THE CHESTER COUNTY HOSPITAL and Health System

Orientation Manual

Patient Safety Assistant (PSA)

Nursing Staff Development

Patient Safety Assistant (PSA)

Job Description

Refer to your folder. Read through carefully.

PSA Initial Competency Assessment Form

This is a legal document and proof of your competency to take care of patients.

- You are responsible for completing it with your preceptor.
- You are responsible for turning it in to your manager at the end of your orientation.
- Once completed and signed, it remains in your HR employee file.

A Patient Safety Assistant is an employee who

- Provides direct observation for patients requiring supervision for safety reasons
- Transports patients to tests within CCH using a wheelchair or stretcher or to an exit at discharge
- Assists patients with ambulation and transfers to and from the bed
- Supports nursing units

There will be times when one PSA will be assigned to more than one patient at the same time on one unit! eg 2-4 Patients.
These situations will include patients:

- Who are intermittently confused
- Who are confused, but don't require 100% direct observation, they require frequent, ongoing dedicated rounds from a PSA without other patient care duties
- Where possible, 2 patients in the same room who need to be observed by sitter

The PSA in this situation is to make continual rounds to all patients assigned. They spend a few minutes per patient: assess for safety, converse, provide support within their role per patient, as needed, and move to the next patient repeat the same process as they continually rotate among their assigned patients. They communicate needs to the NA & RN that are outside of their role. This can work because the PSAs have no other assignment r/t other patients or to unit support.

These PSA 1:1 patient assignments include:

- Suicide precautions = ALWAYS get a 1:1 in a private room
- Patients deemed by RN to be at high safety risk, eg constant climber out of bed, a wanderer, or constant picker at IV etc; or a loud, or agitated, or anxious pt who is calmed by the constant presence of a sitter

Note: The PSA may not study while assigned to observe a patient and must keep the patient in their direct line of vision

Role Responsibilities

Responsibility	Patient Safety Assistants	Nursing Assistant
Documents on Continuous Observation Form	**X**	**only when assigned to 1:1**
Patient Positioning	**X**	**X**
Assist to Bathroom	**X**	**X**
Changes Bed Linen for patient (unoccupied bed)	**X**	**X**
Assist Patient with meals as needed	**X**	**X**
Assist with Bed to chair transfer (if applicable)	**X**	**X**
Transport	**Escorts 1:1 patient or when not assigned to 1:1 general transport duties**	**X**
Attends to General Patient Comfort Needs	**X**	**X**
Engages Patient with activity if applicable	**X**	**X**
Reports Patient Behavior/Movement to RN	**X**	**X**
Assist clinical staff as requested Bathing/Turning	**X**	**X**
Bathing		**X**
Patient Assessment (skin care/intake/output)		**X**
Vitals Signs		**X**
Incontinence Care		**X**
Data Entry Soarian		**X**
Restocks Supplies for Dept	**Only when not assigned to 1:1**	**X**
Delivers Specimens to Lab	**Only when not assigned to 1:1**	**X**
Respond to Call Bells	**Only when not assigned to 1:1**	**X**

Additional PSA Responsibilities

- Restock isolation carts with clean isolation gowns when assigned
- Clean IV Poles and Pumps after use.
    - And in use as needed.
- Clean feeding pumps (sticky) on a daily basis.
- Wipe down counters, COWS, phones, keyboards.
- Clean kitchen counters, date newly opened cartons of juice, and discard expired (30 days old).
- Assists patients with personal activities such as reading, using personal media, diversionary activities such as conversing, playing cards or working on a puzzle
- Disinfect BP cuffs with Saniwipes.
- Keep all equipment on one side of the hall.
- Report all broken equipment to Biomed. Use the red tags to label broken equipment. Send an SOS to Biomed.
- Keep patient care area and work environment neat and organized.
- Assists patients with repositioning, to the bathroom
- Return equipment to Central Supply
- Attend Staff Meetings on a regular basis.

Patient Safety Assistant Assignment Sheet

PSA Name:_____
Month_____Date _____Year_____

Unit:_____

Sitter Responsibility

Room #	Patient Name:	Patient Age:
Falls risk Isolation: NPO Diet: Activity: No visitors Does not speak English: Other:	Reason: Suicide Risk Safety Risk:_____ Comments:	Nurse Name:_____ Manager/Charge RN: Sitter Break time: Sitter meal time: Do NOT leave patient room until relieved by another staff member.

Unit Assignment: Complete all checked items. Place a check mark in PSA column when complete.
Return this form to the Manager/Charge RN when finished.
Return this to:_____RN

Manager/Charge RN √ Assignment	PSA initials when done	Assignment
		Cleans computers on wheels with sani wipes
		Returns _____to Central Supply Dept.
		Cleans microwave in kitchen
		Cleans interior of refrigerator in kitchen
		Discards outdated juice, milk, nourishments from kitchen refrigerator
		Checks for outdated lab tubes in Clean Utility Room
		Places all items along one side of hallways
		Wipes IV Pumps outside surfaces with Sani-wipe and covers with clean plastic bag
		Wipes stretcher mattress & frame with sani-wipes
		Writes today's date on the white board in each patient's room

Patient safety assistant assignment sheet

Age Specific Care

Different age groups mandate different considerations when providing care.

Safety

- Provide age appropriate supervision.
- Use age appropriate safety equipment (side rails on bed; appropriate crib; bed in low position).
- Provide care that adjusts for sensory deficits associated with the aging process.
    - **Visual deficits**: Turn on the lights! Eye glasses on! Objects within easy reach. Large print reading material.
    - **Hearing deficits**: Look at the patient so he can see your mouth when speaking. Speak in a **low pitch tone of voice**; speak clearly.
    - **Speech deficits**: provide paper/pencil; observe gestures, facial expressions.

Communication

- Identify yourself by name and title. Address patient as they request. "How may I address you?"
- Provide privacy and confidentiality. HIPAA
- Treat patients and their families with respect and dignity. Avoid "talking down" to patient.
- Communicate to patient at his/her developmental level.
- Provide teaching at age appropriate level. Identify patient concerns & fears.
    - Adolescents: Supplement information with rationale.
    - Adults: Involve patient in plan of care; use principles of adult learning: visual aides, provide information that is relevant; provide the depth & detail the patient needs/wants, base teaching on patient's previous experience.
    - Senior Adults: Same as adults. Factor in for sensory deficits that have occurred. Avoid talking down to senior adults! They are adults, NOT little kids.

Thermal Regulation

- Prevent over-exposure during bathing and other procedures.
- Older adults are often cold even when the environment is warm. This is due to:
    - poor circulation at the capillary level, especially distal areas like hands and feet.
    - lean body mass; many very old adults are very thin.
    - fragile skin
    - anemia- bones do not produce enough red blood cells (blood)
- ALWAYS ask, "Are you warm enough?"

Activities of Daily Living (ADLs)

- Getting the patient back to their ADLs promotes healing and wellness.
- Routines are important for many senior adults.
    - Provide orienting information such as clock, calendar, during day keep curtains open. Volunteers can obtain a newspaper for the patient.
    - Assess for sundowners syndrome, where the patient is oriented by day but disoriented by night.
    - Encourage family to bring in personal items. This will provide reassurance and help to orient the older adult.

Examples of Patient Equipment

- Vital Signs/BP, Finger Clip, Adhesive Probe

- The Pulse Oximeter is a non-invasive device that reads arterial oxygen saturation expressed as a percentage or in decimal points.
- **Normal oxygenation is above 92%.**
- If the reading is less than .92, tell the patient to take a deep breath!
- **If the number remains less than 92 tell the nurse immediately.**

Remote Telemetry Monitoring

Chest electrodes connect to a transmitter pack that is placed in the pocket of the hospital gown. The patient's cardiac rhythm is then transmitted to the monitor room on the 3rd floor and watched 7/24 by a monitor surveillance technician (MST).

- Care for patients as usual
- Electrodes dry out; remove the old and reapply new electrodes **daily**- during am care.
- Replace loose electrodes as needed.
- A red "hot line" phone will be at the nurse station & hallway
- It's distinct and LOUD. Answer it STAT!
    - If the MST notices any emergent problems they will call on the "Red Phone".
    - Any personnel in the area of the phone are to answer that phone immediately. If the MST identifies a problem that is NOT emergent, leads off or battery running low, they will call the unit on the regular phone.

Communication with the MST is important. Please notify the MST when:

- The electrodes are removed for patient care (example- am care).
- The patient is being transported to another department (keep the monitor on!).
- The patient's monitor has been discontinued by the physician.
- The patient is having physical therapy.
- The patient is being moved or when providing care that might cause interference (turning the patient or getting the patient up to a chair).

Lead Placement- To place the leads. Prepare the skin as follows:

- Clean skin with soap and water. If chest is hairy, carefully shave skin. Dry thoroughly.
- Cleanse skin with alcohol prep pad.
- Snap electrodes to lead wires.
- White and Red are **under the arms**

Hand Hygiene

- Wash your hands before touching the patient and when you leave the room.
- Use the hand sanitizer if you have not touched the patient.

Ways communicable diseases are spread

- Direct contact with patient.
- Contact with dirty linen, equipment, phone, computer, door knobs, other supplies.
- Contact with blood and body excretions- urine, feces, sneezing, coughing, spitting, and wound drainage

Handwashing Steps

1. Wet hands
2. Soap (20 seconds)
3. Scrub backs of hands, wrists, between fingers, under fingernails
4. Rinse
5. Towel Dry
6. Turn off taps with towel

Standard Precautions

Staff is protected by using standard precautions on all patients (if the patient requires isolation precautions, specific actions and procedures are added).

- Gloves: Wear when in contact with blood, urine, feces, and emesis or when in contact with open skin.
- Gowns: Wear to protect skin and when there is a potential for soilage on scrubs.
- Goggles: Wear when there is a likelihood of a spray or splash of body fluids or cough to the face.
- Specimen bags: Zip-lock bags that are used to transport specimens to the lab. Specimens placed in the pneumatic tubes should be double bagged.
- Used sharps are disposed of in the needle boxes including blood glucose lancets.
- All patients have an isolation code entered in the computer even if they are on standard precautions.

Isolation

This is required for the prevention of spread of serious communicable infections.

An isolation sign with specific instructions is placed outside the patient's door to alert hospital staff and visitors.

- Apply isolation arm band and an isolation label on hard chart.
- The infection control practitioner is notified of all isolation patients.
- Isolation attire- gloves, gown, mask as indicated, all donned before entering the room, disposed of inside the room on exiting. Go in clean, come out clean. Keep the germs in the room.
- Private room; patients may room together in a semi private room with a patient with the same infectious organism.
- Visitors wear and dispose of the same protective attire as staff.
- Everyone must wash hands before patient contact and donning gloves and when leaving the room.
- Educate visitors

Isolation Cart equipment

- Carts located in the hallway
- Contain: isolation gowns, gloves, masks, grey isolation laundry bags, red bags, disposable single use paper thermometers and Saniwipes to wipe down equipment.
- Restocked by nursing staff. A grey laundry bag is kept in the patient's room. The grey bag is for used cover gowns which are taken off inside the room before exiting.

Isolation Kit

- On admission, a CPOE order is placed to obtain an isolation kit from the store room.
    - Contains: a stethoscope, blood draw supplies, disposable single use paper rectal and oral thermometers
- On discharge, the stethoscope is recycled- place in the dirty utility room for central supply to sanitize and send back to the store room.

Airborne isolation precautions- germs that float in the air

Used for patients known or suspected to be infected with pathogens transmitted by small particles of evaporated droplets that contain microorganisms and remain suspended in the air.

- Examples- measles, varicella (chickenpox), tuberculosis, and herpes zoster (varicella-zoster).
- Private room, DOOR CLOSED
- Negative pressure room- the air inside the room is vented to the outdoor air. It may also be filtered before being circulated to other inside areas.
- Wear mask, gown, gloves
- If the patient is diagnosed with tuberculosis then a special HEPA mask is to be worn.
    - Annual mask fitting by infection control personnel
- Have you had the chicken pox?
    - People susceptible to measles or chickenpox should not enter the room.
- Patient should not be moved from the room, but if transport is essential, the patient should wear a mask and gown.
- Housekeeping should wait at least 60 minutes before cleaning the room at the time of discharge.

Contact isolation precautions- transmitted by touch

- Examples- touching infected gastrointestinal output, respiratory, skin, or wounds
- Private room- can cohort in a semi private room with a roommate with the same infectious organism
- Wear gloves and gown
- Transport of the patient from the room should be for essential purposes only. Staff should wear gown and gloves. Isolation arm band on patient. Isolation label on hard chart.

Droplet isolation precautions- the 3 foot rule
Droplets expelled during coughing, sneezing, or talking and fall to the ground at about 3 feet.

- Examples- Haemophilus influenza meningitis and pneumonia; Neisseria meningitis and pneumonia; multidrug- resistant Streptococcus meningitis, pneumonia, sinusitis, and otitis media; diphtheria; Mycoplasma pneumonia; pertussis; Adenovirus; mumps; and severe viral influenza.
- Private room, but negative pressure is not indicated; same cohort rule.
- Wear gloves, gown and mask
- The door can remain open.
- Transport of the patient from the room should be for essential purposes only. Staff should wear gown, gloves and mask. Mask patient. Isolation arm band on patient. Isolation label on hard chart.

The Neutropenic patient

A neutophil is a normal type of white blood cell used to fight infection. Neutropenic patients do not have enough neutrophils to fight infection. A cold can be deadly. These patients need to be protected from our germs.

Neutropenic isolation precautions- protecting patients from our germs

- Staff use standard precautions plus wear a mask.
- Visitors wear a mask.
- Neutropenic patients may be a cancer patient, a severely burned or malnourished patient, any patient with immune system compromise
- Private room
- Visitors or staff members with cold or flu symptoms may not enter the patient's room.
- Patient must wear a mask if transported out of the room.
- Fresh fruit or vegetables, and live flowers or plants are not permitted.
- Invasive procedures such as rectal temperatures and injection should be avoided.

Latex Allergies

High Risk Groups for Latex Allergy

- Began in the 1980's with Universal (standard) Precautions; Sudden wide spread use of latex gloves
- Many people got sick from repeated latex exposure.
- Persons with multiple abdominal surgeries; history of vaginal or penile edema after using latex contraceptives; history of mouth swelling after dental procedures; history of asthma or other allergies; history of reaction after contact with latex; anaphylactic reactions of unknown etiology .
- Females (75% of latex allergic persons are female)
- Allergies associated with latex allergy: (persons with 1 or more of these allergies may be latex sensitive/allergic): Bananas, Kiwi, Tropical fruits, Avocados, Chestnuts, Poinsettia plants

- Our goal is to be latex responsible, to provide an environment that minimizes the risk for health problems related to latex exposure.
- Occupational Health Department: if you have a latex allergy or sensitivity, you should discuss this with the occupational health department. If you are a new employee, you should have discussed this during your pre-employment interview physical.
- If the patient has a Latex allergy, place a green Latex Allergy arm band on the wrist.

Body Mechanics- Hands on practice

Good body mechanics are a learned skill and protect you from injury.

- **Basic rules of good body mechanics include:**
  - Maintain a broad base of support by keeping the feet 6 to 8 inches apart, placing one foot slightly forward, balancing weight on both feet, and pointing the toes in the direction of movement. This provides more balance.
  - **Do not bend or twist at the waist.**
  - When lifting from the floor, straighten your back as the object reaches thigh level. Avoid unnecessary bending and reaching. Raise the bed so it is close to your waist. Adjust the over bed table so it is at your waist level.
  - Face your work area to prevent twisting.
  - Use the strongest muscles to do the job. The larger and stronger muscles are located in the shoulders, upper arms, hips, and thighs.
  - Use the weight of your body to help push or pull an object. Whenever possible, push, slide, or pull rather than lift.
  - Carry heavy objects close to the body. Stand close to the object or person being moved.
  - Do not lift objects higher than chest level. Do not lift above your shoulders. Use a step stool to reach an object higher than chest level.
  - Work with smooth and even movements. Avoid sudden or jerky motions
  - Avoid bending for long periods of time.
  - Get help from a co-worker if the person cannot assist with turning or moving. Get help from a co-worker to move heavy people or objects.
  - Use the HOVERMAT and HOVERLIFT- located in the nursing office
  - Use the ROZE Stand-Up lift to move a partially weight bearing patient from a seated position to a seated position (wheelchair to chair, chair to commode). Located on WW1.

Ambulating the Patient

Ambulation prevents complications related to bed rest.

- Atrophy (decreasing muscle tone, especially in the legs) from infrequent weight bearing
- Blood clots- circulation slows down with prolonged inactivity
- Pressure ulcers- skin wounds arise when patients do not change their position
- Constipation- the gut slows down with inactivity
- Pneumonia- inactive patients do not often take deep breaths
- Contractures- muscles tighten when not extended and flexed often

Ambulation "Do's"

- Always ask the nurse prior to ambulating a patient
- Non skid slippers or shoes must be worn.
- If the patient has orthopedic shoes, put them on.

Crutches- Artificial support that assist with walking.

- Three point gait – This is the slow initial gait when only one leg can bear weight. Start with crutches at side. Advance both crutches and weak or affected foot. Transfer body weight forward to the crutches and advance unaffected or good foot forward.

Cane- A cane provides balance and support.

- The cane is used on the good (unaffected) side. There is also a quad cane for extra support.

Walker- This is a four legged device used by an ambulatory patient for balance.

- Lifted and placed in front of patient (back legs even with toes), patient walks into walker. Some walkers have wheels on front for sliding.

Preventing Pressure Ulcers- power point presentation

Making an Unoccupied Bed

- The purpose of making beds correctly: Provides comfort and protection for a patient confined to bed for long periods of time. Care must be taken to prevent wrinkles. They cause discomfort and contribute to pressure ulcers.
- A Draw sheet is often used. Placed under the patient from the shoulders to the knees. Used by 2 caregivers to move the patient up in bed.
- Pink Pad: A soft, fabric pad placed under the buttocks. It absorbs moisture from incontinence. It has a water barrier to protect the bottom sheet. The pink pad is preferable to a chux, as it does not cause skin maceration.
- Disposable bed protectors (chux) are also used. Chux serve a variety of uses. Care should be used, as Chux when wet, can lead to maceration of the skin. It is essential to use body mechanics during bed making to protect your back and conserve energy. Plan bed making appropriately: Place linen in order of use and make one side of bed completely then move to other side.

Patient Hygiene Care

Oral Hygiene

- Oral Hygiene (mouth care) is done to ensure the mouth and teeth are kept as clean as possible.
- This will prevent halitosis or bad breath, mouth sores, oral caries, diseases and infections.
    - Every am **and** pm- toothbrush or swab as indicated by the nurse
    - Dentures are removed at night, brushed and stored in a denture cup labeled with the patient's name
    - If the patient is NPO oral care is done every 2 hours
- Oral hygiene will also make food taste better, so the patient's appetite is stimulated.
- Report the following to the nurse:
    - Dry, cracked, swollen, or blistered lips
    - Redness, swelling, irritation, sores or white patches in mouth or on tongue
    - Bleeding, swelling, redness of gums, loose teeth

Bathing

- **All patients wash-up daily**
- **All patients receive PM care**- face and hands washed, teeth brushed (or swabbed)
- Dentures are removed for the night

Types of baths

- Complete bed bath: the patient is bathed in the bed by nursing staff
- Partial bed bath: The patient sits at the bedside and washes self with assistance.
- Self AM Care: The stable ambulatory patient may shower or wash at the sink.

Basic Principles for bathing patients

- Provide respectful privacy; draw the curtain, keep the patient covered with a bath blanket
- Use warm water and soap; change the water frequently. Use a fresh washcloth & towel as needed.
- Assist the patient as directed by the nurse.

Foley Catheter Care

A Foley catheter is a thin, sterile tube inserted into the bladder by a nurse or physician to drain urine. It is held in place with a small water filled balloon to prevent the catheter from falling out of the bladder. The urine drains through the catheter down below the level of the bladder into a urine collection bag.
When no longer needed, the catheter is discontinued by the nurse or physician.

- Foley catheter care is performed by the NA with daily am care. If the patient is incontinent of stool, catheter care is repeated.

A leg strap is applied to prevent twisting and pulling.

  - Keep the urine collection bag below the level of the bladder and off the floor.
- Empty the urine collection bag at the end of the shift and when full.
  - Communicate to the nurse the amount emptied

What Is CAUTI? (Catheter Associated Urinary Tract Infection)

Why prevent CAUTI?

- Risk of infection, can be very serious and cause pain and discomfort to the patient.
- If a patient acquires a UTI, it will cost the hospital approx. $1200-$1500 to treat it.

- **What are measures that could be used to manage incontinence <u>without</u> use of a Foley catheter?**
  - Frequent toileting. Offer hourly assistance to the bathroom.

- **Methods to prevent CAUTI from occurring in hospitalized patients with an indwelling catheter**
- Administer routine catheter care every day and every time the patient is incontinent of stool.
- Provide enough slack in the tubing to avoid tension
- <u>Never</u> raise the Foley bag above the level of the bladder or leave the Foley bag on the floor
- Secure the Foley to prevent irritation or urethral trauma- use a leg strap device
- Remove Foley catheters ASAP

<u>SCDs- Sequential Compression Devise</u>- improves circulation, prevents blood clots.

- Leg sleeves ARE disposable
- Long clear compressor tubing is NOT disposable
- Inflatable leg sleeves snap onto the air compressor's long clear attached tubing.
- Remove leg sleeves daily for am care and then reapply. Be sure the air compressor machine is on.
- When the SCDs are discontinued, the inflatable leg sleeves are discarded.
- Place the used compressor with attached long clear tubing in the dirty utility room for central supply pick-up, cleaning and reuse.
- SCD air compressor machine will hang on the end of the bed

Feeding Patients

Good nutrition is required to recover from illness, regain strength and heal wounds. Adults and children are positioned to eat while seated and fully upright.

- Communicate to the nurse the amount of foods and fluids that are consumed by the patient.
  - OOB in the chair is the gold standard
  - If eating while in bed- Must be FULLY UPRIGHT in a seated position in the bed- use the 'chair position' feature on the bed.
  - Never feed a patient in a semi recumbent position. It may lead to choking and aspiration.
  - Make sure the food tray is in the patient's reach, open containers as needed.
    - Juice and milk containers, salt and pepper are hard to open.
  - Cut food into bite size pieces.
  - Feed the patient at a pace that allows him to fully chew and swallow the food.
    - Do not rush the patient.
  - Stop feeding if the patient has difficulty swallowing or begins coughing while eating.
    - Report this to the nurse immediately.

Dysphagia (Difficulty or the inability to swallow normally.)

- **Symptoms** - coughing, choking, holding food in mouth or food falling out of the mouth, delayed or painful swallowing, drooling, impaired chewing, changes of eating habits, slow eating, or decreased oral sensation.
- **Causes** - stroke, generalized dementia, spinal cord injury, head and neck tumors, Alzheimer's, Parkinson's, Multiple Sclerosis and other progressive neurological diseases.

Aspiration (Rather than traveling down the esophagus to the stomach, food, liquids, even saliva goes into the lungs.)

- **Symptoms**- chest congestion, increased secretions, wet gurgle voice, coughing, throat clearing, fever spike

Feeding a patient on Dysphagia Precautions

- **PSAs do <u>NOT</u>** feed dysphagia patients.
  - Performed by the nurse or nursing assistant.

Code Blue: Maintenance of Crash Carts

- ∅ **NEVER TAKE EQUIPMENT OR SUPPLIES FROM THE CRASH CART UNLESS YOU ARE USING THEM FOR A CODE BLUE!**

PSA Responsibilities in a Code Blue

If you find a patient unresponsive and not breathing, pull the code button on the wall inside the room; call out for help; lay the patient flat using the CPR hand pull on the side of the bed and lift off the head board. Your coworkers will arrive and assist with rolling the patient onto the head board for CPR compressions. Begin CPR- compress as you practiced in your Basic Life Support (BLS) training.

- 4444 is dialed to communicate a Code Blue to the operator

Emergency skills

- Empty the water pitcher safely into the sink! (spills cause slips and electrocution)
- Clear the space; make room for the Code Team (responders are on the way)
  - Remove the table, chair, commode and any other equipment in the way
  - Look under the bed for tripping hazards (the bed will be moved)
- Provide care for the other patients on the unit
  - A nursing assistant should comfort the roommate- for example, "Isn't it amazing that when you are that sick, all these people show-up to help…YOU are in a safe place."
  - Stay with the Roommate
  - Be calm & comforting

After the Code

- Assist the nurse with room clean up. Wear gloves, standard precautions, to prevent accidental needle stick!
- Assist the nurse with transport of the patient to ICU if needed, or assist with post mortem care.
- Assist the staff by
  - Taking the crash cart to Central Supply (2nd floor).
  - Get a new cart from Central. Take it to your unit. Put the monitor/defibrillator on top of the cart. Plug in the monitor and the portable suction machine

DNR, and Post Mortem Care - power point presentation

Restraints
Demonstration

PATIENT IDENTIFICATION LABEL

THE CHESTER COUNTY HOSPITAL *and Health System*

Continual 1:1 Observation Record

LOCATION CODE

C= Consultation Room
H= Hallway
L= Lounge
0= Off Unit
R= Room
S= Shower

ORIENTATION CODE

1= Alert/Oriented
2= Confused/Disoriented
3=Verbally Appropriate
4= Verbally Hostile
5= Withdrawn & Isolative
6= Active & Socializing
7= Agitated & Pacing
8= Calm & Complient
9= Awake
10= Sleeping
11= Eating
12= Visitors

REASON CODE: Check Appropriate Reason(s)

___ Fall Prevention
___ Elopement Risk
___ Confusion/Disorientation
___ Suicidal Attempt/Ideation
___ Aggressive Behavior
___ Other: (specify) _____

DATE INITIATED: **TIME INITIATED:**

Time	Loc	Orien	Init	Time	Loc	Orien	Init	Time	Loc	Orien	Init	Time	Loc	Orien	Init
0700				1300				1900				0100			
0715				1315				1915				0115			
0730				1330				1930				0130			
0745				1345				1945				0145			
0800				1400				2000				0200			
0815				1415				2015				0215			
0830				1430				2030				0230			
0845				1445				2045				0245			
0900				1500				2100				0300			
0915				1515				2115				0315			
0930				1530				2130				0330			
0945				1545				2145				0345			
1000				1600				2200				0400			
1015				1615				2215				0415			
1030				1630				2230				0430			
1045				1645				2245				0445			
1100				1700				2300				0500			
1115				1715				2315				0515			
1130				1730				2330				0530			
1145				1745				2345				0545			
1200				1800				2400				0600			
1215				1815				2415				0615			
1230				1830				2430				0630			
1245				1845				2445				0645			

Initials	Signature	Initials	Signature

PATIENT IDENTIFICATION LABEL	THE CHESTER COUNTY HOSPITAL and Health System **Continual 1:1 Observation Record**
Notes:	

RN Signature: _____ Date: _____ Time: _____

Purpose of 1:1 Supervision/ Continual Observation

To provide a therapeutically and physically safe environment for patients who have been determined to need continual observation (1:1). Examples- patients who are falls risk, have behavioral issues, exhibit signs of dementia, exhibit post-op confusion, have expressed suicidal ideation and/or attempted suicide.

- Patients assigned to 1:1, continual observation have a staff member assigned at the bedside for the purpose of continuous observation.
- The staff member does not leave the bedside unless relieved by another qualified staff member.
- When a physician or psychiatrist wants to examine, talk with, or do a procedure, the Sitter should ask the physician/psychiatrist if s/he should leave.
    - If the physician/psychiatrist requests them to step out, the Sitter must stay right outside of the patient's door and immediately re-enter the room when the physician/psychiatrist leaves the bedside.
    - For patients with tele-psyche consult, the sitter or RN must remain at the bedside during the tele-psyche consultation.

Handoffs

The following information is given in a hand-off whenever there is a change in the Sitter.

- Patient name, and manner the patient wishes to be addressed, e.g. Mr. Smith, or first name
- Reason for 1:1 observation: e.g. falls risk, confusion, suicide precautions etc
- Significant patient information relevant to the sitter: e.g. patient is/is not allowed OOB to bathroom; patient is NPO, or on fluid restriction; patient may/may not have visitors
- Information that is useful to the Sitter for relating to the patient. E.g. the patient enjoys/does not enjoy conversation/TV/reading. Topics or activities that calm the patient; that agitate or upset the patient. Provides relevant information pertaining to visitors, e.g. persons restricted from visiting.

Safety Information

Important safety information should be reviewed with the sitter.

- The sitter must keep the patient within eyesight at all times.
- The sitter may not leave the room unless another qualified person has relieved the sitter.
- The bathroom door must remain open so that the Sitter can observe the patient

- Review of the list of potentially dangerous items for a suicide precaution patient with the Sitter (see last page for list)
- Review of situations that warrant immediate call for help, e.g. patient verbalizes plan or attempts to harm self; patient attempts to elope; patient attempts to climb out of bed; change in condition, or patient has need for psychosocial support beyond the scope of the Sitter.
- Establish times for relief breaks.
- Review of documentation requirements on the Continual Observation Flow Sheet
- Maintain direct supervision of the patient.
    - Sit in a chair at the bedside or at the foot of the bed.
    - Engage in conversation or activities such as reading to the patient, as appropriate.
    - Avoid use of threatening behavior such as loud voice, or staring with threatening eye contact.
    - Position self so that you are not boxed into the room; place chair between door and patient.
- Use call bell or calls out for help when needed.
- Assist patient, within scope of job description.
- Ensure bathroom door is kept open so that supervision of the patient is maintained.
- Inform RN immediately if items that could be harmful are brought into the room by visitors, or if the patient uses an item in a harmful manner.
- Use call light to summon RN, or calls out for help if patient in immediate danger.

The RN makes frequent assessments of the patient, provides all nursing care to the patient, and communicates with the Sitter on a regular basis.

Suicide Precautions

All patients on continual observation for suicide attempt/suicide ideation will have their belongings searched by nursing personnel for any potential dangerous objects (mirrors, razors, matches, belts, etc). All potential lethal materials are removed from patient room, placed in a Continual Observation.

Documentation

Use the Continual 1:1 Observation Record.

- Label form with patient's name.
- Check reason for 1:1, e.g. Fall Prevention or Suicide attempt, etc.
- Record date and time initiated.
- Location Code (patient's location)
- Orientation Code
- Initials
- Full Signature and Title

For non-suicide observation patients: Document at least once every hour
For suicide precaution patients: Document every 15 minutes

Instruct patient/family/visitors about the need to remove all of patient's personal items and items that could be used to inflict injury or harm. Instruct family/visitors about items not permitted.

Items that are NOT permitted in the room of a patient on suicide precautions:

1. Safety razors or razor blades
2. Lighter fluid, lighters and matches
3. Knives: pocket, pen carving, any type of knife
4. Cosmetics, toiletries, items in glass containers
5. Scissors
6. Mirrors: hand and compact
7. Wire hangers
8. Aerosol cans
9. Ceramic or glass flower pots
10. Nail files, clippers and nail polish
11. Electrical appliances, such as hair dryers, curling irons and electrical razors
12. Personal electronics: music, computer, phone, etc
13. Medications and medication administration equipment and supplies
14. Plastic trash bags, plastic bags of any type, or plastic wrap
15. B/P cuff
16. Shoe laces
17. Balloons
18. Gloves
19. Belts
20. Telephone cord