2018 Licensed Nursing Skills Fair Part I

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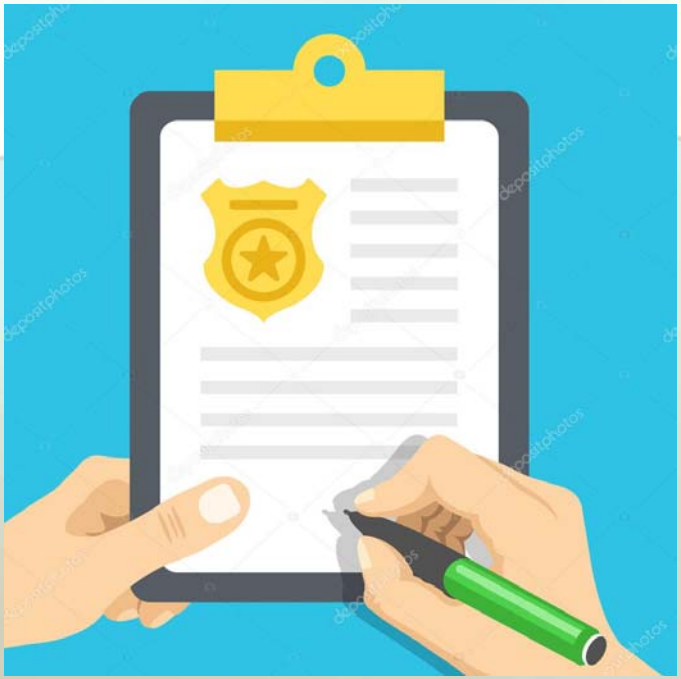
Objectives

- Recall the TJC/CMS Citations and corrective actions
- Explain Nursing Documentation concerns and updates in the Electronic Health Records
- Recall components of the Blood Transfusion (BT) Policy and identify the Licensed Nurse's responsibilities with BTs
- Summarize proper procedures according to the revised Point of Care Pre-Cleaning
- Recall 5 tips to better prepare your patient for surgery
- Explain what USP 797 is

TJC/CMS Citations



PATIENT #1

- Patient #1
  - Admitted to unit at 1:37 PM 6/27/17 for BT/Anemia.
  - First Vital Signs were noted at 4:00 PM.
  - Care plan initiated at 4:09 PM
  - RN 1 notes at 11:06 PM 6/27/17. (9 ½ hours)
  - On the same note, RN 1 indicated NS was infused and that BT started at 5:30 PM 6/27/17.
  - At 7:30 PM patient was noted as having been assisted to BR by another RN.
  - Five minutes later, at 7:35 PM, the patient was found on the BR floor unresponsive and was put back to bed.
  - Two minutes later, at 7:37 PM, the patient coded.
  - 9:42 PM, the patient was pronounced dead.
  - No Admission Assessment until after patient died.
  - Admission Assessment was incomplete.

CMS FINDINGS

- Patient admitted at 1:37 PM
- No evidence of Admission Assessment
- Care Plan initiated before an assessment
- Care Plan did not address risk factors associated with BT
- No Identification of:
  - The patient's care needs (diagnosis)
  - No mention of cognitive level, functional abilities and limitations.
  - No mention of potential risk factors.
    - At 10:52 PM, RN 1 documented patient as being high risk for falls, 2 hours after patient expired.
  - No mention of the level of assistance or supervision required.

CORRECTIVE ACTIONS

- RCA completed
- RN 1 sent for remediation
- RN 1 received a counseling
- Training for all Licensed Nurses (April 2018)
- Changes to our EHR (Vital Signs)
- Unit Supervisor I's will reinforce training
- Auditing per unit
- Progressive Disciplinary Action

TJC/CMS Citations

- CMS Citation: A 386 (p.2)
- Staff not able to retrieve current Policies and Procedures on BT
- Corrective Action: Training
- **Policies and Procedures shall be retrieved in the official GMHA website**
- Caution with searching as policy titles must be accurate

TJC/CMS Citations

- CMS Citation: A 386 (p.3)
- Staff unable to properly explain BT P&P
- Corrective Action: Training
- **Training on BT Policy included in training today, EHR updates to reflect proper documentation of VS and NCPs**

TJC/CMS Citations

- TJC Citation:
- Staff unable to identify how much oxygen available in portable O2 tanks
- Corrective Action: Memo & Training
- **Reminder that there are D & E size tanks, determine how much PSI is left by turning on O2 and checking gauge, to determine how much O2 available for patient view chart to see flow rate and available PSI**

Clinical DOCUMENTATION

Objectives

- Identify TJC/CMS citations relevant to Nursing Documentation
- Identify trends that affect clinical documentation
- Identify the important elements of accurate charting.
- Recall how to properly document in the Electronic Health Record
- Summarize the importance of timely charting and legal impacts it may have

TJC/CMS Citations

- TJC Citation:
- No admission assessment done on Boarder patients in ER
- Concern: Timeliness of Documentation
- Corrective Action: **General Admission Assessments must be done within 24 hours of admission time. Audits are being done to ensure Admission Assessment is done in timely manner**

TJC/CMS Citations

- CMS Citation: A 395 (p.6)
- Documentation of Admission assessment, NCP, Interdisciplinary CP, Nurses' Note
- Concern: Timeliness of Documentation
- Corrective Action: **Training to ensure all patient assessments are completed and documentation is done in a timely manner**

TJC/CMS Citations

- CMS Citation: A 396 (p.11)
- Documentation time of NCP was done after Admission Assessment
- Concern: Timeliness of Documentation
- Corrective Action: **Training to ensure physical assessments are completed before NCPs are initiated.**

TJC/CMS Citations

- CMS Citation: A 395 (p.11)
- Vital signs for patient on blood transfusion input by Non-licensed staff, no authentication or acknowledgement of VS by Licensed staff
- Concern: Complete Documentation
- Corrective Action: Change in EHR to include comment line for BT VS and ability for Licensed staff to acknowledge VS

TJC/CMS Citations

- CMS Citation: A 396 (p.11); A 438 (p.14)
- Initiation and update of NCP to reflect current patient condition
- Concern: Accuracy & Appropriateness
- Corrective Actions: **Suggested NCPs initiated based on admission assessment findings. Staff must select appropriate NCPs.**

TJC/CMS Citations

- CMS Citation: A 438 (p.15b)
- Documentation of VS for BT on manual VS flowsheet was not clear
- Concern: Legible Documentation
- Corrective Action: **All VS are to be documented electronically, BT VS are to be indicated as BT VS and verified by RN**

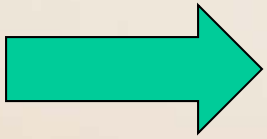
TJC/CMS Citations

- TJC Citation: RC.01.01.01
- Consent for treatment signed- not dated or timed
- Concern: Complete Documentation
- Corrective Action: **Audits to ensure complete documentation**

Trends that affect Documentation

- Case Management
- Rising Health cost
- Nursing shortages
- Litigation
- Legislation and regulation issue

PAPER-BASE DOCUMENTATION



ELECTRONIC HEALTH RECORD

The Purpose of Clinical Record

- Communication and continuity of care
- Accountability
- Legislative Requirement
- Quality Improvement/Peer Review
- Research
- Reimbursement
- Licensing/Accreditation

Elements to Effective Charting

- Timely
- Professional
- Permanence
- Signature
- Accuracy & Appropriate
- Sequence (chronological)
- Terminology
- Completeness
- Legible
- Referencing
  - –Paper vs. electronic

FOCUS

- D-Data
  - The info gathered through the assessment regarding the nursing diagnosis, s/s, patient behavior or significant event
- A-Action
  - The interventions taken by the HCP relatating to the nursing dx, s/s, patient behavior or significant event
- R-Response
  - The patient's response to the actions taken

FOCUS

FOCUS: Ineffective Airway clearance r/t asthma

D: pt states “chest tight and can’t breathe”, BP 160/100 P-110 R-30. exhibits stridor and nasal flaring

A: Administered 2 puffs brochodilator albuterol

R: Pt coughed up 10ml mucus, brownish green color and thick, states “breathing better now” R-22; lungs auscultated and clear bilaterally.

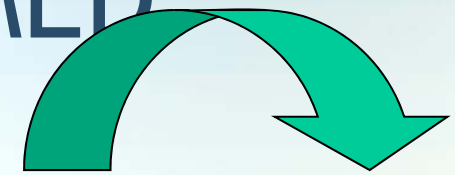
Charting By Exception

- Designed to reduce the amt of info charted about what is “normal” or “unchanged” in a patient care.
- A supplemental charting to preprinted guidelines (such as critical pathways, care plans, flowsheets), wherein exceptions to routine are charted

What do all of these have in common?

- Assessment
- Planning
- Implementation
- Evaluation

Optimum iMED



If you already documented it, there's no need to document in the patient notes.

Regular Routine (use of Notes icon)	Patient Notes
• General admission –Allergies, home medication • Shift assessment • Care Plan • Interdisciplinary Plan of Care • Discharge planning • Flow sheets • Different assessment type	--use for conditions that fall out of the norm, or not available in the assessment type —FOCUS D--data A--action R--response

Nursing Care Plans

- Are NOT TO BE Initiated without having a physical assessment done (bedside assessment of the patient's current condition)

AND

- An initial documentation of that focused assessment in the Nurses' Notes
- Note: The General Admission Assessment must be completed within 24 hours.

Nursing Care Plans

- Suggested Care Plans automatically generated
- Select appropriate NCPs applicable to patient

Things that look legally "fishy"

- A clinical record can look legally suspicious if any of the following appear:

  - Blank spaces
  - Obliterated entries
  - Entries that are out of chronological order
  - Charting between the lines or in the margins for paper documents

  - Note: If you have documentation errors, indicate that an error occurred, with a single line

Documenting High Risk Situation

- In some situations a medical record can be
  - A court document
  - Used to further investigate an adverse outcome or sentinel event (internally and externally)
- Chart carefully when any high-risk situation happens:

  - When care is omitted or refused
  - When an error in care is made
  - When the patient falls or is injured in any way
  - If a sentinel event or near-miss happens.
  - Document according to specific policy requirements (i.e. Falls, Blood transfusion, etc)

Documenting High Risk Situation (Con't)

- Document only the facts surrounding the event.
- Do **NOT** make judgments about the error or place blame.
- *Do NOT document the completion of an "incident" or "variance" report* (or any other agency event report) in the clinical record. (This may compromise any legally protected status of the report form.)
- Make certain your entries are accurate, timed, dated, and signed.
- Include the names of principle persons (physician, supervisor, other staff involved). This will aid in identifying those who witnessed the event and/or the care given to the patient following the event.
- Do **NOT** include the names of other persons whose privacy should be protected (e.g. another patient).
- Do **NOT** falsify facts.

Remember…

- If it was not documented, it was not done
- You will never know when or if you will get subpoena, the clinical record will serve as your memory
- You will never know if your patient will be the subjective of a quality investigation.

Transfusion of Blood and Blood Products

Rhodora Cruz, MSN, RN, CEN

Deputy Assistant Administrator Nursing Services

04/2018

Background

- Removal of Blood Transfusion policy in nursing because it was established in Laboratory Manual, base on a CAP survey that recognized there were too many versions of the policy
- CAP requirement is to have blood transfusion training annually
- 2017 CMS citation:
  - Nursing does not have a blood transfusion policy
  - Nursing is not in compliance to the standard of nursing practice with the transfusion of blood and blood products
- March 2018-the official citation has been received § 482.23 (c) (4) & (c) (5).
  - *Blood transfusion therapy is not included in the nursing plan of care
  - inconsistencies in the documentation of vital signs
  - There is no evidence of registered nurse oversight on the vital signs during the transfusion of blood.
- Ongoing CMS standards and regulation review § 482.23 (c) (4) & (c) (5)
  - Reporting of Adverse events related to blood transfusion

Blood and blood products

WHOLE BLOOD							
		Donor					
Recipient		A	B	O	AB	Rh +	Rh -
A		✓					
B			✓				
O				✓			
AB					✓		
Rh Positive						✓	✓
Rh Negative							✓

RED BLOOD CELLS							
		Donor					
Recipient		A	B	O	AB	Rh +	Rh -
A		✓		✓			
B			✓	✓			
O				✓			
AB		✓	✓	✓	✓		
Rh Positive						✓	✓
Rh Negative							✓

Blood and blood products

PLASMA							
		Donor					
Recipient		A	B	O	AB	Rh +	Rh -
A		✓			✓		
B			✓		✓		
O		✓	✓	✓	✓		
AB					✓		
Rh Positive						✓	✓
Rh Negative						✓	✓

Platelet & Cryopercipitate compatibility: While the same blood type should be the first choice, any blood type component may be used

Policy

- Informed consent is to be provided by the attending physician. Nurses witness the consent signature process.
- **There shall be a blood transfusion care plan included in the patient's plan of care**
  - Blood Transfusion Deficient Knowledge
  - Blood Transfusion Risk for Injury
  - Ineffective tissue perfusion
  - Risk of fluid volume deficit
- Transfusion of blood and blood products shall be done intravenously via a infusion device using compatible filtered blood transfusion tubing set.
  - Tubing sets must be changed every 3rd unit of blood or within 4 hours from start of use, which ever comes first

Policy (cont.)

- Blood and/or blood product must be verified by two licensed personnel, initiated and transfused by a competent licensed nurse or provider, and must be administered within 30 minutes of being released from the Blood Bank
- Best practice is to assist the patient with ongoing blood transfusion to use a bedside commode, if not on strict bedrest. Always advocate for best rest activities for patients undergoing blood transfusion therapy to prevent falls or injuries
- Patient transfers with ongoing blood transfusion must be escorted by the nurse.

Pre-issue/preparation

- Is there an order to transfuse blood and/or blood products?
  - Type and Screen/Crossmatch is a separate order from transfusion of blood/blood products
- Is there a current blood transfusion consent
- Is there a patent IV site-preferred 18G angiocath (adults); 22G angiocath (peds)
- Does the patient have a blood transfusion control number attached to his/her ID band?
- Is the Blood administration set prepped with NSS ongoing KVO.
- Have you taken the patient's pre transfusion vital signs to include temperature.
- Were all the pre transfusion medication orders completed?
- When Blood Bank calls that the blood/blood product is ready to be picked up
  - Bring a patient ID label with you.

Blood pick up and transportation

- Bring the patient ID label with you
- Follow the Blood Bank verification process
  - Recall blood compatibility
  - Patient ID, Pt blood type, Blood Lot#, Patient Control #, expiration date…
- Immediately transport the blood to the unit-ensure it is enclosed in a biohazard specimen bag with the blood request slip.
- Must begin transfusion of the blood/blood product within 30 minutes
  - If there is anticipated delays-return the blood/blood product to laboratory.

Transfusion of blood/blood product

- Verification must be done by two licensed personnel.
- Start the infusion slowly, 2ml/min.
- Remain at bedside for the first 15-30 minutes
  - Monitor patient's vital signs, including temperature
    - Q 5 minutes for 15 minutes
    - Q 15 min for the first hour (x3)
    - Q hour for the remaining of the transfusion (x2-3)
    - **Whole blood/PRBC must be transfused within 4 hours
    - **Plasma/Platelets, rapidly as tolerated (within 20-30 mins – coagulation properties become unstable quickly after thawing)

Transfusion of blood/blood product

- In the first 15 minutes, the blood transfusion is ongoing at a rate of 2mL/min, what is the converted rate in mL/hour?

NOTES on transfusion

- Do not add medication to the blood transfusion line
- Only use Normal Saline with the transfusion of blood and blood products
- Observe the patient closely for any adverse reactions. Make sure you educate the patient to report any of the symptoms of an adverse reaction

Common adverse reactions with blood transfusions

ADVERSE REACTION	SIGN AND SYMPTOMS
Allergic	Rash, hives, pruritus, laryngeal edema, hypotension, and anaphylactic shock
Non-hemolytic febrile reaction	Chills, fever, headache, nausea, vomiting, and dyspnea
Hemolytic Transfusion reaction	Anxiety, chills, fever, back pain, headache, shock, dyspnea, abnormal bleeding, blood in urine
Circulatory Overload	Coughing, cyanosis, chest pain, difficulty breathing, and rapid increase in systolic pressure

What to do in an adverse reaction

- STOP the blood transfusion immediately
  - Disconnect the blood tubing from the patient, and leave the blood unit by the patient. Replace any IV heplock and secure the IV site.
  - Maintain an IV line with NSS until a medical order has been received by the attending physician.
  - Recheck all labels, forms and patient identification to ensure the patient received the correct blood/blood product
- If patient's condition is deteriorating rapidly, call the Rapid Response Team
- Provide supportive nursing care.

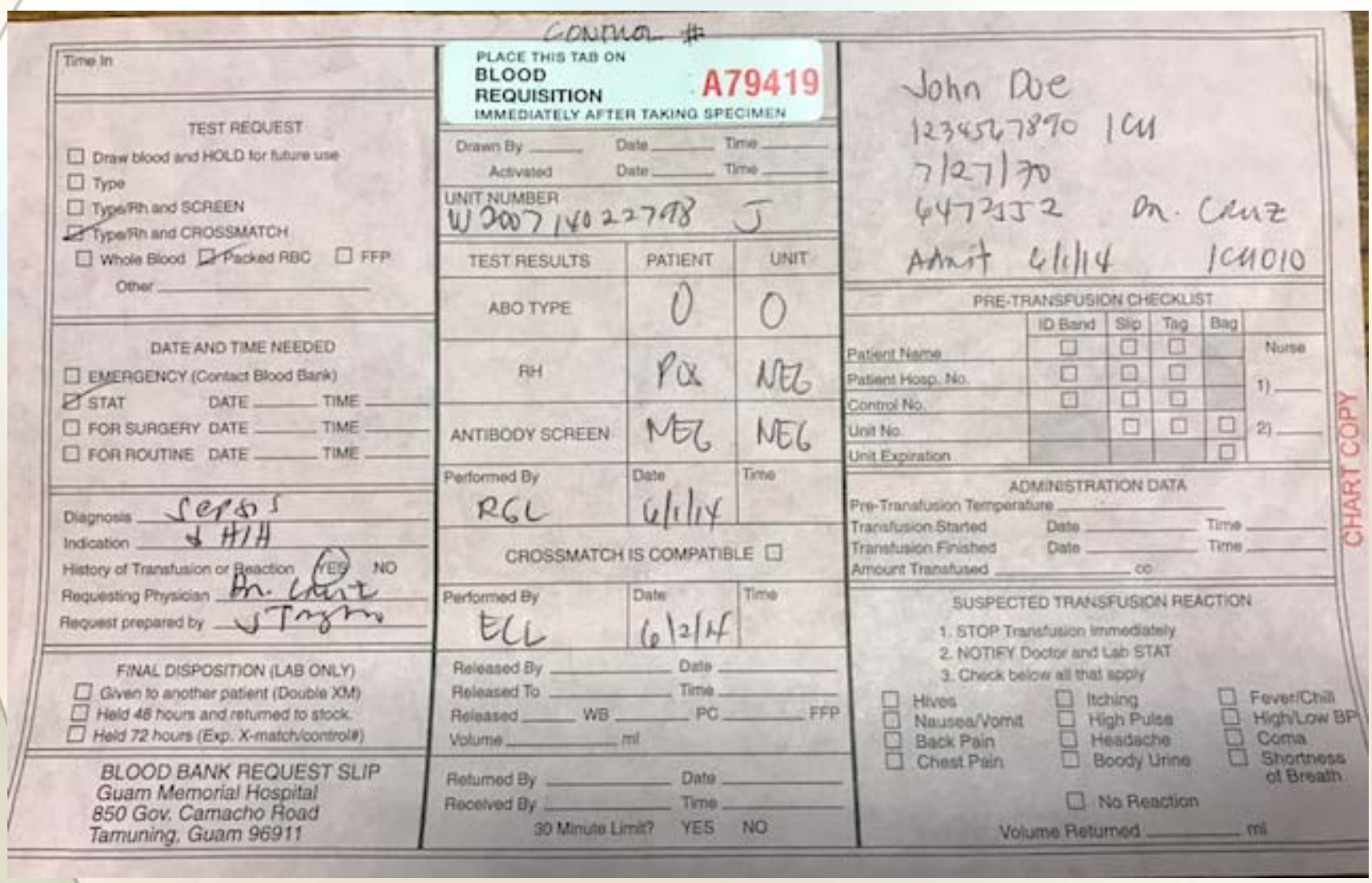
What to do in an adverse reaction

- Notify the attending physician
- Contact blood bank-complete the transfusion reaction workup request and the Patient Safety Occurrence Report
- Obtain urine from the patient.
- Complete the blood bank request slip, indicating the adverse reaction and the infused amount.
- Lab staff will obtain a blood sample from the patient.
- Order in the CPOE, order “Transfusion Reaction Workup” under the attending physician.

Documentation

- Vital Signs, as indicated, shall be documented in the patient's EHR **by the registered nurse. The nurse shall notate the vital signs is for blood transfusion, or post blood transfusion**
- Ensure that upon completion of the transfusion of blood/blood products that the Blood Bank Request slip has been completed: date/time transfusion ended, total volume infused, type of blood/blood product, any adverse reaction.
  - The white copy of the Blood Bank Request slip is returned to blood bank and placed in the pouch provided in the blood specimen bag.
  - The pink copy remains in the patient's medical record
- Post Transfusion documentation includes:
  - Patient's tolerance to the treatment, notating any adverse reactions
  - Total volume infused and type of blood product
  - IV site patency
  - Vital signs post blood transfusion

Blood transfusion pink slip



CONTROL #

Time In

TEST REQUEST
- ☐ Draw blood and HOLD for future use
- ☐ Type
- ☐ Type/Rh and SCREEN
- ☑ Type/Rh and CROSSMATCH
- ☐ Whole Blood ☑ Packed RBC ☐ FFP
- Other _____

DATE AND TIME NEEDED
- ☐ EMERGENCY (Contact Blood Bank)
- ☑ STAT DATE _____ TIME _____
- ☐ FOR SURGERY DATE _____ TIME _____
- ☐ FOR ROUTINE DATE _____ TIME _____

Diagnosis Sepsis
Indication & HTN
History of Transfusion or Reaction (YES) NO
Requesting Physician Dr. Cruz
Request prepared by J Taylor

FINAL DISPOSITION (LAB ONLY)
- ☐ Given to another patient (Double XM)
- ☐ Held 48 hours and returned to stock.
- ☐ Held 72 hours (Exp. X-match/control#)

BLOOD BANK REQUEST SLIP
Guam Memorial Hospital
850 Gov. Camacho Road
Tamuning, Guam 96911

PLACE THIS TAB ON
BLOOD
REQUISITION
IMMEDIATELY AFTER TAKING SPECIMEN
A79419

Drawn By _____ Date _____ Time _____
Activated Date _____ Time _____

UNIT NUMBER
W 2007 140 227918 J

TEST RESULTS	PATIENT	UNIT
ABO TYPE	O	O
RH	POS	NEG
ANTIBODY SCREEN	NEG	NEG
Performed By RGL	Date 6/1/14	Time

CROSSMATCH IS COMPATIBLE ☐

Performed By	Date	Time
ECL	6/2/14	

Released By _____ Date _____
Released To _____ Time _____
Released _____ WB _____ PC _____ FFP
Volume _____ ml

Returned By _____ Date _____
Received By _____ Time _____
30 Minute Limit? YES NO

John Doe
1234567890 ICU
7/27/70
6472352 Dr. Cruz
Admit 6/1/14 ICU010

PRE-TRANSFUSION CHECKLIST

	ID Band	Slip	Tag	Bag	
Patient Name	☐	☐	☐		Nurse
Patient Hosp. No.	☐	☐	☐		1)
Control No.	☐	☐	☐		
Unit No.		☐	☐	☐	2)
Unit Expiration				☐	

ADMINISTRATION DATA
Pre-Transfusion Temperature _____
Transfusion Started Date _____ Time _____
Transfusion Finished Date _____ Time _____
Amount Transfused _____ cc

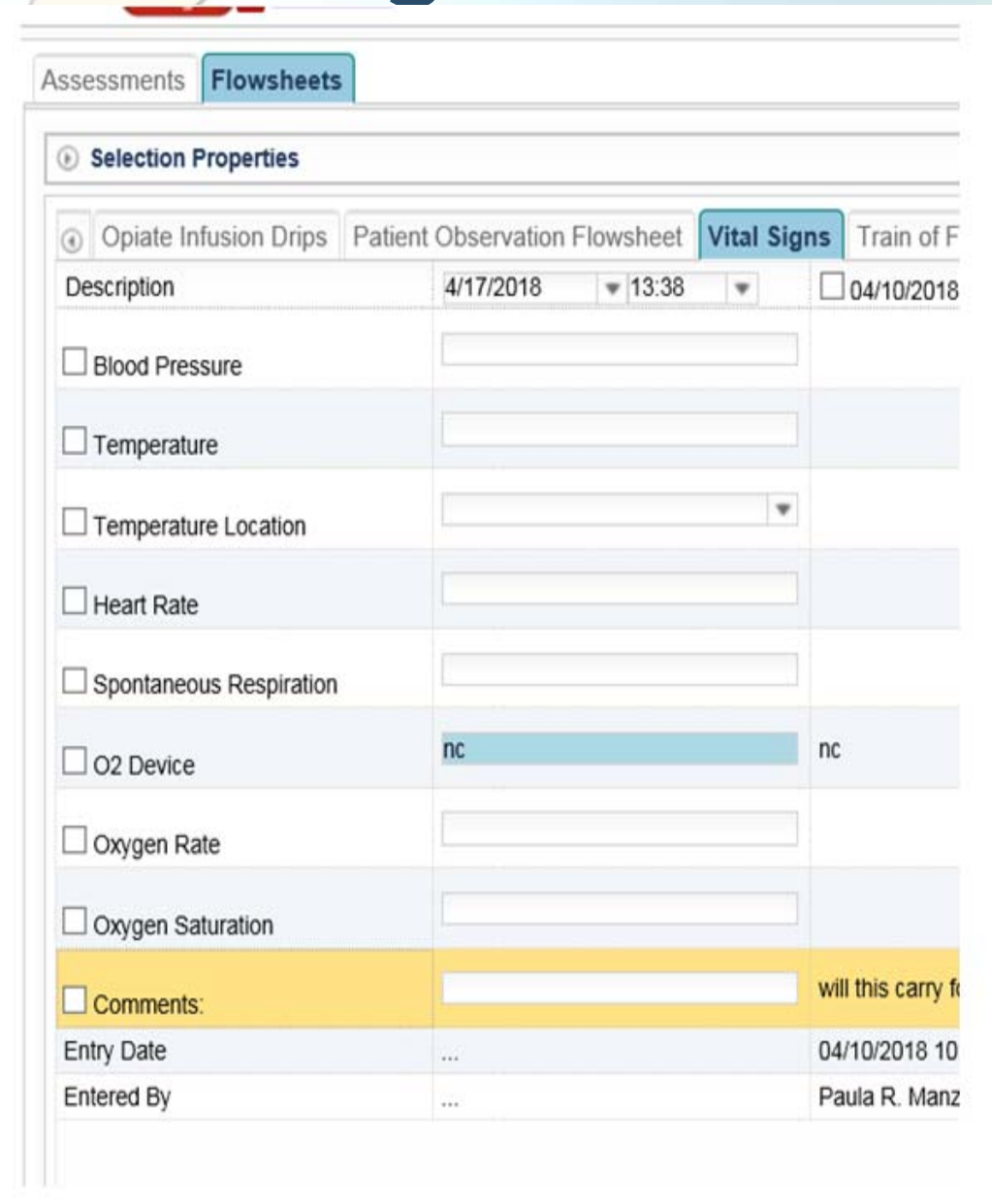
SUSPECTED TRANSFUSION REACTION
1. STOP Transfusion Immediately
2. NOTIFY Doctor and Lab STAT
3. Check below all that apply

- ☐ Hives
- ☐ Nausea/Vomit
- ☐ Back Pain
- ☐ Chest Pain
- ☐ Itching
- ☐ High Pulse
- ☐ Headache
- ☐ Boody Urine
- ☐ Fever/Chill
- ☐ High/Low BP
- ☐ Coma
- ☐ Shortness of Breath
- ☐ No Reaction

Volume Returned _____ ml

CHART COPY

Vital Signs for BT



- **Verification of Blood transfusion entered vitals**
- CNAs can under comments type **“BLOOD TRANSFUSION”** when the vital s taken is during blood transfusion.
- RN has to edit entry made by CNA to verify the vitals.
- Alternatively, the RN can enter the vitals for the blood transfusion themselves.

What's next?

- Check if there are any post-transfusion prescribed laboratory order.

Best practice

- Charge nurses, ensure that blood transfusions are not done by the same nurse at the same time.
- While you are in the patient's room for the first 15 minutes, establish rapport, get additional information for your assessment. It's the best time to provide patient/family education, or update them with their plan of care
- If you can bring a tablet in the patient room, do so. You will be able to do real time documentation.
- If an isolation precaution exists, ensure that you can visibly see the patient and hear the patient.
- Patients with blood transfusion should be at risk of fall due to tissue perfusion alterations or fluid volume deficit, advocate for best rest activities with the physician.
- Always teach patients and families what to expect in terms of blood transfusion reactions which may occur.

FOR FURTHER CLARIFICATION/CONCERNS WITH ANY POLICY, NOTIFY YOUR UNIT SUPERVISOR. WE ARE OPEN TO YOUR PARTICIPATION IN ANY POLICY WITH EVIDENCE BASE PRACTICES.

References

- Nettina, S. (Ed.) (2010). The Lippincott Manual of Nursing Practice (9th ed.). Philadelphia, PA: Lippincott-Raven Publishes

- Brecher, M.E. Ed., Technical Manual, 15th ed. American Association of Blood Banks, Bethesda, MD 2005.

TEST TIME…

- Complete Point of Care Pre-Cleaning Post-Test

Pop Quiz:

1. How many Malignant Hyperthermia Carts are there and where are they located?
2. How would you obtain emergency medications if not readily available on your units?
3. How many Suicide levels are there according to the new policy on Suicide Precautions?

Friendly Reminder on "How to prepare patient for surgery "

Purpose of this reminder:

1. To prevent harm to the patient
2. To avoid delay of cases
3. To protect staff from unexpected lawsuit

Frequently observed conditions in OR Holding Area :

1) Incomplete Verification sheet

---- Please double check if Verification #1 and #2 are filled out before sending patient to OR.

2) Verbal site Verification only says " Yes"

-----Please ask patient to verbalize their understanding of procedure and write down 'Who' stated 'What'.

*Example of proper verbal site verification

⇒ **Patient said "Dr. will remove my gallbladder using scope, but Dr may need to cut open if any complication.**

3) Consent signed by family but no explanation why patient is not able to give signature.

4) Consent signed by POA/Legal guardian but no copy of legal documents in the chart.

----- Signature by POA is invalid without legal document

5) IV HL not patent.

----- Preferably 20G or 18G *Please communicate any delaying issues.

We greatly appreciate your help as a team. We believe "Good preparation, Good team effort for Positive patient outcome."

January 2018 / Ayako Fulgar RNC OR/PACU PI

What is USP 797

Objectives

- Recall the TJC Citations and corrective actions
- Explain Nursing Documentation concerns and updates in the Electronic Health Records
- Recall components of the Blood Transfusion (BT) Policy and identify the Licensed Nurse's responsibilities with BTs
- Summarize proper procedures according to the revised Point of Care Pre-Cleaning
- Recall 5 tips to better prepare your patient for surgery
- Explain what USP 797 is

Types of ongoing Audits

- Blood transfusion- VS monitor by RN including temp, NCP R/T BT, if any BT reactions
- Admission Assessment- done within 24 hours, regardless if patient is boarder pt
- NCP- done after initial focused assessment note (i.e. Nurse's Notes)

Any questions?