



Nursing Instructor Policies

Rev. 11/14



Froedtert Policies & Procedures

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Title: Abbreviations Unacceptable

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0096

Origin Date: 7/15/03

Date Revised: 06/05/2013

Supersedes: 08/04/2012

Topic(s): Documentation

Purpose: To optimize safety among Froedtert Hospital patients by minimizing the use of abbreviations with a high potential for misinterpretation.

A. Abbreviations included on the Unacceptable Abbreviations list have been identified as dangerous abbreviations and are not to be used in any patient specific, clinical documentation at Froedtert Hospital, including the ordering, transcribing, dispensing, administering or monitoring of the effects of medications.

B. Practitioner orders that are unclear will be clarified with the prescriber by the pharmacist or nurse before order verification, medication dispensing and administration to the patient.

C. Abbreviations identified as dangerous based upon external best practice information and internal experience will be considered for addition to the list of Unacceptable Abbreviations.

1. Abbreviations will be added to the list of Unacceptable Abbreviations based upon the recommendation of the Medication Safety Committee and approval from the Pharmacy, Nutrition and Therapeutics Committee.

Policy:

Distribution: Corporate Policy Manual

Author/Medication Safety Officer

Date

President

Date

Authorization:

Vice President, Medical Affairs
Chief Medical Officer

Date

Vice President/Patient Care Services
Chief Nursing Officer

Date

Attachment:

Any attachments referenced have been removed to allow conversion to PDF.
Please print the attachments separately.

Dangerous Abbreviations

Abbreviations NOT acceptable for use at Froedtert

Dangerous Abbreviation	Intended Use	Example / Concern	Correction
MgSO ₄	Magnesium	May be misinterpreted for morphine	Spell out "magnesium"
MSO ₄	Morphine	May be misinterpreted for magnesium	Spell out "morphine"
MS	Morphine	Unclear meaning	Spell out "morphine"
U	units	U may look like a 0 – 10U may be read as 100 units	Spell out "units"
IU	International units	May be read as IV or as 10	Spell out "international units"
tsp	Teaspoonful	May be misinterpreted as tablespoonful	Write out volumes in mL
tbls	Tablespoonful	May be misinterpreted as teaspoonful	Write out volumes in mL
µg	Microgram	May be read as mg resulting in a 1000 fold overdose	Always use mcg
CIV	Cap IV or Continuous IV infusion	Unclear order	Spell out "cap iv" and "continuous iv"
QD	Daily	May be mistaken for QOD or QID	Spell out "daily" or "once daily"
QOD	Every other day	May be read as QID	Spell out "every other day"
TIW	Three times weekly	May be misread as TID	Spell out "three times weekly"
x __d (ie: x 3d)	Times __ doses or days	Unclear if indicates doses or days – may be misinterpreted	Spell out "x __ days" or "x __ doses"
Zero after decimal point	1.0 mg written for 1 mg	Decimal may not be seen clearly - 1.0 mg may be read incorrectly as 10 mg	Do not use terminal zero for doses expressed in whole numbers.
No zero before decimal point	.5 mg written for 0.5 mg	Decimal may not be seen clearly - .5 mg may be read incorrectly as 5mg	Always use zero before a decimal when the dose is less than a whole unit.
'	Minutes	May be seen as a 1 – 5' may be read as 51 instead of 5 minutes	Spell out minutes
"	Seconds	May be mistakenly used for minutes	Spell out seconds
AU, AD, AS	Each ear, right ear, left ear	OU, OD, OS	Specify which ear
OU, OD, OS	Each eye, right eye, left eye	AU, AD, AS	Specify which eye

Title: Admission

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.001

Origin Date: 9/29/1980

Date Revised: 12/11/2013

Supersedes: 11/1/2012

Topic(s): Admit / Discharge / Transfer

Keyword(s): Admission

Purpose: To define admission protocols throughout the organization. To define responsibilities of the RN in the patient admission process.

A. Upon arrival to the hospital:

1. The Admitting Department will enter informational data (name, address, age, admitting diagnosis, physician, etc.) into the computer system.

2. When indicated, the patient will be taken for x-rays and blood work prior to being taken to his/her room.

B. Within 15 minutes of patient arrival to the inpatient area:

1. The patient will be assigned a nurse, who will inform the Health Unit Coordinator (HUC) of the assigned patient's arrival.

2. Introduce the patient and/or significant others to the environment.

3. Evaluate the patient for immediate physical and safety needs. Obtain vital signs including measured (when possible) height and weight.

C. For inpatient status patients, the RN will complete the Admission Navigator.

Policy:

D. For patients who come through Day Surgery, sections of the Admission Navigator will already be completed. Any remaining sections will need to be reviewed and completed upon arrival to the department.

E. For outpatient recovery status patients (typically 4-8 hours) the RN will complete the Admission Navigator with the exception of Care Plans.

F. For outpatient observation status patients (typically less than 24 hours) the RN will complete the Admission Navigator (unless completed by PAT or Day Surgery) with the exception of Care Plans.

G. Within one hour of admission to the patient care unit:

1. The RN will contact the physician and acknowledge orders.

2. If the patient is a transfer from another facility, the RN will review the transfer papers. The HUC will file these under the ETC and other Facility Records sections of the medical record, after the

RN and physician have reviewed them. If legal papers are included with the transfer papers, the HUC will file these under the legal documents section of the medical record.

H. Within 8 hours of admission to the patient care area, the RN will complete the Admission Navigator.

I. Nursing students under the direction of their clinical instructor and Nurse Externs may complete the Admission Navigator. This is to be validated by a RN.

J. In the event where the patient is unable to respond or is uncooperative, and a secondary source is unavailable, the nurse will indicate this information in a note. When the patient is responsive/cooperative or the secondary source is available, the RN will complete the Admission Navigator.

K. Any questions in the patient care profile followed by (req) are required documentation elements that must be completed at the time of admission by a RN.

L. Before placement of the ID band, the RN will verify patient identification by asking the patient to spell their name and state their birth date. If the patient is unable to do so, the RN will ask the patient's significant other to verify this information or verify patient identification from a police report, ambulance record or transfer papers.

M. From the Admission Navigator in Epic, the RN will determine allergies/reactions and place the appropriate color armband clip on the patient and assure placement of the allergy sticker on the chart.

N. Appropriate referrals are initiated by a communication order to Social Services, Spiritual Services, Nutrition Services and Case Management based on assessment information, Best Practice Advisories and patient need.

O. Within 24 hours of admission (excludes outpatient for recovery):

1. Appropriate plans of care will be initiated. (See Care Plan and Patient Education in the Inpatient Environment Policy)

2. The patient and significant other, when appropriate and available, will be included in the plan of care.

3. Outpatient recovery status patients who are rolled over to inpatient status also need 1 and 2 completed.

P. If the patient has been admitted from the ED, the RN will place a new wristband assuring the medical record numbers are the same before removing the ED wristband.

Q. All non-tunneled CVADs placed in place on admission, excluding dialysis and pheresis catheters, will have the site assessed; and, if the date of insertion is not known or the site is infiltrated or infected, it will be removed. Alternate access must be established prior to removal of an existing CVAD, if possible, and clinically indicated. The patient will then be assessed for CVAD need and a new line inserted at another site, if possible and clinically appropriate, within 24 hours.

R. All CVADs (including those from an outside facility) require a chest x-ray or radiographic confirmation for verification of proper placement of the tip before utilized.

S. The RN is ultimately responsible for documentation of the Admission. The extern and student nurse may assist with data collection.

T. The RN will give the patient an information folder which includes reviewing all of the enclosures in the folder with the patient and his/her family. The patient is educated and encouraged to report any concerns related to care, treatment, services and patient safety issues before being discharged. This can include contacting the department manager and/or the Patient Relations department. They are also encouraged to contact The Joint Commission at (800) 994-6610 or emailing: if their concerns about care or safety cannot be resolved.

A. Admission Navigator

1. Sign/Held Orders Section

a. In the Unit or Lab Draw section, the RN will document the patient's blood collection status as Unit Collect or Lab Collect to determine the location lab labels will print.

b. In the Sign/Held Orders section, the RN can view orders that are signed and held for that patient.

c. In the Release Orders section, the RN can release signed and held orders when the patient is located in their unit system list. This will make the orders active.

2. Overview

a. Patient Belongings - Document the belongings at the bedside, the valuables received upon arrival and inform the patient that the hospital is not responsible for lost or stolen articles at the bedside. (See Valuables and Belongings Policy)

b. Active LDA - Review/document any LDA's that are present when the patient arrives to the unit.

c. Allergies - Verify the allergies with the patient and enter appropriate updates. When completed, select "Mark as Reviewed." If the patient reports not having any allergies, "No Known Allergies" is charted in the section. Select the "Mark as Reviewed" button.

d. PTA Medications - Patients who are admitted as Outpatient for Observation status, verify PTA medications with the patient and enter appropriate updates. When completed, select "Mark as Reviewed." For all other patients, the Pharmacist will verify these with the patient and enter appropriate updates.

e. Immunization Report - Review the previously documented immunization history, when available. Verify the immunization history with the patient and enter appropriate updates in the Imm/Injections activity (by selecting the hyperlink in the Immunization Summary Report). If the day of the immunization is unknown, default to the first day of the month that most closely approximates the immunization date. Document in the comments section "estimated date per patient report." Select "Mark as Reviewed" when this information is verified with the patient.

f. Vaccine Screen - Document Pneumococcal and Influenza

Procedure:

Inclusion and Exclusion Criteria. (Pneumococcal and Influenza Vaccination Standing Order Protocol Policy .

g. History - Verify the medical, surgical, and substance and sexuality history with the patient and enter appropriate updates. Select "Mark as Reviewed" once the information is verbally verified with the patient.

h. OB/GYN Status - Document the information as applicable for the patient.

i. Scanned Advance Directives - View only screen of the patient's advance directives that have been scanned into the chart.

3. Patient Care Profile

a. General Information/Advance Directives - Document where the patient arrived from, significant relationships, primary roles / responsibilities, who the patient provides primary care for, tobacco cessation, if the patient has advance directives and that we gave the patient information about advance directives.

b. Audit C Alcohol Screen - The screening assessment will be completed. (Alcohol Screening and Intervention for the Inpatient Policy)

c. Discharge Planning - Document the reason for admission, expected length of hospitalization, anticipated discharge disposition, whom they live with, living arrangements, home accessibility and transportation availability.

d. Nutrition Screen - Document the diet prior to admission/restrictions/preferences, current appetite and complete the nutrition screen.

e. Functional Status Section - Document the prior and current functional level of the patient.

f. Pain History - Document the Pain History of the patient.

g. Abuse Screen - Document if the patient is or has been threatened or abused physically, emotionally or sexually by a partner / spouse / family member.

h. Suicide/Homicide Risk - Document if the patient is having suicidal ideations.

i. Values/Beliefs/Spiritual Care - Document any cultural, religious, spiritual practices that are important for staff to know and if the patient requests a chaplain visit.

j. Patient Profile Doc Flow Sheet - Any other information applicable to the care of the patient will be updated and documented throughout the patient hospital stay.

4. Assessment (See Physical Assessment and Nursing Process Documentation Policy)

a. Fall Risk - Document the falls risk assessment. (See Inpatient Fall Prevention and Management Program Policy)

b. Elopement Risk - Document the elopement risk assessment. (See Unauthorized Absence of a Patient Policy)

c. Braden Scale - Document the Braden scale assessment. (See Physical Assessment and Nursing Process Documentation Policy)

d. Pain Assessment - Document an initial pain assessment. (See Pain Management Policy)

e. Patient Care Summary - See Physical Assessment and Nursing Process Documentation Policy .

h. Progress Note - Document an admission note utilizing the SmartText.rnipadmissionnote.

5. Interventions

a. Best Practice Advisories - Reviewed, accepted and ordered as appropriate. (See Orders - Patient Care Policy)

b. Care Planning - (See Care Plan and Patient Education in the Inpatient Environment Policy)

c. Patient Education - (See Care Plan and Patient Education in the Inpatient Environment Policy Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.)

B. Pediatric Admissions

1. The Pediatric Admission Navigator in Epic will be triggered for all patients less than 18 years of age.

References:

Smith, S.F., Duell, D.J. & Martin, B.C. (2008). *Clinical Nursing Skills* (7th ed.). New Jersey: Pearson Education

Scope:

RN, NE, Student Nurse, Graduate Nurse

Distribution:

Froedtert Intranet

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

—

Signature

Chairperson

Date

Authorization:

—

Signature

Chief Nursing Officer
Vice President, Patient Care Services

Date

Title: Care Plan & Patient Education in the Inpatient Environment

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0176

Origin Date: 8/4/2012

Date Revised: 08/20/2012

Supercedes:

Topic(s): care plans, patient education

Purpose:

A. To define a means of organizing, implementing and documenting a patient's individualized plan of care.

B. To provide the patient/patient representative(s) with individualized teaching to learn skills and behavior that meet patient-focused goals and enhance quality of life.

Definitions:

A. Plan of Care: The plan of care is all-encompassing and is developed/utilized by the interdisciplinary team, including nurses; it includes the patient history, orders, goals, assessments, reassessments, individualized interventions, care plan, and patient education plan. Documentation of the Plan of Care may be found in all parts of the electronic health record (EHR) including orders, medication administration record, patient history profile, Patient Care Summary, flowsheets, notes, care plan, and education/outcome record.

B. Patient Education/Outcome Record: Evidence-based education plan includes documentation of teaching points, including outcome.

- A. The General Plan of Care and Generic Teaching Goals/Outcomes will be applied to all patients in the inpatient environment.
- B. Each inpatient will have an individualized plan of care and teaching record that reflects needs identified by nurses as well as other members of the interdisciplinary team. Plan of care is individualized based on the interventions documented by staff to meet the patient's identified needs.
- C. Care Plans and Patient Education are based upon admission assessment and ongoing assessment of the physiological, psychosocial, spiritual and age-specific needs of the patient and documented in the electronic health record (EHR).
- D. Interdisciplinary team members will document towards specific problems, goals and interventions as appropriate based on their involvement with the patient.
- E. A care plan and teaching record will be initiated within 24 hours of admission (see C01.001 Admission policy).
- F. When adding a care plan template, all goals and interventions will be selected.
- G. The Care Plan and Patient Education are reviewed and documented with the patient/patient representative(s) every shift (see C01.011 Patient Assessment and Nursing Process Documentation Policy).
- H. The Care Plan and Patient Education should be updated, individualized and/or resolved during current hospitalization based on ongoing patient assessment.
- I. Progression toward care plan goals will be assessed and documented by the RN every shift. Documentation of goal progression will be done using the following outcome definitions:
 - 1. Progressing: Patient is showing improvement in meeting goals.
 - 2. Not Progressing: Patient is not showing improvement in meeting goals.
 - 3. Adequate for Discharge: Patient is progressing toward goals and post discharge needs have been addressed.
 - 4. Complete: Patient has met the goal.
- J. An end of shift summary note reflecting patient's progress towards goals should be documented each shift.
- K. By discharge all Care Plans should be resolved using the above definitions for Adequate for Discharge or Complete.
- L. A Learning Assessment will be completed for each inpatient encounter on admission.
- M. Patient Education Records will be updated, individualized and/or resolved during current hospitalization based on patient condition.
- N. Teaching plans provide patients/patient representatives with information about ongoing treatment and post-discharge care including, but not limited to: disease process, use of medication, medical equipment, potential drug-food interactions, rehabilitative needs, availability of community resources and access for further treatment, infection control and safety.

Policy:

O. Documentation of educational progress will be done using the following outcome definitions:

1. Verbalized Understanding: Patient and/or patient representative(s) verbalize they understand the education provided.
2. Demonstrates Understanding: Patient and/or patient representative (s) demonstrates understanding of the education provided.
3. Needs Reinforcement: Patient and/or patient representative (s) require more education to fully understand education provided.
4. No Evidence of Learning: Patient and/or patient representative (s) have neither verbalized nor demonstrated understanding of education provided.

P. Education will be Resolved at discharge using the following definitions:

1. Adequate for discharge: Patient and/or patient representative (s) are progressing towards understanding and continued education needs have been addressed.
2. Education Complete: Patient and/or patient representative (s) have Verbalized or Demonstrated Understanding of the Education.

C01.001 Admission Policy

Associated Policies

C01.028 Discharging a Patient Policy

C01.011 Patient Assessment and Nursing Process Documentation Policy

Scope:

Interdisciplinary

Distribution:

Author Date

Chief Medical Officer Date

Authorization:

President Date

Chief Nursing Officer

Vice President, Patient Care Services Date

Attachment:

Title: Central Venous Access Device Insertion Maintenance and Discontinuation of Tunneled and Non Tunneled Devices

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0002ic

Origin Date: 01/23/1986

Date Revised: 10/10/214

Supersedes: 07/15/2014

Topic(s): Administrative

Purpose: To provide guidelines for safe and consistent care of patients with all central venous access devices (CVAD), including insertion, maintenance and removal in all care environments.

Definitions: CVAD: An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring.

LIP: Licensed Independent Provider

A. CVADs will be placed by credentialed providers in one of the following areas: OR, IR, Pre-Op Holding, Intensive Care Units, Emergency Department, Inpatient Dialysis and/or PACU.

1. Tunneled CVADs will be placed in the Operating Room (OR) or Interventional Radiology (IR) by a Privileged LIPs (see D40.030 -).

2. Peripherally Inserted Central Catheters (PICC) will be placed by a credentialed provider or specially trained RN in any inpatient or outpatient area.

B. During insertion, hand hygiene, maximal barrier precautions and use of appropriate PPEs will be followed. CVADs placed without the above mentioned conditions (emergently) will be replaced as soon as possible or within 48 hours.

C. Catheters will only be placed in the femoral vein in emergency situations and will be replaced at a different site within 24 hours, unless there is a statement from a physician stating a specific contraindication (See D13.083 -) which would be an exception to that statement.

D. All non-tunneled CVADs in place on admission will have the site assessed. If the site appears infiltrated or infected, it will be removed based on provider order. Alternate access must be established prior to removal of an existing CVAD, if possible, and clinically indicated.

E. All CVADs require radiographic or ultrasonic confirmation for verification after placement and as needed for evaluation of catheter dysfunction. Examples of dysfunction include, but not limited to: lack of blood return, difficulty or inability to flush, unusual shoulder, chest or back pain, edema, or complaints of gurgling or flow stream sounds on the same side.

F. CVAD site care will be performed every seven days with an occlusive transparent dressing, every 48 hours if gauze is used or immediately if the dressing becomes oiled, loose and/or non-occlusive.

G. CVADs require a sterile occlusive dressing unless otherwise ordered by a provider.

H. CVAD catheter injection caps will be changed every 96 hours or as signs of blood, precipitate, cracks, leaks or other defects are noted, or if the septum is no longer intact.

I. All CVAD injection sites (including caps) will be scrubbed with an alcohol

Policy:

pad for a minimum of 15 seconds. Wait 30 seconds or until the site is completely dry before accessing the system. If using Curo Cap, ensure the cap has been in place for three minutes before using. The Curo Cap must not be in place for more than 7 days.

J. Blood pressures, venipunctures or brachial arterial punctures will not be performed on the arm where a PICC is inserted in order to avoid damaging the catheter. A pink clip must be placed on the patient's armband to indicate a PICC is present.

K. Do not use a syringe smaller than 10 ml for flushing/capping CVADs. Administration of small quantities of medication should be given in a syringe appropriately sized for the dose required following confirmation of catheter lumen patency.

L. Large bore dialysis/apheresis catheters may only be accessed for intermittent hemodialysis, continuous renal replacement therapy (CRRT) or pheresis related procedures.

M. Catheters placed specifically for hemodialysis or CRRT must have a nephrologist's order prior to using the catheter for any reason other than dialysis or CRRT with documentation of the order in the medical record.

N. A provider order is required for saline flushing and heparin capping of all unused CVAD lumens. Refer to CVAD Reference Table attached to policy for guidance.

O. Tubing and add-on devices (included and not limited to stopcocks, y-connectors, extension sets) will be changed every 96 hours for continuous infusion sets and every 24 hours for intermittent infusion sets.

P. Existing primary and secondary tubing will be replaced when a new CVAD is placed.

Q. When catheter clamps are present, the catheter lumens will be clamped when not in use.

R. If a lumen of a catheter is accidentally broken or pulled apart, the catheter will be clamped proximal to the exit site, wrapped in sterile gauze and the provider will be notified immediately.

S. Blood specimens will be drawn off CVADs only by trained personnel with a written provider order.

T. Tunneled cuffed catheters may not be removed by an RN. Tunneled non-cuffed catheters (tunneled PICCs) may be removed by trained Interventional Radiology RNs.

U. Properly trained staff members who have demonstrated appropriate competency may remove the following lines:

1. Percutaneous catheter introducers/sheaths:
 - a. ICU, Interventional Radiology (IR), Cath Lab and STAT RNs
 - b. Cardiac Cath Lab techs
2. Non-tunneled dialysis catheters:
 - a. ICU, Interventional Radiology (IR), Vascular Access, and STAT RNs
3. Non-tunneled CVADs (other dialysis/pheresis catheters)
 - a. Trained RNs or providers
4. Tunneled non-cuffed chest-placed PICCs
 - a. Interventional Radiology (IR)

V. A supine or Trendelenburg position during removal of any CVAD (includes PICCs and midlines) is preferred unless contraindicated.

CVAD Maintenance

A. CVAD Dressing Change

1. Wash hands.
2. Open the central line kit and don a mask.
3. Don clean gloves.
4. Explain the procedure to the patient. Have the patient turn their head or don a mask.
5. Remove and discard the old dressing.
6. Inspect the skin around the site and note any changes consistent with a local infection.
7. Remove clean gloves, wash hands and don sterile gloves.
8. Clean the skin surrounding the catheter including the securement device or sutures with a Chlorhexidine applicator for 30 seconds using a back and forth motion. Allow the site to air dry completely for a minimum of 30 seconds. Do not blot or wave over site.
9. Replace the catheter securement device if there are no sutures.
10. Cover the site (CVAD and securement device) with a sterile occlusive transparent dressing. If there is a true contraindication to the transparent dressing, an occlusive gauze and tape dressing may be used. Date, time and initial the central line dressing.
11. Do not submerge the CVAD under water. Showering is permitted if the CVAD and connecting device are protected with an impermeable cover.

Procedure:

B. Flushing CVADs

(A copy of the Central Line Reference Table is attached to this policy).

1. Wash hands and don clean gloves.
2. If a clamp is present, unclamp the catheter.
3. The injection cap should be cleaned with alcohol for 15 seconds and allowed to dry for approximately 30 seconds before accessing.
4. Flush with preservative-free 0.9 percent sodium chloride utilizing the push-pause technique.
5. Cap the catheter with heparin, if ordered by the provider.

C. Injection Cap Change

1. Wash hands, don clean gloves and a mask.
2. Scrub the connection with an antiseptic pad for 15 seconds and allow to dry for approximately 30 seconds.
3. Ensure the catheter is clamped before loosening the cap.
4. Place the sterile gauze under the injection cap and disconnect.
5. Apply a new sterile cap.

D. CVAD Removal

1. Non-Tunneled CVAD Removal and Tip Culture Collection

- a. Verify the practitioner order.
- b. Consider any existing conditions or a treatment that may influence the length of time firm pressure is required at the CVAD removal site to achieve hemostasis.
- c. Perform a time out (See Policy CPM.0158).
- d. Confirm the emergency equipment is readily available (O2, suction, etc.).
- e. Turn off all infusions.
- f. Educate the patient, as appropriate. Add the CVAD teaching title to the Patient Education Record and document.
- g. Place the patient in a Trendelenberg or supine position unless contraindicated.
- h. If a catheter tip culture is ordered, obtain sterile scissors, a specimen container and an assistant.
- i. Perform hand hygiene.
- j. Don clean gloves and a surgical mask.
- k. Remove the dressing.
- l. Clean the skin surrounding the catheter with a Chlorhexidine applicator for 30 seconds using a back and forth motion. Allow the site to completely dry for a minimum of 30 seconds. Do not blot or wave over the site.
- m. If present, remove the sutures utilizing the suture removal kit.
- n. Have the patient perform the Valsalva maneuver or hold his/her breathe. (If the patient is unable to cooperate, remove the catheter during expiration).
- o. Remove the catheter at a 90 degree angle from the skin. Grasp the catheter with the dominant hand and slowly withdraw the catheter in a continuous motion. Do not force removal if resistance is felt.
- p. Once removed, immediately cover the insertion site with dry sterile gauze and apply firm pressure until hemostasis is achieved. Monitor the site for bleeding.
- q. If a tip culture is desired, have an assistant cut off two inches of the catheter tip with a sterile scissors and place in a specimen container.
- r. Label the specimen and send it to the Lab.
- s. Cover the insertion site with a sterile gauze and secure with an occlusive transparent dressing.
- t. Keep the occlusive dressing over the site for at least 24 hours or until the site is healed.
- u. Keep the patient flat or keep the insertion site below or at the level of the heart for 30 minutes.
- v. Continue to observe the patient for signs and symptoms of complications.
- w. If the patient shows any signs or symptoms of complications post CVAD removal:

- 1) Apply manual pressure through the dressing over the insertion site.
- 2) Place the bed in the Trendelenberg position and turn the patient onto their left side.
- 3) Apply oxygen to maintain a pulse ox of >90percent.
- 4) Call the Rapid Response Team and the physician.

2. Non-tunneled PICC Removal

- a. Verify the practitioner order.
- b. Consider any existing conditions or a treatment that may influence the length of time firm pressure is required at the CVAD removal site to achieve hemostasis.
- c. Perform a time out (See Policy CPM.0158).
- d. Turn off all infusions.
- e. Educate the patient and document per policy.
- f. Place the patient in a recumbent position with arm positioned below the level of the heart and at a 45-90 degree angle.
- g. Perform hand hygiene.
- h. Don clean gloves.
- i. Remove the dressing loosening edges toward the insertion site.
- j. Clean the skin surrounding the catheter with a Chlorhexidine applicator for 30 seconds using a back and forth motion. Allow the site to completely dry for a minimum of 30 seconds. Do not blot or wave over the site.
- k. If present, remove the sutures utilizing the suture removal kit.
- l. Grasp catheter near the insertion site and slowly withdraw the catheter keeping it parallel to the skin.
 - 1) If resistance is met when removing the catheter, do not apply force.
 - 2) Reposition the arm, wait 15 seconds and try again. If resistance continues, apply a warm, moist compress to the insertion site and upper arm to relieve venospasm. Wait 15 seconds and try again. If resistance persists, redress the catheter/site and notify the provider.
- m. Once removed, immediately cover the insertion site with dry sterile gauze and apply firm pressure until hemostasis is achieved. Monitor the site for bleeding.
- n. If a tip culture is desired, cut off two inches of the catheter tip with sterile scissors and place in a specimen container.
- o. Label the specimen and send it to the Lab.
- p. Cover the insertion site with a sterile gauze and secure with an occlusive transparent dressing.
- q. Keep the occlusive dressing over the site for at least 24 hours or until the site has healed.

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Author/Clinical Nurse Specialist
Cancer Center Day Hospital

Date

Authorization:

Vice President, Quality/Patient Safety/
Performance Improvement

Date

Vice President/Medical Affairs
Chief Medical Officer

Date

Vice President/Patient Care Services
Chief Nursing Officer

Date

Attachment:

Any attachments referenced have been removed to allow conversion to PDF.
Please print the attachments separately.

Title: Confidentiality Policy

Policy Type: Corporate

Department: Compliance

Policy Number: FH-COM.062

Origin Date: 7/1/2014

Date Revised: New

Supersedes: FMLH CPA.0053, CMH 80100-099, SJH Confidentiality of patient information, FHMG MF 08-00 Confidentiality

Entities Impacted: CMH (x) FH (x) FMLH (x) FMCWCP (x) SJH (x) Others: _____

Purpose: A. To outline the responsibility, expectations and accountability for all Workforce Members to maintain and protect the confidentiality of patient, workforce and other business information at Froedtert Health (FH).

B. To describe the consequences for failing to comply with the rules, and expected behaviors or actions.

A. Confidential Information - For purposes of this policy, confidential information includes any non-publicly available information that belongs to FH or is related to FH business operations.

1. Patient's Protected Health Information (PHI): Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:

I. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and

II. Relates to an individual's past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and

III. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person's identity (address, telephone number, birth date, e-mail address, and names of relatives or employers)

IV. Protected health information excludes individually identifiable health information contained in employment records held by a covered entity in its role as employer; in addition to any person who has been deceased for more than 50 years.

2. Information Pertaining to Workforce: Examples include salaries, benefits, employment records, corrective actions, workforce health, occupational health, social security number, and payroll information or data.

3. Business Information: Examples include FH financial, strategic, operations, internal communications or other proprietary information or data that is not publicly available.

Definitions:

B. Froedtert Health (or FH) Affiliate - Froedtert Health affiliate means for purposes of this policy: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc.; St. Joseph's Community Hospital of West Bend, Inc.; Froedtert & The Medical College of Wisconsin Community Physicians, Inc., West Bend Surgery Center, LLC, and Froedtert Surgery Center, LLC. Any other entity that becomes controlled by FH after adoption of this policy also may be considered an affiliate.

C. Workforce Member— For purposes of this policy, FH or FH Affiliate employee, volunteer, trainee, student, temporary employee or other persons whose conduct in the performance of work is under the direct control of FH or a FH Affiliate, whether or not they are paid by FH or FH Affiliate.

D. All terms relevant to the Privacy Rule are defined in the Corporate Policy FH-COM.031- HIPAA Privacy Definitions.

A. All Workforce Members have a legal and ethical responsibility to protect and secure the privacy and confidentiality of information regarding our patients, staff and business activities.

B. A Workforce Member may be granted access to Confidential Information as necessary to fulfill the requirements of his/her defined role and responsibility.

C. A Workforce Member who has access to, or comes into contact with any Confidential Information is only authorized to acquire, access, use, disclose, remove, copy, alter, or destroy information within the scope of our policies and only for the sole purpose of carrying out his/her approved and legitimate job duties and never for personal reasons, malicious use, unethical motivation or for any other unapproved purpose.

D. Each Workforce Member is prohibited from accessing, reviewing, using, copying, disclosing or removing his/her own PHI. The approved methods for obtaining access to one's PHI is to contact the health provider directly, request copies of the medical information from the Health Information Management Department, or by accessing information through MyChart.

E. Workforce Members are prohibited from accessing, reviewing, using, copying, disclosing or removing the PHI of any family members, friends, co-workers, neighbors, patients in the media, VIPs, etc. for any personal reason or other non-legitimate job duty related purposes.

F. Workforce Members do not have any individual rights to or ownership of any information accessed or created by the workforce member during his/her relationship with FH.

G. FH employees are provided proper training and education regarding the confidentiality rules, regulations and expected behaviors and are required to complete all mandatory education within the specified timeframe. A confidentiality agreement must be signed by each FH employee upon hire and as required throughout his/her employment.

H. A confidentiality agreement must be signed by each FH volunteer, student, temporary employee, medical staff member, resident and others that obtain computer access privileges. Signed agreements will be forwarded to the FH Compliance Department.

I. Department leaders may decide to request certain contractors or other vendors to sign the FH confidentiality agreements due to the sensitive information they may come into contact with during their business engagement. Those agreements are to be stored in the departmental files and

Policy:

retained for 6 years after the engagement has ended.

J. Workforce Members have an obligation and responsibility to immediately report to the FH Compliance Department (FH Compliance) any activities that may compromise the privacy and/or security of our staff, business and/or patient information. FH will not retaliate against individuals who, in good faith, bring forth information of non-compliance. For more information on the reporting policy and procedures, refer to corporate policy FH-COM.025 Compliance Reporting, Hotline and Non-Retaliation.

K. FH Compliance will investigate and respond as appropriate to all concerns related to privacy and confidentiality. If a breach of our patient's Confidential Information has occurred, FH Compliance will follow all applicable rules and regulations regarding breach notification and will follow Corporate Policy FH-COM.006 Notification of Breach of Protected Health Information.

L. Routine auditing and monitoring of system use and access may be conducted at any time and without notice. A Workforce Member's system access may be revoked at any time.

M. FH will administer appropriate and consistent sanctions and will take corrective action against those Workforce Members who do not follow the rules, regulations and expected behaviors or actions.

- A. Only the Minimum Amount of Confidential Information must be acquired, accessed, used or disclosed when carrying out any given task. For example:
1. Workforce Members must not access, use or disclose information beyond the scope of his/her job responsibilities and to only access the data elements necessary to carry out his/her legitimate job duties.
 2. Social Security Numbers will not be acquired, accessed, used or disclosed unless it is required to fulfill a business need. This includes having social security numbers on reports or other documents when it is not needed or required.
 3. Electronic security access is granted in accordance with the Workforce Members role and responsibility and in accordance with FH Information Technology policies and procedures.
 4. Reports, spreadsheets and databases will only contain the data elements necessary to fulfill the business purpose.

B. Disposal of Confidential Information must be done in a manner that ensures that the information cannot be identified, recovered or reconstructed and done in accordance with FH Corporate Policy: FH-COM.030. Workforce Members are required to use the locked/secure recycle bins or other authorized manner of disposal for the disposal of all Confidential Information. Confidential Information must never be discarded in regular trash bins or dumpsters.

Procedure:

- C. Storing of Confidential Information must be done in a location that is only accessible to those that require the information. Only store the information as long as required and in accordance to the Record Retention policies and regulatory requirements. For example:
1. Confidential Information in electronic format should not be stored on a shared or public drive, local hard drive, non-encrypted USB or any other device that is not in compliance with FH Information Technology policy and procedures.
 2. Departments should not indefinitely store data, internal reports, spreadsheets or other databases that are used for a specific departmental use to track productivity, quality monitoring or for other internal purposes. (Unless required by law or other requirement, or is specifically addressed in a FH Affiliate record retention policy) Departments should perform regular maintenance of their electronic and physical space to assure that only the necessary data and information is retained.

D. Physical Environment Protections:

1. Keep all Confidential Information physically secure to prevent any unauthorized person from gaining access to the information.
 - a. Areas that do not have the capability of being locked off hours must have an established process to assure that Confidential Information is not left easily

viewable or accessible by others when unattended or during off-business hours.

b. Workforce Members that are in roles where removal of Confidential Information from the facility is authorized, are responsible for the security of the information in his/her possession. Confidential Information should never be left in an unlocked vehicle or in plain sight, or left unattended in a public location where others may steal, view or access it.

c. Confidential Information should not be left carelessly in conference rooms, restrooms, dining locations, photocopiers or other publicly accessible locations. Any Workforce Member who discovers Confidential Information in a public location, is responsible for securing the information (e.g. disposing in the locked/secure recycle bins, or delivering to the owner, when known.)

E. Careful Dissemination of Confidential Information is critical in preventing errors and mishandling of information.

1. When disseminating or handing out documents or other information which contain PHI or other Confidential Information, Workforce Members must validate that they have the correct information prior to dissemination.

Workforce Members must:

a. Positively identify the patient by validating patient identifiers (e.g. name, date of birth and address) prior to distributing any information.

b. Validate each page of the document or information that is to be distributed to ensure that all the correct information is enclosed and that no other information has been accidentally included.

2. When mailing information, verify that all of the correct papers are enclosed prior to sealing the envelope. Ensure that the envelope is properly addressed and select the appropriate type of envelope or sturdy packaging to ensure it will safely secure the documents during the mailing process.

3. When emailing Confidential Information, validate that the correct recipients have been selected to receive the email. If the email is going to another organization outside of Froedtert Health, (this does not include emails to/from MCW), type SECURE in the subject line to force the email to be encrypted. For additional information regarding emailing of confidential information, refer to the Internet and Email Usage Policy FH-IT.025.

4. When routing Confidential Information throughout the health system, information must be protected to the extent possible to maintain its confidentiality. For example, only use the approved inter-office envelopes and complete all of the fields of information required on the outside of the envelope so it is properly delivered.

a. If Confidential Information is misdirected and the recipient is unaware of who the owner or intended recipient is, the recipient may either dispose of the information in a locked recycle bin, or forward the information to the FH Compliance Department for proper identification or disposal.

5. When faxing PHI or other Confidential Information, Workforce Members

must validate that they have the correct fax number, and to use caution when entering the number in the fax machine to prevent errors. Appropriate fax cover sheets must always be used and corporate faxing policy must be followed.

6. When a Workforce Member discovers that Confidential Information was mishandled or accidentally released to an unintended recipient, they must immediately report the incident to his/her leader and to the FH Compliance Department.

F. Computer and other Electronic Security

1. Workforce Members must secure the computer workstation when it is left unattended. They must also:

- a. Notify other Workforce Members when they discover workstations not properly secured.
- b. Notify Department Leader and/or FH Compliance if non-compliant practices continue.

2. Each Workforce Member is responsible for all activity and access that occurs under his/her UserID/password and will be held accountable for any inappropriate activities that may occur.

- a. Never share unique computer UserID/password information with anyone.
- b. Never let anyone else use a computer that they are logged into.
- c. Never write your password down and leave it in a public or unsecure area where others may have access to it.
- d. Never access a computer network, application or any other electronic information under another individual's UserID/password.

3. Strong passwords with a combination of letters, numbers and characters are to be used whenever possible.

4. Workforce Members will not email Confidential Information to his/her personal web email accounts.

5. Workforce Members with mobile devices that contain access to Confidential Information must follow the FH Information Technology approval process and all other policies and procedures.

6. Workforce Members may not make any unauthorized transmissions, inquiries, modifications or purging of Confidential Information and will not modify the workstation configuration, or use or add software to workstations without prior authorization from the FH Information Technology Department and the appropriate Leader.

7. If Workforce Members are provided direction or instruction that is in opposition with computer and/or electronic security policies or rules, or if they become aware of a situation that compromises the security of our systems or unique UserID/passwords, Workforce Members are responsible to immediately report the incident to the FH Information Technology Department.

G. Paging/Messaging Confidential Information

1. When necessary to deliver timely information to care providers, it is acceptable to include limited patient identifiers when sending wireless text pages. The intent is to provide necessary information to assist with safe and efficient care to patients. Workforce Members must:
 - a. Use caution when sending messages to prevent improper disclosures.
 - b. Never include mental health, HIV, sexually transmitted disease, or other highly sensitive information or diagnosis information.
 - c. Provide the minimum amount of information that is necessary.
 - d. Examples of acceptable elements for messaging: Patient full name, date of birth, medical record number, room number, non-sensitive results, description of complaint or reason for message.

H. Verbal Disclosures of Confidential Information requires Workforce Members to comply with the following guidelines:

1. Never discuss confidential business, workforce, or patient information with others that do not have a business reason to know. Examples include
 - a. Do not share interesting or unusual patient situations with others. This includes inappropriate and unprofessional comments or gossip about patients or others.
 - b. Do not share staff members' salary or corrective actions with others that do not require the information.
 - c. Do not share confidential business transactions or other non-public information with others.
2. Care teams must take precautions when talking to patients about his/her health, care and treatment in the presence of others. Request patient visitors to step out of the room prior to discussing Confidential Information with the patient.
3. Speak softly in public areas to prevent others from overhearing the information.
4. Close doors when possible to prevent others from overhearing information they do not require.
5. Use caution when having conversations in public areas such as elevators, dining locations, hallways and restrooms to prevent others from overhearing the conversation.
6. Care teams should be aware of surroundings when discussing patient information in the space directly outside of patient rooms.
7. Professional discretion and judgment should be used when discussing patient information with patient's family or friends. When possible, obtain patient consent prior to disclosing relevant information. In the event the patient is unable to consent, use professional judgment and keep the patient's best interest in mind by sharing information only with family or friends who are currently involved in the patient's care and by limiting the information to what

they need to know about the current episode of care.

8. Information relevant to a patient's insurance claim or detailed bill may be discussed with the guarantor on the patient's account.

9. Voice messages may be left for patients and should generally include very basic information. Do not leave results or specific health information on a voice message. Examples of acceptable information to be left on a voice message are:

- a. Name of the facility calling
- b. Name of the individual calling
- c. Contact information
- d. General comment or statement which describes the purpose of the phone message.
- e. Information about an appointment may include instructions the patient needs to know in order for the patient's appointment not to be cancelled.

I. Reporting Suspected or Known Non-Compliance

1. It is a responsibility of each Workforce Member to immediately report any knowledge or suspicion of non-compliance to the FH Compliance Department. For further details on reporting, please refer to corporate policy- FH-COM.025 Compliance Reporting, Hotline and Non-Retaliation.

J. Sanctions for Breach of Confidentiality

1. Any Workforce Member who fails to comply with the confidentiality rules, policies and/or laws is subject to corrective action up to and including immediate termination of employment or business relationship.
2. Other actions such as remediation education, root cause analysis or other activities may be assigned to the leader and/or Workforce Member, depending upon the incident and severity of the violation.
3. Depending on the violations, reporting to applicable state licensing boards, law enforcement and/or other external agencies may apply.
4. Upon completion of an investigation, a severity level is assigned to the incident based on the facts, circumstances, risk and severity of the incident. The following are common examples of the severity levels associated with a breach of confidentiality.
 - a. Level 1 Severity: Generally involve accidental, careless acts that result in non-compliance or breach of confidentiality. This may include patterns of failure to validate information, such as patient identifiers prior to distributing, mailing, faxing or handling out patient information or other confidential information.
 - (i) Any patterns of careless conduct, disregard of policy and procedures or overall poor performance by a workforce member will result in corrective action.
 - b. Level 2 Severity: Moderate risk or severity of infractions which are

prohibited acts, where despite training, an individual does not follow policies. This may include actions such as inappropriately accessing patient lists in Epic when it is not a defined job responsibility, removing PHI or other confidential information from the facility and it is subsequently lost or stolen, disclosing patient information or location when the patient has opted out of the patient directory, username/password violations, or carelessly disclosing PHI.

(i) FH will hold staff member accountable by following the Corrective Action Policy, which may include written corrective action or immediate discharge.

c. Level 3 Severity: High risk or severity of infraction which involves willful intent, reckless and/or irresponsible acts or complete disregard of the rules. This may include actions such as accessing patient information without any legitimate business purpose (e.g. snooping in records, reviewing for personal reasons or general curiosity), sharing or discussing Confidential Information with others that do not require the information, gossiping about patients or others, or malicious or unethical purposes (e.g. identity theft, personal gain, custody battles, defamation of character, estranged relationships, etc.).

(i) FH has no tolerance for these actions or behaviors and will take immediate corrective action, including immediate discharge.

5. Breaches of confidentiality that constitute violations of HIPAA are subject to civil and criminal penalties. The tiered civil money penalties range between \$100 and \$50,000 per violation, and potentially may be in excess of \$1,500,000 for identical violations in a calendar year, determined based on the nature and extent of the violation, the nature and extent of the harm resulting from the violation, and the history of prior non-compliance and the level of culpability.

FH-COM.030 – HIPAA Privacy Definitions

FH-COM.025 – Compliance Reporting, Hotline and Non-Retaliation

FH-COM.006 – Notification of Breach of PHI

Related Policies:

FH-COM.030 – Disposal of PHI

FH-HR.001 – Corrective Action

FH-IT.025 – Internet and Email Usage

FH-HIM.010 - Faxing of PHI

Distribution:

Froedtert Health Corporate Policy & Procedure Manual

Signatures on File

_____ Date: __6/17/2014__

Author: Rhonda Joseph, Compliance & Privacy Manager

Authorization:

_____ Date: __6/17/2014__

Mary Wolbert, Vice President and Chief Compliance Risk Officer

_____ Date: __6/20/14__

Dennis Pollard, Senior Vice President – Chief Operating Officer

Attachment:

Any attachments referenced have been removed to allow conversion to PDF.
Please print the attachments separately.

Title: Contamination of Personal Clothing and Uniforms

Policy Type: Infection Control Manual

Department: Policies and Procedures

Policy Number: ICM.001.03ic

Origin Date: 03/04/1998

Date Revised: 7/28/2013

Supercedes: 12/11/2011

Topic(s): Infection Control

Purpose: To identify the procedure for handling and cleaning of staff personal clothing or uniforms grossly contaminated with blood/body fluids.

Policy: A. Froedtert Hospital is responsible for the laundering or cleaning of all staff personal clothing or uniforms that become grossly contaminated with blood/body fluids.

B. Staff are responsible for obtaining a clear bag used to collect contaminated linen from your unit, giving information requested so garments may be properly logged, and retrieving items from the linen room after they have been returned from the laundry.

Procedure: A. Staff whose personal clothing or uniform has become grossly contaminated with blood/body fluids will contact their supervisor for assistance in obtaining a clean set of scrubs.

B. Supervisors will inform the linen room staff that a staff member needs a clean set of scrubs. Supervisors will notify Environmental Services to obtain a clean set of scrubs and deliver.

C. After donning clean scrubs, staff will place contaminated clothing into a clear bag and deliver the bag to linen services to be processed by the hospital laundry service. The staff member will fill out a Soiled Personal Clothing Form, obtained from linen services. The staff member will supply the following information: name, unit/department, shift, extension number, and a complete description of item(s) including color, size and number of items.

D. The hospital laundry service will provide commercial laundering service.

E. When the staff members uniform is cleaned, linen services will contact the staff member to pick up clean uniform.

Scope: All

Distribution: Infection Control Manual

	Author, Infection Control Department	Date
	Director, Quality Management & Patient Safety	Date
	Chairman, Infection Control Committee	Date
	Executive Vice President, Operations	Date

Forms: OSHA Bloodborne Pathogen Standard 29CFR1910.1030

Attachment: Any attachments referenced have been removed to allow conversion to PDF.
Please print the attachments separately.

Title: Discharging a Patient

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.028

Origin Date: 1/14/1982

Date Revised: 11/1/2012

Supersedes: 8/4/2012

Topic(s): Admit / Discharge / Transfer

Keyword(s): Discharge, AMA, Against medical advice, unauthorized absence

Purpose: To provide the patient with a safe and courteous departure from the hospital and promote continuity of care once the patient is discharged.

Policy: A. The Discharge Navigator will be completed at time of discharge but no later than eight hours after patient discharge on all patient discharges from the hospital, (excluding deaths) but including discharge/re-admits within the hospital eg. discharge from acute unit to re-admit to inpatient rehabilitation units.

B. The Pharmacist will be responsible for providing teaching related to food/drug interactions and documenting that teaching was provided.

C. The nurse will print and provide the patient/significant other with the After Visit Summary from Epic. The medication reconciliation will have been completed by the physician prior to printing the report. The follow-up and discharge instructions sections will have been completed by the physician, RN and ancillary staff as applicable prior to printing the After Visit Summary.

D. The physician will be notified when a patient indicates he/she is leaving the hospital against medical advice.

A. Address the applicable sections of the discharge navigator which includes but is not limited to:

1. LDA Removal
2. Med Rec Status
3. Discharge Planning
4. Patient Belongings
5. Progress Note
6. Care Plan
7. Patient Education
8. Follow-Up
9. Discharge Instructions
10. Preview AVS

a. It is acceptable to handwrite on the medication list in the After Visit Summary (AVS) for the purposes of providing education to patients upon discharge or clarifying information that is already present in the Electronic Medical Record (EMR). Examples of handwritten information that may be included are:

Procedure:

- Medication indication
- Last dose taken
- Next dose due
- Special administration instructions (e.g. take with food, take on an empty stomach, etc.)

These changes must be made in the Electronic Medical Record prior to printing the AVS.

B. Review expected outcomes on the patient's care plan. (See Care Plan and Patient Education in the Inpatient Environment Corporate Policy CPM.0176)

C. Complete patient education documentation regarding the patient's response to teaching with actual outcomes.

D. Call Security if patient has to retrieve valuables from the cashier.

E. Assist patient to dress as needed and pack belongings.

Document belongings at discharge to verify belongings the patient took home at discharge. (See Valuables and Patient Belongings Corporate Policy)

- F. Provide patient with discharge prescriptions, education for medications and supplies, and clinic appointment information as appropriate.
- G. Review with patient and significant other all arrangements made relating to discharge care and needs. Provide patient and significant others with a copy of After Visit Summary which includes follow-up, medications and discharge instructions.
- H. Notify transporter that patient is ready for discharge.
- I. If applicable assist patient to wheelchair.
- J. Bag unused medication and label with patient's name and place in pharmacy return box in planning area.
- K. Upon discharge gather patient's films/x-rays (both Froedtert and non-Froedtert films) from MD/nursing planning areas and place in transport bin for return to radiology film room.
- L. Discharge against medical advice:
 - 1. Check Medical Record under legal tab for documentation regarding legal status to determine if patient is a risk for unauthorized absence. If documentation indicates there is a legal hold, call Security immediately and refer to Unauthorized Absence Of A Patient Policy Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.
 - a. Notify physician immediately.
 - b. Notify Director of Nursing or Administrative Representative and shift coordinator.
 - c. Document in a note.
 - d. Patient should sign Discharge Against Medical Advice form prior to leaving.
 - e. Patient receives the yellow copy of the form.
 - f. If the patient refuses to sign the form and leaves the hospital, the RN will sign that they witnessed the patient refusing to sign.

Scope: RN

Distribution: Froedtert Intranet

Signatures on file in Nursing Administration Office

Reviewed and approved by Practice Council

Authorization:

Signature	Chairperson	Date
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Signature	Chief Nursing Officer Vice President, Patient Care Services	Date
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Title: Documentation of Nursing Care

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.020

Origin Date: 9/29/1980

Date Revised: 8/20/2012

Supersedes: 8/4/2012

Topic(s): Documentation

Keyword(s): Documentation, nursing care

Purpose: A. To define the responsibility of nursing staff members in documenting the nursing process.

B. To describe which nursing staff members may document the care to be delivered.

Policy: A. The electronic health record (EHR) serves as a means for nurses to communicate among themselves and with other members of the treatment team about the patient's status and to document information necessary for continuity of care.

B. Documentation of nursing care including response to teaching is done through the use of the Care Plan and Patient Education activities in Epic. In addition, the following events must be documented in the EHR:

1. All assessments
2. Admission
3. Transfer
4. Discharge
5. Pre-operative and post-operative condition
6. Change in patient condition
7. Unusual happening or occurrence
8. Notification of physician
9. Shift Summary note

Assessments are documented per Policy [C01.011](#) - Patient Assessment and Nursing Process Documentation.

C. All nursing care provided will be documented in the EHR.

1. Registered Nurses will document on the following:
 - a. Care Plans
 - b. Doc Flow Sheets
 - c. Progress notes
 - d. Shift Assessment Navigator
 - e. Medication Administration Record
 - f. Nursing Admission Navigator
 - g. Nursing Transfer and Arrival Navigators
 - h. Nursing Discharge Navigator
2. Nursing Students may document on the following under the direction of their clinical instructor:
 - a. Doc Flow Sheets
 - b. Progress notes
 - c. Shift Assessment Navigator
 - d. Medication Administration Record
 - e. Nursing Admission Navigator
 - f. Nursing Transfer and Arrival Navigators
 - g. Nursing Discharge Navigator

3. Nurse Externs may document on the following chart forms under the supervision of the RN:

- a. Care Plans
- b. Doc Flow Sheets
- c. Progress notes
- d. Shift Assessment Navigator
- e. Medication Administration Record
- f. Nursing Admission Navigator
- g. Nursing Transfer and Arrival Navigators
- h. Nursing Discharge Navigator

4. PCAs and PCTs may document on doc flow sheets as directed by the RN.

D. The nursing process is used in documenting the patient care:

1. The initial physical assessment is on the Patient Care Summary from within the Admission Navigator.

2. Care plans are initiated within 24 hours of admission and when clinically indicated and are based on the patient's current condition.

3. Interventions are documented in the Patient Care Summary or from the patient's Care Plan.

4. Documentation that nursing care has been provided is accomplished in the following manner:

a. Within the Care Plan. (See Policy #CPM. 0176 - Care Plan and Patient Education in the Inpatient Environment Corporate Policy)

b. Documentation of patient/patient representative teaching is documented in the Patient Education Activity. (See Policy #CPM. 0176 - Care Plan and Patient Education in the Inpatient Environment Corporate Policy)

c. Vital signs, weight and intake and output are documented in applicable doc flowsheets.

d. Other interventions are documented in notes, Doc Flow Sheets and the Medication Administration Record, as appropriate.

5. An end of shift summary note will be documented in the EHR to include the patient's overall condition and response to multidisciplinary interventions during the care interval.

6. Discharge preparation activities will be documented in Care Plans, doc flow sheets, notes, and patient education.

E. All written entries on permanent chart documents will be legible, complete and accurate. If an entry error is made, a single line is placed through the error, the word "Disregard" written above it and then entry continued.

F. All written entries on permanent chart documents must be made with blue/black ink.

G. When initials are used on chart forms, a legal signature must also be written on the form to identify the initials.

References: Smith, S.F., Duell, D.J. & Martin, B.C. (2008). *Clinical Nursing Skills* (7th ed.). New Jersey: Pearson Education

Scope: RN, NE, PCT, PCA

Distribution: Froedtert Intranet

Associated Policies: [CPM.0176](#) - Care Plan and Patient Education in the Inpatient Environment Corporate Policy

[C01.001](#) - Admission Policy

[C01.011](#) - Patient Assessment and Nursing Process Documentation

[C01.028](#) - Discharging a Patient Policy

[C01.105](#) - Patient Transfer Policy

Authorization: Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Signature Chairperson Date

Signature Chief Nursing Officer Date
 Vice President, Patient Care Services

Title: Electronic Access Policy

Policy Type: Corporate

Department: Information Technology

Policy Number: FH-IT.030

Origin Date: 4/12/13

Date Revised: New

Supersedes: FCH-IT.002: Password Reset Policy, FCH-IT.004: User Access Review Policy, CPFCH-0010: Workstation Use Policy, CPFCH-0011: Identity Authentication for Use of ePHI Policy, SJH ADM.001 (Synergy Health) Electronic Communications Policy

Entities Impacted: CMH (x) FH (x) FHMG (x) FMLH (x) SJH (x) Others _____

Purpose: To define and implement controls on access to electronic Froedtert Health networks and systems and Protected Health Information (PHI).

Definitions:

A. Froedtert Health and its affiliates include all entities within the health system.

B. Infrastructure – Includes all Information Technology resources used to capture, store, transmit, view or otherwise process data or images, including equipment, software or network components.

C. Protected Health Information – Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:

1. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and
2. Relates to an individual’s past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and
3. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person’s identity (address, telephone number, birth date, e-mail address, and names of relatives or employers).

Policy Froedtert Health will develop and implement technical, procedural and policy controls for the purpose of securing its electronic data and maintaining the integrity of such data, while allowing appropriate access by its staff to fully carry out their job responsibilities. Specifically, these controls include but are not limited to the following:

A. Safeguarding Data - It is the policy of Froedtert Health to safeguard the confidentiality, integrity, and availability of its electronic data, including PHI, as well as business and proprietary information within its information systems by controlling access to these systems/applications. Access to information systems by all users, including but not limited to workforce members, volunteers, business associates, contracted providers, consultants, and any other authorized user, is established and allowable on a minimum

data necessary basis, to the extent possible.

B. Reporting Incidents - All users are responsible for reporting any incident of unauthorized use or access of Froedtert Health's information systems. The same levels of confidentiality that exist for hard copy PHI, business, and proprietary information apply to digital and/or electronic information within Froedtert Health's information systems and are extended even after termination of employment or termination of access.

C. Access Authorization - The Department Director or designee is responsible for completing a Computer Access Request Form (CAR Form) for the new staff member, completing the new staff member's profile at the top of the form, selecting the appropriate applications for the position, indicating the shared folders to provide access to and indicating any other specific applications or printing needs there might be.

D. Role-based Access – Role categories for each information system or application, as available, are maintained by the Information Technology (IT) Department with the assistance of the Department Leaders and the Human Resources (HR) Department. These Categories are to be reviewed and updated by Department Directors or their designees as necessary. Categories will be determined, in collaboration with independent departments, HR and IT, based on the importance of the applications running on the information system, the value or sensitivity of the data on the information system, security controls on the information system, security controls on the workstation utilized to access the information system, and the extent to which the information system is connected to other information systems. When possible and appropriate, access is granted to users based on these pre-determined categories. Otherwise, individually unique user security will be established.

E. Access Establishment - All requests for access to any of Froedtert Health's information systems and applications must be accompanied by a CAR Form (Addendum 1).

1. Access to information systems and applications will not be granted until the Confidentiality Agreement is reviewed, signed and approved. It is the responsibility of the Department Director, Manager or Supervisor to complete, sign and authorize the CAR Form for each employee in their department. The form will identify any and all system access requirements for the employee. When completed, the CAR Form will be forwarded to the IT Department.

2. IT is responsible for establishing the new employee's access in accordance with the newly completed CAR form.

3. CAR forms are maintained and stored by IT.

F. Access Modification – Modifications to a user's access will be processed

as follows:

1. Controls will be established for the purpose of allowing user passwords to be re-set either by the users themselves or by the IT Service Desk in the event that the user has forgotten his or her password.
2. Prior to resetting a workforce member's password, the IT Service Desk will verify the identity of the person and that the workforce member's employment status is active.
3. In the event of a change in name, department, job classification or job responsibilities, the Cost Center Manager/Supervisor notifies the Human Resources Department of any change and the effective date of the change.

G. Access Termination – Termination of a user's access will be processed as follows:

1. The IT department will de-activate user accounts and prevent access to its network and to all applications and data residing on its network no later than the end of the user's final day of employment or as otherwise indicated below:

- a. MD Exceptions
- b. If timely notification has not been received in IT
- c. Voluntary termination
- d. Termination for cause initiated by Froedtert Health
- e. Other as justified

2. In the event of a termination, IT will remove the terminated staff member's access upon notice from Human Resources. If interim access is required by another department staff member, it should be requested as a change or new addition by the Director/Supervisor through the use of the CAR Form.

H. Access Reviews - Twice per year, the IT Security and Disaster Recovery team will perform a user access review for critical systems. This review will verify:

1. Removal of access for terminated staff.
2. When a non-terminated staff member is identified as having inappropriate access, IT will attempt to contact the staff leader prior to modifying security. At the direction of the IT Security Officer, the workforce security may be modified without approval from the hiring leader.
3. The IT department will periodically perform user access reviews, no less frequent than twice a year, to verify that all terminated users have had their network access deactivated; or, to identify and correct terminated users who still have user access. Such situations will be documented and reported to Corporate Compliance.
4. Documentation of the user access reviews will be maintained by IT for a minimum of seven (7) calendar years or as otherwise required by law. At the end of the retention period, physical documentation will be shredded by an authorized document shredding company.

I. Unique User ID and Password - All staff with authorized access to the network, system or application that contains electronic PHI must satisfy a user authentication mechanism. The authentication mechanism at a minimum will include the use of a unique user identification and password.

1. Workforce members with authorized access to any network, system or application will not misrepresent themselves by using another person's user identification and password, smart card, or other access control mechanism.
2. Workforce members will not permit other persons or entities to use their unique user identification and password, smart card, or other access control mechanism.
3. Workforce members are not allowed to login using another workforce member's password or to allow another workforce member to login using their password.
4. To the extent possible, only unique user identification and login identification will provide access.
5. Workforce members are not allowed to enter data under another workforce member's password.
6. Workforce members will not write down their password and leave the password in a publicly accessible location.
7. Workforce members will make all reasonable attempts to assure that password entry is not observed in a manner that would allow unauthorized access.
8. Three failed attempts at login will result in access denial and notification to the IT Security Administrator for IT owned systems and the Systems Manager(s) for each non-IT owned system.
9. Workforce members may not hide their identity when they access or modify PHI.
10. Workforce members are responsible for the content of any data they enter into the computer or that they transmit through or outside Froedtert Health's system.
11. A reasonable effort by all staff must be made to verify authenticity of the receiving person or entity prior to transmitting electronic PHI.
12. The IT Security Officer will monitor procedures to verify the identity of authorized users and compliance with this policy.

J. Password Authentication Management - Where network authentication occurs via a password, the network will automatically require users to change passwords at a pre-determined interval, no less frequently than semi annually.

1. Users that do not recall their user Login ID and/or password may contact the IT Service Desk. Upon acceptable determination of the identity and authenticity of the requestor, the IT Service Desk will provide the employee with a temporary password. The network will deny user's ability to use a recent prior password.
2. If a user believes their password has been compromised, they must

immediately report the incident to the IT Service Desk or their immediate supervisor who will contact the IT Service Desk.

3. The IT Service Desk will de-activate the password that may have been compromised and will assist in establishing a new password for the user.

K. Automatic Logoff - Each computer workstation will be programmed with an automatic log-off function that will generate a password-protected screensaver when the computer has not received input for the designated number of minutes for the specific workstation. Each user must log-off the system if they are leaving the computer workstation unattended.

L. Workstation Use - The IT Department will maintain an accurate inventory of workstations, their location and their supervision, including remote access workstations.

1. The IT Security Officer will be responsible for monitoring compliance with terms and conditions of software licensing and copyright laws.
2. All computer users will monitor the computer system's operating environment and report potential or real threats to the IT Security Officer.
3. Leaders for each non-IT managed system will be responsible for implementing reasonable methods for maintaining the integrity of electronic PHI including the use of reasonable and appropriate anti-virus software. The software must be updated as needed to protect the integrity of PHI.
4. Leaders for each non-IT managed system, as reasonable and appropriate, will implement and monitor a password control system on all workstations.
5. Leaders for each non-IT managed system will regulate and monitor password or other authorized access means to protect against unauthorized access.

M. Workstation Security - Workstations are the property of Froedtert Health and must always remain on the premises, unless prior authorization by the IT Security Officer has been granted for removal of workstations from the premises.

1. Workstations will be secured in a manner that prevents unauthorized removal.
2. Workstation monitors will be located in as secure a location as possible.
3. Workstation monitors used infrequently will be located in a secure area or locked when not in use.
4. Workstation monitors will be positioned in a manner that the screens are not readily visible to unauthorized users when possible.

Related Policies: FH-HR.001 - Rules of Conduct / Corrective Action Policy

Distribution: Froedtert Health Corporate Policy & Procedure Manual: Information Technology Section

Authorization: Signatures on File

_____ Date: 4/23/13

Author: Hector Joseph, Director and Chief Technology Officer

_____ Date: 4/22/13
Robert DeGrand, Vice President & Chief Information Officer

_____ Date: 4/26/13
Dennis Pollard, Senior Vice President – Chief Operating Officer

Title: Ethics Consultation

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0026

Origin Date: 03/21/1995

Date Revised: 04/09/2013

Supersedes: 03/30/2010

Topic(s): Administrative

Keyword(s): ethics, consult

Purpose: The purpose of an ethics consultation is to bring the expertise and experience of others to bear on a situation that requires clarification of issues and values related to patient care.

A. Access to Ethics Consultation

1. The Ethics Committee works through initial analysis of case problems by one of several ethics consultants who are members of the Ethics Committee. As appropriate, the consultant may act as sole consultant, may assemble and lead an ethics team from available members of the Ethics Committee or may ask the Chair to convene the entire Ethics Committee. The request for the consultation may be made by the attending physician, by the patient (or surrogate for the non-decisional patient), by immediate family members, by involved nursing staff or house staff, by involved social workers or by a chaplain. Requests from nurses, social workers, chaplains, patients and family should be communicated to the medical team and to the appropriate nurse leader for that unit at that time.

2. Ethics consultations requested during normal business hours may be placed through the Operator who will contact the ethics team member on call.

3. After hours, weekends and holidays, any requests for ethics consultations must be directed to the Administrative Supervisor. The Administrative Supervisor will insure that all hospital policies are addressed and will determine whether an ethics consultation is appropriate. He/she will also assist in determining if the consult may wait until normal business hours. When appropriate, the Administrative Supervisor will ask the Operator to contact a member of the Ethics Committee at home.

4. The Operator will have a list of current Ethics Committee members and contact numbers, including an order in which the numbers should be called. If the Ethics Committee member contacted determines that an emergency Ethics Committee meeting needs to take place, the Operator will assist by contacting the other Ethics Committee members.

B. Response to Request for Consultation

1. The ethics consultant will determine the nature of the ethical problem and whether an ethics consultation is appropriate. The attending physician and the appropriate nurse leader for that unit at that time will be notified of an ethics consult. Once a determination is made that an ethics consultation is appropriate, the ethics consultant may attempt to resolve the problem through a telephone consultation. If the problem cannot be resolved through a telephone consultation or, in the consultant's judgment should not be resolved in this manner, the consultant should proceed as follows:

a. Patient Consent for Consultation

Policy:

1) Under most circumstances, the consultant will see the patient. If the patient is decisional, the consultant will notify him or her of the nature of the visit. If the patient objects to the consultation, it should be discontinued. If the patient is not decisional or decision making capacity is uncertain, the agent or proper surrogate must be notified of the ethics consultation at the earliest reasonable opportunity. If the surrogate or agent objects, the consultation should be discontinued.

2) Patient or surrogate refusals of consultation are to be reported to the Ethics Committee Chair who may wish to have the Ethics Committee and clinical staff discuss the type of ethical problem involved as a generic issue but without the use of the patient's chart and without identifying the patient. On occasion, the physician or other health care team member may wish to have the Committee or consultant discuss a specific issue without identifying the patient to the Committee. In either case, the patient (surrogate) does not have to be notified of such a generic discussion of the issue.

b. Initial Evaluation

1) Following patient or surrogate consent to the consultation, the ethics consultant will, as appropriate:

a) Discuss the case with the attending physician, house staff and involved nursing staff.

b) Interview family members and other involved persons and caregivers.

c) Review the chart.

c. Decision Whether to Convene Full Ethics Committee

1) If the problem is uncomplicated, common or previously encountered by the Committee and the assessment of the Ethics Committee may be anticipated, the consultant may resolve the problem without a full meeting of the Ethics Committee.

2) If, in the judgment of the ethics consultant, the full Ethics Committee should review the case, the Chair should convene a meeting.

d. Full Ethics Consultation

1) The Ethics Committee secretary will notify members of the time and place of the meeting.

2) Other persons invited to be present at the meeting may include:

a) the patient, if decisional

- b) relatives, the agent or a surrogate of the non-decisional patient
- c) the attending physician
- d) house staff of the attending team
- e) nurses caring for the involved patient
- f) social workers and chaplains caring for the involved patient
- g) MCW Bioethics graduate students
- h) other physicians or health care professionals whose special expertise is required for deliberation about the present clinical problem

3) All present will be reminded of the need for confidentiality and cautioned not to discuss the case in any context in which the patient may be identified.

4) Discussion will then proceed along the general guidelines that follow.

C. Assessment of the Ethical Problem (by Consultant or Full Ethics Committee)

1. Medical Facts.
2. Patient preference, if known.
3. Other relevant factors.

D. Problem Assessment and Recommendation(s)

1. The ethical problem should be delineated.
2. Ethically appropriate recommendation(s) should be made.

E. Reporting

1. A note of a full Committee or in-person consultation will be placed on the chart by a member of the Ethics Committee, unless the attending physician requests otherwise.
2. A report of all consultations, including telephone contacts, will be made in the Minutes of the Ethics Committee meeting with due regard for patient confidentiality.
3. Minutes of Ethics Committee meetings will go to the Medical Executive Committee.

Distribution: Corporate Policy Manual

Author/Chair of the Ethics Committee Date

President Date

Authorization:

Vice President, Medical Affairs Date
Chief Medical Officer

Vice President, Patient Care Services Date
Chief Nursing Officer

Title: Event Reporting and Investigation
Policy Type: Corporate
Department: Administrative
Policy Number: CPA.0008
Origin Date: 12/01/1985
Date Revised: 04/28/2010
Supercedes: 1/7/2006
Topic(s): Administrative
Keyword(s): Incident reporting, investigation, event report

Purpose: A. To define an event.
 B. To define the circumstances under which an event report must be completed.
 C. To explain the procedure for completing an event report electronically.
 D. To explain the procedure for reporting/investigation of event reports.
 E. To explain the reporting of event report data to appropriate hospital committees.
 F. To explain the procedure of reporting events during a MIDAS Downtime.

Policy: A. An event is an occurrence that is not consistent with the routine operation of the hospital or the routine care of a patient.
 B. In order to promote error reporting and improve all processes and services that support the care of our patients, a non-punitive environment will be provided for event or error reporting by all staff.
 C. Compliance with non-punitive event/error reporting:

1. It is an expectation that all staff members report errors or events electronically through online event reporting.
2. The staff member(s) involved with an error or other event is/are expected to assist in the identification of system failures that may have contributed to the error or event. This may include participation in a root cause analysis.
3. The supervisor/manager who reviews the event report will focus on process improvement opportunities rather than corrective action used to correct individual performance or competency issues.
4. Corrective action is only instituted for intentional acts by the staff member, wrongful or unlawful acts of a staff member, where a staff member demonstrates a consistent pattern of not meeting competency objectives, or if a staff member did not complete an event report when indicated.

 D. An event report must be completed for all events, errors or unusual occurrences involving inpatients, outpatients, visitors and staff. A Staff Accident Report (currently paper form) must be completed for accidents or injuries involving staff and submitted to the department manager. (See Corporate Policy CP4.0032 – Occupational Illness – Injury Claims and OSHA Reporting Procedures.)
 E. If there is a question as to whether the event is reportable, an online event report should be completed.
 F. All events are documented using the electronic forms found on the Froedtert Intranet homepage within the Applications box - Online [Event Reporting](#).
 G. Events should only be discussed with physicians and appropriate

members of the hospital staff.

H. All events where the patient's outcome is significantly different from the expected outcome will be reported to a physician. The physician or his/her designee will notify the patient and, when appropriate, the family about those outcomes that differ significantly from expected outcomes.

I. The Chief Compliance Officer will report a summary of deaths and illnesses associated with medical devices semiannually to the FDA. A medical device is any item used for diagnosis, treatment or prevention of disease, injury or illness that is not a drug.

J. Whenever a serious patient event occurs, the Risk Manager, Senior Vice President of Medical Affairs, Executive Vice President of Operations and Vice President of Patient Care Services should be notified immediately.

K. Timely review and routing of event reports is essential to the maintenance of the hospital's risk management and quality management programs.

L. Information obtained from event reports is used to improve care or services or to prevent future similar events.

Procedure:

Completion of Incident Reports

A. Any staff member who discovers an unusual event involving an inpatient, outpatient, visitor, staff member or contracted staff completes an incident report.

B. Complete the event report as soon as possible prior to the end of the shift after an event occurs so that facts are documented immediately and further investigation is initiated.

C. In completing an event report, use accurate, clear, detailed, objective information rather than judgmental, incriminating statements.

D. When completing an event report electronically, select the appropriate form and complete the information, as requested. There are Help screens for each field on the form indicating what is expected for that particular field.

E. When an event report is completed online, based on the Attributed Departments involved, the report will automatically be forwarded to that department(s) supervisor/manager or designee for review and/or investigation.

F. All events where the patient's outcome is significantly different from the expected outcome must be reported to a physician. The physician or his/her designee notifies the patient and, when appropriate, the family about those outcomes that differ significantly from the expected outcomes. In the Midas computer system, the person completing the event report will enter the physician's findings and treatment as documented in the medical record.

G. In addition to completing the event report, the staff member must document an account of the event in the patient's medical record. The medical record should not include a statement indicating that an event report was completed.

Reporting of Event Reports

A. The entry of the event populates the SmarTrack worklist of the manager/supervisor to review the event. The manager/supervisor accesses the worklist.

B. The staff member's immediate supervisor/manager completes the **MGR/SPV ONLY fields in the User Fields**. If applicable, the manager/supervisor will enter the physician comments.

manager/supervisor enters the other department's name in the Attribution section of Midas.

D. The manager/supervisor completes the Outcomes/Referrals section of Midas to refer an issue on to another department for further investigation. This will populate that department manager's/supervisor's SmarTrack Worklist to prompt further investigation.

E. The entry of the event populates the SmarTrack Worklist of the Risk Manager or designee for review by Risk Management.

F. The entry of the event populates the SmarTrack Worklist of the Quality Management Specialist for verification of correct category selection of the event.

Reporting of Event Data

A. Event report data is reported to various hospital committees where conclusions are drawn, recommendations are made, actions are taken and results of the action are measured. The following committees receive reports of aggregate event data:

1. Quality Care Council (Patient Fall and Medication Events)
2. Pharmacy and Therapeutics Committee (Medication Events)
3. Quality of Care Review Committee (Potential Sentinel Events and Physician Events)
4. Professional Affairs Committee

B. Event report data is published monthly on the Quality Management Department website.

C. Results from event report data are used in safety education, as appropriate. Staff members involved in events related to an education deficit will receive special training as deemed appropriate by the staff member's manager/supervisor.

D. The Risk Manager or designee reviews all event reports and refers them to the appropriate parties or to the attention of the Executive Vice President of Operations, Senior Vice President of Medical Affairs and/or the Vice President of Patient Care Services, as appropriate.

E. The Quality Management Specialist in Quality Management compiles statistical information monthly and as needed.

Reporting/Routing of Event Reports During Downtime

A. During an extended computer downtime (more than eight hours) when the MIDAS system cannot be accessed, events may be reported in the following ways:

1. Wait until MIDAS is back up to enter the event if before the end of your shift.
2. Call or e-mail the Risk Manager.
3. Document the event on the paper Event Report (see attachment).

B. After completion of the paper Event Report, the staff member should route the completed report to the Quality Management e-mail address at the bottom of the form.

C. Quality Management will enter the event into MIDAS within the next business day which will then automatically forward it to Risk Management and the department Supervisor/Manager Worklist.

Distribution: Corporate Policy Manual

Title: Infusion Pump

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.318

Origin Date: 1/13/2005

Date Revised: 9/18/2013

Supersedes: 8/12/2011

Topic(s): Equipment / Supplies

Keyword(s): Infusion pump

Purpose:

- A. To define and explain the features of the Alaris Infusion System.
- B. To provide safe and accurate administration of intravenous fluids via an infusion pump.

A. Anesthesia Mode - A mode that allows the anesthesiologist to access additional drugs in each specific drug library with predetermined anesthesia settings and concentrations. This mode also features permanent pause and the ability to set higher air-in-line settings.

B. Channel Labels - Provides a hospital-defined list of labels which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., pain medication, blood, chemotherapy, etc.) or the catheter location (i.e., Swan, Cordis, etc.).

C. Audible - Sufficiently loud enough based on distance and competing noise on the unit to alert the care provider of malfunction of the equipment.

D. Drug Library - A drug data set to define a list of drugs and concentrations appropriate for each Profile. Programming via the drug data set automates programming steps, including the drug name, drug amount and diluent's volume, and represents established best practice and monitored via Guardrails limit checking.

E. Event Log - The quality control data that is relayed from the Alaris PC Point of Care Unit to the Guardrails CQI Database pursuant to deviations from established safety parameters set within the drug data sets in the Guardrails system and the pump configurations of the medication safety system. The event log records when a Guardrails event occurs and the subsequent programming that occurred.

F. Guardrails - The programming software within the Alaris Infusion System is designed to help prevent programming errors by:

1. Customizing device configurable settings to meet the need of the selected patient population.

2. Comparing user programming with the hospital-defined best practice guidelines.

3. Providing an advisory prompt if an out-of-limit entry is made at

Definition(s):

the time the device is programmed to infuse medications defined in the drug library.

G. Hard Limit - Does not allow the operator of the infusion system to adjust the rate of drug delivery outside of the parameters currently set within the dataset.

H. Profile - Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population (Critical Care/ED, Medical/Surgical, Pediatrics, Neonates and Special).

I. Programming (Point-of-Care) Module - (Commonly referred to as the Brain) The module of the Alaris medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module cannot delivery any medication without a pumping module. Each programming module has the ability to control four pumping modules.

J. Pump Configurations - Set of data that is determined for each profile that controls the overall operation such as maximum rate, air in line sensitivity, pressure and alarms of the programming and pumping modules. Configurations may be established unique to each profile.

K. Pumping Module - The module that is attached to the programming module for the delivery of intravenous fluids or medications.

L. Soft Limit - Allows the operator of the infusion system to adjust the rate of drug delivery above the maximum dose or below the minimum dose. When a soft limit is reached, the operator will be asked to review and approve the infusion rate to assure that an error has not been made before overriding the Guardrails limit. A visual and auditory prompt will occur indicating that the infusion is being delivered above or below the Guardrails limit when⁶³a soft

limit is overridden. The visual alert will stay visible during the infusion.

A. A mechanical infusion pump will control all primary intravenous infusions, including those with additives, and secondary medication infusions. Based on provider discretion and patient's unique clinical condition, IV solutions without medications or additives may be infused without an infusion pump via gravity, pressure bag or IV regulator (i.e., Dial-a-Flow®).

B. All IV infusions with medications and/or concentrated electrolyte solutions will be programmed using the drug library within the infusion pump.

Policy:

C. The profile will be programmed based on a specific patient population and reflect the patient plan of care.

D. When transferring an inpatient from unit to unit, the receiving nurse is responsible for changing the pump profile, if appropriate.

E. All infusions will be programmed in infusion pump at time of administration..

F. PSI settings in infusion pump are fixed.

G. All medications will be programmed using the "Standard" option.

Equipment:

- Programming Module
- Pumping Module
- Intravenous Tubing (pump set tubing)
- Tubing administration set
- IV solutions/blood as ordered by the physician

- A. Explain the procedure to the patient.
- B. Priming the Administration Set
1. Close the roller clamp.
 2. Spike the infusion bag.
 3. Fill drip chamber to 2/3 full.
 4. Open roller clamp and slowly prime tubing.
 5. To remove visible air, invert and tap needle free valve while fluid is passing.
 6. Close the roller clamp.
- C. Load the set into the pump.
1. Remove the blue sheath from the pumping segment of the tubing.
 2. Open the module door and hold the upper fitment above the fitment recess and lower into the recess.
 3. Press the safety clamp fitment into the recess of the pump module.
 4. Firmly press tubing into the Air-in-Line detector.
 5. Close the pump door and lower the latch. Open the roller clamp and verify no fluid is flowing through the drip chamber.
- D. Turn on the pump: Press the system on button.
- E. Select a profile in accordance with patient's plan of care and press confirm.
- F. Under patient ID, enter clinical area identification code and select confirm.
- G. Program primary infusion delivery using Guardrails.
1. Select Channel A-D.
 2. Select Guardrail Drugs, Guardrail Fluids or Basic Infusion.
 3. Select medication from drug library list and then press yes or no.
 4. Enter infusion rate and VTBI (Volume To Be Infused).
 5. Press the start button.

H. Connecting a Secondary Line

The Carefusion pump is a gravity flow pump. You will need to back prime by gravity and hang secondary bag higher than the primary infusion.

Procedure:

- I. Program Piggyback infusion using Guardrails software.
 1. Select Channel Select and secondary.
 2. Select appropriate medication.
 3. Follow pump to program drug using Guardrails software.
 4. Select Start to start infusion.

J. Programming a Dose Calculation using Guardrails

Based on the profile, medications may have upper hard and/or lower hard limits. Hard limits cannot be overridden. If dose is out of range, the pump will display the minimum/maximum dose in the message region.

K. Changing Rate or Dose

It is not necessary to stop the pump to make dose or rate changes.

1. Select Channel A-D.
2. In dose or rate field, enter new numeric value.
3. Press the Start button.

L. Clear Volumes Infused (Shift Totals)

1. Press the Volume Infused key.
2. Obtain primary and secondary volumes infused, document in EHR and hit clear button on the pump.

M. Program Options

Change profile.

1. Turn pump off and back on to change profile area.

N. Lock Out Functions

1. When the pump is in the lock out function, you will be unable to use the pump.
2. Use the black soft button located on the back of the pump.

O. Guardrails

1. All drug library IV medications will be infused using Guardrail programming.

- a. Concerns regarding medications not listed, unavailable or dosage variations are directed to the pharmacy.

2. Bypassing the use of Guardrails will be done only in an emergency and will be terminated at the earliest possible time after the emergent phase is passed.

3. Soft limit Guardrails are adjustable based on the drug dosing limits set within the drug library.

4. Hard limit Guardrails are not to be adjusted.

a. In the event a hard Guardrail limit must be altered, pharmacist consult and physicians orders are required for drug administration.

b. Hard limit Guardrails can only be reprogrammed in the Basic IV fluid mode.

1. No medication name will be displayed in the Basic IV mode, making verification of drugs infused via this route extremely important.

5. Clinical Advisories will display for drugs within the library to alert the administering nurse to cautions applicable for the drug delivery.

P. Alarms

1. At no time should the caregiver disable the alarm so it is not audible unless that caregiver is at the side of the patient during care.

2. Alarms will be answered/addressed immediately by hospital staff member(s).

3. Nurses will ensure that pump alarms are carefully monitored in areas that are remote from the nurse's station.

Q. Equipment Management

1. Cleaning

a. The Alaris pump, both the patient care unit, and modules will be returned to each unit's soiled equipment room to be picked up for cleaning after each individual patient use unless the unit has been designated as one in which a par level has been determined (ED, PACU, Infusion, etc.).

b. If the pump is not returned for cleaning to the equipment room, the department is responsible for cleaning the pump⁶⁷ with a

hospital approved cleaning agent. Cleaning between patient uses is required for all parts of the Alaris pump.

2. Cleaning in Patient Care Areas (by Patient Care Staff and/or Distribution) and Special Precaution Room (by Patient Care Staff and/or Distribution)

a. Pump Brain, Poles, IV Channel, ETC02, Modules, Screen

1. Disassemble all pieces and clean individually.

2. The door units are to be held upright as much as possible during cleaning.

3. The door of the unit needs to be opened and the inside cleaned as well with the disinfectant.

4. Wipe (2 minutes) with PDI Super Sani Wipes or with hospital approved cleaning agent.

5. The IUI connectors should not be cleaned with the disinfectant wipes.

6. Wipe the entire unit down with a dampened cloth with water after you have cleaned it with the disinfectant being careful not to touch the IUI connectors.

7. Air dry.

Scope:

RN

Reference(s):

Alaris System Directions for Use. Supports Guardrails® Suite MX with Guardrails® Point-of-Care software and v9 Operating System software. December 2011

Distribution:

Froedtert Intranet

Title: Intake and Output Documentation
Policy Type: PCS Divisional
Department: Clinical - All PCS
Policy Number: C01.065
Origin Date: 06/26/1985
Date Revised: 02/09/2012
Supercedes: 07/24/2009
Topic(s): Documentation
Keyword(s): I&O, intake and output
Purpose: To insure accurate documentation of intake and output.
Policy: A. Intake and Output will be documented per provider order.
 B. Use the Intake/Output flow sheet in Epic to record intake and output volumes.
 C. Documentation of shift totals will be completed prior to 0759, 1559, and 2359.
 D. Use the Intake/Output activity to review the intake and output data.
 E. Patient weights will be done at approximately the same time every 24 hours or as ordered.
Procedure: A. Intake Documentation
 1. Document the volume of intravenous, oral, enteral, and other intake administered.
 2. Document all blood products according to policy #CPM.0061.
 3. Document the percentage of meals eaten.
 B. Output Documentation
 1. Document the volume of urine, emesis, stool, estimated blood loss (EBL) and other output.
 2. Unmeasurable output will be documented as urine, stool or emesis occurrences.
 3. The RN will document the urine, stool, and emesis assessment.
Clinical Record: Epic
References: Smith, S.F., Duell, D.J. & Marin, B.C. (2004). *Clinical Nursing Skills* (6th ed.). New Jersey: Pearson Education
Scope: RN, NE I & II, PCT, PCA, GN
Distribution: Froedtert Intranet
Authorization: Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

 Signature Chairperson Date

 Signature Chief Nursing Officer Date
 Vice President, Patient Care Services

Title: Internet and Email Usage Policy

Policy Type: Corporate

Department: Information Technology

Policy Number: FH-IT.025

Origin Date: 04/14/2011

Date Revised: 5/27/2014

Supersedes: CPA.0047, SJH.ADM.018, 87400-004

Entities Impacted: CMH (x) FH (x) FMLH (x) FMCWCP (x) SJH (x) Others:

Purpose: To define appropriate uses, processes and controls to protect Froedtert Health, its staff and its resources from the risks associated with use of the Internet, Intranet and e-mail systems.

Definitions:

A. eCAR: Electronic Computer Access Request – required to grant access to systems via the Access Controls policy.

B. Protected Health Information – Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:

1. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and
2. Relates to an individual’s past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and
3. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person’s identity (address, telephone number, birth date, e-mail address, and names of relatives or employers).

Froedtert Health will provide e-mail capability and will allow access to its Intranet and to the Internet for applicable staff for business-related purposes, in accordance with the following conditions and guidelines:

SECTION I: E-Mail and Internet Usage

A. General Use

- 1) The internet is to be used in a responsible, ethical and legal manner, and in accordance with the stated objectives of a staff member's job function.
- 2) All patient information sent via an e-mail system is subject to the confidentiality requirements outlined by federal and state laws. By sending e-mails under this requirement, the sender agrees to adhere and comply with these laws.
- 3) Access to the Internet/Intranet will be granted based on completion of the Froedtert Health Computer Access Request (eCAR) form.
- 4) Failure to adhere to this policy and the guidelines listed below may result in suspension and/or termination of the offender's privilege of network or internet access as well as possible corrective action. Persons who make use of the resources of Froedtert Health to access the Internet do so as guests of Froedtert Health and are expected to conduct themselves accordingly. Conduct which adversely affects the ability of others to use the Internet or which is harmful to others will not be permitted.
- 5) Froedtert Health reserves the right to monitor its computing resources to protect the integrity of its computing systems, workstations and Information Technology facilities.
- 6) Froedtert Health staff agree to send/receive internal patient identifying e-mails between the hospitals and MCW based on the users/recipients need to know. By sending/receiving e-mails, Froedtert Health staff agree not to share any patient identifying information to individuals who do not have a need to know or who are not part of the care or services of the patient or do not need the information to perform his/her job.

Policy:

B. Specific Use – The E-Mail System and the Internet are used to support the following objectives:

- 1) Provide for the information needs of Froedtert Health leaders, physicians and staff to carry out his/her job functions, as well as the Medical College of Wisconsin (MCW) Physicians and students.
- 2) Enhance the remote learning potential of the Internet to physicians, leaders and staff.
- 3) Develop the information access skills and knowledge of physicians, leaders and staff.
- 4) Support the professional development needs of physicians, leaders and staff and enhance communication between them and their professional

colleagues.

C. Personal Use - The E-mail and Internet system is to be used to facilitate only Froedtert Health business. Confidential business information is not for personal use and must not be shared outside the organization, without authorization at any time. Staff will not conduct personal business using the Company computer or email account.

D. Prohibited Use - Froedtert Health's E-mail/Internet system may not be used in any of the following ways:

- 1) to harass, intimidate or threaten,
- 2) to access or distribute obscene, abusive, libelous or defamatory material,
- 3) to distribute chain letters,
- 4) to participate in religious or political debate,
- 5) to conduct any type of personal solicitation or solicitation in any form not related to work or job responsibilities.
- 6) to send patient identifiable information or confidential information to non-business related entities without prior authorization from your leader.
- 7) to send patient identifiable or other confidential information to your personal email account without prior authorization from your leader.
- 8) To communicate or conduct personal business such as income tax forms, credit disputes, loan applications, etc

E. Electronic Transmission of PHI or other Confidential Information - All confidential information sent outside the organization (this does not include emails to MCW) must be encrypted using approved industry standard security measures supported by the Froedtert Health Information Technology (IT) Department. Froedtert staff are advised to type the word "SECURE" in the subject line to force the email to be encrypted.

SECTION II: E-Mail/Internet Ownership, Monitoring, and Special Access

A. Property / Ownership - All electronic information, materials and communications stored or transmitted within the Froedtert Health infrastructure are the property of Froedtert Health.

B. Monitoring E-mail & System Usage

1. Information Technology, a manager or other designated individual, when properly authorized, may access and read any message sent or received via the hospital's e-mail system at any time, whether of a personal or business nature. Information contained in e-mail messages may be revealed to authorities to document staff misconduct or criminal activity.

2. To ensure appropriate use and successful operation of Froedtert Hospital's IT systems and the information they contain, it is sometimes necessary for authorized personnel to access and monitor their contents. Statistical information about each user and other measures of system performance, such as number and size of messages sent and received, time spent using the e-mail system, etc., are routinely collected and monitored by system administrators. While the goal of this type of monitoring is to evaluate and improve system performance, any evidence of violations of this electronic communications policy discovered in the course of this type of monitoring will be reported to the appropriate Froedtert Health leaders.

C. Internet Access Exceptions - Generally, access to internet sites unrelated to the business of healthcare will be restricted, including social networks and web based email accounts. Exceptions can be granted to such restrictions based on compelling business or clinical reasons with executive level approval.

Procedure:

None

Related Policies:

- A. FH-IT.035 – Electronic Access Controls Policy
- B. HIPAA Privacy Policy Regarding Transmission of known ePHI
- C. HIPAA Security Policy for Auditing and also for ePHI technical Safeguards
- D. HIPAA Security Rules: §164.308(a)(4) and §164.312(b)

Distribution:

Froedtert Health Corporate Policy & Procedure Manual: Information Technology Section

Signatures on File

_____ Date: 5/29/14
Hector Joseph, Director and Chief Technology Officer

Authorization:

_____ Date: 5/29/14
Robert A. DeGrand, Vice President & Chief Information Officer

_____ Date: 6/2/14
Dennis Pollard, Senior Vice President – Chief Operating Officer

Title: Isolation
Policy Type: PCS Divisional
Department: Clinical - All PCS
Policy Number: C01.067
Origin Date: 9/29/1980
Date Revised: 10/9/2013
Supersedes: 8/4/2012
Topic(s): Safety / Security
Keyword(s): Isolation

Purpose: To prevent the acquisition and distribution of nosocomial pathogens within the hospital environment. To prevent the transmission of communicable diseases and infection by minimizing contact with the infectious source.

A. The Infection Control staff, Froedtert nursing staff and the medical staff have the responsibility of following appropriate infection control practices relating to patient isolation. Therefore, it is necessary to involve the Infection Control staff in authorizing the discontinuation of all patient isolations. (see also policy Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately. in the online Infection Control Manual)

B. The Infection Control Coordinators will be available for infection control concerns from 7:30 a.m. - 4:00 p.m. on weekdays and from 7:00 a.m. - 1:00 p.m. on Saturdays. Dial 805-3608 with any questions.

C. Isolation measures, according to the guidelines in the Infection Control Manual, will be ordered by the physician or nurse responsible for the care of the patient. In the absence of a physician order, the Infection Control Nurse will be notified and the nursing staff will initiate appropriate isolation measures.

D. Physicians, students, hospital personnel and visitors will comply with the procedures outlined on the isolation sign placed outside the patient's room.

Policy:

E. Discontinuation of isolation measures will require an order from the Hospital Epidemiologist or Infection Control Coordinator.

F. Coordinator Documentation

1. Infection Control department documentation of isolation in the history section and by use of the FYI flag should not be changed by staff.

2. The Infection Control Staff review daily culture results and track patients placed in isolation.

G. Initiating Isolation

1. A green clip will be placed on the patient's white patient alert armband.

2. An isolation cart and the appropriate isolation sign will be placed outside of the patient's room.

H. Negative Pressure Isolation

1. When initiating airborne or airborne/contact isolation requiring a negative pressure room, nursing will place the key switch in the negative position and Plant Operations will be notified. When negative pressure is used the door will be closed and the inner nurse server cabinet door will be kept closed.

2. When discontinuing negative pressure, nursing will return the key to the neutral position and Plant Operations will be notified.

I. Transfer or discharge of isolated patients.

1. When transferring a patient in isolation to another unit the isolation sign will not be removed until the room has been cleaned by EVS.

2. When discharging a patient in isolation, the isolation cart and sign will not be removed until the room has been cleaned by EVS.

3. The hospital epidemiologist and infection control coordinators will be available to discontinue isolation on patients from 7:30am-4:00pm on weekdays and from 7:00am-1:30pm on Saturdays. Dial 805-3608 with any questions.

J. Dispensing Medications to a Patient in Isolation

1. Touchable surfaces will be cleaned every shift with a 10% bleach wipe and allowed to dry. A FDA hospital approved disinfectant wipe (Cavi Wipe) must be used after the surface has dried to remove the bleach residue.

2. Nursing staff will ascertain and collect medications prior to entering the patient room.

A. Contact Precautions (ie., Multi-drug resistant gram negative bacteria and MRSA, etc)

1. Isolation may be discontinued (by Infection Control coordinator) once a negative culture from infected or colonized site is obtained 48 hours after discontinuation of antibiotics.

2. Personal Protective Equipment (PPE)

a. Gloves should be worn when entering patient room. Change gloves after having contact with infective material that may contain high concentration of microorganisms.

b. A gown will be worn when entering patient room if you anticipate contact with environmental surfaces or items in the patient's room. Wear a gown if the patient is incontinent, or has diarrhea, an ileostomy, colostomy or wound drainage.

3. Limit patient transport to essential purposes only. During transport, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces and equipment.

Procedure:

B. Airborne Precautions (i.e., TB)

1. Active TB - Isolation may be discontinued by an Infection Control coordinator once patient has received effective therapy for at least two weeks and is improving clinically.

2. Rule out TB

Isolation may be discontinued by an Infection Control coordinator once three consecutive negative sputum AFB smears have been collected on different days (preferably in the morning). If unable to collect a sputum specimen, a BAL may be ordered and sent for AFB.

3. PPE

a. An N95 respirator should be worn when entering the room of a patient with known or suspected infectious pulmonary tuberculosis.

b. Limit patient transport to essential purposes only. Use surgical mask on patient during transport.

C. Special Precautions

1. VRE - Isolation may be discontinued by an Infection Control

coordinator after three consecutive negative VRE cultures (taken at least one week apart) from stool, rectal or perirectal specimens and one negative culture from any other body site that was known to be colonized/infected with VRE off antibiotic treatment for 48 hours.

2. Rule Out C difficile

- a. One stool specimen should be ordered to rule out C. difficile.
- b. Patients should be put into special isolation during the time C. difficile is being ruled out.
- c. Isolation may be discontinued (by Infection Control coordinator) once a negative stool specimen has been obtained.

3. C. difficile - If a positive culture is obtained, the patient must remain in special isolation for duration of hospitalization.

4. PPE - Gowns and gloves must be worn at all times when in a special precaution room.

5. Patient Transport

a. Patient is restricted to room and may leave only if necessary for medical reasons.

b. If a road trip is necessary, cover transport vehicle with a clean sheet. Patient should wear a clean gown and wash hands prior to leaving room and the vehicle should be cleaned after transport with a bleach wipe.

D. Droplet

1. PPE - A mask should be worn when working within 3 feet of patient (or upon entering room).

2. Limit patient transport of patient from room to essential purposes only. Use surgical mask on patient during transport.

E. Airborne/Contact

1. PPE - Follow guidelines under airborne precautions and contact precautions.

2. Patient transport - patient should wear regular face mask if being transported outside of room. Limit transports to essential purposes only.

F. Contact Infection Control for specific recommendations⁷⁹

for discontinuing isolation or refer to Addendum II in the Infection Control Website under the isolation precautions section.

Smith, S.F., Duell, D.J. and Martin, B.C. (2004). Clinical Nursing Skills (6th ed.). New Jersey: Pearson Education

References:

CDC Isolation Guidelines

Froedtert Infection Control Manual

Scope:

RN, LPN, NE, ICT, MA, PCT, PCA, HUC

Distribution:

Froedtert Intranet

Title: Medication Documentation

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.069

Origin Date: 5/13/1982

Date Revised: 6/25/2014

Supersedes: 1/9/2014

Topic(s): Documentation

Keyword(s): Medication documentation, med documentation, MAR

Purpose: To describe the procedure for documenting medications in Epic on the Medication Administration Record (MAR) and the utilization of Bar Coding.

- A. All medications Intravenous (IV) Fluids minibag IVs and Total Parenteral Nutrition (TPN) will be documented on the MAR in Epic.
- B. The electronic documentation is the medical record.
- C. Any printed versions of the MAR will not be considered part of the medical record.
- D. Nurse Extern and Nursing Students will document medication administration in accordance with Policy .
- E. Documentation will be completed at the time of medication administration to prevent potential duplication by a co-RN. In the case of medications being administered for emergency use the documentation should be completed as soon as the patient is stable or conditions are appropriate.
- F. The responsible RN is to assure all medications are given and documented in the MAR for their shift prior to leaving the unit or department or prior to the patient being transferred to a different unit.
- G. Every attempt will be made to scan the patient's armband. If unsuccessful due to a worn arm band a new band will be retrieved, information verbally verified with the patient and armband placed on the patient prior to scanning. Reasons for not scanning a patient will be entered into the MAR.
- H. Every attempt will be made to scan a medication prior to administration. Reasons for not scanning a medication will be documented in the MAR.
- I. Before administering any medication, the RN will ask the patient if he/she is familiar with the medication. If not, the RN will educate the patient on the new medication and document in the MAR Comments Field.
- J. The RN will ensure informed consent for the use of an investigational drug or documentation by the provider for use of an investigational drug for emergency use is in the patient chart prior to verification. If there is no consent or documentation for emergency use then the RN will notify the Nurse Manger or Administrative Supervisor.

Policy:

K. The RN will notify their Nurse Manager or Administrative Supervisor that an investigational drug is being administered.

A. General

1. To ensure patient safety and congruency of multiple sources of allergies, the RN and/or pharmacist will document all allergies in Epic.

2. When bar coding, if a "Med Order Not Found" bar coding alert is encountered, the RN will cancel the alert and hold the medication until reverified with pharmacy staff.

3. If bar coding is unavailable the RN will change the "Given Time" to the actual time given.

4. Education of New Medications is to include: the classification of the medication and any potential clinically significant adverse drug reactions. This education will be documented in the comments field of the MAR. Exclusions to New Medication Education include: Emergency situations and patients who are confused or unresponsive and do not have a designee present.

Procedure:

5. All actions completed in MAR are tracked and recorded by the name and login of the user. You must always log off the computer when finished. Never leave an open program unattended.

6. During times that one patient is cared for by two RNs, i.e. overlap, the RNs must communicate prior to administering a medication to the co-RN to ensure that the medication has not been given.

7. Any medication pulled on override from Med Select or floor stock will require a subsequent order to be placed.

8. Documentation of medication after the patient is discharged and no longer is listed for that particular unit, can be done so by selecting the correct encounter from Patient Station and documenting in the MAR activity section.

B. Actions

1. Given - Medication was given (time given, initials of RN and the dose will appear in green). Comments will be entered if specific lab values are needed to justify dosing. If the patient does not take

the medication and it is discovered after documentation, edit the entry by canceling entry.

2. Held – The “held” action is based on the physician orders, parameters and critical nursing judgment. The intent is not to give the medication and a comment must be made as to the reason (time held and the RN holding the med will appear in pink).

a. Any one time hold orders, the RN will document "held" and make a comment.

b. Note: If hold order is written as hold medication without specifying length or number of doses the medication will be discontinued by pharmacy and will need a new order from the MD to restart.

c. Note: If a nurse holds a medication based on clinical judgment, the nurse will document on the MAR of the EHR rationale and provider notification of actions. Any additional documentation is provided in the progress notes of the EHR.

3. Missed – Used on a medication that is not given on time, but you have the intention to give it at a later time. Choose a reason for missed such as; sleeping, or no IV access (time will be displayed in red with parentheses around it). If time is to be adjusted due to missed dose refer to the Electronic Medication Administration Record - Administration Time Changes policy. CL-06.100 Comment needed.

4. Refused – Patient refused to take medication.

5. Canceled Entry – Used when any of the above entries were chosen in error (time of dose will appear in black with a line through it) comment needed.

6. Due – Used in conjunction with cancel entry to alert the RN when the medication is due. Can be used to change the due time of a medication once.

7. Med D/C'd – Used by RN when provider writes an order to discontinue a medication to communicate to other care givers not to give medication prior to pharmacy discontinuing medication from the MAR.

8. Sent to OR – Used to communicate that this medication was ordered for the patient and sent with them to the OR.

9. RX Dispense – Used only by Pharmacy for medications sent to different departments.

10. Currently Infusing - Used when a patient is transferred with IV fluids running and the order has not changed.

11. Rate Verify - Used when medication drips are recorded in the Doc Flowsheet activity without change from the previous rate documented.

C. IV Fluids/Continuous Infusions

1. New Bag - All new bags of maintenance IV fluids or titratable continuous medications will be scanned.

2. Rate Change -

a. For rate changes of a maintenance IV fluid, a new order must be placed and sent to pharmacy. Rate changes for maintenance IV fluids will be scanned and documented from the MAR.

b. Rate changes for titratable continuous medications can be recorded from the Doc Flowsheet activity or from the MAR. The action of rate change is used when a rate different from the previous rate is documented in the Doc Flowsheet activity.

3. Rate Verify - Used when medication drips are recorded in the Doc Flowsheet activity without a change from the previous rate documented.

4. Currently Infusing - Used when a patient is transferred with IV fluids running and the order has not changed.

5. Transferred Patients with Continuous IV – Orders placed for transfer and the IV solution did not change. The solution will appear with a start time and the RN will choose currently infusing.

6. Titratable Continuous Medication Infusion – A titratable parameter will appear on the MAR. Pharmacy will not enter a fixed rate. The initial order will come up with a due time. The RN will document the actual time the medication was hung.

a. Changes to titratable infusion rates or specific dosages are

documented in the Doc Flowsheet activity. The changes will show in the MAR with an action of Rate Change or Rate Verify.

b. For drips overridden from the AcuDose, documentation in the Doc Flowsheet activity will not be available until the order has been placed.

7. Drips Ordered at a Specific Rate - Drip will appear as a new order without a rate. RN will document the time the drip was started and enter the rate ordered by the physician.

D. Bolus

1. Fluid Bolus (Current IV solution or different IV solution) – Are not documented in MAR. Use the Intake/Output flow sheet in Epic to record volumes, document type of solution in comment field.

2. Medication Bolus (i.e. Diltiazem (Cardizem), Esmolol, Eptifibatide (Integrellin), Nesiritide) - Medication bolus will appear on the MAR as a separate order with a due time.

E. Heparin Bolus and Heparin Drip Order Set

1. The heparin drip order set will be completely entered into the MAR.

2. The initial heparin bolus will be a separate line item for documentation. Subsequent boluses will be in the PRN section of the MAR.

3. Heparin infusions including new bags and rate changes will be scanned (patient wristband and medication bag) and documented in the MAR. Select the appropriate MAR action and enter units/hr in the dose field or ml/hr in the rate field. Document the Current UFH level and Next UFH level Due Time in the associated flow sheet rows in the MAR screen.

4. If heparin protocol indicates stopping the drip for an amount of time, document using the action of "Stopped" and "Restarted" as appropriate in the MAR.

5. RN will place an order in the Electronic Health Record⁸⁸

(EHR) for the next UFH level draw time using the "per signed prescribing provider" order mode.

6. Use the medication library to set the heparin infusion rate in units per kilogram per hour (units per hour may be ordered in specific patient situations). The volume to be infused on the pump should be set for a maximum of four hours.

F. Insulin and Insulin Drips

1. Insulin Drip – Insulin protocol will appear on the MAR. Pharmacy will not enter a fixed rate. Infusion rates or specific dosages will be documented on the MAR. Rate changes will be documented by scanning the patient wrist band, scanning the medication infusing and documenting new rate with an action of Rate Change.

a. Combination Insulin Orders – Each insulin type will appear as a separate medication line and the RN will need to document on each.

b. Insulin Bolus – Document in the PRN section per insulin protocol.

G. Patch Medications

1. Will appear on MAR in the scheduled medication section. RN will document location of patch in the site and in the comments section.

2. If the patch has a drug free interval a separate order will appear for the RN to document patch removal.

H. PRN Medications

1. PRN medications will be given by scanning the patient wristband and scanning the medication in the MAR

2. Medication administration justification will be documented in a

note or on specific flow sheets.

I. PCA Medications

1. Documentation of PCA syringes will be in the MAR by scanning the patient wristband and PCA syringe. Rate changes will be documented by scanning the patient wristband and syringe through the cover of the infusion pump.

2. Dual sign-off in the MAR is required on any PCA syringe documentation except for the action of "Held."

J. Edit Administration

1. To be used on ones own entry only after the RN has "accepted" or saved an entry in error.

2. When an error is noted in the original entry entered by another RN; the documentation will be edited with a comment written as follows: Administered by: (RN's legal name)
Documented by: (RN's legal name).

K. Pharmacy In-Basket Messaging

1. To be used as a communication tool between RN and Pharmacy. Messages can be linked to specific patients to allow easy transfer of information.

a. Use the In-Basket message with routine priority if the medication is needed within 45 minutes.

b. High priority should be used if the medication is needed within 30 minutes of the request and/or delays would likely result in adverse patient outcomes.

c. If the medication is needed within 15 minutes and lack of dose would likely result in patient harm then call your unit pharmacist when available, otherwise the central pharmacy by phone.

L. Med Select

1. Override Medications – Med Select communicates directly

with Epic. When medications currently not on the patient's profile are dispensed via override from the Med Select, the medication will be displayed on the MAR as a tan line in the Completed Medication section of the MAR

- a. Any medication pulled on override from Med Select will require a subsequent order to be placed.
- b. The RN will document administration.

2. Crediting an Override Medication

- a. If the medication retrieved from the Med Select via the override function is not administered the RN will document Canceled Entry on the tan line for the medication.
- b. The RN will return any unopened medication to the Med Select.
- c. The RN will document medication wasting in the Med Select according to Policy Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.

M. Patient Using Own Meds (and hospital meds at home)

1. As an Inpatient – All medications ordered by the provider listed in the formulary will be provided by pharmacy. Special consideration will be taken if medication is unavailable or not on the formulary. Please see Policy #CL07.000.

2. When on Leave from the Hospital – Document each medication dose that was sent with the patient as Missed and document reason as “patient on pass”. When the patient returns from pass, the RN will document in a progress note the time the patient returned and whether the patient reports they took the medication. The RN will then go back to each missed medication and edit the entry to “Given” with a comment stating the patient took the meds.

3. Respite (Hospice Patients) – Any medication the patient is taking from home will need to be ordered specifically by the provider and verified by the pharmacists. “Patients own medication” will display in the administration instructions.

N. Moderate Procedural Sedation

1. Documentation of incremental doses administered during the procedure will be on the IP Procedure flow sheet in the EHR.

2. Documentation of the total doses of each medication administered will be on the MAR.

O. Pre-Operative/Pre-Procedure Medications

1. Orders for preoperative medication for inpatients will continue to be routed to pharmacy for processing.

2. Provider will place a sign and held order into the EHR with a specific phase of care associated with the order.

3. The RN will release the order to become active at the appropriate phase of care. (Ex. Pre-op, PACU, Post-op)

4. The pre-op/procedural med administration will be documented on the MAR in Epic.

P. Surgical Patients

1. All medications are put auto hold while patient is in surgery.

2. The provider will complete order reconciliation after the procedure is completed.

3. RN will release the sign and held orders when the patient arrives on their unit.

Q. Respiratory Therapy (RT) medications

1. All RT medications will appear as an Active medication on the MAR.

2. RT will document administration in the MAR.

R. Dialysis Medications

1. Dialysis RNs will administer medications to be given in dialysis.

2. These medications will be distinguishable by:

a. The unique frequency of: "Phase of Care: Dialysis⁸²"

b. The medication will be documented by the dialysis nurse in the MAR.

Scope: RN, NE, Nursing Students

The Wisconsin Board of Nursing Standards of Practice N6.03 (2) C Standards of Practice p. 15

References:

Rules of Conduct from the Board of Nursing (*N7.03, (1) E,F Rules of Conduct p. 112*) State of Wisconsin Nursing Code Book, 10/2012

Smith, S.F., Duell, D.J. & Martin, B.C. (2011) *Clinical Nursing Skills* (8th ed.). New Jersey: Pearson Education.

Distribution:

Froedtert Intranet

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Authorization:

—		
Signature	Chairperson	Date

—		
Signature	Chief Nursing Officer	Date
	Vice President, Patient Care Services	

Title: Medication Management

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.068

Origin Date: 9/29/1980

Date Revised: 5/31/2013

Supersedes: 8/4/2012

Topic(s): Drug Therapy

Keyword(s): Medication administration, med administration, MAR, eMAR

Purpose: To define the responsibility of the Nurse in the administration of medications to patients.

A. A unit dose system is used. All medications ordered specifically for an individual patient are secured in the locked drawer in the patient supply cabinet or Med Select Cabinet. The drawer is restocked daily by pharmacy.

B. Medication Keys

1. All keys not signed out to an RN will be locked in a cabinet/drawer.

2. Each RN is responsible for a medication key.

3. Any person who carries a narcotic key away from the hospital must notify the Manager, Director of Nursing or Administrative Supervisor immediately. The key must be returned at once.

4. Missing keys must be reported to the Manager, Director of Nursing or Administrative Supervisor immediately.

C. Medications may only be administered when there is a current, valid physician order and they have been verified by pharmacy unless auto verify is approved in your department.

Policy:

D. The RN must consult with a physician or pharmacist in cases where the RN knows a prescribed medication or route of administration may harm a patient.

E. Nursing students may administer medications under the supervision of their instructor or RN in accordance with Corporate Policy .

F. Graduate Nurses (GN) may pass medications after passing the medication competency test in orientation.

G. The Nurse Extern (NE) may administer medications only:

1. After successful completion of the medication examination.

2. After successful completion of competencies and review of policies related to:

a. Medication administration and documentation

b. Use of intravenous pump

c. Oral, rectal, subcutaneous, intravenous, topical and

eye/ear drop techniques

d. Heparin/enoxaparin (Lovenox), insulin, narcotic procedures

e. Intramuscular procedures

3. After successful completion of clinical unit orientation with RN preceptors from their assigned unit.

4. On the unit in which they were hired on

5. After the RN accountable for the patient checks and approves of medication to be administered.

6. In accordance with Corporate Policy .

H. The NE may administer:

1. Oral medications

2. Medications administered intravenously (outlined on the Unit Specific IV Push Medication Addendum that was developed by the unit educators and unit pharmacists).

3. Subcutaneous Insulin

4. Subcutaneous Heparin and enoxaparin (Lovenox)

5. Rectal medications

6. Eye drops and ear drops

All medications will be checked and approved for administration by the RN accountable for the patient.

I. Before administration of any medication, the nurse will validate that the correct patient is receiving the correct dosage of the correct medication at the correct time by the correct route.

(When applicable, check expiration dates also, i.e., vials, antibiotics, IV mixes). All patients will have their identification verified by the barcode scanner prior to medication

administration. If unable to scan barcode or if bar coding system is unavailable, verify patient identification by asking the patient to state their name and birth date or check patient ID band for name and birth date. (See Policy - Identification of Patients) The nurse will be aware of patient allergies prior to medication administration.

J. Every attempt should be made to administer medications as scheduled. A medication that is scheduled to be given every 4 hours or more often will be administered within 30 minutes of the scheduled time (30 minutes before or 30 minutes after).

K. If a medication that is scheduled to be given every 4 hours or less frequently, the medication will be administered within one hour of the scheduled time (one hour before or one hour after).

L. If the omission of a medication for any reason represents a danger to the patient, the medical team and Nurse Manager (or Administrative Supervisor, if appropriate) must be notified immediately.

M. Wasted doses of any medications are to be discarded appropriately, i.e., in a sharps container. Never discard in a wastebasket. Wasted doses on controlled substances must be documented in the Med Select Cabinet (See Policy - Med Select Cabinet).

N. Labels on medication containers may be changed only by the Pharmacist.

O. Medications are not to be left at a patient's bedside, unless a specific order has been written by the physician.

P. Medications brought into the hospital by the patient are to be:

1. Returned home with a relative; or
2. Locked in the patient medication cabinet. See Policy - Handling, Storing and Record Keeping of Patients Own Medications.
3. If a physician orders patient to take own medications, they must be identified by the Clinical Pharmacist and stored according to Policy - Patient Supplied Medications and Other Medications From an Outside Source.

Q. When a patient is discharged or dies, all unused medications are returned to the inpatient pharmacy. For return of patients own medications in the event of patient death, see Policy - Valuables and Patient Belongings.

R. Investigational drugs require that an informed consent be obtained from the patient or legal guardian by the physician.

1. Contact the pharmacy for specific direction.
2. The RN will ensure informed consent for the use of an investigational drug or documentation by the MD for use of an investigational drug for emergency use is in the patient chart prior to verification. If there is no consent or documentation for emergency use then the RN will notify the Nurse Manager or Administrative Supervisor.

3. The RN will notify their Nurse Manager that an investigational drug is being administered.

S. In the event of a medication error, complete an incident report form and refer to Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately. .

T. In the event of an adverse medication reaction, the RN will notify:

1. The Physician.
2. The Pharmacist, who will initiate appropriate follow-up. The RN will document the reaction in the patient's medical record.

U. All preoperative or "on call to OR" medications will be dispensed and given to patients in the Pre-Op Holding Area, unless a specific physician order is written.

Scope: RN, NE, GN

Distribution: Froedtert Intranet

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Authorization:

Signature	Chairperson	Date

Signature	Chief Nursing Officer	Date
	Vice President, Patient Care Services	

Title: Med Select Cabinet (Automated Drug Dispensing System)

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.260

Origin Date: 11/5/1997

Date Revised: 4/5/2013

Supersedes: 8/4/2012

Topic(s): Drug Therapy

Keyword(s): Med Select, ADDS, ADC, Automated Drug Dispensing System

Purpose: To establish a method for stocking, refilling, tracking and billing medications dispensed through an automated dispensing system.

ADS = Automated Drug Dispensing System

AWS = Administrative Work Station

ADC = Automated Drug Cabinet

BIO ID = Biometrics Identification = The use of a staff member's fingerprints as a means of identification.

Definition(s):

Waste = The act of discarding a portion of a medication when the dose ordered differs from that which is supplied in the Med Select cabinet.

Return = The act of returning a medication, in its original package, unaltered, to the Med Select cabinet.

Witness = A person who is authorized to view and corroborate the transaction(s) of another user.

A. Access to Med Select cabinets will be strictly maintained by pharmacy to insure adequate security for medications, including controlled substances and to provide proper documentation of medication use.

B. Access to the Med Select cabinets will be granted when a Med Select Access Form is completed by a user and signed by the Nurse Manager, Manager for that unit, or their designee.

C. Access to a display terminal will require two forms of ID:

- Proximity Card
- Bio ID
- Login

D. Medication orders will be reviewed by a pharmacist prior to administration of the drug with the following exceptions:

1. A physician controls the ordering, dispensing and administration of the drug, such as in the operating room, endoscopy suite, ED, cath lab and L&D.

2. Emergency situations when time does not permit a review by a pharmacist such as STAT orders or situations when patient harm could result from a delay in administration of the medication. In these situations, medications will be available via the Override function only if they have been flagged by Pharmacy to allow Override. This list of Override medications will be approved by the PNT Committee on an annual basis.

E. The list of override medications will be approved by the PNT Committee as needed and on an annual basis.

F. Any noncontrolled medication that is removed from the Med Select cabinet, remains in its original package and is not administered to the patient, will be returned to the corresponding pocket in the Med Select cabinet.

G. Any noncontrolled medication that is removed from the Med Select cabinet with packaging that is not intact and is not administered to the patient will be wasted.

H. Any controlled medication that is removed from the Med Select cabinet, removed from its original packaging, and not administered

Policy:

to the patient will be wasted. A witness is required to document wasting of controlled substances.

I. Any controlled medication that is removed from the Med Select cabinet, remains in its original packaging and is not administered to the patient will need to be placed in the Return Bin in the Med Select cabinet. Pharmacy personnel are responsible for emptying the Return Bins and providing appropriate accountability. If a controlled medication that is intended to be placed in a Return Bin is too large for that bin, Med Select will direct the user to return that product to the correct bin.

J. Controlled substances stored in the Med Select cabinet will be inventoried every Monday morning by two RNs.

K. Med Select cabinets will be checked for discrepancies by the shift coordinator or designee at the conclusion of each shift. Resolution of any controlled substance discrepancies will be the responsibility of the shift coordinator or designee. The Nurse Manager is responsible for reporting any unresolved discrepancies in Midas as a miscellaneous issue.

L. Pharmacy personnel will be responsible for replacing out of stock medications. Nursing personnel will have the ability to restock non-controlled medications.

M. When necessary, pharmacy will be responsible for a manual opening of the Med Select Cabinet. Controlled substances inventory will be transcribed on the Controlled Drug Administration Record, documentation and charging will be completed using the Controlled Drug Administration Record and inventory of controlled substances will be reconciled jointly by pharmacy and nursing staff and Controlled Drug Administration Record will be returned to pharmacy.

N. Medication expiration dates will be tracked in Med Select.

A. Access and Login

1. Users requiring access to Med Select must complete the Med Select Access Request Form located on the Pharmacy SharePoint site and forward to Pharmacy.

2. Users will be required to change their PIN every 90 days.

3. User logins will expire after 270 days after their account has been idle.

Procedure:

B. Dispensing Medications

1. A blind count remaining for all controlled substances must be entered.

C. Wasting Medications

1. When documenting waste of a controlled substance, another user with witness privileges must document their witness of the actual disposal of the controlled substance in Med Select.

Scope:

RN

Distribution:

Froedtert Intranet

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Signature	Chairperson	Date
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Authorization:

Signature	Chief Nursing Officer Vice President, Patient Care Services	Date
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Signature	Pharmacy Director	Date
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Title: Orders - Patient Care

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0172

Origin Date: 5/15/12

Date Revised: 8/28/2012

Supersedes:

Topic(s):

Purpose: The purpose of this policy is to provide staff with a summary of the requirements for safe ordering practices in all care settings by the disciplines that comprise the healthcare team.

Acknowledgement of an Order-An acknowledgement that the orders have been reviewed.

Allied Staff RN – Registered Nurse (RN) that is employed by a physician and not by the hospital.

Authentication of Orders - When orders are dated, timed and signed by an individual authorized by this policy to order (either by signature or computer entry with the name and discipline). Refer to Section B of this policy.

Clinical Trial Protocol – A document approved by the hospital’s IRB that describes the objective(s), design, methodology, statistical considerations, and organization of a clinical trial. The protocol describes, among other things, what types of people may participate in the trial; the schedule of tests, procedures, medications, and dosages; and the length of the study.

Computerized Order Entry (COE) - A computer system that allows direct entry of medical orders.

Diagnostic Services – An examination or procedure to which the patient is subjected or which is performed to obtain information to aid in the assessment of a medical condition or the identification of a disease.

Electronic Health Record (EHR) - A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting.

Invasive – When the skin or mucosa is penetrated.

Legal Healthcare Record (LHR) - The documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization. The LHR is individually identifiable data, in any medium, collected and directly used in and/or documenting healthcare or health status. It is the legal business record generated at or for a healthcare organization. This record would be released upon request.

Order Set/Smart Set – A tool generally used to assist Prescribing Providers as they write/enter orders. Such tools may include a menu of medications or actions from which the qualified Prescribing Provider makes selections to be applied to a particular patient. An individual may use order sets/smart sets in order to enter verbal or telephone orders if they are authorized to accept them.

Pend – Orders that are entered into the COE system, but are not transmitted to be processed or acted upon. Requires the signature of the supervising/ordering Prescribing Provider before the order can be processed or acted upon.

Prescribing Provider – For the purpose of this policy, a Prescribing Provider is:

- A Doctor of Allopathic or Osteopathic Medicine, Oral Surgeon, Dentist and Podiatrist who is credentialed by Froedtert Hospital and permitted by law to provide care, treatment, teaching or research services in the Hospital without direction or supervision.
- A Resident or Fellow who is enrolled in an accredited graduate medical

Definitions:

education program (GME) sponsored by the Medical College of Wisconsin Affiliated Hospital, Inc. (MCWAH), or who has been granted permission to rotate to Froedtert Hospital within a MCWAH sponsored program, and is permitted by law to provide care, treatment or conduct research in the Hospital with the supervision of a physician or oral surgeon credentialed by Froedtert Hospital.

- An Advanced Practice Nurse Prescriber (APNP), Clinical Nurse Specialist with Prescriptive Authority, or Physician Assistant (PA) that is credentialed through the Hospital Medical Staff Office, and based upon his/her collaborative agreement with his/her supervising physician.

Professional Medical Personnel - An RN, Physician Assistant, Allied Staff RN, Clinical Nurse Specialist (CNS), Respiratory Care Practitioner/Respiratory Therapist, Physical Therapist, Nurse Practitioner (NP), Occupational Therapist, Speech Pathologist, Registered Pharmacist, or Radiation Therapist.

Protocol - Precise and detailed plans for the study of a medical or biomedical problem and/or plans for a regimen of therapy (i.e., Chemotherapy Protocol, Clinical Research Protocol).

Protocol Order– For the purposes of this policy, a protocol order is a set of orders that are consistent with nationally recognized guidelines, developed by qualified Prescribing Providers that are designed for standard management of a patient population with specific diseases, health problems, or sets of symptoms. Such orders delineate under what set of conditions and circumstances action should be implemented when patients present themselves prior to being examined or evaluated by a Prescribing Provider, and can only be initiated in urgent, patient safety situations, or for timely and necessary care.

Telephone Order (T.O.) – An Order from a Prescribing Provider given directly to an individual over the telephone and is co-signed by the Prescribing Provider.

Therapeutic Services – Services that aid the physician or practitioner in the treatment of the patient.

Transcribed Order -An order that is entered into the COE system, which is already written on paper and authenticated by the Prescribing Provider or a physician who does not have medical staff privileges. The original written order is retained in the Legal Healthcare Record.

Verbal order (V.O.) – An order from a Prescribing Provider given directly to an individual face to face and is co-signed by the Prescribing Provider.

A. Order Requirements

1. All Prescribing Providers ordering services in ambulatory or inpatient settings with reasonable access to the EHR Order Entry tools will enter their orders into the COE system. The only exception to this is the following:
 - a. Downtime
 - b. Orders for patients receiving alcohol and/or drug treatment services (AODA)
2. When individuals other than the Prescribing Provider are entering inpatient orders into the system, they must use the appropriate Order Mode (See Attachment Active Ordering Modes).
3. Physicians, NPs, PAs, and APNPs who do not have medical staff privileges, ordering outpatient services that do not have reasonable access to the EHR Order Entry tools may write, fax, or mail orders as long as they include the patient name, date of birth, diagnosis, and the ordering practitioner's name and signature with date and time. The order will be entered as a Transcribed Order.
4. All therapeutic, diagnostic and medication orders must have an order that is authenticated in the EHR.
5. All orders must be written clearly and completely. Orders that are improperly written will not be carried out until rewritten and understood. Hand-written orders must be written legibly.

Policy:

6. All inpatient orders when carried out or implemented must be acknowledged with the individual's initials/name, date, and time, and should be reviewed for appropriateness
7. All outpatient orders for diagnostic and therapeutic services must include the medically necessary clinical indication for the service, patient name, address, date of birth, date the order was issued, name, address and business telephone number of the Prescribing Provider or of the physician, NP, APNP, and PA who do not have medical staff privileges
8. Outpatient orders are valid for one year or as long as medically necessary, whichever is shorter.

B. Who May Order

1. Prescribing Providers may order inpatient care services, outpatient therapeutic and diagnostic services, and medications.
2. Prescribing Providers may order outpatient therapeutic services to be carried out at any of the Froedtert Health Affiliate hospitals.
3. When a Prescribing Provider no longer has medical staff privileges, any orders that were previously placed for therapeutic services become invalid and must be re-ordered by another Prescribing Provider.
4. Only physicians with medical staff privileges or authorized oncology fellows can order high risk hazardous drugs (i.e. chemotherapy) for oncologic

indications. These orders which are entered into the COE system by an APNP or PA must be queued up and can not be acted upon until signed by the physician unless they are modifications to existing chemotherapy orders, then refer to C(1)(g) of this policy.

5. Only physicians with medical staff privileges are authorized to admit patients to the hospital. This can be accomplished by the physician entering the order into the COE system, or by providing a verbal or telephone order to an individual authorized to accept verbal or telephone orders so they can enter it into the COE system.

6. Chiropractors may order diagnostic tests related to musculoskeletal disorders.

7. Nurse Practitioners (NP's) with medical staff privileges may order therapeutic (non-medications) and diagnostic services.

8. Certified Registered Nurse Anesthetists (CRNAs) with medical staff privileges may order inpatient or outpatient therapeutic and diagnostic services, and medications. Froedtert Hospital requires all CRNA orders to be co-signed by their collaborating physician.

9. Physicians, NPs, APNPs, and PAs who do not have medical staff privileges and/or who are not licensed in the State of Wisconsin may order outpatient non-invasive diagnostic services, and physical, occupational, and speech therapy services.

a. Outside of drawing labs or IV placement for delivery of contrast, non-staff physicians may not order invasive services or testing.

b. If departments decide to accept out of state orders or orders from physicians that are not on the medical staff, the following must be completed by the department accepting the order and providing the service:

(1) Check the Medicare List of Excluded Individuals/Entities Database to make sure the physician is not listed-

(2) Check the National Provider Identifier Database to determine if the physician has a valid NPI-

(3) Check the State and Government Licensing websites to verify the physician has a valid state license (Refer to Attachment- *US Licensure Boards*)

(4) If a valid state license cannot be verified, the order is deemed invalid. The patient should be referred to Appointment Services for a Froedtert Health clinician referral (414-805-6633).

c. Written orders from physicians who do not have medical staff privileges will be entered into the COE system by an individual authorized by the department accepting the order. These will be entered as a Transcribed Order.

10. Medical students may write/enter orders but they shall not be acted on until countersigned by a Prescribing Provider (must be pended in the COE system).

C. Verbal/Telephone Orders

1. **Verbal/Telephone Order Requirements:**

- a. Verbal or Telephone orders, if used, must be used infrequently and should not be a common practice.
- b. Verbal orders shall be used only in emergent situations and when access to the EHR would delay care and treatment.
- c. Telephone orders should be used only to meet the care needs of the patient when it is impossible or impractical for the Prescribing Provider to enter the order into the EHR without delaying treatment. Telephone orders are not to be used for the convenience of the Prescribing Provider.
- d. Verbal and telephone orders must be authenticated by a Prescribing Provider who is responsible for the care of the patient within 48 hours of receipt (co-signed). (This provision is premised upon approval by the Wisconsin Department of Health Services of a pending requested waiver of the CMS CoP's requirement of authenticated within 24 hours. If the waiver is not granted, authentication within 24 hours will be required.)
- e. The verbal/telephone order should promptly be entered into the COE system or written in the LHR. The Prescribing Provider's name, receiver's name and appropriate professional title must be identified. The entry shall be dated and timed.
- f. The individual accepting the verbal order or telephone order shall read back the complete order and request verification from the Prescribing Provider.
- g. Modifications to existing chemotherapy orders may be accepted by an approved APNP or PA as a telephone order from an attending physician using the following process:
 - (1) An approved APNP or PA will evaluate a patient who may require chemotherapy dose modification, and discuss the clinical scenario with an attending provider by phone.
 - (2) If the attending provider decides that a dose modification is appropriate, the attending provider will provide the approved APNP or PA a telephone order.
 - (3) The approved APNP or PA will document the telephone order from the attending provider in the EHR, repeat the order back to the ordering physician, modify the dose of chemotherapy in BEACON, and sign the orders.
 - (4) Attending providers are responsible for co-signing the telephone order within 48 hours.
 - (5) This workflow only applies to dose modification for existing chemotherapy orders. It cannot be used to assign a new chemotherapy regimen, or to discontinue a regimen.
 - (6) This process only applies to APNPs or PAs who have oncology roles.
 - (7) The list of approved APNPs and PAs will be created and maintained by the cancer center EHR champion.
 - (8) An addition or removal of an APNP or PA from the list will require an

approval from the CMO's office (in consultation with the CMIO's office).

h. The following medication orders shall not be given verbally or by telephone for either inpatients or outpatients:

(1) New initiation of investigational drugs;

i. Verbal or Telephone orders will not be accepted for high alert medications with the exception of an emergency resuscitative event or a situation where a delay in therapy would compromise the patient's clinical status. The Prescribing Provider must speak directly to the nurse or pharmacist caring for the patient.

2. **Who Can Accept and Carry Out Verbal/Telephone Orders:**

a. RNs, Allied Staff RNs, APNPs, Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), and PAs may accept, enter, and carry out verbal and telephone orders.

b. Respiratory Care Practitioner/Respiratory Therapists, Physical Therapists(PTs), Occupational Therapists (OTs), PT Assistants, OT Assistants, Speech Pathologists, Registered Pharmacists, Audiologists, Optometrists, Radiation Therapists, and Registered Dietitians may accept, enter, and carry out verbal and telephone orders for their respective disciplines and within their scope of practice.

c. Radiologic Technologists, Nuclear Medicine Technologists, Ultrasonographers, Registered Cardiac Diagnostic Sonographers, and Registered Vascular Technologists may accept and carry out verbal and telephone orders for diagnostic services and medications within their scope of practice and job description.

d. Non-licensed staff (including but not limited to: Medical Technologists, Medical Assistants, Administrative Assistants, Radiology Assistants, Radiology Clinical Liaisons, Technicians, New Patient Coordinators, Genetic Counselor, etc.) and Licensed Practical Nurses (LPNs) may accept verbal and telephone orders for outpatient diagnostic tests and for those services they can carry out based on their scope of practice and job description.

1. Any orders for inpatient services or orders for a patient who is on an inpatient unit must be pended and not acted upon until co-signed by the Prescribing Provider.

2. All medication orders must be pended and not acted upon until co-signed by the Prescribing Provider

3. Departments may limit the scope of non-licensed staff to be stricter than the policy statement above, but no department can broaden the scope of a non-licensed staff member beyond what is allowed in this policy.

e. Graduate Nurses may accept verbal/telephone orders for diagnostic and therapeutic services, and for medications.

f. Pharmacy Interns, authorized by department policy, may accept verbal/telephone medication orders. The orders must be pended and may not be acted upon until signed by their precepting Pharmacist.

D. **Protocol Orders, Orders per Policy, and Protocols**

1. Protocol Orders

- a. Inpatient Protocol Orders may be initiated only by Professional Medical Personnel prior to the patient being examined or evaluated by a medical staff member in urgent, patient safety situations, or to provide timely and necessary care, as allowed per the Protocol Order.
- b. Outpatient Protocol Orders may be initiated by Professional Medical Personnel or by other individuals authorized by the outpatient department, prior to the patient being examined or evaluated by a medical staff member in urgent, patient safety situations, or to provide timely and necessary care, as allowed per the Protocol Order.
- c. Protocol Orders must be authenticated within 48 hours by the Prescribing Provider responsible for ordering, providing or evaluating the service.
- d. Protocol Orders may not be individualized or altered.
- e. When Protocol Orders are initiated, they must be signed by the individual initiating them, with the name and appropriate professional title and dated.
- f. Protocol Orders must be reviewed regularly to determine the continued usefulness and safety. The review date must be indicated, and all previous versions must be kept on file permanently in the department authoring the protocol.
- g. All Protocol Orders must be reviewed and approved by the medical staff and nursing leadership.
- h. If the Protocol Orders involve medication administration, they must also be approved by the Pharmacy Nutrition and Therapeutics Committee (PNT)/Pharmacy Committee.
- i. Pharmacists may order lab tests, to monitor medication therapy and assess safety and efficacy according to PNT/Pharmacy Committee approved protocols. A Prescribing Provider co-signature is required.

2. Orders Per Policy

- a. The only approved uses of orders that can be ordered per policy are listed below. These orders do not require a Prescribing Providers's co-signature.
 - (1) Pharmacists may order medications according to policies, Collaborative Practice Agreements and other PNT/Pharmacy Committee approved instances (i.e. therapeutic interchanges).
 - (2) Authorized Pharmacy Interns may enter medication orders according to policies, Collaborative Practice Agreements and other PNT/Pharmacy Committee approved instances (i.e. therapeutic interchanges). Orders will not be acted upon until signed by their precepting Pharmacist.
 - (3) RN's may order pneumococcal and influenza vaccines according to the organizations corporate policy.
 - (4) RNs may order isolation for inpatients based on the hospital's infection

control/isolation policy.

3. Protocols

a. Research Protocols

(1) Individuals identified as personnel listed on the IRB application may enter orders from a Clinical Trial Protocol.

(2) If the individual entering the order is not licensed, they may enter orders for outpatient diagnostic tests, with a co-signature required within 48 hours by the Prescribing Provider.

(a) Any orders for inpatient services or orders for a patient who is on an inpatient unit, must be pended and not acted upon until co-signed by the Prescribing Provider.

(b) Medication orders must be pended and not acted upon until co-signed by the Prescribing Provider.

b. Chemotherapy Protocols

(1) Chemotherapy Protocols may be initiated only by physicians who are credentialed members of the medical staff or by authorized oncology fellows. Chemotherapy orders that are entered into the COE system by a APNP or PA must be queued up and can not be acted upon until signed by the physician unless they are modifications to existing chemotherapy orders, then refer to C(1)(g) of this policy.

E. Order Sets

1. Order Sets require a Prescribing Provider order prior to implementation. This can be accomplished by the Prescribing Provider entering the order into the COE system, or by providing a verbal or telephone order to an individual authorized to accept verbal or telephone orders so they can enter it into the COE system.

2. Order sets including medication orders must be approved through the appropriate governing bodies via the order set review process prior to being initiated.

3. Order sets will be reviewed regularly to determine the continued usefulness and safety. The review date must be indicated, and all previous versions must be kept on file permanently in the department authoring the order set.

F. Challenging or Disputing a Prescribing Provider Order

1. When a practitioner order is felt to be out of range, inappropriate, or potentially harmful to a patient, hospital staff will contact the Prescribing Provider to discuss or clarify the order.

2. If concerns are not sufficiently resolved, hospitals with housestaff will contact the next most-senior physician to discuss the issue, the senior resident and then the attending staff physician.

3. If the hospital does not have house staff or if concerns are not sufficiently resolved, the hospital staff will contact the department leader or Administrative Representative. The department leader or Administrative Representative will contact the Risk Manager on call and/or the Vice

President Medical Affairs for direction.

4. Each contact will be documented by the hospital staff in a Progress Note.

Note: For instructions specific to medication ordering, refer to the Medication Ordering policy.

FMLH - Prosthetic and Orthotic Devices Ordering of (CPM.0009)

FMLH - Medication Ordering Policy

FMLH - Physician Orders for Respiratory Services (AD.1.2.01)

FMLH - Pneumococcal and Influenza Standing Order Protocol (CMP.0102)

FMLH - Do Not Resuscitate DNR (CPM.0063)

Related Policies:

FMLH - Palliative Care Patient Controlled Analgesia (D09.002)

FMLH - Suicide Potential for (CPM.0004)

FMLH - Patient Safety Observation (CPM.0147)

FMLH – Management of Duplicative or Expired Orders (CPM.0175)

FMLH - Non-Physician Provider Order Policy in Epic Oncology Solutions

FMLH - Isolation Guidelines for Resistant Organisms

Distribution:

Froedtert Intranet

Vice President/Patient Care Services

Date

Chief Nursing Officer

Authorization:

Chief Medical Officer

Date

Vice President/Chief Compliance and Risk Officer

Date

- Title:** Organizational Structure of Patient Care Services
- Policy Type:** PCS Divisional
- Department:** Administrative - All PCS
- Policy Number:** A01.001
- Origin Date:** 6/18/1982
- Date Revised:** 5/10/2012
- Supercedes:** 7/1/2010
- Topic(s):** Administrative
- Keyword(s):** Organizational structure
- Purpose:** To describe the organizational structure within the Division of Patient Care Services.
- Policy:**
- A. The Division of Patient Care Services is organized to delineate accountability for the provision of patient care services. Titles and reporting relationships are diagrammed within the current organizational chart ([PCS Org Chart r0501012.pdf](#)).
- B. The Division of Patient Care Services is organized under the administrative direction of the Vice President, Patient Care Services, Chief Nursing Officer, who reports to the President of Froedtert Hospital. Reporting to the Vice President of Patient Care Services are the Directors of Nursing, Director of Case of Management and Social Services, Director of Clinical Systems Communications, Financial and Business Manager, Magnet Program Manager, Senior Nurse Researcher, Nursing Excellence Coordinator, and a Sr. Administrative Assistant. The Vice President, Patient Care Services, Chief Nursing Officer (CNO), is a member of the Executive Senior Management team, Medical Staff Committees, and Board of Directors. The CNO participates and provides leadership on numerous other organizational, leadership, nursing, and interdisciplinary committees.
- C. The Vice President, Patient Care Services, Chief Nursing Officer, approves policies and procedures that impact nursing scope and practice throughout Froedtert Hospital, including areas that directly report to other administrators. The CNO serves as the vehicle of communication to other members of the hospital management team regarding resolution of issues and policy decisions affecting nursing scope and practice.
- D. The Directors of Nursing report to the Vice President, Patient Care Services, Chief Nursing Officer, and are responsible and accountable for the overall management of staff, nursing practice, patient care, and services provided within a defined clinical specialty, group of units, and/or programs. The Directors of Nursing participate with the CNO to develop strategic priorities, oversee program development, define fiscal parameters, and prioritize agendas for nursing and patient care.
- E. The Nurse Managers are responsible and accountable for the 24/7 day-to-day operational activities on an assigned unit(s), including nursing practice, patient care, and services provided according to defined nursing standards of care, hospital policies, and regulatory requirements. Functions of this accountability may be delegated to the Assistant Nurse Manager. Administrative Representatives (in the absence of Nurse Managers) collaborate with patient care unit RN's to ensure nursing resources are allocated and assigned to meet the patient care needs on a shift-to-shift basis.
- F. The Director, Clinical Systems Communications, has line responsibility for the Clinical Systems Communicators and reports to the Vice President, Patient Care Services, Chief Nursing Officer.
- G. The Director, Case Management and Social Services is responsible for the coordination of the clinical and financial aspects of each patient's case to ensure appropriate utilization of resources. This Director develops, coordinates and directs the operations of Case Management and Social Services. This Director also communicates and collaborates with other departments to ensure appropriateness and accuracy of applicable processes and data.
- H. The Director of Quality Management and Patient Safety collaborates

with the Vice President, Patient Care Services, Chief Nursing Officer, to coordinate quality management, infection control, and patient safety issues.

I. The Business and Financial Manager is responsible for financial and data analysis within the division and reports directly to the Vice President, Patient Care Services, Chief Nursing Officer.

J. The Magnet Program Manager collaborates and coordinates with the Nursing Leadership and staff in developing and monitoring nursing-sensitive quality indicators. This position is responsible to coordinate the achievement of Magnet recognition and reports to the Vice President, Patient Care Services, Chief Nursing Officer.

K. The Sr. Nurse Researcher reports to the Vice President, Patient Care Services, Chief Nursing Officer. The person in this position acts as a nurse scientist and joins leaders in nursing and the organization to set the agenda for nursing research at Froedtert Hospital.

L. Nurses are represented on appropriate Hospital and Medical Staff Committees. Division and department Shared Governance Councils and various committees within nursing support the philosophy and objectives of the Division. Nursing Shared Governance at Froedtert Hospital provides a framework that supports that professional nurse engagement and accountability in shared decision-making.

Scope: Patient Care Services
Distribution: Froedtert Intranet
Authorization: Signatures on file in Nursing Administration Office

Signature _____ Date _____
 Chief Nursing Officer
 Vice President, Patient Care Services

Title: Patient Assessment and Nursing Process Documentation

Policy Type: PCS Divisional

Department: Clinical - All PCS

Policy Number: C01.011

Origin Date: 9/29/1980

Date Revised: 7/3/2014

Supersedes: 4/21/2014

Topic(s): Assessment

Keyword(s): Assessments, Physical Assessment, Targeted Assessment

Purpose: To define the process for initial and ongoing physical assessment and nursing process documentation.

A. The RN is responsible for the collection and documentation of a complete nursing assessment used to determine the patient's current condition and response to treatment interventions.

B. A complete head-to-toe assessment will be performed and documented in the Patient Care Summary (Adult, OB, Peds) of the electronic health record (EHR) to determine the patient's current condition and response to treatment/interventions:

1. On admission.

2. At least once during the nurse's period of professional accountability for the patient (minimally once per shift) and as needed based on professional judgment. If a staff RN is working an extra shift (i.e., double) or is working longer than a 10 hour shift (i.e., 12 hour shift), another assessment will be performed and documented. At minimum, 3 assessments will be performed and documented in a 24 hour period.

3. Within 2 hours of patient transfer from one level of care to another.

4. When there is an adverse unexpected physical response to medical or nursing care.

C. The Braden Assessment will be documented on admission and daily on day shift.

D. The head-to-toe assessment minimally includes the following body systems:

1. Cognitive/Perceptual/Neuro

2. HEENT

3. Cardiac

4. Peripheral Neurovascular

5. Respiratory

6. Gastrointestinal

7. Genitourinary

8. Musculoskeletal

9. Skin

Policy:

E. Additional assessment observations will be assessed and documented at least once during the nurse's period of professional accountability for the patient (minimally once per shift):

1. Safety
2. Safety Interventions (as appropriate)
3. Falls
4. Elopement
5. Coping - Observed Emotional State and Plan of Care

Reviewed With

6. Confusion Assessment Method (CAM): CAM-SF/CAM-ICU (CAM assessments excluded for Mom and Baby/Labor and Delivery)
7. Sepsis Screen

F. Additional patient responses will be documented in the Patient Care Summary as clinically indicated:

1. Sleep/Rest/Relaxation
2. Nutrition - Diet/Feeding Tolerance

G. Physical assessment parameters that are within defined limits as defined by Clinical Practice Model (CPM) content will be documented as "WDL" in the Patient Care Summary. "WDL" indicates that all aspects of that particular body system meet the WDL validated criteria and are understood as normal findings.

H. Physical assessment parameters that fall outside of WDL will be documented as "Ex" (WDL Except) in the Patient Care Summary.

I. Assessment findings that fall outside of the WDL values will be documented for affected body system by adding the specific assessment rows as required to completely document the assessment findings.

J. Additional findings that are not included in the WDL definition will be documented in the Additional Assessment rows for that system.

K. Assessment findings that require intervention requires documentation of a reassessment.

L. A targeted physical assessment focused on the specifically relevant body system(s) will be performed and documented when there is deterioration in the patient's clinical condition or after performing interventions designed to improve patient's assessment findings and specific condition.

M. Body system interventions in the Patient Care Summary will be documented at the time the intervention is performed or as soon as reasonably possible given patient's condition.

N. Documentation in the EHR will reflect pertinent findings, changes, interventions and tolerance of care for the nurse's period of professional accountability for the patient (minimally once per shift).

O. An end of shift summary note will be documented in the EHR at the end of each nurse's period of professional accountability for the patient (minimally once per shift) to include the patient's overall condition and response to multidisciplinary interventions during the care interval.

P. Changes to the original assessment will be documented in the EHR prior to end of shift.

Q. The nurse must notify the provider with each initial CAM positive (+) screen. If the patient has been negative for 48 hours, and screens positive again, this is considered a patient change in condition and the provider must be notified.

R. The nurse must notify the provider with each initial positive sepsis screen. The nurse must notify the provider and activate a Rapid Reponse with each initial positive *severe* sepsis screen. The provider must be notified of subsequent positive screens if there is deterioration of vital signs or signs of new organ dysfunction.

Smith, S.F., Duell, D.J. & Martin, B.C. (2008). *Clinical Nursing Skills* (7th ed.). New Jersey: Pearson Education

Dellinger, R.P., Levy, M.M., Rhodes, A., Annane, D., Gerlach, H., Opal, S.M., Sevransky, J.E., Sprung, C.L., Douglas, I.S., Jaeschke, R., Osborn, T.M., Nunnally, M.E., Townsend, S.R., Reinhart, K., Kleinpell, R.M., Angus, D.C., Deutschman, C.S., Machado, F.R., Rubenfeld, G.D., Webb, S.A., Beale, R.J., Vincent, J., Moreno, R., and the Surviving Sepsis Campaign Guidelines Committee including the Pediatric Subgroup (2013). Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2012. *Critical Care Medicine Journal*, 41(2), pages 580-637. Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.

References:

Scope:

RN

Distribution:

Froedtert Intranet

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Authorization:

— Signature	Chairperson	Date
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— Signature	Chief Nursing Officer Vice President, Patient Care Services	Date
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Title: Patient Rights and Responsibilities

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0016

Origin Date: 05/28/1989

Date Revised: 05/02/2013

Supersedes: 05/20/2010

Topic(s): Administrative

Keyword(s): Patient rights, responsibilities

Definitions:

Surrogate Decision Maker - is someone recognized to make decisions on behalf of a patient when the patient is without decision-making capacity or when the individual(s) have given permission to the surrogate to make decisions. This individual may be health care agent(s) as defined in a power of attorney for health care, a legal guardian(s), parent of minor child or other authorized representative, consistent with Wisconsin State statute.

A. Patient Rights

1. The Hospital shall make reasonable response to requests and needs for treatment or service within the Hospital's capacity, its stated mission and applicable laws and regulations. A patient may not be denied appropriate hospital care because of the patient's race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment.

2. The patient shall be treated with consideration, respect and recognition of his/her individuality and personal needs, including the need for privacy in treatment, safety, effective pain management and consideration of psychosocial, spiritual and cultural variables. Unless contraindicated, the patient has the right to safe access to the outdoors, as appropriate, during long lengths of stay. The right to considerate treatment extends particularly to patients who are dying who shall be given optimal comfort and dignity, including treatment of responding to primary and secondary symptoms, as desired, effective pain management and acknowledgement of the psychosocial and spiritual concerns regarding dying and the expression of grief.

3. The patient has the right to be free from all forms of abuse, harassment and financial exploitation.

4. Patients will be provided professional interpreter service free of charge to support effective communication.

5. The patient will be given a copy of the Joint Notice of Privacy Practice.

6. The patient's medical record, including all computerized medical information, shall be kept confidential in accordance with the requirements of state and federal law.

7. The patient or any person authorized by law shall have access to the patient's medical record and/or receive a copy upon request.

8. The patient may request certain restrictions of the hospital's use and disclosure of his/her protected health information (PHI).

9. The patient may request a list of all disclosures made by Froedtert Hospital, as required by federal regulations.

10. The patient may request that his/her medical record be amended if it is believed the information is incomplete or incorrect.

Policy:

11. The patient shall be entitled to know who has overall responsibility for his/her care.

12. The patient, the patient's legally authorized representative or any person authorized verbally or in writing by the patient shall receive, from the appropriate person within the Hospital, notification of admission, information about the patient's illness, course of treatment and prognosis for recovery in terms the patient and/or designated individual can understand.

13. The patient, or Decision Maker have a right to participate in the development and implementation of his or her plan of care, which includes at a minimum the right to participate in the development and implementation of his/her inpatient treatment/care plan, outpatient treatment/care plan, participate in the development and implementation of his/her discharge plan, and participate in the development and implementation of his/her pain management

14. The patient, or Decision Maker shall have the opportunity to make health care decisions in collaboration with his or her physician and to participate to the fullest extent possible in planning for his or her care and treatment, including ethical issues that may arise. The patient or Decision Maker may request an ethics consult to resolve ethical issues that may arise in the course of the patient's care.

15. The patient or his or her Decision Maker shall have access to the Hospital's policies on patient rights and responsibilities.

16. Except in emergencies, the consent of the patient or the patient's legally authorized representative shall be obtained before diagnostic procedures are administered or surgical procedures or other treatments are performed.

17. The patient may refuse treatment, without retaliation, to the extent permitted by law and shall be informed of the medical consequences of the refusal.

18. The patient or the patient's legally authorized representative shall give prior informed consent for the patient's participation in any form of research.

19. Except in emergencies, the patient may not be transferred to another facility without being given a full explanation for the transfer without provision being made for continuing care and without acceptance by the receiving institution.

20. The patient shall be permitted to examine his or her hospital bill and

receive an explanation of the bill regardless of source of payment, and the patient shall receive, upon request, information relating to financial assistance available through the hospital.

21. At the time of admission, the patient shall have access to the hospital's policies and procedures for the initiation, review and resolution of patient complaints. A patient with a complaint is encouraged to contact the Hospital's Patient Relations Department. Any unresolved issues regarding care, treatment, services and safety may be reported to The Joint Commission, the Wisconsin Department of Health and Family Services or, if the complaint relates to privacy of health information, to the United States Department of Health and Human Services at the following addresses:

The Joint Commission
1-800-994-6610
or e-mail concern to:

Wisconsin Department of Health and Family Services
Office of Quality Assurance; Health Service Section
2917 International Lane, Suite 300
Madison, Wisconsin 53704
Telephone: 608-243-2024

Office for Civil Rights
United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201
Telephone: 1-877-696-6775

22. The patient or Decision Maker has the right to consent to receive visitors who he or she designates including, but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend. The patient or the Decision Maker has a right to withdraw or deny consent of visitation at any time.

23. The patient may formulate an advance directive and appoint a surrogate to make health care decisions on the patient's behalf to the extent permitted by Wisconsin law and the hospital's advance directive policy. Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.

24. To the extent permitted by law, any of the rights delineated in this policy may be exercised on the patient's behalf by a guardian, surrogate or other legally authorized representative in the event the patient has been adjudicated incompetent in accordance with law, is found by his or her physician to be

medically incapable of understanding the proposed treatment or procedure, is unable to communicate his or her wishes regarding treatment or is an unemancipated minor.

25. The patient or Decision Maker has the right for their wishes concerning organ/tissue donation to be honored within the limits of the law or hospital capacity.

26. Patients or their legally authorized representative will be informed of any significantly unexpected outcome relating to an event where the patient outcome is different than expected.

27. The patient has the right to be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff or retaliation.

B. Patient Responsibilities

1. The patient or the patient's legally authorized representative is responsible for providing a complete and accurate medical history, including current physical complaints, medications, past illness and hospitalizations and other matters relating to the patient's health.

2. The patient or the patient's legally authorized representative is responsible for cooperating in the patient's treatment, which includes:

a. Communicating to care givers whether or not the plan of care and expectations during hospitalization are understood.

b. Following the plan of care recommended by the treating physician and the instructions of the attending nurses and other caregivers, or upon refusal to do so, accepting the consequences of such refusal.

c. Promptly reporting any unexpected changes in the patient's condition to the treating physician or nurse, therapist or other caregiver.

3. The patient or the patient's legally authorized representative is expected to cooperate with the hospital toward making appropriate arrangements for payment of the hospital's charges for care and treatment, including providing all required information and signing all appropriate documents.

4. The patient or the patient's legally authorized representative is responsible for the patient's observance of the hospital's policies, rules and regulations, including the rules on visitors, noise control and smoking.

5. The patient or the patient's legally authorized representative is expected to treat hospital personnel, other patients and visitors with consideration and respect and to be respectful of the property of other persons and of the hospital.

Distribution:

Corporate Policy Manual

Author/Director of Patient Relations

Date

President

Date

Authorization:

Vice President, Medical Affairs
Chief Medical Officer

Date

Vice President/Patient Care Services
Chief Nursing Officer

Date

Title: Plan For Providing Nursing Care
Policy Type: PCS Divisional
Department: Administrative - All PCS
Policy Number: A01.042
Origin Date: 7/9/1991
Date Revised: 5/10/2012
Supercedes: 9/24/2008
Topic(s): Administrative
Keyword(s): Nursing care, plan
Purpose: To specify the plan for providing nursing care at Froedtert Hospital.
Policy:

A. Nursing services are directed by the Vice President, Patient Care Services, Chief Nursing Officer (CNO), a registered nurse who is a member of the Executive Senior Management team, Medical Staff Committees and Board of Directors. The CNO participates and provides leadership on numerous other organizational, leadership, nursing and interdisciplinary committees.

B. The CNO reports to the President of Froedtert Hospital and is accountable for nursing scope and practice in all Froedtert Hospital settings. The division of Patient Care Services is depicted on the Patient Care Services Organizational Chart (Addendum #1). The chart demonstrates delineated accountability and reporting relationships, displaying lines of authority that delegate responsibility within the division. Position descriptions identify specific responsibilities for each position. The Froedtert Hospital Organizational Chart (Addendum #2) depicts hospital executive leaders and their areas of accountability. A dotted line indicates areas with CNO accountability for nursing scope and practice.

C. A registered nurse supervises and evaluates the nursing care for each patient where and when nursing services are provided. A registered nurse evaluates the care for each patient when admitted to the hospital as an observation or inpatient and when appropriate on an ongoing basis, in accordance with acceptable standards of nursing practice and hospital policy. Evaluation includes assessing the patient's care needs, patient's health status/condition, as well as the patient's response to interventions.

D. A summary of the Plan for Providing Nursing Care is presented to the Executive Senior Management team and Board of Directors annually. Development of the plan considers the following:

- Consistency with the hospital's vision and mission
- Patient requirements for care as the basis for nurse staffing
- Changes in patient programs or populations
- Feedback from patients, families, physicians, other care providers, nursing staff
- Information from quality management, infection control, risk management, utilization review
- Retention and recruitment evaluation
- Financial status of the hospital

E. Organized nursing services are provided at Froedtert Hospital 24 hours a day, 7 days a week. A registered nurse is on duty at all times and a registered nurse provides supervision of nursing services 24 hours a day, 7 days a week.

F. The Nursing Professional Practice Model of Relationship-Based Care focuses on the care of patients and their families/significant others. (Addendum 3.)

1. The following elements contribute to the Nursing Professional Practice Model: Transformational Leadership, Shared Governance, Professional Development, Relationship-Based Care Delivery, Nursing Research & Evidence-Based Practice, and Interdisciplinary Collaboration. These elements serve as the foundation of our caring approach to patient-centered care and, as such, are depicted in the model as surrounding the patient and family.

2. Key drivers influencing our practice include: the Nursing Mission, Vision, and Philosophy; the Froedtert Hospital Mission, Vision, and Values; and the organization's Strategic Priorities.

G. Nurses at Froedtert Hospital provide high-quality, patient-centered care using a Relationship-Based Care Delivery system. Nurses recognize they can provide the most effective care when they know what matters most to each patient and his/her family. Nurses believe patients achieve better outcomes when they feel safe within a trusting relationship with a registered nurse. The nurse-patient relationship is strengthened through continuity of care, thereby improving patient and staff satisfaction. The nurse works closely with nursing colleagues and other members of the healthcare team to reach the goals developed in collaboration with the patient and family. Relationship-Based Care at Froedtert has been adapted from the book, *Relationship-Based Care: A Model for Transforming Practice* (2004). Our Relationship-Based Care Delivery system is comprised of four key elements:

Element 1 - Autonomy and the Nurse/Patient Relationship

Nurses:

- Practice autonomously and make decisions within the scope of their practice consistent with the American Nurses Association Nursing: Scope and Standards of Practice.
- Develop therapeutic relationships with patients and families and advocate on behalf of their patients. This relationship exists whether it's through a single interaction, a single shift, an entire length of stay, or over the course of years.
- Are responsible for assessing, planning, implementing, and evaluating nursing care.
- Collaborate with all members of the interdisciplinary team.
- Prioritize patient care needs and are accountable for nursing care outcomes.
- Practice is guided by evidence-based Standards of Care and Standards of Practice and is incorporated into practice through our Shared Governance structure.

Element 2 - Professional Nursing Care to Meet Patient Needs

- Nurses work a variety of schedules to fulfill the needs of the practice setting. 7/7/0 is the core scheduling model, utilized in the majority of inpatient units. A few other nursing practice settings also use this scheduling model.
- Nurse leaders assure adequate resources to meet patient care needs.
- Patient assignments are determined collaboratively based on complexity of patient care needs and the RN level of competence and experience.
- Every effort is made to maximize continuity of care and caregiver in order to achieve an optimal therapeutic relationship. Nurses facilitate continuity of care using the nursing process, interdisciplinary collaboration, and coordination of healthcare services.
- Nurses have the authority to delegate nursing activities to other care providers, yet retain ultimate accountability for the process and outcomes of care.
- The nurse's delegation of tasks is made based on patient needs, complexity of care, and competency of the individual accepting the delegation.
- Handoff communication is an integral part of the process to support continuity of care in all settings, including the community.

Element 3 - Communication between the Nurse, Patient, and the Healthcare Team

- The nurse collaborates with the patient and significant other(s) along with other members of the healthcare team to identify specific patient needs.
- As a patient advocate, the nurse communicates patient and family needs directly and proactively to the interdisciplinary team.
- Communication between members of the healthcare team is essential to achieving optimal patient outcomes.
- Integrating information and coordinating all aspects of

- Froedtert Hospital's academic setting promotes mutual respect between the nurses, physicians, and other team members. This teaching environment encourages open communication regarding the patient's plan of care and supports a culture of collaboration.

Element 4 - Managing the Healing Environment of Care

- Nursing leaders strive to create an environment in which all staff takes conscious ownership for their patient care in support of the mission and vision of Nursing and Froedtert Hospital.

- Nurses collaborate with each other to facilitate an environment which is safe for both the nurses and patients.
- The nurse delivers patient care within a culture of performance excellence, in alignment with strategic goals and hospital priorities.
- Patients are encouraged to become actively involved in their plan of care within a healing environment.
- Nursing leaders support the professional development of nurses. They influence care by creating a healthy environment that supports autonomous practice.

H. Nursing Shared Governance at Froedtert Hospital provides a framework that supports professional nurse engagement and accountability in shared decision-making. Nursing Shared Governance charters are available on the Shared Governance site on Scout.

- Coordinating Council: Accountable for ensuring an overall coordination, oversight, and prioritization of activities of the individual councils.
- Development Council: Accountable for functions related to nursing education, patient education, professional development and enrichment and recruitment and retention.
- Quality & Safety Council: Accountable to assure high quality nursing care and excellent patient outcomes by monitoring, improving, and evaluating nurse sensitive indicators.
- Professional Practice Council: Accountable for ensuring that practice is evidence-based and there is a consistent standard of practice across all departments.
- Nursing Research Council: Accountable for promoting and facilitating research activities among the nursing staff.
- Ambulatory Council: Accountable for functions related to nursing education, patient education, professional development and enrichment, and recruitment and retention.
- Management Council: Accountable for ensuring human, material, and support resources to support professional nursing practice and for ensuring the effectiveness of structures/processes that are part of the Nursing Professional Practice Model of Relationship-Based Care.

I. Registered nurses at Froedtert Hospital participate in the establishment and maintenance of standards of nursing care and standards of nursing practice within the definition of professional nursing practice within the Wisconsin Administrative Code. Appropriate and sufficient support staff are available to allow the nursing staff to meet the nursing care needs of their patients and significant others. The most current version of the State of Wisconsin Nurse Practice Act can be found on the State of Wisconsin Department of Regulation and Licensing internet site via the internet link below:

http://www.drl.state.wi.us/board_code_detail.asp?boardid=42&locid=0

J. Nursing care is designed to meet the needs of the patient populations served. Nursing care at Froedtert Hospital is delivered to patients in the following areas:

- Inpatient Units - 24/7**
- 2NT - Trauma/Acute Care Surgery
- 3NT - General Surgery
- 3NW - Cardiology/Cardiothoracic Surgery
- 3SW - Medical/Surgical
- 4NE - Internal Medicine/GI
- 4NT - Hematology/Oncology
- 4NW - Internal Medicine/Hem-Onc

4P - Urology/Gynecology
4SE - Internal Medicine
4SW - Transplant/Medicine
5NE - Neuro/General Rehabilitation
5NW - Neurosciences
5SE - Spinal Cord Injury
5SW - Orthopaedics
9NT - Internal Medicine/Pulmonary
Labor & Delivery
Mother/Baby
BMT
CVICU
MICU
NICU
SICU
Vascular Access Team

Surgical/Perioperative Services

Pre-Admission Testing
Day Surgery
OR
PACU
Eye Institute Ambulatory Surgery Center
Eye Institute OR/PACU

Emergency and Extended Recovery

Emergency Department
Extended Recovery Unit

Clinics

Breast Care Clinic
Cancer Center Clinics: Courage, Life, Faith, Hope, Lab
Cancer Center Day Hospital
Cardiology Clinic
Diabetes Care Center
Endocrine Clinic
Eye Institute Ocular Plastics Clinic
Gastroenterology Clinic
Infectious Disease Clinic
Internal Medicine Clinic
Interventional Radiology Clinic
Maternal Fetal Care Clinic
Nephrology/Transplant Clinic (includes Transplant
Surgery, Dialysis Access)
Pulmonary Clinic
Pulmonary Hypertension Clinic
Radiation Oncology Clinic
Reproductive Medicine Center
Rheumatology Clinic (includes Osteoporosis/Calcium
Disorders)
Sickle Cell Disease Clinic
Urology Center
Vascular Surgery Clinic
Wound Healing Clinic

Services

Cardiac Cath Lab
Echocardiology Lab
Endocrine Diagnostic Lab
GI Lab
Infusion Clinic
Interventional Radiology
Manometry Lab
Radiology
Vascular Lab

Staff in other areas/positions may be required to be licensed nurses due to the nature of the job, but do not deliver nursing care as defined by Froedtert Hospital.

K. Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The Vice President, Patient Care Services, Chief Nursing Officer, provides for adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services.

L. FINANCIAL PLAN TO SUPPORT THE NURSING PLAN

1. On an annual basis, during the budget process, each Director of Nursing creates a projected budget that includes a master staffing plan. The development and review of the

projected nursing budget consider these factors:

- Hospital strategic plans impacting the unit/department.
- Hospital vision, mission, and values.
- Nursing vision, mission, and philosophy.
- Improvements and innovations in the provision of nursing care.
- Information from quality management, infection control, risk management, and utilization review.
- Nursing-sensitive quality indicator data.
- Input from patients, patients' families, physicians, and nursing staff.
- Patient care needs on each unit.
- Patient satisfaction survey data.
- Staff engagement survey data.
- National benchmarks for staffing and other nursing-sensitive indicators.

2. The staffing plan is based on the average daily census, acuity, patient care hours, and the number and mix of nursing personnel needed to meet the nursing care requirements of the patients in each clinical area.

3. Nursing care hours for each unit have been determined by a detailed process of workload measurement on a unit basis with participation by nursing leadership and staff nurses. The process results in the hours of care (HOC) for each nursing unit. This standard is used for development of budget, productivity measurement, and day-to-day staffing.

4. Once all of the above information is collected and analyzed, a master staffing plan is created to reflect the core staffing on each nursing unit. The master plan is adjusted on a shift-by-shift basis in accordance with fluctuations in census activity, patient acuity, and/or individual patient needs. These adjustments to the master plan will be made with the use of unit staff additional hours, internal float pool, and unit-specific OPT staff, if needed.

5. Staff qualifications include the requirements noted on each individual position description as well as demonstrated competency for the particular clinical area.

6. Staff non-productive (non-clinical) hours for committee activities, shared governance, quality improvement, continuing education, etc., are built into the staffing plan in addition to the productive hours.

7. Rationale for changes in number and mix of staff will be submitted to the Vice President, Patient Care Services, CNO, for consideration/ approval at times other than during the budget process. The Director of Nursing and CNO will monitor nurse staffing through the daily/bi-weekly shift management and Income Performance Analysis reports, as well as other expense utilization throughout each fiscal year.

8. The staffing plan is evaluated and revised annually and periodically, as necessary, and when creating the subsequent staffing plans. The personnel resource allocations are approved by the CNO as part of the budget review process.

M. QUALITY IMPROVEMENT

The hospital uses a collaborative, organization-wide approach to quality improvement. All staff members participate in the performance improvement process. The Nursing Performance Improvement Plan is integrated into the Froedtert Hospital Performance Improvement Plan. Nursing Shared Governance provides the structure for nurses to participate in decision-making that affects the quality of patient care. Within Shared Governance there are division and department level Quality & Safety Councils. The Quality & Safety Councils coordinate the quality improvement activities. The department level council does quality monitoring and reporting based on identified indicators and documents in an electronic quality report card. Nursing staff collaborate with appropriate disciplines on cross-functional quality improvement issues that impact patient care. The Division Quality & Safety Council and Division Ambulatory Council

report to the Division Coordinating Council. The Division Coordinating Council reports to the Froedtert Hospital Joint Quality Committee.

N. RETENTION AND RECRUITMENT

A Retention and Recruitment sub-committee of the Development Council evaluates and recommends nursing recruitment and retention strategies. Recommendations regarding the retention and recruitment of nursing staff are made by the committee to the Vice President, Patient Care Services, CNO.

ADDENDUM 1: Patient Care Services Organizational Chart

ADDENDUM 2: Froedtert Hospital Organizational Chart

ADDENDUM 3: Nursing Professional Practice Model

- References:**
1. American Nurses Association. (2010). *Nursing: Scope and Standards of Practice*. Washington DC: nursesbooks.org
 2. M. Koloroutis (Ed.), (2004). *Relationship-Based Care: A Model for Transforming Practice*. Minneapolis, MN: Creative Health Care Management.
 3. Wisconsin State Statutes and Administrative Code Related to the Practice of Nursing, June 2006.
 4. American Nurses Association. (2000). *Principles for Nurse Staffing*. Annotated Bibliography compiled by Munley Gallagher, R. & Kany, K.A. Washington, DC.

Scope: RN

Distribution: Froedtert Intranet

Authorization: Signatures on file in Nursing Administration Office

Signature _____ Date _____
Chief Nursing Officer
Vice President, Patient Care Services

Title:	Post-Operative Care
Policy Type:	PCS Divisional
Department:	Clinical - All PCS
Policy Number:	C01.077
Origin Date:	9/29/1980
Date Revised:	8/4/2012
Supercedes:	2/26/2009
Topic(s):	Assessment
Keyword(s):	Post-op care, post-op
Purpose:	To provide ongoing assessment of the patient's general condition, help prevent complications and provide comfort.
Equipment:	<ol style="list-style-type: none"> 1. Surgical bed 2. Absorbent pads 3. Warm blankets 4. IV pole 5. Oxygen source, tubing, and equipment 6. Emesis basin and tissues 7. Sphygmomanometer and stethoscope 8. Thermometer (tympanic, oral, or rectal) 9. Special equipment depending on type of surgery. 10. Pulse oximeter 11. Sterile dressings
Procedure:	<p>A. Wash hands prior to each client contact.</p> <p>B. Introduce self to client, check client ID, orient to time, person, and place.</p> <p>C. Assess patient upon return to room. Assess, airway circulation, respiration, neurological status, dressing change/incision, genitourinary function/skin and gastrointestinal function. Orient client to time, person, and place. Reorient as needed. If new admission, introduce to hourly rounding.</p> <p>D. Assess for effects of anesthesia including general, regional, and local.</p> <p>E. Check dressing upon arrival to unit and then at least every 2-4 hours throughout the first 24 hours, then every shift thereafter.</p> <p>F. Monitor all drainage tubes and suction devices upon arrival to unit and at least every 2-4 hours thereafter.</p> <p>G. Please see Clinical Policy C01.049 for care of NG.</p> <p>H. Monitor vital signs immediately upon arrival to unit and thereafter based on patient assessment with a minimum of every 4 hours for 24 (or as specified by Physician order). Include pulse oximetry every hour for 4 hours, then every 4 hours.</p> <p>I. Check for nausea and vomiting.</p> <p>J. Check IV site and patency frequently; make sure IV site is dated. Record on Flow Sheet.</p> <p>K. Position client for comfort and maximum airway ventilation according to orders.</p> <p>L. Assess patient for pain or discomfort and provide comfort measures and medications as appropriate (e.g., position changes, analgesics as ordered by Physician). Record on Pain Doc flow sheet.</p> <p>M. Monitor for side effects of medications.</p> <p>N. Turn, cough and deep breath every 2 hours for 48 hours or as ordered. Reassess need for TCDB after 48 hours.</p> <p>O. Give back care at least every 4 hours.</p> <p>P. Give oral hygiene at least every 4 hours; if nasogastric tube or</p>

nasal oxygen is inserted, give oral hygiene every 2 hours.

Q. Assess for urinary output upon arrival to unit and every 2-4 hours thereafter, record amount and color, and place client on bed pan 2-4 hours post-op if catheter not inserted.

R. Assess for bowel sounds/flatus every shift and advance diet as tolerated (per Physician's Order). Assess for bowel movement by the third POD and daily thereafter.

S. Bathe client when temperature can be maintained.

T. Keep client warm and avoid chilling, but do not increase temperature above normal.

U. Check physician's orders when to begin the client's postoperative activity. Most clients are ambulated within first 24 hours.

V. Dangle or get client up in chair as ordered.

W. Notify Physician of any significant changes and document.

X. Maintain dietary intake.

Y. Observe for signs/symptoms of possible post-operative bleeding and infection.

- References:** Smith, S. F., Duell, D. J. & Martin, B. C. (2004). *Clinical Nursing Skills* (6th ed.). New Jersey: Pearson Education.
- Clinical Record:** Electronic Health Record
- Scope:** RN
- Distribution:** Froedtert Intranet
- Authorization:** Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Signature	Chairperson	Date
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Signature	Chief Nursing Officer Vice President, Patient Care Services	Date
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Title: Supervision and Cosignature Requirements for Nonphysician Students Interns and Externs

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0126

Origin Date: 03/03/2009

Date Revised: 08/04/2012

Supersedes: 3/3/2009

Topic(s): Documentation

Keyword(s): Epic, Student, Electronic Medical Record, Externs, Interns, Medical Record

Purpose: A. To define supervision requirements for non-physician students, interns and externs.
B. To define the requirements for a co-signature when non-physician students/externs/interns document within the electronic health care record.

- A. Direct supervision will be provided to all non-physician students, interns and externs.
- B. Direct supervision is defined as the clinical instructor, preceptor or staff member who is immediately available to continually coordinate, direct and inspect, at first hand, the practice of the student, intern or extern.
- C. Froedtert Hospital staff responsible for patient care can delegate activities to the extern/intern/student as long as there is direct supervision.
- D. Froedtert Hospital staff remain responsible for the patient care and any subsequent documentation required.
- E. All documentation will require a co-signature.
- F. Electronic flow sheet documentation, in addition to co-signature, requires a written note agreeing and/or addending students' documentation.
- G. The co-signature may be entered by the clinical instructor or preceptor supervising the student or by the Froedtert Hospital staff member responsible for the patient.
- H. The co-signature verifies that the information being documented by the student/extern/intern in the medical record is accurate and complete. The co-signature of an admission note verifies the information document in the admission navigator by the student/extern/intern is accurate and complete.
- I. The co-signature verifies that the information being documented by the student/extern/intern in the medical record is accurate and complete. The co-signature of an admission note verifies the information document in the admission navigator by the student/extern/intern is accurate and complete.
- J. The clinical instructor will co-sign the student medical record entry with their name, credentials and school.
- K. A preceptor or the Froedtert Hospital staff member must co-sign the student/extern/intern medical record with their name and credential.
- L. The co-signer may not change the original student entry but may document an addendum noting any correction or clarification.

Policy:

References:

Wisconsin State Board of Nursing Position Paper "Co-Signing Student Charting" Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.

Scope:

All Clinical Cost Center Managers

Distribution:

Corporate Policy Manual

Author/Director-Nursing Informatics

Date

President

Date

Authorization:

Vice President/Patient Care Services

Date

Chief Nursing Officer

Vice President/Clinical Services

Date

Corporate Policy Manual

Title: Valuables and Patient Belongings

Policy Type: Corporate

Department: Multidisciplinary

Policy Number: CPM.0012

Origin Date: 12/14/1988

Date Revised: 06/06/14

Supersedes: 05/12/11

Topic(s): Administrative

Keyword(s): Valuables, patient belongings

Purpose: To describe the process for handling patient valuables and personal belongings.

- A. The responsibility for the safekeeping of a patient's personal belongings will be assumed by the patient or significant other.
- B. The Hospital will not be responsible for personal belongings or valuables nor shall it reimburse patients for damaged, stolen or lost articles unless otherwise stated in this policy.
- C. Admitting and Nursing personnel must clearly state this policy and procedure to each patient at the time of admission. Nursing staff will document the patient's belongings on admission and transfer to the Patient Belongings list in the electronic health record (EHR).
- D. Personal belongings are described and limited to:
1. Apparel worn by the patient at the time of admission such as shoes, socks and underclothing.
 2. Dentures, personal toiletries, hearing aids and eyeglasses/contact lenses.
 3. Personal assistive devices. These items must be labeled and listed on the belongings list as noted above.
- E. The patient's family will be encouraged to remove personal belongings at the time of admission.

Policy:

- F. Valuables:
1. Valuables include, but are not limited to, money, wallets, keys, jewelry, eye glasses, hearing aids, dentures, credit cards, check books and miscellaneous other personal identification.
 2. Valuables must be retained by a family member or significant other if at all possible.
 3. If no family or significant others are present, call security to lock up the valuables.
 4. The Hospital will not be responsible for valuables that the patient elects to retain in his/her possession.
 5. If the patient is going to have surgery or other procedures or tests performed, the staff will remind the patient that the Hospital will not be responsible for personal valuables and request that they be given to a family member or significant other.
 6. Patients coming in for procedures not performed in the OR will have their belongings held within the department per the established departmental process.
- G. Upon Elective Admission:
1. If the patient has no family or significant other with whom the personal belongings or valuables could be entrusted, the patient may elect to

have such items stored in the Hospital's safe.

2. Nursing will page or call Security.
3. The patient's valuables will be placed in a Valuables Envelope by Security.
4. Before admission to the unit, the patient must sign the Valuables Envelope. The patient will be issued a receipt for the Valuables Envelope.
5. Valuables will be placed in the Hospital safe until they are picked up by the patient.
6. Patients directly admitted from the clinics will have their valuables secured when they arrive on the inpatient unit.

H. Search of Belongings of Unconscious Patients:

1. In the event an unconscious patient is admitted, all valuables found on the patient or among his/her belongings will be stored in the Hospital safe until such time that these valuables are redeemed by the patient.
2. All valuables will be placed in the proper Valuables Envelope to be deposited by Security personnel in the Hospital safe located in the Security Operations Center.
3. It is important to note that two (2) staff members should be present at all times during this process and proper signatures be obtained as witnesses.

A. For patients undergoing Elective Cases - the Hospital's Admitting Department makes phone contact with the patient prior to admission and, in the course of pre-admission procedures, informs the patient of the Valuables and Patient Belongings Policy.

B. Admission to the Emergency Department

1. Emergency Department staff will make every effort to encourage a significant other, family or friend (if applicable) to take the patients belongings into their custody.

2. All patient belongings cut or removed from a patient in Trauma/Arena will be separated if saturated with blood, urine or feces.

3. After being separated, all clothing saturated with blood, urine or feces will be logged into the EHR as being discarded and why. They will also be placed in a clear bag and labeled with a biohazard sticker and disposed of properly.

4. Codes to be used for discarded belongings can be, but is not limited to: C-cut, B-blood, U-urine and F-feces. Combinations can be used as necessary.

5. All patient belongings cut/removed that are not bloody, saturated in urine or feces will be placed in a customary patient belongings bag and placed in the patient room (unless patient is identified as a self-harm patient) and/or transferred with the patient if admitted to the hospital.

Procedure:

6. Self-harm patient belongings will be picked up by security from the Emergency department and stored in room 1933 being logged as such with a blue sticker attached to the bag/s.

7. Patient valuables found inside belongings that are saturated with bodily fluids will be inventoried with security, placed in a clear bag with a bio-hazard sticker if applicable and sealed within a valuables envelope.

8. If law enforcement is present and request patient's belongings (clean or soiled) for investigative purposes they will furnish a paper bag and take them into their custody. Nursing will document in the record that law enforcement has taken possession of the belongings.

9. The Emergency Department staff completes the Patient Belongings List in the EHR, labels, bags and sends all personal belongings with the patient to the receiving unit.

C. 3-Divider Containers

1. Each patient will be given a 3-divider container for safe keeping of personal items (dentures, glasses, contact lenses and hearing aids, etc.). The patient will be instructed on the container's use and will be informed of the valuables policy for the Hospital.

D. Transfers In-House

1. Transfer all personal belongings with the patient in the appropriate

manner and store them in the patient's room (unless the patient has been identified as a self-harm patient). The Patient Belongings List in the EHR will be updated and verified by the receiving unit. If a difference is noted, an incident report shall be filled out and Security will be notified.

2. In the case of a transfer to any of the Intensive Care Units, transfer and store the patient's personal belongings in the assigned patient room in the Intensive Care Unit. Complete the Patient Belongings List in the EHR.

3. In the case of a direct transfer to an OR the belongings will be placed on the bottom of the cart and sent up to the OR with the patient and the ED nurse will complete the patient belongings list in the EHR.

4. Encourage the patient's family member or significant other to take possession of the personal belongings until the patient has been removed from the ICU.

E. Self-Harm Patient Belongings

1. When a self-harm patient is discharged from the hospital, the patient belongings list in the EHR will be reviewed by the staff for that patient.

2. If patient belongings are noted in room 1933, Security will be contacted by staff for delivery of these belongings to the patient's room for dispersal.

3. Upon delivery staff will take charge of the patient belongings and disperse to the patient and/or family as needed.

F. Retrieval of Valuables

1. Security accepts and returns all valuables 24 hours a day.

2. When a patient is discharged from the Hospital, the Patient Belongings List in the EHR will be reviewed by the staff and the patient.

3. Valuables not claimed within 30 days may, at the discretion of the Supervisor of Security, be stored in a secondary secure area and must be picked up between 8AM and 4:30PM, Monday through Friday, at the Security Operations Center.

4. Valuables must be picked up personally by the patient or, alternatively, as provided for in Security Department Policy 87150.39.

5. The valuables of a deceased, unconscious or a patient not able to give informed consent may be released to a close family member (wife, husband, father, mother, son or daughter).

6. The valuables may be turned over to any individual who possesses a legal Power of Attorney or a Power of Attorney for Healthcare.

7. Under certain extraordinary circumstances, valuables may be turned over to a close family member/significant other who has been established by medical staff as having been the decision making individual for the patient.

8. All release of valuables shall be at the discretion of the Supervisor of Security and/or the Director of Risk Management. The individual must have administrative approval for release of the valuables.

G. Patient valuables will be secured for a period of one year after which they will be disposed of per Security Department Policy 87150.39

H. Decedent's Personal Belongings

1. When a patient dies, the nursing staff should encourage the family to take the decedent's personal belongings with them.

2. If the family refuses to take the decedent's personal belongings, the nursing staff should ask the family if they would like the hospital to dispose of the personal belongings.

3. If no family is present, the decedent's personal belongings should be bagged, labeled with the patient's name and transported with the patient to the morgue.

4. The bagged and labeled personal belongings should be placed directly on top of the decedent in the morgue.

5. The funeral home should take the decedent's personal belongings when they pick up the decedent.

6. If the funeral home does not take the decedent's personal belongings, the morgue staff will call the funeral home informing them that the decedent's personal belongings were left in the morgue. The morgue staff will dispose of the decedent's personal belongings if the belongings have not been claimed within 24 hours.

Related Polices:

Any attachments referenced have been removed to allow conversion to PDF. Please print the attachments separately.

Distribution:

Hospital Wide

Author/Director Risk Management Date

Authorization:

Vice President, Medical Affairs Date
Chief Medical Officer

Vice President, Patient Care Date
Chief Nursing Officer

Title:	Skin and Wound Assessment and Management
Policy Type:	PCS Divisional
Department:	Clinical - All PCS
Policy Number:	C01.119
Origin Date:	9/29/1980
Date Revised:	9/10/2014
Supercedes:	5/16/2014
Topic(s):	Techniques / Procedures
Keyword(s):	Wound, wound care, treatment, assessment, dressing, pressure, ulcer
Purpose:	<p>A. Identify altered skin integrity on admission and throughout the patient's hospitalization.</p> <p>B. To identify patients at risk for skin breakdown while hospitalized.</p> <p>C. To initiate measures to prevent skin breakdown.</p> <p>D. To provide best practice recommendations for evaluation and management of skin breakdown.</p>
Policy:	<p>The RN will provide the following skin and wound management:</p> <p>A. A Braden Scale will be completed on admission, on the day shift and with a change in the patient's condition.</p> <p>B. A BASIC head-to-toe visual skin inspection will be conducted as follows:</p> <ol style="list-style-type: none"> 1. On admission 2. Upon receiving a patient transfer 3. Every shift - recommended time is during shift change 4. With a change in the patient's condition or wound condition <p>C. Head-to-toe skin assessment inspection should include focus on bony prominences, assessment for areas of localized heat, edema or induration (hardness), especially in individuals with darkly pigmented skin. Observe skin under medical devices, if appropriate. Ask patient to identify any areas of pain and visually observe area(s).</p> <p>D. A FOCUSED wound assessment will be completed for any wound(s) identified in the basic skin inspection. All dressings and wraps should be removed to visually inspect the wound appearance, unless the original surgical dressing is present, as this dressing will be removed according to MD orders:</p> <ol style="list-style-type: none"> 1. On admission 2. With every dressing change 3. Upon discovery 4. With significant changes in the wound condition

5. With each dressing change, the wound will be observed for developments that may indicate the need for a change in treatment (e.g., wound improvement, wound deterioration, more or less exudate, sign of infection or other complications).

6. Measure wounds EVERY 7 DAYS or with a decline in the wound appearance.

7. Decline in the wound status will be reported to the MD.

E. RN to utilize Wound/Skin Guidelines to implement prevention strategies and to initiate wound treatments. See References.

F. If a pressure ulcer is determined to be hospital-acquired, the RN will:

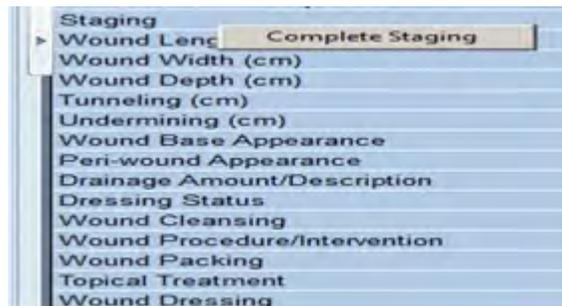
1. Notify the appropriate provider (MD, PA, APNP)

2. Complete Wound-Pressure Ulcer LDA

3. Obtain WOCN consult from MD/PA/APNP

4. Initiate Wound/Skin Guidelines until WOCN consult is completed.

G. Record all findings in Epic Patient Care Summary: Skin. Add new LDA for any alterations in skin integrity found during the assessment. Screen shot below.



Procedure:

A. RN to do:

1. A Braden Scale on admission, upon transfer to the unit and daily.

2. A basic head-to-toe visual skin assessment each shift.

B. RN to initiate and provide continuous documentation in Epic Patient Care Summary: Skin - add an LDA for wound or pressure ulcer.

C. RN to develop and initiate care plan per Wound/Skin Guidelines for RNs when:

1. Braden Scale score of 18 or less.

2. Pressure ulcer or a wound is identified on admission or during the patient's hospital stay.

D. RN to provide ongoing skin care prevention measures and wound care per care plan and wound care treatment orders and will notify MD of decline in skin integrity or

wound assessment.

E. RN to update the Skin and Wound Care Plans and wound care treatment orders as patient's condition warrants.

References:

[Wound/Skin Guidelines for RNs](#) - Froedtert WOCN Website

[Specialty Bed and Mattress Algorithm](#) - Froedtert WOCN Website

CPM Guidelines: CPM Resource Center, An Elsevier Business/Pressure Ulcer Risk Braden; Spring 2013

CPM Guidelines: CPM Resource Center, An Elsevier Business/Skin Integrity; Spring 2013

CPM Guidelines: CPM Resource Center, An Elsevier Business/Pressure Ulcer Adult; Spring 2013

CPM Guidelines: CPM Resource Center, An Elsevier Business/Wound; Spring 2013

Ayello, E., Braden, B. (2002). International Guideline, Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline 2009. How and Why Do Pressure Ulcer Risk Assessment. *Advances in Skin & Wound Care*. 15(3), 125-1331.

Kring, D. (2007). Reliability and Validity of Braden Scale for Predicting Pressure Ulcer Risk. *The Journal of Wound, Ostomy, Continence Nursing*. 34(4), pp399-406.

National Database of Nursing Quality Indicators by the American Nurses Association. 2006-2010

Pressure Ulcer Treatment-Quick Reference Guide-National Pressure Advisory Panel. 2009

Acute and Chronic Wounds-Nursing Management. Second Edition. Bryant, Ruth 2000

Pressure Ulcer Treatment-European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP). 2009

Authorization:

Signatures on File in Nursing Administration Office

Reviewed and approved by Practice Council

Signature Chairperson Date

Signature Wound Care Nurse Specialist Date

Signature WOCN Nursing Director Date

Signature Chief Nursing Officer Date
Vice President, Patient Care Services