Nursing Instructor Policy and Procedure Review

For Home and Community Based Care Long Term Care Facilities 2016

P&SOS Program

Protect and Save Our Skin Program

Systematic evidence based interdisciplinary program designed to prevent the development of skin impairments and to recommend treatment options to promote wound healing consistent with clinical best practices.
P&SOS Program Goals

- Prevent and Treat Pressure Ulcers (PrU) using evidenced based best practices supported by an IDT
- Insure high quality fiscally responsible care to our Residents/Patients in compliance with state and federal regulations
- To encourage, provide and promote staff education and competencies.
- Provide patient and community education

Definition

A pressure ulcer is a localized injury to the skin and/or underlying tissues, usually over a bony prominence, as a result of pressure, or pressure in combination with shear.  

(NPUAP 2009)
Pathophysiology

Deep Tissue Injury

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
Stage I

Intact skin with an area of nonblanchable redness.

Can be painful

Area can be firm or soft.

It signals “AT RISK” for tissue breakdown.

Stage II

Partial thickness tissue loss. (loss of the dermis)

Shallow, open or ruptured serum filled blister without slough or bruising
Stage III

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Unstageable

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, Brown or black) in the wound bed.

Incontinent Associated Dermatitis

Diffuse area of erythema, scaling, vesicles, pustules, weeping, pain/itching, or edema.

Partial thickness skin loss may also occur secondary to maceration and friction.

May see fungal or bacterial secondary infections
Effects of PrU on the Patient/Resident Quality of Life

– Social Isolation
– Depression and anxiety
– Feelings of blame or failure
– Embarrassment from odor or dsg.
– Functional declines
– Fear
– Pain

Key Documentation Issues

• Admission H&P
  – RN
• Medical assessments – Nursing Wound Assessment & Wound Treatment Orders
• IDT assessments
Risk Assessment

• Begins upon admit with Nsg H&P and IDT admission assessments
• Braden
  – Score 18 or less
  – Frequency
  – Revisit the POC with all changes in condition - acute or permanent

Care Plan -
Actual Skin Impairment

• Evaluate effectiveness of current interventions:
  – Current positioning/pressure reducing devices
  – Dressings
  – Infection management
  – Patient subjective response/tolerance to current interventions
  – Staff feedback on current interventions
  – Impact on residents Quality of Life
Roles & Responsibilities

RN

- Nursing H&P Admission/Readmission Assessment
- Skin Impairment Prevention Plan (SIPP) on admission
- Actual Skin Impairment POC (if applicable)
- Braden Scale
- Weekly assessment and documentation of PrU

Roles & Responsibilities

• LPN
  - Full body skin check on pt./res. bath day
  - Tx. as ordered
  - Daily documentation on PrU
  - Participate in evaluation of tx. modality efficacy
Roles & Responsibilities

CNAs
• Pressure Redistribution per Closet Care Plan (CCP)
  • 30 degrees
  – Gached feet
  • Booties, wedges, WC cushions, splints
  • Appropriate chair
  • Monitor for soiling, tears, fit. Check for Bottoming out. Check plugs!

• Proper positioning
  • Friction & shearing
  • Silent ulcers

• Prompt & Proper Incont. Care
  • Check for incont. at least q 2hrs.
  • Use barrier cream/ointment after cleansing
  • Appropriate size brief
  • Report change in cont.
  • Report change in urine and/or feces

Roles & Responsibilities

CNAs:
• Nutrition
  – Meal time intake plus supplements
  – Liquids
    • Check CCP for consistency

• Nourishments
• Report change in ability to chew or swallow
• Accurately record meal intake
  – Liquids recorded in mls
  – Solids recorded in percentages
WCC – Wound Certified Clinicians

- Skin Experts
  - Clinical expert on site
    - They have the ability to perform a wound consultation and make treatment recommendations.

- Skin consults

- Ambassador for Preventive Wound Care

Interdisciplinary Team

It takes a team to have an effective and successful skin program:

Nursing, CNAs, Nutritional Services, PT OT SLP, Pastoral Services, Social Workers, Pharmacy, DME vendors, Home Care Agencies all working hand-in-hand.
Preventing Needle stick Injuries

NEEDLE SAFETY

What is a needle stick?

A “needle stick” means a break in the skin from a needle or other “sharp” such as a scalpel.
What Infections are Caused by Needle stick Injuries?

- An injury from a contaminated needle exposes workers to blood borne pathogens that can cause serious or fatal infections.

- The most serious are:
  - HIV
  - Hepatitis B
  - Hepatitis C

How Common are Needle stick Injuries?

- It is estimated that more than 800,000 injuries occur annually in the United States from needles and other sharps.
- More than half of these injuries are never officially reported.
- You should always report your injuries immediately to ensure that you receive proper follow-up medical care.
Where Do these Injuries Occur?

- These injuries have been reported from all healthcare settings, including:
  - Ambulatory settings
  - Physician offices
  - Nursing homes, skilled nursing facilities
  - Home health, assisted living
  - Hospitals

Timing of Needle stick Injuries

- Needle stick injuries can occur at any time during the use or disposal of a device

- Needle sticks in our division have occurred related to:
  - **Failure** to properly engage safety mechanism on syringes
  - **Safety awareness** r/t handling of used clysis strips
  - **Safety awareness** r/t safe handling of insulin pens after use
  - **Safety awareness** r/t proper disposal of used lancets
How to Protect Yourself…

Be Aware

• Other factors that contribute to needle sticks are:
  – Lack of safety devices
  – Failure to engage safety device after use
  – Inconveniently placed or overfilled sharps containers
  – Busy, congested environments with frequent distractions and rushing

How To Protect Yourself…

Be Prepared

• Prior to performing a procedure using sharps:
  – Ensure all equipment is available and within arms reach
  – Ensure lighting is adequate
  – Place a sharps container nearby and know where it is located
  – Assess patient’s/resident’s capacity for cooperation; request additional help if needed
  – Instruct patient/resident to avoid sudden movement
  – Do not expose sharps/needles until moment of use and keep pointed away from user.
How To Protect Yourself…
Be Prepared

• **During the procedure**
  – Maintain visual contact with sharps during use
  – Remain aware of positioning of other staff to avoid accidental contact
  – Do not pass sharps by hand; place and retrieve from predetermined centralized location/tray
  – Alert other staff when placing or retrieving sharps

How To Protect Yourself…
Be Prepared

• **Post-procedure:**
  – Activate safety features of sharps and check (visual & auditory) to ensure features are activated and locked in place.
  – Ensure all sharps are accounted for and visible.
  – Check trays, linens, waste materials prior to handling for sharps accidently misplaced or left behind
  – Keep fingers away from tip of device when disposing, and avoid placing hands close to the opening of the sharps container.
Patient or resident change in condition

Immediate notification to the unit nurse to initiate an SBAR of any symptom, sign, or apparent discomfort that is:

– Sudden in onset
– A marked change (i.e. more severe) in relation to usual signs and symptoms
– Unrelieved by measures already prescribed

CODE 10
Cardiopulmonary Resuscitation  CPR

- Initiated on all patients/residents without a DNR or without an identified Advanced Directive
- All licensed nursing staff and identified therapy staff are required to obtain and maintain CPR certification

CPR Identification

- **Blue Band** – no DNR or other identified advance directive. **Full Code**

- **White Band** – has a DNR or other advance directive indicating **no CPR**

- **Green Band** – specific to OLV, has a DNR or other advance directive indicating **no CPR**
CODE 10

- Upon identifying a cardio/pulmonary arrest, the need for CPR will be determined by the identifying blue arm band, call for help and remain with the patient/resident.
- A “CODE 10” is announced twice over the paging system and will include the nursing unit and room number or other location. 911 will be notified that “emergency life support” is required at the facility.
- Staff will respond with emergency equipment and the first CPR/AED certified staff member to arrive will position the patient/resident and begin CPR. The Code Leader will assign duties including:
  - Airway Management
  - Cardiac Compressions
  - Defibrillation
  - Intravenous Line Initiation
  - Medication Administration
  - Documentation
  - Family Support
- Documentation related to the event will be completed on the Cardiopulmonary Resuscitation Record.
- CPR will continue until advanced life support systems arrive or a physician’s order to stop CPR is received. The Code Leader will give a comprehensive report to the EMS personnel prior to transport.
- The Code Leader will oversee the resuscitation event, assist as needed, and ensure documentation in the Medical Record.

CCD Pain Management
Goals of Pain Management

✓ Assist your patient/resident with pain management to control their pain to the greatest extent possible.

✓ You may not be able to totally eliminate pain but achieve a noted reduction in the pain, a pain level that your patient/resident can tolerate.

✓ You need to ask what number is an acceptable pain level for them.

Types of Pain

• **Acute pain** – might be mild and last just a moment, or it might be severe and last for weeks or months. In most cases, acute pain does not last longer than six months, and it disappears when the underlying cause of pain has been treated or has healed.

• **Chronic pain** – pain that starts as acute pain and continues beyond the normal time expected for resolution of the problem. **Complete relief of chronic pain is rare.** Chronic pain goals are to minimize the pain and maximize the patients' functioning.

• **Neuropathic pain** – is a complex, chronic pain state that usually is accompanied by neuropathic tissue injury.

• **Breakthrough pain** – sudden episode of severe pain experienced between scheduled doses

• **Incident pain** – unpredictable, associated with movement or certain actions

• **Chronic nonmalignant pain** – prolonged onset
Facts

Inadequately treated pain can lead to:
• Decreased functioning
• Sleep disturbances
• Depression
• Decreased emotional well-being

Challenges to an Effective Pain Evaluation
• Subjective Report
• Healthcare providers disbelief / bias
• Variation in how patient/resident describes pain
• Language and/or cultural barriers
Elements of a Pain Evaluation

- Location
- Description
- Radiation
- Severity or Intensity
- Timing of the pain
- Precipitating & relieving factors
- Associated symptoms (SOB, chest pressure, inflammation, warmth, tenderness)
- Effectiveness of past & present pain interventions
- Satisfaction with current pain management

Subjective Pain Evaluation

Patient’s/resident’s self report is the single most reliable indicator of the existence and intensity of pain

- Pain is whatever the person experiencing it says it is
- Exists whenever he or she says it does
Objective Pain Evaluation

- **Non-verbal cues** (restlessness, fidgeting, pacing/rocking, resistance to movement)
- **Facial Expressions** (grimacing, frowning, clenching jaw)
- **Vocalizations** (crying, moaning, crying out)
- **Physiologic changes** (skin flushing, diaphoresis, change in VS)
- **Changes in behavior** (decreased social interactions, withdrawn, cessation of common routines)
- **Alteration on function/mobility** (inability to perform ADLs, changes in mobility/ROM)
- **Appetite changes/weight loss**

Anticipation of Pain & Precipitating Factors

To help minimize the risk of pain our residents and patients may suffer **evaluate the possibility of what’s the causing pain**:

- Prior to
- During
- Following

Any procedure, treatment, or activity known to potentially cause or exacerbate pain
Non-Pharmacologic Interventions

- Massage
- Repositioning/supportive devices
- Cutaneous stimulation (heat/cold)
- Exercise
- Relaxation/imagery
- Distraction (music, TV, activity involvement)

Pharmacologic Interventions

- Mild Pain (Pain scale 1-4)
  - Acetaminophen
- Moderate Pain (Pain Scale of 5-7)
  - Norco, Percocet, Ultram, Oxycodone
- Severe Pain (Pain Scale of 8-10)
  - Norco, Oxycodone, Percocet, Morphine
  (dose increases with increase in severity of pain)
Things to Consider

• Encourage patient/resident to report & request pain medication upon initial onset (Don’t wait)
• Medicate per order & reassess within 60 minutes
• Document outcome in the electronic medical record
• Notify the medical provider as needed for uncontrolled or persistent pain or adverse consequences
• If a long acting medication is ordered, there should be an order for “breakthrough” pain management
• If the patient/resident is regularly taking a prn medication, notify the medical provider to change pain medication order to a scheduled time so it won’t get missed

Pain Management & Quality Indicators

• Indicators and surveys are used in Continuing Care to assess our effectiveness in the management of our patients/residents pain.
  • We are bench marked against national & state averages.
  • Our goal is to reach the national top decile, 90th percentile, we want to be in the top 10% of patients and residents saying we managed their pain excellently
In summary

We are aware that we have a tremendous opportunity to become better at managing our patients’ and residents’ pain. Not only is this a quality issue but a financial one as well. In order for us to become part of a high performing healthcare system and to reach our goal of top decile performance in the state and nation we must all work together!

Remember – pain is the 5th vital sign!

Pain Policy Highlights:

Pain Evaluation and Monitoring:
• The Pain Tool will be completed as follows:
  – Upon Admission or Readmission
  – Upon initial complaint of pain
  – Annually
  – Significant Change
  – Quarterly
• Pain Tracking will be initiated for each patient/resident receiving scheduled or prn pain medication and will be completed with each administration of pain medication.
• Pain evaluation will include subjective and/or objective observations.
Pain Management Intervention:

If patient/resident complains of pain perform the following:
• Obtain information and document pain site, verbal or non-verbal pain score, description, known precipitating factors to pain.
• Implement non-pharmacological interventions as appropriate.
• Administer pain medication as prescribed by the physician/medical provider.
• Reevaluate patient’s/resident’s pain level within 45 minutes following intervention/medication administration.
• Document follow-up pain score.
• Monitor for adverse medication reactions and document.
• Notify the physician/medical provider if pain management interventions are ineffective and/or adverse reactions are present.

Pain Management Intervention cont.

For patients/residents without an order for pain medication:
  – Initiate Pain Tool.
  – Notify physician/medical provider of results
• Examples of non-pharmacological pain management interventions include, but not limited to:
• Distractions (television/music)
• Imagery/relaxation
• Positioning/massage
• Heat/cold application
• Toileting
• Exercise
• Immobilization
Physician/Medical Provider Notification

- The physician/medical provider will be notified with frequent requests for prn pain medications.
- Patients/Residents will be monitored for adverse consequences and the physician/medical provider will be notified.
- The Contract/Consultant Pharmacist will monitor pain management regimens, and review findings with the Clinical Nurse Manager/Resident Care Coordinator and the physician/medical provider as indicated.
- If pain management interventions are refused by the patient/resident and or their representative, documentation in the medical record will include:
  - Discussion of potential consequences
  - Recommended alternatives or approaches
- Patient/resident education will be provided regarding medication(s) to include potential benefits/risks and alternatives.

Universal Pain Evaluation Scale

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

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Hurt</td>
</tr>
<tr>
<td>1 – 2</td>
<td>Hurts little bit</td>
</tr>
<tr>
<td>3 – 4</td>
<td>Hurts little more</td>
</tr>
<tr>
<td>5 – 6</td>
<td>Hurts even more</td>
</tr>
<tr>
<td>7 – 8</td>
<td>Hurts a Whole lot</td>
</tr>
<tr>
<td>9 – 10</td>
<td>Hurts Worst</td>
</tr>
</tbody>
</table>

Activity Tolerance Scale

- No Pain
- Can Be Ignored
- Interferes with Tasks
- Interferes with Concentration
- Interferes with Basic Needs
- Bed rest Required
CALL DON’T FALL

PAIN MEDICATIONS CAN CAUSE DIZZINESS AND LOSS OF BALANCE.

PLEASE ASK FOR ASSISTANCE PRIOR TO GETTING OUT OF BED

Copy of Patient Education - PRESCRIPTION PAIN MEDICINE GUIDELINES

You may be receiving a prescription pain medication to treat your pain.

Pain medicines taken by mouth will begin to work in about 30 – 45 minutes.

• Notify your nurse if you are experiencing pain
• Notify your nurse if you are still experiencing pain/discomfort after receiving pain medications
• Take your medication as directed.
• Get up slowly since pain medications can cause dizziness.
Use your call button if you need assistance
Common Side Effects:
• **Stomach upset.** Taking your pain medication with food or milk may help decrease stomach upset. Notify your nurse if you are experiencing stomach upset or nausea. Your doctor may have ordered something to relieve your stomach upset, or the nurse can contact your doctor to obtain an order for a medication.
• **Constipation** is common while taking pain medication so be sure to increase your fluids and fiber intake. Stool softeners and laxatives are recommended while on pain medication. Notify your nurse/doctor if you’re experiencing discomfort and/or constipation, or have not experienced relief if medications have been received.
• **Dizziness** may occur while taking pain medication so use extra care getting up from a chair, getting out of bed and when moving about. Use your call button and ask for assistance if you feel dizzy or weak.

Tell your nurse/doctor if your pain does not go away, gets worse or if you develop a new type of pain.

Be sure to tell your doctor/nurse all the prescription, over the counter medications, vitamins, and herbals you were taking prior to admission. Be sure to provide your doctor/nurse with a detailed medical history (heart disease, seizures, lung disease, abnormal blood levels, diabetes etc.).
RESIDENT RIGHTS
AND
RESIDENT ABUSE

It is the right of every patient and resident to be treated with:

- Consideration
- Respect
- Personal Dignity
What constitutes neglect and/or abuse?

• **Neglect**: is a failure to care for a person in a manner which would avoid harm and pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

• **Abuse**: causing intentional pain or harm. This includes physical, mental verbal, psychological, and sexual abuse, corporal punishment, unreasonable seclusion, and intimidation. Abuse also includes rough handling during care giving, medication administration, or moving a patient or resident.

Reporting Neglect and Abuse

• It is a violation of State and Federal law for any person, to neglect or abuse a patient/resident. **Everyone**, including Nursing Instructors and Students, is obligated to report neglect or abuse. If you suspect neglect or abuse, or if a patient/resident tells you they are experiencing this problem, it is important to believe the patient/resident and report the allegation immediately to the Nursing Supervisor or Charge Nurse.
ELOPEMENT
CODE “E”

It is the responsibility of every LTC facility to provide a safe and secure environment for all patients/residents.

It starts with admission to the facility

- Elopement/Unsafe Wandering Risk Evaluation Scale is completed by a licensed nurse as follows:
  - Upon admission/readmission
  - 7 days post admission/readmission,
  - Change from short term stay to long term placement (LTC)
  - new onset of wandering
Elopement/Unsafe Wandering Risk Evaluation Scale

• Used to determine the resident’s/patient’s risk for elopement/unsafe wandering.

• Any patient/resident identified as a risk/high risk for elopement and/or unsafe wandering will be reevaluated monthly.

Elopement “Code E”

• Education will be provided for associates, upon hire, to include responsibility to identify, report, and implement interventions related to elopement/unsafe wandering risk.

• Associates will promote environmental safety by being observant of non patient/resident and low volume traffic areas.

• Missing resident drills will be conducted at least annually.
Missing Patient/Resident

• When it is determined that a patient/resident is suspected missing:
• An overhead announcement of CODE - E will be made for the specific unit. A command post will be established in a centrally located area.
• All associates on all units will begin a search of their immediate area. Upon completion of the search, the department head/designee will contact the command post.
• If the patient/resident is located an overhead announcement of “CODE E All Clear” will be made.
• When the patient/resident is not located…………………………
• Nursing Supervisor/Nurse Manager will:
  – Contact the Director of Nursing & Administrator within 15 minutes of the event
  – Initiate the Elopement Search Assignment form.
  – Secure and isolate the patient’s/resident’s room.
  – Contact all available associates for search assistance/assignments.
  – Organize an internal and external search of the facility. The external search will include the grounds within an approximate ¼ mile radius of the building.
  – Assign monitors for all accessible egresses.

Search Process

• The Administrator or DON will notify the local Police Department and the family within 30 minutes of the incident.
• The police will be provided with the following information:
  – Time discovered missing.
  – Last known location.
  – Description of appearance.
  – Cognitive status and native language.
  – Street Address information that is significant/meaningful to the patient/resident.
  – Any unique identifying information.
  – Patient's/Resident’s ID Packet.
• For residents/patients without an ID packet, a detailed description will be provided along with a photo of the patient/resident
If the resident/patient has not been located following the search…

- The Administrator/DON will:
  - Call the NYSDOH.
  - Work in conjunction with the outside authorities.

- All media inquiries to Catholic Health Public Relations department.

Once the Patient/Resident is Found the Nursing Supervisor/Designee will:

- Complete a patient/resident nursing assessment. Arrange for emergent care, if indicated.
- Notify the search team, authorities, and family/responsible party.
- Notify the Administrator/DON/Designee
- Place the Patient/Resident on visual checks every 15 minutes for the first 24 hours following the incident.
- Maintain communication with the Emergency Department for all transferred patients/residents.
Occurrence Reporting

Objectives:

- To assure that appropriate and immediate intervention is completed on the resident's/ patient’s behalf and to prevent the possibility of a re-occurrence.
- To provide a factual record of the occurrence so that care being given can be evaluated and ensure adequate care standards are followed.
- To provide further associate education through case review and discussion.
- To target problem areas through effective trend analysis, and to promote open channels of communication across all levels within the organization.
- To provide a factual record of occurrences as a basis for immediate notification to the Risk Management Department (as deemed necessary by the IDT) so that the occurrence can be evaluated for potential liability exposure.
Definition of an Occurrence:

• A situation that is not consistent with the acceptable standard care of a resident/patient or a situation which occurs during the routine operation of the facility that has the potential or already has had an untoward effect on resident(s) or patient(s).

Definition of a Fall

• Unintentional change in position coming to the rest on the ground, floor, or onto the next lower surface. May be witnessed, reported by the resident/patient or observer or identified when a resident/patient is found on the floor or ground. (includes an intercepted fall in which the resident/patient would have fallen if they had not been caught by another person).
Occurrence Report - Procedure

- Any one who discovers, witnesses or to whom an occurrence is reported is responsible for reporting the occurrence to his/her supervisor immediately. The Supervisor/Charge Nurse is responsible for completing an “Occurrence Report” by the end of the shift when the incident occurred.

- Any occurrence involving a patient/resident with injury or potential injury must be reported to the charge nurse on the same shift when the injury occurred; employee injury or potential injury must be reported to the employee’s immediate supervisor; visitor injury or potential injury must be reported to the nursing supervisor or nurse manager.

Occurrence Report Procedure, cont..

- Any occurrence with significant injury and/or harm; (Definition of Significant Injury: bone fractures, joint dislocation, closed head injuries with altered consciousness and subdural hematoma) requires immediate notification of the resident’s/patient’s attending physician/provider. In addition, the Director of Nursing OR the Administrator must be notified by the end of the shift in which the incident occurred. (Director of Nursing to also be notified with if an occurrence resulted due to failure to follow care plan)
Occurrence Report Procedure, cont.

- Any occurrence requires notification of the resident’s/patient’s responsible party unless the designee has stated that they do not wish to be notified OR the resident/patient prefers family not to be notified. This is to be documented in the resident’s/patient’s medical record.
- No reference to a completed Occurrence Report shall be made in the Medical Record.
- Occurrence Reports are not a part of the resident’s/patient’s chart and may not be copied or reproduced.

Occurrence Report Procedure, cont.

- Review and update the care plan and closet care plan to reduce risk of further occurrences and communicate change to the staff. The occurrence and adjustment to the care plan will be reviewed at the next interdisciplinary conference (morning report) and the team will determine final adjustment to the care plan.
- The patient/resident will be assessed each shift for a minimum 24 hour follow up period and documentation of the patient’s/resident’s status will be provided on the occurrence report as well as in the Interdisciplinary Notes.
- Upon completion of the 24-hour assessment period, the occurrence report will be forwarded for review (no later than 72 hours following the occurrence) and signed by the Director of Nursing, Administrator and Medical Director.
FALLS

• All patients/residents who have a fall must be evaluated by therapy services

• Neuro checks will be performed with all falls that are unwitnessed.

• Neuro Assessment
  – Q 15 mins. X 4
  – Q 30 mins. X 2
  – Q 4hrs. X 24hrs.

• Notify the MD of all patient/residents on anticoagulant therapy with suspected or actual head injury.

Controlled Substances
Unit Security

• A separate double locked cabinet for controlled substances will be located on each unit in the medication room or at the nurses’ station.
• The keys to the locked cabinet will remain with the designated licensed nurse.
Things to remember regarding controlled substances

- Controlled substances will be double locked in the medication/treatment cart.
- Do not place prn narcotics in the med cart during routine med pass. The packaging is fragile and increases the chances of tears to the foil on the back of the bubble resulting in missing narcotics.
- Always sign out the narcotic in the MAR and the Narcotic Log immediately after administration.
- When wasting a narcotic it is disposed of in the sanitary sewer in the presence of another nurse. A notation is made on the back of the administration record sheet and both nurses initial.
- After completion of Medication Pass, the nurse will return controlled drugs to double locked wall cabinet. If narcotics remain in the med cart, the cart must be tethered.

Fentanyl Patches

- Application to patient’s skin: a pen or magic marker should be used to write the date, time, and initials of the medication nurse on the patch. During the time the patient wears the patch, this documentation should be regularly checked against medication administration records. The patch should also be inspected for cuts, needle holes or other evidence of tampering, such as a dried-out appearance.
- Removal from a patient: it should be rendered both unusable and unrecoverable, fold into and flush down the sanitary sewer. Even after the 72-hour period during which a fentanyl patch is effective for the patient, it still contains a significant amount of drug. As with any other remaining partial dose of a controlled substance, the used fentanyl patch should be disposed of in the presence of another nurse.
CAUTI

What is a CAUTI?

• Catheter Associated Urinary Tract Infection

CAUTI

Risk factors
Long term catheters
• Duration is the most important risk factor
  – Risk increases by 5 -10 % each day
Female
Elderly
Failure to maintain a closed drainage system
  – Catheter & drainage system should not be disconnected unless absolutely necessary
Susceptibility of the host
CAUTI

McGeers Criteria

- Recognized by the CDC & APIC for identifying infections in LTC

CAUTI

- Fever, chills, or new onset hypotension with no alternate site of infection
  - Slight pyrexia is not uncommon in patients/residents with a foley catheter and often lasts only a day (temp > 99 - 100)
  - An isolated incident should not prompt initiation of obtaining an order for a UA/C&S
- Either acute change in mental status or acute functional decline with no alternate diagnosis AND leukocytosis
- New onset of suprapubic pain or angle pain or tenderness in costovertebral area
- Purulent discharge from around the catheter OR acute pain, swelling, OR tenderness of the testes, epididymis, or prostate.

Foul smelling or concentrated urine are not s/s of a UTI

Colonization vs Infection

Bacteriuria – the presence of bacteria in the urine

- Bacteriuria inevitably occurs over time, either by breaks in the sterile system or via the extraluminal route
- Once the urine is colonized, micro-organisms rapidly progress, within 72 hrs. to concentrations > 50,000 colony-forming units.
- Daily risk of bacteriuria with catheterization is 3 – 10%
- By the 30th day of catheterization, bacteriuria is nearly 100%

- Asymptomatic bacteriuria does not require treatment
  - Treatment promotes antibiotic-resistant microbes
  - Only symptomatic infection should be treated in patients/residents with chronic indwelling catheters.

Remember colonization is not an infection
CAUTI

Obtaining a urine sample from a Foley catheter

If an order is obtained for a C&S, the old catheter is removed, a new catheter is inserted, and the specimen is collected from the newly inserted catheter.

- Wash hands
- Apply gloves
- Clean the port at the end of the catheter where the tubing attaches to the catheter bag with an alcohol wipe
- With a needleless syringe withdraw the urine and place in appropriate specimen container.
- Maintain sterility of process so don’t contaminate the sample.

CAUTI

Urinary Catheter Management

- The collection bag is a reservoir for microorganisms; proper handling can reduce the risk of infection
  - Position below the level of the bladder
  - Empty regularly, protecting the spigot from contamination
- Catheter and drainage tubing should not be disconnected unless absolutely necessary
- Wash hands before and after any manipulation of patient’s/resident’s catheter or collection unit to prevent cross contamination
- Secure catheter with a leg strap to prevent movement and traction forces on the catheter
- Catheters are inserted aseptically, using barriers (sterile gloves, drapes, sponges, antiseptic solution, single use packets of lubricant) Use an unused basin to perform peri-care before insertion.
- Do not routinely irrigate plugged catheters, if it’s plugged, replace it.
- Catheter care should be performed each shift and after bowel incontinence.
CAUTI

Ask yourself the following questions, before reporting a patient/resident has a CAUTI.

Have I done a complete assessment/evaluation of my patient/resident?
- What are the VS/LOC and have they changed?
- Have I ruled out all possible causes?
- Have I ruled out alternate sites of infection?
- Was I able to come to a conclusion from the information I gathered from my assessment/evaluation?

Look at the whole patient/resident!

CAUTI

Remember “Think Critically!”
- All patients residents with a chronic Foley catheter are colonized with bacteria
- Before calling the provider for an order for a UA/C&S determine if there may be an alternative reason for the s/s or an alternate site of infection.
- Dark, foul smelling, concentrated urine are not s/s of a UTI; try pushing fluids for 24hrs.
- It’s not abnormal for a patient/resident with a Foley catheter to have a temp of 99° - 100° for a day.
- Do not treat asymptomatic bacteriuria, it promotes antibiotic resistant microbes
- Make sure your documentation includes name of antibiotic, patient’s/resident’s response to the ABT and the adverse reactions you are monitoring for.
CAUTI

- For in-depth information regarding care and management of indwelling catheters, urethra and suprapubic, refer to CCD “Urinary Catheter” policy

If you have questions while you are at one of our facilities please ask the associates for clarification and access to our policies.

Thank you and we hope you enjoy your clinical experience at Catholic Health