



**NURSING INSTRUCTOR
ORIENTATION MANUAL**

Denver Health

Agreement and Understanding of Policy Regarding Confidentiality

Due to the nature of the service provided by Denver Health, all employees, including those working under any form of contract and/or lease and/or through a third party, have an ethical and legal responsibility to respect the confidentiality of certain information. Nothing herein shall be construed to interfere with employees first amendment rights.

Confidential information is defined as information which, when disclosed without authorization, could be prejudicial to the interest of our patients, and/or our employees, and/or Denver Health. Specifically, information pertaining to a patient's records, condition, or personal affairs, as well as information relating to personnel or patient accounts of Denver Health is considered confidential.

Confidential information must never be discussed with anyone at Denver Health who does not have a business need to know such information, or away from Denver Health, except in the line of duty. Confidential patient information may only be released in compliance with Denver Health policy, or with the patient's written consent. Discussion of confidential information should only take place with those having a defined need and/or legal right to know. No confidential information, records or materials may be used, released or discussed without the authorization and approval, as determined by, and/or in compliance with Colorado Law, or the Chief Executive Officer and Medical Director of Denver Health.

Patient records and information of any kind are considered confidential and may be released only by the Chief Executive Officer and Medical Director or other authorized Denver Health personnel in accordance with Denver Health Principles and Practices.

All media requests for information should be referred directly to the director of Public Affairs. After normal working hours the administrative representative on call should be contacted.

Failure to respect the confidentiality of the patients and/or the organization inadvertently or purposefully is a serious infraction which will be regarded as willful misconduct and may result in termination upon the first offense.

.....

I have read the Denver Health policy regarding confidentiality, understand it and agree to abide by all terms and conditions of the 'Confidentiality Policy'.

(Instructors' signature)
Or Students Signature

(Date Signed)

Please Print:

(Instructor name)
Or Students Signature

Date

11/05

FACT SHEET

FACT SHEET

WELCOME TO DENVER HEALTH MEDICAL CENTER

Welcome! We hope that you have a great experience as a clinical instructor at Denver Health (DH). This manual has been put together as a resource to you and it will hopefully answer many of the questions you may have. If at any time, we can assist you, please do not hesitate to call the Department of Nursing Education and Staff Development at (303) 436-6776.

The information in this handbook is designed to help orient you to some of Denver Health's standards and routines. In addition, it may be used as a reference when you are instructing on the units. It is important to note that:

- This information applies to most inpatient units.
- Please refer to DH policies and procedures, found on the DH Intranet called the "Pulse" for further information. Ask the unit Charge Nurse for help with this.
- All Nursing Instructors are expected to comply with DH standards of care/practice, policies and procedures. You will be working with a preceptor during your orientation. The preceptor will help you complete the competency checklists and will familiarize you with unit specific forms, equipment, and procedures.
- We are happy to have you with us. Please do not hesitate to ask questions. We hope your experience at DH is rewarding and provides an opportunity for professional growth.
- We have available to you a Nursing Student Handbook to copy and distribute to the students you will be supervising. Please review the booklet with the students. If questions arise, please ask Charge Nurse, other staff members or call the Department of Nursing Education and Staff Development at 303-436-6776.

NOTE: All material copies for the students and clinical experience should not be made using Denver Health equipment.

Denver Health Mission Statement

Provide access to quality preventive, acute, and chronic health care for all citizens of Denver regardless of their ability to pay.

Provide expert emergency medical and trauma services to Denver and the Rocky Mountain region.

Fulfill public health functions as dictated by the charter and the needs of the citizens of Denver.

Provide for the health education of patients, and to participate in the education of health care professionals.

Engage in research that enhances the health care needs of patients and the educational needs of future health care professionals.

Vision

To be the Best Public Healthcare System in the U.S.

Denver Health Values Statement

We promise to treat patients, visitors, and each other with courtesy, dignity, and respect.

We promise to solve problems through teamwork and good communication.

We promise to strive for excellence through continuous improvement and innovation.

We promise to use our time, talents, and resources responsibly and effectively.

We believe in keeping our promises.

ABOUT DENVER HEALTH

Denver Health was established over 145 years ago, with the mission to care for all citizens of the new frontier town of Denver, Colorado. Known as Denver General Hospital until 1997, it became an independent authority at that time. It is now a 398-bed, acute care, city-county Level I trauma center. Denver Health is Colorado's primary "safety net" institution. 25% of all Denver residents or 160, 000 individuals receive their health care at Denver Health.

INSTRUCTOR GUIDE

Nursing Instructor Orientation Process:

If you are new to Denver Health or a particular unit, you will be required to attend a nursing instructor orientation session. These sessions are scheduled one to two times a month throughout the year. You will be asked to complete an 8 to 12 hour clinical day on the assigned unit of your clinical rotation. You will also meet with the Clinical Placement Coordinator or designee to submit required forms and other papers later during the orientation day. Some of the required information include:

- A current resume
- A copy of your current State of Colorado nursing license
- A copy of your current CPR card
- Evidence of current OSHA safety, HIPAA, and standard precautions training
- A health waiver including TB status (Mom/baby instructors must have evidence of rubella hx)
- A roster of the students in the rotation

If you have any questions about Denver Health policies or procedures, please refer these questions to the Preceptor, Charge Nurse on the unit or the Clinical Placement Coordinator. Denver Health Policies and Procedures are posted on the DH Intranet called "The Pulse."

The nursing instructor competency checklist must be *completed and signed while with preceptor during initial orientation and reviewed annually* thereafter.

Denver Health is a *smoke-free institution*. Smoking is not permitted in the buildings or on the grounds. Please confine smoking to the Plexiglas gazebo on the north side of the employee/visitor parking structure.

Computer Access:

Computer Access is provided for Network Logon and Invision/LCR. Students will not have unsupervised access to the computer system. Nursing Instructors are responsible for student access.

Pyxis access is provided to the Nursing Instructor only. Denver Health does not provide students with independent access. Nursing Instructors are responsible for student access. Your signature on the Pyxis access form is required prior to being assigned and access code. This is done prior to each clinical rotation. Temporary access can be provided on a daily basis by the Charge Nurse. Access will be terminated at the end of the clinical rotation. If you are unfamiliar with the use of Pyxis, please contact the Department of Nursing Education and Staff Development at 303-436-6776.

Information We Need About the Students/Clinical Rotation:

Prior to the rotation, we will need to receive:

- A list of students who will be present on the units and their contact phone numbers and or email address. The students will need to have completed the requirements indicated in the Affiliation Agreement such as HIPAA and OSHA safety and standard precautions training through their school. We will need to receive the *roster, attestation letter and the clinical instructor name* in the Department of Nursing Education and Staff Development 15 days prior to the start of the clinical rotation.
- Course objectives and student responsibilities for that particular clinical experience should also be provided to share with the unit personnel.
- All students must sign a confidentiality statement. Please return this after the first clinical day or before.

Dress Code

- In direct care, inpatient care areas, please wear scrubs/ uniforms. Students must be clearly differentiated from other staff. Follow your school guidelines, and wear your school uniform/smock, etc. Scrubs/uniforms should be neat, clean, pressed and in good repair. In Outpatient areas, students may in addition to the routine attire of scrubs/uniforms may wear business casual *with* a lab coat.
- For Behavioral health rotations, neat, clean, pressed, non-provocative street clothes may be worn. You will receive further direction during your orientation to this area.
- No denim of any kind is permitted.
- If you are on campus to set up clinical assignments, we ask that you wear business casual (no jeans) and a lab coat.
- *All* tattoos are to be covered to promote sensitivity to our patients, employees and their varied values.
- Piercings are limited to two studs in each ear. *No other visible piercing decoration is permitted* (no nose or eyebrow piercings, for example). Please enforce this with your students.
- Hair must be a natural color and well groomed.
- Shoes must be close-toed, clean, well maintained and worn with hose/socks.
- Colognes, perfumes or lotions are to be lightly scented.
- Fingernails should be natural (no acrylic), clean and kept short (nail tips less than ¼"). Polish, if used, should be clear or a light color, and intact without chips or visible wear.
- You may be asked to leave the clinical area if your dress does not follow these guidelines.

Student Conduct Expectations:

- Students are to conduct themselves in a professional manner at all times.
- Gum chewing in patient care areas is not permitted.
- Food/drinks are not permitted in patient care areas.
- Refrain from social contact with patients.
- To reduce congestion and confusion at the unit desks, please limit extraneous conversations at the desk. Students should not be congregating at the unit desk, except to review their patient charts.
- Students may be asked to leave a clinical area if their actions are found detrimental to the patients.

Instructor Conduct Expectations:

- Instructors are to conduct themselves in a professional manner at all times.
- Instructors are expected to *remain with their students on the units at all times*. If makeup days are required, these days must be coordinated in advance and an instructor must be present with the student(s).
- Please do not conduct personal business, including personal cell phone use, while on the unit.
- Instructors are expected to be on the unit, interacting and supervising the students from the start of report to the exit report to the staff is completed by all students.

Identification

- Students and instructors are to **wear picture identification badges**, identifying themselves and their respective schools, at all times. Students should be clearly differentiated as students.
- Students and instructors must wear lab coats, ID badges and identify themselves to the appropriate Charge Nurses if they come in at times other than their clinical.

Illness/Injury/Infection Control

- Students who request clinical rotations and their instructors must be in good health on the days of their visits. Individuals with common upper respiratory illnesses and fever or other contagious conditions are asked to not attend the rotation or clinic on that day and return when their health problems have been resolved. Students who report with such a condition may have their experience deferred by the supervisor in the area or the DH employee who is supervising the student.
- Your assigned unit must be notified 4 hours before the start of your shift if you are unable to report for a scheduled rotation. Be sure to let your students know if there has been a change in the schedule or if the clinical has been cancelled for that day. If as an instructor, you are ill and an oriented substitute cannot be found, please reschedule your shift with your school who will contact the CNE Nursing Education/Staff Development dept (303-436-3431). **Students are not permitted to be on the units without an instructor**, except in specified precepted or observational situations.

- If you or your students are injured during your clinical rotation, follow the instructions given to you by the school. Each school has individual arrangements for student/employee injury. The DH Occupational Health and Safety Clinics are only available to Denver Health employees who are working in that capacity.
- During your visit, please *follow good hand-washing practices* and observe transmission-based precautions where applicable. Take advantage of no-cost or low-cost immunization programs available to you.

Guidelines for Clinical Practice

- Students are to communicate any changes in patient assessment or condition to the nurse responsible for the patient's care and the instructor.
- Students are not permitted to remove medical equipment, supplies or any Denver Health property (including reference books) from the Denver Health campus.
- In an emergency (COR-0) situation, observation by the student is permitted at the discretion of the Denver Health COR team leader.
- The student and the instructor may administer oral and injectable medications.
- The following medications must be verified by the instructor/unit-based RN before administration by the student: insulin, heparin, narcotics, calculated doses, IV medications.
- If a student's implementation of nursing care is determined to be unsafe, the staff RN, team leader or manager may intervene and remove the student from the bedside or care setting.

Pavilion C (Women's Health Building)

- All Units above 1st floor are locked. Access will be provided by pushing the intercom and speaking to a person who will inquire about your purpose.
 - In an emergency, follow the instructions of the unit staff.
- On the **Mom/baby and L/D units**, students may not
- transport a newborn from the nursery to a mom or vice versa. Only staff members with pink ID badges are permitted to perform this function.

On the **Pediatrics unit**, nursing students may not:

- Start IVs
- Give any medication IV push (antibiotics that may be pushed go on a syringe pump)
- Deep suction
- Catheterize

Nursing students may not:

- Administer chemotherapy
- Administer vasoactive drugs (may monitor under direct Denver Health RN supervision)
- Perform endotracheal intubation on any person
- Administer conscious sedation drugs
- Perform arterial blood gas puncture
- Give blood or blood products
- Administer IV push medications, except under the direct supervision of their nursing instructor or a Denver Health RN. No IV push medications may be administered to newborns or children.
- Administer emergency medications (i.e. in a respiratory or cardiac arrest situation).

FORMS

Documentation

- The staff RN or charge nurse can provide documentation guidelines specific to the area in which you will be working. Some general instructions include:
 - All forms are to have a patient name sticker applied to the appropriate area.
 - Place the date and time in the appropriate areas.
 - Make entries in black ink except for the kardex, where a pencil is used
 - Correct any errors by drawing a straight line through the incorrect entry. Put your initials, date and time then write the correct information.
 - Never alter patient records.
 - All corrections and late entries should be clearly marked.
 - Do not use correction fluid or correction tape

24 Hour Chart Checks (may be unit-specific)

A check of all orders written during the previous 24 hours will be done on the night shift. Please check each order against the M.A.R., the Kardex, lab slips, and computer entries. Follow up by completing any orders not completed or unconfirmed medications and indicate your name, date, and time the 24-hour check is completed. This is the minimum requirement. Some floors do checks more frequently. Please check with the Charge Nurse.

As an instructor

Please review and document your review of your students' documentation throughout the shift. A co-signature indicates that you performed whatever procedure with the student and you were actually present to observe what the student did. Please document the review of your students' documentation by signing behind the student's signature your, (Name) (Credentials), Instructor (School).

Ex: T. Novice, NS/ Mary Jones, RN, Instructor, FRCC

Student Assignments:

It is the instructor's responsibility to review patient charts and/or discuss patients with unit staff for the purpose of making student assignments. (HIPAA regulation)

Do not send students unaccompanied to the units to "choose" patients.

Do not have students call the charge nurses on the units to get information about patients for assignments.

Do not assign students to "At-Risk" patients, Policy P-1.1 which includes

- Patients with court-appointed legal guardian
- Patient who appear mentally ill stemming questions of imminent danger to self and others, gravely disabled and placed on a 72 hour Mental Health Hold.
- Patient requiring emergency commitment.
- Patients legally committed with short/long term certification posing acute danger to self or others or gravely disabled.
- Patients after suicide attempt.
- Patients with physical/mental condition that acutely increases their risk of harm to self or others and considered high risk elopement placing them at serious or life-threatening medical risk.
- Patients incapacitated resulting in a lack of sufficient understanding, diminished medical decision making ability and are high risk for elopement placing them at serious or life threatening medical risk.

Mental Health Hold sign is bright **orange** and is located inside the front of the chart. Note the expiration date and time.

Student Nurse Clinical Assignment Worksheet:

- For each clinical day (or week), a *Student Nurse Clinical Assignment Worksheet must be completed.*
- The instructor must post the Assignment Worksheet in the designated location specific to each unit. Staff members should review the assignment to have daily understanding of student's plan of action.
- You will need to list:
 - Course description and objectives
 - Knowledge/skill focus for the day/week
 - Student names
 - Assigned patient
 - Staff nurse assigned to patient

This list will be archived with other unit specific staffing information.

Evaluation Forms:

Students and instructors are given the opportunity and encouraged to provide feedback about the clinical rotation. Please return completed forms via interoffice mail to:

Department of Nursing Education and Staff Development
MC #0261

Or they may be dropped off or mailed to:
Department of Nursing Education and Staff Development
Denver Health Medical Center
777 Bannock Street MC #0261
Denver, CO 80204

CLASSROOM SPACE

In order to reserve meeting space for your pre- and post-conferences, you may call the Nursing Education and Staff Development Dept (303) 436-6776. You can also speak to the Unit CNE or Manager in the area of your clinical rotation for input.

MAINTAINING PATIENT CONFIDENTIALITY

- At all times, maintain patient confidentiality. Patients are not to be discussed in public areas like the cafeteria, hallways or elevators. Be aware of conversations and what may potentially be overheard. Follow the HIPAA guidelines you have learned about in school. HIPAA guidelines forbid the use of knowledge of present or former patients for personal gain.
- Written information about patients that is needed for care plans or projects:
 - Must not contain any type of patient identifier or Protected Health Information (PHI).
 - Patients could be numbered, for exam., but they should not be identified by name, medical record #, birthday, etc.
 - Any written material that contains Protected Health Information should be placed in the shredder bin before leaving the unit.
- Students' access to patient information is limited to assigned patients, **ONLY**, and only the information they would *need to know* to care for their own assigned patients.
- On a *behavioral health* unit, if a student knows a patient, the student must immediately notify the instructor.

If there is a breach of confidentiality, the student will be dismissed from the clinical setting and may be subject to additional disciplinary action.

SAFETY AND EMERGENCY SITUATIONS

- The code word for a fire is "Mr. Gallagher."
- The emergency number to dial to report a fire is **55** on campus. Otherwise, follow the instructions in your area.
- Fire extinguishers on all units are located near the elevators.
- The code word for security is "Dr. Quick" to alert other staff that you need security. Security may be reached by calling (303) 436-7444.
- A COR-0 is a cardiac and/or respiratory arrest. To call a COR-0, dial **55**. *Specify if it is a pediatric COR-0.* Do not dial "0" to call a COR-0. A special COR-0 team, which wears pagers responds to the COR-0 page.
- A Code White is a special protocol in response to severe obstetrical hemorrhage.
- A Code Pink designates infant or small child abduction.
 - Look for possible hiding places, move towards the exits and watch for unusual behaviors.
 - Look for someone carrying a large bag or backpack, large enough to transport a small child or baby out of the building.
 - Notify Security of possible suspicious parties.
 - Await the all clear announced over the PA system.

Review These Situations with Your Students

FIRE: Code word is "Mr. Gallagher"

Emergency Number "55"

Fire Safety Plan (R.A.C.E.) **R**emove/Rescue all personnel from immediate danger

Activate the fire alarm

Confine the fire by closing doors

Extinguish with fire extinguisher

The fire extinguisher on all the units is located near the elevators.

How to use a fire extinguisher: (P.A.S.S.) **P**ull, **A**im the nozzle, **S**queeze the handle, **S**weep the nozzle.

EVACUATION PLAN:

1. Evacuate horizontally to the next safety zone (behind the fire doors which close automatically with alarm).
2. Move the visitors and ambulatory patients first.
3. Move the wheelchair and then bed patients.
4. Evacuate vertically (down to the next floor) only when instructed by the fire department.

SECURITY: Code word is "Dr. Quick" to alert other staff that you need security.

Contact Security at (303) 436-7444

INFANT ABDUCTION PLAN: Code word is "Code Pink". Staff should look for possible hiding places, assist in notifying Security of possible suspicious parties. Await all clear.

CARDIAC ARREST/COR ZERO: Call "55" to activate COR team. The COR team can be called if a patient's status is deteriorating and you need assistance. Specify if it is a pediatric COR-0. A "code white" is another protocol used for situations in obstetrics with a delivery involving a hemorrhage.

REPORTING ON THE JOB INJURIES:

Notify the Charge Nurse of any on the job injury. An Occurrence Report must be completed. Follow your school's guidelines for reporting injuries occurring during clinical rotations.

INFECTION CONTROL:

All staff are responsible for protecting patients from acquiring infections by good hand-washing practice, use of standard precautions, proper care of equipment and helping to maintain a clean environment.

Standard precautions: Good hand-washing. Wear Personal Protective Equipment. Apply and remove at point of patient care task. Must remove before leaving the patient's room (or bedside in shared rooms). Do not eat, drink, apply makeup or lip balm, or adjust contact lenses in the patient care areas.

Transmission-based precautions include airborne, contact and droplet.

Airborne Precautions: For organisms transmitted by small droplet nuclei. Pink sign on door. Wear N95 ("duckbill" mask) particulate respirator. Keep door closed to negative-pressure room. Patient must wear surgical mask if transported.

Contact Precautions: For organisms passed on hands and environmental surfaces. Put on gown & gloves at point of task; remove after task; wash hands before leaving room. Review precautions necessary for patient transport.

Droplet Precautions: For organisms passed by large droplets, sneezed or coughed into caregivers face or onto nearby surfaces. Wear tie-on surgical mask if within 3 feet of patient.

Refer to Infection Control Manual located on all units for more information.

HAZARDOUS MATERIALS: SPIL Secure the area. Protect the persons. Inform Environmental Services. Log or document on spill incident form. MSDS information is available on any chemical used.

DISASTER RESPONSE: A disaster Manual is located on all units (red or orange notebook).

Tornado Warnings: close the curtains. Move the patients away from the windows in the hall. If the patient cannot be moved, cover with a blanket.

Oxygen Shut Off: In an emergency, the Duty Engineer can turn off the O₂. Upon instructions of the Fire Department. The Charge RN may turn off if the Duty engineer is unavailable.

MEDICAL EQUIPMENT: Biomed must check and sticker all equipment. Check for a sticker before use. If there is an equipment malfunction. Remove equipment from service. Notify the Charge Nurse immediately. BioMed and the Nursing Supervisor will also be notified.

PATIENT RIGHTS Refer to DH Policy: Patient Rights and Responsibilities, Section I, A-11

The basic rights of human beings and a concern for personal dignity and human relationships shall be a primary consideration when caring for patients at DH.

Patients have the right to:

1. Be treated with courtesy, dignity and respect.
2. Be comfortable and receive care in a safe setting, including being free from verbal and/or physical abuse.
3. Know the name and professional title of doctors, nurses and other people caring for them.
4. Be told by their caregivers their conditions, what treatment the caregivers recommend, how they expect the patient's condition to change, how pain will be managed and what follow-up care is needed.
5. Know the reason for giving them various tests and treatments, and the names of persons giving them.
6. Know the benefits, risks and discomforts of any procedure or treatment recommended for them.
7. Refuse to sign a consent form.
8. Cross-out any part of the consent form that they do not want applied to their care.
9. Change their mind before undergoing a procedure for which they have given their consent.
10. An explanation of all papers DH staff asks them to sign.
11. Limit those persons visiting them.
12. Expect that staff will respect their personal privacy to the fullest extent allowed by the care they need.
13. Expect that records related to their care will remain confidential, and an explanation of how confidentiality is protected.
14. Arrange for a meeting with another physician for a second opinion.
15. Arrange to change physicians or hospitals.
16. The services of DH necessary for their care without regard to race, color, creed, national origin, age, sex, sexual preference, political party or disability.
17. Refuse to participate in research projects.
18. Instruct their caregivers about their wishes related to life support, durable power of attorney and organ gifts.
19. Know the approximate cost of proposed care.
20. Be informed about DH rules and regulations affecting their care.
21. File a complaint or grievance with a Patient Representative by calling extension 6599.
22. Examine and receive an explanation of their bill.
23. Know that this is a teaching facility and professionals in training will provide some of their care.
24. Express spiritual and cultural beliefs that do not harm others or interfere with their care.
25. Appropriate assessment and management of pain.
26. Formulate advance directives and have health care providers comply with those advance directives.
27. Be free from use of seclusion or restraint in any form, as a means of coercion, convenience or retaliation.

28. Access their own clinical records (except in certain circumstances) such as when a licensed physician, who practices in psychiatry and who is an independent third party, determines that records pertaining to mental health would have a significant negative psychological impact on the patient.

CUSTOMER SERVICE

Providing quality care to DH patients is a priority of our agency. All staff are expected to be professional, courteous, and respectful to patients, visitors, and coworkers. Professional dress is required and your agency's ID badge must be worn at all times.

Tips for Patient/Family-Focused Communications for all staff:

1. Clearly state your name and your role in the patient's care.
2. Knock when entering a hospital or exam room
3. Close the door or pull the curtains for privacy in a hospital or exam room.
4. Make eye contact when speaking.
5. Address the patient and family members as Mr., Mrs., Ms., Sr., Sra., as appropriate.
6. Whenever possible, sit when speaking with the patient or family.
7. Identify and answer questions for the patient's family or other caregiver.
8. Clearly explain what the patient and family will experience after surgery/delivery/procedure.
9. After you explain something, ask, "Do you understand? Do you have any questions?"
10. Always, before concluding any conversation, ask, "Do you have any other questions? Is there anything else I can help you with?"

NURSING ROLES AT DH

- Nursing Operations Manager (NOM) - Responsible for overall management of clinical area
- Nursing Program Manager (NPM) - Responsible for daily operations of unit
- Charge Nurse - Responsible for direct supervision of nurses and unlicensed personnel during assigned shift. Keeps the nursing supervisor informed of the unit status. Makes and readjusts assignments.

Please keep the Charge Nurse apprised of any significant events or changes with your patient assignment, and use him/her as a resource for problem solving.

- Staff Nurse (RN) - Provide direct patient care, plans and implements nursing process, delegates tasks to unlicensed assistive personnel.
- Clinical Nurse Specialist (CNS) - Responsible for coordination of programs and patient care in specialty area.
- Clinical Nurse Educator (CNE) - Responsible for orientation and continuing education on unit.
- Licensed Practical Nurse (LPN) - Provides direct patient care in team relationship with RN. Administers medications, however, in Colorado, LPNs *must obtain an IV Certification prior to starting peripheral IVs or monitoring peripheral IV therapy. LPNs in Colorado cannot delegate.*
- Unlicensed Assistive Personnel - CNA's, Health Care Technicians, Nurse Interns - perform routine patient care activities under the supervision of an RN. May not assess, plan, evaluate care, or administer medications. ***Check with the Charge Nurse for information on duties that can be delegated.***
- Ward Clerk - Maintains medical record, transcribes orders, answers phone.

PEOPLE TO KNOW

Nursing Management	<i>Office Phone</i>	<i>Pager</i>	<i>Mail Code</i>	Title
Daugherty, Kay	65813	760-4009	8201	Chief Nursing Officer
Beckmann, Catherine	66777		0260	Assistant Chief Nursing Officer for Med/Surg, Critical Care, Rehab, ED, and Perioperative
Walker, LaVonna	65607	540-4822	1816	Assistant Chief Nursing Office for Maternal-Child, C.A.R.E.S., Behavioral Health & Correctional Care
Clinical Nurse Specialists				
Carley, Katherine	66630	760-3080	3450	Inpatient Behavioral Health
Paulson, Pam	29163	890-0514	8500	PEDS/Neonatal
Vannice, Sandy	66486	891-3004	8700	Oncology/Department of Medicine
Nursing Directors	Office Phone	Pager	Mail Code	Area
Andis, Ann	66492	826-2570	0212	Perioperative Services
Bock, Jim	68452	123-211	2600	Public Health
Marcia Humphrey	67584	826-1398	0072	Central Supply
Doll, Katherine	63901	461-2168	1807	Adult Specialty Clinics
Kane, Lee Ann	66811	891-6818	8700	Education and Regulatory Compliance
Leeret, Robert	68124	540-3979	0108	ED
Lundin-Martinez, John	63315	461-9121	0320	Outpatient Behavior Health
	66897	207-4762	8000	SICU and Stepdown
Kassatty, Carmen	720-913-3601	826-8869		Correctional Care
Wright, Mark, Director	63505		3440	Denver CARES
Nurse Managers	Office Phone	Pager	Mail Code	Area
Archuleta, Valerie	63432	851-1989	8200	8 Rehab.
Balshaw, Donna	66825	540-4670	8300	4B
Annette Callahan	66858		8200	3B
Boes, Michele	303-602-9441	206-5208	8500	PEDS, NICU
Brown, Jennifer	66272	851-1652	0116	Acute Crisis Svc.
Miller, Margie	65610	826-1298	1816	Correctional Care Medical Facility
Davis, Quin	65826	266-7238	0261	Nursing Administration
Gerardi, Joe	63210		1807	Surgery and Orthopedic Clinics
Ruby Martinez	66688	851-9761	0490	5E- Adolescent Behavioral Health
	68460	461-9996	1490	Adult Inpatient Behavioral Health
Patti Blair	66897	207-4762	8000	SICU
Miller, Ann	68741		3440	Community Detox
Deb Garner	66747	540-3538	8400	Womens' Care Clinic
Mulhern, Ellen	29382		8400	Labor and Delivery
Malone, Dori	29294		8401	Mom Baby
Amie Kirkwood	66490	760-4446	8300	Wound Care
Zerr, Jennifer	68125	208-8482	0911	ED
Vance, Anna	66875		8101	MICU

Clinical Nurse Educators	Area	Clinical Nurse Educator	Area
Smith, Jan (66874); Christy Rose (66620); Leigh Clark (66620)	MICU/CCU SICU	(68365) Lori Lorenz(68366)	OR PACU
Harriet Palmer-Willis (68484)	Inpt Behavioral Health	Craven, Deborah (65827) Davis, Janice ((63431)	Nursing Education/ Staff Development
Jeremy Nelson (68333) Kim Carroll (66825)	3B 4B	Pritchett, Lora (29381) Krosky, Lisa (29289)	3C L & D 4C Mom/Baby
Lundborg, Zita (67595)	8A/9A med/surg	Molly Lintz (29252)	3C NICU
Pam Poldervaart (65610)	CCMF	Roybal, Renee (29164)	2C Pediatrics
Mindy Walden Jennifer Saltzsieder (68145)	ED	Vicki Toliver (720-913-3756) Carol Rogers (720-913-7570)	Correctional Care/ County Jail Correctional Care/City Jail
Maura McHugh (66123) (64858)	Surgical Clinic Ortho Clinic	Debbie Garder (29028)	Women's Care Clinic

PHONE NUMBERS: MAIN HOSPITAL NUMBER: 303-436-6000
PAVILION C NUMBERS: Front desk Security 303-436-4592

Biomed	65885	Transportation	66282
Blood Bank	66929	After 3 pm	BB# 123-865
Central Supply	67585	X-Ray	66011
Chaplain	67729	Portable	BB# 123-273
EKG	66250	CCMF	65601
Employee Health	67115	Emergency Room	68100
Engineering	65840	OR	66488
Environmental Services	65750	PACU	66540
Ethics Consult	67140	MICU	66885
Food Services/Dietary	67757	2ICU	68333
Infection Control	66484	4 East (EtOH/Drugs)	66635
Lab	66944	4 West (Adult Psych)	66644
Laundry	67797	5 East (Teens)	66677
Nursing Supervisor	BB# 123-140	2C (Peds)	29440
Patient Advocate	66599	2C (PICU)	29460
Social Work/Translators	67390	3C (NICU)	29250
Pharmacy (Unit Dose)	67639	4C (Mom-Baby)	29280
Phlebotomy	BB# 123-128	Nursery	29317
Physical Therapy	66330	3C (L & D)	29365
Resource Nurse	BB# 123-932	3B	63483
Respiratory Equipment	BB# 123-310	4B	66800
Staffing Office	66578	8 Rehab	66833
		8A	66826
		9A	66866

PAIN MANAGEMENT

All patients are assessed for pain on admission to Denver Health and periodically during their hospital stay.

Pain assessment is considered the “5th vital sign.” The pain scales used at DH include:

- Self-Report Scale. Patients are asked to rate their pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain.
- The Wong Scale
- The FLACC Scale for use with non-verbal patients (including children)

Examples are located in the back of the Student Handbook.

PQRST is used to evaluate and record a complete pain assessment.

P - Provocative features

- What brought the pain on?
- Have you ever had this pain before?
- What relieves or exacerbates the pain?

Q - Quality of the pain

- Describe the pain. Is it sharp, stabbing, aching, burning, stinging? (This kind of pain is more likely to be superficial.) Or is it deep, crushing, viselike, gnawing? (This kind of pain is likely to be deep organ pain.)

R - Region or location of pain

- Is the pain centralized in the chest, stomach, or other area?
- Is the pain radiating to the neck, arms, back, or jaw?

S - Severity

- How bad is the pain? Compare it to commonly experienced pain (e.g. toothache, burn, Menstrual cramps, sore throat).
- Is there pressure or cramping?
- Do facial expressions give clues to severity?

T - Timing

- Did the pain begin suddenly or gradually?
- How long did it last?
- Is the pain still present?
- If you've had this pain before, is it better or worse now?

MEDICATION ADMINISTRATION (Section III C-8)

Refer to DH Policies: Medication Administration, located on the “Pulse” intranet
Identification of Patient Medication Allergies

The following applies to most inpatient units. Please check with the Charge Nurse, Pharmacist, and Drug Reference manuals for more information.

- A staff physician, resident, intern, nurse practitioner or physician assistant or other licensed individuals with clinical privileges must order all medications.
- Written orders are preferred, or entered into the computerized prescriber order entry (CPOE) except in emergent situations.
- Verbal orders are indicated as TO (telephone order) or VO (verbal order) followed by the physician's name and signature of the person accepting the order.
- Verify that a physician has cosigned any order.

Chemotherapy may only be administered by DH nurses who have completed the chemotherapy educational process.

Medication Storage

- Pyxis medication dispensing systems are used in most clinical areas. Check with the charge nurse for any medication that may not be dispensed in Pyxis.
- All medications are to be secured (stored) in their appropriate locations. Medications are not to be left in patient rooms or stored on the student.
- Medications may not be borrowed from one patient to administer to another patient. This practice bypasses Pharmacy safety checks and may result in patient injury.
- Medications brought into the hospital by the patient are sent home with a family member or sent to pharmacy. They may not be left at the patient's bedside. Disposition of medications is documented on the appropriate flow sheet.

Procedure for Medication Administration

- The nurse is responsible for knowledge of the drug administered. Please check with the Charge Nurse for the resources available on the unit (i.e., drug reference books, Lexi-Comp Reference on Pyxis, DH Pharmacists).
- Medications can be given within up to 30 minutes (before or after) of the ordered time.
- The following must be checked by another nurse before administration:
 - IV digoxin, heparin, and insulin.
 - **When students are giving medications**, the following medications must be verified by the instructor/unit-based RN before administration by the student: insulin, heparin, narcotics, calculated doses, IV medications.
- Before administering the medication, check the time, dose, and route against that described on the Medication Administration Record (MAR).
- Identify the patient by checking the ID band and check for allergies. Use two patient identifiers, including the Financial Identification Number (FIN#) and the patient name. Check the patient's allergies. All inpatients will have a **red** allergy armband. Fall precaution arm bands are **purple**.
- After the medication has been administered, initial the MAR. If a medication is held, circle the time, initial, and document reason on the MAR or flowsheet.
- If a medication is administered by IM or SC injection, record the injection site.
- When administering sliding scale medication, record the amount of the drug administered next to your initials.
- Sign your initials and name in the designated area on the MAR.
- Document the following after completion of the medication administration procedure:
 - __ Evaluation of the patient response to the medication, when appropriate.
 - __ Any identified possible adverse reaction to the medications administered.
 - __ Explanation of any omitted doses.
 - __ Education given the patient.

Transcription and Verification of Medication Orders

1. A blank Medication Administration Record (MAR) is used on the first day of hospitalization. A computer generated MAR will print the following day and until discharge in most clinical areas.
2. Order transcription:
 - The order is transcribed onto the MAR by the Ward Clerk or RN.
 - It is an RN/LPN responsibility to review his/her patient charts and MAR to identify and communicate any new physician orders written during the shift.
 - When taking off an order, place your first initial, last name and title on the order sheet.

Dangerous Abbreviations

Abbreviations have been identified as a leading cause of medication errors. *Dangerous abbreviations* are medical abbreviations used in prescribing medications or treatments that can be easily misinterpreted. The Institute for Safe Medication Practices (ISMP) has identified more than 30 unsafe or error-prone abbreviations. Although abbreviations save time, a recent study showed that 30% of medication orders contained one or more dangerous abbreviations.

The safety of the patient always comes first. If an order is unclear, inform your instructor and staff nurse and take steps to have the order clarified and confirmed. Document the confirmation of the intended meaning before the order is carried out.

THE FOLLOWING ABBREVIATIONS ARE ON THE JCAHO "DO NOT USE LIST"

These abbreviations are **not to be used** in any written communication (orders, progress notes, flow sheets, etc.) in the patient record.

Set	Item	Abbreviation	Potential Problem	Preferred Term
1.	1.	U (for unit)	Mistaken as zero, four or cc.	Write "unit"
2.	2.	IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "unit"
3.	3. 4.	Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".	Write "daily" and "every other day"
4.	5. 6.	Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
5.	7. 8. 9.	MS MSO ₄ MgSO ₄	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine" or "magnesium sulfate"
6.	10. 11. 12. 13. 14.15.	A.S., A.D. A.U. O.S., O.D., O.U.	Mistaken for one another with consequences of administration of eye drops into the ear or into the incorrect eye or ear	Write "left ear," "right ear" or "both ears"; "left eye," "right eye", or "both eyes".

Look alike, Sound alike Drugs

High Alert Look - alike, Sound - Alike Drugs	
<i>Bolded Combinations Are Identified as Particularly Error Prone!</i>	
Adriamycin - Aredia	Heparin - Hespan
Aggrastat - Argatroban	Humalog - Humulin
Alfenta - Sufenta	Hydralazine - Hydroxyzine
Alfentanil - Fentanyl	Hydrocortisone - Hydrocodone
Alfentanil - Sufentanil	Hydromorphone - Morphine
Avalide - Avandia	Hydroxyurea - Hydroxyzine
Avandia - Coumadin	Interferon 2 - Interleukin 2
Bupropion - Buspirone	Interferon alfa 2 - Interferon alfa 2b
Carboplatin - Cisplatin	Miconazole - Micronase
Cardura - Coumadin	Micro-K - Micronase
Coumadin - Avandia	Micronase - Micronor
Cyclosporine - Cyclophosphamide	Morphine - Hydromorphone
Cytotec - Cytoxan	Opium tincture - camphorated tincture of opium
Dacarbazine - Procarbazine	Oxybutynin - Oxycontin
Daunorubicin - Dactinomycin	Paraplatin - Platinol
Daunorubicin - Doxorubicin	Procarbazine - Dacarbazine
Daunorubicin - Idarubicin	Quinidine - Quinine
Demerol - Demulen	Roxanol - Roxicet
Dilantin - Dilaudid	Sufenta - Alfenta
Dobutamine - Dopamine	Sufenta - Survanta
Doxazosin - Doxorubicin	Sufentanil - Alfentanil
Doxil - Paxil	Taxol - Taxotere
Doxorubicin - Idarubicin	TNKase - T-PA
Efidac - Efudex	VePesid - Versed
Ephedrine - Epinephrine	Vicodin - Indocin
Fentanyl - Alfentanil	Vidarabine - Cytarabine
Glipizide - Glyburide	Vinblastine - Vincristine
Glucotrol - Glyburide	Vinblastine - Vinorelbine

Looks-alike, Sounds-alike Medications

A common error that occurs during the medication administration process is confusion between medicines that look and sound alike. Further confusion results when these drugs are stored in close proximity. In an emergent situation, the wrong drug may be mistakenly removed for administration.

Example: A nurse called pharmacy to report that her automated dispensing cabinet did not have enough **epinephrine** to administer a 5 mg dose. A pharmacist immediately reviewed a copy of the order in which the physician had clearly prescribed **ephedrine** 5 mg IV. The report noted that, had there been enough **epinephrine** in unit stock, a 5 mg dose might have been given.

IV THERAPY (Section II A-10)

Refer to DH Policy located on the "Pulse" intranet: IV Therapy
Central Lines

IV Maintenance and Site Care

1. IV bags hang no longer than 24 hours.
2. Administration set changes:
 - TPN and lipid based fluids every 24 hours
 - All other solutions every 96 hours.
3. Site care:
 - Assess IV sites at the beginning of the shift, prior to infusing intermittent infusions or a minimum of every 4 hours.
 - Pediatric patients with continuous IV infusions must have their IV site assessed hourly.
 - Transparent dressings are used on peripheral IV insertion sites.
 - Transparent dressings are used on central lines and are changed every 96 hours, unless there are complications (i.e., redness, drainage at the insertion site) or the dressing becomes non-occlusive.
 - Peripheral IVs are changed:
 - ___ Within 24 hours if IV started prehospital
 - ___ Every 96 hours
 - ___ With any sign of infiltration, phlebitis or infection.
4. Central line IV tubing is changed every 96 hours for regular IV fluids and every 24 hours for TPN.
5. Get an order to discontinue and remove as soon as possible any peripheral IV that is no longer in use. Check with the physician re: necessity of IVs.
6. Peripheral IVs in adults should only be placed in the upper extremities.
7. Foot IVs require a doctor's order

ADULT VASCULAR ACCESS DEVICE GUIDE

If solution is greater than 12.5% Dextrose, tubing changes are required every 24 hrs.

CATHETER	FLUSHING THE CATHETER	DRESSING CHANGE	BLOOD DRAWS	HELPFUL HINTS
Peripheral	3ml normal saline before and after drug	With each site change or every 96 hrs. Use transparent occlusive dressing. Change IV tubing and needleless cap every 96 hrs.	Not recommended. See IV policy for specifics.	Change IV site every 96 hrs or earlier if signs of infection/infiltration. If the IV is in greater than 96 hours a physicians/AHP order is required.
Peripheral Arterial Line	Do not heparin lock	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	May use with VAMP.	No medication administration. Use with a transducer.
Non-tunneled Subclavian; Hohn, Cook, Triple Lumen or Double Lumen	3ml normal saline before and after each drug followed by 3ml Heparin solution (10-100 units/ml). If not in use, flush with 3ml Heparin solution (10-100 units /ml) daily (each lumen).	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	Withdraw and discard 5ml of blood, draw sample, flush with 10-20ml normal saline followed by 3ml Heparin solution (10-100 units/ml).	Ports of triple lumen catheter are used for: 1. Proximal – blood sampling general access. 2. Middle – TPN only or general access 3. Distal – CVP reading, blood products, general access Either port of double lumen catheter may be used for blood sampling or general access. Label ports for use (blood sampling, med admin, IV fluids, etc)
Tunneled Hickman/ Broviac	3ml normal saline before and after each drug followed by 3ml Heparin solution (10-100 units/ml).	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	Discard 5ml blood. Draw blood sample. Flush with 10-20ml normal saline. Flush with 3ml Heparin solution (10-100 units/ml).	Used for long-term central access. If unable to flush, notify MD. May try to de clot using tPA.
Tunneled Groshong	5ml normal saline before and after each drug. If not in use, flush with 5ml normal saline flush daily.	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	Discard 5ml blood. Vigorously flush the catheter with 20ml normal saline after drawing blood.	Used for long-term central access. If unable to flush, notify MD. May try to de clot using tPA.

Implanted port	Flush with 10ml NS initially and after each drug. When infusion completed, flush with 5ml Heparin solution (100 units/ml). If port not in use, flush with 5ml Heparin solution (100 units/ml) once every four weeks.	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	Flush with 2ml NS. Withdraw and discard 5ml blood. Withdraw blood samples, flush with 10-20ml normal saline and then 5ml Heparin solution (100 units/ml).	Used for long-term central access. Refer to Implantable Port Policy for further information. If unable to flush, notify MD. May try to de clot using tPA.
CATHETER	FLUSHING THE CATHETER	DRESSING CHANGE	BLOOD DRAWS	HELPFUL HINTS
				Only use a non-coring needle to access port. Change non-coring needle (Huber) every week. Change needleless cap with IV tubing change or weekly if not in use.
PICC Groshong	Flush with 5ml normal saline after each drug. If not in use flush every day with 5ml normal saline. Use 10ml syringe.	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use. Flush with 10-20mm normal saline after draw.	<i>Use the PICC line for blood draws in Oncology or for blood draws when peripheral access unavailable or pt refuses venipuncture.</i> Withdraw and discard first 5ml blood. Withdraw blood sample.	Used for medium-long term central access. If unable to flush, notify MD. May try to de clot using tPA.
PICC Open-ended	Flush with 5ml normal saline before and after each drug, followed by 3-5ml Heparin solution (10-100 units/ml). If not in use, flush with 3-5ml Heparin solution daily. Use 10ml syringe for flushing and IV medication administration.	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	<i>Use the PICC line for blood draws in Oncology or for blood draws when peripheral access unavailable or pt refuses venipuncture.</i> Withdraw and discard first 5ml blood. Withdraw blood sample. Flush with 10-20mls normal saline. Flush with 5ml Heparin solution (10-100 units/ml).	Used for medium-long term central access. If unable to flush, notify MD. May try to de clot using tPA.
Midline	3ml normal saline flush before and after each drug, followed by 3ml Heparin solution (10 units/ml). Use 10ml syringe for flushing and IV medication administration.	First dressing will be changed 24 hrs after line is placed then gauze dressings will be changed every 48 hrs and prn. Transparent dressings will be changed every 96 hrs and prn. Change needleless cap with IV tubing changes or every 96 hrs if not in use.	Not recommended.	Maximum dwell time 2-4 weeks. If unable to flush, notify MD. May try to de clot using tPA.
Dialysis Catheter	Routine flushing not recommended catheters accessed by dialysis staff only except: 1. For initiation/discontinuation of CVVH. 2. For COR Zero if no other lines present. 3. For medication administration with Renal physician order.	Sterile Dry Gauze dressing with povidone iodine ointment at catheter exit site, at the end of each dialysis session and prn. recommended by NKF/DOQI guidelines.	Routine blood draws not recommended.	See Venous Access Devices used for Hemodialysis and CVVH policy. Care must be taken not to accidentally anticoagulate patient. These lines are locked with Heparin, which needs to be removed before use. 1-5ml of 1/5000 units of Heparin.
Cordis Introducer	FOR USE AND MAINTENANCE BY ICU STAFF ONLY. Must be discontinued prior to transfer to acute care unit.			

PEDIATRIC/NEONATAL VASCULAR ACCESS DEVICE GUIDE

If solution is greater than 12.5% Dextrose, tubing changes are required every 24 hrs.

CATHETER	FLUSHING THE CATHETER	DRESSING/TUBING CHANGE	BLOOD DRAWS	HELPFUL HINTS
PERIPHERAL	If heparin locked, 0.5-1 ml of 2units/ml heparin flush after each med and at least every 8 hours	Tape or transparent dressing when inserted and prn. Change IV tubing and needleless cap every 96 hours.	Not recommended.	Changing IV sites every 96 hours is not necessary if there are no signs of infection or infiltration.
PICC LINE (NICU patients)	Do not heparin lock	Check site every shift. PICC line inserter to change dressing prn (use transparent dressing). CAUTION: PICC lines are not sutured in. * Change tubing every 96 hrs for IVF and every 24 hrs for TPN.	Do not use for blood draws	Consider adding 1 unit of heparin per ml of IVF. Minimum rate 2-3ml/hr. Filter all fluids except lipids.
PICC LINE (Pediatric patients)	Do not heparin lock PICC lines smaller than 23g 2 fr. Larger catheters may be hep locked and should be flushed with 3ml of 10units/ml of heparin flush after each med and at least daily.	Check site every shift. Dressing changes prn (if inserted by NICU staff, they will change dressing) CAUTION: PICC lines are not sutured in. * Change tubing every 96 hrs for IVF and every 24 hrs for TPN.	Do not use for blood draws	Consider adding 1 unit of heparin per ml of IVF. Minimum rate 2-3ml/hr. Filter TPN, do not filter lipids. For infants < 1 year old, filter all fluids except lipids.
BROVIAC Neonate, infant or child >1year old	If heparin locked, flush with 3ml of 2units/ml of heparin flush after each med and at least every 8 hours.	Use transparent dressing, change every 96 hrs and prn. * Change tubing every 96 hrs for IVF and every 24 hrs for TPN.	May use	Filter TPN, do not filter lipids. For infants < 1 year old, filter all fluids except lipids.
SHORT TERM CENTRAL LINE	If heparin locked, flush with 3ml of 2 units/ml of heparin flush after each med and at least every 8 hours.	Use transparent dressing, change every 96 hrs and prn. * Change tubing every 96 hrs for IV and every 24 hrs for TPN.	Use proximal port of triple lumen catheters	Triple lumens: Proximal: blood sampling Middle: TPN or general access Distal: CVP readings or blood admin. Filter all fluids if <1 year old.
UVC	Do not heparin lock single lumen UVC May heparin lock larger port of double lumen UVC. If hep locked, flush port every 8 hrs with 0.5-1ml of 2 units/ml heparin flush using positive pressure technique.	Dressing change N/A. * Change tubing every 96 hrs for IVF and every 24 hrs for TPN.	May use with attending approval only	IV solutions are mixed by pharmacy every 24 hrs. First bag may be mixed in NICU. No TPN or meds through line without attending MD order. Filter IVFs except lipids.
UAC	Do not heparin lock	Dressing change N/A. * Change tubing and VAMP every 96 hrs.	May use (VAMP)	No medication or blood administration through UAC without attending MD order. Filter IVFs.
PERIPHERAL ARTERIAL LINE	Do not heparin lock	Dressing change N/A. * Change tubing and VAMP every 96 hrs.	May use (VAMP)	No K+ . No medication administration. Add 1 unit of heparin /ml of IV fluid.

BLOOD AND BLOOD PRODUCTS (Section 11 A-3)

Refer to DH Policy: Blood Transfusions, located on the “Pulse” intranet.

1. **Students and Instructors may not administer blood.** The student and instructor may monitor the patient during the transfusion including: obtaining baseline vitals prior to start of transfusion, 15 minutes after start, and at the completion of the transfusion. (vitals may be taken prn during transfusion).
2. Prior to administering blood, the RN must verify the blood with another RN or MD (NOT a medical student). Both parties must sign the transfusion tag. This careful identification of the patient is crucial since most life-threatening transfusion reaction result from incorrect identification of patients, resulting in the administration of incompatible blood.
3. Observe the patient frequently the first 15 minutes of the transfusion for signs and symptoms of a transfusion reaction, which include fever, chills, tachycardia, dyspnea, hypotension, nausea, vomiting, flushing, urticaria, chest pain, or pain in the flank or back.
4. If any of these signs or symptoms occur: Report them to the staff nurse assigned to the patient.
 - Stop the transfusion. Remove the blood tubing from the angiocath and attach an IV of NS to keep the IV patent. Take vital signs. Report the reaction to the MD and Charge Nurse. A *Transfusion Reaction Record* needs to be completed.
5. No unit of blood product may hang longer than 4 hours. No medications or other solutions are to be infused into the IV line during the transfusion or added to the blood products.

DENVER HEALTH BLOOD TRANSFUSION

*Student monitoring is permitted

Verify Order

Verify consent has been obtained for blood/blood component/blood derivative

Establish IV access (NS with transfusions)

Completed blood request form to transfusion services

VERIFY IDENTIFICATION AT THE BEDSIDE

By 2 professional, licensed staff (RN, Physician)

Name: pt = tag

ID#: pt = tag

donor# lot#: bag = tag

type & Rh: bag = tag

Expiration date & product: bag = tag

Document on transfusion compatibility tag

RESOLVE ANY DISCREPANCIES

* Check VS (T,P,R & B/P) prior to start

RN or MD to start transfusion within 30 minutes of arrival to unit using appropriate tubing set-up.
Remain with patient for first 5-15 minutes.

* Check VSS (T,P,R & B/P) 15 minutes after start of transfusion

No transfusion reaction

Continue infusion. Complete infusion within 4 hours.

Infusion completed - Check VS (T,P,R & BP)
Discontinue set-up.
Complete Transfusion compatibility tag and place in medical record.

Document volume, pt's condition in medical record

Dispose of bag and tubing in biohazard container

Transfusion reaction

Stop transfusion - Obtain VS

Notify MD. Notify Transfusion Services (ext. 6929)

Disconnect tubing at IV catheter.
Tie knot in tubing & leave attached to bag.

Complete F20-251 Transfusion Reaction Investigation Form
Draw: 1 red top and 1 lavender top.
Send to Transfusion Services along with blood bag containing unused blood, IV tubing, labels and compatibility tag.

Monitor VS, urinary output (color and volume)

Document episode in medical record

RESTRAINTS (Section II A-12; A-12.1)

Refer to DH Policies located on the "Pulse" intranet:

Restraint and Seclusion for Behavioral Management

Physical & Chemical Restraint I Medical and Post-Surgical Care

CMF Conditions of Participation and JCAHO have strict requirements for the use of restraint and/or seclusion. DH must comply with these rulings in order to receive reimbursement for services and to provide optimal patient care.

General Guidelines

1. Use of restraint and/or seclusion is limited to situations that are clinically justified, and only after alternative measure have been determined to be ineffective.
2. Physician orders are required. PRN restraint orders are not allowed.
3. Restraint and/or seclusion must be discontinued at the earliest possible time.
4. Documentation must reflect; alternatives to restraint attempted, reason for restraint use, monitoring and assessment of patient.
5. Behavioral restraints can only be used for *imminent danger to self or others*.



ALTERNATIVES TO RESTRAINT USE

<p style="text-align: center;"><i>PHYSICAL COMFORT</i></p> <ul style="list-style-type: none"> • Optimizing body positioning, alignment • Relieve discomfort • Medication • 2 hour toileting • Discontinue Foley at earliest indication • Repositioning • Evaluate causes of activities/risk <p style="margin-left: 40px;"> <input type="checkbox"/> Itching <input type="checkbox"/> Restraint itself <input type="checkbox"/> Temperature <input type="checkbox"/> Pain <input type="checkbox"/> Hunger <input type="checkbox"/> Irritants <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Impaired vision <input type="checkbox"/> Language barrier </p> <ul style="list-style-type: none"> • Personal belongings within reach <p style="text-align: center;"><i>REORIENTATION/ COMMUNICATION</i></p> <ul style="list-style-type: none"> • Frequent reality re-orientation to surroundings • Family/friend companion • Defusing agitated behavior <p style="text-align: center;"><i>INCREASE OBSERVATION/ MONITORING</i></p> <ul style="list-style-type: none"> • Increased supervision/monitor • Placement of patient near nursing station 	<p style="text-align: center;"><i>MODIFICATION OF ENVIRONMENT/SAFETY</i></p> <ul style="list-style-type: none"> • Limiting physical accessibility to life-support devices • Abdominal binder to cover tubes/drains • Bedrails (Upper only) • Easier access to the bathroom • Decrease environmental stimulation • Behavior modification • Clear pathways • Increased/decreased lighting • Curtain around bed • Beds lower to floor • Accessible call light • Side rail covers • Re-taping of artificial airway • Changing of IV site <p style="text-align: center;"><i>DIVERSION ACTIVITIES</i></p> <ul style="list-style-type: none"> • Distraction (TV, toys, headphones, radio, ambulation, ADL, etc.) • Allow familiar possessions
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Restraints

Medical-Surgical Restraints		Behavioral Restraints
Policy	Standard Policies and Procedures	Standard Policies and Procedures
MD	RN obtains verbal order within 2 hour MD does face-to-face ASAP, signs verbal and writes new order	Face-to-face within <u>ONE</u> hour
	Face to face and reorders every 24 hours	Re-order: <ul style="list-style-type: none"> • Q4 for adults • Q2 for adolescents • Q1 for children Face-to- face: <ul style="list-style-type: none"> • Q8 hours for adults • Q4 hours for adolescents Alternating with verbal: <ul style="list-style-type: none"> • Q 8 hours for adults Q4 hours for adolescents
RN	Assessment on initiation and then minimum Q12 hours	Assessments on initiation and then: <ul style="list-style-type: none"> • Q4 hours for adults • Q2 hours for adolescents • Q1 hour for children
Patient Monitoring	<ul style="list-style-type: none"> • Document q2 hours • “Eyeball” q 15 min • If in 4 points or leathers – need documenting q 15 min 	<ul style="list-style-type: none"> • Q 15 min • Continuous face-to-face monitoring while in restraints
Trial Out	Have up to 2 hours out before new order needed	NONE
Administrative Note	None	<ul style="list-style-type: none"> • If in 12 hours + note needed • 2 or more episodes within 12 hours (Nursing Supervisor on off-shifts)

MONITORING AND DOCUMENTATION FOR MEDICAL/SURGICAL RESTRAINTS

RESTRAINT TYPE	DOCUMENTATION	MONITORING GUIDELINES
Restraint	Alternatives/Interventions	Assessment Policy
CHEMICAL RESTRAINT Examples: Haldol, Ativan	<ul style="list-style-type: none"> • MAR • Flow sheet 	<ul style="list-style-type: none"> • Document patient response post medication administration
<p>PHYSICAL RESTRAINT <i>Must use a quick release knot</i></p> <ul style="list-style-type: none"> • Side Rails. If bed has upper and lower side rails, the upper rails may be up to assist with patient mobility. Must have order for placing lower side rails up or bed/stretcher with only 2 side rails. • Specialty chair with restraining feature • Mitts • Mitts with Straps • Waist Belt • Chest Vest • Soft Limb Restraint 2 point 3 point 	<ul style="list-style-type: none"> • Alternatives/Interventions • Interdisciplinary Patient/Family Teaching Record <p style="text-align: center;">(Identify possible patient and family participation that could limit or halt use of restraint. Provide reason and rationale for use of restraint. Provide information for discontinuing restraint. Inform patient/family what alternatives have been attempted.)</p> <ul style="list-style-type: none"> • Optimal Therapeutic Environment flow sheet • Nursing Plan of Care • If appropriate, Progress Notes • If Side Rails are ordered, place a blue armband on patient. This informs staff from other departments (i.e., PT, RT) that patient has order for side rails X 4 to be up. 	<ul style="list-style-type: none"> • Assessment by RN on initiation, and a minimum every 12 hours <p>(Determine the need to continue/discontinue restraint. Progress toward removal of restraints. Less restrictive measures attempted. Patient response. Plan of care.)</p> <p>Monitoring (at least every 2 hours):</p> <ul style="list-style-type: none"> • Airway checks • Circulation to restrained extremities • Care to skin, observation of skin problems, incontinence, and linen changes • Orientation • Nourishment/Hydration • Elimination • Range of motion/positioning • Call light in reach • VS (minimum of q 8 hrs) • Efforts made to interact with the patient and offer support and direction • Written observations of the patient's activity/risk/response. • Any physical care/comfort measure provided. • Relief period (whenever safe and when patient is awake provide relief periods as often as every 2 hours)
<p>FOR THE FOLLOWING:</p> <ul style="list-style-type: none"> • Soft Limb Restraint 4 point 5 point • Locked Leather Limb 4 point 5 point 	<ul style="list-style-type: none"> • In addition to the above must document visual checks every  <p>15 minutes</p>	<ul style="list-style-type: none"> • Assessment by RN every 2 hours. • Monitoring checks every 2 hours. • Visual checks every 15 minutes.

Least Restrictive Alternatives must always be considered.
 Patient must be removed from restraints at earliest possible time.

LEGAL AND ETHICAL ISSUES

Informed Consent

Refer to DH Policy:

Informed consent is required prior to performing any operative procedure or administering anesthesia, performing an invasive diagnostic or therapeutic procedure, administering blood products. It is the physician's responsibility to obtain informed consent.

Nursing Instructors and students may not witness consent forms.

Ethics Committee

DH has an Ethics Committee. Talk to the Charge Nurse if an ethics consult is required.

Patient Representatives

Patient representatives are advocates for patients' rights and needs. They help mediate and negotiate resolution of patients' complaints. Contact the Charge Nurse if patients or visitors have concerns.

OCCURRENCE REPORTING

An "occurrence" is any incident that falls outside of the orders/treatment for a patient or involves actual or potential harm or injury to a patient or visitor. All occurrences, including "near misses" must be reported. Some occurrences must be reported to the State of Colorado Department of Health by the next business day. The Safe Medical Device Act requires reporting of equipment malfunction. At DH, occurrences are reported by completing the on-line report on the Patient Safety Net.

The following are examples of occurrences that must be reported:

Falls

Medication/IV errors:

Wrong dosage, drug, IV drop rate, patient, route, time

Allergic reaction

Omission

Mislabeling

Non-prescribed or prescribing error

Transcription error

IV/Tissue Damage

Expired/Improper Storage

Pharmacy dispensing error

Diverted drugs (any occurrence in which drugs intended for use by patients is diverted to use by other people)

Patient-on-staff, patient-on-patient or staff-on-patient assaults

Patient leaving against medical advice (AMA)

Suicide, attempted suicide, self-injury

Neurological deficit not present on admission

Patient injury other than injury due to falls (i.e., burns)

Unexpected surgical or anesthesia outcome

Allergic reaction to anesthesia, drugs, or blood

Lack of informed consent

Missed diagnosis/delaying diagnosis

****Students and Nursing Instructors do not witness**

Occurrences that must be reported to the Department of Health within one business day:

- Unexplained death or suspicious circumstances
- Falls resulting in LOC
- AWOL
- Life threatening anesthesia or transfusion reaction
- Occurrences that result in serious injury to patients: brain injury, spinal cord injury, life-threatening complications of anesthesia, life-threatening transfusion errors or reactions, burns
- Alleged verbal, physical or sexual abuse of a patient by another patient, staff, or visitor
- Equipment malfunction or misuse
- Burns
- Diverted Drugs

*****If you're not sure, report the incident.*****

What actions do I take when I discover an occurrence?

1. Monitor patient status.
2. Notify care provider (physician, nurse practitioner or physician assistant) and document notification. Notify the Charge Nurse.
3. Document assessment findings, interventions, and patient response to interventions.
4. Enter the occurrence into the Patient Safety Net online reporting tool. The required information to enter a report includes:
 - Is it an actual or potential event?
 - How do you know about the event?
 - Medical record number
 - The area in which the event occurred in the institution
 - Patient admission date
 - Date of the event
 - Level of harm incurred by the patient or by others

Click on the UHC PSN logo, found on the desktop of the computer. Once you are in the online system, the report must be completed in 15 minutes; after that, you will be logged out and all information entered will be lost and you will need to start over. This restriction is intended to protect patient and staff confidentiality. After entering the required information, click on the *Next* link at the bottom, right-hand corner of the current page. The last screen provides an opportunity for sharing your suggestions for ways to prevent a reoccurrence of this type of event.

5. If occurrence involves equipment, remove the equipment from use (keep any disposables such as tubing with the equipment and do not change the control settings). Notify the Charge Nurse. Biomed and the Nursing Supervisor must be notified.

Tips on Documentation of Occurrences

Documentation on the incident needs to be detailed, objective and specific. Listed below are minimal expectations regarding assessment, interventions and documentation requirements after an occurrence.

OCCURRENCE	ASSESSMENT/INTERVENTION	DOCUMENTATION
Medication Error	<ul style="list-style-type: none"> • Patient response to medication error (i.e., VS, any change in status) • Notify physician • Type of medication error 	<ul style="list-style-type: none"> • Type of medication error and how error discovered. • Assessment of patient/response to med error • Physician notification (including name of physician and physician assessment time)
AWOL	<ul style="list-style-type: none"> • Patient status before AWOL occurred • Was the patient "at risk" to self or others (i.e., medical condition that needs follow-up, patient on a Mental Health Hold, etc.) • Initiate search for patient (Code Walker) 	<ul style="list-style-type: none"> • Time the patient was last seen • Time the physician was notified • Was the patient under any special monitoring at the time of AWOL (i.e., frequent observation checks, etc.) • Your response to locate the patient • Time the family was notified
Fall	<ul style="list-style-type: none"> • Patient status (i.e., V.S., level of consciousness before and after fall, neurological status, any bruises, cuts) • Notify physician • Ongoing reassessment of patient • Document change in care plan to prevent future falls 	<ul style="list-style-type: none"> • Description of how patient found • Patient description of event, if appropriate • Were restraints on the patient? • Any contributing factors (i.e., floor wet) • Assessment findings immediately after event and periodically after event • Physician notification (include name of physician and when physician arrived to evaluate the patient)
Equipment Malfunction	<ul style="list-style-type: none"> • Patient status • Remove equipment from use, keep all accessory materials with equipment (i.e., tubing), do not change settings. • Notify Charge nurse. Biomed and nursing supervisor must also be notified. 	<ul style="list-style-type: none"> • Patient assessment findings • Physician notification (include name of physician and when physician arrived to evaluate the patient) • Biomed and nursing supervisor notification: equipment quarantined, accessory materials quarantined.

RADIOLOGY PROCEDURES:

Patient Prep Required

Contrast Medium may be required:

CT
Gall Bladder
Bowel studies
Bladder studies

Radioisotopes given pre procedure:

DIDA Scan
Gastric Scans
Renal Scan
Thyroid scan
Tagged red cell scan

Patient must be NPO:

Barium Enema
Barium swallow
Gallbladder
Spleen scan
Pancreas scan
Cardiac scan

Consent required:

Angiographic procedures

Phone Numbers for further Information:

Radiology 6011
Ultrasound 7622
CT 7624
MRI 7800
Interventional 6031
Nuclear Medicine 7608

CORRECTIONAL CARE SAFETY POINTS

Denver Health contracts with several Correctional Care Facilities. Correctional Care Patients receive the same standard of care as other patients. However, there are safety guidelines that must be followed.

1. Remove all sharps and items that could be used as a potential weapon from the immediate area (i.e., sharps, long pencils). Be aware of what is routinely available in the patient rooms or exam rooms that may be used as a potential weapon.
2. Correctional care patients may not have long pencils, pens or newspapers
3. Prisoners may be given writing materials including one or two pieces of writing paper and a *short* pencil. If there is a request for additional items, please check with the sheriff.
4. Police hold devices (i.e., shackles, cuffs) are NOT considered medical/surgical restraints. If the correctional care patient requires medical/surgical restraints, DH restraint policies are to be followed.
5. Correctional care patients are not to be told the date, time or place of their next appointment, or the date and time of a procedure or surgery.
6. Do not confirm correctional care appointments over the phone; no information should be given out over the phone about the time/place of an appointment.
7. Correctional care patients may not have any visitors in the clinics.
8. No personal belongings are permitted except hearing aids, glasses, dentures and artificial limbs. The correctional care patient may have these items at the discretion of the sheriff.
9. Staff are not allowed to mail anything or make phone calls for the correctional care patient.
10. If the correctional care patient has any legal questions that need to be addressed, the deputies should address these questions; do not involve ourselves with legal issues surrounding the custody of the patient.
11. The only eating utensil permitted is a plastic spoon. Whenever possible, use disposable dishes and cups.
12. Correctional care patients are not permitted to smoke per DH nonsmoking policy.
13. Reading materials may be available in limited amounts. The sheriff will determine how much material the patient/prisoner is permitted to have.
14. Maintain a therapeutic relationship; limit conversations with the correctional care patient to medical care.
15. Allow security officers or deputies to intervene when necessary and remove yourself from potentially dangerous situations.
16. Communicate with the deputy sheriff as needed.
17. In order to maintain the confidentiality of the correctional care patient, any patient information should be sealed in the appropriate bright yellow envelope and given to the guard to bring back to the sending facility.

ELECTROLYTES: Refer to the DH Pharmacist and reference books for further information.

DRUG	APPROVED NURSING AREA	PREPARATION/INFUSION/MONITORING GUIDELINES
Potassium Acetate and Potassium Chloride	House-wide	<ul style="list-style-type: none"> • Never administer IV push or undiluted • <i>Adult Non-critical care areas:</i> Bolus comes premixed 10mEq/100cc IV solution. Infuse over 1 hour using an infusion pump. A serum potassium level must be evaluated after a series of 3 doses before further administration of potassium. • <i>Adult Critical Care:</i> Maximum dose of 20 mEq/hour in a minimum of 100cc IV solution through a central line using an infusion pump. • <i>Special Handling:</i> There shall be no vials of Potassium Chloride or Potassium Acetate for injection in routine floor stock at DHMC. Commercially available mini-bags containing Potassium Chloride 10mEq and 20mEq in 100ml sterile water for injection will be stocked by the Pharmacy.
Potassium Phosphate	House-wide	<ul style="list-style-type: none"> • Dose is calculated according to the phosphate content. Dosed in mMol. Contact pharmacy for dosing obese patients. • <i>Adult Acute Care Areas:</i> Maximum dose 0.16 mMols/kg for each intermittent dose. (Formula: 0.16mMols x patient's weight in kg. = maximum intermittent dose) Administer each intermittent dose in 100cc IV solution over 6 hours using an infusion pump. The maximum dose is 32mMols in 24 hours. • <i>Adult Critical Care areas:</i> With severe hypophosphatemia (<1mg/dl), a single dose of 0.2 - 0.24 mMols/kg may be given over 6 hours (Formula: 0.24mMols x patient's weight in kg = maximum intermittent dose). Administer each intermittent dose in a minimum of 100cc IV solution over 6 hours using an infusion pump. Maximum phosphate dose in 24 hours may exceed 32mMols depending on laboratory values. • <i>Pediatrics:</i> 0.5 - 1.5 mMols/kg/24 hours. Not to exceed 32mMols in 24 hours. Volume of IV solution may vary depending on dose and type of venous access device (central vs. Peripheral). • <i>Special Handling:</i> There shall be no vials of Potassium Phosphate for injection in routine floor stock at DHMC.
Magnesium Sulfate (for non-OB use)	House-wide	<ul style="list-style-type: none"> • IV pump required • Adult mixing instructions: 1-4 Grams in 100 cc IV solution. Infuse over 1 hour • IV push in COR response
Calcium Chloride	Intermittent infusion-house-wide IV push – Critical Care or COR response	<ul style="list-style-type: none"> • IV pump required for intermittent infusion. • Adult mixing instructions: Mix in 100 cc IV solution and infuse over 30-60 minutes. Do not exceed 100 mg/minute. • Maximum dose is 1 gm. • In a 10% solution, 10 ml = 1 gm = 13.6 mEq Calcium.
Calcium Gluconate	House-wide	<ul style="list-style-type: none"> • IV pump required for intermittent infusion. • Adult mixing instructions: 0.5 gm-2 gm of 10% solution mixed in 100cc of IV solution. In fuse over 30-60 minutes. • In a 10% solution, 10ml = 1gm = 4.65 mEq of Calcium.

TELEMETRY AND ECGs

For Telemetry:

All patients are monitored in Lead II or MCL₁

Lead placement for 3 lead systems:

	Red (RA)	Black (LA)	Green (ground)
Lead II	Rt. infraclavicular fossa	Lt. infraclavicular fossa	5 th ICS, midclavicular line
MCL₁ Select "lead I" on your monitor.	Lt. infraclavicular fossa	4 th ICS, RSB	Rt. infraclavicular fossa

Lead placement for 5 lead systems:

	White (RA)	Black (LA)	Green (RL)	Red (LL)	Brown (chest)
Lead II and Lead MCL₁ Select lead on monitor	Rt. infraclavicular fossa	Lt. infraclavicular fossa	Rt. lower chest	Lt. Lower chest	4 th ICS, RSB

Monitoring Guidelines:

1. A physician must order telemetry.
2. The patient may be off telemetry for medical tests. The patient will not be off telemetry for any other reason (i.e., shower) without a physician order.
3. RNs who have completed the dysrhythmia and ACLS class and demonstrated the knowledge and skills to monitor telemetry will monitor patients on telemetry.
4. It is strongly recommended that patients on telemetry have I.V. access.
5. If a patient on telemetry experiences chest pain, the physician must be notified and a strip recorded.
6. Rhythm strips will be recorded and interpreted on admission and every 4 hours.

12 Lead ECGs:

Lead placement for ECG:

V1	V2	V3	V4	V5	V6
4 th ICS, RSB	4 th ICS, LSB	Between V2 & V4	5 th ICS, MCL	Anterior axillary line between V4 & V6	Level with V4 midaxillary line

Arm leads: inner arms midway between wrist and elbow

Leg leads: inner calf midway between ankle and knee

PARKING, CAFETERIA AND SMOKING

Parking

Parking is available in several areas:

- There are several public lots you may use:
 - Delaware St. employee/visitor parking garage. Turn L off 6th Ave or turn R off 8th Ave. You will pay \$1.50.
 - South side of the Rita Bass EMS Center. This lot is on the corner of 5th Ave. and Bannock. You will need \$1.50 to put in the machine when you leave the lot.
 - Triangular lot at the corner of 7th Ave. and Bannock (across from the Emergency Department).
 - A small lot on the southeast corner of 6th Ave. and Bannock. This is a private lot.
 - A small lot on the west side of Delaware at 7th and Delaware. This is a private lot, owned by an elderly gent who prefers to keep the lot open for patients/visitors, but you may negotiate that with him.
- Street parking is available, but **NOTE** that many streets are posted with 2-hour time limits. Further away from the hospital, you may be able to locate some unposted street parking areas.
- Please do not park in the visitor lot adjacent to the hospital and the Webb Center between Delaware and Bannock. Our visitor parking is limited and we would like to reserve it for our patients and their families.

Cafeteria Hours

The Good Day Café, located in the basement of the main hospital (Pavilion A). Open from 6:30 AM to 6:30 PM, Monday through Friday and from 6:30 AM to 2 PM on weekends.

Meal hours are as follows:

_Breakfast 6:30AM – 8:00 AM

_Lunch 11:00 AM – 1:30 PM

_Dinner 4:30 PM – 6:30 PM

The cafeteria serves a variety of foods at reasonable prices, including a hot line, a salad bar and a taco bar.

Smoke Free Facility

Denver Health is a smoke-free institution. Smoking is not permitted in the buildings or on the grounds. Please confine smoking to the Plexiglas gazebo on the north side of the employee parking structure.

IF YOU ENCOUNTER A PROBLEM AND HAVE A QUESTION

If you have questions, or need clarification, do not hesitate to ask the staff, Charge Nurse or call the Department of Nursing Education and Staff Development office Manager at (303) 436-6776 or the CNE Placement Coordinator at (303)436-3431.

EMPLOYMENT OPPORTUNITIES AT DENVER HEALTH

Denver Health offers a diverse, challenging environment and excellent benefits for nursing professionals. If you are interested in possible employment at Denver Health, please contact the office of Nursing Recruitment and Retention.

Denver Health

Nursing Recruitment

Mail Code #1918

660 Bannock St.

Denver, CO 80204

Phone: (303) 436-7161

Explore our Web site at: www.denverhealth.org

- Current job postings
- Apply online
- Department descriptions

Nurse Interns

Nurse interns are nursing students who become part of the nursing team to help deliver patient care while they learn. Prerequisites for the program:

- Completion of a medical/surgical clinical rotation or equivalent
- Proof of enrollment and successful progress in an accredited school of nursing
- Current BLS certification

Contact Office of Nursing Recruitment if you are interested.

CLÍNICA / DEPARTAMENTO
CAFETERÍA

GRUJÍA

- Clinica de Cirujía
- Clinica de Cirujía Plástica
- Clinica de Neurocirujía
- Centro Pre-Operativo

CLÍNICA ENT (OIDOS, NARIZ Y GARGANTA) / AUDIOLOGÍA

CLÍNICA DEL DENVER HEALTH MEDICAL PLAN

- CLÍNICA DE MEDICINA PARA ADULTOS
 - Estación para la Extracción de Sangre
 - Clinica de Neurología (Medicina para Adultos)
 - Clinica de Oncología (Medicina para Adultos)
 - Clinica Pulmonar (Medicina para Adultos)
 - Clinica Renal (Medicina para Adultos)

CLÍNICA DE OFTALMOLOGÍA / OPTOMETRÍA

- Clinica de los Ojos

Clinica de Proctología

CUIDADOS PARA MUJERES

- Clinica de Cuidados para la Mujer
- Mamografía
- Sala de Observación Obstétrica

Sonograma (Clinica de Cuidados para la Mujer)

EMERGENCIAS

- Sala de Emergencias
- Sala de Emergencias Psiquiátricas

FARMACIAS

- Farmacia para Enfermedades Infecciosas
- Farmacia para Pacientes Externos
- Farmacia para Pacientes Externos en Davis
- Farmacia para Pacientes Internos

LABORATORIOS

- Laboratorio de Cardiología (Electro/eco)
- Laboratorio de Cateterización Cardíaca
- Laboratorio de Función Pulmonar
- Laboratorio de Gastroenterología

NEUROLOGÍA

- Clinica de Neurocirujía
- EEG/EMG (Neurología)

ORTOPEDIA

- Clinica de Ortopedia
- Medicina Deportiva (Ortopedia)
- Podiatría (Clinica Ortopédica)

PEDIATRÍA

- Clinica de Atención Pediátrica Urgente
- Clinica para el Cuidado de Niños

PROGRAMA WIC (Mujeres, Infantes y Niños)

PSIQUIATRÍA

- Clinica de Neuropsiquiatría
- Sala de Emergencias Psiquiátricas
- Servicios Psiquiátricos

RADIOLOGÍA

- Escán de los Huesos (Medicina Nuclear)
- Medicina Nuclear
- Radiología (Rayos-X)
- Sonograma (Radiología)

SALUD PÚBLICA

- Administración de Salud Pública
- Centro de Entrenamiento Preventivo ETS /SIDA
- Clinica de Enfermedades Venéreas para el Área de Denver
- Clinica de Salud Ocupacional y Seguridad
- Clinica de TB (Tuberculosis)
- Clinica de Vacunas /Requisitos de Salud para Viajar
- Enfermedades Infecciosas /Clinica del SIDA
- Estadísticas Demográficas /Certificados de Nacimiento y Defunción)
- Investigación Clínica del SIDA
- Investigación de ETS virales
- Prevención e Investigación del SIDA
- Programa de Prevención y Control del Tabaco
- Prueba del SIDA y Consejería

SALUD DEL COMPORTAMIENTO

- Programa de Metadona

SERVICIOS DENTALES

- Clinica Dental
- Clinica Dental para Pacientes con SIDA

TERAPIA

- Terapia Física
- Terapia del Lenguaje
- Terapia Ocupacional

Trabajo Social Clínico

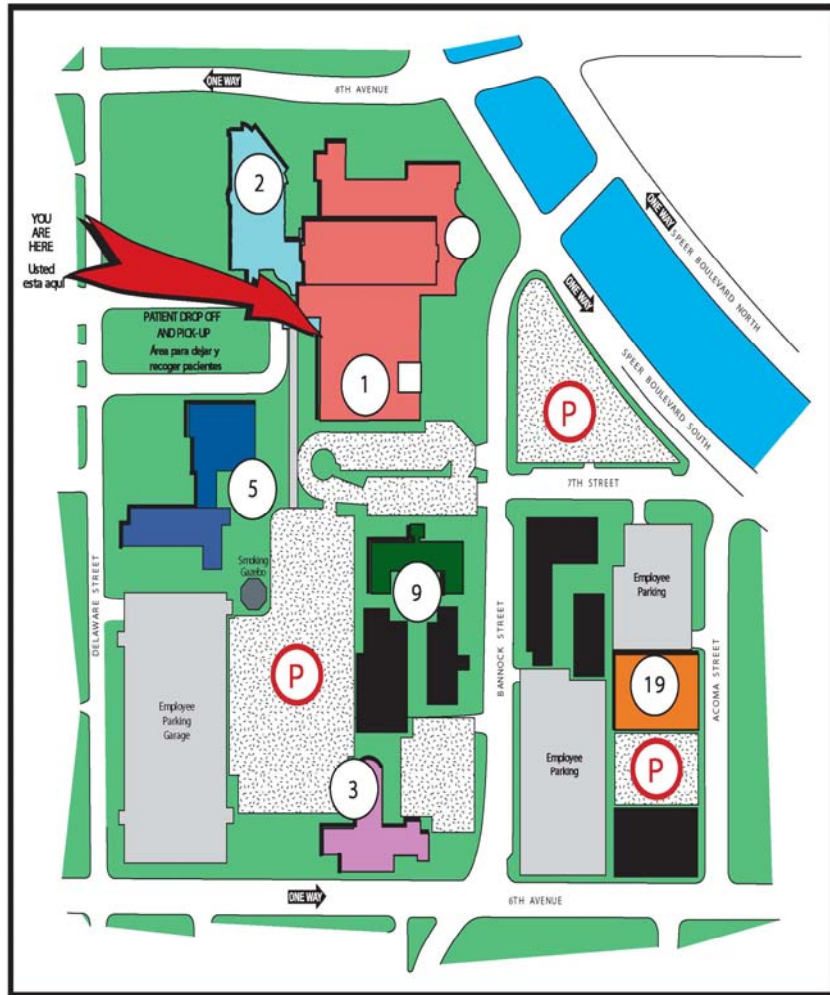
EDIFICIO

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- 1 Denver Health Medical Center**
Main Hospital 777 Bannock
- 2 Western Addition**
780 Delaware Street
- 3 Denver Public Health**
605 Bannock Street
- 5 Davis Pavilion**
700 Delaware Street

- 9 Behavioral Medicine/Library**
667 Bannock Street
- 19 645 Acoma Street**



CAMPUS MAP

Clinic/Department

- Adult Medicine Clinic
- AIDS Prevention & Research
- Audiology (ENT)
- Behavioral Health
- Blood Drawing Station
- Bone Scan (Nuclear Medicine)
- Cafeteria
- Cardiac Cath Lab
- Cardiology Lab (EKG/ECHO)
- Clinical Research on AIDS
- Clinical Social Work
- Dental Clinic
- Denver Health Medical Plan Clinic
- Denver Metro Health STD Clinic
- EEG/EMG (Neurology)
- ENT Clinic (Audiology)
- Eye Clinic
- GI Lab
- HIV Counseling & Testing
- HIV Dental Clinic
- Immunization & Travel Clinic
- Infectious Disease/AIDS Clinic
- Kids Care Clinic
- Mammography
- Methadone Program
- Neurology Clinic (Adult Medicine)
- Neurophysiologic Clinic
- Neurosurgery Clinic
- Nuclear Medicine
- OB Screening Room
- Occupational Health & Safety
- Occupational Therapy
- Oncology Clinic (Adult Medicine)
- Optical Clinic
- Orthopedic Clinic
- Pediatric Urgent Care Clinic
- Pharmacy Infectious Diseases
- Pharmacy Inpatient
- Pharmacy Outpatient
- Pharmacy Outpatient Davis
- Physical Therapy
- Plastic Surgery Clinic
- Podiatry (Orthopedics Clinic)
- Pre-Op Center
- Proctology Clinic
- Psychiatric Emergency Room
- Psychiatric Services
- Public Health Administration
- Pulmonary Clinic (Adult Medicine)
- Pulmonary Function Lab
- Radiology (X-Ray)
- Renal Clinic (Adult Medicine)
- Speech Therapy
- Sports Medicine (Orthopedic)
- STD/HIV Prevention Training Center
- Surgery Clinic
- TB Clinic
- Tobacco Prevention & Control
- Ultrasound (Radiology)
- Ultrasound (Women's Care Clinic)
- Viral STD Research
- Vital Statistics
- WIC Program (Women, Infants, & Children)
- Women's Care Clinic
- X-Ray (Radiology)