Health ONE Rose Medical Center

Important information to review prior to your first day at Rose Medical Center

- All HealthONE staff, providers, direct contractors, and students working or completing any clinical hours in the facilities must get the COVID-19 vaccine, unless there is a valid, documented medical or religious reason for opting out. For students, exemptions must be approved through school and submitted accurately/completely into mCE. Those with medical/religious exemptions, must wear an NiOSH approved KN95 mask at all times (N95 required in COVID/AGP rooms) and adhere to strict social distancing while eating/drinking.

- Access to the electronic health record system (Meditech) and medication dispensing system (Pyxis) has been requested for you. Please log-into your account on your first rotation day because the initial password does expire. When logging in for the 1st time, please use the Password Reset Tool (looks like a padlock icon on the hospital's desktop) to initially set up your password. If you have any issues with your access, please contact facility IT Help Desk *first* (please see Service Desk # on bottom of hospital computer's desktop) and if they are not able to troubleshoot your issue, you may contact Alex at (303) 788-5389 or email him at Alex.Smith@HealthONEcares.com.

- Students at Rose will be provided full access to Pyxis retrieve medications. Students require the appropriate supervision of a registered nurse to remove any medications from the Pyxis. A registered nurse must review all rights of medication administration with the student prior to administration. Students require the appropriate supervision of a Registered Nurse for any medication administration.

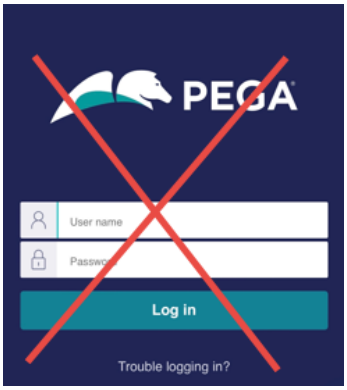
- Students are required to wear their School of Nursing photo badge and RMC student badge at all times during clinical hours. Please plan to obtain your student badge from the Rose Education Department on your first clinical shift with me (Stefanie Benton). The education office is on the ground floor near the auditorium. We will take the main elevators to the ground floor and then walk towards the auditorium. We will pass the "north" elevators and then walk down a glass hallway. At the end of the glass hallway we will continue to walk straight where we will find the education department, which is the second door on their left.

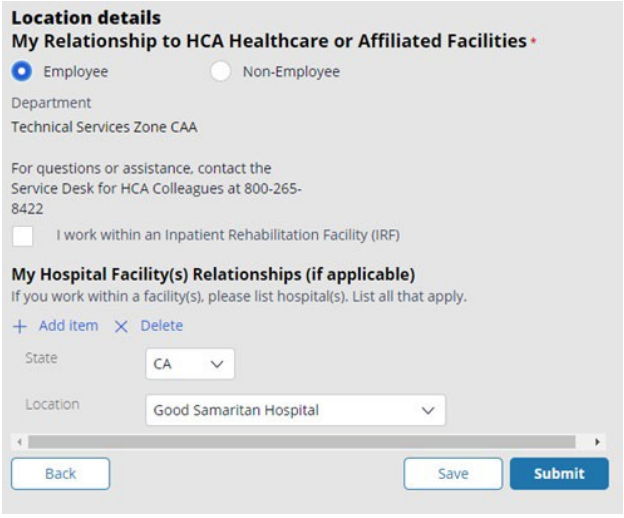
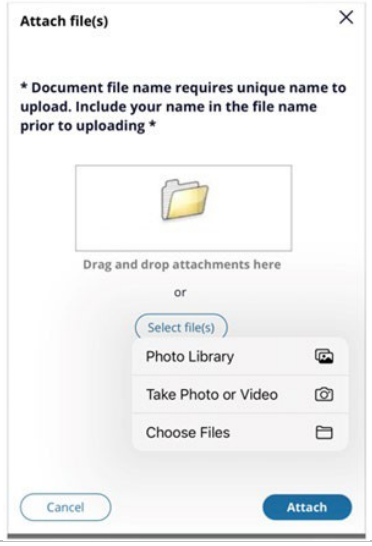
- The badge **MUST** be returned because it is a huge security risk; please ensure you return it on your last day. Failure to return your badge may result in a $50 fine and delay of the release of your clinical grade.

- Parking is free. Students are REQUIRED to park on the upper levels of the Rose parking garage during clinical rotations. It is NEVER acceptable to park in visitor parking areas.

How to Upload COVID-19 and Flu Vaccine Documentation

HCA Healthcare Portal

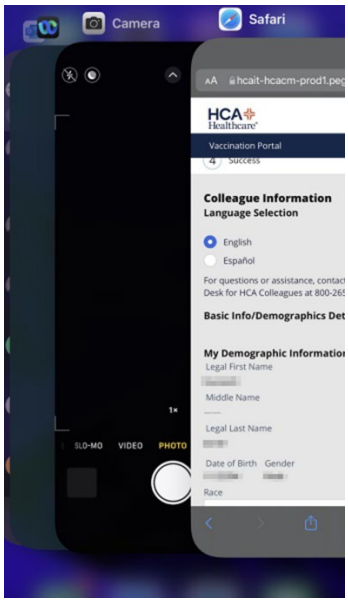
1. Open Safari on iPhone (or other Android browser) and go to **https://hcacovidvaccine.com** or use the QR code to the right from your smartphone camera app to launch the website. You can do this from your personal phone or one of the shared iMobile phones.	
2. Follow the prompts; you will be asked to login with your 3/4 ID and provide colleague information. a. Click "I have a 3/4 ID" – **Do not use "I do not have a 3/4 ID"** b. **New Students:** If you have not logged in before and set a network password, you will use your temporary password in the Password box. Your temporary password is the first letter of first name capitalized, the first letter of last name lowercase, and then @temp! So, if your name is Ann Jones, your temporary password is Aj@temp! A passcode will be sent to your mobile device. Enter it and follow the prompts. You'll be prompted to create a new, strong password. And, you're now enrolled in Identity Connect, which enables you to change your own password moving forward! **Please note:** after this step it will automatically redirect you to the PEGA website. It will not allow you to log in. Please reopen the COVID portal using the QR Code above or **https://hcacovidvaccine.com** **Returning Students:** attempt your last known password to access the system For password support, you can contact HCA IT&S Support Desk at 1-800-265-8422. Once you're able to sign in, follow the steps to record your vaccination status or decision.	 

3. The next screen will require you to input the HCA facilities where you work. Complete your information by selecting the “Add Item” button, then choose the state (Nevada) and facility (i.e. Sunrise, MountainView, Southern Hills). If you work at multiple facilities, please select “Add Item” again to add another entry.	
4. After submitting your answers for facility information, you will be asked to fill out the vaccine declaration. Upon selecting your decision, you will see another prompt asking for additional information. Fill out the prompts as needed or required. When the prompt asks for an attachment, choose “Select File(s)” then “Take Photo or Video” and you can take a snapshot with your smartphone camera. You will still haveto complete additional fields such as vaccineand lot number. Once completed andsubmitted, you will be asked for a final confirmation before submission complete.	

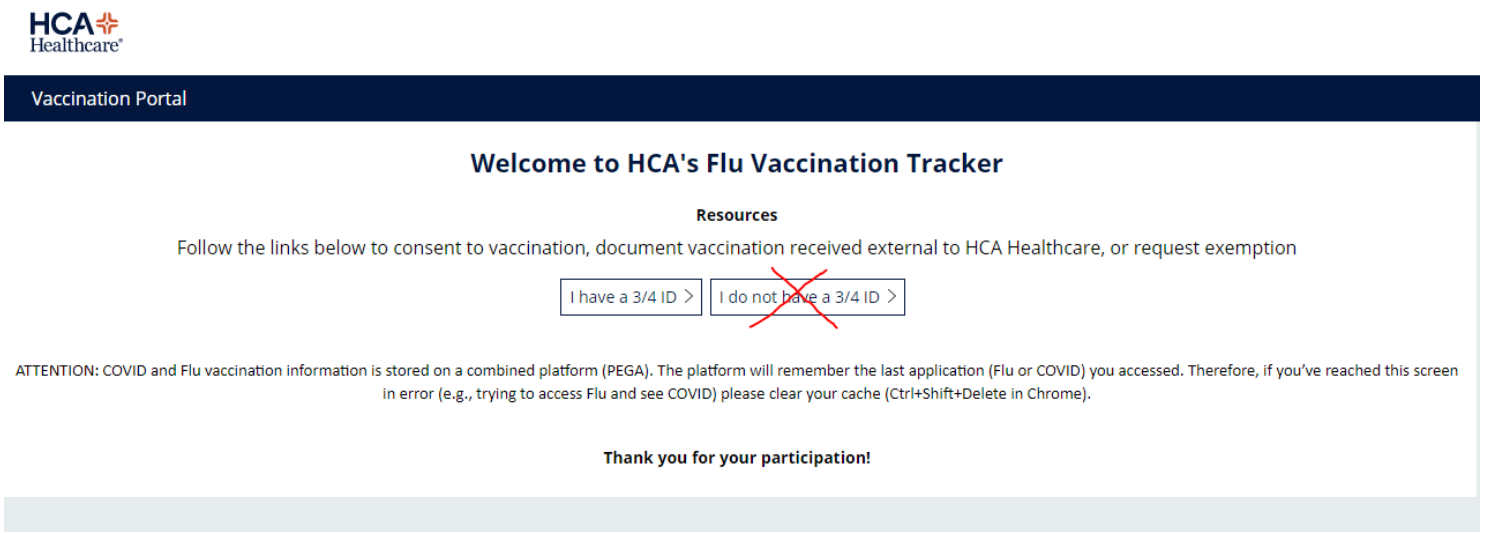
5. Once you've completed submitting your form, make sure to completely close the browser. On iPhones, click the double square in the bottom right corner then click the 'x' to close out that browser.

6. Complete this step to erase your session history and protect your personal information from anyone else that has access to that phone (this is especially true on a shared phone). When trying to connect to hcacovidvaccine.com, if you see someone else's information still logged on, close the browser the same way to clear them out then proceed with your information.

Once you log in, if the PEGA system doesn't allow you to submit vaccine documentation, please contact COVID vaccination support: CORP.workforcehealthandsafety@hcahealthcare.com



For Flu: follow same process, but with this link instead**: https://s2.bl-1.com/h/dr177ky2?url=https://hcait-eecall-prod1.pegacloud.net/prweb/PRAuth/VaccineTrackerFlu



****ATTENTION:** COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reach one of the screens in error (e.g., trying to access Flu and see COVID), please clear your cache (Ctrl+Shift+Delete in Chrome).

HCA/HealthOne Covid and Flu Verification via PEGA

Hello!

The 3-4 IDs in the table, which I will email to you once available, will be used for you to access Meditech (RMHC EHR), but will also be used to document your immunizations (COVID and Flu vaccine) within the HCA vaccine portal (PEGA). With the CMS mandate of the COVID vaccine for healthcare workers, HCA is required to ensure all our students are entered into the HCA vaccine portal (same requirement HCA has for all their employees). Please upload your COVID vaccine/exemption and Flu vaccine/exemption into the HCA system (please note: this is SEPARATE and IN ADDITION to the documentation you have provided in MyClinicalExchange).

Steps for you to take:

1. Please utilize your 3-4 ID (once provided) and review the attached instructions and links below for you to enter in your COVID/Flu vaccine status into the HCA vaccine system (PEGA).
    a. Please complete your vaccine status in PEGA by end of clinical day #1 (ideally prior to your 1st day- link is accessible from outside hospital network)
    b. If you have all documents ready (vaccine card or exemption paperwork), it should be quick to complete (5 minutes)
    c. If you are is a current HealthONE employee or have completed a recent HealthONE rotation (and completed this process already), you can disregard as you do not need to complete again
2. Please send me an email confirmation (sbenton@denvercollegeofnursing.edu) that you have completed this or screen shot of your submission screen (from PEGA) to me, so I can verify it was completed. Please do not submit vaccine cards/exemptions to me directly, as it needs to be in the HCA PEGA system.
3. If you are not complete by end of day #1, you cannot return to clinical until complete.
4. To document both COVID and Flu vaccine/exemption, you must use both links below. Please note: COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reached one of the screens in error (e.g., trying to access Flu and see COVID) please clear your cache (Ctrl+Shift+Delete in Chrome).

   Please see attached directions and click the separate links below for access to each vaccine application/portal page.

**ATTENTION: COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reach one of the screens in error (e.g., trying to access Flu and see COVID) please clear your cache (Ctrl+Shift+Delete in Chrome).

HCA/HealthOne Covid and Flu Verification via PEGA

COVID vaccine/exemption upload link or QR code:	**How to Record your COVID-19 Vaccination Status or Decision** Have your 3-4 ID. Go to https://hcacovidvaccine.com/ **Web address must be entered as listed above.** 3. Click "I have a 3-4 ID".
Flu vaccine/exemption upload link:	How to Record your Flu Vaccination Status or Decision 1. Have your 3-4 ID 2. Go to http://hcaflutrack.com/ Web address must be entered as listed above. 3. Click "I have a 3-4 ID".

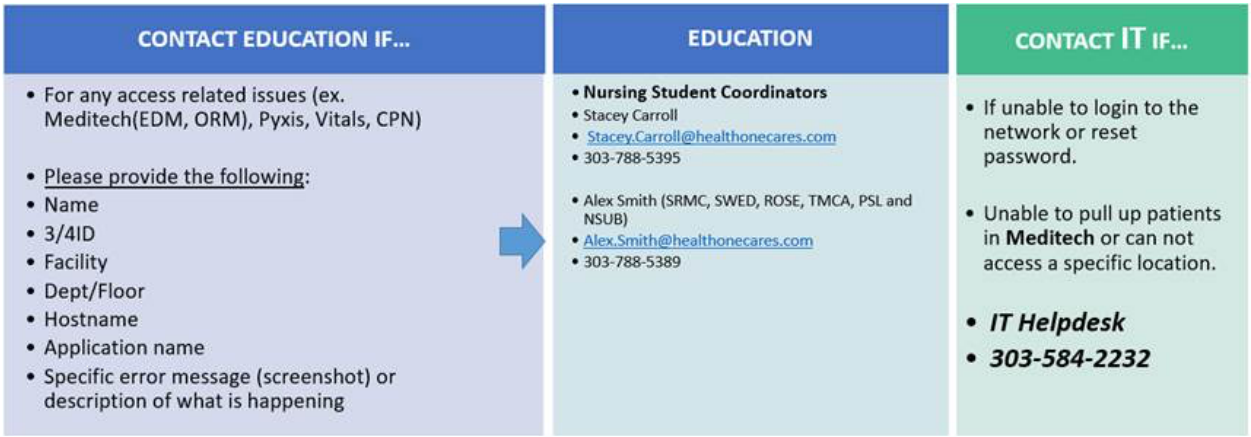
If you are having issues with uploading or accessing the HCA portal/PEGA site: please contact the PEGA system support email: CORP.workforcehealthandsafety@hcahealthcare.com

If you are specifically having issues with the 3-4 ID username not working (i.e. "invalid user" message), please contact the facility's IT Help Desk (this is the number at the bottom of the hospital desktop).

If you continue to have issues, please contact Nicole Hill: Nicole.Hill@Healthonecares.com or Stacey Carroll: Stacey.Carroll@Healthonecares.com (Student coordinators for HealthONE)

We appreciate your help with this to ensure all our students are meeting the requirements and have these vaccinations/exemptions documented within our system.

Meditech Troubleshooting:



Hello Students,

HealthOne Rose Medical Center user IDs (called 3-4 ID) have been created for the you.

New Process: ALL students need to enter in their COVID vaccine status (vaccine card or approved exemption) into the HCA vaccine system (referred to as PEGA). With the CMS mandate of the COVID vaccine for healthcare workers, we are required to ensure all our students and outside instructors are entered into the HCA vaccine system (just like our employees). This needs to be completed **by clinical day #1**.
If not complete by end of day #1, student may not continue in rotation until they have it complete.

Steps to take before first clinical shift:

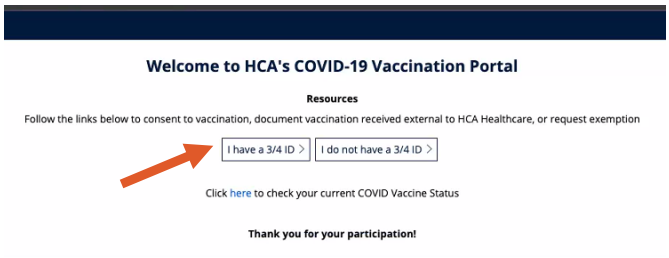
1. Please find your login ID (see table below) and attached instructions for you to enter in your COVID vaccine status into the HCA vaccine system (PEGA).
    a. If they have all documents ready (vaccine card or exemption paperwork), it should be quick to complete (5 minutes)
    b. If you are a current HealthONE employee, you can disregard, as you should have already completed your vaccine status in PEGA
2. Please send an email confirmation that you have completed this or screen shot of your submission screen (from PEGA) to me (**Stefanie Benton**), so I can verify it was completed. Please do not submit vaccine cards/exemptions to me directly, as it needs to be in the HCA PEGA system.
3. If someone is not complete by end of day #1, you will not be able to return to clinical until complete.

If you are having issues with uploading or accessing PEGA? Please have contact the PEGA system support line: **844-674-7431**. If you are having issues specifically with your 3-4 ID username not working, please contact the facility's IT Help Desk (please see troubleshooting table at bottom of email) directly.

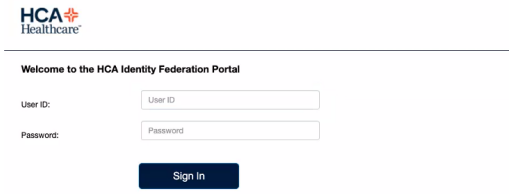
CONTACT EDUCATION IF...	EDUCATION	CONTACT IT IF...
• For any access related issues (ex. Meditech(EDM, ORM), Pyxis, Vitals, CPN) • Please provide the following: • Name • 3/4ID • Facility • Dept/Floor • Hostname • Application name • Specific error message (screenshot) or description of what is happening	• **Nursing Student Coordinators** • Stacey Carroll • Stacey.Carroll@healthonecares.com • 303-788-5395 • Alex Smith (SRMC, SWED, ROSE) • Alex.Smith@healthonecares.com • 303-788-5389 • Rachelle Bucknell (TMCA, PSLM, NSUB) • Rachelle.Bucknell@healthonecares.com • 303-788-5388	• If unable to login to the network or reset password. • Unable to pull up patients in **Meditech** or can not access a specific location. • ***IT Helpdesk*** • ***303-584-2232***

How to Record your COVID-19 Vaccination Status or Decision

1. Have your 3-4 ID.
2. Go to https://hcacovidvaccine.com/
   a. Web address must be entered as listed above.
3. Click “I have a 3-4 ID”.



4. If you know your network password (that you use to log in to an HCA Healthcare computer) enter your 3-4 ID in the User ID box and your network password in the Password box.



5. If you have not logged in before and set a network password, you will use your temporary password in the Password box.
   Your temporary password is the first letter of first name capitalized, the first letter of last name lowercase, and then @temp! So, if your name is Ann Jones, your temporary password is: Aj@temp!
6. A passcode will be sent to your mobile device. Enter it and follow the prompts.
7. You’ll be prompted to create a new, strong password. And, you’re now enrolled in Identity Connect, which enables you to change your own password going forward!
8. Follow the steps to record your vaccination status or decision.

HCA Healthcare®
Center for Clinical Advancement

Unit-Specific Information

UNIT OVERVIEW

- 18 Bed split Ortho Spine Unit located on 1st and 2nd floor of the Wolf building. Access via 1st floor onto the unit, take elevator to OS 2.
- Designated unit in Ortho/Spine Center of Excellence

TEAM MEMBERS

- Director/Manager- Shane Dickard
- Clinical Nurse Coordinators (CNCs)-
  - Diedre Stewart (Days)
  - Amberly Jarvis (Days)
  - Ciara Rodriguez (Nights)
- Clinical Educator-
- Other Team Members –
  - Often 1-2 PCT on during each shift.
  - Medical team includes Hospitalist group coverage 24/7, Ortho Pas, Dr. White
  - RT, Pharmacist, PT/OT.

PATIENT POPULATION

This unit frequently provides care for patients with needs related to Complex orthopedic surgeries. Was previously the COVID-19- only unit.

SHIFT ROUTINES

- Shift change occurs at 7am/7pm
  - Huddle is held in the RN Station
  - Primary RN & Team RN connect
  - Bedside Shift Report

UNIT ROUTINES

- **Unit Maintenance**
  - Environmental Services are available on the unit throughout the shift.
  - After patients are discharged, notify EVS to clean the room. Once cleaned, replace the following items to ensure the room is ready for the next patient:
    - ✓ Cables and disposable leads
    - ✓ Suction liners and tubing
    - ✓ Pulse Ox
    - ✓ BP Cuff

- **Admissions**
  - Primarily admit from OR, ED or direct admit.
  - Patients from the ED should be admitted within 30 minutes of requesting the bed assignment.

- **Discharges**
  - Make sure MD has seen patient prior to all discharges.
  - Charge RN may help with discharges when needed

Care Routines

Item	Change	Owner
Urinary Catheter CHG Care	Q shift and PRN	RN
Peripheral IV	PRN	RN
IV Tubing	Q 96 hrs.	RN
Central Line/ PICC Dressing	Q 7 days & PRN	RN and/or PICC nurse
IV Bags	Q 24 hrs.	RN
Drains	Q8 and PRN	RN

- **Care Routines Cont'**

Intervention	Frequency	Owner
Full Bath	Daily (Day Shift) & PRN	RN/ PCT
ADLs	Q Shift and PRN	RN/PCT and RT
Pressure Ulcer Prevention:	Turn Q 2 hours	RN/PCT
Fall Prevention (Apply yellow armband, socks, door sign)	Upon Identification	RN
Oral Care (ventilated)	Q Shift and PRN	RN/PCT and RT
Foley Care	Q shift & PRN	RN

EMERGENCIES

- **Code Blue**
  - Push the button on the wall behind the patient's bed in the event of a cardiac arrest or dial *05555 and notify operator of "Code Blue in Room XX", also can use iMobile to activate.
- **Rapid Response**
  - In the event of a non-code blue, but worrisome situation activate a response team by dialing *05555 or accessing panel
  - Also tied to 2 Alerts:
    - **Cardiac Alert**
      If chest pain or symptoms of MI identified: Activate by calling/ texting *05555. Responding physician will activate a Cardiac Alert via the operator who pages the cardiac alert team.
    - **Sepsis Alert**
      If sepsis symptoms (2 SIRS criteria with suspected or known infection).
    - **Stroke Alert**
      If stroke symptoms identified.
- **Code Lift**
  For lift assistance.
- **Code Carts**
  - Should be brought to the room in all Code Blue and Rapid Response activations.
  - Locations: At nursing station in same place on both floors.
- **Code Team**
  - ICU RN & CNC responds to all Rapid Responses and Code Blues (Medication RN)
  - 4th Floor Charge RN (Recorder)
  - Respiratory Therapist
  - Hospitalist and/or Intensivist
  - Pharmacist
  - House Supervisor

COMMON EQUIPMENT

- IV Pumps: Plum Pump
- Monitors: No central monitors- Tele boxes monitored by 4C Tele RNs/techs
- VS machine: Welch Allen
- Other: Kangaroo feeding pumps, GE Capnography for post-op patients

UNIQUE PATIENT POPULATIONS

- **Post Op Ortho Patients**
  - This unit cares for post op knee, hip and shoulder patients routinely. There are a variety of precautions for each surgery. Cold therapy and pain medication are paramount on this unit. Please follow all orders as written. The Physical Therapy and Occupational Therapy departments are very active in this unit.

DOCUMENTATION CHECKLIST: DID I FINISH MY CHARTING?

On all patients	Frequency
Vital Signs	Post Op Q4 hrs. x 24, then Q 8 hours/PRN
Shift Assessment - Adult	q-shift/start of shift & with Caregiver change
Care Plan	q-shift/start of shift/PRN
*I&O: Monitor	Q 8 /PRN
*Shift Reassessment	As needed
*Routine Care:	Q shift/end of shift
* ADL/Activity flowsheet	End of shift
*CHG: Reduce MRSA Bath	q24hrs
*Diet: Meal/Snack Intake	PRN
*Vaccine Administration Follow-up	On Admission
*Weight/Height: Monitor	daily if ordered
Neuro Checks	Per order

Additional Charting	Frequency
*Procedural Time Out/Site Verification	for all bedside procedures
Patient Notes	PRN
*Assess: Alcohol Withdrawal (CIWA)	per orders
*Inventory: Personal Belongings	upon admission/transfer out
*Transfer: Send +	upon transfer to another unit or procedure
*Critical and Urgent Test Result	all critical labs
*ADM: Adult History	upon admission within 4 hours of admission
*Inventory Personal belongings	Upon admission, transfer, and discharge
First Point of Contact, Verify Allergies, Med Rec	Upon admission
Suicide/Safety Risk Assessment	Every Shift

HCA Healthcare®
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Rose Medical Center 4 Central Information

UNIT OVERVIEW

- 32 Bed Medical Telemetry Unit located on 4th floor of the building.
- Access via central Elevators.
- Designated unit for chest pain, atrial fibrillation, stroke center.

TEAM MEMBERS

- Director/Manager- Jennifer Gaydosh
- Clinical Nurse Coordinators (CNCs)-
  - Kody Ziller (Days)
  - Natania Smith (Days)
  - Janelle Davis (Nights)
  - Sean Duggan (Nights)
  - Deborah Reshotko (Weekend Days)
  - Dan Sterwald (Weekend Nights)
- Clinical Educator- Freya Stoops
- Other Team Members –
  - Often 2 PCT on during each shift.
  - Medical team includes Hospitalist group coverage 24/7, Cardiac NPs.
  - RT, Pharmacist M-F only, PT/OT,

PATIENT POPULATION

- Cardiac related complaints
- Congestive heart failure
- Atrial Fibrillation
- Diabetes and Peripheral Vascular Disease (PVD)
- Hypertension
- Renal Disease
- Pulmonary disease
- Stroke
- ETOH Withdrawal

SHIFT ROUTINES

- RN Shift change occurs at 7am/7pm
- PCTs shift change occurs at 6am/6pm
  - Huddle is held in the break room
  - Bedside Shift Report

UNIT ROUTINES

- **Unit Maintenance**
  - Environmental Services are available on the unit throughout the shift. Call *07333 or text via iMobile for assistance.
  - After patients are discharged, notify EVS to clean the room.
  - Once cleaned, replace the following items to ensure the room is ready for the next patient:
    - ✓ Cables and disposable leads
    - ✓ Suction liners and tubing
    - ✓ Pulse Ox
    - ✓ BP Cuff
    - ✓ Tele box, electrodes and battery
- **Admissions**
  - Primarily admitted from ED, Cath lab, and direct admission.
  - Patients from the ED should be admitted within 30 minutes of requesting the bed assignment.
- **Discharges**
  - Check with the discharge RN prior to discharging your patient to ensure all core measures have been met.
  - Discharge RN can be found in iMobile.

- **Care Routines**

Item	Change	Owner
Tubing Changes	Q Shift (days)	RN
Central Line Dressing Change	Every Sunday & prn	RN
Urinary Catheter CHG Care	Q shift and PRN	RN
Peripheral IV	Q 96 hrs.	RN
IV Tubing	Q 96 hrs.	RN
Central Line/ PICC Dressing	Q 7 days & PRN	RN and/or PICC nurse
IV Bags	Q 24 hrs.	RN

Intervention	Frequency	Owner
Full Bath	Daily (Day Shift) & PRN	RN/ PCT
ADLs	Q Shift and PRN	RN/PCT and RT
Pressure Ulcer Prevention	Turn Q 2 hours	RN/PCT
Fall Prevention (Apply yellow armband, socks, door sign)	As identified	
Foley Care	Q shift & PRN	RN
Telemetry Strip	Q shift & PRN	RN

EMERGENCIES

- **Code Blue**
  - Push the button on the wall behind the patient's bed in the event of a cardiac arrest
  - Dial *05555 and notify operator of "Code Blue in Room XX".
- **Rapid Response/ Code Yellow/ CAT Team**
  - In the event of a non-code blue, but worrisome situation activate a response team by dialing *05555
  - Also tied to 2 Alerts:
    - **Cardiac Alert**
      If chest pain or symptoms of MI identified. Responding physician will activate a Cardiac Alert via the operator who pages the cardiac alert team.
    - **Sepsis Alert**
      If sepsis symptoms (2 SIRS criteria with suspected or known infection)
- **Code Carts**
  - Should be brought to the room in all Code Blue and Rapid Response activations.
  - Locations: At main nurses station and North nurses station
- **Code Team**
  - ICU RN & CNC responds to all Rapid Responses and Code Blues – Assist with stabilization of patient
  - 4th Floor Charge RN – Records event
  - Respiratory Therapist
  - Hospitalist and/or Intensivist
  - Pharmacist

COMMON EQUIPMENT

- IV Pumps: Plum Pump
- Monitors: GE monitors- Tele boxes monitored by 4C Tele RNs- PCU monitoring includes BP
- VS machine: Welch Allen
- Kangaroo feeding pumps
  - Gravity tube feeding is also available
- GE Capnography

UNIQUE PATIENT POPULATIONS

- **Stroke Patients**
  - Frequent neuro checks Q4
  - NIHSS performed and documented on admission, q 4 hours for first 24 hours, PRN d/t patient changes and if transferred or discharged.
  - All patients must pass bedside swallow eval prior to receiving anything by mouth (including Aspirin).
  - Speech therapy must evaluate all patients that fail bedside swallow eval.
- **Patients Receiving IV Cardiac Medication**
  - Cardizem, Heparin, Amiodarone, etc.

POPULATION SPECIFIC PROTOCOLS:

- **4 Central Intake/Output Policy**
  - All patients are required to have intake and output recorded and charted once per 12-hour shift
  - Patients with Strict I/O ordered per MD are required to have a specific number of Mls in and out recorded and charted once per 12-hour shift
  - The CNA will be responsible for recording and charting intake (oral) and output (urine, fecal, emesis) for all patients
  - CNAs will chart I/O before 1800 and 0600 every shift
  - RNs will be responsible for recording and charting all I/O from IV fluids, chest tubes, wound drains, etc.

- **Management of artery or vein site post cath-lab procedure**
  - Distal pulse checks with vital signs. Assess for swelling, pressure, pain, distal extremity warmth, color, pulses, and sensation.
  - Site assessment post sheath removal (oozing, ecchymosis, pain, hematoma).
  - Assess for urinary retention
  - Monitor patients for urinary retention if unable to void while on bedrest.
  - Bladder scan 6 hours post procedure if unable to void. Notify MD for orders.
  - Patient and family education and teaching
  - Post-Cath bleeding
  - Hold direct manual pressure and/or use SafeGuard until bleeding subsides
  - Resolve subcutaneous lump if possible
  - Consider Femostop if bleeding is persistent
  - Must have physician order

- **Permanent pacemaker and ICD**
  - IV on Left side (R side if right sided device planned)
  - Sutured incision
  - Patient stays overnight a minimum of 1 night
  - Patient returns to floor with a sling to extremity
  - Frequent reassessment of site post-procedure is required to ensure subcutaneous bleeding does not occur
  - Okay to remove dressing if bleeding is suspected
  - Apply direct pressure if bleeding is suspected
  - Replace pressure dressing as needed

COMMON MEDICATIONS – REFERENCE ONLY FOLLOW PHYSICIAN'S ORDER

Drug	Dosing Guidelines
Plavix (clopidogrel)	600 mg PO loading dose 75 mg PO daily
Effient (prasugrel)	60 mg PO loading dose 10 mg daily
Brilinta (ticagrelor)	180 mg PO loading dose 90 mg PO BID
Heparin	Weight based dosing Sheath removal is based on ACT
Angiomax (fractionated Heparin)	Shot half-life (25 min,) Weight based dosing Sheath removal is not based on ACT
Diltiazem	Bolus 5 – 20 mg IV over 2 minutes Start at 5 mg/hr Adjust by 5 mg/hr every 15 minutes Maximum dose: 15 mg/hr
Amiodarone	Bolus 150 – 300 mg Start at 1 mg/min for 6 hours then reduce to 0.5 mg/min

UNIT/FACILITY-SPECIFIC DOCUMENTATION

- PCA and Suicide sitter documentation on paper
- Refer to *Documentation Checklist: Did I Finish My Charting?* Tool in this guide.

RADIOLOGY/CATH LAB EXAM PREPS

U/S	NPO restrictions	Other Prep
Abdomen Complete	NPO x 6-8 hrs. unless pediatric	
Abdomen Limited (to evaluate liver or RUQ pain)	NPO x 6-8 hrs.	
Abdomen Limited (to evaluate hernia)	No prep	
Aorta	NPO x 6-8 hrs. unless STAT emergency	
Pelvic	No	Full bladder
Renal Retroperitoneal	No	Full bladder
MRI		
ERCP	NPO x 6 hrs. unless STAT emergency	
CT		
Angiogram of Coronary Arteries	No	Call IR RNs for prep regarding current medications x7540
NUCLEAR MEDICINE		
HIDA	NPO x 4 hrs. unless suspected leak	
Nuclear Stress Test	NPO x 2 hrs. (no caffeine for 12 hrs. for patients who cannot make target HR on treadmill)	
PET/CT	No food, sugar, gum, or glucose drip x 6 hrs. (water ok).	
IR PROCEDURES		
Paracentesis/Thoracentesis	No	Call IR RNs for prep- also done at bedside on 4C
Cath Lab	All procedures NPO	

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DOCUMENTATION CHECKLIST: DID I FINISH MY CHARTING?

On all patients	Frequency
Vital Signs	Tele Pts Q4 hours/PRN all others Q8 hours/PRN
Shift Assessment - Adult	q-shift/start of shift & with Caregiver change
Care Plan	q-shift/start of shift/PRN
*I&O: Monitor	Q 12 /PRN for CHF pt's
*Shift Reassessment	As needed
*Routine Care:	Q shift/end of shift
* ADL/Activity flowsheet	End of shift
*CHG: Reduce MRSA Bath	q24hrs for lines, Foleys, HD caths
*Diet: Meal/Snack Intake	PRN
*Vaccine Administration Follow-up	On Admission
*Weight/Height: Monitor	daily if ordered
Neuro Checks for Stroke PTs	Q4 hours
NIH	On Admission, transfer, dc and PRN for change in status

Additional Charting	Frequency
*Restraints: Apply/Monitor/Discontinue	At apply/ At removal/Q2hours/Q 15
*Procedural Time Out/Site Verification	for all bedside procedures
Patient Notes	PRN
Alcohol Withdrawal (CIWA)	Q4 or per orders
*Inventory: Personal Belongings	upon admission/transfer out
*Transfer: Send +	upon transfer to another unit or procedure
*Critical and Urgent Test Result	all critical labs
*ADM: Adult History	upon admission within 4 hours of admission
*Inventory Personal belongings	Upon admission, transfer, and discharge
First Point of Contact, Verify Allergies, Med Rec	Upon admission
Suicide/Safety Risk Assessment	Every Shift

Cardiac Cath Lab Pre-Procedure Checklist

ALLERGIES (List in RED): _____ **Latex: Y / N**

			Time/Initial	Comments
Consent signed (both sides): Patient MD	Y Y	N N		
H & P (Complete System Review, w/in 7 days) < 30 days (needs update) > 30 days (needs new)	Y Y Y	N N N		Pre-Admit / Dictated / Meditech MD notified Request MD Office CCL Notified Emergency
Lab reports available (min: H&H, Cr, K+, Coags) ~ Critical Value Identified	Y Y	N		Pre-admit Hospital MD Notified Tx Initiated
Renal Protection Initiated ~ Mucomyst Tx ~ Bicarb Protocol	Y YY	N N N		(by MD order for critical value or HX)
EKG available	Y	N		
CXR available	Y	N		
Other Dx Reports	Y	N		Echo Stress Nuclear Prev. Cath ED Note Card. Consult
Aspirin today	Y	N		Dose:
Time voided:				Foley Dialysis
ID Bracelet on	Y	N		
Hospital Gown (pt otherwise disrobed)	Y	N		
Does patient have glasses (may wear)	Y	N		
Does patient have dentures (do not remove)	Y	N		
NPO since:				
IV or Buff Cap patent (20 ga., lt arm preferred)	Y	N		
Pre-Procedure Teaching	Y	N		Pre-admit Hospital RN Reinforced
Shellfish / Iodine /Contrast Reaction: Describe:	Y	N		MD notified CCL Notified
Pre- Med given for Contrast Allergy	Y	N		
Patient Education Packet received	Y	N		
Pt belongings secured	Y	N		
Pt family in attendance	Y	N		

TPR____ PR____ RR_____ BP _____ O2 Sat_____ RA / O2 _____ lpm

Pre-Medications Administered: none Ht: _____ cm / in Wt:_____ kg / lbs

_____ Time/Initial_____

_____ Time/Initial_____

_____ Time/Initial_____

_____ Time/Initial_____

R.N. Signature_____ Date/Time_____

R.N. Signature_____ Date/Time_____

ROSE Medical Center

Cardiac Cath Lab
Pre-Procedure Checklist

Not part of the permanent medical record

Form # 17196 (10/07/2015)

Patient Information/Label

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Unit-Specific Information

UNIT OVERVIEW

- Med/Onc unit with 35 (Potential to Double up rooms) Beds located on the 5th floor of the building. Access via the central staff elevators. Currently the COVID unit.

TEAM MEMBERS

- Director/Manager- Angela Milano (Manager)
- Clinical Nurse Coordinators (CNCs)
  - Sam Linderman (Days)
  - Daniel Nelson (Nights)
  - Cassie Troxel (Days)
  - Bryn Matthews (Nights)
  - Mini Gonzales (W/E Days)
- Clinical Educator-

PATIENT POPULATION

This unit frequently provides care for patients with needs related to:

- Oncology patients- most commonly: blood cancer, solid tumor cancers and GYN cancers. In order to care for these patient's you must have a chemotherapy certification.
- General medical patients. This may include respiratory patients, patients in withdrawal, dialysis patients etc.
- This unit will also flex to COVID patients and is the only med/surg floor that has COVID patients on it currently.

PHYSICIAN COVERAGE

- SCP is the internal medicine coverage throughout the hospital.
- These physician's cover on a 24-hour basis.
  - ✓ During the day, there are 3 physicians scheduled and usually 1 "swing-shift" SCP physician to help with admissions/overflow.
  - ✓ There is 1 physician on during the night.
- Located at the nurse's station near the secretary's desk is the daily posting of which physician is covering which patient.
- Please refer to this before paging/calling MD.
- You may also call the operator to have the physician over-head paged.

SHIFT ROUTINES

- **Shift change occurs at 7am/7pm**
  - Huddle
  - Primary RN & Team RN connect
  - Bedside Shift Report

- **Assessments**
  - Head to toe assessment every shift and/or with every change in caregiver.
  - Admission history and head to toe assessment on every patient within 4 hours of admission.
- **Insertion and maintenance of peripheral IV's**
  - Includes appropriate documentation/site change (when clinically indicated) and tubing changes every 4-days (96hrs). Unless indicated to be changed related to infusion (i.e. blood/TPN).
  - Label & change flush bags q24hrs
  - New IV catheter only as needed
  - Label and change IV tubing q4 days (96hrs) *new IV = new tubing
  - PICC line/Central line/Infusaport/Dialysis permacath dressing changes per hospital protocol (Q7D on Tuesdays).

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UNIT ROUTINES

- Unit Maintenance
  - Environmental Services (EVS) are available on the unit throughout the shift.
  - Anyone may restock rooms as it is a shared responsibility. If you fill linen or trash, please empty it accordingly.
  - After patients are discharged, notify EVS to clean the room. Once cleaned, replace the following items to ensure the room is ready for the next patient:
    - ✓ Cables and disposable leads
    - ✓ Suction liners and tubing
    - ✓ Electrodes
    - ✓ Pulse Ox
    - ✓ BP Cuff
  - EVS may not dispose of urine or IV fluids/lines.
- **CNA responsibilities:**
  - Obtaining report from RNs on assigned patients
  - Vital signs 0700/1500/1900 – report abnormal values to RN promptly
  - Blood sugar checks at 0800/1200/1700/2100
  - Bed bath/shower/linen changes/meals/activity (*RN to complete 1 shower/linen change)
- **RN responsibilities:**
  - Giving report to CNA on assigned patients
  - Blood sugar checks- report to CNA, which ones need to be done.
  - Complete Intake/Output q12-hours and document in computer.
  - Check assignment sheet to determine which patient you are responsible for completing the linen change/shower.
- **Admissions**
  - May come from variety of places: ED or potentially other hospitals
  - The Charge RN or CNC will receive a notification from the house supervisor and assign a bed and nurse, then notify the receiving RN.
  - Patients from the ED should be admitted within 30 minutes of requesting the bed assignment.
  - See back of packet for more details
- **Discharges**
  - Acknowledge discharge orders on the status board
  - Notify Charge RN, Secretary, and DC RN of discharge
  - See end of packet for more details
- **Care Routines**

Item	Change	Owner
Urinary Catheter CHG Care	Q 24 hrs. and PRN	RN
Peripheral IV	Q 96 hrs.	RN
IV Tubing	Q 96 hrs.	RN
Central Line/ PICC Dressing	Q 7 days (Tues) & PRN	RN and/or PICC nurse
IV Bags	Q 24 hrs.	RN

Intervention	Frequency	Owner
Full Bath	Daily & PRN	RN/ PCT Any Shift
Oral Care (ventilated)	Q Shift and PRN	RN/PCT and RT
Pressure Ulcer Prevention: Prophylactic Mepilex, Air mattress for at risk patients	Turn Q 2 hours	RN/ PCT
Foley Care	Q shift & PRN	RN

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EMERGENCIES

- **Code Blue**
  - Push the button on the wall behind the patient's bed in the event of a cardiac arrest or call *05555 and notify operator of "Code Blue in Room XX".
- **Rapid Response**
  - In the event of a non-code blue, but worrisome situation activate a response team by dialing *05555 or call operator
  - Also tied to 3 Alerts:
    - **Stroke Alert**
      If stroke symptoms identified
    - **Cardiac Alert**
      If chest pain or symptoms of MI identified. Responding physician will activate a Cardiac Alert via the operator who pages the cardiac alert team.
    - **Sepsis Alert**
      If sepsis symptoms (2 SIRS criteria with suspected or known infection).
- **Code Carts**
  - Should NOT be brought in the room. The defibrillator, ambu bag and back board only. Medication tray can be removed or passed from an RN in the hallway.
  - Locations: At nursing station or North nursing station
- **Code Team**
  - ICU RN & CNC responds to all Rapid Responses and Code Blues (Medication/Bedside RN)
  - 4th Floor Charge RN (Recorder)
  - Respiratory Therapist
  - Hospitalist and/or Intensivist
  - Pharmacist
  - Lab Tech

COMMON EQUIPMENT

- IV Pumps: Plum Pump
- Monitors: No central monitors- Tele boxes monitored by 4C Tele RNs
- VS machine: Welch Allen
- Other: Gravity tube feedings in place, Capnography on all patients

UNIQUE PATIENT POPULATIONS

- **Sepsis Patients**
  Follow Sepsis protocol

- **Oncology Patients**
  - This unit has both IV and oral chemotherapy agents.
  - Some medications require special disposal and this alert will come up in the patient's EMAR.
  - The gloves and medication wrappers will be disposed of in the yellow buckets located in the unit.
  - Only chemotherapy trained RNs can administer intravenous chemotherapy.
  - Patient's receiving chemotherapy will be placed on Chemotherapy Precautions which should include placing a waste container in the patient's room and a spill kit must be at the bedside.
  - For assistance with this please consult the Charge RN. Follow all physician orders as prescribed.
- **Diabetic patients, Renal patients, non-acute Telemetry patients**
  - Follow all orders as written.
  - Head to toe assessments are to be completed once per shift and with any caregiver change.
  - Admission history must be completed within 4 hours of arrival to the floor.

RADIOLOGY/CATH LAB EXAM PREPS

U/S	NPO restrictions	Other Prep
Abdomen Complete	NPO x 6-8 hrs. unless pediatric	
Abdomen Limited (to evaluate liver or RUQ pain)	NPO x 6-8 hrs.	
Abdomen Limited (to evaluate hernia)	No prep	
Aorta	NPO x 6-8 hrs. unless STAT emergency	
Pelvic	No	Full bladder
Renal Retroperitoneal	No	Full bladder
XRAY		
Esophagram	NPO x 4 hrs.	
Upper GI	NPO x 8 hrs.	
Small Bowel Follow Through	NPO after midnight	
Modified Barium Swallow	No prep	
Lumbar Puncture	No	Call IR RNs for prep regarding blood thinners. Encourage fluids.
Myelogram	No	Call IR RNs for prep regarding current medications. Encourage fluids.
CT		
Angiogram of Coronary Arteries	No	Call IR RNs for prep regarding current medications x7540
PET/CT	No food, sugar, gum, or glucose drip x 6 hrs. (water ok).	
IR PROCEDURES		
Paracentesis/Thoracentesis	No	Call IR RNs for prep
Cath Lab	All procedures NPO	

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DOCUMENTATION CHECKLIST: DID I FINISH MY CHARTING?

On all patients	Frequency
Vital Signs	Q 8 hours/PRN (Tele patients are Q 4 hours)
Shift Assessment - Adult	q-shift/start of shift & with Caregiver change
Care Plan	q-shift/start of shift/PRN
*I&O: Monitor	Q 12 /PRN
*Shift Reassessment	As needed
*Routine Care:	Q shift/end of shift
* ADL/Activity flowsheet	End of shift
*CHG: Reduce MRSA Bath	q24hrs –central lines, Foleys, HD caths
*Diet: Meal/Snack Intake	PRN
*Vaccine Administration Follow-up	On Admission
*Weight/Height: Monitor	daily if ordered

Additional Charting	Frequency
*Restraints: Apply/Monitor/Discontinue	At apply/ At removal/Q2hours/Q 15 Check Order to be renewed Q4 hours by MD
*Procedural Time Out/Site Verification	for all bedside procedures
Patient Notes	PRN
*Assess: Alcohol Withdrawal (CIWA)	per orders
*Inventory: Personal Belongings	upon admission/transfer out
*Transfer: Send +	upon transfer to another unit or procedure
*Critical and Urgent Test Result	all critical labs
*ADM: Adult History	upon admission within 4 hours of admission
*Inventory Personal belongings	Upon admission, transfer, and discharge
First Point of Contact, Verify Allergies, Med Rec	Upon admission
Suicide/Safety Risk Assessment	Every Shift

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FREQUENTLY USED UNIT PHONE NUMBERS

Lab: *02364

Pharmacy: *02167

5C: *02575

6C: *02675

Nursing Station: 303-320-2575

Charge RN: 720-632-0005

Security: 720-202-5860

ED: *054002455

Door Codes

Clean Utility: 2145*

Dirty Utility: 2570*

Break Room: 2547*

Med Room- badge swipe

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Staff RN Job Expectations

1. **Assessments**
    a. Head to toe assessment every shift and/or with every change in caregiver.
    b. Admission history and head to toe assessment on every patient within 4 hours of admission.

2. **Insertion and maintenance of peripheral IV's**
    a. Includes appropriate documentation/site change (when clinically indicated) and tubing changes every 4-days (96hrs). Unless indicated to be changed related to infusion (ie. blood/TPN).
    b. Label & change flush bags q24hrs
    c. **Label** and change IV tubing q4days (96hrs) ***new IV = new tubing**
    d. PICC line/Central line/Infusaport/Dialysis permacath dressing changes per hospital protocol (Q7D).

3. **Administration of medications**
    a. Scheduled and PRN
    b. New medications as written in the chart

4. **Oxygen Therapy**
    a. Collaborative with Respiratory Therapy as appropriate

5. **Supervision of CNA takes: vital signs, daily weights, intake & output, and FSBS checks as ordered**
    a. Q8hr vitals (Q4hr for tele patients), strict I/O's, daily weights

6. **Supervision of activities of daily living**
    a. Assist/set-up with meals, ambulating and getting patient out of bed to chair, etc.

7. **Mandatory Charting/Computer Documentation**
    a. <u>Under Process Interventions:</u> Assessment, Safety/Risk/Reg, Pain, Routine Care, Lines/Drains/Airways, Teach/Educate, Plan of Care, **Physician Orders****(This is your chart check and MUST be done every shift) Hygiene (CHG bath if patient has central line)
    b. <u>Admissions:</u> Quick start, Admission Health History, Shift assessment, 1st Point of Contact, Safety/Risk (Suicide, Advanced Directives, Sepsis, Skin, Fall risk, Vaccines), Pain, Lines, Teaching, Plan of Care, COVID vaccine assessment

8. **Other/Miscellaneous**
    a. Insertion and care for Foley catheter (*use stat lock to secure Foley)
    b. Dressing changes as ordered
    c. CHG Bathing
    d. Initiating and maintaining infection control precautions as appropriate (i.e. Contact, Neutropenic, Droplet Isolation, etc.)
    e. Assist co-works and answer call lights

PROCEDURE FOR ADMISSIONS

- SBAR will print from ED once bed assigned. Review report and call if you have any questions or clarification **our goal is to have patient to floor **within 15-minutes** of order written in ED!
- Greet patient & get vital signs, height, and weight (CNA can help if available).
- Orient patient to room and instruct them on the use of call light/RN # on board for needs.
- Complete patient history & physical assessment within 4-hours of arriving to floor.
- Enter patient history, physical assessment, 1st point of contact, safety risk, verify allergies and medication reconciliation n computer.
- Enter admission orders into computer (secretary/charge nurse can help if available).
- Acknowledge all medications entered by pharmacy.
- Hang appropriate signs or place appropriate arm bands as needed (i.e. Latex allergy, contact precautions, DNR, No BP/IV R arm, etc.).
- Initiate care plan, medications, and physician orders – for example:
  Get Abx started, initiate respiratory treatment, and/or administer pain medication.

** An admission is not complete without orders being initiated. Don't leave these items for the oncoming shift

PROCEDURE FOR DISCHARGES

- Acknowledge discharge order on the status board
- Document Discharge Instructions in Meditech
- Notify Charge RN, Secretary, and DC RN of discharge
- Contact case manager for home health services or placement needs.
- Ensure medication reconciliation (RXM) is finalized by physician.
- Print patient education from *Care Notes* for admitting diagnosis and for all new medications/prescriptions. Be sure to print signature page for patient to sign verifying information was given on diagnosis/new prescriptions. Place signed copy in chart for JCAHO documentation purposes.
- Print 2 copies and have patient sign the following documentation after review
    - ✓ DC Instructions
    - ✓ Med Rec
- Provide patient with Discharge Folder, including Health One Food and Drug Interaction pamphlet, Side Effects worksheet and Questions for my Caregivers.
- DC PIV and document. If PICC or Central line or Foley, obtain MD order to DC (if appropriate)

- If applicable, complete CHF/Coumadin pre-printed instructions and have RN completing education sign as well as patient.
- Ensure patient received FLU/PNA vaccine if applicable
- If patient is going to SNF or home with home health, notify case manager (if not already aware). Call report to nurse at facility and include update MAR as instructed by case manager.
- Notify secretary/charge nurse when patient leaving unit, in order to DC patient in computer and begin bed tracking.

END OF SHIFT PROCEDURE

- Examine chart for any written orders, ensure electronic orders are acknowledged and completed to the best of your ability.
- Ensure all scheduled medications are given through 0730/1930 before you end your shift. If you are unable to give a medication, be sure to communicate this with the nurse resuming care of the patient.
- Update 5C Healthy Handoff Communication Sheet before verbal/bedside report.

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PROCEDURE FOR SURGICAL PATIENTS

PRE-OP →

1. Your patient will leave the floor for pre-op approx. *1 hour* before scheduled OR time.
2. Adhere to NPO status (8hrs solids, 3hrs clear liquids typical) – patient is not to have anything to eat or drink! (i.e. if diabetic patient becomes hypoglycemic, following diabetic protocol for treating diabetic patient while NPO).
3. Be sure to print all necessary information and place in chart (charge nurse and/or secretary can help with this if available).
   Patient chart must have:

   - ✓ **Completed H&P**
   - ✓ **Current Labs (in computer if ordered)**
   - ✓ **Facesheets and patient labels**
   - ✓ **Surgical Consent**

4. Ensure patient has functioning IV! If patient is a difficult stick and an attempt has been made without success, communicate with pre-op nurse. They are willing to assist in PIV placement if necessary.

5. Ensure patient belongings are removed – **no** jewelry, **no** valuables, and **no** clothes besides hospital gown. Remove glasses and dentures at patient's discretion. You may send glasses with patient if needed to sign surgical consent. Otherwise, leave **ALL** personal belongings and valuables with family or security! Please remember to leave IV pump and PCA in room.

6. Notify pre-op (*02270) if patient is in companion center and/or unable to sign surgical consent. Family member may need to be notified in advance to help sign consent.

7. Call pre-op (*02270) and give report to receiving RN. Send IV Abx if ordered "on-hold" for pre-op/OR

****COMMUNICATION** is key!! If you know your patient is scheduled for surgery, contact pre-op to provide healthy hand-off! Proper *communication* will make the surgical process go smoothly.

PACU →

1. After you get phone call stating your patient has arrived in PACU, take time to prepare the patients room to ensure it is ready for your post-surgical patient!
   Does the patient room have…?

   - ✓ IV pump
   - ✓ SCD's
   - ✓ Vital sign machine
   - ✓ Pulse oximetry
   - ✓ Oxygen set-up

2. The patient will remain in PACU for approximately 1-2 hours for recovery. After receiving an SBAR, *be prepared to meet PACU nurse in patient's room* within 15 minutes to obtain first set of vital signs, perform initial post-op assessment (check incision site, drains, etc.) and start frequent monitoring flowsheet. Be sure to communicate with your CNA about post-op frequent monitoring!

   Post-operative monitoring guidelines/protocol (on back of monitoring flowsheet):

   - ✓ VS and pulse ox on arrival
   - ✓ VS and pulse ox 30 min after arrival
   - ✓ VS & pulse ox 1 hour after arrival
   - ✓ VS 2 hours after arrival
   - ✓ Then q4hr or as indicated

3. Resume *routine care practice guidelines* for post-operative patient. Be sure to check your chart for specific post-operative orders/care instructions!

   Post-op observation includes:

   - ✓ Vital signs and level of sedation per protocol
   - ✓ Presence of pain and comfort measures
   - ✓ Remember surgical patients are your **P.A.L.S…**
     Help prevent post-op infections to ensure their recovery goes well!

     Pain management → if your patients' pain is well managed they will recover sooner!

     Ambulation → get patient OOB as soon as possible; at least 4-6 times/day!

     Lung exercises → cough & deep breath, incentive spirometer every hour while awake!

     SCD's → improve circulation and decrease risk of blood clots

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Unit-Specific Information

UNIT OVERVIEW

- 19 Bed Bariatric/General Surgical Unit located on 6th floor of the building. Access via staff elevators.
- Designated unit in Bariatric Center of Excellence.

TEAM MEMBERS

- Director/Manager- Katie Kelsey
- Clinical Nurse Coordinators (CNCs)-
  - Tara Baker (Days)
  - Katie Kelsey (Days)
  - Deidre Baraga (Nights)
- Clinical Educator-
- Other Team Members –
  - Often 1-2 PCT on during each shift.
  - Medical team includes Hospitalist group coverage 24/7, Surgical Residents, Bariatric NPs.
  - RT, Wound Care RN

PATIENT POPULATION

This unit frequently provides care for patients with needs related to bariatrics, general surgery – with the most common general surgeries: thyroidectomies, colon resections, hysterectomies, etc. Common bariatric surgeries include Lap Adjustable Gastric Band, Lap Gastric Sleeve, Lap Gastric Bypass, and Lap Loop Duodenal Switch, mastectomies, hernia repairs, bladder slings, TURPs, A + P repairs

SHIFT ROUTINES

- Shift change occurs at 7am/7pm
  - Huddle is held in the RN Station
  - Primary RN & Team RN connect
  - Bedside Shift Report

UNIT ROUTINES

Unit Maintenance

- Environmental Services are available on the unit throughout the shift. Call *07333 or text via iMobile for assistance.
- The PCT and nurses restock rooms when able, but this is a shared responsibility.
- After patients are discharged, notify EVS to clean the room. Once cleaned, replace the following items to ensure the room is ready for the next patient:
  - ✓ Cables and disposable leads
  - ✓ Suction liners and tubing
  - ✓ Pulse Ox

- **Admissions**
  - Primarily admit from OR, ED and Direct Admissions.
  - Patients from the ED should be admitted within 30 minutes of requesting the bed assignment.
- **Discharges**
  - Make sure MD has seen patient prior to all discharges.
  - Charge RN may help with discharges when needed.

- **Care Routines**

Item	Change	Owner
Drains	Q 8 hours	RN
Urinary Catheter CHG Care	Q shift and PRN	RN
Peripheral IV	Q 96 hrs	RN
IV Tubing	Q 96 hrs	RN
Central Line/ PICC Dressing/CHG	Q 7 days & PRN	RN and/or PICC nurse
IV Bags	Q 24 hrs	RN

Intervention	Frequency	Owner
Full Bath	Daily (Day Shift) & PRN	RN/PCT
ADLs	Q Shift and PRN	RN/PCT
Pressure Ulcer Prevention	Turn Q 2 hours	RN/PCT
Fall Prevention	Upon identification of risk	RN
Suicide	Follow protocol based on Risk	RN
Foley Care	Q shift & PRN	RN

EMERGENCIES

- **Code Blue**
  - Push the button on the wall behind the patient's bed in the event of a cardiac arrest or dial *05555 and notify operator of "Code Blue in Room XX".
- **Rapid Response**
  - In the event of a non-code blue, but worrisome situation activate a response team by dialing *05555 on a phone, or using an iMobile phone
  - Also tied to 2 Alerts:
    - **Cardiac Alert** If chest pain or symptoms of MI identified
    - **Sepsis Alert** If sepsis symptoms (2 SIRS criteria with suspected or known infection)
- **Stroke Alert**
  If stroke symptoms identified: Activate a Stroke Alert by calling *05555 and tell operator you have a Stroke Alert in X location.
- **Code Carts**
  - Should be brought to the room in all Code Blue and Rapid Response activations.
  - Locations: At the nursing station
- **Code Team**
  - Responders will include: ICU RN (meds/bedside), 4C Charge RN (recorder), RT, Hospitalist MD

COMMON EQUIPMENT

- IV Pumps: IV Pump
- Monitors: Tele boxes monitored by 4C Tele RNs
- VS machine: Welch Allen
- Other: GE Capnography and Kangaroo feeding pumps, Vein Finder, Bladder Scanner

UNIQUE PATIENT POPULATIONS

- **Bariatric Patients**
  - Must adhere to a strict diet with very stringent I & O's.
  - There are 3 stages to the Hospital Bariatric Diet.
  - Absolutely NO high calorie liquids (such as soda, smoothies, sugary drinks and food items, or undiluted juices)
    - ✓ NO carbonated drinks
    - ✓ NO straws
    - ✓ NO solid foods

- **Bariatric Patients Cont'**
  - Each surgery has a unique diet order set. Follow all orders as prescribed by Physician.
  - Activity orders are also paramount and must be adhered to.

UNIT/FACILITY-SPECIFIC DOCUMENTATION

- PCA and Epidural documentation is on paper
- Refer to *Documentation Checklist: Did I Finish My Charting?* Tool in this guide.

RADIOLOGY/CATH LAB EXAM PREPS

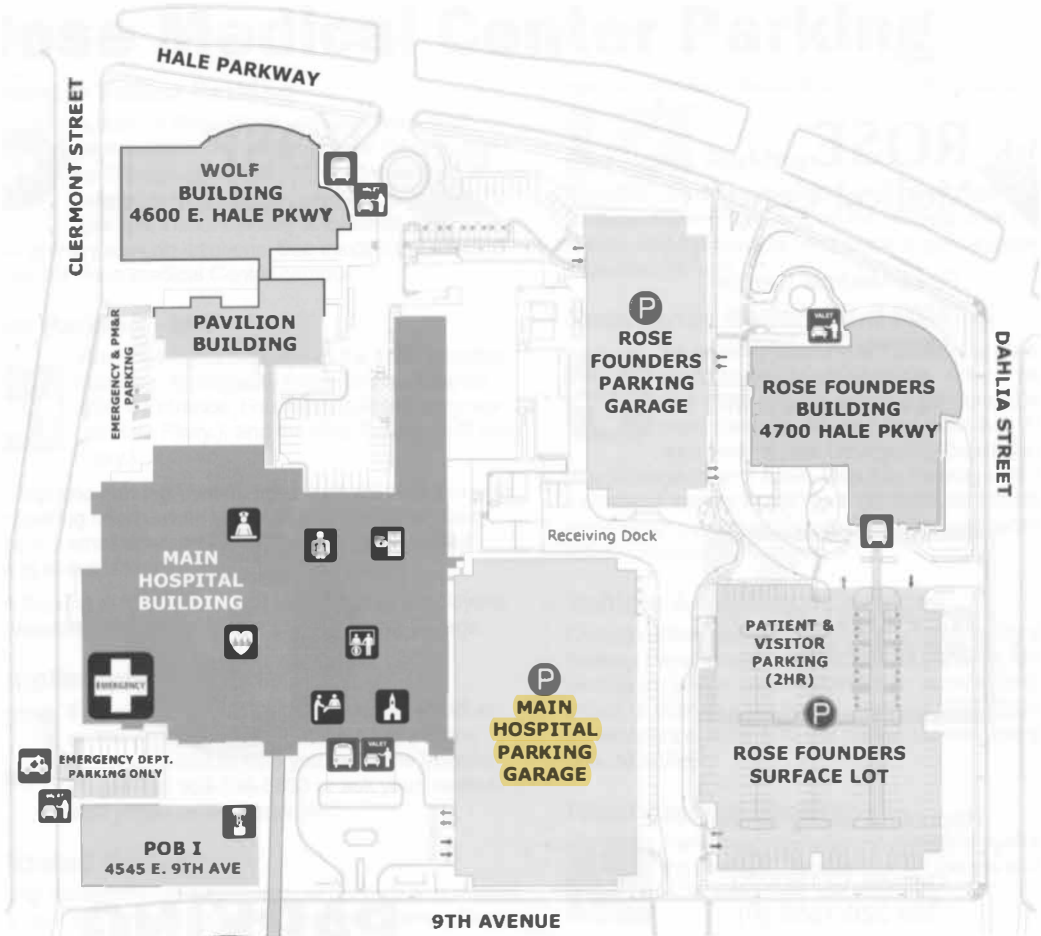
U/S	NPO restrictions	Other Prep
Abdomen Complete	NPO x 6-8 hrs unless pediatric	
Abdomen Limited (to evaluate liver or RUQ pain)	NPO x 6-8 hrs	
Abdomen Limited (to evaluate hernia)	No prep	
Aorta	NPO x 6-8 hrs unless STAT emergency	
Pelvic	No	Full bladder
Renal Retroperitoneal	No	Full bladder
MRI		
ERCP	NPO x 6 hrs unless STAT emergency	
XRAY		
Esophagram	NPO x 4 hrs	
Upper GI	NPO x 8 hrs (NPO at 0400 for some bariatric patients)	
Small Bowel Follow Through	NPO after midnight	
Modified Barium Swallow	No prep (NPO at 0400 for some bariatric patients)	
NUCLEAR MEDICINE		
HIDA	NPO x 4 hrs unless suspected leak	
Gastric Empty	NPO x 4 hrs	
PET/CT	No food, sugar, gum, or glucose drip x 6 hrs (water ok).	
IR PROCEDURES		
Paracentesis/Thoracentesis	No	Call IR RNs for prep
Cath Lab	All procedures NPO	

DOCUMENTATION CHECKLIST: DID I FINISH MY CHARTING?

On all patients	Frequency
Vital Signs	Post OP vitals Q4 x 24 hours then Q 8 hours/PRN
Shift Assessment - Adult	q-shift/start of shift & with Caregiver change
Care Plan	q-shift/start of shift/PRN
*I&O: Monitor	Q 8 /PRN
*Shift Reassessment	As needed
*Routine Care:	qshift/end of shift
* ADL/Activity flowsheet	End of shift
*CHG: Reduce MRSA Bath	q24hrs (must document before midnight)
*Diet: Meal/Snack Intake	PRN
*Vaccine Administration Follow-up	On Admission
*Weight/Height: Monitor	daily if ordered

Additional Charting	Frequency
*Procedural Time Out/Site Verification	for all bedside procedures
Patient Notes	PRN
*Assess: Alcohol Withdrawal (CIWA)	per orders
*Inventory: Personal Belongings	upon admission/transfer out
*Transfer: Send +	upon transfer to another unit or procedure
*Critical and Urgent Test Result	all critical labs
*ADM: Adult History	upon admission within 4 hours of admission
*Inventory Personal belongings	Upon admission, transfer, and discharge
First Point of Contact, Verify Allergies, Med Rec	Upon admission (if not done pre-op, upon arrival to the floor)
Safety/Risk/Regulatory Assessment (including isolation status, sepsis, skin risk, fall risk, and suicide	Every Shift, Change in Patient status and post-surgery

All nurses fill out “Healthy Hand Off” to give to the oncoming shift


HALE PARKWAY
CLERMONT STREET
WOLF BUILDING 4600 E. HALE PKWY
PAVILION BUILDING
EMERGENCY & PMAR PARKING
ROSE FOUNDERS PARKING GARAGE
ROSE FOUNDERS BUILDING 4700 HALE PKWY
DAHLIA STREET
Receiving Dock
MAIN HOSPITAL BUILDING
EMERGENCY
PATIENT & VISITOR PARKING (2HR)
MAIN HOSPITAL PARKING GARAGE
ROSE FOUNDERS SURFACE LOT
EMERGENCY DEPT. PARKING ONLY
POB I 4545 E. 9TH AVE
9TH AVENUE

HCA / HealthOne Meditech Review

The Tool Bar and F keys

F6	Moves cursor to the previous field
F7	Moves cursor to the beginning of a list or top of page/section
F8	Moves cursor to the end of a list or end of the page/section
^F8	Shows parameters (related to Within Defined Parameters)
F11	Exits current screen (WITHOUT SAVING!)
F12	Saves and Files documented information
Rt CTRL	Makes a checkmark to select highlighted item. Press again to remove checkmark.
^Rt CTRL	Checkmarks entire list. Press again to remove all checkmarks.

File/Save (F12)

Exit (F11)

Lookup (F9)

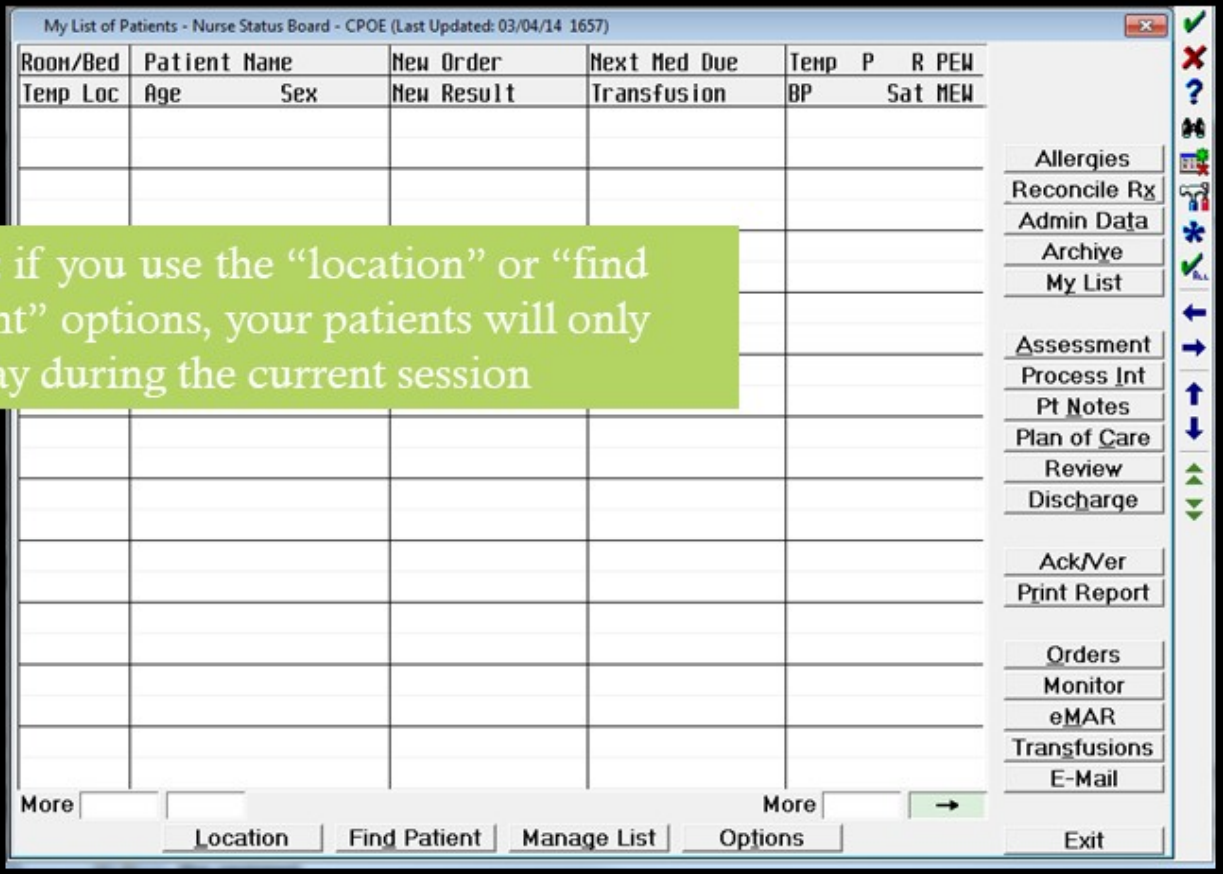
Magic Key (^F12)

Calculator

Select (Rt CTRL)

Select All (^Rt CTRL)

Setting Up the Status Board



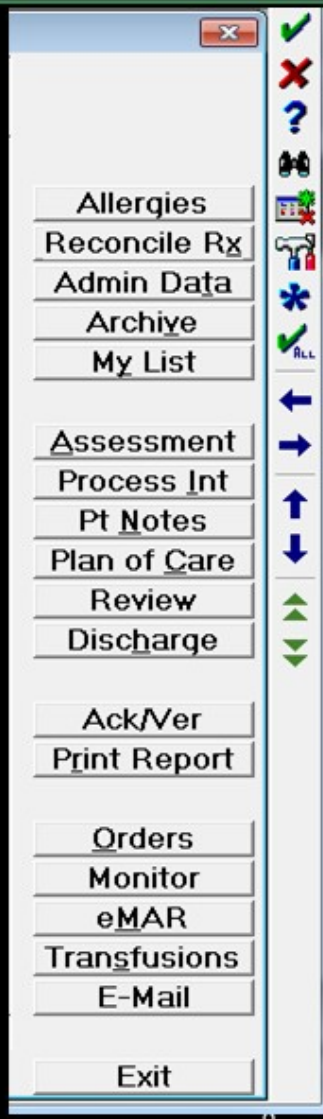
Note: if you use the "location" or "find patient" options, your patients will only display during the current session

1. By Location – to view all patients on a specific unit
2. Find Patient– useful when trying to find a certain patient.
3. By Manage List – useful for making your daily assignments

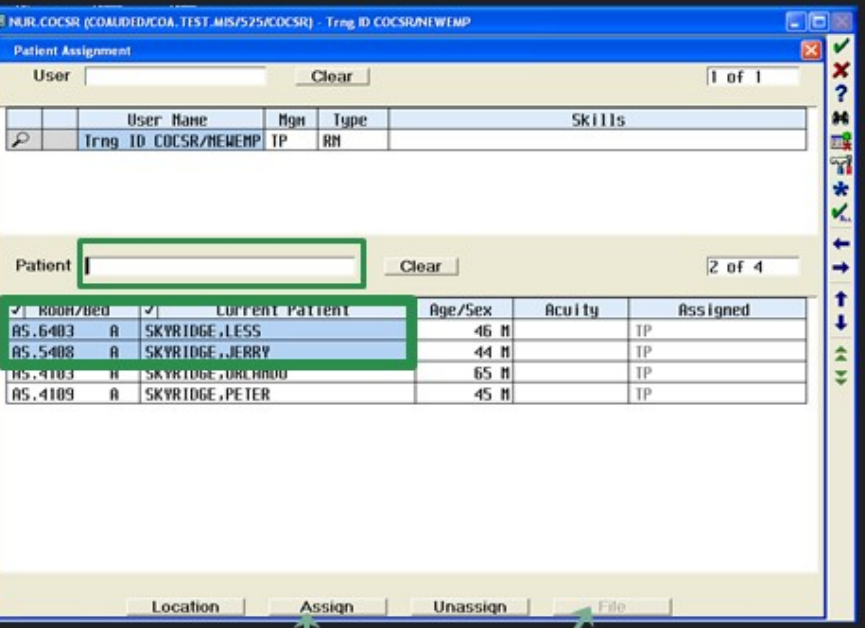
MENU Keys

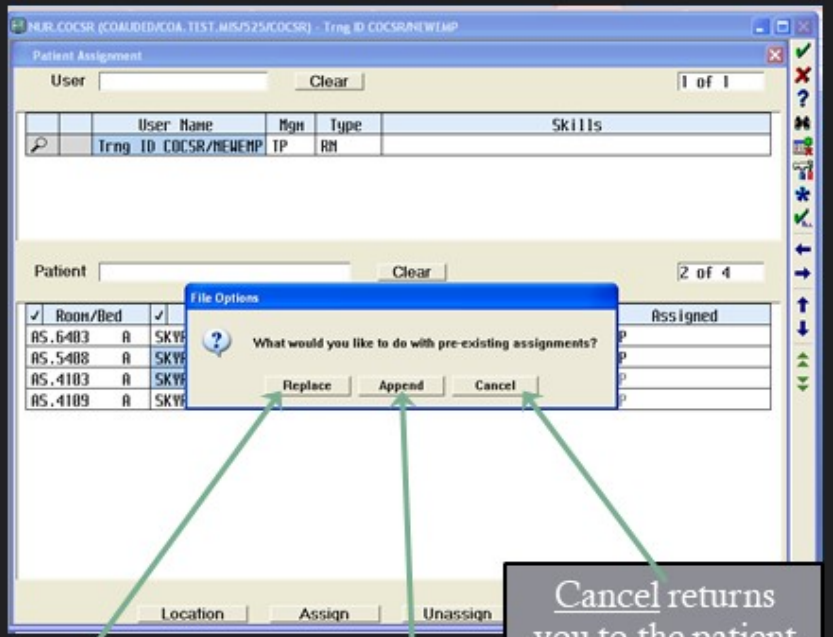
Other important Menu Keys:

- "Allergies" displays a list of patient allergies.
- "My List" refreshes the status board to show your assigned patients.
- "Process Interventions" is where you will document assessments and vital signs.
- "Pt Notes" is to add a note or view notes.
- "Review" This allows you to view test/lab results, vitals signs, dictated reports, etc.
- "eMAR" is used to view the medication list and to give meds.



Manage List/Assigning Patients





After you have selected all the patients you want to assign to yourself for the shift:

a) Click on 'Assign'
b) Click on 'File'

Replace will add the selected patients to the status board and remove any patients that were previously assigned.

Append will add selected patients to the status board without deleting previously assigned patients.

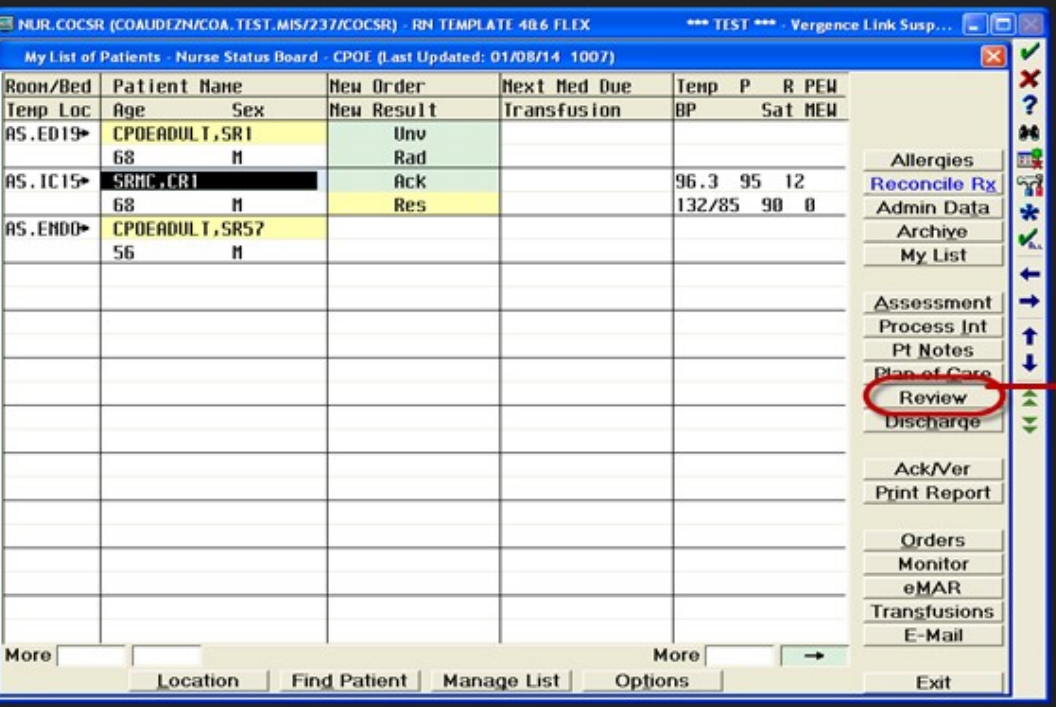
Cancel returns you to the patient assignment board

Status Board

- The status board screen is similar to a white board, enabling you to view current information about you patients.

- The first 3 columns remain static and remain visible at all times.

Clinical Review



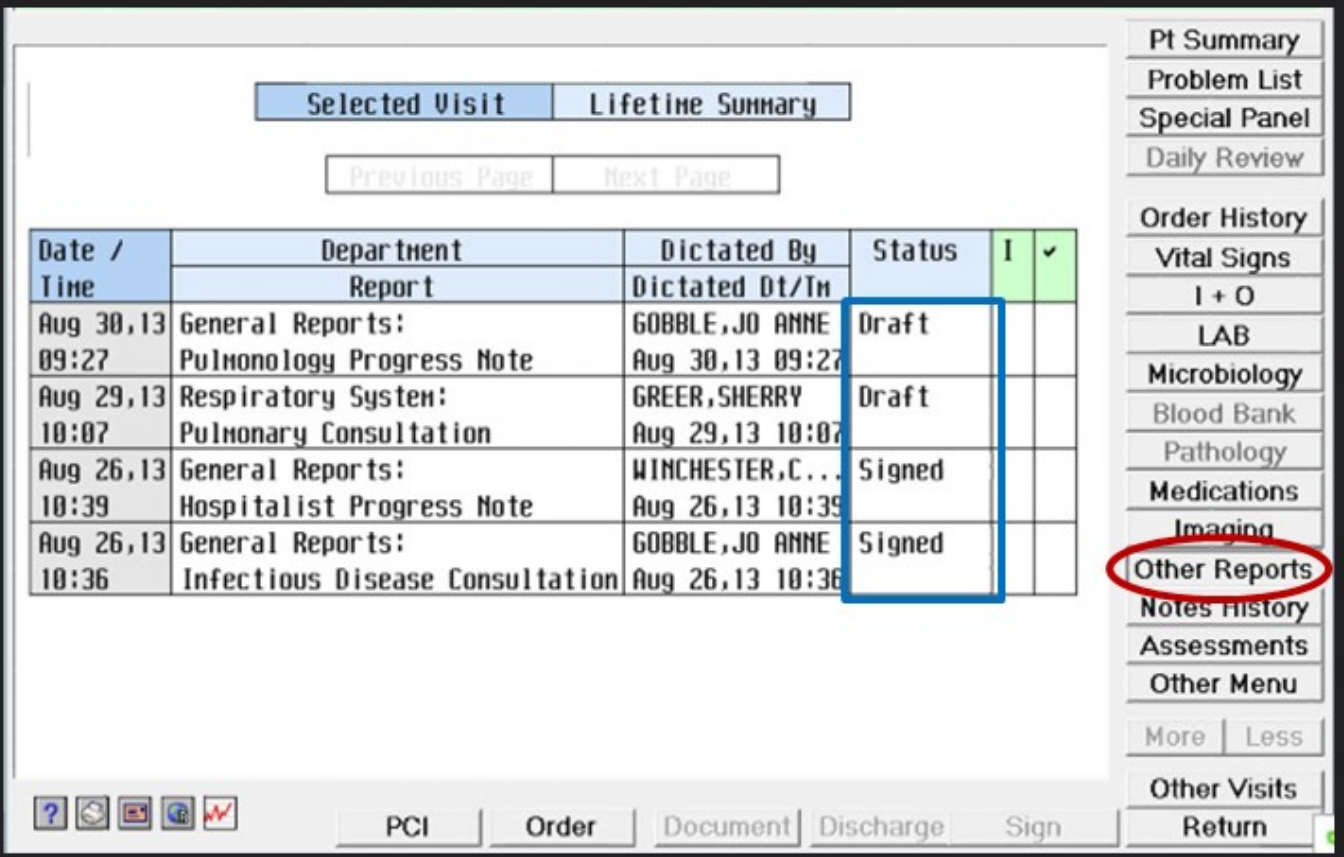
Black tabs: Information available

Grey tabs: NO Information available

Blue tabs: New Information available

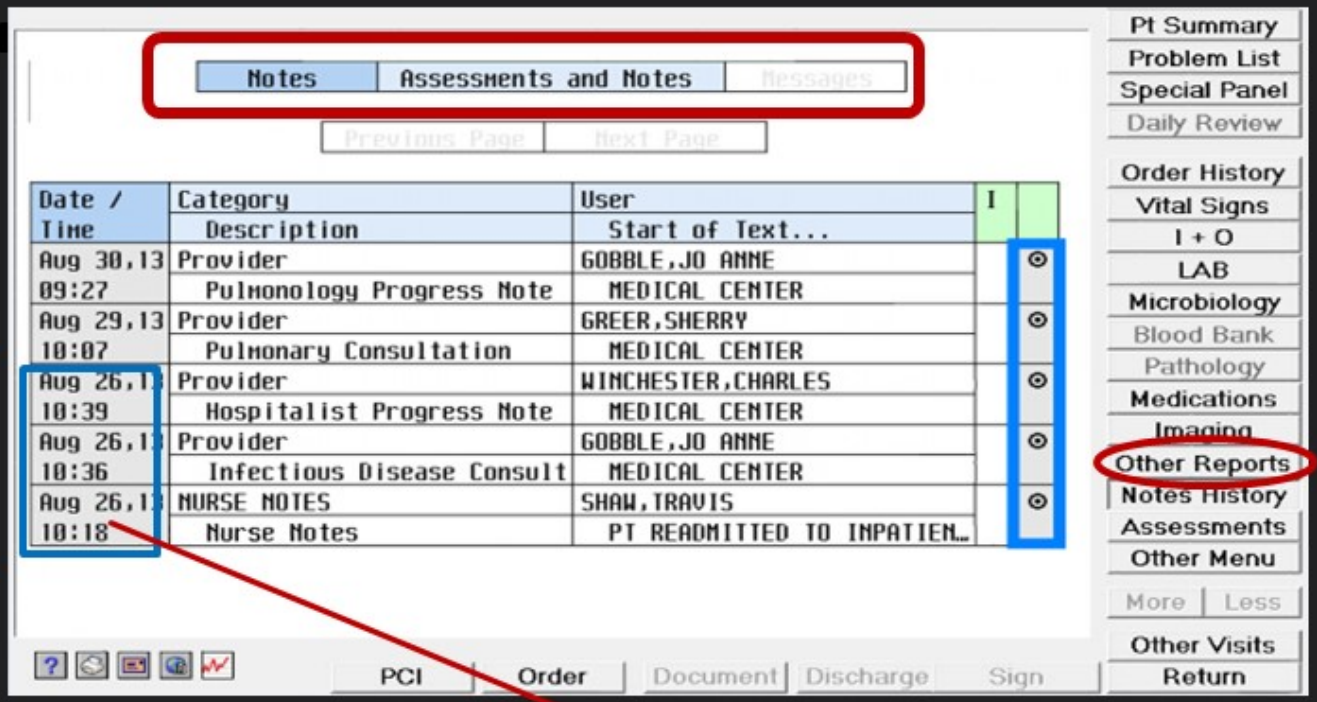
Clinical Review is simply the PATIENT'S chart, just in electronic form.

Other Reports



Includes Provider Reports, H&Ps, Echo Reports, MD Notes

Notes History



Includes:

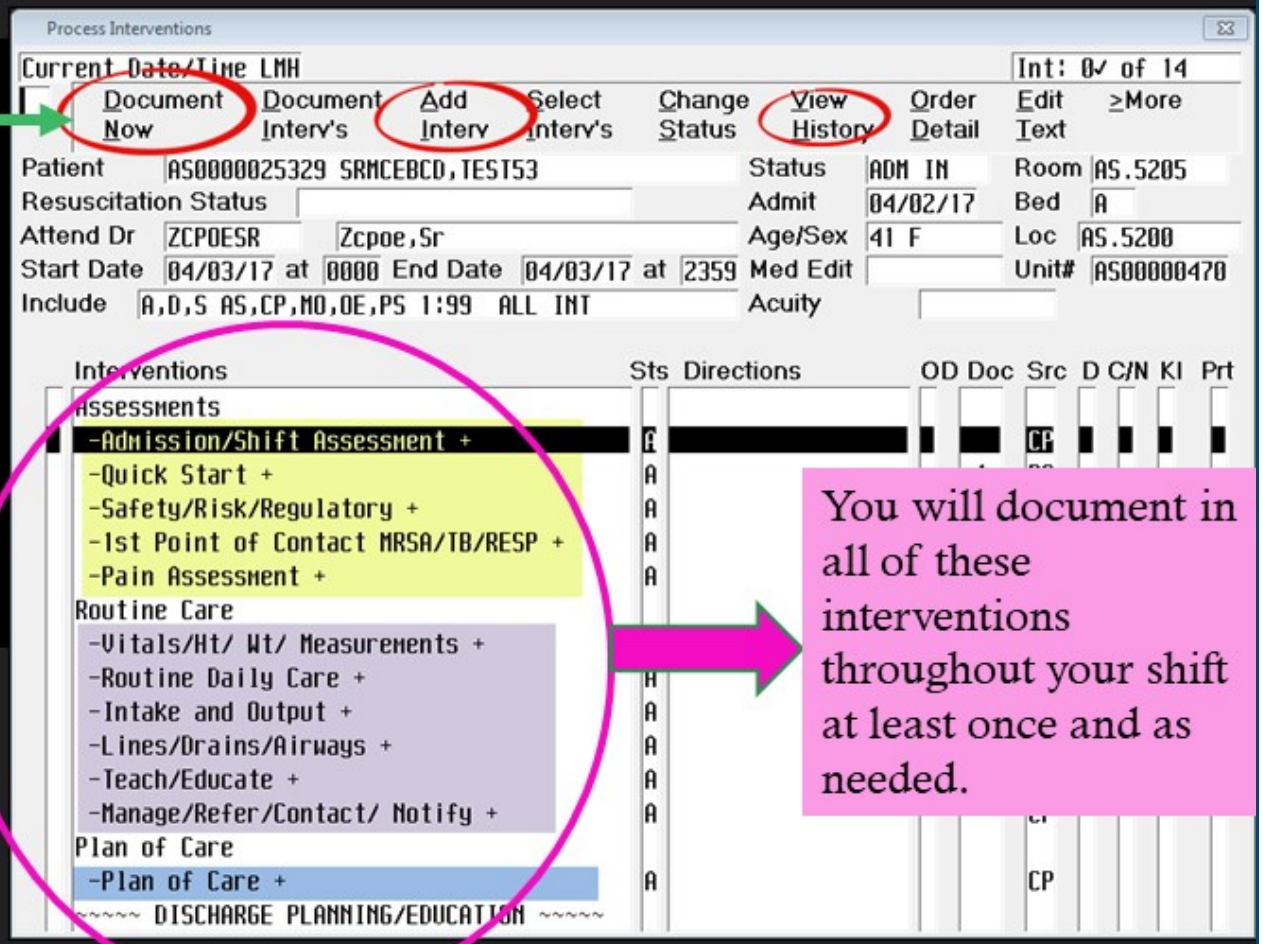
- Consult notes
- Nurse notes
- PT/OT notes
- Resp notes
- Dietary notes
- D/C summary
- Case Mgmt.

Click on the grey box to view the report

Process Interventions

"The Verb Strip" = menu items

- **"Document Now" (DN)** – to document.
- **"Add Interv's" (AI)** – to add new interventions
- **"View History" (VH)** – to view history of documentation; also used to edit or undo documentation errors.



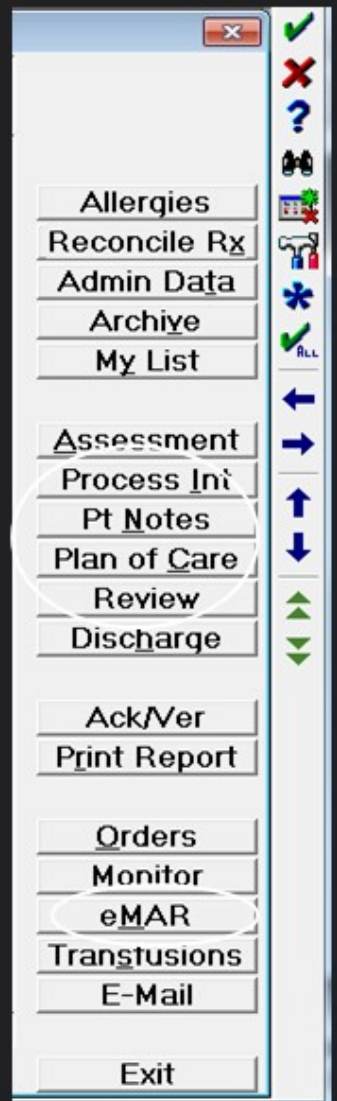
You will document in all of these interventions throughout your shift at least once and as needed.

To document on an intervention:

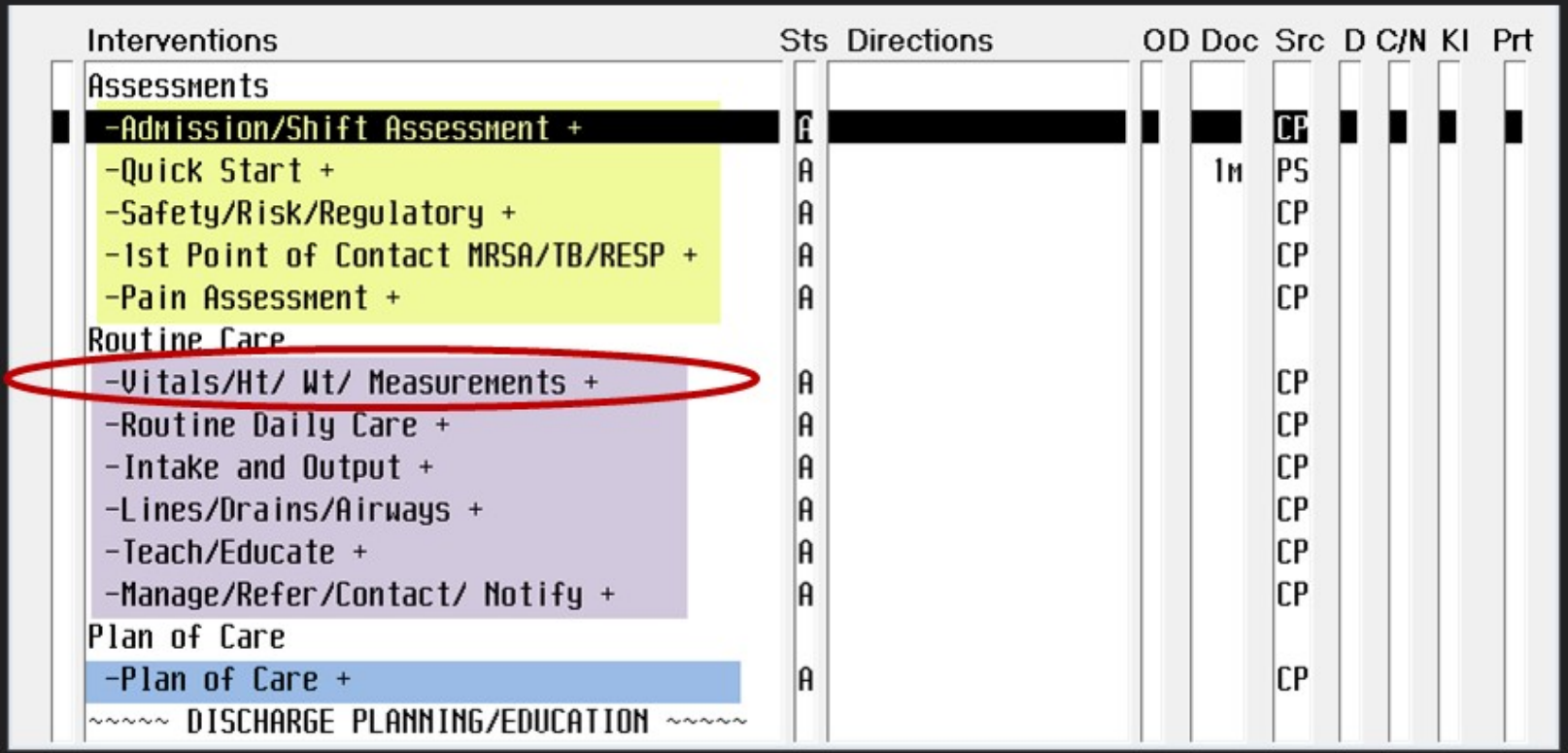
1. Highlight the intervention
2. Select Document Now

Other Daily Documentation

- Update Admin Data
- Pt Notes
- Review Status Board & Acknowledge Orders with preceptor (at LEAST every 2 hours)
- eMAR- medication administration
- Clinical Review

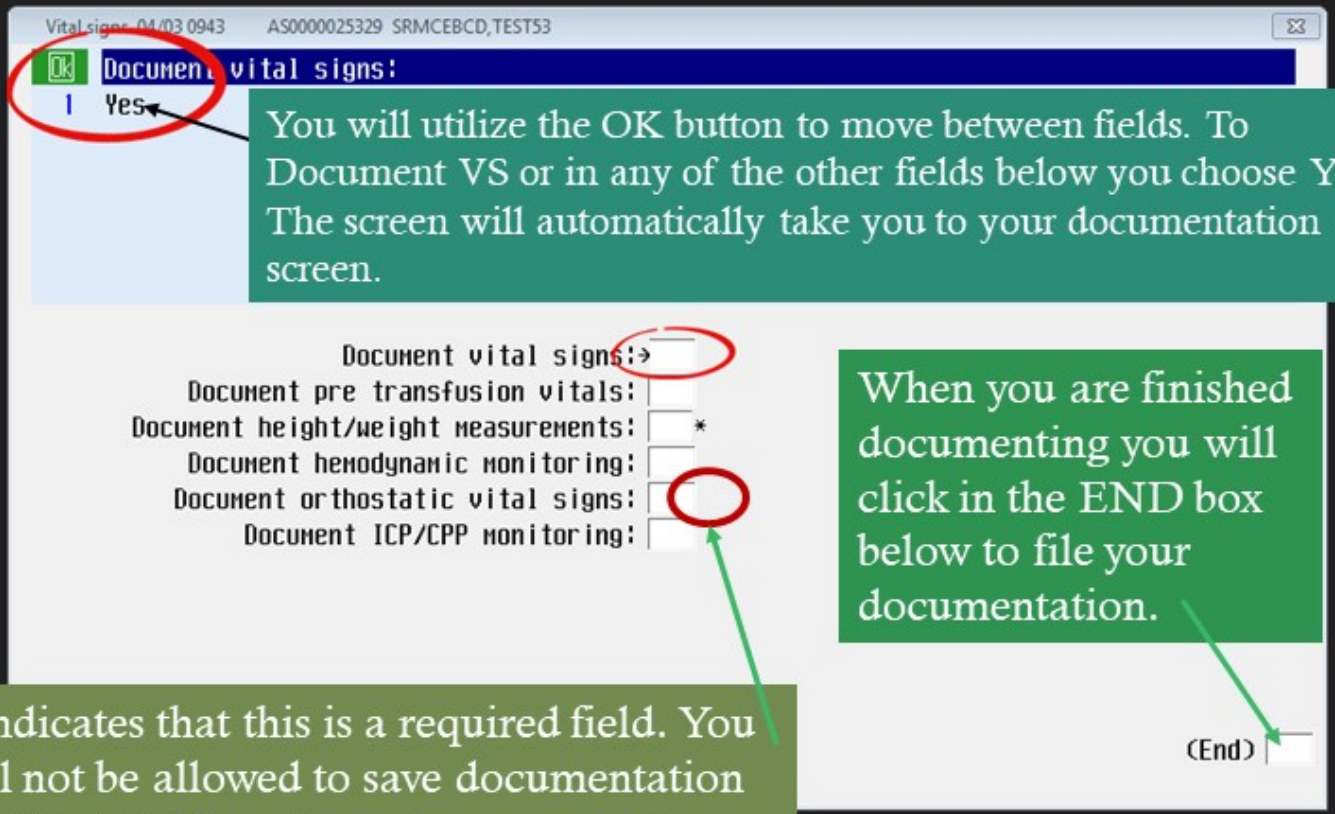


Documenting Vital Signs

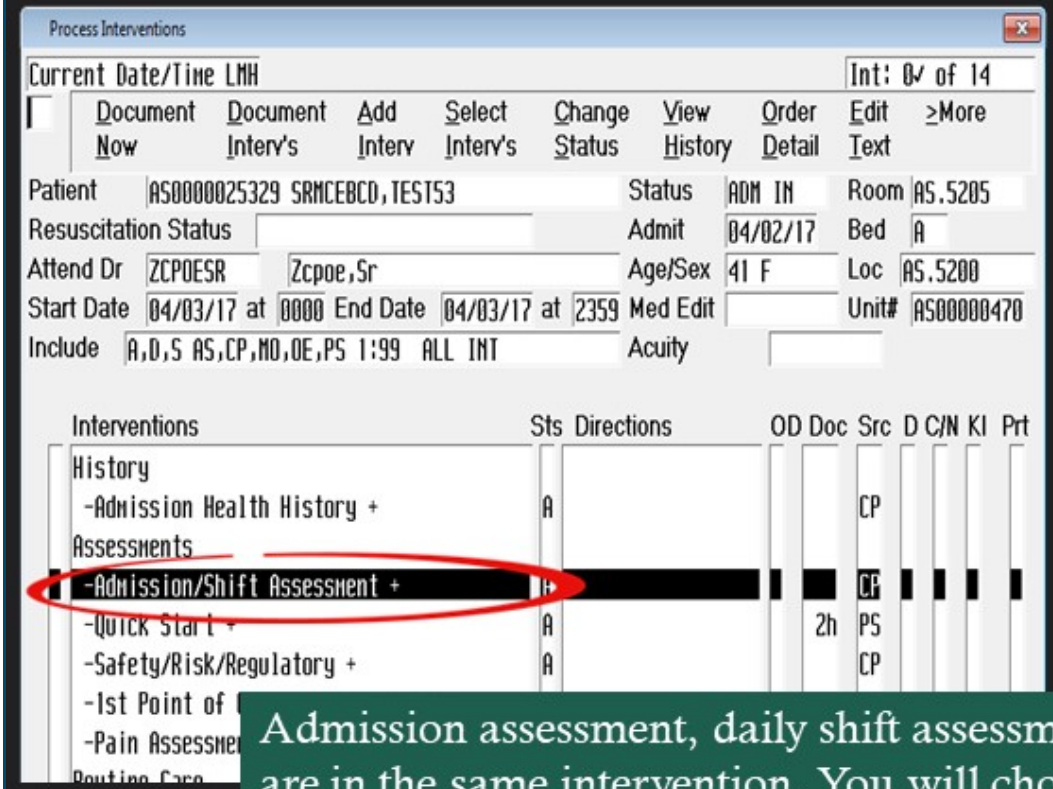


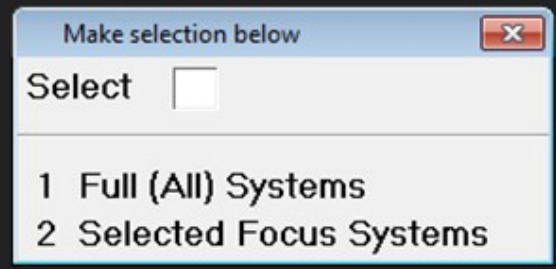
You can document Vital signs, Height, Weight, and other measurements from the above intervention.

Documenting Continued



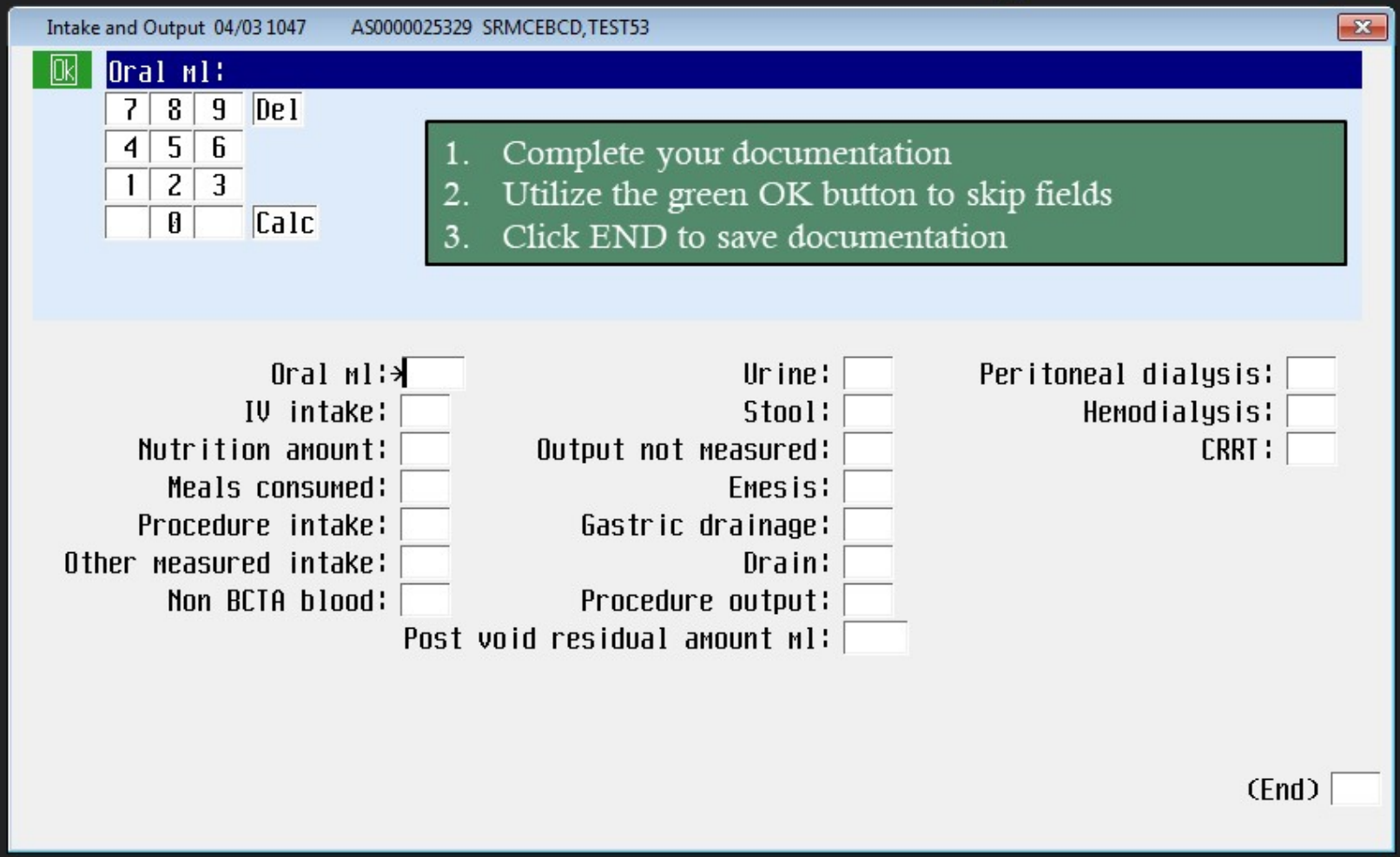
New Admissions Assessment/ Daily Assessments/ Focused Reassessments



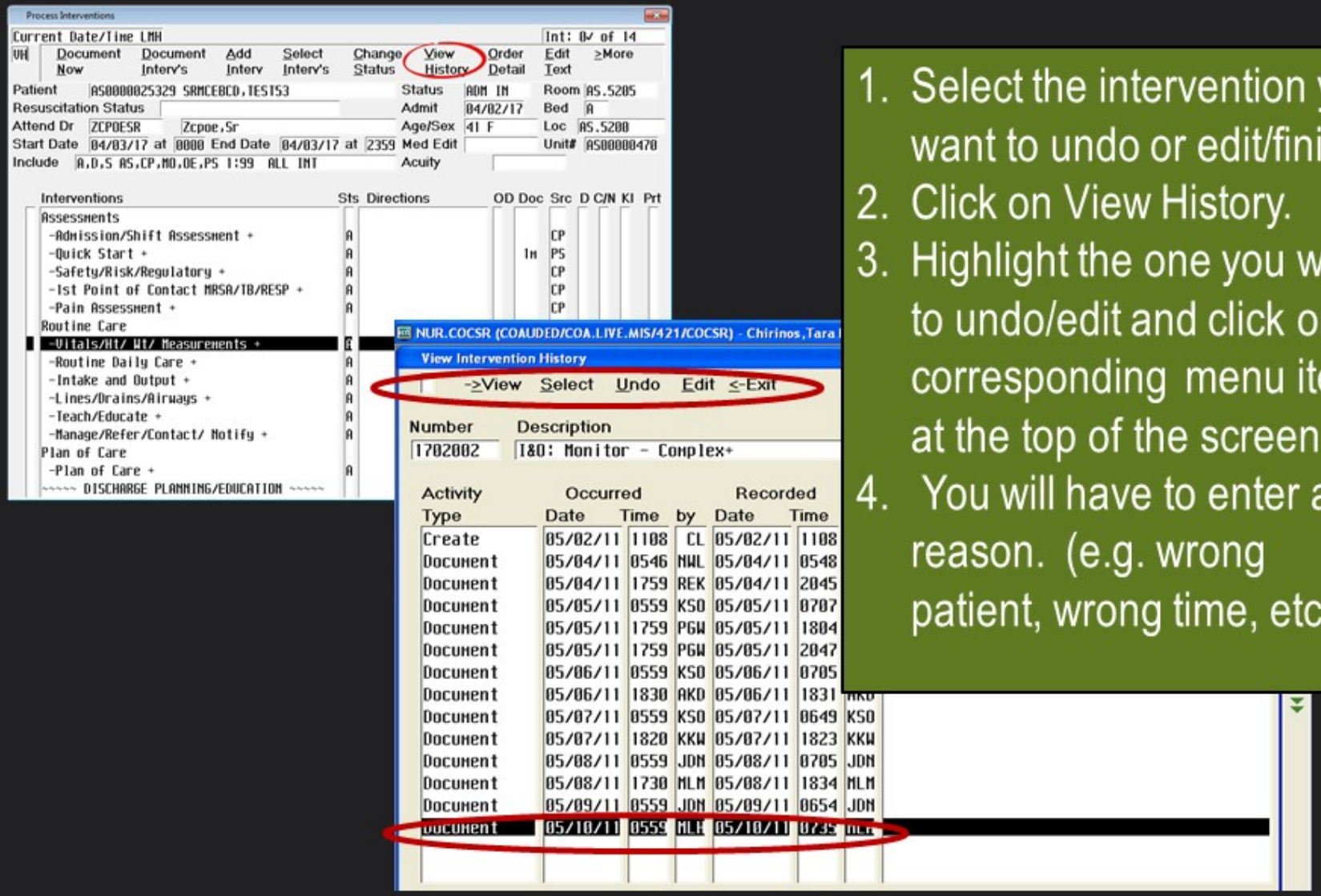


Admission assessment, daily shift assessments and focused reassessments are in the same intervention. You will choose which you would like to do from the options screen.

Intake and Output

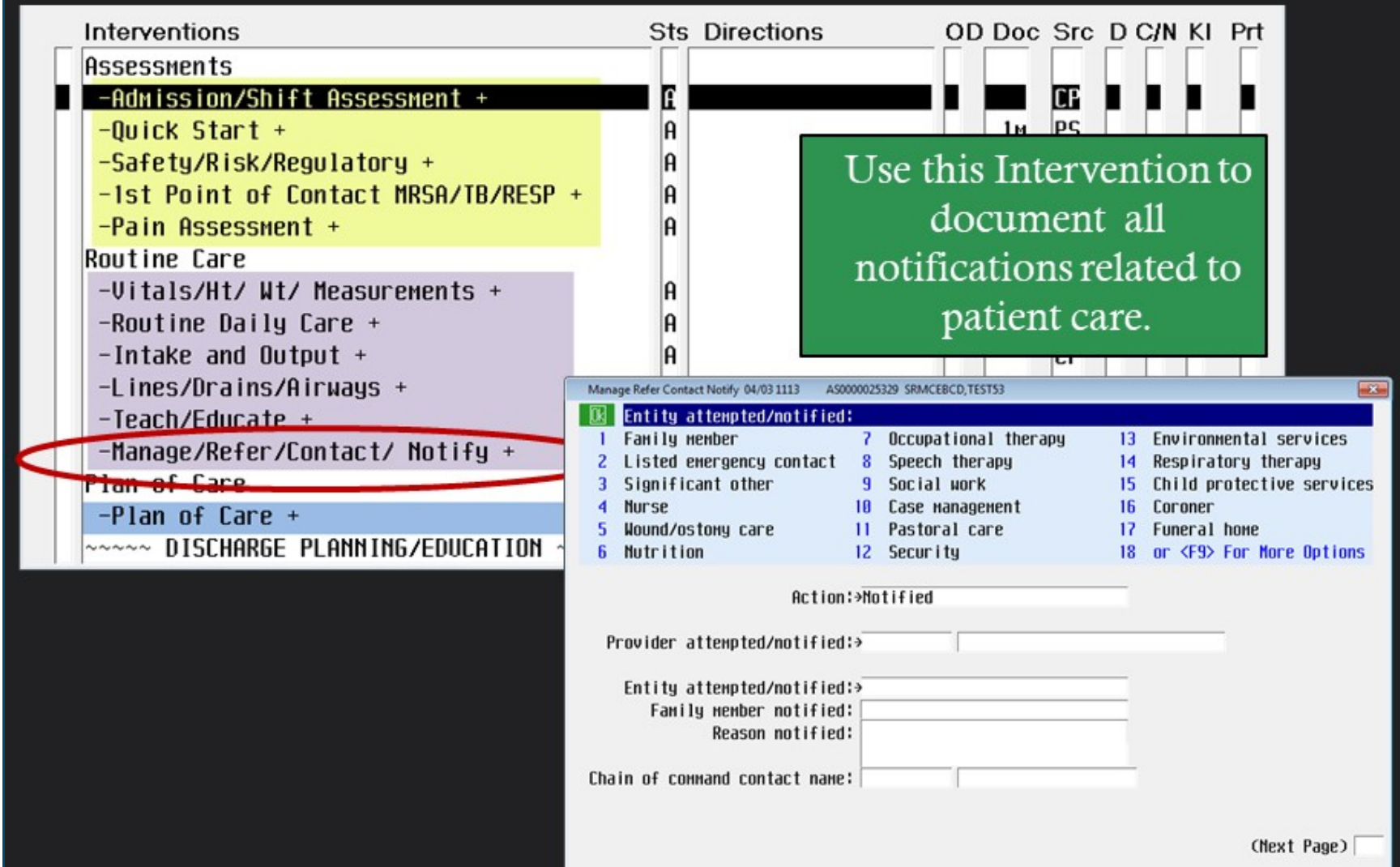


To Edit , Undo or Finish Documenting

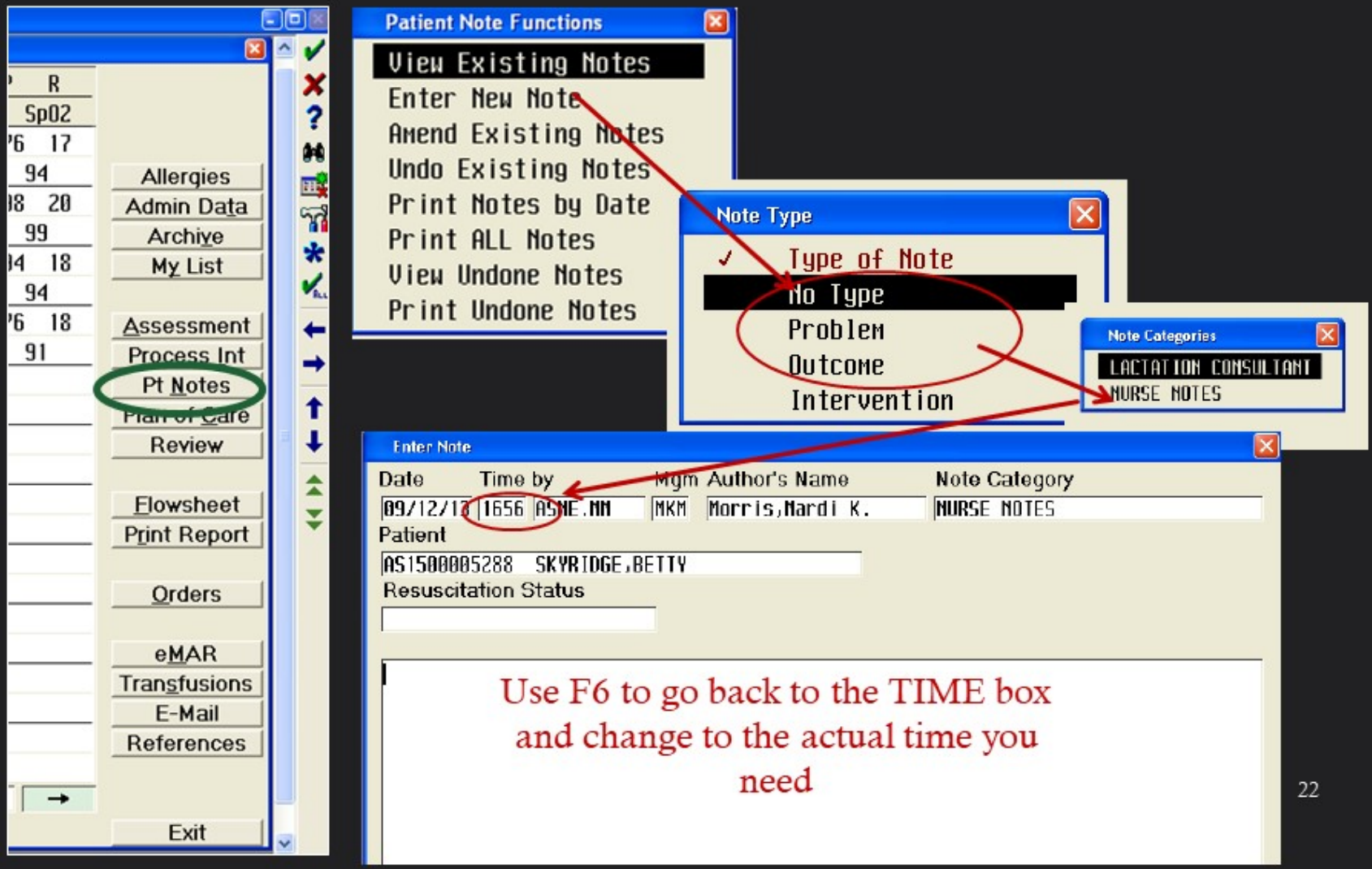


1. Select the intervention you want to undo or edit/finish.
2. Click on View History.
3. Highlight the one you want to undo/edit and click on corresponding menu item at the top of the screen.
4. You will have to enter a reason. (e.g. wrong patient, wrong time, etc.)

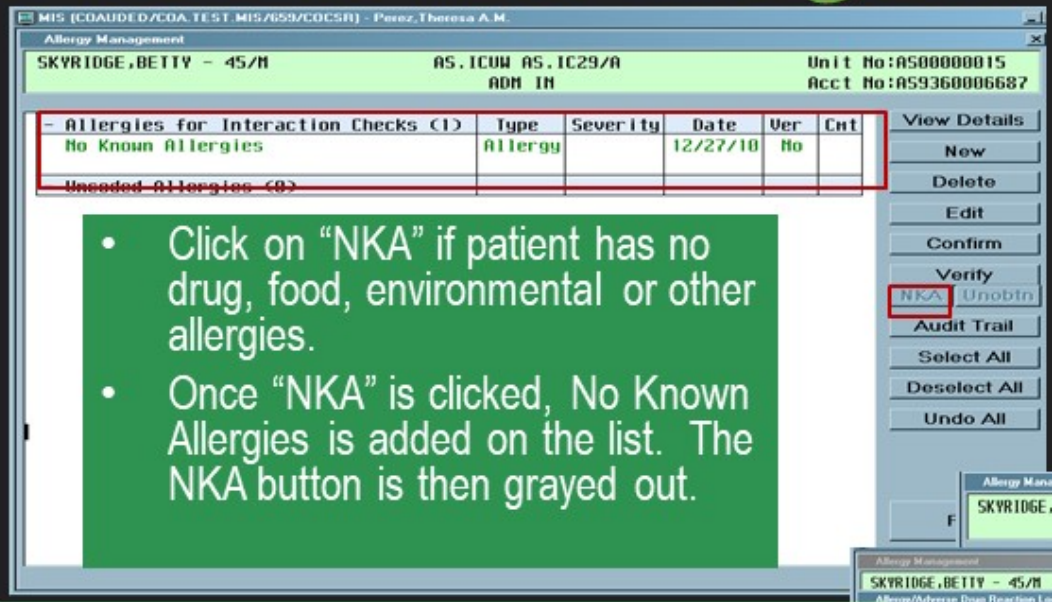
Manage/Refer/ Contact/ Notify



Patient Notes

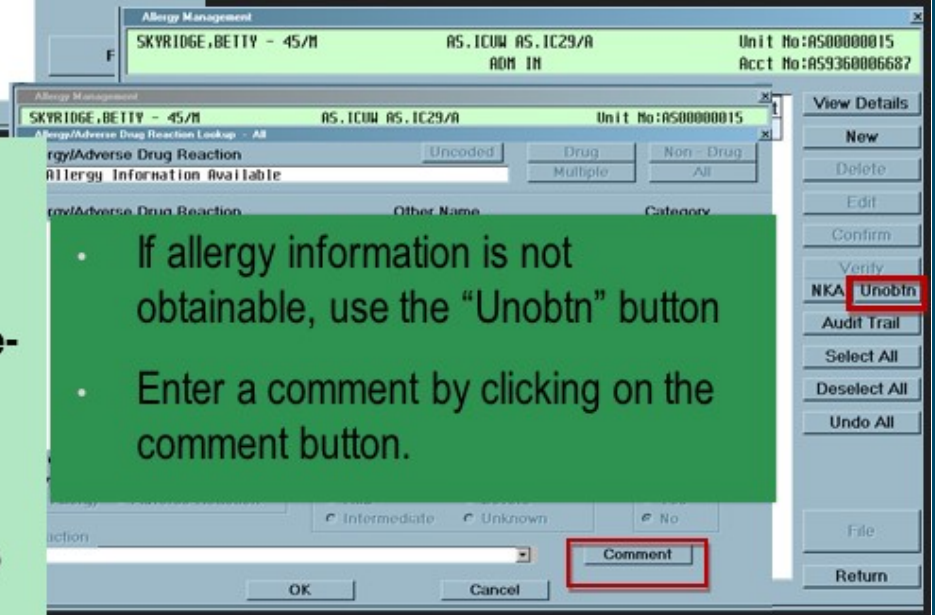


No Known Allergies/ Unobtainable



- Click on "NKA" if patient has no drug, food, environmental or other allergies.
- Once "NKA" is clicked, No Known Allergies is added on the list. The NKA button is then grayed out.

Allergies must be validated on all patients

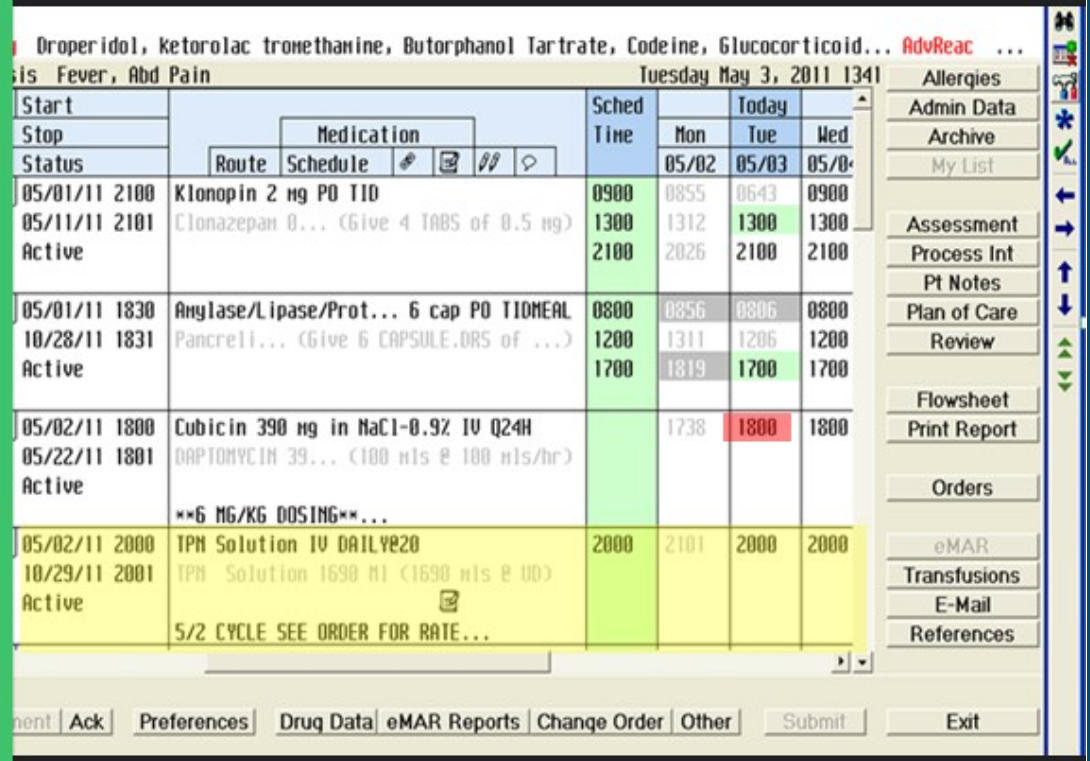


- If allergy information is not obtainable, use the "Unobtn" button
- Enter a comment by clicking on the comment button.

- Click the Verify, Confirm, and File buttons if allergies are correct
- Any **UNCODED** allergies must be **deleted & re-entered as Coded allergies in order to have allergy interaction checks.**
- **Misspelled or free text allergies will drop to UNCODED allergy list and will not be checked for interaction.**

eMAR OVERVIEW

- Light Grey: Previously Given
- Green: Next dose due
- Red: Due now or overdue
- Full Grey Box: Dose note given
- Black: Future Doses
- Yellow: Medication D/C'd



eMAR

Start Date/Time and Stop Date/Time

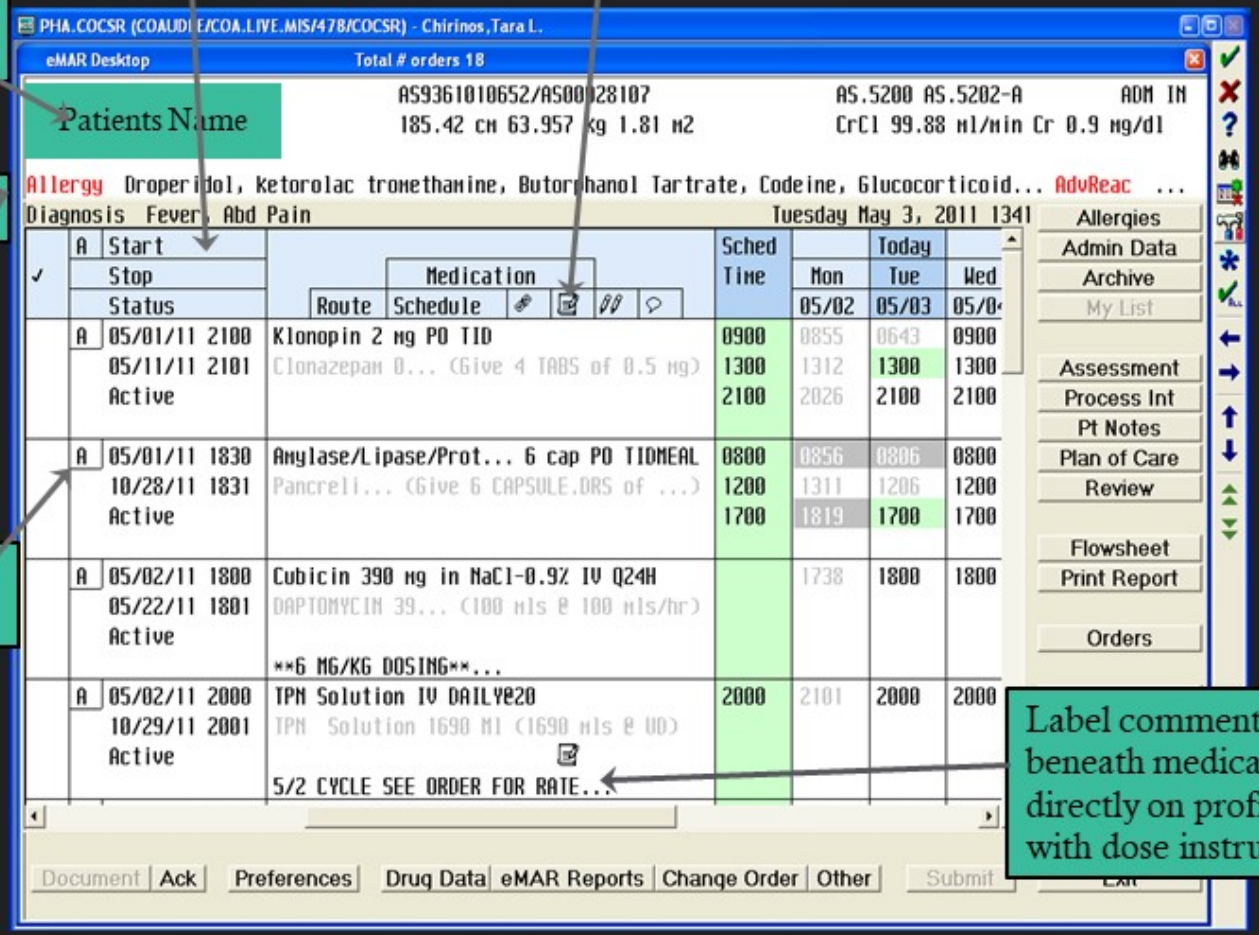
Medication Profile Icons: Clicking on these icons will display information linked to that drug. This includes linked medications, required co-signatures, dose instructions

Confirm name and DOB

Patients Name

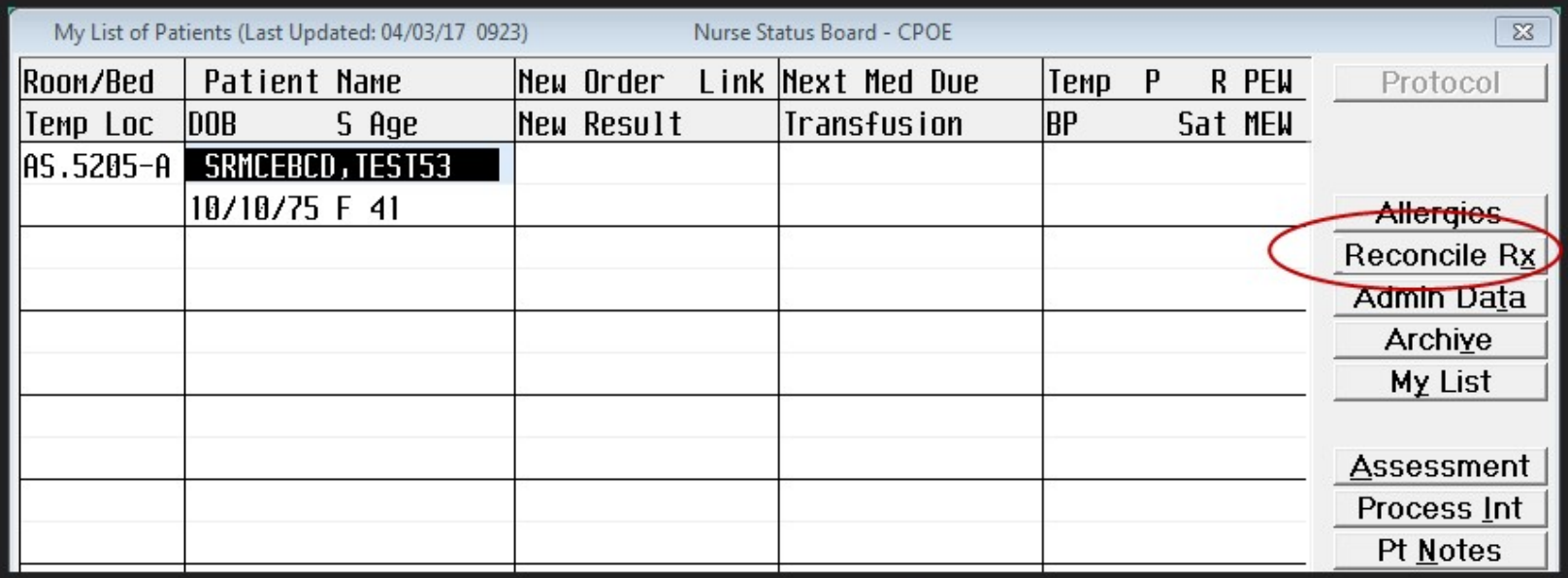
Allergies

"A" means acknowledged



Label comments display beneath medication name directly on profile and also with dose instructions.

Medication Reconciliation



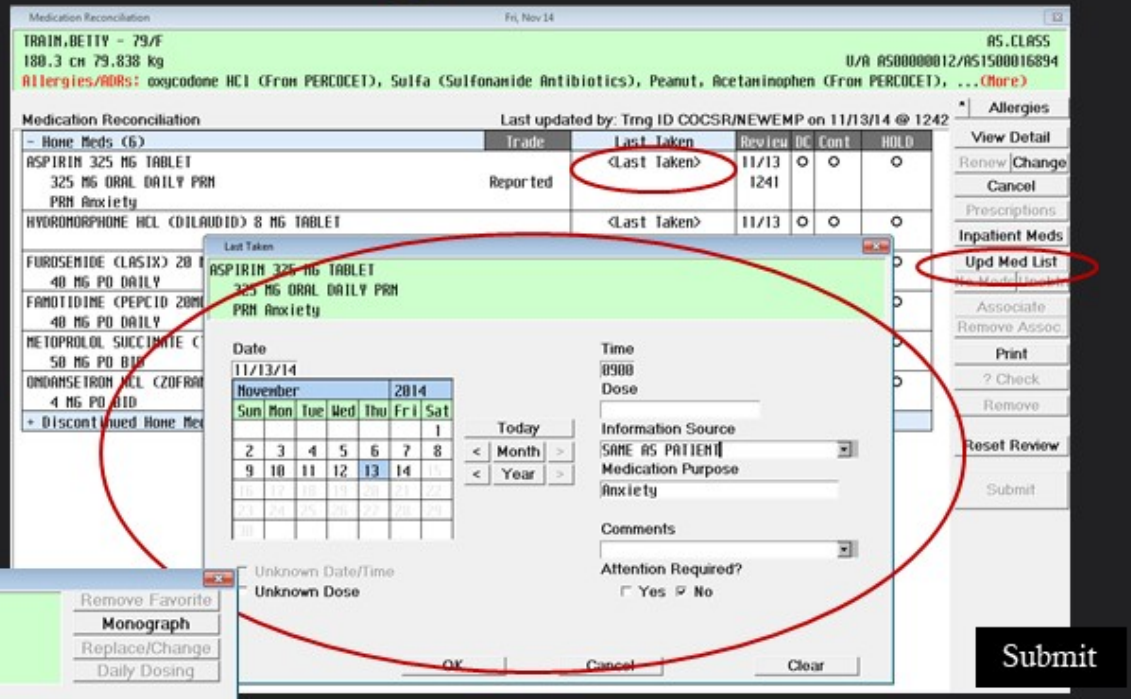
Med Rec MUST be completed:

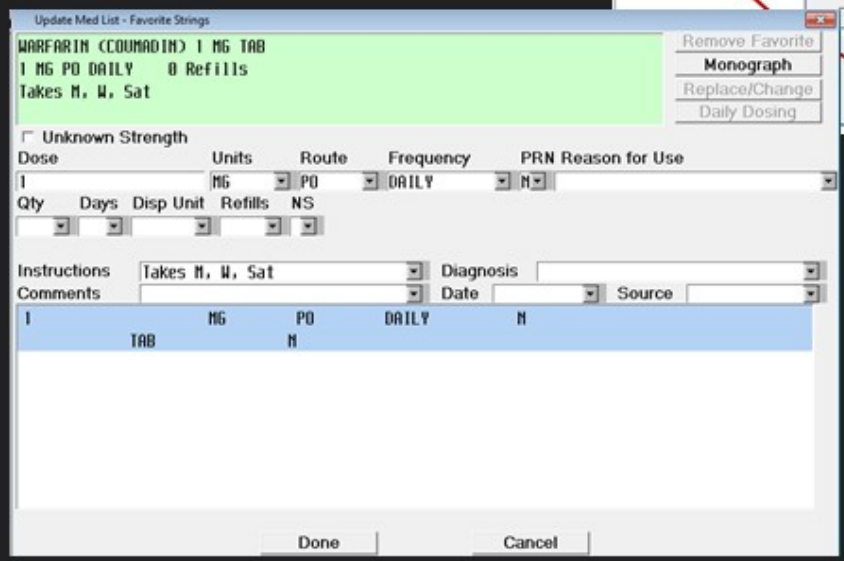
- Admission
- Transfer
- Discharge

- **Review**
  - **You must review each medication**
  - **ADD THE DATE & TIME IT WAS LAST TAKEN**

Reviewing and Adding Home Meds

- Review
  - You must review each medication
  - ADD THE DATE & TIME IT WAS LAST TAKEN





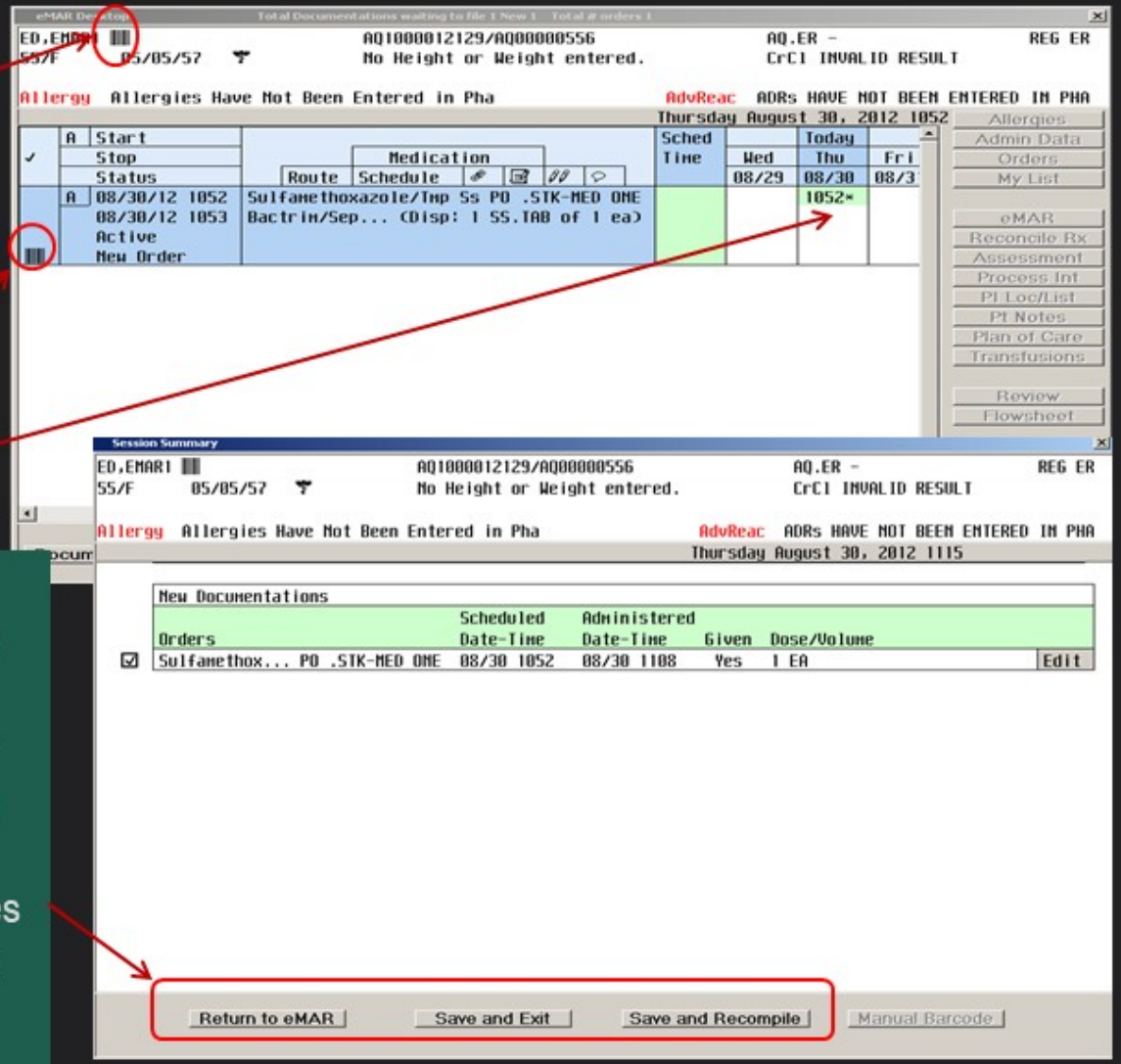
Scanning Patients & Meds

Scan patient armband.

- Barcode appears

Scan medication

- Barcode appears
- Asterisk appears



- "**Return to eMAR**"- Returns to eMAR desktop (Does not file your work)
- "**Save & Exit**"- Files your work and returns to status board
- "**Save & Recompile**"- Files your work and returns you to that patient's eMAR