Table of Contents

Welcome and Introductions ........................................................................................................ 4

Quality ......................................................................................................................................... 4
   A. General Information ............................................................................................................. 4
   B. Patient and Family Centered Care ....................................................................................... 5
   C. Privacy and Health information ............................................................................................. 5
   D. Hand Hygiene ....................................................................................................................... 5
   E. Infection Prevention and Control ........................................................................................... 7
   F. Concerns Regarding Patient Quality ..................................................................................... 13
   G. Disclosure of Adverse Events ............................................................................................... 13

Documentation and Communication ......................................................................................... 13
   A. General Information ............................................................................................................. 13
   B. Medical Records and Dictation ............................................................................................ 14
   C. Standardization of Charts ................................................................................................... 15
   D. Documentation Tips .............................................................................................................. 15
   E. Abbreviations ...................................................................................................................... 17
   F. Goals of Care Designation .................................................................................................. 18
   G. Certification Under Mental Health Act (Form 1) ................................................................. 18
   H. Discharge Against Medical Advice ..................................................................................... 19
   I. Declaration of Death ........................................................................................................... 21

Medication Management ........................................................................................................... 24
   A. Medication Reconciliation ................................................................................................... 24
   B. Formulary ............................................................................................................................. 26
   C. Triplicate Prescriptions ....................................................................................................... 27

Consent ......................................................................................................................................... 28
   A. General Information ............................................................................................................. 28
   B. Blood Transfusions ................................................................................................................ 28
   C. Procedures ............................................................................................................................ 29
   D. Surgery ................................................................................................................................. 29

Emergency Response ................................................................................................................... 29
   A. General Information ............................................................................................................. 29
   B. Emergency Response Code Chart ....................................................................................... 29
   C. Adult Medical Emergency Team (MET) – UAH ................................................................. 29
Welcome and Introductions

Welcome to the Royal Alexandra Hospital. The RAH is an Alberta Health Services 850 bed tertiary care facility affiliated with the University of Alberta.

We provide care over a wide range of emergency and elective medical and surgical procedures. Our patient population ranges from neonates to geriatrics and everything in between. We are dedicated to the concept of patient and family centered care and strive to include the patient and close family as part of the healthcare team. Above all, we strive for high quality patient care as our first priority. We are pleased that you will become a member of our healthcare team and as such we expect you will endeavor to be caring responsible physicians and share in our priorities.

In addition to medical, surgical, and psychiatric and emergency ward as well as >25 operating rooms; the RAH has some unique program and facilities. The RAH is home to the Robbins Pavilion which houses both the Lois Hole Hospital for Women and the C.K. Hui heart Centre. The Lois Hole Hospital, in addition to delivering 6000 babies per year, also houses the Academic Department of Obstetrics and Gynecology and its own Davinci Robot. The C.K. Hui Heart Centre is the largest cardiac center in northern Alberta and specializes in minimally invasive cardiac care. Also within the Robbins Pavilion is the state-of-the-art Robbins Learning Centre including lecture theatres, classrooms, and a Simulator. The RAH is also home to the Regional Eye Centre and Academic Department of Ophthalmology. In addition, the RAH is connected by pedway to the Orthopedic Surgery Centre which is dedicated to hip and knee replacements using the latest technology.

In the sections that follow we will try to provide you with some of the essential information that is traditionally just handed down by word of mouth to new residents. It will be an ever-changing work in progress.

So I would again like to welcome you and if there is anything you require to help you obtain your educational goals here at the RAH please contact the Medical Education Office in room ATC 1107 at phone number 780-735-5239. Sherry Holtet is the Program Assistant and Dr. Laurie Nadwidny is the Site Lead for Medical Education.

Quality

A. General information

The RAH has as its goal to provide high quality patient care in a compassionate and caring environment.
We do this by sharing core values that we hope you will embrace as well. These core values are:

- compassion
- commitment to quality
- respect for the individual
- teamwork
- continual improvement through education and innovation
Through our shared values we strive to achieve our goals. It is our expectation that you will support these values and goals during your time at the RAH.

B. Patient and Family Centered Care

The RAH supports Patient and Family Centered Care. By this we mean we include the patient and their close family members/caregivers as part of the health care team. We do this by keeping them informed and including them in all aspects of decision making from treatment planning to Goals of Care Designations to discharge planning.

C. Privacy and Health information

All residents must comply with the AHS Information Security and Privacy Safeguards. AHS information security and privacy training is mandatory for residents upon commencement of their duties and annually thereafter. Residents must sign an AHS Confidentiality and User Agreement form. Residents must immediately report any information security breach to the AHS Information and Privacy Office of the IT Security and compliance office as appropriate. For urgent matters, such as a potential Information Security Incident, email securityincident@albertahealthservices.ca. If the information security incident requires investigation, an IT Security Analyst will contact you for more information.

D. Hand Hygiene

Clean Hands are a top priority at all Alberta Health Services facilities and as such the RAH has a strict hand hygiene policy that all members of the health care team are expected to follow. It includes, but is not limited to, washing before and after each patient encounter with either soap and water or alcohol based rub. Compliance is audited on a regular basis. Please see the diagrams that follow for further explanation.

Clean Hands are a TOP PRIORITY in our hospitals.

No Excuse

The Clean Hands Commitment

- I will clean my hands
- I will show patients I clean my hands
- I will help others to clean their hands

When to clean your hands
How to clean your hands:

If your hands look and feel clean

Alcohol Based Hand Rub (ABHR)

If your hands are visibly soiled
Or you have been in contact
With a patient with diarrhea

Soap and Water

Always clean your hands before accessing any supplies.
E. Infection Prevention and Control

Strict adherence to Infection Prevention and Control procedures and policies are expected from all members of the health care team. It is your responsibility to familiarize yourself with the procedures and policies in place. The information that follows will provide you with a guide as to when you need to order isolation for your patients and what type of Personal Protective Equipment (PPE) is required by medical providers in different situations.

Screening Tool to determine if an admitted patient needs isolation
If a patient is symptomatic with **diarrhea**, contact isolation.

If coughing, hacking, sneezing **etc**, contact and droplet isolation.
InFLUenza Season

If your patient is:

**ADULT:** Acute onset of respiratory illness with fever and cough, AND with one of more of the following:
- sore throat
- joint pain
- muscle aches
- severe exhaustion

**PEDIATRIC:** Acute onset of any of the following symptoms; runny nose, cough, sneezing, +/- fever.
Note: In children under age of 5, gastrointestinal symptoms may also be present. In patient under age 5 or age 65 and older, fever may not be prominent.

You need to:

Put the patient on **Contact and Droplet Precautions**
Create a space of 2m from the next closest patient
Perform hand hygiene (ABHR or soap and water)
Encourage Respiratory Etiquette (cover their cough) in your patient
N95 respirators are required for aerosol generating medical procedures ONLY in influenza A + B confirmed cases

**REMEMBER TO GET YOUR FLU SHOT**

Diarrhea

If your patient has diarrhea and you don’t know the cause (such as tube feeds, laxative use, etc) you need to put them on **Contact Precautions, start a stool chart and contact IPC (5-4549).**

**Never Discontinue** Additional Precautions without consult from IPC. You must phone IPC (5-4549) and speak to someone.

The only exception to this is if a Pulmonologist wants to discontinue airborne precautions specifically for Tuberculosis.
These signs tell you specifically what type of PPE you need to use for each type of precaution. They are based on how the organism is transmitted.

**Contact** – Gown and Gloves

**Airborne and Contact** – Gown, Gloves, and a fit tested N95 respirator

**Droplet** – Mask and Eye protection (personal glasses do not count!)

**Contact and Droplet** – Gown, Gloves, Mask and Eye protection

**Airborne** – fit tested N95 respirator

If you initiate Additional Precautions on any patient, please call Infection Prevention and Control @ 735-4549 and leave information including patient name, PHN/ULI, and type of precautions implemented and why (symptoms).
PUTTING ON (DONNING) PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. **HAND HYGIENE**
   - A. Using an alcohol-based hand rub is the preferred way to clean your hands.
   - B. If your hands look or feel dirty, soap and water must be used to wash your hands.

2. **Gown**
   - A. Make sure the gown covers from neck to knees to wrist.
   - B. Tie at the back of neck and waist.

3. **Procedure/surgical mask**
   - Secure the ties or elastic bands around your head so the mask stays in place.
   - Fit the movable band to the nose bridge. Fit snugly to your face and below chin.

4. **Eye protection or face shields**
   - Place over the face and eyes and adjust to fit.

5. **N95 respirator**
   - Pre-stretch both top and bottom straps before placing the respirator on your face.
   - Cup the N95 respirator in your hand.
   - Position the N95 respirator under your chin with the nose piece up. Secure the elastic band around your head so the N95 respirator stays in place.
   - Use both hands to mold the metal band of the N95 respirator around the bridge of your nose.
   - Fit check the N95 respirator.

6. **Gloves**
   - Pull the cuffs of the gloves over the cuffs of the gown.
This is very important as you can make yourself sick (inoculate yourself) if you do not do this correctly. You must wash your hands between each step and work from dirtiest (gloves) to cleaner (gown) to cleanest (face – mask and eye protection). This ensures that you have washed your hands 2X before coming in contact with your face.
F. Concerns Regarding Patient Quality

Reporting Concerns with Quality and Safety

Concerns regarding quality and safety are generally reported by the nursing staff. They utilize the AHS tool “Report and Learning System”, or RLS. If you have concern, please discuss it with the Unit Manager who will follow up on your concern.

G. Disclosure of Adverse Events

Disclosure of Adverse Events:

What is disclosure?
Disclosure is a formal process involving open discussion between a patient and/or family members of the healthcare organization about the events leading to harm and/or a close call. We encourage this in consultation with the attending physician in all adverse event situations.

What is harm?
Harm means an unexpected outcome for the patient, resulting from the care and/or services provided, that negatively affects the patient’s health and/or quality of life.

Is Disclosure of Harm different from reporting of Adverse Events?
Disclosure is only one component of the management of the adverse event. An adverse event is an unexpected occurrence that reaches the patient. For more information regarding management and reporting of adverse events please visit the AHS Reporting and Learning System (RLS) webpages http://insite.albertahealthservices.ca/1820.asp

Is the Disclosure of Harm policy different from the Safe Disclosure policy?
Yes. The Disclosure of Harm policy provides structured guidance for disclosing harm to patients and families. The Safe Disclosure policy addresses the reporting of unethical or illegal activity within AHS.

Documentation and Communication

A. General Information
Effective communication with other members of the health care team is vital in providing high quality patient care. The cornerstone of this is DOCUMENTATION. This covers everything from writing orders, dictating, and writing histories to filling out forms for discharge, Goals of Care or death. This is very important and the following information is intended to be a guide to help you perform these duties effectively and efficiently.
B. Medical Records and Dictation

Medical records is located on the 1st floor of the main building in Room 1411 and is open 24/7. Phone number is 735-4222. They are happy to pull charts for you for clinical work, presentations or research projects.

Medical Records Expectations (from AHS Medical Staff Rules)

1.21.3 HEALTH RECORD COMPLETION GUIDELINES

All members of the Medical Staff shall complete health records within the following timelines using the systems made available for handwritten records, dictation, electronic entry, and signature.

<table>
<thead>
<tr>
<th>TYPE OF REPORT</th>
<th>TIMELINES FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Note (History, Physical Examination, Impression &amp; Plan)</td>
<td>Within twenty-four hours following admission except in a surgical emergency, in which case the Admission Note is to be completed, if at all possible, prior to the surgical procedure. Elective Admission Notes may predate admission by up to one year; all such Admission Notes must be updated and validated by the admitting Practitioner within twenty four hours of admission.</td>
</tr>
<tr>
<td>Verbal Practitioner Orders</td>
<td>Verified within twenty-four hours.</td>
</tr>
<tr>
<td>Operative Report</td>
<td>Within twenty-four hours of surgery.</td>
</tr>
<tr>
<td>Anaesthetic Record</td>
<td>At the time of surgery.</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>Within fourteen days of chart being made available for dictation.</td>
</tr>
<tr>
<td>Emergency Notes</td>
<td>Within twenty-four hours of visit.</td>
</tr>
<tr>
<td>Ambulatory/Outpatient Records</td>
<td>Within twenty-four hours of visit.</td>
</tr>
<tr>
<td>Consultation Reports</td>
<td>Within twenty-four hours (preferably upon completion of consultation)</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>Daily progress notes are recommended for Patients in acute care Facilities, unless the Patient is awaiting placement in a Continuing Care Facility in which case a weekly note is recommended. For Patients in Continuing Care Facilities, progress notes are recommended at least monthly. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Patient’s condition or management, and whenever unexpected events or outcomes occur.</td>
</tr>
</tbody>
</table>

Dictations: Dictation, Speech Recognition, and Transcription (DST) system is now live. For immediate telephone support available 24/7, contact DST Hotline at 1-844-944-3099
Admissions:

- All histories must be dictated. Medical records can give you a dictation code if you do not already have one.
- Press “6” at the end of your dictation. This allows quick upload to Netcare.
- Utilize the Admission Bundles and ensure you complete:
  - A patient history
  - Write admission orders
  - Complete Medication reconciliation (Med Rec) Form
  - Consider if the patient is clinically relevant for a GCD conversation
  - Anticipated Day of Discharge (ADOD) – on admission, ADOD needs to be determined for every patient.
  - Plan of Care – document in physician’s orders.

Discharge:

- Patients in hospital greater than 72 hours require discharge dictation. Availability of good quality discharge dictations is an important goal to facilitate communication and quality care.
- Discharging of patients should be determined the day before and all orders, prescriptions (MDV) need to be written on the chart. The goal is to have patients discharged by 0900 H. If discharge orders are not received in a timely fashion, the attending physician will be contacted for discharge orders.
- Med Rec Form – Needs to be reconciled on discharge.

C. Standardization of Charts

While it is the goal of AHS to have charting procedures standardized across the Edmonton Zone, differences between sites currently exist. It is your responsibility to orient yourself to the unit you are working on and their procedures for charting.

Each unit has a Unit Manager (UM) and allocated Charge nurse at the desk. Please touch base with either the UM or the Charge Nurse or the UM or the Charge Nurse regarding the plan of care for your patients daily.

Please return all charts to their proper locations.

D. Documentation Tips

Clinical documentation includes all documentation in the patient’s record that relates to patient care. The attending physician bears the primary responsibility for all documentation contained in the chart.
TIP # 1- Clearly articulate the most responsible diagnosis (MRDx) record.
TIP #2 – Document all comorbidities that impact the patient’s stay
TIP # 3 – Document Complications or Adverse Reactions – reflects acuity of patient
TIP # 4 – Avoid stating Symptoms as Final Diagnosis
TIP # 5 – Document Significant Findings from Radiology/Pathology/Lab reports
TIP # 6 – Document a Diagnosis for each Medication or Therapeutic Treatment
TIP # 7 – Avoid use of Symbols or Abbreviations with Multiple Meanings
TIP # 8 – Document Palliative Care
TIP # 9 – Document Flagged Interventions- these are a reflection of patient acuity
TIP # 10 – Be specific in your diagnoses

- Bacteremia vs. Sepsis
- Chronic vs. Acute
- Cancer vs. History of Cancer
- Staging of decubitus ulcers
- Diabetes Type 1 or Type 2
- Specify “Post-Op”, due to
  Causative organism (for pneumonia, sepsis, etc)
- MI (STEMI/NON-STEMI OR Q-wave/Non Q-wave)
  Stroke (due to embolism, thrombosis, ischemia etc.)
- Dementia Type (vascular, multi-infarct, Alzheimer’s)
- Pneumonia (type, cause, aspiration, ventilator assoc.)
- Chronic Kidney Disease (specify Stage I-V based on GFR)

Documentation should includes terms like “treated”, “medication adjusted”, “uncontrolled”, “prolonged length of stay” to clearly identify co-morbid conditions and accurately reflect patient acuity and use of resources. For best clinical documentation it is recommended that OR Reports be completed immediately after surgery and Discharge Summaries be completed upon discharge

If it isn’t documented – It didn’t happen
# E. Abbreviations

## Alberta Health Services Dangerous Abbreviations, Symbols, and Dose Designations List

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Intended Meaning</th>
<th>Problem/Do Not Use</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>unit</td>
<td>Mistaken for “0” (zero), “4” (four), or cc</td>
<td>Use “unit”</td>
</tr>
<tr>
<td>IU</td>
<td>international unit</td>
<td>Mistaken for “IV” (intravenous) or “10” (ten)</td>
<td>Use “unit”</td>
</tr>
</tbody>
</table>

### Abbreviations for drug names

Mistaken because of similar abbreviations for multiple drugs; e.g., MS, MSO₄ (morphine sulphate), MgSO₄ (magnesium sulphate) may be confused for one another

Do not abbreviate drug names

QD and QOD have been mistaken for each other or as ‘qid’. The Q has also been misinterpreted as “2” (two).

### OD
Every day

Mistaken for “right eye” (OD = oculus dexter)

Use “daily” or “every other day”

### OS, OD, OU
Left eye, right eye, both eyes

May be confused with one another

Use “left eye”, “right eye” or “both eyes”

### D/C
Discharge

Interpreted as “discontinue” whatever medications “follow” (typically discharge medications)

Use “discharge”

### Symbol
Intended Meaning | Problem/Do Not Use | Correction |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>@</td>
<td>at</td>
<td>Mistaken for “2” (two) or “5” (five)</td>
</tr>
<tr>
<td>&gt;, &lt;</td>
<td>Greater than, Less than</td>
<td>Mistaken for “7” (seven) or the letter “L”, confused with each other</td>
</tr>
<tr>
<td>≥, ≤</td>
<td>Greater than or equal to, Less than or equal to</td>
<td>As above for greater than and less than</td>
</tr>
</tbody>
</table>

### Dose Designation

<table>
<thead>
<tr>
<th>Intended Meaning</th>
<th>Problem/Do Not Use</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trailing zero</td>
<td>X.0 mg</td>
<td>Decimal point is overlooked resulting in a 10-fold dose error</td>
</tr>
<tr>
<td>Lack of leading zero</td>
<td>.X mg</td>
<td>Decimal point is overlooked resulting in a 10-fold dose error</td>
</tr>
</tbody>
</table>

*Write it out so there is no doubt!*
F. Goals of Care Designation

Goals of Care Designation (GCD)

GCD conversations should take place, where clinically indicated with the patient, as early as possible in a patient’s course of care and/or treatment. All GCD conversations should be documented on the GCD tracking record so all health care professionals are aware of patient’s advance care wishes.

Residents may have goals of care conversations with patients to determine a GCD Order. The attending physician is ultimately responsible for ensuring that a clinically indicated GCD order has been discussed. Residents need to discuss the GCD order with the attending prior to writing an order and attending must co-sign order in 48 hours.

G. Certification Under Mental Health Act (Form 1)

When a patient is deemed to be suffering from a mental illness that has made them a threat to themselves of others they can be certified under the Mental Health Act and kept in hospital against their wishes. Although any attending physician is allowed to fill out a form on a patient it is usually done only by Emergency Medicine and Psychiatry.
Discharge Against Medical Advice

Situations sometimes arise when patients wish to be discharged from hospital when it is actually in their best interest to stay. If you feel your patient may come to harm from...
discharging themselves, and you have been unable to negotiate options for them to stay in hospital, then it is advised to have the patient sign the Discharge Against Medical Advice form. Please fill it out completely, have the patient sign it and notify the attending physician.

SECTION I: REFUSAL OF PHYSICIAN’S ADVICE

I, ___________________________________________ presently a patient at the ______________________________

hereby acknowledge that I have been advised by Dr. __________________________________________ to undergo or accept

the following: __________________________________________

____________________________________________________________________

(Brief description of proposed operation or procedure)

the nature of which has been fully explained to me.

I HEREBY REFUSE to undergo the above described operation or procedure. I am aware of the implications to my health of such refusal.

FOR GOOD AND VALUABLE CONSIDERATION, I HEREBY UNDERTAKE AND AGREE to hold the doctor, Capital

Health Authority or Caritas Health Group, and any other relevant health care professional free from all liability for any

harmful consequences that may result directly or indirectly by reason of my refusal to adhere to the said physician’s advice.

SIGNED at ______ hour(s), this __________ day of _________ , (Year) _________

(Signature of patient / parent / guardian) (Witness to patient / parent / guardian signature)

SECTION II: DISCHARGE AGAINST ADVICE

• I acknowledge that I have refused recommended health care against the advice of a physician or other health care provider.

• I acknowledge that I have been informed that risks to my health may be involved and I understand the potential consequences.

• I hereby assume any such risk and release the Capital Health Authority or Caritas Health Group, and relevant health care personnel from any liability or responsibility for any consequences, including injury or damages, which may result from my action.

(Signature of Patient / Parent or Legal Guardian) (Date)
I. Declaration of Death

You may be called upon to declare a patient dead at some point in your career. As with everything, there are policies to follow and forms to fill out.

Firstly, you need to examine the body and declare that death has occurred.

You do this by observing the patient for 1 minute with no evidence of breathing, listening to the chest for 1 minute with no evidence of heart sounds and by observing fixed and dilated pupils with no corneal reflex.

Note the time and record your findings and the time in the chart.

Then it is important to notify the charge nurse, the attending physician and most importantly the next of kin.

Consider if it is to be a Medical Examiner’s case in consultation with the attending physician (the back of the death certificate has many helpful points to guide you in this matter).

The attending physician usually fills out the Death Certificate the following day.
**Certificate of Death**  

**the checklist on the back of this form is very helpful.**
Instructions to the Attending Physician

The Medical Certificate of Death must be completed and signed by the attending physician within 48 hours of the death to avoid delaying funeral arrangements. If the attending physician is unable to complete the certificate within the 48 hour time frame, the funeral director or the attending physician is to notify a medical examiner.

This form must not be completed by the medical examiner.

The Medical Certificate of Death is a permanent legal record.

Type or print clearly in black ink.

A. When
   • a Physician
     1. has attended the deceased person in relation to the deceased’s final illness at least once during the 14 days immediately preceding death,
     2. is able to certify the medical cause of death with reasonable accuracy, and
     3. has no reason to believe that the deceased died under circumstances that require the notification of a medical examiner under the Fatality Inquiries Act,

or

When
  1. the death was natural or occurred during an operative procedure or within 10 days after an operative procedure and a physician
  2. is able to certify the medical cause of death with reasonable accuracy, and
  3. is authorized to complete and sign the medical certificate of death under section 19(7) of the Fatality Inquiries Act,

the physician shall within 48 hours of the death complete, sign a medical certificate of death stating the cause of death according to the International Classification.

B. Accidental, violent, or any unnatural deaths cannot be certified by the attending physician and must be reported to the medical examiner.

Checklist for Notification of the Medical Examiner
   • Unexplained deaths.
   • Unexpected deaths when the deceased was in apparent good health or not under the care of a physician.
   • Deaths as a result of violence, accident, suicide or poisoning, irrespective of the time between receipt of the injury and death.
   • Deaths as a result of improper or negligent treatment.
   • Deaths that occur within 10 days of an operative procedure, or while under or during recovery from anesthesia.
   • Deaths while in custody of any person.
   • Deaths resulting from any disease, ill health, injury or toxic substance arising from a person’s occupation at any time (including deaths due to malignant mesothelioma).
   • Death of a formal patient of any mental health facility or any other institution defined in regulations under this Act.
   • Death of a young person under child welfare custody.

C. Refereeing refers to notifying a medical examiner when the attending physician has not been in attendance for 14 days or the death occurs within 10 days of surgery, yet the death was natural, and a physician is able to satisfy a medical examiner that he can give the medical cause of death with reasonable accuracy. The medical examiner may then, under the authority of the Vital Statistics Act, consent to the physician completing and signing the Medical Certificate of Death. The activity of “refereeing” applies only to entirely natural deaths and the medical examiner, under the circumstances, is required by law to ask the physician about the cause and manner of death.

D. An Interim Medical Certificate of Death may be issued when
   1. the cause of death cannot be determined within 48 hours of the death, and
   2. either
      (a) an autopsy is performed, or
      (b) an investigation is commenced under the Fatality Inquiries Act,

   and
   3. the physician who performs the autopsy or the medical examiner who commences an investigation under the Fatality Inquiries Act considers that the body is no longer required for the purposes of the autopsy or investigation.

The final Medical Certificate of Death must be completed and signed and delivered to Vital Statistics within 60 days after the Interim Medical Certificate of Death is issued per Section 33(4) of the Vital Statistics Act.

E. Examples
   The following examples illustrate the essential principles in completing the Medical Cause of Death section.

<table>
<thead>
<tr>
<th>Part 1</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Cause of death, giving</td>
<td>(a) Lobar pneumonia due to (or as a consequence of)</td>
<td>Acute peritonitis</td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>Antecedent Cause(s) if any, next</td>
<td>(b) due to (or as a consequence of)</td>
<td>Acute appendicitis</td>
<td>Coronary thrombosis</td>
</tr>
<tr>
<td>state the Underlying Cause last</td>
<td>(c)</td>
<td>Atherosclerotic coronary artery disease</td>
<td></td>
</tr>
</tbody>
</table>

Part 2

Other Significant Conditions contributing to death but not causally related to immediate cause of (a) above

| | | Diabetes | Cancer of breast |

DVS3122 (2012/05)
Medication Management

A. Medication Reconciliation

Medication reconciliation is the method of tracking patient’s medications from admission, throughout their hospital stay and upon discharge to ensure clear communication to all concerned exactly what medications the patients requires.

There are 5 elements of Medication Reconciliation

1) Best Possible Medication History (BPMH) – on admission a medication history is taken using at least 2 sources (eg. Netcare, pharmacy, Family doctor, patient or caregiver)

2) Whenever possible the patient or caregiver should be one of those sources

3) Each medication should have the name, dose, route and frequency.

4) Every medication on the BPMH should be accounted for on the admission orders (even if it is to be held of discontinued)

5) Document the rationale for change or discontinuation of medications.

See attached form.
5 Elements of Quality MedRec

1. Use at least 2 different sources for Best Possible Medication History (BPMH).

2. Whenever possible, a patient/caregiver interview should be one of the sources of information.

3. Each medication order should have name, dose, route, and frequency.

4. Every medication on BPMH should be accounted for on admission orders.

5. Prescriber has documented rationale for changed or discontinued/held meds.

Did you know 67% of patients have at least one error in their prescription medication history.

Did you know a study of MedRec at admission found a 43% reduction in actual adverse drug events caused by errors in admission orders.

Documenting the rationale for changes facilitates communication to patients/caregivers/family as well as other healthcare providers at all transitions.

www.albertahealthservices.ca
B. Formulary

RAH Pharmacy 735-4464 is available to answer any questions relating to the medications for your patient.

AHS Provincial Drug Formulary

The Drug Formulary is a listing of pharmaceutical products that have been approved by the Pharmacy/Drugs and Therapeutics Committees (P&T or DTC) of all of the former health regions within AHS. These committees include representation from physicians, pharmacists, nurses, and other health professionals. Its purpose is to evaluate and provide recommendations of Drug Formulary status based on the evidence of efficacy, safety, and cost-effectiveness. The Drug Formulary applies to inpatient hospital and community health sites but does not apply to continuing care centres within AHS.

The Drug Formulary is routinely updated, available on-line, and provides:

- A list of all drug formulary items
- Drug Formulary restrictions and guidelines for use
- Therapeutic interchanges
- Other relevant formulary-related information

Formulary Policy and Related Documents

- [Provincial Drug Formulary System Policy](#)
- [DTC Position Statement on the Use of Non-Formulary Drugs in Patient Care Order Sets, Care Pathways](#)
- [AHS Outpatient Cancer Drug Program Benefit List](#)

For more information about the Drug Formulary, please contact [AHS Drug Utilization](#).

- Low-Cost Non-Formulary (NF) Process

  Applies to NF medications where the cost per course of therapy is less than $1500.

  [Standard AHS Low-Cost NF Process](#)

AHS NF Order Assessment Algorithm

A Low Cost NF Process and a NF Order Assessment Algorithm are available to all zones/sites within AHS. To meet each zone/site’s specific needs, the Pharmacy departments have been given the option to customize the algorithm. Click on this link to access the Royal Alexandra Hospital NF Order Assessment Algorithms: [Royal Alexandra Hospital (RAH)](#)

For more information about the AHS Low-Cost NF Process, please contact your site Pharmacy manager or [AHS Drug Utilization](#).

Drug Prescribing Practices & Abbreviations:

There are several resources on Insite:

http://insite.albertahealthservices.ca/6006.asp

C. Triplicate Prescriptions

Triplicate Prescription Program (TPP) and AHS

Medication List (generic names)

• Buprenorphine (refer to “Prescriber Notes” on CPSA website)
• Butalbital preparations
• Butorphanol
• Dextropropoxyphene
• Fentanyl/Sufentanil/Alfentanil
• Hydrocodone – Dihydrocodeinone
• Methylphenidate (exception: Concerta® brand of methylphenidate is excluded from TPP requirements)
• Meperidine – Pethidine
• Ketamine
• Hydromorphone – Dihydromorphinone
• Methadone (may be prescribed only by physicians authorized by Health Canada for opioid dependency or pain management)
• Morphine
• Pentazocine
• Tapentadol
• Normethadone
• Oxycodone

For a printable list that includes sample trade names, refer to the CPSA website:
http://www.cpsa.ab.ca/Libraries/pro_tpp/TPPMedicationList_Generic.pdf?sfvrsn=0

Physicians are not required to write a triplicate prescription for orders for TPP medications for inpatients in an AHS facility.

In order to prescribe TPP drugs in the community, a Triplicate Prescription Program form must be used. Physicians, including residents, who prescribe analgesics on discharge, are encouraged to enroll in the Triplicate Prescription Program and obtain triplicate prescriptions from the College of Physicians and Surgeons of Alberta.

Medical residents must obtain approval from their program director prior to registering with the Triplicate Prescription program. Application forms are available from program directors and on the CPSA website.
Triplicate Prescription Pad - use and re-ordering

Following registration, medical residents receive a personalized triplicate prescription pad which contains fifty prescription forms. A re-order form is included in the pads, with a limit of one pad per order per medical resident. Pads may be re-ordered by phone, fax or email using the re-order form.

Note: The prescriber information will be different from that of other registered physicians; instead of clinic location details, residency program information will be printed. Other areas of the form remain the same.

For more information, refer to the Information for the Prescriber publication or contact the TPP department at CPSA.


Consent

A. General Information

Consent from the patient or their legal guardian must be obtained before any treatment or procedure is begun. Although most patients are willingly in hospital and accepting of treatment, some things require written and signed consent. These things include but are not limited to, invasive procedures (ex. Biopsy), surgical procedures, invasive diagnostic imaging injection of contrast), and blood transfusions. For procedures that require written consent, the risks and benefits must be discussed with the patient. The procedure must be clearly written with no abbreviations. If the patient is agreeable, they are asked to sign and date the consent form. A physician must sign as well. For some procedures it is acceptable for a resident to sign but others require the attending physic to sign, this will need to be clarified with your service.

B. Blood Transfusions

Consent: Consent forms must be completed correctly including signed with date and time.

Blood Transfusions, Policy & Consent:

Obtaining informed consent for administration of blood products is a requirement for accreditation of all hospital facilities. Ensure you sign and include date and time. This link will take you to “Blood and Blood Products Informed Consent Frequently Asked Questions”

C. Procedures
There are procedure consent forms available on each unit and in Emergency.

D. Surgery
When a patient is booked for surgery, patient and procedure specific consent forms are automatically generated.

Emergency Response

A. General Information

It is important to know how to get help if your patient’s condition suddenly deteriorates into a life-threatening situation. Apart from notifying and requesting help from your Chief Resident or Attending Physician there are other services you can activate.

You can “call a code” at any time you feel the situation requires it. The Emergency Response Code Chart is included for your reference.

If you patient requires urgent care but you don’t feel you need to call a code then you can activate the Rapid Response Team (RRT) at the RAH and the Adult Medical Emergency Team (MET) at the UAH.

B. Emergency Response Code Chart

This chart is provided in the next few pages and is also provided with your ID badge.

C. Adult Medical Emergency Team (MET) – UAH

MET can be activated for a sudden or acute physiologic change. By calling 33# the MET team will be activated and respond within 15 minutes.

D. Rapid Response Team (RRT) – RAH

The RAH Rapid Response Team is an RN/RT led triage model. The RRT operates differently than the MET. When you call the RRT, and RN/RT will arrive within 15 minutes and work directly with you to assist you in caring for your patient. The RRT will not take over the care of your patient but the RRT goal is to “Help You Make it Happen”. RRT can escalate to an intensivist if needed. If the patient requires ICU care the attending physician must be notified.

The following pages indicates when it would be appropriate to activate the RRT.

Note: The MET and RTT triggers are the same.
## Emergency Response Codes

### Quick Reference Sheet

**Emergency / Disaster Management**  
**September 7, 2010**  

<table>
<thead>
<tr>
<th>Code</th>
<th>Who can activate this code?</th>
<th>Insert # to call from your site-specific plan</th>
<th>What do I need to do?</th>
</tr>
</thead>
</table>
| **CARDIAC ARREST / MEDICAL EMERGENCY**  
**CODE BLUE** | Anyone who finds a person in cardiac arrest or seriously injured | | • Check for unresponsiveness  
• Call for help  
• Call switchboard or 911  
• Start CPR if required and trained |
| **FIRE**  
**CODE RED** | Anyone discovering a fire or smoke | | • R- remove from danger  
E- ensure door closed  
A- activate alarm  
C- call switchboard or 911  
T- try to extinguish  
P- pull pin  
A- aim  
S- squeeze  
S- sweep |
| **VIOLENCE / AGGRESSION**  
**CODE WHITE** | Anyone who is threatened | | • All available staff respond to area |
| **HOSTAGE**  
**CODE PURPLE** | Anyone discovering the incident | | • Notify Protective Services or Police  
• Cordon off area  
• Do not enter area of hostage taking  
• Refer to dept/service plan in Emergency Response Manual |
| **MISSING PERSON**  
**CODE YELLOW** | Manager / Designate | | • Search immediate work area  
• Assist as directed by response personnel  
• Observe for suspicious activity |
| **BOMB THREAT / SUSPICIOUS PACKAGE**  
**CODE BLACK** | Anyone who receives a bomb threat or finds a suspicious package | | • Alert others  
• Record info on Bomb Threat Checklist  
• Conduct visual search  
• Report any suspicious packages |
| **SHELTER IN PLACE / AIR EXCLUSION**  
**CODE GREY** | Administration, Facilities Maintenance & Engineering | | • Stay indoors  
• Close all windows and doors  
• Be prepared to evacuate if necessary |
| **EVACUATION**  
**CODE GREEN** | Manager / Designate  
Fire, Police | | • Follow instructions  
• Provide assistance as required |
| **CHEMICAL SPILL / HAZARDOUS MATERIAL**  
**CODE BROWN** | Anyone who encounters a spill | | • Stop all work  
• Contain the spill as trained  
• Remove unnecessary personnel  
• Assess if Minor or Major spill |
| **MASS CASUALTY INCIDENT**  
**CODE ORANGE** | Admin On-call or Designate will activate Administrative fan-out | | • Refer to dept/service plan in Emergency Response Manual  
• Bring in AHS identification card |

---

1 These are the 10 Emergency Response Codes approved for AHS. Those slight variations used by some former health regions are in the process of being transitioned out.

www.albertahealthservices.ca
Pastoral Care services may be requested at anytime (24 hour coverage) by contacting the switch board (0) and asking for the Chaplain On-Call. He/She will be helpful in accessing help for more specific spiritual needs as well (ex Aboriginal ceremonies) when requested. During the day requests or referrals may be made through their office 735-4119.
F. Addiction Recovery Community Health (ARCH) Team

ARCH team assists patients who have an active substance use issue and/or are dealing with social inequity. Team includes a social worker, nurse practitioner and a physician. Working in partnership with the admitting team, ARCH can assist with:

- Complicated drug and alcohol withdrawal
- Assessment and treatment recommendations for any substance of misuse
- Counseling and motivational interviewing
- Initiation or maintenance of opioid agonist therapy (e.g. methadone or buprenorphine)
- Harm reduction supplies and overdose prevention
- Linkage to primary and community based care
- Housing, health care coverage, ID
- Health promotion and disease prevention

The full team is available 0800 to 1600 H Monday to Friday. ARCH physician is available for urgent medical consults every day from 0800 to 2100 H. To initiate a consult, please page the team at 780-445-2902.

G. Security Watch

Security Watch vs. Patient Watch
Security watch is a uniformed security officer for higher risk patients. Security watch is requested when there is a risk of violence towards staff, other patients or the patient being watched. Security watch is a service that provides close visual monitoring of patients who have displayed violent behavior towards staff or other patients.

Patient watch is requested for regular patients with relatively low risk level. Patient watch is provided where there is no identified risk of violence towards staff or patients. Patient Watch is a service that provides visual monitoring of patients who are at risk of wandering, eloping, pulling tubes, suicidal, dementia and other conditions requiring heightened level of observation.

A Patient Watch Request Form must be completed to request either of these types of coverage.
Your Safety and Well-Being

A. General Information

Your safety is very important. We will do our best to keep you protected from physical, emotional or infectious threats. There are protocols put in place for exactly those reasons, please follow them. If you feel your needs in this regard are not being met please notify the Medical Education office in ATC 1107.

B. Personal Protective Equipment

It is our expectation that you will practice every day precautions for every patient you see such as; Hand Hygiene, Respiratory Etiquette, Sharps Disposal and the use of PPE.

C. Needlestick Injury

If you suffer a needlestick injury or another form of blood and bodily fluid exposure (ex. Eye splash) there are important things that you need to do for your own safety. There is a protocol to follow. If this occurs call 1-888-482-8550 and you will be guided through the process using the staff incident/injury reporting kit.

Needlestick Injury:
Link to Consent form: http://insite.albertahealthservices.ca/frm-18213.pdf

D. Security

Security Services are available to assist you whether it is for protection from a threatening patient or escorting you to your car. See the following for details. They have also provided some tips for theft prevention.

E. N95 Fit Testing

It is important that you be fit tested for the proper style and model of N95 mask for you. This is for your protection to guard against inhaled pathogens when circumstances require its use.

Protective Services:

We provide the safewalk program 24/7 to staff members parked on AHS property. Our scope includes, but is not limited to:

- Excellence in customer service
- General inquiries (i.e. lost and found, door openings, safewalk to vehicles)
- Fire and Life Safety Checks (i.e. fire drills, reporting of safety issues, staff welfare checks, and inspections)
- Continued patrols of the facility and grounds
- Patient Watch/Constant Watch Services
By incorporating the following theft prevention tips into our daily routines, we can assist in creating a more safe and secure environment for all:

1. Ensure you wear your Hospital I.D at all times.
2. Challenge those (e.g., Can I help you?) who are not wearing appropriate I.D.
3. Always be alert for suspicious persons and/or activities. Report all suspicious persons immediately to Protective Services @ ext. 54287 or if off site at (780) 735-4287.
4. Always lock the office door(s) when leaving the area unattended; even when leaving for very short periods of time.
5. Do not bring large sums of money or valuables to work.
6. Never leave valuable personal property (e.g., cell phones, jewellery, I-Pods) or attractive Hospital property (e.g., cell phones, laptops, memory sticks) accessible to the ‘would be’ thief. Maintain an inventory of valuables including description, serial number and value.
7. Always ensure computer memory sticks are password protected or encrypted and that this practice is strictly adhered to by all staff.
8. Be observant in your work area concerning new computers and associated peripherals, especially those that are located in the more common areas. If you notice something out of the norm (e.g., suspicious persons/activity, a computer with wires disconnected for no apparent reason) contact Protective Services immediately.
9. Always lock purses/wallets out of site and in a secure (locked) location.
10. Maintain the minimum amount of departmental keys required and develop strict key control practices.
11. Do not leave keys or access cards in plain sight and accessible to others; carry them on your person.
12. Do not identify or mark keys to identify the room number or location.
13. Never share banking or credit card information with telephone callers.
14. Never leave items of value in your vehicle that will be in plain view of those passing by. Ensure that they are hidden from view.
15. Ensure all thefts (perceived or actual) are reported to Protective Services immediately.
F. Food Availability

Food is available in the food court in the basement level of the DTCOR from 6:30 am until 9:00 pm, 7 days a week. Frozen and refrigerated food, as well as snacks, are available 24 hours from adjacent vending machines.

G. Library Services

The RAH library is located on the 1st floor of the main building in ATC room 1418. The librarians are very helpful with regard to literature searches from research projects or presentations. They can be reached 735-5832.

H. Workplace Harassment

Alberta Health Services is committed to providing a working environment free of harassment. Harassment, including sexual harassment, is considered unacceptable and subject to disciplinary review. Complaints will be investigated in a timely, objective and sensitive manner. (Alberta Health Services Policy # SWE-02). If you have any questions please feel free to contact the Medical Directors Office 735-4113.

Switchboard

A. General Information

Dial “0” for Switchboard. Switchboard needs up to date contact information for every resident and current call schedules.

B. How to Pick up a “Parked” Call

A parked call is a call which has been placed on hold by the switchboard that can be directly picked up from most phones within the hospital. Parked calls are usually outside calls (hospitals, clinics, doctors, etc), but may also be inside calls from phones with numbers that cannot be dialed.

Parked calls are located at the internal phone numbers 19600-19609.

The following number designates a parked call when it is received in your pager:

7354111960_

When you are inside the hospital:

1. Pick up a hospital phone, dial 1960_ and say hello, who you are, etc.
2. If there is no busy signal but not one responds, repeat yourself at least once more.
a. if you hang up the phone the call will also be hung up
b. You will not be able to redial the number and the called will have to call the switchboard to be placed on hold again.

3. If you receive a busy signal:
   a. The person on hold may have hung up, or
   b. The parked call is returning to the switchboard. When a parked call is unanswered for a few minutes they return to the switchboard to allow us to know they are still waiting on hold.
   When the call is in the process of returning to us, you will be unable to answer it.
   c. Therefore, wait a few minutes and try again or call the switchboard and ask if there is a call parked for you at 1960_.

When you are outside the hospital:

1. Call 780-735-4111
2. Advise switchboard who you are and that you have a parked call on 1960_.

Policies and Protocols

A. ERAS and Fasting Guidelines

Modern Fasting Guidelines and Preoperative Carbohydrate Loading:
- Patients must stop eating solid food 8 hours before surgery and clear fluids 3 hours before surgery.
- Preoperative carbohydrate loading. Patients consume 100 g of carbohydrate the night before surgery and 50 g carbohydrate 3 hours before surgery in liquid form to support faster gastric emptying and to minimize aspiration risk.
- The patient should drink 3 cups of apple or cranberry juice the evening before surgery and 2 cups of apple or cranberry juice 3 hours before surgery.
- Guidelines recommend diabetic patients follow the modern fasting guidelines and preoperative carbohydrate loading. However, it is important give diabetes medications as per usual practice and to monitor blood glucose levels.
- If physicians have concerns about carbohydrate loading in some patient populations (e.g. patients on fluid-restricted diets; gastroparesis, diabetics on insulin; renal patients), order the modern fasting guidelines without preoperative carbohydrate loading.

Enhanced Recovery After Surgery (ERAS) Protocol Bundle:
Colorectal surgeries in Edmonton fall under the ERAS protocol. ERAS protocol is best practice in perioperative care.

B. Diabetes Referral

Adult Diabetes Program Referral (www.albertahealthservices.ca/edmdiabetes.asp)
- A regional booking system offering a single point of referral for all diabetes services at multiple locations.
• Standardized triaging of referrals to match patient need to the best level of service/provider.
• Patients can self-refer into diabetes education classes.
• Support for primary health care providers including electronic monitoring and telephone advice.

DIAL (Diabetes Information and Advice Line for Physicians/Health Care Providers Only) 780-735-1050

• Health care providers can access a team of diabetes nurses, dietitians and diabetologists for:
  o Telephone consultation regarding management options
  o Hours of operation, 0900h to 1600h, Monday to Friday

C. Observation Units

Key Rules for Medical Observation Unit

• No intubation without ICU/CCU present
• Don’t do things you don’t know how to do and can’t deal with the complications
• Don’t use BiPAP without consultation with Pulmonary or ICU
• Don’t use vasopressors or inotropes
• Without expert back up for airway support the following cannot be performed in MOU: electrical cardioversion; conscious sedation for procedures
• No Swan Ganz catheters, temporary pacemakers, continuous sedation (Propofol); mechanical ventilation (except chronic stable home vent patients); neuromuscular blockade.

If you feel you need to break one of these rules, consult ICU or CCU or call a Code Blue.

D. Swallowing Assessments

Swallowing Assessments:
What to do when an SLP is not available to perform a swallowing assessment –.
Competency in Clinical Feeding and Swallowing Assessment in Adults
http://in site.albertahealthservices.ca/hpsp/tms-hpsp-ot-slp-council-competency-in-clinical-

E. Comfort Beds

5 East Comfort Beds: These beds are for C2 patients and in certain circumstances, C1 patients. There are strict criteria for these beds; a referral form must be completed prior to the patient coming to the unit.

Observation Room Admission Criteria:
**Surgical Observation Beds – PCU 31 & 33:** 12 designated Surgical Observation Beds for patients who are hemodynamically stable, but require: invasive blood pressure (e.g. arterial line), or invasive central venous pressure monitoring or intracranial pressure monitoring (e.g. EVD), cardiac monitoring, neck injury (blunt or penetrating) or chest injury (facial smash – Lefort III), hypovolemic shock resuscitation or post op patients with potential airway concerns. May be admitted directly from Emergency department, operating room, or transferred from a critical care bed or from another inpatient unit.

Physician orders must be written indicating admission to the Surgery Observation Rooms. **Under no circumstances are continuous infusions of inotropic or vasoactive medications to be administered.**

**Medical Observation Unit (MOU) – 6 beds on 6 West.** Any medical patient can be admitted. Cardiac monitoring and arterial line with monitoring, central lines with CVP monitoring, and expanded medical interventions possible. Patients who require short term monitoring (48-72 hours – reviewed daily) for stable arrhythmias (rapid afibrillation), diabetic ketoacidosis, COPD requiring BiPAP, and correction of electrolyte abnormalities. May consider ICU consult for ‘shared care’.  

**F. Disaster Planning**

In the event of a disaster, go to your assigned unit. DO NOT go to Emergency unless called. If at home, stay at home until your regular shift unless called to come in. DO NOT call the hospital. Bring your AHS ID to the hospital if called to come in.
Policy Listings

Here is a list of policies most often searched (control + click to follow the link—please note these can only be accessed through an AHS computer or VPN):

**Clinical Documents**

- Advance Care Planning & Goals of Care Designation
- Bridge Supply of Medication for Discharged Patients
- Cancer Drug Administration To Outpatients
- Consent to Treatment/Procedure(s)
- Creutzfeldt-Jacob Disease (CJD) Surgical Precautions
- Dangerous Abbreviations, Symbols and Dose Designations
- Disclosure of Harm
- Dispute Prevention & Resolution in Critical Care Settings
- Expressed Breast Milk: Safe Management
- External Beam Radiation Therapy Wait Time Access
- Hand Hygiene
- Harm Reduction for Psychoactive Substance Use
- Interaction between Alberta Health Services & Third Party Advocates
- Invasive Infusion Line & Tubing Verification
- Medication Reconciliation
- Newborn Metabolic Screening Program
- Patient Concerns Resolution
- Patient Identity Verification
- Patient Repatriation
- Patient Safety Reporting
- Pharmacist Administration of Intramuscular or Subcutaneous Medications
- Pharmacist Ordering of Laboratory Tests
- Procedural Sedation
- Provincial Drug Formulary System
- Safe Infant Sleep
- Safe Surgery Checklist
- Single-Use Medical Devices
- Standardized Medication Concentrations for Parenteral Administration
- Venous Thromboembolism Prophylaxis

Link to Clinical Policies (found on AHS Insite) [http://insite.albertahealthservices.ca/9558.asp](http://insite.albertahealthservices.ca/9558.asp)