JOINT COMMISSION READINESS
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This employee guide is designed to assist you in preparing for our upcoming Joint Commission survey. It will provide you with helpful hints and information on important policies and processes. Your knowledge of this information is not only crucial to our success during the survey, but also to our ability to deliver the highest quality of care to our patients. As you review this guide, think about how your work supports our mission to deliver quality patient care. We can expect an unannounced survey some time between January 27, 2010 and December 31, 2011.

You will find additional information on the Joint Commission preparedness page on the portal.

Mount Auburn Hospital's primary purpose is to improve the health of the residents of Cambridge and surrounding communities. Our services are delivered in a personable, convenient and compassionate manner, with respect for the dignity of our patients and their families.
I

GENERAL SURVEY INFORMATION
WHAT IS THE JOINT COMMISSION SURVEY?
The Joint Commission (TJC) surveys healthcare organizations to ensure their compliance with nationally based standards. These standards are organized into the following chapters:
* Accreditation Participation Requirements
* Emergency Management
* Environment of Care
* Human Resources
* Infection Prevention and Control
* Information Management
* Leadership
* Life Safety
* Medical Staff
* Medication Management
* National Patient Safety Goals
* Nursing
* Performance Improvement
* Provision of Care, Treatment and Services
* Rights and Responsibilities of the individual
* Surveillance, Prevention and Infection Control
* Transplant Safety
* Waived Testing
WHAT HAPPENS DURING THE SURVEY?
The “Survey Team” will spend five days at Mount Auburn Hospital conducting patient tracers to assess our compliance with Joint Commission Standards and evaluate our systems for providing care and services.

WHAT CAN I DO TO PREPARE FOR THE SURVEY?
1. Become familiar with the National Patient Safety Goals and know what Mount Auburn is doing to address them.
2. Become familiar with the standards that apply to your job and department.
3. Review The Joint Commission Preparedness resources on the portal.
4. Ask your manager if you are unsure how to interpret the standards.
6. Understand Mount Auburn’s policies and procedures including: fire, disaster, infection control, the various code alerts, incident and adverse drug event reporting.
7. Look at your documentation the way a surveyor would.
   ✶ Is the assessment complete?
   ✶ Is there a documented plan of care?
   ✶ Is the entry dated, timed, authenticated and legible?
   ✶ Are there unapproved abbreviations in your documentation?
   ✶ Is pain assessed and reassessed at the required intervals?
   ✶ Is the status of the patient’s Health Care Proxy documented?
   ✶ Is there documentation of the patient’s wishes if the proxy is not available?
   ✶ Do you use and document restraints in accordance with MAH policies?
SURVEY ETIQUETTE

- Be professional, kind and courteous.

- If you do not understand the question, ask the surveyor to repeat the question or ask them to rephrase it.

- Be truthful, if you don’t know the answer, state that you can always use your supervisor or manager as a resource or you can refer to a policy or manual.

- Answer the question with just the information required, don’t embellish.

- Support your co-workers, add relevant information as appropriate. Show that patient care is a team effort.

- It is understandable that you might be nervous. Just take a breath and take your time. The surveyors are asking you about things that you do everyday, try to relax so that the good patient care you provide can shine through.
WHAT IS A PATIENT TRACER?

A patient Tracer allows the surveyors to follow the experience of a patient as they interact with all the different services in the hospital.

At Mt. Auburn, the surveyors will select patients from the hospital census. They will choose patients with specific diagnosis to match the areas that they want to visit. They will survey each area that the patient visited (such as emergency room, cardiac cath lab, radiology, etc.) over their course of treatment. Surveyors will read the entire chart, then observe direct care, medication administration, and the care planning process. They may interview individual patients or family members and review additional medical records to assure compliance. They will interview staff about performance improvement measures, their roles and responsibilities, and training and orientation.

The surveyors will also choose patients that reflect the specific Priority Focus Areas that have been chosen for Mt. Auburn Hospital. Priority Focus Areas are systems that are most critical to the delivery of patient safety and quality of care.
The key Joint Commission Priority Focus Areas for 2010 include:

- Assessment and care/services
- Communication
- Credentialed Practitioners
- Quality improvement expertise/activities
II

STANDARDS
**DOCUMENTATION**

- Care must be documented to evidence that it occurred. Documentation is the key way we communicate with the health care team.

- The nursing assessment and care plan play a key role in the care of the patient, therefore, all components must be complete and accurate. It is one of the initial ways that patient referrals are triggered, so completion and follow through are vital.

- All entries into the medical record must be legible, dated, timed and authenticated.

- Do not use unsafe/unapproved abbreviations.

- Be prepared to assist with and explain all aspects of the medical record, both computerized and paper.

- Multidisciplinary documentation means that we show how we collaborate with all members of the team in planning and providing care. At MAH, this occurs when all caregivers document treatment and education in the progress notes. The nursing plan of care is in the patient bedside book for reference by other caregivers.
ASSESSMENTS/HISTORY AND PHYSICALS

- It is through the initial nursing assessment that all initial referrals are generated and the plan of care is formulated.
- Once the nursing assessment is completed, it triggers care providers to involve other departments in the patient’s plan of care.
- All department assessments MUST be completed within a specified timeframe – refer to your department policies for specifics.
- Reassessment is made each time there is a change in the patient’s condition, transfer to another service or patient care area, or prior to moderate sedation or anesthesia.
- Each patient must receive a history and physical examination no more than 30 days before or 24 hours after admission. Documentation must be placed in the patient’s medical records within 24 hours of admission.
- When a history and physical examination is recorded within the 30 days prior to admission, there must be an updated medical record entry that documents an examination for any changes in the patient’s condition.
- This updated documentation must be in the medical record within 24 hours after admission.
- The requirement for H&Ps refers to all admissions and must be met before a patient undergoes an invasive procedure or surgery.
ADVANCED DIRECTIVE

• A legal document that tells health care providers what a patient’s health care wishes are if they become unable to make their own decisions, and who they want to appoint to make decisions for them.

• It can be called a Living Will, Mass. Health Care Proxy or Durable Power of Attorney for Healthcare.

• Admitting asks if the patient has one and offers information if he/she doesn’t. Social Work will assist if a patient wants to execute one. Physicians and nurses need to know the status and where the document is located. Patients can choose not to have one, but that refusal must be documented.
Pain Management

- Every patient has the right to good pain management. It starts with the nursing assessment and continues until discharge.

- Use a pain scale appropriate to the patient.
  - Numeric - alert, conversive adult patient.
  - Wong - Baker Faces - alert, Non-English speaking adult or child.
  - FRAAC - unresponsive patient
  - NIPS - infant

- Reassessment is done after each intervention (medication, repositioning, ice, heat, etc.) Effect of intervention must be documented. If it’s not documented, it didn’t happen.

- Patients and family need to be educated about management of pain, options available, and the use of the pain scale.
**RESTRAINTS**

- Restraints are always used as the last alternative for patient safety.

- Limit the use of restraints to clinically, justified situations, only after documentation of preventative or alternative strategies failed or were inappropriate.

- Use of 4 side rails is also considered a restraint.

- Follow policy as to required restraint orders, reorders, monitoring and patient safety.

- The death of a patient while in restraints or within 24 hours of restraint must be reported immediately to the Risk Manager.

- Removal of clothing from a patient without their consent requires an MD order. Clothing should be returned as soon as it is safe to do so.
MEDICATION MANAGEMENT

• Independent check by a second nurse prior to administration is required for Insulin, Heparin, Low molecular weight heparin, Chemotherapy, Potassium and Calculated Medication Infusions and is documented on the medication administration record.

• Pyxis override function should be used in emergencies only.

• Range Orders are not permitted. Orders for pain medication are written for each level of pain.

• All PRN orders shall have an indication for use.

• All medications must be kept in secure or locked areas.

• Medications given to a patient in error must be documented by submitting an incident report, progress note with any treatment in response to the error, on the one time medication administration record.

• Utilizing the transfer function in CPOE, patient medications are individually reviewed and reconciled after surgery.
• All orders must include date, time, drug name, dose, route, frequency of administration, signature and printed name.

• It is the responsibility of the ordering physician to assure that medication orders are legible and in correct form, and it is the responsibility of the Nursing and Pharmacy Staff to clarify the orders if they are not.
PATIENT RIGHTS, ETHICS & PRIVACY

• The Patient’s Bill of Rights is found in the Library, the Patient Handbook (provided upon admission), and is posted in the Admitting area. Summary brochures are found throughout the hospital.

• Informing patients and their families of their rights is an important aspect of patient education. Patient Rights include the right to: respect and dignity, privacy and confidentiality, safety, refuse treatment, informed consent to treatment, effective pain management and participation in discharge planning.

• Patients must sign their own consent forms. If the patient is unconscious or otherwise incapable of signing, the consent may be a legal guardian, health care proxy or next of kin in that order.

• Ethical concerns can be brought to your supervisor or manager, or contact the Ethics Committee directly through Social Work at x 5050. The Ethics Committee can assist patients, family and staff with difficult and complex health care issues.
• Addressing patients as Mr/Mrs, drawing curtains, knocking on doors, asking family of roommates to step out for a short time, only first 3 letters of last name on boards and charts.

• The goal of Information Management is to obtain, manage, and use information to improve patient care in a confidential manner.

• Patient satisfaction surveys (Press Ganey) are conducted, results aggregated and information disseminated to managers to communicate to staff.
PATIENT EDUCATION

- Interdisciplinary patient and family education is based upon assessed needs, abilities, barriers, learning preferences and readiness to learn.

- Upon admission, patients are assessed for any barriers to learning (*language, emotional, cognitive, psychological, physical*) and how they learn best (*reading, explanation, demonstration, hands-on, audiovisual*). These remain constant throughout hospitalization and apply to all disciplines who educate the patient.

- Prior to each teaching session, the patient **must be assessed for readiness to learn** (*are they in pain, sedated, do they want family members present, etc.*).

- Every patient must receive education about their medication, nutrition, pain, medical equipment, plan of care, patient safety and discharge plan.

- Be prepared to discuss the resources you use for patient and family education.

- Patient education is multidisciplinary. Everyone who teaches **must** document in the progress note: Topic, Readiness to Learn, who was taught, Method Used, and Outcome.
INFECTION PREVENTION

- Hand decontamination before and after patient contact is the single most effective way to prevent the spread of infection.
- Refer to the National Patient Safety Goal on Infection Safety.
- Use soap & water if hands are visibly soiled and after using the rest room.
- **Standard Precautions:** Used on all patients regardless of diagnosis.
  - **Staff:** Treat all patients blood/body fluids or specimens as if they were infected with blood-borne pathogen. Wear personal protective equipment based on risk of exposure.
- **Contact Precautions:** Private Room
  - **Staff:** Must wear gloves for every entry into a patient’s room. Wear gown for any patient contact. Alcohol Handwash *(CalStat)* required after glove and gown removal.
    - Patient record is in a gray binder
    - Precautions are posted on the Bulletin Board & Administrative Data Screen in Meditech.
~ Visitors: Encourage to wear gloves & gown with patient contact.

• Contact Precautions Plus: Private Room
  ~ Staff: Must wear gloves & gown for every entry into a patient’s room. Hand washing with SOAP & WATER after removing gloves & gown.
    • Patient record is in a gray binder
    • Precautions are posted on the Bulletin Board & Administrative Data Screen in Meditech.
  ~ Visitors: Should wear gloves & gown for every entry into a patient’s room. Hand washing with SOAP & WATER after removing gloves & gown.

• Droplet Precautions: Private Room
  ~ Staff: Must wear surgical mask when within 3 ft. of patient.
  ~ Patient: Must wear surgical mask when transported to other areas of the hospital.
  ~ Visitors: Must wear surgical mask.

• Expanded Droplet Precautions: Private Room
  ~ Staff: Must wear surgical mask.
• **N95 respirator mask required for**: Intubations, Extubation, Bronchoscopy, Sputum Induction, Nebulizer Treatment
  ~ **Patient**: Must wear surgical mask when transported to other areas of the hospital.
  ~ **Visitors**: Must wear surgical mask.

• **Airborne / Respiratory Isolation**: Private Room with negative air flow & door closed at all times. *(Needham: 708, 709, 710, 710, Critical Care: 11, 12, 19, 20, ED 1-8, South: 514)*
  ~ **Staff**: Must wear N95 mask.
  ~ **Patient**: Must wear surgical mask when transported to other areas of the hospital.
  ~ **Visitors**: Must wear N95.
Rapid Response System

The purpose of the Rapid Response System (RRS) is to identify and treat the deteriorating patient. The RRS has a two-tier team approach: The Primary Rapid Response Team and the Secondary Rapid Response Team.

Any member of the healthcare team or a patient’s family can activate the RRS.

Activation Triggers:
- Staff concern
- Family concern
- Acute change in:
  - Heart rate <40 or > 130 bpm
  - Systolic blood pressure < 90 mm Hg
  - Respiratory rate < 8 or > 28 breaths per min
  - Saturation < 90 percent despite O2
  - Conscious state
  - Urinary output < 50 ml in 4 hours

Patient triggers
Nurse/Caregiver Pages the Primary Response Team
If Secondary Team is needed: Page “Rapid Response”

Page Script: Patient name, Location, “Trigger,” Which trigger, Caregiver name and call-back number
ENVIRONMENTAL SAFETY

• All employees must wear their name badges at work.
• MAH is a no smoking facility.
• Know how to access policy manuals on-line and how to find the various groups of policies (e.g. Infection Control, Safety, Medication Management).
• Safety Training: Safety training at orientation, Annual Education Fair, Monitor articles, during Joint Commission Tracers.
• You report any unsafe condition to your supervisor or to Protective Services (5040).
• Fire drills are held quarterly per shift on all patient areas.
• You should know how to properly clean up any chemical or biohazard spills that may occur in your area. Report any chemical spills to protection service x 5040.
• Eyewash stations: flush with water for 15 minutes, all stations inspected weekly.
• **Code Red:** (FIRE)
  ~ Know location of two closest exits, evacuation map, fire alarm pull station, extinguishers, and gas/ vacuum O² shut off *(O² can be shut off per clinical person in change. Only respiratory therapy may turn it back on).*
• **MAH Codes:**
  ~ Know all Emergency Numbers and codes: refer to the emergency card with your name badge.

• **Code Triage:**
  ~ Disaster drills are held at least twice per year. Know what your role is in the event of a disaster.

• **Code Gray:**
  ~ Code Gray is an emergency code available to any MAH staff who needs assistance with a patient or visitor who poses a safety or security risk to him/herself or others.

  Dial x 22 and report a “Code Gray” when a person has become agitated, hostile or uncontrollable and additional help is needed to restore a safe environment.

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<tr>
<td>Bomb Threat</td>
<td>Code White</td>
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<td>Cardiac Arrest</td>
<td>Code Blue</td>
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<td>Infant Abduction</td>
<td>Code Pink</td>
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<td>Disaster Plan Activation</td>
<td>Code Triage</td>
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<td>Fire</td>
<td>Code Red</td>
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<td>Hazmat / Radiation</td>
<td>Code Orange</td>
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<tr>
<td>Trauma Team</td>
<td>Code Yellow</td>
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<tr>
<td>Crisis Team</td>
<td>Code Gray</td>
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<tr>
<td>Medical Emergency</td>
<td>STAT</td>
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**Performance Improvement**

Performance improvement (PI) helps us achieve better patient care and hospital systems by measuring the performance of processes and using that data to make improvements.

MAH Leadership helps select PI priorities and encourages multidisciplinary staff involvement in improvement activities.

There are many ways an opportunity for improvement may be identified. Root Cause Analysis (RCA) findings; Failure Mode and Effect Criticality Analysis (FMECA) findings; hospital wide indicator trending; Morbidity and Mortality rounds; Departmental QI committees; Quality Review Committee process; and regulatory gap identification are all ways that projects may be prioritized for an improvement process.

**2009 FMECA: eMAR and BMV**

Prior to the implementation of eMAR and BMV, the Medication Reliability Committee performed a FMECA on the process as it was known to be high risk. Each step in the process was evaluated for potential or existing failures. Once identified, the failure modes were evaluated for cause, effect(s), ability to detect and recommended action.
Examples of failure modes included:

- **Failure Mode:** Sliding scale insulin appears at the bottom of the eMAR and could be missed if each page is not reviewed. **System Redesign:** Administration times were assigned to insulin and when do it moves to the top of the cue for administration.

- **Failure Mode:** Medications ordered as now and continue confusing if scheduled time has passed. **System Redesign:** When providers place an order, they are prompted, “would you like the first dose given now?” This has clarified when the first dose is to be given.

- **Failure Mode:** When a one time medication is given and documented, the status on eMAR remains active. **System Redesign:** The time assigned to the medication turns gray, the text box turns yellow and the medication drops to the bottom of the list. These three changes are intended to clarify which medications are to be given and which have been given.

- **Failure Mode:** Zero dose medications such as inhalers or ointments require the nurse to enter what was administered (# of puffs, ointment applied, etc.). **System Redesign:** Units of measure default has been built so the nurse documents an application or the number of puffs.

- **Failure Mode:** Documentation can be undone altering documentation back to original state. **System Redesign:** Undo button made unavailable for use.
**MODERATE SEDATION**

- Two clinicians required: Physician must have privileges for both the procedure and for conscious sedation and be ACLS certified. The patient monitor (RN, MD, or PA) must also be certified competent in ACLS and have taken the MAH website Moderate Sedation Competency, to monitor the patient’s airway and response to medications, monitor vital signs and is familiar with all monitoring and emergency response equipment.

- Only administered in MICU, SICU, GI Unit, Interventional Radiology, ED, PACU, EP and Cath Labs. Documentation required: H & P within 30 days, which must be updated within 24 hrs or immediately before procedure. Airway and ASA classification by MD, and a doctors order for medications. NPO status must be noted.

Reference - Moderate Sedation Policy - MAH website under Clinical portal *(key word Sedation and Analgesia)*
**Performance Improvement Hospital Wide**

**Medication Safety**
- eMar/BMV
- Smart Pumps
- PCA Smart Pumps
- CPOE order sets

**Patient Falls**
- **Bed Alarms** that include recordable voice prompts which can be customized for the individual patient
- **Fall mats** available which help reduce injury from falls
- Pharmacist Assessment of Unit based Fall Prevention Committees

**Triage of Patients**
- PIT Program

**Staff Safety**
- New equipment available to aid in lifting patients intended to reduce staff injuries
**CORE MEASURES**

**Acute Myocardial Infarction (AMI)**
- ASA at arrival
- ASA prescribed at discharge
- ACEI or ARB for EF< 40
  - Beta blocker prescribed at discharge
- PCI within 90 minutes of arrival (*STEMI’s*)
- Statin prescribed at discharge
- Adult smoking cessation counseling

**Heart Failure (HF)**
- Discharge instructions include diet, activity, weight monitoring, medications, symptoms worsening, and follow-up
- Left ventricular function assessed (EF)
- ACEI or ARB for EF< 40
- Adult smoking cessation counseling

**Pneumonia (PN)**
- If ordered, blood culture is collected prior to administering first antibiotic
- Initial antibiotic received within 6 hours of arrival
Initial antibiotics selected for CAP consistent with current guidelines
Assess and administer pneumococcal and influenza vaccines as indicated
Adult smoking cessation counseling

**Surgical Care Improvement Project (SCIP)**
- Prophylactic antibiotics given within 1 hour of surgical incision
- Prophylactic antibiotic selection consistent with current guidelines
- Prophylactic antibiotics D/C’d within 24 hours of surgery end time (48 hours for cardiac)
- Clippers for hair removal
- Cardiac surgery patients with controlled 6 AM post-op blood glucose
- Recommended VTE prophylaxis within 24 hours of surgery end time
- Beta blocker documented perioperatively for patients on BB pre-admission
- Urinary catheter removed by post-op day 1 or 2
- Perioperative temperature management for surgical patients

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**SENTINEL EVENTS**

- An unexpected occurrence involving death or serious physical or psychological injury and include Infant abduction or discharge to wrong family, Loss of limb or function, Rape, Hemolytic transfusion reaction, Surgery on the wrong patient or wrong body part, Suicide of a patient and Death or major permanent loss of function related to nosocomial infection.

- A sentinel event signals the need for immediate investigation and response via Root Cause Analysis. This process identifies the most basic or causal factor which contributed to the event. It also includes the action plan and a plan for monitoring.

- If a sentinel event occurred, you must notify your manager, the hospital Risk Manager, or the hospital’s Quality and Safety Department.
COMPETENCY / HUMAN RESOURCES

- You show that you are competent to do your job based upon orientation and training, in services and continuing education, performance evaluations including age specific competencies and experience, also education, licenses, certifications, and registrations.

- All employees attend the hospital’s orientation program to learn core safety concepts.

- Your supervisor evaluates your competency by direct observation, return demonstration, written tests, and results from quality measures.

- To determine whether there are competency issues in our hospital, we look at annual evaluations, patient complaints, patient satisfaction, incident reports, infection rates, turnaround times, complication rates, medical record reviews, etc.
DISCLOSURE

- Patients and when appropriate, their families are informed about the outcome of care, including unanticipated outcomes.

- The patient’s attending physician usually reports the event to the patient. The hospital’s Disclosure Response Team is notified.

PATIENT COMPLAINTS

- Two of the most important elements when addressing a patient complaint are your empathy your ability to listen without interruption. You should discuss all patient complaints with your manager. The manager in your area will refer patient grievances to the Director of Patient Relations within the Quality & Safety Department.
IN SUMMARY:

All Staff Will Need To Demonstrate:

- How care is coordinated by the multidisciplinary team?
- How care and treatment decisions are communicated to the patient’s care team and the patient/family?
- How patient safety goals are implemented?
- How critical lab values are reported?
- How the patient’s educational needs are assessed, met and documented?
- How your unit collects data on patient satisfaction and how you use this information in your practice?
- When was your last fire drill?
- How are medications safely administered?
- How are patients properly identified?
- Show how your care planning is multidisciplinary and patient specific?
- What is your policy on verbal orders, telephone orders, range orders, and prn medications?
- How Performance Improvement data collection and analysis has changed the way that you practice. Be prepared to give specific examples of PI projects, data and practice.
- How pt handoffs occur?
- What is the medical record process?

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III

NATIONAL PATIENT SAFETY GOALS
NATIONAL PATIENT SAFETY GOALS

The Joint Commission has made patient safety a high priority and a key component in the survey process. Listed below, you will notice that each goal has an accompanying box titled “MAH Compliance.” Please read and become familiar with these MAH compliance strategies and understand how they apply to you in your area.

The purpose of the Joint Commission’s National Patient Safety Goals (NPSGs) is to promote specific improvements in patient safety. Each year, a group of nationally recognized experts in patient safety work with the Joint Commission to identify potential goals from Sentinel Events that have been submitted by healthcare organizations. Best practices are used to establish requirements and the goals are published mid-year.
2010 NPSG AT A GLANCE

• GOAL 1 – Improve the accuracy of patient identification.
  ~ Use of Two Patient Identifiers
  ~ Eliminating Transfusion Errors

• GOAL 2 – Improve the effectiveness of communication among caregivers.
  ~ Timely Reporting of Critical Tests and Critical Results

• GOAL 3 – Improve the safety of using medications.
  ~ Labeling Medications and Containers
  ~ Reducing Harm from Anticoagulation Therapy

• GOAL 7 – Reduce the risk of health care-associated infections.
  ~ Meeting Hand Hygiene Guidelines
  ~ Preventing Multi-Drug Resistant Organism Infections
  ~ Preventing Central-Line Associated Blood Stream Infections
  ~ Preventing Surgical Site Infections
• **GOAL 8** – Accurately and completely reconcile medications across the continuum of care.
  ~ Comparing Current and Newly Ordered Medications
  ~ Communicating Medications to the Next Provider
  ~ Providing a Reconciled Medication List to the Patient
  ~ Settings in Which Medications are Minimally Used

• **GOAL 15** – The organization identifies safety risks inherent in its patient population.
  ~ Identifying individuals at Risk for Suicide

• **UNIVERSAL PROTOCOL**
  ~ Conducting a Pre-Procedure Verification Process
  ~ Marking the Procedure Site
  ~ Performing a Time-Out
NPSG 01.01.01 – Patient Identification

Use at least two patient identifiers when providing care, treatment or services.

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient’s room number or physical location is not used as an identifier.

2. Label containers used for blood and other specimens in the presence of the patient.

MAH Compliance

- MAH policy “Identification of Patients” describes our process for using pt name and DOB before any invasive procedure, test, phlebotomy infusion or administration of blood products or medication.
- MAH never uses room number as a patient identifier.
- Use 2 pt identifiers when labeling blood and other specimens in the presence of the patient.
NPSG 01.03.01 – Transfusion Errors

Eliminate transfusion errors related to patient misidentification

Elements of Performance for NPSG.01.03.01

1. Before initiating a blood or blood component transfusion:
   ~ Match the blood or blood component to the order,
   ~ Match the patient to the blood or blood component.
   ~ Use a two-person verification process.

2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient.

3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the processes determined by the hospital.

MAH Compliance

Mount Auburn Hospital’s clinical policy “Transfusion of blood” outlines proper identification procedures.
NPSG 02.03.01 – Critical Test Results and Values

Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Elements of Performance for NPSG

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
   ~ The definition of critical results of tests and diagnostic procedures
   ~ By whom and to whom critical results of tests and diagnostic procedures are reported
   ~ The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures

2. Implement the procedures for managing the critical results of tests and diagnostic procedures.

3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.
Mount Auburn Hospital has selected two critical tests which require communication to the ordering MD no matter what the results is.

**MAH Critical Tests:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Critical Test</th>
<th>Chosen TAT</th>
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<tbody>
<tr>
<td>OR</td>
<td>Frozen sections</td>
<td>30 mins</td>
</tr>
<tr>
<td>Radiology</td>
<td>Head CT r/o acute stroke <em>(when Stroke Protocol is activated.)</em></td>
<td>30 mins</td>
</tr>
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**MAH Compliance**

1. Critical test results are immediately communicated to the ordering MD.
2. 100% of critical test results are reviewed for timelines of reporting
NPSG 03.04.01 – Labeling Medication Containers

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.

Elements of Performance for NPSG.03.04.01
1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   ~ Medication name
   ~ Strength
   ~ Quantity
   ~ Diluent & volume (if not apparent from the container)
   ~ Expiration date when not used within 24 hours
   ~ Expiration time when expiration occurs in less than 24 hours
4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

6. Immediately discard any medication or solution found unlabeled.

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

**MAH Compliance**

This goal applies to any surgical or other procedural setting, prep area, pre-op holding, and PACU. In addition, it applies to all procedural areas that use medications or solutions including, but not limited to, radiology and other imaging services, endoscopy units and patient care units where “bedside” procedures are done.

These labeling guidelines are currently being monitored in the OR, Day Surgery, GI, Cath Lab and Interventional Radiology.
**NPSG 03.05.01 – Anticoagulation Therapy**

Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

**Elements of Performance for NPSG.03.05.01**

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.

3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.

4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.

5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
6. A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.

7. Provide education regarding anticoagulant therapy to prescribers, staff, patients and families. Patient/family education includes the following:
   ~ The importance of follow-up monitoring
   ~ Compliance
   ~ Drug-food interactions
   ~ The potential for adverse drug reactions and interactions

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of that action in a time frame determined by the organization.

**MAH Compliance**

Mount Auburn Hospital has developed the following protocols to ensure therapeutic anticoagulation is achieved and maintained:

~ Heparin: Cardiac, DVT and Neuro
~ Intergrilin
~ Warfarin Initiation
NPSG 07.01.01 – Hand Hygiene

Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

MAH Compliance

Health Care Workers must wash or disinfect their hands prior to and after every patient contact. If gloves are worn, hands must be washed after their removal and before leaving the patient/clinical area. They should also be washed after contact with inanimate surfaces likely to have been contaminated. Artificial nails are not permitted for those with direct patient care contact or with contact with patient food or environment.
NPSG.07.03.01 – Prevent MRSA Infections

Implement evidence-based practices to prevent health care-associated infections due to multi-drug resistant organisms in acute care hospitals.

MAH Compliance

All patients admitted to the hospital with a history of a multi-drug resistant organism are placed on precautions based on the mode of transmission. Patients with MRSA, VRE, and ESBL are placed on Contact Precautions. Patients with C.difficile are placed on Contact Precautions Plus.

Patients scheduled for a surgical implant (joint replacement, cardiac by pass, etc.) are screened for MRSA preoperatively.
NPSG.07.04.01 – Prevent Central Line Infections
Implement evidence-based practices to prevent central line-associated bloodstream infections.

MAH Compliance
Mount Auburn Hospital implements evidenced-based practices to prevent bloodstream infections by following the recommendations in the “APIC Guide to the elimination of Catheter-related bloodstream infections”. Recommended practices at the time of insertion include hand washing, the use of an insertion checklist, aseptic technique including full barrier precautions, CHG skin prep and application of the CHG impregnated dressing prior to removal of the sterile field. After insertion the catheter site is covered with a chlorhexadine impregnated tegaderm which is changed every Tuesday and if it becomes damp, loose or soiled. Need for the catheter is continuously assessed and promptly removed when it is no longer essential.
**NPSG.07.05.01 – Prevent Surgical Site Infections**

Implement evidence-based practices for preventing surgical site infections.

**MAH Compliance**

Prophylactic antibiotics are administered preoperatively according to the National Surgical Care Improvement Project. When hair removal is necessary, hair is removed using clippers. Intraoperative oxygen levels are maintained above 92%. Warming devices are utilized to achieve a body temperature above 96.8 upon operative completion.

Patients undergoing surgery that require the insertion of an implant undergo preoperative screening for MRSA. All implant patients are given CHG for preoperative bathing. Patients that are found to be colonized with MRSA are treated with intranasal Mupirocin, preoperatively. MRSA positive patients receive Vancomycin for surgical prophylaxis.
NPSG 08.01.01 – Med Reconciliation: Home List

There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.

1. At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient and, as needed, the family are involved in creating this list.

2. The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.

3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.
4. When the patient’s care is transferred within the hospital (for example, from the ICU to a floor), the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.

MAH Compliance

All patients being cared for at MAH have their home medication list reviewed by a physician.

The list is reconciled:
- Before admission orders are written
- at transfer to another level of care
- at discharge from MAH
NPSG 08.02.01 – Med Reconciliation: Communication to Next Provider and to Pt on Discharge

A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.

Elements of Performance for NPSG.08.02.01
1. The patient’s most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.
2. At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.

MAH Compliance

An automated transfer form provides the receiving unit with a reconciled medication list. Discharge instructions are autofaxed to the PCP and provided to the patient and include the medication list.

Patient being discharged to a SNF or nursing home have their list communicated on the Page 1 / Page 2.
NPSG 08.03.01 – Medication Reconciliation: List to Patient/Family

When a patient leaves the hospital’s care, a complete and reconciled list of the patient’s medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family. Note: This standard is not in effect at this time.

Patient Discharge Instructions (PDI) contained a reconciled medication list which is provided to the patient on discharge.
NPSG.08.04.01 – Medication Reconciliation:
Minimal Use Locations

Elements of Performance for NPSG.08.04.01

1. The hospital obtains and documents an accurate list of the patient’s current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.

2. When only short-term medications (for example, a preprocedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient’s current medication list, the patient and, as needed, the family are provided with a list containing the short-term medication additions that the patient will continue after leaving the hospital. Note 1: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When patients leave these-settings, a list of the original, known, and current medications does not need to be provided, unless the patient is assessed to be confused or unable to comprehend adequately. In this case, the patient’s family is provided both medication lists and the circumstances are documented.
3. In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic)

4. In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the patient’s current, known long-term medications.

5. In these settings, a complete, documented medication reconciliation process is used when: The patient is required to be - subsequently admitted to an organization from these settings for ongoing care.

6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient’s know primary care provider or original referring provider or a known next provider of services.

**MAH Compliance**

The reconciled medication list is available to PCP’s through Meditech and auto faxed.
NPSG 15.01.01 – Suicide Risk Assessment

The hospital identifies safety risks inherent in its patient population.

Elements of Performance for NPSG.15.01.01
1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient’s immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

MAH Compliance

**Emergency Department:** Patients are screened and “yes” answers prompt further screening. Patients thought to be a risk are placed on 1:1 and items are searched. Patients assessed as currently suicidal are not discharged. Written discharge instructions include to call 911 and go to nearest ED.

**Wyman 2:** MD assessment addresses suicidality in detail. All patients receive 15 min checks their first hour and those at risk are placed on 1:1. Discharge instructions include to call 911 and go to nearest ED. Patients presenting with a primary psychiatric diagnosis are assessed for risk to self at triage in the ED and care is adjusted according to need (i.e. sitter, protection services, belongings search, etc.). If identified as a risk, a psychiatric consult is initiated.

On discharge, patients who are assessed as safe are given suicide hotline information.
**UNIVERSAL PROTOCOL — 1A**

**Conduct a preoperative verification process as described in the Universal Protocol**

1. Verification of the correct person, procedure, and site should occur during the following (as applicable):
   - At the time the surgery/procedure is scheduled.
   - At the time of preadmission testing and assessment.
   - At the time of admission or entry into the facility.
   - Anytime the responsibility for care of the patient is transferred to another caregiver.
   - With the patient involved, awake and aware, if possible.
   - Before the patient leaves the preoperative area or enters the procedure/surgical room.

2. The following is reviewed prior to the start of the procedure:
   - Relevant documentation (e.g. H&P, consent, nursing/preanesthesia assessment).
   - Relevant images, properly labeled and displayed.
   - Any required implants and special equipment.
   - Require blood products.

**MAH Compliance**

Upon admission to the pre-procedure room, the RN completes a checklist verifying the correct patient, correct procedure, correct surgical/invasive procedure consent and correct site. Once in the OR/procedure room, the circulating/procedure nurse confirms the identity of the pt with the anesthesiologist or physician/CRNA. The procedure will not start until all questions are resolved.
**Universal Protocol — 1B**

Mark the operative site as described in the Universal Protocol

1. Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.
2. The mark must be unambiguous and used consistently throughout the hospital. *(Note: for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.)*
3. The mark must be positioned to be visible after the patient is prepped and draped.
4. The method of marking and type of mark should be consistent throughout the organization.
5. At a minimum, mark all cases involving laterality, multiple structures *(fingers, toes, lesions)*, or multiple levels *(spine)*.
6. The person performing the procedure should do the site marking.
7. Marking must take place with the patient involved, awake and aware, if possible.

**MAH Compliance**

It is MAH policy to identify the operative site for all patients undergoing surgery or an invasive procedure. Site marking is initialed by the physician and includes patient involvement. No patient is allowed in the OR/procedure room without the verification checklist.
Conduct a “time out” immediately before starting the procedure as described in the Universal Protocol

1. The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

2. The process must involve the entire operative team, use active communication, and must, at least, include:
   - Correct patient identity
   - Correct side and site
   - Agreement on the procedure to be done
   - Correct patient position
   - Availability of correct implants and any special equipment or special requirements

3. When two or more procedures are performed on the same patient, and person performing the procedure changes, perform a time out before each procedure is initiated.

4. The process is briefly documented, such as in a checklist.

5. The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

**MAH Compliance**

A time out is initiated by the surgeon/physician just prior to surgical incision or start of the invasive procedure. The team pauses to confirm all bullets above in #2, and that the site marking is visible if applicable. If for any reason a discrepancy arises, the procedure is not begun. The discrepancy is resolved and a new time out takes place.
Ensure that the patient, H&P, consent and the OR/procedure schedule all agree as to the procedure, the site and the side. If any one does not agree, the case should not proceed until the discrepancy is fixed. Paper work must be corrected PRIOR to moving the patient into the room.
MAH Policy References For NPSGS

* Identification of Patients
* Medication Order, Writing
* Medical Records, Abbreviations
* Ordering, Guidelines for
* Hand Hygiene
* Serious Incidents/Sentinel Event/Root Cause Analysis
* Medication Reconciliation
* Suicidal Patients
* Universal Protocol: “Time Out”
* Universal Protocol: “Site Verification”
V

SURVEY QUESTIONS & ANSWERS
**Survey Questions and Answers**

Q. What do you do when you have a needle stick injury?
A. Wash wound immediately with soap and water, force bleed if possible, report to supervisor, report to WIC or Emergency Dept. and complete incident report.

Q. How do you ensure that emergency medications are consistently available, controlled and secure?
A. Code carts are locked with a yellow lock after pharmacy supplies the medications. The cart is opened and inventory checked on the unit where a green lock is applied. Every day, the cart is checked for the integrity of the green lock.

Q. What factors do you consider when making out a patient assignment?
A. Complexity of patient care needed, competency and skills of caregiver, amount of supervision needed, infection control and safety concerns.

Q. Who determines if a patient has a health care proxy and who provides information to the patient? Does every patient have to have one?
A. Admitting asks if the patient has one and provides information. Social Work will assist if a patient wants to execute one. Physicians and nurses need to know the
status and where the document is located. Patients can choose not to have one, but their refusal must be documented.

Q. How do you provide patients with privacy and respect?
A. Addressing patients as Mr/Mrs. Drawing curtains, knocking on doors, asking family of roommates to step out for a short time, first 3 letters of last name on boards and charts.

Q. Describe how patients are involved in deciding to withhold resuscitative services.
A. Discussion between physician & patient & family; family conferences; Review DNR policy, Ethics Committee is a resource to assist families having difficulty with decisions. Involve social service.

Q. When point of care testing is performed, what are the methods used to ensure competency and reliability?
A. Staff is oriented to point of care testing done in their area during orientation and competence is validated with the competency checklist. Glucometers require quality control testing by each new user and the lab maintains the quality control.

Q. What prompts a patient reassessment?
A. Reassessment is done when there is a change in the
patient’s condition and at transfer. Documentation entries should address response to treatment, medication, or progress toward goals.

Q. Have you maintained, tested and inspected medical equipment? How do you know equipment is safe to use?
A. Equipment must be visually checked and tested prior to each use and inspected by bioengineering every 1 year. Check bioengineering tag to see if inspection is within time frame.

Q. When is informed consent obtained?
A. Patient signs consent for treatment upon admission. Consent is also obtained by the physician for procedures, anesthesia and blood product administration.

Q. Demonstrate how you verify medication orders and identify patients before you administer medications.
A. Medication orders are transcribed and verified by separate individuals. Pharmacy verifies medication orders. Prior to administration, 2 identifiers are checked name and financial number for medications; name and date of birth for all other procedures, labs. etc.

In EMAR (electronic medication administration Record) the order is verified by pharmacy and the nurse acknowledges this is a reasonable medication for this patient.
No transcription occurs. For EMAR areas, in addition to the usual patient identification procedure the patients ID band is scanned.

Q. By what method do you evaluate how patients feel about the care they receive?
A. Patient satisfaction surveys (Press Ganey) are conducted, results aggregated and information disseminated to managers to communicate to staff.

Q. Are the goals and scope of the services provided by the unit defined?
A. Review the scopes of service located on the MAH Portal. What types of patients do you see.

Q. What are the areas for which patient/family education must be provided?
A. Medications, personal hygiene, equipment, rehabilitation, discharge planning, modified diet, community services available, food/drug interactions, pain management, and safety in the hospital.

Q. Is there evidence of communication across your organization?
A. Interdisciplinary patient record. Nursing assessment with multidisciplinary trigger referrals, staff meetings and minutes, Monitor newsletter, Meditech messages.
Q. What is the scope of your assessment?
A. All assessments include physical, social, and psychosocial information, abuse, pain and educational concerns (barriers to learning and learning preferences) and a home med list are required.

Q. What is the timeframe for completion of the initial admission assessment of nursing care needs?
A. Specific to location: Med/Surg - 8 hrs.; Critical care 1 hour; ER and MCH upon arrival.

Q. When is a patient’s pain level assessed and reassessed?
A. Upon admission, pain is assessed. If this is a problem for the patient, pain is assessed Q4 hrs. When interventions are provided, pain must be reassessed to determine the effectiveness of the intervention.

Q. What model of PI do we follow? What is your specific unit looking at for PI and how has that changed your delivery of care?
A. PDCA: Plan, Do, Check, Act;

Q. List specific PI indicators for your unit and how your practice has changed because of it.
A. Hospital wide: Fall risk, restraint reduction, noise reduction, skin care, unit rounding, Code Gray, RR (see page 29)
Q. What do we do to identify victims of abuse?
A. Every patient is screened for abuse via nursing assessment. Policies located on-line; Social Service referral.

Q. What process improvement teams have your department participated in?
A. Pneumococcal and Influenza Vaccination, VAP, Patient ID, Handwashing. Think about unit specific initiatives; noise levels (pt satisfaction), careplanning, CHF get with the guidelines, smoking cessation education for MI, CHF & pneumonia.

Q. What would you do in response to a fire?
A. Rescue patient
   Alarm - dial 22
   Contain fire
   Extinguish fire

Q. What number do you dial for emergency assistance?
A. 22

Q. What substances are hazardous in your department?
A. Give examples (chemo, cleaning agents, formalin) also know what to do if there is a spill- how do you clean it up. MSDS (Material Safety Data Sheets) can be obtained on the portal.

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Q. What areas are authorized to administer Moderate Sedation (IV conscious sedation) at MAH?
A. Nurses who have been deemed competent and MD. Areas allowed: Endoscopy, Radiology, ER, Cardiac Cath Lab, EP Lab, GI Unit, and Critical Care.

Q. How are patients educated about food and drug interactions?
A. Food & Drug Interactions brochure located in patient’s WELCOME packet; Nursing may consult dietary and/or pharmacy for additional patient education. Education may be documented on the Med-Surg flowsheet or in progress notes.

Q. What cleaning solution would you use to clean up a blood or body fluid spill?
A. GD 80

Q. How do you document patient education on the side effects of medications they will be taking after discharge?
A. Provide and discuss with Pharmacy monographs or Caregroup web site medication sheets. Document education on med-surg flowsheet or progress notes.

Q. What are the patient safety risks in your department?
A. Some examples are: Patient falls, medication errors, wrong site surgery, infections, infant abduction pressure ulcers.
Q. How do you know if someone is competent to perform their job?
A. Annual competency assessment including age specific & dept. specific competencies completed with performance appraisals; orientation, continuing education, in-services, certification.

Q. How do you determine (assess) the learning needs of patients and families?
A. In nursing assessment, assess educational barriers and learning preferences. Assess needs based upon diagnosis, and patient's level of knowledge and deficits.

Q. What are the employee safety risks in your department?
A. Some examples are: needle sticks, workplace violence, chemical exposure, infection, back injuries.

Q. How do you monitor medication effects on patients?
A. Assessment prior to medication, reassessment after; vital signs, lab values, asking patients if desired effect was achieved and documentation of results. This is essential with the initial dose of a new medication in EMAR, you are prompted to document this reassessment.

Q. How long do you flush eyes using an eyewash station if exposed?
A. 15 Minutes
Q. When do you reassess a patient?
A. Reassessment is done when warranted by patient condition and to assess response to treatment, medication, and progress toward treatment goals;

Q. How many clinicians are required to be involved during moderate sedation?
A. Two, the credentialed physician doing the procedure and the certified monitor who monitors the patient’s condition.

Q. What must a PRN medication order include?
A. The order must be properly written with no prohibited abbreviations and must always include the indication for use. Must not have a range in the dose or frequency.

Q. How do you assess and reassess patients for pain?
A. Pain is considered the fifth vital sign. Asking patients if they have pain occurs at admission assessment, and Q4hrs until the patient is pain free for 24 hours. Reassess after every intervention.

Q. What must you document prior to initiating restraints?
A. You must document how preventative or alternative strategies failed or were not appropriate and the behavior that couldn’t be managed in a different manner.
Q. When should a physician reassess a patient who is going to surgery?
A. Prior to anesthesia.

Q. Where can you find information in the chart about the Health Care Proxy?
A. On the face sheet of the admission, advanced directives are identified. In old record, an Advanced Directive on File sticker will be on the medical record. The document should be moved to the new chart.

Q. What identifiers do you use prior to administering medications, treatments, etc.
A. Compare 2 items on requisitions, Medication sheets with the patient’s ID. For Inpatients: Patient’s name and financial number or medical record number are checked each time. Outpatient: Patient’s name and date of birth.

Q. Who obtains the informed consent?
A. The physician performing the procedure must obtain the informed consent.

Q. How do you dispose of unused narcotics?
A. Using Pyxis with two-nurse verification.
Q. How do you know if your patient has religious, spiritual or cultural practices that they want to continue while hospitalized?
A. The nursing assessment form addresses this question.

Q. How do you know what other disciplines have taught to your patient?
A. All patient education is documented in the medical record.

Q. How do you assess readiness to learn and when should it be assessed?
A. Readiness to learn should be assessed prior to each educational session by asking the patient if it is a good time to learn; assessing the level of pain; assessing the amount of sedation, etc.

Q. When administering a medication that is ordered via a Range Order, how do you know what dose/frequency to start with?
A. Medication orders with ranges must be clarified to determine either one dose or write indications for when the different doses may be given.

Q. Before beginning a chest tube insertion, what must be verified?
A. Follow the Universal Protocol including proper site marking by MD, review of pertinent documentation and
a “Time Out” immediately prior to procedure where a final verification of correct patient, procedure and side are validated.

Q. Why are Violent/ Self destructive Restraints used?
A. Violent/ Self Destructive restraints are used to protect the patient or others from harm because of an emotional or behavioral issue.

Q. What are the 3 conditions that need to be met in order to place a patient in restraints?
A. 1) They can only be implemented to protect the patient or others
2) Alternatives tried and failed
3) The least restrictive restraint must be used

Q. What are two unique patient safety factors that are triggered when Violent Self Destructive Restraints are used?
A. 1) Patients placed in restraint for Violent/Self destructive issues have an attendant with them constantly
2) Psychiatric Consult

Q. Orders for Violent/ Self Destructive Restraints for Adults must be written within what time frame after application?
A. One hour.
Q. Orders for Non violent/Medical-Surgical restraints must be written within what time frame after application?
A. Orders for Non-violent Restraints must be obtained PRIOR to applying the restraint. If the restraint is discontinued, a new order must be obtained.

Q. Renewal for Violent/Self Destructive Restraints must be written within what time frame?
A. Every 4 hours while the patient is in restraints. Every 3 hours for Mental health patients.

Q. Can the physician give a verbal order for restraints?
A. The nurse may apply restraints ONLY in order to maintain the patient’s or other’s safety. The order must be written by a physician after a face-to-face assessment within 1 hour.

Q. What is the criteria to apply medical – surgical restraints?
A. High risk for falls, wandering, and extubation/interfering with treatment.

Q. Once there is an order for a Non-violent/Med-Surg restraint, when can the restraint be discontinued?
A. The restraint can be discontinued when the patient no longer meets the criteria for their application. No order is needed for discontinuation.
Q. How often do patients in Non-Violent Med-Surg Restraints need to be assessed by a nurse?
A. The RN assesses the patient at least every 2 hours.

Q. If a patient’s restraints are discontinued before the MD makes an assessment and writes the order, is the order still necessary?
A. Yes. There must be an order for each restraint. A restraint episode begins the moment of application.

Q. What is the RN assessing every 2 hours when a patient is in restraints?
A. Need for continued restraint use, CSM, removal and reapplication, need for food or fluids, elimination, and ROJM attended to.

Q. Are PRN orders for restraints valid?
A. Restraint PRN orders are not acceptable.

Q. When does a restraint related death need to be reported?
A. Within 24 hours of a death in which the patient
   1) was restrained at the time of death
   2) If the restraint was on within 24 hrs of death
   3) within 7 days if the death is felt to be related to the restraint

   (See Death Communication Form)
Q. Can you utilize a family member to interpret for a non English-speaking patient?
A. To maintain confidentiality and accuracy, usage of family and friends should be avoided. Children under 18 may never be permitted to interpret. At no cost to them, all patients have the right to a medical interpreter assigned through the MAH Interpreter Services Department. Bilingual staff may only interpret in non clinical situations. Patients may refuse Interpreter Services and should sign a Refusal of Interpreter Services form.

Q. What is Mount Auburn’s mission?
A. To improve the health of the residents of Cambridge and surrounding communities. Our services are delivered in a personable, convenient, and compassionate manner, with respect for the dignity of our patients and their family.

Q. How is medical equipment checked for safety and accuracy?
A. Inspection is annually by biomedical technicians.

Q. What is code Pink?
A. Initiated to manage infant abduction. Alerts all staff to be looking for someone with a baby leaving the hospital.

Q. What code is called for an adult cardio-pulmonary arrest?
A. Code Blue, Call 22.
Q. What is a code orange?
A. Used for HAZMAT spills, Radiation incidents that exceed incidental and are noxious/toxic, have gotten into the air, and are at risk of danger to self or others.

Q. How is residual chemotherapy disposed of?
A. Any chemo residual (including tubing, needles, bags etc.) are considered chemo waste and disposed of in puncture proof yellow containers affixed with chemo-precaution label.

Q. What is Code Triage?
A. This initiates our Disaster Plan.

Q. What is Code White?
A. Bomb Threat.

Q. What do you call for a medial emergency?
A. Dial 22 for medical situations where there is a pulse and the patient is breathing.

Q. What is Code Red?
A. Fire.

Q. Who do you call for an abusive/aggressive patient?
A. Dial x 22 and report a “Code Gray” when a person has become agitated, hostile and additional help is needed to restore a safe environment.
Q. **How would you know where a fire is located when the fire alarm goes off?**
A. Count the bells and refer to Emergency Fire Procedure sign in your area to identify the location.

Q. **Where would you evacuate to?**
A. Check your emergency Fire procedure sign. The first level of evacuation is usually moving people beyond a fire door.

Q. **What does it mean when a patient has a falling star at their bedside?**
A. The patient is at greater risk for falling and requires close attention for their safety.

Q. **When are patients assessed for their fall risk?**
A. All patients are assessed for their fall risk at the time of admission, each shift thereafter and when there is a change in condition. Assessment must reflect how the patient is at that moment.

Q. **How does our staff care for the terminally ill?**
A. Patient’s level of care may be deemed “Comfort Measures Only.” Our CMO orders and protocol outlines appropriate care and comfort measures to help the patient and family in those difficult times.
Q. Are verbal orders used on a regular basis?
A. No, verbal orders should be taken only in emergency situations.

Q. When should telephone orders be taken?
A. When the physician is not present in the hospital and does not have access to a computer.

Q. What should the nurse do when taking a telephone order?
A. The nurse should write the order, read it back to the MD to confirm, and then enter the order into CPOE. *(Computerized physician order entry as a TORB order)*

Q. What are the elements of a complete medication order?
A. Date and time ordered; complete name of drug; dose; route of administration; frequency of administration. Indications for PRN orders, signed name, printed name and beeper #.

Q. What are “Five Rights” of medication administration?
A. Right patient; right medication; right dose; right time; right route.

Q. What constitutes a medication error?
A. Any violation of the 5 rights of medication administration. *(Right patient, right medication, right dose, right time and right route).*
Q. Where do you document an unusual occurrence?
A. Enter the occurrence in the on-line safety reporting system on the CareGroup portal. Any affect on a patient should be documented in the Medical Record.

Q. **What constitutes a safe and effective handoff?**
   ✦ Opportunity to ask/respond to questions
   ✦ Up-to-date information
   ✦ Verification of Information
   ✦ Opportunity to review relevant information
   ✦ Limited interruptions

Q. Is this medication order correct? MS 4.0 mg IM QD PRN
A. Should be: Morphine Sulfate 4 mg IM daily PRN for pain

Q. Are all patients cared for using Standard Precautions?
A. Yes, used on all patients regardless of diagnosis or infection status.

Q. What are the kinds of Transmission-based Precautions?
A. Contact
   Droplet
   Airborne
   Contact Plus

Q. What is the single most effective way to prevent the spread of disease?
A. Hand washing.
Q. If hands are visibly soiled or contaminated, can a waterless antiseptic agent be used?
   A. No, hands are to be washed with soap and water when visibly soiled or contaminated, or after using the rest rooms.

Q. If gloves are worn, hand washing is not needed? True or False
   A. False, you must wash hands despite the use of gloves because they may become perforated during use.

Q. Waterless hand hygiene agents (*Calstat*) are appropriately used in what circumstances?
   A. These products may be used when hands are not visibly soiled and in most other clinical bedside situations, and before and after every patient contact. Not effective for contact plus precautions.

Q. Can health care workers wear artificial nails?
   A. No, health care workers performing direct patient care are restricted from wearing artificial nails.

Q. Can health care workers wear nail polish?
   A. Yes, natural nails must be clean and be no longer than 1/4 inch longer than the fingertip; if wearing nail polish, it must not be cracked, chipped or scratched.
Q. Can nurses use multiple dose vials?
A. Yes, but they should be inspected for integrity and contamination; use aseptic technique each time vial is used; and discarded if expiration date is reached.

Q. Medication Reconciliation must be done when?
A. Medication Reconciliation must be done on admission, transfer and discharge

Q. How do you ensure linen is free of contaminants for patients?
A. Linen carts MUST remain covered at all times. Linen brought into a room (even if unused) must be considered contaminated.

Q. Why is food and drink not permitted on patient units?
A. Food and drink are vehicles for transmitting infections between people. In addition, they may cause harm to the permanent medical record and IS equipment.

Q. How do you know when equipment is clean?
A. Clean equipment is tagged by housekeeping when cleaned. Once brought into a patient room, remove the tag. Once the equipment is no longer needed, return it to the dirty utility room to be cleaned and re-tagged.
Q. How do you encourage patients to identify quality and safety concerns?
A. Encourage patient to SPEAK UP and report concerns to you.

Q. How should a specimen be labeled?
A. A specimen should be labeled in front of the patient using 2 identifiers between the label and the patient’s ID bracelet.

Q. What Symptoms should be identified as triggers to call a “Rapid Response”?
A. Staff member is worried about the patient:
   * Heart rate <40 or >130 bpm
   * Systolic blood pressure <90 mm hg
   * Respiratory rate <8 or >28 per min
   * Saturation <90 percent despite O²
   * Conscious state
   * Urinary output to <50 mlin 4 hours

Q. To Page a Rapid Response what needs to be done?
A. * page script
   * patient name
   * location
   * “Trigger”
   * which Trigger
   * care givers name and call back number
Q. When would you call the secondary Rapid Response Team?
A. Once the primary team is at the bedside and after initial interventions are done and the patient’s condition continues to decline.

Q. How do you call the secondary Rapid Response Team?
A. Text page “Rapid Response”

Q. What are the three main components to the Universal Protocol?
A. 1). Preoperative verification
    2). Site Marketing
    3). Time Out