Crenshaw Community Hospital

Nurse Orientation

GENERAL PSYCHIATRIC NURSE ORIENTATION CHECKLIST				
Name:			Date:	
Skills	Competent	Date	Employees Initials	Preceptor Initials

UNIT OVERVIEW				
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.				
Nurse Orientation				
Unit Orientation				
1. Tour of Hospital				
2. Introduction to unit layout and to unit staff				
3. Introduction of South Wing Policy & Procedures				
4. General computer orientation				
5. Answering phones/Properly identifying yourself				
6. Badge Requirements				
7. Location of Call Rosters				
8. Unit Rules for Patients and Employees				
9. Rounding Requirements/Documentation				
10. Confidentiality /HIPAA				
Time Clock				
1. Demonstrates ability to clock in/out				
2. Demonstrates ability to change job code (if needed)				
3. Understands meal time procedure clock out/in				
Key Nursing Department Policies and Procedures				
1. Location of Policies and Procedures Manual (house wide)				
2. Dress Code				
3. Staffing and Scheduling				
4. Calling off, Calling in, Requesting time off				
5. Assignments, Delegation, Charting				
6. SBAR				
7. Incident Report				
8. Medication Error Reporting				
9. Chain of Command				
10. Staff Performance Guidelines				
Employee Introductory Period (90 day) and Annual				
1. Introductory Review (90 Day) Evaluation Orientation				
2. Annual Evaluations				
Employee Changes				
1. Employee Status Changes				
2. In-House Position Transfer Request				
Safety				
1. Global Hazard Communication				
2. OSHA Standards				
a. Closed Toed Shoes				
b. No Food/Drink in the clinical work area				
c. Nothing under the sink				
d. Doors closed				

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e. All vials labeled with opened date (multidose vials expire 28 days from opening date)				
f. Refrigerator/Freezer temps daily				
g. Contact times for cleaners				
h. Nothing stored in biohazard bags				
i. Sharps containers				
3. Unit Safety				
a. Identifying and Responding to Safety Hazards				
b. Reporting Broken Equipment/Maintenance Request				
c. De-escalation and Crisis Prevention Intervention				
d. Unit Security-Key padded doors and locked doors				
e. Environmental rounding				
Isolation/Universal Precautions				
1. State Requirements, indications and practice guidelines for:				
a. Standard Precautions				
b. Airborne Precautions				
c. Reverse Isolation				
d. Droplet Precautions				
2. Demonstrates safe practice to prevent spread of infection regarding the following:				
a. Isolation room set up				
b. Patient care items				
c. Linen				
d. Waste				
e. Patient's Chart				
f. Visitors				
g. Transporting isolation patients				
3. Demonstrates use of the following to prevent spread of infection regarding the following:				
a. Hand washing				
b. Use of waterless alcohol-based hand sanitizers				
• After entering a patients room				
• After glove use				
• After medication administration				
• Does not cover C-Diff- must wash hands with soap and water				
c. Process for cleaning showers between patients				
d. Process for cleaning washer between patients				
Emergency Response				
1. Emergency Codes				
2. Rapid Response • How to initiate • When to initiate • Who responds • How to document				

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3. Code Team				
4. Fire Procedure/Evacuation				
Behavioral Restraints/Seclusion				
1. States definition and purpose of Behavioral Restraints and Seclusion in the acute care setting				
2. Identifies time guidelines for notification of physician and re-evaluation for Behavioral Restraints and Seclusion				
3. Documents less-restrictive interventions attempted prior to initiation of Behavioral Restraints and Seclusion				
4. Identifies all requirements necessary for the MD order to meet all parameters of the policy				
5. Documents observation, assessments, and nursing care at prescribed intervals on flow sheet				
6. Applies Behavioral Restraints devices according to manufacturer's recommendations				
7. Documentation Requirements				
General Nursing				
Admission and Assessment				
1. Assesses patients subjectively and objectively using techniques of interviewing, inspecting, auscultation, and palpation. Completes and documents initial and ongoing assessment and reassessment as needed.				
2. Admission Assessment completed by RN within 8 hrs				
3. Accurately identifies patients via two identifiers				
4. Admission Through-put Process form ER				
5. Body Audit				
6. Elopement Precautions				
Discharge Procedures				
1. Understands court and voluntary discharge process				
2. Understands AMA discharge process				
3. Understanding the Emergency Hold Order process				
Documentation				
1. Dates, times and signs name (at minimum: first initial/last name and legal signature when so required).				
2. Initiates and updates plan of care				
3. Verification of all telephone orders with repeat of order after written and "Read-Back" documentation				
4. Documentation is legible, timely, objective, specific, complete, accurate, concise and completed in a timely manner				
5. Documents as above on all unit-specific forms and inputs all patient information into appropriate logs as per policy.				
6. Demonstrates ability to perform 24 hour chart checks				
Vital Sign Monitor				
1. Measures BP and pulse safely and correctly				

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2. Selects appropriate cuff and measurement site				
3. Identifies potential circulation and skin integrity problems				
4. Notifies appropriate personnel/MD of abnormal findings and/or implements interventions.				
Fall Assessment				
1. Understands all Psych patients are fall risk				
2. Implements appropriate protocols				
a. Non slip socks or shoe worn				
b. Frequent rounding				
Blood Glucose Monitoring				
1. Understands use & maintenance of Blood glucose machine				
Specimen Collection				
1. Correctly Collects specimen for sputum, urine and stool				
2. Labels container accurately at point of collection				
3. Documents lab specimen accurately on all required forms				
4. Utilizes biohazard bag for transport of specimen				
Medication Administration				
1. Ensures that the Right medication is given to the Right patient at the Right time in the Right dose and by the Right route and Right reason				
2. Accurately uses safety needles				
3. Observes for and documents desired effects, side effects, adverse drug reactions, and allergic reactions for all age specific categories.				
4. Documents medication administration accurately				
5. Manages Controlled substances safely and securely				
6. Recognizes patients' rights				
7. Appropriately manages and stores patient home medications • Home medications are not stored at bedside • Inventoried and secured in security bag in patient's presence • All controlled substances require 2 signatures				
8. Medication Reconciliation Process				
9. Reporting and Recording Medication Errors				
10. Anti-Psychotic Medication Education (on admission)				
11. Medication Ordering Process				
12. Staff has met with Manager and reviewed, understands and will comply with Medication Administration and Documentation Policy.				
Pharmacy Orientation				
1. Pharmacy after hours procedure				
2. Narcotic Counts • Sign out process • Wasting of narcotic process				

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• Responsibility of narcotic keys • Medication discrepancy process/log book				
EKG				
1. Application of the electrodes				
1. Patient Information Requirements				
2. Loading paper				
Wound Care				
1. Wound Care Log book and Flow chart				
2. Wound Care Documentation in EMR				
Care of the Suicidal Patient				
1. Suicide Risk Assessment				
2. Suicide Precautions				
a. Understanding 1:1 LOS/1:1 WAL Process				
3. Documentation in the EMR				