

Due Date: October 31, 2021

Department of Nursing:

1. Non-Violent Restraints [exclude RNPH]
2. Violent Restraints [exclude RNPH]
3. Non-Violent Restraints: RNPH

Unit-Specific:

1. Fall Prevention: Adult Medical-Surgical/ICU/Pediatrics/SMH Perinatal
 - a. Includes auto-assignment of Post Fall Care
2. Fall Prevention: RRH Perinatal
 - a. Includes auto-assignment of Post Fall Care
3. Post Fall Care: Adult ICU/Adult Medical-Surgical/Pediatrics/Perinatal
4. Catheter Associated Urinary Tract Infection (CAUTI)
 - a. Includes auto-assignment of CHG [exclude Perinatal]
 - b. Includes auto-assignment of Hand Hygiene
5. Central Line Associated Bloodstream Infection (CLABSI)
 - a. Includes auto-assignment of CHG [exclude Perinatal]
 - b. Includes auto-assignment of Hand Hygiene
6. Clostridium Difficile (C. diff)
 - a. Includes auto-assignment of Hand Hygiene
7. Infection Prevention: CHG [exclude Perinatal]
8. Infection Prevention: Hand Hygiene
 - a. Upcoming eLearning
9. Safe Patient Handling-Required
 - a. 15 separate SPH equipment observation checklists

Unit Selection:

1. Avasure [exclude Perinatal]
2. Constant Observation Aide (COA) [exclude RNPH]

3. 1:1 Patient Observation: RNPH
4. Care for a Suicidal Patient [exclude RNPH]
 - a. Optional eLearning: [Constant Observation Aide \(COA\) for the Suicidal Patient](#)
5. Delirium Prevention: Adult Medical-Surgical
6. EKG: 5-Lead
7. EKG: 12-Lead
8. Vital Signs and Change in Patient Condition (Adult Sepsis \geq 18 years)
9. Vital Signs and Change in Patient Condition (Pediatric Sepsis $<$ 18 years)
10. Vital Signs: Orthostatic Blood Pressure

Department of Nursing:

1. OBSERVATION CHECKLIST: Non-Violent Restraints [exclude RNPH]

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes that should be reported to the RN after you round on the patient <u>Enter Paragraph Return here</u> <i>i.e. restraints are too tight, there are signs of injury, patient is pulling on lines/tubes, getting out of bed, yelling, crying, and kicking</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State basic patient care for a patient in non-violent restraints <u>Enter Paragraph Return here</u> <i>i.e. toileting, hygiene, hydration, nutrition, and positioning</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State when all four side rails are a restraint <u>Enter Paragraph Return here</u> <i>i.e. all four side rails are up to keep the patient in bed is a restraint</i> <u>Enter Paragraph Return here</u> <i>i.e. all four side rails up for seizure precautions is not a restraint</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate putting on non-violent restraints used on your unit and as directed by RN <ul style="list-style-type: none"> • Examples include: <i>soft restraints, mesh vests, mittens-restrained, posey stay safe bed, elbow immobilizer, and no-no's</i> 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<input type="checkbox"/> Demonstrate repositioning and range of motion every two hours (assist RN as needed)	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
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2. OBSERVATION CHECKLIST: Non-Violent Restraints: RNPH

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes that should be reported to the RN after you round on the patient Enter Paragraph Return here <i>i.e. restraints are too tight, there are signs of injury, patient is pulling on lines/tubes, getting out of bed, yelling, crying, and kicking</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State basic patient care for a patient in non-violent restraints Enter Paragraph Return here <i>i.e. toileting, hygiene, hydration, nutrition, and positioning</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State when all four side rails are a restraint Enter Paragraph Return here <i>i.e. all four side rails are up to keep the patient in bed is a restraint</i> Enter Paragraph Return here <i>i.e. all four side rails up for seizure precautions is not a restraint</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate putting on soft restraints, mittens-restrained, no-no's, as directed by RN	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate repositioning and range of motion every two hours (assist RN as needed)	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

3. OBSERVATION CHECKLIST: Violent Restraints [exclude RNPH]

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the duties of the Constant Observation Aide (COA) <u>Enter Paragraph Return here</u> <i>i.e. refer to separate Constant Observation Checklist as a reference</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the patient changes that should be reported to the RN <u>Enter Paragraph Return here</u> <i>i.e. immediate danger to patient, family, or staff</i> <u>Enter Paragraph Return here</u> <i>i.e. restraints are too tight, there are signs of injury, patient is pulling on lines/tubes, getting out of bed, yelling, crying, and kicking</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State basic patient care for a patient in violent restraints <u>Enter Paragraph Return here</u> <i>i.e. toileting, hygiene, hydration, nutrition, and positioning</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State when all four side rails are a restraint <u>Enter Paragraph Return here</u> <i>i.e. all four side rails are up to keep the patient in bed is a restraint</i> <u>Enter Paragraph Return here</u> <i>i.e. all four side rails up for seizure precautions is not a restraint</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate putting on violent restraints (tuff cuffs) as directed by RN	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<input type="checkbox"/> Demonstrate repositioning and range of motion every two hours (assist RN as needed)	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
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Unit-Specific:

1. OBSERVATION CHECKLIST: Fall Prevention: Adult Medical-Surgical/ICU/Pediatrics/SMH Perinatal

- Includes auto-assignment of Post Fall Care observation checklist

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for hourly rounding and proactive toileting/voiding (potty) <u>Enter Paragraph Return here</u> <i>i.e. prevent falls</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State general fall prevention actions to keep a safe environment <u>Enter Paragraph Return here</u> <i>i.e. bed low, 2-3 side rails and locked, clutter free room, and non-skid socks/footwear when out of bed</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State high fall-risk prevention actions <u>Enter Paragraph Return here</u> <i>i.e. yellow fall risk arm band, yellow falling star sign outside room, and do not leave patient alone in the bathroom</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors and situations to report to the RN that may increase fall risk <u>Enter Paragraph Return here</u> <i>i.e. increased confusion, agitation, discomfort, weakness, and change in vital signs</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate Chair/Bed Alarm and gait belt as directed by RN	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<p><input type="checkbox"/> Demonstrate [6 Ps] purposeful rounding</p> <p><u>Enter Paragraph Return here</u></p> <p><i>i.e. pain, personal needs (potty/timed voiding), position, placement of personal items (items/call light), prevent falls, and pump (report pump alarms/empty IV bags to RN)</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
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2. OBSERVATION CHECKLIST: Fall Prevention: RRH Perinatal

- Includes auto-assignment of Post Fall Care observation checklist

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for hourly rounding and proactive toileting/voiding (potty) <u>Enter Paragraph Return here</u> <i>i.e. prevent falls</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State general fall prevention actions to keep a safe environment <u>Enter Paragraph Return here</u> <i>i.e. bed low, 2-3 side rails and locked, clutter free room, and non-skid socks/footwear when out of bed</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State high fall-risk prevention actions <u>Enter Paragraph Return here</u> <i>i.e. yellow fall risk arm band, yellow falling star sign outside room, and do not leave patient alone in the bathroom</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors and situations to report to the RN that may increase fall risk <u>Enter Paragraph Return here</u> <i>i.e. increased confusion, agitation, discomfort, weakness, and change in vital signs</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate gait belt as directed by RN	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<p><input type="checkbox"/> Demonstrate [6 Ps] purposeful rounding</p> <p><u>Enter Paragraph Return here</u></p> <p><i>i.e. pain, personal needs (potty/timed voiding), position, placement of personal items (items/call light), prevent falls, and pump (report pump alarms/empty IV bags to RN)</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
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3. OBSERVATION CHECKLIST: Post Fall Care

- Included with all Fall Prevention observation checklists assignments

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the CACP/CCP post fall response <u>Enter Paragraph Return here</u> <i>i.e. stay with the patient, do not move patient, and notify RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State how often vital signs are taken post fall when head injury occurs or is suspected <u>Enter Paragraph Return here</u> <i>i.e. every 30 minutes x 2 hours, then every 2 hours x 24 hours, and then every 4 hours</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors and situations to report to the RN <u>Enter Paragraph Return here</u> <i>i.e. change in behavior, confusion, pain, and dizziness</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation



4. OBSERVATION CHECKLIST: Catheter Associated Urinary Tract Infection (CAUTI)

- Includes auto-assignment of Hand Hygiene observation checklist
- Includes auto-assignment of CHG observation checklist

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the importance of hand hygiene, CHG treatment, Foley catheter care, and Pericare <u>Enter Paragraph Return here</u> <i>i.e. to prevent infection (CAUTI)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the patient changes that should be reported to the RN <u>Enter Paragraph Return here</u> <i>i.e. pelvic (lower abdomen) and perineum pain, tubing discomfort at insertion site, urine leakage around Foley tube, breaks/leakage from tubing, and skin breakdown</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the changes in urine that should be reported to the RN <u>Enter Paragraph Return here</u> <i>i.e. low/no urine output, odors, change in color, blood clots, tissue or mucous plugs</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State next steps if patient/family refuses CHG treatment, Pericare or Foley care <u>Enter Paragraph Return here</u> <i>i.e. notify RN/Charge RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate care of a patient with a Foley: <ul style="list-style-type: none"> • Pericare every shift and prn (<i>i.e. after bowel movement</i>) • Foley catheter care every shift and prn (<i>i.e. after bowel movement</i>) 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<ul style="list-style-type: none"> Foley care every shift and prn (<i>i.e. after bowel movement</i>) <p><u>Enter Paragraph Return here</u> <i>i.e. Perform Pericare/Foley Care using the steps below:</i></p> <ol style="list-style-type: none"> Perform hand hygiene Don new gloves Using extra packet (2-CHG cloths) Perform Pericare (using 1 separate CHG cloth) Perform Foley care (using 1 separate CHG cloth) <ol style="list-style-type: none"> Starting at the meatal area, clean 6 inches of Foley catheter, cleaning down, tubing away from body Document both Pericare and Foley Care in electronic health record (EHR) <p><u>Enter Paragraph Return here</u> <i>i.e. maintain unobstructed urine flow without dependent loops, Foley bag remains below the bladder, empty the drainage bag when 1/2 to 2/3 full or more frequently and prior to transport</i></p>		
<p><input type="checkbox"/> State how often the PrimaFit/PrimoFit is changed</p> <p><u>Enter Paragraph Return here</u> <i>i.e. every 12 hours or when soiled</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> State how often the PrimaFit/PrimoFit suction canister and tubing is changed</p> <p><u>Enter Paragraph Return here</u> <i>i.e. discard canister when 2/3 full or every 24 hours and change canister tubing every 24 hours</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate correct PrimaFit placement</p> <p><u>Enter Paragraph Return here</u></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select]</p>

<p><i>i.e. Place on incontinent female patients when delegated by RN; refer attached reference</i></p> <ol style="list-style-type: none"> 1. Clean patient’s perineum per cleansing standard of practice 2. Position device vertically with Tapered End Cap facing downward and white fabric facing patient’s labia 3. Align Tapered End Cap with perineum and place device between the labia and against the urethral opening 4. Ensure absorbent fabric is covering the urethral meatus 5. Curve the device toward the patient’s lower abdomen 6. Change every 12 hours or when soiled 7. Connect PrimaFit tubing to suction canister tubing 8. Make sure canister lid is completely closed 9. RN will connect and set wall suction 10. Do not EMPTY canister 11. Write urine output on canister and document in electronic health record (EHR) per unit protocol 12. Discard canister when 2/3 full or every 24 hours 13. Change canister tubing every 24 hours 14. Notify RN if skin breakdown is observed 	 <p>PrimaFit Care Partner Tip Sheet rev</p>	<p>Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate correct PrimoFit placement</p> <p><u>Enter Paragraph Return here</u></p> <p><i>i.e. Place on incontinent male patients when delegated by RN; refer attached reference</i></p> <ol style="list-style-type: none"> 1. Clean patient’s perineum and penis/glans per cleansing standard of practice 2. Place PrimoFit so it fits around the penis 3. Change every 12 hours or when soiled 4. Connect PrimoFit tubing to suction canister tubing 5. Make sure canister lid is completely closed 6. RN will connect and set wall suction 	<p>##/##/####</p>  <p>PrimoFit Care Partner Tip Sheet rev</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>

<ul style="list-style-type: none"> 7. Do not EMPTY canister 8. Write urine output on canister and document in electronic health record (EHR) per unit protocol 9. Discard canister when 2/3 full or every 24 hours 10. Change canister tubing every 24 hours 11. Notify RN if skin breakdown is observed 		
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5. OBSERVATION CHECKLIST: Central Line Associated Bloodstream Infection (CLABSI)

- Includes auto-assignment of Hand Hygiene observation checklist
- Includes auto-assignment of CHG observation checklist

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the importance of hand hygiene and CHG treatment <u>Enter Paragraph Return here</u> <i>i.e. to prevent infection (CLABSI)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the central line dressing observations that should be reported to the RN <u>Enter Paragraph Return here</u> <i>i.e. dressing is loose, wet, or soiled</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State next steps if patient/family refuses CHG treatment <u>Enter Paragraph Return here</u> <i>i.e. report to RN/Charge RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

6. OBSERVATION CHECKLIST: Clostridium Difficile (C. diff)

- Includes auto-assignment of Hand Hygiene observation checklist
- **Center auto-assign to In-patient units with above average C-Diff rates in the previous 6 months (FY 21 Q1 and Q2)**
 - RRUCLA (including RNPH and RR Pediatrics) = 9.86 % average rate (4ICU, 5PICU, 7ICU, 6E, 6W, 7E, 7W, 8E, and 8W)
 - Santa Monica Hospital (including SMH Pediatrics) = 5.20% average rate (AMN, 4SW, 4NW, 5MN, and 4CWICU)

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason to follow contact spore precautions <u>Enter Paragraph Return here</u> <i>i.e. prevent the spread of C. difficile</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the correct disinfectant product and wet time for cleaning <u>Enter Paragraph Return here</u> <i>i.e. bleach wipe and the bleach container lists wet time</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the correct way to perform hand hygiene when exiting the room <u>Enter Paragraph Return here</u> <i>i.e. soap and water for 20 seconds</i>		
<input type="checkbox"/> State the stool type to report to RN <u>Enter Paragraph Return here</u> <i>i.e. unformed/watery stool</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State next steps if patient/family refuses to follow isolation precautions (<i>i.e. hand hygiene, not wearing PPE, or leaving room with PPE on</i>) <u>Enter Paragraph Return here</u> <i>i.e. report to RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<input type="checkbox"/> Demonstrate contact spore precautions <u>Enter Paragraph Return here</u> <i>i.e. clean hands on room entry, wear a gown on room entry, and wear gloves on room entry</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate placing or verifying isolation sign is visible outside the door <u>Enter Paragraph Return here</u> <i>i.e. place or verify isolation sign</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate environmental cleaning <u>Enter Paragraph Return here</u> <i>i.e. use dedicated use of equipment to a single patient (e.g. BP cuff), use bleach disinfectant for all re-usable patient care equipment, and use bleach disinfectant to clean surfaces in the room</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

7. OBSERVATION CHECKLIST: Infection Prevention-CHG Treatment [exclude Perinatal]

- Included with CAUTI and CLABSI observation checklist assignment; assign once

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit


REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for CHG treatment <u>Enter Paragraph Return here</u> <i>i.e. to prevent infection</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State where CHG cloths cannot be used on the body <u>Enter Paragraph Return here</u> <i>i.e. face</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State next steps if patient/family refuses CHG treatment <u>Enter Paragraph Return here</u> <i>i.e. report to RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate patient privacy <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate CHG treatment (daily), in correct order, with six cloths and allow to air dry <u>Enter Paragraph Return here</u> <i>i.e. Provides CHG treatment in the correct order</i> <ol style="list-style-type: none"> 1. Wipe neck, shoulders, and then chest 2. Wipe both arms and hands 3. Wipe abdomen then groin and perineum 4. Wipe right leg and foot 5. Wipe left leg and foot 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

6. Wipe back of neck, back, and then buttocks		
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8. OBSERVATION CHECKLIST: Infection Prevention-Hand Hygiene

- Included with CAUTI, CLABSI, C. diff observation checklist assignment; assign once

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the importance of hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. to prevent infection</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State when to use soap and water for hand hygiene and alcohol-based hand sanitizer for hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. C. difficile patient, hands are visibly soiled</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate hand hygiene with soap and water for 20 seconds <u>Enter Paragraph Return here</u> <i>i.e. follows correct steps; refer attached reference</i> <ol style="list-style-type: none"> 1. Wet hands with water 2. Apply enough soap to cover all hand surfaces 3. Rub hands palm to palm 4. Right palm over left dorsum with interlaced fingers and vice versa 5. Palm to palm with fingers interlaced 6. Backs of fingers to opposing palms with fingers interlocked 7. Rotational rubbing of left thumb clasped in right palm and vice versa 8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa 	##/##/####  Hand_Hygiene-Handwash Handrub.pdf	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<ul style="list-style-type: none"> 9. Rub each wrist with opposite hand 10. Rinse hands with water 11. Dry hands thoroughly with a single use towel 12. Hands are now safe 		
<p><input type="checkbox"/> Demonstrate hand hygiene with alcohol-based hand sanitizer until dry (20 seconds)</p> <p><u>Enter Paragraph Return here</u></p> <p><i>i.e. follows correct steps; refer attached reference</i></p> <ul style="list-style-type: none"> 1. Apply a palmful of the product in a cupped hand, covering all surfaces 2. Rub hands palm to palm 3. Right palm over left dorsum with interlaced fingers and vice versa 4. Palm to palm with fingers interlaced 5. Back of fingers to opposing palms with fingers interlocked 6. Rotational rubbing of left thumb clasped in right palm and vice versa 7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa 8. Once dry, hands are safe 	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>

9. Safe Patient Handling

TAP (BMAT 3; under 150 lbs./68 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for TAPS • State when to escalate to AirTAP • State recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Press max inflate button on low air loss mattress • Use proper body mechanics, including hand grip placement and bed height • Place TAPS under patient • Use proper bed height during bed level activities and use of Trendelenburg position • Demonstrate boosting and lateral transfers with slide board 	##/##/####	

Slideboard/Rollboard (unable to assist):

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for TAPS/SHEET with slideboard • State when slideboard is indicated for lateral transfer • State cleaning process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Lock brakes on bed • Press max inflate button on low air loss mattress • Use proper body mechanics, including hand grip placement and bed height • Roll patient onto side with proper technique • Place slideboard under TAPS or sheet • Place transfer surface and lock brakes • Demonstrate lateral transfers with slideboard or sheet 	##/##/####	

AIR TAP/XXL (BMAT 1-2; over 150 lbs./68 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Air TAP • State when to escalate to XXL AirTAP • State recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Press max inflate button on low air loss mattress • Use proper body mechanics, including hand grip placement and bed height • Inflate Air TAP/XXL • Use proper bed height during bed level activities and use of Trendelenburg position • Demonstrate boosting and lateral transfers 	##/##/####	

Maxi Move (BMAT 1; capacity 500 lbs./226.8 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Maxi Move • State when to escalate to Bariatric device Tenor (brought by Lift Team) • State purpose and indications for limb sling • State proper cleaning procedure and recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Maxi Move • Confirm brakes are unlocked during use • Demonstrate proper sling placement in bed and chair • Demonstrate fall recovery and/or transfer bed-to-chair • Demonstrate proper use of limb sling • Identify the emergency lowering mechanism 	##/##/####	

Sara Plus (BMAT 2; patient can sit, not stand; capacity 420 lbs./190.5 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for the Sara Plus • State how to select proper size sling • State proper cleaning procedures and recycling/disposal process • State when to escalate to Bariatric sit-to-stand device SteadyAid (used by PT/OT) 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Sara Plus • Demonstrate sit-to-stand using the sling (hook and unhook device) • Confirm brakes are unlocked when lowering patient • Demonstrate use of the emergency lowering mechanism 	##/##/####	

Sara Stedy (BMAT 3; patient can stand; capacity 400 lbs./181.4 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for the Sara Stedy • State proper cleaning procedures 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Sara Stedy • Confirm brakes are locked when lifting or lowering patient • Demonstrate sit-to-stand using gait belt • Demonstrate stand-to-sit 	##/##/####	

Safe Patient Handling: Unit Specific (9 items)

Amputee Sling (BMAT level 1 and 2. Amputee (above knee, below knee or double amputee; use if necessary); select size (Red S – 31-75 lbs. /14-34 kg., Yellow M – 75-145 lbs. /34-66 kg. , Green L – 145-250 lbs. /66-113 kg., and Purple XL – 250-500 lbs. /113-227 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for amputee sling • State location of amputee slings • State location of 2 point hanger bar • State when to escalate for amputee sling • State proper cleaning procedure and recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Press max inflate button on low air loss mattress (application in bed) • Use proper body mechanics and bed height • Place amputee sling under patient • Use proper bed height during bed level activities • Demonstrate boosting in bed and OOB transfer to chair • Place sling under patient (application in chair) • Use proper body mechanics • Demonstrate transfer chair back to bed 	##/##/####	

Guldmann Ceiling Lift (BMAT 1-2; capacity 770 lbs./350 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Guldmann ceiling lift • State proper cleaning procedure and recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when using the ceiling lift • Demonstrate proper handling and safety when using ceiling lift • Demonstrate proper sling placement in bed and chair • Demonstrate fall recovery and/or transfer bed-to-chair • Identify the emergency lowering mechanism • Return ceiling lift to designated location when not in use 	##/##/####	

Golvo (BMAT 1-2; capacity 199kg./440 lbs.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Golvo • State location of Golvo • State when to escalate to Bariatric device Maxi Move < 500 lbs. or Tenor > 500 lbs. (brought by Lift Team) • State cleaning process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Golvo • Confirm brakes are unlocked during use • Demonstrate proper sling placement in bed and chair • Demonstrate fall recovery and/or transfer bed-to-chair • Identify the emergency lowering mechanism 	##/##/####	

MATS (Used only with Brachytherapy pts.) (BMAT 1-2; over 150 lbs./68 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for MATS • State when to escalate to XXL AIR TAP • State recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Press max inflate button on low air loss mattress • Use proper body mechanics, including hand grip placement and bed height • Inflate MATS • Use proper bed height during bed level activities and use of Trendelenburg position • Demonstrate boosting and lateral transfers 	##/##/####	

Quickmove (BMAT 3-4; capacity 170 kg./375 lbs.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Quickmove • State location of Quickmove • State cleaning process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Use proper body mechanics • Demonstrate sit to stand using gait belt • Demonstrate use and adjustment of seat 	##/##/####	

RoWalker (BMAT 3; patient can stand; capacity 396 lbs./179.6 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for the RoWalker • State proper cleaning procedures 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Use proper body mechanics • Demonstrate adjustment of arm support (height adjustment) • Demonstrate sit to stand using gait belt • Demonstrate use and adjustment of red walking sling (attaches to RoWalker) 	##/##/####	

SallyTube (under 794 lbs./360 kg.; unable to assist)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for the SallyTube • State when to escalate to AirTAP • State proper cleaning procedures and recycling/disposal process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environmental barriers (side rails/room equipment) • Press max inflate button on low air loss mattress(s) • Use proper body mechanics, including hand grip placement and bed height • Demonstrate proper placement (SallyTube under sheet) and removal of assistive device • Demonstrate boosting and lateral transfers 	##/##/####	

Sara Flex (BMAT 2; patient can sit, not stand; capacity 440 lbs./199.6 kg.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for the Sara Flex • State how to select proper size sling • State proper cleaning procedures and recycling/disposal process • State when to escalate to Bariatric sit-to-stand device Steady aid (used by PT/OT)	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Sara Flex • Demonstrate sit-to-stand using the sling (hook and unhook device) • Confirm brakes are unlocked when lowering patient • Demonstrate use of the emergency lowering mechanism 	##/##/####	

Viking (M) (BMAT 1-2; capacity 199kg. /440lbs.)

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Verbalize the following: <ul style="list-style-type: none"> • State purpose and contraindications for Viking (M) • State location of Viking (M) • State when to escalate to Bariatric device Tenor (brought by Lift Team) • State cleaning process 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate the following: <ul style="list-style-type: none"> • Remove environment barriers (side rails/room equipment) • Use proper body mechanics when pushing the Viking (M) • Confirm brakes are unlocked during use • Demonstrate proper sling placement in bed and chair • Demonstrate fall recovery and/or transfer bed-to-chair • Identify the emergency lowering mechanism 	##/##/####	

Unit Selection:

1. OBSERVATION CHECKLIST: Avasure [exclude Perinatal]

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for video monitoring (Avasure) <u>Enter Paragraph Return here</u> <i>i.e. Increase patient and staff safety</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate response to Avasure STAT alarms <u>Enter Paragraph Return here</u> <i>i.e. immediately respond to STAT alarm</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

2. OBSERVATION CHECKLIST: Constant Observation Aide (COA) [exclude RNPH]

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State who the COA must get report from and the questions to ask <u>Enter Paragraph Return here</u> <i>i.e. off going COA and RN</i> <u>Enter Paragraph Return here</u> <i>i.e. why the patient needs a COA, care needs, how the patient might act, where to sit, and how to contact the nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the duties of a COA <u>Enter Paragraph Return here</u> <i>i.e. alert to patient at all times, do not leave the patient at any time (RN must [provide coverage], keep door open and remain within arms distance, and bathroom safety (keep bathroom key)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient changes to report to the RN <u>Enter Paragraph Return here</u> <i>i.e. restraints are too tight or there are signs of injury, patient is pulling on lines/tubes, getting out of bed, yelling, crying, and kicking</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors to report to the RN right away and who to call for help, if needed <u>Enter Paragraph Return here</u> <i>i.e. patient tries to leave, hurt themselves or others</i> <u>Enter Paragraph Return here</u> <i>i.e. RN, Charge RN, Security, and Code Gray</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State basic patient care for a patient with a COA	##/##/####	Drop Down Choices:

<p><u>Enter Paragraph Return here</u> <i>i.e. vital signs, toileting, hygiene, hydration, nutrition, and positioning</i></p>		<p>[Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate basic patient care for a patient with a COA <u>Enter Paragraph Return here</u> <i>i.e. constant monitoring and observation the patient for safety, comfort, or signs of distress</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate safety measures to keep the patient and room safe including the bathroom <u>Enter Paragraph Return here</u> <i>i.e. remain with patient at all times</i> <u>Enter Paragraph Return here</u> <i>i.e. ensure the bathroom door is unlocked at all times, door must be partially open when patient is in the bathroom; COA must have bathroom key at all times and give key to oncoming COA</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>


3. OBSERVATION CHECKLIST: 1:1 Observation of Patient: RNPH

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> Give and receive report which includes patient care needs and the purpose of 1:1 observation <i>Note:-Must select direct observation</i> <u>Enter Paragraph Return here</u> <i>i.e. off going COA and RN</i> <u>Enter Paragraph Return here</u> <i>i.e. why the patient needs a COA, care needs, how the patient might act, where to sit, and how to contact the nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the duties while observing a patient on 1:1 observation status <u>Enter Paragraph Return here</u> <i>i.e. alert to patient at all times, do not leave the patient during assigned time (unless another staff member is available to provide coverage and handoff is communicated) door open and remain close enough to intervene as needed (arms' length distance for suicidal observation)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient changes to report to the RN <u>Enter Paragraph Return here</u> <i>i.e. restraints are too tight or there are signs of injury, patient is pulling on lines/tubes, getting out of bed, yelling, crying, and kicking, and increased suicidal thoughts</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors to report to the RN right away and who to call for help, if needed <u>Enter Paragraph Return here</u>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<p><i>i.e. patient tries to leave, hurt themselves or others, increasing impulsivity or physical instability</i> <u>Enter Paragraph Return here</u> <i>i.e. Report to the RN, Charge RN, Security, and Staff Assist</i></p>		
<p><input type="checkbox"/> State basic patient care for a patient on 1:1 observation status <u>Enter Paragraph Return here</u> <i>i.e. vital signs, toileting, hygiene, hydration, nutrition, and positioning</i></p>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<p><input type="checkbox"/> Demonstrate basic patient care for a patient on 1:1 observation status <i>Note:-Must select direct observation</i> <u>Enter Paragraph Return here</u> <i>i.e. constant monitoring and observation the patient for safety, comfort, or signs of distress</i></p>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<p><input type="checkbox"/> Demonstrate safety measures to keep the patient and environment safe including the bathroom <i>Note:-Must select direct observation</i> <u>Enter Paragraph Return here</u> <i>i.e. remain with patient at all times</i></p>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

4. OBSERVATION CHECKLIST: Care of a Suicidal Patient [exclude RNPH]

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for the security search and why patients are not able to keep their belongings <u>Enter Paragraph Return here</u> <i>i.e. remove at risk items</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the duties of a Constant Observation Aide (COA) for a suicidal patient <u>Enter Paragraph Return here</u> <i>Form # 16816 Guidelines for Constant Observation Aide (COA) Assigned to Suicidal Patients; refer attached reference</i> <i>i.e. alert to patient at all times, do not leave the patient at any time (RN must provide coverage), keep door open and remain within arms distance, and bathroom safety (keep bathroom key)</i>	##/##/####  16816_002 COA Suicidal Patient Guide	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the safety precautions for a suicidal patient <u>Enter Paragraph Return here</u> <i>i.e. do not leave the patient alone at any time including restroom safety, be alert to the patient at all times</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State issues to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. patient tries to leave, hurt themselves or others</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate in Suicide Safety Rounds with the RN (on admission, once per shift, and as needed) <u>Enter Paragraph Return here</u> <i>i.e. remove at risk items</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

5. OBSERVATION CHECKLIST: Delirium Prevention: Adult Medical-Surgical

- RR: 5E, 6E, 6N, 6W, 7E, 7N, 7W, 8E, 8N, 8W
- SMH: 3NW, 4NW, 5NW, 4SWW, AMN, 4MN, 5MN

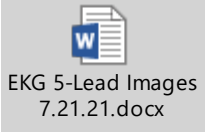
Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the reason for delirium prevention <u>Enter Paragraph Return here</u> <i>i.e. to keep patient safe/prevent injury and other problems like dehydration</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State general delirium prevention actions <u>Enter Paragraph Return here</u> <i>i.e. help with frequent reorientation, sleep-wake cycle, mobilization, sleep, calming activities, hydration/nutrition, fall/injury prevention, preventing sensory loss, and avoiding restraints</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State patient behaviors and situations to report to the RN that may increase the risk of injury/fall <u>Enter Paragraph Return here</u> <i>i.e. increased confusion, agitation, discomfort, weakness, and change in vital signs</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate general delirium prevention actions, as directed by the RN including: <u>Enter Paragraph Return here</u> <ol style="list-style-type: none"> 1. Frequent reorientation (<i>i.e. using calendars, clocks, family photos</i>) 2. Maintain sleep-wake cycle (<i>i.e. bright light during the day: open shades/blinds or turn on lights; minimal sound/light at night</i>) 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<ol style="list-style-type: none"> 3. Prevent sensory loss (<i>i.e. use visual and hearing aids and adaptive communication devices e.g. pocket talker</i>) 4. Help patient with sleep (<i>i.e. back massage, noise-reduction</i>), mobilization, hydration, nutrition, and fall/injury prevention 5. Use restraint alternatives as directed by RN 6. Provide calming activities (<i>i.e. music, games, art</i>) as directed by RN 		
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6. OBSERVATION CHECKLIST: EKG 5-Lead

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit


REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. sudden chest pain, pale skin, and excessive sweating</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State how often to change the electrodes <u>Enter Paragraph Return here</u> <i>i.e. daily after CHG bath</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. use soap and water or alcohol-based hand sanitizer for hand hygiene</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate patient privacy <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate lead placement on patient’s chest, on soft area, away from bones: <i>Note:-Must select direct observation</i> <u>Enter Paragraph Return here</u> <i>i.e. refer attached reference</i> <ol style="list-style-type: none"> 1. Right Arm (RA) White: Next to right shoulder under clavicle 2. Left Arm (LA) Black: Next to left shoulder, under clavicle 3. Right Leg (RL) Green: Right side of abdomen 	##/##/####  EKG 5-Lead Images 7.21.21.docx	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation


<p>4. Left Leg (LL) Red: Left side of abdomen, below the rib cage</p> <p>5. V1 Brown: 4th intercostal space, right sternal border</p>		
<p><input type="checkbox"/> Demonstrate connecting lead wires to leads and to monitor or telemetry box</p> <p><u>Enter Paragraph Return here</u></p> <p><i>i.e. connect lead wires to lead and connect to monitor or telemetry box; refer attached reference</i></p>	<p>##/##/####</p>	<p>Drop Down Choices:</p> <p>[Please select]</p> <p>Direct Observation</p> <p>Verbal Confirmation</p>

7. OBSERVATION CHECKLIST: 12-lead EKG

- NOTE: Majority of 12 Leads are done on Philips-checklist includes both methods (Portable Machine/Philips Monitor)

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. sudden chest pain, pale skin, and excessive sweating</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. use soap and water or alcohol-based hand sanitizer for hand hygiene</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate patient privacy <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate lead placement on patient’s chest <u>Enter Paragraph Return here</u> <i>i.e. refer attached reference</i> Start with the yellow in V2 placement, the other leads follow in order: <ol style="list-style-type: none"> 1. V₁ Red: Fourth intercostal space at the right border of the sternum 2. V₂ Yellow: Fourth intercostal space at the left border of the sternum 3. V₃ Green: Halfway between V₂ and V₄ 4. V₄ Blue: Fifth intercostal space at the left midclavicular line 	##/##/####  EKG 12-Lead Images 6.2.21.docx	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<p>5. V₅ Brown: Level with V₄ at the anterior axillary line (or halfway between V₄ and V₆, if the anterior axillary line is ambiguous)</p> <p>6. V₆ Purple: Level with V₄ at the maxillary line</p>		
<p><input type="checkbox"/> Demonstrate connecting lead wires to leads <u>Enter Paragraph Return here</u> <i>i.e. connect lead wires to lead and connect to monitor</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate performing a 12-lead EKG as directed by RN with either Philips monitor or portable machine (per unit protocol) <u>Enter Paragraph Return here</u> <i>i.e. Perform a 12 lead EKG: Philips Monitor; refer attached reference</i></p> <ol style="list-style-type: none"> 1. Capture 12 lead (by SmartKey or by touching on HR numeric→12→Capture 12 Lead 2. Wait for clear waves and no artifact 3. Touch Capture Waves-screen will change to White 12 Lead screen 4. At bottom of screen, touch STORE and SEND (Sends to Central/Patient Link for analysis) 5. Two beeps: 1st (sends to Central for analysis) and 2nd (when analysis is received back to bedside monitor) 6. Print, as directed by RN 7. To complete 12 Lead you must EXPORT <ol style="list-style-type: none"> a. Export at Bedside: Select EXPORT key once Analysis is received back by the bedside monitor b. Export at Central Monitor: Go to 12 Lead Capture Review, select the 12 lead you want 	<p>##/##/####</p> <p> EKG 12-Lead Images 6.2.21.docx</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>

<p>to export and then on the right hand side select EXPORT (icon with 12 Lead and Arrow)</p> <p><u>Enter Paragraph Return here</u> <i>i.e. Perform a 12 lead: Portable Machine Monitor; refer attached reference</i></p> <ol style="list-style-type: none"> 1. Get the EKG machine and supplies 2. Turn on EKG machine and follow prompts displayed on the screen 3. Push the standardized button to check sensitivity (1cm standardization is normal) 4. Change “gain” only if directed by RN 5. Print two copies of the EKG and give to RN 		
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8. OBSERVATION CHECKLIST: Vital Signs and Change in Patient Condition (Adult Sepsis ≥ 18 years)

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. changes in vital signs, patient is confused or not waking up</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the reason vital signs must be documented immediately <u>Enter Paragraph Return here</u> <i>i.e. changes in vital signs (respiratory rate, oxygen saturation, pulse, blood pressure and temperature) can happen before a patient’s condition changes or worsens</i> <u>Enter Paragraph Return here</u> <i>i.e. documenting vital signs immediately tells the RN and care team of the patient’s condition</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the vital signs to report to the RN for Adult Sepsis <u>Enter Paragraph Return here</u> <i>i.e. report vital signs</i> <ul style="list-style-type: none"> • Temperature is greater than 38.3C or less than 36C • Heart rate is greater than 90/minute • Respiratory rate is greater than 20/minute • Blood pressure change (<i>top number is less than 90 or drops by 40 mm Hg, mean arterial pressure [MAP] is less than 65</i>) 	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the actions to take if the primary RN is not responding or available <u>Enter Paragraph Return here</u> <i>i.e. tell charge nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<input type="checkbox"/> Demonstrate hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. use soap and water or alcohol-based hand sanitizer for hand hygiene</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate patient privacy as needed <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate and document vital signs in a timely manner <u>Enter Paragraph Return here</u> <i>i.e. perform vital signs and document in electronic health record (EHR), as directed by the nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

9. OBSERVATION CHECKLIST: Vital Signs and Change in Patient Condition (Pediatric Sepsis < 18 years)

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the patient changes to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. changes in vital signs, patient is confused or not waking up</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the reason vital signs must be documented immediately <u>Enter Paragraph Return here</u> <i>i.e. changes in vital signs (respiratory rate, oxygen saturation, pulse, blood pressure and temperature) can happen before a patient’s condition changes or worsens</i> <u>Enter Paragraph Return here</u> <i>i.e. documenting vital signs immediately tells the RN and care team of the patient’s condition</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the vital signs to report to the RN for Pediatric Sepsis (patients < 18 years) <u>Enter Paragraph Return here</u> <i>i.e. vital sign parameters are outside of the ordered parameters per RN report</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the actions to take if the primary RN is not responding or available <u>Enter Paragraph Return here</u> <i>i.e. tell charge nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. use soap and water or alcohol-based hand sanitizer for hand hygiene</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<input type="checkbox"/> Demonstrate patient privacy as needed <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate and document vital signs in a timely manner <u>Enter Paragraph Return here</u> <i>i.e. perform vital signs and document in electronic health record (EHR), as directed by the nurse</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

10. OBSERVATION CHECKLIST: Vital Signs: Orthostatic Blood Pressure

Note: Verbal Confirmation should only be selected if skill is infrequently performed on unit

REQUIRED SKILL	DATE	VALIDATION METHOD
<input type="checkbox"/> State the vital signs to report to the RN right away <u>Enter Paragraph Return here</u> <i>i.e. changes in orthostatic blood pressure</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State changes in the patient to report to the RN <u>Enter Paragraph Return here</u> <i>i.e. dizziness/light-headedness, nausea, vision changes, fainting, sweating or paleness</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the actions to take if the primary RN is not responding or available <u>Enter Paragraph Return here</u> <i>i.e. notify charge RN</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> State the reason vital signs must be documented immediately <u>Enter Paragraph Return here</u> <i>i.e. changes in vital signs (respiratory rate, oxygen saturation, pulse, blood pressure and temperature) can happen before a patient's condition changes or worsens</i> <u>Enter Paragraph Return here</u> <i>i.e. documenting vital signs immediately tells the RN and care team of the patient's condition</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation
<input type="checkbox"/> Demonstrate hand hygiene <u>Enter Paragraph Return here</u> <i>i.e. use soap and water or alcohol-based hand sanitizer for hand hygiene</i>	##/##/####	Drop Down Choices: [Please select] Direct Observation Verbal Confirmation

<p><input type="checkbox"/> Demonstrate patient privacy as needed <u>Enter Paragraph Return here</u> <i>i.e. close privacy curtain or door and cover patient (limit exposure)</i></p>	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>
<p><input type="checkbox"/> Demonstrate and document orthostatic blood pressure (patient standing/patient can't stand) <u>Enter Paragraph Return here</u> <i>i.e. Steps to orthostatic blood pressure (patient standing)</i></p> <ol style="list-style-type: none"> 1. Check baseline blood pressure and pulse while patient is lying in bed 2. Patient stands for one minute 3. Ask the patient about dizziness, weakness, or vision changes associated with the change in position 4. Observe for sweating or paleness 5. Obtain blood pressure while patient stands (same arm and equipment) 6. Check pulse 7. Repeat steps again at 3 minutes 8. Document in electronic health record (EHR) <p><u>Enter Paragraph Return here</u> <i>i.e. Steps to orthostatic blood pressure (patient can't stand)</i></p> <ol style="list-style-type: none"> 1. Check baseline blood pressure and pulse while patient is lying in bed 2. Patient sits for one minute 3. Make sure that the patient sits with the back and arms supported, with legs uncrossed and both feet on the floor because crossing the legs can increase blood pressure 	<p>##/##/####</p>	<p>Drop Down Choices: [Please select] Direct Observation Verbal Confirmation</p>

<ol style="list-style-type: none"> 4. Ask the patient about dizziness, weakness, or vision changes associated with the change in position 5. Observe for sweating or paleness 6. Obtain blood pressure while patient sits (same arm and equipment) 7. Check pulse 8. Return the patient to a lying position, if has symptoms with the position change 9. Document in electronic health record (EHR) 		
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