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WELCOME AND INTRODUCTION

This booklet is designed to help orient you to The Johns Hopkins Hospital (JHH) policies and protocols. This information applies to most adult inpatient units. Standards for specialty units such as Pediatrics, PACU, ED, and ORs may vary. Consult the Nurse Manager or Charge Nurse in these areas for additional information.

- All agency nurses, nursing students and faculty are expected to fully comply with the JHH standards of care/practice, policies and procedures.
- RNs at the JHH maintain primary responsibility for the care of our patients.

For more info, see Pediatric Protocols/Procedures -
www.insidehopkinsmedicine.org/pediatricnursing/peds_index.html

Resources

- This booklet reviews fundamental elements of the JHH policies/procedures. More information about the protocols and procedures summarized in this booklet can be found on the JHH Nursing intranet available on all public workstations within the JHH and the JHU School of Nursing. These websites are only accessible via a JHH secure computer.
- We are happy to answer any questions you may have so please do not hesitate to ask. The Nurse Manager, Nurse Clinician IIIs, or Charge Nurses are your primary clinical and administrative resources on the nursing units. Nurse Practitioners, Clinical Specialists, Nurse Educators, and Shift Coordinators are also available for consultation within most departments.

For more info, see http://intranet.insidehopkinsmedicine.org/nursing
For detailed information on JHH policies see HPO (Hopkins Policies Online)
http://www.insidehopkinsmedicine.org/hpo/
For detailed information on JHH skills and procedures

CODE OF CONDUCT

JHH has defined personal and professional standards of conduct and acceptable behavior for all people while carrying out assigned responsibilities at the Hospital, including its regulated sites. The standards of conduct outlined below will help to ensure a positive environment for staff, patients, and visitors and a culture that optimizes patient care and safety.

This code applies to anyone providing care and services, including agency nurses and students.
Standards of Conduct and Professionalism:
♦ Treat all persons, including patients, families, visitors, employees, trainees, students, volunteers, and healthcare professionals with respect, courtesy, caring, dignity, and a sense of fairness and with recognition of and sensitivity to the needs of individuals from diverse backgrounds (including gender, race, age, disability, nationality, sexual orientation, and religion).
♦ Communicate openly, respectfully, and directly with team members, referring providers, patients, and families in order to optimize health services and to promote mutual trust and understanding.
♦ Encourage, support, and respect the right and responsibility of all individuals to assert themselves to ensure patient safety and the quality of care.
♦ Resolve conflicts and counsel colleagues in a non-threatening, constructive, and private manner.
♦ Teach, conduct research, and/or care for patients with professional competence, intellectual honesty, and high ethical standards.
♦ Promptly report to supervisor any individual who may be impaired in his or her ability to perform assigned responsibilities due to any cause.
♦ Promptly report adverse events and potential safety hazards and encourage colleagues to do the same.
♦ Willingly participate in, cooperate with, and contribute to briefings, debriefings, and investigations of adverse events.
♦ Respect the privacy and confidentiality of all individuals. Adhere to all JHH policies and HIPAA regulations regarding personal health information.
♦ Uphold the policies of The Johns Hopkins Hospital.
♦ Utilize all Johns Hopkins facilities and property, including telecommunication networks and computing facilities, responsibly and appropriately.
♦ Participate in education and training required to perform job duties.
♦ Be fit for duty during work time, including on-call responsibilities.

For more information, refer to the supporting policies for this code of conduct or go to [http://www.insidehopkinsmedicine.org/hpo/policies/39/143/policy_143.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/39/143/policy_143.pdf)

ORIENTATION INFORMATION

Required forms and instructions can be found on the Nursing Intranet at: [http://www.hopkinsmedicine.org/nursing/benefits/education/student_clinical_placements.html](http://www.hopkinsmedicine.org/nursing/benefits/education/student_clinical_placements.html)

The agency nurse orientation form is at the following link: Appendix D [http://www.insidehopkinsmedicine.org/hpo/policies/40/352/policy_352.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/40/352/policy_352.pdf)
Agency nurse practice

Agency nurses MAY:

- Have access to narcotic cabinet keys and/or a PYXIS ID number, and may count or administer controlled substances at the discretion of the Nurse Manager.
- Administer IV push medications for adults according to the JHH Intravenous Push list with demonstrated competency.
- Perform selected activities (e.g. chemotherapy administration, point of care lab testing, etc.) provided they complete the same training/competency validation as JHH staff. Activities requiring special training are identified in this booklet.
- LPNs may administer all medications except IV push; IV chemotherapy; initiate or manipulate complex infusion devices (PCA); titrate/wean continuous infusions

*For more info, see IV Push Med Policy*


Private duty agency nurses:

- **May not** administer medications, perform any patient treatments, or document in the medical record.
- **May** provide comfort measures and assist the patient with ADLs only.

Nursing student practice

Nursing students MAY:

- Administer medications if faculty is onsite. The faculty is responsible for closely supervising students with medication administration. In Pediatrics, **ALL** medications administered (including PO) by a student must be under the direct supervision of the instructor.
- Administer medications under the supervision of a JHH RN preceptor if doing an independent clinical practicum. This applies to BSN students and all JHUSON CAPP program students. Some department policies are more restrictive re. students administering medications. Please check your department policy to verify.
- Administer IV push medications only if RNs in that department/unit are allowed to do so, and only under the direct supervision of the faculty.
- Administer controlled substances under the direct supervision of the faculty. The instructor will be assigned a temporary Pyxis password each day. The nursing instructor can then sign the controlled substance out of Pyxis and supervise the student administering it.
- Document nursing care, including assessment, notes, flow sheets, medication administration. Documentation must be reviewed for accuracy and cosigned by faculty prior to the students leaving the nursing unit.
- The student and/or faculty must give a verbal report to the responsible nurse prior to leaving the nursing unit.
- Serve as a witness for written informed consent.
Nursing students MAY NOT:

- Administer chemotherapy.
- Administer medications if they are employed/working as a Clinical Nursing Extern (CNE) or Clinical Technician or Associate (CT or CA).
- Hang/administer blood products. They may monitor the patient before, during, and after a transfusion.
- Take verbal orders.
- Initiate/implement restraints. Nursing students may perform and document observations and other delegated activities according to the protocol.
- Scrub in during surgical procedures.
- Perform Point of Care Testing
  - NovaStat Strip blood glucose meter
  - HemoCue hemoglobin testing
  - Gastrocult gastric occult blood testing
  - Hemocult fecal occult blood testing
  - Urine dipsticks
  - pH with nitrazine paper
  - Pregnancy testing
- Perform Carefusion (Barcode SCV –Specimen Collection Verification)
- Serve as a witness for telephone informed consent

CONFIDENTIALITY

Every patient treated at the JHH has the right to expect that personal and medical information will be kept confidential. Access to patient medical and non-medical information is permitted only to provide appropriate and necessary care, according to Maryland law and the JHH policy. Confidential information includes all aspects of the medical record, lab reports, lists of Hospital admissions, procedure schedules, and billing and insurance information.

To protect patient confidentiality:

1. Avoid discussing patients in public places, such as elevators, hallways, and cafeterias.
2. Protect the patient's medical record from use by unauthorized persons.
3. Protect computer screens and phone conversations from unauthorized observers.
4. Do not discuss patient information unless authorized by the patient or law.
5. Do not look at medical record information unless you have a “need to know.” (This does not include your own curiosity about a patient who is not under your care)

Avoid giving information over the telephone. Directory information is permitted; this consists of the patient's presence on the unit and condition (e.g., good, fair, poor, guarded – with minimum detail). This does not pertain to Psychiatry and Drug and Alcohol Treatment areas, which have very strict protection under the law. In these areas you cannot confirm or deny patient's presence on unit.
## HIPAA

### HIPAA Training

All new agency nurses (per diem and contracted), Faculty instructors and students are required to complete the Health Insurance Portability and Accountability Act (HIPAA) training prior to starting on the clinical units.

**Agency nurses:**
- Must complete the HIPAA training through their agency.

**Nursing school faculty and students:**
- If HIPAA training has been completed at their school, the instructor must provide the JHH Nursing Education Coordinator documentation stating that HIPAA training was completed at (the name of) school and the list of instructor and student names who completed the HIPAA training. All faculty and students coming to the JHH must sign a Johns Hopkins confidentiality pledge and return the signed document(s) to the JHH Nursing Student Coordinator.
- If HIPAA training has not been completed at their school, faculty and students must complete HIPAA training in myLearning as a guest and provide a certificate of completion to JHH Nursing Student Coordinator.

## PATIENT BILL OF RIGHTS FOR THE JHH

1. You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
2. You have the right to receive care in a safe environment free from all forms of abuse, neglect or harassment.
3. You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
4. You have the right to be told the names of the doctors, nurses and all health care team members directing and/or providing your care.
5. To have a family member or person of your choice and your own doctor to be notified promptly of your admission to the hospital.

### Patient Responsibilities

Patient’s also have responsibilities while they are being cared for at the JHH. Listed below are examples:

1. You are expected to provide complete and accurate information (personal and medical).
2. You should provide the hospital or your doctor with a copy of your advance directive if you have one.
3. You are expected to ask questions when you do not understand information or instructions.
4. You are expected to actively participate in your pain management plan.
5. You are expected to treat all hospital staff, other patients and visitors with courtesy and respect.

For a complete listing of the Patient Bill of Rights and Responsibilities see: http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/pdfs/bill_of_rights.pdf

VIP patients
Celebrities, VIPs, and other high-visibility patients often come to the JHH. While their visits here can be a cause of excitement and attract attention from staff and other visitors, we all must remember that these patients deserve the same respect, privacy and confidentiality we give to all our patients. As tempting as it may be to want to talk to these people about matters not related to their visit to Hopkins, or even to ask for their autographs or photographs, we must remind ourselves that doing so can be very distressing to celebrities, as it would to any other patient.

PATIENT IDENTIFICATION

Verifying correct patient identification information is the responsibility of everyone who interacts with a patient. Clinical personnel need to verify patient identification before initiating a procedure, sedation, treatment, or transportation. Use patient’s name, history number or date of birth for outpatient areas to confirm the patient’s identity.


PARKING/ID badges

Due to severely limited parking on the JHH campus, there are no special parking rates available for students, faculty or agency personnel. (Agency RNs note: All parking expenses are the responsibility of the Travel RN.)
Who should get an ID badge?

- Instructors
- GYN/OB Independent Practicum Student (This gives them security and scrub access)
- Students who work off shifts to take advantage of the free parking. Students may park for free only during these designated times: Monday - Friday, 4:00 p.m. - 8:30 a.m. and all day Saturday, Sunday and designated holidays.

How do I get a badge?

- To get a temporary JHH ID badge, email Allie Butanis, abutani1@jhmi.edu, with your name, school, social security number, date of birth and the last day of your clinical rotation. Allie will process and submit your request to the ID office, where you will pick up your badge. (Directions and information will be provided to you by Allie after she received your request)

Where to park?

- Students may park in any garage, except for the Orleans Street parking garage. For a list of the parking garages available and a map of our campus, go to: [http://www.hopkinsmedicine.org/security_parking_transportation/parking/](http://www.hopkinsmedicine.org/security_parking_transportation/parking/)
- For your personal safety, we strongly recommend that you park in one of the hospital garages and pay the fee if you are not eligible for free parking. Car pool with other students to split the cost, if possible.
- Parking questions? Contact the Parking Department, 410-955-5333.
- Need a security escort to and from the garage? Call 410-955-5585, 24/7.

Other:

- **Students** are required to wear school ID. For students going into secured areas, such as labor & delivery/post-partum, the Security Department must be provided with their social security numbers. The security guard in the area will have the list of student names and social security numbers, and will allow the student entry into the area. Once in the secured area, the faculty member, who will have an authorized photo ID, will be responsible for "swiping" the student out of the area.
- **Per diem Agency** – If working on a nursing unit on a recurring basis may be eligible for JHH temporary ID, at the discretion of the Nurse Manager. See Nurse Manager/Educator for the needed form.
- **Contracted Agency** are required to wear a JHH temporary ID. See Nurse Manager/Educator for the needed form.
SAFETY AND LEGAL ISSUES

“The Johns Hopkins Hospital strives for safety in patient care, teaching, and research.” This is the JHH safety mission statement.

To support this mission, JHH has developed an Ethical Framework for Safety, which is online at http://www.insidehopkinsmedicine.org/hpo/policies/39/142/appendix_25931.pdf?CFID=123876751&CFTOKEN=fb49aa3126de5bf4-5E047B64-A051-D9B4-C3CFE62066C826FA

What can you do to promote patient safety?

• Look for system flaws and at your own work for potential threats to safety.
• Share your ideas for safety improvement.
• Think before you act.
• Speak up and report mistakes.
• For immediate concerns, use your departmental chain of command and call existing emergency phone numbers.
• For urgent patient safety concerns, contact your supervisor.
• Report events in Patient Safety Net (PSN)—
• The JHH Compliance Line (1-877-WE-COMPLY), is used to report workplace concerns such as non-compliance with policies and safety issues. The Compliance Line is not equipped for urgent response.

For more info on patient safety initiatives at JHH, see http://www.insidehopkinsmedicine.org/safety/

Any employee who has concerns about the safety or quality of care provided by JHH may report these concerns to the Joint Commission (TJC). JHH will take no disciplinary action because the employee reports concerns to TJC.

To report a safety concern to TJC, call 1800-994-6610 or go to: http://www.jointcommission.org/

Remember, patient safety begins with you!

National Patient Safety Goals for 2013

Identify patients correctly

• Use of two patient identifiers in two places. Use two identifiers when administering medications, blood or blood components, collecting blood samples or other specimens, or when providing other treatments or procedures.
• Eliminate transfusion errors
• Actively involve the patient, and as needed, the family, in the identification and matching process.
• Patients on a special diet who receive a tray or snack must have their name and history number on the tray ticket compared to the information on their arm band.
• Label all specimens in the presence of the patient.
• All inpatients must have a safety band at all times.

**Improve staff communication**

• Read back verbal or telephone orders and critical action values. (Write it down and read it back to ensure accuracy of telephone or verbal communications.)
• Create a list of abbreviations not to use (see below)
• Timely reporting of critical tests and results
• Manage hand-off communications by allowing an opportunity for questions and limiting interruptions.

For more information, go to

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**Abbreviations Prohibited at JHH:**

- “U” for unit
- “IU” for international unit
- Lack of leading zero (.2 vs 0.2)
- Trailing zero (2.0 could be mistaken for 20)
- MSO₄ or MS for Morphine
- MgSO₄ for Magnesium Sulfate
- QD for once daily
- QOD for every other day

For more information go to the medical abbreviation policy at the following link:

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**Use medicines safely**

• Manage look-alike/sound-alike medications
• Label medications and containers with drug name, strength, amount, expiration time if occurs in less than 24 hours.
• Ensure completion of medication reconciliation
  • For more information see,
• Take extra care with patients who take medicines to thin their blood
• Use extra caution/care when working with High Alert Medications: Chemotherapy, Heparin, Infused Parenteral Opiods, Infused Insulin, and Concentrated Electrolytes.

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**Prevent infection**

• Comply with hand hygiene guidelines
• Prevent Multi-Drug Resistant Organism infections
• Prevent central line-associated blood stream infections
• Prevent surgical site infections
• Prevent infections from urinary catheters

Identify patient safety risks
• Implement a fall reduction program
• Identify individuals at risk for suicide

Prevent mistakes in surgery
• Wrong site, wrong procedure, wrong person surgery can be prevented. At JHH, we follow the **Universal Protocol**. This includes:
  – A pre-operative, pre-procedural verification process.
  – Marking the operative site for procedures involving right/left distinction, multiple structures (such as fingers and toes) or multiple levels (as in spinal procedures).
  – Time out immediately before starting the procedure, involving active communication among all members of the surgical/procedural team.

Additional safety reminders:
MRI Safety Reminders
• The MRI Procedure Screening Form must be completed prior to every MRI scan. A powerpoint that reviews MRI safety can be viewed via following this link [www.rad.jhmi.edu/mri/MRI%20%20safety.ppt](http://www.rad.jhmi.edu/mri/MRI%20%20safety.ppt)
• All electrodes and cables must be removed prior to MRI, as they have been known to cause burns.
• Pacemakers are contraindicated. Some implantable devices are MR compatible. Call 5-4266 if you have questions.
• The MRI machine is always on. Remove all metal before entering the MRI area.
• Extension tubing must be used for oxygen, IVF or PCA.
• For patients receiving CPN call the VAD team to apply the extension tubing and flush.

**MEDICINAL EQUIPMENT SAFETY**

Basic Safety Tips:
• Make sure all patient care equipment is appropriately cleaned and disinfected prior to use and in between patients.
• Use equipment only if you have been appropriately trained. Seek instruction from experienced user.
• Use equipment in the manner it was intended for use. Never alter or use for non-approved functions (i.e. using an IV pump for tube feedings).


Broken/Malfunctioning Equipment:
• If you suspect an equipment problem, remove it from patient use **immediately**.
• Clearly label the equipment as broken and write out the problem using the pre-printed broken equipment labels.
• If the patient has been injured, call Clinical Engineering to pick the equipment. Leave any disposables or accessories intact (i.e. tubing). This will help in the investigation of the problem.
• Refer to the equipment ID number (this is on the yellow barcode tag on the equipment) and complete a PSN report.

See patient care equipment policy for more information

OXYGEN SAFETY

Oxygen Outage
Most units have emergency oxygen H cylinders for use in case of loss of wall oxygen pressure.

If your unit has backup H cylinders, and your unit loses wall oxygen pressure:
• Locate the oxygen zone valve and shut it OFF.
• Attach the back-up oxygen H cylinder to the nearest wall oxygen outlet by plugging it into the wall outlet. Open the valve on top of the tank, and the wall pressure should return.
• Call x 5-4444; report your location, the loss of oxygen pressure, and your use of the back up H cylinder.
• Notify the charge nurse and medical staff of the emergency. Try to conserve oxygen use as much as possible.
• Contact Oxygen Therapy or Respiratory Therapy for more oxygen cylinders.

If your unit does NOT have backup H cylinders:
  – When the oxygen alarm sounds, verify abnormal oxygen pressure and place oxygen dependent patients on E cylinders (transport tanks). Try to conserve usage.
  – Make overhead page on the nursing unit: “Piped oxygen outage procedures are now in effect.”
  – Call x5-4444 to report the oxygen outage.
  – Page Oxygen Therapy technician/Respiratory Therapy for more cylinders as needed.
  – Operators will use the oxygen emergency call list and announce a hospital wide overhead page. "Piped oxygen outage procedures now in effect."
  – At the end of the outage, operators will announce that the “Piped oxygen outage procedures are no longer in effect.”

For more info on oxygen outage procedures, see.

Oxygen Cylinder Safety
Medical gas cylinders (oxygen, nitrous oxide, compressed air, etc.) can be dangerous if not restrained by a chain or stand. If a cylinder falls and the nozzle cracks, it can be propelled through walls like a rocket.

- Secure all cylinders, empty or full, at all times.
- Only one tank can be secured by a strap or a chain.

Do not:
- Use cylinders to hold open doors.
- Place cylinders on the bed beside a patient.
- Lay any cylinder flat on its side.
- Send non-aluminum cylinders to MRI.

For more information, see http://www.hopkinsmedicine.org/hse/Policies/HSE_Policies/indiv_sections/HSE018.pdf

SUICIDE PRECAUTIONS

*Note: The following information does not apply to patients in the Department of Psychiatry. If you are working on a psych unit, refer to the Psychiatry Standard of Care Manual.*

Patients who express suicidal ideation or demonstrate behaviors that jeopardize their safety will have an observer assigned to them at all times with registered nurse accountability.

- The RN is accountable for the patient under observation by a non-RN observer.
- The RN is responsible for assessing the patient twice per 8 hour shift or 3 times per twelve-hour shift and for documentation.

An RN may initiate suicide precautions and a physician must countersign the order by the end of the next calendar day. The physician must write the order for a patient observer.

**Family members and significant others are not permitted to assume responsibility for one-to-one accompaniment/observation.**

In order to protect the patient from self-harm and environmental hazards, the following actions are to be taken:

1. The patient: staff ratio is one to one. The observer assigned to the patient is relieved of other duties.
2. The observer keeps the patient in direct sight at all times. (No pulled curtains or closed doors.)
3. Stay within 5 feet of the patient at all times.
4. Go everywhere with the patient (on and off the unit).
5. Potentially hazardous items are removed from the patient's person, belongings, and the
room. The patient uses only an electric razor.
6. Meals are served on paper products with a metal spoon.
7. When dare, maintain visual contact. Use a night-light as needed.

For more info, see Suicide Precautions

REPORTING OF EVENTS

Untoward Events
An untoward event does not necessarily mean someone did something wrong; however, it does mean something occurred which was unexpected or unusual and as such, is important for follow-up and trending. Contact the Charge Nurse or the patient’s nurse as soon as an untoward event happens.

PATIENT SAFETY NET (PSN)

- PSN is a web-based event reporting system, available on all public workstations at JHH.
- It is used to report medication events, adverse drug reactions, equipment/supply and device events, falls, skin breakdown (pressure ulcers, burn, lacerations), unexpected events during surgical or invasive procedures, unexpected events during respiratory care procedures and treatments, events related to laboratory and/or radiology tests, unexpected complications of procedures, treatments, and tests, etc.
- Triggers email alerts to appropriate managers and staff
- What is reported in PSN? (not a comprehensive list)
  - Medication events
  - Adverse drug events
  - Equipment/supply and device events
  - Falls
  - Skin breakdown
  - Incomplete count
  - Wrong procedure/wrong side
  - Mislabeled specimens
  - Refusal of treatment
  - Incorrect identification of patient
- PSN is not used to report urgent events (such as fire, flood etc)
  - Blood transfusion reactions, staff injuries, and body fluid exposure are not reported in PSN.

Go to the following link for additional training materials and access to the PSN system.

http://www.insidehopkinsmedicine.org/psn/

The goal is prevention, not blame.
For more info, see:

Event Reporting Policy

Nursing Practice Events Policy

Contact the Law Office (x5-7949) Immediately for:

- Any event causing temporary harm and required initial or prolonged hospitalization or permanent harm
- Near-death event (e.g., required ICU care or other intervention necessary to sustain life)
- Patient suicide
- Patient rape
- Infant abduction
- Discharge of infant to wrong family
- Hemolytic transfusion reaction
- Surgery on the wrong patient or body part
- Retained sponges
- Radiation overdose
- Nosocomial infections with permanent loss of function
- Unanticipated death of full term infant
- Death or serious injury caused by medical error

Subpoenas

- If you are contacted by an attorney or receive a subpoena related to a JHH event immediately contact the JHH Legal Department, x5-7949. There is an attorney on call 24/7. Do not engage in a discussion with the other party.

NURSING ROLES AT JHH

Nurse Manager - Responsible for overall quality of patient care on unit

Nurse Clinician III (NCIII)
• RN; Provides clinical, administrative, and/or educational leadership on unit

**Nurse Clinician II (NCII)**
• RN; Provides direct patient care
• Plans and implements nursing process
• Provides direct supervision, delegates tasks to unlicensed assistive personnel

**Nurse Clinician I (NCI)**
• Entry level RN
• Provides direct patient care
• Plans and implements nursing process

**Licensed Practical Nurse (LPN)**
• Provides direct patient care in team relationship with RN
• Administers medications

**Unlicensed Assistive Personnel – Clinical Nursing Extern, Clinical Technician, Certified Nursing Assistant, Surgical Technician**
• Performs routine patient care activities under the supervision of an RN
• May not assess, plan, evaluate care, or administer medications

**CCSR (Clinical Customer Service Representatives)**
• Maintains medical record
• Communication hub of unit

**Support Associate (SA), OR Associate (ORA)**
• Maintains unit environment
• Does not provide independent direct patient care

*To see the JHH job descriptions, go to*
http://intranet.insidehopkinsmedicine.org/nursing/administration/descriptions_skills_checklist/

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**CLINICAL CARE**

**ALLERGY ALERT COMMUNICATION TOOL AND WRISTBAND FOR ADMITTED PATIENTS**

This protocol applies to all patients (adults and pediatrics) in the JHH and is implemented whenever patient allergies or sensitivities to medications, food, or latex are identified on admission and throughout the hospitalization.
Registered nurses are responsible for:

- Screening all patients on admission for known allergies, sensitivities and reactions.
- Verifying allergies with the History and Physical (H&P), admission orders, and the patient and documenting on the Allergy Alert Communication Tool.
- Updating and reviewing the Allergy Alert Communication Tool.
- Applying allergy/sensitivities wrist band to the patient. The Allergy wristband should be placed on the same extremity as patient identification band (preferably).
- Requesting that the patient remove ALL non-JHH colored wristbands that are being worn at the time of admission.
  
  **NOTE:** Anesthesia places a GREEN color wristband on patients with difficult airway. **DO NOT REMOVE THIS WRISTBAND.**
- Teaching the patient and family members about the purpose of the allergy wristband. Also explain the hazards of wearing a wristband to those who refuse to remove.

Prior to administering any medication the RN/LPN will:

- Review the ordered medication and check for allergies/ sensitivities.
- Verify the presence of Allergy Alert wristband.
- Complete a PSN report if the patient has known allergies and does not have an Allergy Alert wristband.

Food hypersensitivity is recognized by The Johns Hopkins Hospital as a potentially life - threatening disorder.

- Food allergies are documented in Sunrise Clinical documentation and orders. The food allergies will appear on the patient’s menu. Validate the appropriate transfer of food/formula allergy to diet orders entry system.

- Staff who care for patients with a peanut or nut allergy should know that Purell (waterless hand sanitizer) does **not** consistently remove the peanut allergen from the hands. Therefore, it is recommended that staff **use soap & water** to wash their hands when caring for patients with a peanut or nut allergy.


LATEX ALLERGY

There are 3 types of problems associated with rubber products:

1. Irritation
2. Contact dermatitis>Type IV hypersensitivity – generally confined to the area of contact, related to rubber chemical exposure, occur within 24-48 hours of exposure, and are rarely life threatening.
3. IgE-antibody mediated allergies/Type I hypersensitivity) – manifest as a spectrum of local
to systemic reactions, are related to rubber protein exposure (sometimes attached to glove
cornstarch powder), occur within minutes of exposure, and can be life threatening.

Signs/symptoms of Type I hypersensitivity to latex include:

- Skin: rash, swelling, hives, itching, redness, irritation
- Eyes: itchiness, tearing, watering, redness
- Upper airway: runny nose, throat tightness/swelling, sneezing
- Lower airway: asthma, wheezing, cough, shortness of breath, chest discomfort
- GI: nausea, vomiting
- Cardiovascular: chest pain, palpitations, hypotension, lightheadedness, tachycardia

While it is uncommon, life threatening anaphylactic shock may occur within minutes of
exposure. It is most likely to occur when the skin barrier has been broken or exposure is across a
mucous membrane (e.g., inhaling glove cornstarch powder with adsorbed latex protein, blowing
up a balloon, using a condom, with a rectal/colon examination, urethral catheterization, or dental
surgery).

Direct skin contact with latex is not necessary for a reaction to occur. For example, allergenic
latex proteins are adsorbed on glove powder which, when latex gloves are snapped on and off,
become airborne and can be directly inhaled.

**Identification of Latex Allergy Patients**

2. Post sign to communicate risk.
3. Follow Allergy Alert Communication Tool and Wristband policy
4. Notify authorized prescriber if a latex allergy or sensitivity is documented.

**Prevention of Allergic Reactions**

1. Use products that limit patient exposure:
   - Use only synthetic (non-latex) gloves in the patient's room. This includes gloves used
     for other patients and for cleaning room.
   - Keep the door of patient's room closed to decrease exposure to airborne allergens.
   - Puncture multidose medication vials one time only, and then discard (unless using a
     multidose vial adaptor).
2. Patient education:
   - Provide info to the patient for obtaining an allergy alert bracelet.
   - Tell all health care providers (do not count on it being in chart).
   - Carry autoinjectable epinephrine/B-agonist inhaler.
   - Identify natural latex rubber containing products.

**Diagnosis and Treatment of Latex Anaphylaxis**

Anaphylaxis generally occurs 20-60 minutes after exposure to latex, and presents with
hypotension, bronchospasm, and rash. (Hypotension is the most common sign. Rash doesn't always occur.) Treatment is similar to the treatment of severe allergic reactions caused by other antigens.

Emergency nursing care includes:
- Stop contact with latex.
- Do not leave patient. Call for help.
- Have epinephrine and other emergency medications readily available.
- Maintain airway. Initiate CPR if indicated.
- Monitor vital signs.
- Place patient in Trendelenburg (unless contraindicated for other reasons)
- Complete a PSN report

For more info, see Latex Allergy Protocol and a list of products known to contain latex

BLEEDING PRECAUTIONS

For more info about the Bleeding precautions policy go to

Bleeding precautions should be initiated on all patients at HIGH risk for bleeding, including:

Patients receiving any of the following medications:
- Those receiving systemic therapeutic anticoagulant therapies (not prophylaxis except as defined below):
  - Unfractionated heparin
  - Low molecular weight heparin (e.g., enoxaparin, dalteparin, tinzaparin)
  - Pentasaccharides (e.g., fondaparinux)
  - Direct thrombin inhibitors (e.g., argatroban, lepirudin, bivalirudin)
  - Vitamin K antagonists (e.g., warfarin)
- Patients who are on two or more antiplatelet drugs (ASA, NSAIDs, clopidogrel, prasugel, ticagrelor, or ticlopidine)
- Thrombolytic agents (e.g., streptokinase, tissue plasminogen activator, reteplase, recombinant)
- GPIIb/IIIa inhibitors (e.g., abciximab, eptifibatide, tirofiban)
- Drotrecogin alpha (XigrisTM)

Patients that have a disease process that puts them at risk for bleeding
- Coagulation disorders (hemophilia)
- Platelet count less than 50,000 mm3
- Uremia (BUN > 80 mg/dl)
- Hepatic dysfunction with hypofibrinoginemia (fibrinogen level<100mg/dL), aPTT ratio > 1.3, or prolonged INR (>1.5)
- Patient who have a history of GI bleed and are taking ASA or NSAID

Patients who are on anti-platelet (ex. Aspirin, clopidogrel, ticlopidine) or anticoagulant agents of any dose (including prophylaxis) prior to intracranial surgery.

**Nursing Responsibilities**

- Implement bleeding precautions and post a bleeding risk sign to communicate the risk to other bedside providers.
- Monitor pertinent lab values
- Provide patient and family education
- Provides patient and family education regarding bleeding precautions.
- If frequent vital signs are needed, alternate the BP cuff between arms. Limit the use of automatic BP cuffs.
- If ordered maintain current type and screen in Blood bank.

**Nursing Assessment**

- Observe for visible and occult bleeding.
- Relevant laboratory tests, if ordered, prior to administration of high risk medications that reflect abnormalities in coagulation (e.g., PT/INR prior to administration of warfarin)
- Assess neurologic examination for changes in orientation, wakefulness, headache and unilateral motor abnormalities, which are indicative of a possible intracranial bleed.

**Safety**

- Assess patient’s ability to safely manage self care without injury or fall every shift.
- Even minor injury can induce potentially life-threatening bleeding so conservative measures are recommended (a bump to the head needs to be assessed)
- Take measures to decrease the risk of patient injury (ie provide clutter free environment and adequate lighting)
- Do not use straight razors, cuticle scissors, or nail clippers.
- Encourage use of soft bristled toothbrush. If patient is currently flossing they can continue this practice.
- Avoid IM injections and repeated IV punctures. In Pediatrics, avoid SQ and heel sticks.
- Avoid invasive procedures whenever possible. In pediatrics no nasal suctioning is to be performed; suction only to the end of the endotracheal tube.
- Apply pressure over any puncture site for 3-5 minutes.
- Implement measures to prevent constipation
- Implement humidification/flushing procedures if there are bloody secretions. ie NS nose spray
- Discuss with other healthcare providers (ie respiratory therapist, physical therapists) how their care is altered in a patient on bleeding precautions.

For patients receiving Heparin there are specific protocols that must be followed. Please the following for more information:
Only nurses who have documented competency for administration of blood and blood products may administer blood.

**Informed Consent**

- Informed consent must be obtained by the provider before any blood and/or blood products may be administered (except in the case of an emergency). The RN will review this consent form prior to requesting blood from the blood bank.
- Any licensed healthcare team member may witness patient identification with an authorized prescriber and complete documentation on the Blood Product Requisition Form.
- Documentation for refusal of blood and blood products or limitations to blood and blood products is completed on the Blood and Blood Product Consent Form and filed in the medical record.

**Dispensing Blood Products**

- Blood products will be dispensed to any member of the healthcare team with a Transport Authorization Form.
- Pneumatic tube requests may be sent via fax using the Blood Product Request Form.
- Emergency blood transports are not sent via pneumatic tube.
- Request for dispensed blood is an indication that the patient is ready to be transfused within 30 minutes and there will be no delay in transfusion. However, any blood that is not used is to be immediately returned to Transfusion Medicine. Blood may hang for a maximum of 4 hours.

**Pre-administration**

- Verify informed consent and authorized prescriber order.
- Assure patency of IV and adequate IV catheter size.
- Obtain baseline VS (temperature, BP, respirations, and pulse).
- Administer premedications if prescribed.
- Verification process: Patient identity, correct product, expiration date, product bag intact, blood product requisition form and blood product label match: patient’s name and history.
number, blood donor id number and product code name, ABO and Rh compatibility for RBCs; plasma ABO compatibility for platelets or plasma.

- Notify Transfusion Medicine immediately of any discrepancies between the blood product requisition form, blood product, and patient identification.
- The Blood Product Requisition Form MUST remain attached to the blood product while infusing.

**Administration**

- Use only NSS (before, during and after transfusion) to flush.
- Unless ordered by authorized prescriber in emergent situation, transfuse only one unit at a time.
- Don’t store in a unit refrigerator
- Return unused unit of blood to Transfusion Medicine IMMEDIATELY.
- All blood products must be filtered with the appropriate filtering device. Cryoprecipitate requires a special infusion set supplied by Transfusion Medicine.
- Intermittent blood infusion set should be disposed of after each each unless consecutive units are administered.
- Continuous blood administration sets shall be changed every 24 hours.
- Assess and record VS at baseline, at 15 minutes and at completion of transfusion.
- Begin transfusion at prescribe rate. Closely observe patient for the first 15 minutes of the transfusion at prescribed transfusion rate. If no signs and symptoms of a reaction, continue the transfusion.
- Frequently observe the patient within the first 15 minutes for: headache, anxiety, chills, dyspnea, chest pain, hypotension, flank pain, rash, hives, bronchospasm, pruritis, hypertension, and a rise in temperature > 1°C.
- Upon completion of the transfusion the RN or LPN will:
  - Obtain vital signs.
  - Maintain venous access by flushing line with NS and re-establishing IV fluids or return to previous lock status.
  - Place a copy of the Blood Product Requisition Form in the medical record after the infusion information is completed.
  - Document that the patient received the blood.
  - Document volume of blood transfused, estimated (300mL) or actual (via the infusion pump) on the I+O flowsheet.
  - Dispose of tubing as appropriate.

**Patient Transport**

- Transfusions should be completed prior to patient transfer to provide for consistent observation.
- In the event the patient needs to be transported prior to the completion of the transfusion, the patient must be transported with an authorized prescriber or RN present. These individuals must remain with the patient until the transfusion is completed or care is transferred.

*For more info, see Blood Transfusion Policy*
CARDIAC ARRESTS

When You Find a Patient Who Has Arrested

1. Stay with the patient.
2. Call for help. Call **x 5-4444** and let the operator know:
   - This is a medical emergency
   - If a child or adult is involved
   - Which emergency team you need
   - Unit, room number, phone number

The JHH uses several different teams to respond to medical emergencies. Each team consists of individuals with specific training to deal with different kinds of medical emergencies. See table below.

It is vital to get the right team to the right location as quickly as possible. To ensure that staff call the correct team, the card below should be located near hospital phones to help staff when calling for an emergency medical team. If there is ever doubt about which team to call, then call the adult arrest team for an adult and the pediatric rapid response team for a child.

3. Put a cardiac board/headboard under the patient and initiate CPR. Always initiate CPR unless there is a written physician’s DNR order.
4. Ventilate the patient using the manual resuscitation bag/mask attached to oxygen.
5. When the AED arrives, attach to the patient while CPR is being performed and begin analysis after 2 minutes of CPR. Defibrillation using the AED analysis mode should be done as quickly as possible.

*If your patient is already on a monitor and you are trained in defibrillation, begin resuscitation per your unit routine.*
Emergency Equipment Needed

- AED defibrillator and pads
- Emergency cart – adult or pediatric
- Emergency drug boxes – adult or pediatric
- Suction machine
- Manual resuscitation bag/mask bag and mask (available in the bottom section of the crash cart)
- EKG machine

When the Emergency Cart & Equipment Arrives:

1. Place the cardiac board or headboard of the bed under the patient and begin CPR (if indicated) until the AED arrives.
2. Ventilate the patient with the manual resuscitation bag that should be attached to oxygen.
3. Attach the AED electrodes on the patient.
4. Follow steps for AED operation.
5. Prepare the equipment necessary for intubation and suction.
6. Prepare the equipment necessary for an IV or central line.
7. Prepare syringes of epinephrine (prefilled syringe available).
8. Document interventions on the Resuscitation Flowsheet (Adult or Pediatric versions). This is the official order sheet for the arrest and must be signed by the authorized prescriber. It is a permanent part of the medical record and the top copy should be filed in the patient’s chart. The bottom copy is sent to the CPR office.

Sunrise units can add in the CPR macro that includes the same information as the Resuscitation Flowsheet.

Reminder when a pediatric patient or an adult patient weighing less than 40 kg is admitted, the nurse is responsible for printing, verifying the accuracy, and signing a CPR card and placing it on the front of the patients bedside chart. Go to https://orchid.hosts.jhmi.edu/tpn/cpr/ for more information.

If the patient is a pediatric-sized adult weighing less than 40 kg, the adult emergency and adult crash cart are used during the resuscitation event.

For more info, see CPR Policy
CHEMOTHERAPY

- Only nurses who have demonstrated initial and annual competency may administer chemotherapy.


DISASTER CODES

<table>
<thead>
<tr>
<th>Event</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>Code Red</td>
</tr>
<tr>
<td>Cardiac Resp Arrest</td>
<td>Code Blue</td>
</tr>
<tr>
<td>Bioterrorism</td>
<td>Code Yellow Bio</td>
</tr>
<tr>
<td>Chemical</td>
<td>Code Yellow Chemical</td>
</tr>
<tr>
<td>Radiation</td>
<td>Code Yellow Radiation</td>
</tr>
<tr>
<td>Patient Influx</td>
<td>Code Yellow ED (Up to 10 patients from a single event)</td>
</tr>
<tr>
<td>Patient Influx</td>
<td>Code Yellow Hospital (More than 10 patients from a single event)</td>
</tr>
<tr>
<td>Abduction</td>
<td>Code Pink</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>Code Gold</td>
</tr>
<tr>
<td>Elopement</td>
<td>Code Gray</td>
</tr>
<tr>
<td>Combative Person</td>
<td>Code Green</td>
</tr>
</tbody>
</table>

In the event of a disaster:

- Remain calm.
- If there is a critical event, broadcast emails and other means will disseminate information swiftly. Departments will activate their own command centers.
- If you are at work, listen to the hospital overhead pages. Once a disaster plan is implemented, report to the supervisor for further instructions.
- If you work in an area with no overhead paging, report immediately to the supervisor for further instructions.

If you are at home when a disaster or critical event happens in the area, stay at home and keep your phone line open. Do not attempt to call work because the phone lines will be very busy. Wait for further instructions from the supervisor.

If you see/receive a suspicious package/mail:

- Stay calm.
Do not open or handle the package or mail.

Put the item down gently.

Isolate the item if possible.

Call Security at x5-5585.

For more info, see Critical Event Preparedness http://www.insidehopkinsmedicine.org/cepar/

DOCUMENTATION OF THE NURSING PROCESS

- All documentation standards and forms will be covered in Sunrise Clinical Documentation class. All faculty, students, and agency staff must attend class in order to obtain access to the system.

- Instructors must complete an online Sunrise order system via JHM Interactive BEFORE attending class. Instructors can register for class by calling the JHMCIS training center at 410-614-0958. Students must also take a 2 hour Sunrise class, which can also be arranged by calling the JHMCIS training center.

- Agency nurses will register for Sunrise classes through their units.

FALL PRECAUTIONS

Fall Risk Assessment
All adult inpatients at JHH are evaluated daily for fall risk by using the JHH Fall Risk Fall Assessment Tool.

<table>
<thead>
<tr>
<th>AGE (SINGLE-SELECT)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 60 – 69 years (1 point)</td>
<td></td>
</tr>
<tr>
<td>□ 70 – 79 years (2 points)</td>
<td></td>
</tr>
<tr>
<td>□ ≥ 80 years (3 points)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FALL HISTORY (SINGLE-SELECT)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ One fall within 6 months before admission (5 points)</td>
<td></td>
</tr>
</tbody>
</table>
**ELIMINATION, BOWEL AND URINE (SINGLE-SELECT)**
- Incontinence (2 points)
- Urgency or frequency (2 points)
- Urgency/frequency and incontinence (4 points)

**MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (SINGLE-SELECT)**
- On 1 high fall risk drug (3 points)
- On 2 or more high fall risk drugs (5 points)
- Sedated procedure within past 24 hours (7 points)

**PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDs, ETC) (SINGLE-SELECT)**
- One present (1 point)
- Two present (2 points)
- 3 or more present (3 points)

**MOBILITY (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)**
- Requires assistance or supervision for mobility, transfer, or ambulation (2 points)
- Unsteady gait (2 points)
- Visual or auditory impairment affecting mobility (2 points)

**COGNITION (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)**
- Altered awareness of immediate physical environment (1 point)
- Impulsive (2 points)
- Lack of understanding of one’s physical and cognitive limitations (4 points)

*Moderate risk = 6-13 Total Points, High risk > 13 Total Points Total Points

Patients who receive a 6-13 on the Fall Risk Assessment tool are considered Moderate Risk for Fall. Patients who receive > 13 points are considered High Risk for a fall. Implement the following strategies based on the patient’s risk:

### Fall Prevention Intervention Guidelines by Risk Category

<table>
<thead>
<tr>
<th>LOW FALL RISK</th>
<th>MODERATE FALL RISK</th>
<th>HIGH FALL RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall risk score: 0-5 points</td>
<td>Fall risk score: 6-13 points</td>
<td>Fall risk score: &gt;13 points</td>
</tr>
<tr>
<td>Maintain safe unit environment, including:</td>
<td>• Institute flagging system: yellow card outside room and yellow sticker on medical record. Hill ROM flag (if available), assignment board/electronic board. Implement measures listed under low fall risk and:</td>
<td>• Institute flagging system: red card outside room and red sticker on medical record, assignment board/electronic board; Hill ROM flag, if available Implement measures listed under low/moderate risk and:</td>
</tr>
<tr>
<td>- Remove excess equipment/supplies/furniture from rooms and hallways.</td>
<td></td>
<td>• Remain with patient while</td>
</tr>
<tr>
<td>- Coil and secure excess electrical and telephone wires.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Restrict window openings

The following are examples of basic safety interventions:

• Orient patient to surroundings, including bathroom location, use of bed, and location of call light.
• Keep bed in lowest position during use unless impractical (as in ICU nursing or specialty beds)
• Keep top two side rails up (excludes box beds). In ICUs, keep all side rails up.
• Secure locks on beds, stretchers, and wheelchairs.
• Keep floors clutter/obstacle free (with attention to path between bed and bathroom/commode)
• Place call light and frequently needed objects within patient reach. Answer call light promptly.
• Encourage patients/families to call for assistance when needed.
• Display special instructions for vision and hearing.
• Assure adequate lighting, especially at night.
• Use properly fitting nonskid footwear.

• Monitor and assist patient in following daily schedules
• Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate.
• Reorient confused patients as necessary
• Establish elimination schedule, including use of bedside commode, if appropriate.
• Activation of bed/chair alarm

Evaluate need for:
• PT consult if patient has a history of fall and/or mobility impairment.
• OT consult
• Slip resistant chair mat (do not use on shower chair)
• Use of seat belt, when in wheelchair * See Med/Surg Restraint policy

• toileting
• Observe q 60 minutes unless patient is on activated bed or chair alarm.
• If patient requires an air overlay, use side rail protectors/extenders.
• When necessary, transport throughout hospital with assistance of staff or trained caregivers. Consider alternatives, e.g., bedside procedure. Notify receiving area of high fall risk.

Evaluate need for the following:
• Moving patient to room with best visual access to nursing station
• Activated bed/chair alarm
• Low bed
• Protective devices, e.g. hipsters, helmets
• 24 hour supervision/sitter
• Physical restraint / enclosed bed (only with authorized prescriber order).

On admission, discuss patient/staff partnership in preventing falls while hospitalized and provide the patient and family with the handout Patient Safety Guide to Preventing Falls in the Hospital.

For patients assessed to have continued risk for falls in the community environment, incorporate fall prevention strategies into the discharge plan and provide the patient with the handout Guide to Preventing Falls at Home.

Both of the above handouts can be found on the JHH Nursing Intranet in the Falls Policy as Appendix C and D, see below.

For more info, see Fall Precautions
INFECTION CONTROL

Artificial Nails
Artificial nails, including overlays, gels wraps, acrylics, are **NOT** permitted when providing direct, hands-on patient contact. Nail length must not be longer than ¼ inch beyond the fingertips. Nail polish is permitted as long as it is not cracked or chipped.

*For more info, see Hand Hygiene Policy*

Hand Hygiene
The following products are used for hand hygiene at JHH:
- Purell (waterless hand sanitizer) – Acceptable alternative to soap and water handwashing unless there is visible soil on the hands. It effectively destroys organisms and penetrates under fingernails better than soap. It contains emollients and is less drying than soap and water. It is not effective against C. Difficile.
- Soap and water – Take 15 seconds to vigorously rub together all surfaces of lathered hands and rinse under a stream of water. Dry with a paper towel. Use the paper towel to turn the faucet off.

**Hand hygiene with either a waterless hand disinfectant or soap and water is required:**
- Upon entering and leaving a patient room or environment
- When carrying supplies or transporting a patient into or out of a room, hand hygiene is required as soon as hands are free
- Between patient contacts
• Before donning and after removing gloves
• Before moving from a contaminated body site during patient care to a clean body site
• Before and after handling an invasive device (regardless of whether or not gloves are used).
• After contact with blood or body fluids or excretions, mucous membranes, non-intact skin or wound dressings or items contaminated with these body fluids
• Before handling food or oral medications
• And any time as needed such as after sneezing or coughing, before handling medications.

Soap and water required:
• Before eating
• After using the rest room
• Any time hands are visibly soiled
• After caring for a patient on contact precautions for C. difficile or other spore forming organisms, rotavirus, or norovirus.
  o The physical action of washing and rinsing hands is recommended because alcohols, chlohexidine, iodophores, and other antiseptic agents have poor activity against spores.
• Before caring for a patient with a food allergy
• When there is a significant build-up of waterless hand disinfectant

Approved Hand Hygiene Products
• The Hospital Epidemiology and Infection control (HEIC) Committee must approve all hand hygiene and hand moisturizing agents. Agents that have not received HEIC approval may not be used in patient care areas. All hand hygiene agents must be compatible with chlorhexidine gluconate (CHG).

Patient Education
• Staff are encouraged to educate patients and their families to practice hand hygiene measures while in the facility.
• Staff are encouraged to educate patients and families to remind healthcare workers to perform hand hygiene.

Isolation
• The 4 types of isolation used at the JHH are contact, droplet, airborne and maximum isolation.
  - The elements required for each are included in the chart below.
  - The appropriate sign/sticker is placed on the front of the chart, on the wall above the bed, and on the door.
• Biohazardous waste is placed in red plastic bags.
• Small used equipment is placed in unwaxed bags, closed, and labeled before being returned to the dirty utility room /CSD.
Large equipment is wiped with disinfectant before being removed from the patient's room.

When isolation is discontinued, the door sign is left in place until the Support Associate/Housekeeping has completed cleaning of the room.

- Contact isolation now requires staff to wear a gown and gloves to go into the patient’s room. These are to be thrown away before leaving the room. Patients with VRE and Acinetobacter are placed on Contact isolation.
- For patients on Airborne isolation, staff must wear a PAPR or N-95 respirator to go into the room.
- Maximum isolation is used for patients with VRSA or VISA.

For more info, see Isolation Policy

Personal Respiratory Protection

When caring for patients on airborne precautions and patients receiving aerosolized Ribaviran, it is essential that you use a respiratory protection device.

At JHH, there are two options for respiratory protection for staff:

- PAPR (Powered Air Purifying Respirators) – primary device

  - N-95 Respirators – for staff who cannot use a PAPR. You must be fit tested before wearing this respirator.

For more info, go to http://intranet.insidehopkinsmedicine.org/nursing/staff_education/docs/PAPR.pdf and to watch a video on the use of a PAPR, go to http://webcast.jhu.edu/mediasite/Viewer/?peid=282cec39dc364f4db12292399a97ab341d
**Standard Precautions**

Standard Precautions require:

- **Standard precautions** are to be used on all hospital patients, regardless of their diagnosis or presumed infectious status, when coming into contact (or risk of contact) with any of the following: blood, all body fluids, secretions and excretions except sweat, nonintact skin, or mucous membranes,
- Consistent and thorough hand hygiene.
- Extreme care to prevent needle stick and other injury from sharp instruments.
- **Barrier precautions:**
  - Gloves for contact with any body fluids or surfaces soiled with fluids.
  - Gowns, face masks, and eye coverings during procedures in which there is any expected spray or splash. High risk activities for spraying/splashing include: drawing arterial blood gases, suctioning respiratory secretions, emptying urine containers, changing dressings, administering blood.
- All equipment must be cleaned with a hospital approved disinfectant/germicide following manufacturers recommendations.


**INFORMED CONSENT**

Informed consent is required prior to performing any operative procedure or administering anesthesia, performing an invasive diagnostic or therapeutic procedure, administering blood products, engaging in any investigational process, or removing organs or tissue from a living or dead person for any purpose. It is the physician's responsibility to obtain informed consent. Telegraphic consents and consent sent by FAX are acceptable. Telephone consent is acceptable. The nurse's responsibilities in informed consent are as follows:

- Witness the patient's signature on the consent form. **Nursing students may NOT serve**
as a witness for telephone informed consent.

- Contact the physician if the patient is uncertain of or expresses ambivalence about undergoing the procedure.
- Verify that a properly completed consent is in the patient's chart prior to a procedure. Premedication should not be administered before the informed consent is obtained.
- Complete the preop/preprocedure checklist.
- Do not send the patient to the OR unless a consent is completed.
- Review the consent form for completeness including making certain that the surgical site is identified.

For more info, see Informed Consent Policy

PAIN MANAGEMENT

Relief of pain and suffering is integral to the mission of JHH.

Pain is defined an unpleasant sensory and emotional experience associated with actual/potential tissue damage or described in terms of such damage. It is highly personal and subjective meaning it is whatever the patient says it is, existing wherever he/she says it does. Self-report of pain is considered the most reliable indicator of pain and is often accompanied by emotional and spiritual responses, such as suffering or anguish.

Acute pain can be defined as the normal expected physiological response. Chronic pain is defined as pain that exists beyond it expected time frame (generally considered 3 months).

Pain management is multidisciplinary and collaborative. It includes ongoing and individual assessment, planning, intervention, and evaluation of pain and pain relief.
It applies to all patient encounters at JHH.

Below is a summary of the JHH inpatient requirements for pain assessment and screening.
# Inpatient Fast Facts Pain Assessment Chart

## Pain Management...

**It’s the Right Thing to Do!**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Pain Rating</th>
<th>Pain Assessment</th>
<th>Notes</th>
</tr>
</thead>
</table>
| On Admission    | Document with admission assessment               | Document within 12 hours of admission if patient has moderate or severe pain, or patient wants pain addressed | - If chronic or persistent pain, document in Admission Screening Note within 24 hours  
- Document pain goal on admission if:  
  - patient has pain  
  - is able to self-report  
  - is greater than 7 years old  
  - wants their pain addressed |
| Ongoing         | For all inpatients, document pain rating:  
  - A minimum of 12 hours  
  - Prior to any PRN pain medications  
  - Within 4 hours after a PRN pain medication | Perform a pain assessment every 12 hours if:  
  - Patient is receiving routinely scheduled pain medications  
  - Has moderate (4-6) or severe (7-10) pain on the FACES or NRS scale  
  - Wants their pain addressed | Assessment includes a description of the pain characteristics, presence of adverse pain management regimen, physical exam/observation of the pain site if applicable  
**NOTE:** If pain characteristics are unchanged, it is acceptable to document a comment in the cell “Unchanged” |

### Where to Document?

- The Pain Rating can go on the Pain Flow Sheet or on the Vital Signs Flow Sheet (Note: pain ratings will flow over to the Pain Flow sheet from the Vitals FS but ratings do not flow from the Pain FS back to the Vital FS).  
If you want to use the Vital Sign FS option, you must add the parameter to your flow sheet

### Who Can Document?

- For patients able to self-report, a RN, LPN, CNI, Clin A, ClinT, CMA or therapists can obtain a pain rating using the Numerical Pain Rating Score (NRS) or the FACES scale  
Other scales require a RN or LPN to perform

### Reminders to help encourage documentation

- Consider having the CCSR send a reminder to the staff via ASCOM phone to do pain reassessments q4.  
During handoffs, ask each other if all the pain assessments are done. Be mindful of the reminder you receive after you sign off any PRN pain medication. The reminder will be in “orders” until you either complete the order or it autocompletes in 5 hours.  
- Add a pain rating row to the Vital Signs FS.
**Major Pain Rating Tools**
The screening tool is selected by the RN based on the patient’s age and communication ability.

<table>
<thead>
<tr>
<th>Population (Age-related)</th>
<th>Criteria</th>
<th>Pain Rating Scale</th>
<th>May be Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Patient able to speak and give self-report of pain intensity (greater than 7 years old)</td>
<td>0-10 Numerical Rating Scale (NRS)</td>
<td>All Staff</td>
</tr>
<tr>
<td>Adults and Pediatrics</td>
<td>Non-verbal/Cognitively impaired patients (greater than</td>
<td>Behavioral (BPA)</td>
<td>RN or authorized prescriber</td>
</tr>
</tbody>
</table>
### Pediatrics

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Pain Scale</th>
<th>Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm and full-term neonates (Recommended for children 0-9 months)</td>
<td>Neonatal Infant Pain Scale (NIPS)</td>
<td>RN or authorized prescriber</td>
</tr>
<tr>
<td>Pre-verbal or nonverbal up to 7 years old</td>
<td>FLACC-R</td>
<td>RN or authorized prescriber</td>
</tr>
<tr>
<td>Verbal or can point to appropriate FACE (greater than 3 years old)</td>
<td>FACES</td>
<td>RN or authorized prescriber</td>
</tr>
</tbody>
</table>

For more info, see Pain Protocol

---

### Patient Controlled Analgesia (PCA)

JHH has specific protocols for care of the adult patient receiving any type of PCA on the Nursing intranet. Only RNs with demonstrated competence may initiate the pump or manipulate pump settings.

In Pediatrics, the Pediatric Pain Service manages PCA. Only RNs with demonstrated competence may initiate the pump or manipulate pump settings. For more information, refer to the Department of Pediatrics policy/protocol/procedure manual or see the charge nurse/nurse manager.

For more info, see PCA Protocols

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### POINT OF CARE TESTING

Point of care/near patient tests (POCT) also referred to as bedside tests or waived tests are laboratory tests performed on the nursing unit rather than in a laboratory setting. All nursing staff that perform point of care testing must complete approved educational programs and competency testing.

Nursing Students may NOT perform POCT. Students should be involved in the critical thinking with the RN preceptor/or faculty member about the result and the associated patient symptoms and management.
- NovaStat Strip blood glucose meter
- HemoCue hemoglobin testing
- Gastroccult gastric occult blood testing
- Hemocult fecal occult blood testing
- Urine dipsticks
- pH with Nitrazine and Hydrion
- Pregnancy testing

For more info, see http://pathology2.jhu.edu/pointofcare/poct/index.cfm

**MEDICATION ADMINISTRATION**

Information presented below reviews the highlights of the JHH Medication Order and Administration policies.

For complete information, see the Medication Administration Management Policy at http://www.insidehopkinsmedicine.org/hpo/policies/39/91/policy_91.pdf

**Drug References**

- The online drug references, MicroMedex and the JHH Drug Formulary (lexi-Drugs), are the JHH standard reference. They can be accessed on any public workstation from the Clinical Practice, Drug information page of the Nursing intranet – http://intranet.insidehopkinsmedicine.org/nursing/clinical_practice/drug_information/
- Use of pocket references is discouraged because they sometimes provide incomplete or inaccurate info.

**Nursing Responsibilities (RN/LPN)**

- Accountable for reviewing his/her patient orders when accepting a patient assignment and at least every 4 hours thereafter, and at the end of the shift to identify, verify and communicate any new provider orders entered during the shift.
- Administer meds for specific doses as ordered while the patient is hospitalized
- Follow standard dosing times
- Refer to hospital and departmental policies for:
  - Meds requiring independent verification by 2nd nurse
  - Meds that may be given IVP
  - Infusion meds requiring administration on an IV pump
  - IV meds given on an IV pump requiring tamper resistant mode
- LPNs may NOT administer IVP meds, chemotherapy, initiate or titrate PCAs or continuous IV medication infusions.
- Conduct a nurse order review
- The use of verbal orders shall be minimized. If taken the person receiving the order shall enter it
and read it back verbatim to the authorized prescriber.

- **Types of orders**
  - STAT - verbalized immediately to nurse and administered within 30 minutes.
  - NOW - verbalized to nurse and administered within 2 hours.
  - ROUTINE - administered at next routine time after pharmacy delivery.

- Hold orders are interpreted to mean discontinue. The exception to this is when an order is written to hold a medication for a single dose or when a physiological parameter is outside of a specific range. Example "Digoxin 0.25 mg po each morning at 0900. Hold if apical pulse is <60/minute."

### Medication Storage

- Medications are secured in carts/areas/refrigerators, which are locked unless being used.
- Select medications may be stored in the patient's room. These medications must be labeled with the patient's name and date opened, and discarded at manufacturer’s original expiration date or at time of discharge. They include, but are not limited to topical wound and skin care products and meds used by patients as part of a unit-specific med administration teaching protocol. See [http://www.insidehopkinsmedicine.org/hpo/policies/39/78/policy_78.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/39/78/policy_78.pdf) for a complete list of medications that can be kept at the bedside.
- Medications used to treat anaphylactic reactions may be kept in a patient’s room during the administration of a drug in the clinical setting where anaphylaxis may occur.
- ICUs may store non-expired emergency medications in patient rooms. All drugs must be in the original packaging except in the NICU/PICU.
- Emergency medications may be obtained from the emergency drug box, floor stock/Pyxis or may be procured from the pharmacy.
- On admission, patient medications are sent home with a family member or secured on the nursing unit. Disposition of medications is recorded on the Adult Initial Screening/Planning Tool.
- Upon discharge, patient medications brought from home may be returned to the patient unless the physician responsible for the patient indicates otherwise in a discharge order.
- All patient medications sent by pharmacy, which are not needed or out-dated, are returned to the pharmacy via the pharmacy return bin.
- When transferring a patient from one unit to another, the transferring unit sends the patient’s medication supply to the new unit.
- Neuromuscular blocking agents are segregated from other medications. See Appendix C of the link below for more information related to high alert medications. [http://www.insidehopkinsmedicine.org/hpo/policies/39/78/policy_78.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/39/78/policy_78.pdf)

### Medication Administration

- RN is responsible for reviewing changes in medication orders and on the MAR.
- Label all medication containers.
- Remember that all multi dose vials must be dated when opened for a 28 expiration date.
- Oral syringes are to be used when administering oral medications that must be given by a syringe.
Orders for IV fluids (excluding parenteral nutrition) will be continued for the specific time interval indicated in the order. If no interval is indicated, the therapy will be continued until a discontinue order is written.


Non-emergent first doses are provided by the pharmacy. Processing orders through Pharmacy allows for important safety checks.

In the following situations, first dose medications may be obtained from Pyxis/floorstock: STAT doses; emergent doses (clinical status of patient would be compromised); physician control (physician assures that medication is accurately prepared and administered).

Maintain unit dose packaging of medications until immediately prior to administration. Medication cups are not used to store unpackaged medications.

Medications should be administered within one hour of the scheduled time unless otherwise indicated.

When the nurse is unable to administer a medication at the scheduled time, the drug may be administered up to two hours prior to the next scheduled time without changing standard administration times. Note the actual time of administration on the MAR. Administer the next dose at the regularly scheduled time.

When the drug cannot be given within two hours of the next standard time, consider the previous dose as omitted and note on MAR. If an omitted dose requires administration, an order from an authorized prescriber is required.

For drugs ordered once a day or less, if the dose is late by more than 12 hours, notify the authorized prescriber.

Prior to administering medication:
- Review ordered medication with respect to action, outcome, side effects, etc.
- Select appropriate medications from the storage space
- Check time, dose, route of the pre-packaged medication against the MAR
- Check patient allergies
- Compare two patient identifiers (e.g., name and history number OR in outpatient areas, name and birth date) listed on the prescriber order to the MAR. The patient’s name and history number on the medication order, the MAR and the patient’s identification band must all be matched prior to medication administration.

Preferred method: Bring MAR next to patient for direct comparison

When the MAR cannot be directly viewed next to the patient, create an intermediate document with the patient’s two identifiers (examples: an index card stamped with an addressograph printing of the patient’s name and history number; a stamped flowsheet that is in the patient’s bedside chart). The intermediate document must be matched to the patient identifiers on the MAR when selecting medications and then brought to the patient, along with that patient’s medications, to match with the patient’s identification band prior to medication administration.

Medications that require INDEPENDENT verification by the RN administering the medication and a second RN and documentation of patient, drug, dose, route, administration
time and pump settings (as appropriate) and initiation and with rate and bag changes.

- Drugs where both checks shall be completed prior to administration:
  - Chemotherapy
  - IV immune globulin (IGIV)
  - IV insulin infusion
  - IVP insulin

- Drugs where the second check shall be completed as soon as possible following the first check:
  - IV PCA
  - Epidural analgesia
  - Intrathecal analgesia
  - IV heparin
  - Continuous infusion of IV opioids

- Nurses should refer to their functional unit standards for the following: other medications requiring independent verification by a second nurse; infusions via an infusion pump; medications that may be given IV push and IV medications that are put in the tamper resistant mode.

- Antibiotics ordered as “on call” for operative or other procedures will be sent with the patient for administration in the OR or procedure area.

- For patients leaving the nursing unit for a test or procedure and returning to the same sending unit or level of care.
  - Continue PCA and continuous infusions unless otherwise ordered by an authorized prescriber.
  - For patients going to ORs, procedural or testing areas from in the following areas, medications will be held: all ICUs, Medicine, Neurology, Obstetrics, Oncology (including Pediatric Oncology), and Psychiatry. Medication reconciliation is NOT required for held orders.
  - For non-ICU patients in GYN, Neurosurgery, Pediatrics, all surgical services and Ophthalmology going to other procedural areas (not an OR) or testing areas, medications will be held.
  - For non-ICU patients in GYN, Neurosurgery, Pediatrics, all surgical services and Ophthalmology going to an OR for a procedure, medications will be discontinued with the exception of those procedures listed in the link below. Medication reconciliation will then occur when the new orders are written before the patient returns to the sending unit.

Orders that may be implemented by the RN without cosignature from an Authorized Prescriber include the following:

- Bath oil
- Over-the-counter lozenges
- Over-the-counter topical protectants/emollients (e.g., Lubriderm, A&D ointment) which are used in a preventive manner. The exception to this authorization are agents used as a treatment (i.e., for an excoriated area). These require an order from an authorized prescriber.
- Lacrilube eye ointment
- Change in specific administration times to conform to standards for the nursing unit *(exception: cannot switch from an evenly scheduled regimen such as q6h to an unevenly scheduled regimen such as QID).*
- Change from a small volume nebulizer (SVN) to a metered dose inhaler (MDI) with spacer to administer aerosolized medications
- Change between a non-sustained-release solid oral dosage and an oral liquid
- Reorder replacement supply of multiple dose medications previously ordered by an authorized prescriber (e.g., lotions, eye drops).
- Saline flush solution for central and peripheral IV lines and for arterial lines.
- Karaya for ostomy site use.
- Chloraseptic spray
- Artificial tears

**IV Push Medications**
- In the event of a cardiopulmonary arrest, an RN may administer the following agents IV push, upon the verbal or written request of a physician without regard to the location of the patient: Adenosine, amiodarone, atropine, calcium chloride, calcium gluconate, diphenhydramine, epinephrine, hydrocortisone, lidocaine, magnesium sulfate, naloxone, sodium bicarbonate, vasopressin.

**Controlled Substances**
- **Following the JHH policy/procedure for controlled substance handling is critically important. Failure to comply with the JHH standards will result in extremely serious consequences for the nurse.**
- On most units, controlled substances and replacement doses are stored in PYXIS, which is a protected computerized storage cabinet.
- Access:
  - All JHH nurses and commercial agency nurses who are working on an extended contract on one consistent unit are given a confidential user ID and password or Bio ID by the pharmacy for use with all transactions involving the Pyxis MedStation. If the user password becomes public knowledge or is otherwise compromised, the user is responsible for immediately changing the password using the Change Password Function and for notifying the nurse manager within 72 hours.
- Administration of controlled substances:
  1. At Pyxis MedStation, conduct a visual count of the drug in the pocket and verify the inventory prior to withdrawing the dosage unit.
  2. Promptly discard wasted, contaminated, refused or partial doses in presence of a second nurse, using the Pyxis waste procedure. PCA (if not obtained from the unit Pyxis Medstation) and controlled substance infusions drip wastage are documented on the MAR. Return drugs to the MedStation only if in an intact dosage form, and in the presence of a witness, using the Return Med Function. Controlled substance patches, such as Fentanyl, should be removed from the patient, folded in half, sticky portion
face down and flushed down the toilet, per manufacturer’s recommendations.

3. Errors/discrepancies are resolved immediately using the Resolve Discrepancy Function. A witness is required to resolve all discrepancies.

4. When last dose of drug is administered from the package, open a new package. Only one package of each drug strength/form should be opened at a time.

5. If controlled substance is given to a physician to administer, record physician’s name, dose and time on MAR.

6. Document administration of controlled substance on MAR.

For more info about controlled substances, see

Food-Drug Interactions

- If a medication has a significant food-drug interaction, Pharmacy staff will identify the first dose of the drug with a label indicating a food-drug interaction.
- Clinically important drug/food interactions are listed in the JHH drug formulary. http://intranet.insidehopkinsmedicine.org/nursing/clinical_practice/drug_information/
- At time of discharge the nurse/pharmacist will educate the patient concerning food-drug interactions for any discharge medication he/she will be receiving and provide the patient with a patient education handout for these medications.

Investigational Drugs (IND)

- An IND is any drug not approved for general commercial sale or a drug being studied with the intent of changing FDA approved labeled use of.
- A completed investigational drug date sheet (IDDS) shall be placed in the patient’s medical record. Any questions should be directed to the principle investigator or designee.
- IND must be given and documented at the exact times listed in the protocol and documented on the MAR.

Documentation

- Medication administration is documented on the Medication Administration Record (MAR) after administration of the medication.
- Evaluate the patient’s response to the medication, as necessary.

Medication Errors

Nurses have an obligation to report medication events via Patient Safety Net (PSN), http://www.insidehopkinsmedicine.org/psn/

- Prompt reporting of medication events in good faith will not result in punitive action by the Hospital against the involved individual(s), except as mandated by law or regulatory requirements. (See Safety/Legal Issues section)
Respiratory Therapy Services

The Respiratory Therapy Department provides the following services on adult inpatient units 24 hours/day, 7 days/week unless otherwise indicated.

- CPAP, BiPAP, IPPB
- Oxygen delivery equipment for greater than 40% \( \text{O}_2 \).
- Consultation for patients on small volume nebulization/metered dose inhaler (Monday-Friday 7am-7pm)
- Trach tube changes (Monday-Friday 7am-7pm)
- Arterial blood gas sampling (Monday-Friday 7am-7pm)
- Chest PT (7pm-7am) if requested by PT for frequency no greater than Q6h - Shared responsibility with Rehab/PT
- Special gas therapy

Check with the Charge Nurse/patient's nurse to find out RT services provided on your specific unit.

Nursing Staff Responsibilities

A provider order is required for all oxygen therapy use.

The nursing staff is responsible for:

- Set up of oxygen equipment.
- Changing respiratory tubing - "wet" tubing every 48 hours; "dry" tubing every week (7 days).

For more info, see
Restraints and Regulatory Agencies

Failure to correctly use or monitor patients in restraints can lead to serious injury or even death. Many nurses erroneously believe that restraints increase safety when this isn't necessarily true. We are working to change the culture to decrease the use of seclusion and restraints. Evidence-based practice suggests this can be done successfully even with violent patients.

Because of the risk of injury from restraints, JCAHO has implemented strict standards about their use.

The JHH philosophy regarding the use of restraint and seclusion is:
- All patients have the right to be free from restraint that is not medically or legally necessary.
- Seclusion and restraint only used in situations where there is imminent danger or harm & other interventions have been ineffective.
- In these situations, the least restrictive device or method that manages the safety need is always the best choice.
- At JHH we do NOT use medication as a restraint. We DO use it to support healing when it is considered a part of the patient’s standard drug treatment.

The JHH has 2 polices for restraints. Patient behavior determines which policy is used.

Restraint (physical) to support healing in the non-violent patient
Restraint and seclusion: management of violent &/or self-destructive patient behavior presenting an imminent safety risk to self or others

JHH staff must be able to:
* Demonstrate knowledge of alternatives to restraint
* Demonstrate an understanding of how to choose the least restrictive intervention based on individualized assessment
* Staff will demonstrate the safe application of restraint or seclusion used in the hospital, including recognition of incorrect application (This is done in orientation and reinforced annually).
* Recognize and respond to signs of physical or psychological distress in patients being held, restrained or secluded

Be aware that there are underlying causes of threatening behaviors including but not limited to the following:
- Untreated pain
- Confusion
- Miscommunication
• Cultural misunderstandings
• Fear
• Anxiety and anger

There are behaviors, events and environmental factors that may trigger restraint use such as:
• Impatience, inattention, or not listening
• Speaking too loudly or softly
• Implied threats or gestures
• Unwanted touch

Be aware of escalating behaviors (Cursing, destruction of property, hands and teeth clenched, red face etc.) and strategies for de-escalation such as exercise, listening to TV or music, writing in a journal etc).

Restraints can be dangerous. Monitor for the following:

Physical distress
  * Approximately 100 people/year are seriously injured and/or die because of a restraint
    * This may include respiratory distress/anoxia from a restraint that impedes adequate respiration.
  * Injury to peripheral nerves or inadequate circulation due to limb restraints that are applied too tightly
  * Skin breakdown may result from friction and shear as well as from being applied too tightly

Psychological distress
  * Even when the decision to use a restraint is correct, psychological distress can result, particularly among those who have previously been the victims of violence and/or abuse
  * Offer support, frequently explain the behavior that will allow the restraints to be discontinued and remove them as soon as possible.
  * Discuss with the treatment team whether there is a need for professional support

In addition to the above also monitor the following:
  * Respiratory status
  * Circulatory status
  * Skin integrity
  * Vital signs
  * Hydration, hygiene, elimination, ROM

Procedure
  * Explain to the patient the reason for the restraint or seclusion
  * Review any special requirements pertaining to Pediatric or adolescent patients or those being treated in Psychiatry
* Inspect the device & ensure it is safely applied but loose enough to allow for adequate circulation, effective breathing pattern, prevent alteration in skin integrity and facilitate quick release
* Secure the restraint to the furniture frame or bed frame that moves vertically when the bed position is adjusted

<table>
<thead>
<tr>
<th>Indications</th>
<th>VIOLENT PROTOCOL</th>
<th>NON-VIOLENT PROTOCOL</th>
</tr>
</thead>
</table>
| • Used to manage violent or self-destructive behavior presenting imminent risk to self or others  
  o Aggression or violent behavior with serious threat of danger to self or others  
  • Strategies aimed at extinguishing or de-escalation have proven unsuccessful. | • Used to support healing in Med/Surg Patients  
  o Prevent dislodgement of medical necessary devices  
  o Lack of understanding of physical or cognitive limitations  
  • Repeated non-compliance with activity restrictions  
  o Agitation  
  o Delirium tremors |  |

<table>
<thead>
<tr>
<th>Patient behavior</th>
<th></th>
</tr>
</thead>
</table>
| • Jeopardizes immediate physical safety of the patient, staff or others. Examples of behaviors include: combative, kicking, biting, hitting, verbally/physically threatening, engaged in self-harm | • Not engaged in self-harm or harm of others  
  • Pulling lines, tubes |

<table>
<thead>
<tr>
<th>Nurse initial action</th>
<th></th>
</tr>
</thead>
</table>
| • Nurse may initiate in emergency situation with immediate physician notification  
  • Request provider in person evaluation within one hour.  
  o Implement chain of command if no provider response within fifty minutes.  
  • In emergency application situations, restraint order must be obtained either during the emergency application or immediately (within a few minutes) after the restraint/seclusion has been applied. | • Nurse may initiate with immediate physician notification |

<table>
<thead>
<tr>
<th>Authorized Prescriber (physician, PA, NP) Initial Order</th>
<th></th>
</tr>
</thead>
</table>
| • Within one hour of restraint/seclusion application  
  • Date/time of order  
  • Specific type of restraint/seclusion  
  • Maximum duration of restraint/seclusion from time initiated  
  • Specific rationale  
  • Special precautions, if any, to safeguard patient | • Within 24 hours of restraint application  
  • Date/time of order  
  • Specific type of restraint  
  • Specific rationale for restraint  
  • Special precautions, if any, to safeguard the patient |

<table>
<thead>
<tr>
<th>Authorized prescriber re-order</th>
<th></th>
</tr>
</thead>
</table>
| • Every 4 hours for adults age 18 and older  
  • Every 2 hours for children and adolescents age 9 to 17  
  • Every one hour for children under age 9 | • By the end of the next calendar day |

<table>
<thead>
<tr>
<th>Authorized prescriber face-to-face evaluation</th>
<th></th>
</tr>
</thead>
</table>
| • Evaluation of patient’s immediate situation within 1 hour and every 24 hours as long as the patient is in seclusion or restraints  
  • Patient’s reaction to intervention  
  • Patient’s behavioral and medical condition  
  • The need to continue or terminate restraint or seclusion. | • Within 24 hours of initiation of restraint intervention |

<table>
<thead>
<tr>
<th>Restraint observation requirements</th>
<th></th>
</tr>
</thead>
</table>
| • Every 15 minutes  
  • Four point limb restraints or greater and seclusion require constant observation. This can be delegated to unit based nursing staff or a CPO (Certified Patient | • Limb restraints – Psychiatry areas every 15 minutes; non-psychiatry areas every 2 hours  
  • Four point restraints or greater (four... |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Security staff may assist to restrain a patient under the direction of the RN.</td>
</tr>
<tr>
<td></td>
<td>• Security staff may NOT provide independent patient observation.</td>
</tr>
</tbody>
</table>
| Observations | • Every 15 minutes  
  o Indications for continued use  
  o Patency of airway and respirations  
  o Skin integrity  
  o Neurovascular status  
  o Maintenance of body alignment |
|             | • Every 2 hours  
  o Alternatives to restraints are ineffective  
  o Indications for continued use  
  o Patency of airway and respirations  
  o Skin integrity  
  o Neurovascular status  
  o Maintenance of body alignment |
| Interventions | • Every 2 hours while awake  
  o ROM (every 4 hours when asleep)  
  o Offer food and fluids  
  o Opportunity for toileting |
|             | • Every 2 hours while awake  
  o ROM (every 4 hours when asleep)  
  o Offer food and fluids  
  o Opportunity for toileting |
| Nursing Documentation (Violent High Frequency Flowsheet) | • Date/time each episode was initiated and discontinued  
  • Whether a formal call for additional staff response was required  
    ✓ Names of staff assisting in restraint/seclusion  
    See screenshot #2.  
    ✓ Circumstances while restraining/secluding the patient  
  • Specific type of restraint/seclusion used See screenshot #2  
  • Whether the patient was permitted to wear own clothes or other attire, and if not, rationale  
  • Consideration or failure of less restrictive interventions  
  • Condition or symptoms that warranted use of restraint/seclusion  
  • Description of any physical injury to patient or others resulting from placement of patient in restraint/seclusion  
  • Description of the patient's behavior  
  • The patient's physical and mental status assessments  
  • Any environmental factors that may have contributed to the situation at the time of the intervention  
  • Observations/interventions to meet comfort, nutritional, physical, and elimination needs See screenshot #4  
  • Patient response to the intervention used  
  • Rationale for continued use of intervention |
|             | • Date/time each episode was initiated and discontinued  
  • Implementation of restraint protocol  
  • Conditions or symptoms that warrants use of restraint  
  • Consideration or failure of less restrictive interventions  
  • Type of restraint  
  • Observations/interventions to meet comfort, nutritional, and elimination needs  
  • Any injuries sustained and treatment during restraint implementation  
  • Any significant changes in the patient's condition  
  • Any environmental factors that may have contributed to the situation at the time of the intervention. |
**SAFE HANDLING OF HAZARDOUS DRUGS**

All hazardous drugs distributed by the Pharmacy are labeled with brightly colored stickers. All of these medications require hazardous drug handling. These include chemotherapeutic drugs, all hazardous drugs that are not chemotherapy, all investigational drugs.


The 3 major routes for accidental exposure include: absorption, injection, or ingestion.

**Prevention of Inhalation of Aerosolized Particles**

- Hazardous drugs should **never** be diluted, mixed, crushed, dissolved, or transferred from one syringe or intravenous container to another outside of the Bio-Safety Cabinet.
- Pre-prime IV administration sets with a compatible solution.
- Avoid opening or disconnecting the tubing. If you must disconnect wrap the connection with gauze to prevent aerosolization.
- Use a closed system transfer device (CSTD) which will decrease the risk of exposure via aerosolization or drippage. The PhaSeal product is used for adult patients at JHH.

For more information go to the following links:
[http://phaseal.com/](http://phaseal.com/) for the vendor’s instructional video
[http://intranet.insidehopkinsmedicine.org/bin/y/f/PhaSeal_reference_card.pdf](http://intranet.insidehopkinsmedicine.org/bin/y/f/PhaSeal_reference_card.pdf) the vendor’s user guide
[http://intranet.insidehopkinsmedicine.org/bin/i/t/PhaSeal_fast_facts.pdf](http://intranet.insidehopkinsmedicine.org/bin/i/t/PhaSeal_fast_facts.pdf) the JHH fast facts
Avoiding Contact with Skin and Mucous Membranes

- Wear approved gloves (blue in color-double glove if you wish) and an impermeable gown (white designated chemotherapy-when needed) when working with hazardous drugs and contaminated body fluids or excreta.
- Change gloves to maintain an effective barrier and washing hands **before and after** working with hazardous drugs, and whenever contamination is suspected.
- Limit work area and use an absorbent plastic pad to contain any accidental spillage.
- Wear goggles or facial splashguard during drug handling or disposal if there is any risk of splashing.
- Follow correct procedures quickly and efficiently in case of a spillage or contamination.

Avoiding Accidental Ingestion of Hazardous Drugs

- Separate hazardous drug work and storage areas from locations where people eat and drink.
- Wash hands before and after working with hazardous drugs or contaminated body fluids.
- Avoid hand to mouth or hand to eye contact while working with hazardous drugs or contaminated body fluids.

Excreta & Body Fluids

Excreta and other body fluids from patients who receive hazardous drugs are considered contaminated for **48 hours** after the last drug dose. A hazardous drug sign should be on the patient’s door and a sticker should be on the front of the chart to alert staff when patient is traveling to different departments in case of body fluid spillage.

**Disposal of drug administration materials and patient body fluids contaminated by hazardous drugs:**

- Dispose of used needles, syringes and any small breakable items in a sharps container.
- Do not recap, remove from syringes or cut needles.
- Dispose of all supplies by wrapping in a plastic backed absorbent pad and putting in a Hazardous Drug Waste Container.
- Wear protective gown and gloves when dealing with contaminated linens. These should be placed into a hospital laundry bag and tied closed. This bag should then be placed tied end first into a 2nd hospital laundry bag and then tied close.

**Spills**

- Cover it with a plastic backed absorbent pad (Chux) with the plastic side facing up.
- Notify others in the area of the spill and remove visitors and other patients from the area.
Clean up of spills is based upon the estimated size of the spill.
- If the spill is less than five (5) ml, the nurse or other appropriately trained personnel may clean up the spill.
- If the spill is more than five (5) ml but less than 500 ml, Support Associates have been specially trained to clean the spill.
- If the spill is more than 500 ml, call the emergency number (x5-4444). The Safety Department will provide assistance or advice.

All mercury spills must be cleaned by the Safety office.

**Disposal of Hazardous Drug Waste**

There are 2 types of hazardous drug waste chemical waste or residual/trace waste.

Chemical waste is unused drug greater than 1 inch of free liquid or more than 3% of the material remaining in the container. This must be disposed of in a black waste container. P listed drugs (as noted on the medication label) must be disposed of as chemical waste regardless of the amount of material remaining.

Residual/trace waste are contaminated items used in the preparation, administration and handling of hazardous materials (ie vials, IV bottles, syringes, gloves, tubing etc) and where less than 1 inch of free liquid remains or less than 3% of material remains in the container.

**Exposure**

During immediate care have the supervisor complete an Employee Report of Incident form.

**Eye:**
- **Immediately flush the eye with water for 15 minutes** using the eye, face and body spray unit.
- Have a co-worker call the Emergency Room, advise them of the incident and make special note of the exact drug that was splashed into the eye.
- After the eye has been flushed for 15 minutes, go to the Emergency Department for examination.

**Skin:**
- Wash the skin thoroughly with soap and water for **15 minutes**.
- Go to the Compensation Clinic or Emergency Department for examination.

**Injection:**
- If the drug has been injected into the tissue, do not remove the needle. **Draw back on the plunger of the syringe and remove drug.**
- **Call 5-STIX**
- Go to the Compensation Clinic or Emergency Department for examination.

**Glass cut:**
- Rinse the area with large amounts of water for **15 minutes**.
- Wash the area with soap and rinse again with water.
- Go to the Compensation Clinic or Emergency Department for examination.

"Right to Know" Law

- JHH has complied with the Right to Know Law by compiling chemical information lists and establishing a file of Material Safety Data Sheets (MSDS) from these lists, checking that containers are labeled, and providing employees with training. A copy of the JHH Chemical Information List and MSDSs for chemicals used at JHH are available on-line.

SEDATION

Only registered nurses with demonstrated and documented competency, as specified in the protocol, may implement the protocol and perform the monitoring required. See the charge nurse, nurse manager, or nurse educator for more information about this education if it pertains to your nursing unit.

The protocol is implemented for moderate and deep sedation/analgesia for procedures that includes:
- Administration of sedative (e.g., benzodiazepines) alone or in combination with opioid analgesic agents for the purpose of inducing moderate or deep procedural sedation via one of several routes (IV, IM, inhalation, oral, rectal, or intranasal).
- Titration of repeated doses of sedatives or titration to effect for procedures.
- Administration of any combination of sedative and narcotic analgesic drugs for procedures (even if PCA pump is “turned off” before the procedure or if patient is receiving scheduled sedatives and an opioid analgesic is added for the procedure).
- Use of anesthetizing agents such as propofol and ketamine (deep sedation medications administered by a provider credentialed for deep sedation).
- Pediatric patients given chloral hydrate, oral pentobarbital, or transmucosal fentanyl (alone or in combination with other agents) for procedures or episodic treatments.

The protocol DOES NOT apply to:
- Use of pure anxiolytics or sedative drugs in low doses given once and expected to have little sedative effect.
- Pre-operative medications
- Analgesic therapies used alone (without concomitant drugs with sedative properties) for ongoing pain control.
- Local anesthesia without sedation
- Drugs used solely for the purpose of managing altered mental status and/or as a restraint.
- Patients receiving intravenous sedating drugs under approved treatment protocols.
- Patients who are endotracheally intubated and mechanically ventilated.

Remember, however, that even with “low” doses of sedatives or narcotics, the resulting level of sedation may be deeper than desired. Since sedation occurs along a continuum, nurses need to be prepared for greater alterations in mental status and cardiopulmonary function than normally anticipated.

JHH has an “Adult/Pediatric Moderate and Deep Sedation/Analgesia for Diagnostic, Operative and Invasive Procedures and for Episodic Treatments and Therapies” protocol.

For the complete Adult/Pediatric sedation protocol

VASCULAR ACCESS DEVICES

The following information is a summary of the JHH policy for adult patients with VADs. Refer to the Pediatrics protocol/policy for care of pediatric patients.

For more info, see Adult VAD Policy

This policy applies to all adult patients with the following catheter, including, but not limited to:
- Peripheral intravenous line (PIV)
- Single lumen, multi-lumen catheters; tunneled and non-tunneled, cuffed and uncuffed
- Implantable port
- Peripherally inserted central catheter (PICC)
- Arterial catheter
- Dialysis or hemapheresis catheter

Central Lines: Insertion
In order to place a central line, staff (physician, NP or PA) must have delineated clinical privileges and documented training/competency.

How will I know if they are competent to insert a central line?
If you are unsure you may ask for validation of their competency.
Monitor for safe insertion of the line utilizing the Central Line Insertion Care Team Checklist.

VAT and PESS team what info to include??

**General Principles**

- An authorized prescriber’s order is required for insertion, discontinuation and maintenance for VADs (if not being inserted or discontinued by them).
- ALL VADs placed under non-sterile conditions in emergent situations shall be removed as soon as it is medically feasible.
- Patients with a non-tunneled VAD in place on admission shall have the site assessed and if the date of insertion is not known or the site is infiltrated or infected, it shall be removed and a new line inserted at another site within 24 hours.
- Use of large-caliber temporary central VADs, such as introducers/sheath devices (e.g., Cordis, 14 gauge without integral extension), is limited to the ICU, IMC, ED, OR, PACU, CVIL and IRC (exception: dialysis or hemepheresis catheters). These catheters shall be removed/replaced PRIOR to transfer to general care areas.
  
Large caliber catheters are occasionally placed on the floor during emergencies before transfer to the ICU or OR.
- Good hand hygiene with hospital-approved soap and water or waterless alcohol-based cleanser is required before VAD insertions.
- ALWAYS, use meticulous **aseptic technique whenever you access a VAD!**
- Chlorhexidine gluconate in 70% isopropyl alcohol is the antiseptic standard for central, arterial and peripheral VAD insertions and site care. No topical antibiotic ointment or cream is to be used on VAD sites.
- ChloraPrep® should not be used on patients with irritated skin, or neonates under 1000G and less than 2 weeks old. A supply of Tincture of Iodine will be maintained for these patients or those intolerant to chlorhexidine.
- Chlorhexidine gluconate shall be used on relatively clean skin. If necessary, clean and de-fat skin with alcohol swab or soap and water
  
  Use friction and allow the antiseptic to fully dry (usually requires about 30 seconds) before applying the dressing.
  
Povidone iodine shall be avoided for VAD skin prep unless the patient cannot tolerate alcohol based products.
  
If povidone iodine must be used, the skin shall first be de-fatted with soap and water, and then dried. This must be allowed to stay on the skin for at least 2 minutes, to permit it to release the 1% iodine required for sterility.
- Stopcocks:
  
  o Shall only be used when it is necessary to balance a central VAD;
  
  o Shall not be hooked together;
  
  o Shall be capped when not in use.
- To minimize the risk of contamination, manipulation/blood drawing from the VAD system shall be kept to an absolute minimum. Injection ports, hubs, and Clave® adaptors shall be scrubbed with a 70% alcohol swab before accessing the system.
- Unused ports shall be flushed, according to protocol, capped with needleless connector (Clave) or sterile cap, and clamped (where a clamp is present on the VAD).
- All connections shall be luer locked.
- A syringe barrel size of 10cc or greater shall be used to troubleshoot or flush any VAD to avoid excessive pressure and possible rupture of catheter or dislodgement of clot. Forced flushing with a smaller barrel size syringe shall never be used to clear a VAD.
- Prior to administering medications through a VAD, check for blood return.
- Patients with femoral line catheters may mobilize per order.

*For VAD site specific management see appendices of the Adult VAD Policy [Link]*

**Insertion of a Central VAD:**
An assistant is required to be at the bedside for all central line insertions. (PICC insertion is exempt).

- The assistant is responsible for monitoring for the safe insertion of the central line and completing the Central Line Insertion Checklist.
- The Assistant can be a nurse, resident/intern, clinical fellow, staff physician, NP or PA with documented competency and delineated clinical privileges or a clinical technician with specialized training per unit standard.
- Nursing staff acting as an assistant must participate in the time out.
- Medical and Nursing students can **NOT** act as an assistant.
- Sterile technique is required for central VAD insertions.
- **Insertions, rewire and removals of a central subclavian or internal/external jugular VAD’s require that the patient be placed in TRENDELENBURG position unless the patient’s condition contradicts this position.**

**Line confirmation:**
- All central lines, including femoral, will be assessed for successful venous placement
  - Unused ports of multilumen central catheters shall be aspirated, flushed, according to protocol, capped, and clamped.
- Confirmation of proper placement by chest x-ray, fluoroscopy or CT is required for all central VADs, before using the line and before increasing fluids above 10 cc/hr.
  - The VAD shall be flushed and capped, or kept open with a physiologic solution at 10cc/hr or less, pending confirmation. In the case of CPN line placement, D10W may be infused at 10cc/hr until placement is confirmed.
- Patients admitted to the hospital with central VAD access (excluding dialysis or hemepheresis catheters) must have tip location confirmed by chest x-ray, fluoroscopy or CT within 12 hours of admission.
- All non-tunneled central VADs (exception PICC lines) shall be sutured securely in place.
- PICCs can be secured with steri-strips or other securement devices.

**Removals & Rewires**
- The need for central VAD’s is reviewed daily and if the patient no longer needs the line it should be discontinued.
Only staff who have **demonstrated competency** may remove a VAD non-tunneled, non-cuffed central venous catheters with a provider order.

- RNs may **NOT** remove central arterial, non-tunneled or tunneled phereis or dialysis catheters or other tunneled lines of any kind.
- The physician is responsible for removing:
  - femoral venous and arterial sheaths, and central lines in patients with a known bleeding diathesis (PT INR or a PTT ratio > 1.3, platelets < 50K) or if patient is on therapeutic dosing of thrombolytics/anticoagulants (including but not limited to reteplase, IV heparin, enoxaparin, lepirudin, argatroban, coumadin and IV platelet inhibitors).
  - The nurse may remove central VAD for patients on anticoagulants for Venous Thromboembolism (VTE) Prophylaxis.
  - The provider is responsible for scheduling removal of tunneled central catheters or implanted ports by appropriate personnel in pre-established locations.

**Rewiring**

- For rewires, all central VAD insertion guidelines shall be followed. An X-ray confirming proper tip location is required when rewiring large bore catheters (e.g., Cordis, Shiley, 14 gauge or larger Arrow). Smaller gauge catheter rewires(less than 14g) do not require x-ray, unless clinically indicated.
- Whenever possible, a new administration set and fluid shall be used when a line is rewired/re-sited.

**Site Assessment**

- Patients shall be encouraged to report any changes in their catheter site or any new discomfort to their healthcare provider.
- Check for blood return prior to infusion at least every 12 hours or more frequently if the patient is receiving medication that is caustic to the vein
- Patients with a peripheral VAD in place on admission shall have the site assessed and if the date of insertion is not known or the site is infiltrated or infected, it shall be removed and a new line inserted at another site.
- If a localized infection is suspected at the VAD insertion site or tunnel, the physician shall be informed and a bacterial and/or fungal culture of the site obtained.
- Assess for signs of infiltration, phlebitis or infection, pain, redness, swelling, induration, disruption of flow or lack of blood return.
  - VADs not in continuous use, at least daily
  - VADs connected to infusion pump/gravity volume controller, at least every 8 hrs.
  - VADs in use but not connected to infusion pump/gravity volume controller at least every 2 hrs.
  - VAD sites may be required to be assess more frequently if dicated by other protocols.
  - If a gauze dressing is being used, assess for phlebitis and infection at the time of dressing change.

Infiltration will be graded based on the following scale:
<table>
<thead>
<tr>
<th>Grade</th>
<th>Scale/Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Symptoms</td>
</tr>
<tr>
<td>1</td>
<td>+/- pain&lt;br&gt;Skinned blanched&lt;br&gt;Cool to touch&lt;br&gt;Edema &lt;1 inch in any direction</td>
</tr>
<tr>
<td>2</td>
<td>+/- pain&lt;br&gt;Skinned blanched&lt;br&gt;Cool to touch&lt;br&gt;Edema 1-6 inches in any direction</td>
</tr>
<tr>
<td>3</td>
<td>Mild- moderate pain&lt;br&gt;Skinned blanched, translucent&lt;br&gt;Gross edema &gt;6 inches in any direction&lt;br&gt;Cool to touch&lt;br&gt;Possible numbness</td>
</tr>
<tr>
<td>4</td>
<td>Skin blanched, translucent&lt;br&gt;Skin tight leaking&lt;br&gt;Skin discolore, bruised, swollen&lt;br&gt;Gross edema &gt;6 inches in any direction&lt;br&gt;Deep pitting edema&lt;br&gt;Circulatory impairment&lt;br&gt;Moderate- severe pain&lt;br&gt;Infiltration of any amount of blood product or vesicant</td>
</tr>
</tbody>
</table>

Phlebitis will be graded based on the following scale:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Clinical Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Symptoms</td>
</tr>
<tr>
<td>1</td>
<td>Erythema at access site with or without pain</td>
</tr>
<tr>
<td>2</td>
<td>Pain at access site with erythema and/or edema</td>
</tr>
<tr>
<td>3</td>
<td>Pain at access site with erythema and/or edema&lt;br&gt;Streak formation&lt;br&gt;Palpable venous cord</td>
</tr>
<tr>
<td>4</td>
<td>Pain at access site with erythema and/or edema&lt;br&gt;Streak formation&lt;br&gt;Palpable venous cord &gt; 1 inch in length&lt;br&gt;Purulent drainage</td>
</tr>
</tbody>
</table>

See link for policy on Monitoring and Management of Infiltration and Extravasation of Vesicant and Non-Vesicant agents
**Tubing Management**

- Manipulation of the VAD system shall be kept to an absolute minimum.
- Injection ports, hubs and needleless adaptors should be scrubbed for at least 10 times with a 70% alcohol swab before accessing the system. Allow the alcohol to dry completely before connecting any IV tubing or syringe to the system.
- A new administration set and fluid shall be used when a line is rewired/re-sited.
- All continuous administration sets, shall be changed and labeled no more frequently than 96 hours. Needleless connectors should be changed at the same time as the IV tubing.
- All intermittent administration sets that are disconnected from the primary set between infusions should be changed and labeled every 24 hours.
- All VAD administration set tubing shall be primed and inspected for the presence of air. Air shall be eliminated before tubing is connected to IV device.
- Unused ports shall be flushed, according to protocol, capped with needleless connector (or sterile cap) and clamped (where a clamp is present on the VAD).
- All connections shall be luer locked.
- If VAD tubing becomes disconnected, the connecting port shall be scrubbed with a 70% alcohol swab and new tubing attached at the needleless connector.
- An in-line filter shall be used for adult patients who have potential or proven central cardiac shunt and for medications specified by the physician or pharmacist. Refer to [http://www.insidehopkinsmedicine.org/hpo/policies/39/91/policy_91.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/39/91/policy_91.pdf) for chart that lists the drugs that require an inline filter.

**Fluids and Additives**

- All continuous central VAD fluids (including PICCs) shall be administered by infusion pump, except in the operating room, PACU, procedure areas and in emergency situations or when rapid fluid resuscitation is needed.
- An infusion pump is recommended for peripheral IV fluids
  - Refer to departmental guidelines for a list of specific fluids or medications that require an infusion pump.
- KVO (keep vein open) for non-PICC is 100cc/hr and 20cc/hr for PICCs.
- The distal port of multi-lumen central VADs shall be used for blood transfusions, colloid fluid, high volume fluid administration or CVP monitoring.
- VAD fluids shall be changed no more frequently than every 96 hours. Pressure monitoring flush solutions, which shall be changed as necessary, with a minimum of at least every 96 hours.
- Anyone adding medication to VAD fluids shall affix a label listing the name, concentration of the additive, date, time and his/her initials. Do not write on the plastic bag.
- All fluid bags should be labeled with the date and time hung.

Discharge Planning

- Patients being discharged with a VAD shall have documented home care arrangements made prior to discharge or a continuum of care treatment plan documented.
- The JHH Home Care Coordinator or Home Support Services, a branch of PESS, shall be notified prior to patient discharge, to assist with the discharge plan for home VAD Therapy.
- The discharging nurse will teach the dressing/flush for the device with the plan for the home care nurse to review and reinforce the education at home.

Additional reminders

- CPN (Central Parenteral Nutrition) dressings and administration sets are changed by the VAT team where applicable.
- Patients transferred from another institution or admissions from home with CPN may continue infusion until evaluated by PESS, or their physician, or comparable dextrose/electrolyte solution is obtained from pharmacy. Additional bags brought from home may not be hung.
- Only nurses who have demonstrated competency may access and maintain hemodialysis and plasmapheresis catheters.
- Only nurses who have demonstrated competency may draw labs from a central VAD.
- Only nursing who have demonstrated competency may perform a central VAD dressing change.

Documentation

- Dressing changes are documented on the nursing flow sheet/Sunrise and a label is placed on the dressing including date of dressing change, initials of person changing the dressing and catheter gauge for peripheral VADs.
- The following is documented in the patient’s medical record:
  - VAD site assessment is documented with each dressing change by the nurse.
  - VAD flushes
  - Initial implementation of the VAD protocol
  - Removal of VAD
  - Reportable conditions, actions taken, and patient response

Reportable Conditions

<table>
<thead>
<tr>
<th>Reportable Conditions</th>
<th>Report to Authorized Prescriber</th>
<th>Complete PSN (F-8 IV Site Complications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of blood return in a central VAD unresolved after troubleshooting</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accidental removal</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Breach of policy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Burning along the VAD tunnel while flushing or</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Complications during line placement (including but not limited to arterial puncture, suspected air embolism, pneumothorax, lost or retained wire, hematoma, inappropriate line placement)</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Disconnect with significant blood loss</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Evidence of grade 2 or greater phlebitis</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Excessive bleeding/drainage at the site</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Infection</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Infiltration of vesicant drugs per Extravasation Policy</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Leaking, or damaged catheter or equipment</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Malpositioned central lines</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>New or significant swelling/edema</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Pain or ringing in the ears while flushing or during infusion</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Persistent pain at the insertion site or in the shoulder on the same side of the VAD</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Resistance to flushing or infusion, distended veins on the same side as the VAD</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Suspected air or catheter embolism</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Suspected arterial placement</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Suspected blood clot</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Unsecured VAD, (i.e., broken sutures, not sutured correctly)</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Bleeding at line insertion site during or immediately after mobilizing a patient with a femoral catheter</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Dislodgement or removal of a catheter due to mobilization</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Malfunctioning of line after mobilization</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Acute limb ischemia within 24 hours of mobilization in patients with femoral arterial lines</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
This information is a brief overview of the standards of nursing care at the JHH. Please see the JHH Nursing intranet (http://www.insidehopkinsmedicine.org/nursing) for more information. If you have any questions, please see the charge nurse or nurse manager on your unit.