NURSING EDUCATIONAL BOOKLET
(Quick Guide)

1440 (2019)
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Introduction:

Nursing is both responsive and proactive profession. As nurses, we are sensitive to the changing needs of those for whom we care…

"Education and Training is an ongoing process rather than a single event that occurs at anytime or any place."

Each nursing staff together with his/her manager, is responsible for ongoing achievement of the learning objectives to improve job performance based on Standards of Care.

The purpose of preparing this booklet is to make all the necessary information related to: "The Joint Commission International and CBAHI" demands nurses who are clinically competent and able to provide optimum care, and that requires a quick reference to assist us in making our patient needs.

Nurses can use this booklet as a source as well as a guide for reliable and accessible information on important nursing issues. Also to develop delivery and communication strategies for assuring effective utilization of educational materials.

Who can use this booklet?

All nurses working at AL OMRAN GENERAL Hospital can use this booklet whether you're a new staff, experienced nurse, or a clinical preceptor to help you acquire the necessary information to safely care for patient based on the international standard.

Note:

This booklet is not meant to be as replacement for the detailed policies and procedures.
The Nursing Mission:

To promote special health care to all patients by providing the excellent quality nursing care through the application of National and international Standards which will lead to good satisfaction of patients and community.

The Nursing Vision:

The Nursing Department in AL OMRAN GENERAL Hospital will be the best accredited department that provides the highest quality nursing care in region by the Year 2030 (1450 H).

Values:

- Patient Safety
- Privacy and Confidentiality
- Teamwork
- Commitment
- Innovation
- Integrity
"Six" (6) International Patient Safety Goals:
(Introduced by Joint Commission in 2007 to promote Specific Improvements in Patient Safety)

1. To Identify Patient Correctly
   - Use at least 2 ways to identify a patient during:
     ➢ giving of medications
     ➢ giving blood and blood products
     ➢ taking blood samples
     ➢ taking other samples for clinical testing
     ➢ providing treatment or procedure
   - The two (2) unique Identifiers are:
     ➢ Patient's Medical Record number (MRN)
     ➢ Patient's Full Name
   - The patient's Room Number must never be used to identify patients

2. To Improve Effective Communication
   - Communication can be Verbal, Electronic or Written
   - Staff must use "read back" to verify the complete order or test result in situation like:
     ➢ Verbal Order
     ➢ Telephone Order
     ➢ Reporting of Critical Result value

   Note:
   The Receiver of the information will write down the complete order of test result (or enter into the computer). A colleague will then be requested to read back the written order or test result to the individual who gave the order or test result.

   - The order or test result is confirmed by the individual who gave the order or test result.

3. To Improve Safety of High-Alert Medications
   - Remove concentrated electrolytes from patient care areas except when clinically necessary, this includes but not limited to the following:
     ➢ Potassium Chloride
     ➢ Potassium Phosphate
     ➢ Sodium Chloride > 0.9%
4. Ensure Correct- Site, Correct-Procedure, Correct-Patient Surgery
   - Make sure it is the correct patient using two patient identifiers
   - Verify the correct documents (medical records, consent, radiological images, laboratory results, etc.)
   - Mark the correct site and involve the patient or legal guardian
   - Verify correct equipment and implants, if needed
   - Conduct the "time-out" process, just before the surgery/invasive procedure

5. Reduce the Risk of Health Care Associated Infections (HAI)
   - Hand washing – is a single most important procedure for preventing Nosocomial Infection.

Infection Control Practices to include:
   ➢ Strict hand hygiene (observing "Five" (5) Moments of Hand Hygiene)
     1. Before patient contact
     2. Before an aseptic task
     3. After body fluid exposure risk
     4. After patient contact
     5. After contact with patient surroundings
   ➢ Use of PPE's (Personal Protective Equipment)
     Put on in this order: Hand hygiene, Gown, Mask, Goggles or Face shield, Gloves
     Remove in this order: Gloves, Gown, Face shield or Goggles, Mask, Hand hygiene
   ➢ Use of Aseptic Techniques for all invasive procedures and any procedure requiring asepsis
   ➢ Safe Handling and disposal of sharps
   ➢ Proper handling of contaminated items
   ➢ Respiratory hygiene and cough etiquette/manners (covering nose/mouth when coughing/sneezing, using tissues to maintain respiratory secretions, dispose in nearest waste disposal and perform hand hygiene).
   ➢ Use appropriate color code bags:
     1. Yellow bag: infectious waste, container w/ blood/body fluids that cannot be emptied, all specimens: blood, body fluid, swabs, etc., chemotherapy waste
     2. Black bag: general waste, items NOT moderately or grossly soiled in blood/body fluids.

6. Reduce the Risk of Patient Harm Resulting from Falls
   - Assess each patient's risk for falls
   - Reassess as indicated by patient's change in condition, medication, etc.
   - Take action to decrease or eliminate any identified risks
   - Document all the assessments
Quality Improvement Process

What is Quality?

The clear and comprehensive definition for quality is written by Total Quality Management Experts (TQM). "Doing the right thing right the first time." Standards are created when experts are able to understand what the right things are and how the right things are best achieved.

Methodology:

The Quality Improvement model used in AL OMRAN GENERAL Hospital is FOCUS-PDCA Cycle. This scientific method is employed identifying quality indicators and measuring processes.

The model's name is an acronym that describes the basic components of the improvement process. First, FOCUS on a particular issue. The steps include:

- Find a process to improve
- Organize to improve a process
- Clarify current knowledge of the process
- Understand variation
- Select a process improvement

Then, move through a process improvement plan, PDCA.

- **Plan:** - create a timeline of resources, activities, training and target dates. Develop a data collection plan, the tools for measuring outcomes, and thresholds for determining when targets have been met.
- **Do:** - implement interventions and collect data.
- **Check:** - analyze results of data and evaluate reasons for variation.
- **Act:** - act on what is learned and determine next steps. If the intervention is successful, work to make it part of standard operating procedure. If it is not successful, analyze sources of failure, design new solutions and repeat the PDCA cycle.

Note:

The Performance Improvement (PI) project should begin with FOCUS, if a process already exist. If a process does not exist, begin with PDCA.
Nursing Quality Indicators:

An indicator is a measurable variable/characteristic that can be used to determine the degree of adherence to a standard or achievement of quality goals.

The purpose of indicators is to monitor performance by assessing the degree of discrepancy between actual and expected performance.

The Nursing Department participates in the Hospital-wide QI plan by collecting data, monitoring indicator, analyzing the aggregated data and acting on recommendation for improvement.

Based on Standards, the Essential Nursing Quality Indicators for Monitoring includes but is not limited to the following:

- Medication Error
- Patient Fall
- Pressure Ulcer
- IV Therapy (adherence to policy)
- Hand washing (adherence to policy)
- Nurse's Role in CPR
- Infection Control

Sentinel Event:

Definition: - is an unexpected occurrence involving death or serious physical or psychological injury or the risk there of not related to the natural course of a patient's illness or underlying condition. Physical injury includes loss of limb or function.

(Example of Sentinel Events):

- Suicide
- Homicide
- Surgery on wrong patient or body part
- Impairment (major /permanent loss of bodily function – physical / psychological)
- Unexpected death not related to patients underlying medical condition
- Rape
- Child abduction or discharge to the wrong family
Root Cause Analysis (RCA):

Definition: is a process for identifying the basic or causal factors of an adverse event. Root cause analysis primarily focuses on systems and processes, not individual performance.

How to Conduct a Root Cause Analysis?

➢ Describe the process to conduct a credible root cause analysis.
➢ Explore attitudes regarding the "sharp end" of adverse events.
➢ Given scenarios, will be to go through the process of conducting a credible root cause analysis.

*What happened?*  
- Witnesses
- Physical evidence
- Sketches /
  Photographs
- Records &
  Documentation
- Medical evidence

*How did it happen?*  
- Causal factors
- Focus on Problem-
  Solving not on blame
- System & Process based
- Concentrate on individual.

*Why did it happen?*  
- Findings
- Probable cause
- Judgment of needs

*Recommendations:*  
- If accepted, are appointed a lead implementer.

Occurrence Variance Report (OVR):

An incident may be defined as any event that has caused harm, or has the potential to harm a patient, visitor or staff member, or any event which involves malfunction, damage or loss of equipment or property, and any event which might lead to a complaint.

An OVR / Incident Report should be completed if any of the following occur:

- An error or mistake that injures, or could have injured a patient, employee or visitor.
- Failure or shortage of direct patient care equipment, utility or material that had adverse impact, or could have adverse impact upon patient care outcome.
- An incident that caused an angry reaction by a patient or family member.
- An incident that inhibits a process or system and has an adverse effect upon patient care.
Assessment and Care of Patient:

Patient Assessment – is an ongoing, dynamic process that takes place in many inpatient and outpatient settings, departments and clinics. It consists of three (3) primary processes:

- Collecting information and data on patient's physical, psychological, social status & health history.
- Analyzing the data and information, including the results of laboratory and imaging diagnostic tests, to identify the patient's health care needs.
- Developing a plan of care to meet the patient's identified needs.

Patient assessment is appropriate when it considers the following:

- patient's condition
- age
- health needs
- patient's requests/preferences.

These processes are most effectively carried-out when the various health professionals responsible for the patient "work together".

Care of Patient – is the Health Care organization's main purpose and responding to each patient's unique needs requires a high level of planning and coordination. Certain activities are basic to patient care which may be preventive, palliative, curative or rehabilitative.

These includes:

- Planning and delivering care to each patient
- Monitoring the patient to understand the results of the care
- Modify care when necessary
- Completing the care
- Planning the follow-up
Fall Prevention and Management:

A Fall is an unexpected change in position that causes a person to land on an object on the floor or other lower level (witnessed), or is reported to have landed on the ground (unwitnessed).

When to assess/re-assess patient for fall?

- All patients should be assessed on admission for risk factors of falling using Morse Fall Scale (classified as Low, Medium or High Risk)

- Re-assessment should be performed on the following:
  - Whenever changes in patient's status noted (physiological, functional or cognitive change).
  - Whenever a fall occurs
  - Whenever being transferred to another patient's care unit

Preventive measurement to reduce risk of patient harm resulting from fall includes:

1. Communication (Orient patient; Patient/Family Education; Shift Report; Plan of Care)
2. Toileting (Implement bowel/bladder program; Provide urinal/commode at bedside; etc.)
3. Environment (Lowered bed position; Personal belonging within reach; No clutter, etc.)

A Fall Incident Report should be completed following any patient's fall.
Pain Assessment and Re-assessment:
(The patient's right to receive appropriate pain assessment and effective management will be respected & supported through continuity of care.)

Pain is defined as:
- unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- is highly personal and subjective. ("Self-Report" of pain is considered the most reliable indicator of pain.

Pain Assessment – is a comprehensive evaluation of patient's pain (but not limited to location, intensity, frequency, duration of pain, aggravating factors, effects on activities of daily living, sleep pattern and psychosocial aspects of patient's life) using standardized Pain Measurement tool or Pain Assessment Checklist.

Pain Assessment Checklist used:
- Faces Pain Rating Scale (Adult)
- FRAAC Pain Scale (for both Pediatric and Adult)

Pain Management – is the use of pharmacological and non-pharmacological intervention to control the patient's identified pain.

Pain Relief Guidelines / Pharmacological Interventions (when to assess?):
- Oral Analgesic – reassess in one (1) hour
- Intramuscular (IM) – reassess in 30 minutes
- Intravenous (IV) – reassess in 15 minutes

Non-Pharmacological Interventions:
- Heat/ Cold packs as prescribed
- Repositioning, turning, and/or ambulating as tolerated
- Exercise, massage, immobilization, TENS
- Relaxation exercises (deep breathing, rhythmic breathing)
- Distractions

Note: The physician is notified for any ineffective management of pain when pain score is >4.
Physical Restraint:

Definition: – is an approved mechanical device or devices which restrict the movement of the whole or a portion of the patient's body for the purpose of preventing harm to self or others.

Types of Restraint:

- **Soft Restraint** – is a cloth type garment or limb-body holder, which prevents the patient from climbing out of bed.
- **Seclusion** – is the voluntary confinement of a person in a room or an area where the person is physically prevented from leaving.
- **Chemical Restraint** – a medication used to control behavior or restrict the patient's freedom of movements and designed to put the person to sleep and not treat the underlying condition.
- **Therapeutic Devices** – are devices used to reduce the risk of injury but which are not considered restraints and do not require orders for implementation.

Points to Remember:

- Initiation of Physical Restraint is by the Physician's order only. Orders for the restraints shall not exceed twenty-four (24) hours in duration.
- Recurrent use of Restraint: A registered Nurse or Physician shall document in the patient's record the justification for recurrent use of restraints in addition to the patient's physical and behavioral status.
- Assessment of patient's physical and psychological well-being shall be made throughout the restraint period with a maximum of two (2) hours interval.
  - Application of restraint devices – ensuring that patients have as much freedom as possible.
  - Circulation and degree of movement in the extremities are evaluated.
  - Each restrained limb is released from restraints and examined from bruising or skin tears and exercised (range of motion) every two (2) hours.
- Meals are provided at regular time and fluids are offered every two (2) hours to ensure nutrition and hydration.
- Elimination needs are met at least every two (2) hours or as requested. Hygiene is offered on a daily basis.
Medication Safety:

Medication Administration – is a basic nursing function that involves skillful technique and consideration of the patient's development and safety; involves providing the patient with a substance prescribed and intended for the diagnosis, treatment, or prevention of a medical illness or condition. Therefore, medication is the leading cause of patient harm in health care institutions.

Strategies used to decrease the Incident of Medication Error:

- Ten "10" Right of Medication:
  ✓ Right Patient
  ✓ Right Drug
  ✓ Right Route
  ✓ Right Time
  ✓ Right Approach
  ✓ Right Dose
  ✓ Right Frequency
  ✓ Right Documentation
  ✓ Right Infusion
  ✓ Right Dilution

- Prohibited Abbreviations:
  (In accordance with "Prohibited Abbreviation", the use of certain abbreviations is prohibited.)

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<th>Do Not Use:</th>
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<tr>
<td>U</td>
<td>Unit</td>
</tr>
<tr>
<td>IU</td>
<td>International Unit</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd</td>
<td>Daily</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod</td>
<td>Every other day</td>
</tr>
<tr>
<td>Trailing zero (X.0)</td>
<td>X mg</td>
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<tr>
<td>Lack of leading zero (.X)</td>
<td>0.X mg</td>
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<tr>
<td>MSO4</td>
<td>Morphine Sulfate</td>
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<tr>
<td>MgSO4</td>
<td>Magnesium Sulfate</td>
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<td>ug</td>
<td>Mcg</td>
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<tr>
<td>cc</td>
<td>Ml</td>
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<tr>
<td>D/C</td>
<td>&quot;Discharge&quot; and &quot;Discontinue&quot;</td>
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<tr>
<td>HS</td>
<td>&quot;Half strength&quot; or &quot;bedtime&quot;</td>
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<tr>
<td>SC, SQ, sub q</td>
<td>&quot;subcut&quot; or &quot;subcutaneous&quot;</td>
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<tr>
<td>&gt; and &lt;</td>
<td>&quot;greater than&quot; or &quot;less than&quot;</td>
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- Look-Alike, Sound-Alike and High Alert Medications
  (All High Alert Medications should have an independent double check before administration)

- Medication Error (Errors can occur during prescribing, dispensing and/or administration.)

- Adverse Drug Reaction (Includes anaphylaxis, arrhythmias, convulsions, hallucination and shortness of breath, rashes and other reactions.)

Note: Make sure that the patient allergy status is documented in Physician Order Sheet or Medication Protocol
Patient and Family Rights:

Patient care outcomes are improved when patients and, as appropriate, their families or those who make decisions on their behalf are involved in care decisions and processes in a way that matches cultural expectations.

Among are the Rights and Responsibilities of Patients/ Families, but not limited to:

✓ PRIVACY

The patient has the right to refuse to talk to or meet anyone who is not officially involved in healthcare provided to him/her including visitors. Medical assessment & examination are to be conducted in designated areas out of the sight and hearing of others.

✓ CONFIDENTIALITY

Only direct health care providers have access to patient's files and details of their condition.

✓ REFUSAL OF TREATMENT

When a patient refuses care or chooses to discontinue treatment, he/she will be advised of the consequences of his/her refusal and the expected outcome of this decision.

✓ INFORMED CONSENT

The patient/family is entitled to have a complete explanation of the medical procedure required for his/her treatment, including risks and benefits of the proposed procedure, its complications and alternative treatments.

✓ PAIN MANAGEMENT

Patients have the right to have his/her pain assessed and addressed as part of his/her treatment plan.

✓ SAFETY

The patient had the right to expect appropriate and reasonable provision of personal safety as well as treating facilities, environment, and personnel practices are concerned.

✓ RESPECT, DIGNITY AND CONSIDERATION

Patients have the right to considerate and respectful care at all times and under all circumstances with due recognition of his/her personal dignity.
Patient and Family Education:

Patient and family education helps patient to participate in their care and make informed care decisions. **Education takes place when the patient interacts with his or her physician or the nurse.**

Effective education begins with assessment of patient's and family's learning needs. This assessment determines not only what needs to be learned but how the learning can best occur. Because many staff help educate patients and families, it is important that staff members coordinate their activities and focus on what patients need to learn.

**Learning is most effective when it suits patients the following:**
- preferences for learning
- religious and cultural values
- reading and language skills

**Education includes:**

- knowledge needed during the care process
- knowledge needed after the patient is discharged to another care site or home
- information on community resources for additional care and required follow-up care
- how to access emergency services if necessary

Facility Safety:

Health care organizations work to provide safe, functional, and supportive facilities for patients, families, staff, and visitors.

6 Areas of Facility and Organizational Activities to include:

- **Safety and Security**
  - Safety – the degree to which the organization's buildings, grounds and equipment do not pose a hazard or risk to patients, staff or visitors.
  - Security – protection from loss, destruction, tampering, or unauthorized access or use.

- **Hazardous materials** – handling, storage, and use of radioactive and other materials are controlled, and hazardous waste is safely disposed.

- **Emergency Management** – response to epidemics, disasters and emergencies is planned and effective.

- **Fire Safety** – property and occupants are protected from fire and smoke.

- **Medical Equipment** – equipment is selected, maintained, and used in a manner to reduce risks.

- **Utility Systems** – electrical, water, and other utility systems are maintained to minimize the risks of operating failures.
Fire Safety Codes: (When you discover a Fire)

Code "RED" Procedure:
R – Remove patients, visitors and personnel from the immediate fire area. Consider removing patients and staff from the adjoining rooms / floors. Disconnect exposed oxygen lines from wall outlets.
A – Activate the fire alarm and notify others in the affected area to obtain assistance. Follow your organization's emergency reporting instructions.
C - Contain the fire and smoke by closing all doors.
E – Extinguish the fire if it is safe to do so.

Fire extinguisher's techniques:
P – Pull-out the safety pin
A – Aim nozzle at the base of the fire
S – Squeeze the operating lever and handle
S – Sweep over the fire

Note: In case of fire, the nurse in-charge of the unit/area is responsible with the "shutting-off" of oxygen valves by breaking the glass.

Definition of Terms:

➢ Standard – an expected level of performance written by an authoritative body. It relates to structures in place, the performance processes, or measurable outcomes achieved.

➢ Occurrence Variance Report (OVR) / Incident Report – the documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established policies and procedures or practices.

➢ High Alert/ High Risk Medications – are drugs that bear a heightened risk of causing significant patient harm when they are used in error (e.g. Insulin and Heparin, etc.)

➢ Look-alike-Sound-alike (LASA) Medications - medication names that look similar or sound similar have been identified as a potential source of error in health care systems.

➢ SBAR (Situation-Background-Assessment-Recommendation) – is a very effective tool that provides a common and predictable structure to the communication.

➢ Near-Miss – is an unplanned event that did not result in injury, illness or damage, but had the potential to do so.

➢ Assisted Fall – when staff members attempt to minimize the impact of the fall by attempting to break patient's fall.

➢ Morse Fall Scale – a tool used to assess patient's risk level of fall.

➢ Panic Value – alert /critical value from a laboratory result that must be reported immediately to a clinician (e.g. such severity as to mandate urgent therapy).
References:

2. JCI 4th Edition, Hospital Standards
3. OGH - Nursing Quality Improvement Plan, 1440
4. CBAHI Standards Manual

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