

First Point of Contact Screening (FPOC)

- ❑ Complete FPOC within 24 hours:
 - ❑ Every patient must have an FPOC screening assessment completed within the first 24 hours of admission.
- ❑ Ensure accuracy and completeness:
 - ❑ All fields must be filled out thoroughly to provide a comprehensive overview of the patient's status.
 - ❑ If you are unable to obtain answers to the questions from the patient, ask the family or facility they came from to help clarify.
- ❑ Identify potential issues early:
 - ❑ Accurate documentation helps to detect possible problems promptly, supporting timely interventions, and improved patient outcomes.
 - ❑ Accurately identifying items like recent antibiotic use is critical in identifying the potential for C.Diff. Early identification leads to prompt testing, treatment, and aids in prevention.

The top section of the FPOC form includes fields for Patient Type (Emergency, Outpatient, Inpatient/Observation, Resuming, Outpatient Surgery), Patient Admitted/Transferred From (Home, Nursing Home, Long Term Care Facility, Other Healthcare Facility, Other Hospital, Jail/Prison, Homeless Shelter, Other), Name of Facility (Non-Emergency Patients Only), Is Reason for Visit Open Joint Replacement/Open Spine/Open Heart Surg? (Non-Emergency Patients Only), Is the Patient Receiving Dialysis? (Non-Emergency Patients Only), Preferred Language (Emergency Patients Only), Accessibility Needs (Emergency Patients Only), Crosswalk (Abbreviation, Translation, Blind/LV, Deaf/Hard of Hearing, LEP, Proficiency), Language Services (Emergency Patients Only), Language Services Type (Emergency Patients Only), Other Auxiliary aids detail (Emergency Patients Only), Patient/representative present AND ABLE to complete infection screening? (Yes, No), Have you or a close contact traveled outside the US? (Yes, No), and Which countries? (dropdown and text field).

The bottom section of the FPOC form includes Risk factors for C. Diff. (None, Antibiotics last 28 days, In last 3-6 months, Diarrhea w/ blood, fever), Have you ever had TB or a positive TB skin test? (Yes, No), Recent close contact with a person who has flu like illness, COVID, or TB? (Yes, No), Flu like illnesses include but are not limited to COVID-19, SARS, MERS, etc. (checkbox), Fever > 100.4 F or 38.0 C (Yes - In the last 7 days, No), Patient states shortness of breath (Yes, No), Cough (not related to allergy or COPD) (Yes - In the last 7 days, No), Persistent cough (Yes - greater than 3 weeks, No), Cough with blood production (Yes - In the last 7 days, No), Sore Throat (Yes - In the last 7 days, No), Night Sweats (Yes - In the last 7 days, No), Unexplained weight loss (Yes - In the last 7 days, No), Fatigue (Yes - In the last 7 days, No), Body Aches (Yes - In the last 7 days, No), Rash (Yes - In the last 7 days, No), Nasal congestion (not w/ allergy/sinus infection) (Yes - In the last 7 days, No), Mask applied and patient isolated and receiving unit/department notified: (Yes, No), Patient Isolated and Receiving Unit/Dept Notified (Yes, No), C difficile Point of Entry Screening Status (Positive C difficile Risk, Negative C difficile Risk, Unable to Assess), TB Point of Entry Screening Status (Positive TB Risk, Negative TB Risk, Unable to Assess), Respiratory Point of Entry Screening Status (Positive Respiratory Risk, Negative Respiratory Risk, Unable to Assess).

Broset Violence Checklist: Age Change

Go-Live 11/25/25

The Broset Violence Checklist must now be completed for **ALL patients** (exclusions: newborns admitted to MOMB or NICU). This updates the previous policy, which excluded patients under age 12.

- ❑ This is a tool used to evaluate patient's risk upon admission, and as part of ongoing assessment for signs of violence or behaviors that may indicate a risk for impending violence.

Broset Violence Checklist	
Confusion	Disoriented, unaware of time, people, or location
Irritability	Annoyed, angry, unable to tolerate others
Verbal Threatening	Intent to intimidate or threaten another person
Attacking Objects	Throwing or kicking objects, slamming doors
Boisterousness	Overtly loud, yelling
Physically Threatening	Intent to threaten, aggressive stance, clenched fists

1. **Score of Zero (0) = Minimal risk for violence**
2. **Score of one or two (1-2) = Moderate risk for violence**
 - Preventative measures should be taken
3. **Score of greater than two (>2) = High risk for violence**
 - Preventative measures should be taken, and a plan should be created for how to manage/intervene with a violent episode.

Brøset Violence Checklist 1PC.PSYI.0093



Clinical Updates

New Vial-2-bag Medication Conversions: Go-Live 12/10/25

- Amiodarone 150mg/100ml D5W (Bolus)
 - Amiodarone 150mg/3ml vial will be in Pyxis.
 - The D5W 100ml IV bag (Non-PVC bag) will be in Pyxis.
 - Vial-2-bag adapter will be in the nursing supply room.
- Amiodarone 450mg/250ml D5W (Drip)
 - Amiodarone 450mg/9ml vial will be in Pyxis
 - The D5W 250ml IV bag (Non-PVC bag) will be in Pyxis.
 - Vial-2-bag adapter will be in the nursing supply room.
- Vasopressin 20 units/100ml NS (Drip)
 - Vasopressin 20 units/1ml vial will be in Pyxis.
 - The NS 100ml IV bag and the vial-2-bag adapter will be in the nursing supply room.
- Vabomere (Meropenem/Vaborbactam) 2gm/250ml NS
 - This is a "restricted" medication and therefore will only be dispensed from the main pharmacy. It will be dispensed as a "kit" that contains the Vabomere vial, 250ml NS, and the Vial-2-bag adapter.

Methylprednisolone dose adjustment in Critical Care Plans: Go-Live 12/9/25

- Changed to reflect more standard doses of steroids for common ICU conditions. If higher doses are needed, they may be ordered outside of the standard ICU plan.
- Change from 125 mg, IV push Q6hr to 40 mg, IV push Q12H
- Change from 125 mg, IV push Q8hr to 40 mg, IV push Q24H
 - Removing addition dose

methylPREDNISolone (SoluMEDROL)		40 mg, Inj, IV Push, Q12HR, T;N
VTE Prophylaxis		40 mg, Inj, IV Push, Q12HR, T;N
☒ Venous Thromboembolism (VTE/DVT) Prophylaxis Pla... Planned Pen...		40 mg, Inj, IV Push, Q24HR, T;N

New Powder Vial Reconstitution Process

Go-Live December 9th, 2025

Scan the QR Code to complete the required HealthStream module



The new process relocates sterile diluents (water for injection/saline) from the supply room to the Pyxis to ensure the correct diluent is pulled with the medication vial. It requires nurses to scan the diluent and manually adjust the final dose and volume in the electronic documentation to reflect the actual reconstituted product being administered.

The drug and diluent will both show beneath the order on the MAR.

Why the Change?

- Enhance Patient Safety: This new process is designed to minimize the risk of medication errors associated with incorrect diluent usage and inaccurate dose/volume documentation.
- Ensure Correct Diluent: Moving the diluents into the Pyxis and linking them to the pull prompt creates a system-level check to help ensure the correct diluent (Sterile Water or Saline) is selected for reconstitution.

Medication	Dose	Frequency	Route	Volume	Concentration
acetazolamide	250 mg	q6h	IV Push	2.5 mL	100 mg/mL

Locating Reconstitution Instructions

- Reconstitution can be found in the MAR Note. Left Click the push-pin symbol and select comments. Note the amount of the diluent needed for reconstitution. This will need to be documented when the medication is documented on the MAR.

Medications	11/06/2025 11:18 EST	11/06/2025 11:08 EST
Scheduled acetazolamide 250 mg inj. IV Push, Daily, 11/06/25 11:30:00 EST, Routine		
acetazolamide sterile water	250 mg IV Push Ant	2.5 mL IV Push Ant

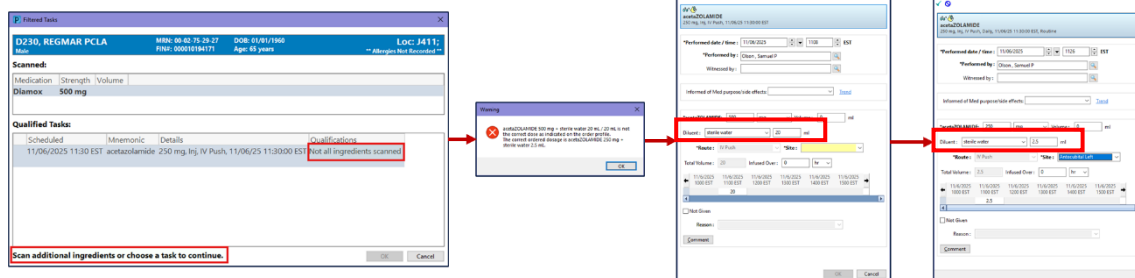
MAR Note
11/06/2025 10:59 EST Tuztl, Zkbaup X 500 mg/min max. Final concentration 100 mg/mL when reconstituted with 5 mL sterile water. ***Pharmacist must ensure volume matches ordered dose based on concentration***

At the Pyxis

- When the medication is pulled from Pyxis, the nurse will be prompted to also remove the diluent (sterile water or sterile saline).
 - Sterile Water and Sterile Saline will no longer be available in the supply room.
- Reconstitution should occur at the patient's bedside.
- Note: If a medication is removed using the Pyxis override function, the nurse will also need to override the diluent (sterile water or sterile saline).

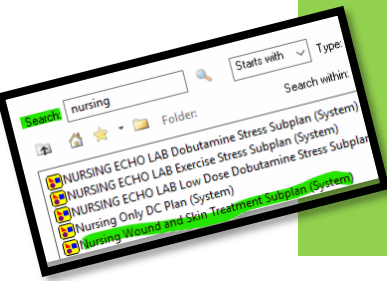
Using the Bar Code Medication Administration (BCMA) Process

- Prior to administration, the nurse will scan the powder medication vial and the diluent (sterile water or sterile saline).
- Adjust the amount of diluent used to reflect the amount indicated on the MAR Note.



Wound of the Week (wow!): What is it?

CHART IT RIGHT



Wound Type
Abrasion
Avulsion
Bite
Blister
Burn
Cannulation
Contusion
Crush
Denuded
Donor Site
Excoriation
Friction/Shear
Gunshot Wound
Heel Sticks
Hematoma
Incontinence associated skin damage
IV Extravasation
Laceration
Lesion
Moisture associated skin damage
Moisture Fissure
Non-pressure
Operative/Incision
Penetrating
Pin Site
Pressure Injury
Puncture
Scab
Skin Tear
VAD Driveline

Excoriation



LINEAR SCRATCHES

Incontinence Associated Skin Damage



Moisture Associated Skin Damage



Traversing Wet and Icy Surfaces

Navigating wet and icy surfaces requires some careful consideration to avoid slips and falls. Here are some tips to help you stay safe:

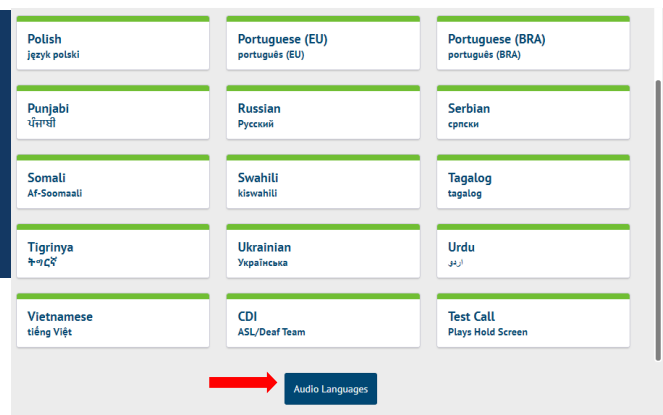
- ❑ **Wear Appropriate Footwear:** Shoes with good traction and non-slip soles can make a big difference. Avoid smooth-soled shoes.
- ❑ **Take Small Steps:** Short, deliberate steps help you maintain better balance and reduce the risk of slipping.
- ❑ **Keep Your Hands Free:** Use your arms for balance, but avoid carrying heavy items that can affect your stability. Use the elevator when carrying bulky items.
- ❑ **Walk Slowly:** Rushing increases the risk of slipping. Take shorter steps at a slower pace.
- ❑ **Keep an Eye Out for Changing Surfaces:** Be aware of the surface you are walking on and adjust your pace when needed. If possible, walk on cleared paths or areas with gravel or sand.
- ❑ **Keep Your Feet Flat:** Walk flat-footed with your feet pointed slightly outward. This increases your contact area and stability. Penguin waddle!
- ❑ **Maintain a Wide Stance:** Spread your feet apart to increase your balance and lower your center of gravity.
- ❑ **Use Handrails:** If available, use handrails or other supports to help with balance.
- ❑ **Avoid Slippery Areas:** Look ahead to spot and avoid particularly slippery surfaces/icy patches.
- ❑ **Be Mindful of Black Ice:** Black ice is hard to see but can be extremely slippery. Be extra cautious in shaded areas or early in the morning.
- ❑ **Use Caution When Entering or Exiting Vehicles:** The areas around cars can be particularly icy. Take extra care when getting in or out.
- ❑ **Practice Falling Safely:** If you do slip and fall, try to fall with your body relaxed to reduce the risk of injury. Aim to fall on your side rather than your back or front.

**All accidents and injuries should be reported using Vigilanz. Call Mission WorkWell (828-213-9600) to be seen if medical attention is required as a result of your injury.



How to use the AMN Language Services Application for Audio

**DON'T SEE THE LANGUAGE YOU NEED?
MORE THAN 200 LANGUAGES ARE
AVAILABLE OVER AUDIO.**

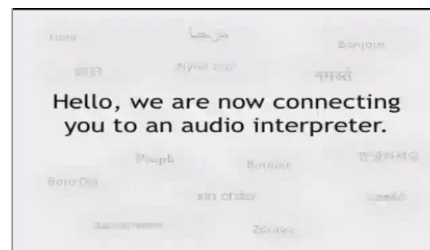


Select the “Audio Languages” button.

The Video languages home screen will disappear and you will be redirected to a white hold screen confirming an interpreter will be with you shortly.



Once the operator is entering the session, another screen will appear letting you know you are being connected. Once connected, state the language you need.



While in the session, the “End” button will disappear. Tap the screen and the end button will appear at the bottom of the screen to end the call.

CUSTOMER SUPPORT: 855-663-1231

Gentherm heating canisters will replace Owens and Minor canisters starting 12/16/25. Pads will remain the same.

Old product



New product



The Micro-Temp® LT Localized Heat Therapy System is intended to warm a patient's body part through conductive heat transfer. The conductive heat therapy is provided by circulating warm water through localized temperature therapy pads. The Micro-Temp® LT Unit is composed of a heater, a circulating pump, and a microprocessor. The Micro-Temp® LT is intended for use by appropriately trained healthcare professionals in healthcare facilities and in home care environments.

- 1 Check that the power switch is in the "O" position (unit is off).
- 2 Check the level of sterile water or water that has been passed through a filter less than or equal to 0.22 microns in the reservoir. To do so, twist off the cap of the water fill opening and check if the water is visibly touching the strainer. If needed, carefully add sterile water. Do not use de-ionized water. Do not overfill.
- 3 Insert the plug into a properly grounded receptacle.
- 4 Lay the localized heat therapy pad flat towards the unit.
- 5 If the pad is already filled, check that there are no leaks. Water leaks present a risk of infection. Leaking pads should never be used.
- 6 Connect the pad to the Micro-Temp® LT unit.

OPERATING THE MICRO-TEMP® LT SYSTEM:

- 1 Turn power switch to the "I" ON position.
- 2 When started up, the Micro-Temp LT unit flashes the 42°C default set point four times and then it will show the actual water temperature.
- 3 Press and hold the "SET" button, then press either the up or down arrow to change the SET temperature display to the desired patient temperature. The display can only be set between 20°C – 42°C. When the desired set temperature is displayed, release the arrow and SET buttons.
- 4 A physician's order is required for the use of the device and setting the temperature of the blanket/pad.



At least every 20 minutes, or as directed by physician, check patient's temperature and skin condition at area in contact with blanket/pad.

TROUBLE SHOOTING:

ALARM NOTE:

Power Failure: If power is removed from the unit without actuating the power switch (I/O switch), a "Power/Failure Caution" LED flashes and audible indicator sounds. This continues until power is restored to the unit, or until the power switch is turned to the "O" (OFF) position. If power is restored to the unit, the unit will resume previous operation.

ALARM NOTE:

>1°C (2°F): If the set point temperature has been set at least 1°C (2°F) lower than the actual circulating water temperature, the display flashes the actual water temperature, an audible indicator sounds 2 beeps while flashing the red "Power/Failure Caution" LED and the heater shuts off. If the water temperature does not return to set point after 9 minutes, the 2 beep audible indicator will again sound and the red "Power/Failure Caution" LED will again flash. The actual water temperature will continue to flash until the water temperature returns to the set point.

ALARM NOTE:

HL (High Limit): If the circulating water temperature has reached the high temperature limit of 44°C (+5°C or -5°C). when this occurs, the red "Power/Failure Caution" LED illuminates, an audible indicator sounds continuously, and the pump and heater shut off. This indicator condition cancels only after the unit has been powered down and the water temperature has cooled below 42°C. The unit should not be used again until it is serviced.

ALARM NOTE:

Low Water: This indicator condition occurs when the unit is low on water. When this occurs, the yellow "Low Water" LED illuminates and the pump and heater shut off. Once sufficient water level is obtained the unit returns to previous operation.

ALARM NOTE:

Tilt Switch: This indicator condition occurs when the unit has tilted beyond approximately 20° in any direction. When this occurs, an audible indicator sounds, the red "Power Failure/Caution" LED flashes, and the heater and pump shut down. Once the unit returns to an acceptable operating angle, the unit returns to previous operation.