ADVANCE DIRECTIVES DNR & POLST

Alexian Brothers Health System

PLANNING FOR CARE

- Advance Directives: Requesting Copies/ Follow Up
- POA- Health Care/Living Will
- Acting on behalf of the patient wishes/not own!
- Decisional Capacity & Qualifying Condition
- **ABMC requirements vs SAMC for Surrogacy**
- **Completion of Surrogate Form: 2 Physicians + Witness.**
- Illinois Surrogate Act

(1) the patient's guardian of the person;
(2) the patient's spouse;
(3) any adult son or daughter of the patient;
(4) either parent of the patient;
(5) any adult brother or sister of the patient;
(6) any adult grandchild of the patient;
(7) a close friend of the patient;
(8) the patient's guardian of the estate.

DNR STATUS

- In no way influences level/standard of medical and nursing care provided
- DNR only addresses if heart/breathing stops- do we resuscitate or not?
- NO MENU DNR
- All or Nothing
- Suspension for Surgery/Anesthesia

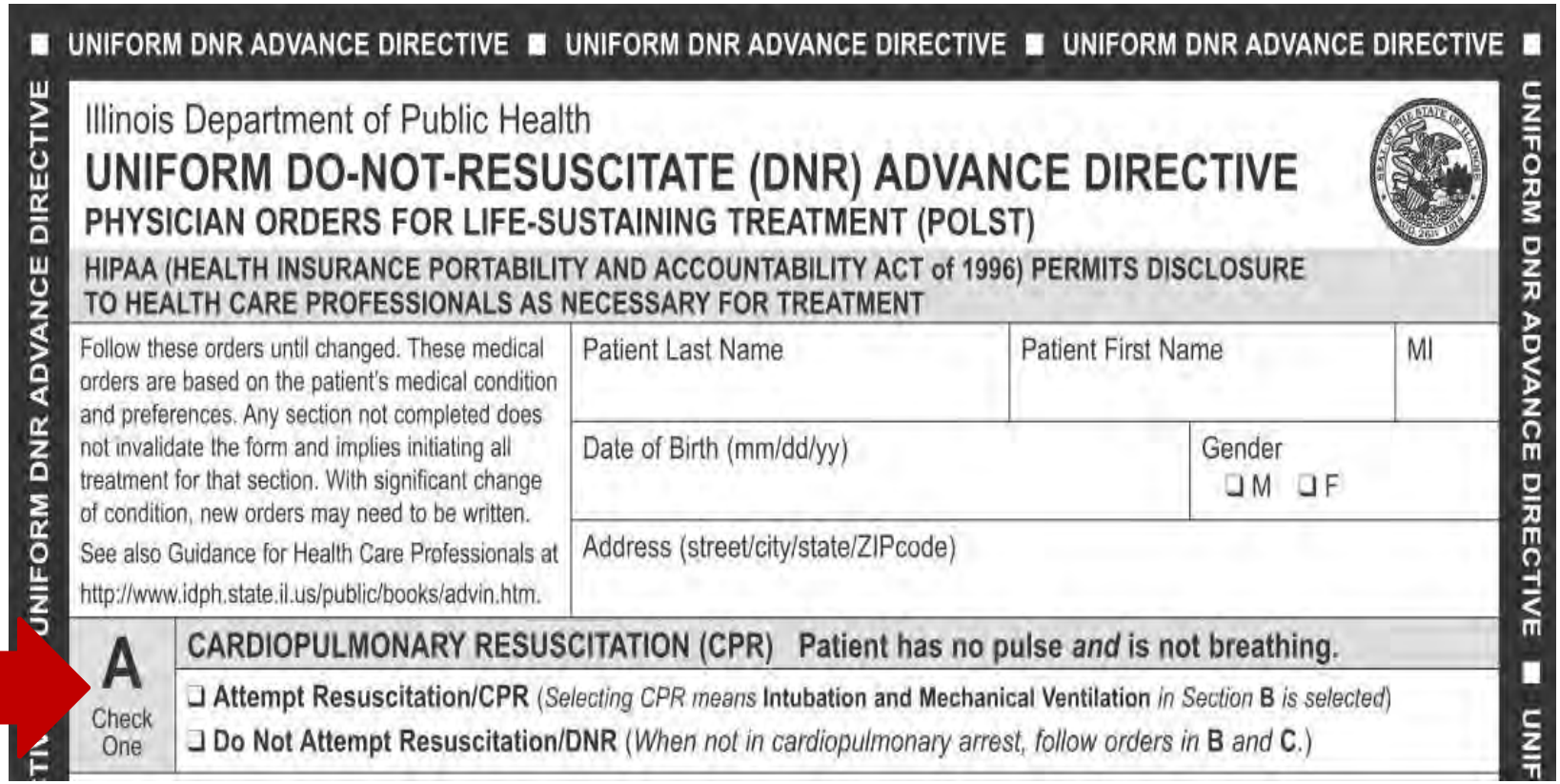
DNR ORDERS AT ALEXIAN

- Use of State Form/POLST
- Admission of Patient with POLST form/ Procedure
- Inpatient Procedure for DNR status & Pre Arrest Options
- Changes to DNR status

MAJOR POINTS FOR NURSES AT ABHS

- Purpose of this new State of Illinois form is planning end of life wishes…. Hence, that is why the State form **now includes an option for Full Resuscitation/CPR,** Artificial Nutrition, etc…
- Always review the form carefully since up until now anyone with a state DNR form was assumed to be NO CODE; Now – no assumptions can be made.
- The Color of the State Form is "Hot Pink"

Intro to Illinois's new idph uniform
DNR Advance Directive



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Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written.

See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advin.htm.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A Check One

CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse *and* is not breathing.

❑ **Attempt Resuscitation/CPR** (*Selecting CPR means* **Intubation and Mechanical Ventilation** *in Section* **B** *is selected*)

❑ **Do Not Attempt Resuscitation/DNR** (*When not in cardiopulmonary arrest, follow orders in* **B** *and* **C**.)

MAJOR POINTS CONT…

- Its not about a FORM- the form helps guide a CONVERSATION.
- Intended for patients with serious/chronic conditions with life expectancy 1 year
- The State Form- is a valid medical order and must be honored… even if previous version of the form is used…even if MD who signed it is NOT on staff at our hospital.
- As soon as practical, the inpatient DNR/pre-arrest orders should be entered in Alexicare by the physician or TORB as the State Form is not intended to be used as inpatient DNR orders.

Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

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Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse *and* is not breathing. (Check One)

- ❑ **Attempt Resuscitation/CPR** *(Selecting CPR leaves* **Intubation and Mechanical Ventilation** *in Section* **B** *is selected)*
- ❑ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS Patient has pulse and/or is breathing. (Check One)

- ❑ **Comfort Measures Only** (Allow Natural Death): Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.* **Treatment Plan: Maximize comfort through symptom management.**
- ❑ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**
- ❑ **Intubation and Mechanical Ventilation** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Life support measures, including intubation, in the intensive care unit.**
- ❑ **Additional Orders** _____

C — ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired. (Check One (optional))

- ❑ No artificial nutrition by tube.
- ❑ Defined trial period of artificial nutrition by tube.
- ❑ Long-term artificial nutrition by tube.

Additional Instructions (e.g., length of trial period)

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

- ❑ Patient
- ❑ Parent of minor
- ❑ Agent under health care power of attorney
- ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E — SIGNATURE OF ATTENDING PHYSICIAN

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Physician Name *(required)*	Phone ( ) _____ - _____
Attending Physician Signature *(required)*	Date *(required)*

UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is **always voluntary** and is for persons with advanced or serious illness or frailty. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	**Date Prepared**

Completing the IDPH Uniform Do Not Resuscitate (DNR) Advance Directive Form

- **The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

IDPH 13-501

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

CTIVE ■ UNIFORM DNR ADVANCE DIR

B
Check One

MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.

❑ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.* **Treatment Plan: Maximize comfort through symptom management.**

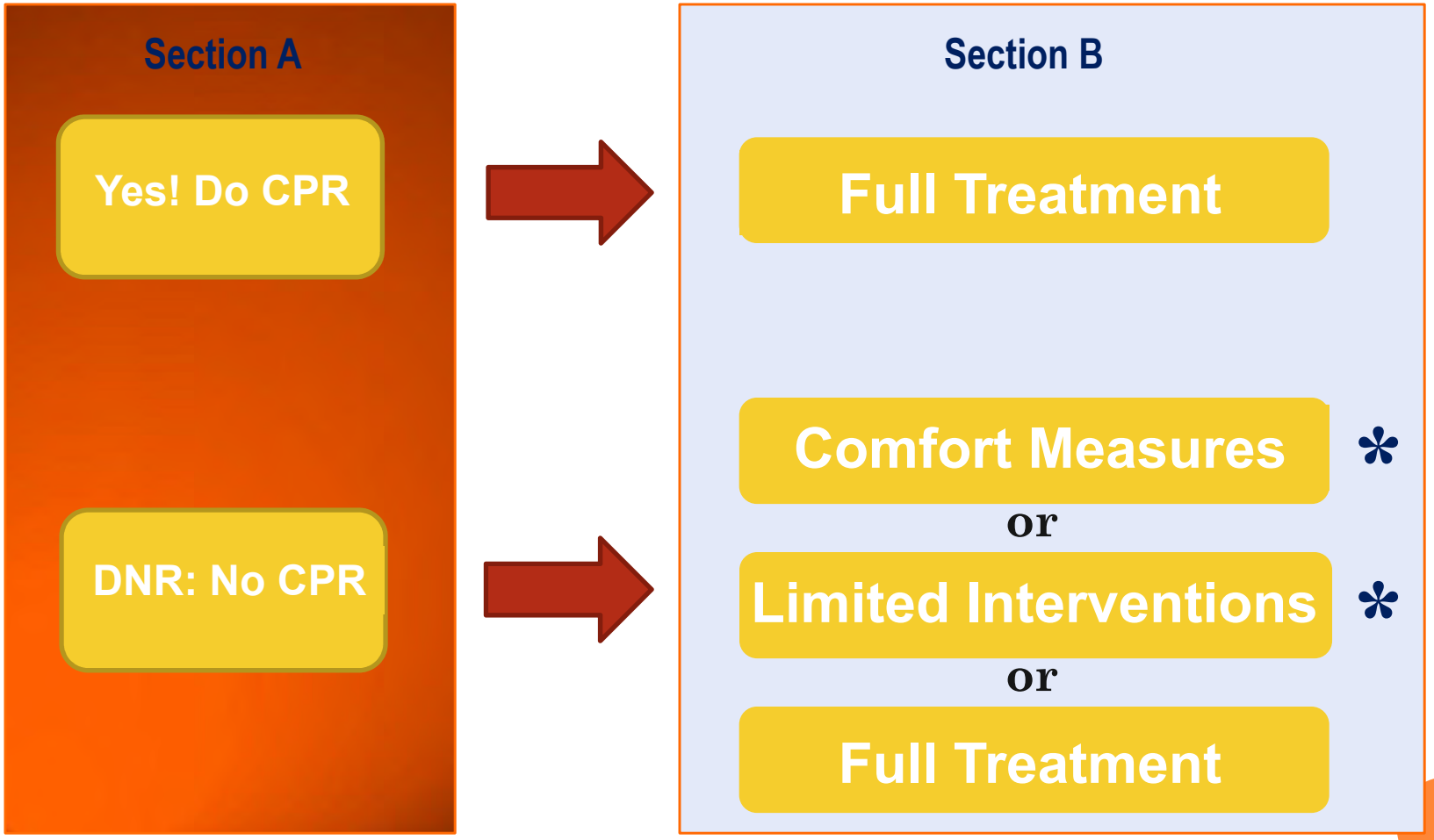
❑ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**

❑ **Intubation and Mechanical Ventilation** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Life support measures, including intubation, in the intensive care unit.**

❑ **Additional Orders** _____

M DNR ADVANCE DIRECTIVE ■ UNIFO

Section "A" choices influence medical interventions in Section "B"



**Requires documentation of a "qualifying condition" ONLY when requested by a Surrogate.*

Requirements for a VALID FORM

- Patient name
- Resuscitation orders (Section “A”)
- 3 Signatures
  - Patient or legal representative
  - Witness
  - Physician (revision Jan 2015- NP’s, PA’s may sign… we await revised form)

- All other information is optional
- Pink paper is recommended to enhance visibility, but color does not affect validity of form
- Photocopies and faxes ARE acceptable.

MAJOR POINTS CONT…

- Phone orders may be taken by RN's for inpatient DNR/Pre-Arrest
- Highly recommend a nursing note is also entered into the record when phone consent is obtained since if Alexicare is used, there is no where to document the nurse witnessing the DNR order.
- ABHS practice: Phone Orders are NOT permitted on the State DNR/POLST Form, **MUST be signed by the physician prior to leaving/transferring from our facility as per the State of Illinois** "A completed form that does not contain the signature of an attending physician is NOT valid."

MAJOR POINTS CONT…

- **Original copies are given to patient upon discharge**.. Copies are made for our medical records.

CHANGES CONT…

- **DNR means if patient is in cardiopulmonary arrest, NO CPR, NO intubation, No Electrical interventions…**

  DNI, chemical code, CPR only etc… are NOT acceptable orders!

- **DNR OR FULL CODE ARE THE ONLY OPTIONS**

  However, a patient who is DNR may have specific PRE-ARREST WISHES for situations of clinical instability. :

PRE ARREST OPTIONS

1. **Vasopressor Meds-** if they are hypotensive
2. **Antiarrhythmic Meds-** to treat rhythm disturbances
3. **Intubation**- situational/short term

OR None of the above-

The patient may want Comfort Care only if they are DNR and become clinically unstable.

PRE-ARREST options should be discussed with the patient by the physician and can be ordered as "PRE ARREST" interventions; this can provide useful direction to nursing and rapid response staff.

FORM USE

- In Alexicare, DNR status & Pre Arrest Options can be seen in the Patient Banner
- Always pass on DNR status and Pre-Arrest choices (if applicable) during Nursing Report!
- State DNR form should be placed under “Advanced Directives Tab” in chart.
- If any changes are made in DNR status or wishes, the current form needs to be voided, and a new one completed.
- Social Services can Assist with any Advance Directives Completion. At ABMC: Spiritual Services as well!


Advance Directives
Making Choices for Safe Landings!

MISSION & VALUES

AMITA HEALTH™

Adventist Midwest Health

&

Alexian Brothers Health Systems

A Joint Operating Company

Welcome to a partnership that marks a new beginning in healthcare - **AMITA Health**

2015

- Two great health systems have joined together - Adventist Midwest Health and Alexian Brothers Health System. A new beginning, with opportunity that treasures and respects our faith traditions, past accomplishments and more profoundly realizes our sacred missions.
- 5 Alexian Hospitals & 4 Adventist Hospitals = ONE

AMITA HEALTH™

OUR RICH HISTORIES

- **Alexian Brothers Health System** has its roots in the Gospel and the Catholic religious congregation known as the Alexian Brothers. Their 800-year Catholic mission of reaching out to the poor, sick and dying, especially the marginalized and powerless, led to their first hospital in Chicago in 1866, when Brother Bonaventure Thelan carried the first patient from the streets to a small wood-framed house on Dearborn Street. It has since expanded to be a vibrant health system in the northwest suburbs of Chicago, part of Ascension Health, the nation's largest Catholic and non-profit health system.

OUR RICH HISTORIES

- **Adventist Midwest Health** goes back to 1866, when the Seventh-day Adventist Church established the Western Health Reform Institute in Michigan. From that first "Sanitarium," 1,000 Adventist hospitals and clinics have served around the globe, including Chicago, since 1904. "To Extend the Healing Ministry of Christ" is to care for the physical ailments of patients, and more. Our care reflects the ministry of Jesus Christ, who cared totally (body, mind, and soul) for whomever was before him. Adventists have been pioneers in preventative health ministry, promoting practical principles to create a healthier and longer life.

2015

- NOT a merger.
- The Alexian Brothers Hospitals continue to be owned by Ascension Health- the largest Catholic Healthcare system in the United States with nearly 130 hospitals in 23 States.

ASCENSION HEALTH

J.O.C.

- What is a Joint Operating Company (JOC)?

A Joint Operating Company (JOC) allows two separate owners to integrate their operations to achieve a common goal while maintaining separate ownership of their assets. The JOC will allow Alexian Brothers Health System and Adventist Midwest Health to work in unison while preserving the Catholic and Adventist identities and mission priorities that define Alexian Brothers and Adventist, respectively.

The Alexian Brothers hospitals continue to be bound to the Ethical and Religious Directives for Catholic Healthcare Services.

- **How was the name AMITA Health chosen?**

It was important to us to choose a name that reflects our shared values and long histories of serving the health needs of our communities. With the guidance of an agency that specializes in healthcare branding, representatives from across our new company came together and gained a deep understanding of both organization's brands, missions, patients and associates in order to create a powerful, emotionally resonate and sustainable brand. More than 2,000 words, combinations and potential names were developed to reflect the mission and goals of the group.

OUR CORE VALUES

- Friendship
- Truth
- Mutual Respect

MISSION

- Faith based call to Healing
- **A Sacred Mission- extending the healing ministry of Jesus Christ.**
- **Caring for patients, families, and communities.**

WORKING FOR, AMITA HEALTH™ YOU HELP US FULFILL OUR MISSION- THANK YOU !

Bedside Handoff

Expectation: every RN at every shift handoff

Goals:

- Improve patient safety
- Improve the patient experience (every patient deserves a good handoff)
- Support consistent, high quality, accountable handoff (every nurse deserves a good handoff)

Must haves: Report

- is at the bedside and includes use of the WOW
- involves the patient and/or family
- is SBAR format (Situation, Background, Assessment, Recommendations)
- Includes checking key clinical care components **together** i.e. IV sites, drips, devices, etc…
- Utilizes a clinical care components checklist
- Incorporates the use of and updates the White Board

Clinical Care Components: "what does it look like", confirms what is being said in handoff is what you see

- Tubes/drains (where, what is draining, issues?)
- NG (to suction? to feeding?)
- Chest tube (suctions amount? Drainage? Air leak?)
- Oxygen (settings?)
- Trach (extra trach? Ambu bag? Suction set up?)
- Pressure ulcers? (Where and what stage)
- Wounds and dressings (dry and intact; dated and current?)
- Wound Vac
- Central line dressing (dry and intact? dated and current? swab caps on?)
- IV tubing (dated and current? swab caps on?)
- IV site (look ok? current?)
- Infusions: IV's/ PCAs/Epidurals (what is running, correct dose/rate?)
- SCDs (are they on? Why not?)
- Foley (bag with dated sticker? what is the indication? Can it come out? On the Nurse driven protocol? Bag off of floor? stat locked?)
- Fall Risk (bed alarm on? Signage posted?)

White Board: Is it up to date? Pain meds addressed: assessment and last dose given? Discharge plan/goals current?
Visual room inspections before leaving: call light, urinal, phone, all within reach? clutter?

Metrics:

- **HCAHPS Communication with Nurses**: consistently score 77.67 or higher
- **CLABSI Bundle**:100% for dressing dated and current, dressing dry and intact, and tubing labeled and current
- **Foley Days**

Bedside Handoff: The Hands On of Hand Off

Clinical Care Components Guideline/Checklist Tool:

- Tubes/drains
- NG
- Chest tube
- Oxygen
- Trach
- Pressure ulcer: staging
- Wounds and dressings
    - dry and intact
    - dated and current
- Wound Vac
- Central lIne dressing
    - dry and intact
    - dated and current
    - swab caps on
- IV tubing
    - dated and current
    - swab caps on
- IV site
    - appearance
    - current
- Infusions: IV's/ PCAs/Epidurals
    - right drug
    - right dose/rate
- SCDs
- Foley
    - bag with dated sticker
    - indication
    - plan for d/c
    - nurse driven protocol
    - bag off of floor
    - stat lock
- Fall Risk
    - bed alarm on
    - signage posted
- White Board
    - pain assessment/time pain medication last given
    - discharge plan/goals for the day completed
    - updated

- Visual room inspection

CLINICAL CODES

SAINT ALEXIUS MEDICAL CENTER

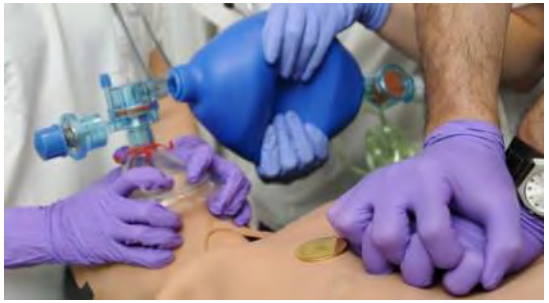
ALEXIAN BROTHERS MEDICAL CENTER

ACTIVATION OF ALL CLINICAL CODES

- DO NOT CALL THE OPERATOR
- DIAL **911** with the exception of RRT
- RRT activation at ABMC: DIAL 7787 Rapid Response Team Response RRTR (7787)

CODE BLUE

- Called for all patients, visitors, employees found to be <u>without pulse or without breathing!</u>
- CALL 911- or hit Code Blue Button if applicable.
- Bring Crash Cart to the room asap
- Immediately Begin CPR- (Backboard) Compression Only unless Bag/Valve Mask Available



CODE BLUE

- Do not wait for Code Team arrival/ connect AED, turn on, apply pads, press Analyze, Shock if advised, CLEAR first.
- Code Blue Response Team
- Hypothermia Induction Protocol

OB CODE CRIMSON

- Called by Labor & Delivery or Mother Baby RN or physician when early interventions to control bleeding have been unsuccessful and patient meets criteria for pregnancy related hemorrhage.

RAPID RESPONSE TEAM (RRT)

- Critical care RN
- Respiratory Therapist
- Immediate access to intensivist
- And YOU!

RRT

- General Criteria
  - *Respiratory distress*
  - *Acute changes in heart rate or blood pressure*
  - *Acute changes in mental status, speech, vision, sudden numbness, weakness.*
  - *Chest Pain*
  - *Hypoglycemia unresponsive to interventions*
  - *Uneasy feeling*
- ANYONE CAN ACTIVATE RRT
- RRT is called for Inpatients only!

FAMILY ACTIVATED RRT

- Family Activation of RRT: At SAMC, on Admission, information brochure directs family to dial #3333 for RRT activation
- Family Activation at ABMC: dial #911.

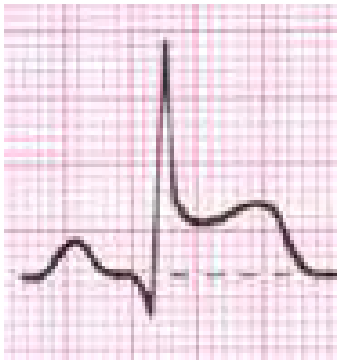
YOUR ROLE

- Provide pertinent patient information to the responder/team including applicable labs, medications given, recent vitals, etc.
- Utilize SBAR
- Contact/Page the Attending Physician
- Gather equipment/supplies as directed by responder.

CARDIAC ALERT

- Called for Acute MI patients
- Inpatient Cardiac Alert: Activated by RRT RN/Physician.
- ER patients: called by ER physician or ER RN
- GOAL: Activate Cath Lab Team

  Cardiac Intervention/ Door to Balloon Time= 90 minutes or less



SEPSIS ALERT

- Sepsis alerts are activated by an RRT.
- Typically called for hypotension or other symptoms: RRT RN will screen for severe sepsis and then call SEPSIS ALERT
- Known or suspected infection, Temp, HR, RR, WBC count and signs of organ dysfunction – Lactic Acid level >4, urine output, hypotension, MS changes,
- GOAL: Fluid resuscitation, Blood Cultures, Antibiotic, Pressors, perhaps Blood & Dobutrex as needed.
- SEPSIS alerts are also called in ICU.

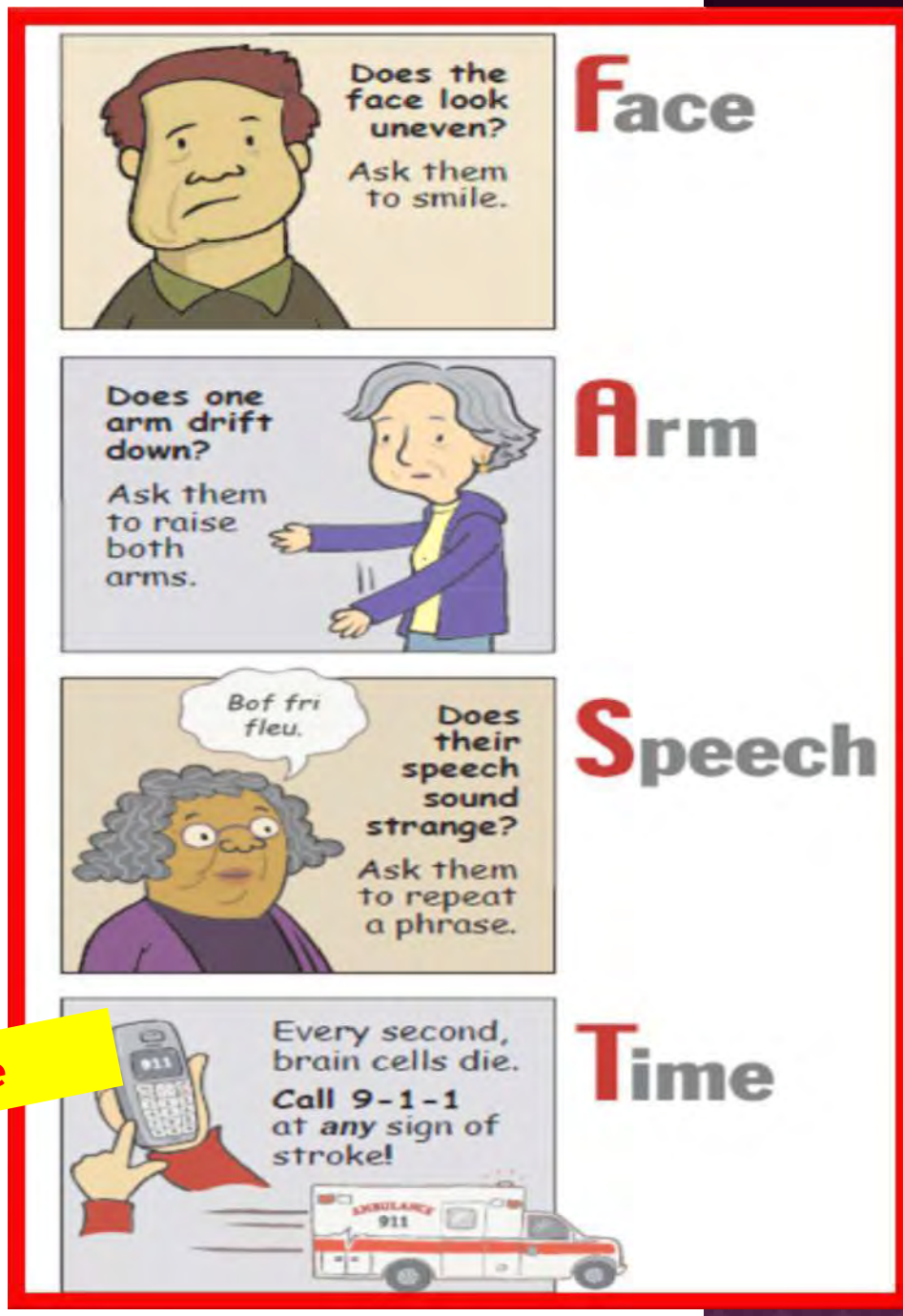
STROKE ALERT

- Stroke Alerts are activated by RRT.
- If you think your patient is having signs/symptoms of a stroke CALL RRT.
- Perform a Bedside Blood Glucose
- RRT RN will evaluate
- Inpatients: CALL RRT
- ER: DIAL 911 to activate Stroke Alert
- **A Stroke alert should be called on any patient with symptom onset < 12 hours**

STROKE STRIKES
F.A.S.T.
YOU SHOULD, TOO!

Every minute matters!

2 million brain cells die every minute



SIGNS AND SYMPTOMS OF A STROKE

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

WHO RESPONDS TO A STROKE ALERT?

- ED MD and ED RN (In the ED)
- Neurologist / Neurologist PA
- RRT
- Lab - phlebotomy
- Radiology - CT table is cleared
- APNs (Stroke Coordinator)
- Pharmacy is alerted for tPA

GOAL OF STROKE ALERT = QUICK DIAGNOSIS AND TREATMENT

- Ischemic = Clots = Drano for the Braino
  - tPA up to 4.5 hours
  - Interventional stroke rescue up to 12 hours

- Hemorrhagic = Stop The Bleeding!
  - Anticoagulant reversal
  - BP control
  - Possible neurosurgical intervention

WHAT HAPPENS AT A STROKE ALERT

- Initiate stroke alert orders
  - Continue to determine last known normal
  - Labs and bedside glucose (lab results within 45 minutes)
  - CT (CT started within 25 minutes / interpreted within 45 minutes)
  - NIHSS (neurologist contact within 15 minutes)
  - EKG
  - Inclusion/exclusion for tPA
  - Treatment decision (IV tPA goal = 60 minutes)
  - Nursing swallow/dysphagia screen

CODE WHITE

- Called for any Visitor, Employee, NON-Inpatient who is in need of medical attention.
- Do NOT call if in Cardiac Arrest/ Call Code Blue.
- Do NOT call if current Inpatient/ Call RRT.
- Team Response: ER RN/MD & RRT RN

PEDIATRICS

- Pediatric Code Blue
- Pediatric RRT

QUESTIONS, COMMENTS??

ALEXIAN BROTHERS HEALTH SYSTEM

TO REPORT AN EMERGENCY DIAL "911"

Category	Event Type	Code
Disaster	Disaster Plan Activation	Code Triage (Standby/Internal/External)
	Evacuation	Code Purple
	Bomb Threat	Code Black
Safety / Security	Fire	Code Red
	Violent Incident – Security Assistance	Code Gray
	Violent Incident – Police Assistance	Code Silver
	Behavioral Emergency	Code Green (ABBHH only)
	Hazardous Material Release	Code Orange
	Infant / Child Abduction/Elopement	Code Pink*
	Adult Elopement	Code Gold
	Utility Failure	Announced as is, e.g., phone, water, electric, fire alarm panel
	Severe Weather	Announce as is, e.g., Severe Weather Alert
	Event Conclusion	"Code _____ All Clear"
Medical Clinical **(Site specific)**	Cardiac Arrest/Medical Emergency	Code 99/Code Blue (ABBHH) Code Blue (ABMC & SAMC) Code Blue Jr. (peds arrest – ABMC)
	AMI	Cardiac Alert (ABMC/SAMC)
	Ill or injured person on hospital property	Code 99 (ABBHH) Code White (ABMC) N/A (SAMC)
	Massive Bleeding in Labor & Delivery	OB Code Crimson (ABMC/SAMC)
	Rapid Response Team Activation	RRT (SAMC) N/A (ABMC)
	Stroke Patient	Stroke Alert (ABMC/SAMC)
	Trauma Team Activation	Category I Trauma Emergency Department (ABMC) (SAMC-rolling out later) Category 2 Trauma Emergency Department (SAMC)

*Announced as: "Code pink infant" or "code pink, age/sex" (e.g., 10 y/o male)

11/2014

ALEXIAN BROTHERS
Health System

FALL PREVENTION

What is all the BUZZ about?

We want our patients to  SAFE

- The Fall Prevention program is about decreasing patient falls and eliminating fall related injuries
- Our goal…365 days without a serious patient injury from a fall event

What is all the BUZZ about?

- Using proven Fall Prevention techniques & interventions for patients assessed to be at High Risk for falling

  - Assessment
  - Fall Prevention Bundle
  - "Beyond the Bundle"

What is all the BUZZ about?

- Identify & recognize patients at High Risk for falls in your department
- Committing to patient safety by ensuring the Fall Prevention Bundle is in place for patients at High Risk for falls and following through with the expectations of the bundle
- Creating a culture where Fall Prevention is everyone's responsibility

What is a Fall?

- "…a sudden , unintentional decent, with or without injury, that results in the patient coming to rest on the floor, on or against some other surface (e.g. a counter), on another person, or on an object (e.g. trash can)…

Falling1.jpg

- Types of falls included:
  - Physiological
  - Environmental
  - Assisted

Components of the Program

Assessment Tool

- Specific to a patient population / department
- Used to determine a patient's risk factors for falling
- Completed on admission, every shift, or with a change in the patient's condition

Fall Risk Level

- Category of risk as determined by the assesment tool
- 2 Tier system for ABHS
  - UNIVERSAL Fall Risk precautions
  - HIGH Fall Risk precautions

Interventions (Bundle)

- Proven techniques and actions to prevent the patient from falling

Assessment Tool

Hendrich II Fall Risk Model

Adult Fall Risk Assessment ✔

Questionnaire

Gender	○ Male ○ Female
Confusion/Disorientation/Impulsivity	○ Yes =Patient may be disoriented to time, place, and/or person. =Patient is unable to retain or receive instructions or displays impaired safety or personal judgment: a cluster of global transient changes and disturbances in attention, cognition, psychomotor activity, level of consciousness, and/or sleep/wake cycles. =This may be a progressive neurological state, drug induced, or behavioral in origin. =Stroke patients (left hemi) may exhibit impulsive, unpredictable behavior as a results of the cerebral insult. ○ No =Patient doesn't display any of these.
Symptomatic Depression	○ Yes =Medical diagnosis of depression. =Nursing assessment finds the patient appears depressed, hopeless, in a melancholic mood, is not interacting appropriately, and/or is tearful, withdrawn, or the patient states they are depressed. =A general loss of interest in life events. =If the depression is managed with drugs and/or therapies, they DO NOT score additional points when the depression is in therapeutic control. ○ No =Patient doesn't display any of these.

	=Patient doesn't display any of these.
Altered Elimination	○ Yes =Altered elimination from the clinical norm, such as incontinence, nocturia, frequency, urgency, or stress incontinence, diarrhea or related to use of cathartics. =This does NOT include a Foley or indwellling catheter UNLESS it causes symptoms referenced above while in use with the patient. =When the catheter is removed, it can be a high-risk time until normal elimination is established. ○ No =Patient doesn't have any of these.
Dizziness/Vertigo	○ Yes =Medical diagnosis of vertigo or the patient reports they feel like they are spinning or the room is spinning. =Sway path may be present when the patient stands (circular motion upon arising). =This is often seen in the aging adult with poor gait and balance and can occur as a result of some drug side effects. =Often seen in the newly delivered obstetric patient. ○ No =Patient doesn't display any of these.
Any Administered Antiepileptics	○ Yes =Patient is receiving one or more of the following medications: =Carbamazepine, Divalproex Sodium, =Ethotoin, Ethosuximide, =Gabapentin, Lamotrigine, =Mephenytoin, Methsuximide, =Phenobarbital, Phenytoin, =Primidone, Topiramate, =Trimethadione, Valproic Acid ○ No =Patient is NOT receiving any of the drugs listed

Any Administered Benzodiazepines	○ Yes =Patient is taking one or more of the following medications: =Alprazolam, Buspirone, =Chlordiazepoxide, Clonazepam, =Clorazepate Dipotassium, =Diazepam, Flurazepam, =Lorazepam, Midazolam, =Oxazepam, Temazepam, =Triazolam =Includes Benzodiazepine-like drugs ○ No =Patient is NOT receiving any of the drugs listed

et Up & Go Test
=With patient sitting in a chair (preferred) or on the side of the bed, place palm of hands flat on thighs and ask the patient to stand without assistance.
=Score the patient according to the guidelines below.
*If the patient is unable to perform the test (unconscious, drug-induced coma, traction, debilitation/atrophy, and/or bed rest order) score all other risk factors that can be assessed.
=If the patient scores a 5 or greater (without the Get Up & Go) and can ATTEMPT to get up they should be considered "high risk for falls".
=If they cannot attempt to get up at all, but have risk points, they should be considered "pending high risk" and placed on the fall prevention guidelines as soon as they can ATTEMPT to get up.

Get Up & Go Test	○ Ability to Rise in a Single Movement ○ Pushes Up, Successful in One Attempt ○ Multiple Attempts, but Successful ○ Unable to Rise Without Assist during test/medical order/can't access (OR if a medical order states the same and/or complete bed rest is ordered) *If unable to assess, document this on the patient chart with date and time.
Fall Risk Total Score	

*Completed on admission and with every shift assessment
* Perform a reassessment with a change in the Patient's condition

Score of 5 or Greater = HIGH FALL RISK

The Fall Prevention "BUNDLE"

HIGH
Fall Risk Precautions

- YELLOW non-slip slippers
- Gail Belt

- Safety alert signage outside room
- Safety alert signage above bed

- Bed alarm / chair alarm on at all times

- Supervised toileting
- Supervised ambulation

- "Fall Precautions" on white board
- Activity & Assist level on white board

Safety Precautions - Documented

SINATRA,FRANK F000000134 - PCS Flowsheet - HIM Dept: SAMC (ALB/ALB.TEST6.07F/ALB.TEST6.07F) - (TEST 6.07) - Cordts,Julie D [CST]

Sinatra,Frank F00000001602 F000000134
48 M 05/31/1966 5ft 4in 115lb BSA:1.55m² BMI:19.7kg/m² E00000335
ADM IN F.ICU F.354-A Allergy/Adv: Sulfa (Sulfonamide Antibiotics), peanut, codeine, meperidine HCl, (More)

Mon Dec 29
13:24
by JDC

SAFETY PRECAUTIONS ✓

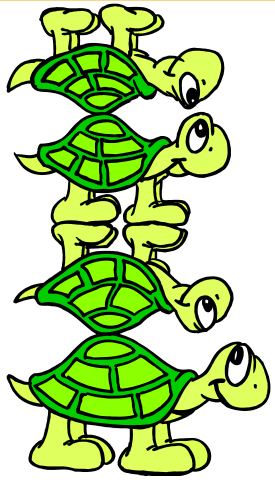
Safety

Signage Bed/Chart	○ Yes ○ No
Instruct to Call for Assist	○ Yes ○ No
Necessary Items in Reach	○ Yes ○ No
Call Light in Reach	○ Yes ○ No
Family at Bedside	○ Yes ○ No
Siderails	○ Up X 1 ○ Up X 2 ○ Up X 3 ○ Up X 4-Restraint
Bed in Low Position	○ Yes ○ No
HOB Elevated (Degrees)	
Obstacle Free Environment	○ Yes ○ No
Appropriate Footwear	○ Yes ○ No
Toilet/Ambulation Assisted	○ Yes ○ No
Bed Alarm	○ Yes ○ No
Bed Alarm Refused	○ Yes ○ No Comment:
Close Call Alarm	○ Yes ○ No
Restrictive Device	○ Yes ○ No
Restraints	○ Yes ○ No Document on Appropriate Restraint Intervention
Safety Alternative	☐ Bed Alarm ☐ Relaxation Techniques ☐ Chair/Wheelchair Alarm ☐ Hourly Rounds ☐ Mitt/Untied ☐ Elopement Alarm ☐ Abdominal Binder/Clothes ☐ Clothing Over Tubes ☐ Sitter ☐ Self-Release Seat Belt ☐ Seizure Pads ☐ Diversional Activities ☐ Instructions for Safety ☐ Frequent Observations
Comment	

Mode | Hide Text | Recall | Edit | Add Note | Save

Balancing Safety & Privacy

Supervised Toileting =
being within an arm's length of patient



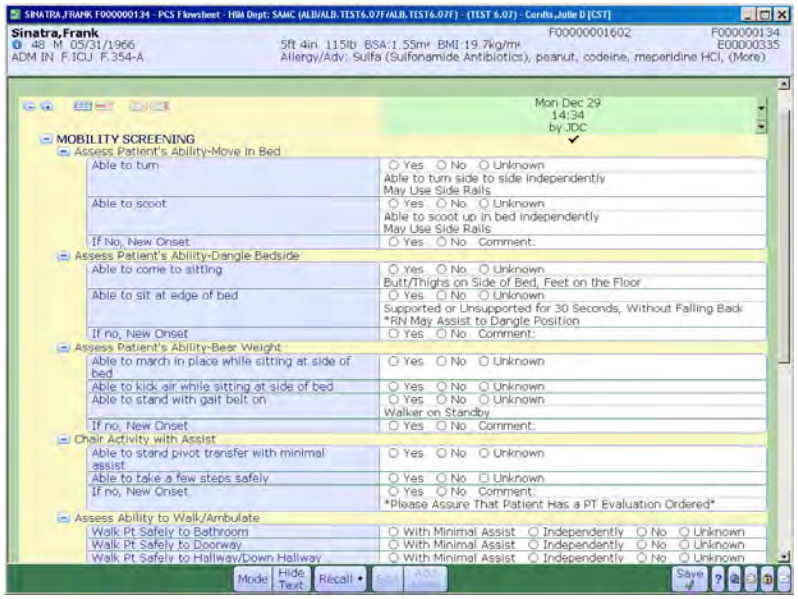
- Provide education
- Reinforce Importance

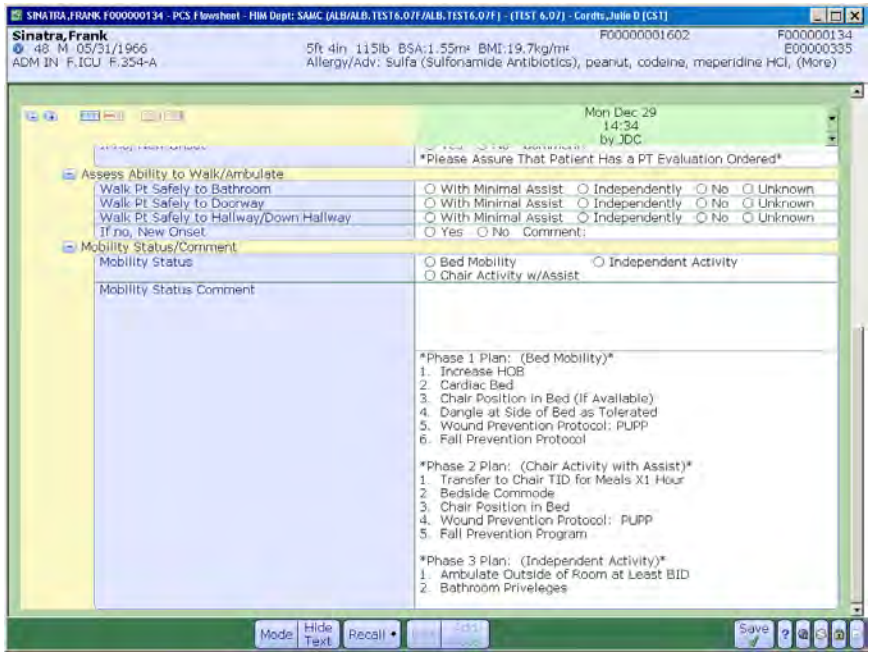
Balancing Safety & Mobility

- Confinement to bed or a chair is not fall prevention
- Loss of strength is a hazard of immobility & strength helps prevent falls
- Mobility progression and strength is a shared goal between nursing and therapy services
- Maintain Safety
  - Activity based on the appropriate **PHASE OF MOBILITY**
  - Practice correct **TRANSFER** techniques
  - Use appropriate **EQUIPMENT** (gait belt, walker) & **GUARDING** when ambulating patients

Balancing Safety and Mobility

Mobility Screening Assessment
Standard of Care
Documentation at 8am and 8pm





Balancing Safety & Mobility

Phase 1	Phase 2	Phase 3
ROM HOB up	Bedside chair as able	Walking on unit w/assist
Cardiac Bed Chair Position in bed (if Available)	Chair X 20 min; QD-BID then TID X 1 hr Goal- up for meals	Bathroom privileges
Dangle BID X 6-10 min As Tolerated	Bedsice Commode Chair Postion in Bed Amb to bathroom w/assist or walker	Walk on nursing unit BID with or without assist
Wound Prevention Protocol: PUPP Fall Prevention Protocol	Wound Prevention and Fall Prevention	Walk around nursing unit TID or more

Beyond the Bundle… Hourly Rounding

- Hourly Rounding
  - Environmental Assessment
    - alarms, bed height, obstacles
  - Address the 4 P's
    - Pain
    - Personal Needs (aka "Potty)
    - Position
    - Placement

Hourly Rounding

Safe Care Checks
Inpatient Hourly Rounding Log

Environmental Safety Check

- Over the bed table w/in reach
- Call light & phone w/in reach
- Curtains/doors open in applicable areas
- Bed alarm hooked up & functional
- Check for trip hazards
- Garbage can w/in reach
- Personal items w/in reach
- Beds & Chairs in low and locked position

Date: Room #:

Time	High Fall Risk	Admission	Discharge	4 P's to be discussed (Pain, Potty, Position & Possessions)	Sleeping	Off Unit	Fall Prevention 1.Bed Exit Chair Alarm on at all times 2.Yellow Slippers 3.Sign outside room 4.Sign above bed 5."High Fall Risk" on white board 6.Activity/assistance level on white board 7.Bed cable connections **(Compliance of ALL items is required, if answer is NO explanation is mandatory**		COMMENTS	Staff Initials
	Y/N						Y/N			
24	Y/N									
02	Y/N									
04	Y/N									
06	Y/N									
Note: Move to every 1 hour rounds										
07	Y/N									
08	Y/N									
09	Y/N									
10	Y/N									
11	Y/N									
12	Y/N									
13	Y/N									
14	Y/N									
15	Y/N									
16	Y/N									
17	Y/N									
18	Y/N									
19	Y/N									
20	Y/N									
21	Y/N									
22	Y/N									
23	Y/N									

PCT's – Round every 2 hours on EVEN hours (around the clock)
RN's – Round every 2 hours on the ODD hours (7am – 11pm)

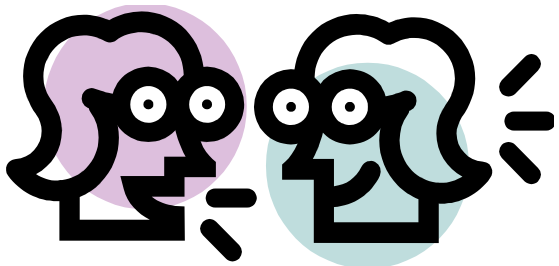
This document is not part of the legal record – please destroy.

Form# 7460521 (Rev: 04/09/14)

Beyond the Bundle… Communication

- Provide education to patients and family members on admission
  - Engage them to be our partners in Fall Prevention
  - **Fall Prevention Information letter**
  - **"3 Reasons Why Fall Prevention is Important"**
- Communicate effectively the measures we have in place to keep them safe and why
- Reinforce at each new patient encounter and during hourly rounding
- Listen when patients communicate needs and concerns

Beyond the Bundle…
Communication



FALL PREVENTION INFORMATION

Dear Patient and Family,

Your doctors, nurses, and therapists at Alexian Brothers Health System want you to be safe. We are asking that you help us keep yourself or your loved one from falling.

Falling is a real danger for people in the hospital. Some things that increase the risk of falls, include:

- Unfamiliar environment of a hospital room
- Medications
- Physical conditions such as difficulty walking, impaired hearing or sight, incontinence, or confusion
- Frequent trips to the bathroom

If you or your family member is someone who could be at risk for falling, we may put the following safety precautions into place:

- Signs as a reminder of the risk of falling
- Non-slip socks
- Use of a bed or chair alarm
- Rounding by the nursing staff
- Assistance with bathroom activities
  - ✧ While we sincerely value your privacy, your safety is a priority and we may be within arm's reach while you are in the bathroom.

As our partner in preventing falls, we ask that:

- Patients do not get out of the bed or chair without help from the nursing staff. Please call for assistance.
- Visitors tell the nursing staff when they are leaving the room
- Only nursing staff turn off safety alarms

Our goal is to provide safe care and prevent falls. We appreciate the important role you play in helping to keep our patients safe and free from harm.

Please sign and date below that you have read and understand this information.

Patient or Family Representative _____ Date ____ Time ____

Witness _____ Date ____ Time ____

ALEXIAN BROTHERS HEALTH SYSTEM

FALL PREVENTION INFORMATION

ITEM # 0004782
FORM # 36914 01/14
(Consent)

CON

Patient Name

WHITE - Patient's Medical Record CANARY - Patient's Copy

Beyond the Bundle… Communication

- Staff Signed the form as a contract.
- Failure to adhere to the contract may result in disciplinary action.
- Disciplinary action is a 2 point write-up

FALLS PREVENTION

- It is an expectation that all falls bundles will be implemented on our high fall risk patients at all times

Fall Prevention Bundle

1. Bed Exit / Chair Alarm on at all times
2. Yellow slippers
3. Sign above bed
4. Gait Belt
5. "High Fall Risk" on white board
6. Activity/assistance level on white board
7. Never leave a high fall risk patient alone in the restroom

- It is an expectation that we stay with our high fall risk patients when ambulating and in the restroom

_____If these safety initiatives are not in place and a patient falls, it is understood that a two point corrective action will occur

_____If any patient is found unattended or without pieces of the fall bundle, a two point corrective action will occur

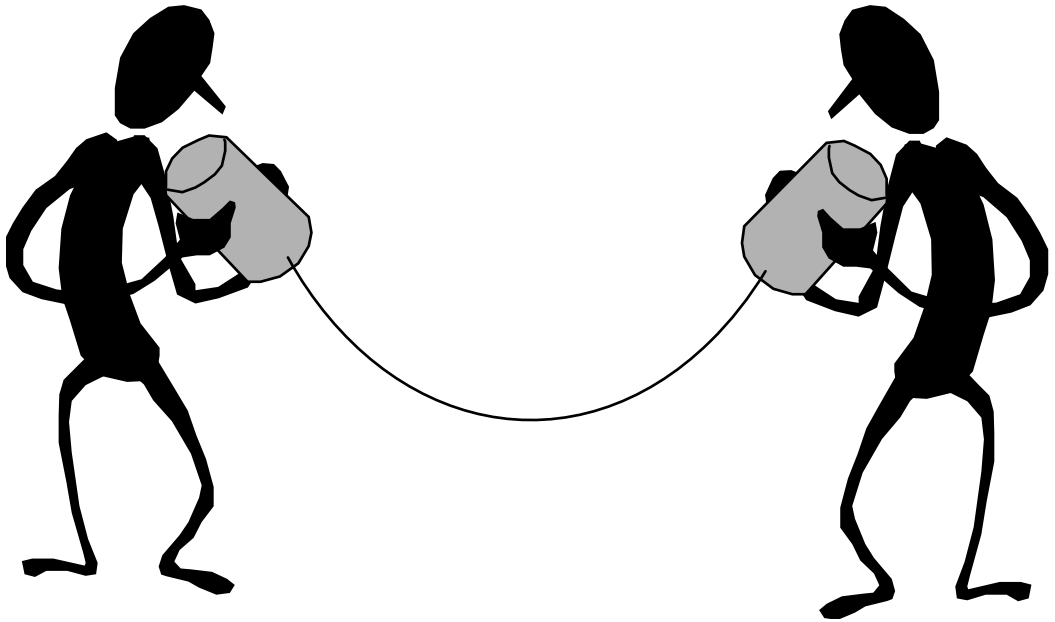
200% accountability- it can found by a leader, coworker or patient

Employee_____ Date_____

Leader_____ Date_____

Beyond the Bundle… Communication

- Interdepartmental and interdisciplinary communication:
  - Fall Risk Level
  - Mobility Level
  - Assistance Level



Beyond the Bundle… Teamwork

When it comes to safety,
there is not "your patient" or "my patient"
…only "OUR patients"

- Be empowered to speak up if you see a break in Fall Prevention Practices
- Your voice could prevent a fall…an injury…a death

Beyond the Bundle…
Teamwork

we can help

I see the light….

and make things right!

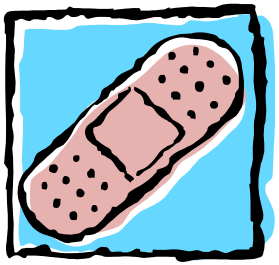
Goal:
Promptly meet our patients needs

Who:
Begins with nursing staff and will move to include ancillary care areas ie: transport, physical therapy, phlebotomy, etc.

Process:
Anyone who sees a call light responds by personally answering the light. If the person answering the light cannot meet with patients request at that time, the patient's nurse or charge nurse should be notified to meet the need.

Fall Follow-Up

- Patient first



  - RRT, Physician and family notification, objective event note

- Participation in post-fall Huddle and completion of Debriefing form should include those associates:
  - Directly involved or witness to the event (includes non-nursing)
  - Assigned to the patient
  - Working in the department at the time of the event, as appropriate

Fall Follow-UP

FALL DEBRIEFING TOOL

WHO

Patient Sticker

•Select all which apply:

- ☐ Alert & Oriented x ____
- ☐ Confused
- ☐ Dementia
- ☐ Delirium
- ☐ unable to retain / receive safety instructions
- ☐ impaired safety / personal judgment related neurogical/behavioral/drug induced reasons

WHAT

•WHAT interventions were in place at the time of the fall?

- ☐ Yellow nonslip socks (not ARH)
- ☐ Other nonslip footwear
- ☐ Wheelchair self release belt
- ☐ Risk signage above bed
- ☐ Risk signage outside door
- ☐ Risk level / activity level on white board
- ☐ Low Boy bed
- ☐ Side rails up x _____
- ☐ Restraint: _____
- ☐ Call light within reach → on at time of fall? ☐ Yes ☐ No
- ☐ Bed alarm armed → sounding at time of fall? ☐ Yes ☐ No
- ☐ Chair alarm on patient → sounding at time of fall? ☐ Yes ☐ No
- ☐ Supervised toileting/ambulation → associate/family within arm's length of patient? ☐ Yes ☐ No

•WHAT was the patient's Fall Risk Level prior to this fall? _____

•Do Huddle members believe this is appropriate for this patient? ☐ Yes ☐ No

•If High Fall Risk, was the patient aware that he/she was at risk for a fall? ☐ Yes ☐ No

•Patient/family Fall Prevention education provided and documented prior to the fall? ☐ Yes ☐ No

WHERE

•WHERE were the assigned caregivers for this patient on the unit at the time of the fall?

- RN _____
- PCT _____

•Total # of staff: _____

•Census: _____

WHEN

•TIME of fall: _____

•Last TIME an associate rounded: _____ → Toileted? ☐ Yes ☐ Refused ☐ Not offered

•Do you think the side effects of medications contributed to this fall? ☐ Yes ☐No

•In the 4 hours prior to the fall, indicate below if any of the following were administered:

☐ antihypertensives ☐ diuretics ☐ narcotics ☐ psychotropics ☐ sleeping aids

WHY

•The patient said he/she fell *BECAUSE* _____

•The huddle group thinks the patient fell *BECAUSE* _____

AND attempted to get out of bed/chair *BECAUSE* _____

WHY? _____

WHY? _____

HOW

HOW was the Plan of Care changed…

• What interventions may have prevented the fall and are now in place?

_____

• HOW would the Huddle members classify this fall? ☐ Preventable ☐Not Preventable

Charge RN: _____

Huddle Members: _____

_____

_____

_____

_____

☐ AlexiCARE Event Note completed

☐ Quantros completed

Return completed form to Unit Director

(Directors: please verify/edit 24 Hour Injury level in Quantros)

11/2012

NOT A PART OF THE MEDICAL RECORD

Form #7462621

Fall Follow-Up

- When a fall occurs we ask:
  - Why did this happen?
    - Sometimes we have to dig a little deeper

  - What could have been done differently or better to prevent this fall?

HIPAA

THE PATIENT HAS A RIGHT TO CONFIDENTIALITY

CONFIDENTIALITY

- Confidentiality is maintained in all matters concerning any discussions of patient cases, consultation, diagnosis and treatment.
- Discussion of patient information in elevators, nursing stations, cafeteria or any other public place is strictly forbidden.
- **Patient information (chart, medications, lab/test results, health history, etc..) is only accessed on a "need to know" basis in order to provide care**.
- It is a violation of patient rights to access the medical records of family members, neighbors, friends, or co-workers.

CONFIDENTIALITY

- Care should be taken to dispose of any waste containing patient information in appropriately designated containers.
- Care should be taken via use of appropriate cover sheets and disclaimers when faxing/scanning patient records.
- Personal cell phones may not be used to photograph or transmit patient records at any time.

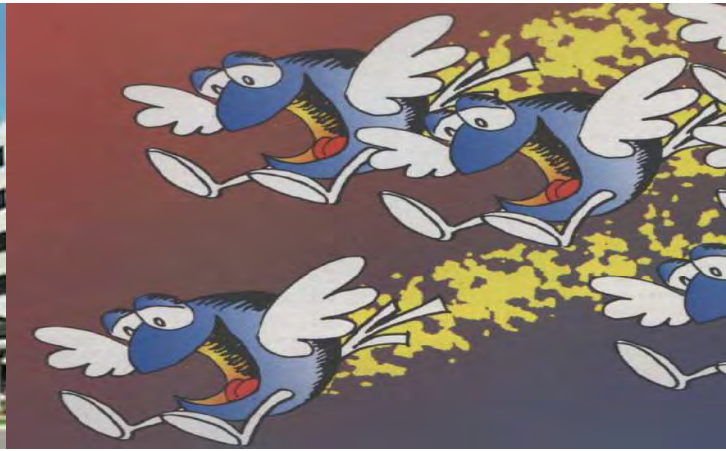
CONFIDENTIALITY

- Interviews, examinations and treatments shall be done in surrounding which are designed to give visual and auditory privacy to the patient.
- Respect for a patient's privacy includes, but is not limited to, utilization of: privacy curtains and health care workers announcing themselves before entering a patient's room.
- Patient information will be provided to only those involved in the patient's care or individuals authorized by law or regulation. All others must have written consent from the patient or patient representative before patient information will be released.

CONFIDENTIALITY

- Patient may select a HIPAA password upon admission; it should be entered into Alexicare.
- Information may be provided by nursing staff only to those to with whom the patient or their designee has shared the password.
- Violation of the patient's right to confidentiality brings serious consequences including termination of employment.

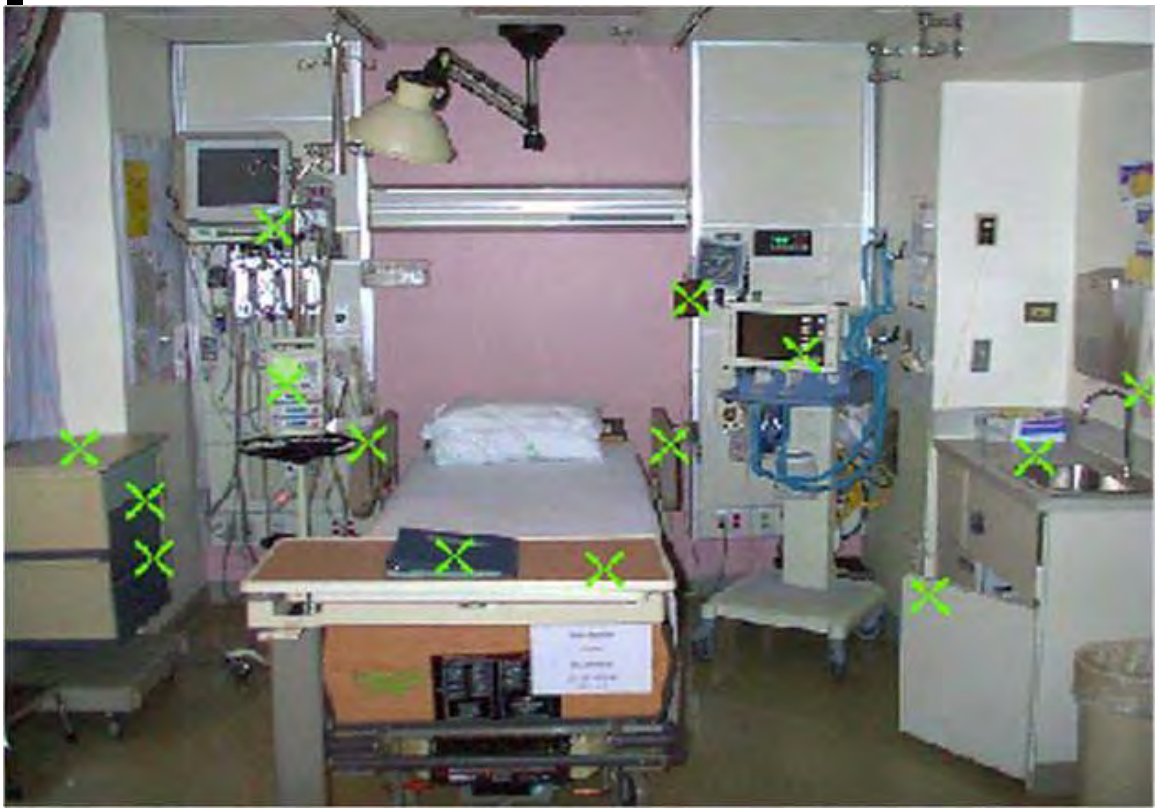
Your Role in
Infection Prevention & Control
at St. Alexius Medical Center



Presentation Overview

- Ways to protect patients and yourself!
  - Engineering Controls
    - Hand Hygiene
    - Personal Protective Equipment
  - 5 types of Isolation Precautions
  - Additional Safety Measures and Information (Blood borne pathogens)
  - Resources

Infection causing “germs” can be any place.
We need to protect our patients and ourselves.

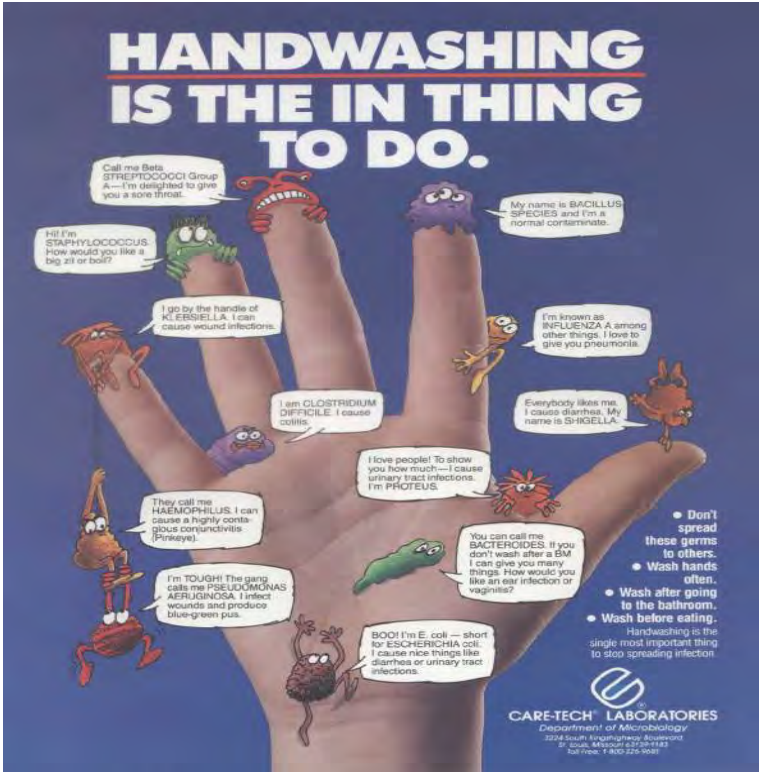


Survival of Pathogens in the Environment

C Difficile	> 5 months!
Staphylococcus	7 months
VRE	4 months
Aceintobacter	5 months
Norovirus	3 weeks
Adenovirus	3 months
Rotovirus	3 months
SARS, HIV etc.	Days to week
H1N1- Influenza A	Few days

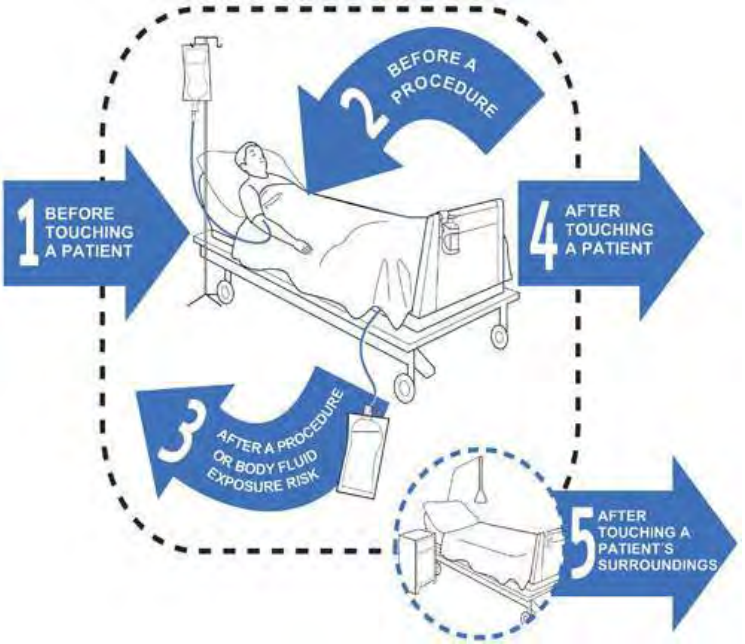
Hand Hygiene

- **Hand hygiene is the single most important procedure in preventing infection.**
- **Includes washing hands with soap and water or use of Recens Foam**



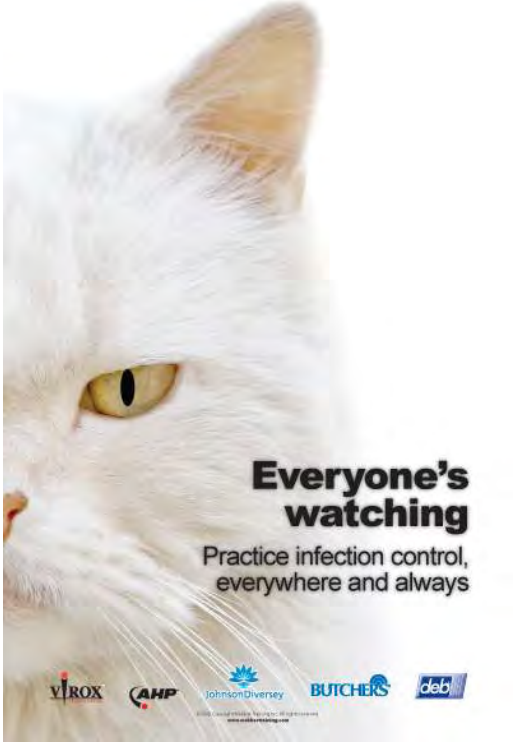
Hand Hygiene

- The 5 moments of Hand Hygiene

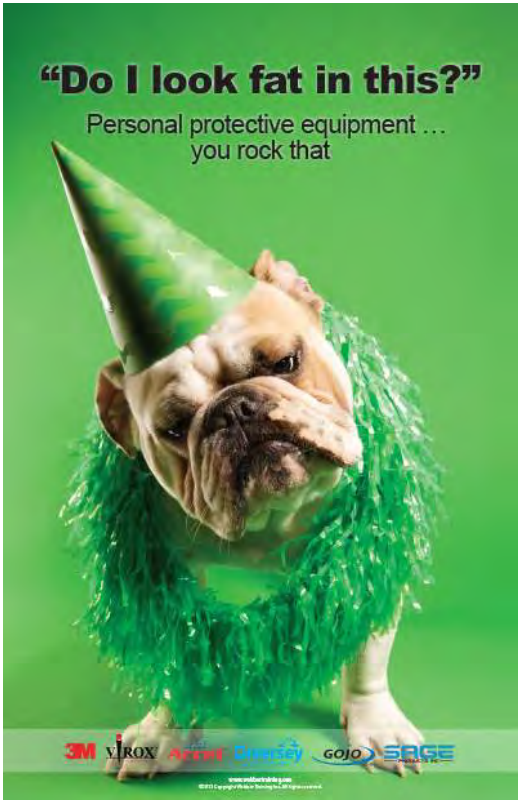


Infection Prevention & Control

- In addition to Hand Hygiene,
  - Personal Protective Equipment and Isolation Precautions are used to prevent and to control infections.

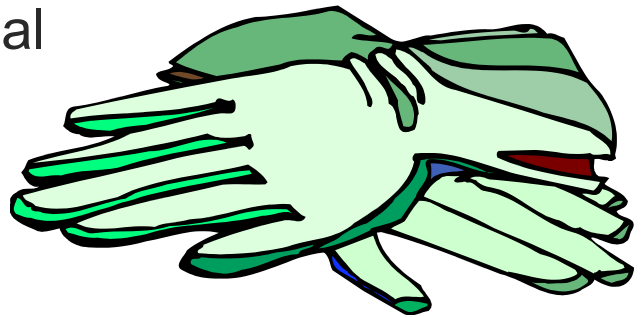


Personal Protective Equipment



Personal Protective Equipment

- Gloves
  - Perform hand hygiene before and after using gloves
  - REMOVE BEFORE LEAVING ROOM
  - CHANGE after having contact with infectious material



Personal Protective Equipment

- **Gowns**
  - If you anticipate having contact with body fluids or infectious material
- **Goggles**
  - To protect eyes from sprays & splashes
- **Masks**
  - Wear with goggles for protection of nose and mouth

Personal Protective Equipment

Examples of surgical masks

Personal Protective Equipment

N-95 Mask

*You must be fitted in your pre-employment physical to wear the proper sized mask

*If you can not be fitted for N-95, obtain PAPR from your unit supplies.

Personal Protective Equipment

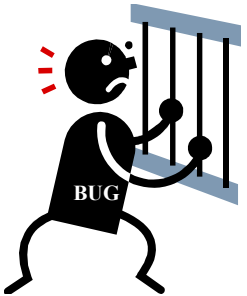
- PPE Cabinets
  - Located in patient care areas
  - Contents:
    - Personal Protective Equipment
    - Seal easy mask for mouth to mouth resuscitation)
    - Spill kit (bleach pad)

PPE cabinets should be checked every shift for adequate supplies

Why Isolation Precautions?

- Used to prevent the spread (transmission) of microorganisms from a known or potential source to another patient or health care worker

- KEEP THE “BUG” IN THE ROOM



Isolation Precautions

- 5 Types:
  1. Standard Precautions
  2. Contact Isolation
  3. Special Contact Isolation
  4. Droplet Isolation
  5. Airborne Isolation

1. Standard Precautions

- Developed by the Centers for Disease Control and Prevention (CDC) to provide the widest possible protection against the transmission of infection
- CDC officials recommend that health care workers handle all blood, body fluids (including secretions, excretions, and drainage), tissues, and contact with mucous membranes and broken skin as if they contain infectious agents, regardless of the patient's diagnosis.

1. Standard Precautions

- Standard precautions may include wearing appropriate Personal Protective Equipment (PPE) for the task to be performed.
- In other words “dress for the occasion”.

1. Standard Precautions

- Example:
  - Wearing gloves during a blood draw
  - Wearing gloves, gown, face and eye protection (goggles or face shield) during an arterial stick
  - Wearing a mask or N95 during aerosol generating procedures such as bronchoscopy, suctioning, or intubation

1. Standard Precautions

- If you can reasonably anticipate splash or splatter to your clothing, face, or other body parts, you **MUST** wear the PPE to cover that area.

- PPE may include, but is not limited to:
  - Gloves
  - Gowns
  - Lab coats
  - Face masks
  - Eye shields and/or goggles.

1. Standard Precautions

- **Must** be used **with every patient** cared for in all healthcare settings.
- This includes the newborn through the geriatric patient.
- **NO EXCEPTIONS!**

2. Contact Precautions

- Prevents the spread of infectious diseases transmitted by contact with body substances or items contaminated with the infectious agent.

2. Contact Precautions

- Requires the use of gloves and gowns by associates, visitors, and family members that have contact with the patient, the patient's support equipment, or items soiled with body substances containing the infectious agent.
- Thorough hand hygiene and proper handling and disposal of contaminated items are essential.
- Call BUGS (2847) for non-compliant family or visitors

CONTACT

ISOLATION

STOP!

DO NOT ENTER WITHOUT PROTECTION

ALTO! No entrar sin protección!

CONTACT

2. Contact Precautions

- Commonly used with:
  - MRSA - colonized or infected
  - CRE & VRE - colonized or infected
  - Draining wounds (unable to be contained in a dressing)
  - RSV
  - Scabies
  - Impetigo - Pediculosis

2. Contact Precautions

- Transporting a Patient with Contact Precautions:
  - **ALWAYS** notify the receiving department of Contact Precautions prior to sending the patient.
  - Transporting a patient
    - Remove gowns and gloves **BEFORE** leaving the room
    - Follow hand hygiene protocol
  - Carry a clean pair of gloves in case of an emergency while transporting the patient
  - Equipment removed from a patient room must be cleaned with a hospital approved disinfectant product.

3. Special Contact Precautions

- Requires the use of gloves and gowns and hand hygiene with soap and water
- Rooms are sanitized with BLEACH when
  - the patient is discharged
  - transferred from that room
  - isolation is discontinued and the patient remains hospitalized.
  - Privacy curtains **must** be changed.
  - Environmental Services department receives a C. difficile report daily to assure compliance with Infection Control policy

SPECIAL CONTACT

SPECIAL CONTACT

ISOLATION

STOP!

DO NOT ENTER WITHOUT PROTECTION

ALTO! No entrar sin protección!

3. Special Contact Precautions

- Commonly used with:
  - C. Difficile (C. Diff) – infected / symptomatic
  - Norovirus

4. Droplet Precautions

- Prevent the spread of infectious diseases transmitted by coughing or sneezing
- Requires use of a mask
  - Rule out Influenza / Confirmed Influenza
  - Streptococcus pharyngitis, bacterial pneumonia, scarlet fever
  - Haemophilus influenza / Neisseria Meningitidis
  - Mycoplasma pneumonia
  - Pertussis (whooping cough)
  - Rubella (German Measles)

DROPLET

ISOLATION

STOP!

DO NOT ENTER WITHOUT PROTECTION

ALTO! No entrar sin protección!

DROPLET

4. Droplet Precautions

- Transporting a Patient:
  - Patient movement and transport should be limited to essential purposes only.
  - ALWAYS notify the receiving department of isolation precautions ahead of time
  - Patient requires a surgical MASK (if tolerated).
  - The healthcare worker should remove their mask BEFORE leaving the room
  - Follow hand hygiene protocol

5. Airborne Precautions

- Used in addition to standard precautions, prevents the spread of infectious diseases transmitted by pathogens that are breathed, sneezed, or coughed into the environment.
- Effective airborne precautions require a negative-pressure room with the door kept closed to maintain the proper air pressure balance between the isolation room and the adjoining hallway or corridor.

AIRBORNE

AIRBORNE

ISOLATION

STOP!

DO NOT ENTER WITHOUT PROTECTION

ALTO! No entrar sin protección!

5. Airborne Precautions

- A Physician order is not needed
- Commonly used for:
  - Ruling out Tuberculosis or known active TB cases
  - Chicken Pox*
    - Varicella
    - disseminated Herpes zoster (shingles)
  - Rubeola (Measles)
  - SARS*
  - Monkeypox*

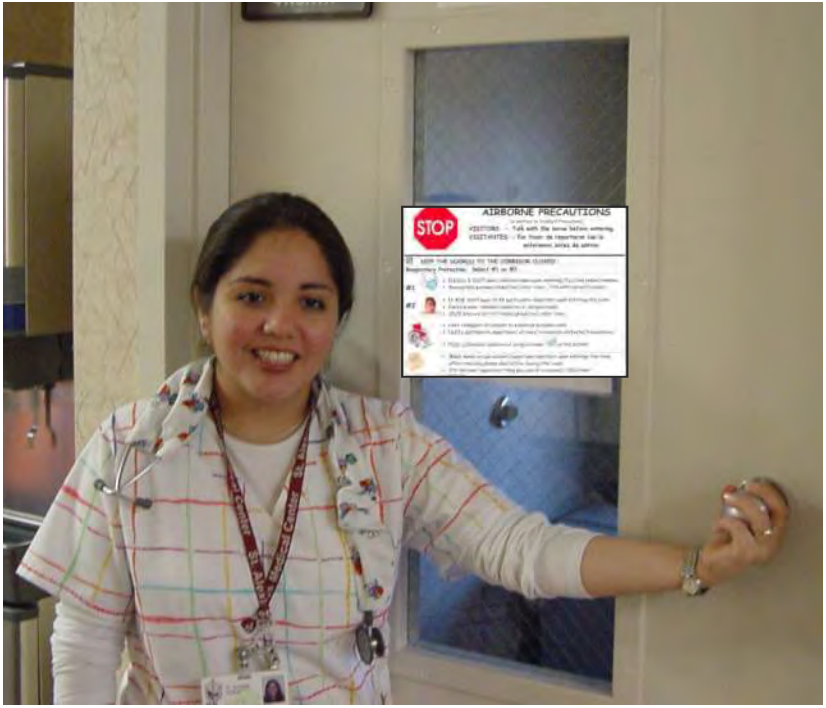
**may require Contact and Airborne Isolation Precautions*

5. Airborne Precautions

- Negative Pressure rooms require special air handling and ventilation with 6-12 air changes per hour
- The room **doors must remain closed at all times** and the patient must remain in the room
- N-95 and PAPR are for healthcare workers only
- Standard masks for all visitors and family members (call BUGS x2847 for non-compliance)

5. Airborne Precautions

Entering the Anteroom



5. Airborne Precautions

Inside the Anteroom

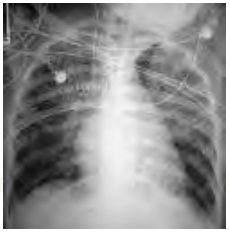
*The hallway door must be closed before you enter the patient room door to provide the negative airflow protection of this isolation room.

5. Airborne Precautions

- **Airborne Precautions for TB are initiated**
  - when there is a:
    - Diagnosis of “rule out TB”
    - Physician order for sputum for AFB
    - Symptoms suggestive of TB
    - Chest x-ray suggestive of TB

- Patients with the following symptoms require prompt identification and isolation:
  - Persistent cough (greater than 2 weeks)
  - Bloody sputum
  - Night sweats
  - Anorexia
  - Fever

5. Airborne Precautions



- Tuberculosis Exposure Control Plan
  - Found on the intranet in Policy Tech under SAMC /Infection Control /ABHS
- There are criteria for discharge of a TB patient to the home environment
- The Case Manager/Social Worker consults with Infection Preventionist to coordinate the follow-up care with the public health department prior to patient release

Additional Safety Measures for Infection Prevention & Control

- Sharp Containers
  - Never allow to be filled beyond the line!
  - Be sure to activate the safety mechanism

"Hear the Click or Risk a Stick"

Additional Safety Measures for Infection Prevention & Control

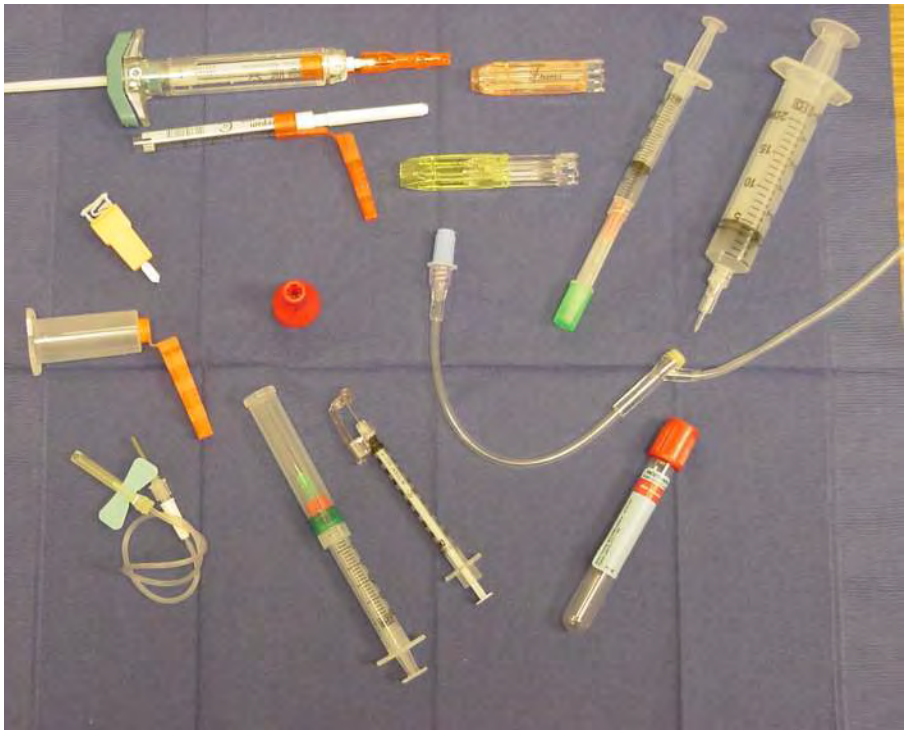
Biohazard Waste Container – Regulated Waste

Additional Safety Measures for Infection Prevention & Control

- Needle stick Safety and Prevention Act (H.R. 5178
  - November 6, 2000 law authorized OSHA
  - April 18, 2001 Standard took effect
- Hospitals are required to evaluate and purchase safety devices such as needles with safety devices.

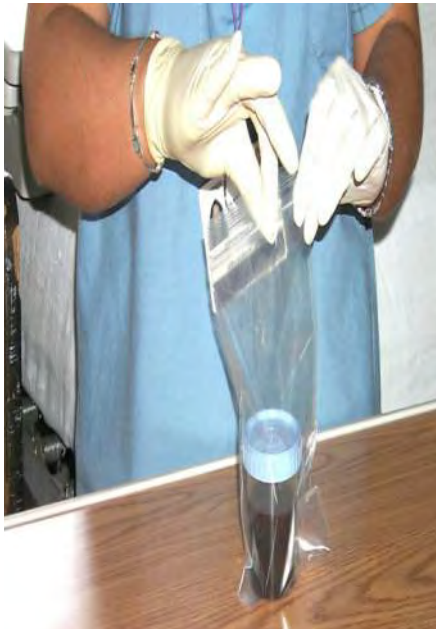
Additional Safety Measures for Infection Prevention & Control

Examples of Sharps Safety Devices



Additional Safety Measures for Infection Prevention & Control

- Specimen Collection
  - Specimen container placed in Ziploc bag
  - If outside of bag is contaminated, double bag
  - Junior Volunteers (under 18 years of age) may **not** transport specimens
  - Volunteers will bring a red tackle box for specimen transfer



Additional Safety Measures for Infection Prevention & Control

- Care of Equipment (Cleaning & Disinfecting):
  - When indicated, restrict the use of non-critical patient-care equipment to a single patient to avoid cross contamination.
  - Clean equipment in your area or department according to manufacturer recommendations to protect the integrity of the equipment.

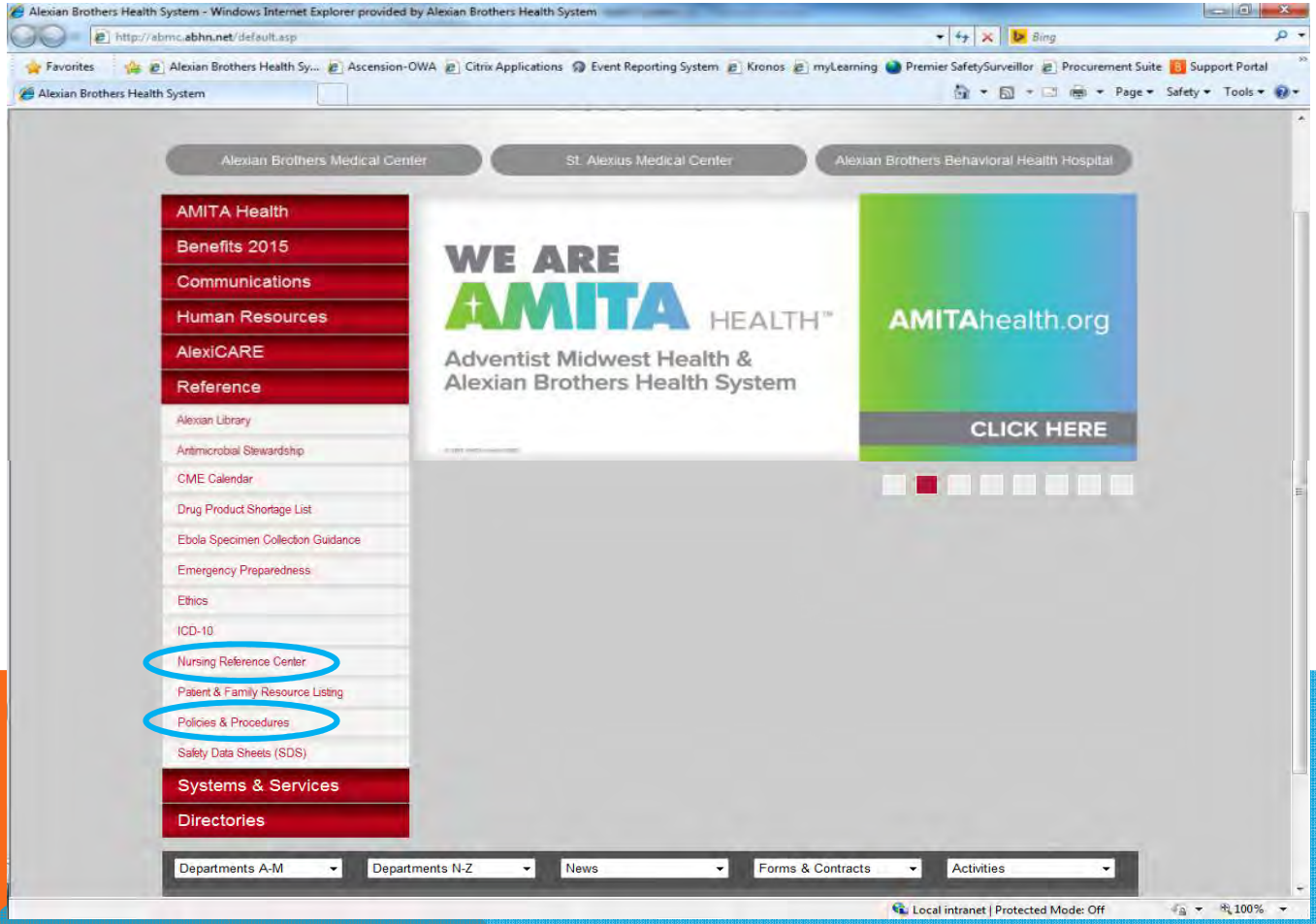
Care of Equipment

- Clean equipment between patient use with hospital approved disinfectants
  - vital sign machines, IV poles, pulse oximeters, blood pressure cuffs, etc.
- Only hospital approved disinfectants are used to clean equipment.
- Know the contact times to allow for the disinfection process to occur.

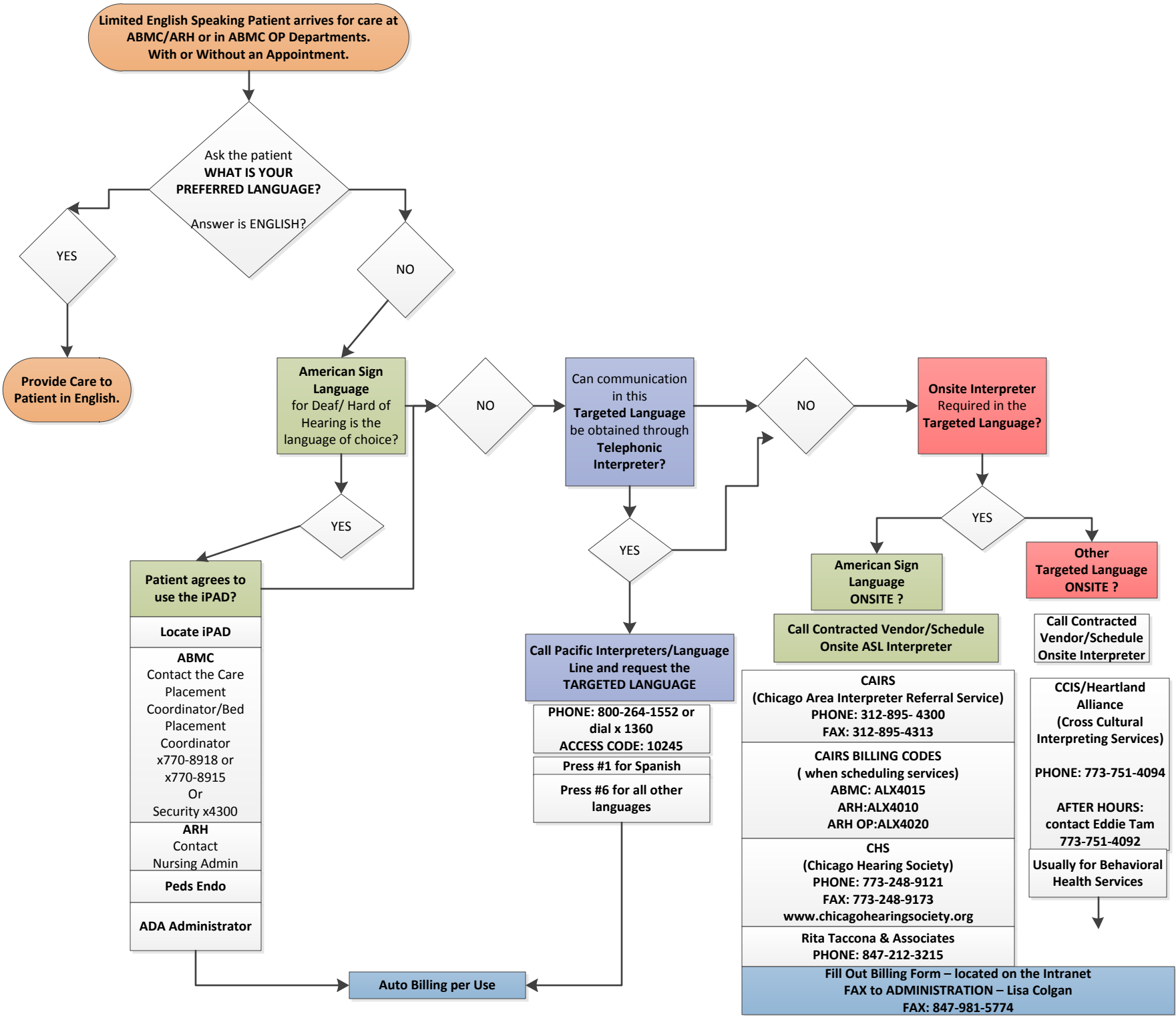
Additional Information for Clinicians:

- Infection Control Policies are on the intranet in Policy Tech. Choose SAMC has a reference table for isolation precautions.
- You may refer to this section when there are questions about “type and duration” of precautions/isolation needed for selected infections and conditions.
- Nursing should send a message informing the Infection Control Nurse when a patient is placed in isolation.
  - The message should include the source (ie. urine) and the reason (ie. MRSA, physician documentation, etc.)
- Nursing **documents every shift** that isolation precautions are maintained.

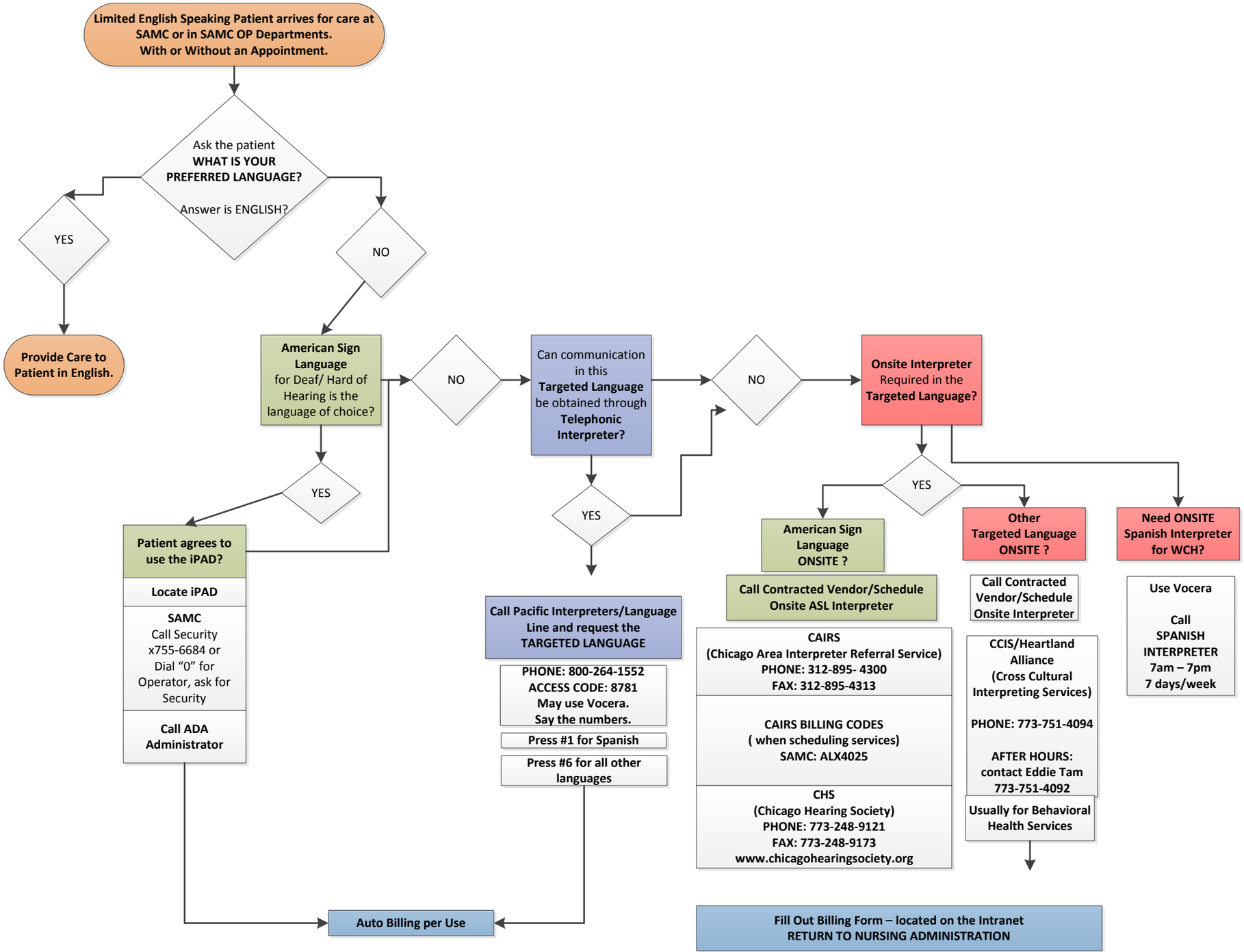
ADDITIONAL INFORMATION FOR CLINICIANS:



ABMC INTERPRETER DECISION WORKFLOW – PATIENT's PREFERRED LANGUAGE



SAMC INTERPRETER DECISION WORKFLOW – PATIENT's PREFERRED LANGUAGE



IV THERAPY BASICS

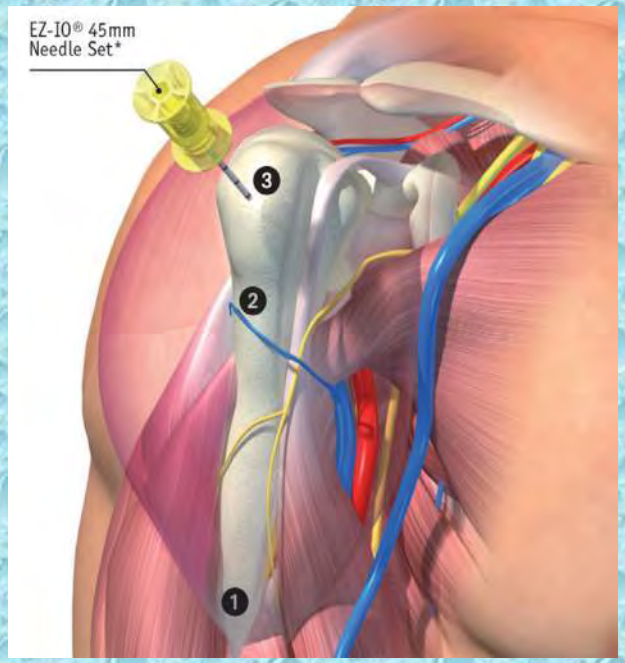
PROVIDING CARE AT ALEXIAN

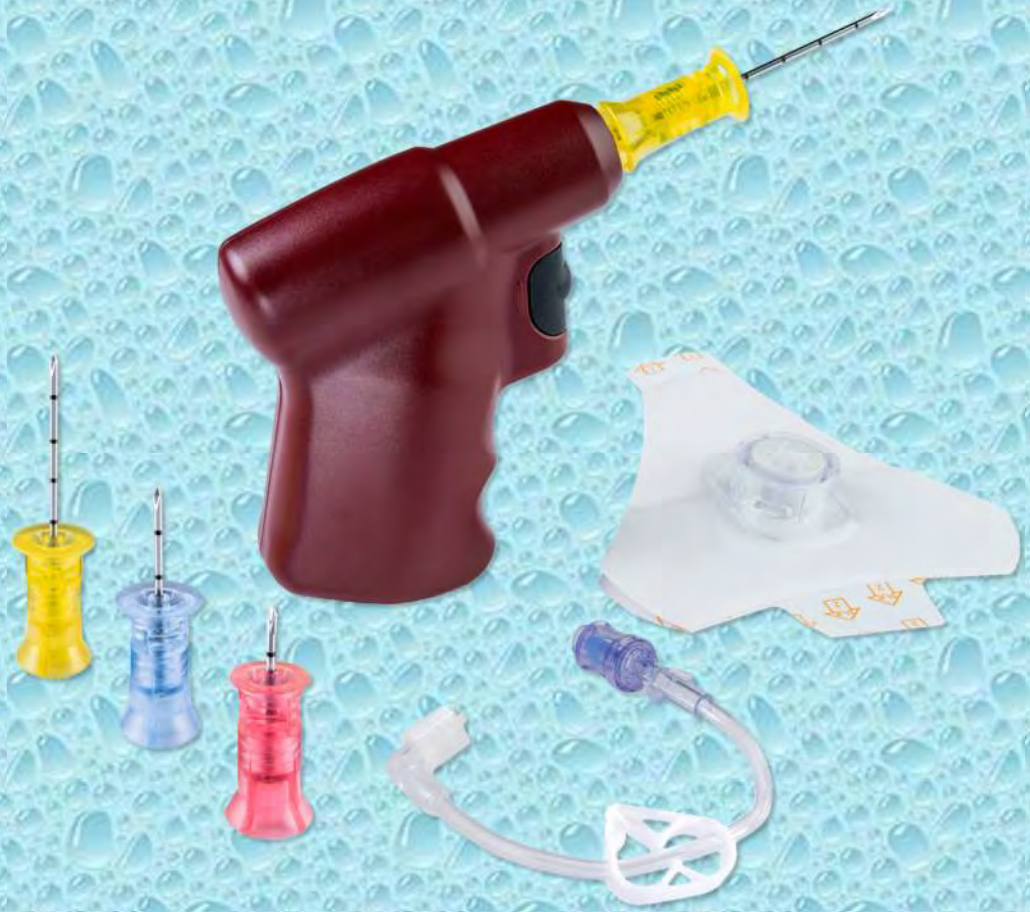
- Responsibility lies with the **staff RN** for IV initiation and maintenance.
- Vascular Access Team is available in a supportive role for difficult sticks and for PICC line placement.
- Staff nurse should try twice, then call charge RN to try, then call IV therapist.

VASCULAR ACCESS TEAMS
SAMC versus ABMC

- Major difference: ABMC has coverage till 9pm every day; SAMC: coverage till 5pm M-F

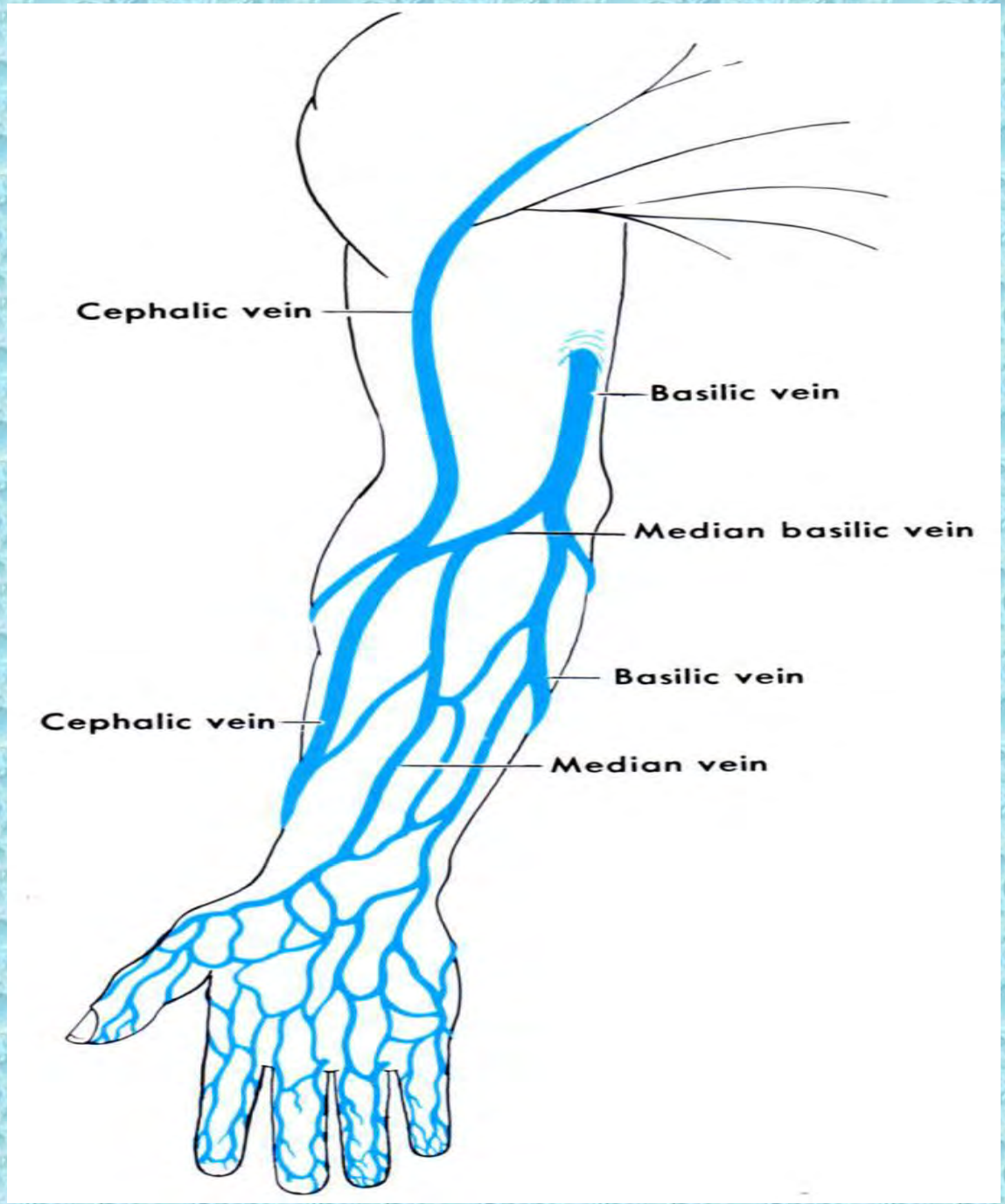
EMERGENT IO ACCESS/ RRT





DETECTIVE WORK

- TAKE YOUR TIME
- Start distal and work yourself up.
- Look for soft, pliable, straight veins
- Avoid slapping the arm/hand or using double tourniquets.
- Avoid hard, bumpy, sclerotic veins, areas of hematoma, skin irritation, extremities with AV fistula, mastectomy sides, etc
- Dangling Extremity/Dilatation/Rubbing with Chloraprep/works best!


Cephalic vein
Basilic vein
Median basilic vein
Basilic vein
Cephalic vein
Median vein

Peripheral IV Catheters

- Protectiv Plus catheters (straight catheters) are predominately used; winged Intimas are used in specialty areas at ABMC for chemo, codes and pediatrics.
- The following is the color coding that is generally a universal color/gauge sizing: 24 gauge, yellow hub; 22 gauge, blue hub; 20 gauge, pink hub; 18 gauge, green hub; 16 gauge, gray hub; 14 gauge, red hub
- **Nothing smaller than 22G should be used on adult inpatients!**
- Extension sets must be used between the hub of a Protectiv Plus and the IV tubing to facilitate tubing changes

NEEDLE GAUGE SELECTION

- Forearm IV's best
- CT injection will need 20G antecubital
- Too large Gauge in small vessel will irritate wall and be short lived!
- L/D, critical care/ trauma = 18G minimum
- Blood TX: 20G but 22G ok

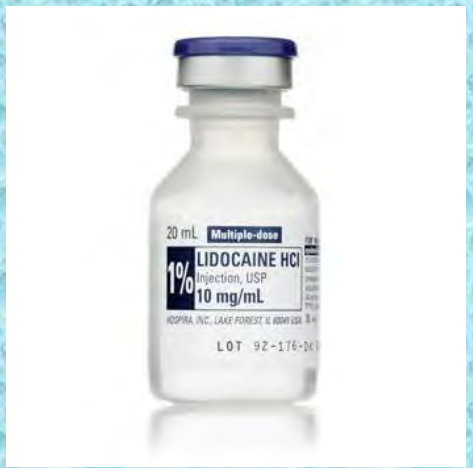
SKIN PREP

- CHLORA-PREP **NOT ALCOHOL** IS USED AS A SKIN PREP

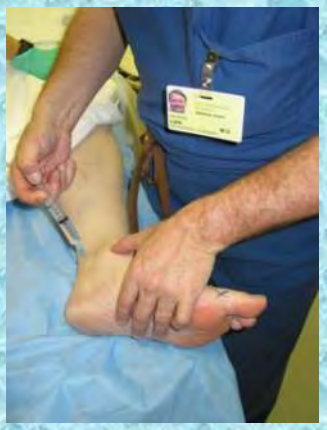
  (back & forth motions for 30 seconds)
- WAIT TILL DRY
- AVOID TOUCHING AREA PRIOR TO STICK AFTER CLEANSING.

OTHER TIDBITS

- Excessive Hair: Trim if necessary/ Do not shave!
- Anesthetic: ABMC upon patient request- Intradermal Lidocaine Injection/ SAMC only Outpatient areas: buffered Lidocaine "poppers"



TIDBITS



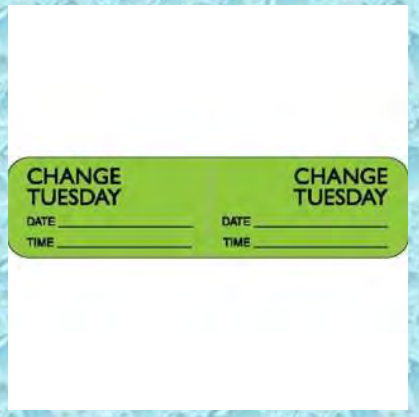
- Avoid placing tape, ointments, or gauze under the transparent IV dressing.
- Avoid excessive amounts of tape which harbors bacteria.
- **If absolutely necessary, you may start IV in a lower extremity. Must obtain MD order first!**

DRESSING

- J LOOP –primed- (**we use Baxter One Link extension tubing)- * OK FOR CT INJECTION!**
- TEGADERM
- MINIMAL TAPE:Many patients have allergies to tapes, so we have several types available: silk, paper, and plastic. Sensitive skin or skin that is thin and tears easily, Paper Tape= Best!
- LABEL- date started, gauge, and initials

TUBINGS

- PLEASE USE LABELS ON IV TUBING
- Per policy- please handwrite the date/time you hung the new tubing and the date it should be changed.
- The sticker placed on the tubing should have the pre-printed DAY of the WEEK reflecting when it should be changed.
- **Changing tubing when due is another component of Infection Prevention.**



IV SITE CARE

- **Site Assessment at both SAMC/ABMC : <u>Q2H on all running IV's,</u> Q8H if site not in use.**
- **<u>Peripheral sites are good for 96 hours</u>**
- Dressings are changed as needed, minimally with site change or when wet/soiled.
- Saline locks are flushed with 3cc saline every shift and before and after any medications, IVPB, etc.

K.V.O/T.K.O

- Nursing policy is **20ml/hour** unless MD orders otherwise. **(Adult Patients)**

TUBING CHANGES

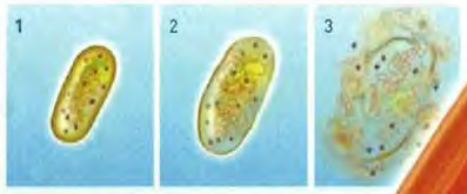
- ***Peripheral*** IV tubings are **96 hour** changes and with site change if tubing at least 24 hours old.
- Tubings on ***central lines*** are **96 hour** *changes.
- Secondary ***(intermittent)*** tubing is a **24 hour** change.
- ***Hyperal***- **24 hour** change
- Label tubings and bags accordingly.

SWAB CAPS- Policy Changes

- **Swab caps should be applied to ALL Central Line tubing access ports not in use.**
- **Swab caps should be used on <u>Peripheral IV tubing</u> access ports in: ICU/TCU/PICU/NICU and any patient on Neutropenic Precautions (ANC <1000).**
- Swab caps should be replaced with new ones each time they are removed.
- **<u>SWAB CAPS HELP PREVENT INFECTION</u>**
- **<u>STILL NEED TO SCRUB PORT WITH ALCOHOL SWAB FOR 15 SECONDS ON SUBSEQUENT IVP/USAGE***</u>**

Disinfection Cap Protects IV Connectors

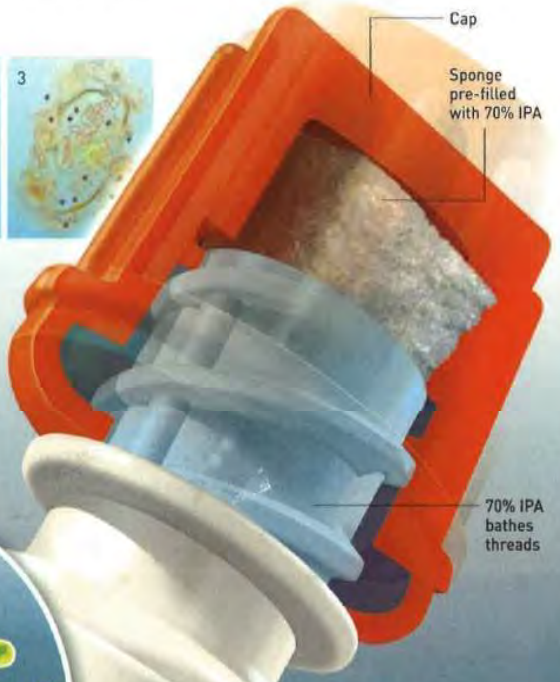
The FDA-cleared disinfection cap helps protect needleless IV connectors from pathogens that can cause central line-associated bloodstream infections (CLABSI), by providing aseptic access and passive disinfection.[1] To apply, a nurse twists the antiseptic-barrier cap onto an IV connector after the catheter is placed, bathing the connector in 70% IPA.[2] The cap remains in place until the next catheter access. No drying time is needed when it is removed. Observation of the orange cap assures compliance with Joint Commission standards.[3]



Cell death by IPA

When exposed to 70% isopropyl alcohol, harmful bacteria absorb the solution, making the cells swell, then breakdown and die. An in vitro study found that after 5 minutes of contact time with the cap, there were zero* colony-forming units (CFUs) detected on the IV connectors.[4]

*Below detectable limits.

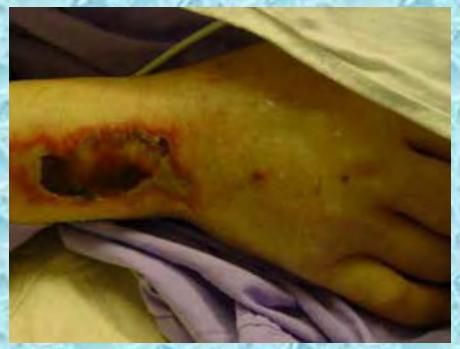


Manual scrubbing—previously the only standard technique for disinfection—results in poor compliance and inadequate disinfection of the IV connector.[6,7]

Presented as a scientific poster at APIC 2011 annual conference in Baltimore, MD. See references on reverse side.

ASSESSMENT

- Infiltration- "non-vesicant" meds/solution into surrounding tissues.
- Extravasation – "vesicant" meds/solution into surrounding tissues.
- Examples of vesicants: Dilantin, K-Rider, Dopamine, Levophed, Calcium Chloride/Gluconate etc.



Infiltration Criteria

- 0+: No symptoms
- 1+: Skin blanched, edema < 1 inch, cool to touch, with or without pain
- 2+: Skin blanched, edema 1-6 inches, cool to touch, with or without pain
- 3+: Skin blanched, translucent, gross edema > 6 inches, cold to touch, mild to moderate pain, possible numbness
- 4+: Skin blanched, translucent, skin tight, leaking, skin discolored, bruised, swollen, gross edema >7 inches, deep pitting tissue edema, circulatory impairment, moderate to severe pain, ****INFILTRATION OF ANY AMOUNT OF BLOOD PRODUCT, IRRITANT, OR VESICANT.** (this requires the filing of a Quantros report).**

TREATING EXTRAVASATION

- Consulting with Pharmacy & Physician
- Stop the running solution but do NOT pull out the IV line… you may need to use it to administer antidote
- *Pressors: Dobutrex, Dopamine, Levo, Neo, Epi*
- Regitine shortage/ Terbutaline substitute SQ
- Regitine 10mg diluted/ Terbutaline 1mg diluted in 10ml saline/ use 25/26 Needles!

TIDBITS

- Time honored nursing practice of "elevating extremity" with infiltrations NOT evidenced based.

- Cold/Warm packs??

COMPRESSES

- **HOT**- isotonic solutions, normal PH- heat promotes absorption by increasing circulation to the area
- **COLD**- hypertonic, elevated PH (giving warm to someone in this case = further displacement of solution into tissues)

PHLEBITIS

- Inflammation of vein. (acceptable phlebitis rates should be 5% and below)
- Warm compresses
- Send catheter for culture.
- Antibiotics?

Phlebitis Criteria

- 0: No clinical symptoms
- 1+: Erythema with or without pain, edema may or may not be present, no streak formation, no palpable cord
- 2+: Erythema with or without pain, edema may or may not be present, streak formation, no palpable cord.
- 3+: Erythema with or without pain, edema may or may not be present, streak formation, palpable cord.

DOCUMENTATION

- **Vascular Access Screen in Meditech**
- All documentation is done here: routine care, assessments, phlebitis assessment, central line care, Mediport, IV insertions/attempts.

IVPB

- MAKE SURE YOU MIX THE MEDICINE AND GET IT INTO THE BAG
- MAKE SURE SECONDARY TUBING ROLLER CLAMP IS OPEN

Back Priming Technique (for IVABs)

- **Fewer entries into the IV system**
- **Decrease supply cost**
- **Save RNs time**

First, close the regulator clamp of the continu-flo tubing (for gravity infusion) or push the stop button if using an IV pump.

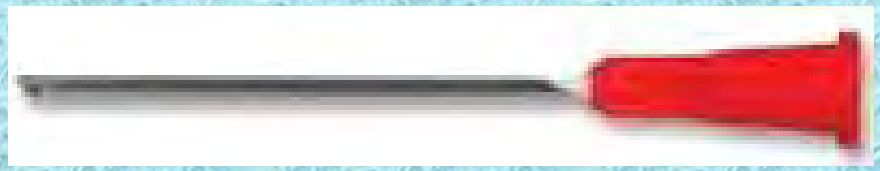
Lower the empty secondary bag, from a previous infusion, until the top of the bag is at the level of the check valve.

Open the roller clamps on both sets and allow the IV fluid to flow from the primary bag into the secondary tubing for 5 seconds, which will be approximately @25 mls. This is the amount of IV fluid required to clear the residual fluid from the previous IVPB, from the secondary tubing.

When using this method, the primary IV fluid must be compatible with the secondary medication.

NEEDLE SAFETY

- O.S.H.A compliance
- Use needles only for IM/SQ injections.
- NEEDLESS devices for vial access, IVP, drawing from glass ampule.
- Blunt tip cannula, filtered straw, etc.



NEEDLE SAFETY

- Needle will lock in safety chamber
- Always Activate the Needle Guard – even if you are inches away from Sharps Container!

NEEDLE STICK INJURY

- Wash Site with Soap/Water thoroughly
- Report Immediately to Charge RN/Supervisor
- ER Testing
- Prophylaxis Treatment

SPECIMEN LABELING EDUCATION

Patient Safety Issues Related to Labeling

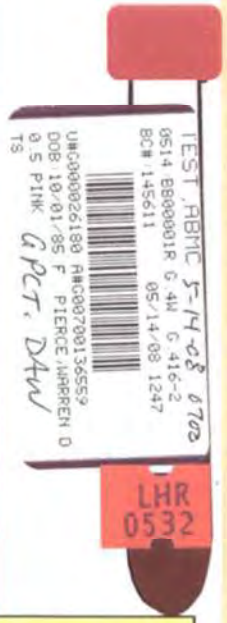
LABORATORY LABELING REQUIREMENTS

Patient identification must be verified and specimen(s) labeled at the bedside.

Sample Labeling

In order for the Lab Instruments to read the barcode on the label the following guidelines must be followed:

- **Place the barcode vertically on the tube with the patient's name toward the stopper.**
- Label must be **free of wrinkles** and not extend past the bottom of the tube.
- Label should cover the manufacture's label.
- Make certain the container type on the label matches the specimen/tube you are labeling.



Per regulation all Lab specimens are required to be positively identified. **Clearly write** both your assigned Meditech log in (example: GPCTKXJ) and the time of collection on the **Master Label**.

SEND ALL EXTRA LABELS TO THE LAB WITH THE SPECIMEN(S)

Mandatory Blood Bank Labeling

The Lab Barcode Label should be used whenever possible. Place the blood bank number sticker from the blood bank band on the sample. The following **handwritten** information is also required:

- **The collectors Meditech Log In ID**
- **The Date & Time of Collection**

If the barcode label is not available you must clearly write the **Patient's Name and Medical Record Number** along with the above information.

Perfectly labeled specimen

Full patient name is visible

Specimen quality is visible

Whole barcode is straight

No writing by the barcode

Test name is visible

LABEL PRINTING ISSUES

MISSING TEST AT BOTTOM OF LABEL

MISSING NAME AT TOP OF LABEL

If this happens your unit will need to contact the Help Desk to realign the printer.
Inform them this is “affecting patient care”.

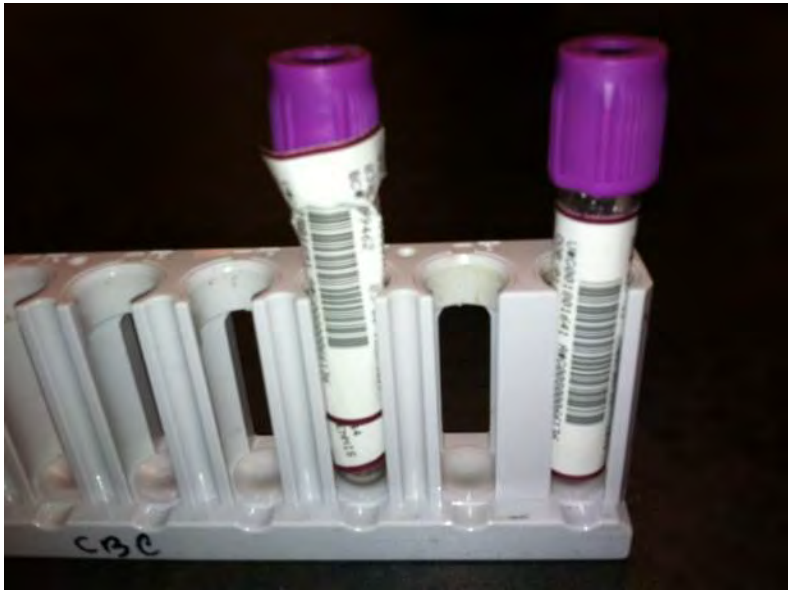
PLACEMENT OF LABEL ON TUBE

LABELS MUST BE STRAIGHT SO LASER CAN READ BARCODE

Instruments will not run tests on the tubes with defective labels therefore delay in results

PLACEMENT OF LABELS ON TUBE

LABEL IS LOCATED TOO HIGH ON TUBE



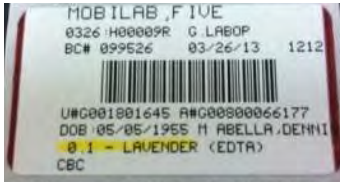
LABEL COVERS TOO MUCH OF THE TUBE. SPECIMEN NOT VISIBLE.

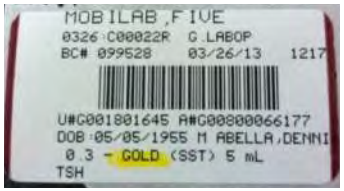
HINT: PLACE BARCODE LABEL DIRECTLY OVER MANUFACTURE LABEL

Lab central processing has to reprint labels
Relabeling creates opportunity for mislabeling.

CORRECT LABEL ON CORRECT COLOR TUBE

THE CORRECT TUBE COLOR IS INDICATED ON THE LABEL.





AFFIX THE CORRECT LABEL TO THE CORRECT TUBE COLOR.

MASTER LABEL REQUIREMENTS

Clearly print **AlexiCARE** login ID next to "Collected By" and collect time next to "Time" on this master label and send to the Lab

We need to enter this information in the computer for regulatory compliance.

WRITING ON LABELS

DO NOT WRITE ON THE BARCODE LABEL except on the Blood Bank Label (next slide)

Laser

Laser

Instruments will not read this barcode therefore will not run tests

Blood Bank Tubes

Clearly print your assigned AlexiCARE ID, time and date of collection on the tube. Also place the unique blood bank band number sticker on the sample.

- If barcode label is not available you must clearly write the patient's name and DOB along with AlexiCARE ID, date and time of collection

WRINKLED LABEL

Carefully label the specimen so the label is not wrinkled. The instruments can not read these labels

Lab central processing has to reprint these labels. Relabeling creates opportunity for mislabeling.

Perfectly labeled specimen

Full patient name is visible

Specimen quality is visible

Whole barcode is straight

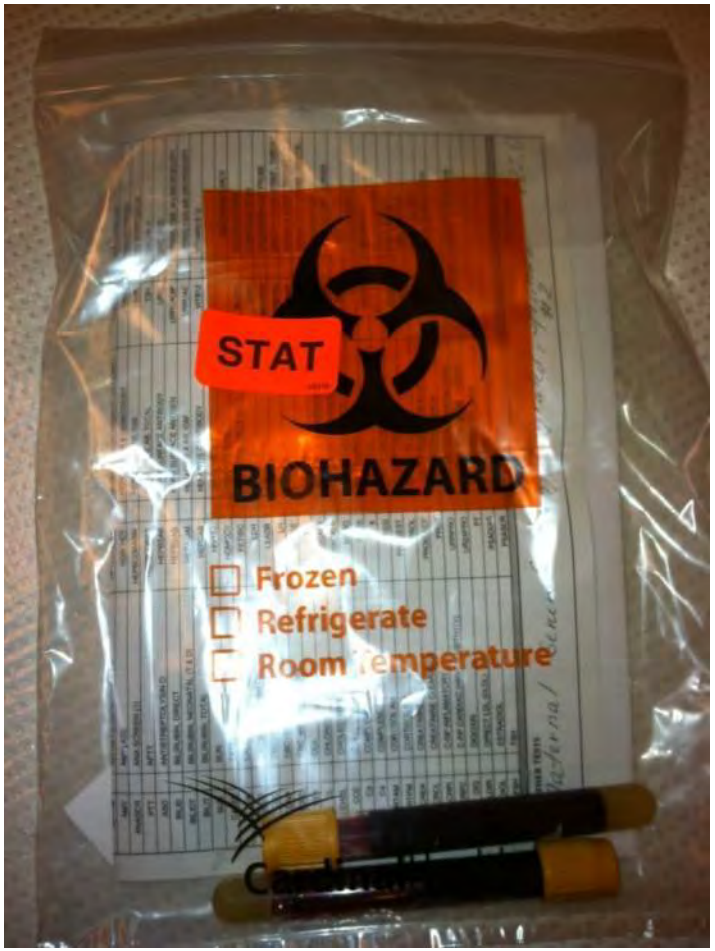
No writing by the barcode

Test name is visible

STATS

When sending stats from the floor put **STAT** sticker on the outside of the bag.

This will aid in processing the specimen quicker.



THANK YOU

Thank you

from

The Core Lab

With your help we will be able to improve quality care for our patients.

MEDICATION MANAGEMENT

Mariusz Kosla, RN, MSN, CCRN-CMC

COMPREHENSIVE MEDICATION HISTORY

- Medication Lists often not updated/inaccurate
- Obtain Pharmacy Information
- Opportunity to Assess for Education Needs
- Polypharmacy- especially in the elderly
- Over the Counter Medications, Vitamins, Herbal Supplements.

MEDICATIONS FROM HOME

BEST TO SEND HOME WITH FAMILY!

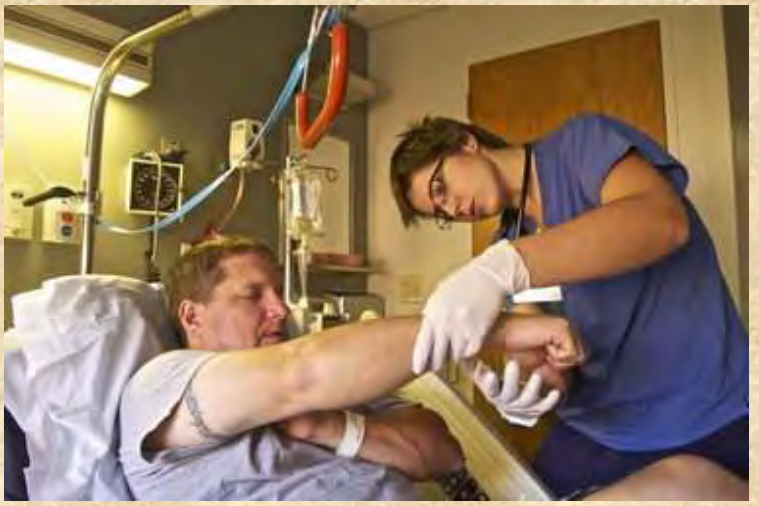
- *If the patient has an order to take "own meds" the medication must be sent to pharmacy for verification.*
- *Medications must NOT be left at the bedside. Can be placed in Pyxis "patient specific meds."*

MEDICATIONS FROM HOME

- If there is no order for self-meds and/or no family available to take meds home, medication will be sent to pharmacy for storage. (NO storage on nursing unit)
- Must be sealed/labeled with patient name.
- Receipt will be given for “Patient’s personal medication.”
- Drugs will be destroyed 30 days after discharge or upon patient expiration.

MEDICATION ADMINISTRATION

- RIGHT MEDICATION
- RIGHT DOSE
- RIGHT PATIENT
- RIGHT ROUTE
- RIGHT TIME



(2) IDENTIFIERS (NAME & BIRTHDATE)

EMAR- BARCODE SCANNER

PHYSICIAN ORDERS

- Telephone orders must be read back to the MD and documented as T.O.R.B
- Verbal orders are taken in Emergency situations. Orders must be repeated back to MD and documented as V.O.R.B
- When entering TORB in CPOE make sure you select the Doctor who actually gave order and not just a doctor from their physician group as the doctor will reject co-signature.

THERAPEUTIC DUPLICATION

- Prescribing multiple medications for the same indication without a clear distinction when one agent should be administered over another
- (2 pain meds for same pain level) ***
- Joint Commission (patient safety issue- RN can't just randomly choose which to give)
- Prescriber must clearly state reason for PRN orders (dropdown box choices)
- Pharmacists clarify any unclear orders
- RN's clarify any unclear Telephone orders

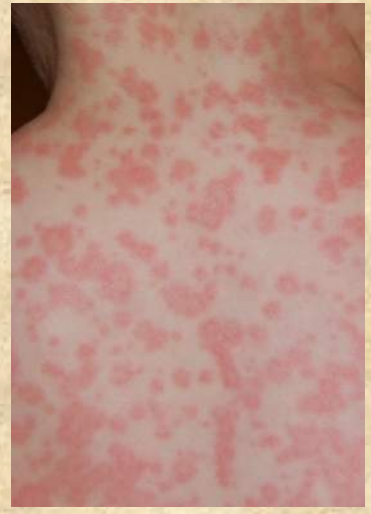
FOOD & DRUG INTERACTIONS

- Can be significant depending on the medication.
- Grapefruit Juice: Potential reaction with any Medications dependant on Cytochrome P450 in its metabolic pathway. (about 60% of all medications)

Taking a medication with grapefruit juice can make it super potent!

ADVERSE DRUG REACTIONS

- Any unintended, undesirable, and unexpected effect of a prescribed medication.
- Treat patient/Notify MD/Document reaction/allergy
- Document in patient record along with any follow-up actions.



A.D.R.

- ADR's are reviewed by the P/T committee
- Pharmacy reports to the F.D.A. significant ADR's
- Death, Life-threatening, Disability, Congenital anomaly, or required intervention to prevent permanent impairment/damage.

PYXIS MEDSTATION

- ABMC: User ID is 1st (3) letters of your last name and the last (4) numbers of your SS#
  Example: Peter Parker SS# 123-45-6789
  Login would be: PAR6789

PYXIS

- SAMC: User ID is your AD LOGIN (network/computer ID) Example: PPARKER01
- For both Facilities your initial password is: PASSWORD *(see green sheet in folder for review)*

PYXIS

- PYXIS “OVER-RIDE” is available for certain medications. (These will vary based upon unit management team approval selection)
- Drugs such as Glucagon, Atropine, Benadryl, are commonly included.

PYXIS

- Addition to controlled substances inventory should be witnessed by an RN and counts verified.

  All controlled substance discrepancies must be resolved prior to shift ending. If unable to resolve , Nursing Director or designee must be contacted.
- Discrepancies are documented through the Pyxis system
- Divergence by Staff may be a reality.

MEDICATION ERRORS

- Any preventable event that may cause or lead to inappropriate medication use or patient harm. (1.3million patient injuries per year in USA according to FDA)
- Violation of any of the "5 patient rights"
- NON-PUNITIVE environment
- NEED TO REPORT MED ERRORS & NEAR MISSES USING QUANTROS

MEDICATION ERRORS

- Monitor the patient and treat as needed.
- Report to MD who ordered the drug or to Attending MD if error involved drug not profiled.
- DOCUMENT- DOCUMENT!

PREVENTION

- Looking at your own practice & routines.
- PATIENT SAFETY! PATIENT SAFETY!
- Always know your medications, usual doses, applicable labs/drug levels to monitor. YOU ARE THE FINAL CHECK FOR YOUR PATIENT!
- CALL MD, QUESTION, CLARIFY, BE THE PATIENT ADVOCATE!

PROFESSIONAL PRACTICE

- If you are ever uncomfortable carrying out a physician order for any reason speak with the ordering physician first.
- Seek guidance from your charge RN, director, or clinical educator.
- Utilize the chain of command if necessary.
- PATIENT SAFETY IS #1 PRIORITY!!!

NURSING PRACTICE

- Medication Management is a major role in the professional practice of Nursing.
- It is CRUCIAL for the nurse to know the indications, appropriate doses, preparation, related laboratory monitoring, food and drug interactions, PRIOR to administering a medication.

NURSING PRACTICE

- Anyone can read an order, read a label, read an ID band and give a DRUG.
- YOU NEED A NURSE TO LOOK AT THE ENTIRE PICTURE FOR THE SAKE OF OUR PATIENT'S SAFETY!!!

WHAT ARE HIGH ALERT DRUGS?

- Any medication error has the potential to harm your patient, but certain “high alert” drugs and drug categories pose an even greater risk of significant harm or death.
- The IHI (Institute for Healthcare Improvement), the ISMP (Institute for Safe Medication Practices) and The Joint Commision have identified the following as “high alert drugs”

HIGH ALERT DRUGS

- Insulin
- Anti-coagulants such as Heparin & Warfarin (coumadin)
- Opioids
- Concentrated Electrolytes
- Chemotherapy drugs
- Intravenous pressors, neuro-muscular blocking agents and anti-arrhythmics.

INSULIN

- Standard insulin infusion concentration is 250units/250ml = 1:1 concentration (likely need to run with IV fluid/tko solution)
- It is critical to prime/waste 20ml of the solution prior to connecting to patient in order to adequately saturate binding sites along the tubing and deliver insulin appropriately to the patient.

INSULIN – SAFETY CHECK

- Dedicated line- nothing infuses with Insulin.
- IV solution, pump rate, and bolus dose will be checked by 2 RN's when the bag is started/changed, rate adjusted, bolus given.
- Bolus doses will be documented on eMAR and RN (double check) -NO BOLUS DOSES THROUGH IV PUMP at this time, (to be permitted shortly)
- Alexicare-documentation of double check

INSULIN

- Blood glucose levels should be closely monitored during IV insulin infusion. (1-2 hours minimum)
- K+ levels should be followed closely during IV insulin therapy since insulin will promote movement of K+ into the cell and can therefore contribute to low serum K+ levels. Should be above 3.5mEq/L to start insulin drip.

HEPARIN

- Standard concentration of Heparin is 25,000units/250ml
- Independent double checks are REQUIRED for calculations and pump programming of Heparin infusions + ARGATROBAN

ANTI-COAGULANTS

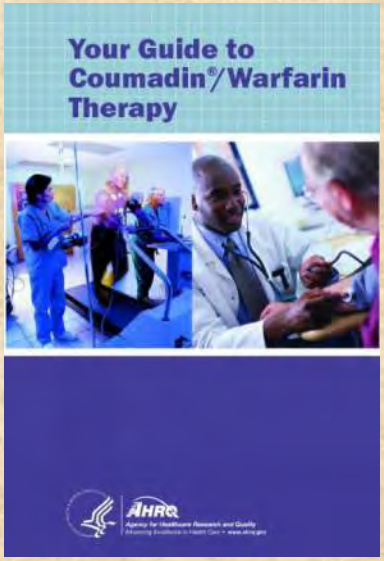
- Lovenox (Enoxaparin) is another form of Heparin but is administered SQ and due to its molecular structure and rate of absorption does not require PTT monitoring.
- Patients with epidural catheters in place should NOT receive anti-coagulants or anti-platelet agents. Lovenox may not be started sooner than 8 hours after epidural catheter removal.

ANTI-COAGULANTS

- Coumadin may be ordered by physician to be dosed by Pharmacy.
- Therapeutic range for INR is 2-3. The physician may prescribe a higher therapeutic range for certain diagnoses.

ANTI- COAGULANTS

- Food/Drug interaction should be provided to patients on Coumadin therapy.
- Coumadin education booklets ENG/SPANISH.
- Patients on Coumadin (new) will be seen by dietician!



- Patients receiving Anti-Coagulant therapy and those on aspirin and anti-platelet agents such as Plavix, Prasugrel, Pradaxa, Xarelto, Brilinta, Eliquis, should be monitored for bleeding.
- In rare instances spontaneous retro-peritoneal bleeds have been reported. Assess for c/o backpain, tachycardia, hypotension.

NOVEL ANTICOAGULANTS/ REVERSAL

- Reversal is a problem (Only Pradaxa- Dialyzable)
- FFP?
- Life threatening Bleeding/Major Surgery: FEIBA- Prothrombin Complex Concentrates can be given IV infusion -quicker and more effective than FFP but with RISKS
- Warfarin Reversal: Vitamin K- with caution Higher doses= Resistance to therapy for 1-2 weeks. IV/PO doses only. SQ should be avoided.

ELECTROLYTES

- Concentrated K+, hypertonic saline and other electrolytes are stored ONLY in the pharmacy dept.
- Electrolytes may NEVER be added to solutions at the bedside.
- Solutions containing electrolytes must always be administered via infusion pump

ELECTROLYTES

- Potassium supplementation may be administered orally, NGT/GT, IV, or per protocol.
- K+ replacement IV exceeding 10meQ/hour requires continuous cardiac monitoring.
- K+ replacement should not exceed 20meQ/hour.

POTASSIUM & MAGNESIUM PROTOCOLS

- Oral preference always over IV if possible for better absorption/outcomes.
- Dosing based on daily EGFR.
- EGFR- accurate measure of kidney function- (uses Creat, Age, Sex, Race)
- Note Exclusion Criteria
- Protocol valid x 7 days only, then need new order!
- Can always call MD to change infusion times to facilitate appropriate care ie… 3gm Mg over 9 hours, one IV site multiple antibiotics due…. ****

PROTOCOLS

- Just a quick reminder..in CPOE when ordering subsequent doses based on previously ordered protocol use (Heparin, K, Mg, etc…) Use “Signed Protocol” as a source… otherwise physician will receive signature request for each entry…..

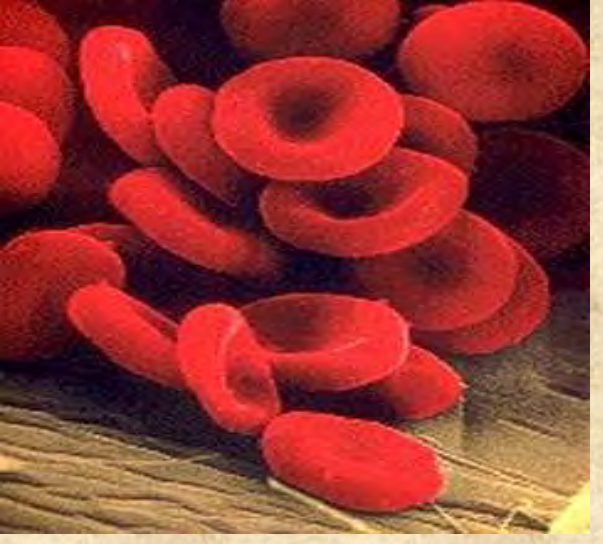
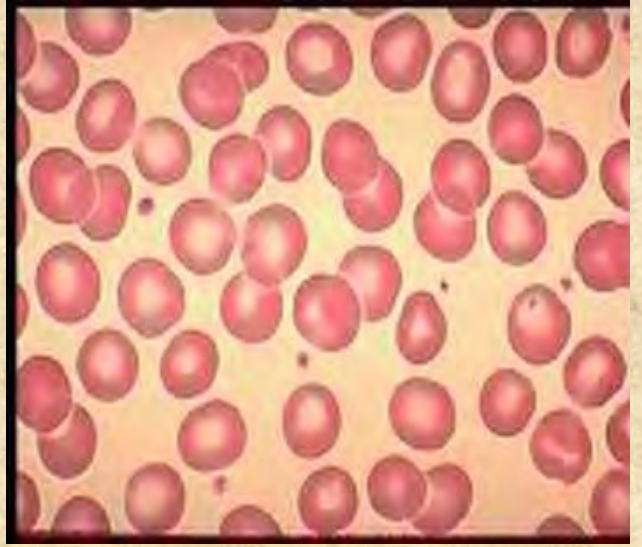
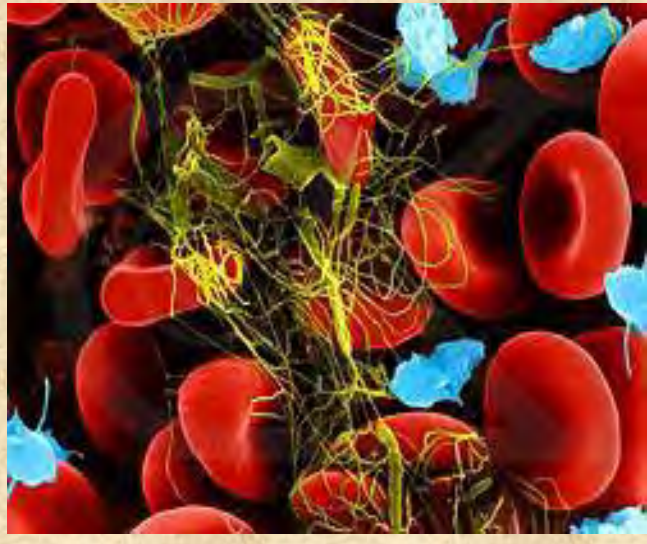
OTHER HIGH ALERTS

- Chemotherapy drugs- (unit specific) should be prepared, handled, administered based on current policy/procedure by authorized staff.
- IV vasopressors/anti-arrhythmic agents (unit specific) should be administered by staff after appropriate training.

CREATING A CULTURE OF SAFETY

- You as the nurse play a KEY ROLE in creating a culture of safety for our patients.
- Ensure medication safety knowing the drugs you administer, following the “5 rights” and monitoring appropriately.
- Take extra precautions when administering “HIGH ALERT MEDS”
- Identify medication errors and near-misses

QUESTIONS? SUGGESTIONS? COMMENTS?

BLOOD PRODUCT TRANSFUSIONS

RISKS OF TRANSFUSIONS

- ✓ HIV = 1 in 2.3 million
- ✓ HCV = 1 in 2 million
- ✓ HBV = 1 in 350,000
- ✓ West Nile=1 in 350,000
- ✓ Other Immune Reactions

BLOOD TRANSFUSION BASICS

- 30 million blood products transfused annually in US with PRBC being most common.
- O negative universal donor
- AB+ universal recipient

BLOOD TRANSFUSION BASICS

- Most common blood types: **0+/ A+** @ 34-38% of population in U.S.A
- Patients that are RH- may receive RH- products only. If a patient is RH+ they may receive either + or (-)

TO TRANSFUSE OR NOT TO TRANSFUSE

- Since 1942 we've used 10HB/30HCT as a-trigger – it is not evidence based!
- Numerous studies now confirm that more transfusions= more complications, increased length of stay and higher mortality
- New transfusion trigger HB 7gm or below with considerations for acutely symptomatic anemic patients and anemic patients with Acute MI/CAD

POINTS TO PONDER- SOME GRAY AREAS

- Sepsis- early goal directed therapy – first 6 hours transfuse to HB 10g/dl, once tissue hypoperfusion resolved, goal Hb 7gm/dl
- Acute MI- (STEMI) transfusion beneficial in elderly patients with HB <10gm/dl.
- Symptomatic Anemia (fatigue, dyspnea on exertion, tachycardia) with HX: CAD- transfusion may be benefical Hb <10gm/dl

CRITICAL VALUE

- Note that a HB drop of 3gm or more is considered a critical value and needs to be called to the physician even though the HB may not be in the transfusion range.

SPECIFIC PRBC ORDERS

- Physicians must order PRBC transfusions via CPOE order set for Blood products.
- Routinely only (1) unit PRBC may be ordered at a time. (active hemorrhage exempted)

BLOOD TRANSFUSION BASICS

- Patient is informed by physician of indication/risks/benefits.
- Obtain signature on consent form. Telephone consent acceptable- 2 persons needed. MD- can document medical necessity in emergencies.
- **CONSENT IS VALID FOR ENTIRE HOSPITALZATION.**
- IV started, saline **TKO (20ml)**, vitals checked, consent checked- NOW- GO PICK UP BLOOD!

BLOOD PRODUCT PICK UP PROCEDURE

- Blood Product Pick Up Slip & Administration Record is (all in one) RN to complete top portion of form in lieu of Blood Product Pick up Slip. This then must be brought down to Blood Bank to pick up products.
- Blood-tubing system* new hospital only
- This same form will later be used for documentation of “double check” and vitals during transfusion on nursing unit.

Complete top NURSING part -→ and bring down with you to pick up product from Blood Bank.

Record all vitals-→

Product info to be filled out by Blood Bank and verified with person picking up. ←

←Double Check Verification- check off boxes and signatures

Place in chart-White completed copy of form , yellow copy to Blood Bank ***

BLOOD PRODUCT ADMINISTRATION RECORD
(Document one blood product per page.)

NURSING

Blood Product:
- ☐ Red blood cells
- ☐ Platelets
- ☐ Fresh frozen plasma or plasma
- ☐ Cryoprecipitate # _____
- ☐ Reconstituted whole blood
- ☐ Other: _____

Special Needs:
- ☐ Leukocyte reduced
- ☐ CMV Negative
- ☐ Irradiated
- ☐ Autologous
- ☐ Sickle cell Negative
- ☐ Other: _____

BLOOD BANK NUMBER: _____ (obtained from patient wristband)

Donor blood type: _____ Donor unit number: _____ (Optional aliquots)

Volume: _____ Issue date: _____ Time: _____

Recipient blood type: _____

I have verified the following: (check appropriate boxes during verification)	Transfusionist: Signature _____	Verified by: Signature _____
Physician order	☐	
Consent signed	☐	
Blood product label	☐	☐
Unit issue transfusion card	☐	☐
Blood Bank identification number	☐	☐
Patient wristband identification	☐	☐

VITAL SIGNS

Date	Time		Temperature	Pulse	Respiration	Blood pressure	Signature
		Pre-transfusion					RN
		Time started	Blood warmer ☐yes ☐no Temperature _____ degrees Celsius				RN
		15 minutes after start of transfusion					RN
		1 hour after start of transfusion					RN
		2 hours after start of transfusion					RN
		3 hours after start of transfusion					RN
		At completion of transfusion					Completed by RN Amount given _____
		Post-transfusion (within 1 hour after transfusion completed)					RN

If the patient's temperature rises 2°F or if the patient exhibits any other symptoms of a transfusion reaction, initiate the following:
a. Stop the transfusion, start normal saline with new IV tubing at the hub of the catheter and cap the blood tubing using sterile technique.
b. Notify the physician and the Blood Bank immediately.
c. Collect blood and urine samples and complete a Report of Suspected Transfusion Reaction form.
d. Return entire infusion set to the Blood Bank, along with samples and paperwork.

ALEXIAN BROTHERS
St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169

BLOOD PRODUCT ADMINISTRATION RECORD
(Document one blood product per page.)

ITEM # 0008400
FORM # F783 NS 07/11
(Lab/Pathology)

LAB

Patient Name

WHITE - Chart CANARY - Blood Bank

BLOOD BANK ID BANDS

- BLOOD BANK WILL "BAND" ALL PATIENTS WITH "**RED" ID BAND** WHEN BLOOD IS DRAWN FOR TYPE AND CROSSMATCH!!!
- Expire 72 hours- need new T/C.. RN's please check especially on patients going to O.R.

TRANSFUSIONS

- An 18-20 gauge needle is recommended and filtered tubing should always be used, 22G are acceptable but anything smaller for adult transfusions is not.
- **No additional filter is necessary with blood tubing for ROUTINE transfusions**.

FILTERS

- Leukocyte Removal Filter is used upon MD order or by issuance of Blood Bank r/t previous history of reactions.
- This filter must NOT be primed with Saline!
- Canadian Study by Herbert found decreased mortality with leukoreduced products. (Leuko poor products not always available)
- **An additional filter will only be used if leuko poor/reduced products not available!**

TUBING SETS

- Tubing can be used for 1 unit ONLY (exception Rapid Infuser 2 units)
- Tubing primed with .9NS only
- Leukocyte removal filters are (1) time use only.

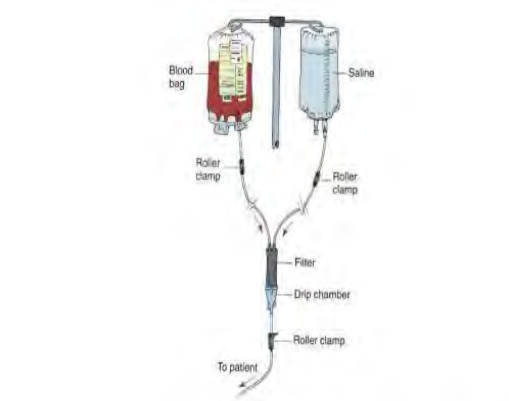


Figure 15-20 Blood transfusion tubing.

BLOOD TRANSFUSION BASICS

- Blood/blood products should be infused via IV pumps.
- Pre-medication is not standard but based on MD preference (ie. Tylenol, benadryl etc.). 2002 Study by Wang found no efficacy in using pre-medications.
- If ordered, should be given 30 minutes prior to start of transfusion unless other specific MD order.
- Furosemide pre or post transfusion –evidence based for poor EF/CHF patients.

TRANSFUSION

- Blood products may NOT be stored in the unit and infusion **MUST BEGIN within 30 minutes and complete within 4 hours of blood bank release not hang time!**
- **Verification must occur at the Bedside with another RN.**
- Close observation of the patient during transfusion is essential especially during the first 15 minutes. Blood should be infused at slower rate during this time then increased.
- RN must escort patients receiving blood transfusions during transport!

BLOOD TRANSFUSION

- Vitals are checked prior to transfusion (within 30 minutes) and 15 minutes after start , then hourly and post transfusion- ALL RECORDED ON TX RECORD..
- Examples of Blood Reactions:
- **Rise in temp 2 degrees F or more** with/or without chills, chest pain, hypotension, backache, rash, hives, itching, dyspnea,flushing,nausea, blood in urine etc.
- **STOP TRANSFUSION IMMEDIATELY!**

REACTIONS!!!!!!

- INFUSE .9NS (SEPARATE)
- MONITOR VITALS
- CALL M.D.- TREAT AS ORDERED
- Notify Blood Bank
- Collect fresh urine sample.
- Order Transfusion Workup (in computer)
- Send blood product and all tubings back to blood bank.

DOCUMENTATION

- Complete Suspected Transfusion Reaction Report.
- Document the reaction and associated assessments/interventions in the Progress Notes!

REPORT OF SUSPECTED TRANSFUSION REACTION

NURSING

Date of reaction	Time started	Time stopped	Amount infused	Time of reaction	Blood bank wristband number

Component: ☐ Packed cell ☐ Plasma ☐ Platelet ☐ Cryoprecipitate ☐ Other

IV fluids given with transfusion: | Blood warmer used? ☐ Yes ☐ No

Donor unit number:

Is there agreement of all information on IT card, blood bag and all paperwork? ☐ Yes ☐ No

☐ Increased pulse	☐ Dyspnea	☐ Fever	☐ Rash	☐ Heat or pain along vein
☐ Decreased blood pressure	☐ Chills	☐ Shock	☐ Hypotension	☐ Back pain
☐ Hemoglobinuria	☐ Nausea	☐ Flushing	☐ Other pain (specify)_____	
☐ Temperature 2°F ↑ baseline	☐ Vomiting	☐ Urticaria	☐ Other (specify)_____	

Pre-transfusion				Post-transfusion				Previous transfusions	Previous reactions
Temperature	Pulse	Respiration	Blood pressure	Temperature	Pulse	Respiration	Blood pressure	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
								Obstetrical history Para _____ Gravida _____	

History of allergy? ☐ Yes ☐ No — Premedication

Chills within the last 48 hours? ☐ Yes ☐ No

Clinical diagnosis — RN signature

LABORATORY

Is there agreement of all identification information of pre-transfusion specimen, IT card, blood bag and all paperwork? ☐ Yes ☐ No (explain)

	Pre-transfusion	Post-transfusion
Color of plasma		
Direct Coomb's		
Spun urine		
ABORH		

Notify Pathologist of any irregularity immediately!!!

Additional Studies Indicated		
Time:	**Signature:**	**Date:**

PATHOLOGY

Interpretation

Physician signature:	**Date:**

ALEXIAN BROTHERS
St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169

REPORT OF SUSPECTED TRANSFUSION REACTION

ITEM # 0008986
FORM # F17260 NS 05/11
(Lab/Pathology)

LAB

Patient Name

WHITE - Chart CANARY - Patient's Copy

ROUTINE DOCUMENTATION

- Make sure transfusion record is complete with all signatures and vitals.
- White copy- chart/Canary copy- B/Bank
- Observe patient for one hour after transfusion.
- Record volume infused in I/O
- Dispose of bag, tubings in red biohazard bag.

Complete top NURSING part -→ and bring down with you to pick up product from Blood Bank.

Record all vitals-→

Product info to be filled out by Blood Bank and verified with person picking up. ←

←Double Check Verification- check off boxes and signatures

Place in chart-White completed copy of form , yellow copy to Blood Bank ***

BLOOD PRODUCT ADMINISTRATION RECORD
(Document one blood product per page.)

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Blood Product:
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- ☐ Cryoprecipitate # _____
- ☐ Reconstituted whole blood
- ☐ Other: _____

Special Needs:
- ☐ Leukocyte reduced
- ☐ CMV Negative
- ☐ Irradiated
- ☐ Autologous
- ☐ Sickle cell Negative
- ☐ Other: _____

BLOOD BANK NUMBER: _____ (obtained from patient wristband)

Donor blood type: _____ Donor unit number: _____ (Optional aliquots)

Volume: _____ Issue date: _____ Time: _____

Recipient blood type: _____

I have verified the following: (check appropriate boxes during verification)	Transfusionist: Signature _____	Verified by: Signature _____
Physician order	☐	
Consent signed	☐	
Blood product label	☐	☐
Unit issue transfusion card	☐	☐
Blood Bank identification number	☐	☐
Patient wristband identification	☐	☐

VITAL SIGNS

Date	Time		Temperature	Pulse	Respiration	Blood pressure	Signature
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BLOOD PRODUCT ADMINISTRATION RECORD
(Document one blood product per page.)

ITEM # 0008400
FORM # F783 NS 07/11
(Lab/Pathology)

LAB

Patient Name

WHITE - Chart CANARY - Blood Bank

TYPES OF REACTIONS

- Hemolytic- Most FATAL - #1 cause is mismatched blood.
- Febrile- Non-Hemolytic- (most common) S/S- fever, chills. C/b antibody reaction with plasma in products.
- Allergic- (second most common) S/S can vary from hives, itching, wheezing, to full anaphylaxis. Usually no fever.

TYPES OF REACTIONS

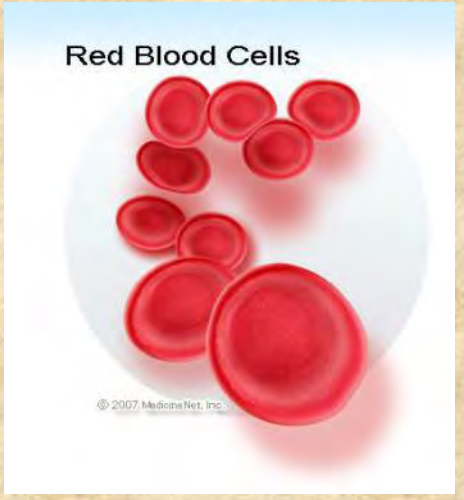
- Bacterial- r/t contamination of product. S/S high fever, chills, renal failure, shock, can occur even several hours post TX
- Overload- r/t administration too quickly to decompensated patient (cardiac) S/S cough, dyspnea, crackles.

OTHER TIDBITS

- Never infuse medications or fluids through your blood transfusion line except .9NS.
- Usually other IV infusions will be turned TKO in order to prevent volume overload. Check with MD.
- FFP- you must notify blood bank when you need it. Remember it takes 30-60 minutes to THAW and when thawed EXPIRES in 24 hours.

TIDBITS

- Re-assessing H/H post transfusion.
- Looking at hydration status and its effect on lab results r/t concentration or dilution.
- General rule of thumb 1 unit PRBC will raise HB 1gm



SPECIAL SITUATIONS

- Patients have a right to refuse any treatment including blood products. Call MD, document in chart.
- Jehovah's witnesses
- Massive transfusions: hypocalcemia due to massive citrate infusion, metabolic alkalosis, drop in core body temperature, hyperkalemia.
- Blood Warmer/Rapid Infuser

OTHER COMPLICATIONS

- **T.R.A.L.I- Transfusion Related Acute Lung Injury** 1/5000 TX incidence.
- 3rd most common cause of death from transfusion. C/b granulocyte or HLA antibodies in donor reacting with recipient WBC which aggregate in Lungs. Typically in patients with severely weakened immune systems. Starts within 6 hours!


My Blood type is
BE NEGATIVE
GENERATORMEME.COM

Alexian Brothers Health System
Acute Care Ministries

Quality/Patient Safety Overview
2015

ALEXIAN BROTHERS
Health System
Our Passion is Powerful Medicine™

What Am I Responsible For?

Patient Safety and Care

How Do I Achieve Patient Safety?

Patient Identification - Ask the Patient

- **“What Is Your Name?”**
- **“Please state your Date of Birth”**
- **Use wristband, orders to check**

Only colored wristbands used are:

- **RED for Blood Bank**
- **HOT PINK for Restricted Use Extremity**
- **NEON GREEN for Difficulty Swallowing**

Current wristband should be used. All others CUT OFF such as transfer from another org, OP procedure, etc.

How Do I Achieve Patient Safety?

- Prevent Deep Vein Thrombosis -use of Anticoagulation, SCD, mobility
- React to Alarms – What is alarm telling you?
- Report Critical TEST outcomes timely
- Report Critical VALUES/ RESULTS timely
- Assess patient's for suicide and keep patient's safe
- Assess for pressure ulcers and mobilize patients often
- Call Rapid Response Team / Families can too!
- Prevent Falls – use alarms, gait belts, stay with patient, ask for help

How Do I Achieve Patient Safety?

SAFE USE OF MEDICATIONS

- **Label medications on/off sterile field**
- **Write expiration date when not used within 24 hours**
- **Independent double checks of high-risk medications**
- **Discard all unlabeled medications immediately**
- **Use individual patient doses**
- **Education on anticoagulation**
- **Safe narcotic use**
- **Medication Reconciliation – list upon admit, reconcile for change of care setting**
- **Educate patient on medication usage**

How Do I Achieve Patient Safety?

DOCUMENTATION

- **Clear and legible**
- **DATE, TIME, SIGN – used as required , all medical documents**
- **Assessment/ Re Assessments completed timely**
- **Pain managed, Assessed and Re Assessed**

How Do I Achieve Patient Safety?

INFECTION PREVENTION/CONTROL

- **Hand Hygiene!!! (GEL IN/GEL OUT)**
- **Use of PPE (personal protective equipment) to manage MDRO (multi – drug resistant organisms) (MRSA, C-Diff, VRE, CRE)**
- **Prevent CAUTI (Catheter-Associated Urinary Tract Infection) – Foley Management**
- **Prevent CLABSI (Central Line-Associated Bloodstream Infection)**
- **Prevent Surgical Site Infections (SSI)**
- **Clean Equipment**
- **Use of appropriate antibiotics**

How Do I Achieve Patient Safety?

USE UNIVERSAL PROTOCOL – for all procedures

- **STOP and validate – patient, procedure/test, side, site**
- **ALL team members involved in the surgery PAUSE for validation**
- **“STOP THE LINE” to keep patients safe**
- **Mark the procedure site, if applicable**
- **Double check Blood Products/Transfusion**

PROCESS

- **Pre-procedure Verification of procedure, with patient involved**
- **Mark the Site**
- **PAUSE for TIME-OUT before procedure begins**
- **Perform COUNTS after surgery/procedure**

How Do I Achieve Patient Safety?

ASK & USE PATIENT PREFERRED LANGUAGE/non-English speaking

- **Use TELEPHONE INTERPRETERS (phones have access codes) for ALL LANGUAGES (Language Cards Available)**
- **Use AMERICAN SIGN LANGUAGE INTERPRETERS (CAIRS, CHS)**
  - **Central Area Interpreter Referral Service**
  - **Chicago Hearing Society**
  - **Video Remote Interpreting (i PAD)**
- **SAMC – on-site Spanish speaking interpreters Mon – Sun 7am-7pm**

How Do I Achieve Patient Safety?

TOP ORGANIZATIONAL PRIORITIES

- **FALL PREVENTION (limited harm with falls)**
- **HAND HYGIENE for INFECTION PREVENTION**
- **PATIENT ID – "FINAL CHECK" of specimens**
- **UNIVERSAL PROTOCOL**

"HEALING WITHOUT HARM" - Use your HIGH RELIABILITY TOOLS

KEEP ME SAFE

HEAL ME

BE NICE TO ME… IN THAT ORDER!!!

Understanding THE BECAUSE…Implementing systems to make it tough to make mistakes!

ALEXIAN BROTHERS HEALTH SYSTEM

TITLE: Personal Social Media and Technology Use			Number: C-118
CATEGORY: Compliance			
SUBCATEGORIES Privacy			
Current Revision Date: 10-08-14	Supersedes: 06-20-12	Original Effective Date: 05-25-11	Page 1 of 3

PURPOSE:

To establish guidelines for use of personal technology, social media and blogs.

POLICY:

Alexian Brothers Health System (ABHS) supports its workforce members' use of social media and blogs for personal and professional use, recognizing that workforce members have a strong voice in representing the organization. The following guidelines have been established to inform and guide ABHS Workforce members who:

- are active in various social media networks;
- choose to make the connection on their personal profiles to ABHS; or
- post their ABHS email as part of their online profiles and persona.

ABHS has ethical, business, legal and regulatory responsibilities to protect confidential and proprietary information of its patients, workforce, and business. Additionally, ABHS encourages its workforce to use good judgment when engaging in such media in order to preserve ABHS's reputation and brand identity. ABHS workforce must be aware of the impression they create about ABHS and others when they develop and/or participate in social media and must ensure that their communication is not causing harm to ABHS, a health care provider, or any individual, including staff, patients and visitors.

SCOPE:

This policy applies to all ABHS workforce.

DEFINITIONS:

Blog: A blog is a website maintained by an individual or organization with regular entries of commentary, descriptions of events, or other materials such as graphics or video. Blogs may provide commentary or news on a particular subject; others function as more personal on-line diaries.

Friending: The act of requesting someone to be your friend on Facebook.

Social Media: For the purposes of this policy social media is an online social structure made up of individuals or organizations that are tied by one or more specific types of interdependency, such as values, visions, ideas, financial exchange, friendship, business operations, professional exchange, etc. Social media sites operate on many levels, from families up to the level of nations, and play a critical role in determining the way information is exchanged, problems are solved, organizations are run, and the degree to which individuals succeed in achieving their goals.

Workforce: Under the Health Insurance Portability and Accountability Act (HIPAA), the workforce is defined to include employees, medical staff members, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

PROCEDURES:

A. General Guidelines
    1. The provisions of this policy should not be interpreted to restrict or interfere with any workforce member's federal or state labor law rights, any applicable rights under the First Amendment to the United States Constitution or equivalent state law rights, or any whistleblower protection under federal and state law.
    2. Communications should be consistent with the ABHS employee handbook, Code of Conduct, and *Alexian Workplace Ethics.*
    3. The workforce member must ensure that blogging and social media networking activity does not interfere with his/her work commitments.
    4. It is imperative that ABHS workforce's online activities are respectful and professional to fellow workforce members, business partners, competitors and patients. Online personas should be appropriate and professional, and workforce members posting on the internet should use a personal email address for identification, not their alexian.net or alexianbrothers.net email address.
    5. Communications in online communities should never contain information that identifies a patient's identity or health condition in any way. Even a casual reference, such as the fact that the employee was a patient's caregiver, is a HIPAA violation since it acknowledges that an individual was or is hospitalized. These rules apply even if the patient was specifically profiled on an ABHS social media site. Also in compliance with HIPAA privacy law, never post or publish photos relating to patients or their care. In general, ABHS encourages workforce members to err on the side of caution and refrain from even vague references to patient care duties.

B. Representing ABHS on Public Social Media Platforms
    1. Workforce members do not represent ABHS. Only those employees officially designated may speak on behalf of ABHS. Unless specifically authorized, workforce members may not hold themselves out to be ABHS representatives.
    2. To protect ABHS's intellectual property, trademarks, and copyrights, the names, logos, and corporate identity of ABHS and its affiliates may not be used without prior consent.
    3. Where a workforce member's connection to ABHS is apparent, he/she should make it clear that he/she is speaking for him or herself and not on behalf of ABHS. In those circumstances, the ABHS workforce member may want to include this disclaimer: "The views expressed on this [blog; website] are my own and do not reflect the views of my employer." The workforce member should consider adding this language to the "About Me" section of his/her blog or social networking profile.

C. Reputation of ABHS, its Facilities, Physicians and its Workforce
    1. A large part of ABHS's business, and the livelihood of its workforce, depends on our patients' confidence in the quality of health care ABHS facilities provide. As such, workforce members should carefully consider whether their posts will have an effect on the reputation of ABHS, its affiliates, workforce, patients, or visitors.
    2. If a workforce member's personal online activities are inconsistent with, or would negatively impact ABHS's reputation or brand, that workforce member should not refer to ABHS or its affiliates, and he or she should not identify the connection to ABHS.

D. Maintaining Professionalism
    1. ABHS workforce members are required to maintain a professional relationship with patients, families and visitors. Friending, emailing, or other after hours contact with a patient, family member or visitor is strongly discouraged – this is especially true in the case of minor patients. Exception is made in cases where the workforce member already has an established friendship before he/she becomes a patient.
    2. To maintain the professional relationship with employees, supervisors should refrain from friending their employees in order to prevent any perception of unequal treatment.

E. Legal Liability and Risks
    1. When an individual posts information to a shared or public forum, he/she is legally responsible for his/her opinions and commentary. Each individual posts information at his/her own risk and should understand that outside parties can pursue legal action against others based on the content of a posting. Authors or posters may be held personally liable by third parties for any commentary determined to be dishonest, defamatory, obscene, proprietary, or libelous.

F. Disciplinary Action
    1. The inappropriate use of social media and blogs by workforce members that conflicts with ABHS's mission and values, violates enterprise administrative policies and procedures, and/or compromises the privacy and security of confidential patient health or proprietary business information shall be subject to corrective action, up to and including termination. In addition, breach of confidential patient health information may also be subject to legal proceedings and/or criminal charges.

REFERENCES:
45 CFR 160.103