FACULTY AND STUDENT Clinical Orientation Content
The ProMedica mission is to improve your health and well-being.

Your role as a student or faculty member who interacts with our patients is important in helping us uphold this mission.
Safety + Quality = Satisfaction

Excellence
SAFETY IN PATIENT CARE

• As you learned in the CORE orientation module, safety is extremely important in Health Care. Since your clinical learning will involve caring for patients, this focus on safety becomes even more important. This module will cover many aspects of safety in the clinical setting. Please **STOP** and ask the staff you work with if you have questions about any of this material.

• **REFERENCES:** There are Policies & Procedures available on the intranet (myProMedica) for more information on topics provided in this module. Please be sure you know how to access them and use them as needed.
Safety is a priority!

- Patients assume that we will keep them safe
- Safety is connected to patient satisfaction
  “Patient-reported service quality deficiencies were associated with adverse events and medical errors. Patients who report service quality incidents may help to identify patient safety hazards” - Taylor BB et al. Medical Care 2008 Feb;46(2):224-228

From the patient’s perspective:
  “Keep me safe”
  “Don’t harm me”
  “Be Nice to Me”
Patient Safety: Accuracy of Patient Identification

- Use at least two patient identifiers (neither can be the patient’s room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.
- **Patient is asked** to verbalize first and last name and birth date.
- Verify information patient verbalized by checking armband, MAR, lab order, or other hard copy patient identification that is carried into the room.
SBAR is one example of a standardized framework for a team to communicate about the patient’s condition. You will see SBAR used in a variety of ways.

• **S** = situation,
• **B** = background,
• **A** = assessment,
• **R** = recommendations

**Critical Test Reporting:** Certain diagnostic and monitoring tests have been determined to have a critical value to the care of the patient. When these test results are at the critical level, immediate communication must occur. The department performing the test (e.g. lab or radiology) will call a member of the care team with the results.

– The individual making the call is responsible for documenting the date and time of call, and the name of the person who receives the critical results.

– The primary care nurse is responsible for reporting the critical values to the ordering physician. The date and time of such reporting shall be documented in the medical record.

– The primary care nurse is also responsible for ensuring that the ordering physician is aware of critical values prior to the patient being discharged to another level of care.

– All critical test results and critical values must be read back by the receiving individual to ensure accuracy.
Do not dismiss any concerns or questions the patients may have.

Double check and keep the patient safe.

Speak up

• The “Speak Up” program is sponsored by The Joint Commission and other safety-focused organizations and urges patients to get involved in their care.

• **S**peak up – patients have the right to ask questions if they do not understand or have concerns.

• **P**ay attention to the care they receive – Make sure they are getting the right treatments and/or medications.

• **E**ducate themselves about their diagnosis, medical tests they are going to undergo and the treatment plan.

• **A**sk a trusted family member or friend to be their advocate.

• **K**now what medications they are taking and why they take them.

• **U**se a hospital they trust.

• **P**articipate in all decisions about their treatment.
Time out

• Prior to the initiation of surgical/invasive procedures, regardless of where it is done in the hospital, the patient must be identified according to hospital policy. Exceptions to this practice include IV starts and Foley insertions. Please see hospital policy for full details.

Marking the site

• If the procedure/surgery involves laterality (right or left), multiple levels (spine), or multiple structures (toes and fingers).
• The site is marked by the physician using his/her initials.
• A final verification Time Out must occur.
• Failure of any of these to happen requires postponement of the procedure.
• The surgeon has final determination of the surgical site and is responsible for verification of x-rays and other imaging studies.

Site Marking and Time Out may only be waived in procedures designated as “emergency”.
PATIENT SAFETY:
FALL PREVENTION

• Falls are the result of patient-related factors (confusion, etc.), co-morbidities (hypotension, UTI, etc.), and the environment (wet floors, slippers, etc.)

• Patients must be assessed for fall risk upon admission to the hospital and are re-assessed at least every 24 hours

• Fall prevention strategies are based upon individual patient need

• All patients regardless of fall risk should be oriented to the room environment, lights, call system, side rails, and level of assistance needed
PATIENT SAFETY: FALL PREVENTION

• **Routine safety interventions:**
  - Hourly patient rounding
  - Call light in reach – “Call Don’t Fall”
  - Bed wheels locked
  - Top rails are up except in case of chest tube
  - Ensure the environment is free of hazards for falls
  - Bed in lowest position
  - Furniture neatly arranged
  - Rest periods for tired patients
  - Answer calls in timely manner

Additional Fall Risk interventions include:
- Patient and/or Family education about fall prevention
- Frequent patient observation
- Use non-skid footwear
- Fall Risk prevention in Plan of Care
- Provide diversion activity
- Assist/supervise patient when transferring, walking, or toileting

*Fall Risk Identification per Hospital Policy* – such as yellow arm band or red slippers and door/chart stickers and flags.
Bed alarms
MEDICATION SAFETY

• In addition to double identification of the patient, several other details lead to safe medication administration....every med, every time
  – Complete medication order
  – Five Rights
    • Double check the line entry point if not giving PO. Assure the tubing is actually IV, NG, etc
    • Double check calculations
    – Does the med make sense for this patient at this time? If not, STOP and ask!
• Double checks are required with another nurse for several medications. Be sure to check the specific hospital policy:
Adverse Drug Events

• Definition: An undesirable or unexpected event that requires discontinuing a drug, modifying a dose, prolonging hospitalization, or providing supportive treatment

• Adverse Drug Events may include but are not limited to the following:
  – Diarrhea
  – Hives
  – Seizures
  – Headache
  – Rash
  – Bradycardia
  – Abnormal lab values
  – Bleeding from anticoagulants
  – Difficulty breathing or altered mental status
MEDICATION SAFETY

Adverse Drug Events

• With any medication, be sure to assess for adverse drug events
• Ensure that the medication is being given at the correct time in relation to the patient’s treatment plan or diet
• When an adverse drug event is observed, a report to Pharmacy must be made promptly
MEDICATION SAFETY - ANTICOAGULANTS

• Reduce the likelihood of patient harm associated with the use of anticoagulant therapy

• Examples of Anticoagulation Medications:
  – Coumadin (warfarin)
  – Lovenox (enoxaprin)
  – Heparin
  – Lepiridan
  – Argatroban
  – Arixtra (fondaparinux)
  – Angiomax (bivalirudin)
  – Pradaxa (dabigatran etexilate)
MEDICATION SAFETY- ANTICOAGULANTS

- Benefits of Anticoagulation Therapy:
  - Prophylaxis of thromboembolism or stroke
  - Treatment for thromboembolism

- Potential Side Effects:
  - Bleeding
  - Excessive bruising, petechiae, hematoma
  - Decrease Hbg, Hct, Platelet counts
  - Heparin Induced Thrombocytopenia
  - Hemorrhage
  - Hypersensitivity reaction
Follow-up Monitoring is Essential
- PT, PTT, INR’s, Platelet counts, Hgb, Hct, Creatinine, and Liver Function tests may be ordered
- Specialized anticoagulation order sheets must be utilized where applicable

Patient Education and Compliance:
- Educate patients about drug regimen and follow-up lab work
- Utilize anticoagulation discharge instructions
- Educate patients about dietary restrictions (such as foods that are high in Vitamin K)
- Check for drug interactions
Perhaps the single most important action needed to greatly slow down the development and spread of antibiotic-resistant infections is to change the way antibiotics are used.

This commitment to always use antibiotics appropriately and safely is known as ANTIMICROBIAL STEWARDSHIP.

ProMedica’s Antimicrobial Steward Program (ASP)

- The goal is to “optimize clinical outcomes while minimizing unintended consequences of antimicrobial use”
- Elements of the antimicrobial stewardship program include:
  - Reduce inappropriate antimicrobial use
  - Monitor and prevent bacterial resistance
  - Decrease time of appropriate antimicrobials
  - Provide direct, real-time feedback to providers on antimicrobial selection
  - Optimize antimicrobial regimens
  - Education for patient/families and healthcare staff
  - Track antimicrobial usage
Successful implementation of ASP has many beneficial outcomes including:
- Decrease ICU and hospital length of stay
- Decrease time to appropriate antimicrobial agent
- Reduction in antibiotic related adverse events
- Decreased in antimicrobial resistance patterns
- Reduction in super-infections
- Decrease pharmacy department antimicrobial cost

What is the role of the Nurse in ASP?
As coordinators of care, nurses:
- Are antibiotic first responders and central communicators
- Are 24-hour monitors of patient status, safety, and response to antibiotic therapy
- Assure that cultures are performed before starting antibiotics
- Review medications as part of their routine duties and can prompt discussions of antibiotic treatment, indication, and durations
- Use evidence-based infection prevention techniques to minimize antimicrobial resistance.
Students participating in the care of a patient receiving blood must be aware of the signs and symptoms of a transfusion reaction. Be sure to alert the Patient’s RN for any sign of a reaction.

- **The first 15 minutes of the infusion is one of the most critical times for a transfusion reaction to occur;** therefore, nursing personnel should remain with the patient for those 15 minutes.

- Patients who experience signs and symptoms of a transfusion reaction during or within approximately 4 hours after transfusion, shall be managed for transfusion reaction.

- Transfusion reactions may occur during or after a transfusion or up to 24 hours post transfusion.
MANAGEMENT OF TRANSFUSION REACTIONS (continued)

- Notify RN of change in vital signs or if the patient demonstrates signs/symptoms of a reaction.
- Due to the anesthetized state of the patient and the rapidity of which multiple units may be administered in the OR, a reaction may be delayed.
- The most common complication of a blood transfusion reaction is febrile non-hemolytic (FNH) caused by an immune response to cytokines or white blood cells in the stored blood.
- During, or shortly after, a whole blood or other blood product transfusion the patients temperature will increase by 1 degree C or more in the absence of any other stimuli.

The following signs/symptoms should alert the Care giver to the possibility of a blood reaction:

**NOTE:** All body temperatures shall be obtained from the same site (oral, axillary, aural or rectal) using the same device.
In the core orientation material, you learned a little about handling emergency situations in a health care facility. In this module we will talk about how to protect the patient in these emergent situations.
EVACUATION
Types of fire evacuation:

1. Horizontal evacuation
   - moving people from any section of the building where danger exists from smoke or fire to an area on the same floor of the same building which is protected by a fire (smoke) door

2. Vertical evacuation
   - moving patients down to a safe area, one to two floors below the fire
   - Never use elevators.
Evacuation Safety

Total evacuation

- Everyone is removed from the building because of dense smoke or fumes or other danger.
- Those evacuated first should be those in immediate danger and floor by floor; this will be determined by the incident commander.

If time permits, patient charts should be gathered and moved with the patients also.

METHODS TO MOVE NON-AMBULATORY PATIENTS:

1. Move the entire bed.
2. Use of a cart.
3. Wheelchair.
4. Blanket drag – Head first with six or eight inches of blanket extending beyond the head.
ParaSlyde Evacuation Sled.

- This device enables you to move patients more efficiently and more effectively to safer areas in case of an emergency evacuation.
- Weighs 7 lbs.
- Can carry a patient weighing up to 500 lbs.
- Is designed and constructed with 12 MM corrugated polypropylene.
- 2 handles at the head and 2 handles at the foot allow 2 person, 3 person, or 4 person operation to assist the decent of non-ambulatory patients.
Severe Weather conditions:
- TORNADO WATCH
- TORNADO WARNING
- THUNDERSTORM WATCH
- THUNDERSTORM WARNING

YOUR ACTIONS?
- If you are away from your unit, return to it immediately.
- Close all shades, drapes, and blinds to minimize the danger from flying glass.
- Escort employees, visitors or others from areas that may be a danger; i.e., entrances, glass enclosed waiting areas due to flying glass. Move persons to inner hallways, enclosures, etc.
- Locate flashlights in the department.
If the electrical system fails the generators go on in 10-15 seconds. Have all critical patient care equipment plugged into the critical power outlets, which are color coded RED.

Safety principles when working with electricity:

- Patient care equipment should be connected to the receptacle closest to the patient.
- Unplug and plug in all electrical equipment with the power switch in the OFF position.
- Never pull plugs from the wall by pulling on the cord.
QUALITY

• The 2\textsuperscript{nd} aspect of care that is very important is the quality of care and quality of the patient’s experience. Again, since as a student you will provide direct care to our patients, it is important for you to know how to support these important areas of focus.

• When it comes to delivering quality care you are part of our team.
Our Goal is Service Excellence

In alignment with our Mission, Vision and Values, our goal is to ensure that every patient has an excellent patient experience.

• Consistency from everyone is important in achieving this goal.

YOU MAKE A DIFFERENCE!
Research has shown that hourly rounding:

• Reduces call light usage
• Reduces patient falls
• Reduces hospital acquired pressure ulcers
• Improves patient perception of pain management
• Increases patient satisfaction
Providing Safe, Quality Care
Every patient     Every employee     Every time

Hourly Ranging includes checking on the patient’s
• Pain/Comfort
• Position
• Potty/Toileting
• Possessions/Call Light
• Communication/Courtesy

It’s important that we anticipate patient’s needs. Be proactive vs. reactive (address patient needs before they have to ask)
CORE MEASURES (QUALITY MEASURES)

• Core measures use evidence-based medicine to perform patient care that has been proven to result in better outcomes for patients

• There are certain qualifications that must be met in the national clinical focus areas to ensure higher payment from Medicare and other payers

• The National Clinical Focus Areas are:
  – Heart Failure (HF)
  – Acute Myocardial Infarction (AMI)
  – Pneumonia (PN)
  – Surgical Care Improvement Project (SCIP)
  – Stroke (STK)
To meet the standard of practice the patient must:

– Have complete discharge instructions
– Have a left ventricular function assessment
– Have an ACE inhibitor or an ARB prescribed at discharge
ACUTE MI CORE MEASURES

- Aspirin given at arrival and prescribed at discharge
- Beta blocker given at arrival and prescribed at discharge
- ACE Inhibitor/ARB prescribed at discharge
- Thrombolyis within 30 minutes
- Percutaneous coronary intervention within 90 minutes
- Adult smoking cessation counseling
PNEUMONIA CORE MEASURES

• Oxygenation assessment
• Blood cultures performed before 1st antibiotic given at the hospital, and within 24 hours of hospital arrival
• Adult smoking cessation counseling
• Antibiotic given within 6 hours of hospital arrival
• Initial antibiotic selection for community required pneumonia in immunocompetent patients
• Influenza and pneumococcal vaccinations upon discharge
SURGICAL CARE IMPROVEMENT PROJECT CORE MEASURES (SCIP)

• Infection Prevention:
  – Recommended antibiotic given within one hour prior to surgery
  – Antibiotic discontinued within 24 hours after surgery
  – Appropriate hair removal
  – Normothermia (colon patients)
  – Glucose control (cardiac patients)

• Venous thromboembolism prophylaxis:
  – Ordered by the physician
  – Received by the patient

• Cardiovascular
  – Patients on beta blockers prior to admission receive them within the hospital
STROKE CORE MEASURES

- Venous thromboembolism prophylaxis
- Anti-thrombotic medication prescribed upon discharge
- Anticoagulation therapy for atrial fibrillation/flutter
- Thrombolytic therapy
- Anti-thrombotic therapy by end of hospital day 2
- Statin medication prescribed on discharge
- Stroke education performed within the hospital
- Patient assessed for rehabilitation
To assure every patient experience is the best it can be, each day, we each need to answer three simple questions:

- What did I do today to be the best at what I do? (Value: Excellence)
- What did I do today to find a better way forward in delivering high-quality, compassionate care? (Value: Innovation)
- What did I do today to treat our patients and each other with respect and dignity? (Values: Compassion and Teamwork)
Responsiveness of Hospital Staff

All team members can make a positive impact on patients’ perception of responsiveness of hospital by following the GIANT principles:

- **Greet**: make eye contact; “Good morning/ afternoon/ evening”
- **Introduce**: My name is ___. I am ___ (explain role). I will be ___ (explain task).
- **Action**: “I am sorry this happened. How can I make it better?”
- **Notice**: “Can I help you find something? Let me show you” (take them there)
- **Thank**: Be sure to thank patients, families and co-workers
Responsiveness of Hospital Staff

• Response to call button: It is important to our patients that once their call is answered, they get help in a timely fashion
• Good rule of thumb- anyone within a 5 foot range of a call light should respond to the call to see what the patient needs
• Getting help to use the bathroom as soon as patients want: It’s important to our patients that they get timely help when they need to use the bathroom. Be sure to notify the appropriate person quickly if you cannot help the patient
Every team member should ask prior to leaving a patient’s room, “Is there anything else I can do for you? I have time.”

If you need additional help with a patient’s request, notify the nurse or nursing assistant/tech directly.
Service Recovery

• Every employee should feel empowered to initiate service recovery when a patient/customer has received less than excellent service
• The best person to initiate service recovery is the person who discovers the issue
• The best way to start service recovery is to acknowledge the complaint and apologize for not meeting expectations. “I am sorry that we didn’t meet your expectations”
• As a student, please then get assistance from a hospital employee to guide the remainder of the service recovery.
End-of-life Care

- Patients have the right to receive treatments to manage symptoms and keep them comfortable at the end of life. These types of treatments are known as palliative care.
- Palliative care can also help people manage symptoms of non-life-limiting conditions, such as rheumatoid arthritis.
- The goal of palliative care is to help people maintain comfort and quality of life, regardless of whether their disease is curable. Based on patient preferences, palliative care may be combined with other treatments to prolong your life or to cure your condition.
Patients can expect that their reports of pain shall be believed, that education shall be provided, that staff shall be committed to pain management and shall respond in a manner that meets the needs and expectations of the patient.

“Pain is inevitable, but suffering is optional.”
PAIN MANAGEMENT

The best and most reliable source for identifying pain is the patient’s own verbal communication. If the patient cannot tell someone about the pain, body language and physiological status can provide clues to the presence of pain. However, nonverbal behaviors should not be used to refute a patient’s verbal complaint of pain.

The caregivers in a hospital are NOT to JUDGE a patient’s perception of pain, but treat the pain as the patient describes it.
Inpatient comment –
“I did not know that the nurses and doctors use a particular scale and the rating I was given for my pain was personal to me and the staff questioned my rating since what I gave as a number meant to them that I should have been unable to talk or move around. Pancreatitis hurts and no drug can get rid of the pain entirely. The drugs given just make you able to rest and talk and move around a little without screaming or begging for help.”
IDENTIFICATION OF PEDIATRIC ABUSE

• Physical
  – Unexplained cuts, burns, bruises, fractures
  – Problems at school
  – Fear of adults
  – Self-destructive or suicidal behavior
  – Physical condition does not match explanation from caregiver

• Sexual
  – Pain or bleeding with urination or defecation
  – Inappropriate interest/knowledge of sexual acts
  – Nightmares and bed wetting
  – Changes in appetite
  – Secretiveness

• Neglect
  – Lack of care
  – Unbathed/dirty
  – Extreme hunger

• Emotional
  – Depression
  – Hostility
  – Lack of concentration
  – Eating Disorders
IDENTIFICATION OF ELDER / DEVELOPMENTALLY DISABLED ADULT ABUSE

• Physical
  – Burns
  – Unexplained cuts, bruises, fractures
  – Signs of being restrained
• Neglect
  – Dehydration/Malnutrition
  – Extreme hunger
  – Bed sores
  – Unbathed/dirty
• Emotional
  – Depression
  – Non-communicative
  – Caregiver belittles, threatens, or controls patient
• Sexual
  – Bruises around breasts, inner thighs, or genitals
  – Unexplained venereal disease
  – Unexplained vaginal, penile, or anal bleeding
• Financial Exploitation of Elders:
  – Sudden close relationship with a much younger person
  – The caregiver’s only means of support is the patient
  – The caregiver restricts the elder’s contact with the community
IDENTIFICATION OF DOMESTIC VIOLENCE

• Physical:
  – Discrepancy between injury and history given by patient
  – Verbal admission of abuse
  – Multiple injuries in varying degrees of healing
  – Disproportionate amount of time between injury and time medical treatment is sought
  – Injuries on areas that are normally covered by clothing
  – History of being “accident prone”
  – Untreated old injuries

• Psychological or Verbal Abuse
  – Complaints of chronic pain
  – Bizarre or inappropriate history
  – Alcohol or drug abuse history in patient or spouse
  – Depression regarding family situation
  – Previous suicide attempts

• Sexual
  – Assault
  – Rape
Thank you for being part of the ProMedica team while you learn. Please ask any employee for further information on any of these topics. We hope you will consider ProMedica as a place of employment when your education is complete.