SW/CC Consult

- Acute
  - **SNF** (eg. many, et al) for ortho, dressing changes, ostomies, IV meds, TF, PT/OT/ST, dressing changes, decub ulcers, et al
  - **LTAC** (eg. BSH, et al) same as SNF but more severe medical conditions
  - **Acute Rehab** (eg. BIR, et al) for stroke, spinal cord injury, congenital deformities, amputation, trauma, brain injury, burns, et al
- Chronic
  - 1st: home w/ family support
  - 2nd: home w/ home health care
  - 3rd: assisted living (AL) you live in a collection of apartments and you are provided with meals, meds, etc
  - 4th: extended care facility aka long term care aka nursing home (NH) paid by Medicaid, it's like a hospital
- End of Life
  - **Palliative Care** (enforce that dying is a normal part of life, does not hasten nor postpone life, the focus is on pt-defined goals which usually include dying in comfort and dignity, having control of end-of-life issues, saying good-bye, etc)
  - **Hospice** (eg. Vitas, e al) is like palliative care but it is reimbursed by Medicare and therefore there are specific criteria (pt has <6mo to live)

Suture

- Tying
  - Instrument Tie
  - Two Handed Tie (start with sutures crossed, finger, thumb and cross over, finger, thumb and cross over, etc) or (start with sutures NOT crossed, finger and cross over, thumb, finger and cross over, thumb, etc)
  - One Handed Tie (start with sutures NOT crossed "triangle" and cross over, "three finger"?, repeat)
- Knots: square vs granny vs slip (+ surgeon)
- Flush out wound
- Lidocaine w/ Epi
- first stitch bisects lacertion in middle so as to best approximate edges
- bite width < bite depth so as to create a curvilinear path which creates eversion when tying
- bite width = suture spacing
- Non-Absorbable (close epidermis)
  - Monofilament: **Prolene**, Ethilon vs Braided: Silk
  - Face: 5,6,7-0 vs Ext: 4,5,6-0 vs Trunk: 3,4,5-0
  - Simple Interrupted: most common, try to do flask shaped dermal base wider than epidermal apex b/c this creates the most eversion which decreases the liklihood of depressed scars b/c scars pull out, the bigger the bite the less tension but the worse the coaptation of the edges
  - Simple Running Unlocked: easier to do therefore good for long wounds
  - Simple Running Locked: aka "baseball" good for mild tension areas
  - Horizontal/Vertical Mattress: good for mod tension areas (if high tension consider dermal stiches)
  - Removal: Face 0.5wk follow w/steristrips vs Scalp 1wk follow w/steristrips vs Trunk 1.5wks vs Ext 2wks
  - NB staples for scalp
- Absorbable (close dermis) need if high tension and dead space
  - Monofilament: Monocryl, PDS vs Braided: **Vicryl**, Gut (Plain or Chromic)
  - if you need to close deep tissue than you typically use one gauge thicker suture than what you use to close skin
  - Dermal-Subdermal: most common, kind of like simple interrupted
  - Subcuticular ("snake"): if no tension can use this alone with no need for epidermal exposed sutures better cosmetic result, bury knot at each end so no visible knots
  - Subcutaneous ("spiral"): kind of like simple running unlocked, easier to do therefore good for long wounds

Procedure Note for any Invasive Procedure

- Procedure: “Performed procedure “W” for diagnosis “X””
- Consent: “Procedure, benefits, risks (bleeding, infection, injury, anesthesia) and alternatives explained to patient/(surrogate w/ witness) who voiced understanding of the information and consented to the procedure. Consent form signed and in chart”
- Physicians: list
- Description: position, area prepped and draped in sterile fashion, #cc of anesthetic/sedation administered, description of procedure, result/yield
- Complications: “Pt tolerated the procedure well w/o any apparent complications”
- EBL: amount in cc
- Disposition: “Specimen Sent to “Y” and the following tests were ordered “Z”
- Follow-UP: eg. “CXR after central line”
- NB REMEMBER TO FILL OUT ENTRY IN YOUR PROCEDURE BOOK

Death

- Confirm Code Status
- Check ID
- Check Response to Stimuli, Vitals, CV (pulses and heart tones), Pulm (respirations), Brainstem Reflexes (pupil reactivity aka fixed and dilated)
- Agree on Exact Time of Death w/ Nurses
- There is a stamp that has to be filled out
- Notify immediately even in the middle of the night the private physician and family (tell them that their loved one is not doing well and that they need to come in, never tell them over the phone that their loved one has died, once they arrived tell them that their loved one died peacefully)
- Ask family about if they would like to view the body and ask about autopsy, donor status, funeral home
- There is a form to fill out
- Complete Death Note: "Called by nursing to see pt regarding unresponsiveness. Pt found to be unresponsive to verbal/auditory/tactile stimuli, pulseless and w/o heart tones, breathless, pupils fixed and dilated, and absent brainstem reflexes including (type of reflexes tested). The pt was pronounced dead at (time) on (date). The pt's private physician and family were notified. Autopsy and anatomy gift donation were discussed with family. Coroner was or was not notified."
- Family must sign necessary documentation to document desire/refusal for autopsy/anatomy donation
- Call the coroner if the cause of death is suspicious (criminal act, hospital procedure, poisoning, inpt <24hrs, etc) and document
- Attending must fill out death certificate
- If pt dies w/in 24hrs of admission an automatic autopsy is done. If after 24hrs talk to families about it b/c the ratio of autopsies to deaths in an institution is a quality care measure

Types of Lines

- **PIV**
- **PICC**
- **T/QLC**
- **Hickman** (kind of like a T/QLC that has a dacron cuff to induce fibrotic tissue adherence preventing bacterial migration)

- **Port-A-Cath** (different types including Mediport, etc, graft under skin connecting to right SC which can be accessed when needed with a catheter like a central line when getting inpt chemo and then deaccessed when they go home)
- Dialysis Access (refer)
- **Jackson Pratt (JP) Drain** (semi-stiff tube attached to a small plastic bulb) vs Penrose Drain (just a flexible tube)
- **Antecubital Vein Phlebotomy**: set up 20G (not any smaller b/c will cause hemolysis) needle with vacutainer hub, apply torniquet, find vein, swab alcohol pad, apply traction to the skin below the proposed site with non-dominant hand, advance needle/hub with dominant hand at 15-30 degrees and bevel up, press the first tube into the vacutainer hub, **first remove tourniquet and then remove needle to prevent venous blood from leaving punctured vein because it has nowhere to go**, apply pressure to site, band-aid
- **Peripheral Venous Catheter**: apply tourniquet, find vein anywhere on dorsum of hand or forearm, swab alcohol pad then swab with povidine iodine pad, apply traction to the skin below the proposed site with non-dominant hand, with dominant hand advance catheter/needle assembly (20G not any smaller b/c will cause hemolysis) thru skin at 45 degrees bevel up and then thru vein at 20 degrees, once you see a flash of blood into the hub chamber push in one more mm, pull needle out while at the same time advancing catheter until you hub it, put pressure just distal to tip of catheter, release tourniquet (tourniquet was there to bulge the vein so that you can hit it), heplock it or attach IV fluid bag (to check and see if it is in vein, lower the bag below level of iv and see if blood fills catheter), secure with occlusive dressing, **ONLY LASTS 3 DAYS**

Tube	**Additive (use)**	**Order**	**# of Inversion**	**Volume**	**Use**
Light Blue	Citrate (AC)	1st	5	3mL	
Gold/GOST	Silicon (separateserum and clot)	2nd	5	6mL	Chem10

Red	None	3rd	5	Small: 7mL Large: 15mL	Rarely Used after advent of SST
Green	Heparin (AC)	4th	10	Small: 7mL Large: 10mL	Osmotic Fragility Drug Assays
Yellow	Acidified Citrate Dextrose (AC)	5th	10	8.5mL	Immunology
Grey	NaFl (inhibits glycolysis) KOxalate (AC)	6th	10	7mL	
Pink	EDTA (AC)	7th	10	6mL	Blood Bank
Lavender	EDTA (AC)		10	4mL	CBC