin
- Description of insertion site
- Signs & symptoms
- Interventions
- Patient complaint
- IV credits
- MD update, orders
Discontinuation

Process

• Gather supplies
• Remove line
• Needle/catheter into sharps
• IV bags/tubing in regular waste basket
• Blood tubing/bags into red plastic bag
• HIPAA: Either detach patient label from IV bag and discard in shredder box or blacken out the name with marker on the label
Vascular Access Devices
Vascular Access Devices (VAD’s)

RNs and GNs can
- Access, De-Access, Flush line
- Blood Sample
- Administration of IV fluids, meds, TPN, blood or blood products
- CVP monitoring
- Site Care
- Removal of PIC/PICC: credentialed, per hospital scope of practice or competency
- LPN’s may not perform any of these on VAD’s
VAD Insertion

Time out is done prior

- Full (Sterile) barrier precautions utilized
- Xrays done to confirm placement
- MD order needed to initiate fluids
Remember- Central Line Bundle

- Hand hygiene
- **Inserting provider** in full barrier garb
- **Asst:** If entering sterile field must have on sterile gown and gloves
- Sterile drape covering patient
- Prep with chlorhexadine
- Site selection – Subclavian, Internal Jugular
- Daily review of line need
VAD Overview

Process
- Site assess q 8 hours and prn
- Change tubing every 96 hrs
- Exceptions: TPN q 24hrs, Diprovan q 12 hrs (ICU)
- Label tubing (date/time)
- Cap change every 96 hours, or when blood is seen in access cap
- No need to change after every blood draw
Curos Caps for CLABSI Prevention
One Time Use Only
Follow MD Orders for Flush
If No Orders – Follow Policy

Catheter Maintenance Summary

<table>
<thead>
<tr>
<th>Catheter Type</th>
<th>Flush</th>
<th>Site Care/Dressing Change</th>
<th>Initiating Continuous Infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Peripheral catheter</td>
<td>Intermittent trap should be flushed a minimum of every 12 hours with 3 mL or more of normal saline and after every access.</td>
<td>Short peripheral insertion site rotated every 48 hours. Sterile transparent dressing, label with date, time, and nurse initials on separate sticker. Remove tape away from insertion site. Condition of insertion must be assessed at minimum every 2 hours.</td>
<td></td>
</tr>
<tr>
<td>Midline Peripheral catheter</td>
<td>Not in use: every 24 hours with 2.5 mL of Heparin 100 USP, I.V.</td>
<td>Not in use: every 24 hours with 2.5 mL of 100 USP, I.V. Heparin flush solution.</td>
<td>Not in use: every 24 hours with 2.5 mL of 100 USP, I.V. Heparin flush solution.</td>
</tr>
<tr>
<td>Central: Peripherally Inserted Central Line (PICC)</td>
<td>Only use a syringe with a bore diameter equivalent to a 10 mL syringe.</td>
<td>Not in use: every 24 hours with 2.5 mL of 100 USP, I.V. Heparin flush solution.</td>
<td>Not in use: every 24 hours with 2.5 mL of 100 USP, I.V. Heparin flush solution.</td>
</tr>
<tr>
<td>Central: Tunneled Central Venous Catheter</td>
<td>Tiedown: Not in use: every 7 days with 50 mL Normal Saline.</td>
<td>Not in use: every 7 days with 50 mL Normal Saline.</td>
<td>Not in use: every 7 days with 50 mL Normal Saline.</td>
</tr>
<tr>
<td>Central: Percutaneous Non-Tunneled Catheter</td>
<td>Non-tiedown: Not in use. Flush each day every 8 hrs. with 15 mL of Normal Saline.</td>
<td>Not in use: every 24 hours with 10 mL NS and 2.5 mL heparin flush solution.</td>
<td>Not in use: every 24 hours with 10 mL NS and 2.5 mL heparin flush solution.</td>
</tr>
</tbody>
</table>

**Initiating Continuous Infusion**

- 1. Verify patient identification.
- 2. PINC. Measure upper arm circumference – halfway between acromial area and shoulders prior to initiating therapy.
- 3. Maintain access technique.
- 4. Prime IV tubing.
- 5. Scrub venous injection port with alcohol and allow to air dry unless port protector has been applied for a minimum of 3 minutes.
- 6. Correct 10 mL syringes with NS and an appended catheter.
- 7. Check for competency by drawing blood back and then flush with 10 mL NS. If no blood return, but catheter flushes casually, notify provider and document.
- 8. Connect IV tubing to the injection port using the lock boss system.
- 10. Set IV pump for pump and date. Undrape catheter. Start pump.
- 11. Lumen IV tubing with date, time, and nurse initials.
- 12. PICC:
  - a. Observe patient for any signs of airlessness of breath.
  - b. Observe upper arm and shoulder for swelling, pain, and tenderness every 2 hours during infusion.
Central Line Dressing Change

- Gather supplies: clean & sterile gloves, biopatch and transparent dressing, chloraprep, sterile gown, mask, pen
- Don clean gloves and gown
- Remove old dressing
- Inspect site
- Remove clean gloves & wash hands
- Apply sterile gloves
Central Line Dressing Change

- Clean insertion site with Chloraprep 15 seconds and then allow to dry for 30 seconds
- Biopatch & dressing application
- Label dressing
- Document on site and patient tolerance of the dressing change
Pain Management
Pain

“Pain is whatever the person says it is, existing whenever the person says it is”

(Margo McCaffery, 1968)
Types of Pain

Acute
  • Rapid onset

Chronic non malignant
  • Prolonged onset

Cancer
  • Rapid or prolonged onset

Neuropathic
  • Nerve damage
Non Pharmacologic Interventions

- Positioning
- Repositioning
- Cold or warm applications
- Quiet environment
- Relaxation techniques
- Support of family and friends

Document attempts to use and patient response
Mild Pain 1-3/10

Use of

- Analgesics
- Adjuvant medications
- Peripheral analgesics
Moderate Pain 4-6/10

Use of:
- Weak opioids
- Non-opioid analgesic
  - T & C # 3
  - Lortab
  - Vicodin
  - Percocet
  - OxyContin
Severe Pain 7-10/10

Use of:

Strong opioid

• Morphine
• Hydromorphone
• Methadone
• Fentanyl
Faces and Numeric Scales

- Numeric scale preferred
- Faces scale is used if applicable
Admission Assessment

- Establish a patient pain relief goal
- Assess patient’s pain
- Pain descriptors
- Effects on their ADLs
- Cultural, psychosocial aspects of pain
Non Verbal Patients

Assessment on an individual basis

- Behavioral gestures
- Vital signs
- Reported pain from family or others
Neonatal Pain Assessment

- All infants assessed on admission to any newborn unit/area
- Assess minimally once a shift
- Assess pain before, during and after procedures
- Reassess within 1 hour of intervention, or within minutes if acute pain is noted
- Reassess then within 2 hours or at time of next assessment
- Document findings using NIPS
Neonatal Infant Pain Scale (NIPS)

- **Facial Expression**
  - Relaxed or grimace (0 or 1)
- **Cry**
  - No cry, whimper or vigorous cry (0-2)
- **Breathing Patterns**
  - Relaxed or change noted (0-1)
- **Arms**
  - Relaxed or flexed/extended (0-1)
- **State of Arousal**
  - Sleeping/awake or fussy (0-1)
## Adult Non Verbal Pain Scale

<table>
<thead>
<tr>
<th>Categories</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Face</strong></td>
<td>No particular expression or smile.</td>
<td>Occasional grimace, tearing, frowning, wrinkled forehead.</td>
<td>Frequent grimace, tearing, frowning, wrinkled forehead.</td>
</tr>
<tr>
<td><strong>Activity (movement)</strong></td>
<td>Lying quietly, normal position.</td>
<td>Seeking attention through movement or slow, cautious movement.</td>
<td>Restless, excessive activity and/or withdrawal reflexes.</td>
</tr>
<tr>
<td><strong>Guarding</strong></td>
<td>Lying quietly, no positioning of hands over areas of body.</td>
<td>Splinting areas of the body, tense.</td>
<td>Rigid, stiff.</td>
</tr>
<tr>
<td><strong>Physiology (vital signs)</strong></td>
<td>Stable vital signs</td>
<td>Change in any of the following: * SBP &gt; 20 mm Hg. * HR &gt; 20/minute.</td>
<td>Change in any of the following: * SBP &gt; 30 mm Hg. * HR &gt; 25/minute.</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Baseline RR/SpO₂ Compliant with ventilator</td>
<td>RR &gt; 10 above baseline, or 5% ↓SpO₂ mild asynchrony with ventilator</td>
<td>RR &gt; 20 above baseline, or 10% ↓SpO₂ severe asynchrony with ventilator</td>
</tr>
</tbody>
</table>
Behavioral Gestures

- Crying
- Moaning
- Grimacing
- Posturing
- Rigidity
- Restlessness
Pasero Opioid Induced Sedation Scale (POSS)

S = Sleep; easily to arouse

• Acceptable: No action necessary; may ↑ opioid dose as ordered

1. Awake and alert

• Acceptable: no action necessary; may ↑ opioid dose as ordered

2. Slightly drowsy, easily aroused

• Acceptable: no action necessary; may ↑ opioid dose as ordered
3. Frequently drowsy, arousable, drifts off to sleep during conversation

Unacceptable:

• Notify provider
• Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory
• Consider administering a non-sedating, opioid-sparing non-opioid, such as acetaminophen or an NSAID, as ordered
POSS

4. Somnolent, minimal or no response to verbal or physical stimulation

Unacceptable:

• Stop opioid
• Notify provider and/or call Rapid Response
• Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory
Pain Assessment

- Ongoing process
- Re-evaluation of pain
- Purposeful rounding
- Assess after pain med
- And after any intervention
Assess and Reassess, cont.

Purposeful rounding question
• Assess minimally at least once a shift
• Documentation every 8 hours

Post operative guidelines
• Every 2 hours for 1st 24 hours
• Every 4 hours after that
Reassessment After Medications

Know your patient’s
- Pain meds
- Side effects
- Pain mgmt. routine

Patient sleeping when you attempt to do reassessment?
- Nurse may document “patient is sleeping”
- This completes the reassessment
Non Pharmacologic Interventions

Don’t forget these can be effective

• Positioning
• Repositioning
• Quiet environment
• Relaxation techniques
• Cold or warm applications
• Support of family and friends

Document any interventions used along with patient response
Treat Patient as an Individual

Get answers to the following questions:

- Pain prior to admit?
- Pain now?
- Meds prior to admit?
- Meds on now?
- NPO status?
- On new medications?
Documentation

Document

- New onset pain
- Initial pain scale
- Descriptors
- Interventions
- Response
- Reassessment
- Untoward effects
Lastly

Geriatric pts: consider renal, liver impairments
Pediatric: weight based dosing

Refer also to other policies
• PCA
• Epidural
• Neonatal pain: NIPS
Patient Controlled Analgesia
Prior to Starting PCA

Assess patient’s risk factors for sleep apnea
Patient’s who are at risk for sleep apnea are at a higher risk for Respiratory Depression
Risk Factors

- Basal infusion use
- Age >70 years
- Obesity
- Abdominal or thoracic surgery
- CNS depressant
- Renal, cardiac, pulmonary, or hepatic disease
- No opioid tolerance
Side Effects of Opioids

- Pruritus
- Constipation
- Nausea/Vomiting
- Sedation
- Respiratory Depression
- Death
RN Responsibilities with PCA

- Initiate PCA
- Change syringe
- Discontinue PCA
- Assess patient’s response
RN Responsibility for Start Up

- ID patient
- Review MD order
- Allergy status
- Current medications
Two RN responsibility

Review orders when
• Initiating PCA
• Transferring patient
• Syringe, dose change
• Shift change
Two RN Verification Responsibility

Verification includes correct:
- Medication
- Dosage
- Delay interval
- 1 hour limit

Every 8 hours:
- Note history
- Document
- Clear pump
PCA Start Up continued

- Label tubing with date, time, “PCA only”
- Attach to distal “Y”

Start up
- Initiate Bolus dose
- Initiate PCA infusion
- Monitor patient response
Ongoing PCA Therapy

- Assessment of patient
- Documentation of patient response
- Update provider if patient is experiencing any breakthrough pain or a change in the patient’s condition
Of Note

• Reversal agents – know where to find, if ordered
• IM or PO analgesics are not recommended during PCA
• PCA tubing change every 96 hrs
PCA Education

- Instruct patient and family on PCA use
- **NO** Proxy dosing
- Document in medical record any teaching done
Assessment

Start up & q 4 hours:
- Baseline VS
- Respiratory rate for 1 full minute
- Pain scale (0 – 10)
- Sedation - POSS

Ongoing:
- Respiratory rate and quality
- Sp02
- ETCO2 if available
- Pain
- Sedation
- Patient response
- Side effects
<table>
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<td>Acceptable: No action necessary; may increase opioid dose as ordered</td>
</tr>
<tr>
<td>1. Awake and alert</td>
</tr>
<tr>
<td>Acceptable: no action necessary; may increase opioid dose as ordered</td>
</tr>
<tr>
<td>2. Slightly drowsy, easily aroused</td>
</tr>
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<td>Acceptable: no action necessary; may increase opioid dose as ordered</td>
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<td>3. Frequently drowsy, arousable, drifts off to sleep during conversation</td>
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</table>
Assessment Frequency

For 1\textsuperscript{st} 24 hours
• Initial full set of VS and assessment

Then do ongoing assessment only
• Every 1 hour x 4
• Every 2 hours for the remaining 20 hrs

After 1\textsuperscript{st} 24 hours do Vital Signs and assessment
• Every 4 hours until discontinued
# Monitoring Parameters

<table>
<thead>
<tr>
<th>Monitoring Parameters</th>
<th>Vital signs +</th>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP</td>
<td>T</td>
</tr>
<tr>
<td>Initial Assessment</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Every 1 hour x 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every 2 hours for the remaining 24 Hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every 4 hours</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Assessment

Start up & every 4 hours

- Baseline VS
- Respiratory rate*
  - Taken for 1 full minute
- Pain scale (0 – 10)
- Sedation scale - POSS (Formerly MAAS)

Ongoing

- RR – 1 full minute
- Respiratory quality
- Sp02 %
- ETC02 (if available)
- Pain scale
- Sedation scale
- Patient response
- Narcotic side effects
PCA Flow Sheet Documentation
Nocturnal Hypoxia

During first 24 hours:
At night:
Higher risk for
• Hypoventilation
• Nocturnal hypoxia

Assess respirations for:
• Rate, depth & rhythm when patient is asleep
• Do not awaken, then assess
Facts to Know

• Patients with induced respiratory depression or over sedation can be easily stimulated to a higher level of consciousness & RR

• Assessment findings may not help detect nocturnal hypoxia in a patient who is woken up by nurse, or self awakening
Reversal Agent Protocol (Adult)

Known or suspected over dosage:
RR of < 10, BUT easy to arouse
- Remove PCA control from patient
- Administer 6L/min O2 via mask
- VS, including pulse oximetry
- Notify provider
- Obtain new orders for overall patient management, including pain medication
Reversal Agent Protocol (Adult)

Known or suspected over dosage:
RR < 8, difficult to arouse, POSS level ↓
- Call RRT
- Remove PCA control from patient
- Give 02 via ambu bag, facemask
- VS, including pulse oximetry
- Notify provider
- Consider Narcan administration
Disposal of Unused PCA

- Unused drug is flushed down the drain
- Two RN’s must witness and document in PYXIS
Statement

After reading through the contents of this presentation of current Catholic Health policies, you understand that anytime you encounter a procedure or equipment that is unfamiliar to you, it is your responsibility to contact the appropriate resource person before proceeding with the hands on care associated with the procedure or equipment.
Thank you