RESOURCE PACKET

Students
Nursing Instructors

Saint Agnes
Medical Center

Revised 6/2025

Mission and Vision Statements/Core Values/ Actions

Mission Statement

We, Saint Agnes Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Vision Statement

*Saint Agnes Medical Center will be THE **most** rusted health partner **for life.***

Core Values

- ***Reverence** – We honor the sacredness and dignity of every person.*
- ***Commitment to those who are poor** – We stand with and serve those who are poor, especially those most vulnerable.*
- ***Justice** – We foster right relationships to promote the common good, including `sustainability of Earth.*
- ***Safety** – We embrace a culture that prevents harm and nurtures a healing, safe environment for all.*
- ***Stewardship** – We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.*
- ***Integrity- We are faithful to who we say we are.***

Our Actions

As a Trinity Health colleague, I will,

- *Listen to understand.*
- *Learn continuously.*
- *Keep it simple.*
- *Create solutions.*
- *Deliver outstanding service.*
- *Own and speak up for safety.*
- *Expect, embrace and initiate change.*
- *Demonstrate exceptional teamwork.*
- *Trust and assume goodness of intentions.*
- *Hold myself and others accountable for results.*
- *Communicate directly with respect and honesty.*
- *Serve every person with empathy, dignity and compassion.*
- *Champion diversity, equity and inclusion.*

Workplace Safety

Workplace Safety

The Safety Manual, located on InTouch, includes an area-specific safety policy, which addresses on-the-job safety precautions relevant to that department.

Workplace safety concerns can be reported by contacting a supervisor, placing a VOICE report or calling the Safety Officer at **ext. 3721**.

Workplace Violence Security Plan (SC005)

- Workplace Violence Security Plan is in the Security section of Safety Manual.
- All staff members are required to inform their immediate supervisor of an act or threat of violence from a visitor, patient, medical or hospital staff, or contractor.
- Staff members are encouraged to report threats from family and/or acquaintances outside of work if they feel that there is a possibility the threat may be carried out in or around the workplace.
- All staff members will immediately contact Security through the switchboard at **ext. 3300** if an act of violence is in progress. Staff members in buildings not on the Medical Center main campus will also **dial 9-911**.

Workplace Injury or Illness Reporting Procedures for Staff Members/Volunteers

If a staff member or volunteer is injured on the job, follow these steps:

1. If you witness a visitor, physician or student accident, you should report it to Security immediately by dialing **ext. 3300**.
2. Security will take a report, regardless of whether the person requires medical attention or not. If the person requires medical treatment, Security will assist him or her to the Emergency Department.
3. If you do not need medical treatment, file an online Trinity Health Employee Incident Report within 24 hours.

The Joint Commission

2025 Hospital National Patient Safety Goals

(Easy-To-Read)

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

Patient Rights/Organizational Ethics

Patient Rights

- Patient Bill of Rights is posted throughout the facility. Patients are given a copy of their rights upon admission.
- Patients have the right to make complaints without jeopardizing future care.
- Patients are informed of their right to receive information about Advance Directives when admitted to the hospital. An Advance Directive is a document that allows patients to name someone else to make healthcare decisions for them if they become unable to do so for themselves. Contact the Center for Spiritual Care or Clinical Social Work Services if a patient would like information.
- Patients have a right to receive a Notice of Privacy Practices. This notice describes how individually identifiable information about the patient will be used and disclosed and how the patient can get access to this information.

Confidentiality/Privacy

- Individually Identifiable Patient Health Information or Protected Health Information (PHI) is confidential.
- Saint Agnes Medical Center is required by law to maintain the privacy of individually identifiable patient health information.
- PHI comes in many forms, including electronic, paper and oral.
- The Privacy regulations cover all forms of PHI.
- Only the minimum amount necessary to perform a specific task or job should be accessed by authorized staff in the medical record.
- Conversations containing PHI should be avoided in public places such as hallways, elevators, lounges and cafeterias. If you're on a cell phone, remember to move away from the public.
- Only the minimum amount necessary to perform a job should be shared with other personnel on a need-to-know basis.

- A written authorization from the patient or patient representative is required for use of photographic equipment including cell phone cameras.
- If you observe or suspect a privacy- or security-related incident, report it immediately through VOICE, 24-Hour Integrity Alertline at **1-866-477-4661** or call the Compliance Department at **ext. 3967**.
- A written authorization from the patient must be obtained before a patient's medical record can be made available to anyone not directly involved with his or her care.

Any breach of confidentiality will be subject to corrective action up to and including termination of employment.

Reporting Quality, Safety, and Organizational Integrity Issues

We encourage you to report quality, safety, and organizational integrity issues as follows:

1. Look at Saint Agnes Medical Center policy and read the Trinity Health Standards of Conduct. Talk with your manager.
2. If you are not comfortable asking your manager or are not satisfied with advice received through existing policies or procedures, contact a higher-level manager.
3. If you still are not satisfied, call your Local Integrity Officer at **ext. 3967**.
4. If none of the above steps resolves your question or concern, call the 24-Hour Integrity Alertline ***(1-866-477-4661)***.

Research Human Subject Protection

Institutional Review Board *(IRB)* is an administrative body established by federal law to protect the rights and welfare of human research subjects. All research studies involving human subjects require prior IRB review and approval. IRB is administered through the Saint Agnes Clinical Research Center and is responsible for continuous oversight of all research activities.

- Only IRB-approved research can be conducted at Saint Agnes.
- Participation in research is voluntary and confidential.
- Participants must be consented to participate using a valid, date-stamped, IRB-approved informed consent for the study.
- All participants must receive a copy of the signed and dated informed consent document and the "California Experimental Subject's Bill of Rights."
- Principal Investigator *(physician)* is responsible for conducting the study in compliance with federal law and according to protocol.
- Participants may contact the IRB Chairperson if they believe their rights have been violated.
- Information concerning clinical research at Saint Agnes Medical Center can be found on the intranet under Department Resources, Clinical Research.

Emergency / Disaster Management

Emergency/Disaster Management Plan

- Disaster Plan is located on Docushare, Safety Manual/Emergency Response/#ER001 – Emergency Response Plan *(also called **HICS** or Hospital Incident Command System)*.
- The Medical Center uses the HICS for emergency management. HICS stands for Hospital Incident Command System. It is a "system" or a "structure" or a "framework" for our Medical Center's Disaster Plan. HICS is based on the premise that every disaster is different, thus requiring different resources *(both human and material)*. It is also based on the fact that the Medical Center cannot come to a grinding halt while taking care of disaster victims. We must continue to give quality care to our existing patients.

Procedure

In the event of a disaster, Medical Center personnel will be alerted by any of these means:

- Telephone
- Radio
- Television
- Messenger
- Police officer
- Other staff members
- Text message

Staff entry into the hospital during a disaster will only be permitted through the back door by the Lab and with a hospital identification badge.

General Principles of HICS Disaster Management System

Each response will be different. Emphasis is to maintain "business as usual." Hospital Command Center is announced overhead.

Code Triage

- Maintain business as usual unless instructed otherwise.
- Department person "In Charge" completes the Department Status Report and delivers it to the Hospital Command Center within 10 minutes.
- Activate Emergency Call List ONLY IF INSTRUCTED TO DO SO by Incident Commander. It is the individual responsibility of all personnel to keep the emergency telephone call-in list current.

Code Triage – Internal *(Location)*

- Department person "In Charge" completes Department Status Report and delivers it to Hospital Command Center within 10 minutes.
- Available staff reports to Labor Pool if requested.
- Only related job action sheets will be assigned and activated.

Infection Prevention and Control

Infection Prevention and Control will be a major focus of The Joint Commission. National Patient Safety Goal #7 stresses the need to reduce the risk of Healthcare-Acquired Infections (HAI).

Infection Control Officers for Saint Agnes are Dr. Robert Libke, Hospital Epidemiologist, and Anna Macedo, Infection Prevention and Control Coordinator.

The hospital must identify infection risks, set goals and a prevention plan. **You should know the risks, rates of infection and plans for infection prevention that your unit has identified.** Focus on:

- Pathogens/organisms – "bugs" or "germs"
- Procedures/devices *(i.e., Foley, central line)*
- Cleaning and disinfection of medical equipment, devices, supplies and their storage
- Sharps and infectious waste disposal
- Environmental cleaning
- Hand hygiene, cough etiquette and respiratory hygiene

We communicate responsibilities for preventing infection to our employees and physicians through Scene, DocTalk, posters, CAT and training. For visitors, patients and families, we provide information about infection prevention, hand hygiene, cough etiquette and respiratory hygiene with Healthy TV videos, posters, brochures and Respiratory Hygiene Stations that provide masks, tissues and hand gel.

Patient Education: Be sure that patients with MRSA, C. diff or VRE receive handouts and oral education about infection prevention.

Be sure patients who have surgery or a central line receive handouts and oral education about infection prevention. Then ***document*** on InTouch in PowerChart, Adhoc, Patient Education Form.

Hand Hygiene

All employees must comply with World Health Organization *(WHO)* and Centers for Disease Control *(CDC)* hand hygiene guidelines.

The WHO "5 Moments for Hand Hygiene" include:

1. Before touching a patient
2. After touching a patient
3. Before an aseptic procedure
4. After blood/body fluid exposure risk
5. After touching the surroundings

Other important times to perform hand hygiene: before putting on and after removing gloves, before eating or preparing food, and after using the bathroom.

Perform hand hygiene for at least 20 seconds. Both alcohol hand gel and soap and water are acceptable methods. *Exception:* if hands are visibly soiled or after caring for a patient with C. diff, wash with soap and water only.

Patient care providers *(anyone who touches patients)*, environmental services, dietary, sterile processing and sterile supplies employees are not allowed to wear artificial nails, and natural nails may not extend beyond fingertips. Nail polish must be fresh and in good repair.

The Joint Commission will be watching to see if employees wash hands at the right times.

Standard Precautions

Use personal protective equipment *(PPE)*, which may include gloves, mask, eye protection *(face shield or goggles)*, cover gowns/aprons, shoes to prevent exposure to blood or body fluid.

You are responsible for knowing where to find PPE and using the proper PPE. ALWAYS put on PPE BEFORE crossing the threshold of the patient's room. ALWAYS wash your hands after removing PPE.

Transmission-based Precautions

Based on the "bug" and how it is spread. Includes:

- **Contact:** MRSA,VRE, C. diff and other multidrug-resistant

organism (MDRO) – wear gown and gloves for contact with patient or environment.

- **Droplet:** Flu, Meningitis – wear mask *(surgical or N95)*, eye protection if droplets may come near the eye.
- **Airborne:** TB, Shingles, Novel Flu – N95 mask *(PAPR hood for High Hazard procedures)* and NEGATIVE Airflow room. Be sure the monitor is turned on. Check airflow daily. **Keep doors closed!**

Steps for Transmission-based Precautions

1. Explain to patient and family the need for isolation. If diagnosed with MRSA, VRE or C. diff, or other MDRO, provide handout and document education.
2. Notify Bed Control at the start and stop of isolation – enter order for Isolation *(contact, droplet, airborne)* or discontinue isolation in **EPIC.**
3. Place patient in private room or cohort with matching organism.
4. Place sign on door.
5. Document date/time of isolation in **EPIC.**
6. Assist family/visitors with proper precautions and provide handout.

If a suspect/known active TB patient is ready for discharge, contact Infection Control or Discharge Planning to obtain approval from the County Health Department before discharging patient.

Notify both the receiving and referring organization *(hospital/EMT)* for any reportable disease or infection requiring isolation identified at Saint Agnes. All Reportable Communicable diseases MUST be reported to the County Health Department in a timely manner *(see Infection Control Policy)*.

Cleaning

It is everyone's job to keep the environment clean. Focus on frequently touched objects. Use gloves when using hospital-approved cleaning products and know how long the item needs to stay wet *(contact or*

dwell time). The contact time for the cleaning wipes is on the label of the container. PDI purple top is 2 minutes. PDI Bleach wipes, orange top is 4 minutes. **Keep the lids closed!** If the surface dries in a shorter time than required, it needs to be re-applied, so it stays wet.

Employee Health and Infection Prevention

- Use Standard and Transmission-based precautions.
- Get your vaccines: Covid-19, Flu, Hepatitis B *(free)*.
- Annual TB testing and N95 Fit testing.
- Follow up with Employee Health *(ED after hours)* for exposure to blood/body fluids *(within 2 hours of exposure)*, TB or other infectious/communicable disease. The Bloodborne Pathogen (BBP) and Aerosol Transmissible Disease *(ATD)* Control Plans are located in the Infection Control Manual in Docushare on InTouch.
- Spills of blood/body fluids: If small, put on gloves, wipe with paper towel, then disinfect with germicidal wipe. For larger spills, contact Environmental Services.

Hazardous Materials / Waste Management

Safety Data Sheets

- S.D.S. = Safety Data Sheets
- S.D.S. ARE NO LONGER KEPT IN EACH DEPARTMENT.
- S.D.S. can be accessed through MSDS online by clicking the Safety Data Sheets icon in your ZENworks window.
- **In 2014**, M.S.D.S. was changed to S.D.S. *(Safety Data Sheets)* in compliance with new Global Harmonization System (G.H.S.).
- A master S.D.S. Manual is in Environmental Services Deptartment.
- S.D.S. tells you everything you need to know about a product: storage requirements, personal protective equipment requirements, spill/leak procedures, and so forth, through the use of pictograms.

Laboratory, SPD, Radiology, Pharmacy, Oncology, Engineering, Environmental Services, and, at times, some of the nursing departments are examples of some departments where hazardous materials can be found. Some departments have members that are trained to handle small quantity spills. These should only be performed by staff members with up-to-date competencies. For other spills, the department should refer to the Hazardous Materials Policy.

If you are exposed to a hazardous material, you must inform your supervisor, complete an online TH Incident Report, and, if needed, report to the Emergency Department immediately.

Mock hazardous material spill drills are conducted routinely. Remember, all secondary containers used for chemicals must be labeled correctly *(name of chemical, name and address of manufacturer, hazard warning – i.e., flammable, toxic, etc.)*. What is a secondary container? Whenever a chemical is removed from its original container and placed into another container, such as a spray bottle, it is called a secondary container.

Waste

1. ***Medical Waste*** consists of:
   A. *Sharps waste* – must be disposed of in rigid containers with lids that seal securely and then disposed of in a red-lined container.
   B. *Chemo sharps waste* – must be disposed of in special yellow chemo containers.
   C. *Biohazardous waste (any item that drips with blood/body fluids freely or when compressed)* – must be placed in RED bags.
2. ***Recyclable Waste*** *(includes all colors of paper)* – must be disposed of in designated recycle containers to maintain confidentiality.
3. ***Regular Waste*** *(any waste that does not fall into the above categories)* – may be disposed of in regular trash cans. Any item containing patient-specific information MAY NOT be placed in regular trash unless shredded.
4. ***Pharmaceutical Waste***

   Pharmaceutical Waste Program is designed to prevent medications from harming the environment. To accomplish this, federal, state, and local regulations state that pharmaceutical waste must be managed according to their toxicity classification.

   Five categories of waste

   A. *Pharmaceutical waste* – Place in white and purple containers.
   B. *RCRA hazardous* – Place in black containers.
   C. *Fentanyl patches* – Folded in half and disposed of in white and purple containers.
   D. *Chemotherapy waste* – Place in yellow containers.
   E. *Inhalers and compressed anesthesia gases* – Bag and return to pharmacy or dispose of in black container labeled for this purpose.

For more information, refer to* Safety Manual *(Policy HM001 – Hazardous Materials Management Plan).

Refer to Pharmaceutical Waste Disposal Grid to determine if it is classified as RCRA, chemo or regular pharmaceutical waste. Sharps are not to be placed in pharmaceutical waste containers.

PHARMACEUTICAL WASTE shall be defined as any prescription or over-the-counter medication that may be partially used, opened and unused. These items include capsules, tablets, powders, liquids, injectables, topicals, suppositories, ophthalmics and otics, and IV solutions with medications. These items must be differentiated from items previously designated as hazardous cytotoxic waste and those items listed under the Federal Resource Conservation and Recovery Act *(RCRA)*.

All pharmaceutical waste shall be handled, stored and disposed of within the Medical Center in accordance with waste management law and compliance with Senate Bill 1966, chapter 536 (SB 1966) as regulated by California Department of Public Health Services *(CDPH)* and local waste water management *(Public Owned Treatment Works – POTW)*.

1) Hazardous cytotoxic *(chemotherapy agents)* waste shall be disposed of in accordance with Saint Agnes policy regarding proper handling and disposition of cytotoxic agents *(currently in place). (Oncology Unit Policy A-3, Pharmacy Policy 7170-IV-110)*

2) Pharmaceutical hazardous waste listed under the RCRA shall be logged and disposed of in accordance to waste management law. RCRA pharmaceutical hazardous waste must be returned to Pharmacy for disposal. Items shall be logged in regard to product name, NDC number, strength and amount disposed of in Pharmacy if a black container is not in the area.

   Waste shall be disposed of in pharmaceutical hazardous waste containers labeled for incineration only. Items identified under RCRA shall include cough syrups with alcohol content greater than 24%, all inhalers*, compressed anesthesia gases*,

Appendix A

SHARPS & PHARMACEUTICAL WASTE

SHARPS — yes → Pour any liquids into Pharmaceutical waste container before putting into sharps box

Needles
Broken glass vials
Broken ampules
Blades
Scalpels
Razors
Pins
Clips
Staples
All empty syringes with trace amt of med-not pourable.
Sharps from procedures
Specimen devices in Endo

SHARPS DISPOSAL CONTAINER

no →

LIQUID IV SOLUTION — yes → Only NS, LR, Dextrose ± Electrolytes or Multivitamins → yes → Discard down the drain → Put bag or bottle in trash

no →

CONTROLLED SUBSTANCE — yes →

Narcotic tablets
Narcotic wastage- what you can squirt out of the syringe.
Narcotics in IV bag
PCA wastage
Narcotic drips
Narcotic skin patches

no →

LIQUID — yes →

Pourable liquid
Liquid from syringe
IV bag with meds
TPN
Glass vials/ampules
Eye drops

no →

SOLID — yes →

Tablets
Capsules
Ointment tubes
Lotions
Partially filled bottle
Suppositories
Partial tablets
Powders
Other transdermal patches

Left over meds from isolation room except insulin pens and aerosols inhalers

PHARMACEUTICAL WASTE CONTAINER

NOTE:
Put fluid filled bag in Pharmaceutical waste including tubing – **EXCEPT:** Narcotic fluids must be squirted in.

EMPTY bags & tubing go into REGULAR trash.

BOX FULL?

Nursing to contact SERV at 7378 – EVS will remove & replace container

no →

RCRA WASTE — yes →

P & U Listed drugs
Insulin-pen & vial
Aerosol inhalers
Alcohols >24%
DES tablets
Barium
Lindane
Selenium
Trypan blue
Physostigmine
Nicotine*
Warfarin*
*Includes wrapping

Left over insulin pens and aerosols inhalers from isolation room

RCRA - Resource Conservation and Recovery Act

no →

CHEMO and Hazardous Drugs — yes →

Tubing
Empty IV bags
Empty bottle
Empty vials
Syringes
Gloves
Pads
Masks
Gowns
Wipes
All supplies used to make and administer chemo meds

YELLOW TRACE CHEMO WASTE CONTAINER

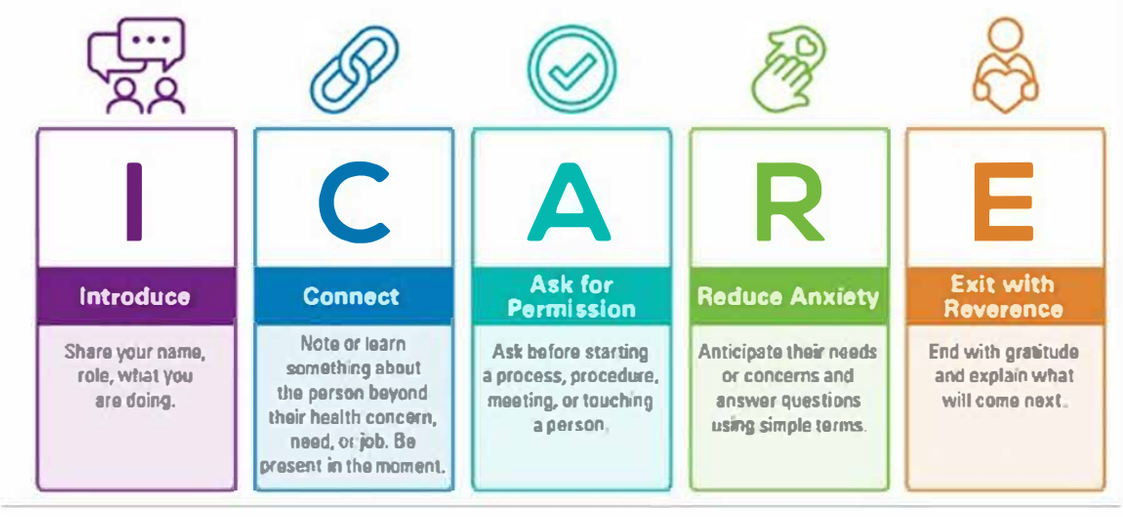
RETURN ALL UNUSED Chemo, Items involved in chemo spill > trace waste
Tubing & empty IV w/arsenic trioxide Chemo to ONCOLOGY PHARMACY-2W

3.20.23

For questions, call Pharmacy @ ext.3132

Purposeful Hourly Rounding & ICARE

- ICARE is a Relationship-building model that demonstrates our Trinity Health culture
- Using ICARE incorporates communication best practices known to enhance patient understanding and satisfaction
- Our reputation in the community is important. Patient satisfaction is a key aspect of improving our reputation
- When patients understand their care, they are more likely adhere to the recommended guidelines and education that has been provided
- Use ICARE with every interaction with patients, caregivers and family members



Saint Agnes
A Member of Trinity Health

Purposeful Hourly Rounding Scripting using ICARE

Sample Scripting – you may use your owns words as long as you address the 3 Ps while including ICARE communication best practices.

Key Points:

- Registered Nurses are responsible for hourly rounds. As appropriate, RNs may delegate rounding to other members of the care team (LVN, NA, ECT, etc.).
- Hourly rounding must be purposeful, include ICARE communication best practices and address the patient's needs, specifically including Pain, Potty and Positioning.
- If medications were administered during the previous round, please ask the patient if they are experiencing any side-effects that were previously discussed. This will help them remember the conversation and feel a connection.
- Patient-Centered Care: Always ask open-ended questions to engage the patient and make them feel heard.
- Documentation: Be sure to document every round and patient request to ensure patient centered handoff between shifts and continuity of care.

Step 1. Nurse reviews the patient chart. Prioritizes round based on patient acuity. Nurse enters patient room/area – ICARE: Introduce & Ask Permission

- "Good [morning/afternoon], [Patient's Name]. My name is [your name] and I am your nurse. I am here for your hourly rounding to check your comfort and make sure everything is going well.
- "How are you feeling? I want to make sure we address everything that matters to you."
- "Would it be ok if I check in on your comfort and needs now?"

Step 2. Check the 3 Ps – ICARE: Make a connection

- Pain: "Are you experiencing any pain or discomfort?" or "Did the medication I gave you help to decrease your pain level?" or "What is your current pain level on a scale of 0-10?" Assess per department policy. If pain is present, make sure it is addressed.
- Potty: "Do you need assistance with using the restroom?" "It's time to try going to the bathroom again."
- Position: "Would you like to adjust your position for comfort?" or "It's time to change your position, can I help you move to your other side?"
- Ask: "Are you experiencing any side effects of the ____ medication that I gave you earlier?"

Step 3. ICARE: Reduce anxiety.

- "You can expect to have someone check on you every hour. But please let us know if you need anything in between by pressing your call light or calling me directly."
- What else can I do while I am here?" or "Is there anything else I can help you with?"

Step 4. Close the interaction – ICARE: Exit with Reverence and Gratitude

- Be sure to set expectation of when you will return. "Thank you for allowing me to check in. "I'll return in 1 hour to check in for the next hourly round".

Saint Agnes Medical Center
Preventing Patient Harm Agreement

Nursing care is instrumental in preventing harm to patients and improving patient outcomes. This packet includes valuable information, policy excerpts and bundle components.

Included in this packet:

1. Skin Pressure Injury
2. Falls Prevention
3. CLABSI Prevention Bundle
4. CAUTI Prevention Bundle
5. C. Diff and other Isolation
6. Hand washing
7. CDC Criteria and Algorithm
8. SAMC Central line maintenance bundle
9. C. Diff Algorithm

Preventing Hospital Acquired Infections and Injuries

1. Skin Pressure Injury (HAPI) Policy

a. **REPOSITION:** Bed bound patients must be repositioned a minimum of every two hours. Position change must be documented in EMR. Heels must be floated/elevated.

b. **4 EYES WITHIN 4 HOURS SKIN ASSESSMENT:** Completed upon admission, transfer, or anytime a patient has been off the unit in excess of 4 hours. Two individuals -at least one RN, complete a thorough head to toe assessment and compare findings prior to documentation by the RN.

c. **BRADEN SCORE:** order must be changed from Q 24, to Q 12 and assessment must be completed and documented each shift.

d. **SKIN INTERVENTIONS:** need to match Braden Assessment: EX: moisture- document use of barrier creams, and documented when provided.

e. **DEVICE RELATED PRESSURE AREAS**: All device related pressure areas must be assessed for potential device related skin injury. (NG tubes, arm boards, SCDs, splints, oxygen administration systems such as NC or HHF, etc.)

f. **WOUND WEDNESDAY:** Skin injuries will be thoroughly assessed, including measurements and documented a minimum of once a week (wound Wednesdays).

g. **IPOC**: must be initiated for any skin issues.

h. **VOICE:** report must be completed for all pressure injuries present on admission and/or pressure injuries that progress to the next stage, become unstageable or develop after admission

i. **WOUND AND OSTOMY CONSULT**: for any Stage III, IV, SDTI, unstageable injuries or any HAPI.

2. Falls Prevention Policy

a. FALL ASSESSMENT: must be completed using Hester Davis Fall Assessment Scale and documented each shift

b. ALARMS: Falls prevention interventions will be initiated and documented: bed and chair alarms, low bed position, floor mats

c. VISUAL AIDES:
- Patients at high risk for fall will have yellow socks and yellow arm band
- Signage on door

d. AMBULATION:
- All patients will ambulate with staff assistance and be at least one arm length away from staff anytime out of bed or chair
- Staff will stay with all patients when using the bathroom, bedside commode

e. ROUNDING:
- Purposeful hourly rounding on patients to assist with bathroom trips and other needs will be conducted to prevent patients from trying to do things by themselves which puts them at risk for falling

f. VIDEO MONITORING:
- AVA sitter

g. POST FALL:
   - VOICE report must be completed after all patient falls
   - Post Fall Huddle form
   - Post Fall assessment
   - 24 hour Post Fall assessment

3. CLABSI Prevention Bundle (See Attached)

a. **INSERT:** Insertion must be documented by RN in Epic under LDA Avatar
b. **ASSESS:**
   - Daily for need to continue. Advocate for early removal if no indications are present
   - Document each shift and PRN for central line site and dressing condition (every 4 hours required in ICUs). Clean, dry, intact, no gaps
c. **DRESSING CHANGE:** performed at a minimum of every 7 day and PRN if dressing is loose or drainage is present
   - Dressing changes will be Sterile technique
   - Dressing changes must be documented in EPIC
   - Changed on Sundays: Even numbered rooms change on day shift and Odd numbered rooms change on night shift.
d. **SWAB CAPS:** will be used on every injection port
   - Injection ports will be scrubbed with alcohol pads before each access
   - Peripheral line ports also have swab caps when a patient has a central line
e. **DAILY CHG BATH:** per protocol
   - For all patients with a central line
     ***All patients admitted with central lines will need to have blood cultures ordered and drawn on admission

4. CAUTI PREVENTION BUNDLE (See Attached)

a. **INSERT:**
   - Prior to insertion, patient must meet criteria for insertion. Use Urinary Device Decision Tree to determine need for Foley catheter. Document in EMR
   - Peri-care with soap and water prior to insertion of catheter
   - Ensure sterile technique.
   - Document insertion and removal in EPIC under LDA Avatar
b. **ASSESS FOR NEED:**
   - Assessed daily to determine that the patient meets criteria to continue the Foley catheter.
   - If no contraindication:

- Remove at earliest possible date or by 2nd midnight if criteria is Urinary Retention
- Rationale for continuing the Foley catheter must be documented
- Patient transferring to lower level of care, discontinue Foley catheter (criteria for Critically Ill Patient is not allowed on inpatient units)

c. **MAINTENANCE AND PERI-CARE:**
- Every shift: high quality peri-care will be performed a minimum of every shift
- Special attention to peri-care technique with patients who are incontinent of stool to prevent contamination of urinary tract with gut flora
- Empty Foley bag prior to transport
- Stabilization device. Maintain closed connection. Label collection container with patient name. Bag below the bladder, no kinks, dependent loops or pressure points

d. **SPECIMEN COLLECTION:**
- Aseptic technique

e. **REMOVAL:**
- Remove at earliest possible date or by 2nd midnight if criteria is urinary retention
- If no contraindications for removal, follow RN Driven Removal Protocol. (contraindications include: MD order to keep Foley catheter in place due to either difficult insertion, s/p urinary/gynecological surgery, urinary retention or urinary catheter was present on admission)

4. C DIFF AND OTHER ISOLATION

f. **TESTING:**
- Send stool per C Diff Algorithm. Other causes of diarrhea? Adequate specimen (10mL)?
- Use the language line to assess patient bowel habits and diarrhea. Are there cultural barriers to communication?
- There are 2 different tests that lab runs. The first test is a PCR, if this is positive, then the lab will run a toxin test
- The toxin test helps the physician to decide on treatment

b. **ISOLATION PRECAUTIONS:**
- Isolate as soon as C Diff is suspected; ensure isolation is ordered and documented in EPIC
- C Diff PCR positive requires Contact Isolation for the duration of the hospital stay even if the toxin is absent
- Toxin absent treatment is at the discretion of the physician. It is important that the physician is aware of the Toxin results
- Clean with bleach and not purple wipes
- If C Diff PCR is negative, isolation can be discontinued

c. **PERSONAL PROTECTIVE EQUIPMENT (PPE):**
   - Contact Isolation: gown and gloves must be worn for ANY ENTRY into a contact isolation room. Don PPE in proper order
   - Remove PPE in the proper order. Place completely in hamper
   - Wash hands with soap & water. DO NOT USE HAND SANITIZER
   - Educate visitors on the purpose of gowns and gloves to prevent them from walking outside the patient room/space with PPE in place

d. **COMMUNICATION:**
   - Discuss BMs, C diff tests and verify isolation order during handover. Manage up any issues
   - Use C Diff Algorithm and consult with Infection Control Team to determine appropriateness of sending stool for C Diff

e. **ANTIBIOTICS:**
   - Advocate for discontinuing unnecessary antibiotics or mismatch of antibiotic with resistant sensitivities
   - Antibiotic stewardship committee consult

MOST IMPORTANT!!

PERFORM HAND HYGIENE:

- Frequent and thorough handwashing is the first and most important step in preventing infections
- Know the 5 Moments for hand hygiene
- Minimum time of 20 seconds
- All finger and hand surfaces must be cleansed
- Be a team player. Remind others politely and receive reminders gracefully

Saint Agnes Medical Center
Patient and Family Guide to Fall Prevention

Welcome to Saint Agnes Medical Center. We believe that the ultimate goal of patient care is to provide an environment that facilitates safety in the least restrictive environment possible.

It is our goal to work with you towards a speedy recovery and keep you safe in the process; but no matter how watchful we are, people still have falls.

Only if we all work together – doctors, nurses, therapists, patient care assistants, patients and families – can we hope to maintain the highest level of safety from falls.

Why do falls happen?

Falls happen in the hospital because:

- Some medicine can make people feel dizzy or sleepy. Often new medicines are given in the hospital, and we can never know for sure who will react with one of these side effects.
- Being sick and spending time in bed can make you weak and unsteady when you get up.
- Waking up in a strange place can be confusing, or even scary. If you have had a sleeping pill it can be even worse.
- Patients have an urgency to use the bathroom.

How you can help us keep you safe:

- Please tell us if you use a cane or walker at home, if you have ever fallen before, have had (a) seizure(s), have trouble hearing or seeing, or have ever had trouble remembering where or who you are.
- Only YOU really know if you need help getting up or getting somewhere, be honest with yourself and us if you need help.It will be less trouble to ask for help than recover from an injury caused by a fall.

- Use the call light by your bed or in the bathroom to ask for help. If someone does not come right away, please be patient. **Call for help and wait for the help to arrive.**
- You may feel dizzy or weak after lying for a long time. Sit on the edge of the bed a few minutes before standing, and then stand a minute before beginning to walk.
- Walk slowly and carefully when out of bed. Do not lean on items such as IV poles or tables with wheels.
- Wear your own footwear or non-slip footwear when walking. If you do not have your own, ask your nurse and they will provide you with some.
- If the doctor or nurse tells you not to get up without help, please follow their instructions. **Call for help and wait for the help to arrive.**
- Do not lower your side rails or tamper with protective devices. These things remind you to ask for help to get up and make it easier for us to keep you safe. If they need to be moved, ask your nurse.
- If something spills, please call someone to wipe it up so that no one slips.

A special note for family and friends:

We highly encourage you to stay with your friend or family member. Research has indicated that your presence helps to decrease the number of falls. Please speak to the nursing staff if you are interested in staying, arrangements can be made.

We have developed an individualized plan of care, which is located at the head of the bed.

If you have any unanswered questions or concerns, please do not hesitate to share them with the nursing staff and/or nursing supervisor.

Hester Davis Fall Risk Assessment Scale

Risk Factor	Score
Last Known Fall – this is the **only** section that is "single" select. Every other section has "multiple" select options	0=No falls 1=Within the last year 2=Within the last six months 3=Within the last month 4=During the current hospitalization
Mobility – "multiple" select options	0=No limitations 1=Dizziness/generalized weakness 2=Immobilized/requires assist of one person 3=Use of assistive device/requires assist of two people 4=Hemiplegic, paraplegia, or quadriplegia
Medications - "multiple" select options	0=No meds 1=Cardiovascular or central nervous system 2=Cardiovascular and central nervous system 3=Diuretics 4=Chemotherapy in the last month
Mental Status/LOC/Awareness - "multiple" select options	0=Awake, alert, and oriented to date, place, person 1=Oriented to person and place 2=Lethargic/oriented to person only 3=Memory loss/confusion and requires reorientation 4=Unresponsive/noncompliance with instructions
Toileting Needs - "multiple" select options	0=No needs 1=Use of catheters or diversion devices 2=Use of assistive device (Bedside commode, bedpan, urinal) 3=Incontinence 4=Diarrhea/frequency/urgency
Volume/Electrolyte Status - "multiple" select options	0=No problems 1=NPO greater than 24 hours 2=Use of IV fluids/tube feeds 3=Nausea/vomiting 4=Low blood sugar/electrolyte imbalances
Communication/Sensory - "multiple" select options	0=No deficits 1=Visual (Glasses)/hearing deficit 2=Non-English patient/unable to speak/ slurred speech 3=Neuropathy 4=Blindness or recent visual change
Behavior - "multiple" select options	0=Appropriate behavior 1=Depression/anxiety 2=Behavioral noncompliance with instruction 3=Ethanol/substance abuse 4=Impulsiveness
Risk Level	**Total Score**
Low Risk	**7-10**
Moderate Risk	**11-14**
High Risk	**15 or greater**

Hester Davis Fall Risk Assessment

Implement appropriate interventions based on identified risk level:

All patients – Universal fall precautions

Low Risk – Score of 7-10 - Universal fall precautions, plus:

- Yellow non-skid socks
- Yellow armband
- Fall precaution sign at entrance of patient room
- Offer bedpan, bedside commode, or bathroom at least every two hours
- Communicate to staff, patient, and family members the current fall prevention care plan
- Patient risk specific interventions
- Bed in lowest position; floor mats

Moderate Risk – Score of 11-14 - All low-risk interventions, plus:

- Stay within arm's reach of patient at all times when patient is ambulating or toileting
- Gait belt with transferring and ambulation. Use for all high risk patients
- Bed/chair alarm
- Patient specific interventions
- Consider Ava sitter/ 1:1 sitter for moderate to high risk patients

High Risk – Score > 15 - All low and moderate interventions, plus

- Consider referral to PT and use of mobility techs to assist with ambulation.
- Patient specific interventions

Hester Davis Fall Risk Care Plan will be initiated for all patients scoring 7 or above

Other interventions:

- Education with patient/family brochures, patient falls agreement

Saint Agnes Medical Center
Central Line Maintenace Bundle

SITE CARE:

1. Site care Q week every Sunday/PRN (Mediport needle/dressing Q 7 days-excluded from Sunday dressing change)
2. Cleanse site with CHG for 30 seconds and allow to air dry
3. Verify securement device is in place for unsutured lines
4. Apply SKIN PREP and place sterile transparent CHG impregnated dressing
6. Date/Time/Initial site and Document in the Electrolic Health Record (EHR)

FLUSHING:

1. Every 12 hours minimum when solution is not infusing, per orders, or PRN
2. Pulseatile technique (short boluses of the flush solution interrupted by short pauses)
3. Flush before and after each use

NEEDLELESS CONNECTORS:

1. Change needleless connector/stopcocks every 96 hours when the continuous infusion system is changed, every 7 days with the dressing change if a continuous system in not used, and PRN
2. Document change(s) in the EHR
3. Scrub with 70% alcohol vigorously for 15 seconds prior to acess and apply new disinfecting port protector following each use

IV SOLUTIONS:

1. IV solutions changed with every new central line placement
2. IV solutions are changed every 24 hours/label bag with expiration date/time

IV TUBING:

1. Continuous infusion tubing and stopcocks changed every 96hr/PRN and labeled with expiration date/time
2. Maintain piggyback connection to primary IV. If it is necessary to disconnect, it is now intermittent tubing and must be relabled with new expiration date/time (24 hours)
3. Intermittent infusion tubing (saline lock) changed every 24 hours
4. Place new sterile red cap to exposed end after each intermittent use. DO NOT attach exposed end to same set (looping)
5. TPN/Lipid IV tubing/stopcocks changed every 24 hours and/or every bag, whichever is sooner
6. IV tubing/stopcocks changed with every new central line placement
7. Document tubing change in the EHR

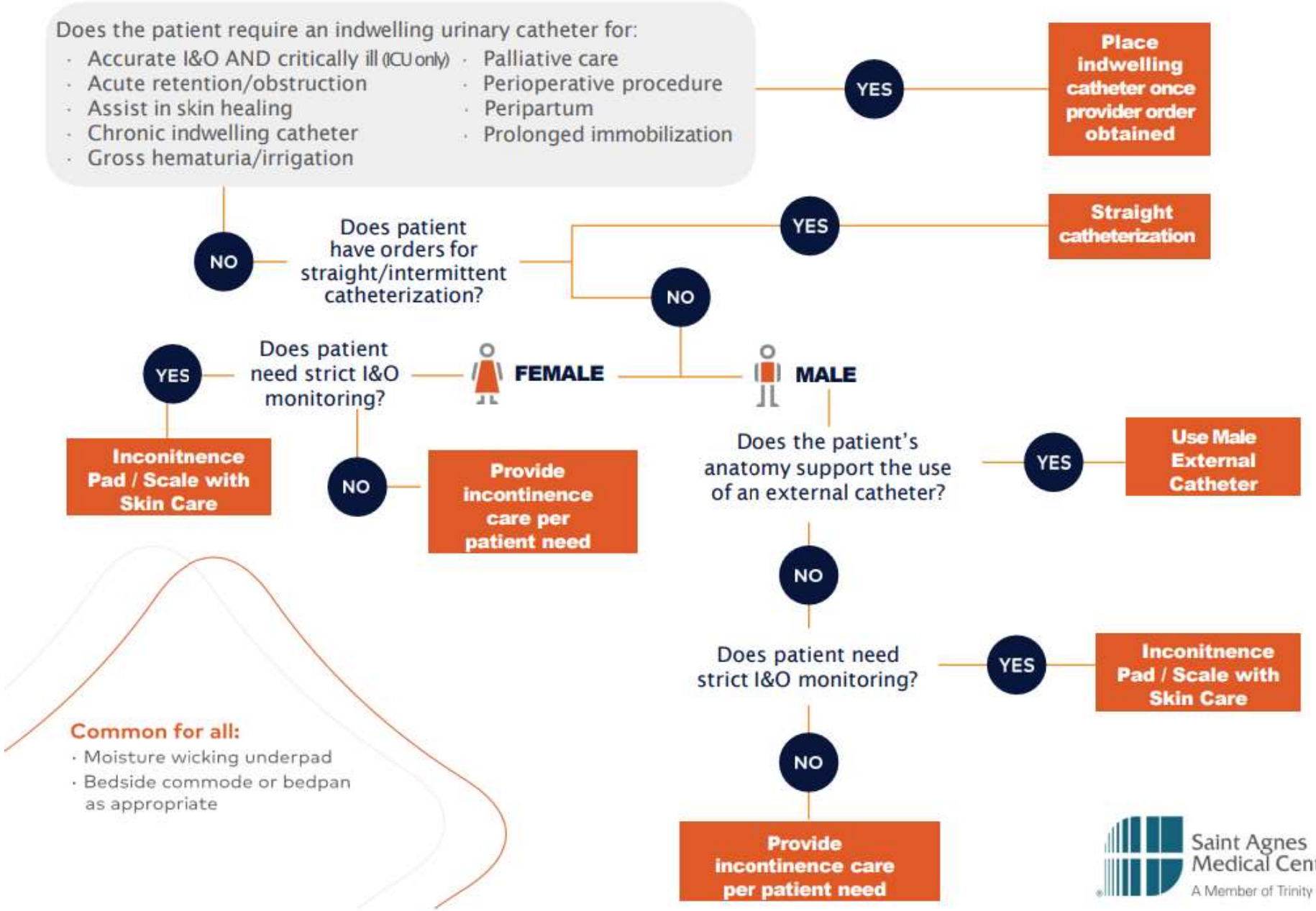
ADDITIONAL MEASURES:

1. Comply with hand hygiene requirements per Hand Hygiene Policy C-2
2. All patients with a central line must receive a CHG bath daily
3. Follow current daily auditing process
3. Assess neccessity of central line daily and notify provider when criteria is not met
4. Provide education to patient/family on CLABSI prevention strategies

Policy M-5 & K-24
INS Standards of Practice 2021
Revised 2024

Saint Agnes Medical Center
A Member of Trinity Health

Urinary Device Decision Tree

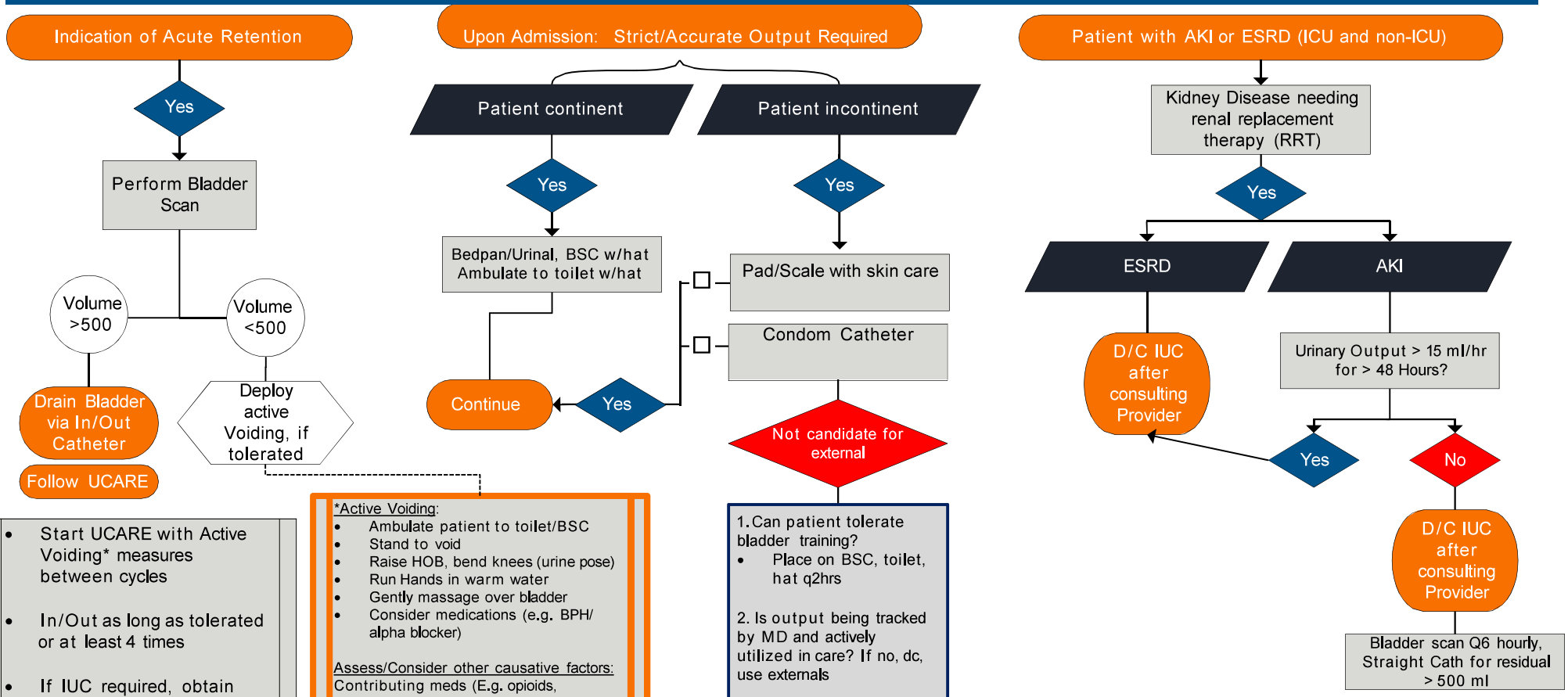


Saint Agnes Medical Center
A Member of Trinity Health

Pre-Catheter Avoidance Review and Exclusion (P-CARE)

Saint Agnes Medical Center
A Member of Trinity Health

Evaluate ability to capture urinary output using processes below for: Acute Retention, Strict/Accurate Output, AKI, Urology



- Start UCARE with Active Voiding* measures between cycles
- In/Out as long as tolerated or at least 4 times
- If IUC required, obtain order for alpha blocker medication
- DC IUC at 48 hours post medication start, then retry active voiding, In/Out
- Notify MD
  Consider Urology Consult

*Active Voiding:
- Ambulate patient to toilet/BSC
- Stand to void
- Raise HOB, bend knees (urine pose)
- Run Hands in warm water
- Gently massage over bladder
- Consider medications (e.g. BPH/ alpha blocker)

Assess/Consider other causative factors:
Contributing meds (E.g. opioids, antihistamines, anticholinergics)

1. Can patient tolerate bladder training?
   - Place on BSC, toilet, hat q2hrs
2. Is output being tracked by MD and actively utilized in care? If no, dc, use externals

IUCs can be approved up to first 48 hours then reviewed daily:
- (ICU Only) Critical I&O REQUIRING hourly reads
- CBI w/active hematuria
- GU surgery
- Chronic IUC vetted, no option, keep
- Urology ordered, need active plan of care and oversite while in-house

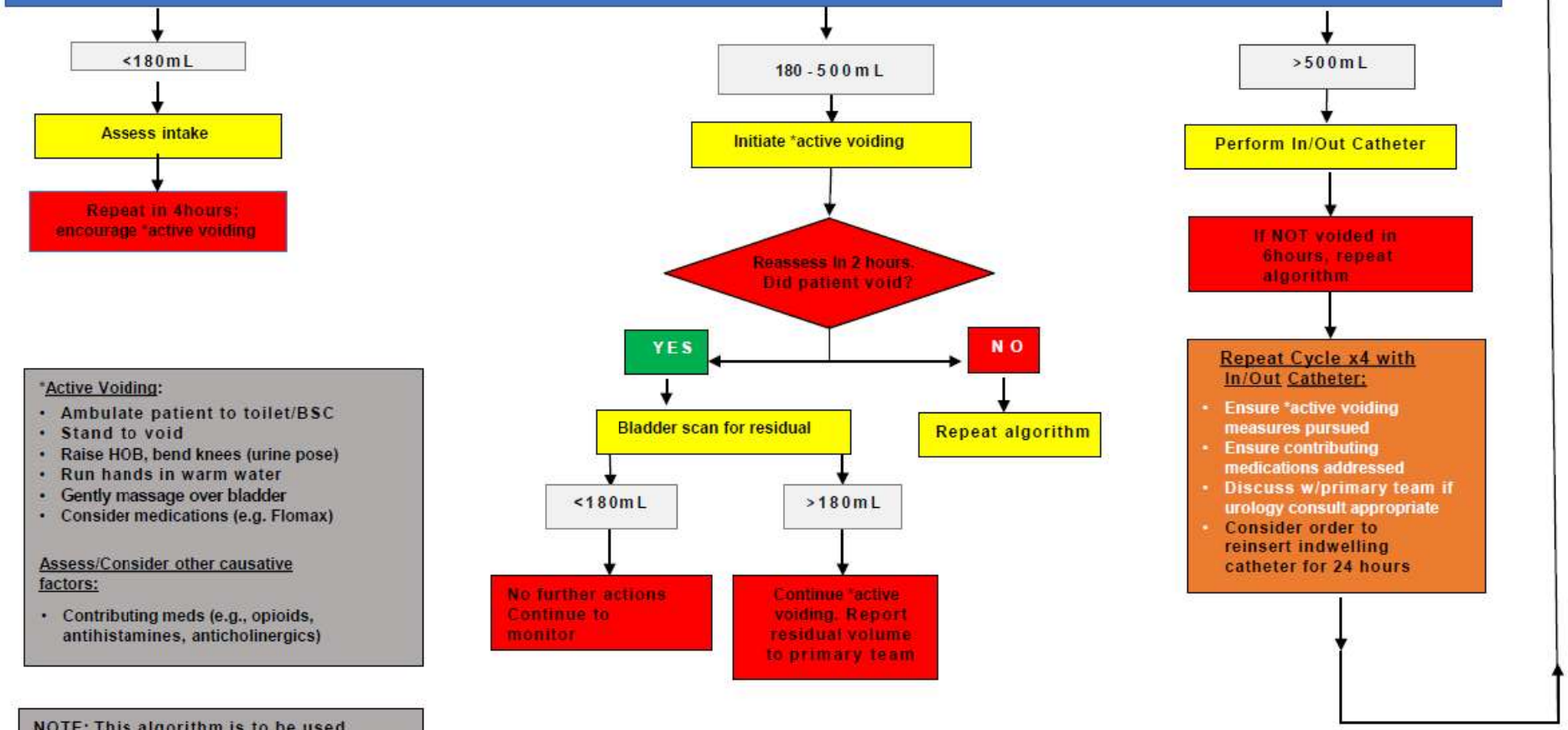
Oliguria = 400-500 ml/24 hours OR 15 mls/hr
IUC = Indwelling Urinary Catheter

04/04/2024

Urinary Catheter Algorithm for Acute Retention & Early Removal (UCARE)

Saint Agnes Medical Center
A Member of Trinity Health

Remove urinary catheter by midnight on day 2 and provide a catheter *rest day* for calendar day 3.
Actively encourage patient to void. **If unable to void within 4-6 hours, perform Bladder Scan:**



*Active Voiding:

- Ambulate patient to toilet/BSC
- Stand to void
- Raise HOB, bend knees (urine pose)
- Run hands in warm water
- Gently massage over bladder
- Consider medications (e.g. Flomax)

Assess/Consider other causative factors:

- Contributing meds (e.g., opioids, antihistamines, anticholinergics)

NOTE: This algorithm is to be used in conjunction with the Nurse Driven Foley Removal algorithm. Exemptions areas defined in that process.

BladderScanvolumesperAmericanNursesAssociation.ANACAUTI PreventionTool.2015.

CDIFF Testing Algorithm

ISOLATE AT FIRST SUSPICION

Patient on Day 1, 2 or 3 of Admission

- Day 1 = day the patient physically went to the first inpatient location
- Use this process also for admitted patient still in the ED

Does patient present to the hospital with diarrhea?
Patient stated they had diarrhea at home?
Was 1 loose stool observed?

YES → **ORDER CDIFF TEST!**

Patient on or After Day 4 of Admission

- Infection Control will review the chart and reach out to the provider team to determine test appropriateness.
- If you are unsure whether to test or not, contact Infection Control via Secure Chat.
- Otherwise apply the following:

Does the patient have diarrhea?
(=3 loose stools in 24hrs)

NO → **DO NOT TEST!*** *(If <3 loose stool, Continue Isolation, and monitor)*

YES ↓

Was there a prior negative test in the last 7days?

Yes → **DO NOT TEST!*** *(check with Infection Control about isolation)*

NO ↓

Was there a prior positive test in the last 60 days? *(recurrence is very common, it may be appropriate to just treat and isolate)*

Yes → **DO NOT TEST!*** *(check with Infection Control about isolation)*

NO ↓

Review chart, does pt have other causes for loose stool? *(e.g. stool softener/laxatives, bowel prep, lactulose, tube feeding, recent antibiotics, or other GI disease)?*

Yes → **DO NOT TEST*** *Dc' other causes if possible, cont. isolation, reassess pt in 48 hrs*

NO ↓

Review chart, does pt have other symptoms of CDIFF *(e.g. fever, elevated WBC, abdominal pain, intra-abdominal surgery)*

NO → **CONTACT INFECTION CONTROL**

YES → **ORDER CDIFF TEST!**

Always isolate positive patients for the entirety of their stay!
Do **NOT** test for cure !!!

** For DO NOT TEST: work with MD and Infection Control to dc' order and isolation need*

Thinking about retesting for CDIFF?

PRIOR POSITIVE TEST: *(in the last 60 days)*

- Retesting to document **CLEARANCE** of the toxin/organism is **NOT** recommended because patients may shed the organism or toxin for several weeks after treatment.
- Retesting to **DISCONTINUE ISOLATION** should **NOT** be done. CDIFF positive Patients will remain on isolation for the entire length of their stay!
- Retesting upon **REQUEST OF RECEIVING FACILITY** to show proof of a negative test should **NOT** be done. If this happens please contact Infection Control.

DO NOT RE-TEST !!!

- Retesting due to **RE-EMERGENCE OF SYMPTOMS** (patient was treated for CDIFF, clinically improved; but is showing symptoms again consistent with CDIFF) **MAY BE APPROPRIATE** but only in isolated cases. Consider evaluation by an Infectious Disease physician. Empiric treatment is often utilized for such cases, without the need of a test.

MAY RE-TEST? *(Contact Infection Control)*

PRIOR NEGATIVE TEST: *(in the last 7 days)*

- Retesting to **CONFIRM A PRIOR NEGATIVE** is typically **NOT** necessary. Sensitivity of the CDIFF PCR is higher (>99%) than previously employed assays, obviating the need for multiple tests.

DO NOT RE-TEST !!!

- If strong suspicion for CDIFF remains (risk factors, symptoms other than diarrhea), and alternative causes have been ruled out, consider evaluation by an Infectious Disease physician or empiric treatment.

MAY RE-TEST? *(Contact Infection Control)*

SEPSIS SCREENING TOOL

If Presenting with 2 or more of the following:	
TEMP > 38.3 ° C OR < 36 ° C	2 + 1 = SEPSIS
HR > 90 beats/minute	
RR > 20 breaths/minute	
WBC > 12,000/mm3 OR < 4,000/mm3 OR > 10 % BANDS	
Plasma Glucose > 140 mg/dl (Non-diabetic)	
Recent Change in Mental Status (unrelated to primary neuro pathology)	
Plus 1 of these:	
Known or Suspected Infection	*Obtain Lactate Level
Current or Recent Antibiotic Therapy (not prophylaxis)	
PLUS ONE OR MORE ORGAN DYSFUNCTION:	
Respiratory: SaO2 < 90%, Increase oxygen requirements, OR Invasive/Non-Invasive Mechanical Ventilation	SEPSIS + Organ Dysfunction = SEVERE SEPSIS
Cardiovascular: SBP < 90 OR MAP < 65 OR SBP decrease > 40 New Vasopressor OR Increasing requirements	
Metabolic: Lactate > 2 mmol/L	
Renal: Urine output < 0.5ml/kg/hr; Creatinine increase > 50% from baseline OR > 2 mg/dl	
Hematologic: Low platelets < 100,000/mm³ INR > than 1.5 or aPTT > 60 sec	
Hepatic: Serum Total Bilirubin > 2mg/dl	*Initiate Sepsis Bundle: Blood Cultures, Antibiotics, Repeat Lactate Level
CNS: Change in Mental Status (unrelated to primary neuro pathology)	
Ileus Present	
Lactate > 4 mmol/L and/or Hypotension post Fluid Bolus	**SEPTIC SHOCK** *30ml/kg Fluid Bolus

K. Panosian 10/12/2018

Severe Sepsis Antibiotics

Hang Broad Spectrum Antibiotics FIRST

Hang Vanco **LAST:** it takes 90 min to infuse

(The following applies to the initial dose of Antibiotic therapy for treatment of the Septic patient)

Broad Spectrum Monotherapy

If the following broad-spectrum antibiotics are ordered with a non-broad spectrum antibiotic, Hang 1 of the following First:

- **Cefepime (Maxipime)**
- **Ceftazidime (Fortaz)**
- **Levofloxacin (Levaquin)**
- **Ceftriaxone (Rocephin)**
- **Ampicillin/Sulbactam (Unasyn)**
- **Piperacillin/tazobactam (Zosyn)**
- **Imipenem/Cilastatin (Primaxin)**

Physician Guide to Combination Therapy

In order to meet CMS broad-spectrum antibiotic guidelines, if any of the following antibiotics are ordered, one from column A & column B must be paired together. Note: Both antibiotics must be started within 3 hours of severe sepsis.

COLUMN A

- **Amikacin (Amikin)**
- **Gentamicin (Garamicin)**
- **Tobramycin (Nebcin)**
- **Ciprofloxacin (Cipro)**
- **Aztreonam (Azactam)**

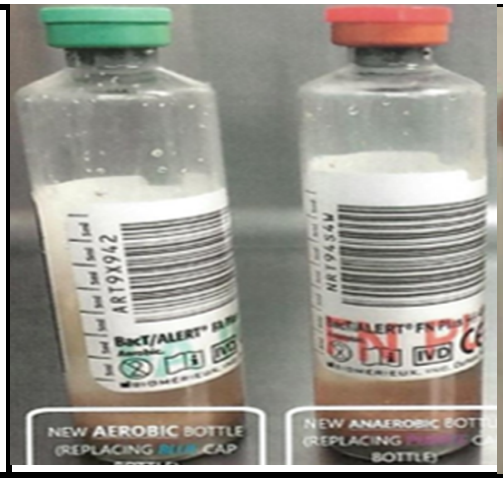
COLUMN B

- **Cefazolin (Ancef)**
- **Clindamycin (Cleocin)**
- **Daptomycin (Cubicin)**
- **Vancomycin (Vancocin)**
- **Azithromycin (Zithromax)**
- **Erythromycin (Erythrocin)**

Revised 10/23/18 KP

Order of Draw

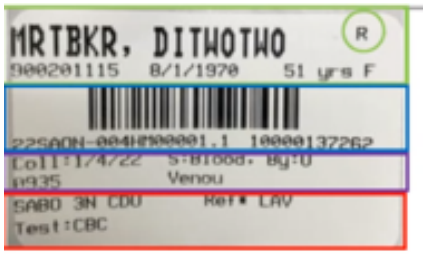
Lab # x3646



COMMON TESTS FOR EACH TUBE COLOR & TYPE

GREEN PST TOP TUBE		GOLD SST TOP TUBE	RED TOP TUBE	LAVENDER TOP TUBE
Basic Metabolic Panel		Thyroid Stimulating Hormone	Drug Levels	CBC / Hemogram
Comprehensive Metabolic Panel		Pregnancy Test/Beta HCG	Digoxin	ESR
Ionized Calcium		Hepatitis Panel/All Hepatitis Testing	Vancomycin	BNP
Sodium	Phosphorous	HIV	Salicylate	Platelet Count
Potassium	Lipase	C-Reactive Protein	Acetaminophen	Ammonia (on ice)
Magnesium	Creatinine	RPR		Hemoglobin A1C
Amylase		Mono		

ORANGE TOP TUBE	BIUE TOP TUBE	PINK TOP TUBE	GREY TOP TUBE
Troponin	Protime / PTT	Type & Screen	Alcohol (don't use alcohol prep)
	D-Dimer	X Match Units	Lactic Acid (on ice)
	Fibrinogen	ABO/Rh	



Medication Administration

Specimen Collection & POC Device Scanning

Blood Administration

FOR CLARIFICATION OF MISCELLANEOUS TEST CALL 53130

Trinity Health has historically used multiple delivery methods for insulin. It was determined that Trinity Health should align organizationally to one method for insulin delivery to decrease variation, optimize systems for safe and effective insulin delivery, and steward our resources through less medication waste. The Institute for Safe Medication Practices (ISMP) found that insulin pens and insulin prepared from vials were both acceptable.

Insulin	Type	How Dispensed
Insulin Lispro (HumaLOG)	Short-acting insulin; onset of action is 3-15 min	Shared multi-dose vial in Pyxis
Insulin Regular (HumuLIN R)	Short-acting insulin; onset of action is 3-15 min	
Insulin NPH (HumuLIN N)	Intermediate-acting insulin; onset of action is 2 hrs	
Insulin Lispro Protamine 75%/Insulin Lispro 25% (HumaLOG 75/25)	Combination (short and intermediate acting insulin); onset of action is 30 min	
Insulin NPH 70%/Insulin Regular 30% (HumuLIN 70/30)	Combination (short and intermediate acting insulin); onset of action is 30 min	
Insulin Glargine (Lantus)	Long-acting insulin; onset of action is 2hrs	Pharmacy prepares and dispenses patient specific doses

The process for drawing up insulin doses out of the shared multi-dose vial will be new for all nursing colleagues. It is important to follow the steps outlined below when removing insulin doses from Pyxis:

Short-Acting/Intermediate-Acting/Combination Insulin

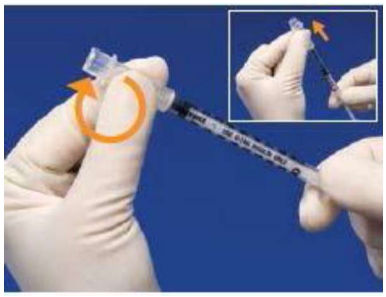
- Remove insulin for one patient at a time
- Apply barcode ready label found in Pyxis pocket to insulin syringe before drawing up the dose
- Check the expiration date on the insulin vial
- Draw up dose and **validate and verify** insulin drug and dose ordered
- Enter the dose removed (in units) into Pyxis
- Insulin vials cannot be removed from the Pyxis area

Long-Acting Insulin

- Patient specific long-acting insulin doses will be delivered to the floor before the dose is due. Make sure to validate and verify the dose ordered and dose dispensed to ensure patient safety.

Extra attention is needed when preparing and administering this medication, especially if different insulins could be retrieved from stock. Current policy requires a double check when retrieving insulin that is not under a specific patient profile in a Pyxis.

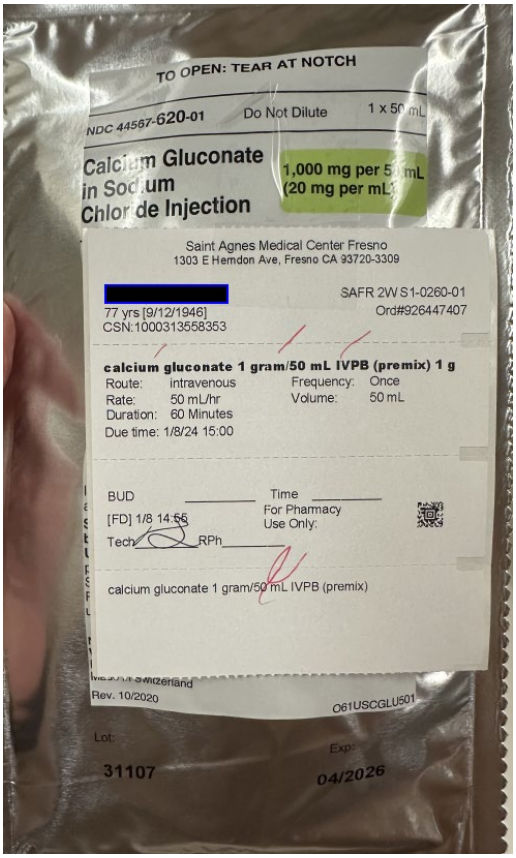
To transport syringe, extend the shield forward until you hear a click and feel the positive stop. The needle is now protected for transport but the syringe is not permanently locked.

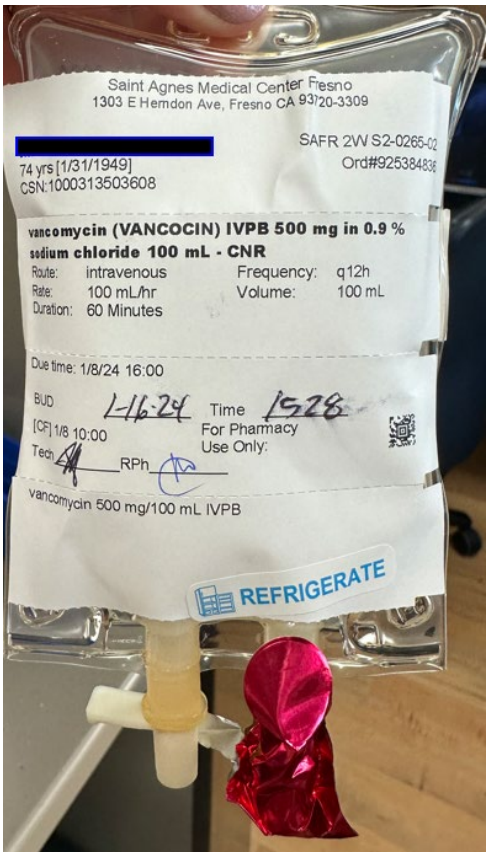


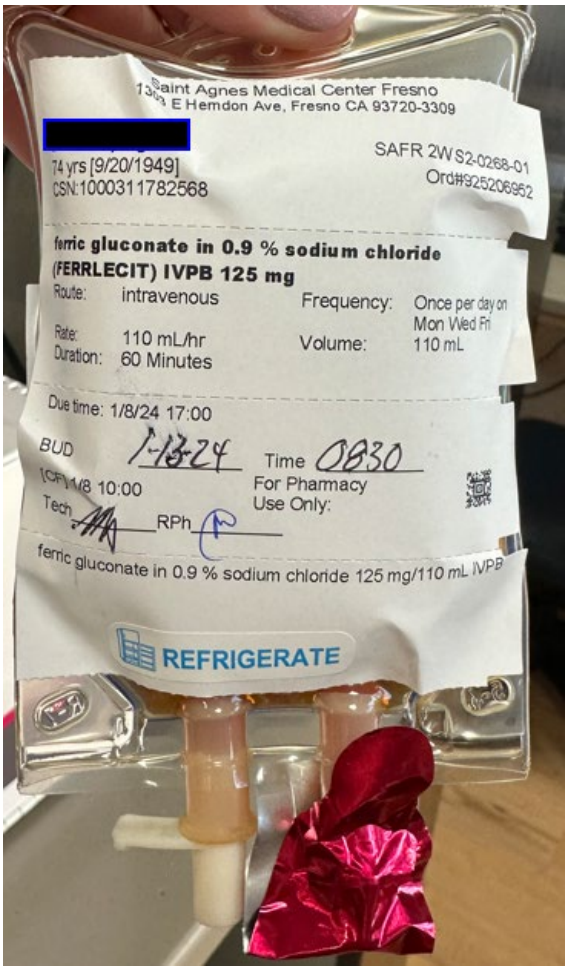
To permanently lock syringe, extend shield forward until it clicks, then twist the shield in either direction until it clicks again to indicate final-lock.

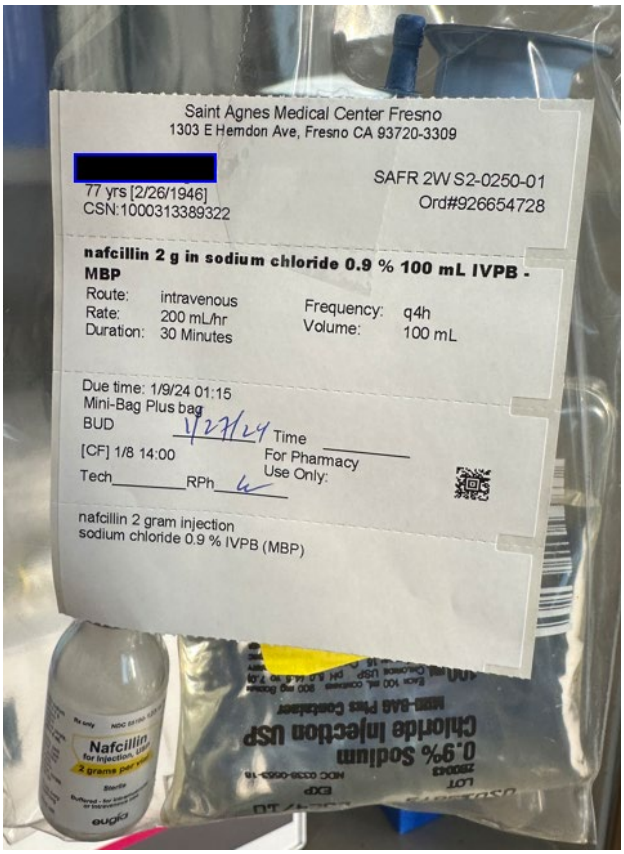
IV Medication Safety - Review labels thoroughly. Inspect bag thoroughly (front and back).

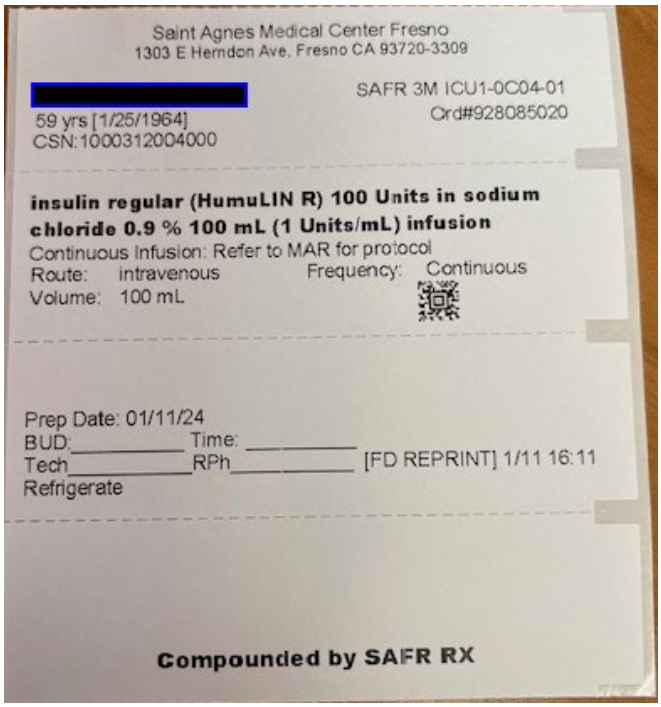
Patient name is marked out. Pharmacy hand writes the expiration date on the label










Saint Agnes Medical Center Fresno
1303 E Herndon Ave, Fresno CA 93720-3309

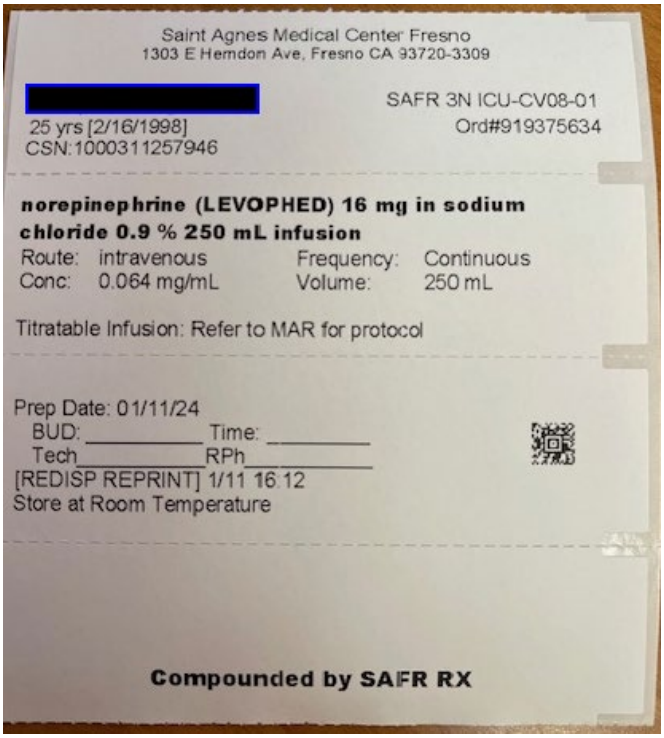
[redacted]
59 yrs [1/25/1964]
CSN:1000312004000

SAFR 3M ICU1-0C04-01
Ord#928085020

insulin regular (HumuLIN R) 100 Units in sodium chloride 0.9 % 100 mL (1 Units/mL) infusion
Continuous Infusion: Refer to MAR for protocol
Route: intravenous Frequency: Continuous
Volume: 100 mL

Prep Date: 01/11/24
BUD:_____ Time: _____
Tech_____RPh_____ [FD REPRINT] 1/11 16:11
Refrigerate

Compounded by SAFR RX


Saint Agnes Medical Center Fresno
1303 E Herndon Ave, Fresno CA 93720-3309

[redacted]
25 yrs [2/16/1998]
CSN:1000311257946

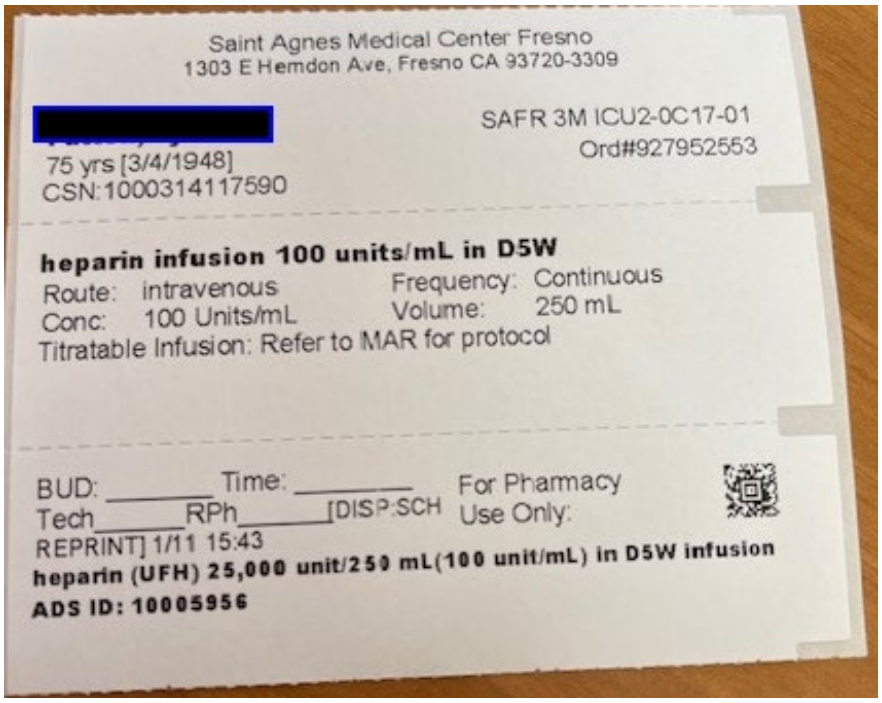
SAFR 3N ICU-CV08-01
Ord#919375634

norepinephrine (LEVOPHED) 16 mg in sodium chloride 0.9 % 250 mL infusion
Route: intravenous Frequency: Continuous
Conc: 0.064 mg/mL Volume: 250 mL

Titratable Infusion: Refer to MAR for protocol

Prep Date: 01/11/24
BUD:_____ Time: _____
Tech_____RPh_____
[REDISP REPRINT] 1/11 16:12
Store at Room Temperature

Compounded by SAFR RX


Saint Agnes Medical Center Fresno
1303 E Herndon Ave, Fresno CA 93720-3309

[redacted]
75 yrs [3/4/1948]
CSN:1000314117590

SAFR 3M ICU2-0C17-01
Ord#927952553

heparin infusion 100 units/mL in D5W
Route: intravenous Frequency: Continuous
Conc: 100 Units/mL Volume: 250 mL
Titratable Infusion: Refer to MAR for protocol

BUD:_____ Time: _____
Tech_____RPh_____[DISP:SCH
REPRINT] 1/11 15:43
For Pharmacy Use Only:
heparin (UFH) 25,000 unit/250 mL(100 unit/mL) in D5W infusion
ADS ID: 10005956

These are “High Risk – High Alert” (HRHA) drugs

*Note- There is no identifier on the label stating that this drug is HRHA

The EHR will prompt for dual sign off when required (HRHA medications).

It the RNs responsibility to review the drug label, infusion bag, order, patient identification (perform the 5 rights) and document in the EHR.

Recognizing and Reporting Impaired Physicians or Clinicians ...
That's not my job, or is it?

A central obligation of all care providers is to protect patients from harm. With this in mind, the medical staff and Saint Agnes Medical Center leadership are responsible to consider and address staff and physician health issues that might jeopardize hospital operations and/or compromise the quality or safety of patient care.

Clinician impairment may be related to physical, psychiatric, emotional illness, or substance abuse. A process has been established to address these types of issues through the Professional Practice Committee for physicians. For hospital staff member concerns, Human Resources guidelines can be found in the Employee Handbook.

Physician Related Concerns: One purpose of the Professional Practice Committee is to ensure that issues of physician impairment are handled in a sensitive, fair, uniform, and confidential manner with consistency and fair treatment in accordance with Medical Staff Bylaws.
Hospital Staff Related Concerns: Issues related to staff impairment will be dealt with in a similar manner in accordance with the Employee Handbook and state or federal laws.
What to watch for: Impairment can take many forms, but there are common signs or symptoms to watch for. It is important to look for trends in attitude, actions, and appearance. Signs of impairment typically emerge in the following areas: physical appearance, family and home, community, hospital, and employment history.

- Increased problems in quality of care, decline in clinical and/or technical skills
- Making rounds or taking breaks at odd or inappropriate times
- Inappropriate orders, lack of decisiveness, disjointed thoughts
- Consistently unavailable or inappropriate responses to phone calls
- Social withdrawal
- Missed appointments
- Repeated "illnesses"
- Smell of alcohol on their breath
- Tremors
- Needle tracks

Reporting:

- If a hospital staff member, medical staff member, or other care provider has reasonable cause to believe that a physician or hospital staff member is impaired, that individual should immediately contact the nursing supervisor, Human Resources, or one of the medical staff leaders (department chair, President of the Medical Staff, or Chief Medical Officer) and report the concern.
- You will remain anonymous.
- For physicians, if reasonable cause is established, the nursing supervisor or medical staff leader will contact the appropriate individuals (medical staff) who will determine whether suspension is warranted. For hospital staff members, if reasonable cause is established, the nursing supervisor will contact Human Resources who will work with the department manager to determine the appropriate level of corrective action.

There are resources available to individuals with mental health or substance abuse problems. Saint Agnes Medical Center encourages individuals with substance abuse problems to seek rehabilitation and may allow an individual to return to work after successful completion of a rehabilitation program. For further information, please contact Medical Staffing Office, Human Resources, or hospital leadership, or refer to the appropriate policies and procedures available on Docushare.

Abuse: Do You Know The Signs and Symptoms?

Staff Education

You play an important role in protecting patients from continued abuse. There are several different types of abuse. The type of abuse occurring may be one of or a combination of two or more of the following:

1. Physical neglect
2. Physical abuse
3. Emotional abuse
4. Psychological abuse
5. Financial abuse
6. Sexual abuse

Mandated Reporters: Certain individuals working with the public are identified as "mandated reporters". These individuals have a legal responsibility to report to the appropriate agency any signs or symptoms of abuse or neglect. Health care professionals are mandated reporters. This would include, but is not limited to, physicians, nurses, emergency clinical technicians, paramedics, clinical social workers, pharmacist, and other allied health professionals.

- It is critical to identify suspected victims of abuse.
- Patients should be assessed for signs of abuse on admission and throughout the continuum of care.

Consider the following:

Indicators of Physical Abuse:

1. Multiple injuries at various stages of healing
2. Patient seen repeatedly in the Emergency Department
3. Fractures that require significant force, or that occur rarely by accident
4. Significant delay between time of injury and seeking help

Indicators of Physical Neglect:

1. Evidence of poor health care such as untreated infections, pressure ulcers or contractures, over medication or under medication, dehydration or malnutrition
2. Poor personal hygiene, especially teeth; presence of lice or fleas
3. Missing or broken assistive devices, such as glasses, dentures, hearing aids

Indicators of Emotional Abuse:

1. Depression, low self-esteem, unusual fearfulness, hunger for attention and socialization
2. Suicide attempts
3. Being quiet when caregiver is in room
4. In children, slow emotional and intellectual development, especially language
5. In older children, drug or alcohol addition, vandalism, school absenteeism

Indicators of Financial Abuse:

1. Nonpayment of utilities, unexplained loss of income
2. Pressure to endorse checks
3. Unanswered mail and bills, and uncashed checks
4. Money or access to job withheld

Indicators of Psychological Abuse:

1. Psychological abuse happens by instilling fear
2. Feeling that self or children are threatened, blackmail, destruction of pets or property, harassment

Indicators of Sexual Abuse:

1. In children and elders: sexually transmitted disease, recurrent UTI
2. In adolescents: pregnancy

Behavioral Indicators of Abuse in Children and/or Adolescents:

1. Excessive daydreaming
2. Regressive behavior such as bed wetting
3. Running away from home
4. Profound and rapid personality change
5. Rapidly declining school performance

What to do:

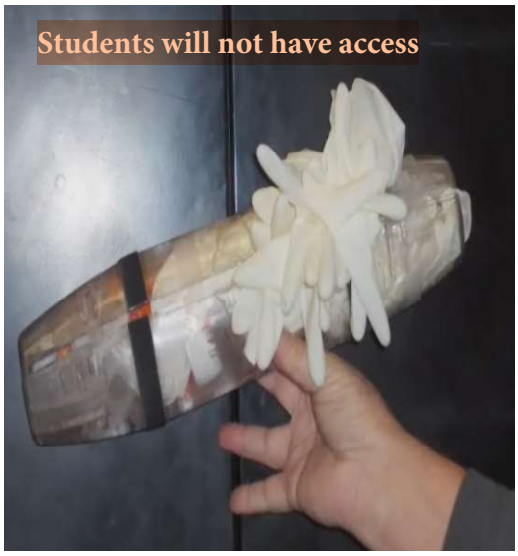
- Anytime any indicators of abuse are present, notify SAMC's Social Services Department, Ext, 3158. Social Services will coordinate an investigation and determine if evidence suggesting abuse exists
- Assist the physician with any necessary assessments
- Provide a safe and supportive environment:
  - With patient permission, limit visitors and/or telephone calls
  - Identify if there are any restraining orders in effect: notify SAMC Security if appropriate
  - Separate victim from suspected abuser
  - Provide one consistent caregiver when possible
  - Remain with victim as much as possible
  - Reassure victim of their safety
- Reporting:
  - In all cases of suspected abuse, Social Services will make an immediate telephone report to police or sheriffs department and/or the appropriate county protective services agency.
  - Refer to Patient Care Policy and Procedure, A-30, Suspected/Abused Child or Adult, for guidance
  - Whenever a telephone or verbal report is made, a written report must be sent to the appropriate agency/agencies within 36 hours
  - If Social Services has not documented in Powerchart that a report has been completed, contact them to do so
- Provide Community Resources:
  - Social Services will provide appropriate community resources
  - Safe placement may be offered by law enforcement and/or protective agency

Review:

1. The following individuals are mandated reporters:
   a. Clinical Social Workers
   b. Nurses
   c. Physicians
   d. Paramedics
   e. All of the above
2. All patients should be assessed for signs or symptoms of abuse upon admission and ongoing throughout their hospitalization.
   a. True
   b. False
3. A telephone report to SAMC's Social Services Department is necessary when you suspect a case of abuse.
   a. True
   b. False

Pneumatic Tube System

Dos and Don'ts to save time and frustration



Reduce Downtime:

- Loose items (like gloves) are sucked out of the carrier and melt into the tube.
- Packaging issues cause 99% of the downtime and are preventable. System can be down for hours and hours.

How to Package an item:

- Select a carrier that has black velcro strips that are not worn/smooth.
- Secure lids on all specimens
- Double bag ALL specimens, ensuring zip lock bags are sealed to contain spills.
- Nothing should protrude from carrier
- Both latches must be closed completely.

Dos

- DO make sure that the carrier is latched completely and properly.
- DO make sure that nothing is protruding from the carrier prior to sending to prevent blockage and system failure.
- DO make sure that all Patient samples are double bagged and bags are sealed tightly to prevent leakage.
- Do make sure that specimen containers such as urine samples are closed tightly to prevent leakage.
- DO immobilize item (use foam or towel) to ensure integrity
- DO bag everything that is sent through the system.
- DO return surplus carriers to station "0" promptly as soon as your carrier count reaches your assigned maximum count
- DO place samples in inside bag, place into another bag and seal. If sending paperwork with sample, place inside the outside bag prior to sealing to avoid possible contamination due to leakage.

Don'ts

- DON'T overload the carrier. If you are stuffing the carrier and struggling with closure, it is over-filled.
- DON'T send money, checks or vouchers.
- DON'T forget to place item in a sealed double bag system.
- DON'T send more than one carrier at a time. You must wait until the first carrier leaves station before sending another one.
- DON'T send food or drink items.
- DON'T send formalin or formalin preserved specimens.
- DON'T send CSF or other difficult to collect specimens
- DON'T send emerging disease specimens
- DON'T place your hands in carrier loading area if there is an incoming carrier
- DON'T send electronics (cell phones, pagers, etc.)

Saint Agnes Medical Center
Competency Assessment

Soft Limb Restraint Application

This document is to be used in conjunction with the new employee's orientation packet and/or ongoing employee education. For new hire review: Sign/Date the orientation packet when you use this competency checklist to review or demonstrate how to perform **Soft Limb Restraint Application**.

CRITICAL ELEMENTS
CRITICAL THINKING / KNOWLEDGE
1. **Policy & Procedure:** RESTRAINT/SECLUSION FOR PATIENT SAFETY, Index C-9
2. Restraints are applied by trained staff following manufacturer's instructions as outlined below.
TECHNICAL / SKILL
1. Attach the female end of the quick-release buckle (short strap) to an unmovable part of the bed frame, out of the patient's reach. (There are 2 hooks on each side of the hospital bed designed for restraint application Do not attach to side rail or head/footboard). Secure by feeding the female end through the loop in the strap.
2. Insert the male end of the cuff strap into the female end of the short strap. Listen for a "snapping" sound. Pull firmly on straps to ensure a good connection. To limit unwanted adjustment, tie an overhand knot with the excess strap directly below the quick-release buckle.
3. Wrap the limp holder cuff around the patient's wrist/ankle so the buckle and connecting strap is on the ulnar side of the wrist (opposite the thumb) or lateral malleolus (outer side) of the ankle.
4. After securing the Velcro to the top of the cuff. Slide ONE finger (flat) between the cuff and the inside of the patient's wrist or ankle to ensure proper fit. The strap must be snug, but not compromise circulation.
5. Close the quick-release buckle on the cuff. Insert ONE finger (flat) under the buckle and pull the strap snug, but not so tight as to restrict circulation.
6. Release the quick-release buckle, twist buckle 180°, and reconnect. Listen for a "snapping" sound.
7. Attach the Velcro at the end of the cuff strap to the "fuzzy" backing on the cuff to keep the quick-release buckle from sliding.
8. Adjust the bed strap(s) to allow desired freedom of movement, without compromising patient or caregiver safety.
9. To remove cuffs, unsnap quick-release buckles and release Velcro fastener.
INTERPERSONAL / ATTITUDE
1. When restraints are required, they are managed in such a manner that the rights of the patient are promoted, patient dignity is maintained as much as possible, and inherent risks are minimized.

Reference:
Posey® Limb Holders 2532, 2551 Application Instructions for Wrist and Ankle.
9.21.20 - I9277 Limb Holder 2532 2551 IFU 022119 (webareacontrol.com)

NEW Color-Coded Wristbands

The national standard

Red means Allergy Alert!

An allergy to anything – food, medicine, latex, dust, grass, pet hair, etc. – should be documented. The wristband reminds caregivers to check the allergy before delivering food, medicine or other aspects of care. This is very important to avoid unpleasant or serious reactions.

Purple means "Do-Not-Attempt-Resuscitation Order" has been written by the physician.

When patients have expressed an "end-of-life" wish, the hospital and its caregivers want to honor it. When a DNAR order is written, staff will transcribe the specific type (*Full, Limited, or Comfort*) on the wristband.

Yellow means Fall Risk.

Nurses continuously assess patients to determine if they need extra attention to prevent a fall. Sometimes a person may become weakened due to illness or because of a recent surgery. This wristband indicates that this patient needs to be assisted when walking to avoid a possible fall.

Pink means Restricted Extremity.

Some patients have past or current conditions that would prohibit the use of a certain extremity for various reasons. This wristband will alert hospital staff to not use this extremity for blood draws, IV insertion or other medical procedures.

Green means Latex Allergy.

If a patient has an allergy to latex, it is very important to alert hospital staff. Many products used in hospitals are "latex-free"; however, some products may still be made from latex. Contact with these items can cause an allergic reaction. Other nonlatex products can be substituted for use when a patient has a latex allergy.

Blue with Blood Bank Info means either prior blood drawn as an outpatient or wristband applied in the ED.

Keep this wristband on the patient. It can be utilized to verify accurate patient identification if a blood transfusion is ordered or during a downtime.

~~White with Blood Conservation means patient has specific requests for blood use.~~

~~If a patient's refusal to use blood/blood products is not absolute (i.e., agrees to transfusion only as a life-sustaining measure after all other nonblood interventions have been used), this wristband is used to alert duties to these wishes.~~

White with NO Blood means patient DOES NOT receive a blood transfusion.

If a patient refuses a transfusion under any circumstance, this wristband will be applied.

COMMITTED to Patient Safety

CODE RED - FIRE

A fire alarm, sprinkler or smoke detector has been activated at the medical center. Remember R.A.C.E. for proper response to the fire Rescue – Alarm (call 3300 and activate pull box) – Contain – Extinguish and P.A.S.S. for appropriate steps in using a fire extinguisher. Pull – Aim – Squeeze – Sweep

Refer to Safety Manual Policy ER005

CODE YELLOW - BOMB THREAT

All Staff members are asked to search their own area for unusual items but do not touch them. Call 3300 if you find something suspicious or if you receive the bomb threat. Do not use cell phones and 2-way radios until your area has been cleared.

Refer to Safety Manuel Policy ER006

CODE BLUE - CARDIAC/RESPIRATORY ARREST

If a patient is in need of resuscitation press Code Blue button or call 3300. A designated team and an available physician will respond.

CODE ORANGE - HAZARDOUS MATERIAL SPILL

A significant hazard materials release, either within the hospital or in the community. The decontamination team will report to an announced location. Staff not assigned to the decontamination team should avoid the area if at all possible.

Refer to Safety Manuel Policy ER003

CODE PINK - INFANT OR PEDIATRIC ABDUCTION

STOP, LOOK AND BE AWARE

Detain any suspicious person and call 3300 an/or press the Door Exit Alarm (Code Pink button) twice. Door Exit Alarms are located near the exits in the Main Building and the West Wing.

Refer to Safety Manuel Policy ER007

CODE SILVER – HOSTAGE/WEAPON SITUATION

If there is a weapon or hostage situation, Code Silver will be announced with a location. Security will respond to barricade the area. Staff in the immediate area will attempt to get patients, visitors and themselves to safety behind closed doors.

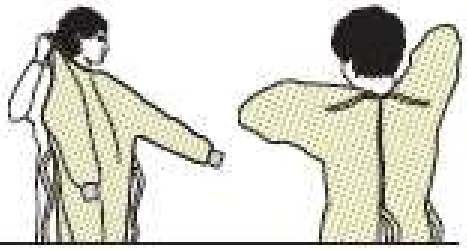
Refer to Safety Manuel Policy ER012

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

1. GOWN

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



2. MASK OR RESPIRATOR

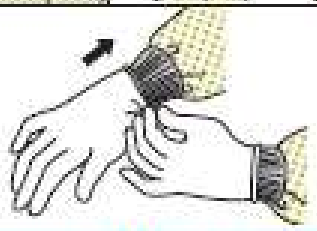
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



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

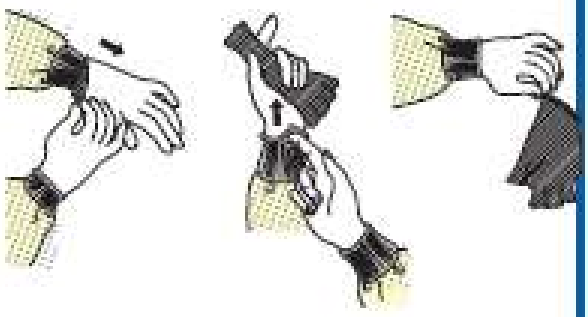
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

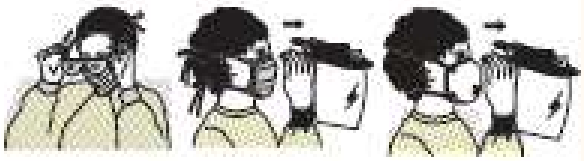
1. GLOVES

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



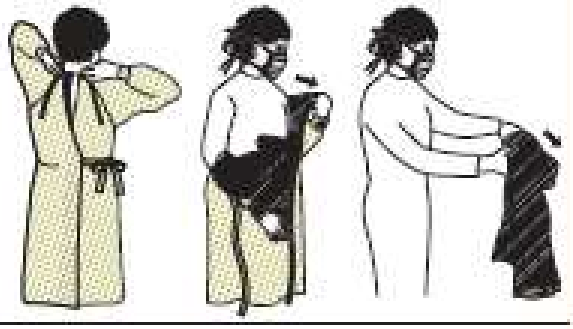
2. GOGGLES OR FACE SHIELD

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



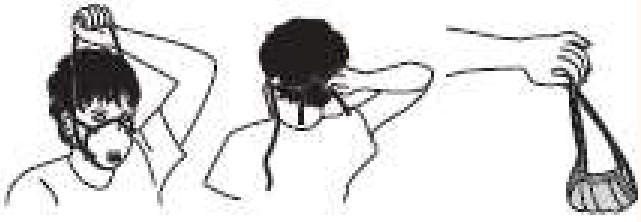
3. GOWN

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



4. MASK OR RESPIRATOR

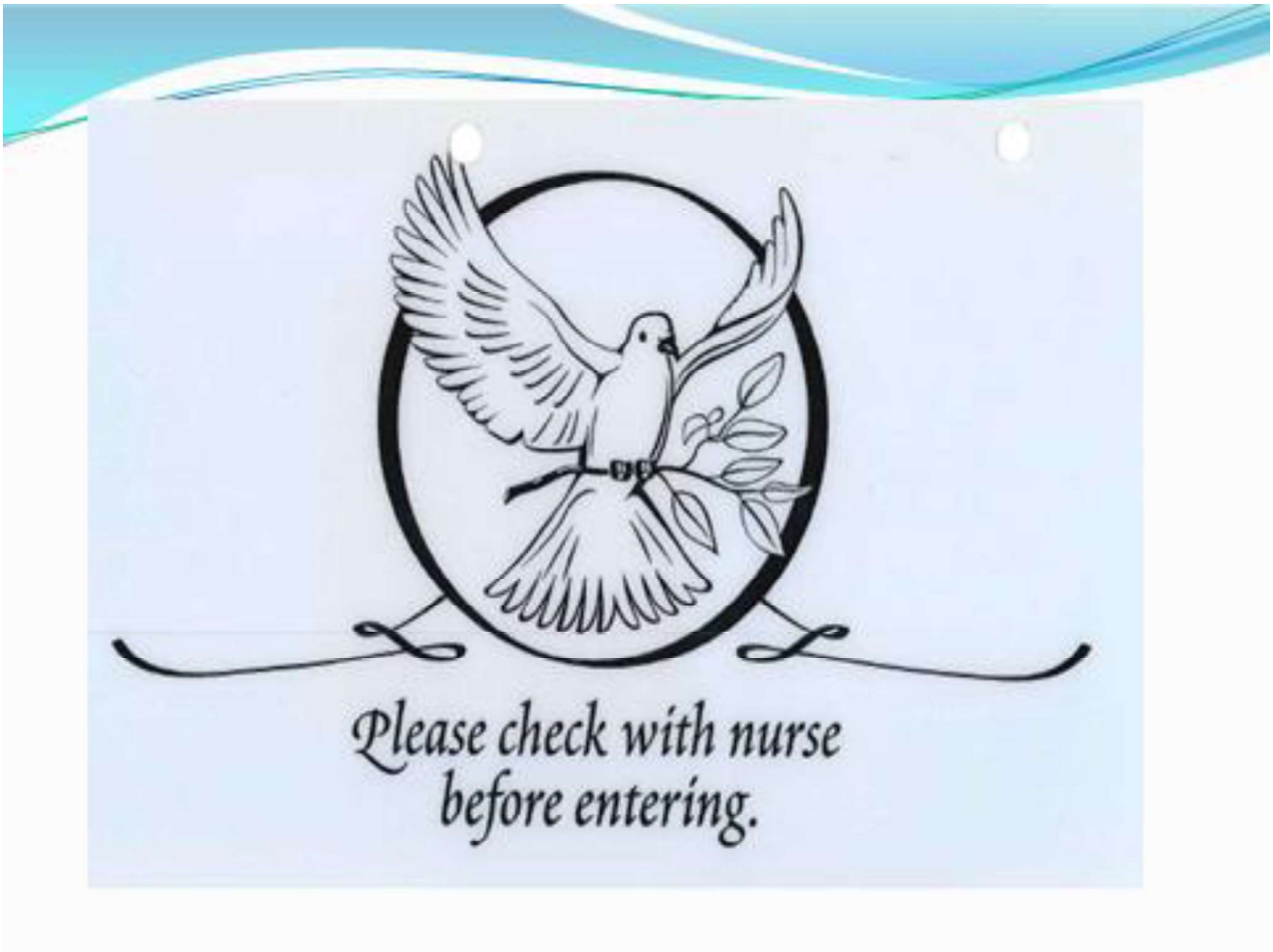
- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container



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

CDC

Dove sign indicates deceased patient in room



When to Activate an RRT?

The person at the bedside determines that the patient is clinical unstable, at high risk of deterioration, or has an acute change in one or more of the following:

- –Staff member, patient or family, “worried” about the pt
- –Heart rate less than 50 or greater than 120
- –Systolic BP less than 90mmHg or more than 180mmHg
- –Respiratory rate less than 8 or greater than 30
- –Ox sat, less than 90% or needing increased O2
- –Urine output less than 60 ml in 2 hours
- –New or prolonged seizure activity
- –Acute significant bleeding
- –Chest pain
- –New onset SOB
- –Unexplained agitation or altered mental status that requires immediate intervention
- –Perception that the patient requires prompt intervention to prevent further deterioration.

The staff member notifies the PC and

calls the RRT ext 3300

Updated Ext. 5-3300

Oxygen and Cylinder Safety

- Cylinders must always be:
  - In a rolling cart
  - Chained to a wall
  - Securely strapped to a gurney
  - Full or empty – see to it that the cap is on, straight and snug
  - **Never** – leave cylinders standing alone…they must be secured
  - **Do NOT** – ever place oxygen tank next to the patient in bed or on a gurney
  - **Do** stow away the tank in tank space under the gurney or hang it from the bed
  - Cylinders have a digital display
    - Shows remaining time of oxygen in HOURS:MINUTES at the set flow rate
    - Recalculates if flow rate is increased or decreased
  - Audible alarm occurs
    - When tank is 1/4 full
    - When there is only 15 minutes remaining
    - Continues alarming q15sec until empty or turned off

- **Oxygen is a medication and a potential missile propeller**
  - Oxygen restrictions for non-licensed staff.