

Care of Patients II

6. Question:

Answer:

1. How are patient care plans developed?

1. A care plan is developed by many disciplines - Physical Therapy, Nutritional Services, Occupational Therapy, Nursing, Physicians, etc. Staff discuss their plans, review notes/consults from other disciplines, etc to ensure collaboration. The patient, the patient's family or significant other is involved. Consults are used to initiate collaboration with other healthcare professionals.

2. Where can the care plans be found?

2. Care Plans are documented in the medical record in the appropriate area.

7. Question:

Answer:

Explain the procedure to follow prior to a patient receiving anesthesia.

1. Obtain an informed consent policy.
2. Medical record reflects that caregivers have discussed anesthesia with patient and their families.
3. Anesthesia notes that patient's are reassessed prior to induction.
4. A pre-op checklist is completed prior to induction.
5. The anesthesia plan is documented in the Medical Record.

8. Question:

Answer:

Explain the monitoring of patient's during anesthesia and in the post-operative period.

1. Intraoperative monitoring is documented on the anesthesia flow sheet.
2. The circulating nurse documents the patient's status in the intra-operative record.
3. PACU documents monitoring on its flow sheet.
4. The anesthesiologist discharges the patient from the PACU or orders for the patient to be transferred when they meet preapproved medical criteria.

9. Question:

1. Where is the Conscious Sedation Policy?

2. What is required before Conscious Sedation and where is it documented?

Answer:

1. Hospital Policy Manual 5.26

2. A patient assessment which is documented on the anesthesia form or the conscious sedation form. MD Preprocedure assessment includes history of family/personal problems with anesthesia/sedation:
Auscultation of the heart and lungs
Airway evaluation
Pertinent physical exam
Review of abnormal lab results.
Evaluation of blood/blood component requirements (if applicable)
RN Assesses:
NPO Status
Pain level
Current medications
-Skin and musculoskeletal
Allergies/adverse reaction assessment
Tobacco/alcohol/drug use
Level of consciousness
Pregnancy
Psychological status
Level of activity

10. Question:

How do you know what medications are available in this institution?

Answer:

The hospital formulary lists each type of medication in the hospital. This is found on the invision computer on Hospital Home Page- Systems, Policies & Alerts. Then click on formulary.

For personal computers, use the following website address:

http://www.sh.lsuhs.edu/policies/policy_manuals_via_ms_word/formulary/index.htm

11. Question:

How do you distribute patient specific medication information to all appropriate caregivers?

Answer:

On admission, the nurse documents a patient's known allergies, height and weight in the medical record. These are also required fields when entering the patient in the Invision system. Known allergies and weight are also documented on the MAR and on the physician's first order sheet. The information is available for pharmacy and dietary. A copy of the Physician's first order sheet is sent to pharmacy so that pharmacy may have the allergy/weight information. Allergy information is also recorded on the patient's allergy bracelet and chart.

Pharmacy doesn't fill a medication order until allergies are known unless an emergency medication is needed.

12. Question:

What is required to dispense food or a nutritional product to a patient?

Answer:

A diet order is required from a physician or a licensed independent practitioner.

13. Question:

How are patient's dietary intakes evaluated?

Answer:

1. Nursing observes and documents patient's tolerance to their diets in the nurse's notes.
2. Nursing and dietary monitor intake when a patient is on a calorie count.
3. Medical staff uses this information to make changes as needed.
4. Special meals are provided as needed.

14. Question:

1. Who writes the criteria for blood transfusions?
2. If a physician orders a transfusion that does not meet the criteria for a transfusion, how is this handled?

Answer:

1. Blood Utilization Review Committee (BURC) writes the criteria for transfusions.
2. At Blood Utilization Review Committee (BURC), physician reviewers complete an indicator form. Transfusions that are not acceptable are referred to the Medical Staff Peer Review Process and the appropriate department peer reviewer.

15. Question:

Select one patient record. Review for the following:

1. Needs identified on admission.
2. Goals established for the patient.
3. Teaching / Learning needs of the patient and/or significant other.
4. A documented plan of care.
5. An evaluation of interventions.
6. Involvement of other disciplines in the patient's care.

Answer:

Evidence of 1-6 are required in the medical record.

16. Question:

What is the proper procedure to document narcotic waste?

Answer:

Follow Hospital Policy 8.13 for Medication Control procedure for narcotic waste.

17. Question:

How frequently must a patient in restraints be reassessed?

Answer:

Every 2 hours by a licensed nurse and documented on the patient restraint flowsheet for nonviolent PATIENTS.

For behavioral health or severely aggressive/violent patients: Continuous face-to-face monitoring.

Assess and document every 15 minutes as appropriate to the type of restraint used by the qualified RN/LPN:

The patient is unharmed and a safe environment is being maintained,

Circulation checks and range of motion in the extremities if restrained,

Vital signs as appropriate,

Nutrition, hygiene and elimination,

Level of distress, and psychological status,

Alertness and readiness for discontinuation of restraint or seclusion.

Re-evaluation is performed by a qualified RN or MD to evaluate the appropriateness of the patient's treatment plan and to work with the patient to identify ways to help him/her regain control of behavior. Re-evaluation of the patient occurs at least:

every 4 hours for adults 18 years and older;

every 2 hours for children and adolescents ages 9 – 17; and

every 1 hour for children under 9 years of age;

and determine if the behavior that precipitated the use of restraints is still present or if restraints can be discontinued.

Hospital Restraint Policy 5.15, 5.15.1 and 5.15.2

18. Question:

How often do narcotics for patients need to be reordered?

How often benzodiazepine (alprazolam, lorazepam diazepam etc.) orders must be rewritten.

When do inpatient medication orders expire for all medications?

Will the preprinted Medication Administration Record have a reminder when medications are about to expire?

Answer:

Narcotic orders are to be rewritten every 72 hours. If the order has expired, it is the nurse's responsibility to notify the MD.

Orders for benzodiazepines must be rewritten every 14 days.

Orders for all medications expire after 30 days.

Yes. A notice will be printed in the MAK system and/or Medication Administration Record on the day before a medication order is scheduled to expire.

19. Question:

Do you withhold medication if the MD writes an order for NPO?

Answer:

The MD shall indicate any medication to be given after the patient is made NPO.

20. Question:

1. Where is the Patient's Rights Policy located?

2. Identify aspects of Patient's Rights.

Answer:

1. The policy is located in the Hospital Policy Manual in the Patient Handbook and is posted.

2. Aspects of Patient's Rights include: Access to Care, Information, Respect, Communication, Privacy, Confidentiality, Consent, Safety, Right to Refusal, Consult, Pain Management, Identity of Care Givers, Transfer and Continuity of Care, Patient Responsibilities, Hospital Rules and Regulations, Hospital Policy 5.17

21. Question:

How are emergency medications securely stored and inventory monitored?

Answer:

They are maintained in an Automated medication system or a crash cart with a secure lock. Crash Cart lock verified every 24 hours.

22. Question: Answer:
What is the procedure for monitoring a patient on Suicide Precautions? Observation. Document behavior. Label chart. Notify other personnel. Remove dangerous objects. Observe every 15-30 minutes.
23. Questions: Answer:
What is the procedure for attempted elopement? Attempt to return. If occurrence turns into pursuit, let patient go and notify UPD.
Notify MD and complete variance report.
24. Question (Psychiatry Unit Only): Answer:
What is the time limit for seclusion? Four hours. Assess patient continuously and document every 15 minutes.
26. Question: Answer:
How is the use of restraints determined? The use of restraints is determined by the need to protect the patient from harm or others from injury or to prevent removal of tubes/IV's/dressings and are only used as a last resort after non-physical alternatives have failed unless safety issues demand an immediate physical response. Alternative interventions are attempted prior to restraint (behavioral intervention, distraction, communication using non-threatening body language/tone of voice, more frequent observation, quiet surroundings, room change, comfort measures, obtaining family/sitter support, reorientation, treatment change, or night light, obtaining a psych consult etc.,).

27. Question:

What is the nursing care for a patient who is restrained / secluded?

Answer:

Patient assessment is performed at least every 2 hours for nonviolent patients.

- Behavioral Health/Severely aggressive/violent patients are continuously monitored, with documentation, every 15 minutes – refer to hospital and unit specific policy.
- Reassess the need for restraints.
- Assess skin, circulation checks, offer assistance with ADL's, provide for range of motion and repositioning, whether restraint has been properly applied, level of distress/agitation, alternatives attempted and outcome, and patient well-being, safety, dignity and rights maintained.
- Assess whether restraints/seclusion is still needed. Qualified RN or MD makes the decision to discontinue restraint/seclusion use.

28. Question:

Where is patient education documented related to the use of restraints/seclusion?

Answer:

On the interdisciplinary education form, the restraint flow sheet, in the nurse's notes and/or progress notes.

29. Question:

Who may apply restraints?

Answer:

Any staff who is trained to do so as evidenced by documentation of competency in the employee's file.

30. Question:

When can restraints be ended?

Answer:

Discontinue restraints ASAP. The MD or qualified RN makes the decision to discontinue restraints, based on observation and assessment that the patient no longer needs the restraint to protect self or others; tubes/lines/dressings have been discontinued, or behavioral guidelines ordered by the physician have been met and documented.

Care of Patients II

31. Question: Answer:
When a restraint is terminated prior to expiration of the order, do you need to obtain a new order if the patient has to be placed in restraints again? Yes.
32. Question: Answer:
1. Who can order restraints? 1. A physician.
2. How long is a restraint order valid? 2. For nonviolent patients, the initial order can be valid for a maximum of 24 hours. If the patient needs restraints past the 24 hour period, the MD must reassess the patient. Document need for restraints in the medical record. The reorder for nonviolent patients is valid for a maximum of one calendar day. For behavioral health/severely aggressive patients: The restraint orders is limited to 4 hours for adults, two hours for 9-17 year olds and one hour for patients less than 9. Per Hospital policy, the MD can have the qualified RN reassess the patient and call for a verbal order in the same time increments as the original order. After this, the MD must personally reassess the patient and write a new order. Therefore, the M.D. must personally re-examine an adult in 8 hours and all patients 17 years or less in 4 hours.
33. Question: Answer:
1. Who can consult dietary if there is a special dietary need? 1. MD, RN, LPN – Hospital Policy 5.3
2. If a dietician is not available, what material is available for your use related to dietary instruction? 2. Nutritional Services Manual which is located on the unit.

34. Question (Psychiatry Only): Answer:
What is the procedure for time-out? Not greater than 30 minutes, no locking devices on door.
35. Question: Answer:
Where is it documented that the MD has reviewed the risks of transfusion and alternative blood transfusion plans with the patient? In the patient record – on the Blood Consent Form.
Hospital Policy 5.16.1 Informed Consent.
36. Question: Answer:
How are staff trained to administer/monitor chemotherapy? Refer to Chemotherapy Policy C46 in Nursing Policy Manual
Monitor:
Complete chemotherapy course, take written exam and score 80%.
Complete chemotherapy skills checklist.
Administer:
Meet the requirements for monitoring
Successful administration of 3 chemotherapeutic agents under supervision of an RN and documented on the skills checklist.
At the patient's bedside, verify with a second RN –
The patient, chemotherapy drug and dosage to be administered with the physician's order prior to administration.
Annual Requirements to Monitor or Administer Chemotherapy:
Complete annual competency requirements listed in Nursing Policy C46.
Complete Chemotherapy review and examined score at least 80% on the test annually.
Review LSUHSC-S Safety Policy and Procedures for use of Chemotherapy drugs (3.2).
Ongoing Chemotherapy education with at least 2 documented programs per year. (It is recommended that staff attend a live Didactic Chemotherapy course annually).
Evidence of at least one formal in-service/chemotherapy offering annually.

Successful completion of a Chemotherapy Competency checklist under the supervision of a RN with documented competency in Chemotherapy.

37. Question:

What is your area's medication error rate? How are errors reported, traced, and trended?

Answer:

Specific to area. Errors are reported via a variance report and trended through Hospital Performance Improvement. This information is shared in meetings

38. Question:

Are all medications secure and locked? If they are not locked, are they under constant supervision of the person administering them?

Answer:

Yes. Carts and cabinets where unit dose medications are stored must be closed/locked when not being used. This also includes normal saline flushes and lidocaine vials. IVPB's should be kept in the locked refrigerators. Medications sent in the tube system should not lay around on countertops—they must be locked in the unit dose cart/cabinet/refrigerator. Return any discontinued medications to the pharmacy or place in a designated (locked) area on each floor for pharmacy to pick up.

39. Question:

Describe how you assess for pain in your patients.

Answer:

Patient's are assessed for pain and at the initial clinic visit, on admission to the hospital, post invasive procedure and when the patient complains of pain. If pain is present, a more comprehensive pain assessment is performed and the MD is notified. See Hospital Pain Policy 5.34 for further information.

40. Question:

What pain scale is used to assess pain intensity for patients who are less than 5 years old or unable to self-report pain?

Answer:

The FLACC Pain Scale:

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories (F) Face, (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

To measure intensity using the FLACC scale;

- Score each component as a subscore (face, legs, activity, cry, consolability)
- Total subscores to determine FLACC score

Notify the physician if the patient's pain is ≥ 5 using the FLACC and/or unacceptable to the patient.

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41. Question:

What pain scale is used to assess the pain intensity of patients ages 5 – 12?

Answer:

The Wong-Baker Faces pain Rating Scale:

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain (hurt).

Face 0 is very happy because he doesn't hurt at all. Face 8 hurts a whole lot more.
 Face 2 hurts just a little bit. Face 10 hurts as much as you can imagine,
 Face 4 hurts a little more although you don't have to be crying to feel this bad.
 Face 6 hurts even more
Ask the person to choose the face that best describes how he is feeling.

Notify the physician if the patient's pain is ≥ 5 using the Wong-Baker FACES pain Rating Scale and/or unacceptable to the patient.

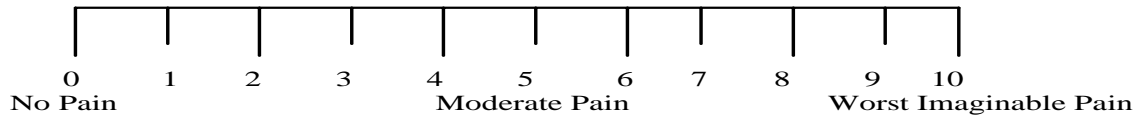
From Wong D.L.; Hockenbery-Eaton M; Wilson D; Winkelstein M.L.; Ahmann E; DiVito-Thomas P.A.; Whaley and Wong's Nursing Care of Infants and Children, ed 6, St. Louis, 1999, p. 2040. Copyrighted by Mosby Inc. Reprinted by permission.

42. Question:

What pain scale is used to assess pain intensity for patients ages 13 years or older who can self-report pain?

Answer:

The Numerical Pain Intensity Scale (NPIS):



- Staff will ask the patient to score their pain on a scale of 0-10 with 0 representing no pain and 10 the worst imaginable pain.
- Notify the physician if the patient's pain is ≥ 5 using the Numerical pain Intensity Scale (NPIS) and/or unacceptable to the patient.

43. Question:

Describe the information collected on the comprehensive pain assessment.

Answer:

Pain location
Intensity
Duration
What makes pain better/worse
Pain management history
Pain treatment goal
Other information as appropriate.

44. Question:

If a patient is not in pain, how often do you reassess for pain.

Answer:

Post invasive procedure and when the patient complains of pain.

45. Question:

Is pain management monitored through performance improvement? What are the findings from Performance Improvement?

Answer:

Yes. Describe PI results on pain management.

46. Question:

How are patients educated about pain management?

Answer:

The Patient Handbook has some information. The nurse, physician, or other health care providers provide education about pain management.

Describe any written materials available.

47. Question:

How does staff administering investigational drugs receive education about the research drug?

Answer:

All healthcare professionals, prior to administering an investigational drug, must complete a competency assessment form (SN 1146) to be filed in their department.

Hospital Investigational Drug Use Policy 5.4.8.

48. Question:

What four requirements must be written on a typenex armband?

Answer:

Patient's full name
Patient's medical record number
First initial, full last name of phlebotomist
Date

49. Question:

When a transfusion reaction has occurred, what are the first four steps that should be taken?

Answer:

Stop transfusion immediately. Provide appropriate emergency care and notify MD.
Fill out transfusion reaction form.
Draw red and purple top tubes.
Send tubes, form and transfusion set to the Blood Bank.

50. Question:

What rate (minimum/maximum) should a unit of packed red blood cells be transfused?

Answer:

A unit of red blood cells can be transfused at any rate (using doctor's orders), but must be stopped at 4 hours.

51. Question: Answer:
How do you get laboratory results? Check Invision. If results should be out and are not available, contact the Clinical Laboratory for further information at Ext. 5-5700.
52. Question: Answer:
How do you add an additional verbal test (given over the phone) once the specimen is in the Clinical Lab? Key in additional tests requested by verbal order from the MD; notify Clinical Lab.
53. Question: Answer:
What level of nursing staff is responsible for receiving clinical laboratory panic values called by the Clinical Laboratory? Hospital – RN
Clinics – Designated nursing staff as defined in policy.
54. Question: Answer:
If you are uncertain about specimen requirements for a specific laboratory test, where can you find this information? The Yellow Lab Manual contains specific information concerning collection and special instructions for all tests performed in the lab as well as many tests sent out by referral. If still unclear, call the lab for further information.
55. Question: Answer:
PRN Orders should include specific indications and intervals for dosing. (True/False) True. Ranges such as every 2-3 hours prn are not acceptable. A specified interval such as every 3 hours is acceptable.

Hospital Pain Policy 5.34

56. Question:

Answer:

(True/False)

True

When writing pain medication doses, range orders should be avoided unless accompanied by a sliding scale.

Hospital Pain Policy 5.34

Examples:

Inappropriate order for pain:

Morphine 4-10 milligrams IVP every 3 hours

Appropriate orders for pain:

For pain rating 5-7, administer morphine 5 milligrams IVP every 2 hours prn pain;

For pain rating 8-10 administer morphine 10 milligrams IVP every 2 hours prn pain, etc.)

57. Question:

Answer:

Only one long acting pain medication should be prescribed at a time.

True

(True/False)

Hospital Pain Policy 5.34

58. Question:

How does staff ensure Clinical Alarms are managed safely?

Answer:

The user verifies proper alarm settings and functions when they place a patient on the equipment.

Alarm settings are activated according to unit criteria/medical condition/etc.

Alarms are sufficiently audible with respect to distances and competing noise within the unit.

When possible, patients and families are instructed to notify staff when alarms sound.

The call bell is placed within reach so patient's may call staff for alarms.

Special needs patients are placed close to the nurse's station so staff may hear the alarms.

Nursing assistants make rounds on patients and notifies nurses when alarms sound.

Staff uses the patient call system to check for alarms.

Many units have special alarms.

59. Question:

Any patient with a behavioral health disorder that requires restraints follows the guidelines for unanticipated severely aggressive patients.

This includes patients in the emergency room who are awaiting transfer to the psychiatry unit and need restraints.

True/False

Answer:

True

Hospital Policy 5.15 and 5.15.2

60. Question:

When a patient with a behavioral health disorder is restrained in EMS or area other than the psychiatry unit, the physician collaborates with psychiatric physicians to ensure appropriate evaluation of the patient until the transfer occurs.

Answer:

True

61. Question: (For the Psychiatry Unit)
What might make restraint use more vulnerable for a behavioral health patient?
- Answer:
Preexisting medical conditions or any physical disabilities and limitations;
Any history of sexual or physical abuse.
62. Question:
Observation:
Can labeled empty syringes be found in your area?
- Answer:
No. (Surveyors look for this practice and have issued citations for this).
63. Question:
What are the criteria to admit/discharge a patient from your area?
- Answer:
Answer will be unit and department specific. Refer to departmental/unit policies/standards/guidelines.
64. Question:
When a critical value is called to a nursing unit, how is this managed?
- Answer
In-Patient Areas:
When the laboratory technician calls the nursing unit to report a critical lab value, an RN or RN Applicant shall record the patient's name and the critical lab value on a card. The nurse will "read back" the patient's name and the critical lab value to the laboratory technician and document, the patient's name, critical lab value, and "read back" in the narrative nurses' notes. The nurse shall then immediately notify the physician of the critical lab value. The card shall be placed on the outside cover on the front of the chart. The nurse shall record the notification of the physician, the physician's name and any orders/instructions given.
* Note: Inpatient Discharge: For discharged patients, the nurse shall instruct the lab to call the ordering physician. See Hospital Policy: 5.30, Reporting of Laboratory Critical/Non-critical Test Results. See Nursing Policy N43 Nursing Documentation Rules and Regulations for specifics regarding inpatient nursing.