PAM Rehabilitation
Hospital of
Centennial Hills
A Post Acute Medical Hospital

June 18, 2019

Rick Combs, Director
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89701-4747

Dear Mr. Combs:

Pursuant to NRS 439.877(4)(d) (AB280), which requires patient safety committees in medical facilities to report annually on the facilities review, revision, and usage of patient safety checklists and policies, the following is a summary of PAM Rehabilitation Hospital of Centennial Hills activities during July 2018 – June 2019:

All checklists and polices were reviewed. Several checklists and policies had minor revisions. The PAM Rehabilitation Hospital of Centennial Hills Patient Safety Plan includes the patient safety and policy compliance requirements. Attached you will find a report summarizing the specific checklists and policies.

Please do not hesitate to contact me should you require additional information.

Sincerely,

Donna Rolshouse RN, CPHQ

Donna Rolshouse, RN, CPHQ
Director Quality Management
PAM Rehabilitation Hospital of Centennial Hills

POST ACUTE MEDICAL

SUBJECT: Table of Contents for Nursing	**PAGE:** Page 1 of 2
PUBLICATION: NSG 00	**FORMS:**
EFFECTIVE DATE:	**REVIEWED/REVISED DATE:** Revised January 29, 2019
APPROVED BY: *Kathleen M. Brown, DNP, MSHA, BSN* Kathleen M. Brown, DNP, MSHA, BSN Executive Vice President and Chief Clinical Officer	

POST ACUTE MEDICAL

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QUALITY POLICIES

POLICY #	POLICY NAME
QM 01 (/policies/Quality/Policies/QM 1 - Clinical databases.pdf)	Clinical databases
QM 02 (/policies/Quality/Policies/QM 2 - PISafety Committee.pdf)	PI Safety Committee
QM 03 (/policies/Quality/Policies/QM 3 - QAPI Plan.pdf)	QAPI Plan
QM 04 (/policies/Quality/Policies/QM 4 - Sentinel Event and Root Cause Analysis.pdf)	Sentinel Event and Root Cause Analysis
QM 05 (/policies/Quality/Policies/QM 5- Failure Mode Effects Analysis.pdf)	Failure Mode Effects Analysis
QM 06 (/policies/Quality/Policies/QM 6 - Medical Staff Bylaws and Rules and Regulations Revisions.pdf)	Medical Staff Bylaws and Rules and Regulations Revisions
QM 07 (/policies/Quality/Policies/QM 7 -Ethics Committee.pdf)	Ethics Committee
QM 08 (/policies/Quality/Policies/QM 8 - Informing Patients or Families of Unanticipated Outcomes.pdf)	Informing Patients or Families of Unanticipated Outcomes

QM 09 (/policies/Quality/Policies/QM 9 - Patient-Family Complaint Policy.pdf)	Patient-Family Complaint Policy
QM 10 (/policies/Quality/Policies/QM 10 Conflict of Interest final.pdf)	Conflict of Interest final
QM 11 (/policies/Quality/Policies/QM 11 - Grievance Policy.pdf)	Grievance Policy
QM 12 (/policies/Quality/Policies/QM 12 - Critical Incidents.pdf)	Critical Incidents

FORMS POLICIES

FORM #	FORM NAME
QM 5A (/policies/Quality/Policies/QM 5A - FMEA Form.pdf)	FMEA Form
QM 5B (/policies/Quality/Policies/QM 5B - Guide for FMEA.pdf)	Guide for FMEA
QM 10A (/policies/Quality/Policies/QM 10A - Conflict of Interest Attestation form.pdf)	Conflict of Interest Attestation form

Back to P & Ps Index (corporate.html)

INFECTION CONTROL POLICIES

POLICY #	POLICY NAME
IC 01 (/policies/Infection Control/Policies/1. Infection Control Plan.pdf)	Infection Control Plan
IC 02 (/policies/Infection Control/Policies/2. Infection Control Risk Assessment.pdf)	Infection Control Risk Assessment
IC 03 (/policies/Infection Control/Policies/3. Infection Surveillance.pdf)	Infection Surveillance
IC 04 (/policies/Infection Control/Policies/4. Communicable Disease Reporting.pdf)	Communicable Disease Reporting
IC 05 (/policies/Infection Control/Policies/5. Standard Precautions.pdf)	Standard Precautions
IC 06 (/policies/Infection Control/Policies/6. Transmission Based Precautions.pdf)	Transmission Based Precautions
IC 6A (/policies/Infection Control/Policies/6A. IsolationAppendix.pdf)	Isolation Appendix

IC 07 (/policies/Infection Control/Policies/7. Cdiff Precautions.pdf)	Cdiff Precautions
IC 08 (/policies/Infection Control/Policies/8. Hand Hygiene.pdf)	Hand Hygiene
IC 09 (/policies/Infection Control/Policies/9. Pet Visitation & Service Animals.pdf)	Pet Visitation & Service Animals
IC 10 (/policies/Infection Control/Policies/10. Donning and Removal of Personal Protective Equipment.pdf)	Donning and Removal of Personal Protective Equipment
IC 11 (/policies/Infection Control/Policies/11. Privacy Curtain Changes.pdf)	Privacy Curtain Changes
IC 12 (/policies/Infection Control/Policies/12. Terminal Cleaning Patient Rooms.pdf)	Terminal Cleaning Patient Rooms
IC 13 (/policies/Infection Control/Policies/13. Chlorhexidine Bathing.pdf)	Chlorhexidine Bathing

IC 14 (/policies/Infection Control/Policies/14. Bloodborne Pathogens Exposure Control Plan.pdf)	Bloodborne Pathogens Exposure Control Plan
IC 15 (/policies/Infection Control/Policies/15. Employee Illness.pdf)	Employee Illness
IC 16 (/policies/Infection Control/Policies/16. Immunizations and the Health Care Worker.pdf)	Immunizations and the Health Care Worker
IC 17 (/policies/Infection Control/Policies/17. Infection Control Monitoring During Construction.pdf)	Infection Control Monitoring During Construction
IC 18 (/policies/Infection Control/Policies/18. Use of Fans in Hospital Setting.pdf)	Use of Fans in Hospital Setting
IC 19 (/policies/Infection Control/Policies/19. Tuberculosis Control Plan.pdf)	Tuberculosis Control Plan
IC 20 (/policies/Infection Control/Policies/20. Medical Questionnaire TB control plan.pdf)	Medical Questionnaire TB control plan

IC 21 (/policies/Infection Control/Policies/21. Tuberculin Testing For Employees Form .pdf)	Tuberculin Testing For Employees Form
IC 22 (/policies/Infection Control/Policies/22. Eval for Previous Positive TB Skin Test.pdf)	Eval for Previous Positive TB Skin Test
IC 23 (/policies/Infection Control/Policies/23. IC bioterrorism.pdf)	IC bioterrorism
IC 24 (/policies/Infection Control/Policies/24. IC Influx policy.pdf)	IC Influx policy
IC 25 (/policies/Infection Control/Policies/25. IC Surge Capacity work sheet.pdf)	IC Surge Capacity work sheet
IC 26 (/policies/Infection Control/Policies/26. Cleaning of Patient Equipment.pdf)	Cleaning of Patient Equipment
IC 27 (/policies/Infection Control/Policies/27. Temperature Monitoring and Cleaning of Refrigerators Freezers.pdf)	Temperature Monitoring and Cleaning of Refrigerators Freezers

IC 27A (/policies/Infection Control/Policies/27A. Refrigerator Temperature Log.pdf)	Refrigerator Temperature Log
IC 27B (/policies/Infection Control/Policies/27B. Freezer Temperature Log.pdf)	Freezer Temperature Log
IC 28 (/policies/Infection Control/Policies/28. Pennsylvania Hepatitis C Screening Policy.pdf)	Pennsylvania Hepatitis C Screening Policy
IC 28A (/policies/Infection Control/Policies/28A. Pennsylvania Hep C Consent.pdf)	Pennsylvania Hep C Consent
IC 29 (/policies/Infection Control/Policies/29. Immunization of Elderly.pdf)	Immunization of Elderly
IC 30 (/policies/Infection Control/Policies/30. Neutropenic Precautions.pdf)	Neutropenic Precautions

INFECTION CONTROL FORMS

FORM #	FORM NAME

IC 13 #1 (/policies/Infection Control/Forms/Home Guidelines for Persons with Multiple Drug Resistant Organisms - IC 13 %231.doc)	Home Guidelines for Persons with Multiple Drug Resistant Organisms
IC 15 #1 (/policies/Infection Control/Forms/Infection Control Evaluation - IC 15 % 231.doc)	Infection Control Evaluation Form
IC 19 #1 (/policies/Infection Control/Forms/Physician%27s Orders for Contact Isolation - IC 19 %231.doc)	Physician's Orders for Contact Isolation
IC 19 #2 (/policies/Infection Control/Forms/Approved Signage for Contact Isolation-IC19-2.doc)	Approved Signage for Contact Isolation
IC 22 #1 (/policies/Infection Control/Forms/Tuberculosis Risk Assessment - IC 22 % 231.doc)	Tuberculosis Risk Assessment
IC 22 #2 (/policies/Infection Control/Forms/TB Screening Questionnaire - IC 22 %232.doc)	TB Screening Questionnaire
IC 22 #3 (/policies/Infection Control/Forms/Respirator Medical Evaluation Questionnaire - IC 22 %233.doc)	Respirator Medical Evaluation Questionnaire
IC 22 #4 (/policies/Infection Control/Forms/TB Screening Routing Form - IC 22 %234.doc)	TB Screening Routing Form
IC 23 #1 (/policies/Infection Control/Forms/Bloodborne Pathogens Quiz - IC 23 % 231.doc)	Bloodborne Pathogens Quiz

IC 24 #1 (/policies/Infection Control/Forms/Employee Injury Post Exposure Protocol - IC 24 %231.doc)	Employee Injury Post Exposure Protocol
IC 26 #1	Report of Possible Exposure of Transporter (TDH form, obtain from EMS)
IC 29 #1 (/policies/Infection Control/Forms/Fact Sheet - Vancomycin Resistant Enterococcus - IC 29 %231.doc)	Fact Sheet: Vancomycin Resistant Enterococcus
IC 29 #2 (/policies/Infection Control/Forms/Fact Sheet - Clostridium difficile - IC 29 % 232.doc)	Fact Sheet: Clostridium difficile
IC 29 #3 (/policies/Infection Control/Forms/Fact Sheet - Head Lice - IC 29 %233.doc)	Fact Sheet: Head Lice
IC 29 #4 (/policies/Infection Control/Forms/Fact Sheet - MRSA - IC 29 %234.doc)	Fact Sheet" MRSA
IC 29 #5 (/policies/Infection Control/Forms/Fact Sheet - Scabies Treatment-IC-29-5.doc)	Fact Sheet - Scabies Treatment
IC 30 #1 (/policies/Infection%20Control/Forms/Refrigerator%20Temperature%20Log.doc)	Refrigerator Temperature Log
IC 30 #2 (/policies/Infection Control/Forms/Freezer Temperature Log.doc)	Freezer Temperature Log
IC 33 #1 (/policies/Infection%20Control/Forms/Influenza%20vaccine%20consent.doc)	Influenza Vaccine Consent
IC 33 #2 (/policies/Infection%20Control/Forms/Hep%20B%20Consent.doc)	Hepatitis Vaccine Consent

IC 34 #1 (/policies/Infection Control/Forms/IC 34-1 form.doc)	Housekeeping, Cleaning, Discharge Procedures
IC 35 #1 (/policies/Infection Control/Forms/VACCINATION DECLINATION OR OBJECTION FORM.doc)	Vaccination Declination Form
IC 35 #2 (/policies/Infection Control/Forms/Immunization consent form.doc)	Immunization consent Form

Back to P & Ps Index (corporate.html)

PAM Rehabilitation Hospital of Centennial Hills

QUALITY AND PATIENT SAFETY PLAN

DATE: 01/11/2019

This plan was created by the PAM Rehabilitation Hospital of Centennial Hills Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
PAM Rehabilitation Hospital of Centennial Hills
6166 North Durango Drive
Las Vegas, Nevada 89149

Prepared by Donna Rolshouse, R.N., C.P.H.Q.
Director of Quality Management
Patient Safety Officer

Contents

Commitment to Patient Safety

PAM Rehabilitation Hospital of Centennial Hills is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, PAM Rehabilitation Hospital of Centennial Hills Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in PAM Rehabilitation Hospital of Centennial Hills are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, PAM Rehabilitation Hospital of Centennial Hills has developed this

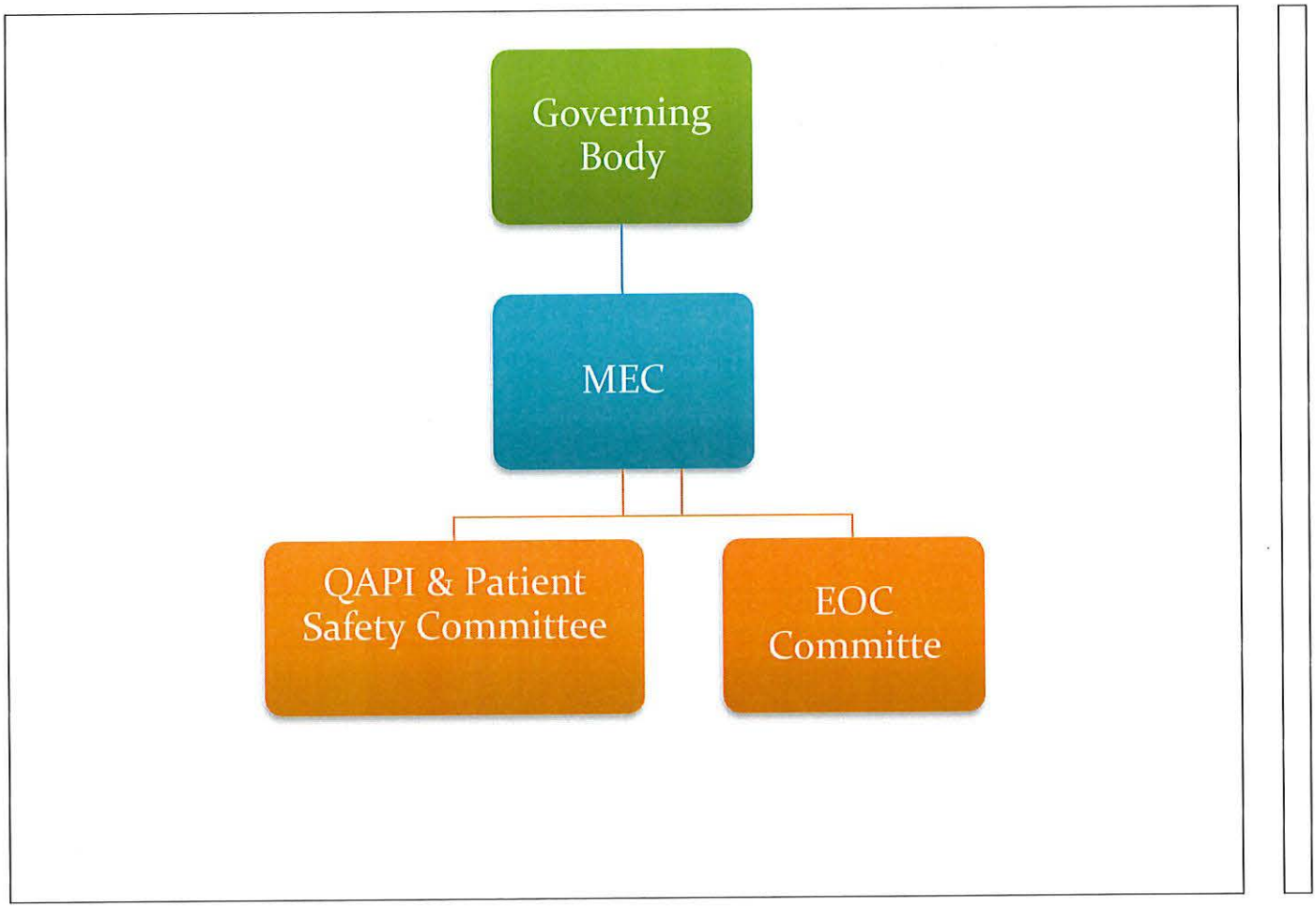
Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.



Quality and Patient Safety Plan

Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4) (b).
- Receive reports from the patient safety officer pursuant to NRS 439.870.
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:

  (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

  (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

  (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plan.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA effort

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Hand hygiene compliance	90%	Observations and training, one on one coaching if indicated	12/31/2019	Entire clinical team
PPE Compliance	90%	Observations and training, one on one coaching if indicated	12/31/2019	Entire clinical team
Patient Safety with scanning medications	100%	Scan all medications, all medications will have barcode and be scanned; education and monitoring	12/31/2019	Pharmacy and Nursing
Keep falls at a minimum; no injuries	Fall rate ≤7.0	Risk assessments; fall precautions implemented; monitoring; huddles for data collection	12/31/2019	Nursing, therapy
Safe and successful discharges, keep LOA and acute transfers out to a minimum	Rate <10.0	Hourly rounding; rapid responses if indicated and change in condition, post-acute huddles for information	12/31/2019	Entire clinical team
No hospital acquired pressure ulcers, =>stage 3	Zero	Daily and weekly skin assessments; education;	12/31/2019	Nursing

Components and Methods

Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

PAM Rehabilitation Hospital of Centennial Hills will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in PAM Rehabilitation Hospital of Centennial Hills to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

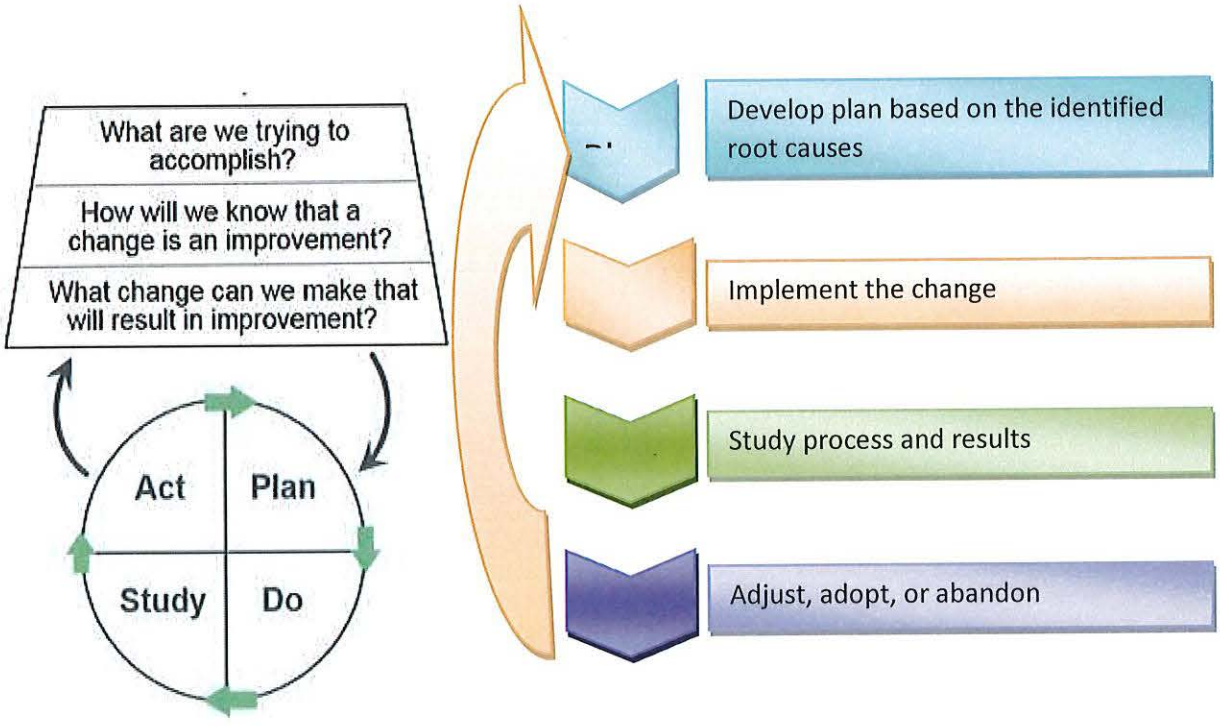
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. PAM Rehabilitation Hospital of Centennial Hills is using from RMPRO, erehab, meridian, for tracking the sentinel events, healthcare infection data, and internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
    - Proper instructions concerning prescription medications;
    - Instructions concerning aftercare;
    - Any other instructions concerning his or her care upon discharge; and
    - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/

- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Institute for Healthcare Improvement (IHI) defines **medical harm** as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death."

Facility-Associated Infection: (NRS 439.802)

"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805)
"Medical facility" means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

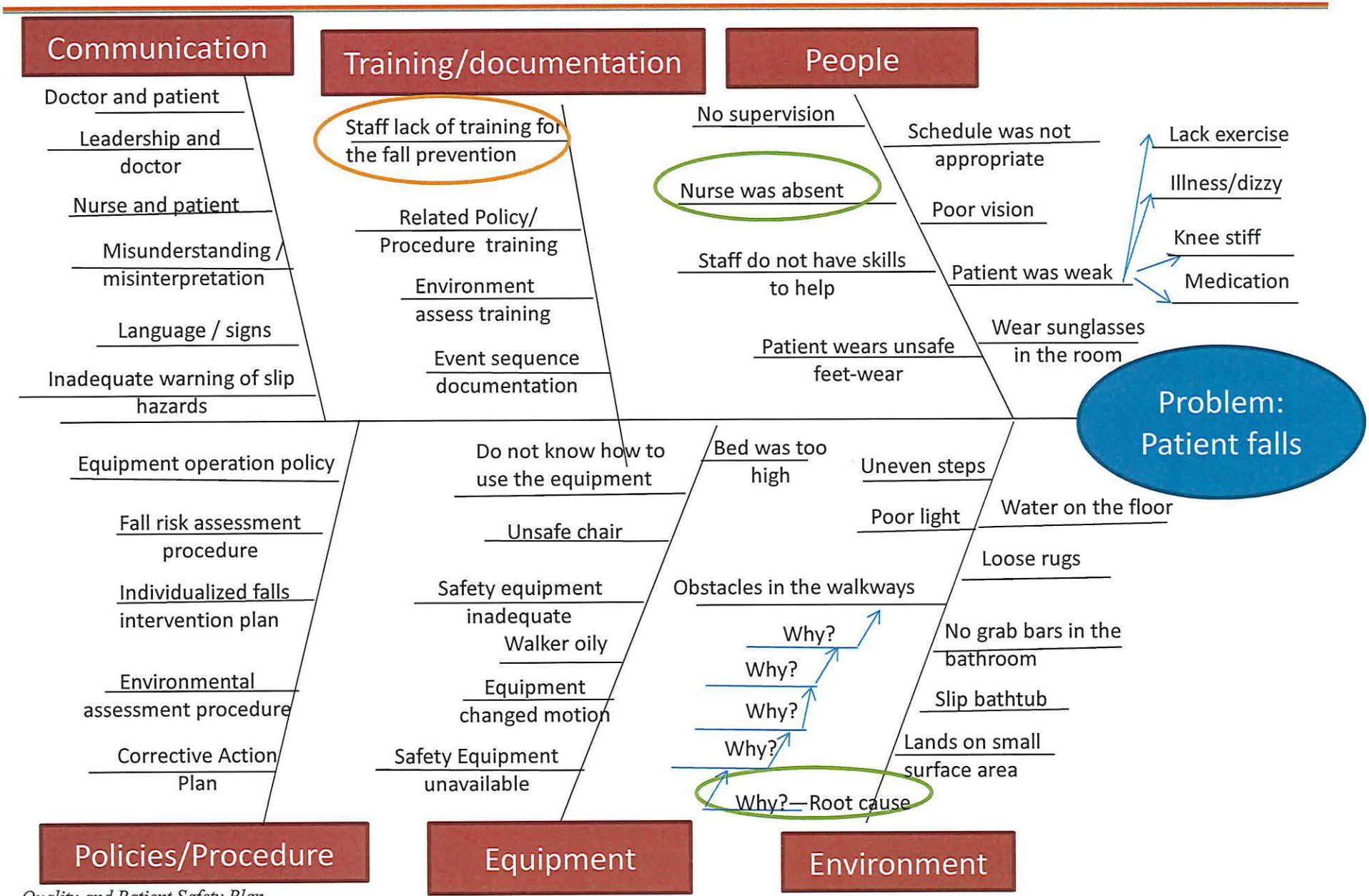
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
		ACTION PLAN:		
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.	Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	Establish Patient Safety Council.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		**Date:**	
Telephone/ Email:		**Cycle:**	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	**Summarize what was learned: success, failure, unintended consequences, etc.**

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	**Describe what modifications to the plan will be made for the next cycle based on what you learned.**
☐ Adapt: modify changes and repeat PDSA Cycle	
☐ Adopt: expanding changes throughout organization	
☐ Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	

Monthly / Quarterly Report	
Items	**Description**
1. What is your goal?	
2. Report on the PDSA cycle	
3. What system and practices are working well? Explain.	
4. What areas for improvement did the data identify?	
5. What barriers or system issues have been encountered implementing action activities?	
6. Action plans to address the barriers or system issues	
7. Lesson learned	
8. Support needed	
9. Additional discussion	
Notes:	

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission	x			
Reassess risk daily and with changes in patient condition	X			
Implement patient-specific intervention to prevent falls and injury	X			
Communicate risk across the team; use handoff forms, visual cues, huddles	X			
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)	X			
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds	X			
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives	X			
Incorporate multidisciplinary input for falls	X			
Prevention from PT, OT, MD, RN and PharmD	X			
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient	X			
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls	X			

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1]

	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by hospital
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:
Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:
Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management
Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must
ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

POST ACUTE MEDICAL

STROKE STANDING ORDER AND PROTOCOL

Initiate immediate supportive care:

- O2 (keep O2 sat > 94%)
- Finger Stick Blood Glucose
- Cardiac Monitor

↓

Call MD

↙ ↘

Inclusion

Use standing order on patients 18 years or older with these symptoms: (may be transient or persistent)

- Facial drop
- Unequal grips/arm drift
- Slurred speech
- Change in mental status- as documented by friend or family member- not related to drugs, alcohol, trauma, seizure or diabetes
- Sudden *loss* of vision (complete or a portion of a visual field)
- Ataxia [dramatic, acute changes in coordination (arms, legs, or gait) or inability to make smooth, intentional movements in a patient with *normal* mental status]

Exclusion

This standing order should not be used on patients with these characteristics:

- Age < 18 years
- Shock and/or respiratory distress
- Symptom onset >6 hours or unknown
- Cardiac dysrhythmias where resuscitative measures might be needed
- Unconscious/unresponsive
- FSBG <70 mg/dl
- Head trauma, drug or alcohol intoxication or seizure with postictal state likely

↘ ↙

Orders

If clear, acute neurologic changes are present:

- Initiate IV NS at 20ml/hr
- Establish and relay "STROKE ALERT" with time last seen normal
- Call 911

Physician Signature: _____ Date: _____ Time: _____am/pm

Nursing Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

Asthma/COPD Dyspnea Standing Order and Protocol

Inclusion

History of respiratory disease (asthma, COPD), wheezing with increased work of breathing.

Call MD

Asthma:

- Albuterol nebulized therapy
  - 2.5 mg via nebulizer for dyspnea. May repeat every five minutes to a max of three doses as needed for dyspnea.

For Presumed **Asthma** and severe respiratory distress unresponsive to initial therapy:

Administer Epinephrine*:

- Adults (wt >30kg)
- Epinephrine 1:1000 (1mg/ml). Inject 0.3mg (0.3ml) intramuscularly. May repeat dose every 10 minutes for 3 doses as needed for severe respiratory distress.
- Magnesium Sulfate 2 grams in 50 ml SWFI/D5W
  - Administer IVPB over 15 minutes

*Epinephrine anaphylaxis Kit

- 2-vials/amps Epinephrine 1:1000 1ml (1mg/ml)
- 4-1cc syringes
- 4-22G 1-inch needles
- 4- alcohol pads

COPD:

- Albuterol 2.5mg and Ipratropium 0.5mg via nebulizer as needed for dyspnea.
  - May repeat Albuterol 2.5mg every five minutes to a max of three doses as needed for dyspnea.
- IV access and NS fluid bolus:
- 500ml NS IV over one hour. May repeat times one as needed for blood pressure control.
- Methylprednisolone sodium succinate
  - 2mg/kg IVP to a max of 125mg administer over 3 minutes

For Presumed **COPD** and severe respiratory distress unresponsive to initial therapy:

STAT MD/RT

Physician Signature: _____ Date: _____ Time: _____am/pm

Nurse Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

Anaphylaxis/Allergic Reaction Standing Order

Call MD

Unstable Allergic Reaction:

- Signs of shock, severe respiratory distress or airway compromise

Stable Allergic Reaction:

- Urticaria (Hives)
- Sense of dyspnea
- Sense of oropharyngeal swelling
- Sense of throat tightness

For UNSTABLE allergic reaction:

- Administer Epinephrine*:
  - Adults (wt >30kg)
- Epinephrine 1:1000 (1mg/ml). Inject 0.3 mg (0.3ml) intramuscularly. May repeat dose every 10 minutes for 3 doses as needed for signs of shock, severe respiratory distress or airway compromise.
- Continue with orders outlined in Stable Order Reaction.

*Epinephrine anaphylaxis kit

- 2-vials/amps Epinephrine 1:1000 1ml (1mg/ml)
- 4-1cc syringes
- 4-22G 1-inch needles
- 4- alcohol pads

For STABLE allergic reaction

Following the administration of Epinephrine:

- Albuterol nebulized therapy
  - Administer 2.5mg via nebulizer as needed for dyspnea. May repeat every five minutes to a maximum of three doses as needed for dyspnea
- Albuterol 2.5mg and Ipratropium 0.5mg via nebulizer as needed for dyspnea.
  - May repeat Albuterol 2.5mg via nebulizer every five minutes to a max of three doses as needed for dyspnea.
- IV access and NS fluid bolus:
  - 500ml NS IV over one hour. May repeat times one as needed for blood pressure control.
- Diphenhydramine
  - 1mg/kg IVP to a max of 25mg administer over 1 minute
- Methylprednisolone sodium succinate
  - 2mg/kg IVP to a max of 125mg administer over 3 minutes

Special Note:

- Multiple diseases may mimic anaphylaxis (i.e.: Angioedema, Scombroid Toxicity, Anaphylactoid Reaction, etc.). Treatment for these diseases is the same as anaphylaxis as outlined above.

Physician Signature: _____ Date: _____ Time: _____am/pm

Nurse Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

SEIZURE STANDING ORDER AND PROTOCOL

Initiate immediate supportive care:

During Seizure:

- Protect patient from injury
- Remove Obstacles

Post Seizure:

- Oxygen to keep
- Cardiac monitor
- Blood glucose

↓

Call MD

↓

Inclusion

Use standing order on patients with:

- Status epilepticus
- Generalized seizure activity
- Febrile seizure
- Focal seizure activity
- Postictal mental status

Exclusion

Do not use Standing Order on patients with:

- Hypoglycemia
- Dysrhythmias where ACLS interventions might be considered

↓

Seizure activity on arrival

↓

Lorazepam- IV/IM — 2mg (13kg to 40kg), 4mg (greater than 40kg) If IV administration slow IVP over 3 minutes

↓

Obtain IV access

↓

Continued seizure 10 minutes after initial medication →

If seizures continue after 10 minutes administer **one additional dose**

Lorazepam- IV

2mg (13kg to 40kg),
4mg (greater than 40kg)
IV administration slow IVP over 3 minutes.

CAUTION: Use of benzodiazepines (lorazepam) administered IV must be accompanied by **monitoring the airway** as respiratory depression may occur. Use caution with concomitant use of benzodiazepines and opioids as there is an increased the risk of extreme sleepiness, respiratory depression, coma, and death.

Physician Signature: _____ Date: _____ Time: _____am/pm

Nurse Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

DYSPNEA STANDING ORDER AND PROTOCOL

Inclusion

All patients complaining of dyspnea, cough, tachypnea, or in respiratory distress

↓

Call MD & Proceed

↓

Exclusion

Standing order should NOT be used on patients with the following symptoms:

- Chest Pain
- Dysrhythmia (ACLS)
- Hemorrhage
- Smoke Inhalation
- Toxic Exposure
- Seizure
- Absent Breath Sounds
- Trauma

↓

Initiate supportive care:

1. Place patient in position of comfort
2. Supplemental O2 to achieve O2 Sat >94%
3. Obtain vital signs
4. IV Access
5. Cardiac monitor
6. If respiratory failure- consider Airway Management Protocol

↓ ↓ ↓

Dyspnea SO **Anaphylaxis Protocol**	Dyspnea SO **Asthma/COPD Protocol**	Dyspnea SO **CHF/Volume Overload Protocol**

Special Note: Other causes of dyspnea include pneumonia, pneumothorax, pulmonary contusion, pulmonary embolism, or toxic ingestion (i.e. aspirin).

Physician Signature: _____ Date: _____ Time: _____am/pm

Nurse Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

CHF/VOLUME OVERLOAD DYSPNEA STANDING ORDER AND PROTOCOL

INCLUSION

History of volume overload (CHF, Renal Failure) with increased work of breathing or dyspnea.

Call MD

For **Normotensive** (SBP >90 mmHg) patients:

- O2 at 2L per N.C.
- 12-lead ECG and continuous cardiac monitor
- IV saline lock
- Nitroglycerin
  - Nitropaste one-half inch to anterior chest wall. Hold if SBP <90mmHg

For **Hypotensive** (SBP <90 mmHg) patients:

- O2 at 2L per N.C.
- 12-lead ECG and continuous cardiac monitor
- IV saline lock

Physician Signature: _____ Date: _____ Time: _____am/pm

Nursing Signature: _____ Date: _____ Time: _____am/pm

POST ACUTE MEDICAL

CHEST PAIN STANDING ORDER AND PROTOCOL

Initiate immediate supporting care:

- Oxygen to keep O2 sat > 94%

Inclusion

Use standing order on patients > 35 years of age with any of these symptoms:

- Dull, aching or substernal epigastric pain/pressure
- Radiation of pain/pressure to arm, shoulder, neck, jaw or back
- Associated diaphoresis and/or shortness of breath

Exclusion

Standing order **should not** be used on patients with these conditions:

- Dysrhythmias- where ACLS protocols might be considered
- Pulmonary edema (Follow CHR/Volume Overload Dyspnea SO)

1. Administer Aspirin: Give (4) – 81 mg chewable tablets (324mg), if patient has not already taken prior to admission
2. Initiate IV NS @20 ml/hr (if permitted)
3. Cardiac Monitor
4. Acquire 12-lead ECG
5. Call Medical Doctor
6. If Systolic BP >110mmHg, give one (1) **NTG** 0.4 mg SL every 5 minutes until pain relieved OR to a maximum of 3 doses; hold NTG if BP < 90mmHg systolic
7. If pain unrelieved by NTG, administer **Morphine Sulfate** 2 mg IVP every 5 minutes until pain relieved OR to a maximum dose of 20 mg; hold Morphine if BP < 90mmHg Systolic
8. If BP < 90mmHg Systolic- place patient in supine position with legs elevated (Trendelenburg) & give 250 ml NS IV bolus over 30 minutes.

Assess for Hemodynamic Instability

If unstable, contact Physician STAT!

If **STEMI-** Dial 911

If **no** ST elevation on ECG: await further orders

Physician Signature: _____ Date: _____ Time: _____am/pm

Nurse Signature: _____ Date: _____ Time: _____am/pm

Name:

Date:

RT SHIFT CHECKLIST

Instructions:

Initial each task when completed

Write N/A if task does not need to be done OR does not apply to your shift

Circle if unable to complete task

SUNDAY- SATURDAY (PAYROLL PERIOD)

___ Clock-IN while checking the LAB, log temp, frig, centrifuge & empty trash/clean if needed

___ Check C-Arm Room for trash, ensure machines are plugged in, simple maintenance

___ *Check Census against Treatment Sheets*

___ Check Green RT folder at Nurses Station

____**FIRST TASK - Identify the Patient's on CONTINUOUS O2- obtain an Sp02 and drop *YOUR* 12hr 02 Charge (This is to be completed ONCE per shift - PER RT AT *THE BEGINNING OF YOUR FIRST ROUNDS*- Please do NOT complete this task for others). ENSURE O2 SIGNS ARE CORRECT AND TAPED ABOVE FLOWMETER!!!!!!!!!!!!!!!!!!!!!!!!**

___ **Complete the assigned TXN's**

___ Complete assigned tasks (IS, **Pulse Ox checks for RA pt's,** check BiPap/CPAP pt's)

___ Check **CODE STATUS** on your patients- identify assigned personnel for CODE/RR

___ Check PT Board – Identify Dialysis Patients- days of dialysis. Complete O2 check ASAP

___ Update **ALL RT Assigned patient's and Patient Partner** whiteboards with correct RT on shift

___ Check indoor tank inventory .Ensure 12 Full tanks in RT room- 6 tanks in hall closet- **DAYS**

___ Bring EMPTY tanks to the Outside tank farm- bleed the remainder of the tank per PRAXAIR- **DAYS**

___ **#** Empty tanks and # Full tanks in 02 Farm **-DAYS**

___ Ensure **ALL** tanks are tagged appropriate

___ ENSURE MEDICATION/RT Orders are correct

___ Stock RT Room

___ Ensure all RT standby equipment is cleaned, set-up, bagged and ready to be applied

___ **IF AVAILABLE**- TXN's can be started for next shift (RT EVAL's are priority)

___ Acknowledge **ALL YOUR ORDERS** before the next RT arrives (microscope)

___ Complete **MEDICATION EDUCATION** (Including Medication Frequency Change, 02 Inhalation)

___ **Verify ALL TNXS's that were given are cleared before the next RT arrives (calendar- main screen)**

___ FIX ANY MEDICATION ERRORS/DISCREPENCIES- Notify Pharmacy/RT Manager

___ **Update Treatment Sheets on the WOW and reprint if needed**

___ **Log into Trident ONCE A WEEK**

___ **"ZONE OF HOSPITATLITY"**.....make eye contact & smile! Warmly greet & welcome each new admit, visitor, MD & fellow team members. Provide immediate service recovery. Display appropriate body language at ALL times. 10ft and 5ft .....within 10ft make eye contact and warmly smile to acknowledge. Within 5ft use a warm and sincere greeting utilizing eye contact and a friendly gesture of acknowledgment. **THIS IS OUR NEW 10 AND 5 STAFF RULE.**

_____ _____

7AM-7PM Therapist Signature & Date **7PM-7AM Therapist Signature & Date**

Comments:

_____

_____

_____

_____

PLEASE CALL AIMEE FOR ANY RmPro RELATED INCIDENTS

*****NEW PATIENT PARTNER ROOMS – 2007,2008, 2009**/ Please hang my sign/write my name**

PLEASE CHECK WITH RT MANAGER FIRST BEFORE ASKING ANOTHER RT TO COVER A SHIFT

Effective 6/29/18, Updated 10/4/18, 11/29/18, 2/12/19, 4/1/19, 5/6/19

Discharge Plans Icon (Man in Door) --> Special Instructions --> Template --> D/C Nursing D/C Note

In Note type things pertinent to patient

Skin care assessment --> completed with_____

Take all meds as directed, activity and diet as tolerated (unless special orders)

Document skin condition

Belongings verified with_____

Discharge instructions signed and documented and placed in chart

Add a note regarding the discharge and include the following:

Patient A&O x 4 (mental status), cooperative with staff, medication compliant, attended all therapies. Patient has received orders to discharge home with HHA. (home, SNIF, etc.) Patient has received all d/c and educational information. Patient has his own walker/wheelchair (mode of transport) and will be transported by personal vehicle (GMT, etc) accompanied by ____(who).

Go under Clinical Pharmacology Icon on the desktop to print educational material:

Patient education tab --> Discharge Instructions tab, put information pertinent to their discharge. Once added hit print and yellow box pops up- type in patient's name, doctor that cared for them and check the box that says Create Handout Documentation Page.

Have them review and sign Belongings sheet from the chart under the discharge tab.

Print Patient Discharge instructions under Reports Icon (looks like mountains)

Print Patient Discharge Summary Report

Print Discharge Medication Report, if doctor has not done the discharge summary and meds are not listed print the Medication Profile Report so you can review meds with the patient.

PERSONAL MEDICATIONS BROUGHT FROM HOME

Place original in chart, keep (1) copy with bag, give (1) copy to patient.

Patient Sticker Here:

Medication	strength (mg/mcg)	# of tabs/capsules	verified by:		Returned # of tabs/capsules	verified by:	
			RN	RN/LVN		RN	RN/LVN

Date: _____

Patient signature: _____

RN signature: _____

RN/LVN signature: _____

Date Returned: _____

Patient signature: _____

RN signature: _____

RN/LVN signature: _____

PAM Rehabilitation Hospital of Centennnial Hills
Las Vegas, Nevada

Fire Watch Checklist

Date:	**Start Time:**
Shift: 1 2 3	**Finish Time:**
Conducted by:	**Job Title:**

Item	Conditions	Yes	No	N/A	Contact
1	There is fire, smoke, or a smell of smoke, or other evidence of a fire or incipient fire.				
2	Fire alarm pull stations, smoke detectors, or heat detectors are blocked, obstructed, or rendered inaccessible.				
3	Fire alarm pull stations, smoke or heat detectors, bells or other fire alarm elements are damaged or broken.				
4	Fire extinguishers are blocked, or obstructed, or rendered unavailable for immediate use.				
5	Fire extinguishers are damaged, missing, or have not been inspected for the month.				
6	Fire or smoke doors are blocked or obstructed by materials, equipment, or wedging.				
7	Fire or smoke doors are damaged, broken, or unable to close fully, or latch appropriately.				
8	Exit lights or illumination of the corridor is burned out or not operating properly.				
9	Exit path is blocked or obstructed. Exit stairs contain any material, or supplies, or debris.				
10	Exit door at bottom of stair is obstructed, nonfunctional, or unable to easily open.				
11	Exit stairs lighting is not operational; areas of the stair are dark or not visible.				
12	Corridors have supplies, equipment, trash, debris, or other materials obstructing any part of corridor.				
13	Trash, debris or other combustible materials stored in rooms or areas adjacent to the corridor.				
14	Construction materials or equipment storage obstruct the corridor, exit path, stairs, or other use areas.				
15	Fire separations have holes, penetrations or unprotected openings.				
16	There are holes in walls, floors, or fire separations, or other visible changes in the building fire construction exist that could cause injury or risk to patients or staff.				
Other					
Other					

PAM Rehabilitation Hospital
Environmental Services
Orientation Checklist

Name:_____

Job Title:_____

Date Hired:_____

	Date	Initials
1. Gave employee job description		
2. Explained Organizational Chart.		
3. Discussed open door policy/ communication.		
4. Introduced employee to department staff.		
5. Explained work hours (including lunch and breaks)		
6. Discussed/ demonstrated time cards and clock-in procedures.		
7. Discussed reporting of absences, tardiness, and illness.		
8. Discussed departmental goals.		
9. Department meeting and in-service requirements.		
10. Explained hospital safety and emergency code procedures.		
11. Location of MSDS manual.		
12. Location of Safety manual.		
13. Explained/ demonstrated location of Policy and Procedure manual		
14. Isolation procedures.		
15. Infection Control.		
16. Hazardous materials.		
17. Cleaning of Patient Rooms.		
18. Cleaning of Dismissal/ Discharges.		
19. Cleaning of Nurses' Station.		
20. Sweeping and Mopping of Hallways.		
21. Cleaning of Offices.		
22. Cleaning of Pool Area.		
23. Cleaning of Lobby/ Public restrooms.		
24. Lockers.		
25. Distribution of keys.		
26. Performance Evaluations.		
27. Uniform and Personal appearance.		
28. Telephone use.		
29. Disciplinary action.		
30. Cafeteria services.		

I have been provided with a copy of my job description and understand the contents.

Employee Signature:_____

Supervisor Signature:_____

Managers Checklist

Dietary Pam

Las Vegas

Daily Checklist:

Am Check:

1. Food Temp Logs are completed

2. Refrigeration/ Hot Box logs are completed

3. Trayline audit is complete for Am & Lunch

4. Walk through around kitchen is completed daily by manager checking equipment sanitizer buckets, dates and lables on food item, Ice machine and hood system.

Angela Cayaban

Cleaning/Closing Checklist

Shift: PM Food Tech

	11-Jun	12-Jun	13-Jun	14-Jun	15-Jun	16-Jun	17-Jun
ITEM	**MON**	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
All breakfast prep completed for next day.							
Work tables cleaned/sanitized; top surface and bottom shelves							
Floor swept & mopped and free of grease, trash, and water							
Deck brush floors in cold prep area.	office side	x	x	tray line side	x	x	x
DIET CLERK: Nourishment rooms restocked to par level. Record number of items stocked in log	South	North	South	North	South	North	
All large prep sinks(3) & handwashing sink in cold prep area cleaned with lemon lift, dried.							
Clean both Pass thru units; everything covered, labeled, dated (nothing expired!)							
Change out pans in glass front pass though.	x	x	x	x		x	x
Walk in cooler audit - check for labels & expiration dates	x	x	x	x	x		x
All product used on shift is labeled & dated							
All product produced on shift is labeled & dated							
Run ice scoop through the dishmachine							
TECH: Take sanitizer upstaris to nourishment rooms sanitize coffee machines: trays, bottle brush holes for product.							
TECH: Take sanitizer upstaris to nourishment rooms sanitize refrigerators							
Clean & Sanitize coffee machine. Sanitize inside and out.			weekly flushing of cafe coffee system.				
Clean & Sanitize soda machine & catch tray. Remove nozzles, scrub with brush & replace							
Dump tea, wipe out urn with soap & water, rinse. Disassemble spigot & soak in QA sanitizer. Wipe under machine							
Slicer cleaned & sanitized, ready for next use							
Empty DON sanitizer buckets & place dirty utility towels in bag							
Place clean DON bucket on top of work station							

Cleaning/Closing Checklist

Shift: PM Food Tech

	11-Jun	12-Jun	13-Jun	14-Jun	15-Jun	16-Jun	17-Jun
ITEM	**MON**	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
All breakfast prep completed for next day.							
Work tables cleaned/sanitized; top surface and bottom shelves							
Floor swept & mopped and free of grease, trash, and water							
Deck brush floors in cold prep area.	office side	x	x	tray line side	x	x	x
DIET CLERK: Nourishment rooms restocked to par level. Record number of items stocked in log	South	North	South	North	South	North	
All large prep sinks(3) & handwashing sink in cold prep area cleaned with lemon lift, dried.							
Clean both Pass thru units; everything covered, labeled, dated (nothing expired!)							
Change out pans in glass front pass though.	x	x	x	x		x	x
Walk in cooler audit - check for labels & expiration dates	x	x	x	x	x		x
All product used on shift is labeled & dated							
All product produced on shift is labeled & dated							
Run ice scoop through the dishmachine							
TECH: Take sanitizer upstaris to nourishment rooms sanitize coffee machines: trays, bottle brush holes for product.							
TECH: Take sanitizer upstaris to nourishment rooms sanitize refrigerators							
Clean & Sanitize coffee machine. Sanitize inside and out.			weekly flushing of cafe coffee system.				
Clean & Sanitize soda machine & catch tray. Remove nozzles, scrub with brush & replace							
Dump tea, wipe out urn with soap & water, rinse. Disassemble spigot & soak in QA sanitizer. Wipe under machine							
Slicer cleaned & sanitized, ready for next use							
Empty DON sanitizer buckets & place dirty utility towels in bag							
Place clean DON bucket on top of work station							

South Rm#2

Cart Delivery Time

Date		Breakfast	Arrival Time	Initials			Lunch	Arrival Time	Initials			Dinner	Arrival Time	Initials
1-Jul														
2-Jul														
3-Jul														
4-Jul														
5-Jul														
6-Jul														
7-Jul														
8-Jul														
9-Jul														
10-Jul														
11-Jul														
12-Jul														
13-Jul														
14-Jul														
15-Jul														
16-Jul														
17-Jul														
18-Jul														
19-Jul														
20-Jul														
21-Jul														
22-Jul														
23-Jul														
24-Jul														
25-Jul														
26-Jul														
27-Jul														
28-Jul														
29-Jul														
30-Jul														
31-Jul														

Warm Springs Kyle — Month: Jul-18

QUATENARY AMMONIA Concentration Log for Pot sink

Please log the level of P.P.M. concentration in the 3rd compartment of the POT SINK to ensure that everything is properly sanitized.
The log should be filled in and signed by those who are directly involved in filling the Pot Sink.
200 ppm of Quatenary Ammonia is the required concentration level.

	A.M.	P.M.			A.M.	P.M.	
DATE	PPM Conc.	PPM Conc	Signature	DATE	PPM Conc.	PPM Conc	Signature
1				23			
2				24			
3				25			
4				26			
5				27			
6				28			
7				29			
8				30			
9				31			
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							

Pam Las Vegas

1. DISPLAY COOLER (café line)
2. COLD PASS THRU
3. LINE FREEZER
4. GLASS FRONT PASS THRU (trayline)
5. WALK IN COOLER
6. WALK IN FREEZER

Report temperatures that are outside of the noted range to supervisor immediately

REFRIGERATION AND FREEZER TEMPERATURE'S NORMAL RANGES
REFRIGERATION 30 TO 41 F / FREEZER -10 TO 18 F

MONTH: Jul-18

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	AM																															
	PM																															
2	AM																															
	PM																															
3	AM																															
	PM																															
4	AM																															
	PM																															
5	AM																															
	PM																															
6	AM																															
	PM																															

Pam Las Vegas

DISHMACHINE TEMPERATURE RECORD

"Good washing and sanitizing demands correct temperatures"

Jul-18

	BREAKFAST		LUNCH		DINNER	
DATE	FINAL RINSE 180°-or higher	INITIALS	FINAL RINSE 180°-or higher	INITIALS	FINAL RINSE 180°-or higher	INITIALS
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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25						
26						
27						
28						
29						
30						
31						

IF TEMPERATURE IS UNACCEPTABLE, CIRCLE TEMPERATURE AND GET HELP TO SOLVE PROBLEM!

Warm Springs Kyle Month July-18

QUATINARY - PPM Concentration Log

Please log the level of P.P.M. concentration in Sanitizer Buckets to ensure that everything is properly sanitized.
The log should be filled in and signed by those who are directly involved in filling the Sanitation Buckets.
150-400 ppm of QUATINARY SOLUTION is the required concentration level.

	A.M.	P.M.	
DATE	PPM Conc.	PPM Conc	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			

	A.M.	P.M:	
DATE	PPM Conc.	PPM Conc	Signature
23			
24			
25			
26			
27			
28			
29			
30			
31			

FOOD TEMPERATURE RECORD

Jul-18

INSTRUCTIONS FOR USE OF THIS FORM:
Take the temperatures of each menu item and record the time and temperature below. If a food item is out of range place a check mark in the "UN" box to signify that it is out of the proper temperature range. Reheat the food item until it is above 165 degrees. Place the food item back on the steam table and record the corrected temperature and time in the two right colums.

HOT FOODS MUST BE HELD AND SERVED AT 135 DEGREES OR HIGHER.
COLD/CHILLED FOODS MUST BE SERVED AT 41 DEGREES OR LOWER.

BREAKFAST

NAME _____

ITEM	TIME	Reg TEMP	Grd TEMP	Puree TEMP	UN	TIME	TEMP
EGGS							
MEAT							
POTATOES							
FRENCH TOAST							
PANCAKES							
WAFFLES							
FRUIT JUICE							
Hot Cereal							
Super Cereal							

LUNCH

NAME _____

ITEM	TIME	Reg TEMP	Grd TEMP	Puree TEMP	UN	TIME	TEMP
MEAT							
STARCH							
VEGETABLE							
ALT. MEAT							
ALT. STARCH							
ALT. VEGETABLE							
GRAVY							
SOUP							
SALAD							
DRINK							

DINNER

NAME _____

ITEM	TIME	Reg TEMP	Grd TEMP	Puree TEMP	UN	TIME	TEMP
MEAT							
STARCH							
VEGETABLE							
ALT. MEAT							
ALT. STARCH							
ALT. VEGETABLE							
GRAVY							
SOUP							
SALAD							
DRINK							

North - Rm #230-257

Cart Delivery Time

Date		Breakfast	Arrival Time	Initials			Lunch	Arrival Time	Initials			Dinner	Arrival Time	Initials
1-Jul														
2-Jul														
3-Jul														
4-Jul														
5-Jul														
6-Jul														
7-Jul														
8-Jul														
9-Jul														
10-Jul														
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22-Jul														
23-Jul														
24-Jul														
25-Jul														
26-Jul														
27-Jul														
28-Jul														
29-Jul														
30-Jul														
31-Jul														

South Rm#2

Cart Delivery Time

Date		Breakfast	Arrival Time	Initials			Lunch	Arrival Time	Initials			Dinner	Arrival Time	Initials
1-Jul														
2-Jul														
3-Jul														
4-Jul														
5-Jul														
6-Jul														
7-Jul														
8-Jul														
9-Jul														
10-Jul														
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27-Jul														
28-Jul														
29-Jul														
30-Jul														
31-Jul														

PAM REHABILITATION HOSPITAL OF LAS VEGAS

CRASH CART CHECK VERIFICATION

Month:_____ , Year _____

DATE	TIME	CHART LOCKED	LOCK #	O2 PSI	ADULT AMBU BAG	SUCTION	CHG (JOULES)	DEFIB PADS	EQUIPMENT EXP. DATE	SIGNATURE

** Crash cart to be checked twice a day at the beginning of each shift and filed monthly.**

Transporting patient's on contact isolation precautions!

Patient's on contact isolation need to follow the steps outlined below when the patient is taken out of the room. Following these steps reduces the chance of spreading bacteria.

The staff transporting will ensure the following steps are done with (or for) the **patient:**

a. Change pt. into **a clean hospital gown** (do NOT keep extra gowns sitting in the room and use these – they are contaminated with bacteria! You MUST get a **new clean gown when you go in to care for the patient!)**
b. Assist patient with hand hygiene (alcohol rub is acceptable)
c. Apply a clean, disposable gown over the patient
d. Apply a pair of clean gloves to the patient
e. Once the patient is in the w/c or on the stretcher, cover the patient with a CLEAN sheet from the linen cart (remember do NOT use a sheet that has been stored in the patient room!), and wipe down rails with disinfecting wipe before leaving the patient's room

---

The staff transporting the patient is responsible for performing the following steps:

a. Remove the PPE you have had on while prepping the patient (Remove at the doorway where waste receptacles are located!)
b. Perform hand hygiene, alcohol based handrub is ok

It is **NOT** necessary for the transporter to wear a gown or gloves while patient is taken to and from the destination.

However, you should put an extra pair of gloves in your pocket for use if needed.

Ensure that healthcare workers receiving patient are aware of isolation status!

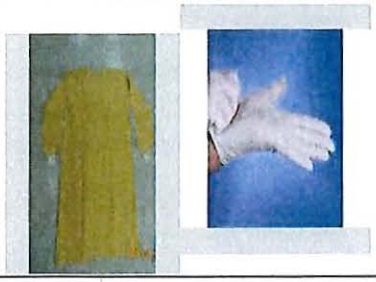
Transporter should **apply a new gown and gloves before physically assisting the patient once the destination is reached**.

ATTENTION:

VISITORS & HOSPITAL STAFF

VISITORS: MUST wear a regular (surgical) mask when entering the room! Please talk to a nurse BEFORE entering if you have any questions

AIRBORNE PRECAUTIONS
DOOR MUST REMAIN CLOSED!

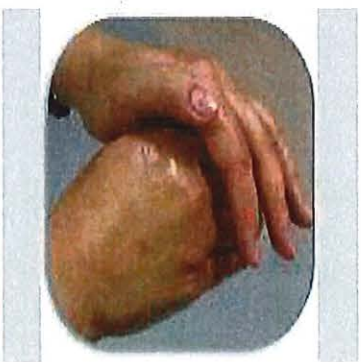


N 95 MASK MUST be worn by employees, GOWN and GLOVES

*__MUST__ be worn to enter this room

EQUIPMENT:

*Single patient use equipment
*Disposable when possible
*Disenfect all equipment before it leaves the room



BEFORE exiting the room remove your gloves & gown

Once in ante room close the room door THEN remove your mask!

Perform appropriate hand hygiene

* using soap and water OR alcohol based hand rub

Patient transport from the room is limited to essential purposes ONLY!

Transporting patient's on AIRBORNE isolation precautions!

Patient's on airborne isolation need to follow the steps outlined below when the patient is taken out of the room. Following these steps reduces the chance of spreading bacteria.

The staff transporting will ensure the following steps are done with (or for) the **patient:**

a. Change pt. into **a clean hospital gown** (do NOT keep extra gowns sitting in the room and use these – they are contaminated with bacteria! You MUST get a **new clean gown when you go in to care for the patient!)**
b. Assist patient with hand hygiene (alcohol rub is acceptable)
c. Apply a clean, disposable gown over the patient
d. Apply a (regular, surgical) mask to the patient!!
e. Apply a pair of clean gloves to the patient
f. Once the patient is in the w/c or on the stretcher, cover the patient with a CLEAN sheet from the linen cart (remember do NOT use a sheet that has been stored in the patient room!), and wipe down rails with disinfecting wipe before leaving the patient's room

---

The staff transporting the patient is responsible for performing the following steps:

a. Remove the PPE you have had on while prepping the patient (Remove at the doorway where waste receptacles are located!) EXCEPT your N95 mask
b. Exit the room and close the door behind you THEN remove your N95 (while you are in the ante room still)
c. Perform hand hygiene, alcohol based handrub is ok

It is **NOT** necessary for the transporter to wear a gown, mask or gloves while patient is taken to and from the destination.
However, you should put an extra pair of gloves and a mask in your pocket for use if needed during transport.

Ensure that healthcare workers receiving patient are aware of isolation status!

Transporter should **apply a new gown, mask, and gloves before physically assisting the patient once the destination is reached.**

Transporting patient's on contact isolation precautions!

Patient's on contact isolation need to follow the steps outlined below when the patient is taken out of the room. Following these steps reduces the chance of spreading bacteria.

The staff transporting will ensure the following steps are done with (or for) the **patient:**

a. Change pt. into **a clean hospital gown** (do NOT keep extra gowns sitting in the room and use these – they are contaminated with bacteria! You MUST get a **new clean gown when you go in to care for the patient!)**
b. Assist patient with hand hygiene (alcohol rub is acceptable)
c. Apply a clean, disposable gown over the patient
d. Apply a pair of clean gloves to the patient
e. Once the patient is in the w/c or on the stretcher, cover the patient with a CLEAN sheet from the linen cart (remember do NOT use a sheet that has been stored in the patient room!), and wipe down rails with disinfecting wipe before leaving the patient's room

---

The staff transporting the patient is responsible for performing the following steps:

a. Remove the PPE you have had on while prepping the patient (Remove at the doorway where waste receptacles are located!)
b. Perform hand hygiene, alcohol based handrub is ok

It is **NOT** necessary for the transporter to wear a gown or gloves while patient is taken to and from the destination.

However, you should put an extra pair of gloves in your pocket for use if needed.

Ensure that healthcare workers receiving patient are aware of isolation status!

Transporter should **apply a new gown and gloves before physically assisting the patient once the destination is reached**.

ATTENTION:

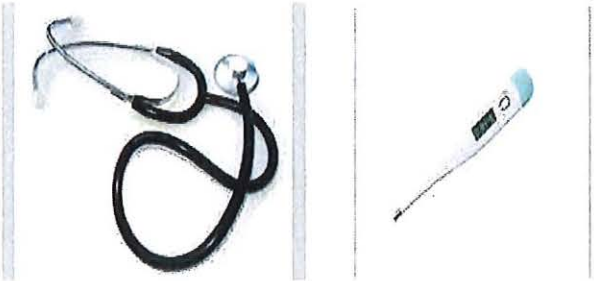
VISITORS & HOSPITAL STAFF

VISITORS: please talk to a nurse before entering if you have any questions

DROPLET PRECAUTIONS

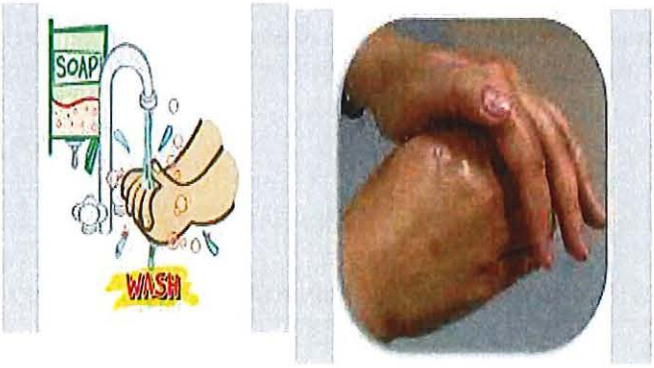
MASK, GOWN and GLOVES

*__MUST__ be worn to enter this room



EQUIPMENT:

*Single patient use equipment
*Disposable when possible
*Disenfect all equipment before it leaves the room



BEFORE leaving the room

*Remove gloves, mask and gown
*Perform hand hygiene
wash with soap and water or use the alcohold based hand rub provided

Patient transport from the room is limited to essential purposes ONLY!

Transporting patient's on DROPLET isolation precautions!

Patient's on droplet isolation need to follow the steps outlined below when the patient is taken out of the room. Following these steps reduces the chance of spreading bacteria.

The staff transporting will ensure the following steps are done with (or for) the **patient:**

a. Change pt. into **a clean hospital gown** (do NOT keep extra gowns sitting in the room and use these – they are contaminated with bacteria! You MUST get a **new clean gown when you go in to care for the patient!)**
b. Assist patient with hand hygiene (alcohol rub is acceptable)
c. Apply a clean, disposable gown over the patient
d. Apply a (regular, surgical) mask to the patient!!
e. Apply a pair of clean gloves to the patient
f. Once the patient is in the w/c or on the stretcher, cover the patient with a CLEAN sheet from the linen cart (remember do NOT use a sheet that has been stored in the patient room!), and wipe down rails with disinfecting wipe before leaving the patient's room

---

The staff transporting the patient is responsible for performing the following steps:

a. Remove the PPE you have had on while prepping the patient (Remove at the doorway where waste receptacles are located!)
b. Perform hand hygiene, alcohol based handrub is ok

It is **NOT** necessary for the transporter to wear a gown, mask or gloves while patient is taken to and from the destination.
However, you should put an extra pair of gloves and a mask in your pocket for use if needed during transport.

Ensure that healthcare workers receiving patient are aware of isolation status!

Transporter should **apply a new gown, mask, and gloves before physically assisting the patient once the destination is reached**.

ATTENTION:

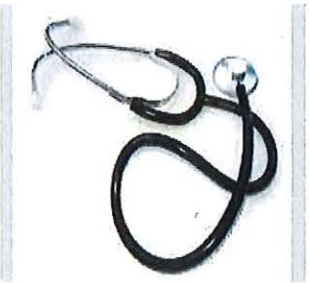
VISITORS & HOSPITAL STAFF

VISITORS: please talk to a nurse before entering if you have any questions

CONTACT PRECAUTIONS!

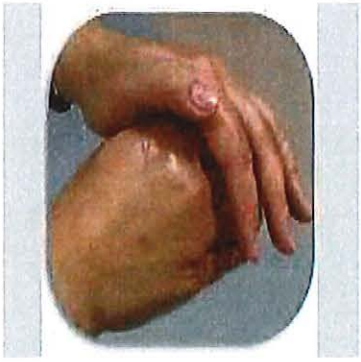
GOWN and GLOVES:

*BOTH **MUST** be worn to enter this room



EQUIPMENT:

*Single patient use equipment
*Disposable when possible
*Disinfect all equipment before it leaves the room



BEFORE leaving the room

*Remove gloves and gown
*Perform hand hygiene
* wash with soap and water OR use the alcohol based hand rub provided

ATTENTION:

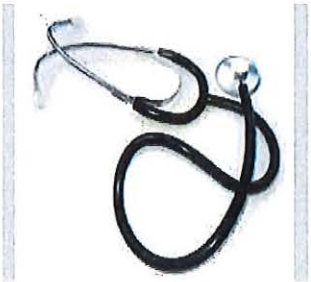
VISITORS & HOSPITAL STAFF

VISITORS: please talk to a nurse before entering if you have any questions

SPECIAL CONTACT PRECAUTIONS!

GOWN and GLOVES:

*BOTH **MUST** be worn to enter this room



EQUIPMENT:

*Single patient use equipment
*Disposable when possible
*BLEACH to disinfect

BEFORE leaving the room

*Remove gloves and gown
*Wash your hands with soap and water, use a paper towel to turn off the water when you are done

Patient transport from the room is limited to essential purposes ONLY!

Patients on special contact precautions (+ c diff.) will NOT be transported outside of their rooms unless medically necessary!

When the patient must be transported for a medically necessary reason:
The staff transporting will ensure the following steps are done with (or for) the **patient:**

a. Bathe patient immediately before transporting, *if time allows*
b. Change pt. into **a clean hospital gown** (do NOT keep extra gowns sitting in the room and use these – they are contaminated with spores! You MUST get a **new clean gown when you go in to care for the patient!)**
c. Assist patient with washing their hands with soap and water
d. Apply a clean, disposable gown over the patient
e. Apply a pair of clean gloves
f. Once the patient is in the w/c or on the stretcher, cover the patient with a CLEAN sheet from the linen cart (remember do NOT use a sheet that has been stored in the patient room!), and wipe down rails with bleach wipe before leaving the patient's room

---

The staff transporting the patient is responsible for performing the following steps:

a. Remove the PPE you have had on while prepping the patient (Remove at the doorway where waste receptacles are located!)
b. Thoroughly wash your hands with soap and water, using friction to "scrub spores off of your hands"
c. Use a paper towel to turn off the water
d. Ensure you don't touch any area in the contaminated room after hands have been washed

It is **NOT** necessary for the transporter to wear a gown or gloves while patient is taken to and from the destination. *However, you should put an extra pair of gloves in your pocket for use if needed.*

Ensure that healthcare workers receiving patient are aware of isolation status!

Transporter should **apply a new gown and gloves before physically assisting the patient once the destination is reached**.

Hand Hygiene PI Observation Tool

Date	RM / MRN #	Employee / Visitor	BEFORE Patient/Environment Contact	AFTER Patient/Environment Contact	DONNED PPE Appropriately	DOFFED PPE Appropriately	1:1 Education	Education Type / Comments Contact - Respiratory - Hand Hygiene (HH)
		☐ RN ☐ EVS ☐ LVN ☐ PT ☐ C.N.A. ☐ PHARM ☐ RT ☐ LAB ☐ MD ☐ NP ☐ AGENCY ☐ VISITOR ☐ OTHER	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ PPE Donned Appropriately ☐ Gown ☐ Mask ☐ Goggles/Face Shield ☐ Gloves Isolation Type ☐ NA ☐ Droplet	☐ PPE Doffed Appropriately ☐ Gloves ☐ Goggles/Face Shield ☐ Gown ☐ Mask ☐ Contact ☐ Airborne	☐ Yes ☐ No	☐ C ☐ R ☐ HH
		☐ RN ☐ EVS ☐ LVN ☐ PT ☐ C.N.A. ☐ PHARM ☐ RT ☐ LAB ☐ MD ☐ NP ☐ AGENCY ☐ VISITOR ☐ OTHER	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ PPE Donned Appropriately ☐ Gown ☐ Mask ☐ Goggles/Face Shield ☐ Gloves Isolation Type ☐ NA ☐ Droplet	☐ PPE Doffed Appropriately ☐ Gloves ☐ Goggles/Face Shield ☐ Gown ☐ Mask ☐ Contact ☐ Airborne	☐ Yes ☐ No	☐ C ☐ R ☐ HH
		☐ RN ☐ EVS ☐ LVN ☐ PT ☐ C.N.A. ☐ PHARM ☐ RT ☐ LAB ☐ MD ☐ NP ☐ AGENCY ☐ VISITOR ☐ OTHER	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ PPE Donned Appropriately ☐ Gown ☐ Mask ☐ Goggles/Face Shield ☐ Gloves Isolation Type ☐ NA ☐ Droplet	PPE Doffed Appropriately ☐ Gloves ☐ Goggles/Face Shield ☐ Gown ☐ Mask ☐ Contact ☐ Airborne	☐ Yes ☐ No	☐ C ☐ R ☐ HH
		☐ RN ☐ EVS ☐ LVN ☐ PT ☐ C.N.A. ☐ PHARM ☐ RT ☐ LAB ☐ MD ☐ NP ☐ AGENCY ☐ VISITOR ☐ OTHER	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ PPE Donned Appropriately ☐ Gown ☐ Mask ☐ Goggles/Face Shield ☐ Gloves Isolation Type ☐ NA ☐ Droplet	PPE Doffed Appropriately ☐ Gloves ☐ Goggles/Face Shield ☐ Gown ☐ Mask ☐ Contact ☐ Airborne	☐ Yes ☐ No	☐ C ☐ R ☐ HH
		☐ RN ☐ EVS ☐ LVN ☐ PT ☐ C.N.A. ☐ PHARM ☐ RT ☐ LAB ☐ MD ☐ NP ☐ AGENCY ☐ VISITOR ☐ OTHER	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ Alcohol Gel ☐ Soap & Water ☐ None * Soap & Water for C Diff	☐ PPE Donned Appropriately ☐ Gown ☐ Mask ☐ Goggles/Face Shield ☐ Gloves Isolation Type ☐ NA ☐ Droplet	PPE Doffed Appropriately ☐ Gloves ☐ Goggles/Face Shield ☐ Gown ☐ Mask ☐ Contact ☐ Airborne	☐ Yes ☐ No	☐ C ☐ R ☐ HH

Hand Hygiene Compliance is defined by: 1. HH BEFORE and AFTER each patient contact 2. HH BETWEEN changing gloves 3. Use of soap & water for C Diff patients

Revised 10/2017

PAM REHAB HOSPITAL OF CENTENNIAL HILLS
BLOOD REVIEW TOOL

Confidential information collected under the protection of the Health Care Quality Improvement Act of 1986

Patient Name:_____ **MR#:**_____ **Age:**_____
Date of Admit:_____ **Primary MD:**_____
MD Ordering Blood:_____
Date Blood Ordered: _____ **Date Blood Administered:** _____
Number of units administered:_____
Blood Product:
Whole Blood Packed Cells FF Plasma Platelets Factor_____
Pre-Transfusion HGB/HCT:_____/_____ Post-Transfusion HGB/HCT:_____/_____
Further physician review not necessary if Hgb less than 8 or platelets less than 20,000.)
REASON FOR TRANFUSION:_____

SCREENING CRITERIA	YES	NO	N/A	MD Reviewer
1. Was the physician order specific/complete/appropriate?				
2. Was a consent for blood signed prior to administration?				
a. by physician?				
b. by patient?				
3.Was there a transfusion reaction/complication?				
4. If transfusion reaction/complication, was:				
a. blood stopped?				
b. physician notified?				
c. transfusion reaction form completed?				
5. Did death occur due to a transfusion reaction?				
6. Did patient expire within 72 hours of transfusion with blood or blood products?				

Reviewer Comments: _____

_____

Physician Reviewer Comments:

_____

_____

_____

Evaluation:
___1. Justified
___2. Documentation -clinical practice acceptable but documentation issue exists
___3. Inappropriate quality/utilized inappropriately
___4. Inappropriate quality/unexpected (Requires Committee PeerReview/Action)

_____ _____

Reviewer/Date **Physician Reviewer/Date**

12 and 24 hour Chart Check Audit

Month of Audit:

Instructions: This tool captures the compliance for 12 and 24 hour chart checks. It is designed to calculate compliance rates based on the Y, N, or NA a complete ten(10) direct observations monthly (5 day and 5 night).

Place a Y (yes) N(no) or NA (not applicable) under the appropriate chart tab for the indicator you are auditing below	Chart #1 MR#	Chart #2 MR#	Chart #3 MR#	Chart #4 MR#	Chart #5 MR#	Chart #6 MR#	Chart #7 MR#	Chart #8 MR#
Review physician orders for errors in transcription.								
Are all new orders transcribed and addressed (including kardex, brain, care plan, TAR, etc.)								
All must be completed to get yes, if one item missing section is a no								
Reviews care plan updated with most recent information								
Has the nurse authenticated (date time sign) the 12 hour or 24 hour chart check								
FOR EMR hospitals worklist cleared and incorrect orders removed								
Do not remove rows								
Compliance %	0%	0%	0%	0%	0%	0%	0%	0%

Open Chart Audit

Month of Audit:

Instructions: This tool captures the compliance for open chart audits. It is designed to calculate compliance rates based on the Y, N, or NA answers. Y reviews monthly. Please monitor the records for the indicators listed below. These indicators should be monitored for > 90 % compliance.

Place a Y (yes) N(no) or NA (not applicable) under the appropriate chart tab for the indicator you are auditing below	Chart #1 MR#	Chart #2 MR#	Chart #3 MR#	Chart #4 MR#	Chart #5 MR#	Chart #6 MR#
Pain assessment (anything missing for patient is a no)						
Reassessment of pain(anything missing for patient is a no)						
Daily weights if ordered(anything missing for patient is a no)						
Weekly Braden scale(anything missing for patient is a no)						
Skin assessments done weekly (anything missing for patient is a no)						
Weekly pictures of wounds(anything missing for patient is a no)						
Restraint documentation(anything missing for patient is a no)						
Dialysis order with each treatment(anything missing for patient is a no)						
RN assessment every 24 hours(anything missing for patient is a no)						
Do not remove rows						
Compliance %	0%	0%	0%	0%	0%	0%

Credentialing Instructions: This tool captures the compliance for credentialing files. It is designed to calculat next 3 months (include physician and allied health) must be audited monthly.

Place a Y(yes) N (no) or NA (not applicable) under the appropriate file for the appropriate process				
Description of Credential file (LIP specialty CRNP, etc.)				
Primary Source Verification (dated prior to start date)				
National Practitioner Bank				
Verified Education and training				
Verified Board Certifications				
Reference letters from peers				
Verified DEA license				
Verified malpractice insurance				
Picture of LIP				
DOP				
OPPE/FPPE				
Emergency management LIP				
Flu				
TB				
Opioid Education				
Antimicrobial Stewardship Education				
Restraint Attestation				
Compliance %	0%	0%	0%	0%

Hourly Rounding Observation

Month of Audit:

Instructions: This tool captures the compliance for hourly rounding. It is designed to calculate compliance rates based on the Y, N, or NA answers. You hourly rounding (50% day-night 50% night-day) monthly.

	1	2	3	4	5	6	7	8
Who are you rounding on RN, LPN, CNA, etc.)								
Introduces self and explains hourly rounding								
White board is up-to-date with correct date, nurses name, CNA/PCT name, when next pain medication due, leadership/patient partner name and number **(all or none)**								
Asks patient about pain status-medicates or communicates next dose								
Asks patient if they are comfortable Move the patient up in bed. Rearrange pillows. Offer extra blankets. Turn patients who are at high-risk for skin breakdown								
Asks patient if they need to use the bathroom Assist the patient to the bathroom. **If the patient has dementia takes the patient to the bathroom**								
Arrange the patient's possessions. Ensure the call light, bedside table, water pitcher and phone are within reach. Refills water pitcher. Communicates when they or someone from the healthcare team will return								
Documents on hourly rounding tool								
Do not delete rows								
Compliance %	0%	0%	0%	0%	0%	0%	0%	0%

Month of Audit:

Instructions: This tool captures the compliance for HR files. It is designed to calculate compliance rates b (include nurse, CNA, RT, PT, OT, Case Mgt., etc.) must be audited monthly.

Primary Source Verification (dated prior to start date) and license				
Current CPR or ACLS if required				
Signed Job Description				
Education level required on Job Description				
General Hospital Orientation				
Job specific orientation (DON, DQM, DCM, etc.)				
Competencies-new hire				
Any special competencies (sterilization, conscious sedation)				
DSC education/competencies				
Yearly competencies				
RELIAS online training				
Most Recent Evaluation – signed and dated by employee and supervisor/manager				
Do not delete rows				
Compliance %	0%	0%	0%	0%

Shift Report Observation

Month of Audit: January

Instructions: This tool captures the compliance for shift report. It is designed to calculate compliance rates based on the Y, N, or NA answers. You must observe six (6) shift reports (50% day-night 50% night-day) monthly.

Description of report (RN-RN, RN-LVN, LVN-LVN, LVN-RN)							Average
Occurs at bedside							
Outgoing nurse introduces oncoming nurse to patient and or family							
Most recent physical assessment given							
All tubes and lines addressed (what is running, how much output, etc.)							
Fall status discussed							
Pending labs, procedures reports, discussed							
Any new orders to address labs, procedures, test results discussed							
Name of pain medication and last time given							
Telemetry rhythm							
Any other pertinent information							
Care plan reviewed and updated							
Oncoming nurse informs patient and or family they will return after final report is received.							
Do not delete rows							
Compliance %	0%	0%	0%	0%	0%	0%	0%

Monthly EC Rounds Assessment Checklist

Month of Audit:

Instructions: This checklist includes tasks to do every day to help ensure continuous compliance with Join requirements and your organization's policies and procedures. For best results, the review should be perf unit/department director, supervisor, or other designee.

Place a Y (yes) N(no) or NA (not applicable) under the appropriate chart tab for the indicator you are auditing below	Week 1	Week 2	Week 3	Week 4
Lighting				
Is there adequate lighting indoors and outdoors?				
Are all lights working?				
Hallways and Floors/Carpet				
Are hallways clear to allow safe and adequate space for walking?				
Are hallways clear to allow safe and adequate space for passage of carts, wheelchairs, and beds?				
Are floors/carpets clean, dry, and slip resistant?				
Are floors/carpets in good condition and free from tripping or falling hazards (bumps, tears, and so on)?				
Are hallways clear of any wires or cables extending across?				
Are "wet floor" signs in use?				
Walls and Ceilings				
Are walls and wall finishes in good condition and free from damage (such as holes or water)?				
Are all wiring/cables in walls and ceilings properly sealed and covered?				
Are electrical boxes or outlet covers in walls or ceilings in proper order ie. NOT missing or damaged?				
Are all ceiling tiles in place?				
Are all ceiling tiles in good condition and free from damage (such as holes or water)?				
Elevators				
Are elevator call buttons and lights working properly?				
Are elevator panels working properly?				
Elevators (continued)				
Are elevator floors clean and in good condition?				

Are elevator walls and ceilings clean and in good condition?				
Worker Safety				
Can staff explain techniques to prevent common worker injuries?				
No-Smoking Policy				
Is everyone adhering the the no-smoking policy? i.e. No evidence of smoking.				
Identification				
Are all employees wearing ID badges in plain view (or per organization policy)?				
Are all contracted workers and construction workers wearing ID badges in plain view (or per organization policy)?				
Access Control				
Are access control measures active in security-sensitive areas?				
Can staff explain what to do if they notice a person who doesn't belong in a security-sensitive area?				
Worker Safety and Other Threats				
Can staff explain their roles in protecting patients?				
Can staff explain how to protect themselves?				
Can staff explain security codes?				
Can staff explain how to get help in a security emergency?				
Medication				
Are medication rooms and carts locked, per organization policy?				
Are unattended medications properly taken care of?				
Medical Records				
Are paper medical records secure?				
Are electronic medical records secure?				
Means of Egress				
Are exit sign lights working?				
Are exits clearly and correctly marked?				
Are hallways clear of debris and equipment?				
Are all items in hallways intended for use within 30 minutes?				

Doors				
Are doors free of being propped/held/wedged open?				
Are they clear to close (nothing obstructing)?				
Do they close properly?				
Do fire and stairwell doors latch firmly?				
Are door interrupters (closing devices) working?				
Fire Extinguishers				
Are they clearly identified?				
Do they have current inspection tags?				
Are extinguisher safety seals in place?				
Do they have clear access, with nothing in the way?				
Fire Alarm Pull Stations				
Do they have clear access, with nothing in the way?				
Are they clearly identified?				
Are they easy to find quickly?				
Fire Hazards				
Are windows and heating/AC units free of linens?				
Are floors free of linens?				
Are items stored at least 18 inches below a sprinkler head?				
Do portable space heaters conform to applicable local and federal codes?				
Combustible Materials				
Are combustible materials properly stored?				
Are they properly labeled?				
Are they kept in a safe, designated location?				
HAZARDOUS MATERIALS AND WASTE				
Are hazardous materials properly stored, depending on hazards (flammable, corrosive, and so on)?				
Are they properly labeled?				
Are staff using correct procedures for disposal?				
Is the hazardous materials inventory (if required) current?				
Safety Data Sheets (SDS)				
Can staff explain how to find an SDS?				

Can staff describe the information contained in an SDS?				
Is there a current chemical inventory, updated within the last 12 months?				
Has staff been briefed on the "Right to Know" requirement regarding chemicals used on the job, per the Occupational Safety and Health Administration (OSHA)?				
Medical Waste				
Is medical waste in red biohazard bags or labeled bins?				
Is it properly stored and disposed of?				
Is it properly separated and segregated?				
Inspection Status				
Are the inspection tags current?				
Can staff explain how to tell if the equipment inspection is current?				
Can staff explain how to label broken equipment?				
Equipment Cleaning and Storage				
Is equipment clean and stored properly?				
Can staff recognize clean and dirty equipment and supplies (including linens) by storage methods?				
Can staff recognize full and empty oxygen tanks by storage methods?				
Competency in Use				
Can staff adequately explain the use of all department equipment?				
Electrical Systems				
Are emergency power electrical outlets clearly marked with red covers?				
Are the red outlets being used for critical equipment?				
Are electrical/communication panels that are accessible to the public locked?				
Medical Gas Zone Values				
Are valves marked with identity and locations served?				
Is the valve box accessible, with nothing in the way?				

Does staff know who is allowed to shut the zone valves off?				
Compliance %	0%	0%	0%	0%

POST ACUTE MEDICAL

SUBJECT **Cleaning Checklist**	PAGE: 1
PUBLICATION Environmental Services	FORMS:
EFFECTIVE DATE: October 2016	REVIEWED/REVISED DATE: November 13, 2017
APPROVED BY: Albie Shaffer VP Facilities Management	

PURPOSE & SCOPE

To ensure all areas of hospital are kept clean & sanitary.

POLICY

All areas of the hospital will receive Housekeeping services on a daily basis. Individual office cleaning will be shared responsibility between Housekeeping & the department/service occupying that office. Common/public areas will be cleaned by Housekeeping.

FORMS USED

Daily checklists for each floor.

PROCEDURE

1. Floors: Floors will be stripped & re-waxed on an as needed basis.
2. Carpets: Carpets will be cleaned as needed.
3. Outside Windows: All exterior windows will be cleaned bi-annually.
4. Ceiling Light Fixtures: Cleaned as necessary.
5. Windows/Glass: Cleaning is best when using a commercial glass cleaner & a clean cloth. It may be necessary to frequently replace cloth to prevent streaking.
6. Furniture: Upholstery will not be chemically cleaned unless chemical has been previously tested on an obscure spot. Wooden/metal furniture can be cleaned as often as necessary with a damp cloth.
7. Carpets: Vacuumed weekly, or as needed due to traffic. Carpets are spot cleaned & extracted as needed.
8. Walls & Ceilings: These surfaces will be washed with hospital-approved disinfectant when soiled.
9. Cubicle Curtains: Will be removed & laundered bi-monthly, or when visibly soiled.
10. Air Vents: Clean all vent screen surfaces with a cloth. Remove all vent screens as needed, & clean interior vent covers. Follow same procedure used in cleaning surface screens.

POST ACUTE MEDICAL

SUBJECT 12/24 Hour Chart Check	PAGE: Page 1 of 2
PUBLICATION: NSG 01	FORMS:
EFFECTIVE DATE: September, 2014	REVIEWED/REVISED DATE: October 2016; Revised January 28, 2019
APPROVED BY: *Kathleen M Brown, DNP, MSHA, BSN* Kathleen Brown, DNP, MSHA, BSN Executive Vice President and Chief Clinical Officer	

SCOPE:

This policy applies to the following hospitals of Post Acute Medical:
PAM Rehabilitation Hospitals of Allen, Victoria, Clearlake, Beaumont, Round Rock, Corpus Christi, Tulsa, Overland Park, Dover, and Centennial Hills. Warm Springs Rehabilitation Hospitals of Kyle, San Antonio, Thousand Oaks, and Westover Hills.

PAM Specialty Hospitals of Luling, Bayfront, Corpus Christi North, Corpus Christi South, San Antonio, New Braunfels, Texarkana, Victoria North, Victoria South, Lufkin, Hammond, Covington, Wilkes Barre, Tulsa and Milwaukee.

POLICY:

All physician orders will be reviewed by a licensed nurse every 12 hours by day shift and every 24 hours by night shift.

PROCEDURE:

1. The day shift nurses will review the physician orders and the accuracy of implementation for each patient / chart every 12 hours. Night shift will do the same every 24 hours.

2. The nurse will compare the physician orders to the following as required and place a check mark next to each order after verification:
   - A. Medication Administration Record
     - a. New MAR to new orders. (12 hour and 24 hour)
     - b. New MAR to old MAR. (24 hour)
     - c. All errors found will be corrected on the new MAR, and pharmacy will be notified.
     - d. Physician orders to include date, time, and physician signature.
     - e. All orders to be noted by the unit secretary and a licensed nurse each with a time, date and signature.
   - B. Wound Care Record (Daily and weekly forms)
   - C. Restraints
   - D. Kardex/Nursing Brain
   - E. Laboratory Requisitions & Log
     - a. All labs have been drawn and results in patient's record.
     - b. All future labs are requested and documented on the proper requisition forms as needed

POST ACUTE MEDICAL

SUBJECT 12/24 Hour Chart Check	PAGE: Page 2 of 2
PUBLICATION: NSG 01	FORMS:
EFFECTIVE DATE: September, 2014	REVIEWED/REVISED DATE: October 2016; Revised January 28, 2019
APPROVED BY: *Kathleen M Brown, DNP, MSHA, BSN* Kathleen Brown, DNP, MSHA, BSN Executive Vice President and Chief Clinical Officer	

c. Appropriate forms will be updated at time of the appropriate chart check.

3. The nurse will check the patient's room to ensure that equipment has been applied or discontinued as ordered.

4. The nurse will report any errors in physician orders, medication administration, to the physician for instructions, clarification or new orders.

5. If the nurse finds an error on MAR pharmacy will be notified per facility protocol. If applicable, an Unusual Occurrence Report will be completed.

6. Once all chart checks have been completed, the nurse will draw a line down the left margin of the order sheets from the starting point of the chart check to the ending point and will annotate either 12 hour chart check or 24 hour chart check as appropriate with the nurse's date, time and signature and credential.

POST ACUTE MEDICAL

SUBJECT: ID Bracelet	PAGE: 1 of 1
PUBLICATION: NSG 26	FORMS:
EFFECTIVE DATE: September 2013	REVIEWED/REVISED DATE: September 2014 Reviewed April 2017 Revised January 28, 2019
APPROVED BY: Kathleen M Brown, DNP, MSHA, BSN Kathleen M Brown, DNP, MSHA,BSN Executive Vice President and Chief Clinical Officer	

SCOPE

This policy applies to the following hospitals of Post Acute Medical:

PAM Rehabilitation Hospitals of Allen, Victoria, Clear Lake, Beaumont, Round Rock, Corpus Christi, Tulsa, Overland Park, Dover, and Centennial Hills. Warm Springs Rehabilitation Hospitals of Kyle, San Antonio, Thousand Oaks, and Westover Hills.

PAM Specialty Hospitals of Luling, Bayfront, Corpus Christi North, Corpus Christi South, San Antonio, New Braunfels, Texarkana, Victoria North, Victoria South, Lufkin, Hammond, Covington, Wilkes Barre, Tulsa and Milwaukee.

PURPOSE

To provide a safe environment by ensuring each patient receives the appropriate care.

POLICY

Each patient will have an identification band placed within one hour of admission, and will retain an ID bracelet through the entire hospitalization.

PROCEDURE

1. The unit clerk will provide the completed identification band to the nurse responsible for the admission assessment.
2. The nurse will validate spelling of patient's name and other identification information is correct. If medical condition prohibits patient from validating information, significant other or family members will be asked to validate information.
3. The nurse will ensure that the ID band has been placed on the patient's wrist.

PATIENT EDUCATION

1. Explain purpose to patient/family.

SUBJECT Fall Prevention	PAGE: 1 of 7
PUBLICATION: NSG 22	FORMS:
EFFECTIVE DATE: September, 2013	REVIEWED/REVISED DATE: September 2014 Reviewed April 2017 Revised January 17, 2018 September 28,2018
APPROVED BY: *Kathleen M Brown, DNP, MSHA, BSN* Kathleen M Brown, DNP, MSHA,BSN Executive Vice President and Chief Clinical Officer	

SCOPE:

This policy applies to the following hospitals of Post Acute Medical:
PAM Rehabilitation Hospitals of Allen, Victoria, Clearlake, Beaumont, Round Rock, Corpus Christi, Tulsa, Overland Park, Dover, and Centennial Hills. Warm Springs Rehabilitation Hospitals of Kyle, San Antonio, Thousand Oaks, and Westover Hills.

PAM Specialty Hospitals of Luling, Bayfront, Corpus Christi North, Corpus Christi South, San Antonio, New Braunfels, Texarkana, Victoria North, Victoria South, Lufkin, Hammond, Covington, Wilkes Barre, Tulsa and Milwaukee.

POLICY:

To identify patients who present a risk for falls and to provide reasonable measures to prevent falls and fall related injuries. This policy and procedure applies to all patients to whom care is rendered at PAM hospitals.

PURPOSE:

To provide a guide for assessing patients who are at risk for falling and for implementing precautionary measures to reduce the probability that a patient will fall or to reduce the probability the patient will sustain a serious injury in the event of a fall. When appropriate, patients and families should be involved in identifying fall risk factors and implementing fall prevention measures.

DEFINITIONS:

A **fall** is defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on

POST ACUTE MEDICAL

SUBJECT Fall Prevention	PAGE: 2 of 7
PUBLICATION: NSG 22	FORMS:
EFFECTIVE DATE: September, 2013	REVIEWED/REVISED DATE: September 2014 Reviewed April 2017 Revised January 17, 2018 Revised September 28, 2018

Fall without injury is defined as no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall

Fall with injury (except major) is defined as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall related injury that causes the patient to complain of pain

Fall with major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

ESSENTIAL INFORMATION:

1. Risk assessment tools should be utilized as a frame of reference to enhance predictability of patient falls and selection of prevention strategies. Patients are assessed for the presence/absence of fall risk factors and given a score which identifies them as no, low, or high fall risk. Nurses will conduct an initial fall risk assessment. Then daily any member of the healthcare team will conduct an assessment, and/or with any change in a patient's clinical status, and post fall.

2. Fall Etiology:

- Fall risk factors include intrinsic risks of cognitive, vision, gait or balance impairment, and/or the extrinsic risks of assistive devices, inappropriate footwear, and restraint, use of non-sturdy furniture or equipment, poor lighting, uneven or slippery surfaces.
- Fall causes include, among others, orthostatic hypotension, arrhythmia,

- infection, generalized or focal muscular weakness, syncope, seizure, hypoglycemia, neuropathy, and medication.
- Assess and document patient-are environment for extrinsic risk factors to fall and institute corrective action:
  - Floor surfaces for spills, wet areas, unevenness
  - Proper level of illumination and functioning of lights (night light works)
  - Table tops, furniture, beds are sturdy and are in good repair
  - Grab rails and grab bars are in place in the bathroom
  - Use of adaptive aides work properly and are in good repair.
  - Bedrails do not collapse when used for transitioning or support.
  - Patient gowns/clothing do not cause tripping.
  - IV poles are sturdy if used during ambulation and tubing does not cause tripping.

FALL RISK ASSESSMENT

The nursing fall risk assessment and interventions are based on the use of the modified **Morse Fall Scale**. Patients will be assessed for fall risk factors upon admission, daily, change in clinical status, transfer to a new setting, and post fall.

Item	Scale	Scoring
1. History of falling; immediate or within 3 months	25	_____
2. Age: ≥ 65 years	15	_____
3.Ambulatory aid None, Bedrest/nurse assist Crutches Cane Walker Wheelchair Holds on to Furniture	 0 15 30	 _____

4. Medications commonly associated with fall risk None Psychotropic, antidepressants, benzodiazepines Cardiovascular, antihypertensive Both Medication Categories	 0 15 15 30	_____
5. Continuous IV infusion or Heparin lock	20	_____
6. Gait/ Transferring Normal/bedrest/ immobile Weak/ Dizziness Impaired	 0 10 20	_____
7. Mental Status Oriented to own ability Forgets/Limitations	 0 15	_____

Risk Level	**MFS**	**Action**
No Risk	0 - 30	See **Universal Fall Prevention Interventions**
Low Risk	31-55	See **Standard Fall Prevention Interventions**
High Risk	>56	See **High Risk Fall Prevention Interventions**

POST ACUTE MEDICAL

SUBJECT Fall Prevention	PAGE: 5 of 7
PUBLICATION: NSG 22	FORMS:
EFFECTIVE DATE: September, 2013	REVIEWED/REVISED DATE: September 2014 Reviewed April 2017 Revised January 17, 2018

UNIVERSAL FALL PREVENTION INTERVENTIONS

Patients who are scored "no risk" on the modified **Morse Fall Scale** (score 0-30) will have the following interventions considered by the healthcare team. The healthcare team should tailor the interventions to be patient specific.

- Orient patient to surroundings and hospital routines.
- Bed in low position
- Use treaded socks for patients when out of bed.
- Personal items, call bell, cane/walker within reach
- Room cleared of all unnecessary equipment
- Lock all moveable equipment before transferring patient

STANDARD FALL PREVENTION INTERVENTIONS

Patients who are scored "low risk" on the modified **Morse Fall Scale** (score of 31-55) will have the following interventions considered for implementation by the healthcare team in addition to the **Universal Interventions**. The healthcare team should tailor the interventions to be patient-specific.

- Assess the patient's coordination and balance before assisting with transfer and mobility activities.
- Initiate treatment for impaired vision, hearing (provide eyeglasses/hearing aids when available).
- Pharmacist to evaluate medication profile for fall risk.
- Review medications with physician.

- Place colored non-skid socks
- Place fall risk signs on door and above bed
- Offer toileting at breakfast, lunch and dinner, before bedtime and with pain medication administration.
- Approach patient towards unaffected side to maximize participation in care.
- Transfer patient towards stronger side.
- All ambulatory aides within reach/on functional side
- Consider using a non-skid floor mat
- Bed and/or chair alarms
- Alarms at exits where available
- Consider using low beds for patients at risk for falls
- Family member with patient
- Increased observation level of patient

HIGH RISK FALL PREVENTION INTRVENTIONS

These interventions are designed to be considered for patients with multiple risk factors, who are scored "high risk" on the modified **Morse Fall Scale** (score of >56), and have fallen. They are designed to reduce severity of injuries due to falls as well as to prevent falls from reoccurring, supplementing **Universal and Standard Fall Prevention Interventions**. The healthcare team should tailor the interventions to be patient-specific.

- Apply yellow fall risk armband.
- Remain with patient while toileting.
- Offer toileting at breakfast, lunch and dinner, before bedtime and with pain medication administration.
- Review medications for fall risk and adjust as indicated.
- Consider using a non-skid floor mat
- Consider using a low bed.
- Consider referral to services such as PT/OT, audiology, ophthalmology, and cardiology.
- Optimize treatment of underlying medical conditions.
- Evaluate and treat for pain.

POST ACUTE MEDICAL

SUBJECT Fall Prevention	PAGE: 7 of 7
PUBLICATION: NSG 22	FORMS:
EFFECTIVE DATE: September, 2013	REVIEWED/REVISED DATE: September 2014 Reviewed April 2017 Revised January 17, 2018

EDUCATION:

- Actively engage patient and family in all aspects of Fall Prevention Program.
- Instruct patient in all activities prior to initiating assistive devices.
- Instruct patient in medication time/dose, side effects, and interactions with food/medications.

POST FALL ASSESSMENT:

Initiate the Post Fall Algorithm

Complete Post fall huddle

Complete fall analysis tool

Enter the incident into the incident reporting system

POST ACUTE MEDICAL

SUBJECT: Blood Transfusion Pre and Post Documentation	PAGE: 1 of 2
PUBLICATION: NSG 13	FORMS: See Section 12.3
EFFECTIVE DATE: February 11, 2004	REVIEWED/REVISED DATE: May 23, 2015 Reviewed April 2017; Revised January 28, 2019
APPROVED BY: *Kathleen M Brown, DNP, MSHA, BSN* Kathleen M Brown, DNP, MSHA,BSN Executive Vice President and Chief Clinical Officer	

SCOPE

This policy applies to the following hospitals of Post Acute Medical:
PAM Rehabilitation Hospitals of Allen, Victoria, Clearlake, Beaumont, Round Rock, Corpus Christi, Tulsa, Overland Park, Dover, and Centennial Hills. Warm Springs Rehabilitation Hospitals of Kyle, San Antonio, Thousand Oaks, and Westover Hills.

PAM Specialty Hospitals of Luling, Bayfront, Corpus Christi North, Corpus Christi South, San Antonio, New Braunfels, Texarkana, Victoria North, Victoria South, Lufkin, Hammond, Covington, Wilkes Barre, Tulsa and Milwaukee.

PURPOSE AND SCOPE

To insure proper documentation is completed prior to and after transfusion of blood and/or blood components.

POLICY

Blood transfusions will be performed in accordance with all appropriate control measures outlined below to ensure patient safety. Documentation will be completed in order to record the procedure and the patient's response to the administration of blood.

PROCEDURE

1. Once an order has been received for blood or blood product transfusion, the nurse must explain the transfusion process to the patient including possible risks.

2. If, after explanation of the transfusion process the patient chooses to refuse the transfusion:
   a. The nurse must obtain and witness a signed Refusal of Treatment Form.
   b. The physician must be notified.
   c. The refusal of the transfusion must be documented in the nurse's notes.

3. If, after an explanation of the transfusion process the patient chooses to accept the transfusion:
   a. The nurse must verify the doctor's order.

POST ACUTE MEDICAL

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b. The nurse must obtain and witness a signed Informed Consent for Blood Transfusion.
c. The nursing or laboratory personnel must obtain a sample for type and cross.
d. The nursing or laboratory personnel must place a blood bank red arm band on the patient and a sticker from the blood bank armband on the blood sample for type and cross. The sample must be labeled with the patient's name and SSN, the date and time, and the phlebotomist's initials. The sample and all remaining stickers shall be sent to the Blood Bank along with the completed Compatibility Testing Requisition.

4. Once blood is received from the blood bank, the following steps are taken **FOR EACH UNIT BEFORE THE BLOOD IS HUNG:**
   a. Blood unit and paperwork must be inspected by two licensed nurses (verifying nurse may be an LVN if necessary). Both must check and verify five identifiers (i.e., unit number, blood type, expiration date, volume, armband sticker - on unit and unit paperwork).
   b. Both licensed nurses must **go to the patient's bedside** and compare and match the patient armband and sticker number with the name and number on the blood unit.
   c. Each nurse must then sign the Transfusion Record.
   d. Unit must be hung within 30 minutes of receipt on the unit.
   e. The nurse hanging the transfusion must then fill out the Blood Transfusion Monitoring Record.
   f. Pre Infusion Vital Signs must be taken and documented on the Transfusion Record and the Blood Transfusion Monitoring Record.
   g. During transfusion vitals signs must taken Q15min x 4 then Q30min x 2 then Q60min x 2 (or as defined by the facilities blood bank form) and documented on the Blood Transfusion Monitoring Record. The first set of Vitals taken at Q15min must also be recorded on the Transfusion Record.
   h. Unit must be completed within 4 hours of start time.
   i. Each unit must have its own monitoring form completed.
   j. Upon completion of each unit of the transfusion:
      i. Post transfusion Vital Signs must be taken and documented on the Transfusion record and the Blood Transfusion Monitoring Record. All post transfusion information must be completed on the Transfusion Record.

POST ACUTE MEDICAL

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ii. The original copy (paper) of the Transfusion Record must be attached to the Transfusion Monitoring Record and placed in the patient's chart.
iii. The copy of the Transfusion Record and the empty blood bag must be returned to the Blood Bank.

PATIENT SAFETY COMMITTEE PAM Rehabilitation Hospital of Centennial Hills
H-8682-Hos-0---PAM Rehabilitation Hospital of Centennial Hills

TO: Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care.
RE: 439.877,4.(d)

CHECKLIST REPORT: (6/18/19)

1. All checklists in place reviewed and approved for use by the Patient Safety Committee in (June /2019).
2. All checklist in use are approved upon development/implementation by the Patient Safety Committee.
    a. No new added to Patient Safety Plan. Approved 2/27/19.
3. No amendments to existing document formats were recommended by the Patient Safety Committee.
4. Current check lists:
    a. Nursing:
        i. Daily:
            I. 12 and 24 hour checklist for chart orders
            II. Patient identification
            III. Crash cart daily checks
            IV. Fall risk assessments
            V. Blood Administration
            VI. New June 2019 - Standing orders:
                a. Stroke
                b. Asthma/COPD
                c. Anaphylaxis/Allergic reactions
                d. Seizure
                e. Dyspnea
                f. CHF/Volume overload
                g. Chest pain

        ii. Procedure: We are IRF, no procedures performed

        iii. DC Checklists: discharge instructions summary
    b. Rehab:
        i. Procedure: All patients receive rehab services, checklist for patient identifier
    c. Respiratory:
        i. Procedure: Patient identifier
        ii. RT shift checklist
    d. All staff:
        i. Patient Identification, hand washing, Isolation precautions
    e. Social Services:
        i. Patient identifier

f. Safety:
    i. Hand hygiene
    ii. Food- Temperature of food checks
    iii. Equipment working check
    iv. Validate accurate tray check
    v. Accurate diet check
    vi. Isolation precautions
g. Environmental Services:
    i. Daily room checklist for cleanliness
    ii. Terminal clean checklist
    iii. Plant ops daily equip checklist
    iv. EOC weekly checklists
h. Outside Vendors:
    i. Dialysis checklist
    ii. Pharmacy
        I. Narcotic audit
        II. Daily review of antibiotics
        III. Medication reconciliation
    iii. Diagnostic Lab
        I. Patient identifiers
        II. Isolation Precautions.

5. Patient Safety Committee approved all existing checklists and reviews any new presentations at the monthly Patient Safety Committee meetings in the new business and or safety agenda section.
6. In 2018-2019, 37 various checklists were approved for utilization and utilized daily and prn based on topic, completed by staff and vendors who supply services to patients at PAM Rehabilitation Hospital of Centennial Hills.