DEFINITIONS:

- Critical Results: Findings (even if from routine tests) which always require rapid communication of the results, i.e., panic values or red-line values.

- Generally critical results or “panic” values are defined by the medical staff, with input from nursing services for specific tests.

- However, critical results are understood to be any resultant test values/levels/ interpretations where delays in reporting have the potential for causing serious adverse outcomes for patients.

POLICY:

- Critical results of tests and diagnostic procedures for the organization include:

  ______________________________ ______________________________

  ______________________________ ______________________________

  ______________________________ ______________________________

- The following individuals may report critical results of tests and diagnostic procedures:

  ______________________________ ______________________________

  ______________________________ ______________________________

  ______________________________ ______________________________

- The following licensed healthcare providers are permitted to receive the results of critical results of tests and diagnostic procedures:

  ______________________________ ______________________________

  ______________________________ ______________________________

  ______________________________ ______________________________

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SUBJECT: STAFF EDUCATION - ANTICOAGULATION MANAGEMENT PROGRAM	REFERENCE #3006
	PAGE: 1 OF: 4
DEPARTMENT: ORGANIZATIONWIDE	
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- ___________________ Hospital's Anticoagulant Management Program (AMP) ensures that all patients receiving anticoagulant therapy shall be monitored and followed to reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
  - All patients prescribed anticoagulants shall be followed by the AMP service and will receive individualized, coordinated care while receiving this medication.
  - The AMP shall provide a consistent mechanism for the assessment, monitoring and education of patients receiving anticoagulation medications.
- All prescribers of anticoagulant therapy, as well as healthcare providers caring for patients on anticoagulants, shall receive, at the time of orientation, annually and as needed, education and training on:
  - Approved protocols for the initiation and maintenance of anticoagulation therapy appropriate to the medication used
  - Required laboratory testing:
    - Baseline coagulation status
    - Continuous INR monitoring
  - Heparin ordering requirements:
    - Prescribers must include the calculated dose and the dose per weight (i.e., milligrams per kilogram) or body surface area to facilitate an independent double check of the calculation by a pharmacist, nurse or both.
      - For morbidly obese patients, the standard nomograms may not be accurate.

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DEFINITION:

- According to the Institute for Healthcare Improvement (http://www.ihi.org/ihi), "The Central Line Bundle is a group of evidence-based interventions for patients with intravascular central catheters that, when implemented together, result in better outcomes than when implemented individually."

- The central line bundle has five (5) key components:

  - Hand hygiene
  - Maximal barrier precautions
  - Chlorhexidine skin antisepsis
  - Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters
  - Daily review of line necessity, with prompt removal of unnecessary lines

POLICY:

- A standardized supply kit shall be used for insertion of central and PICC lines.

- Aseptic technique shall be followed for the insertion and care of intravascular catheters.

- Catheters shall be properly anchored after insertion.

- Hand Hygiene:

  - Hand hygiene shall be followed before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing or dressing an intravascular catheter.

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SUBJECT: MEDICATION RECONCILIATION/ VERIFICATION	REFERENCE #5002
	PAGE: 1 OF: 7
DEPARTMENT: ORGANIZATIONWIDE	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

- Medication reconciliation applies across the continuum of care, this includes inpatients and outpatients.

- Medication reconciliation is a multidisciplinary process between Nursing, the Pharmacist and the physician with patient/family involvement.

DEFINITION:

A medication is any product designated by the Food and Drug Administration (FDA) as a drug, as well as any sample medications, herbal remedies, vitamins, nutriceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents, respiratory therapy treatments, parenteral nutrition, blood derivatives and intravenous solutions (plain, with electrolytes and/or drugs). This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen and other medical gases.

POLICY:

- __________________ Hospital will implement and maintain a process to obtain and document a complete list of a patient's current medications upon admission.

- Medication reconciliation is a multidisciplinary process between Nursing, the Pharmacist and the physician with patient/family involvement.

- Medication reconciliation/verification will be performed:

  - Upon admission/entry into the hospital, i.e., Emergency Department, Surgery, Direct Admits

  - When a patient is transferred or referred to another setting, service, practitioner or level of care within or outside of this organization

  - Any transition of care where new medications are ordered or existing orders are rewritten (as defined by the organization)

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SUBJECT: PRESSURE ULCER PREVENTION PROGRAM	REFERENCE #7002
	PAGE: 1 OF: 3
DEPARTMENT: LONG TERM CARE	
	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITION:

- The NPAUP defines a pressure ulcer as, "*a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result or pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated*."

- Pressure ulcers can occur whenever pressure has impaired circulation to tissue. Pressure ulcers develop when soft tissues are compressed between a boney 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:

    - **Suspected Deep Tissue Injury:**

        - Purple or maroon in color, localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

        - The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to the adjacent tissue.

        - Deep tissue injury may be difficult to detect in residents with dark skin tones. Evolution of the injury may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

    - **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.

        - Dark pigmented skin may not have visible blanching; the color may be different from the surrounding area.

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