Critical Access Hospital
(775) 289-3001

WBR
William Bee Ririe

Rural Health Clinic
1500 Ave H, Ely NV

October 13, 2011

Director of the Legislative Counsel Bureau
Attn: Oren Malkiewich
401 S. Carson Street
Carson City, Nevada 89701-4747

Dear Mr. Malkiewich:

I am enclosing the Patient Safety Plan and supporting attachments for William Bee Ririe Hospital and Rural Health Clinic.

If you have questions, you can contact me at 775-289-3001 extension 223 or jjensen@wbrhely.org.

Sincerely,

Jan Jensen

Jan Jensen, RN - CEO

JJ:cjc
enclosures

WILLIAM BEE RIRIE HOSPITAL AND RURAL HEALTH CLINIC

PATIENT SAFETY PLAN AND ATTACHEMENTS

WBRH and RHC Patient Safety Plan include the following;

- Patient safety plan
- Policy and Procedure Compliance with safety checklists and policies
- Policy and Procedure for Discharge of Patient
- Policy and Procedure for Patient Discharge Instructions
- Policy and Procedure for Patient Identification
- Policy and Procedure for Hand Hygiene
- Policy and Procedure for Pre-operative surgical check list
- Central line insertion check list

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

ADMINISTRATION POLICY & PROCEDURES

Department: Facility Wide	**Program/Manual: Administration**
Policy Subject: Patient Safety Plan	**Section Number: P**
Effective Date: 01/1990	**Revision Date: 09/26/2011**
Approved: Jan Jensen, CEO	Dale Derbidge, Board Chairman

I. INTRODUCTION

The Patient Safety Program supports and promotes the mission, vision and values of William Bee Ririe Hospital and Rural Health Clinic through organizational prioritization of patient, visitor and employee safety.

The patient safety program is implemented through the Enterprise Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally report's findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II. PURPOSE

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient safety priorities in the development and revision of processes, functions and services.

III. MISSION, VISION AND VALUES

In support of the mission, vision and values of this organization the Patient Safety Program promotes;

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care.

- A focus on comprehensive, integrated quality service
- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

IV. OBJECTIVES

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about health care and promote open communication
- Collect and analyze date, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally and findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the WBRH and RHC, including, without limitation, performing required pursuant to NRS 439.835
- Duties pursuant to 439.835 are
  a) A person who is employed by WBRH and RHC shall, within 24 hours after becoming aware of a sentinel event that occurred at WBRH and RHC, notify the patient safety officer of the sentinel event.
  b) The patient safety officer shall, within 13 days after receiving notification, report the date, the time and a brief description of the sentinel event to The Health Division and facility representative if that person is different from the patient safety officer.
  c) If the patient safety officer of WBRH and RHC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event

that occurred at WBRH and RHC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event report the date, time and brief description event to those listed in b) above.

- Take such action as he or she determine to be necessary to insure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at WBRH and RHC
- Report to the Enterprise safety committee regarding any action taken in accordance to the above paragraph.
- Upon discovery notify the CEO immediately.

The Enterprise Safety Committee shall meet each month

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall indentify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. Is shall provide recommendations concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership will include: CEO, CNO, CIO, Pharmacist, QIC, Infection Control, Materials Manager, Environmental Safety Officer, Patient Safety Officer, a Medical Staff Member, and 1 member of the governing body.

VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

a) Patient safety
b) Adverse drug events (medication errors and adverse drug reactions)
c) Health acquired infections
d) Patient Falls
e) Other patient incidents/unexpected clinical/medical events
f) Unsafe conditions
g) Visitor safety
    - Visitor incidents

h) Employee safety
    - Blood/body fluid exposures
    - Occupational diseases
    - Communicable disease exposures
    - Musculoskeletal injuries
    - Immunization programs
    - Other employee incidents
i) Environmental safety
    - Product recalls
    - Drug recalls
    - Product/equipment malfunction
    - Construction –Infection Control Risk Assessment
    - Water Quality
    - Air Quality
    - Disaster Planning
    - Security incidents
    - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Mediation Practices (ISMP)

- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. DEFINITIONS

Adverse (Sentinel) Event is defined as an unexpected occurrence that involving facility-acquired infection, death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb function. The phrase "or the risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

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 Administrator.

Medical Error is defined as failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors may or may not cause harm.

Serious Error is an error resulting in patient injury including the potential to cause permanent injury or transient but potentially life-threatening harm

Minor Error is an error that does not cause harm or have the potential to do so

Near Miss is an error that could have caused harm but did not reach the patient because it was intercepted.

VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:

- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)

- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. allergy information current
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.
- Use a team approach to safety; hold focused safety meetings

- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

XII. METHODOLOGY

A. Structure
   - Proactive risk prevention strategies
   - Identification of High Risk Areas
   - General Incidences (Patient Injuries)
   - Potential or actual adverse events (medication errors)

B. Method – Establish a process for;
   - Identification, Selection, Prioritization
   - Data Collection and Analyses
   - Development of Actions
   - Implementation
   - Reporting
   - Follow-up

C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.
   Utilize applicable tools to facilitate improvement; for example
   - PDCA: Plan, Do Check Act with focus on process improvement
   - FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
   - RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus in on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors.

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
    - Employee injuries
    - Potential lawsuits
    - Resolutions
    - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
e. The results of the program that assesses and improves staff willingness to report errors.
f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;
    - Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV. NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORAMTION COMPILED OR SIDDEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE IN EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

NURSING POLICY & PROCEDURES

Department: Nursing	**Program/Manual: Nursing**
Policy Subject: Compliance with Safety Checklists & Policies	**Section Number: C**
Effective Date: 08/2011	**Revised:**

POLICY

Responsible Department Heads will periodically conduct quality improvement studies to monitor compliance with and effectiveness of patient safety checklists and policies.

PROCEDURE

A. Monitoring may include but is not limited to review of records, quality review reports, video monitoring, audits of sanitation supplies and patient questionnaires.

B. These quality improvement studies will be reviewed by the Enterprise Safety Committee.

C. At least annually the patient safety checklists will be reviewed and revised as necessary to assure they reflect the most current standards in patient safety protocols. At this time the Committee will consider any additional checklists and/or policies that may be appropriate for adoption.

D. Summary of annual review, including development revision and usage of the patient safety checklist and policies will be reported to the Legislative Committee on Healthcare.

Date of Revision

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

NURSING POLICY & PROCEDURES

Department: Nursing	**Program/Manual: Nursing**
Policy Subject: Discharge of Patient	**Section Number: D**
Effective Date: 1981	**Revised: 8/29/2011**

POLICY

All patients discharged from the hospital will be accompanied to the vehicle of transport by a member of the nursing staff.

Patients discharged may proceed to the vehicle via stretcher (air transport), wheelchair or may ambulate (as condition warrants).

PROCEDURE

A. Attending physician writes discharge and/or transfer order on chart.

B. Nursing personnel assist patient as needed in dressing, organizing patient's personal property and returning all valuables that may have been checked for safekeeping.

1. Valuable receipt slip must be signed by the responsible party and the nurse.

2. Prescriptions, if so ordered by the physician, are given to the patient or responsible party.

3. Discharge instructions are given to the patient.

C. Patients may leave the facility from the front door or the ambulance exit.

D. Obstetrical patients – if via wheelchair, mother holds infant. If ambulant, nurse carried infant to transport vehicle. Infants will be only discharged to a car seat properly restrained.

E. Infant boarders – nurse carries infant to transport vehicle and gives to responsible party.

CHARTING

A. Chart time of discharge, method of leaving premises, stretcher, wheelchair, ambulated or carried.

B. Chart patient's condition at time of discharge.

C. Neonates or pediatric patients – note to whom patient is discharged and their relationship. Complete ID form and attach neonate ID band.

1. Neonates – note all instructions given. Give immunization information.

D. Ward Clerk will dismantle chart and send to Medical Records.

Date of Revision

1985 1986 1987 1988 1990 03/91 03/92 03/93 04/94 03/95 03/96 03/97 03/98 04/99 08/29/2011

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

NURSING POLICY & PROCEDURES

Department: Nursing	**Program/Manual: Nursing**
Policy Subject: Patient Discharge Instructions	**Section Number: P**
Effective Date: 11/2003	**Revised: 8/29/2011**

PURPOSE

To provide follow-up care instructions for patients and their families upon discharge from the hospital.

POLICY

A. Discharge instructions will be provided to all patients discharged from the hospital.

B. Any licensed or certified health care worker may enter data on the form. The registered nurse (RN) or licensed practical nurse (LPN), in collaboration with other disciplines involved in the care of the patient, will ensure that the information provided to the patient is appropriate and complete.

C. The signature of the patient or surrogate will be obtained after the RN determines that the discharge instructions are understood.

D. The original copy of the "Discharge Instructions" will be placed in the patient's medical record, the patient will receive the copy.

E. Patients under 18 years old must be discharged to a parent or legal guardian, unless the patient is an emancipated minor.

PROCEDURE

A. Discharge instructions are located in Electronic Health Record (EHR) in flowsheet/list format.

B. Patient will be given medication instructions, instructions concerning after care and any other instruction concerning his/her care after discharge.

C. The RN will instruct the patient about the problems that require a telephone call to the physician. Include the physician's name and telephone number. Document the telephone number for the Emergency Department.

D. Reinforce the use of educational materials provided to the patient and surrogate. Review the patient's and surrogate's level of understanding, special instructions, diet, activities, equipment, supplies and available community resources.

If the patient has smoked within the past 12 months, include quitting smoking advice.

Record any special educational materials given to the patient.

E. Supplemental discharge instructions may be provided by other health care disciplines.

F. Record the patient's appointment dates, times, locations, physician name, and phone numbers.

G. Document medication information on the form, and the time of the next dose.

H. Document where, how, when, and with whom the patient was discharged.

I. The patient/surrogate will sign the form.

J. The RN will witness, date, time, and sign the form.

Date of Revision:
11/29/2011

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

ADMINISTRATION POLICY & PROCEDURES

Department: Nursing/Admitting **Program/Manual: Administration**

Policy Subject: Patient Identification **Section Number: P**

Effective Date: 11-27-2001 **Revision Date: 10-22-2007**

PURPOSE:

To ensure the safety of all patients by identifying patients accurately by proper patient identification.

POLICY:

All patients must have a completed and legible identification band (I.D.) secured to their person at all times. Two patient identifiers will be verified when providing care, treatment or services. These identifiers will be the patients legal name **AND** date of birth.

PROCEDURE:

1. All patients admitted to the hospital and the emergency department will have a patient identification band placed on their person. Customarily around their wrist. Exception is taken when a patient presents as a critical patient as triaged by a Registered Nurse or a Physician. When the determination is made that the patient is NOT critical the admitting clerk will go to the patient for the completion of the admission process and at that time place the identification band on the patient.

2. The admitting department will complete the admission process as per their identification policy and procedure and place the patient identification band on the patient prior to the patient leaving the admitting department.

3. The identification band will contain BOTH the patient's name and date of birth.

4. If the patient is to be admitted directly to a bed, the admitting clerk will go to the patient for the completion of the admission process and at that time place the identification band on the patient.

5. If the patient's identification band is removed for any reason, the admitting department will be notified for a new band. The new band will be placed immediately on the patient.

6. At no time should any patient be without an identification band.

7. Prior to the start of any procedure and/or blood draw, a final verification during which active communication is used to confirm the identity of the patient is done.

8. Patients who present to the William Bee Ririe Hospital who are not conscience and have no identification or a patient representative to identify them will be registered as a Jane/John Doe, will be given a pseudo social security number, and a pseudo date of birth. The patient will be identified by the pseudo name, and date of birth until their actual identity can be discovered.

9. In the event that more than one patient is admitted with the same name, admitting will write in red ink "name alert", as well as the patient's name and date of birth on the I.D. bracelet. Admitting will also exchange the I.D. bracelet for the already admitted patient(s) and include in red "name alert" along with the patient's name and date of birth.

10. Patients who present to the William Bee Ririe Hospital for O.P. ancillary services such as lab work, X-ray's, etc. are not required to wear an identification band. The hospital employee who will be performing the procedure/test will verify the patient's identification by asking the patient for their legal name and date of birth. The employee will then double check the patient information against the order form. Containers used for blood and other specimens are labeled in the presence of the patient.

Do Regularly check the legibility of identity bracelets. Replace any bracelets, in which **any** part of the patient's details has become illegible.

Do always check the details of patients even if you think you know them well.

Do double check verbally and physically that the details of the patient matches the details in the patient's medical record.

Do not read the patients details to them and allow them to passively agree with you. Ask the patient to give **you** their full detail.

Do not accept a patient's pointing to the printed information. Speak to the patient and check.

ALERT!
DO NOT PROCEED with any procedure if the patient has no identity bracelet. The identity bracelet must be replaced before the procedure can begin.

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC
ADMINISTRATION POLICY & PROCEDURES

Department: Infection Control / Nursing	**Program/Manual:Administration/Nursing**
Policy Subject: Hand Hygiene	**Section Number: I**
Effective Date: 11/1/2010	**Revision Date: 11/1/2010**

POLICY

It shall be the policy of William Bee Ririe Critical Access Hospital and Rural Clinic that all employees shall follow specific hand hygiene practices in order to minimize the spread of infectious microorganisms.

PROCEDURE/PURPOSE

Spread of microorganisms from person-person, from person-enviroment, or environment-person often occurs through transient hand carriage. Therefore, hand washing, and hand hygiene are essential components of infection prevention and control.

DEFINITIONS

Staff- All employees, volunteers, and students.

General hand washing agent- for purposes of this policy, any liquid soap.

Antiseptic hand washing agent- triclosan or chlorhexidine products.

Alcohol based handrub(ABHR)- a hand hygiene product that that does not require the use of water. Not to be used with visibly soiled hands, or Clostidium Difficile patients. Bottles should be disposed of when empty and are not re-filled or topped off with additional product.

Hand lotion- for purposes of this policy, small personal use containers or mult-use pumps that are smaller than 16 ounces – but not refilled (to decrease the risk of contamination.)

Hand hygiene/cleanse- includes the use of either soap and water or an ABHR to remove transient hand microbes.

Patient contact- includes, but is not limited to touching a patient or a patient's bed(bed linens, mattress, bed rails, bedside table, etc.), taking vital signs, repositioning a patient, changing a dressing, starting an IV, performing venipuncture, accessing a patients IV, etc.

POLICY STANDARDS

A. Staff may only use hand hygiene agents and hand lotions approved by Infection Control. (IC)

B. Hand hygiene will be performed in each of the following situations:

1. Upon entering and leaving a patients room (eg., inpatient, procedure room.)This does not apply to food passers during routine tray passing or in the ambulatory clinic setting, unless hands become contaminated.

2. Before and after each patient contact.

    a. Between patient contacts if more than one patient in the room.
    b. Before and after contact with patients who are not in a room(e.g., on a stretcher, in open bays, etc.)

3. After any patient contact where there is some likelihood of contamination with moist body substances.

4. After touching potentially contaminated inanimate objects (eg., medical equipment.)

5. Before preparing/handling sterile items or supplies, medications, or food.

6. Before handling/ inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical scrub.

7. Before and after glove removal.

8. Before and after eating.

9. Whenever a hospital policy requires hand hygiene.

C. Antiseptic hand washing agent (soap) and water is required (do not use ABHR)

1. When hands have been potentially soiled with moist body substances.

2. After handling use dressings, sputum containers, soiled urinals, catheters, bedpans, or changing a diaper.

3. Following personal hygiene (use of the restroom, blowing nose, contact lens care, etc.)

4. Whenever patient has suspected or confirmed case of C.difficile.

D. ABHR may be used in each of the following situations

1. When hands are not visibly soiled with blood, body fluids, or any organic manner.
2. In situations where hand washing facilities are not available.

E. An antiseptic hand washing agent shall be provided in all patient rooms, soiled rooms, appropriate clean rooms, OR, ICU,ED, Nursery, Labor and Delivery, and treatment rooms.

F. In outpatient clinic exam rooms, clinical laboratories, and visitor areas, a general hand washing agent may be provided.

G. Bar soap shall not be used for mulit-patient/personnel use.

H. Disposable soap containers preferred. If a dispenser needs to be reused,it must be cleaned and filled with fresh soap product after emptied. Liquid soap is to never be added to a partially full dispenser.

I. Hand lotion may be used to prevent drying associated with hand washing and prevent irritation from glove use.

J. If a staff member's job includes "hands on" direct patient care:

1. Nails are to be kept short (cannot extend past the tip of the finger.) and clean.
2. Nail polish may be worn if well manicured; chipped polish must be removed.
3. Artificial nails or artificial nail products (e.g., gel nails, tips, overlays, wraps, nail jewelry, etc.) may not be worn.

K. Each patient care unit and service area shall be responsible for monitoring compliance with the standards of this policy.
L. All staff are encouraged to remind others about hand hygiene, including fellow staff members, visitors, and patients.
M. Any staff member observed to be in non-compliance with this policy are to be reported to their supervisor for education and/or corrective action.

PROCEDURE ACTIONS

A. Soap and Water

1. Wash hands with friction for a total of at least 15 seconds. Pay particular attention to under nails and between fingers.
2. Rinse well. Blot hands, and dry with paper towel.
3. Use a dry paper towel to turn off hand- operated faucet.
4. Apply lotion periodically throughout the day.

B. Alcohol-based handrub (ABHR)

1. Apply the product to the palm of hand.
2. Spread across hands, rub hands together.
3. Rub in briskly until dry.

C. Hand cleansing technique when hands are soiled and soap and water are unavailable. (e.g., on an EMS vehicle or during a water shortage)

1. Remove as much gross or visible soiling as possible using any kind of cloth. Paper toweling, or moist towelettes (such as baby wipe type products) If using moist towelettes, completely wet and cover skin surfaces, and wipe as clean as possible with paper toweling.
2. Apply alcohol-based handrub as above.
3. This procedure can be used both before and after glove usage.

REFERENCES

The joint Commision, *Comprehensive Accreditation Manuals for Hospitals.*
APIC Text of Infection Control & Epidemiology, **APIC**
Guideline for Hand Hygeine in Health- Care Settings. **(www.cdc.gov/handhygeine)**

AUTHOR

Infection Control

Signature _____ **Date** _____

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL

POLICY/PROCEDURE: Pre-Operative Surgical Checklist

INITIATING DEPARTMENT: Surgical Services EFFECTIVE 05/94

PURPOSE:

To establish guidelines to ensure the patient has received proper preparation for an operative procedure.

POLICY:

A "Surgical Checklist" will be completed on all patients entering the Operating Suite. The "Surgical Checklist" will be reviewed and completed by a Licensed Nurse on the Nursing Unit prior to the patient's transfer to the Operating Suite. The "Surgical Checklist" will be further reviewed by the Circulating Nurse in the assigned operating room. Any omissions on the patient's chart could result in the cancellation o the operative procedure.

RESPONSIBILITIES:

Operating Practitioner

- Order appropriate testing in sufficient time for completion prior to scheduled procedure.
- Document "Informed Consent"
- Complete History and Physical Examination.

Registered Nurse – Nursing Unit

- Review, complete and sign "Surgical Checklist" prior to releasing the patient for transfer to the Operating Suite.
- Ensure surgical site is marked per policy.
- Patients with incomplete laboratory results or documentation, i.e., History and Physical, **WILL NOT BE RELEASED** to the Operating Suite until information is on the patient's chart.

Circulating Nurse

- Reviews, completes the "Surgical Checklist" prior to taking the patient into the operating room.

PROCEDURE:

The "Surgical Checklist" is found in the electronic health record under E-Forms. It must be completed and signed by the appropriate persons prior to surgery.

Refer to attachment for example of "Surgical Checklist" for required pre-operative information.

Date of Revision	Distribution	Administrative Approval
3/95 3/97 4/99 4/01 4/03 3/96 3/98 3/00 4/02 1/11		

William Bee Ririe Hospital
Surgical Preop Checklist

YES	YES	N/A	
☐	☐	☑	History and Physical in chart
☐	☐	☑	Hospital Surgery Consent signed and in char
☐	☐	☑	Physician Consent signed and in chart
☐	☐	☑	Initial Interview & Physical Assesment compl
☐	☐	☑	Anesthesia Consent completed
☐	☐	☑	Lab Results on chart / in EHR
☐	☐	☐	Radiology Results on chart / in EHR
☐	☐	☐	EKG on chart
☐	☐	☐	Blood Band on patient
☐	☐	☐	Blood Available
☐	☐	☑	ID Band checked and confirmed with patient
☐	☐	☑	Operative site confirmed with patient
☐	☐	☐	Operative site marked by physician and visib
☐	☐	☐	Hibiclense shower done
☐	☐	☐	Skin Prep completed
☐	☐	☐	SCDs / TED hose on patient
☐	☐	☐	Glasses / Contacts removed
☐	☐	☐	Hearing Aid removed
☐	☐	☐	Undergarments removed
☐	☐	☐	Dentures / partials removed
☐	☐	☑	MAR / Allergies Available
☐	☐	☐	Prosethesis removed
Unit RN INITIALS	OR RN INITIALS		
Date	Date		
Time	Time		

Patient voided / cathed at (Time) NPO (Since:)

PT Name CPSI 333 Sex M DOB 12242001 Age 9 Acct # CPSI0333 MR# 135336

* Consent matches physician order

CENTRAL LINE INSERTION CHECLIST

GOAL > To decrease patient harm from catheter-related bloodstream infections.

WHO > An operator and a monitor (Clinician placing central line & individual observing procedure.)

ROLES> The monitor assures compliance with the checklist elements, and any breaks in sterile technique.

CONSIDER PLACEMENT OF INTRAOSSEOUS (IO) NEEDLE FOR THE FOLLOWING CONDITIONS:

- ☐ Urgent need for vascular access.
- ☐ Patient with difficult vascular access. (IVDA, DM ,etc.)

INTRAOSSEOUS (IO) VASCULAR ACCESS ALTERNATIVE:

- ☐ Bridge to immediate vascular access, allowing time for adherence to current CVL ptotocol (allows for immediate initiation of treatment)
- ☐ Alternative to subclavian/jugular/femoral lines when long-term central lines are not absolutely required.

PROCEDURE PLANNING	YES	NO	COMMENTS/RATIONALE
Emergent Placement	☐	☐	If Yes, initiate immediate treatment with IO access.
Timeout documented separately	☐	☐	
Consent documented separately	☐	☐	

INSERTION SITE: ☐ SUBCLAVIAN ☐ INTERNAL JUGULAR ☐ FEMORAL

☐ PICC ☐ OTHER(SPECIFY)

The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible or the Dacron cuff being extruded.

Procedure

1. Explain the procedure to the client/family. Position the client for comfort.

2. Wash hands. Refer to the Hand Washing procedure.

3. Assemble equipment and prepare flush.

4. Open dressing change kit and put on mask.

5. Apply non sterile gloves and gently remove old dressing, being careful not to dislodge catheter.

6. Examine the catheter insertion site for signs of redness, swelling, inflammation, and tenderness.

7. Inspect the catheter and hub for any evidence of kinked or weakened areas, loss of integrity, or changes in the length of exposed tubing.

8. Discard old dressing and remove non-sterile gloves and dispose.

9. Apply sterile gloves.

10. Clean catheter site with a Chlorhexidine, starting from exit site and moving outward in circular motion to cover an area 10 cm in diameter.

11. Let Chlorhexidine *air dry*. **Do not wipe off.** If patient is allergic to Chlorhexidine or if Dr prefers, you may use povidone-iodine swabs. *(neonates& pediatrics less than 2 months of age are not recommended chlorhexidine. Ask physician.)*

12. Redress the site with sterile transparent dressing, sealing catheter in straight position. *Do not coil the catheter.*

13. Anchor catheter to the client's skin using tape. Avoid placing tape on transparent membrane.

14. Clean old injection cap and catheter end. (scrub the hub at least 15 seconds) remove old cap.

15. Replace new cap.

16. Pulsate Flush with appropriate flush. *Refer to Flush Procedure.*

17. Wash hands. *Refer to the Hand Washing procedure.*

Documentation Guidelines

Document in the clinical record:

1 The client's tolerance of the procedure.

2. Condition of the site.

3. The patency of the line and the flush used.

4. The date and time of dressing change.

WILLIAM BEE RIRIE HOSPITAL
OUTPATIENT TREATMENT RECORD

Patient: CPSI01 GEORGE **Sex:** F **Age:** 11 **DOB:** 06042000 **Time:** 1206 **Date** 082411 **MR#:** 99999

Physician: **Height: (inches)** **Weight (lbs):** **ACCT #:** 10073721

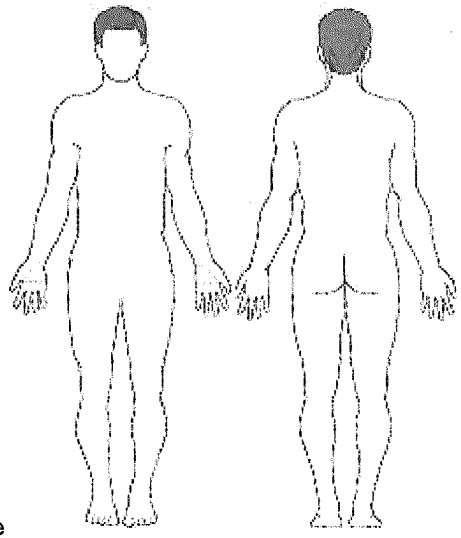
Initial assessment completed by:

BREATHING: ☐ Clear to auscultation / WNL
☐ Shallow ☐ Crackles ☐ Dyspnea ☐ Rhonchi ☐ Wheezing
☐ Tachypnea ☐ Diminished ☐ Grunting ☐ Stidor ☐ Retracting
☐ Cough ☐ Productive ☐ Non-Productive
Comments:

CIRCULATION ☐ Skin warn, dry, intact. WNL
Skin/Mucous Membrane:
☐ Pink ☐ Pale ☐ Flushed
☐ Cyanotic ☐ Mottled ☐ Jaundiced
☐ Warm ☐ Dry ☐ Hot
☐ Cool ☐ Diaphoretic ☐ Moist
Comments:

NEURO: ☐ Awake, alert, oriented X3. WNL
Pain Scale
☐ Confused ☐ Lethargic
☐ Unresponsive ☐ Combative
☐ Headache ☐ Dizziness
☐ Slurred Speech ☐ MAE w/ purpose
Pupils: Reaction
L R
Comments:

Physical Observations



☐ WNL / None
A: B:
C: D:

CARDIAC ☐ WNL
☐ Bradycardia ☐ Tachycardia ☐ Arrhythmia
Pulses WNL ☐ RUE ☐ LUE ☐ RLE ☐ LLE

GI ☐ WNL / No complaints
Abdomen ☐ Soft ☐ Firm ☐ Flat
☐ Distended ☐ Round
Last BM: Last PO Intake:
Bowel Sounds ○ Active ○ Hypoactive ○ Absent
Nausea ○ Yes ○ No
Vomiting X
Diarrhea X
Comments:

GU ☐ WNL / No complaints
☐ Discharge ☐ Dysuria ☐ Her
☐ Frequency ☐ Incontinence ☐ Urg
Indwelling Foley Cath Size
Comments:

OB/GYN ☐ N/A LMP:
Gravida Para Abortions
EDCI FHT:
Prenatal Care ○ Yes ○ No
Comments:

MUSCULOSKELETAL ☐ WNL / No Complaints
Pain Scale Location of pain
Tenderness/Swelling ○ Yes ○ No
Motor sensory intact distal to injury ○ Yes ○ No
Decreased ROM ○ Yes ○ No Deformity noted ○
Comments:

PEDIATRIC ☐ N/A
Comforted by caregiver ○ Yes ○ No ○ N/A
☐ Playful ☐ Lethargic ☐ Crying/Fussy
Developmentally appears stated age ○ Yes ○ No
OFC (< 1 year old)
Comments:

CURRENT DIAGNOSIS & TREATMENT ORD

Peripheral Edema	
Comments:	

VITAL SIGNS

Time		TEMP	New	PULSE	New	RESP	New
B/P	New			SAO2	New		

CURRENT HOME MEDICATIONS

Medication:	whiskey	**Dose:**	
Frequency:		**Route:**	
Last Dose:		**Patient Compliant?:**	N **Needs Education?:** N
Comments:			

Allergies

DAUNORUBICIN	DARVON	12 HOUR COLD MAXIM	

IV ACCESS RECORD

☐ Arrived with IV access in place ☐ IV Patent IV Site ☐ IV access DC'D

Start Time Fluids IV Rate Catheter Size

IV Site DC Time ☐ Catheter Tip Intact Total IV Intake

CENTRAL LINE DRESSING CHANGE AND / OR ACCESS RECORD

TYPE OF DEVICE

☐ PICC
☐ Porta Cath
☐ Other

SITE

☐ Right
☐ Left
☐ Subclavian
☐ Femoral
☐ Brachial

CONDITION OF SITE

☐ Site Clean Dry and Intact without S/S of infection
Other ☐

Dressing Change or Port Access

☐ Cleaned with Chloraprep
☐ Allergic to Chloraprep Cleaned with Other
☐ Air Dry for 30 Seconds after Cleaning
☐ Portacaths Accessed with Huber Needle
☐ Central Line Dressing Kit Used
☐ Covered with Sterile Dressing
☐ Aseptic Technique Followed

Central Line Flushing

☐ Hub Was Scrubbed with Chloraprep for 15 Seconds
☐ Line Flushed Per MD Orders

Patient Tolerated Procedure

- ☐ Pt Tolerated Procedure Well
- ☐ Other
- ☐ Huber Needle D/C'd Intact
- ☐ Site Remained Accessed Covered With Sterile Dressing and Secured

NARRATIVE

Patient: CPSI01 GEORGE **Sex:** F **Age:** 11 **DOB:** 06042000 **Time:** 1206 **Date** 0824:

Physician: **MR #:** 9999999999 **ACCT #:** 10073721 **PAGE 2 OF 2**

Other Other ☐

HOUSEKEEPING CHECKLIST

FOR DAILY CLEANING -PATIENT ROOM CLEANING:

Date:_____

Room:_____

Time:_____

Instruction	Component	Yes	No	N/A
At start, perform hand hygiene.				
Put on PPE.(If indicated)				
Disinfect high-touch surfaces:	Door knobs/handles/surface			
	Bed frame/rails			
	Mattress			
	Call button			
	Phone			
	Overbed table & drawer			
	Countertop			
	Light switches			
	Furniture			
	Arms of patient chair			
	Seat of patient chair			
	All other miscellaneous horizontal surfaces			
	Window sills			
	Bedside commode			
	Medical equipment (e.g., IV controls)			
	Spot clean walls with disinfectant cloth			
Disinfect:	BATHROOM, including:			
	Bathroom door knob			
	Toilet horizontal surface/seat			
	Toilet lever/flush			
	Faucets (at sink)			
	Bathroom handrails			
	Sink			
	Tub/shower			
	Mirror			
Clean:	Overhead light (if the bed is empty)/Lights			
	TV & stand			
Clean floor:	Dust mop tile			
	Wet mop tile			
Replace as needed:	Hand sanitizer			
	Paper towels			
	Soiled curtains			
Misc.				
	Replace as needed: Pillows, mattresses.			
Other:	Empty trash & replace liner			
Discard dust cloths.				
Change mop heads after each isolation room.				
Remove PPE before exit.				
Perform hand hygiene.				

Any significant areas not mentioned above (please describe):

This room looks clean and ready for use:
Sign-off by environmental services employee cleaning the room:_____