WMC Health
Westchester Medical Center Health Network

2019 WMC Bon Secours Charity Health System Annual Education Module For Charity Clinical Staff

Patient Safety

- Patient Identification
- Blood Transfusion
- Clinical Alarm Safety
- Improve Staff Communication
- Suicide Risk
- Restraints
- Pressure Injuries
- PureWick
- CHG Bathing

Outcomes

At the completion of this program, participants will be able to:

- Staff will maintain patient safety by adhering to the National Patient Safety Goals dedicated to identification of patients, critical results and medication administration.

Patient Identification

We accurately and appropriately identify our patients by using two (2) patient specific identifiers prior to the initiation of any procedure, treatment, services or transfers:

Name and the **Date of Birth**.

Please click "Resources" in the upper right hand corner to refer to your policy

Patient Identification

If patient is unable to provide date of birth or a discrepancy exists the **medical record number** will be the second patient identifier.

The patient's room number or physical location **CANNOT** be an identifier!

Do You Know?

- Unidentified patient will be entered into the computer as “John or Jane Doe” and will receive a unique medical record number and patient ID band.

- Once patient’s identity is known Patient Access will issue a new ID band.

  *** The healthcare provider is responsible for replacing the ID band with the corrected patient information.**

Do You Know?

- In the event a patient identification band must be removed if it interferes with treatment or it becomes too tight fitting, a new patient identification band shall be placed on the patient's alternative wrist or ankle prior to removing the old patient identification band.

Do You Know?

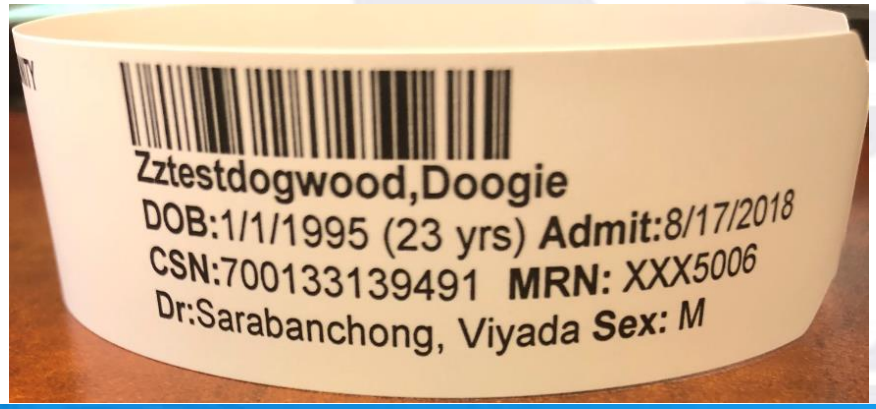
- Prior to surgical procedures, if the patient identification band is on the operative extremity, it is removed and replaced to the non-operative side. This is done prior to the patient receiving any medications or other care.

- Prior to induction, a new patient identification band shall be placed on the patient's alternative wrist or ankle prior to removing the old patient identification band.
  - The assigned healthcare provider will ask the patient to state their name and DOB and will compare for accuracy before removing and replacing.
  - The removed band will be discarded in the "shredder bin."

Patient Identification

Two Patient Identifiers must be confirmed with the patient for all procedures and treatments including but not limited to:

- ✓ medication administration
- ✓ blood sampling
- ✓ blood and blood products administration
- ✓ clinical/medical invasive and noninvasive procedures
- ✓ labeling specimens



Blood Administration

GSH Only

Blood and blood components may be obtained from the Blood Bank by a RN or other designated staff (Unit Clerk, Care Partner or Tech) using the completed Blood Dispensing Request Form, which must have a patient label. The RN is responsible for completing the form, indicating the product requested, based on the order from the L.I.P.).

Blood Administration

Read back should be done between the persons dispensing and picking up the blood using Blood Dispensing Request Form, Transfusion Record and Blood or Blood component bag.

Check the patient's name, Date of Birth, medical record number, components requested, Patient's ABO/RH, Donor ABO/RH, Donor unit # and Expiration date/time.

Please click "Resources" in the upper right hand corner to refer to your policy

Blood Administration

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Good Samaritan Hospital
St. Anthony Community Hospital
Bon Secours Community Hospital

(Affix Patient Information Label Here)

BLOOD DISPENSING REQUEST – PLEASE USE PATIENT LABEL

NURSE REQUESTING BLOOD MUST SIGN HERE

X _____ RN

COMPONENTS REQUESTED (CHECK ONE)

☐ PACKED CELLS ☐ PLATELETS
☐ WHOLE BLOOD ☐ CRYOPRECIPITATE
☐ FRESH FROZEN PLASMA ☐ RHOGAM

PRODUCT ATTRIBUTE REQUESTED, as Physician's Request (CHECK ALL THAT APPLY)

☐ LEUKODEPLETED ☐ IRRADIATED ☐ CMV NEG
☐ SICKLE CELL NEG

NO. OF UNITS REQUESTED

Date of Request:

Location:

FOR LABORATORY USE ONLY

Unit Number	Date	SIGNED OUT BY: X _____
Blood Type	Time	Person Picking up Blood: X _____

Form #0709 Revised 3/18

Blood Administration

The transfusion tag **must remain attached** to the blood bag throughout the transfusion.

After taking blood from the Blood Bank, the staff member must go **directly** to the nursing unit and not carry blood around on other errands.

Transfusion must be started within 30 minutes of leaving the Lab.

Transfusion must be completed within 4 hours from the time the blood leaves the Lab.

Blood Transfusion Safety

- Vital signs required to be taken and **documented** on the Transfusion Record in the EHR for transfusion are as follows:
  - ✓ Pre transfusion (within half an hour prior to start of transfusion)
  - ✓ 15 minutes into transfusion
  - ✓ 1 Hour
  - ✓ 2 Hours
  - ✓ 3 Hours
  - ✓ 4 Hours
  - ✓ Completion of Blood
  - ✓ *1 Hour post transfusion*

How Can You Use Alarm Systems Safely?

- Ensure that alarms on medical equipment are heard and responded by clinical staff trained to address alarm issues
- Care Partners and Techs will not adjust parameters of high-risk clinical alarms
- All clinical alarm signals on medical systems must be on when equipment/systems is used on a patient
- Don’t forget to change telemetry batteries daily

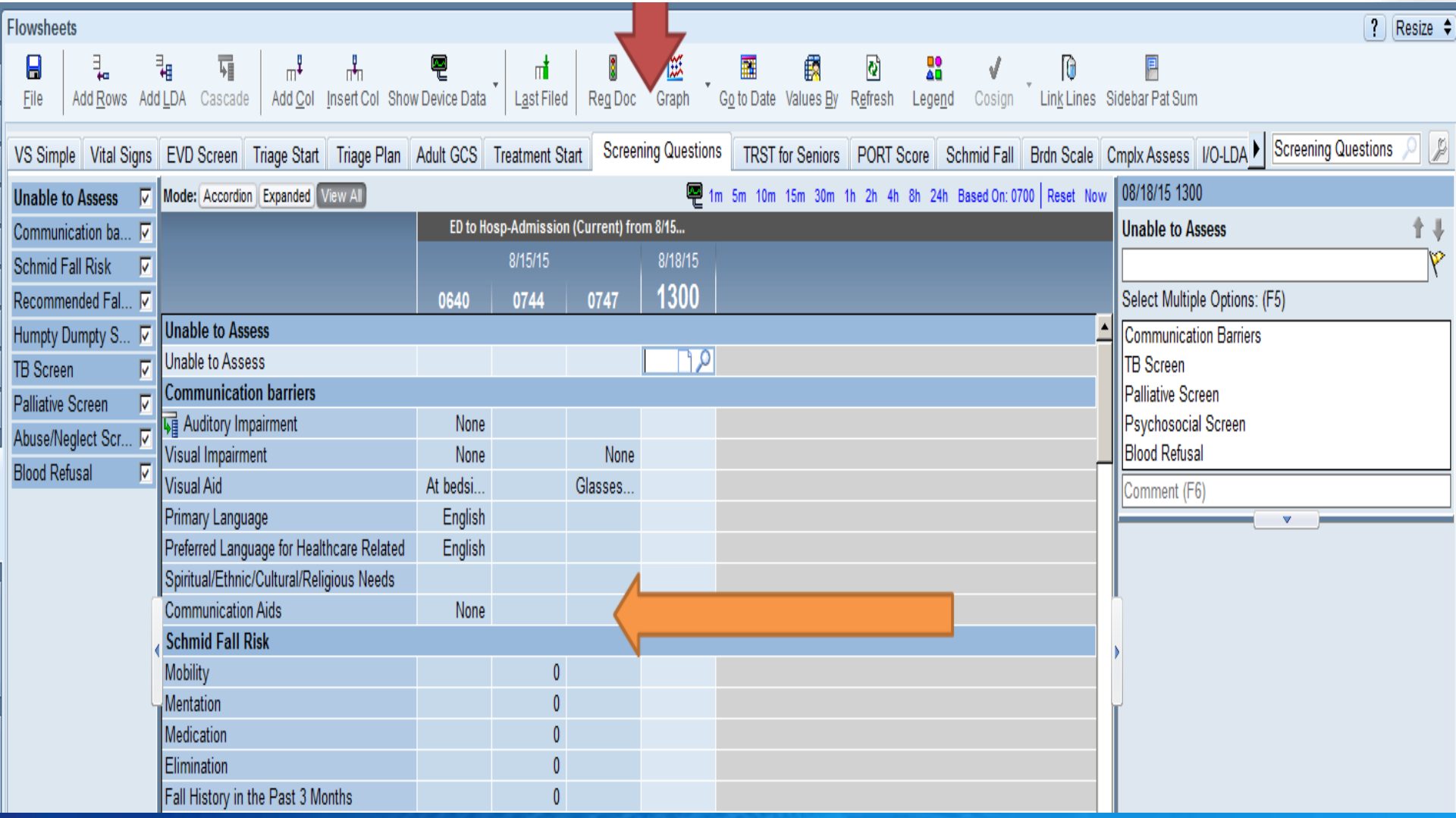
A prioritized list of high-risk alarms are:

- **Ventilator alarms**
- **Cardiac / Telemetry alarms**
- **NICU alarms**

Improve Staff Communication

- Bedside Report
- SBAR
- ISBAR- Communication with Physicians
- Patient Safety Huddle
- Critical Lab Results
- Cyracom® Phone (document after each use in ConnectCare—Communication Aids—Include Operator #).

Documentation of Communication Aid in ConnectCare



Caregiver Handoffs

Situation

•I am calling about Mr./Mrs. _____:
•I am calling because:

Background

•Here is some additional information about the problem:

Assessment

•I think the problem is that:

Recommendation

•Can we get _____ done on the patient (labs/tests)?
•Can we give the patient _____ ?
•Can you come evaluate the patient now?
•Can you talk to the family about the patient's code status?
•If the patient does not get better, when would you want us to call again?

Questions?

Caregiver Handoffs

The primary objective of a handoff is to provide accurate information about patient's current condition and care, as well as any recent or anticipated changes in their condition.

Handoff communication is done:

- At shift change
- At transfer of care in the in-patient setting
- When patients are transferred to other facilities

Caregiver Handoffs

Good communication provides a safer environment for our patients and staff, *as well as* meeting The Joint Commission's National Patient Safety Goal requirements.

Charity uses the SBAR format as a standardized approach to (handoff) communication.

The **ISBAR** format is also used to communicate with physicians about their patient's condition.

ISBAR

Identify	**Yourself - *"I am.."*:** Name, role/position, location **The patient - *"I am calling about my patient.."*:** Name, age, sex, location
Situation	**Briefly describe the situation** **- *"I am calling because.."*** **Vital signs:** P, BP, RR, SpO2, Temperature
Background	**Briefly describe relevant medical history, reason for admission and history of presentation**
Assessment	**Summarize the facts** **Briefly give your assessment** (ABCDE) **and/or diagnosis** **What actions have you made so far?**
Recommendation	**Clearly state what you are requesting** E.g. advise/review/transfer/treatment?

Nørgaard S, Hindborg M, Jensen L, Kristensen C

Caregiver Handoffs

Before Calling the Physician/Licensed Independent Practitioner (LIP) know the:

- Pt's diagnosis
- Pt's history and any pertinent information relevant to your call
- Results of pertinent lab tests, cultures and other diagnostic tests that have been done
- Patient's current medications

National Patient Safety Goal # 15: Identify Patients At Risk For Suicide

Patients at risk for suicide must be identified and be protected by having their immediate safety needs met by the most appropriate action plan based on their level of risk.

Suicide Screening
Risk Factors for Suicide

- The Joint Commission Requirement - All patients are screened for suicide risk
- Initiative of the U.S. Preventive Services Task Force
- Psychiatric Disorders are a major risk factor for suicide
- More than 90% of patients who attempt suicide have a major psychiatric disorder
    - Depression
    - Bipolar disorder
    - Alcoholism or other substance abuse
    - Anxiety disorder
    - Post traumatic stress disorder

Patients at Risk for Suicide Include:

- Previous suicide attempts
- Patients with a plan, act, or preparation towards making a suicide attempt
- Highly impulsive behavior
- Stressors, such as a recent loss of a loved one or financial difficulties
- New diagnosis, existing terminal and/or severe medical illness

Please click "Resources" in the upper right hand corner to refer to your policy

The Caregivers Role

- Report essential information to staff interacting with the patient.
- Report any indications of potential or actual patient risks.
- **Complete the Environment Patient Safety Checklist on initial assessment and each shift.**

Environment Patient Safety Checklist

- An Environment Patient Safety Checklist will be completed.
- Patient will change into hospital attire and belongings will be removed from room and returned to patient upon discharge.

Policy/Procedure

Appendix G

Environment Patient Safety Checklist/Suicidal Precautions
(remove items unless medically necessary)

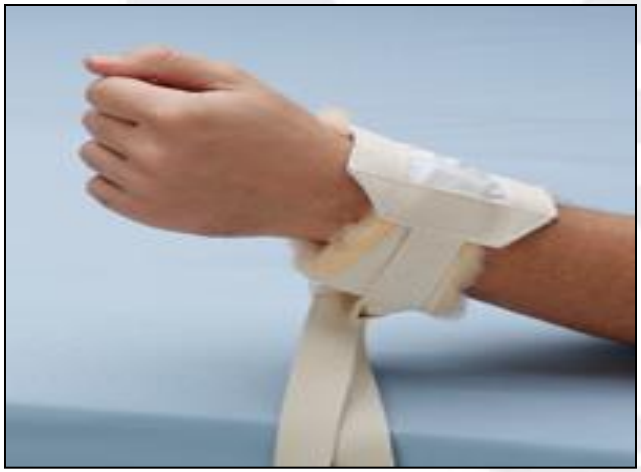
	Items Checked	Date/Initials		
		Shift	Shift	Shift
☐	Remove plastic bags/Replace with paper bag			
☐	Search/Remove patient belongings			
☐	Remove all shoe laces and strings			
☐	Patient in hospital gown			
☐	Remove the oxygen regulator, oxygen tubing, & suction from wall			
☐	Remove IV pole/pump from room			
☐	Remove hand sanitizer from room			
☐	Safe-Tray for all meals			
☐	Remove electrical cords not needed for medical care			
☐	Remove shower curtain			
☐	Remove all sharps from room/patient belongings			
☐	Remove extra bedding			

Write rationale for leaving any equipment in the room.

Notes:

Restraints

- In keeping with our mission, we strive to create an environment which protects the patient's health and safety, while preserving dignity, rights, safety, and well being.
- A restraint is anything that inhibits patient movement.
- Limit restraint use to clinically justified situations in which preventative and alternative strategies have failed and have been documented.
- It is critical to look for the cause of agitation, confusion, etc. so that a restraint can be avoided or removed as soon as possible.



Restraints

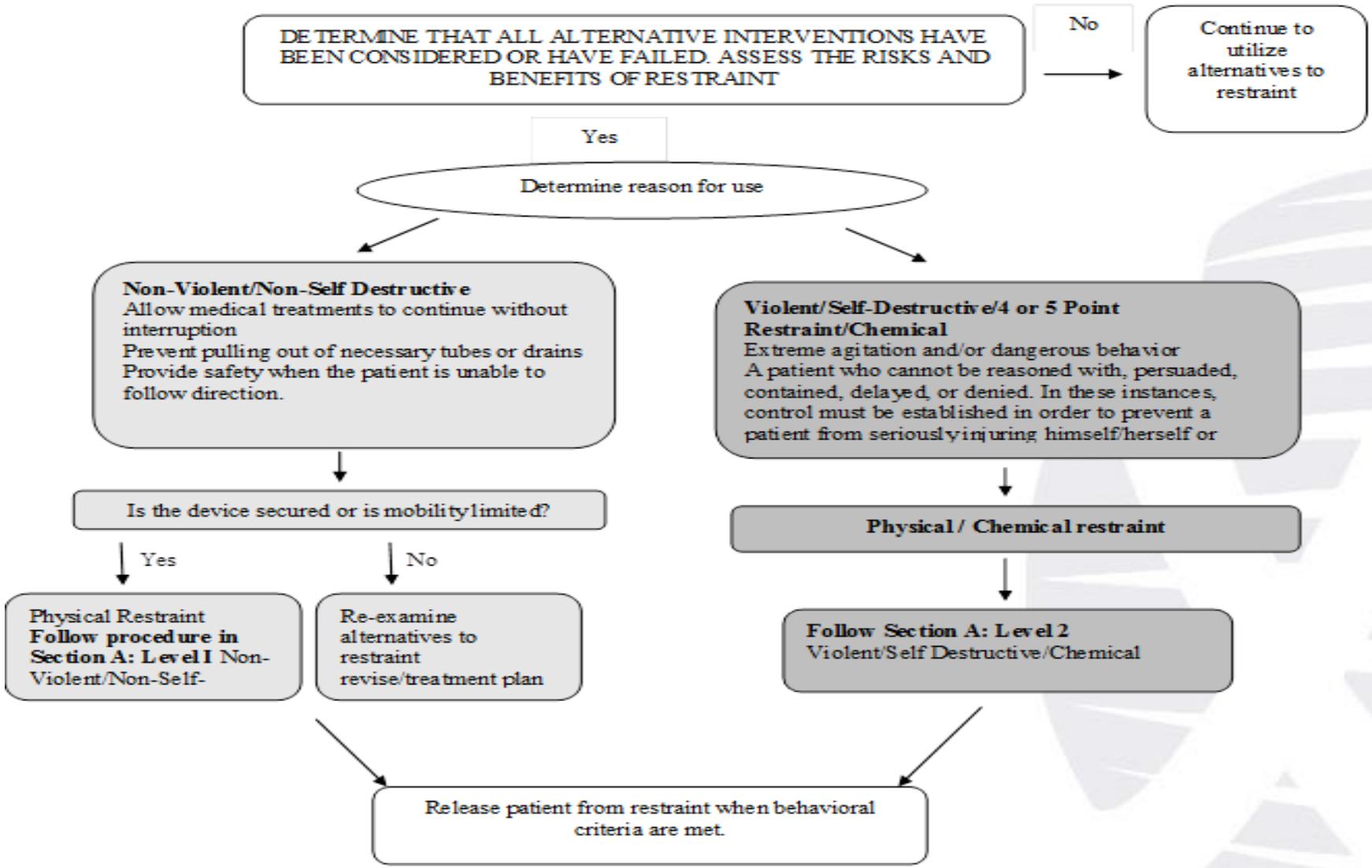
Non-Violent/Non Self-Destructive: Level One restraint standards are implemented for medical or surgical purposes and apply when the primary reason for use directly supports medical healing and to:

- Allow medical treatments to continue without interruption
- Prevent pulling out necessary tubes or drains
- Provide safety when the patient is unable to follow directions

Please click “Resources” in the upper right hand corner to refer to your policy

Restraints

Violent/Self-Destructive/4-5 Point Restraint/Chemical Management : Level Two restraint standards are implemented to protect the individual against injury to self or others resulting from an emotional or behavioral disorder. These standards apply to any patient regardless of the setting who presents with extreme agitation and/or dangerous behavior. Such patients cannot be reasoned with, persuaded, contained, delayed or denied. In these instances, control must be established in order to prevent a patient from seriously injuring himself/herself or others.


DETERMINE THAT ALL ALTERNATIVE INTERVENTIONS HAVE BEEN CONSIDERED OR HAVE FAILED. ASSESS THE RISKS AND BENEFITS OF RESTRAINT
No
Continue to utilize alternatives to restraint
Yes
Determine reason for use
Non-Violent/Non-Self Destructive
Allow medical treatments to continue without interruption
Prevent pulling out of necessary tubes or drains
Provide safety when the patient is unable to follow direction.
Violent/Self-Destructive/4 or 5 Point Restraint/Chemical
Extreme agitation and/or dangerous behavior
A patient who cannot be reasoned with, persuaded, contained, delayed, or denied. In these instances, control must be established in order to prevent a patient from seriously injuring himself/herself or
Is the device secured or is mobility limited?
Physical / Chemical restraint
Yes
No
Physical Restraint
Follow procedure in Section A: Level I Non-Violent/Non-Self-
Re-examine alternatives to restraint revise/treatment plan
Follow Section A: Level 2
Violent/Self Destructive/Chemical
Release patient from restraint when behavioral criteria are met.

Restraints

- Threatening the use of a restraint is prohibited. Restraints will never be used as discipline.
- Know the restraint policy for your unit/area.
- In an **emergency**, a restraint may be initiated **by an RN** as needed to maintain patient safety and facilitate treatment:

  ✓A LIP order must be obtained within **1 hour for nonviolent/non self-destructive management.**

  ✓A LIP order must be obtained within **30 minutes for violent/self-destructive/chemical management.**

Non-Violent/Non Self-Destructive Restraints for Patient Safety

- The Licensed Independent Practitioner (LIP) must **see and evaluate** the patient within **1 hour** of the application of the restraint.
- Medications may be used for facilitating treatment.
- The **order** for the restraint specifies:
  - ✓reason needed
  - ✓time limitation (not to exceed 24 hours)
  - ✓nature of the restraint conditions
  - ✓time of expiration

Non-Violent/Non Self-Destructive Restraints for Patient Safety

Monitoring and Documentation:

- Obtain vital signs immediately after application of restraints and every 2 hours.
- Monitor patient safety and comfort on initiation and every 30 minutes.
- Release restraints every 2 hours unless the patient is asleep to assess range of motion, skin and assessment for release.
- If the restraint is required for another 24 hours, the patient must be reassessed and a new order obtained.

Violent/Self-Destructive/Chemical Restraint for Patient Safety

- The LIP must **see and evaluate** the patient within **30 minutes** of the application of the restraint.
- **The order may not exceed**:
  - Adults: 2 hours
  - Children/Adolescent:
    - Ages 9-17: 1 hour
    - Ages under 9: 30 minutes

Violent/Self-Destructive/Chemical Restraint for Patient Safety

Monitoring and Documentation:

- Patient must be on Constant Observation
- Order must be obtained within 30 minutes
- Monitor patient safety and comfort on initiation and every 15 minutes
- Documentation of vital signs every 15 minutes on the behavioral health unit
- Restraints are released one at a time every 2 hours, unless asleep

Caregivers Role

- Have a clear understanding of the risks and benefits of restraints.
- Perform ROM, offer fluids and nutrition, and provide for elimination needs.
- Follow the policy specific to the reason for the restraint.
- **RN justification for restraint use should be included in shift documentation.**
- Provide and document education given to the patient and their family.

Restraints

- The CMS guideline is to report the **death** of a patient who has had a restraint applied **within 24 hours** of death.
- Any death occurring **within one week** after the restraints were used, where it is “reasonable to assume” that the use of the restraints contributed directly or indirectly to a patient’s death, must be reported.

Restraints

All RNs, Care Partners and Techs must demonstrate competency annually.

In addition, Preventing and Managing Crisis Situations (PMCS) **(BSCH)** or Crisis Intervention Training **(GSH and SACH only)** classes are required:

- **BSCH-** Every year if employed in the MHU, ND, ED, or if you sit for 1:1 observations
- **GSH**- Every year if employed in ED, 3W, or if you sit for 1:1 observations
- **SACH**- Every year if employed in ED, ICU, and Care Partners

Pressure Injuries

Charity promotes pressure injury prevention and reduction by:

- Identifying patients at risk for pressure injuries
- Preventing pressure injuries from developing
- Assessing and treating existing pressure injuries

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Preventing Pressure Injuries

- Use a pressure redistribution surface
- Maintain or enhance level of patient activity
- Off load heels with heel lift boot or pillow (document)
- **Remove TEDS, SCD, heel lift boots every shift and PRN**
- Reposition minimally every 2 hours
- Maintain head of bed at/or below 30º
- Monitor skin under medical devices
- Refer patient to PT/OT with the provider

Please click “Resources” in the upper right hand corner to refer to your policy and resources for Good Samaritan Hospital

GSH: Incontinence PAD Awareness

- Underpads are to be used for incontinent patients ONLY.
- Do not add incontinent pads to beds until patient needs require them.
- Do not use a draw sheet with an incontinent pad (if applicable to your facility).
- Avoid excess linen on bed.

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A member of the
Westchester Medical Center Health Network

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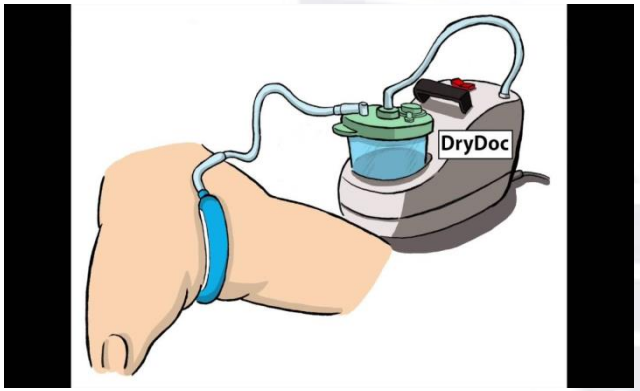
Preventing Catheter-Associated Urinary Tract Infections (CAUTIs)

- Urinary tract infection is the most common type of healthcare-associated infection.
- It is the nurse's responsibility to implement practices known to prevent CAUTIs.
- Inappropriate use of urinary catheters leads to an increased incidence of infections.

Preventing Catheter-Associated Urinary Tract Infections (CAUTIs)

- Before inserting a catheter, consider other alternatives such as timed toileting, condom catheters, PureWick ®, intermittent straight catheterization, etc.

- Best practices to prevent infection include confirming that the patient has an indication for the catheter before insertion.



Quick Tips About PureWick®,

- Wall vacuum will be set at **40mmHg** (low setting) continuous
- If leaking occurs reposition or change the PureWick
- Do NOT use on patients with diarrhea
- Do NOT transport patient off the unit while PureWick is in place
- **Do NOT use with diapers or tegaderm to hold in place**
  - Disposable mesh underwear can be used to secure
- NOT LATEX FREE

Please click "Resources" in the upper right hand corner to refer to your policy

CHG Bathing

The Charity policy for CHG bathing includes:

- All Adult Critical Care patients, Non ICU patients who have an invasive device (PICC line, etc.) and patients who are on Contact Isolation Precautions will be bathed with 2% CHG cloths daily unless contraindicated.
- Patients undergoing surgery unless contraindicated
- Test for allergies on inner wrist at least 10 minutes prior to bathing
- Do not use on mucous membranes

- Chlorhexidine gluconate (CHG) replaces routine bathing for entire ICU stay.
- Do NOT use soap below the jawline. Certain soaps and lotions can inactivate CHG.
- Only use CHG-compatible lotions and/or barrier products.
- Dispose of all cloths in the trash. Do NOT flush.

BATHE WITH CHG USING FIRM MASSAGE TO REMOVE BACTERIA

INCONTINENCE:

- Clean with chux and water, NOT soap.
- Then bathe with CHG cloths, air dry.
- Use as many CHG cloths as needed.
- Apply CHG compatible barrier.
- Repeat throughout the day, as needed.

LINES AND TUBES:

- CHG is safe on lines, tubes, and devices.
- Bathe with CHG right up to dressing.
- Okay to bathe over occlusive dressings.
- After bathing skin, clean 6 inches of tubes/Foley nearest patient.

ONLY USE CHG CLOTHS *BELOW* THE JAWLINE

Skin may feel sticky for a few minutes.
Do NOT wipe off. Allow to air dry.