Competency Day 2016

ICARE

Competency Day makeup 2016

ICARE: Patient Experience and Education

- **I**nitiate
  - The power of first encounters
- **C**ommunicate
  - The power of language
- **A**nticipate
  - The power of listening
- **R**espond
  - When expectations aren't met
- **E**ducate
  - Teach-back and Positive intent statements

ICARE: Initiate

- The 5 W's
  - Who I am
  - What you can expect
  - When you will see me
  - Where you can find me
  - Why you should trust me
- Build trust
  - Provide clear explanations
  - Validate the person's feelings
    - Ex: "Are you concerned about your procedure?"
  - Use the three P's

ICARE: Communicate

- Be aware of non verbal language
  - Use the three P's: Pause, Position, Peer
- **Avoid** trigger words like:
  - "I can't"
  - "Our policy is…"
  - "Hang on a second"
- **Use** power words and phrases
  - Be very clear, state exactly what you will do
  - Confirm your knowledge/experience
  - Give specific time frames
    - Ex: "I will be back at 2pm." not "I will be back in a little bit."

ICARE: Anticipate

- Avoid "one-uping" the patient
  - Ex: "I'm tired too, I've been working all day!"
- Use Empathy
  - Ex: "It's tough to get by when youre thirsty, but can't have anything to drink. I imagine that is frustrating."
- Use Summarizing Statements
  - Summarize what the patient has said, and say it back to them, this ensures that you've understood them correctly

ICARE: Respond

- Blameless Apologies
  - Use “I” not “We”
  - Be sincere and prompt in your response
- Make sure to set expectations
- Keep patients informed of delays
  - Especially when there needs to be a change in the expectations you just set

ICARE: Educate

- Use Teach-Back method
  - "Can you tell me how you are going to take your Coumadin?"
  - "Can you tell me when you are going to call the doctor?"
- Use positive intent statements to let the patient know WHY they need to do things
  - "I want to explain your discharge sheet to you SO THAT you will know what to do when you get home"
  - "You need to take this Coumadin everyday so that you don't get another blood clot."

Infection Control

Competency Day makeup 2016

2016 Infection Control

Proper Cleaning of Equipment

CLEANING RESPONSIBILITY FRAMEWORK

ITEMS	STANDARD	METHOD	GROUP RESPONSIBLE	COMMENTS
Anesthesia cart	When visibly soiled	Disinfectant wipes	Nursing / OR tech	
Bear hugger	Discontinuation and when visibly soiled or dusty	Hospital approved disinfectant	Nursing / UA	Blankets are disposable
Beds – MS, SCU, OB	Discharge or when visibly soiled	Hospital approved disinfectant	EVS	
Bed/Chair monitors	After Use	Hospital approved disinfectant	Nursing / UA	
Bed Pans	After use, discard at discharge	Disinfectant wipes	Nursing / UA	
Bed Rails	Daily and Terminal	Hospital approved disinfectant	EVS	
Bedside Tables	Daily and Terminal	Hospital approved disinfectant	EVS	
Billi Bed/Lights/blanket	After Use	Disinfectant wipes	Nursing	
Bladder Scanner	After Use	Hospital approved disinfectant	Nursing / UA	
Blood Warmers	After Use	Hospital approved disinfectant	Nursing / UA	
BP Cuffs	After Use	Disinfectant wipes	Nursing / UA	
Call Bells	Daily and Discharge	Hospital approved disinfectant	EVS	
Cardiac Monitors	Discharge	Hospital approved disinfectant	EVS	
Circumcision Table	After Use	Disinfectant wipes	Nursing / UA	
Commodes Bedside	After Use and at Discharge	Hospital approved disinfectant	UA/EVS	
CPM machine	Discontinuation or when visibly soiled	Hospital approved disinfectant	Physical Therapy or Rental Company	
CPAP/BiPAP Machines	Discontinuation or when visibly soiled	Hospital approved disinfectant	Respiratory	
Crash Carts	Monthly or when visibly Soiled	Hospital approved disinfectant	Nursing / UA	
Cribs	Discontinuation or when visibly soiled	Hospital approved disinfectant	EVS	
C-Section Delivery Case Carts	After Use	Disinfectant wipes	Nursing / UA	
Doppler	After Use	Disinfectant wipes	User	
EKG Leads	After Use	Hospital approved disinfectant	User	
EKG Machine	After Use	Disinfectant wipes	User	
Epidural Cart	After Use	Disinfectant wipes	Nursing / UA	
Epidural Pumps	After Use	Hospital approved disinfectant	EVS	
Exam Lights	After Use	Hospital approved disinfectant	EVS	
Exercise Equipment	After Use	Disinfectant wipes	Nursing / PT	
Fax/Copy machine	Q6 months	Disinfectant wipes	IT	
Feeding Pumps	Discontinuation or when visibly soiled	Hospital approved disinfectant	EVS	
Fetal Monitor Carts	After Use	Disinfectant wipes	Nursing / UA	
Gate Belt – Cloth	Between patients	Laundry	EVS	

Cleaning Chemicals

- PPE?
- Cleaning Products?
- Kill Time or Wet time?
- Oxivir 1 minute,
- Super Sani Wipe, 2 minutes
- Bleach, 5 minutes

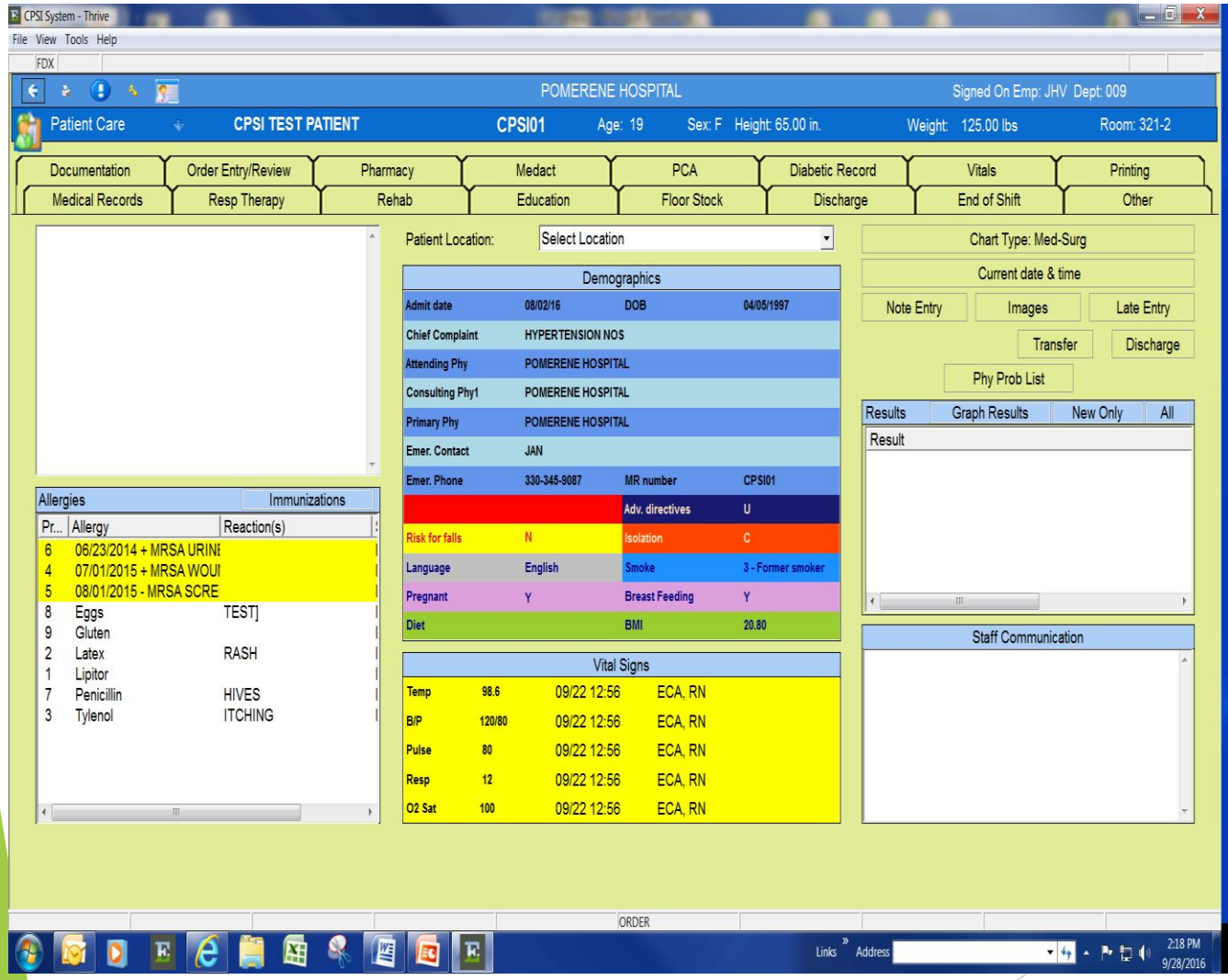
Blood Spills

- Hazmat tote Location?
- Round room
- Broken Glass?
- Use dust pan or other mechanical means
- Large quantity versus small quantity
- Less than 10cc
- What product to use?
- Dispatch Solution
- What policy to use?
- Spill Containment and Clean-up

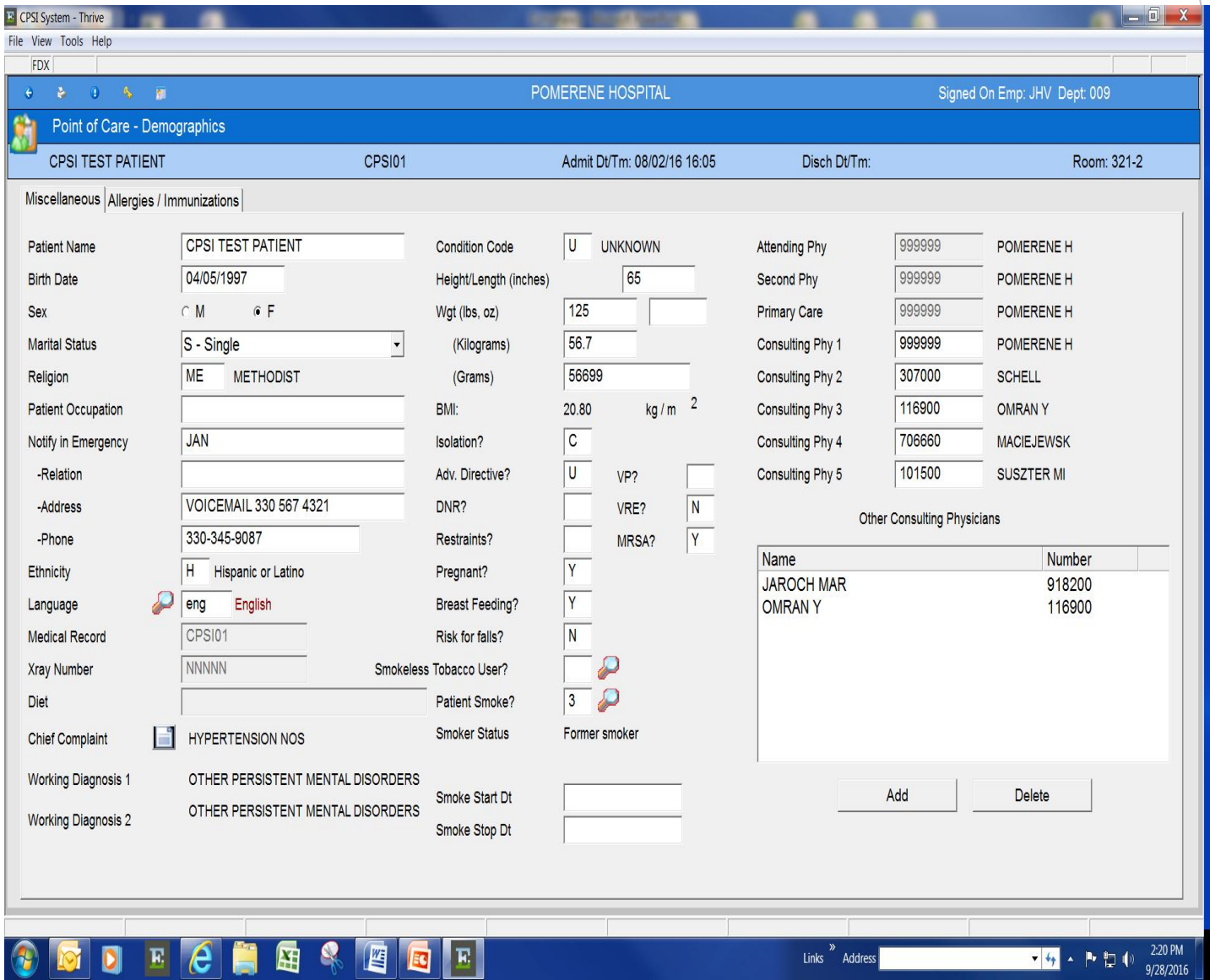
Nasal Decolonization of MRSA

- What is nasal decolonization?
- The act of removing or killing off colonies of bacteria
- Who gets this decolonization?
- Hips, Knees and Bowel surgeries and known carriers of MRSA.
- How do we decolonize these patients?
- Use NOZIN nasal sanitizer pre-op and on admission x 3 doses 10 minutes apart.
- Repeat with one dose every 8 hours.
- Obtain a nasal swab for MRSA prior to sanitizing on known carriers
- Protocol – Does not require physician order

Identifying MDRO patients



Demographics Page



Isolation Rooms

- Isolation Cart
- Obtain from storage room by 324
- Isolation Sign
- Place appropriate isolation sign on door
- Safe Zone
- Only 3 foot into room from threshold
- Proper cleaning product placed on top of cart
- Oxivir for MRSA and Clorox for C-Diff

Isolation Rooms con’t.

- **Airborne rooms**
- Door closed
- Record room exchange rate Q-shift
- Record on Pressure record found in Isolation book in top drawer of cart.
- Test once a shift with visual smoke to verify negative flow.
- Record on pressure record
- Send record to I.C. at discharge

CDC IV.H. Safe Injection Practices

- IV.H.1. **Use aseptic technique** to avoid contamination of sterile injection equipment.
- IV.H.2. **Do not administer medications from a syringe to multiple patients**, even if the needle or cannula on the syringe is changed
- IV.H.3. **Use fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors) for one patient only and dispose appropriately after use.** Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
- IV.H.4. **Use single-dose vials for parenteral medications whenever possible.**
- **Do not administer medications from single-dose vials or ampules to multiple patients** or combine leftover contents for later use.
- IV.H.6. **If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.**
- IV.H.7. **Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations;** discard if sterility is compromised or questionable.
- IV.H.8. **Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.**

Scrub the Hub

- Which hubs have to be scrubbed before accessing?
- Every port on the system,
- Injection ports into bags or bottles
- Injection ports on administration sets,
- **Needless connectors**,
- Hub of a catheter itself are potential portal of entry for infection.
- Stopcocks and injection ports should be capped when not being used.
- Standard: Alcohol swab x 15 seconds

Restraints

Competency Day makeup 2016

Restraints

- Review policy
- The use of restraint is based on the assessed needs of the patient. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
- Restraint devices are to be applied / removed only by staff authorized, trained, and with the demonstrated competency to do so.
- Training on restraints must occur annually for all staff involved in direct patient care

Ordering Restraints

- In emergency application situations, the order must be obtained either during the emergency application of the restraint, or immediately (within a few minutes) afterwards.
- Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
- Staff cannot discontinue a restraint intervention, and then re-start it under the same order.

Patient Monitoring

- Patients placed in restraint for violent or self-destructive behavior should be monitored every **15 minutes** at the very **minimum**.
- Patients placed in restraint for safety, non-violent, and non-destructive behavior should be monitored at a minimum of every **2 hours**.

Patient Assessment

- Ongoing assessment means that the patient will be evaluated to determine the patient's response to the restraint.
- This assessment shall include: checking the patient's vital signs, hydration and circulation; the patient's level of distress and agitation; or skin integrity), and may also provide for general care needs (e.g., eating, hydration, toileting, and range of motion exercises. This assessment shall also determine if the patient continues to require restraint.

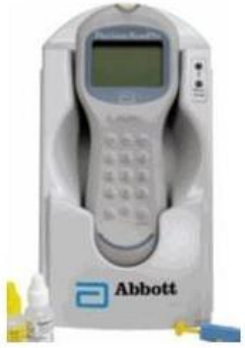
- Patients placed in restraint for **violent or self-destructive behavior** should be assessed at least **every 60 minutes / 1 hour**.
- Patients placed in restraint for **safety, non-violent, and non-destructive behavior** should be assessed at least every **2 hours**.

Glucometer

Competency Day makeup 2016

GLUCOMETER

- HIGH and LOW controls must be run once every 24 hours
- If patient results are >450 or <50 for adults or >450 or <40 for children 3 months of age or less, REPEAT the test
- Dock meter to upload results
- Refer to *ADM 205 Critical Results* and *PC 102 Bedside Glucose Monitoring Policies*
- If a critical result is given repeat the test with a fresh test strip by applying a drop of blood from the same puncture site as the first sample, if possible. If the value is still below 40 mg/dL, order a glucose and send sample to laboratory for testing.



Rapid Response/Code Blue

Competency Day makeup 2016

Rapid Response vs. Code Blue

- Code Blue:
  - Cardiac or Respiratory arrest.
  - CPR in progress
  - Death imminent without intervention
- Rapid Response:
  - Pt could deteriorate without intervention
  - Examples but not limited to:
    - HR < 45 or >140 BPM
    - New Onset Seizure
    - Change in LOC
    - CVA Symptoms
    - Respiratory Distress

How to Call a Code Blue or Rapid Response

- Dial 800 and state “Rapid Response Team to room XXXX” or “Code Blue in room XXXX” 3 times

Rapid Response/Code Blue

- Know where you equipment is
  - Rapid Response bag is at the front desk (admitting)
  - Med-Surg/SCU
    - Broselow Cart next to room 301
    - Adult Crash cart in SCU
  - OB
    - Adult Crash Cart at Nurse's Station
    - Neonatal Cart in Nursery
  - Cardiovascular
    - In stress lab between treadmills
  - ED
    - Broselow Cart and Adult Crash Cart in between rooms 3 &4
  - Surgical Services
    - Broselow Cart in hallway to OR
    - Adult Crash Cart in Ambulatory Care and PACU

Chest Tubes

Competency Day makeup 2016

Chest Tubes

- Remove air and fluid from pleural space
- Prevent drained air and fluid from returning back into pleural space or chest cavity
- Restore negative pressure in the pleural space to allow lung to re-expand
- Average adult chest tube size: 24Fr – 32Fr

  - Thoracostomy: insertion of a chest tube through the chest wall to drain air and/or fluid

Set up

- Step 1: Fill water seal to 2cm line using pre-filled ampule attached to back of system
- Step 2: Connect chest drain to patient
- Step 3: Connect suction to chest drain (if ordered)
- Step 4: Turn suction source on

Oasis Dry Suction Water Seal

- Chamber 1: Fluid collection
  - Nursing records amount of drainage per shift or as ordered
  - Write on white surface to mark fluid levels
- Chamber 2: Water seal
  - Window into pleural space
  - If air is leaving chest, will see bubbling in water seal window
    - Gentle bubbling
  - Calibrated air leak monitor (1 low to 5 high) provides a method to trend the patient's air leak

Oasis Dry Suction Water Seal

- Chamber 3: Suction control
  - Continuously balances changes in patient air leak and wall suction
  - Suction level comes pre-set to -20cmH2O of suction
    - Requires physician order to change
    - Can be adjusted from -10cmH2O to -40cmH2O
  - IF suction ordered
    - Turn vacuum regulator to -80mmHg to expand orange bellows to delta mark (may turn higher if needed)
    - **Must have physician order for suction

NG Tubes

Competency Day makeup 2016

NG Tube insertion and Maintenance

- Review Policy T 51.03 Nasogastric Tubes: Levin or Salem Sump, Insertion and Removal of
- Assessment:
  - Assess patency of nares
  - Assess client's medical history:
    - Nosebleeds
    - Nasal surgery
    - Deviated septum
    - Anticoagulation therapy
  - Assess client's gag reflex.
  - Assess client's mental status.
  - Assess bowel sounds.

NG Tube Insertion and Maintenance

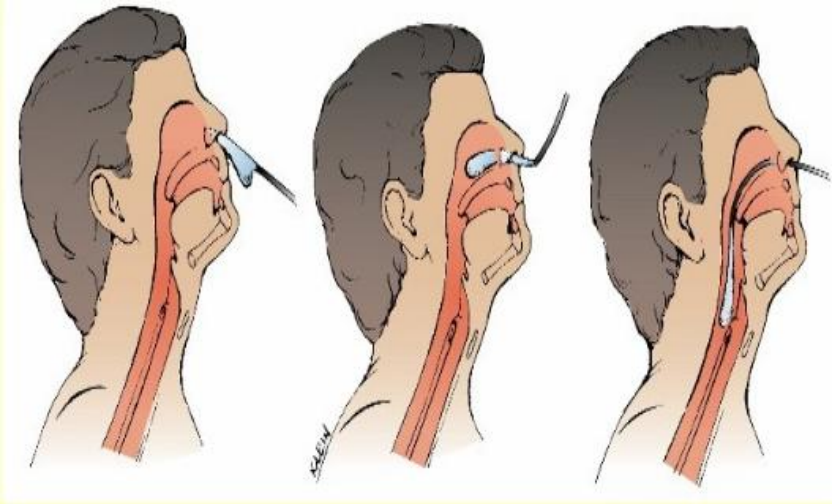
- Gather equipment:
  - 14 0r 16 Fr NG tube
  - Lubricating jelly
  - PH test strips
  - Tongue blade
  - Flashlight
  - Emesis basin
  - Catheter tipped syringe
  - 1 inch wide tape or commercial fixation device
  - Suctioning available and ready

NG Tube Insertion and Maintenance

- Explain procedure to client
- Position the client in a sitting or high fowlers position. If comatose-semi fowlers.
- Examine feeding tube for flaws.
- Determine the length of tube to be inserted.
  - Measure distance from the tip of the nose to the earlobe and to the xyphoid process of the sternum.
  - Mark with tape
  - Flush tube with 20cc sterile water to ensure patency
- Prepare NG tube for insertion
  - Lubricate the first 3inches with water based lubricant
    - NEVER use a petroleum based lubricant

Implementation

- Wash Hands
- Put on clean gloves
- Lubricate the tube
- Hand the client a glass of water
- Gently insert tube through nostril to back of throat (posterior nasopharnyx). Aim back and down toward the ear.
- Have client flex head toward chest after tube has passed through nasopharynx

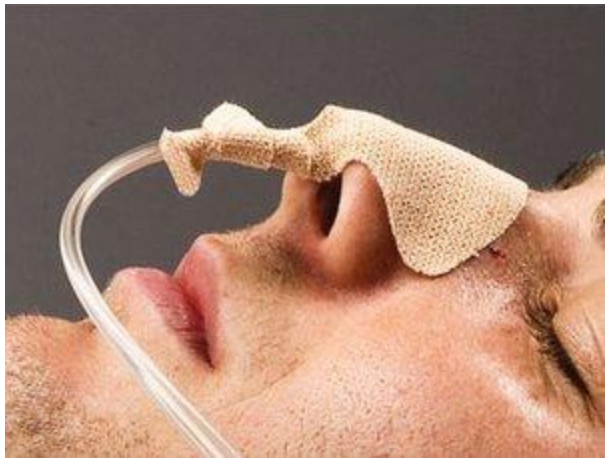


Implementation Cont.

- Emphasize the need to mouth breathe and swallow during the procedure.
- Swallowing facilitates the passage of the tube through the oropharnyx.
- Advance tube each time client swallows until desired length has been reached.
- Do not force tube. If resistance is met or client starts to cough, choke or become cyanotic stop advancing the tube and pull back.

Implenentation Cont.

- Check placement of the tube.
  - Deliver 20-30cc air bolus, listen for gurgling
  - **X-ray confirmation**
- Secure tube to nose with tape or coverlet dressing.
- Secure tubing to patient's gown with tape tab and safety pin.



Evaluation

- Observe client to determine response to procedure.

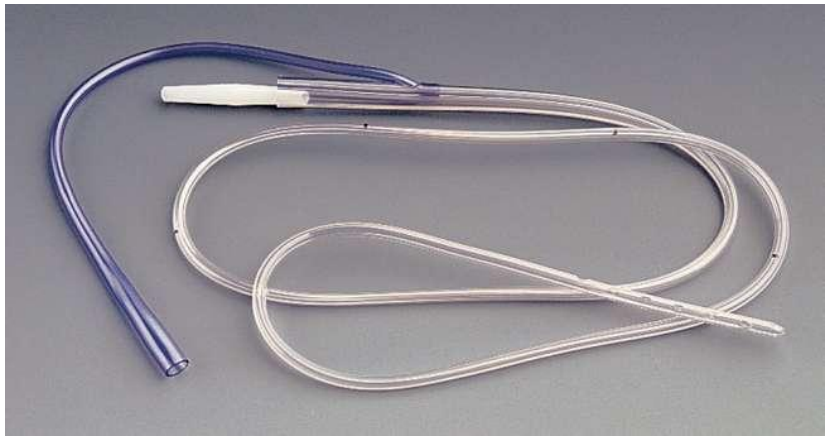
- ALERTS!!! Persistent gagging – prolonged intubation and stimulation of the gag reflex can result in vomiting and aspiration
  - Coughing may indicate presence of tube in the airway.

Evaluation Cont.

- Note location of external site marking on the tube
- Documentation
  - Size of tube, which nostril and client's response.
  - Record length of tube from the nostril to end of tube
  - Record aspirate amount and characteristics

Special Considerations

- Following verification by x-ray of tube placement. The nurse is responsible for ensuring that the tube has remained in the intended position before administering formula or medication through the tube.
  - Verify the NG tube's positioning is correct by instilling 20mL air into the tube while auscultating with stethoscope approximately 3" below the sternum for an "air bubble."
  - After an air bubble is heard, aspirate a small amount of stomach contents to verify patency of NG tube and return aspirate.



Special Considerations

- Observe skin at nares for erosion or breakdown with prolonged intubation.
- Potential complications from prolonged intubations include, sinusitis, esophagitis, esophagotracheal fistula, gastric ulceration, pulmonary and oral infections.
- Violent coughing with insertion indicates NG may have entered trachea, remove and try again.
- Monitor electrolyte balances when NG is to suction.
- Assure the air vent of Salem-sump tube remains dry and open to air to allow proper venting.

- During and after feedings, ensure the patient's HOB is elevated MINIMUM 30 degrees

NG Removal

1. Explain procedure to patient, assist to Fowler's position.
2. Provide privacy. Don gloves
3. Drape chest with chux or towel.
4. Irrigate tube with 10cc H_20 or NS or clear of gastric contents that may irritate tissues.
5. Untape tubing and clamp.
6. Ask patient to inhale and hold breath, then quickly and smoothly remove tube onto towel as patient exhales – to prevent aspiration of material. Discard of wastes properly.
7. Wash hands.
8. Assist patient with mouth care, and clean nose of tape residue.

Blood Administration and Blood/Fluid Warmer

Competency Day makeup 2016

Blood Administration

- Review Policies:
  - T07-01 Blood and/or Blood Products
  - T07-05 Blood Transfusion Reaction Workup
- Important Considerations
  - Make sure you are using the patient's medical record number, not just the "A" number to identify patient (along with other identifiers)
  - Wear gloves while handling/setting up blood product
  - Ensure paperwork is filled out completely
    - Blood completed or d/c'd
    - How much was infused
    - Was it peripheral or central
    - Was there a reaction

MEMORENE HOSPITAL
981 WOOSTER ROAD MILLERSBURG, OHIO 44654

----PATIENT NAME------	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
[redacted]	M	63	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

OPD: DARON YASSE ATT: SEC: PRI:
PAT PHONE: (330)834-2043

----PROCEDURE---	BB CROSSMATCH ADDITIONAL UNIT			ORDER # 94694
--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
9/22/16 1145	9/22/16 1238	9/22/16 1250	9/22/16 1407	9/22/16 1407
LAM	ADM	ADN	MDS	MDS

***REQUEST FOR BLOOD OR BLOOD COMPONENT UNIT # 2

Component	LRPC
Pt's ABO/Rh	O NEGATIVE
Unit's ABO/Rh	O NEGATIVE
Unit's Unit No	W042816010042
Unit Exp Date	10/11/2016
Compatibility	COMPATIBLE
Pt's BB ID #	YXHR 0842

Transfusion comments

I have confirmed the above required items at the time of unit issue:
Issuing Tech .: [signature]

PT ID VERIFIED AT BEDSIDE PRIOR TO BLOOD ADMINISTRATION
PT ID VERIFIED AND DOCUMENTED BY TWO NURSES
PT Name same on unit tag, BB ID Bracelet, and blood administration form
Verify PT name by asking to state name(if poss.)
Pt's MR Number on unit tag is the same as BB ID Bracelet and admin form
Verify Pt's ABO Group/Rh from admin form, and unit tag
Verify unit number from unit and blood administration form
Informed consent obtained?
I have checked the above listed items and there was no discrepancy
B1 RN signature .[signature] Date/Time .9/22/16 1800 PM
B2 RN signature .[signature] Date/Time .9/22/16 1850

***RECORD OF PATIENT'S RESPONSE

	Date/Time	Temp	BP	Pulse	RESP	RN
Prior to transfusion	9/22 1800	97.2	140/72	99	16	[signature]
Start of transfusion	9/22 1815	97	96/62	92	16	[signature]
15 MINUTE CHECK	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Blood complete/DC	9/22 1923	98.1	90/64	87	18	[illegible]

***SITE: Central Vein Peripheral Vein Central Artery Peripheral Artery
***AMOUNT GIVEN (1/4, 1/2, 3/4 or Full unit)
***WAS THERE A REACTION TO THE TRANSFUSION? Yes.. No...
If so, notify the physician and the lab immediately, and initiate a
[illegible] Transfusion Reaction form
***COMPLETE FORMS ENTIRELY. KEEP CARDBOARD COPY ATTACHED TO UNIT.
PLACE WHITE COPY ON CHART. RETURN YELLOW COPY TO LAB ASAP UPON
COMPLETION OF TRANSFUSION.

1
U

Blood Transfusion Reaction

- S/S of a transfusion reaction include:
  - Fever, defined as an increase in temperature >2°F or >1°C above body temperature.
  - Chills with or without rigor
  - Respiratory distress, including wheezing, coughing, and dyspnea
  - Hyper- or hypotension
  - Abdominal, chest, flank, or back pain
  - Pain at the infusion site
  - Skin manifestations, including urticaria, rash, flushing, pruritis, and localized edema
  - Jaundice or hemoglobinuria
  - Nausea/vomiting
  - Abnormal bleeding
  - Oliguria/anuria

Blood Transfusion Reaction

- When a patient who is receiving blood or a blood component is suspected of having a transfusion reaction the nurse must discontinue the transfusion immediately – do not allow any more blood in the filter or tubing to be infused. Maintain patency of the IV with 0.9 sodium chloride (normal saline). Monitor vital signs frequently, and remain with patient.
- Tubing and blood product should be removed, and saved for analysis.
- The nurse must notify the doctor and the lab immediately. Provide a description of clinical findings.
- Careful reverification of patient identification, blood bands and requisitions should be completed by two staff RN's.

Blood Transfusion Reaction

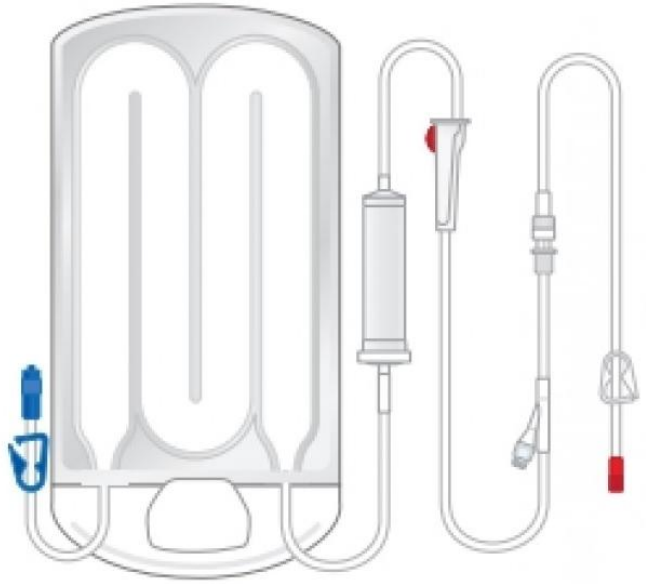
- Patient's symptoms should be treated according to physician's orders after stopping the transfusion.
- A urine specimen should be collected and sent to the lab as soon as possible for a "Stat" Urinalysis. The nurse should note on the requisition that this is a possible transfusion reaction. Only one (1) urine specimen is required.
- The nurse should fill out the Blood Transfusion Reaction Report form and send it to the Lab immediately along with the remainder of the blood in the blood bag and the tubing.
- A copy of both the Blood Transfusion Report and the Reaction Investigation Log sheet are sent to the pathologist for his review and comments. (Lab will forward these completed forms to the pathologist.)
- The original copy of both forms will be placed on the patient's chart and a copy of each will be kept in the lab.

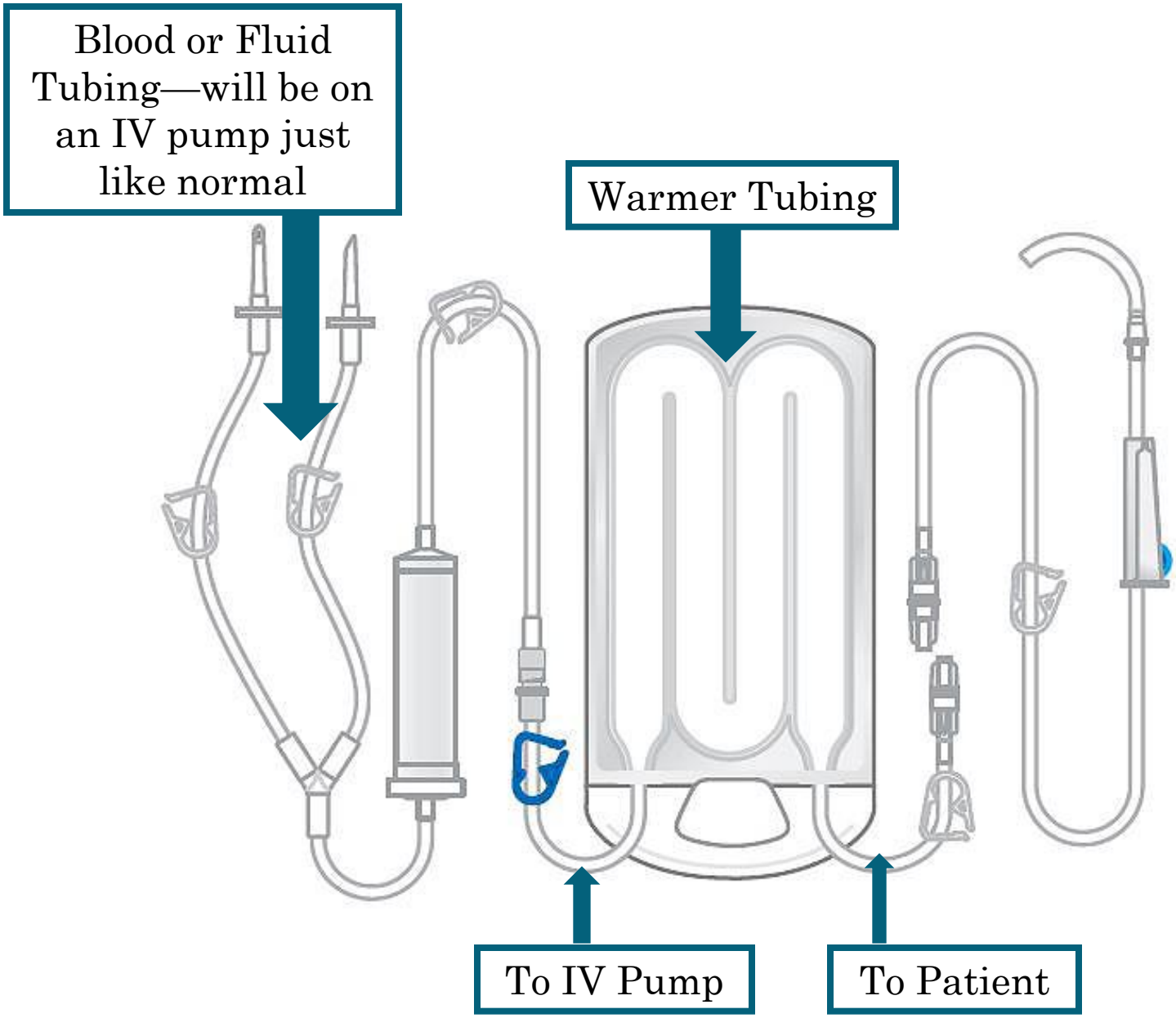
Ranger Blood/Fluid Warmer

- Review Policy T107.07 Blood/Fluid Warmer, Ranger

Ranger Blood/Fluid Warmer

- Heats fluids to 105 degrees F
- DO NOT prime warmer tubing before putting it into the warmer—It goes in empty
- The Ranger has no pumping action, only warming




Blood or Fluid Tubing—will be on an IV pump just like normal
Warmer Tubing
To IV Pump
To Patient

Pharmacy update

Competency Day makeup 2016

Black Box Policy

- Review Policy: Pharmacy Waste Management
- Lids on black boxes will be kept closed at all times when not in use.
- Controlled substances ARE NOT disposed of in the black box.
  - Controlled substances are to be wasted in the sewer.
  - **Except** used Fentanyl patches will continue to be returned to Pharmacy per policy.
- Place items below in plastic zip lock bags and put in Pharmacy Return Basket.
  - Warfarin / Coumadin tablets AND their empty Unit Dose packaging
  - Nicotine patches and their empty wrappers
  - Aerosol inhalers

What Goes in the Black Box?

- Any partially used or opened vials or ampoules, tablets and capsules
- Partially used medicated creams, ointments, shampoos
- Partially used IV/IVPB bags and tubings with medication added (clamp tubing or fold bag and tape if no tubing).
- Partial bags of TPN only if it contains Selenium or Chromium
- Used alcohol and iodine prep pads only if wet enough to squeeze out droplets of liquid
- Non-controlled medication remaining in syringes must be squirted into the black box, then the empty syringe / needle is discarded in a Sharps box.

What **DOES NOT** go in the Black Box?

- Empty IV/ IVPB bags
  (entire dose given or IV's with less than 3% of original volume)
- Empty vials, ampoules *(or less than 3% of original volume)*
- IV tubing
- Sharps
- Biohazard Waste

Sewer/Sink Disposal:

- Partial bags of plain IV solutions or irrigation solutions (D5W, LR, NS, etc.)
- Lipids and amino acids (with no further medications)
- Electrolytes (i.e. Magnesium, Potassium, Sodium, Calcium)
- Controlled Substances

INSULIN PENS-**ONE PEN ONE PATIENT**

- Insulin pens, once used, can only be used for that patient
- An insulin pen should NEVER be used on more than one patient, regardless of needle changes/etc.
- Insulin pens should be labeled with the patient's sticker an stored in the patient's specific medications in the Pyxis

Insulin pens that contain more than one dose of insulin are only meant for one person. ***Insulin pens should never be used for more than one person. They are only approved for use on individual patients, even when the needle is changed or when there is leftover medicine. No exceptions.***

The ***One & Only Campaign is a public health effort to eliminate unsafe medical injections. To learn more about safe injection practices, please visit OneandOnlyCampaign.org.***

For the latest news and updates, follow us on Twitter @injectionsafety and Facebook/OneandOnlyCampaign.

This material was developed by CDC. The ***One & Only Campaign is made possible by a partnership between the CDC Foundation and Lilly USA, LLC.***

Safe injection Practices

Competency Day makeup 2016

SINGLE-DOSE OR MULTI-DOSE?

NOT ALL VIALS ARE CREATED EQUAL.

Dozens of recent outbreaks have been associated with reuse of single-dose vials and misuse of multiple-dose vials. As a result of these incidents, patients have suffered significant harms, including death. CDC and the One & Only Campaign urge healthcare providers to recognize the differences between single-dose and multiple-dose vials and to understand appropriate use of each container type.

This information can literally save a life.

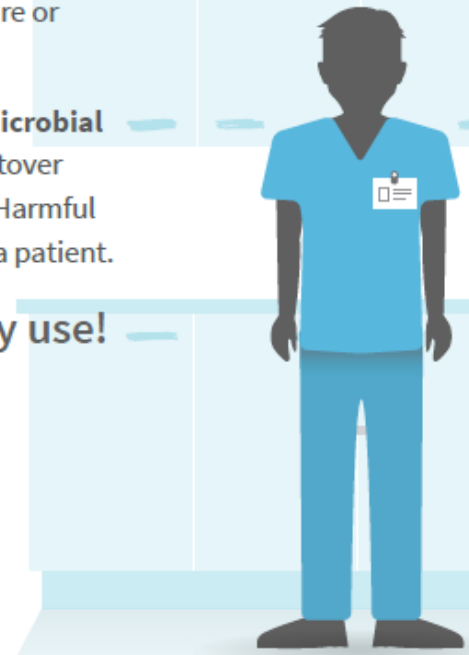
THE PROVIDER

DO YOU MULTI-DOSE?

A SINGLE-DOSE VIAL (SDV) is approved for use on a **SINGLE** patient for a **SINGLE** procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save leftover medication from these vials. Harmful bacteria can grow and infect a patient.

DISCARD after every use!



A MULTIPLE-DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, ***ideally even MDVs are used for only one patient.***

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on bloodborne viruses (i.e. hepatitis B, hepatitis C, HIV).

Discard MDVs when the beyond-use date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vial is in question!

SIZE DOES NOT MATTER!

SDVs and MDVs can come in any shape and size. ***Do not assume*** that a vial is an SDV or MDV based on size or volume of medication. ***ALWAYS check the label!***

FAQs Regarding Safe Practices for Medical Injections:

www.oneandonlycampaign.org/content/healthcare-professional-faqs

SAFETY STEPS

FOLLOW THESE INJECTION SAFETY STEPS FOR SUCCESS!

BEFORE THE PROCEDURE

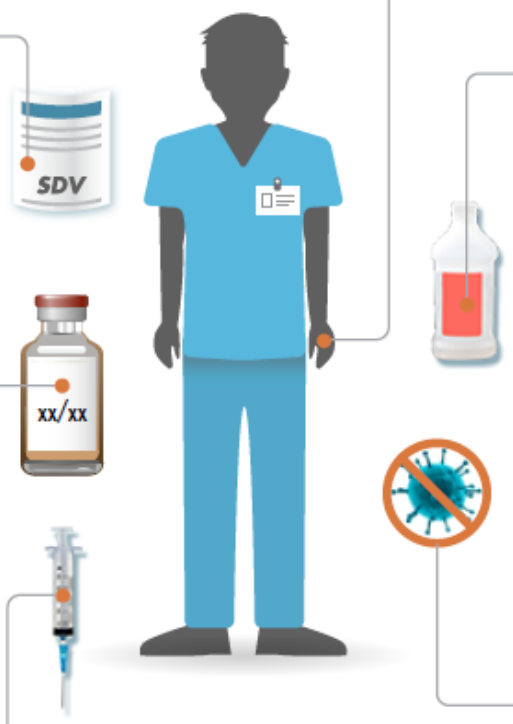
Carefully ***read the label*** of the vial of medication.

- If it says single-dose and it has already been accessed (e.g. needle-punctured), ***throw it away.***
- If it says multiple-dose, ***double-check the expiration date*** and the beyond-use date if it was previously opened, and visually inspect to ensure no visible contamination.
- When in doubt, throw it out.

DURING THE PROCEDURE

Use aseptic technique.

- Use a new needle and syringe for every injection.



- Be sure to clean your hands immediately before handling any medication.
- Disinfect the medication vial by rubbing the diaphragm with alcohol.
- Draw up all medications in a clean medication preparation area.

AFTER THE PROCEDURE

Discard all used needles and syringes and SDVs after the procedure is over.

MDVs should be discarded when:

- the beyond-use date has been reached
- doses are drawn in a patient treatment area
- any time vial sterility is in question

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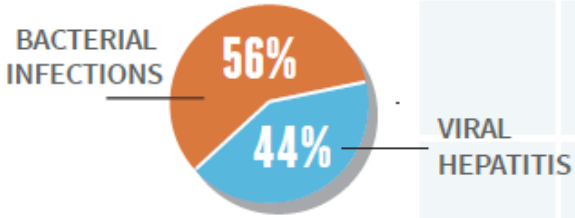
THE PATIENT

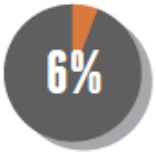
WE ARE ALL PATIENTS.

50 OUTBREAKS AND COUNTING

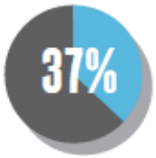
Since 2001, at least 50 outbreaks involving unsafe injection practices were reported to CDC



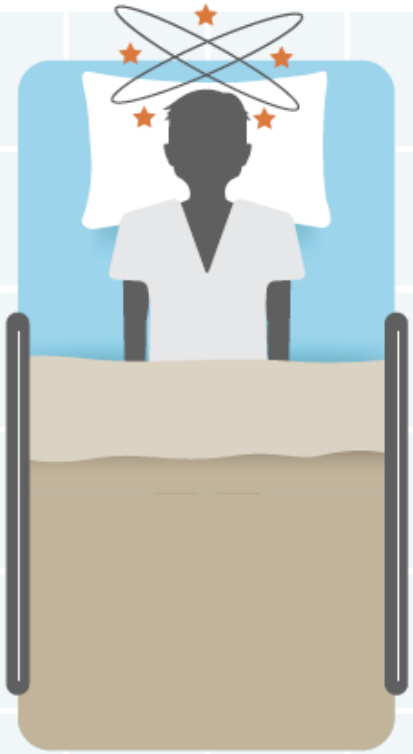
- 90% (n=45) occurred in outpatient settings
- Many hundreds of infected patients
- Over 150,000 patients notified and tested



6% of U.S. health professionals have admitted to using single-dose vials for ***more than one patient.***



A recent study showed that 37% of new hepatitis infections in older adults may be due to unsafe medical injections.



3 QUESTIONS EVERY PATIENT SHOULD BE ENCOURAGED TO ASK:

As a provider, be prepared to answer your patients' questions about safe injection practices.

Did you wash your hands?

Did you use a clean needle and syringe to draw up this medication?

Is this medication from a single-dose vial? Have you used this vial of medication on another person?

IMAGINE IT WAS YOU!

AT THE END OF THE DAY WE'RE ALL PATIENTS.

Knowing how to properly identify single-dose and multiple-dose vials will prevent infections and can save lives. Following basic safe injection procedures is not something to take for granted – there is too much at stake. Educate yourself and those around you.

Do your part to make healthcare safe...
One injection at a time.

ONEANDONLYCAMPAIGN.ORG