



MASSACHUSETTS  
GENERAL HOSPITAL

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PCS QUALITY & SAFETY



**2017-2018**  
**Joint Commission**  
**Regulatory Readiness**  
**Resource Guide**

# Joint Commission National Patient Safety Goals

## Identify patients correctly

- Always use 2 patient identifiers
- Two person verification for blood product administration

## Improve staff communication

- Report critical results on a timely basis

## Use medications safely

- Label all medications and solutions
- Utilize and teach safe practices for anticoagulation therapy
- Maintain and share accurate patient medication information

## Use alarms safely

- Respond promptly to every clinical alarm
- Individualize parameter limits for the patient

## Prevent Infections

- Use hand hygiene
- Adhere to Infection Control guidelines
- Educate patients and families

## Identify safety risks

- Identify patients at risk for suicide or self-harm

## Universal Protocol

- Conduct a pre-procedure check, mark the site, and perform a Time Out/Pause to verify

# Quality Assurance Performance Improvement (QAPI)

## Quality:

- Know your unit-specific Quality Data and Improvement Plans
- Prevent Falls, Pressure Injury and Hospital Acquired Infections
- Utilize IPASS for handovers

## Speak Up for Safety:

- Share errors and near misses through narratives and filing of safety reports
- Keep suicidal patients in sight at all times. Use the suicide checklist and order set
- Scan all medications before administering
- Report eCare related safety concerns

## Excellence Every Day:

### Enhance the Patient Experience:

- Provide **Efficient, Effective, Equitable, Timely, Safe, Patient-Centered Care**
- Promote patients' understanding of safe use and side-effects for medications
- Facilitate Quiet at Night
- Increase the use of Interpreter Services

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## **EXCELLENCE EVERY DAY**

At Massachusetts General Hospital, our Excellence Every Day philosophy means we commit to providing the best possible care to every patient and family in every moment of every day.

We are focused on meeting the needs of patients and families by creating systems that support the highest level of quality and safety. Our efforts to achieve Excellence Every Day include validation by the American Nurses Credentialing Center's designation as a Magnet hospital and by external regulatory agencies in the form of on-site surveys.

MGH is visited by the Joint Commission every 3 years to validate that we are meeting standards and continuing to provide exemplary, safe care to our patients. Other important surveys we participate in are those that recognize excellence and/ or are required to validate advanced, disease specific, certifications.

Examples include:

- Joint Commission Laboratory survey
- Joint Commission Comprehensive Stroke Certification survey
- Joint Commission Left Ventricular Assist Device (LVAD) Certification survey
- CMS End Stage Renal Disease licensure survey
- Massachusetts Department of Mental Health licensure survey
- Massachusetts Department of Public Health (DPH) Infection Control survey

Thank you for your contributions to our success in providing an environment where the EED philosophy comes alive for our patients, families and the entire MGH community.

**You are Simply the Best!**

## RESOURCES FOR PATIENTS, FAMILIES AND STAFF

- **Mass General Patient Guide** ~ located on each inpatient unit
- **Patient Rights and Responsibilities** ~ located on each unit
- **The Maxwell & Eleanor Blum Patient and Family Learning Center**
  - A health information resource center available to Mass General patients, families and staff
  - The PFLC staff can help with information searches and provide a variety of pamphlets, periodicals, books and videos on many health- and disease-related topics
  - Computers with Internet access are available for on-site use.
  - White Building, 1st Floor, Room 110 • (617) 724-7352
  - PFLC@partners.org • [www.massgeneral.org/pflc](http://www.massgeneral.org/pflc)
  - Monday – Friday, 9am – 4:30pm; closed weekends and holidays
- **Medical Interpreter Services**
  - Provides professional interpreters for all limited English proficient (LEP), deaf and hard of heard (DHH) patients
  - Patients have a legal right to a professional medical interpreter 24/7 free of charge whether it is in person, over the phone or by video
  - Using family members or other staff to interpret is strongly discouraged Call 617-726-6966 for a professional interpreter
  - When a patient insists on using a family member, they must sign a waiver form
  - More information on MGH Interpreter and Translation services is available at: <http://www.massgeneral.org/interpreters>
- **MGH Disability Program**
  - Assists patients during their MGH visit
  - Helps patients with disabilities, and their caregivers, to plan visits
  - Responds to concerns and suggestions regarding access

- Provides support and services including but not limited to necessary accommodations:
  - Specialized Call Bells
  - Hearing Enhancers and Magnifiers
  - ASL interpreters or Communication Access Realtime Translation (CART) Services
  - Patient lifts
  - Wheelchair accessible scales
  - Large print documents, Braille
  - Portable Video phones for the Deaf
  - Wheelchair accessible shuttles
  - Accessible rooms and bathrooms (if one is not available at the time of admissions every effort will be made to transfer the patient when one becomes available)
  - Height adjustable accessible exam tables
  - Ambassador or volunteer wheelchair escort

For more information call the disability program manager at 617-726-3370 or check our webpage [www.massgeneral.org/accessibility](http://www.massgeneral.org/accessibility)

- **Optimum Care Committee**

- Representatives are available to clinicians, patients and families to help address ethical issues
- Consults may be placed Monday – Friday from 8:00a - 4:00p (except on holidays observed by MGH)
- Partners Telephone Directory → Ethics Support → PHS Page Status → You will find the phone # to call or person to page for consult intakes

- **Office of Patient Advocacy**

- Supports patient's rights and responsibilities
- Serves as liaison to patients, family and staff to resolve healthcare concerns and grievances

- Provides accommodations and other services to patients with disabilities to ensure equitable care
- Serves as hospital civil rights officer
- (P) 617 726-3370
- Email: [mghpatientadvocacy@partners.org](mailto:mghpatientadvocacy@partners.org)

## **WHAT WILL THE JOINT COMMISSION SURVEYORS REVIEW DURING THE GENERAL HOSPITAL SURVEY?**

The Joint Commission survey is designed to confirm that a hospital follows its own guidelines and policies as well as national standards. The JC general hospital survey will be 5 days in length.

Using the patient's medical record as a road map, surveyors will assess the care provided to patients in both inpatient and ambulatory sites.

A surveyor will arrive at your practice area accompanied by MGH leadership.

The surveyor will:

- Review a patient's record with caregivers
- Observe care
- Interview caregivers
- Interview patients
- Tour the unit

The nurse caring for the patient the Clinical Nurse Specialist / Nursing Practice Specialist and/or Nursing Director will participate in the record review. Because the surveyor will not know how to navigate the MGH patient record, they will ask you to help locate the documentation they want to review.

As the surveyor tours the unit and observes care, he or she may interview other members of the healthcare team including UCs, PCAs, NPs, PAs, physicians and allied health professionals.

### **Patient interview**

The Joint Commission surveyors will ask the nurse caring for the patient if the patient is able to be interviewed. If yes, the JC surveyor will interview the patient and family without other members of the healthcare team present.

## Questions to patients and families may include such topics as:

- Patient and family education
- Advance directives (Health Care Proxy)
- Patient and family participation in care planning
- Pain management
- Staff responsiveness
  - Help when they need it
  - Response to questions
- Continuity of care
- Understanding of medications
- Preparation for discharge
- Environment e.g. noise, cleanliness

## ***Remember***

- Surveyors know the standards, but YOU know your practice, your patients and their families
- Breathe and take your time answering the surveyor's questions, be direct and to the point with your response
- You will not be alone, your Nursing Director, CNS/ NPS and others will be there to support you
- If you don't know the answer to a question, it's okay to say "I don't know but I do know where to find the answer".
- A full list of resources can be found at the end of this book
- Tell positive stories! If the surveyor asks you a question that relates to a special project on your unit or in the hospital talk about it!

## How does the JC Surveyor "*trace*" a patient's MGH experience?

The surveyor will ask you to navigate your patient's electronic medical record in order to trace the patient's care via associated documentation. The surveyor will ask you to show them documentation in the electronic record including:

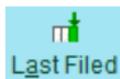
- Admission overview and assessment (Initial Nursing Assessment)
- Advance directives/health care proxy available or documentation regarding a discussion about HCP is present in record.
  1. The HCP is found in the maroon book if it has been provided during the current admission
  2. It is found in the Advanced Care Planning module or the Media tab if it has been previously scanned
- Accurate and up-to-date allergies
- Consent for surgery/procedures (found in the maroon book for current admission)
- Timeout/Universal Protocol completed for every invasive procedure that requires an informed consent
- Progress Note
  - Provides a synthesis of the patient's overall progress
  - Focuses on problems that are not progressing in the Plan of Care (POC)
  - Documents assessments that need to be captured outside of flowsheet
- Transfer of care
  - Note should be a synthesis, the same as a progress note
  - Reviews the POC, problems should be up-to-date and resolved if no longer active
  - Review and update the Education activity
- Plan of Care (POC) Activity
  - Individualized for the patient
  - Based on assessment and re-assessment of the patient's specific risk factors
  - Progression of problems toward end goals is up-to-date (progressing, not progressing, resolved)
  - Patients at risk for falls, pressure injury, suicide or self-harm have these problems documented in the POC activity and flowsheet
  - Discharge planning

- Educational Activity
  - Patient and family preferred learning style is identified
  - Patient and family education has been implemented
  - Patient/family understanding of educational content has been evaluated
  - Patient and / or family understands medications and side effects
- Flow Sheet Activity
  - Timeout flowsheet (aka Universal Protocol)
  - VS, Intake/Output
  - Safety risks including suicide, self-harm, falls, pressure injury are documented on the Screening Flowsheet
  - Restrain flowsheet – documentation reflects the restraint in use for the patient or discontinued
  - Provider notification of critical lab values is documented in the Assessment Flowsheet
  - Blood Admin flowsheet – Transfusions are stopped and all VS are present
  - Accurate documentation of items (e.g., infusions, restraints) that need to be “stopped” to indicate that they have been discontinued

- Utilize these flowsheet tools



***“Go To Date”*** takes you directly to a specific date on the flowsheet



***“Last Filed”*** takes you to the last filed information



***“Hide Completed”*** allows you to organize Flowsheets. Remember to deselect this when you are searching for specific information

## • Other documentation reviewed

- Evidence of implementation of Provider orders
- The interdisciplinary plan of care and follow through is evident through summary activity including overview, patient story, and index tabs
- Documentation that nurse-driven consults have been completed
- Assessments by Provider-ordered consultants (e.g., PT, OT, SLP, Social Work) are documented
- Handover/transfer of care is careful and systematic (IPASS, transfer note)
- OR and Anesthesia notes are accessible in: chart review → encounter → anesthesia event/surgery
- Discharge planning is documented in progress notes
- No unapproved abbreviations are used

**The Patient Header** provides easy access to select patient information

The screenshot shows a patient header with the following information:

Allergy: Heparin An...	Language: English	Wt: 129.3 kg...	Isolation: Contact	Acute Care P...
Code: Full (Presum	Need Interp: No	BMI: 43.33 k...	Precautions: Seizure precau...	MOLST NOT...
			FYI: No Draw Left Arm	Patient Gate...
			Special Needs: Speech Imp...	

such as:

- Preferred language
- Isolation details
- Precautions
- Selecting either the MOLST or Code Status headings will bring you to the Advanced Care Planning Module. The Health Care Proxy / Advanced Directive can be found here **or** in the Media tab
- “FYI” shows you important patient-specific information that has been flagged by staff
- Acute care plan (if activated)

## Competency, Scope of Practice, Checking Credentials

**The surveyor may ask you:**

### ***How are you competent to do your job?***

Staff are competent through completion of an accredited program, professional licensure, MGH onboarding, continuing education, in-service education, annual training, and validation of performance. Specialty certification is encouraged.

### ***What is the scope of your job?***

The ANA defines the legal scope of nursing practice related to medications, therapeutics, and treatments this way:

Nurses make clinical decisions in order to assist in the development and implementation of a strategy of care to accomplish defined goals. Nurses also evaluate the patient's response to care and treatment. A duly authorized prescriber (MD, APRN, PA) order is required for all medications and all medical therapeutics and treatments. Examples may include blood tests, oxygen, urinary catheter irrigations, EKGs, and point of care testing.

### ***If a provider that you don't know shows up on your unit to do a procedure, how do you know he or she is privileged to perform the procedure?***

I can look the provider up through the MGH Delineation of Privileges

Intranet site: *Partners Application* ► *Clinical References* ► *MGH Delineation of Privileges Intranet Site*

### ***How is patient information completely and safely communicated?***

Communication of the ongoing plan of care among nurses and between interdisciplinary team members is accomplished through one-on-one discussions and a variety of other means:

- The IPASS framework is one tool employed by clinicians
  - I - illness severity
  - P - patient summary

- A - action list
  - S - situation awareness and contingency planning
  - S - synthesis or read-back.
- Electronic health record is accessed to review the patient summary / patient story
  - Warm Handover: A conversation between caregivers at the time of transition of care from one clinician to another allows staff to synthesize and discuss
    - Patient history
    - Active problems
    - Interventions
    - Patient responses
    - Next steps
    - Information regarding family/significant others
    - Questions & concerns
  - Interdisciplinary rounds highlight
    - Ongoing plan of care
    - Current problems and interventions
    - Changes to plan of care
    - Changes to treatment strategies
    - Plan for safe discharge
  - Huddles provide an opportunity to address patient and unit-specific concerns

***When a patient goes to a test or procedural area, how is clinical information provided to staff in those areas?***

1. A “Ticket to Ride” (aka the Internal Patient Transfer form) is sent with the patient. The “Ticket to Ride” contains relevant information, pulled from the EHR, that the receiving area needs upon arrival of the patient.
2. Warm handovers are encouraged to address specific patient needs or concerns

## **HOW DO WE ASSURE QUALITY FOR OUR PATIENTS?**

Nursing-Sensitive Indicators (NSIs) are measures and indicators that reflect the structure, processes and outcomes of nursing care (American Nurses Association, 2004). They showcase the impact of nursing care.

### **Surveyors may ask about Quality Assurance and Performance Improvement (QAPI) initiatives on your unit and throughout the hospital**

- Most inpatient units monitor patient falls, pressure injuries, restraint use, Catheter-Associated Urinary Tract Infections (CAUTI) and Central Line-Associated Bloodstream Infections (CLABSI)
- Know your unit-specific NSI Quality Data and Performance Improvement Plans
- Reference your unit-specific Excellence Everyday Quality Board
- Describe Practice Improvement projects in place on your unit and how they have benefitted your patients

## **Clinical Quality NSIs**

### **Fall Prevention**

[http://www.mghpcs.org/eed\\_portal/EED\\_fallprevention.asp](http://www.mghpcs.org/eed_portal/EED_fallprevention.asp)

The falls prevention program at MGH is referred to as the LEAF program (Let's Eliminate All Falls). The program has 3 components:

1. Identification of patients at risk
  - Every patient is screened on admission, daily, and with any change in status using the Morse Falls scale (adults) or Graf PIF (pediatrics). This helps inform a customized plan of care and patient/family education.
2. Fall risk communication
  - If the patient is at risk, the nurse initiates a fall prevention plan and documents specifics in the POC activity and flowsheet.
  - Information is provided through patient handovers, hourly rounding, signage, or other unit-based strategies

- The patient and family are instructed about fall risk and interventions.
- When a patient is going off the floor, the Internal Patient Transfer form (aka “Ticket to Ride”) is sent with patients to inform the receiving clinician of the patient’s risk.
- The review of unit-specific fall trends is posted on the Excellence Every Day bulletin board.

### 3. Interventions

- Some interventions apply to all patients, regardless of risk
  - Call light is within reach
  - Room is clear of clutter
  - Teaching is done regarding the side effects of medications
- Interventions are customized or added for patients at moderate or high risk then documented in the plan of care. These interventions may include:
  - Use of bed alarms with customized sensitivity setting 1-3
  - Patient placement near nursing station
  - Patient kept within arm’s length during ambulation and assisted toileting
  - Consults to PT or OT and use of assistive devices
  - Each unit monitors rate of falls and falls with injury quarterly
  - Unit-specific performance improvement plans for reducing and/or eliminating falls are re-assessed and modified based on unit-specific trends.
  - Rates and plans are posted on unit-based bulletin boards

### **Pressure Injury Prevention**

[http://www.mghpcs.org/eed\\_portal/EED\\_skin.asp](http://www.mghpcs.org/eed_portal/EED_skin.asp)

Skin integrity is evaluated as a part of the initial nursing assessment. The Braden scale, which is completed on admission, daily, and with any changes, is used to gauge the patient’s level of risk for development of a pressure injury. As shown in the Skin Care Guideline, interventions are guided by the subscale scores for sensory perception, moisture, activity,

mobility, nutrition, friction or sheer. If the score is one or two, there's something to do!

If a pressure injury is present:

- Consult CNS/NPS for pressure injuries Stage 3 and above
- Treat patients at risk for, and patients with, pressure injury per Skin Care Guideline and provide wound care as ordered
- Document pressure injury measurements on admission, weekly, or whenever acute changes are noted
- Document location and condition of the wound bed (tissue type and type/amount of exudate) and peri-wound margin
- Document the patient's response to treatment
- File a safety report

### Catheter-Associated Urinary Tract Infections (CAUTI) Prevention

[http://www.mghpcs.org/eed\\_portal/EED\\_CAUTI.asp](http://www.mghpcs.org/eed_portal/EED_CAUTI.asp)

The most effective means to prevent a CAUTI is to remove the catheter.

#### **A.R.M.** your patients against CAUTI by:

- **Avoid** the use of catheters (except for hospital-approved indications)
  - Consider alternatives (straight catheter, condom catheter, etc.)
  - Ask: "what is the indication for the catheter?"
  - **Never** use a catheter for the management of incontinence
- **Reduce** the number of days a catheter is in place by:
  - Use of the Nurse Driven Protocol for Catheter Removal
  - Regularly assess ongoing need for catheter
- **Maintain** the catheter below the level of the bladder and avoid dependent loops
  - Perform daily catheter care using warm soap and water
  - Maintain a closed system and avoid disconnecting the catheter from the drainage bag
  - Use only the sterile port to obtain urine specimens
  - Secure the catheter to prevent urethral trauma and traction

- Insert catheters using aseptic technique
- Use hand hygiene before touching catheter
- Use a separate, patient-labeled container for emptying collection systems
- Do not routinely replace catheters

## **Central Line-Associated Bloodstream Infections (CLABSI) Prevention**

[http://www.mghpcs.org/eed\\_portal/EED\\_centralines.asp](http://www.mghpcs.org/eed_portal/EED_centralines.asp)

The following actions are taken to prevent Central Line-Associated Bloodstream Infections (CLABSI) during insertion and line access (NPSG)

- A standardized kit and protocol are used
- During insertion, a qualified individual monitors for breaks in sterile technique and stops the procedure if breaks are noted
- Hand hygiene is performed with antimicrobial soap or alcohol-based hand sanitizer prior to donning sterile gloves for catheter insertion
- Maximal sterile barrier precautions are followed during insertion, including:
  - head to toe sterile drape
  - sterile gown
  - masks and hair covers worn by everyone in the room
- After insertion:
  - the Provider and the Monitor complete and sign the Central Line Checklist in Epic
  - a Chlorhexidine impregnated sponge dressing is applied at the insertion site to prevent introduction of skin microorganisms into the blood stream.
  - a disinfecting alcohol port protector is used to keep access points on IV tubing continuously disinfected.
  - patients and families are educated about prevention of infection

## Safe Restraint Use / Reduction

[http://www.mghpcs.org/eed\\_portal/EED\\_restraints.asp](http://www.mghpcs.org/eed_portal/EED_restraints.asp)

A restraint is any manual, physical or mechanical device, material or equipment that immobilizes or reduces the ability to move arms, legs, head or body freely. Document details of restraint use in the restraint flowsheet.

- Customize restraint use to specific patient needs
- Always attempt least restrictive measures before applying restraints
- Medications are not used to involuntarily restrain patients
- Removing restraints for a “trial period” should not be done
- If the patient is taken out of restraints and needs to be put back in, this is a new episode of restraint and a new order is required. This is true even if the patient has only been out of restraints a short time
- Removing restraints to deliver care *is acceptable* provided they are reapplied once specific care has been completed
- Siderails *are not considered restraint*: When used to prevent a patient from sliding or rolling out of bed; this includes padded side rails for seizure precautions. When used in conjunction with another restraint, they are treated as a safety precaution
- Siderails *are considered a restraint*: When the intent is to restrict the patient from getting out of bed; this is true even if using fewer than 4 siderails

The restraint grid can be found with the Restraint and Seclusion policy in ellucid <https://hospitalpolicies.ellucid.com/documents/view/1378>

Non Violent and Violent Restraint Guide		
	Non Violent	Violent
Indications/ Patient Behavior	<b>Non-violent/non-self destructive restraint</b> is used for patients presenting with symptoms/changes related to their medical-surgical condition, for example, delirium due to high fever, sepsis, dementia, substance withdrawal and substance intoxication. These behaviors interfere with the patient's own safety and medical treatment or healing, for example: pulling at lines, tubes and dressings catheters, thrashing in bed. This also includes situations where there is a significant risk for self-exhaustion (i.e. Prolonged wearing).	<b>Violent/Self Destructive restraint</b> is used for the management of behavior that jeopardizes the immediate physical safety of the patient or staff member or others. These patients present with behavioral health symptoms. For example psychotic episodes, mania, attempted suicide, physical assault. These patients primarily require behavioral health services (psychiatry)
Order initiation and expiration	<ul style="list-style-type: none"> <li>A physician, physician's assistant, or advance practice nurse order is required for the application of restraint</li> <li>In emergency, order must be obtained during the application or as soon as possible after the restraint application</li> <li>Orders need to be rewritten daily</li> </ul>	<ul style="list-style-type: none"> <li>An physician, physician's assistant, or advance practice nurse order is required for the application of restraint</li> <li>In emergency, order must be obtained during the application or as soon as possible after the restraint application</li> <li>Need to be written every 4 hrs for adults &gt; 18yrs, every 2 hrs for 9-17yrs, every hr. for &lt; 9yrs</li> </ul>
MDC/NPPA Assessment, Monitoring and Documentation	<b>Daily assessment which will include:</b> <ul style="list-style-type: none"> <li>type of restraint</li> <li>reason for restraint</li> <li>restraint release criteria</li> </ul>	<b>Daily assessment which will include:</b> <ul style="list-style-type: none"> <li>type of restraint</li> <li>reason for restraint</li> <li>restraint release criteria</li> </ul> A documented face-to-face assessment of the patient's physical/medical and psychological status within one hour. This will include: <ul style="list-style-type: none"> <li>An evaluation of the patient's immediate situation</li> <li>The patient's reaction to the intervention</li> <li>The patient's medical and behavioral condition</li> <li>The need to continue or terminate the restraint or seclusion</li> <li>Any injury to the patient must also be documented.</li> </ul>
Nursing Assessment, Monitoring and Documentation	<b>At least once per shift:</b> <ul style="list-style-type: none"> <li>clinical justification (rationale for continued use)</li> <li>alternative or less restrictive interventions attempted</li> <li>discontinuation criteria,</li> <li>patients response</li> <li>type, location and status (start, continued, discontinued) of restraint device</li> </ul> <b>*Every 2 hours:</b> <ul style="list-style-type: none"> <li>Applicable restraint monitoring (i.e. psychological status, circulation, range of motion fluids, food/meal, toileting) shall be done at least every 2 hours and documented at least once per shift</li> </ul> <p>* Validation that the above monitoring/evaluation occurred every 2 hours and that the restraint was released when appropriate may be documented via attestation at the end of the flow sheet</p>	<b>At least once per shift:</b> <ul style="list-style-type: none"> <li>clinical justification (rationale for continued use)</li> <li>alternative or less restrictive interventions attempted</li> <li>discontinuation criteria,</li> <li>patients response</li> <li>type, location and status (start, continued, discontinued) of restraint device</li> </ul> <b>*Every 15 minutes:</b> <ul style="list-style-type: none"> <li>Applicable restraint monitoring (i.e. psychological status, circulation, range of motion fluids, food/meal, toileting) shall be done every 15 minutes and documented at least once per episode</li> </ul> <p>* Validation that the above monitoring/evaluation occurred every 15 minutes and that the restraint was released when appropriate may be documented via attestation at the end of the flow sheet.</p>

## Pain Assessment and Re-assessment

[http://www.mghpcs.org/eed\\_portal/EED\\_pain.asp](http://www.mghpcs.org/eed_portal/EED_pain.asp)

A pain treatment plan including stated problem, goals, interventions and individual response is noted in the Plan of Care Activity. Goals that are not progressing should also be documented in the progress note.

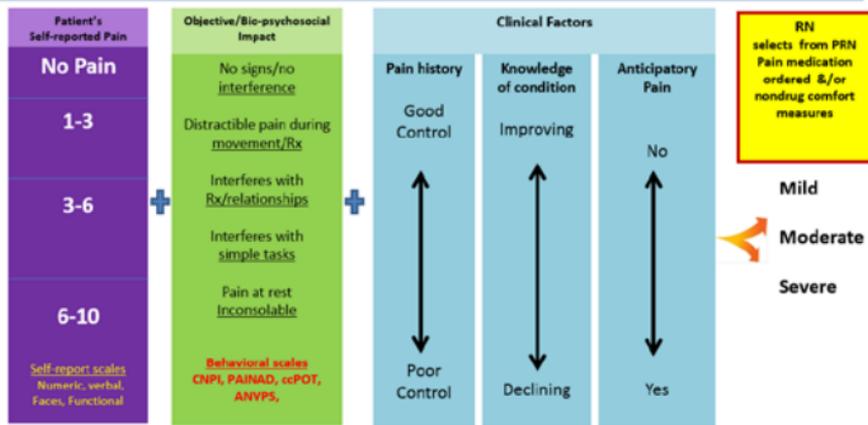
- Pain is assessed and documented on admission and every 8 hours throughout hospitalization
- Pain is assessed before administering analgesic medications then re-assessed after administering analgesic medications

- Pain is assessed using an appropriate method, based on age and verbal ability
- Examples of validated tools include, but are not limited to:
  - **Adults:** Numeric Pain Scale, Simple Descriptive Scale, Functional Pain Scale
  - **Pediatrics:** The Neonatal, Pain, Agitation & Sedation Scale (NPASS), Faces Pain Scale, and the revised-Face, Legs, Activity, Cry, Consolability (r-FLACC) scale
  - **Critical Care or Non-verbal:** Critical Care Pain Observation Tool (CPOT), The Checklist of Non-Verbal Pain Indicators (CNPI).
  - **Patients with Delirium or Dementia:** Pain Assessment in Advanced Dementia (PAINAD)
  - Comatose or minimally conscious state: Nociception Coma Scale (NCS)

## PRN PAIN MEDICATION SELECTION GUIDELINES: MILD-MODERATE-SEVERE

### PAIN ASSESSMENT

Patient's Self-report + Objective Assessment + Clinical Judgment = Mild-Moderate-Severe



#### Important consideration

Decrease the need for PRN opioid analgesics by discussing with healthcare team the feasibility of scheduling routine non-opioid pain medications

For more information refer to the Pain Assessment and Reassessment policy in Ellucid <https://hospitalpolicies.ellucid.com/documents/view/1077>  
<https://hospitalpolicies.ellucid.com/documents/view/9283>

## **PCS QAPI initiatives**

Patient satisfaction reflects the patient's perception of the quality of care received during the hospitalization. Nurses have great influence on all aspects of the patient experience especially related to coordination of care, ensuring patient's comfort, patient education and respectful professional interactions. Some tips to improve patient satisfaction include:

### **Courtesy and Respect**

- Introduce yourself and your role when meeting patient for first time
- Greet patient by name
- Knock on patients' room before entering
- Apologize for delays
- Include family members in the discussion when appropriate
- Pay attention to patients' physical comforts when leaving the room – pull up the covers, make sure they can access the call button and their tray
- Close interactions with: “What other questions do you have for me?”; “Is there anything else I can do for you now?”

### **Listening**

- Don't rush
- Make eye contact especially when asking a question
- Listen to patient's perspective – try not to interrupt
- Use short summaries to demonstrate you understand what patient is telling you
- Use non-verbal language – lean forward, nod, use facial expression and posture to provide encouragement

### **Care Coordination**

- Include patient and family in care plan; Involve interpreters for LEP patients
- Foster good communication among the members of the interdisciplinary care team
- Use IPASS
- Document in EHR in real time

## **Discharge Information**

- Provide written information including symptoms or health problems for patients to be aware of after discharge
- Nurses follow up through discharge phone calls allowing the patient to ask additional questions and the nurse to verify that adequate post discharge follow-up is in place. This is the last step in the patient hospital journey.

## **Partners QAPI initiatives - Patient Satisfaction**

### **Quiet at Night**

- Educate patients and family members on Quiet Times upon admission
- Encourage visitors to take a break during designated Quiet Times
- Bundle night shift care across role groups
- Ensure signage is in place in patient rooms and around unit
- Reduce environmental noise

### **Staff Responsiveness**

- Promote responsiveness with all role groups
- Purposeful safety rounding
- Leave the patient room in the same way you found it or better
- Use VOALTE to close loop with colleagues

### **Medication Communication**

- Start patient education early during patients' admission
- Utilize "teach back" method
- Review medications on day of discharge & include family in discussion
- Explain each new medication's purpose and check for understanding
- Describe the possible side effects of new medications and check for understanding

## **CULTURE of SAFETY**

Safety culture reflects the behaviors, beliefs and values within and across all levels of an organization as they relate to safety and clinical excellence. All culture is local and every unit, or specific work setting, has its own unique culture that may or may not be exactly the same as the organizational culture.

There are the 3 major components of a Safety Culture

1. Just culture- staff feel safe raising questions and concerns and reporting safety events in an environment that emphasizes a non-punitive response to errors and near misses
2. Reporting culture-staff realize errors are inevitable and are encouraged to speak up for safety by reporting errors and near misses
3. Learning culture- staff regularly collect and learn from defects and successes, openly sharing data and information, applying best evidence to improve work processes and patient outcomes

## **HOW DO WE ASSURE SAFETY FOR OUR PATIENTS?**

The National Patient Safety Goals represent areas of risk identified by the Joint Commission as requiring high priority focus. Surveyors may ask about measures to ensure patient safety on your unit and throughout the hospital. Describe unit specific as well as hospital-wide initiatives guided by the National Patient Safety Goals and Nursing Sensitive Indicators (NSI)

### **Submit Safety Reports**

Report “near misses” as well as adverse events through the Safety Reporting System.

### **Identify Patients Correctly (NPSG)**

- Always use 2 patient identifiers. Inpatient: Name and MRN. Outpatient: Name and Date of Birth.
- Use an active identification process; encourage patient participation when possible by asking them to tell you their name and date of birth while you are checking their ID band

### **Provide transfusion therapy safely (NPSG)**

**Q** *How do you verify the identity of a patient who is receiving a transfusion?*

**A** In the presence of the patient two qualified clinicians, one of whom is the transfuser, positively identify the patient and match the blood component to the patient.

Patient ID:

- One clinician checks the name and MRN on the patient ID band
- The clinician verifying confirms the name and MRN on the blood component
- The patient's ID band is scanned

Blood component match:

- One clinician checks the label on the patient information side of the blood component for product number, expiration date and blood type
- The clinician verifying views the label on "donor" information side of the blood component to confirm the product number, expiration date and blood type
- The blood component is scanned

Q ***What is your procedure for monitoring vital signs before and after transfusion of blood products.***

A Stay with patient for at least the first 5 minutes after the patient begins receiving the blood product.

Obtain temperature and vital signs at the:

**Start** of the infusion; 0-60 minutes prior to start

**During** the infusion if > 30 minutes (recommended @ 5-30 minutes)

**End** of the infusion; 0-30 minutes after stopping

Note:

1. Scanning the blood product defines the start time and documents "new bag" on the blood admin flowsheet
2. "Stopping" the transfusion in the flowsheet defines the "end time". If not stopped the documentation is incomplete
3. Blood pressure, heart rate, respiratory rate, and temperature must all be documented in the same flowsheet column

Q ***What are the signs of a transfusion reaction? What would you do***

A

***if you suspected one was occurring?***

Fever, chills, rigor, changes in VS, respiratory symptoms, pain, nausea, vomiting, flushing, urticaria, and pruritis are possible signs of transfusion reactions. Stop the transfusion; remove the blood product and tubing but do not discard; slowly administer .9% NaCl IV to keep IV patent; obtain VS; notify responding clinician, draw a 10cc blood specimen in a lavender top tube; place blood bag, tubing, and lavender top tube in plastic bag along with a *Request for Investigation of Suspected Transfusion Reaction* form and send to blood bank. Send urine for hemaglobinuria to Hematology.

**Collect specimens and perform Point of Care Testing (POCT) safely**

Specimens are collected using appropriate procedures and precautions

- Specimens labeled in the presence of the patient
- Doctor's order present for all specimens

Staff should be able to easily locate lab-related policies and procedures

For more information refer to the MGH Laboratory handbook

<http://mghlabtest.partners.org/poct.htm>

**Q *Describe your procedure for obtaining specimens? (NPSG)***

A Match the patient's name and MRN on the label with the name and MRN on the patient's wristband. Label the specimens in the presence of the patient. Label the container, not the cap.

**Q *What POCT do you perform on your unit?***

A Units vary. Examples include blood glucose, stool for occult blood and urine dipstick.

**Q *How are you competent to perform POCTs?***

A I demonstrate competency during orientation and as part of annual required training. Annually I complete a training module in HealthStream and complete the required quiz. I also successfully perform a quality control test at least once a year.

**Q *Who performs phlebotomy on your unit? When and how are***

***they trained? How is competency evaluated?***

A Patient Care Associates (PCAs) perform phlebotomy. During orientation, PCAs receive classroom training, and complete a precepted practicum during which they demonstrate competencies on the skills checklist. Competency is maintained through frequent performance of blood draws.

***How do you prevent spread of infections while performing POCTs?***

A Glucometers are wiped between patients with a hospital-approved disinfectant such as Super Sani-cloth. Appropriate precautions are used depending on the patient.

***How do you know the glucometer is working properly?***

A A hi/lo control test is performed every 24 hours by either an RN or PCA. If a PCA performs the test and the repeat result is out of range, he or she reports to the RN. The RN arranges for the meter to be replaced.

***How long are glucometer controls and strips good for?***

A Both Hi and Lo controls are labeled with the manufacturer's expiration date. However, once a bottle is open it is good for 90 days. Strips are good for 180 days once opened. Vials must be labeled with the date of opening.

***What do you do if a glucometer result is 462?***

A Results above 400 are considered a critical value. If the procedure was performed by a PCA, he or she notifies the RN immediately. The RN notifies the physician who then orders a venous specimen.

***What do you do if a glucometer result is 42?***

A Results below 50 are considered a critical value. Same as above.

***What is a hemocult slide used for?***

A To check for blood in the stool. It is not designed to check for blood in other specimens such as gastric contents.

Q ***How do you ensure that the hemocult slides perform correctly?***

A By storing them away from moisture and light, and by conducting the performance monitor (QC) with each test; QC's are documented in the log.

Q ***Where do you document results of a hemocult test?***

A In the Hemocult QC log and in EPIC using Enter/Edit.

Q ***What do you do if a hemocult test is positive?***

A Report the result to the Provider.

Q ***How frequently is urine dipstick QC performed?***

A When bottle is initially opened and every 30 days it is still in use. Bottle must be dated after QC passes with "QC OK" and date. Documentation is put on the urine dipstick QC log.

Q ***Where are urine dipstick results documented?***

A In EPIC using the Enter/Edit function

### **Critical Results (NPSG)**

- A "read back" of the critical result, using 2 patient identifiers, occurs between the clinician (MD, NP, PA, RN) receiving the result and lab staff reporting the result
- When the RN receives the critical result, it is communicated promptly to the responding provider
- The exact time of communication, mode of communication, name and title of the responding provider are documented in the *Provider Notification* section of the Assessment Flowsheet

### **Use Medications Safely (NPSG)**

## A. Anticoagulation Therapy (NPSG)

Anticoagulants are high risk medications, careful attention to orders and administration is necessary. Examples of anticoagulants used at MGH include:

- Heparin
  - Warfarin
  - Low Molecular Weight Heparin (LMWH)
  - Direct Oral Anticoagulants (DOACs)
  - Direct Thrombin inhibitors
  - 2b3a inhibitor
- 
- Know the anticoagulants used in your patient population.
  - Refer questions to your pharmacy colleagues and our educational resources (e.g., Lexicomp, EED portal: [http://www.mghpcs.org/eed\\_portal/EED\\_anticoag.asp](http://www.mghpcs.org/eed_portal/EED_anticoag.asp))
  - Program infusion pumps using the drug library
  - Monitor lab values pertinent to anticoagulation therapy: Hct, PT/INR, PTT, platelets kidney & liver function
  - Communication regarding brief interruptions to anticoagulation therapy should include the Prescriber, the patient, and those involved in the care of the patient related to these events (e.g., surgery, invasive procedures)
  - Educate patients and their families about:
    - Who to contact regarding management of their anticoagulation
    - Signs and symptoms of complications and subsequent actions to take
    - Daily dose regimen
    - Importance of follow-up with anticoagulation management
  
    - Importance of periodic blood testing (INR) for patients taking warfarin
    - Food, drug, and herbal interactions
    - Importance of communication with Prescriber to manage brief interruptions in anticoagulation therapy such as when having

- procedures/ surgery.
- Patients on LMWH or DOACs should receive printed information from Epic, Partners Handbook (MGH Patient Education Documents) or the EED anticoagulation site
- Patients on warfarin should receive a copy of the “Guide to Using Warfarin”

## **B. Medication Reconciliation (NPSG)**

Nursing, Pharmacy and Providers should collaborate to assure that patient med lists are accurate throughout admission and for discharge

- Review of Prior To Admission (PTA) medication list is performed by the nurse to determine accuracy and to flag medications no longer taken by the patient
- The Provider reviews and edits the PTA med list and performs Medication Reconciliation. This is the documentation of the decision to order, continue, modify or discontinue medications.
- At discharge, the provider reconciles each medication, including PTA medications and active orders, by reviewing and editing the discharge orders which generates the medication list in the After Visit Summary (AVS).
- The nurse reviews the medication list, and gives the patient a copy of his/her After Visit Summary (AVS) which includes medications instructions the patient should follow when discharged from the hospital.
- The AVS is saved as part of the electronic record and is sent to the next healthcare facility when the patient is discharged to another healthcare facility.

## **C. Medication labeling**

Medications and solutions must be labeled when they are removed from their original, labeled container and not immediately administered. This applies both on and off the sterile field. If there is an intermediate step or the medication leaves the clinician’s hand before administering a medication, it must be labeled, even if it is the only medication being given at that time.

When the person who labels the medication is not the one administering it, two individuals, including the one who will administer the medication, must verify the medication label both verbally and visually

#### **D. Medication Administration Safety**

- Before administration, verify the 5 rights, visually inspect the medication and make sure that it is not expired and no contraindications exist
- Scan barcodes on all medication and continuous infusions before administration
- Administer IV infusions using a smart pump drug library with minimum and maximum limits
- Before administering a new medication, inform the patient/family about any potential clinically significant adverse reactions or other concerns
- Error prevention strategies have been put in place for high risk medications. Example: Different types of insulins are physically separated in Omnicell to prevent wrong insulin errors
- Tall man lettering or labels are used to prevent errors with sound-alike/look-alike drugs (SALAD). Examples include HYDROcodone and oxyCODONE; diTIAZem and diazepam

#### **DI. Medication Storage and Security**

- Medications are not stored at the bedside (with rare exceptions such as inhalers stored in drawer when not in use. see policy <https://hospitalpolicies.ellucid.com/documents/view/1690>).
- Medications not under direct observation of the RN are secured in approved locked medication closets/storage areas, Omnicells, code carts, etc., this includes insulin and IV solutions.
- Different types of insulin are stored separately in Omnicell
- All medications, especially those requiring refrigeration, are promptly put away

- Tuberculin and Insulin are the only multi-dose vials approved for multiple patient use; *Pharmacy places expiration date label on Tuberculin and Insulin vials when issued; Expiration is 28 days after issue by Pharmacy*
- Pill cutters are individual, labeled and stored in patient specific bin
- Date of the first medication to expire in the code cart is noted on the outside of the cart, to ensure that none of the medications are expired.

### Use Alarms Safely (NPSG)

Using the following guidelines can help eliminate non-actionable alarms and reduce alarm fatigue.

- A** - Assess DAILY monitoring needs
- L** - Learn proper electrode care and O<sub>2</sub> Sat probe placement
- A** - Admit the patient to the monitor
- R** - Respond to all alarms immediately - Review history/events every 4 hours
- M**- Minimize irrelevant alarms by individualizing parameter limits e.g., HR, SPO<sub>2</sub>
- S** - Standby mode for interruptions in monitoring and/or transport

For more information refer to the physiologic monitoring resources webpage in PCS clinical resources:

<http://intranet.massgeneral.org/pcs/PhysMon.asp>

### Prevent Infections (NPSG)

#### Antimicrobial Stewardship (NEW)

The Joint Commission has developed “Antimicrobial Stewardship” standards for hospital staff and providers. Staff involved in antimicrobial ordering, dispensing, administration, and monitoring must be educated about antimicrobial resistance and antimicrobial stewardship practices. Patients and family are educated regarding the appropriate use of antimicrobial medications including antibiotics.

## Infection Control

What type of questions will the surveyor ask?

Q *What are the most common ways you prevent transmission of infections from one patient to the next?*

A Hand hygiene before and after contact with the patient and/or the patient's environment (NPSG) **and** early identification of patients requiring isolation and timely placement on appropriate isolation.

Q *How do you know if one of your patients has MRSA, VRE, C-difficile or an MDRO? (NPSG)*

A There are several ways that I find out:

- I review laboratory reports
- Infection Control or Microbiology laboratory notifies the nursing unit
- Physicians also inform us
- Patients known to have these organisms are identified in Epic with an Infection Status banner in the header of the electronic medical record. When an order is written for Isolation, the type of Isolation required is displayed in the Isolation banner, also in the header
- When patients are transferred from another hospital, I read the history. When I transfer a patient or send them for a test, I pass on the information regarding Isolation

Q *What type of Isolation is required for patients with MRSA or VRE or an MDRO Gram-negative organism? (NPSG)*

A Patients with **known or suspected** MRSA, VRE or an MDRO are placed on **Contact Isolation**.

- They're placed in a private room or cohorted in a semi-private room with another patient infected or colonized with the same organism. Patients with an MDRO may NOT be cohorted in the same room.

- Gloves are worn on entry into the room and gowns are worn when there is anticipated contact with the patient, surfaces, and equipment.
- Equipment is dedicated to the patient if possible. If equipment is shared, it is cleaned and disinfected with hospital-approved disinfectant (Virex Plus or Super Sani -Cloth).

Q ***What type of Isolation do you use with patients who have C.diff? (NPSG)***

A Patients with **known or suspected C. diff** are placed on **Contact Isolation PLUS**. This is similar to Contact Isolation with two primary differences. After contact with the patient or the environment, hands must be washed with soap and water first, then disinfected with Cal Stat. Patient rooms and equipment are cleaned daily with bleach-based disinfectant. If equipment is shared, it is cleaned and disinfected with hospital-approved bleach-based disinfectant.

Q ***Describe the procedure for donning and removing gown and gloves.***

A The steps are: perform hand hygiene, place the isolation gown over the shoulders, and tie the gown at both the neck and waist. Ensure that the gown provides full coverage of clothing (both front and back). Put on gloves, pulling them up and over the cuffs of the gown. When leaving the room, take gloves off first, then gown, and then perform appropriate hand hygiene. Note: Disposable gowns may require a different technique.

Q ***If a patient on Isolation is leaving the unit to go to x-ray, how does the transporter know the patient is on Isolation. How does radiology know? (NPSG)***

A The isolation status is entered as an order in Epic and appears in the patient header for all care team members to view and the isolation status is also included in the transport request. In addition, the transporter is informed by the sign on the door or by talking

with the nurse. The Epic Internal Patient Transport report also known as “Ticket to Ride” includes Isolation and Precaution orders. This report is auto-printed and placed in the record sent with the patient.

Q ***What training have you received regarding infection control and what does it include? (NPSG)***

A I've received training about general infection control practices such as hand hygiene, blood borne pathogens, tuberculosis guidelines, and other MGH practices to prevent healthcare-associated infections such as MRSA, VRE, C. diff, central line-associated blood stream infections, surgical site infections, and catheter-associated urinary tract infections.

Q ***When did you receive this training? (NPSG)***

A During orientation and it is repeated each year as part of required annual training. We also discuss the need for urinary catheters and central lines in daily rounds on the unit.

Q ***Describe the steps that are taken to prevent infection when inserting a central line. (NPSG)***

A Hand hygiene is performed prior to donning sterile gloves for catheter insertion.

Maximal sterile barriers are maintained during insertion.

A qualified individual monitors for breaks in sterile technique during insertion and completes the Central Line Checklist in Epic.

A standardized kit and protocol are used.

Patients and families are educated about prevention of infection.

A disinfecting alcohol port protector is also used to keep access points on IV tubing continuously disinfected.

Q ***Describes steps that are taken to prevent surgical site***

***infections. (NPSG)***

- A
- Use aseptic technique during invasive procedures. This includes use of sterile equipment, skin preparation, and managing the environment
  - Use aseptic technique during dressing changes and closely monitor wounds
  - Educate patients and families about ways to prevent surgical site infection

Q ***Describe a few ways you prevent urinary tract infections. (NPSG)***

- A
- Limit the use of urinary catheters to the MGH-approved indications for use and remove them as soon as possible.
  - Follow the Nurse-driven protocol for removal when ordered.
  - Insert using sterile technique and equipment
  - Perform meatal care per procedure, secure the catheter, do not disconnect the catheter from the drainage tube unless necessary to irrigate and avoid routine irrigations
  - Obtain specimens through the specimen port.
  - Avoid kinking of the tube, keep the urine bag lower than the bladder, and off the floor

Q ***How do you prevent hospital-acquired pneumonia?***

- A
- Take steps to prevent aspiration
  - Use hand hygiene and other appropriate measures to prevent cross-contamination
  - Ensure that the respiratory equipment is appropriately cleaned and disinfected.
  - Administer vaccines against influenza, pneumococcal pneumonia and educate patients/families about infection
  - For ventilated patients, implement the prevention bundle including oral care, HOB elevation and daily assessment for readiness to wean.

Q

***What do you do if a patient is suspected of having TB?***

- A The patient is placed on Airborne Isolation. Staff entering the room must wear an N-95 mask. The patient is placed in a private room with negative air pressure. The negative air pressure is checked every day either by performing the tissue test or looking at the ping-pong ball.

***What other precautions do you take when caring for patients on Airborne Isolation?***

- A I wear an N-95 respirator that I have been fit-tested for when in the room. I perform a fit-check every time I use an N-95 respirator. Patients leaving the room must wear a surgical mask and should leave only for necessary procedures.

***When must you wash your hands with soap and water?***

- A When my hands are visibly soiled, after using the toilet and before eating. Hands must also be washed with soap and water after caring for a patient on isolation for *C. diff* or *Norovirus*.

***When are gloves worn?***

- A Clean, non-sterile gloves must be worn when touching blood, body fluids, secretions, excretions, mucous membranes, and contaminated medical equipment.

***Where are infection control policies located?***

- A Infection Control Policies are available online in the allucid policy management system under MGH MGPO Hospital-Wide Policies.

***What is your policy regarding employees and volunteers who have symptoms of, or have been exposed to, infectious disease/illness?***

- A Employees and volunteers must contact Occupational Health Service if they have: skin lesions and/or rash, especially if lesions are weeping or fever is present; non-intact skin or dermatitis; conjunctivitis or “pink eye”; diarrheal illness; cough of more than

two weeks (unless explained by a non-infectious disease); new onset of jaundice; exposure to chickenpox, TB, or other contagious condition or when their primary diagnosis is a communicable disease such as chickenpox, staph skin infections, and influenza. Employees and volunteers should not come to work if they have a fever of 100.5°F or more and one or more of the following symptoms:

- Runny nose or nasal congestion
- Sore throat
- Cough
- Body aches

Q ***How do you know that equipment has been cleaned and disinfected between patients?***

A Centrally-managed equipment is located on the LEAN cart and is tagged as clean by Materials Management. Equipment that is cleaned on the unit is kept in a clean equipment storage room or another designated clean equipment storage area. Items that are stored in the hallway are covered with a clear bag to indicate they have been cleaned. Dirty equipment is kept in the soiled utility room until it can be cleaned and disinfected. If I am not sure about the status of a piece of equipment, I assume it's dirty and clean it prior to patient use.

Q ***Where are you permitted to have food and drink on the patient care units?***

A Eating is restricted to the staff lounge, conference room, or private offices. Drinks are allowed at the nurses' station on low, interior surfaces only. Drinks are not allowed in the hallway such as on WOWs, bedside tables, counters between patient rooms, and portable chart racks.

Q ***What are the contact times (i.e. how long the surface should remain wet) for cleaning products to assure effective disinfection?***

A The contact times for hospital-approved disinfectants are:

- Virex Plus - 3 minutes
- Clorox Bleach Germicidal Cleaner - 3 minutes
- Dispatch Bleach wipes - 3 minutes
- Super Sani-Cloth wipes - 2 minutes
- Sani-Cloth HB wipes - 10 minutes

### **Identify Safety Risks (NPSG)**

Identify patient populations at high risk, such as those with Limited English Proficiency (LEP), Substance Use Disorder (SUD), and those at risk for falls. Implement appropriate interventions for patients with positive screening.

On admission patients are:

- Interviewed about language proficiency and preferences
- Screened for SUD
- Screened for fall risk

Identify patients at risk for **suicide** and **self-harm**

- All inpatients are screened as part of the initial nursing assessment to identify those who may be at risk for suicide
- When a nurse assesses a patient to be at immediate risk for suicide, he or she assures the patient is in the view of an observer at all times
- Handoff information about the patient's safety needs is exchanged between the observer and the RN
- Patients in settings other than inpatient (e.g. ambulatory, ED) are assessed for suicide risk if factors suggest that suicide may be a significant clinical concern
- Suicide checklists are available to help guide staff as they implement safety precautions

There are 4 unique suicide checklists in Ellucid as appendices to the policy. Also available to order from The Allied Group

- Inpatient (#89696)
- PCA / Observers (#89709)
- Ambulatory (#89695)
- ED (#89697)

The image shows four overlapping checklist forms for suicide precautions. Each form has a title bar, a 'ELEMENTS' table, and a 'Notes' column. The forms are:

- Ambulatory Checklist for the Care of the Patient at Risk for Suicide and/or Self Harm**: Includes elements like 'Initial Assessment', 'Ongoing Assessment', and 'Discharge Instructions'. A green oval labeled 'Ambulatory' is overlaid on the title bar.
- CARE OF THE PATIENT ON SUICIDE PRECAUTIONS (Inpatient)**: Includes elements like 'Initial Assessment', 'Ongoing Assessment', and 'Discharge Instructions'. A green oval labeled 'Inpatient' is overlaid on the title bar.
- CARE OF THE PATIENT ON SUICIDE PRECAUTIONS (Emergency Department)**: Includes elements like 'Initial Assessment', 'Ongoing Assessment', and 'Discharge Instructions'. A green oval labeled 'ED' is overlaid on the title bar.
- CARE OF THE PATIENT ON SUICIDE PRECAUTIONS (Emergency Department)**: A second, partially obscured ED form.

## Time Out also known as Universal Protocol (NPSG)

Required for all invasive procedures that require an informed consent in order to verify:

- Correct patient: Use two patient identifiers and have patient actively participate when possible
- Correct procedure: Verify that the procedure planned matches what the patient expects and/or the procedure consent
- Correct site; the site should be marked and the marking should be visible after the patient is prepped and draped
- Correct equipment

## Document the “Time Out” by completing the checklist in Epic.

The “Time Out” checklists are found:

- Bedside procedures performed on the care unit: The time out flowsheet is found in the facility preference list
- Procedural areas: The “time out” tab is found within the procedure log or sedation narrator specific to that procedural area
- Procedures in the OR: The Peri-op Checklist is found on the Intra Op Navigator. There are three sections: Huddle, Time Out, Debrief

## Time Out checklist for bedside procedures performed on the care unit:

ED to H...	7/26/17	1400	Last Filed Value
<b>Time-Out</b>			
What Procedure (s)?	<input type="text"/>		nontunneled...
Two identifiers?			Yes
Site verification (including			Yes
Team introduced and concerns			Yes
Site marking visible?			Yes
Antibiotic(s) administered?			No (comme...
Labeled medication and			Yes
Labs/Imaging/Implants/Equipment			Yes
Time-Out occurred?			Yes

## Peri-Op checklist for Procedures in the OR

The **Huddle** is to discuss the anticipated needs of the patient ahead of time to assure all are prepared for any unexpected challenges

Huddle				
Has the patient been identified with 2 identifiers?	<input type="radio"/>	Yes	No	
Has the Procedure (including Side, Site and Level) been verified?	<input type="radio"/>	Yes	No	
Is the site marked?	<input type="radio"/>	Yes	No	
Consents verified?	<input type="radio"/>	Yes	No	
H&P verified?	<input type="radio"/>	Yes	No	
Position verified?	<input type="radio"/>	Yes	No	
Correct laterality?	<input type="radio"/>	Yes	No	N/A
Team concerns discussed?	<input type="radio"/>	Yes	No	
Difficult airway?	<input type="radio"/>	Yes	No	
Risk of blood loss discussed and preparations made?	<input type="radio"/>	Yes	No	N/A
Imaging, implants and equipment available?	<input type="radio"/>	Yes	No	
VTE Prophylaxis discussed?	<input type="radio"/>	Yes		
Allergies discussed?	<input type="radio"/>	Yes	No	

The **Time Out** is a complete pause taken by all team members just before skin incision or start of procedure to do the final safety check

Timeout					
Has the patient been identified with 2 identifiers?	<input type="radio"/>	Yes	No		
Allergies discussed?	<input type="radio"/>	Yes	No		
Has the appropriate antibiotic been given?	<input type="radio"/>	Yes	No	N/A	
Has everyone in the room been introduced?	<input type="radio"/>	Yes	No		
Has the Procedure (including side, site and level) been verified?	<input type="radio"/>	Yes	No		
Is the site marking visible in the prepped field?	<input type="radio"/>	Yes	No		
Are there any nursing concerns?	<input type="radio"/>	Yes	No		
Are there any surgeon concerns?	<input type="radio"/>	Yes	No		
Position verified?	<input type="radio"/>	Yes	No		
Imaging, implants and equipment available?	<input type="radio"/>	Yes	No		
Sharps handling agreed upon?	<input type="radio"/>	Yes	No		
Fire Risk Safety Assessment					
Procedure site	<input type="radio"/>	Above saphid	Below saphid		
Open oxygen source	<input type="radio"/>	Face Mask	Nasal Cannula	None	
Ignition source	<input type="radio"/>	Cautery	Fiberoptic light source	Laser	None
Prepping Agent	<input type="radio"/>	Alcohol-based	Other volatile chemical	Non-volatile chemical	None
<b>Fire Risk</b>					

The **Debrief** is to discuss key concerns for recovery and management of the patient. This is completed at the conclusion of the procedure, prior to the patient leaving the OR.

### Debriefing

Name of procedure verified?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Appropriate labeling of specimens confirmed by nurse and surgeon?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="N/A"/>
Estimated blood loss discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Blood products and fluids given discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Nursing concerns discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Anesthesia concerns discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Surgeon concerns discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Wound Classification verified?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Pain Management plan discussed?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	
Sponge, needle and instrument counts correct?		<input type="button" value="Yes"/>	<input type="button" value="No"/>	

## PREPARING FOR PATIENT EMERGENCIES

### Response To Change In Patient Condition

Rapid Response Teams provide patients with a timely clinical evaluation during an unexpected decline in clinical condition

- Warning signs may appear before a critical event by an average of 6 to 8 hours. Early recognition may prevent further deterioration helping to avoid a critical event, decreasing cardiopulmonary arrests and patient mortality
- Patients and families should be encouraged to ask questions about care and to let staff know if they are concerned about any change in condition
- Rapid Response Teams are meant to support, NOT replace, current existing emergency responses such as: Code Blue Teams, Airway Consult(RICU), Surgical Airway, Acute Stroke Team

<b>RESPIRATORY</b> Breathing Rate/Pattern O2 Sat < 90	<b>CARDIAC</b> Heart Rate/Rhythm Blood Pressure Urine Output <50 for 4 Hrs
ANYONE <b>ADULT TRIGGERS</b> ANYTIME	
<b>NEUROLOGICAL</b> Conscious State/Mental Status Stroke Symptoms Seizure	<b>OTHER</b> Bleeding Pain "I'm very concerned."
<b>RESPIRATORY</b> Work of Breathing Respiratory Rate O2 Sat	<b>CARDIAC</b> Heart Rate/Rhythm Blood Pressure Mottling/Capillary Refill
ANYONE <b>PEDIATRIC TRIGGERS</b> ANYTIME	
<b>NEUROLOGICAL</b> Mental Status	<b>OTHER</b> "I'm very concerned." Uncontrolled Pain
<b>RESPIRATORY</b> Work of Breathing Respiratory Rate O2 sat	<b>CARDIAC</b> Heart Rate/ Rhythm Blood Pressure
<b>Neonatal Triggers</b>	
<b>NEUROLOGICAL</b> Mental Status	<b>OTHER</b> "I'm very concerned." Low Blood Sugar

## Code Cart

The Code Cart / Defibrillator Checklist must be completed every day. The lock numbers on the cart and tracking form MUST match. If they are different or if the lock is not red call the code cart exchange room @ x 64602. These checklists are kept for 3 months in the Nurse Director's files before being discarded. The Joint Commission surveyor will review 3 months of checklists which must be perfectly complete.

## Code Cart and Defibrillator Checklist

CODE CART/DEFIBRILLATOR CHECKLIST			
Check Code Cart lock integrity and Defibrillator on days of unit/departement operation			
UNIT: _____	MONTH: _____	YEAR: _____	
<b>ZOLL R Series Plus® Defibrillator</b>			
Check that the defibrillator is:			
<ul style="list-style-type: none"> <li>▶ "Code Ready" with three green lights: battery charged, AC power (plugged in), green check mark <input type="checkbox"/></li> <li>▶ Either PADDLES or PADS ("One-Step") must be connected to pass the automatic 2 am test. If translucent PADS are connected the test will FAIL.</li> </ul>			
For areas with PADS ONLY check that:		For areas with PADS and PADDLES check that:	
<ul style="list-style-type: none"> <li>• Rack has:                             <ul style="list-style-type: none"> <li>- ADULT AREAS: one set of adult PADS connected to the multifunction cable</li> <li>- PEDIATRIC AREAS: one set of either pediatric or adult PADS connected to the multifunction cable</li> <li>- One package of ECG electrodes</li> <li>- End-Nasal CO<sub>2</sub> adapter: ADULT/Pediatric for ADULT areas, ADULT/Pediatric for PEDIATRIC areas</li> </ul> </li> <li>• Drawer is stocked with:                             <ul style="list-style-type: none"> <li>- One package of recording paper</li> <li>- ADULT AREAS: one extra set of ADULT PADS</li> <li>- PEDIATRIC AREAS: one set each of adult <input type="checkbox"/> pediatric PADS</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• PADS or PADS are connected to the multifunction cable</li> <li>• Drawer is stocked with:                             <ul style="list-style-type: none"> <li>- Conductivity gel, one package of recording paper, one package of ECG electrodes</li> <li>- End-Nasal CO<sub>2</sub> adapter: ADULT/Pediatric for ADULT areas, ADULT/Pediatric and neonatal/Pediatric for PEDIATRIC areas</li> <li>- ADULT AREAS: one set of adult pads</li> <li>- PEDIATRIC AREAS: one set of both pediatric and adult PADS</li> </ul> </li> </ul>		
All PADS and ECG electrodes must be sealed and within expiration date			
If there is a problem with the defibrillator or a RED X is displayed, call the Department of Biomedical Engineering at x 41333. The lock on the Code Cart must be RED (no other color is acceptable). RED indicates an intact cart, blue lock indicates a used cart.			
Date	Time	Lock numbers on cart <input type="checkbox"/> tracking form MUST match. If they are different or if the lock is not RED, call the Code Cart Exchange @ x 6882	Defibrillator <input type="checkbox"/> meets required elements of daily check
		Code Cart #2 RED lock # <input type="checkbox"/> LOCK # on the Pharmacy Tracking System	Defibrillator # <input type="checkbox"/> equipment meets required elements of daily check Signature _____ Signifies all equipment meets required elements of the daily check
		Code Cart #2 RED lock # <input type="checkbox"/> LOCK # on the Pharmacy Tracking System	

### Defibrillator

A Code Readiness test is automatically performed every night at 2am on all Zoll defibrillators

#### Q. How do you assure that the defibrillator is ready for this test?

A. Paddles or One Step Pads must always be connected to ensure that the device is set up for the Code Readiness test. Always Turn device off and plug into power source when not in use

#### Q. How does staff know that the Code Readiness test was successful?

A. Success is designated by display of a green check mark.

A failed test is designated by:

1. Display of a red X
2. A failed message on the defibrillator screen
3. A paper printout displaying the time of the test and the reason for the failure

#### Q. What are some reason the test may fail?

A. Reasons that the Code Readiness test may fail include:

1. Pads or paddles are NOT connected

2. The translucent Propadz are attached
3. The power cable is not plugged in
4. There may be a system problem

**Q. What do you do when a red X is displayed as the test result?**

A. Call Biomed (x41333) to check the device

**Q. What happens if the machine is in use when the Code Readiness test is performed?**

A. The Code Readiness test will be deferred until the next 2am test

## **ENVIRONMENT OF CARE TOUR**

**Who will be involved?** The JC surveyor will tour the unit or department accompanied by MGH escorts and unit or department leadership. During the tour, the surveyor will observe practice and will ask staff questions about the work environment and fire safety.

**What will the surveyor observe?**

***In addition to the environmental items mentioned in the Infection Control Section of this booklet the surveyors will observe:***

- Compliance with HIPAA regulations
- Security of medications and IVs (med carts, med and IV closets locked)
- Code Cart locks checked daily (see checklist page 31)
- Fire extinguisher not blocked by equipment, inspection up to date
- Oxygen tanks secured and stored per standards, storage racks labeled with proper signage
- Access to exit doorways not blocked
- Corridors kept clear (all equipment on one side of hallway)
- Response to clinical alarms and call lights
- Patient food refrigerator checked; out of range actions noted; patient food dated
- No food or drink in patient care areas, clean supply or soiled areas, or where specimens collected

- MED gas zone shut off valves labeled and not blocked
- Stairways kept clear
- 18 inch Rule - Nothing, include shelving, racks, storage, etc., can be within 18-inches of the sprinkler head discharge plane unless against a perimeter wall
- Electric/equipment rooms not blocked
- Linen chute doors not blocked or propped open

## WHAT WILL THE SURVEYOR ASK WHILE TOURING THE AREA?

### Equipment

**Q** *What do you do if you if a piece of medical equipment malfunctions or fails?*

**A** Remove the device, sequester, call Biomedical Engineering to report; submit a safety report, complete a yellow tag.

**Q** *How do you know a medical device is safe to use?*

**A** Each piece of equipment has a sticker which shows when it was inspected by Biomedical Engineering.

**Q** *What is the process if there is a recall or hazard alert on a piece of equipment?*

**A** MGH has a recall officer; Biomed and Materials Management work together to act on the alert.

### Spills

**Q** *What do you do if there is a chemo spill on this unit?*

**A** The chemo spill kit, which is available on the unit, is used to clean it up. The materials used to clean it up are placed in the chemo bucket.

**Q** *Show me your SDS (Safety Data) sheets.*

- A SDS sheets for drugs are available through pharmacy. SDS sheets for other chemicals are available on the (Partners Applications→Utilities→ SDS Safety Data Sheets). The User Name and Password are both MGH.

The image shows a screenshot of the MSDS SOURCE website. At the top, there is a dark blue header with the text "MSDS SOURCE" and a tagline "The Web's Most Cost Effective MSDS Service". Below the header is a yellow section titled "Subscriber Login". A red arrow points to the "Username:" field, which contains the text "MGH". The "Password:" field also contains "MGH". Below the fields are two buttons: a green "Login" button and a grey "Abort" button. A small note above the fields states "This site is for the use of MSDS Source customers only".

## Disaster and Fire Safety

- Q ***What is your role in a disaster that results in an influx of patients to your organization?***
- A Follow directions of my nursing director, resource nurse, or Clinical Nursing Supervisor.
- Q ***What would you do if you saw smoke coming out of a patient's room?***
- A I would implement the hospital's fire plan which, is R.A.C.E., by "R"escuing the patient, sounding the "A"larm, "C"ontaining the fire by closing the door to the room after the patient has been evacuated, and, finally, if it is safe to do so, "E"xtinguish the fire.
- Q ***Show me the fire extinguishers and fire alarm pull stations on this unit.***
- A Fire alarm pull stations are usually located by exit doors and by the nurses station. One fire extinguisher is usually located near nurses station and each unit has others located appropriately based on the

unit floor plan. All fire extinguishers are clearly marked.

**Q** *Where are the oxygen shut off valves? Under what circumstances would you turn off the oxygen supply?*

**A** If a patient is on oxygen in the room where the fire is and I couldn't get in the room safely to turn off the bedside oxygen flowmeter. Know where the shut off valve is for your unit

### **Cardboard**

**Q** *How should cardboard be handled in patient card areas?*

**A** Cardboard must not be stored anywhere it can get wet. Cardboard outer shipping boxes cannot be stored, they must be discarded

**Q** *How should cardboard be disposed of?*

**A** All cardboard must be disposed of in a separate dumpster or receptacle for recycling cardboard

### **Unit Refrigerators**

**Q** *How long can patient food remain in the refrigerator before you must throw it away?*

**A** Three days.

**Q** *What do you do if you find out that the temperature in the refrigerator has been out of range?*

**A** Call Buildings and Grounds and/or notify the OM.

## **CLINICAL AND SUPPORT RESOURCES FOR STAFF**

- Ellucid
- Excellence Everyday Portal
- Excellence Everyday Quality Boards – Quality data and PI Plans
- Partners Handbook
- PCS Clinical Resources webpages
- Badge Tags
- Nursing Director
- Clinical Nurse Specialist
- Resource Nurses
- Operations Managers
- Collaborative Governance Champions
- Infection Control Liaison
- Staff of the PCS Office of Quality and Safety (ext. 3-0140)
- Staff of the PCS Clinical Informatics team (ext. 3-4082)
- Staff of the MGH/ MGPO Compliance office (ext. 6-9169)

## Notes

## Notes