

## **REQUIRED LEARNING 2021 FOR CUSTOMER CARE ROLES**

This learning packet is for North Memorial Hospital individuals in a customer care role. It presents fundamental and important information that helps us create a safe and caring environment for our customers and team members. The information provided on various topics have been contributed by NMH subject matter experts.

The topics covered in Part 1 are:

- Customer Care Team Members
- Medication Safety
-

## Customer Care Team Members

# Content for Customer Care Team Members

2021



*Click on a box to view topic.*

Vocera

Patient  
(Customer)  
Identification

Specimen  
Labeling for  
Lab Testing

Point of Care  
Lab Testing

Surgical and  
Procedural  
Site Marking

Time Out

Stop the Line

Critical Results  
and  
Communication

Patient  
(customer)  
Hand Off

Verbal and  
Telephone  
Order Safety

Care Plans

Pain  
Management

Fall  
Prevention

Pressure  
Injury  
Prevention

Lift  
Equipment  
Review

**Great Job!**  
**Click here to continue.**

## Patient Identification

How many patient identifiers are required for administering medications, collecting blood samples, and other specimens for clinical testing (not including Blood Bank samples), and providing treatments or procedures or services?

1

2

3 or more

Services include transporting patients within North Memorial Health Hospital and transferring patients to other healthcare facilities.

## Patient Identification

How many patient identifiers are required for administering medications, collecting blood samples, and other specimens for clinical testing (not including Blood Bank samples), and providing treatments or procedures or services?

1

2

3 or more

Services include transporting patients within North Memorial Health Hospital and transferring patients to other healthcare facilities.



**Correct!**

Patient identification includes active involvement of the patient, if able, and/or family. If possible, always ask the patient to state their name and DOB.

## Patient Identification

- The patient identification (ID) bracelet must be on the patient at all times; it cannot be taped to the bed.
- The patient's room number or physical location is NEVER used as an identifier.
- If the patient's identity is unknown refer to the Section: *Patients that Present with Unknown Identifying Information* in the *Patient Identification* policy.



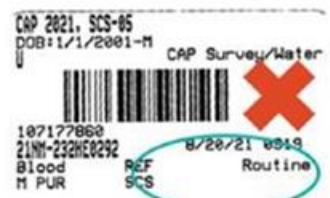
## Specimen Labeling for Lab Testing

- The correct labeling of laboratory specimens is critical to customer care and customer safety.
- Print specimen labels only when you are ready to collect the sample from the customer.
- If any part of the patient (customer) identification is missing and/or "cut off" from the label, you may hand write it. Call IT for any label printer problems.
- Collect all blood samples according to established "Order of Draw" and mix well immediately after collection. Refer to Laboratory section under Clinical Services tab on the Intranet for more information.

## Specimen Labeling for Lab Testing (cont)

The Laboratory are asking for your help in being diligent about properly labeling the blood samples that you are sending to the lab for testing. There is highly sensitive instrumentation that reads barcoded blood specimens to identify both the patient sample and the testing request. Mislabeled specimens cause rejection of samples and delays.

- Apply the label STRAIGHT with the tube cap on your left.
- Place the patient barcoded label over the original tub label (not over the clear opening – we need to see in there!)
- Write your initials or E# and the date and time of collection on the bottom, **lower right corner of the barcoded label**, with ink (Yes, we know it is a small space!)
- **Do NOT write anything next to the barcode.**
- No black pen, Sharpie marker, or pencil. You can use a red pen; this does not interfere with the instrument barcode readers.



## Point of Care Laboratory Testing

Patient (customer) identification is the first and most important step in performing bedside testing on our customers. All Point of Care testing requires the HAR (encounter) number for patient (customer) ID. The team member performing the testing must accept the responsibility toward assuring the accuracy of every single result. Following the individual testing procedures in C360 and adhering to all of the test requirements are mandatory.



## Point of Care Laboratory Testing

North Memorial Clinical Laboratory supports Point of Care testing in the hospital:

- Whole blood glucose testing
- EPOC blood gas and chemistry reporting in the ED, NICU, ICU's and OR
- Activated clotting time (ACT) in OR, Cath Lab, and A4
- Urinalysis and hCG in the ED
- AmniSure ROM (rupture of fetal membranes) in Labor and Delivery

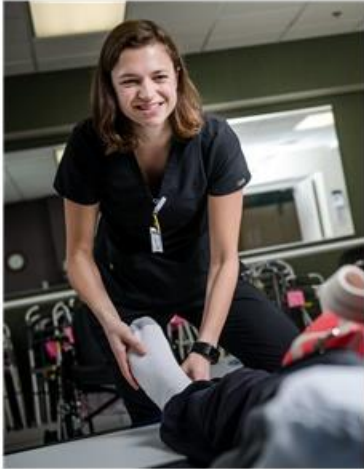
There is required initial and annual competency for all waived testing (WBG, urinalysis Clinitek, and hCG), and an additional 6 month AND annual competency for "moderate complexity" testing (EPOC, Hemochron and AmniSure).

Strep test is usually done in ED, but not during COVID.

## Surgical & Procedural Site Marking

Surgical and procedural site marking occurs to ensure the correct procedure is completed on the correct customer. Customer site marking occurs before procedures, regardless of where the procedure will be performed, e.g. Operating Room (OR), Patient Care Center (PCC), Post Anesthesia Care Unit (PACU), Interventional Radiology (IR), or the customer's room. Verification occurs at multiple points in the care of the customer and requires coordination between the privileged provider performing the procedure, the customer or legal guardian, and all members of the surgical/procedural team.

## Surgical & Procedural Site Marking



The privileged provider performing the procedure marks the correct surgical or procedure site. With the customer awake and aware, if possible, the privileged provider will mark the procedure or operative site with their initials. The site will be marked with a permanent marker that will be visible when any draping or prepping of the site occurs. When unable to mark the site, this is documented on the Alternate Site Marking Tool.

## Surgical & Procedural Site Marking

For anesthesia procedures, such as regional blocks, the anesthesiologist will mark the site with an "A" and circle the "A". For procedures involving the spine and ribs, intra-procedure imaging with opaque instruments marking the specific boney landmarks will be taken and are compared with the pre-procedure imaging. Final verification is the comparison of pre- and intra-procedure imaging by the privileged provider performing the procedure.



Associated Policy: Time Out

## Time Out

Just prior to the incision, injection, or procedure start, a final verification process "Time Out" is performed. Through active verbal participation, the privileged provider performing the procedure and surgical or bedside procedure will initiate the "Time Out" by stating "Let's do the Time Out."



## Time Out

All team members will stop their routine duties and focus their attention on the final verification of:

Customer identity using two identifiers;	Informed consent form/source documents;
Correct operative or invasive procedure;	Correct procedure side or site (and level if appropriate);
Necessary imaging, equipment, implants, or other special requirements available, as appropriate;	Correct customer position;
Visualization of the marked site(s), if applicable;	Pre-procedural antibiotic administered, if appropriate
Fire Risk Assessment is conducted for all procedures in the Operating Room and as applicable for procedures outside the Operating Room, e.g. Cardiac Catheterization Lab, Interventional Radiology, Emergency Department and at the bedside. The Fire Risk Assessment is completed by the Anesthesia Provider, when present.	
Medication on field	Allergies

- Associated Policy: Time Out



## Stop the Line

**All team members, medical staff, students and volunteers have the responsibility and authority to immediately intervene to protect the safety of a customer, to prevent a customer safety event and subsequent customer harm.**

Any team member providing customer care will immediately stop and respond to the request to stop for clarification to reassess the customer's safety. This is a proactive practice to **speak up** in advocating for all our customers receiving care. North Memorial Health leadership supports all personnel to speak up and advocate for customer safety.

Any team member who observes or becomes aware of an imminently harmful situation in customer care has the authority and responsibility to speak up and request the process be stopped in order to clarify the customer safety situation.



## Stop the Line

### **Examples of care situations of concern might be:**

- A customer is being prepared for a surgical procedure, when you notice missing elements on the informed consent and another team member is present to transport the customer to the OR.
- A team member enters a customer's room to transport them to another unit for testing and when checking the patient (customer) identification, the arm band is missing and you observe the customer transferred to the wheelchair in preparation to leave the room.



## Stop the Line

Team member is to verbalize "Stop the Line, I have a customer safety concern," at least two times to ensure that the request has been heard by all parties involved.



- A "Stop the Line" situation takes priority over any provider and/or licensed independent practitioner order or intervention. Care is resumed when all of the involved parties are in agreement that the concern(s) have been resolved, explained and/or reconciled.

## Stop the Line Non-Compliance or Retaliation

When there is non-compliance in responding to the "Stop the Line" request, the Chain of Command (Administrative Consult policy) process is followed.

Care situations, in which a "Stop the Line" request was verbalized and not honored are reported, reviewed and followed up by clinical leadership.

Retaliation by any individual against a team member making a good-faith request to "Stop the Line" will not be tolerated. Medical Staff leaders and/or Human Resources are to be consulted if retaliation occurs or is perceived to occur.

## Information for Vocera Users

The Vocera badge is to be used primarily for internal business to relay information that pertains to active customer care and to assist staff in being responsive to customer's needs.

Every attempt should be made to achieve appropriate communication practices to limit disruption to the customer and care teams within NMH and to protect customer information. Inappropriate or vulgar language shall not be used. Be aware of the volume of your device settings and your voice when using Vocera.



## Maintaining Confidentiality During Calls

Team members must always be aware of their surroundings and protect patient information as outlined by HIPAA. The following options will help maintain confidentiality during calls:

- Walk to a private area to take the call
- Place the call "on hold" and walk to a private area to take the call
- Transfer the call to a nearby phone and resume the call
- Return the call at another time
- Do not leave messages that include customer identifiable data
- Do not leave messages that include medical verbal orders. Vocera messaging shall not be used to give or receive medical verbal orders.



## Reminders for Vocera Use

- Be courteous and respectful when answering a call on Vocera.
- Set the stage for a caller "Hi this is ----, I am with a customer, how can I help you?"
- If calling someone on Vocera, be mindful that they may not know who is calling and may be busy, say "Hi this is----, is this a good time?" or "Hi this is ---, can you please call me when you are finished?"

More detail about communicating via Vocera can be found in the policy "Appropriate Use of Vocera Communication System" found in C360 on the North Memorial Intranet.



## Patient (Customer) Hand Off

Customer hand offs have been identified as a vital opportunity to pass on information from team member/provider to team member/provider in order to keep a customer safe.

## Patient (Customer) Hand Off

NMH procedure for customer hand-off is as follows:

- Use **SBAR** (Situation, Background, Assessment and Recommendation) framework to pass on critical information about the customer and his/her care.
- Read-back to verify important information.
- SBAR is to be used in the customer's medical record notes as well as in verbal communications between health care professionals.

## Verbal and Telephone Order Safety

- Verbal and Telephone orders are given directly from the ordering physician to the approved care team member taking the order. No third party should be involved.
- Ordering physician will clearly state the order, spelling out any "sound alike" words. No abbreviations should be used.
- The approved care team member who receives the order will repeat it back and the individual that gave the order then must confirm that the read back is correct.



## Critical Results and Communications

- Critical tests and critical results are reported and documented as a priority and are timely.
- Results must be communicated to or received by the responsible licensed caregiver (RN or MD) who may take action on behalf of the customer.
- Verification of customer identification and the reported critical value must always be confirmed with a “read back” of the information by the qualified recipient.
- Please see Critical Communications, Results and Findings policy for more information.

## Pain Management

At North Memorial, we take a holistic approach to pain management and focus especially on making sure our customers are comfortable during their hospitalization. In addition to medications and non-pharmacologic treatments (such as aromatherapy and heat/cold compresses), comfort enhancing techniques include a quiet environment conducive to healing, a warm smile and conversation, and attention to details (for example, making sure the call light is within reach, watching for non-verbal signs of discomfort). We believe everyone has a role in helping our customers.

## **Improve Recognition & Response to Changes in a Customer's Condition**

All customers will receive the best level of pain control that can safely be provided in order to prevent unrelieved pain. See Policy and Procedure: Pain Management. Pain management includes regular pain assessments that include level of pain, location, intervention, reassessment and appropriate customer/family intervention/education.



## **Pain Management Best Practices**

- Providing customers/family with verbal and written information about pain management, including pharmacologic and non-pharmacologic interventions.
- Teaching customers/families to use a pain rating scale that is age, condition, and language appropriate for reporting pain intensity and that the goal of pain management is prevention. (Example pain scales: Numeric, Verbal, N-Pass, FLACC, Faces, Behavior.)
- Developing an individualized pain management plan which includes the customer's goal for pain management, customer preferences for treatment, age, type of pain, risk for cognitive impairment, history of chemical dependency, chronic pain and cultural beliefs and practices.
- Perform hourly rounding using PEEP (Pain, Elimination, Environment, Positioning) as a tool each hour to ensure pain is being managed and reassessed.
- Using the CareBoards for communicating comfort goal, plans and interventions to team members and customer/family.

## Pain Assessment

- **An *INITIAL* assessment is required prior to pain intervention.** Best practice shows to do this within 30 minutes.
- **Re-evaluation of pain control must be completed minimally every 2 hours.** Best practice is 30 minutes after an IV medication intervention, 60 minutes after a PO/IM pain medication intervention or 15-60 minutes after a non-pharmacological intervention.

## Plan of Care

An individualized plan of care and customer education is developed and documented within 24 hours of admission and includes goals and interventions.

The care plan is reassessed and individualized to the customer every shift and with condition changes, and includes the following:

- Goals which are consistent with the provider's plan for medical care
- Nursing interventions
- Evaluation of customer's progress towards the goals
- Reflection of findings on assessments, both physiological and psychosocial factors
- Discharge planning
- Interdisciplinary assessments (as applicable)

## Plan of Care

The care team member documents the customer's progress towards meeting the plan of care goals which have been the focus of care.

The care plan and customer education is resolved when goals are met, teaching completed or customer is discharged or transferred.

## Fall Prevention for Customers

NMH's fall rate is above statewide fall rates. The following are basic actions that should be done for every customer to assist in identifying and preventing falls:

Fall Risk Assessment	Medications	Educate Customer and Family
Rounding	Identify	Interventions

## Fall Prevention for Customers

### Fall Risk Assessment

- Conduct a falls assessment (Hendrich II and the Risk for Injury for adults, or Humpty Dumpty assessment for pediatric customers) to determine risk on arrival, admission, every shift thereafter, and with any change in condition.
- If the customer does not score as a fall risk, implementing interventions is acceptable if nursing judgment deems the customer at risk.
- If the customer has fallen within the last year they are considered a risk for falls. A history of falls is considered a risk factor for future falls.

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## Fall Prevention for Customers

### Medications

- Determine what medications a patient is taking that might increase dizziness and what conditions the customer has that might increase the likelihood of falls.
- Consult pharmacy if you have any concerns.

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## Fall Prevention for Customers

### Educate Customer and Family

- Inform the customer and family how to prevent falls.
- Encourage the customer to:
  - wear non-slip socks when ambulating
  - call for assistance
  - use assistive devices
  - keep items within reach
- If they are a fall risk, instruct them to call for assistance every time they get up.
- Educate regarding alarms; they are intended to keep customer safe.

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## Fall Prevention for Customers

### Rounding

- Complete Hourly Rounding including the components of PEEP (Pain, Elimination, Environment, Positioning) on each customer, noting that fall interventions are appropriately in place and activated for those at high risk. Most of the hospital falls have been related to a customer needing to toilet. Be proactive with scheduled toileting and ask every hour during Hourly Rounding about toileting.

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## Fall Prevention for Customers

### Identify

- Use green light indicator outside of room, check fall risk on the care board, place a green wrist band and red socks on customers to identify them as a fall risk.

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## Fall Prevention for Customers

### Interventions

- Always stay within arm's reach when a high fall risk customer is on the toilet or commode.
- Use bed alarms and chair alarms-ensure they are on and working. Keep beds at the lowest level and keep wheels locked. Use the Seated Positioning System for customers at risk of sliding out of the chair.
- Keep items within reach. A large number of falls occur because customers are reaching for something. Ensure the trash basket, water, personal items, and call light are within reach before leaving the room.
- Gait belts should be used consistently and sent with patients to ancillary departments to assist in transfers. Utilize assistive devices and wheelchairs as appropriate based on customer condition.
- Consistent use of interventions is KEY in preventing falls.

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## Pressure Injury Prevention

- NMHH continues to have reportable pressure injuries. **Specifically, device related and bony prominence pressure injuries are of concern.**
- Preventing hospital acquired pressure injuries is imperative for customer safety here at North Memorial Health. Pressure injury prevention requires a team approach. Identifying customers at risk for skin breakdown is the initial step. Once an at-risk customer has been identified it's imperative for the whole team to implement prevention measures immediately and remain consistent until the risks have been removed.

## Pressure Injury Prevention cont.

Head to toe assessment  
reminders

Pressure injury prevention  
interventions

Communication & escalation

Resources

Click the buttons to the left for more  
information on each topic.

## Pressure Injury Prevention cont.

Head to toe assessment reminders

Pressure injury prevention interventions

Communication & escalation

Resources

### HEAD TO TOE ASSESSMENT REMINDERS

**Admission:** All customers should be assessed from head to toe within 4 hours of admission and transfer to inpatient unit. Assessment includes:

- "Two Sets of Eyes"
- Inspecting and palpating skin and bony prominences.
- Ensure documentation of measurements for wounds that require them.
- Utilize Rover devices to take pictures of any PTA wound/skin issues.

**Ongoing and Change in Condition:**

- Med-Surg every 8 hours
- ICU every 4 hours

## Pressure Injury Prevention cont.

Head to toe assessment reminders

Pressure injury prevention interventions

Communication & escalation

Resources

### PRESSURE INJURY PREVENTION INTERVENTIONS

- Provide thorough skin care
- Review nutritional status
- Reposition patients with a Braden of 18 or less minimally every 2 hours.
- Limit supine positioning
- Look under, remove and reposition mechanical devices, per standard, to decrease pressure related events.
- Perform PEEP (Pain, Elimination, Environment, Positioning) rounds each hour to ensure repositioning is being completed and pressure injury prevention measures are in place.
- Use tools such as TAPs, Z-Flo, Seated Positioning System, heel boots, etc. to offload and redistribute pressure



## Pressure Injury Prevention cont.

Head to toe assessment reminders

Pressure injury prevention interventions

Communication & escalation

Resources

### COMMUNICATION & ESCALATION

- Educate customers and family about the risks and how to prevent skin break down.
- Discuss pressure injury prevention with managing provider
- Develop and individualize a plan of care that includes pressure injury prevention and skin care.
- Communicate findings or concerns to care team, this includes during every customer hand off, report, and interdisciplinary rounds.
- If you see something new or of concern, place interventions and escalate through a WOCN consult, safety first and through the charge RN.

## Pressure Injury Prevention cont.

Head to toe assessment reminders

Pressure injury prevention interventions

Communication & escalation

Resources

### RESOURCES

- Utilize support tools in the electronic health record such as the Skin Accordion to synthesize information related to skin.
- See the Pressure injury Prevention policy for specific standards and expectations.



## Objectives

The learner will be able to:

- Identify lifting equipment that is available at North Memorial Health Hospital.
- Review cases studies regarding which piece of equipment to use.

## We Know That Bedrest is Bad!

Prolonged immobility is correlated with:

- Increased length of stay
- Increased admission to nursing homes
- Falls during and after hospitalization
- Loss of independence after discharge
- Increased cost of hospitalization



## Tips for Mobilizing Patients

Progressing mobility:

- Begin with bed mobility (have patient help to roll, boost, etc.)
- Sit at edge of bed
- Standing at bedside
- Transfer to chair (for meals)
- Walk to the bathroom vs. use of commode
- Walk in the halls

*At any point, if these activities require a heavy assist of 2 or more people, consider using lift equipment.*

## Equipment Available at NMHH



Stand Aid



EZ Stand



Mechanical Lift



Hover Mat

Click on each piece of equipment to learn more.

#### Who?

- Customer must have the strength and stability to lift and support themselves, but who have difficulty walking

#### How to Use:

- Assist of 1. (**Recommended to use with assist of 2:** *remember if customer loses consciousness, they will let go of equipment and fall*)
- Prior to transfer, raise the two split seat units up
- Position Stand Aid in front of customer and place feet onto the foot tray lining up shins/knees to the pads
- **Lock both rear casters**
- Have customer grab cross bar using their own strength to stand
- Lower both split seat units behind customer, then customer can lower themselves down to seat
- Unlock wheels, transfer customer to new surface. Align customer with new surface **and lock wheels**
- Have customer pull up to standing position
- Raise the two split seat units up
- Stand by customer as they lower onto the new surface
- Ensure customer is safely positioned, then unlock the casters



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#### Who?

- Customers who can sit with supervision, follow commands well and are a heavy assist of two to transfer to a chair or commode. They also must be able to bear 50% of their weight.

#### How to use:

- **Requires 2 team members** (not family or visitors)
- Weight max is labeled on a sticker on the lift
- Ensure you know the location of the emergency lever or button
- Safety check should include assessing for holes/rips in sling and ensuring the battery is charged
- Identify sling/belt size by looking at the tag on the sling.
- **Apply belt 2 inches above the waistline and tighten**
- Lock wheels.
- Position **patient's feet onto foot tray**, positioning knees into knee pad and Velcro behind legs
- Hook shortest loops of sling/belt onto the stand arm hooks.
- **Raise patient slightly an retighten belt if needed**
- Transfer with one team member standing with patient and the other controlling the lift.
- When lowering, lock the wheels and guide the patient down to a proper position using the sling/belt.



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### Who?

- Customers who can follow directions, non combative and are a heavy assist of 2 or more.  
This can be used to transfer from chair, bed or even the floor in certain cases.

### How to use:

- **Requires 2 team members** (not family or visitors)
- Weight max is labeled on a sticker on the lift
- Ensure you know the location of the **emergency lever or button**
- Safety check should include assessing for holes/rips in sling and ensuring the battery is charged
- Identify sling size by looking at the tag on the sling.
- Apply sling
  - Hook shorter loops by patient's shoulders and longer loops by patient's legs
  - The **color of hoops should match at each level.**
  - Criss cross the leg loops and loop into each other
- **Lock the wheels** when raising patient from the floor
- One team members should stand with patient and other should be using remote and controlling the lift
- Transfer patient to appropriate position and ensure patient safety prior to removing sling



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### Who?

- To be used to transfer any customer from a flat surface to another flat surface, uses appropriate ergonomics for staff and is most comfortable for patients.

### How to use:

- **Requires assist of 4 team members**
- 1200 pound weight limit
- **Lock wheels of bed and stretcher** prior to use
- Center patient on Hovermatt prior to inflation
- Attach safety buckles loosely around customer to **ensure customer is in the center of the Hovermatt**
- Attach hose of hovermatt to the mat and then power on an inflate mat.
- After transfer, ensure Hovermatt is centered on desired location before deflating
- Hovermatt is not designed to stay underneath patient and is **not skin friendly**. Remove hovermatt as soon as patient is back into their bed.



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# Patient Scenarios and Equipment Review

## Scenario #1

Susan is a 75 year old woman who presents after a fall resulting in a hip fracture. Pt underwent surgery and is now weight bearing as tolerated to her left leg. You were able to assist the patient into a standing position, though once standing she is having trouble with pivoting to the recliner chair. ***What piece of equipment could you utilize to assist in this transfer?***



Stand Aid



EZ Stand



Mechanical Lift



Hover Mat



## Scenario #1



Correct, it's a Stand aid.

Susan is able to stand and bear weight but is having difficulty pivoting. The stand aid is great for customers who can stand and have the strength to hold themselves up.

## Scenario #2

Ray is a 60 year old male who presented to the hospital initially with a lower leg wound. After a prolonged hospital stay, he is now status post below the knee amputation. Overall, Ray is very deconditioned and weak. You attempt to help him sit up at edge of bed, though he has poor sitting balance and requires assist of 2+ people for safety. ***What piece of equipment could you use to assist Ray with getting into the wheelchair to come to his therapy appointment?***



Stand Aid



EZ Stand



Mechanical Lift



Hover Mat

## Scenario #2



Correct, the safest way to transfer Ray would be to use the Mechanical lift (also known as a Hoyer or Floor lift)

## Scenario #3

Esther is a 75 year old female who presents with urinary tract infection and generalized weakness. During report, you were told Ester was a heavy assist of 3 to get up to the chair during day shift. She is now requesting to use the commode. She is not combative, can follow commands well and has no weight bearing restrictions. You were able to assist her into sitting at edge of bed where she is able to sit with supervision. ***How would you complete this transfer to the commode?***



Stand Aid



EZ Stand



Mechanical Lift



Hover Mat

## Scenario #3



Correct, The EZ stand. Esther meets all the qualifications to be able to use the EZ stand.

### Who?

- Customers who can sit with supervision, follow commands well and are a heavy assist of two to transfer to a chair or commode. They also must be able to bear 50% of their weight.

## Scenario #4

Bobby is a 42 year old who has been complaining of pain in his leg and his arm. He is going to get some xrays and needs to be transferred from his bed to a stretcher. ***What is the safest, most comfortable way to transfer him to a stretcher?***



Stand Aid



EZ Stand



Mechanical Lift



Hover Mat

## Scenario #4



Correct, the Hover mat. This is the most comfortable way to transfer him.

## End of Course

Congratulations, you've reached the end of this module.

**CLOSE THIS MODULE.**

## Medication Safety

# Medication Safety

Full Length - 2021



### This Course Will Discuss the Following Topics:

- Medication dispensing
- Medication safety
- Medication security
- Controlled substances
- Range orders and titrations
- Medication history and reconciliation
- Antimicrobial stewardship
- Hazardous medications and disposal
- Pharmacy Services



## Medication dispensing

- Over 80% of doses come from Omnicell. The MAR can tell you the dispense location.

acetaminophen (TYLENOL) tablet 1,000 mg : Dose 1,000 mg : oral : EVERY 6 HOURS : 



Admin Instructions:

MAX dose of acetaminophen is 4000 mg (4 g) per 24 hours

Ordered Admin Amount: 2 tablet (2 x 500 mg tablet)

Last Admin: Today 09/03/20 at 0811 (Given)

Dispense Location: 541 Omnicell

- Doses that come from the pharmacy are tracked in Epic so you know where they are. Check the Epic message to pharmacy button. Once tubed or delivered, doses are stored in the patient specific bin in Omnicell.



### Recent dispensing events

Due	Action	Date/Time
09/02 1700	Left pharmacy via Tube	09/02 1237

### Recent dispensing events

Due	Action	Date/Time
09/02 0359	Received in NMR 7W	09/01 1737

## Knowledge Check I

Where do you look in Epic to find out where your meds are?

- ☒ MAR under message to pharmacy button
- ☐ MAR under admin comments
- ☐ Call the Pharmacy
- ☐ None of the above

## Medication Safety

- Medications need to be labeled. Anything outside the original package needs to have a label on it if it isn't being administered immediately. If a medication leaves your hand/hits the table, the syringe needs a label! If a medication is not labeled, discard it.
- All medication administrations must be supervised. No self administered medications allowed.
- We use Tallman letters for Look-alike, Sound-alike (LASA) meds (ex. ALPRAZolam & LORazepam).

MEDICATION ADDED		
PATIENT	RM #	
DRUG		
AMOUNT	RATE	ML/HR
ADDED BY	BASE SOL'N.	
DATE	TIME	
EXP. DATE		
THIS LABEL MUST BE AFFIXED TO ALL INFUSION FLUIDS CONTAINING ADDITIONAL MEDICATION		

More information: Look-Alike/ Sound-Alike (LASA) Medications policy and procedure.

## Knowledge Check II

Are self administered drugs allowed?

☐ Yes

☒ No

## Medication Safety: High Risk Medications

- High risk medications have a higher risk of harm if not used correctly.
- Medications that require an independent double check include:
  - IV anti-thrombotics (eg. heparin, bivalirudin)
  - Non-oral chemotherapy
  - Epidural administration by nursing
  - Stock insulin vials
  - PCAs and Intravenous opioid infusions
  - IV epoprostenol
  - IV magnesium sulfate 4 g and 40 g infusions
- To mitigate this risk, we employ the **independent double check** whereby a second nurse **WITHOUT** conferring with the first, verifies the six medication administration rights.
- More information: High Risk Medication Policy



## Knowledge Check III

Which of these is an example of an independent double check?

- ☒ You ask your colleague to confirm the correct dose for the patient.
- ☐ You ask your colleague to confirm that this is 15 units of insulin.
- ☐ You ask your colleague if the rate of the pump is 150 ml/hr.
- ☐ All of the above.

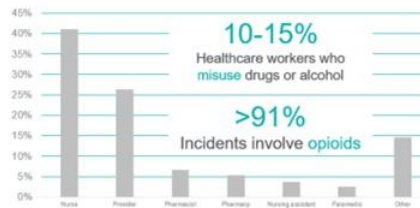
## Medication security

- Home medications use is **restricted** except under specific circumstances. Medications brought in from home should be **sent home** if possible OR inventoried into secure medication bag and **sent to pharmacy**.
- All medications sent through the tube system will be sent using a code.
- Medications need to be secured at all times. Only take what you need at the time. If a medication is removed from Omnicell and not opened/used, return the medication immediately.

More information: Medication Selection, Procurement, Storage, and Control policy and procedure

## Controlled substances

- Diversion is the transfer of a controlled substance from a **lawful to an unlawful** channel of distribution or use.
- It is **everyone's responsibility** to recognize and report suspected diversion.
- It's your responsibility to resolve discrepancies on the shift that they are created.



[Click on this link to view how to resolve a discrepancy in the Omnicell quick reference guide.](#)

More information: Controlled Substance Diversion Monitoring and Reporting policy and procedure.

## Knowledge Check IV

What is the correct order to resolve a discrepancy? Put the following steps in the correct order.

1. Cycle count medication in question.
2. Run a report to see who was involved in last counting.
3. Follow up with previous user to determine cause.
4. Document discrepancy reason in the machine.
5. Call pharmacy if unable to resolve.

## Range and titratable orders

- Range orders are only allowed for the **dose** NOT for **frequency**
  - **YES**: morphine 2 - 4 mg IV every 2 hours prn pain
  - **NO**: morphine 2 mg IV every 2 - 4 hours prn pain
- Dose range maximum should be no more than 4 times the minimum (e.g., hydromorphone 0.2 mg to 0.8 mg).
  - Exclusions: Infusions, insulin, contrast, intra-procedure medications, non-systemic routes of administration, comfort/palliative care.
- When administering start with the lowest dose in the range. If you deem it is appropriate to start at a higher dose, document your reasoning in the comment section.
  - Higher doses are reasonable based upon presence of uncontrolled symptoms, upon home dose, or patient's response to recent doses of medication in the same pharmaceutical class.
  - Future doses should be based on customer response.
- Titratable infusion should follow the order parameters and the administration instructions.

More information: Medication Range Orders policy and procedure



## Knowledge Check V

When can you start on the higher end of the dose range?

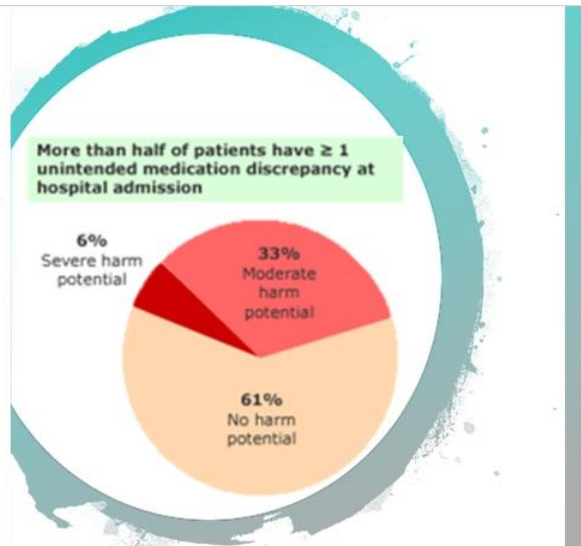
- ☐ Based upon presence of uncontrolled symptoms.
- ☐ Based upon home dose.
- ☐ Patient's response to recent doses of medication in the same pharmaceutical class.
- ☒ All of the above.

## Medication history and reconciliation



## Medication history and reconciliation

- **Step 1:** get the most accurate medication list possible, including drug name, dose, frequency, route and last dose taken.
- **Step 2:** providers then determine what will continue and change on admission, transfer, and/or discharge.
- **Step 3:** the reconciled list is given to the customer and explained on discharge.
  - **Who:** An accurate list is everyone's responsibility.
  - **Why:** Medication discrepancies can lead to harm.



- More information NMHH Medication Reconciliation Role Responsibilities Procedure or Maple Grove Hospital Reconciliation Role Responsibilities Procedure.

## Antimicrobial Stewardship

- Up to 50% of the time antibiotics are not optimally prescribed (either not needed, incorrect dosing or duration)
- Antimicrobial Stewardship is the effort to measure and improve how antimicrobials (including antibiotics) are used, improve patient outcomes, and decrease resistance to antibiotics
- Our Antibiotic Stewardship Program (ASP) contacts
  - Dr. Leslie Baken (Infectious Disease)
  - Emily Herstine, PharmD, BCPS(Clinical Specialist)

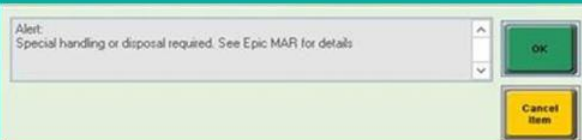


- Find the current antibiograms here: <https://nmonline.sharepoint.com/sites/clinical/SitePages/ASP.aspx>

## Hazardous drugs & disposal

- To inform front line users of hazardous drug handling requirements there is an alert in Omnicell AND more detailed information in the MAR.

Omnicell



MAR



## Hazardous Drug Handling

- There are reproductive and lactating risks associated with hazardous drugs. Using proper PPE reduces this risk but does not eliminate it.
- Epic is your guide to which medications are hazardous.
- Pregnant team members, those planning to become pregnant, and lactating individuals have the option to limit or avoid exposure.
- Completion of this module confirms you understand the risks of handling hazardous drugs.

## Knowledge Check VI

Where do you find information if a drug is hazardous or requires special disposal?

- ☐ A. Omnicell
- ☐ B. MAR
- ☐ C. Intranet
- ☒ A and B
- ☐ Any of the above

## Pharmacy Services

- The Department of Pharmacy Services is committed to providing pharmaceutical care that focuses on ensuring appropriate, effective, and safe drug therapy for our customers.
- The Pharmacy Department supports this mission by assuring optimal use of medications focusing on safe and effective patient care.
- If you have any questions or issues related to medication management, please call Pharmacy to assist. We are here to help!

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Otherwise, click this box to close this window and return to Healthstream.