

T H O R A C I C S E R V I C E

Orientation Manual for Residents and Fellows



St. Joseph's
Healthcare  Hamilton

McMaster
University 

D I V I S I O N O F T H O R A C I C S U R G E R Y

“ *Let the surgeon be bold in all sure things, and fearful in dangerous things; let him avoid all faulty treatments and practices. He ought to be gracious to the sick, considerate to his associates, cautious in his prognostications. Let him be modest, dignified, gentle, pitiful, and merciful; not covetous nor an extortionist of money; but rather let his reward be according to his work, to the means of the patient, to the quality of the issue, and to his own dignity.* ”

~ Guy De Chauliac, 1360

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WELCOME

We would like to extend a warm welcome to all of the new and returning Residents and Fellows.

Welcome to the Thoracic Surgery Division at St Joseph's Healthcare Hamilton. We hope you will enjoy your rotation with us. The service is very busy. You will work hard and learn a great deal.

This manual has been prepared to give you some hands-on information about how the Thoracic Service operates. It is not intended to be exhaustive and the service will change and expand over time.

The 4 Chest Unit will offer a wide variety of patients, surgeries, and experiences to enhance your practise. The staff are here as your colleagues to collaborate with you as part of our St. Joseph's Healthcare mission to provide optimal patient care. We understand the challenges that you face as you rotate through different clinical services every 2-3 months, while maintaining a high standard of patient care. Therefore, this manual has been created to assist with your orientation to the Thoracic Service.

The nursing staff and allied health members of this program appreciate the knowledge and expertise of our physicians, and we look forward to working with you. We trust that in return you will respect and appreciate the knowledge and expertise offered to you on this unit.

In this manual, you will find helpful hints and directions pertaining to the Thoracic surgery service, the Step Down Unit, and the Thoracic Unit. Please ask anyone of us if you have any questions, or concerns; we are here to work together to fulfill the St. Joseph's Healthcare mission and values and provide safe patient care.



St. Joseph
Healthcare

Welcome

**Thoracics
Surgical Step**

Leadership

Anne Marie MacDonna
Dr. Stuart Archibald—
Dr. Yaron Shargall—

If you have compliments
or comments or concerns
please speak with a member of our
Our Unit Manager is Deanna B
or Patient Relations

The Thoracic Unit

4 Chest is comprised of 3 separate units: the Surgical Step Down Unit (SDU), Head and Neck Unit (H&N), and the Thoracic Unit (4Chest). There is a total of 35 beds on the unit, 17 beds for the Thoracic Service, 8 Surgical Step Down beds, and 10 beds are designated Head & Neck; however at any given time thoracic patients may occupy these beds. The Head and Neck program is a separate program and will not be included in this orientation package.

Surgical Step Down is an 8-bed Level II Critical Care Unit—for those patients who require close observation and interventions for single organ failure. This may include non-invasive ventilation; and those who transition from a Level III Critical Care Unit. A large patient population from the Thoracic Service will be pre-booked for the Step Down Unit for immediate post-operative monitoring.

The Thoracic Unit is where most patients will be located until discharge home. On

occasion thoracic patients may be located in the Head and Neck Unit and/or other units in the hospital due to bed flow issues. In addition, at any given time, there will be several more patients for which the thoracic service will be **consulted**. Most of the time, these off-service patient consults will not present active issues overnight, however, make sure that you have a full sign-over list so you will have a good idea as to the treatment plan for each of those patients.



THE TEAM

Name	Position	Extension	
Dr. Y. Shargall Cell/Pager: 416-356-1552	Chief of Thoracic Surgery	X 33229	
Dr. C. Finley Pager: 2569	Thoracic Surgeon	X 33556	
Dr. C. Schieman Pager: 2230	Thoracic Surgeon Residency Program Director	X 37370	
Dr. W. Hanna Pager: 7100	Thoracic Surgeon	X 35916	
Paulette Aubry	Residency Coordinator	X 32267	
Laura Schneider	Research Coordinator	X 35877	lschnei@mcmaster.ca
Deanna Burnet Pager: 905-546-9050	Nurse Manager & Surgical Bed Flow Coordinator	X 33175	
Linda Gandy Pager: 8749	Nurse Educator	X 32010	lgandy@stjoes.ca
Lorraine Martelli-Reid Kathy Lubera RN	Lung Diagnostic Assessment Program (DAP)	X 35941	
Anna Tran, RN Cell: 905-870-0624	Integrated Comprehensive Care Coordinator	X 37696	

Other Useful Numbers

Switchboard	"0"	Radiology	X 36009
SJH Paging	X 33311	Film Library	X 33606
Direct 905-521-5070		Firestone Clinic	X 3600 then press "3"
St. Joseph's Healthcare	905-522-4941	Heather Connor (Speech and Language)	Pager # 915
OR Booking	X 36007	Tina Bear (PT)	Pager #8559
OR Front Desk	X 33387	Kristy Vaughan (PT)	Pager #8565
X 33855 (after 4pm)		Jodie Lavelle (Occupational Therapist)	Pager #167
Surgeon's Lounge	X 33397	Gisele Iskandar (Pharmacist)	Pager #X 32164
Bed Booking	X 33183	Jennifer Akimoto (Dietitian)	Pager # 8858 X 33509
Thoracic Unit	X 35290	Amardeep Singh (Social Worker)	Pager #905-524-7123
StepDown Unit	X 34009	MUMC Answering Machine	905-521-5030
Head & Neck Unit	X 33504		
Emergency Department	Triage Desk X33551 Charge Nurse X35830		
ICU	X 33350		
Endoscopy Booking	X 33289		
Endoscopy Charge Nurse	X 35215		

Thoracic Service Residency Program

There are four active Thoracic surgeons currently on service, namely, Dr. Y. Shargall, Dr. C. Finley, Dr. C. Schieman, and Dr. W. Hanna. You will be assigned to one of the surgeons at the beginning of your rotation.

Each team rounds on their own patients, and will look after issues related to patients' care during the day. It is expected that the on-call resident will receive a full sign-over from the other team in the early evening of his/her call day. You will, therefore, know all the patients on the service and will be able to provide the most appropriate care for the entire service. It is also expected that you will be in contact with the staff surgeon on-call that night, and will review all active issues.

Please refer to Appendix I - III for a brief job description that is specific for residents in Thoracic Service. These documents have

been extracted from the larger Resident's Program documents provided by McMaster University.

Appendix IV and V are documents pertaining to infection control practices in keeping with St. Joseph's Healthcare's corporate initiative to provide safe care for all patients and a healthy work environment for all staff. More information regarding infection control practices and personal protective equipment (PPE) can be found on the "My StJoes" website or by contacting Nancy Peddle, the Infection Control Nurse (X32954).

You will also find a master schedule included for all the staff surgeons in the Thoracic Surgery Service and a master schedule which may be used to facilitate your weekly planning.



The Nurses



Comprised of over 70 full time and part time Registered Nurses (RN) and Registered Practical Nurses (RPN).

RNs work 12 hour shifts 7am – 7pm and 7pm – 7am. RPNs work 8 hour shifts 7am – 3pm, 3pm – 11pm.

Nursing staff to patient ratio varies from 1:2 in the Step Down Unit and 1:4-6 on the Thoracic Unit.

The RNs and RPNs collaborate together to provide patient care. We also have a large number of new staff and student nurses working together most days. As regulated health professionals, all nurses are accountable to the College of Nurses of Ontario and patient care is assigned to the nurses based on their knowledge, skills and experience. If you have any questions concerning skill levels please address them with the nurse in charge.

The Nurse Practitioner

The nurse practitioner for the Thoracic team primary practice is focused on clinical patient care. With this, the nurse practitioner will work collaboratively with the residents to maintain high standards of care and provide ongoing clinical management of the thoracic patients while the residents fulfill their other duties within the OR and clinics. In addition to this the nurse practitioner provides educational opportunities for the unit staff and collaborates on research with the residents and staff physicians.



We are extremely fortunate to have the skills and expertise of our nurse practitioner Jacob Rushton

It is an expectation that the residents touch base with the nurse practitioner each morning prior to OR and clinics to communicate plan of care, as well as, in order for the nurse practitioner to be aware of any patient specific issues. Each day the nurse practitioner will provide a handover report for the on-call resident, however, this will not replace but supplement additional handover from the other teams' residents at the end of the day.



Surgical Step Down Unit (SDU) Information

Dr. Y. Shargall is the Medical Director of the Surgical Step Down Unit.

The Most Responsible Physician (MRP) is responsible for patient care while in Step Down. The thoracic surgeon is typically the MRP.

Patients must be seen by **8am** each day, before you, the Resident or Fellow, go to the Operating Room. This will facilitate timely transfers out of the Step Down Unit, and allow booked surgeries of the day to commence; otherwise surgeries are in jeopardy of being cancelled due to lack of Step Down beds.

The physician covering the Critical Care Response Team (CCRT) will also assist as the Surgical Step Down Co-ordinator. Their role is to actively facilitate admissions and discharges from the SDU in addition to providing critical care and medical support when required. If patients are deemed stable enough to be transferred to the Thoracic Unit, **a written order** indicating authorization to transfer must be in the chart prior to transfer.

All CCRT orders need to be confirmed and approved (cosigned) by thoracic service before they should be implemented.

As a level II Critical Care unit we offer:

- 5 Lead Cardiac Monitoring
- The ability to perform bedside bronchoscopy
- Gastroscopy may be performed with support of endoscopy staff
- Non-invasive Ventilation (BiPAP, CPAP)
- Basic hemodynamic monitoring (arterial lines, central venous pressure monitoring.)
- Continuous SpO₂ monitoring and airway monitoring beds
- Administration of inotropes and vasopressor medications





Thoracic Unit Information

This 17 non-monitored bed unit has up to 6 non-centralized 5-lead cardiac monitoring (telemetry) beds available for thoracic patients only. A higher level care bed should be sought for patients requiring 50% oxygen or greater (ie. Step Down Unit.). Additional monitoring ability, including oximetry beds, will be implemented in 2012.

All charge nurses are trained to pull chest tubes independently with the assistance of another Registered Nurse. Chest tubes can also be removed by a physician with the assistance of a nurse or another Resident/Fellow. It is desired that you will have at least one other person to assist you with any chest tube removal.

We are currently in the process of training all of the charge nurses to pull chest tubes; however, once the training program is completed ALL Registered Nurses will be trained to pull chest tubes. If you require assistance to remove a chest tube, please ask any one of the Registered Nurses. Chest tube removal kits, which will contain all supplies necessary to remove a chest tube, can be found on each of the units. An URGENT CXR (PA & LAT) must be ordered immediately after the last chest tube is removed.

Helpful Points

- ***A doctor's board is provided at each nursing station (on both the thoracic and Step Down Unit) to address outdated medications/clarifications, suggested consultations for additional team members, or any other patient concerns. Please check this during rounds to address these issues as this will reduce the need to contact you during the day.***
- ***Please speak to the charge nurse after rounding on the patients in order to facilitate timely discharge and accommodate new admissions.***
- ***Consultations must be made physician to physician; nurses cannot call for an initial consult. All recommendations made by the consulting service need to be reviewed and approved by thoracic service before being implemented.***
- ***If a radiology diagnostic test needs to be done urgently, contact the radiologist directly to ensure timely completion of the test. Please personally talk with the on-call radiologist to explain the clinical context of the problem.***
- ***Charts with orders are to be flagged appropriately (red flag) and returned to the chart rack when not in use. If the order is urgent or STAT please notify the unit clerk or nurse and the order will be processed and implemented as soon as possible.***
- ***As the Resident on call it is your responsibility to ensure that you have received FULL handover from the outgoing fellow/resident team and/or provided FULL handover to incoming team or fellow/resident on call. It is also your responsibility to touch base with the on-call staff surgeon so that both of you are aware of all the issues and concerns. It may also be beneficial to call the Thoracic/Step Down Unit around 10pm or 11pm to check if there are any new/recent concerns from the nursing staff.***



Equipment Storage

The **Bronchoscope Cart & Tower** is located in the Step Down Unit equipment room; this equipment must **NEVER** leave the unit. This cart should always be fully stocked for each use, with masks, Xylocaine, bite blocks, etc.

The **Central line/Arterial line Cart** is located in the Step Down Unit Equipment Room, fully stocked with various types/sizes of catheters, tubing, Xylocaine, sutures, etc.

The **Chest Tube Cart** is located in the Step Down Unit Equipment Room. This cart is stocked with various sizes of chest tubes, insertion trays, Xylocaine, sterile gloves, sutures, and dressings. There will be specific trays for pigtail, percutaneous and regular chest tube insertion. If you are inserting a chest tube on another unit, please gather the appropriate supplies to take with you for the insertion. Chest Tube Removal Kits are also available at each nursing station.

All other supplies (dressing supplies, personal protective equipment (PPE), suctioning equipment, minor procedure trays, etc) can be found on the shelves in front of the Step Down nursing station or in the clean core in 4Chest.



Map of Step Down Unit

- **Equipment Room**
- **Nurse Supplies**
- **Nursing Stations**
- **Elevator**



Discharge Home

The SDU, H&N, and 4Chest Unit continuously operates at 100% full capacity; therefore, discharges must be projected in order to make discharge preparations. It is your responsibility to anticipate discharges and discuss them with the staff surgeon, the patient, their family/caregivers, the responsible nurse and the charge nurse. Hospital standard for discharge time is 11am.

Please assess your patient, dictate discharge summaries, and write discharge orders for them prior to discharge. Most thoracic patients upon discharge require:

- Prescription for analgesia and bowel routine (please provide sufficient quantity)
- Follow-up appointment with PA/LAT Chest XRay requisition -- indicate follow-up time:
 - Dr. Yaron Shargall 1-2 weeks
 - Dr. Christian Finley 2-3 weeks
 - Dr. Colin Schieman 3 weeks
 - Dr. Waël Hanna 3 weeks
- Instructions for staple/suture removal; may be removed by either the GP
 - chest tube site (5 days post chest tube removal)
 - incision site (7-10 days post surgery)

Document all anticipated needs. For patients requiring complex care at home (homecare, home oxygen, nutritional follow-up, social work assistance, etc), make sure to start the process as soon as possible and not the day before.

Home Care = Community Care Access Centre (CCAC) referrals are to be completed at least 48 hours in advance to facilitate preparation and

delivery of the proper supplies needed for the discharge. The Allied Health professional involved with the patient's care will assess for required therapy services/equipment that may be needed on discharge. The CCAC binder is present at each nursing station with all the appropriate forms needed for each discharge. These must be signed by a physician.

Most importantly speak to the patient about their pending discharge. Follow-up with the nurse or charge nurse to ensure all forms are signed for discharge.

Please discuss any discharge concerns and needs with the Integrated Care Coordinator (ICC) on Thoracics as soon as possible. The ICC will assist you in accessing these services for the patient and ensure that there is no delay in the discharge. The ICC for the Thoracic Division is Anna Tran, RN.

The Integrated Comprehensive Care Project introduces a new process of care that will directly link hospital and community care services for patients undergoing thoracic surgery and for patients with pleural effusion. The ICC will work closely with all members of the healthcare team in order to facilitate a smooth transition from the treatment phase into the recovery phase of the the patient care journey. She will follow the patient in the hospital and collaborate with the St. Joseph's Home Care team to ensure that the patient receives the care and support they need when they return home. This may include services such as nursing, physiotherapy, respirology, and/or speech and language pathology. The ICC will continue to be available to assist the patient during their recovery time at home.



Allied Health

Physiotherapy

The physiotherapists (3) for the Thoracic Service, both on the floor and in the ICU are Pager #8559 and Pager #8565.

The physiotherapist helps to achieve the patient's highest level of physical functioning prior to discharge

- Physiotherapy requires a written doctor's order. Please note that there is a difference between chest physiotherapy and normal physiotherapy.
- The goal of chest physiotherapy is to facilitate clearance of secretion.
- If mobilization/ambulation is also required, a separate order must be written indicating this (ie. Chest physio and ambulate.)
- Physiotherapy over the weekend is only available for those patients at a high risk for pulmonary complications or unless specifically ordered (ie. Weekend Physio), please make sure to define those patients by Friday afternoon.
- Chest physiotherapy is not indicated for the following conditions:
 - Pulmonary edema
 - Pleural effusion
 - Pulmonary embolism

Occupational Therapy

Our Occupational Therapist – pager #167.

The practice of occupational therapy is the assessment of function and adaptive behavior and the treatment and prevention of disorders which affect function or adaptive behavior to develop, maintain, rehabilitate or augment function or adaptive behavior in the areas of self care, productivity and leisure.

- A referral to Occupational Therapy should be made when:
 - There is a discrepancy between the client's baseline function and current level of function.
 - The client is no longer able to function independently and the team requires input to determine an appropriate discharge plan.
 - The client, family or caregivers are reporting functional decline and there are goals for improving their function or facilitating their recovery.
 - The client, family or caregivers identify that the client was not able to cope at home with existing supports and services.
 - The client is demonstrating functional cognitive decline which may impact safety and function.
 - The client has decreased activity tolerance and would benefit from energy conservation education
 - The client has decreased skin integrity
 - The client is unable to ambulate and may benefit from a wheelchair
 - The client requires splinting or has limited upper extremity function

Allied Health



Pharmacist

Our Pharmacist – extension 32164.

The pharmacist is available on the unit everyday from 8am to 4pm.

All pharmacy suggestions/clarifications must be cosigned by a physician in order to be implemented.

*** Please sign the Pre-Admission Medication History *** - This form is completed by the pharmacist in the pre-op clinic for all elective surgery patients. This form will contain all medications the patient is on and simply requires a check mark in the Continue, Hold, or Discontinue column and a signature at the bottom of the form.

The pharmacist's role includes:

- Maintaining a computerized patient medication profile with access through Clinical Browser or HBO
- Reviewing each medication order for a patient, in conjunction with the patient's medication profile for:
 - Allergies, appropriate dose, dosing interval, dosage form, route of administration, clinically significant drug interactions, therapeutic duplication, formulary status, therapeutic goals
- Obtaining or clarifying patient medication histories
- Patient consulting regarding newly started medications providing drug information to staff and patients
- Discharge planning

Speech and Language Therapy

Our Speech-Language Pathologist (S-LP) – pager #915.

- Participates as a member of a multi disciplinary team for education and management of patients.
- A referral can be made for Swallowing if patients experience signs of oral or pharyngeal dysphagia.

St. Joseph's Healthcare Hamilton
PreAdmission Medication History Form-Elective Surgery
PHYSICIANS ORDERS
 Allergies: _____
 DUST: _____ CONFIRMED _____

Home Meds

Date/Time of last dose

Physician Order Section: Choose 'continue' D/C' or 'hold' and signature

PHYSICIAN SIGNATURE FOR PRE-ADMISSION MEDS POST SURGERY
 *** Note: All changes in the City Surgery section are the most recent order ***

Medication Name, Dose, Route, Frequency, and/or Indication (include regular prescription, over-the-counter, PRN and injections)	PHYSICIAN'S ORDER (changed since your PAAU visit? Date and Time Last Taken (yyyy/mm/dd) / (hh:mm))	CONTINUE	D/C	HOLD (give reason)	CHANGE YES (Indicate Change in Column Below)

Figure 1 Pre-admission Medication History Form

- A referral can be made for Speech and Language if patients experience communication deficits (i.e. Aphasia, Dysarthria).
- Any specific request and/or instructions should be discussed in person with the S-LP
- S-LP documents all patient assessments and progress notes in the health record.

Social Worker

Our social worker – pager #905-524-7123.

You need to assess your patient holistically and anticipate any potential discharge issues in order to involve social work services as soon as possible. The social worker is there to provide:

- Psychosocial counseling for patients and families to assist in coping with diagnoses, diseases, various losses, and palliation.
- Participates in and arranges family meetings to maximize support and understanding for families and patients, to discuss discharge planning, diagnosis, and future care needs (ie. Place and plan of care).
- Provides information on subjects such as: Trillium Drug Program, Power of Attorney, Respite, various cancer resources and services, Government programs, transportation issues, and placement to long-term or other levels of care.
- Facilitates paperwork and transfer of patient to Long-term or other care facility prior to discharge.

Dietitian

Our Dietitian – pager # 8858 or extension 33509.

- Responsible for nutritional assessment, planning & education of all patients requiring intervention.

- Documents all patient assessments, progress and clinical nutritional outcomes in the health record.
- Participates as an integral member of a multidisciplinary team in the education and management of patients.
- Diet orders where the RD should be involved include: TPN, Tube feeding, Calorie Counts, Food Allergies, NPO>5 days, CF>3 days, FF> 5 days, high calorie diet, etc.
- All orders for Total Parenteral Nutrition (TPN) must be written on the TPN order sheet.
- A new TPN form must be used if any changes are made to the original TPN order including changes in rate, solution, and/or additives.
- All TPN orders must be received in Pharmacy by 1pm in order for it to be prepared by the evening of the same day. Any orders written after 1pm will be supplied for the evening of the following day.
- Dietitian must be consulted for all TPN orders. If unsure of what to order, start patient on the Peripheral/Central Starter formula.

Infection Prevention & Control

Our IPC – extension 33385 or by paging.

The Infection Prevention & Control Department supports the unit by doing daily review of patient records and laboratory reports to determine if additional precautions are required or may be discontinued. Other surveillance programs include monitoring for surgical site infections post thoracotomy and central line associated blood stream infections in the Step-Down Unit. If patients, families or staff have concerns regarding Infection Prevention & Control issues, the IPC will meet to discuss those concerns.



Patient Care

Preoperative assessment: Before participating in any surgery, it is expected that the Resident and/or Fellow has reviewed the charts and investigations of the patient being admitted to the Thoracic Service. The surgeons' secretaries will typically gather the charts the day prior to surgery. It is your responsibility to contact the staff surgeon prior to the surgery in order to discuss the specifics of the planned surgery and any possible complications, or specific risk factors or considerations related to the on-coming surgery.

Operative Days: Patients are admitted for operations on the same day of surgery. The first patient on the list must have their surgical site marked promptly by 7:30am. This is usually done by the chief resident. There is a green sticker in the chart that must be filled in. The patient will not be taken to the Operating Room (OR) without it and any delay in surgical marking will delay the entire list. In case of non-compliance, the staff surgeon will be notified.

Residents and Fellows must be present in the OR by 8:00 am, as the patient is being prepared. You must be present during the induction of general anesthesia in case there are any problems during the intubation which may require your assistance. A foley catheter is usually inserted by the surgical Fellow or Resident.

The appropriate images should also be loaded on the computer system. At the end of the procedure remember to review and **SIGN** the **Pre-admission Medication History Form (Figure 1)**, specifying which medications to continue and which medications to put on HOLD (give reason; ie hold analgesia while patient is on epidural). Document in the patient's chart: the procedure, any complications, and the participating surgeons and the operators. Complete and sign the **Standardized Order forms (Figure 2)**. As part of the post-operative orders you need to include **physiotherapy assessment** for ambulation, and chest physio. If the patient had surgery on Friday you need to specify '*physio to assess over the weekend*' as part of the orders.

Endoscopy

The Endoscopy Suite is located on the 3rd floor of the Mary Grace Wing. Each surgeon has a designated time there for procedures. The schedule for the week is distributed each Friday morning and it is the Resident's/Fellow's responsibility to review and plan time to attend. Make sure you know which procedure is being done, why it is being done, and what to look for.

Standardized Thoracic Orders


		<input type="checkbox"/> Charlton Campus <input type="checkbox"/> King Campus <input type="checkbox"/> West 5th Campus	
PHYSICIAN'S ORDERS POST-OPERATIVE LUNG RESECTION SURGERY			
Orders with <input type="checkbox"/> or _____ must be initialled or filled in to be activated.			
ORDER WRITTEN DATE _____ (yyyy/mm/dd) TIME (hh:mm): _____		<input type="checkbox"/> No Known Allergies <input type="checkbox"/> ALLERGIES/REACTIONS: _____ 1. Admit to: <input type="checkbox"/> Surgical Step Down Unit <input type="checkbox"/> Thoracic Unit <input type="checkbox"/> Intensive Care Unit <input type="checkbox"/> Medical Step Down Unit	
ORDERS TRANSCRIBED DATE _____ (yyyy/mm/dd) TIME (hh:mm): _____		2. Admit Under: _____ 3. Diagnosis: _____ 4. Procedure: _____	
SIGNATURE / DISCIPLINE _____		5. Nutrition: <input type="checkbox"/> NPO <input type="checkbox"/> Clear fluids <input type="checkbox"/> Full fluids <input type="checkbox"/> Advance diet as tolerated when bowel sounds present <input type="checkbox"/> Tube Feeds _____	
TRANSCRIPTION CHECKED BY DATE _____ (yyyy/mm/dd) TIME (hh:mm): _____		6. Activity: <input type="checkbox"/> Head of bed 45° or greater <input type="checkbox"/> Activity as tolerated <input type="checkbox"/> May come off chest tube suction to ambulate <input type="checkbox"/> Do not remove chest tube suction to ambulate <input type="checkbox"/> For Pneumonectomy patients – nurse operative side down <input type="checkbox"/> Other _____	
SIGNATURE / DISCIPLINE _____		7. Vitals: <input type="checkbox"/> Routine post-operative as per unit policy <input type="checkbox"/> Oxygen _____ to keep oxygen saturation greater than _____ to maximum of 40% O ₂ by mask then call MD <input type="checkbox"/> Record intake and output <input type="checkbox"/> Daily weight <input type="checkbox"/> Continuous cardiac monitoring <input type="checkbox"/> Continuous oxygen saturation monitoring <input type="checkbox"/> Central venous pressure monitoring q _____ hours	
SIGNATURE / DISCIPLINE _____		8. Chest X-Ray: <input type="checkbox"/> Portable CXR in recovery room <input type="checkbox"/> Portable CXR daily while chest tubes insitu <input type="checkbox"/> Daily <input type="checkbox"/> Portable CXR <input type="checkbox"/> PA/LAT CXR	
SIGNATURE / DISCIPLINE _____		9. Intravenous: <input type="checkbox"/> IV _____ fluid at _____ mL/hr <input type="checkbox"/> Saline lock when drinking well <input type="checkbox"/> Fluid restriction _____ mL/24 hours <input type="checkbox"/> Total fluid intake _____ mL/hour <input type="checkbox"/> Other _____	
Date (yyyy/mm/dd) _____		Time (hh:mm) _____	
Printed Name _____		Counter Signature _____	
Signature _____		Initial _____	Discipline _____
PD 7891 (2011-08) HIM		WHITE - CHART	YELLOW - PHARMACY
Page 1 of 3			

Figure 2 Standardized Physicians Order form

There are standardized orders for Lung Resection Surgery and Esophagectomy Surgery.

Educational Rounds

Education Rounds occur every Monday morning at 7:00am in the BMO conference room on the 2nd floor of the Juravinski Tower and includes clinical teaching rounds, case discussions, and combined rounds with Radiology and Respiriology service. Each Resident is expected to present, at least once, a topic of choice/interest during their thoracic rotation. Consult with the chief resident for the academic curriculum.

On the first and third Monday of each month there are designated rounds with Diagnostic Imaging. This takes place in the Radiology Seminar Room on Level O, by the Diagnostic Imaging Department, at 7:00am.

Every second Friday of each month there are also Multidisciplinary combined Radiology/Respirology rounds being held in the Radiology Seminar Room.

A weekly tumour board round (Multidisciplinary Cancer Care meeting, or MCC) takes place every Friday between 12:00pm and 1:00pm at the Juravinski Cancer Center and occasionally at St. Joseph's Healthcare. The meeting is teleconferenced to the Radiology Seminar Room at St. Joseph's Healthcare. It is expected that fellows and residents take part in these rounds unless they are needed in the Operating Room.

In addition, as part of the collaboration between the Division of Thoracic Surgery at McMaster



University and the University of Toronto, weekly teaching rounds from Toronto are being broadcasted every Friday afternoon. The fellows and residents are expected to be present in these rounds.

Ward Rounds

Ward Rounds for Thoracic Service will usually commence at 6:30am in the Step Down Unit. This allows for the Thoracic team to identify problems and potential discharges early to facilitate the patient flow. If there is a patient under the Thoracic Service on a different unit, due to overflow, that patient must also be seen before 8:00am.

Patient Rounds

Weekly patient rounds occur every Friday morning at 7:00am in the BMO conference room. You are expected to have rounded on all the patients (SDU, 4Chest, ICU, and overflow) by 7:00am each Friday in order to give handover to the weekend on-call staff.



On-Calls

On-calls are from home and can often be demanding. Remember that being on-call from home is a privilege and not a right. It is your responsibility to be available at a moments notice should your presence be required on the patient unit. It is inappropriate and dangerous to ask the nurse to make a diagnosis and/or treatment plan. Perform **evening rounds** on all patients before going home, as well as touching base with the charge nurse in order to identify potential problems before they happen.

In the event of an unstable patient or if you live more than 15 minutes away by car you must stay on hospital premises. If you require overnight accommodation a sleep room, with shower is available on the thoracic floor.

In case of a patient's acute deterioration the staff on-call and/or the surgeon most responsible for the patient must be notified. According to your level of experience you may have a more senior colleague to call for assistance before the staff surgeon.

Just like yourselves, the nursing staff is comprised of all various degrees of education and levels of experience. It is important to remember to be professional, respectful, and patient with one another, and view conflict as an opportunity for learning and growth.

The Thoracic Service also covers for consultations at the Hamilton General Hospital, the Juravinski Hospital, and McMaster Hospital. If you are called for a consult please notify the staff surgeon on-call to discuss the case and determine a treatment plan before you go and assess the patient, unless it is URGENT.

The same principle applies if you are called to see a patient in the Emergency Department (ED). If a patient is asked by one of the staff surgeons to come to the hospital for admission via ED then you must do a complete assessment (take history, dictation, order investigations and book a bed for admission if necessary). If the patient comes to ED on their own then the Emergency Physician will assess him/her and you will be called for a consultation.

Please discuss the patient with the on-call or most responsible staff surgeon prior to any invasive intervention; such as a chest tube insertion, or admission. Again it is your responsibility to book a bed (refer to the useful number section in this manual) in case of admission.

D.A.V.I.D

For every admitted patient remember to write in the order sheet the following points:

D: Diagnosis

A: Activity (if the patient can be mobilized)

AAT = activity as tolerated, DAT = diet as tolerated. If you don't specify this the patient won't be fed. In case of procedure remember to keep the patient starved (write NPO = nil per os) and specify the starting time.

V: Vitals (how often do you want them taken – every shift is often appropriate, unless otherwise stated)

I: Investigations (what do you want – blood work, x-rays, tests, remember the nurses follow the orders directly, if it is not ordered, it will not be done).

D: Drugs (for newly admitted patients you have to order all medications (ie. Home medications) they are taking in the order sheet)

Bed booking is then in charge of finding a hospital bed for the patient once you have admitted them. You may have to specify if the patient needs to be on the Thoracic Unit or if they may be Off-Serviced to the first available bed on another unit.

Clinics

Each surgeon has specific clinic days, there is usually one or more clinic every day. You will be expected to attend these clinics unless you are needed in the Operating Room or if an emergency arises (e.g. emergency consultation, etc.). It is expected that the Fellow or Resident



will assess the patient and present the findings to the staff surgeon. You will then accompany the staff surgeon to meet the patient and discuss with them the plan of care. This is an important educational opportunity.

Lung Diagnostic Assessment Program (DAP) Clinics

The Lung Diagnostic Assessment Program (Lung DAP) is a centralized point of entry for patients who are suspected of having lung cancer. They are referred by their family physicians/other community health professions after a suspicious CXR/CT-scan. You, the Resident, will work with the Nurse Navigator to assess the patient and determine a plan of care. The Nurse Navigator will facilitate timely diagnostic testing and be a consistent point of contact for the patient.

Each staff surgeon has a DAP clinic once a week where they will consult with new patients, as well as follow-up once patients have completed the diagnostic testing process. **Any dictations completed during this clinic should be dictated using priority code #16, as this will be picked up and transcribed within the hour.**

Once again we welcome you to the Thoracic Service at St. Joseph's Healthcare and hope that the experience will be both educational and memorable. If you have any concerns or conflicts, please do not hesitate to contact Dr. Colin Schieman (Resident Program Director), Dr. Y. Shargall (Division Head of Thoracic Surgery), or Deanna Burnet (Nurse Manager). We are all committed to providing you with the best learning experience possible.

APPENDIX

APPENDIX I:

Job Description of a Chief Thoracic Resident

APPENDIX II:

Resident Expectations, Duties, & Advice for Thoracic Resident

APPENDIX III:

Thoracic Surgery Resident CanMEDS Portfolio Guidelines

APPENDIX IV:

4 Moments of Hand Hygiene

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Routine Practices

APPENDIX I: Job Description of a Chief Thoracic Resident

CLINICAL RESPONSIBILITIES



Ward

The Chief Thoracic resident will assist and supervise the junior residents and house staff in daily ward care of patients. The Chief resident will round with the junior residents/housestaff-team and provide them with direction in carrying out management plans for all patients. The Chief resident is expected to be directly familiar with those patients he/she has operated on and also provide supervision of the care and have knowledge of the remaining patients. The Chief resident will ensure that adequate chart documentation occurs on all patients, and that residents complete dictations.

Clinic

Attendance to at least one clinic per week is required. The Chief resident is expected to evaluate both new consultations and follow-up patients in the clinic.

Operating Room

The Chief resident's role will vary according to the number of the other residents and housestaff. Their role will also vary according to the learning requirements of the junior members. There may be opportunity for the chief resident to act as the teaching assistant to the junior resident on the smaller cases. All residents are expected to attend the OR in a timely fashion to help with patient positioning and to become familiar with the chart if the case is being done on an outpatient basis. Attendance by the chief to most of the teams cases is expected.

Emergency Room

The Chief resident will provide backup for the junior residents who are assigned to the emergency room both during the day and occasionally at night. If manpower is limited the chief resident may be the primary provider of surgical consultation in the emergency room.

Other

Attendance at Monday and Friday teaching rounds, JCC Tumour Board rounds, is mandatory.

TEACHING RESPONSIBILITIES

Resident Rounds

The Chief resident is expected to present and organize Monday teaching rounds on a regular

basis. The chief resident has a curriculum that should be followed.

Ward teaching

It is expected that part of attending ward rounds with the residents is that the chief residents will use case examples as starting points for educational discussion with the junior residents, including the assigning of mini-projects for the junior residents to explore and research clinical issues.

Teaching of other health care professionals

When rounding with other health care professionals, the chief resident is expected to explain and teach all those in attendance for the education of all involved.

Teaching of medical students

It is expected that chief residents will take the

time to provide teaching to the clinical clerks in a variety of clinical settings.

ADMINISTRATIVE RESPONSIBILITIES

Call Schedule

The Chief resident must make the on call schedule and publish it according to PARO guidelines

Rounds Schedule

The chief resident will assign the teaching rounds to the junior residents and provide a schedule to the Program Director.

Vacation Planning

The chief resident will handle vacation requests, assistance with difficult schedules may be sought thru the teaching unit director.



APPENDIX II: Resident Expectations, Duties, & Advice for Thoracic Residents



WARD WORK

You are responsible for the care of the ward patients on your team, in conjunction with your senior and/ or chief resident and your staff person.

Charts

Daily notes are to be completed on each chart. The only exception is the ALC patient awaiting placement. Those charts should have notes at least each week, and if they are any changes in the patients condition, or plans for placement.

Discharge summaries must be dictated for each patient that is admitted for 2 days or longer or for any patient who has multiple issues, or needs multiple follow-up investigations or appointments. If there are any issues that are

expected to be followed by the family doctor in the short term, it is best to place a call to the family doctor to update them.

The face sheet of the chart needs to be completed for each patient regardless of length of stay. This must be done in detail including all patient diagnoses, and procedures.

All procedures on patients must be documented in the progress notes; central lines have a separated sheet that needs to be completed. If the clinical clerk is writing daily progress notes, you are responsible to monitor the quality of those notes.

Patient Rounds

You are expected to round on your patients prior to the beginning of teaching rounds. Although you may not be able to finish at that time, you should check on the ward to be sure there are no urgent issues and to look in on your sickest patients. You may complete more thorough rounds later in the am. It is essential to check your patients prior to going to the OR for the day. Afternoon rounds should also be done, to check on investigations, labwork, and patient progress. This round should not take you too long and must be done before you go home. If there are any ongoing concerns, or additional issues that need to be followed through the evening, please communicate with the resident



on call for the evening. Most wards have clipboards at each end of the ward that need to be checked each day and the issues

dealt with, this includes medication reorders, and other nursing identified issues for you to deal with.

Please look for the nurse assigned to your patients when you are seeing patients. Make sure you communicate directly with the nurse regarding patient care, and any new orders or changes to existing orders. The ward nurses are with your patients all day and night. Talk to them; ask them for their opinion about the patients. Check with the nurses, do they have any orders that need to be written or co-signed, do they have any concerns about the patients. When your staffperson arrives on the ward, greet them and check to see if they want you to accompany them on walk around rounds. Even if you have already seen the patients, this is an opportunity for your staff to give you bedside teaching. Ask the staffperson questions, especially around physical exam findings and what is normal for the post op courses of your patients.

Multidisciplinary Rounds

Typically these are held once per week per team. These rounds allow all the involved health care providers to review patient progress and plans. It is especially valuable for discharge planning and for communication amongst your colleagues. Please make every attempt to attend these rounds.



MARKING

The most senior resident is responsible for “marking” the patient prior to entry into the OR.

This is an essential step in our patient safety program.

OPERATING ROOM

Surgical residents are expected in the operating room whenever their staffperson has a case. They are expected to arrive in sufficient time to assist with patient transfer, positioning and review the chart if they are not already familiar with the case. Residents participating in the surgery are expected to be familiar with the patient's history, physical findings, investigations,

APPENDIX II: Resident Expectations, Duties, & Advice for Thoracic Residents (Continued)

the rationale for the planned operation, and the specific steps and surgical techniques. You are expected to be ready to discuss the case, and actively participate in the discussions. This is essential to good patient care. Many aspects of excellent surgical care involve the pre-operative planning and communication. Do not ever show up late to the operating room, unprepared, and expect to start cutting. Just as the staff surgeon is expected to manage his/her time schedule to show up on time, so must the resident.

If you are post call, you are expected to still come to the operating room if your staff is operating. You may leave post-call as per the PARO guidelines.

Junior residents are expected to scrub into cases. You are encouraged to discuss the cases and ask relevant questions. During the case, a junior resident can learn through observation: for example, what incision is being used and why, how do you get the best retraction, lighting, exposure. What are the steps of the operations, what are the pitfalls at each point in the operation? Which instruments are being used and why? How is the best way to hold and use those instruments? What are the alternatives? How can you contribute as an assistant? Learning to be a good assistant is one of the first steps in becoming a good surgeon. Gradually, junior residents will be

assigned certain tasks within an operation, and with time the frequency and number of tasks will increase.

Introduce yourself to the operating room staff and let them know your position. Make sure you are present at the end of the case to assist with patient transfer off the OR table and then into the PACU. Some operating rooms want the resident to get out their own gowns and gloves to give to the scrub nurse with each case; check with your nurses, what they prefer.

More senior residents should make a point of discussing their particular learning goals in the operating room with each surgeon they work with. Take the lead in asking for feedback on technical skills, and any advice the staffperson has for you.

Offservice residents will also be expected in the operating room. This will provide them with exposure to common cases, living anatomy, and principles of surgical decision making. They may also be needed as surgical assistants.

ON CALL DUTIES

All Residents are expected to participate fully in the on call schedule. If you are junior you may be paired with a senior resident until you are ready to take call on your own. The frequency of call will depend upon the number of residents

participating, holidays, etc, and within PARO agreements. The call ranges from 1 in 3 to 1 in 4. This is to maximize your operative exposure. When there are two residents on call, first call will go to the junior resident. Clinical clerks should not be sent to the emergency room by themselves until the resident has had a chance to personally review the referral and be certain it is appropriate for the clerk to start with. This principle holds true for all surgical referrals, patients referred from the ER should not be left waiting. If you are detained with other responsibilities, let the attending surgeon know.

Please see the appendix A for guidelines regarding the notification of the Most Responsible Physician.

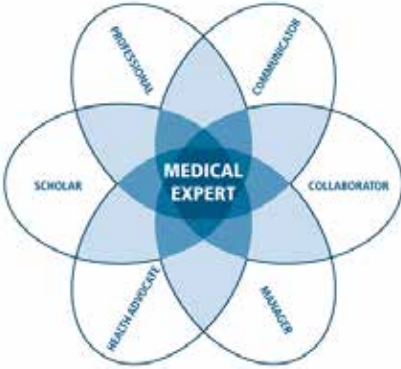
ON THE WARDS

These Tips Come from a Variety of Sources: Your Staffpeople, Nurses and Previous Residents.

- Call Computer Services for a password and access to the hospital EMR
- Fill in requisitions for tests.
- Inform the RN of any STAT orders
- Flag all other orders
- Discharges need to be planned in adequate time to meet patient/family and home care needs. Discuss discharge plans with R.N. and attending physician. Write orders and scripts the day before discharge.
- Organize your bloodwork, i.e., try to order everything you want the first time so the patient isn't poked multiple times
- If you tell a patient you are going to change an order or their diet, don't forget to write the order.

- It's OK to peek under dressings or take them off, just make sure you let the nurse know that you have done that so they can be redone.
- When you first come to the ward, let the staff know who you are and who you are working with and what your pager number is.
- Try to return pages promptly, check your pager in between cases in the OR
- Sign out your pager when you are off call or not in the hospital
- If you want a consult from another medical service, you must call them yourself.
- Learn how to work the ECG machine. (contact the ECG technician to arrange a teaching session if required.)
- Call your senior resident when you are unsure about something, or if a patient is sick, it is always better to call than to have to answer in the morning why you didn't call.
- Before retiring at night (if you get a chance!) go to the ward and check to see if they need anything, best time to check is around 11 o'clock, this might save you some phone calls later.
- If you have any questions, concerns or suggestions, please let your Program Director or chief resident know.

APPENDIX III: Thoracic Surgery Resident CanMEDS Portfolio Guidelines



PROFESSIONAL PORTFOLIO GUIDELINES:

Residents are responsible for updating this on an ongoing basis, with contribution of activities reflected in all 7 CanMEDS categories.

To be submitted to Program Director on a bi-monthly basis – should also be available on request at other times.

MEDICAL EXPERT

MEDICAL TRAINING

- List medical education
- Postgraduate education

COURSES and CONFERENCES

- List conferences attended relevant to Thoracic Surgery

- Attendance at weekly residency academic half-day

EMPLOYMENT HISTORY

- List any work or volunteer positions, if relevant to medical expert role in Thoracic Surgery

COMMUNICATOR

- List any half-days or lectures attended relevant to the communicator role (OR reports, patient consent, capacity, breaking bad news etc.)
- Challenging or significant discussions with patients and their families
- List “Dictations and consultations reviewed on a daily basis, during individual rotations and on-call reporting duties”
- Recruiting patients for research project

COLLABORATOR

- List the multidisciplinary rounds you have participated in at the various sites, for instance surgical rounds, other working multidisciplinary rounds, etc.
- Consultations with referring clinicians and clinical services when request is made for thoracic consultation/opinion: discussion regarding most appropriate work-up/management and evaluation of patient, during daytime rotations and particularly on-call.
- Research collaborations with other staff, residents, health care professionals or other departments

MANAGER

- List any leadership workshops attended
- List any thoracic business conferences or workshops attended
- Canadian association presentations relevant to this topic
- List any half-day presentations or multi-disciplinary half-days relevant to this topic
- List Senior resident roles, Chief resident
- List any committees you have participated on during residency (PGE, REC resident rep, RPC, PARO)
- Any scheduling or organizational activity that you have been involved with during residency
- Any departmental meetings attended relevant to managing and running a department
- Keeping your surgical log up to date

HEALTH ADVOCATE

- Any relevant volunteer community service experiences
- Any education sessions on smoking/alcohol consumption cessation program
- Other

SCHOLAR

RESEARCH AND PUBLICATIONS

- List your research projects, posters, papers
- Include both completed projects and work in progress, relevant to Thoracic Surgery
- Include any presentation you have made at meetings and annual research day – for meetings, list the name of the meeting, location and date

- List the articles you presented and talked about at the Journal Club
- Please cite published material, according to standard format
- Include any grants or relevant awards

TEACHING

- Please include the TOPIC & DATE for each of the below
- Please list formal presentations you have made including: departmental or subspecialty rounds, academic half-days, journal club
- Any teaching sessions for other residents or medical students (for instance Surgical Foundations teaching); anatomy teaching sessions, technical skills for junior residents, radiology session for junior residents)
- Any clinical skills teaching or tutoring, medical student interests groups you have presented or organized or participated in.
- List presentations during rotations, if you were asked to give a talk
- “Teaching on the Fly” course – list date you attended

PROFESSIONAL

- List any professional organizations you belong to: e.g. provincial, OMA
- List professional roles you have held in any residency or professional organization
- List any professional workshops attended
- List any half-day or multi-disciplinary half-day topic attended, relevant to this role
- List any professional recognition awards, including hospital recognition awards or prizes

APPENDIX IV: 4 Moments of Hand Hygiene

Your 4 Moments for Hand Hygiene







1 BEFORE initial patient / patient environment contact	WHEN? Clean your hands before touching patient or any object or furniture in the patient's immediate surroundings, when entering – even if the patient has not been touched. WHY? To protect the patient, yourself and the health care environment from harmful patient germs.
2 BEFORE aseptic procedure	WHEN? Clean your hands immediately before any aseptic procedure. WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body.
3 AFTER body fluid exposure risk	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal). WHY? To protect yourself and the health care environment from harmful patient germs.
4 AFTER patient / patient environment contact	WHEN? Clean your hands after touching patient or any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched. WHY? To protect the patient, yourself and the health care environment from harmful patient germs.

Illustration: WHO/FAO, "The 5 Moments for Hand Hygiene", 2009. Available from www.infectioncontrolandhandhygiene.com, n.d.

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APPENDIX V: Routine Practices

ROUTINE PRACTICES ARE FOR THE ROUTINE CARE OF ALL PATIENTS. THIS MAY INCLUDE: GLOVES, GOWN, MASK, EYE PROTECTION, DEDICATED PATIENT CARE EQUIPMENT, ENVIRONMENTAL CONTROL, AND ALWAYS, HANDWASHING. ADDITIONAL PRECAUTIONS, AS WELL AS ROUTINE PRACTICES, ARE NECESSARY FOR CERTAIN PATHOGENS OR CLINICAL PRESENTATIONS

ISOLATION SIGN	WHEN AND HOW TO USE ISOLATION <i>Isolation signs must remain on the patient door, curtain or divider until cleaning has taken place</i> Notify Infection Prevention and Control Always clean hands before and after care, treatment and/or contact with the environment				
 <p>STOP Airborne Precautions</p> <p>Use with Routine Practices Additional Precautions: Airborne Precautions</p>	<p>Use Airborne Precautions for:</p> <ul style="list-style-type: none"> • Mycobacterium tuberculosis (or suspect TB) - pulmonary or laryngeal • Measles (Rubella) • Chicken pox (Varicella zoster virus) • Disseminated zoster <p>To Do:</p> <ul style="list-style-type: none"> • Negative pressure ventilated room required • Keep door closed at all times • All healthcare workers entering the room to wear N95 respirator for TB patients • Seal-check respirator on every entry to the room • Only immune healthcare workers should be assigned to patient with known/suspected chicken pox, disseminated zoster or measles. Exceptions to be discussed with Occupational Health and Infection Prevention and Control • Refer to facility policy for guidelines during transport of suspect TB cases 				
 <p>STOP Droplet Precautions</p> <p>Use with Routine Practices Additional Precautions: Droplet Precautions</p>	<p>Use Droplet Precautions for:</p> <ul style="list-style-type: none"> • Bacterial Meningitis (meningococcal) until 24hrs of appropriate antibiotic therapy • Pertussis (Whooping Cough) • Rubella (German Measles) • Mumps (infectious parotitis) • Epiglottitis (Haemophilus influenzae Type B) • Invasive Group A Streptococcus * Add contact Precautions if draining wound - until 24hrs of appropriate antibiotic therapy <p>NOTE: Not all illnesses or conditions have been listed which require Droplet Precautions</p> <p>To Do:</p> <ul style="list-style-type: none"> • Maintain at least a 2 meter separation between patients and draw a privacy curtain • Wear procedure/surgical face mask and eye protection within 2 meters of patient • Patient to wear a procedure/surgical mask when outside of room • Only immune healthcare workers to be assigned to patient with known or suspected mumps/rubella. Exceptions to be discussed with Occupational Health and Infection Prevention and Control • Pregnant healthcare workers should not be assigned a patient with rubella 				
 <p>STOP Droplet/Contact Precautions</p> <p>Use with Routine Practices Additional Precautions: Droplet/Contact Precautions</p>	<p>Use Droplet/Contact Precautions for:</p> <ul style="list-style-type: none"> • Patients presenting with new/worse cough or new/worse shortness of breath that is abnormal for this patient AND FEVER 38°C or greater (Elderly and Immunocompromised may not have a fever) • Influenza (seasonal) • Any Acute Viral Respiratory Illness • Norovirus - if vomiting • Invasive Group A Streptococcus - if draining wound - until 24hrs of appropriate antibiotic therapy <p>NOTE: Not all illnesses or conditions have been listed which require Droplet/Contact Precautions</p> <p>To Do:</p> <table border="1" data-bbox="355 1128 1033 1223"> <thead> <tr> <th>Acute Care</th> <th>Non-Acute Care</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> • Wear gloves on room entry • Wear gown for direct care or when in contact with items in a patient's environment • Wear a procedure/surgical mask and eye protection within 2 meters of patient </td> <td> <ul style="list-style-type: none"> • Wear gown and gloves when providing direct care or when in contact with items in client/resident environment • Wear a procedure/surgical mask and eye protection within 2 meters of client/resident </td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Maintain at least a 2 meter separation between patients and draw a privacy curtain • Patient should wear a procedure/surgical mask when outside of isolation room • Dedicate or clean and disinfect shared equipment after each use 	Acute Care	Non-Acute Care	<ul style="list-style-type: none"> • Wear gloves on room entry • Wear gown for direct care or when in contact with items in a patient's environment • Wear a procedure/surgical mask and eye protection within 2 meters of patient 	<ul style="list-style-type: none"> • Wear gown and gloves when providing direct care or when in contact with items in client/resident environment • Wear a procedure/surgical mask and eye protection within 2 meters of client/resident
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 <p>STOP CONTACT PRECAUTIONS</p> <p>Use with Routine Practices Additional Precautions: Contact Precautions</p>	<p>Use Contact Precautions for:</p> <ul style="list-style-type: none"> • Diarrhea • Draining infected wounds if secretions cannot be contained • Lice/Scabies • C. difficile * (requires twice daily room cleaning) • Norovirus: use Droplet/Contact Precautions if vomiting • Antimicrobial Resistant Organisms (ARO), Example: MRSA, VRE, ESBL, Multi-drug Resistant Pseudomonas <p>NOTE: Not all illnesses or conditions have been listed which require Contact Precautions</p> <p>To Do:</p> <table border="1" data-bbox="355 1414 1033 1484"> <thead> <tr> <th>Acute Care</th> <th>Non-Acute Care</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> • Wear gloves on room entry • Wear gown for direct care or when in contact with items in a patient's environment </td> <td> <ul style="list-style-type: none"> • Wear gown and gloves when providing direct care or when in contact with items in client/resident environment </td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Do not share toileting equipment • Persons may ambulate outside of room as long as they fit the 5 C's: Clean hands; Clean clothes and equipment; Contained drainage; Contained (or contained); Compliant (with instructions) • Dedicate or clean and disinfect shared equipment after each use 	Acute Care	Non-Acute Care	<ul style="list-style-type: none"> • Wear gloves on room entry • Wear gown for direct care or when in contact with items in a patient's environment 	<ul style="list-style-type: none"> • Wear gown and gloves when providing direct care or when in contact with items in client/resident environment
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