On behalf of over 600 nurses, we welcome you to SoutheastHEALTH. We believe your experiences and education here will be rewarding, challenging, and anchor your professional practice.

Our commitment to you is to provide exemplary nursing education and practice experiences. Our promise to you is to be excellent role models, mentors, and teachers to enhance your training while you spend time with us.

SoutheastHEALTH has the best educated, most experienced, and most nurses certified in their specialty practice in Southeast Missouri. Over 50% of our professional are prepared at the Baccalaureate or Masters level, many of whom began entry into practice as LPNs and at the Associate Degree level of education. Our average years of experience is 10-15 years, depending on the area of practice. What that means is that you will have experienced coaches and mentors working with you. One in three nurses have validated their clinical excellence by certification in their area of specialty practice.

We will share our experience, our knowledge, and our expertise with you as you have your clinicals here. We welcome your inquiry, your need to have discussions with our staff about Best Practices and we accept the responsibility of sharing in your education.

You are the future of nursing. Welcome to SoutheastHEALTH.

In this manual you will find basic information regarding your clinical experience, as well as policies and procedures, safety codes, best practices, and letters from our nursing managers.
Southeast Missouri Hospital

Mission
Together we make a difference through our commitment to excellence in health care.

Vision
As a leading provider of health services, Southeast Missouri Hospital is dedicated to continuous improvement of the region’s health status in a collaborative cost-effective manner.

Statement of Values
To accomplish our mission and vision, we uphold these values:

Vision for Change
Our challenge in preparing for tomorrow’s health needs is to keep contemporary care available for those we serve. By evaluating the present, setting appropriate goals, being flexible and innovative, we prepare daily to meet and shape the future of health care in our region.

Access to Care
We believe that all patients in our care are entitled to quality health services, information and confidentiality about their care, and treatment with dignity and compassion in all of life’s stages.

Leadership with Responsibility
Dedicated to maintaining public trust and a high level of integrity, our Hospital leaders strive to balance progress with costs, regulations and competition while always preserving the human touch. As a not-for-profit Hospital, we are pledged to enhancing quality of life through wise use of human and material resources in medical and civic endeavors.

Unity of Purpose
A spirit of cooperation, mutual respect and concern is promoted by our Hospital family to deliver efficient and coordinated services. We also work together to provide patients and families with reassurance, support and care that is sensitive to all their needs.

Excellence in Performance
At Southeast Missouri Hospital, we have made a commitment to excellence in individual performance, technology and facilities. This tradition of excellence is expressed by helping patients attain the highest quality of life they are capable of achieving and by providing regional leadership for health care issues and developments.

Service Above Self
To demonstrate professionalism, ethics and devotion to duty is our charge; to serve with enthusiasm and compassion is our spirit. Recognizing that technology is in our hands and people are in our hearts, we take pride in giving our personal best for the benefit of others.
STUDENT POLICY

STANDARD:
To provide general guidelines for students, including Nursing, Medical Students, Respiratory Therapy, etc., while at SoutheastHEALTH for clinical experience.

POLICY:
Any student wishing to have clinical experience at SoutheastHEALTH must contact Educational Services before clinicals begin. Students are individuals who are permitted to observe or perform work as part of the formal education and are not considered employees of the organization. Students will be subject to the following provisions:
1. A written contract or Letter of Agreement
2. Completion of a personal information sheet
3. Proof of health status (upon request)
4. Proper identification – photo id
5. Safety training
6. Compliance with parking policies
7. Orientation to the organization

CONTRACTS
A copy of contracts or Letters of Agreement with Institutions will be sent to Educational Services and legal counsel for review. Once approved, contracts will be signed by a senior executive of administration. Contracts will be maintained in Educational Services.

NEW AFFILIATIONS
New schools who want to form an affiliation with SoutheastHEALTH, must contact Educational Services. The request will then be reviewed by the Medical Executive Committee for medical students or Senior Leadership for all other students. Approval for a new affiliation will come from these reviews. New affiliations will only be accepted from schools in Missouri or Southern Illinois University, unless specifically requested by senior administration.

PERSONAL INFORMATION
Each student will complete a personal information sheet which will be sent to Educational Services.

HEALTH
Certain health requirements/immunizations should be included in contracts or Letters of Agreement. All students with patient contact will be required to have a TB skin test. Students completing clinical between October 1 and April 30 will be required to follow the employee policy for seasonal influenza vaccination. Other health screenings may be required based on clinical or non-clinical settings.

IDENTIFICATION AND DRESS CODE
All students will wear a temporary photo identification badge issued by Educational Services or a recognized school/college/program identification badge while in the Hospital. Students will be in compliance with the Hospital dress code.
SAFETY TRAINING
Safety training will be job/student specific. Students will be informed of fire safety, severe weather policies, and accident reporting. Other safety programs, such as standard precautions, will be student specific. The safety training is scheduled by Educational Services. The training must be completed before the clinical experience begins.

PARKING (Cape Girardeau County Only)
When students are at Southeast Hospital during the hours of 0600-1400, Monday through Friday, the Broadway/Sunset or West End/Broadway parking lots should be utilized. Parking permit will be issued by Educational Services.

CONFIDENTIALITY
Students will be held to the same standard of confidentiality as SoutheastHEALTH employees. (See Confidentiality policy under Ethics/Patient Rights). To protect patient confidentiality no copies of any part of the medical record are permitted. If information is needed for class assignments, it may be hand copied from the record without identifying the patient.

EDUCATIONAL OPPORTUNITIES
Students may attend seminars provided by SoutheastHEALTH. Fees vary by program, The Library is available for student use between the hours of 7:30 a.m. and 4:30 p.m. Monday through Friday; excluding Holidays.

ISSUES INVOLVING STUDENTS
Any problem regarding students and their clinical experience should be directed by staff to their department manager. The manager should discuss these concerns directly with the students faculty representative. If the situation is not easily rectified, the issue should then be directed by the department manager to the Director of Educational Services for discussion.
DRESS CODE

While a student at SoutheastHEALTH we expect that you will adhere to our dress code. Please dress in a professional manner. Remember that you represent your school, this hospital, and nursing as a profession, to the patients we serve.

• A uniform or a lab coat over street clothes is required when in a clinical setting. Specialty areas may have a more specific dress code to follow.

• Clothing should be professional. NO blue jeans, shorts, or sleeveless tops. NO tight fitting or short-in-length apparel.

• Shoes should be non-permeable, soft soled, color coordinated and clean. NO open-toed shoes in patient care areas. Socks or hose, color coordinated, required.

• A Student Identification Badge is required – either issued by your school or by SoutheastHEALTH’s Education Department. Wear your ID badge whenever you are in the hospital or clinical setting.

• Artificial fingernails are prohibited for those persons providing direct patient care.

• Body piercings are prohibited. Tattoos should be covered.

• Avoid excessive jewelry, makeup, perfume or cologne.
PARKING

Southeast Hospital (Cape Girardeau)

Parking space allocations at Southeast Hospital are made on the basis of space availability, safety, and the needs of the various groups of users. In order to best accommodate all users (physicians, employees, students, patients, and visitors) specific parking designations have been made.

Student parking is limited to two parking lots:

Broadway/Sunset Lot
Broadway/West End

For students working at Southeast Hospital (Cape Girardeau), a parking permit will be issued by Educational Services. Students discovered parking in an unapproved lot will be identified and the Student ID will be seized by Security Staff, as well as receiving a ticket. The IDs will be given to the Security Director and the Student must meet with the Security Director for the return of the ID. The second offense will result in the Students removal from clinicals.

Students arriving at the hospital after 2pm for clinicals are allowed to follow employee parking guidelines as follows:

Because of the reduced demand for parking after 3:30 p.m., nightly and weekends by all user groups, evening, night and weekend shift employees may park in most VISITOR parking areas during the period of 2 p.m. to 8 a.m. daily. The exception to this rule is the East Lot (Lower Emergency Department Lot), where employees are allowed to park in the last three rows after 6:00 p.m. It is suggested that night shift employees park in the upper levels of the parking garage or on the lots that serve the garage off Lacey Street for convenience and safety. Evening and night shift employees may not park in the Physician's Parking Area, Cardiac Rehab or Outpatient Surgery reserved parking, Patient Drop Off or Pick Up areas, Handicapped Spaces, the East half of level D of the main Hospital parking garage. To utilize the East half of Level D an issued hang tag is required 24 hours.

Off-Site & Regional Locations

Students participating in clinicals at off-site locations (Cancer Center, Healthpoint, physician clinics, etc.) or regional locations should speak to their clinical supervisor regarding appropriate parking areas. Every effort should be made to maintain the best available parking spots for our patients and visitors.
TOBACCO FREE

SoutheastHEALTH is dedicated to providing a healthy environment for all people who enter its facilities and grounds. Consistent with our mission and our statement of values, SoutheastHEALTH is committed to making a healthy difference in people’s lives by providing a tobacco free environment.

Tobacco use of any kind, including electronic cigarettes (e-cigarettes), is not permitted at any time within any SoutheastHEALTH facility.

SoutheastHEALTH staff (employees, physicians, contract staff, students, etc.) will not use tobacco or e-cigarettes during their shift at any time, including breaks/lunch while on SoutheastHEALTH campus (SoutheastHEALTH campus includes the areas surrounding SoutheastHEALTH campus up to 50 yards of SoutheastHEALTH property). The purpose for the 50 yards distance is to prevent trespassing, loitering, and littering around our neighbors. It is important to maintain a good neighbor relationship.
# TELEPHONE USAGE

*Please turn your cell phones off or on silent while in the clinical areas. Cell phones are prohibited in some areas of the hospital.*

## Hospital Telephone/Pager Usage

<table>
<thead>
<tr>
<th>LOCAL CALLS</th>
<th>LONG DISTANCE CALLS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From an employee area:</strong></td>
<td><strong>For hospital business use only</strong>:</td>
</tr>
<tr>
<td>1. Dial 9 for an outside line</td>
<td>1. Call the switchboard by dialing “0”</td>
</tr>
<tr>
<td>2. Dial the local number after hearing the dial tone</td>
<td>2. Give the operator your name and department you are calling from</td>
</tr>
<tr>
<td><strong>From a patient room:</strong></td>
<td>3. Ask for a long distance line for hospital business</td>
</tr>
<tr>
<td>1. Dial 8 for an outside line</td>
<td>4. When you hear a dial tone, dial 1-area code-phone number</td>
</tr>
<tr>
<td>2. Dial the local number after hearing the dial tone</td>
<td></td>
</tr>
</tbody>
</table>

## TRANSFERRING CALLS

<table>
<thead>
<tr>
<th>Into patient rooms:</th>
<th>To Other Departments or Extensions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Dial 7+the room number <em>(5+Room number for Pediatric Rooms)</em></td>
<td>2. Enter the 4-digit number</td>
</tr>
</tbody>
</table>
EMERGENCY CODES

Cape Girardeau County

TO CALL A CODE DIAL 5200 (Hospital Campus) AND GIVE SWITCHBOARD THE INFORMATION, IF NO ANSWER DIAL 7711 ANNOUNCE 3 TIMES “CODE_____” AND YOUR LOCATION BY DEPT. OR UNIT

Off-site locations will dial 911 for emergency situations.

CODE BLUE
RESPIRATORY OR CARDIAC ARREST
This could happen to a patient, visitor, employee, or volunteer. Call the code, stay calm, start CPR. You may also be asked to direct traffic or keep visitors away from the area so that the code team can work.

CODE ADAM
INFANT OR CHILD ABDUCTION
Look and listen down hallways, in stairways and exit doors in your area for anything strange and out of the ordinary.

CODE YELLOW
TORNADO WATCH HAS BEEN ISSUED
Continue working, but plan for moving of patients and visitors if needed

CODE RED
TORNADO WARNING HAS BEEN ISSUED, CITY SIRENS ARE SOUNDING, OR TORNADO SPOTTED
Move visitors and patients into the hallway, away from windows.

CODE “99”
FIRE
If you are the one who finds the fire, stay calm, call for help, make sure visitors, patients and employees are safe, pull fire alarm and call the code, confine the fire (close doors), extinguish or evacuate.

CODE “BT”
BIOLOGICAL OR CHEMICAL THREAT
Stay calm and await instructions from your manager. Close doors.

CODE SHOW-ME
UNANNOUNCED SURVEY
Joint Commission / Center for Medicare-Medicare / Department of Health & Senior Services surveyors are in the hospital.

CODE 100
BOMB THREAT
Remain in your area and await further instruction.

CODE SILVER
VIOLENT INTRUDER
Stay calm. Do not enter the area until determined safe by the police department.

CODE STARR
DISRUPTIVE PERSON
Stay calm and wait for STARR (Safe Training & Responsible Restraints) trained personnel to arrive.
## EMERGENCY CODES

### Regional Facilities

### FACILITY ALERT

<table>
<thead>
<tr>
<th>Event</th>
<th>Recommended Plain Language</th>
<th>Alternate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evacuation</td>
<td>“Facility Alert + Evacuation + Descriptor (location)”</td>
<td>None</td>
</tr>
<tr>
<td>Fire</td>
<td>“Code Red + Descriptor (location)”</td>
<td>Plain Language</td>
</tr>
<tr>
<td>Hazardous Spill</td>
<td>“Facility Alert + Hazardous Spill + Descriptor (location)”</td>
<td>Code Orange</td>
</tr>
</tbody>
</table>

### WEATHER ALERT

<table>
<thead>
<tr>
<th>Event</th>
<th>Recommended Plain Language</th>
<th>Alternate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Weather</td>
<td>“Weather Alert + Descriptor (threat/location) + Instruction”</td>
<td>None</td>
</tr>
</tbody>
</table>

### SECURITY ALERT

<table>
<thead>
<tr>
<th>Event</th>
<th>Recommended Plain Language</th>
<th>Alternate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abduction</td>
<td>“Security Alert + Descriptor (threat/location)”</td>
<td>Code Pink</td>
</tr>
<tr>
<td>Missing Person</td>
<td>“Security Alert + Descriptor”</td>
<td>None</td>
</tr>
<tr>
<td>Armed Violent Intruder/Active Shooter/Hostage</td>
<td>“Security Alert + Descriptor (threat/location)”</td>
<td>Code Silver</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>“Security Alert + Descriptor (threat/location)”</td>
<td>Code Black</td>
</tr>
<tr>
<td>Combative Patient/Person</td>
<td>“Security Alert + Security Assistance Requested + (location)”</td>
<td>None</td>
</tr>
</tbody>
</table>

### MEDICAL ALERT

<table>
<thead>
<tr>
<th>Event</th>
<th>Recommended Plain Language</th>
<th>Alternate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass Casualty</td>
<td>“Medical Alert + Mass Casualty + Descriptor”</td>
<td>None</td>
</tr>
<tr>
<td>Medical Decontamination</td>
<td>“Medical Alert + Medical Decontamination + Descriptor”</td>
<td>None</td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>“Code Blue + Descriptor (location)”</td>
<td>Plain Language</td>
</tr>
</tbody>
</table>
FIRE & OTHER SAFETY CONCERNS

When responding to a fire, remember the acronym RACE:
- Rescue
- Alarm
- Confine
- Extinguish / Evacuate

For Extinguisher use – PASS:
- Pull
- Aim
- Squeeze
- Sweep

EQUIPMENT / ELECTRICAL SAFETY
- DO NOT use any equipment in which you have not been trained to operate.
- If equipment failure occurs, seek help from the staff or your instructor. The equipment must be taken out of service and a work order sent.
- DO NOT place liquids near electrical equipment.
- DO NOT use unauthorized extension cords.
- DO NOT disconnect a plug from the wall by grasping the cord.
- Report any frayed cords, broken plugs, equipment that is overheating, or any shocks received from equipment.

CHEMICAL SAFETY
DO NOT use any chemical that you are not familiar with its safety or use.
- Material Safety Data Sheets (MSDS) are available to answer questions about chemicals/products you may come in contact with.
- If a chemical spill occurs, seek help from the staff or your instructor.

MEDICAL GAS and VACUUM SYSTEMS
3 Method are used to avoid mix-ups:
- *product label
- *product specific gas connections
- *cylinder or outlet color code

The following are the color codes for medical gases:
- Oxygen - green
- Helium - brown
- Carbon dioxide - grey
- Nitrogen - black
- Nitrous oxide - blue
- Medical air - yellow

O2 and Tank Safety:
- Never handle oxygen equipment after applying petroleum based products to your hands.
- Most lip balms have petroleum in them. This is a fire hazard.
- NEVER leave a tank out of its holder.
- DO NOT attempt to change a tank regulator without proper instruction.
HIPAA & CONFIDENTIALITY

Health Insurance Portability and Accountability Act

HIPAA addresses the privacy and security of individuals’ health information by establishing nationwide standards concerning the privacy and security of health information and how it can be used or disclosed.

The Privacy Rule standards address the use and disclosure of individuals’ health information as well as standards for individuals’ privacy rights to understand and control how their health information is used by organizations holding the information.

The Security Rule establishes a national set of security standards for protecting certain health information that is held or transferred in electronic form.

Both Rules apply to Protected Health Information.

All employees, volunteers, physicians, students, vendors, contractors must follow HIPAA Rules.

- Compliance with HIPAA is mandatory.
- Health information is any information, written, spoken, or electronic, that relates to the health of the individual, the health care provided, or payment for care provided.
  Protected Health Information (PHI) Includes:
  - Any information – verbal, written, electronic – that relates to a patient’s:
    - Identity/name/image
    - Address/phone number/email
    - Age/ date of birth
    - Social security number
    - ANY medical information/medical history including diagnosis, treatments, medication, observation, procedure, etc.
    - Any other identifying information.
  
  Regulations have identified 18 different ‘identifiers’ of PHI.

- Information is used on a “need to know” basis. Discussions concerning patients are conducted in a private area. Avoid conversations regarding patients in hallways, elevators, or any public area.
- No patient information, verbal or written including copies of medical records, are permitted outside the hospital.
- Confidentiality includes use of computers. Do not give out your password!
HIPAA Privacy Rule:
- Patients have a right to have their health information kept private and secure.
- Disclosing PHI is prohibited and illegal unless the patient gives permission or an exception applies.
- Authorization forms must be signed.
- Patients can request restricts as to who can access or receive their information.
- Minimum necessary rule: you can only access the minimum necessary to accomplish the intended purpose.
- Don’t disclose information unless you are certain you’re allowed to under the Rule.
- If you have questions or concerns, do not hesitate to contact the department manager or the compliance officer.

HIPAA Security Rule:
- Establishes national standards for the security of electronic PHI.
- Physically lock up and safeguard all ‘paper’ records.
- Never place documents containing PHI in regular trash (must be shredded).
- Always access and use computer equipment, media and software according to SoutheastHEALTH policy.
- Secure electronic records:
  o Never post or share your password
  o Never use someone else’s password
  o Always log out (even if stepping away for just a moment)
  o Keep computer screens out of view by others
- Special precautions must be taken to remove all patient information before computer equipment is discarded.

SoutheastHEALTH’s Corporate Compliance Officer
Regina Faulkenberry, J.D., CHC
Associate General Counsel/Corporate Compliance Officer
Regina is available to you at:
(573) 651-5541
text extension 5541
General Counsel Office (1st floor - 1708 Lacey)
2015 National Patient Safety Goals

Reduce the risk of health care-associated infections.

★ Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. (MDROs)
★ Comply with current CDC or World Health Organization guidelines for hand hygiene.
★ Implement practices to prevent central line-associated bloodstream infections. (CLABSI)
★ Implement evidence-based practices for preventing surgical site infections. (SSI)
★ Implement evidence-based practices to prevent indwelling catheter associated urinary tract infections (CAUTI).

Improve the effectiveness of communication among caregivers.

★ Report critical results of tests and diagnostic procedures on a timely basis.

The hospital identifies safety risks inherent in its patient population.

★ Identify patients at risk for suicide.

Improve the accuracy of patient identification.

★ Use at least two patient identifiers when providing care, treatment, and services.
★ Label containers used for blood or other specimens in the presence of the patient.
★ Eliminate transfusion errors related to patient misidentification.

Improve the safety of using medications.

★ Label all medications, medication containers, and other solutions on and off the sterile field in peri-operative and other procedural settings.
★ Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
★ Maintain and communicate accurate patient medication information.

Universal Protocol

★ Conduct a pre-procedure verification process.
★ Mark the procedure site.
★ A time-out is performed before the procedure.

Reduce the harm associated with clinical alarm systems

★ Improve the safety of clinical alarm systems

PERFORMANCE IMPROVEMENT (PI Projects)

What is performance improvement?

- It’s an ongoing effort to find new and better ways of doing things
- It focuses on processes, not people
- It includes not only improvement of clinical processes of care, but also business and administrative functions and patient satisfaction.
- It measures how we do things and how we make changes to the processes when needed to improve the quality of care we give our patients.

SoutheastHEALTH’s problem solving model –
FOCUS & PLAN-DO-CHECK-ACT (PDCA).

F inding an opportunity to improve

O rganize a team

C larify the current process

U nderstand the variables

S elect what needs to be fixed

If an opportunity for improvement should occur you can contact the Quality Management department for further details.

REPORTING ERRORS

Team building and willingness to report errors are practiced at Southeast Hospital. If an error should occur see the Event Report policy for direction. It is located in the Documentation section of the Organizational Policy and Procedure Manual in the computer system. Event reports are completed to provide information about an unplanned, unexpected, or untoward event. Event reports are confidential and NOT part of the medical record. They are completed by the staff involved and then forwarded to the Quality Management Department.
**FALLS PREVENTION**

**Hourly Rounding**

Hourly patient rounding is a patient care model and an effective process for improving patient and nursing care excellence. Goals of patient rounding include:

- Improved Clinical Outcomes
- Improved Patient Safety
- Reduction in Call Light Use
- Increased Patient Satisfaction
- Increased Employee Satisfaction
- Decrease Falls
- Improve Team Communication
- Decrease Skin Breakdown

**Common Causes of Falls**

- Patients getting out of bed without assistance
- Patients getting up to the bathroom without assistance
- Patients getting up to the BSC without assistance
- Staff not responding quickly enough to call lights
- Staff not using gait belt on patients
- Clutter on the floor
- Patients not wearing non-skid footwear
- The bed wheels not being locked
- Side rails not up (2 or 3 rails should be up at all times)

**Guidelines of Hourly Rounding**

- Focus on the 4 P’s + 1
  - PAIN, POTTY, POSSESSIONS and POSITION
  - The + 1 is PLAN OF CARE
- Address PLAN OF CARE on 1st Round of Nurse’s Shift, and when changes occur in patient status
- Explain Hourly Rounding program on 1st round
- Address the 4Ps on all other rounds
- Rounding occurs every hour from 0400 to 2200
- Every two hours from 2200 to 0400
- When you wake a patient for care and first thing in the morning, you take the patient to the bathroom
- Do NOT wake a patient for Hourly Rounding, unless necessary to do so.

If a patient is at high risk for falls, a yellow ID band will be placed on the patient’s wrist, a “High Fall Risk” sign will be placed above the patient’s bed, and a “Patient Alarm in Use” door knob hanger will be placed on the door to the room.

**WHY ARE FALLS SUCH A BIG DEAL?**

- Patient safety is in jeopardy
- Patient’s quality of life decreases after a fall
- Falls are expensive, costing on average $17,000
- Falls decrease patient, physician, and staff satisfaction scores
- Statistics indicate falls are the leading cause of death due to injury in patients over 65
SBAR: Hand-Off Communication

**SITUATION**
One sentence description of the situation with your patient. 
Your name, patient name, unit, room number, the problem you are calling about.

**BACKGROUND**
Important and brief information related to the situation with your patient. 
Admission diagnosis, date of admission, medical history, brief

**ASSESSMENT**
State the physical assessment pertinent to the problems and offer conclusions about the present situation. 
Vital signs, O₂ status, mental status, skin color, musculoskeletal, rhythm changes, etc.

**RECOMMENDATION**
Recommendation – explain what you think needs to be done. 
Transfer to another level of care, talk to patient/family, consult, any tests needed, change in treatment.

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**About Hand-Off Communication**

**Purpose:** To provide accurate information about a patient’s care, treatment, service, current condition and any recent or anticipated changes.

**Definition:** An interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another team for the purpose of ensuring the continuity and safety of the patient’s care.

PATIENT RIGHTS & ETHICS

Every patient has the right to expect and receive high quality care.

- **Privacy and Respectful Care**
  - Includes privacy, security and safety including freedom from all forms of abuse and harassment.
  - Keep information confidential and protect medical records

- **Care Decisions / Informed Consent**
  - Inform patient about their care and allow them to participate in decisions related to care.
  - Obtain from the physician complete current information concerning the diagnosis, treatment and prognosis in terms the patient can understand.
  - Receive information from physician necessary to give informed consent to any procedure/treatment

- **Advance Directives / Ethical Issues**
  - Advance directives can include living wills of durable power of attorney are respected to the extent provided by law.
  - Patients or their designated representatives have the right to participate in the consideration of ethical issues involved in their care.
  - Refer to the policy “Ethics Policy on Consultation” on the next page, but can also be found in the Organizational Policy and Procedure Manual.
  - Minors and incapacitated adults may be represented by a surrogate for ethical matters.

- **Refusal of Treatment**
  - The patient has the right to refuse treatment to the extent permitted by law.

**Cultural Diversity**

*Mission: To create an environment respectful of everyone’s uniqueness.*

- Don’t let your own beliefs influence your interaction with others of different backgrounds.
- Be aware and understand patient’s cultural background.
- Respect and accept cultural differences and similarities.
- Adapt care to the patient’s healthcare beliefs, values, and norms.
PURPOSE:
In accordance with Southeast Hospital's commitment to quality health care, access to an Ethics Committee for a consult should be made available to anyone connected to a patient's care when there is an existing or potential ethical problem.

POLICY:
A request for an ethical consultation may come to the Ethics Committee, or a portion of it, at any time by a patient or family, and/or the physician or staff. The Ethics Committee, comprised of physicians, nurses, chaplain, administration, nursing administration, social worker, quality management representative, and community members, will be sensitive to the concerns of all involved with the patient's care, will be advisory in its capacity, and will act on each request with the following process in mind.

ACCESS:
Any of the following can access the Ethics Committee:
1. Physician: Request on patient's chart for consultation
2. Staff: Request to Ethics Committee chairperson (physician) or convener or any member of the Ethics Committee.
3. Patient/family: Request to staff member who should notify a member of the Ethics Committee.

INTAKE:
The Ethics Committee chairperson or any member of the Ethics Committee will be notified of the initial request from physician, staff, patient, or family. The chairperson will determine:
1. The need for consultation (with family and physician consent).
2. The parties and committee members to be involved in the consultation.
3. The extent of information needed prior to the consultation.

REVIEW:
The Ethics Committee chairperson or member will determine the meeting place and time, reminding all participants of patient confidentiality as well as the review process may include the following:
1. Facts: All medical and psychosocial information gathered regarding diagnosis and prognosis of patient's condition.
2. Stakeholders: A listing and prioritizing of all parties who have a stake in the patient's outcome.
3. Principles: A listing and prioritizing of the major ethical principles applicable to the patient's situation.
4. Options: A committee consensus of the best options to be proposed to the patient, family, physicians and staff.

DOCUMENTATION
Documentation of all options in a written summary held on file in Administration; patient's chart will also be documented when requested or as appropriate.

EVALUATION:
Each consultation will be evaluated by the committee in regard to the hospital's stated policy, process and procedure.

REFERENCES:
INFECTION CONTROL & BLOODBORNE PATHOGENS

Adherence to the practice of STANDARD PRECAUTIONS (a combination of Universal Precautions and Body Substance Isolation) is expected of all nursing staff. Nursing staff serves as a role model for all healthcare workers in the use of personal protective equipment and adherence to established guidelines.

STANDARD Precautions shall be followed by all personnel which includes: Personal Protective Equipment will be worn when splashing, spraying, or contact with blood or body fluids is anticipated.

Personal Protective Equipment (PPE) includes gowns, gloves, masks, goggles or face shields. Wear the appropriate PPE for the task or anticipated exposure.

Following proper hand hygiene techniques is also part of standard precautions.

Points to remember:

- Using standard precautions includes meticulous hand washing.
- Wear appropriate gloves.
- Use gown, mask, goggles, gloves for obvious blood and body fluid exposure.
- Use safety needles and devices. No needle recapping.
- Students should not care for TB patients in respiratory isolation in which staff must wear N-95 masks. Students are not fit tested for these masks.
- Use biohazard bags when transporting lab specimens and contaminated waste.

If injured or have an exposure to blood or body fluids:

- Wash area immediately
- Report the event immediately to your instructor and the unit charge nurse or manager.

In addition to Standard Precautions there may be patients on a Transmission Based Precaution:

- Contact Precautions
- Droplet Precautions
- Airborne Precautions

Please read the sign posted on the patient’s door. This will provide you the information necessary to care for a patient on a transmission based precaution. Remember, as a student you cannot care for a patient in which a N-95 mask is required.
WASH YOUR HANDS

Good hand hygiene is the single most important way to reduce the spread of infection.

HAND DECONTAMINATION:

1. Use plain lotion soap and water or an antimicrobial soap and water--
   - If hands are visibly soiled (important to physically remove the material)
   - Before eating
   - After using the restroom
   - If exposure to Bacillus anthracis or other spore forming pathogens such as Clostridium Difficile is suspected or proven

2. Use an alcohol-based hand rub in all other recommended situations below, unless hands are visibly soiled--
   - Before and after direct patient contact
   - After contact with patient’s intact skin (e.g., as in taking a pulse or blood pressure, or lifting a patient).
   - When moving from a contaminated body site to a clean body site during patient care.
   - After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
   - Before donning gloves when inserting IV catheters, urinary catheters, or other invasive devices.
   - After removing gloves.
   - Before donning sterile gloves

HAND-WASHING TECHNIQUE

1. Sleeves turned up to expose wrists.
2. Turn on the faucet so that warm water is flowing. Wet hands.
3. Use 3-5 ml of soap to create a visible lather.
4. Wash palms and wrists, in between fingers and under nail beds, covering all skin surfaces and under rings creating a vigorous scrubbing action for at least 15 seconds.
5. Rinse thoroughly with warm running water, being sure to remove all soap residue.
6. Pat hands dry with a clean paper towel. Discard the towel.
7. With another clean paper towel, turn off the faucet. You may use this same towel to open the door. Discard the second paper towel.
8. If using an automatic towel dispenser with a finger operated lever, release enough length of towel prior to washing. By doing so, you will have the clean paper towel ready when drying your hands.

ALCOHOL-BASED WATERLESS ANTISEPTIC HAND DECONTAMINATION TECHNIQUE:

1. Dispense 3 grams, approximately a ping pong ball size into palm of hand to keep hands wet for 15-20 seconds.
2. Rub hands together, covering all surfaces of hands, fingers, and wrists. Rub vigorously until hands are dry.

*There has been one reported occurrence of alcohol hand gel that remained “wet” on the hands and ignited after static electricity was created by removing a polyester isolation gown and then touching metal.

Artificial fingernail enhancements are prohibited for those providing direct patient care. Also, natural fingernails are to be neatly manicured and no longer than 1/4 inch length beyond the tip of the fingernail for those providing direct patient care. Artificial nail enhancements contribute to nail changes that can increase the risk of colonization and transmission of pathogens to patients.

Gloves: The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. We need to wear gloves when providing direct patient care, but do not wear them in the halls.
NEEDS OF THE DYING PATIENT

As Dr. Kubler-Ross states, we cannot give loving and caring support to dying patients and their loved ones until we face our own death and mortality within the depths of our being.

KEY TERMS

GRIEF is the process of psychological, social, and somatic reactions to a perceived loss.

MOURNING is a response to loss that is culturally and socially influenced and includes a wide array of intrapsychic processes, conscious and unconscious, that are a result of loss.

BEREAVEMENT is the state of having suffered a loss.

Many theorists have described the grief process as having stages or phases which include:

1. Shock, disbelief, and numbness
2. Intense mourning, developing awareness and acceptance of the unwanted reality of the loss, accompanied by disorganization.
3. Reestablishment of homeostasis, recovery, restitution and reorganization

PHYSICAL SYMPTOMS AND PATIENT CARE

1. The patient’s sensation and power of motion as well as his reflexes are lost in legs first and gradually in his arms.
   a. Sheets should not be snug.
   b. Turn frequently and give special attention to the positioning of patient’s legs.
2. As peripheral circulation fails, there is a “drenching sweat” and the body surface cools, regardless of room temperature.
   a. Utilize lighter clothing and fresh circulating air.
3. The dying patient always turns his head toward the light.
   a. Indirect lighting should be provided in the room and significant others should be seated near the patient at the head of the bed.
4. The dying patient’s touch sensation is diminished, yet the dying can sense pressure.
   a. You should find out if the patient likes to be touched.
5. The dying patient may seem in pain throughout the dying process.
   a. If, however, all of his other needs are met and if he is at the stage of acceptance where he has said all he feels he needs to say, he may need minimal pain medication.
6. The dying patient is often conscious to the very end.
   a. You need to give total care to the very end.
7. Spiritual needs often arise most strongly at night.
   a. If a patient has had a strong spiritual life, he’s apt to want to talk about it and share his experiences with those near him.
ORGAN AND TISSUE DONATION

In accordance with Missouri law, it is the policy of Southeast Missouri Hospital that when death occurs, Mid America Transplant Services (MTS) will be notified and MTS Coordinators will offer the opportunity to donate tissue and/or organs to family members of suitable donors.

All requests for donation will be done ONLY by MTS. When a family member initiates the subject of organ or tissue donation, they should be referred to the MTS coordinator on call.

STUDENTS AND PATIENT RESTRAINTS

SoutheastHEALTH believes in maximizing independence, functional capacity, and quality of life for our patients. Restraint use may violate the rights of patients, reduce the quality of life and pose physical and psychological risks. Alternatives to restraints will be considered and attempted prior to the initial use of restraints and during ongoing assessment when restraints are deemed necessary.

Alternatives to restraints may include reorientation, reinforced patient teaching, diversional activities, warm blanket, sitting with a patient, comfort measures, relaxation channel on TV, soothing objects to hold, offering food or fluids, and frequent toileting. In some instances a patient may have a “sitter” staying with them.

The nurse will assess the patient’s behavior to determine the need for restraint after the appropriate alternatives have been unsuccessful. A physician’s order must be obtained when using restraints. There are two general classifications of restraint: Nonviolent Restraint or Violent / Self Destructive Restraint.

Indications for Nonviolent Restraints:
• Patient is confused, unable to follow commands, actively pulling at lines / tubes / monitors.
• Patient is confused and unable or not allowed to ambulate but actively attempts to crawl out of bed or chair.

Indications for Violent or Self Destructive restraints:
• Used for violent or self destructive behavior

Restraints will not be used in a manner that causes physical discomfort, harm or pain to the patient.

Staff will be in charge of determining the need for restraint, obtaining the appropriate orders, and applying and removing restraints on patients. Patients in “Nonviolent” restraints are monitored every 2 hours. Patients in “Violent or Self Destructive” restraints are monitored every 15 minutes. Documentation of the patient observation is completed on the restraint flowsheet which may be kept at the foot of the bed on a clip board. The staff is in charge of monitoring and documentation. Ask nursing staff if you have any specific questions. Assessment of a patient in restraints would include skin integrity, circulation, respiratory status, general status, proper placement, and any comfort needs. Do not do anything with restraints unless directed by a nurse.

For more information about restraint use see the policy “Guideline For the Use of Restraint & Seclusion” in the hospital Policy and Procedure Manual on the computer. The policy is located in the Organizational Manual, Safety/Precautions section.
GENERAL PRINCIPLES OF PAIN MANAGEMENT

1. As healthcare providers, staff shall be committed to pain management, respond quickly to reports of pain with state of the-art pain management and provide general information about pain and pain relief measures.
2. The patient’s report of pain will be an integral part of the assessment.
4. Consider the simplest dosing schedule and refrain from the IM route.
5. Encourage regular (around-the-clock) dosing.
7. Non-pharmacologic management as needed and as appropriate.
8. Management of side effects, e.g. constipation, sedation, confusion, etc.
9. Patient/family will be appraised of all options in order to participate in his or her pain management, including requesting alternative pain management approaches and refusing or requesting revision of the current pain management without fear of reprisal.
10. Patient will receive pain management that is administered with respect and dignity by professional caregivers who consider each patient to be a unique individual worthy of compassionate care and expect that all reasonable safety and security measures will be taken in the provision of pain management.
11. Provide pain management that is monitored and evaluated on an on-going basis to continually improve that quality of care is delivered.
12. Provide pain management that is appropriate and efficient.
13. Schedule activities, e.g. wound care, physical therapy, walking, turning, etc. during the peak effective time of analgesic medicines.
14. For PRN pain management orders, the nurse may reduce the dose only after calling the physician with a condition report and receiving orders.

Assessment of pain:
- Pain will be assessed using the pain rating scale of 0-10 (0 being no pain and 10 being severe pain).
- For children, use the FACES Pain Rating Scale.
- For patients unable to communicate, use the non-verbal scale.
- For newborns and infants up to 1 year old, use the neonatal infant pain scale (NIPS).

Document the pain rating, action taken, and response to the management or the patient’s pain.
- Pain should be reassessed following administration of analgesics. Reassessment should occur within one hour following medication administration. Reassessment may be sooner depending on the route of administration and the severity of pain.
Logging On:
1. Click on Soarian icon.
2. Log on with personal Username.
3. Clinical Application opens.

Logging Off:
1. Make sure charting is completed and signed.
2. Click Log Off button in right upper hand corner.

Select a Nursing Station:
1. Click on the nursing station on the top left corner to select appropriate area.
2. Click on the blue door icon in the Entity Selection screen.
3. Click on desired nursing station and click OK at the bottom of the screen.

Nurse Assignment Tool:
1. Select Nurse Assignment Tool icon from Census screen to assign patients to the user for a defined date and time.
2. The Assignment End Date/Time is the end time that the nurse is responsible for the patients. This defaults to 12 hours later than the current date. Change if needed.
3. Click Assign next to the patients for whom you are responsible. The date and time defaults. Change as appropriate.
4. If you select someone by mistake, click to cancel the assignment.
5. Click Save.
6. An informational message appears. Click Close.
7. The patients assigned to you appear at the top with a white background. The rest of the patients have a grey background.
Documentation – Accessing Assessments

1. From the Open Census, click on the Charting icon for the patient for whom you wish to chart.
2. On the Charting screen, click on Documentation from the navigator on the left. This opens the Assessment Browser screen.

3. From the Filtered list select an assessment to chart.
4. Under the Scheduled/Incomplete Assessments list are the patient’s assessments that have been started but are not complete, e.g., saved with a status of In Progress.
5. Enter the appropriate data on the document. Be sure to scroll to the bottom of the document to chart all the fields.
6. After all data has been entered, navigate to the Status. Select In Progress if the assessment has not been completed.
7. If finished, select a Status of Complete. Select In Progress if the assessment has not been completed.
8. Click Save to save the documentation.

NOTE: When a document is saved, fields with data that were entered incorrectly (outside of predefined values) or fields that required data but were omitted will display in pink. These fields must be completed before the document can be saved.

Documentation Statuses
Documents should be saved with a status of Complete if possible.
- Complete: The clinician has finished the documentation.
- In progress: The document has been started but still needs to be completed.
- Eroneous: Information has been charted in error, or on the wrong patient.

Documentation Icons

<table>
<thead>
<tr>
<th>Button</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Back to Assessment Browser" /></td>
<td>Back to Assessment Browser</td>
<td>Return to the Assessment Browser without saving data that was entered on a document</td>
</tr>
<tr>
<td><img src="image" alt="View Previous Documents" /></td>
<td>View Previous Documents</td>
<td>View previously charted documents, one at a time</td>
</tr>
<tr>
<td><img src="image" alt="Add a Note" /></td>
<td>Add a Note</td>
<td>Add a clinical note</td>
</tr>
<tr>
<td><img src="image" alt="Revision History" /></td>
<td>Revision History</td>
<td>View the history of changes made to an assessment</td>
</tr>
<tr>
<td><img src="image" alt="Revert to Previous Saved Document" /></td>
<td>Revert to Previous Saved Document</td>
<td>Clear data from the document, from the point of the previous save. If the assessment was not previously saved, all charting fields will be cleared</td>
</tr>
<tr>
<td><img src="image" alt="Save Document" /></td>
<td>Save Document</td>
<td>Saves the document</td>
</tr>
</tbody>
</table>
MEDICATION ADMINISTRATION

PYXIS

In order to use the hospital Pyxis system for medication administration you will need to complete a PYXIS form received from Educational Services. Once this is completed, your instructor will assist you on the unit to enter yourself in the Pyxis system.

Pyxis access:

- As new user, use your Pyxis username (usually ‘stu-first, middle, last initial’) and enter “newuse” as the password.
- The next screen will ask if you want to register your bio-ID. Press YES
- Then create a new password (at least 5 characters). You will enter it twice. Please use something different than you used for the computer.
- Next it will ask you to create a bio ID – scan your fingerprint 4 times.
- Follow the prompts until finished.

Each student is responsible to read and be familiar with the Medication policies (in computer under Intranet).

REMEMBER IF IN DOUBT, DON’T!

Never give a medication you are not familiar with. Use the “5 rights” as a guide.
Basic MAK Workflow

1. Access MAK from Links in Soarian Clinicals.
Students will enter their username without the “stu-“ prefix in badge scan box and re-enter the same information in verify badge scan. Student will then select “Save“.  **Hitting “enter” on keyboard instead of “save” will kick you out of system.**

2. Select the function from the MAK navigator. Scan the bar code on the **patient ID bracelet**.

If pharmacy has entered any new orders, the MAK system will default to the **Med Summary** screen. On the **Med Summary** screen, the nurse will **verify** the order placed in the system by the physician by comparing the order on the screen against the physician’s order as written.

![Physician Order for ZZZZSCHANKTEST, ZAK Order #: 372](image)

3. If there is a problem or issue with the order, the nurse may open an **Intervention** which will be sent to the pharmacy for follow-up.

4. If there are no drug orders waiting to be verified, the system will default to the **Active Worklist.** The **Active Worklist** will display the scheduled medications that
are due within the window and display all PRN medications that may be given. Select the item to be given by placing the cursor on the line item and pressing the left mouse button.

5. After highlighting the order, scan the bar code on the drug or item. If the item scanned is the correct medication for that order, a green check mark will appear and the item will be highlighted in green. If the item scanned is the incorrect item, a red “x” will appear and the item will be highlighted in red.

6. The system will drop to the next item on the list, or the nurse can select another item to scan. Step 5 would then be repeated.

7. When the patient had taken or all medications have been administered, the nurse will press Continue and then the Chart button on the screen.

8. Once you chart the medications and answer any appropriate questions, medications will be moved from the Active Worklist to the Charted Worklist.

Scheduling:

- Unless written instructions given on MAR, medications may be given an hour before or after the scheduled time.

- Meal Specific: meds must be given within 15 minutes of the indicated time on the MAR.

- Diet Specific: only foods from Food Service can be given to patient unless dietitian approves.

**ACCU-CHEK**

The Accu-chek Inform meter is what we use to check a patient’s blood glucose. You will need to be trained on the use of this equipment and assigned a user ID number. This number will be assigned by Educational Services. Remember your number. It will be used throughout all your clinical rotations at this facility. Training on the Accu-Chek meter will need to be done yearly.

**ACCU-CHEK ID NUMBER: ________________________________**
<table>
<thead>
<tr>
<th>Level</th>
<th>Nursing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Level</td>
<td>Emergency Department (Elevator K)</td>
</tr>
<tr>
<td>1st Floor</td>
<td>Surgery Department</td>
</tr>
<tr>
<td></td>
<td>Endoscopy Services</td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
</tr>
<tr>
<td>2nd Floor</td>
<td>ICU (Elevator F)</td>
</tr>
<tr>
<td></td>
<td>Orthopedics (Elevator F - go right)</td>
</tr>
<tr>
<td></td>
<td>OB / Nursery (Elevator C)</td>
</tr>
<tr>
<td>3rd Floor</td>
<td>Medical Telemetry (Elevator C)</td>
</tr>
<tr>
<td></td>
<td>Surgical Progressive Care Unit (SPCU)</td>
</tr>
<tr>
<td></td>
<td>Oncology (Elevator D)</td>
</tr>
<tr>
<td></td>
<td>CTU (Elevator K or Elevator F - go left)</td>
</tr>
<tr>
<td>4th Floor</td>
<td>Inpatient Rehabilitation Facility (Elevator C)</td>
</tr>
<tr>
<td></td>
<td>Neurology (Elevator D)</td>
</tr>
<tr>
<td></td>
<td>Cardiac Progressive Care Unit (Elevator F)</td>
</tr>
<tr>
<td>5th Floor</td>
<td>Short Stay Obs. Unit (Elevator D)</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Unit (Elevator D)</td>
</tr>
<tr>
<td></td>
<td>5H Surgical (Elevator F)</td>
</tr>
<tr>
<td>Off Site</td>
<td>Hospice</td>
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<tr>
<td></td>
<td>Home Health</td>
</tr>
</tbody>
</table>
1st
FLOOR
Emergy Department

Welcome to Southeast Hospital’s Emergency Services. We are delighted to have you and want to make ourselves available to answer your questions and help you find your way around. If at any time you have questions, feel free to ask any nurse or charge nurse.

We are a 25 bed Emergency Department. On the average, we see and treat about 38,000 patients per year, handling patients of all ages, from the newborn to the centenarian, and all services from pediatrics to trauma. We are a designated chest pain and stroke center.

We approach each patient care as a team effort, with the physician as team leader, and a registered nurse, unit tech and secretary making up the team. It takes all members doing their jobs conscientiously to provide the highest quality of patient care to our clients.

More detailed information follows to help you become oriented as quickly as possible to the Emergency Department’s procedures and policies. We hope this material and our staff’s assistance will make your time in Emergency both a positive and valuable learning experience.

Nurse Manager: Lori Merritt, MSN, RN, CFRN
Emergency Services 651-5555
Orientation to the Emergency Department

Team Organization
1. The Emergency Team is composed of physicians, registered nurses, emergency technician, and clerical staff at all times.
2. The nurse manager is responsible for all personnel other than physicians, though continuous collaboration between physicians and nursing staff is essential to the operation of the Emergency Department.
3. Because of the multi-faceted patient problems requiring emergency care, educational background and experience are vital aspects in choosing personnel for the department. In general, most nurses have 1-2 years experience before coming to this area, and may have prior critical care experience. All physicians and nurses are trained in the early stages of their employment in advanced cardiac life support and trauma care. Continuous upgrading of knowledge is required. Many of the technicians are either Paramedic or EMT field trained; others are student nurses or CNAs.

Admissions
1. A daily call roster is maintained in the Emergency Department for all medical/surgical services as well as O.R. teams and social services.
2. Should a patient need to be admitted to the hospital, the emergency physician will consult with a hospitalist, the patient’s private physician and/or a specialist who will admit to the hospital. The emergency physician may not admit patients to the hospital, nor is he allowed to treat patients after admission except for a Code Blue (cardiac/respiratory arrest).
3. When a patient is admitted to the floor or specialty unit, the emergency nurse faxes a complete report of treatment and procedures done in the Emergency Department to the receiving nurse, followed by a phone call for any needed clarification.

Duties of Nursing Personnel
Examples of the duties of staff members are listed below:

<table>
<thead>
<tr>
<th>Registered Nurse</th>
<th>Unit Technician</th>
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<tbody>
<tr>
<td>Team Leader</td>
<td>Defibrillation</td>
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<td>Patient Assessments</td>
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<td>NG Insertion</td>
<td>Physician Liaison</td>
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<td>Wound Care</td>
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<tr>
<td>Dressings</td>
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<tr>
<td>Monitor Interpretation</td>
<td></td>
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<tr>
<td>Catheterizations</td>
<td></td>
</tr>
</tbody>
</table>
Patient Flow

1. Patients are seen and treated according to the severity of their problems. A triage nurse is responsible for the sorting of patients to ensure compliance with this standard of practice.

2. A patient chart is generated at the time of registration. The majority of our documentation is done in the EMR.

3. Dependent upon room availability, patient presentation, and severity of illness or injury, the patient is either placed in a triage office or taken directly to an ER treatment room for the triage assessment.

4. The triage assessment includes subjective and objective data which aids in determining an ESI level (patient acuity).

5. Once the patient is placed in a treatment room, an RN and The physician complete a physical assessment/exam. The physician makes a diagnostic judgment and orders the required procedures, lab, x-rays, and medication.

6. The RN is responsible for carrying out procedures, treatments, and medication. RNs may perform these measures themselves or direct the other team members.

7. When the patient is ready for dismissal, the RN is responsible for instructing the patient in care and follow-up.

Standards of Care

1. Our aim is to provide the highest quality patient care attainable; without regard to race, creed, color or economic status.

2. Nationally, Standards of Care have been established by the organization governing care in Emergency Departments: Emergency Nurses Association, Joint Commission; and locally by Missouri Bureau of Emergency Medical Services. We operate under Nursing Standards of Practice and policies which are on file in the department. Feel free to browse through these.

3. These policies and standards ensure that patients receive the level of care expected, comparable to a hospital of similar size and capabilities. They also ensure we meet the expectations of the police, coroners, department of health and other community facilities. But most of all, they give us guidelines by which we practice our professions, providing care, compassion and expertise to the community.
Perioperative Department

On behalf of the Perioperative Department, welcome to Southeast HEALTH. You have embarked on a new and exciting journey in surgery, and we hope that you find the experience rewarding, and fulfilling, as well as an enjoyable and true learning experience. We hope that there are many things that you will see and that it will be a “fun” experience for you.

Changes in basic nursing education during the past twenty years have affected all areas of nursing practice, but have had a major impact on the specialty area of perioperative nursing. Confronted with the dilemma of compacting a continually growing body of nursing knowledge into a static time frame, curricula in nursing no longer offers extensive or, in many instances, any experience in perioperative nursing.

We are pleased that you are taking this opportunity to broaden your horizons and experience a new type of nursing care and that you will be exposed to the roles and responsibilities of professional perioperative nurses. During this experience, you will see and begin to appreciate and understand:

A. Principles and practices of surgical asepsis  
B. Normal body and organ function  
C. Surgical treatment of a disease  
D. Patient response to surgery  
E. Legal implications of informed consent  
F. Surgical risk factors and complications

The Perioperative staff will be happy to assist you in any way possible. Please feel free to ask questions – there are no such things as dumb questions – questions are a sign of intelligence and that you want to learn. Please contact me, Susan Bond, if you have any questions or concerns during your rotation in our department.

Again, we welcome you and hope that this experience will be interesting and rewarding for you!

Sincerely,

Faith True, BSN, RN,CIC,CGRN,CNA,CHL,BC  
Director of Perioperative Services

Janice Quade, BSN, RN, CNOR  
O.R. Nurse Manager

Nancy Voelker, BSN, RN  
PeriAnesthesia Nurse Manager

Susan Bond, BSN, RN, CNOR  
Perioperative Educator/Coordinator
Guidelines for O.R. Observation

On the day you are scheduled to observe surgeries at Southeast Health, please follow the instructions below:

1. Come to the Pre-Surgery Testing Waiting Room. Arrive at 0800 am on the day of your observation. This area is located on the first floor of the hospital. Directions are as follows:

   Lobby>>>>>Hallway to the Left (towards Surgical Waiting)>>>>>Chapel>>>>>Surgical Waiting Room (on the left)>>>>>Surgical Waiting Room (on the left)>>>>>Surgical Waiting Room (on the left)>>>>>Surgery Check In (on the right)>>>>>Pre-Surgery Testing Area (destination).

   Please wait in the hallway to the right of the Pre-Surgery Testing Area. I will then greet you and escort you to the O.R. Classroom. My office is located inside the O.R. Classroom.

2. Please wear your student ID badge the day of your observation.

3. Students will change into scrubs and place their belongings in the lockers provided. Please do not bring valuables with you. Place your keys/money in your scrub pockets. Absolutely NO CELL PHONES. Once dressed, assignments will be arranged and you will begin your shadowing experience.

4. You may not bring a jacket to wear in the O.R. nor will long sleeves be allowed under your scrubs. A T-shirt can be worn as long as none of the clothing is exposed.

5. You must “foam in” upon entering a room or a department. You must “foam out” upon leaving a room or a department, or in between any patient contact. This is a MANDATORY hand washing practice for all O.R. staff and should be followed accordingly.

6. Mask and eye protection will be required while observing. These personal protective devices will be supplied during your observation and must be worn in all O.R. suites.

7. Please remind staff of your need to have a lunch/bathroom break. Generally, the staff member you are assigned with will give you instructions concerning this issue.

8. Please BE SURE TO EAT BREAKFAST the day you come to surgery. This can make a big difference in your experience.

9. During observation, if you feel “hot, nauseated, see spots, or feel weak” please either have a seat on the floor or notify the nurse in the room IMMEDIATELY!!! Do not leave the room unescorted.

10. When you have completed your observation experience, please go back to the classroom. Put scrub clothes into the blue bag hamper. All paper products should be thrown away. You MAY NOT take scrub clothes home with you.

11. Your observation day in the O.R will be arranged by your nursing instructor.

12. Enjoy your day!!! I hope it is a fulfilling learning experience. If you have any questions please contact me at 573-651-5576 or 573-331-6971. If unsuccessful, you can call the Main Surgery Office at 573-651-5562.

Susan E. Bond, BSN, RN, CNOR
Perioperative Education Coordinator
COURTESIES AND REGULATIONS OF SURGERY

1. In the O.R. do not touch or get closer than 12” to the sterile field. If in doubt as to what is sterile – ASK the circulating RN or the ORT. Report ANY contamination at once so that it can be remedied quickly. The RN will position you to watch as soon as the case begins.

2. If you feel “faint”, “dizzy”, “see spots”, “weak”, or anything whatsoever out of the ordinary, DO NOT try to leave the room unescorted. Instead, get the attention of the RN or Anes, in the room, or if they are busy, then sit on the floor with your head between your legs for a few minutes. If you should leave the room alone and faint, you will hit the floor. Our floors are very hard!! Do NOT be embarrassed by sitting on the floor. We have surgeons who have had to do the same!

3. Make certain you wear show covers and head covers – push all hair well up inside the head cover. Men with beards must wear hoods; ask about them if you can’t locate them in the doctors’ locker room. No heavy makeup or perfumes are allowed and NO dangling earrings or bracelets. Jewelry is not necessary in the OR. You may wear a watch and wedding/engagement rings.

4. Masks are worn in the OR rooms and removed as you leave the room. If you stay to watch another case, you will need to wear a clean mask which can be found above the scrub sinks. Wear the mask with a shield. For those of who wear glasses, please wear the mask with a shield as well.

5. Keep conversation limited in the O.R. Some surgeons enjoy teaching more than others. Try to take your clue from the circulators as to whether you should ask questions or not.

6. Don’t lock your knees! Always keep one leg bent slightly – helps you to relax and it is easier on your back when standing for long periods of time.

7. Be relaxed. Breathe!!! Enjoy. Learn a lot! Smile!
Welcome to Southeast Hospital’s Digestive Health Center. It is a specialized procedural area specifically designed for the diagnosis and treatment of gastrointestinal disease processes, and assisting respiratory therapy with bronchoscopy. The Center consists of five procedure rooms and five pre-op/recovery rooms, treating both inpatients and outpatients.

The staff of the Digestive Health Center has numerous responsibilities throughout all phases of a patient’s visit. In addition to assisting physicians during procedures, the staff must assess, teach, pre-op and recover patients.

A variety of procedures are performed in this unit by the Gastroenterologists and the specially trained GI Nurses:

**Upper Endoscopy (Gastroscopy)** - visual exam of the esophagus, stomach and upper section of the small intestines.

**Lower Endoscopy (Colonscopy)** – visual exam of the entire colon from the rectum to the cecum.

**Flexible Sigmoidoscopy** – visual exam of the rectum and sigmoid colon.

**Endoscopic Hemostasis** of any type: sclerosis or banding of varices, heater probe, electrosurgical cautery, and argon plasma coagulation.

**Esophageal Dilatation** – enlarging strictures or narrowed areas in the esophagus to allow for easier passage of food and liquid.

**Esophageal Manometry** – measuring muscle stimulus and activity in the esophagus.

**Ambulatory 24 Hour pH studies** – measuring the acid levels in the esophagus through a complete Circadian cycle.

**Endoscopic Retrograde Cholangiopancreatography (ERCP)** – injection of radiopaque dye in the biliary tree to check for abnormalities.

**Sphincterotomy and Biliary Tract Stone Removal** – enlarging the opening of the ampulla by way of an endoscopic incision and removing retained stones.

**Stenting of strictures in any gastrointestinal lumen** – esophageal, colon or biliary systems.

**Percutaneous Endoscopic Gastrostomy Jejunostomy Tube Insertion** – placement of a gastrostomy/jejunostomy tube through the abdominal wall endoscopically.
**Retrieval of foreign bodies** – removal of any object swallowed which will not pass through the GI tract

**Ablation of Tissue in the Gastrointestinal Tract** – using argon plasma coagulation to destroy tissue

**Bronchoscopy** – visual exam of the bronchi of the lungs

**Thoracentesis** – surgical puncture of the chest wall for removal of fluids.

Patient age varies from the adolescent to the elderly, and each receives care based on his or her specific needs. Because of analgesic and sedative medications given during procedures, each patient is monitored before, during and after the procedure. Blood pressure, pulse, respiration, oxygen saturation and cardiac rhythm are monitored at specific intervals to ensure that the patient’s status is not compromised.

Endoscopy requires acute visual perception combined with manual dexterity and special technical abilities. Due to progressive technological advancements, Gastroenterology is a rapidly evolving and expanding field. The endoscopes themselves have evolved from the fiberoptic lens to the video camera chip lens, which magnifies and projects the area being viewed onto a large television monitor for the entire endoscopy team to see. The Digestive Health Center is committed to providing all patients with optimal treatment and professional care in an environment of ever changing economy and technology.

Please feel free to ask any questions you may have. We have a variety of textbooks and manuals in the Digestive Health Center if more in-depth information about procedures of gastroenterology is needed.

Nurse Manager: Jennifer Deschenes, RN, CST
Digestive Health Center: X5801
Welcome to Pediatrics and the Pediatric Special Care Unit. We are delighted to have you with us and will be happy to assist you in any way that we can. The following are some guidelines to help answer some questions you may have regarding our standard routines. Please feel free to ask questions of my staff or me at any time.

Pediatrics is an 8-bed unit working with children ages 24 hours to 16 years. We see a wide range of admissions including surgical, medical and psychiatric patients. We are parent-oriented with our care and encourage parents and family members to help in taking care of their child.

Two of the eight beds can be used for The Pediatric Special Care Unit to work with more critically ill children. We work on a nurse/patient ratio of 1:2 based on the severity of the child’s condition. All patients are on cardiac monitors. Parents are not restricted from their child while in the PSCU and are allowed to stay with them continually, pending procedures.

I hope that your experience on Pediatrics/PSCU will be a pleasant one. Once again, don’t hesitate to ask for assistant.

Nurse Manager: Sheila Beussink. MSN,RN,NE-BC
(573)651-5553
1. **Have FUN.** Play with the kids. Make the hospital stay as non-traumatic as possible for kids. Do not leave kids unattended, go to playroom with them. If a child is febrile, keep the child in his/her room. May take them toys and books.

2. **Vital Signs:**
   - Routine times are 12-6-12-6. If ordered every 3 hours, they are 12-3-6-9-12-3-6-9.
   - Chart vital signs on temperature book. Book is located at Nurse’s Station.
   - Blood pressure will only be for specific patient; this is located on the worksheet.
   - Use appropriate size blood pressure cuff—will cause blood pressure to vary.

3. **I&O:**
   - **EVERYONE**
   - Diaper or urine check for each time voided.
   - Accurate is with diaper weights.
   - *Diaper weight – weight diapers dry and write this number on the diaper, weight diaper wet then subtract the two.*
   - NA will collect the I & O sheets, place new ones at bed, and chart I & O.

4. **Stool and Emesis Chart:**
   - Used for patient admitted with gastroenteritis.
   - BM’s – chart color, consistency, odor, amount, time.
   - Diaper wipes to clean BM’s - not washcloths.
   - Stool culture.

5. **Urine Specimens:**
   - Collect as if obtaining a clean voided specimen. May see the use of a U-bag or an adult clean-catch container.

6. **Daily Weights:**
   - Weights are done in kilograms.
   - All babies under 6 months are weighed in the nude.
   - Weights are usually done on night shift.

7. **Formulas and Fluids:**
   - Different size bottles and difference type of formulas.
   - Under 3 months of age use sterile water to mix formula.
   - Infants are to be positioned on their backs after a feeding.
   - NEVER prop a bottle.

8. **Surgery Beds:**
   - Make bed with a flat sheet, two cloth underpads at the head of the bed.
   - IV pole at the bedside (located in the hall closet).
   - Place washcloth and emesis basin on the bedside table.

9. **Laundry:**
   - Place all linen in the covered square hamper. Change laundry bags when half full.

10. **Medications:**
    - Be ACCURATE – everything is calculated to weight.
    - IM injections – never more than 1 cc per thigh – 23 gauge 1 inch needle.
11. **Infusion Pumps:**
   Every patient on Pediatrics with an IV infusing will have an infusion pump.
   Check IV every hour. Use running total on infusion pump.
   Cassettes changed every 72 hours, piggybacks every 24 hours.
   NEVER purge the infusion pump when attached to the patient.
   NEVER turn the infusion pump OFF – if you can't fix it, get the nurse or your instructor
2nd
FLOOR
Welcome to the ICU where we have 14 intensive care beds. We also have four beds specified for acute renal dialysis. In these units, we are capable of caring for virtually any type of patient except small children and infants.

You are being provided with general nursing guidelines for care to help your time with us be a pleasant educational experience. Should you have any additional questions, please do not hesitate to ask your preceptor or the Charge Nurse on duty.

The ICU Charge Nurses and Nurse Manager welcome any suggestions you may have for making this a more pleasant experience for the student nurse.

Cathy McClard, BSN, RN, TNS, CCRN, NE-BC
Nurse Manager
(573)651-5563
ICU Guidelines for Care

1. Charge Nurses: One designated for each shift. Please keep this nurse informed of any changes, problems or questions.

2. Assessment:
   - Initial: Within 2 hours of start of shift
   - Follow-up: Every 4 hours

3. Vital Signs:
   - On admission: q 15” x 4, q 30” x 4, q 1° x 4, then q 2° on even hours.
   - Vasoactive infusions: q 15” when titrating, if not titrated or 2 hours and patient stable. It is the nurse’s responsibility to chart vital signs on ICU flowsheet and in the graphic

4. Intake and Output:
   - Foley: hourly urine output, use urine meter bag
     Empty foley and drainage bags at 0500 – 1300 – 2100
   - IV’s: clear infusion pumps at 0500, 1300, and 2100 and IV LTC’s
     It is the nurse’s responsibility to chart all I & Os in hospital graphic and total 24 hour I & Os

5. Diet: Chart type of diet and % eaten on graphic

6. Weights: Daily weights required on all patients. This is to be done in early AM.

7. Care Plans: Review and revise daily.

8. Activity Levels: All patients are on bed rest unless otherwise ordered.

9. Standing Orders: May start 02 prn
   - May start IV prn
   - May obtain ABG’s or pulse ox. Ask Charge Nurse as needed for assistance before doing

10. Notification of Charge Nurse:
    a. Unexpected changes in condition
    b. Inability to start IV
    c. Before calling any doctor in late evening or night hours
    d. Problems with families or visitors
Welcome to 2-East Orthopedics at Southeast Hospital. We will be happy to assist you in any way to make your time on this unit productive and informative. Feel free to ask any further questions at any time.

Orthopedics is an 8-bed unit which cares for pre/post-operative orthopedic patients and total Joint replacement patients. Our patient/nurse ratio is 5 patients to 1 nurse and 6:1 on the night shift with nursing care provided through a team approach including: nurse assistants, Unit techicians physical therapists, and respiratory therapists together with the RN.

Again, welcome and do not hesitate to let one of us know if we can help.

Cindy Raganyi, BSN, RN
Nurse Manager
(573)651-5822
Orthopedics

The orthopedic unit is an 8-bed unit. The telephone number to our nurses’ station is Ext. 5822.

The primary patient population is the adult requiring orthopedic interventions – surgical or non-surgical. Persons electing to have joint replacements are also patients on our unit. The most common joint replacements are the Total Hip Replacement and the Total Knee Replacement.

The Orthopaedic Associates of Southeast Missouri are the primary physicians caring for the patients on our unit. Medical/Surgical overflow patients are also admitted to our unit under the care of other specialists of the Southeast medical staff. Southeast Missouri Hospital also employs physicians referred to as Hospitalists who admit patients throughout the hospital and also do consultations on many of the patients.

The Orthopedic Unit staff consists of registered nurses and nurse assistants. The staff works together as a team to provide optimal patient care. The staffing is determined by the acuity of the patients as well as the census.

There are many terms that you will read and use on Orthopedics. The following is a list of common terms and abbreviations:

**Toe Touch Weight Bearing (TTWB):** Allowing the weight of the affected extremity to rest on the floor. No weight should be transferred through the lower extremity during walking.  
**Partial Weight Bearing (PWB):** Allowing partial weight to be transferred through the affected lower extremity with the balance of the weight carried by the hands on the walker or crutches. Partial weight is usually allowed to tolerance.  
**Full Weight Bearing to Tolerance (FWB) or Weight Bearing as Tolerated (WBAT):** Allowing as much weight as the patient can tolerate up to full weight, to be borne on the affected extremity. A walker or crutches may be used to assist the patient in bearing the balance of the weight.  
**Non-Weight Bearing (NWB):** No weight being borne through the affected lower extremity.

**Miscellaneous Assessment Information:**
- Circulatory checks every two hours (x) 12 hr, then every 4 hrs
- Vital signs every 4 hrs
- Notify charge nurse if UO < 30cc/hr post-op
- I&O every 8 hrs
- Overhead trapeze on orthopedic patient beds
- Pain Documentation with assessment and prn Q 4 hrs
- Q Shift skin documentation on every lower extremity fracture

**Abbreviations:**
- AAROM: Active Assistive Range of Motion  
- AC: Acromioclavicular  
- AK: Above Knee  
- AKA: Above Knee Amputation  
- Amb.: Ambulatory  
- BK: Below Knee  
- BKA: Below Knee Amputation  
- BSC: Bedside Commode  
- CPM: Continuous Passive Motion  
- EPI: Epidural  
- Fx: Fracture  
- LE: Lower Extremity  
- ORIF: Open Reduction Internal Fixation  
- PROM: Passive Range of Motion  
- PT: Physical Therapy  
- ROM: Range of Motion  
- SLR: Straight Leg Raises  
- THR: Total Hip Replacement  
- TKR: Total Knee Replacement
During your rotation on Postpartum, many learning experiences will be available which may include:

1) IV Therapy
2) Pre and post-operative cesarean, tubal ligation and D&C care
3) Post vaginal delivery care
4) Daily assessments
5) Mother/Baby care
6) Care of patient with pre-eclampsia, diabetes, hypertension, pregnancy induced hypertension, and hyperemesis
7) SHARE, bereavement support

While spending time in the Labor and Delivery area you may have the opportunity to observe the following:

1) Vaginal delivery
2) Cesarean delivery
3) Tubal ligation
4) Dilatation/Curettage
5) Care of the laboring patient
6) Care of the recovery room patient

Some technical experiences in which you may participate in both areas include:

1) Surgical preps/vaginal preps
2) Enemas
3) Catheterization
4) Dressing changes
5) Fetal monitoring
6) IV therapy
7) Epidural placement

We hope to make this time in your student career as informative as possible as well as enjoyable. If at any time you have any questions or ideas, please don’t hesitate to ask. We look forward to your participating with our staff in a team effort on behalf of our patients.

Britton May, MSN, RNC-OB
Obstetrics Nurse Manager
(573)651-5560
NURSERY AND NICU

1. The well-baby nursery provides routine newborn care.
2. The NICU is a Level III nursery for those sick and/or early babies requiring more intensive care than can be provided in the routine well-baby setting.
3. All personnel in the well-baby and NICU must do a 3-minute scrub before beginning care of any newborn. Proper hand hygiene is required after touching each newborn.
4. Daily weights are done on the 11-7 shift. Vital signs are done each shift.
5. We use a rooming-in concept for the majority of our couplets. Baby stays with mom as much as possible. We bring the baby to the nursery for assessments and procedures unless the mother requests otherwise. Baby’s remain in the mom’s room throughout the night unless she requests otherwise.
6. When taking the baby to the mother’s room, ID bracelets must be matched EVERYTIME.
7. The father or support person will also wear a bracelet with the same number as mom and baby.
8. Teaching mothers about mom and baby care is vital. Much of our focus is on teaching and ensuring material is understood by all those in direct care or support of mom and baby.
9. A lactation nurse will make rounds on all moms regardless of their feeding preference. Listening to their teaching can provide valuable insight into infant nutritional needs.
10. Most parents want to tell the world about their new baby. However, staff members and students must remember all information about our patients is confidential including the birth, sex of newborn and previous history or current information.
11. Infant safety is of utmost importance. Therefore, we have three forms of safety. Students go with a staff member wearing the second form of ID. Identify yourself to the mother. Also instruct the mother never to leave the baby unattended in her room even for a short time. The security transponder is our third form.
12. The NICU is an intensive care area, therefore we restrict traffic in and out related to infection and in order to decrease noise and stimulation for these sensitive patients.
13. During your time in the NICU you may be asked to perform routine newborn care, but more intensive procedures will be left to the NICU nurses while you observe and assist if needed.
14. Remember to ask questions if unclear about something. We hope your experience here is an enjoyable one. Please feel free to share your questions, concerns and ideas with us.

Britton May, MSN, RNC-OB  Sheila Beussink MSN, RNC
Obstetrics Nurse Manager  Director of Maternal Child Services
(573)651-5560  (573)651-5560
3rd
FLOOR
Welcome to the Medical Telemetry Unit. We are delighted to have students and will be happy to assist you in any way possible. The following guidelines will help answer questions you may have regarding the unit. Feel free to approach us with any further questions you may have.

The Medical Telemetry Unit is a 31-bed unit consisting of both private and semi-private rooms. We care for patients with a variety of general medical diagnoses. Some patients admitted to the Medical Telemetry Unit will receive cardiac monitor. Nursing care is provided through a team nursing process. Our patient/nurse ratio is 5:1 on dayshift and 6:1 on nightshift. Nursing assistants assist with the care of our patients.

We hope you enjoy your experience with us.

Nurse Manager: Debbie Hoffman, BSN, RN, TNS, CCRN
(573)651-5571
MEDICAL TELEMETRY UNIT POLICIES

All patients are cardiac monitored unless otherwise ordered. A telemetry pack is placed on the patient on admission and an admission strip is interpreted by the admitted nurse. The monitor tech then runs a telemetry strip for each patient at least every 8 hours and these strips are provided to the nurses for interpretation. Telemetry strips are filed in the patient’s chart with an interpretation notation.

The Medical Telemetry Unit cares for a high volume of infectious patients. We strictly follow hospital policies with regard to patient placement and infection control. All equipment is routinely cleaned weekly. Special stethoscopes and blood pressure cuffs have been designated for patients with resistant infections. This equipment is sent to central service for cleaning between patients. Items such as gait belts, walkers, gerichairs, bedside commodes, etc., are cleaned between patients.

The Medical Telemetry Unit follows the hospital standard for adult patient.

Vital Signs: assessed and documented every 4 hours and PRN.

Physical Assessment: An initial assessment is completed once per shift. Every 2 hours check on your patient. Document any significant information.

Intake and Output: every 8 hours and prn.

Activity: per physician’s order

IV Safety: Intravenous fluids are administered via infusion pumps.

Pain Management: Pain is assessed and documented using a pain scale every 4 hours and PRN. Pain is reassessed within 1 hour of administration of pain medication.
Welcome to Surgical Progressive Care / Oncology. We will be happy to assist you in any way to make your time on this unit productive and informative. The following guidelines will help answer questions you may have regarding the unit, however feel free to ask any further questions that you may have.

Surgical Progressive Care Unit / Oncology is a 20-bed unit which accepts any pre/post-operative patient who requires cardiac monitoring, administration of IV anti-arrhythmic drugs and/or increased observation. This unit also cares for Oncology patients. Our patient/nurse ratio is 4-5:1 with nursing care provided through a modified team nursing process.

We hope you enjoy your experience with us.

Nurse Manager: Valorie Rhodes, RN
(573)651-5841
POLICIES AND PROCEDURES
SURGICAL PROGRESSIVE CARE UNIT / ONCOLOGY

This is a 20-bed unit. The SPCU side specializes in the care of the adult pre- and post-operative patient requiring cardiac monitoring, ventilator support, administration of anti-arrhythmic drugs, renal dose dopamine and/or increased observation. Dobutrex, platelet inhibitors, Primacor, brevibloc and NTG is accepted on this floor and cases will be considered by the attending nurse and physician based on patient condition and severity. Post-operative open heart, vascular and thoracic surgeries as well as complicated surgical cases comprise the most frequent diagnosis in this area. When the medical progressive care unit is full, we do receive medical patients with the following diagnoses: angina, coronary artery disease, COPD, CHF and dysrhythmia.

Nursing staff on this unit consists of a nurse manager, staff registered nurses, staff licensed practical nurses, nurse assistants and monitor technicians. Requirements of the staff are as follows.

Registered Nurses
Current state licensure
- BCLS Certification
- Basic Arrhythmia
  - After 1 year of employment
- Advanced Arrhythmia

Licensed Practical Nurses
- Current state licensure
- BCLS certified
- Basic Arrhythmia
- IV Certified

Nurse Assistant
- BCLS Certified

Monitor Technician
- Basic Arrhythmia

Therapies Include:
Medication Administration (including IV platelet inhibitors, antiarrhythmic drugs, renal dose dopamine and nontitrating vasoactive drugs as mentioned)
Telemetry Monitoring
Respiratory Support Services (chronic ventilator patients or “no code blue” patients)
IV Therapy
Physical/Occupational/Speech Therapy

Patient Care Includes:
Patient/Family Education
Infection Control
Patient Safety
Standards of Care
Nursing Process
Discharge Planning
Assignments are made by the nurse manager or the charge nurse. Assignments are made according to the acuity level of the patient and the abilities of the caregivers available. Assignments are to follow practices outlined in the Nursing Policies and Procedures. The RN making these assignments will be familiar with these policies and procedures and will review them as necessary to keep his/her information current.

The Oncology Patients have some specific needs:

1. Those patients receiving internal radiation (implants) or those who ingest radioactive are placed on radiation precautions. Time spent with those patients should be kept to a minimum. These patients will be in a private room. Students and float staff will not go into those rooms. Oncology employees will have radiation badges that measure the amount of radiation received from these patients.

2. Those patients who are on “Neutropenic Precautions” or “Good Handwashing Isolation” should have a limited number of visitors to avoid exposure to possible pathogens. If you have a cold or any other contagious condition you should not deliver care to these patients. These patients will be in private rooms. There should be no cut flowers, potted plants or fresh fruit brought into these rooms. When transporting these patients to other departments, a mask should be given to the patient. Float staff will not be assigned to care for these patients.

3. Those patients on “Platelet Precautions” should not receive IM injections or suppositories. Hold pressure on all venous sticks for 5 minutes or longer if necessary. A private room is not required. A sign stating patient is on “Platelet Precautions” should be hung over the patient’s bed.

4. If a patient has a temperature spike, the nurse who has that patient or the charge nurse should be notified. There is the possibility that blood cultures need to be ordered for the patient. Administer antipyretics after blood cultures are obtained. Recheck temperature after 30 minutes of administration of the antipyretic.
Welcome to the CardioThoracic Unit. We are extremely pleased that you have shown an interest in our unit. The following information may answer questions regarding CTU; however, you should feel free to direct any additional questions to the staff.

We are a 12-bed critical care unit which focuses on thoracic or vascular surgery. We do primary care with a patient to staff ratio of 1:1 or 2:1 utilizing 12-hour shifts. You will be exposed to different types of procedures and equipment for example ventilators, monitors, infusion pumps, and cardiac assist devices. Do not be frightened by the number of alarms; they have different meanings and do not always indicate emergency situations.

Cathy McClard, BSN, RN, TNS, CCRN, NE-BC
Nurse Manager
(573)651-5842
Guidelines for Care

11. Charge Nurses: One designated for each shift. Please keep this nurse informed of any changes, problems or questions.

12. Assessment:
   - Initial: Within 2 hours of start of shift
   - Follow-up: Every 4 hours

13. Vital Signs:
   - On admission: q 15" x 4, q 30" x 4, q 1° x 4, then q 2° on even hours.
   - Vasoactive infusions: q 15" when titrating, if not titrated or 2 hours and patient stable. It is the nurse’s responsibility to chart vital signs on ICU flowsheet and in the graphic

14. Intake and Output:
   - Foley: hourly urine output, use urine meter bag
     - Empty foley and drainage bags at 0500 – 1300 – 2100
   - IV’s: clear infusion pumps at 0500, 1300, and 2100 and IV LTC’s
     - It is the nurse’s responsibility to chart all I & Os in hospital graphic and total 24 hour I & Os

15. Diet: Chart type of diet and % eaten on graphic

16. Weights: Daily weights required on all patients. This is to be done in early AM.

17. Care Plans: Review and revise daily.

18. Activity Levels: All patients are on bedrest unless otherwise ordered.

19. Standing Orders: May start 02 prn
   - May start IV prn
   - May obtain ABG’s or pulse ox. Ask Charge Nurse as needed for assistance before doing

20. Notification of Charge Nurse:
   - e. Unexpected changes in condition
   - f. Inability to start IV
   - g. Before calling any doctor in late evening or night hours
   - h. Problems with families or visitors
4th FLOOR
Inpatient Rehabilitation Facility

Welcome to the Inpatient Rehabilitation Facility (IRF). We welcome you and look forward to assisting you with your clinical experience. Feel free to ask any questions or to ask for assistance from any staff member.

The IRF is a 13-bed unit that has a very wide variety of medical and surgical patients with an ability to rehab home. The unit is now equipped with telemetry so the nursing staff is able to care for all medical conditions with the exception of cardiac drips and ventilator patients. Rehab ready means that the patient will be able to actively participate in 3 hours of therapy daily along with overcoming their illness. The skilled health care professionals on the IRF unit work together as a team in conjunction with the disciplines of therapy department (PT, OT, ST), dietary, pharmacy, social work, respiratory therapy and the medical director to help the patients return as quickly as possible to the highest level of independence.

The IRF has a goal to provide you with a meaningful and worthwhile learning experience, so please feel free to ask for any learning opportunities.

Joy Frey, BSN, RN, CRRN
Nurse Manager
(573)651-5551
Inpatient Rehabilitation Unit – General Information

1. VITAL SIGNS: Assessed and documented every 8 hours and PRN. (0645, 1445, 2245)

2. PHYSICAL ASSESSMENT: Performed and documented by an RN/GN or LPN/GPN on day and evening shift and a mini-assessment completed by night shift. Performed and documented by an RN/GN a minimum of every twenty-four (24) hours and PRN.

3. DOCUMENTATION: Shall consist of an initial assessment and a mini-assessment or closing note each shift. (A shift is twelve (12) hours.) Additional documentation shall reflect patient status changes and care provided. No change in assessment can be documented at the end of the shift. Patient notes are documented as warranted. Staff must document FIM (Functional Impairment Measure) scale rates on patient’s performance of activity.

4. INTAKE AND OUTPUT: Assessed and documented every eight (8) hours and PRN.

5. DIET TYPE AND APPETITE: Assessed and documented three (3) times a day with appetite being recorded in percentages (%). Also document snacks and supplements.

6. FALL PREVENTION: Patients are classified according to the “Fall Prevention” policy.

7. SKIN ASSESSMENT SCALE: Assessed and documented based on Hospital policy.

8. ACTIVITY: Patients are encouraged to participate in the Rehab program. All patients must be up with a staff member only unless it is their “Independence Day” and they will be discharged within 24 hours.

9. WEIGHTS: Weighed on admission and PRN. If the patient has a history of CHF, the patient will be weighed daily at 0600.

10. PAIN ASSESSMENT: Assessed with initial assessment and mini assessment and PRN.

11. TELEMETRY: Must have an order for a patient to be placed on telemetry. If ordered, telemetry strips will be run q12 hours and PRN for any changes noted. Nursing must document at least q12 hours on telemetry.

12. ORAL CARE: Provide BID and PRN.

13. BATHING: Showered/bathed daily and PRN with linens changed Monday, Wednesday, Friday, and PRN.

14. CLOTHING: Dressed in street clothes with shoes on daily.

15. WASHCLOTHS: Provided before and after all meals.

16. DINING ROOM: Encouraged to eat all meals in dining room with staff supervision. If a patient does not eat his or her meals in the dining room, staff is to document in the medical record.

17. PATIENT RIGHTS: Explained and a copy given to the patient and their significant other(s).

18. INTERDISCIPLINARY TEAM: Meets weekly to discuss each patient’s plan of care. Care plans are discussed. IDCP Attendance Record is signed by the disciplines caring for the patient. The social worker updates family/patient regarding the meeting and documents information in computer system.

19. DIETARY CONSULTS: Each resident will receive dietary screening with 48 hours of admission.

20. PRIVACY: Patient’s privacy is to be respected by the staff knocking on the doors and announcing who they are before entering the room.
Welcome to the Neurosciences Unit. We are happy to assist you in this learning opportunity. We hope the time spent on our unit is productive and informative. The following guidelines will help answer questions you may have regarding our unit; however, feel free to contact the Nurse Manager with any further questions.

The Neurosciences Unit is a 19 bed unit. We care for patients who require extensive neurological care. We also have cardiac monitoring and may administer IV anti-arrhythmic drugs. Our patient/nurse ratio is 5:1 with nursing care provided through a modified team nursing process.

Nurse Manager: Martha Senter, BSN, RN
(573)651-5558
Welcome to the Neurosciences Unit. We hope your experience with us is beneficial. The following is a list of guidelines to help you to work in our unit. If you have any questions or need any assistance, please do not hesitate to ask any nurse.

1. Assessments are done at the beginning of the shift and four hours later. You may assess your patient more often if needed.

2. Vital signs are taken routinely every four hours on an 8/12/4 schedule. The NA normally takes P, R, T, BP.

3. Any patient on telemetry will need a representative strip on the chart with interpretation by the end of the shift.

4. Telemetry pads should be dated when placed on chest, and should be changed every 48 hours.

5. Intake and outputs are done on every patient every shift. The sheet is kept in the patient’s room on the closet or bathroom doors. The NA will collect them and enter them in the computer. IVF’s are to be documented by the nurse.

6. Water pitchers are filled by NA at the time they pick up I & O’s.

7. Intake includes: PO intake, tube feedings, IV fluids, blood
   Output includes: Urine – per voiding and per Foley
   JP Drain – Empty every 8 hours
   Colostomy – Empty every shift
   Liquid Stools
   Hemovac – Empty every 8 hours
   NG Drainage – Empty every 8 hours
   Estimated Blood Loss – From Surgery Sheet
   Chest Tubes – Measure and mark on tape on the bottle (time & date)

8. Daily weights are done on Night Shift. Chart weight in the computer.


10. Central line dressing changes are done every 7 days and as needed by the RN.

11. Activity is per physician’s orders.

12. The nurse should accompany the physician when making rounds.

13. Notify the physician of any of the following:
   - change in the level of consciousness or vital signs
   - any significant change in neuro status
   - any change from baseline heart rhythm
Welcome to Cardiac Progressive Care. We are delighted to have students and we will be happy to assist you in any way possible. The following guidelines have been established to help answer questions you may have regarding our unit. However, you should feel free to ask Susan Lewis, Nurse Manager, if there are any further questions.

CPC is a 23-bed unit. We care for patients with health problems which require extensive nursing care, which could include antidysrhythmic drips, Dopamine, Dobutrex, Nitroglycerin, temporary pacemakers or chronic ventilators. We also care for patients having Coronary Angiograms (COA), Percutaneous Transluminal Coronary Angiograms (PTCA), coronary or renal stents, coronary ablation and ICD or pacemaker implantation. All of our patients are cardiac-monitored unless otherwise ordered. Nursing care is provided through a team nursing process. Our patient/nurse ratio is 4.5:1 on day shift and 5:1 on night shift.

Susan Lewis, BSN, RN, NE-BC
Nurse Manager
(573) 331-6582
Policies for CPC

All patients are cardiac-monitored unless otherwise ordered.

All patients are to have I & O recorded every shift.

Vital signs are taken every 4 hours, less patient’s condition warrants more frequently.

Routine medication schedules are followed except on antidysrhythmics which are given around the clock.

Any patient on an antidysrhythmic drip who must leave the floor for diagnostic testing must be monitored and accompanied by a Registered Nurse who has completed orientation.

Standing Orders –
  May start 02 2L prn
  May start IV D5W KVO
  May give NTG sublingual for chest pain if BP is about 90

Guidelines for Administration of Lidocaine and Atropine

Give 1 to 1.5 mg/kg of lidocaine for –
  sustained ventricular tachycardia and patient is symptomatic

Give 0.5 mg of Atropine, may be repeated every 5 minutes up to 2 mg (only 4 doses) for –
  heart rate less than 40 for 1 minute and symptomatic
  heart rate less than 30 for 1 minute

Nurse should always –
  check telemetry strip
  check BP
  administer lidocaine or atropine
  obtain telemetry strip to document need for medication
  notify physician
  if patient does not have an IV – put in a saline lock

Document –
  nurses’ notes
  telemetry strip (write on strip – lidocaine or atropine given)
  write order – per ACLS protocol Dr./nurse
  mark the medication on the MAR
  chart in 10-20 minutes the effect of the drug
Guidelines for Treatment of Chest Pain

If a patient has chest pain –
  check BP
  give 02 at 2 liters per nasal cannula (standing order)
  give NTG (standing order)
  may give NTG 5 minutes apart for a total of 3 if BP remains
  above 90 – always check BP before each NTG!

If chest pain is relieved – do nothing else
  If patient has repeated episodes of chest pain – notify physician

If chest pain is not relieved, give a total of 3 NTG then Morphine or Dilaudid if ordered.
Notify physician.
If further pain medication is not ordered – call physician for order.

All chest pain should be treated as cardiac unless proven otherwise with angiography.

Cardiac pain may be exhibited by pain only in the arm, jaw, neck, or back.

Document –
  detailed description of pain and rating of pain on scale of 1-10
  vital signs
  telemetry rhythm
  medication given
  relief from medication
  administration of 02
  if physician was notified
5th
FLOOR
The Psychiatric Unit

We are pleased to welcome you to the Psychiatric Unit. On our 14-bed locked acute psychiatric unit, we treat such emotional and mental illnesses as depression, anxiety, psychosis and bipolar disorder. The Psychiatric Unit is a voluntary unit as in any other unit in the Hospital. We do not admit involuntary commitment patients.

We are happy to have you gain educational and professional experience with our interdisciplinary team, and the team will assist you in any way possible. The following guidelines have been prepared to help answer questions you may have regarding your unit and alleviate any stress you may have. If you have any questions about our unit or routine, feel free to ask us.

Tonya Wooden, BSN, RN
Nurse Manager
(573)651-5595
This is an introduction to the Psychiatric Unit at Southeast Missouri Hospital. We hope it will assist you in being informed, thus, making you more at ease while you are doing your clinical rotation on our unit. Our objective is for you to get the total picture of how the unit, with its Interdisciplinary Team, works toward providing a safe, caring, and therapeutic environment for all patients.

The Basics:

1. The Psychiatric Unit is a voluntary adult unit, accepting patients who sign themselves in. They must be: agreeable to admission by a psychiatrist on staff, medically stable, 18 years of age or older, and able to participate in the therapies.

2. The Psychiatric unit is a “locked unit” because we frequently care for patients who have threatened suicide, attempted suicide, or otherwise are deemed at risk for suicide; therefore, we are required to provide a safe and secure environment. This is just one of the many regulations we had to meet to maintain licensure. Being a locked unit also minimizes the number of people on the unit and protects the confidentiality of patients.

3. We have fourteen (14) beds – all semi-private accommodations and two (2) seclusion rooms. There are no call lights, telephones, TVs, wall oxygen or suction in these rooms. The electrical systems have been modified to meet safety regulations. If we should have a code, our crash cart is located on our neighboring unit and checked every eight (8) hours to verify its readiness.

4. Team members wear white lab coats over appropriate street clothes/scrubs. Please do not wear jeans, short dresses or skirts. Hems must be at knee-level. We recommend no neckties unless clip-on, no long necklaces or chains, or scarves. Wear comfortable, clean shoes and socks or hose, and appropriate foundation garments. Use reasonable good taste in your attire, remembering many of our patients are here because they feel unable to control their behaviors. Your appearance and “body language” may send a message to restless, agitated patients and have a definite impact on behavior.

5. On arrival to the unit, which is on the 5th floor, east wing, you will approach the double doors and push the button on the wall, or pick up the phone and identify yourself when a team member answers. You will be greeted by a team member and introduced to others. If you have not signed a confidentiality agreement already, you will be asked to do so at this time.

6. A team member will give you a brief tour of the unit and assign specific duties to you. Your clinical instructors will make your patient assignments. Team members will work to make this a learning experience for you and will be happy to answer any questions you might have.

7. Team members wear a hospital identification badge. Students are instructed to cover last names.

8. Students are encouraged to attend groups and observe their patient’s participation when seating is available, and at the discretion of the group facilitator. Feel free to ask the group facilitator questions before and/or after the session. If seats are not available, please do not stand and
Students are encouraged to look beyond the activity and observe the patient’s interactions with others, functioning level, concentration skills and frustration level.

9. All charting is done on the computerized integrated progress notes. If there is an error, you may amend your note entry in the computer. Always spell re-read your notes for accuracy. Please use correct spelling and legible penmanship. Do not take charts away from the nurses’ station without permission of the charge nurse. The doctors and/or other professionals must have access to the charts for documenting their assessments. Remembers, the contents of the patient’s medical record are highly confidential. Do not take notes off the unit and do not discuss patients or events on the psychiatric unit anywhere other than on the unit or in clinical conferences. A breach of confidentiality is a serious offense. You may chart your initial assessment before the staff nurse does. Be alert to when social workers and doctors are “in session” with patients so as not to interrupt that therapy. Any paperwork that has patient information on it must be placed in the PHI receptacle prior to leaving the unit.

10. Introduce yourself to your assigned patient and offer your assistance. Feel confident and reassure him/her that you, your instructor, and Psychiatric unit team members are all available if needed. Interact with a patient as you feel comfortable and the patient is receptive. Encourage the patient to ventilate, allow him/her to choose the direction of the conversation. Be a good listener, avoid giving information about yourself and don’t be authoritative or judgmental. If a patient voices concerns or questions, or demonstrates inappropriate behavior, inform the charge nurse of your observations.

11. In your charting:

a. Be specific in describing the patient’s appearance, behaviors, orientation and interactions.

b. Chart to the interventions in the treatment plan, writing the problem number first, e.g. – Nursing: ITP #1. Patient denies any active suicidal thoughts or plan at this time but says, “I feel safe here. I don’t think I would feel this way if I were at home. You know I looked into my insurance policies to see if they would pay off for suicidal deaths and then I spent a lot of time trying to figure out how I could make it look accidental.” Suicide precautions continue – patient is dressed in green scrub suit, and documentation is completed on flow sheet every 15 minutes. N. Smith, SN.

c. Please do not take any portion of the chart out or leave any notes lying around. Carry them in your pocket and dispose of them in the PHI receptacle at the end of your day before leaving the unit. Nothing that could identify a patient should leave this unit.

d. While you are doing your clinicals on the Psychiatric Unit, you will be given the opportunity to observe the formulation of treatment planning and the multidisciplinary team in action. The treatment plans are individualized and our program is structured to meet the patients’ needs. Team members welcome the opportunity to work with students, hoping your rotation with us will be a rewarding and educational experience.
1. Routine vital signs are done as follows:

   TPR – BID – 0800 and 1600
   B.P. – QID – 0800, 1100, 1600, and 2000
   (VS may be done more frequently as patient condition warrants or as per physician order)

2. All patients are weighted weekly on Tuesday mornings unless ordered more frequently per nurse or physician.

3. Documentation of patient’s appetite is done by percentages and should be recorded on the VS sheet and entered in the electronic record.

4. Medication schedule is as follows (unless ordered differently):

   Daily – 0900
   BID – 0900 and 2100
   TID – 0900, 1300, and 2100
   QID – 0900, 1300, 1700 and 2100

   If you have any questions about when a medication should be given, be sure to ask a nurse.

5. Suicide precautions will be followed per physician’s order and per the psychiatric unit’s policy and procedure for suicide precautions.

6. Monitor B.P. closely (before meds are given) on patients receiving antipsychotic medications (i.e., Haldol, Thorazine, Mellaril), antidepressant medications (i.e., Desyrel) and antianxiety medications (i.e. Librium). Consult psychiatric nurse if B.P. is greater than 170 or less than 100 systolic, or greater than 100 or less than 50 diastolic. The physician may need to be notified and medication held.

7. Documentation is done in the Electronic medical record using the shift assessment within one hour of the start of shift, then using a narrative note a minimum of every four hours for the remainder of the shift. Documentation of close observations every 15 minutes, or every 30 minutes, or every hour as ordered by the physician are documented in the electronic medical record. All PRN medication administrations and follow-up note evaluating effectiveness must be documented in the electronic medical record.

8. Panic button for emergency situations are located at the Nurses’ Station, the offices of the social workers and physician and behind each door in the solariums. Personal panic alarms are also available at the nurses’ station for any high risk patients.

9. The Psychiatric Unit is a smoke-free environment. To promote wellness, there is no smoking allowed, and passes are not issued for the purpose of smoking. Alternative nicotine produces (i.e., patches, inhalers, gum) will be ordered as needed.
10. Charting needs to include the following:

Affect/Mood
Eye contact
Medication and response
Neurological response (ie, tremors, rigidity, etc.)
Interactions (include orientation)
Behavior
Appetite/Eating
Activity
Elimination
Physical Assessment

11. Charting is to be problem-oriented; that is, each entry must address one specific problem that has been identified on the nursing assessment or on the Individual Treatment Plan when it has been formulated.

12. All forms utilizing documentation by initial must have signatures to identify the initials. Examples include MARS, close observation/suicide precaution flow sheets, grooming sheets and patient teaching record.

COMMONLY ORDERED MEDICATIONS ON THE PSYCHIATRIC UNIT

<table>
<thead>
<tr>
<th>Common Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haldol</td>
<td>Paxil</td>
</tr>
<tr>
<td>Navane</td>
<td>Zoloft</td>
</tr>
<tr>
<td>Prolinx</td>
<td>Prozac</td>
</tr>
<tr>
<td>Elavil</td>
<td>Thoraxine</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Desyrel</td>
</tr>
<tr>
<td>Mellalir</td>
<td>Pamelor</td>
</tr>
<tr>
<td>Valium</td>
<td>Ativan</td>
</tr>
<tr>
<td>Xanax</td>
<td>Wellbutrin</td>
</tr>
<tr>
<td>Tranxene</td>
<td>Librium</td>
</tr>
<tr>
<td>Buspar</td>
<td>Benadryl</td>
</tr>
<tr>
<td>Congentin</td>
<td>Artane</td>
</tr>
<tr>
<td>Zyprexia</td>
<td>Effexor</td>
</tr>
<tr>
<td>Resperdal</td>
<td>Seroquel</td>
</tr>
<tr>
<td>Depakote</td>
<td>Ambien</td>
</tr>
<tr>
<td>Remeron</td>
<td>Serzone</td>
</tr>
<tr>
<td>Klonopin</td>
<td>Celexa</td>
</tr>
<tr>
<td>Vistaril</td>
<td>Geodon</td>
</tr>
<tr>
<td>Abify</td>
<td>Symbax</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Lunesta</td>
</tr>
<tr>
<td>Emsam</td>
<td>Invega</td>
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</tbody>
</table>

COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>Side Effect</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>Hypotension</td>
</tr>
<tr>
<td>Constipation</td>
<td>Sedation</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Tremors</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
<td>Blurred vision</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>R rigidity</td>
</tr>
</tbody>
</table>
Short Stay Observation Unit

The Observation Unit is a 12 bed unit, located on 5East and is operated on a 24-hour basis.

The observation unit is a decision making unit for patients who need further evaluation to determine if their condition is one that requires Inpatient services. Observation patients are those patients with acute onset illnesses who require more time beyond the Emergency Department or Physician’s office to determine if the patient can be appropriately cared for at home or needs to be admitted to the hospital as an inpatient.

Patients placed in observation status are considered outpatients. Patients who meet inpatient criteria will not be cared for in this unit, they will be transferred to an inpatient unit. Types of patients typically seen in an observation unit are abdominal pain, fever, syncope, dehydration, dizziness, headache, chest pain (low level) and asthma.

This unit is managed by the Nurse Manager of the Observation Unit. Medical care is provided primarily by the Hospitalists. Internist and Family practice physicians may also care for patients on this unit.

Nurse Manager: Donna Frye, BSN, RN
x6631 or x6780
5 Surgical Unit

Welcome to 5-Surgical! We are a 23-bed surgical unit for those patients having any type of general surgery including urology, ENT and GYN cases. Our goal on 5-Surgical is to provide optimum pre and post-operative care for our patients through a team effort. We are excited to have students join us in this effort.

The experiences you have on 5-Surgical are very important to your professional future. We sincerely hope that your time with us will be rewarding for you. Please allow us to assist you whenever possible. Any questions or concerns that you have may be directed to the nurse manager or the charge nurse on your shift.

A list of special policies, procedures, etc. that you may come in contact with on 5-Surgical has been provided. Please familiarize yourself with this information in order to make your clinical on 5-Surgical a wonderful learning experience.

Nurse Manager: Cindy Raganyi, BSN, RN
(573)651-5559
POLICIES/PROCEDURES
5 SURGICAL UNIT

1. All patients are on I & O.

2. The crash cart is located on the back hall of the unit containing a defibrillator. It should be obtained immediately in the event of a Code Blue.

3. NPO lists are located on the ice machine.

4. Each nurse is responsible for hanging and maintaining his/her own IV therapy.

5. Vital signs are routinely taken at 0800, 1200, 1600, 2000, 2400, and 0400, every four hours and by physician orders.

6. Post-op vital sign flowsheets are kept at the nurses’ station on the bulletin board.

7. Pocket masks, blood pressure cuffs, suction machines, and infusion pumps are available in all patient rooms.

8. Special three-way catheters and continuous bladder irrigation require special attention and expertise.

9. PCA – Patient Controlled Analgesia is utilized on 5-Surgical. These patients require the following
   a. Every 4 hour vital signs.
   b. Narcan available.
   c. Pulse ox every shift.
   d. No other analgesics may be given unless specifically ordered.

10. Epidural analgesia is also used on 5-Surgical. These patients require the following:
    a. Every 4 hour vital signs.
    b. Insertion site dressing check at least every shift and document.
    c. Narcan available.
    d. No other analgesics, sedatives, hypnotics unless ordered by anesthesiologist.
    e. Pulse ox
    f. Notify Anesthesia of any anticoagulant order.

11. For general surgeons and GYN surgeons, if temperature is 101 or greater, call the physician. Call urologist for temperature greater than 102. Do not give antipyretic or antibiotics until blood cultures are drawn (if they are ordered).

12. Charting standards are as follows: A head-to-toe assessment must be documented at the beginning of each 8 or 12 hour shift. Any changes, procedures, PRNs, etc., must be documented. If there have been no changes, “no change in assessment” may be documented at the end of the shift or rounds report per computer.
13. Each nurse is responsible for obtaining his or her own IV left-to-counts, and charting them with intake and outputs. Also CBI must be completed by the nurse. All I & O’s are documented by the nurse.

14. End of shift report with updates and shift report sheet is tape recorded for the ongoing shift.

15. Mark all chest tube/suction canisters at the end of every shift with the following:
   a. Level of fluid
   b. Shift, date, and time
   c. Do not empty

16. All patients with chest tubes must have shodded kellys and 3-inch by 36-inch Vaseline gauze placed at the head of their beds.

17. Patients with wired jaws must have wire cutters and suction at their bedside.

18. Absolutely no laxatives, enemas, or suppositories on colon resections or appendectomy patients unless specifically ordered by the surgeon.

19. Nurses must make rounds with all physicians.

20. When packing a wound, use sponges and dressing supplies or use specific physician orders.

21. All post-operative patients must dangle the evening of surgery. Leg routine and turn, cough, and deep breathe every 2 hours minimally unless otherwise ordered. Ambulation occurs the next day. All surgery patients have compression devices.

22. All post-operative patients may immediately be up to the rest room with assistance unless otherwise ordered.

23. Pre-operative teaching is completed by the nurses.

24. All patients receive a folder for all teaching materials upon discharge.
Off Site Locations
SOUTHEAST HOSPITAL HOME HEALTH AGENCY

- All RN staffing with extensive clinical nursing backgrounds in: Pediatrics, Neonatology, Cardiology, Oncology, Medical-Surgical, Neurology/Neuro-Surgical, ICU/CCU, Gerontology, GI, ENT, Infusion Therapy, Urology, Orthopedics, Nursing Education and Wound Care (WOCN-wound and ostomy certified nurse).

- A Hospital-based Home Health Agency with immediate access to resources in clinical specialty areas of practice including: Lactation, Wound/ET, Diabetic, Hospice/Palliative Care, Infusion Therapy, Neurosurgical, Cardiology/Cardiovascular Surgery, Pharmacology, and Psychology.

- Over 30 years of service to the following Counties: Cape, Bollinger, Perry, Scott, and portions of Stoddard, New Madrid, Mississippi Counties. (removed county behind each)

- Continuing educational opportunities to ensure staff competency through access of Southeast Missouri Hospital's education such as inservices/CEU’s and the most up to date information of the home care industry by active participation with local and national organizations: MAHC (the Missouri Association for Home Care) and NAHC (the National Association for Home Care).

- Examples of Skilled Nursing Needs Provided to Clients: Disease management/teaching for self reporting/care (ie: CHF, DM, COPD), wound care/teaching including VAC systems, infusion therapy-peripheral/central lines, pain management, bowel/bladder training, short and long term foley/supra pubic catheter changes, enterostomal care and teaching, injections/medication teaching, venipuncture, as long as it isn’t the sole skilled need, drain or pin site care/instructions, Enteral/Parenteral (including TPN/PPN) therapy/teaching, surgical teaching/follow up care, home safety instructions/caregiver teaching, and pediatric/neonatal-newborn medical/surgical needs. We also provide skilled therapy needs with Physical, Occupational and Speech Therapy. We offer secondary services such as Medical Social Work; Registered Dietician, and Nurse Assistant.

Nurse Manager: Kimra Beckett, MSN, RN, NE-BC  
(573) 335-6609 or 1-800-910-4355
POLICY:
All student nurses that will make independent visits will submit a copy of a Criminal Background Check to be coordinated by the Education Department of SEH and they will maintain the copy.

ORIENTATION FOR NURSING STUDENTS:
• Shall include but not be limited to:
  On or prior to the first clinical day the student shall complete orientation in the Home Health office which shall include:
  1. Introduction to preceptors and Nurse Manager (if available).
  2. Location of supplies and general office environment and location of the permanent chart along with the general contents.
  3. Videos:
      o Street Smarts (for students who follow preceptors for more than one shadowing experience).
  4. Emergency/safety procedures, personal and client—they will be given a copy of homecare’s safety/fire/disaster plan and it will be reviewed prior to beginning a clinical experience with their preceptor. Then nurse manager or his/her designee will review required professional dress (lab coat—if they have available to them, nursing school name tag which should be in plain sight, appropriate street clothes or scrub outfits—no jeans or leggings, no shorts shorter than 4” above knee, no provocative clothing or open toed shoes).
  5. Currently, Student nurses are not required to document. The preceptor will do this and the student will not make independent visits—their preceptor will be present at all times. The clinical experience in Home Health will include:
      • (Day one with the preceptor)
        a. General information about home health nursing visits/reimbursement and/or regulatory requirements
        b. Student responsibilities/review of clinical experiences of the student and acceptable procedures/assessments the student may be doing with the preceptor supervising.
        c. Introduction to the assigned preceptor and their clients each day.
        d. Students may do assessment and other care under the supervision of the preceptor and in accordance to the nursing schools policies and legal restrictions.

General Guidelines for Community Health Students:
• After mastery of intravenous therapy content and laboratory experiences, nursing students may perform the following procedures under the supervision of the clinical faculty member or a staff RN, or independently at the discretion of the faculty member:
  1. Assess and document status of IV site and equipment
  2. Start a peripheral IV site provided the medication to be administered is a continuation of therapy.
  3. Change IV bags and tubing per agency schedule of as required by client status.
  4. Change dressings on an IV site per agency policy of as needed.
  5. Add secondary IV medications to an existing peripheral IV.
  6. Change dressings on an IV site per agency policy of as needed.
  7. Discontinue a peripheral IV catheter and document procedure.
  8. May perform a venipuncture for the purpose of obtaining a lab specimen.
  9. May perform the following central line care:
     a. All care of central lines and must be observed by the agency RN at least once before the procedure may be done independently by the student.
     b. After competency is determined by the agency staff, students may change central line dressings, draw blood or administer medications through the central line or the PICC.
  10. May fill "safe-med" boxes.
  11. May give oral medications and/or injections of medications—using the (5) rights and complying with the (2) person identifiers.
  12. May perform a head to toe assessment including vital signs with the preceptor’s supervision. May do clinical teaching with the preceptor’s clinical supervision.
  13. Ostomy and Foley catheter insertions as per determination by the students past experiences/competency—may be pre-determined by the HH supervisor, the HH preceptor or the clinical instructor.
Students may do the following ONLY UNDER THE DIRECT SUPERVISION OF THE CLINICAL FACULTY MEMBER OR THE STAFF RN:

1. Administer IV push medications, other than peripheral flushes without direct supervision of an agency RN or the Clinical Instructor.
2. Access any implanted access devices.
3. Perform PICC dressing change except with direct supervision of a staff RN.

Students MAY NOT:

1. Initiate IV therapy
2. Administer chemotherapeutic agents, but may monitor client response and status.
3. May not insert weighted enteral feeding tubes.
4. Receive telephone orders from a physician.
5. Insert a PICC line.

• The Home Health management, the clinical supervisor, and/or the clinical instructor will determine what procedures may or may not be performed by a student based on the student’s experience and performance.

• Guidelines for Leadership and Management and Nursing Specialties will be as per instructors preference.
Southeast Hospice provides care and support for terminally ill patients and their families. We help patients in the last stages of a terminal illness live as fully and comfortably as possible. The focus of hospice is redirected to caring not curing, as patients at the end of life may no longer be responding to aggressive, curative therapies. Hospice strives to provide not only pain control for our patients, but also relief of other distressing symptoms such as: shortness of breath, restlessness and nausea. Emotional and spiritual issues are also addressed through our team approach with our social workers and spiritual counselor. Together we strive to enhance living along life’s journey.

Southeast Hospice is comprised of experienced staff that are experts in pain and symptom management. Our nurses are available to answer questions or concerns 24 hours a day. As a student, you would be with one of our nurses, observing them care for our patients in the field. Students are not expected to care for any patient's on their own.

Nurse Manager: Teal Biri, BSN, RN
(573)651-5821