ST VINCENT'S HOSPITAL
MELBOURNE

Agency Nurse Information Pack

Agency Nurse Information Pack

Contents

Section		Page
1.	Introduction	3
2.	Compliance and the Legislation	3
3.	Code of Conduct	3
4.	Workplace Culture and Equity	3
5.	Occupational Health & Safety	7
6.	Waste	8
7.	Emergency Management	9
8.	Quality and Safety	12
9.	Locations and Campus Maps	44
10.	Access – Emergency Care Centre & Department of Critical Care Medicine	46
11.	Car Parking	47
12.	Agency Nurse Documentation	50
13.	Smoke Free Policy	52

1 Introduction:

This booklet is to assist Labour Hire Employees engaged by SVHM, to have a greater understanding of the working environment. You must ensure that prior to the commencement of your shift, you have an ID badge, you have read and understood this booklet and received orientation to the department in which you will be working.

2 Compliance and the Legislation:

SVHM is committed to the safety of Staff, Labour Hire employees and Visitors who attend our sites. There is a legal obligation under the Occupational Health & Safety Act, 2004 to ensure a safe working environment, along with Regulations, Codes of Practice, Guidance material and Australian Standards, covering different aspects of safety.

Section 25(1)(a)(b) & (c) of the Occupational Health & Safety Act, 2004 - Duties of employee's states:

1) While at work, an employee must-

a) take reasonable care for his or her own health and safety;
and

b) take reasonable care for the health and safety of persons
who may be affected by the employee's acts or omissions at a workplace; and

c) co-operate with his or her employer with respect to any action taken by the employer to comply with a requirement imposed by or under this Act or the regulations.

3 Code of Conduct

The SVHM Code of Conduct provides guidelines regarding the appropriate way to interact with patients, visitors and other staff. There is a copy located in each department, ask the Person in Charge for a copy. Adhering to the guidelines will assist in the delivery of high quality outcomes and a working environment where both the rights and responsibilities of staff are acknowledged.

In broad terms, this code encourages you to use your knowledge and skills to perform your duties to the best of your ability; foster collaboration by working together; communicate with respect and tolerance and work constructively to resolve conflict.

4. Workplace Culture and Equity:

St Vincent's (STV) is committed to providing a workplace where people are treated fairly and with respect, and in line with the values of the Mary Aikenhead Ministries. Discrimination, harassment, bullying and victimisation are behaviours that can be unlawful and can cause significant disharmony in the workplace. Any such behaviour is contrary to STV values.

SVHM is committed to providing a workplace free from harassment, where all members of staff are treated with dignity, courtesy and respect. Report any incident of harassment immediately to the Person in Charge.

Definitions

What is discrimination?

It is unlawful to discriminate or take adverse action against a person in employment or prospective employment on the basis of particular attributes or personal characteristics specified by federal or state law. These protected attributes are:

- Age

- Carer status
- Parental status
- Disability
- Impairment
- Family Responsibilities
- Employment activity
- Gender identity
- Lawful sexual activity
- Sexual orientation
- Intersex Status (as defined)
- Industrial activity
- Marital or relationship status
- Physical features
- Political belief or activity
- Pregnancy or breastfeeding
- Race (including colour, nationality, ethnicity and ethnic origin)
- Religious belief or activity
- Sex
- Personal association with someone who has, or is assumed to have one of these personal characteristics

Discrimination laws apply to a number of areas including employment and the provision of goods and services (which includes services provided by hospitals).
In respect to employment, discrimination laws apply when:

- Determining who should be offered employment and the terms of conditions it is offered.
- Dismissing an employee.
- Denying or limiting employee access to benefits, promotions, and transfers.
- Subjecting an employee to any other detriment.

What is direct discrimination?
Direct discrimination is treating or proposing to treat a person unfavourably on the basis of an attribute or personal characteristic specified as unlawful by equal opportunity law, regardless of the motive of the person in breach of the law and regardless of whether they are aware of the discrimination or consider the treatment to be unfavourable.
For example if a job applicant were to be rejected for employment on the grounds that they are female and might become pregnant, this would be unlawful.
What is indirect discrimination?
Indirect discrimination occurs when intentionally or unintentionally, the imposition or intention to impose an unreasonable requirement, condition or practice has, or is likely to have, the effect of disadvantaging persons with an attribute or personal characteristic specified as unlawful by equal opportunity law. This type of discrimination occurs when a requirement, condition or practice, which appears to be neutral, in fact has a disproportionately negative impact on a particular group.
For example whilst it may appear neutral for a manager to require that a weekly staff meeting be held at 7.00 am, that would not be the case if any of those who must attend have family responsibilities that prevent their attendance. In such circumstances the manager would be guilty of indirect discrimination, unless the requirement to hold the meeting at that time was a reasonable requirement.

Are there situations where discrimination can occur?
In some situations, the law does provide a limited capacity to discriminate i.e. to behave in a manner that would otherwise be unlawful discrimination. For example, whilst it is generally unacceptable to discriminate against a person on the basis of a protected attribute, a decision not to appoint a person with a protected attribute to a particular role is unlikely to be unlawful if:

- the person, because of that protected attribute, cannot perform the inherent requirements of the role; and
- The changes necessary to enable the person to fulfil the inherent requirements of the position cannot be reasonably accommodated, having regard to factors such as cost, time and the impact on others of making the adjustment.
- The offering of employment to one sex is a genuine occupational requirement

What is harassment?
For behaviour to be harassment it must:

- Be unwelcome; and
- Result in the victim feeling offended, humiliated or intimidated, in circumstances where it is reasonable that they felt this way; and
- Have occurred as a result of one of the protected attributes listed in this policy.

Harassment can occur as a single act or as a series of incidents.
Behaviour can constitute harassment even if it was not intended to offend or harm. For example, it can constitute harassment if a person overhears a conversation or sees something on another person's computer screen, if what they overheard or saw offends them.
Some examples of harassment include:

- Mimicking another person's accent;
- Making fun of someone with a disability;
- Making comments that put down another person on the basis of their race, sexuality, pregnancy or any other protected attribute.

What is sexual harassment?
Sexual harassment is a specific form of unlawful harassment. It is behaviour of a sexual nature that is uninvited or unwelcome, which a reasonable person, having regard to all of the circumstances, could have anticipated would possibly have caused that other person to feel humiliated, intimidated or offended.
Behaviour that is based on mutual attraction, friendship and respect is not likely to constitute sexual harassment as long as the interaction is consensual and reciprocated.
Both men and women can be sexually harassed, by someone of the same or the opposite sex.
Sexual harassment can occur at work or outside the workplace and outside normal business hours.
Just because someone does not object to inappropriate behaviour at the time it occurs, does not mean that they are consenting to the behaviour. Such behaviour can still be sexual harassment.
Similarly, behaviour does not have to be intentional for it to be sexual harassment.
Sexual harassment can be physical, written or verbal. Examples of sexual harassment include:

- Making unwelcome comments or asking intrusive questions about a person's sexuality, sex life or physical appearance;
- Making sexually oriented jokes, innuendo, comments or conversation;

- Behaving suggestively e.g. leering, ogling or making obscene gestures;
- Engaging in unwanted physical contact such as by patting, touching, hugging or brushing against another person's body;
- Issuing sexual propositions or repeatedly requesting dates;
- Promising or threatening or pressuring for sexual favours;
- Repeatedly providing unwanted gifts such as flowers or chocolates;
- Displaying screensavers, photographs, objects etc. of a sexual nature;
- Making offensive phone calls or sending offensive text messages;
- Sending offensive messages, pictures or material using electronic communication systems such as email;
- Posting offensive or inappropriate material or comments using social media technologies such as Face Book or Twitter (refer STV Social Media Policy);

What is racial harassment?
Racial harassment is another specific form of unlawful harassment. Racial harassment includes harassing a person because of their colour, race, descent, ethnicity, national origin or nationality. Racial harassment can take many forms, including but not limited to: threats, abuse, insults, taunts and racially based jokes.

What is bullying?
Workplace bullying is repeated and unreasonable behaviour directed toward a person or group of people, that creates a risk to their mental or physical health and safety.
As behaviour must be repeated to be regarded as bullying, bullying must involve a pattern of behaviour that is of a persistent nature. This behaviour may however exhibit itself as a series of diverse incidents rather than as a pattern of identical or similar incidents.
As behaviour must also be unreasonable for it to be regarded as bullying, bullying behaviour must also be of such a nature that a reasonable person, having regard to all the circumstances, would expect that this behaviour would victimise, humiliate, undermine or threaten another person.
Bullying can take many forms. For instance bullying can take verbal, physical or written form and can involve any technology used for transmitting messages or information e.g. email, instant messaging, mobile phone etc.
Some examples of behaviour which if repeated or part of an unreasonable pattern of behaviour, would be regarded as bullying include:

- Verbal and physical abuse, for example, screaming, swearing, throwing objects;
- Intimidation, threats, belittling remarks;
- Spreading rumours or innuendo;
- Making offensive comments about a person on internet sites such as Face Book, MySpace and Twitter;
- Deliberate exclusion or isolation of a person from workplace activities or colleagues;
- Unreasonable and persistent criticism;
- Unreasonable allocation of workload;
- Assigning meaningless tasks unrelated to a person's job.

What is Victimisation?
Victimisation is when someone is retaliated against or subjected to pressure, adverse comment, isolation or other detrimental behaviour because they have made or propose to:

- Make a genuine complaint about discrimination, harassment, bullying or victimisation; or
- Appear as a witness for a person making such a complaint; or
- Provide information or support to a person making such a complaint.

Victimisation is not acceptable at SVHM.
An example of victimisation would be to exclude a person from a training opportunity because they have made a complaint.

What is not discrimination, bullying, harassment or victimisation?
Action taken properly by managers and supervisors in accordance with STV policies and procedures will not constitute bullying, harassment, discrimination or victimisation. For example, the following will not constitute discrimination, bullying, harassment or victimisation:

- Fair allocation of work and rosters;
- The setting of reasonable performance goals, standards and deadlines;
- The provision of constructive feedback;
- Properly conducted performance counselling and performance management processes etc.

Similarly, isolated differences of opinion or conflicts between managers/supervisors and their staff will not of themselves constitute discrimination, bullying, harassment or victimisation.

Intersex status
Is defined to mean the status of having physical, hormonal or genetic features that are:
(a) neither wholly female nor wholly male; or
(b) a combination of female and male; or
(c) neither female nor male.

Please see the Workplace Culture and Equity – Preventing Discrimination, Bullying, Harassment and Victimisation for the procedure to follow.

5 Work Health and Safety Policy:

- Policy Statement:
  St Vincent's Health Australia acknowledges its moral responsibility and legal obligation under the Work Health & Safety Legislation and commits to protecting its workers against risks to their health and safety by providing a safe and positive work environment that actively promotes individual wellbeing.
- Policy Procedures and Outcomes:
  We commit to fostering a culture that aspires to 'zero harm' and one that is focused on protecting and promoting work health, safety and wellbeing;
- Application:
  This policy applies to all facilities and services owned and managed by St Vincent's Health Australia.
- Incident Reporting
  Each Labour Hire employee is responsible for reporting and recording incidents, accidents and near misses that occur in the workplace. These are reported via Riskman. Please seek assistance from the Person in Charge. The incident must be completed by the conclusion of

your shift, prior to you leaving the workplace. You should also notify your Employer as soon as possible.

- Aggression Management
  If involved in an Aggressive Incident, please note that Debriefing and Peer Support Services are available. Discuss this with the Person in Charge.
- Smoking Policy:
  SVHM is a Smokefree environment. Smoking is **not** permitted within the grounds of any campus, including the car park.
- Hazardous Substances/Dangerous Goods
  If you are exposed to a Hazardous Substance or Dangerous Good, immediately seek assistance from the Person in Charge of the shift.

6 Waste

- General Waste
  - Consists of items that can be safely sent to municipal landfill that do not cause potential risks to those handling the waste or contaminate ground water. This excludes items containing patient, staff or financial details that contravene privacy legislation
- Recycled Waste:
  - Commingled Waste – Aluminium cans, steel cans, plastic drink bottles, glass jars or bottles. Anything with the recycling symbol**, except for hazardous/dangerous goods containers.**
  - Confidential Paper – Any document which if disclosed may breach privacy legislation, cause inconvenience and/or embarrassment to SVHM, it's patients, customers or staff.
  - General Paper – Documents and paper, which are not confidential in nature and cardboard – Any cardboard boxes.
- Clinical Waste:
  - Clinical Waste – Material contaminated by blood or bodily fluids
  - Sharps – Items that can penetrate the skin of a person handling the waste or can penetrate a clinical waste bag. This includes all syringes **with or without** needles.
  - Cytotoxic Waste – All items and materials that have any contact with cytotoxic materials and will not pierce a bag.
  - Cytotoxic Sharps – Includes all equipment and materials that have had any contact with cytotoxic materials and will pierce a plastic bag. This includes all syringes **with or without** needles.
  - Contaminated Glass – Glass containers that have contained blood products or residual pharmaceuticals that have not been cleaned out prior to disposal.
  - Radioactive Waste – Any object, material, paper, line or other substance that has had direct contact with ionising radiation.
  - Pharmaceutical Waste – Any amount of solid, semi-solid or liquid drugs or any container that has had pharmaceuticals with visible residue.
  - Laboratory Waste – All materials from microbiology laboratories, all liquid cultures, limbs, body parts, chemicals and specific waste from research experiments where this is stipulated by regulations such as quarantine regulations or the designation as a GMAC laboratory.
  - Placenta Waste – Clinical waste that results from the birthing process in Delivery Suite. Typically this waste includes the placenta and umbilical cord.

7 Emergency Management:

It is imperative that you familiarize yourself with the Emergency Colour Responses, location of break glass alarms, exits, WIP phones (Red phones) and firefighting equipment, such as Extinguishers.

All staff have an active involvement in the management of emergency situations by following directions from Response Team and Area Wardens.

Emergency Contact:

- At SVHM and SGH dial 2222. This is displayed at work station two in each ward.
- At Residential Aged Care facilities please call 000.

Emergency Codes

Code Red – Fire – All Campuses
• Dial 2222 / 000 and state type of incident / location / bed no. • Assist and rescue anyone in immediate danger if safe to do so • Activate a Break Glass Alarm • Extinguish fire if safe to do so, do not place yourself at risk • Warn others • Report to Area Warden • Close doors to the area to restrict fire and smoke spreading • Await for further instruction

Code Blue – Medical Emergency
• Ring buzzer or verbally alert another employee • Commence resuscitation procedure, if qualified • Dial 2222 / 000 and state type of incident / location / bed no. • Ensure resuscitation trolley is taken to the scene

Code Purple – Bomb threat / Extortion / Suspicious Packages
• Always treat as a genuine situation • Dial 2222 / 000 and state type of incident / location • If you have answered a call, ask questions such as where, when, what type, why, how long etc • Obtain the attention of another person • Do not touch any unidentified objects • When call is finished, **DO NOT** hang up the phone • Minimise the use of mobile phones and pagers in threat area only

Code Orange – Evacuation
• Dial 2222 / 000 and state type of incident / location • Report to Area Warden • Await instructions • Prepare patients • Close doors behind you • Leave lights on • Do not re-enter danger area

Code Yellow – Internal Emergency

There are a number of situations which could constitute an internal emergency. These situations can include power failure, gas leak, explosion, flood, substance leak. It is important to note that there is no set manner in which these situations are managed, it depends entirely on what the circumstances are.

- Dial 2222 / 000 and state type of incident / location
- Remove persons to safety
- Report to Area Warden
- Give information of exact location , type of incident, persons involved and assistance required

Code Brown – External Emergency

This is a situation which is external to SVHM, however it has a direct impact on the way in which the functions of the campus are performed.

Example: Food poisoning outbreak resulting in large volume of people attending for treatment.

There is no set manner in which these situations are managed, it depends entirely on what the circumstances are. Plans will be implemented depending upon the requirement at the time.

- Report to Area Warden
- Await instructions
- SVHM Staff Hotline 1300 795 885

Code Grey – Aggressive Behaviour

- If possible raise the alarm by dialing 2222 / 000, activate a duress alarm or alert another employee
- State type of incident / location
- Isolate self and others from aggressor if possible
- Follow directions from Code Grey Team upon their arrival

Code Ivory – Correctional Health Security Breach

- Dial 2222 / 000 and state type of incident / location
- Report to Area Warden
- Remain in area until advised
- Correctional staff / Police / Security Personnel involved only

Code Black – Hold up / Armed Threat

- If possible raise the alarm by dialing 2222 / 000, activate a duress alarm or alert another employee
- Try to cooperate with the person and stay calm. Reason with the offender, if possible
- In an armed threat scenario, give the person what they want, they may leave the area.
- Obey instructions and DO NOT place yourself in jeopardy
- Always attempt to position yourself near a doorway or exit point to enable a quick escape, if required. DO NOT turn your back. Stand up if possible for added mobility
- In an Armed Threat, Robbery situation, external assistance will be sought
- Complete a characteristic checklist, noting appearance, clothing, distinguishing features, weapons etc.

- Fire/Smoke Doors
  Will close automatically in the affected area through the operation of a Break Glass Alarm, Smoke Detector or the Sprinkler System. Fire Doors are rated for a period of 2 hours. These doors do not lock, so you can still pass through.
- Smoke Detectors
  Smoke Detectors do not emit an audible noise but do send a signal to the EWIS Panel, which activates chimes, local fire alarm, sends a signal to the Fire Brigade and activates fire doors in the affected area.
- Sprinkler System
  Sprinklers operate individually and each one covers approximately 2 square meters
- EWIS Panel (Early Warning Information System)
  The EWIS Panel's operate automatically and will either commence emergency chimes or send a pre-programmed message to the affected department or organization. This process will commence upon activation of a Smoke Detector, Break Glass Alarm or a Sprinkler being activated.
- WIP (Red) Phones (Warden Intercom Phones)
  WIP Phones are red in colour and are monitored in emergency situations. The phones do not sound like a normal telephone but emit a high pitched noise. To operate, simply pick up and wait for respond team member to answer.
- Break Glass Alarms
  In case of a fire, break the glass and push button. The same processes will occur as a Smoke Detector, EWIS chimes will activate, sends a signal to the local Fire Brigade and fire doors will close automatically in the affected area
- Fire Extinguishers
  The majority of Fire Extinguishers in the Health Service are either C02 (Carbon Dioxide) or Dry Chemical. In some instances, Water and Foam extinguishers are located in departments. It is important you are aware where extinguishers are located. The operation of each type of extinguisher is the same and instructions are on the extinguisher.**C02 and Dry Chemical extinguishers can be used on any type of fire. Water extinguishers should be used on normal combustibles such as wood and paper fires. Foam extinguishers should be used for cooking and flammable liquid fires.**

Agency Nurse Information Pack

8 Quality and Safety

PREAMBLE

This document provides an overview of the critical quality and safety issues facing us at SVHM, the systems and process in place to reduce and manage these clinical risks and the important role all staff play in delivering the highest quality health care.

This information is primarily for clinical staff (those who deal directly with patient care) but will also assist those in non-clinical roles understand the indirect impact upon clinical care delivery. Policies and procedures in this document can also be found on SVHM's policy intranet page. All new staff are encouraged to familiarise themselves with this important resource, and contact their manager if they have any questions about how it relates to their role.

TABLE OF CONTENTS

Quality Safety and Consumer Engagement

Infection prevention and control

Medication safety

Patient identification and procedure matching

Clinical handover

Blood and blood products

Pressure injury prevention and management

Clinical deterioration

Falls prevention and management

What is clinical governance?

"The system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks, and fostering an environment of excellence in care for consumers/patients/residents"

Source: Australian Council on Healthcare Standards (2004) *ACHS News* Vol. 12 1-2 Sydney

What are clinical governance systems and structures?

At SVHM these include: policies to guide practice, performance measurement, performance review, reporting systems, committee structures, credentialing processes, training and education, strategic and operational planning processes.

What are the three themes within the SVHM/SVHA clinical quality and safety policy?

That healthcare is:

- Consumer/patient centred
- Driven by information
- Organised for safety

What are your responsibilities for quality and safety?

Managers

- Ensure that staff attend necessary training
- Promote a culture that supports learning and encourages reporting of errors
- Implement systems to deal with and learn from complaints and incidents, and to identify and manage risks
- Implement the safety and quality program at a local level

Clinical staff

- Take personal responsibility for the quality and safety of their work
- Be aware of and comply with organisational policies and procedures
- Maintain adequate skills and knowledge necessary to safely and skilfully undertake their work
- Take all necessary care and precautions when undertaking clinical procedures
- Collaborate and clearly communicate with the patient/client and the healthcare team
- Ensure that clinical work is conducted within the limits of individuals training, professional designation and legislative requirements
- Participate in clinical risk management and quality improvement activities as part of day to day work

Non clinical staff

- Take personal responsibility for the quality and safety of their work
- Be aware of and comply with organisational policies and procedures
- Report incident and accidents and collaborate with management to resolve safety issues
- Maintain adequate skills and knowledge necessary to safely and skilfully undertake their role
- Take all necessary care and precautions when performing their duties
- Participate in risk management and quality improvement activities as part of day to day work

What is the SVHM improvement methodology?

SVHM's PDSA (plan, do, study, act) model has been adapted from the IHI model for improvement, and is based on the three questions:

- What are we trying to improve?
- What change can we make that will result in an improvement
- How will we know the change is an improvement?

The PDSA cycles are then used to test the change. More help on improvement methodology may be requested from the Quality and Risk team or Redesign.

What are the local improvement planning arrangements?

All departments have an improvement plan in the improvement system, allowing SVHM to cascade down to a ward/department level the quality and safety priorities for the organisation. Improvement tools to guide staff through the process are also located in the improvement system within MAPS

What is consumer engagement?

The consumer centred approach ensures that services are consumer focussed and responsive to their needs in order to achieve positive health outcomes. To do so, consumers and the treating team form a partnership based on providing appropriate information, enacting various mechanisms for involvement, valuing the consumers' opinion and treating the consumer with respect and dignity

What can you do to further improve consumer engagement?

Some further strategies to engage and partner with consumers include:

- Providing information in an appropriate format
- Supporting patients and allowing their desired level of involvement in decision making
- Surveying consumers for their views of our services and actioning on this information for continuous improvement

The following **Infection Control** information applies to all employees, patients and visitors of SVHM.

STAFF IMMUNISATION

SVHM's Employee Health Program aims to minimise the risk of transmission of Vaccine Preventable Diseases (VPD). Immunisations are offered to all employees and volunteers at SVHM, and participation in the program is at the responsibility of each individual. Details of staff VPD history, vaccination and immunisation status are maintained on a secure database.

INVASIVE DEVICES

Only medical staff and registered nurses who have successfully completed SVHM's approved training and competency programs may insert peripheral cannulae. Staff in high risk wards may be required to undertake education and competency on the management of CVADs.

STANDARD PRECAUTIONS

All blood and body substances (other than sweat) should be considered potentially infectious. A standard level of care (standard precautions) is applied to all people regardless of their perceived or confirmed infectious status. Further precautions (additional precautions) are recommended for patients known or suspected to be infected or colonised with micro-organisms that cause infections and that may not be contained by standard precautions alone. Additional precautions may also be required to protect immunocompromised patients from cross-infection from other patients, employees and visitors; the term adopted by SVHM is Protective Environment.

Standard precautions are essential work practices designed to achieve the basic level of infection control required for the prevention of transmission of infection. They shall be used for all patients at all times and in the handling of blood (including dried blood), all body fluids, secretions and excretions (excluding sweat) regardless of whether they contain visible blood non-intact skin and mucous membranes.

Standard Precautions are designed to protect Health Care Workers (HCWs) and patients from contact with infectious agents either in a recognised or an unrecognised infection. The infection control practices described below are recommended, regardless of patient diagnosis or presumed infectious status. The application of standard precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated contact with blood, body fluids or pathogens. For example, only gloves may be required for some interactions, but others may require the use of both gloves and face shields. *SVHM is a no gloves hospital for contact precautions. SVHM utilises hand hygiene.*

Essential work practices for standard precautions are:

- Appropriate hygiene practices, particularly appropriate hand hygiene practice before and after all contacts with patients or their environment

- Use of personal protective equipment, which may include gloves, impermeable gowns, plastic aprons, masks, face-shields and eye protection
- Aseptic technique, including appropriate use of skin disinfectants
- Appropriate handling and disposal of sharps and other clinical waste
- Reprocessing of reusable equipment and instruments, including appropriate use of disinfectants
- Environmental controls, including design and maintenance of premises, cleaning and spills management
- Provision of support services such as laundry and food services

HYGIENE PRACTICES

Hand Hygiene

Effective hand de-contamination is the most important hygiene measure in preventing the spread of infection. Intact skin is a natural defence against infection so hand care is important in maintaining skin integrity. Cuts and abrasions should be covered by water-resistant occlusive dressings and changed as required to maintain integrity. It is expected that all new employees will complete the Hand Hygiene on-line training within one month of commencing at SVHM.

Personal attire/hair/fingernails/jewellery

HCWs clothing should be clean. Long hair should be tied back or covered and facial beards covered when undertaking aseptic or sterile procedures.
HCWs must:

- Wear clothes that allow for bare forearms to ensure proper compliance with required hand hygiene protocols, not wear cardigans or jackets when providing direct patient care
- Avoid wearing a lanyard if possible and if not, ensure the lanyard does not come into contact with patients when providing direct patient care
- Rings (other than single bands such as wedding bands) must not be worn, fingernails should be short and clean, and no artificial fingernails as they contribute to increased bacterial counts
- Rings, bracelets, wristwatches and artificial fingernails must not be worn when performing invasive procedures
- Scrubs (operating theatre attire) are only to be worn in Operating Suite, PACU, DSA, Endoscopy and Sterile Processing Centre. Staff must change into street clothes when leaving these areas. Scrubs (or part thereof) are not to be worn in any other departments of the hospital

Eating/drinking

HCWs must not eat or drink in the clinical area.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Gloves

Gloves are not a substitute for appropriate hand hygiene practices and must be worn when touching blood, body fluids, secretion, excretions and contaminated items. Hand Hygiene must be performed prior to donning gloves, which should be put on immediately prior to the task and before touching contaminated items or equipment. Such procedures may include: touching mucous membranes of any person, touching non-intact skin of any person inserting and removing peripheral IV cannulae, giving injections venepuncture and checking blood sugar levels, emptying drainage bags and bottles and suction bottles handling equipment/materials contaminated with blood/other body substance

Removal of gloves

Gloves must be removed immediately after use and before touching non-contaminated items and environmental surfaces. Hand decontamination must then be performed in case infectious agents have penetrated through unrecognised tears or have contaminated hands during removal. Removal of gloves and hand decontamination should also be performed between separate procedures on the same patient. Gloves should be removed and discarded immediately if they are damaged or torn and hand decontamination performed. The type of gloves worn should be appropriate to the task

Protective Eyewear

Protective eye goggles or face-shields must be worn during any procedure where there is potential for splashing or spraying of blood or other body substances. Eye protection is essential for all operative and dental procedures, when suctioning patients and during manual cleaning. Standard prescription glasses and contact lenses are NOT considered protective.

Masks and Personal Respiratory Protection Devices

A filter mask should be worn during any procedure that has the potential to generate aerosol droplets, splashes or sprays of blood or other body substances. A well-fitting particulate filter (0.3m) mask must be used for the care of all patients with a suspected or confirmed infection that can be transmitted via the airborne route.

Protective Clothing

A linen gown should be worn for all activities where spray or soiling with blood or other body substance is possible. A plastic apron may be used under the linen gown when there is potential for strike through of blood or other body substance to clothing underneath. Most routine patient care activities at the bedside do not require protective clothing. Gowns should be removed and disposed of into the linen skip as soon as the activity has been completed. Plastic aprons, if re-usable, must be cleaned with neutral detergent and dried. Linen gowns must not be stored (or hung up) and then re-used. Sterile pre-packed gowns must be used in all aseptic procedures requiring a sterile field. These include but are not limited to surgical procedures, insertion/care of central vascular access devices, insertion of IDCs, and collection of blood cultures.

Footwear

HCWs should wear enclosed footwear that protects them from injury or contact with sharp objects (e.g. if sharps are accidentally dropped).

ASEPTIC TECHNIQUE

This is the infection prevention method and precautions taken during invasive clinical procedures to prevent the transfer of microorganisms from the health care worker, procedure equipment or the immediate environment to the patient. The framework can be divided into standard aseptic technique and surgical aseptic technique.

Key Principles of Aseptic Non Touch Technique

Always perform hand hygiene

Never contaminate key-parts

Touch non key-parts with confidence

Take appropriate infection control precautions

- Keep the exposure of the susceptible sites to a minimum
- Use sterile or non-sterile gloves following a risk assessment on the nature of the susceptible site and the procedure being undertaken
- Sequence practice to ensure efficient, logical and safe order of tasks

HANDLING AND DISPOSAL OF SHARPS AND CONTAMINATED WASTE

Sharps

The inappropriate handling of sharps is the major cause of incidents involving potential exposure to blood-borne diseases. Sharps must be handled with care at all times. The person who has used a sharp instrument is responsible for its immediate and safe disposal following use.

Contaminated Waste

All (and only) contaminated waste must be placed in the appropriate, SVHM approved, yellow, biohazard-labelled bins.

OCCUPATIONAL EXPOSURES

If you sustain an injury – splash or sharps injury that involves patients' blood or body substances, the Occupational Exposure Coordinator (OEC) will manage the incident for you. OECs are contactable 24/7 on page 777 at the Fitzroy campus. Other campuses should check the OE poster that is clearly displayed in clinical areas. Follow the directions for first aid, notify your supervisor and page the OEC. All incidents are managed by clinical staff, including any medical actions such as medication or vaccination.

CLEANING OF THE ENVIRONMENT

Routine cleaning should follow the normal procedures as per the Hospital Cleaning Manual. The use of detergent and water is suitable for all surfaces, including ceilings, walls, floors and furniture.

Special cleaning applies for patients in Additional precautions - refer to the Cleaning of Patient Care Areas Policy in the Infection Control Manual.

CLEANING AND DE-CONTAMINATION OF REUSABLE EQUIPMENT

For **equipment** commonly used in clinical areas there is a table outlining cleaning instructions for specific equipment in the Cleaning and De-contamination of Reusable Equipment Policy.

All items labelled as "Single Use" are to be discarded appropriately after use. SVHM does not approve the re-use, reprocessing or re-sterilisation of any medical item which is labelled by the manufacturer as "single use" or "single patient use".

Equipment for reprocessing by the Sterile Processing Centre shall be cleaned of gross contamination as close to time of use as possible, (may be achieved by dry wiping, wet wiping and rinsing), placed in the Sterile Processing Centre (SPC) container in the Utility Room provided for transport (containers are puncture-resistant, leak proof, and have an appropriately fitting lid). **Equipment / instruments for reprocessing** in specialist areas, i.e. Day Procedure / Theatres refer to the standard operating procedures for those departments.

SVHM request that you familiarise yourself with the policies in the Infection Control Manual.

Further resources can be found on the Infection Control intranet page.

If you have any queries regarding infection control including immunisation please contact the Infection Control Team on Ext.4704

INTRODUCTION

Providing medicines to patients is the most common type of treatment used in health care, but the process is recognised as one of the most complex. The process includes the storing, prescribing, dispensing, administering and monitoring of the effects of medicines and may involve up to 100 steps from the time a medical officer writes a new medication order, until the time the medicine is administered to the patient.

There are a number of active committees at SVHM responsible for overseeing medication safety, including: Pharmacy Quality Council, Medicines & Therapeutics Advisory Committee, Medication Safety Project Working Group (MSPWG) and the Medication Safety Incident Review Group.

Due to its common use and complex process, medicines are associated with a higher rate of errors and adverse events compared to other health care interventions. In Australia, studies have reported that
2 – 5 % of drug charts contain prescribing errors and 5 – 18% of medicines are administered in error.

Please complete a report on Victorian Health Incident Management System (VHIMS) if you become aware of a medication error or near miss event. VHIMS is located in the quick links on the intranet home page. New users are required to create a new login using the network login and password. Examples of reportable medication incidents are listed below.

- Where the medication is administered by the incorrect route
- Where the medication is administered at the incorrect dose/rate
- Where the medication is administered to the incorrect patient
- Where the medication is administered at the incorrect date or time
- Where the incorrect medication is administered
- Where a medication has been omitted
- Where the medication chart has not been signed or other documentation related incident
- Where the patient has refused the medication and as a consequence, care may be compromised.

If you have any VHIMS related enquiries contact the Clinical Risk Administrator on ext. 3934

RELATED SVHM POLICIES

Medication Policy

All staff who are authorised to possess, prescribe, store, distribute or administer medicines should ensure they are familiar with the SVHM Medication Policy.

- Policy, Index & Reference
- Section 1 - Prescription of Medication
- Section 2 - Medication Charts

- Section 3 - Medication History & Reconciliation
- Section 4 - Discharge Prescriptions
- Section 5 - Pharmaceutical Benefit Scheme (PBS)
- Section 6 - Outpatient Prescriptions
- Section 7 - Drug of Addiction Prescriptions
- Section 8 - Pharmacy Services and Supply of Medication to Clinical Areas
- Section 9 - Storage of Medication in the Acute and Sub Acute Wards
- Section 10 - Administration of Medication
- Section 11 - Specific Administration Procedures
- Section 12 - Risk Management
- Section 13 - Adverse Drug Reactions (including Allergies)
- Appendix 1 - Nurse Practitioner Renal Care Medicines Formulary

Other Related Policies

- Antimicrobial Policy
- Cytotoxic Administration and Safe Handling
- Dose Administration Aids
- Employee Health Nurse - Nurse Immuniser
- Enrolled Nurse Scope of Practice
- Epidural Analgesia
- Insertion & Management of Subcutaneous Cannulas / Subcutaneous Fluid Hydration
- Intravenous Peripheral Cannulae & Management
- Nitrous Oxide Inhalation Analgesia
- Radioiodine Therapy
- Special Analgesia Nursing Observations
- Subcutaneious Drug Infusion with a Niki T34 Syringe Driver
- Total Parenteral Nutrition (TPN)

RESOURCES

The Medicines Information Centre (MIC)

Open Monday to Friday between 08:30 - 17:30 hours

The Medicines Information Centres primary goal is to improve the quality of patient care by answering enquiries related to medication use. The service is available to all SVHM healthcare professionals and patients/carers.

The MIC can be contacted on extension 4359, via pager 1285, fax to 4174 or via email: druginfo@svhm.org.au.

Visit the intranet for further information:
http://business/sites/pharmacyservices/MedInfo/default.aspx

Protocols

The Medication Administration Protocols Manual is on the intranet in Health Service Policies & Procedures and contains information on:

- Anticoagulation Protocols
- General Medication Protocols
- Pain Management Protocols
- Palliative Care Protocols.

Other Resourses

Category	Resource	How to access
General Medicines Information	MIMS	Clinicians' Health Channel.
	AusDI	http://ausdi.hcn.com.au
	AMH	Clinicians' Health Channel
	Therapeutics Guidelines	Clinicians' Health Channel
	UpToDate	Quick link on the intranet home page
	Micromedex	Clinicians' Health Channel.
Drug Interactions	Lexi-Interact	Part of Up-to-Date (see above)
	MIMS	Clinicians' Health Channel
	AusDI Interactions	http://ausdi.hcn.com.au/
Adverse Drug Reactions	TGA ADR database	http://www.tga.gov.au/daen/daen-entry.aspx
	Meylers Side Effects of Drugs	Contact MIC
Parenteral Medicines Administration	Australian Injectable Drugs Handbook	http://aidh.hcn.com.au/
Complimentary Medicines	Natural Medicines Comprehensive Database	Contact MIC
	NCCAM	http://nccam.nih.gov/health

Citation Databases	PubMed	Clinicians' Health Channel
	Embase	Clinicians' Health Channel
	New PubMed	http://newpubmed.com/

STORAGE

Medicines, as defined by law, are drugs and poisons which are controlled by the *Drugs, Poisons and Controlled Substances Act 1981* and the Drugs, Poisons and Controlled Substances Regulations 2006. This includes:

- Medicines available with a prescription from a doctor or other registered prescriber
- Medicines only available from a pharmacy
- Drugs of dependence.

Storage and distribution of drugs and poisons are also controlled by SVHM policies and procedures. Safe storage of medicines is critical to the safety of our patients and visitors.

Schedule 4 (S4) medicines need to be stored in the patient's locked medication drawer, the locked medication rooms, the medication trolley or the After-Hours cupboard located on each floor. Access is via hospital ID swipe card, keys or coded entry pad.

Schedule 8 (S8) medicines are to be stored in the locked drug cupboard located in each of the medication rooms. All transactions involving these drugs must be witnessed and recorded in the S8 Administration Book.

Schedule 11 (S11) medicines are to be stored in the locked drug cupboard located in each of the medication rooms. All transactions involving these drugs must be witnessed and recorded in the S11 Administration Book.

Please contact the MIC for any further information regarding the legislative requirements for safe storage and distribution of medicines at SVHM, and refer to Section 9 of the SVHM Medication Policy.

PRESCRIBING

Only authorised prescribers are allowed to prescribe medications, and those authorised should only prescribe within their field of knowledge and expertise. If a prescriber is unfamiliar with the prescribing requirements of a particular medication or particular patient, expert advice from a unit specialist or clinical pharmacist should be sought.

For details of the prescribing policy at SVHM, refer to Section 1 of the Medication Policy.

Principles of Good Prescribing for Antimicrobial Drugs

(Source: Healthcare Infection Control Special Interest Group: Australasian Society for Infectious Diseases)

Principle 1:

- Antimicrobial selection and dosage should comply with national guidelines:
  - variance should be justified
  - allergy should be assessed.

Principle 2:

- Indication for treatment should be documented.

Principle 3:

- Microbiological assessment – always consider and collect necessary specimens PRIOR to first dose.

Principle 4:

- Evaluate at 48 - 72 hours: assess whether antimicrobial treatment needs to be modified (de-escalation):
  - cease treatment?
  - switch to oral?
  - narrow to identified pathogen?

Principle 5:

- Duration or review date should be specified.

ADMINISTRATION

As in Section 10 of the Medication Policy, only authorised staff are allowed to administer medications to patients. All medication administration should be documented and checked as per Section 10 of the Medication Policy.

For parenteral medication administration, SVHM's Medication Administration Protocols Manual and the Australian Injectable Drugs Handbook should be used to guide administration. These resources can be accessed via the Pharmacy Department intranet page.

ADVERSE DRUG REACTIONS & ALLERGIES

Adverse drug reactions (ADRs) are harmful, unintended reactions to medicines that occur at doses normally used for treatment and can vary from life-threatening anaphylaxis to minor common side-effects.

ADR assessment is required for all admissions to determine previous reactions. Detailed information about previous ADRs including "Nil Known" must be documented in the patients' medical record, the ADR section of all medication charts and prescriptions and in the alert section of PAS. All patients with an ADR should wear a red identification band with patient identification label, and an alert card should also be completed and given to patients with an ADR.

All new and suspected ADRs must be reported using the e-form available on the forms page of the hospital intranet. All documentation listed above should be completed for new ADRs. See Section 13 of the Medication Policy for further information on adverse drug reactions.

Agency Nurse Information Pack

HIGH RISK MEDICINES – PINCH

High risk medications have a heightened risk of causing serious or catastrophic harm when used in error. High risk medications include medications with a low therapeutic index and medications that present a high risk when administered via the wrong route or when other system errors occur.

Examples of high risk medicines include the “PINCH” medications, which are:

Potassium

Insulin

Narcotics

Chemotherapy

Heparin and other anticoagulants

Although mistakes may not be more common with these medications, the consequences of an error can clearly be more devastating to patients.

INTRODUCTION

Patient identification and the matching of patients to an intended care process is an activity that is performed in all care settings. Risks to patient safety occur when there is a mismatch between a given patient and components of their care, whether those components are diagnostic, therapeutic or supportive. As patient identification is an activity that is performed frequently, it can often be seen as a relatively unimportant task. At SVHM, we realise that correct patient identification processes are at the core of patient care and we have taken steps toward reducing the risks to our patients such as implementing the standard national identification band and the surgical safety checklist.

The Patient Identification and Procedure Matching Project Working Group within SVHM uses current best practice information to identify and encourage innovations associated with patient identification and procedure matching and progress these to completion. The working group also assumes governance in reviewing related incidences as well as patient identification and procedure matching processes utilised at SVHM with the overall aim to prevent associated patient harm.
You can contact the project working group on: patientidandproceduerematching@svhm.org.au

RELATED SVHM POLICIES

- Correct Patient, Correct Procedure/Investigation, Correct Side/Site
- http://intranet/Policies/Clinical%20Policies/Patient%20Resident%20Client%20Identification.pdf
- Medication Policy – Section 10: Administration of Medication
- Surgical Safety Checklist

CLINICIAN RESPONSIBILITIES

"Correctly identify all patients whenever care is provided and correctly match patients to their intended treatment."

Australian Commission on Safety and Quality in Health Care: Standard 5

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Throughout health care, the failure to correctly identify patients and match that information to an intended clinical intervention continues to result in wrong person, wrong site procedures, medication errors, transfusion errors and diagnostic testing errors. Correctly identifying and verifying we have the right patient at every point of care is the best thing we can do as health care professionals to ensure that we dramatically reduce the risks associated.

The role of clinicians is essential to ensuring patient identification errors and mismatching events are minimised and the risk of harm to our patients is reduced. Listed above are some of the relevant policies related to patient identification and procedure matching. Many of the day to day care requirements of our patients requires effective patient identification processes, from giving medication, taking blood, or preparing for surgery. If adequate identification processes are not followed, our patients are put at great risk. It is your responsibility to ensure that the correct identification process has been followed. If you're unsure, look up the policy, they are all accessible from the Intranet home page.

PATIENT IDENTIFICATION

Effective from the 1st of September 2015 all patients admitted to SVHM are to wear a single white identification band.

- Patients require only one patient identification band
- A single white band shall be applied to any patients who do not have any allergies or known adverse drug reactions
- No other coloured bands are permitted to be worn
- Red bands are no longer applied for patients with a known adverse drug reaction or allergy. The adverse drug reaction and/or allergies must be recorded on the patient medication charts and in the medical record and alerts form. Clinical staff are required to check with the patient (where possible) and the clinical record to confirm patient allergy or reactions prior to the administration of treatment or medication

Position of Band

- The band shall be applied to the patient's wrist. If both wrists are unable to be used, the band may be applied to the patient's ankle
- Identification bands should not be placed on the ankle of patients wearing compression stockings due to the increased risk of skin tears
- If the patient's medical condition prohibits the application of an identification band, the band must be attached to a visible part of the patient's body, using tape appropriate to the patient's condition/adverse drug reactions/allergies. If the use of any form of identification band is not possible, the identification details must be written on a part of the patient body that is visible and appropriate, using an indelible marker pen

SVHM uses the Surgical Safety Checklist to ensure all patients undergoing surgical procedures are correctly identified throughout the surgical process. The checklist also ensures that procedure matching and consent processes are conducted correctly. Even clinicians not working in theatre areas will become familiar with this tool as, along with other pre-operative documentation, it is a crucial step in preparing your patients for surgery and handing their care over to theatre staff.

Every Patient.
Every Time.

StV

ST. VINCENT'S MELBOURNE

SURGICAL SAFETY CHECKLIST

UR No.: _____

Surname: _____

Given Name: _____

D.O.B.: _____

Please fill in if no Patient Label available

Team members to tick boxes as items are checked and communicated, sign and note time under each section

Date of surgery: .....

ON ARRIVAL

Holding Bay

Nurse confirms with patient/ward nurse:

Identity ❑ Yes

Consent ❑ Yes

Site marked ❑ Yes ❑ N/A

SV699 Pre-Procedure Risk Assessment/Consent form

❑ Yes ❑ No ❑ N/A

Allergies ❑ Yes ❑ No

List: _____

Presence of medical record:

❑ Yes

No. of medical records: _____

Tests, films and results

Pathology ❑ Yes ❑ N/A

ECG ❑ Yes ❑ N/A

X-Rays ❑ Yes ❑ N/A

No. of film envelopes: _____

Any special equipment/ devices/implants:

❑ Yes ❑ N/A

List: _____

Pressure ulcer risk:

❑ Very high ❑ High

❑ Moderate ❑ Low

Ward Nurse:

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

Holding Bay Nurse:

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

SIGN IN

Before Anaesthesia Start

Anaesthetist confirms:

Identity ❑ Yes

Site ❑ Yes

Consent ❑ Yes

Procedure ❑ Yes

Site marked ❑ Yes ❑ N/A

Nerve block time-out ❑ Yes ❑ N/A

Allergies checked

❑ Yes

Anaesthesia safety checks completed ❑ Yes ❑ N/A

Surgeon present

❑ Yes

Appropriate monitoring planned and available

❑ Yes ❑ N/A

Difficult airway or aspiration risk

❑ Yes ❑ No ❑ N/A

❑ Equipment avail.

❑ N/A

Risk of blood loss(>500ml)

❑ Yes ❑ No

Cross-match/Group&Hold checked and valid

❑ Yes ❑ N/A

Number units available _____

Anaesthetic Nurse:

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

Anaesthetist

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

TIME OUT

Before Skin Incision

All team members:

❑ Name/role introduced

❑ Patient's identity checked

❑ Procedure/consent checked

Site marked and visible

❑ Yes ❑ N/A

Essential imaging displayed

❑ Yes ❑ N/A

❑ Equipment checked

❑ X-ray booked ❑ N/A

❑ Prosthesis ❑ N/A

❑ Other: _____

❑ Pressure points protected

Scrub Nurse:

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

Anticipated critical issues considered:

❑ Operative duration

❑ Blood loss

❑ Antibiotic prophylaxis-within 1 hr

❑ ASA score/additional concerns

❑ VTE prophylaxis

❑ Steroid prophylaxis

❑ Other: _____

Surgeon/Anaesthetist

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

SIGN OUT

Before Leaving Room

Instrument nurse verbally confirms with the team the:

❑ Name of the procedure

❑ Final count correct

❑ Specimen type, number and labelling

❑ Equipment problems

List issues: _____

❑ Skin integrity checked and intact:

Comments: _____

Scrub Nurse:

Signature: _____

Name (printed): _____

Designation: _____

Time: _____

SURGICAL SAFETY CHECKLIST - ST. VINCENT'S MELBOURNE

SV000730

SV 730 10/11

Developed by the World Health Organisation in 2008 and adapted for St Vincent's Melbourne in 2011

CLINICAL HANDOVER

The following **Clinical Handover** information applies to all employees involved in clinical care.
Clinical handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis." (Australian Medical Association, Safe Handover: safe patients. Guidance on clinical handover for clinicians and managers 2006.)

Clinical Handover may be verbal (face-to-face or telephone), written (hand written or electronically recorded notes) or electronic message based (electronic task board, paging). Delegation, referral and formal handover of care between individual staff members and units are all components of clinical handover.
Whenever possible, handover should occur face-to-face and involve the patient; this is the SVHM preferred method of handover and offers the least opportunity for miscommunication

ISBAR should be used for all telephone handovers
ISBAR (**I**dentify, **S**ituation, **B**ackground, **A**ssessment, **R**equest) is a minimum information tool that provides a structured and formalised model of communication between staff.

ISBAR for clear communication	
I	**IDENTIFY:** Yourself (name, position, location) & patient
S	**SITUATION:** Why you are calling (if urgent, say so)
B	**BACKGROUND:** Give relevant information
A	**ASSESSMENT:** What you think is going on?
R	**REQUEST:** What you want from them?

IDENTIFY: Name, position & location. Ask to speak to the correct person. Patient details: unique ID number, ward & bed

SITUATION: Why you are calling? What is currently happening? If URGENT, say so!

BACKGROUND: Give relevant information e.g. admission diagnosis and date, brief relevant medical history and treatment summary

ASSESSMENT: Vital signs, your clinical impressions and what you think is going on

REQUEST: State what you want from them – e.g. to come and review the patient? Or to provide management advice?

It is expected that all new employees complete the ISBAR on-line training within one month of commencing at SVHM.

INTRODUCTION

Treatment with blood and blood products can be lifesaving, however, as biological materials they are not without risk. Screening and testing of donors and donated blood and ensuring that decisions to transfuse follow consideration of all treatment options, their risks and benefits all contribute to minimising the inherent risks.

The Hospital Transfusion Committee (HTC) has endorsed the National Blood Authorities "Patient Blood Management Guidelines" to guide our clinical transfusion practice. The HTC has developed local policies regarding contemporary evidence based transfusion practice available for your reference on the SVHM Intranet.

The HTC assumes governance in reviewing transfusion related incidences and suspected reactions to blood products. Regular clinical practice audits are completed to gauge performance against national and local clinical practice guidelines. Much work is undertaken to educate staff, improve clinical practice and reduce the inherent harm associated with transfusion.

You can contact the project working group on: patientidandproceduramatching@svhm.org.au

RELATED SVHM POLICIES

- Patient / Resident / client Identification
- Consent for the Administration of Blood and Blood Products
- Administration of Red Cell for Transfusion at SVHM
- Platelet Transfusion at SVHM
- Fresh Frozen Plasma (FFP) Transfusion at SVHM
- Cryoprecipitate (CRYO) Transfusion at SVHM
- Administration of IVIg
- Guidelines for the Management of Patients Who Refuse Blood and Blood Products
- Massive Transfusion
- Blood Group, Crossmatch, Pretransfusion Request and Specimen Labelling Requirements
- Management of Bellovac ABT Drain

CLINICAL RESPONSIBILITIES

- Safe and appropriate prescribing and clinical use of blood and blood products
- Accurate recording of the patient's indications for the use of blood and blood products, monitoring during the transfusion episode, response to transfusion and reporting of suspected reactions or adverse events including near miss incidents
- Patients and carers are informed about the risks and benefits of using blood and blood products and about the available alternatives when a plan for treatment is developed

Australian Commission on Safety and Quality in Health Care: Standard 7

Agency Nurse Information Pack

To verify that all staff involved with the prescription, patient monitoring and transporting of blood and blood products across SVHM, the prescribed modules of the BloodSafe e-Learning program (or similar program endorsed by the HTC) must be completed:

Designation within SVHM:	BloodSafe eLearning Australia Modules to complete:
Medical Staff: Intern, Resident or Registrar Division 1 Registered Nurse (All Grades)	Collecting Blood Specimens Clinical Transfusion Practice
Division 2 Registered Nurse (All)	Collecting Blood Specimens Advised to complete: Clinical Transfusion Practice
Scientist: Haematology/Transfusion Laboratory	Clinical Transfusion Practice
Pathology Collection Staff	Collecting Blood Specimens Transporting Blood Products
Support Services Associate	SVHM: Transporting Blood Products

For Support Services Associates, the HTC has endorsed an in-house program produced by the Clinical Nurse Consultant – Transfusion.

Staff who work in areas of the hospital that do not transfuse patients are not required to complete the activities; discuss this with your supervisor if you are unsure.

BloodSafe e-Learning Australia courses are endorsed by a range of college and organisations. You can usually claim one credit point for each hour you spend completing the courses.

Endorsements include:

- AOA (Australian Orthopaedic Association)
- ANZCA (Australian & NZ College of Anaesthetists)
- HSANZ (Haematology Society of Australia & New Zealand)
- RCPA (The Royal College of Pathologists of Australasia)
- RACP (Royal Australasian College of Physicians)
- RCNA (Royal College of Nursing Australia)

INTRODUCTION

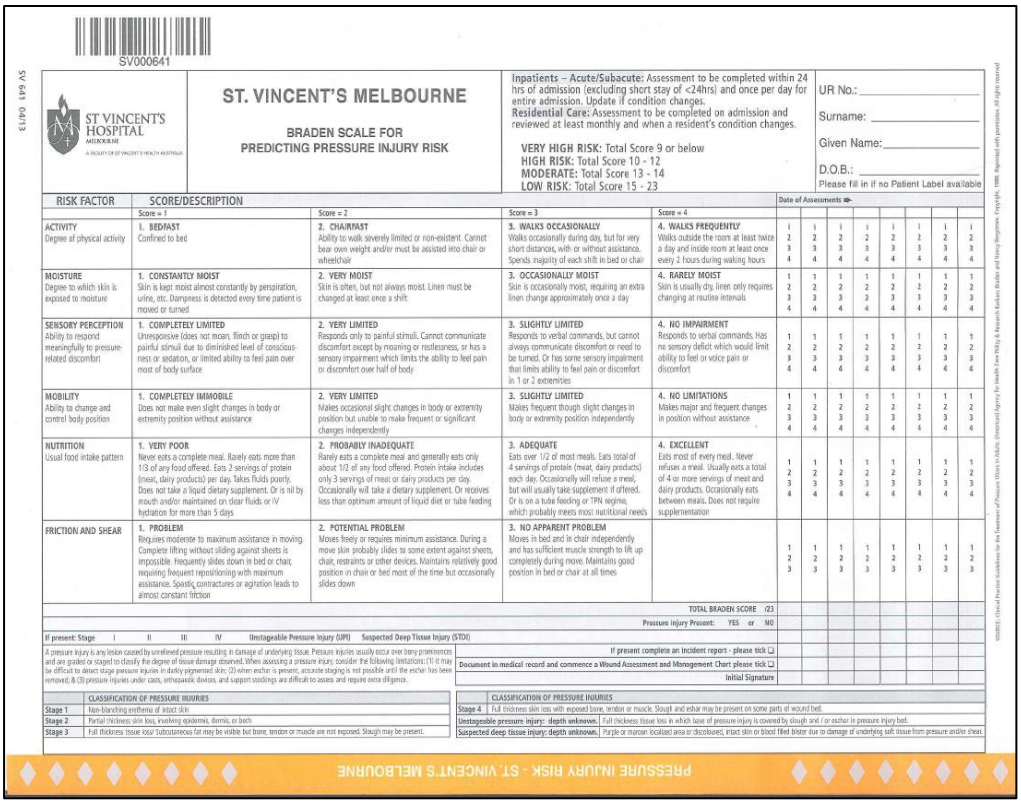
A pressure injury, also known as a bedsore or ulcer, is an area of skin that has been damaged due to unrelieved and prolonged pressure. A pressure injury can look like a reddened or blistered area on the skin and is usually found on a bony part of the body like the heels, tail bone or toes.

Although we are aware that pressure injuries are preventable adverse events, they continue to remain a problem in all health care settings. One Australian estimate of pressure injury prevalence in acute and sub-acute health facilities ranged from 5.6% to 48.4%, whereby hospital acquired pressure injuries accounted for 67.6% of these[1]. Pressure injuries can negatively impact on patient morbidity, mortality, pain level, discomfort, mobility and independence and can be a financial burden to organisations with patients experiencing protracted hospital admissions. The management of pressure injuries at SVHM requires a multidisciplinary team approach.

The Skin Integrity Project Working Group is the governance working group at SVHM responsible for developing the action plan for Standard 8. The working group reviews pressure injury prevalence and serious incidences, audits local ward compliance with guidelines, evaluates data and reviews guidelines and policies to ensure alignment with best practice. Each local ward area has a nominated Skin Champion who acts as a conduit for communication between the ward and the working group.

You can contact the project working group on: pressureinjuries@svhm.org.au
The intent of National Standard 8: preventing and managing pressure injuries, is to prevent patients from developing pressure injuries; managing pressure injuries in line with hospital policy and best practice standards if they occur. This includes ensuring there are evidence based systems and standardised risk assessment tools for clinicians to use, for example, the **St Vincent's Braden Scale for predicting pressure injury risk chart** (below):

[1] Australian Wound Management Association. Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury (2012). Osbourne Park, WA. Cambridge Media.



SV000641

ST VINCENT'S HOSPITAL MELBOURNE

ST. VINCENT'S MELBOURNE

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Inpatients – Acute/Subacute: Assessment to be completed within 24 hrs of admission (excluding short stay of <24hrs) and once per day for entire admission. Update if condition changes.
Residential Care: Assessment to be completed on admission and reviewed at least monthly and when a resident's condition changes.

VERY HIGH RISK: Total Score 9 or below
HIGH RISK: Total Score 10 - 12
MODERATE: Total Score 13 - 14
LOW RISK: Total Score 15 - 23

UR No.:
Surname:
Given Name:
D.O.B.:
Please fill in if no Patient Label available

RISK FACTOR	SCORE/DESCRIPTION				Date of Assessments ➨
	Score = 1	Score = 2	Score = 3	Score = 4	
ACTIVITY Degree of physical activity	1. BEDFAST Confined to bed	2. CHAIRFAST Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	3. WALKS OCCASIONALLY Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. WALKS FREQUENTLY Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours	1 2 3 4
MOISTURE Degree to which skin is exposed to moisture	1. CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned	2. VERY MOIST Skin is often, but not always moist. Linen must be changed at least once a shift	3. OCCASIONALLY MOIST Skin is occasionally moist, requiring an extra linen change approximately once a day	4. RARELY MOIST Skin is usually dry, linen only requires changing at routine intervals	1 2 3 4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	1. COMPLETELY LIMITED Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, or limited ability to feel pain over most of body surface	2. VERY LIMITED Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, or has a sensory impairment which limits the ability to feel pain or discomfort over half of body	3. SLIGHTLY LIMITED Responds to verbal commands, but cannot always communicate discomfort or need to be turned. Or has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities	4. NO IMPAIRMENT Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	1 2 3 4
MOBILITY Ability to change and control body position	1. COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance	2. VERY LIMITED Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. SLIGHTLY LIMITED Makes frequent though slight changes in body or extremity position independently	4. NO LIMITATIONS Makes major and frequent changes in position without assistance	1 2 3 4
NUTRITION Usual food intake pattern	1. VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings of protein (meat, dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. Or is nil by mouth and/or maintained on clear fluids or IV hydration for more than 5 days	2. PROBABLY INADEQUATE Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. Or receives less than optimum amount of liquid diet or tube feeding	3. ADEQUATE Eats over 1/2 of most meals. Eats total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take supplement if offered. Or is on a tube feeding or TPN regime, which probably meets most nutritional needs	4. EXCELLENT Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	1 2 3 4
FRICTION AND SHEAR	1. PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. POTENTIAL PROBLEM Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. NO APPARENT PROBLEM Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times		1 2 3
				TOTAL BRADEN SCORE /23	
				Pressure Injury Present: YES or NO	

If present: Stage I II III IV Unstageable Pressure Injury (UPI) Suspected Deep Tissue Injury (SDTI)

A pressure injury is any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure injuries usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. When assessing a pressure injury, consider the following limitations: (1) it may be difficult to detect stage pressure injuries in darkly pigmented skin; (2) when eschar is present, accurate staging is not possible until the eschar has been removed; & (3) pressure injuries under casts, orthopaedic devices, and support stockings are difficult to assess and require extra diligence.

If present complete an Incident report - please tick ☐
Document in medical record and commence a Wound Assessment and Management Chart please tick ☐
Initial Signature

CLASSIFICATION OF PRESSURE INJURIES	
Stage 1	Non-blanching erythema of intact skin
Stage 2	Partial thickness skin loss, involving epidermis, dermis, or both
Stage 3	Full thickness tissue loss! Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present.
Stage 4	Full thickness skin loss with exposed bone, tendon or muscle. Slough and eshar may be present on some parts of wound bed.
Unstageable pressure injury: depth unknown	Full thickness tissue loss in which base of pressure injury is covered by slough and / or eschar in pressure injury bed.
Suspected deep tissue injury: depth unknown	Purple or maroon localised area or discoloured, intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear.

PRESSURE INJURY RISK - ST. VINCENT'S MELBOURNE

The Pan Pacific Guideline for the Prevention and Management of Pressure Injury is the primary resource for National Standard 8: http://www.awma.com.au/publications/publications.php#pipm

Posters displayed throughout the hospital like this illustrate the Pressure injury classification system utilised at St Vincent's

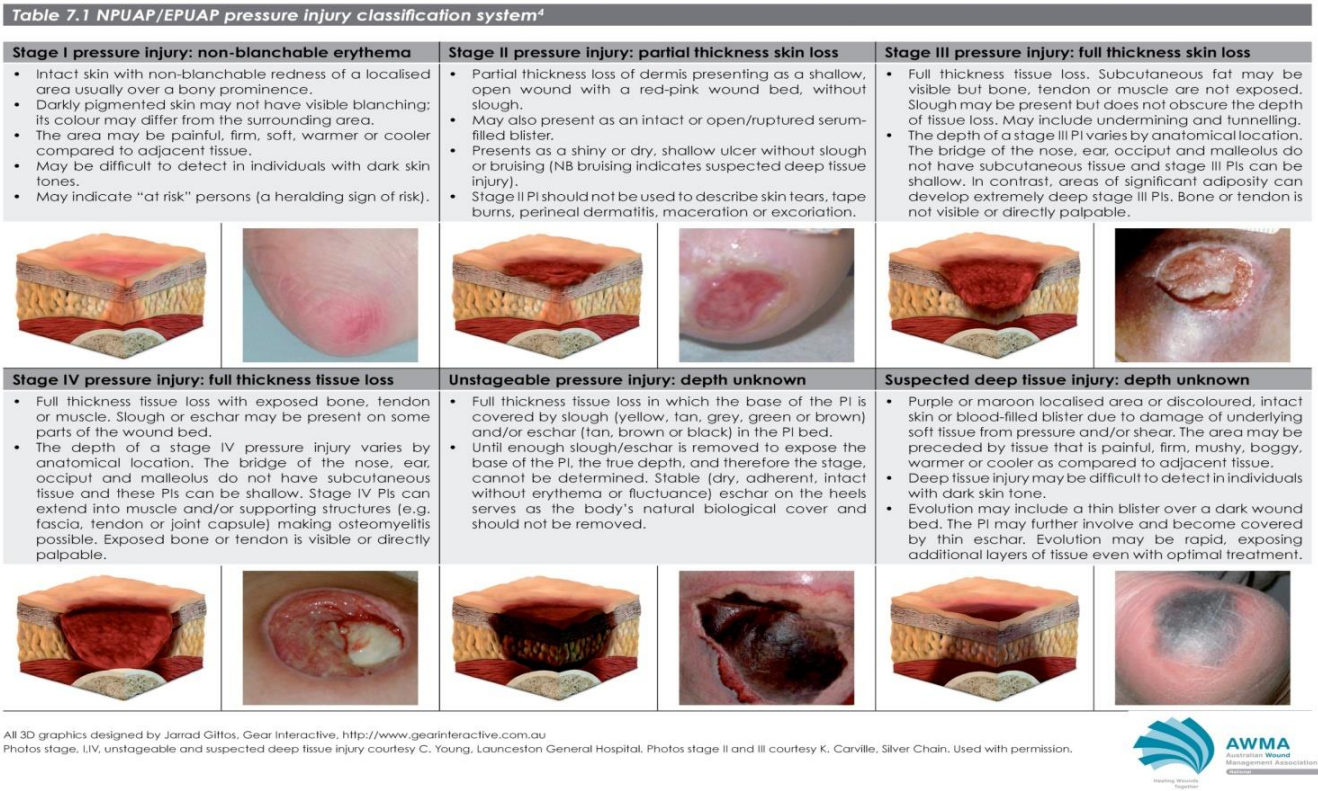


Table 7.1 NPUAP/EPUAP pressure injury classification system[4]

Stage I pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a heralding sign of risk).

Stage II pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage III pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.

Suspected deep tissue injury: depth unknown

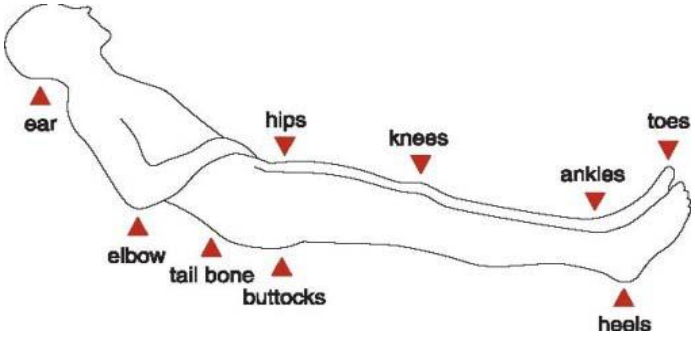
- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

All 3D graphics designed by Jarrad Gittos, Gear Interactive, http://www.gearinteractive.com.au
Photos stage, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain. Used with permission.

AWMA Australian Wound Management Association Inc.

Pressure injuries are preventable but when they occur, it contributes to the care needs of patients and prolong their time in hospital. Risk factors for pressure injury include, but are not limited to: decreased mobility, nutritional status, skin integrity, age and oxygen perfusion to pressure points.

COMMON PRESSURE INJURY PREVALENCE POINTS



RELATED SVHM POLICIES

- Skin Integrity
- Pressure Injury Prevention Clinical Practice Guidelines
- Skin Tear Prevention and Management Guideline
- Wound Care Product Guidelines
- Wound Dressing

These guidelines and policies are accessible on the intranet within the Skin / Integumentary section.

CLINICAL RESPONSIBILITIES

As a clinician at SVHM you are require to:

- Conduct and accurately document a skin assessment and risk assessment for every patient in line with SVHM guidelines
- Ensure all pressure injuries identified are staged accurately in line with SVHM guidelines
- Document and implement appropriate best practice prevention and management strategies in line with SVHM guidelines and evaluate their effectiveness

Prevention and management interventions on page 2 of the Braden Scale for predicting pressure injury risk

ST VINCENT'S HOSPITAL MELBOURNE

ST. VINCENT'S MELBOURNE

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

INTERVENTIONS FOR THE PREVENTION OF PRESSURE INJURY RISK

The table below provides a guide to interventions which should be considered for all patients assessed at risk, and additional interventions to be considered for patients assessed as moderate to very high risk. There may be other interventions more appropriate for individual patient risk factors, thus the table should not replace clinical judgement.

UR No.: _____
Surname: _____
Given Name: _____
D.O.B.: _____
Please fill in if no Patient Label available

RISK FACTOR	STEP 1 INTERVENTIONS FOR ALL PATIENTS TO PREVENT PRESSURE INJURY	STEP 2 ADDITIONAL INTERVENTIONS FOR ALL PATIENTS WITH MODERATE TO VERY HIGH RISK OR EXISTING PRESSURE INJURY
ACTIVITY & MOBILITY	☐ Inspect pressure points daily ☐ Educate patient to shift weight every 15 minutes when sitting ☐ Reposition at least every 2 hours ☐ Avoid positioning on trochanter (hip) ☐ Avoid head of bed elevation of more than 30 degrees (unless medically indicated) ☐ Consult Physiotherapy ☐ Consult Occupational Therapy (for seating requirements and pressure relieving devices) ☐ Consult Podiatry	☐ Reposition at least once every hour if chairfast ☐ Use pressure relieving device/equipment as recommended by Occupational Therapy/Podiatry ☐ Use pillows or foam wedges to protect bony prominences ☐ Elevate heels from bed using a heel wedge ☐ Use alternating air mattress replacement ☐ Consult Prosthetics & Orthotics for bed-resting AFO (ankle foot orthosis) ☐ Use bed cradle ☐ Conduct regular comprehensive skin inspection for at risk patients and document in progress notes ☐ Refer to Occupational Therapy for seating and pressure care assessment
PREVENTATIVE DEVICES	☐ Ensure patient has a preventative pressure cushion when sitting out of bed ☐ Educate patient on use of preventative pressure cushion ☐ Consider use of heel wedge under bed sheet to prevent heel damage	
MOISTURE	☐ Wash with tepid water ☐ Avoid overuse of soap, consider use of soap alternative ☐ Moisturise skin with an approved moisturiser ☐ Protect skin from urine/faeces with barrier cream ☐ Toilet regularly ☐ Manage urinary incontinence ☐ Manage faecal incontinence/diarrhoea/constipation	
SENSORY PERCEPTION NUTRITION	☐ Ensure adequate and appropriate pain control ☐ Encourage oral intake ☐ Weekly weight ☐ Refer to Dietician if concerned about nutritional intake and/or patient has a stage 2 – 4 pressure injury	
FRICTION & SHEAR	☐ Do not drag patient during transfers and positions changes ☐ Use lifting devices and/or slide sheets	
DOCUMENT	☐ Patient is consulted and informed of prevention and management plan (interventions as above) ☐ Comprehensive skin assessment is undertaken for all patients and documented in progress notes	

Interventions should be documented **on admission** and **updated** when a change in patient condition warrants review. If there is a change in condition requiring additional interventions then tick the relevant boxes, sign and date. If an intervention is no longer required sign, date and write N/A next to the intervention.

SV 641 04/13

- Complete the online Skin integrity learning package via EKP
- Complete a VHIMs incident for every pressure injury identified
- If a pressure injury is present, complete a wound management chart in line with SVHM guidelines
- Ensure identified pressure injuries and prevention and management strategies are handed over
- Inform patients with a high risk of pressure injury and their carers about the risks, prevention strategies and management of pressure injuries
- Consider attending non-mandatory training, for example, the Wound Management Study Day or the annual SkinTASTIC Expo in March to keep up to date with best practice standards in pressure injury management.

KEY MESSAGE

- Pressure injuries are avoidable in most cases, early intervention and management reduces risk
- Pressure injuries impact on patient length of stay, health outcomes, financial cost to the organisation and quality of life
- Pressure injuries can occur in any setting from emergency departments to rehabilitation and even on transfer between wards
- Familiarise yourself with SVHM guidelines and polices to ensure compliance with skin and risk screening, management of pressure injuries and reporting requirements

GENERAL

Basic Life Support (BLS) training is available to clinical SVHM employees. The following health professionals are required to complete a BLS competency assessment annually:

- Enrolled Nurses
- Registered Nurses
- Junior Medical Staff
- Senior Medical staff
- Physiotherapists
- Occupational Therapists
- Speech Therapists
- Radiographers
- Psychologists

It is recommended that SSA staff be given the opportunity to attend BLS training if they wish.

All medical and nursing professionals who are responsible for providing direct patient care in a critical care area at SVHM [ICU, ED, CCU] should complete an ALS (Advanced Life Support) competency assessment annually [excluding rotating Graduate and G2PDY Nurses]. Medical and nursing members of the Respond Blue teams should complete an ALS competency assessment annually.

The SVHM Clinical Education and Simulation Unit provides mandatory training in BLS and ALS for all pre-vocational medical staff. This process involves an online component to review the most recent information regarding resuscitation, attendance at a primary ALS skills simulation session as well as a "Managing a deteriorating patient" simulation session. These programs can be accessed via EKP. Specialist medical staff are also welcome to attend these courses for refresher training.

Staff are also required to undertake a once off ISBAR competency.

STRUCTURE OF SVHM'S BLS COMPETENCY ASSESSMENT

The BLS competency assessment is conducted by a Nurse Educator or another member of staff designated by SVHM to provide instruction in BLS. It is a 2-part process involving:

1. Satisfactory completion of the BLS online learning package on EKP.
2. Satisfactory demonstration and articulation of BLS techniques in a scenario-based assessment.

This scenario should incorporate the use of BLS equipment (e.g. AED, manual resuscitator bag) available in the health professional's usual area of practice. Steps in preparing for BLS competency assessment include:

1. Reading these BLS guidelines
2. Reviewing local Code Blue/Respond Blue policies

3. Completing the resuscitation equipment checking procedure in your area of practice
4. Participating in a BLS workshop conducted by a Nurse Educator or another member of staff

MEASUREMENT AND DOCUMENTATION OF OBSERVATIONS

The Australian Commission on Safety and Quality in Health care has set out six observations that must be documented for every patient whenever you take a set of vital signs. These are:

- Respiratory Rate
- Oxygen Saturations
- Blood Pressure
- Heart Rate
- Temperature
- Sedation score

Ongoing auditing will be conducted to assess compliance and evaluation.

FREQUENCY OF OBSERVATIONS / MONITORING PLANS

Physiological observations play a significant role in detecting clinical deterioration and abnormalities may occur early or late in the deterioration process or at any time during a patient's acute hospital admission. Patients in acute care settings can often go for prolonged periods without having physiological observations being measured. This can mean that clinical deterioration may not be recognised and treatment may be delayed.

- The frequency of observations should be consistent with the clinical situation of the patient
- The **minimum standard** is at least **once per eight hour shift**

Some patients may require more or less frequent observations, depending on their current clinical situation, treatment goals and requirements. For example, when the goal is to provide comfort and dignity to patients who are dying, observations may be measured less frequently. This needs to be documented in the "Frequency of Observations/Monitoring Plan" section on the Observation and Response Chart (ORC).

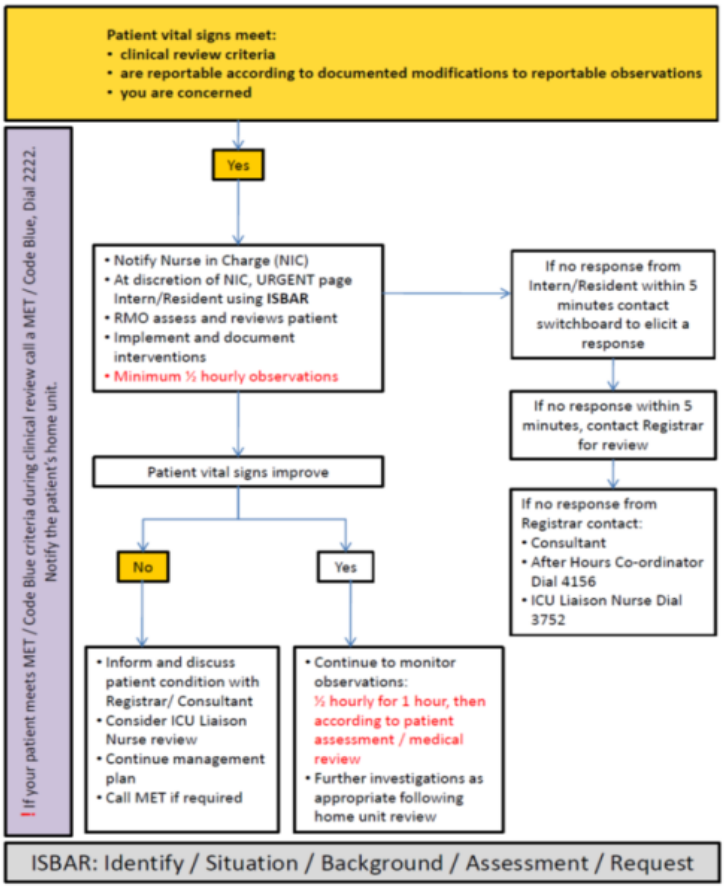
- **Medical officer** to document if observations are to be measured **less than** minimum standard (once per eight hour shift)
- **Medical officer or Nurse** to document if observations are to be measured **greater than** minimum standard (once per eight hour shift
- If no frequency is documented, the minimum standard is once per eight hour shift

There will be ongoing auditing to assess our compliance and identify areas for improvement.

ESCALATION OF CARE

Understanding how to respond to abnormal physiological measurements is a complex process. It can be difficult for health professionals to know when and who to call. Delays in responses to clinical deterioration are associated with poorer outcomes for patients. The latest research shows that deranged vital signs are observable up to 48 hours before an adverse event. *Preece MHW, et al. (2012).* Therefore, adverse events are predictable and potentially avoidable.

Refer to the flow chart for the escalation of care process for a patient who meets the clinical review criteria (orange shaded area on the ORC) or who you are concerned about.



Agency Nurse Information Pack

FAMILY ESCALATION OF CARE

Investigation into adverse events has indicated that delays in escalating care can occur despite families and carers identifying clinical deterioration in patients. Families and visitors provide additional surveillance for health professionals. If signs of clinical deterioration are recognised, family may inform a nurse or doctor who should do a complete set of observations and escalate care accordingly if required.

Patients and families should be informed of the process to escalate care on admission.
In essence, the informal process is being formalised. Your responsibility is to inform your patient/family/carer on admission that if they are worried about a change in their condition, they should let their nurse or doctor know.

YOUR RESPONSIBILITIES

- Complete BLS or if applicable ALS competencies annually
- Complete ISBAR competency
- Document all six core physiological observations
- Document observations according to the Monitoring Plan or the minimum standard on the ORC
- Use the Escalation of Care flowchart to support your clinical decision to escalate care
- Inform your patients to let the nurse or doctor know if they have concerns about a recent change in their condition
- Ensure the Acute Resuscitation form has been completed

FURTHER INFORMATION

The Deteriorating Patient Project Working Group.

Phone: 9288 2846

Email: deterioratingpatient@SVHM.org.au

Intranet: Review the relevant SVHM policies:

- Code Blue
- Medical Emergency Team (MET)
- Basic Life Support (BLS) Guidelines

- Advanced Life Support (ALS) Guidelines
- Escalation of Care Guidelines
- Frequency of Core Physiological Observations Guidelines
- Clinical Handover Guidelines
- Care Planning in Advance "Best CARE"
- Not for Cardiopulmonary Resuscitation

Falls are a leading cause of injury in hospitals and are increasingly prevalent due to an ageing and more frail patient population. At SVHM, the falls prevention program is based on best practice and is outlined in SVHMS Falls Prevention and Management Guidelines. All clinical staff are required to understand and work within the SVHM Falls Guidelines at all times. The Falls Project Working Group governs our organisational approach to falls prevention and management and can be contacted on: falls@svhm.org.au.

There are several key steps to preventing falls and harm in hospital.

PATIENT ENVIRONMENT

Ensure that the patient environment is free of falls hazards, including clutter, and that required objects are within patient reach. Patients should be encouraged to call for assistance early rather than waiting for their need to become urgent. Many patients experience injurious falls because they did not want to disturb staff or to be a burden. Cognitively impaired patients require frequent (at least hourly) offers of assistance with comfort, toileting etc.

IDENTIFY AT RISK PATIENTS VIA THE FALLS SCREEN AND ASSESSMENT

A **Falls Screen** is to be carried out on ALL admitted patients and should be documented on the Nursing Admission Risk Assessment Form SV700 (in acute) or the NH STRATIFY form SV961. Answering 'yes' to any question requires a falls *assessment* to be undertaken.

The Falls Assessment tool used at SVHM is a validated tool which has proven to be an accurate predictor of falls risk, however, clinical judgement should always prevail. If you believe a patient to be a high falls risk, then the appropriate interventions should be instituted.

A management plan is required for all patients assessed as a HIGH risk. The plan includes six basic nursing interventions which are aimed at 'keeping the patient safe'. They should accompany multidisciplinary strategies which are based on the risk factors identified. The plan of care should be developed and discussed with patients and family and documented in the medical record.

StV

ST. VINCENT'S MELBOURNE

NORTHERN HEALTH - STRATIFY FALLS ASSESSMENT

UR No.:_____
Surname: _____
Given Name:_____
D.O.B.: _____
Please fill in if no Patient Label available

Instructions:
1) Assessment to be completed for all patients who screen positive on admission (i.e. are >65yrs ❑ and/or have a history of falls ❑ and/or nurse assesses as at risk of falling ❑)
2) All patients assessed as high risk to have management plan completed and interventions applied according to risk factors. Interventions in bold are mandatory for all high risk patients.
3) Reassess following every fall, when there is a change in patient condition or function and/or when there is a change in environment (e.g. on transfer).

FALLS PREVENTION The Northern Hospital Modified Stratify (TNH-Stratify) Evaluated through TNH Research Project: "Evaluation of The Northern Hospital Modified Stratify" 2008		Score
1. Fall: current admission?	Yes, Patient had a fall/s during current admission	3
2. Fall: within 12 months?	Yes, Patient had fall/s in the last 12 months (Check pt info on admission form)	1
3. Mental State?	Yes, Patient is e.g. confused, agitated, intellectually challenged, impulsive	1
4. Mobility?	Yes, Patient needs supervision or assistance when mobilising	1
5. Impaired Balance?	Yes, Patient has impaired balance and/or hemiplegia	1
6. Age?	Yes, Patient is 80 years or older	1
7. Toileting?	Yes, Patient is in need of frequent toileting	1
8. Vision?	Yes, Patient is visually impaired to the extent that everyday function is affected	1
9. Drug/Alcohol	Yes, Patient presented with drug/alcohol related problems	1
Risk Score/Level	3 or more = High Risk	

Assessment Date and Signature	Tick appropriate box indicating presence of risk factor.	Management plan for high risk patients	Report falls
------/ -------/-------	Tick if answer yes. Score of 3 or more is high risk.	❑ Alert sign above bed ❑ Physio referral ❑ Hi-Low Bed ❑ Bathroom: MUST Supervise patient ❑ Bed/Chair alarm ❑ Adhere to toileting regime TOILETING REGIME Pt Self/Prompt/Staff Assist Every: 1/2/ _____ hours Continent? Yes/No/Accidents ❑ Management Plan discussed with patient/family	Complete VHIMS for every inpatient fall. Date of fall/Incident report: Fall 1 _____ Fall 2 _____ Fall 3 _____ Fall 4 _____
----------	❑ Fall current admission (3) ❑ Fall within 12 months (1) ❑ Mental state (1) ❑ Mobility (1) ❑ Impaired balance (1) ❑ Age >80 (1) ❑ Toileting (1) ❑ Vision (1) ❑ Drug & alcohol (1) SCORE of 3 or more is HIGH RISK Low ❑ High ❑ Complete Management Plan		

Other Comments/Interventions:

SV 961 03/13

NORTHERN HEALTH - STRATIFY FALLS ASSESSMENT - ST. VINCENT'S MELBOURNE

IMPLEMENTATION OF BEST PRACTICE STRATEGIES

It is mandatory for all patients who are assessed as a HIGH risk to have a falls alert sign placed above their bed area; this should occur after consultation with the patient and/or family. It is also mandatory that these patients receive a physiotherapy review and assessment. Other factors that need to be considered include:

- Medical assessment for underlying conditions that are contributing to risk
- Review of patient medication, particularly psychotropic medications and other drugs that are known to increase the risk of falling
- Allied health referral based on individual needs
- Best practice management of delirium
- Use of hi-low beds to prevent injuries associated with falls from height. Confused patients who are a falls risk should always be placed on a hi-low level bed. The use of cot sides in this patient group has been shown to increase injury. Standard beds lower to 40cm off the ground and should be put to the lowest level pending hi-low bed availability
- Bed/chair alarms can be useful in patients who require supervision whilst ambulating but are confused and unable to press the buzzer and wait for assistance. Proximate alarms are available on the wards and can also be hired when required

The full list of preventative strategies can be accessed via the SVHM Falls Prevention Guidelines.

TOILETING

Serious injuries and deaths have occurred in patients falling in bathrooms. Patients who are a falls risk and are confused should NEVER to be left unsupervised in the bathroom. A specific 'red alert' has been developed for this patient group and should be placed above the patient's bed instead of the standard orange falls alert. Additional caution is required for patients who have an increased tendency to bleed, such as patients on anticoagulation or with platelet/clotting disorders.

"IF IN DOUBT… HANG ABOUT"

POST FALL MANAGEMENT

- All patients who sustain a fall require an assessment, including basic life support, baseline and ongoing monitoring and investigation of suspected injuries
- Following a fall, the patient's falls assessment should be reviewed to ensure it identifies any additional risk factors and strategies that are required. This should be done with consideration to the particular fall and contributing factors. Patients should be asked if they remember any detail about the fall and this should be included in documentation
- Families/NOK should be informed as soon as possible that the fall has occurred
- The fall, any contributing factors, injuries and open disclosure should be documented in the medical record

REPORTING

- SVHM promotes a safe reporting culture and all falls, hazards and near misses should be reported in the VHIMs incident reporting system

YOUR RESPONSIBILITIES

- Complete the online Falls Module available in EKP (this is required by all clinical staff including nurses, junior medical officers and relevant allied health as a 'once off' training and at your manager's discretion)
- Always work within the SVHM Falls Prevention and Management Guidelines
- Report all falls, hazards and near misses

9 St Vincent's Health Melbourne Locations

- St Vincent's Hospital Melbourne – **see campus map below**
  41 Victoria Parade, Fitzroy VIC 3065

Clinical Area	Specialties
10 East	Stroke, Renal, Neurology, Dermatology & General Medicine
10 West	Neurosurgery /Neurology
9 East	Orthopaedics
9 West	Orthopaedic Oncology
8 East	General Medicine (Medical Unit)
8 West	General Medicine (Medical Unit)
7 East	Upper Gastrointestinal/Hepatobiliary /Breast & Endocrine Surgery
7 West	Colorectal/Gastroenterology/Urology (Surgical Unit)
6th Floor	Oncology, Haematology & Palliative Care (Medical Unit)
5 West	Ear Nose Throat (ENT), Plastics & Vascular (Surgical Unit)
Medi-Hotel	Pre & Post Treatment Low Acuity Patient Accommodation
Mental Health Inpatient	Acute Mental Health
St Augustine's	Correctional Health
4 East	Cardiothoracic/Respiratory
4 West	Coronary Care Unit / Cardiology
ICU	Intensive Care Unit
ECC	Emergency Department
GEM - Fitzroy	Geriatric Evaluation and Management (Bolte Wing)
Rehab - Fitzroy	Sub-Acute Rehabilitation (Bolte Wing)

- St George's Hospital Kew – **see campus map below**
  283 Cotham Road, Kew VIC 3101

Clinical Area	Specialties
Ellerslie Unit	Transition Care
GEM - Kew	Geriatric Evaluation and Management
Rehab - Kew	Sub-Acute Rehabilitation

- Caritas Christi Hospice Kew
  104 Studley Park Rd Kew 3101

- Prague House - Care of the Homeless
  253 Cotham Road, Kew VIC 3101

- Residential Aged Care
    - Auburn House
      98 Camberwell Road, Hawthorn East VIC 3123
    - Cambridge House
      Cambridge Street, Collingwood VIC 3066
    - Riverside House
      2 River Street, Richmond VIC 3121
    - Normanby Unit (Co-located at St George's Kew)
      283 Cotham Road, Kew VIC 3101
- Community Health
    - Clarendon Community Mental Health Centre
      52 Albert Street, East Melbourne VIC 3002
    - The Footbridge
      Napier Street, North Fitzroy VIC 3068
    - Hawthorn Community Mental Health Centre
      642 Burwood Road, Hawthorn East VIC 3123
    - St Vincent's Rehabilitation Centre Northcote
      92 Dennis Street, Northcote VIC 3070

10. Access for Emergency Care Centre & Department of Critical Care Medicine (ICU) only

Any agency nurse who has been contracted to work at St Vincent's Hospital Melbourne (SVHM) Emergency Department [ECC] or the Department of Critical Care Medicine [DCCM] are on arrival to go to Security [located on Ground Floor IPS Building] to collect a SVHM Agency Swipe Card. This card will provide the contracted nurse with access & egress to the relevant Department & Medication Rooms & IT systems.

If you have been booked to work in either of these departments the following applies:

- Present to Security Department before starting work in ECC & DCCM
- Produce photo ID which will be viewed by the Security Officer for verification purposes
- You will be expected to sign the Security Register when Security Officer hands you the SVHM Agency Swipe Card
- You will be required to leave your Driver's License or Agency Docket Book with Security for collection at the end of your shift
- Proceed to ECC or DCCM to work your shift
- At the completion of your shift you will be required to return to Security to:
    1. Return your swipe card
    2. Security Officer will sign the Security Register that you have returned the swipe card and will return your driver's license or agency docket book

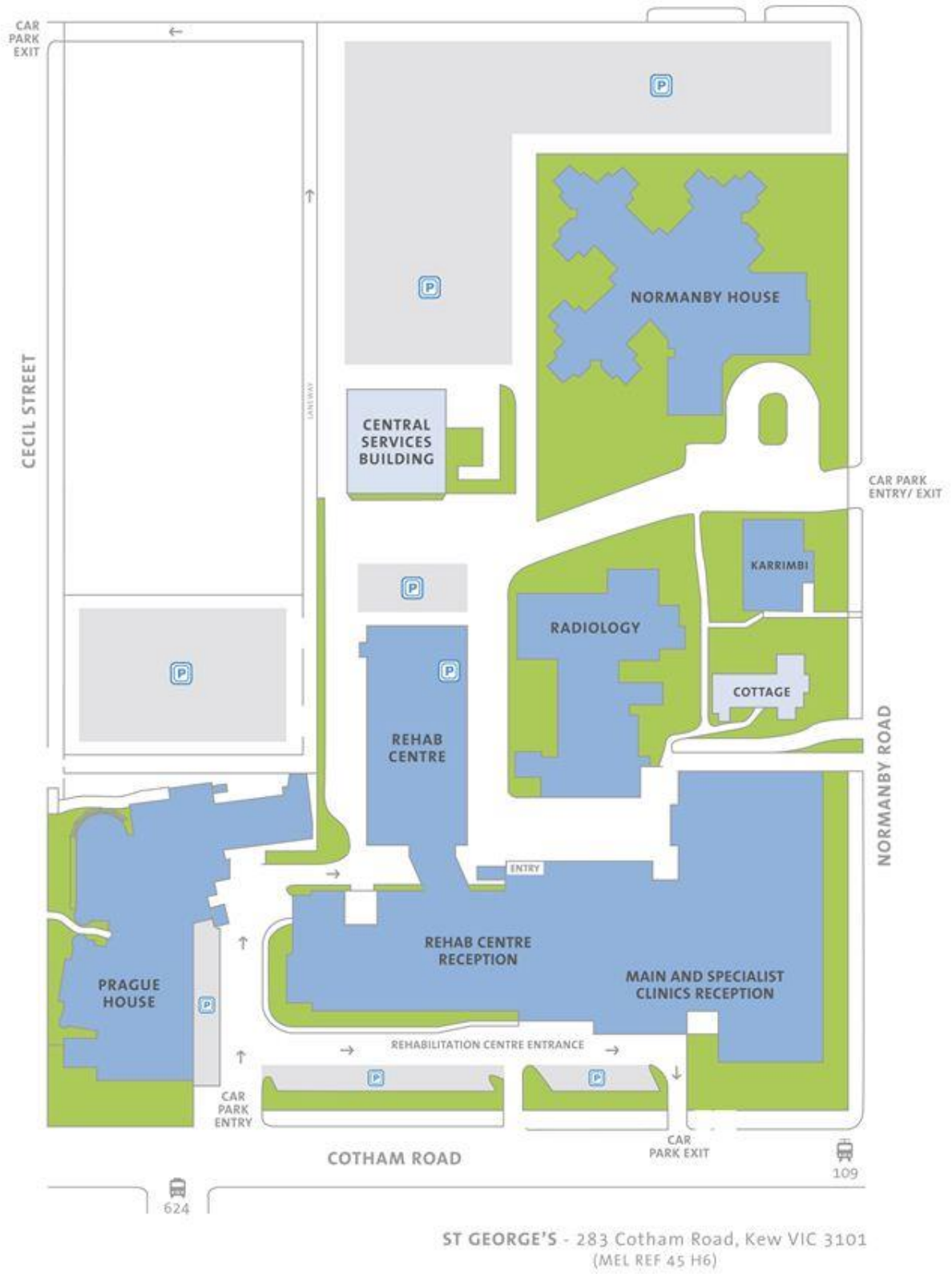
Please note: No other form of identification will be accepted, i.e. Medicare Card, Working with Children Card, credit card and the like, car or house keys are also not acceptable. If you don't have the appropriate photo identification, a security card will not be issued.

The purpose of this is to ensure that all SVHM Agency Swipe Cards are accounted for & that there is a record of the contractor who has been allocated one of these cards to work in ECC & DCCM.

11 Car Parking

St Vincent's Hospital Melbourne Campus Map

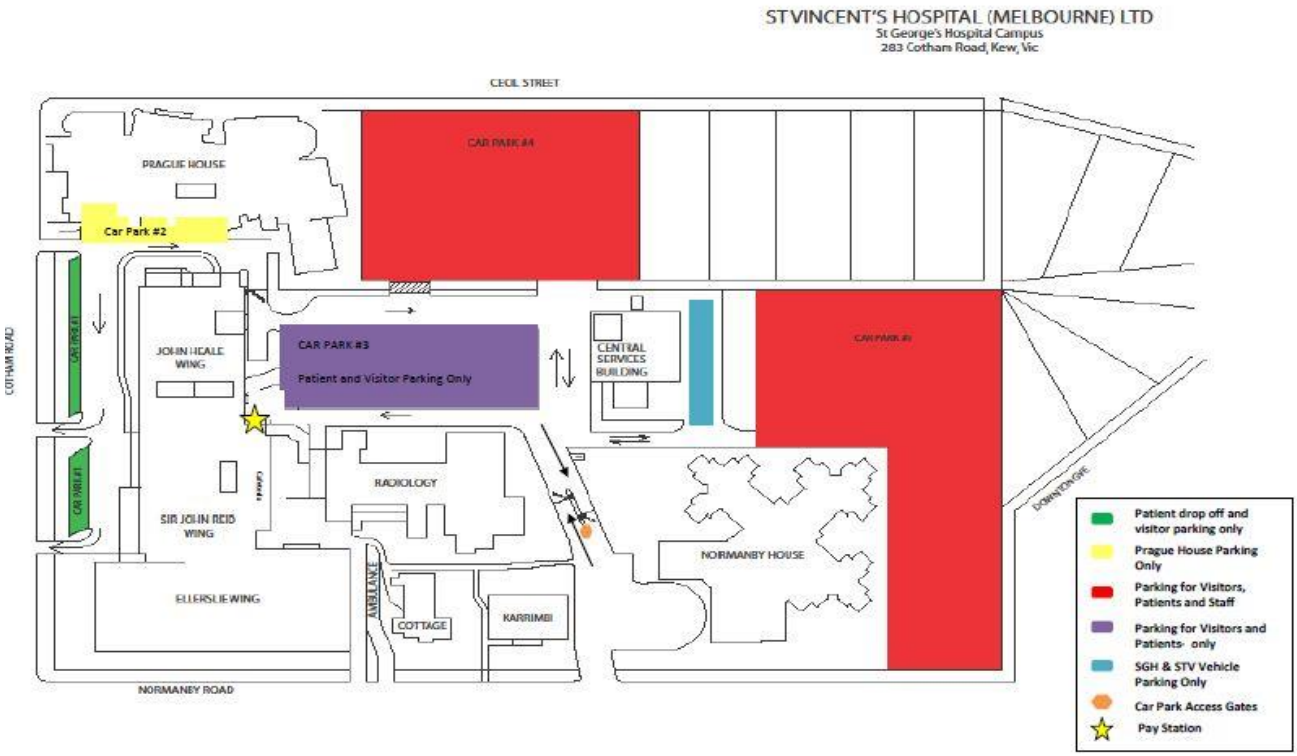
St George's Hospital Kew Campus Map



St Vincent's Hospital Fitzroy Campus Car Park Map

Please note that parking can be limited and the surrounding areas are patrolled by parking inspectors.

St George's Hospital Kew Car Park Map



12 Agency Nurse Attendance and Documentation

Upon arrival if you have any concerns re your booked shift please call your agency to confirm the shift details – if any problems arise the agency is to contact SVHM allocations office / After Hours coordinator.

At the end of each shift agency staff are required to complete an agency attendance docket in clear legible English handwriting. Please ensure to have this signed by the nurse in charge and leave the hospital copy of the attendance docket in the designated area of the unit.

Smoke Free Workplace

As of July 2009, and continuing into the future, St Vincent's has adopted a clear position about tobacco smoking.

Smoking is not permitted in SVHM buildings, vehicles or outdoor areas within the boundary of any of our facility sites except where a designated smoking area (DSA) has been approved solely for the use of patients.

Smoking is not permitted within 4 metres of an entrance to a public health service, unless that area is used as part of a café/restaurant.

With regard to the complexities of the addiction to nicotine, SVHM offers support to patients while they are within St Vincent's and also to staff who are looking to either stop smoking altogether or to manage their cravings while at the workplace.