Kennedy Health Is now

Jefferson Health

Student Nurse Core Orientation Guide

EDU January 2018

Instructors: Pages 76-78 MUST be graded, signed and returned to Williamae Hazelton, Clinical Education, 3rd Floor, Stratford Campus upon completion

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Professional Practice Model

A professional Practice Model is a schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate and develop to provide the highest quality of care for those served by the organization. (ANCC, 2010)

Our model is represented by the key images of the **lantern, candle** and **heart.**

- The ***base of the lantern*** represents the foundation upon which our practice is built. Nightingale and Watson are the theorists that guide our practice with a strong focus on quality, safety, and compassion. We embrace the concept of relationship-based care and we are committed to fostering relationships with patients, families and colleagues to promote excellent safety and quality outcomes through the implementation of evidence-based practice.

  From this foundation arise the four ***pillars of the lantern***: accountability, collaboration, communication, and leadership. The pillars uphold the ***top of the lantern*** and sustain the mission, vision, and values. Through these supports we are able to realize advancement in professional development and shared governance. This fosters a collegial environment between management and clinical nurses that promotes collaborative decision making related to practice, quality, and competence.

- The ***candle*** is at the center of everything and represents our passion: the patients, families, and community that we serve. Nursing at Jefferson Health is represented by the ***flame***. The light represents our warm and nurturing essence and radiates the values that each team member holds: respect, innovation, excellence, integrity, pride, and service. Through these values we strive to meet the physical, cultural, and spiritual needs of our patients, families, and community.

- The ***heart*** at the top of the lantern is symbolic of our tradition for providing compassionate care to those we serve.

Jefferson Health Nurses Light the Way for our Patients, Family and Community.

The Relationship-Based Model of Care at Jefferson Health

Theorists

Florence Nightingale and **Jean Watson** are the theorists upon which our practice model is built. Nightingale, the first nursing theorist, identified that good health is linked to the **Five Environmental Factors:** fresh air, pure water, efficient drainage, cleanliness, and light. In addition, warmth, quiet environment, and nutrition were key aspects to improving health. Nightingale was the founder of hourly rounding, carrying her lamp as she rounded on her patients. She identified that nursing is both an art and a science. These components remain the cornerstone of the nursing profession.

Jean Watson's **Theory of Caring** takes the basic aspects of Nightingale and builds upon it to incorporate caring, faith, and hope. The major components of her theory infuse the **10 Carative (Caring) Factors:**

1. **Embrace altruistic values and practice loving kindness with self and others.**
2. **Instill faith and hope and honor others.**
3. **Be sensitive to self and others by nurturing individual beliefs and practices.**
4. **Develop helping-trusting caring relationships.**
5. **Promote and accept positive and negative feelings: authentically listen to another's story**
6. **Use creative scientific problem-solving for care decision-making.**
7. **Share teaching and learning that addresses the individual needs and comprehension styles.**
8. **Create a healing environment for the physical and spiritual self which respects human dignity.**
9. **Assist with basic physical, emotional, and spiritual human needs.**
10. **Be open to mystery and allow miracles to happen.**

Caring is the essence of nursing and focuses on the nurse-patient relationship. The essence of nursing care can be experienced in the moment when one person connects to another. Compassion and care are conveyed through our relationships with others. This is the core of nursing practice.

Relationship-Based Care

The framework used to provide nursing care at Jefferson Health is the **Relationship-Based Care Model.** Relationship-based care is built upon principles that encourage engagement of healthcare providers and leaders throughout the organization and promote exemplary performance. Relationships are patient centered, grounded in mutual respect and encompass patients, families, the healthcare team, and one's self. The Relationship-Based Care Model includes three crucial relationships:

1. The relationship between caregivers and the patients and families they serve.
    a. The clinician understands that individual experiences will determine how a patient will face their illness.
    b. The clinician strives to understand what is most important to the patient and actively engages the patient in their care to promote safety, quality, and satisfaction.
2. The caregiver's relationship with self
    a. This relationship is nurtured by self-knowing and self-care
3. The relationship among members of the healthcare team
    a. Quality care occurs in environments where the standard among members of the healthcare team is to respect and affirm each other's unique scope of practice and contribution to promote a culture that supports caring and healing.

Nightingale's and Watson's theories are congruent with Relationship-Based Care and visibly align with the philosophy of nursing and the mission, vision, and values of the organization. Through this model, Jefferson Health nurses serve as patient advocates, putting the patient and family at the center of our work. We strive to make a difference in the lives of those we touch each day.

Resources

Koloroutis, M, Felgen, J., et. al (2004). Relationship-based care: A model for transforming practice. Minneapolis, MN: Creative Health Care Management.

Watson Caring Science Institute& International Caritas Consortium (2013). Caring science (definitions, processes, theory). Retrieved April 28, 2014 from http://watsoncaringscience.org/about-us/caring-science-definitions-processes-theory/

Jefferson Health Nursing's Philosophy

The foundation of our philosophy is built on the work of Florence Nightingale and Jean Watson, which supports the mission, vision, and values of the organization.

Through relationship-based care, nurses are empowered to provide safe, quality care in a respectful, compassionate, and competent manner.

Our focus centers around patients, families, colleagues, and self. Care delivery is defined within the Nursing Professional Practice Model

Jefferson Health System Facilities

In addition to Med-Surg, ICU/CCU, Same Day Surgery, Special Procedures, ED and

Interventional Radiology, hospital campus specialties include:

Cherry Hill	Behavioral Health Services Hypothermia Treatment Primary Stroke Center
Stratford	Acute Hemodialysis ACE Unit (Acute Care for the Elderly) Bariatric Services Hypothermia Treatment Inpatient Hospice (VITAS) Primary Stroke Center
Washington Township	Acute Hemodialysis Women's and Children's Services Neonatal Intensive Care Unit (NICU) Pediatrics Obstetrics Comprehensive Stroke Center Cardiac Cath Lab

Jefferson Health System - Community and Allied Health Services

- Free Standing Surgical Center (WT)
- Health Care Center at Washington (ECF and Sub acute)
- Jefferson Home Care
- Family Health Center (WT & Voorhees)
- Diabetes Control-Outpatient Education (WT/ Voorhees)
- Outpatient Dialysis (WT & Voorhees)
- Wound Care Center (WT)
- Balance Center (WT/ST Campuses)
- Radiation Oncology (WT)
- Bariatric Services
- STAT Transport Services
- Jefferson Medical Equipment
- Senior Services; Support Groups; Wellness Classes
- Life Support Training Center
- The Jefferson Health Cancer Center
- Neurosurgery Service
- Robotic Surgery (WT)
- Sleep Centers
- Orthopedic Care with Rothman Institute

Visiting Hours

8:00 am – 8:00 pm on all Medical-Surgical units.

Children may visit, only if accompanied by an adult. ICU – 8 am to 8 pm unless patient is critical or unstable. No children under 14 years old are allowed in the patient rooms. Children are permitted in the waiting area but can not be left unattended.

Smoke-Free

Jefferson Health System is a smoke-free environment. There is no smoking anywhere on Kennedy Property. Rowan, our neighboring university is now smoke

–free.

Parking: Due to limited parking, students are encouraged to car pool. Please reserve the closest spaces for our patients and visitors.

CHERRY HILL: Off campus parking for day shift (ask instructor for guidelines). Visitor lot after 2pm and on weekends.

STRATFORD: Visitor lot – use furthest parking spaces

WASHINGTON TOWNSHIP: Parking lot at Municipal Building located on Egg Harbor Road. Shuttle service (Mon-Fri) 5:45am- 9am and 2:45pm-8pm

Photo Identification Badges:

All students **MUST** wear their <u>school</u> PHOTO ID badges at all times.

Jefferson Health Dress Code Requirements in the Clinica

- No artificial nails includes Gel Nails and Gel Polish
- No visible piercings, other than earrings
- Tattoos are to be covered.
- Uniform according to school policy

Cafeterias

Breakfast	6:30am - 9:30 am
Lunch	11:30 am – 2:00 pm
Dinner	4:30 pm – 6:30 pm

Telephone Use

- No cell phone use in the hospital!!
- **If electronic devices are used for research for patient care…make sure patient and staff is aware of this use…EDUCATION of patient is essential!**
- Dial "9" for local outside calls
- When answering the phone:
  - State nursing unit, your name and status (student nurse).
  - Write down the message and give to the charge nurse immediately.
  - If the Lab calls to report "critical" test results, give the phone to an RN.
  - **Only an RN may take a message regarding "critical" test results**.
  - Refer all calls about patient's status to the RN. Do not give out any patient information.
- Emergency Calls – if individuals need to contact you, they may call your unit extension and ask for your instructor.

Patient Bill of Rights

Jefferson Health adheres to the New Jersey Department of Health's Patient's Bill of Rights. It is posted in every department, patient room, and in the Patient Information Guide.

Medical Ethics Advisory Consult (M.E.A.C.)

The M.E.A.C. addresses ethical issues or conflicts concerning a patient's care. Anyone with a patient care concern can request an ethics consultation. **Dial "O"** on any hospital phone and ask to speak with someone regarding an ethics consultation.

Jefferson Health Initiatives

- ***AIDET is a framework for communication***
- ***When used consistently it produces meaningful and powerful results!***

KENNEDY HEALTH

- **Acknowledge:**
  - Ask permission to enter patent room
  - Put patient and family at ease
  - Always use the patient's name
- **Introduce:**
  - Tell patient your name, title
  - Tell patient years of experience
  - Manage up yourself
  - Manage up others
- **Duration:**
  - Tell how long you will be there
  - Explain any delay
- **Explanation:**
  - What you will be doing and why
  - What to expect
  - Plan for the future
- **Thanks:**
  - Tell patient – you enjoy taking care of them; your goal is to provide very good care
  - Thank patient and family for using Kennedy

"AIDET"

Ending……..
"Is there anything else I can do for you? I have the time "

KENNEDY HEALTH

As a Nursing Associate, we ask that you consistently practice the following:

- ✓ Follow the **10-5 Rule**
- ✓ Use **AIDET** as a communication tool
- ✓ **Wear your name badge** above the waist
- ✓ **Hourly Rounding** that is **PURPOSEFUL**:
  - ✓Bedside Report that is engaging
  - ✓Accurate use of the White Board
- ✓ **Manage Up:** "See something, say something, do something"
- ✓ Focus on creating **"WOW"** experiences for our patients and their families so they will **ALWAYS** return to and recommend KHS

KENNEDY HEALTH

What is it?

A Program that designates all active call lights as:
"NO PASSING ZONES"

If a patient light goes on, associates MUST ANSWER the active call lights *immediately* even if it is not your assigned patient room

Why Are We Implementing?

- •To Increase Response Time
- •To Improve Safety
- •To Increase Patient Satisfaction
- •To Increase Patient Perception of the Timeliness of the Delivery of Care

KENNEDY HEALTH

Confidentiality of Patient Information (HIPAA)

Federal Law, the Health Insurance Portability & Accountability Act (HIPAA), requires that hospitals and hospital workers follow strict security measures to protect confidentiality of patient health information. Some implications for students include:

- Student nurses and clinical instructors are held to the same standards as all clinical staff at Jefferson Health.
- Never discussing the patient's name, diagnosis, etc. in hallways, elevators, cafeteria, or with family and friends. Even an anonymous discussion can violate confidentiality.
- Keep chart forms, records, reports and computer screens with patient information covered from public view.
- Obtain permission from patients before discussing care in front of their visitors.
- Never discussing patient information in a private place where others can hear. Pull the curtain when another patient is in the room.
- Never disclosing patient information over the phone. Students must refer all callers and visitor inquires to the charge nurse.
- Referring calls or inquires from the media(newspapers/TV, etc.) to the department manager.
- Students may not divulge any clinical information via Social Networking Programs.
- **NO texting on the clinical units**

Student Nurses and Clinical Instructors are required to review the module

"Student Nurse HIPAA Education" and sign/return the Jefferson Health System Confidentiality Agreement

To report HIPAA violations: call 856-346-7500

Student Nurse HIPAA Education

January 2014

Introduction

HIPAA is a federal law that protects the privacy of patients and all information about them.

Health information privacy and security

HIPAA gives patients the right to have their information kept private and secure. It is more than just a good idea-it is a federal law with penalties – even criminal ones – for violations.

HIPAA Basics

Confidentiality of Patient Information

Federal Law, the Health Insurance Portability & Accountability Act (HIPAA), requires that hospitals and hospital workers follow strict security measures to protect confidentiality of patient health information. Some implications for students include:

- Student nurses and clinical instructors are held to the same standards as all clinical staff at Kennedy.
- Never discussing the patient's name, diagnosis, etc. in hallways, elevators, cafeteria, or with family and friends. Even an anonymous discussion can violate confidentiality.
- Keep chart forms, records, reports and computer screens with patient information covered from public view.
- Obtain permission from patients before discussing care in front of their visitors.
- Never discussing patient information in a private place where others can hear. Pull the curtain when another patient is in the room.
- Never disclose patient information over the phone. Students must refer all callers and visitor inquires to the nurse.
- Refer calls or inquires from the media(newspapers/TV, etc.) to the charge nurse or nurse manager.
- Students may not divulge any clinical information via Social Networking Programs. There should be NO texting on the clinical units.

To report HIPAA violations at Kennedy Health System call 856-346-7500

HIPAA and You

As a student nurse you will have constant access to patient information. Besides caring for patients you may regularly see confidential patient information, interact with family or visitors or handle discarded notes or other papers containing patient information. So it is important for your to understand what HIPAA requires in terms of privacy and security.

PHI

What does it stand it stand for?

HIPAA protects patient health information.

Protected health information is known as "**PHI**".

What does it include?

HIPAA sets rules for when and how healthcare staff members may use or release patient's PHI. PHI includes any health-related information that can be lined to a specific patient. This includes demographic and financial information, (such as address, insurance ID number) as well as health information such as diagnosis code. PHI takes many forms such as paper, oral or written.

Medical Information

Medical Information

PHI also includes medical or health-care related information if it can be one specific patient, including:

a. Information regarding the patient's current, past or future health condition, treatment or medications.
b. Testing results
c. Discharge planning information such as physical therapy or home health visits.
d. Billing information

Treatment, payment and healthcare operations

HIPAA permits healthcare staff members to use and share PHI to do their job for three reasons without needing patient permission:

a. Treatment
b. Payment
c. Operations

Case Scenario 1: Celebrity Sighting

A famous celebrity arrives at the hospital – you walk into the patient's room and are surprised to see this celebrity in the hospital bed.

What do you do?

Celebrity Sighting– (continued)

Later that morning while you are on break in the cafeteria, you ask around to see if anyone knows why he is in the hospital.

Two other staff members overhear your conversation. The three of you start to talk about the rumor that he is really dating the local sportscaster.

Celebrity Sighting – (continued)

The BIG question…….

This chit chat seemed harmless because it is among fellow students/staff members who all work at Kennedy. It's not like you are going to go home and tell your neighbor that you met Mr. Big. There's no harm no foul as you didn't do anything inappropriate.

Or did you?

Celebrity Sighting - (continued)

THE ANSWER:

In a word, **YES.** You shouldn't have revealed that this celebrity was a patient. It was inappropriate for you to talk about this individual since your fellow students/staff members may not be involved in that patient's care. Additionally, this conversation wasn't part of your student nurse responsibilities and it took place in a very public area – the cafeteria.

This is a violation of the patient/celebrity's right to privacy. You are **ONLY** allowed to use, disclose or tell someone PHI when it is necessary for your job. Otherwise, disclosing information about a patient that you have no responsibility for, is prohibited.

Famous Cases

Here are some famous cases in which healthcare staff members have violated a someone's right to privacy:

- In March 2008, the UCLA Medical Center fired 13 employees and suspended 6 others for snooping in Brittany Spear's medical records.
- In April 2009 Kaiser Permanente fired or suspended 45 employees for snooping in the new octuplet's mother's medical record
- In July of 2011, the University of California at Los Angeles Health System agreed to settle potential HIPAA violations for $865,000, resolving two separate complaints, filed with the Office of Civil Rights (OCR) on behalf of two celebrity patients who received care at one of their healthcare facilities.

Minimum Necessary

Need to Know

Only staff members who "need to know" PHI to do their jobs may have access to it. HIPAA requires healthcare workers to use or share ONLY the "minimum necessary" information to do their jobs. Ask yourself the following questions before looking at patient information:

- Do I need this information to do my job?
- What is the least amount of information to do my job?

Examples of using minimum necessary and need to know standards

You may need to know dietary information about a particular patient to your job. But you probably don't need to know other medical information about the patient to do your assigned tasks. Therefore, do not look at other information about this patient, or any other patients.

Or perhaps you come across some discarded test results as you are cleaning a room after a patient has been discharged. Don't look at the information since you do not have a need to know about this patient. If you should recognize this patient's name , remember you must keep this information to yourself.

Privacy

Don'ts for protecting privacy

- Do not discuss patients with anyone except when necessary for work-related purposes.
- Do not share information that you accidentally overhear or see with anyone who doesn't need to know the information to do his or her job.
- Do not discuss a patient's condition or treatment with family members or other visitors. Instead, politely, refer these people to the clinical staff member who can handle their questions appropriately.

Discarded patient information

Don't throw away patient information in a wastebasket without shredding it or following the organization's procedures for destroying confidential information. The wastebasket could get knocked over, or the contents could fall off a recycling truck and blow down the street.

If you should come across PHI in a trash bin , left unattended on a countertop or discarded in some other way, you should tell your clinical instructor or another person in authority so the PHI can be disposed of properly.

Case Scenario 2

Sometimes you just want to share…

You deliver lunch to a patient that you recognize is your parent's neighbor. You chat with the patient for a few minutes to catch up on "old times" and then go back to work. You are careful not to ask the patient about why she is in the hospital.

Case Scenario 2 - (continued)

Later that evening when you return home you call your mother and you tell her that you saw her neighbor today at the hospital.

Should you have shared this information with mom?

Case Scenario 2 - (continued)

In a word, **NO**, you should not have shared anything about the neighbor's visit to the hospital with your mom.

Chatting with the patient is okay as long as she initiates the conversation. But you should absolutely **not** tell your mother, or anyone else that you saw the patient as it is a HIPAA violation to share information you learn at work with people outside the hospital. Consider that the patient may not want your mother or anyone else for that matter to know that she has been hospitalized.

Again, you shouldn't share patient information with anyone who doesn't have a need to know it. This includes your family members!

Patients and HIPAA

Patient Directory

A patient directory is a list of patients within a facility. It provides certain information to people, including visiting clergy, family or friends, who ask for the patient by name.

Directories are permitted by HIPAA to include the following information:

- Name
- Location
- General Condition

Patients do not have to be included in the directory if they do not wish to be listed. If a patient choses not to be listed in our facility directory their name will not be listed on our census. Should you know that an individual is in the facility, but is not listed on the census **you cannot acknowledge that the patient is in the hospital.**

Family and Friends

HIPAA requires hospitals and other healthcare providers to get permission from a patient before sharing PHI with the patient's family members or friends. At Kennedy patients are provided a Confidentiality Code which is a unique 4 digit code that they can share with the individuals they designate to receive PHI. Without this code only general information such as the patient's condition and location.

Even if the family member has "the code" be careful NOT to provide a patient's family or friends with information you learn while doing your job. If the patient or their family or friends ask you do so, alert the nurse or another staff member who is caring for the patient so that he/she can provide the assistance the patient requires.

Handling Patient Requests

What if a patient asks you to get him a copy of his medical record or update his contact information?

- As much as you would like to assist the patient with his request you need to talk to a nurse or another staff member who is caring for the patient.
- Student nurses should never copy or print any part of the medical record to give to a patient.

High-Risk Situations

Elevators, lobbies and other public areas

There are high-risk areas where you might be tempted to ask about a patient, probably without realizing the risk. Remember these places and situations where it is probably appropriate to discuss PHI. Elevators can be convenient place to talk as you go from floor to floor, but it is probably impossible for outsiders to avoid listening in.

Classroom and Labs at your school: Specific patient information such as name or other identifying information should **NOT** be discussed in the academic setting. When discussing a patient's condition for educational purposes only general non-specific clinically relevant information should be shared in a private location.

Lobbies or other public places – DO NOT TALK about patients in public places, such as cafeterias, parking lots. Be sure to keep your voice low or move to a private place if all possible.

Printouts – DO NOT LEAVE printed information lying around, and file it or dispose of it properly when you are finished. **Never** take PHI outside clinical facility.

Protecting Physical Security

You can help protect physical security by doing the following:

- Do not use a computer unless you have authorization to do so and you have been given your own user ID (sometimes called username or logon ID).
- If you need to use a computer to do your job, keep your computer screen tilted away from public areas or use a privacy screen. Log off the computer when you finish.
- If you see disks or CDs lying around that may have PHI on them, turn them over to your clinical instructor or the charge nurse.
- If you work with PHI, don't leave information lying around. Always remember to turn papers over that contain PHI so that this information is out of public view.
- Always use the shredder boxes located throughout our facilities when disposing of documentation that contains PHI. **NEVER** put patient information into waste baskets.
- If you see unprotected PHI as you do your job, turn it over to your clinical instructor or the charge nurse.

Consequences for Breaking the Rules

Fines – Breaking HIPAA's privacy or security rules can mean either civil or criminal penalties. Under the HIPAA Omnibus Final Rule, civil monetary penalties range from $100 to $50,000 for each violation, not to exceed $1.5 million for all such violations in a calendar year.

Criminal and Civil Penalties – Criminal penalties for wrongful disclosure of patient information can include not only large fines , but also prison time.

Severity: The criminal penalties climb as the severity of the offense increases. For example selling treatment information about a celebrity's hospital visit to the local news media, or using your job to gain access to patient's financial and/or insurance information and then selling it to identity thieves may carry a much stiffer penalty than gabbing about the celebrity in the cafeteria. Penalties for these types of violations can go as high as $250,000 fine and 10 years in prison.

Reporting Violations and Getting Help

Kennedy expects that it's entire workforce which also includes our volunteers, medical and nursing students/instructors, etc. to adhere to its privacy and security policies, but it recognizes that some people may break the rules. Under HIPAA, part of our responsibility as an organization is to monitor compliance and investigate any breaches or privacy/security complaints.

Report violations and suspected violations

You should report violations and suspected violations to our Privacy Office or Corporate Compliance Office by calling 1-855-235-1959.

Do not fear retaliation

If you should report a violation or a suspected violation you should not fear retaliation. In fact, consider it as being part of your job to report instances in which you suspect that someone is violation our privacy and security policies.

Conclusion

As you do your job keep in mind the importance of patient privacy and security. It is not enough for Kennedy to have the right policies for protecting privacy. Your must follow those policies and take an active role our compliance efforts.

Parting Notes

- Protecting patients' privacy and confidentiality is part of everyone's job.
- The next time you overhear or see a privacy violation, be empowered to bring this situation to your clinical instructor or a staff member's attention.
- Lastly, always remember to value the privacy of others the same way you want the confidentiality or your private health information to be respected.

We thank you for your time and commitment to protect our patients' health information.

COBRA and EMTALA Laws

- **COBRA** stands for the Consolidated Omnibus Budget Reconciliation Act.
- **EMTALA** stands for the Emergency Medical Treatment & Active Labor Act.

- All individuals who come to the Emergency Department seeking care must receive an appropriate medical screening exam regardless of their ability to pay.
- All individuals seeking emergency care at a hospital point of entry other than ED (OB, Admissions, etc.) must be given some sort of screening examination to determine if an emergency medical condition exists.
- A medical screening examination must never be delayed by placing phone calls to request pre-authorization from insurance companies for treatment.
- If you encounter a person in the hospital asking for directions to the ED or who is experiencing a medical problem, you must assist them to the ED.
- If an individual arrives on hospital grounds but is not technically in the ED, that person is considered to have come to the ED and is entitled to receive a medical screening exam

Infection Control Guidelines

Proper HANDWASHING and drying are the most effective means of infection control. Wash your hands even if you wear gloves. Change gloves between patients and wash your hands! Waterless, alcohol-based sanitizer is also available in designated locations on patient care areas.

Isolation: Follow the directions on the specific isolation sign posted outside the patient's room regarding proper protective equipment to wear before entering.

Types of Isolation

- **Standard Precautions**-used for all patients regardless of disease or condition
- Contact Precautions- (grey sign)
- Contact Precautions-(green sign) for clostridium difficile (C-diff)
- Airborne Precautions – (peach sign) N-95, TB fit tested mask necessary. **Student nurses will not be assigned to a TB or airborne precaution patient.**
- Droplet Precautions (blue sign)
- Neutropenic Precautions – (white sign)

What to do if a blood borne pathogen exposure occurs (needle stick, etc.)

- Notify your instructor and the unit manager immediately.
- Together, fill out a Healthcare Incident Report **(QUANTROS is our electronic incident reporting system).**
- Fill out the BSE (Body Substance Exposure) "Lab Only" form.
- Blood work will be drawn from you and from the patient.

PPE Use for Sterile Procedures Outside of the Operating Room

- **Signage - " STOP - Do Not Enter – Sterile Procedure in Progress"**
- Gowns – sterile gowns required if at the sterile field
- Eye Protection – if directly involved with procedure or observing
- Face mask – Required for all entering the room
- Hat – Required for all entering the room
- Gloves – required if involved in procedure. Sterile gloves if involved in sterile procedure

Limit the number of times staff need to enter patient room during the sterile procedure.

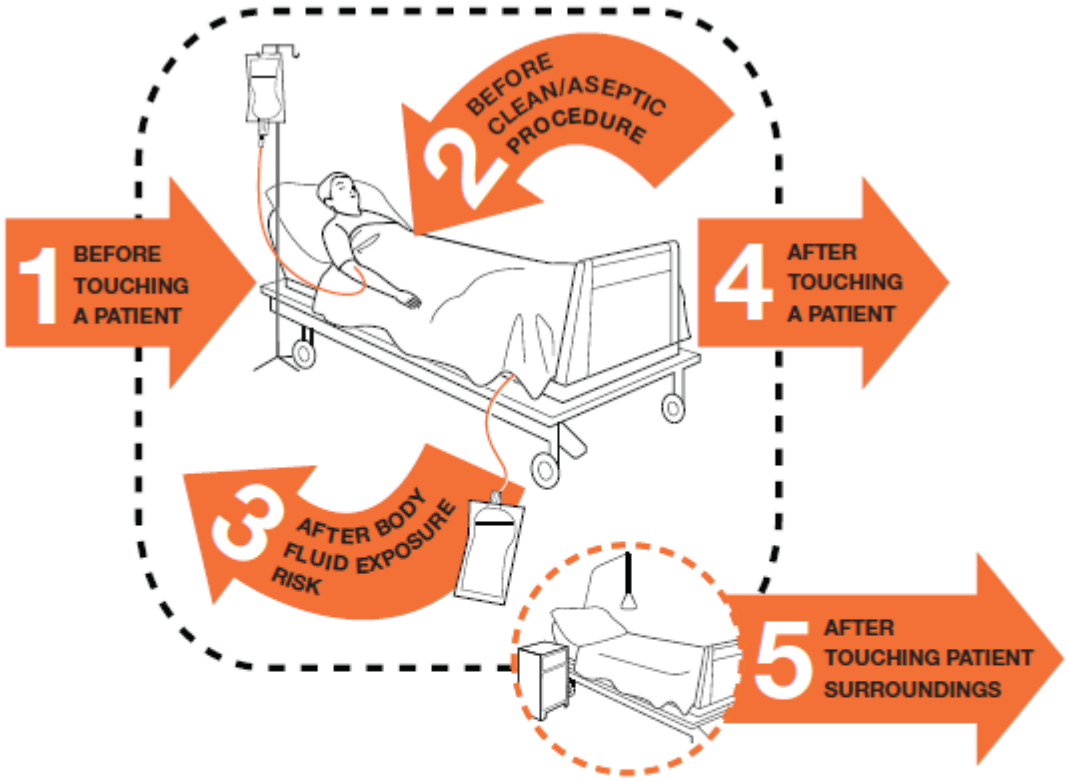
Hand Hygiene Guidelines

When to use Soap and Water *Antimicrobial or non antimicrobial soap may be used*	**When to use Alcohol-Based Sanitizer**
1. When visibly soiled with blood, urine, or other body fluids	1. Before having direct contact with patients
2. Before and after using a restroom	2. Before putting on gloves when inserting a central intravascular catheter, indwelling urinary catheter, peripheral vascular catheters or other devices that do not require a surgical procedure
3. If exposure to Bacillus anthracis is suspected or proven. Spores respond poorly to alcohol preparations.	3. After contact with body fluids or excreta, mucous membranes, non intact skin, and wound dressings if hands are not visibly soiled (Gloves should be worn)
	4. When moving from a contaminated body site to a clean body site during patient care
	5. After contact with inanimate objects including medical equipment, in the immediate vicinity of the patient
	6. After removing gloves

Handwashing Procedure

Soap and Water	**Alcohol-Based Sanitizer**
1. Wet hands with warm water. Hot water may increase the risk of dermatitis.	1. Apply product (about a dime size) to palm of hand.
2. Apply adequate soap.	2. Vigorously rub hands together, covering all surfaces of hands and fingers, until hands are dry.
3. Vigorously rub hands together for at least 30 seconds covering all surfaces of hands and fingers.	
4. Rinse hands with water and dry thoroughly with a disposable towel.	
5. Use the towel to turn off the faucet.	

Remember the 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

Infection Control is everyone's Responsibility and Foley catheters must come out in 48 hours *except:*

1. Bladder outlet Obstruction
2. Incontinent with Stage 3-4 Pressure Ulcer
3. Strict I / O
4. Immediate Post- Op
5. End of Life Request
6. Irrigation / Installation of Bladder Medication
7. Neurogenic Bladder

SAFETY

Material Safety Data Sheets (MSDS)

- Have been standardized for consistent information regarding chemicals world wide.
- This is known as the "Globalized Harmonization System" of classification and labeling or "GHS".
- Now called "Safety Data Sheets" (SDS)
- Refer to the MSDS for information regarding each hazardous chemical in your area.
- Know the location of your unit's MSDS sheets (hint: they are on-line)!

Equipment Safety

- Never use broken equipment.
- Take equipment out of use, place a label, describing how it is broken, and report it to your primary nurse or the manager. A request for repair must be completed.
- Oxygen tank storage: Empty and partially full O2 cylinders should be stored in "**red**" rack. Only full O2 cylinders should be stored in "**green**" rack

Radiation Safety

When you see a radiation safety sign on the door of a patient's room, make sure you check with the nurse prior to entering. Pregnant associates or visitors should NEVER enter the room of a patient receiving therapeutic radiation. Students are not assigned patients receiving therapeutic radiation.

Emergency Codes

To report an emergency in the hospital:

Dial **2222**

from any phone and indicate code and location of code.

Code ***Red***	Fire
Code ***Blue***	Cardiac Arrest
Code ***White***	Pediatric Code
Code ***Triage***	Disaster
Code ***Orange***	HazMat Incident
Code **Gray**	Security Alert
Code ***Amber***	Abduction
Code ***Brown***	Fire Alarm not operable
Code ***Yellow***	Bomb Threat
Code ***Green***	All Clear
Code ***ECHO***	Elopement
Code ***45***	Intruder with a weapon
Tier 1 Alert	Patient Behavior Escalating

Code Red = Fire

To call a Code Red: (WHEN YOU SEE SMOKE OR FLAME)

- Dial 2222, tell the operator **"*Code Red - the Nursing Unit - Campus*"**
- Pull the nearest fire alarm pull box.

Code Red Procedure

- Close all doors (to contain smoke).
- Visitors are to remain on the nursing unit.
- No one is to use the elevators.
- Wait in your assigned area for further instruction.

"R.A.C.E." for fire emergency procedure

Rescue – people in immediate danger
Alarm – sound the alarm
Control – control or confine the fire
Extinguish – extinguish or evacuate

"P.A.S.S." to operate a fire extinguisher

Pull – pull the pin on the handle
Aim – aim the nozzle at the base
Squeeze – squeeze the handle
Sweep – sweep from side to side

Code Blue = Cardiac/Respiratory Arrest

Code White = Pediatric Cardiac/Respiratory Arrest(<100 pounds)

Dial **"2222"** from the bedside or nearest phone.

When the operator answers, state*, "Code Blue ……. Unit …….. Campus……"*

- If you hear a Code Blue announced on your unit
  - Bring the code cart from the nursing station to the patient's room.
  - The defibrillator must be UNPLUGGED before moving the code cart.

- Members of the "Code Team" who will respond to Code Blue include the
  - Resident/intern.
  - Nursing supervisor.
  - Charge nurse; patient's nurse.
  - ICU/ED nurse.
  - EKG Technician.
  - Respiratory therapy tech.

- The student nurse's role in a Code Blue may include
  - Performing CPR.
  - obtaining patient's chart, foot stool, IV pole, or other equipment
  - assisting with the other patient in the room or elsewhere on the nursing unit

Do Not Resuscitate (DNR) Orders

- Physician must order "Do Not Resuscitate" on the patient's electronic order sheet and document the patient/family's DNR decision in the progress notes.
- The DNR order will display on the Current Orders Screen and is the first tab in the nurse's Clinical Summary view.
- Purple "DNR" bracelet is applied by the RN

Rapid Response Team (RRT)

A Rapid Response Team is a group of healthcare professionals who respond quickly to any threatened clinical deterioration.

<u>When is an RRT called? When there is (a)</u>

- <u>any</u> concern about a patients clinical presentation
- change in blood pressure
- change in heart rate
- chest pain
- change in mental status
- seizure
- respiratory distress
- decreased urine output

<u>Who can call an RRT?</u>

Anyone
Students
Healthcare workers

Medical Personnel
Patients
Families and Support people

How is an RRT called?

- Dial 2222
- State you need the RRT activated
- The team will respond in less than 5 minutes

Members of the RRT team include the

- ICU resident
- critical care registered nurse
- critical care respiratory therapist
- nursing supervisor

Student role in RRT

- If students/ instructor call the RRT, be prepared to provide up to date clinical data on the change in the patient's medical condition.
- If the RRT is NOT on your assigned patient, accept direction from the RN leading the RRT Response team.

OB Emergency Response Team (OBERT) – *Washington Twp. Campus Only*

Activated for any obstetrical emergency that occurs in any area of the hospital

Similar to medical RRT – pre-designated personnel responding that are necessary for any obstetrical emergency.

Jefferson Health in Washington Township is now a Comprehensive Stroke Center

Stroke Alert

This is a medical emergency! At Jefferson Health, we can call an RRT and then overhead page "Stroke Alert to (name of unit) as time is critical to restoring oxygen to the brain.

When is an Stroke Alert called? When there is (a):

- **SUDDEN** numbness or weakness of the face, arm or leg—especially one side of the body
- **SUDDEN** confusion, trouble speaking or understanding
- **SUDDEN** trouble seeing in one or both eyes
- **SUDDEN** trouble walking, dizziness, loss of balance or coordination
- **SUDDEN** severe headache with no known cause

What can YOU do?

- **F** Face: Ask the person to smile
- **A** Arms: ask the person to raise both arms
- **S** Speech: ask the person to repeat a simple sentence
- **T** Time: call RRT then Stroke Alert

"DON'T STALL MAKE THE CALL!"

Sepsis Alert

- The Need for SPEED! Time is Tissue….
- Early identification and intervention produces optimal clinical outcomes.
- **Screening Criteria:**
  - Temperature < 96.8 or > 101
  - HR > 90
  - Respirations > 20 or PaCO2 < 32 mm Hg
  - WBC's > 12K, < 4K or > 10% Bands
  - Acute change in mental status
- **Along with:**
  - Clinical suspicion of infection
  - Systolic blood pressure < 90 mm Hg

Aggressive treatment is started immediately. This therapy includes aggressive fluid resuscitation along with antibiotics and often IV pressors.

Early Recognition of Sepsis

STEP 1

Assesses Patient Upon Arrival and Each Time Vital Signs are Taken.

Respiratory Rate > 20	YES	NO
Heart Rate > 90	YES	NO
Temperature < 36 (96.8) or > 38 (100.4)	YES	NO

If you circled "YES" to *ONE* or NONE, the evaluation is complete and no further action is necessary.

BUT, if *TWO* or *THREE* are "YES," then **ALERT** the nurse to perform Step 2.

STEP 2

RN Assesses Patient After Being Alerted by CNA/Tech.

Check blood pressure and lab work		
Is MAP < 65	YES	NO
Is WBC < 4 or > 12	YES	NO

If **BOTH** of the above are **"NO,"** then page the Primary Team or overnight Intern to alert them SIRS Criteria has been met for this patient, and to request a STAT Lactate. If no CBC done, call doctor for STAT CBC. If no response received, call RRT.

If **EITHER** of the above are **"YES,"** then immediately call a **RAPID RESPONSE** for Sepsis Evaluation.

Spiritual and Terminal Care Considerations

- Locate the patient's advance directive and follow the patient's wishes.
- Consider religious beliefs. Offer to contact an appropriate clergy member.
- Provide emotional support, information, privacy, dignity and comfort to the family.
- Identify the psychological stage of dying and offer appropriate interventions.
- See the Comfort Care Policy C-12 (Nursing Standards Manual).

Fall Prevention / Fall Protection Bundles

Fall risk is assessed **every shift**, and documented in the electronic shift assessment. The Morse Fall Assessment Scale is used to assess every patient coming into the hospital. The Fall Risk assessment must be communicated using SBAR format during Bedside Report.

All patients are placed on **STANDARD FALL PREVENTION/ PRECAUTIONS** which include:

- Personal care items within arm length

- Maintain a clear path to the bathroom, closet and exit
- Ensure bedside commode/urinal is positioned next to bed if indicated
- Keep room clutter to a minimum
- Instruct patients in medication time/dose, side effects, and interactions

If the patient is assessed as being at risk for falling, the **FALL PROTECTION BUNDLE** is initiated. The acronym "**S T E A DY"** is useful to remember the interventions.

- **S**ignage - *In place*
- **T**oileting program – *Purposeful hourly rounds*
- **E** ngage everyone – *Whiteboard*
    - Patient activity level written on all white boards
    - Patient and family teaching on fall prevention *using the Teach Back Method*
- **A** larm – *Activated*
    - Alarm activation on beds / chairs / and personal alarms
- **D** iscuss – *Beside report*
    - Fall information completed at every walking rounds hand off to include:
    - environment is free of fall hazards
    - use of *low bed* if appropriate
    - discussion regarding last pain medication
    - current fall risk score **(TO BE ASSESSED EVERY 12 HOURS) and reassessed if there is a fall.**
- **Y** ellow – *Yellow fall risk bracelet and yellow socks*

All Falls must be documented in QUANTROS our incident reporting system…

Maintaining Skin Integrity

- Assess the entire skin surface every shift and in the assessment chapter for skin.
- Refer and utilize the Braden Scale for risk assessment and corresponding interventions.
- Speak to the instructor /co-assigned RN for additions and changes to the patients plan of care for accurate electronic documentation.
- Reposition patient every 1 hour while in the chair.
- Refer to the Skin Breakdown Prevention / Wound Care policies. Must be assessed **daily**!
- **Consulting the Wound Care Nurse is a nursing order, no physician order required.**

Cultural Diversity and Respecting Cultural Normality for patient care

Assess patients and family's specific beliefs and responses to

- Death, dying and mourning
- Pain
- Food and dietary practices/preferences
- Blood transfusions/organ donation
- Medications
- Sexually-related diagnoses and treatments
- Pregnancy and childbearing

- Communication Assessment must note presence of any barriers to be noted on admission
- We offer patients the use of the AT&T *Language Line* (obtained from Guest Services), to access an interpreter for many languages. We also have communication boards for patients.

Avoid using a family member to translate for informed consent issues.

Assistance for the hearing impaired is also available from Guest Services.

Communication is more than use of the Language Line

- Do they understand English? Speak English? Or have limited English proficiency?
- Disease process or interventions interfering with communication abilities?

Contact Guest Services/Supervisor to obtain a phone.

Pain Management Considerations

- Pain is assessed/documented using either the Severity Scale (0= none; 10= worst) or the FLACC (non-verbal) scale.
- Pain is assessed upon admission, every shift, and as indicated by the patient's diagnosis or condition.
- Alternatives and adjuncts to pain medication are incorporated into the individualized patient's care plan. When assessing the patient for pain, include information and interventions that have worked in the past for the patient.
- After the patient receives pain medication, assess/document the response within 30-60 minutes…**DOCUMENT REASSESSMENT!**
- Pain is considered the 5th vital sign at Jefferson Health and must be assessed with vital signs and documented appropriately in the **PAIN ASSESSMENT chapter in SOARIAN.**

Patient Colored Wrist Bands

Color	Text on Band	Purpose of Band	Who identifies?	Who applies?
Red	Allergy alert	Identify patient allergies	Registered Nurse	Registered Nurse
Yellow	Fall Precautions	Identify fall risk patient	Registered Nurse	Registered Nurse
Hot pink	Do Not Use This Extremity	Identifies patients with compromised circulation	Registered Nurse	Registered Nurse
Purple	Do Not Resuscitate	Identify patients with an order for Do Not Resuscitate	Registered Nurse	Registered Nurse
Green	Latex Allergy	Identifies patients with a latex allergy	Registered Nurse	Registered Nurse
White with Red Text	No Blood	Identifies patients enrolled in Blood Conservation program	Registered Nurse	Registered Nurse
Blue Typenex	Nurse handwrites patient information on the band.	Identify patients who have had blood drawn for a Type and Screen	Individual drawing blood specimen for Type and Screen	Individual drawing blood specimen for Type and Screen
Red Typenex	*"NM"* handwritten by nuclear medicine technician	Identify patients who have had blood drawn for a nuclear study	Individual drawing blood specimen for nuclear testing	Individual drawing blood specimen for nuclear testing

Family Colored Wrist Bands

Color	Text on Band	Purpose of Band	Who identifies?	Who applies?
Blue	Patient's identification label	Identifies parent/legal guardian of a minor	Registered Nurse	Registered Nurse
Orange	Labor and Delivery Visitor	Identifies support persons for the patient	Registered Nurse	Registered Nurse
Navy Blue	NICU parent	Identifies parent of the neonatal intensive care patient	Registered Nurse	Registered Nurse

Waste Disposal Colors

Red Bags **(Regulated Medical Waste)**	**More than 20 ml's of blood or grossly bloody dressings**
Blue Bags	All linen is considered contaminated; only fill linen hampers ¾ full.
Clear Bags	Regular trash and recyclables; IV bags and tubing
Black Bags	Papers with patient information
White Bags	Chemotherapy waste

Linen Use in Patient Care Areas

DO:

- change bed sheets daily; save thermal blanket for on-going use.
- use 1 towel per bath.
- use a draw sheet for moving the patient up in bed and to cover patier transport.
- use pillows, not blankets, for positioning.
- place all/any soiled linen in the blue "Soiled Linen" hamper.
- place defective linen in the "Reject Linen" bag.

Basic Bed Linens

- Knit contour bottom sheet
- Draw sheet
- Top sheet
- Thermal blanket
- Pillow with case

DO NOT:

- store/hoard linens in patient's rooms.
- change thermal blankets every day – only when soiled.
- use towels for other than patient bathing.
- throw any linens in the trash.
- use snap gowns unless patient has an IV or is on Telemetry.
- change sheets on the bed of a patient to be discharged that day(just tidy them).
- use multiple thermal blankets – add warmth by placing another sheet or bath blanket on patient.
- send bassinet blankets or infant undershirts home with the baby's family.
- remove scrubs from facility premises.
- **Reusable Underpads**
- Used only for incontinent patients in bed, chair, wheelchair or stretcher.

- Use ONE at a time on patient's bed.
- Replace them only when damp or soiled.
- Use to move patient up in bed/chair.
- Place in soiled linen hamper.

Giving Medications

Medications are to be given ONLY under the direct supervision of your instructor.
Stock and controlled medications are dispensed from the AcuDose Rx cabinet.
The instructor will have access to the AcuDose cabinet.

- Take the Work Station on Wheels (WOW) to the patient's bedside and match **2 forms of the patient's I.D. – NAME and DATE OF BIRTH** - and Allergies before giving medications. Ensure each step in the MAK administration process is followed. The instructor will document the medications administered by the student in MAK. Two RN's are required to check doses of "High Alert" IV infusion (drip) medications PPINCH POLICY – PCA, Potassium and electrolyte replacement, Insulin, Chemotherapy (not to be assigned to student nurses) and Heparin – see policy! Now **PITOCIN** is considered a high alert medication) **(High- Alert Medication Policy H-1)**
- **Student Nurse may care for patients with PPINCH meds, just may not manage the medication.**
- Watch out for "Look Alike-Sound Alike" (LASA) drugs (see list posted on units).
- Communicate any issues to the primary nurse when administering medications.
- A medication error must be reported immediately to the physician and the nurse manager. The physician must assess the patient. A hospital **QUANTROS** report is required.

> - Timeframe for administration of scheduled medications is **60 minutes** before and after scheduled time.
> - Antibiotic administration **is 30 minutes** before or after scheduled time.

Adverse Drug Reaction (ADR) Form If you suspect an ADR:

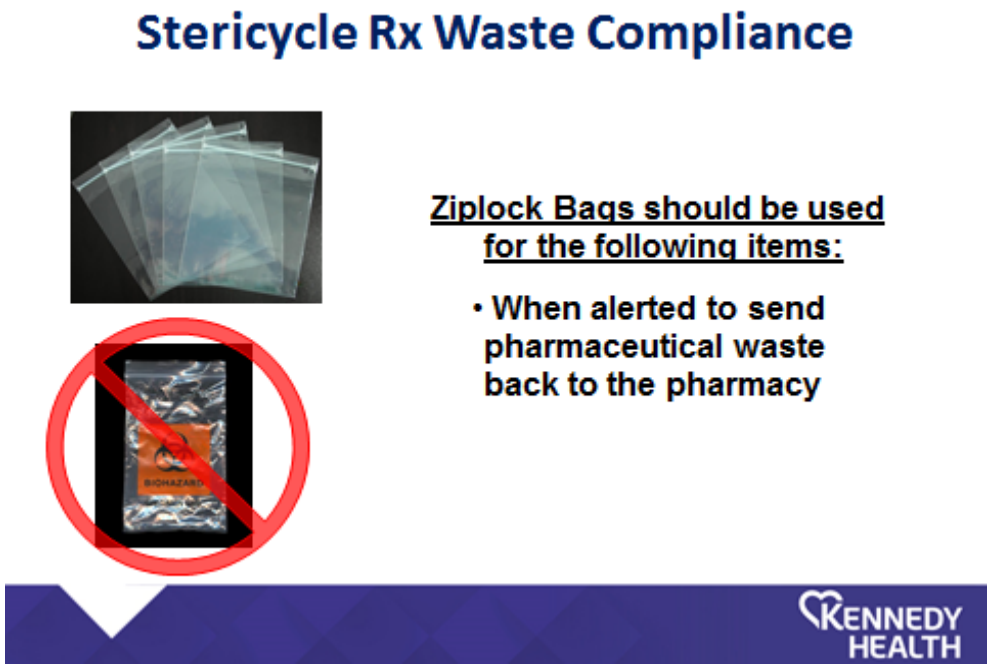
- ✓ Notify the RN.
- ✓ Complete the ADR Form and send to Pharmacy
- ✓ Pharmacy will document the allergy and severity in the computer MAK system

Food and Drug Interactions – If you suspect a food or drug interaction:

- ✓ Pharmacy will send a Food-Drug Notification form when necessary. Educate the patient and document that teaching was done (use Education chapter of shift assessment or stand alone

Education form). **Also, note in patient/family's own words, the response to teaching in your documentation.**

Medications



Documentation Guidelines

- All documentation is done electronically for daily care and medication administration.
- There are some "hybrid charts" where there will also be paper documentation for example: restraint use, Code Reports, some IV medication drips)
- Discontinued/Cancelled orders will display in light gray font on the current orders screen for 24 hours. Use the Filter Data option to view discontinued orders after this time period.

- **Refer to the Jefferson Health Policy regarding acceptable and unacceptable abbreviations. (There is limited spell check in SOARIAN but please take your time and check your spelling)**

References and Resources On-line

- Nursing Standards Manual (Nursing Portal)
  - Policies and Procedures
  - Lippincott Nursing Skills
- Lexicomp (Nursing Portal and Soarian) is our primary source of patient education at Jefferson Health
  - Drug Reference
  - Medical Reference
  - Patient Education Materials - use Lexicomp
- Utilize **TEACH-BACK Methodology** (example: CHF and focus on the RN role and did the RN do a good job teaching the needed information to the patient and family)

Observation Rotation Guidelines

ICU/ ED and OR (special requests to the Nurse Managers and Coordinator for Academic Relations (Debbie Malone)

It is possible for instructors or students to request to have an observational clinical rotation (usually 1 clinical shift per student) in our ICU and Emergency Departments.

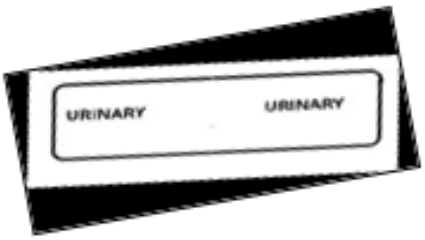
1. All requests must have student name, date and time of observational period and be submitted in writing (**observation form)** to Coordinator of Academic Relations and will be forwarded to Nurse Manager for approval.
2. All Students must **OBSERVE ONLY** and report to the Charge Nurse when going to the clinical unit.
3. Students will evaluate every observational experience and submit evaluation to Clinical Instructor for forwarding to . Coordinator of Academic Relations.
4. This experience has been seen to be helpful for both the students and the clinical instructors to manage the clinical opportunities on their assigned clinical units.

Some **Friendly Reminders**

1. All used IV pumps and bedside commodes should be placed in the dirty utility room for cleaning before the next patient use.
2. Remove all linen that is not being used from chairs and from closets.
3. Linen is not to be carried down the hallway. Place soiled linen in a portable hamper (blue linen bag) outside the patient's room.
4. Place used needles/syringes in the sharps containers located on the med carts, in the med room and in the patient room.
5. **Student nurses are not authorized to use glucose meters but may observe Point of Care Testing at the bedside.**
6. **Always use 2 forms of patient ID – NAME and DATE of BIRTH (not the room number)** when checking the patient's identification prior to giving meds and performing treatments.
7. **Do NOT leave Jefferson Health with any hospital/ patient clinical information.**

Reducing the Risk with Tubing Labels

- FOUR HIGH RISK Tubing's are:
- The labels will be **white** with **large black print**:
    1. INTRAVENOUS
    2. ENTERAL
    3. URINARY



4. **Epidural tubing is already a different color and is labeled by Anesthesia**

KENNEDY HEALTH

Safety Concerns

Before You Leave the Unit

- Make sure your patient is safe.
- Update the intake and output sheet with the most current data.
- Recheck the medication work list on the Workstation on Wheels (WOW) with your instructor to be sure all meds are accurately and completely documented.
- Report off to the co- assigned RN: the amount left in the IV, insure the IV pump is functioning and the patient is safe in their room.
- Document and share with co-assigned RN any patient teaching completed.
- Review with co-assigned nurse any additional information to be incorporated into the electronic documentation for the patient's plan of care.

Restraints…Reduce the Use:
Violent versus Non-Violent

Depends on the behaviors of the patient…not the location of the patient.
See Policy R-2 on line on the Jefferson Health Intranet for additional information.

Goal - to reduce the use of restraints. Restraint application is in response to a particular behavior. Assess the challenging or unsafe patient behavior, identify the patient need, manage and treat the symptoms instead of applying the restraint!

Definitions:

- ✓ **Restraint** - any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely. At Jefferson health it is an unusual and temporary measure to protect patient.
- ✓ **Seclusion** – involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.
    - Seclusion may only be used for the management of violent or self-destructive behavior (not available on the medical-surgical units)
- **Non-Violent Management-** Used due to a potential or demonstrated interference with life support devices, dressings, tubing, lines; used to promote healing and reduce their safety risk.
- **Violent Management-** Used when the patient exhibits combative, violent or destructive behavior that jeopardizes their physical safety, the safety of staff or others.

  The type of standard used is determined by the patient's behavior, no matter what their diagnosis or the location of their room.
- ✓ **Emergent Situation –** Occurs when other means of control are not effective and patients are in imminent danger of causing harm to themselves, others, or physical property.
- ✓ **LIP** (Licensed Independent Practitioner) is the one who can order restraints and seclusion of patient independently, with the scope of the individual's license and consistent with the individuals granted clinical privilege.

BEFORE RESTRAINTS ARE APPLIED:

- **Assess**
    - Assess the reason for the behavior and correct the possible cause (e.g. pain – need for toileting – emotional distress – unfamiliar surroundings).
- **Attempt Alternatives** (Collaborate and discuss with RN alternative available at Jefferson Health)
    - Provide companionship, supervision and social support: ask family and friends or a volunteer to stay with the patient.

- Change or eliminate bothersome treatment. Remove unnecessary equipment ASAP. Disguise or protect catheters/tubes/IV. Use restraint alternative products available through Storeroom - skin sleeve
- Modify the environment. Reduce light, decrease noise, and make the call bell accessible.
- Provide psychosocial interventions by communicating to the patient, explain procedures, and provide reality orientation (calendars, TV, radio, clock).
- Offer diversity and physical activities: ambulation, games, cards.Design creative alternatives. Post a sign reminding the patient to use the call bell for bathroom assistance.

- **Inform and Educate** the patient and family of the potential need for restraints and what change in behavior is required in order to remove the restraints.
  - The family may be able to stay with the patient and serve as an alternative to restraint application
- **Document**
  - The specific alternatives attempted prior to applying restraints must be documented on the Restraint order and Flow record.
  - Document patient education with patient and/or family and understanding of teaching for use of restraints and removal of restraints criteria.

If restraints must be used…..

- Always start out with the least restrictive restraint and progress to a more restrictive restraint if necessary

Summary of Standards

TOPIC	**Non-violent Management**	**Violent Management**
PRN orders are NEVER acceptable and cannot be implemented.		
Order valid for	May not exceed 24 hours	Each order may only be renewed in accordance with the following limits for up to a total of 24 hours Age dependent: ≥ 18 years: 4 hours 9-17 years : 2 hours ≤ 8 years : 1 hour
Order renewals A new restraint order and flow sheet must be initiat with each new order for a restraint	After 24 hours of use the physician/LIP would need to conduct another face-to-face assessment prior to writing another non-violent management No verbal	The physician conducts an in-person evaluation at least; Every 8 hours for patients 18 years and older Every 4 hours for patients 17 and

	renewals!	younger A verbal/telephone re-order may be obtained and written on the restraint/seclusion order form using the time limits specified for every other order up to 24 hours.
Nursing Observation/ **Documentation Frequency**	Observe patient at least every hour for comfort, safety and movement based on patient acuity. Document at least every hour.	**At least every 15 minutes**

Considerations:

1. Special Considerations for **Emergency Department Patients**:
   - Restrained patients in the ED are treated according to the guidelines for Violent Management. Restraint orders in the Emergency Department are limited to 4 hours in duration.
2. **Written Orders**
   - Only the physician/LIP may write an order for restraints. The physician/LIP must include the following in the order:
     - Type of restraint/device or seclusion
     - Reason for restraints, choosing only violent or non-violent reasons on the order flow sheet
     - Duration of order
     - Mental Status of the patient
     - Physician Signature, Beeper#, Date and Time

     Note: If Physician Order Section is not complete – then the order is not valid

3. **Verbal Orders**
   - ✓ In non-emergent and non-violent situations verbal/telephone orders are **NOT** accepted.
     - Physician must do a face to face assessment of the patient and execute a written order prior to the application of restraints
   - In case of emergent application where a verbal order is required the nurse must:
     - Complete the verbal order section and indicate physician notified, date, time, and RN signature
     - Physician must assess the patient face-to face and sign the verbal order for restraints within 1 hour of the time restraints were applied.

- If the physician does not sign the order within 1 hour, discontinue restraint use and attempt alternatives
- If the restraints are discontinued within one hour of application, the physician must still conduct the face-to-face assessment of the patient and document there is no need for restraint use.

4. **Care Planning**

- The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care in the computer
  - The RN incorporates the goals of restraint use in the care plan to reflect assessments, interventions and evaluations
  - The plan of care shall be updated if restraints are discontinued early

5. **Restraint documentation process is NOT electronic at this time!**

- ✓ Restraint Order/Flow sheets must be filled in completely to document appropriate care and patient/family education.
- ✓ If there is a change in the patient's behavior that may require additional restraints or a change in the type of restraint a **new order must be obtained**
- ✓ Restraint or seclusion use must be discontinued at the earliest possible time regardless of the length of time of the order.
- ✓ Documentation on the flow sheet must indicate when and why restraints were removed
- ✓ Responsibilities
  - Physician – **Face-to Face Assessment**
  - RN assesses the patient, implements restraint and /or seclusion
  - Support Staff – can assist with application of restraints, monitor a patient in seclusion and care for patients under the direct supervision of the RN only after having receiving education and performing a competency.
  - The Nurse Manager, or Supervisor is notified immediately of;

    1. Any patient injury or death occurring while a patient is in restraints or seclusion.

    2. Any death of a patient within 7 days of being restrained and/or secluded.

TIER 1 ALERT

- Used to get additional help in de-escalating a patient whose behaviors have become challenging and disruptive on the unit.

- Any behavior management program focuses on verbal –de-escalation skills to "talk down" a person, so that person is less apt to act out behaviorally. (See ACT Tip Sheet as a resource to expand assessment of challenging patient behaviors on a clinical unit)

- This is like calling an RRT when early changes in patient behavior are recognized in the medical patient.

Please use this resource as Jefferson Health is cutting edge in having this type of support on the Medical-Surgical and Emergency Units.

A.C.T. (Assessment, Communication and Teamwork)

A – ASSESSMENT

- Assess the patient:
  - Consider medical status (hypoxia, hypotension, hyper/ hypoglycemia, pain, need to urinate, hunger/ thirst, etc.)
  - Consider substance withdrawal (use screening tools to determine withdrawal status, determine last use of substance)
  - Consider untreated/ undertreated psychiatric symptoms such as psychosis (delusions/ hallucinations) or dysphoric mood (anxious, depressed etc)
  - Violence History (past history of violence is greatest predicator for future violence)
- Assess the Environment:
  - Safety, safety, safety (look for objects in room that could be used to harm self/ others)
  - Look for patterns or triggers for problematic behaviors
- Assess yourself:
  - Perform a "self-check" Be aware of your feelings towards the patient (biases, counter transference etc.) and your feelings about being with the patient (fear, insecurity etc.)
  - Recognize your strengths and weaknesses, seeking support when needed

C- COMMUNICATION

- Communicate with Staff:
  - Provide a meaningful report to the sitter including assessment data identified above, review 1:1 sitter responsibilities, and provide guidelines for those behaviors that should be immediately reported to RN
- Communicate with Patient:
  - Be respectful towards patient. Identify yourself and ask them what they would like to be called
  - Begin shift by discussing expectations for shift
  - Allow the patient to make choices and provide input as often as possible to seek "win/ win" situations (shower time, food choices, where to sit etc.)
  - Remain non-judgmental and avoid offering "advice"
  - Be genuine and honest in your interactions (keep promises made)

T- TEAMWORK

- Psychiatric Consultation:
  - Identify specific questions/ concerns to be addressed
- Maximize resources present:
  - Use a show of support to help increase structure and encourage good choices
- Seek input from Social Workers / Case Managers
- Use Code Gray or Tier 1 Alert as an emergent means of bringing extra resources

New Safe Room Procedure

The following items are needed to create a Safe Room:

1. Safe Room sign

2. Safe Room checklist
3. Patient valuables envelopes
4. Brown paper bags – put trash cans with plastic bags outside of room if no paper bag.
5. Wireless remote – If there isn't one, the PSA or tech must hold the remote.

Other items that are needed:

1. Green scrubs
2. Patient belonging bags.

Keep the following rules in mind:

1. The Safe Room Checklist is to be completed **each shift** – follow the directions on the checklist to provide a Safe Room.
2. **Therapeutic 1:1s *will not* *have a roommate*.**
   a. Remove the bed from the room to decrease cords.
   b. Remove furniture from the room to decrease harmful outcomes for staff and patients.

3. All trash cans are to be removed from the room (because of the plastic trash can liner) and bathroom (until we are able to obtain paper bag trash can liners).
4. PSA/PCT will hold on to all TV remotes, telephones, and call bells (any device that has a cord).
5. Any basic room equipment with a cord (call bell cords, electric cords, and light switch cords) will be put in a bag, marked with the room number, and placed in the Safe Room box. This ensures the equipment is available when the Safe Room patient leaves.
    a. Remember to remove items from the other bed from the room
6. Place patient belongings in a patient belonging bag with a patient label
7. Remove any unnecessary furniture from the room so that it can't be thrown at someone or something.
8. Remove all detachable/removable hanging risk items, if possible, and unless medically necessary:All excess tubing (Suction, IV, Oxygen, etc.),Monitoring Equipment (BP/EKG cables) unless items needed for continuous monitoring

Check List Below is to be used when Patients are in the Safe Room

Environment of Care/Patient Safety
Safe Zone Checklist

Checklist must be completed at the beginning of every shift and when there is a change in Therapeutic Sitter.	Initials					
Item Checked	Time	Time	Time	Time	Time	Time
Place the patient in a room which provides the best observation and protection. Never leave patient unattended or behind a closed curtain/door. "Safety Over Privacy"						
Orange "Safe Zone" sign is posted on the entry door						
Remove ALL sharp objects (needles, scalpels, knives, scissors, nail files, coat hangers, glass items etc.)						
Remove in-room sharps container or use locked containers						
Remove all detachable/removable hanging risk items, if possible and unless medically necessary: • Suction tubing • Oxygen tubing • Excess IV tubing • Monitoring Equipment (BP/EKG cables) unless items needed for continuous monitoring • Electric cords/bed cords(if detachable)/window blind cords • Telephone & cord • Light switch cord (shorten) • Nurse call light (provide bell) • TV controller (provide remote wireless controller)						
Remove plastic trashcan liners (replace with brown paper bag)						
Remove extra linen (patient to have bottom sheet, blanket & pillow)						
Visually inspect room/bathroom and remove/reduce risk of potentially harmful objects as best as possible: • Extra furniture • Extra plastic bags (bedroom & bathroom) • Extra supplies						
Inspect patient belongings, initiate Patient Belongings Record. Remove potentially harmful objects or contraband from patient environment. This includes: *patient medications, glass or sharp items, toiletry items containing alcohol, make up in glass or with mirror, matches/lighters, aerosol spray cans, razor, belts, straps, ties, shoe laces, dental floss, and jewelry.* Remove items from patient room and place in secured location or send home with family. Allowable items: Eyeglasses, wedding ring, non-breakable toiletries						
Safe Tray for meals or finger foods. No metal or cans/bottles of any type. Plastic utensils (1 fork & 1 spoon, no knife). **Utensils must be counted before & after meals**						
Visitors: Ask patient if he/she wants a visit. Inform family/visitor the level of observation/precautions and rationale. "My name is ___ and I am here to help keep your loved one safe. This room is a Safe Zone which means we limit the type of items in the room to maintain a safe environment"						
Monitor any item(s) brought in by visitors. Remove an item considered unsafe and return to the visitor when they leave						

Initials	**Signature/Status**	**Initials**	**Signature/Status**	**Initials**	**Signature/Status**

Nursing Role Models

RN – Nurse Manager

Responsible for the management of staff as well as the care and safety of the patient. Acts as a liaison, resource and facilitator within the healthcare system.

RN – Charge Nurse

Coordinates unit activities, cares for patients, and acts as a clinical resource to other healthcare team members

RN – Case Manager

Monitors the care for each patient. Communicates with the insurance providers and social services to validate approval of hospital stay and discharge planning

RN – Staff Nurse

Coordinates patient care activities with other team members, provides direct patient care.

PCT /CNA – Patient Care Tech / Certified Nurse Aide

Performs patient care tasks under the direction of the RN

Monitor Technicians

Monitors the telemetry signals for the Telemetry and Remote Telemetry units.

US – Unit Secretary

Transcribes orders, prepares charts, answers telephones and makes appointments

RN-Navigator

Uses collaborative process to ensure that the patient and managed appropriately and expedites though the health care continuum. Assesses plans and intervenes and evaluates and coordinates the options and services required to meet the patient and health care needs while promoting quality, cost-efficient care.

Clinical Educators/ Advanced Practice Nurses (APN's)

Some are direct care givers, unit-specific, campus specific or system wide. Get to know them, they are a phenomenal resource for Jefferson Health.

Safe Patient Handling Program

jefferson Hospital has been very active in the Safe Patient Handling Legislations passed in NJ recently and has purchased equipment to move the patient safely and also to protect our health care associates from hurting themselves. They include:

- Rollerboards
- EZ Glider Sheets
- Viking & Sabina Lifts and other assistive devices/ equipment to prevent potential injuries **Please get to know the SUPER USERS on your units and call Physical Therapy for any additional information.**

SAVE YOUR BACK….PLEASE USE THESE ASSISTIVE DEVICES

Electronic Documentation

Student Nurse Documentation and Work Lists

Documentation in Soarian:

Students may **NOT** document Admission Assessments, Allergies, Home Medications, Plan of Care, or Clinical Notes in Soarian.

Student nurses **MAY** chart on Shift Assessments, Patient Positioning, Patient Belongings, Vital Signs, Height & Weight, I&O, Education, ADL, Calorie Count and Nutritional Intake forms.

1. Student nurses must save the form in an “In Progress” status.
2. The student’s instructor will access the “In Progress” forms from the Clinical Documentation Work list and review the student’s entry.
3. After agreeing with or editing the student’s data, the instructor will save the form as “Complete”.
4. After the instructor has saved the form as “Complete”, the student may edit the content from the Patient Record if necessary. The instructor must approve the edited content. The form history will show that the student has edited the form.

Note: For Capstone nursing students assigned to an RN Preceptor – the RN will perform the instructor processes above.

Task Worklists:

Student nurses have "view only" access to the following worklists:

- ☐ Alerts
- ☐ Clinical Documentation
- ☐ Specimen Collection
- ☐ Interventions
- ☐ New Results

1. Students open and view the work lists to see patient-specific tasks needing attention.
2. Students perform work list tasks (interventions or specimen collection) within the student nurse scope and under the direction of instructor.
3. Students will report the completion of work list tasks to the instructor.
4. Instructor removes the item from the Intervention or Specimen Collection work lists to document completion of the task.

- Student will use a generic patient label placed on the specimen container. Once the nurse collect specimen has been obtained, the instructor will enter the date and time collected from the Specimen to be Collected Worklist and status as complete – this will generate the lab label that is to be placed directly on top of the generic label. (See Printing Labels from the Specimen to be collected worklist Tipsheet on the Soarian Education page.)

Note: For Capstone nursing students assigned to an RN Preceptor – the RN will perform the instructor processes above. ***

~ Within Defined Limits Definition ("WDL") Guide~

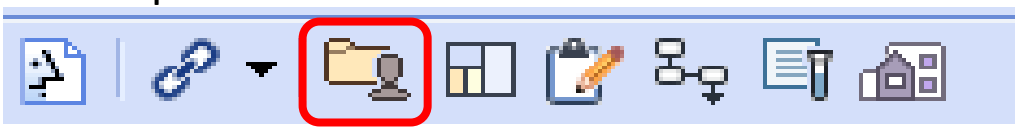
Form Name	WDL Definition	Section	Element(s)	Positive Findings
HEENT	• No visual disturbances hearing impairments per patient • No nasal impairment • Mucous membranes pink and moist	• Eye Assessment	• Discharge • Redness • Edema	• "None"
		• Ear Assessment	• Discharge • Earache	• "None"
Neurological	• Awake, alert, oriented to person, place, time and situation • Follows commands • Strength equal in all extremities • Speech intact	• General Information	• Right Pupil Reaction • Left Pupil Reaction	• "Brisk"
		• Additional Information	• Ptosis • Facial Droop	• "None"
Cardiovascular	• No chest pain/pressure per patient • No edema • No cyanosis • Turgor satisfactory • Capillary refill < 3 seconds • Palpable radial and pedal pulses • Regular apical pulse • Skin Warm & Dry	• Assessment	• Brachial Pulse • Radial Pulse • Popliteal Pulse • Post Tibial Pulse • Dorsal Pedal Pulse • Femoral Pulse • Carotid Pulse	• "Palpable
Respiratory	• Clear Breath Sounds, equal in all lobes • Respirations regular, non-labored, without use of accessory muscles, • Chest excursion symmetrical, • trachea midline, No Cough, • Breathing on Room Air	N/A	N/A	N/A

Gastrointestinal	• Bowels sounds active in all quadrants • Abdomen soft, non-tender, non-distended • Absence of nausea, vomiting, cramping, diarrhea and constipation • No pain with bowel movement • No difficulty swallowing	• Assessment	• Stool Description	• "Soft" • "Formed
GU	• Voids clear yellow urine without difficulty • Bladder non-distended, Continent of urine	N/A	N/A	N/A
Musculoskeletal	• Full range of motion; symmetry of extremities; equal muscle tone bilaterally • No assistance/assistive devices needed • ADLs within functional limits	N/A	N/A	N/A
Integumentary	• Skin warm, dry, and intact, • skin color consistent for ethnicity and age	N/A	N/A	N/A
Psychosocial	• Affect, appearance, behavior, and communication appropriate to age and situation, • interacts appropriately with all care providers; ADL's within functional limits, • No reported suicidal ideations, no reported homicidal ideations, no reported hallucinatory experiences	N/A	N/A	N/A

Viewing Patient Record Data

Where to access:

- **From the Open Census toolbar**



- **On any patient header screen (on the tab toolbar)**

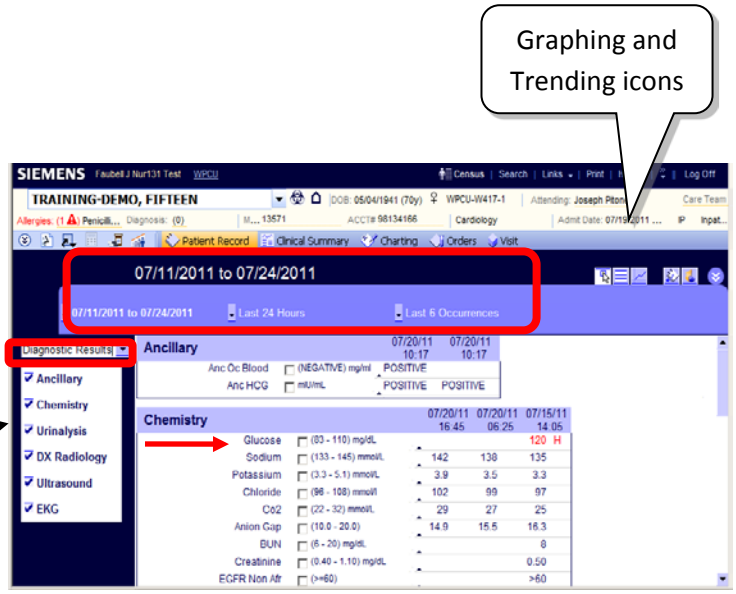
When to access:

To view diagnostic results and other patient data such as:

- Diagnostic results
- Patient Factors
- Order occurrence status
- Transcribed reports
- Medication reconciliation event history
- Clinical Documentation

How to filter and view Patient Record data:

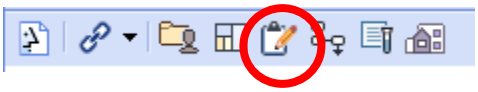
1. Leave the default of 'Past 7 Days' or chose a different filter (Calendar, Occurrences, or Timeframe).
   Click the ▼ to select options for that filter.
2. Select a flowsheet.
3. Click the box next to items to graph or trend, if desired.



Data from previous visits may display on the Patient Record, depending on the timeframe or number of occurrences you chose as a filter. Check the date/time of the displayed data carefully!

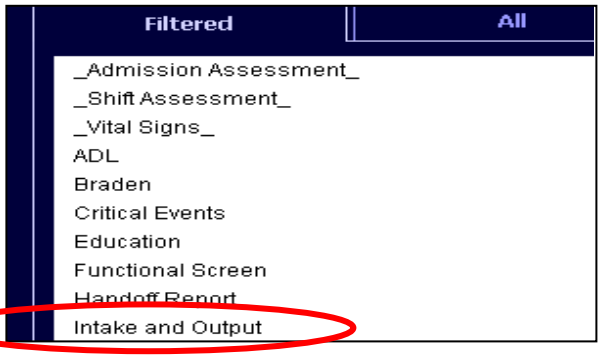
Intake & Output

▶ Click on the **Charting icon** in the Open Census view, OR on the **Charting Tab** in the patient header bar.



▶Select the **Documentation** option from the Charting Navigator (left side of screen)

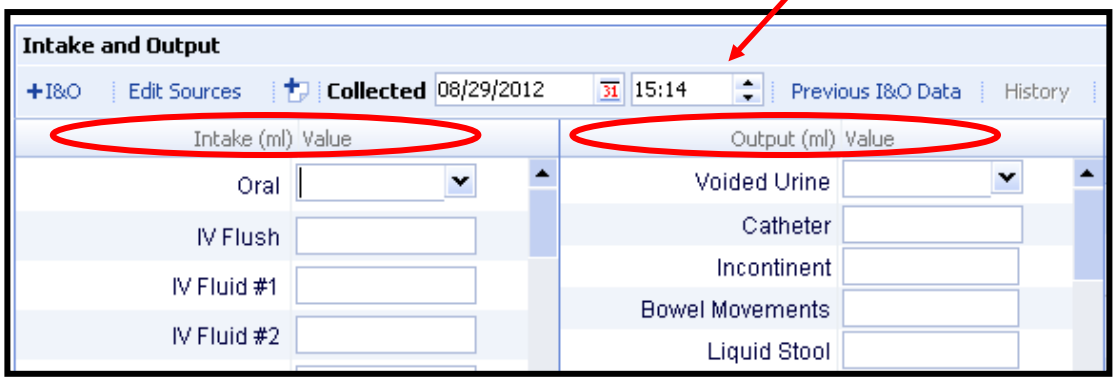
▶From the Filtered List, select the **Intake and Output** assessment form.



When the form opens:

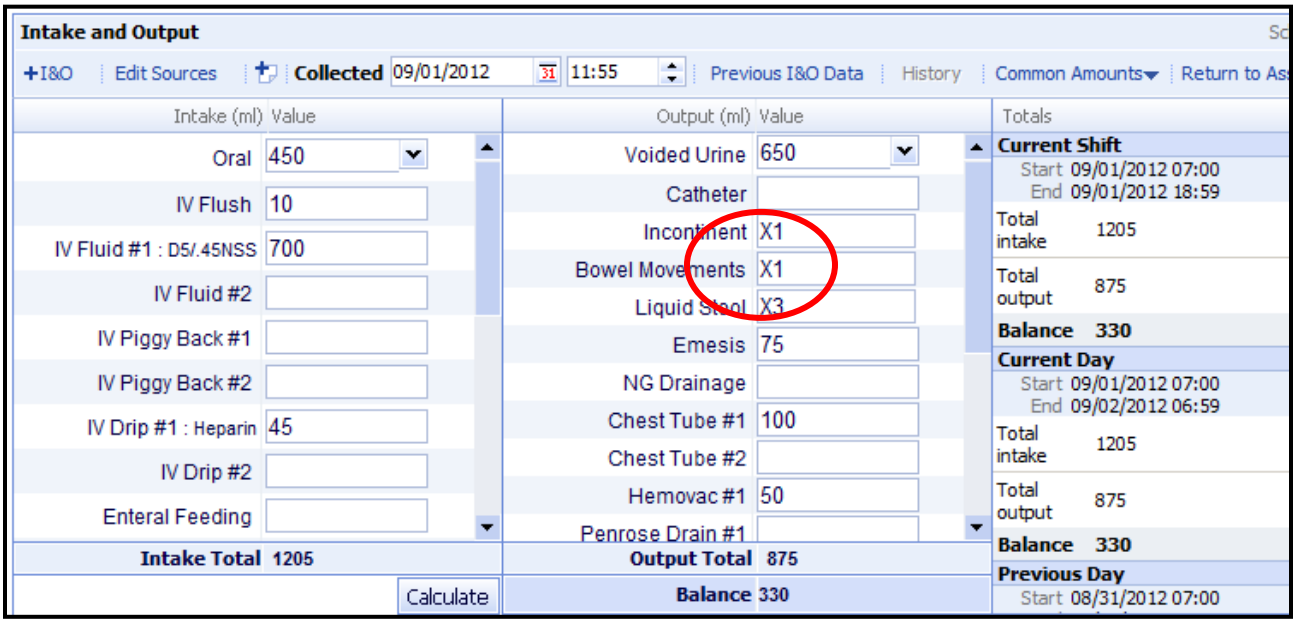
▶Click the **Collected** to set the date/time the I&O data was collected, if different from the time you are charting.

- ***Intake*** sources appear in the left column. ***Output*** sources appear on the right column.



▶Enter volume values in the appropriate source fields in the Intake and Output columns.

▶After you have entered all the information, click **Calculate** at bottom of screen.



When documenting episodes of incontinence, BM, or liquid stool, which can't be measured in volume, always enter the number of episodes using this format (see example).

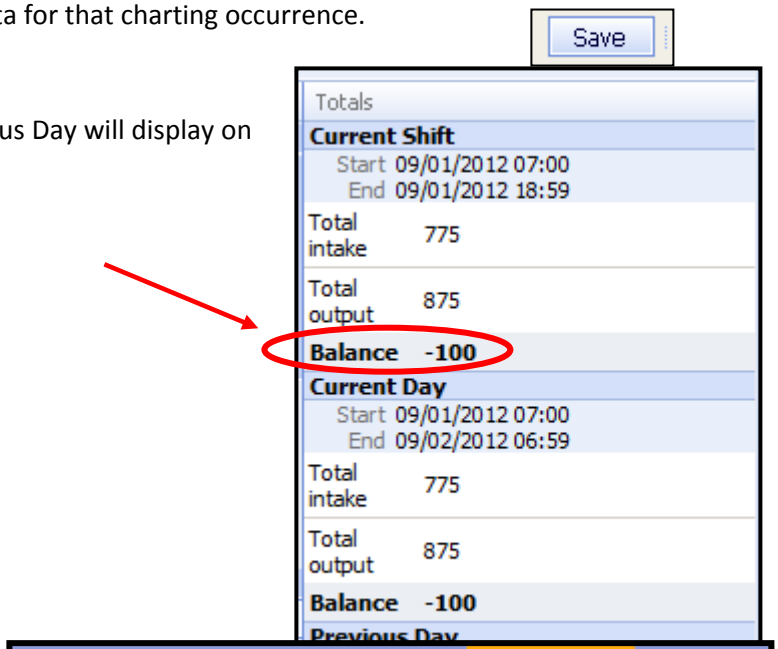
- Incontinent X2
- BM X1
- Liquid Stool X3

*Note: If you do not include the "**X**", the number will be added as volume (ml's) instead of as the number of episodes.*

▶As with other Student Nurse forms, the only available status is *'In Progress'*. The Instructor will status the Intake & Output form as *'Complete'* after appropriate review.

If you are entering data for another person, enter that person's name in the *'Charted For'* field.

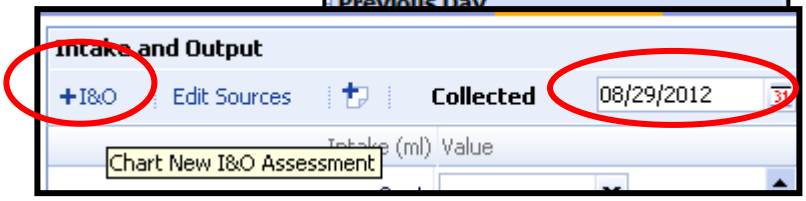
▶Click **Save,** at the bottom of the screen**,** to save data for that charting occurrence.



Current TOTALS for the Shift, Current Day and Previous Day will display on right side of the form.

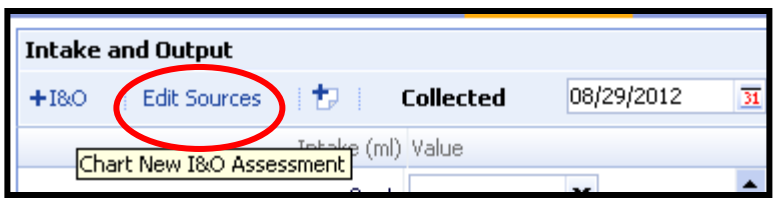
- A negative balance is indicated with minus sign.

To quickly chart data that was collected at a different time for that patient, click the **+I&O** *shortcut* button and begin a fresh flowsheet. Enter the Collected date/time, as above.



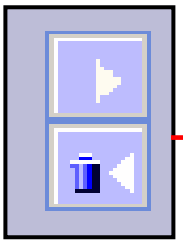
Additional I&O Charting Points:

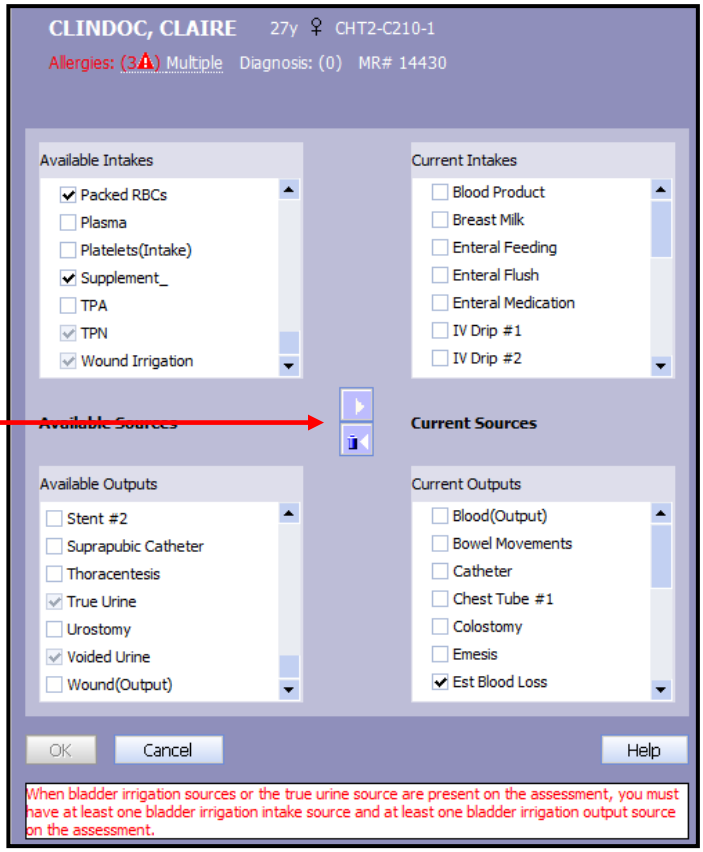
☐ **Adding or Deleting a Source:**
If you need to chart a value for a source that does not appear in the column, click on the Edit Sources tab. You can select a new source to add to the Intake or Output columns. For example, you may want to add PRBC's and Supplement sources or remove an Estimated Blood Loss source.



The ‘Add/Remove Sources’ box appears. Select the appropriate source from the Available or Current *Intake* sources and/or the Available or Current *Output* sources .

Use the ‘Add’ arrow or the ‘Discard’ arrow to make your changes to the sources that will appear on the form.

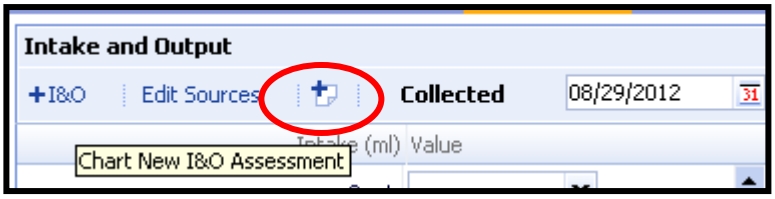




Click **OK** when your changes are made.

Note: You cannot remove a source that was charted on within the last 24 hours.

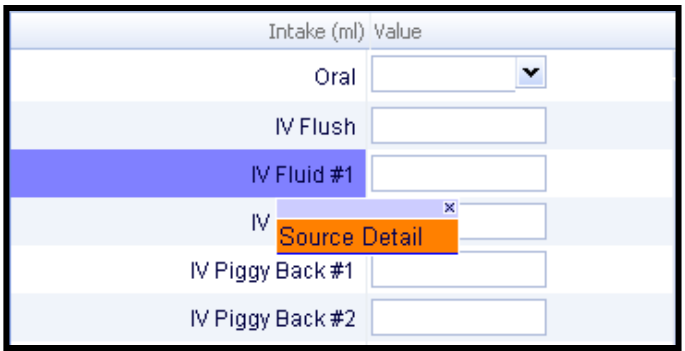
☐ If you need to enter a clinical note related to the Intake and Output episode, the Instructor has the ability to document using the “Add a Note” icon.

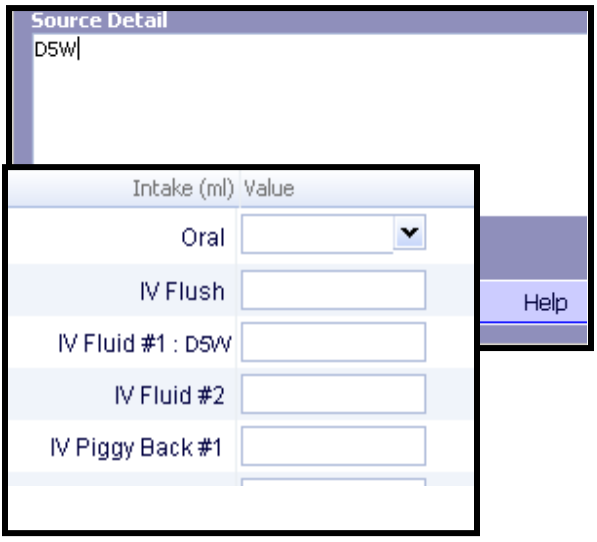


☐ **You can also create a specific Label, to further clarify a source:**

(This example shows the addition of a *D5/W* label to the *IV Fluid #1* source.

- Click directly on the **Source Name** that appears on the form.
- Click **Source Detail**.
- Type in the desired source label.
- Click the **Continuous Charting** box if you want the label to remain for future charting. (You can remove the label at any time by un-clicking the checkbox)
- Click **Save**.

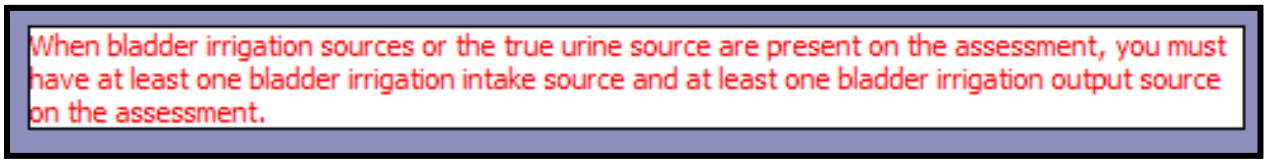




☐ **To Chart CBI True Urine Volume:**

- Calculate the CBI fluid intake and Output drained from catheter on a worksheet during your shift.
- Make sure that all of these Sources are added to your I&O form:
  - Intake: **Cont Bladder irrig**
  - Outputs: **Cont Bladder irrig Out** and **True Urine**

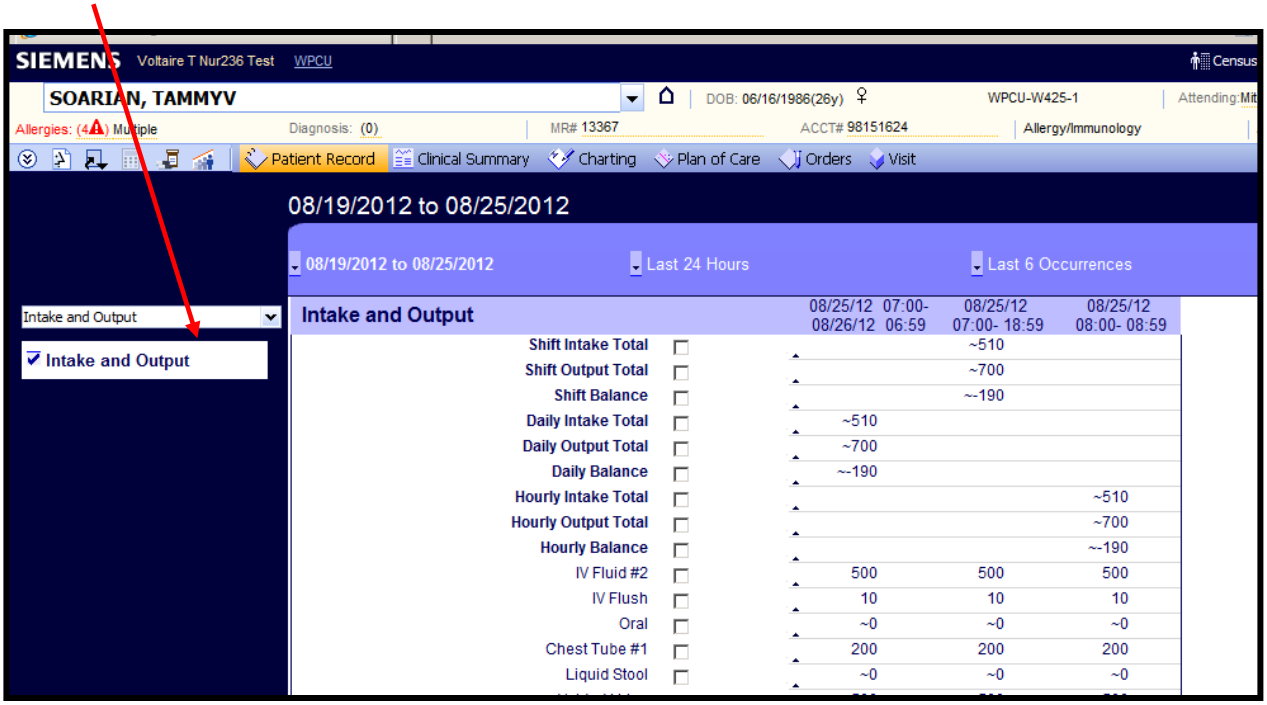
You will see a warning on the "Add/Remove Sources" box if you do not select all sources.

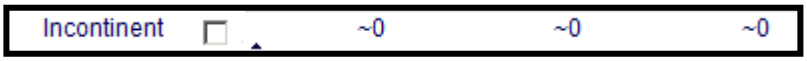


- Add the total values to appropriate source fields on the Intake & Output form at the end of the shift.

No need to click the Calculate button. Soarian auto-calculates the True Urine on the form.

To view Intake and Output data in the Patient Record, select the **Intake and Output, Diagnostic Results** , or **Clinical Documentation** flowsheets , and locate the date/time of the charting occurrence(s).



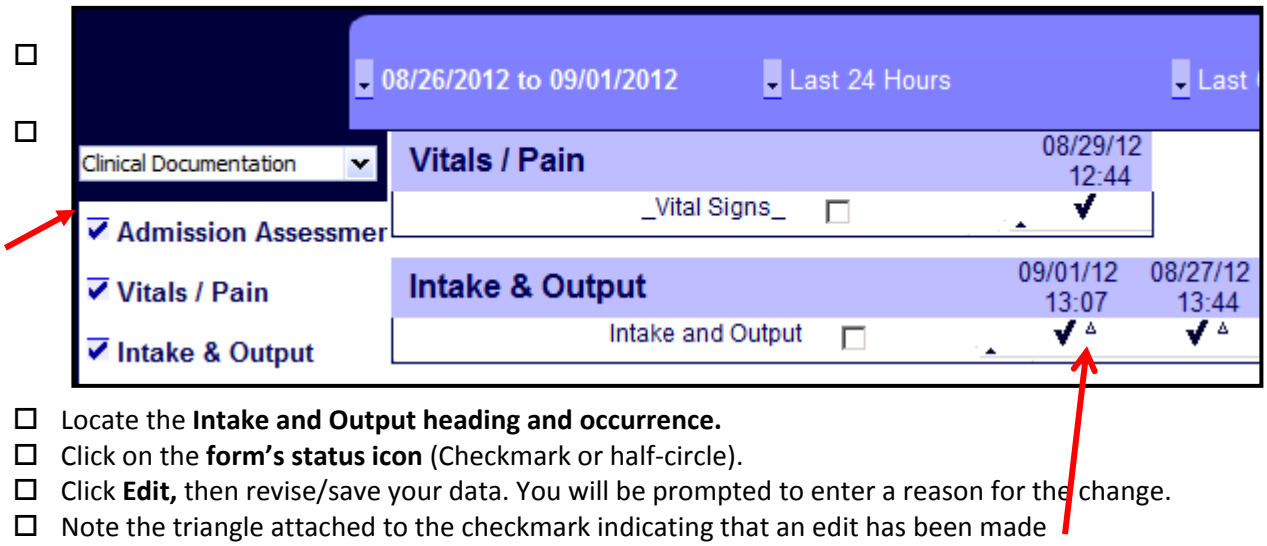


Intake and Output is also displayed on the **Clinical Summary**, in the **Intake and Output tab** in the Results section.

To Edit an I/O form (that has been saved as Complete)

NOTE: Instructor will need to edit a form that has been saved as complete.

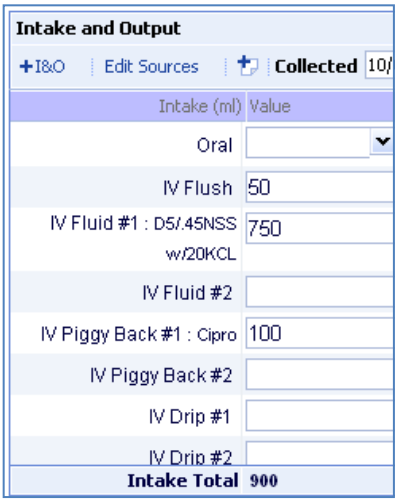
- ☐ Open the **Clinical Documentation flowsheet** in the Patient Record.
- ☐
- ☐

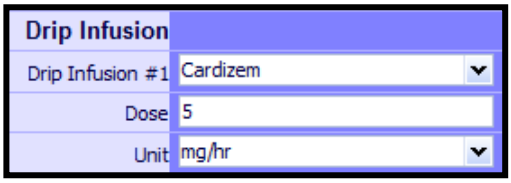


- ☐ Locate the **Intake and Output heading and occurrence.**
- ☐ Click on the **form's status icon** (Checkmark or half-circle).
- ☐ Click **Edit,** then revise/save your data. You will be prompted to enter a reason for the change.
- ☐ Note the triangle attached to the checkmark indicating that an edit has been made

***

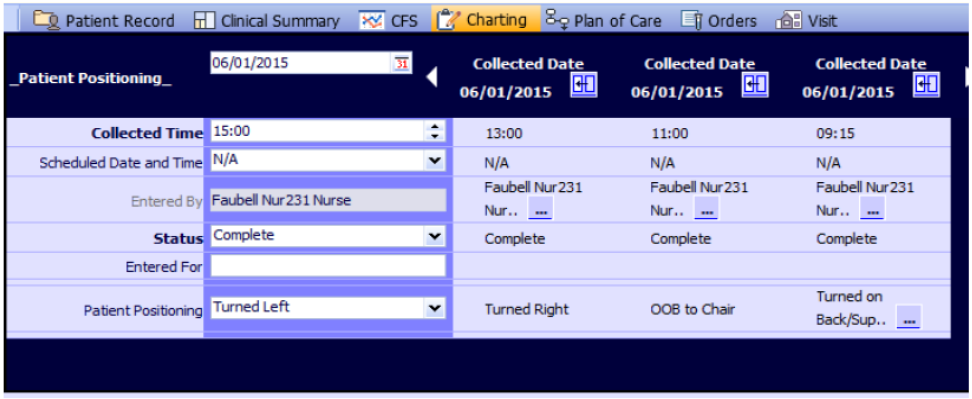
IV Charting FAQ's

Topic	Where to chart?	When to chart?
IV Intake Volume	On the I&O form (from Filtered list) 	☐ During shift -When an IV bag is finished ☐ End of shift – Enter IV volume infused as usual ☐ Per unit protocol (ex: ICU documents hourly I&O) Soarian keeps a running I&O total, so a total does not need to be manually tallied at shift end. Monitor the running totals as part of patient assessment.

Topic	Where to chart?	When to chart?
RAPID IV Rate Changes	For rapidly titrated **critical care** meds, chart the rate changes on the **Vital Sign Form** - in the **Drip Infusion** section (bottom of the form). (Replaces documenting these changes on the I&O section of the paper flowsheet)  *NOTE: Patients in ICU, NICU and Stepdown beds will have these medication titrations documented on the Critical Care Flowsheet.*	When rate is changed per titration parameters.

Patient Positioning

RNs, PCTs, and CNAs will document each patient turning/positioning on the *new*, columnar Patient Positioning flowsheet.



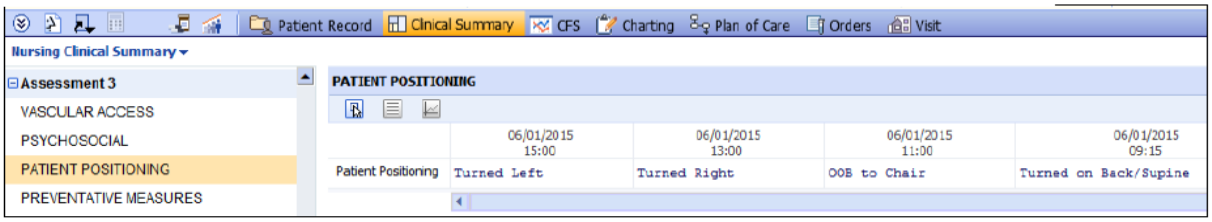
The Patient Positioning flowsheet is located on the top of the Filtered list.

Turning/positioning options are no longer in the Preventative Measures drop-down on the Integumentary, Braden, Pressure Ulcer, and ADL forms.

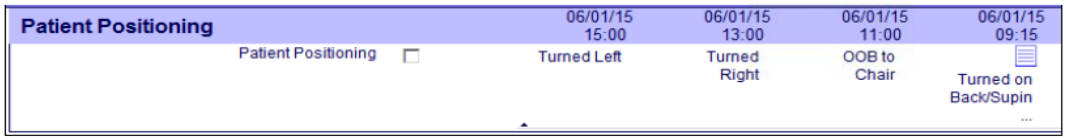
Open a new Patient Positioning flowsheet to document each occurrence.

Patient Positioning Documentation Can Be Viewed:

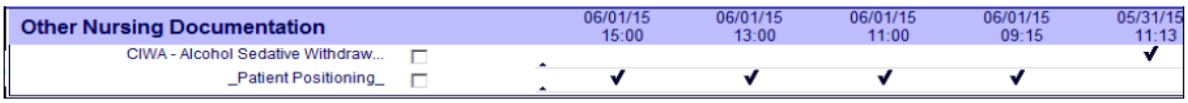
Clinical Summary → Assessment Section → Patient Positioning



Patient Record → At-A-Glance Flowsheet → Patient Positioning



Patient Record → Clinical Documentation Flowsheet → Other Nursing Documentation

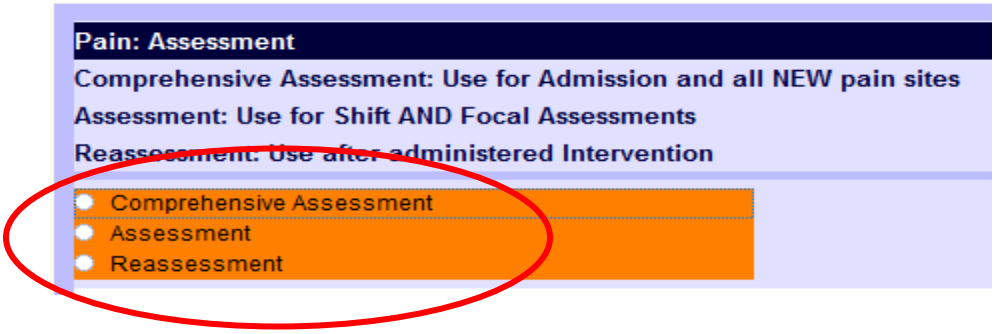


Pain Assessment & Reassessment Documentation

Pain assessment and reassessment, including pain scale and location, will be documented on the Pain form:

- Pain identified upon admission: Document in Pain chapter of the Admission form.
- Pain identified after admission: Document in Pain chapter of Shift Assessment form or use the standalone Pain form.
- Pain Reassessment: Document in **new** Shift Assessment (Pain section) or on a **new** Pain Form from the Filtered list.

PAIN - Comprehensive Assessment, Assessment or Reassessment is indicated on the Soarian Pain Assessment form (Shift Assessment chapter or stand-alone Pain form
Select the appropriate radio button:

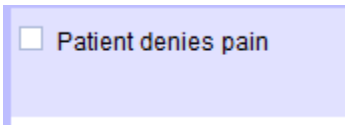


- ☐ Click **Assess** for initial assessments; Click **Reassess** when charting reassessments after a pain intervention.
- ☐ Chart pain reassessments on a new version of the form rather than editing the initial pain assessment form.
- ☐ Follow policy and your unit protocol for pain assessment/reassessment frequency.

Charting the Pain Assessment/Reassessment

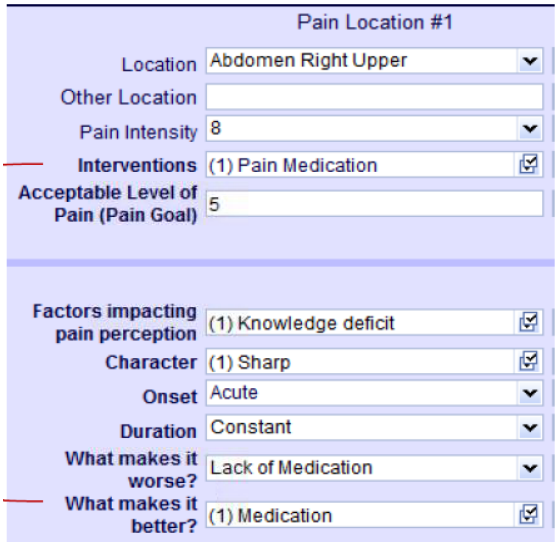
Click the **Pain** chapter. Select the appropriate pain scale for your patient. The form contains multiple pain scale options.

If the patient reports no pain, check the Patient denies pain check box.



Complete other fields as applicable and per the Pain Management Policy. Note that when a Comprehensive Pain Assessment is selected and an intensity is entered, the comprehensive assessment fields become mandatory.

The Pain Assessment Form contains areas to document four (4) pain locations simultaneously on one page. Pain locations carry forward to ensure consistency in documenting against that location.



When documentation is complete, adjust the collected date/time, <u>if necessary</u>, and address the

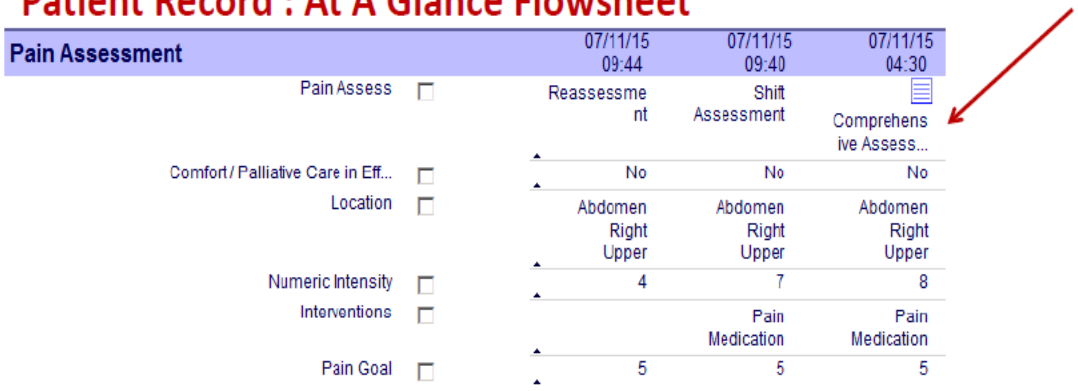
Status of the assessment form as either In- progress (student) or Complete (Instructor).

Click the **pencil icon** in the right lower corner of the screen to **sign/save** the document.

Pain Assessment documentation can be viewed in the Patient Record (At a Glance Flowsheet) or in the Clinical Summary PAIN Tab located in the Quick Look section.

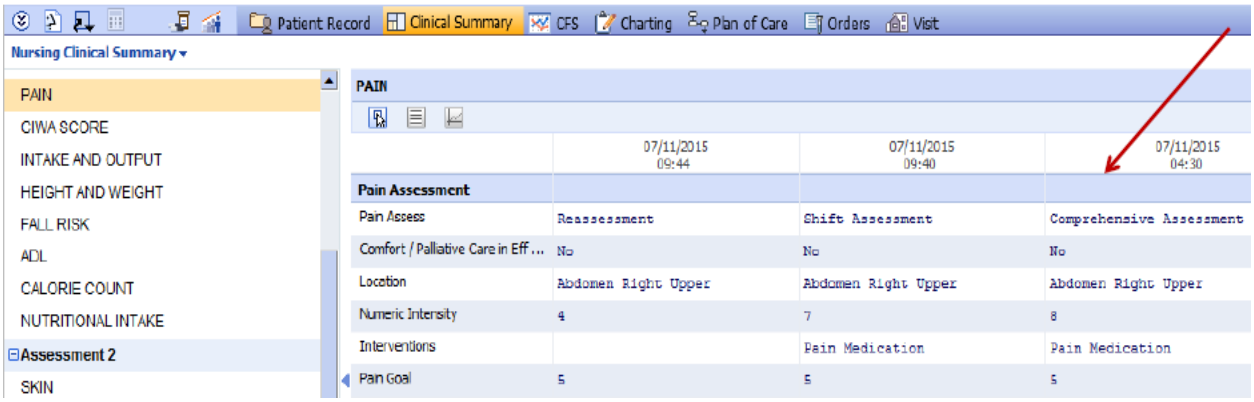
Viewing Pain Assessment Documentation

Patient Record : At A Glance Flowsheet



Pain Assessment		07/11/15 09:44	07/11/15 09:40	07/11/15 04:30
Pain Assess		Reassessment	Shift Assessment	Comprehensive Assess...
Comfort / Palliative Care in Eff...		No	No	No
Location		Abdomen Right Upper	Abdomen Right Upper	Abdomen Right Upper
Numeric Intensity		4	7	8
Interventions			Pain Medication	Pain Medication
Pain Goal		5	5	5

Clinical Summary: Pain Display



Patient Record | Clinical Summary | CFS | Charting | Plan of Care | Orders | Visit

Nursing Clinical Summary

- PAIN
- CIWA SCORE
- INTAKE AND OUTPUT
- HEIGHT AND WEIGHT
- FALL RISK
- ADL
- CALORIE COUNT
- NUTRITIONAL INTAKE
- Assessment 2
- SKIN

PAIN

Pain Assessment	07/11/2015 09:44	07/11/2015 09:40	07/11/2015 04:30
Pain Assess	Reassessment	Shift Assessment	Comprehensive Assessment
Comfort / Palliative Care in Eff...	No	No	No
Location	Abdomen Right Upper	Abdomen Right Upper	Abdomen Right Upper
Numeric Intensity	4	7	8
Interventions		Pain Medication	Pain Medication
Pain Goal	5	5	5

At A Glance Flowsheet is an excellent quick and easy view that provides a *snapshot of various findings but may not be inclusive of all elements in the assessment.*

Student Nurse Scavenger Hunt

tem	✓	Item	✓
Clerical Items		**General Equipment**	
CODE Clipboards (Amber Alert, Code 45, Code Echo)		Manual B/P cuff/ Electronic Vital Sign Machine	
WOW- work station on wheels for documentation		Thermometer (electronic)	
Physical Environment		Pulse oximeter	
Clean utility room		Standing scale	
Dirty utility room		**Supplies**	
Pantry		Bedpans and urinals (female and male)	
Nurse's lounge		Shaving supplies	
Patient showers		Linens and hampers	
Patient rights plaques		Rejected linen bag	
Hand sanitizers		Alcohol wipes	
White Boards and markers		Specimen collection devices	
Patient Beds / Hi-Lo Beds (Alarms, Weighing a Patient, M attress		Skin Care Products (wounds and ostomy care)	
Emergency Equipment		Gloves (sterile and non-sterile)	
Fire alarm pull box		Sharps disposal boxes (Including the Black Box/ RYCA Box)	
Fire extinguishers locations		Denture cups	
Fire exits		Tape	
Main oxygen shut off valve		Sterile urine specimen cup	
Code cart		**Stat Loc (urinary and central lines)**	
Portable oxygen tank		Lotion	
Portable suction		Wash basin	
Ambu bag		4x4 gauze dressings	
Patient Education		Culturettes	
Diabetic education packets/ Meters		Patient Isolation Signs	
Unit Specific Brochures		Band-Aids	
Lexicomp (Our Patient Education resource)		Storage bins for used oxygen/empty oxygen tanks	
Resources		IV tubing / Blood Tubing	
Nursing policy manual- on-line		Toothbrushes	
MSDS sheets- on-line		Spoons and straws	
LASA (Look alike sound alike medication poster)		Drinking cups	

Post Test

FOR CLINICAL ORIENTATION FOR STUDENT NURSES and INSTRUCTORS

Please answer the following after reviewing the current STUDENT NURSE GUIDE

Mark T (True) or F (False) for each of the following statements:

____ 1. The number to call in Jefferson Health for any code is 3-3-3-3.

____ 2. At Jefferson Health, anyone can dial "O" for operator for a Medical Ethics Consult.

____ 3. Jefferson Health associates must not wear artificial nails/gel nails while providing direct patient care.

____ 4. Patient safety is everyone's job at Jefferson Health, if you see something wrong report it, change it or fix it.

____ 5. Standard Isolation Precautions will be used for all patients regardless of disease or condition.

____ 6. A family member may translate and review consents with their loved one.

____ 7. Use of the RED BAGS (Regulated Medical Waste) when there is more than 20 ml's of blood.

____ 8. The 2 patient identifiers used at Jefferson Health are patients name and date of birth.

____ 9. When a patient gives consent for a procedure, in or out of the OR, a "time-out" must be completed. The patient will actively participate in this process if able.

____10. The Clinical Instructor must be present when students pass medications.

Match the description on the right to the column on the left:

____ 11.	Code ECHO	A.	Patient Elopement
____ 12.	QUANTROS	B.	Pull, Aim, Squeeze, Sweep
____ 13.	Tier 1 ALERT	C.	Electronic Incident Reporting System
____ 14.	P-A-S-S	D.	All Clear
____ 15.	Code Green	E.	Patient Behavior Escalating

Multiple choice:

16. How could you report an unsafe condition?
    a. Notify the manager/supervisor
    b. Notify the maintenance department
    c. Call the Safety Hotline 856-582-2899
    d. All of the above

17. Jefferson Health associates using computer systems may:
    a. Access and review clinical results of family and friends
    b. Use for personal reasons such as online shopping during non-busy times
    c. Only access information related to his/her job duties
    d. Share his/her password to increase team efficiency

18. An associate notices an elderly woman in a patient gown wandering near the cafeteria. When asked if she needs assistance the woman begins to run away. Which emergency code should be called to extension 2222?
    a. Code Gray
    b. Code Echo
    c. Tier 1 Alert
    d. Code Amber

19. You find an empty oxygen cylinder (tank) or oxygen tank ½ full on the floor in a hallway. Which of the following is the most appropriate action for you to take?
    a. Call a Code Orange
    b. Place it in the Red oxygen cylinder rack
    c. Place in the Green oxygen cylinder rack
    d. Carry it to the Storeroom for storage

20. What two identifiers are correct for an associate to use to confirm a patient's identity at Jefferson Health?
    a. Patient name and date of birth
    b. Medical record number and date of birth
    c. Patient name and medical record number
    d. None of the above

21. If you see someone with signs and symptoms of a stroke, what would you do?
    a. Call a doctor
    b. Call an RRT (2222) in the hospital or 911 in the community
    c. Notify administration
    d. None of the above

22. The purpose of the Universal Spill Kit is to contain an unknown substance until the MSDS is read for specific clean-up and disposal instructions.
    True or False

TRUE OR FALSE

23. All Emergency Departments and inpatients are screened for suicide risk.
    True or False

24. Standard Precautions are healthcare practices such as hand hygiene and using Personal Protective Equipment (PPE) that should be used when caring for patients to help prevent the spread of infectious agents.
    True or False

25. Every patient must be assessed for communication barriers. This clinical information must be accurately communicated via SBAR when handing off clinical care to another health care worker.
    True or False

Student Validation Form

I. Jefferson Health Hosipital
   a. Nursing Practice Model
   b. Relationship Based Care Practice
   c. Nursing Philosophy

II. General Hospital Information
   a. Campus Specific Services
   b. Community Services
   c. Visiting Hours
   d. Smoke Free Environment
   e. Parking
   f. Identification Badges
   g. Dress Code
   h. Cafeteria
   i. Telephone Use

III. Patient's Rights
   a. Medical Ethics Advisory Committee
   b. Patient Bill of Rights
   c. Confidentiality of patient Information (HIPAA)
   d. COBRA/EMTALA

IV. Infection Control
   a. Hand Hygiene
   b. Isolation
   c. Blood Borne Pathogen Exposure
   d. Urinary Catheter Bundle

V. Safety/Emergency Preparedness
   a. Safety Data Sheets
   b. Equipment Safety
   c. Radiation Safety
   d. Reporting an emergency
   e. Codes and their meaning
   f. Code Red
      i. Code Red Procedure
      ii. R.A.C.E.
      iii. P.A.S.S
   g. Code Blue and Code White
      i. Code Team
      ii. The Student Role
      iii. Do Not Resuscitate Orders (DNR)
   h. Rapid Response Team
   i. Stroke Alert

VI. General Patient Care
   a. Spiritual and Terminal Care
   b. Fall Prevention/Protection Bundles
   c. Maintaining Skin Integrity
   d. Patient/Family wrist bands
   e. Cultural Diversity
   f. Pain Management
   g. Waste Disposal
   h. Linens

VII. Medication Administration
   a. Work list and charting
   b. Stock and controlled drugs Patient Identification Food and drug interaction
   c. Adverse drug reactions

VIII. Documentation
   a. General Rules

IX. Role of the Student Nurse with EHR

X. References and Resources
   a. Nursing Standards Manual
   b. Lippincott Procedures
   c. Lexicomp
      i. Drug / Medical Reference
      ii. Patient Education
      iii. Care Notes

XI. General Points
   a. Used commodes and IV poles-dirty utility room
   b. Sharps disposal
   c. Use of patient charts
   d. Students may not use glucometers
   e. Must use 2 forms of patient ID

XII. Restraints
   a. Goals and Definitions
   b. Non-violent and Violent Management
   c. Tier 1 Alert/ Code Gray
   d. Safe Room

XIII. Nursing Role Models
   a. Nurse Manager
   b. Charge Nurse
   c. Case Manager/
   d. Staff RN
   e. CNA/PCT
   f. Monitor Technician
   g. Unit Secretary
   h. RN Navigator

XIV. Leaving the unit
   a. Patient Safety
   b. Documentation
   c. Nurses Report

XV. Surgical Rotation Observation Guidelines
   a. Proper Attire
   b. Case set up/ observation

IX. Student Nurse Scavenger Hunt

X. Validation Sign Off

XI. HIPAA Confidentiality Agreement

Name (Print):_____

Signature: _____

School: _____ Date: _____

Return this sheet to Williamae Hazelton, Clinical Education, 3rd Floor, Stratford Campus

CONFIDENTIALLY AGREEMENT

All sections **MUST** be completed fully. Any questions, please contact the Nursing Education Office.

INSTRUCTIONS:	
1. Please **PRINT** or **TYPE** all information using a ballpoint pen. 2. Fill in all requested information. 3. Carefully **read** the Confidentiality Statement. 4. Sign, date and return the completed form.	**Return Completed Document to**: Undergraduate Students Only: Debbie Malone, 18 E. Laurel Rd, Stratford, NJ 08084 Graduate Students Only: Holly Curcio, 2201 Chapel Ave West, Cherry Hill, NJ 08002

USER INFORMATION – PLEASE PRINT CLEARLY

Student Name: Click here to enter text.

Email address: Click here to enter text. *(Will be used for notification purposes only)*	**Phone**: Click here to enter text. *(Will be published in internal directory)*
Expiration Date: Click here to enter a date.	***Access will be terminated on expiration date. If student is returning for a different semester a new form is required.***
Job Title: _____**Nursing Student**_____ Semester: Click here to enter text.	**School:** Click here to enter text.

CONFIDENTIALITY STATEMENT AND REQUIRED USER SIGNATURE

I understand and agree that the information/data I, as a nursing student, will receive or be exposed to patient health information that is considered ***CONFIDENTIAL.*** Under **NO** circumstances will such information available to me be used, conveyed or discussed by me, unless required in the performance of my duties. I will adhere to all organizational policies that define the confidential information and the protection of that information at the Jefferson Health. I will **not use or disclose PHI that is obtained** via any computing resource or shared with me by my preceptor at the Jefferson Health including, but not limited to; wireless, Internet, **personal** smart devices, unless it is permitted by Privacy laws. I understand that access to PHI is strictly for business purposes. System access will be tracked and monitored for proper use. Furthermore, I agree to the following:

a. I will not make any unauthorized copies of data, which includes photography, and will not save any confidential information to portable media devices (memory sticks, CDs, and other devices);
b. I will not email data to another email account except as expressly provided for in the secure networking environment provided Jefferson Health;
c. **I ACKNOWLEDGE AND AGREE THAT I WILL NOT DIVULGE, RELEASE OR SHARE PROTECTED HEALTH INFORMATION TO WHICH I AM PARTY TO without patient authorization.**
d. **Additionally, I acknowledge that I am responsible for ALL PATIENT information that I AM permitted to access and/or view. I understand this access can be monitored at any time;**
e. I agree to notify the Educational Instructor/Help Desk **IMMEDIATELY** if I become aware or suspect that a potential or actual breach of patient information and/or if I have reason to believe that there has been a misuse of data;
f. I agree to secure patient information that is in my possession or at my workstation before leaving my work area to prevent others from accessing confidential information;
g. **I agree to never access data or ask an associate to gain access and/or print documents pertaining to my own PHI, my family members, friends or coworkers, celebrities, public figures, etc. unless the access is necessary to provide education and training or unless this information is needed for me to perform a business related function.**
h. I agree to use the appropriate sources (lab, medical imaging, medical records or patient portal) to request/obtain copies of information contained in my own personal medical record.
i. I will not install or use illegal copies of software on corporate computers;
j. I will not text **ANY** data **or take photos of patients or patient information nor will I post information regarding ANY patient "interesting events" on social media.**
k. **I am aware that any unauthorized access to, alteration or destruction of PHI will result in disciplinary action/termination from this program.**

Third Party Beneficiaries: Jefferson Health and I agree that any patient whose PHI is disclosed under this agreement is an intended third party beneficiary to this agreement.

Indemnification: I agree to indemnify and to hold Jefferson Health harmless from any losses or damage, including reasonable attorney fees incurred in defending itself from a claim by a patient that I breached such patient's right to confidentiality.

Student Signature: _____ **Date:** _____

Witness _____ **Date:** _____

2018 **Post Test Answer Sheet**

FOR CLINICAL ORIENTATION FOR NURSING STUDENTS/ INSTRUCTORS

T (True) or F (False)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Matching

11._____
12._____
13._____
14._____
15._____

Multiple Choice

16._____
17._____
18._____
19._____
20._____
21._____

T (True) or F (False)

22._____
23._____
24._____
25._____

Name:_____

School of Nursing: _____

Date:_____**Semester:**_____

GRADE: _____ (Each question is worth 4 points)

Instructor: _____

Instructors: Pages 76, 77, and 78, MUST be graded, signed and returned to Williamae Hazelton, Clinical Education, 3rd Floor, Stratford Campus upon completion