

**RN GENERAL ORIENTATION CHECKLIST
EMERGENCY DEPARTMENT
CRENSHAW COMMUNITY HOSPITAL**

Name:	Date:
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This orientation checklist is not a substitute for the General Hospital Orientation provided by Crenshaw Community Hospital for all employees, nor is it a substitute for individual education and experience required to meet the minimum standards of care required by the State of Alabama for the particular licensure of the individual staff member.

Skills	Competent	Date	Employee Initials	Preceptor Initials
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Overview

1. Tour of Hospital				
2. General Unit Orientation				
3. General Computer Orientation				
a. CPSI				
b. Time Clock				
4. Answering phones, Identifying Yourself				
5. Overhead Paging				
6. Badge Requirement				
7. SBAR - How to Give Report				
8. Vehicle Parking Policy				
9. Unit Work Schedule				
10. 15 Minute breaks, lunch, and Time Clock				
11. Procedure for "Call-In" Absences				
a. Must be at least 2 hours prior to shift				
b. Weekend call-ins will work the following weekend				
12. Chain of Command				
13. Location of Policy and Procedure				
14. HIPPA				
15. EMTALA				
16. Incident Reporting				
17. QA Improvement Projects				
18. Core Measure Policies and Time Frames				
19. Emergency Department/Supervisor Keys				

Safety

1. SDS - Location and Use				
2. Infection Control				
3. OSHA Standards				
4. Closed toe, non-mesh shoes				

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5. No Food or Drink				
6. Nothing under Sinks				
7. Doors Closed related to Fire Alarm, other				
8. All Vials Labeled (Medication and Specimen)				
9. Fridge/Warmer Temps Daily				
10. Contact Times for Various Cleaners				

Skills

Emergency Codes (Code Blue, Silver, etc.)				
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Disaster Plan

1. Who Acts as Incident Commander?				
2. Where is the Disaster Information Located?				
3. Where do you Report?				
4. What are Unit Responsibilities?				

Rapid Response (Dr. Ice)

1. How to Initiate				
2. When to Initiate				
3. Who Responds				
4. How to Document				

Evacuation During a Disaster				
Where to go and where to move patients				
Restraint Policy & How to Initiate/Document				
Medical and Behavioral Restraint policies				
Triage				
1. Assessment Form Complete				
2. Age Specific Vital Signs Obtained and Charted				

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3. Documentation				
a. Nursing Diagnosis				
b. Assessment				
c. Medication Reconciliation				
d. Medical History				
4. Verify Armband Placement and Accuracy				

Placing Patient in ED Exam Room

1. Door to Exam Room within 7 Minutes				
2. Place Patient in a Gown when applicable				
3. High Acuity Patients Placed on Tele Monitor				
4. Initial Rhythm Strip or EKG				
5. Nursing Protocol Orders for Specific Complaints				
6. Clear Previous Patient from Room Monitor				
7. Notify ED MD of patient's arrival				

Special Services Patients

1. Place Patient in Gown (All SW Patients)				
2. All Patient Possessions placed in Storage Bin				
3. Notify South Wing of Patient's Arrival				
4. Obtain Blood and Urine Specimen for Appropriate Diagnostics				
5. EKG and Portable Chest				
6. Lab Levels for Applicable Medications				
7. Suicide Precautions as Necessary				
8. Documentation in CPSI				
9. Calling Report to South Wing				
10. South Wing Staff to Perform Inventory of Patient Possessions				
11. Requires 2 SW Staff for Transfer				

Admitting Patients to North Wing

1. Call North Wing for Room Assignment as soon as Disposition is known				
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2. Call report to Receiving Nurse				
3. All Patients to be in a gown				
4. Follow Applicable Core Measures Rules per Diagnosis				
5. Complete ED Charting and Charges Prior to Computer Transfer of Patient				
6. All Patient Belongings Transferred with Patient				

Patient Transfers

1. Obtain Preference from Patient/Family if Applicable				
2. Contact Receiving Facility for MD to MD Conference				
3. When Patient has been Accepted, Call for Applicable EMS Transport and Documentation of Time of Call				
4. Call Report to Receiving Facility				
5. Complete CCH Transfer Form with Patient/Family Consent Signature				
6. Complete EMS Transport Form if Applicable				
7. Print Patient's Chart for Transfer				
8. Notify Registration if AIR EMS for ETA and Landing Lights.				

Post Mortem Procedures

1. Death Certificate to be Completed Online by MD				
2. Notify Organ and Eye Banks within one hour of Time of Death				
3. Obtain Funeral Home Preference from Family				
4. Notify Funeral Home				
5. Obtain consent to Release Body from next of				
6. Confirm MD order to "Release Body"				
7. Body Preparations as Appropriate				

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Isolation Techniques

1. Setting up an Isolation Room				
2. Entering and Exiting an Isolation Room with PPE				
3. Cleaning of Room and Contents as Applicable				

Lab Orientation

1. Location of Lab and Blood Bank				
2. Where to Place Lab Specimens				
3. Blood Glucose Checks				
4. Glucometer Device Quality Control Daily				

Administering Blood Products

1. Obtain Written Order				
2. Obtain Consent				
3. Products Must be Identified and Checked by RN Administering blood and another Licensed Staff				
4. Vital Signs According to CCH Policy				
5. Demonstrate Proper Administration				
6. Be Aware of Potential Adverse Reactions				
7. Policy for Emergency Release of Products				
8. Documentation Complete from Start to Finish				

Pain Management

1. Pain Scale Assessment				
Reactions				
3. Documentation of Effectiveness of Intervention				

Code Blue Overview

1. Location of Defibrillator				
2. Defibrillator Testing/Documentation Every Shift by RN				

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3. Location of Code Cart and Respiratory Equipment				
4. Restocking Procedure Following a Code				
5. Code Documentation				
6. Cardioversion/Defibrillation Procedures				
7. External Pacing				
8. Knowledge of Critical Care Meds and Location of Critical Care Med Binder				
9. Charging, Use, and Cleanup of Video Laryngoscope				

Respiratory and Airway Management

1. Application of Pulse Oximetry Meter				
2. Application of ETCO ₂ monitor and ranges				
3. Application of Supplemental Oxygen				
4. Nasal Canula				
5. Face Mask				
6. Non-Rebreather				
7. Oral Airway				
8. Nasal Airway/Trumpet				
9. Assist With Intubation/Setup and Procedure				
10. Proper Use of BVM				
11. Setup of Ventilator				
a. Initial Settings				
b. Vent Settings Titration				
c. Alarm management				
12. RSI Policy and Location of Medications with Knowledge of Possible Adverse reactions				

Current BLS				
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Current ACLS				
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EKG

1. Monitor Lead Placement				
2. 12-Lead EKG Lead Placement				
3. EKG Device Paper Replacement				

Wound Care

1. Documentation of Wound Care				
2. Document Measurements of Wound				
3. Demonstrate Proper Wound Cleaning				
4. Demonstrate Proper Wound Dressing				
5. Reposition Patient Every 2 hours for Pressure Relief if Applicable				

Animal Bites and Reportable Diseases

1. All Animal Bites must be Reported to County Health Department				
2. Documentation of all conversations to legal authorities regarding Animal				
3. Confirm Patient is up-to-date on Tetanus Vaccine				
4. Report any "Reportable Diseases" to ADPH or other required authority				

Central Line Care

1. Location and Setup of Sterile Line Kits				
2. Knowledge of Policy for Central Line Initial Dressing Application and Dressing Changes				

Handwashing Technique

1. Demonstration				
2. Proper Use of Chemical Based Hand Sanitizers				

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Sterile Glove Application				

IV Therapy

1. Insertion of IV				
a. All IVs to be flushed at least every 8 hours				
2. Initial Setup of Tubing				
3. Tubing Change every 72 Hours				
4. How to Disconnect IV				
5. Use of IV Pumps				
6. Pediatric Buretrol				
7. Policy on Critical IV Medications				
a. Patient Requires 2 Large Bore IVs with at least one in a Large Vein				
b. No IV Pushes in same line with Critical Drips				
c. IV Tubing must be labeled at Patient				
d. Drip Conversion Chart to be Hung on IV Pole for Each Cardiac Medication				
e. IV Pumps set for titration per medication				
f. All critical IV drips require flowsheet documentation				

Assessing Neurovascular Status

1. Document History and Current Assessment				
2. Assess for Changes Q15 Minutes or as MD Orders and Document				

Tracheostomy Care - Cleaning and Suctioning				
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Foley Catheters

1. Insertion - Male				
2. Insertion - Female				
3. Intermittent Irrigation if Applicable				

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4. Document any urine return upon Insertion				
5. Nephrostomy Care				
7. Suprapubic Care				

Specimen Collection

1. Labeling				
2. Clean Catch Urine				
3. Female Quick Cath				
4. Sputum				
5. Stool				
6. Wound Cultures				
7. RSV, FLU, Strep				

Suction

1. Suction Setup				
2. Oral Suctioning				
3. Tracheal Suctioning				
4. Low Intermittent Suction to NG/OG				
5. Continuous Suction				
6. Suction Cannister Change				
7. Monitoring and Documenting I/O for Suction Cannister				

Pharmacy and Medications

1. Pharmacy Orientation				
2. Pharmacy After Hours				
3. Narcotics withdrawal from Omnicell				
a. How to address Omnicell discrepancies by end of shift				
b. How to document Narcotic Waste				
4. Medication Administration and Documentation				
5. Safety Procedures "The Rights"				

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6. Staff has met with Manager and reviewed, understands and will comply with Medication Administration and Documentation Policy.				

Patient Safety and Ergonomics

1. Safe Transfer Techniques and Ambulation				
2. Bed to Chair Transfers				
3. Bed to BSC Transfers				
4. Transfers To/From Stretchers				

**Procedures Beyond Basic Education: The
Following Procedures Require Certification and
Check-off Prior to Performing**

1. Nasogastric Tube Insertion and Care				
2. Central Line Care				
3. EZ-IO Setup, Insertion and Care				
4. PEG Tube Replacement				
5. EJ IV Insertion and Care				
6. Application of Tourniquets				