The Johns Hopkins Hospital

Agency Nurse & Nursing School Faculty Orientation 2011

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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 gives the major points 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 III, 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

Additional information for instructors and faculty (forms, instructions, requirements) can be found at:

http://www.hopkinsmedicine.org/nursing/benefits/education/student_clinical_placements.html

MISSION, VISION AND VALUES OF JHH

The mission of Johns Hopkins Medicine is to improve the health of the community and world by setting the standard of excellence in medical education, research and clinical care. The vision of Johns Hopkins Medicine is to provide a diverse and inclusive environment that:

- fosters intellectual discovery
- creates and transmits innovative knowledge
– improves human health
– provides medical leadership to the world

The core values of JHH are:
Excellence and Discovery
Leadership and Integrity
Diversity and Inclusion
Respect and Collegiality

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

ORIENTATION FORM

Below is the nursing school faculty orientation and the unit based competency checklist.

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

The Johns Hopkins Hospital Department of Nursing

Appendix D

NURSING SCHOOL FACULTY ORIENTATION FORM

The JHH must receive documentation of faculty orientation before the student experiences may begin.

Faculty name: ________________________  School: ___________________________
Work phone #:________________________   Home phone #: _____________________
Email address: _______________________ Pager #: ___________________________
JHH clinical unit: _____________________ Days/Hours of week: _________________

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

Please initial and date the following activities after completion.

_______ Read the JHH Orientation for Nursing School Faculty booklet and complete post-test.

_______ Meet with Nurse Manager to discuss unit standards, routines, and expectations.

_______ Share one or two shifts on the nursing unit. The amount of time needed for orientation will be left to the Nurse Manager’s discretion. (Only required the first time faculty is bringing students to a unit.)

_______ Complete Annual Unit Based Competency Validation Checklist and return completed form to Kelly Reif in Central Nursing.
Attend Sunrise Clinical Manager training. Instructors may register for class by calling the JHMCIS training center at 410-614-0958 or emailing CIStrain@jhmi.edu.

- Students must complete the “POE Sunrise Orders for Nursing Students” online course in myLearning.
- Submit Clinical Information System Access Form to JHMCIS Security BEFORE students can gain access to Sunrise. Fax the Confidentiality Agreements for each student to JHMCIS security with the Access Form. JHMCIS Security will email you your students’ access logon/password within 48 hours.
- Access Authorization Form – (Needed for Clinical Instructors/Faculty) – submitted to JHMCIS Security by Kelly Reif after Student & Information Form is received from the Clinical Instructor.

Complete HIPAA training (Only required one time). Training can be provided by the college/university or the JHH self study packet.

Sign Johns Hopkins Confidentiality Agreement for Students. (Only required one time)

Review Infection Control for Nursing Students with each student before starting.

Submit this form and all required paperwork for each student and faculty member to Kelly Reif in Central Nursing, Administration 220, 410-828-4933, fax 410-828-4977, kreif@jhmi.edu. Forms must be completed one week prior to the start of clinical. (Confidentiality Form, HIPAA, Nursing School Faculty Form)

Signature of faculty member validating completion of orientation:

_________________________________________  Date _______________
This form will be completed by the unit based preceptor and submitted to Kelly Reif, Administration 220, JHH, 600 N. Wolfe St., Baltimore, MD 21287-1720, phone 410-828-4933, fax 410-828-4977, kreif@jhmi.edu.

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<td>• Pregnancy testing</td>
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Due to severely limited parking on the JHH campus, there are **no special parking rates** available for students, faculty or agency personnel. (Travel RNs note: All parking expenses are the responsibility of the Travel RN.)

It is strongly recommended that hospital garages be used for parking for safety reasons, or that car pools or public transportation be used to defray parking expenses.

Nursing faculty and students may have access to free parking on weekends and evenings/nights during the week (4PM-8AM). A temporary JHH ID is needed for this. Faculty should come to Nursing Administration 220 to pick up the required form to get this ID.

### SECURITY and ID BADGES

**Security and ID badges**

- **Faculty** are required to wear a JHH temporary photo ID badge. Contact JHH Nursing Education Coordinator, kreif@jhmi.edu, 410-955-0785 to make arrangements to pick up required form.
- **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.
- **Local 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.
- **Traveling Agency** are required to wear a JHH temporary ID. See Nurse Manager/Educator for the needed form.

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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 Associate, 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

Clerical Associate (ClerA) or 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
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 bedside blood glucose testing
• Perform Point of Care Testing
  o NovaStat Strip blood glucose meter
  o HemoCue hemoglobin testing
  o Gastrooccult gastric occult blood testing
  o Hemocult fecal occult blood testing
  o Urine dipsticks
  o pH with nitrazine paper
  o Pregnancy testing
• Perform Carefusion (Barcode SCV –Specimen Collection Verification)
• Serve as a witness for telephone informed consent

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_1380.pdf.

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.
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 2011

Improve accuracy of patient identification
- Use of two patient identifiers
- Eliminate transfusion errors
- Actively involve the patient, and as needed, the family, in the identification and matching process.
- Check 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.
- 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 barcoded armband at all times.

Improve the effectiveness of communication among caregivers
- 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 http://www.insidehopkinsmedicine.org/hpo/policies/39/55/policy_55.pdf
For more information go to the medical abbreviation policy at the following link: http://www.insidehopkinsmedicine.org/hpo/policies/39/114/policy_114.pdf

**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

**Improve safety of medications**
- Manage look-alike/sound-alike medications
- Label medications and containers with drug name, strength, amount, expiration time if occurs in less than 24 hours.
- Reduce harm from anticoagulation therapy
- Use extra caution/care when working with High Alert Medications: Chemotherapy, Heparin, Infused Parenteral Opiods, Infused Insulin, and Concentrated Electrolytes.

Anticoagulation therapy can be high risk for patients for multiple reasons: complex dosing, follow up monitoring is required, and patient compliance can be inconsistent.

Implement bleeding precautions policy on any patient receiving warfarin and heparin (unfractionated or low molecular weight).
  - Post Bleeding Precautions sign on patient’s door and document education of the patient/family on Patient Teaching Tool.

Remember to always check the patient’s INR before giving warfarin and monitor ongoing lab results for any patient on heparin or warfarin.


**Reduce the risk of health-care associated infections**
- Comply with hand hygiene guidelines
- Sentinel events resulting from infection
- Prevent Multi-Drug Resistant Organism infections
- Prevent central line-associated blood stream infections
- Prevent surgical site infections
- Provide the patient with information on infection control measures for hand hygiene practices, respiratory hygiene, and contact precautions as applicable to the patient’s condition.
Accurately and completely reconcile medications across the continuum of care

• Compare current and newly ordered medications
• Communicate medications to the next provider
• Provide a reconciled medication list to the patient
• Settings in which medications are minimally used


Reduce the risk of patient harm resulting from falls

• Implement a fall reduction program

Encourage patients’ active involvement in their own care as a patient safety strategy

• Encourage patients and families to report concerns about safety.
• Use the Partnership Pledge for patient and family education.

For more information go to: http://devsearch.hopkinsmedicine.org/search?q=cache:OaDeHeZPzm0J:www.insidehopkinsmedicine.org/jcaho/resources/OurPartnershipPledge.pdf+partnership+pledge&client=Insidehopkinsmedicine_frontend&ie=UTF-8&output=xml_no_dtd&proxystylesheet=Insidehopkinsmedicine_frontend&access=p&oe=UTF-8

• If a patient/family has concerns, encourage them to contact Patient Relations.
• If the patient/family concerns cannot be resolved with Patient Relations, they are encouraged to contact the Joint Commission.

The organization identifies safety risks inherent in its patient population

• Identify individuals at risk for suicide (applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)

Improve recognition and response to changes in patient’s condition

• Request assistance for a patient with a worsening condition

Staff are required to know how to directly request additional assistance when the patient’s condition appears to be worsening.

• When the staff member calls 5-4444, either the Rapid Response Team (RRT) or Code Team will be activated, depending on the coverage area.
• Patients and families are also encouraged to seek assistance when the patient's condition worsens.
  – For the adult patient, they can request assistance through the RN. In pediatrics, they can make a direct call to the Pediatric RRT.

• For more information, refer to the Medical Emergency Management Annual Review Module or the CPR Policy at: http://www.insidehopkinsmedicine.org/hpo/policies/39/57/policy_57.pdf
Additional safety reminders:

Universal Protocol
• 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.
• For surgical/procedural patients, educate the patient on measures that will be taken to prevent adverse events during the procedure, such as prevention of infection, site marking and appropriate identification procedures.

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%20safety.ppt](http://www.rad.jhmi.edu/mri/MRI%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.

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.

Practice using PSN by entering a medication error or any other sample event that you would like by clicking on the link: [http://www.insidehopkinsmedicine.org/psn/](http://www.insidehopkinsmedicine.org/psn/) and choose “training mode.”

**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.

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 the medical record (including the EPR), 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 -- not a lot of 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.

HIPPA
**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.

1) Patients seen in the Emergency Department (ED) will be screened for allergies and sensitivities. This information is documented in the ED medical record. The RN receiving a patient from the ED is responsible for initiating the Allergy Communication Tool and applying the RED allergy wristband.

2) Patients scheduled to receive sedation or anesthesia will have the allergy wristband applied prior to the administration of sedation/ anesthesia.
   a) The healthcare provider will apply the allergy wristband prior to medical procedure.
   b) The RN/LPN may initiate the Allergy Communication Tool as determined by the specific area/clinic.

**Registered nurses are responsible for:**
- Screening all patients on admission for known allergies, sensitivities and reactions.

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**HIPAA Training**

All new agency nurses (travelers and local agency), 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:
- Travel nurses and local agency nurses – must arrive at JHH with proof of HIPAA training completion.

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.
• Verifying allergies with the History and Physical (H&P), admission orders, and the patient.
• Initiating the Allergy Alert Communication Tool and placing the tool in the medical record.
• Updating and reviewing the Allergy Alert Communication Tool.
• **Applying allergy/sensitivities wristband 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.

For more info about the Allergy Alert Communication Tool and Wristband, see http://www.insidehopkinsmedicine.org/hpo/policies/39/13/policy_13.pdf

**BLEEDING PRECAUTIONS**

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)
• Thrombolytic agents (e.g., streptokinase, tissue plasminogen activator, reteplase, recombinant)
• GPIIb/IIIa inhibitors (e.g., abciximab, eptifibatide, tirofiban)
• Drotrecogin alpha (Xigris®)

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 hypofibrinogenemia (fibrinogen level < 100 mg/dL), aPTT ratio > 1.3, or prolonged INR (> 1.5)

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.
• Maintain head of bed elevation at 20-30 degrees unless supine is required for clinical procedures. Trendelenberg should be avoided related to the increase in intracranial pressure and bleeding risk.
• If frequent vital signs are necessary, alternate the blood pressure cuff between arms at least hourly. Avoid frequent use of automatic blood pressure cuffs.
• If ordered, maintain current type and screen in the Blood Bank, and verify blood product availability according to authorized prescriber order. Type and screen must be reordered every 72 hours.
• Provides patient and family education regarding bleeding precautions.

**Nursing Assessment for Bleeding**
• Visible blood from wounds, injection sites, or around catheters.
• Evidence of “old blood” demonstrated by dark stools or coffee ground emesis.
  - Per order send specimen to lab for occult blood testing unless authorized to perform bedside POCT.
• Blood in excreta or from mucous membranes (mouth, urine, stool, sputum, NG drainage)
• Rapid drop in blood pressure (decrease of > 20 mmHg) or increase in heart rate (> 20 beats/minute) from baseline.
• Petechia and ecchymoses in the subcutaneous tissue.
• Pain or swelling at a site that has been previously injured and may incur bleeding.
o Assess limb or abdominal circumference when pain is accompanied by increased size of a body area, or skin tension (possible compartment syndrome or retroperitoneal hematoma)

- Sudden cessation of excreta that has been previously bloody (e.g., urine, sputum, stool) that may signal clotting and occlusion.
- Joint, abdominal, back pain or paresthesia that may signal compartment syndrome.
- 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 heads needs to be assessed)
- Take measures to decrease the risk of patient injury (i.e. 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. i.e NS nose spray
- Discuss with other healthcare providers (i.e 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:

_For pediatric patient see, Heparin, Mgt of the Pediatric Patient Receiving_
_http://www.insidehopkinsmedicine.org/hpo/policies/50/2548/policy_2548.pdf_

_For Adult patients see Heparin Mgt of the Adult Patient Receiving_
• Only nurses who have demonstrated initial and annual competency may administer chemotherapy.


AVOIDING CONSTRUCTION HAZARDS AT JHMI

• New construction and renovations are ongoing on all parts of campus.

• Be aware of certain hazards!
  – Never enter into a closed off area. Read your signs and obey them!!
  – Slips, trips, and falls are a common hazard. Be aware of your surroundings!
  – Noise and vibration can be an issue.
  – Asbestos removal— will always be communicated to all area occupants.

• At times during renovations, egress corridors or exit stairwells may need to be temporarily closed for safety reasons. If this happens, occupants will be educated on the closure(s) and on other routes of egress.

• Any other fire safety building deficiencies that may occur that would affect your area (i.e. sprinkler systems, smoke detectors, fire doors) will be communicated to you.

• If there are any safety concerns during construction projects, always call the Safety office at 5-5918.

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.
Scoring not completed for the following reason(s) (check any that apply). Enter risk category (i.e. Low/High) based on box selected.

- Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.
- Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization.
- Patient has experienced a fall during this hospitalization. Implement high fall risk interventions throughout hospitalization.
- Patient is deemed high fall-risk per protocol (e.g. seizure precautions). Implement high fall-risk interventions per protocol.

### Complete the Following and Calculate Fall Risk Score. If no box is checked, score for category is 0.

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE</strong> (&lt;SINGLE-SELECT&gt;)</td>
<td></td>
</tr>
<tr>
<td>60 – 69 years</td>
<td>(1 point)</td>
</tr>
<tr>
<td>70 – 79 years</td>
<td>(2 points)</td>
</tr>
<tr>
<td>≥ 80 years</td>
<td>(3 points)</td>
</tr>
<tr>
<td><strong>FALL HISTORY</strong> (&lt;SINGLE-SELECT&gt;)</td>
<td></td>
</tr>
<tr>
<td>One fall within 6 months before admission</td>
<td>(5 points)</td>
</tr>
<tr>
<td><strong>ELIMINATION, BOWEL AND URINE</strong> (&lt;SINGLE-SELECT&gt;)</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>(2 points)</td>
</tr>
<tr>
<td>Urgency or frequency</td>
<td>(2 points)</td>
</tr>
<tr>
<td>Urgency/frequency and incontinence</td>
<td>(4 points)</td>
</tr>
<tr>
<td><strong>MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS</strong> (&lt;SINGLE-SELECT&gt;)</td>
<td></td>
</tr>
<tr>
<td>On 1 high fall risk drug</td>
<td>(3 point)</td>
</tr>
<tr>
<td>On 2 or more high fall risk drugs</td>
<td>(5 points)</td>
</tr>
<tr>
<td>Sedated procedure within past 24 hours</td>
<td>(7 points)</td>
</tr>
<tr>
<td><strong>PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INdwELLING CATHETERS, SCDs, ETC</strong> (&lt;SINGLE-SELECT&gt;)</td>
<td></td>
</tr>
<tr>
<td>One present</td>
<td>(1 point)</td>
</tr>
<tr>
<td>Two present</td>
<td>(2 points)</td>
</tr>
<tr>
<td>3 or more present</td>
<td>(3 points)</td>
</tr>
<tr>
<td><strong>MOBILITY</strong> (&lt;MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER&gt;)</td>
<td></td>
</tr>
<tr>
<td>Requires assistance or supervision for mobility, transfer, or ambulation</td>
<td>(2 points)</td>
</tr>
<tr>
<td>Unsteady gait</td>
<td>(2 points)</td>
</tr>
<tr>
<td>Visual or auditory impairment affecting mobility</td>
<td>(2 points)</td>
</tr>
<tr>
<td><strong>COGNITION</strong> (&lt;MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER&gt;)</td>
<td></td>
</tr>
<tr>
<td>Altered awareness of immediate physical environment</td>
<td>(1 point)</td>
</tr>
<tr>
<td>Impulsive</td>
<td>(2 points)</td>
</tr>
</tbody>
</table>
Lack of understanding of one’s physical and cognitive limitations (4 points)

* Moderate risk = 6-13 Total Points, High risk > 13 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><strong>LOW FALL RISK</strong></th>
<th><strong>MODERATE FALL RISK</strong></th>
<th><strong>HIGH FALL RISK</strong></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.</td>
<td>Institute flagging system: red card outside room and red sticker on medical record, assignment board/electronic board; Hill ROM flag, if available</td>
</tr>
<tr>
<td>▪ Remove excess equipment/supplies/furniture from rooms and hallways.</td>
<td>Implement measures listed under low fall risk and:</td>
<td>Implement measures listed under low/moderate risk and:</td>
</tr>
<tr>
<td>▪ Coil and secure excess electrical and telephone wires.</td>
<td>▪ Monitor and assist patient in following daily schedules</td>
<td>▪ Remain with patient while toileting</td>
</tr>
<tr>
<td>▪ Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger.</td>
<td>▪ Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate.</td>
<td>▪ Observe q 60 minutes unless patient is on activated bed or chair alarm.</td>
</tr>
<tr>
<td>▪ Restrict window openings</td>
<td>▪ Reorient confused patients as necessary</td>
<td>▪ If patient requires an air overlay, use side rail protectors/extenders.</td>
</tr>
<tr>
<td>The following are examples of basic safety interventions:</td>
<td>▪ Establish elimination schedule, including use of bedside commode, if appropriate.</td>
<td>▪ 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.</td>
</tr>
<tr>
<td>▪ Orient patient to surroundings, including bathroom location, use of bed, and location of call light.</td>
<td>▪ Activation of bed/chair alarm</td>
<td>Evaluate need for:</td>
</tr>
<tr>
<td>▪ Keep bed in lowest position during use unless impractical (as in ICU nursing or specialty beds)</td>
<td>Evaluate need for:</td>
<td>▪ PT consult if patient has a history of fall and/or mobility impairment.</td>
</tr>
<tr>
<td>▪ Keep top two side rails up (excludes box beds). In ICUs, keep all side rails up.</td>
<td>▪ OT consult</td>
<td>▪ Slip resistant chair mat</td>
</tr>
<tr>
<td>▪ Secure locks on beds, stretchers, and wheelchairs.</td>
<td>▪ Activation of bed/chair alarm</td>
<td></td>
</tr>
<tr>
<td>▪ Keep floors clutter/obstacle free (with attention to path between bed and bathroom/commode)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Place call light and frequently needed objects within patient reach. Answer call light promptly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- 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

<table>
<thead>
<tr>
<th>(do not use on shower chair)</th>
<th>• Use of seat belt, when in wheelchair * See Med/Surg Restraint policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>alarm</td>
</tr>
<tr>
<td></td>
<td>• Low bed</td>
</tr>
<tr>
<td></td>
<td>• Protective devices, e.g. hipsters, helmets</td>
</tr>
<tr>
<td></td>
<td>• 24 hour supervision/sitter</td>
</tr>
<tr>
<td></td>
<td>• Physical restraint / enclosed bed (only with authorized prescriber order)</td>
</tr>
</tbody>
</table>

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

If a Patient Falls

1. If a patient fall occurs, immediately post-fall:
   - Assess mental/physical status of patient to identify changes from pre-fall status and degree of injury.
   - Assess whether patient can be moved and returned to bed/chair.
   - Assess need to transport patient by stretcher and/or with assistance.
   - Treat sustained injuries.
   - Notify provider.
   - Inspect environment to recognize and rectify hazards.
   - Interview patient and witnesses.
   - Assess need for activity limitations (out of bed with assistance or bed rest with full side rails).
   - Reassess need for enclosed bed.
   - Reassess need for sitter.
   - Reassess need for physical restraint as defined in institutional protocols.

2. If a fall-related injury occurs, make a follow-up assessment of patient’s post-fall condition as needed (no earlier than 8 hours and no later than 24 hours) to identify delayed sequelae. Follow-up assessment should include:
   - Physiological status
   - Mental status
   - Treatment modality changes that may have contributed to the fall.
FIRE SAFETY

If you discover a fire or smoke on an inpatient unit, react immediately:

1. Remove patient(s) and other individuals from immediate danger.
2. Close the door to contain smoke and fire.
3. Pull the nearest fire alarm. (Follow the route of exit to locate the nearest fire alarm pull station.)
4. Call x5-4444. Tell the operator the location of the fire, the type of fire (if known), your name and extension number.
5. Alert the charge nurse. The charge nurse is responsible for coordination of emergency response on the unit until the JHH Fire Response Team and the Baltimore City Fire Department arrive.
6. Do not attempt to use a fire extinguisher (unless trained annually to do so).
7. Do not open windows unless directed by the Baltimore City Fire Department. Provide a window key if applicable.

NEXT:

1. Account for all patients.
2. Assure all patients that the “Fire Emergency Plan” is in operation.
3. Direct visitors to remain with patients in their rooms or to an area of refuge or a building that is not in alarm.
4. Close all room and corridor doors. This maintains fire compartmentation throughout the unit.
5. Clear all unnecessary volunteers and visitors from the corridors. Direct to an area of refuge or out of the building.
6. Clear corridors of mobile equipment. Make sure all equipment is moved away from fire/smoke doors so that they can close.
7. If you are off the floor when an alarms sounds or a fire emergency is announced for your unit, return to your unit immediately using the stairway or an elevator in an adjacent building and assist with emergency procedures.

8. When the incident is over, a designated person on the unit should complete the Fire Incident Response Evaluation Form and forward it to the Safety office.

**REMEMBER:**

- Do not attempt to use a fire extinguisher (unless trained annually to do so), but know their locations for use by fire response personnel.
- When needed, seal doors with wet linen to block the spread of smoke.
- Do not open windows unless instructed to do so by the Baltimore City Fire Department.
- Do not block open doors that are equipped with a door closure.

**MEDICAL GASES:**

- Provide an alternate, portable oxygen/medical gas source for those patients requiring it.
- Disconnect all medical gases at the wall outlet only if the patient is in immediate danger, or the oxygen zone shut-off valve is being closed under the direction of the charge nurse, Fire Department, Safety Dept.
- Only the charge nurse (or another nurse at the direction of the charge nurse) is authorized to shut off the zone valve after an assessment of patients requiring oxygen/medical gas in the affected zone is conducted.
- Do not use the emergency zone shut-off valve for oxygen unless the room or compartment is fully engaged by fire or is inaccessible OR the equipment cannot be disconnected or turned off at the source, OR you are directed to do so by the Baltimore City Fire Department.

**EVACUATION PREPARATION:**

- Do not evacuate in mass unless directed by the Baltimore City Fire Department, Safety Department, or Security.
- If assistance is needed to evacuate patients, call x5-4444.
- Identify patients requiring continuous life support or monitoring.
- Identify patients requiring assistance for evacuation.
- Use horizontal (same floor) evacuation routes. Do not use elevators unless specifically directed by the Fire Department.
- If assistance is needed to evacuate patients, call x5-4444, ask the operator to page “Emergency, all available doctors and nurses please report to (building) (floor).”

**Evacuation of patients should occur by the following methods:**

- Ambulatory patients: Assist to safe area.
- Bed-ridden patients: Roll bed to safe area or use emergency carry.
- Wheelchair patients: Wheel to safe area. If necessary, carry down stairs.
Be thoroughly familiar with the locations of these items on your unit:

- Fire alarm boxes
- Fire extinguishers (used only by professionally trained fire responders)
- Medical gas zone valves and areas served by the valves (labeled near the valve)
- Back up oxygen cylinders
- Evacuation routes and refuge areas

"Business Occupancies"

"Business Occupancies" in the Hospital are required to evacuate all patients, staff, students, and visitors when the fire alarm sounds on these floors. These areas include all outpatient, office, and classroom/conference room areas. "Evacuation" means leaving the building under alarm, which most often may be done by moving horizontally to an adjacent building.

For more info, see Fire Safety

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

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 the rubber
contact, are 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**

1. While obtaining the patient history, nurse will ask about past reaction to any latex/rubber product, allergy to banana, avocado, apricot, kiwi, papaya, or passion fruit, and history of neural tube defects and congenital GU abnormalities.
2. Document this information on patient history form, Allergy Alert Communication form, and Medication Administration Record (MAR).
   - Enter allergies into Nutrition system to notify nutrition department.
   - Provider will document allergy on order sheet.
3. Latex allergy signs are posted on the patient's door and above the patient's bed. Tape is available for the front of the patient's medical record/chart. It is also noted on the Call report to nurse in receiving area/unit before patient transported/transferred. Notify transport personnel of allergy.

**Prevention of Allergic Reactions**

1. 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.
   - Use latex-free products. If you think there is a chance that there is latex in a product, avoid using it or use a barrier. The JHH Materials Management Department will serve as a resource about latex-free products available. Also there is a
• If no latex-free alternative exists, use stockinette or kling as a barrier (i.e., blood pressure cuff, tourniquet).
• Keep the door of patient's room closed.
• Avoid patient exposure to latex when transported off the unit.
• Put patient first on the daily schedule for procedure areas and operating room.
• Puncture multidose medication vials one time only, and then discard (unless using a multidose vial adaptor).

2. Teach the patient to:
• Wear Medic-Alert bracelet at all times.
• 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.
• Refer to standard teaching plan and patient handout in JHH Patient Education Manual.

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)

For more info, see Latex Allergy Protocol

List of Products That MAY Contain Latex
(Note: This is NOT a complete list. Check product packaging prior to use.)

- ace wraps/TEDS
- airways
- ambu bags
- balloons (non-Mylar)
- Band-Aids
- bathing suits/caps
- carpet backing
- catheters
- condom catheters
- condoms
- feeding nipples
- foam rubber
- gloves
- Halloween masks
- heating blankets
- hemodialysis equip
- hot water bottles
- isolation/OR masks
- make-up
- multidose vial
contraceptive sponges  nasogastric tubes

craft supplies  pacifiers
crutch tips/pads  glue
dental devices  rubber bands
diaphragms  rubber mats
drains  rubber plants
elastic fabric  sports handles
electrode pads  stethoscope tubing
endotracheal tubes  surgical tape
enema tips  tourniquets
erasers tool handles  toys
face mask & straps  ventilator hose

For more info, see JHH Products Containing Latex

MEDICINAL EQUIPMENT SAFETY

Basic Safety Tips:
Make sure all patient care equipment is appropriately cleaned and disinfected prior to use and in between patients.

  – Reminder when using Sani Cloths you must wear gloves and the minimum contact time is 2 minutes.

See the Cleaning and Disinfection policy for more information at

  • 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).
  • Report equipment problems to CES at 5-2100, don’t work around broken equipment.

Broken/Malfunctioning Equipment:

  • If you suspect an equipment problem, remove it from patient use immediately.
  • If the patient has been injured, leave any disposables or accessories intact (i.e. tubing). This will help in the investigation of the problem.
• Clearly label the equipment as broken and write out the problem using the pre-printed broken equipment labels.
• Call Clinical Engineering at 5-2100, ext 515 to pick up any equipment involved in a PSN event. (Use the orange broken equipment tag)
• 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 (beeper 3-7912 or 3-7913, phone x5-6238).

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 (beeper 3-7912 or 3-7913, phone x5-6238) 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, contact Respiratory Therapy.
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

PATIENT BILL OF RIGHTS FOR THE JHH

1. To receive considerate, respectful and compassionate care regardless of your age, gender, race, national origin, religion, sexual orientation or disabilities.
2. You have the right to receive care in a safe environment free from all forms of abuse, neglect or harassment.
3. To be called by your proper name and to be told the names of the doctors, nurses and other health care team members involved in your care.
4. To have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital.
5. To be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment and expected outcome of treatment, including unanticipated outcomes. You have the right to give written informed consent before any non-emergency procedure begins.
6. To have your pain assessed and to be involved in decisions about managing your pain.
7. To be free from restraints and seclusion in any form that is not medically required.
8. To expect full consideration of your privacy and confidentiality in care discussions, examinations and treatments. You may ask for a chaperone during any type of examination.
9. To access protective and advocacy services in cases of abuse or neglect. The hospital will provide a list of protective and advocacy resources.
10. To participate (family members or friends with the patient’s permission) in decisions about your care, treatment, and services provided, including the right to refuse treatment.
to the extent permitted by law. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.

11. To agree to or refuse to take part in medical research studies. You may at any time withdraw from a study.

12. To sign language or foreign language interpreter services. We will provide an interpreter as needed.

13. To make an advance directive appointing someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help to complete one.

14. To be involved in your discharge plan. You can expect to be told in a timely manner of the need for planning your discharge or transfer to another facility or level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.

15. To receive detailed information about your hospital and physician charges.

16. To expect that all communications and records about your care are confidential, unless disclosure is allowed by law. You have the right to see or get a copy of your medical records and have the information explained, if needed. You may add information to your medical record by contacting the Medical Records Department. Upon request, you have the right to receive a list of who your personal health information was disclosed to.

17. To give your consent about the media’s use of recordings or photographs. You have the right to withdraw consent up until a reasonable time before the recording or photograph is used.

18. To discuss an ethical issue related to your care with a member of the Ethics Service, a member is available on beeper at all times. To reach a member dial, 410-283-6104. After three beeps, enter your phone number and then the pound sign (#). An Ethics Service member will return your call.

19. To pastoral and other spiritual services. Chaplains are available to help you directly or to contact your own clergy. You can reach a chaplain at 410-955-5842 between 8 am and 5 pm weekdays. At other times, please ask your nurse to contact the chaplain on call.

20. To voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse manager or a department manager. You may also contact the Patient Relations Department at 410-955-2273 or email patientrelations@jhmi.edu. If your concern is not resolved to your satisfaction, you have the right to request a review by the Maryland Department of Health & Hygiene, Office of Health Care Quality, Hospital Complaint Unit, Spring Grove Hospital Center, Bland Bryant Building, Catonsville, Maryland 21228, 410-402-8016 or toll free 1-877-402-8218. You may also contact the Joint Commission Office of Quality Monitoring, One Renaissance Boulevard, Oakbrook Terrace, IL 60181, toll free 1-800-994-6610, or complaint@jointcommission.org.

**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 are expected to ask questions when you do not understand information or instructions.
3. You are expected to actively participate in your pain management plan.
4. You are expected to treat all hospital staff, other patients and visitors with courtesy and respect.

For update and additional information about the JHH’s Patient Bill of Rights go to the following link:
http://www.insidehopkinsmedicine.org/operations_integration/patientBOR.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.

For more info, see Pt. Identification Policy

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 every hour, for directing the care given by the observer, 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 is in close proximity to the patient at all times.
3. The observer keeps the patient in direct sight at all times. Patients may not pull curtains or close doors that block them from the observer's sight.
4. Potentially hazardous items are removed from the patient's person, belongings, and the room.
5. Packages received by the patient are opened in the presence of the observer. All sharp or potentially hazardous items are removed.
6. The patient uses only an electric razor.
7. Meals are served on paper products with a metal spoon.
8. Night-lights are utilized.
9. The observer accompanies the patient everywhere - both on and off the unit.
10. All patient visitors report to the nurses' station before seeing the patient.
11. **For more info, see Suicide Precautions**

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**CLINICAL CARE**

**BLOOD AND BLOOD PRODUCTS**

**Informed Consent**

- Informed consent must be obtained by the physician 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.
- Any patient that refuses blood products will have the “Refusal of Transfusion of Blood and Blood Products” form completed and filed in the medical record.

**Blood Product Ordering**

- Blood that is crossmatched will be held for a patient for 24 hours only. After that time, it will
be released without notification of the authorized prescriber.

**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 (5-0132) using the Blood Product Request Form.
- Emergency blood transports are not shipped 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 (adults: 20 gauge or larger; pediatrics: size depends on age/size of patient).
- Obtain baseline VS (temperature, BP, respirations, and pulse).
- Administer premedications if prescribed.
- Verify: Patient identity, type of product, blood product bag intact, blood product requisition form and blood product label match (ABO and Rh compatibility for RBCs; plasma ABO compatibility for platelets or plasma if administering to pediatric patients or patients weighing < 40 kg or patient receiving more than 600cc of incompatible platelet or plasma product in a 24 hour period).
- Notify Transfusion Medicine immediately of any discrepancies between the blood product requisition form, blood product, and patient identification.

**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.
- Blood cannot hang longer than 4 hours.
- All blood products must be filtered with the appropriate filtering device. Cryoprecipitate requires a special infusion set supplied by Transfusion Medicine.
- Blood infusion set should be changed within 24 hours of initiating transfusion.
- Drugs or medications must not be added to the blood component bag prior to or during administration.
- Only blood warmers approved by Clinical Engineering may be used and temperature of infused blood should be in the range of 35 – 41°C.
- 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.
  - Dispose of the empty bag and tubing in a red bag waste receptacle.
  - Document that the patient received the blood.
  - Document I+Os.

**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

**DOCUMENTATION OF THE NURSING PROCESS**

The information presented describes standards for documentation on most inpatient units at JHH. Some departments and specialty areas have different forms and documentation standards. All critical care and IMC units use the Sunrise computerized documentation system. Check with the charge nurse/nurse manager for documentation guidelines/standards specific to the unit on which you are working.

- Specifics of Sunrise will be covered in class.

**General instructions**

- All forms are imprinted with patient's ID plate. If the patient’s plate is not available, the patient’s name and history number are printed on the form.
- Entries are made in blue or black ink.
- Errors are corrected by drawing a straight line through and writing the word "error" and the correction above with your initials, date, and time.
- Do not erase, obliterate, or attempt to edit notes previously written. Do not use correction fluid or tape.
- When signing any part of the medical record print including: first initial of legal name (not
nickname or alternative spelling), full last name and title. Example: "N. Nurse, R.N."

- Nursing student documentation, including assessment, plans of care, notes, flowsheets, medication administration, should be reviewed for accuracy and must be cosigned by the faculty member.

- Never alter patient records. All corrections and late entries should be clearly marked as such.

- Late entries, entries made out of time sequence, or addenda should be clearly marked as such in the record, and properly dated, time and signed.

**Adult Initial Screening/Planning Tool**

**Purpose/use:**
- Documents critical patient information that reflects the admission status of the patient pertinent to the current hospitalization.
- Includes initial patient screens including pain, violence/abuse screen, nutrition, functional status, psychosocial issues, pastoral/cultural needs, and discharge planning needs.
- Appropriate referrals are made based on the initial screening.

**Completion of form:**
- Patient’s RN must assure completion of the form, including identification of the patient’s needs for referral and discharge planning within 24 hours.
- RN may delegate the completion of this form to the Unlicensed Assistive Personnel (UAP). The UAP may complete page 1 except for the allergy, medication and violence sections. The patient/family may not complete the form.
- NCIII/designee will review this form to assure all appropriate referrals are made within 24 hours of admission. (Agency nurses may not function as the NCIII designee).

**Discharge Planning Tool**

- If the patient screens positive/ a need for a referral is identified on the Adult Initial Screening/Planning Tool, the NCIII/designee completes this form.
- May be used by several discharge planners during the patient’s hospitalization.
- Also used to document ongoing discharge planning and referrals while the patient is hospitalized. Permanent part of the medical record.

**Multiday Flowsheet**

- Covers a 5-day period.
- Kept at the patient’s bedside.
- RN assigned to the patient is responsible for assuring that all required documentation is completed by any person to whom certain aspects of care is delegated.
- Used to document:
  - **Assessment** - A full assessment must be completed at least once in a 24-hour period. An RN must complete the initial assessment and plan of care. Printed norms or minimal data elements are provided for each system. You compare your patient to the printed norm. If the assessment is consistent with the printed norm,
place a check ✓ in the box under the date and time that corresponds with the assessment. If the assessment deviates from the printed norm place an asterisk ✰ in the box. Abnormal assessments must be assessed every shift. (based on an 8 hour shift).

- **Plan of care** - The RN must review the patient’s plan of care daily and add or discontinue plans as appropriate for patient care.

- **Other patient data**, including pain assessments, vital signs/ graphic summary, pulse oximetry readings, blood glucose recordings, I & O, Braden score/ pressure ulcer risk, fall risk assessment, high frequency measures, phlebitis score.

- **Nursing notes** – Include assessment that deviates from pre-printed statement, nursing interventions, response to interventions, and progress toward meeting outcomes.

Addendum forms are available if more space is needed for nursing notes or high frequency interventions.

**Multidisciplinary Problem List**

- Initiated within **24 hours** of admission by the RN.
- Used to document acute problems and to document expected outcomes of the hospitalization/episode of care.
- RN evaluates the patient’s progress toward achieving outcomes in the Nursing Notes every 24 hours and when the patient is transferred/discharged.
- Kept in the patient’s bedside chart until patient transfer/discharge. Continue to use problem lists that accompany transferred patients.

**Patient Education Documentation Tool**

- Documents a patient’s ability to learn, including cultural and religious practices, emotional barriers, physical and/or cognitive limitations, or language barriers that impact on learning.
- The ability to learn section of the form must be completed by the RN prior to teaching. (Readiness and willingness to learn is documented daily on the nursing flowsheet.)
- Also used to document all of the education that a patient has received while in the hospital. Standard Teaching Plans (STPs) used during teaching sessions are listed on this form along with whether the STP objectives have been met.
- If a Standard Teaching Plan is not available, the nurse develops an individualized teaching plan for the patient. This is written on the Patient Education tool.

**Standard Teaching Plans (STPs)**

- There are standard teaching plans (STPs) for some of the most common diagnoses seen at the JHH. They can be found on the Nursing intranet.
- You may print the STP from the nursing web site and document your patient/family teaching directly on the form. Then attach it to the Patient Education Tool.
• These are used as guides to facilitate patient education.

**Transfer of Care to another Facility Form**

• Communicates pertinent clinical information regarding the patient’s status and ongoing care needs to the transfer facility.
• RN is responsible for completing the nursing section of this form and documenting ongoing active problems.
• Physician is responsible for writing the appropriate transfer orders, which will accompany the patient.
• Each discipline (social work, physical therapy, occupational therapy, &/or nutrition) is responsible for completing the appropriate section to include a summary of active health problems at the time of transfer.
• The bottom section of the form indicates the name of the facility or home care agency responsible for providing care to the patient upon transfer. Indicate whether the patient has an advance directive and if so, assure that a copy is sent to the facility/home care agency. The transfer nurse should sign the bottom of the form in the designated space.
• Form is printed on 3part NCR paper. The first page (white) is a permanent part of the medical record. The second copy (yellow) is sent to the transfer facility. The third copy (pink) may remain on the nursing unit.

**Discharge Instructions**

• Used to provide written information for the patient/family to follow after he/she is discharged from the hospital.
• The RN uses information obtained from the Physician Discharge Orders to complete these forms. Once completed, the RN may delegate the teaching of these forms to the CNI/LPN.
• To prevent errors that could occur when nurses copy information from the patient’s prescription onto the MEDICINE section of this form, **only the NAME of the medicine needs to be written in this section** if a patient receives a prescription. **DOSE, ROUTE, and FREQUENCY** should be written only if the patient is not given a prescription or if the medication is an over-the-counter drug.
• Upon discharge, the patient shall be given written instructions regarding the updated list of medications the patient is to take after discharge. These instructions will include the information regarding new medications ordered for the patient as indicated by an authorized prescriber. The patient will be instructed that if they have a concern or question about any of their medications, they should discuss this with the prescriber who ordered the medication.
• Discharge Instructions must be written so that the patients/families can understand the information provided. **Medical abbreviations or medical jargon should not be used.**
• **Write neatly and legibly** so that the patient/family can read it.
• If your patient **requires Home Care services**, a 3rd page entitled “Discharge Instructions for Home Care Services” may be completed by the NCIII or patient’s nurse.
• The "*Guide to Using Medicines the Right Way*" can be found on the back page of the white copy that is given to patients when they are discharged. Review all of the information on this form with the patient and/or family member. Have the patient/significant other sign all
pages, indicating understanding of information presented and receipt of medications brought in from home as well as valuables.

- Preprinted Discharge Instructions are available for many common discharge diagnoses and critical paths. These preprinted forms can be accessed from the nursing web site.
- This form is in 3 part NCR paper. The white copy is given to the patient/significant other on discharge. The second copy (yellow) is a permanent part of the medical record. And the third copy (pink) can remain on the nursing unit.

**Interagency Referral Form**

- Johns Hopkins Home Care generally documents referral information electronically in EPR. In the absence of such documentation, the Interagency Referral Form may be used when a home care referral is made to communicate pertinent clinical and financial information regarding the patient’s insurance; clinical status and ongoing home care needs. This form may also serve as the physician orders for home care.
- Physician is responsible for writing discharge orders to include activities permitted, home care services desired, treatments including frequency and assessments, equipment needs and medication dose/frequency/route and therapeutic goals. When this form is used, the physician is also responsible for completing the physician certification section and signing the form.
- This is a 3-part NCR form. The first copy (white) is faxed or mailed to the home care agency. The second copy (yellow) is a permanent part of the medical record. The third copy may remain on the nursing unit.

**Critical Paths**

- Critical paths are multidisciplinary plans of care for a defined patient population.
- The path has been developed to identify routine tests, procedures, medications, teaching and expected outcomes that should be achieved at various points during the patient’s hospitalization.
- Each path consists of the following:
  - Preprinted MD Admission Orders
  - Available in Sunrise as order sets
  - Preprinted Problem List and Patient Education Objectives
  - Preprinted Critical Path
  - Preprinted Discharge Instructions
- These forms can be individualized by crossing out items that do not apply to the patient or by not initiating certain items such as certain problems on the problem list.
- The Critical Path is the plan of care for the patient. No other care plan or problem list is required unless the patient “falls” off the pathway.
- The RN or Case Manager is responsible for initiating the critical path on admission.
- The multidisciplinary team is responsible for implementing and evaluating patient care according to the critical path form throughout the patient’s episode of care.
- All activities/interventions outlined on the path do not require individual signatures. Initial and time the following only:
  - Specific interventions and protocols that have been added, deleted or revised as
individualized for the patient.
- Interventions that are not met and the item is circled and moved to the following day.
- Interventions that are preceded by small boxes.

**Additional forms:**
You may be expected to document patient information on several other forms:

- Preprocedure/Preoperative Checklist
- Wound Observation Flowsheet
- Neurologic/Neurovascular Assessment Flowsheet
- Pain Flowsheet
- Restraint Flowsheet
- Chemotherapy Administration Checklist
- Adult Resuscitation Orders and Flowsheet
- EKG Observation Forms

**PAIN MANAGEMENT**

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

Pain is an unpleasant sensory and emotional experience associated with actual/potential tissue damage or described in terms of such damage. Highly personal and subjective. 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 often accompanied by emotional and spiritual responses, such as suffering or anguish.

One type of pain, acute, 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).

Below is a summary of the JHH inpatient documentation requirements for pain assessment and screening.

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<thead>
<tr>
<th>What?</th>
<th>When?</th>
<th>Where?</th>
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<tbody>
<tr>
<td>Initial screen for presence of pain</td>
<td>On admission per unit standard</td>
<td>Appropriate unit based form or computer based system</td>
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<tr>
<td></td>
<td>- Within 2 hours for ICU/IMC and Psych ED</td>
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<td></td>
<td>- Within 4 hours for general care units and telemetry</td>
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<td>- Within 30 minutes for L&amp;D and ED</td>
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<td></td>
<td>(For patients with moderate (4-6) or severe pain (7-10) RN will conduct pain history and authorized prescriber will be notified.)</td>
<td></td>
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<tr>
<td>What?</td>
<td>When?</td>
<td>Where?</td>
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| Initial assessment | - At JHH, nurses and unlicensed assistive personnel (UAPs) screen every patient for pain on admission.  
- UAPs may implement non-pharmacologic interventions and must notify the nurse if the patient’s score is moderate or severe or if the patient wants it addressed.  
The screening tool is selected by the RN based the patient’s age and communication ability. | Appropriate unit based form or computer based system |
| RN assessment | - Assessment **shall include** pain rating, location, quality, onset, duration, and pattern, alleviating/aggravating factors, physical exam/observation, pain management history (for persistent pain) and the patient’s pain goal (rating the patient would like to obtain). | |
| Ongoing Assessment | - Nursing staff will obtain the ongoing pain scores at the following intervals based on the severity of pain. | Appropriate unit based form or computer based system |
| Pain Category | Frequency | Authorizer prescriber – on daily rounds or with each outpatient encounter |
| Mild | A minimum of every 12 hours |
| Moderate | Assess pain as clinically indicated  
(Best practice would be to assess 2-4 hours after a PRN dose of medication is administered) |
| Severe | |
| Assess effectiveness of | - When pain occurs on a regular basis, medication should be given on an around-the-clock (ATC) schedule to ensure adequate pain relief.  
- Around-the-clock dosing schedule is preferred whether the patient is in | |

<table>
<thead>
<tr>
<th>Pain Category</th>
<th>All 10 point scales</th>
<th>NIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>1 – 3</td>
<td>1 - 3</td>
</tr>
<tr>
<td>Moderate</td>
<td>4 - 6</td>
<td>4 - 6</td>
</tr>
<tr>
<td>Severe</td>
<td>7 - 10</td>
<td>7</td>
</tr>
<tr>
<td>What?</td>
<td>When?</td>
<td>Where?</td>
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| Pharmacologic interventions | pain or not.  
- If given only on an as needed basis (PRN) when the patient is in pain, this type of schedule may lead to periods of severe pain.  
- RN/LPN shall, at a minimum, evaluate and document in the medical record the effectiveness of pharmacologic interventions:  
  - Scheduled medications every shift  
  - PRN medications within 2-4 hours of administration |
| Assess effectiveness of non-pharmacologic interventions | The effectiveness of non-pharmacologic interventions should be assessed and documented at appropriate intervals.  
- Non-pharmacological interventions should be considered based on patient preference and the degree of pain relief obtained. Options include heat or cold, massage and vibration, distraction (music, videos, games), relaxation techniques, transcutaneous electrical nerve stimulation (TENS). |
| Assess 24 hour pain rating and Patient Global Impression of Pain | For patients with moderate or severe pain, who are greater than 7 years old and can self-report you may use the following tools once every 24 hours.  
24 hour pain rating using the NRS, ask patient ‘Over the past 24 hours, what number would you rate your pain?’  
PGIC- Patient Global Impression of Change assesses how much the patient’s pain has improved or worsened relative to their baseline status using a 7 point scale. |
| RN Responsibility | Screen patients on admission and throughout hospitalization  
Initial and on-going pain assessment as indicated  
Assessment of effectiveness of pain interventions  
Notify authorized prescriber if pain intervention is ineffective, adverse reactions, and other reportable conditions  
Administer ordered medications per policy  
Provide patient education including but not limited to pain risks, importance of effective pain mgt, measures/tools used to assess pain, options for treating pain, provide written instructions |

### Major Pain Rating Tools

<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 (greater than 7 years old)</td>
<td>Patient able to speak and give self-report of pain intensity</td>
<td>0-10 Numerical Rating Scale (NRS)</td>
<td>All Staff</td>
</tr>
<tr>
<td>Adults and Pediatrics (greater than 7 years old)</td>
<td>Non-verbal/Cognitively impaired patients</td>
<td>Behavioral (BPA)</td>
<td>RN or authorized prescriber</td>
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</tbody>
</table>
Patient Controlled Analgesia (PCA)

JHH has the following protocols for care of the adult patient receiving PCA on the Nursing intranet: IV, epidural, and intrathecal. 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

Reportable Conditions

The RN will report the following to the physician and document on the appropriate unit based nursing flowsheet/computer entry system:

- Uncontrolled pain
- Pain interventions that do not achieve the patient’s pain goal
- New or worsening pain
- Adverse effects from pain medications - respiratory depression/distress
- Other - change in mental status, myoclonus, nausea or vomiting, urinary retention, constipation, pruritis, sensory/motor changes

Patient Education

- The nurse will teach the patient:
  - How to rate and communicate their pain level using the appropriate scale.
  - His/her pain management plan, including the patient’s pain goals.
  - Importance of around the clock medication scheduling
- Document all patient instruction given and the patient’s/family’s response to education on the Multidisciplinary Patient Education form/computer.
To access the patient education materials, go to

Discharge Planning

- All patients discharged with pain should have a pain management plan established by the multidisciplinary team and patient.
- The patient’s goals should include a pain rating; his/her expected activity level, function, and quality of life.
- The patient and family should be given written instructions related to pain management, including:
  - Name, dosage, and administration schedule for all pain medications.
  - Information on each medication:
    - Side effects - how to manage, what needs to be reported
    - Onset of action
    - When to begin to titrate
- Discharge needs related to pain management are documented on the Discharge Planning Tool.

For more info, see Pain Protocol

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/competency testing.

Nursing Students may NOT perform POCT.
Information presented below reviews the highlights of the JHH Medication Order and Administration policies. Specifics of Sunrise order system will be covered in class.

Instructors must complete an online Sunrise order systems 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.

ORDERS

- An existing written order may not be corrected, altered, added to, or modified in any way. If change is necessary, the order is discontinued, and a new order written by an authorized prescriber.
- If an error is noticed immediately after writing an order and before a copy has been sent to the pharmacy, the entry can be corrected by placing a single line through the incorrect material and clearly writing the correct information along with the prescriber’s initials. If a written order has been initiated or a copy has been sent to the pharmacy, the incorrect order must be discontinued and a new order written.
- The patient’s weight (actual or estimated) is documented onto the admission order sheet prior to forwarding the orders to the pharmacy or placed into the order entry system.

Prescribers

- Authorized prescribers are physicians (MD), doctors of osteopathy (DO), dentists (DDS), podiatrists, certified nurse practitioners (CRNP), certified physician assistants (PA-C), and certified nurse midwives (CNM). The CRNP, PA-C and CNM may only prescribe within the scope delineated in their Physician Sponsor Written Agreements.
- Medication orders that are written by a medical student, including the sub-intern, must be countersigned before the nurse may administer the medication.
- Sub-Interns are authorized to receive and record verbal orders from authorized prescribers.
- Consulting physicians may only write a verbal order on behalf of an authorized prescriber of the service responsible for the patient, which is cosigned by an authorized prescriber responsible for the patient by the end of the next calendar day.

For more info, see http://pathology2.jhu.edu/pointofcare/poct/index.cfm
orders written by consulting physicians who share responsibility for the patient during the procedure do not need to be co-signed.

**Verbal Orders**
- The use of verbal orders is to be minimized.
- Consulting physicians, registered nurses, registered pharmacists, physician assistants, sub-interns, respiratory therapists, and ALS EMTs are authorized to accept verbal orders from authorized prescribers.
- Whenever verbal or telephone orders are taken, the person receiving the order shall write the order down, then read it back verbatim to the prescriber so that the accuracy of transcription can be verified by the prescriber.
- The authorized individual accepting the verbal order shall enter the order on the JHH order sheet or enter the order electronically, sign the order (with his/her professional designation), record the name of the authorized prescriber with the prescriber’s ID number and flag the order for signature by the prescriber.
- The ordering prescriber or an authorized prescriber from the team responsible for the patient shall sign such orders by the end of the next calendar day. Other healthcare providers may act upon a verbal order prior to this co-signature.

**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.
- **CO-SIGN** - alerts the physician that there are orders that need to be co-signed.
- **VERIFY TRANSCRIPTION** - alerts the patient’s nurse that there are new orders that need to be reviewed and verified

**Hold Orders**
- 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."

**Order Pick-up and Delivery**
- Pharmacy personnel pick-up orders and delivers at least every two hours.

**Formulary vs. Non-formulary**
- Patients may not use their own supply of medications if the medication is on the Hospital formulary unless the patient is taking a complementary and alternative medication or a patient is participating in a JHM-IRB approved protocol. The patient may use his or her own supply of an IRB-approved study medication whether or not that medication is on the formulary.
- A **Non-formulary Request Form**, available on the nursing unit or electronically, accompanies orders for non-formulary medications. Non-formulary drugs are usually available within 24-
48 hours.

- A patient's own supply of non-formulary medication may be used until the pharmacy acquires the medication. The physician/pharmacist must inspect the drug and document in the medical record that the drug has been identified. The physician must write a complete medication order including a statement that patient's own supply may be used. The nurse must secure the medication and administer it to the patient.

- Non-formulary controlled medications or complementary and alternative medications (CAMs) will not be obtained.

For more info, see the CAM protocol at http://www.insidehopkinsmedicine.org/hpo/policies/39/22/policy_22.pdf

Transfers

- When a patient is transferred to another service, to or from a different level of care, or if the patient has major surgery, all medication orders are discontinued and rewritten.

- When a patient’s care is transferred to another attending within the same service and/or the patient is relocated to a new room within the same service, new orders are not required.

Discontinuation of Orders

- Written orders are discontinued on the MAR by writing "D/C" over the drug name and drawing a line through the remaining administration times.

- An order to discontinue a medication should refer to the name of the drug being discontinued and not to the order number being discontinued.

- In situations where active orders for a medication include both PRN and routinely scheduled doses, or when active orders include both an immediate and sustained-released form of the medication, an order to discontinue the drug will be interpreted as discontinuing all schedules and all forms of the discontinued medication, unless explicitly stated otherwise. On units with Sunrise, each unwanted medication order must be discontinued individually.

Transcription of Written Medication Orders

- The RN is accountable for reviewing his/her patient charts/electronic orders when accepting a patient assignment and at least every 4 hours to identify/communicate new provider orders written during the shift.

- The Clerical Associate is responsible to check for newly written orders a minimum of two times per 8 hour shift, with the last check occurring within two hours of going off duty. Order checks are indicated by documenting name, date and time at the end of the most recently written orders.

- The Clerical Associate transcribes the order and signs off (with first initial, last name and title) within two hours of the writing/printing of the order, as applicable. In the absence of a Clerical Associate, orders may be transcribed by an RN/LPN.

- The RN checks the accuracy of the orders and indicates this by signing his/her name and title on the order sheet and placing his/her initials next to the order number on the MAR, or noting orders in the electronic record.

Verification of MAR

The nurse, prior to using a newly generated automated paper MAR, must complete verification of
the MAR. The nurse accomplishes this by:

- Comparing the previous day's MAR to the current day's MAR.
- Resolving discrepancies by comparing the MAR to the order sheet or electronic orders.
- Checking for any new medication orders.
- Communicating discrepancies to the pharmacy as needed.
- Documenting verification on the MAR.

**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. See [http://www.insidehopkinsmedicine.org/hpo/policies/39/78/appendix_15229.pdf?CFID=55099908&CFTOKEN=b83252aeb0f40861-CFFE8BE0-B8E9-A9DF-4747A2B6263CAFFC](http://www.insidehopkinsmedicine.org/hpo/policies/39/78/appendix_15229.pdf?CFID=55099908&CFTOKEN=b83252aeb0f40861-CFFE8BE0-B8E9-A9DF-4747A2B6263CAFFC) 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.

**Medication Administration**

- RN is responsible for reviewing changes in medication orders and on the MAR.
- 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.
  - Check for initial transcription and verification of MAR by RN
  - 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 (Example: computer monitor next to patient’s bed, computer-on-wheels (COW) brought to patient, paper MAR brought next to patient.)
- 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 pump setting, dose, concentration and verification of original order upon initiation and with rate and bag changes include: IV PCA, epidural analgesia, Intrathecal analgesia, IV heparin, IV insulin, IV chemotherapy and continuous opioid infusion.
- 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.
- Sample medications may never be administered to an inpatient.
- Antibiotics ordered as on call for operative procedures will be sent with the patient to the OR. All other medications for the OR or diagnostic/therapeutic procedures will be administered at the time ordered. If ordered on call, the medication will be administered when the patient is called for the OR or procedure.
- For patients leaving the nursing unit for a test or procedure and returning to the same sending
unit or level of care.
  o Continue PCA and continuous infusions unless otherwise ordered by an authorized prescriber.
  o 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.
  o 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.
  o 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.

- Patients and/or designated care giver may self-administer medications as part of a supervised medication teaching program. An authorized prescriber must write a complete medication order and the medication administration must be directly observed by the RN/LPN, and documented on the MAR by the RN/LPN as self administered.

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 regularly employed, weekend program, float pool 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.
  - The Nurse Manager/Nurse educator or designee is responsible for determining which functions the commercial agency nurse will conduct on the individual nursing unit, and will review the controlled substance policies with the employee, and require a signed confidentiality statement prior to providing the employee with the User ID and password.
- To obtain additional Controlled Substances from Pharmacy, the nurse or designee goes to the appropriate Pharmacy Satellite with JHH photo identification badge and *Controlled Substance Request Form*. The nurse accepting the drugs verifies that the correct drug has been received and refills or loads the drug into the MedStation, or in the controlled substance cabinet (remote function).
- Administration of controlled substances:
  1. Obtain drug from the MedStation or cabinet using Remove Med Function.
  2. Conduct a visual count of the drug in the pocket and verify the inventory prior to withdrawing the dosage unit.
  3. 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.
  4. Errors/discrepancies are resolved immediately using the Resolve Discrepancy Function. A witness is required to resolve all discrepancies.
  5. 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.
  6. If controlled substance is given to a physician to administer, record physician's name, dose and time on MAR.
7. Document administration of controlled substance on MAR.
8. If drug is needed immediately and Pyxis MedStation is non-functional, obtain needed dose from a nearby unit. The patient's PAT COM should be entered into the lending units Pyxis MedStation.

For more info about controlled substances, see http://www.insidehopkinsmedicine.org/hpo/policies/62/2099/policy_2099.pdf

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.
- Areas which have automated systems will have alerts noted on automated MARs. Areas which do not have automated MARs will place a label indicating Food Drug Interaction on the MAR.
- 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.

For more info about food-drug interactions, see http://www.insidehopkinsmedicine.org/hpo/policies/39/91/appendix_19566.pdf?CFID=55099908&CFTOKEN=b83252aeb0f40861-CFFE8BE0-B8E9-A9DF-4747A2B6263CAFFC

Miscellaneous
- Remember that all multi dose vial must be dated when opened and dated 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.
- Medications may be administered to a distraught or mourning relative if the physician writes an order on the related patient’s order sheet specifying the name of the relative receiving the medication.
- Do not crush hazardous drugs.

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.
- The principal investigator will place a copy of the Drug Data Sheet (DDS) in the patient’s medical record. A completed DDS must be present prior to administration of the first dose of drug unless an emergency situation exists.
- If an IND is in multidose packaging, the principal investigator's name and phone number must be on the package label. "Investigational", will be written on the drug label.
• Prior to administering an IND, the nurse will review the DDS and direct questions to the principal investigator.
• 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.
• One-time orders are documented on the MAR after administration.
• A STAT order not administered within 30 minutes will turn red for an overdue task in the Sunrise system. For STAT orders with the paper MAR, the nurse would sign off the medication on the MAR and in the medical record.
• For PRN orders in Sunrise, document that PRN orders were given in the purple trough.
• Continuous drug infusion therapies are documented on the MAR when the infusion is hung for Sunrise units. On paper MAR they are documented when they are hung and discontinued/completed.
• Sliding scale medications in Sunrise are recorded by documenting the actual glucose value and meter number, the amount of drug administered and site. On paper MARs, strike a line through the administration time and document the amount of insulin given, site and the initials of person administering the medication.
• Omitted medications on paper MARs are circled with reason why the drug was omitted on the MAR. In Sunrise an omitted drug is marked as not done and an X appears in the cell. The nurse must also document the reason why the drug was omitted (patient refused, patient not available, nauseated, etc.). The reason can be viewed under details.
• Refer to the departmental references for specific documentation criteria for Pediatrics, Oncology, and ICUs.

Drug References
• The online drug references, MicroMedix and the JHH Drug Formulary, 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/
• The JHH drug information pharmacist is also available at x5-6348.
• Use of pocket references is discouraged because they sometimes provide incomplete or inaccurate info.

Medication Errors
• Nurses have an obligation to report medication events via Patient Safety Net (PSN), the JHH’s online event reporting system. http://www.insidehopkinsmedicine.org/jpl/uhc/psn_gateway.html
• 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

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% O₂.
- 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.

For more info, see

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

The JHH has 2 polices for restraints.

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

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 statements above also monitor
* 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
Observe the non-violent patient a minimum of q 2 hours and document

* airway patency/presence of respirations (every 15 minutes in Psych)
* skin integrity
* circulation (for limb restraints)
* maintain body alignment
* Every 2 hours during waking hours, provide
  * ROM
  * Food and fluids as per clinical condition with meals at regularly scheduled times
  * Bathing and oral hygiene at least once/24 hours
  * Toileting

Observe the violent patient a minimum of q 15 minutes and document

* Patient behaviors
* airway patency/presence of respirations
* Every 2 hours, (q 1 hour for the patient in 4 point restraints) check
  * skin integrity
  * circulation (for limb restraints)
* Every 2 hours during waking hours, provide
  * ROM
  * Food and fluids as per clinical condition with meals at regularly scheduled times
  * Bathing and oral hygiene at least once/24 hours
  * Toileting

Nursing responsibilities in the protocol for the non-violent patient

* A nurse may restrain a patient in an emergency with a nursing order
* The patient’s authorized prescriber must be notified
  * By the end of the next calendar day in order to conduct an in person evaluation, sign the verbal order for restraint and if clinically indicated, write a new time limited order for the ongoing use of restraint
* Every 4 hours, the nurse assesses
  * Ineffective alternatives
  * Indications for the continued use of the restraint
  * Type of restraint
* Only a nurse may discontinue a restraint as soon as the patient meets discontinuation criteria – this discontinues the 24 hour order
  * If the patient’s condition changes & restraint is required again, a new order must be obtained

Nursing responsibilities in the protocol for the violent patient

* In violent or self-destructive behavior situations, the nurse may write a verbal order for the use of restraint or seclusion
  * MD must perform an initial face-to-face assessment within 1 hour of the restraint being applied and write an order as well
* Orders are time limited
  * 4 hours for adults (>/= 18 years of age)
  * 2 hours for children and adolescents between 9-17
  * 1 hour for children <9
* New time limited hours must be written at the appropriate interval and the MD must do an in person re-evaluation every 24 hours
* There are additional protocol requirements for nursing and team reassessment in Psychiatry
* Every 2 hours (or more often as needed), the nurse makes an assessment as to whether restraint or seclusion continue to be necessary – discontinuation occurs when the need for restraint or seclusion no longer apply
* If restraint or seclusion is needed again, a new order must be obtained and a prescriber evaluation performed
* A patient may never be restrained while in locked door seclusion

**Other protocol responsibilities**

* When applying a limb restraint to a child <13, avoid the application of force on long bone joints
* 4 point (or greater) limb restraints will not be applied to a child <13 with possible exceptions for children
  * Who have suffered head trauma
  * Genitourinary procedures
  * ECMO
  * Trauma pending clearance of a C-spine injury
  * Femoral lines in place
* Patients in 4 point restraints or in seclusion, must be observed at all times by a trained observer
* Patients who must leave the unit for another area of the hospital must be accompanied by a trained observer, except in a few specific circumstances
SAFE HANDLING OF HAZARDOUS DRUGS

All hazardous drugs distributed by the Pharmacy are labeled with three combinations of bright colored stickers. All of these medications require hazardous drug handling.

- All chemotherapeutic drugs are labeled with a bright yellow sticker.
- All hazardous drugs that are not chemotherapy are labeled with an orange sticker.
- All investigational drugs will be labeled with a yellow sticker and an orange sticker.

To see the procedure for Safe Handling of Hazardous Medications, see http://www.insidehopkinsmedicine.org/hpo/policies/39/2811/policy_2811.pdf

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.
- Prime IV administration sets in a way that avoids aerosolization.
- Minimize disruptions of the IV administration set used to infuse the hazardous drugs. If you must disconnect the tubing from side injection ports, stopcocks or extension tubing, wrap the connection with gauze to prevent aerosolization.
- Paper masks do not protect against aerosolized hazardous drugs, however, they are helpful in preventing skin from being splashed. The nurse is most at risk for this type of exposure when priming tubing, disconnecting tubing or syringes, and disposing of contaminated excreta and bodily fluids.

Avoiding Contact with Skin and Mucous Membranes

- Wash hands prior to administering medications.
- Use nitrile gloves and an impermeable gown while 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.
- Wear approved chemo-gown.
- 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 an impervious 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.
- Protective gowns and linens that may been contaminated with hazardous drugs or with body fluids of patients who have received these drugs should be handled by personnel wearing protective gowns and gloves and disposed of in the laundry hamper.

**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 or EVS (Environmental Services) will provide assistance or advice.

All mercury spills must be cleaned by the Safety office.

*For more info, see Safe Handling of Hazardous Medications*  

**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 Wilmer Emergency Room (5-5347), 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 Wilmer 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.
• 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 is available from Health, Safety and Environment, x5-5918.

SEDATION

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

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.

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.

For more info, see 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.

ALWAYS, use meticulous aseptic technique whenever you access a VAD!

Central Lines: Insertion

There are guidelines for the physician, NP or PA with delineated clinical privileges to insert central lines. These guidelines require the following:
1. Complete the online VAD training.
2. Need to have 5 supervised VAD insertions above the diaphragm and 5 supervised VAD insertions below the diaphragm. This is required of both the adult and pediatric patient population.

3. Once they have completed their 5 insertions for that patient population and anatomical area they may independently insert lines for that site only.

**Who may supervise?**

- It must be at least a 2nd year resident or above, NP or PA who have documented competency and delineated clinical privileges to insert a central line.
- For patients less than 12 years the supervisor is a PICU fellow or a general pediatric surgery fellow.

**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. Some departments are using a computer based program to keep track of the central line insertions. EValue is one program that may be used in your department.

JHH Nursing staff that will assist with central line insertion must also complete the Healthstream course “Central Vascular Access Device Insertion”.

**General Principles**

- An authorized prescriber’s order is required to insert or discontinue a VAD, if VAD is not being inserted or discontinued by a physician, nurse practitioner or physician assistant.
- 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.
- Chlorhexidine gluconate in 70% isopropyl alcohol is the antiseptic standard for central, arterial and peripheral VAD insertions and site care. Remember to use friction and allow the ChloraPrep® to dry before applying the dressing.
- 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.
- Chlorhexidine gluconate shall be used on relatively clean skin. If necessary, clean and defat skin with alcohol swab or soap and water
  - If the patient is intolerant to chlorhexidine, 1% tincture of iodine shall be used.
  - Allow the antiseptic to fully dry (usually requires about 30 seconds)
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. The povidone iodine 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:**
  a. Shall only be used when it is necessary to balance a central VAD;
  b. Shall not be hooked together;
  c. 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 cleaned 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.**

- **On non-emergent lines, consultation with the CVIL/IRC shall be considered on patients who are high risk (see definition above).**

- **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.

### 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 will immediately notify the operator of any deviation from the steps in the checklist and stop the procedure if necessary.
- 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.
- If the operator requires supervision for the procedure, an assistant in addition to the supervisor will be necessary. The supervisor may waive the assistant role if in their best judgment they are able to assume the role of the assistant and supervisor.
- **Nursing staff that assist with central VAD insertions must complete the Healthstream course Johns Hopkins – Central Vascular Access Device Insertion.**
- **Nursing staff acting as an assistant must participate in the time out.**
- **Medical and Nursing students can NOT act as an assistant.**
- A dedicated assistant during PICC line placement is recommended, but not required.

Sterile technique is required for central VAD insertions.

1. Good hand hygiene with hospital-approved soap and water or waterless alcohol-based cleanser is required before central VAD insertion.
2. A surgical hand scrub is required before insertion of tunneled catheters, implanted ports, and permanent dialysis or hemepheresis catheters.
<table>
<thead>
<tr>
<th>Person inserting Central line</th>
<th>Assistant for Central line insertion</th>
<th>Person inserting Arterial line in radial or dorsalis pedis site</th>
<th>Person inserting a femoral or axillary arterial catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap ( cover scalp, beard, mustaches)</td>
<td>Cap ( cover scalp, beard, mustaches)</td>
<td>Cap ( cover scalp, beard, mustaches)</td>
<td>Cap ( cover scalp, beard, mustaches)</td>
</tr>
<tr>
<td>Mask</td>
<td>Mask</td>
<td>Mask</td>
<td>Mask</td>
</tr>
<tr>
<td>Sterile gown</td>
<td>Sterile gown ( if any chance of crossing sterile field) or Isolation gown</td>
<td>Sterile gown</td>
<td>Sterile gown</td>
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<tr>
<td>Sterile gloves</td>
<td>Gloves</td>
<td>Sterile gloves</td>
<td>Sterile gloves</td>
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<tr>
<td>Sterile patient drape to cover patient from head to foot</td>
<td>Large sterile work area</td>
<td>Sterile patient drape to cover patient from head to foot</td>
<td></td>
</tr>
<tr>
<td>Eye protection or face shield</td>
<td>Eye Protection or Face shield</td>
<td>Eye Protection or Face shield</td>
<td>Eye protection or face shield</td>
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</tbody>
</table>

**Insertions, rewire and removals of a central subclavian or internal/external jugular VAD’s require that the patient be placed in TRENDELENBURG position.** If the patient’s condition contradicts this position the provider placing the line will make this determination and will clearly explain the risks to the patient or consent designee and document these risks in the medical record. For femoral VADs and PICC insertions the patient shall be supine.

**Line confirmation:**
- All central lines, including femoral, will be assessed for successful venous placement by transduced CVP or estimated CVP by fluid column test during insertion to prevent accidental arterial line placement.
  - Unused ports of multilumen central catheters shall be aspirated, flushed, according to protocol, capped, and clamped.
- **Confirmation of proper placement (catheter tip in distal portion of the superior vena cava or the SVC/atrial junction) 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.
  - In emergency situations or in the OR, proper placement may be judged based on hemodynamic assessment until a chest x-ray can be obtained.
- **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.**
  - If patient is a readmission within 7 days, has chest xray on file in EPR indicating proper placement and there are no assessment parameters indicating malposition, re-xray is not necessary.
• 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
• Only personnel who have demonstrated competency may remove a VAD following specific departmental policies.
• A provider order is required to discontinue a VAD by the nursing staff. This includes arterial, central and peripheral lines.
• The need for central VAD’s is reviewed daily and if the patient no longer needs the line it should be discontinued.
• The physician is responsible for removing:
  ▪ femoral venous and arterial sheaths
  ▪ Central lines if the patients PT INR or a PTT ratio >1.3, and platelets <50K or if the patient is receiving thrombolytic/anticoagulant

• 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 following are considered prophylactic dosing for VTE:

  **Drug Usual prophylaxis dose**
  - Heparin 5000 units SC q 8 hrs
  - Enoxaparin (Lovenox) 40 mg SC daily, OR 30 mg SC BID
  - Fonduparinox (Arixtra) 2.5 mg SC daily
  - Dalteparin (Fragmin) 2500 units SC daily OR 5000 units SC daily

• The physician is responsible for scheduling removal of tunneled central catheters or implanted ports by appropriate personnel in preestablished locations (i.e. IRC, OR).

Rewiring
• During re-wires, lumens or caps shall **never** be cut in order to place a guidewire or to assist with sterilization.
• For rewrites, 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 rewrites(less than 14g) do not require x-ray, unless clinically indicated.
• A new set of sterile gloves shall be worn prior to handling the new catheter. This can be accomplished by double gloving in the beginning and/or using the assistant to help.
• Whenever possible, a new administration set and fluid shall be used when a line is rewired/resited.
Site Assessment

- Patients shall be encouraged to report any changes in their catheter site or any new discomfort to their healthcare provider.
- Check for “flash” of blood prior to infusion or flush more frequently if the patient is receiving medication that is caustic to the vein see Vesicant Administration: Monitoring and Management of Extravasation, http://www.insidehopkinsmedicine.org/hpo/policies/39/20/policy_20.pdf
- 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 – daily
  - VADs connected to infusion pump/gravity volume controller – every 8 hrs.
  - VADs in use but not connected to infusion pump/gravity volume controller every 2 hrs.
  - VADs covered with a gauze dressing – site assessed at time of dressing change and other assessment as above
- Phlebitis shall be graded based on the following criteria:

<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</td>
</tr>
<tr>
<td></td>
<td>Streak formation</td>
</tr>
<tr>
<td></td>
<td>Palpable venous cord</td>
</tr>
<tr>
<td>4</td>
<td>Pain at access site with erythema and/or edema</td>
</tr>
<tr>
<td></td>
<td>Streak formation</td>
</tr>
<tr>
<td></td>
<td>Palpable venous cord &gt; 1 inch in length</td>
</tr>
<tr>
<td></td>
<td>Purulent drainage</td>
</tr>
</tbody>
</table>

Tubing Management

- Manipulation of the VAD system shall be kept to an absolute minimum.
- Clean the injection ports, hubs and Clave adaptors 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 VAD is re-sited.
- Stopcocks shall only be used when it is necessary to balance a central VAD, and stopcocks shall not be hooked together. Stopcocks shall be capped when not in use.
- All continuous administration sets, shall be changed and labeled no more frequently than 72 hours, with a maximum hang time of 96 hours. Propofol tubing must be changed every 6 hours.
♦ Intermittent administration sets that are disconnected from the primary set between infusions should be changed and labeled every **24 hours**.
  - All intermittent infusion set tips shall be capped with a **NEW STERILE CAP** when not in use. A new sterile cap shall be placed with every use.
  - Tubing ends will not be inserted into “y” connections as a substitute for a sterile cap.
  - Administration sets include the path from the spike of tubing entering the fluid container to the hub of the VAD. Infusion pump cassettes, transducers, y-connectors, filters, and needless connectors, including the Clave® are considered part of the administration set and therefore, shall be changed according to the above guideline (H.5). Catheter hub shall be cleansed with alcohol swab and allowed to dry when changing the needleless connector (Clave®).
  - A short extension tube may be connected to the catheter and may be considered a portion of the catheter to facilitate aseptic technique when changing administration sets.

- 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 needless connector (Clave®) 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 cleaned 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 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.
- Non-tunneled catheters in oncology patients require at least 10cc/hr infusion through each lumen. For all other adult patients, a 10cc/hr infusion through at least one lumen of non-tunneled line is recommended.
- 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 every 24 hours, except 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.

Remember to label the catheter when troubleshooting or de-clotting a line.

**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) administration sets are changed by the VAT team where applicable.
- In non-tunneled catheters a 10cc/hr infusion is required through at least one port (In Oncology at least a 10cc/hr infusion through each lumen is required). The other ports may just be flushed, clamped and capped off with a sterile cap.
- Remember a PICC is a central line so all infusions must be on a pump.
- 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. These catheters must have an order to “lock the catheter with heparin”. You need to identify the exact size of the catheter in order to determine how much heparin/NSS to use.

**Documentation**
- A written order is required for:
  - Insertion and discontinuation of VAD
  - IV fluids and rate of administration
  - Heparin flush
- VAD insertion will be documented in the medical record and include, gauge, type of VAD, anatomical site, date and time of insertion, number of attempts, name of operator and name of supervisor if applicable.
- Competency of the operator will be documented as required by:
  - Each residency program and shall be viewable when requested at any time.
  - Orientation and/or skills competency checklist for nursing staff.
- A physician will document confirmation of central VAD placement including the anatomical location in the medical record.
- 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.
  - Only nurses who have demonstrated competency or VAT may change a PICC with StatLock® dressing.
- VAD site assessment is documented with each dressing change by the nurse.
- VAD flushes (NSS and Heparin) are documented on the MAR and the nursing flow sheet/Sunrise.
- Removal of VAD and site assessment at time of removal will be documented in the medical record.
- Reportable conditions, actions taken, and patient response shall be documented on the patient record.

## 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 during infusion</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</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Troubleshooting Symptoms</td>
<td>VAD Status</td>
<td>Cause Likely</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>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>
</tbody>
</table>

**Dressing Changes**

- Only nursing personnel who have demonstrated competency may perform a central VAD dressing change.
- Sterile transparent dressings are changed every 7 days or if it becomes damp, loose or soiled.
- Patients who have skin breakdown or oozing, an occlusive gauze dressing may be used, and changed when soiled or every 24 hours. Gauze dressings may also be used for patients who do not tolerate a semi-permeable transparent dressing. Routine gauze dressing is changed every 48 hours.
- Topical antibiotic ointment or cream shall **not** be used as prophylaxis on insertion sites.
- For patient showering, the site, catheter and connecting devices shall be covered with an impermeable dressing and the dressing shall be changed immediately after the shower.
- Apply a mask to patient for dialysis, pheresis, and Oncology patients.
- Only dialysis nurses and nursing staff who have received specialized training may open, flush, or change dressings on hemodialysis catheters.
- Only Parenteral-Enteral Support Service (PESS) team nurses may change dressings and access CPN lines in non-oncology areas.
- Label dressing with date/time initials and if PICC dressing, length of internal/external catheter segments.

**Blood Draws and Flushes**

- A syringe barrel size of 10cc or greater shall be used to flush any VAD to avoid excessive PSI and possible rupture of catheter or dislodgement of clot.
- Blood may be drawn from central VADs by individuals with specialized training.
  - On general care units (exception Oncology and Pediatrics) central line blood sampling should be performed by the VAT, whenever possible.
- Blood cultures should **NOT** be obtained from central lines routinely. Central lines should be used for blood cultures only if adequate blood cultures cannot be obtained peripherally (see Blood Culture protocol at [http://www.insidehopkinsmedicine.org/hpo/policies/69/3264/policy_3264.pdf](http://www.insidehopkinsmedicine.org/hpo/policies/69/3264/policy_3264.pdf)).
- Blood may be drawn from the distal port (largest) of central VADs, ensuring all other lumens are clamped.
- Access VAD catheters as infrequently as possible. Only nurses who have demonstrated competency may access and maintain VADs.
- If it is necessary to draw blood from a line:
• Use a 10cc syringe (or larger) so as not to collapse the catheter or the vessel.
• Draw from the largest port, ensuring all other lumens are clamped.
• Discard the first 6cc and flush the catheter with 10cc of bacteriostatic 0.9% NS after sampling if the line is in continuous use.

Note: The above procedure is different in Peds.
• If the catheter is not in continuous use, flush it routinely according to the schedule in table format in the policy.

• For information regarding troubleshooting/declotting information please refer to the VAD policy.

For more info, see Adult VAD Policy

COMPETENT CARE

ABUSE & NEGLECT

It is the responsibility of all healthcare professionals, including nurses, physicians, and social workers, to assess all patients for abuse or neglect, and to initiate the appropriate referrals.

The JHH policy states that all patients suspected to have been physically or emotionally abused, neglected and/or exploited will be assessed, and that the necessary and appropriate treatment, education, reporting, and referrals will be provided.

The health care team (registered nurses, physicians, social workers) will assess all patients suspected to have been physically or emotionally abused, neglected, or exploited; initiate the appropriate reporting to the Adult/Child Protective Services; coordinate needed services with other community agencies for patient care.

What Children Are Most Vulnerable?

Very young children (ages 3 and younger) are the most frequent victims of child deaths due to abuse/neglect. This population of children is the most vulnerable because of their dependency, small size, and inability to defend themselves.
Signs of Physical Abuse

Physical Indicators
- Bruises & welts in various stages of healing
- Burns: demarcation, cigarette
- Lacerations: facial laceration on infant, laceration to external genitalia, unexplained injury
- Skeletal injuries: epiphyseal separation, linear skull fracture, multiple fractures in various stages of healing
- Head injuries: absence of hair, subdural hematoma, retinal hemorrhage, unexplained injury
- Unexplained malnutrition/failure to thrive

Behavioral Indicators
- Lack of crying or excessive crying
- Unusually quiet
- Child afraid to go home
- Child reports injury by parent

Signs of Neglect

The child:
- Lacks needed medical or dental care, immunizations, or glasses.
- Is consistently dirty and has severe body odor.
- Lacks sufficient clothing for the weather.
- Begs or steals food or money.
- States that there is no one at home to provide care.
- Is frequently absent from school.
- Abuses alcohol or other drugs.

The parent or caregiver:
- Appears to be indifferent to the child.
- Seems apathetic or depressed.
- Behaves irrationally or in a bizarre manner.
- Is abusing alcohol or other drugs.

Signs of Possible Sexual Abuse
- Has difficulty walking or sitting.
- Reports nightmares or bedwetting.
- Experiences a sudden change in appetite.
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior.
- Becomes pregnant or contracts a venereal disease, particularly if under age 14.
• Runs away.

• Reports sexual abuse by a parent or another adult caregiver.

**Actions to take for suspected child abuse/neglect**

All suspected cases of abuse or neglect **must** be reported by contacting your unit/departmental social worker.
The social worker is responsible for initiating the appropriate reporting to the Adult/Child Protective Services and as needed coordinating services with other community agencies for patient care.

**Domestic Abuse**

Domestic violence is a cycle of power and control that mounts a physical, sexual, and/or psychological assault against a spouse or intimate partner. What begins as name calling and belittling can escalate to physical violence. What starts as a push into a wall can lead to a broken arm or a fatal injury.

**Signs of intimate partner abuse:**

- Head, face, and neck injuries
- Bruises in various stages of healing
- Vaginal/anal trauma
- Chronic irritable bowel syndrome
- Chronic pain
- Pelvic inflammatory disease
- Pre-term labor
- Depression
- Unexplained malnutrition

**Just Ask the Question**

Victims of domestic abuse may not spontaneously offer information, but many well admit to being in abusive relationships if asked.
The question should be broached when the nurse feels the time is right, but the **nurse must be alone with the woman.** Asking about abuse in front of a possible abuser may trigger an abusive episode.

**Reporting adult intimate partner abuse:**

Mandatory reporting is **NOT** required for physical assault by an intimate partner; however you may offer a social work referral.

**Vulnerable Adult**
A vulnerable adult is one who lacks the physical or mental capacity to provide for his/her daily needs. All suspected cases of vulnerable adult abuse or neglect must be reported even if the caregiver is an intimate partner.

**Elder abuse may include:**

- Physical
- Emotional
- Sexual
- Exploitation
- Neglect
- Abandonment

**Signs and symptoms of physical abuse include:**

- Bruises, black eyes, welts, lacerations, and rope marks
- Bone fractures, broken bones, and skull fractures
- Open wounds, cuts, punctures, untreated injuries in various stages of healing
- Sprains, dislocations, and internal injuries/bleeding
- Broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained
- Laboratory findings of medication overdose or under utilization of prescribed drugs
- An elder's report of being hit, slapped, kicked, or mistreated
- An elder's sudden change in behavior
- The caregiver's refusal to allow visitors to see an elder alone

**Signs and symptoms of elder neglect include:**

- Dehydration, malnutrition, untreated bed sores, and poor personal hygiene
- Unattended or untreated health problems
- Hazardous or unsafe living condition/arrangements (e.g., improper wiring, no heat, or no running water)
- Unsanitary and unclean living conditions (e.g. dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing)
- An elder's report of being mistreated

**Actions to take**

All suspected cases of elder abuse or neglect must be reported, even if the caregiver is an intimate partner. Do this by contacting your unit/departamental social worker.

As with child abuse/neglect, the social worker is responsible for initiating the appropriate reporting to the Adult/Child Protective Services and as needed coordinating services with other community agencies for patient care.

For more information about abuse & neglect, see the web pages listed below or contact your departmental social worker.
The RN, MD or social worker will document the following information in the patient’s medical record:

- Chief complaints, description of the event, abuser and the relationship to the patient
- History of abuse and social history
- Medical history
- Detailed description of injuries, including location and nature

**Legal Requirements of Reporting:**

**Child Abuse & Neglect (Any person under the age of 18)**
- Abuse/neglect of children **must** be reported to the social worker and Child Protective Services.

**Adult Abuse & Neglect (Any person 18 - 65 years old)**
- For intimate abuse, offer the patient a social work referral for legal recourse and alternate living arrangements.
- Vulnerable adult abuse/neglect **must** be reported to the social worker and Adult Protective Services.

**Elderly Abuse & Neglect (Any person over the age of 65)**
- Elderly abuse **must** be reported to the social worker and Adult Protective Services.

For more info, see Abuse/Neglect Policy


**AGE-SPECIFIC CARE**

In general, people grow and develop in stages that are related to...
their age and share certain qualities at each stage. The charts on the next few pages describe some basic facts about human growth and development that you can use in providing age-appropriate patient care. These facts should be used only as guidelines, and you should treat each patient as an individual and avoid stereotyping.

<table>
<thead>
<tr>
<th>Age</th>
<th>Normal VS</th>
<th>Communication</th>
<th>Comfort</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant (0-12 mos)</td>
<td>Heart rate: Resting, awake - 80-150</td>
<td>• Introduce self to caregiver</td>
<td>• Keep pt. warm &amp; dry</td>
<td>• Keep side rails up</td>
</tr>
<tr>
<td></td>
<td>Resting, asleep - 70-120</td>
<td>• Explain procedures to caregiver</td>
<td>• Allow for usual feeding schedule</td>
<td>• Give nonflammable toys</td>
</tr>
<tr>
<td></td>
<td>BP: 65-91/50-54</td>
<td>• Talk slowly, calmly to infant</td>
<td>• Avoid continuous bright lights</td>
<td>• Avoid small objects within reach that could cause choking</td>
</tr>
<tr>
<td></td>
<td>Resp: 30-35</td>
<td>• Infant has stranger anxiety beginning at 6-9 months</td>
<td>• Cuddle</td>
<td>• Transport in size appropriate means</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimize separations from parent or caregiver</td>
<td>• Allow caretaker nearby</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allow pt to keep pacifier, blanket, comfort toy</td>
<td>• Keep side rails up</td>
<td></td>
</tr>
<tr>
<td>Toddler/ preschooler (1-5 yrs)</td>
<td>Heart rate: Resting, awake - 60-100</td>
<td>• Introduce yourself</td>
<td>• Keep pt warm if not active</td>
<td>• Do not leave unsupervised - does not recognize danger</td>
</tr>
<tr>
<td></td>
<td>Resting, asleep - 70-110</td>
<td>• Can understand simple commands, but may choose to not cooperate</td>
<td>• Do not separate from favorite toy, blanket, comfort toy, or adult</td>
<td>• Keep side rails up</td>
</tr>
<tr>
<td></td>
<td>BP: 90-95/54-56</td>
<td>• Do not rush patient</td>
<td>• Allow older toddler to talk, verbalize fears</td>
<td>• Transport in crib, stroller, wagon with side rails</td>
</tr>
<tr>
<td></td>
<td>Resp: 21-25</td>
<td>• Allow to touch equipment</td>
<td>• Can tolerate short separation from parent</td>
<td>• Give nonflammable toys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Include parent in explanations</td>
<td>• If frightened, may accept explanations/exams given on</td>
<td>• Avoid small objects within reach that could cause choking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ask parent to explain directions in familiar words</td>
<td>&quot;Teddy&quot; or favorite toy/stuffed animal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use familiar characters for older toddlers</td>
<td>• Invasive procedures are especially stressful to toddlers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Preschoolers may view illness as punishment for bad behavior</td>
<td>• Regression occurs with hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

82
<table>
<thead>
<tr>
<th>Age</th>
<th>Normal VS</th>
<th>Communication</th>
<th>Comfort</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>School age</td>
<td>Heart rate: 60-110</td>
<td>• Introduce yourself&lt;br&gt;• Able to understand more complex&lt;br&gt;explanations&lt;br&gt;• Talk to child directly&lt;br&gt;• Allow time for questions&lt;br&gt;• Likes to explore equipment before use&lt;br&gt;• Likes to get involved and make decisions&lt;br&gt;• Allow time for repeated questions&lt;br&gt;• Maintain privacy for older child</td>
<td>• Be subtle in encouraging child to keep comfort objects with him/her&lt;br&gt;• May need parent&lt;br&gt;• Use calm, unrushed approach&lt;br&gt;• Allow child some input on decisions&lt;br&gt;• Maintain contact with peers</td>
<td>• Curious&lt;br&gt;• Able to accept limits&lt;br&gt;• Transport in wheelchair or cart with side rails</td>
</tr>
<tr>
<td>(6-12 yrs)</td>
<td>BP: 97-112/57-71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resp: 18-30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent</td>
<td>Heart rate: 60-100</td>
<td>• Introduce yourself&lt;br&gt;• Use adult vocabulary&lt;br&gt;• Do not talk down to youth&lt;br&gt;• Very curious – take time for explanations&lt;br&gt;• Allow time for questions&lt;br&gt;• Needs privacy&lt;br&gt;• Independence is important in later adolescence&lt;br&gt;• Permit choices&lt;br&gt;• Set realistic goals</td>
<td>• Very modest - allow privacy&lt;br&gt;• Sometimes comfortable knowing parent is nearby&lt;br&gt;• Permit caretaker to accompany pt if desired&lt;br&gt;• Body image is very important&lt;br&gt;• Remain non judgemental</td>
<td>• Can recognize danger&lt;br&gt;• Transport as an adult&lt;br&gt;• Use Fall protocol to assess fall risk</td>
</tr>
<tr>
<td>(13-17 yrs)</td>
<td>BP: 102-128/60-80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resp: 16-20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>Heart rate: 60-100</td>
<td>• Introduce yourself&lt;br&gt;• Call pt by title and last name&lt;br&gt;• Do not address by “honey,” “dear,” “sweetie,” etc.&lt;br&gt;• Explain procedures, giving details&lt;br&gt;• Allow time for questions&lt;br&gt;• Be respectful</td>
<td>• Maintain adult’s privileges – decision making, privacy, routine of personal habits&lt;br&gt;• Offer assistance with personal care&lt;br&gt;• Inform of available amenities/services&lt;br&gt;• Inform of hospital policies</td>
<td>• Use Fall protocol to assess fall risk</td>
</tr>
<tr>
<td>(18-65 yrs)</td>
<td>BP: 90-130/60-85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resp: 16-20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Normal VS</td>
<td>Communication</td>
<td>Comfort</td>
<td>Safety</td>
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<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Elderly adult (65+ yrs)</td>
<td>Heart rate: 60-100</td>
<td>• Same as above for “adult”</td>
<td>• Same as above for “adult”</td>
<td>• Use Fall protocol to assess fall risk</td>
</tr>
<tr>
<td></td>
<td>BP: 140-160/70-90</td>
<td>• Determine if pt uses hearing aid</td>
<td>• Do not rush pt</td>
<td>• Keep needed items within reach, including walking aids</td>
</tr>
<tr>
<td></td>
<td>Resp: 16-20</td>
<td>• Make sure hearing aid is worn and is functioning</td>
<td>• Ask family to bring in familiar items from home</td>
<td>• Transport in wheelchair or stretcher with rails. Weak or confused pts may need special safety measures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Speak slowly, clearly, looking at patient</td>
<td>• If pt confused, introduce yourself every time, orient frequently</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use deeper voice, do not shout</td>
<td>• Keep pt warm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Put objects where pt can see them</td>
<td>• May need repeated offers of assistance with personal care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If pt wears glasses, have available and clean</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Keep room well lit; use night light</td>
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</tr>
</tbody>
</table>

**CARE OF THE DYING PATIENT**

**Advance directives**

**Nursing staff responsibilities:**

- Receive copy of the Advance Directives Notification Form, Advance Directive, and/or Patient Wishes Form, and place document(s) in the legal section of the medical record.
- Notify the attending physician if patient revokes an existing Advance Directive or Patient Wishes Form, and write a note in the Progress Notes section of the medical record.
- May serve as witness of patient signature on an Advance Directive.
- Even if a patient has an advance directive, the physician must write the Do Not Resuscitate order in the medical record. Nurses CANNOT act solely on the advance directive in the State of Maryland.

*For more info, see Advance Directives Policy*


**Do not resuscitate (DNR) orders**

- DNRs are legal and valid, and must be ordered by the attending physician or his/her designee.
- The order MUST be written in the patient’s medical record.
- Failure of the attending physician to countersign a DNR order written by a designee within 24 hours does NOT invalidate or terminate the order. If the attending physician has not countersigned or discontinued the DNR order within 24 hours, the order remains in force while increased efforts are made to have the attending physician complete this requirement.
A DNR order should be mutually discussed and arrived upon by the physician and patient or patient's family, if indicated.

In the absence of a DNR order, resuscitation is initiated ("slow codes," etc. are not legal).

**There are JHH resources to help address conflicts or provide information.**
- Palliative care services are available in the pediatric (5-5503 or 5-6451) and adult medicine (4-5284) departments. These services are available to all staff.
- The JHH Ethics Service can be paged for assistance when conflicts arise. The Ethics Service pager is 3-6104.

For more info, see DNR Policy

**Changing Goals of Care**

- A patient may be admitted with the goal of curing or reversing a condition, however as illness progresses, the goals may change to rehabilitation; prolonging life so the person may see a grandchild marry or graduate; not prolonging dying; or comfort in dying.

- Once these new goals are established, the particular treatments to meet the goals are decided in discussions between the team and the patient and family.

- Goals for cure and for palliation (e.g., symptom management) can be simultaneous.

Sometimes there are conflicts among clinicians or with clinicians and families about the goals of care. There are JHH resources to help address conflicts or provide information.

- Palliative care services are available in the pediatric (5-5503 or 5-6451) and adult medicine (4-5284) departments. These services are available to all staff.

- The JHH Ethics Service can be paged for assistance when conflicts arise. The Ethics Service pager is 3-6104.


**Is your patient dying?**

- The dying process can take days or even weeks.
- Some patients tend to “linger” in their dying while others have a sudden and swift decline.
- The uncertainty of a timeline can cause family distress. Educating the family about the normal dying process can help ease their distress.
Early signs of dying
- Bed bound
- Loss of interest and ability to eat/drink
- Changes in cognition
- Hypoactive delirium
- Hyperactive delirium
- Increasing sleepiness

Mid stage of dying
- Mental status continues to decline
- Upper airway secretions that patient is unable to clear ("death rattle")
- Fever can be present with unidentifiable source

Late stage of dying
- Comatose
- Cool, mottled extremities from shunting blood to vital organs
- Change in respiratory pattern: fast, slow or uneven breathing
- Fever

Pain and other symptoms
- Many patients will have pain, shortness of breath, delirium and fatigue as they are dying.
- Patients may also experience emotional and spiritual distress. Collaboration with pastoral care, palliative care, social work and Child Life will help in addressing these symptoms.
- These symptoms can and should be managed to relieve distress at the end of life.

For the dying patient, interdisciplinary care (nursing, clergy, social work, medicine, nutrition, and other therapies) is needed to meet the needs of both the patient and family.

For more information, contact the JHH palliative care services.

CULTURALLY COMPETENT CARE

Last year, Johns Hopkins served patients from over 124 countries! Cultural competence means understanding & respecting the patient’s cultural values, beliefs & practices when providing health care.

Steps in becoming culturally competent:
1. Understand your own cultural beliefs.
2. Learn about other cultures, especially attitudes toward health care and ways of communicating/interacting.
3. Ask for help. You cannot be expected to know all the nuances of each of the world cultures and customs and languages. However, you are expected ask for help when
needed.

The JHH International office [www.jhintl.net](http://www.jhintl.net) is available to help you.
- For an interpreter, call x4-4685.
- For information on specific cultures, contact the International Office at x5-8032
- For information/inservices about cultures, call x2-3216

**Family members, particularly children, should NOT be used for interpreting medical discussions.**

*For more info, see Interpreting Services*  

### Patient Behavior Related to Their Culture

Patients may vary in their cultural behaviors based on the following:

- Length of time in the US
- Desire to assimilate
- Rural vs. urban
- Sub-groups, minorities, sub-cultures...
- Education level
- Social and economic status

### Cultural Assessment

When caring for a patient from another culture, it is helpful to find out:

- Where the patient was born?
- If an immigrant, how long has the patient lived in this country?
- How strong is the patient's ethnic identity?
- What are the primary and secondary languages, speaking and reading ability?
- What is the patient's religion, its importance in daily life and current practices?
- What are the health and illness beliefs and practices?
- What are customs and beliefs around such transitions as birth, illness and death?

The risk of cultural competence training is **STEREOTYPING.** Unfortunately, learning about different cultures requires the use of **GENERALIZATIONS.**

### Tips for Providing Culturally Competent Care

**DO:**

- Try to understand people’s values, since values will influence their behavior.
- Keep in mind that there is always individual variation within a group.
- Use translated patient education materials and charts from the JHH Nursing Intranet or Micromedix.
- Include and understand the family as much as possible.
- Call for a professional interpreter.
DO NOT:

- Stereotype. Don’t project your own cultural perceptions and biases.
- Expect that all patients make their own decisions. In some cultures that value family, important decisions are made by the family. In cultures where males are dominant, the husband may make the final decisions regarding the health care of his wife and children.
- Make clinical decisions based on communications in a language that you are not proficient.
- Assume the patients want to be informed of a fatal diagnosis. Ask the patients upon admission to whom they would like information about their condition to be given.

*For translated patient education materials, see*
http://intranet.insidehopkinsmedicine.org/nursing/patient_education/international/

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**ETHICS**

JHH is committed to protecting patients' rights and providing ethical care. For more information, see the following:

- **JHH Code of Ethics**

If you think a patient's rights are being violated or a patient is being treated unethically at any time, you may initiate an Ethics Committee consultation or call the Compliance Hotline at 1-877-WE COMPLY.

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**IMPAIRED HEALTHCARE PROFESSIONAL**

An impaired healthcare provider is one who is unable to meet the requirements of the code of ethics or standards of practice as a result of alcohol, drugs, or psychiatric illness that interferes with his/her cognitive, interpersonal, or psychomotor skills.

**Impairment Warning Signs**

- Deteriorating appearance
- Weight loss
- Decline in personal hygiene
- Frequent use of mints or mouthwash
- Unexplained bruises
- Slurred speech
- Tremors, unsteady gait
• Lethargy
• Smell of alcohol on the breath
• Mood swings
• Lying
• Isolation from coworkers
• Forgetfulness or poor concentration
• Becoming uncharacteristically quiet or excessively talkative
• High rates of absenteeism for implausible reasons
• Deteriorating performance
• Inability to meet deadlines or achieve goals that others can easily accomplish
• Actions that reflect poor judgment
• Lack of previously demonstrated enthusiasm
• Noncompliance with accepted policies and procedures
• Sloppy, illegible, incorrect, or incomplete documentation

**Impairment Warning Signs: Psychological**

- Sudden emotional outbursts - anger, tears, laughter
- Mood swings especially early or late in the work day
- Overreactions to criticism
- Blaming others for poor performance
- Making inappropriate statements
- Rambling or incoherent speech
- Isolation from co-workers/Increasing social withdrawal
- Disinterest in teamwork

**Impairment Warning Signs: Job Performance**

- High rates of absenteeism for implausible reasons
- Deteriorating performance
- Inability to meet deadlines or achieve goals that others can easily accomplish
- Actions that reflect poor judgment
- Lack of previously demonstrated enthusiasm
- Noncompliance with accepted policies and procedures
- Sloppy, illegible, incorrect, or incomplete documentation

Isolated behaviors do not always provide hard evidence of substance abuse. In fact, even though a pattern of clues suggests that something is amiss, caution must be exercised in drawing conclusions.

**Effects of Impaired Practice**

- High potential for patient harm/death
- Medical errors and poor healthcare delivery
- Diverting medications from patients
- Dysfunctional work environment
- Work suspension and/or termination
• License revocation
• Family/relationship problems
• Health problems, overdose, suicide

If you suspect impairment, do NOT:

- Ignore or deny the situation.
- Enable the person by covering up mistakes, making excuses, or performing his/her duties to protect his/her job.
- Assume the “counselor” role for the individual.

By doing these things, you prevent the individual from getting the help she/he needs and put patients in jeopardy.

You are professionally and personally obligated to report it!

If you suspect a healthcare professional/coworker is impaired, DO:

- Intervene immediately to protect the safety of any patients in danger of physical or emotional harm due to the healthcare provider’s actions.
- **Immediately** report observations of unsafe practices or impaired behavior to your nurse manager/supervisor.
- DOCUMENT ACCURATELY AND COMPLETELY ANY SUSPICIOUS BEHAVIORS OR INCIDENTS THAT HAVE OCCURRED.

If you are experiencing behaviors or symptoms of concern:

The Faculty and Staff Assistance Program (FASAP) is a benefit that helps faculty, staff, employees and their families cope with a variety of personal problems. The program's clinicians can help you assess your concerns and support you when pressures and challenges arise.

For more info, see [www.fasap.org](http://www.fasap.org) or call 410-955-1220 or 443-997-3800.

The Department of Nursing of the Johns Hopkins Hospital established the Nursing Professional Assistance Committee (NPAC) to assist nurses (RNs & LPNs) with behavioral, cognitive, emotional, physical or substance abuse concerns that impedes one’s performance and safe practice of nursing.

- The NPAC works to facilitate the well-being and rehabilitation of distressed or impaired nurses as an alternative to discipline or dismissal. The committee encourages referrals from the Johns Hopkins Hospital nursing community and acts as an advocate for nurses who follow its policies and recommendations.
ORGAN AND TISSUE DONATION

Why is donation important?

- Donation saves lives of potential recipients.
- Donation gives donor families a lifetime of grief support by the lasting legacy of their loved ones.

Donation gives hope to families who are facing tragic loss.

Transplant Resource Center of Maryland (TRC) is now known as: The Living Legacy Foundation Maryland Donor Referral Line (MDRL) 410-242-1173

Referrals for potential organ/tissue donation are made by calling the Maryland Donor Referral Line 410-242-1173.

- Patients who have a Glasgow Coma Scale of 3 or for whom withdraw of support is being considered should be referred to the MDRL for potential ORGAN donation, allowing time for on-site evaluation and approach planning by Living Legacy staff.
- All inpatient deaths are referred to the MDRL by admitting staff for potential TISSUE/EYE donation evaluation.
- The Living Legacy staff will determine organ/tissue donation suitability.
- JHH staff should NOT discuss donation with families without a plan that includes the Living Legacy staff.
- The Living Legacy staff may contact the RN caring for the patient for clinical information, medical history, family information, and time of transport to the morgue.

There are NO HIPAA restrictions when sharing information for potential organ/tissue evaluation with MDRL or TRC/Living Legacy.

In Maryland, there are currently over 2400 people waiting for organ transplants; that number exceeds 106,000 nationally.

The Johns Hopkins Hospital supports offering families the option of organ and tissue donation in accordance with Federal and State laws and JCAHO regulations.

- ICU RNs and MDs are closely involved with patients and families facing end of life decisions.
- Tissue and eye transplants help people improve their quality of life.

**Three types of donors:**

1. Organ Donation Following Brain Death
• Patients must have severe cerebral impairment that meets the criteria for a Glasgow Coma Scale 3

• Patients are on artificial life support (ex, mechanical ventilation) and end organ perfusion continues despite neurological death (pt still has organized cardiac activity).

• Organs and tissues can be recovered.

2. Organ Donation Following Cardiac Death

• Patients have severe acute irreversible central nervous system injury who do not meet the criteria for brain death and for whom the family or surrogates have decided to withdraw life-sustaining measure (ventilator/vasopressors).

• The degree of neurological injury should in all cases necessitate the need for mechanical ventilation.

• The ICU RN and MD provided palliative care during the withdraw process in or nearby the OR; organs are recovered after cardiac death has been declared.

3. Tissue Donors

• Tissue donation can occur when either brain death or cardiopulmonary death has been declared.

• Each potential tissue donor is evaluated on an individual basis.

• One tissue donor can enhance the lives of over 100 recipients.

When do we call for potential tissue/eye donors?

• All ICU patient deaths should be reported to admitting within 15 minutes of expiration.

• All ICU pt deaths should be referred to the Maryland Donor Referral Line within 1 hour of expiration

• TRC/Living Legacy staff may ask the nurse or MD for information on patient history, clinical data, time transported to morgue and family information.

Who talks to families about donation?

• The Living Legacy/TRC staff will talk to families about donation with JHH staff.

• It is important that JHH staff NOT mention donation to families. Every effort is made to determine whether or not the patient is medically suitable for donation before offering donation as an option for families.

Family Advocate

The Family Advocate is a JHH chaplain who has received special training in donation protocols and family support. The Family Advocate serves as a 24 hour dedicated resource to provide impartial emotional, spiritual and crisis intervention support to the family of any patient who has
been referred to Living Legacy for potential organ donation, regardless of donation outcome. JHH staff can page the Family Advocate on call: 410-283-6000.

**Transplant Program Coordinator**

The JHH Transplant Program Coordinator is responsible for the supporting the donation process, education of hospital staff, data collection and monitoring of family and staff satisfaction with the organ donation process. This person may also serve as a family advocate and may be reached on beeper 410-283-6667.

To support ethical organ and tissue donation and to meet the spiritual and emotional needs of families, JHH has two interdisciplinary protocols related to organ/tissue donation:


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**EMERGENCY MANAGEMENT & DISASTER PLAN**

**AIRWAY MANAGEMENT**

Everyone knows that in an emergency maintaining an airway is a top priority, but what happens when anesthesia arrives and intubating or bagging a patient becomes nearly impossible? Or a trauma patient who has a jaw wired shut and a large amount of facial edema self-extubates? Or a patient with a tumor displacing his trachea develops respiratory distress? Getting the right providers to the patient quickly can make the difference between life and death.

An Adult Emergency Airway Team is now available by calling x5-4444 and telling the paging operator that you have an "airway emergency." Staff can activate an emergency airway team made up of Anesthesiologists, Otolaryngology Head and Neck Surgery Specialists and Trauma Surgeons, to respond to these difficult airway emergencies.

To assist the emergency airway team in their efforts, specially designed Adult Emergency Airway carts are stored in the following locations:

1. Adult ED
2. GOR (2) BLALOCK 725
3. MICU
4. NCCU
5. WBG OR (2) Weinberg OR room # 3333
6. WICU
7. Nelson 2 OR (L&D)
8. Weinberg 5 Staff Locker room between 5C-5D

Indications for the use of airway carts include but are not limited to:
1. Adult patients who cannot be ventilated following standard intubation algorithms or loss of airway or loss of airway.
2. Actual or potential airway intervention is needed for a patient. Uses include but are not limited to:
   a. Known or suspected difficult airways
   b. Rapid Sequence Intubation (RSI) in a non-OR setting
   c. Any procedure where maintenance of an airway may be compromised.
3. Carts are not recommended for diagnostic procedures when other, more appropriate, diagnostic tools or specialty carts may be available.

Place a green “difficult airway” arm band on the patient if assessed and confirmed by the provider as having a difficult airway. Arm bands can be ordered from Standard Registry.


### 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.

![Card with emergency contact information]
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.

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**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/](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

JHH EMERGENCY/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.hopkins-ecpar.org/
INTERDISCIPLINARY TEAMWORK

Interdisciplinary teamwork is critical in providing quality care to all patients and building a culture of safety. Communication between nursing staff, physicians, social workers, dieticians, OT/PT, respiratory therapy, etc. is needed to meet the needs of patients.

This can occur in formalized situations, such as daily physician rounds or multidisciplinary patient care/discharge planning meetings, or as a routine part of daily care.

Remember:
- Together
- Everyone
- Achieves
- More

INFECTION CONTROL

Artificial Nails
Artificial nails, including overlays, gels wraps, acrylics, are **NOT** permitted when working in a clinical area. 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*

Blood Borne Pathogen Exposure
If you have a blood borne pathogen exposure, **immediately dial x5-STIX (5-7849)**, which is the JHH’s 24-hour hotline for evaluating exposures. To expedite the process, have available the source, patient's name and history number, as well as the patient's risk factors for hepatitis and HIV. Notify the Charge Nurse. Complete an employee incident report. Students should report the exposure to the faculty and include the name of the school on the incident report.

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.
- Between patient contacts if more than one patient is in a room.
- Before and after touching a patient who is not in a room, for example, on a stretcher or wheelchair.
- Before donning and after removing gloves.
- Before handling an invasive device (regardless of whether or not gloves are used).
- After contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings.
- 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.
  - 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 hypersensitivity.
- 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 is encouraged to educate patients and their families to practice hand hygiene measures while in the facility.
- Staff is encouraged to educate patients and families to remind healthcare workers to wash/sanitize hands.
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.

<table>
<thead>
<tr>
<th>Isolation Type</th>
<th>DROPLET PRECAUTIONS</th>
<th>CONTACT PRECAUTIONS</th>
<th>AIRBORNE PRECAUTIONS</th>
<th>MAXIMUM PRECAUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cart/Storage area</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Private room</td>
<td>Required** unless cohorted †</td>
<td>Required** unless cohorted</td>
<td>Required</td>
<td>Required ** unless cohorted</td>
</tr>
<tr>
<td>Door closed</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mask/Eye Protection</td>
<td>If within 3 feet of patient</td>
<td>No</td>
<td>To enter room ‡</td>
<td>No, unless organism in sputum or</td>
</tr>
<tr>
<td>Gown</td>
<td>To enter room</td>
<td>To enter room</td>
<td>No</td>
<td>To enter room</td>
</tr>
<tr>
<td>Gloves</td>
<td>To enter room</td>
<td>To enter room</td>
<td>No</td>
<td>To enter room</td>
</tr>
<tr>
<td>Large reusable items: wash with approved germicide</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>One to One Nursing</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Linen: leak resistant bag at bedside</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Dedicated thermometer</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Dedicated B/P apparatus</td>
<td>Yes or Disposable cuff</td>
<td>Yes or Disposable cuff</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Special transport</td>
<td>Patient in face mask and clean linens</td>
<td></td>
<td></td>
<td>Patient in clean linens</td>
</tr>
<tr>
<td>Disposable meal tray</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Change cubicle curtains at discharge</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Procedures not done in room should be done at end of day</td>
<td>Preferred</td>
<td>Preferred</td>
<td>Preferred</td>
<td>Required</td>
</tr>
</tbody>
</table>
All equipment should be cleaned between patient uses regardless of isolation status.

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 Ribavirin, 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

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.


Prevention of Catheter Associated Blood Stream Infections (CLABSI) and Surgical Site infection (SSI)
As part of the JCAHO National Patient Safety goals to reduce hospital acquired infections, we are working to prevent CLABSIs and SSIs through the following actions.

Prevention of CLABSIs
Prior to insertion
- Utilize the Evidence-Based, Central Line Insertion Care Checklist. See below.
- Utilize a standardized central line cart or central line bundle kit that contains all necessary supplies for insertions

During Insertion
Utilize the Central Line Insertion Checklist- stop the procedure if steps are not followed:
- Perform hand hygiene prior to catheter insertions.
- Utilize maximum barrier precautions during insertions and rewires which include cap, mask, sterile gown and gloves for the inserter and supervisor and head to toe drape for patient
- Utilize chlorhexidine based antiseptic for cleaning insertion site. Let dry.

Avoid femoral vein unless no other site is available.

Maintenance:
• Perform hand hygiene prior to any central line manipulations.
• Always “Rub the Hub” before accessing the ports.
• Adhere to standardized dressing care as outlined in the appropriate VAD Policy (HPO).
• Replace VAD dressings when the dressing becomes damp, loosened, soiled or when inspection of the site becomes necessary.
  – Minimum is every 7 days for transparent dressings or every 48 hours for gauze dressings.
• Perform daily assessment of the need for a catheter and remove catheters when no longer indicated.

**Surgical Site Infection (SSI) Prevention**

**Pre-operative Interventions**
• Identify and treat remote infections
• Postpone elective procedures until remote infection resolves
• Control glucose (HA1c to <7%)
• Encourage pre-operative smoking cessation (>30 days prior)
• Chlorhexidine washes the night before and day of surgery
• Complete and document patient education: “Keeping You Safe During Surgery and Procedures” available in HPO

**Intra-operative Interventions**

For the Patient
• Avoid hair removal
• Never shave; use clippers if necessary
• Proper skin antiseptic; allow to DRY
• Maintain normothermia (>36.0C)
• Control serum glucose (<200)
• Antimicrobial prophylaxis
  • Right agent, right dose, right timing (within 1 hour before incision)
  • Redose every 3-4 hours and for 1500cc blood loss

For OR Personnel
• Proper attire with masks tied
• Hair covered
• No jewelry
• Proper surgical scrub of hands and nails
• Proper aseptic and sterile technique

**Post-operative Interventions**

• Place a sterile dressing for 24-48 hours
• Thorough hand hygiene and sterile supplies for wound dressing change
• Control blood glucose (<200)
• Discontinue antimicrobial prophylaxis within 24 hours after surgery (within 48 hours for cardiac surgery)

For more information go to the following

VAD policy
Surgical Site Infections
Catheter Associated Blood stream Infections

**SUMMARY**

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.
AGENCY AND FACULTY NURSE ORIENTATION POSTTEST

TRUE or FALSE:

1. Medication orders that are written by a medical student, including subinterns, must be countersigned before the RN can administer the medication.

2. It is necessary to wear a PAPR when entering an airborne isolation room.

3. The provider must obtain informed consent before any blood/blood products may be administered.

4. Any nurse may administer chemotherapy.

5. You must wash your hands with soap and water or Purrell before and after going into a patient’s room.

6. When signing your name to the patient record, use your first initial of your legal name, full last name and title - for example: N. Nurse, RN.

7. Direct healthcare providers can wear artificial nails as long as they wear gloves.

8. If you discover a fire or smoke on an inpatient unit, you should react immediately by removing the patient(s) and other individuals from immediate danger, closing the door to contain smoke and fire, pulling the nearest fire alarm, calling 5-4444, and alerting the charge nurse.

9. The JHH Code of Conduct only applies to JHH full-time staff.

10. When taking a verbal order, the person receiving the order performs a verification read back verbatim to the prescriber.

11. All adult patients at the JHH are evaluated daily for fall risk.

12. Patients are assessed for pain minimally every day.

13. When a patient is transferred to another service or to or from a different level of
care all medication orders are discontinued and rewritten.

14. Hazardous drugs should never be diluted, mixed, crushed, dissolved, or transferred from one syringe or IV container to another outside the bio-safety cabinet.

15. Family members can be used as interpreters for patients who do not speak English

16. All nursing staff that perform point of care testing (POCT) must complete approved educational programs and competency testing.

17. Staff who care for patients with a peanut or nut allergy should use Purell to wash their hands.

18. Nursing students may serve as a witness for informed consent.

19. Only the name of the medication needs to be written on the discharge instructions if the patient receives a prescription.

20. Only RNs and LPNs with demonstrated competency may initiate and manipulate PCA pumps.

21. Clinical Engineering should be called to pick up any equipment involved in a PSN event.

22. Oxygen cylinders can be placed on the bed next to the patient for transport.

23. Blood transfusions should be completed prior to patient transfer/transport to provide for consistent observation.

24. Family members can be used as observers for patients on suicide precautions.

25. Pain goal is the rating the patient would like to obtain- their goal for treatment of pain.

26. RNs are only to administer medications via IV push (IVP) during emergent situations.

27. Controlled substances require a witness for waste including disposal of used controlled substance patches i.e. Fentanyl.

28. For a DNR (do not resuscitate) order to be valid it must be written in the patient’s
medical record by the attending physician or his/her designee.

_____ 29. There are no HIPAA restrictions when sharing information with The Living Legacy Foundation regarding organ donation.

_____ 30. In a patient emergency, the rapid response team should be called for critical physiological deterioration i.e. non-arrest emergencies.

MULTIPLE CHOICE:

_____ 31. An agency nurse may:
   a.) Have access to the narcotic cabinet keys and/or pixies ID number (at the discretion of the nurse manager).
   b.) Administer IV medications to adults according to JHH policies.
   c.) Administer chemotherapy, provided they have completed the same competency training of a JHH RN.
   d.) All of the above.

_____ 32. Nursing students may not:
   a.) Take verbal orders
   b.) Initiate/implement restraints
   c.) Hang blood products
   d.) Administer medication chemotherapy
   e.) All of the above except D
   f.) All of the above.

_____ 33. If a patient has a latex allergy, signs are posted where?
   a.) On the patient’s door
   b.) On the patient’s gown
   c.) On the patient’s chart/medical record
   d.) On the patient’s allergy alert wristband
   e.) A, C, and D are correct

_____ 34. When caring for a patient with a venous access device (VAD) the following statements are true:
   a.) Sterile technique is required for central VAD insertion
   b.) Sterile transparent dressings are changed every 7 days or if becomes damp, loose or soiled.
   c.) Do not use transparent dressings on patients who have skin breakdown. Use Primapore tape.
   d.) Patients with a central line cannot shower
   e.) All are true except D
   f.) All of the above are true

_____ 35. The sedation protocol is implemented for moderate and deep sedation/analgesia
that includes:

a.) Administration of sedative alone or in combination with opioid analgesic agents for the purpose of inducing moderate or deep procedural sedation via one of several routes.

b.) Titration of repeated doses of sedatives or titration to effect for procedures.

c.) Administration of any combination of sedative and narcotic analgesic drugs for procedures.

d.) Use of anesthetizing agents such as propofol and ketamine.

e.) Pediatric patients given chloral hydrate, oral pentobarbital, or transmucosal fentanyl (alone or in combination with other agents) for procedures or episodic treatments.

f.) All of the above.

_____ 36. If you have been exposed to a bloodborne pathogen, call:

a.) 911
b.) Nurse Manager
c.) 5-STIX
d.) 5-4444

_____ 37. The following abbreviations are prohibited at JHH:

a.) 'U' (unit)
b.) 'IU' (international unit)
c.) 'QD' (every day)
d.) 'MSO4' (morphine sulphate)
e.) None of the above
f.) All of the above

_____ 38. It is the nurse's responsibility to report suspected abuse and/or neglect to the social worker for:

a.) Children under the age of 18
b.) Vulnerable adults
c.) Elderly persons over the age of 65
d.) All of the above

_____ 39. When administering blood:

a.) Use only NSS
b.) Unless ordered by the authorized prescriber in an emergent situation, transfuse only one unit at a time.
c.) Hang for no more than 4 hours
d.) Assess and record VS at baseline; 15 minutes and at the completion of the transfusion.
e.) A, B, and C are correct
f.) All of the above

_____ 40. Hand hygiene with soap and water is required when:

a.) Hands are visibly soiled.
b.) When caring for a patient with C. Difficile  
c.) Before eating  
d.) All of the above

_____ 41.  What would you do if you found a patient in cardiac arrest?  
a.) Stay with the patient and call for help.  
b.) Ask someone to page the arrest team at x5-4444.  
c.) Initiate CPR unless there is a written Do Not Resuscitate (DNR) order.  
d.) When the AED arrives, attach the electrodes and begin analysis on the defibrillator.  
e.) All of the above.

_____ 42.  What information is used to confirm a patient’s identity?  
a.) Patient’s social security number  
b.) Patient’s name  
c.) Patient’s home address  
d.) Patient’s JHH history number  
e.) Both B and D are correct

_____ 43.  How often (at minimum) is the RN responsible for reviewing his/her patient charts/electronic orders for new provider orders?  
a.) Every 15 minutes  
b.) Every 12 hours  
c.) Every 4 hours

_____ 44.  Which medications require an independent verification by the RN administering the medication and a second RN?  
a.) IV and Epidural PCA  
b.) IV heparin  
c.) IV insulin  
d.) IV chemotherapy  
e.) All of the above

_____ 45.  Which of the following are the 4 isolation categories at the JHH?  
a.) Strict, Droplet, Airborne, Maximum  
b.) Contact, Special, Respiratory, VIP  
c.) Contact, Droplet, Airborne, Maximum

_____ 46.  After you have dialed 5-4444 for a patient emergency, what information must you give to the operator?  
a.) Tell them this is a medical emergency  
b.) If a child or adult is involved  
c.) Which emergency team you need  
d.) The unit, room number, and the unit phone number  
e.) All of the above
47. A written order is required for:
   a.) Insertion and discontinuation of VAD
   b.) IV fluids and rate of administration
   c.) Heparin flush
   d.) All of the above

48. Patients with an allergy will wear what color wristband?
   a.) Green
   b.) Yellow
   c.) Red

49. Bleeding precautions should be initiated on all patients at HIGH risk for bleeding, including?
   a.) Patients receiving systemic therapeutic anticoagulant therapies
   b.) Patients receiving thrombolytic agents
   c.) Patients that have a disease process that puts them at risk for bleeding
   d.) Patients who are on anti-platelets prior to intracranial surgery.
   e.) All of the above

50. Orders for restraints must be obtained from physicians and renewed how often?
   a.) Every 12 hours
   b.) At the end of the next calendar day
   c.) Every 48 hours
   d.) At the end of 3 days