RN Orientation

2025

Hackensack Meridian *Health*

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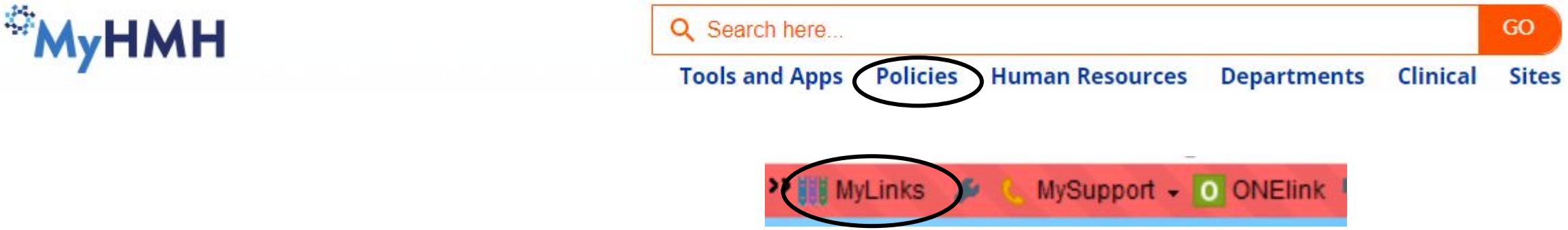
PolicyStat

PolicyStat is the repository of network and campus specific information regarding practice and procedure within the organization.
PolicyStat can be accessed via the HMH homepage and within EPIC.



Access to PolicyStat is only available after the hire process is completed. Please do not attempt to log in prior to your starting date.

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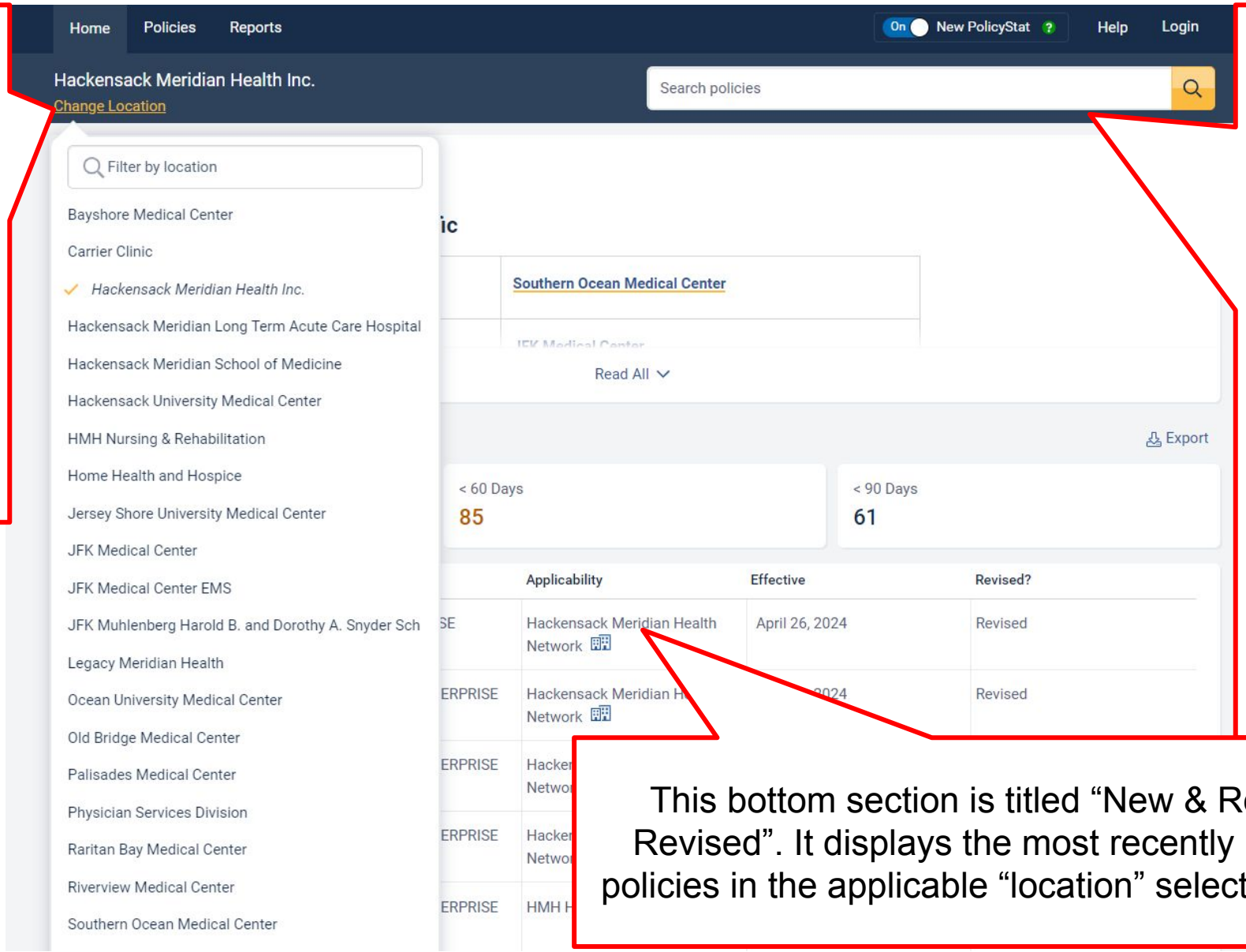
PolicyStat is separated by “location”. Please ensure that you have selected the applicable work “location” prior to viewing policies. HMH Inc. will display all network aligned policies but nothing campus specific.



Once you have selected the appropriate work location you can search for the policy title you are looking for. The site functions like google in that it will look for the listed term or terms in the policy title and the body of the policy. For example typing in the search term “foley” will suggest the GU Management/Urinary Catheter policy.

This bottom section is titled “New & Recently Revised”. It displays the most recently updated policies in the applicable “location” selected above.

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You can scroll through the policy or use the table of contents.

Home | Policies | Reports | On New PolicyStat | Help | Login

Hackensack Meridian Health Inc.
Change Location

Search policies

Table of Contents

Attachments (3)

Status Active PolicyStat ID 9092430

Print Share

Hackensack Meridian Health

Ensure the policy you have selected is applicable to your work area and location.

Owner: Mcnicholas, Miriam: Dir Prof Prac Clinical Policy
Policy Area: Nursing-General-ENTERPRISE
Applicability: Hackensack Meridian Health Network

Urinary Catheter/GU Management

A. Operational Definitions:

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection that meets the Centers for Disease Control (CDC) definitions.

Healthcare Associated Infection (HAI): a localized or systemic condition resulting from the adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of admission to the care setting to be considered an HAI.

Indwelling Urinary Catheter (IUC): a catheter inserted into the urinary bladder through the urethera, is left in place, and is connected to a closed collection system; Urinary catheters are retained in the bladder by means of a balloon at the tip of the catheter which is inflated with sterile water after placement is confirmed, this includes coude catheters.

Intermittent Straight Catheterization: a procedure performed to drain the urinary bladder as needed, and the catheter is removed and disposed of immediately thereafter. This straight in and out urinary catheter is a NON-indwelling urinary catheter.

Nephrostomy Tube: a tube that is placed either percutaneously or surgically into the kidney.

Suprapubic Tube: a tube that is surgically placed or percutaneously placed into the bladder through the skin of the lower abdomen that diverts urine. Patient may be able to void naturally if the tube is clamped.

Bladder Scan/Scanner: A bladder scanner is a portable, hand-held ultrasound device, which is used to perform a non-invasive scan of the bladder. The scanner has an ultrasound probe and transducer to reflect sound waves from the patient's bladder to the scanner. It is used to measure the volume of urine in the bladder

B. Policy Statement:

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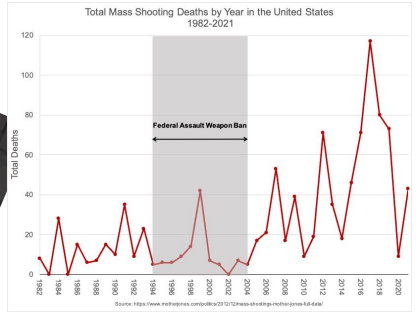
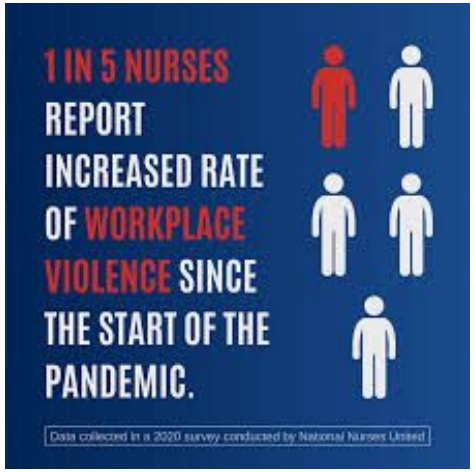
The World Around Us is Changing…



House passes workplace violence prevention bill



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Hackensack Meridian Health is committed to delivering the highest quality care while ensuring a safe and healing environment.

Aggressive behavior affects our ability to meet this commitment and will not be tolerated.

Team Members should report all observed Aggressive and suspicious behaviors to security immediately. Together we will secure our environment and ensure safety for all.

Remember if you **“See Something Say Something”**

How do you report an event?

- **Call your Security Department**
- **Submit a OneLink Report**
- **Dial 7777 from any hospital landline & remember to use plain language**

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What is Aggressive Behavior "?"

An act or threat occurring at the workplace that can include any of the following: verbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; or physical assaults involving staff, licensed practitioners, patients, or visitors.

Examples of workplace violence:

- Physical assault
- Verbal harassment
- Abusive language
- Threats
- Interfering with patient care

Safety tips to protect yourself:

- Use early detection or warning signs as a tool to contact security and avoid further escalation
- Always be conscious of distance between you and the individual
- Maintain a Personal Space of 3 to 6 FT to avoid contact (kicking or punching)
- If your cornered or grabbed by an individual, yell for help and do your best to run to a safe place

HMH Aggressive Behavior & Safety Training

Our Defense-

- Understand behaviors escalate into a harmful dispute
- Listen with empathy - listen for the answers from the patient/person; what are they trying to tell you; verify the understanding of what they are saying or asking
- Protect ourselves through general awareness
- Always have a plan- discuss, envision & drill
- Use your gut instinct as a warning.

Medication Safety

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Medication Reconciliation

- **Ensure a complete and appropriate medication reconciliation has been completed:**
  - **Information should be obtained from the following and include drug name, dose, route, and frequency:**
    - Medications from the patient's list of medications from home, family, nursing home, or rehab facility, etc.
    - Additional methods to verify may include
      - ED medication reconciliation form from the patient's chart
      - Patient's prescription history online
      - Patient's own pharmacy to verify current medications
    - Include any patient allergies

Patients Own Medication

Reasons Why a Patient's Own Medication ***May Not*** be Used	Reasons Why a Patient's Own Medication ***May*** be Used
• Products not approved by the FDA • Injectables • The medication is expired. • Tampered or potentially altered medications • Integrity of medication is compromised • Sample medications	• Patient is on a compassionate use or emergency use protocol • Non-formulary medication the pharmacy cannot easily obtain • Investigational medications • Patient assistance program medications (excluding samples) • Medications dispensed by HMH retail pharmacy for use as bridge therapy for Global BMT patients as they transition from inpatient to outpatient

Paper Form if not accessible in EMR

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PATIENT'S OWN MEDICATION LOG SHEET

ATTACH TO MEDICATION RECONCILIATION FORM & RETURN MEDICATION TO PATIENT UPON DISCHARGE

PATIENT LAST NAME: _____ DATE RECEIVED: _____/_____/_____

PATIENT FIRST NAME:_____ PATIENT ROOM NUMBER: _____

MEDICATION NAME	STRENGTH	DOSAGE FORM	QTY	PHARMACIST INITIALS	DATE	RN INITIALS	DATE	STORAGE LOCATION:

MEDICATIONS RECEIVED TO BE VERIFIED:
UPON ADMISSION:

RN SIGN/DATE when medication received: _____
PATIENT SIGN/DATE when medication given to nurse: _____
PHARMACIST SIGNDATE when medication received: _____

** **Patient's own medication should be sent home with the patient's family or significant other whenever possible. In the event that a patient's own medication must be utilized, the nurse shall complete the above information and bring the form and patient's medication to the pharmacy to be identified and the appropriate information documented on this sheet. When completed, this sheet must be copied and one copy will be given to the nurse for the patient's chart, one will be filed in the Main Pharmacy "Patient own medication binder".**

UPON DISCHARGE:
PHARMACIST SIGN/DATE when medication (*if stored in pharmacy*) is returned to nurse: _____
PATIENT SIGN/DATE when medications have been returned: _____
RN SIGN/DATE when medication returned to patient: _____

Retain patient medications in the pharmacy departme ed. Controlled substances will be handled in accordance with applicable regulations.

103%

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Pain Management

1. Perform initial and ongoing pain assessment
2. Use the appropriate pain scale to assess a patient's level of pain
3. Identify specific goals for pain management for each individual patient
4. **Pain medications administered must correlate with a patient's reported level of pain**
5. If a revised order is needed, contact the provider
6. Document EVERYTHING
   - Documentation should include all reported pain scores, calls to providers, and any concerns the patient or family may have
   - Pain reassessment is completed within a maximum of one hour following pain medication administration

Pain Severity Scales

1-3 = Mild Pain

4-6 = Moderate Pain

7-10 = Severe Pain

HMH Network-High Alert, High Risk Medication

High-alert medications are those medications that bear a heightened risk of causing significant patient harm and/or sentinel events when they are used in error and, as a result, require special safeguards to reduce the risk of error.

HMH Network Policy-High Alert, High Risk Medication (PolicyStatID 10534793)

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High Risk Medications Requiring an Independent *RN Double Check*

Opioids, Benzodiazepine & Ketamine infusions:

- Fentanyl
- Hydromorphone
- Morphine
- Methadone
- Lorazepam
- Midazolam
- Ketamine

Concentrated electrolyte infusions:

- Hypertonic saline (concentration greater than 0.9%)
- Magnesium sulfate (20gm/500ml and 40gm/1000ml)

Anticoagulant infusions(rate/dose change)

- Heparin
- Argatroban

Thrombolytic intravenous & intra-arterial:

- Exception: use for catheter clearance, use in procedural areas (time out conducted in the procedural areas), Intravenous infusion at HUMC (pharmacist responds to code strokes)

Antineoplastic agents (parenteral injections/infusions)

Inhaled Epoprostenol

Neuromuscular blocking agent infusions:

- Cisatracurium
- Atracurium
- Pancuronium
- Rocuronium
- Vecuronium

Intravenous Insulin

Pediatric medications:

- Insulin
- Methadone
- Dobutamine
- Vasopressor infusions

Parenteral Nutrition

Intrathecal administration

HMH Network Policy-High Alert, High Risk Medication - ***See Attachment for full details***

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Oral and Intravenous Anticoagulants

- Warfarin
  - INR must be ordered daily when warfarin is ordered
  - RN must check and document/acknowledge INR prior to warfarin administration
  - If INR results as “critical”, the RN will report the value to the ordering provider immediately ,but no longer than 15 minutes
- Heparin
  - Follow site specific orders or use heparin nomogram
  - May use PTT or antifactor Xa for monitoring
  - If PTT or Xa results are “critical”, the RN will report the value to the ordering provider immediately ,but no longer than 15 minutes

HMH USES PLAIN LANGUAGE ALERTS

To Report an Emergency:

Dial _____**x 7777**_____ and follow these steps

STATE THE ALERT TYPE

For Example: *Facility Alert, Security Alert or Medical Alert*

STATE THE EVENT TYPE CLEARLY

For Example: *Fire, Active Shooter or Cardiac Emergency*

STATE THE SPECIFIC LOCATION

For Example: *Emergency Waiting Room; or 3rd Floor East*

IF YOU HEAR AN ALERT, PLEASE FOLLOW YOUR AREA'S EMERGENCY PROTOCOLS

Overhead examples include:

- *Medical Alert Adult Code 3 East*
- *Security Alert Active Shooter Emergency Waiting Room*
- *Facility Alert Fire Kitchen*

Once the emergency situation has been resolved, an all-clear will be given:
TYPE OF ALERT + TYPE OF EVENT + LOCATION + ALL CLEAR

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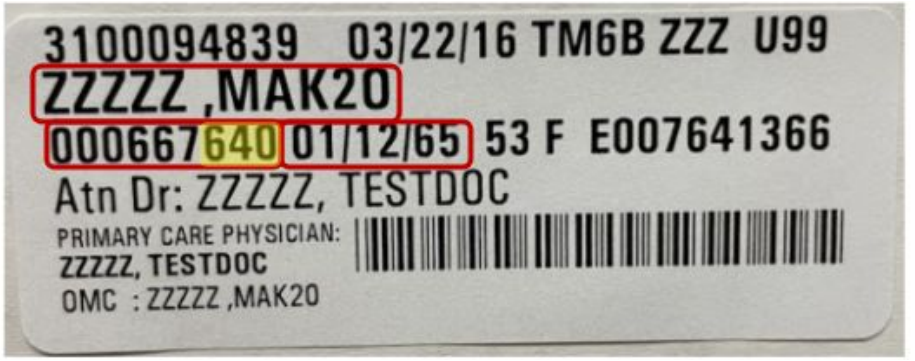
Patient Identification

Easy as 1, 2, 3

Patient Identification is a perennial top 10 patient safety concern

- HMH standardized the process across the network to eliminate variation and the opportunity for harm
- Patient identification will include:
  1. Patient's full name
  2. Patient's date of birth
  3. **Last three digits** of the medical record number



- To ensure proper identification of all patients requiring services at all HMH facilities, the patient will be actively involved in the identification verification process when possible.
- If the patient is not able to state their full name: The health care provider compares and verifies the patient's full name, date of birth AND the last three digits of the medical record number on the patient's ID wristband with another source (i.e., Medication Administration Record [MAR], requisition form, order, Laboratory barcode label, etc.) to match the patient with the care, treatment or services provided.

Patient ID
Easy As 1, 2, 3

- **Three patient identifiers** will be used in all care areas prior to administering medications, taking blood samples and other specimens for clinical testing (labeled in the presence of the patient), transporting or providing any other treatments, procedures or diagnostic testing.

For Patients Receiving Blood and Blood Products:

- Patient identification for blood and blood products will be in accordance with the Obtaining a Type and Screen Specimen and the HMH-Network- Blood and Blood Product Administration (Adult) policies. Patients will be identified using full name, date of birth, and the full medical record number and the blood bank labeling system will be used according to the prescribed procedure.

Patient ID
Easy As 1, 2, 3

- Identification must be carried out immediately prior to providing ANY care, treatment or service, or any specimen collection. If the staff member leaves or is otherwise interrupted prior to beginning the test, treatment or procedure, then the staff member needs to repeat the identification process.

- ALL Outpatients receiving treatment will have a Patient ID wristband placed on his/her arm. **EXCEPT** when photo identification is utilized. For example in Rehabilitation Services or Radiation Oncology

- The patient's room number or physical location is NEVER used as an identifier

- No procedure, treatment, service, or any specimen collection shall be conducted when the patient's identity cannot be verified because the Patient ID wristband is illegible, or missing unless a life threatening emergency exists.

Blood / Blood Product Transfusions

- A consent for Blood products must be obtained by a licensed practitioner
- **All blood products must be administered through a Y-type blood administration set via IV Pump**
- Packed Red Blood Cells (PRBC) must be transfused within 4 hours

- The Y-type blood administration set can be used for 2 units of PRBC as long as the transfusion of both units is completed within 4 hours
- If transfusion cannot be initiated, blood product must be returned immediately within 30 minutes of release from the Blood Bank
- Unless clinically contraindicated, infuse slowly, not more than 2ml per minute (120/mL/hr) for the first 15 minutes

- Monitor and Document **Vital Signs**:
  - **15 minutes after the start** of transfusion
  - **every hour** during transfusion
  - if transfusion reaction is suspected OR any change in patient condition
  - **post transfusion** (up to 15 minutes post transfusion)
- Monitor and Document **Suspected Reaction (YES or NO):**
  - every hour during transfusion
  - post transfusion (up to 15 minutes after transfusion ends)

HMH Network Policy-Blood and Blood Product Administration (Adult) (PolicyStatID 14429512)

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Collection and labeling of specimen must be completed at the bedside!!

Drawing Specimen for Type & Screen / Crossmatch

Identify patient with **THREE** identifiers: Full name, date of birth, and medical record number

- Request patient to verbally identify self by **full name, date of birth,** and verifying **last three digits of medical record number**

➔ If using wireless printer: choose patient from the worklist activity and select labs that need to be collected.

- Scan patient's wristband
- Print labels, ensure information on label matches patient's ID band and scan each label

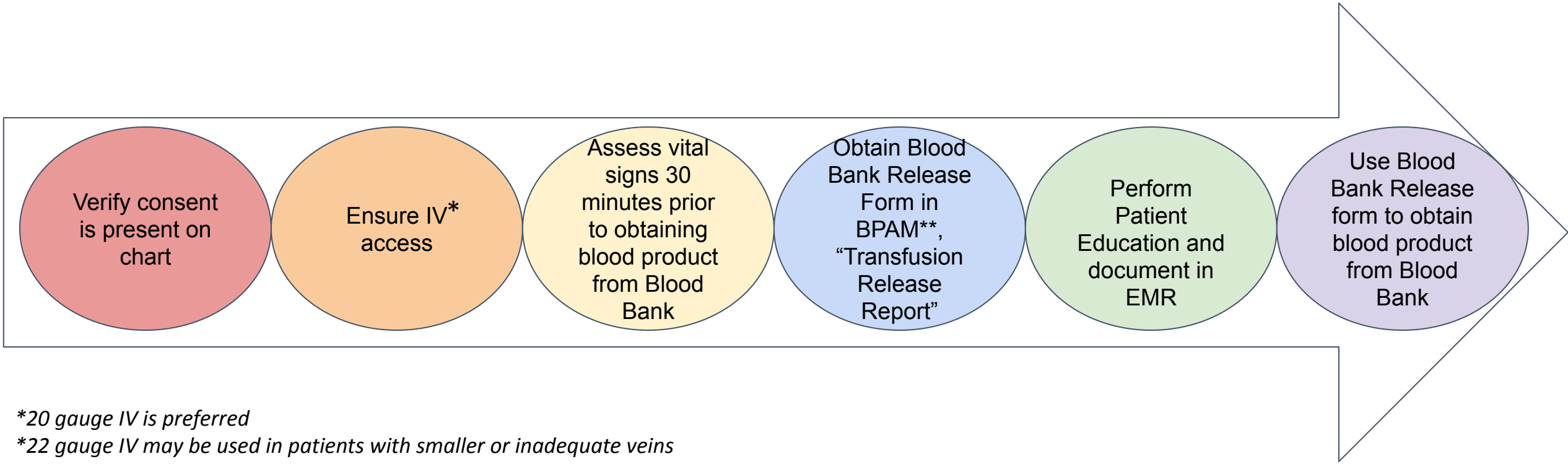
➔ If wireless print is unavailable: Use preprinted label from chart and attach to blood tube. Ensure information on label matches patient's ID band

- Include the following information on label:
  - date and time of collection
  - Peoplesoft Number and/or legible signature or printed name of the individual obtaining blood specimen

The specimen for cross-match will expire at 23:59 hours on the third day after specimen collection. Day zero is the day of the draw

** Patients without a historical type present in the Blood Bank computer system will be required to have a second confirmatory ABO/Rh test

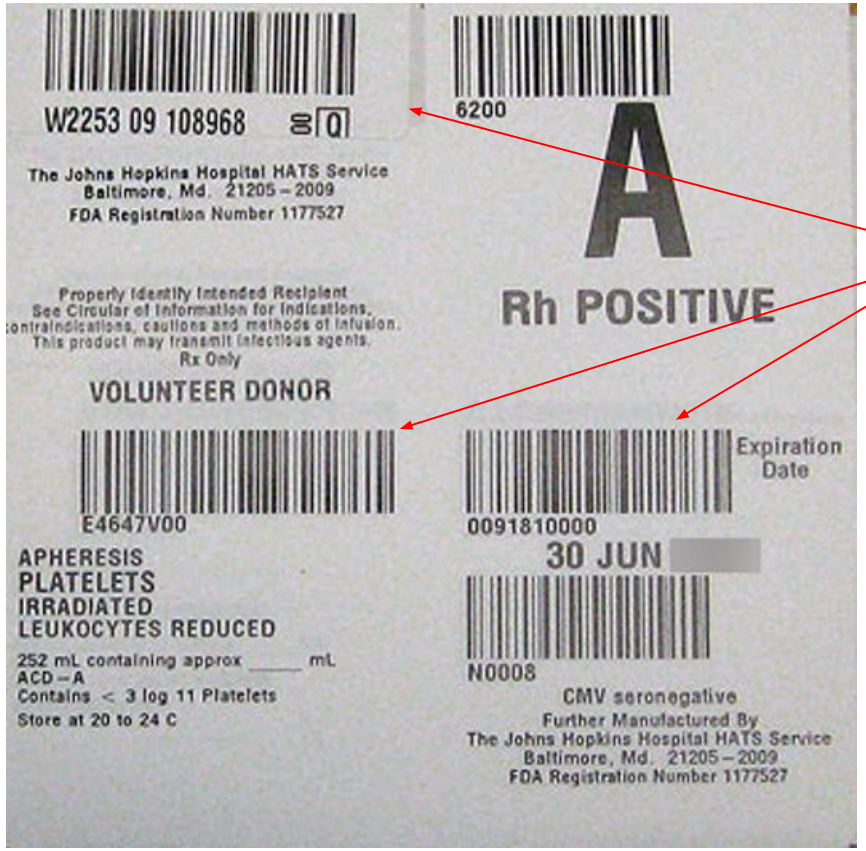
Before Obtaining Blood/ Blood Product Transfusion



**20 gauge IV is preferred*
**22 gauge IV may be used in patients with smaller or inadequate veins*

***BPAM = Blood Product Administration Module*

Verification of Blood Product



Verification must be performed at the bedside by two RNs, or RN and LIP:

Verify Patient's ID and Unit of Blood prior to spiking the bag

1. ***Spell, compare, & match*** the **Patient's name**, **Date of Birth** and **Medical Record Number** on patient's ID band with the white sticker on the blood tag, and EPIC BPAM record or transfusion tag. Any discrepancies noted, return to blood bank

2. Scan the 3 barcodes on the blood bag: Unit number, product code, and expiration date

3. Match the unit number on the white sticker with the unit ID number on the blood bag or transfusion tag

4. Match the ABO/RH type located on the blood bag with the white sticker on the blood bag and the ABO/RH displayed in BPAM or ABO/RH on transfusion tag

5. Two RNs or RN and LIP must electronically sign in BPAM or sign transfusion tag

****If the unit of blood should leave the bedside prior to being initiated, the verification process MUST be repeated prior to beginning the infusion**

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During Blood and Blood Product Transfusion

Monitor Vital Signs: temperature, pulse, respiration & blood pressure:

- **15 minutes after the start** of transfusion
- **every hour** during transfusion
- if transfusion reaction is suspected OR any change in patient condition
- **post transfusion** (up to 15 minutes post transfusion)

- Unless clinically contraindicated, infuse slowly, not more than 2 ml per minute(120/mL/Hr) for the first 15 minutes.
- **Observe and document the patient for signs and symptoms of transfusion reaction throughout the administration process, at least every 1 Hour and up to 15 minutes after the transfusion has been terminated**.
- If at any time a transfusion reaction is suspected, immediately stop the transfusion and implement the procedure/protocol for transfusion reactions. Document in the Blood Administration Flow Sheet.
- Administer blood & blood components through the IV Pump using the Y-type micron filter tubing to connect the blood to the pump.

Ending Blood / Blood Product Transfusion

When transfusion is complete:

- ❑ Clamp blood line tubing above micron filter
- ❑ Release the saline line clamp above the micron filter
- ❑ Flush the tubing with 30 – 50 ml 0.9% NaCl until clear

Complete the following steps in Epic once infusion is complete:

- ❑ Click the syringe icon in the rate row of the BPAM Flowsheet
- ❑ click the "Action" Drop-down menu and select "**Stopped**"
- ❑ click Accept
- ❑ Document post vital signs up to 15 minutes post transfusion
- ❑ Enter volume of the infusion
- ❑ Document in "Suspected Reaction" row

Complete the transfusion:

- ❑ Right click ***Status of Transfusion***
- ❑ click ***Complete***

When using the paper transfusion tag (aka blood slip), Document the following:

- ❑ Signature and printed name of the person ending the transfusion
- ❑ Date and Time transfusion ended
- ❑ Presence or Absence of adverse reaction
- ❑ Volume transfused
- ❑ Post-transfusion Vital Signs (up to 15 minutes post-transfusion
- ❑ Document in EMR in "Suspected Reaction" row

Place completed transfusion tag in "Laboratory" Section of patient's chart

Suspected Transfusion Reaction

STOP transfusion immediately

and

Start new administration set with 0.9% normal saline

Assess Symptoms and obtain vital Signs

STOP transfusion in EMR in Blood Administration Flowsheet

Notify Physician, Blood Bank Tech, Nurse Manager

Document **YES** on suspected transfusion reaction row in the flowsheet and complete cascading rows

- Document volume of blood transfused

Return the follow to the Blood Bank:

- Blood product
- Tubing
- Copy of completed transfusion tag *(if applicable)* to Blood Bank

Obtain blood specimen and 1st voided urine

- Label specimens at bedside and include, "Transfusion Reaction Specimen"

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Suspected Transfusion Reaction

Obtain Vital Signs

every 15 min. x4
then
every 30 min. x4
then
every 1 hour x4 until return to baseline

- Document vital signs and signs & symptoms of suspected transfusion reaction on the Blood Administration Flowsheet in the EMR.

HMH Network Policy-Blood and Blood Product Administration (Adult)
(PolicyStatID 14429512)

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R.I.S.E. (Fall) Prevention

Orientation Presentation

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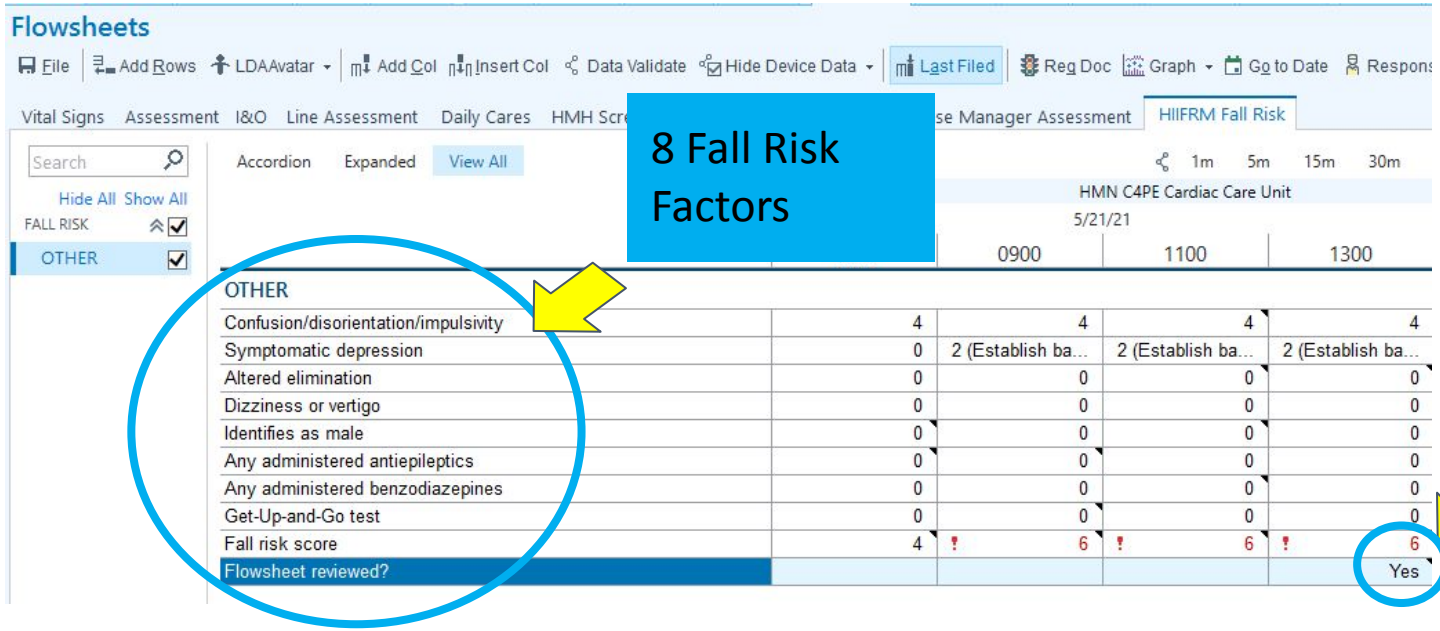
Evidence-based Fall risk screening tools at Hackensack Meridian *Health*

- Hendrich II- Adults (In pt and out pt Adults)
- Humpty Dumpty (Peds)
- I’M SAFE (Peds)
- Edmonson (Behavioral Health)

Automated Adult Fall Risk Assessment in Epic

The Hendrich Fall Risk FlowSheet is now automated in Epic.

Documentation from various disciplines across the e**lectronic health record** has contributed to the score.



8 Fall Risk Factors

Review the automated fields and if you agree with the score indicate “Yes” under “Flowsheet reviewed”.

You will still need to perform and manually enter the Get Up and Go Test Score.

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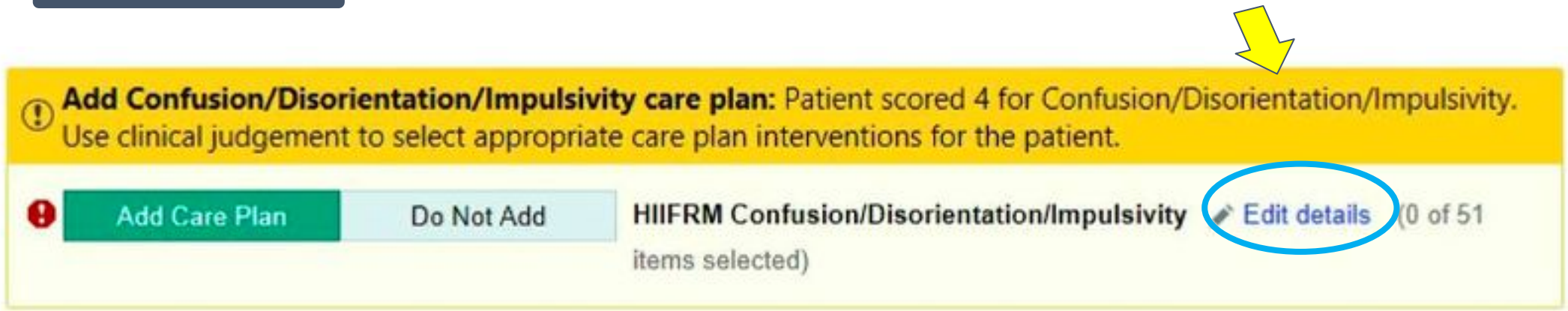
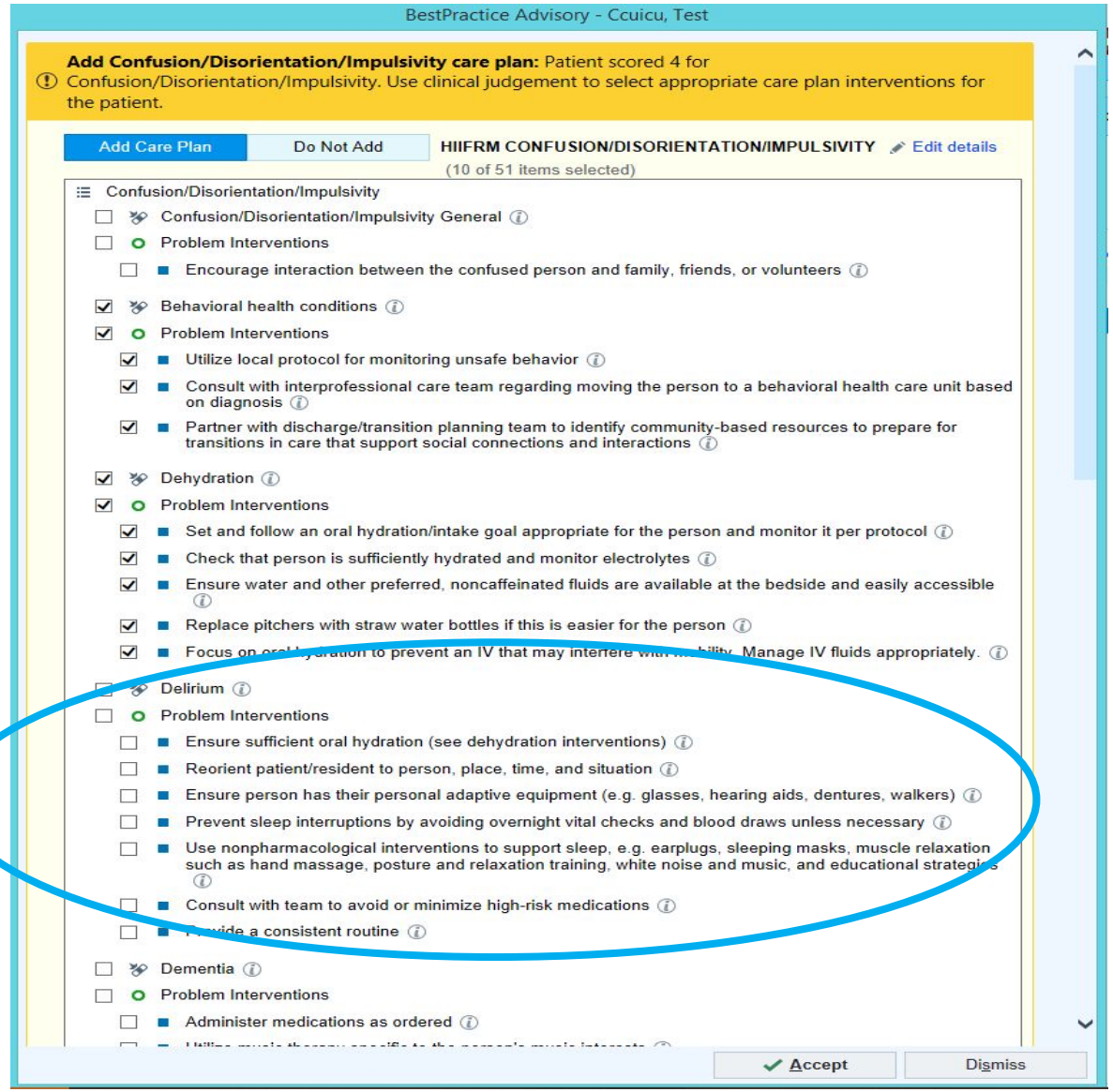
For each positive **risk factor**, a best practice advisory will appear.

Select “Edit details” to review all possible patient specific interventions.



Assess the root cause of the positive risk factor and select the appropriate interventions.

Selected interventions will appear in the **Care Plan**. To add or delete refer to the Plan of Care tab.



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If a Fall Occurs . . .

- Any staff member who finds a patient or visitor who has fallen should remain with and verbally reassure the person and call for help.
- An assessment must be made before the person is helped up to determine the extent of any injuries.
- Review the **Post Fall Assessment and Management** Attachment in the policy for all required and suggested actions
- Document the fall in ONELINK and EPIC as required
- **Report injurious falls to nursing management IMMEDIATELY**
- Implement appropriate NEW fall interventions that are patient specific based on your assessment
- Revise the Plan of Care in the documentation system

Early Mobilization: Bedside Mobility Assessment (BMAT)

A tool designed to assess patient mobility in acute care. The BMAT allows nurses (and other healthcare workers) to determine the appropriate patient handling and mobility equipment or device to safely move or mobilize the patient.

PolicyStat ID: 7287859

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BMAT Frequency

The Bedside Mobility Assessment will be performed by the RN unless contraindicated: *

- Within 24 hours upon admission (inpatient or observation) or transfer into the unit. Every effort should be made to perform the BMAT as soon as possible after arrival to the unit.
- Daily, and/or when there is a noted change in the patient condition
- The RN will document the assessment level of 1,2,3 or 4 and pass or fail in the EMR.
- The RN will develop a mobility plan of care based on the assessment level parameter passed and identify the recommended mobility equipment and activity plan.

Contraindications and further information listed in policy: Bedside Mobility Assessment

BMAT Levels

- Level 1-Should be able to rise from semi-reclined position & maintain seated balance for 2 minutes or greater without assistance. **Proceed to level 2 Assessment.**
- Level 2 - able to stretch one leg and straighten one knee, bend & flex ankle & point toes. **Proceed to level 3 Assessment.**
- Level 3 -**Pass** - able to raise from sitting to standing position with or without an assistive device & remain standing for count of five. Able to repeat x 1. **Proceed to Level 4 Assessment.**
- Level 4 - able to demonstrate unassisted balance & gait stability with steps and marching. **Score level 4.**

If a patient is unable to complete the task, STOP. No further assessment needed. Level 1,2 and 3 are scored at the level the patient failed. If patient fails at Level 4, score at Level 3.

Event Reporting/ONElink

PolicyStat ID: 15293024

ONElink can be accessed through citrix, the HMH homepage or directly in EPIC.

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A ONElink should be entered to documenting any unusual, unexpected or potential adverse event.

- **Event-** Any actual or potential event, process, or outcome that is not consistent with the normal routine operations or the routine care of an individual patient

- **Safety Event** - Any event, incident, or condition that could have resulted or did result in harm and can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error.

REPORTING: All team members are required to complete an Event Report whenever they believe that the definition of an event has been met. There is no negative consequence for reporting an event that does not meet the definition.

Event Report/ONElink is not intended to express opinions or place blame. Please provide only factual information and as many details as possible.

RESPONSIBILITY FOR REPORTING AN EVENT: ANYONE with an HMH approved logon can complete an Event Report utilizing our electronic event reporting system, ONElink. The team member most closely involved with or witness to the occurrence has the responsibility either to initiate an event report or ensure that one has been completed.

CONFIDENTIALITY: Event Reports are confidential, as they have been designed to facilitate self critical analyses. Team members will refrain from discussing any unusual occurrence on social media or in the presence of team members, patients, visitors and/ or others outside the system

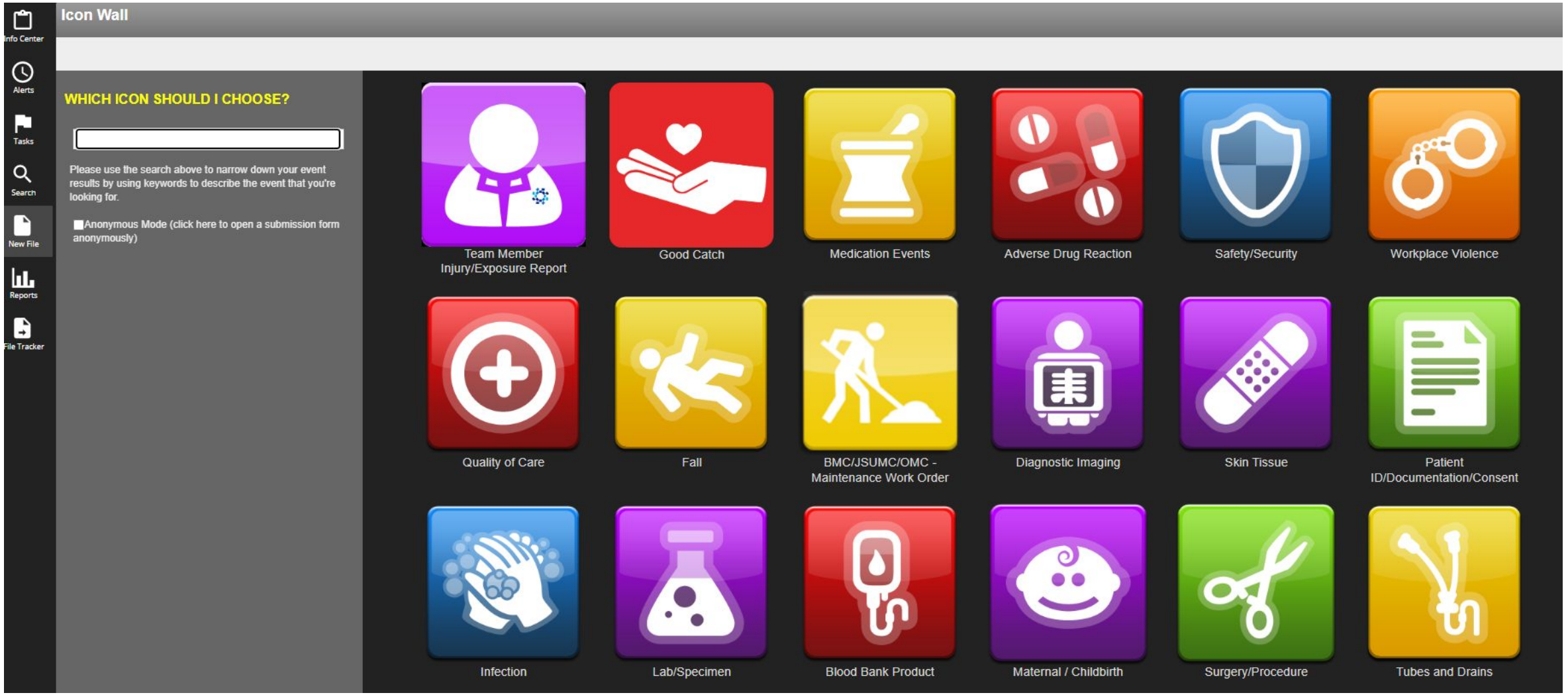
DOCUMENTATION: Submission of an Event Report does not replace the need for other documentation. For example, in patient care related events, the clinical facts pertinent to the event must be charted in the patient's medical record by the appropriate caregiver.

DO NOT make mention of an Event Report or a ONELink being filed in any patient medical record. ONELink reports are confidential and protected by the Patient Safety Act N.J.S.A. 26:2H-12.23-12.25. The facts entered into ONElink and the medical record should be consistent. Additionally, accusations, criticisms, opinions must be avoided.

PROCEDURE:

1. The Team Member involved in, observing, or discovering the unusual occurrence is responsible for initiating a report of the event.
2. ONELink can be found on the "Dashboard" and Hackensack Meridian Health Intranet and can also be accessed while in Epic.
3. The information is confidential and duplication of the report is prohibited.
4. The occurrence report will be completed as soon as practical and all mandatory fields will be completed.
5. Team members will refrain from discussing any unusual occurrence with or in the presence of team members, patients, visitors or others outside the system.

Occurrences should be entered under the most appropriate icon available. Additional information rows will appear allowing for further specification and a brief description of the event in narrative form.

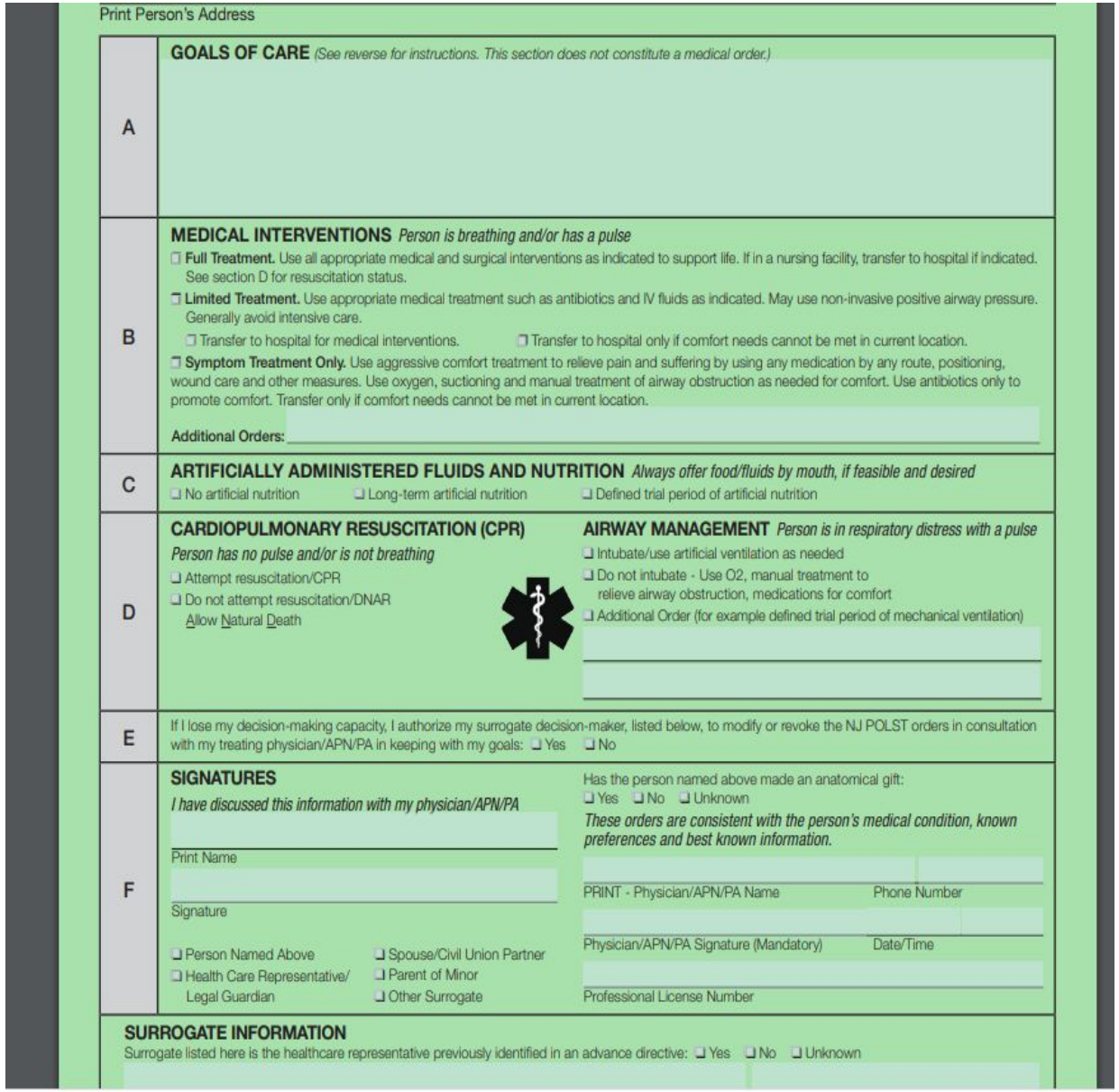


POLST & Advance Directive

What is a POLST?

- Portable Order for Life Sustaining Treatment
- Completed by a Physician, APN, PA
- Portable from outpatient to inpatient
- Can be completed by patient (capacitated) or surrogate (incapacitated).
- Modified or voided at any time by patient or surrogate
  - Section E - Limits the surrogate
- Transcribe the POLST order on admission.

NJ POLST



Print Person's Address

A — GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B — MEDICAL INTERVENTIONS *Person is breathing and/or has a pulse*

- ❑ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.
- ❑ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ❑ Transfer to hospital for medical interventions.
  - ❑ Transfer to hospital only if comfort needs cannot be met in current location.
- ❑ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION *Always offer food/fluids by mouth, if feasible and desired*

❑ No artificial nutrition ❑ Long-term artificial nutrition ❑ Defined trial period of artificial nutrition

D — CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

❑ Attempt resuscitation/CPR

❑ Do not attempt resuscitation/DNAR
Allow Natural Death

AIRWAY MANAGEMENT *Person is in respiratory distress with a pulse*

❑ Intubate/use artificial ventilation as needed

❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort

❑ Additional Order (for example defined trial period of mechanical ventilation)

E

If I lose my decision-making capacity, I authorize my surrogate decision-maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN/PA in keeping with my goals: ❑ Yes ❑ No

F — SIGNATURES

I have discussed this information with my physician/APN/PA

Print Name

Signature

❑ Person Named Above ❑ Spouse/Civil Union Partner
❑ Health Care Representative/ Legal Guardian ❑ Parent of Minor
❑ Other Surrogate

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

PRINT - Physician/APN/PA Name Phone Number

Physician/APN/PA Signature (Mandatory) Date/Time

Professional License Number

SURROGATE INFORMATION

Surrogate listed here is the healthcare representative previously identified in an advance directive: ❑ Yes ❑ No ❑ Unknown

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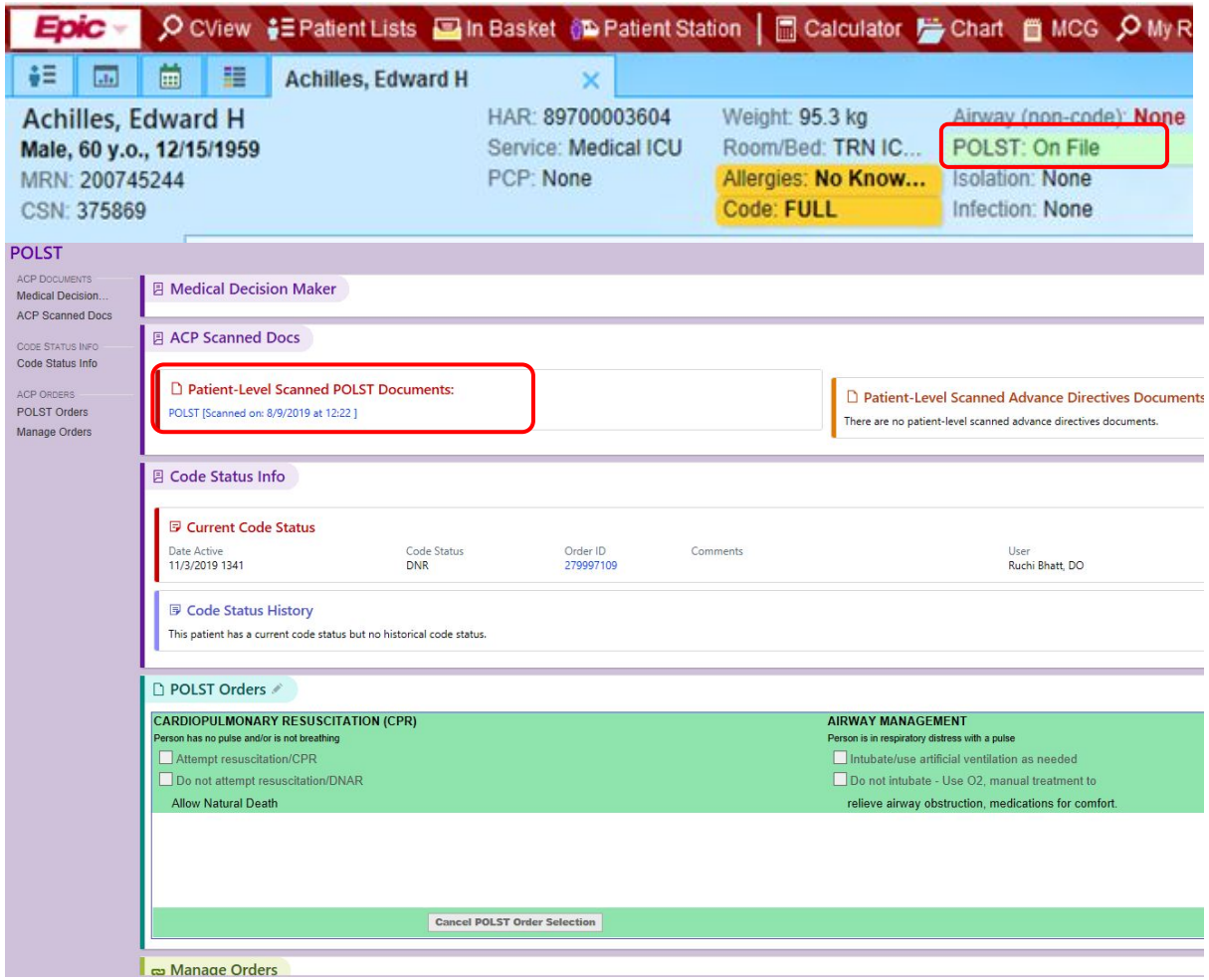

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HIM: POLST (Practitioner Order for Life Sustaining Treatment)

Practitioner Order for Life Sustaining Treatment (POLST) Queue. There is a dedicated fax line set up for this document type. Once faxed, the document will qualify for the POLST queue within OnBase. HIM will access the queue and index the document. Once complete, the document will file to the patients chart.

How it Works

To ensure that POLST document types are processed immediate and after hours, follow these steps:

1. Ensure document(s) are legible and have a minimum of three patient identifiers. Examples: Name, MRN, DOB, CSN, etc.
2. Remove staples, paperclips, etc.
3. Sender must complete fax cover sheet to include name of sender, contact phone number, and department.
4. PMC Fax document to 201-854-8360

   HUMC Fax document to 551-996-0694

   JFK Fax document to 848-245-8500

   BMC, RBMC, RMC, JSUMC, OMC, SOMC Fax document to 732-324-3230

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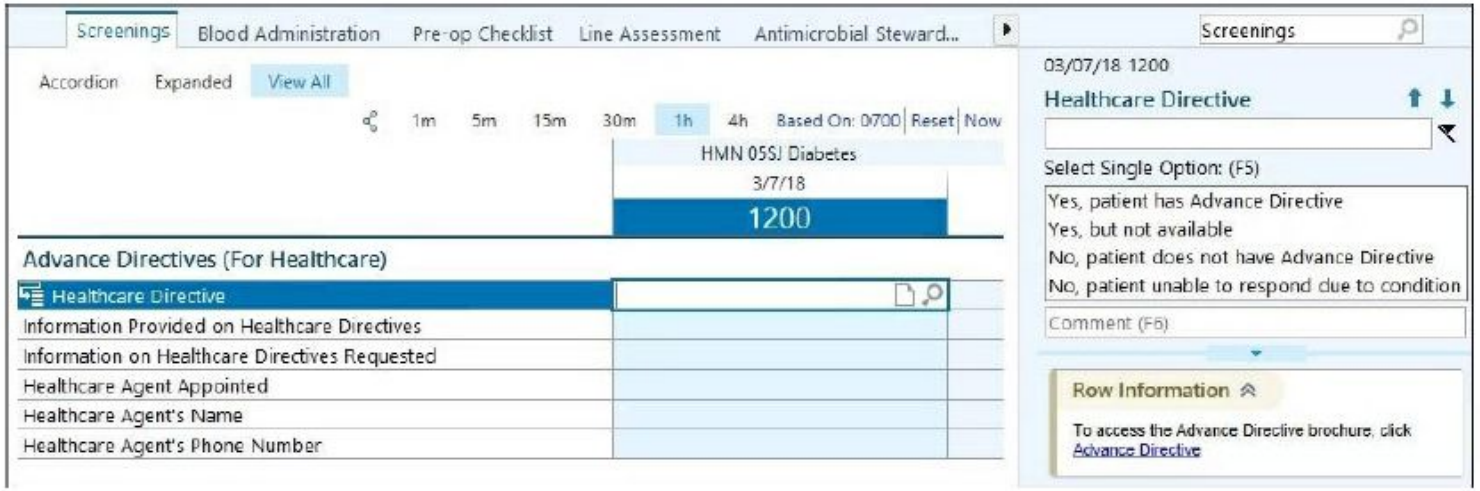
FLOWSHEET DOCUMENTATION: ADVANCE DIRECTIVES

To ensure that Advance Directives are properly documented, an additional row will cascade if a patient has an Advance Directive but they and and/or their family cannot produce it during the initial screening. The new flowsheet row will prompt nursing staff via the Admit Required Documentation feature to revisit the issue within 24 hours.

How it Works

1. Open patient's chart. Navigate to **Flowsheets** activity. Open **Screenings** flowsheet group.
2. Appropriately document status of patient's **Advance Directive (for Healthcare)**.



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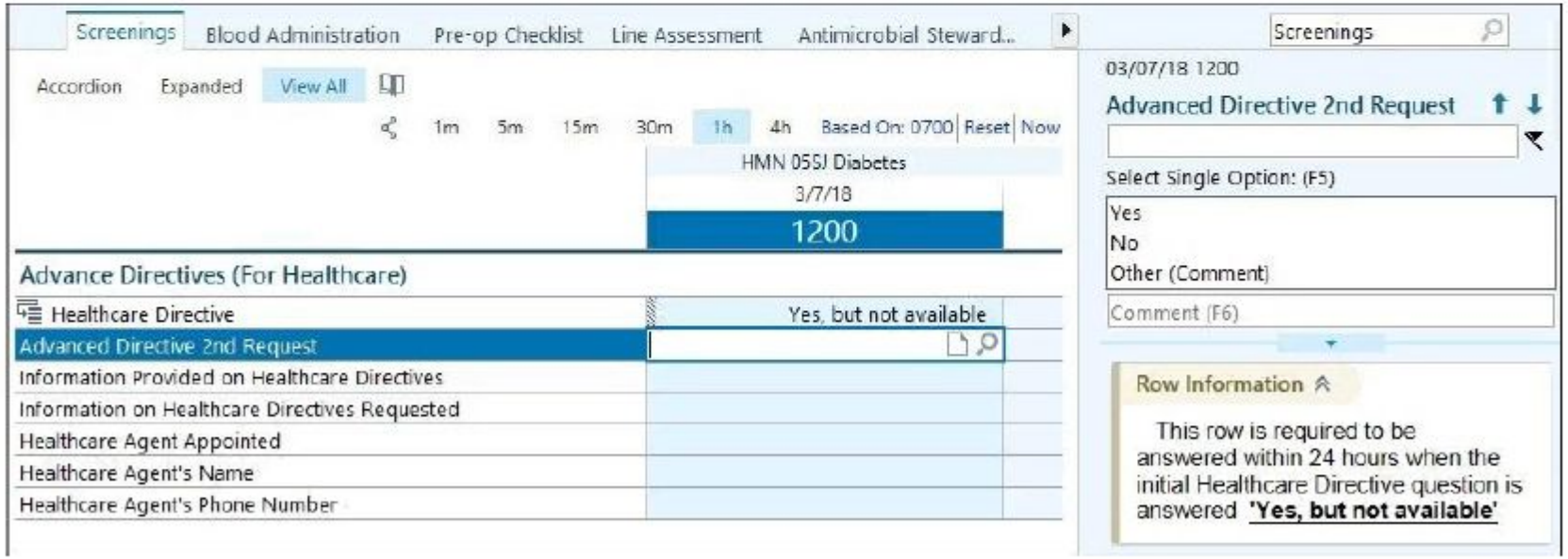
3. If patient has an Advance Directive but they and/or their family do not have it during the initial screening, a new row will cascade and prompt to ask about an Advance Directive within 24 hours.
4. If the new row is added to Epic, it must be documented on within 24 hours to satisfy the requirements of admission documentation.



IPASS

How will you use IPASS?

- Each time the patient transitions from one caregiver to another you will conduct an IPASS report as part of your handoff.
  - Change of Shift *Bedside* Report
  - Nursing Unit to Unit transfers
  - Sending a Patient to a Diagnostic or Treatment area
  - Temporary Nursing Coverage
  - Other such times when the nursing care of a patient is relinquished and accepted by another registered nurse.

You will continue to utilize SBAR for those emergent times when you need to convey information quickly i.e., during a Rapid Response.

NEW IPASS-Report Transfer Process for Emergency Department to Inpatient Units

- For patients being transferred from the emergency department to an inpatient unit hand off can be communicated utilizing an IPASS review in the electronic medical record.

- A call or secure chat (method determined by campus) notification from the emergency room nurse to the receiving unit will confirm the sending of the patient in 15 minutes from the time of the phone call.
- ***This phone call from the ED is the opportunity to notify the ED if room/bed is not ready with an appropriate reason, or request a verbal report.***

- Both the sending nurse and receiving nurse will complete synthesis documentation that IPASS report was reviewed and completed.***The absence of a signature DOES NOT mean the patient transfer will not occur.***

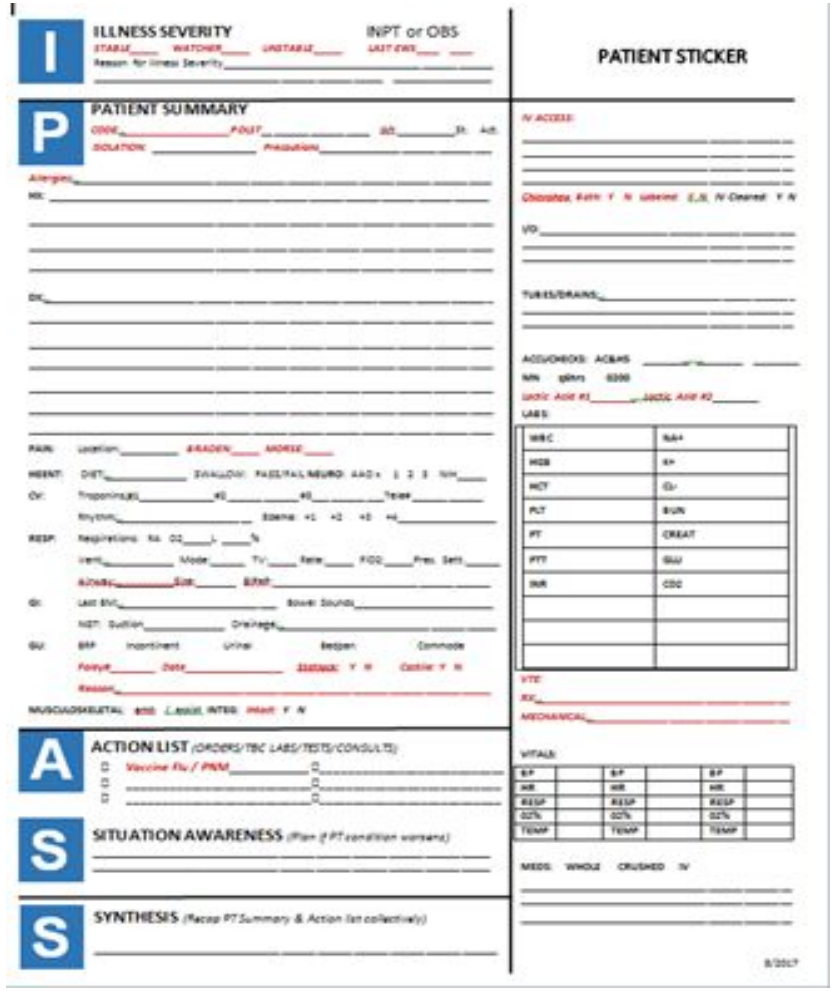
- The opportunity for discussion between the giver and receiver of information can occur at anytime. The synthesis of information by the receiver, including having any questions addressed, completes the handoff process.

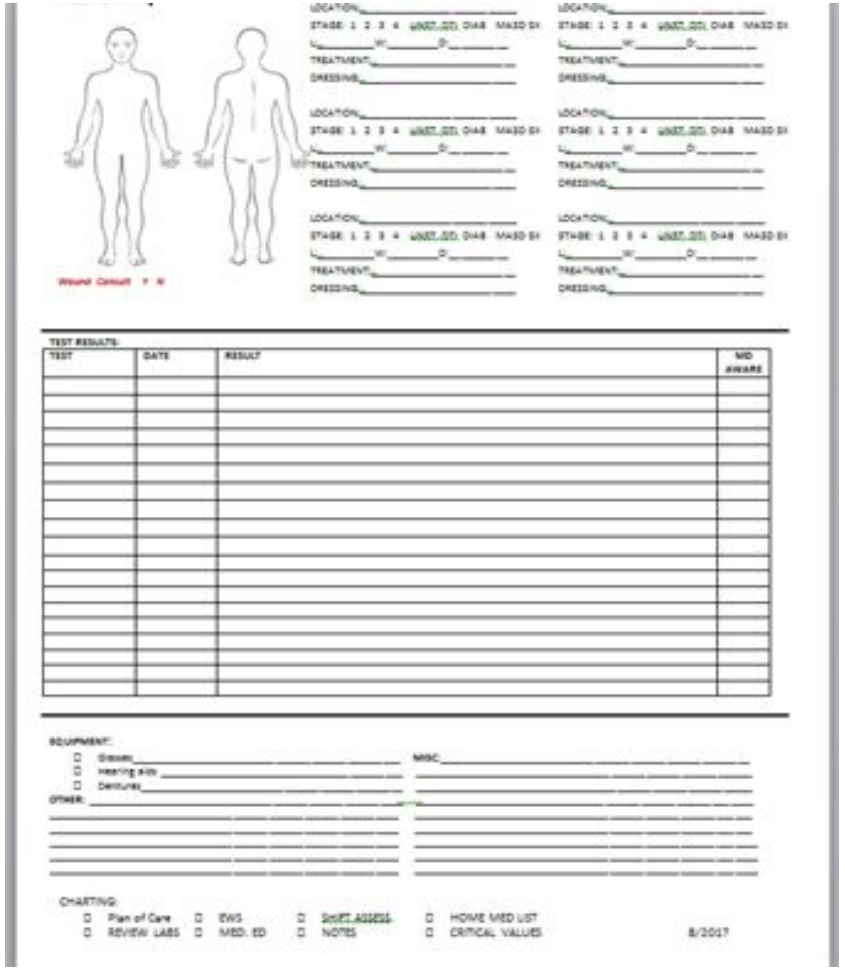
Additional Key Points

- If there are 2 or more Emergency Room patients going to the same floor/unit every effort will be made to allow a 15 minute wait time in between sending the patients.Its the receiving units responsibility to notify the ED if there are multiple admissions to the unit.

- Because a patient may require a nurse accompaniment for transport based on clinical status, for example telemetry with nurse and monitor does not exclude that patient from an electronic IPASS report

- The Emergency Department Smart Phrase MUST be used in the summary in IPASS which includes:
  - Sending nurses' name and extension where they can be reached
  - How the patient takes medications
  - Mobility Status
  - Voiding Status





You may see the original IPASS form used by some staff for gathering data.

However, in the next slide and during your EPIC class you will see EPIC IPASS which is used for handoff reporting throughout HMH.

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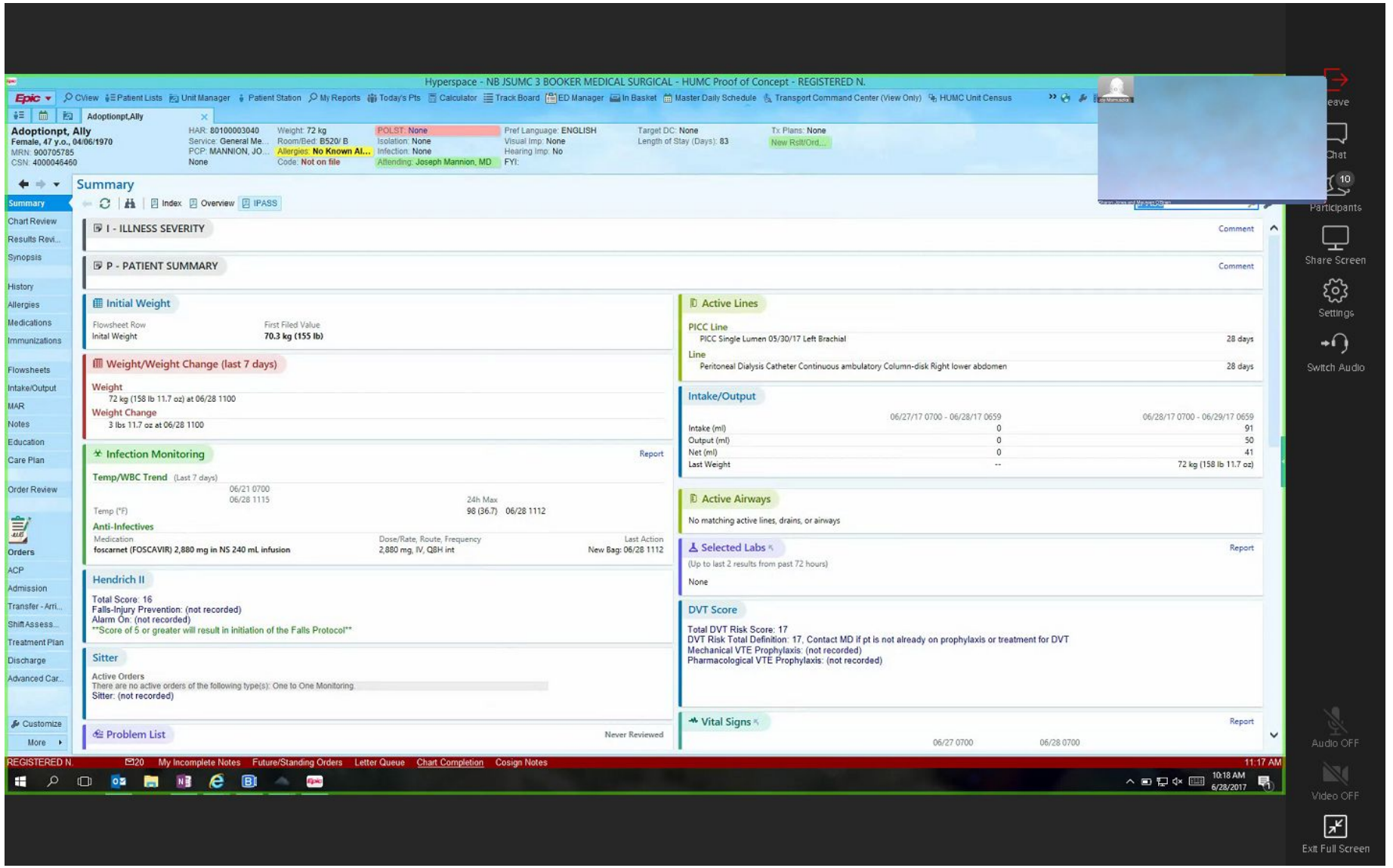

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Medical Alert:
Sepsis

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Medical Alert, Sepsis : Systematic rapid response to providing evidenced based sepsis care to patient in severe sepsis/ septic shock.

Early Antibiotics: Administer antibiotics as soon as possible. *Goal is < 1 hour from order*

Fluid Resuscitation: Rapid (rate determined by physician) administration of 30 ml/kg of intravenous crystalloid fluid

Hypotension:

- Systolic blood pressure (SBP) less than 90 mmHg ***OR***
- Mean arterial pressure (MAP) less than 65 mmHg ***OR***
- SBP decrease> 40 mmHg below normal for age or known baseline

Sepsis 3-hour Bundle

Surviving Sepsis Campaign

To be completed within 3 hours of time of presentation:

- Measure lactate level
- Obtain blood cultures prior to administration of antibiotics
- Administer broad spectrum antibiotics
- Administer 30 mL/kg crystalloid for hypotension or lactate ≥ 4 mmol/L
    - **2 BPs must be documented within 1 hour of fluid completion**

To be completed within 6 hours of time of presentation:

- Repeat lactate level if initial is > 2
- Administer IV vasopressors as ordered for persistent hypotension (SBP < 90 or MAP < 65) after completion of fluid resuscitation.

"Time of presentation" is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.

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HAI Prevention Bundles

*For **ALL** Patients…*

- *Hand Hygiene*
- *Prompt Removal of Devices*
- *Daily Bathing*
- *Daily Gown and Linen Change*
- *Daily Cleaning of High Touch Surfaces (Vents, IV Pumps, Monitors, and Leads)*

Central Line

- ✔ Daily Review of Indication
- ✔ Daily CHG Bathing
- ✔ CHG- Containing Dressing in Place
- ✔ Dressing Clean, Dry, Intact, and Dated
- ✔ IV Tubing Dated and Within Date
- ✔ Alcohol Impregnated Caps for All Unused Ports
- ✔ Scrub the Hub

IUC

- ✔ Daily Review of Indication
- ✔ Peri-Care Q Shift and as needed
- ✔ Stat-Lock in Place and Dated
- ✔ Tubing without Kinks or Dependent Loops to Allow for Unobstructed Drainage
- ✔ Collection Bag Below the Bladder and Off the Floor
- ✔ Maintain Closed System

Ventilator

- ✔ Daily Sedation Vacation
- ✔ HOB 30 - 45 degrees
- ✔ Oral care Q 4 Hours and as needed
- ✔ Peptic Ulcer and VTE Prophylaxis

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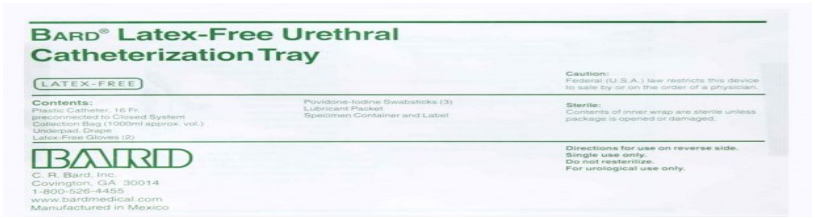
Alternatives to consider prior to IUC Insertion- Critical Thinking!

- **Male External Catheter**: a provider order is not needed for the application of a male external catheter.
- **External Female Catheter**: a provider order is not needed for the application of a female external catheter.
- **Straight Catheterization**: **a provider order is needed**. When applicable, intermittent straight catheterization is preferred rather than insertion of an indwelling urinary catheter.

Remember external catheters are gender specific



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Female Purewick *for* External Urine Management

BD

Indications

- Female patients who do not meet indications for an indwelling urinary catheter (IUC)
- Female patient who is not able to ambulate safely to bathroom or a commode
- Female patient who cannot use a bedpan

Contraindications

- Female patients with retention
- Female patients who <u>can</u> safely ambulate to the bathroom or a commode
- Female patients who can use a bedpan
- **Caution** use with patients with frequent bowel incontinence and who are experiencing moderate/heavy menstruation

Expectations

- Discuss the indication for Purewick during MDRs daily
- Document the approved indication for the Purewick as part of the RN assessment in Epic

- **Transgender female patients who have had gender affirming surgery require physician intervention for use.**

RN Assessment of an appropriate indication is required before use

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Male Purewick *for* External Urine Management

Indications

- Male patients who do not meet indications for an indwelling urinary catheter (IUC)
- Male patient is not able to ambulate safely to bathroom or a commode
- Male patient who cannot use a urinal
- Male Condom catheter cannot be used (edema, anatomy, etc.)

Contraindications

- Male patients with retention
- Male patients who can safely ambulate to the bathroom or a commode
- Male patients who can use a urinal
- Male patients who can use a condom catheter

Expectations

- Discuss the indication for Purewick during MDRs daily
- Document the approved indication for the Purewick as part of the RN assessment in Epic

- **Transgender male patients who have had gender affirming surgery require physician intervention for use.**

RN Assessment of an appropriate indication is required before use

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Nurse Driven Removal of a Urinary Catheter

- Assess the necessity/indication of the catheter every shift and document in the medical record.

Discontinuation of indwelling urinary catheter is based on:

- The resolution of the condition/circumstances for catheter insertion.
- When the patient/family are able to perform intermittent catheterization as ordered by the Provider for urinary retention.
- Within 48 hours of insertion, unless there is physician documentation to maintain the urinary catheter beyond this timeframe.

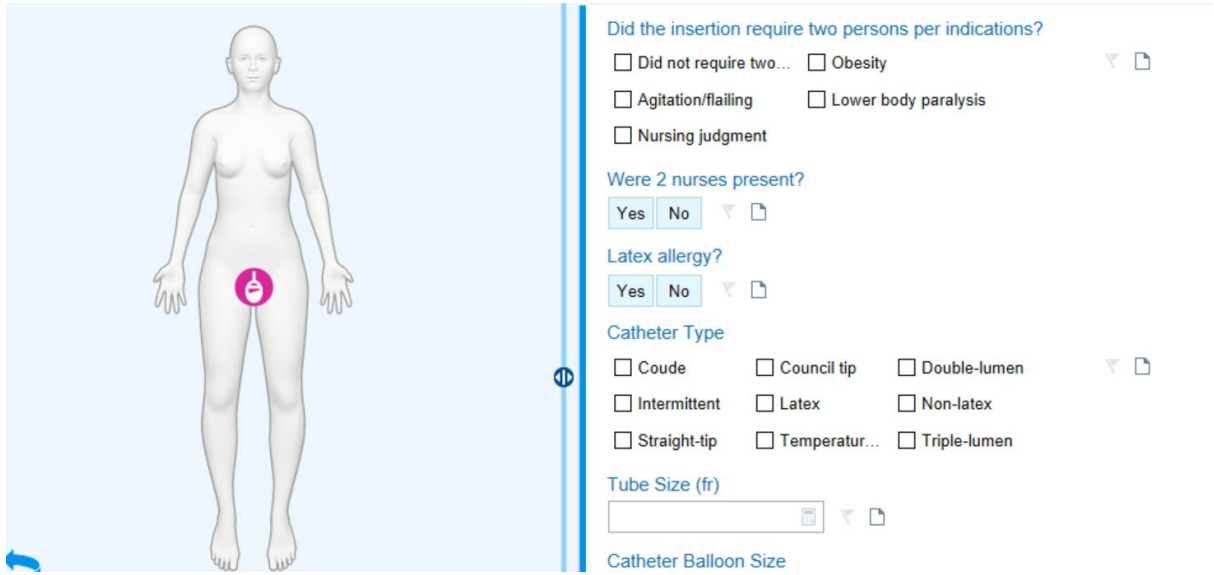
Urinary Catheter Insertion Checklist Guidelines:

- At the time of insertion, a *Urinary Catheter Insertion Checklist* will be completed by the nurse or physician inserting IUC.

- If the patient meets the criteria for a two person insertion, the checklist will be completed by a second nurse in the room.

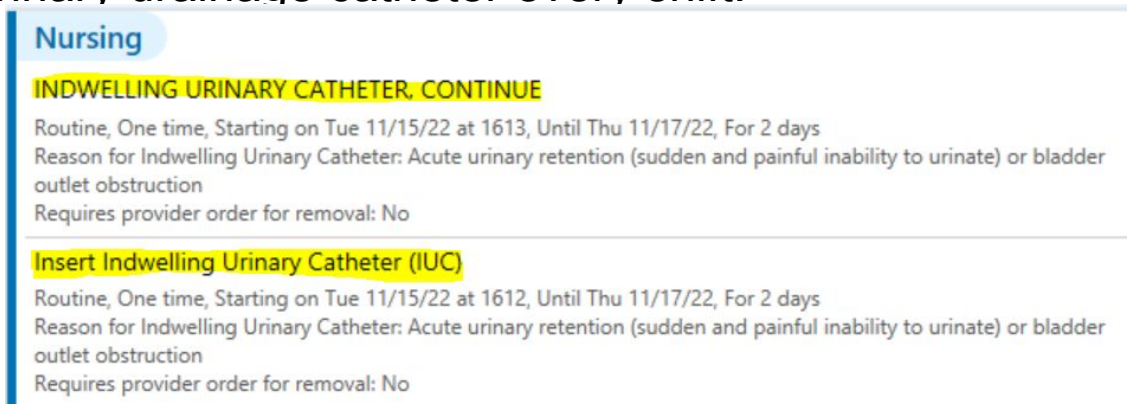
- **Two person insertion criteria:**
  - **Obesity**
  - **Agitation/flailing**
  - **Lower body paralysis**
  - **Nursing judgement**

**Can document external devices on LDA



Maintenance

- IUC Insertion must meet a CDC indication
- Alternatives to IUC must be attempted prior to insertion of IUC
- A provider order is required at insertion and every 48 hours for maintenance of all urinary drainage catheters.
- At the time of insertion, a Urinary Catheter Insertion Checklist will be completed by the nurse or physician inserting the IUC.
- A daily urinary catheter maintenance bundle will be documented in the EMR on all patients with an indwelling urinary drainage catheter every shift.



CAUTI Maintenance Bundle

- Change catheter only for specific documented indications. Patient indications of this need may include mechanical dysfunction or blockage of the urinary system, and contamination of the closed system.
- Indwelling catheters should not be changed at arbitrary fixed intervals.

- NOTE: **Breaking the seal of the system is not recommended practice.** If a drainage collection system with a urimeter is indicated for strict urine output monitoring and a catheter is currently in place without a urimeter, **re-insert a catheter with the correct drainage collection system rather than disconnecting the current system to change only the drainage collection urimeter.**

CAUTI Maintenance Bundle

Assessed daily for ongoing approved indication; **no approved indication no catheter .**

Alternatives are reconsidered

For surgical patients with catheter at or beyond 48 hours obtain order for catheter to be removed or provider documents indication daily.

For medical patients without indications, remove the catheter within 48 hours of insertion in the absence of an order otherwise .

Obtaining a Urine Culture/Sample

If you need to obtain a culture from a urinary catheter that has been in place greater than 14 days, a new catheter is placed prior to obtaining the culture (IDSA Guidelines published in 2010).

- ***Please note if the catheter was placed by urology, discuss with the provider prior to replacing the catheter or collecting a specimen.***

GOAL ZERO: CLABSI

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TYPES:

CVCs can be:

Tunneled (the distal end of the catheter extending outside the vein is tunneled subcutaneously to a distant site). Catheters are usually long-term and contain a cuff that adheres to tissue, holding the catheter in place. Examples include and not limited to: Hickman, Broviac, Tesio.

Non-tunneled (the distal end of the catheter extends from the body at the vein insertion site and is sutured or secured to the skin using wings attached to the catheter. Usually short-term catheters. Examples include and not limited to: triple-lumen catheter (TLC), femoral catheter, and temporary dialysis/therapeutic catheter.

Nurses and advanced practice clinicians who have received initial education and demonstrated competency in performing the procedure may remove non-tunneled CVCs.-

Examples of Central Lines

- TLC (TRIPLE LUMEN CATHETER)
- PICC (PERIPHERALLY INSERTED CENTRAL CATHETER)
- PORTA CATH
- DIALYSIS CATHETER (PERMACATH / SHILEY)
  - **NOT SHUNTS!**

Nurses and advanced practice clinicians who have received initial education and demonstrated competency in performing the procedure may remove PICCs.

CLABSI Prevention Bundle: **Insertion**

For bedside procedures, a safety observer (RN or licensed independent provider) is required to be present during the insertion procedure to ensure aseptic and sterile technique is maintained throughout the duration of the procedure.

a. Safety observer is responsible for ensuring aseptic and sterile technique and completing the insertion checklist.

HRO in action-Stop the line

CLABSI Prevention II: Maintenance and Removal: Nurse Led

- ✔ **Maintenance**
  - ✔ Access appropriately “Scrub the Hub”
  - ✔ Daily site assessment
  - ✔ Catheter dressing management
  - ✔ IV tubing management
  - ✔ Antiseptic caps-Dual Caps
  - ✔ Daily chlorhexidine baths
- ✔ **Prompt Catheter Removal**
  - ✔ Review necessity daily (MDR, shift to shift handoffs)-Daily with MD
  - ✔ Document daily clinical necessity and maintenance bundle

DualCap®

Disinfection & Protection System

- Disinfects rapidly and automatically at both IV catheter points
- Locks in ongoing protection against intravascular infections
- For every patient with a **central line or peripheral line**
- Light blue cap for **every access point of IV tubing** including Peripheral IVs
- Dark blue **for end of IV tubing when disconnected**
- Single use only- if removed for any period of time, must replace with new cap
- Any additional access to the IV tubing requires ‘scrubbing the hub’ with an alcohol pad once the cap has been removed (flushing a med, administering an additional med)

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Products from PDI

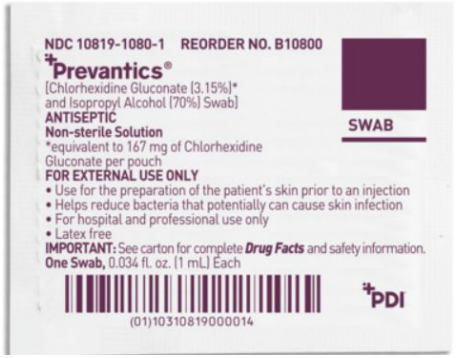
Antisepsis with 3.15% CHG + 70% Alcohol

Device Swab

Preferred Product for Scrub the Hub

5 Second Scrub Time

Skin Prep

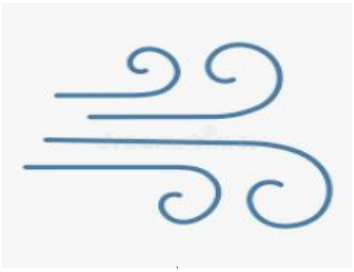


Use to prep the skin prior to IV insertion or blood culture collection

For patients >2 months old

15 Second Scrub Time

USE w/Dual Caps



Air Dry

Resources

[PDI Prevantics Device Swab FAQ]

[Device Swab Training Video]

[Skin Prep Training Video]

Description	PeopleSoft #
Prevantics Device Swab	8151921
Prevantics Skin Prep	PS 7012046

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Best Care Bundle: CLABSI MAINTENANCE

✔Sterile dressing change: * refer to site product dressing preference for CHG dressing

✔For **MAINTENANCE**: CVC site scrubbed with Chlorhexidine preparation for 60 seconds EACH SIDE of the swab stick and let dry 2 minutes with dressing change

✔Continuous maintenance IV tubing not used for blood/blood products / lipids replace at 96 hours; TPN / lipid infusion tubing replaced within 24 hours; blood / blood products as per policy.

✔Chlorhexidine bath daily for all patients *with central lines* in Medical-Surgical; daily for *all patients in ICU (be aware of contraindications / sensitivities with CHG)*

CHG Baths

- Appropriate body hygiene is necessary to decrease transmission of multidrug resistant organisms and to decrease the rate of hospital acquired infections.

- All patients with central venous access device defined as a catheter inserted into a large vein typically terminating in the superior vena cava of any kind over the age of 2 months will receive a daily bath with CHG.

- **ICUs and Oncology units must bathe all patients in the unit regardless of central line with CHG to reduce the bioburden of the unit.**

CHG Baths

All patients with a central line will have a CHG bath DAILY and AS NEEDED!

Incontinence:

- Clean with disposable Sage Bath washcloths or soap and water (these are CHG compatible).
- Apply CHG compatible barrier.
- Repeat throughout the day, as needed.

Lines and Tubes:

- CHG is safe on lines, tubes, and devices.
- Bathe with CHG right up to dressing.
- Urinary catheter care as per HMHN policy

Contraindications to CHG

- Patients with a known allergy or hypersensitivity to Chlorhexidine gluconate (CHG) should be bathed with facility approved soap and not CHG.
- Patients under 2 months of age.
- Patients with epidural or lumbar drains are excluded from this protocol.

CHG Baths

Chlorhexidine Gluconate replaces routine bathing for patients with Central lines, including Port a cath, PICC, Dialysis catheters, TLC.

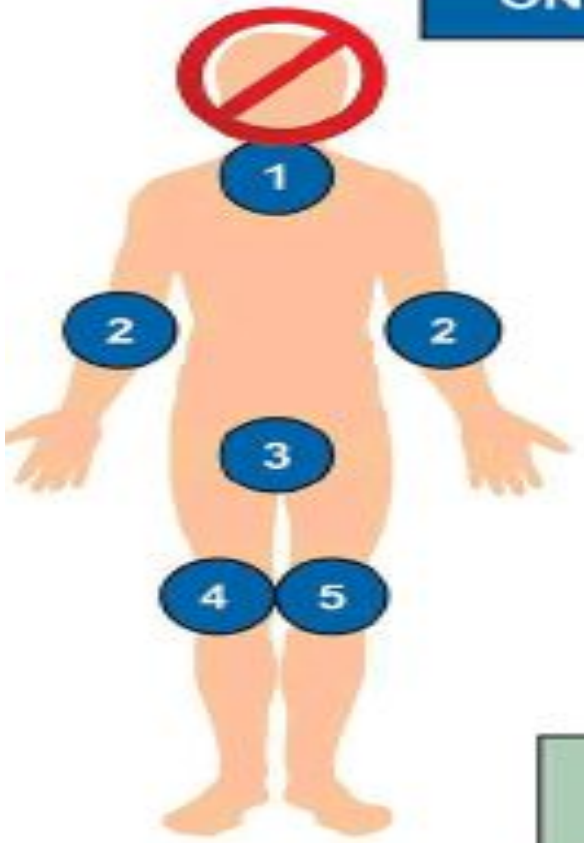
Do NOT use soap below the jawline. Certain soaps can inactivate CHG

Only use CHG compatible lotions and/or barrier products

Dispose of all cloths in the trash, do NOT flush

Bath with CHG using firm massage to remove Bacteria.

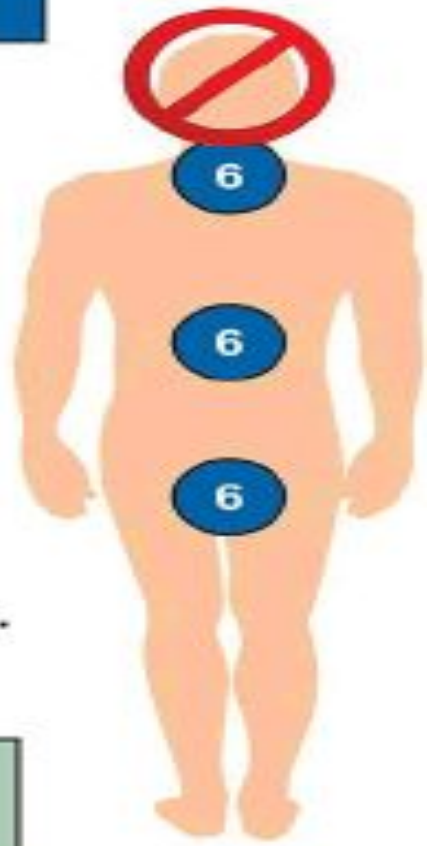
ONLY USE CHG CLOTHS *BELOW* THE JAWLINE



Front

1. Neck, shoulders, and chest.
2. Both arms and hands.
3. Abdomen then groin and perineum.
4. Right leg and foot.
5. Left leg and foot.
6. Back of neck, back, and then buttocks.

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



Back

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Peripheral Intravenous Catheter (PIV) Management in Adult patients

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Key Points in Inserting a Peripheral IV

- When the insertion site is changed, a new sterile IV administration set must be used for all infusions
- Blood samples may be obtained upon insertion and from indwelling short peripheral catheters
- Obtaining blood cultures from short peripheral catheters at insertion or during the dwell is ***not*** recommended
- All patients with continuous cardiac monitoring must maintain a patent intravenous access
- Remove peripheral IV catheters when clinically indicated, based on findings from site assessment and/or clinical signs and symptoms of systemic complications.
- *no more than 2 attempts per clinician* and limit total attempts to *no more than 4*. Notify LIP if unable to start Peripheral IV Catheter.
- Chlorhexidine (CHG) will be utilized on all IV access sites. If contraindicated, tincture of iodine, povidone-iodine, or 70% alcohol may be used.
- If no venous sites are visible or easily palpated, use vein visualization device (available in the unit)
- Label dressing with date, time, gauge, and inserter initials
- Disinfecting port protectors will be utilized on all peripheral IV catheters

Assessment of a Peripheral IV

Inspect and palpate site and dressing for signs and symptoms of infiltration/extravasation

Frequency of Assessment:

- ✔ At least every 4 hours on all in-patients receiving medications/fluids and as applicable for outpatients
- ✔ Every 1 to 2 hours for patients who are critically ill/sedated or have cognitive deficits
- ✔ Every hour for neonates/pediatric patients and patients receiving blood products
- ✔ Minimally every hour, or more often during continuous infusions of irritants, vesicants and vasoconstrictive agents

IV Site, Dressing, and Solution Change

IV Site	Remove peripheral IV catheters when clinically indicated based on findings from site assessment and/or clinical signs and symptoms of systemic complications. Change IV within 24 to 48 hours if inserted under emergent conditions or in the field.
Dressing	Routine dressing : at least every 5 days, but no longer than every 7 day Gauze dressings : at least every 2 days PRN when dressing becomes damp, loosened, and/or visibly soiled
Solution	every 24 hrs

CATHETER CARE MAINTENANCE

Administration Type	**Administration Set**	**Set Change Frequency**
Continuous	Primary and secondary sets	No more frequently than every 96 hours
Intermittent	Primary and secondary sets	Every 24 hours
Hemodynamic and arterial pressure monitoring	Disposable or reusable transducer and/or dome and other components of the system, including the administration set	Every 72 - 96 hours
Blood and Blood components	Continuous (may use 1 administration set for 2 units of PRBC as long as completed within 4 hours) or single unit	At end of 4 hour
Intravenous fat emulsion (IVFE)	Continuous or single unit	Every 24 hours
Parenteral nutrition	Continuous with intravenous fat emulsion	Every 24 hours
	Continuous without fat emulsion	Every 24 hours
	Cyclic or intermittent delivery	Every 24 hours
Propofol infusion		Every 6-12 hours

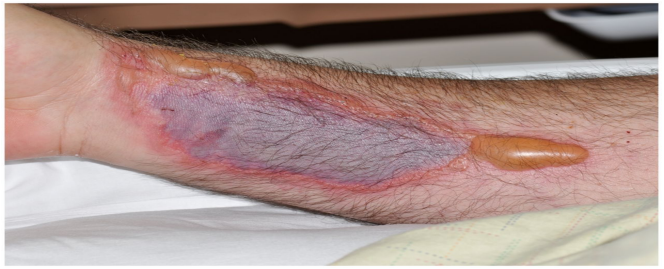
REPORTABLE CONCERNS: Policy Update

Phlebitis: the inflammation of a vein and may be accompanied by pain, erythema, edema, streak formation, and/or palpable cord.

- If phlebitis is present, perform the following:
  - Stop infusion (if applicable)
  - Notify LIP
  - Apply warm compress
  - Elevate limb
  - Administer analgesics, such as anti-inflammatory agents, if ordered by LIP
  - Complete occurrence reporting
- Additionally, perform the following based on the type of phlebitis:
  - Chemical phlebitis – evaluate infusion therapy and need for different vascular access, different medication, or slower rate of infusion; determine if catheter removal is needed.
  - Mechanical phlebitis – stabilize catheter, monitor for 24 to 48 hours; if signs and symptoms persist past 48 hours, remove catheter.
  - Bacterial phlebitis – remove catheter, monitor for signs and symptoms of systemic infection.

Standardized Phlebitis Scale to Document (Visual Phlebitis Scale)	
Score	**Observation**
0	IV site appears healthy
1	One of the following is evident: Slight pain near IV site OR slight redness near IV site
2	Two of the following are evident: · Pain at IV site · Erythema · Swelling
3	All of the following signs are evident: · Pain along path of cannula · Induration
4	All of the following signs are evident and extensive: · Pain along path of cannula · Erythema · Induration · Palpable venous cord
5	All of the following signs are evident and extensive: · Pain along path of cannula · Erythema · Induration · Palpable venous cord · Pyrexia

Extravasation/ Infiltration



Interventions:

- Immediately stop the infusion upon identification of infiltration/extravasation.
- Leave the existing IV catheter in place and disconnect the IV tubing
- Attempt to aspirate drug and amount obtained
- Notify MD/LIP and complete a Onelink incident report
- Follow the attached HMH-approved guidelines for Extravasation of Chemotherapy, Non-chemotherapy, vesicants, and irritants (see attached list of antidotes and extravasation algorithm)
- elevate affected extremity
- Monitor site every 4 hrs for 72 hrs and every shift thereafter. Monitoring may be adjusted as clinically needed

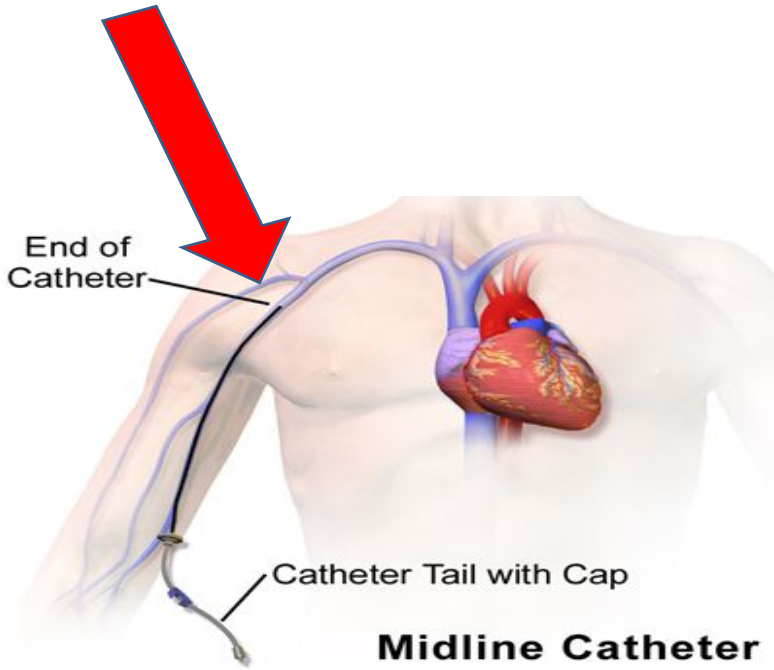
Documentation:

- Date, time and site of infiltration/extravasation
- Catheter type and size
- Physician or LIP notified, medication administered, method of administration and estimated volume of fluid that escaped into the tissue
- Patient complaints or experience during the infiltration/extravasation
- The last time blood return was checked prior to suspected infiltration/ extravasation
- Appearance of access site

Peripheral Line
Midline Catheter

Midline Catheter

- NOT a central venous catheter
- Tip of the catheter placed at or below the axillary vein (not in the great vessels)
- Peripherally inserted 8-25 cm in length
- Secured using sutures or Statlock
- Reduces risk of insertion complications associated with central venous catheters



Midline Catheter - Key Points

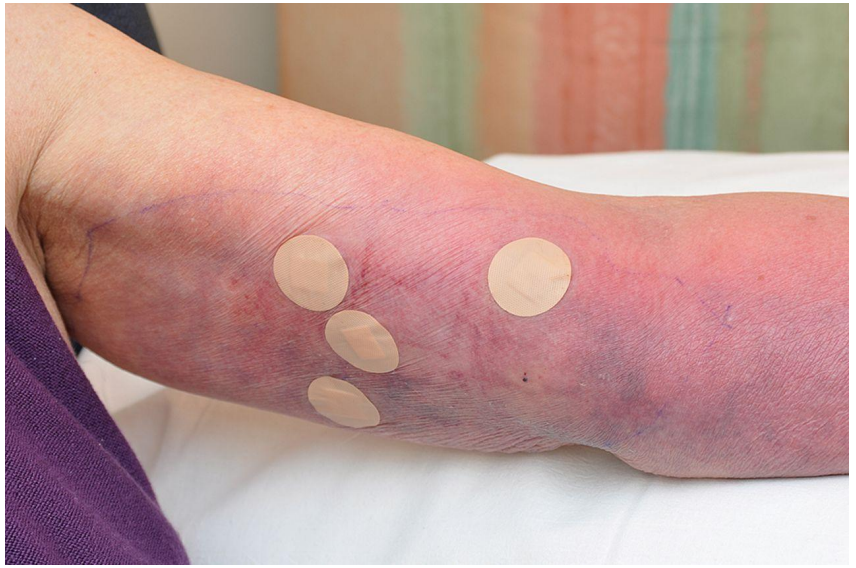
- Prior to use, obtain provider order to use (and remove) midline
- Max dwell time is 28 days - LIP order is required to maintain beyond max dwell time
- No blood pressure proximal to midline (can use forearm if necessary)
- May be used for blood sampling (if blood return present)
- Cannot use Cathflo® Activase® (alteplase) for catheter clearance - contraindicated

Midline Catheter

- X-ray confirmation of tip not necessary prior to use, but can be used to assess placement if there is a concern
- Can only be used for CT contrast (power injection) if blood return is verified
- Measure arm circumference on insertion and when clinically indicated
  - 10cm above antecubital fossa
  - 3cm increase +/- edema - call MD

Midline Catheter

- Use with caution for some medications classified as irritants/vesicants
- During emergency, medications can be administered via midline for a short period of time (except chemotherapy) but once patient stabilized need alternate access
- It is safe to administer blood products through midline catheter
- Incompatible intravenous medications cannot be infused via dual lumen midline



RED = Not recommended, high risk of phlebitis

YELLOW = Use caution and increase monitoring, intermediate risk of phlebitis.

STOP **DO NOT GIVE VIA MIDLINE CATHETER**	• **Calcium Chloride** [vesicant] • **Chemotherapy** [vesicant] • **Dextrose solution ≥ 12.5%** [vesicant] • **Dopamine > 5 mcg/kg/min** [vesicant] • **Epinephrine** [vesicant] • **3% Hypertonic saline** [vesicant] • **Mannitol (≥20%)** [vesicant] • **Nafcillin** (*cont. infusion*) [vesicant] • **Norepinephrine** [vesicant] • **Parenteral Nutrition** [vesicant] • **Phenylephrine** [vesicant] • **Potassium replacement** [vesicant at conc > 10 mEq/100mL] • **Vasopressin** [vesicant]	**CENTRAL LINE IS REQUIRED** **HIGH RISK OF PHLEBITIS**
USE CAUTION **THROUGH MIDLINE CATHETER** **INCREASE MONITORING**	• **Acyclovir** {irritant} • **Aminophylline** (*intermittent*)[vesicant] • **Amiodarone** < 2mg/mL [vesicant] • **Calcium Gluconate** [vesicant] • **Dextrose 10% - 12.4%** *(infusion)* [vesicant] • **Dobutamine** [vesicant] • **Dopamine ≤ 5 mcg/kg/min** [vesicant] • **Iron Sucrose** {irritant} • **Pamidronate** • **Pentobarbital** {irritant} • **Phenobarbital** {irritant} • **Phenytoin** [vesicant] • **Potassium replacement** [≤ 10 mEq/100mL] {irritant} • **Sodium Bicarbonate** (*Infusion)* [vesicant]	**INTERMEDIATE RISK OF PHLEBITIS** **Use caution and increase monitoring by visually inspecting the site with each administration**

MIDLINE

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GREEN - Low risk of phlebitis

GO **MAY ADMINISTER VIA MIDLINE CATHETER**	**If a medication is acceptable to be given peripherally, then it is acceptable to be administered via a midline catheter unless otherwise indicated.** **The following medications can be administered via midline:** • **Amphotericin B** • **Doxycycline** {Irritant} • **Erythromycin** {Irritant} • **Esmolol** [vesicant] • **Ferric Gluconate** • **Imipenem/Cilastatin** • **Nafcillin (intermittent)** [vesicant] • **Oxacillin** • **Propofol** **The following medications have restrictions listed below:** • **Vancomycin** (for ≤ 14 days duration) {Irritant}	**LOW RISK OF PHLEBITIS**

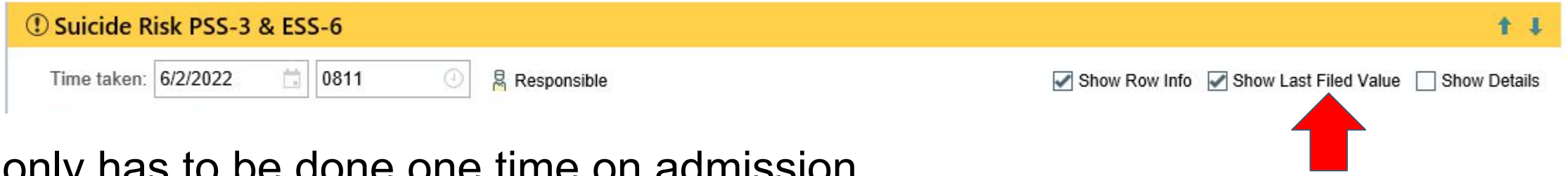
- During an emergency, medications can be administered via a midline for a short period of time (except chemotherapy). Once patient is stabilized, the recommended access must be obtained.

M I D L I N E

HMH Suicide prevention

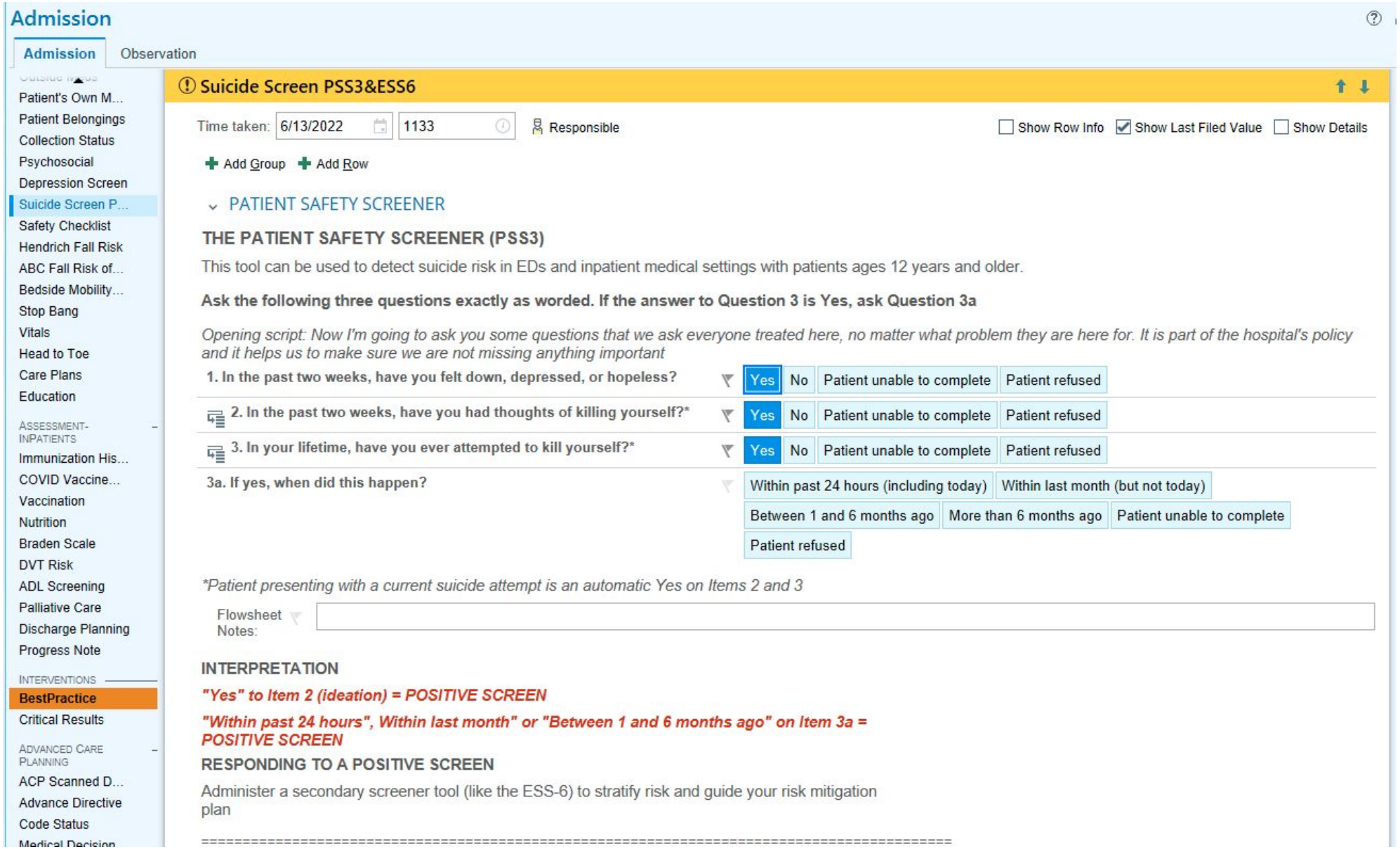
Suicide Risk Assessment

When admitting a patient, check to make sure that the patient's PSS-3/ESS-6 was done,complete the screening



- It only has to be done one time on admission.
- In order to view the results **and verify the assessment is completed correctly** utilize **last filed value**.
- If patient has a positive screen, follow policy for interventions:

HMH Suicide Risk Screening, Assessment and Prevention Process



- **Step 1:** Complete the PSS-3 if it is not yet done
- A positive PSS-3 screening will trigger the ESS-6 to populate

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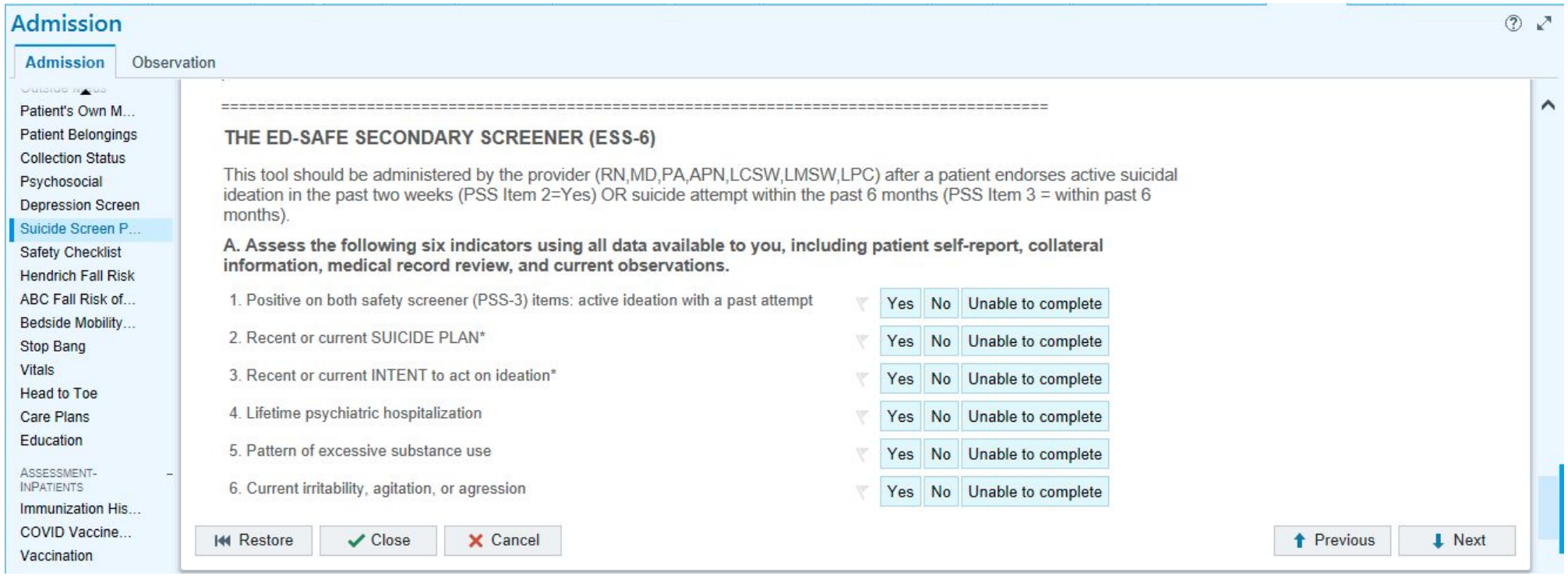

Answering yes to both plan **and** intent will put the patient at high risk. The patient will be placed on 1:1 observation as per policy.

A positive score for either plan **or** intent will put the patient at moderate risk. The patient is to be placed on a 1:1 observation

-If neither question regarding plan or intent are positive the patient is at mild risk and is to be placed on a 1:1 observation.

In ALL cases the provider is to be notified for further action..

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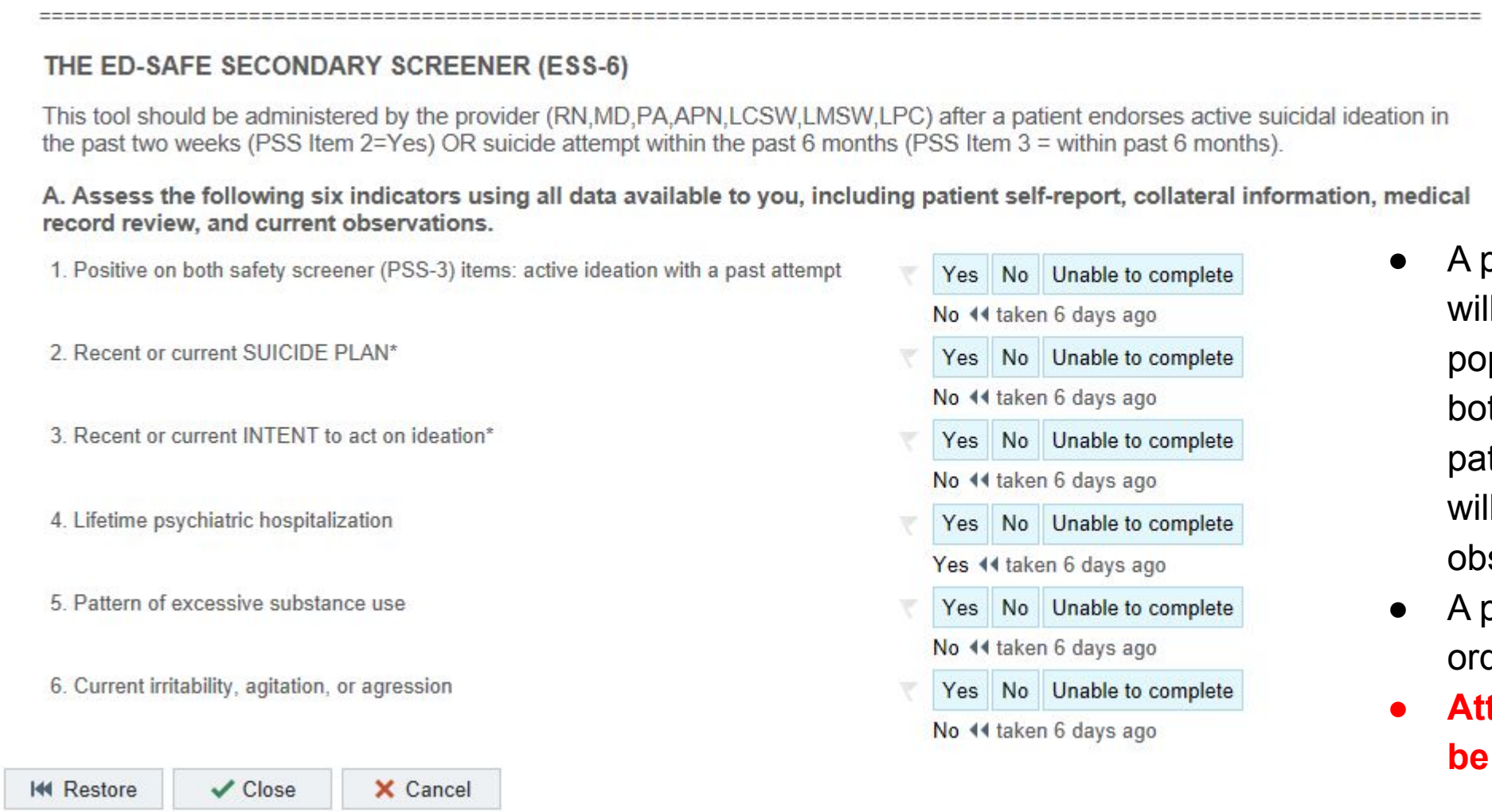

THE ED-SAFE SECONDARY SCREENER (ESS-6)

This tool should be administered by the provider (RN,MD,PA,APN,LCSW,LMSW,LPC) after a patient endorses active suicidal ideation in the past two weeks (PSS Item 2=Yes) OR suicide attempt within the past 6 months (PSS Item 3 = within past 6 months).

A. Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations.

1. Positive on both safety screener (PSS-3) items: active ideation with a past attempt — Yes | No | Unable to complete — No ◂◂ taken 6 days ago
2. Recent or current SUICIDE PLAN* — Yes | No | Unable to complete — No ◂◂ taken 6 days ago
3. Recent or current INTENT to act on ideation* — Yes | No | Unable to complete — No ◂◂ taken 6 days ago
4. Lifetime psychiatric hospitalization — Yes | No | Unable to complete — Yes ◂◂ taken 6 days ago
5. Pattern of excessive substance use — Yes | No | Unable to complete — No ◂◂ taken 6 days ago
6. Current irritability, agitation, or agression — Yes | No | Unable to complete — No ◂◂ taken 6 days ago

⏮ Restore | ✔ Close | ✖ Cancel

- A positive score on the PSS-3 will trigger the ESS-6 to populate. Answering yes to both plan **and** intent will put the patient at high risk. The patient will be placed on 1:1 observation.
- A psychiatric consult should be ordered
- **Attending provider needs to be notified of positive screen**

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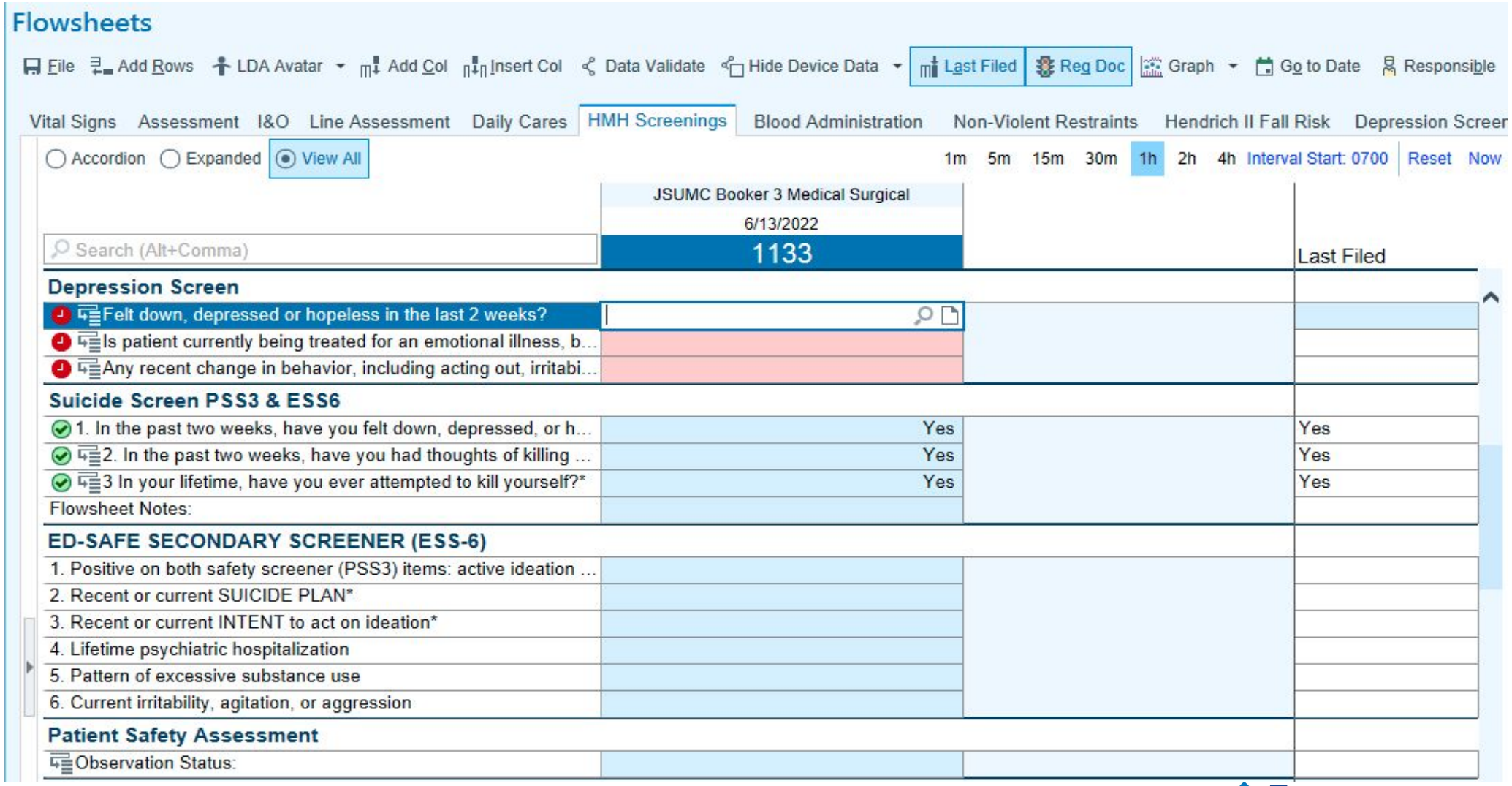
EPIC View from Flowsheet



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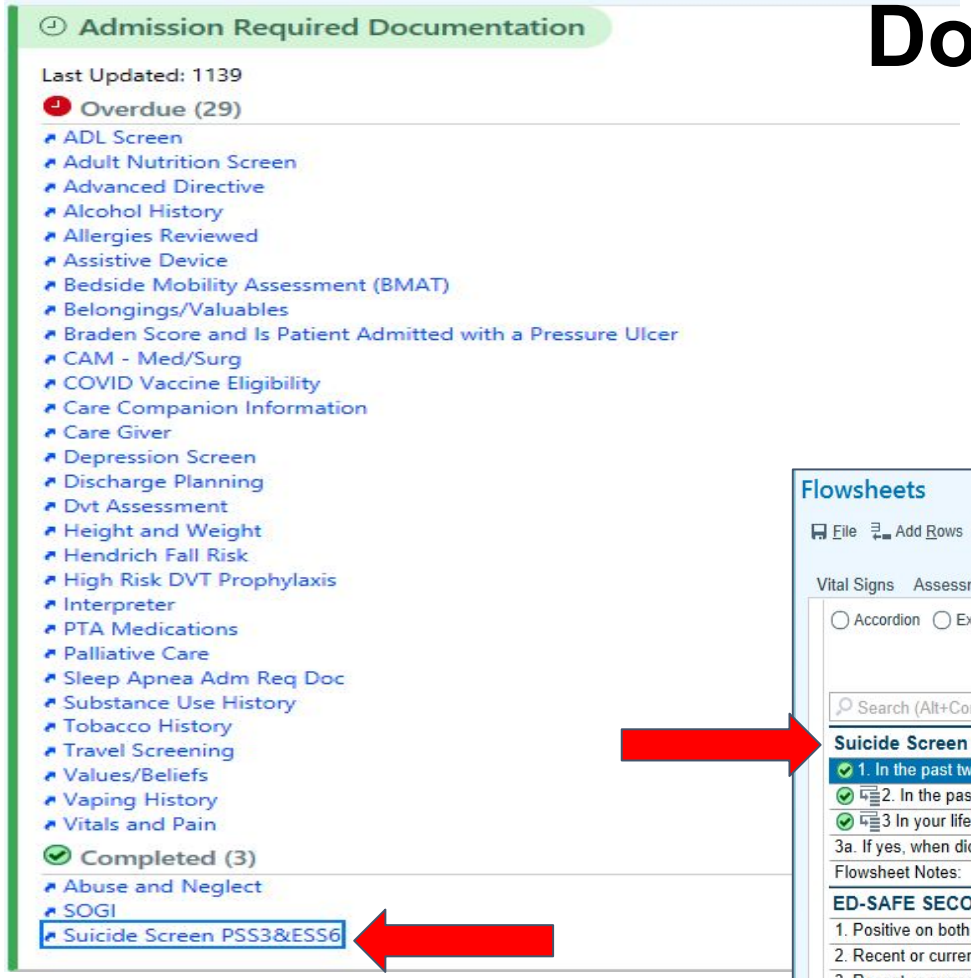
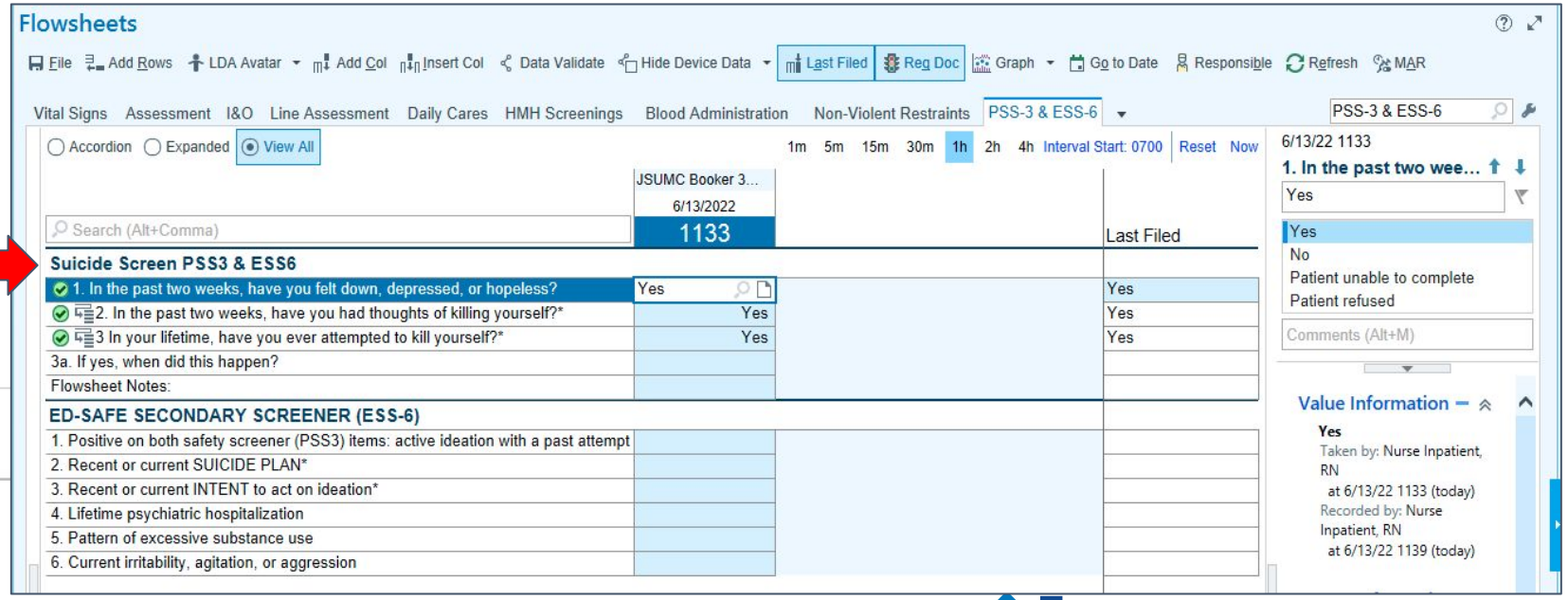
View of Suicide Screen in Admission Required Documentation





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Pediatric Suicide Risk Screening for Ages 8yrs-17yrs old

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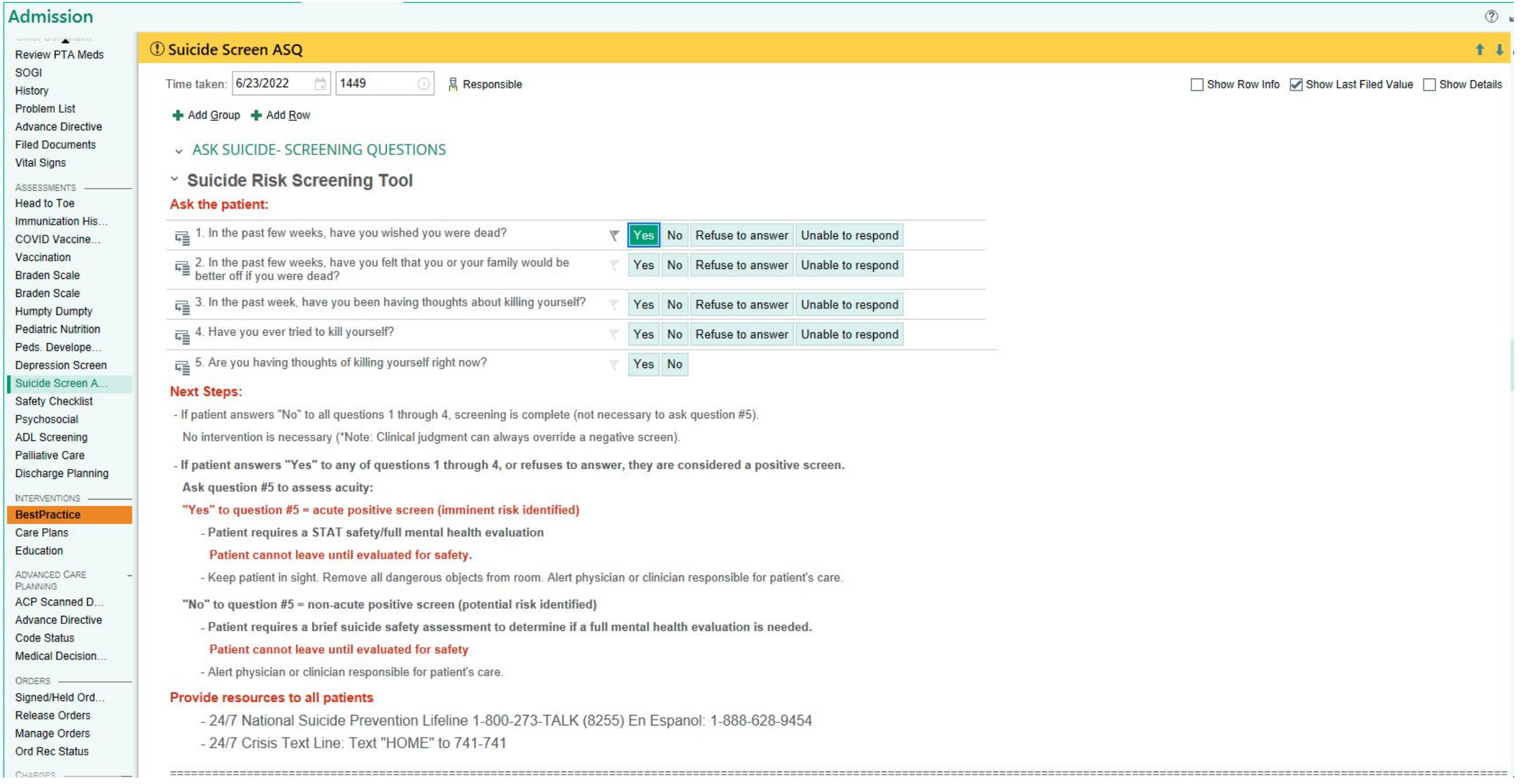
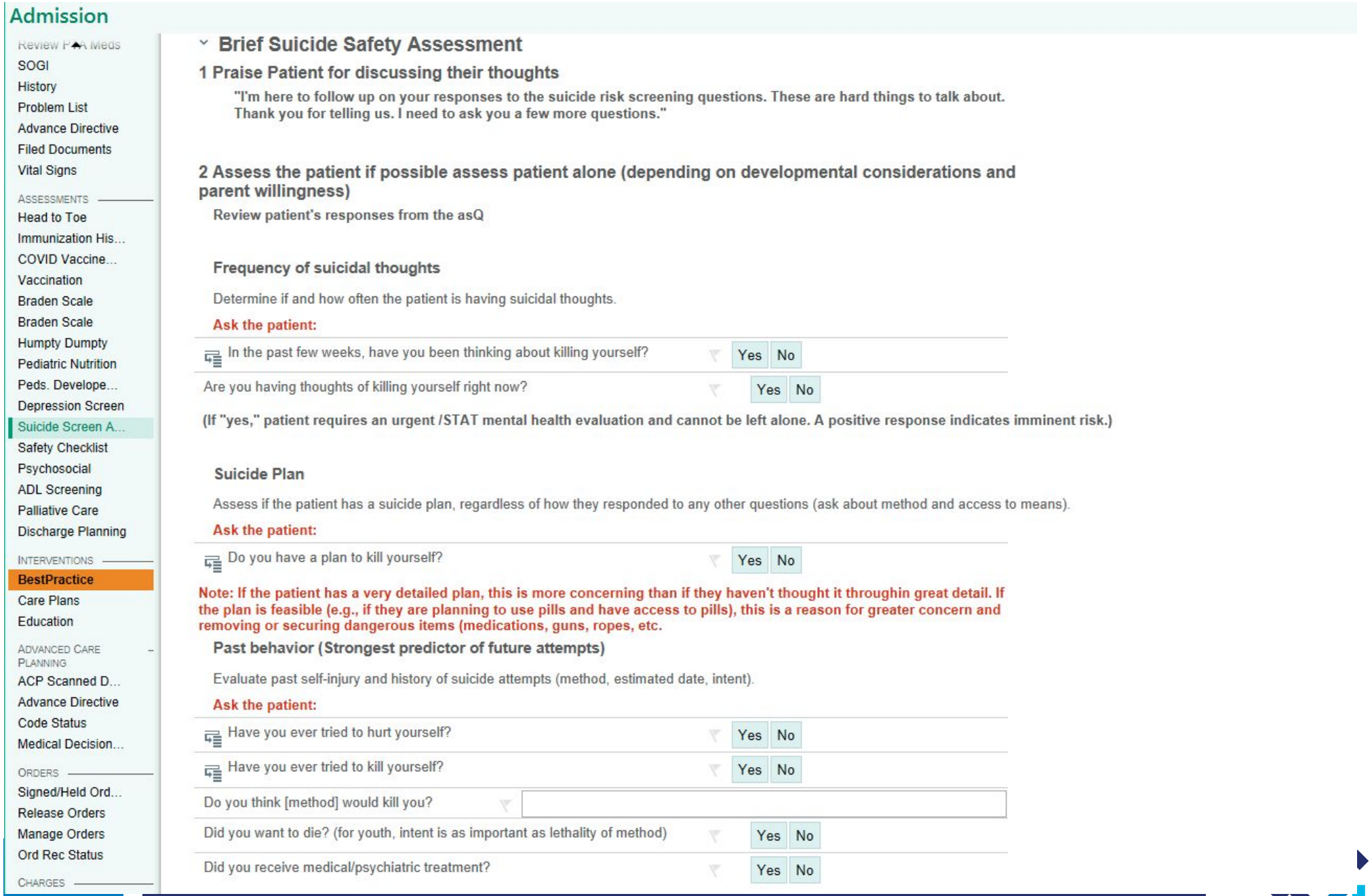
ASQ Suicide Screen in Admission Navigator for Pediatrics





Complete the ASQ if it is not yet done. **Remember to check for last filed.**

A positive ASQ screening will trigger the Brief Suicide Safety Assessment to populate and you must **immediately** place the patient on a 1:1 observation and notify provider.

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Admission

Review PA Meds
SOGI
History
Problem List
Advance Directive
Filed Documents
Vital Signs

ASSESSMENTS
Head to Toe
Immunization His...
COVID Vaccine...
Vaccination
Braden Scale
Braden Scale
Humpty Dumpty
Pediatric Nutrition
Peds. Develope...
Depression Screen
Suicide Screen A...
Safety Checklist
Psychosocial
ADL Screening
Palliative Care
Discharge Planning

INTERVENTIONS
BestPractice
Care Plans
Education

ADVANCED CARE PLANNING
ACP Scanned D...
Advance Directive
Code Status
Medical Decision...

ORDERS
Signed/Held Ord...
Release Orders
Manage Orders

Symptoms

Depression:

In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do? Yes No

Anxiety:

In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge? Yes No

Impulsivity/Recklessness:

Do you often act without thinking? Yes No

Hopelessness:

In the past few weeks, have you felt hopeless, like things would never get better? Yes No

Irritability:

In the past few weeks, have you been feeling more irritable or grouchier than usual? Yes No

Substance and alcohol use:

In the past few weeks, have you use drugs or alcohol? Yes No

Other concerns:

Recently, have there been any concerning changes in how you are thinking or feeling? Yes No

Support & Safety

Support network:

Is there a trusted adult you can talk to? Yes No

Who?

Have you ever seen a therapist/counselor? Yes No

Safety question:

Do you think you need help to keep yourself safe? (A "no" response does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety) Yes No

Reason for living:

What are some of the reasons you would NOT kill yourself?

Review PRN Meds
SOGI
History
Problem List
Advance Directive
Filed Documents
Vital Signs
ASSESSMENTS
Head to Toe
Immunization His...
COVID Vaccine...
Vaccination
Braden Scale
Braden Scale
Humpty Dumpty
Pediatric Nutrition
Peds. Develope...
Depression Screen
Suicide Screen A...
Safety Checklist
Psychosocial
ADL Screening
Palliative Care
Discharge Planning
INTERVENTIONS
BestPractice
Care Plans
Education
ADVANCED CARE PLANNING
ACP Scanned D...
Advance Directive
Code Status
Medical Decision...
ORDERS
Signed/Held Ord...
Release Orders
Manage Orders
Ord Rec Status
CHARGES
Charge Capture

3 Interview patient and parent /guardian together

***If patient is >= 18 ask patient's permission for parent to join.**

Say to the parent:

"After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

Your child said (reference positive responses on the asQ). Is this something he/she shared with you?	Yes No
Does your child have a history of suicidal thoughts or behaviors that you're aware of?	Yes No
Does your child seem sad or depressed?	Yes No
Withdrawn?	Yes No
Anxious?	Yes No
Impulsive?	Yes No
Hopeless?	Yes No
Irritable?	Yes No
Reckless?	Yes No
Are you comfortable keeping your child safe at home?	Yes No
How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)	
Is there anything you would like to tell me in private?	

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

- ○ Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry, keep patient safe in ED
- ○ Further evaluation of risk is necessary: Request full mental health/safety evaluation in the ED
- ○ No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous item (medications, guns, ropes, etc.)

○ Send home with a safety plan ○ No further intervention is necessary at this time

5 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK(8255), En Espanol: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Key Points:

- A validated tool will be used to screen and an evidenced based process will be used to assess patients in the hospital, in behavioral health settings and in outpatient/ambulatory settings as applicable for their risk for suicide
- At any point in the screening process, a RN may initiate site specific **Suicide/Safety Precautions-HMH Safety Precautions and Observation Guidelines**
- All individuals who screen positive on the PSS 3 or ASQ should have appropriate precautions in place to ensure their safety during their care encounter.
- A positive screen requires immediate provider notification and 1:1 supervision
- For those patients deemed "at risk" for suicide an evidenced based safety plan will be completed with the patient at discharge in all settings
- Hand-Off communication for patients must include the screening results on either the PSS3, ASQ and/or the Patient Safety Secondary Screener as well as safety precautions that are in place
- Every patient has the right to a safe environment that is appropriate to their clinical condition, including environmental safety for those patients identified to be at risk for suicide
- Completion of the screening tool(s) and assessment will result in a suicide risk stratification that will be documented in the electronic health record.

Policy Reference: *Suicide Risk Screening, Assessment and Prevention Process*

Key Points:

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Safety Precautions and Observation Guidelines for Risk of: Elopement or Harm to Self or Others

1:1 Observation : is a method of patient treatment/management in which a care provider maintains continuous visual observation with the ability to immediately intervene when necessary until such time as the physician discontinues the need for constant 1:1 observation.

1:1 Observer: is a team member who has taken the Patient Observation Course and has completed the necessary competencies to perform 1:1 patient observation.

Elopement Risk: when a patient is at risk for leaving the unit in an unexpected, unauthorized manner

It is the policy of HackensackMeridian to provide a safe environment for patients, team members, medical staff, and visitors by addressing the care of patients who are at risk of harm to self or others, including risk for suicide, homicide, violence, and any safety concern including elopement risk.

RESTRAINTS

Follow HMH Nursing General Enterprise Policy: Restraints Policy

Policystat ID 11540527

All patients have the right to be free from restraints, of any form, that are not clinically determined to be necessary, or are used as a means of coercion, discipline, convenience, or retaliation by staff.

The use of restraints/seclusion is an exceptional event, initiated after alternatives have been unsuccessful.

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RESTRAINTS

Restraints are used to prevent serious disruption of treatment, to prevent imminent harm to the patient, others or to the environment and are limited to the following two situations; non-violent disruption of treatment and violent, self-destructive behavior.

Seclusion is a type of restraint. Seclusion may be used only for the management of violent or self-destructive behavior

Licensed Practitioner (LP) - For the purpose of ordering restraint or seclusion, an LP is any practitioner permitted by State law and hospital policy as having the authority to order restraints or seclusion for patients

A resident who is authorized by State law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LP by the regulation

- A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore he/she is not licensed or independent
- A medical school student is not an LP. A Nurse Practitioner or Physician's Assistant is an LP

	Non-Violent	Violent, Self-Destructive	
Order Parameter **(Time Limit)**	Every 24 hours	Adult Age 9-17 years Age < 9 years	Every 4 hours Every 2 hours Every 1 hour
Evaluation by LIP			
Face to Face Evaluation	Within one hour of initial order	Within one hour of initial order	
Subsequent Evaluation	At least once every 24H	At least once every 24H	
Nursing Care			
Visual Observation	Continuous or periodic	Monitor at all times **1:1 observer**	
Documentation of visual observations	Minimum every **2 hours**	Every **15 minutes** for 1:1	
Vital Signs	Every 2 hours	Every 2 hours	
Nursing Assessment and Interventions	Same for both Violent, Self-Destructive and Non-Violent Indication. Interventions include Plan of Care, Patient and Family Education		

Additional TimeFrames

Every Two (2) hours:

- Mental status
- Cognitive function
- Current behaviors indicating need for restraints
- Circulation and skin assessment
- Vital Signs
- Clinical status with re-evaluation for the continuing need for restraints
- Release of Restraints to:
    - Assess skin circulation and integrity
    - Perform skin care
    - Perform range of motion at a minimum of 5 minutes/limb
- Patient comfort needs inclusive of:
    - Fluids and Nutrition offered
    - Repositioning
    - Toileting

Every Four (4) hours:

- Ambulation if clinically feasible

Every twenty-four (24) hours

- Hygiene needs

Removal Guidelines

Restraints may be removed and or discontinued in accordance with the original physician's or other LIPs order.

- When agitation is decreased
- When the patient is able to verbalize the behavior leading to restraint/seclusion and the expectation for release
- When the patient is in control of behavior and no longer a harm to self or others
- Time of removal and behavior that supports removal should be documented.

Restraints should be removed as soon as safely feasible regardless of when the order expires.

Universal Transfer Form (UTF)

2022 HMH Updates on UTF applicability

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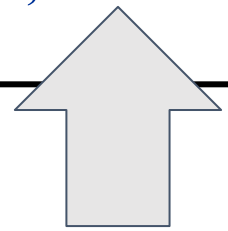
Universal Transfer Form

- A state-wide, mandatory use “transfer form”
- Inpatient / resident transfers between licensed health care facilities and programs. Including Home Care.

To / From	□□	From / To
Hospital	□□	Hospital
Hospital	□□	SNF, NF, ALF, Sub-acute Care, Home Care
SNF, NF, ALF, Sub-acute Care, Home Care	□□	SNF, NF, ALF, Sub-acute Care, Home Care



Process:(In December 2021, the Universal Transfer Form converted to an **Electronic Format** in **EPIC)**

Upon discharge to another healthcare facility or going home with home care services:

1. All sections of the UTF will be completed to the best of the licensed healthcare facility or program's ability.

The UTF is not complete if medication information is not attached.

2.Send a completed, paper copy of the UTF and the medication list with a patient when a patient is transferred.

3 Retain a completed copy of the UTF and medication list sent with a patient when a patient is transferred as part of the patient's medical record.

Code Stroke: Recognize the Warning Signs

Code Stroke: The acute treatment window for patients identified with stroke-like symptoms with last known well within 24 hours and will continue until the decision is made regarding acute treatment options as recommended by Code Stroke Neurologist (thrombolytics/endovascular or neurosurgical intervention).

BE FAST: sudden change in **B**alance, **E**yes/vision, **F**acial symmetry, **A**rm or leg weakness, **S**peech changes) relies on critical, **T**ime-sensitive care management to reduce cerebral tissue damage.

- Sudden change in Balance, dizziness, vertigo, ataxia, or incoordination
- Sudden change in vision
- Sudden change in motor strength and/or sensation to the face, arm, or leg on one side
- Sudden difficulty in understanding or producing speech
- Sudden change in the level of consciousness
- Sudden severe headache with no known cause

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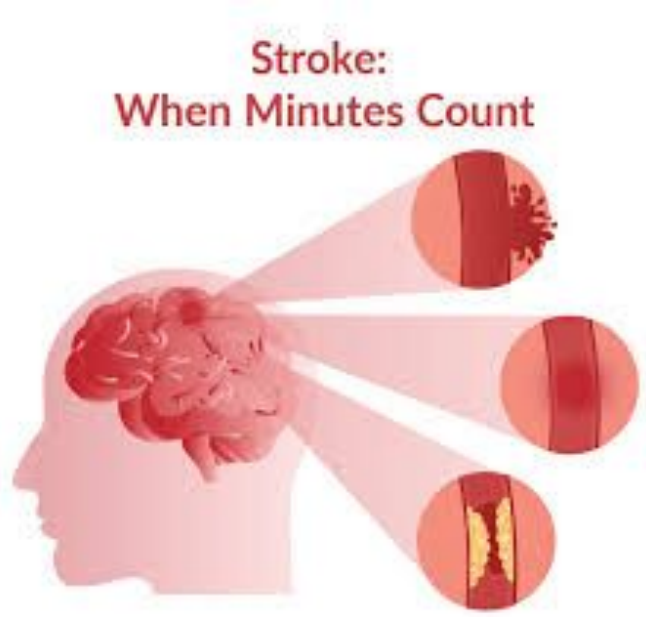
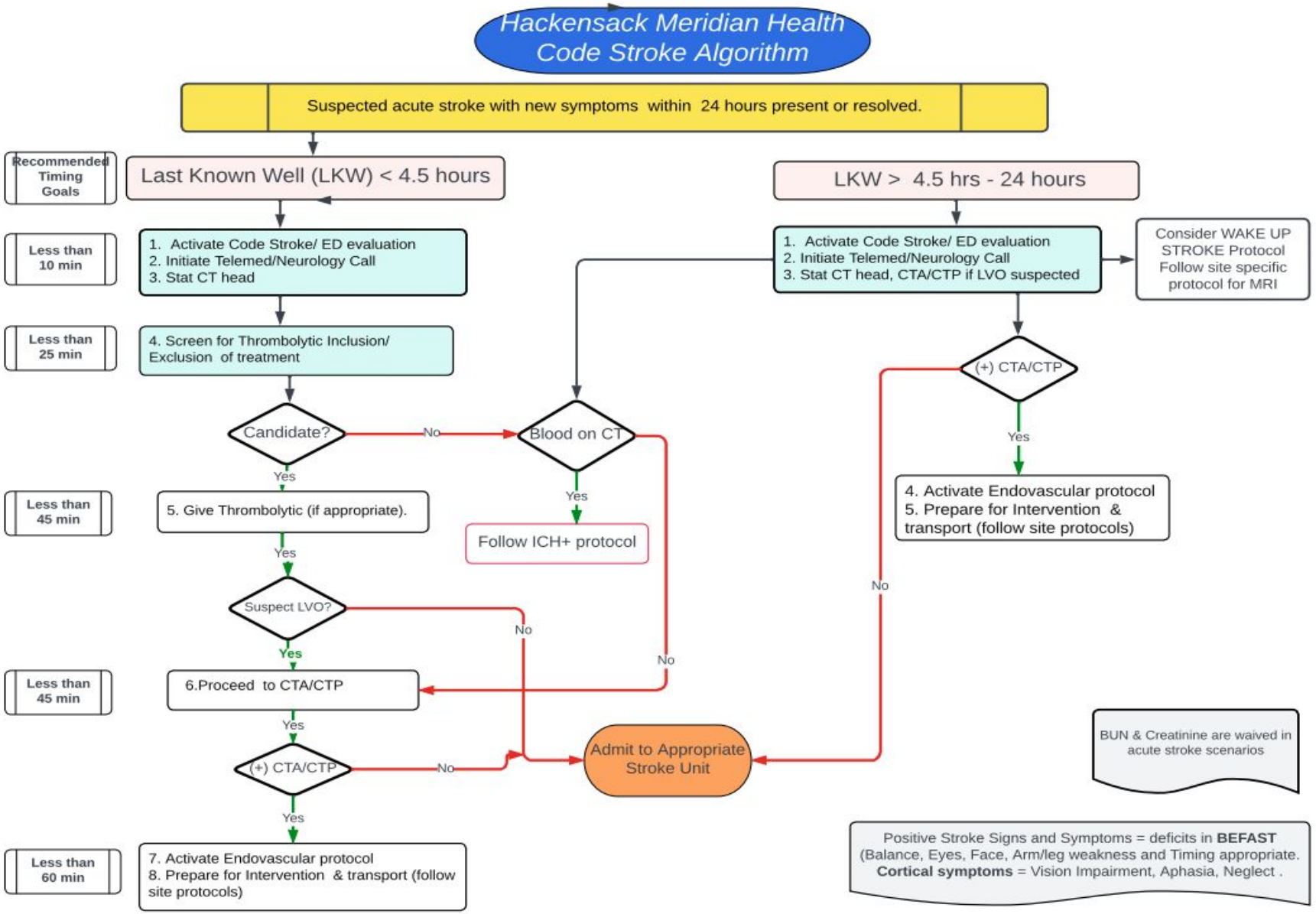
If you suspect stroke: recall immediate goals of treatment

- Reduction of brain injury
- Restore blood flow to the ischemic core
- Preserve the Penumbra (viable tissue around ischemic core)
- Hemodynamic stability
- Airway protection - ABCs. Maintain oxygenation



Call the Rapid Response Team!!! Ascertain Last Well Known (LWK): the date and time at which the patient was last known to be without the signs and symptoms of the current stroke or in their normal state of health.



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National Institute of Health (NIH) Stroke Scale

To be completed by NIH Certified RN/APN/Physician when stroke is suspected.

NIH Stroke Scale Score	Stroke Severity
0	No stroke symptoms
1-4	Minor stroke
5-15	Moderate stroke
16-20	Moderate to severe stroke
21-42	Severe stroke

Screening Checklist for IV Thrombolytic for Acute Ischemic Stroke With careful consideration and the weighing of the risks vs. benefits, patients may receive fibrinolytic therapy despite one or more precautions. Complete hemianopia, severe aphasia, and visual or sensory extinction are considered potentially disabling despite NIHSS score.

Precautions:

Yes	No	
		Blood glucose 50 mg/dl or below, or 400 mg/dl or above (may treat abnormals and reassess)
		Documented left heart thrombus (IIb)
		Seizure at the onset of stroke; consider post-ictal phenomenon
		Recent MI within 90 days (IIa)
		Pregnancy and early post-partum < 14 days
		Risk of bleeding from acute pericarditis, hemostatic defects; hemorrhagic ophthalmic conditions; septic thrombus, or occluded AV cannula.
		Presence of intracranial conditions that may increase the risk of bleeding (AVM or large intracranial aneurysm)
		Major surgery or severe trauma within 14 days
		Lumbar puncture/Arterial puncture at noncompressible site in the previous 7 days (IIb)

**The conditions listed under precautions are not preclusions to treatment, but should be considered in assessing the individual risks and benefits for tenecteplase administration.

Screening Checklist for IV Thrombolytic for Acute Ischemic Stroke: Exclusions

Yes	No	(YES = DRUG CONTRAINDICATED)
		Evidence of intracranial hemorrhage on non-contrast head CT
		High clinical suspicion of subarachnoid hemorrhage, even with normal CT scan
		History of previous intracranial hemorrhage, intra-axial neoplasm,
		Elevated blood pressure, unresponsive to treatment (systolic BP >185 and/or diastolic BP >110)
		History of stroke, head trauma, intracranial or intraspinal surgery in the previous 90 days
		Structural GI malignancy or recent GI bleeding event within 21 days
		Active internal bleeding
		Suspicion of infective endocarditis
		Suspicion of aortic arch dissection
		Coagulopathy: platelet count <100000/mm^3 INR > 1.7 | aPTT > 40 seconds | PT > 15 seconds
		Receipt of treatment dose low molecular weight heparin (LMWH) in past 24 hours and aPTT is greater than 40 seconds
		Taking an oral anticoagulant and INR is greater than or equal to 1.7
		Currently using Apixaban (Eliquis), Dabigatran (Pradaxa), Edoxaban (Savaysa) or Rivaroxaban (Xarelto) within 48 hrs
		Extensive regions of hypodensity suggesting irreversible damage; or mild non-disabling stroke

Code Stroke: Treatment Decision/ Protocol

- Emergency Department(ED) Code Stroke Activation:
  - Patients presenting with BEFAST stroke-like symptoms within 24 hours of last known well (LKW). The ED Code Stroke order set is implemented as appropriate

- Medical Alert Adult-Inpatient Code Stroke:
  - The first responder should immediately activate the Rapid Response (RRT)/ Code Stroke Team by dialing #7777
  - The Rapid Response Team initiates Advanced Cardiac Life Support (ACLS) protocols for acute stroke and performs the NIH screening examination using BE FAST
  - If there is clinical suspicion of acute stroke, the Rapid Response Team leader will immediately call the operator to page Medical Alert Stroke Team

- Follow site-specific protocol/algorithm
- Neurology consultation is STAT
- Decision to Treat: With the recommendation of the On-Call Neurologist, the ED provider, the Hospitalist, or Stroke practitioners may enter the order for thrombolytic medication
- The On-call neurologist/designee will discuss candidacy for mechanical thrombectomy with the Endovascular physician provider and follow site-specific protocol

Informed Consent 2024

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May 15, 2024 HMH Released the New Harmonized Informed Consent Policy and Informed Consent Forms

All RN's are responsible for reviewing the new harmonized policy in PolicyStat to acknowledge topics not covered in this presentation.

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Policy & Purpose Statement

It is the policy of Hackensack Meridian Health ("HMH" or the "Network") to respect patients' right to make informed decisions about all aspects of their health care. Mutual respect and consideration for the patient's personal preferences, values, expectations and goals of care are incorporated in the personal plan of care and the informed decision making process.

Surgery or non-operative/invasive procedures ("Surgery or Procedures"), the administration of anesthesia services ("Anesthesia Services"), Critical Care and Emergency Medicine Sedation and Analgesia for Procedures ("Sedation"), and Transfusions of Blood, Blood Products, or Both ("Blood Transfusions"), identified in medical staff and hospital policies require the patient's written Informed Consent. The purpose of this Informed Consent Policy ("Policy") is to set forth the required elements of the Informed Consent processes as determined by HMH, including the Informed Consent forms required to be used at all Network facilities, as set forth in Section 8.A of this Policy, to document the occurrence of the Informed Consent process.

Who is a “Responsible Practitioner”?

A Responsible Practitioner is a physician who is a doctor of medicine or osteopathy, dentist, podiatrist, optometrist or chiropractor, or a licensed practitioner (“LP”), such as an advanced practice practitioner (“APP”), physician assistant (“PA”), advanced practice nurse (“APN”) including a certified registered nurse anesthetist (“CRNA”), nurse practitioner (“NP”) and a certified nurse midwife (“CNM”) who is a member of the medical staff with medical privileges, and who has primary responsibility for performing the Surgery or Procedures or administering Anesthesia or Sedation.

What must the Responsible Practitioner discuss with the Patient or Surrogate to Obtain Informed Consent?

- The name and description of the proposed surgery or procedures, anesthesia services, sedation, or transfusion of blood, blood products or both
- The material risks and potential complications, including the possible duration of incapacitation (i.e., the expected period of time that the patient is unable to make medical decisions), anticipated benefits, and alternatives, as well as the likely outcomes if the surgery or procedures, anesthesia services, sedation, or blood transfusions are refused
- Whether the patient has existing Do Not Attempt Resuscitation ("DNAR") and/or Do Not Intubate/Airway Management ("DNI/Airway Management") Orders and the conditions and timeframes under which the DNAR and/or DNI/Airway Management Orders will be active, revised, suspended, and reinstated (based on clinical indicators)
- Significance of the patient's Informed Consent and provides a sufficient and timely opportunity to ask questions

Informed Consent Adult Patient's Designated Surrogate Decision-Maker

The Responsible Practitioner and Anesthesiologist must be satisfied that the patient has the ability to understand and appreciate the nature and consequences of the particular decision at hand involving the proposed treatment or procedures, and the ability to reach a reasoned decision based upon this information.

If the patient lacks decisional capacity to make the decision at hand, the patient's designated surrogate decision-maker ("surrogate") and standards for surrogate decision-making are determined according to applicable HMH policies.

A nurse may witness the patient's (or surrogate decision makers) signature on the consent form. If the patient (or surrogate) has questions or hasn't received all the necessary information, the nurse should wait to witness the signature until the practitioner or other health care provider who will perform the procedure addresses all the patient's (or surrogate's) concerns.

In this situation, the nurse should be alert for communication from the patient (or surrogate) that indicates a lack of understanding. If such a concern arises, the nurse should report the concern using the proper chain of command established in the facility.

Informed Consent for Minors

Except in an emergency, the authorization of the minor's parent or legal guardian for Surgery or Procedures, anesthesia services, sedation and analgesia, and blood administration must be obtained and the Informed Consent forms signed by at least one (1) parent or the legal guardian.

In an emergency, the Responsible Practitioner will proceed without the written informed consent of the parent or legal guardian. A ONELink will be generated and the medical reason documented in the minor's medical record. The parent or legal guardian's informed consent should be obtained in writing as soon as possible after the treatment.

In certain circumstances, a court order provides guidance on legal custody of the minor. If both parents have legal custody, then unless otherwise stated in the court order, either parent who has legal custody may consent. If sole custody is granted to one parent, only the parent with sole custody may provide Informed Consent.

Informed Consent for Minors

If there is a conflict between the parents regarding Informed Consent (and the parents are married or both parents have legal custody) treatment should not proceed unless an emergency exists. The Care Team determines the reasons for the refusal and attempts to resolve whatever conflicts may exist. Reasonable alternatives to the proposed treatment should be discussed with the parent(s) or legal guardian(s), and the discussion should be documented in the minor's medical record.

If a minor is at school, camp, or in the care of others, and the parents or legal guardian are not available for consent, no treatment or procedure should take place unless an emergency exists or unless the person in charge of the minor has a written statement from the parents or legal guardian authorizing them to give Informed Consent. In all cases, reasonable efforts should be undertaken to contact the parents or legal guardian to verify the written Informed Consent before proceeding.

For minors able to participate in their own healthcare decision-making or emancipated minors, see PolicyStat - Involving Minors in Clinical Care Decision Making, Including Minor Assent and Informed Consent. Questions regarding the decision making and Informed Consent for minors may be referred to Risk Management. Bioethics is an additional resource.

Minors in the Care of the New Jersey Division of Child Protection and Permanency

The Division of Child Protection and Permanency (DCP&P) has legal authority to consent to Surgery or Procedures, anesthesia, diagnosis tests, and medical treatment for a minor whenever DCP&P has guardianship or pursuant to:

(i) A voluntary placement agreement,

(ii) "Dodd Law" removal based on emergent circumstances without parent permission, or

(iii) Court order specifying that DCP&P has the authority to issue such consent.

If a minor is under DCP&P supervision, a foster parent or residential placement representative is authorized to provide Informed Consent for the minor on a routine basis. In an emergency when immediate Informed Consent is essential and DCP&P cannot be contacted within the time available, a foster parent or residential placement representative may provide Informed Consent for the minor.

The foster parent or residential placement representative must notify DCP&P as soon as possible after consenting to such treatment.

All questions concerning Informed Consent for minors with DCP&P referrals should be directed to the Social Worker or Risk Management.

What are the RN's Responsibilities Regarding Informed Consent?

Every attempt should be made to have the required Informed Consent forms signed prior to the patient entering the perioperative or procedure area. It is the duty of the RN to:

Ensure that the Informed Consent forms are complete, have no discrepancies and are signed, including date and time, and that they are in the medical record prior to the administration of Anesthesia Services and the beginning of Surgery or Procedures.

In the event the RN determines that the required Informed Consent forms and/or the medical orders in the electronic medical records are not complete, have discrepancies, or have not been signed, the RN will notify the Responsible Practitioner and the operating room or procedural location personnel.

Communicate questions of the patient (or surrogate) and changes in the status of the patient's Informed Consent to the Responsible Practitioner and the operating

What are the RN's Responsibilities Regarding Informed Consent?

Communicating to the physician any changes in the status of the consent; that is, the patient no longer agrees to submit to the treatment for which consent was previously obtained.
Ensure the Informed consent form is signed, dated and timed and is placed in the medical record.
Directing any questions that the patient may pose concerning the treatment/procedure to the patient's physician.
Notifying their nurse manager or the Risk Manager of situations that are apparently in conflict with the policies and procedures outlined by this policy.
In the case of patients who are incapable of consenting, assisting the physician in identifying the appropriate legally authorized representative.

What are the RN’s Responsibilities Regarding Informed Consent?

Confirm the patient's identity using at three patient identifiers: last name, date of birth, last 3 digits off their medical record number.

Assess the patient's or surrogate decision maker's learning style and ability to make informed decisions.

Evaluate the patient's or surrogate decision maker's understanding of the informed consent process.

Identify the patient's or surrogate decision maker's preferred language. Contact a medical interpreter if the practitioner doesn't share proficiency in a common language to ensure that the patient or surrogate understand the practitioner's explanation and to allow the patient or surrogate to communicate concerns.

The practitioner providing or ordering the care, treatment, or service should discuss (in clear language) the care, treatment, or service with the patient or surrogate decision maker.

Assist with providing instructional materials in alternative formats, such as audio, visual, and written materials, as needed.

Elicit questions from the patient or surrogate decision maker to determine any additional concerns.

Ensure that the patient or surrogate decision maker feels free to ask questions to help process the information.

New Practice Changes Regarding DNAR/DNI Orders

Existing DNAR Orders ***are not*** automatically suspended, but rather require the Responsible Practitioner and Anesthesiologist, as part of the Informed Consent process, to discuss and document the status of existing DNAR and Airway Management Orders with the patient or surrogate prior to procedure.

If the decision has been made to modify the patient's code status from DNAR to Full Code during the Surgery or Procedures and then from Full Code back to DNAR after the Surgery or Procedures, the Responsible Practitioner will include the corresponding Orders in the patient's medical record.

Recognizing that the indications for airway management, including intubation, may be different in the operative or procedural setting from other care settings, the Responsible Practitioner also discusses with the patient (or surrogate) options and preferences for airway management during the perioperative or periprocedural period. The decision of the patient (or surrogate) regarding airway management will be confirmed and/or modified by the Anesthesiologist and, if modified, the Anesthesiologist will communicate the modifications to the Responsible Practitioner and document the patient's medical record.

The recovery RN releases postoperative orders, which include code status and airway management orders, when the patient meets criteria for recovery from anesthesia.

New Practice Changes Regarding DNAR/DNI Orders

Substantive Practice Change

For the special conditions required to revise, revoke, or modify a POLST, the Responsible Practitioner and Anesthesiologist should refer to the applicable policies of the particular HMH Network entities.

In the event the patient's postoperative condition in the PACU deteriorates, the ACT and/or Care Team will respond and take such actions as they deem appropriate under the circumstances in the exercise of their professional medical judgment, including discussing goals of care with the patient (or surrogate).

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Emergency Action - Implied Consent

It is the policy of HMH to do that which is immediately and reasonably necessary for the preservation of life, limb and health of the patient. In emergencies, treatment of a patient without written consent is authorized under the doctrine of "implied consent."

The physician should also determine whether a delay in obtaining consent would cause a serious aggravation of the patient's condition or result in death.

Should the physician determine that emergency action is warranted, he/she should document that decision and the reasons for it in the patient's medical record.

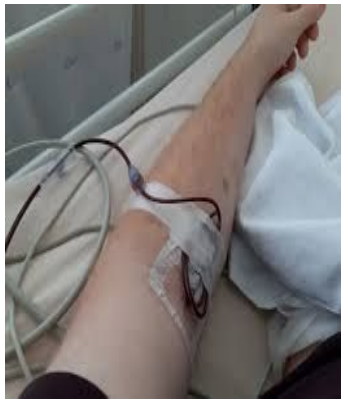
If the patient is conscious and competent, expressly refuses to consent to treatment (even if such treatment may be medically necessary to preserve his or her health or life), the patient's refusal of treatment must be honored. The physician should impress upon the patient the need for treatment and the potential problems/consequences if treatment does not proceed.

If refusal persists, this situation must be fully documented in the medical record.

4 Types of Informed Consent for Treatments/Procedures

1. Surgery or non-operative/noninvasive procedures (Such as chemotherapy or hormone therapy)
2. Receipt/refusal of blood and or blood and/or blood product transfusion
3. Critical care and emergency medicine sedation and analgesia for procedures
4. Anesthesia services

Examples of other treatment/procedures requiring consent



Radiation therapy
Dialysis
Electroconvulsive therapy
Voluntary Sterilization
All experimental procedures
Certain diagnostic tests
Tests for sexually transmitted diseases, pregnancy, or treatment of drug/alcohol use/abuse, or treatment for a psychiatric condition or family planning

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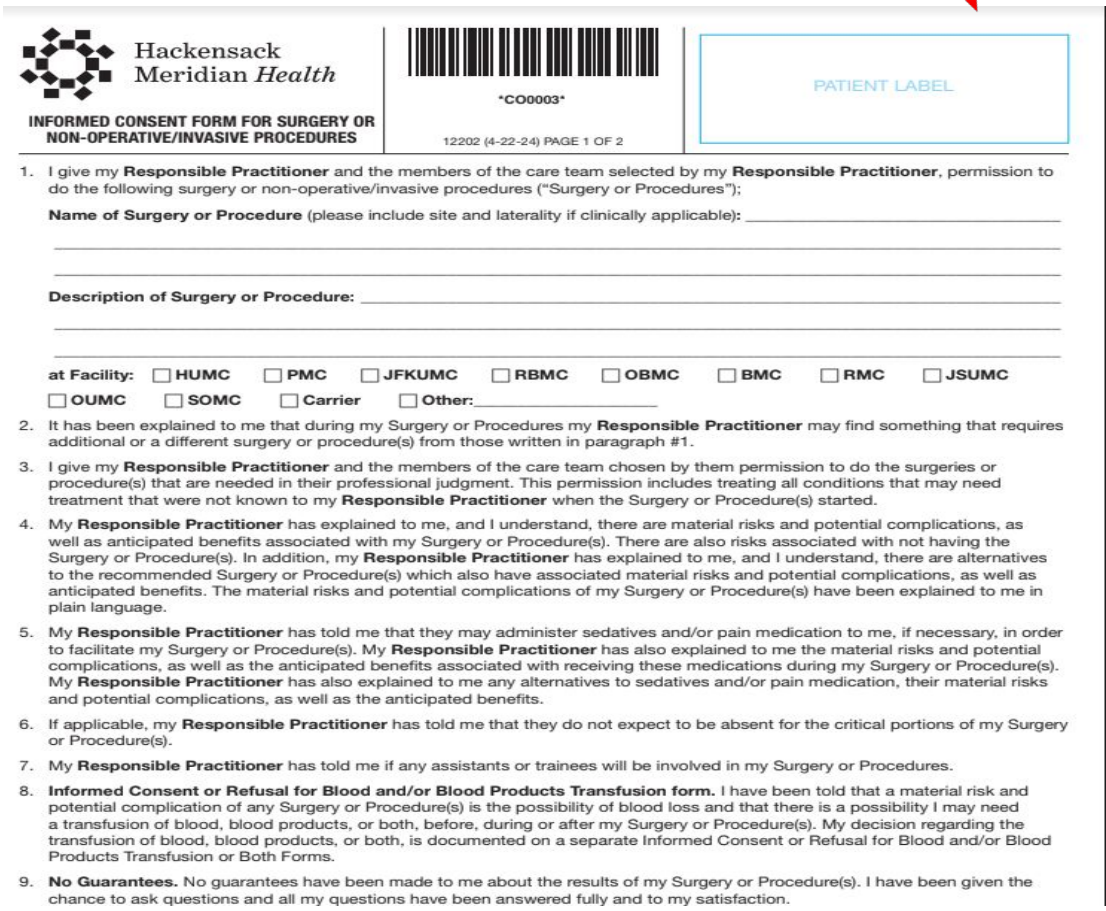
Informed Consent For Surgery or Non-Operative/Invasive Procedures

The Responsible Practitioner is required to use the HMH Informed Consent Form for Surgery or Procedures ("HMH IC Form for Surgery") attached to the new Policy as Attachment 1 (English) & 1.A (Spanish). Recognizing the variation of material risks and potential complications, and anticipated benefits of different surgeries and procedures, the HMH IC Form for Surgery may be customized to include procedural specific risks and anticipated benefits.



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INFORMED CONSENT FORM FOR SURGERY OR NON-OPERATIVE/INVASIVE PROCEDURES

12202 (4-22-24) PAGE 1 OF 2

1. I give my **Responsible Practitioner** and the members of the care team selected by my **Responsible Practitioner**, permission to do the following surgery or non-operative/invasive procedures ("Surgery or Procedures");

   Name of Surgery or Procedure (please include site and laterality if clinically applicable): _____

   _____

   _____

   Description of Surgery or Procedure: _____

   _____

   _____

   at Facility: ☐ **HUMC** ☐ **PMC** ☐ **JFKUMC** ☐ **RBMC** ☐ **OBMC** ☐ **BMC** ☐ **RMC** ☐ **JSUMC**
   ☐ **OUMC** ☐ **SOMC** ☐ **Carrier** ☐ **Other:**_____

2. It has been explained to me that during my Surgery or Procedures my **Responsible Practitioner** may find something that requires additional or a different surgery or procedure(s) from those written in paragraph #1.
3. I give my **Responsible Practitioner** and the members of the care team chosen by them permission to do the surgeries or procedure(s) that are needed in their professional judgment. This permission includes treating all conditions that may need treatment that were not known to my **Responsible Practitioner** when the Surgery or Procedure(s) started.
4. My **Responsible Practitioner** has explained to me, and I understand, there are material risks and potential complications, as well as anticipated benefits associated with my Surgery or Procedure(s). There are also risks associated with not having the Surgery or Procedure(s). In addition, my **Responsible Practitioner** has explained to me, and I understand, there are alternatives to the recommended Surgery or Procedure(s) which also have associated material risks and potential complications, as well as anticipated benefits. The material risks and potential complications of my Surgery or Procedure(s) have been explained to me in plain language.
5. My **Responsible Practitioner** has told me that they may administer sedatives and/or pain medication to me, if necessary, in order to facilitate my Surgery or Procedure(s). My **Responsible Practitioner** has also explained to me the material risks and potential complications, as well as the anticipated benefits associated with receiving these medications during my Surgery or Procedure(s). My **Responsible Practitioner** has also explained to me any alternatives to sedatives and/or pain medication, their material risks and potential complications, as well as the anticipated benefits.
6. If applicable, my **Responsible Practitioner** has told me that they do not expect to be absent for the critical portions of my Surgery or Procedure(s).
7. My **Responsible Practitioner** has told me if any assistants or trainees will be involved in my Surgery or Procedures.
8. **Informed Consent or Refusal for Blood and/or Blood Products Transfusion form.** I have been told that a material risk and potential complication of any Surgery or Procedure(s) is the possibility of blood loss and that there is a possibility I may need a transfusion of blood, blood products, or both, before, during or after my Surgery or Procedure(s). My decision regarding the transfusion of blood, blood products, or both, is documented on a separate Informed Consent or Refusal for Blood and/or Blood Products Transfusion or Both Forms.
9. **No Guarantees.** No guarantees have been made to me about the results of my Surgery or Procedure(s). I have been given the chance to ask questions and all my questions have been answered fully and to my satisfaction.

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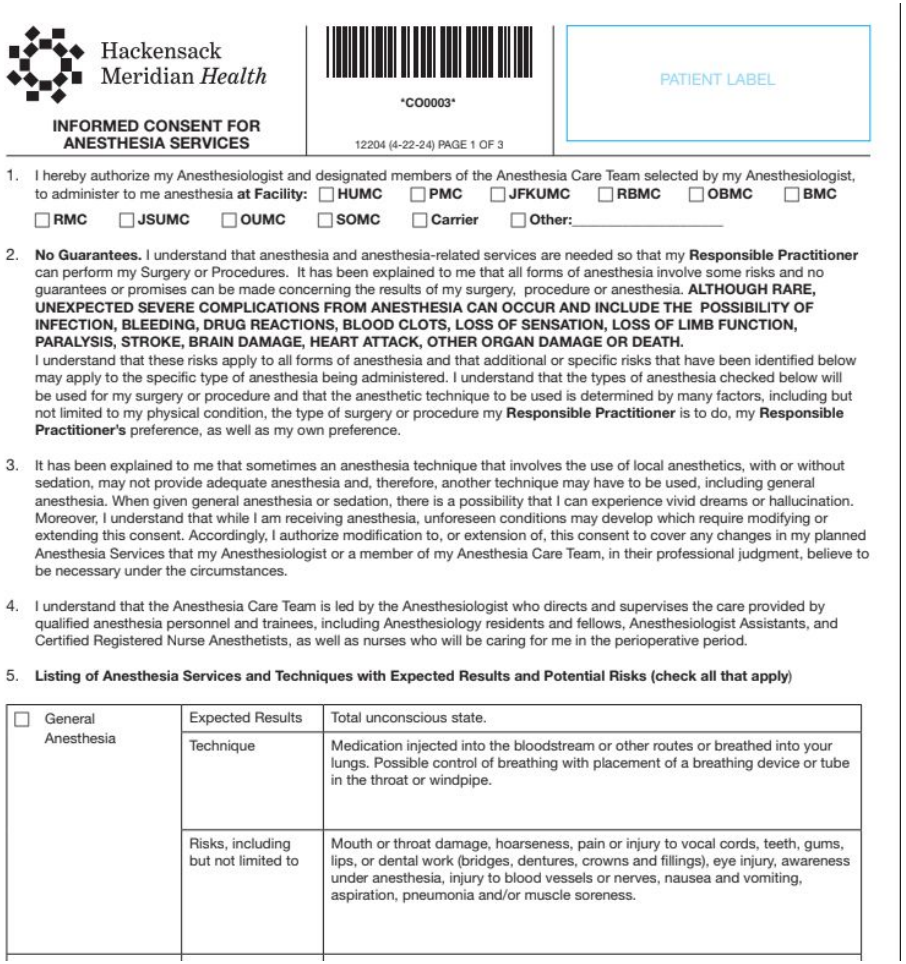
Informed Consent for Administration of Anesthesia and Anesthesia-Related Services

NEW

Anesthesiologist is required to use the HMH Informed Consent Form for the Administration of Anesthesia and Anesthesia-Related Services ("HMH IC Form for Anesthesia Services") attached to the Policy as Attachment 2 (English) & 2.A (Spanish).



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INFORMED CONSENT FOR ANESTHESIA SERVICES

12204 (4-22-24) PAGE 1 OF 3

1. I hereby authorize my Anesthesiologist and designated members of the Anesthesia Care Team selected by my Anesthesiologist, to administer to me anesthesia **at Facility:** ☐ **HUMC** ☐ **PMC** ☐ **JFKUMC** ☐ **RBMC** ☐ **OBMC** ☐ **BMC** ☐ **RMC** ☐ **JSUMC** ☐ **OUMC** ☐ **SOMC** ☐ **Carrier** ☐ **Other:**_____

2. **No Guarantees.** I understand that anesthesia and anesthesia-related services are needed so that my **Responsible Practitioner** can perform my Surgery or Procedures. It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my surgery, procedure or anesthesia. **ALTHOUGH RARE, UNEXPECTED SEVERE COMPLICATIONS FROM ANESTHESIA CAN OCCUR AND INCLUDE THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK, OTHER ORGAN DAMAGE OR DEATH.** I understand that these risks apply to all forms of anesthesia and that additional or specific risks that have been identified below may apply to the specific type of anesthesia being administered. I understand that the types of anesthesia checked below will be used for my surgery or procedure and that the anesthetic technique to be used is determined by many factors, including but not limited to my physical condition, the type of surgery or procedure my **Responsible Practitioner** is to do, my **Responsible Practitioner's** preference, as well as my own preference.

3. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not provide adequate anesthesia and, therefore, another technique may have to be used, including general anesthesia. When given general anesthesia or sedation, there is a possibility that I can experience vivid dreams or hallucination. Moreover, I understand that while I am receiving anesthesia, unforeseen conditions may develop which require modifying or extending this consent. Accordingly, I authorize modification to, or extension of, this consent to cover any changes in my planned Anesthesia Services that my Anesthesiologist or a member of my Anesthesia Care Team, in their professional judgment, believe to be necessary under the circumstances.

4. I understand that the Anesthesia Care Team is led by the Anesthesiologist who directs and supervises the care provided by qualified anesthesia personnel and trainees, including Anesthesiology residents and fellows, Anesthesiologist Assistants, and Certified Registered Nurse Anesthetists, as well as nurses who will be caring for me in the perioperative period.

5. **Listing of Anesthesia Services and Techniques with Expected Results and Potential Risks (check all that apply)**

☐ General Anesthesia	Expected Results	Total unconscious state.
	Technique	Medication injected into the bloodstream or other routes or breathed into your lungs. Possible control of breathing with placement of a breathing device or tube in the throat or windpipe.
	Risks, including but not limited to	Mouth or throat damage, hoarseness, pain or injury to vocal cords, teeth, gums, lips, or dental work (bridges, dentures, crowns and fillings), eye injury, awareness under anesthesia, injury to blood vessels or nerves, nausea and vomiting, aspiration, pneumonia and/or muscle soreness.

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Informed Consent for Critical Care and Emergency Medicine Sedation and Analgesia for Procedures

NEW

The doctor is required to use the HMH Informed Consent Form for Critical Care and Emergency Medicine Sedation and Analgesia for Procedures ("HMH IC Form for Critical Care and Emergency Medicine Sedation and Analgesia") attached to the Policy as Attachment 3 (English) & 3.A (Spanish).

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PATIENT LABEL

MED CONSENT FOR CRITICAL CARE AND EMERGENCY MEDICINE SEDATION AND ANALGESIA FOR PROCEDURES

12201 (4-22-24) PAGE 1 OF 1

(To be used by non-anesthesiologist physicians administering sedation or analgesia only and not performing the procedure)

1. I give my **Responsible Practitioner** permission to administer to me sedative medications, pain medications, or both, for my procedure(s) **at Facility:** ☐ **HUMC** ☐ **PMC** ☐ **JFKUMC** ☐ **RBMC** ☐ **OBMC** ☐ **BMC** ☐ **RMC** ☐ **JSUMC** ☐ **OUMC** ☐ **SOMC** ☐ **Carrier** ☐ **Other:**_____
2. My **Responsible Practitioner** has explained to me, and I understand the anticipated benefits, material risks and potential complications, and alternatives to receiving these sedative and pain medications, as well as the possible consequences of not receiving these medications during my procedure. The material risks and potential complications of receiving sedative and pain medications include, but are not limited to, pain on injection of the medications, changes in my blood pressure and heart rate, and decreased breathing or level of oxygen, possibly requiring the insertion of a breathing tube. I also understand that these medications are not intended to provide me with general anesthesia and I may or may not be aware of and remember portions of my procedure.
3. My **Responsible Practitioner** has told me and I understand that they will be present during the entire procedure while administering these medications and monitoring me.
4. My **Responsible Practitioner** has told me if any assistants or trainees will be involved in administering my sedative and pain medications during my procedure.
5. **No Guarantees.** No guarantees have been made to me about having my procedure performed while receiving sedative and pain medications. I have been given the chance to ask questions and all my questions have been answered fully and to my satisfaction.
6. **Clarification of Patient's Code Status and Airway Management (if applicable).** My **Responsible Practitioner** has discussed with me if I have a Do Not Attempt Resuscitation (DNAR) or Do Not Intubate (DNI) Order in place. If I have a DNAR or DNI Order, they have talked to me about my preference about keeping or changing those orders in effect while I am receiving sedative or pain medications or undergoing or recovering from my procedure.
7. **Outpatient Surgery or Procedures.** My **Responsible Practitioner** has explained to me and I understand that there may be other risks associated with receiving sedative or pain medications, or both, in an outpatient setting, including the risk of transfer or admission to the hospital, if needed.
8. **Patient's Acknowledgment and Informed Consent.** I acknowledge that I have read this Form (or had it read to me), understand the expected results, benefits, material risks and potential complications, and alternatives to receiving sedative and pain medications during my procedure. I have had the chance and enough time to ask questions and receive answers to my satisfaction. I have the knowledge, information, and understanding to reach an informed decision. By signing this Form, I am providing my informed consent to receive sedative or pain medications or both during my procedure.

Patient Name (PRINT): _____

Signature of Patient: _____ Date:_____ Time: _____AM/PM

If patient unable to sign; name of Surrogate (PRINT): _____

Relationship of Surrogate to Patient: _____

Signature of Surrogate: _____ Date:_____ Time: _____AM/PM

For Telephone and Verbal Informed Consent; a Registered Nurse (RN) must witness the consent process

Name of Witness (RN) (PRINT): _____

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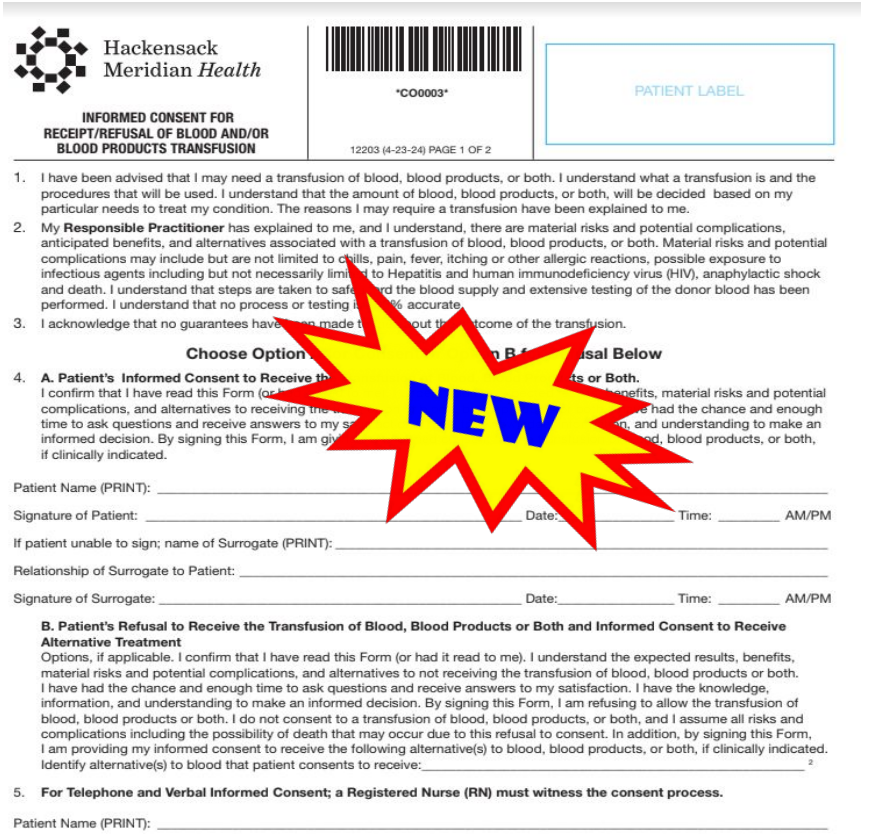
Informed Consent or Refusal for Blood and/or Blood Products Transfusion Form

The transfusion of blood, blood products, or both is a material risk and potential complication of any Surgery or Procedures. The Responsible Practitioner is required to use the HMH Informed Consent or Refusal for Blood and/or Blood Products Transfusion form attached to this Policy as Attachment 4 (English) and 4.A (Spanish).



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PATIENT LABEL

INFORMED CONSENT FOR RECEIPT/REFUSAL OF BLOOD AND/OR BLOOD PRODUCTS TRANSFUSION

12203 (4-23-24) PAGE 1 OF 2

1. I have been advised that I may need a transfusion of blood, blood products, or both. I understand what a transfusion is and the procedures that will be used. I understand that the amount of blood, blood products, or both, will be decided based on my particular needs to treat my condition. The reasons I may require a transfusion have been explained to me.
2. My **Responsible Practitioner** has explained to me, and I understand, there are material risks and potential complications, anticipated benefits, and alternatives associated with a transfusion of blood, blood products, or both. Material risks and potential complications may include but are not limited to chills, pain, fever, itching or other allergic reactions, possible exposure to infectious agents including but not necessarily limited to Hepatitis and human immunodeficiency virus (HIV), anaphylactic shock and death. I understand that steps are taken to safeguard the blood supply and extensive testing of the donor blood has been performed. I understand that no process or testing is 100% accurate.
3. I acknowledge that no guarantees have been made to me about the outcome of the transfusion.

Choose Option A or B Below

4. **A. Patient's Informed Consent to Receive the Transfusion of Blood, Blood Products or Both.**
I confirm that I have read this Form (or had it read to me). I understand the expected benefits, material risks and potential complications, and alternatives to receiving the transfusion of blood, blood products or both. I have had the chance and enough time to ask questions and receive answers to my satisfaction. I have the knowledge, information, and understanding to make an informed decision. By signing this Form, I am giving my consent for the transfusion of blood, blood products, or both, if clinically indicated.

NEW

Patient Name (PRINT): _____

Signature of Patient: _____ Date: _____ Time: _____ AM/PM

If patient unable to sign; name of Surrogate (PRINT): _____

Relationship of Surrogate to Patient: _____

Signature of Surrogate: _____ Date: _____ Time: _____ AM/PM

B. Patient's Refusal to Receive the Transfusion of Blood, Blood Products or Both and Informed Consent to Receive Alternative Treatment
Options, if applicable. I confirm that I have read this Form (or had it read to me). I understand the expected results, benefits, material risks and potential complications, and alternatives to not receiving the transfusion of blood, blood products or both. I have had the chance and enough time to ask questions and receive answers to my satisfaction. I have the knowledge, information, and understanding to make an informed decision. By signing this Form, I am refusing to allow the transfusion of blood, blood products or both. I do not consent to a transfusion of blood, blood products, or both, and I assume all risks and complications including the possibility of death that may occur due to this refusal to consent. In addition, by signing this Form, I am providing my informed consent to receive the following alternative(s) to blood, blood products, or both, if clinically indicated.
Identify alternative(s) to blood that patient consents to receive: _____

5. **For Telephone and Verbal Informed Consent; a Registered Nurse (RN) must witness the consent process.**

Patient Name (PRINT): _____

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KEEP GETTING BETTER

For a Series of Procedures or Treatments Necessary to Treat One (1) Condition. Practice Change!

If a series of procedures or other treatments (including blood transfusions, wound debridement, electroconvulsive therapy, chemotherapy or dialysis) are necessary to treat one (1) condition, the series of procedures or other treatments may be covered by one HMH Informed Consent form, provided that the form indicate that a series of procedures or other treatments are expected.

The Informed Consent form is **valid for the series of procedures or treatments set forth in the Informed Consent forms for up to one (1) year** from the date of signing**.** However, the patient's clinical condition may necessitate obtaining a new informed consent in the event that the patient's condition changes in a material way that could impact the risks, benefits and alternatives of treatment to such extent that the Responsible Practitioner feels it is appropriate to engage the patient or surrogate in the informed consent process again. If the patient's clinical condition necessitates obtaining a new informed consent, the Responsible Practitioner will complete a new informed consent form and document the change in patient’s condition in the patient’s medical record. Conversely, if the patient's clinical condition has not changed from the time of the original informed consent, the Responsible Practitioner will document no change in condition in the medical record.

Time Validity of Signed Informed Consent Forms

Substantive Practice Change

Informed Consent Form For Surgery or Non-Operative/Invasive Procedures

Valid for **90** calendar days from the date of signing, *unless the patient's health condition during that time has changed* so as to impact the material risks and potential complications, anticipated benefits, or alternatives of the treatment as determined by the Responsible Practitioner, the patient revokes Informed Consent, or the patient is discharged from the admission for the treatment for which Informed Consent was given.

Time Validity of Signed Informed Consent Forms

Substantive Practice Change

Informed Consent Form for Anesthesia Services

Valid for **30** days from the date of signing

Now a separate Informed Consent Form for Anesthesia Services and must be signed by both the patient and Anesthesiologist

Time Validity of Signed Informed Consent Form

Substantive Practice Change

Informed Consent or Refusal for Blood and/or Blood Products Transfusion

Signed HMH Informed Consent or Refusal for Blood and/or Blood Products Transfusion Forms **are valid from the date of signing for 90 calendar days (whether signed in the hospital or the Responsible Practitioners' office)** or for the **term of the admission**, unless the patient's health condition during that time has changed so as to impact the material risks and potential complications, anticipated benefits, or alternatives of the treatment as determined by the Responsible Practitioner, the patient revokes Informed Consent or Refusal for Blood and/or Blood Products Transfusion, or the patient is discharged from the admission for the treatment for which Informed Consent was given.

Requires a separate Consent for Receipt/Refusal for Blood and/or Blood Products

Time Validity of Signed Informed Consent Forms

Substantive Practice Change

Critical Care and Emergency Medicine Sedation and Analgesia for Procedures Form

To be used in these settings by the non-anesthesiologist physician who is administering sedation for the Responsible Practitioner

What does it mean when you say " the RN witness will be removed from the process?"

An RN is no longer required to be a witness for the signing of an informed consent when it is a surgeon-to-patient and/or surrogate face-to-face interaction.

An RN is only required to be a witness if the Informed Consent Process was completed verbal or via telephone. There is a section in the policy and on the Informed consent form(s) that will address the need for RN witness " * For Telephone and Verbal Informed Consent; a Registered Nurse (RN) must witness the consent process *"

Verbal Informed Consent

Verbal Informed Consent may be obtained when the patient with capacity is unable to sign the Informed Consent forms or when the surrogate for a patient who lacks capacity to make the decision at hand is not present and the Informed Consent process is conducted by telephone.

The Responsible Practitioner and Anesthesiologist will document in the patient's medical record the required elements of the Informed Consent process, as well as the reason Verbal Informed Consent was necessary. Verbal Informed Consent **must be witnessed by an RN**, who signs the Informed Consent form, including the date and time of signature and, if applicable, the relationship between the surrogate and the patient.

Informed Consent by Telephone or Video-Conferencing

When the patient (or surrogate) is unable to provide in-person written Informed Consent, Informed Consent may be obtained by telephone or video-conferencing. Informed Consent by telephone or video-conferencing must be witnessed by a RN. The required elements of the Informed Consent process, as well as the reason Informed Consent by telephone or video-conferencing was necessary, will be documented in the patient's medical record.

When a surrogate is providing Informed Consent by telephone or video-conferencing, the RN speaks with the surrogate and confirms the surrogate's full name, determines the surrogate's relationship to the patient, validates the treatment to be performed, and corroborates that the Responsible Practitioner engaged in the Informed Consent process with the surrogate, which included an opportunity for the surrogate to ask questions. Any question raised by the surrogate during the discussion with the RN will be referred to the Responsible Practitioner providing the treatment. Thereafter, the RN signs the Informed Consent form as the witness, including the date and time of signature, as well as the relationship of the surrogate to the patient.

Time Validity of Signed Informed Consent Forms

Substantive Practice Change

Consent Witness

- ***One RN Witness*** - **ONLY** verbal informed consent and telephone informed consent must be witnessed by one (1) individual.

  The witness **must** be a registered nurse (RN)

Informed Consent by Facsimile or Email

The HMH Informed Consent Form for Surgery or Procedures signed (including date and time) by the patient (or surrogate) at the Responsible Practitioner's medical office may be transmitted to the hospital, surgical center, or ambulatory care center where the patient's Surgery or Procedures is to be performed as soon as possible, but no more than 90 calendar days prior to Surgery or Procedures. The signed Informed Consent form will be scanned into the patient's medical record prior to the administration of Anesthesia Services and the beginning of Surgery or Procedures.

Interpretive Services for Limited English-language Proficiency

When interpretive services are necessary for Informed Consent for Surgery or Procedures and Anesthesia or Sedation, the Responsible Practitioner and Anesthesiologist should refer to the Foreign Language Interpreter Policy.

Guidelines, Prevention and Treatment of Pressure Injuries

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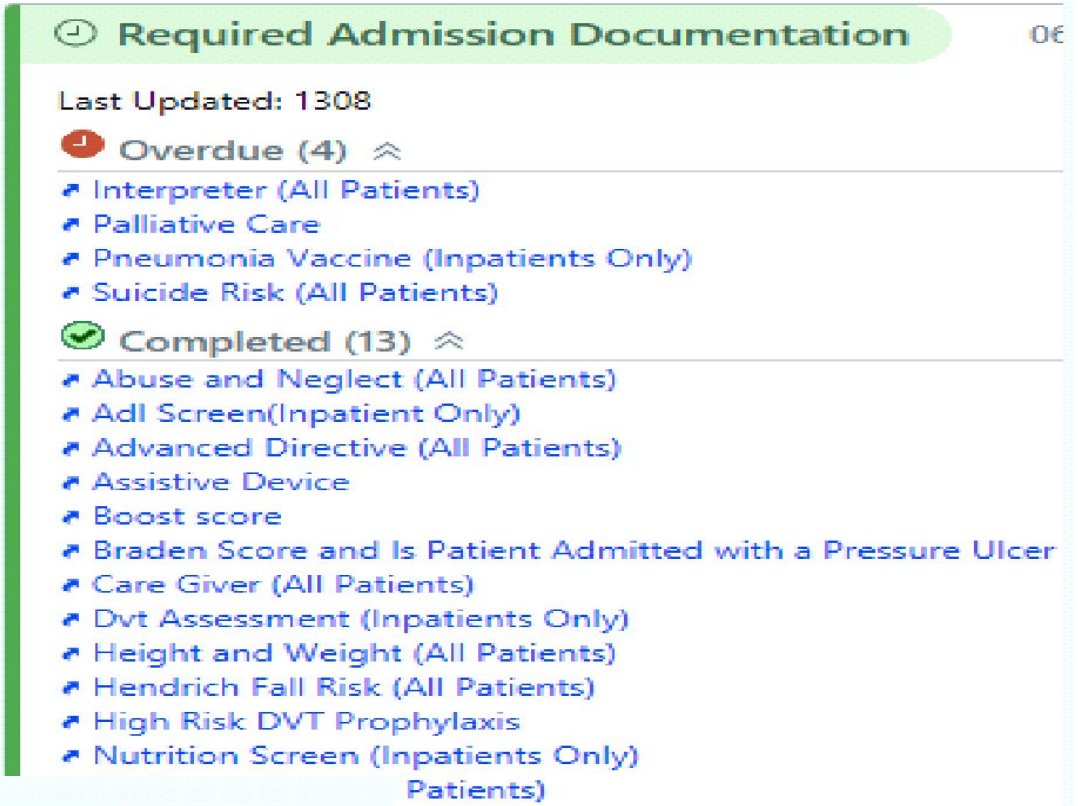
KEEP GETTING BETTER

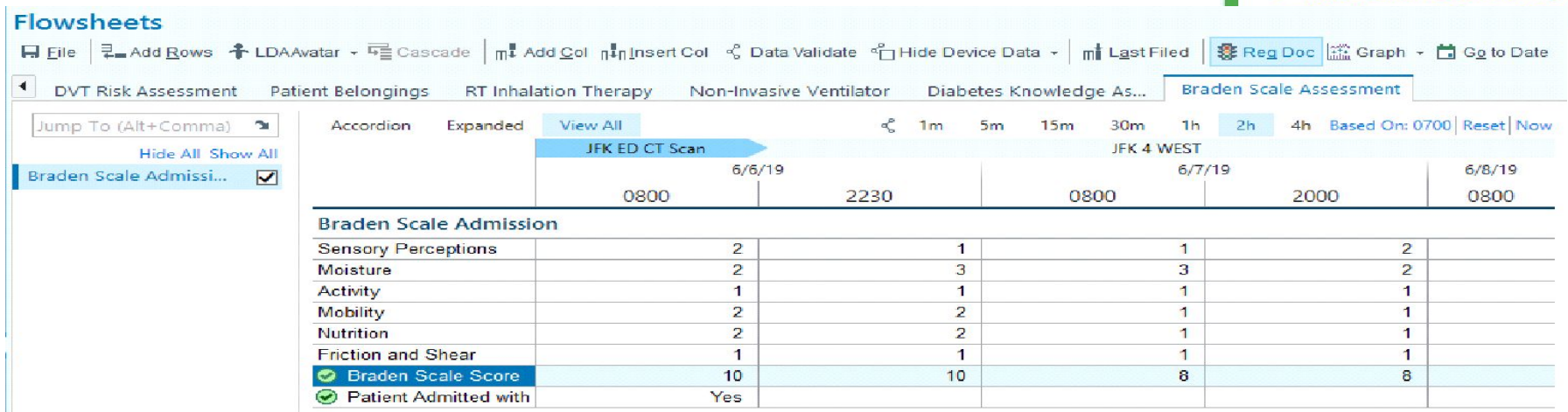
Patient Assessments

- Upon admission, all patients will have an initial skin assessment done and a Braden Scale Score
- Every shift, all patients will have:
  - A skin assessment (two RNs)
  - A Braden Scale Score
- If a patient has a pressure injury, a pressure injury assessment will be done
- Document any surgical wound, vascular wound, diabetic wound, etc

Initial Skin Assessment

- Upon admission to the hospital EPIC identifies items as “Required Admission Documentation”
- All patients must have a Braden Score documented as well as answering the question, “Is patient admitted with a pressure ulcer?”
- Initial skin assessments are done as a **<u>two</u>** nurse check





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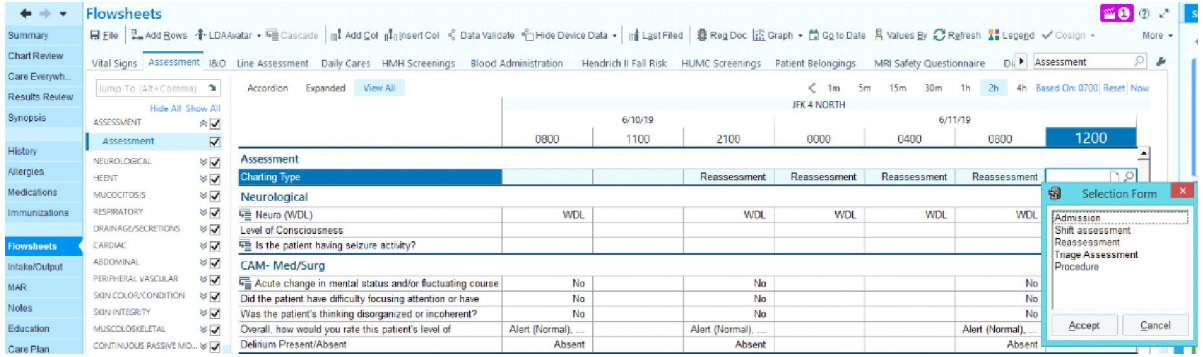
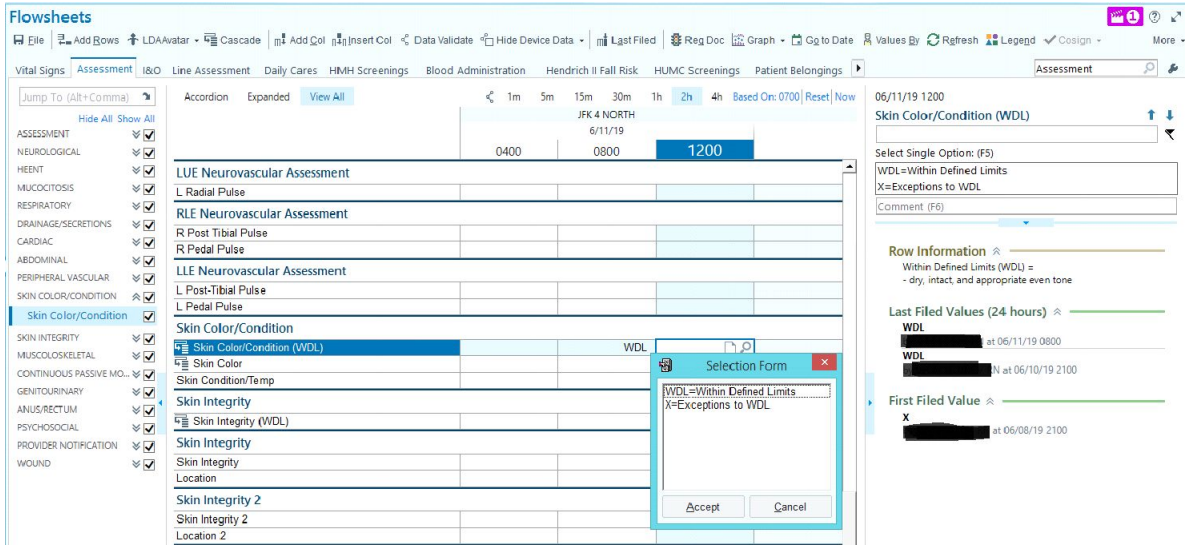
Daily assessments

- Every shift a skin assessment must be completed
- This is a general overview of the patient's skin condition





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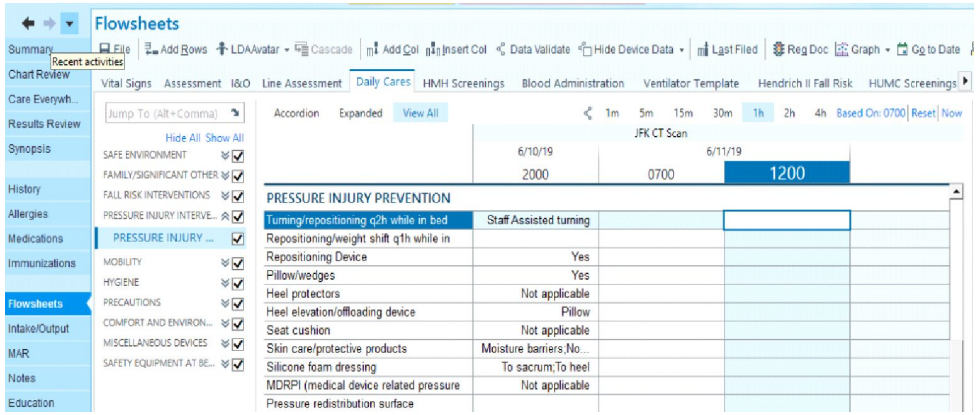
Braden Scale Score

- A risk assessment tool devised to help identify patients who are at risk for developing a pressure injury
- Comprised of 6 subscales that equal a total score between 6 and 23
  - Subscales include: sensory perception, moisture, activity, mobility, nutrition and friction/shear
- Scores 19-23 are at minimal risk
- Scores 15-18 are at risk
- Scores 13-14 are at moderate risk
- Scores 10-12 are at high risk
- Scores 9 and less are very high risk
- Be aware, people may have the same score for varying reasons
- Implement prevention strategies specific to each subscale

Pressure Injury Prevention

- Anyone with a Braden Score less than or equal to 18 must have pressure injury prevention measures in place
- An alert will warn you when a Braden Score of 18 or less was documented to remind you to enter your prevention measures



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Weekly Wound Assessment

- All wounds will be measured and documented weekly as well as on admission, discharge, and transfer
- Any patient who is admitted with skin documented as intact on admission and develops a wound must have a OneLink safety report completed
    - Internal reporting system for Risk Management to be notified
- Any patient with a wound that is worsening must have a OneLink report completed
- Consult the wound team for any wounds, whether community acquired or hospital acquired

TICKET TO RIDE

The “Ticket to Ride” is a hand-off communication form initiated by the primary nurse when he/she will not be present during patient transport and off unit procedure/ testing

Patients are not to be transported without the “Ticket to Ride”

The “Ticket to Ride” should remain with the patient during ALL moves between units and services

The “Ticket to Ride” does not replace nurse to nurse handoff of care utilizing the IPASS communication tool

The ONLY time the “Ticket to Ride” is not required if the primary nurse accompanies the patient during the entirety of transportation and off unit procedure and testing OR if the primary nurse accompanies the patient during transportation and then hands off to another nurse using IPASS

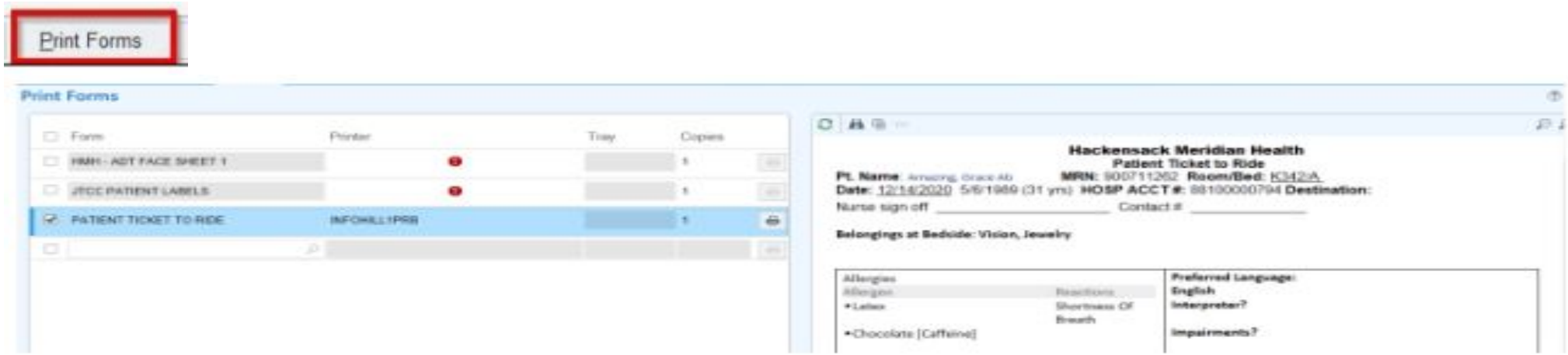
PROCEDURE

Nursing: Pre-transport Assessment

- **Individual patient care needs will be documented on the “Ticket to Ride” by the nurse prior to the patient being transported off unit**
  - The primary nurse from the sending unit is responsible for completing the “Ticket to Ride”
  - ALL components of the form should be filled out prior to transport
  - The nurse should assess the patient as close to the time of transport as possible to ensure the “Ticket to Ride” best reflects patient condition
  - Sign/date/time the form
  - A phone number where the nurse can be reached must be included
  - For higher acuity patient, please refer to HMH policy

PROCEDURE

- Steps to preparing the “Ticket to Ride”
  - Access the “Ticket to Ride” by selecting the desired patient
  - Click the “Print Forms” tab
  - Locate the “Ticket to Ride” from the available print options and select the applicable printer location
  - Alternatively, the ticket will auto-print once transportation team members accept a transportation request on the “Rover” application



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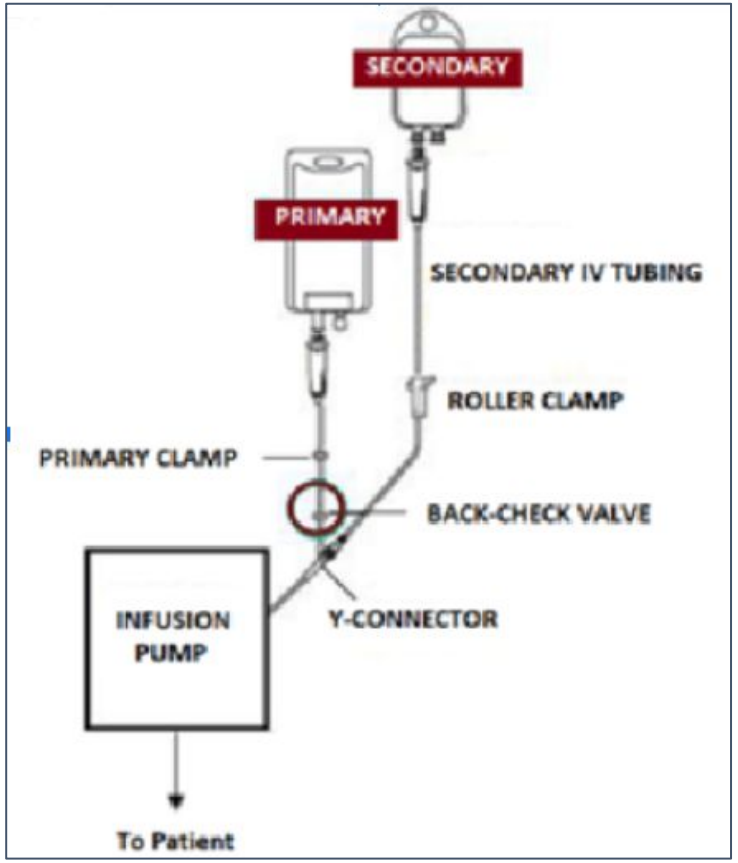
Carrier Fluid

Small volume intermittent infusion (less than or equal to 100 mL) need a carrier fluid (flush bag) in the absence of a primary infusion order to minimize residual drug in the tubing. Choose the carrier fluid that is the same diluent as the intermittent infusion.

- Small-volume intermittent infusions (less than or equal to 100 mL) must be flushed to prevent medication loss and ensure patient safety - **up to half** of a small volume infusion can remain in the tubing
- A **Carrier Fluid** is a small bag (50 to 250 mL) of compatible fluid that is used as a **PRIMARY** infusion to allow administration of the intermittent infusion via a secondary administration set
- A **Carrier Fluid** should always be programmed on the pump as a **Primary infusion**
- A **Carrier Fluid** should be set as the **same rate** of the small volume intermittent infusion



Intervention

HMH recognized an opportunity to optimize medication administration for small volume intermittent infusions. To ensure flushing occurs after small volume intermittent infusions occurs the following directives apply:

Small volume intermittent infusion with compatible active primary infusion

- Ensure secondary infusion is compatible with primary infusion.
- Lower the primary infusion bag utilizing HMH approved device.
- Change tubing every 96 hours -or- every 24 hours if/when disconnected/detached.

NO CHANGE IN PRACTICE

Small volume intermittent infusion <u>without</u> compatible active primary infusion

- Review “Flush Infusion panel” and identify compatible flush solution. The flush solution should match the diluent of the small volume infusion.
- Lower the primary infusion bag utilizing HMH approved device.
- Infusion rate of flush solution will match the infusion rate of the small volume infusion.
- Change tubing every 96 hours -or- every 24 hours if/when disconnected/detached.

CHANGE IN PRACTICE

Bariatric Equipment

Knowing the weight capacity of existing equipment is critical for safety.

Bariatric Equipment in our hospital includes:

-Chairs -Commodes

-Beds/Mattress -OR tables

-Wheelchairs -Examination tables

-Toilet supports -Lifting and transfer equipment

As an accredited center, all bariatric equipment will be labeled with the weight capacity label that is placed where staff can see it

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