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Model for a competency-based orientation and training program for nurses in psychiatric facilities.

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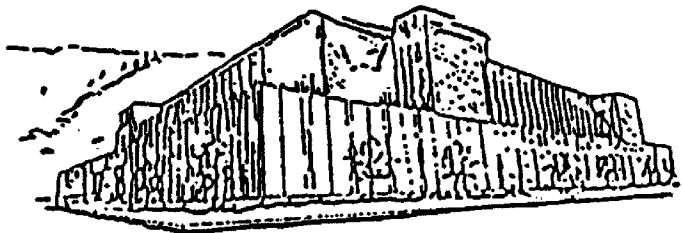
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MODEL FOR A COMPETENCY - BASED

ORIENTATION AND TRAINING PROGRAM

FOR NURSES IN PSYCHIATRIC FACILITIES

by

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CHAPTER I

INTRODUCTION

Statement of the Problem

The delivery of health care in the United States is
undergoing a fundamental change. With the advent of
"managed care", the healthcare industry is being reorganized
to reduce costs. As a result of this reorganization,
insurance carriers are becoming involved in decisions
regarding actual patient care. Through the utilization
review process, managed care companies evaluate the
efficiency and appropriateness of each health care service.
Not only must the health care service be provided in the
most cost effective manner, but it must also be delivered
competently. While managed care companies are requiring
cost-effectiveness, the public is demanding that quality of
care not be sacrificed. As a result, health care providers
are under cross cutting pressures to provide more intensive
treatment in a shorter period of time for less money and
without reducing quality of care.

In response to the pressures from managed care
reviewers, insurance companies, and the general public,
hospitals are continually seeking ways to provide quality

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care while cutting costs and maintaining a profit. Since the largest segment of any hospital's budget involves labor costs, human resources are the first area targeted for cost saving proposals. As a result, hospitals are being forced to reevaluate staffing patterns at the same time they are being pressured to ensure the competence of all health care professionals. Their success in this regard is subject to review by state and federal survey agencies as well as professional accreditation survey organizations.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the recognized accreditation survey organization for health care, continually seeks to improve the quality of care provided to the public (JCAHO, 1995). While recognizing the pressures hospitals face in the market place, JCAHO asserts that "healthcare organizations exist to maximize the health of people they serve while using resources efficiently" (JCAHO, 1995; 27) In an effort to help hospitals achieve that goal, JCAHO has developed performance based standards which focus on "actual performance of clinical and organizational functions and processes that most significantly impact patient care" (JCAHO, 1995; 27). Through the standards related to management of human resources, JCAHO emphasizes that hospitals must focus "on the number and qualifications of staff sufficient to provide the care related to the mission of the hospital" (JCAHO, 1995; 35). Hospitals must design

"a staff orientation process that provides initial job training and information, including an assessment of an individual's capability to perform specified responsibilities" (JCAHO, 1995; 365). The hospital must also design a system "to assess an individual's ability to achieve job expectations as stated in his or her job description" (JCAHO, 1995; 370).

Finally, JCAHO requires "the organization's leaders to develop programs to promote the recruitment, retention, development, and continuing education of all staff members" (JCAHO, 1995; 284). In short, development of an orientation program of the kind described in this paper, followed by continued assessment and improvement of staff competency, is the key to a hospital's ability to meet those standards.

Within Crest View Hospital, a for-profit psychiatric hospital in Casper, Wyoming, specialized knowledge and skills are required to effectively treat individuals in emotional crisis. In rural states, such as Wyoming and Montana, graduates of nursing programs have little opportunity to develop these skills within their formal educational program. New graduates enter the market place with basic knowledge and skills related to the nursing process, yet lack the experience needed to function effectively in a specialized clinical setting. With little opportunity to develop competency prior to employment, Crest View Hospital must define the required competencies

and determine a method to teach them in a cost effective manner. Given the limited time and resources allocated for training and orientation for new employees, a self-directed competency-based orientation and training program is greatly needed.

The purpose of this research project is to develop an orientation and training guide for nurses based on competence areas required within a psychiatric hospital setting. Utilization of the guide will enable the new graduate nurse to engage in self directed learning while providing patient care under direct and indirect supervision of an experienced psychiatric nurse. Although the orientation guide is being developed for use within Crest View Hospital, the goal is to utilize the underlying model throughout the parent corporation.

Methodology

In August 1994, the management team of Crest View Hospital met to formulate a strategic plan for the hospital. The management team consisted of the Administrator, Director of Nursing (D.O.N.), Program Directors, Department Managers, Medical Director, Clinical Director, and representatives of the medical staff. One of the strategies identified for improving existing programs was to identify staff training needs and to establish a core training/orientation program for new staff. The team responsible for addressing this

need consisted of the three treatment program directors and the Director of Nursing. Additional committee members were to be added as deemed appropriate. Completion of the project was projected for September, 1995.

The initial task for the committee was to review the current training program and identify areas requiring modification. Review of current practice revealed that new employees were being placed on the clinical unit without a formal hospital orientation. Under current practice, nurse managers for the clinical units assigned each new employee to an experienced employee to shadow and observe for several days. However, due to increased patient census and staffing constraints, new employees were often asked to perform required tasks immediately, learning by trial and error. Experienced staff were frustrated by the lack of knowledge exhibited by new staff and their inability to perform competently in the clinical setting. The new staff, by contrast, were frustrated at not having a clear understanding of what they needed to know and do. General orientation checklists were handed to the new employees on the first day of employment but were quickly lost as there was no time for anyone to review them. The new employees who could learn quickly in a chaotic situation survived on the clinical units, and those who needed structure and clear direction quickly resigned out of frustration. Nursing staff agreed the turnover rate was appalling, but they

believed they had limited responsibility to help correct the situation. When individually polled about what would make learning how to work in a psychiatric hospital easier, both experienced and new staff expressed the desire to have some type of study guide available so that new employees could prepare themselves before reporting to work. Orientation to the physical layout of the facility could be easily accomplished through on-the-job-training, but developing a basic understanding of the dynamics of the clinical setting would require independent preparation.

Although the committee initially focused on developing the orientation/training program for all staff in the Nursing Department, it soon was decided to narrow the program's focus to the registered nurses as they were capable of providing all aspects of patient care. Due to a limited employment pool, nurses were more difficult to replace when a resignation occurred. The committee determined that if retention of registered nurses was improved through the development of an orientation/training guide, the concept would be expanded to the other positions within the Nursing Department. With the focus now on registered nurses, the Program Directors requested to be replaced on the committee by the Unit Nurse Managers.

Following the initial assessment of orientation and training needs, the revised committee began reviewing the following resources to determine how best to develop staff

competency: 1) recommendations for general hospital orientation developed by the parent corporation, 2) 1994 and 1995 JCAHO standards regarding orientation and training, 3) the job description/performance evaluation for nurses developed in 1993, 4) the standards of nursing practice adopted by Crest View Hospital in 1993, and 5) monthly performance improvement data related to direct patient care. In addition, fifteen sister hospitals within the Sterling Health Care Corporation were contacted regarding individual orientation programs. Of the five hospitals that responded, two hospitals had program outlines and workbooks available to share. However, they requested that any suggestions for improvement be shared in a reciprocal manner. The remaining hospitals contacted expressed similar frustrations regarding orientation and training of staff and expressed great interest in what Crest View Hospital was seeking to do.

In addition to reviewing current practices and evaluating recommended practices for orientation and training, the Director of Nursing and Unit Nurse Managers reviewed performance evaluations of new/probationary staff in an effort to target poor performance areas that could be addressed through the initiation of a self-directed orientation and training guide. As all performance evaluations involved an interview with staff to review the written evaluation, the committee members were afforded an additional opportunity to solicit input regarding

orientation/training needs.

Following internal resource review, the committee utilized the following external resources in gathering baseline information regarding orientation and training needs from a broader clinical perspective: 1) Elon Schlossberg, Psychiatric Clinical Nurse Specialist consultant, under contract with Sterling Health Care Corporation, 2) review of the del Bueno Model of competency development and the Dreyfus Skill Acquisition Model, and 3) attendance at the "Nursing Competency: Strategies Update for 1995" workshop in Casper, Wyoming.

The information gathering phase of the project as outlined above occurred over a six month period. By March, 1995, the committee began the process of outlining the core competency areas for Crest View Hospital with anticipated implementation of a self-directed training guide for newly hired graduate and registered nurses by May 1, 1995.

CHAPTER II

SELF-DIRECTED ORIENTATION MODEL

A systematic approach to training involves at least three steps: 1) self-directed assessment of training needs, 2) delivery of training and development programs, and 3) evaluation of the effectiveness of the results. The self-directed orientation model developed at Crest View Hospital incorporates each of these steps. Accordingly, the self-directed orientation guide contains five sections: 1) an evaluation of baseline skills, 2) an orientation to the hospital as a whole, 3) an orientation to the treatment units, 4) an orientation to the registered nurse position within the hospital, and 5) evaluation of the orientation/training program. (The orientation/training guide is found in Appendix A.)

On the first day of employment, the new employee reports to the assigned Unit Nurse Manager and is given the Orientation/Training Guide. The Guide is reviewed with the employee. Expectations for self study are explained as well as the time frames for completion of orientation checklists.

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Evaluation of Baseline Skills

Evaluation of baseline skills is conducted within the first three days of employment. When possible, it may be initiated prior to the initial employment start date but no later than the first day of employment. Each nurse is asked to self-assess clinical skills through completion of the Skills Inventory. The Skills Inventory will help identify any specialized training, such as cardiopulmonary resuscitation (CPR), that will need to be scheduled within 30 days of employment. If such training is not required immediately, it can be scheduled at any time within the first year of employment. In addition, the new employee is asked to take a test evaluating general knowledge of psychology and critical thinking abilities related to situations that may be encountered in a psychiatric facility. The results are reviewed by the Unit Nurse Managers (who were involved in the hiring process) and then are filed in the individual's unit competency file for future reference.

Assessment of baseline knowledge of medication and its administration, and the legal responsibilities of the nurse related to this area, is facilitated through the use of the General Pharmacy study guide. The nurse is required to review the study guide and take the self test on each section within the first two days of employment. The self-test is reviewed with the Unit Nurse Manager. A minimum

score of 90% is required before the nurse begins orientation on the hospital medication system. The results are filed in the employee's unit competency file for future reference.

General Hospital Orientation

General Orientation is scheduled for an eight (8) hour period once a month and is open to all new employees within the organization. While the Orientation Guide provides a philosophical overview of Crest View Hospital, the formal orientation focuses on the mission and organizational structure of the hospital and outlines basic required knowledge of safety, infection control, inquiry calls, and customer relations. General orientation is conducted by designated administrative staff and is structured in a lecture/classroom format. The hospital orientation checklist included in the Orientation Guide outlines employee performance/knowledge expectations by the end of the eight hour session. The completed general orientation checklist is placed in the employee's personnel file.

Unit Orientation

Each employee is assigned to either the Child/Adolescent Unit or the Adult Unit for initial unit orientation. The new employee is assigned to an experienced staff member (not necessarily a nurse) during this phase. Utilizing a checklist, the preceptor orients the employee to the

physical layout of the unit, the equipment used on the unit, the daily program schedules, the patient handbooks which outline treatment expectations, privileges, etc., and location of forms and documents required in a medical record. Unit Orientation is time and task specific, with emphasis on helping the new employee demonstrate basic knowledge of the treatment unit in a short period of time. Equally important to becoming familiar with the physical layout of the unit is understanding the therapeutic milieu or community that is created in a psychiatric setting. Within the Orientation Guide, selected readings are provided to facilitate the employee's orientation to psychiatric treatment.

During orientation to the unit and the therapeutic community contained therein, the Unit Nurse Manager begins to familiarize the new employee with the location of policy and procedure manuals as well as establishing the priority of nursing functions required on each unit. Established in policy and outlined in the Orientation Guide, the nursing functions are prioritized in the following manner: 1) Safety Needs; 2) Physical/Medical Needs; 3) Therapeutic Milieu Needs; 4) Individual Needs; 5) Family Needs; 6) Patient/Family Education; and 7) Discharge Planning. Prioritizing nursing functions for the employee helps set the stage for indepth orientation to the registered nurse position.

Position Orientation

Orientation to nursing in a psychiatric hospital begins with an introduction to basic nursing staff functions and the specific knowledge, skills, and critical thinking abilities required to perform them. Beginning with self evaluation and continuing through each level of orientation, the new employee is being prepared for the beginning of on-the-job training. The orientation guide contains the job description/performance evaluation instrument, separated into standards of performance. Resources for self-directed learning, such as video tapes, key policies and procedures, or selected readings, are identified for each standard to help the new employee achieve success in each functional area. The outlined standards are presented in order of importance for a registered nurse. Demonstration of the skills and knowledge outlined in the job description is conducted on an ongoing basis during the employee's on-the-job training. The new employee is assigned to work with an experienced licensed nurse on a regular basis. The new employee is expected to utilize the suggested resources during the performance of duties. Suggested videos are checked out for viewing at home, with the expectation the nurse will discuss the video with the Nurse Manager the following day. This phase of orientation/training will last between 90 and 180 days, during which time the employee should be able to demonstrate satisfactory job performance.

The job description provides the basis for self evaluation by each nurse in preparation for formal evaluation by the Unit Nurse Manager after three and six months. By the end of the first year, the new employee should be consistently demonstrating competent behavior, knowledge, and skills.

For efficiency in orientation, each nurse is assigned to a primary patient unit and Unit Nurse Manager. However, each nurse must be able to work on either unit should the need arise. Cross training of the employee to the alternate unit is facilitated when the employee demonstrates basic knowledge and skills related to the job description and the primary work unit. Cross training is scheduled with the receiving Unit Nurse Manager and follows the unit orientation previously outlined. While the basic skills and knowledge outlined in the job description remains the same across all units, their application will vary according to the age and developmental level of the patient population being served. Cross training includes reading the designated patient handbooks and following the unit rules and regulations outlined therein, becoming familiar with the physical layout of the unit and required safety procedures, and becoming familiar with age specific and developmental differences in regard to psychiatric treatment. Unit specific checklists related to identified knowledge areas are utilized. Additional cross training is achieved through attendance at in-service education opportunities, unit

meetings, and nurses' meetings scheduled monthly throughout the organization.

The need for specialized training in non-violent physical crisis intervention (CPI) is identified during job position orientation and is scheduled for the employee with certified instructors. Training for CPI is scheduled within 90 days of beginning employment. Successful completion of the training is evaluated through demonstration of skills and written tests. These skills are updated on a yearly basis.

Evaluation

Evaluation occurs on an ongoing basis at the individual and unit level. Individual evaluation occurs through completion of checklists, demonstration of skills and knowledge during on-the-job training, self- and formal evaluation of performance outlined in the job description, evaluation of reported individual medication error rates, and evaluation of variance reports related to safety of patients and staff. The Unit Nurse Managers are responsible for monitoring the new employee's progress and immediately addressing potential problem areas identified through error rates and variance reports.

Unit/organization evaluation occurs through risk management and performance improvement activities, which includes monitoring staff turnover. Continual monitoring of

this area helps the management team determine the effectiveness of orientation and continuing education activities. It also helps the organization evaluate its overall commitment to staff. The ultimate test of the effectiveness of the orientation/training program, including the self-directed orientation guide, is through the successful completion of the JCAHO survey process, scheduled for July, 1996.

CHAPTER III

CONCLUSION

While orientation and training are recognized as keys to the development and retention of competent employees, many organizations fail to commit the resources necessary to achieve those goals. Increased economic constraints are now encouraging organizations to be creative in orienting employees in the most efficient manner possible.

Utilizing an orientation guide accomplishes two goals. First, performance expectations are clearly outlined for the new employee, thereby reducing uncertainty and providing a basis for self evaluation. Second, knowledge and skill areas are outlined for the preceptor to help bring structure and direction to the orientation/training period. Through utilization of the guide, the new employee can become a functional team member, achieve success on the job, and develop a sense of competency.

Implementation of the guide is presently occurring on a limited basis. Organizational changes, together with low patient census, have curtailed hiring of new staff since May 1, 1995. New staff scheduled to begin work after that time have had to delay their start dates one to two months and to

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begin working in a part-time status only (24 hours or less a week). The optimal conditions under which to orient an employee (40 hours a week for a minimum of three months) have not occurred. However, introducing the guide to the new employees has helped them stay focused on what they need to be learning when they are actually scheduled to work. It has also helped the preceptor to remain focused on helping the new nurse learn key skills and procedures. In view of the present internal constraints, new employees may remain at the novice level longer than anticipated. Nonetheless, they have a tangible "reminder" of the knowledge and skills required to progress from a novice level to the advanced beginner level and ending at the competent level of nursing practice.

The orientation guide continues to be a "work in progress", both from an implementation standpoint and a development standpoint. The present guide is serving as a prototype for other guides for non-licensed employees within nursing services. While the non-licensed staff require fewer technical skills in working with patients, they still need the therapeutic milieu knowledge base and interpersonal skills required of registered nurses.

The long-range goal of Crest View Hospital is to have orientation guides available for each department within the hospital. Hospital-wide utilization of the guides should enable us to monitor staff competency more consistently and

demonstrate an organized approach to addressing staff development and retention issues. It is also hoped that it will provide a model for other health care facilities to follow.

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APPENDIX A

ORIENTATION GUIDE FOR REGISTERED NURSES

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CREST VIEW HOSPITAL

ORIENTATION GUIDE FOR

REGISTERED NURSES

TO: New Employees

FROM: Burl Maurer, Clinical Services Director
             Pat Palm, Director of Nursing Services
             Donna Nurss, Child/Adolescent Unit Nurse Manager
             Linda Robinson, Adult Unit Nurse Manager

RE: Orientation and Training

We would like to take this opportunity to welcome you to Crest View Hospital and the Nursing Services Department. The Orientation Guide you are receiving signals the beginning of a partnership between you and Crest View Hospital. Orientation is an ongoing process which is reflected through a formal general orientation, on-the-job-training under the supervision of a Unit Nurse Manager, and self-directed learning. The Orientation Guide will provide you with the framework to learn the skills necessary to work effectively within the psychiatric hospital setting.

The Orientation Guide is divided into the following sections: 1) Self-assessment, 2) General Orientation, 3) Unit Orientation, 4) Position Orientation, and 5) Evaluation. Each section contains checklists, selected readings, and/or pertinent information to assist you in self-directed learning. The Self-Assessment section will need to be reviewed and completed within two working days of the start of your employment. The information obtained from this section will enable the Unit Nurse Manager to evaluate your training needs and facilitate an effective orientation program for you. If you have any questions regarding any of the sections of the Guide, please let us know.

General Orientation is scheduled for the second Tuesday of each month. If you are beginning employment prior to that time, the Unit Nurse Manager will schedule you to attend. Unit orientation will occur over a three day period under the direction of the Unit Nurse Manager. Both Mental Health Specialists (MHSs)and nurses will assist you in this activity. Position Orientation is conducted by a Registered Nurse (RN) under the supervision of the Unit Nurse Manager. This is concurrent with Unit Orientation but extends throughout the probationary period (180 days). Specialized training in Non-violent Crisis Intervention (CPI) will be scheduled for you within 60 days of the beginning of your employment.

Evaluation occurs on an on-going basis through completion of checklists, performance evaluations at three and six months, direct observation, and evaluation of medication errors and variance reports. The evaluation process is a mutual responsibility and we encourage you to bring any problems to your Unit Nurse Manager immediately, as well as suggestions on improving the orientation/training process. At the conclusion of your probationary period, you will be asked to complete an orientation evaluation survey to help us determine the effectiveness of the Orientation Guide and program.

Self-directed learning involves regular attendance at Nursing Services meetings. The General Nurses Meeting is held on the first Thursday of the month with a choice of attendance time at 2:00 PM or 4:00 PM. The meeting is generally 1 hour long and focuses on nursing standard issues. The second meeting is a Unit Nurses Meeting scheduled for the 3rd Thursday of the month. The Unit meeting is conducted by the Nurse Managers and focuses on unit specific issues. Additional educational opportunities are offered throughout the hospital and are printed on a monthly inservice calendar. You will receive one with your paycheck. The inservice calendar is also posted on each unit.

Once again, welcome to Crest View Hospital!

ORIENTATION GUIDE

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A:\TBLCONTE.NTS

SELF ASSESSMENT

CREST VIEW HOSPITAL & COUNSELING CENTER

SKILLS INVENTORY

Please complete the Skills Inventory to assist us in evaluating your experience and qualifications as a licensed nurse. Return the completed inventory to your Unit Nurse Manager for review and evaluation of your orientation/training needs. Thank you!

Print Name:_____Position:_____

Date of Hire:_____Date completed:_____

CERTIFICATIONS:

Are you ACLS certified?	YES_____	NO_____	Expires:_____
Are you CPR certified?	YES_____	NO_____	Expires:_____
Are you certified in psychiatric nursing?	YES_____	NO_____	Expires:_____
Are you certified in addiction nursing?	YES_____	NO_____	Expires:_____

Other certifications:_____

MY EXPERIENCE (number of years):

Psychiatry _____ a) Child _____ b) Adolescent _____ c) Adult _____

d) Geriatric _____ e) Cognitively Impaired _____ f) Addictions Tx _____

g) Eating Disorders _____

Supervisory experience:_____ a) Nurse Manager _____ b) Charge Nurse ____

Other:_____

COMPETENCY IN GENERAL NURSING SKILLS:

Please check the column that best describes your experience level with each skill.

Key: 0 = never done
      1 = familiar with, would need supervision
      2 = experience in, independent

NURSING SKILL:	EXPERIENCE LEVEL		
	0	1	2
ADMINISTERING MEDICATIONS:			
a. Unit Dose	___	___	___
b. Non-unit dose	___	___	___
c. IM	___	___	___
d. Z track	___	___	___
e. SQ	___	___	___
f. PO	___	___	___
g. IV	___	___	___
h. Rectal	___	___	___

1

SKILLS INVENTORY

NURSING SKILL: **EXPERIENCE LEVEL**
                                                      0   1   2

CATHETERIZATION:
a.   Male   ___   ___   ___
b.   Female
                                                     ___   ___   ___

SPECIMEN COLLECTION:
a.   Clean catch
b.   Urine drug screen (UDS)   ___   ___   ___
c   Chain of custody - UDS   ___   ___   ___
d.   Sputum   ___   ___   ___
e.   Stool   ___   ___   ___
f.   Throat culture   ___   ___   ___

ASSISTING PHYSICIAN WITH PHYSICAL EXAM:
a.   Patient set up
b.   GC Smears   ___   ___   ___
c.   Assisting with Vaginal Cultures   ___   ___   ___
d.   Assisting with PAP Smears   ___   ___   ___

DRAWING OF BLOOD SAMPLES:
a.   Fingerstick
b.   Venipuncture   ___   ___   ___
                                                     ___   ___   ___

DIABETIC CARE:
a.   Insulin Injections
b.   Use of Glycometers (Accucheck)   ___   ___   ___
c.   Signs of Reactions   ___   ___   ___
d.   Health Teaching   ___   ___   ___

FALL PREVENTION: PATIENTS WITH
a.   Crutches   ___   ___   ___
b.   Wheelchair   ___   ___   ___
c.   Walker   ___   ___   ___
d.   Cane   ___   ___   ___
e.   TENS   ___   ___   ___
f.   Seizure disorder   ___   ___   ___
g.   Neurological problems   ___   ___   ___

UNIVERSAL PRECAUTIONS:
a.   Sterile Dressing Change   ___   ___   ___
b.   Wound Care   ___   ___   ___
c.   AIDS/HIV   ___   ___   ___

COMPETENCY IN PSYCHIATRIC NURSING SKILLS:

ASSESSMENTS:
a.   Mental Status Exam   ___   ___   ___
b.   Evaluation: Suicidality   ___   ___   ___
c.   Evaluation: Homicidality   ___   ___   ___
d.   Evaluation: Assault Potential   ___   ___   ___
e.   Evaluation: Elopement Potential   ___   ___   ___
f.   Evaluation: Addictive Behaviors   ___   ___   ___
g.   Evaluation: Withdrawal Status   ___   ___   ___
      1.   ETOH   ___   ___   ___
      2.   Stimulants   ___   ___   ___
      3.   Narcotics   ___   ___   ___
      4.   Barbiturates   ___   ___   ___
      5.   Hallucinogenics   ___   ___   ___

2

SKILLS INVENTORY

NURSING SKILL:	EXPERIENCE LEVEL:		
	0	1	2

THERAPEUTIC TECHNIQUES:

		0	1	2
a.	Alliances	___	___	___
b.	Responses/Communication	___	___	___
	1. Reflective listening	___	___	___
	2. Redirection	___	___	___
	3. Confrontation	___	___	___
c.	Milieu Management	___	___	___
d.	Group Process	___	___	___
e.	Dealing w/ Treatment Resistance	___	___	___
f.	Behavior Management Techniques	___	___	___
g.	Cognitive Therapy	___	___	___
h.	Assertiveness Training	___	___	___
i.	Multi Family Group	___	___	___
j.	Family Therapy	___	___	___
k.	AMA Prevention/Intervention	___	___	___
l.	Stress Management	___	___	___
m.	Anger Management	___	___	___
n.	12 Step Program	___	___	___

TRANSPORTING/ESCORTING PATIENTS ON OUTINGS :___   ___   ___

CRISIS MANAGEMENT:

		0	1	2
a.	De-escalation techniques	___	___	___
b.	Non-violent physical holds	___	___	___
c.	Seclusion	___	___	___
d.	Mechanical Restraints	___	___	___

INPATIENT DISORDERS YOU HAVE EXPERIENCE WITH:

		0	1	2
a.	Schizophrenia	___	___	___
b.	Personality Disorders	___	___	___
c.	Obsessive/Compulsive Disorder	___	___	___
d.	Bipolar Disorder	___	___	___
e.	Phobic/Anxiety Disorders	___	___	___
f.	Oppositional Disorder	___	___	___
g.	Attention Deficit Disorder	___	___	___
	1. Child	___	___	___
	2. Adolescent	___	___	___
	3. Adult	___	___	___
h.	Psychotic Disorders	___	___	___
i.	Drug and ETOH	___	___	___
j.	Sexual Addictions	___	___	___
k.	Eating Disorders	___	___	___
l.	Dissociative Disorders	___	___	___
m.	Post Traumatic Stress Disorder	___	___	___

EXPERIENCE WITH DETOX PROTOCOL   ___   ___   ___

PSYCHIATRIC MEDICATIONS:

		0	1	2
a.	Antidepressants	___	___	___
	1. TCA	___	___	___
	2. MAO Inhibitors	___	___	___
	3. Prozac	___	___	___
b.	Lithium	___	___	___
c.	Antipsychotics	___	___	___
d.	Anticholenergics	___	___	___

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SKILLS INVENTORY

NURSING SKILL:		EXPERIENCE LEVEL:		
		0	1	2
e.	Detox Medications	___	___	___
	1. Benzodiazepines	___	___	___
	2. Methadone	___	___	___
	3. Catapres	___	___	___
	4. Phenobarbital	___	___	___
f.	Antihypertensives	___	___	___
g.	Procardin	___	___	___
h.	Clozapine	___	___	___

ADVERSE DRUG REACTIONS:				
a.	Tardive Dyskinesia	___	___	___
b.	Anaphylactic Shock	___	___	___

MEDICAL EQUIPMENT I HAVE USED:				
a.	12 Lead EKG Machine	___	___	___
b.	Alcosensor/Breathalizer	___	___	___
c.	Portable Oxygen Tanks	___	___	___
d.	Other (Please list)			
	_____	___	___	___
	_____	___	___	___
	_____	___	___	___

CONTINUING EDUCATION:

Please list seminars, courses, and inservices that you have attended in the last five years that you feel have helped you gain knowledge and growth in Psychiatric Nursing.

NAME OF EDUCATION PROGRAM   DATE ATTENDED

1.
2.
3.
4.
5.

****

I certify that my answers to the Skills Inventory are true and correct. I realize as a professional that I am responsible for keeping my skills current. I also realize that it is my responsibility to notify my immediate Nursing Supervisor or the Director of Nursing should I have any questions regarding specific care, equipment operation, medication administration and care procedures pertinent to patients to whom I am rendering care.

_____   _____
Employee Signature   Date

_____   _____
Reviewed by: Date
A:\NURSKILL.INV

4

BASELINE COMPETENCY TEST: PSYCHOLOGY; PROBLEM SOLVING

Employee Name:_____ Test Date:_____

Reviewed by: _____ Date:_____

Score: General:____/16 Percent correct:_____ Total Score:____/40

      Adult:____/14 Percent correct:_____

      Adol.:____/10 Percent correct:_____

GENERAL:

1. Schizophrenia is best described as:
   a. Chronic memory deficit
   b. Decreased brain cell metabolism
   c. Intense hate of family
   d. A loss of contact with reality

2. A delusion is:
   a. A type of hallucination characterized by false sensory experiences
   b. A form of slowed thought processes
   c. A false belief, often of persecution or grandeur
   d. A great amount of somatic passivity

3. A person clinically diagnosed as "bipolar disorder" is characterized by:
   a. Episodes of mania and depression
   b. Hallucination and delusions
   c. Delusions and dissociation
   d. Psychophysiological pain

4. Hypochondriasis is a disorder that features:
   a. Somatic symptoms
   b. Many delusions
   c. Hallucinations
   d. Disorientation

5. Pedophilia is described as:
   a. Psychosexual disease featuring voyeurism
   b. Psychosexual disorder featuring homosexuality
   c. Disorder characterized by adults having sexual acts with children
   d. Disorder that features certain fetishes

6. Anorexia Nervosa is a clinical syndrome that features:
   a. Binging and purging
   b. A voluntary refusal to eat to maintain body weight
   c. Severe nausea that decreases appetite
   d. Overeating and intentional vomiting

7. Bulimia may be described as:
   a. Chronic organic brain disorder
   b. Disorder in which one has multiple personalities
   c. Disorder that features ongoing hallucinations
   d. Clinical syndrome that features binging and purging

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8. The unit environment and suicidal patients's personal effects should be checked carefully and regularly for harmful objects.
   a. True
   b. False

9. When a patient is on suicide precautions, nursing staff should:
   a. Monitor the patient every 15 minutes
   b. Search the patient's room for contraband (if suspected)
   c. Document every shift, patient's behavior and precaution maintained
   d. All of the above

10. When a patient is on elopement precaution staff should:
    a. Monitor the patient frequently and document patient's behavior and location
    b. Maintain the patient behind locked unit doors
    c. Provide walks within the hospital and outside to assess the level of trust established
    d. All of the above
    e. a and b

11. Assault precautions requires the following responsibilities:
    a. Monitoring patient every 15 minutes and documenting assessment
    b. Ensuring patient remains on the unit at all times
    c. Documenting every shift an assessment of the patient
    d. All of the above

12. The letters "DT's" refer to:
    a. Detention theories
    b. Do not take
    c. Diseases of the thyroid
    d. Delirium tremens

13. The term "Coke" refers to:
    a. Coca-cola
    b. Cocaine
    c. Crank
    d. Acid

14. Drug users who require increasing doses of drugs to experience a result have developed the following:
    a. sensitivity to the drug
    b. tolerance for the drug
    c. withdrawal from the drug
    d. indifference to the drug

15. If a person begins experiencing withdrawal symptoms after ceasing to use a drug, the person has developed:
    a. A physical dependence
    b. A psychological dependence
    c. An intolerance
    d. A need to be hospitalized

16. Erickson's heirarchy of needs includes the following except:
    a. Safety and security
    b. Self esteem
    c. Employment security
    d. Feeling of belonging

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During shift report, you were told that Mr. Smith has been restless
throughout the previous shift and has been pacing the floor talking to
himself in angry tones. During your shift, Mr. Smith tells you that the
devil is very angry and is telling him to "straighten out this unit".
Mr. Smith has been upset like this in the past and has attempted to hit
other patients and destroy furniture. You believe you have a good
rapport with Mr. Smith so you will attempt to work with him.

17. You are concerned about Mr. Smith because his behavior is a sign
     of:
     a. Possible assaultive or violent behavior occurring
     b. Sudden withdrawal from reality in the near future
     c. A viral infection
     d. An increasing state of depression

18. Which of the following observations of Mr. Smith's behavior
     indicates he may become assaultive or violent?
     a. Restlessness and pacing
     b. Talking to himself in angry tones
     c. Tells you the devil has told him to "straighten out the
         unit"
     d. All of the above

19. You have decided to speak with Mr. Smith about his behavior.
     Which of the following is an appropriate statement to make to Mr.
     Smith:
     a. Mr. Smith, I've noticed that you seem tense today. Tell me
         what is on your mind.
     b. Mr. Smith, if you don't stop all this walking and talking
         about the devil, I'll have to lock you up.
     c. Mr. Smith, you really must calm down before someone gets
         hurt and you end up in seclusion.
     d. Mr. Smith, I'm going to put you in seclusion for a little
         while so you can get control of yourself.

20. Your talking with Mr. Smith has not helped to calm him. He has
     become violent, however, no other people are in danger. You
     should:
     a. Rush him by yourself because you are sure you can handle
         him.
     b. Have two or three other staff members help you crowd him so
         he feels secure.
     c. Wait for help and give him room so he doesn't feel
         threatened.
     d. Ask three of four patients to help you so you can get him
         into seclusion before someone gets hurt.

Mrs. Doe, age 85, has been forgetful lately. She seems to remember past
events very well but cannot remember what has happened recently. She
also seems to forget the date, where she is, and the name of the Mental
Health Specialists and the nurses who care for her. You would like to
help reorient her to the present time, place, and people.

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21. Reality orientation would probably be the best approach to use with Mrs. Doe. Which statement best describes reality orientation?
   a. Therapeutic meetings with 5 to 10 patients that last 30-60 minutes.
   b. Regularly scheduled meetings with the patient and his or her family.
   c. An on-going approach which attempts to bring or maintain the patient in the real world.
   d. Regularly scheduled meetings with a therapist.

22. Mrs. Doe has been talking to you as if you were her son or daughter. How should you respond?
   a. Answer her as if you were her son or daughter while you continue your work.
   b. Call her "Mother" and encourage her to consider you her son or daughter.
   c. Ignore her until she addresses you by your name.
   d. Gently remind her of your name, where she is, and the date.

23. The best approach you could take with Mrs. Doe is which of the following:
   a. Calm, unhurried
   b. Warm and accepting
   c. Kind and tactful
   d. Respectful
   e. All of the above
   f. None of the above

Mr. Miller was admitted to the alcohol detox unit yesterday. Today you notice that his face is flushed and his are bloodshot. He has a had a poor appetite and seems very anxious. Earlier in the shift, he screamed that there were bugs crawling on his hand, but you did not see anything.

24. The bugs Mr. Miller saw crawling on his hands are an example of:
   a. Illusions
   b. Delusions of grandeur
   c. Visual hallucinations
   d. Auditory hallucinations
   e. None of the above

25. The symptoms of bloodshot eyes, flushed face, poor appetite, anxiety and seeing bugs indicates which of the following situations:
   a. Infection caused by run-down condition
   b. Possible heart attach
   c. Withdrawal from reality
   d. Alcohol withdrawal

26. While the patient is showing these signs and symptoms, you should do which of the following:
   a. Leave the patient alone because other people agitate him.
   b. Assess him frequently for changes in symptoms and the need for medical management.
   c. Allow the patient up and out of bed any time he/she wants, without assistance.
   d. Provide a quiet, lighted, safe environment, while monitoring vital signs and observing for seizures.
   e. b and d

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27. Once Mr. Miller has no more alcohol in his system, we know that he is no longer in need of treatment.
    a. True
    b. False

You have been caring for Ms. Jones over the past week. Ms. Jones is a young woman, recently divorced, who is very depressed and has unsuccessfully attempted suicide twice in her lifetime. You are concerned about her because the anniversary date of her only child's death is today. Two days ago she talked about how life was not worth living any longer. Today she appears happy and is thanking everyone for their help, indicating she is being discharged so she can go home and get her life in order.

28. You are concerned that Ms. Jones may attempt suicide based on the following observations:
    a. A sudden change in mood from hopeless to happy.
    b. She wants to go home in order to get her life in order.
    c. She has accepted the losses in her life.
    d. a and b

29. You want to find out if Ms. Jones is thinking about suicide.
    a. Share your observations regarding her sudden change in mood and ask her if she is thinking about hurting or killing herself.
    b. Don't worry as her treatment has made her better.
    c. Observe her closely without asking her if she is thinking about suicide.
    d. Congratulate her on her progress and assist her with discharge planning.

30. Ms. Jones denies she is thinking about suicide and maintains a cheerful attitude. Later, her roommate asks to speak with you and shares that Ms. Jones told her she would soon be leaving to go to a better place. Based on this information, you should:
    a. Assign staff to keep Ms. Jones in eyesight at all times.
    b. Contact her physician and share your observations and assessment of the situation.
    c. Search Ms. Jones' room for potentially harmful items and remove them to a secured area.
    d. Share your concerns with Ms. Jones and reiterate your role of keeping her safe and free from harm.
    e. All of the above.

Employee Name:_____   Pre-test date:_____

Reviewed by:_____   Date:_____

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SITUATIONAL QUESTIONS: ADOLESCENT PATIENTS
(Questions 31 - 40)

Robert, age 14, a new patient, has been sitting alone, mumbling to himself throughout the shift. He seems very shy and sometimes moody. He has said that alien creatures from Mars are coming to get him and he is afraid to leave the unit. The other adolescents say he is "faking" it and is just avoiding school.

31. When Robert refuses to leave the unit because of his fear of alien creatures, you should:
    a. Tell him how silly those fears are and insist that he go to school with the other patients.
    b. Lock him in the seclusion room so he will feel safe.
    c. Tell Robert you will not speak with him until he stops talking about alien creatures.
    d. Remain calm and matter-of-fact and attempt to gain his trust while determining his mental and emotional state.

32. A therapeutic environment for Robert would be:
    a. Noisy, hurried, and busy
    b. Simple, consistent, and predictable
    c. Full schedule with frequent schedule changes
    d. No limits set for Robert's safety

33. In meeting Robert's emotional needs, you should:
    a. Show you care and want him to get better
    b. Show you accept him despite his current thinking
    c. Encourage him to develop trust in you
    d. Support positive behaviors
    e. All of the above

34. The other adolescents taunt Robert for his thinking and fears. You can best help Robert deal with his peers by:
    a. Insist he tell them to stop teasing him.
    b. Tell him it would be best to share his thoughts with only you.
    c. Address the taunting behaviors in Community Meeting.
    d. Taunt the other patients when they display unusual thoughts or behaviors and then tell them "Now you know how Robert feels".

Andrea, age 16, is readmitted to the Residential Treatment program. She recently ran away from home for the fifth time in the last four months and was picked up by the police while hitchhiking in a state of drug-induced euphoria. She is accompanied to the Unit by her case worker.

35. "I'm back!" Andrea sarcastically tells the Unit at large. Which one of the following statements Andrea could make about her readmission that would show the best prospects for her eventual success in the program.
    a. "I'm here because my parents were bugging me."
    b. "I'm here because my case worker threatened me with the Girl's School if I didn't straighten up."
    c. "I'm here because I made a mess of it on the outside."
    d. "I'm here because I missed all of you!"

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36. During the Nursing Intake interview, Andrea answers each question with a question, tells you to "Fuck off!" and then sarcastically asks if you know how to do your job. You recognize you are having difficulty maintaining control of the interview. Which one of the following actions would be best for you to take:
   a. Explain to Andrea that you do know your job and you would appreciate her cooperation.
   b. Tell Andrea you do not appreciate her "mouth" and that she will sit there until the interview is completed, even if it takes all shift.
   c. Calmly redirect Andrea to the task at hand, while setting limits regarding her behavior.
   d. Leave the room and seek help from other staff members.

37. Which one of the following statements would be best to use when explaining to Andrea why she must abide by hospital regulations.
   a. "If you don't follow the rules, your privileges will be taken away."
   b. "You are not the only person here. The rest of us have rights too that must be respected."
   c. "It is not always easy, but the rules must be followed so that everybody gets a fair shake."
   d. "You may break the rules if you want, but don't expect any sympathy from us if you get caught."

38. Which one of the following qualities would be best for the nursing staff to show when taking disciplinary measures with Andrea?
   a. Strictness
   b. Acceptance
   c. Consistency
   d. Permissiveness

39. A behavior modification system is implemented each time any adolescent or child behaves in an inappropriate way. At those times, which one of the following ideas is the most basic and most important for the staff to convey to the patient?
   a. The patient, as a person, is accepted. The behavior is what needs to be modified.
   b. Everyone must cope with some restrictions on his/her actions.
   c. No one would bother with the patient if the staff did not care about him/her.
   d. If the patient cannot control his/her behavior, others will have to control the behavior for him/her.

40. Nursing staff tries to provide the adolescents with corrective emotional experiences that will influence their present behavior positively. Which one of the following possible interventions would constitute a corrective emotional experience for a patient?
   a. Give the patient gifts to make up for earlier suffering.
   b. Treat the patient's behavior more objectively than others have in the past.
   c. Promise the patient material rewards and extra privileges for good behavior.
   d. Allow the patient complete freedom in deciding what available therapies he/she will utilize.

Employee Name:_____ Pre-test Date:_____

Reviewed by:_____ Date:_____

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CREST VIEW HOSPITAL AND COUNSELING CENTER

Medication Administration - Study Guide

GOAL: This study guide is designed to provide the nurse with basic drug information to review toward the process of documenting nursing competency in medication administration at Crest View Hospital.

OBJECTIVES: At the completion of this unit, the participant will:

1.   Demonstrate proficiency in calculating the following:
     a. conversion of weights and measures
     b. drug calculations
     c. IV drip rates

2.   Outline nursing responsibilities relative to medication and its administration.

3.   Outline nursing legal responsibilities in the administration of medication.

4.   Provide pertinent information to be included in a program of patient education for drug therapy.

DIRECTIONS FOR USE:

1.   Read the review material in each section.
2.   Complete the study questions prior to beginning your second day of employment.
3.   Meet with the Unit Nurse Manager on your second day of employment to review your answers.
4.   Your reviewed answer sheets will be filed in your competency file.

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CONVERSION OF MEASURES

LIQUID MEASURES

1000 ml = 1 liter

1 cc = 1 ml

30 ml = 1 oz.

16 ml = 4 drams

1 dram = 4 ml

1 tablespoon = 15 ml

1 teaspoon = 5 ml

1000 mcg = 1 mg

METRIC MEASURES

60 mg = 1 grain

30 mg = 1/2 grain

1 kilogram = 2.2 lbs.

1000 mgm = 1 gram

kilo = 1000

milli = 1/1000

centi = 1/100

1 gram = 15 grains

To convert from grams to milligrams - multiply by 1000.

To convert from milligrams to grams - divide by 1000.

To convert from pounds to kilograms - divide by 2.2.

To convert from kilograms to pounds - multiply by 2.2.

To convert from grains to milligrams - multiply by 60.

To convert from milligrams to grains - divide by 60.

MATHEMATICAL CONVERSIONS AND CALCULATIONS

Since you often have to interpret drug orders and solve problems of dosages and solutions quickly, you should know how to make certain mathematical calculations.

The unit-dose system eliminates some of the mathematics involved in administering medications. However, even when this system is used you will sometimes have to make calculations and conversions. Also, to double check for accuracy, you will need to know how to calculate a dispensed dose.

It is important to know how to make conversions from one system (i.e metric apothecary, and household) to another, since drugs or solutions on hand may not be in the same system as that written by the doctor.

CONVERSION PRINCIPLES

Procedure for conversion between units of the Metric System:

1.   To change milligrams to grams, to change milliliters to liters, or to change grams to kilograms, DIVIDE by 1000.

2.   To change liters to milliliters, grams to milligrams, or kilograms to grams, MULTIPLY by 1000.

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EXAMPLES: Q.   64 mg = _____Gm.

A.   64 - 1000 = 0.064 Gms.

Helpful Hint: when dividing by 1000, move the decimal point 3 spaces to the left.

Q.   0.5 L = _____ ml.

A.   0.5 x 1000 = 500 ml.

Helpful Hint: when multiplying by 1000, move the decimal point 3 spaces to the right.

PROCEDURE FOR CONVERSION WITHIN THE APOTHECARIES SYSTEM

The proportion method is the simplest for these conversions.

A proportion shows the relationship between two equal ratios.

Think 8 is to 16 as 1 is to 2. Write 8:16 = 1:2.

The first and fourth terms of a proportion are called the extremes, and the second and third terms are the means. In a proportion, the product of the means equals the product of the extreme.

Example: 8:16 = 1:2   8 x 2 = 16; 16 x 1 = 16

BE CAREFUL TO KEEP THE UNITS (cc, mg, etc.) IN THE LAST TWO TERMS IN THE SAME ORDER AS THEY OCCUR IN THE FIRST. Write the known quantity as the first and second term and the unknown equivalent as the third and fourth terms of the proportion when one term of the proportion is unknown.

Example: 3 mg: 5 cc = x mg : 10 cc or $\dfrac{3 \text{ mg}}{5 \text{ cc}} = \dfrac{x \text{ mg}}{10 \text{ cc}}$

The unit of measure for the answer is the unit of measure that was "X". In the above problem we are looking for x mg. so the final answer is in mg.

Example: 5x = 3 x 10
            5x = 30
            x = 30 - 5
            x = 6 mg.

CONVERSION BETWEEN THE METRIC AND APOTHECARIES SYSTEMS

Some essential equivalents must be learned in order to convert between these two systems. The proportion method of conversion is the easiest way to carry out these conversions. The same procedure is used here as is used when carrying out operations within the apothecaries system.

Problem: 150 lb. = _____ kg.

Solution: Write the conversion value you know: 2.2 lb = 1 kg

            Then add the unknown (in the same order) to the proportion:

            2.2 lb : 1 kg = 150 lb : X kg   2.2X = 150;
                                                 X = 150 - 2.2;
                                                 X = 68.2 kg

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Problem:      6 drams = _____ millimeters

Solution:     Write the proportion you know:  1 dram = 4 ml

              Add the unknown to the proportion:

              1 dram : 4 ml = 6 drams : X ml      1X  = 4 x 6
                                                   X  = 24 ml
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Problem:      The MAR sheet reads Digoxin 0.5 mg. The ampule label reads
              0.25 mg per cc.

Solution:     Write the dose strength you know and add the unknown.

              0.25 mg : 1 cc = 0.5 mg : X cc      0.25 x X = 1 x 0.5
                                                  .25x = .50
                                                  x = .50 - .25
                                                  X = 2 cc

Answer:       Give 2 cc of Digoxin from this ampule.
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Problem:      The MAR sheet reads Thorazine 20 mg.  The Thorazine vials
              are labeled 25 mg per ml.

Solution:     25 mg : 1 ml = 20 mg : X ml         25 X = 20
                                                  X = 20 - 25
                                                  X = .8 ml

Answer:       Give .8 ml of Thorazine from this vial.
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CALCULATING I.V. FLOW RATES

When administering I.V. fluids, you must calculate and regulate the
number of drops per minute to administer a prescribed amount of solution
in a designated period of time. Maintaining proper flow rates for
prescribed solutions is essential to prevent complications. I.V.
administration sets are constructed to deliver a specific number of
drops per milliliter. This is called the drop factor and can be found
on the package containing the set.

If the order does not spell out the rate of flow in drops per minute,
the following formula may be used to figure this out:

Total number of mls. to be infused: x Drop factor = Rate in drops per
min.; Total number of minutes infusion is to run.

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Example:      If an order is given for 1000 ml D5W to run for 8 hours and
              the drop factor is 10 drops per minute for the particular
              tubing used.  How many drops per minute should the IV
              infusion be set to run?

                   1000 ml      X 10 = drops per minute
                   480 minutes

                   100 X 10 = 20.8 drops (gtt)/minute = 21 gtt/minute
                    48
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STUDY QUESTIONS: MATHEMATICAL CONVERSIONS AND CALCULATIONS

Conversion of Measures:

1.   0.7 gram = _____ milligrams

2.   0.5 gram = _____ milligrams

3.   3.5 gram = _____ milligrams

4.   1000 milligrams = _____ grams

5.   3500 milligrams = _____ grams

6.   500 milligrams = _____ grams

7.   1 ounce = _____ ml

8.   3 ounces = _____ ml

9.   15 pounds = _____ kilograms

10.   30 pounds = _____ kilograms

11.   42 kilograms = _____ pounds

12.   20 kilograms = _____ pounds

13.   18 kilograms = _____ pounds

14.   3000 milligrams = _____ grains

15.   2800 milligrams = _____ grains

Calculations:

1.   A patient is to receive 450,000 units of penicillin G benzathine
      suspension (Bicillin). Bicillin is supplied 300,000 units per
      millimeter. How many millimeters should the patient receive?

      a.   0.67 ml
      b.   0.75 ml
      c.   1.5 ml

2.   You have an order for Inderal 20 mg p.o., and the only strength
      available is 10 mg tablets. How many tablets should you
      administer?

      a.   1 tablet
      b.   4 tablets
      c.   2 tablets

3.   The physician ordered Demeral 60 mg IM. You have available 75 mg
      per 1.5 ml. Calculate ml needed to give 60 mg.

      a.   .44 ml
      b.   1.2 ml
      c.   1.0 ml

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4. The physician ordered 5mg/kg of medication for a patient weighing 150 lbs. How many mg would you administer?

    a. 340 mg or 340.9 mg or 341 mg
    b. 538.2 mg or 538 mg
    c. 400 mg

5. An initial order of Gantrisin 4 Gm is to be administered to a patient. Gantrisin is available in 500 mg tablets. How many tablets should be administered to the patient?

    a. 2 tablets
    b. 5 tablets
    c. 8 tablets

6. Lasix 15 mg p.o. has been ordered by the physician. The dose available is 10 mg tablets. How many tablets should be given to administer 15 mg.?

    a. 1 1/2 tablets
    b. 2 tablets
    c. 1/2 tablet

7. Milk of Magnesia 60 cc was ordered by the physician. Milk of Magnesia is available in doses of 30 cc = 1 oz. How many ounces should be administered for the patient to receive 60 cc?

    a. 1 ounce
    b. 2 ounces
    c. 4 ounces

8. The doctor orders Atropine 0.1 mg IM on call to OR. Atropine is available as Atropine 0.4 mg per cc. How many cc's would be given to administer 0.1 mg?

    a. 0.25 cc
    b. 0.50 cc
    c. 1 cc

9. The doctor orders Potassium Chloride 15 mEq p.o. You have available 5 mEq in 5 cc. How many cc's would be given to administer 15 mEq?

    a. 15 cc
    b. 10 cc
    c. 3 cc

10. Orinase is ordered 1 gm after breakfast, 0.5 gm after lunch and dinner. Orinase is available in 500 mg tablets. How many tablets are to be given after each meal?

    a. breakfast, lunch, and dinner - 1 tablet after each meal
    b. breakfast 2 tablets, lunch 1 tablet, dinner 1 tablet
    c. breakfast 1 1/2 tablets, lunch 1/2 tablet, dinner 1/2 tablet

11. Valium 8 mg IM stat has been ordered. Valium is available 10 mg per 2 ml. How many ml would be administered to give 8 mg?

    a. 2 ml
    b. 8 ml
    c. 1.6 ml

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12. The order reads Heparin 4500 U subq. Heparin is supplied in 5 ml vials containing 10,000 U per ml. How many ml must be administered to obtain 4500 U?

   a.   0.45 ml
   b.   0.60 ml
   c.   1.6 ml

13. Dilantin is ordered 25 mg IM q 8 hr. Dilantin is available as 100 mg/2 cc ampule. How many cc's should be given to administer 25 mg?

   a.   1.5 ml
   b.   0.5 ml
   c.   0.25 ml

14. The order reads "500 cc D5W per 6 hours IV". The IV administration tubing has a drop factor of 15. How many drops per minute should the IV infusion be set to run?

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MEDICATION ADMINISTRATION AND NURSING RESPONSIBILITIES

Directions: This section on medication administration and nursing responsibilities provides information pertinent to proper methods of medication administration. Read the information, then answer the study questions at the end of this section.

The Six Rights of Administering Medication

Do you recall the Six Rights system of administering medication? A recent pharmaceutical study found that, although nurses expressed knowledge of rules for giving medication, almost two-thirds of all medication errors occurred because nurses disregarded the Six Rights system.

As a review, before giving any medication, compare the doctor's orders with the order written on your patient's MAR sheet, then ask yourself these questions:

> RIGHT NAME: Is the patient's name the same?
>
> RIGHT DRUG: Is the ordered drug the same?
>
> RIGHT DOSE: Is the ordered dose the same?
>
> RIGHT ROUTE: Is the ordered route the same?
>
> RIGHT TIME AND FREQUENCY: Is the time and frequency of administration the same?
>
> RIGHT TECHNIQUE: Do I know the correct technique to use for this med?

Of course, after asking these questions if you find any discrepancy, no matter how small, withhold the medication until you have checked thoroughly for the accuracy of the order. This may include talking with a pharmacist or the attending physician.

The following should be followed by the nurse in administering patient medication:

1. In the unit dose system, all medications should be administered from the patient's individual cassette on the med cart.

2. The nurse should devote complete attention to preparing the medication for administration.

3. Select the drug product and compare it to the patient's MAR sheet - checking the amount, route, and time drug is to be given.

4. Unlabeled medications should never be used.

5. Read the label before: a. Removing from the drawer;
                           b. and again before administering to the patient.

6. Give only the medications for which there is a doctor's order.

7. Take the medication cart to the patient area. Always check the patient's photograph before giving medication.

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8.   The medication should not be removed from the single dose package until it is administered to the patient.

9.   The person administering the medication should stay with the patient until the dose has been taken. The exception to this would be specific medications which are left at the patient's bedside per doctor's written order.

10.   All administered, refused, or omitted medications should be recorded on the MAR sheet. The recording process on the MAR should occur immediately after administering medications to each patient and before proceeding to the next patient.

11.   Contact the pharmacist if there are any questions concerning dosage, calculation, or mixing of medications.

12.   Any medication reaction should be reported to the patient's physician or the prescribing physician immediately.

KNOW THE DRUGS YOU GIVE

Make it a practice to know the medications you are giving. Think of the following:

1.   Is the prescription appropriate for the patient's present or pre-existing condition? If not, consult a drug text, or ask the attending physician to clarify the order.

2.   Is the dose within safe limits? If you are not sure, consult a drug text, call the pharmacist, or visit with the attending physician.

3.   Is the ordered route compatible with the patient's condition? For example, has an antiemetic been ordered to be given orally to a patient who is vomiting?

4.   Is the medication compatible with the other medications the patient is taking? Again, check your drug text, or talk with the pharmacist.

5.   What food or medications will affect the drug's absorption? Once more your drug text or pharmacist can help you clarify any questions.

6.   What is the expected effect of the medication and what are typical side effects associated with this medication? See that drug text.

7.   Does the patient have any history of allergies to this medication or similar groups of drugs? Investigate this with the patient and discover the type of reaction.

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LEGAL RESPONSIBILITIES

Nurses do have a legal responsibility for the drugs they administer. They are responsible for safe, accurate drug orders, and should have sufficient drug knowledge to recognize or question erroneous orders. The fact that a doctor writes an erroneous order does not excuse the nurse from legal liability if he/she carries out the order.

Nurses have a legal responsibility for storing narcotics and other controlled substances in a locked container. These drugs should only be administered to whom they are prescribed, recording each dose given on an appropriate narcotic sheet as well as the patient's MAR sheet. Counting the amount of each controlled drug at the end of a working shift and reporting discrepancies is also a nursing legal responsibility.

Reporting medication errors is part of a nurse's professional and legal responsibility. A medication error is defined as administering the wrong medication, the wrong strength, at the wrong time (over 1 hour before or after the dose is to be given), to the wrong patient. A medication error is also an "omission of a drug, or administration of medication to a patient with a known allergy to the medication".

The procedure at Crest View Hospital for RNs and LPNs in reporting a medication error are:

1. As soon as an error has been identified, the Nurse Manager or D.O.N. should be notified immediately.

2. The prescribing physician or attending physician is called, stating what was given versus what was ordered.

3. The pharmacist should be notified of the error if a new drug is needed or if it was Pharmacy's error.

4. The patient's vital signs should be checked frequently, if indicated, and any deviation from normal for the patient should be reported to the physician.

5. A Medication Error Report should be made out stating the error and what corrective action was taken. On the Medication Error Report, the nurses should never put why the error was made or they should not be apologetic about the error.

6. The drug error should be recorded in the patient's chart as to what was given. The admission or blame for the drug error should not be stated in the chart. All reaction or side effects should be charted. The Medication Error Report should never be mentioned in the patient's chart.

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MEDICATION ADMINISTRATION AND NURSING RESPONSIBILITIES - Study Questions

Answer these questions based on information provided and your good nursing judgement:

1. Which of these beverages, when given with aspirin, is most likely to prevent gastric distress?

   a. tea
   b. milk
   c. 7 up

2. Pyridium is a drug commonly used in the treatment of urinary tract infections. Which of these effects frequently occur?

   a. burning on urination
   b. increased urgency to urinate
   c. discoloration of urine

3. The administration of which of these drugs requires the observation of blood pressure?

   a. Lasix
   b. Digitalis
   c. Penicillin

4. As you are preparing to give a patient his medication, the patient comments, "I've never taken this many pills before at once!" Your response at this point would be to:

   a. check to make sure you have the right patient and right medications
   b. tell the patient "perhaps they have started you on some new medications"
   c. administer the medication

5. Mr. Jones was admitted because of a fractured hip. The doctor prescribes MS 5 mg q 4 hr for hip pain. As you start to give Mr. Jones the prescribed MS, he mentions that one time when he received a pain shot he got "awful drowsy and they couldn't get his blood pressure". Your response to this statement would be to:

   a. do further investigation into the symptoms mentioned and the type of drug used
   b. proceed with administration of the medication as ordered
   c. reassure Mr. Jones that even though he may have had one bad experience that this medication will really help

6. Dr. Brown writes the following order: Give Digoxin 5 mg IV stat. If, in carrying out this order, the patient would suffer dire consequences, for example, cardiac arrest, could the nurse be held liable for her actions?

   a. No, the doctor has the final voice in drug orders which he writes.
   b. No, if the nurse followed policies/procedures for safe drug administration.
   c. Yes, the fact that a doctor writes an erroneous order does not excuse the nurse from legal liability if he/she carries out the order.

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7.	The 7-3 shift was hectic. When 3-11 came on, one of the day
	nurses comments, "Take my word for it, we didn't use any narcotics
	today, we were too busy. Let's skip narcotic count so we can go
	home sooner." Your response should be:

	a.	OK
	b.	"Hey, how about if a couple of us from 3-11 just count
		sometime this evening?"
	c.	"I can tell you've been busy, but we do need to do the
		narcotic count."

8.	According to the policy at Crest View Hospital, the nurse who
	discovers a medication error should perform which of the following
	steps first?

	a.	Notify the Nurse Manager or D.O.N. and prescribing
		physician.
	b.	Fill out a Medication Error Report.
	c.	Record what medication was given in the patient's chart.

9.	The Six Rights of Administering medication includes all of the
	following except:

	a.	Right patient
	b.	Right drug
	c.	Right dose
	d.	Right route
	e.	Right doctor
	f.	Right time and frequency

10.	In doing the change of shift drug count, it is discovered that two
	tubexs of Morphine are missing. The counting nurse should take
	which of the following actions:

	a.	Report the missing tubexs and take whatever steps are
		necessary to find the missing tubexs.
	b.	Review the patient's charts for dosages of Morphine used on
		previous shifts.
	c.	Check with fellow nurses to see if someone forgot to enter
		check out information on Morphine on to the Narcotic sheets.
	d.	All of the above.

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PATIENT EDUCATION WITH DRUG THERAPY: THE NURSE'S ROLE

Directions: Read through the information provided on patient education dealing with drug therapy and the role of the nurse. Then answer the study questions. Answers to the study questions are at the end of this unit.

Teaching patients about their drug therapy should be a daily occurance in a nurse's practice. General guidelines to use in your teaching with patients include:

1. Take medications as directed. The therapeutic effect greatly depends on taking medications correctly. Altering the dose or time may cause overdosage or underdosage.

2. Do not start or stop drugs without consulting your doctor. Drug therapy is often a state of delicate balance. Altering this balance increases risks of drug interactions, adverse effects, and loss of therapeutic effectiveness.

3. Do not keep drugs for long periods. The chemical composition of drugs tends to become altered over a period of time.

4. Do not take medications prescribed for others, even if the problems seem similar. The chance of having the right drug in the right dose is extremely remote and the risk of adverse reactions is extremely high under such circumstances. So many factors influence an individual's response to drugs, that outcome is not predictable when do-it-yourself drug therapy is instituted.

5. Develop a routine for taking medications. For example, take them at the same time and place each day. Having a routine helps a patient remember to take medication as directed.

6. Do not keep medications in the bathroom medicine cabinet. Medication may deteriorate more rapidly due to warmth and moisture.

7. Never put several different medications in one container. The risk of taking the wrong medication or wrong dose is greatly increased if this is done. In addition. the drugs may interact chemically, altering the drug composition.

8. Take medication in a well lighted area. This practice helps in reading the label to insure that the drug taken is the one intended.

9. Keep all medications out of the reach of children and never refer to medication as candy. This will help to prevent accidental ingestion and poisoning.

10. For each specific drug, provide the following instructions:
    a. Name of the drug
    b. Purpose of the drug
    c. Dosage schedule
    d. Method of administration
    e. Adverse reactions or side effects to be reported
    f. Miscellaneous instructions such as safety measures for taking certain drugs, storage, drug or food incompatibilities, etc. as indicated
    g. Resources available in the community for further drug information, if needed after hospital dismissal.

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It is a good practice to have the patient repeat this information back to you to make sure they have understood the instructions you gave them. Documentation in the nurse's notes of your teaching is also vital in this process.

Some teaching principles of adult education to use and think about when doing your patient education concerning medication include the following:

1. Physical and mental readiness are necessary for learning.

   a. Is the patient physically able to learn?
   b. Has the disease or illness caused him/her to regress physically or mentally?
   c. Is the physical environment attractive to learning? For example, is the setting quiet and is it a time in which there will be few interruptions?

2. New learning must be based on previous knowledge and experience.

   a. What does the patient know about the subject?
   b. What can he/she already tell you or demonstrate about the subject?

3. An individual needs motivation in order to learn.

   a. Does the patient have a reason to want to learn? Does he/she know there is a need to learn?
   b. Is there anything that keeps this person from wanting to learn? For example, lack of energy, emotions, fear of the unknown, etc.?

4. Perception is necessary for learning.

   a. What hospital day is it for this patient?
   b. What procedures has the patient had done that day?
   c. Does the patient have questions?
   d. Is sensory function intact?
   e. How does the patient feel about his/her problem?

5. An individual learns what he/she actually uses or what has relevance.

   a. What exactly does this patient need to learn to maintain optimal health?
   b. Does the patient see this as being important?
   c. Is the time right for teaching this patient?

6. Satisfaction reinforces learning.

   a. What is realistic praise for this patient?
   b. What can make this learning experience pleasant for this patient?

7. Effective learning requires active participation.

   a. How can I provide the patient with opportunities to participate?
   b. How can I evaluate learning? When will I know and how will I know learning has taken place?

PATIENT EDUCATION WITH DRUG THERAPY: THE NURSE'S ROLE – Study Questions

1. For each drug prescribed, list at least four instructions to include in your teaching:

    a._____

    b._____

    c._____

    d._____

2. After drug information has been given to a patient, it is a good idea to have them _____ to help you see if the patient has heard and comprehended your information.

3. Patients should be advised to do all of the following except:

    a.   Take medication as directed.
    b.   Do not start or stop drugs without consulting your doctor.
    c.   Keep all medications in one container for convenience.
    d.   Keep all medications out of the reach of children.

4. Which of the following factors do you think could interfere with the patient teaching process?

    a.   The patient experiencing nausea and vomiting.
    b.   Visitors
    c.   Change of shift
    d.   All of the above.

5. How could a nurse evaluate to see if learning has occurred?

    a.   Have the patient repeat the information back to the nurse.
    b.   Ask questions about the information given.
    c.   a & b
    d.   Document teaching efforts in nurses notes.

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CREST VIEW HOSPITAL & COUNSELING CENTER
Study Guide - Commonly Used Psychiatric Medications

Directions: Prior to administering psychotropic medications within this facility, please review the following medications. Be prepared to provide the following information to the Unit Nurse Manager or designee upon oral examination: 1) Generic and Brand name; 2) Dosages and Routes; 3) Classification; 4) Potential food-drug, drug-drug interactions; 5) Effects and Side Effects of medication; and 6) Required monitoring and frequency (lab, EKG, etc.).

(The list of medications may change as physician prescribing patterns change. Before administering any new medication, please review it as indicated above.)

1) Risperdal

2) Prozac

3) Paxil

4) Benztropine

5) Haloperidol

6) Tegretol

7) Atenolol

8) Librium

9) Lithium

10) Depakote

11) Lorazepam

12) Klonopin

13) Trazadone

14) Zoloft

Resources for Learning Medications:

1) The Nurse's Drug Handbook (RN); 7th Edition (located on Adult Unit)

2) Facts and Comprehensive Drug Interaction Facts (copy in Pharmacy and Casper College Library)

3) Crest View Pharmacist

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Employee Name:_____   Oral Examination Date:_____

Reviewed by: _____   Passed: ___ Yes ___ No

Re-examination date:_____   Passed: ___ Yes ___ No

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GENERAL HOSPITAL ORIENTATION

CREST VIEW HOSPITAL AND COUNSELING CENTER

You are this hospital.

You are what people see when they arrive here.

Yours are the eyes they look into when they're frightened and lonely.

Yours are the voices people hear when they walk through our halls
and when they try to sleep
and when they try to forget their problems.

Yours are the comments people hear when you think they can't.

Yours is the intelligence and caring that people hope they'll find.
If you're noisy, so is the hospital.
If you're rude, so is the hospital.
And if you're wonderful, so is the hospital.

No guest, no patients can ever know the real you--
the you that you know is there--unless you let them see it.
All they can know is what they see and hear and experience.

And so this hospital has a stake in your ATTITUDE
and in the collective ATTITUDES
of everyone who works here.

It is judged by your performance.

The hospital is the care YOU give,
the attention YOU pay,
the courtesies YOU extend.

YOU ARE THIS HOSPITAL.

(Darla Dirks)

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VISION STATEMENT

The staff of Crest View Hospital and Counseling Center is
dedicated to providing specialized behavioral health services through
clinical excellence, cost effective treatment, and education to Wyoming
and surrounding areas.

We promote a caring environment, respecting the needs of each
other, our patients, families and the communities we serve.

PHILOSOPHY

Crest View has chosen to implement this vision by way of a
continuum of services. The specific programs provided are designed to
respond to the changing needs of patients and families in the
communities and region which Crest View serves.

Crest View Hospital adheres to the principle that patients should
receive a level and type of treatment that is consistent with their
problems. Crest View Hospital endeavors to provide highly focused
treatment in the shortest and least expensive manner possible. The
continuum of services provided by the Hospital is an effective,
efficient and financially viable means of offering services at the level
of care necessary for the current condition of the identified patient
and his/her family.

1

STATEMENT OF VALUES

The values of Crest View Hospital are an extension of the vision statement and philosophy of the organization. The values serve to hold a group of diverse individuals together in working toward a common mission.

__Market Orientation:__ Crest View Hospital serves a wide range of clients including patients, their families, referral sources, payor sources and each other. We are genuinely interested in all of these clients and we respond to all of them in a courteous and effective manner.

__Constant Innovation:__ Crest View Hospital is committed to continual improvement by way of flexibility, problem solving and actively seeking new ideas and promoting continuous education of our staff. All Hospital staff are encouraged to continually find more efficient and more effective ways to perform.

__Financial Sensitivity:__ Providing Mental Health Services is our business. The integrity of services provided to our clients is ensured by sound fiscal planning and business practices. Running the Hospital as efficiently as we can conceive makes the Hospital more able to be sensitive to the issue of spiraling health care costs.

__Teamwork:__ Teamwork is essential to good patient care and to the overall success of the Crest View Hospital and Counseling Center. Teamwork requires direct and open communication, mutual support and encouragement throughout the Hospital, and is fostered by an atmosphere which promotes professional growth and development of employees.

__Leadership/Initiatives:__ Leadership and initiative are vital to the success of Crest View Hospital. They require the attitudes, values and behaviors which encourage individuals and the organization to succeed in a changing environment. Leaders motivate others to achieve the mission and values of Crest View Hospital and Counseling Center.

STAFF AND CREST VIEW HOSPITAL - MUTUAL EXPECTATIONS

In recent times Crest View has been quite successful in a very difficult and competitive field. This success is owed to many factors including a staff that has been willing to do things differently as a part of an organizational response to changing demands from the market place. The extent to which Crest View's staff is competent with focused treatment and committed to the Hospital's Vision, Values and Philosophy will help determine the extent to which the Hospital can continue to be successful.

Crest View Hospital and Counseling Center must continue to respond to a rapidly changing market place. The response is, to a significant degree, the continual refinement and improvement of programs, clinical interventions and support delivery on the part of the Hospital as a whole and on the part of each and every staff and professional staff member. The Hospital and the Hospital's work-force therefore have a strong bond of mutual reliance and responsibility.

The Hospital as a whole and each staff member, share the responsibility of ensuring that the results achieved by the Hospital continue to improve. Each staff member must take responsibility for establishing a healthy work environment. A healthy work environment promotes staff development and enhances our chances of making therapeutic changes in the lives of our patients. The systems for individual improvement provided by the Hospital are chiefly the

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Continuing Education Program and ongoing supervision. The Hospital is committed to continual improvement of these systems. The success of these systems requires the thoughtful and active participation of each staff member.

ORIENTATION AND TRAINING

Orientation should acquaint employees with Crest View Hospital's general operative systems and with the employees' specific area of functioning. Because of the rapid rate of change in the way mental health services are provided, it is necessary for the Hospital to continually adapt and, it is hoped, improve its services. This constant need for change requires the staff of the Hospital to be flexible and open to developing skills not heretofore required in mental health services. This need for constant adaptation requires the Hospital to provide or to make provisions for training and retraining of its employees so that they can gain those skills necessary for them to excel.

The role of staff in this program is not passive. The Hospital expects staff to take the initiative to help identify training needs and then to actively participate in the program to improve individual skills.

A HEALTHY WORK ENVIRONMENT

A health work environment is one which is characterized by a fair and respectful atmosphere that promotes a positive and constructive emotional climate. Such an environment provide staff with opportunities to improve skills and challenges and motivates them to exercise creativity and innovation.

Most importantly, at Crest View Hospital, a health work environment is one where all who work at the Hospital enjoy this association and feel a sense of ownership in what the Hospital accomplishes. The values of open, honest communication and of teamwork are implemented fully when our work environment is at its healthiest.

SUPERVISION

Supervision gives employees regular feed back as to how they are performing work tasks and how they are personifying the values of the organization. Employees should expect their supervisor to help them solve problems, suggest ways of improvement and to generally be a constructive force in helping the employee to perform his/her job to the best of his or her ability. When work performance is not up to standard or when attitudes become negative it is important that supervisors immediately discuss the problems. The idea is to give the employee the information or training necessary to immediately improve the difficulty. Competent supervision helps the employee to be empowered and to take responsibility for creatively consummating his or her duties.

Employees should view themselves as half of a partnership where the supervisory process is concerned. Problems, concerns, and suggestions can be shared in this process. Supervisors will not always know an individual supervisee's particular concerns or unique perspective. To the extent that an employee wishes assistance with a given issue, he or she must bring the issue to the supervisory setting. In addition, it is expected that the employee will actively participate in the supervisory process so that it can be used as a means of enhancing professional growth.

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FINAL THOUGHTS

Crest View Hospital can continue to prosper and to be an excellent place of continued employment if those of us who work here are diligent in carrying out our roles. It is hoped that staff will grow and gain greater satisfaction from being a part of an organization that accomplishes therapeutic change in the lives of children, adolescents, adults and their families.

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GENERAL ORIENTATION OUTLINE

NEW EMPLOYEE RESPONSIBILITY:

Every new employee will read the Employee Handbook within their first week of employment. Any questions should be addressed to their supervisor or the Human Resources Director and a signed statement of receipt will be placed in their personnel file.

SUBJECT CONTENT OF NEW EMPLOYEE GENERAL ORIENTATION SESSION:

A.   The New Employee Orientation includes, but is not limited to:

1.   Introduction to the Hospital.

2.   Relationships and description of Sterling Health Care Corporation.

3.   General employee information, including benefits such as medical and dental insurance, disability, and 401K plan, equal employment opportunities, pertinent personnel policies such as vacation, sick time, etc.

4.   Importance of Quality Improvement and Infection Control.

5.   Fire and Safety, Disaster Plan, MSDS sheets, OSHA regulations, Safety.

6.   Telephone inquiry calls/confidentiality.

7.   Employee health.

8.   Incident Reports/Risk Management.

9.   Dietary Procedures, meals, etc.

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PERSONNEL FILE COMPLETION CHECKLIST

In order for your application for employment to be considered complete, the following items must be provided to the Human Resources Director prior to beginning employment but no later than 30 days following the start of employment. Failure to provide the requested items within the designated time frames may result in suspension of employment until such items are received. If you have any questions regarding any of the requested items, please contact the Human Resources Director or your Unit Nurse Manager.

Application: **Date Received**

1) Signed and dated Application for Employment   _____

2) Release Authorization (AVERT)   _____

3) Transcripts from accredited college/university _____

4) Current license/certification   _____

5) CPR Certification   _____

6) 3 Letters of Reference   _____

Health Related Items:

1) Physical History Questionnaire   _____

2) CBC   _____

3) TB Skin test   _____

4) Hepatitis B vaccination request/refusal   _____

Signed Statements:

1) Signed Awareness Statement   _____

2) Signed Confidentiality Statement   _____

3) Signed Code of Ethics   _____

4) Receipt of Dress Code   _____

5) Job Description   _____

6) Receipt of Employee Handbook   _____

Payroll:

1) Signed W-4 and I-9   _____

2) Explanation of Benefits   _____

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To the New Nursing Staff Employee:

Welcome to our staff. This package of learning objectives and other information has been developed to help you focus your activities during your orientation. All of the applicable objectives in this packet are to be initiated by the 3rd day of your orientation and completed by your 10th working day. Obviously, that is going to require you to be a "self-motivator" as you work with the person(s) assigned to orient you. Objectives not met by the end of the 10th day will have to be completed as arranged through the Unit Nurse Manager or Director of Nursing Services.) As each objective is accomplished, it is to be dated and signed by the staff member training you on that particular task. When all objectives are completed, you are to bring the Learning Objectives form to the Unit Nurse Manager, who will discuss your orientation with you. The form will become a part of your personnel file. We are happy to have you as part of our staff.

For All Nursing Personnel:

Demonstrates knowledge of the locations of things listed below by pointing them out to a staff member by the end of the 1st day of orientation.

___fire alarms	___patients' belongings boxes
___fire extinguisher	___storage for patient meds
___exits	brought from home
___staff keys	___old charts
___groups rooms	___the medical records drawer
___patients' laundry room	___emergency kit
___patients' telephones	___BP cuff and stethoscope
___employee restroom	___thermometers
___security panel for locked	___restraints
doors	___personal care supplies
___examination room	___medical treatment supplies
___medication room	___lab requisitions
___business offices	___pertinent phone numbers
___copier and office supplies	___policy manuals
___charts and chart forms	___adolescent school & day rooms
___chart admission packets	___adult day/group rooms

By my signature, I certify that I have read and understand the job description for my position and the listing of the routine tasks I am expected to accomplish on the various shifts. I agree to meet these expectations.

_____   _____
Signature   Date

By my signature, I certify that I have at least begun to study the Nursing Policy and Procedure Manual and that I agree to implement the policies and procedures as they are defined therein. I recognize that failure to do so may be grounds for dismissal.

_____   _____
Signature   Date

_____   _____
Reviewed by: Date

(Place in Personnel File upon completion)

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FIRE/SAFETY/DISASTER

EMPLOYEE ORIENTATION FORM

1. Location and use of fire alarms   _____

2. Location of smoke doors   _____

3. Location of fire exits   _____

4. Location and use of fire extinguisher   _____

5. Proper response to alarms   _____

6. Isolation of the fire   _____

7. Evacuation of fire area   _____

8. Evacuation of the building   _____

9. Location of emergency phone numbers   _____

10. Location of emergency shut-offs   _____

11. Hazard communication, hazard surveillance
    work orders   _____

12. Smoking Policies   _____

_____   _____
Employee Name   Date

This employee participated in New Employee Orientation on

_____.

_____   _____
Safety Officer   Date

(Place in Personnel File upon completion)

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FIRE SAFETY

I. **INTRODUCTION**

Fire, no matter where it strikes, is a terrifying experience that can result in tragedy.

Fire safety in a health care facility means keeping people safe while providing quality patient care. Patients should feel their needs are being cared for and that they are safe. One of the things they should feel safe from is fire. Yet, over 16,000 fires occur each year in hospitals. People die in these fires. We have been fortunate in this facility not to have had any serious injuries or deaths.

When smoke or fire is discovered immediate action is called for. Although staff may be frightened, thanks to training, most staff stay calm and know exactly what to do. The confidence that comes from such knowledge is picked up by patients, and panic is prevented. This process is especially important for psychiatric patients, whose emotional controls are weaker and behaviors less predictable.

The purpose of this inservice is to be able to prevent fires at Crest View Hospital, and accept that responsibility for fire prevention belongs to everyone.

II. **CAUSES OF FIRE**

What causes fire in health care facilities?

There are four (4) basic causes of fire.

1. Careless Smoking

    To reduce the danger:

    a. Enforce all smoking rules. Observe no-smoking areas in the hospital.

    b. Provide proper ashtrays wherever smoking is allowed.

    c. Empty ashtrays frequently, checking for live ashes.

    d. Closely monitor any patients who may have a tendency to smoke in bed or to smoke in restricted areas.

    e. Be alert to sedated patients smoking habits.

2. Pressurized Oxygen

    Used improperly, oxygen can cause an explosion or can intensify an already burning fire.

    To reduce the danger:

    a. Store oxygen cylinders in designated storage   areas, with valve caps in place.

    b. Never smoke around oxygen.

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3.   Flammable Liquids and Gasses

Many materials used in routine cleaning and maintenance can ignite or explode if used carelessly.

To reduce the danger:

a.   Store flammables in approved safety containers that are clearly labeled. Place containers in designated metal cabinets away from heat.

b.   Never smoke around flammables.

4.   Electrical Equipment:

Electrical equipment like hair dryers, shavers, etc., can be a fire hazard, if in bad condition, or if used improperly.

To reduce the danger:

a.   Ground equipment properly.

b.   Check wires for broken, crushed, cracked, brittle or frayed insulation and other defects.

c.   Don't overload outlets.

d.   Safety check all staff and patients personal appliances (all must be checked by maintenance and have an approved label).

III.   PREVENTIVE MEASURES

To a large extent, you are in the best position to prevent fires from happening If you are alert, you are in an excellent position to spot fire hazards wherever they may be.

Spotting fire hazards, of course, are only part of the job of fire prevention.

The other part is doing something about the hazards you have spotted.

A.   Good housekeeping is the best insurance against fires. Always place refuse in metal containers that are kept well away from heat sources. Keep in mind that carelessness, when handling combustible materials, could start a fire.

B.   Report any fire or safety hazard that you feel should be investigated.

C.   Do not leave house cleaning equipment or other hospital equipment in passageways where exits will be blocked. All exits must be well lighted and clearly marked with exit signs.

D.   Check fire doors, never wedge or prop them open. Be sure they are unobstructed, and that they open easily and close tightly to prevent the spread of fire.

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E.	Know and comply with smoking regulations. Smoke only when and where it is permitted.

F.	Know the location and use of the fire alarm system and fire fighting equipment.

G.	Have patients personal appliances (e.g., hair dryers, curlers, etc.) checked and tagged.

The following are three (3) things that are necessary for a fire to exist:

Oxygen or air (to support combustion)

Heat (ignition source - matches or lighter)

Fuel (something to burn)

Remove any of these and you stop the fire.

OXYGEN

HEAT   **FUEL**

IV.	CLASSES OF FIRES AND TYPES OF EXTINGUISHERS

Learn the location of fire extinguishers and how to use them.

A.	Frequently review instructions on how to use the fire extinguishers.

B.	Know the different classes of fires and which extinguishers to use.

CLASS A FIRES:
Ordinary combustibles, such as wood, rubbish, paper and textiles.

1.	Water hose

2.	Tri-Class (ABC) dry chemical (excellent).

CLASS B FIRES:
Flammable liquids, such as oils, paints, gasoline, alcohol, etc.

1.	Carbon Dioxide, (excellent). Carbon Dioxide leaves no residue and does not affect equipment or foodstuffs.

2.	Tri-Class (ABC) dry chemical (excellent). Chemical powder smothers fire, screen of dry chemical shields operator from heat.

3.	Never use water. It will spread the fire, not put it out.

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V. **IN CASE OF FIRE**

<u>GENERAL INSTRUCTIONS</u>

A. Be calm, quiet, alert

B. In case of fire, never shout "FIRE!".

C. Look to your supervisor for instructions on what to do.

D. Do not become panicky. Remember that panic can turn an orderly evacuation into chaos and tragedy.

E. We know that fires can happen, so always guard against them constantly.

Use R-A-C-E to help you remember what to do:

R - Rescue   only if there is imminent danger.

A - Alarm   pull the alarm and call the operator.

C - Confine   close all doors as you check each room.

E - Evacuate   always lateral evacuation. A general evacuation should occur if there is immediate danger.

And/Or

E - Extinguish only if it is safe to do so.

Use of restraints in emergencies:

An uncooperative patient - it may be necessary to use "walking restraints" to evacuate an uncooperative patient. A combative patient may also need to have ankle restraints. A blanket drag or under arm drag may be required. If so, the restrained patient should be evacuated "head first", never "feet first". Clinical staff members should have corridor and restraint keys on their person at all times!

VI. **SAFETY ON THE UNITS**

In order to provide a safe environment for the patients and employees of Crest View Hospital, it is imperative that all personnel know what to do in a fire or other disaster situations.

Each staff member must know what his responsibilities are, as well as, how to use the fire fighting equipment.

Fire Drills

All hospital personnel will respond as though a true emergency exists. There will be no deviation from the procedures stated for the actual disaster as opposed to a practice drill.

Avoid panic. The greatest danger in most fires is panic. Don't alarm patients by excited motion. Never shout "FIRE". Appear to be calm and move with assurance.

Read the Fire Plan and Emergency Preparedness Plan in The

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Administrative Policy and Procedure Manual during formal orientation.

The Charge Nurse makes fire position assignments daily for each staff member which appears on the shift nursing assignment sheet.

Your attitude is the key to the smooth operation of our Fire Safety Plan.

Stay alert -- never take fire safety for granted.

So you can help prevent fires:

*KNOW - How fires are caused.

*PRACTICE - Preventive measures

*REPORT - Unsafe conditions

*LEARN - What to do if a fire occurs

*REMEMBER - Patient lives could depend on you.

A:\FIRESFTY.RDG

UNIT ORIENTATION

REGISTERED NURSE ORIENTATION - ADULT UNIT

Orientee's Name/Title:_____ Date of Hire:_____

Review with Mental Health Specialist:

	Date Reviewed (staff Signature)	Return Demonstration (Staff Signature)
Layout of Unit	_____	_____
Schedule	_____	_____
Patient Handbook	_____	_____
Phones	_____	_____
Patient Smoking Area	_____	_____
Confidentiality	_____	_____
Visitors/Sign In	_____	_____
Contact with other Patients	_____	_____
Room Contents	_____	_____
Patient Dress Policy	_____	_____
Sharps	_____	_____
Contraband	_____	_____
Admission/Discharge	_____	_____
Passes	_____	_____
Outside AA Meetings	_____	_____
Bedtime Procedures	_____	_____
Locked Door Security Panel	_____	_____

Review with Registered Nurse:

	Date Reviewed	Return Demonstration
Narcotic Count	_____	_____
Medication Cart	_____	_____
Admission	_____	_____
Discharge	_____	_____
Orders	_____	_____
Documentation	_____	_____
Precautions	_____	_____
Seclusion	_____	_____
Restraints	_____	_____
Detoxification	_____	_____
Contacting MDs, Lab, Consults	_____	_____
Fire Control Panel	_____	_____

_____ has reviewed the above information and
has satisfactorily verbalized knowledge or returned a demonstration.

_____   _____
Preceptor Signature   Date

_____   _____
Reviewed by   Date

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REGISTERED NURSE ORIENTATION - ACUTE ADOLESCENT UNIT

Orientee's Name/Title:_____ Date of Hire:_____

Review with Mental Health Specialist:

	Date Reviewed (staff Signature)	Return Demonstration (Staff Signature)
Layout of Unit	_____	_____
Schedule	_____	_____
Patient Handbook	_____	_____
Phones	_____	_____
Confidentiality	_____	_____
Visitors/Sign In	_____	_____
Contact with other Patients	_____	_____
Room Contents	_____	_____
Patient Dress Policy	_____	_____
Sharps	_____	_____
Contraband	_____	_____
Admission/Discharge	_____	_____
Passes	_____	_____
Bedtime Procedures	_____	_____
CD Tract	_____	_____
Elopement	_____	_____
School	_____	_____
Prevention of Sexual Interaction	_____	_____
Parent/Patient Interaction	_____	_____
Level/Point System	_____	_____
Locked Door Security Panel	_____	_____

Review with Registered Nurse:

Narcotic Count	_____	_____
Medication Cart	_____	_____
Admission	_____	_____
Discharge	_____	_____
Orders	_____	_____
Documentation	_____	_____
Precautions	_____	_____
Seclusion	_____	_____
Restraints	_____	_____
Contacting MDs, Lab, Consults	_____	_____
Fire Control Panel	_____	_____

_____ has reviewed the above information and
has satisfactorily verbalized knowledge or returned a demonstration.

_____   _____
Preceptor Signature   Date

_____   _____
Reviewed by   Date

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REGISTERED NURSE ORIENTATION - CHILDREN'S UNIT

Orientee's Name/Title:_____ Date of Hire:_____

Review with Mental Health Specialist:

	Date Reviewed (staff Signature)	Return Demonstration (Staff Signature)
Layout of Unit	_____	_____
Schedule	_____	_____
Patient Handbook	_____	_____
Phones	_____	_____
Confidentiality	_____	_____
Visitors/Sign In	_____	_____
Contact with other Patients	_____	_____
Room Contents	_____	_____
Patient Dress Policy	_____	_____
Sharps	_____	_____
Contraband	_____	_____
Admission/Discharge	_____	_____
Passes	_____	_____
Bedtime Procedures	_____	_____
Locked Door Security Panel	_____	_____
Elopement	_____	_____
School	_____	_____
Prevention of Sexual Interaction	_____	_____
Parent/Patient Interaction	_____	_____
Level/Point System	_____	_____

Review with Registered Nurse:

Narcotic Count	_____	_____
Medication Cart	_____	_____
Admission	_____	_____
Discharge	_____	_____
Orders	_____	_____
Documentation	_____	_____
Precautions	_____	_____
Seclusion	_____	_____
Restraints	_____	_____
Contacting MDs, Lab, Consults	_____	_____
Fire Control Panel	_____	_____

_____ has reviewed the above information and
has satisfactorily verbalized knowledge or returned a demonstration.

_____   _____
Preceptor Signature   Date

_____   _____
Reviewed by   Date

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REGISTERED NURSE ORIENTATION - RESIDENTIAL TREATMENT PROGRAM

Orientee's Name/Title:_____ Date of Hire:_____

Review with Mental Health Specialist:

	Date Reviewed (staff Signature)	Return Demonstration (Staff Signature)
Layout of Unit	_____	_____
Schedule	_____	_____
Patient Handbook	_____	_____
Phones	_____	_____
Confidentiality	_____	_____
Visitors/Sign In	_____	_____
Contact with other Patients	_____	_____
Room Contents	_____	_____
Patient Dress Policy	_____	_____
Sharps	_____	_____
Contraband	_____	_____
Admission/Discharge	_____	_____
Passes	_____	_____
Bedtime Procedures	_____	_____
CD Tract	_____	_____
Elopement	_____	_____
School	_____	_____
Prevention of Sexual Interaction	_____	_____
Parent/Patient Interaction	_____	_____
Level/Point System	_____	_____
Locked Door Security Panel	_____	_____

Review with Registered Nurse:

	Date Reviewed	Return Demonstration
Narcotic Count	_____	_____
Medication Cart	_____	_____
Admission	_____	_____
Discharge	_____	_____
Orders	_____	_____
Documentation	_____	_____
Precautions	_____	_____
Seclusion	_____	_____
Restraints	_____	_____
Contacting MDs, Lab, Consults	_____	_____
Fire Control Panel	_____	_____

_____ has reviewed the above information and has satisfactorily verbalized knowledge or returned a demonstration.

_____   _____
Preceptor Signature   Date

_____   _____
Reviewed by   Date

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Guidelines for Milieu Management
(Prepared by Elon Schlossberg, Psychiatric Clinical Nurse Specialist)

A Therapeutic Community exists within a program/unit when

- The sense of membership and belonging to the community plays a central role in the individual patient's life,

- Each member of the community, staff and patients, feels a sense of responsibility for the welfare of other members of the community and for the community as a whole,

- There is a clear boundary between who belongs and who does not belong to the community,

[NOTE: The "membership" boundary means 1) that each member of the community, both staff and patients, can distinguish if an individual, whether a staff member of the facility, a prospective patient, a visitor, a family member, or a helping professional, is a member of the community, and 2) that there are a set of traditions through which a new member joins the community.]

- There are a set of values, norms for behavior, and beliefs which are actively supported and maintained by community members,

- A primary value is that the individual patient will learn and practice adaptive living skills and social behaviors, and

- There is an expectation that community members will participate in activities, value one another as individuals, and learn to care about and trust one another.

A Therapeutic Community in an in-patient unit provides a therapeutic forum. The unit is not just a safe place for the patient to reside while he/she receives individual psychotherapy. Rather the community confronts the patient's maladapted behaviors and supports the patient as he/she learns and practices new, adaptive skills and during crises and critical times during the day such as meals, visits, wake-up, and bedtime to prevent reversion to previous maladapted behavior patterns.

DEFINITIONS

Milieu Management is the art of utilizing the features of the Therapeutic Community including the physical environment, the rules, the values, the program activities, and peer pressure to provide and maintain a culture which support the patient in learning and practicing adaptive living skills and social behaviors.

The Role of the Therapeutic Community is to focus on individual and common problems of the patients.

The Role of the Patient is to:

1) Join the Therapeutic Community,

2) Share his/her problems, thoughts, feelings, and ideas with the staff and other patients,

3) Participate in unit meetings and activities,

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4) Learn to trust in other patients and the staff: that they are important, that they can help, and that they can be helped,

5) Take responsibility for his/her own behavior,

6) Confront others' maladapted behaviors,

7) Listen to others as they share their problems, thoughts, feelings, and ideas,

8) Support others during crises and as they learn and practice new, adaptive skills, and

9) Be trustworthy.

The Role of Staff is to:

1) Model assertive, problem-solving behaviors,

2) Support, assist, and demonstrate respect for community members,

3) Provide guidance to the community and individual community members,

4) Help maintain the integrity and safety of the community,

[NOTE: The word "safety" has a highly specialized meaning in this context. "Safety" means that the social and physical environment, the therapeutic milieu, is such that therapeutic work can occur. The rules, structure, traditions, physical environment, and values of the community are used to protect patients both from physical manifestations of their own and other's aggressive impulses and from perceived threats from sources outside of the inpatient unit. "Safety" does not mean an absence of conflict; much of the therapeutic work occurs through the exploration and resolution of conflicts which arise within the therapeutic milieu. "Safety" mean that the trust in the therapeutic relationship is maintained.]

5) Be trustworthy,

6) Be aware of the dynamics and impact of the therapeutic community,

7) Respond to all members of the community with unconditional positive regard, i.e. the individual patient is always acceptable although his/her behavior may not be, and

8) Facilitate the therapeutic community as it focuses on individual and common problems of patients.

[NOTE: It is NEVER appropriate for staff members to offer for discussion or discuss their own problems with patients.]

The Role of the Family (when family is available) is to support the patient's growth and development through their on-going contact with the patient and their involvement in family therapies.

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The Role of Outside/Community Agencies is to interface with the
Therapeutic Community to maintain open lines of communication and to
provide continuity of care through the patient's admission and
discharge.

OBJECTIVES OF THE THERAPEUTIC COMMUNITY

The objectives of the Therapeutic Community are:

1)   To provide a safe, nurturing environment in which patients can
      develop a sense of trust in staff and other patients such that
      they can share and scrutinize their problems, feelings, concerns,
      and beliefs,

2)   To establish a framework of rules, customs, traditions, and values
      which will assist the patient in establishing and maintaining
      control of his/her impulsive behavior(s),

3)   To provide a means by which a patient can integrate new and
      positive experiences, using these experiences to increase
      self-esteem,

4)   To provide a social environment conducive to the patient
      practicing new, adaptive living skills and social skills, and

5)   To provide a social environment in which each patient will be
      empowered to experience success.

THERAPEUTIC USE OF SELF

Participation in a Therapeutic Community requires that each staff member
learn to use him/herself in a therapeutic manner. Certain issues require
special consideration:

BOUNDARIES

Staff members must maintain clear and consistent boundaries between
themselves and patients. These boundaries include:

-        setting limits' on patients behaviors, consistent with the
         patients age and functional level in a therapeutic manner
         avoiding punitive responses,

-        defining for patients that the staff member's role is a
         helping relationship within the context of the treatment
         program, not a friendship or a love relationship,

-        defining for the patients that the staff member's
         relationship with them is time-limited but that each patient
         is valued within that context,

-        setting limits on the amount of personal information which
         the staff member shares with patients, and

-        ensuring in each interaction with a patient that it is the
         patient's needs, not the staff member's needs which are
         being met.

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Patients commonly test all of these boundaries as they develop a therapeutic alliance with staff members. By testing these limits patients are questioning:

Will I be accepted for who I am?

Am I safe here?

What is this relationship I am entering into?

How intimate will I be with the staff?

What is my role here?

Will the problems I have experienced outside of the treatment program be replicated here?

Will I be victimized here?

Will I be understood?

Staff members must learn to recognize that when, for example, a patient asks "Have you ever been abused?" or "Have you ever used drugs?", he/she is not asking about the staff member's past. Rather the patient is asking "Can you understand and have empathy for what I have experienced and how I feel?" It is this deeper question that needs a response such as "You seem to be wondering if I can understand how you feel." In all such interactions, the focus must remain on the needs and feelings of the patient.

USE OF LABELS

Staff are to avoid using diagnostic or pejorative labels when discussing patients. Each label establishes a set of expectations for patient's behavior which can be and often is self-fulfilling. Often the labels are a means for staff to communicate dislike, discomfort, or distrust of a particular patient. Remember that each patient deserves unconditional positive regard - the patient is acceptable; his/her behavior may not be.

STAFF PREJUDICES

Each staff members brings to the Therapeutic Community his/her own set of beliefs and ideas, some of which will not be beneficial to the patients. If a particular patient engenders discomfort in a staff member because of the patient's history, behavior, or ideas, this should be discussed in clinical supervision and never displayed in the community.

READING THE MILIEU

A staff member's primary focus is the needs of the group; the secondary focus is the needs of the individual patient in relation to the group. To be an effective milieu manager, each staff member must learn to "read the milieu". "Reading the milieu" involves assessing how the community, peer group, and the treatment team are functioning as a whole. Distinguishing features of the functioning of the therapeutic community require continuous monitoring and evaluation.

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"Happy" Noise Versus "Disruptive" Noise

An important distinguishing feature in the functioning of the community is whether the "noise" of the community is "happy" or "disruptive." "Happy" noise is the normal background hum or social noise of patients involved in their daily routines. "Disruptive" noise is a symptom of a problem or conflict that the peer group or an individual patient is having difficulty resolving. When "disruptive noise" occurs, staff needs to respond. Effective response does not suppress or eliminate conflict within the patient group, rather it facilitates conflict resolution.

Interactive Patterns

A second distinguishing feature of the functioning of the therapeutic community is the interactive patterns between individual patients, between groups of patients, and between patients and staff. When the therapeutic milieu is functioning well, all members of the patient group are actively engaged in the task of the therapeutic community. This task is to focus on the individual and common problems of members of the group.

Certain interactive patterns are symptomatic of the ill health of the therapeutic milieu. These patterns include but are not limited to:

1) The formation of cliques –

   which are small sub-groups of patients who join together with an agenda different from that of the therapeutic community. Cliques exert influence on individual members of the patient group through the process of inclusion and exclusion of non-members of the clique. Cliques often form to espouse and/or support a set of values in variance to that of the community.

2) Pairing –

   which involves the formation of an unhealthy exclusive alliance between two patients. Pairings can be sexual or can be characterized as an enmeshed or over-involved friendship. Staff must remember that the task of each patient is to work on his/her individual problems. Involvement in a sexual relationship alliance with another patient represents a means of avoiding this task. The development of an enmeshed or over-involved friendship is another means of avoiding therapeutic work. Frequently the enmeshed relationships involve keeping secrets from the rest of the community.

3) Isolating –

   which is when one or more patients actively avoids involvement in formal and/or informal group activities.

4) Scapegoating –

   which is when one or more members of the therapeutic community, staff or patients, become the focus for blame for problems within the milieu.

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5) Patients Versus Staff -

which is seen when the patients fill the time in community meetings and group activities with complaints about the facility, the staff, or the physical environment.

Secretive Behavior

A third distinguishing feature of the functioning of the therapeutic community is the presence of secretive behavior among the patient group. Staff members should keep in mind that the reason patients keep "secrets" is not usually maliciousness. Rather, secretive behavior is evidence of patients' lack of trust in staff or lack of trust in the safety and integrity of the therapeutic milieu. This is a failure of staff to maintain a trustworthy stance with patients. Secrets often involve contraband, sexual acting-out, suicidal ideation, elopement plans, or intimidation by fellow patients. If staff is not perceived as caring, limit-setting, and trustworthy, a code of behavior, "don't tell," is supported by the patient group.

The presence of "secrets" within the therapeutic community is discovered retrospectively as the result of investigation of major acting-out behavior by patients. Most commonly, when a patient engages in or plans to engage in some major acting-out behavior, other patients know that this behavior has or will occur. Prospectively, the presence of "secrets" within the therapeutic community may be suspected when groups of patients cease their conversation when a staff member approaches, when the general level of anxiety on the unit rises, when discussion of significant issues is avoided in community meetings and group therapy, or when enmeshed friendships develop between patients.

Increased Limit-Testing

The next symptom of dysfunction within the therapeutic milieu is an increase of limit-testing by individual patients and/or by groups of patients. Limit-testing represents efforts by members of the community to elicit attention, limits, and a caring response from staff members. It can be exhibited as destructive aggression (even minor incidents of violence directed at self, others, or property or property defacement are significant), refusal or avoidance of program activities, and/or violation of basic program rules, values, or customs. A basic principle related to limit-testing is that if the patients' unstated needs are not met, the intensity of the limit-testing will increase until staff responds adequately to the patients' needs. Staff's first response needs to be to find out what the unstated problem is. If the unstated problem is not responded to, there may be contagion of the limit-testing to other members of the community.

Factors Related to Staff

Finally, staff members' behavior, interaction patterns, style of relating to patients, and style of implementing program change has a significant impact on the function/dysfunction of the therapeutic milieu. Patients need staff members to demonstrate clear-cut boundaries between their roles and patients' roles. Patients also desire the safety and reassurance of staff members' nurturance, competence, consistency, and fantasized omnipotent ability to control the individual patient's destructive impulses. Staff indecision (often related to either anxiety or poor communication between personnel), role diffusion,

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7)   Structures which support, maintain, and regulate the
        Therapeutic Community,

8)   Structures which provide an avenue for communication between
        the Therapeutic Community and other systems,

9)   Customs and traditions which provide a sense of continuity
        to the Therapeutic Community,

10)   Systems of leadership through which executive decisions can
        be made for, by, and/or about the Therapeutic Community, and

11)   Distinct sub-systems which interact with one another to
        develop and maintain the social culture of the Therapeutic
        Community.

Like all living systems the Therapeutic Community strives to maintains
an internal homeostasis. Homeostasis is maintained through formal and
informal social processes. Informal social processes include limits
placed on individual patients by staff and/or peers, the relative
satisfaction/dissatisfaction patients experience in social relationships
within the therapeutic milieu, and the community culture to which the
social group (staff and patients) ascribe. Formal social processes
include staff meetings (for clinical supervision), Community Meetings,
group therapies, and activity therapies.

Community Meetings and other therapeutic interventions with individuals
and groups serve a regulatory social function. These and other formal
structures of the therapeutic milieu are implemented to maintain an
optimum social environment in which patients can work through social and
emotional problems. If the social environment within the Therapeutic
Community is over-regulated, patients will not have the opportunity to
perform the therapeutic "work" necessary for them to derive benefit from
their experience. In this circumstance, staff exclusively provide
external controls for patients rather than providing patients with the
opportunity to learn to modulate, moderate, and change their own
behavior. On the other hand, if the social environment of the
Therapeutic Community is under-regulated, patients' unacceptable
behaviors will escalate until sufficient external controls are enacted
to maintain the safety of the physical and social environment.

Similarly some critical needs of patients are:

1)   The need for a boundary between "me" and "not me" i.e
        the need to be an individual,

2)   The need for a boundary between permitted behaviors and
        forbidden behaviors,

3)   The need to have physical needs met, such as hygiene,
        food, and exercise,

4)   The need for intellectual stimulation,

5)   The need for communication with others,

6)   The need to be empowered to make decisions,

7)   The need to belong,

8)   The need for recreation,

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9)   The need for safety and nurturance, and

10)   The need to successfully grow and develop.

Just as staff must respond to the needs of the Therapeutic Community to help it maintain its homeostasis, the staff must also respond to the needs of individual patients to help them maintain their integrity as an individual. It must be kept in mind however that a staff member's primary focus is the needs of the group; the secondary focus is the needs of the individual patient in relation to the group. This means that interventions developed to address the needs of individual patients are most effectively implemented in the group format.

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Managing the Community Meeting
(Prepared by Elon Schlossberg, Psychiatric Clinical Nurse Specialist)

The Therapeutic Community Meeting is the primary group forum in which the traditions and values of the therapeutic community are established, communicated to patients, and supported. The community meeting addresses multiple agendas. In the community meeting patients will:

-   orient new patients to the rules, values, standards, and traditions of the treatment center,

-   promote the expectation that all patients are actively involved in treatment,

-   promote a sense of commonality among patients,

-   address in the "here and now" problems which occur within the community,

-   confront one another's maladaptive behaviors,

-   practice leadership skills within the framework of the student government, and

-   say goodbye to peers who are being discharged from the program.

Staff will:

-   role model assertive, problem-solving behaviors,

-   support and assist community members,

-   provide guidance to the community and individual community members, and

-   communicate with the community.

There are two types of community meetings:

1) Community meetings which occur at regular intervals as a part of the Program Activity Schedule

2) Community meetings which are called in lieu of another scheduled activity to address emergent problems within the therapeutic milieu.

The agenda of a given community meeting will depend upon the focus of that meeting. In general there are 4 foci for the agenda. These are:

-   Welcoming new patients to the community

-   Attending to community business functions

-   Addressing problems which have arisen within the community

-   Saying good-bye to patients who are being discharged

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Agenda of regularly scheduled community meetings:

1) Review of the community values/rules and rules of the community meeting by the Community President or another patient.

2) Introductions of new patients

   a) Each community member will introduce him/herself answering the questions:

   What is my name?
   Why am I here?
   What am I working on?

3) Any new business

4) Community problems

5) Goodbyes

   a) Each community member will say goodbye to the patient who is leaving answering the following questions:

   What will I remember about you?
   What do you need to work on after you leave?

NOTE: Welcoming new patients and saying good-bye to patients who are being discharged are a priority for the community. If there is not sufficient time to say goodbye in a community meeting because of other pressing business, another community meeting will be called, in lieu of a scheduled activity, to say goodbye to the patient who is leaving.

Agenda of community meetings called in lieu of another scheduled activity:

1) Review of the community values/rules and rules of the community meeting by the Community President or another patient.

2) Identification of the problem which needs to be addressed by the community.

3) Identification of the expected outcome of the community meeting i.e. the community will be safe.

4) Discussion which includes solutions

5) Additional plans or schedule changes

The recommended duration of a community meeting is 45 minutes. Community meetings should never exceed 1 hour in duration.

Community members are expected to maintain respectful behavior toward
themselves and others at all times during the Community Meeting.
Respectful behavior includes:

- Demonstrating active listening skills,

- Using "I" statements when identifying or discussing a
  problem,

- Allowing all community members to express their opinions,
  feelings, and ideas,

- Accepting ownership for one's own behavior, and

- Avoiding name-calling, scapegoating, or offensive language.

The following are symptoms that the Community Meeting was not effective:

1) If staff talks more that the patients do,

2) If no interpersonal or community problems are raised,

3) If there is no resolution to identified problems,

4) If a weaker member of the community is scapegoated,

5) If a staff member is scapegoated,

6) If the patients fill the time with complaints about the
   facility, the staff, or the physical environment, or

7) If the meetings are consistently running over. (This is a
   sign that staff are not allowing the patients ample time to
   process the material. More time does not mean a better
   meeting!)

A:\COMUNITY.MTG

Guidelines for Maintaining Unit Safety and Security
(Prepared by Elon Schlossberg, Psychiatric Clinical Nurse Specialist)

Unit Safety Checks

Unit safety checks are to be done at the beginning of each shift. Staff makes a visual inspection of each designated area of the unit to note and correct damage and safety hazards.

Night shift personnel do not inspect patient rooms or bathrooms because this would disturb patients' rest.

When performing the safety check, staff is to do the following in each designated area:

a) Identify any damage and complete a work order;

b) Visually inspect the area for contraband including toiletry articles that should have been returned to the Basket Room such as hair-dryers, curling irons, and electric razors;

c) Visually inspect the area for sharps including glass items, nail clippers, and razors;

d) Inspect the receptacles to assure that they are clear of obstructions;

e) Check the bathroom as in a) through d) above if applicable; and

f) Visually inspect the area for soiled or wet linen not properly stored.

The visual inspection does **NOT** include opening drawers or closets in patient rooms. This level of inspection is only done during a room search.

Room Searches

Room searches are performed under the direction of the RN when it has been determined that either:

a) There is reasonable suspicion that one or more patients possess contraband in their room(s) including but not limited to cigarettes, lighters or matches, drugs, alcohol, or weapons, or

b) One or more patients are expressing suicidal ideation or other thoughts of self-harm and staff need to assure that sharps and other objects with which the patient(s) could injure themselves are not available in the patient(s)' rooms.

When performing a room search staff is to inspect at minimum the following areas:

BEDROOMS

- inside drawers and closets
- pockets in clothing
- inside socks
- under the mattress

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- inside the zipper of the mattress
- inside pillow cases
- around the edge of the lights
- that windows and light bulbs are intact
- window sill and curtains
- vent covers
- access panels, if present
- tops of closets
- under bottoms of chairs
- in clothes hampers
- under and behind beds
- wall outlets

BATHROOMS

- back of toilets
- inside toilet tank
- top and underside of sink
- inside the bathtub
- inside the bathtub curtain
- inside the toilet paper roll and dispenser
- wall outlets
- lights and vents

Unit Security Checks

Each evening following bedtime, staff will complete a unit security check to ensure that all exits and non-essential areas of the unit are locked.

Guidelines For Patient Observation

Patient Rounds

Patient Rounds will be completed on all patients every hour to determine the location and status of each patient. Children and adolescents must be checked a minimum of every thirty (30) minutes.

If you are unable to locate a patient, notify the charge nurse and immediately begin to search for the patient.

15 Minute Checks

15 minute checks are to be completed on patients who have been placed on Suicide, Assaultive, Elopement or other safety precautions.

The 15 minute observations are to be documented on the designated 15 Minute Check Sheet. When complete the 15 Minute Check Sheet is to be filed in the patient's medical record.

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Cardinal Values of a Behavioral Health Treatment Program
(Prepared by Elon Schlossberg, Psychiatric Clinical Nurse Specialist)

Safety

Definition: Safety means protection from harm or threats of harm from others or from one's own impulses.

Guiding principles:

- Staff and patients will work together to maintain a secure, protected environment which is free of dangerous objects and substances.

- Staff will provide supervision and monitoring of patients.

Non-violence

Definition: Non-violence is to be free from threats, intimidation, physical harm, and the use of physical force to coerce obedience.

Guiding Principles:

- Staff will utilize limit-setting as opposed to punitive methods to establish and teach self discipline.

- Staff will not use verbal/physical threats to insure compliance.

Respect

Definition: Respect is to demonstrate courteous behavior directed toward self and others and to refrain from behavior which is intentionally abusive to self or others.

Guiding Principles:

- Each person will be treated in an equal and impartial way respecting their human differences, personal goals, beliefs, and values as we establish a trusting therapeutic relationship.

Structure

Definition: The provision of a consistent and predictable milieu.

Guiding Principles:

- Clearly stated rules and expectations will be given to the patient, parents, and staff and posted in a visible area on the unit.

- Scheduled activities will begin and end on time.

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Responsibility

Definition: Making important choices that will affect self and others.

Guiding Principles:

- Responsibility is the quality of answering for one's acts and decisions and fulfilling one's obligations.

- Patients will be encouraged to participate in the process of problem resolution.

Growth

Definition: To encourage the development of each individual's unique abilities and skills to its fullest potential.

Guiding Principles:

- Praise and positive reinforcement will be used to facilitate a positive emotional, behavioral, and social change.

- Staff will encourage the patient to recognize their areas of personal growth.

- Staff will encourage the patient to reinforce self for any positive changes made.

- Staff will encourage and support each individual's spiritual search for their purpose and meaning in life.

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POSITION ORIENTATION

REGISTERED NURSE ORIENTATION CHECKLIST

Orientee's Name/Title:_____Date of Hire:_____

Preceptor:_____

	Date Reviewed (Staff Initial)	Returned Demonstration (Staff Initial)
SAFETY FUNCTIONS:		
I. Safety:		
Communication/Memo Book	_____	_____
Emergency Plans	_____	_____
Emergency Kit, O2, Suction	_____	_____
Fall Prevention	_____	_____
Intershift Report	_____	_____
Observation Flow Sheets	_____	_____
Restraints	_____	_____
Seclusion	_____	_____
Suicide Precautions	_____	_____
Unit Rounds	_____	_____
Variance/Occurrence Reporting	_____	_____
II. Infection Control		
Bloodborn pathogens	_____	_____
Employee health	_____	_____
Handwashing	_____	_____
Nosocomial infections	_____	_____
Universal Precautions	_____	_____
PHYSICAL/MEDICAL NEEDS:		
III. Admission Procedures:		
Admission Assessment/Intake	_____	_____
Admission Entry Note	_____	_____
Admission on Computer System	_____	_____
Advanced Directives	_____	_____
Alcosensor	_____	_____
Body Search	_____	_____
Confidentiality	_____	_____
Consents	_____	_____
Consults	_____	_____
Detoxification - CIWA	_____	_____
Inquiry Call/Triage	_____	_____
Lab Forms	_____	_____
Old Charts - Medical Records	_____	_____
TB Skin Test	_____	_____
Types of Admissions:		
Involuntary	_____	_____
Voluntary	_____	_____
23 Hour Observation	_____	_____
Partial/Day Treatment	_____	_____
Valuables/Inventory Form	_____	_____
IV. Medications:		
Physician Order Forms	_____	_____
Med. Admin. Record (MAR)	_____	_____
Adverse Drug Reaction form	_____	_____
Medication Incident Report	_____	_____
Narcotic Count Sheet	_____	_____
OPUS Medication System/Cart	_____	_____
Pharmacy Order Sheet	_____	_____
Vital Signs/EKG Monitoring	_____	_____

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RN ORIENTATION CHECKLIST: Page 2

V.   **Charting:**
        Basics of charting   _____   _____
        Initial Treatment Plan   _____   _____
        Treatment Plan Updates   _____   _____
        MD Orders   _____   _____
        Nursing Kardex   _____   _____

THERAPEUTIC MILIEU NEEDS:
VI.   **Therapeutic Community:**
        Community Group   _____   _____
        De-escalation techniques   _____   _____
        RN led groups   _____   _____
        Skills building groups   _____   _____
        Treatment Program Schedules   _____   _____

INDIVIDUAL PATIENT/FAMILY NEEDS:
VII.   Patient Handbooks
        Patient Rights/Responsibilities _____   _____
        Telephone Privileges   _____   _____
        Visitors   _____   _____

PATIENT/FAMILY EDUCATION NEEDS:
VIII.   Medications   _____   _____

DISCHARGE PLANNING NEEDS:
IX.   **Discharge Procedures:**
        AMA Prevention
        AMA Discharge   _____   _____
        Discharge Entry Note   _____   _____
        Discharge Forms   _____   _____
        Elopement   _____   _____
        Emergency Room Visit   _____   _____
        Transfer to Other Facilities _____   _____

X.   **Miscellaneous:**
        Assignment of Duties   _____   _____
        Exam Room Set-up/Cleaning   _____   _____
        Night Shift Duties:
          Census Sheets   _____   _____
          Chart Audit/Review   _____   _____
          Refrigerator Temp. Checks   _____   _____
          Secure Building   _____   _____

_____ has completed the orientation
checklist satisfactorily within 30 scheduled working days of beginning
employment.

_____   _____
Employee   Date

_____   _____
Preceptor   Date

_____   _____
Unit Nurse Manager   Date

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ORGANIZATION OF NURSING STAFF FUNCTIONS

In order to provide a therapeutic environment, meet the patient's basic needs and support the treatment process, the Nursing Services staff should provide patient care according to the following priorities.

1. **SAFETY NEEDS:** In order for patients to be able to participate in therapy, a sense of trust must be established beginning at the most basic level. The patients must experience themselves as free from harm from self, others or the environment. Nursing Services staff are responsible for maintaining safety procedures, giving safety and risk serious consideration when exercising judgement and conducting regular review of the physical environment.

2. **PHYSICAL/MEDICAL NEEDS:** Patients must have a basic level of physical/medical stability in order to actively participate in the psychotherapeutic activities. In addition, any problems in these areas should be given adequate attention to avoid the development of more serious problems. Nursing Services staff are responsible to assess the patient's medical needs and respond accordingly, either through communication with the physician or through appropriate intervention to meet the patient's needs.

3. **THERAPEUTIC MILIEU NEEDS:** Because the actions and needs of the group of patients affect other patients, the needs of the group will be given priority over the needs of the individual. Also, the interactions between patients and between staff and patients provides a significant therapeutic arena in which other treatment activities are integrated, making the milieu an important process. It is the responsibility of the Nursing Services staff to manage the milieu, meaning to assess, diagnose and intervene with the patient community in order to maintain the therapeutic, productive nature of this process.

4. **INDIVIDUAL NEEDS:** Patients have individualized needs for support, limit setting, feedback, encouragement, motivation, and assistance. Nursing Services staff will provide appropriate interventions in these areas, giving consideration to the priorities previously mentioned.

5. **FAMILY NEEDS:** The patients' families and significant others have a need for information related to the patient's status and treatment process and for emotional support. Nursing Services staff may assist other clinical staff in providing assistance to the family.

6. **PATIENT/FAMILY EDUCATION:** The nursing staff play a substantial role in the patient and family's education. Staff provide education and information related to medications, behavior and emotional management, communication, self-responsibility, and activities of daily living.

7. **DISCHARGE PLANNING:** The nursing staff initiate discharge planning at the time of admission by identifying the presence of risk factors and sharing that information with the patient's Case Manager. Nursing staff will assist the patient as indicated.

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Guidelines for Intershift Report
(Prepared by Elon Schlossberg, Psychiatric Clinical Nurse Specialist)

In order to enhance communications between shifts and improve the consistency of the care we provide to our patients, please use the following guidelines for the content of the intershift report.

1. Current Census - How many patients are currently on the unit?

2. Discharges - Who was discharged during the shift?

3. Admissions - Who was admitted during the shift?

4. Global tenor of the milieu - What is the feeling or tone of the peer group?

5. Significant events - Did anything unusual occur on the unit? If so, what?

    Examples:

    physical altercations
    seclusion or restraint
    elopement (attempt, reported plan)
    suicide attempts
    dangerous property destruction
    serious medication reactions

6. Patient Report - For each patient report:

    Name
    Age
    Gender
    Physician
    Precaution Status
    Level Status (Children and Adolescents)
    Allergies
    Chief Complaint (behavioral descriptive)
    Detoxification status (adult CD patients)
    Current focus of treatment
    Any change in the patient's condition

7. Pending Business

    pending discharges
    anticipated admissions
    issues requiring follow-up

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STANDARD I: Demonstrates understanding of nursing process and incorporates into daily practice.

1. Completes nursing assessment within 8 hours of admission.

2. Determines nursing diagnosis based upon admission assessment within 24 hours.

3. Has patient/family sign necessary papers upon admission and provides program information in the absence of admission office personnel.

4. Assess patients daily.

5. Participates in developing treatment plans which reflect individual patient needs.

6. Revises or adds to treatment plan as needed.

7. Performs interventions specified on nursing care plan within expected frequency.

8. Addresses discharge needs.

9. Addresses patient education needs.

10. Charting is problem specific.

11. Interacts with patient therapeutically at all times.

12. Evaluates need for special intervention procedures and follows established policies and procedures regarding implementation of such procedures.

REFERENCE MATERIALS:

Videos:	Psychiatric Nursing - NCLEX Review	(50 min.)
	Defense Mechanisms - NCLEX Review	(40 min.)
	Dynamics of Treatment Planning	(22 min.)

KEY Policies and Procedures:
Multidisciplinary Treatment Plans.........................NSA 1310
Nursing Care Plans.......................................NSA 1330
Routine Nursing Duties...................................NSA 1490

Admission Note..NSC 2020
Admission - Involuntary.................................NSC 2030
            Voluntary...................................NSC 2031
Detoxification and Assessment Scale (CIWA-Ar)...........NSC 2185
Nursing Assessment and Reassessment.....................NSC 2410
Neurological Assessment.................................NSC 2450
Orthopedic Injuries.....................................NSC 2480
Seizures - Charting.....................................NSC 2660
Seizures - Procedures...................................NSC 2661
Sick Protocol...NSC 2665
Search Policy and Procedures............................NSC 2650
     Authorization for Search...........................NSC 2651
     Belongings (Patient)...............................NSC 2652
     Room Search..NSC 2653

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Related Readings/Handouts:
Admission and Discharge
Standards of Touch in Therapeutic Relationships
Therapeutic Use of Self

STANDARD II: **Understands medication indications and risks and documents per policy.**

1. Transcribes orders correctly at all times.

2. Signs off orders correctly.

3. Documents all medications given.

4. Documents effects of PRN medication.

5. Does patient medication teaching.

6. Evaluates patient's side effects and notifies M.D. PRN.

7. Knowledgeable about adverse drug reactions and follows established policies and procedures regarding physician notification and intervention.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures:
Adverse Drug Reaction...................................NSA 1060

Administration of Medication from Home....................NSC 2010
Food/Drug Nutrient Interaction Counseling.................NSC 2250
Medication Administration Records (MAR)...................NSC 2370
Medication Administration System - OPUS...................NSC 2371
Medication Errors..NSC 2380
Patient and Significant Other Education..................NSC 2541
Transcription of Medication Orders.......................NSC 2710
Verbal/Phone Physician's Orders..........................NSC 2770

Related Readings/Handouts:
Medication Administration - Study Guide
List of Frequently Prescribed Medications

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STANDARD III: Demonstrates effective leadership/communication skills.

1. Gives complete and accurate shift report.

2. Prescribes, delegates and coordinates delivery of all patient care during shift. All team tasks are completed.

3. Demonstrates clinical expertise. Teaches patients, Mental Health Specialists and LPNs needed skills.

4. Uses established channels of communication.

5. Orients new employees as assigned.

6. Notifies DON or Assistant DON of staffing difficulties or problem and attempts at resolution.

7. Reviews acuity sheets daily and accurately and appropriately determines staffing needs.

8. Adheres to established policies and procedures.

9. Participates in hospital committees.

10. Accepts changes in work assignments readily.

11. Follows chain of command.

12. Ensures team members clock in and out on time.

13. Demonstrates problem solving skills.

14. Ensure patient rights are not violated during shift.

15. Modifies practice/performance based on clinical supervisor.

16. Maintains patient confidentiality at all times.

17. Demonstrates knowledge of specific treatment programs and ability to follow such programs consistently.

18. Ensures physicians' orders are transcribed in a timely manner and properly executed.

19. Ensures notification of physicians of abnormal lab results, special interventions, etc. in a timely manner and implements additional orders if necessary.

20. Provides treatment input in decision making process with treatment team.

21. Accepts input/consultation for other team members.

22. Shares knowledge with other team members in an appropriate and timely manner.

23. Maintains a safe therapeutic environment for patients and other employees.

24. Displays tact and patience when dealing with patients, visitors and employees.

25. Demonstrates knowledge of safety procedures (fire, disaster, bomb threat, etc.) to assure a safe environment.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures:
Conduct Involving Patients..................................NSA 1140
Ethics Hotline...NSA 1271
Patient's Rights and Responsibilities......................NSA 1360

Acuity System...NSC 2000
Confidentiality...NSC 2140
Confidential Treatment of Medical Records..................NSC 2150
        Release of Information.............................NSC 2151
        Release of Information - Drug and Alcohol Abuse Pt...NSC 2152
        Release of HIV Testing Results.....................NSC 2152

Related Readings/Handouts:
Guidelines for Intershift Report

Guidelines for Milieu Management

Managing the Community Meeting

STANDARD IV: **Participates in continuing education.**

1. Maintains valid CPR certification.

2. Has eighteen hours of staff development each year.

3. Participates in initial Inquiry Call training and periodic retraining.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures:
Inservice Education/Continuing Education...................NSA 1290

Related Readings/Resources:
National Center for Continuing Education, Inc.
P.O. Box 1407
Roseville, CA 95678-8407
1-800-824-1254
(Home study continuing education credits)

STANDARD V: Demonstrates regular attendance patterns.

1.   Has no greater than five occasions of excused absence in a year.

2.   Attends nursing department monthly meetings ten out twelve times a year.

3.   Attends clinical staffing when on duty 90% of the time as assigned.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures:
Employee Health Program..................................NSA 1250

Related Readings/Handouts:
Employee Handbook

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STANDARD VI: **Understands 12 step process.**

1.   Verbalizes understanding of the 12 steps.

2.   Facilitates patient attendance at step meetings.

3.   Incorporates 12 steps into nursing practice.

REFERENCE MATERIALS:

Videos: Chemical Dependency - NCLEX Review Series (30 min.)

KEY Policies and Procedures: None

Related Readings/Handouts:
Suggest attendance at an AA Meeting and an Alanon Meeting as part of orientation to CD treatment

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STANDARD VII: **Understands quality assessment and improvement process.**

1.   Insures collection of Q.A. data as assigned.

2.   Provides input into annual Q.A. plan.

3.   Modifies practice based on Q.A. feedback.

4.   Development of Q.A. plan as assigned.

5.   Implements necessary changes based on Q.A. data.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures: None

Related Readings/Handouts:
Participation in Quality Assurance activities will be assigned by the Nurse Managers.

STANDARD VIII: Demonstrates knowledge of lectures/group therapy content
and purpose.

1.   Organizes and prepares lecture content.

2.   Presents lectures in a professional manner.

3.   Leads and co-leads groups as assigned.

4.   Documents patient's participating in group/lecture as assigned.

5.   Starts and ends groups/lectures on time.

ORIENTATION GUIDELINES/TOOLS:

Videos: None

Policies and Procedures: None

Related Readings/Handouts: Observation of the types of group therapy will
be scheduled during the first 14 days of employment.

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STANDARD IX: **Completes inquiry process in a professional manner.**

1.   Answers telephone promptly and takes identifying information from individuals seeking help, admission or information regarding Crest View Hospital.

2.   Completes inquiry form and routes to admission coordinator.

3.   Makes every effort to have callers schedule immediate face-to-face interview.

REFERENCE MATERIALS:

Videos: Successfully Handling the Inquiry Call   (60 min.)

KEY Policies and Procedures:
Inquiry Process...NSC 2310

Related Readings/Handouts:
Successfully Handling the Inquiry Call Workbook*

*Inquiry Training will be conducted during General Orientation, with refresher training occurring every 3 - 6 months.

STANDARD X: Demonstrates understanding of variance reporting.

1. Observes established policies and procedures regarding variance (incident) reporting.

2. Monitors the accurate and timely completion of variance reports by LPNS, and Mental Health Specialists.

3. Assures completed variance reports are promptly routed to the Director of Nursing or Hospital Administrator for review.

4. Evaluate need for and facilitate medical treatment for injuries of patients or staff as a result of a variance or incident.

REFERENCE MATERIALS:

Videos: None

KEY Policies and Procedures:
Conduct Involving Patients...................................NSA 1140
Ethic Hotline..NSA 1271
Variance Reports...NSA 1560

Related Readings/Handouts:

STANDARD XI: Documentation.

1.   Charts each shift on assigned patients or on patient specific special intervention procedures.

2.   Charts by problem and behavioral observations.

3.   Assures completion of flow sheets on precautions, 1:1 observations, behavior modification programs, etc. by assigned staff.

4.   Notes are legible, clearly written, dated, timed and signed.

5.   Charts group notes, in relation to topic, duration, behavioral observations, for each group as assigned.

6.   Charts admission note and discharge note in a timely manner.

REFERENCE MATERIALS:

Videos: Documentation: Your Best Defense   (33 min)

KEY Policies and Procedures:
Approved Abbreviations.......................................NSA 1090
Admission Note..NSC 2020
Charting/Progress Notes.....................................NSC 2120
Intravenous Therapy - Documentation.........................NSC 2320
Medical Testing & Documentation.............................NSC 2360
Seclusion/Restraint Flow Sheet..............................NSC 2641
Seizures - Charting...NSC 2660
Sick Protocol...NSC 2665
Suicide Precautions...NSC 2680

Related Readings/Handouts:
Basics of Charting
Charting and Documentation
Continued Inpatient Treatment/Progress Note
Basic Components of Progress Note

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STANDARD XII: **Understands Infection Control.**

1.   Promptly notifies Infection Control Coordinator of potential infections in the patient population.

2.   Participates in Infection Control inservices.

3.   Demonstrates knowledge of infection control in patient care.

4.   Participates in infection control activities as assigned.

REFERENCE MATERIALS:

Videos: Infection Control - Breaking the Chain   (16 min.)

KEY Policies and Procedures:
Employee Health Program.....................................NSA 1250
Hepatitis and Needle Stick Guidelines.......................NSC 2270
HIV Testing...NSC 2290
Infectious Disease Control and Isolation Directive.........NSC 2300
        Collection of Potentially Infectious Specimens.......NSC 2301
        Cleaning up of Emesis/Blood/Urine Spills.............NSC 2302
Needles and Sharps Disposal................................NSC 2400
Sick Protocol..NSC 2665
Universal Blood and Body Fluids............................NSC 2730

Related Readings/Handouts:

EVALUATION

EVALUATION PROCESS - GENERAL COMMENTS

Orientation and training is a dynamic process that begins the first day you report to work at Crest View Hospital and continues throughout your employment. This process is a partnership between the hospital and you. The Orientation Guide serves as the outline for your orientation and training as well as a self-evaluation guide for your growth and development as a licensed professional.

While the Orientation Guide is designed to serve as a reference for you, there are documents contained within it that need to be completed and reviewed with the Unit Nurse Manager. These documents will be filed in your Personnel file or Unit Competency File to help document your progress. The following items will need to be completed and reviewed with the Unit Nurse Manager within the first 30 days of employment:

                                                    Date Completed

1)   Skills Inventory   _____
2)   Baseline Competency Test   _____
3)   Medication Study Guide   _____
4)   Psychotropic Medications   _____
5)   Personnel File Checklist   _____
6)   General Hospital Checklist   _____
7)   Fire/Safety/Disaster Checklist   _____
8)   Unit Specific Checklists   _____
9)   RN Orientation Checklist   _____

Additional checklists and competency tests may be given to you during the probationary period. The Unit Nurse Manager will keep you informed regarding this area.

The Unit Nurse Manager will be responsible for scheduling a three month and six month evaluation with you. The evaluation utilizes the same form as your job description, which is contained within this manual. The evaluation is done face-to-face and is designed to be an educational process.

If you have any questions regarding orientation and training, your probationary period, or Crest View Hospital in general, please let your Unit Nurse Manager know.

At the end of your probationary period (180 days), we ask that you complete the "Orientation Guide Evaluation" and give it to your supervisor. Your comments will be greatly appreciated and will help us evaluate and improve the process.

Thank you!

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ORIENTATION GUIDE EVALUATION

Employee Name/Title:_____

Date began orientation:_____ Evaluation Date:_____

Please Circle One:

1.   Overall rating of __Self-assessment__ materials:

Poor   Satisfactory   Good   Excellent

Suggestions/Comments:_____

_____

_____

2.   Overall rating of __General Hospital Orientation__:

Poor   Satisfactory   Good   Excellent

Suggestions/Comments:_____

_____

_____

3.   Overall rating of __Unit Orientation__:

Poor   Satisfactory   Good   Excellent

Suggestions/Comments:_____

_____

_____

4.   Overall rating of __Position Orientation__:

Poor   Satisfactory   Good   Excellent

Suggestions/Comments:_____

_____

_____

5.   Overall rating of the __Orientation Guide__:

Poor   Satisfactory   Good   Excellent

Suggestions/Comments:_____

_____

_____

Thank you!

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