

SUBJECT: "HAND-OFF" COMMUNICATION	REFERENCE #2011
DEPARTMENT: ORGANIZATIONWIDE	PAGE: OF:
APPROVED BY:	EFFECTIVE: REVISED:

POLICY:

- "Hand-off" communication will take place whenever there is a change in the patient's/client's/resident's caregivers. Caregivers include all clinical staff and physicians.
- "Hand-off" communication shall include:
 - Accurate patient/client/resident information regarding care, treatment and services
 - Current patient's/client's/resident's condition
 - Recent or anticipated changes in the patient's/client's/resident's condition
- All information will be presented in a clear, concise manner.
- Healthcare professionals shall be allotted the time to "hand-off" patient communication and to ask and answer questions with minimal interruption. It is hoped that this will lessen the amount of information that might be forgotten or simply not conveyed.
- Examples of patient/client/resident care transitions where "hand-off" communication will take place:
 - At the change of shift between nurses
 - Writing or tape recording report does not allow for questions; therefore, it is not acceptable for the "handing-off" of patient/client/resident information.
 - When a nurse leaves the unit for a period of time, such as lunch or to accompany a patient to another unit or diagnostic department
 - Temporary responsibility of the patients under the care of the departing nurse is given to another licensed nurse.

SUBJECT: MEDICATION AND SOLUTION ADMINISTRATION IN THE OR	REFERENCE #3008
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DEPARTMENT: SURGICAL SERVICES	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- All medications and solutions in the perioperative area shall be labeled. This includes medications and solutions on and off the sterile field.
- The label will include:
 - The name of the medication/solution
 - Strength of the medication/solution
 - Date
 - The initials of the individual preparing and labeling the medication.
- The following medications and solutions must be labeled when removed from their original containers:
 - Medications:
 - Prescription medications
 - Other products designated by the FDA as a drug
 - Over-the-counter drugs
 - Herbal supplements
 - Dietary supplements
 - Vitamins
 - Nutraceuticals

SUBJECT: FALL PREVENTION GUIDELINES	REFERENCE #9003
DEPARTMENT: ORGANIZATIONWIDE - PATIENT CARE	PAGE: 1 OF: 2
APPROVED BY:	EFFECTIVE: REVISED:

HOW TO PREVENT FALLS:

- All patients/residents will be assessed on admission and continuing throughout the stay using the fall assessment guidelines. History of falls prior to or during hospitalization shall be documented on plan of care.
- Patient/resident/family will be instructed about safety measures and rationale, including to call for assistance before getting out of bed, rise slowly, keep necessary items within reach and the proper use of canes, walkers, wheelchairs and crutches.
- Family members will be encouraged to take an active role in observing the patient/resident as frequently as possible and alerting nursing staff of any perceptions regarding the patient's/resident's sensorium or physical functioning.
- Patients/residents at risk for fall will be placed as close as possible to the nursing station.
- Ambulatory patients/residents shall wear proper foot gear; regular shoes or well fitting slippers.
- Patients/residents undergoing procedure preparation (such as bowel prep) will be monitored closely to assure attendance when necessary.
- Wheelchair patients/residents need special instruction about weight distribution and balance of weight.
- Patients/residents on crutches need practice. Make sure your patients/residents are steady on them before they walk unattended. Help keep the way clear.
- Pick up everything spilled or dropped on floor. Liquids, paper, even flower petals can be dangerous to a person on crutches.
- Pull wheeled vehicles through doorways, so you lead the way and can see where you are going.

SUBJECT: PRESSURE ULCER PREVENTION PROGRAM	REFERENCE #14002
	PAGE: 1 OF: 9
DEPARTMENT: LONG TERM CARE	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITION:

- A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. Pressure ulcers can occur whenever pressure has impaired circulation to tissue. Pressure ulcers develop when soft tissues are compressed between a bony prominence and the surface of an object, i.e., mattress, seat of a chair, catheter compressed between a resident’s thighs.
- Pressure ulcers are usually located over a bony prominence, such as the sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle.
- Pressure ulcers are described as:
 - Stage I Non-blanchable erythema of intact skin is the heralding lesion of skin ulceration. Discoloration of skin, warmth, edema or hardness, pain or itching may be indicators of a pressure ulcer in residents. These indicators will be evident after the pressure on the area has been removed for 30-45 minutes.
 - Stage II Partial thickness skin loss involves epidermis and/or dermis. The ulcer is superficial. The ulcer presents clinically as an abrasion, blister or shallow crater.
 - Stage III Full-thickness skin loss involves damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
 - Stage IV Full thickness skin loss with extensive destruction, tissue necrosis or damage to fascia, muscle, bone or supporting structures (i.e., tendon, joint capsule) is involved. Sinus tracts and undermining may be present.
- Note that some evidence suggests that it may be harder to identify erythema in an older adult with darkly pigmented skin. For dark-pigmented individuals, assess signs of skin discoloration as well as evidence of pressure ulcer development, such as boggy, induration, coolness or increased warmth.