SECTION: **PATIENT CARE**

SUBJECT: **Topical Anesthetic Cream**

APPROVED BY: _____
Clinical Director for Maternal Child Services

POLICY

The goal of the Maternal Child Health Department (MCH) at Arrowhead Regional Medical Center(ARMC) is to provide atraumatic pain management for needle-stick procedures, if time and patient condition allows.

PROCEDURE

I. Obtain provider order for topical anesthetic cream, including dose, preferably at the time the order for the procedure is written

II. Dosage of topical anesthetic cream from a five (5) gram tube:
- A. One (1) gram is equal to a narrow strip of cream 1.5 inches in length and 0.2 inches in width
- B. Two (2) grams is equal to 2 strips
- C. Two and a half grams is equal to 2.5 strips
- D. Infants three (3) to 12 months of age use up to a maximum dose of two (2) grams of cream
- E. Children 1 to 6 years of age use up to a maximum dose of 10 grams of cream
- F. Children aged 7-11 years use up to a maximum dose of 20 grams of cream
- G. Adolescents and adults use 2.5 grams per 20-25 cm^2
- H. A maximum of 2 doses at least 12 hours apart may be given to children over 3 months of age in any 24 hour period

III. Apply topical anesthetic cream 30-60 minutes before procedure
- A. Perform hand hygiene
- B. Don gloves
- C. Identify patient using two patient identifiers
- D. Assess patient for the most accessible venipuncture sites
- E. Apply topical anesthetic cream to at least two (2) anticipated venipuncture sites.
  1. Cover the sites with the topical anesthetic cream. Spread a thick layer over the venipuncture area, do not rub the topical anesthetic cream in
  2. Apply a transparent dressing over the topical anesthetic cream so it is completely covered
  3. Smooth the edges to avoid leakage
- F. For lumbar taps cover the site of the lumbar tap with topical anesthetic cream, do not rub the topical anesthetic cream in and cover with a transparent dressing

G. After 30-60 minutes, remove the dressing, remove remaining topical anesthetic cream and proceed with procedure

IV. Do not apply topical anesthetic cream near the eyes or on open wounds

V. Contraindications for use
- A. Allergies to lidocaine or prilocaine
- B. Liver disease
- C. Glucose-6-Phosphate Dehydrogenase deficiency
- D. Idiopathic methemoglobinemia
- E. Non-intact skin
- F. Infants less than three (3) months of age
- G. Procedures requiring heel stick
- H. Mother's diagnosed with HELLP Syndrome

VI. Report the following to the physician
- A. Itching
- B. Erythema
- C. Edema
- D. Urticaria

VII. Patient/Family Education
- A. Pharmacologic and non-pharmacologic pain management options
- B. Importance of leaving site of topical anesthetic cream covered

VIII. Documentation
- A. Administration of topical anesthetic cream
- B. Patient/Family education provided and patient/family response
- C. How patient tolerated procedure

REFERENCES: **Regulatory Agency Standards**
Bowden, V. & Greenburg, C. Pediatric Nursing Procedures
Britt, R. "Using EMLA cream before venipuncture". Nursing 2018
MedlinePlus Medical Encyclopedia. "Glucose-6-Phosphate Dehydrogenase Deficiency". Retrieved from https://medlineplus.gov/ency/article/000528.hym
EMLA Cream 5% Package Leaflet
EMLA retrieved from https://www.drugs.com/pro/emla/html
MedlinePlus Medical Encyclopedia. "Methemoglobinemia" retrieved from https://medlineplus.gov/ency/article/000562.htm

DEFINITIONS:

Topical Anesthetic Cream: provides dermal analgesia by a release of lidocaine and prilocaine from the cream into the dermal and epidermal layers of the skin and by the accumulation of lidocaine and prilocaine in the vicinity of pain receptors and nerve endings.

Glucose-6-Phosphate Dehydrogenase deficiency: deficiency of the enzyme critical for the proper function of red blood cells. Hemolysis can occur when there is a deficiency in this enzyme which can lead to anemia

Idiopathic methemoglobinemia: blood disorder in which an abnormal amount of methemoglobin, a form of hemoglobin, is produced. With methemoglobinemia the hemoglobin can carry oxygen, but is unable to release the oxygen effectively to the tissues

ATTACHMENTS: **Attachment A:** EMLA Cream Maximum Recommended Dose, Application Area and Application Time by Age and Weight

APPROVAL DATE:

	Policy, Procedure and Standards Committee
11/07/2019	**Quality Management Committee** **Applicable Administrator, Hospital or Medical Committee**
11/21/2019	**Medical Executive Committee** **Applicable Administrator, Hospital or Medical Committee**
2/26/2019	**Nursing Standards Committee** **Applicable Administrator, Hospital or Medical Committee**
	Board of Supervisors **Approved by the Governing Body**

REPLACES:

EFFECTIVE: **02/19** **REVISED**: _____ **REVIEWED:** **10/19**

Attachment A

EMLA CREAM RECOMMENDED DOSE, APPLICATION AREA AND APPLICATION TIME BY AGE AND WEIGHT
For Infants and Children Based on Application to Intact Skin

Age and Body Weight Requirements	Maximum Total Dose of EMLA Cream	Maximum Application Area	Maximum Application Time
0 up to 3 months or less than 5 kg	1 gram	10 cm^2	1 hour
3 months up to 12 months and greater than 5 kg	2 grams	20 cm^2	4 hours
1 year to 6 years and greater than 10 kg	10 grams	100 cm^2	4 hours
7 years to 12 years and greater than 20 kg	20 grams	200 cm^2	4 hours

https://www.drugs.com/pro/emla.html

SECTION: **PATIENT CARE**

SUBJECT: **BLOOD PRODUCTS, REFUSAL OF: PREGNANT WOMEN**

APPROVED BY: _____
NURSE MANAGER

POLICY

Pregnant women declining blood and blood products are managed in order to optimize fetal and maternal outcomes.

PROCEDURE

I. Prenatal Care
   A. Practitioners assess patients refusing blood or blood products prenatally to develop a plan of care
      1. Obtain routine laboratory tests, as ordered by the Practitioner
      2. Provide iron, as ordered by the Practitioner
      3. Consider epoetin alpha in patients with a Hemoglobin less than 10 grams per deciliter who are refractory to iron supplementation
      4. Encourage dietary changes to ensure an optimal hematocrit (meat, poultry, and fish)
         a. Vegetarians may need additional iron supplementation
      5. Consider consultations with Maternal-Fetal Medicine, Hematology, and Anesthesiology, as needed
   B. Following a comprehensive assessment by the Practitioner, patients are provided acceptable alternative options using the "Consent/Refusal for Blood and Blood Product Alternatives" form (Attachment A)

II. Intrapartum
   A. On admission obtain the patient's healthcare proxy, complete the "Consent/Refusal for Blood and Blood Product Alternatives" form, and explain the plan of care, including the risk of postpartum hemorrhage/hysterectomy
   B. Obtain routine laboratory tests, as ordered by the Practitioner
   C. Write "No blood" on orange band and place on patient's wrist
   D. Ensure adequate intravenous access
   E. Notify Anesthesiology for consultation
   F. Consider consultation with Maternal-Fetal Medicine and Hematology, if indicated
   G. Place the locked postpartum hemorrhage cart with medication box outside the patients room
      1. Medication box includes Pitocin (oxytocin) and Cytotec (misoprostol)
      2. Postpartum tamponade balloon
   H. Ensure methylergonovine (Methergine), carboprost tromethamine (Hemabate), and tranexamic acid (Lysteda) are readily available at the time of delivery

III. Postpartum
   A. Active management of third stage of labor
   B. Registered nurse remains at bedside for one (1) hour after delivery
   C. Repair perineal damage promptly
   D. Ensure orange "No blood" band is placed on patient's wrist
   E. Place the locked postpartum hemorrhage cart with medication box outside the patient's room

1. Medication box includes oxytocin (Pitocin) and misoprostol (Cytotec).
2. Postpartum tamponade balloon
3. Ensure methylergonovine (Methergine), carboprost tromethamine (Hemabate), and tranexamic acid (Lysteda) are readily available at the time of delivery

IV. Document
   A. The Registered Nurse witnesses the "Consent/Refusal for Blood and Blood Product Alternatives" form
   B. Orange "No blood" band placed on patient refer to AOM policy 110.43
   C. Intravenous placement and laboratory tests drawn
   D. All consultations
   E. All nursing interventions

REFERENCES: Administrative Operations Manual Policy 110.43 "Use of Color-Coded Armbands"

Administrative Operations Manual Policy 900.04 "Patient's Rights – Refusal of Blood"

Center to Advance Palliative Care. (2014). Healthcare Proxy vs. Living Will. Retrieved on January 8, 2018 from https://getpalliativecare.org

CMQCC

Gyamfi, C. & Mirza, F. (2010) Management of pregnancy in the Jehovah's Witness. *Contemporary OB/GYN.*

The Joint Commission

DEFINITIONS: Healthcare Proxy "is a document that appoints someone to make medical decisions for you, if you are in a situation where you can't make them yourself"

ATTACHMENTS: Attachment A: Consent for Blood and Blood Product Alternatives

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
01/05/2018	**Nursing Standards Committee**
02/15/2018	**Pharmacy and Therapeutics** Applicable Administrator, Hospital or Medical Committee
03/20/2018	**Blood Utilization Committee** Applicable Administrator, Hospital or Medical Committee
11/07/2019	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
11/21/2019	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: N/A
EFFECTIVE: **3/22/18** **REVISED:**
REVIEWED: **8/2019**

Attachment A

Consent/Refusal for Blood and Blood Product Alternatives

I hereby consent to receive the blood products and alternatives marked below. I request no other blood derivatives be administered during my current pregnancy, other than the ones that I have designated in this consent. I hereby release the Arrowhead Regional Medical Center, its personnel, my physician(s), and any other person participating in my care from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives. The possible consequences of such refusal on my part have been fully explained to me by my Attending Physician and I fully understand the consequences.

( ) Blood
( ) Fresh Frozen Plasma
( ) Rhogam
( ) Epoetin alfa
( ) Platelets
( ) Cryoprecipitate
( ) Albumin
( ) Isolated Factor Preparations
( ) Nonblood Plasma Expanders
( ) Hemodilution
( ) Cell Saver
( ) None of the Above

_____
Patient's Name (please print)

_____	_____	_____
Patient's Signature	Date	Time
_____	_____	_____
Witness	Date	Time

Por medio de la presente doy mi consentimiento para recibir los productos de sangre y las alternativas marcadas abajo. Solicito que no se administren otros derivados sanguíneos durante mi actual embarazo, aparte de los que he designado en este consentimiento. Por la presente, libero al Arrowhead Regional Medical Center, a su personal, a mi médico(s), y a cualquier otra persona que participe en mi cuidado de cualquier responsabilidad por reacciones desfavorables o resultados adversos debido a mi rechaso de permitir el uso de sangre o sus derivados. Las posibles consecuencias de tal rechazo de mi parte me han sido explicadas completamente por mi médico tratante y entiendo completamente las consecuencias.

- ☐ Sangre
- ☐ Plasma fresco congelado
- ☐ Rhogam
- ☐ Epoetin Alfa
- ☐ Plaquetas
- ☐ Crioprecipitado
- ☐ Albúmina
- ☐ Preparaciónes factoriales aisladas
- ☐ Expansores de plasma no sanguíneo
- ☐ Hemodilución
- ☐ Ahorrador de célula
- ☐ Ninguna de las anteriores

_____	_____	_____	_____
Nombre del Paciente (favor de escriber en letra de imprenta)	Firma del Paciente	Fecha	Hora

_____	_____	_____	_____
Nombre del Testigo (favor de escriber en letra de imprenta	Firma del Testigo	Fecha	Hora

ARROWHEAD REGIONAL MEDICAL CENTER

CONSENTIMIENTO/RECHAZO DE SANGRE Y ALTERNATIVAS DE PRODUCTOS DE SANGRE

DISTRIBUTION: Blanco – Tabla Amarillo – Farmacia Rosa– Banco de Sangre Oro – Paciente

SECTION: **PATIENT CARE**

SUBJECT: **BASSINET TECHNIQUE, INDIVIDUAL**

APPROVED BY: _____
Clinical Director

POLICY

Each infant has an individual bassinet/incubator/warmer/crib with individual supplies.

PROCEDURE

I. The nurse providing care ensures that supplies/linen are restocked for the oncoming shift
II. Infants are moved to a clean incubator every seven (7) days, the incubator is labeled with the change date
III. Bassinets in the Neonatal Intensive Care Unit (NICU) are changed when visibly soiled and/or upon discharge of the patient
IV. Double walled incubator and infant warmer e.g. Giraffe Omnibeds are changed every 14 days and as needed
V. Bassinets, incubators, cribs, and double walled incubator and infant warmers are cleaned between each patient.

REFERENCES: Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2017). Guidelines for Perinatal Care (8th ed).

Title XXII 70547 (b) (24)

The Joint Commission Standards

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

10/21/2019	**Nursing Standards Committee**
11/07/2019	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
11/21/2019	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Applicable Administrator, Hospital or Medical Committee
	Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: **10/2019** **REVISED**: _____

REVIEWED:

ARROWHEAD REGIONAL MEDICAL CENTER
Department of Nursing
MATERNAL-CHILD DEPARTMENT

SECTION: PATIENT CARE

SUBJECT: **Breastfeeding/Breastmilk Use: Mothers/Neonates with Positive Drug Screens**

APPROVED BY: _____
Nurse Manager

POLICY:
Breastfeeding is recognized as the ideal feeding method for infants due to the numerous short and long-term benefits to both mother and infant.

Mothers and/or infants with positive urine drug screens (UDS) are informed of the results by the provider and counseled when planning to breastfeed/breastmilk feed their infant.

PROCEDURE

I. Screening and referral

A. A provider order is obtained for a urine drug screen and a Social Service consult when an expectant mother presents to Labor and Delivery (L&D) with risk factors of substance misuse, history of substance use disorders, positive drug screen during pregnancy, or self-reports substance use or dependence.

B. The Pediatric/Neonatology provider is informed of the mother's substance use history and urine drug screen results to determine further screening needs of the infant

C. A Lactation consult is ordered when a mother-infant dyad presents with the above risk factors and the mother desires to breastfeed/breastmilk feed

II. Patients who have a positive UDS for opiates after receiving narcotics during the current hospitalization may continue to breastfeed as planned. Mother is instructed to observe infant for:

A. Sedation/sleepiness

B. Poor feeding, e.g. less than 8 feedings in a 24-hour period and/or feeding intolerance

C. Less than the recommended wet/soiled diapers per days of life

III. Substances of use and abuse

A. Nicotine (smoking/vaping/patches) use contributes to a lower milk supply and earlier weaning

1. Mother is counseled regarding smoking reduction/cessation and the risks linked to smoking when breastfeeding

a. Instruct mother to avoid smoking immediately before or during breastfeeding/pumping
b. Mothers who smoke are instructed to smoke after breastfeeding/pumping to decrease exposure to the infant
c. Mothers who smoke are advised to smoke outside of the home and wear a cover jacket and hat while smoking
d. Family members who smoke are advised to smoke outside (when possible using a cover jacket) of the home to reduce second and third hand smoke exposure

2. Provide the mother with smoking cessation community resources as needed

3. Provide written instructions regarding smoking cessation and the risks linked to smoking when breastfeeding

B. Alcohol use contributes to lower milk supply, infant slow weight gain, shortened sleep cycles of the infant and decreased motor development.

1. Mother is counseled of the risks associated with alcohol consumption during lactation, including advising mother to avoid more than 1-2 drinks per week (1 drink = 2oz liquor, 8oz of wine, or 2 beers)

2. Mothers are instructed to resume breastfeeding 2 hours after consuming one drink, there is no need to express/pump and discard their breastmilk after consuming only one drink

3. When consuming 2 or more drinks within a 2-hour period, the mother must express/pump and discard her milk.

4. Consuming beer or other alcoholic beverages to do not increase milk supply, rather may contribute to a lower milk volume due to the dehydrating factors of alcohol.

5. Mothers identified with an alcohol misuse/addiction are counseled against breastfeeding, and referred to community resources for treatment and follow up.

6. Provide written instructions regarding alcohol use and breastfeeding

C. Cannabis/Tetrahydrocannabinol(THC) use (inhaled, edibles, topical) may affect neurodevelopmental growth of the infant. Mothers identified as using cannabis are counseled regarding abstinence when planning to breastfeed.

1. A provider order is obtained for a neonatal urine and/or meconium drug screen

2. There is no definite consensus of the time frame required to eliminate THC from the breastmilk. Infants of mothers with positive UDS or infants with a positive UDS/meconium drug screen are instructed to pump and discard their milk until the mother's drug screen is negative.

3. Mothers who plan to breastfeed are counseled regarding building and maintaining a milk supply while waiting until a negative drug screen is obtained. Drug screens are followed by the mother's obstetrics or primary care provider.

4. Provide mothers who plan to breastfeed with a prescription for a double electric breast pump (preferably hospital grade)

5. Collaborate with Social Services for the plan of care/referrals needed for the mother-infant dyad

6. Provide verbal and written instructions regarding establishing and maintaining a milk supply

D. Any form of cocaine and methamphetamine is incompatible with breastfeeding. The mother is counseled regarding the risks of breastfeeding/breastmilk feeding, which may lead up to and including death.

1. Provide verbal and written instructions regarding suppression of lactation

2. Demonstrate hand expression and other comfort measures to reduce engorgement

E. Heroin and opioid misuse/dependence:
1. A provider order is obtained for a neonatal urine and/or meconium drug screen

2. Breastfeeding/breastmilk use is contraindicated for an infant whose mother is not in a treatment program. The mother is counseled regarding the risks of breastfeeding/breastmilk feeding, which include infant lethargy, poor feeding and respiratory depression that may lead up to and including death.

3. Neonates exposed to heroin or other opioids in utero may demonstrate signs of withdrawal and must be assessed on a regular basis, refer to MCH 5216 Drug Withdrawal: Neonatal

4. Collaborate with Social Services for the plan of care/referrals needed for the mother-infant dyad

5. Provide verbal and written instructions regarding:

    a. Suppression of lactation

    b. Demonstrate hand expression and other comfort measures to reduce breast engorgement

F. Mothers with opioid dependence, enrolled in a substance abuse treatment program and receiving Methadone or Buprenorphine are:

1. Encouraged to breastfeed as planned

2. Neonates exposed to heroin or other opioids in utero may demonstrate signs of withdrawal and must be assessed on a regular basis, refer to MCH 5216 Drug Withdrawal: Neonatal

    a. Anticipatory guidance is provided to the mother regarding abrupt breastfeeding cessation and the possibilities of infant withdrawal
    b. Mother is directed to seek primary care physician consultation regarding weaning

3. Counseled to observe their baby and return to their infant's provider for any of the following signs:
    D. Sedation/sleepiness, e.g. unable to wake infant within a 4-hour period
    E. Poor feeding, e.g. less than 8 breastfeedings in a 24-hour period and/or feeding intolerance
    F. Less than the recommended wet/soiled diapers per days of life

4. Collaborates with Social Services for the plan of care/referrals needed for the mother-infant dyad

5. Provide verbal and written instructions regarding breastfeeding while in a treatment program

IV. Provide verbal and written instructions to the mother on the preparation of breastmilk substitutes

V. Documentation includes:

A. UDS results
B. Provider notification
C. Parent education provided

DEFINITIONS: **Alcohol use: 1 drink is equivalent to: 2oz of liquor or 8oz of wine or 2 beers**

REFERENCES:

Academy of Breastfeeding Medicine. ABM Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015; 10:3. DOI: 10.1089/bfm.2015.9992
https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/21-drug-dependency-protocol-english.pdf

American Academy of Pediatrics (2013) The Transfer of Drugs and Therapeutics Into Human Breast Milk: An Update on Selected Topics. DOI:10.1542/peds.2013-1985
https://pediatrics.aappublications.org/content/pediatrics/132/3/e796.full.pdf

Center for Disease Control (2017).
https://www.cdc.gov/marijuana/pdf/marijuana-pregnancy-508.pdf

Hale, Thomas W. (2019). Medications & Mother's Milk. New York, New York: Springer Publishing Company, 2019. ISBN: 9780826135582

https://kellymom.com/bf/can-i-breastfeed/lifestyle/smoking/

https://kellymom.com/bf/can-i-breastfeed/lifestyle/alcohol/

Lawrence, Ruth and Lawrence, Robert. Breastfeeding: A Guide for the Medical Profession, 8th Edition. Philadelphia, PA: Elsevier, Inc. 2016. ISBN: 978-0-323-35776-0

Maternal Child Health Policy 5201 Baby Friendly Hospital Initiative

MothertoBaby.org https://mothertobaby.org/fact-sheets-parent/

ATTACHMENTS:

APPROVAL DATE:

	Policy, Procedure and Standards Committee
10/21/2019	**Nursing Standards Committee** **Applicable Administrator, Hospital or Medical Committee**
11/07/2019	**Quality Management Committee** **Applicable Administrator, Hospital or Medical Committee**
11/21/2019	**Medical Executive Committee** **Applicable Administrator, Hospital or Medical Committee**
	Board of Supervisors **Approved by the Governing Body**

REPLACES:

EFFECTIVE: 10/19 **REVISED:**

REVIEWED:

SECTION: **PATIENT CARE**

SUBJECT: **SURROGATE BIRTH PLAN**

APPROVED BY: _____
Nurse Manager

POLICY

Provide care and establish parental rights of the family with a surrogate birth plan utilizing a multidisciplinary team approach.

PROCEDURE

Labor and Delivery Unit

I. A patient admitted to the Labor and Delivery Unit (L&D) with a surrogate birth plan, is registered and banded according to Administrative Operations Manual Policy No. 610.12 "Patient Identification."

II. A "Judgement of Maternity and Paternity" court order is provided by the patient admitted to L&D with a surrogate birth plan ("Birth Mother") or by the "Legal Parent(s)." From here on out a "Judgement of Maternity and Paternity" court order is referred to as Judgement.

III. Notify Social Services upon patient admission to L&D
   A. Request a Social Service consult per physician order
   B. Page the Social worker on-call
   C. Biopsychosocial assessment is completed within 24 hours of consult order
   D. Social Worker to remain involved through discharge

IV. The original copy of the Judgement with a certified official seal is placed in the Birth Mother's chart and a copy in the newborn's chart. In the case of multiple births, an original certified copy is required for each newborn.

V. The L&D Registered Nurse (RN), discusses the birth plan with the Birth Mother and the Legal Parents. Only the Birth Mother may consent to clinical intervention and management of the pregnancy, labor, and delivery.

VI. If the Judgement is unavailable at the time of birth, Social Services contacts the surrogate agency's legal counsel.

VII. When the Birth Mother presents with a threat of preterm delivery or suspected complications of the newborn, and a Neonatology consult is requested by Obstetrics,

establish communication with the Legal Parent(s). To contact Legal Parent(s) who are abroad – see Attachment A.

VIII. After the delivery, the newborn is registered and banded under the Legal Parent's name, as stated in the Judgement:
A. The four (4) identification band set is placed as follows:
1. Band # 1 – newborn's ankle
2. Band # 2 – newborn's wrist
3. Band # 3 – Legal Parent
4. Band # 4 – Legal Parent
B. If the Legal Parents are not present at the time of delivery, the newborn is banded with the Legal Parent's name
1. Band # 1 – newborn's ankle
2. Band # 2 – newborn's wrist
3. Band # 3 – shredded
4. Band # 4 – shredded
5. Photo identification is requested from the Legal Parent(s) upon arrival and matched to the Judgement of. Once matched, Legal Parent(s) receive identification bands.

IX. If no Judgement is provided by the Birth Mother or the Legal Parents at the time of delivery, the Birth Mother and newborn(s) are registered according to Maternal Child Health Policy No. 5233 "Identification of the Newborn."

Mother – Baby Unit

I. After delivery of the newborn, only the Legal Parent(s) consent to cares/procedures for the newborn.

II. If no Judgement is available, the Birth Mother is asked to consent for treatment of the newborn. However if she declines giving consent, Social Services contacts the surrogate agency's legal counsel.

III. If there is an agreement/contract with the Birth Mother to provide breast milk for the newborn:
A. Using a general consent, obtain a signed consent from the Legal Parent(s) to feed the breastmilk.
B. The Birth Mother is given a breast pump and instructed on pumping, milk collection, storage and transportation. The newborn's identification labels with the newborn's legal name are given to the Birth Mother to label the expressed milk. Maternal Child Health Policy No. 5209.1
C. The Legal Parent(s) are also given instructions regarding storage and transportation of expressed breast milk to the hospital if they plan to bring the milk to the hospital

IV. The *Newborn Screening Test* Form is completed using the Legal Parent(s)'s name, address and pediatrician who assumes care of the newborn.

V. *Birth Certificate*
A. The original certified copy with court seal of the Judgement of Maternity and Paternity is given to the birth clerk to attach to the Certificate of Live Birth. For multiple births, an original certified copy of the Judgement of Maternity and Paternity is attached to each newborn's certificate for submission to the county.

B. The birth certificate is filled out by the Legal Parent(s) according to the Judgement of Maternity and Paternity. Medical information in the birth certificate pertaining to the pregnancy and labor and delivery are of the Birth Mother.

Neonatal Intensive Care Unit

I. After delivery of the newborn, only the Legal Parent(s) give consent to cares/procedures for the newborn.

II. If no Judgement of Maternity and Paternity is available, the Birth Mother is asked to consent for treatment of the newborn. However if she declines giving consent, Social Services contacts the surrogate agency's legal counsel.

III. If there is an agreement/contract with the Birth Mother to provide breast milk for the newborn:
   A. Using a general consent, obtain a signed consent from the Legal Parent(s) to feed the breastmilk.
   B. The Birth Mother is given a breast pump and instructed on pumping, milk collection, storage and transportation. The newborn's identification labels with the newborn's legal name are given to the Birth Mother to label the expressed milk. Maternal Child Health Policy No. 5209.1
   C. The Legal Parent(s) are also given instructions regarding the storage and transportation of expressed breast milk to the hospital

IV. The *Newborn Screening Test* Form is completed using the Legal Parent(s)'s name, address and pediatrician who shall assume care of the newborn

V. Social Services/Case Management obtain medical insurance information from the Legal Parents

VI. Case Management collaborates with the multidisciplinary team and Legal Parent(s) for discharge planning and outpatient referral process

REFERENCES:

Administrative Operations Manual Policy No. 610.12 "Patient Identification"

American College of Obstetricians and Gynecologists. (2016). Family building through gestational surrogacy. Committee Bulletin No. 660

Maternal Child Health Policy No. 5233 "Identification of the Newborn"

Maternal Child Health Policy No. 5209.1 "Breastmilk Collection, Storage and Usage"

The Joint Commission

DEFINITIONS:

Surrogate Pregnancy - involves a women known as a gestational carrier who agrees to bear a genetically unrelated child with the help of assisted reproductive technologies for an individual or couple who intend to be the legal and rearing parents

Birth Mother - the woman who gives birth to a child, regardless of whether she is the genetic mother or subsequently brings up the child

Legal Parents - Person(s) identified in a Judgement of Maternity and Paternity as the legal parent(s) with all parental rights, or legal guardians

Judgement of Maternity and Paternity - a court order signed by a Superior Court Judge with an official court seal that specifies the intended/legal parent(s) of an infant born, or to be born via surrogate

ATTACHMENTS: **Using LSA Service with non-LSA Phone**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
12/07/2018	**Nursing Standards Committee** **Applicable Administrator, Hospital or Medical Committee**
11/07/2019	**Quality Management Committee** **Applicable Administrator, Hospital or Medical Committee**
11/21/2019	**Medical Executive Committee** **Applicable Administrator, Hospital or Medical Committee**
	Board of Supervisors **Approved by the Governing Body**

REPLACES:

EFFECTIVE: 10/18 **REVISED**:

REVIEWED: 08/19

ATTACHMENT A

Using LSA Services with non-LSA Phone

Definition: Language Service Associates (LSA)
Goal: Coordinating long distance conference calls with legal parents who are abroad or out of state when there is an expected premature birth or neonatal complications requiring intensive care.

1. Identify need to contact legal parents abroad or out of state
2. Notify social services to contact surrogate agency to ensure legal parents call to call the designated unit(s) to provide them with appropriate information.
3. Utilize a phone that has conference call capabilities.
4. Have the patient's medical record number ready (LSA will ask for it)
5. When the legal parents have called the hospital explain what they can expect. Let them know they will be placed on a brief hold while all disciplines are added to the call (let the parents know this will take a few minutes):
    a. press conference, call LSA: 1-855-350-7840, enter code 8001234 when prompted
    b. select the desired language
    c. provide the patient medical record number when requested
    d. attain LSA interpreter ID number (you will need to document this on the patient EMR)
    e. merge the call by pressing the connect or conference button on your phone (option will vary depending on the phone being used)
    f. Verify you have both parties on the line
    g. Once verified, press conference button again. Dial physician's phone number.
    h. Let the physician know all intended parties are on the line before connecting call
    i. Merge the call by pressing connect or conference button on your phone
    j. Verify you have all 3 parties on the line.
    k. Continue the above process as many times necessary to get all intended personnel on the same line
    l. Stay on the phone until the conference call has been completed
    m. Thank all participants involved
6. Document in the note section: names of participants, LSA interpreter ID number (name not required), and information and plan of care discussed during the call under the note section. Make sure to link your note so it remains in EMR