SAVOY
MEDICAL CENTER
Our Family – Healing Yours

WELCOME

TO

AGENCY ORIENTATION PACKET

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INTRODUCTION

Number of Beds in Facility: 180

Brief Description of Scope of Care/Patient Population Served

Each patient care service area has a defined scope of care document available (see attached).
The scope of care includes:

- the types (such as the most frequent diagnosis) and ages of patients;
- type (s) of services most frequently provided (such as procedures, services, etc.);
- hours of operation and method used for ensuring that the hours of operations meet the needs of the patients to be serviced with regards to availability and the timeliness and the high tech, skills of the care providers that may be expected.

Patient population served
Medicare 37%
Medicaid 40%
Other 23%
Case mix 1.2 on average

Languages of Populations Served:

☐ Hispanic **X Creole** ☐ French Canadian ☐ Other

Clinical Services Provided

X Same Day Surg./Out Pt.	X Med/Surg	X OR
X SICU	X Emergency Department	X PACU
X MICU	X Oncology	X Psych
	X GI	

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Our Mission Statement

"Above all else, we are committed to the care and improvement of human life. In the recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve."

Customer Service

You will come into contact with many customers while working in our facility. It is important to treat each customer with respect and dignity. Our goal is to assure that each patient, family member and visitor feels cared about during his or her stay here. The customer service role is as important as the care you provide.

We recognize and affirm the unique and intrinsic worth of each individual.

We treat all those we serve with compassion and kindness.

We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.

We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

Ethics

We will strive to be honest and forthright and meet the highest ethical standards, especially in the areas of marketing, admission, transfer, discharge billing practices and relationships between its patients and staff, to members of health café providers and payers.

We are committed to a code of ethical business and professional behavior which protects the integrity of clinical decision making, regardless of how the hospital is compensated or shares financial risk with its leaders, managers, clinical staff, and licensed independent practitioners.

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Locations

Area	Location	Telephone Ext.	Hours of Operation
Nursing Office	1st floor 3 story building	371	7A-5P Monday-Friday
Pharmacy	1st floor 3 story building	161	7A-7P
Laboratory	1st floor 3-story building	141	24/7
Cafeteria	1st floor single story building	584 or 576	7A-9A 11P-1P
Central Supply	1st floor supply building	168, 153 or 169	8A-5P M-F on call 24/7
Medical Records	1st floor single story building	173	8A-4P M-F on call after hours and weekends
ER	1st floor 3 story building	199 or 707	24/7

Personnel

Name	Title	Phone Ext.
Laurie Manuel	CNO	**373**
Joan Delafosse	Staffing Coordinator	**371**
Janie Berzas	Educator	**277**
Tony Costa	Risk Manager	**132**
Anita Coker	Infection Control	**293**
Tony Costa	Security	**132**

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GENERAL INFORMATION

CRITERIA	DESCRIPTION
1. Location of parking facilities:	Parking lot on north side of hospital
2. During your first assignment you must follow this procedure:	**You are required to present your license, BLS card, and ACLS/PALS if applicable.** Nursing Administration Office 7A-5P M-F Assigned unit after hours and call supervisor. The required paperwork will be provided at first assignment.
3. The orientation provided by our facility includes:	Report to unit 1 hour prior to shift and charge nurse/designee will orient to unit and complete required paperwork..
4. Returning Agency Personnel are to follow this procedure when reporting to work:	Report to unit assigned. Use your time sheet to clock time in and out. At completion of shift have supervisor sign time sheet and make copy to turn in to Nursing Administration.
5. Shift times are as follows: **You are expected to report on time for scheduled shift. Disciplinary action will be taken for excessive tardiness**	0645-1515 (7-3) 0645-1915 (7A) 1445-2315 (3-11) 2345-0715 (11-7) 1845-0715 (7P) 1045-1915 (11A-7P)
6. Meal and break times are assigned as follows:	Meals and Breaks are assigned per charge nurse.
7. The procedure for signing & leaving time slips is:	Charge nurse or supervisor must sign time sheet. Give to supervisor
8. Smoking – Our smoke Free Policy prohibits all health care members, customers and visitors from smoking in the workplace. Designated areas for smoking are located:	All smoking areas are located outside the facility in following locations: Courtyard Doctor's parking area Area between main entrance and Women's Pavilion.
9. You are required to present a clean, neat professional appearance.	

10. Unit/Pt assignments will be based on the documented qualifications and competencies of the nurse and the needs of the patient.	Nursing personnel will be assigned duties within their scope of practice and responsibility **You may be assigned unit responsibilities including but not limited to glucometer quality control, code cart check , etc. during your shift.
11. Our Nursing Care delivery System is:	Team
12. The following Patient Care Protocols are available to assist you in delivering care:	High Risk Fall, decubitus Pneumonia/Flu, MRSA
13. The Policy & Procedures are located:	Policies are located in manuals on each nursing unit.
14. The procedure for locating patient supplies & ensuring charges is:	Patient supplies are located on each nursing unit in storage areas and PAR closets. Charges are by Accudose and sticker system.
15.. Agency RN's are responsible for the following Order Transcriptions:	Signing off physician orders for shift Order Entry and 24 hour chart check
16. Infection Control:	Standard Precautions are used for all patients Refer to Infection Control Manual for specifics procedures of various ordered isolations Utilize personal protective equipment where there is potential for exposure of blood or infectious body fluids Scrupulous hand washing technique Utilize designated containers for disposal of sharps and biohazardous.
17. The following is utilized for conflict resolution occurring in the patient care setting.	Initiate chain of command as follows: Charge RN Shift Supervisor Unit Manager/Director CNO
18. Occurrence Reporting should be completed within 24 hours of any incident involving:	**Injury** to patient, visitor or employee **Patient falls**, **Errors** in medication administration, treatments tests etc, pt signing out **AMA,** theft, loss or damage to property or equipment belonging to any personnel, pt/family, employee or facility
19. The procedure for Incident Reporting is:	Reported per Meditech Notify: Supervisor and if patient occurrence notify family and physician

20. Performance Evaluation: An agency evaluation will be provided to your company. This should be presented to the appropriate personnel at the facility by the employee: *During first shift worked *Annually The employee will obtain the completed form from the facility and forwarded to AAS for file or ask the facility to forward a copy to AAS.	None
21. Floating: The AAS policy is that you will be expected to float to compatible areas within the hospital according to patient care needs and by your documented competency.	
22. Cancellations: Please notify your agency **as soon as possible** if you need to cancel a scheduled shift to allow time to obtain a replacement.	You have 2 hours prior to start of shift to cancel or be Canceled. Disciplinary action will be taken for late call -ins or excessive cancellation.
23.If you are injured on the job you must notify **your agency**. The procedure for the facility includes:	Complete occurrence report in Meditech and notify supervisor. Emergencies will go to ER immediately. Occurrence reports are forwarded to injury coordinator-

EMERGENCY CODES AND OTHER SAFETY REMINDERS

For all Codes See Emergency Preparedness Guide (red book located at each nurses station)

CODES	DEFINITION	PROCEDURE
Code Red	Fire	RACE and PASS
Code Blue	Cardiopulmonary Arrest	**Dial** 505 to notify PBX. Code Team available in facility ☐Yes ☐No (Insert here any hospital specific practice)
Code Blue	Pediatric Cardiac Arrest	**Dial** 505 to notify PBX. Code Team available in facility ☐Yes ☐No (Insert here any hospital specific practice)

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Code Orange	Chemical Spill	See Emergency Preparedness Guide (Red Book kept at each nursing station) Call ext 153 and 188. Obtain copy of MSDS. Each unit has book and ER has master MSDS book.
Code Yellow	Disaster	See Emergency Preparedness Guide
Code White	Combative Situation	Dial 121 and advise operator of location. Operator will announce code white and location. Safety and alerted personnel will respond and use hospital approved Non Violent Crisis Intervention Management techniques to assist staff in controlling situation.
Code Black	Bomb Threat	Stay calm and keep person on phone. Have another person call 911. Also call ext 121 to report bomb threat and notify supervisor.
Code Pink	Infant Abduction	See Emergency Preparedness guide
Code Yellow- Delta	Bioterrorism Event	See Emergency Preparedness Guide
Code Yellow -MCI	Mass Casualty Event	See Emergency Preparedness Guide
Code Gray	Severe Weather	See Emergency Preparedness Guide

SAFETY REMINDERS

WHEN YOU DISCOVER A FIRE

R	Rescue	Anyone in danger.
A	Alert	Activate Fire Alarm and dial extension 22
C	Contain	The Fire, close doors
E	Extinguish	The fire if possible

WHEN YOU FIGHT THE FIRE (using Fire Extinguisher)

P	Pull the Pin Out	Twist the Plastic Pin Holder
A	Aim	At the base of the Fire
S	Squeeze	The handle to discharge Agent
S	Sweep	From Side to Side

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DOCUMENTATION FORMAT

Insert in Designated Column the Format Used (see samples)

Areas	MEDITECH	PAPER	COMMENTS/OTHER
ICU	admission, Care Plan, ssessments/notes eMAR, Order entry	MRSA Screening Form	
Med Surg	Admissions, assessments, care plans, notes, Order Entry, EMAR	MRSA Screening Form	
Pediatrics	Same as Med/Surg	Same as Med/Surg	
PACU	Assessments, care plans, notes, order entry	MAR	
Emergency		All documentation on paper.	
Other: Rehab	Checklist on rehab on what to document on Meditech	Rehab documentation is all on paper.	

STANDARDS OF CARE/PRACTICE

ASSESSMENT/ REASSESSMENT

1. **Assessments are to be completed in the following time frames by the RN**

Area	Initial admission assessment completion time frame.	Reassessment time frame
ICU		Q 2 hr and prn
Med/Surg	**Within 8 hours**	**Q12H and prn**
Pediatrics	**Within 8 hours**	**Q12H and prn**
Emergency	**Triage is timely and consistent.**	**prn**
PACU	**On admission**	**Q15 minutes and prn**
Rehab	**Within 8 hours**	**Q 12 hours and prn**

2. Assessment for admission will include biophysical needs, safety needs, psychosocial, self care, educational and discharge needs. A physical assessment and a history will be completed.

3. The assessment will be utilized to initiate the plan of care incorporating input from patient, family and other disciplines as needed. The Care Plan will be updated as condition/needs change and as per hospital policy.
4. Nursing will provide each patient with appropriate assistance.
5. Nursing will promptly and accurately follow through on medical and nursing orders
6. The nurse will continually evaluate changes in patient condition and response to treatment and notify the physician of same.
7. Reassessment of needs will continue throughout the patient's length of stay.

CARE PLANS

1. The **RN** is responsible for **generating** the Care Plan on admission, **reviewing, updating** and **evaluating** each actual problem every 24 hours.	Care plan requires collaboration with all disciplines involved in the care of the patient.
2. The Care Plan for documentation is located:	On Meditech
3. The requirements for documenting on the Care Plan include:	☐ Meditech – if last documented time of care plan review showing on the process screen is > 24 hours, must be reviewed/updated during your shift and prn.

PATIENT FAMILY EDUCATION

1. It is the responsibility of each nurse to Document Education provided to PT/Family as indicated	**The Education Assessment form will be completed upon admission by the RN.** The patient/family can expect to be provided with education/knowledge regarding **New Medications, Food & Drug Interactions, Disease Process, Medical/Surgical Procedures, Equipment , Discharge Planning.**
2. The Procedure to document Patient Education in Meditech is: ☐ NA	Meditech (Under interventions) 1. Scroll down under the header pt/family education 2. Highlight. 3. Enter DI, complete form choosing from list or entering a narrative to describe content of your teaching.
3. The Procedure for documentation of Patient Education on paper is: ☐ NA	Pre-op/Post-op teaching form.
4. The format for educating patients on new medications is:	Notify pharmacist or go to Clinical Pharmacy on PC OT choose drug data on EMAR screen

5. Education Resource information for PT/family is located	Some brochures, handouts on unit. Others can be obtained through Education department during business hours. Food and drug brochures are located in pharmacy.

ADMINISTRATION OF MEDICATIONS

1. Allergies and weights must be communicated per policy to pharmacy prior to filling of order.	Pharmacy will only dispense a medication after receiving a copy of the physician's order. Orders are faxed to pharmacy. After Faxing, they are stamped FAXED
2. Nurses signing off the physician's order must acknowledge medications in EMAR.	Transcriptions are to include ALLERGIES, name, strength, route, frequency and time of medication. (insert any other info)
3. Nurses must administer medications through the EMAR system. Patient and medications must be scanned prior to administration.	Military time is used. The approved medication frequency schedule is as follows: Daily: 0900 Q8 hr :9A-5P-1A Bid : 9 -5 Q12hr: 9-9 Tid : 9-1-5 HS 9P : Qid : 9-1-5-9 ac: 7-11-5 Q 4h: 7-11-5-9-7-11-5-9 pc : 9-1-6 Q6h :12-6-12-6
4. The procedure for routine checking MARS each shift prior to administration of medications is:	24-hr chart check. Done on 11P-7A shift. Nurse does chart check and signs off chart, dates and times.
5. The procedure for reconciliation of the MAR is:	Pharmacy delivery time: 8PM Shift responsible: 11P-7A **Procedure**: 24 hour chart check
6. The procedure for resolving / communicating to pharmacy any MAR discrepancies:	Copy of order sent to pharmacy.
7. The automated system utilized for medication is: Patients routine Stock Narcotics	McKesson Accudose
8. Agency employees needing an access code to the automated system will:	Contact Janie Berzas ext 277.

9. The procedures for obtaining a missing medication from pharmacy is:	Contact pharmacy or after hours the night supervisor.
10. The procedure for reporting a medication error is:	Complete Occurrence report in Meditech. Notify Physician and supervisor. Forward report to risk manager and department manager.
11. Unless ordered otherwise, daily oral Anticoagulants are given :	0900
12. Heparin Administration Requires:	Protocol used
13. TPN/Lipid standard hanging time is:	0900
15. Any patient having an **adverse drug reaction must be reported as follows:**	Notify physician, complete adverse drug reaction form, forward to and notify pharmacy. Document in patient record
16. Food supplements are entered on the MAR	

IV THERAPY

1. IV SITE CARE /SITE CHANGE per policy is:	Chart under interventions in Meditech. Change bag every 24 hours. Change site every 96 hours unless contraindicated. Change primary tubing every 96 hours. Check site Q shift and prn.
2. IV tubing change per policy is:	Change primary tubing every 96 hours.
3. IV fluids are documented as follows:	emar, and in Meditech under the appropriate intervention.
4. The procedure for adding IV admixtures to fluids & giving piggy backs is:	Pharmacy mixes all IVPBs.

PHLEBOTOMY

1. Phlebotomy is performed by lab	RNs access mediports otherwise phlebotomy is performed by Lab Personnel

SPECIMEN COLLECTION/LABELING/TRANSPORTING

1. Specimens to be collected during your shift are identified by:	Listed on Kardex from checking orders during shift.,
2. Each Meditech Label must be checked to the patients armband prior to obtaining any Specimen:	All labeling is completed at the patient's bedside at the time of specimen collection. Labels applied to specimens and sent with specimens must include **clearly CSS___ ___ ___** (your 3 initials assigned by AAS) **the date and time**. Specimens are to then be placed in specimen bags for delivery.
3. The documentation of "collection of specimen "in the Meditech system is performed by:	Nursing
4. The responsibility/procedure to transport collected specimens to the lab is:	Nursing

BLOOD/BLOOD PRODUCT ADMINISTRATION

1. Patient consent is required prior to transfusion of blood/ blood products and remains valid throughout hospitalization.	**Patients receiving blood require this check and procedure to hang:** The lab comes to the patient's room and applies BB bracelet. The RN does not go get the blood until the patient has a BB bracelet. Two licensed personnel; one must be RN, check order, the blood/blood products to lab slip and to BB bracelet. Final check is done in patient's room.
2. Assessment of patient vital signs for transfusion is:	Prior to start and 15 minutes after initiation and post transfusion.
3. The following personnel may obtain blood products from the blood bank with proper patient identification:	RN or LPN, Chart is **presented** for patient ID to the lab.
4. Some important criteria to be followed for transfusions includes:	18 guage intracath preferred. IV started with NS. Use infusion pump Blood warmer if ordered obtained from OR or ICU, Filters for platelets obtained from Accudose Blood tubing to be used for only up to 2 units.
5. The format for documentation of a transfusion is: **A Blood transfusion (unit) will have a 4 hour infusion limit although 2 hour is preferred unless otherwise ordered by a physician.**	Meditech , fill out lab blood slip & in notes whatever applies

6. If a blood transfusion reaction is suspected or evident, the following procedure is to be followed:	**STOP THE TRANSFUSION IMMEDIATELY** Notify the Physician Keep IV open with NS At bedside check all labels, forms, and pt ID. Report suspected reaction to lab so blood samples can be drawn. In Meditech, it is ordered as Transfusion Reaction Workup. Collect urine sample ASAP order as Transfusion Reaction Workup. Complete transfusion report form. Keep copy for chart. Send bottom copy to lab along with the d/c bag of blood, the administration set without the needle and the attached IV solutions. .

BEDSIDE GLUCOSE MONITORING

1. The tool utilized for Bedside Glucose monitoring is:	Accu check Advantage
2. The procedure for documenting blood glucose results is:	EMAR – Meditech – Paper Flow Sheet if indicated
3. The procedure when bedside glucose monitoring results are out of range is :	Correlate lab draw

INTAKE & OUTPUT

1. The procedure for documenting I & O is:	Q 12° in Meditech Intervention

DAILY WEIGHTS

Daily Weights are performed:	All pts are weighted on admission unless contraindicated. Daily weights on pts receiving diuretics, are edematous, have ascites, CHF or any disease entity . Pts are weighted before breakfast. 11-7 shift responsible. Document under interventions in Meditech.

CARE OF THE PATIENT GOING FOR A PROCEDURE OR SURGERY.

Pre-op/Pre-Procedure	Complete the checklist which is located in Meditech. Print

	and place on Chart prior to patient leaving for surgery. Ensure that all required tests have been completed, results are on the chart and abnormals have been reported to the physician. Pre-op/procedure orders need to be checked and completed. The consent is signed.
Post-op/Post Procedure	It is your responsibility to review all orders to ensure appropriate Follow-up care and institution of physician orders and changes in medications. Document in Meditech for initial post op care under proper intervention.

REPORTING CHILD/ADULT/ELDERLY/SPOUSE ABUSE

Each staff member has an affirmative duty to report any actual or suspected case of child/adult/elderly abuse or neglect.	Contact Social Services/Case manager

PATIENT RIGHTS

All patients can expect to receive consideration for respectful care, privacy, confidentiality, dignity and continuity of care.	The nurse will provide respectful care to the patient and his/her significant others while maintaining confidentiality.
DNR A physician's order is required. Complete all required forms per hospital policy.	Advance Directives information given to patient or if patient incapacitated to person with Durable Power of Attorney.
Patients and/or significant others will be given written information on Advanced Directives upon admission.	A copy of the Living Will, Durable Power of Attorney and/or Health Care Surrogate Designation must become part of the patient's medical record. **You are responsible to follow through and ensure the documents are obtained and placed in the medical record if you ascertain during your Admission History that documents have been enforced prior to admission**
When the patient does not speak or understand the predominant language, he/she will have access to and interpreter:. The process to obtain an interpreter is:	Language line is available. Kept in ER.

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PAIN MANAGEMENT

1. An assessment of Pain will be completed on admission following this format:	Meditech in Admission System Assessment
2. An ongoing assessment of pain and management will continue throughout the patient's hospital stay following this format:	Use scale provide in Meditech (1-10). Use Meditech intervention meds PRN effectiveness.
3. Patients response to pain following intervention must be documented as follows:	Document response following intervention in Meditech under PRN effectiveness.

PATIENT SAFETY/FALL RISK

1. Nursing staff will assess the patient for safety/fall risk at the time of admission, q2h if indicated by change in condition:	Document in Admission Assessment.
2. Safety rounds are completed and documented as follows:	Document in Meditech under interventions under safety rounds. Q 2 ° if indicated Document in Shift Assessment
2. The following reporting system is used for all patient falls:	Document in Meditech on QM module. Report to nursing supervisor. Document in Meditech under Post Fall Assessment

RESTRAINTS

Patient population (s) or risk factors of those prone to the use of restraints:	Restraint Policy will be attached
Least Restrictive Interventions that are used to eliminate the need for restraints for these patients: (The least restrictive type of restraint that is effective will be used)	One on One
Criteria for the use of restraints:	Safety for behavioral – based criteria

Restraints may only be used upon order from a physician. Continuation of Orders:	And re-ordered Q 24° if continuation occurs and timed for no more than 24° Documentation in Meditech.

STORAGE OF PT BELONGINGS/LOST BELONGININGS

Patient belongings should be sent home when possible. The procedure for storage of personal belongings is:	Form and contain is kept at each nursing unit.
Patient **valuables** should be sent home or given to hospital security. The procedure for securing valuables is:	Notify nursing supervisor, place valuables in security envelope, detach claim stub and attach to patient chart.
Please check all patient rooms carefully prior to discharge to prevent loss of pt items.	If items are found at the bedside, the following should be done: give to patient. If patient has left, notify supervisor.

PATIENT TRANSFERS

The following procedure is followed for transfers within the facility (unit to unit).	Documentation in Meditech, admission office notified, pt transported by bed, stretcher or wheelchair. All pt belonging accompany pt unless pt is going to ICU. Then they are given to family or locked up. company patient, etc.
Transfers from facility to facility require the following :	The hospital abides by the EMTALA act (Emergency Medical Treatment and Labor Act). Prior to the transfer of a patient please refer to hospital specific policies and consult with the charge nurse to ensure compliance.

PATIENT DISCHARGES

The following procedure is followed for discharges to a lower level of care: Lower level of care is defined as SNU, ALF, and Nursing Home.	Contact Case Manager for assistance in transports to lower levels of care. They will notify receiving facility and assist in completing forms.
The procedure for discharges to home is as follows:	In Meditech under interventions, complete under discharge planning the discharge summary and the discharge instructions. Print two copies. Give the instructions to patient and family. Assure understanding and have pt sign one form to be placed on chart. Pt keeps a copy. Follow-up office appoints are made and documented on discharge

	instructions. Patient is provided prescriptions or prescriptions are faxed to pharmacy of patient's choice. Nursing staff or Volunteers take patient out to his/her car at main entrance by wheelchair.

Savoy Medical Center
General Orientation
Agency Staff

ACKNOWLEDGEMENT:

I acknowledge that I have received training as stated above and have been given the opportunity to have my questions answered.

Name (please print) _____

Name (signature) _____ Date _____