

Student Nurse Handbook and Guidelines

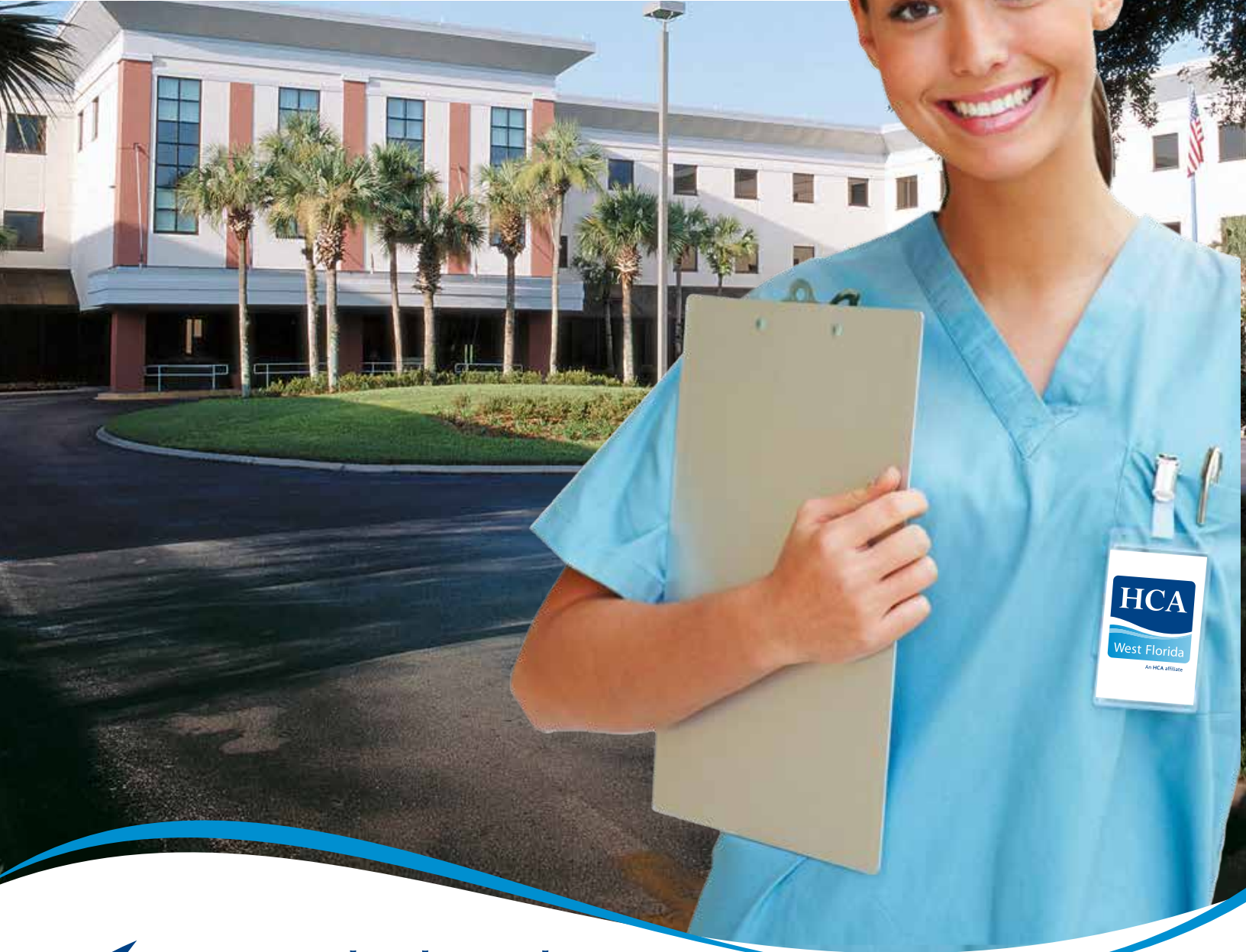




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About

CENTRAL FLORIDA REGIONAL HOSPITAL

Central Florida Regional Hospital is a 226-bed facility serving the residents of Seminole and West Volusia Counties.

The hospital is widely known for its cutting-edge technology, innovative programs and superb medical staff.

HCA MISSION AND VALUES STATEMENT

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.

In pursuit of our mission, we believe the following value statements are essential and timeless.

We recognize and affirm the unique and intrinsic worth of each individual.

We treat all those we serve with compassion and kindness.

We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.

We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

VISION STATEMENT

Central Florida Regional Hospital will be the hospital of choice in the communities we serve.

NURSING

At Central Florida Regional Hospital we value the opportunity to influence the future of our Nursing Profession by our mentorship of the nursing students that do their clinical training within our walls. As we work with the students we are ever mindful of our primary duty to our patients assuring that all care given is of the same standard of quality.

According to the Florida Nurse Practice Act, "Clinical training means direct nursing care experiences with patients or clients which offer the student the opportunity

to integrate, apply and refine specific skills and abilities based on theoretical concepts and scientific principles."¹

While we as nurses often see our primary roll with students as to help them apply skills learned in the classroom to real world situations, we are also honing and shaping the future of our profession. Our clinical expertise, attitudes and values are being observed closely by these students. Just as we are accountable to provide the care necessary to allow our patients the greatest opportunity to return to the most optimal health possible, we are also responsible to be role models for the next generation of nurses on how to provide that care. We are living examples of the professionals they may become.

As per our Student Affiliation Policy, the nursing staff will "Assist the instructor by observing students performing basic skills (according to student's needs). Assigned staff members may assist the instructor in guiding student activity."² Working collaboratively with the nursing instructor, the nursing staff will find clinical opportunities that will meet the objectives for the clinical day as specified by the nursing instructor. This can be done as part of the pre-shift Huddle. The charge nurse will share the objectives for the students for that day and ask that the staff inform the nursing instructor of opportunities that are available.

Though the clinical instructor is responsible for the students and staff assist each student to acquire clinical experience through the care of our patients, the nurse assigned each patient is ultimately responsible that all care ordered or required is carried out.

Per the Student Affiliation Policy, each student is to report off to the nurse assigned the patient he/she cared for or the charge nurse. By providing handoff communication, the student is working with the nurse to maintain safe, quality care for the patients we serve

¹Nurse Practice Act, Florida Statute 464.003

²Student Affiliation Policy EDU.007

HOSPITAL SERVICES & GENERAL INFORMATION

Central Florida Regional Hospital demonstrates its commitment to the Seminole, Volusia and surrounding communities by assessing what essential services will be needed on a regular basis. Based on this assessment, listed below are the essential, regularly provided diagnostic, therapeutic, and rehabilitative services provided to the community.

Inpatient Services:	Services Available on an In and Out-Patient Basis:
<ul style="list-style-type: none"> Cardiac Intensive Care Open Heart Surgery Cardiology Services Acute Dialysis Medical/Surgical Services Medical & Surgical Intensive Care Neurology Services Neurosurgical Services Newborn Nursery (Level 1) Obstetrical/Gynecological Services Orthopedics Respiratory Care Services Inpatient Rehab 	<ul style="list-style-type: none"> Computerized Tomography Magnetic Resonance Imaging Laboratory and Pathology Nuclear Medicine Diagnostic Radiology Respiratory Therapy Ultrasonography Cardiac Catheterization Lithotripsy Physical Therapy Chronic Dialysis Laser Surgery Neurodiagnostics Cardiopulmonary Rehabilitation Services Oncology/Chemotherapy Radiation Therapy Sleep Disorder Studies Chronic Wound Care Mammography Electrophysiology Speech Therapy Hyperbaric Medicine

GENERAL INFORMATION

PARKING:

Security will escort any student/instructor to their vehicle when requested. Students and instructors are asked to park in either employee parking lot on the West side of the building (loading dock side). When coming into the building, students should meet their instructor in the cafeteria or on their assigned unit instead of congregating in the front lobby. We appreciate your cooperation so that we may better serve our patients and their families and visitors.

Hospital employees/students are not allowed to park in the Medical Arts Building parking lot, as those spaces are reserved for the patients and staff of that building.

CAFETERIA HOURS:

6:30 – 9:30 am, 11:00 am – 2:00 pm, 5:00 – 6:30 pm
Vending machines are located on the first floor by the cafeteria and in the ER waiting room.

SMOKING:

Central Florida Regional Hospital is a tobacco free facility and supports a smoke free/drug free workplace. Smoking of any type is not permitted on hospital property including electronic cigarettes.

SECURITY:

Everyone is responsible for hospital security. Never share keypad access codes or prop doors open. Students leaving after dark may request an escort by dialing ext. 20998 or calling the hospital operator.

NAME BADGES:

Before starting a clinical rotation, students will go to the Human Resources Department to obtain a Name Badge. Students are responsible for wearing the name badge while at CFRH and for returning the badge to HR when their final rotation is completed.

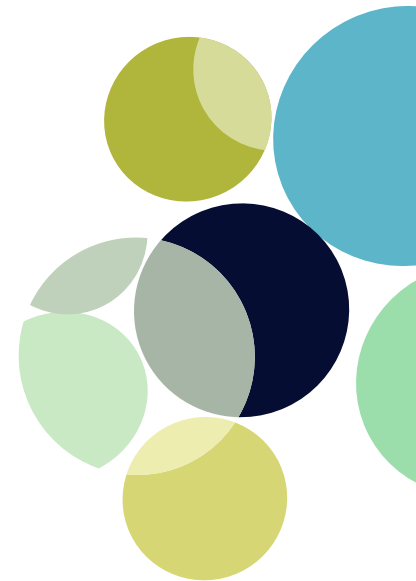
DRESS CODE:

Students are expected to maintain good hygiene and a professional appearance when at CFRH and to comply with their school's dress code policy. Students not complying with the Dress Code will be sent home. Additional guidelines include:

- Shoes: No open toe, sling back, or shoes with holes/openings.
- Artificial nails are prohibited.
- Visible body piercing other than earrings is prohibited.
- Fragrances/perfumes should be worn conservatively so as to not bother patients and others.
- Tattoos must not be visible.

MINISTERIAL SERVICES:

Rev. Bruce Scott, a local Presbyterian minister, makes rounds to the patients a few hours each day Monday - Friday. If a patient wants to speak with a spiritual leader of their own faith, they can make arrangements themselves or they can contact the information desk at ext. 35654 for assistance



INTERPRETER SERVICES:

CFRH will provide, within its ability, Interpreter Services at no charge to the patient. CFRH uses the CyraCom system for all instances requiring interpreter services. The blue CyraCom phones or stickers with information on how to contact CyraCom from a standard phone, can be found in all clinical areas. REMEMBER to DOCUMENT use of Interpreter Services in the patient's medical record. General instructions for use are:

Connecting ClearLink™

ClearLink's™ simple color coded connection theme clearly communicates how to Link immediately to CyraCom's Transparent Language Services:

1. Plug ClearLink™ into a phone jack labeled with a blue decal
2. Lift the LEFT handset and listen for a dial tone
3. Press the Blue ACCESS Button – wait for the system to answer
4. Press the ACCT/PIN Button – when prompted
5. Follow the rest of the prompts

Using the speaker phone:

Using the speaker phone function at the beginning of a call:

1. Connect ClearLink™ to an analog phone line
2. Depress the Speaker Phone button
3. Adjust the speaker volume with the LEFT handset volume control
4. Link with CyraCom by pressing the Blue Access Button

Switching to the speaker phone function in the middle of a call:

1. Depress the Speaker Phone button
2. Hang-up the handsets
3. Adjust the speaker volume with the LEFT handset volume control

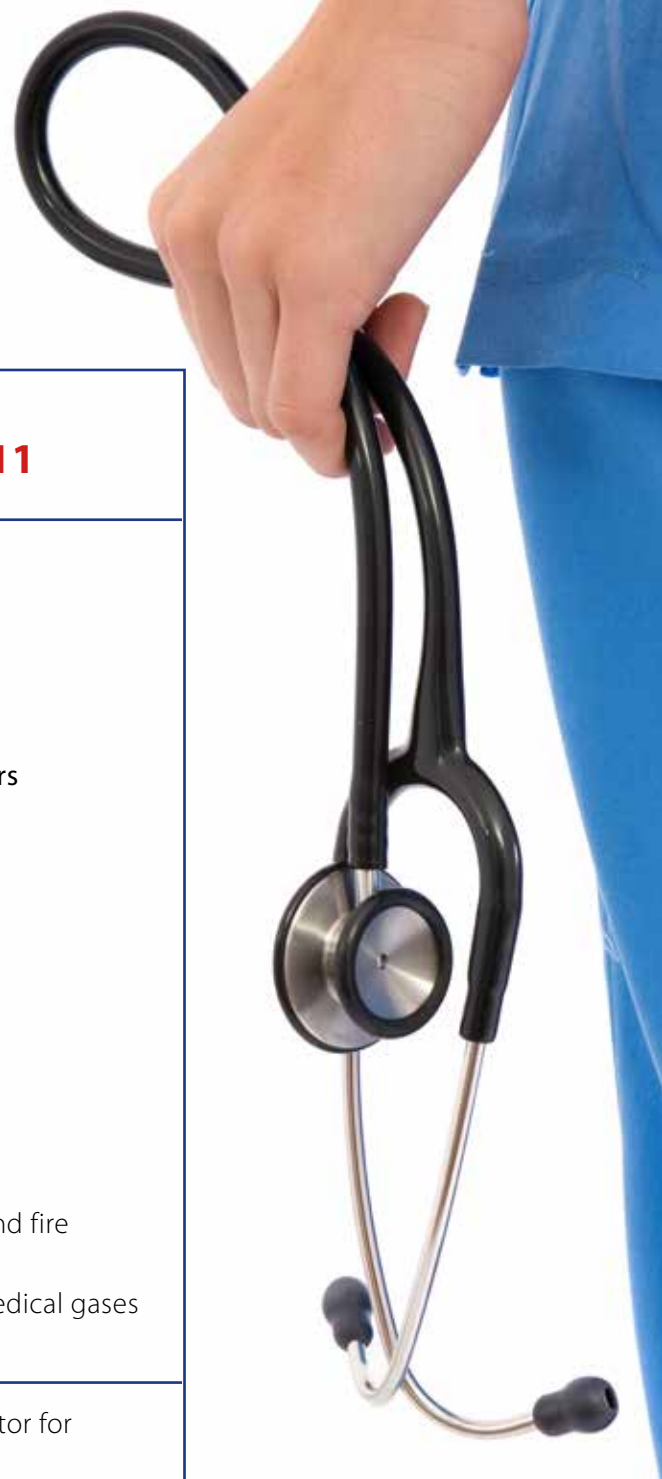
Switching back to the handsets in the middle of a call:

1. Simply lift the handsets

We also provide Sign Language Interpreter services through the use of a Workstation on Wheels and webcam. To access a Sign Language Interpreter, please contact the Nursing Supervisor



General Guidelines for STUDENT RESPONSE TO EMERGENCY CODES



CODE NAME	GENERAL RESPONSE
<p>CODE RED (FIRE)</p>	<p>Hospital Emergency Phone Number *31111</p> <p>IF YOU DISCOVER A FIRE:</p> <p>Remove/Rescue people in danger Activate nearest fire alarm pull station Contain fire by closing doors & windows Call 111 to report location of fire Extinguish fire or Evacuate beyond fire doors</p> <p>TO OPERATE A FIRE EXTINGUISHER:</p> <p>Pull the Pine Aim Low (start 10 feet back) Squeeze Handle Sweep from side to side</p> <p>OTHER GUIDELINES:</p> <ul style="list-style-type: none"> • Do not use elevators. • Follow instructions from nursing or security. • Know locations of Fire Alarm Pull Stations and fire extinguishers in your area. • Only Cardiopulmonary Staff may turn off medical gases (O2).
<p>CODE GREEN (DISASTER)</p>	<ul style="list-style-type: none"> • Students report to your instructor or preceptor for instructions.
<p>CODE BLACK (BOMB THREAT)</p>	<ul style="list-style-type: none"> • Turn OFF all cell phones and radios until the “all clear” is announced. • Help search department. Report anything suspicious or unusual to the department director/coordinator or charge nurse. • Do NOT touch any suspicious object! • If a student receives a bomb threat call, note any particulars of caller’s voice, choice of words, and background noise.

CODE NAME	GENERAL RESPONSE
	Hospital Emergency Phone Number *31111
CODE PINK (INFANT ABDUCTION)	<ul style="list-style-type: none"> If possible, prevent anyone from leaving the building. However, do not use force or put yourself in danger. If suspicious person leaves, follow them and obtain car tag number and description. Report to Security/Law Enforcement immediately. Watch for any suspicious behavior such as carrying a large bag or package or wearing a coat or loose fitting clothing that could conceal a small child. Report it to the switchboard operator.
CODE BROWN (HAZARDOUS WEATHER)	Assist nursing staff as instructed to: <ul style="list-style-type: none"> Move patient beds to most interior wall. Secure the area and equipment. Secure the medical records.
CODE PURPLE (TORNADO)	Called when a tornado warning has been issued or there is an immediate threat to the hospital. <ul style="list-style-type: none"> Assist in moving patients as far away from windows as possible. Close patient room doors and window blinds. Pull privacy curtains. Stay clear of all glass and doors. Encourage visitors not to leave, but visitors may leave if they so desire.
CODE BLUE (CARDIAC ARREST)	If patient is unresponsive, dial *31111 and call a Code Blue.
CODE GRAY (MANPOWER EMERGENCY)	<ul style="list-style-type: none"> No response is necessary. Students should call *31111 to report any person who becomes unruly or violent in their area.

CODE NAME	GENERAL RESPONSE
	Hospital Emergency Phone Number *31111
CODE ORANGE (ACTIVATE DECON TEAM)	Purpose of code is to alert Decontamination Team and others that are involved in patient decontamination. No response is necessary by the students.
CODE SILVER (ACTIVATE SHOOTER)	Called when someone is actively shooting or using any other deadly weapon. <ul style="list-style-type: none"> Lock yourself in the room you are in at time of threatening activity. Do NOT stay in an open hall. Keep patients and visitors away from windows.
CODE WHITE (HOSTAGE SITUATION)	<ul style="list-style-type: none"> Return to your assigned unit. Follow instructions from Charge Nurse or Department Director. Use telephones for emergency purposes only.
CODE YELLOW (FACILITY LOCKDOWN)	Called to control hospital access during emergency situations. Security will lock all public and peripheral doors. <ul style="list-style-type: none"> Badge access only. No response is necessary by students.
CODE "M" (MISSING PATIENT)	Called when a patient is discovered missing from their care area. <ul style="list-style-type: none"> PBX Operator will give a brief description of the patient and where they belong when announcing the Code M. Help staff, particularly in the adjacent areas, search department/unit for missing patient. Report findings to Charge Nurse.

Additional Information may be found on the CFRH Intranet website/Policy Manuals/ Safety and Infection Control Manual And in the "Code Quick Reference and Kardex" located in every department.

JUST THE FACTS

Cleaning Products for Surfaces and Contact Time

Hospital approved cleaning product list for patient equipment and hard surfaces

Complete guidelines can be found on the Intranet: Safety and Infection Control Policy # 3011

KEY POINTS:

- **CONTACT TIME:** the length of time the disinfectant remains visibly wet on a surface before drying for the disinfectant to be effective
- Follow manufacturer's recommendations for cleaning and disinfection of equipment, they are the PRIMARY source for direction
- All shared patient equipment must be cleaned and disinfected between patient use
- Contamination due to blood, body fluids, gross filth, or heavy deposits/debris is a two-step cleaning process
 - o First Step: Use disinfectant to remove gross contamination
 - o Second Step: Repeat application of disinfectant for full contact time. Allow to air dry.
- Only use microfiber cloth or wipes impregnated with disinfectant; washcloths or cotton towels prevent the disinfectant from working properly
- Avoid spraying disinfectant on or into electrical equipment to prevent equipment damage/malfunction or electrical shock

Product Name®	Generic Name	Contact Time
3M HB Quat (shelf life after dilution is 60 days)	Quaternary Ammonia (Quat)	10 minutes
3M HB Quat TB (ready to use –no dilution)	Quaternary Ammonia (Quat)	10 minutes
Super Sani-Plus Wipes	Quaternary Ammonia (Quat) contains 55% Alcohol	2 minutes
PDI BLEACH	Sodium hypochlorite (0.55% NaOCl) 5500 ppm (Bleach)	1 minute (bacteria, viruses,) 2 min (tuberculosis, fungi) 4 minutes C. difficile
Sani-Plus HB Use limited to Mammography and Vascular Ultrasound. Keyboards/ CPOE	Quaternary Ammonia (Quat) Alcohol Free	10 minutes
Alcohol use limited to stethoscope, telephone, blood glucose meter, otoscope, ophthalmoscope, tanometer	Ethyl or Isopropyl 70-90%	10 seconds

GUIDE FOR ISOLATION PRECAUTIONS

Disease or Condition	Standard	Droplet	Airborne	Contact	Duration/Comments
Abscess, ulcer, or wounds (draining, major)	X			X	Until drainage stops or can be contained by dressing
Chickenpox (Varicella)*	X		X	X	Negative pressure room until lesions crusted
Clostridium difficile (C.Diff) Place on isolation if suspected until cause of diarrhea is identified	X			X	Use of gown and gloves on entry to room. Duration of illness WASH HANDS WITH SOAP & WATER
Conjunctivitis, acute viral	X			X	Duration of illness
Diarrhea (acute infective etiology suspected) Noroviruses-Place on isolation if suspected until cause of diarrhea is identified	X			X	Diapered children or incontinent adults WASH HANDS WITH SOAP & WATER, Hypochlorite solution to clean environment
Diphtheria (pharyngeal)	X			X	Until 2 cultures negative 24 hrs apart
Epiglottitis (Haemophilus influenzae)	X	X			Until 24 hrs after start of effective treatment
Hepatitis A, E	X			X	Contact precautions for diapered or incontinent patient for duration of illness
Hepatitis B (include D), C, G	X				See specific recommendations for dialysis pts
HIV	X				
Novel Strain, Influenza	X	X		X§	7 days from onset of symptoms; § w/diarrhea N95 for aerosol producing procedures
Influenza (viral) Human (seasonal influenza)	X	X			5 days from onset of symptoms except in immunocompromised pts, duration of illness
Avian Flu (e.g H5N1, H7, H9 strains)					See current avian influenza guidance www.cdc.gov/flu/avian/professional/infect-control.htm
Lice (Pediculosis)	X			X	Until 24 hrs after start of effective treatment www.cdc.gov/ncidod/dpd/parasites/lice/default.htm
Measles (Rubella, Rubeola)*	X		X		Negative pressure for duration of illness
Meningitis – known or suspected bacterial (N. meningitidis, Haemophilus influenza)	X	X			Until 24 hrs after start of effective treatment mask and face protection for intubation
MRSA (infection/colonization) MRSA pneumonia	X	X		X	Until two negative screen swabs of nares or negative culture of infected source (sputum, wound, urine, etc) 1 year of original infection
Multi-drug resistant organisms (MDRO's) other, VISA/VRSA/Pseudomonas species/S. pneumoniae, ESBL's or KPC E.coli, Kl. pneumoniae, Acinetobacter baumannii, Stenotrophomonas maltophilia, Burkholderia cepacia, Ralstonia pickettii	X	X**		X X	Colonization or infection. Duration of hospitalization **If patient with pneumonia due to MDRO's use droplet precaution until 72 hours after initiation of effective drug therapy
Mumps*	X	X			Until 9 days after onset of swelling
Pertussis (Whooping Cough)*	X	X			Until 5 days after effective therapy
Pneumonia caused by mycoplasma, Strept. group A., Staph, invasive H. Influenzae B, Adenovirus, Pertussis, Parvovirus 19, etc	X	X			For the first 24 hours of effective antibiotic therapy www.cdc.gov
RSV	X	X		X	Duration of illness
SARS	X		X	X	Duration of illness + 10 days after resolution of fever and respiratory symptoms are absent
Scabies	X			X	Until 24 hrs after start of effective treatment
Shingles disseminated, or in immune compromised patient *	X		X	X	Until lesions completely crusted over
Shingles localized lesions that can be covered/contained in patient with intact immune system *	X				If they are not disseminated but large enough that they cannot be contained/covered use contact precautions until lesions are crusted.
Streptococcal Disease (group A) , Major Pneumonia	X	X X		X	Until 24 hrs after start of effective treatment
Small pox	X		X	X	Until all scabs have crusted and separated (3-4 wks)
TB (Mycobacterium tuberculosis), known or suspected including HIV + patients	X		X		Negative pressure till 3 negative AFB or 14 days of effective therapy
VRE (colonization or infection)	X			X	Gown and glove on entry to room. Duration of hospitalization

* Susceptible Healthcare workers or non-vaccinated should not enter room

STANDARD PRECAUTIONS **ARE USED FOR ALL PATIENTS (ISOLATION)**

Standard precautions apply to (1) blood, (2) all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; (3) non-intact skin, (4) mucous membranes.

HAND HYGIENE: After touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves; between patient contacts. Before and after patient contact.

GLOVES: Are worn when you anticipate contact with blood, body fluids, mucous membranes, or non-intact skin of ALL patients, and when handling contamination items or surfaces. Put on clean gloves just before touching patient. Change gloves during patient care if hands will move from a contaminated body site (i.e. perineal area) to a clean body site (i.e. face)

MASK, EYE PROTECTION, FACE SHIELD: Are worn during patient activities that are likely to generate aerosols, splashes, and sprays, especially during suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosol (e.g. SARS), wear a fit-tested N-95 or higher respirator, gloves, gown, and face/eye protection.

NEW – Special Lumber Procedures - Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space. (i.e. myelograms, lumbar puncture and spinal or epidural anesthesia)

GOWNS: Are worn during procedures and patient care activities when contact of clothing/exposed skin with blood or body fluids, secretions, and excretions is likely.

SHARPS: Never recap, bend or break needles. Place used disposable needles and sharps in a disposable puncture resistant container at the point of use. If recapping is required, use a one handed scoop technique. Do not pass off sharps, place in designated "safe zone" for individual to obtain.

EQUIPMENT: Clean equipment with a hospital approved disinfectant between uses. Dedicate equipment or use disposable equipment in isolation rooms. "Clean"/"Dirty" equipment must be stored separately.

ENVIRONMENTAL CONTROL: Routinely clean and disinfect environmental surfaces such as side rails, over bed tables, bedside tables, phones, call lights, and frequently touched surfaces.

VISITORS and FAMILY: All visitors should be instructed in proper hand hygiene. Visitors actively involved in direct care shall be instructed in gowning and gloving as appropriate.

SAFE DRESSING AND REMOVAL of Personal Protective Equipment (PPE) is important to prevent contamination to oneself and the environment – refer to CDC chart in isolation rooms/unit.

LINENS: Handle in a manner that prevents transfer of microorganisms to others and the environment. All used linen is considered contaminated, handle with gloves

TRANSMISSION BASED PRECAUTIONS:

CONTACT: Use for pathogens that are transmitted from direct skin-to-skin contact, or indirect contact with a contaminated object in the patient's environment.

- Place patient in a private room with a contact sign on the door
- Wear gown and gloves when entering patient room.
- Remove gown prior to leaving room.
- Gloves are to be removed prior to leaving the room.
- Dedicate equipment to the room, or disinfect prior to removing from the room.
- If transporting notify receiving department of the patient's isolation. Patient to wear clean gown and be wrapped in clean sheet for transport.
- Perform hand hygiene before entering and upon leaving the patient's rooms

DROPLET: Use for patients who are diagnosed or suspected of an infection that can be spread on droplets of sputum. These germs can travel distances (3 – 6 feet) and can cause infection when they land on your mucous membranes.

- Place patient in a private room with a droplet sign on the door.
- Wear a surgical mask when entering the room of the patient.
- Dedicate equipment to the room, or disinfect prior to removing from the room.
- Avoid transporting patient unless necessary. If transporting is necessary place a surgical mask on the patient.
- Perform hand hygiene before entering and upon leaving the patient's rooms

AIRBORNE: Use when a patient is suspected of an infection that can travel throughout the patient's room on the air currents, (e.g. SARS, TB, Measles, Bird flu, & Chickenpox. **KEEP DOOR CLOSED AT ALL TIMES TO MAINTAIN NEGATIVE PRESSURE IN THE PATIENT'S ROOM!!**

- Place patient in a negative pressure room with an airborne sign on the door.
- Wear the N95 particulate respirator mask

each time you enter the room.

- - Visitors and family should wear the surgical mask or N95 when entering the patient's room.
- - Dedicate equipment to the room, or disinfect prior to removing from the room.
- - Transport only when necessary. If transporting, place a surgical mask on the patient. The receiving department needs to be informed of patient's isolation status prior to moving the patient.
- - Perform hand hygiene before entering and upon leaving the patient's rooms

NEW ELEMENTS FOR STANDARD PRECAUTIONS.

- **Respiratory Hygiene/Cough Etiquette**
Patients, family, visitors entering the hospital with undiagnosed transmissible respiratory infections with signs of illness including cough, congestion, runny nose, increased sputum production are to be given the following:
 - o Instructed on covering mouth/nose w/ tissue and prompt disposal, don surgical mask for coughing person, hand hygiene, and spatial separation, ideally >3 feet from others.
 - o Provide hand hygiene supplies and instruction to perform in or near waiting rooms
 - o Healthcare workers with respiratory infection are advised to avoid direct patient contact, if not possible mask should be worn when providing patient care.
- **Safe Injection Practices.**
 - Use aseptic technique
 - Do not administer medication from a syringe to multiple patients even if needle changed
 - Use fluid infusion and administration sets for one patient only
 - Syringe/needle/cannula are sterile, single use items; not to be reused for a subsequent patient or access a medication or solution. It is considered contaminated once it has been used to enter or connect to a patient IV bag or administration set. Change connector
 - Use single dose vials or ampules whenever possible
 - Do not administer medication from single dose vials to multiple patients
 - Syringe/needle/cannula must be sterile to access multidose vials.
 - Do not keep multidose vials in immediate patient treatment area. Store per manufacturer's guideline, discard 28 days after opening or if sterility is compromised or questionable.

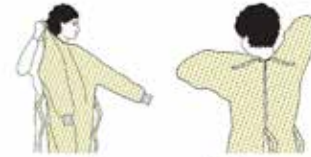
INFECTION PREVENTION IS IN YOUR HANDS!

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

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 waist².



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 respirator³.



3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



4. GLOVES

- Extend to cover wrist of isolation gown



SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES

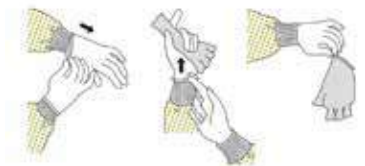
- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glovet
- Discard gloves in waste container

2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

3. GOWN

- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard



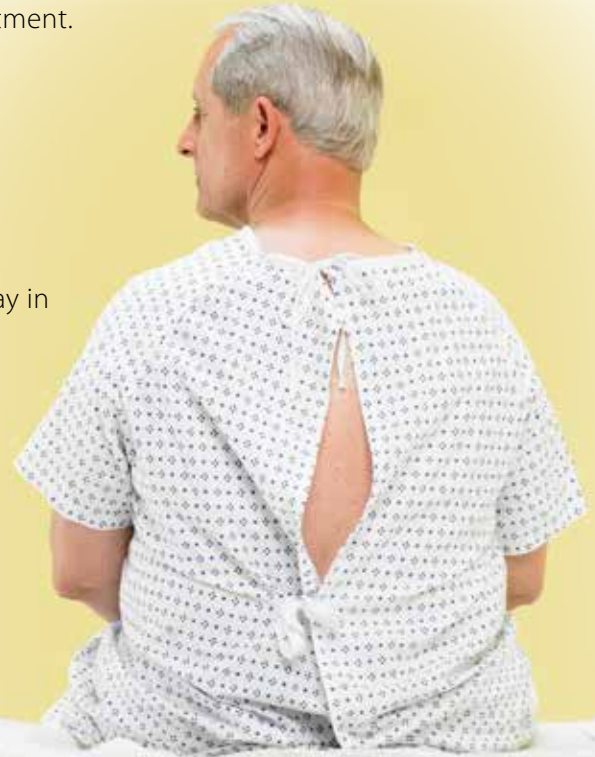
4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container



STUDENT RESPONSIBILITIES

1. Comply with hospital policies and procedures.
2. Perform duties assigned and report any problems to instructor or hospital preceptor.
3. Wear appropriate attire or designated student uniform and hospital name badge. Practice good personal hygiene at all times when in the facility.
4. Comply with facility's Ethics & Compliance Program and the Code of Conduct.
5. Maintain strict hospital and patient confidentiality.
6. Receive information and support from the hospital staff before starting patient care or other learning assignment.
7. Perform procedures within the guidelines and policies of the department after demonstrating competency in the educational setting of their program.
8. For clinical areas, the student must document all medications, treatments, vital signs and care given to patients in the patient's medical record as appropriate for that department.
9. Use hospital-approved abbreviations only.
10. Notify the hospital preceptor if leaving the department and give an update report.
11. Report to the hospital preceptor at the beginning and end of each day in the facility.
12. Maintain a current CPR Certification.
13. Practice good body mechanics.
14. When unable to work in the department as scheduled, contact the hospital preceptor or appropriate department staff prior to the beginning of the shift.



Highlights from the CFRH Student Affiliation Policy

- a. Documentation in the Medical Records - All documentation in the patient's medical record will be reviewed for accuracy and cosigned by the Clinical Instructor or hospital preceptor.

1. HIPAA

- a. Students should refer any requests for patient information from family/friends to the patient's nurse. Patient information should only be shared with hospital staff who have a "need to know".
- b. Never share computer passwords or leave a computer unattended before logging off.
- c. Students may not at any time make copies of any part of a patient's medical record. Students may make notes, but may not record any of the 19 elements considered by HIPAA to qualify information as "Protected Health Information". The 19 elements are:
 - i. Patient Name
 - ii. Address including street, city, county, zip code and equivalent geocodes
 - iii. Names of relatives
 - iv. Name of employers
 - v. Birth date
 - vi. Telephone numbers
 - vii. Fax Numbers
 - viii. Electronic e-mail addresses
 - ix. Social Security Number
 - x. Medical record number
 - xi. Health plan beneficiary number
 - xii. Account number
 - xiii. Certificate/license number
 - xiv. Any vehicle or other device serial number
 - xv. Web Universal Resource Locator (URL)
 - xvi. Internet Protocol (IP) address number
 - xvii. Finger or voice prints
 - xviii. Photographic images
 - xix. Any other unique identifying number, characteristic, code

2. Restrictions

Student nurses in an RN Program may perform any procedure written in an RN job description except:

- a. Blood administration
- b. Experimental drugs
- c. IV chemotherapy
- d. IV narcotics
- e. PCA pump
- f. Removal of a central venous access device or central venous catheter
- g. Take verbal or telephone orders from physicians
- h. Transcribe orders
- i. Other unit specialty procedures as indicated by the unit coordinator. May assist with admissions, assessing patients and initiating nursing diagnosis if checked by the instructor and/or preceptor and cosigned.



3. N95 Respirator

Prior to participating in the care of a patient on Airborne Precautions (example: TB Patient), the student must be fit-tested for the N95 respirator currently in use at CFRH. For more information, see the Isolation chart on page 8.

4. Occupational Exposure

While in the facility, if a student is involved in a situation resulting in cross-contamination or exposure to a communicable disease:

- a. Clean exposed area well with soap and water. If eyes or mucous membrane are involved, rinse the area with copious amounts of water.
- b. Do NOT delay treatment.
- c. The Occupational Health Nurse should be notified (ext. 27322 or pager 407-444-6996 between 7:30 am – 4:00 pm, Monday - Friday)
- d. Occurrence Report is completed and submitted to the Occupational Health Nurse.
- e. The Occupational Health Nurse will notify the instructor and take appropriate action.
- f. After hours, the student or instructor should go to the Emergency Room and the ER personnel will contact the Occupational Health Nurse. An Occurrence Report must also be completed.
- g. The student/instructor will need to have the patient's name and location when they go to the Emergency Room.



5. In the event that a student or instructor develops a **communicable disease** the school should notify the Occupational Health Nurse, at 407-321-4500, ext. 27322 immediately and provide the following information.

- a. Symptoms and date of onset.
- b. Diagnosis
- c. Treatment, if any.
- d. Nursing Unit and patients assigned to student within the past 7 days.

Student/Instructor will not be allowed to return to the clinical area until he/she is cleared by a physician.

6. Problem Solving

Students should address problems or issues regarding patient care or hospital staff/facilities with their instructor or the Department Director/Coordinator.

STANDARDS OF CARE

Patient Identification

Prior to patient care, we use two identifiers to confirm the patient's identity. This is usually done by asking the patient their name and date of birth. Arm bands can be used to help communicate valuable information but should not be used solely for patient identification.

Other arm bands are:

- o White – Identification Band
- o Purple – AND (Allow Natural Death)
- o Red – Allergy
- o Pink – Do not use limb
- o Yellow – Fall risk
- o Green – Latex allergy
- o Green and White – Blood Band
- o Orange – Anticoagulated

Assessment/Reassessment

Assessments are to be completed in the following time frames:

Area	Admission assessment	Reassessment
Critical Care	Within 2 hours	Q2 hours and prn
Telemetry/PCU	Within 2 hours	Q4 hours and prn
Med/Surg	Within 4 hours	Q12 hours and prn
Rehab	Within 4 hours	Q12 hours and prn
Labor & Delivery	Within 2 hours	Q15 minutes and prn while in active labor
Post Partum	Within 4 hours	Q12 hours and prn
Nursery	Within 4 hours	Q12 hours and prn
Emergency	Emergent -within 2 hours Urgent - within 4 hours Non-urgent -within 4 hours	Q1 hour and prn Q 4 hours and prn Q 4 hours and prn
PACU	Immediately	Q10 minutes and prn

Assessment for admission will include biological and physical needs, safety needs, psychosocial, self care, educational and discharge needs. A physical assessment and a history will be completed (Complete History, Assessment, Evaluation for Suicide Risk, DVT, Fall Risk and Pneumonia/Flu on admission).

Plan of care, Education, and Discharge Planning

Plan of Care and Discharge Planning are initiated on Admission. Plan of Care will be updated and prioritized every shift and as needed.

Discharge Medication Reconciliation needs to be completed on admission, transfer to another unit, postoperatively, and at discharge. Upon discharge two nurses need to confirm accuracy before patient is discharge

Education is part of the plan of care and discharge planning. Patient and/or family education is prioritized, given and documented every shift.

PATIENT SAFETY

SBAR for Communication

The handoff tool that we use is the SBAR approach. Anytime a patient's care is handed off from one caregiver to another we use

- Situation
- Background
- Assessment
- Recommendation

SBAR handoff tools can be printed in Meditech. If a patient goes to off the unit without nurse, a "Ticket to Ride" is sent.

Fall Risk

Fall risk assessments will be completed on admission, every shift, after significant condition changes, and after a fall occurs. If the patient is designated a high risk for fall, the following precautions are completed

- A Yellow Star magnet is placed on the door
- The top two side rails are placed in the up position.
- The call light and patient items are kept within reach
- Have a Bed Check in place and functioning
- Keep the bed in the low position at all times
- Keep the patient in a room close to the nurses' station if possible

Educate the patient and family regarding the High Risk potential and protocol



Core Measures

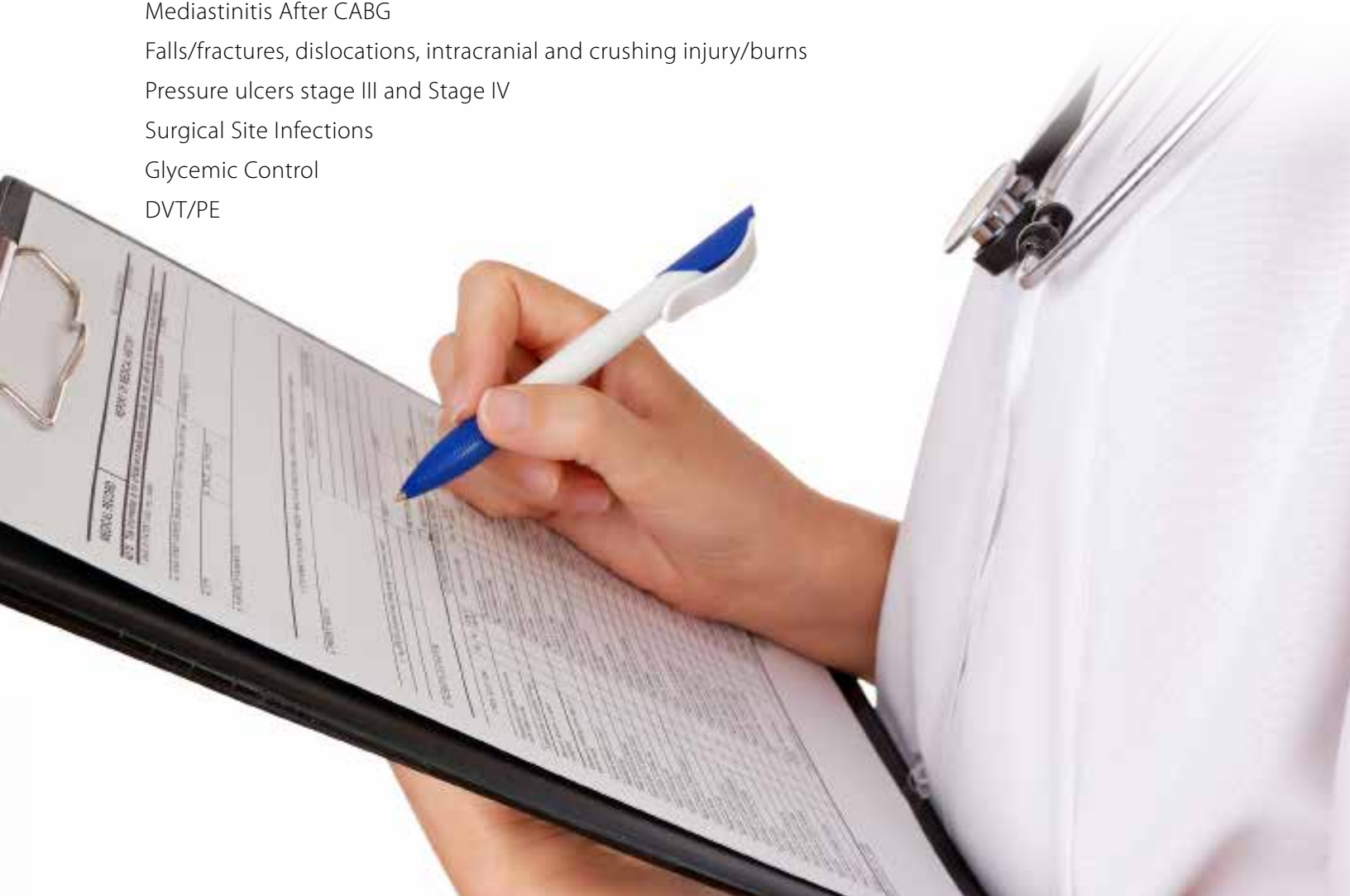
Core Measures are evidence-based, scientifically-researched standard of care which have been shown to result in improved clinical outcomes for patients. Hospital compliance to the Core Measures are publicly reported and benchmarked. The Core Measure currently being monitored include

- Acute Myocardial Infarction
- Acute Congestive Heart Failure
- SCIP – Surgical Care Improvement Project
- Community Acquired Pneumonia
- VTE prophylaxes
- Stroke

HAC – Hospital Acquired Conditions

HACs are preventable conditions that complicate patient's hospital stays and can be detrimental to the patients healing. HACs also increase the cost of hospitalization and effect reimbursement. Conditions that are present on admission must be documented or the are considered to be hospital acquired. Examples of HACs include

- Foreign Object left in during surgery
- Air embolism related to Central Venous Catheters
- Delivery of ABO-incompatible blood products
- Catheter associated UTI
- Vascular catheter associated infections
- Mediastinitis After CABG
- Falls/fractures, dislocations, intracranial and crushing injury/burns
- Pressure ulcers stage III and Stage IV
- Surgical Site Infections
- Glycemic Control
- DVT/PE




Medication Administration

To reduce medication errors, remember the 5 Rights of Medication Administration

We also need to:

1. Know more about the patient: It is important to take note of all lab studies including liver, kidney function studies and drug allergies.
2. Know the drugs: Patient's receive the wrong medication because the drug name is similar to another drug; look alike and sound alike drugs can cause problems.
3. Use drug references and consult with the hospital pharmacist: As Needed: you can VIEW/PRINT the Pharmacy monographs for your patient in the eMAR
4. Focus on the medication administration: Poor lighting, cluttered workspace and interruptions have been documented as something that distracts the nurse's focus from medication administration.
5. Listen to the patient: Patients questions and concerns can signal the nurse to potential problems.



**RIGHT DRUG
RIGHT DOSE
RIGHT ROUTE
RIGHT TIME
RIGHT PATIENT**

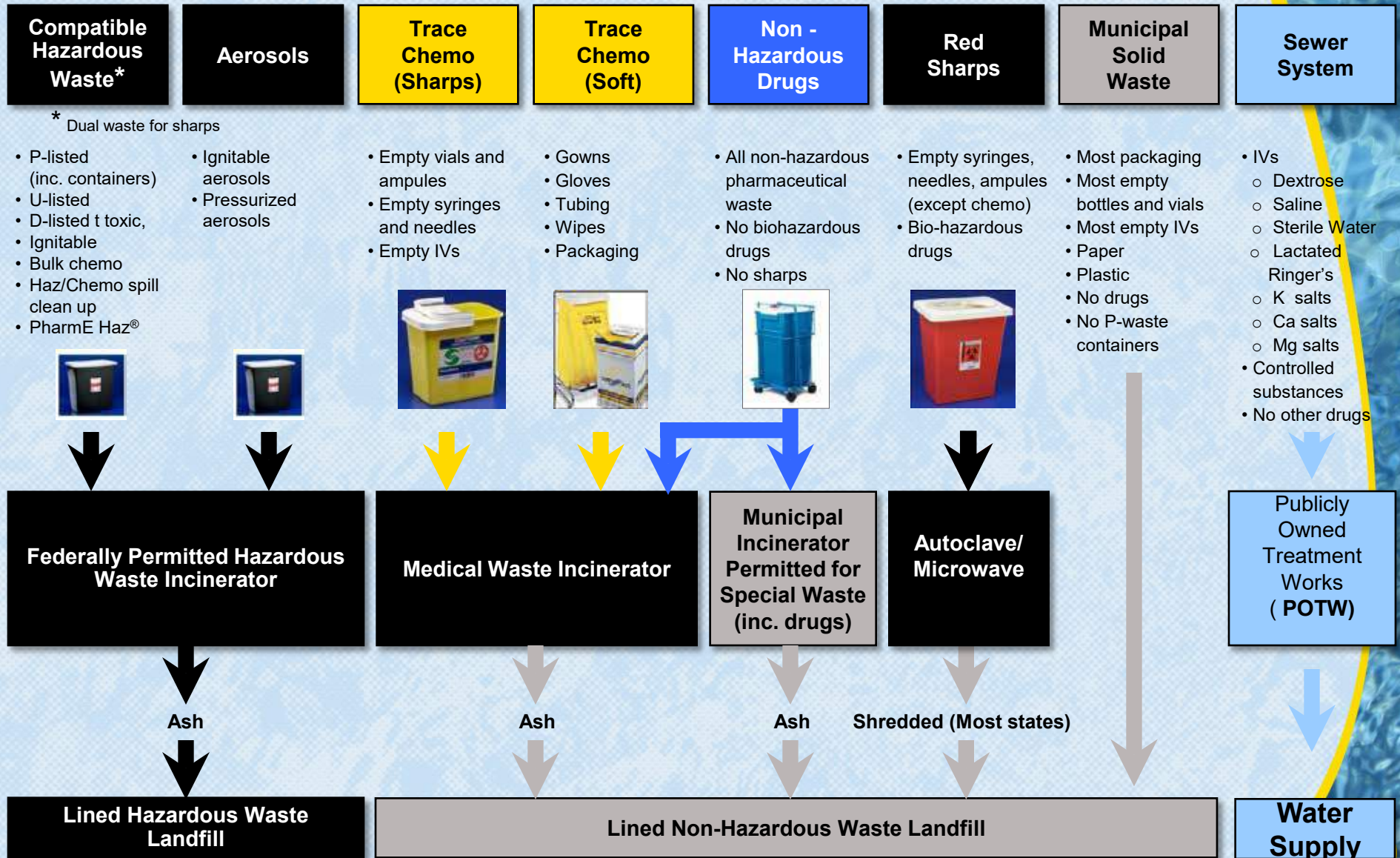
Medication Administration

Students will **not** be given access to the Pyxis System. The student's instructor will need to access Pyxis to obtain the patient medications for the student to pass.

All unused medications need to be returned to the Pyxis or disposed of properly See the Pharmaceutical Waste Guide for proper waste management.



Summary of Pharmaceutical Waste Streams



CFRH INFORMATION

& PROCEDURE REVIEW

RESTRAINTS

<p>Non Violent/ Non Self-Destructive Behavior Restraint Used to temporarily limit mobility when patient is in danger or at risk of harming self.</p> <p>Least restrictive restraint necessary is the restraint to be used.</p> <p>Mitt restraints</p> <p>Soft (wrist) restraint</p>	<p>Restraints are only used when all other measures have been exhausted when the patient exhibits behavior that compromises the effectiveness or outcome of treatment. (Examples would be the patient who is not cognitively intact making direct attempts to remove an artificial airway, invasive lines, tubes or catheters: or at risk of falling.)</p> <p>A restraint is to be used only if needed to improve the patient’s well-being and if less restrictive means have been determined ineffective.</p> <p>All measures attempted to keep the patient safe without restraints including, having a family member sit with the patient, must be attempted and documented. Other examples of alternative interventions are distractions techniques such as another object to hold, assisting the patient to the bathroom or a bed check monitor.</p> <p>When all else has been attempted the charge nurse or house supervisor must do a 2nd tier review noting all the other measures that were attempted.</p>
<p>Violent/Self-Destructive Behavior Restraint</p> <p>Physical restraint used when patient is aggressive and violent.</p> <p>Hard restraints (Tough cuffs)</p>	<p>The use of restraints to manage behavior is an emergency measure reserved for those occasions when an unanticipated, severely aggressive or destructive behavior places the patient or others in imminent danger.</p>
<p>Restraints may only be used upon order from a physician.</p> <p>Restraint Orders must include:</p> <ul style="list-style-type: none"> • Clinical Justification for the restraint • Duration of use • Date/time ordered • Type of restraint • Behavior-based criteria for release 	<p>The use of ANY RESTRAINT requires a Licensed Independent Practitioner’s order specifying the type of device, the purpose of the device and the length of time the restrain is to be used. The order cannot be written as a standing order or on an “as needed” (PRN) basis. If the restraint is ordered by an LIP other than the treating physician, the treating physician is to be consulted as soon as possible.</p> <p>A written or telephone order for restraints for Non Violent/Non Self-Destructive Behavior is to be obtained prior to the application of restrain whenever possible. The responsible LIP countersigns or authenticates the order within 24 hours of the restraint being initiated. If the use of a restraint continues to be clinically justified, the order must be renewed at least once every 24 hours.</p> <p>A face to face assessment by a physician, LIP, RN or Physician Assistant (that has shown competency for assessment for restraints) must be done within one (1) hour of application of restraints for Violent/Self-Destructive Behavior. A face to face assessment must be done even if restraints are stopped within the hour. If the face to face assessment is not done by the treating physician, he/she must be consulted as soon as possible. The use of a restraint must be limited to the duration of the emergency safety situation. The order is time limited to a maximum of 4 hours for adults, 2 hours for children ages 9-17 and one hour for children under 9 years of age. The order may only be renewed in the previously mentioned increments for up to a total of 24 hours. At that point, the LIP must reevaluate the patient face to face before writing a new order.</p>

CFRH INFORMATION & PROCEDURE REVIEW (cont.)

RESTRAINTS

Discontinuance of Restraints

If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints and requirements restart.

Temporarily releasing restraints for toileting, to feed, or provide range of motion are not considered discontinuation of restraints.

History of observed medical or behavioral risks such as falls or confusion is to be documented on the admission and shift assessments.

A second tier review will have to be documented before the restraint monitoring screen can be accessed.

Continuation of Orders

The patient and his/her family must receive education on why they are being restrained and what criteria must be met to discontinue restraints per Joint Commission Standard.

The Restraint documentation in Meditech must be initiated immediately after a patient is put in restraints. Alternative interventions attempted and the patient's response, prior to application of restraints, are to be documented. The behavior warranting the restraint, type of restraint, circulation checks, toileting, extremity ROM, fluids offered and other interventions and observations are to be documented at **least every two hours.**

Any patient in restraints must be assessed **for Safety, Rights and Dignity three times an hour** while in restraints.

The Plan of Care is to include application and monitoring of restraints.

Ensure that a Licensed Independent Practitioner's order is obtained whenever restraints are applied and renewed according to policy (Administrative Policy No. 900A825). The order is to be signed and authenticated within 24 hours of initiation when a verbal or telephone order is obtained, including date and time.

Document patient/family education on Restrain Form or Patient Education Record.

Safety

All patients in restraints are to be monitored closely to prevent Injury.

Signs of injury associated with a patient being restrained are poor circulation of the extremity, difficulty breathing or increased agitation or mental changes.

Glucose Monitoring System Quick QC Guide.

At CFRH we use the **StatStrip Meter** for our glucose monitoring.

User ID: Scan the instructor/nurse name badge. The student's name badge will not have this function.

Patient ID: Scan the barcode on the patient's armband.

Comment Codes are required on ALL tests.

For patient tests: Student nurse should use: "RN notified"

For control tests: Pass: Everyone should use "No action needed"

Fail: Use "Repeat Test" or "Operator Error"

Expiration Dates: If opening a new bottle of strips or a new bottle of control solution, the bottle needs to be marked with the open date, discard date and the initials of the person that opened the bottle.

Strips are good for 180 days after opening or until the expiration date on the bottle.

Control Solutions are good for 90 days after opening or until the expiration date on the bottle.

Other Tips:

The top on the bottle of the test strips must be kept tightly closed at all times.

The StatStrip meter should be held level or slightly downwards when applying a sample.

"HIGH" indicates that the blood glucose reading is greater than 600mg/dl. Repeat the test to make sure it is not a user error and obtain a lab draw if it continues to read "HIGH".

"LO" indicates that the blood glucose reading is below 10mg/dl. Repeat the test, treat the patient, and obtain a lab draw.

Documentation

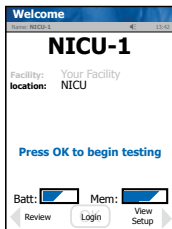
The inform meters download into Meditech once they are put in the base unit. You can find results by either looking under "Laboratory Data" then "Point of Care" or under "Recent Clinical Findings". The only charting done in Meditech is by the RN when using eMAR to administer insulin or an oral agent.



BEDSIDE GLUCOSE MONITORING



Glucose Monitoring System Quick Operating Guide



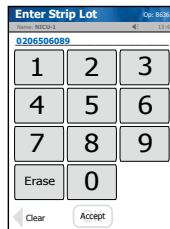
1 From Home screen, press Login.



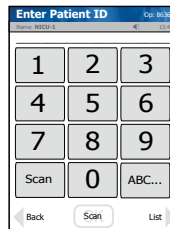
2 Enter or scan Operator ID and press Accept.



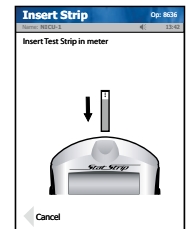
3 From Patient Test screen, press Accept.



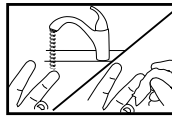
4 Check Strip lot no. and press Accept.



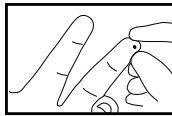
5 Enter or scan Patient ID and press Accept.



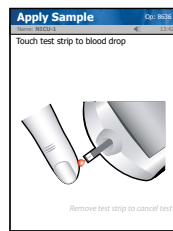
6 Insert Test Strip into Meter.



7 Wash patient's hand thoroughly and massage finger to stimulate blood flow.



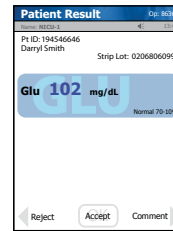
8 Use safety lancet to puncture finger / squeeze finger to form blood drop. Wipe away the first blood drop.



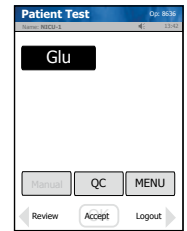
9 Touch strip to blood drop. Result will appear within 6 seconds.

10 Warning!

The test strip must fill completely upon touching the blood droplet. If the test strip does not fill completely, do not touch the blood droplet a second time. Discard the test strip and repeat the test with a new test strip.

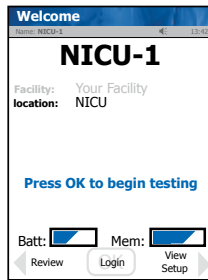


11 To accept result, press Accept. To reject result, press Reject.

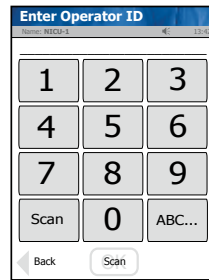


12 To review other results, press Review from Patient Test screen.

Glucose Monitoring System Quick QC Guide



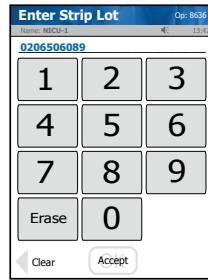
1 From Home screen, press Login.



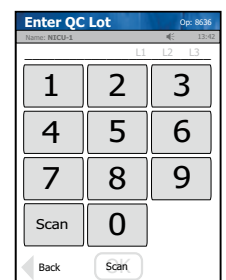
2 Enter or scan Operator ID and press Accept.



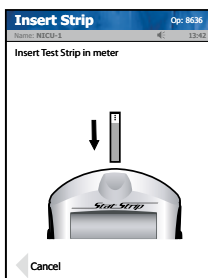
3 From Patient Test screen, press QC.



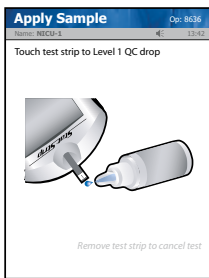
4 Check Strip lot no. and press Accept.



5 Enter QC lot no. and press Accept.



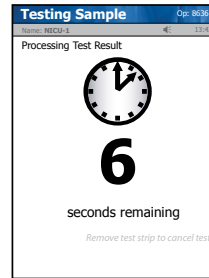
6 Insert Test Strip into Meter.



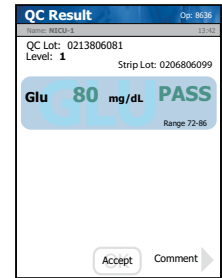
7 Touch drop from QC bottle to strip. Result will appear within 6 seconds.

8 Warning!

The test strip must fill completely upon touching the QC droplet. Do not add a second QC drop to the test strip. Discard the test strip and repeat the test with a new test strip.



9 Result will appear within 6 seconds.



10 To accept result, press Accept.

Policy MM.018

Hypoglycemia Protocol Tips

1. Hypoglycemia Protocol Order Sheet (NEW)

- a. An order must be obtained before utilizing the protocol. This order will be automatic for patients that are on medication to treat their diabetes.

2. Hypoglycemic Treatment Options

Oral Treatment Option

Fast Acting Carbohydrate
(one oral treatment)

- a. 4 oz fruit juice
- b. 4 oz regular soda pop
- c. Glucose Gel Packet*– 15 grams (NEW)
- d. 4 oz applesauce*
- e. 3 packets jelly/jam/honey*

***For patients who can ingest oral intake but are on fluid restriction or dialysis)**

Alternate Treatment Option

Fasting Acting IV or IM glucose

- a. Dextrose 50% for I.V.P (½ amp.)
(For unconscious or NPO patients use IV Dextrose.)
- b. 1 mg Glucagon I.M. or Subcutaneous
(For NPO patients with no IV access.)

Notify MD of treatment from this category immediately or if the blood sugar is 50 mg/dl or below.

3. Blood Sugar less than 70mg/dl

- a. Use one treatment option (listed above) for blood sugar that is <70 mg/dl.
- b. Recheck blood sugar in 30 minutes following protocol.
- c. If blood sugar remains <70, repeat treatment according to protocol.
 - Continue to recheck blood sugar and repeat treatment until blood sugar is greater than 70.
- d. **Notify MD of glucose events.** (This is to ensure that the patient's medication is modified as needed.)

5. When the **treated** Blood Sugar is greater than 70

- a. After treatment and upon attaining a blood sugar that is greater than 70, IF it will be **more than one hour before the next meal**, give the patient a snack of 1 complex carbohydrate and 1 meat/protein. (e.g. ½ sandwich or 2 graham crackers and 1 single serving peanut butter)
- b. Recheck the blood glucose in one hour.

6. Notify MD Immediately

- a. **Notify MD** of treatment immediately if IV Dextrose or Glucagon is given OR if the blood sugar level is 50 mg/dl or below.
- b. If there is no response from the MD within 30 minutes continue the Protocol and initiate the chain of command.
- c. MD may change plan of care.

7. Documentation

- a. All Blood sugar results and treatments must be documented (including juice, gel, applesauce, soda, IV Dextrose, etc.).

8. Glucose Gel Packet-Glutose

(Treatment Options)

Glutose 15 delivers 15 grams of pure glucose for rapid response of hypoglycemia. Available on Override in every Pyxis (NEW)

Directions: To treat a hypoglycemic episode before unconsciousness occurs-

- a. Twist tip off
- b. Squeeze entire contents of the tube into the patient's mouth and ask the patient to swallow.
 - Do NOT administer to unconscious patient or those unable to swallow.
 - Not recommended for children under 2 years of age.

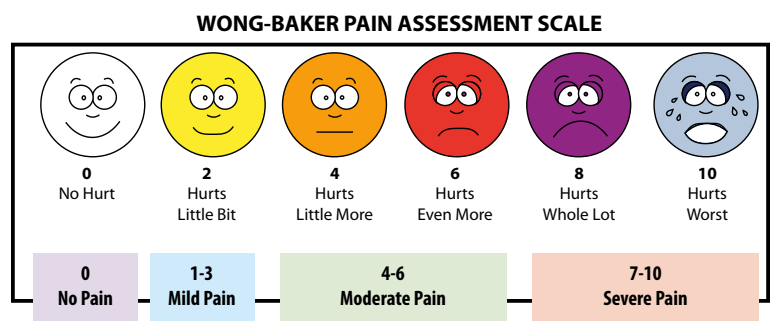
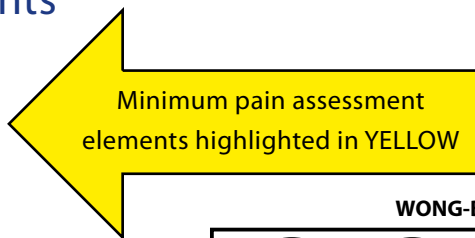
HOW DO YOU EFFECTIVELY MANAGE YOUR PATIENT'S PAIN?

A Pain Assessment is to done at least:

- Upon admission and with routine shift assessment
- Assess patient's pain management history: Do they take pain meds routinely? How do they manage their pain @ home?
- After known pain-producing event
- With each new report of pain
- After each pain management intervention allowing sufficient time for treatment effect to peak (typically within 30 – 60 minutes after intervention); INCLUDE PAIN SCORE
- At report of inadequate pain control

Pain Assessment Elements

- Pain Score (Intensity/Severity)
- Patient Goal for pain control
- Location
- Character (type of pain)
- Aggravating / relieving factors
- Onset & duration



DOCUMENTATION

Category	Scoring		
	1	2	3
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position Moves easily	Squirming, shifting back & forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, scream or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the 5 categories (Face, Legs, Activity, Cry, Consolability) is scored from 0-2, total score between 0 – 10.

FLACC PAIN ASSESSMENT SCALE

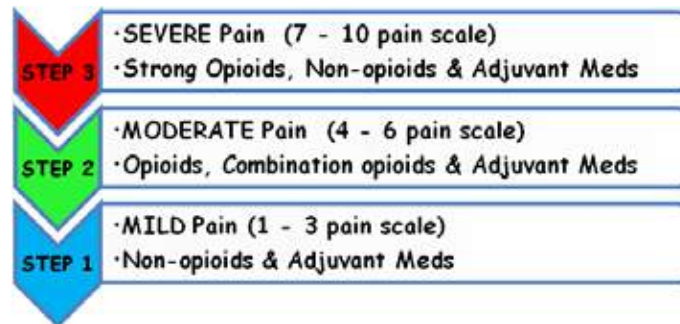
Pain assessments need to be documented in Pain Management Interventions eMar Administration

STRATEGIES for PAIN MANAGEMENT



PAIN MANAGEMENT Most Successful when therapies are used in combination

WORLD HEALTH ORGANIZATION Analgesic Ladder



STEP 1 MILD PAIN (1-3 pain scale)	STEP 2 MODERATE PAIN (4 - 6 pain scale)	STEP 3 SEVERE PAIN (7 - 10 pain scale)
Non-Pharmacological Therapies (see list above)	Non-Pharmacological Therapies (see list above)	Non-Pharmacological Therapies (see list above)
Non-opioids Acetaminophen • Limit dose 4 gm/day Non-steroidal anti-inflammatory drugs (NSAID) • Salsalate (Disalcid) • Ibuprofen (Motrin) • Naproxyn (Naprosyn)	Combination Opioids Percocet (Oxycodone with Acetaminophen) Lortab (Hydrocodone with Acetaminophen)	Strong Opioids Morphine Oxycotin Methadone Hydromorphone (Dilaudid) Fentanyl (Duragesic*) Hydrocodone
Adjuvant Meds Meds that are not typically used for pain, but can be helpful in the management of pain. Antidepressants Sedatives Anti-anxiety meds Muscle relaxants Anti-seizure meds	Adjuvant Meds (see STEP 1)	Non-opioids (see STEP 1) Adjuvant Meds (see STEP 1)

What do you do if your patient's pain IS NOT relieved or if it is "NOT time" for the next dose of pain medication? (Policy 900A813)

- Call Pharmacy and ask for a Pharmacy Consult.
- Consider the need for a Physical Therapy Consult.
- Call the physician to discuss pain management & changing medication orders.
- If the physician does NOT call back within 25 minutes, consider the following options: call AGAIN, utilize your charge nurse/clinical manager or nursing supervisor to assist you in communicating with the physician.
- Consider Non-Pharmacological Therapies such as heat, cold, & review patient's medications: look for non-opioids or adjuvant meds that could be administered.

MEWS

Modified Early Warning System

When Vital Signs-BP, T, P, RR and Level of Consciousness (LOC) are put in the neuron or put in the computer manually, a calculation will be done.



Level of Consciousness

You would put in one of the letters (A-V-P-U) that is appropriate.

A-Alert

V-Responds to Voice (you need to call their name several times before the patient responds)

P-Responds to Pain (you need to shake the patient or squeeze the patient's shoulder muscle before the patient responds)

U-Unresponsive (patient does not respond to any of the above.)

If the calculation determines that the patient's MEWS score is:

***5 or greater**

OR

***the new MEWS score has increased by 2-**

An *ALERT will printout within 15 minutes to the printer in the nurses' station.

At that point the Primary Nurse or Charge Nurse will need to go and assess the patient and then do what is necessary...

This is a tool to help staff to recognize changes in patient status sooner!

Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

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.

NPSG.01.03.01

Make sure that the correct patient gets the correct blood when they get a blood transfusion.

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. Make sure the patient knows which medicines to take when they are at home. 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. Use the goals to improve hand cleaning.

NPSG.07.03.01

Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01

Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify patient safety risks

NPSG.15.01.01

Find out which patients are most likely to try to commit suicide.

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.



This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

SERVICE HABITS

These are the “service habits” that are key expectations for all employees of Central Florida Regional Hospital as we strive to provide excellent service to our patients and their families.

Patient Connection at the Bedside

Incorporate patient connection at the bedside into daily nursing routine at least once per shift -- review plan of care and goals for shift. RNs will begin with shift report and with each succeeding encounter build on previous encounters. Encounters will include sitting at patient’s side with eye level communication and therapeutic touch.

- Knock before entering, use AIEDT patient introduction, sanitize hands
- Listen attentively to the patient
- Avoid acronyms and medical jargon – explain things in a way the patient can understand
- Appropriate touch conveys a sense of caring and breaks down barriers to communication (therapeutic), i.e. handshake, pat, handholding
- Exit room with phrase “Do you need anything else before I go?” and “I will be back in...” – Sanitize hands



Hourly Patient Rounding

Conduct hourly rounding and maintain rounding log and assess 4 key factors; Pain, Potty, Position, Placement

- Make sure to address 4 key factors while conducting hourly rounds and update whiteboard on pain scale.
- If purpose is related to a task, identify the task and duration
- If purpose not related to a task, explain you are conducting hourly rounds to ensure the patient has everything they need.

Whiteboards

Use white boards in all patient rooms. The white board ensures the patient is aware of critical information regarding their stay, such as team of caregivers’ names, times of tests and procedures, etc. Your accountability is to maintain (and/or ensure) accurate and up to date information on the boards in a neat and orderly manner.

- Ask patient if their preferred name may be written on whiteboard
- Ensure timely and consistent use.
- The patient’s nurse is accountable to complete & maintain (and/or) ensure accurate, up-to-date information on boards
- Whiteboard updated during bedside report when outgoing RN introduces incoming RN to patient.
- Discharge Planning section – Case Manager fills in name and phone number
- Expected discharge date – to be left to Case Manager’s discretion to write on board as appropriate.
- Housekeeping section – Housekeeper to write name in the a.m. and extension 31081 or the appropriate contact number.
- Dietary section – Dietary to write contact number.

Patient Introduction

Use key words for initial introduction/all interactions with patients; Acknowledge, Introduction, Explanation, Duration, Thank you.

- Acknowledge – be attentive and greet patient making eye contact – call the patient by name if possible
- Introduction – State your name and department and your role in their care
- Explanation – describe what you will be doing, explain if there will be pain or discomfort and any post procedures instructions – offer to answer questions or concerns and resolve any complaints
- Duration – provide an expectation of how long test or event will take and ensure patient’s family is aware of duration if appropriate
- Thank You – thank the patient for the opportunity to care for them and include the phrase “It has been my pleasure....”. Make sure there is nothing else they need.

Key Words at Key Times








Use key words during key time/interactions with patients. Using key words during interactions with our patients assures them we care about their environment, privacy, and care.

- Privacy & Respect – Ensure curtains are pulled for privacy. Cover patient during a procedure and during escort to another location. Tell them we want to be sure to respect your privacy.
- Transport – When transporting a patient at discharge, thank the patient for choosing CFRH. Tell the patient “It has been our pleasure to care for you. I hope we have exceeded your expectations and we hope you will recommend CFRH to your family and friends.”
- Quietness – Ask patient if they want their door closed slightly to provide a quiet environment. After an “event” on a unit, apologize to patients for the disturbance and tell them we strive to provide a quiet environment.
- Pain Management – When giving medication for pain tell patient what the medication is, side effects, etc. Tell the patient “It is our goal to assist you in effectively managing your pain.”
- Housekeeping Visit – When cleaning patient rooms – Knock, ask permission to enter, introduce self, role, purpose and duration of visit. Ask if this is a good time for the patient.
- Food Delivery – Use patient’s name. When placing the meal tray, ask if patient needs help opening containers or packaging.

No Passing Zone

All staff (regardless of patient assignment) looks for call light signals and respond quickly when a patient has requested help

- Ground rules – NOBODY passes a call light and pay attention to isolation signs
- Non-clinical employees – see if there is something you can do to help or report needs to the charge nurse and/or nurse

Non-Clinical Staff	
Requests Within Your Scope	Requests Outside Your Scope
 Turn overhead light on/off	 Requests for medication
 Move personal items	 Bathroom assistance
Change the channel on the TV	 Food or drink
Provide a blanket	 Addressing any bedside alarms
Assist with using the phone	 Medical / clinical questions

Greetings Janneice, This Art is a client supplied Jpg. Please supply the original art used so your requested changes can be made.

Promote Quietness for Healing

Identify and address opportunities to reduce and/or minimize ambient noise in the care environment, i.e. overhead paging, time of floor maintenance, speak softly, close doors

- Speak softly whenever possible and avoid talking directly outside patients' rooms
- Ensure all beepers and cell phones are on "vibrate only" mode.
- Close patients' doors whenever possible to reduce noise from hallways etc.
- Minimize or eliminate overhead paging
- Dim lights during hours of 8 pm to 6 am

Effective Pain Management

Assess, reassess and manage pain in a timely and effective manner. Pain is a vivid and real issue for our patients that is central to their experience in our hospitals. Effective plans to address and manage pain issues are key to enhanced patient perception of care/service.

- Assess patient's pain and review patient's chart.
- Administer pain analgesic & document pain assessment.
- Assure patient that we will help manage their pain.
- Advise patient of the pain medication you are administering and any side effects.
- Check back with patient within an hour to ensure pain is managed, or more quickly if clinically indicated.
- If patient is still uncomfortable, continue with intervention as appropriate.
- Ask patient if there is anything else you can do to help him/her feel more comfortable.

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Clutter & Cleanliness

Manage cleanliness and clutter at all times. Patients are entitled to expect everything in our hospitals to be clean - not just floors, surfaces, furniture and toilets, but also equipment used in their treatment and care.

- Cleanliness is everyone's responsibility – not just Environmental Services.
- Keep hallways clean and clear of clutter.
- Keep all beds, gurneys, chairs, computers and carts not in immediate use out of the hallways
- Keep all work areas, nursing stations, reception desks and other areas visible to patients and their families organized and neat.
- Do not tape any notes, papers, posters or other written communication to walls, doors, etc.

Repairs & Maintenance

Plant Operations employees round on units, promoting timely response to patient needs. Employees take an active role in ensuring all needs for maintenance and repair are reported to Plant Ops in a timely manner.

- If you see something that needs to be repaired, follow appropriate process to report it.
- Use electronic work orders and repair request books to document needed repairs.

You ARE the difference in the care of our patients. The only way we can live up to our shared commitment and achieve increased performance is if we each take action – every day! This commitment and these "service habits" are not an option. This must be our focus in ensuring we continue to provide the kind of care we want to be known for and know we provide. Everyone's role is to follow each "habit" and remember service is the core of what we do in every patient encounter.

KRAMES ON-DEMAND

QUICK START INSTRUCTIONS

Find and Print a HealthSheet (Three Methods)

Browse Method

- Click BROWSE tab.
- Click on a category or sub-category to view a list of healthsheets.
- Click on the HealthSheet title to view.
- Enter patient's name and special notes in boxes, top left (optional).
- To Print, click the GO (Print is the default action) button.

Keyword Method

- Type search term into search box at top Left; click GO.
- Click on the HealthSheet title to view.
- Enter patient's name and special notes in boxes, top left (optional).
- To Print, click the GO (Print is the default action) button.

Folder Method

- Click FOLDER tab.
- Open the Department or Topic folder you want.
- Click on the HealthSheet title to view.
- Enter patient's name and special notes in boxes, top left (optional).
- To Print, click the GO (Print is the default action) button.

Action Options Boxes (drop down)

- **TEXT SIZE** allows selection from 5 print sizes (Normal is the default).
- **LANGUAGE** allows viewing or printing HealthSheets in any available language.
- **PRINT DUPLICATE** allows printing a duplicate copy.

Find and Print a Drug Information Sheet

- Click MEDICATIONS tab; then click the NAME button.
- Type drug name (brand or generic) into search box; click SEARCH.
- Click the drug name (blue link) on search results page.
- For SPANISH, click the ESPANOL link.
- To Print, click the GO (Print is the default action) button.

Action (drop down) Box

- **PRINT** the current HealthSheet (default).
- **ADD TO EDUCATION CART** stores the HealthSheet in the Education Cart.
- **VIEW IN...**allows viewing HealthSheets in any available language.

Batch Print HealthSheets

- Add selected HealthSheets and Drug Information Sheets to the Education Cart.
- Click EDUCATION CART tab.
- Check boxes next to sheets you want.
- Click PERSONALIZE and PRINT from the ACTION (drop down) box.
- Enter patient's name and special notes in boxes.
- To Print, click the GO button.

RESOURCES FOR INSTRUCTORS AND STUDENTS

Computer Access

When a student is new to the hospital, a computer access will be setup for the student by Staff Development. The setup requires the student's full name, date of birth, and social security number. After the access has been setup, if the student has problems logging in or forgets their pass codes, they will need to call the IT&S Customer Service line at ext. 35629.

In an effort to reduce the time people spend calling the service desk, IT&S has introduced a tool in which people can reset passwords on their own.



If you take the two minutes necessary to create a profile in Password Reset, that allows you to reset your password or unlock your account from any computer. No waiting on hold with the service desk! More time for patient care.

The tool can be accessed several ways:

- 1) By typing passwordreset in an Internet Explorer window
- 2) Double clicking the icon on any workstation Desktop
- 3) Clicking the link on the intranet
- 4) By typing 'passwordreset' in the User name field on a full logon workstation

Atlas keyword: Password Reset

<https://passwordreset.hca.corpad.net/psynch/nph-psf.exe>

eMAR Carts

There are 2 eMAR carts for student use, one for the 2nd floor and one for the 3rd floor. Please NOTE: The carts must be checked out from the Staff Development office on the 1st floor. For computer equipment problems, please contact the IT&S Customer Service line at ext. 35629.

Stat Strip

Each instructor's badge will contain a Statstrip barcode. This barcode can be used by the students during their rotation.

CFRH Intranet

The hospital's policies and procedures are located online in the hospital's Intranet. It can be accessed through an icon on the eMAR cart laptop.

Nursing Procedure Manual

CFRH utilizes Lippincott's Nursing Procedures and Skills as a Nursing Procedure Manual; you may access this resource by clicking on the Lippincott icon on the desktop of the student computer.

Krames On-Demand

KOD is a web-based, print-on-demand patient education system for providing instant access to thousands of high-quality, illustrated patient education topics. All handouts are available in English and Spanish with some available in other languages. Topics cover conditions, procedures, health promotion, disease management, and wellness. There are also 2000 Drug Information sheets for patients.

