Welcome to Thomas Jefferson University Hospital Department of Nursing Online Pool Orientation

In order to prepare you for your professional nurse orientation class you are required to complete the following before participating with any onsite orientation:

Read this curriculum and watch all required videos.
Register and complete both Pool Nurse post-tests.
A passing grade of 80% or higher is required.
Complete all HealthStream modules prior to attending Nursing Orientation class.

Purpose

Our online curriculum is meant to provide you with a foundation supplemented by classroom orientation for service, safety, and practice initiatives as a staff nurse at Thomas Jefferson University Hospital (TJUH). As a Magnet – designated facility we emphasize our Professional Practice Model as well as Nursing Department and hospital performance improvement activities.

Thomas Jefferson University Hospital Mission Statement

Thomas Jefferson University Hospitals are dedicated to improving the health of the communities we serve.

- We are committed to setting the standard for excellence in the delivery of patient care, patient safety, and the quality of the healthcare experience
- Providing exemplary clinical settings for educating the healthcare delivery professionals who will form the collaborative healthcare delivery team of tomorrow
- Leading in the introduction of innovative methodologies for healthcare delivery and quality improvement
Our Values

We live by certain values at Jefferson Hospital, and these values shape and influence all of our decisions and actions. These values are:

I) Innovation: Renew, change or create ideas, services, technologies and/or ways of doing things that provide organizational value.

S) Service Excellence: Provide exceptional experience to our customers, including students, alumni, benefactors, clinicians, patients, families and fellow employees.

C) Collaboration: Work effectively with others across the Jefferson community to achieve a common purpose and create value.

O) Ownership: Take responsibility for achieving excellent results.

R) Respect: Demonstrate a consistently open-minded, courteous and compassionate approach to all.

E) Empowerment: Take action to control work and decision making to affective positive outcomes.

Department of Nursing Mission, Vision and Philosophy

Mission

The Department of Nursing at TJUH shares the organization's dedication to improving the health of our patients and communities by delivering excellence in patient care and providing exemplary clinical settings for educating health professionals. Nurses play a pivotal role in fulfilling Jefferson's goal to provide safe, compassionate, efficient, affordable, and high quality health care. We continually seek to improve nursing care delivery through research and evidence-based practice. Jefferson nurses serve as role models and teachers for students and other health professionals.

Vision

Members of the Department of Nursing achieve the mission by providing state-of-the-art care to all patients and their families based on our shared values of excellence, innovation, integrity, respect, caring with compassion, teamwork and communication. These values
will be evident in everything we do and say. The Department of Nursing creates an environment that fosters the pursuit of knowledge, continuous improvement, interdisciplinary collaboration, and professionalism. Although patients choose Jefferson for our advanced medicine and clinical excellence, they will remember the compassion, respect, and outstanding nursing care they receive.

Philosophy of Nursing

Our patients are the focal point of all we do. We respect the inherent dignity and uniqueness of every individual without regard to social or economic status, lifestyle, or the nature of existing health problems. Using the nursing process as a framework, we coordinate an interdisciplinary plan of care that reflects sensitivity to the patient's developmental stage, spiritual beliefs, and cultural value system. Nurses serve as teachers, and routinely advocate to safeguard the health, safety, privacy, and rights of our patients and their families. We view patients as active participants in their care and we respect their right to set their own goals for promoting or restoring health, or experiencing a peaceful death.

We believe that nursing is an art and a science -- a dynamic and continually evolving profession. Nursing practice responds to changes in technology, regulatory requirements, and society but always remains grounded in empathy, competence, and knowledge. Validation of the knowledge base for nursing occurs through research, evidence-based practice, and critical analysis. The decisions and actions of the professional nurse fall within the legal scope of practice and the professional code of ethics. Jefferson nurses promote the professional image of nursing through their compassion and clinical expertise. We demonstrate our commitment to promoting the health of our communities by participating in health education, screening, and support groups.

Jefferson nurses embrace lifelong learning. We accept responsibility to ensure our own competence and professional growth through ongoing education. The Department of Nursing facilitates nursing education by offering a broad array of continuing education courses and by providing financial support for external professional conferences. Jefferson nurses serve as role models and mentors to nursing students and to our colleagues. We seek proficiency for ourselves and support our colleagues through the progression of professional growth from novice to expert.

Our commitment to building a highly skilled professional nursing staff hinges on our ability to identify and attract individuals who are inquisitive, innovative, and adaptable traits we associate with successful nurses. In keeping with this belief, the Department of Nursing makes the Recruitment and Retention program a top-level priority. Key elements of our Recruitment and Retention effort include maintaining strong relationships with our academic partners, promoting professional development and career advancement, and recognizing excellence among the staff.
The Department of Nursing works collaboratively with other hospital departments to ensure high quality patient care in a safe environment for both the patient and the nurse. The department vigorously promotes the use of information technology to enhance safety and to support data-driven management and clinical decision-making. The Department of Nursing uses feedback from patient satisfaction surveys and performance improvement activities to evaluate our services and to promote innovative improvement in our patient care delivery. We believe that an organizational structure built on shared governance, professional peer review, interdisciplinary collaboration, standards of care and practice empowers nurses and contributes to optimal patient care outcomes.

Magnet Designation

TJUH received its second ANCC Magnet recognition in 2013. This designation recognizes excellence in nursing; it is the highest award given to hospitals for nursing excellence. Less than 7% of hospitals in the U.S. have achieved this designation.

The Magnet Recognition Program is a framework for organizing nursing practice around five key components: Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovations, & Improvement, and Empirical Outcomes. The components focus on establishing effective structures and processes that produce exemplary results, reflecting the reality of nursing’s impact and ability to influence patient outcomes. Empirical outcomes are required to be demonstrated in each of the other four categories; it is not a component in and of itself. This new design is developed to encourage nurses to ask the burning questions, the “so what” of their activities; what differences have been made as a result of the interventions, activities, and committee work conducted by MAGNET nurses?

Organizing around the Magnet standards provide support for excellence in practice and helps us critically evaluate the structures we have in place to encourage staff nurse involvement in decision making, autonomous practice, and research. Furthermore, it exemplifies that we foster an environment that promotes collaboration, a focus on advancing nursing through certification and continuing education.

Here at TJUH, we have a flat organizational structure which empowers nurses to become involved in leadership roles to improve nursing practice and patient outcomes. We have three Staff Nurse Leadership Groups: Professional Development, Quality, Safety and Outcomes, and Evidence Based Practice and Research. In addition, we have seven Resource Groups: Multicultural, Diabetes, Pain, Infection Control, Falls, Dermal Defense, and Nursing Informatics. There are members of these committees on each unit.

To ensure we critically examine the outcomes of the work we are doing requires a team approach. Every unit has a Nursing Dashboard which is a graphical depiction of the trends in quality of care provided on that unit. We are committed to continuous improvement and everyone working on the unit is a critical member of that improvement process. While you are here at Jefferson, please take time to learn what the priorities are on the unit you are
working on, how you contribute to the action plans for improvement, and take pride in contributing to our quest for excellence as we sustain the Magnet Culture!

Customer Service

In keeping with TJUH mission, vision and values, the hospital places the needs of patients above all else. Customer service is a key element for success in all businesses, including healthcare providers. Outstanding service is our goal to all of our customers, both internal and external.

TJUH customer service standards include:

- Greet each customer using an appropriate friendly and courteous manner.
- Demonstrate active listening skills.
- Speak and respond to customers in a calm, respectful manner.
- Demonstrate to customers the knowledge of the TJUH systems and services. Maintain strict confidentiality regarding patients and all other confidential information.
- Serve as a role model to other employees.
- Seek mutual resolution to conflict situations, using problem solving techniques.
- Strive to maintain positive working relationships throughout the Hospital.

We encourage you to show a positive, effective attitude when dealing with customers. Below are communication guidelines on how to achieve this.

Hello/Goodbye and AIDET

To assist in communication and relationship building, a powerful framework, AIDET, is recommended.

The AIDET acronym stands for:

Acknowledge; Introduce; Duration; Explanation and Thank you

Communicate in a friendly manner.

Promptly welcome your customers in a warm, friendly manner. Introduce yourself by using your name and by asking, “How may I help you?”

Within 10 feet of encountering any individual, look up, make eye contact, and smile
Within 5 feet of encountering that same individual, continue eye contact, and smile and acknowledge with a friendly greeting (hello, good morning, welcome to Jefferson, etc.)

Each last encounter with an individual should be demonstrated by making eye contact, smiling, and acknowledging the person’s departure with a kind send-off (“Good bye” or “Thank you for choosing Jefferson”)

We use AIDET to reduce a patient’s and family’s anxiety. AIDET is used to help eliminate the unknown for our patients. AIDET lets the patient know “why” you’re doing something – by answering the “why,” you demonstrate you care. AIDET uses key words at key times. AIDET is patient-focused; it allows us to treat patients the way we would want to be treated.

**BY USING AIDET:**

Patients will be satisfied

Physician will be satisfied because their patients are

Patients will be more engaged and clinical outcomes will improve

**Acknowledge**

When beginning the initial interactions with a patient and families and other health care team members, greet them, use eye contact, smile, and speak to them as if you were expecting them. Show them they are important. Example: “Hello Mrs. Johnson”

Knock before entering room. “May I come in Miss Young?” Greet with a Smile, “Good morning/Good afternoon, how can I help you today?”

**Introduce**

By providing information about yourself and other team members, you help patients and families to get to know you and the care team, which will reduce anxiety.

**Duration**

- Give the patient and family an estimate of how long the planned task or process will take.
- Explain the timeframe of procedures, the anticipated duration of waits and update patients if the timing changes.
- This helps patients and families manage their expectations as it pertains to time.

**Education**
Remember, what’s routine for you is not routine for the patient.
Our goal is to keep the patients and families informed. Give a clear explanation for all the things that you are doing.

Information helps to decrease anxiety. For example, explain why you are drawing blood and what should be expected when the test is complete.

Thank you

Take time to thank patients and families. Thank them for using our facilities, for their patience, for allowing you to care for them, etc. Ask if there is anything else you can do for them before ending the interaction.

Resources for customer service issues are: Unit Charge nurse, Nurse Manager, Nursing Supervisors, and Patient Services at X5-7777.

Security

For general information, you may contact the Security office at 5-8888. In case of an emergency, call Security at 811. The security staff on duty will respond immediately to the call. At MHD the Security Office extension is 9238, and in case of emergencies call Security at 77.

The Security Services department employs full time, professionally trained security officers. Officers are on duty 24 hours a day, 7 days a week, every day of the year. They patrol inside and outside the Hospital.

Codes and Conditions

**Code Blue** (Inpatient areas Only): is a cardiac or respiratory arrest. Determine unresponsiveness, Dial “123”, give location (building, unit, room number). Take interim actions as appropriate (ie: CPR). At MHD dial “77”

**RRT** (Rapid Response Team): is a condition in which the patient’s cardiac, respiratory, or neurologic system changes or deteriorates. TJUH : Dial “5-6074” to initiate an RRT, at JHN dial 3-9999, and at MHD dial “77”

**Code Red** : is a condition in which fire, flames, or smoke is seen. Implement RACE acronym. Pull the nearest fire alarm box and dial “811”.

**Code I** : is a missing child or infant abduction. Notify Security by dialing phone extension “811”. Give a description of the abductor, child and or infant and provide the direction that the abductor took when leaving the area/building.
Patient Services Department

**Interpreter Phone Information**: Each nursing unit has an interpreter phone. The phone location and how to use the phone should be reviewed on the nursing unit. To request an in-person language interpreter call Patient Services at EXT. 5-7777, and at MHD call Joan Jurek at Ext. 9987.

Additional information regarding Interpreter services can be accessed through the TJUH Intranet/Clinician tab found under the Policies and Procedures section. 

*Review Hospital Policy: 112.11 Interpretation services for non-English Speaking and Hearing-Impaired Patients* for additional information.

You have a big role to play when it comes to creating an environment that demonstrates respect and sensitivity toward other cultures. It is the policy of TJUH to respect the cultural and ethnic needs and desires of the patients that we serve is at all possible.

This may include:

- Respect the patient’s beliefs regarding the origin of illness
- Provide kosher or vegetarian meals / respecting dietary restrictions
- Providing alternatives such as electric candles for rituals since actual candles cannot be used within the hospitals
- Provide an interpreter so that the patient can participate in decisions regarding care.

Contact the Patient Services Department at 5-7777, or the Nursing Supervisor, or visit the Multicultural Resource Group on the nursing intranet site when on campus for information and assistance on issues of cultural diversity.

**Suspected Abuse, Neglect, Violence, and Exploitation Assessment**

Population Specific considerations should also be utilized for patients when there is suspected abuse or neglect. Thomas Jefferson University Hospital policy 113.34 supports licensed health care providers in directing them to “identify, document and when appropriate report suspected cases of physical, sexual, domestic, child and elder abuse.” Similarly, *Policy 113.12 SUSPECTED ABUSE, NEGLECT, DOMESTIC VIOLENCE OR.pdf* has a list of “Criteria for Identifying Victims of Abuse, Neglect, Domestic Violence or Exploitation” and *Appendix 2 of that same policy* provides an “Age Appropriate Abuse Screening Tool.” This tool provides the health care provider with sample inquiries that facilitate the assessment and plan of care for an individual who is suspected of being abused or neglected.
Social Media Policy

This policy addresses the use of social media such as blogging, twittering, social networking, WIKIs, and websites while at work/school as well as away from work/school. Click here to review the Social Media policy number 102.63.

Hospital and Nursing Policies/Procedures

Safe practice depends on referencing hospital and nursing policies and procedures.

You can access online policies and procedures via the TJUH Intranet. Click on the “Clinician” or “Administration” tab (figure 1) at the top of the screen to access these resources.

Environment of Care

Smoking within Jefferson buildings and designated outside areas, including all building entrances is prohibited.

Handling Sharps Safely

The primary prevention technology used in the hospital includes: needle free access valve, needle free IV and phlebotomy products, needle free drug delivery products, and needle free filled syringes.

It is important to protect the health of the healthcare providers but, in the event of a needle stick or other blood and body fluid exposure, follow the procedure listed below to decrease the provider’s risk of exposure to disease that can be acquired.

- Never recap used needles by hand. If needles must be recapped use one handed scoop method or recapping device (activate protective covering).
- Do not bend or break needles.
- Keep used sharps separate from other items such as gauze and alcohol wipes.
- Always point a used sharp away from your body.
- If assisting with a procedure always be aware of where the sharp is being placed.
• Never clean up broken glass by hand.
• Dispose of used needles, lancets, blades, and other sharps into a designated sharps container.
• Never discard a sharp into a plastic trash bag.
• Do not overfill a sharps container. If it appears to be over \( \frac{2}{3} \) full, notify Environmental Services Center City Campus/JHN dial extension 503-6260, and at MHD dial extension 1300.
• Do not open, reach into, empty, or clean a sharps container.
• When using sharps remember to activate the protective cover. If you are not familiar with safety product, ask for assistance.

If you receive a puncture by a needlestick or sharp instrument, or if you are splashed with someone’s blood or body fluid, you run the risk of exposure to any of the following bloodborne pathogens: HIV, hepatitis C, or hepatitis B.

Needlestick injuries are most likely to occur when caregivers are disposing of sharp instruments, gathering materials during patient care and treatment, administering a procedure to a patient, processing specimens, or collecting trash and linens.

The launch of a new Jefferson website for needlestick safety identifies the proper steps to take if you are accidentally injured:

1. Wash the exposed area with soap and water. Do not use bleach.
2. If fluid splashed in your eyes, remove your contacts immediately. Rinse with tap water or with sterile saline for 15 minutes.
3. If fluid splashed into your mouth, rinse your mouth thoroughly with tap water.
4. Advise your supervisor that you have been exposed.
5. Complete an accident report and have your supervisor sign it, if possible.
6. Report to University Health Services (UHS) at 833 Chestnut Street, Suite 205, or, if UHS is closed, to the TJUH Emergency Department as soon as possible. Methodist Hospital Division (MHD) employees should report to Healthmark or to the MHD Emergency Department after hours. Do not wait until the end of your shift. If antiviral medication is required, the CDC recommends taking the initial dose within two (2) hours of the exposure for the most effective treatment.
7. Identify your patient’s name, medical record number, and the name of the attending physician of the patient. The patient will be referred to as the “source patient.”
8. UHS will contact the physician to order the appropriate testing of the source patient once you have reported the exposure within 72 hours; the exposure has been determined to be significant; and you have undergone testing for HIV. Testing a patient without reporting the exposure is against TJUH policy and is not in accordance with Pennsylvania Act 148, the Confidentiality of HIV-Related Information Act.

**NOTE:** If HIV prophylaxis is indicated it should be started as soon as possible after the
exposure. The ideal is within 2 hours but can be started up to 24 hours post exposure.

**Event Reporting-Patient Safety Net**

All employees and staff members are responsible for promptly reporting any event involving a patient or visitor (as soon as possible following its occurrence, but not later than 24 hours). The person who witnessed or discovered the event, or to whom it is reported (i.e., supervisor) is responsible for initiating the event report and notifying the appropriate staff, such as the attending physician, nursing supervisor, or department head.

Electronic Reporting: TJUH utilizes web-based electronic reporting through the Patient Safety Net (PSN). The PSN may be accessed through the TJUH Intranet Home Page, either under the Administration, Clinician, or Emergency/Safety tabs by selecting the Event Reporting (PSN) link.

All required fields must be completed as directed. The reporter should provide a brief, complete and accurate description of how the event occurred, including only facts witnessed by or related to the reporter. Pertinent statements made by the patient, family or visitor may be included in quotes. The report should not include any information identifying patients, or blaming staff for the outcome. Reports are not punitive. Event reports are forwarded electronically to the appropriate managers for review, investigation and action.

**Joint Commission National Patient Safety Goals**

**Improve the accuracy of patient identification**

TJUH requires the use of two identifiers whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatment or procedures. These two identifiers are specifically the Name and Birth Date. All patients must have a TJUH ID bracelet.

**Improve the effectiveness of communication among caregivers**

TJUH has a standardized list of abbreviations and also a list of “Do Not Use Abbreviations” posted on each clinical unit.

Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.

TJUH uses many opportunities for hand–off communication. These include: shift report, rounding, white boards in patient rooms, critical value test result reports, Transfer and Discharge Summary, Interdisciplinary Plan of Care, and trip slips. A trip slip is a card that is used when transferring a patient off the unit for testing or to another unit. It contains priority information to communicate to the next health care team member such as falls risk, activity, types and locations of tubes and drains and any language preferences. These are used to promote interdepartmental and interdisciplinary communication about patients’ care.

**Use alarms safely**

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

**Improve the Safety of Using Medications**

TJUH has standardized and limited the number of drug concentrations available.

A list of look-alike/sound-alike drugs is available on each nursing unit to prevent errors involving the interchange of these drugs.

Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.

Reduce the likelihood of patient harm associated with use of anticoagulation therapy by using approved orders for initiation and maintenance of therapy, using only oral unit-dose products, prefilled syringes, or premixed infusion bags when available and use programmable pumps for intravenous heparin administration.

Use Carenotes to provide education to patient and family on specific drug therapy. Patient education documentation on the Interdisciplinary Plan of Care is required.

**Reduce the risk of healthcare-associated infections**

TJUH complies with the current Center for Disease Control (CDC) hand hygiene guidelines or World Health Organization guidelines.

TJUH sets goals for improving hand hygiene guidelines.

TJUH implements evidence based practices to prevent health care-associated infections for multidrug resistant organisms, central line bloodstream infections and surgical site infections.
Accurately and completely reconcile medications across the continuum of care

TJUH has a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission. This is with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list, and reconciles during the hospital stay and upon discharge the medication list for patient and family. Medication reconciliation during discharge is facilitated through the patient electronic record (Jeff Chart) by the provider. These instructions are reviewed with the patient and/or family.

A complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

Prevent mistakes in surgery

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body. Mark the correct place on the patient’s body where the surgery is to be done. Pause before the surgery to make sure that a mistake is not being made.

Reduce the risk of patient harm

Falls

TJUH nursing staff assess and reassess each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen, and take action to address any identified risks.

Patients at TJUH are assessed for falls risk daily and on admission. Reassessment takes place also when a patient is transferred to another unit, incurs a fall or has a change in clinical status. Measures are taken to prevent falls by creating a safe environment for patients, using non-slip footwear (yellow) and by utilizing special equipment to prevent falls.

As a result of a Six Sigma project, Jefferson uses a process called “ETAR” to prevent falls.

\[
\begin{align*}
E &= \text{Educate staff and patients} \\
T &= \text{Toilet patients every 2 hours} \\
A &= \text{Alarm: apply Level 2 bed alarm for high risk patients at all times and at bedtime for everyone} \\
R &= \text{Response to emergency call lights is all staff’s responsibility}
\end{align*}
\]
We want to take this opportunity to remind all staff members that they can prevent a patient from falling and becoming seriously injured. If a red flashing light is seen over a patient’s door it means a patient needs immediate help and should not get up without assistance. Any staff member or student should go to the patient’s room and tell the patient not to get up until assistance arrives. This simple action could keep our patients safe.

Hourly rounding on all patients has been implemented to help to decrease falls. Each hour patients are checked for pain, positioning, personal needs and safety needs. Urine output is documented every two hours on the I & O Flowsheet. It is the TJUH expectation that you will actively participate in this safety initiative.

**Pressure Ulcer**

**Skin assessments** and intervention are completed utilizing the Braden Pressure Ulcer Risk Assessment for adults and the pediatric population. Assessments are interventions are documented each shift on Assessment Record 1 in our clinical information system (JeffChart).

**Nurse Sensitive Indicators**

TJUH is strongly committed to exploring ways to improve patient outcomes. We utilize data collected from patients on falls, pressure ulcers, restraints, hospital acquired infections and nurse satisfaction scores and compare TJUH data to other hospitals that are academic medical centers and/or Magnet facilities. This comparison is conducted by using data from the National Database of Nursing Quality Indicators (NDNQI), TJUH develops plans to improve quality of patient care based on this data.

TJUH nursing staff assesses and identifies patients at risk for suicide and takes steps to address patient safety needs and appropriate setting for treatment.

**Universal Protocol for preventing wrong site, wrong procedure, wrong person surgery.**

Wrong site, wrong procedure, wrong person can be prevented. The universal protocol is intended to achieve this goal. The elements of the protocol involve a “pre-operative verification process”, “marking the operative site”, and including a “Time Out” before starting the procedure.

Click here to view form for: Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery

**Patient Education**
CareNotes® System

Jefferson’s primary source for printed patient education materials is CareNotes. The CareNotes System can be accessed via the TJUH Intranet, Clinician page, under ‘Patient Education’. CareNotes provides concise, customizable education materials that address patient condition, treatment, laboratory tests, follow-up care, psychosocial issues, continuing health, and the most frequently administered drugs. The content is available in English and Spanish; some content also available in 13 additional languages. The content is written at a 5-7th grade reading level.

GetWellNetwork

Jefferson University Hospital provides additional opportunities for patient education through the GetWellNetwork. The GetWellNetwork is an on demand interactive tool that offers patients and families educational videos and information about health and illness. This network is available in many patient rooms.

The GetWellNetwork can be used to:

- Learn about procedures and medications
- Communicate with the hospital staff
- Access information about hospital services and facilities
- Provide feedback to staff
- Watch on demand movies
- Email family and friends
- Surf the Intranet

All this can be done right from the television in the patient’s room. The Video library of over 300 vendor and TJUH customized health education videos. You are able to create lists of frequently viewed videos to facilitate on-line ordering (JeffChart) of educational topics for an individual patient.

At our Methodist campus we have TIGR Health TV channel providing pre-programmed educational content via the television in the patient’s room.

Health Literacy

Health literacy is defined in Health People 2010 as: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

Health literacy includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, healthcare providers directions and consent forms and the ability to negotiate complete care systems.
Functional health literacy is the ability to apply reading and numeracy skills in a health care setting.

Health literacy varies by context and setting and is not necessarily related to years of education or general reading ability. The “average” American reads at the 8th or 9th grade level and one out of five American adults reads at the 5th grade level or below; yet most health information is written at a high school level or above. Due to illness, stress, the effects of medication and other factors, a person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment.1

Why does health literacy matter?

- Nearly half the population of the US, approximately 90 million people, have difficulty understanding and using health information2
  - Vulnerable populations include the elderly (age 65+), minority and immigrant populations, those with low income (half read below the fifth-grade reading level), people with chronic mental and/or physical health conditions
- Poor health literacy is a stronger predictor of a person’s health than age, income, employment status, educational level, and race3
- Problems with compliance and medical errors may be based on poor understanding of healthcare information. Only 50% of all patients take medications as directed4
- Low health literacy is consistently linked with more hospitalization; greater use of emergency care; lower use of preventive care such as mammography screening and influenza vaccination; poorer ability to interpret labels and health messages; and, among elderly persons, worse overall health status and higher mortality rates6
- Improving health literacy will help to improve outcomes5

What does health literacy matter to Jefferson!

- Patients need to understand health information and treatment options in order to make informed decision about their care
- Patients who are not able to understand care management instructions may frequent the emergency department and require re-admission to manage their chronic condition
- Inability to manage one’s own healthcare results in excess utilization of costly healthcare products and services and may increase length-of-stay
- Patients who are not able to follow discharge instructions are more likely to relapse and require readmission
- Improving health, one patient at a time, will help us accomplish our mission of improving the health of the communities we serve
• Promoting compliance, self-management, and appropriate use of resources strengthens our connection with our patients and their families.

Good communication between the clinician and the patient/family is an essential component to patient and family education.¹

### Six steps to improving interpersonal communication with patients/families¹

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<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Slow Down</td>
<td>Communication can be improved by speaking slowly, and by spending just a small amount of additional time with each patient. This will help foster a patient-centered approach to the clinician-patient interaction.</td>
</tr>
<tr>
<td>2.</td>
<td>Use plain, nonmedical language</td>
<td>Explain things to patients like you would explain them to your grandmother.</td>
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<td>3.</td>
<td>Show or draw pictures</td>
<td>Visual images can improve the patient’s recall of ideas.</td>
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<td>4.</td>
<td>Limit the amount of information provided—and repeat it</td>
<td>Information is best remembered when it is given in small pieces that are pertinent to the tasks at hand. Repetition further enhances recall.</td>
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<tr>
<td>5.</td>
<td>Use the “teach-back” technique</td>
<td>Confirm that patients understand by asking them to repeat back your instructions.</td>
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<tr>
<td>6.</td>
<td>Create a shame-free environment: Encourage questions</td>
<td>Make patients feel comfortable asking questions. Consider using the Ask-Me-3 program. Enlist the aid of others (patient’s family or friends) to promote understanding.</td>
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### Behaviors that Improve Communication¹

- Use orienting statements: “First I will ask you some questions, and then I will listen to your heart.”
- Ask patients if they have any concerns that have not been addressed.
- Ask patients to explain their understanding of their medical problems or treatments.
- Encourage patients to ask questions.
- Sit rather than stand.
Listen rather than speak.

The Teach Back Method

Teach Back is a simple and effective technique used to assess a patient’s understanding of a concept or topic. Teach Back involves asking patients to explain or demonstrate what they have been told or taught.

Research has shown that Teach Back is effective for improving patient understanding and outcomes. Providers can use teach back to identify patient-specific barriers to communication, for example, low health literacy, cognitive impairments, and limited English proficiency.

You can say to the patient,

“I want you to explain to me how you will take your medication so I can be sure I have explained everything correctly,”

Or

“Please show me how you will use the asthma inhaler, so I can be sure I have given you clear instructions.”

Or

“When you get home your spouse will ask you what the doctor said, what will you tell your spouse?”

DO NOT ask a patient, “Do you understand?” Instead, ask patients to explain or demonstrate how they will undertake a recommended treatment or intervention. Do not ask yes/no questions.

For more than one concept, chunk (teach 2 to 3 main points for the first concept) the information and then check using teach back before moving on to the next concept.

Asking patients to recount instructions can alert you to the individuals’ particular needs and challenges and helps you tailor communication more effectively. If the patient does not explain correctly, assume that you have not provided adequate teaching. Re-teach the information using alternate approaches. You should use teach back as a tool for assessing your own communication skills.

Use clear, straightforward expression—use only as many words as necessary. This will help the patient/caregiver concentrate on the message instead of being distracted by complicated language!

It is important to not appear rushed, annoyed, or bored during these efforts!

Three-Day Integrated Teach Back

It is difficult for patient/caregivers to remember information that they may hear for the first time and/or that is condensed into the day of discharge. Providers need to ask patients/caregivers to teach back answers to a short list of condition-specific questions each day for three days with each daily set of questions focused on a different aspect of self-management: knowledge, attitude, and behavior.

Sample Script

Each day of your stay in the hospital, we will ask you a few questions. Your answers to these questions will help us make sure that WE are doing a good job explaining the
important to you about your medical condition and what you need to do to take care of yourself when you go home. Answer the questions using your own words. You do not need to repeat exactly what you heard us tell you.

Day One: (Assesses knowledge)
1. What is the name of your water pill?
2. Do you have a scale at home? What weight gain should you call your doctor about?
3. What foods should you avoid when you have heart failure?
4. What are your symptoms of heart failure?

Day Two: (Assess attitude)
1. Why is it important to take your medicine for heart failure every day?
2. Why is it important to avoid food with sodium (salt)?
3. Why is it important to watch for the symptoms of heart failure?
4. Why is it important to watch for weight gain?

Day Three: (Assess behavior)
1. How will you remember to take your water pill every day?
2. How do you plan to change to a low sodium (salt) diet?
3. How will you check for heart failure symptoms every day?
4. How will you weigh yourself every day?
Documentation of Patient Education

Interdisciplinary Plan of Care Record (IPOCHG
Patient Education Record

The IPOC helps to facilitate communication between the health care providers and the patient and his or her family. It also serves as the patient education record.

The IPOC helps transition the patient through the continuum of care in a seamless, safe, and effective way by:

- Identifying patient needs, including education, and discharge planning
- Resolving patient issues
- Progressing the patient towards discharge

General Information

The IPOC is a form used by all members of the healthcare team: nursing, PT, OT, nutrition and dietetics, rehab, social work, case management, pastoral care, pharmacy, speech therapy, and respiratory therapy.

This document serves as a centralized collection for collaboration and prioritization of goals and objectives for patient care.

The Interdisciplinary Plan of Care (IPOC) at Center City campus is a paper form that is found in the patient’s chart. It has its own pink chart tab. At Methodist campus the IPOC is in JeffChart.

The IPOC must be initiated by the RN upon completion of the admission history and after performing an initial assessment. It must be initiated within 24 hours of the patient’s admission. The nurse is responsible for prioritizing the goals once a day, on day shift.

Additionally, the IPOC must be revised when:

- The level of care changes.
- There is a major change in the patient’s condition.
- The patient has an extended length of stay in the hospital.

Staff Education

STATREF/ Davis Drug Guide for nurses and Lexicomp provide comprehensive drug information for nursing staff at Jefferson. The current version contains over 4,600 trade
and generic drugs that are up-to-date and practical, and that supply all the information nurses need to safely administer medications.

**Pain Management**

**Philosophy of Pain Management**

At TJUH, we use Margo McCaffrey’s definition of pain: “*Pain is whatever the experiencing person says it is, existing whenever he/she says it does.*” The patient’s self-report of pain is the single most reliable indicator of pain.

**Cultural Considerations in Pain Assessment**

It is important to obtain specific cultural considerations to individualize a patient’s pain management. This can be done by asking the patient if there are cultural considerations he/she would like to incorporate, by using reference materials – such as can be found on the Multicultural Resource Group intranet site for more information.

**Setting a Patient’s Pain Goal**

This is a goal that will enable the patient to participate in normal activity of daily living.

**Pain Scales Used at TJUH**

There are several forms of pain scales in use at Jefferson, based on the patient population. Per hospital policy Pain Assessment 113.30 Use numerical rating scale 0-10 in various language options, Wong-Baker faces, PIPS, CRIES, CHEOPS, NIPS, or behavioral observation checklist for those adult patients who are unable to communicate.

**Numerical Rating Scale from 0 to 10**

This scale is available in multiple languages. Zero indicates the patient does not have any pain. Ten indicates the patient has severe pain.

**Wong – Baker Faces Scale**

Faces are used in this scale to represent a level of pain intensity from 0 to 10. A face with a zero underneath it indicates the patient does not have any pain. A face with a ten underneath it indicated the patient has severe pain.

**PIPP – (Premature Infant Pain Profile)**
The PIPP pain scale is used for infants. It uses gestational age with multiple assessment factors.

**CNPI Scale**

The CNPI scale is a checklist of non–verbal pain indicators used for adult patients who are unable to self-report verbally or with hand gestures. The patient is observed for 3 – 5 minutes to obtain a pain score. A score of 12 is the maximum score in the CNPI scale.

**Frequency of Pain Assessment and Reassessment and Documentation**

A pain assessment is performed and documented upon admission, after any known pain producing event, and with each new patient report of pain, and routinely when vital signs are taken (at least each shift).

**It is important to perform and document a pain reassessment after a pharmacological agent is given and or an intervention (i.e. ice, heat, repositioning) based on the time of onset.**

The pain assessment and reassessment is documented in the clinical information system (JeffChart) on the “Pain Flowsheet”. Information on how to document this information is reviewed in the online computer training video. Please review this carefully.

**Restraints**

A restraint is any involuntary method of restricting an individual's freedom of movement or normal access to his/her body.

Restraints are used for medical-surgical care to control behaviors that are non-violent or non-aggressive in nature. A restraint device may be used to protect the patient from accidental/intentional self-discontinuation of therapeutic interventions (i.e. IV lines, drains, catheters, ventilator, pacemaker, IABP, etc.) when alternative interventions have failed and to promote medical healing. Restraints may also be used when patients are assessed to be at high risk for fall/injury due to impaired sensory or motor function and/or are not cognizant to follow commands and alternatives have failed.

Some examples of restraints used at Jefferson are: Soft belt, Soft Limb, Peek a Boo Mitts, Padded Limb Restraint, and Enclosure Bed. Geri Chairs are used in geriatric psych only.

Before restraints are considered, alternatives to restraints are attempted. This can include examples such as:
Non-physical interventions are the first choice as alternatives to restraint and seclusion, unless safety issues demand an immediate physical response. Interventions to prevent the need for restraint and seclusion address the underlying problem. Alternatives include, but are not limited to:

- modifying the environment to make it safer
- reducing sensory stimulation
- involving the patient in activities of daily living
- moving the patient closer to the nurses’ station for closer observation
- one to one care
- family member at bedside
- providing comfort and relieving pain
- reviewing and assessing the medication profile
- redirecting the patient’s focus
- employing verbal de-escalation
- time-out, less than 30 minutes (behavioral health setting only)

In the event that these alternatives are ineffective, an order for the application of a restraint is obtained from the physician. The order is effective for 24 hours for a non violent justification.

During the time the patient is in the restraint, the patient is assessed every 2 hours for the following elements to ensure that the patient’s safety and health are maintained:

**Document the following items on the Non Behavioral Flowsheet in JeffChart:** Patient's physical needs (release of restraint/ to provide range of motion to restrained limb)
* circulation checks
* elimination
* hydration
* nutrition and hygiene are assessed and addressed at least every two hours while the patient is awake

It is not necessary to wake sleeping patients, however patient needs must be met as soon as possible after the patient awakens. There are several approved sources for patient and family education print and electronic materials.

Note: Patient education materials are meant to provide supplemental information on a disease, condition, test, procedure or medication and are **NOT** a substitute for Physician Discharge Instructions.

Refer to Hospital Policy: Patient Education Plan, #113.14

**Documentation**

**Nursing History Form**
The Nursing Admission History is completed electronically in JeffChart.

The Nursing Admission History is used to obtain pertinent health and social history from patients. **This form is to be completed within 12 hours of the patient’s admission. All sections must be completed. Triggers for consults by Nutrition and Dietetics and Social services occurs automatically as part of the assessment. A MRSA order is automatically placed when identified in this process.**

If the patient is unable to provide information, it is obtained from their families and/or significant others or from previous medical records. Members of the healthcare team utilize data obtained from the Admission History to plan and manage the patient’s care during their hospitalization. The Admission History form was developed to meet standards of care for hospital accreditation and licensure; therefore, it is important that all sections be completed.

**Advance Directives**

An Advance Directive is a written document that states the patient’s direction about healthcare in the event that he or she is no longer able to make their wishes known. This includes a Living Will and/or Durable Power of Attorney for Healthcare. An Advance Directive can be a combination of both documents.

As part of the electronic Nursing Admission History, this section is completed. All adult inpatients are asked if they have an Advance Directive. All adult inpatients shall be provided with written information, which explains Advance Directives and hospital policies on implementing Advance Directives. In the case of unconscious or otherwise incompetent patients, the patient’s surrogate or decision maker shall be asked. This information will be documented in the medical chart.

If the patient has an Advance Directive, the patient/patient surrogate shall be asked to make it available, and a copy shall be placed on the medical record.

**If a copy of the Advance Directive is not produced on admission:**

If the patient wishes to develop a new Advance Directive the nurse contacts the Social Work Department to assist the patient.

If a patient has an Advance Directive, but did not present it on admission, he or she may verbalize the substance of the Advance Directive that will be documented in the medical chart by the physician, and co-signed by the patient when possible.

*If the patient is unconscious or incompetent at the time of admission, and therefore unable to receive information or articulate his/her Advance Directive status, this will be indicated on the nursing admission history. If the patient should become responsive and regain decision-making capacity, an inquiry will be made regarding his/her Advance Directive*
status. This information will be documented in the medical record. The Department of Social Work can provide further information about, or assistance with, executing an Advance Directive.

Focus Note

A focus note is a description of the patient’s experience or potential experience that is the main concern of your nursing care for the day or shift. A focus note is written in a D.A.R. note. (Data, Action, Response)

Focus charting provides a format that is organized, logical and time efficient. The focus, data, action and response are related to one another.

Focus charting supports the analytical basis of the nursing process. It demonstrates your ability to process patient data and evaluate patient response.

Information from clinical information system flow sheets (vital signs, I&O’s, etc.) need not be repeated in the focus note unless it clarifies or substantiates the focus.

Components of Focus Note

1. Date/Hour entry made

2. Focus

This is a sentence or phrase describing what the patient is actually experiencing or has potential for experiencing. It denotes a patient problem or strength on which nursing care will be centered. The focus is often related to the reason for the patient’s hospitalization. More than one focus can be identified when charting, however each focus must have its own, data, action and response.

Data, Action, and Response:

Data – This is the documentation of subjective and objective data, which support the Focus statement.

Action – This summarizes your interventions in response to the patient’s problem or strength. Writing only pertinent interventions related to the focus minimizes double documentation. (All nursing actions are documented on your flowsheets).

Response – The effect of the nursing intervention is documented. The response may be an observation based on your nursing assessment, a patient sign or symptom, a patient’s feedback, a test result, or other data.
The Focus Can Be Derived From Various Sources:

How do the components of Focus Charting relate to the Nursing Process?

Table 1. Comparison Focus charting and Nursing Process

<table>
<thead>
<tr>
<th>Nursing process component</th>
<th>Focus charting component</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Data: Patient behaviors, nursing observation</td>
<td>States having pain, 8 on scale of 1-10</td>
</tr>
<tr>
<td>Planning</td>
<td>Action: Nursing intervention</td>
<td>Pain medication given</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Response: Patient’s response based on nursing assessment or patient feedback</td>
<td>States pain now a 2 on a 1-10 scale.</td>
</tr>
</tbody>
</table>

- Focus notes are written in the paper progress note section of the patient’s chart.
- In general care units, one focus note is required every 24 hours on day shift, and with any event or change in the patient’s condition.
- In critical care units, one focus note is required per shift.

Please review the supplemental documents and related videos and then proceed to the post tests.

Pre-requisites for attending classroom orientation:
Both curriculum Pool Post-Tests must be successfully completed with a passing grade of 80% prior to attending classroom orientation. You are ineligible to attend classroom orientation if you do not obtain a passing grade after two attempts for each post-test. Contact the Nursing Recruitment Office for further instructions.