Student Nurses

Core Orientation Materials

When coming to Children’s Healthcare of Atlanta for your clinical experience, please follow these guidelines:

**Patient Confidentiality:** A reminder that students must follow all HIPAA rules and regulations, maintain patient confidentiality, and maintain the patient’s and family’s right to privacy. Do not disclose or use any information regarding any current or former Children’s patient or the patient’s family without authorization. This includes taking photographs, videotaping, and/or discussing patients verbally or in writing outside of the classroom setting. Failure to comply will result in the student being asked to leave the clinical setting.

**Identification:** Students and Faculty must wear a Children’s badge and their school identification badge at all times.

**Dress Code:** When coming to any Children’s facility to review assigned charts, please follow Children’s business casual dress code policy. Scrubs are permitted by faculty and students. Denim, capris, sleeveless shirts, t-shirts (including Children’s employee t-shirts), and open-toed shoes are considered inappropriate. (Please refer to our Dress Code Policy). Follow your school’s uniform requirements. Visible body piercings, other than in earlobes, are not permitted. Visible body art such as tattoos should be covered at all times. **Artificial nails are not allowed when providing direct patient care.**

**Policies and Procedures:** Students and Clinical Instructors/Faculty will be able to access all policies and procedures. Refer to the appropriate policies prior to performing patient care procedures, on any unit, throughout the entire academic year.

**Communication & Electronic Devices:** When on the unit, students should not monopolize the nurse’s station and lounges. Use of cell phones should be limited to emergencies only. For educational purposes, cell phones & portable electronic devices may be utilized (i.e. look up medications, diagnoses information) away from patient care areas, such as in the nursing lounge or station. Communicate use of these devices with departmental/unit educator and/or charge nurse. When interacting with patients and family, please remember to keep “small talk” subject matter appropriate.
Mission, Vision, & Values

Dedicated to All Better. Whether treating a toddler in an emergency or supporting a teen through chemotherapy treatments, we are dedicated to the care of each patient. It's through multidisciplinary teamwork at every level of Children's Healthcare of Atlanta and with the families that we are able to achieve excellence in pediatric care.

Serving Our Patients
All patients, parents/caregivers, visitors, and employees are customers of Children's and should be treated that way. You, as a faculty/student, are an ambassador for our healthcare system, and it is important that you positively support our mission, vision, and values.

Mission: To make kids better today and healthier tomorrow

Vision: Best Care ... Healthier Kids

Values:
- Care about people
- Passionate about kids
- Dedicated to better
Relationship-Based Care

Relationship-Based Care (RBC) is the model of care for Nursing at Children's. RBC focuses healthcare delivery on three crucial relationships that are supported by and sustain a caring and healing environment. These relationships are the: (1) nurse’s relationship with patients and families, (2) nurse’s relationship with colleagues, and (3) nurse’s relationship with self. RBC at Children’s is built upon 11 guiding principles, which are illustrated below:

Nurse-Patient Relationship & Decision Making
The nurse-patient relationship is the foundation of patient care. The nurse is the primary patient advocate and facilitates decision-making to ensure a comprehensive plan of care. This is achieved through RBC Primary Nursing.

Work Allocation/Patient Assignment
Staff scheduling supports the continuity of relationships for care providers and patients. Patient assignments are patient-centered and promote the continuum of care. Coordination of care is driven by the priorities of patient’s unique needs. The RN is responsible for all aspects of the assigned patient’s care, whether rendered personally or delegated to others. Activities may be delegated to LPNs, PCTs, Lab Techs, Social Services, Child Life, etc. The designee should be competent, and delegated duties are based on demonstrated skill and scope of designee. The RN is responsible for monitoring documentation and accuracy of delegated care. Care that is delegated to an unlicensed provider should not require nursing judgment.
Communication & Teamwork
All healthcare team members clearly communicate roles and responsibilities. Healthcare team members communicate pertinent information choosing the appropriate venue to match the need or intent. Healthcare team members build a culture of mutual respect and trust that fosters teamwork across the system.

Primary Nursing
The care delivery system chosen for our nursing areas at Children's is Primary Nursing. With Primary Nursing, a therapeutic relationship is established between an RN and an individual patient and family. Within the relationship, the nurse has the responsibility to identify the patient’s unique health needs and to communicate and coordinate those needs with other members of the health care team. The relationship is initiated by the nurse and is in effect for the length of the patient’s stay in a room, department or unit. One of the hallmarks of the primary nursing role is the clarity with which RN’s accept responsibility for decision-making regarding the patient’s care. Another hallmark is that once the nurse-patient relationship is established, it is known to the patient, family, physician and other members of the team.

Primary Nursing in its traditional form typically assigns patient’s to primary and associate nurses for a length of stay and subsequent visits. Even though this traditional approach of patient assignment may not seem applicable to all environments, Primary Nursing as part of Relationship-Based Care allows nurses in all settings to apply primary nursing principles in innovative ways that leverage the therapeutic relationship between the nurse, the patient and family, and create a caring and healing environment. Primary Nursing fits perfectly in all settings because no matter where a patient receives care at Children's, the nurse's role is always to establish a therapeutic relationship, identify the patient’s unique health needs and to communicate and coordinate those needs with other members of the health care team.

In the out-patient or ambulatory settings, it is important for nurses to understand that while the patients they see each day are episodic, caregivers must take time to connect with patients and families. These connections are no less important to the patients and families than the longer term relationships established by an in-patient nurse. In the out-patient setting, it isn't so much about the nurse’s primary assignments of patients, but rather how to have a therapeutic relationship in a short amount of time. It is finding creative ways to clarify caregiver roles so that all parties know who is responsible for what. This can be done in a number of ways:

- Staff picture board visible for patients and families
- When possible, have the same nurse care for that child and family during their entire length of their visit, especially during procedures
- Staff biographies posted for patients and families.

Actions to Support the Nurse-Patient Relationship
The following actions are taken to ensure the nurse-patient relationship:
1. There is a clear assignment of nurses to patients.
2. The nurse accepts full responsibility for coordinating the patient’s care during an assigned period of time (this may be days, weeks, a shift, or the period of time it takes to perform a function such as triage, preop, etc.).
3. The nurse is accountable for all aspects of his or her assigned patient’s care, whether that care is rendered personally or delegated to others.
4. The nurse demonstrates WE CARE behaviors with patients and families:

<table>
<thead>
<tr>
<th>W</th>
<th>Who am I? “I will be caring for you today.”</th>
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<tbody>
<tr>
<td>E</td>
<td>Explain your role in the patient’s care.</td>
</tr>
<tr>
<td>C</td>
<td>Call patients and parents by their preferred name.</td>
</tr>
<tr>
<td>A</td>
<td>Advocate for the patient and Ask “why.”</td>
</tr>
<tr>
<td>R</td>
<td>Review the plan of care while sitting at the bedside. Have the patient/family create a goal for the day.</td>
</tr>
<tr>
<td>E</td>
<td>Everyone is involved in the patient’s care.</td>
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Healthcare Insurance Portability & Accountability Act (HIPAA)

HIPAA is designed to protect patient privacy and rights to control health information. Protected Health Information (PHI) is anything that identifies a patient such as name, address, phone number, account number, medical record number, Social Security number, photos, email address, etc.

A copy of the Children's Privacy Notice is provided to every parent/caregiver on admission. This booklet describes the types of uses and disclosures Children's might make of the patient's PHI, a description of the patient's rights, and how a patient might go about enforcing those rights.

As a student/faculty, you have access to confidential patient information or confidential information about the patient of the family. All information about a patient is confidential, and this information cannot be disclosed to anyone. The law provides for possible civil and criminal penalties for disclosure of confidential patient information.

For any HIPAA-related questions and issues, contact the Children's Privacy or Security office.

Your Role with HIPAA - **DO:**
- Know how to access Children's policies on Careforce for releasing PHI
- Know how to locate Children's Security and Privacy Policies on Careforce
- Secure your workstations at all times to prevent unauthorized access
- Be careful where PHI is being discussed
- Contact Medical Records anytime you have a question or request for medical records
- Use a fax coversheet when faxing information
- For computer access, use a strong password that has uppercase, lowercase, numbers, symbols – no dictionary words
- Always log out from the computer when leaving it unattended
- Always shred, or put in a shredding bin, any paperwork needing disposed of that has PHI on it
- Only access protected patient medical and financial information as needed in order to perform job responsibilities/duties
- Know mobile devices can pose a risk to patient PHI and should be secured at all times.
- Know that non-medical staff is prohibited from using personal devices to take photographs of patients for any purposes.
- Know that you can be found personally liable, fined up to $250,000 and/or imprisoned for up to 10 years if involved with a HIPAA violation.
Your Role with HIPAA - **DON'T:**

- Leave PHI out in any open area
- Discuss patient's PHI in an unsecure area
- Share your login or password to any system or application with ANYONE
- Discuss or post any patient information on any social network
- Access patient information in Children's applications if it is not for a treatment, payment, or operational purpose
- Write your password on a sticky and leave it lying around
- Take photos of patients on personal devices
- Access patient charts if you are not directly caring for that patient
Infection Prevention

All health care providers have a role in infection prevention. Your role includes:

- Hand hygiene
- Environmental infection prevention
- Vaccinations
- Dress to Protect for standard precautions and transmission-based precautions
- Provide education of infection prevention practices with patients and families

Standard Precautions

Standard Precautions apply to (1) blood, (2) all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood, (3) non-intact skin, and (4) mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Standard Precautions are used for the care of all patients, regardless of diagnosis. Standard Precautions consist of the following:

- **Hand Hygiene**: is performed before and after contact with each patient and after touching any equipment or environmental surface. Always perform hand hygiene before and after eating and drinking, after using the restroom, and after sneezing/coughing. Gloves are not a substitute for hand hygiene, and hand hygiene is to be performed after removing gloves.

- **Personal Protective Equipment (PPE)**: gloves, gowns, masks, face/eye protection. *Only wear PPE when providing direct patient care/transport. Remove PPE when in halls/nursing station. Only wear PPE during transport if patient intervention is necessary (ex. constant suctioning, bagging).*
  - **Gloves**: use when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin.
  - **Face Protection (covering eyes, nose, and mouth)**: use during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, and excretions (i.e. suctioning, patient coughing and not covering mouth).
- **Gown**: use to protect skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluid, secretions or excretions.
- **Mask**: A mask is used only once. DO NOT lower it around your neck and reuse.
- **Respiratory Hygiene/Cough Etiquette**
- **Safe Injection Practices**
  - Single use needles for each injection
  - Single dose vials; Multi-dose vials may be used on single patients only
- **Special Lumbar Puncture Practices**
  - Discard all uncontained (uncontained means not in a cart, closed cabinet or drawer) patient supplies and linen in room at time of discharge.

**Soiled linen**: Used linen is considered infectious and cannot be placed on the floor or other room surfaces. Discard directly into blue linen bags/linen containers and avoid overfilling.

**Sharps container**: Sharps (needles, IV catheters, broken ampoules) must be discarded in the sharps containers. Be sure sharp is completely inside box. Avoid overfilling ("full: is at fill line level").

**Beverages**: Covered beverages are allowed at clinical workstations. Staff are not allowed to eat/leave food in clinical areas, clinical work stations, or patient bedsides.

**Stuffed animals**: Stuffed toys cannot be properly cleaned and are not appropriate to share between patients or as a decorative display in clinical and open public areas within reach of a child.

**Red biohazard container**: Place waste in the appropriate container. Red biohazard trash is for biohazard materials only. Regular trash is for everything else.

**Hand Hygiene**
Proper hand hygiene is the single most important means of preventing infection for you and others. Good hand hygiene includes:
- soap and water wash with friction for 15-20 seconds
- alcohol-based foam or gel
- no artificial nail surfaces (gels, acrylics, overlays)
- nails should not extend ¼ inch past end of finger

Gloves are NOT a replacement for hand hygiene. You should always perform hand hygiene AFTER glove removal. Hand hygiene is:
- Performed before PPE
- After contact with blood, body fluids, secretions, contaminated items
- Immediately after removing PPE
Before and after patient contact
After contact with the patient’s environment (to avoid transfer of microorganisms to other patients or environments)
Between “dirty and clean” tasks during patient care (e.g. changing diaper then flushing IV)

Your 5 moments for HAND HYGIENE

Hand washing with soap and water (instead of alcohol-based products) should be done:
- After using the restroom or when your hands have body fluids on them. Alcohol doesn’t work well for protein-containing body fluids.
- When hands are visibly soiled. Soap and water cleans, while alcohol disinfects.
- When patients have Clostridium difficile (C. diff)

Environmental Cleaning
Effective surface cleaning is one of the most important ways to prevent and control infections. High touch surfaces can be a continuous source of transmission if no regular preventive surface cleaning is performed. Examples of high touch surfaces include computer key boards, bedrails, telephones, light switches, remote controls, monitors, ventilators, employee badges, and door handles. Super Sani-Cloth wipes are the product used to clean these surfaces. There is a 2-minute “kill” time, with no fanning or blowing to speed drying. Gloves should be worn for repeated or extended use/handling of the wipes but are not necessary for quick use.

Immunizations
Students and faculty must meet the same immunization requirements as our employees (see Health Screen Requirements Form Exhibit C). Protect yourself, your family, and our patients from:
- MMR (Measles, Mumps, & Rubella)
- Hepatitis
- Varicella (Chickenpox)
- Tdap (Tetanus and Pertussis)
- Influenza (the flu)
- Tuberculosis (TB)
Respiratory Etiquette
Hospitals are a breeding ground for viruses. Cover YOUR cough/sneeze with your elbow, sleeve, or tissue. Practice hand hygiene after coughing, sneezing, or blowing your nose. Students and faculty are asked to stay at home if experiencing illness symptoms. Symptomatic patients with acute respiratory illness (rhinorrhea, nasal congestion, sore throat, cough) should wear a surgical/procedure mask when outside their room, as well as any symptomatic parents and siblings. There are visitation limits during respiratory season, which is typically between October 1 - April 1, as deemed by Infection Prevention and Epidemiology.

Transmission-Based Precautions
Isolation is used for all patients with suspected or known infections. Training in isolation technique is required if entering room. Door signs indicate a patient in isolation and the type of precautions. Keep doors on isolation rooms closed to enhance communication. Parents of patients in isolation should be counseled not to visit other patient rooms, and they should be taught appropriate hand hygiene for isolation type.
Faculty/Student Orientation

Fire, Safety, and Security

The purpose of the safety program at Children's is to ensure a safe environment for all patients, visitors, staff, and students.

Safety Guidelines
Children's uses a code system to alert staff, students, and volunteers of emergencies throughout the facility. To notify an operator of an emergency situation within the hospitals, dial ext. 5-6161. Be sure to give the location and type of emergency. Dial 911 if you are located at any of the other Children’s facilities (ambulatory care, off-site locations, Tullie Office Park).

Your Part in Remaining Safe
- Always be alert
- Always wear your Children's and school's student ID badges
- Report suspicious persons to Security
- Protect and secure your valuables
- Security escorts are available 24/7

Needle Stick Exposure or Mucous Membrane Exposure
All persons (Children's staff, any other health care worker including students, and any visitor) who experience any kind of sharps, percutaneous, or mucous membrane exposure to blood and/or other body fluids, have prolonged direct contact with blood over a large area of the body, and/or receive or administer mouth-to-mouth-resuscitation should notify the charge nurse, clinical instructor, and call the Needle Stick/Mucous Membrane Exposure Hotline at 404-785-7777.

Workplace Violence
Workplace violence can be physical assault, aggressive behavior meant to intimidate, and verbally abusive behavior. It can be perpetrated by employees, family members, spouses, patients, and parents. All incidents of workplace violence should be reported to Security immediately.

Visitation
Visitors other than parents and guardians are asked to comply with Children's visiting hours of 8:30am to 8:30am (other more limited hours may be in place in the ICUs and other critical care areas). Visitors under the age of 10 years are required to submit to screening for infectious diseases. Visitors, other than parents and guardians, who are in our facilities after “normal” visiting hours are required to register with Security and wear an ID badge. Individuals who are convicted of crimes that require them to register under Georgia’s Sexual Offender Registry laws (42-1-12) are prohibited from being in a place where children
"congregate" or are in a "Child Care Facility." Therefore, they could be guilty of violating the law by coming into our facilities. If you suspect or have reason to believe an individual may be a registered sex offender, contact the Security department immediately. We have a process in place to determine if an individual is a registered sex offender.

**Emergencies**

Every department has a policy and procedure manual containing instructions for staff, students, and volunteers to follow in a variety of emergency situations. You may check with the supervisor for each area you are assigned for emergency procedures. It is important for you to familiarize yourself with the different codes and the appropriate way to respond to each.

**Emergency Codes**

- **Evacuation**: follow the directions of the supervisor or charge person
- **Code Red**: fire or smoke emergency. Perform RACE and PASS procedure and follow charge person instructions.
- **Code Blue**: cardiac or respiratory arrest. Activate code blue button (patient's room/nursing station), dial emergency number, and/or call for help.
- **Code Green**: internal or external disaster. Follow charge person instructions.
- **Code Yellow**: bomb threat or actual bomb. Remain calm and report information using emergency number.
- **Code Pink**: kidnapping or missing child. Dial emergency number and report information.
- **Code Silver**: active shooter/hostage taken. Dial emergency number and follow charge person instructions.
- **MSDS**: Material Safety Data Sheets give detailed information about hazardous chemicals and their safe use. Located on each unit and on Careforce.

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When a fire alarm is activated, the operator announces a Code Red. This is followed by the location of the alarm. If the fire is not in your area, move to the nearest hallway and await further instructions from the staff. When the alarm stops and the "all clear" announcement are made, you may return to your regular activity. If you discover a fire, follow the below procedures:

- **R** Rescue anyone in danger
- **A** Activate the fire alarm at a pull station and dial ext. 5-6161 inside the hospital, dial 911 at any of the other Children's facilities
- **C** Contain the smoke and fire by closing the doors
- **E** Extinguish the fire if possible. If not, evacuate the area.

Fire alarm boxes are located next to every fire exit and the stairwell. Fire extinguishers are located in hallway cabinets, fire hose cabinets, and in some offices. Know the location of the nearest fire alarm to your work area.
To operate a fire extinguisher, follow the instructions on the label:

- **P** Pull the pin
- **A** Aim hose at the source of the flames (blue part of flame is hottest)
- **S** Squeeze the handle
- **S** Sweep the nozzle from side-to-side

If the fire will not extinguish, evacuate the area and close the door behind you. Security and fire department personnel will respond to the area. Direct them to the location of the fire.

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**Code Blue: Medical Emergency**

Code Blue designates an internal cardiac or respiratory arrest. Children’s has a Code Team that will respond to this code and assume responsibility for continued delivery of cardiopulmonary resuscitation. If you encounter anyone who is breathless and/or pulseless, please alert staff immediately by activating the code blue button (patient’s room/nurse's station), dialing the emergency number, and/or calling for help. Basic Life Support (BLS) is initiated by any health care provider with current CPR training upon discovery of an individual who is breathless and/or pulseless. BLS is not initiated in any patient who has a “DO NOT RESUSCITATE” order written and placed in the patient’s chart. A Code Blue can be called for an impending arrest when the skills of the Code Team are needed to appropriately manage the patient and prevent an actual respiratory/cardiac arrest.

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**Code Green - Mass Casualty Incident**

Code Green designates an internal or external disaster that results in multiple casualties needing emergency care. Each department has assigned responsibilities during a Code Green. During a Code Green, report to your instructor or preceptor immediately to find out how to help.

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**Code Yellow - Bomb Threat**

Code Yellow designates a bomb threat. If you receive a call relating to a bomb threat, proceed carefully and follow the protocol listed:

- Attempt to keep caller on the line as long as possible
- Ask the caller to repeat the message
- Write down the exact message
- Ask for the location of the bomb and time it will explode
- Ask the caller, "Why did you plant the bomb here?"

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**Code Pink - Kidnapping or Missing Patient**

Code Pink designates a kidnapping or missing patient situation. Students should report to your instructor or preceptor immediately to find out how to help.

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**Code Silver - Active Shooter and/or Hostage Taken**

Code Silver designates situations where hostile person(s) with weapon(s) are posing a threat or have taken hostages. Upon hearing a Code Silver overhead page, “Shelter in Place” procedures will be initiated. DO NOT go to the areas specified in the Code Silver. "Shelter in Place" procedures include:
• Moving into a nearby room that can be locked; if not locked, barricade the door with furniture.
• Remain calm and encourage others to stay within the secured area/department
• Close all blinds, turn out all lights, silence all phones, and remain quiet
• Listen for additional overhead page announcements and follow procedures after the announcements are made
• Wait for the "Code All Clear" overhead pages before resuming normal operations
Faculty/Student Orientation

Compliance

The Children’s Compliance program focuses on the prevention of fraud and abuse in federal, state, and private healthcare plans. All health care providers and volunteers are expected to report any perceived or potential violation of the law. The Standards of Conduct or our policies and procedures can be found on Careforce or by calling the toll-free Compliance Line at 1-877-373-0126. The 12 Standards of Conduct are based on our core values:

1. Quality of Care
2. Compliance with Laws and Regulations
3. Billing and Coding
4. Protection of Property
5. Conflicts of Interest
6. Employee Responsibility
7. Health and Safety
8. Human Resources
9. Non-Retaliation Policy
10. Compliance Reporting
11. Professional Staff Responsibility
12. Physician Contracting

Fraud, Waste, and Abuse
The Federal and State False Claims Acts prohibit knowingly submitting claims that contain or make use of a false statement on a claim submitted for payment. Mistakes in coding and billing, even unintentional, can have negative consequences for Children’s including fines, penalties, criminal prosecution, and exclusion from participating in Medicare and Medicaid.

Gifts
Gifts pose a risk for conflict of interest or fraud and/or abuse related to Anti-Kickback laws and regulations. Children’s Policy 1.11 on gifts states that:

- A health care provider may never receive cash gifts or cash equivalents, such as gift cards, gift certificates, or tickets to music or sporting events from patients or their families.
- An health care provider is prohibited from soliciting gifts
- An health care provider may never accept gifts in exchange for obtaining or retaining a contract with Children’s

YOUR Compliance Obligation
If you have knowledge of or, in good faith, suspect any wrongdoing, immediately notify the person in charge, Human Resources, or the Compliance Office. Retaliation or reprisal against anyone for such a report is strictly prohibited.
Child Abuse

As a pediatric health care provider, you are a mandated reporter for suspected child abuse, neglect, or exploitation. If you have cause to believe or suspect a child has been abused, contact the Social Work Department immediately. They are on call 24 hours a day, 7 days a week. The social worker will conduct an assessment and make any needed reports to appropriate outside agencies. If you make a report in good faith, you are immune from both criminal and civil liability. Failing to make a report can cause you to be found guilty of a misdemeanor.

Forms of Abuse

- **Neglect** – failing to provide for a child’s needs for shelter, nutrition, medical care, education, etc.
- **Physical** – hitting, biting, burning, kicking, etc.
- **Sexual** – enticing or coercing a child to engage in sexual acts, exhibiting genitals, or forcing a child to witness sexual activities
- **Emotional** – constant criticism, threats, rejection; withholding love, support, or guidance. Often seen as an indicator of other types of abuse.
- **Munchausen by Proxy** – deliberately making a child sick or convincing medical personnel that a child is sick. (Includes exaggerating, fabricating, or inducing symptoms)

Possible Signs of Abuse

Often the BEST indication of possible abuse is if the history provided by caretaker or child is inconsistent with the injury or developmental level of the child, and/or the history changes over time or when told to different medical providers or hospital personnel. Suspect possible abuse if you care for a patient with:

- Unexplained bruises, bruises or welts that resemble objects, bruises in multiple stages of healing, fractures
- Fractures (particularly skull injuries of any kind) in infants under 1 year of age- 50% of fractures under age 1 are the result of abuse
- Burns that show a uniform depth of burn and a distinct border, burns with a sock or glove-like appearance, overlapping burns
- Behavioral changes- the child suddenly is afraid of a person or place, begins to do badly in school or act out. Includes regression to previously outgrown behaviors such as bedwetting, thumb sucking, or baby talk.
- Redness, irritation or infection of the genital area or anus, STIs, pregnancy
- Depression, eating disorders, self-injurious behavior, suicide attempts
- Caretaker delays in seeking medical attention for a child
Commercial Sexual Exploitation of Children (CSEC)
This is the newest acknowledged form of child abuse and occurs as sexual abuse accompanied by exchange of cash or other things of value to the child or a third person. There are approximately 400 female victims in Georgia each month. Boys and transgender youth can also be victims. CSEC is also known as "prostitution of children" and "domestic minor sex trafficking." Possible signs of CSEC include:

- Child is accompanied by a dominating, older, unrelated adult (male or female)
- Adult insists on speaking for child
- Child acts fearful/submissive or hostile toward adults
- May not be able to present identification
- Tattoos of someone's name or nickname
- History of multiple STIs or pregnancies
- Acute medical concern such as rape, drug intoxication/withdrawal, or serious injury
- May show signs of physical abuse
Impact of Illness

Children usually develop in a predictable, consistent pattern. However, each child is an individual and will "set his own pace" in accomplishing developmental milestones. Care providers need to pay attention to each individual child's abilities and strengths, building on these factors while working and playing with the child. Care providers can teach parents how to best support and promote their child's development. Children progress through developmental phases, which encompass physical, emotional, and cognitive tasks. If a child becomes developmentally delayed during illness or injury, catch up can usually occur without significant long-term problems.

Role of the Family
The child needs continual support during hospitalization. One of the biggest challenges to providing normalization for the hospitalized child is maintaining a level of involvement of the family. Siblings play an important role in the development of their brother or sister, and vice versa. Siblings, as well as the hospitalized child, have similar emotional and behavioral adjustments and reactions to hospitalization. Parents may need help in understanding these behavior changes.

Effect of Illness and Injury
Attention must be paid to the emotional and psychosocial support of the child, including pain management. Establishing trust and assessing individual abilities are critical prior to planning and implementing care interventions. The impact of illness on the development of the child has the potential for negative consequences. Care providers should anticipate this and plan care that supports the child physically and emotionally during procedures, and provides opportunities for ongoing development.

Coping Behaviors
A child in the hospital may present some of the following behaviors:

- Regression - aggravated by hospital procedures, which may cause loss of independence
- Use of fantasy - uses escape mechanism, but may need you to be the bridge back to reality
- Denial - rejects procedures, routines, and/or illness
- Rebellion - refuses to cooperate with procedures, angry toward family and staff
- Submission - becomes passive, withdrawn, or isolated

Normalization
Normalization is a key factor in minimizing negative aspects of hospitalization. Whenever possible, provide normal and familiar experiences and environment for the child (decorate room with bright colors, provide comfort items like favorite blankie). Incorporate play and play
therapy as components of care. A child who is not given the chance to play for extended time periods will regress to earlier developmental behaviors and become sad and withdrawn.

Child Life Therapists
For the hospitalized child, a vital member of the care team is the Child Life Specialist. They provide individual and group activities which give the child a sense of normalcy, allows for play, and gives the child an outlet for the release of emotions. They also provide preparation and emotional support for procedures through medical play.

Supporting the Patient - NEONATE/INFANT
Neonates and infants are unable to verbalize their needs and feelings but can express them in other ways. Care providers must recognize changes in their behavior (type of cry, heartbeat, positioning of body) and individualize and adjust care accordingly. Ongoing needs include: security, closeness to primary care giver, and bonding. Interventions which assist in meeting these needs include:

- Reduce the amount of negative stimuli
- Speak with soothing tones
- Provide swaddling
- Position to facilitate hand to mouth contact
- Provide unlimited opportunities for sucking
- Encourage parent involvement in care
- Incorporate home rituals

Supporting the Patient - EARLY CHILDHOOD (1-5 years)
Illness, injury and hospitalization can be a frustrating experience due to lack of control over their circumstances. The early child often views procedures and hospitalization as punishment. Interventions which support the early child include:

- Incorporate home rituals
- Provide familiar objects (comfort items)
- Provide explanations in simple concrete terms shortly before interventions
- Incorporate parental support
- Limit choices to 2 when possible

Supporting the Patient - LATE CHILDHOOD (5-13 years)
When facing injury or illness, this age group may regress to dependant behaviors, relying on caregivers to do things for them they previously did for themselves. Interventions which support the late child include:

- Assure them that it is okay to cry and yell during procedures
- Proceed slowly when approaching child
- Avoid using terms “good boy” or “good girl”, instead use “good job!”
- Explain unfamiliar machines and noises
- Set limits on behaviors up front
- Include explanations of what child might smell, see, and feel during procedures
- Avoid talking about the child or other patients where they can hear
- Allow time to socialize with peers
- Allow choices when possible
- Encourage discussion of feelings
- Reassure patient that body is intact

Supporting the Patient - ADOLESCENT (13-17 years)
This age group works towards establishing independence from their parents. Concerns are related to body image, sexuality, peer groups, and intimate relationships. They have a strong tendency to identify with one or two individuals, rather than a group. Interventions which support the adolescent include:
- Provide privacy
- Encourage visits with peers
- Promise only what you can deliver
- Allow for discussions of feelings
- Reassure that body is intact
- Use clear and precise explanations
- Allow choices when possible

Supporting the Patient - ADULT (over 17 years)
Children's provides care for patients ages birth to 21 years. For the adult patient over 17 years of age, a healthcare experience or illness can have very different social and emotional effects. They must be given the opportunity and authority to make point of are decisions when possible. It can be very unsettling for an adult to be a patient in a pediatric hospital. Remember that just as each child has his own way of coping with stressful situations, the same applies for an adult. Treat each patient as an individual. Questions to keep in mind when dealing with the adult patient include:
- Is the patient employed and missing work?
- Is this patient a parent?
- Is the patient married?
- Are there transportation issues?
- Does the patient have advanced directives?

Interventions which support the adult include:
- Provide adequate privacy
- Involve in care decisions
- Keep therapeutic boundaries with the health care team
- Give choices whenever possible to foster independence
- Refer for individual, family, marital or crisis counseling
- Prepare well in advance for procedures as adults need time to ask questions
Risk Management

Risk management is a combination of proactive and reactive functions. This is accomplished by the prevention and reduction of injury and/or damage to patients, visitors, and property. Risk management involves investigation and loss control involving occurrences, accidents, serious adverse events, and near misses.

Everybody is a risk manager for identifying concerns, as we strive to provide a warm, caring, and safe environment. It is the responsibility of all employees, students, and professional staff to participate in risk management efforts by working safely, identifying and reporting events, and alleviating conditions or practices that may cause injury, property damage, or financial losses.

Risk Point
A risk point is a specific place in a process or system that is susceptible to error or system breakdown.

Sentinel Event
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, not related to the natural course of the patient's illness or underlying condition, or risk thereof.

Occurrence Reports
An occurrence report should be completed on all incidences/occurrences. Children's uses ONS as its computerized occurrence reporting system.

Medical Record Documentation - DO Document
- Factually and objectively
- Parent's/legal guardian's disruptive behavior or non-compliance with treatment

Medical Record Documentation - DON'T Document
- Risk Management or Legal has been notified
- ONS has been submitted
- Causation, fault, or blame

Medical Abbreviations
Children's maintains a list of DO NOT USE ABBREVIATIONS. These may be found in Policy 7.34, or via the Intranet link on Careforce in Stedman's Abbreviations, Symbols and Acronyms Reference Manual.
Product/Medical Device Recalls
Children's has an established Recall Program for managing external recall notifications and safety alerts, in accordance with TJC, OSHA, FDA, and CMS regulatory requirements.

Managing Disruptive Behavior
When encountering a patient and/or family member who is disruptive, initial steps include addressing and de-escalating the disruptive behavior and possibly holding a Patient Care Conference. If the behavior continues, a Disruptive Behavior Team should be consulted. This team includes the physician, Unit Manager, Risk, Security, Social Work, Patient Representative, House Supervisor, and possibly others. One option that maybe considered by the Team is an Individual Behavior Contract (IBC). When there is a perceived imminent threat, contact Security. If a parent/legal guardian is removed, the need to continue the ban will be review every 24-72 hours. The results will be shared with the parent/legal guardian and documented in the medical record.

Patient Representatives
Health care providers who become aware of any complaint should work to immediately resolve the concern whenever possible. If the concern is not resolved, or the patient requests the concern be handled through the formal grievance process, staff should promptly refer the issue to the campus patient representative. Patient Representatives serve as a point of contact and liaison between patients, families, medical staff, and the organization for patient complaints and grievances. Feedback from patients and families is utilized to continually improve the patient and family experience. What is considered a “grievance”?• A written complaint regarding patient care, abuse or neglect, compliance with CMS conditions of Participation, or a Medicare beneficiary billing complaint
• Written complaints are always considered a grievance, whether from an inpatient, outpatient or a patient that has been discharged
• A verbal complaint regarding patient care that is not resolved by staff at the time of the complaint
• When the patient/parent/legal guardian requests that their complaint be handled through the formal grievance process
Faculty/Student Orientation

Medication & Pharmacy Services

Medication Safety
- Identify your patient using 2 patient identifiers (name and medical record number).
- If you don’t know what it is or what it’s for... look it up.
- If you are needing more than 2 of something... re-check your dose and calculations.
- Always have your high alert drugs double checked and co-signed.
- Don’t ignore clinical advisories.
- Use guardrails on pumps.

5 Rights
The caregiver reviews the medication label and product for consistency and accuracy for:

![Five Rights Diagram]

Gaining Cooperation
Getting a toddler to take medicine can be challenging! Factors for success include the child’s ability to cooperate, age/growth/development, their previous experience with various medication routes, and your approach. Here are some tips on gaining cooperation for medication administration:
- Prepare children based on their developmental level
- Incorporate play
- Offer choices
- Be honest
- Be firm
- Expect success and communicate that to patient and caregivers.
Oral Medications
- Determine how patient best takes/likes medicine: liquid... pills... crushed??
- Commercially prepared elixirs are the safest form
- Meds should not be mixed with essential foods or in a bottle with formula
- Use syringes for small amounts, up to 2 tsp (10cc) and plastic medicine cups for larger doses
- Empty gel-caps are available from pharmacy

IM Injections
Remember to utilize behavioral and pharmacologic interventions for needle pain. When the volume of an IM injection dose exceeds the recommend Max volume for IM injection (see chart below), the pharmacy will dispense the dose in multiple labeled syringes.

<p>| Maximum Volume For IM Injection |</p>
<table>
<thead>
<tr>
<th>Age</th>
<th>Max IM Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant/Toddler</td>
<td>1 mL</td>
</tr>
<tr>
<td>3 – 6 yrs</td>
<td>1.5 mL</td>
</tr>
<tr>
<td>6 -15 yrs</td>
<td>2 mL</td>
</tr>
<tr>
<td>15 yrs - adult</td>
<td>2.5 mL</td>
</tr>
</tbody>
</table>

SQ Injections
SQ injections are utilized for the following:
- Small doses, usually under 0.5mL
- Non-irritating medications
- Heparin, Insulin, allergy shots
- Small syringe and needle. Usually 1mL syringe with 25g needle 5/8"

Be sure to alternate sites and locations for SQ injections.

Pharmacy Services
Pharmacy services within the main hospitals are available 24 hours per day, 7 days per week, and are provide valuable support in the clinical area for the following:
- Drug information
- Scheduling of drug levels
- Pharmacokinetics
- Medication errors
- Potential drug interactions

It is also important to know and how to access available resources when administering medications. Pediatric Dosing handbooks, Children's Formulary of Accepted Drugs (online), Lexicomp Clinical Reference Library (online), and Micromedex (online) are available, as well as the pharmacist.
Faculty/Student Orientation

Family-Centered Care

We know there is more to treating a child than just superior clinical care. At Children’s, we treat the whole child—and the whole family—by caring for their mental, developmental, spiritual, and emotional needs. The focus of the caregiver team is on the impact of chronic disorders and easing the pressure on patients, siblings and parents while in the hospital and after they have returned home. As a result, Children’s offers:

- 24-hour family visitation, including the Intensive Care Units
- In-hospital playrooms so children can enjoy time with siblings and other children
- In-room sleeping sofas so a parent can always be close
- Local accommodations through the Mason House and Ronald McDonald houses for extended stays
- Sleep rooms, showers, business centers, and other in-hospital amenities for family members
- Events and camps that give patients a chance to do the things other children do—such as swimming, arts and crafts, and team sports
- Programs that give teenagers opportunities to discuss issues and socialize with other teens
- Interactive, closed-circuit, children’s TV programs
- Family support groups for many specialties, including asthma, cancer and blood disorders, cardiac, diabetes and transplant
- An accredited hospital-based school program that helps children complete school assignments and keep up with classes
- The Big Apple Circus Clown Care SM Unit, which administers a healthy dose of laughter to patients, families and visitors

Our dedication to family-centered care means parents become partners in their child’s healing. Families are supported by a multidisciplinary team that includes: nurses, physicians, social workers, therapists, nutritionists, interpreters, pharmacists, chaplains, child life specialists, and teachers.

Elements of Family-Centered Care

Family-Centered Care contains the following elements:

- **Knows the family is the constant in the child’s life while the health care team and services come and go.** The health care team does this by (1) seeking input from the parents since they know their child best, (2) letting parents help with the child’s care and (3) showing parents how to care for the child

- **Works together with parents as a team at all levels in caring for the child, making policies, creating programs, and sharing ideas on how to create better services.** The health care team does this by (1) meeting with the parents to share concerns and
ideas to create the best plan of care for the patient, (2) using the Parent Advisory Board to find out what parents want and need when they are in a health care setting, and (3) working with parents to put together family weekends and events that allow time for parent-parent and parent-staff support

- **Honors each patient and family member no matter their race, culture, income level, and heritage.** The health care team does this by (1) treating each child and family member the same, (2) making resources available to all families, and (3) asking each family how can we make their stay better and easier for them.

- **Gives open and honest information to parents about their child’s care.** The health care team does this by (1) talking openly with the parent about the child’s care plan, (2) answering questions, and (3) showing parents the “Patient and Parent Rights and Responsibilities.”

- **Recognizes each family has its own strengths and ways of coping with stress and change.** The health care team does this by finding the good things about each child and family, learning what helps a family cope, and through telling families about Child Life, Pastoral Care, and Social Work.

- **Provides help to families to meet their emotional, financial, and spiritual needs.** The health care team does this by (1) letting parents sleep with their child and/or finding parents a place to sleep, (2) helping parents when they do not have money for a meal or a bus pass, and (3) showing parents where the chapel is.

- **Provides services that meet the developmental needs of all age groups.** The health care team does this by (1) learning about the “Impact of Illness” and ways to help each age group cope, (2) teaching the child about what they will see, hear, feel, taste, and smell, and (3) finding out what each child likes to play with.

- **Assures that the health care system is meeting the needs of the patients and families.** The health care team does this by (1) learning the Patient and Family Rights (2) getting the Patient Representatives to help a family when they feel the health care system is not meeting their needs, and (3) asking the families what do they need.

### Role of the Caregiver

1. **Build trust between you and the child by:**
   - Knock on the door before going in his room
   - Call the child by name
   - Find out what the child likes to play with
   - Give the child time to play
   - Offer choices when there is a choice (“Do you want me to use your left arm or right?” instead of, “Can I take your blood pressure?”)
   - Follow through with promises
   - Tell the child what you are going to do before you do it
   - Let the child know it is okay to cry

2. **Involve the family in the child’s care (they know their child best!) by:**
   - Teach the parent how to help with the child’s treatment
   - Let a parent comfort their child during a procedure
   - Tell parents about the garden, playroom, school room, and library
• Give the brother or sister a job to help the child (color a picture, tell a story, hold a hand)
• Answer questions
• Let the child talk to their parent on the phone
• Help the child write a story about their day to share with their parent

3. Help make the medical experience positive by:
• Send the child to the playroom
• Bring the child a toy from the playroom
• Have the family bring toys, books, clothes and pictures from home
• Point out how the child is helping (i.e. “You did a great job holding still!” or “You helped your body when you took a big breath!”)
• Let the child know crying is okay
• Let the child know it is okay to not like the hospital
• Give the child a job they like

Cultural Competence
Every culture enriches our lives with its own unique beauty and wisdom. Yet we all share the same hopes and dreams, the same need for love and home and kinship. These are the common threads that bind us together as one family in one world. Culture is defined as shared values, patterns, norms, meaning, and knowledge, traditions, customs, art history, folklore and behavior of a certain group. Ethnicity is what ties us to a group such as race, nationality, and language. As health care workers, you should:

1. Accept and respect different cultures
2. Be aware of how the differences can influence how we work with patients
3. Create ways to meet the cultural needs of our patients
4. Utilize approved culturally-appropriate resources and available tools within Children's

Communication
To teach a family, you must be able to communicate effectively. For families with language barriers, use Translation Services, an Interpreter, or the AT&T Language Line. Do not use a child/sibling or the patient to give parents information. Think about the words you are using (“I.V.” sounds like “ivy” and “flush” is what you do to the toilette).
Pain Management

Pain is defined as: “an unpleasant sensory and emotional experience associated with actual or potential tissue damage” and "whatever the experiencing person says it is, existing whenever the experiencing person says it does."

There are many MYTHS about children and pain. Among these are:
- infants do not feel pain
- pain cannot be accurately assessed in infants
- a child who sleeps cannot be experiencing pain
- children adapt to pain and painful procedures active children are not in pain
- opioid use in infants and children is unsafe and leads to addiction

There are also many FACTS about children in pain that refute the above myths:
- infants demonstrate behavioral, physiologic, and hormonal indicators of pain
- behaviors/physiological indicators of pain can be reliably assessed
- intensity of painful experiences increases with each insult
- activity is a means of distraction and coping in children with pain
- opioid use is as safe for children as adults
- psychological dependence does not occur when opioids are used to treat pain

Pain Assessment
The assessment of pain includes 5 key points to remember:
1. pain is the 5th vital sign
2. assess for pain frequently and reassess
3. use a consistent tool for pain assessment
4. document
5. involve parents and caregivers

Treatment of Pain
In the treatment of pain in children and infants, there are some key factors to remember:
- combine medications and behavioral techniques
- know how the medications work that you are giving for pain management
- reassess and titrate
- avoid “as needed dosing”,
- educate patients and parents in regard to pain and pain management

Key Elements of Communication
When communicating, always give complete and accurate information. You will need to learn about the procedure that is going to occur, determine what information to share with the child and family, provide sensory information, explain the sequence and length of the procedure,
and monitor the accuracy of the information. When teaching families about opioids, explain to them that dosages are based on weight, address their concerns for addiction, and discuss signs and symptoms of respiratory depression. Things to include in your assessment and documentation will include the following:

- Location
- Intensity
- Quality
- Onset/Duration
- Patterns
- Expression of pain
- Relieving factors
- Causes/Effects of Pain

Center for Pain Relief
Children's has a Pain Team that consists of physicians, psychologists, and nurse practitioners. The Pain Team should be consulted for patients with unmanaged pain, when the primary care team frustrated/concerned, and/or if the patient is not making progress. The Pain Team manages all epidurals and some PCAs. Nurses can request a consultation with a physician's order. Patients are assessed by the psychologist as well as the pain medicine specialist.

Hierarchy of Pain Intensity
The hierarchy of pain intensity delineates in order the best way to determine a patient’s pain, from most significant to least significant:

1. The patient’s self-report of pain
2. Pathologic conditions or procedures that usually cause pain
3. Behaviors (facial expression, body movements, crying)
4. Report of pain from caregiver close to patient
5. Physiologic measures (BP, HR, RR)

Children's uses different assessment tools to determine pain rating. They include the following:

<table>
<thead>
<tr>
<th>Tool based on patient's age, developmental stage, level of consciousness, culture, &amp; language</th>
<th>Pain assessment tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonates</td>
<td>CRIES</td>
</tr>
<tr>
<td>Pre/Non-verbal children</td>
<td>FLACC</td>
</tr>
<tr>
<td>Pre-school/Younger school-age children</td>
<td>FACES</td>
</tr>
<tr>
<td>Older school-age/adolescents</td>
<td>Numeric Pain Rating Scale</td>
</tr>
<tr>
<td>Child unable to self-report and no appropriate pain tool available</td>
<td>APP (Assume Pain Present</td>
</tr>
</tbody>
</table>
Non-Pharmacologic Pain Management
Patients tell us that needles and procedural pain are their biggest fears. They fear tape removal. Fear intensifies their perception of pain. Below are some helpful non-pharmacologic ways to decrease pain and anxiety in the pediatric setting:

- Needles: use comfort positions and utilize needle stick pain management and behavioral interventions.
- Tape: ask about band aids. Use adhesive remover.
- Parents: parents are always welcome. Make sure to educate parents on what will happen (prevent fainting). Teach parents to distract their child.
- Being apologetic and emphatic is not necessarily helpful. Doing so increases reporting of pain and decreases coping behaviors. Rather, give the child a 'job to do' and say, "I know you can get through this. Your job is I need you to blow on this pinwheel."
- Utilize Child Life

Needle Pain Management
All patients undergoing needle sticks (i.e. new IV, port-a-cath access, PICC line insertion, IM/SQ injections) should receive pharmacologic and non-pharmacologic interventions based on standing order guidelines, their age, and their preference. Refer to the policy and procedure for the Needle Pain Management standing order guidelines.
Faculty/Student Orientation

Patient & Family Education (PFE)

Patients and families have a right and responsibility to manage their own healthcare needs. All patients and families coming in contact with our system receive quality education appropriate to their assessed needs and the care, treatment and services provided. The goal of patient education is to improve patient health outcomes, promote recovery, speed return to function (biopsychosocial), promote optimal health behavior, and involve the patient and family in the decision making process. The educational process is coordinated among care givers. Patient and family education (PFE) is based on the patient's assessed needs and abilities. It is provided by healthcare professionals to foster a better understanding of:

- The plan for care, treatment, services and discharge
- Basic health practices and safety
- The safe and effective use of medical equipment and supplies
- The safe and effective use of medication
- Pain, risks for pain, the pain assessment process, the importance of pain management and pain management techniques
- Nutrition interventions and modified diets
- Information on oral health
- Habilitation or rehabilitation techniques to help them reach the maximum independence possible
- Falls reduction strategies

Learning Needs Assessment
The Learning Needs Assessment (LNA) is the first and most important step in patient education. It puts the focus on the learners (patient and family) and allows you to individualize your teaching. Performing a learning needs assessment helps to ensure that you teach the right information in the right way. Remember to reassess learning needs often, as circumstances may change over time.

The LNA allows you to assess:
- What the patient/family wants and needs to learn
- What the patient/family knows already
- How the patient/family learns best

The LNA also allows you to assess for factors that may require special adaptations in order for learning to occur, such as:
- Language, cultural, and religious needs
- Emotional readiness
- Reading ability
- Financial concerns
Cultural Competence
Children’s is a culturally diverse organization. Use the Kleinman questions to assess cultural needs that relate to care and education:
- What do you call your child’s illness?
- What do you think caused it?
- Why do you think it started when it did?
- What do you think the illness does to your child?
- What are the chief problems it causes?
- How severe is the illness? Will it last a long time or will it be better soon?
- What do you fear most about your child’s illness?
- What kind of treatment would you like to have for your child?
- What are the most important results that you hope to get from your child’s treatment?

Literacy Screening
You can use the SILS (Single Item Literacy Screen) as part of a complete biopsychosocial assessment in order to provide clues to poor health literacy skills. Ask the following question:

"How often do you need someone to help you when you read instructions, pamphlets, or other written materials from your doctor, nurse, therapist, or pharmacist?"

1. Never  
2. Rarely  
3. Sometimes  
4. Often  
5. Always

Scores higher than 2 indicate that there may be some difficulty with reading health-related materials.

Teaching Tips
Use active listening skills to gather information from the patient/family. Teach based on the Learning Needs Assessment (LNA). Chunk information and repeat new or difficult information often.
- Adults can remember 6-8 things at a time.
- They can remember only 1-3 things at a time when stressed (like in a medical setting).

Use age-appropriate techniques when teaching kids, such as dolls, picture books, and medical play. Use plain, conversational language and concrete terms and ideas. Active, hands-on learning techniques are helpful using teaching dolls, kits, games, and models. Reinforce your teaching with illustrations, written materials, and videos.

Evaluate Learning
Remember that there is a big difference between teaching and learning. Ask for feedback in a non-threatening manner and evaluate often. The hallmark of learning is a behavior change: "Can the patient/family self manage?" To evaluate whether learning occurred:
• Use "teach-back" - ask the learner to teach back and repeat information using his or her own words.
• Use "show-me" - watch the learner do a return demonstration of a skill he or she has learned.
• Use "open-ended" questions.
• Create a scenario – talk about a problem that could occur and ask them what they'd do in the event that it occurs at home.

Documentation
Communicate learning status to the entire interdisciplinary team, as appropriate. Document your teaching, any resources used, and the patient/family's response (i.e. did they "get it" or do they need more instruction) within the medical record. Provide plainly written discharge instructions for use at home.
IV Therapy

Children are special individuals with their own needs. As they enter the hospital setting, many tests and procedures are done which are different to them and at times invasive. As a caregiver, it is your responsibility to help the patients feel at ease, to have patience with them, and to use our resources when available (i.e., Child Life, Vascular Access Team). Prior to initiating an IV, the caregiver should always communicate what the procedure may entail using appropriate terminology and support measures.

Types of IV Lines

- Peripheral
- CVL
  - Implanted Ports
  - Peripherally Inserted Central Catheters (PICC)
- Intraosseus

Preparation and Pain Management

Behavioral and pharmacologic interventions should be combined in an effort to relieve anxiety and pain. **Behavioral Interventions** consist of the following:

- Parental presence is comforting to children and should be promoted whenever possible
- Be honest – explain in simple language what the child will see, hear, taste, smell and feel, using words, pictures and dolls
- Treatment rooms, if available, should be used for venipuncture so that patients can rest and relax in their bed. The patient room/bed should be a safe zone.
- Utilize "Positioning for Comfort" – a therapeutic approach to positioning children for painful procedures, which aims to minimize a child's feelings of helplessness and vulnerability while promoting feelings of security and control
- Provide choices and give the patient a 'job' to do.
- Encourage the patient to express feelings. For example, tell the child that "it's ok to cry, and your most important job is to keep your hand still."
- Provide praise and direction. For example, "I want you to blow these bubbles" or "Good job holding your arm still!"
- Use one voice in the room. Multiple voices or people speaking will increase anxiety and confusion.

**Pharmacologic Interventions** consist of utilizing the Children's policy and procedure for "Needle Pain Management Standing Orders" and referring to the "Needle Pain Management Poster" in selecting and using the appropriate topical therapy.

**IV Safety**

IV Safety consists of the following:
- Teach the patient/parents/caregiver about the signs and symptoms of PIV infiltrate
- Encourage them to communicate concerns to you quickly
- Utilize the "TLC" Poster found in patient rooms
- PIV will be assessed even if the child is sleeping
IV Therapy

**PIV Basics**
- Wear gloves with all PIV entries
- Utilize pain management strategies
- 3 sticks and you’re out
- Check site q 1 hr
- Prep with CHG using a 30/30 scrub and allow dry
- Use a securement device

**CVL Basics**
- Wear gloves with all CVL/PICC entries
- Wear mask when line is open to air
- Limit line entries
- Use 10 cc syringes
- Flush unused lines using the heparin protocol
- Assess line necessity daily
- Prep with CHG using a 30/30 scrub and allow dry
- Port-a-Cath needle-re-access every 7 days

**Reducing Blood Stream Infections (BSIs)**

**Line Access Bundle:**
- Hand hygiene and non-sterile gloves
- Scrub the hub using a CHG wipe 15/15 (15 secs scrub, 15 secs dry)
- Enter hub without contamination

**CVL Maintenance Bundle:**
- Hand hygiene & non-sterile gloves
- Sterile technique
- Appropriate dressing
- Change dressing if damp, loose or visibly soiled
- CHG prep (unless contraindicated)
- 30 second scrub/30 second dry

**PIV Infiltrate**
- Prevention
- Stop infusion and notify provider
- Remove IV unless antidote ordered
- Administer treatment
- Document and submit ONS

**IV Therapy Basics**
- Utilize growth and Development considerations
- Fluid balance record (I&O)
- Daily weights on continuous fluids
- Maintain a dry occlusive dressing
- Verify right fluid, rate and medications
- Check labels
- Wear gloves with all IV entries

**Line Maintenance**

*Perform hand hygiene*
*Put on mask & non-sterile gloves*

**Tubing** - change down to IV catheter
- Replace IV tubing with a new CVL
- IVF and tubing Q 96 hrs
- Q 24 hrs for Lipids & TPN/Albumin
- TPN Q 96 hrs

**Fluid**
- Pharmacy prepared Q 24 hrs
- All other fluids Q 96 hrs

**Injection cap change**
- Wear mask
- Vigorously scrub hub connection with CHG and let dry thoroughly
- Every tubing change/line access
- When blood is visible in cap
- Minimum Q 7 days when line not in use

*Dedicated to All Better*
Non-Sterile Gloves and Masks Required when CENTRAL LINES (CVL/PICC) are Open to Air

Spiking new IV fluid bags
Tubing and Injection Cap changes (tubing change requires tubing to be changed all the way down the line/catheter)

Non-Sterile Gloves now required for:
ALL line (Central Line and Peripheral Line) entries, including medication administration

REMEMBER: When changing injection caps, scrub the connection between the hub of the catheter and injection cap with CHG. Using aseptic technique, remove the old cap and vigorously scrub the catheter opening with a CHG wipe, and then connect the new injection cap.
Deteriorating Patient

Children’s has an active multidisciplinary team and a system initiative whose goals are to identify and manage the deteriorating patient. The Rapid Response Team and the nurse’s use of the Pediatric Early Warning Scale (PEWS) score help facilitate early assessment, identify trends, and guide/provide intervention for the deteriorating patient.

Cardiopulmonary arrest in infants and children is rarely a sudden event. Instead, it is often the end result of a progressive deterioration. There are three final pathways to pediatric arrest: respiratory, cardiovascular, and neurological.

**PEWS**

PEWS consists of using an evidence-based scoring tool to give a patient a numerical number in 3 categories: behavior, cardiovascular, and respiratory. These scores determine frequency of assessment/reassessment and interventions needed. It can help serve as a communication tool to identify trends and provides an objective snapshot of what’s going on with the patient.

**Respiratory Distress/Failure**

Respiratory distress leading to respiratory failure is the most common cause of pediatric arrest. Signs and symptoms of respiratory distress include the following:

- increased respiratory rate. Note: an elevated respiratory rate is often the first sign of respiratory distress.
- grunting
- nasal flaring
- retractions
- cyanosis
- stridor
- decreased chest expansion
- altered level of consciousness

**Cardiovascular Failure/Shock**

Cardiovascular failure or shock is the 2nd most common cause of pediatric arrest. Because pediatric shock is a “slippery slope” that is much more easily treated in the early stages, it is critical to recognize the early signs and symptoms. Early recognition and treatment of shock can prevent cell damage, organ failure, and possible death. Signs and symptoms of cardiovascular failure/shock include the following:

- Hypotension. Note: this is a late indicator.
- Poor perfusion/perfusion changes (changes in skin color, increased capillary refill time)
- Difficulty in obtaining pulse oximetry readings or lowering readings
- Tachycardia not explained by fever or agitation
- Oliguria
- Changes in mental status

**Neurological Failure**
Parents may report that the child is sleeping more than normal. A child in early neurological failure may be overly compliant for procedures such as vital signs or lab draws. The child who is not responsive to painful stimuli or doesn’t “fight back” should raise grave concern. Changes in vital signs in neurological failure are due to increased intracranial pressure (ICP). The changes include hypertension, bradycardia, and unequal pupils.

**Monitoring the Deteriorating Patient**
Any time there is concern that a patient may be deteriorating or that actual changes are rapidly occurring, the physician should be immediately notified, and the patient should be closely monitored. Utilization of other resources (e.g. Charge Nurse, House Supervisor, Rapid Response Team @ 5-TEAM, Respiratory Therapy, IV Access Decision Tree) should be initiated according to PEWS scoring and unit-based guidelines. The unstable patient should not be left unattended. Monitoring should include frequent or even continuous monitoring of vital signs and thorough documentation of observations and treatment.