Name: _________________________________ Completion Year: _______________

Directions: Upon completing the selected skill for the selected age group, the evaluator will place their initials, date, and method used to evaluate in the space provided. This will signify all aspect of care have been demonstrated correctly for the corresponding age group. The full signature and title are required of the evaluator. All sections must be addressed, use N/A to indicate not applicable.

Method Codes:
O=Observation of care provided,
W=Written exam (must be used in conjunction with an observation of care provided to establish competency),
S=Skills Lab (simulation),
N/A = Not Applicable results in non-competence.

• All competency checklists will be forwarded to Human Resources and filed in the colleague’s record.
### Cultural Diversity

*Demonstrates cultural specific interventions while assessing, planning and evaluating patient care. See Cultural Diversity Table located on the intranet, education department page*

<table>
<thead>
<tr>
<th>Medical Record Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(For cultural diversity use only)</td>
</tr>
</tbody>
</table>

### Patient Safety Measures

- X Identifies patient using two patient identifiers per policy and procedure.
- X Identifies changes in vital signs or condition.
- X Properly uses and responds to any and all alarms.
- X Verbalizes Fall precautions and is compliant with policy and procedure.
- X Assesses patient’s condition according to unit policy.
- X Uses proper body mechanics for self and patient.
- X Ensures patient’s call light is within patient’s reach at all times.
- X Maintains patient area so it is clear and clutter free.
- X Ensures bed, stretchers, and wheelchairs are locked at all times when not in transit.
- X Maintains bed / stretcher in lowest position when not at patient’s bedside.
- X Demonstrates sterile technique.
- X Demonstrates knowledge of thermoregulation and the potential for complications.

### Ventriculostomy Devices

- X Documents a full body assessment including an in-depth neurological assessment as ordered by the physician and unit policy.
- X Ensures all connections are secure and tubing length is sufficient to allow patient movement in bed, preventing displacement of the device.
- X Assesses dressing, observes for CSF leakage.
- X Levels drip chamber of drainage device to the foramen of Monroe (middle of ear).
- X Demonstrates adjustments of drainage system as per physician order (example: 5 cms above zero reference).
- X Verbalizes potential complications, signs, and symptoms. Verbalizes action plan / treatments for complications.
- X Conveys all changes in patient response / condition to physician.
- X Documents all patient and family education on appropriate form in medical record.
- X Documents all care / treatment provided in medical record.
### Coding the Meter:
States coding is necessary when new vial is opened, Properly inserts Code Key and leaves in the meter.

### Routine testing procedure:
- Washes hands and dons gloves, Positive patient I.D. using 2 required identifiers
- Select the puncture site on the lateral aspect of the finger
- Position the finger in an independent position and massage towards the fingertip
- Cleanse site with 70% alcohol pad. Allow to dry
- Position sterile lancet against skin push the release switch and puncture skin
- Lightly squeeze the patient’s finger wipe away first drop of blood
- Proceed with patient testing, turn power button ON
- Enters or scans operator ID, Presses forward arrow
- Selects patient test, Enters patient ID, Presses forward arrow
- Confirms code number by scanning the strip vial
- Removes test strip from vial and inserts in the strip port, Immediately recaps vial
- When flashing drop appears on the meter display, applies blood
- Verifies that entire test window is covered with blood
- Reads results, enters comment code, if necessary
- Presses the forward arrow to return to main menu, if no further testing is desired, presses OFF button.

### Reviewing Results:
- Presses power ON button, Enters or scans operator ID
- Selects review results on the main menu screen
- Presses the up or down arrows to display various test results
- Selects patient, enters or scans patient ID for desired result
- Presses the up or down arrows to display various results for the selected patient
- Selects ALL to return to viewing all results
- Selects QC to view QC results, Presses the up or down arrows to display the various QC results
- Educated on maltose interference

### Quality Control:
- Demonstrates what to do when “QC due Immediately” appears on the display
- Verbalizes when to discard solution (3 months after opening or the expiration date whichever comes first)
- Performs the quality control test exactly like a routine test, using one drop of control solution instead of blood
- Compares the result obtained with the target range for validation.
**KNOWLEDGE TEST - Indicate TRUE (T) or FALSE (F) for each below:**

- The Accu-Chek inform system records operator and patient ID information.
- The test strip is placed in the test strip slot with the yellow target area or test window facing up.
- The proper site for the finger puncture is on the side of the finger tip.
- If the drop of blood is not large enough to cover the yellow target area, it is acceptable to add another drop within 15 seconds.
- Glucose solutions do not have to be dated when first opened.

<table>
<thead>
<tr>
<th>Fire Safety</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Demonstrates knowledge of fire safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Identifies risk factors and high risk procedures or equipment</td>
<td></td>
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<tr>
<td>X Identifies location of fire extinguishers</td>
<td></td>
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<tr>
<td>X Identifies fire evacuation route for surgical services</td>
<td></td>
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</tbody>
</table>

**Indicate TRUE (T) or FALSE (F) for each below:**

- Head and neck procedures present a higher risk for fire.
- Allowing prep solutions to dry helps diminish fire potential.
- It is the responsibility of everyone to be familiar with use location and proper use of fire extinguishers and the location of pull stations.

<table>
<thead>
<tr>
<th>Code Blue Management</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Retrieves crash cart when requested.</td>
<td></td>
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<tr>
<td>X Initiates BLS (CPR) as indicated.</td>
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<tr>
<td>X Calls 1999 as indicated.</td>
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<tr>
<td>X Acts as a runner for needed supplies and documents on code blue record.</td>
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<tr>
<td>X Ensures patient privacy is maintained.</td>
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<tr>
<td>X Administers meds according to current ACLS protocol if ACLS certified.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Latex Allergy</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Demonstrates care for the patient with latex allergy.</td>
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<tr>
<td>X Demonstrates assessment skills to identify latex allergy / sensitive skin.</td>
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<tr>
<td>X Notifies surgical staff of patient’s latex allergy.</td>
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<tr>
<td>X Identifies latex versus non latex supplies and equipment.</td>
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<tr>
<td>Aspect of Care</td>
<td>Pediatrics</td>
<td>Adult</td>
<td>Geriatrics</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Anesthesia Awareness</td>
<td></td>
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<tr>
<td>X Verbalizes knowledge regarding anesthesia awareness</td>
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<tr>
<td>X Verbalizes the definition of anesthesia awareness.</td>
<td></td>
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<tr>
<td>X Identifies contributing factors and at risk patients.</td>
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<tr>
<td>X Verbalizes potential negative impact.</td>
<td></td>
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<tr>
<td>X Verbalizes the management necessary, actions, and responsibilities when anesthesia awareness occurs.</td>
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<tr>
<td>Medication Administration</td>
<td></td>
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</tr>
<tr>
<td>X Accurately and safely administers and / or provides a medication to the surgical field, ensuring correct labels on medications.</td>
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<tr>
<td>X Verbalizes knowledge of the ‘5’ rights of medication administration.</td>
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<tr>
<td>X Verifies patient allergies.</td>
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<tr>
<td>X Scans medications prior to administration.</td>
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<tr>
<td>X Completely documents responses to medication.</td>
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<tr>
<td>X Checks expiration date on medication and solutions prior to administration.</td>
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</tr>
<tr>
<td>X Correctly obtains medications from the Omnicel Machine.</td>
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<tr>
<td>Malignant Hyperthermia</td>
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<tr>
<td>X Demonstrates knowledge of the care of the patient with Malignant Hyperthermia</td>
<td></td>
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<tr>
<td>X Describes pathophysiology and identifies early signs and symptoms,</td>
<td></td>
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<td></td>
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<tr>
<td>X Identifies medications to treat condition</td>
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<tr>
<td>X Identifies non-pharmaceutical interventions required to treat condition</td>
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<tr>
<td>X Identifies location of MH cart.</td>
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</tbody>
</table>

Indicate TRUE (T) or FALSE (F) for each below:

- Malignant Hyperthermia is an uncontrolled increase in skeletal muscle metabolism where a patient’s body temperature rises to potentially lethal levels as a result of certain anesthesia agents.  
- You will need to obtain 36 vials of Dantrolene during a Malignant Hyperthermia crisis. 
- A bottle of Dantrolene requires 60 ml non-bacteriostatic sterile water for reconstitution.
<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Protocol</td>
<td></td>
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<tr>
<td>X Verbalizes the definition of Universal Protocol.</td>
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<tr>
<td>X Verbalizes risk factors that may interfere with Universal Protocol and action plan if Universal Protocol is not followed.</td>
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<tr>
<td>X Verbalizes who participates in the Universal Protocol, the method followed and completes appropriate documentation.</td>
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<tr>
<td>X Verbalizes the appropriate persons who may mark the procedure / surgical site.</td>
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<tr>
<td>Demonstrates Universal Protocol with verification of:</td>
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<td></td>
</tr>
<tr>
<td>- Correct patient</td>
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<td></td>
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<tr>
<td>- Correct procedure</td>
<td></td>
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<td></td>
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<tr>
<td>- Correct surgical site</td>
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<tr>
<td>- Availability of equipment and implants</td>
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<tr>
<td>- Skin marking is visible after draping</td>
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<tr>
<td>- Imaging studies present as indicated</td>
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<tr>
<td>- Antibiotic administration</td>
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</tbody>
</table>

Indicate TRUE (T) or FALSE (F) for each below:

- Universal Protocol is the procedure used by staff to assure correct person, procedure, and procedure site for invasive procedures.
- The MD initials designating the appropriate incision site must be visible after draping.
- The Universal Protocol Time Out is performed in the OR or Endoscopy Room immediately prior to the surgery or procedure.

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and Team Building</td>
<td></td>
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</tr>
<tr>
<td>X Demonstrates the ability to communicate with others any information necessary to ensure a safe patient care and work environment. Including patient issues to the RN when transporting to a new unit.</td>
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<tr>
<td>X Demonstrates a positive attitude and role model for new staff members. Assists team members with completion of tasks and improvement of turnover times.</td>
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<tr>
<td>X Assists in all peri-operative departments as needed. Including Endoscopy, Special Care, PACU, and Nursing Units.</td>
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<tr>
<td>X Introduces self to patients and informs patient and family of purpose of transport – to surgery, endoscopy, etc.</td>
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<tr>
<td>X Maintains professional behavior during all contact with patients and family members as well as peers and co-workers.</td>
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<tr>
<td>X Assists family members to the surgical waiting room.</td>
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<tr>
<td>X Resolves conflicts in a mature manner in compliance with RMCBP policies and procedures. Seeks assistance as needed from charge nurse or Director.</td>
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</tr>
<tr>
<td>Aspect of Care</td>
<td>Pediatrics</td>
<td>Adult</td>
<td>Geriatrics</td>
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<tr>
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<tr>
<td><strong>Anesthesia and Adjuncts</strong></td>
<td></td>
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</tr>
<tr>
<td>X</td>
<td>Verbalizes knowledge regarding anesthesia agents and how they relate to the patient.</td>
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<tr>
<td>X</td>
<td>Identifies inhalation agents and their action</td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes neuromuscular blockade agent action</td>
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<tr>
<td></td>
<td>- Non depolarizing</td>
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<tr>
<td></td>
<td>- Depolarizing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Verbalizes reversal agents and their possible complications</td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes knowledge of regional and peripheral anesthesia agents and the monitoring necessary.</td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes side effects for epidural and spinal anesthesia</td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes understanding of dermatome levels and how to evaluate them</td>
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<tr>
<td>X</td>
<td>Verbalizes understanding of benzodiazepine, normal dosage ranges, and reversal agent</td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes understanding of narcotic administration, normal dosage ranges, and reversal agent.</td>
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<tr>
<td>X</td>
<td>Verbalizes appropriate fluid management as it relates to the NOP and surgical patient.</td>
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</tr>
<tr>
<td><strong>Pain Management and Patient Comfort</strong></td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes understanding of pain management, use of the pain scale, and appropriate documentation:</td>
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<tr>
<td></td>
<td>- Assesses location of pain</td>
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<td></td>
<td>- Assesses intensity of pain by obtaining number through the pain scale 0-10 or by facial expression.</td>
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<td></td>
<td>- Obtains description of quality of pain</td>
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<td></td>
<td>- Obtains information regarding onset of pain</td>
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<td></td>
<td>- Demonstrates ability to reflect that pain is the 5th vital sign</td>
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<td></td>
<td>- Defines pain behaviors</td>
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<td></td>
<td>- Verbalizes that pain may be expressed in methods other than verbal</td>
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<td></td>
<td>- Verbalizes that medication is only one component of pain management</td>
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<td></td>
<td>- Assesses patient per policy to verify response to pain management</td>
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<td></td>
<td>- Verbalizes understanding of narcotic titration techniques</td>
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<td></td>
<td>- Verbalizes understanding of narcotic reversal techniques and monitoring post reversal.</td>
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<td></td>
<td>- Verbalizes that a pain level of 4 or less is most desirable</td>
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<tr>
<td></td>
<td>- Documents pain management thoroughly so that it accurately reflects care provided.</td>
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<tr>
<td><strong>Nausea / Vomiting and Patient Comfort</strong></td>
<td></td>
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<tr>
<td>X</td>
<td>Verbalizes understanding of nausea / vomiting recognition and treatment and appropriate documentation:</td>
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<tr>
<td></td>
<td>- Identifies risk factors for PONV</td>
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<td></td>
<td>- Identifies consequences of post operative nausea and vomiting</td>
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<td></td>
<td>- Correctly identifies factors that stimulate the vomiting center in the brain</td>
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<td></td>
<td>- Identifies medications used to treat nausea / vomiting</td>
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<td></td>
<td>- Identifies non-pharmacological actions used to treat nausea / vomiting</td>
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<td></td>
<td>- Documents treatments for nausea / vomiting</td>
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</tr>
</tbody>
</table>

2011 PACU / OR Hold Competencies Page 7 of 18
<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post Operative / Post Procedure Patient Care</strong></td>
<td></td>
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<tr>
<td>X</td>
<td>Demonstrates ability to manage the PACU / OR Hold patient.</td>
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<tr>
<td>X</td>
<td>Receives PACU / OR Hold patient in a timely fashion upon arrival.</td>
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<tr>
<td>X</td>
<td>Carefully listens to report from CRNA and RN.</td>
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<tr>
<td>X</td>
<td>Applies O2</td>
<td></td>
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<tr>
<td>X</td>
<td>Applies monitors correctly.</td>
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<tr>
<td>X</td>
<td>Assures alarms are set and audible at all times while patient is in PACU / OR Hold.</td>
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<tr>
<td>X</td>
<td>Performs assessment to include:</td>
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<tr>
<td></td>
<td>- BP, heart rate, rhythm</td>
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<td></td>
<td>- Airway status</td>
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<tr>
<td></td>
<td>- Pulse oximetry</td>
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<tr>
<td></td>
<td>- Application of O2 as needed</td>
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<tr>
<td></td>
<td>- Zeroing invasive lines to monitor if present</td>
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<tr>
<td></td>
<td>- Pain level using pain scale</td>
<td></td>
<td></td>
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<td></td>
<td>- Skin character</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Dressings and condition of dressings</td>
<td></td>
<td></td>
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<td></td>
<td>- Circulation checks as indicated for procedure</td>
<td></td>
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<tr>
<td></td>
<td>- Monitor and sensory functions post regional anesthesia</td>
<td></td>
<td></td>
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<tr>
<td>X</td>
<td>Provides warming measures to patient as needed</td>
<td></td>
<td></td>
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<tr>
<td>X</td>
<td>Patient temperature comfort level is minimally documented every 30 minutes</td>
<td></td>
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<tr>
<td>X</td>
<td>Promptly identifies post anesthesia shaking and addresses appropriately.</td>
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<tr>
<td>X</td>
<td>Promptly identifies metabolic issues and takes prompt, appropriate actions</td>
<td></td>
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<tr>
<td>X</td>
<td>Provides pain management measures to patient, including use of epidural drips and nerve blocks.</td>
<td></td>
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<tr>
<td>X</td>
<td>Demonstrates ability to assist anesthesia staff with insertion of epidurals and nerve blocks</td>
<td></td>
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</tr>
<tr>
<td><strong>Discharging PACU / OR Hold Patients</strong></td>
<td></td>
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<tr>
<td>X</td>
<td>Demonstrates effective management of the PACU / OR Hold patient for preparation for discharge:</td>
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<td></td>
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<td></td>
<td>- Patients are minimally at 96.8F</td>
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<tr>
<td></td>
<td>- Airway is patent (exception ICU patient)</td>
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<tr>
<td></td>
<td>- Vital signs are stable (exception ICU patient)</td>
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<tr>
<td></td>
<td>- Documentation and patient charges are accurate and complete</td>
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<tr>
<td></td>
<td>- Orders are scanned to pharmacy</td>
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<tr>
<td></td>
<td>- All equipment assigned to patient is functioning properly</td>
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<tr>
<td></td>
<td>- Report given to receiving RN</td>
<td></td>
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<tr>
<td></td>
<td>- Patients who are going to a monitored bed are transported with a monitor</td>
<td></td>
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<tr>
<td></td>
<td>- All immediate and urgent orders are completed</td>
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</tr>
<tr>
<td><strong>Fall Risk</strong></td>
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</tr>
<tr>
<td>X</td>
<td>Identifies and evaluates the fall risk potential of our patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Evaluates the fall risk potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Takes appropriate actions to assure patient safety</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bar Coded Blood Transfusion

- MEDITECH Blood Bank module sends an alert to NUR Status Board when a product is ready to be released.
  - Click the “Ready” in the transfusion column to view all products ready for pick-up

- Verifies physician order, obtains consent, obtains supplies, completes the vital signs and then completes Pre-Issue Checklist in “Process Intervention”. The checklist will auto print and it is taken with the BPH 11 to the Blood Bank to pick up the blood product. The checklist includes the following):
  - Physician order received
  - Consent signed
  - Pre-transfusion vital signs completed (within 30 minutes before transfusion initiated)
  - Transfusion reaction history reviewed
  - Vital Signs reviewed
  - IV Patency checked in a large vein (20 gauge or larger for adults)
  - Pre-medications given if applicable
  - Equipment and supplies – blood tubing, 0.9% Normal Saline (DO NOT USE D5W)

NOTE: System will not let you go past a question on the BCTA Transfusion Pre-Issue Checklist if the appropriate response is not entered. Therefore, you should ensure that all tasks have been performed PRIOR to completing the Pre-Issue Checklist.

- The person picking up the product and the Blood Bank will present a Blood Component Order Form and the completed pre-issue Checklist

- The Blood Bank Technologist will document the product issue within the Blood Bank module so that the product status updates to “Issued”. In turn, the Blood Bank module will update the BBK indicator on the Nursing Status Board to “Issued”. NOTE: The responsible nurse has \textbf{10 minutes} from the time the product was issued in Blood Bank to begin the transfusion.

Access the Process Transfusion Screen by either of 2 methods:
  - Click the Transfusions button located on the NUR Status Board
  - Click the BBK indicator in the Transfusion column. Then, click the Transfusions button on the Blood Products Screen (Either process, the system will take you to the BCTA Process Transfusion Screen)

- On the Process Transfusion screen if there are special instructions for the RN from the blood bank a “Special Instructions” button will backlight. The special instructions must be reviewed and are accessed by selecting the button.

- Reviews the following tests will be associated with the following products by the RN:
  - Cellular products – HGB, HCT
  - Fresh frozen plasma – PT, PTT, INR,
  - Cryoprecipitate - fibrinogen

- Assembles needed supplies
<table>
<thead>
<tr>
<th>Using BCTA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Nurse receives the blood product</td>
</tr>
<tr>
<td>- Identify the patient using the facilities two identifiers.</td>
</tr>
<tr>
<td>- The RN will log onto the system using their ID and password.</td>
</tr>
<tr>
<td>- They will perform the steps that are required in BCTA:</td>
</tr>
<tr>
<td>- Scan the patient’s armband</td>
</tr>
<tr>
<td>- Scan the Blood bank armband</td>
</tr>
<tr>
<td>- Scanning the three blood product labels (in a specific sequence)</td>
</tr>
<tr>
<td>- Second nurse to verify scanning of correct patient and blood product</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiates the transfusion and closely monitor the patient for 15 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- A slow infusion rate (approximately 30ml/hr) during first 15 minutes permits identification of</td>
</tr>
<tr>
<td>a severe hemolytic reaction as soon as possible. Infusion rate after the first reassessment</td>
</tr>
<tr>
<td>can be increased based on patient status, physician order and recognizing all transfusions</td>
</tr>
<tr>
<td>must be administered within 4 hours of issuance by blood bank.</td>
</tr>
<tr>
<td>- No more than one unit of blood may be transfused at a time unless specifically ordered by the</td>
</tr>
<tr>
<td>physician (emergency procedures are excluded)</td>
</tr>
<tr>
<td>- Standard transfusion filtered tubing must be changed after every two (2) units of blood</td>
</tr>
<tr>
<td>- Blood transfusion should be infused via infusion pump</td>
</tr>
<tr>
<td>- Leukocyte filters are not needed (Florida Blood Service pre-filters for Leukocytes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitors Vital Sign during transfusion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Initial set of vital signs prior to (within 30 minutes) beginning the transfusion</td>
</tr>
<tr>
<td>- Another set of vital signs 15 minutes after beginning the transfusion</td>
</tr>
<tr>
<td>- Final set of vital signs when the transfusion is discontinued</td>
</tr>
<tr>
<td>NOTE: These are minimum requirements; therefore, vital signs may be taken more frequently</td>
</tr>
<tr>
<td>based on unit practice and patient presentation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reassessment of Patient during blood transfusion will include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Vital signs defined as temperature, blood pressure, pulse and pulse oximetry</td>
</tr>
<tr>
<td>- Observes signs and symptoms of suspected blood transfusion reaction. Verbalizes signs and</td>
</tr>
<tr>
<td>symptoms of transfusion reactions.</td>
</tr>
<tr>
<td>- Observes for volume overload. Verbalizes signs and symptoms of fluid overload</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limits Blood transfusion time to four (4) hours to complete (from issuance to completion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- During the transfusion, BCTA will display a warning to the RN alerting them to the remaining</td>
</tr>
<tr>
<td>transfusion time. If that time limit is exceeded a warning will display stating that the 4 hour</td>
</tr>
<tr>
<td>time limit has been exceeded and the transfusion must be stopped.</td>
</tr>
</tbody>
</table>

| Monitors patient's temperature. If temperature is initially greater than 38.3°C (101°F) or        |
| raises greater than 1°C (1.8°F) during the transfusion, a warning flag will alert and an          |
| information box will be displayed alerting the RN.                                               |

<p>| Selects the &quot;HOLD&quot; button in BCTA If a transfusion needs to be stopped. Documents the reason      |
| for the hold. When and if the transfusion is resumed, the RESUME button will be selected, and    |
| the reason it was resumed.                                                                      |</p>
<table>
<thead>
<tr>
<th>Bar Coded Blood Transfusion (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood Warmer:</strong></td>
</tr>
<tr>
<td>- Attaches blood warmer to an IV pole, plug into outlet, turns on. Checks alarms and all functions</td>
</tr>
<tr>
<td>- Prepares and hangs Y-set with a blood bag and a 0.9% normal saline solution</td>
</tr>
<tr>
<td>- Keeps the blood line clip on the Y-set closed. Remove the cover from Y-set’s needle adaptor and prime the tubing with Saline solution and replace cover.</td>
</tr>
<tr>
<td>- Attaches to patient end of fluid bag or tubing. Opens roller clamp to purge system of air.</td>
</tr>
<tr>
<td>- Places drip chamber/bubble trap in recommended position. Insert the warming bag into the warmer.</td>
</tr>
<tr>
<td>- Begins infusion and adjusts rate and temperature.</td>
</tr>
<tr>
<td>- Documents use of warmer on record.</td>
</tr>
<tr>
<td><strong>Mild allergic reaction:</strong></td>
</tr>
<tr>
<td>- Stop The Transfusion</td>
</tr>
<tr>
<td>- Click the “HOLD” Button In BCTA</td>
</tr>
<tr>
<td>- Contact the physician for medication orders and an order to resume the transfusion</td>
</tr>
<tr>
<td><strong>Transfusion reaction:</strong></td>
</tr>
<tr>
<td>- Monitor for suspected reaction. If the patient develops signs/symptoms of a suspected reaction, the RN will STOP the product from transfusing, maintain IV access with normal saline with new tubing, verify patient and product identification, and notify the physician.</td>
</tr>
<tr>
<td>- Click the HOLD button while the Blood Bank is notified.</td>
</tr>
<tr>
<td>- RN will enter “SUSPECTED TRANSFUSION REACTION” from the (Reactions Button) appropriate screen. Once the Signs/Symptoms have been documented.</td>
</tr>
<tr>
<td>- The nurse will contact the physician for treatment orders</td>
</tr>
<tr>
<td>- A transfusion reaction work up is ordered through Order Entry.</td>
</tr>
<tr>
<td>- Return the blood component to the blood bank (including the set up tubing) in a biohazard bag.</td>
</tr>
<tr>
<td>- Obtain a post transfusion blood sample (1 red and 2 purple top tubes) and send to Blood Bank ASAP</td>
</tr>
<tr>
<td>- Obtain first voided (or catheter) urine specimen and send to laboratory, indicating to check for free hemoglobin</td>
</tr>
<tr>
<td>- Clearance must come from the Blood Bank to resume the transfusion. Once cleared from the Blood Bank to restart the blood, the physician must be called to obtain an order to restart the blood.</td>
</tr>
<tr>
<td>Bar Coded Blood Transfusion (cont.)</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Completing transfusion:</strong></td>
</tr>
<tr>
<td>- Documents total volume upon completion of transfusion. When ending the transfusion (END Button) the total volume of the transfusion defaults into the volume infused screen. NOTE – if entire product is not transfused, the Nurse must edit this entry.</td>
</tr>
<tr>
<td>- Clicks on the (SECTIONS Button) to document intake of the blood product and saline in PCD.</td>
</tr>
<tr>
<td>- Files electronically the post transfusion documentation (i.e., vital signs) entered via the “Documentation” button on BCTA will be sent to the Blood Bank Module where they will be stored in the patients electronic record.</td>
</tr>
<tr>
<td>- Exercises knowledge in troubleshooting documentation errors. When using BCTA if the END button is selected in error it can be restarted by contacting the blood bank and using the following procedure:</td>
</tr>
<tr>
<td>▪ Calls the blood bank requesting that they reactivate the transfusion.</td>
</tr>
<tr>
<td>▪ Completes Blood Component Order Form which includes placing a bar-coded number from the back of the transfusing blood product and a Patient ID sticker on the form.</td>
</tr>
<tr>
<td>▪ Faxes or delivers completed form to the blood bank.</td>
</tr>
<tr>
<td>▪ Blood bank reactivates the transfusion in Meditech and notifies the RN that the transfusion has been re-started in the system (Blood Bank Manager reviews and maintains the BCTA Transfusion restart form, according to facility and state guidelines).</td>
</tr>
<tr>
<td>▪ Selects embedded BCTA Transfusion restart form.</td>
</tr>
<tr>
<td><strong>Downtime Procedure and Registration in Meditech:</strong></td>
</tr>
<tr>
<td>- Maintains and uses current downtime procedures in the event Meditech is down or the patient has not been registered in Meditech.</td>
</tr>
<tr>
<td>- Enters data manually (vital signs and I&amp;O etc.) in BCTA once Meditech is available.</td>
</tr>
<tr>
<td><strong>Transferring patients:</strong></td>
</tr>
<tr>
<td>- If the transfusion is initiated in a clinical area NOT using BCTA, the receiving clinical area will continuing documentation by the non-BCTA process for the unit infusing. If additional blood or blood products are ordered, then the receiving clinical area will then follow the BCTA clinical practice.</td>
</tr>
<tr>
<td>Aspect of Care</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td><strong>Conscious Sedation / Moderate Sedation</strong></td>
</tr>
<tr>
<td>X Successfully completes a learning activity on IVCS (found on the Intranet – department pages, education, SLP section). Provides proof of ACLS knowledge.</td>
</tr>
<tr>
<td>X Shows proof of a current CPR card.</td>
</tr>
<tr>
<td>X Demonstrates proper use of the following oxygen delivery systems and airway management techniques:</td>
</tr>
<tr>
<td>- Inserts oral airway</td>
</tr>
<tr>
<td>- Inserts nasopharyngeal airway</td>
</tr>
<tr>
<td>- Correctly uses bag value mask device</td>
</tr>
<tr>
<td>- Pulse oximetry</td>
</tr>
<tr>
<td>- Portable oxygen tank preparation and setup</td>
</tr>
<tr>
<td>- Nasal cannula application</td>
</tr>
<tr>
<td>- Verturi mask</td>
</tr>
<tr>
<td>- Non-rebreather mask</td>
</tr>
<tr>
<td>- Partial rebreather mask</td>
</tr>
<tr>
<td>X Ensures all correct steps in the “time out” procedure have occurred.</td>
</tr>
<tr>
<td>X Verbalizes pharmacological agents used in IVCS to include (but not be limited to) Versed, Valium, Morphine, Demerol, Dilaudid, Romazicon, and Narcan.</td>
</tr>
<tr>
<td>X Verbalizes components of a physical assessment.</td>
</tr>
<tr>
<td>X Documents continuous assessment, diagnosis, outcome, and evaluation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ventilator Management</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Assess respiratory rate, observes patient for increased work of breathing</td>
<td></td>
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<tr>
<td>X Recognizes / verbalizes signs and symptoms of respiratory distress.</td>
<td></td>
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<tr>
<td>X Assesses Endo-tracheal tube for cuff leak, if present notifies respiratory therapy immediately</td>
<td></td>
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<tr>
<td>X Validates ETT placement using two methods, i.e.: bilateral breath sounds, Chest X-Ray, confirms cm mark on tube.</td>
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<tr>
<td>X Checks the ventilator settings with latest ordered (tidal volume, rate, mode, and FIO2)</td>
<td></td>
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<tr>
<td>X Obtains order for Chest X-Ray to confirm tube placement and Arterial Blood Gases.</td>
<td></td>
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<tr>
<td>X Ensures safety equipment is within easy reach or in use:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Oximeter</td>
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<tr>
<td>- Suction</td>
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<tr>
<td>- Ambu bag with facemask</td>
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<tr>
<td>- Flow meter</td>
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<td></td>
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<tr>
<td>- Emergency Trach tray</td>
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<tr>
<td>- Spare Trach and obturator.</td>
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<td></td>
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</tr>
<tr>
<td>X Recognizes / verbalizes oxygenation and acid / base imbalances from ABGs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Performs patient care activities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Suctioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oral care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X - Pain management</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Ventilator Management (cont.)

Recognizes / verbalizes the signs and symptoms of respiratory distress including but not limited to:

- Hypoxia
- Atelectasis/pneumonia
- Bronchospasm / Laryngospasm
- Air way obstruction
- Aspiration
- Pulmonary edema
- Pulmonary Embolism
- Pneumothorax

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care of the Pulmonary Artery Catheter</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X</td>
<td>Obtains Chest X-Ray after insertion, any manipulation and daily as ordered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Documents catheter insertion date and depth of insertion in medical record.</td>
<td></td>
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</tr>
<tr>
<td>X</td>
<td>Checks and tightens all connections and stopcocks at least every shift.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Levels and calibrates (zero) the transducer at least every shift using the phlebostatic axis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Continuously observes hemodynamic lines and waveforms with documentation of pressures every hour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Changes pressure tubing and sets up with site dressing every 96 hours.</td>
<td></td>
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</tr>
<tr>
<td>X</td>
<td>Labels tubing with date and time hung.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Keeps pressure bag at 300 mmHg.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>To troubleshoot an absent waveform – ensures no vented caps are present on stopcocks or stopcocks are not open to transducer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>To troubleshoot a dampened waveform – ensures line is free of air, pressure bag is inflated to 300 mmHg, and attempts a routine flush using the intraflow device.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>To troubleshoot a continuously wedged waveform – ensures balloon is deflated, has patient cough or change positions, and obtains order for Chest X-Ray to confirm position. <strong>DO NOT FLUSH CATHETER!</strong> Notifies the physician immediately if unable to unwedge catheter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Documents interventions after troubleshooting in the medical record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>When obtaining a wedged pressure, use no more than 1.5 cc of air and maintain wedge for no more than 2 respiratory cycles. To ensure patency of balloon, allow the syringe to refill with air once wedge pressure has been obtained. Documents pressure in the medical record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspect of Care</td>
<td>Pediatrics</td>
<td>Adult</td>
<td>Geriatrics</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td><strong>Cardiac Output Measurement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Assembles necessary equipment and washes hands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Prepares and primes the CO tubing, connects to proximal port (blue), and connects to the monitoring system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Positions patient supine, no more than 20 degrees elevation of head of bed.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Verifies PA waveform on monitor and notes EKG tracing.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Observes patient’s inspiratory and expiratory chest excursion.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X At the end of expiration, rapidly and smoothly injects solution, making injection in less than 4 seconds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Observes CO curve and notes the resulting value.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Repeats the injection process for a total of 3 – 4 values.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Averages these values and records the Cardiac Output value in the medical record.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Disconnects the apparatus and observes the PA waveform to ensure proper placement is maintained.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Auto Syringe Pump</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Demonstrates infusion of maintenance fluid at 30 cc/hr via PDI or 50 cc/hr via manifold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Connects microbore tubing from 50 cc syringe to PDI or manifold ports</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Demonstrates usage of medication concentrations per Pharmacy guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Ensures all syringes have labels with patient’s name, location, date, time, medication concentration, and initial. Identifies patient correctly with two identifiers per policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Demonstrates / recognizes the syringe line as the dedicated concentrated continuous infusion medication line. Bolus medications and PRN medications should not be delivered via the PDI line.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Demonstrates correct set up, programming, and cleaning according to manufacturer’s guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Demonstrates tubing changes per hospital policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chest Tube</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Gathers insertion supplies and chest drainage system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Sets up drainage system by filling chambers with water and attaching to wall suction.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Identifies patient using <strong>two</strong> patient identifiers. Explains procedure to patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Ensures consent has been signed in non-emergent situation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Positions patient for procedure and provides analgesic as ordered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Assists physician during insertion and promotes patient comfort.</td>
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<tr>
<td>X Ensures fluctuation of water seal chamber, bubbling, and drainage system function.</td>
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<tr>
<td>X Applies occlusive pressure dressing to site and dates.</td>
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<tr>
<td>X Assesses site dressing, drainage system function, drainage characteristics, and vital signs at least every shift.</td>
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<tr>
<td>X Troubleshoots CT for water seal leaks, air leaks, and drainage problems.</td>
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<tr>
<td>X Documents results on patient’s record.</td>
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</table>
### Central Line Insertion and Maintenance

- **X** Explains procedure to patient. Ensures Patient marks correct site per policy.
- **X** Verifies consent obtained in non-emergent situation.
- **X** Prepares IV solution or flush solution.
- **X** Assemble all equipment needed.
- **X** Shaves and preps site as indicated.
- **X** Positions patient supine with head away from insertion site.
- **X** Assists physician with procedure and supports patient.
- **X** Connects IV tubing or flushes port when physician verifies catheter placement.
- **X** Identifies ports appropriately.
- **X** Places occlusive sterile dressing and dates, time, initials site.
- **X** Ensures patient comfort post procedure.
- **X** Documents procedure in patient’s record.
- **X** Assesses site with dressing changes and checks for signs and symptoms of infection. Notifies the physician of significant findings.

### PCA Management

- **X** Verifies physician orders for med, dose, bolus, and maintenance.
- **X** Places medication bag into PCA device and locks device.
- **X** Connects bag to PCA tubing.
- **X** Primes tubing.
- **X** Sets infusion mode, dose, time delay, and one-hour limit.
- **X** Connects PCA tubing to IV tubing.
- **X** Presses start to initiate infusion.
- **X** Provides patient with control button and instructions for use.
- **X** Documents procedure in patient’s record.

### Stryker / Constavac Reinfusion

- **X** Washes hands and dons gloves.
- **X** Releases large clamp on tubing connecting reservoir to re-infusing bag.
- **X** Holds tubing so that it forms a loop below the base of the reservoir.
- **X** Presses and holds down lever on top of the reservoir to prime loop.
- **X** When loop is primed, lower tubing and bag to facilitate blood flow.
- **X** Clamps tubing with large clamp close to the bag and re-infuse according to blood transfusion procedure, including Pall filter.
- **X** At 6 hours post activation, the tubing connecting the reservoir to the blood bag will be cut 2 inches from the reservoir and capped with the attached red cap.
<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Pediatrics</th>
<th>Adult</th>
<th>Geriatrics</th>
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<tbody>
<tr>
<td><strong>On-Q PainBuster Pump</strong></td>
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<tr>
<td>X Identifies ON-Q PainBuster components:</td>
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<tr>
<td>- Tubing clamp – open</td>
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<tr>
<td>- Flow restrictor – flow rate is not adjustable. Taped or in direct contact with skin. Avoid cold therapy in area.</td>
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<td>- Filter – not covered</td>
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<tr>
<td>- Catheter – occlusive dressing intact</td>
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<tr>
<td>X Verbalizes where to locate flow rate and fill volume on pump.</td>
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<tr>
<td>X Checks medication label</td>
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<tr>
<td>X Verbalizes when a change in the size and appearance of the pump is noticeable (24-30 hours after surgery).</td>
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<tr>
<td>X Patient Monitoring:</td>
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<tr>
<td>- Identifies at least 3 symptoms of local anesthetic toxicity <em>(blurred vision, dizziness, ringing / buzzing in ears, metallic taste, numbness around mouth, fingers, and/or toes, drowsiness, confusion)</em></td>
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<tr>
<td>- Describes intervention if patient exhibits symptoms of local anesthetic toxicity <em>(close pump tubing clamp and immediately notify physician).</em></td>
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<tr>
<td>X Patient complains of pain:</td>
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<tr>
<td>- Describes how to assess patient’s pain.</td>
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<tr>
<td>- Identifies what to troubleshoot to ensure pump is infusing <em>(clamp open, no kinks in tubing, filter not taped or covered, flow restrictor taped or in direct contact with skin).</em></td>
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<tr>
<td><strong>Arterial Blood Pressure Catheter Monitoring</strong></td>
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<tr>
<td>X Identifies indications for arterial pressure monitoring and assembles necessary equipment for insertion of arterial catheter. Prepares transducer set up by flushing with fluid according to policy. Prepares pressurized bag to 300 mmHg.</td>
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<td>X Performs “Allen’s test” to arm intended for arterial catheter insertion and documents results.</td>
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<td>X Assists physician with procedure by supporting the patient’s hand and dorsiflexing the patient’s wrist. Secure catheter and transducer set up according to policy.</td>
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<tr>
<td>X Level and zero transducer to atmospheric pressure to obtain accurate arterial blood pressure reading. Compare this reading with a non-invasive BP reading using a sphygmomanometer. Document both readings to validate accuracy.</td>
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Arterial Blood Pressure Catheter Monitoring (cont.)

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<tr>
<td><strong>X</strong></td>
<td>Identify normal arterial waveform. Assess pulse, color, temperature distal to the insertion site every shift and PRN.</td>
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<tr>
<td><strong>X</strong></td>
<td>Assess site for infection signs and symptoms each shift. Changes dressing and tubing according to policy.</td>
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<tr>
<td><strong>X</strong></td>
<td>Draws blood from arterial catheter using blood sampling port according to policy, flushing the catheter clear using the intraflo device. Labels specimens and ensures specimens are transported to lab immediately.</td>
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<tr>
<td><strong>X</strong></td>
<td>Discontinues Arterial catheter by removing sutures and while holding slight pressure withdraw catheter in one smooth motion, ensuring the catheter is intact. Hold direct pressure over puncture site until bleeding has stopped. Apply pressure dressing. Document procedure and patient’s response to it.</td>
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</table>

- The above competency checklist identifies the age population for which the PACU / OR Hold completed the aspect of care and the method used to validate competency.

- Completion of the above checklist validates that the PACU / OR Hold is competent to provide care for patients in the validated aspects of care.

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<tr>
<th>INITIALS</th>
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