STUDENT AND INSTRUCTOR MANUAL

TALLAHASSEE MEMORIAL HEALTHCARE

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Introduction

Welcome to Clinical Orientation! Our goal this first week is to make you feel welcome as a new colleague at Tallahassee Memorial HealthCare and provide you with the resources you will need to succeed in your role here at TMH.

Contact Information

TMH Education Center:
850-431-5405
1623 Medical Drive, Suite 3
Tallahassee, FL 32308

Human Resources, Academic Liaison
850-431-5786
Center for Healthcare Careers
Tallahassee Memorial HealthCare
1623 Medical Drive
Tallahassee, FL 32308
academic.info@tmh.org

Epic Training
TMH Support Services Center
1860 Capital Circle NE
Tallahassee, FL 32308
epictraining@tmh.org

Objectives

- Identify effective methods, based on TMH policies and procedures, to integrate collaboration and effective communication into clinical practice.
- Discuss methods to prevent patient harm and provide safe care with integration of TMH's evidence-based standards and policies.
- Identify processes designed to provide quality patient care.

Purpose

To empower all colleagues and patient and family advisors to work together to improve the organization for everyone.

TMH Vision

To be known as the most engaged and supportive organization in America.

TMH Mission Statement

Transforming Care

Advancing Health

Improving Lives

TMH ICARE Values

Integrity: Be honest, ethical, and transparent

Compassion: Be kind

Accountability: Be responsible for your behavior

Respect: Treat everyone with dignity

Excellence: Do your best each and every time

How to View Policies and Procedures

Policies and procedures can be viewed on PolicyTech. To navigate to PolicyTech:

1. Open SPARK
2. Click the blue *Policies & Procedures* icon
3. Click *Search PolicyTech for Policies*
4. Click *Continue*
5. Enter your TMH email address and enter

To access SPARK, ask a TMH colleague for assistance.

PolicyTech

For patient care policies:

1. Use the left-hand navigation to select *Documents*
2. Select *Browse*
3. Select *Provision of Care*
4. Use the drop-down menu to select the department you are looking for

You can also use the search bar to enter the policy or key words.

For EBSCO:

1. Use the left-hand navigation to select *Additional Links*
2. Select *Dynamic Health Procedure (EBSCO)*

Please note: students and volunteers are unable to access SPARK or PolicyTech. Ask a colleague to assist you with finding policies and procedures.

Where to Find the Patient's Advance Directive

There are two ways to find this information:

1. Advance directives are documented upon admission within the Admission Navigator > Directive > Healthcare Directives
2. To find a scanned Advance Directive document (if available), go to Epic > Chart Review > Media tab

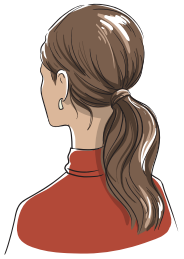
OneSource

OneSource is the online database to access Instructions for Use (IFUs) for all current products, surgical instruments, medical devices, implantable biologics, medical equipment, materials, and other devices.

Access OneSource at www.onesourcedocs.com and enter the following credentials:

Username: Tallahassee **Password**: Talla*850

Clinical Appearance Expectations

	**Fingernails** • Must be no longer than 1/4 inch. • Artificial nails are not allowed. This includes tips, forms, wraps, appliques, acrylics, dip, and gel nails. Chipped polish is not allowed.
	**Eyelashes** • Mascara on natural lashes is allowed. Artificial lashes are not allowed.
	**Hair** • Hair longer than shoulder length must be tied back or contained in a net. • Extreme hairstyles, hair glitter, hair jewelry, beads, feathers, and flowers are not allowed.
	**Piercings** • Maximum of 2 earrings in 2 piercing holes in each ear. 1 piercing of the nostril is allowed, and must be one small stud or clear/flesh colored retainer. • Other piercings on the face, head, mouth, tongue, neck, ears, hands, or other visible body parts are not allowed.
	**Clothing** • Scrubs in the designated color are allowed. • Oversized and undersized clothing, athletic wear, hoodies, denim, leggings, and flip-flops are not allowed. Clothing that is revealing or exposes cleavage or midriff area is also not allowed. Sunglasses must not be worn indoors.

Basic Environment of Care: Items to Monitor

- Hallways are clear of equipment.
- No equipment is stored in front of electrical panels, oxygen shutoff valves, or fire extinguishers.
- Wall cabinets are closed.
- PPE caddies are stocked and containers closed.
- PPE is not worn outside of a patient room.
- Masks should cover the nose and mouth. Remove and discard when no longer in use. Masks cannot be worn around the neck.
- Colleagues entering an isolation room must don the appropriate PPE, correctly.
- No paper signs, signs must be laminated. Signage is not allowed to be taped to the door or window. ICU clings are acceptable.
- No food or drink outside of Hydration Stations or designated break areas.
- Emergency carts checked daily. No EKG strip left on the side of the defibrillator.
- Expiration dates:
  - Most IV fluids - 24 hours, tubing - 4 days, TPN - 24 hours
  - Insulin pens - may vary, consult chart in med room
  - Opened multi-dose vials - usually 28 days
  - PICC or central line dressing - 7 days
  - BBG test strips - 180 days, controls - 90 days

Antibiotic Resistant Organisms

According to the CDC, 2.8 million new cases of drug-resistant bacterial strains occur per year, leading to approximately 35,000 deaths per year.

Some examples of these strains include:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Vancomycin-resistant enterococci (VRE)
- Extended-spectrum beta-lactamase (ESBL) producing gram negative bacteria
- Carbapenem-resistant Enterobacterales (CRE)

Antibiotic Resistance at TMH

Annually, the number of multidrug-resistant organisms reported from the TMH Microbiology Lab include approximately:

- Over 700 MRSA isolates
- 500 ESBL producing organisms
- 150 VRE isolates
- 75 CRE organisms

Multidrug-resistant infections are associated with a **higher mortality rate** and result in the use of antibiotics that are **more costly with a broader spectrum**, and may require **combination therapy**.

Contact precautions are implemented to reduce the risk of spread from the healthcare provider to other patients and to themselves.

Antibiotic Allergies

Penicillin is the most reported antibiotic allergy. 10% of the population reports a penicillin allergy, but less than 1% of the whole population is truly allergic.

Alternatives to penicillin (or similar beta-lactam agents) are often **broader spectrum** and are **not** the first line of treatment.

When collecting an allergy history, document the **patient's reaction** and **how long ago** it happened. This will help the healthcare team evaluate the validity of the reported allergy and make the informed decisions if the patient needs antibiotics.

Optimizing Antibiotic Therapy

Spectrum	• Choosing the **narrowest spectrum antibiotic** that is active against the infection • Reviewing cultures and sensitivities • Using the institution's Antibiogram
Dose & Duration	• Prescribing the **appropriate dose** and for the **shortest duration** that will result in treatment of the infection. • Pharmacists monitor antibiotics that are renally eliminated, and adjust doses accordingly per the **Antibiotic Renal Dosing Policy.**
Adverse Effects	• Weighing antibiotic **risks and adverse effects** for each individual patient. • Such as: C. difficile infections; hematologic, electrolyte, and mucocutaneous reactions. • Avoiding antibiotics with side effects in specific patient populations: ◦ *Example*: Fluoroquinolones can cause Myasthenia Gravis exacerbations.

Therapeutic Drug Monitoring

Therapeutic Drug Monitoring is routinely performed for the below agents, for which the therapeutic and toxic ranges are close together:

- Vancomycin
- Aminoglycosides
  - Amikacin
  - Gentamicin
  - Tobramycin

TMH pharmacists follow the Pharmacokinetic Dosing Policy to manage the monitoring and dose optimization of these antibiotics.

The Timing of Levels is Drug-Specific

Peaks	• Aminoglycosides - collect 1 hour after end of infusion • Vancomycin – collect 2 hours after end of infusion
Troughs	• Collect 30 minutes prior to next dose (vancomycin and aminoglycosides) • Per policy, do NOT hold a scheduled dose while awaiting a trough result, unless ordered to by a pharmacist or prescriber
Randoms	• Aminoglycoside random levels will be scheduled for a specific time • Vancomycin random levels can be utilized any time during dosing interval (between a peak and trough)

Nursing's Role in Antibiotic Stewardship

- Always adhere to patient contact precautions to prevent the spread of antibiotic resistance
- Obtain and complete an accurate allergy history
- Adhere to administration times and level collections times of antibiotics with therapeutic drug monitoring
- Educate patients about their antibiotics and associated adverse effects

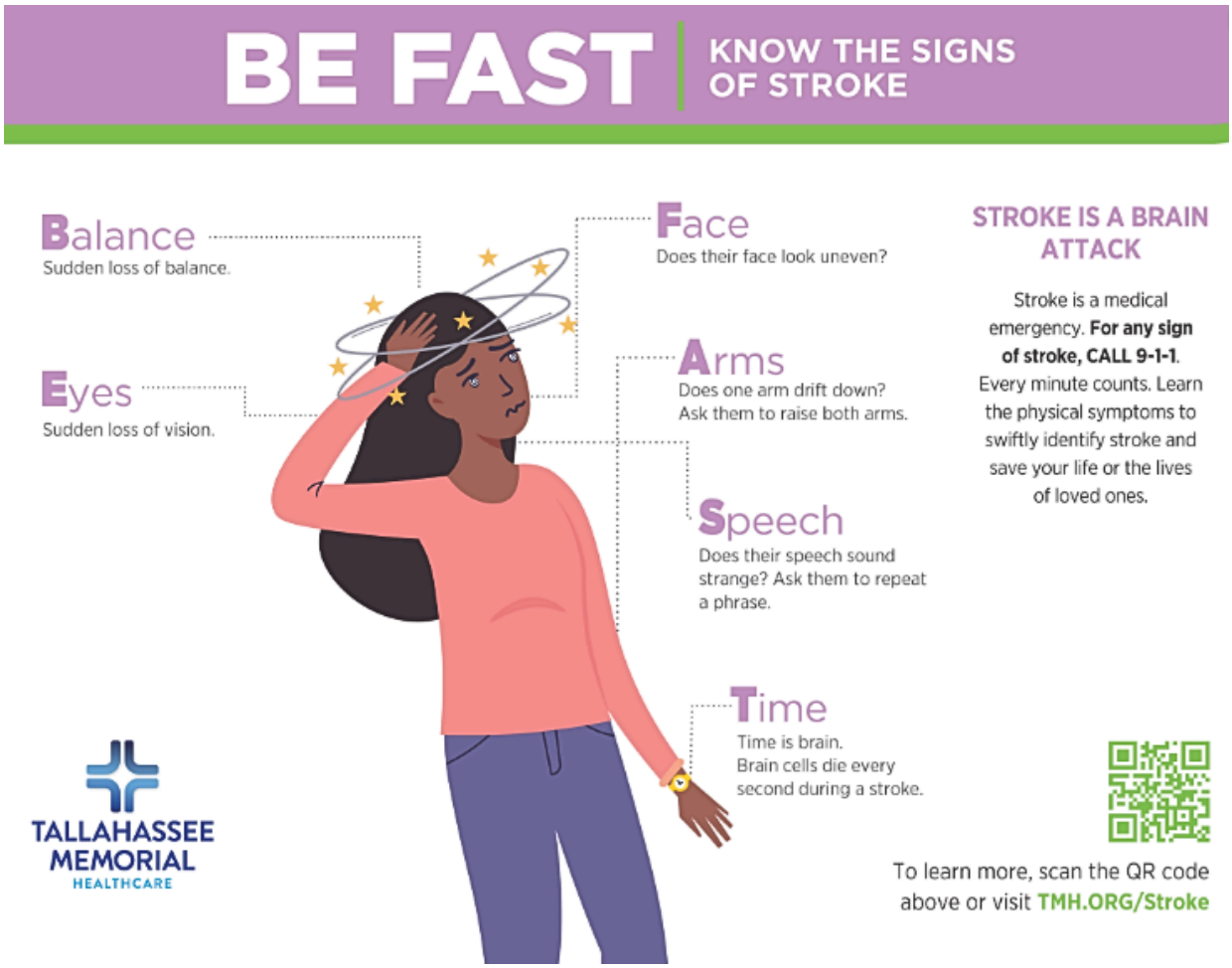
What Does a Stroke Look Like?

A stroke is a medical emergency and every second counts. Being able to quickly recognize stroke signs and symptoms is crucial to receiving quick and effective stroke treatment.

Common stroke symptoms include:

- Sudden numbness or weakness in the face, arms, or legs - especially on one side of the body
- Sudden confusion, trouble speaking, or difficulty understanding speech
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance, or lack of coordination
- Sudden severe headache with no known cause

BE FAST



Bedside Report

Bedside change-of-shift report is an evidence-based practice TMH incorporates into our Core Concepts, Patient- and Family-Centered Care.

Being physically in the room allows time for both nurses to:

- Look at dressings
- Check IVs
- Talk with the patient and family about the plan of care, daily goals, and safety

Evidence reveals that bedside report decreases patient anxiety and helps patients feel more involved in their care.

Situation-Background-Assessment-Recommendation (SBAR)

S	**Situation:** What is happening at the present time? • Introductions - state name and role • Patient name - room #, location, age, diagnosis, admit date, primary MD, consults • Code status • Problems, concerns, issues • Recent/current procedures • Safety issues
B	**Background:** What are circumstances leading up to this situation? • Chief complaint - what, where, how long, attempted treatment • History • Allergies • Height and weight • Communication barriers
A	**Assessment:** What does the patient look like? • Vital signs • Neurological • Respiratory • Cardiovascular • IV access • Chest tubes • Gastrointestinal
R	Recommendation: What should we do to correct the problem? • Plan of care - education, discharge planning, recommended support, equipment, follow-up • Interdisciplinary involvement - PT, OT, ST, dietary, social services • Case management • Physician to evaluate the patient

Ticket to Ride

The Ticket to Ride will be used for hand-off information for non-invasive diagnostic testing. The transporting colleague will verify the patient's name and patient identification number with comparison document in presence of patient before the patient is moved.

Patient Education

Patient education is performed on admission and is personalized based on the RN's assessed needs and plan of care. All health care providers collaborate in the patient and family's education. Education is documented by the professional who provides the education.

Hourly Rounds

Purposeful hourly rounding is an evidence-based best practice. This practice improves patient experience and satisfaction, and decreases adverse patient events. Integrating into your clinical practice will increase patient safety, decrease bell call use, and help the unit work more efficiently as a team.

Structure:

- Team up with support personnel (CNA, PCA, Nurse Extern, etc.) and collaborate
- Trade off hourly rounds for even and odd times
- Ensure clear communication between team members
- Address the patient's 4 P's:
  - Pain
  - Position
  - Potty (toileting)
  - Prevention of fall

The Joint Commission

2025 Hospital National Patient Safety Goals

(Easy-To-Read)

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Improve health care equity	
NPSG.16.01.01	Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

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Patient Labels

To maintain HIPAA compliance, all patient identification labels must be removed from IV bags, tubes, or medications and placed in shredder boxes. If the label is unable to be removed, all patient information must be blacked out with a black permanent marker and the item must be placed in biohazard or sharps container.

Solid Waste

Solid waste should be disposed of in a clear bag. Solid waste includes:

- Trash
- Wrappers
- Food, formula, containers
- Gloves
- Disposable patient items
- Drapes
- Diapers
- Bed pans and urinals
- Foley and other drainage
- Bags not containing blood
- Empty IV containers
- Nonhazardous medication

Recycling

Recyclable items should be placed in the designated blue recycling containers. Items that can be recycled include:

- Cardboard
- Paper
- Plastic
- Glass
- Bottles
- Cans

Other opportunities:

- Alcohol, Formalin, Xylene
- Medical devices
- Sleeves
- Food waste
- Toner and printer cartridges
- Skids

Batteries should be returned to EVS separately.

Regulated Medical Waste

Regulated medical waste should be disposed of in the **red bags** labeled *infectious waste*. Regulated medical waste includes:

- Blood and other potentially infectious materials (OPIM)
- Blood administration (tubing and bags)
- Hemovacs - Pleurovacs
- Containers containing blood
- Dressings soaked with blood or OPIM
- Gloves, tubing, or canisters with blood or OPIM
- All disposable items soaked with blood or OPIM
- Lab specimen biohazard bags

All **pathological waste**, such as body parts, organs, and tissues, must be **refrigerated** until pickup.

Contact the **Radiation Safety Officer** for disposal of all **radioactive products**.

All biohazard bags must be cinched closed, neck of the bag folded over (goose neck), cord wrapped around the fold, and tied so that nothing can leak out.

Ref: State of FL Code 64E-16.004(2)(c) and 64E-16.005(1) and (1)(b)

Sharps

Sharps should be disposed of in the reusable sharps container. Sharps include:

- All sharps (glass, needles, pins, blades, scalpels, razors, staples, staple guns)
- All empty Carpujects, Tubexes, and empty syringes
- Intact glass bottles with bloody fluid or OPIM
- Trocara, Thoracentesis glass evacuation bottles
- Introducers (guide wires, sharps from procedures, or specimen devices)
- Syringes

Chemotherapy

All supplies used to administer chemotherapy (cytoxic) medications should be disposed of in the designated **yellow biohazard container**, including:

- Tubing
- Soiled gloves
- Syringes
- Pads
- Gowns
- Masks
- Wipes

Return all unused Bulk Chemotherapy directly to the pharmacy.

Pharmaceutical Waste – Controlled Substances

All DEA controlled drugs must be disposed of in the designated **green container**. DEA controlled drugs include, but are not limited to:

- Demerol
- Duramorph
- Fentanyl
- Hydromorphine
- Methadone
- Morphine

Keep the following in mind:

- These containers are not for the disposal of needles
- No bottles, syringes, needles, or wrappers should be placed in the container
- Pills must be taken out of wrappers so they can dissolve
- Liquid controlled substances must be emptied from their container (syringes or bags) into the green bucket solidifier solution
- All of these steps render drugs unusable, which keeps us in compliance

All unopened, expired controlled substances should be returned directly to the pharmacy.

Pharmaceutical Waste – Hazardous Waste

All unopened medication should be disposed of in the designated **black and white containers** and returned to the pharmacy. This includes all medications with 3% or more remaining that are not hydration or controlled drugs.

Remember needles are not to be disposed of in this container, they must go in the sharps container.

No hydrations solutions:

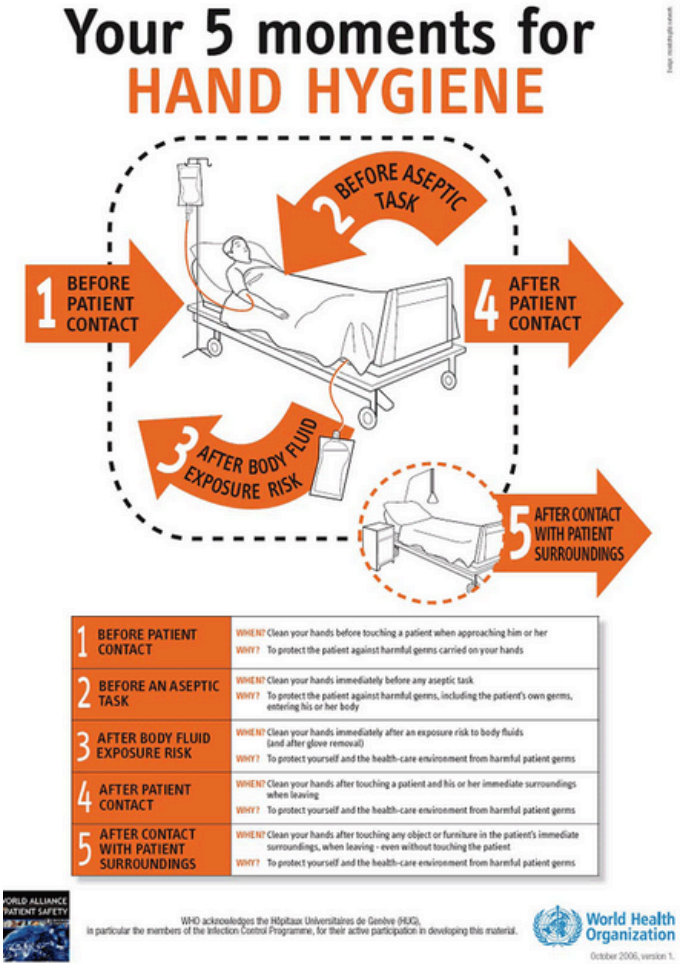
- Dextrose
- Potassium chloride
- Ringers
- Sodium bicarbonate
- Sodium chloride
- Sterile water

Hand Hygiene

You should perform hand hygiene:

- Before patient contact
- Before putting on gloves
- After removing gloves
- After patient contact
- After body fluid exposure risk
- After contact with a patient's surroundings
- Whenever hands may have become contaminated

Soap and water should be used instead of alcohol-based hand rub if hands are visibly dirty, after using the toilet, or when in contact with a patient on enteric contact isolation.



PPE

You can find information on types of PPE needed for patient isolation in the following locations:

- Infection Control tab in Epic
- Signage on the door of an isolated patient's room
- Infection Prevention department – contact via Voalte or dial extension 16152

Disinfecting Wipes

Always wear gloves when using disinfecting wipes.

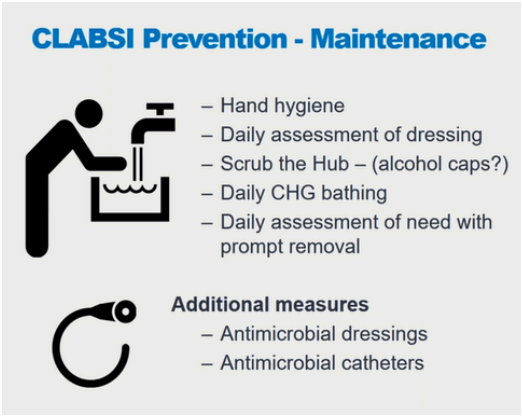
Surfaces must remain wet for the amount of time indicated on the container for the surface to be fully disinfected.

Preventing CLABSI

CLABSI = central line-associated bloodstream infection

Ways to prevent:

- Assess need for central line vs other IV access
- Remove central line when no longer needed
- Maintain dressing integrity, changing every 7 days using BioPatch or CHG dressing
- Change central line/PICC dressings promptly when loose, dirty, or wet
- Disinfection caps (ex: Curos, SwabCaps) on all ports
- Aseptic technique when giving IV meds/fluids



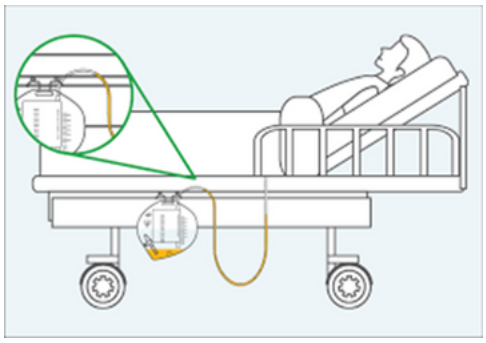
Preventing CAUTI

CAUTI = catheter-associated urinary tract infection

Ways to prevent:

- Use of external urinary collection devices (PureWick, condom catheter, male/female urinal) instead of indwelling Foley catheter
- Remove Foley catheter when no longer needed
- Careful daily pericare and catheter care
- Use bladder scanners and straight catheters instead of insertion of Foley
- Always use aseptic technique
- Prevent dependent loops that block urine flow
- Keep drainage systems closed

3-7% daily risk of infection the longer a catheter is in place.



Nurse-Driven CAUTI Reduction Protocol

Our goal is to reduce the number of CAUTIs hospital wide. The Nurse-Driven CAUTI Reduction Protocol is an evidence-based best practice that is supported by the CDC and The Joint Commission. Literature shows adoption of a nurse-driven process can reduce the number of catheters inserted and overall catheter days.

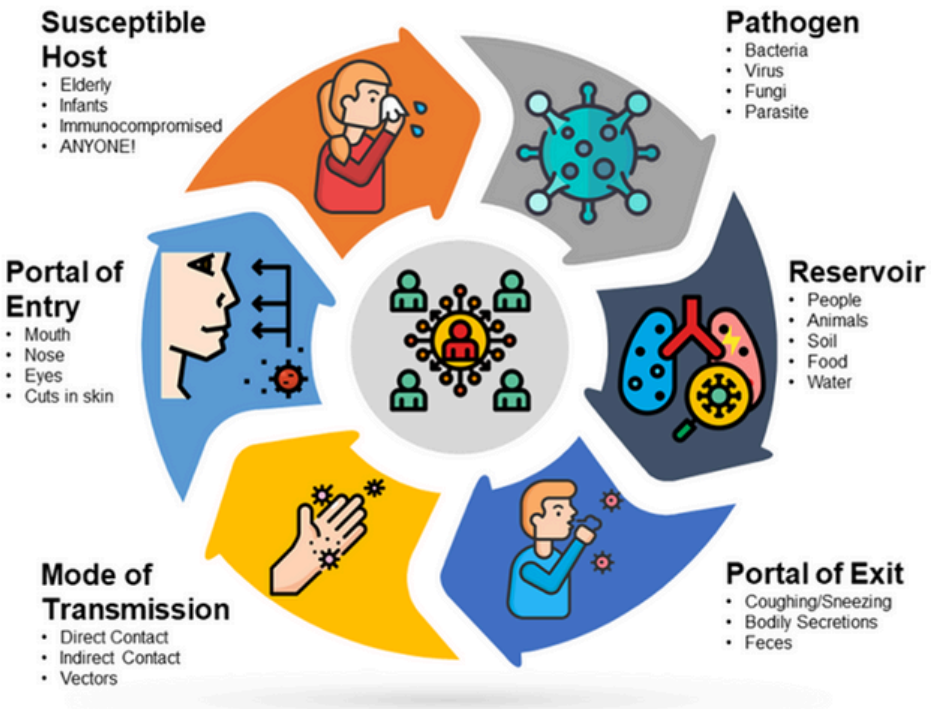
Unless the physician opts out of the Nurse-Driven CAUTI Reduction Protocol, the nurse may discontinue the catheter once the patient fails to meet criteria.

Criteria includes:

- Acute urinary retention or bladder outlet obstruction
- The need for accurate measurements of urinary output to guide treatment (every 2 hours or more frequent measurements)
- Perioperative use for selected surgical procedures (catheter to be removed as soon as possible, preferably within 24 hours unless there are appropriate indications for use)
- To assist in healing of open sacral or perineal wounds in incontinent patients
- Patient requiring prolonged immobilization (ex: potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures)
- To improve comfort when addressing a care goal in a dying patient
- Catheter placed or managed by urologist
- Required by practice guidelines (ex: patient receiving tPA, Arctic Sun)

Fewer catheter days = fewer CAUTIs

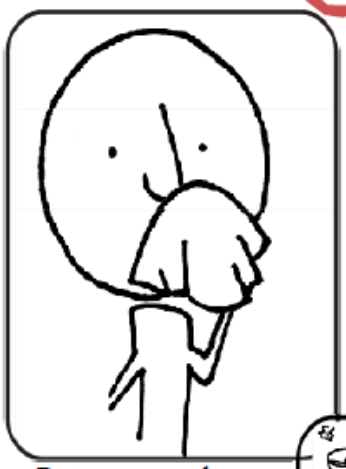
Chain of Infection



Occupational Safety and Health Administration (OSHA) Regulations

- Rules to protect workers from bloodborne pathogens (Hepatitis B Virus, Hepatitis C Virus, Human Immunodeficiency Virus, Hemorrhagic Fevers e.g. Ebola)
- Eating, drinking, applying cosmetics, and/or handling contact lenses are prohibited in work areas where there is likelihood of occupational exposure with blood or body fluids
- Food and drinks shall not be kept in refrigerators, shelves, cabinets, or countertops where blood or other potentially infectious materials are present
- Eating/drinking during patient rounds is prohibited

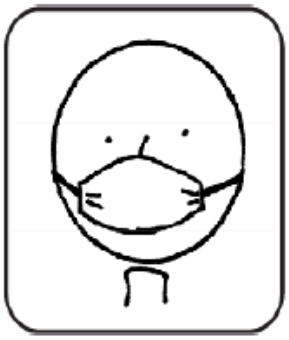
Cover your Cough



Cover your mouth and nose with a tissue when you cough or sneeze

Cough or sneeze into your upper sleeve, not your hands.

Put your used tissue in the waste basket.



You may be asked to put on a surgical mask to protect others.

Clean your Hands

after coughing or sneezing.

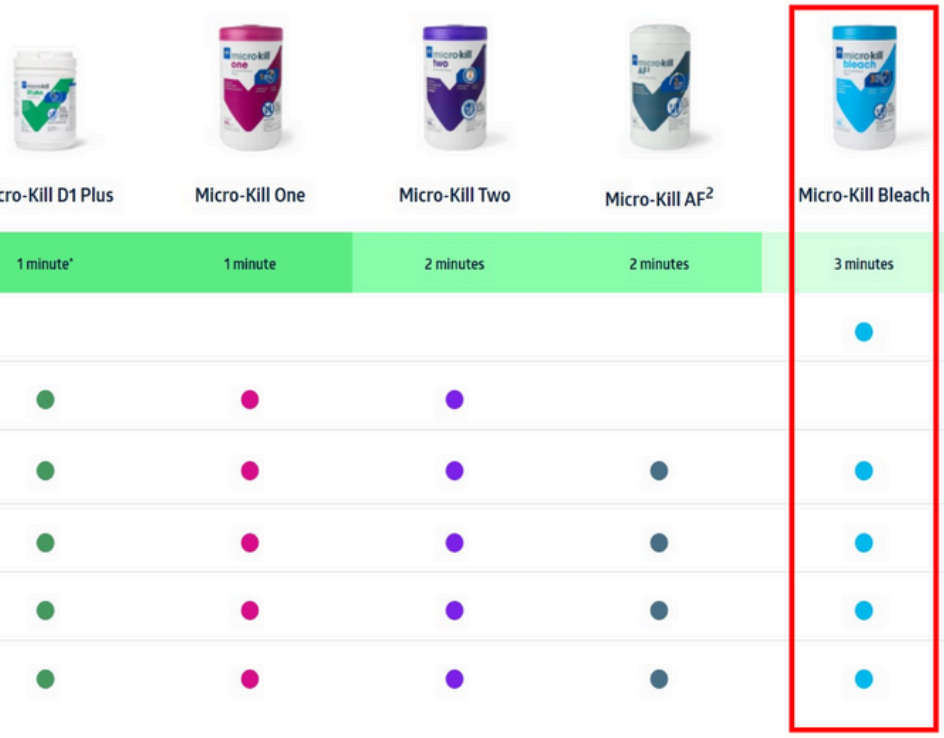
Wash with soap and water

or clean with alcohol-based hand cleaner.

Minnesota Department of Health
717 SE Delaware Street
Minneapolis, MN 55414
612-676-5414 or 1-877-676-5414
www.health.state.mn.us

Medline Micro-Kill Wipes

NEW DISINFECTANT LINE



	Micro-Kill D1 Plus	Micro-Kill One	Micro-Kill Two	Micro-Kill AF[2]	Micro-Kill Bleach
Contact time[1]	1 minute*	1 minute	2 minutes	2 minutes	3 minutes
Bacterial endospore					●
Mycobacteria	●	●	●		
Non-enveloped viruses	●	●	●	●	●
Fungi	●	●	●	●	●
Vegetative bacteria	●	●	●	●	●
Enveloped viruses	●	●	●	●	●

Experience:

Medline Micro-Kill® Wipes

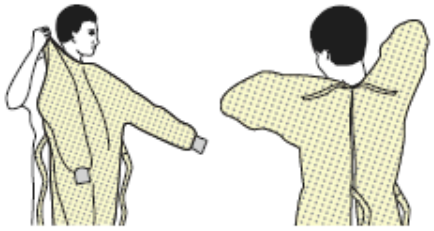
- Micro-Kill Two kills 32 micro-organisms including C.auris
- Micro-Kill Bleach kills 62 micro-organisms including C.diff
- Micro-Kill AF2 kills 47 micro-orgnaisms in 2 minutes or less

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

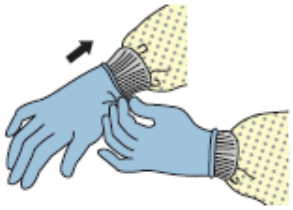
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

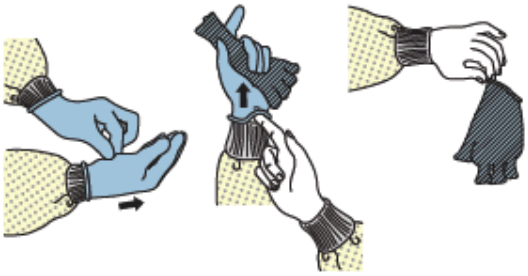
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

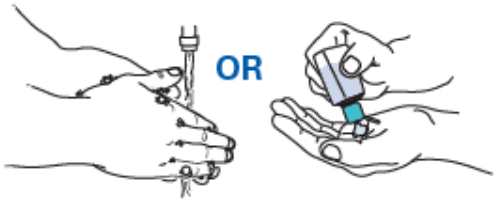
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



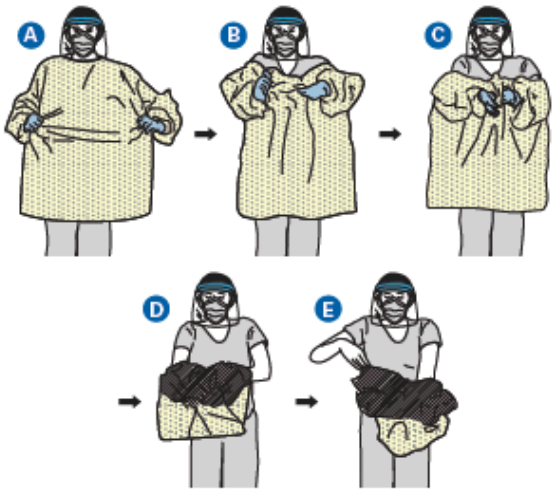
PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



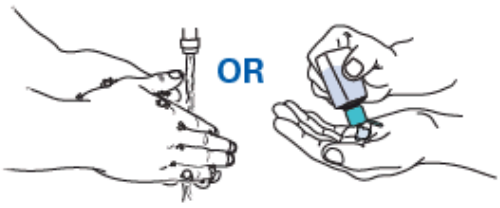
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

Medical Emergency Team (MET)

The MET assists in assessment, evaluation, interventions, and the plan of care for patient stabilization as a preventative measure before the patient codes.

The MET nurse will assist the floor nurse as a consultant until the patient is stabilized. If the patient needs to be transferred to a higher level of care, the MET nurse may stay with the patient to assist the floor nurse until the patient reaches their destination.

When to Call MET

- The patient has a significant change in vital signs or level of consciousness including:
  - Respiratory distress
  - Threatened airway
  - Change in breathing pattern
  - Decreased oxygen saturation
  - Over-sedation
  - Change in blood pressure, heart rate/rhythm, or chest pain
  - General distress – any concern over a patient's condition
- The patient has no/inadequate response to interventions
- Inadequate response from the physician
- After consultation with other unit resources
- You feel uncomfortable with the situation
- If you think the patient is having a cardiac event (STEMI) or a stroke

Note: Sometimes calling an ICU nurse and discussing your concerns (using SBAR communication) can help the situation before initiating a MET call.

Who Can Activate a MET Call?

Anyone! This includes family members. Family members and visitors may be better able to identify an acute change in the patient's condition, such as signs and symptoms of stroke, chest pain, respiratory distress. Families can be given a hospital brochure which describes the MET and how the team is activated.

How to Activate MET

Please locate the number as part of your unit orientation. The phone number for MET is also listed on the MET SBAR form.

MET Members

- ICU nurse
- Respiratory therapist
- Bedside nurse
- Nursing supervisors - respond to ground floor calls in public areas

Role of the Bedside Nurse

- Initiate the MET call
- Stay at the patient's bedside, have a computer and patient's bedside chart available
- Give completed MET Call Nursing Report SBAR to MET RN on arrival
- MET will assist with patient assessment and interventions
- Communicate the assessment to the physicians
- Document (clinical progress notes)

Code Blue

Call a Code Blue when there is no pulse or the patient is not breathing.

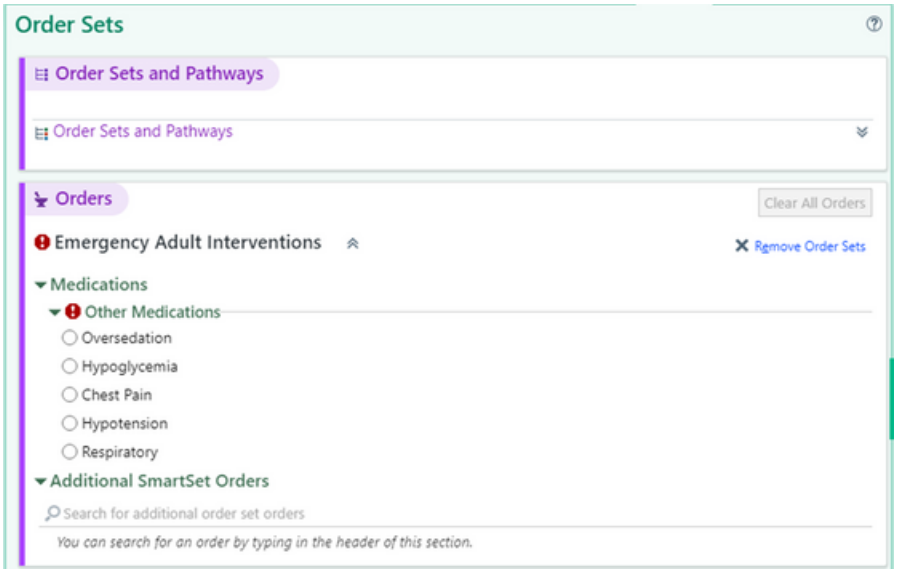
Inside the main hospital: Dial 88 and give the operator the Code Blue location

Outlying facilities: Call 911

- TMH Rehab Center
- Outpatient rehab facilities
- Behavioral Health Clinic
- Urgent Care Center
- Physician Practices (including POB)
- Sleep Center
- Family Medicine Residency Program
- Cancer Center

Emergency Adult Interventions

Emergency Adult Interventions are located in Epic-orders.



The ordering physician is the attending MD. Notify the MD that the Emergency Adult Interventions order set has been implemented along with assessment of patient, interventions implemented, as well as outcome from intervention.

MET to Stroke Alert

Only the ICU/MET nurse or MD can call a stroke alert. Outside of the ICU, if any patient shows signs of a stroke, call MET.

The ICU nurse will do an NIH Stroke Scale evaluation before calling a stroke alert. When the MD arrives and orders a CT scan, don't waste time!

Visitors

If a visitor or colleague arrests or presents with an apparent emergency medical condition in the hospital, a Code Blue, Code Blue 13, or MET call will be initiated, emergency care and treatment will be initiated, and the person will be stabilized and transported to the Bixler Emergency Center for further care.

For any individual on hospital property who requests emergency treatment, or if a layperson observer believes the individual is suffering from an emergency medical condition, security will be notified to assist that individual and call 911. This includes the main hospital campus, parking lots/garages, sidewalks, and driveways within 250 yards of hospital property.

Fall Definitions

- **Fall**: A sudden, unintentional descent that results in the patient coming to rest on the floor, on or against some other surface (ex: a counter), on another person, or on an object (ex: a trash can).
- **Assisted fall**: A fall when someone was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent.
- **Physiological fall**: A fall attributable to one or more intrinsic, physiological factors including:
  - Falls caused by a sudden physiologic event (hypotension, dysrhythmia, seizure, TIA, stroke)
  - Falls occurring due to side effects drugs (opioids, sedatives, hypnotic, psychotropic or cardiovascular drugs)
  - Falls related to the patient's physical condition (delirium, intoxication, dementia, gait instability or poor vision)
- **Developmental fall**: A fall in which an infant, toddler, or preschooler who is learning to stand, walk, run, or pivot falls as part of the developmental process of acquiring these skills.
- **Baby/child drop**: A fall in which a newborn, infant, or child being held or carried by a healthcare professional, parent, family member, or visitor falls or slips from that person's hands, arms, lap, etc.
- **Intentional fall**: A fall when a patient age 5 or older falls on purpose or falsely claims to have fallen. May be to gain attention, manipulate situations or seek pain medications.

Cause of Falls

Intrinsic: Related to the patient's condition.

- Agitation, confusion
- Incontinence, frequency, urgency (diuretic or laxative use)
- Changes in mental status, including dementia and depression
- Lower extremity weakness, mobility/balance/strength problems, neuropathy
- Postural or orthostatic hypotension
- Use of diuretics, tranquilizers, sedative-hypnotic drugs, or antihypertensive drugs
- Reduced visual acuity, perceptual changes (ex: inability to perceive depth, reduced contrast sensitivity, slowing darkness adaptation), loss of hearing
- Poor impulse control, belief that asking for help is inappropriate

Extrinsic: Related to the environment.

- Wet floor, poor lighting, clutter/cords/equipment
- Improper bed or bedside commode height, wheelchair or bed not locked
- Call light/possessions out of reach
- Lack of non-slip footwear
- No grab bars, ambulation aids (cane, walker)
- Attachment to equipment (IV, EKG)

Fall Risk Assessment

Fall risk assessments are performed on admission and periodically throughout stay with changes in condition or level of care.

Assessments include **Morse Score for adults** and **Humpty Dumpy for pediatrics**.

Risk scoring tools are not a definitive predictor of fall risk. Overreliance on the total score causes other factors to be overlooked. Use sub-scores to help further define specific risk:

- History of recent falls
- Two or more diagnoses
- Use of walking aid to move around - neurologic or musculoskeletal problems
- IV therapy - attachment to equipment
- Gait - balance or posture interferes with normal balanced movement
- Mental status - patient may not recognize or admit to risks

Use scores with the patient history and assessment to establish a proactive fall prevention plan of care:

1. **Gait:** Needs a steadying hand or someone nearby when ambulating.

2. **Incontinence:** Establish a toileting schedule and get the patient up when it is time. Do NOT rely on an accurate answer to "Do you need to pee?"

3. **Medication change (diuretic, antihypertensive):** Risk of orthostatic hypotension - dangle before getting up, have someone present when getting up from chair or bed.

4. **Poor lighting or vision: L**ights on when moving in room; keep clear path to bathroom.

5. **Educate patient and family** on why the patient is at risk for falls and what they can do to help prevent them. Use Teach Back to ascertain understanding.

Fall Precautions

Universal: For all patients

- Clear pathways
- Wipe up all spills immediately
- Call bell & personal items within reach
- Proactive rounding – Pain, Potty, Position, and Possessions
- Provide non-skid footwear

High risk: Morse > 55 or Humpty Dumpty > 12

- Sign on door
- 3 side rails raised when in bed
- Bed and chair alarms set
- Toileting on a schedule - every 2–3 hours
- Always remain within arms' length when OOB, including when the patient is on the toilet in bathroom and BSC
- BSC/walker to be hidden in bathroom when not in use
- Use Fall Tips poster to reinforce education, the specific reasons the patient is at risk and the tailored interventions to prevent falls

Post-Fall Procedure and Management

Patient assessment:

- Assess Vital signs-temperature, pulse, respiration, blood pressure and pain
- Check for injuries, change in level of consciousness
- Review current medications - patients on anticoagulation may require closer monitoring
- Notify physician if appropriate
- Notify family/caregiver if appropriate
- Document the fall, patient assessment, VS, recalculation of Morse Score in the chart

Care processes:

- What was the cause of fall?
- What are the patient's risk factors?
- Were there medication changes within last 24 hours?
- Did the patient receive high risk medication (opioid, sedative, hypnotic, laxative, diuretic) within last 4 hours?
- Was the patient using a mobility aid? Wearing glasses? Hearing Aid? Correct footwear? Clothing dragging or tangled? Tubes or lines interfere?
- Did the patient environment (bed conditions, floor condition, call light availability, restraints, etc.) contribute?
- Ask "Did we miss something before the patient fell? What would we do differently?"

Step 1: Conduct a Risk Fall Assessment

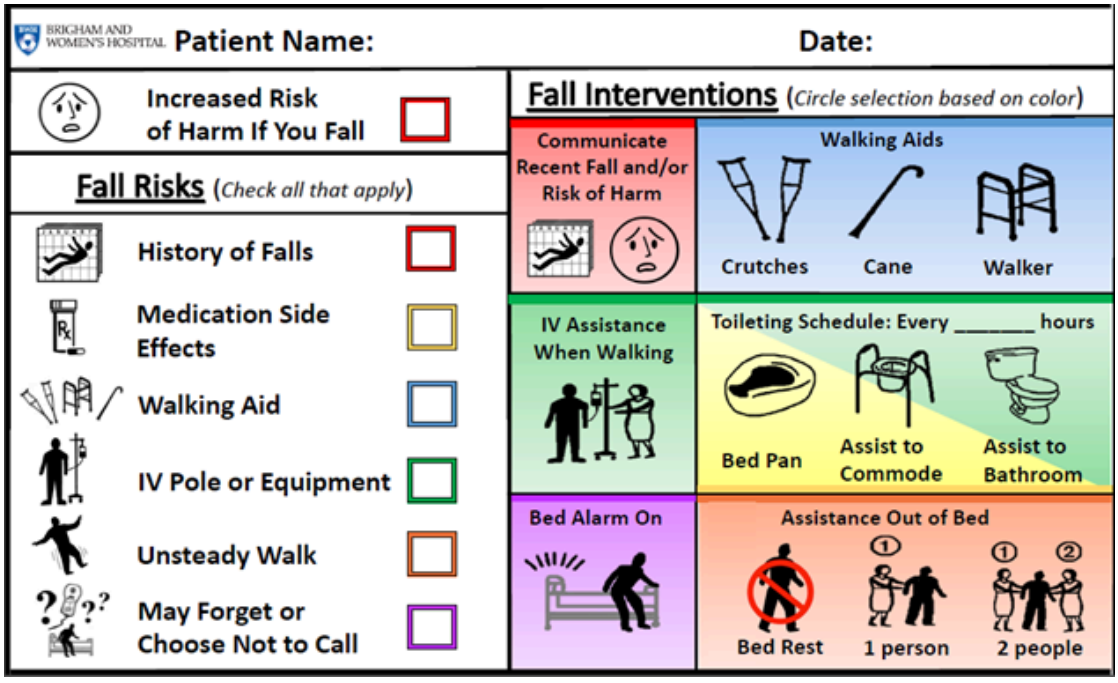
ABCS of Harm: Besides fall risk, consider the increased possibility of harm if a fall occurs

- **Age**: 85 years or older, degree of frailty
- **Bones**: Osteoporosis, risk or history of fracture
- **Coagulation**: Risk for bleeding, low platelet counts or on anticoagulants
- **Surgery**: Lower limb, major abdominal or thoracic surgery

Morse Fall Score

Variables		Score	
History of Falling	no	0	
	yes	25	
Secondary Diagnosis	no	0	
	yes	15	
Ambulatory Aid	None/bed rest /nurse assist	0	
	Crutches/cane/ walker	15	
	Furniture	30	
IV or IV access	no	0	
	yes	20	
Gait	Normal/bed rest/ wheelchair	0	
	Weak	10	
	Impaired	20	
Mental status	Knows own limits	0	
	Overestimates or forgets limits	15	
		Total	

Step 2: Complete a Tailored Fall Prevention Plan



Step 3: Fall Prevention Process

Here are some tips to engage the patient and family to consistently implement the plan:

- Review Morse score and fall prevention plan every shift
- Update bedside Fall Tips poster every shift
- Explain the fall prevention plan:
  - Ensure the patient and family understand the risk factors and can play a role in making sure the fall prevention plan is implemented consistently
  - Frequently educate and remind the patient how to implement the plan

Fall Prevention and Treatment Policy

A fall risk assessment is required:

- Every shift
- When transferring from one unit to another
- After a fall

High risk precautions (Morse > 55 or Humpty Dumpty > 12):

- Sign on the door
- Bed and chair alarms used
- Three side rails up when patient is in bed
- Remain within arms' length when patient is out of bed on BSC or toilet in bathroom
- Fall Tips poster updated 0900 and 2100 (adults only)

After a fall:

- Vital signs within 30 minutes, update Morse score within 2 hours
- Notify nurse manager within 2 hours
- Documentation in chart
- Notification of MD as needed, notification of family as needed

Department huddle to discuss fall and changes to patient plan of care to prevent a repeat fall.

Fall Safety and Prevention – Risk Assessment

When an audit is performed on a patient with a Morse score > 55, the following is checked:

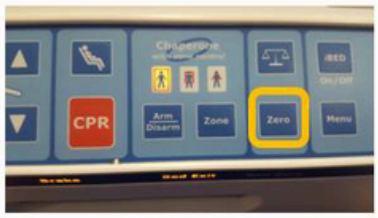
- Sign on door
- Patient and family educated on risk for falls
- Three side rails up
- Bed in low position
- Family Pass – for when family leaves room and patient alone
- Brake set
- Bed/chair alarm set, use bed alarms zone II
- Non-slip socks on
- iBed Awareness Set on
- Never leave them on the BSC or toilet, stay within arms' length, start toileting schedule

Stryker Bed Exit Alarms

Step 1: Zero the bed

1. Zero the bed before patient admission. Place all equipment, linens & other items needed for the patient on the bed.
2. Press and hold the Zero button and follow the instructions on the digital display. Items on the when when zeroed will not be added to the weight of the patient.

Note: If you do not set the scale for zero before placing a patient on the bed, bed exit may not operate properly.



Step 1: Arm the Bed Exit Alarm

1. Make sure the bed has been properly zeroed without the patient in the bed.
2. Press & release the Arm/Disarm key. The largest zone (Zone 1) light will illuminate when armed.
3. To change the zone, push Zone key until the desired zone is illuminated.

Note: For patients who are a fall risk, Zone 1 should be used.

Stryker iBed Awareness Alarms

Step 1: Set the bed position to be monitored.

Set the bed in the desired configuration:

- Brakes ON
- Side rail position with 2 or 3 rails up (3 rails if on Fall Precautions)
- Bed height LOW
- HOB elevated up to 30 deg if desired
- Bed exit alarm ON if on Fall precautions

Step 2: Press and hold the "iBed On/Off" button to activate iBed Awareness

To Arm:
Set the desired bed configuration.

1. Push and release the iBed key (all three green lights on the footboard will illuminate).

2. If one of the parameters is changed, an amber light on the footboard will flash indicating the bed is no longer in the prescribed position. The digital display and nurse dashboard will indicate what has been altered.

To Disarm:
To deactivate iBed Awareness, push and hold the iBed key. The footboard lights will turn off.

Management of Clinical Alarms

All alarm systems incorporated into medical equipment and into patient monitoring systems must be activated whenever the piece of equipment is in use.

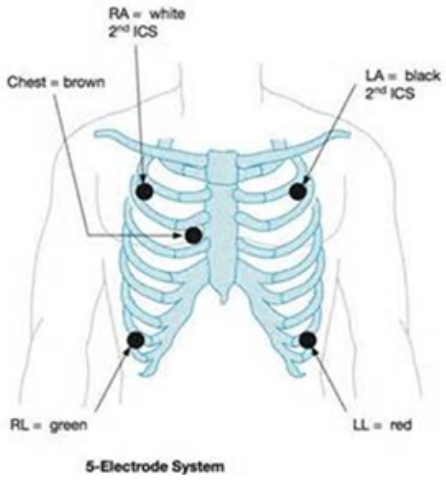
Alarms will not be disabled or inactivated at any time and it will be verified by the oncoming RN at the beginning of each shift that:

- Alarms are set to activate at appropriate settings
- Alarms are sufficiently audible with respect to distances and competing noise within the unit

Alarm volume levels must be maintained at an easily audible level at all times by patient care and medical staff.

Patient care staff responsible for monitoring must respond to alarms immediately by assessing the patient and following the chain of command notification process when patient monitoring issues arise.

Respiratory therapy is primarily responsible for setting and validating ventilator equipment alarm limits, function, and audibility.



5-Electrode System

Adult patients' ECG electrodes and pulse oximetry (SpO2) disposable sensors are to be replaced daily. Evidence suggests that changing ECG electrodes daily decreases the number of false alarms by 46%. Correct lead placement must be verified each shift as well.

Alarm Parameters

Alarm parameters for each unit are programmed into the unit-specific, color coded modules and will be evaluated annually. Following evaluation of the alarm data, the Alarm Committee and Clinical Engineering will implement needed parameter changes to decrease nuisance alarms.

A physician order is required to change a parameter for a patient specific alarm limit that is outside of the programmed set or learned parameters.

Alarm Parameters

Parameters	PULSE OX %		HEART RATE		BP SYSTOLIC		BP DIASTOLIC		BP MEAN		RESP RATE		EtCO2	
			BPM		mmHg		mmHg		mmHg		Breaths/min		kPa/mmHg	
Departments	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**
Neonatal (<4 weeks old)	88	100 (RA or FiO2 21%) 95 (if on O2)	80	200	35	95	20	60	24	70	Apnea > 20 sec			
Peds 1 (< 12 months old)	92	100	80	170	75	135	35	85	50	90	10	60		
Peds 2 (12-36 months)	92	100	80	150	75	135	45	95	55	95	8	50		
Peds 3 (3-5 years old)	90	100	70	150	85	145	50	90	50	110	7	40		
Peds 4 (6-13 years old)	90	100	60	150	100	150	60	100	90	110	6	40		
All Adult (14 or greater)	88	100	40	180	90	180	40	120	60	120	8	32	25	55

How to Know Medical Equipment is Safe

Look for alarms, signs of damage, or unusual operations before putting a piece of equipment on a patient. Watch for signs of unusual operation (noise, smell, light) before leaving the patient.

Most medical equipment has a power-on self test that will alert the user to any malfunction through an alarm or a message on its display. Do NOT use any equipment that alarms after power up and/or shows signs of damage or unusual operation. Notify a charge nurse promptly.

Maintenance Stickers

Only certain equipment requires preventative maintenance (PM). The PM sticker will show you when the next PM is due.

The device is out of PM compliance after the month that it shows it's due. For example: if the device is due 09/2019, the device is within compliance throughout the month and out of compliance beginning 10/1/2019.

An unexpired maintenance sticker does not guarantee that the equipment is safe to use. An expired maintenance sticker also does not mean the equipment is unsafe. Notify your charge nurse if you find a past-due maintenance sticker.

How to Know Medical Equipment is Clean

"Clean" room designation will mean any patient care equipment in the room (IV pole, walker, beside commode) is also clean.

On each unit, cleaned equipment will be stored in the clean equipment area, designated area, or cleaned patient room. Clean patient care equipment with approved disinfectant between each patient use (stethoscopes, reusable blood pressure cuffs, glucometers, etc.).

Medical Equipment Stickers

CEID numbers are used to identify each device in our database. Be sure to have this number available when callinh to report issues.

Inspection stickers should be checked when using medical devices. If the date is expired, the sticker is missing, or the sticker is illegible please call ext. 13182 to report it.

This is for equipment not needing preventative maintenance. Since service is only performed if it malfunctions, it will not have a due date written for inspection. Ex: handheld dopplers, opthalmascopes, wall suction regulators.

This is for incoming rental or demo equipment. It indicates that Clinical Engineering has approved the device for use.

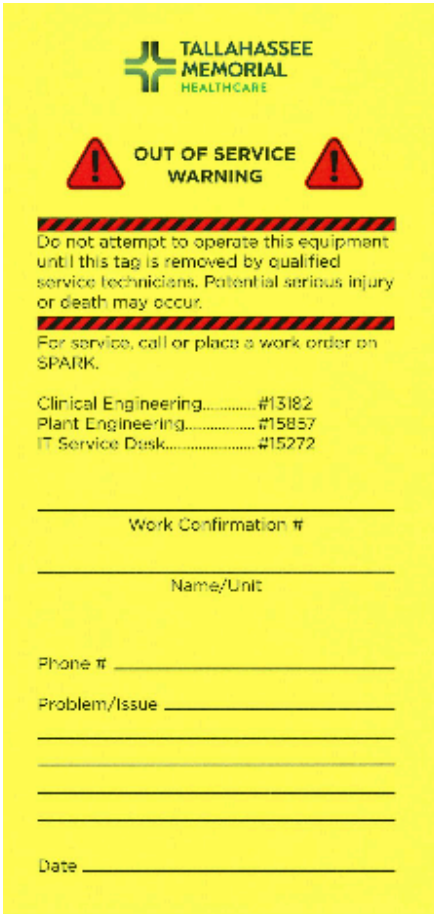
Broken Equipment

Remove broken or malfunctioning equipment from circulation and tag with an "Out of Service" tag - (available on SPARK and for order from the Print Shop. A colleague should notify Biomedical/Clinical Engineering.

When reporting broken equipment, please provide the following:

- Clinical Engineering ID (CEID) or Equipment ID #
- Specific location of the device
- Your name and number
- Brief description of the problem

If the equipment is involved in a patient incident, quarantine the equipment including all accessories and disposables. Do not throw anything away and do not change machine settings. Do not investigate the failure yourself! You could corrupt the memory or create further problems or hazards.


TALLAHASSEE MEMORIAL HEALTHCARE

OUT OF SERVICE WARNING

Do not attempt to operate this equipment until this tag is removed by qualified service technicians. Potential serious injury or death may occur.

For service, call or place a work order on SPARK.

Clinical Engineering.....#13182
Plant Engineering.....#15857
IT Service Desk.....#15272

Work Confirmation #

Name/Unit

Phone # _____

Problem/Issue _____

Date _____

Hospira Plum 360 CCA

To ensure safe and accurate IV infusions, always use the correct unit-specific Clinical Care Area (CCA) and choose the correct medication that is being administered, located in the drug library feature within the Plum pump.

Plum 360 Pump CCA

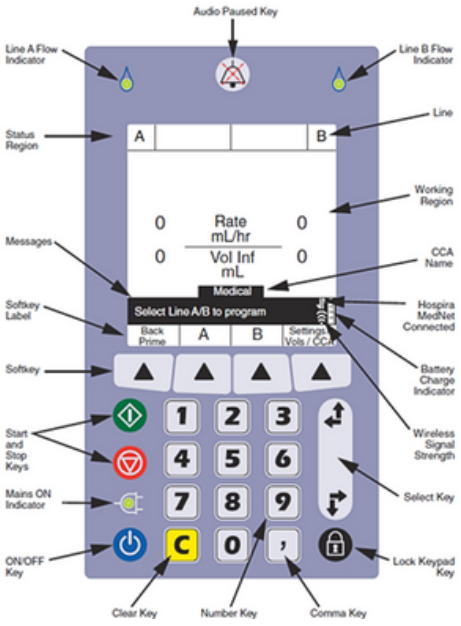
CCA Name	Service Line
Anesthes	Anesthesia
Bixler ER	Emergency services
Bixler Peds	Emergency services
Cath Lab	Special Procedures
CDU	Medicine - adult
CPCU	Medicine - adult
Critical Care	ICU - medical
Crit hePARINs	ICU - medical
DMCU	Medicine - adult
FCU	Obstetrics/gynecology
IMCU	ICU - medical
HV PCU	Special Procedures
LD	Labor & Delivery
Medical	Medicine - adult
NICU	ICU - neonatal
NIMCU	ICU - medical
Oncology OP	Oncology - adult
Oncology IP 7A	Oncology - adult
PACU	ICU - surgical
PICU	ICU - pediatrics
Pediatrics	Medicine - pediatric
Peds KK	Medicine - pediatric
Specials	Anesthesia
Surgical	Surgical - adult
Training	Other specialty

Supplies Needed

- **New tubing, including filter tubing different sizes**
  - IV fluids via central line use 0.22 micron
  - Lipids use 1.2 micron
- **IV tubing labels**
  - Color-coded Monday - Sunday
  - IV tubing expires within 4 days, single use
  - Put date to be changed, include time if expiring within 24 hours of hanging
- **KVO**
  - Saline lock, unless MD writes a rate of infusion
- **Orange caps**
  - Must be on at least 5 minutes before port accessed
- **Alcohol preps**
  - Scrub hub for 30 seconds
  - Allow to air dry before port accessed
- **Caps to cover ends of tubing (male/female)**
  - Never loop tubing into itself
- **Sample pharmacy labels**
  - IV fluids expire in 24 hours, labels must have expiration date and time written on them
  - Pharmacy generates labels containing FIN and patient's name
    - Remove entire label and put in shredder box or sharps container
    - Completely mark through PHI with permanent black marker and discard in trash

IV Pump Buttons

- **Battery life**
  - 3 hours of operation at 125 mL/hr on single line, or delivers at least 250 mL if more than 126 mL/hr on one line
  - Takes 8 hours to recharge when running at 125 mL/hr on one line
- **Wireless integration**
- **Antenna**
- **On/off**
- **Start**
  - Most confirm by pressing "yes" to start the infusion
- **Stop**
- **Silence button**
- **Select**
  - Moves cursor between fields on the display



IV Pumps

Priming tubing - 19 mL total (13 mL below the cassette)

Loading cassette

Selecting Clinical Care Areas (CCA)

Drug Library - hard and soft limits
- Hard limits (LHL and UHL) cannot be overridden
- Soft limits (LSL and USL) can be overridden

Programming
- Channel A
- Channel B
- Titrating infusion - do not need to stop infusion to do
- Loading dose and maintenance dose - 2 steps
- Multistep - can program up to 10 steps
- Piggyback vs Concurrent mode
- Call back - can use for piggyback, loading dose, and multistep deliveries
- Delayed start

Back prime for air - needs syringe

Lock and unlock keypad - 2 locations
1. Lock keypad → 0963 → enter
2. Settings/Vols/CCA → lock keypad → 0963 → enter

Clearing volumes: Settings/Vols/CCA → press down arrow → choose volumes infused
- 3 options: Clear A, Clear B, or Clear Total

Troubleshooting alarms (see manual) - Distal Occlusion Reset

IV Insertion Site Labeling

Peripheral IV Catheter	Label	When to Change
Adults	Date of insertion	When clinically indicated
Pediatric/Neonatal	Date of insertion	When clinically indicated
Midline Catheter (MLC)	Date to be removed & 7-day dressing change	By midnight of 29th day

TMH IV Tubing Policy

IV Tubing	Label	When to Change
IV Infusion	Date	By midnight of 4th day
Intralipids	Date and time	Change with every bottle
TPN	Date and time	*If only TPN (no Intralipids):* 4 days *If Intralipids also hanging:* 24 hours
PCA or PCEA Pump	Date	By midnight of 3rd day
Lipid-Based Medications (Propofol, Clevidipine)	Date and time	Every 12 hours
Blood & Blood Products	No label needed	Change with every bag

IV Bag Policy

IV Infusions	Label	When to Change
IV Infusion	Date and time	24 hours
Intralipids	Date and time	24 hours
Lipid-Based Medications (Propofol, Clevidipine)	Date and time	12 hours
Infusion Prepared at Bedside in Emergency	Medication name, amount, date, and time	24 hours
Infusion or Medication Prepared by Pharmacy	Date and time	As indicated by pharmacy, not to exceed 24 hours
Blood & Blood Products	Leave green crossmatch tag attached	4 hours

Main Pharmacy

Open 24/7

Located on ground floor, near *A* elevators

Decentralized Pharmacists

Stationed throughout TMH's main campus Rehab and Behavioral Health Center, Cancer Center, and Northeast Emergency Center.

Medication Dispensing Machine – Pyxis ES Management

Obtaining access to Pyxis machine is established during unit specific orientation, by unit managers.

Medication Monitoring

Pharmacy and nursing management review Pyxis transactions for diversion and variance from the month's standard deviation of controlled substances. Controlled substance discrepancies on Pyxis machines must be resolved by the nursing unit within 24 hours of the discrepancy occuring.

Multi-Dose Vials

Only vials that are clearly labeled by the manufacturer for multiple dose use.

Can only be used to administer medication for one patient. New needle and syringe are to be used with each entry into the vial.

Multi-dose vial may be used until 28 days from the initial time of entry or until otherwise indicated by the manufacturer. Expiration date is to be written on patient label and flagged on vial.

Pill Splitters

Every patient that needs a pill splitter is to have a patient-specific pill splitter as a charge item. The pill splitter is to be labeled with the patient's label on the pill splitter device, **not** on the pill box. Patient-specific pill splitters are to be placed in the patient's assigned specific bin.

When in doubt, call the Pharmacist!

Main Pharmacy number: 850-431-MEDS or ext. 16337

No Pass Zone

Every colleague, every call light, every alarm, every day.

When you see a call light, employees (regardless of who you are) should knock on the door, introduce yourself, and ask how you can help or if you can assist in any way to obtain the right help.

If you yourself cannot perform the patient's request, immediately go to the clinical staff for help. Acknowledge the patient's needs and assure them that help is on the way.

Why?

We are a center that practices Patient-Centered Care.

How?

Never pass by a call light or alarm - identify the patient's needs

Observe the patient's privacy

Provide the help they request OR

Access who can help provide what is needed

Scope of practice = safety first: do not put a patient at risk, practice safe care: connect them with the appropriate team member who can assist them safely in their needs if you are unable to

Smile

Script

"Hello, my name is _____, I noticed that your call light is one. Is there anything I can help you with?"

If you **can:** *"Yes, I can help you with that."*

If you **cannot:** *"Let me find someone that can help you. I'll let you know how long it will take."*

Before leaving: *"Is there anything else I can do for you? I have the time."*

Key Concepts

- Answer all call lights and respond to alarms
- Pick up trash and declutter at every chance
- Wash hands in front of the patient, before and after each patient encounter
- Be accountable
- Keep a quiet environment to help promote healing

Assessment and Documentation

Assess **all** patients for pain using the appropriate pain scale, at least every shift. Patients should be involved in the plan of care and treatment for pain whenever possible.

A **personalized pain goal** is the verbal or written goal stated by the patient, describing the desired level/intensity of pain that will allow the patient to achieve comfort in physical, functional, and psychosocial domains.

Reassess patients **within 1-2 hours** of each pain intervention to determine effectiveness and safety. Reassess patients on **PCA** every **2 hours** for the first 24 hours.

For **long-acting or continuous medications**, such as PCA (after first 24 hours), continuous opioid infusions, MSContin, Oxycontin, or Fentanyl patches, reassess pain at least every **4 hours**.

0-10 scale and FACES scale are subjective (patient chooses number or face that represents their pain).

CPOT (for adult critically ill ICU ventilated or non-ventilated patients), **pain behaviors**, **FLACC scale** (for peds), **NIPS scale** (for neonates), and **Assume Pain Present** (for patients on ventilator who are sedated/paralyzed and cannot verbally or behaviorally express pain presence) are also available in Epic if patient is unable to provide a subjective 0-10 pain rating. Patient report is always preferred.

For a sleeping patient, assess respiratory rate and depth, and ensure arousability (S = sleeping but easy to arouse). Do **not** rate pain 0/10 if patient is asleep - 0-10 scale is a subjective scale, and 0 means the patient stated their pain rating is 0. You **cannot** assume pain is 0 because they are asleep.

Emergency Interventions

If Narcan or Romazicon are required for patient rescue, follow the Emergency Interventions order set and notify the physician.

Patient Education

Inform patients and families about:

- How to use pain scale
- Pain management plan and options
- Appropriate use of any pump
- Personalized pain goal
- What to do if pain is unrelieved
- Safe use, storage, and disposal of opioid medications when prescribed

2 information pamphlets, *Know the Risks of Opioids* and *Alternatives to Opioids*, have been added to the Patient and Family Guides that are distributed to patients on admission. Be sure to reference these when doing opioid/family education.

Range Orders

The maximum dose in a range order may not be more than 4x the minimum dose.

It is still TMH policy to start with the lowest dose in the range initially. Exceptions:

- Patient has already been receiving a higher dose of the same medication at home, for at least one week prior to admission without any difficulty
- Patient has received a higher dose of the medication on a previous nursing unit without difficulty

For pain medications: after **30** minutes, the nurse may administer 100% of the initial dose.

For symptoms other than pain (itching, nausea, constipation, anxiety, etc): after **60** minutes, the nurse may administer 100% of the initial dose.

When the maximum dose in the range has been administered, the nurse cannot give another dose until the dose frequency has been reached, even if the medication is ineffective. The frequency begins when the maximum dose is given.

Policy states: "All subsequent doses of the medication may begin at the dose that provided the patient with relief unless patient assessment indicates a reduction in dose is required." Documented assessment, vital signs, labs, note, etc. must show the reason for reducing the dose.

Elderly Patients

Patients 61-70 years are at 2.8x greater risk of over sedation.

Patients 71-80 years are at 5.4x greater risk of over sedation.

Patients 81 and older are at 8.7x greater risk of over sedation.

To prevent over sedation, always consider:

- **Patient risk factors** such as opioid naivete, respiratory dysfunction, OSA, age, and significant comorbidities (especially diminished kidney and liver function).
- **Iatrogenic risk factors** such as thoracic or upper abdominal surgery, and multiple sedating medications (PCA plus Benadryl, Phenergan, Ativan).

At-Risk Patients

For at-risk patients, consider the following:

- Maximize non-sedating pain relievers
- More cautious dosing, lowest dose in range
- More cautious intervals
- Avoid giving sedating meds simultaneously
- More frequent monitoring
- Maximize non-pharmacologic techniques: breathing, relaxation methods, guided imagery, music therapy, animal therapy, therapeutic touch

Multimodal Pain Management

Multimodal pain management is considered best practice - the use of 2 or more different classes of pain medications to alleviate pain by different mechanisms, and hopefully reduce the amount of opioid medication required.

Point to remember: Opioids are only 30-50% effective. How can we manage the other 50 -70%?

Therapeutic Duplication

Therapeutic duplication is the practice of prescribing multiple medications for the same indication (ex: pain, nausea, itching, constipation) without a clear distinction of when one agent should be administered over another.

Prescribers should make clear through medication orders as to which medication should be given under which circumstance.

Unless otherwise indicated, oral doses should be administered first. Parenteral doses if oral doses are ineffective or patient is NPO, nauseated, vomiting, or otherwise unable to tolerate PO.

Unless otherwise indicated, non-opioids should be administered prior to opioids in order to minimize use of opioids and opioid-related adverse drug effects.

Pain Management Clinical Nurse Specialist

Available for patient, staff, or physician consultation. The specialist can answer questions about pain management therapies, pain pumps, pain resources, and Therapeutic Touch.

For more information, call ext. 19396. You can also ask your charge nurse to search "*pain management*" on SPARK.

High-Risk/High-Alert Medications

High-risk/high-alert medications are drugs that, when used in error, cause higher risk of significant patient harm.

Independent double-checks are used for certain high-risk medications in which the two nurses verify:

- Provider orders
- Dose calculations/dose changes
- IV pump/syringe pump settings

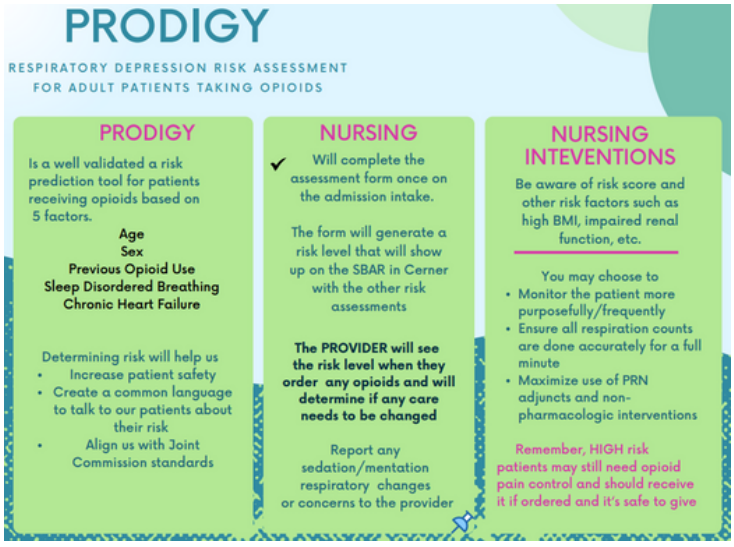
Examples of high-risk/high-alert medications:

- Anticoagulants (heparin, warfarin)
- Opioids (includes PCA or continuous infusion)
- Insulin
- Benzodiazepines (lorazepram, midazolam)
- Neuromuscular blocking agents
- Antineoplastic agents
- Concentrated electrolytes
- Sound-alike, look-alike drugs (SALAD)

Some methods to reduce medication errors with SALAD include:

- Using Tall-Man Lettering: Technique that helps differentiate look-alike drugs by capitalizing letters in the drug name. For example, NICARdipine, NIFEdipine, and niMODipine.
- Posting SALAD list (with Tall-Man lettering) in each medication room.
- Using bar-code technology at point of medication administration.

Prodigy



Respiratory Care

"**Wean the 'O' so they can go**" - a patient weaned off oxygen may be ready for discharge.

Situation

Patients on oxygen need to be assessed daily for the continuing need. TMH policy allows Respiratory Care and Nursing to wean patients off oxygen.

Background

Does the patient wear oxygen at home or will need to continue it after discharge?

Is there an MD order not to wean off oxygen?

Why was oxygen ordered for this patient? Have the clinical conditions changed to allow weaning without causing hypoxia?

Assessment

Respiratory Care will assess every patient on oxygen daily for continuing need. Oxygen is to be weaned as long as saturation is kept 92% or greater (COPD patients' saturation will be kept between 88% - 92%).

Oxygen will be discontinued altogether after the patient has been on room air for 24 hours.

Recommendation

Discuss the patient's oxygen needs and clinical situation with the Respiratory Therapist every shift.

Explain the process to the patient and family, also explain the difference between hypoxia and exertional dyspnea, and the role oxygen plays in wound healing.

Inform the MD if there are problems with weaning.

Inform the Case Manager if the patient will need to be on oxygen after discharge.

Consult Respiratory Care if you have questions.

Liters of O2 per Minute	Approximate FiO2
1	0.24
2	0.28
3	0.32
4	0.36
5	0.40
6	0.44

Flow Meters

Green flow meter = oxygen
Yellow flow meter = medical air

Flow rates and flow systems:

Low flow oxygen:

- Nasal cannula ⅛ liters per minute, up to 44% Fi
- Simple mask higher flow rate and % FiO2

High flow oxygen:

- Venturi mask 4-12 liters per minute, up to 50% FiO2
- Non-rebreather mask 10-15 liters per minute, 80-100% FiO2

CPAP and BIPAP

CPAP = Continuous Positive Airway Pressure

1 level of pressure on exhalation.

Used for obstructive sleep apnea. Often patients bring their own machines from home.

BIPAP = Bi-level Positive Airway Pressure

2 levels of pressure - inspiration and expiration.

Ordered for severe respiratory distress, fluid overload, and end-of-life care.

Cylinder Safety

Secure O2 tank when transporting patients. Check regulator gauge to determine amount of compressed gas in cylinder.

- **In-use cylinders:** As indicated by the dial. Must be in green rack.
- **Empty cylinders:** In the red zone, as indicated by the dial. Must be in red rack.

O2 tank transporter

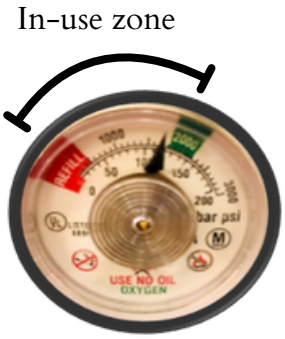
O2 tank holder on hospital bed

Incentive Spirometer

Encourages deep breathing, most often ordered post-op.

Have patient inhale slowly and deeply. The goal is to maintain the "ball" at mid-level of tube for a count of 6-10 during inhale.

Include in plan of care and encourage patient to use several times during the day. Schedule around next does of pain medication.



Respiratory Contact Information

Lead therapist **ext. 14203** or **pager 0911**

Located near MS/CV on first floor. Each floor has assigned respiratory therapist 24/7.

General Information

Only physicians, APRNs, or PAs may order restraints. Order must indicate the type(s) of restraints to be used and the rationale. The least restrictive form of restraint that protects the physical safety of the patient, staff, or others will be used. Attempt alternative, less restrictive interventions prior to utilizing any restraints.

Trial release is not permitted. A temporary, directly supervised release for the purpose of giving care (toileting, feeding, or ROM exercises) may occur.

Discontinue restraints at the earliest possible time. An order is not needed to discontinue a restraint once the release criteria are met. The release criteria will be directly related to the reason for initiating the use of restraints.

Update and document IPOC every shift.

Non-Violent Restraints

The use of restraints for medical or surgical purposes, when the primary reason for their use directly supports medical healing.

Clinical justification:

- Allow medical treatments to continue without interruption
- Prevent pulling out of necessary tubes or drains
- Provide safety when the patient is unable to follow direction

Order expires when restraints are removed or patient is discharged. If restraints are discontinued but needed again later, a new order is required.

Assess patient every two hours and as needed for:

- Safety/signs of any injury (RN/LPN only)
- Circulation/skin integrity
- Nutrition and hydration
- Range of motion exercises
- Hygiene and elimination
- Physical and psychological status and comfort (RN/LPN only)
- Readiness for discontinuing restraints (RN/LPN only)

Vital signs will be monitored every 4 hours.

Social Media/Social Networking

While using social media, students and volunteers are expected to adhere to all applicable federal, state, and local laws. These laws include, but are not limited to: Health Insurance Portability and Accountability Act of 1996 (HIPAA), copyright, libel, and false advertisement laws.

Students and volunteers shall also follow TMH policies and procedures concerning confidentiality, release of patient information, computer, email and Internet usage, compliance and use of photographs and video. Never take pictures or videos in patient care areas.

All rules and policies that apply to other TMH communications apply, including but not limited to: respecting colleagues, patients, visitors, and one another; protecting confidentiality, privacy, and security; and the safeguarding and proper use of TMH assets.

Inpatient Documentation Responsibilities

Documentation is your story about the patient's time in our care. The story you write, whether it is correct or incomplete, is the final account of what happened with that patient. REMEMBER – "If it wasn't documented in the medical record, it didn't happen."

Your story has four audiences:

- The other medical professionals caring for our patient
- Surveyors or lawyers determining if your care was appropriate
- Billers/coders submitting claims for payment
- Regulatory auditors determining the level of medical necessity and accuracy of codes

If your record is incomplete or inaccurate, there are consequences for each of the four audiences:

- For medical professionals, the patient's care suffers
- For surveyors or lawyers, this indicates that a lawsuit or investigation may be warranted
- For billers, the claim is rejected or pays at a reduced rate
- For regulatory auditors, requests for monies paid to the hospital may have to be returned to payer

Only the following authorized individuals may enter information into the medical record and sign each entry:

- Licensed/certified clinicians
- Individuals authorized in accordance with TMH policies and procedure
- Other personnel as determined by the applicable State Practice Act
- Medical staff rules and regulations

Inpatient Documentation Responsibilities (Cont.)

Each audience is looking at the record for different reasons, but they are looking for the same information. Is it accurate? Is it complete? Is it timely? The documentation must be timely (to ensure accuracy). This generally means at the point of service or within the same day.

Remember:

- An accurate, timely, and well-documented record is the best tool to ensure:
  - Safe, high quality patient care
  - Reduced liability for practitioners and the facility
  - Appropriate reimbursement
- Complete all documentation on assigned patients promptly
- Have all documents reviewed by the TMH RN or faculty instructor
- Follow up and document the patient's response to any PRN medications

NURSING-PARAMEDIC STUDENT RESPONSIBILITIES

Policy	
Title: Nursing-Paramedic Student Responsibilities	**Effective Date:** 10/09/2024
Version Number: 2	**Last Reviewed:** 10/09/2024
Issuing Department: 6011 - Nursing Administration	**Approved By:** Kyrie Thomas
Creation Date: 07/28/2014	**Owner:** Catherine Pfeil

I. POLICY:

A. The TMH Registered Nurse (RN) assigned to the patient will retain complete oversight and accountability for all care.

B. For clinical rotations, the faculty instructor must be onsite and readily available. For rotations where students will be observing only, faculty will only need to be available by telephone. With all clinical rotations, the faculty instructor must communicate student names/assignments, objectives, tasks to be performed and the instructor's contact information to applicable department leadership such as Nurse Manager and/or Charge Nurse.

C. Senior students completing their final Practicum Internship may be paired with a TMH RN for their clinical rotation. In this case, the faculty instructor may not be present at TMH, but must be able to be contacted by telephone if needed.

D. TMH colleagues in a clinical rotation, as either a student or faculty, must adhere to these guidelines for students.

II. PROCEDURE:

A. RN, Licensed Practical Nurses (LPN) or Paramedic faculty instructors or the TMH nurse will collaborate with the Charge Nurse or Nurse Manager on patient assignments.

B. Instructors or the TMH nurse must oversee delegated procedures for assigned students.

C. Instructors or the TMH nurse must accompany the nursing or paramedic student for all gastric (naso-, oro-gastric or PEG), parenteral (including IVs), sublingual and transdermal medications. Nursing students may administer oral medications independently only with the approval of the Instructor or TMH nurse.

NURSING-PARAMEDIC STUDENT RESPONSIBILITIES (CONT)

D. Students will not be provided access to the Pyxis machine. All medications must be withdrawn by an instructor or a TMH nurse.

E. If the medication to be administered is a controlled substance requiring wasting, 2 licensed nurses must waste or witness the waste, one of whom must be a TMH nurse.

F. Students are allowed to perform delegated waive testing under the direct supervision of the TMH nurse or faculty instructor.

G. The TMH nurse assigned to the patient will:

1. Assign appropriate duties to the nursing or paramedic student;
2. Clearly define the duties and responsibilities assigned to the student;
3. Retain accountability for all care delivered to the patient.

H. RN, LPN and paramedic students are expected to:

1. Receive a bedside SBAR handoff report at the start of the shift.
2. Provide a bedside SBAR handoff to the TMH nurse at the end of their shift.
3. Perform positive patient identification before the administration of a medication or performance of a procedure.
4. Follow up and document the patient's response to any PRN medications.
5. Complete all documentation on their assigned patients promptly.
6. Have all documentation reviewed by the TMH nurse or the faculty instructor.
7. Report all patient changes promptly to the TMH nurse.

I. RN, LPN and paramedic students are not allowed to:

1. Enter any isolation room requiring an N95 respirator (mask);
2. Collect laboratory or blood bank specimens;
3. Set up, refill or program PCA or PCEA pumps;
4. Administer chemotherapy, heparin or insulin infusions;
5. Administer, regulate, or discontinue blood products;
6. Accept verbal or telephone orders from a provider;
7. Perform RN Review of orders.

J. RN, LPN and Paramedic students may start a peripheral IV after they have met their program's requirements for training in this skill. Their instructor or a TMH nurse must be present at all times. A TMH nurse will take over if specimen (blood) collection is required after the IV start.

III. REFERENCES:

A. FS §464.019, Approval of nursing education programs

B. FS § 401.2701, Emergency medical services training programs

C. Panda, S., Dash, M., John, J., Rath, K., Debata, A., Swain, D., ... & Eustace-Cook, J. (2021). Challenges faced by student nurses and midwives in clinical learning environment–A systematic review and meta-synthesis. Nurse Education Today, 101, 104875.

D. Solomon, Y. (2020). Comparison between problem-based learning and lecture-based learning: Effect on nursing students' immediate knowledge retention. Advances in medical education and practice, 947-952.

E. Wallin, K., Hörberg, U., Harstäde, C. W., Elmqvist, C., & Bremer, A. (2020). Preceptors experiences of student supervision in the emergency medical services: A qualitative interview study. Nurse education today, 84, 104223

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