THE TOP POLICIES AND PROCEDURES FOR OUTPATIENT SURGERY

Laura Harrington, RN, BS, MHA, CPHQ

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CHAPTER ONE

PATIENT CARE

The goal of performing an assessment and developing a plan of care is to improve outcomes for the patient. The things that caregivers notice, teach, act on, or mediate greatly affect such outcomes.

This chapter contains policies dealing with pain management, sedation, and education, which affect processes to deliver safe patient care. The policies should support individualized patient-specific care and reflect current practice. Using a multidisciplinary approach to patient care gives patients and the healthcare team the vision of and ability to provide the best treatment possible.

Medical error statistics consistently point to poor communication as the reason that many problems occur. Written policies are a form of communication and should be understood by and accessible to all staff.

The three ambulatory care accreditors—the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC)—as well as other regulatory agencies place a high emphasis on safe patient care. This focus on patient safety is reflected in accreditation standards. For example, in 2004 the JCAHO created patient safety guidelines related to surgical site marking and the AAAHC revised its anesthesia standards a few years ago.

With the focus on safer quality of healthcare delivery, it is critical that organizations to review policies regularly to ensure that patient care processes are documented and practiced by staff.

	Pain Management Policy and Procedure							
Department:		Policy number	: 1-1					
Section:	Patient Care	Effective date:		Page: 1 0F 4				
Title:	Pain Management	○ Non-clinic	al					
Approved by	:	Review date: Revision date	:					

Purpose:

To provide a standardized facility-wide approach to pain management.

Policy:

It is the responsibility of all caregivers to monitor patients' pain and take appropriate actions.

Patient rights

Patient rights include receiving an assessment and appropriate management of pain. This right is addressed by being

- included in the patient bill of rights, which is available in a brochure to each patient upon admission to the facility and is posted in a poster format in the waiting area(s)
- included in patient teaching at the time of patient admission
- included in discharge instructions

Education of patient

Preprocedure

- Facility staff will discuss with patients and their families
 - that pain management is an important part of their care
 - how much pain to expect and how long it may last
 - that pain relief measures will be provided quickly in response to reports of pain
 - the pain rating tools that will be used during their stay to evaluate levels of pain
 - how and when to request interventions for comfort/symptom relief
 - identifying an acceptable level of pain that enables the patient to perform allowable activities after discharge

Postprocedure

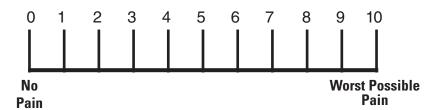
- Facility staff will discuss with patients and their families
 - managing pain at home, noting frequency of pain, occurrences, intensity, times of medication, and relief
 - causes of pain, preventative measures to control pain, and specific management options

PAIN MANAGEMENT POLICY AND PROCEDURE (CONT.)

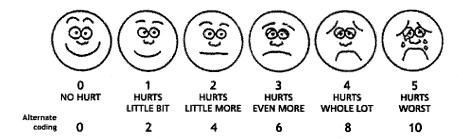
- use of drugs and controlling their common side effects
- when to contact their physician for further assistance and will provide the physician's telephone number

Assessment

- All patients will be screened for pain upon admission into a care delivery area. Thereafter, patients are monitored for pain whenever
 - an intervention or treatment to relieve pain is provided
 - their caregiver changes
 - their level or location of care changes
- Patients identified with pain will be further assessed for location, intensity, and character of pain.
- To facilitate rating pain intensity, the following tools are used:
 - Adults: 0–10 adult numerical scale select pain with 0 as "no pain" and 10 as "worst possible pain."



- Pediatrics: 0-10 Wong-Baker Faces Pain Rating



PAIN MANAGEMENT POLICY AND PROCEDURE (CONT.)

 Infants and preverbal children behavioral observation Faces, Legs, Activity, Cry, Consolability (FLACC scale)

Category	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							

Intervention

- If pain is rated >4 or is unacceptable to the patient (causing them to desire pain relief measures, regardless of the rating), there will be an intervention to reduce the pain.
- Patient is assessed for drug allergies, and physician orders are reviewed for appropriate medication orders and time of dose administration prior to giving.
- Evaluate effectiveness of pain medication with the same pain intensity scale utilized prior to intervention.
- Continue interventions as prescribed and applicable to the patient's needs for relief. Recommended interventions include the following:
 - Noninvasive methods (i.e., repositioning, massage, music, distraction). Effectiveness of pain intervention is checked within 30 minutes to one hour after treatment.
 - Pharmacologic treatment:
 - Nonopioid analgesics:
 - -Aspirin and other salicylates, acetaminophen, and non-steroidal anti-inflammatory drugs (NSAIDS) are useful for acute and chronic pain due to a variety of etiologies such as surgery, trauma, arthritis, and cancer
 - -These agents have a ceiling effect, do no produce tolerance or dependence, are antipyretic, and their mechanism of action (excluding acetaminophen) is inhibition of cyclooxygenase

PAIN MANAGEMENT POLICY AND PROCEDURE (CONT.)

thus preventing formation of prostaglandin's and sensitizing peripheral nerves and central sensory neurons to painful stimuli

- Opioid analgesics:
 - -Opioid analgesics are added to nonopioids to manage acute pain and chronic cancer-related pain that does not respond to nonopioids alone.
 - -Sedation, constipation, nausea and vomiting, itching, and respiratory depression are the most common side effects of opioids. Recommend a stool softener to each patient to prevent constipation.
- Effectiveness of pain intervention is checked one hour after treatment for oral medications and 30 minutes after treatment for intramuscular or intravenous medications. If pain intervention is not effective, the physician is notified.

Documentation

- The initial pain screening is documented on the appropriate record
- Subsequent assessments of pain, interventions, and patient response to treatment are documented on the appropriate record
- Pain management instructions are provided on the discharge instructions
- The post-op call form contains questions that rate the facility's pain assessment for each patient

Staff education

- An annual inservice will be provided for nursing staff on pain assessment and management, including psychosocial, cultural, and spiritual diversity, and, if indicated, need for referral for unresolved pain or continued pain treatment
- Annual competency assessment occurs in those care delivery areas where pain management has been identified as a staff education and assessment need

Patient satisfaction

- During any postdischarge calls, staff will collect data from the patient about the effectiveness of his
 or her pain management
- The patient has the opportunity to respond on a mailed patient satisfaction survey with any comments regarding their pain management

Performance improvement

The organization will monitor the way pain is managed and its effectiveness through the performance improvement program.

PATIENT ASSESSMENT POLICY AND PROCEDURE Department: Policy number: 1-2 Section: PATIENT CARE Effective date: Page: 1 of 3 Title: PATIENT ASSESSMENT Approved by: Review date: Revision date:

Purpose:

To provide guidelines in the systematic collection of data used to determine patients' health status for developing a plan of care.

Policy:

Every patient admitted to the facility shall receive an initial assessment and screen by a qualified individual for the development of a plan of care to meet his or her needs. The scope of assessment for each discipline is defined in departmental policies. The scope and intensity of the assessment is determined by the patient's

- · condition/diagnosis
- · care setting
- · desire for care
- response to any previous care
- consent to treatment

Pertinent patient-related data is consistently communicated to the appropriate members of the healthcare team. Any abnormal physical or diagnostic findings are reported to the physician. It is the responsibility of the physician to make referrals for conditions that warrant further assessment/care not provided within the facility's scope of services.

Initial assessment

Upon a patient's admission to a patient care unit, a qualified clinician(s) will assess him or her to determine immediate needs and to collect assessment date. Initial assessment time frames are defined in departmental policies.

Screening/initial assessment criteria may include but are not limited to

- proper identification of the patient, using two patient identifiers
- social assessment
 - alcohol/drug use
 - educational level
 - sensory deficits

PATIENT ASSESSMENT POLICY AND PROCEDURE (CONT.)

- developmental stage (age-specific needs)
- spiritual/cultural needs
- language barriers
- social support network
- · results of relevant laboratory and diagnostic testing
- signs of possible abuse/neglect
- health history and current level of wellness, including potential for pregnancy
- previous surgical/anesthesia experiences
- appropriate physical assessment of applicable body systems, including physical or mental impairments, mobility and communication limitations. Body system assessment may include
 - respiratory
 - cardiovascular
 - neurological
 - muskuloskeletal (functional-needs screen)
 - gastrointestinal (nutritional-needs screen)
 - genitourinary
 - integumentary
- · advance directive, if available
- psychological and emotional status
- economic or employment status
- medications patient is currently taking (prescriptions, over the counter, herbal/nutritional supplements, etc.)
- known allergies, including latex
- presence of pain
- presence and disposition of jewelry, valuables, contact lenses, dentures, and other prosthetics
- · discharge planning needs
 - safe transportation
 - availability of responsible adult to assist with home care
 - preparation of the home
 - discharge limitations
 - appropriate referrals
 - procurement of supplies
 - equipment as needed

PATIENT ASSESSMENT POLICY AND PROCEDURE (CONT.)

Further assessment and reassessment

Based on the initial assessment of patient and established plan of care, reassessments are performed and documented throughout the care process and, if applicable, at follow-up appointments.

Reassessment time frames are defined in departmental policies. Reassessments shall take place under a variety of conditions, which include

- when there is a significant change in the patient's diagnosis or condition
- after a treatment, therapy, or procedure
- · whenever a patient transfers from one level of care to another
- upon discharge from the facility

The plan of care will be reviewed regularly and revised as appropriate to the patient's condition and the ongoing assessment process.

Documentation

Data from the initial and continued assessments are documented by various clinical disciplines on common forms and included in a common medical record to ensure that patient needs are appropriately identified and that care and service are coordinated effectively. Assessment and reassessments are documented in the following reports, as applicable:

- Medical staff
 - History and physical
 - Progress notes
 - Pre/Postanesthesia note
 - Consultation reports
 - Operative reports
 - Discharge summary
 - Clinic notes
- Nursing staff
 - Departmental assessment record
 - Discharge record
 - Clinic notes

	Moderate Sedation Policy and Procedure							
Department:		Policy number: 1-3						
Section:	PATIENT CARE	Effective date:	Page: 1 of 9					
Title:	MODERATE SEDATION, NON-ANESTHESIA PERSONNEL	O Non-clinical						
Approved by:		Review date: Revision date:						

Purpose:

To provide uniform standards for all patients receiving moderate intravenous (IV) sedation in order to minimize the associated risks.

Policy:

Defined levels of sedation

- **Minimal sedation** is defined as a state of pharmacologically induced anxiolysis during which 1) patients respond normally to verbal commands 2) cognitive function and coordination may be impaired 3) ventilation and cardiovascular functions are unaffected.
- Moderate sedation is defined as a state of pharmacologically induced minimally depressed consciousness that (1) allows protective reflexes to be maintained (2) retains the patient's ability to maintain a patent airway independently and continuously (3) permits appropriate response by the patient to verbal command and physical stimulation.
- Deep sedation is defined as a pharmacologically induced state of depressed consciousness or unconsciousness from which a patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes and includes the ability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command.

Desired patient outcomes for moderate sedation

Perception of pain altered

Mood alteration

Patient cooperation enhanced

Protective reflexes intact

Vital signs stable, with minimal variation

Amnesia usually present to some degree

Consciousness is maintained

Rapid, safe return to activities of daily living

Undesirable patient outcomes for moderate sedation

Aspiration

Severely slurred speech

Hypotension or hypertension

Bradycardia

Agitation and combativeness

Hypoventilation

Respiratory depression

Airway obstruction

Apnea

The objectives of moderate sedation

These objectives include the following:

- To relieve anxiety and produce amnesia
- To accomplish goals by means of good preprocedure communication and instructions, low levels
 of visual and auditory stimuli in the sedation room, and maintenance of patient warmth and covering
- To relieve pain and other noxious stimuli
- Supplement local/topical anesthetics and block pain sensation
- · To achieve adequate sedation with minimal risk
- No interference with the patient's ability to communicate verbally or maintain a patent airway

Staffing

Moderate intravenous sedation requires the continuous presence of a

- physician who is qualified and credentialed to provide moderate sedation
- qualified registered nurse with Advanced Cardiac Life Support (ACLS) certification and, as applicable, Pediatric Advanced Life Support (PALS-certified) trained to administer moderate sedation under the supervision of the procedural physician
- nurse whose only responsibility will be the continuous uninterrupted care/monitoring of the patient

Personnel

The physician must

- have appropriate clinical privileges for the specific procedure to be performed and for the administration of sedation and analgesia
- select and order the analgesic/sedation agents
- be able to assess total patient care requirements during moderate sedation and recovery
- have credentials (if a nonanesthesiology physician) that include
 - review of moderate sedation policy/procedure
 - review of consent for moderate sedation
 - at a minimum, basic life support certification

Nursing personnel

- There will be documentation that each nurse has completed a training inservice. Each nurse will be reevaluated annually for competency.
- Competency assessment is documented through various methods to include a self-study package and a self-assessment quiz.
- There will be periodic inservices for moderate IV sedation providers as indicated by performance improvement activities and changes in available drugs/technology.

Licensed professionals

The following criteria must be met by all licensed professionals responsible for a patient receiving sedation and analgesia:

- Be familiar with appropriate dosages, routes of administration, actions, adverse reactions, and interventions required for adverse reactions and accidental overdoses
- Have demonstrated competency in recognizing an airway obstruction and be proficient in the skills of basic life support
- Be able to rescue from deep sedation
- Be familiar with the principles of oxygen delivery and respirator physiology; have demonstrated competency in assessing the patient's physiologic parameters including, but not limited to, adequacy and rate of respiration, oxygen saturation, blood pressure, heart rate, and level of consciousness
- Competent to manage a compromised airway and to provide adequate oxygenation and ventilation

Informed consent

The patient/guardian must be informed about the risks of and alternatives to sedation as a component of the planned procedure. The explanation of risks and alternatives is the responsibility of the physician who is performing the procedure and supervising the moderate sedation. Informed consent must be completed and documented in the patient's record prior to the elective sedative procedure.

Environment/on-site equipment

The environment where the induction of sedation occurs will have provisions for emergency power for lighting, resuscitation equipment, monitoring equipment, and telephone. Regular testing will be documented on the electrical outlet connected to an emergency power distribution system, emergency lighting, and battery packs to ensure proper function. All equipment and supplies must be suitable for the age and size of the patients being treated and located to provide immediate access to the patient.

On-site equipment requirements include

- blood pressure monitoring system, automatic or manual
- · pulse oximeter with alarm
- electrocardiogram
- oxygen supply with masks and nasal cannulas, including positive pressure oxygen delivery device
- suction source with regulator and catheters
- nasal and oropharyngeal airways
- · syringes/needles/IV supplies

Equipment immediately available includes

- emergency resuscitation cart
- telephone or other device capable of summoning immediate assistance in an emergency

Preprocedure

Assessment is the responsibility of the physician who is performing the procedure, in collaboration with the registered nurse who will provide the moderate sedation under the supervision of the physician. The assessment will be completed and documented in the patient's record prior to the elective sedative procedure. The assessment includes

· medical history

- presence of disease of major organ system
- current medications
- drug allergies
- alcohol or tobacco use
- previous experience with anesthesia
- focused physical exam
 - cardiac evaluation
 - respiratory evaluation
 - airway evaluation
- nulla per os (nothing by mouth [NPO]) restrictions prior to procedure; standard NPO guidelines are, for adults, no solids six to eight (6–8) hours prior to the procedure
- · vascular access
- required equipment is assembled at bedside and is in good working order
- baseline vital signs, 0₂ saturation, and level of consciousness

It is the responsibility of the physician performing the procedure to assess the complexity of the procedure and the physical status of the patient and to determine the need of assistance of anesthesia personnel in administering the IV sedation. A decision to utilize department of anesthesia staff for the administration of IV sedation should be considered in any patient with the following:

- A potential airway problem, including sleep apnea patients
- Serious cardiopulmonary, central nervous system, renal, or hepatic disease
- IV sedative medication dose requirements greater than dosage guidelines allow for administration by nonanesthesiologist physicians (Versed 10 mg and Demerol 150 mg IV over 1 hour)
- Morbid obesity
- Class 3 status

After appropriate assessment, the patient is assigned American Standard Association (ASA) physical status classification by the physician in collaboration with the nurse.

- Class 1: A normal, healthy patient
- Class 2: A patient with mild systemic disease
- Class 3: A patient with a serve systemic disease that limits activity but is not incapacitating

Patients are reassessed immediately prior to administering sedation to determine whether they remain candidates for the planned sedation.

Intraprocedure

Sedation/Analgesia orders are documented in the patient's medical record and are the responsibility of the patient's physician. All medications are administered by the physician or licensed nurse. The one monitoring the patient will maintain a time-based record of any drugs administered.

All patients who receive IV moderate sedation will have the following continuously monitored by the physician or licensed nurse:

- Blood pressure/heart rate
- Pulse oximetry
- Ventilatory function
- Electrocardiogram (EKG) monitoring, which is done
 - at the physician's discretion
 - on patients with history of hypertension
 - on patients with history of cardiac disease
 - on patients over the age of 65 (per ASA guidelines)
 - for patients that inadvertently progress to deep sedation
- · Level of consciousness

Parameter data will be recorded on the moderate sedation record at five-minute intervals. Blood pressure/cardiac rate/oxygen saturation strips will be included in the patient medical record.

The range of patient responses to medication range from moderate sedation to deep sedation to general anesthesia. The moderate sedation provider must document the level of consciousness during and immediately after the administration of intravenous sedative medications. The following guidelines will be used:

- Stage 1: Awake; not drowsy; little or no evidence of drowsiness but patient level of anxiety is noticeably reduced.
- Stage 2: Drowsy and calm; drowsiness is apparent from slowed or slurred speech.
- Stage 3: Asleep; responds to soft voice/light touch. Intense drowsiness with patient occasionally fully asleep. However, the patient is easily aroused by verbal commands.
- Stage 4: Asleep and unresponsive to verbal commands. Patient must be shaken or physically stimulated to be aroused.

- Stage 5: Asleep and unarousable. Asleep and unresponsive unless surgical stimulation is applied.
- Stage 6: General anesthesia. Unarousable to surgical stimulation. Unconscious.
- Stages 4, 5, and 6 are to be avoided.

Events such as, but not limited to, emesis, cardiorespiratory depression/distress, vasobagal reaction, or diaphoresis should be documented. Documentation should include interventions and subsequent patient response.

Management of emergencies/complications

- The physician is responsible for the diagnosis and treatment of complications related to the procedure and IV sedation.
- In an emergency situation, anesthesia personnel (when available) will respond and assist the attending physician in management of the patient.
- If excessive sedation/respiratory depression occur, per instructions from the attending physician, the patient may receive reversal medications (e.g., Romazicon, Narcan). However, the initial activity should always be airway management.
- For patients who receive moderate sedation by nonanesthesia personnel, an ACLS-certified health-care provider must be in attendance.

Postprocedure

- A patient who undergoes moderate IV sedation is transferred to the PACU when the aldrete score is 8 or greater.
- A report is given to the unit nursing staff that includes any significant complications that occurred during or following the sedation.
 - This report includes the patient's presedation medical history, sedation administered, observed side effects or complications, and use of any pharmacologic antagonists
 - The nurse responsible for the patient should review the record of the procedure and sedation
 - Postprocedure orders, including appropriate monitoring requirements, are written by the responsible physician or proceduralist
 - During transport of a patient under sedation and analgesia, the patient shall be accompanied by a person who can initiate cardiopulmonary resuscitation and has appropriate qualifications and equipment for monitoring sedation en route

Discharge

- The following criteria will be used to assess the patient's readiness for discharge. A physician is
 responsible for discharge unless the patient meets unit-specific discharge criteria that have been
 approved by the medical staff. Supportive documentation in the medical record should clearly
 reflect that
 - the patient's cardiovascular function and airway patency are satisfactory and stable
 - the patient is alert and protective reflexes are intact
 - the patient can ambulate unassisted if not prevented by injury or prior state of health
 - the patient is accompanied by a responsible adult
 - for a very young child or handicapped person, incapable of the usual responses, the presedation level of responsiveness is achieved
 - the aldrete score is 8 or greater (or return to "baseline")
- The adult responsible for the patient shall receive written instructions prior to discharge that include
 - information about expected behavior following sedation
 - limitations of activities or precautions
 - instructions for eating
 - warning signs of complications
 - special instructions in case of emergency
 - specific procedure-related instructions, when indicated
 - telephone number (available 24 hours/day) to contact the medical service responsible for the patient's care
 - notation in the medical record that instructions were received and understood by a responsible adult

Performance improvement

Key aspects of sedation/analgesia will be monitored quarterly to track and improve outcomes, care provided, and compliance with standards. The following are outcomes related to the use of sedation and analgesia:

- No complications related to pharmacologic agents
- Cardiac/respiratory stability
- · Hemodynamic stability
- · Postprocedure return to clinical and functional baseline parameters

Moderate Sedation Policy and Procedure (cont.)

	Medication Administration Guidelines										
Midazolam (Versed)	Initial Dose: Titrate 0.5 mg–1 mg into infusing IV line over one min	Total Dose: 10 mg (in one hour)	Duration: 1–2.5 hours	Potential Adverse Reactions: Respiratory depression, apnea, excessive sedation with drowsiness to obtundation, hypotension, phlebitis at site of injection, and hiccough							
Diazepam (Valium)	Initial Dose: Titrate 1 mg-2.5 mg into infusing IV line over one min	Total Dose: 10 mg (in 30 min)	Onset: 1–5 min Duration: 2–6 hours	Potential Adverse Reactions: Respiratory depression, apnea, excessive sedation							
Flumazenil (Romazicon)	Initial Dose: 0.2 mg–1 mg IV q20min at 0.2 mg per min	Total Dose: 1 mg	Onset: 1-2 min (6-10 peak) Duration: 20 minutes to 3 hours	Potential Adverse Reactions: May induce central nervous system excitation including seizures, acute withdrawal, nausea, dizziness, and agitation							
Meperidine (Demerol)	Initial Dose: Titrate 12.5 mg–25 mg into infusing IV line over 30 sec	Total Dose: 150 mg in one hour	Onset: 1–5 min Duration: 1–2 hours	Potential Adverse Reactions: Respiratory depression, apnea, hypotension, peripheral circulatory collapse, cardiac arrest, lightheaded- ness, dizziness, n/v, diaphoresis, tachycardia, bradycardia, dysphoria							
Naloxone (Narcan)	Initial Dose: 1 mcg/kg in increments titrated against patient response at q2–3 min. intervals into IV line; dilute 0.4 mg/cc (1 amp) to 10 cc total for a concentration of 40 mcg per cc	Total Dose: 1 mg	Onset: 1–2 min Duration: Less than 1 hour	Potential Adverse Reactions: May cause reversal of analgesia, hypertension, arrhythmias, rare pulmonary edema, delirium							

SEDATION AUDIT TOOL

lu	mber of patients receiving mode	rate sedation	for the month	by above phys	sician:
	Indicator	Patient #	Patient #	Patient #	Patient # and dosage
	1.Patients receiving Demerol >150 mg				
	2. Patients receiving Versed > 10 mg				
	3. Patients receiving Reversal agent				
	4. Patients whose level of consciousness reached				
	5. Patients whose O2 sat. dropped below 90% for > 30 sec				
	6. Patients who experienced > 30% drop in blood pressure and/or > 30% change in pulse rate for > 1 minute				
	7. Patients whose recovery time is >90 minutes due to physiological status affected by sedation				
·	No charts were reviewed The following charts were reviev sedation, and findings are summ	arized			

SEDATION AUDIT TOOL (CONT.) Conscious sedation review log Versed > **Greater than 30% Patient sticker** Demerol > Reversal Level of Oxygen 150 mg given? 10 mg given? agent given? consciousness saturation is drop in blood pressure or 30% at stage 4 below 90% for change in pulse or more? greater than 30 rate for greater seconds than 1 minute? Date:

PATIENT AND FAMILY EDUCATION POLICY							
Department:		Policy number: 1-4					
Section:	PATIENT CARE	Effective date:	Page: 1 0F 4				
Title:	PATIENT/FAMILY EDUCATION	O Non-clinical					
Approved by:		Review date: Revision date:					

Purpose:

- To outline the process in which the educational needs of the patient and family are assessed.
- To describe the process in which potential barriers to learning are identified and overcome.
- To document the process in which the organization provides education based on the identified needs
 of the patient and family.

Scope:

This is a facility-wide document and applies to all patient care areas.

Policy:

- The patient/family teaching record will be used to document patient/family education. (Attachment A)
- The patient/family teaching record is a permanent part of the patient's medical record.
- Any discipline providing patient/family education will document on the form.
- All patients/significant others will be assessed prior to receiving education and during the process of education to determine their level of understanding and skill and any barriers to learning.
- An appropriate preprinted or a blank form may be used. The information will be customized to the patient/family.
- If a patient/family does not meet learning needs at discharge, follow-up documentation is necessary.
- General education and teaching guidelines:
 - The goal(s) of patient/family education should be to enable the recipient to maximize his or her ability to engage in behaviors that will optimize a healthful lifestyle.
 - The provision of patient/family education is based primarily upon identified need. The level and intensity of this education should be consistent with the needs of the patient/family.
 - The provision of patient/family education is interactive in nature. Active involvement of the patient/family in developing and implementing educational "plans" is recommended.
 - The provision of patient/family education is collaborative in nature. Members of the healthcare teamwork together to ensure that the needs of the patient/family are met.

PATIENT AND FAMILY EDUCATION POLICY (CONT.)

- The patient/family should be evaluated to determine whether they have received the education that was intended for them. For education that is didactic in nature, this evaluation can be accomplished by having the patient/family provide verbal feedback. If the education is skill-driven, then evaluation is ideally accomplished by return demonstration.
- Patients should be provided with appropriate after-care instructions when discharged from any care setting. The scope and intensity of this instruction should be consistent with the needs of the patient/family.
- Patients should be provided with instruction about specific drug/drug and food/drug interactions
 when discharged from the care setting, if they have been provided with the medication by the
 organization at the time of discharge.
- Provision of education should be conducted in a manner appropriate to the patient/family's developmental/functional age.

Procedure:

Assessment of the patient/family needs

- Patients and their families are assessed upon admission or point of care to determine what learning needs they may have that will enable them to engage in healthy behavior, recover from surgery, return to an optimal level of functioning, and be involved in decisions about their care.
- The scope and intensity of such an assessment is dependent upon the care setting and the patient/family anticipated level of interaction with the surgery facility.

Assessment of potential barriers

In assessing learning needs, the following are taken into account:

- The beliefs and values of the patient/family. This encompasses both personal and cultural beliefs, as well as value systems.
- The educational level of the patient/family, including issues regarding literacy.
- The primary and secondary language of the patient/family, in both verbal and written form.
- The presence of any emotional barriers or motivators.
- The presence of any physical or cognitive limitations that might impede the learning process.
- The presence of any psychological or social barriers that might impede the learning process.
- Any financial implications regarding care choices made.
- Readiness of the patient/family to enter into the learning process and actively participate in care.

PATIENT AND FAMILY EDUCATION POLICY (CONT.)

• Types of learning needs

As appropriate to the care setting and patient presentation, the patient/family is assessed for the following types of learning needs:

- Safe and effective use of medication, including potential food/drug interactions
- Safe and effective use of medical equipment
- Understanding the disease process or health problem
- Understanding diet, any restrictions thereof, and interactions, as well as the role and importance of proper nutrition
- Understanding the purposes, risks, benefits, and alternatives to treatments and invasive or diagnostic procedures
- Understanding rights and responsibilities
- Understanding rehabilitation processes or the potential for such processes, as appropriate
- Understanding community resources available to assist the patient/family in continuing their health education and care upon discharge from the facility
- Understanding how to acquire the necessary follow-up care and treatment
- Maintaining personal hygiene and grooming
- Maintaining wellness
- Providing for self-care or care of another following surgery
- Effective management of pain
- The role of the patient/family in promoting a safe healthcare delivery system

Assessment of learning preferences

The patient/family is assessed to determine the preferred method of receiving instruction. Religious or cultural beliefs may also determine preferred learning styles. It is recognized that individuals can receive and process information in a variety of ways, such as

- self-instruction
- individual or small group discussion and interaction
- interactive methodologies

PATIENT AND FAMILY EDUCATION POLICY (CONT.)

Roles of the healthcare team

Physician

- As the recognized leader of the healthcare team, the physician provides expertise and guidance
 to the team in meeting the educational needs of the patient/family. This includes informing team
 members of patient/family learning needs, the medical/clinical status of the patient, and anticipated follow-up care. This information assists the team in developing a plan to meet the educational needs of the patient/family.
- The physician is directly responsible for providing patient/family education relative to securing an informed consent for any surgical, invasive, or diagnostic procedures, as required by law. The physician is also responsible for educating the patient/family so that informed consent is required for the use of blood products, moderate/deep sedation, or anesthesia. The physician is also primarily responsible for discussing and educating the patient/family regarding the patient's diagnosis, prognosis, and medical treatment.

Nurse

- The registered nurse (RN) is responsible for assessing the learning needs of the patient/family in any area where nursing is practiced as appropriate to the care setting. Based on this assessment, the RN then develops a plan to educate the patient/family while under care/service.
- The RN provides basic direct patient/family education for any learning need identified (except that necessary for informed consent).
- The RN is responsible for ensuring that the provision of patient/family education by other health-care disciplines is integrated and coordinated into the patient's overall plan of care.

Other healthcare providers

Other members of the healthcare team, as well as those previously listed, will often provide what
is termed "incidental" education. This education is relative to a task or routine care procedure
involving the patient or family.

ATTACHMENT A: PATIENT/FAMILY TEACHING REPORT

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